2019

2018

2017

2016

2015

2014

2013

2012

2011

2010

MHI Form 10-Q for the Period Ended September 30, 2019

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended September 30, 2019
OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100	
Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.001 Par Value	MOH	New York Stock Exchange

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer Accelerated Filer Non-Accelerated Filer Smaller reporting company

Emerging growth company

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes No

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as ofOctober 25, 2019, was approximately 62,700,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED SEPTEMBER 30, 2019

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CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In millions, except per-share amounts) (Unaudited)			
Revenue:				
Premium revenue	$ 4,084	$ 4,337	$ 12,085	$ 13,174
Premium tax revenue	119	110	367	320
Health insurer fees reimbursed	—	83	—	248
Service revenue	—	130	—	391
Investment income and other revenue	40	37	103	93
Total revenue	4,243	4,697	12,555	14,226
Operating expenses:				
Medical care costs	3,523	3,790	10,360	11,362
General and administrative expenses	323	311	953	998
Premium tax expenses	119	110	367	320
Health insurer fees	—	87	—	261
Depreciation and amortization	21	25	68	76
Restructuring costs	—	5	5	38
Cost of service revenue	—	111	—	349
Total operating expenses	3,986	4,439	11,753	13,404
Gain on sale of subsidiary	—	37	—	37
Operating income	257	295	802	859
Other expenses, net:				
Interest expense	22	26	67	91
Other expenses (income), net	2	10	(15)	25
Total other expenses, net	24	36	52	116
Income before income tax expense	233	259	750	743
Income tax expense	58	62	181	237
Net income	$ 175	$ 197	$ 569	$ 506
Net income per share:				
Basic	$ 2.81	$ 3.22	$ 9.15	$ 8.32
Diluted	$ 2.75	$ 2.90	$ 8.80	$ 7.60

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In millions) (Unaudited)			
Net income	$ 175	$ 197	$ 569	$ 506
Other comprehensive income (loss):				
Unrealized investment income (loss)	—	1	17	(5)
Less: effect of income taxes	—	—	4	(1)
Other comprehensive income (loss), net of tax	—	1	13	(4)
Comprehensive income	$ 175	$ 198	$ 582	$ 502

See accompanying notes.

CONSOLIDATED BALANCE SHEETS

	September 30, 2019	December 31, 2018
	(Dollars in millions, except per-share amounts)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,679	$ 2,826
Investments	1,757	1,681
Receivables	1,280	1,330
Prepaid expenses and other current assets	140	149
Derivative asset	21	476
Total current assets	5,877	6,462
Property, equipment, and capitalized software, net	379	241
Goodwill and intangible assets, net	176	190
Restricted investments	79	120
Deferred income taxes	82	117
Other assets	108	24
	$ 6,701	$ 7,154
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,975	$ 1,961
Amounts due government agencies	612	967
Accounts payable and accrued liabilities	478	390
Deferred revenue	207	211
Current portion of long-term debt	15	241
Derivative liability	21	476
Total current liabilities	3,308	4,246
Long-term debt	1,239	1,020
Finance lease liabilities	233	197
Other long-term liabilities	90	44
Total liabilities	4,870	5,507
Stockholders' equity:		
Common stock, $0.001 par value, 150 million shares authorized; outstanding: 63 million shares at September 30, 2019, and 62 million shares at December 31, 2018	—	—
Preferred stock, $0.001 par value; 20 million shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	160	643
Accumulated other comprehensive income (loss)	5	(8)
Retained earnings	1,666	1,012
Total stockholders' equity	1,831	1,647
	$ 6,701	$ 7,154

See accompanying notes.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Total
	Outstanding	Amount				
			(In millions)			
			(Unaudited)			
Balance at December 31, 2018	62	$ —	$ 643	$ (8)	$ 1,012	$ 1,647
Net income	—	—	—	—	198	198
Adoption of new accounting standard	—	—	—	—	85	85
Partial termination of 1.125% Warrants	—	—	(103)	—	—	(103)
Other comprehensive income, net	—	—	—	5	—	5
Share-based compensation	1	—	3	—	—	3
Balance at March 31, 2019	63	—	543	(3)	1,295	1,835
Net income	—	—	—	—	196	196
Partial termination of 1.125% Warrants	—	—	(321)	—	—	(321)
Other comprehensive income, net	—	—	—	8	—	8
Share-based compensation	—	—	18	—	—	18
Balance at June 30, 2019	63	—	240	5	1,491	1,736
Net income	—	—	—	—	175	175
Partial termination of 1.125% Warrants	—	—	(90)	—	—	(90)
Share-based compensation	—	—	10	—	—	10
Balance at September 30, 2019	63	$ —	$ 160	$ 5	$ 1,666	$ 1,831

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
			(In millions)			
			(Unaudited)			
Balance at December 31, 2017	60	$ —	$ 1,044	$ (5)	$ 298	$ 1,337
Net income	—	—	—	—	107	107
Adoption of new accounting standards	—	—	—	(1)	7	6
Exchange of 1.625% Convertible Notes	2	—	108	—	—	108
Other comprehensive loss, net	—	—	—	(6)	—	(6)
Share-based compensation	—	—	1	—	—	1
Balance at March 31, 2018	62	—	1,153	(12)	412	1,553
Net income	—	—	—	—	202	202
Partial termination of 1.125% Warrants	—	—	(113)	—	—	(113)
Other comprehensive income, net	—	—	—	1	—	1
Share-based compensation	—	—	15	—	—	15
Balance at June 30, 2018	62	—	1,055	(11)	614	1,658
Net income	—	—	—	—	197	197
Partial termination of 1.125% Warrants	—	—	(306)	—	—	(306)
Conversion of 1.625% Convertible Notes	—	—	4	—	—	4
Other comprehensive income, net	—	—	—	1	—	1
Share-based compensation	—	—	7	—	—	7
Balance at September 30, 2018	62	$ —	$ 760	$ (10)	$ 811	$ 1,561

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2019	2018
	(In millions) (Unaudited)	
Operating activities:		
Net income	$ 569	$ 506
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	68	104
Deferred income taxes	7	(32)
Share-based compensation	29	20
Amortization of convertible senior notes and finance lease liabilities	5	18
(Gain) loss on debt extinguishment	(15)	25
Non-cash restructuring costs	—	17
Gain on sale of subsidiary	—	(37)
Other, net	(5)	6
Changes in operating assets and liabilities:		
Receivables	50	(507)
Prepaid expenses and other current assets	(6)	(117)
Medical claims and benefits payable	14	(144)
Amounts due government agencies	(355)	(511)
Accounts payable and accrued liabilities	37	398
Deferred revenue	(4)	(55)
Income taxes	4	118
Net cash provided by (used in) operating activities	398	(191)
Investing activities:		
Purchases of investments	(1,938)	(1,202)
Proceeds from sales and maturities of investments	1,890	2,070
Purchases of property, equipment and capitalized software	(30)	(24)
Other, net	(2)	(23)
Net cash (used in) provided by investing activities	(80)	821
Financing activities:		
Repayment of principal amount of 1.125% Convertible Notes	(240)	(236)
Cash paid for partial settlement of 1.125% Conversion Option	(578)	(477)
Cash received for partial termination of 1.125% Call Option	578	477
Cash paid for partial termination of 1.125% Warrants	(514)	(419)
Proceeds from borrowings under Term Loan Facility	220	—
Repayment of Credit Facility	—	(300)
Repayment of 1.625% Convertible Notes	—	(64)
Other, net	24	7
Net cash used in financing activities	(510)	(1,012)
Net decrease in cash, cash equivalents, and restricted cash and cash equivalents	(192)	(382)
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	2,926	3,290
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 2,734	$ 2,908

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Nine Months Ended September 30,	
	2019	2018
	(In millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (7)	$ (6)
Details of sale of subsidiary:		
Decrease in carrying amount of assets	$ —	$ (243)
Decrease in carrying amount of liabilities	—	59
Transaction costs	—	(12)
Receivable from buyer - recorded in prepaid expenses and other current assets	—	233
Gain on sale of subsidiary	$ —	$ 37
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 124	$ 321
Loss on 1.125% Conversion Option	(124)	(321)
Change in fair value of derivatives, net	$ —	$ —
1.625% Convertible Notes exchange transaction:		
Common stock issued in exchange for 1.625% Convertible Notes	$ —	$ 131
Component allocated to additional paid-in capital, net of income taxes	—	(23)
Net increase to additional paid-in capital	$ —	$ 108

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

September 30, 2019

1. Organization and Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides managed healthcare services under the Medicaid and Medicare programs and through the state insurance marketplaces (the "Marketplace"). We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. The Other segment includes the historical results of the Medicaid management information systems ("MMIS") and behavioral health subsidiaries we sold in late 2018, as well as certain corporate amounts not allocated to the Health Plans segment.

The Health Plans segment consists of health plans operating in 14 states and the Commonwealth of Puerto Rico. As of September 30, 2019, these health plans served approximately 3.3 million members eligible for Medicaid, Medicare, and other government-sponsored healthcare programs for low-income families and individuals including Marketplace members, most of whom receive government subsidies for premiums. The health plans are generally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization ("HMO").

Our health plans' state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal ("RFPs") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Subsequent Events

Texas Health Plan. On October 29, 2019, the Texas Health and Human Services Commission (HHSC) notified our Texas health plan, Molina Healthcare of Texas, Inc., that HHSC intends to award contracts to Molina Healthcare of Texas, Inc. for the STAR+PLUS program in the Hidalgo and North East service areas. The awards will be for an initial contract term of 3 years, and anticipated to have an operational effective date of September 1, 2020. STAR+PLUS is a Texas Medicaid Managed Care program integrating the delivery of Acute Care services and Long-Term Services and Supports (LTSS) for people who are age 65 or older, blind, or disabled. Currently, our Texas health plan services the Bexar, Dallas, El Paso, Harris, Hidalgo, and Jefferson service areas, with total membership of approximately 86,000 enrollees. Under the existing STAR+PLUS contract, the premium revenue for this program amounted to approximately $1.2 billion for the nine months ended September 30, 2019.

New York Health Plan. On October 10, 2019, we entered into a definitive agreement to acquire certain assets of YourCare Health Plan, Inc. Upon the closing of this transaction, expected to occur in early 2020, we will serve approximately 46,000 Medicaid members in seven counties in Western New York. The purchase price of approximately $40 million will be funded with available cash, and the closing is subject to customary closing conditions.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., and its subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the nine months ended September 30, 2019 , are not necessarily indicative of the results for the entire year ending December 31, 2019.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2018. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in our December 31, 2018, audited consolidated financial statements have been omitted.

These unaudited consolidated interim financial statements should be read in conjunction with our audited consolidated financial statements for the fiscal year ended December 31, 2018.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable of our Health Plans segment;
- Health plans' contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plans' quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Settlements under risk or savings sharing programs;
- The assessment of long-lived and intangible assets, and goodwill for impairment;
- The determination of reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for litigation outcomes;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in non-current "Restricted investments" in the accompanying consolidated balance sheets.

	September 30,	
	2019	2018
	(In millions)	
Cash and cash equivalents	$ 2,679	$ 2,814
Restricted cash and cash equivalents	55	94
Total cash, cash equivalents, and restricted cash and cash equivalents presented in the statements of cash flows	$ 2,734	$ 2,908

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive healthcare services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid Program

Medical Cost Floors (Minimums), and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded liabilities under the terms of such contract provisions of $95 million and $103 million at September 30, 2019 and December 31, 2018, respectively. Approximately $78 million and $87 million of the liabilities accrued at September 30, 2019 and December 31, 2018, respectively, relate to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at September 30, 2019 and December 31, 2018.

Profit Sharing and Profit Ceiling. Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at September 30, 2019 and December 31, 2018.

Retroactive Premium Adjustments. State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, based on our best estimate of the ultimate premium we expect to realize for the period being adjusted.

Medicare Program

Risk Adjusted Premiums. Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and Centers for Medicare and Medicaid Services ("CMS") practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjusted premiums and Medicare Part D settlements were insignificant at September 30, 2019 and December 31, 2018.

Minimum MLR. The Affordable Care Act ("ACA") has established a minimum annual medical loss ratio ("Minimum MLR") of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. The amounts payable for the Medicare Minimum MLR were not significant at September 30, 2019 and December 31, 2018.

Marketplace Program

Risk Adjustment. Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score (risk adjustment payable), and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score (risk adjustment receivable). We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. As of September 30, 2019, Marketplace risk adjustment payables amounted to $285 million and related receivables amounted to $76 million, for a net payable of $209 million. As of December 31, 2018, Marketplace risk adjustment payables amounted to $466 million and related receivables amounted to $34 million, for a net payable of $432 million.

Minimum MLR. The ACA has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. Aggregate balance sheet amounts related to the Minimum MLR were insignificant at September 30, 2019 and December 31, 2018.

A summary of the categories of amounts due government agencies follows:

	September 30, 2019	December 31, 2018
	(In millions)	
Medicaid program:		
Medical cost floors and corridors	$ 95	$ 103
Other amounts due to states	69	81
Marketplace program:		
Risk adjustment	285	466
Cost sharing reduction ("CSR")	—	183
Other	163	134
Total amounts due government agencies	$ 612	$ 967

Quality Incentives

At many of our health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned only if certain performance measures are met. Such performance measures are generally found in our Medicaid and MMP contracts. As described in Note 1, "Organization and Basis of Presentation–*Use of Estimates*," recognition of quality incentive premium revenue is subject to the use of estimates.

We believe that the adjustments to prior years noted below are generally indicative of the potential future changes in our estimates as of September 30, 2019. The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In millions)			
Maximum available quality incentive premium - current period	$ 47	$ 48	$ 138	$ 135
Quality incentive premium revenue recognized in current period:				
Earned current period	$ 46	$ 39	$ 109	$ 97
Earned prior periods	5	9	35	32
Total	$ 51	$ 48	$ 144	129
Quality incentive premium revenue recognized as a percentage of total premium revenue	1.2%	1.1%	1.2%	1.0%

Medical Care Costs

Marketplace Program

In the nine months ended September 30, 2018, we recognized a benefit of approximately $81 million in reduced medical care costs related to 2017 dates of service, including $5 million in the third quarter of 2018, as a result of the federal government's confirmation that the reconciliation of 2017 Marketplace CSR subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Leases

Right-of-use ("ROU") assets represent our right to use the underlying assets over the lease term, and lease liabilities represent our obligation for lease payments arising from the related leases. ROU assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. Lease terms may include options to extend or terminate the lease when we believe it is reasonably certain that we will exercise such options. If applicable, we account for lease and non-lease components within a lease as a single lease component.

Because most of our leases do not provide an implicit interest rate, we generally use our incremental borrowing rate to determine the present value of lease payments. Lease expenses for operating lease payments are recognized on a straight-line basis over the lease term, and the related ROU assets and liabilities are reduced to the present value of the remaining lease payments at the end of each period. Finance lease payments reduce finance lease liabilities, the related ROU assets are amortized on a straight-line basis over the lease term, and interest expense is recognized using the effective interest method.

The significant majority of our operating leases consist of long-term operating leases for office space. Short-term leases (those with terms of 12 months or less) are not recorded as ROU assets or liabilities in the consolidated balance sheets. For certain leases that represent a portfolio of similar assets, such as a fleet of vehicles, we apply a portfolio approach to account for the related operating lease ROU assets and liabilities, rather than account for such assets and the related liabilities individually. A nominal number of our lease agreements include rental payments that adjust periodically for inflation. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

For further information, including the amount and location of the ROU assets and lease liabilities recognized in the accompanying consolidated balance sheet, see Note 13, “Leases.” For further information regarding our adoption and implementation of Accounting Standards Update (“ASU”) 2016-02, *Leases (Topic 842),* see *Recent Accounting Pronouncements Adopted,* below.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years, or 10 years average life for structured securities. Restricted investments are invested principally in cash, cash equivalents, and U.S. Treasury securities. Concentration of credit risk with respect to accounts receivable is generally limited because our payors consist principally of the federal government, and governments of each state or commonwealth in which our health plan subsidiaries operate.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of foreign and state taxes, nondeductible expenses such as the Health Insurer Fee (“HIF”), certain compensation, and other general and administrative expenses. The effective tax rate will not be impacted by HIF in 2019 given the 2019 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including projected pretax earnings, the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Recent Accounting Pronouncements Adopted

Leases. In February 2016, the Financial Accounting Standards Board (“FASB”) issued Topic 842, which was subsequently modified by several ASUs issued in 2017 and 2018. Topic 842 was issued to increase transparency and comparability among organizations by requiring the recognition of ROU assets and lease liabilities on the balance sheet. Most prominent among the changes in Topic 842 is the recognition of ROU assets and lease liabilities by lessees for those leases classified as operating leases. In addition, Topic 842’s disclosures are required to meet the objective of enabling users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases. Topic 842’s transition provisions are applied using a modified retrospective approach; entities may elect whether to apply the transition provisions, including disclosure requirements, at the beginning of the earliest comparative period presented or on the adoption date.

We adopted Topic 842 effective January 1, 2019, and elected to apply the transition provisions as of that date. Accordingly, we recognized the cumulative effect of initially applying the standard as an adjustment to the opening balance of retained earnings on January 1, 2019. In addition, we elected the available practical expedients and implemented internal controls and key system functionality to enable the preparation of financial information on adoption.

As indicated in the accompanying consolidated statements of stockholders’ equity, the cumulative effect adjustment was an increase of $85 million to retained earnings, relating primarily to the transition provisions for sale-leaseback arrangements that did not qualify for sale treatment. Accordingly, such arrangements for certain office buildings were de-recognized and recorded as finance lease ROU assets and lease liabilities. The difference between the de-recognized assets and lease financing obligations resulted in an increase to retained earnings. The recognition of these arrangements as finance lease ROU assets and lease liabilities will not materially impact our consolidated results of operations over the terms of the leases.

Software Licenses. In August 2018, the FASB issued ASU 2018-15, *Customer’s Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract,* which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. We early adopted ASU 2018-15 effective January 1, 2019, using the prospective method, with no material impact to our financial condition,

results of operations or cash flows. Adoption of this guidance may be significant to us in the future depending on the extent to which we use cloud computing arrangements that qualify as service contracts.

Recent Accounting Pronouncements Not Yet Adopted

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, as modified by:

- ASU 2018-19, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses* ;
- ASU 2019-04, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments*; and
- ASU 2019-05, Financial Instruments - *Credit Losses (Topic 326), Targeted Transition Relief* .

This standard introduces a new current expected credit loss ("CECL") model for measuring expected credit losses for certain types of financial instruments and replaces the incurred loss model. The CECL model requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount companies expect to collect over the instrument's contractual life after consideration of historical experience, current conditions, and reasonable and supportable forecasts. This standard also introduces targeted changes to the available-for-sale ("AFS") debt securities impairment model. ASU 2016-13 is effective beginning January 1, 2020, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted.

The most significant type of financial instrument reported in our consolidated balance sheets, subject to the CECL model, is Receivables. As of September 30, 2019, over 70%, or approximately $970 million of the Receivables balance constitutes receivables from state and federal government agencies. Based on our preliminary analysis, we believe that the credit risk associated with such receivables is nominal due to a very low risk of default.

The AFS debt securities impairment model will apply to "Investments" reported in our consolidated balance sheets. We believe that the credit risk associated with our non-government issued Investments is nominal due to the high quality of such investments.

We are currently evaluating the processes and controls necessary to adopt and implement ASU 2016-13, along with the effects the adoption will have on our consolidated results of operations and financial condition.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission ("SEC") did not have, nor does management expect such pronouncements to have, a significant impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of net income per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In millions, except net income per share)			
Numerator:				
Net income	$ 175	$ 197	$ 569	$ 506
Denominator:				
Shares outstanding at the beginning of the period	62.2	61.3	62.1	59.3
Weighted-average number of shares issued:				
Exchange of 1.625% Convertible Notes	—	—	—	1.3
Stock-based compensation	—	—	0.1	0.2
Denominator for net income per share, basic	62.2	61.3	62.2	60.8
Effect of dilutive securities:				
1.125% Warrants (1)	0.8	5.6	1.8	5.0
1.625% Convertible Notes	—	0.6	—	0.5
Stock-based compensation	0.6	0.4	0.6	0.3
Denominator for net income per share, diluted	63.6	67.9	64.6	66.6
Net income per share: (2)				
Basic	$ 2.81	$ 3.22	$ 9.15	$ 8.32
Diluted	$ 2.75	$ 2.90	$ 8.80	$ 7.60

(1) For more information and definitions regarding the 1.125% Warrants, including partial termination transactions, refer to Note 9, “Stockholders' Equity.” The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method.

(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to the three-tier fair value hierarchy. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 4, “Fair Value Measurements,” in our 2018 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability (see Note 8 “Derivatives,” for definitions and further information). These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of September 30, 2019, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. The 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such derivative instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the nine months ended September 30, 2019.

Our financial instruments measured at fair value on a recurring basis at September 30, 2019, were as follows:

	Total	Observable Inputs (Level 1)	Directly or Indirectly Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,129	$ —	$ 1,129	$ —
Mortgage-backed securities	303	—	303	—
Asset-backed securities	110	—	110	—
Government-sponsored enterprise securities ("GSEs")	97	—	97	—
Municipal securities	68	—	68	—
U.S. Treasury notes	40	—	40	—
Foreign securities	7	—	7	—
Certificates of deposit	3	—	3	—
Subtotal - current investments	1,757	—	1,757	—
1.125% Call Option derivative asset	21	—	—	21
Total assets	$ 1,778	$ —	$ 1,757	$ 21
1.125% Conversion Option derivative liability	$ 21	$ —	$ —	$ 21
Total liabilities	$ 21	$ —	$ —	$ 21

Our financial instruments measured at fair value on a recurring basis at December 31, 2018, were as follows:

	Total	Observable Inputs (Level 1)	Directly or Indirectly Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,123	$ —	$ 1,123	$ —
Asset-backed securities	82	—	82	—
GSEs	163	—	163	—
Municipal securities	114	—	114	—
U.S. Treasury notes	181	—	181	—
Foreign securities	4	—	4	—
Certificates of deposit	14	—	14	—
Subtotal	1,681	—	1,681	—
1.125% Call Option derivative asset	476	—	—	476
Total assets	$ 2,157	$ —	$ 1,681	$ 476
1.125% Conversion Option derivative liability	$ 476	$ —	$ —	$ 476
Total liabilities	$ 476	$ —	$ —	$ 476

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our notes payable are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the Term Loan Facility is classified as a Level 3 financial instrument, because certain inputs used to determine its fair value are not observable. As of September 30, 2019, the carrying amount of the Term Loan Facility approximated fair value because its interest rate is a variable rate that approximates rates currently available to us.

	September 30, 2019		December 31, 2018	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	(In millions)			
5.375% Notes	$ 695	$ 744	$ 694	$ 674
4.875% Notes	327	334	326	301
Term Loan Facility	220	220	—	—
1.125% Convertible Notes [1],[2]	12	34	240	732
Totals	$ 1,254	$ 1,332	$ 1,260	$ 1,707

(1) The fair value of the 1.125% Conversion Option (the embedded cash conversion option), which is reflected in the fair value amounts presented above, amounted to $21 million and $476 million as of September 30, 2019, and December 31, 2018, respectively. See further discussion at Note7, “Debt,” and Note 8, “Derivatives.”

(2) For more information on debt repayments in 2019, refer to Note7, “Debt.”

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets to be available-for-sale. The following tables summarize our investments as of the dates indicated:

	September 30, 2019			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,125	$ 5	$ 1	$ 1,129
Mortgage-backed securities	302	1	—	303
Asset-backed securities	109	1	—	110
GSEs	97	—	—	97
Municipal securities	68	—	—	68
U.S. Treasury notes	40	—	—	40
Foreign securities	7	—	—	7
Certificates of deposit	3	—	—	3
Totals	$ 1,751	$ 7	$ 1	$ 1,757

	December 31, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,131	$ —	$ 8	$ 1,123
Asset-backed securities	83	—	1	82
GSEs	164	—	1	163
Municipal securities	115	—	1	114
U.S. Treasury notes	181	—	—	181
Foreign securities	4	—	—	4
Certificates of deposit	14	—	—	14
Totals	$ 1,692	$ —	$ 11	$ 1,681

The contractual maturities of our available-for-sale investments as of September 30, 2019 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 498	$ 498
Due after one year through five years	875	878
Due after five years through ten years	107	108
Due after ten years	271	273
Totals	$ 1,751	$ 1,757

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains amounted to $11 million in the third quarter of 2019 and nine months ended September 30, 2019. Gross realized investment losses were insignificant in the third quarter of 2019 and nine months ended September 30, 2019. Gross realized investment gains and losses were insignificant in the third quarter of 2018 and nine months ended September 30, 2018.

We have determined that unrealized losses at September 30, 2019, and December 31, 2018, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of September 30, 2019:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 151	$ 1	90	$ —	$ —	—
Totals	$ 151	$ 1	90	$ —	$ —	—

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2018:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 509	$ 3	285	$ 412	$ 5	298
Asset-backed securities	—	—	—	68	1	52
GSEs	—	—	—	127	1	76
Municipal securities	—	—	—	87	1	90
Totals	$ 509	$ 3	285	$ 694	$ 8	516

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in cash, cash equivalents, and U.S. Treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current "Restricted investments" in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

Our held-to-maturity restricted investments are carried at amortized cost, which approximates fair value. Such investments amounted to $79 million at September 30, 2019, and mature in one year or less.

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated.

	September 30, 2019	December 31, 2018
	(In millions)	
Fee-for-service claims incurred but not paid ("IBNP")	$ 1,424	$ 1,562
Pharmacy payable	128	115
Capitation payable	57	52
Other	366	232
	$ 1,975	$ 1,961

"Other" medical claims and benefits payable includes non-risk provider payables, where we act as an intermediary on behalf of various government agencies, for certain providers, without assuming financial risk. Such receipts from government agencies and payments to providers do not impact our consolidated statements of income. Non-risk provider payables amounted to $239 million and $107 million as of September 30, 2019, and December 31, 2018, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amounts by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability, based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30,	
	2019	2018
	(In millions)	
Medical claims and benefits payable, beginning balance	$ 1,961	$ 2,192
Components of medical care costs related to:		
Current period	10,613	11,670
Prior periods [1]	(253)	(308)
Total medical care costs	10,360	11,362
Change in non-risk and other provider payables	131	60
Payments for medical care costs related to:		
Current period	8,996	9,866
Prior periods	1,481	1,706
Total paid	10,477	11,572
Medical claims and benefits payable, ending balance	$ 1,975	$ 2,042

(1) The September 30, 2018, amount includes the 2018 benefit of the 2017 Marketplace CSR reimbursement of $81 million.

Our estimates of medical claims and benefits payable recorded at December 31, 2018, and 2017 developed favorably by approximately $253 million and $308 million as of September 30, 2019, and 2018, respectively.

The favorable prior year development recognized in the nine months ended September 30, 2019, was primarily due to lower than expected utilization of medical services by our Medicaid members, and improved operating performance. Consequently, the ultimate costs recognized in 2019, as claims payments were processed, were lower than our original estimates in 2018.

7. Debt

As of September 30, 2019, contractual maturities of debt were as follows. All amounts represent the principal amounts due on the debt instruments outstanding as of December 31 for each year presented, based on September 30, 2019 balances.

	Total	2020	2021	2022	2023	2024	Thereafter
	(In millions)						
5.375% Notes	$ 700	$ —	$ —	$ 700	$ —	$ —	$ —
4.875% Notes	330	—	—	—	—	—	330
Term Loan Facility	220	6	16	22	22	154	—
1.125% Convertible Notes	12	12	—	—	—	—	—
Totals	$ 1,262	$ 18	$ 16	$ 722	$ 22	$ 154	$ 330

All of our debt is held at the parent, which is reported, for segment purposes, in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets:

	September 30, 2019	December 31, 2018
	(In millions)	
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 12	$ 241
Term Loan Facility	3	—
Lease financing obligations	—	1
Debt issuance costs	—	(1)
	$ 15	$ 241
Non-current portion of long-term debt:		
5.375% Notes	$ 700	$ 700
4.875% Notes	330	330
Term Loan Facility	217	—
Debt issuance costs	(8)	(10)
Totals	$ 1,239	$ 1,020

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In millions)			
Contractual interest at coupon rate	$ —	$ 1	$ 1	$ 5
Amortization of the discount	1	5	5	18
Totals	$ 1	$ 6	$ 6	$ 23

Credit Agreement

We are party to a Credit Agreement, which provides for an unsecured delayed draw term loan facility (the "Term Loan Facility"), and an unsecured $500 million revolving credit facility (the "Credit Facility"). Borrowings under our Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Agreement, we are required to pay a quarterly commitment fee.

The Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of September 30, 2019, we were in compliance with all financial and non-financial covenants under the Credit Agreement and other long-term debt. Effective as of the date of the Sixth Amendment to the Credit Agreement described below, there are no guarantors as parties to the Credit Agreement.

Term Loan Facility. In January 2019, we entered into a Sixth Amendment to the Credit Agreement that provided for a delayed draw Term Loan Facility in the aggregate principal amount of $600 million, under which we may request up to ten advances, each in a minimum principal amount of $50 million, until July 31, 2020. The Term Loan Facility will amortize in quarterly installments, commencing on September 30, 2020, equal to the principal amount of the Term Loan Facility outstanding multiplied by rates ranging from 1.25% to 2.50% (depending on the applicable fiscal quarter) for each fiscal quarter. The Term Loan Facility expires on January 31, 2024; any remaining outstanding balance under the Term Loan Facility will be due and payable on that date. As of September 30, 2019, $220 million was outstanding under the Term Loan Facility. Each advance under the Term Loan Facility results in a permanent reduction to its borrowing capacity; therefore, our borrowing capacity under the Term Loan Facility as of September 30, 2019, was $380 million.

Credit Facility. The Credit Facility expires on January 31, 2022; therefore, any amounts outstanding under the Credit Facility will be due and payable on that date. As of September 30, 2019, no amounts were outstanding under the Credit Facility, and outstanding letters of credit amounting to $2 million reduced our borrowing capacity under the Credit Facility to $498 million.

5.375% Notes due 2022

We had $700 million aggregate principal amount of senior notes (the "5.375% Notes") outstanding as of September 30, 2019, which are due November 15, 2022, unless earlier redeemed. Interest, at a rate of 5.375% per annum, is payable semiannually in arrears on May 15 and November 15. The 5.375% Notes contain customary non-financial covenants and change in control provisions.

4.875% Notes due 2025

We had $330 million aggregate principal amount of senior notes (the "4.875% Notes") outstanding as of September 30, 2019, which are due June 15, 2025, unless earlier redeemed. Interest, at a rate of 4.875% per annum, is payable semiannually in arrears on June 15 and December 15. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

1.125% Cash Convertible Senior Notes due 2020

In the nine months ended September 30, 2019 , we received conversion requests and we entered into privately negotiated note purchase agreements with certain holders of our outstanding 1.125% cash convertible senior notes due January 15, 2020 (the " 1.125% Convertible Notes").

In the third quarter of 2019, we paid $161 million to settle $55 million aggregate principal amount, or $54 million aggregate carrying amount, of the 1.125% Convertible Notes, including the related 1.125% Convertible Notes' embedded cash conversion option (which is a derivative liability we refer to as the "1.125% Conversion Option") and the mark to market valuation adjustments discussed below.

In the nine months ended September 30, 2019 , we paid $794 million to settle $240 million aggregate principal amount, or $232 million aggregate carrying amount, of the 1.125% Convertible Notes, including the related 1.125% Conversion Option and the mark to market valuation adjustments discussed below.

In the three and nine months ended September 30, 2019 , we recorded a loss on debt extinguishment of $2 million, and a gain on debt extinguishment of approximately $15 million, respectively, for the 1.125% Convertible Notes repayments (net of accelerated original issuance discount amortization), primarily relating to mark to market valuations on the partial terminations of the Call Spread Overlay executed in connection with the related debt repayments. These amounts are reported in "Other expenses (income), net" in the accompanying consolidated statements of income. No common shares were issued in connection with the transaction.

In connection with the 1.125% Convertible Notes purchases, we also entered into privately negotiated agreements in the first, second, and third quarters of 2019, to partially terminate the Call Spread Overlay, defined and further discussed in Note 8, "Derivatives," and Note 9, "Stockholders' Equity." The net cash proceeds from the Call Spread Overlay partial termination transactions partially offset the cash paid to settle the 1.125% Convertible Notes.

Following the transactions described above, $12 million aggregate principal amount of the 1.125% Convertible Notes were outstanding at September 30, 2019. Interest at a rate of 1.125% per annum is payable semiannually in arrears on January 15 and July 15. The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date. The 1.125% Convertible Notes mature on January 15, 2020; therefore, they are reported in current portion of long-term debt.

Concurrent with the issuance of the 1.125% Convertible Notes in 2013, the 1.125% Conversion Option was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option fully settles or expires. This initial liability simultaneously reduced the carrying value of the 1.125% Convertible Notes' principal amount (effectively an original issuance discount), which is amortized to the principal amount through the recognition of non-cash interest expense over the expected life of the debt. The effective interest rate of 6% approximates the interest rate we would have incurred had we issued nonconvertible debt with otherwise similar terms. As of September 30, 2019, the 1.125% Convertible Notes had a remaining amortization period of less than one year, and their 'if-converted' value exceeded their principal amount by approximately $28 million and $581 million as of September 30, 2019 and December 31, 2018, respectively.

Cross-Default Provisions

The indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	September 30, 2019	December 31, 2018
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 21	$ 476
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 21	$ 476

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in “Other expenses (income), net.” Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, “Supplemental cash flow information.”

1.125% Convertible Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

In the nine months ended September 30, 2019 , in connection with the 1.125% Convertible Notes purchases (described in Note 7, “Debt”), we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased.

In the third quarter of 2019, we received $105 million for the settlement of the 1.125% Call Option (which is a derivative asset), and paid $90 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $15 million from the Counterparties.

In the nine months ended September 30, 2019 , we received $578 million for the settlement of the 1.125% Call Option (which is a derivative asset), and paid $514 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $64 million from the Counterparties.

1.125% Call Option

The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, “Fair Value Measurements.”

1.125% Conversion Option

The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, “Fair Value Measurements.”

As of September 30, 2019, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes mature on January 15, 2020, as described in Note 7, “Debt.”

9. Stockholders' Equity

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, “Derivatives,” in 2013, we issued 13.5 million warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, if the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Following the transactions described below, 0.3 million of the 1.125% Warrants remain outstanding.

As described in Note 8, “Derivatives,” in the nine months ended September 30, 2019, we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased.

In the third quarter of 2019, we paid $90 million to the Counterparties for the termination of 1.4 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in-capital for the same amount.

In the nine months ended September 30, 2019, we paid $514 million to the Counterparties for the termination of 5.9 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in-capital for the same amount.

Share-Based Compensation

In connection with our employee stock plans, approximately 184,000 shares of common stock vested or were purchased, net of shares used to settle employees’ income tax obligations, during the nine months ended September 30, 2019.

Share-based compensation is recorded to “General and administrative expenses” in the accompanying consolidated statements of income. Total share-based compensation expense amounted to $10 million and $7 million, respectively, in the three months ended September 30, 2019 and 2018. Total share-based compensation expense amounted to $29 million and $20 million, respectively, in the nine months ended September 30, 2019 and 2018.

Equity Incentive Plan

In the second quarter of 2019, our stockholders approved the Molina Healthcare, Inc. 2019 Equity Incentive Plan (the “2019 EIP”). The 2019 EIP provides for awards, in the form of restricted stock awards, performance units, stock options, and other stock– or cash–based awards, to eligible persons who perform services for us. The 2019 EIP will remain in effect until its termination by the board of directors; provided, however, that all awards will be granted no later than May 8, 2029. Concurrent with the adoption of the 2019 EIP, the Molina Healthcare, Inc. 2011 Equity Incentive Plan was amended, restated and merged into the 2019 EIP. A maximum of 2.9 million shares of our common stock may be issued under the 2019 EIP.

As of September 30, 2019, there was $55 million of total unrecognized compensation expense related to unvested restricted stock awards (“RSAs”), and performance stock units (“PSUs”), which we expect to recognize over remaining weighted-average periods of 2.5 years and 1.8 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 16.2% for non-executive employees as of September 30, 2019.

Also as of September 30, 2019, there was $5 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.0 year. No stock options were granted or exercised in the nine months ended September 30, 2019.

Activity for RSAs, performance stock awards ("PSAs") and PSUs is summarized below:

	RSAs	PSAs	PSUs	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2018	399,795	3,132	201,383	604,310	$ 71.50
Granted	228,902	—	141,828	370,730	137.53
Vested	(133,828)	(3,132)	(10,528)	(147,488)	72.21
Forfeited	(46,780)	—	(11,616)	(58,396)	87.99
Unvested balance, September 30, 2019	448,089	—	321,067	769,156	$ 101.93

The aggregate fair values of RSAs, PSUs and PSAs granted and vested are presented in the following table:

	Nine Months Ended September 30,	
	2019	2018
	(In millions)	
Granted:		
RSAs	$ 32	$ 26
PSUs	19	16
Total granted	$ 51	$ 42
Vested:		
RSAs	$ 18	$ 14
PSUs	2	—
PSAs	—	3
Total vested	$ 20	$ 17

Employee Stock Purchase Plan

In May 2019, our stockholders approved the Molina Healthcare, Inc. 2019 Employee Stock Purchase Plan (the "2019 ESPP"), which superseded the Molina Healthcare, Inc. 2011 Employee Stock Purchase Plan (the "2011 ESPP"). A maximum of 3.0 million shares of our common stock may be issued under the 2019 ESPP, the terms of which are substantially similar to the 2011 ESPP. The 2019 ESPP will continue until the earliest of: termination of the 2019 ESPP by the board of directors (which may occur at any time); issuance of all of the shares reserved for issuance under the 2019 ESPP; or May 9, 2029.

10. Restructuring Costs

Restructuring costs are reported by the same name in the accompanying consolidated statements of income.

IT Restructuring Plan

Management is focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we began a plan to restructure our information technology department (the "IT Restructuring Plan") in 2018, which is reported in the Other segment. In early 2019, we entered into services agreements with an outsourcing vendor who manages certain of our information technology services.

We expect the IT Restructuring Plan to be substantially completed by the end of 2019. We estimate that we will incur approximately $15 million of cumulative total costs, which is lower than the $20 million reported in our Annual Report on Form 10-K for the year ended December 31, 2018, because more of our IT employees transitioned to our outsourcing vendor than originally contemplated. Once employed by our outsourcing vendor, such employees are no longer included in the IT Restructuring Plan, resulting in lower one-time termination costs.

As of December 31, 2018, there was $6 million accrued under the IT Restructuring Plan, primarily for one-time termination benefits that require cash settlement. In the nine months ended September 30, 2019 , we incurred $2 million of other restructuring costs, paid $5 million to settle one-time termination benefits, and paid $3 million to settle other restructuring costs. As of September 30, 2019, no amounts were accrued under the IT Restructuring Plan.

As of September 30, 2019, we had incurred cumulative restructuring costs under the IT Restructuring Plan of $11 million, including $7 million of one-time termination benefits and $4 million of other restructuring costs (primarily consulting fees).

2017 Restructuring Plan

As of December 31, 2018, accrued liabilities of $18 million remained for the restructuring and profitability improvement plan approved by the board of directors in June 2017 (the "2017 Restructuring Plan"). In the nine months ended September 30, 2019 , we incurred $3 million of restructuring costs for adjustments to previously recorded lease contract termination costs, and paid $7 million to settle one-time termination and lease contract termination costs. As of September 30, 2019, accrued liabilities of $14 million remained for lease contract termination costs under the 2017 Restructuring Plan. We expect to continue to settle these liabilities through 2025, unless the leases are terminated sooner.

11. Segments

We currently have two reportable segments: our Health Plans segment and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Margin for our Health Plans segment is referred to as "Medical Margin," which represents the amount earned after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the segments. Therefore, the underlying Medical Margin is the most important measure of earnings reviewed by the chief operating decision maker.

The following table presents total revenue by segment. Inter-segment revenue was insignificant for all periods presented.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In millions)			
Total revenue:				
Health Plans	$ 4,239	$ 4,565	$ 12,546	$ 13,826
Other	4	132	9	400
Consolidated	$ 4,243	$ 4,697	$ 12,555	$ 14,226

The following table reconciles margin by segment to consolidated income before income taxes:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(In millions)			
Margin:				
Health Plans	$ 561	$ 547	$ 1,725	$ 1,812
Other	—	19	—	42
Total margin	561	566	1,725	1,854
Add: other operating revenues (1)	159	230	470	661
Add: gain on sale of subsidiary	—	37	—	37
Less: other operating expenses (2)	(463)	(538)	(1,393)	(1,693)
Operating income	257	295	802	859
Other expenses, net	24	36	52	116
Income before income tax expense	$ 233	$ 259	$ 750	$ 743

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, and investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, and restructuring costs.

12. Commitments and Contingencies

Legal Proceedings

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously collected revenues.

In the ordinary course of business we are involved in legal actions, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and reasonably estimable, but the outcome of legal actions is inherently uncertain and our estimates of such losses could change as a result of further developments of these matters. For certain pending matters, accruals have not been established because such matters have not progressed sufficiently through discovery or factual development to enable us to reasonably estimate a range of possible loss. An adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and Children's Health Insurance Program ("CHIP") programs. The states and Commonwealth in which we operate our health plans regularly face significant budgetary pressures.

13. Leases

As discussed in Note 2, "Significant Accounting Policies," we elected the Topic 842 transition provision that allows entities to continue to apply the legacy guidance in Topic 840, *Leases*, including its disclosure requirements, in the comparative periods presented in the year of adoption. Accordingly, the Topic 842 disclosures below are presented as of and for the three-month and nine-month periods ended September 30, 2019, only.

We are a party to operating and finance leases primarily for our corporate and health plan offices. Our operating leases have remaining lease terms up to 10 years, some of which include options to extend the leases for up to 10 years. As of September 30, 2019, the weighted average remaining operating lease term is 4 years.

Our finance leases have remaining lease terms of 2 years to 19 years, some of which include options to extend the leases for up to 25 years. As of September 30, 2019, the weighted average remaining finance lease term is 16 years.

As of September 30, 2019, the weighted-average discount rate used to compute the present value of lease payments was 5.6% for operating lease liabilities, and 6.5% for finance lease liabilities. The components of lease expense were as follows:

	Three Months Ended September 30, 2019	Nine Months Ended September 30, 2019
	(In millions)	
Operating lease expense	$ 9	$ 26
Finance lease expense:		
Amortization of right-of-use ("ROU") assets	$ 4	$ 12
Interest on lease liabilities	3	11
Total finance lease expense	$ 7	$ 23

Supplemental consolidated cash flow information related to leases follows:

	Nine Months Ended September 30, 2019
	(In millions)
Cash used in operating activities:	
Operating leases	$ 28
Finance leases	12
Cash used in financing activities:	
Finance leases	4
ROU assets recognized in exchange for lease obligations:	
Operating leases	95
Finance leases	245

Supplemental information related to leases, including location of amounts reported in the accompanying consolidated balance sheets, follows:

	September 30, 2019
	(In millions)
Operating leases:	
ROU assets	
Other assets	$ 69
Lease liabilities	
Accounts payable and accrued liabilities (current)	$ 28
Other long-term liabilities (non-current)	49
Total operating lease liabilities	$ 77
Finance leases:	
ROU assets	
Property, equipment, and capitalized software, net	$ 233
Lease liabilities	
Accounts payable and accrued liabilities (current)	$ 8
Finance lease liabilities (non-current)	233
Total finance lease liabilities	$ 241

Maturities of lease liabilities as of September 30, 2019, were as follows:

	Operating Leases	Finance Leases
	(In millions)	
2019 (for the three months ended December 31, 2019)	$ 9	$ 6
2020	28	23
2021	18	23
2022	12	22
2023	10	21
Thereafter	8	311
Total lease payments	85	406
Less imputed interest	(8)	(165)
Totals	$ 77	$ 241

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS ("MD&A")

FORWARD-LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements included in this quarterly report, other than statements of historical fact, may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, or expected. Those known risks and uncertainties include, but are not limited to, risks and uncertainties related to the following:

- *the numerous political, judicial, and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including the ultimate outcome on appeal of the Texas et al. v. U.S. et al. matter;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk adjustment requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment;*
- *effective management of our medical costs;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of our efforts to retain existing or awarded government contracts, and the success of any requests for proposal protest filings or defenses, including the pending Texas STAR+PLUS and STAR/CHIP RFPs;*
- *the ability to manage our operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion medical cost corridor, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*

- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of our health plan in Puerto Rico, including the resolution of the debt crisis and the effect of the PROMESA law, the effects of political and regulatory instability, and the impact of any future significant weather events;*
- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *our ability to consummate, integrate, and realize benefits from acquisitions;*
- *complications, member confusion, eligibility re-determinations, or enrollment backlogs related to the renewal of Medicaid coverage, as well as the chilling effect of the new so-called public charge rule;*
- *government audits, reviews, comment letters, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to our provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings, including litigation involving the ACA to which we are not a direct party;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of our California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *the failure to comply with the financial or other covenants in our credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of funds on hand to pay the amounts due upon conversion or maturity of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care industry;*
- *increases in government surcharges, taxes, and assessments;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm;*
- *the unexpected loss of the leadership of one or more of our senior executives; and*
- *increasing competition and consolidation in the Medicaid industry.*

Readers should refer to the section entitled “Risk Factors” in our Annual Report on Form 10-K for the year ended December 31, 2018, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This Quarterly Report on Form 10-Q and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management’s Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2018.

OVERVIEW

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed healthcare services under the Medicaid and Medicare programs, and through the state insurance marketplaces (the "Marketplace"). Through our locally operated health plans in 14 states and the Commonwealth of Puerto Rico, we served approximately 3.3 million members as of September 30, 2019. The health plans are generally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization ("HMO").

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. The Other segment includes the historical results of the Medicaid management information systems ("MMIS") and behavioral health subsidiaries we sold in late 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Beginning in 2019, we no longer report service revenue or cost of service revenue as a result of the sales of the MMIS and behavioral health subsidiaries noted above.

THIRD QUARTER 2019 HIGHLIGHTS

In summary, we produced pretax earnings of $233 million, and net income of $175 million in the third quarter of 2019, resulting in an after-tax margin of 4.1%. On a year-to-date basis, pretax earnings were $750 million and net income was $569 million, resulting in an after-tax margin of 4.5%. These results include, on a consolidated and year-to-date basis, a medical care ratio ("MCR") of 85.7% and a general and administrative ("G&A") expense ratio of 7.6%.

Program Performance

We have a broad and well diversified business portfolio, and all of our lines of business and our local health plans are continuing to perform well for the third quarter and nine months year to date.

In the Medicaid business, our MCR for the third quarter was sequentially flat at approximately 88.1%. These results were in line with our expectations and performance in this business continued to be stable, as we have achieved an 88.2% MCR for the first nine months of the year.

Our Medicare business, comprising our Medicare Special Needs Plans and MMP products, continued to perform well in the third quarter and was also in line with our expectation. The 85.6% MCR in the third quarter was fairly stable compared to 85.2% MCR in the second quarter of this year. We achieved an 85.2% MCR for the first nine months of the year, as we continue to manage high-acuity members by providing access to high-quality healthcare at a reasonable cost, including our management of long term services and supports, or LTSS, benefits which are embedded in our MMP product. Additionally, we continue to see the results of our quality and risk adjustment efforts, as our Medicare risk scores are becoming more commensurate with the acuity of this population and risk adjustment revenue has increased.

Our Marketplace business has also continued to perform well and the results are in line with seasonal expectations, as we reported a 71.2% MCR for the third quarter compared to 67.2% MCR in the second quarter of this year. For the first nine months of the year, the Marketplace MCR was 66.7%, and the attractive margin profile of this business will allow us to be more competitive on premium rates, increase value added benefits, and offer more competitive commissions in 2020, so we can grow membership - albeit at a lower, but still attractive and more sustainable margin.

G&A Expenses

Our G&A expense ratio increased 60 basis points to 7.6% in the nine months ended September 30, 2019 , from 7.0% for the same period in 2018, due mainly to the year-over-year decline in total revenues.

Balance Sheet and Capital Management

We continue to improve our balance sheet, as we repaid an additional $55 million aggregate principal amount of our 1.125% Convertible Notes in the third quarter, for a total of $240 million year to date. The impact of capital deployment actions in the quarter resulted in lower interest expense, a slight loss on repayment of the convertible notes, and a lower share count.

FINANCIAL SUMMARY

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
	(Dollars in millions, except per-share amounts)			
Premium revenue	$ 4,084	$ 4,337	$ 12,085	$ 13,174
Premium tax revenue	119	110	367	320
Health insurer fees reimbursed	—	83	—	248
Investment income and other revenue	40	37	103	93
Medical care costs	3,523	3,790	10,360	11,362
General and administrative expenses	323	311	953	998
Premium tax expenses	119	110	367	320
Health insurer fees	—	87	—	261
Restructuring costs	—	5	5	38
Gain on sale of subsidiary	—	37	—	37
Operating income	257	295	802	859
Interest expense	22	26	67	91
Other expenses (income), net	2	10	(15)	25
Income before income tax expense	233	259	750	743
Income tax expense	58	62	181	237
Net income	175	197	569	506
Net income per diluted share	$ 2.75	$ 2.90	$ 8.80	$ 7.60
Operating Statistics:				
Ending total membership	3,346,000	3,999,000	3,346,000	3,999,000
MCR [1]	86.3%	87.4%	85.7%	86.2%
G&A ratio [2]	7.6%	6.6%	7.6%	7.0%
Premium tax ratio [1]	2.8%	2.5%	2.9%	2.4%
Effective income tax rate	24.7%	24.0%	24.1%	31.9%
After-tax margin [2]	4.1%	4.2%	4.5%	3.6%

(1) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) G&A ratio represents general and administrative expenses as a percentage of total revenue. After-tax margin represents net income as a percentage of total revenue.

CONSOLIDATED RESULTS

NET INCOME AND OPERATING INCOME

Net income in the third quarter of 2019 amounted to $175 million, or $2.75 per diluted share, compared with $197 million, or $2.90 per diluted share, in the third quarter of 2018. Operating income of $257 million in the third quarter of 2019, was lower compared with $295 million in the third quarter of 2018, mainly resulting from the year-over-year decline in premium revenue. Additionally, results for the third quarter of 2018 included the recognition of a $37 million gain on the sale of subsidiary.

Net income in the nine months ended September 30, 2019 , amounted to $569 million, or $8.80 per diluted share, compared with $506 million, or $7.60 per diluted share, in the nine months ended September 30, 2018 . Operating income amounted to $802 million in the nine months ended September 30, 2019, compared with $859 million in the nine months ended September 30, 2018 .

In the third quarter and nine months ended September 30, 2019 , net income per diluted share was favorably impacted by the reduction of the dilutive impact of the 1.125% Warrants, as a result of the 1.125% Warrants partial termination transactions that settled between September 2018 and September 2019. See further discussion in Notes to Consolidated Financial Statements, Note 9, “Stockholders' Equity.”

PREMIUM REVENUE

Premium revenue decreased $253 million in the third quarter of 2019, when compared with the third quarter of 2018. Member months declined 18%, partially offset by a per-member per-month (“PMPM”) revenue increase of 12%. Premium revenue decreased $1,089 million in the nine months ended September 30, 2019, when compared with the nine months ended September 30, 2018 . Member months declined 18%, partially offset by a PMPM revenue increase of 10%. The premium revenue decline in both periods was primarily in the Medicaid and Marketplace programs.

The decline in Medicaid premium revenue was driven primarily by the loss in membership due to the previously announced loss of the New Mexico Medicaid contract, along with the resizing of the Florida Medicaid contract as reported throughout 2018. This was partially offset by Medicaid premium rate increases, and the impact of a $57 million reduction in premium revenue recognized in the third quarter of 2018, relating to a retroactive California Medicaid Expansion risk corridor for the state’s 2017 fiscal year.

The decline in Marketplace premium revenue was primarily due to declining membership, which also drove a relatively smaller benefit from prior year Marketplace risk adjustment in 2019 compared with 2018, partially offset by premium rate increases.

MEDICAL CARE RATIO

The consolidated MCR decreased to 86.3% in the third quarter of 2019, from 87.4% in the third quarter of 2018. The consolidated MCR in the third quarter of 2018 would have been 86.4% excluding the retroactive California Medicaid Expansion risk corridor adjustment and a slight benefit from the Marketplace cost sharing (“CSR”) reimbursement related to 2017 dates of service. Prior period reserve development in the quarter was negligible.

The consolidated MCR decreased to 85.7% in the nine months ended September 30, 2019 , from 86.2% in the nine months ended September 30, 2018. The consolidated MCR in the nine months ended September 30, 2018, would have been 86.5%, excluding the retroactive California Medicaid Expansion risk corridor adjustment and the $81 million benefit from the Marketplace CSR reimbursement related to 2017 dates of service.

The improvement in both periods was due to a decrease in the Medicaid and Medicare MCRs, partially offset by an increase in the Marketplace MCR.

PREMIUM TAX REVENUE AND EXPENSES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.8% in the third quarter of 2019, compared with 2.5% in the third quarter of 2018; and 2.9% compared with 2.4% for the nine months ended September 30, 2019 and 2018, respectively. The increase is mainly attributed to the state of Michigan’s implementation of an insurance provider assessment in 2019, and the state of Illinois’ implementation of a managed care organization provider assessment in the third quarter of 2019.

INVESTMENT INCOME AND OTHER REVENUE

Investment income and other revenue increased to $40 million in the third quarter of 2019, compared with $37 million in the third quarter of 2018, and increased to $103 million in the nine months ended September 30, 2019 , compared with $93 million in the nine months ended September 30, 2018, mainly due to gains realized on the sale of certain investments in the third quarter of 2019, and improved annualized portfolio yields overall in 2019.

G&A EXPENSES

The G&A expense ratio increased to 7.6% in the third quarter of 2019, from 6.6% in the third quarter of 2018, and increased to 7.6% in the nine months ended September 30, 2019, compared with 7.0% in the nine months ended September 30, 2018 . These increases were due mainly to the year-over-year decline in total revenues.

HEALTH INSURER FEES

There are no health insurer fees ("HIF") expensed or reimbursed in 2019 due to the moratorium under Public Law No. 115-120. In the third quarter of 2018 and the nine months ended September 30, 2018 , the HIF amounted to $87 million and $261 million, respectively, and HIF reimbursements amounted to $83 million and $248 million, respectively.

RESTRUCTURING COSTS

We incurred restructuring costs of $5 million in the nine months ended September 30, 2019 , mainly due to true-ups of lease terminations recorded in our 2017 Restructuring Plan. In the third quarter of 2018 and the nine months ended September 30, 2018 , we incurred restructuring costs of $5 million and $38 million, respectively, related to our 2017 Restructuring Plan.

INTEREST EXPENSE

Interest expense declined to $22 million in the third quarter of 2019, from $26 million in the third quarter of 2018, and declined to $67 million in the nine months ended September 30, 2019 , from $91 million in the nine months ended September 30, 2018 . As further described below in "Liquidity," we reduced the principal amount outstanding of our 1.125% Convertible Notes by $240 million in the nine months ended September 30, 2019 , and reduced total debt by $759 million in the year ended December 31, 2018. The decrease in interest expense in 2019 was partially offset by interest expense attributable to $220 million borrowed under our Term Loan Facility in the nine months ended September 30, 2019 .

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $1 million and $5 million in the third quarter of 2019, and 2018, respectively, and $5 million and $18 million in the nine months ended September 30, 2019 and 2018, respectively. The decline in 2019 is due to repayment of our convertible senior notes throughout 2018 and in the nine months ended September 30, 2019 . See further discussion in Notes to Consolidated Financial Statements, Note 7, "Debt."

OTHER EXPENSES (INCOME), NET

In the third quarter of 2019 and the nine months ended September 30, 2019 , we recognized a loss on debt repayment of $2 million, and a gain on debt repayment of $15 million, respectively. In the third quarter of 2018 and the nine months ended September 30, 2018 , we recognized losses on debt repayment of $10 million and $25 million, respectively, in connection with convertible senior notes repayment transactions. The net gain year to date in 2019 was due to a favorable mark to market valuation on the partial termination of the Call Spread Overlay executed in connection with the related debt repayment. See further discussion in Notes to Consolidated Financial Statements, Note 7, "Debt."

INCOME TAXES

The provision for income taxes was recorded at an effective rate of 24.7% in the third quarter of 2019, compared with 24.0% in the third quarter of 2018, and 24.1% in the nine months ended September 30, 2019 , compared with 31.9% in the nine months ended September 30, 2018 . The effective tax rate was higher in 2018 due to higher non-deductible expenses in 2018, primarily related to the non-deductible HIF. The HIF is not applicable in 2019 due to the moratorium under Public Law No. 115-120.

SUMMARY OF NON-RUN RATE ITEMS

The table below summarizes the impact of certain expenses and other items that management believes are not indicative of longer-term business trends and operations. The individual items presented below increase (decrease) income before income tax expense.

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2019		2018		2019		2018	
	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]
	(In millions except per diluted share amounts)							
(Loss) gain on debt repayment	$ (2)	$ (0.03)	$ (10)	$ (0.12)	$ 15	$ 0.18	$ (25)	$ (0.33)
Restructuring costs	—	—	(5)	(0.06)	(5)	(0.06)	(38)	(0.45)
Gain on sale of subsidiary	—	—	37	0.42	—	—	37	0.43
	$ (2)	$ (0.03)	$ 22	0.24	$ 10	$ 0.12	$ (26)	$ (0.35)

(1) Except for permanent differences between GAAP and tax (such as certain expenses that are not deductible for tax purposes), per diluted share amounts are generally calculated at the statutory income tax rate of 22.6% and 22% for 2019 and 2018, respectively.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums. Our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our Health Plans segment is the MCR, which represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Margin for our Health Plans segment is referred to as “Medical Margin.” Medical Margin amounted to $561 million in the third quarter of 2019, and $547 million in the third quarter of 2018. Medical Margin amounted to $1,725 million in the nine months ended September 30, 2019, and $1,812 million in the nine months ended September 30, 2018. Management’s discussion and analysis of the changes in the individual components of Medical Margin follows.

See Notes to Consolidated Financial Statements, Note 11, “Segments,” for more information on our reportable segments.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 14 states and the Commonwealth of Puerto Rico. As of September 30, 2019, these health plans served approximately 3.3 million members eligible for Medicaid, Medicare, and other government-sponsored healthcare programs for low-income families and individuals, including Marketplace members, most of whom receive government premium subsidies.

TRENDS AND UNCERTAINTIES

Decline in Membership and Premium Revenue

Medicaid Program

Our Medicaid contracts in New Mexico and in all but two regions in Florida terminated in late 2018 and early 2019. As a result, our Medicaid membership has decreased to approximately 96,000 members in Florida as of September 30, 2019, from 468,000 members in Florida and New Mexico, in the aggregate, as of December 31, 2018. In 2019, we continue to serve Medicare and Marketplace members in both Florida and New Mexico, as well as Medicaid members in two regions in Florida.

In addition, our Medicaid membership has declined further in Puerto Rico as a result of the entry of more managed care organizations to that market late last year. We served approximately 186,000 members in Puerto Rico as of September 30, 2019, compared with 252,000 members as of December 31, 2018.

Our Medicaid premium revenues have decreased 9% in the nine months ended September 30, 2019, when compared with the nine months ended September 30, 2018, primarily as a result of the changes described above. We expect our Medicaid premium revenues to continue to decline in 2019 compared with 2018.

Marketplace Program

We estimate that our 2019 Marketplace end-of-year enrollment will decrease to approximately 270,000 members due to expected attrition. This projected enrollment is lower than the 289,000 and 362,000 members enrolled as of September 30, 2019, and December 31, 2018, respectively. Consequently, we expect our Marketplace premium revenues to continue to decrease in 2019 compared with 2018.

Status of Upcoming Contract Re-Procurements

Medicaid Program

Texas Health Plan. On October 29, 2019, the Texas Health and Human Services Commission (HHSC) notified our Texas health plan, Molina Healthcare of Texas, Inc., that HHSC intends to award contracts to Molina Healthcare of Texas, Inc. for the STAR+PLUS program in the Hidalgo and North East service areas. The awards will be for an initial contract term of 3 years, and anticipated to have an operational effective date of September 1, 2020. STAR+PLUS is a Texas Medicaid Managed Care program integrating the delivery of Acute Care services and Long-Term Services and Supports (LTSS) for people who are age 65 or older, blind, or disabled. Currently, our Texas health plan services the Bexar, Dallas, El Paso, Harris, Hidalgo, and Jefferson service areas, with total membership of approximately 86,000 enrollees. Under the existing STAR+PLUS contract, the premium revenue for this program amounted to approximately $1.2 billion for the nine months ended September 30, 2019. We are seeking to understand the basis for HHSC's selection of intended contract awards. We do not expect this matter to affect our earnings during fiscal year 2019.

Our Texas health plan has submitted a request for proposal ("RFP") response with regard to the STAR/CHIP program. We currently expect the STAR/CHIP award to be announced in the fourth quarter of 2019. The STAR/CHIP program is currently expected to have an operational effective date of December 1, 2020. As of September 30, 2019, our Texas health plan served 116,000 members under the existing STAR/CHIP contracts, under which we estimate annualized premium revenues of approximately $310 million in 2019.

Ohio Health Plan. We have received information that the state of Ohio expects to release its Medicaid contract RFP early in 2020, with an announcement of the awards expected in the third quarter of 2020, and an operational effective date of January 1, 2021.

California Health Plan. We have received information that the state of California expects to release its Medicaid contract RFP in 2020, with new contracts effective in 2023.

Losses of any of our Texas, Ohio, or California Medicaid contracts could have a material adverse effect on our business, financial condition, cash flows, and results of operations.

MMP Program

Our California, Illinois and Ohio MMP contracts have been extended, with one-year renewal terms, through December 31, 2022. These contracts represent aggregate annualized revenues of approximately $910 million in 2019.

Our Michigan, South Carolina and Texas MMP contracts are active through December 31, 2020. In October 2019, the Michigan Medicaid agency submitted a three-year extension request to CMS.

Pressures on Medicaid Funding

Due to states' budget challenges and political agendas at both the state and federal levels, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal or state spending on the Medicaid program, constitute a fundamental change to the federal role in healthcare and, if enacted, could have a material adverse effect on our business, financial condition, cash flows and results of operations. These proposals include elements such as the following, as well as numerous other potential changes and reforms:

- Changes in the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the

future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis;
- Requiring Medicaid beneficiaries to work; and
- Limiting the amount of lifetime benefits for Medicaid beneficiaries.

ACA

In December 2018, in a case brought by the state of Texas and nineteen other states, a federal judge in Texas held that the ACA's individual mandate is unconstitutional. He further held that the individual mandate is inseverable from the entire body of the ACA, and thus the entire ACA is unconstitutional. The District Court stayed its order pending appeal, and the decision has now been appealed to and argued before a three judge panel of the Fifth Circuit Court of Appeals. A decision of that court is expected in the fourth quarter of 2019, after which the case may be further appealed to the United States Supreme Court. Any final, non-appealable determination that the ACA is unconstitutional would have a material adverse effect on our business, financial condition, cash flows, and results of operations.

MEMBERSHIP

The following tables set forth our Health Plans membership as of the dates indicated:

	September 30, 2019	December 31, 2018	September 30, 2018
Ending Membership by Program:			
TANF and CHIP	1,993,000	2,295,000	2,436,000
Medicaid Expansion	598,000	660,000	664,000
ABD	364,000	406,000	415,000
Total Medicaid	2,955,000	3,361,000	3,515,000
MMP – Integrated [1]	58,000	54,000	55,000
Medicare Special Needs Plans ("Medicare")	44,000	44,000	45,000
Total Medicare	102,000	98,000	100,000
Total Medicaid and Medicare	3,057,000	3,459,000	3,615,000
Marketplace	289,000	362,000	384,000
	3,346,000	3,821,000	3,999,000
Ending Membership by Health Plan:			
California	580,000	608,000	623,000
Florida [2]	136,000	313,000	395,000
Illinois	224,000	224,000	223,000
Michigan	361,000	383,000	394,000
New Mexico [2]	24,000	222,000	234,000
Ohio	292,000	302,000	315,000
Puerto Rico	186,000	252,000	320,000
South Carolina	134,000	120,000	117,000
Texas	350,000	423,000	436,000
Washington	818,000	781,000	770,000
Other [3]	241,000	193,000	172,000
	3,346,000	3,821,000	3,999,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) Our Medicaid contracts in New Mexico and in all but two regions in Florida terminated in late 2018 and early 2019. During 2019, we continue to serve Medicare and Marketplace members in both Florida and New Mexico, as well as Medicaid members in two regions in Florida.
(3) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

THREE AND NINE MONTHS ENDED SEPTEMBER 30, 2019, COMPARED WITH THREE AND NINE MONTHS ENDED SEPTEMBER 30, 2018

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, MCR and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended September 30, 2019						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	6.0	$ 1,225	$ 202.46	$ 1,071	$ 176.88	87.4%	$ 154
Medicaid Expansion	1.8	696	385.63	622	345.25	89.5	74
ABD	1.1	1,247	1,136.67	1,097	1,000.56	88.0	150
Total Medicaid	8.9	3,168	353.81	2,790	311.70	88.1	378
MMP	0.2	399	2,328.70	345	2,010.50	86.3	54
Medicare	0.1	160	1,230.01	134	1,029.75	83.7	26
Total Medicare	0.3	559	1,854.96	479	1,587.61	85.6	80
Total Medicaid and Medicare	9.2	3,727	402.76	3,269	353.31	87.7	458
Marketplace	0.9	357	410.23	254	292.21	71.2	103
	10.1	$ 4,084	$ 403.40	$ 3,523	$ 348.06	86.3%	$ 561

	Three Months Ended September 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.4	$ 1,379	$ 187.03	$ 1,228	$ 166.41	89.0%	$ 151
Medicaid Expansion	2.0	671	333.11	640	317.62	95.3	31
ABD	1.2	1,322	1,054.92	1,186	946.38	89.7	136
Total Medicaid	10.6	3,372	316.86	3,054	286.86	90.5	318
MMP	0.2	353	2,159.72	323	1,981.45	91.7	30
Medicare	0.1	156	1,157.71	121	895.25	77.3	35
Total Medicare	0.3	509	1,706.95	444	1,490.63	87.3	65
Total Medicaid and Medicare	10.9	3,881	354.70	3,498	319.63	90.1	383
Marketplace	1.2	456	394.02	292	252.61	64.1	164
	12.1	$ 4,337	$ 358.46	$ 3,790	$ 313.23	87.4%	$ 547

	Nine Months Ended September 30, 2019						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	18.3	$ 3,594	$ 196.01	$ 3,141	$ 171.30	87.4%	$ 453
Medicaid Expansion	5.4	2,055	380.08	1,810	334.85	88.1	245
ABD	3.3	3,590	1,097.94	3,200	978.64	89.1	390
Total Medicaid	27.0	9,239	342.03	8,151	301.77	88.2	1,088
MMP	0.5	1,193	2,368.38	1,034	2,051.90	86.6	159
Medicare	0.4	489	1,270.32	399	1,037.24	81.7	90
Total Medicare	0.9	1,682	1,892.63	1,433	1,612.29	85.2	249
Total Medicaid and Medicare	27.9	10,921	391.44	9,584	343.53	87.8	1,337
Marketplace	2.8	1,164	414.17	776	276.28	66.7	388
	30.7	$ 12,085	$ 393.52	$ 10,360	$ 337.37	85.7%	$ 1,725

	Nine Months Ended September 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	22.3	$ 4,145	$ 186.12	$ 3,705	$ 166.35	89.4%	$ 440
Medicaid Expansion	6.1	2,184	359.37	1,957	322.01	89.6	227
ABD	3.7	3,864	1,034.25	3,550	950.11	91.9	314
Total Medicaid	32.1	10,193	317.70	9,212	287.10	90.4	981
MMP	0.5	1,077	2,173.90	941	1,899.26	87.4	136
Medicare	0.4	470	1,171.59	385	959.54	81.9	85
Total Medicare	0.9	1,547	1,725.71	1,326	1,479.06	85.7	221
Total Medicaid and Medicare	33.0	11,740	355.96	10,538	319.50	89.8	1,202
Marketplace	3.8	1,434	379.91	824	218.44	57.5	610
	36.8	$ 13,174	$ 358.42	$ 11,362	$ 309.12	86.2%	$ 1,812

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid Program

The Medical Margin of our Medicaid program increased $60 million, or 19% in the third quarter of 2019 when compared with the third quarter of 2018, and increased $107 million, or 11% in the nine months ended September 30, 2019 , when compared with the nine months ended September 30, 2018. The increase in both periods was due to improvement in the overall Medicaid MCR, which more than offset the impact of declining Medicaid premium revenue. The Medicaid MCR decreased to 88.1% from 90.5%, or 240 basis points, in the third quarter of 2019 when compared with the same period in 2018, and decreased to 88.2% from 90.4%, or 220 basis points, in the nine months ended September 30, 2019 , when compared with the same period in 2018.

The Medicaid MCR for both periods in 2019 benefited from improvements across all programs. The MCR for TANF and CHIP improved for both periods due to PMPM premium revenue increases. The improved MCR for the ABD program was principally driven by increases in premium revenue PMPM, lower pharmacy costs from re-contracted pharmacy benefits management, and our continued focus on medical cost management.

The decrease in the Medicaid Expansion MCR for both periods in 2019 when compared to 2018, was mainly due to the impact of a $57 million reduction in premium revenue, recognized in the third quarter of 2018, relating to a retroactive California Medicaid Expansion risk corridor for the state's 2017 fiscal year.

Medicaid premium revenue decreased $204 million and $954 million in the third quarter of 2019 and the nine months ended September 30, 2019 , respectively, mainly due to the loss in membership in connection with the termination of our Medicaid contracts in New Mexico and in all but two regions in Florida in late 2018 and early 2019, partially offset by net rate increases in certain other markets. As noted above, we expect lower Medicaid premium revenue throughout 2019, when compared with 2018.

Medicare Program

The Medical Margin of our Medicare program increased $15 million, or 23%, in the third quarter of 2019, when compared with the third quarter of 2018, and increased $28 million, or 13%, in the nine months ended September 30, 2019 , when compared with the nine months ended September 30, 2018. Premiums continue to increase compared with the prior year, mainly due to risk scores that are more commensurate with the acuity of our population.

Marketplace Program

The Marketplace Medical Margin decreased $61 million in the third quarter of 2019, when compared with the third quarter of 2018, and decreased $222 million in the nine months ended September 30, 2019 , when compared with the nine months ended September 30, 2018 . The decrease in both periods in 2019 is mainly attributed to a decrease in premium revenues, driven by a decrease in membership of over 20%, partially offset by premium rate increases and increased premiums tied to risk scores. Additionally, the decrease in premiums in both periods in 2019 reflects a relatively smaller benefit from prior year Marketplace risk adjustment in 2019 compared with 2018. As noted above, we expect Marketplace premium revenue to be lower in 2019, when compared with 2018.

The decrease in Medical Margin for the nine months ended September 30, 2019 , was partially driven by the impact of the $81 million CSR reimbursement recognized in the nine months ended September 30, 2018 . The CSR benefit related to 2017 dates of service and was recognized following the federal government's confirmation that the reconciliation would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

The MCR for the Marketplace program amounted to 71.2% in the third quarter of 2019, compared with 64.1% in the third quarter of 2018, and 66.7% in the nine months ended September 30, 2019 , compared with 57.5% in the nine months ended September 30, 2018 . The increased MCR in both periods in 2019 reflects a relatively smaller benefit from prior year Marketplace risk adjustment in 2019 compared with 2018, and the impact of higher acuity membership, partially offset by the impact of rate increases and increased premiums tied to risk scores. Additionally, the increase in MCR for the nine months ended September 30, 2019 , reflects the impact of the CSR reimbursement recognized in the nine months ended September 30, 2018.

FINANCIAL PERFORMANCE BY HEALTH PLAN

The following tables summarize member months, premium revenue, medical care costs, MCR, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Medicaid and Medicare

	Three Months Ended September 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.6	$ 510	$ 315.90	$ 423	$ 261.97	82.9%	$ 87
Florida	0.3	130	436.99	127	427.80	97.9	3
Illinois	0.7	257	383.41	232	347.28	90.6	25
Michigan	1.1	401	373.01	332	307.97	82.6	69
Ohio	0.9	615	687.38	563	628.98	91.5	52
Puerto Rico	0.6	117	209.25	102	182.53	87.2	15
South Carolina	0.4	151	379.20	138	347.23	91.6	13
Texas	0.7	592	912.76	540	833.51	91.3	52
Washington	2.3	643	269.52	570	238.55	88.5	73
Other [1] [2]	0.6	311	437.60	242	341.29	78.0	69
	9.2	$ 3,727	$ 402.76	$ 3,269	$ 353.31	87.7%	$ 458

	Three Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.7	$ 435	$ 249.00	$ 446	$ 255.22	102.5%	$ (11)
Florida	1.0	388	363.16	362	339.33	93.4	26
Illinois	0.7	207	312.72	182	274.98	87.9	25
Michigan	1.1	397	350.05	321	282.49	80.7	76
New Mexico [2]	0.6	304	471.66	275	426.69	90.5	29
Ohio	0.9	584	624.84	532	568.93	91.1	52
Puerto Rico	1.0	179	189.65	162	171.96	90.7	17
South Carolina	0.4	124	354.53	112	318.56	89.9	12
Texas	0.7	577	848.47	525	772.14	91.0	52
Washington	2.3	511	226.77	444	197.04	86.9	67
Other [1]	0.5	175	334.29	137	261.49	78.2	38
	10.9	$ 3,881	$ 354.70	$ 3,498	$ 319.63	90.1%	$ 383

	Nine Months Ended September 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	4.9	$ 1,508	$ 306.96	$ 1,286	$ 261.76	85.3%	$ 222
Florida	1.0	418	410.71	374	367.95	89.6	44
Illinois	2.0	726	365.35	632	318.26	87.1	94
Michigan	3.3	1,199	370.77	990	305.99	82.5	209
Ohio	2.7	1,835	682.59	1,653	614.89	90.1	182
Puerto Rico	1.8	341	190.42	301	167.98	88.2	40
South Carolina	1.2	427	368.35	378	326.61	88.7	49
Texas	2.0	1,789	910.64	1,623	826.20	90.7	166
Washington	7.1	1,868	261.92	1,691	236.98	90.5	177
Other [1] [2]	1.9	810	402.31	656	325.93	81.0	154
	27.9	$ 10,921	$ 391.44	$ 9,584	$ 343.53	87.8%	$ 1,337

	Nine Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.3	$ 1,446	$ 270.63	$ 1,299	$ 243.14	89.8%	$ 147
Florida	3.2	1,147	356.15	1,069	331.93	93.2	78
Illinois	1.8	551	308.45	474	265.47	86.1	77
Michigan	3.4	1,161	343.08	983	290.26	84.6	178
New Mexico [2]	2.0	936	469.19	875	438.70	93.5	61
Ohio	2.8	1,670	590.71	1,474	521.26	88.2	196
Puerto Rico	2.9	549	190.34	501	173.83	91.3	48
South Carolina	1.1	369	350.94	323	306.76	87.4	46
Texas	2.1	1,715	831.21	1,554	753.31	90.6	161
Washington	6.8	1,666	245.40	1,544	227.41	92.7	122
Other [1]	1.6	530	323.84	442	269.98	83.4	88
	33.0	$ 11,740	$ 355.96	$ 10,538	$ 319.50	89.8%	$ 1,202

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

(2) In 2019, "Other" includes the New Mexico health plan. The New Mexico health plan's Medicaid contract terminated on December 31, 2018, and therefore its 2019 results are not individually significant to our consolidated operating results.

Health Plans Segment Financial Data — Marketplace

	Three Months Ended September 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 57	$ 371.07	$ 33	$ 210.87	56.8%	$ 24
Florida	0.1	41	349.53	25	212.00	60.7	16
Michigan	—	7	431.41	4	289.45	67.1	3
Ohio	—	25	792.96	19	626.30	79.0	6
Texas	0.4	142	351.04	105	257.68	73.4	37
Washington	0.1	45	719.67	33	548.75	76.2	12
Other (1)	0.1	40	480.41	35	408.35	85.0	5
	0.9	$ 357	$ 410.23	$ 254	$ 292.21	71.2%	$ 103

	Three Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 49	$ 309.04	$ 37	$ 235.63	76.2%	$ 12
Florida	0.2	66	548.60	45	362.39	66.1	21
Michigan	—	12	233.51	7	145.13	62.1	5
New Mexico	0.1	28	419.20	18	249.33	59.5	10
Ohio	0.1	27	485.08	18	336.86	69.4	9
Texas	0.6	228	357.54	134	209.80	58.7	94
Washington	—	44	656.70	34	518.75	79.0	10
Other (2)	—	2	NM	(1)	NM	NM	3
	1.2	$ 456	$ 394.02	$ 292	$ 252.61	64.1%	$ 164

	Nine Months Ended September 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.5	$ 174	$ 364.72	$ 101	$ 210.76	57.8%	$ 73
Florida	0.4	152	389.44	81	207.22	53.2	71
Michigan	—	27	474.12	15	265.95	56.1	12
Ohio	0.1	79	801.90	53	543.00	67.7	26
Texas	1.3	457	344.19	331	249.44	72.5	126
Washington	0.2	143	744.47	97	509.50	68.4	46
Other (1)	0.3	132	494.59	98	364.71	73.7	34
	2.8	$ 1,164	$ 414.17	$ 776	$ 276.28	66.7%	$ 388

	Nine Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.6	$ 171	$ 326.82	$ 89	$ 169.98	52.0%	$ 82
Florida	0.5	211	491.13	67	155.24	31.6	144
Michigan	0.1	40	248.24	23	145.38	58.6	17
New Mexico	0.2	93	426.07	55	247.57	58.1	38
Ohio	0.2	84	466.75	58	324.91	69.6	26
Texas	2.0	679	330.92	440	214.65	64.9	239
Washington	0.2	139	654.78	105	497.00	75.9	34
Other [2]	—	17	NM	(13)	NM	NM	30
	3.8	$ 1,434	$ 379.91	$ 824	$ 218.44	57.5%	$ 610

(1) "Other" includes the New Mexico, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results in 2019.
(2) "Other" includes the Utah and Wisconsin health plans, where we did not participate in the Marketplace in 2018. Therefore, the ratios for 2018 periods are not meaningful (NM).

Health Plans Segment Financial Data — Total

	Three Months Ended September 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 567	$ 320.67	$ 456	$ 257.55	80.3%	$ 111
Florida	0.4	171	412.29	152	366.86	89.0	19
Illinois	0.7	257	383.41	232	347.28	90.6	25
Michigan	1.1	408	373.92	336	307.68	82.3	72
Ohio	0.9	640	690.88	582	628.89	91.0	58
Puerto Rico	0.6	117	209.25	102	182.53	87.2	15
South Carolina	0.4	151	379.20	138	347.23	91.6	13
Texas	1.1	734	696.46	645	611.78	87.8	89
Washington	2.4	688	280.85	603	246.36	87.7	85
Other [1] [2]	0.7	351	442.14	277	348.40	78.8	74
	10.1	$ 4,084	$ 403.40	$ 3,523	$ 348.06	86.3%	$ 561

	Three Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.9	$ 484	$ 253.96	$ 483	$ 253.60	99.9%	$ 1
Florida	1.2	454	382.20	407	341.70	89.4	47
Illinois	0.7	207	312.72	182	274.98	87.9	25
Michigan	1.1	409	345.28	328	276.88	80.2	81
New Mexico [2]	0.7	332	466.63	293	409.68	87.8	39
Ohio	1.0	611	616.95	550	555.83	90.1	61
Puerto Rico	1.0	179	189.65	162	171.96	90.7	17
South Carolina	0.4	124	354.53	112	318.56	89.9	12
Texas	1.3	805	611.01	659	500.14	81.9	146
Washington	2.3	555	239.25	478	206.38	86.3	77
Other [1]	0.5	177	336.18	136	260.19	77.4	41
	12.1	$ 4,337	$ 358.46	$ 3,790	$ 313.23	87.4%	$ 547

	Nine Months Ended September 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.4	$ 1,682	$ 312.08	$ 1,387	$ 257.25	82.4%	$ 295
Florida	1.4	570	404.81	455	323.37	79.9	115
Illinois	2.0	726	365.35	632	318.26	87.1	94
Michigan	3.3	1,226	372.58	1,005	305.29	81.9	221
Ohio	2.8	1,914	686.80	1,706	612.35	89.2	208
Puerto Rico	1.8	341	190.42	301	167.98	88.2	40
South Carolina	1.2	427	368.35	378	326.61	88.7	49
Texas	3.3	2,246	682.10	1,954	593.50	87.0	292
Washington	7.3	2,011	274.52	1,788	244.10	88.9	223
Other (1) (2)	2.2	942	413.13	754	330.48	80.0	188
	30.7	$ 12,085	$ 393.52	$ 10,360	$ 337.37	85.7%	$ 1,725

	Nine Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.9	$ 1,617	$ 275.64	$ 1,388	$ 236.61	85.8%	$ 229
Florida	3.7	1,358	372.07	1,136	311.09	83.6	222
Illinois	1.8	551	308.45	474	265.47	86.1	77
Michigan	3.5	1,201	338.83	1,006	283.77	83.7	195
New Mexico (2)	2.2	1,029	464.92	930	419.78	90.3	99
Ohio	3.0	1,754	583.29	1,532	509.52	87.4	222
Puerto Rico	2.9	549	190.34	501	173.83	91.3	48
South Carolina	1.1	369	350.94	323	306.76	87.4	46
Texas	4.1	2,394	581.74	1,994	484.70	83.3	400
Washington	7.0	1,805	257.82	1,649	235.59	91.4	156
Other (1)	1.6	547	334.26	429	262.27	78.5	118
	36.8	$ 13,174	$ 358.42	$ 11,362	$ 309.12	86.2%	$ 1,812

(1) “Other” includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.
(2) In 2019, “Other” includes the New Mexico health plan. The New Mexico health plan’s Medicaid contract terminated on December 31, 2018, and therefore its 2019 results are not individually significant to our consolidated operating results.

OTHER

The Other segment includes the historical results of the Medicaid management information systems (“MMIS”) and behavioral health subsidiaries we sold in late 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Beginning in 2019, we no longer report service revenue or cost of service revenue as a result of the sales of the MMIS and behavioral health subsidiaries noted above.

FINANCIAL OVERVIEW

The Other segment margin in the third quarter and nine months ended September 30, 2018 , was insignificant.

LIQUIDITY AND FINANCIAL CONDITION

LIQUIDITY

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

We maintain liquidity at two levels: 1) the regulated health plan subsidiaries; and 2) the parent company. Our regulated health plan subsidiaries generate significant cash flows from premium revenue, which is generally received a short time before related healthcare services are paid. Such cash flows are our primary source of liquidity. Thus, any decline in our profitability may have a negative impact on our liquidity. A majority of the assets held by our regulated health plan subsidiaries is in the form of cash, cash equivalents, and investments.

When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plan subsidiaries is generally paid in the form of dividends to our parent company to be used for general corporate purposes. In the third quarter of 2019 and nine months ended September 30, 2019, the parent received $430 million and $1,064 million, respectively, in dividends from the regulated health plan subsidiaries. In addition, the parent received $185 million in dividends from the regulated health plan subsidiaries during October 2019.

To satisfy minimum statutory net worth requirements, the parent company may contribute capital to the regulated health plan subsidiaries. In the third quarter of 2019 and nine months ended September 30, 2019 , the parent contributed capital of $19 million and $25 million, respectively, to the regulated health plan subsidiaries.

Cash, cash equivalents and investments at the parent company amounted to $796 million and $170 million as of September 30, 2019, and December 31, 2018, respectively. The increase in 2019 was mainly due to the dividends received from regulated health plan subsidiaries, as described above, and proceeds from borrowings under the Term Loan Facility, partially offset by principal repayments of our outstanding 1.125% Convertible Notes, as described further below in “Cash Flow Activities.”

Investments

After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of less than 10 years, or less than 10 years average life for structured securities. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels.

Our restricted investments are invested principally in cash, cash equivalents, and U.S. Treasury securities; we have the ability to hold such restricted investments until maturity. All of our unrestricted investments are classified as current assets.

Cash Flow Activities

Our cash flows are summarized as follows:

	Nine Months Ended September 30,		
	2019	2018	Change
	(In millions)		
Net cash provided by (used in) operating activities	$ 398	$ (191)	$ 589
Net cash (used in) provided by investing activities	(80)	821	(901)
Net cash used in financing activities	(510)	(1,012)	502
Net decrease in cash, cash equivalents, and restricted cash and cash equivalents	$ (192)	$ (382)	$ 190

Operating Activities

We typically receive capitation payments monthly, in advance of payments for medical claims; however, government payors may adjust their payment schedules, positively or negatively impacting our reported cash flows from operating activities in any given period. For example, government payors may delay our premium payments, or they may prepay the following month's premium payment.

Net cash provided by operations for the nine months ended September 30, 2019 was $398 million, compared with $191 million used in operations in the nine months ended September 30, 2018 . The $589 million increase in cash flow was due to the net impact of timing differences in receivables, payables and other current assets, settlements with government agencies, mainly related to the final 2017 CSR settlement paid in 2019, and timing of premium receipts.

Investing Activities

Net cash used in investing activities was $80 million in the nine months ended September 30, 2019 , compared with $821 million provided by investing activities in the nine months ended September 30, 2018 , a decrease in cash flow of $901 million. The year over year decline was primarily due to increased purchases of investments, net of lower proceeds from sales and maturities of investments, in the nine months ended September 30, 2019.

Financing Activities

Net cash used in financing activities was $510 million in the nine months ended September 30, 2019 , compared with $1,012 million in the nine months ended September 30, 2018. In the nine months ended September 30, 2019 , net cash paid for the aggregate 1.125% Convertible Notes-related transactions amounted to $794 million, partially offset by proceeds of $220 million borrowed under the Term Loan Facility. In the nine months ended September 30, 2018, net cash used in financing activities included net cash paid for the aggregate 1.125% Convertible Notes-related transactions of $710 million, the $300 million repayment of the Credit Facility, and $64 million repayment of the 1.625% Convertible Notes.

FINANCIAL CONDITION

We believe that our cash resources, our borrowing capacity available under our Credit Agreement as discussed further below in "Future Sources and Uses of Liquidity—Future Sources," and internally generated funds will be sufficient to support our operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months.

On a consolidated basis, at September 30, 2019, our working capital was $2,569 million, compared with $2,216 million at December 31, 2018. At September 30, 2019, our cash and investments amounted to $4,517 million, compared with $4,629 million at December 31, 2018.

Regulatory Capital and Dividend Restrictions

Each of our regulated HMO subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulations. Such statutes, regulations and capital requirements also restrict the timing, payment and amount of dividends and other distributions, loans or advances that may be paid to us as the sole stockholder. To the extent our HMO subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus (net assets) requirement for these subsidiaries was estimated to be approximately $1,100 million at September 30, 2019, compared to $1,040 million at December 31, 2018. Our HMO subsidiaries were in compliance with these minimum capital requirements as of both dates.

Under applicable regulatory requirements, the amount of dividends that may be paid through the remainder of 2019 by our HMO subsidiaries without prior approval by regulatory authorities as of September 30, 2019, is approximately $56 million in the aggregate. Our HMO subsidiaries may pay dividends over this amount, but only after approval is granted by the regulatory authorities.

Debt Ratings

Our 5.375% Notes and 4.875% Notes are rated "BB-" by Standard & Poor's, and "B2" by Moody's Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs.

Financial Covenants

Our Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Agreement.

Credit Agreement Financial Covenants	Required Per Agreement	As of September 30, 2019
Net leverage ratio	<4.0x	0.9x
Interest coverage ratio	>3.5x	15.3x

In addition, the indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. As of September 30, 2019, we were in compliance with all covenants under the Credit Agreement and the indentures governing our outstanding notes.

Capital Plan Progress

In the first quarter of 2019, we repaid $46 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants.

In the second quarter of 2019, we repaid $139 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants.

In the third quarter of 2019, we repaid $55 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants. Following these transactions, the remaining principal amount outstanding of our 1.125% Convertible Notes is $12 million.

FUTURE SOURCES AND USES OF LIQUIDITY

Future Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related healthcare services. Such cash flows are our primary source of liquidity. Thus, any decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes.

Credit Agreement Borrowing Capacity. As of September 30, 2019, we had available borrowing capacity of $380 million under the Term Loan Facility, following our draw down of $220 million in the first half of 2019. Under the Term Loan Facility, we may request up to ten advances, each in a minimum principal amount of $50 million, until July 31, 2020. In addition, we have available borrowing capacity of $498 million under our Credit Facility. See further discussion in the Notes to Consolidated Financial Statements, Note 7, “Debt.”

Savings from the IT Restructuring Plan. Management is focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we began a plan to restructure our information technology department (the “IT Restructuring Plan”) in 2018, which is reported in the Other segment. In early 2019, we entered into services agreements with an outsourcing vendor who manages certain of our information technology services. We expect the IT Restructuring Plan to be substantially completed by the end of 2019. We currently estimate that this plan will reduce annualized run-rate expenses by approximately $10 million to $15 million in the first full year, increasing to approximately $25 million to $30 million by the end of the fifth full year. Such savings, if achieved, would reduce Other segment general and administrative expenses in our consolidated statements of income. Further details are described in the Notes to Consolidated Financial Statements, Note 10, “Restructuring Costs.”

Future Uses

Acquisition. On October 10, 2019, we entered into a definitive agreement to acquire certain assets of YourCare Health Plan, Inc. Upon the closing of this transaction, expected to occur in early 2020, we will serve approximately 46,000 Medicaid members in seven counties in the Western New York and Finger Lakes regions. The purchase price of approximately $40 million will be funded with available cash, and the closing is subject to customary closing conditions.

Regulatory Capital Requirements and Dividend Restrictions. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

1.125% Convertible Notes. The fair value of the 1.125% Convertible Notes was $34 million as of September 30, 2019, which amount reflects both the principal amount outstanding and the estimated fair value of the 1.125% Conversion Option. We have sufficient available cash, combined with borrowing capacity available under our Credit Agreement, to fund conversions, and to repay the outstanding principal amount of the 1.125% Convertible Notes at maturity on January 15, 2020. Refer to the Notes to Consolidated Financial Statements, Note 7, “Debt,” for a detailed discussion of the 1.125% Convertible Notes, including recent transactions.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2018, was disclosed in our Annual Report on Form 10-K for the year ended December 31, 2018.

Other than the financing transactions described in the Notes to Consolidated Financial Statements, Note 7, “Debt,” there were no significant changes to this previously filed information outside the ordinary course of business during the nine months ended September 30, 2019 . See also Note 13, “Leases,” for a summary of the maturities of our lease liabilities as of September 30, 2019.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, “Medical Claims and Benefits Payable ,” for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the nine months ended September 30, 2019 , to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2018.

- *Contractual provisions that may adjust or limit revenue or profit* . For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Goodwill and intangible assets, net.* There have been no significant changes, during the nine months ended September 30, 2019 , to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2018.

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2019, the fair value of our fixed income investments would decrease by approximately $39 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. As of September 30, 2019, $220 million was outstanding under the Term Loan Facility. For further information, see Notes to Consolidated Financial Statements, Note 7, “Debt.”

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures. Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company’s “disclosure controls and procedures” (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Securities Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC’s rules and forms.

Changes in Internal Control Over Financial Reporting. There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2019 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 12, “Commitments and Contingencies.”

RISK FACTORS

Certain risks may have a material adverse effect on our business, financial condition, cash flows, results of operations, or stock price, and you should carefully consider them before making an investment decision with respect to our securities. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in “Risk Factors,” in our Annual Report on Form 10-K for the year ended December 31, 2018. The risk factors described in our Annual Report on Form 10-K for the year ended December 31, 2018, are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, results of operations, or stock price.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended September 30, 2019, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
July 1 - July 31	375	$ 140.31	—	$ —
August 1 - August 31	—	$ —	—	$ —
September 1 - September 30	—	$ —	—	$ —
Total	375	$ 140.31	—	

(1) During the three months ended September 30, 2019, we withheld 375 shares of common stock, to settle employee income tax obligations, for releases of awards granted under the Molina Healthcare, Inc. 2011 Equity Incentive Plan. This plan was amended, restated and merged into the Molina Healthcare, Inc. 2019 Equity Incentive Plan. For further information refer to Note 9, "Stockholders' Equity."

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INDEX TO EXHIBITS

Exhibit No.	Title	Method of Filing
10.1	First Amendment, dated August 1, 2019, to the Master Services Agreement for Information Technology Services, dated February 4, 2019, by and between Molina Healthcare, Inc. and Infosys Limited.	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
101.INS	XBRL Taxonomy Instance Document.	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document.	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: October 30, 2019

/s/ JOSEPH M. ZUBRETSKY

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Dated: October 30, 2019

/s/ THOMAS L. TRAN

Thomas L. Tran
Chief Financial Officer and Treasurer
(Principal Financial Officer)

FIRST AMENDMENT TO THE MASTER SERVICES AGREEMENT

This First Amendment (the "Amendment") dated **August 1, 2019** (the "Amendment Effective Date"), is made to the Master Services Agreement (the "Agreement") by and between **Molina Healthcare, Inc.,** ("Molina") and
Infosys Limited ("Service Provider") dated February 4, 2019.

For good and mutual consideration, the sufficiency of which is hereby acknowledged, this Amendment amends the Agreement in the manner set forth below.

The parties agree to the following:

1. Purpose; Limited Application of Amendment. The purpose of this Amendment is to amend the terms and conditions of the Agreement as set forth below.

2. Definitions. Capitalized terms used herein and not otherwise defined shall have the meaning given to them in the Agreement.

3. Amendments to the body of the Agreement. The body of the Agreement is modified as follows:

A. Clause 4.1 of the Agreement is hereby deleted and replaced in its entirety with the following language "Molina may extend the term for a maximum of one (1) additional period of twelve (12) months."

4. Amendments to Schedule 1 ("Definitions and Interpretation") of the Agreement. Schedule 1 of the Agreement is modified as follows:

A. The definition of "Initial Expiry Date" is hereby deleted and replaced in its entirety with the following language: "'**Initial Expiry Date**" means the date five (5) years after the Effective Date."

5. Amendments to Appendix 3A (Pricing Matrix). Appendix 3A (Pricing Matrix) is hereby deleted and replaced in its entirety with a new Appendix 3A dated the Amendment Effective Date, a copy of which is attached herewith and incorporated to the Agreement by this reference. For the purpose of clarity, Infosys is amending this workbook to reflect the billing milestones and Year 6 pricing and discounts.

A. *Infrastructure Services - Charges* - Infosys will bill for the Infrastructure services in accordance with Schedule 3 and depicted in the new Appendix 3A dated the amendment Effective Date.

B. *Azure Services - Charges* -Infosys will bill Azure services as outlined in new Appendix 3A dated the Amendment Effective Date.

6. Azure Foundation Charges. The parties agree on the additional charges for Azure Foundation ("**Azure Foundation**" as used in this Agreement means the building and securing of Azure infrastructure and PaaS services, and virtual networking resources per Molina standards, to be consumed by applications. This also includes defining and implementing access model, automation for provisioning of resources and access, cleaning up technical debts). The additional Azure Foundation Charges shall be as set forth in Schedule 1 to this Amendment. The scope for Azure Foundation as agreed by the parties will be delivered and completed by October 31, 2019. Any additional scope or changes will be taken up as a separate contract and negotiated separately.

7. Discounts. The parties agree to apply the discounts set forth in Schedule 1 to this Amendment.

8. Amendments to Clause 58.

A. Service Provider expressly disclaims any warranties relating to any Azure licenses or other materials licensed by Molina from Microsoft.

B. The provisions of Section 58.1 (Indemnification by Service Provider) shall not apply to any IPR Claim arising out of any Azure licenses or other materials licensed by Molina from Microsoft.

C. The liability caps set forth in Section 58.4 (Limitations Caps) of the Agreement shall not increase by more than $500,000 as a result of the inclusion in the calculation of the limitation of liability set out in Clause 58.4 of the MSA of Charges payable by Molina as license fees for Infosys Azure Transformation and Operations Management ("iATOM"). For the avoidance of doubt, the limitation on the amount the Service Provider's liability may increase set out in the previous sentence shall not apply with respect to any increase in any other Charges payable by Molina in connection with the Agreement.

D. The liability caps set forth in Section 58.4 (Limitations Caps) of the Agreement shall not increase as a result of any separate license fees payable by Molina specifically for Microsoft products, including but not limited to Azure licenses fees payable to the Service Provider under Statement of Work #1 under this Agreement.

9. No Further Amendment. Except as expressly modified by this Amendment, the Agreement shall remain unmodified and in full force and effect. Each party to this Amendment hereby ratifies their respective obligations under the Agreement. In the event of a conflict between the terms and conditions of the Agreement and the Amendment, the provisions of this Amendment shall prevail.

IN WITNESS WHEREOF, the undersigned are duly authorized to execute this Amendment as of the Amendment Effective Date.

Molina Healthcare, Inc.	**INFOSYS LIMITED**
By: /s/ James Woys	By: /s/ Venkateshwaran Ananth
(signature)	*(signature)*
Name: James Woys	Name: Venkateshwaran Ananth
(printed)	*(printed)*
Title: EVP, Health Plan Services	Title: Senior Vice President
(printed)	*printed)*
Date: August 7, 2019	Date: August 7, 2019

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2019 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: October 30, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Thomas L. Tran, certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2019 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 30, 2019

/s/ Thomas L. Tran

Thomas L. Tran

Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2019 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 30, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2019 (the "Report"), I, Thomas L. Tran, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 30, 2019

/s/ Thomas L. Tran

Thomas L. Tran

Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended June 30, 2019

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2019
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.001 Par Value	MOH	New York Stock Exchange

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer ☒ Accelerated Filer ☐ Non-Accelerated Filer ☐ (do not check if a smaller reporting company)

Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of July 26, 2019, was approximately 62,711,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED June 30, 2019

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CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(In millions, except per-share amounts) (Unaudited)			
Revenue:				
Premium revenue	$ 4,049	$ 4,514	$ 8,001	$ 8,837
Premium tax revenue	110	106	248	210
Health insurer fees reimbursed	—	104	—	165
Service revenue	—	127	—	261
Investment income and other revenue	34	32	63	56
Total revenue	4,193	4,883	8,312	9,529
Operating expenses:				
Medical care costs	3,466	3,850	6,837	7,572
General and administrative expenses	328	335	630	687
Premium tax expenses	110	106	248	210
Health insurer fees	—	99	—	174
Depreciation and amortization	22	25	47	51
Restructuring costs	2	8	5	33
Cost of service revenue	—	118	—	238
Total operating expenses	3,928	4,541	7,767	8,965
Operating income	265	342	545	564
Other expenses, net:				
Interest expense	22	32	45	65
Other (income) expenses, net	(14)	5	(17)	15
Total other expenses, net	8	37	28	80
Income before income tax expense	257	305	517	484
Income tax expense	61	103	123	175
Net income	$ 196	$ 202	$ 394	$ 309
Net income per share:				
Basic	$ 3.15	$ 3.29	$ 6.34	$ 5.10
Diluted	$ 3.06	$ 3.02	$ 6.04	$ 4.68

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(In millions) (Unaudited)			
Net income	$ 196	$ 202	$ 394	$ 309
Other comprehensive income (loss):				
Unrealized investment income (loss)	10	1	17	(6)
Less: effect of income taxes	2	—	4	(1)
Other comprehensive income (loss), net of tax	8	1	13	(5)
Comprehensive income	$ 204	$ 203	$ 407	$ 304

See accompanying notes.

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CONSOLIDATED BALANCE SHEETS

	June 30, 2019	December 31, 2018
	(Dollars in millions, except per-share amounts)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,253	$ 2,826
Investments	2,070	1,681
Receivables	1,239	1,330
Prepaid expenses and other current assets	132	149
Derivative asset	169	476
Total current assets	5,863	6,462
Property, equipment, and capitalized software, net	373	241
Goodwill and intangible assets, net	180	190
Restricted investments	98	120
Deferred income taxes	70	117
Other assets	106	24
	$ 6,690	$ 7,154
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,767	$ 1,961
Amounts due government agencies	984	967
Accounts payable and accrued liabilities	373	390
Deferred revenue	30	211
Current portion of long-term debt	65	241
Derivative liability	169	476
Total current liabilities	3,388	4,246
Long-term debt	1,241	1,020
Finance lease liabilities	232	197
Other long-term liabilities	93	44
Total liabilities	4,954	5,507
Stockholders' equity:		
Common stock, $0.001 par value, 150 million shares authorized; outstanding: 63 million shares at June 30, 2019, and 62 million shares at December 31, 2018	—	—
Preferred stock, $0.001 par value; 20 million shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	240	643
Accumulated other comprehensive income (loss)	5	(8)
Retained earnings	1,491	1,012
Total stockholders' equity	1,736	1,647
	$ 6,690	$ 7,154

See accompanying notes.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
	(Unaudited)					
Balance at December 31, 2018	62	$ —	$ 643	$ (8)	$ 1,012	$ 1,647
Net income	—	—	—	—	198	198
Adoption of new accounting standard	—	—	—	—	85	85
Partial termination of 1.125% Warrants	—	—	(103)	—	—	(103)
Other comprehensive income, net	—	—	—	5	—	5
Share-based compensation	1	—	3	—	—	3
Balance at March 31, 2019	63	—	543	(3)	1,295	1,835
Net income	—	—	—	—	196	196
Partial termination of 1.125% Warrants	—	—	(321)	—	—	(321)
Other comprehensive income, net	—	—	—	8	—	8
Share-based compensation	—	—	18	—	—	18
Balance at June 30, 2019	63	$ —	$ 240	$ 5	$ 1,491	$ 1,736

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
	(Unaudited)					
Balance at December 31, 2017	60	$ —	$ 1,044	$ (5)	$ 298	$ 1,337
Net income	—	—	—	—	107	107
Adoption of new accounting standards	—	—	—	(1)	7	6
Exchange of 1.625% Convertible Notes	2	—	108	—	—	108
Other comprehensive loss, net	—	—	—	(6)	—	(6)
Share-based compensation	—	—	1	—	—	1
Balance at March 31, 2018	62	—	1,153	(12)	412	1,553
Net income	—	—	—	—	202	202
Partial termination of 1.125% Warrants	—	—	(113)	—	—	(113)
Other comprehensive income, net	—	—	—	1	—	1
Share-based compensation	—	—	15	—	—	15
Balance at June 30, 2018	62	$ —	$ 1,055	$ (11)	$ 614	$ 1,658

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2019	2018
	(In millions) (Unaudited)	
Operating activities:		
Net income	$ 394	$ 309
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	47	73
Deferred income taxes	19	(6)
Share-based compensation	19	13
Amortization of convertible senior notes and finance lease liabilities	4	13
(Gain) loss on debt extinguishment	(17)	15
Non-cash restructuring costs	—	17
Other, net	3	4
Changes in operating assets and liabilities:		
Receivables	91	(315)
Prepaid expenses and other current assets	18	(181)
Medical claims and benefits payable	(194)	(267)
Amounts due government agencies	17	205
Accounts payable and accrued liabilities	(61)	349
Deferred revenue	(181)	(42)
Income taxes	(3)	127
Net cash provided by operating activities	156	314
Investing activities:		
Purchases of investments	(1,162)	(914)
Proceeds from sales and maturities of investments	791	1,335
Purchases of property, equipment and capitalized software	(20)	(14)
Other, net	(2)	(9)
Net cash (used in) provided by investing activities	(393)	398
Financing activities:		
Repayment of principal amount of 1.125% Convertible Notes	(185)	(89)
Cash paid for partial settlement of 1.125% Conversion Option	(473)	(134)
Cash received for partial termination of 1.125% Call Option	473	134
Cash paid for partial termination of 1.125% Warrants	(424)	(113)
Proceeds from borrowings under Term Loan Facility	220	—
Repayment of Credit Facility	—	(300)
Other, net	27	(1)
Net cash used in financing activities	(362)	(503)
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(599)	209
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	2,926	3,290
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 2,327	$ 3,499

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Six Months Ended June 30,	
	2019	2018
	(In millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (7)	$ (6)
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 166	$ 135
Loss on 1.125% Conversion Option	(166)	(135)
Change in fair value of derivatives, net	$ —	$ —
1.625% Convertible Notes exchange transaction:		
Common stock issued in exchange for 1.625% Convertible Notes	$ —	$ 131
Component allocated to additional paid-in capital, net of income taxes	—	(23)
Net increase to additional paid-in capital	$ —	$ 108

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

June 30, 2019

1. Organization and Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides managed healthcare services under the Medicaid and Medicare programs and through the state insurance marketplaces (the "Marketplace"). We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. The Other segment includes the historical results of the Medicaid management information systems ("MMIS") and behavioral health subsidiaries we sold in the fourth quarter of 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Prior to the fourth quarter of 2018, the MMIS subsidiary was reported as a stand-alone segment.

The Health Plans segment consists of health plans operating in 14 states and the Commonwealth of Puerto Rico. As of June 30, 2019, these health plans served approximately 3.4 million members eligible for Medicaid, Medicare, and other government-sponsored healthcare programs for low-income families and individuals including Marketplace members, most of whom receive government subsidies for premiums. The health plans are generally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization ("HMO").

Our health plans' state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal ("RFPs") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., and its subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the six months ended June 30, 2019, are not necessarily indicative of the results for the entire year ending December 31, 2019.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2018. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in our December 31, 2018, audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our audited consolidated financial statements for the fiscal year ended December 31, 2018.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable of our Health Plans segment;
- Health plans' contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plans' quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Settlements under risk or savings sharing programs;
- The assessment of long-lived and intangible assets, and goodwill for impairment;

- The determination of reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for litigation outcomes;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in non-current "Restricted investments" in the accompanying consolidated balance sheets.

	June 30,	
	2019	2018
	(In millions)	
Cash and cash equivalents	$ 2,253	$ 3,401
Restricted cash and cash equivalents	74	98
Total cash, cash equivalents, and restricted cash and cash equivalents presented in the statements of cash flows	$ 2,327	$ 3,499

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive healthcare services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid Program

Medical Cost Floors (Minimums), and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded liabilities under the terms of such contract provisions of $93 million and $103 million at June 30, 2019 and December 31, 2018, respectively. Approximately $76 million and $87 million of the liabilities accrued at June 30, 2019 and December 31, 2018, respectively, relate to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at June 30, 2019 and December 31, 2018.

Profit Sharing and Profit Ceiling. Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at June 30, 2019 and December 31, 2018.

Retroactive Premium Adjustments. State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, based on our best estimate of the ultimate premium we expect to realize for the period being adjusted.

Medicare Program

Risk Adjusted Premiums. Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and Centers for Medicare and Medicaid Services

("CMS") practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjusted premiums and Medicare Part D settlements were insignificant at June 30, 2019 and December 31, 2018.

Minimum MLR. The Affordable Care Act ("ACA") has established a minimum annual medical loss ratio ("Minimum MLR") of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. The amounts payable for the Medicare Minimum MLR were not significant at June 30, 2019 and December 31, 2018.

Marketplace Program

Risk Adjustment. Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score (risk adjustment payable), and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score (risk adjustment receivable). We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. As of June 30, 2019, Marketplace risk adjustment payables amounted to $625 million and related receivables amounted to $71 million, or a net of $554 million. Approximately $390 million of the net amount at June 30, 2019 relates to 2018 dates of service. As of December 31, 2018, Marketplace risk adjustment payables amounted to $466 million and related receivables amounted to $34 million, or a net of $432 million.

Minimum MLR. The ACA has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. Aggregate balance sheet amounts related to the Minimum MLR were insignificant at June 30, 2019 and December 31, 2018.

A summary of the categories of amounts due government agencies follows:

	June 30, 2019	December 31, 2018
	(In millions)	
Medicaid program:		
Medical cost floors and corridors	$ 93	$ 103
Other amounts due to states	93	81
Marketplace program:		
Risk adjustment	625	466
Cost sharing reduction ("CSR")	—	183
Other	173	134
Total amounts due government agencies	$ 984	$ 967

Quality Incentives

At many of our health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2019, are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2019.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(In millions)			
Maximum available quality incentive premium - current period	$ 46	$ 47	$ 91	$ 87
Quality incentive premium revenue recognized in current period:				
Earned current period	$ 37	$ 34	$ 63	$ 58
Earned prior periods	10	12	30	23
Total	$ 47	$ 46	$ 93	81
Quality incentive premium revenue recognized as a percentage of total premium revenue	1.2%	1.0%	1.2%	0.9%

Medical Care Costs

Marketplace Program

In the first half of 2018, we recognized a benefit of approximately $76 million in reduced medical care costs related to 2017 dates of service as a result of the federal government's confirmation that the reconciliation of 2017 Marketplace CSR subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Leases

Right-of-use ("ROU") assets represent our right to use the underlying assets over the lease term, and lease liabilities represent our obligation for lease payments arising from the related leases. ROU assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. Lease terms may include options to extend or terminate the lease when we believe it is reasonably certain that we will exercise such options. If applicable, we account for lease and non-lease components within a lease as a single lease component.

Because most of our leases do not provide an implicit interest rate, we generally use our incremental borrowing rate to determine the present value of lease payments. Lease expenses for operating lease payments are recognized on a straight-line basis over the lease term, and the related ROU assets and liabilities are reduced to the present value of the remaining lease payments at the end of each period. Finance lease payments reduce finance lease liabilities, the related ROU assets are amortized on a straight-line basis over the lease term, and interest expense is recognized using the effective interest method.

The significant majority of our operating leases consist of long-term operating leases for office space. Short-term leases (those with terms of 12 months or less) are not recorded as ROU assets or liabilities in the consolidated balance sheets. For certain leases that represent a portfolio of similar assets, such as a fleet of vehicles, we apply a portfolio approach to account for the related operating lease ROU assets and liabilities, rather than account for such assets and the related liabilities individually. A nominal number of our lease agreements include rental payments that adjust periodically for inflation. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

For further information, including the amount and location of the ROU assets and lease liabilities recognized in the accompanying consolidated balance sheet, see Note 13, "Leases." For further information regarding our adoption and implementation of Accounting Standards Update ("ASU") 2016-02, *Leases (Topic 842),* see *Recent Accounting Pronouncements Adopted,* below.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years, or 10 years average life for structured securities. Restricted investments are invested principally in certificates of deposit and U.S. Treasury securities. Concentration of credit risk with respect to

accounts receivable is generally limited because our payors consist principally of the federal government, and governments of each state or commonwealth in which our health plan subsidiaries operate.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of foreign and state taxes, nondeductible expenses such as the Health Insurer Fee ("HIF"), certain compensation, and other general and administrative expenses. The effective tax rate will not be impacted by HIF in 2019 given the 2019 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including projected pretax earnings, the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Recent Accounting Pronouncements Adopted

Leases. In February 2016, the Financial Accounting Standards Board ("FASB") issued Topic 842, which was subsequently modified by several ASUs issued in 2017 and 2018. Topic 842 was issued to increase transparency and comparability among organizations by requiring the recognition of ROU assets and lease liabilities on the balance sheet. Most prominent among the changes in Topic 842 is the recognition of ROU assets and lease liabilities by lessees for those leases classified as operating leases. In addition, Topic 842's disclosures are required to meet the objective of enabling users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases. Topic 842's transition provisions are applied using a modified retrospective approach; entities may elect whether to apply the transition provisions, including disclosure requirements, at the beginning of the earliest comparative period presented or on the adoption date.

We adopted Topic 842 effective January 1, 2019, and elected to apply the transition provisions as of that date. Accordingly, we recognized the cumulative effect of initially applying the standard as an adjustment to the opening balance of retained earnings on January 1, 2019. In addition, we elected the available practical expedients and implemented internal controls and key system functionality to enable the preparation of financial information on adoption.

As indicated in the accompanying consolidated statements of stockholders' equity, the cumulative effect adjustment was an increase of $85 million to retained earnings, relating primarily to the transition provisions for sale-leaseback arrangements that did not qualify for sale treatment. Accordingly, such arrangements for certain office buildings were de-recognized and recorded as finance lease ROU assets and lease liabilities. The difference between the de-recognized assets and lease financing obligations resulted in an increase to retained earnings. The recognition of these arrangements as finance lease ROU assets and lease liabilities will not materially impact our consolidated results of operations over the terms of the leases.

Software Licenses. In August 2018, the FASB issued ASU 2018-15, *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract,* which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. We early adopted ASU 2018-15 effective January 1, 2019, using the prospective method, with no material impact to our financial condition, results of operations or cash flows. Adoption of this guidance may be significant to us in the future depending on the extent to which we use cloud computing arrangements that qualify as service contracts.

Recent Accounting Pronouncements Not Yet Adopted

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, as modified by:

- ASU 2018-19, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses*;
- ASU 2019-04, *Codification Improvements to Topic 326, Financial Instruments - Credit Losses, Topic 815, Derivatives and Hedging, and Topic 825, Financial Instruments*; and
- ASU 2019-05, Financial Instruments - *Credit Losses (Topic 326), Targeted Transition Relief*.

This standard introduces a new current expected credit loss ("CECL") model for measuring expected credits losses for certain types of financial instruments and replaces the incurred loss model. The CECL model requires

companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount companies expect to collect over the instrument's contractual life after consideration of historical experience, current conditions, and reasonable and supportable forecasts. This standard also introduces targeted changes to the available-for-sale ("AFS") debt securities impairment model. ASU 2016-13 is effective beginning January 1, 2020, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted.

We have determined that the CECL model will apply primarily to "Receivables" and "Restricted investments" reported in our consolidated balance sheets. The AFS debt securities impairment model will apply to "Investments" reported in our consolidated balance sheets. We are currently evaluating the processes and controls necessary to adopt and implement ASU 2016-13, along with the effects the adoption will have on our consolidated results of operations and financial condition.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission ("SEC") did not have, nor does management expect such pronouncements to have, a significant impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of net income per share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(In millions, except net income per share)			
Numerator:				
Net income	$ 196	$ 202	$ 394	$ 309
Denominator:				
Shares outstanding at the beginning of the period	62.1	61.2	62.1	59.3
Weighted-average number of shares issued:				
Exchange of 1.625% Convertible Notes	—	—	—	1.1
Stock-based compensation	—	—	—	0.1
Denominator for net income per share, basic	62.1	61.2	62.1	60.5
Effect of dilutive securities:				
1.125% Warrants (1)	1.3	4.9	2.4	4.8
1.625% Convertible Notes	—	0.4	—	0.5
Stock-based compensation	0.6	0.2	0.6	0.2
Denominator for net income per share, diluted	64.0	66.7	65.1	66.0
Net income per share: (2)				
Basic	$ 3.15	$ 3.29	$ 6.34	$ 5.10
Diluted	$ 3.06	$ 3.02	$ 6.04	$ 4.68
Potentially dilutive common shares excluded from calculations: (1)				
Stock-based compensation	—	0.4	—	0.4

(1) For more information and definitions regarding the 1.125% Warrants, including partial termination transactions, refer to Note 9, "Stockholders' Equity." The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable were not included in the computation of diluted net income per share because to do so would have been anti-dilutive.

(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to the three-tier fair value hierarchy. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 4, “Fair Value Measurements,” in our 2018 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability (see Note 8 “Derivatives,” for definitions and further information). These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of June 30, 2019, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. The 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such derivative instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the six months ended June 30, 2019.

Our financial instruments measured at fair value on a recurring basis at June 30, 2019, were as follows:

	Total	Observable Inputs (Level 1)	Directly or Indirectly Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,297	$ —	$ 1,297	$ —
Mortgage-backed securities	249	—	249	—
Asset-backed securities	161	—	161	—
Government-sponsored enterprise securities (“GSEs”)	159	—	159	—
Municipal securities	109	—	109	—
U.S. Treasury notes	87	—	87	—
Certificate of deposit	6	—	6	—
Other	2	—	2	—
Subtotal - current investments	2,070	—	2,070	—
1.125% Call Option derivative asset	169	—	—	169
Total assets	$ 2,239	$ —	$ 2,070	$ 169
1.125% Conversion Option derivative liability	$ 169	$ —	$ —	$ 169
Total liabilities	$ 169	$ —	$ —	$ 169

Our financial instruments measured at fair value on a recurring basis at December 31, 2018, were as follows:

	Total	Observable Inputs (Level 1)	Directly or Indirectly Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,123	$ —	$ 1,123	$ —
Asset-backed securities	82	—	82	—
GSEs	163	—	163	—
Municipal securities	114	—	114	—
U.S. Treasury notes	181	—	181	—
Certificates of deposit	14	—	14	—
Other	4	—	4	—
Subtotal - current investments	1,681	—	1,681	—
1.125% Call Option derivative asset	476	—	—	476
Total assets	$ 2,157	$ —	$ 1,681	$ 476
1.125% Conversion Option derivative liability	$ 476	$ —	$ —	$ 476
Total liabilities	$ 476	$ —	$ —	$ 476

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our notes payable are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the Term Loan Facility is classified as a Level 3 financial instrument, because certain inputs used to determine its fair value are not observable. As of June 30, 2019, the carrying amount of the Term Loan Facility approximates fair value because its interest rate is a variable rate that approximates rates currently available to us.

	June 30, 2019		December 31, 2018	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	(In millions)			
5.375% Notes	$ 695	$ 732	$ 694	$ 674
4.875% Notes	326	335	326	301
Term Loan Facility	220	220	—	—
1.125% Convertible Notes [1],[2]	65	231	240	732
Totals	$ 1,306	$ 1,518	$ 1,260	$ 1,707

(1) The fair value of the 1.125% Conversion Option (the embedded cash conversion option), which is reflected in the fair value amounts presented above, amounted to $169 million and $476 million as of June 30, 2019, and December 31, 2018, respectively. See further discussion at Note 7, “Debt,” and Note 8, “Derivatives.”

(2) For more information on debt repayments in 2019, refer to Note 7, “Debt.”

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets to be available-for-sale. The following tables summarize our investments as of the dates indicated:

	June 30, 2019			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,292	$ 6	$ 1	$ 1,297
Mortgage-backed securities	248	1	—	249
Asset-backed securities	161	—	—	161
GSEs	160	—	1	159
Municipal securities	108	1	—	109
U.S. Treasury notes	87	—	—	87
Certificates of deposit	6	—	—	6
Other	2	—	—	2
Totals	$ 2,064	$ 8	$ 2	$ 2,070

	December 31, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,131	$ —	$ 8	$ 1,123
Asset-backed securities	83	—	1	82
GSEs	164	—	1	163
Municipal securities	115	—	1	114
U.S. Treasury notes	181	—	—	181
Certificates of deposit	14	—	—	14
Other	4	—	—	4
Total current investments	$ 1,692	$ —	$ 11	$ 1,681

The contractual maturities of our available-for-sale investments as of June 30, 2019 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 821	$ 821
Due after one year through five years	917	921
Due after five years through ten years	124	125
Due after ten years	202	203
Totals	$ 2,064	$ 2,070

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and six months ended June 30, 2019 and 2018, were insignificant.

We have determined that unrealized losses at June 30, 2019, and December 31, 2018, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of June 30, 2019:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ —	$ —	—	$ 263	$ 1	168
GSEs	—	—	—	114	1	67
Totals	$ —	$ —	—	$ 377	$ 2	235

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2018:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 509	$ 3	285	$ 412	$ 5	298
Asset-backed securities	—	—	—	68	1	52
GSEs	—	—	—	127	1	76
Municipal securities	—	—	—	87	1	90
Totals	$ 509	$ 3	285	$ 694	$ 8	516

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. Treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current “Restricted investments” in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

The contractual maturities of our held-to-maturity restricted investments are carried at amortized cost, which approximates fair value, as of June 30, 2019, are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 92	$ 92
Due after one year through five years	6	6
Totals	$ 98	$ 98

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated.

	June 30, 2019	December 31, 2018
	(In millions)	
Fee-for-service claims incurred but not paid ("IBNP")	$ 1,346	$ 1,562
Pharmacy payable	117	115
Capitation payable	63	52
Other	241	232
	$ 1,767	$ 1,961

"Other" medical claims and benefits payable includes amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $112 million and $107 million as of June 30, 2019, and December 31, 2018, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amounts by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability, based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30,	
	2019	2018
	(In millions)	
Medical claims and benefits payable, beginning balance	$ 1,961	$ 2,192
Components of medical care costs related to:		
Current period	7,069	7,870
Prior periods [1]	(232)	(298)
Total medical care costs	6,837	7,572
Change in non-risk and other provider payables	4	56
Payments for medical care costs related to:		
Current period	5,585	6,248
Prior periods	1,450	1,652
Total paid	7,035	7,900
Medical claims and benefits payable, ending balance	$ 1,767	$ 1,920

(1) The June 30, 2018, amount includes the 2018 benefit of the 2017 Marketplace CSR reimbursement of $76 million.

Our estimates of medical claims and benefits payable recorded at December 31, 2018, and 2017 developed favorably by approximately $232 million and $298 million as of June 30, 2019, and 2018, respectively.

The favorable prior year development recognized in the six months ended June 30, 2019, was primarily due to lower than expected utilization of medical services by our Medicaid members, and improved operating performance. Consequently, the ultimate costs recognized in 2019, as claims payments were processed, was lower than our original estimates in 2018.

7. Debt

As of June 30, 2019, contractual maturities of debt were as follows. All amounts represent the principal amounts of the debt instruments outstanding.

	Total	2020	2021	2022	2023	2024	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ 700	$ —	$ —	$ —
4.875% Notes	330	—	—	—	—	—	330
Term Loan Facility	220	6	16	22	22	154	—
1.125% Convertible Notes	67	67	—	—	—	—	—
Totals	$ 1,317	$ 73	$ 16	$ 722	$ 22	$ 154	$ 330

All of our debt is held at the parent, which is reported, for segment purposes, in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets:

	June 30, 2019	December 31, 2018
	(In millions)	
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 65	$ 241
Lease financing obligations	—	1
Debt issuance costs	—	(1)
	$ 65	$ 241
Non-current portion of long-term debt:		
5.375% Notes	$ 700	$ 700
4.875% Notes	330	330
Term Loan Facility	220	—
Debt issuance costs	(9)	(10)
Totals	$ 1,241	$ 1,020

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(In millions)			
Contractual interest at coupon rate	$ —	$ 2	$ 1	$ 4
Amortization of the discount	1	6	4	13
Totals	$ 1	$ 8	$ 5	$ 17

Credit Agreement

We are party to a Credit Agreement, which provides for an unsecured delayed draw term loan facility (the "Term Loan Facility"), and an unsecured $500 million revolving credit facility (the "Credit Facility"). Borrowings under our Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Agreement, we are required to pay a quarterly commitment fee.

The Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of June 30, 2019, we were in compliance with all financial and non-financial covenants under the Credit Agreement and other long-term debt. Effective as of the date of the Sixth Amendment to the Credit Agreement described below, there are no guarantors as parties to the Credit Agreement.

Term Loan Facility. In January 2019, we entered into a Sixth Amendment to the Credit Agreement that provided for a delayed draw Term Loan Facility in the aggregate principal amount of $600 million, under which we may request up to ten advances, each in a minimum principal amount of $50 million, until July 31, 2020. The Term Loan Facility

will amortize in quarterly installments, commencing on September 30, 2020, equal to the principal amount of the Term Loan Facility outstanding multiplied by rates ranging from 1.25% to 2.50% (depending on the applicable fiscal quarter) for each fiscal quarter. The Term Loan Facility expires on January 31, 2024; any remaining outstanding balance under the Term Loan Facility will be due and payable on that date. As of June 30, 2019, $220 million was outstanding under the Term Loan Facility, including a $120 million draw-down in the second quarter of 2019. Each advance under the Term Loan Facility results in a permanent reduction to its borrowing capacity; therefore, our borrowing capacity under the Term Loan Facility as of June 30, 2019, was $380 million.

Credit Facility. The Credit Facility expires on January 31, 2022; therefore, any amounts outstanding under the Credit Facility will be due and payable on that date. As of June 30, 2019, no amounts were outstanding under the Credit Facility, and outstanding letters of credit amounting to $2 million reduced our borrowing capacity under the Credit Facility to $498 million.

5.375% Notes due 2022

We had $700 million aggregate principal amount of senior notes (the "5.375% Notes") outstanding as of June 30, 2019, which are due November 15, 2022, unless earlier redeemed. Interest, at a rate of 5.375% per annum, is payable semiannually in arrears on May 15 and November 15. The 5.375% Notes contain customary non-financial covenants and change in control provisions.

4.875% Notes due 2025

We had $330 million aggregate principal amount of senior notes (the "4.875% Notes") outstanding as of June 30, 2019, which are due June 15, 2025, unless earlier redeemed. Interest, at a rate of 4.875% per annum, is payable semiannually in arrears on June 15 and December 15. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

1.125% Cash Convertible Senior Notes due 2020

In the first half of 2019, we entered into privately negotiated note purchase agreements with certain holders of our outstanding 1.125% cash convertible senior notes due January 15, 2020 (the "1.125% Convertible Notes").

In the second quarter of 2019, we repaid $139 million aggregate principal amount, or $134 million aggregate carrying amount, of the 1.125% Convertible Notes. In addition, we paid $358 million to settle the 1.125% Convertible Notes' embedded cash conversion option feature at fair value (which is a derivative liability we refer to as the "1.125% Conversion Option").

In the first quarter of 2019, we repaid $46 million aggregate principal amount, or $44 million aggregate carrying amount, of the 1.125% Convertible Notes. In addition, we paid $115 million to settle the 1.125% Convertible Notes' embedded cash conversion option feature at fair value.

In the three and six months ended June 30, 2019, we recorded gains on debt extinguishment of $14 million and $17 million, respectively, for the 1.125% Convertible Notes repayments (net of accelerated original issuance discount amortization), primarily relating to a favorable mark to market valuations on the partial terminations of the Call Spread Overlay executed in connection with the related debt repayments. These gains are reported in "Other (income) expenses, net" in the accompanying consolidated statements of income. No common shares were issued in connection with the transaction.

In connection with the 1.125% Convertible Notes purchases, we also entered into privately negotiated agreements in the first and second quarters of 2019, to partially terminate the Call Spread Overlay, defined and further discussed in Note 8, "Derivatives," and Note 9, "Stockholders' Equity." The net cash proceeds from the Call Spread Overlay partial termination transactions partially offset the cash paid to settle the 1.125% Convertible Notes.

Following the transactions described above, $67 million aggregate principal amount of the 1.125% Convertible Notes were outstanding at June 30, 2019. Interest at a rate of 1.125% per annum is payable semiannually in arrears on January 15 and July 15. The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date. The 1.125% Convertible Notes mature on January 15, 2020; therefore, they are reported in current portion of long-term debt.

Concurrent with the issuance of the 1.125% Convertible Notes in 2013, the 1.125% Conversion Option was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in

fair value reported in our consolidated statements of income until the 1.125% Conversion Option fully settles or expires. This initial liability simultaneously reduced the carrying value of the 1.125% Convertible Notes' principal amount (effectively an original issuance discount), which is amortized to the principal amount through the recognition of non-cash interest expense over the expected life of the debt. The effective interest rate of 6% approximates the interest rate we would have incurred had we issued nonconvertible debt with otherwise similar terms. As of June 30, 2019, the 1.125% Convertible Notes had a remaining amortization period of less than one year, and their 'if-converted' value exceeded their principal amount by approximately $157 million and $581 million as of June 30, 2019 and December 31, 2018, respectively.

Cross-Default Provisions

The indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	June 30, 2019	December 31, 2018
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 169	$ 476
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 169	$ 476

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in "Other (income) expenses, net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Convertible Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

In the first and second quarters of 2019, in connection with the 1.125% Convertible Notes purchases (described in Note 7, "Debt"), we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased. In the second quarter of 2019, this resulted in our receipt of $358 million for the settlement of the 1.125% Call Option (which is a derivative asset), and the payment of $321 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $37 million from the Counterparties.

In the first quarter of 2019, this resulted in our receipt of $115 million for the settlement of the 1.125% Call Option, and the payment of $103 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $12 million from the Counterparties.

1.125% Call Option

The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further

discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, “Fair Value Measurements.”

1.125% Conversion Option

The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, “Fair Value Measurements.”

As of June 30, 2019, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes mature on January 15, 2020, as described in Note 7, “Debt.”

9. Stockholders' Equity

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, “Derivatives,” in 2013, we issued 13.5 million warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, if the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Following the transactions described below, 1.7 million of the 1.125% Warrants remain outstanding.

As described in Note 8, “Derivatives,” in the first half of 2019, we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased.

In the second quarter of 2019, we paid $321 million to the Counterparties for the termination of 3.4 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in-capital for the same amount.

In the first quarter of 2019, we paid $103 million to the Counterparties for the termination of 1.1 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in-capital for the same amount.

Share-Based Compensation

In connection with our employee stock plans, approximately 180,000 shares of common stock vested or were purchased, net of shares used to settle employees’ income tax obligations, during the six months ended June 30, 2019.

Share-based compensation is recorded to “General and administrative expenses” in the accompanying consolidated statements of income. Total share-based compensation expense amounted to $10 million and $7 million, respectively, in the three months ended June 30, 2019 and 2018. Total share-based compensation expense amounted to $19 million and $13 million, respectively, in the six months ended June 30, 2019 and 2018.

Equity Incentive Plan

In the second quarter of 2019, stockholders approved the Molina Healthcare, Inc. 2019 Equity Incentive Plan (the “2019 EIP”). The 2019 EIP provides for awards, in the form of restricted stock awards, performance units, stock options, and other stock– or cash–based awards, to eligible persons who perform services for us. The 2019 EIP will continue in effect until its termination by the board of directors; provided, however, that all awards will be granted no later than May 8, 2029. Concurrent with the adoption of the 2019 EIP, the Molina Healthcare, Inc. 2011 Equity Incentive Plan was amended, restated and merged into the 2019 EIP. A maximum of 2.9 million shares of our common stock may be issued under the 2019 EIP.

As of June 30, 2019, there was $62 million of total unrecognized compensation expense related to unvested restricted stock awards (“RSAs”), and performance stock units (“PSUs”), which we expect to recognize over remaining weighted-average periods of 2.7 years and 2.1 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 15.2% for non-executive employees as of June 30, 2019.

Also as of June 30, 2019, there was $7 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.3 years. No stock options were granted or exercised in the six months ended June 30, 2019.

Activity for RSAs, performance stock awards ("PSAs") and PSUs is summarized below:

	RSAs	PSAs	PSUs	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2018	399,795	3,132	201,383	604,310	$ 71.50
Granted	218,245	—	138,994	357,239	137.42
Vested	(129,526)	(3,132)	(10,528)	(143,186)	70.57
Forfeited	(29,597)	—	(5,010)	(34,607)	83.05
Unvested balance, June 30, 2019	458,917	—	324,839	783,756	$ 101.20

The aggregate fair values of RSAs, PSUs and PSAs granted and vested are presented in the following table:

	Six Months Ended June 30,	
	2019	2018
	(In millions)	
Granted:		
RSAs	$ 30	$ 25
PSUs	19	16
Total granted	$ 49	$ 41
Vested:		
RSAs	$ 18	$ 14
PSUs	2	—
PSAs	—	3
Total vested	$ 20	$ 17

Employee Stock Purchase Plan

In May 2019, stockholders approved the 2019 Employee Stock Purchase Plan (the "2019 ESPP"), which superseded the 2011 ESPP. A maximum of 3.0 million shares of our common stock may be issued under the 2019 ESPP, the terms of which are substantially similar to the Molina Healthcare, Inc. Employee Stock Purchase Plan (the "2011 ESPP"). The 2019 ESPP will continue until the earliest of: termination of the 2019 ESPP by the board of directors (which may occur at any time); issuance of all of the shares reserved for issuance under the 2019 ESPP; or May 9, 2029.

10. Restructuring Costs

Restructuring costs are reported by the same name in the accompanying consolidated statements of income.

IT Restructuring Plan

Management is focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we began a plan to restructure our information technology department (the "IT Restructuring Plan") in 2018. In early 2019, we entered into services agreements with our outsourcing vendor under which they manage certain of our information technology services.

We expect to complete the IT Restructuring Plan by the end of 2019, incurring cumulative total costs of approximately $15 million in the Other segment. This estimate of cumulative total costs is lower than the $20 million reported in our Annual Report on Form 10-K for the year ended December 31, 2018, because more of our IT employees transitioned to our outsourcing vendor than originally contemplated. Once employed by our outsourcing vendor, such employees are no longer included in the IT Restructuring Plan, which therefore resulted in lower one-time termination costs.

As of December 31, 2018, there was $6 million accrued under the IT Restructuring Plan, primarily for one-time termination benefits that require cash settlement. In the first half of 2019, we incurred $2 million of other

restructuring costs, and paid $5 million to settle one-time termination benefits and $2 million to settle other restructuring costs. As of June 30, 2019, there was $1 million accrued under the IT Restructuring Plan.

As of June 30, 2019, we had incurred cumulative restructuring costs under the IT Restructuring Plan of $11 million, including $7 million of one-time termination benefits and $4 million of other restructuring costs (primarily consulting fees).

2017 Restructuring Plan

As of December 31, 2018, accrued liabilities of $18 million remained for the restructuring and profitability improvement plan approved by the board of directors in June 2017 (the "2017 Restructuring Plan"). In the first half of 2019, we incurred $3 million of restructuring costs for adjustments to previously recorded lease contract termination costs, and paid $4 million to settle one-time termination and lease contract termination costs. As of June 30, 2019, accrued liabilities of $17 million remained for lease contract termination costs under the 2017 Restructuring Plan. We expect to continue to settle these liabilities through 2025, unless the leases are terminated sooner.

11. Segments

We currently have two reportable segments: our Health Plans segment and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Description of Earnings Measures for Reportable Segments

Margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Margin for our Health Plans segment is referred to as "Medical Margin," which represents the amount earned after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the segments. Therefore, the underlying Medical Margin is the most important measure of earnings reviewed by the chief operating decision maker.

The following table presents total revenue by segment. Inter-segment revenue was insignificant for all periods presented.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(In millions)			
Total revenue:				
Health Plans	$ 4,190	$ 4,752	$ 8,307	$ 9,261
Other	3	131	5	268
Consolidated	$ 4,193	$ 4,883	$ 8,312	$ 9,529

The following table reconciles margin by segment to consolidated income before income taxes:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(In millions)			
Margin:				
Health Plans	$ 583	$ 664	$ 1,164	$ 1,265
Other	—	9	—	23
Total margin	583	673	1,164	1,288
Add: other operating revenues [1]	144	242	311	431
Less: other operating expenses [2]	(462)	(573)	(930)	(1,155)
Operating income	265	342	545	564
Other expenses, net	8	37	28	80
Income before income tax expense	$ 257	$ 305	$ 517	$ 484

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, and investment income and other revenue.
(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, and restructuring costs.

12. Commitments and Contingencies

Legal Proceedings

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously collected revenues.

In the ordinary course of business we are involved in legal actions, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and reasonably estimable, but the outcome of legal actions is inherently uncertain and our estimates of such losses could change as a result of further developments of these matters. For certain pending matters, accruals have not been established because such matters have not progressed sufficiently through discovery or factual development to enable us to reasonably estimate a range of possible loss. An adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and Children's Health Insurance Program ("CHIP") programs. The states and Commonwealth in which we operate our health plans regularly face significant budgetary pressures.

13. Leases

As discussed in Note 2, "Significant Accounting Policies," we elected the Topic 842 transition provision that allows entities to continue to apply the legacy guidance in Topic 840, *Leases*, including its disclosure requirements, in the comparative periods presented in the year of adoption. Accordingly, the Topic 842 disclosures below are presented as of and for the three-month and six-month periods ended June 30, 2019, only.

We are a party to operating and finance leases primarily for our corporate and health plan offices. Our operating leases have remaining lease terms up to 10 years, some of which include options to extend the leases for up to 10 years. As of June 30, 2019, the weighted average remaining operating lease term is 4 years.

Our finance leases have remaining lease terms of 3 years to 19 years, some of which include options to extend the leases for up to 25 years. As of June 30, 2019, the weighted average remaining finance lease term is 17 years.

As of June 30, 2019, the weighted-average discount rate used to compute the present value of lease payments was 5.5% for operating lease liabilities, and 6.6% for finance lease liabilities. The components of lease expense were as follows:

	Three Months Ended June 30, 2019	Six Months Ended June 30, 2019
	(In millions)	
Operating lease expense	$ 8	$ 17
Finance lease expense:		
Amortization of right-of-use ("ROU") assets	$ 4	$ 8
Interest on lease liabilities	4	8
Total finance lease expense	$ 8	$ 16

Supplemental consolidated cash flow information related to leases follows:

	Six Months Ended June 30, 2019
	(In millions)
Cash used in operating activities:	
Operating leases	$ 19
Finance leases	7
Cash used in financing activities:	
Finance leases	3
ROU assets recognized in exchange for lease obligations:	
Operating leases	95
Finance leases	241

Supplemental information related to leases, including location of amounts reported in the accompanying consolidated balance sheets, follows:

	June 30, 2019
	(In millions)
Operating leases:	
ROU assets	
Other assets	$ 77
Lease liabilities	
Accounts payable and accrued liabilities (current)	29
Other long-term liabilities (non-current)	56
Total operating lease liabilities	$ 85
Finance leases:	
ROU assets	
Property, equipment, and capitalized software, net	$ 233
Lease liabilities	
Accounts payable and accrued liabilities (current)	$ 7
Finance lease liabilities (non-current)	232
Total finance lease liabilities	$ 239

Maturities of lease liabilities as of June 30, 2019, were as follows:

	Operating Leases	Finance Leases
	(In millions)	
2019 (excluding the six months ended June 30, 2019)	$ 18	$ 11
2020	28	22
2021	18	22
2022	12	21
2023	10	21
Thereafter	9	311
Total lease payments	95	408
Less imputed interest	(10)	(169)
Totals	$ 85	$ 239

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS ("MD&A")

FORWARD-LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements included in this quarterly report, other than statements of historical fact, may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, or expected. Those known risks and uncertainties include, but are not limited to, the following:

- *the numerous political, judicial and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including the ultimate outcome on appeal of the Texas et al. v. U.S. et al. matter;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk adjustment requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment;*
- *effective management of our medical costs;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of our efforts to retain existing or awarded government contracts, including the success of any requests for proposal protest filings or defenses, including the Texas STAR+PLUS and STAR/CHIP RFPs;*
- *the ability to manage our operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion medical cost corridor, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*

- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of our health plan in Puerto Rico, including the resolution of the debt crisis and the effect of the PROMESA law, the effects of political and regulatory instability, and the impact of any future significant weather events;*
- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, eligibility re-determinations, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits, reviews, comment letters, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to our provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings, including litigation involving the ACA to which we are not a direct party;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of our California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *the failure to comply with the financial or other covenants in our credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of funds on hand to pay the amounts due upon conversion or maturity of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care industry;*
- *increases in government surcharges, taxes, and assessments;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm;*
- *the unexpected loss of the leadership of one or more of our senior executives; and*
- *increasing competition and consolidation in the Medicaid industry.*

Readers should refer to the section entitled “Risk Factors” in our Annual Report on Form 10-K for the year ended December 31, 2018, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This Quarterly Report on Form 10-Q and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management’s Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2018.

OVERVIEW

Molina Healthcare, Inc., a FORTUNE 500, multi-state healthcare organization, arranges for the delivery of healthcare services to individuals and families who receive their care through the Medicaid and Medicare programs, and through the state insurance marketplaces (the "Marketplace"). Through our locally operated health plans in 14 states and the Commonwealth of Puerto Rico, we served approximately 3.4 million members as of June 30, 2019. The health plans are generally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization ("HMO").

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. The Other segment includes the historical results of the Medicaid management information systems ("MMIS") and behavioral health subsidiaries we sold in the fourth quarter of 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Prior to the fourth quarter of 2018, the MMIS subsidiary was reported as a stand-alone segment. Beginning in 2019, we no longer report service revenue or cost of service revenue as a result of the sales of the MMIS and behavioral health subsidiaries noted above.

SECOND QUARTER 2019 HIGHLIGHTS

In summary, we produced pretax earnings of $257 million, and net income of $196 million in the second quarter of 2019, resulting in an after-tax margin of 4.7%. On a year-to-date basis, pretax earnings were $517 million and net income was $394 million, resulting in an after-tax margin of 4.7%. These results include, on a consolidated and year-to-date basis, a medical care ratio ("MCR") of 85.5% and a general and administrative ("G&A") expense ratio of 7.6%.

Program Performance

Our second quarter and year-to-date results met or exceeded our expectations, and our financial and operational profiles are strong.

In our Medicaid business, we achieved an 88.3% MCR for the first half of the year and performed well, with TANF and ABD generally performing in-line with our expectations. Medicaid Expansion results were better than we expected, mainly due to rate advocacy efforts. Additionally, medical cost trends in general remained well managed across all medical cost categories as the result of our continued improvement in utilization management and payment integrity initiatives, and we continued to improve our retention of quality incentive premium revenues.

Performance in our Medicare business, comprising our Special Needs Plans and Medicaid-Medicare Plan ("MMP") products, continued to perform well, managing to an MCR of 85.0% for the first half of the year. We are continuing to manage high-acuity members, including long-term services and supports ("LTSS") benefits embedded in our MMP product, and risk-adjusted revenue has increased, as our risk scores are more commensurate with the acuity of this population. Our medical margin performance provides us with flexibility to reinvest margins in additional benefits, which should help us maintain our product competitiveness as we position to grow this business in 2020 and beyond.

Finally, our Marketplace business continues to perform in line with our expectations, and we managed to an MCR of 64.7% for the first half of the year. We continue to generate risk scores that are more commensurate with the acuity of our membership, and as a result, we are paying less into the risk adjustment transfer pool than we anticipated. The risk pool has seasoned and our medical cost trend is stable and well-managed, and our monthly membership lapse rate is within our expected level of less than 2%. These results and metrics were in-line with our expectations, and our medical margin performance also gives us flexibility to make any changes in rates, value-added benefits to the product, and commissions that we believe may be necessary to grow membership in 2020, while still achieving a sustainable and attractive margin.

Health Plan Performance

We significantly improved the performance of our locally operated health plans in 2018, and they have continued to perform well into 2019. Comments relating to California, Ohio, Washington and Texas, our largest health plans from a revenue standpoint, follow:

California continues to perform well in its diversified book of business in one of the more complex network environments in the country, and the MCR is performing in the mid to low 80s as a result of effective low-cost networks and effective medical cost management. Our California plan is poised to grow, particularly in returning to meaningful market share in the Marketplace.

In Ohio, we are serving 297,000 members, and we are generating strong medical margins. With a total MCR of 87.3% for the second quarter and 88.2% for the first half of the year, the temporal spike in medical costs due to the introduction of the behavioral health benefit, and the higher acuity mix due to redetermination efforts, has been ameliorated by our strong rate advocacy in the state.

In Washington, we have a well-diversified portfolio of products and our medical margin performance is returning to a level that is consistent with past periods, even with the confluence of significant membership growth due to our successful re-procurement, and the introduction of the new integrated behavioral health benefit. The relatively higher medical cost trends experienced in the first quarter, due to the significant growth, have abated due to increased focus on managing in-patient costs and care management.

In Texas, we await the announcement of awards for the state's program for the aged, blind or disabled ("ABD"), known in Texas as STAR+PLUS, the program for Temporary Assistance for Needy Families ("TANF"), known in Texas as STAR, and the Children's Health Insurance Program ("CHIP"), in the third quarter of this year. The continued, strong performance of our ABD program is built upon our solid skilled nursing facility network and an effective platform for managing personal attendant services.

G&A Expenses

Our G&A expense ratio increased 40 basis points to 7.6% in the first half of 2019, from 7.2% for the same period in 2018, due mainly to the year-over-year decline in overall revenues.

Balance Sheet and Capital Management

We continue to improve our balance sheet, as we repaid an additional $139 million aggregate principal amount of our 1.125% Convertible Notes in the second quarter, for a total of $185 million year to date. The impact of capital deployment actions in the quarter resulted in lower interest expense, a gain on repayment of the convertible notes, and a lower share count. In addition, we have received conversion notices for approximately $9 million principal amount of our 1.125% Convertible Notes that will be settled in the third quarter of 2019.

FINANCIAL SUMMARY

	Three Months Ended June 30,		Six Months Ended June 30,	
	2019	2018	2019	2018
	(Dollars in millions, except per-share amounts)			
Premium revenue	$ 4,049	$ 4,514	$ 8,001	$ 8,837
Premium tax revenue	110	106	248	210
Health insurer fees reimbursed	—	104	—	165
Investment income and other revenue	34	32	63	56
Medical care costs	3,466	3,850	6,837	7,572
General and administrative expenses	328	335	630	687
Premium tax expenses	110	106	248	210
Health insurer fees	—	99	—	174
Restructuring costs	2	8	5	33
Operating income	265	342	545	564
Interest expense	22	32	45	65
Other (income) expenses, net	(14)	5	(17)	15
Income before income tax expense	257	305	517	484
Income tax expense	61	103	123	175
Net income	196	202	394	309
Net income per diluted share	$ 3.06	$ 3.02	$ 6.04	$ 4.68
Operating Statistics:				
Ending total membership	3,370,000	4,063,000	3,370,000	4,063,000
MCR (1)	85.6%	85.3%	85.5%	85.7%
G&A ratio (2)	7.8%	6.9%	7.6%	7.2%
Premium tax ratio (1)	2.6%	2.3%	3.0%	2.3%
Effective income tax expense rate	24.0%	33.8%	23.9%	36.2%
After-tax margin (2)	4.7%	4.1%	4.7%	3.2%

(1) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) After-tax margin represents net income as a percentage of total revenue. G&A ratio represents general and administrative expenses as a percentage of total revenue.

CONSOLIDATED RESULTS

NET INCOME AND OPERATING INCOME

Net income in the second quarter of 2019 amounted to $196 million, or $3.06 per diluted share, compared with $202 million, or $3.02 per diluted share, in the second quarter of 2018. Current quarter net income was driven by lower operating income, which amounted to $265 million in the second quarter of 2019, compared with $342 million in the second quarter of 2018, mainly resulting from the year-over-year decline in premium revenue.

Net income in the six months ended June 30, 2019, amounted to $394 million, or $6.04 per diluted share, compared with $309 million, or $4.68 per diluted share, in the six months ended June 30, 2018. Operating income amounted to $545 million in the six months ended June 30, 2019, compared with $564 million in the six months ended June 30, 2018.

In both the second quarter and six months ended June 30, 2019, earnings per diluted share improved due to the reduction of the dilutive impact of the 1.125% Warrants, as a result of the termination transactions that settled

between June 2018 and June 2019. See further discussion in Notes to Consolidated Financial Statements, Note 9, “Stockholders' Equity.”

PREMIUM REVENUE

Premium revenue decreased $465 million in the second quarter of 2019, when compared with the second quarter of 2018. Member months declined 18%, partially offset by a per-member per-month (“PMPM”) revenue increase of 8%. Premium revenue decreased $836 million in the six months ended June 30, 2019, when compared with the six months ended June 30, 2018. Member months declined 18%, partially offset by a PMPM revenue increase of 9%. In both periods, lower premium revenue was primarily in the Medicaid and Marketplace programs.

The decline in Medicaid premium revenue was driven primarily by the loss in membership due to the previously announced loss of the New Mexico Medicaid contract, along with the resizing of the Florida Medicaid contract as reported throughout 2018, partially offset by Medicaid premium rate increases.

The decline in Marketplace premium revenue was driven primarily by a relatively smaller benefit from prior year Marketplace risk adjustment in 2019 compared with 2018 due to declining Marketplace membership, partially offset by Marketplace premium rate increases.

MEDICAL CARE RATIO

The consolidated MCR increased to 85.6% in the second quarter of 2019, from 85.3% in the second quarter of 2018, and decreased to 85.5% in the six months ended June 30, 2019, from 85.7% in the six months ended June 30, 2018.

The increased MCR in the second quarter of 2019 was mainly due to a relatively smaller benefit from prior year Marketplace risk adjustment in 2019 compared with 2018, and the impact of higher acuity Marketplace membership, partially offset by the impact of Marketplace rate increases and increased premiums tied to risk scores.

The improved MCR in the six months ended June 30, 2019 was mainly due to improvement in the TANF and ABD programs, partially offset by an increased MCR in the Medicaid Expansion program, primarily in California. In addition, the MCR for the six months ended June 30, 2018, included the benefit of the cost sharing (“CSR”) reimbursement related to 2017 dates of service, described in further detail below.

PREMIUM TAX REVENUE AND EXPENSES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.6% in the second quarter of 2019, compared with 2.3% in the second quarter of 2018; and 3.0% compared with 2.3% for the six months ended June 30, 2019 and 2018, respectively. The increase is mainly attributed to the state of Michigan’s implementation of an insurance provider assessment in 2019.

INVESTMENT INCOME AND OTHER REVENUE

Investment income and other revenue increased to $34 million in the second quarter of 2019, compared with $32 million in the second quarter of 2018, and increased to $63 million in the six months ended June 30, 2019, compared with $56 million in the six months ended June 30, 2018, mainly due to improved annualized portfolio yields in both periods.

G&A EXPENSES

The G&A expense ratio increased to 7.8% in the second quarter of 2019, from 6.9% in the second quarter of 2018, and increased to 7.6% in the six months ended June 30, 2019, compared with 7.2% in the six months ended June 30, 2018. This increase was primarily due to the impact of lower overall revenues in 2019.

HEALTH INSURER FEES

There are no health insurer fees (“HIF”) expensed or reimbursed in 2019 due to the moratorium under Public Law No. 115-120. In the second quarter of 2018 and the six months ended June 30, 2018, the HIF amounted to $99 million and $174 million, respectively, and HIF reimbursements amounted to $104 million and $165 million, respectively.

RESTRUCTURING COSTS

We incurred restructuring costs of $2 million and $5 million in the second quarter of 2019 and the six months ended June 30, 2019, respectively, mainly due to true-ups of lease terminations recorded in our 2017 Restructuring Plan. In the second quarter of 2018 and the six months ended June 30, 2018, we incurred restructuring costs of $8 million and $33 million, respectively, related to our 2017 Restructuring Plan.

INTEREST EXPENSE

Interest expense declined to $22 million in the second quarter of 2019, from $32 million in the second quarter of 2018, and declined to $45 million in the six months ended June 30, 2019, from $65 million in the six months ended June 30, 2018. As further described below in "Liquidity," we reduced the principal amount outstanding of our 1.125% Convertible Notes by $185 million in the six months ended June 30, 2019, and reduced total debt by $759 million in the year ended December 31, 2018. The decrease in interest expense in 2019 was partially offset by interest expense attributable to $220 million borrowed under our Term Loan Facility in the six months ended June 30, 2019.

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $1 million and $6 million in the second quarter of 2019, and 2018, respectively, and $4 million and $13 million in the six months ended June 30, 2019 and 2018, respectively. The decline in the first half of 2019 is due to repayment of our convertible senior notes throughout 2018 and in the first half of 2019. See further discussion in Notes to Consolidated Financial Statements, Note 7, "Debt."

OTHER (INCOME) EXPENSES, NET

In the second quarter of 2019 and the six months ended June 30, 2019, we recognized debt extinguishment gains of $14 million and $17 million, respectively, and in the second quarter of 2018 and the six months ended June 30, 2018, we recognized debt extinguishment losses of $5 million and $15 million, respectively, in connection with convertible senior notes repayment transactions. The gain in 2019 was due to a favorable mark to market valuation on the partial termination of the Call Spread Overlay executed in connection with the related debt extinguishment. See further discussion in Notes to Consolidated Financial Statements, Note 7, "Debt."

INCOME TAXES

The provision for income taxes was recorded at an effective rate of 24.0% in the second quarter of 2019, compared with 33.8% in the second quarter of 2018, and 23.9% in the six months ended June 30, 2019, compared with 36.2% in the six months ended June 30, 2018. The effective tax rate for 2019 differs from 2018 as a result of higher non-deductible expenses in 2018, primarily related to the non-deductible HIF. The HIF is not applicable in 2019 due to the moratorium under Public Law No. 115-120.

SUMMARY OF NON-RUN RATE ITEMS

The table below summarizes the impact of certain expenses and other items that management believes are not indicative of longer-term business trends and operations. The individual items presented below increase (decrease) income before income tax expense.

	Three Months Ended June 30,				Six Months Ended June 30,			
	2019		2018		2019		2018	
	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]
	(In millions except per diluted share amounts)							
Restructuring costs	$ (2)	$ (0.02)	$ (8)	$ (0.10)	$ (5)	$ (0.05)	(33)	(0.39)
Gain (loss) on debt extinguishment	14	0.17	(5)	(0.06)	17	0.21	(15)	(0.21)
	$ 12	$ 0.15	$ (13)	$ (0.16)	$ 12	$ 0.16	$ (48)	$ (0.60)

(1) Except for permanent differences between GAAP and tax (such as certain expenses that are not deductible for tax purposes), per diluted share amounts are generally calculated at the statutory income tax rate of 22.6% and 22% for 2019 and 2018, respectively.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums. Our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our Health Plans segment is the MCR, which represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Margin for our Health Plans segment is referred to as “Medical Margin.” Medical Margin amounted to $583 million in the second quarter of 2019, and $664 million in the second quarter of 2018. Medical Margin amounted to $1,164 million in the six months ended June 30, 2019, and $1,265 million in the six months ended June 30, 2018. Management’s discussion and analysis of the changes in the individual components of Medical Margin follows.

See Notes to Consolidated Financial Statements, Note 11, “Segments,” for more information on our reportable segments.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 14 states and the Commonwealth of Puerto Rico. As of June 30, 2019, these health plans served approximately 3.4 million members eligible for Medicaid, Medicare, and other government-sponsored healthcare programs for low-income families and individuals, including Marketplace members, most of whom receive government premium subsidies.

TRENDS AND UNCERTAINTIES

Decline in Membership and Premium Revenue

Medicaid Program

Our Medicaid contracts in New Mexico and in all but two regions in Florida terminated in late 2018 and early 2019. As a result, our Medicaid membership has decreased to approximately 97,000 members in Florida as of June 30, 2019, from 468,000 members in Florida and New Mexico, in the aggregate, as of December 31, 2018. In 2019, we continue to serve Medicare and Marketplace members in both Florida and New Mexico, as well as Medicaid members in two regions in Florida.

In addition, our Medicaid membership has declined further in Puerto Rico as a result of the entry of more managed care organizations to that market late last year. We served approximately 200,000 members in Puerto Rico as of June 30, 2019, compared with 252,000 members as of December 31, 2018.

Primarily as a result of the changes described above, our Medicaid premium revenues have decreased 11% in the six months ended June 30, 2019, when compared with the six months ended June 30, 2018, and we expect our Medicaid premium revenues to continue to decline in 2019 compared with 2018.

Marketplace Program

We estimate that our 2019 Marketplace end-of-year enrollment will decrease to approximately 270,000 to 280,000 members due to expected attrition. This enrollment is lower than the 308,000 and 362,000 members enrolled as of June 30, 2019, and December 31, 2018, respectively. Consequently, we expect our Marketplace premium revenues to continue to decrease in 2019 compared with 2018.

Status of Upcoming Contract Re-Procurements

Medicaid Program

Texas. In late 2018, our Texas health plan submitted two separate request for proposal (“RFP”) responses: one with regard to the STAR+PLUS program; and the other with regard to the STAR/CHIP programs. Based on the state’s July 9, 2019, addendum to the STAR+PLUS RFP, we currently expect the STAR+PLUS, and STAR/CHIP awards to be announced in the third quarter of 2019, with an operational effective date of September 1, 2020. As of June 30, 2019, our Texas health plan served 86,000 members under the existing STAR+PLUS contract, under which we estimate annualized premium revenues of approximately $1,660 million in 2019. As of June 30, 2019, our Texas

health plan served 116,000 members under the existing STAR/CHIP contracts, under which we estimate annualized premium revenues of approximately $310 million in 2019.

Ohio. We have received information that the state of Ohio expects to release its Medicaid contract RFP early in 2020, with an announcement of the awards likely in the third quarter of 2020, and an operational effective date of January 1, 2021.

California. We have received information that the state of California expects to release its Medicaid contract RFP in 2020, with new contracts effective in 2023.

A loss of any of our Texas, Ohio, or California Medicaid contracts would have a material adverse effect on our business, financial condition, cash flows, and results of operations.

MMP Program

California. In late April 2019, the Centers for Medicare and Medicaid Services ("CMS") approved the California Medicaid agency's request for a three-year extension of its duals demonstration program, through December 31, 2022. We estimate annualized premium revenues of approximately $180 million in 2019 under our California MMP program.

Illinois. The current authority for our MMP program in Illinois ends December 31, 2019. In March 2019, the Illinois Medicaid agency submitted a request to CMS for a one-year extension of its duals demonstration program, through December 31, 2020, with a possible three-year extension through 2022. We estimate annualized premium revenues of approximately $130 million in 2019 under our Illinois MMP program.

Ohio. In late April 2019, CMS approved the Ohio Medicaid agency's request for a three-year extension of its duals demonstration program, through December 31, 2022. We estimate annualized premium revenues of approximately $580 million in 2019 under our Ohio MMP program.

Pressures on Medicaid Funding

Due to states' budget challenges and political agendas at both the state and federal levels, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal or state spending on the Medicaid program, constitute a fundamental change to the federal role in healthcare and, if enacted, could have a material adverse effect on our business, financial condition, cash flows and results of operations. These proposals include elements such as the following, as well as numerous other potential changes and reforms:

- Changes in the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis;
- Requiring Medicaid beneficiaries to work; and
- Limiting the amount of lifetime benefits for Medicaid beneficiaries.

ACA

In December 2018, in a case brought by the state of Texas and nineteen other states, a federal judge in Texas held that the ACA's individual mandate is unconstitutional. He further held that the individual mandate is inseverable from the entire body of the ACA, and thus the entire ACA is unconstitutional. The District Court stayed its order pending appeal, and the decision has now been appealed to and argued before a three judge panel of the Fifth Circuit Court of Appeals. A decision of that court is expected by October of 2019, after which the case may be further appealed to the United States Supreme Court. Any final, not-appealable determination that the ACA is unconstitutional would have a material adverse effect on our business, financial condition, cash flows, and results of operations.

MEMBERSHIP

The following tables set forth our Health Plans membership as of the dates indicated:

	June 30, 2019	December 31, 2018	June 30, 2018
Ending Membership by Program:			
TANF and CHIP	2,008,000	2,295,000	2,464,000
Medicaid Expansion	595,000	660,000	675,000
ABD	359,000	406,000	415,000
Total Medicaid	2,962,000	3,361,000	3,554,000
MMP – Integrated [1]	57,000	54,000	55,000
Medicare Special Needs Plans (“Medicare”)	43,000	44,000	45,000
Total Medicare	100,000	98,000	100,000
Total Medicaid and Medicare	3,062,000	3,459,000	3,654,000
Marketplace	308,000	362,000	409,000
	3,370,000	3,821,000	4,063,000
Ending Membership by Health Plan:			
California	590,000	608,000	639,000
Florida [2]	142,000	313,000	398,000
Illinois	221,000	224,000	219,000
Michigan	360,000	383,000	397,000
New Mexico [2]	26,000	222,000	241,000
Ohio	297,000	302,000	320,000
Puerto Rico	200,000	252,000	326,000
South Carolina	130,000	120,000	114,000
Texas	360,000	423,000	450,000
Washington	811,000	781,000	776,000
Other [3]	233,000	193,000	183,000
	3,370,000	3,821,000	4,063,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) Our Medicaid contracts in New Mexico and in all but two regions in Florida terminated in late 2018 and early 2019. During 2019, we continue to serve Medicare and Marketplace members in both Florida and New Mexico, as well as Medicaid members in two regions in Florida.
(3) “Other” includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

THREE AND SIX MONTHS ENDED JUNE 30, 2019, COMPARED WITH THREE AND SIX MONTHS ENDED JUNE 30, 2018

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, MCR and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended June 30, 2019						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	6.1	$ 1,196	$ 196.36	$ 1,048	$ 172.13	87.7%	$ 148
Medicaid Expansion	1.8	695	384.94	594	328.85	85.4	101
ABD	1.1	1,176	1,088.48	1,061	981.84	90.2	115
Total Medicaid	9.0	3,067	341.72	2,703	301.15	88.1	364
MMP	0.1	406	2,421.89	356	2,118.95	87.5	50
Medicare	0.2	166	1,296.99	132	1,034.43	79.8	34
Total Medicare	0.3	572	1,934.17	488	1,648.73	85.2	84
Total Medicaid and Medicare	9.3	3,639	392.52	3,191	344.14	87.7	448
Marketplace	0.9	410	440.20	275	295.71	67.2	135
	10.2	$ 4,049	$ 396.87	$ 3,466	$ 339.72	85.6%	$ 583

	Three Months Ended June 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.5	$ 1,393	$ 186.18	$ 1,205	$ 161.13	86.5%	$ 188
Medicaid Expansion	2.1	761	372.04	676	330.83	88.9	85
ABD	1.3	1,288	1,033.34	1,209	969.27	93.8	79
Total Medicaid	10.9	3,442	319.52	3,090	286.89	89.8	352
MMP	0.1	367	2,224.30	313	1,893.91	85.1	54
Medicare	0.2	157	1,168.40	133	989.33	84.7	24
Total Medicare	0.3	524	1,751.49	446	1,488.85	85.0	78
Total Medicaid and Medicare	11.2	3,966	358.23	3,536	319.37	89.2	430
Marketplace	1.2	548	440.93	314	253.04	57.4	234
	12.4	$ 4,514	$ 366.57	$ 3,850	$ 312.68	85.3%	$ 664

	Six Months Ended June 30, 2019						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	12.3	$ 2,369	$ 192.83	$ 2,070	$ 168.56	87.4%	$ 299
Medicaid Expansion	3.6	1,359	377.30	1,188	329.65	87.4	171
ABD	2.2	2,343	1,078.40	2,103	967.59	89.7	240
Total Medicaid	18.1	6,071	336.20	5,361	296.85	88.3	710
MMP	0.3	794	2,388.88	689	2,073.30	86.8	105
Medicare	0.3	329	1,290.88	265	1,041.06	80.6	64
Total Medicare	0.6	1,123	1,911.98	954	1,624.97	85.0	169
Total Medicaid and Medicare	18.7	7,194	385.82	6,315	338.67	87.8	879
Marketplace	1.9	807	415.94	522	269.14	64.7	285
	20.6	$ 8,001	$ 388.66	$ 6,837	$ 332.11	85.5%	$ 1,164

	Six Months Ended June 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	14.9	$ 2,766	$ 185.66	$ 2,477	$ 166.32	89.6%	$ 289
Medicaid Expansion	4.1	1,513	372.39	1,317	324.19	87.1	196
ABD	2.5	2,542	1,023.83	2,364	951.99	93.0	178
Total Medicaid	21.5	6,821	318.11	6,158	287.22	90.3	663
MMP	0.3	724	2,180.86	618	1,858.87	85.2	106
Medicare	0.3	314	1,178.58	264	992.05	84.2	50
Total Medicare	0.6	1,038	1,735.05	882	1,473.30	84.9	156
Total Medicaid and Medicare	22.1	7,859	356.59	7,040	319.43	89.6	819
Marketplace	2.6	978	373.67	532	203.34	54.4	446
	24.7	$ 8,837	$ 358.40	$ 7,572	$ 307.11	85.7%	$ 1,265

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid Program

The Medical Margin of our Medicaid program increased $12 million, or 3% in the second quarter of 2019 when compared with the second quarter of 2018, and increased $47 million, or 7% in the six months ended June 30, 2019, when compared with the six months ended June 30, 2018. The increase in both periods was due to improvement in the overall Medicaid MCR, which more than offset the impact of declining Medicaid premium revenue. The Medicaid MCR decreased to 88.1% from 89.8%, or 170 basis points, in the second quarter of 2019 when compared to the same period in 2018, and decreased to 88.3% from 90.3%, or 200 basis points, in the six months ended June 30, 2019, when compared with the same period in 2018.

The improved Medicaid MCR for both periods in 2019 mainly resulted from a lower MCR in the ABD program, which was principally driven by lower pharmacy costs from re-contracted pharmacy benefits management and our continued focus on medical cost management. The improvement in the MCR for the second quarter of 2019 was additionally driven by a decrease in the Medicaid Expansion MCR, which improved 350 basis points when compared with the second quarter of 2018, mainly due to the impact of rate increases and retrospective premium increases. The Medicaid Expansion MCR increased slightly in the six months ended June 30, 2019, when compared with the six months ended June 30, 2018, due to lower premium revenue in California and higher inpatient and outpatient fee for service costs in California. The decline in Expansion premium revenue in California mainly resulted from the rate reduction we received in July 2018.

Medicaid premium revenue decreased $375 million and $750 million in the second quarter of 2019 and the six months ended June 30, 2019, respectively, mainly due to the loss in membership in connection with the termination of our Medicaid contracts in New Mexico and in all but two regions in Florida in late 2018 and early 2019, partially

offset by net rate increases in certain other markets. As noted above, we expect lower Medicaid premium revenue throughout 2019, when compared with 2018.

Medicare Program

The Medical Margin of our Medicare program increased $6 million, or 8%, in the second quarter of 2019, when compared with the second quarter of 2018, and increased $13 million, or 8%, in the six months ended June 30, 2019 when compared with the six months ended June 30, 2018. Premiums continue to increase and are higher compared with the prior year, mainly due to risk scores that are more commensurate with the acuity of our population.

Marketplace Program

The Marketplace Medical Margin decreased $99 million in the second quarter of 2019, when compared with the second quarter of 2018, and decreased $161 million in the six months ended June 30, 2019, when compared with the six months ended June 30, 2018. The decrease in both periods in 2019 is mostly attributed to a decrease in premium revenues, driven by a decrease in membership of over 20%, partially offset by premium rate increases and increased premiums tied to risk scores. Additionally, the decrease in premiums in both periods in 2019 reflects a relatively smaller benefit from prior year Marketplace risk adjustment in 2019 compared with 2018, and the impact of higher acuity membership. As noted above, we expect Marketplace premium revenue to be lower in 2019, when compared with 2018.

The decrease in Medical Margin for the six months ended June 30, 2019, was partially driven by the impact of $76 million of CSR reimbursement recognized in the six months ended June 30, 2018. The CSR benefit related to 2017 dates of service and was recognized following the federal government's confirmation that the reconciliation would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

The MCR for the Marketplace program amounted to 67.2% in the second quarter of 2019, compared with 57.4% in the second quarter of 2018, and 64.7% in the six months ended June 30, 2019, compared with 54.4% in the six months ended June 30, 2018. The increased MCR in both periods in 2019 reflects a relatively smaller benefit from prior year Marketplace risk adjustment in 2019 compared with 2018, and the impact of higher acuity membership, partially offset by the impact of rate increases and increased premiums tied to risk scores. Additionally, the increase in MCR for the six months ended June 30, 2019, reflects the impact of the CSR reimbursement recognized in the six months ended June 30, 2018.

FINANCIAL PERFORMANCE BY HEALTH PLAN

The following tables summarize member months, premium revenue, medical care costs, MCR, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Medicaid and Medicare

	Three Months Ended June 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.6	$ 499	$ 305.40	$ 415	$ 253.85	83.1%	$ 84
Florida	0.3	126	417.10	120	399.22	95.7	6
Illinois	0.6	242	364.15	215	323.96	89.0	27
Michigan	1.1	403	376.39	332	310.08	82.4	71
Ohio	0.9	630	701.22	553	615.59	87.8	77
Puerto Rico	0.6	122	198.95	109	177.56	89.2	13
South Carolina	0.4	140	362.24	125	322.55	89.0	15
Texas	0.7	598	916.74	551	844.02	92.1	47
Washington	2.4	611	257.79	535	225.67	87.5	76
Other [1] [2]	0.7	268	394.85	236	347.43	88.0	32
	9.3	$ 3,639	$ 392.52	$ 3,191	$ 344.14	87.7%	$ 448

	Three Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 517	$ 289.80	$ 441	$ 247.36	85.4%	$ 76
Florida	1.2	377	353.81	362	339.31	95.9	15
Illinois	0.6	203	311.60	170	261.59	84.0	33
Michigan	1.2	388	342.45	331	292.20	85.3	57
New Mexico [2]	0.7	313	469.88	290	435.36	92.7	23
Ohio	1.0	535	571.08	482	514.57	90.1	53
Puerto Rico	0.9	184	188.26	165	168.20	89.3	19
South Carolina	0.4	123	350.22	107	304.20	86.9	16
Texas	0.7	576	835.66	510	740.55	88.6	66
Washington	2.2	571	252.61	526	232.49	92.0	45
Other [1]	0.5	179	322.99	152	274.59	85.0	27
	11.2	$ 3,966	$ 358.23	$ 3,536	$ 319.37	89.2%	$ 430

	Six Months Ended June 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	3.3	$ 998	$ 302.59	$ 863	$ 261.66	86.5%	$ 135
Florida	0.7	288	399.86	247	343.24	85.8	41
Illinois	1.3	469	356.16	400	303.50	85.2	69
Michigan	2.2	798	369.66	658	305.00	82.5	140
Ohio	1.8	1,220	680.20	1,090	607.85	89.4	130
Puerto Rico	1.2	224	181.91	199	161.40	88.7	25
South Carolina	0.8	276	362.68	240	315.84	87.1	36
Texas	1.3	1,197	909.59	1,083	822.59	90.4	114
Washington	4.8	1,225	258.10	1,121	236.19	91.5	104
Other [1] [2]	1.3	499	383.07	414	317.56	82.9	85
	18.7	$ 7,194	$ 385.82	$ 6,315	$ 338.67	87.8%	$ 879

	Six Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	3.6	$ 1,011	$ 281.14	$ 853	$ 237.26	84.4%	$ 158
Florida	2.2	759	352.68	707	328.26	93.1	52
Illinois	1.1	344	305.94	292	259.87	84.9	52
Michigan	2.3	764	339.56	662	294.19	86.6	102
New Mexico [2]	1.4	632	468.00	600	444.44	95.0	32
Ohio	1.9	1,086	573.87	942	497.75	86.7	144
Puerto Rico	1.9	370	190.68	339	174.74	91.6	31
South Carolina	0.7	245	349.15	211	300.87	86.2	34
Texas	1.4	1,138	822.72	1,029	744.05	90.4	109
Washington	4.5	1,155	254.64	1,100	242.48	95.2	55
Other [1]	1.1	355	318.94	305	273.97	85.9	50
	22.1	$ 7,859	$ 356.59	$ 7,040	$ 319.43	89.6%	$ 819

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

(2) In 2019, "Other" includes the New Mexico health plan. The New Mexico health plan's Medicaid contract terminated on December 31, 2018, and therefore its 2019 results are not individually significant to our consolidated operating results.

Health Plans Segment Financial Data — Marketplace

	Three Months Ended June 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 61	$ 382.22	$ 35	$ 220.31	57.6%	$ 26
Florida	0.1	50	390.03	30	236.50	60.6	20
Michigan	—	10	521.67	6	308.37	59.1	4
Ohio	0.1	24	754.67	19	565.69	75.0	5
Texas	0.3	167	379.29	117	267.12	70.4	50
Washington	0.1	51	803.11	35	548.48	68.3	16
Other (1)	0.1	47	527.41	33	376.04	71.3	14
	0.9	$ 410	$ 440.20	$ 275	$ 295.71	67.2%	$ 135

	Three Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 73	$ 426.16	$ 21	$ 117.92	27.7%	$ 52
Florida	0.1	100	698.31	38	269.86	38.6	62
Michigan	—	15	288.67	7	146.97	50.9	8
New Mexico	—	31	418.82	18	247.06	59.0	13
Ohio	—	31	518.64	23	381.46	73.6	8
Texas	0.7	222	330.12	160	238.72	72.3	62
Washington	0.2	56	787.80	41	572.48	72.7	15
Other (2)	—	20	NM	6	NM	NM	14
	1.2	$ 548	$ 440.93	$ 314	$ 253.04	57.4%	$ 234

	Six Months Ended June 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.3	$ 117	$ 361.73	$ 68	$ 210.71	58.2%	$ 49
Florida	0.3	111	406.52	56	205.17	50.5	55
Michigan	—	20	492.23	11	255.98	52.0	9
Ohio	0.1	54	805.96	34	505.10	62.7	20
Texas	0.9	315	341.18	226	245.82	72.0	89
Washington	0.1	98	756.26	64	490.84	64.9	34
Other (1)	0.2	92	501.13	63	344.61	68.8	29
	1.9	$ 807	$ 415.94	$ 522	$ 269.14	64.7%	$ 285

	Six Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.4	$ 122	$ 334.47	$ 52	$ 141.73	42.4%	$ 70
Florida	0.3	145	468.36	22	73.13	15.6	123
Michigan	0.1	28	254.69	16	145.49	57.1	12
New Mexico	0.1	65	429.19	37	246.77	57.5	28
Ohio	0.1	57	458.48	40	319.53	69.7	17
Texas	1.4	451	318.93	306	216.83	68.0	145
Washington	0.2	95	653.89	71	486.90	74.5	24
Other [2]	—	15	NM	(12)	NM	NM	27
	2.6	$ 978	$ 373.67	$ 532	$ 203.34	54.4%	$ 446

(1) "Other" includes the New Mexico, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results in 2019.
(2) "Other" includes the Utah and Wisconsin health plans, where we did not participate in the Marketplace in 2018. Therefore, the ratios for 2018 periods are not meaningful (NM).

Health Plans Segment Financial Data — Total

	Three Months Ended June 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 560	$ 312.21	$ 450	$ 250.87	80.4%	$ 110
Florida	0.4	176	408.99	150	350.47	85.7	26
Illinois	0.6	242	364.15	215	323.96	89.0	27
Michigan	1.1	413	378.86	338	310.05	81.8	75
Ohio	1.0	654	703.09	572	613.85	87.3	82
Puerto Rico	0.6	122	198.95	109	177.56	89.2	13
South Carolina	0.4	140	362.24	125	322.55	89.0	15
Texas	1.0	765	700.15	668	611.53	87.3	97
Washington	2.5	662	271.96	570	234.05	86.1	92
Other [1] [2]	0.8	315	410.27	269	350.76	85.5	46
	10.2	$ 4,049	$ 396.87	$ 3,466	$ 339.72	85.6%	$ 583

	Three Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 590	$ 301.73	$ 462	$ 236.04	78.2%	$ 128
Florida	1.3	477	394.38	400	331.13	84.0	77
Illinois	0.6	203	311.60	170	261.59	84.0	33
Michigan	1.2	403	340.08	338	285.78	84.0	65
New Mexico [2]	0.7	344	464.90	308	416.99	89.7	36
Ohio	1.0	566	567.96	505	506.66	89.2	61
Puerto Rico	0.9	184	188.26	165	168.20	89.3	19
South Carolina	0.4	123	350.22	107	304.20	86.9	16
Texas	1.4	798	585.50	670	492.23	84.1	128
Washington	2.4	627	268.84	567	242.80	90.3	60
Other [1]	0.5	199	360.90	158	285.65	79.1	41
	12.4	$ 4,514	$ 366.57	$ 3,850	$ 312.68	85.3%	$ 664

	Six Months Ended June 30, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	3.6	$ 1,115	$ 307.88	$ 931	$ 257.10	83.5%	$ 184
Florida	1.0	399	401.69	303	305.23	76.0	96
Illinois	1.3	469	356.16	400	303.50	85.2	69
Michigan	2.2	818	371.91	669	304.10	81.8	149
Ohio	1.9	1,274	684.77	1,124	604.12	88.2	150
Puerto Rico	1.2	224	181.91	199	161.40	88.7	25
South Carolina	0.8	276	362.68	240	315.84	87.1	36
Texas	2.2	1,512	675.34	1,309	584.90	86.6	203
Washington	4.9	1,323	271.34	1,185	242.96	89.5	138
Other (1) (2)	1.5	591	397.61	477	320.90	80.7	114
	20.6	$ 8,001	$ 388.66	$ 6,837	$ 332.11	85.5%	$ 1,164

	Six Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	4.0	$ 1,133	$ 286.07	$ 905	$ 228.44	79.9%	$ 228
Florida	2.5	904	367.18	729	296.29	80.7	175
Illinois	1.1	344	305.94	292	259.87	84.9	52
Michigan	2.4	792	335.59	678	287.23	85.6	114
New Mexico (2)	1.5	697	464.11	637	424.58	91.5	60
Ohio	2.0	1,143	566.77	982	486.79	85.9	161
Puerto Rico	1.9	370	190.68	339	174.74	91.6	31
South Carolina	0.7	245	349.15	211	300.87	86.2	34
Texas	2.8	1,589	567.95	1,335	477.43	84.1	254
Washington	4.7	1,250	267.01	1,171	250.05	93.6	79
Other (1)	1.1	370	333.35	293	263.24	79.0	77
	24.7	$ 8,837	$ 358.40	$ 7,572	$ 307.11	85.7%	$ 1,265

(1) “Other” includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.
(2) In 2019, “Other” includes the New Mexico health plan. The New Mexico health plan’s Medicaid contract terminated on December 31, 2018, and therefore its 2019 results are not individually significant to our consolidated operating results.

OTHER

The Other segment includes the historical results of the Medicaid management information systems (“MMIS”) and behavioral health subsidiaries we sold in the fourth quarter of 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Prior to the fourth quarter of 2018, the MMIS subsidiary was reported as a stand-alone segment. Beginning in 2019, we no longer report service revenue or cost of service revenue as a result of the sales of the MMIS and behavioral health subsidiaries noted above.

FINANCIAL OVERVIEW

The Other segment margin in the second quarter and six months ended June 30, 2018, was insignificant.

LIQUIDITY AND FINANCIAL CONDITION

LIQUIDITY

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

We maintain liquidity at two levels: 1) the regulated health plan subsidiaries; and 2) the parent company. Our regulated health plan subsidiaries generate significant cash flows from premium revenue, which is generally received a short time before related healthcare services are paid. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. A majority of the assets held by our regulated health plan subsidiaries is in the form of cash, cash equivalents, and investments.

When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plan subsidiaries is generally paid in the form of dividends to our parent company to be used for general corporate purposes. In the three and six months ended June 30, 2019, the parent received $345 million and $634 million, respectively, in dividends from the regulated health plan subsidiaries.

To satisfy minimum statutory net worth requirements, the parent company may contribute capital to the regulated health plan subsidiaries. In the three and six months ended June 30, 2019, the parent contributed capital of $6 million to the regulated health plan subsidiaries.

Cash, cash equivalents and investments at the parent company amounted to $467 million and $170 million as of June 30, 2019, and December 31, 2018, respectively. The increase in 2019 was mainly due to cash dividends received from our regulated health plan subsidiaries, and proceeds from borrowings under the Term Loan Facility, partially offset by principal repayments of our outstanding 1.125% Convertible Notes, as described further below in “Cash Flow Activities.”

Investments

After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of less than 10 years, or less than 10 years average life for structured securities. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels.

Our restricted investments are invested principally in certificates of deposit and U.S. Treasury securities; we have the ability to hold such restricted investments until maturity. All of our unrestricted investments are classified as current assets.

Cash Flow Activities

Our cash flows are summarized as follows:

	Six Months Ended June 30,		
	2019	2018	Change
	(In millions)		
Net cash provided by operating activities	$ 156	$ 314	$ (158)
Net cash (used in) provided by investing activities	(393)	398	(791)
Net cash used in financing activities	(362)	(503)	141
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	$ (599)	$ 209	$ (808)

Operating Activities

We typically receive capitation payments monthly, in advance of payments for medical claims; however, government payors may adjust their payment schedules, positively or negatively impacting our reported cash flows from operating activities in any given period. For example, government payors may delay our premium payments, or they may prepay the following month's premium payment.

Net cash provided by operations for the six months ended June 30, 2019 was $156 million, compared with $314 million in the six months ended June 30, 2018. The $158 million decrease in cash flow was due to settlements with government agencies, mainly related to the final 2017 CSR settlement paid in 2019, timing of CMS Medicare premium receipts in 2018, and the use of cash associated with declines in Medicaid and Marketplace membership. These items were partially offset by a net benefit from timing differences in other current assets and liabilities.

Investing Activities

Net cash used in investing activities was $393 million in the six months ended June 30, 2019, compared with $398 million provided by investing activities in the six months ended June 30, 2018, a decrease in cash flow of $791 million. The year over year decline was primarily due to lower proceeds from sales and maturities of investments, net of purchases, in the six months ended June 30, 2019, largely driven by cash flow needs associated with our financing activities, as described below.

Financing Activities

Net cash used in financing activities was $362 million in the six months ended June 30, 2019, compared with $503 million in the six months ended June 30, 2018, an increase in cash flow of $141 million, due to less cash used in 2019 compared with 2018. In the six months ended June 30, 2019, net cash paid for the aggregate 1.125% Convertible Notes-related transactions amounted to $609 million, partially offset by proceeds of $220 million borrowed under the Term Loan Facility. In the six months ended June 30, 2018, net cash used in financing activities included net cash paid for the aggregate 1.125% Convertible Notes-related transactions of $202 million, and the $300 million repayment of the Credit Facility.

FINANCIAL CONDITION

We believe that our cash resources, our borrowing capacity available under our Credit Agreement as discussed further below in "Future Sources and Uses of Liquidity—Future Sources," and internally generated funds will be sufficient to support our operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months.

On a consolidated basis, at June 30, 2019, our working capital was $2,475 million, compared with $2,216 million at December 31, 2018. At June 30, 2019, our cash and investments amounted to $4,423 million, compared with $4,629 million at December 31, 2018.

Regulatory Capital and Dividend Restrictions

Each of our HMO subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulations. Such statutes, regulations and capital requirements also restrict the timing, payment and amount of dividends and other distributions, loans or advances that may be paid to us as the sole stockholder. To the extent our HMO subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus (net assets) requirement, for these subsidiaries was approximately $1,050 million at June 30, 2019, and $1,040 million at December 31, 2018. Our HMO subsidiaries were in compliance with these minimum capital requirements as of both dates.

Under applicable regulatory requirements, the amount of dividends that may be paid through the remainder of 2019 by our HMO subsidiaries without prior approval by regulatory authorities as of June 30, 2019, is approximately $127 million in the aggregate. Our HMO subsidiaries can pay dividends over this amount, but only after approval is granted by the regulatory authorities.

Debt Ratings

Our 5.375% Notes and 4.875% Notes are rated "BB-" by Standard & Poor's, and "B2" by Moody's Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs.

Financial Covenants

Our Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Agreement.

Credit Facility Financial Covenants	Required Per Agreement	As of June 30, 2019
Net leverage ratio	<4.0x	1.0x
Interest coverage ratio	>3.5x	14.7x

In addition, the indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. As of June 30, 2019, we were in compliance with all covenants under the Credit Agreement and the indentures governing our outstanding notes.

Capital Plan Progress

In the first quarter of 2019, we repaid $46 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants.

In the second quarter of 2019, we repaid an additional $139 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants. Following these transactions, the remaining principal amount outstanding of our 1.125% Convertible Notes is $67 million.

FUTURE SOURCES AND USES OF LIQUIDITY

Future Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related healthcare services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes.

Credit Agreement Borrowing Capacity. As of June 30, 2019, we had available borrowing capacity of $380 million under the Term Loan Facility, following our draw down of $220 million in the first half of 2019. Under the Term Loan Facility, we may request up to ten advances, each in a minimum principal amount of $50 million, until July 31, 2020. In addition, we have available borrowing capacity of $498 million under our Credit Facility. See further discussion in the Notes to Consolidated Financial Statements, Note 7, “Debt.”

Savings from the IT Restructuring Plan. Management is focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we began a plan to restructure our information technology department (the “IT Restructuring Plan”) in 2018. In early 2019, we entered into services agreements with our outsourcing vendor under which they manage certain of our information technology services. We expect the IT Restructuring Plan to be completed by the end of 2019. We currently estimate that this plan will reduce annualized run-rate expenses by approximately $15 million to $20 million in the first full year, increasing to approximately $30 million to $35 million by the end of the fifth full year. Such savings, if achieved, would reduce Other segment general and administrative expenses in our consolidated statements of income. Further details are described in the Notes to Consolidated Financial Statements, Note 10, “Restructuring Costs.”

Future Uses

Regulatory Capital Requirements and Dividend Restrictions. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

1.125% Convertible Notes. The fair value of the 1.125% Convertible Notes was $231 million as of June 30, 2019, which amount reflects both the principal amount outstanding and the estimated fair value of the 1.125% Conversion Option. The 1.125% Convertible Notes mature on January 15, 2020. As conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the applicable indenture. We have received conversion notices for approximately $9 million principal amount that will be settled in the third quarter of 2019.

We have sufficient available cash, combined with borrowing capacity available under our Credit Agreement, to fund conversions as they occur, and to repay the outstanding principal amount of the 1.125% Convertible Notes at maturity. Refer to the Notes to Consolidated Financial Statements, Note 7, “Debt,” for a detailed discussion of the 1.125% Convertible Notes, including recent transactions.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2018, was disclosed in our Annual Report on Form 10-K for the year ended December 31, 2018.

Other than the financing transactions described in the Notes to Consolidated Financial Statements, Note 7, “Debt,” there were no significant changes to this previously filed information outside the ordinary course of business during the six months ended June 30, 2019. See also Note 13, “Leases”, for a summary of the maturities of our lease liabilities as of June 30, 2019.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, “Medical Claims and Benefits Payable,” for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the six months ended June 30, 2019, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2018.

- *Contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Goodwill and intangible assets, net.* There have been no significant changes, during the six months ended June 30, 2019, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2018.

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2019, the fair value of our fixed income investments would decrease by approximately $37 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. As of June 30, 2019, $220 million was outstanding under the Term Loan Facility. For further information, see Notes to Consolidated Financial Statements, Note 7, “Debt.”

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures. Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company’s “disclosure controls and procedures” (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the “Exchange Act”)), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC’s rules and forms.

Changes in Internal Control Over Financial Reporting. There has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2019 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 12, “Commitments and Contingencies.”

RISK FACTORS

Certain risks may have a material adverse effect on our business, financial condition, cash flows, results of operations, or stock price, and you should carefully consider them before making an investment decision with respect to our securities. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in “Risk Factors,” in our Annual Report on Form 10-K for the year ended December 31, 2018. The risk factors described in our Annual Report on Form 10-K for the year ended December 31, 2018, are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, results of operations, or stock price.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended June 30, 2019, including shares withheld by us to satisfy our employees’ income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
April 1 - April 30	136	$ 142.69	—	$ —
May 1 - May 31	2,195	$ 130.81	—	$ —
June 1 - June 30	408	$ 152.56	—	$ —
Total	2,739	$ 134.64	—	

(1) During the three months ended June 30, 2019, we withheld 2,739 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

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INDEX TO EXHIBITS

Exhibit No.	Title	Method of Filing
10.1	2019 Equity Incentive Plan - Form of Restricted Stock Award Agreement (Employee/Officer with No Employment Agreement)	Filed herewith.
10.2	2019 Equity Incentive Plan - Form of Performance Stock Unit Award Agreement (Employee/Officer with No Employment Agreement)	Filed herewith.
10.3	2019 Equity Incentive Plan - Form of Restricted Stock Award Agreement (Officer with Employment Agreement)	Filed herewith.
10.4	2019 Equity Incentive Plan - Form of Performance Stock Unit Award Agreement (Officer with Employment Agreement)	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
101.INS	XBRL Taxonomy Instance Document.	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document.	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: July 31, 2019

/s/ JOSEPH M. ZUBRETSKY

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Dated: July 31, 2019

/s/ THOMAS L. TRAN

Thomas L. Tran
Chief Financial Officer and Treasurer
(Principal Financial Officer)

Molina Healthcare, Inc. 2019 Equity Incentive Plan
Restricted Stock Award Agreement

This RESTRICTED STOCK AWARD AGREEMENT (this "Agreement") effective as of [DATE] is between Molina Healthcare, Inc., a Delaware corporation (the "Company"), and [EMPLOYEE NAME], an employee of the Company or one of its Affiliates (the "Grantee"), pursuant to and subject to the terms and conditions of the Molina Healthcare, Inc. 2019 Equity Incentive Plan (the "Plan"). The Company desires to award to the Grantee a number of shares of the Company's common stock, par value $.001 per share (the "Common Stock"), subject to certain restrictions as provided in this Agreement, in order to carry out the purpose of the Plan. The purpose of this Agreement is to evidence the terms and conditions of an award of restricted stock granted to the Grantee under the Plan.

Accordingly, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Company and the Grantee hereby agree as follows:

Section 1. Award of Restricted Stock.

Effective as of [DATE] (the "Effective Date"), the Company grants to the Grantee a restricted stock award of [NUMBER OF SHARES] shares of Common Stock (the "Shares"), subject to the terms and conditions set forth in this Agreement and in accordance with the terms of the Plan (the "Restricted Stock Award").

Section 2. Rights with Respect to the Shares.

(a) Stockholder Rights. With respect to the Shares, the Grantee shall be entitled at all times on and after the date of issuance of the Shares to exercise the rights of a stockholder of Common Stock of the Company, including the right to vote the Shares and the right to receive dividends on the Shares as provided in Section 2(b) hereof, unless and until the Shares are forfeited pursuant to Section 3 hereof. However, the Shares shall be nontransferable and subject to a risk of forfeiture to the Company at all times prior to the dates on which such Shares become vested, and the restrictions with respect to the Shares lapse, in accordance with Section 3 of this Agreement.

(b) Dividends. As a condition to receiving the Shares under the Plan, the Grantee hereby agrees to defer the receipt of dividends paid on the Shares. Cash dividends or other cash distributions paid with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms, and conditions as the Shares to which they relate, shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary, and shall be forfeited in the event that the Shares with respect to which the dividends were paid are forfeited.

(c) Issuance of Shares. The Company shall cause the Shares to be issued in the Grantee's name or in a nominee name on the Grantee's behalf, either by book-entry registration or issuance of a stock certificate or certificates evidencing the Shares, which certificate or certificates shall be held by the Secretary of the Company or the stock transfer agent or brokerage service selected by the Secretary of the Company to provide such services for the Plan. The Shares shall be restricted from transfer and shall be subject to an appropriate stop-transfer order. If any certificate is issued, the certificate shall bear an appropriate legend referring to the restrictions applicable to the Shares. The Grantee hereby agrees to the retention by the Company of the Shares and, if a stock certificate is issued, the Grantee agrees to execute and deliver to the Company a blank stock power with respect to the Shares as a condition to the receipt of this Restricted Stock Award. After any Shares vest pursuant to Section 3 hereof, and following payment of the applicable withholding taxes pursuant to Section 6 of this Agreement, the Company shall promptly cause to be issued a certificate or certificates, registered in the Grantee's name, evidencing such vested whole Shares (less any Shares withheld to pay withholding taxes) and shall cause such certificate or certificates to be delivered to the Grantee free of the legend and the stop-transfer order referenced above. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share at the time certificates evidencing the Shares are delivered to the Grantee.

Section 3. Vesting; Forfeiture.

(a) Vesting. Subject to the terms and conditions of this Agreement, [one-fourth (1/4th)] [one-third (1/3rd)] of the Shares shall vest, and the restrictions with respect to the Shares shall lapse, on each of the first, second, [and] third/[, and fourth] anniversaries of the Effective Date if the Grantee remains continuously employed by the Company or an Affiliate of the Company until such respective vesting dates.

(b) Forfeiture. If the Grantee ceases to be employed by the Company and all Affiliates of the Company for any reason prior to the vesting of the Shares, Grantee's rights to all of the unvested Shares shall be immediately and irrevocably forfeited, including the right to vote such Shares and the right to receive dividends on such Shares.

(c) No Early Vesting. Unless otherwise determined by the Committee in its sole discretion, or otherwise provided in an agreement with, or plan of the Company applicable to the Grantee, in no event will any of the Shares vest prior to their respective vesting dates set forth in Section 3(a) hereof.

Section 4. Restrictions on Transfer.

Until the Shares vest pursuant to Section 3 hereof, neither the Shares, nor any right with respect to the Shares under this Agreement, may be sold, assigned, transferred, pledged, hypothecated (by operation of law or otherwise) or otherwise conveyed or encumbered and shall not be subject to execution, attachment or similar process. Any attempted sale, assignment, transfer, pledge, hypothecation or other conveyance or encumbrance shall be void and unenforceable against the Company or any Affiliate of the Company.

Section 5. Distributions and Adjustments.

(a) If any Shares vest subsequent to any change in the number or character of the Common Stock of the Company through any stock dividend or other distribution, recapitalization, stock split, reverse stock split, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase or exchange of shares or other securities of the Company, issuance of warrants or other rights to purchase shares of Common Stock or other securities of the Company or other similar corporate transaction or event such that an adjustment is determined by the Committee to be appropriate in order to prevent dilution or enlargement of the benefits or potential benefits intended to be made available under this Agreement, then the Committee shall, in such manner as it may deem equitable, in its sole discretion, adjust any or all of the number and type of such Shares.

(b) Any additional shares of Common Stock of the Company, any other securities of the Company and any other property distributed with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate and shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary.

Section 6. Taxes.

(a) The Grantee acknowledges that the Grantee will consult with the Grantee's personal tax adviser regarding the income tax consequences of the grant of the Shares, payment of dividends on the Shares, the vesting of the Shares and any other matters related to this Agreement. In order to comply with all applicable federal, state, local or foreign income tax laws or regulations, the Company may take such action as it deems appropriate to ensure that all applicable federal, state, local or foreign payroll, withholding, income or other taxes, which are the Grantee's sole and absolute responsibility, are withheld or collected from the Grantee.

(b) In accordance with the terms of the Plan, and such rules as may be adopted by the Committee administering the Plan, the Grantee may elect to satisfy tax withholding obligations arising from the receipt of, or the lapse of restrictions relating to, the Shares by (i) delivering cash, check, bank draft, money order or wire transfer payable to the order of the Company, (ii) having the Company withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes, or (iii) delivering to the Company shares of Common Stock having a Fair Market Value equal to the amount of such taxes. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share. The Grantee's election must be made on or before the date that the amount of tax to be withheld is determined. If the Grantee does not make an election, the Company will withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes.

Section 7. Non-Solicitation.

(a) Non-Solicitation (Employees). The Grantee acknowledges and agrees that during the period of Grantee's employment by the Company (or any Subsidiary), and for a period of one (1) year after termination of Grantee's Service Relationship for any reason, with or without Cause, Grantee shall not directly or indirectly, either alone or in concert with others, solicit, entice, or encourage the hiring of any employee of the Company (or any Subsidiary) unless such person was involuntarily terminated or laid off by the Company (or any Subsidiary).

(b) Non-Solicitation (Customers). During the Grantee's employment with the Company and for a period of one (1) year after the Grantee's date of termination, the Grantee shall not, directly or indirectly: (i) contact or solicit, or direct any person, firm, corporation, association or other entity to contact or solicit, any of the Company's customers for the purpose of providing any products and/or services that are the same as or similar to the products and services provided by the Company to its customers during the term of the Company's employment; or (ii) divert or attempt to divert, for his direct or indirect benefit, or for the benefit of any other person, firm, corporation, association or other entity, the business of any customer of the Company; or (iii) influence or attempt to influence any customer of the Company to transfer its business to the Grantee or any person, firm, corporation, association or other entity; or (iv) in any other manner knowingly interfere with, disrupt or attempt to disrupt the relationship of the Company with any of its customers. In addition, the Company will not disclose the identity of any such customers to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever.

[SECTION 8 FOR NON-CALIFORNIA EMPLOYEES]
[Section 8. Non-Competition.

During the Grantee's employment with the Company and for a period of one (1) year after the Grantee's date of termination, the Grantee shall not, recognizing the national scope of the Company's business, directly or indirectly, engage, or participate in or in any way render services or assistance to (including, without limitation, as an officer, director, employee, consultant, agent, lender or equityholder) any business that competes, directly or indirectly, with any product or service of the Company or any of its subsidiaries or affiliates within the United States of America.]

Section 9. Nondisparagement.

The Grantee agrees that he/she will not disparage the Company or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. The Grantee further agrees that he/she will not direct anyone to make any disparaging oral or written remarks to any third parties.

Section 10. Confidentiality.

The Grantee agrees to keep and maintain in strict confidence all confidential and proprietary information of the Company (or any Subsidiary) during and after the term of employment by the Company, and to never directly or indirectly make known, divulge, reveal, furnish, make available, or use any confidential information (except in the course of regular authorized duties on behalf of the Company or any Subsidiary). Grantee's obligations of confidentiality hereunder shall survive termination of employment regardless of any actual or alleged breach by the Company (or any Subsidiary) in connection with such termination, until and unless any such confidential information shall have become, through no fault of Grantee, generally known to the public or unless Grantee is required by law to make disclosure (after giving the Company or any Subsidiary notice and an opportunity to contest such requirement). Grantee's obligations under this Section are in addition to and not in limitation or preemption of all other obligations of confidentiality which Grantee has to the Company under general legal or equitable principles. All documents and other property including or reflecting confidential information furnished to Grantee by the Company or otherwise acquired or developed by the Company shall at all times be the property of the Company (or any Subsidiary). Upon termination of employment, Grantee shall return to the Company (or any Subsidiary) any such documents or other property (including copies, summaries, or analyses of the foregoing) of the Company (or any Subsidiary) which are in Grantee's possession, custody, or control.

Section 11. Definitions.

Terms not defined in this Agreement shall have the meanings given to them in the Plan.

Section 12. Governing Law.

The internal law, and not the law of conflicts, of the State of [California]/[Delaware] will govern all questions concerning the validity, construction and effect of this Agreement.

Section 13. Plan Provisions.

This Agreement is made under and subject to the provisions of the Plan, and all of the provisions of the Plan are also provisions of this Agreement. If there is a difference or conflict between the provisions of this Agreement and the provisions of the Plan, the provisions of the Plan will govern. By accepting this Restricted Stock Award, the Grantee confirms that the Grantee has received a copy of the Plan, represents that the Grantee is familiar with the terms and provisions of the Plan, and hereby accepts this Restricted Stock Award subject to all the terms and provisions of the Plan.

Section 14. No Rights to Continue Service or Employment.

Nothing herein shall be construed as giving the Grantee the right to continue in the employ or to provide services to the Company or any Affiliate, whether as an employee or as a consultant or otherwise, or interfere with or restrict in any way the right of the Company or any Affiliate to discharge the Grantee, whether as an employee or consultant or otherwise, at any time, with or without cause. In addition, the Company or any Affiliate may discharge the Grantee free from any liability or claim under this Agreement.

Section 15. Entire Agreement.

This Agreement together with the Plan supersede any and all other prior understandings and agreements, either oral or in writing, between the parties with respect to the subject matter hereof and constitute the sole and only agreements between the parties with respect to said subject matter. All prior negotiations and agreements between the parties with respect to the subject matter hereof are merged into this Agreement. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party or by anyone acting on behalf

of any party, which are not embodied in this Agreement or the Plan and that any agreement, statement or promise that is not contained in this Agreement or the Plan shall not be valid or binding or of any force or effect. Notwithstanding the foregoing, if the Grantee is subject to a written employment, change in control, severance or similar agreement with the Company or plan with respect thereto, and the Grantee would be entitled under the express provisions of such agreement or plan to accelerated vesting of the Restricted Stock Award in connection with the termination of the Grantee's employment in the circumstances set forth in that agreement, the provisions of such agreement shall control with respect to such vesting rights, and the corresponding provisions of this Agreement shall not apply.

Section 16. Modification.

No change or modification of this Agreement shall be valid or binding upon the parties unless the change or modification is in writing and signed by the parties. Notwithstanding the preceding sentence, the Plan, this Agreement and the Restricted Stock Award may be amended, altered, suspended, discontinued or terminated to the extent permitted by the Plan.

Section 17. Shares Subject to Agreement.

The Shares shall be subject to the terms and conditions of this Agreement. Except as otherwise provided in Section 5, no adjustment shall be made for dividends or other rights for which the record date is prior to the issuance of the Shares. The Company shall not be required to deliver any Shares until the requirements of any federal or state securities or other laws, rules or regulations (including the rules of any securities exchange) as may be determined by the Committee to be applicable are satisfied.

Section 18. Severability.

In the event that any provision that is contained in the Plan or this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or would disqualify the Plan or this Agreement for any reason and under any law as deemed applicable by the Committee, the invalid, illegal or unenforceable provision shall be construed or deemed amended to conform to applicable laws, or if it cannot be so construed or deemed amended without, in the determination of the Committee, materially altering the purpose or intent of the Plan or this Agreement, such provision shall be stricken as to such jurisdiction or Shares, and the remainder of the Plan or this Agreement shall remain in full force and effect.

Section 19. Headings.

Headings are given to the sections and subsections of this Agreement solely as a convenience to facilitate reference. Such headings shall not be deemed in any way material or relevant to the construction or interpretation of this Agreement or any provision hereof.

Section 20. Grantee's Acknowledgments.

The Grantee hereby agrees to accept as binding, conclusive and final all decisions or interpretations of the Committee or the Board of Directors of the Company, as appropriate, upon any questions arising under the Plan or this Agreement. Any determination in this connection by the Company, including the Board of Directors of the Company or the Committee, shall be final, binding and conclusive. The obligations of the Company and the rights of the Grantee are subject to all applicable laws, rules and regulations.

Section 21. Parties Bound.

The terms, provisions and agreements that are contained in this Agreement shall apply to, be binding upon, and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives and permitted successors and assigns, subject to the limitation on assignment

expressly set forth herein. This Agreement shall have no force or effect unless it is duly executed and delivered by the Company.

Section 22. Counterparts.

This Agreement may be executed in counterparts, each of which shall constitute an original, but both of which when taken together shall constitute a single contract. Delivery of an executed counterpart of a signature page of this Agreement by telecopy shall be effective as delivery of a manually executed counterpart of this Agreement.

IN WITNESS WHEREOF, each of the parties has executed this Agreement, in the case of the Company by its duly authorized officer, effective as of the day and year first above written.

MOLINA HEALTHCARE, INC.

By: _____
[NAME]
Its: [TITLE]

PARTICIPANT,

_____
[NAME]

MOLINA HEALTHCARE, INC.
2019 EQUITY INCENTIVE PLAN

PERFORMANCE STOCK UNIT AWARD AGREEMENT

THIS PERFORMANCE STOCK UNIT AWARD AGREEMENT (this "Agreement") dated [DATE], by and between MOLINA HEALTHCARE, INC., a Delaware corporation (the "Corporation"), and [NAME] (the "Participant"), evidences the award of Performance Units (the **"Award"**) granted by the Corporation to the Participant as to the number of Performance Units first set forth below.

Total Number of Performance Units:[1] [NUMBER OF UNITS]

Award Date: [GRANT DATE]
Performance Period for the Award: [PERFORMANCE PERIOD]

Vesting[1, 2] The Award shall vest and become nonforfeitable as provided in Section 2 of the attached Terms and Conditions of Performance Unit Award (the "Terms").

The Award is granted under the MOLINA HEALTHCARE, INC. 2019 EQUITY INCENTIVE PLAN (the "Plan"), by and between the Corporation and the Participant, and is subject to the Terms attached to this Agreement (incorporated herein by this reference) and to the Plan. The Award has been granted to the Participant in addition to, and not in lieu of, any other form of compensation otherwise payable or to be paid to the Participant. Capitalized terms are defined in the Plan if not defined herein. The parties agree to the terms of the Award set forth herein. The Participant acknowledges receipt of a copy of the Terms, the Plan, and the Prospectus for the Plan.

The Participant acknowledges and agrees that the Corporation may deliver, by electronic mail, the use of the Internet, including through the website of the agent appointed by the Committee to administer the Plan, the Corporation intranet web pages or otherwise, any information concerning the Corporation, this Award, the Plan, and any information required by the Securities Act of 1933, as amended, and the rules and regulations promulgated thereunder.

PARTICIPANT

_____
[NAME]

MOLINA HEALTHCARE, INC.
a Delaware corporation

By: _____
[NAME]/[TITLE]

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[1] Subject to adjustment under Section 4.2 of the Plan.
[2] Subject to early termination under Section 10.7 of the Plan.

TERMS AND CONDITIONS OF PERFORMANCE UNIT AWARD

1. Performance Units.

Each Performance Unit constitutes an unfunded and unsecured promise of the Corporation to deliver up to two shares of the Corporation's common stock to the Participant (subject to adjustment as provided in Section 4.2 of the Plan) pursuant to the terms of this Agreement, subject to the vesting provisions in Exhibit A. The Performance Units shall be used solely as a device for the determination of the payment to eventually be made to the Participant if such Performance Units vest pursuant to Section 2. The Performance Units shall not be treated as property or as a trust fund of any kind.

2. Vesting.

Subject to Section 7, the Award shall vest and become nonforfeitable at the vesting percentage levels set forth in Exhibit A, based on the achievement of the Performance Goals established by the Committee and set forth on Exhibit A attached hereto for the Performance Period. In the event that the performance condition with respect to the Award is achieved, the Award shall become unconditionally due. Subject to Section 7, any Performance Units subject to the Award that do not vest in accordance with Exhibit A shall terminate as of the last day of the Performance Period.

3. Continuance of Service.

Except as otherwise expressly provided in Section 7 below, the vesting schedule requires continued Service through each applicable vesting date as a condition to the vesting of the Award and the rights and benefits under this Agreement; and Service for only a portion of any vesting period, even if a substantial portion, will not entitle the Participant to any proportionate vesting or avoid or mitigate a termination of rights and benefits upon or following a termination of Participant's Service as provided in Section 7 below or under the Plan for such vesting period (or for any later vesting period).

Nothing contained in this Agreement or the Plan constitutes an employment or service commitment by the Corporation, affects the contractual obligations pursuant to any employment or service commitment agreement if Participant is party to such agreement, or in the absence of such agreement affects Participant's status as an employee at will who is subject to termination without cause, confers upon the Participant any right to remain employed by or in service to the Corporation or any Subsidiary Corporation, interferes in any way with the right of the Corporation or any Subsidiary Corporation at any time to terminate Participant's Service, or affects the right of the Corporation or any Subsidiary Corporation to increase or decrease the Participant's other compensation or benefits. Nothing in this paragraph, however, is intended to adversely affect any independent contractual right of the Participant without his consent thereto.

4. Limitations on Rights Associated with Performance Units.

The Participant shall have no rights as a stockholder of the Corporation, no dividend rights and no voting rights with respect to the Performance Units and any shares of Common Stock underlying or issuable in respect of such Performance Units until such shares of Common Stock are actually issued to and held of record by the Participant. No adjustments will be made for dividends or other rights of a holder for which the record date is prior to the date of issuance of the stock certificate.

5. Restrictions on Transfer.

Unless otherwise determined by the Committee, neither the Award, nor any interest therein may be sold, assigned, transferred, pledged or otherwise disposed of, alienated or encumbered, either voluntarily or involuntarily. The transfer restrictions in the preceding sentence shall not apply to (a) transfers to the Corporation, or (b) transfers by will or the laws of descent and distribution.

6. Conversion of Performance Units; Issuance of Common Stock.

On or as soon as administratively practicable following the last day of the Performance Period, and in any event, no later than March 15 of the year following the year in which the vesting event occurs (which payment schedule is intended to comply with the "short-term deferral" exemption from the application of Section 409A of the Code), unless such payment is deferred in accordance with the terms and conditions of the Corporation's non-qualified compensation deferral plans, the Corporation shall deliver to the Participant the respective number of

shares of Common Stock (either by delivering one or more certificates for such shares or by entering such shares in book entry form, as determined by the Corporation in its discretion) for the Performance Units (if any) that vest in accordance with Section 2, unless such Performance Units terminate prior to the given vesting date pursuant to Section 7. The Corporation's obligation to deliver shares of Common Stock with respect to any vested Performance Units is subject to the condition precedent that the Participant or other person entitled under the Plan to receive any shares with respect to the vested Performance Units deliver to the Corporation any representations or other documents or assurances required pursuant to Section 14 of the Plan. The Participant shall have no further rights with respect to any Performance Units that are paid or that are terminated pursuant to Section 7.

7. Effect of Termination of Employment.

If the Participant's Service ceases for any reason (the last day that the Participant's Service is referred to as the Participant's "Severance Date"), the Participant's Performance Units, to the extent unvested on the Severance Date, shall terminate and be forfeited as of the Severance Date. If any unvested Performance Units are terminated hereunder, such Performance Units shall automatically terminate and be cancelled as of the applicable termination date without payment of any consideration by the Corporation and without any other action by the Participant, or the Participant's beneficiary or personal representative, as the case may be.

8. Adjustments Upon Specified Events.

The Committee may accelerate payment and vesting of the Performance Units in such circumstances as it, in its sole discretion, may determine. In addition, upon the occurrence of certain events relating to the Corporation's stock contemplated by Section 4.2 of the Plan (including, without limitation, an extraordinary cash dividend on such stock), the Committee shall make adjustments in the number of Performance Units then outstanding and the number and kind of securities that may be issued in respect of the Award. No such adjustment shall be made with respect to any ordinary cash dividend paid on the Common Stock. Furthermore, the Committee shall adjust the performance measures and performance goals referenced in Exhibit A hereof to the extent (if any) it determines that the adjustment is necessary or advisable to preserve the intended incentives and benefits to reflect (1) any material change in corporate capitalization, any material corporate transaction (such as a reorganization, combination, separation, merger, acquisition, or any combination of the foregoing), or any complete or partial liquidation of the Corporation, (2) any change in accounting policies or practices, (3) the effects of any special charges to the Corporation's earnings, or (4) any other similar special circumstances.

9. Tax Withholding.

Subject to Section 16 of the Plan and such rules and procedures as the Committee may impose, upon any distribution of shares of Common Stock in respect of the Award, the Corporation shall automatically reduce the number of shares to be delivered by (or otherwise reacquire) the appropriate number of whole shares, valued at their then Fair Market Value, to satisfy any withholding obligations of the Corporation or its Subsidiary Corporations with respect to such distribution of shares at the minimum applicable withholding rates; provided, however, that the foregoing provision shall not apply in the event that the Participant has, subject to the approval of the Committee, made other provision in advance of the date of such distribution for the satisfaction of such withholding obligations. In the event that the Corporation cannot legally satisfy such withholding obligations by such reduction of shares, or in the event of a cash payment or any other withholding event in respect of the Award, the Corporation (or a Subsidiary Corporation) shall be entitled to require a cash payment by or on behalf of the Participant and/or to deduct from other compensation payable to the Participant any sums required by federal, state or local tax law to be withheld with respect to such distribution or payment.

10. Non-Solicitation.

10.1 Non-Solicitation (Employees). The Participant acknowledges and agrees that during the period of Participant's employment by the Corporation (or any subsidiary), and for a period of one (1) year after termination of Participant's Service Relationship for any reason, with or without Cause, Participant shall not directly or indirectly, either alone or in concert with others, solicit, entice, or encourage the hiring of any employee of the Corporation (or any Subsidiary) unless such person was involuntarily terminated or laid off by the Corporation (or any subsidiary).

10.2 Non-Solicitation (Customers). During the Participant's employment with the Corporation and for a period of one (1) year after the Participant's date of termination, the Participant shall not, directly or indirectly: (i) contact or solicit, or direct any person, firm, corporation, association or other entity to contact or solicit, any of the Corporation's customers for the purpose of providing any products and/or services that are the same as or similar to the products and services provided by the Corporation to its customers during the term of the Corporation's employment; or (ii) divert or attempt to divert, for his direct or indirect benefit, or for the benefit of any other person, firm, corporation, association or other entity, the business of any customer of the Corporation; or (iii) influence or attempt to influence any customer of the Corporation to transfer its business to the Participant or any person, firm, corporation, association or other entity; or (iv) in any other manner knowingly interfere with, disrupt or attempt to disrupt the relationship of the Corporation with any of its customers[, and in each of (i) through (iv) if such activities post-termination of employment involve the use of trade secrets or other confidential information, as defined in Section 12, of the Corporation]. In addition, the Corporation will not disclose the identity of any such customers to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever.

11. Nondisparagement.

The Participant agrees that he/she will not disparage the Corporation or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. The Participant further agrees that he/she will not direct anyone to make any disparaging oral or written remarks to any third parties.

12. Confidentiality.

The Participant agrees to keep and maintain in strict confidence all confidential and proprietary information of the Corporation (or any subsidiary) during and after the term of employment by the Corporation, and to never directly or indirectly make known, divulge, reveal, furnish, make available, or use any confidential information (except in the course of regular authorized duties on behalf of the Corporation or any subsidiary). Participant's obligations of confidentiality hereunder shall survive termination of employment regardless of any actual or alleged breach by the Corporation (or any subsidiary) in connection with such termination, until and unless any such confidential information shall have become, through no fault of Participant, generally known to the public or unless Participant is required by law to make disclosure (after giving the Corporation or any subsidiary notice and an opportunity to contest such requirement). Participant's obligations under this Section are in addition to and not in limitation or preemption of all other obligations of confidentiality which Participant has to the Corporation under general legal or equitable principles. All documents and other property including or reflecting confidential information furnished to Participant by the Corporation or otherwise acquired or developed by the Corporation shall at all times be the property of the Corporation (or any subsidiary). Upon termination of employment, Participant shall return to the Corporation (or any subsidiary) any such documents or other property (including copies, summaries, or analyses of the foregoing) of the Corporation (or any subsidiary) which are in Participant's possession, custody, or control.

13. [NON-CALIFORNIA EMPLOYEE ONLY] [Non-Competition.

During the Participant's employment with the Corporation and for a period of one (1) year after the Participant's date of termination, the Participant shall not, recognizing the national scope of the Corporation's business, directly or indirectly, engage, or participate in or in any way render services or assistance to (including, without limitation, as an officer, director, employee, consultant, agent, lender or equityholder) any business that competes, directly or indirectly, with any product or service of the Corporation or any of its subsidiaries or affiliates within the United States of America.]

14. Notices.

Any notice to be given under the terms of this Agreement shall be in writing and addressed to the Corporation at its principal office to the attention of the Secretary, and to the Participant at the Participant's last address reflected on the Corporation's records, or at such other address as either party may hereafter designate in writing to the other. Any such notice shall be given only when received, but if the Participant is no longer an employee of the Corporation, shall be deemed to have been duly given by the Corporation when enclosed in a properly sealed envelope addressed as aforesaid, registered or certified, and deposited (postage and registry or

certification fee prepaid) in a post office or branch post office regularly maintained by the United States Government.

15. Plan.

The Award and all rights of the Participant under this Agreement are subject to, and the Participant agrees to be bound by, all of the terms and conditions of the provisions of the Plan, which are incorporated herein by reference. In the event of a conflict or inconsistency between the terms and conditions of this Agreement and those of the Plan, the terms and conditions of the Plan shall govern. The Participant acknowledges having read and understood the Plan, the Prospectus for the Plan, and this Agreement. Unless otherwise expressly provided in other sections of this Agreement, provisions of the Plan that confer discretionary authority on the Committee do not (and shall not be deemed to) create any rights in the Participant unless such rights are expressly set forth herein or are otherwise in the sole discretion of the Committee so conferred by appropriate action of the Committee under the Plan after the date hereof.

16. Construction; Section 409A.

It is intended that the terms of the Award will not result in the imposition of any tax liability pursuant to Section 409A of the Code. This Agreement shall be construed and interpreted consistent with that intent. Notwithstanding any provision of this Agreement to the contrary, if the Participant is a "specified employee" as defined in Code Section 409A and, as a result of that status, any portion of the payments under this Agreement would otherwise be subject to taxation pursuant to Code Section 409A, the Participant shall not be entitled to any payments upon a termination of his Service until the earlier of (i) the date which is six (6) months after his termination of Service for any reason other than death, or (ii) the date of the Participant's death; provided the first such payment thereafter shall include all amounts that would have been paid earlier but for such six (6) month delay. The Corporation and the Participant agree to act reasonably and to cooperate to amend or modify this Agreement to the extent reasonably necessary to avoid the imposition of the tax under Code Section 409A.

17. Entire Agreement; Applicability of Other Agreements.

This Agreement and the Plan, together constitute the entire agreement and supersede all prior understandings and agreements, written or oral, of the parties hereto with respect to the subject matter hereof. The Plan and this Agreement may be amended pursuant to Section 17 of the Plan. Such amendment must be in writing and signed by the Corporation. The Corporation may, however, unilaterally waive any provision hereof in writing to the extent such waiver does not adversely affect the interests of the Participant hereunder, but no such waiver shall operate as or be construed to be a subsequent waiver of the same provision or a waiver of any other provision hereof. Notwithstanding the foregoing, if the Participant is subject to a written employment, change in control or similar agreement with the Corporation that is in effect as of the Participant's Severance Date and the Participant would be entitled under the express provisions of such agreement to greater rights with respect to accelerated vesting of the Award in connection with the termination of the Participant's employment in the circumstances, the provisions of such agreement shall control with respect to such vesting rights, and the corresponding provisions of this Agreement shall not apply.

18. **Limitation on Participant's Rights.**

Participation in this Plan confers no rights or interests other than as herein provided. This Agreement creates only a contractual obligation on the part of the Corporation as to amounts payable and shall not be construed as creating a trust. Neither the Plan nor any underlying program, in and of itself, has any assets. The Participant shall have only the rights of a general unsecured creditor of the Corporation (or applicable Subsidiary Corporation) with respect to amounts credited and benefits payable in cash, if any, with respect to the Performance Units, and rights no greater than the right to receive the Common Stock (or equivalent value) as a general unsecured creditor with respect to Performance Units, as and when payable thereunder.

19. **Forfeiture and Corporation's Right to Recover Fair Market Value of Shares Received Pursuant to Performance Units.**

If, at any time, the Board or the Committee, as the case may be, in its sole discretion determines that any action or omission by Participant constituted (a) wrongdoing that contributed to (i) any material misstatement in or omission from any report or statement filed by the Corporation with the U.S. Securities and Exchange Commission

or (ii) a statement, certification, cost report, claim for payment, or other filing made under Medicare or Medicaid that was false, fraudulent, or for an item or service not provided as claimed, (b) intentional or gross misconduct, (c) a breach of a fiduciary duty to the Corporation or a Subsidiary Corporation, (d) fraud or (e) non-compliance with the Corporation's Code of Business Conduct and Ethics, policies or procedures to the material detriment of the Corporation, then in each such case, commencing with the first fiscal year of the Corporation during which such action or omission occurred, Participant shall forfeit (without any payment therefore) up to 100% of any Performance Units that have not been vested or settled and shall repay to the Corporation, upon notice to Participant by the Corporation, up to 100% of the Fair Market Value of the shares of Common Stock at the time such shares were delivered to the Participant pursuant to the Performance Units during and after such fiscal year. The Board or the Committee, as the case may be, shall determine in its sole discretion the date of occurrence of such action or omission, the percentage of the Performance Units that shall be forfeited and the percentage of the Fair Market Value of the shares of Common Stock delivered pursuant to the Performance Units that must be repaid to the Corporation.

20. Counterparts.

This Agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

21. Section Headings.

The section headings of this Agreement are for convenience of reference only and shall not be deemed to alter or affect any provision hereof.

22. Governing Law.

This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of [Delaware]/[California] without regard to conflict of law principles thereunder.

EXHIBIT A

PERFORMANCE GOALS

Molina Healthcare, Inc. 2019 Equity Incentive Plan
Restricted Stock Award Agreement

This RESTRICTED STOCK AWARD AGREEMENT (this "Agreement") effective as of [DATE] is between Molina Healthcare, Inc., a Delaware corporation (the "Company"), and [NAME OF EMPLOYEE], an employee of the Company or one of its Affiliates (the "Grantee"), pursuant to and subject to the terms and conditions of the Molina Healthcare, Inc. 2019 Equity Incentive Plan (the "Plan"). The Company desires to award to the Grantee a number of shares of the Company's common stock, par value $.001 per share (the "Common Stock"), subject to certain restrictions as provided in this Agreement, in order to carry out the purpose of the Plan. The purpose of this Agreement is to evidence the terms and conditions of an award of restricted stock granted to the Grantee under the Plan.

Accordingly, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Company and the Grantee hereby agree as follows:

Section 1. Award of Restricted Stock.

Effective as of [DATE] (the "Effective Date"), the Company grants to the Grantee a restricted stock award of [NUMBER OF SHARES] shares of Common Stock (the "Shares"), subject to the terms and conditions set forth in this Agreement and in accordance with the terms of the Plan (the "Restricted Stock Award").

Section 2. Rights with Respect to the Shares.

(a) Stockholder Rights. With respect to the Shares, the Grantee shall be entitled at all times on and after the date of issuance of the Shares to exercise the rights of a stockholder of Common Stock of the Company, including the right to vote the Shares and the right to receive dividends on the Shares as provided in Section 2(b) hereof, unless and until the Shares are forfeited pursuant to Section 3 hereof. However, the Shares shall be nontransferable and subject to a risk of forfeiture to the Company at all times prior to the dates on which such Shares become vested, and the restrictions with respect to the Shares lapse, in accordance with Section 3 of this Agreement.

(b) Dividends. As a condition to receiving the Shares under the Plan, the Grantee hereby agrees to defer the receipt of dividends paid on the Shares. Cash dividends or other cash distributions paid with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms, and conditions as the Shares to which they relate, shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary, and shall be forfeited in the event that the Shares with respect to which the dividends were paid are forfeited.

(c) Issuance of Shares. The Company shall cause the Shares to be issued in the Grantee's name or in a nominee name on the Grantee's behalf, either by book-entry registration or issuance of a stock certificate or certificates evidencing the Shares, which certificate or certificates shall be held by the Secretary of the Company or the stock transfer agent or brokerage service selected by the Secretary of the Company to provide such services for the Plan. The Shares shall be restricted from transfer and shall be subject to an appropriate stop-transfer order. If any certificate is issued, the certificate shall bear an appropriate legend referring to the restrictions applicable to the Shares. The Grantee hereby agrees to the retention by the Company of the Shares and, if a stock certificate is issued, the Grantee agrees to execute and deliver to the Company a blank stock power with respect to the Shares as a condition to the receipt of this Restricted Stock Award. After any Shares vest pursuant to Section 3 hereof, and following payment of the applicable withholding taxes pursuant to Section 6 of this Agreement, the Company shall promptly cause to be issued a certificate or certificates, registered in the Grantee's name, evidencing such vested whole Shares (less any Shares withheld to pay withholding taxes) and shall cause such certificate or certificates to be delivered to the Grantee free of the legend and the stop-transfer order referenced above. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share at the time certificates evidencing the Shares are delivered to the Grantee.

Section 3. Vesting; Forfeiture.

(a) Vesting. Subject to the terms and conditions of this Agreement, [one-third (1/3rd)] of the Shares shall vest, and the restrictions with respect to the Shares shall lapse, on each of the [first, second, and third anniversaries] of the Effective Date if the Grantee remains continuously employed by the Company or an Affiliate of the Company until such respective vesting dates.

(b) Forfeiture. If the Grantee ceases to be employed by the Company and all Affiliates of the Company for any reason prior to the vesting of the Shares pursuant to Section 3(a) hereof, Grantee's rights to all of the unvested Shares shall be treated in accordance with the terms of his Employment Agreement with the Company, dated as of [DATE] (the "Employment Agreement").

(c) No Early Vesting. Except as provided in the Employment Agreement or unless otherwise determined by the Committee in its sole discretion, in no event will any of the Shares vest prior to their respective vesting dates set forth in Section 3(a) hereof.

Section 4. Restrictions on Transfer.

Until the Shares vest pursuant to Section 3 hereof, neither the Shares, nor any right with respect to the Shares under this Agreement, may be sold, assigned, transferred, pledged, hypothecated (by operation of law or otherwise) or otherwise conveyed or encumbered and shall not be subject to execution, attachment or similar process. Any attempted sale, assignment, transfer, pledge, hypothecation or other conveyance or encumbrance shall be void and unenforceable against the Company or any Affiliate of the Company.

Section 5. Distributions and Adjustments.

(a) If any Shares vest subsequent to any change in the number or character of the Common Stock of the Company through any stock dividend or other distribution, recapitalization, stock split, reverse stock split, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase or exchange of shares or other securities of the Company, issuance of warrants or other rights to purchase shares of Common Stock or other securities of the Company or other similar corporate transaction or event such that an adjustment is determined by the Committee to be appropriate in order to prevent dilution or enlargement of the benefits or potential benefits intended to be made available under this Agreement, then the Committee shall, in such manner as it may deem equitable, in its sole discretion, adjust any or all of the number and type of such Shares.

(b) Any additional shares of Common Stock of the Company, any other securities of the Company and any other property distributed with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate and shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary.

Section 6. Taxes.

(a) The Grantee acknowledges that the Grantee will consult with the Grantee's personal tax adviser regarding the income tax consequences of the grant of the Shares, payment of dividends on the Shares, the vesting of the Shares and any other matters related to this Agreement. In order to comply with all applicable federal, state, local or foreign income tax laws or regulations, the Company may take such action as it deems appropriate to ensure that all applicable federal, state, local or foreign payroll, withholding, income or other taxes, which are the Grantee's sole and absolute responsibility, are withheld or collected from the Grantee.

(b) In accordance with the terms of the Plan, and such rules as may be adopted by the Committee administering the Plan, the Grantee may elect to satisfy tax withholding obligations arising from the receipt of, or the lapse of restrictions relating to, the Shares by (i) delivering cash, check, bank draft, money order or wire transfer payable to the order of the Company, (ii) having the Company withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the

[redacted]

obligations of confidentiality which Grantee has to the Company under general legal or equitable principles. All documents and other property including or reflecting confidential information furnished to Grantee by the Company or otherwise acquired or developed by the Company shall at all times be the property of the Company (or any Subsidiary). Upon termination of employment, Grantee shall return to the Company (or any Subsidiary) any such documents or other property (including copies, summaries, or analyses of the foregoing) of the Company (or any Subsidiary) which are in Grantee's possession, custody, or control.

Section 10. Definitions.

Terms not defined in this Agreement shall have the meanings given to them in the Plan.

Section 11. Governing Law.

The internal law, and not the law of conflicts, of the State of California will govern all questions concerning the validity, construction and effect of this Agreement.

Section 12. Plan Provisions.

This Agreement is made under and subject to the provisions of the Plan, the Employment Agreement, and the Company's Change in Control Severance Plan, as may be amended from time to time (the "Change in Control Severance Plan"), and all of the provisions of the Plan, the Employment Agreement, and the Change in Control Severance Plan, are also provisions of this Agreement. If there is a difference or conflict between the provisions of this Agreement and the provisions of the Plan, the Employment Agreement, and the Change in Control Severance Plan, then the provisions of the Plan, the Employment Agreement, and the Change in Control Severance Plan will govern. By accepting this Restricted Stock Award, the Grantee confirms that the Grantee has received a copy of the Plan, the Employment Agreement, and the Change in Control Severance Plan, and represents that the Grantee is familiar with the terms and provisions of the Plan, the Employment Agreement, and the Change in Control Severance Plan, and hereby accepts this Restricted Stock Award subject to all the terms and provisions of the Plan, the Employment Agreement, and the Change in Control Severance Plan.

Section 13. No Rights to Continue Service or Employment.

Nothing herein shall be construed as giving the Grantee the right to continue in the employ or to provide services to the Company or any Affiliate, whether as an employee or as a consultant or otherwise, or interfere with or restrict in any way the right of the Company or any Affiliate to discharge the Grantee, whether as an employee or consultant or otherwise, at any time, with or without cause. Subject to the terms of the Grantee's Employment Agreement, the Company or any Affiliate may discharge the Grantee free from any liability or claim under this Agreement.

Section 14. Entire Agreement.

With the exception of the Grantee's Employment Agreement and the Change in Control Severance Plan, this Agreement together with the Plan supersede any and all other prior understandings and agreements, either oral or in writing, between the parties with respect to the subject matter hereof and constitute the sole and only agreements between the parties with respect to said subject matter. All prior negotiations and agreements between the parties with respect to the subject matter hereof are merged into this Agreement. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party or by anyone acting on behalf of any party, which are not embodied in this Agreement or the Plan and that any agreement, statement or promise that is not contained in this Agreement or the Plan shall not be valid or binding or of any force or effect.

Section 15. Modification.

No change or modification of this Agreement shall be valid or binding upon the parties unless the change or modification is in writing and signed by the parties. Notwithstanding the preceding sentence, the Plan, this Agreement and the Restricted Stock Award may be amended, altered, suspended, discontinued or terminated to the extent permitted by the Plan.

Section 16. Shares Subject to Agreement.

The Shares shall be subject to the terms and conditions of this Agreement. Except as otherwise provided in Section 5, no adjustment shall be made for dividends or other rights for which the record date is prior to the issuance of the Shares. The Company shall not be required to deliver any Shares until the requirements of any federal or state securities or other laws, rules or regulations (including the rules of any securities exchange) as may be determined by the Committee to be applicable are satisfied.

Section 17. Severability.

In the event that any provision that is contained in the Plan or this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or would disqualify the Plan or this Agreement for any reason and under any law as deemed applicable by the Committee, the invalid, illegal or unenforceable provision shall be construed or deemed amended to conform to applicable laws, or if it cannot be so construed or deemed amended without, in the determination of the Committee, materially altering the purpose or intent of the Plan or this Agreement, such provision shall be stricken as to such jurisdiction or Shares, and the remainder of the Plan or this Agreement shall remain in full force and effect.

Section 18. Headings.

Headings are given to the sections and subsections of this Agreement solely as a convenience to facilitate reference. Such headings shall not be deemed in any way material or relevant to the construction or interpretation of this Agreement or any provision hereof.

Section 19. Grantee's Acknowledgments.

The Grantee hereby agrees to accept as binding, conclusive and final all decisions or interpretations of the Committee or the Board of Directors of the Company, as appropriate, upon any questions arising under the Plan or this Agreement. Any determination in this connection by the Company, including the Board of Directors of the Company or the Committee, shall be final, binding and conclusive. The obligations of the Company and the rights of the Grantee are subject to all applicable laws, rules and regulations.

Section 20. Parties Bound.

The terms, provisions and agreements that are contained in this Agreement shall apply to, be binding upon, and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives and permitted successors and assigns, subject to the limitation on assignment expressly set forth herein. This Agreement shall have no force or effect unless it is duly executed and delivered by the Company.

Section 21. Counterparts.

This Agreement may be executed in counterparts, each of which shall constitute an original, but both of which when taken together shall constitute a single contract. Delivery of an executed counterpart of a signature page of this Agreement by telecopy shall be effective as delivery of a manually executed counterpart of this Agreement.

IN WITNESS WHEREOF, each of the parties has executed this Agreement, in the case of the Company by its duly authorized officer, effective as of the day and year first above written.

MOLINA HEALTHCARE, INC.

By: _____
[NAME]
Its: [TITLE]

GRANTEE

_____
[NAME]

MOLINA HEALTHCARE, INC.
2019 EQUITY INCENTIVE PLAN

PERFORMANCE STOCK UNIT AWARD AGREEMENT

THIS PERFORMANCE STOCK UNIT AWARD AGREEMENT (this "Agreement") dated [DATE], by and between MOLINA HEALTHCARE, INC., a Delaware corporation (the "Corporation"), and [NAME] (the "Participant"), evidences the award of Performance Units (the "**Award**") granted by the Corporation to the Participant as to the number of Performance Units first set forth below.

Total Number of Performance Units:[1] [NUMBER OF UNITS]

Award Date: [DATE]
Performance Period for the Award: [PERFORMANCE PERIOD]

Vesting[1, 2] The Award shall vest and become nonforfeitable as provided in Section 2 of the attached Terms and Conditions of Performance Unit Award (the "Terms").

The Award is granted under the MOLINA HEALTHCARE, INC. 2019 EQUITY INCENTIVE PLAN (the "Plan") and that certain Employment Agreement, dated as of [DATE] (the "Employment Agreement"), by and between the Corporation and the Participant, and is subject to the Terms attached to this Agreement (incorporated herein by this reference) and to the Plan and the Employment Agreement. The Award has been granted to the Participant in addition to, and not in lieu of, any other form of compensation otherwise payable or to be paid to the Participant. Capitalized terms are defined in the Plan if not defined herein. The parties agree to the terms of the Award set forth herein. The Participant acknowledges receipt of a copy of the Terms, the Employment Agreement, the Plan, and the Prospectus for the Plan.

The Participant acknowledges and agrees that the Corporation may deliver, by electronic mail, the use of the Internet, including through the website of the agent appointed by the Committee to administer the Plan, the Corporation intranet web pages or otherwise, any information concerning the Corporation, this Award, the Plan, and any information required by the Securities Act of 1933, as amended, and the rules and regulations promulgated thereunder.

PARTICIPANT

_____
[NAME]

MOLINA HEALTHCARE, INC.
a Delaware corporation

By: _____
[NAME]/[TITLE]

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[1] Subject to adjustment under Section 4.2 of the Plan.
[2] Subject to early termination under Section 10.7 of the Plan.

TERMS AND CONDITIONS OF PERFORMANCE UNIT AWARD

1. Performance Units.

Each Performance Unit constitutes an unfunded and unsecured promise of the Corporation to deliver up to two shares of the Corporation's common stock to the Participant (subject to adjustment as provided in Section 4.2 of the Plan) pursuant to the terms of this Agreement, subject to the vesting provisions in Exhibit A. The Performance Units shall be used solely as a device for the determination of the payment to eventually be made to the Participant if such Performance Units vest pursuant to Section 2. The Performance Units shall not be treated as property or as a trust fund of any kind.

2. Vesting.

Subject to Section 7, the Award shall vest and become nonforfeitable at the vesting percentage levels set forth in Exhibit A, based on the achievement of the Performance Goals established by the Committee and set forth on Exhibit A attached hereto for the Performance Period. In the event that the performance condition with respect to the Award is achieved, the Award shall become unconditionally due. Subject to Section 7, any Performance Units subject to the Award that do not vest in accordance with Exhibit A shall terminate as of the last day of the Performance Period.

3. Continuance of Service.

Except as otherwise expressly provided in Section 7 below, the vesting schedule requires continued Service through each applicable vesting date as a condition to the vesting of the Award and the rights and benefits under this Agreement; and Service for only a portion of any vesting period, even if a substantial portion, will not entitle the Participant to any proportionate vesting or avoid or mitigate a termination of rights and benefits upon or following a termination of Participant's Service as provided in Section 7 below or under the Plan for such vesting period (or for any later vesting period).

Nothing contained in this Agreement or the Plan constitutes an employment or service commitment by the Corporation, affects the contractual obligations pursuant to any employment or service commitment agreement if Participant is party to such agreement, or in the absence of such agreement affects Participant's status as an employee at will who is subject to termination without cause, confers upon the Participant any right to remain employed by or in service to the Corporation or any Subsidiary Corporation, interferes in any way with the right of the Corporation or any Subsidiary Corporation at any time to terminate Participant's Service, or affects the right of the Corporation or any Subsidiary Corporation to increase or decrease the Participant's other compensation or benefits. Nothing in this paragraph, however, is intended to adversely affect any independent contractual right of the Participant without his consent thereto.

4. Limitations on Rights Associated with Performance Units.

The Participant shall have no rights as a stockholder of the Corporation, no dividend rights and no voting rights with respect to the Performance Units and any shares of Common Stock underlying or issuable in respect of such Performance Units until such shares of Common Stock are actually issued to and held of record by the Participant. No adjustments will be made for dividends or other rights of a holder for which the record date is prior to the date of issuance of the stock certificate.

5. Restrictions on Transfer.

Unless otherwise determined by the Committee, neither the Award, nor any interest therein may be sold, assigned, transferred, pledged or otherwise disposed of, alienated or encumbered, either voluntarily or involuntarily. The transfer restrictions in the preceding sentence shall not apply to (a) transfers to the Corporation, or (b) transfers by will or the laws of descent and distribution.

6. Conversion of Performance Units; Issuance of Common Stock.

On or as soon as administratively practicable following the last day of the Performance Period, and in any event, no later than March 15 of the year following the year in which the vesting event occurs (which payment schedule is intended to comply with the "short-term deferral" exemption from the application of Section 409A of the Code), unless such payment is deferred in accordance with the terms and conditions of the Corporation's non-qualified compensation deferral plans, the Corporation shall deliver to the Participant the respective number of

shares of Common Stock (either by delivering one or more certificates for such shares or by entering such shares in book entry form, as determined by the Corporation in its discretion) for the Performance Units (if any) that vest in accordance with Section 2, unless such Performance Units terminate prior to the given vesting date pursuant to Section 7. The Corporation's obligation to deliver shares of Common Stock with respect to any vested Performance Units is subject to the condition precedent that the Participant or other person entitled under the Plan to receive any shares with respect to the vested Performance Units deliver to the Corporation any representations or other documents or assurances required pursuant to Section 14 of the Plan. The Participant shall have no further rights with respect to any Performance Units that are paid or that are terminated pursuant to Section 7.

7. Effect of Change in Control or Termination of Employment.

7.1 Effect of Change in Control. In the event of a Change in Control, if, within twenty-four (24) months following a Change in Control, the Participant's Service is terminated by the Corporation without Cause or the Participant terminates his employment for Good Reason, then the Performance Units shall become immediately 100% vested and the Corporation shall deliver to the Participant the greater of (i) one share of Common Stock for each Performance Unit that vested as result of such termination, or (ii) such greater number of shares of Common Stock for each Performance Unit that the Participant may be entitled to receive pursuant to the Corporation's change in control severance plan, as may be amended from time to time.

7.2 **Effect of Termination of Participant's Service**. If the Participant's Service ceases for any reason other than as set forth in Section 7.1 (the last day that the Participant's Service is referred to as the Participant's "Severance Date"), the Participant's Performance Units, to the extent unvested on the Severance Date, shall terminate and be forfeited as of the Severance Date.

For purposes of this Agreement, the following terms shall have the following respective meanings.

"Cause" shall have the meaning given to such term in the Employment Agreement.

"Employment Agreement" shall mean the Employment Agreement made as of [DATE], between the Participant and the Corporation, as may be amended from time to time.

"Good Reason" shall have the meaning given to such term in the Employment Agreement.

If any unvested Performance Units are terminated hereunder, such Performance Units shall automatically terminate and be cancelled as of the applicable termination date without payment of any consideration by the Corporation and without any other action by the Participant, or the Participant's beneficiary or personal representative, as the case may be.

8. Adjustments Upon Specified Events.

The Committee may accelerate payment and vesting of the Performance Units in such circumstances as it, in its sole discretion, may determine. In addition, upon the occurrence of certain events relating to the Corporation's stock contemplated by Section 4.2 of the Plan (including, without limitation, an extraordinary cash dividend on such stock), the Committee shall make adjustments in the number of Performance Units then outstanding and the number and kind of securities that may be issued in respect of the Award. No such adjustment shall be made with respect to any ordinary cash dividend paid on the Common Stock. Furthermore, the Committee shall adjust the performance measures and performance goals referenced in Exhibit A hereof to the extent (if any) it determines that the adjustment is necessary or advisable to preserve the intended incentives and benefits to reflect (1) any material change in corporate capitalization, any material corporate transaction (such as a reorganization, combination, separation, merger, acquisition, or any combination of the foregoing), or any complete or partial liquidation of the Corporation, (2) any change in accounting policies or practices, (3) the effects of any special charges to the Corporation's earnings, or (4) any other similar special circumstances.

9. Tax Withholding.

Subject to Section 16 of the Plan and such rules and procedures as the Committee may impose, upon any distribution of shares of Common Stock in respect of the Award, the Corporation shall automatically reduce the

number of shares to be delivered by (or otherwise reacquire) the appropriate number of whole shares, valued at their then Fair Market Value, to satisfy any withholding obligations of the Corporation or its Subsidiary Corporations with respect to such distribution of shares at the minimum applicable withholding rates; provided, however, that the foregoing provision shall not apply in the event that the Participant has, subject to the approval of the Committee, made other provision in advance of the date of such distribution for the satisfaction of such withholding obligations. In the event that the Corporation cannot legally satisfy such withholding obligations by such reduction of shares, or in the event of a cash payment or any other withholding event in respect of the Award, the Corporation (or a Subsidiary Corporation) shall be entitled to require a cash payment by or on behalf of the Participant and/or to deduct from other compensation payable to the Participant any sums required by federal, state or local tax law to be withheld with respect to such distribution or payment.

10. Non-Solicitation.

10.1 Non-Solicitation (Employees). The Participant acknowledges and agrees that during the period of Participant's employment by the Corporation (or any subsidiary), and for a period of one (1) year after termination of Participant's Service Relationship for any reason, with or without Cause, Participant shall not directly or indirectly, either alone or in concert with others, solicit, entice, or encourage the hiring of any employee of the Corporation (or any Subsidiary) unless such person was involuntarily terminated or laid off by the Corporation (or any subsidiary).

10.2 Non-Solicitation (Customers). During the Participant's employment with the Corporation and for a period of one (1) year after the Participant's date of termination, the Participant shall not, directly or indirectly: (i) contact or solicit, or direct any person, firm, corporation, association or other entity to contact or solicit, any of the Corporation's customers for the purpose of providing any products and/or services that are the same as or similar to the products and services provided by the Corporation to its customers during the term of the Corporation's employment; or (ii) divert or attempt to divert, for his direct or indirect benefit, or for the benefit of any other person, firm, corporation, association or other entity, the business of any customer of the Corporation; or (iii) influence or attempt to influence any customer of the Corporation to transfer its business to the Participant or any person, firm, corporation, association or other entity; or (iv) in any other manner knowingly interfere with, disrupt or attempt to disrupt the relationship of the Corporation with any of its customers, and in each of (i) through (iv) if such activities post-termination of employment involve the use of trade secrets or other confidential information, as defined in Section 12, of the Corporation. In addition, the Corporation will not disclose the identity of any such customers to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever.

11. Nondisparagement.

The Participant agrees that he/she will not disparage the Corporation or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. The Participant further agrees that he/she will not direct anyone to make any disparaging oral or written remarks to any third parties.

12. Confidentiality.

The Participant agrees to keep and maintain in strict confidence all confidential and proprietary information of the Corporation (or any subsidiary) during and after the term of employment by the Corporation, and to never directly or indirectly make known, divulge, reveal, furnish, make available, or use any confidential information (except in the course of regular authorized duties on behalf of the Corporation or any subsidiary). Participant's obligations of confidentiality hereunder shall survive termination of employment regardless of any actual or alleged breach by the Corporation (or any subsidiary) in connection with such termination, until and unless any such confidential information shall have become, through no fault of Participant, generally known to the public or unless Participant is required by law to make disclosure (after giving the Corporation or any subsidiary notice and an opportunity to contest such requirement). Participant's obligations under this Section are in addition to and not in limitation or preemption of all other obligations of confidentiality which Participant has to the Corporation under general legal or equitable principles. All documents and other property including or reflecting confidential information furnished to Participant by the Corporation or otherwise acquired or developed by the Corporation shall at all times be the property of the Corporation (or any subsidiary). Upon termination of employment, Participant shall return to the Corporation (or any subsidiary) any such documents or other property (including copies,

summaries, or analyses of the foregoing) of the Corporation (or any subsidiary) which are in Participant's possession, custody, or control.

13. Notices.

Any notice to be given under the terms of this Agreement shall be in writing and addressed to the Corporation at its principal office to the attention of the Secretary, and to the Participant at the Participant's last address reflected on the Corporation's records, or at such other address as either party may hereafter designate in writing to the other. Any such notice shall be given only when received, but if the Participant is no longer an employee of the Corporation, shall be deemed to have been duly given by the Corporation when enclosed in a properly sealed envelope addressed as aforesaid, registered or certified, and deposited (postage and registry or certification fee prepaid) in a post office or branch post office regularly maintained by the United States Government.

14. Plan and Employment Agreement.

The Award and all rights of the Participant under this Agreement are subject to, and the Participant agrees to be bound by, all of the terms and conditions of the provisions of the Plan and the Employment Agreement, both of which are incorporated herein by reference. In the event of a conflict or inconsistency between the terms and conditions of this Agreement and those of the Plan and the Employment Agreement, the terms and conditions of the Plan and the Employment Agreement shall govern. The Participant acknowledges having read and understood the Plan, the Prospectus for the Plan, the Employment Agreement, and this Agreement. Unless otherwise expressly provided in other sections of this Agreement, provisions of the Plan and the Employment Agreement that confer discretionary authority on the Committee do not (and shall not be deemed to) create any rights in the Participant unless such rights are expressly set forth herein or are otherwise in the sole discretion of the Committee so conferred by appropriate action of the Committee under the Plan and the Employment Agreement after the date hereof.

15. Construction; Section 409A.

It is intended that the terms of the Award will not result in the imposition of any tax liability pursuant to Section 409A of the Code. This Agreement shall be construed and interpreted consistent with that intent. Notwithstanding any provision of this Agreement to the contrary, if the Participant is a "specified employee" as defined in Code Section 409A and, as a result of that status, any portion of the payments under this Agreement would otherwise be subject to taxation pursuant to Code Section 409A, the Participant shall not be entitled to any payments upon a termination of his Service until the earlier of (i) the date which is six (6) months after his termination of Service for any reason other than death, or (ii) the date of the Participant's death; provided the first such payment thereafter shall include all amounts that would have been paid earlier but for such six (6) month delay. The Corporation and the Participant agree to act reasonably and to cooperate to amend or modify this Agreement to the extent reasonably necessary to avoid the imposition of the tax under Code Section 409A.

16. Entire Agreement; Applicability of Other Agreements.

This Agreement, the Plan, and the Employment Agreement together constitute the entire agreement and supersede all prior understandings and agreements, written or oral, of the parties hereto with respect to the subject matter hereof. The Plan and this Agreement may be amended pursuant to Section 17 of the Plan. Such amendment must be in writing and signed by the Corporation. The Corporation may, however, unilaterally waive any provision hereof in writing to the extent such waiver does not adversely affect the interests of the Participant hereunder, but no such waiver shall operate as or be construed to be a subsequent waiver of the same provision or a waiver of any other provision hereof. Notwithstanding the foregoing, if the Participant is subject to a written employment, change in control or similar agreement with the Corporation that is in effect as of the Participant's Severance Date and the Participant would be entitled under the express provisions of such agreement to greater rights with respect to accelerated vesting of the Award in connection with the termination of the Participant's employment in the circumstances, the provisions of such agreement shall control with respect to such vesting rights, and the corresponding provisions of this Agreement shall not apply.

17. **Limitation on Participant's Rights.**

Participation in this Plan confers no rights or interests other than as herein provided. This Agreement creates only a contractual obligation on the part of the Corporation as to amounts payable and shall not be construed

as creating a trust. Neither the Plan nor any underlying program, in and of itself, has any assets. The Participant shall have only the rights of a general unsecured creditor of the Corporation (or applicable Subsidiary Corporation) with respect to amounts credited and benefits payable in cash, if any, with respect to the Performance Units, and rights no greater than the right to receive the Common Stock (or equivalent value) as a general unsecured creditor with respect to Performance Units, as and when payable thereunder.

18. **Forfeiture and Corporation's Right to Recover Fair Market Value of Shares Received Pursuant to Performance Units.**

If, at any time, the Board or the Committee, as the case may be, in its sole discretion determines that any action or omission by Participant constituted (a) wrongdoing that contributed to (i) any material misstatement in or omission from any report or statement filed by the Corporation with the U.S. Securities and Exchange Commission or (ii) a statement, certification, cost report, claim for payment, or other filing made under Medicare or Medicaid that was false, fraudulent, or for an item or service not provided as claimed, (b) intentional or gross misconduct, (c) a breach of a fiduciary duty to the Corporation or a Subsidiary Corporation, (d) fraud or (e) non-compliance with the Corporation's Code of Business Conduct and Ethics, policies or procedures to the material detriment of the Corporation, then in each such case, commencing with the first fiscal year of the Corporation during which such action or omission occurred, Participant shall forfeit (without any payment therefore) up to 100% of any Performance Units that have not been vested or settled and shall repay to the Corporation, upon notice to Participant by the Corporation, up to 100% of the Fair Market Value of the shares of Common Stock at the time such shares were delivered to the Participant pursuant to the Performance Units during and after such fiscal year. The Board or the Committee, as the case may be, shall determine in its sole discretion the date of occurrence of such action or omission, the percentage of the Performance Units that shall be forfeited and the percentage of the Fair Market Value of the shares of Common Stock delivered pursuant to the Performance Units that must be repaid to the Corporation.

19. Counterparts.

This Agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

20. Section Headings.

The section headings of this Agreement are for convenience of reference only and shall not be deemed to alter or affect any provision hereof.

21. Governing Law.

This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of California without regard to conflict of law principles thereunder.

EXHIBIT A

PERFORMANCE GOALS

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2019 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: July 31, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Thomas L. Tran, certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2019 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 31, 2019

/s/ Thomas L. Tran

Thomas L. Tran

Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2019 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 31, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2019 (the "Report"), I, Thomas L. Tran, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 31, 2019

/s/ Thomas L. Tran

Thomas L. Tran
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended March 31, 2019

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2019

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ (do not check if a smaller reporting company)

Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of April 26, 2019, was approximately 62,619,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED March 31, 2019

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CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2019	2018
	(In millions, except per-share amounts) (Unaudited)	
Revenue:		
Premium revenue	$ 3,952	$ 4,323
Premium tax revenue	138	104
Health insurer fees reimbursed	—	61
Service revenue	—	134
Investment income and other revenue	29	24
Total revenue	4,119	4,646
Operating expenses:		
Medical care costs	3,371	3,722
General and administrative expenses	302	352
Premium tax expenses	138	104
Health insurer fees	—	75
Depreciation and amortization	25	26
Restructuring costs	3	25
Cost of service revenue	—	120
Total operating expenses	3,839	4,424
Operating income	280	222
Other expenses, net:		
Interest expense	23	33
Other (income) expenses, net	(3)	10
Total other expenses, net	20	43
Income before income tax expense	260	179
Income tax expense	62	72
Net income	$ 198	$ 107
Net income per share:		
Basic	$ 3.19	$ 1.79
Diluted	$ 2.99	$ 1.64

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2019	2018
	(In millions) (Unaudited)	
Net income	$ 198	$ 107
Other comprehensive income (loss):		
Unrealized investment gain (loss)	7	(7)
Less: effect of income taxes	2	(1)
Other comprehensive income (loss), net of tax	5	(6)
Comprehensive income	$ 203	$ 101

See accompanying notes.

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CONSOLIDATED BALANCE SHEETS

	March 31, 2019	December 31, 2018
	(Dollars in millions, except per-share amounts)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,224	$ 2,826
Investments	1,508	1,681
Receivables	1,359	1,330
Prepaid expenses and other current assets	124	149
Derivative asset	516	476
Total current assets	6,731	6,462
Property, equipment, and capitalized software, net	376	241
Goodwill and intangible assets, net	185	190
Restricted investments	100	120
Deferred income taxes	76	117
Other assets	111	24
	$ 7,579	$ 7,154
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,995	$ 1,961
Amounts due government agencies	932	967
Accounts payable and accrued liabilities	444	390
Deferred revenue	207	211
Current portion of long-term debt	198	241
Derivative liability	516	476
Total current liabilities	4,292	4,246
Long-term debt	1,121	1,020
Finance lease liabilities	234	197
Other long-term liabilities	97	44
Total liabilities	5,744	5,507
Stockholders' equity:		
Common stock, $0.001 par value, 150 million shares authorized; outstanding: 63 million shares at March 31, 2019 and 62 million shares at December 31, 2018	—	—
Preferred stock, $0.001 par value; 20 million shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	543	643
Accumulated other comprehensive loss	(3)	(8)
Retained earnings	1,295	1,012
Total stockholders' equity	1,835	1,647
	$ 7,579	$ 7,154

See accompanying notes.

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CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
	(Unaudited)					
Balance at December 31, 2018	62	$ —	$ 643	$ (8)	$ 1,012	$ 1,647
Net income	—	—	—	—	198	198
Adoption of new accounting standard	—	—	—	—	85	85
Partial termination of 1.125% Warrants	—	—	(103)	—	—	(103)
Other comprehensive gain, net	—	—	—	5	—	5
Share-based compensation	1	—	3	—	—	3
Balance at March 31, 2019	63	$ —	$ 543	$ (3)	$ 1,295	$ 1,835

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
	(Unaudited)					
Balance at December 31, 2017	60	$ —	$ 1,044	$ (5)	$ 298	$ 1,337
Net income	—	—	—	—	107	107
Adoption of new accounting standards	—	—	—	(1)	7	6
Exchange of 1.625% Convertible Notes	2	—	108	—	—	108
Other comprehensive loss, net	—	—	—	(6)	—	(6)
Share-based compensation	—	—	1	—	—	1
Balance at March 31, 2018	62	$ —	$ 1,153	$ (12)	$ 412	$ 1,553

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2019	2018
	(In millions) (Unaudited)	
Operating activities:		
Net income	$ 198	$ 107
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	25	37
Deferred income taxes	15	(6)
Share-based compensation	9	6
Amortization of convertible senior notes and finance lease liabilities	3	7
(Gain) loss on debt extinguishment	(3)	10
Non-cash restructuring costs	—	17
Other, net	3	2
Changes in operating assets and liabilities:		
Receivables	(29)	(83)
Prepaid expenses and other current assets	20	(239)
Medical claims and benefits payable	34	(163)
Amounts due government agencies	(35)	172
Accounts payable and accrued liabilities	(30)	319
Deferred revenue	(4)	130
Income taxes	43	78
Net cash provided by operating activities	249	394
Investing activities:		
Purchases of investments	(185)	(389)
Proceeds from sales and maturities of investments	366	543
Purchases of property, equipment and capitalized software	(6)	(4)
Other, net	(4)	(5)
Net cash provided by investing activities	171	145
Financing activities:		
Repayment of principal amount of 1.125% Convertible Notes	(46)	—
Cash paid for partial settlement of 1.125% Conversion Option	(115)	—
Cash received for partial termination of 1.125% Call Option	115	—
Cash paid for partial termination of 1.125% Warrants	(103)	—
Proceeds from borrowings under Term Loan	100	—
Other, net	1	(5)
Net cash used in financing activities	(48)	(5)
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	372	534
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	2,926	3,290
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 3,298	$ 3,824

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Three Months Ended March 31,	
	2019	2018
	(In millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (7)	$ (5)
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 155	$ 63
Loss on 1.125% Conversion Option	(155)	(63)
Change in fair value of derivatives, net	$ —	$ —
1.625% Convertible Notes exchange transaction:		
Common stock issued in exchange for 1.625% Convertible Notes	$ —	$ 131
Component allocated to additional paid-in capital, net of income taxes	—	(23)
Net increase to additional paid-in capital	$ —	$ 108

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

March 31, 2019

1. Organization and Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides managed health care services under the Medicaid and Medicare programs and through the insurance marketplaces (the "Marketplace"). We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. The Other segment includes the historical results of the Medicaid management information systems ("MMIS") and behavioral health subsidiaries that were sold in the fourth quarter of 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Prior to the fourth quarter of 2018, the MMIS subsidiary was reported as a stand-alone segment.

The Health Plans segment consists of health plans operating in 14 states and the Commonwealth of Puerto Rico. As of March 31, 2019, these health plans served approximately 3.4 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals including Marketplace members, most of whom receive government subsidies for premiums. The health plans are generally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization ("HMO").

Our health plans' state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal ("RFPs") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., and its subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the three months ended March 31, 2019, are not necessarily indicative of the results for the entire year ending December 31, 2019.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2018. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in our December 31, 2018, audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our audited consolidated financial statements for the fiscal year ended December 31, 2018.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable of our Health Plans segment;
- Health plans' contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plans' quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Settlements under risk or savings sharing programs;
- The assessment of long-lived and intangible assets, and goodwill for impairment;

- The determination of reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for litigation outcomes;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in non-current "Restricted investments" in the accompanying consolidated balance sheets.

	March 31,	
	2019	2018
	(In millions)	
Cash and cash equivalents	$ 3,224	$ 3,729
Restricted cash and cash equivalents	74	95
Total cash, cash equivalents, and restricted cash and cash equivalents presented in the statements of cash flows	$ 3,298	$ 3,824

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid Program

Medical Cost Floors (Minimums), and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $98 million and $103 million at March 31, 2019 and December 31, 2018, respectively. Approximately $87 million of the liability accrued at both March 31, 2019 and December 31, 2018, relates to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at March 31, 2019 and December 31, 2018.

Profit Sharing and Profit Ceiling. Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at March 31, 2019 and December 31, 2018.

Retroactive Premium Adjustments. State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare Program

Risk Adjusted Premiums: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and CMS practices. Consolidated balance sheet

amounts related to anticipated Medicare risk adjusted premiums and Medicare Part D settlements were insignificant at March 31, 2019 and December 31, 2018.

Minimum MLR. The Affordable Care Act ("ACA") has established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. The amounts payable for the Medicare Minimum MLR was not significant at March 31, 2019 and December 31, 2018.

Marketplace Program

Risk adjustment. Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score (risk adjustment payable), and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score (risk adjustment receivable). We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. As of March 31, 2019, and December 31, 2018, the Marketplace risk adjustment payable amounted to $568 million and $466 million, respectively. As of March 31, 2019, and December 31, 2018, the Marketplace risk adjustment receivable amounted to $51 million and $34 million, respectively.

Minimum MLR. The ACA has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. Aggregate balance sheet amounts related to the Minimum MLR were insignificant at March 31, 2019 and December 31, 2018.

Quality Incentives

At many of our health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2019, are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2019.

	Three Months Ended March 31,	
	2019	2018
	(In millions)	
Maximum available quality incentive premium - current period	$ 45	$ 40
Quality incentive premium revenue recognized in current period:		
Earned current period	$ 26	$ 24
Earned prior periods	20	11
Total	$ 46	$ 35
Quality incentive premium revenue recognized as a percentage of total premium revenue	1.2%	0.8%

A summary of the categories of amounts due government agencies is as follows:

	March 31, 2019	December 31, 2018
	(In millions)	
Medicaid program:		
Medical cost floors and corridors	$ 98	$ 103
Other amounts due to states	90	81
Marketplace program:		
Risk adjustment	568	466
Cost sharing reduction	—	183
Other	176	134
	$ 932	$ 967

Medical Care Costs

Marketplace Program

In the first quarter of 2018, we recognized a benefit of approximately $70 million in reduced medical care costs related to 2017 dates of service as a result of the federal government's confirmation that the reconciliation of 2017 Marketplace cost sharing reduction ("CSR") subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Leases

Right-of-use ("ROU") assets represent our right to use the underlying assets over the lease term, and lease liabilities represent our obligation to make lease payments arising from the related leases. ROU assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. Lease terms may include options to extend or terminate the lease when we believe it is reasonably certain that we will exercise such options. Operating lease ROU assets are reported in other assets, and operating lease liabilities are reported in accounts payable and accrued liabilities (current), and other long-term liabilities (non-current) in our consolidated balance sheets. Finance lease ROU assets are reported in property, equipment, and capitalized software, and finance lease liabilities are reported in accounts payable and accrued liabilities (current), and finance lease liabilities (non-current) in our consolidated balance sheets.

Because most of our leases do not provide an implicit interest rate, we generally use our incremental borrowing rate to determine the present value of lease payments. Lease expenses for operating lease payments are recognized on a straight-line basis over the lease term, and the related ROU assets and liabilities are reduced to the present value of the remaining lease payments at the end of each period. Finance lease payments reduce finance lease liabilities, the related ROU assets are amortized on a straight-line basis over the lease term, and interest expense is recognized using the effective interest method.

Short-term leases (with a term of 12 months or less) are not recorded as ROU assets or liabilities in the consolidated balance sheets. We account for lease and non-lease components as a single lease component. For certain leases that represent a portfolio of similar assets, such as a fleet of vehicles, we apply a portfolio approach to account for the related operating lease ROU assets and liabilities, rather than account for such assets and liabilities on an individual basis. A nominal number of our lease agreements include rental payments that adjust periodically for inflation. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants.

For further information regarding our adoption of Accounting Standards Update ("ASU") 2016-02, *Leases (Topic 842),* see *Recent Accounting Pronouncements Adopted,* below.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a

maximum maturity of 10 years. Restricted investments are invested principally in certificates of deposit and U.S. Treasury securities. Concentration of credit risk with respect to accounts receivable is generally limited because our payors consist principally of the governments of each state in which our health plan subsidiaries operate.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee ("HIF"), certain compensation, and other general and administrative expenses. The effective tax rate will not be impacted by HIF in 2019 given the 2019 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including projected pretax earnings, the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Recent Accounting Pronouncements Adopted

Leases. In February 2016, the Financial Accounting Standards Board ("FASB") issued Topic 842, which was subsequently modified by several ASUs issued in 2017 and 2018. Topic 842 was issued to increase transparency and comparability among organizations by requiring the recognition of ROU assets and lease liabilities on the balance sheet. Most prominent among the changes in Topic 842 is the recognition of ROU assets and lease liabilities by lessees for those leases classified as operating leases. In addition, Topic 842's disclosures are required to meet the objective of enabling users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases. Topic 842's transition provisions are applied using a modified retrospective approach under which entities may not retrospectively adjust any periods prior to the earliest comparative period presented, or at the beginning of the period of adoption, whichever is later. Entities may elect whether to apply the transition provisions, including disclosure requirements, at the beginning of the earliest comparative period presented or on the adoption date.

We adopted Topic 842 effective January 1, 2019, and have elected to apply the transition provisions as of January 1, 2019. Accordingly, we recognized the cumulative effect of initially applying the standard as an adjustment to the opening balance of retained earnings on January 1, 2019. In addition, we elected the available practical expedients and implemented internal controls and key system functionality to enable the preparation of financial information on adoption.

As indicated in the accompanying consolidated statements of stockholders' equity, the cumulative effect adjustment was an increase of $85 million to retained earnings, relating primarily to the transition provisions for sale-leaseback arrangements that did not qualify for sale treatment. Accordingly, such arrangements for certain office buildings were de-recognized and recorded as finance lease ROU assets and lease liabilities. The difference between the de-recognized assets and lease financing obligations resulted in an increase to retained earnings. The recognition of these arrangements as finance lease ROU assets and lease liabilities will not materially impact our consolidated results of operations throughout the terms of the leases.

See Note 13, "Leases," for the required disclosures under Topic 842, including the amount and location of the ROU assets and lease liabilities recognized.

Software Licenses. In August 2018, the FASB issued ASU 2018-15, *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract,* which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. We early adopted ASU 2018-15 effective January 1, 2019, using the prospective method, with no material impact to our financial condition, results of operations or cash flows. Adoption of this guidance may be significant to us in the future depending on the extent to which we use cloud computing arrangements that qualify as service contracts.

Recent Accounting Pronouncements Not Yet Adopted

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount companies expect to collect over the instrument's

contractual life. ASU 2016-13 is effective beginning January 1, 2020, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted. We are in the early stages of evaluating the effect of this guidance.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission ("SEC") did not have, nor does management expect such pronouncements to have, a significant impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of basic and diluted net income per share:

	Three Months Ended March 31,	
	2019	2018
	(In millions, except net income per share)	
Numerator:		
Net income	$ 198	$ 107
Denominator:		
Shares outstanding at the beginning of the period	62.1	59.3
Weighted-average number of shares issued:		
Exchange of 1.625% Convertible Notes	—	0.5
Denominator for basic net income per share	62.1	59.8
Effect of dilutive securities:		
1.125% Warrants (1)	3.5	4.4
1.625% Convertible Notes	—	0.7
Stock-based compensation	0.6	0.3
Denominator for diluted net income per share	66.2	65.2
Net income per share: (2)		
Basic	$ 3.19	$ 1.79
Diluted	$ 2.99	$ 1.64
Potentially dilutive common shares excluded from calculations: (1)		
Stock-based compensation	0.1	0.4

(1) For more information and definitions regarding the 1.125% Warrants, including partial termination transactions, refer to Note 9, "Stockholders' Equity." The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable were not included in the computation of diluted net income per share because to do so would have been anti-dilutive.

(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to the three-tier fair value hierarchy. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 4, "Fair Value Measurements," in our 2018 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability (see Note 8 "Derivatives," for definitions and further information). These derivatives are not

actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of March 31, 2019, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. The 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such derivative instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of income for the three months ended March 31, 2019.

Our financial instruments measured at fair value on a recurring basis at March 31, 2019, were as follows:

	Total	Observable Inputs (Level 1)	Directly or Indirectly Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 947	$ —	$ 947	$ —
U.S. Treasury notes	168	—	168	—
Government-sponsored enterprise securities (“GSEs”)	166	—	166	—
Municipal securities	112	—	112	—
Asset-backed securities	75	—	75	—
Mortgage-backed securities	23	—	23	—
Certificate of deposit	14	—	14	—
Other	3	—	3	—
Subtotal - current investments	1,508	—	1,508	—
1.125% Call Option derivative asset	516	—	—	516
Total assets	$ 2,024	$ —	$ 1,508	$ 516
1.125% Conversion Option derivative liability	$ 516	$ —	$ —	$ 516
Total liabilities	$ 516	$ —	$ —	$ 516

Our financial instruments measured at fair value on a recurring basis at December 31, 2018, were as follows:

	Total	Observable Inputs (Level 1)	Directly or Indirectly Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,123	$ —	$ 1,123	$ —
U.S. Treasury notes	181	—	181	—
GSEs	163	—	163	—
Municipal securities	114	—	114	—
Asset-backed securities	82	—	82	—
Certificates of deposit	14	—	14	—
Other	4	—	4	—
Subtotal - current investments	1,681	—	1,681	—
1.125% Call Option derivative asset	476	—	—	476
Total assets	$ 2,157	$ —	$ 1,681	$ 476
1.125% Conversion Option derivative liability	$ 476	$ —	$ —	$ 476
Total liabilities	$ 476	$ —	$ —	$ 476

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our notes payable are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the Term Loan is classified as a Level 3 financial instrument, because certain inputs used to determine its fair value are not observable. As of March 31, 2019, the carrying amount of the Term Loan approximates fair value because its interest rate is a variable rate that approximates rates currently available to us.

	March 31, 2019		December 31, 2018	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	(In millions)			
5.375% Notes	$ 695	$ 725	$ 694	$ 674
4.875% Notes	326	327	326	301
1.125% Convertible Notes [1],[2]	198	716	240	732
Term Loan	100	100	—	—
	$ 1,319	$ 1,868	$ 1,260	$ 1,707

(1) The fair value of the 1.125% Conversion Option (the embedded cash conversion option), which is reflected in the fair value amounts presented above, amounted to $516 million and $476 million as of March 31, 2019, and December 31, 2018, respectively. See further discussion at Note 7, “Debt,” and Note 8, “Derivatives.”

(2) For more information on debt repayments in the first quarter of 2019, refer to Note 7, “Debt.”

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets to be available-for-sale. The following tables summarize our investments as of the dates indicated:

	March 31, 2019			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 949	$ 1	$ 3	$ 947
U.S. Treasury notes	168	—	—	168
GSEs	167	—	1	166
Municipal securities	113	—	1	112
Asset-backed securities	75	—	—	75
Mortgage-backed securities	23	—	—	23
Certificates of deposit	14	—	—	14
Other	3	—	—	3
	$ 1,512	$ 1	$ 5	$ 1,508

	December 31, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,131	$ —	$ 8	$ 1,123
U.S. Treasury notes	181	—	—	181
GSEs	164	—	1	163
Municipal securities	115	—	1	114
Asset-backed securities	83	—	1	82
Certificates of deposit	14	—	—	14
Other	4	—	—	4
Total current investments	$ 1,692	$ —	$ 11	$ 1,681

The contractual maturities of our available-for-sale investments as of March 31, 2019 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 927	$ 926
Due after one year through five years	550	547
Due after five years through ten years	12	12
Due after ten years	23	23
	$ 1,512	$ 1,508

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three months ended March 31, 2019 and 2018, were insignificant.

We have determined that unrealized losses at March 31, 2019, and December 31, 2018, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of March 31, 2019:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 207	$ 1	96	$ 403	$ 2	280
GSEs	—	—	—	122	1	71
Municipal securities	—	—	—	87	1	91
	$ 207	$ 1	96	$ 612	$ 4	442

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2018:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 509	$ 3	285	$ 412	$ 5	298
GSEs	—	—	—	127	1	76
Municipal securities	—	—	—	87	1	90
Asset-backed securities	—	—	—	68	1	52
	$ 509	$ 3	285	$ 694	$ 8	516

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. Treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current "Restricted investments" in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

Our held-to-maturity restricted investments are carried at amortized cost, which approximates fair value. Such investments amounted to $100 million at March 31, 2019, and mature in one year or less.

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated.

	March 31, 2019	December 31, 2018
	(In millions)	
Fee-for-service claims incurred but not paid ("IBNP")	$ 1,411	$ 1,562
Pharmacy payable	114	115
Capitation payable	59	52
Other	411	232
	$ 1,995	$ 1,961

"Other" medical claims and benefits payable includes amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $278 million and $107 million as of March 31, 2019 and December 31, 2018, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amounts by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,	
	2019	2018
	(In millions)	
Medical claims and benefits payable, beginning balance	$ 1,961	$ 2,192
Components of medical care costs related to:		
Current period	3,560	4,033
Prior periods [1]	(189)	(311)
Total medical care costs	3,371	3,722
Change in non-risk provider payables	171	45
Payments for medical care costs related to:		
Current period	2,197	2,498
Prior periods	1,311	1,438
Total paid	3,508	3,936
Medical claims and benefits payable, ending balance	$ 1,995	$ 2,023

(1) March 31, 2018, includes the 2018 benefit of the 2017 Marketplace CSR reimbursement of $70 million.

Our estimates of medical claims and benefits payable recorded at December 31, 2018, and 2017 developed favorably by approximately $189 million and $311 million as of March 31, 2019, and 2018, respectively.

The favorable prior year development recognized in the first quarter of 2019, was primarily due to lower than expected utilization of medical services by our Medicaid and Marketplace members and improved operating performance. Consequently, the ultimate costs recognized in 2019, as claims payment were processed, was lower than our original estimates in 2018.

7. Debt

As of March 31, 2019, contractual maturities of debt were as follows. All amounts represent the principal amounts of the debt instruments outstanding.

	Total	2020	2021	2022	2023	2024	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ 700	$ —	$ —	$ —
4.875% Notes	330	—	—	—	—	—	330
1.125% Convertible Notes	206	206	—	—	—	—	—
Term Loan	100	3	7	10	10	70	—
	$ 1,336	$ 209	$ 7	$ 710	$ 10	$ 70	$ 330

All of our debt is held at the parent, which is reported, for segment purposes, in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets:

	March 31, 2019	December 31, 2018
	(In millions)	
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 199	$ 241
Lease financing obligations	—	1
Debt issuance costs	(1)	(1)
	$ 198	$ 241
Non-current portion of long-term debt:		
5.375% Notes	$ 700	$ 700
4.875% Notes	330	330
Term Loan	100	—
Debt issuance costs	(9)	(10)
	$ 1,121	$ 1,020

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended March 31,	
	2019	2018
	(In millions)	
Contractual interest at coupon rate	$ 1	$ 2
Amortization of the discount	3	7
	$ 4	$ 9

Credit Agreement

We are party to a Credit Agreement, which provides for an unsecured delayed draw term loan facility described below (the "Term Loan"), and an unsecured $500 million revolving credit facility (the "Credit Facility"). Borrowings under our Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Agreement, we are required to pay a quarterly commitment fee.

The Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of March 31, 2019, we were in compliance with all financial and non-financial covenants under the Credit Agreement and other long-term debt. Effective as of the date of the Sixth Amendment to the Credit Agreement described below, there are no guarantors as parties to the Credit Agreement.

In January 2019, we entered into a Sixth Amendment to the Credit Agreement that provided for a delayed draw term loan facility in an aggregate principal amount of $600 million, under which we may request up to ten advances, each in a minimum principal amount of $50 million, until July 31, 2020. The Term Loan will amortize in quarterly installments, commencing on September 30, 2020, equal to the principal amount of the Term Loan outstanding multiplied by rates ranging from 1.25% to 2.50% (depending on the applicable fiscal quarter) for each fiscal quarter. The Term Loan expires on January 31, 2024; therefore, any remaining outstanding balance under the Term Loan will be due and payable on that date. As of March 31, 2019, $100 million was outstanding under the Term Loan. Each advance under the Term Loan results in a permanent reduction to its borrowing capacity; therefore, our borrowing capacity under the Term Loan as of March 31, 2019, was $500 million.

The Credit Facility expires on January 31, 2022; therefore, any amounts outstanding under the Credit Facility will be due and payable on that date. As of March 31, 2019, no amounts were outstanding under the Credit Facility, and outstanding letters of credit amounting to $2 million reduced our borrowing capacity under the Credit Facility to $498 million.

5.375% Notes due 2022

We had $700 million aggregate principal amount of senior notes (the "5.375% Notes") outstanding as of March 31, 2019, which are due November 15, 2022, unless earlier redeemed. Interest on the 5.375% Notes at a rate of 5.375% per annum is payable semiannually in arrears on May 15 and November 15. The 5.375% Notes contain customary non-financial covenants and change in control provisions.

4.875% Notes due 2025

We had $330 million aggregate principal amount of senior notes (the "4.875% Notes") outstanding as of March 31, 2019, which are due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes at a rate of 4.875% per annum is payable semiannually in arrears on June 15 and December 15. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

1.125% Cash Convertible Senior Notes due 2020

In the first quarter of 2019, we entered into a privately negotiated note purchase agreement with certain holders of our outstanding 1.125% cash convertible senior notes due January 15, 2020 (the "1.125% Convertible Notes"), pursuant to which we repaid $46 million aggregate principal amount, or $44 million aggregate carrying amount, of the 1.125% Convertible Notes. In addition, we paid $115 million to settle the 1.125% Convertible Notes' embedded cash conversion option feature at fair value (which is a derivative liability we refer to as the "1.125% Conversion Option").

In the three months ended March 31, 2019, we recorded a gain on debt extinguishment of $3 million for the 1.125% Convertible Notes purchase (net of accelerated original issuance discount amortization), primarily relating to a favorable mark to market valuation on the partial termination of the Call Spread Overlay executed in connection with the related debt extinguishment. This gain is reported in "Other (income) expenses, net" in the accompanying consolidated statements of income. No common shares were issued in connection with the transaction.

In connection with the 1.125% Convertible Notes purchases, we also entered into privately negotiated agreements in the first quarter of 2019, to partially terminate the Call Spread Overlay, defined and further discussed in Note 8, "Derivatives," and Note 9, "Stockholders' Equity." The net cash proceeds from the Call Spread Overlay partial termination transactions partially offset the cash paid to settle the 1.125% Convertible Notes.

Following the transaction described above, we had $206 million aggregate principal amount of the 1.125% Convertible Notes outstanding at March 31, 2019. Interest at a rate of 1.125% per annum is payable semiannually in arrears on January 15 and July 15. The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date. The 1.125% Convertible Notes are convertible by the holders within one year of the current balance sheet date until they mature; therefore, they are reported in current portion of long-term debt.

Concurrent with the issuance of the 1.125% Convertible Notes in 2013, the 1.125% Conversion Option was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option fully settles or expires. This initial liability simultaneously reduced the carrying value of the 1.125% Convertible Notes' principal amount (effectively an original issuance discount), which is amortized to the principal amount through the recognition of non-cash interest expense over the expected life of the debt. The effective interest rate of 6% approximates the interest rate we would have incurred had we issued nonconvertible debt with otherwise similar terms. As of March 31, 2019, the 1.125% Convertible Notes had a remaining amortization period of less than one year, and their 'if-converted' value exceeded their principal amount by approximately $456 million and $581 million as of March 31, 2019 and December 31, 2018, respectively.

Cross-Default Provisions

The indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

Subsequent Events

1.125% Convertible Notes. In April 2019, we entered into privately negotiated note purchase agreements with certain holders of our outstanding 1.125% Convertible Notes. Under these agreements, we repaid $128 million aggregate principal amount, or approximately $123 million aggregate carrying amount, of the 1.125% Convertible Notes. In addition, we paid $332 million to settle the 1.125% Convertible Notes' embedded cash conversion option feature at fair value.

Credit Agreement. We drew down an additional $120 million under the Term Loan in April 2019, further reducing borrowing capacity by that amount permanently.

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	March 31, 2019	December 31, 2018
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 516	$ 476
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 516	$ 476

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in "Other (income) expenses, net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Convertible Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

In the first quarter of 2019, in connection with the 1.125% Convertible Notes purchases (described in Note 7, "Debt"), we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased. In the first quarter of 2019, this resulted in our receipt of $115 million for the settlement of the 1.125% Call Option (which is a derivative asset), and the payment of $103 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $12 million from the Counterparties.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, "Fair Value Measurements."

As of March 31, 2019, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within twelve months of March 31, 2019, as described in Note 7, "Debt."

9. Stockholders' Equity

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, “Derivatives,” in 2013, we issued 13.5 million warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, if the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Following the transactions described below, 5.1 million of the 1.125% Warrants remain outstanding.

As described in Note 8, “Derivatives,” in the first quarter of 2019, we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased. In the first quarter of 2019, we paid $103 million to the Counterparties for the termination of 1.1 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in-capital for the same amount.

Subsequent Event

In April 2019, we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased. Pursuant to these transactions, we paid $298 million to the Counterparties for the termination of 3.1 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in-capital for the same amount.

Share-Based Compensation

In connection with our employee stock plans, approximately 84,000 shares of common stock vested or were purchased, net of shares used to settle employees’ income tax obligations, during the three months ended March 31, 2019.

Share-based compensation is generally recorded to “General and administrative expenses” in the accompanying consolidated statements of income. Total share-based compensation expense for the three months ended March 31, 2019 and 2018, amounted to $9 million and $6 million, respectively.

As of March 31, 2019, there was $71 million of total unrecognized compensation expense related to unvested restricted stock awards (“RSAs”), and performance stock units (“PSUs”), which we expect to recognize over a remaining weighted-average period of 2.9 years and 2.3 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 14.1% for non-executive employees as of March 31, 2019.

Also as of March 31, 2019, there was $8 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.5 years. No stock options were granted or exercised in the three months ended March 31, 2019.

Activity for RSAs, performance stock awards (“PSAs”) and PSUs, for the three months ended March 31, 2019, is summarized below:

	RSAs	PSAs	PSUs	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2018	399,795	3,132	201,383	604,310	$ 71.50
Granted	215,178	—	138,994	354,172	137.37
Vested	(119,994)	(3,132)	(10,528)	(133,654)	68.24
Forfeited	(14,220)	—	(4,140)	(18,360)	74.03
Unvested balance, March 31, 2019	480,759	—	325,709	806,468	100.91

The aggregate fair values of RSAs, PSAs and PSUs granted and vested are presented in the following table:

	Three Months Ended March 31,	
	2019	2018
	(In millions)	
Granted:		
RSAs	$ 30	$ 23
PSUs	18	14
	$ 48	$ 37
Vested:		
RSAs	$ 16	$ 12
PSUs	2	—
PSAs	—	3
	$ 18	$ 15

10. Restructuring Costs

Restructuring costs are reported by the same name in the accompanying consolidated statements of income.

IT Restructuring Plan

Management is focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we began a plan to restructure our information technology department (the "IT Restructuring Plan") in 2018. In early 2019, we have entered into services agreements with Infosys Limited under which Infosys manages certain of our information technology services.

We expect to complete the IT Restructuring Plan by the end of 2019, incurring cumulative total costs of approximately $15 million in the Other segment. This total has decreased compared with the $20 million reported in the 2018 Form 10-K due to more of our IT employees transitioned to Infosys than originally contemplated, resulting in lower one-time termination benefit costs.

As of March 31, 2019, we had incurred cumulative restructuring costs under the IT Restructuring Plan of $11 million, including $7 million of one-time termination benefits and $4 million of other restructuring costs (consulting fees).

As of December 31, 2018, there was $6 million accrued under the IT Restructuring Plan, primarily for one-time termination benefits that require cash settlement. In the first quarter of 2019, we incurred $2 million of other restructuring costs, and paid $2 million to settle one-time termination benefits and $1 million to settle other restructuring costs. As of March 31, 2019, there was $5 million accrued under the IT Restructuring Plan.

2017 Restructuring Plan

As of December 31, 2018, we had $18 million of accrued liabilities for the 2017 Restructuring Plan. In the first quarter of 2019, we incurred $1 million of restructuring costs for adjustments to previously recorded lease contract termination costs implemented pursuant to the restructuring and profitability improvement plan approved by our Board in June 2017 (the "2017 Restructuring Plan"), and paid $3 million to settle one-time termination and lease contract termination costs. As of March 31, 2019, there was $16 million accrued for lease contract termination costs under the 2017 Restructuring Plan. We expect to continue to settle these liabilities through 2025, unless the leases are terminated sooner.

11. Segments

We currently have two reportable segments: our Health Plans segment and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Description of Earnings Measures for Reportable Segments

Margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Margin for our Health Plans segment is referred to as “Medical margin,” which represents the amount earned by the segments after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the segments. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker.

The following table presents total revenue by segment. Inter-segment revenue was insignificant for all periods presented.

	Three Months Ended March 31,	
	2019	2018
	(In millions)	
Total revenue:		
Health Plans	$ 4,117	$ 4,509
Other	2	137
Consolidated	$ 4,119	$ 4,646

The following table reconciles margin by segment to consolidated income before income taxes:

	Three Months Ended March 31,	
	2019	2018
	(In millions)	
Margin:		
Health Plans	$ 581	$ 601
Other	—	14
Total margin	581	615
Add: other operating revenues [1]	167	189
Less: other operating expenses [2]	(468)	(582)
Operating income	280	222
Other expenses, net	20	43
Income before income taxes	$ 260	$ 179

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, and investment income and other revenue.
(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, and restructuring costs.

12. Commitments and Contingencies

Legal Proceedings

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously collected revenues.

In the ordinary course of business we are involved in legal actions, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and reasonably estimable, but the outcome of legal actions is inherently uncertain and our estimates of such losses could change as a result of further developments of these matters. For certain pending matters, accruals have not been established because such matters have not progressed sufficiently through discovery or factual development to enable us to reasonably estimate a range of possible loss. An adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Steamfitters Local 449 Pension Plan v. Molina Healthcare, Inc., et al. On October 5, 2018, the Steamfitters Local 449 Pension Plan filed its first amended class action securities complaint in the Central District Court of California against the Company and its former executive officers, J. Mario Molina, John C. Molina, Terry P. Bayer, and Rick Hopfer, Case 2:18-cv-03579. The amended complaint purports to seek recovery on behalf of all persons or entities

who purchased Molina common stock between October 31, 2014, and August 2, 2017, for alleged violations under Sections 10(b) and 20(a) of the Securities Exchange Act of 1934, as amended, and Rule 10b-5 promulgated thereunder. The plaintiff alleges the defendants misled investors regarding the scalability of the Company's administrative infrastructure during the identified class period. On December 13, 2018, the Court granted the Company's motion to dismiss in its entirety and closed the case. On January 9, 2019, plaintiffs appealed to the United States Court of Appeals for the Ninth Circuit. The Company believes it has meritorious defenses to the alleged claims and intends to defend the matter vigorously. At this time, we are not able to estimate a possible loss or range of loss that may result from this matter or to determine whether such loss, if any, would have a material adverse effect on our financial condition, results of operations, or cash flows.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and Children's Health Insurance Program ("CHIP") programs. The states and Commonwealth in which we operate our health plans regularly face significant budgetary pressures.

13. Leases

As discussed in Note 2, "Significant Accounting Policies," we elected the Topic 842 transition provision that allows entities to continue to apply the legacy guidance in Topic 840, *Leases*, including its disclosure requirements, in the comparative periods presented in the year of adoption. Accordingly, the Topic 842 disclosures below are presented as of and for the three-month period ended March 31, 2019, only.

We are a party to operating and finance leases primarily for our corporate and health plan offices. Our operating leases have remaining lease terms up to 10 years, some of which include options to extend the leases for up to 10 years. Our finance leases have remaining lease terms of 3 to 19 years, some of which include options to extend the leases for up to 25 years.

The components of lease expense were as follows:

	Three Months Ended March 31, 2019
	(In millions)
Operating lease cost	$ 9
Finance lease cost:	
Amortization of ROU assets	$ 4
Interest on lease liabilities	4
Total finance lease cost	$ 8

Supplemental consolidated cash flow information related to leases follows:

	Three Months Ended March 31, 2019
	(In millions)
Cash used in operating activities:	
Operating leases	$ 9
Finance leases	$ 4
Cash used in financing activities:	
Finance leases	$ 1
ROU assets recognized in exchange for lease obligations:	
Operating leases	$ 94
Finance leases	$ 241

Supplemental information related to leases, including location of amounts reported in the accompanying consolidated balance sheets, follows:

	March 31, 2019
	(Dollars in millions)
Operating leases	
Other assets	$ 83
Accounts payable and accrued liabilities	31
Other long-term liabilities	62
Total operating lease liabilities	$ 93
Finance leases	
Property, equipment, and capitalized software, net	$ 237
Accounts payable and accrued liabilities	$ 7
Finance lease liabilities	234
Total finance lease liabilities	$ 241
Weighted average remaining lease term	
Operating leases	4 years
Finance leases	17 years
Weighted average discount rate	
Operating leases	5.5%
Finance leases	6.6%

Maturities of lease liabilities as of March 31, 2019, were as follows:

	Operating Leases	Finance Leases
	(In millions)	
2019 (excluding the three months ended March 31, 2019)	$ 27	$ 16
2020	28	22
2021	18	22
2022	12	21
2023	9	21
Thereafter	9	311
Total lease payments	103	413
Less imputed interest	(10)	(172)
	$ 93	$ 241

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS ("MD&A")

FORWARD-LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements included in this quarterly report, other than statements of historical fact, may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, or expected. Those known risks and uncertainties include, but are not limited to, the following:

- *the numerous political, judicial and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including the ultimate outcome on appeal of the Texas et al. v. U.S. et al. matter;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk adjustment requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment;*
- *effective management of the Company's medical costs;*
- *the Company's ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of the Company's efforts to retain existing or awarded government contracts, including the success of any requests for proposal protest filings or defenses;*
- *the Company's ability to manage its operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of its care management initiatives;*
- *the Company's receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *the Company's ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *the Company's estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion medical cost corridor, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and the Company's ability to recognize revenue amounts associated therewith;*

- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of the Company's health plan in Puerto Rico, including the resolution of the debt crisis and the effect of the PROMESA law, and the impact of any future significant weather events;*
- *the success and renewal of the Company's duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across the Company's health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, eligibility redeterminations, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits, reviews, comment letters, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to the Company's provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;*
- *changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings, including litigation involving the ACA to which we are not a direct party;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of the Company's California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize the Company's expansion and growth, repay the Company's outstanding indebtedness at maturity and meet its liquidity needs, including the interest expense and other costs associated with such financing;*
- *the Company's failure to comply with the financial or other covenants in its credit agreement or the indentures governing its outstanding notes;*
- *the sufficiency of the Company's funds on hand to pay the amounts due upon conversion or maturity of its outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care industry;*
- *increases in government surcharges, taxes, and assessments;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm;*
- *the unexpected loss of the leadership of one or more of our senior executives; and*
- *increasing competition and consolidation in the Medicaid industry;*

Readers should refer to the section entitled "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2018 for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This Quarterly Report on Form 10-Q and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2018.

OVERVIEW

Molina Healthcare, Inc., a FORTUNE 500, multi-state healthcare organization, arranges for the delivery of health care services to individuals and families who receive their care through the Medicaid and Medicare programs, and through the insurance marketplaces (the "Marketplace"). Through our locally operated health plans in 14 states and the Commonwealth of Puerto Rico, we served approximately 3.4 million members as of March 31, 2019. The health plans are generally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization ("HMO").

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. The Other segment includes the historical results of the Medicaid management information systems ("MMIS") and behavioral health subsidiaries that were sold in the fourth quarter of 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Prior to the

fourth quarter of 2018, the MMIS subsidiary was reported as a stand-alone segment. Beginning in 2019, we no longer report service revenue or cost of service revenue as a result of the sales of the MMIS and behavioral health subsidiaries noted above.

FIRST QUARTER 2019 HIGHLIGHTS

In summary, we produced pretax earnings of $260 million and net income of $198 million in the first quarter of 2019, resulting in after-tax margin of 4.8%. These results include, on a consolidated basis, a medical care ratio ("MCR") of 85.3% and a general and administrative ("G&A") expense ratio of 7.3%.

Overall, the MCR decreased by 80 basis points in the first quarter of 2019, from 86.1% in the first quarter of 2018, driven by year-over-year improvement in the underlying performance across all our programs.

Program Performance. The underlying performance improved across all our programs on a year-over-year basis. The Medicaid MCR decreased to 88.5% from 90.8%, and the combined Medicare MCR improved 10 basis points, from 84.8% to 84.7%. The Marketplace MCR also improved on a year-over-year basis, excluding a $70 million benefit of the 2017 Marketplace cost sharing reduction ("CSR") subsidies recognized in the first quarter of 2018.

Health Plan Performance. We significantly improved the performance of our locally operated health plans in 2018, and our largest health plans, from a revenue standpoint going forward, have continued to perform well into 2019. California, Illinois, Michigan and Texas, four of our largest plans, performed well during the quarter, and Florida effectively managed the transition of lost regions. In Ohio, our MCR increased year-over-year, mainly due to cost pressures in Medicaid from a shift in the Medicaid Expansion risk pool and a newly carved-in behavioral health benefit, both of which have not been adequately rated.

Operational Improvements. We continue to gain operating efficiencies, as our G&A expense ratio has improved 30 basis points year over year, from 7.6% in the first quarter of 2018. Additionally, we have recently announced new partnerships to upgrade our technology to improve claims payment processes, and to enhance utilization management of certain specialty areas.

Balance Sheet and Capital Management. In the first quarter of 2019, we repaid $46 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants.

In April 2019, we repaid an additional $128 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants. Following these transactions, the remaining principal amount outstanding of our 1.125% Convertible Notes is $78 million. In addition, we have received a conversion notice for $7 million principal amount that will be settled in August 2019.

FINANCIAL SUMMARY

	Three Months Ended March 31,	
	2019	2018
	(Dollars in millions, except per-share amounts)	
Premium revenue	$ 3,952	$ 4,323
Premium tax revenue	138	104
Health insurer fees reimbursed	—	61
Investment income and other revenue	29	24
Medical care costs	3,371	3,722
General and administrative expenses	302	352
Premium tax expenses	138	104
Health insurer fees	—	75
Restructuring costs	3	25
Operating income	280	222
Interest expense	23	33
Other (income) expenses, net	(3)	10
Income tax expense	62	72
Net income	198	107
Net income per diluted share	$ 2.99	$ 1.64
Operating Statistics:		
Ending total membership	3,393,000	4,061,000
MCR (1)	85.3%	86.1%
G&A ratio (2)	7.3%	7.6%
Premium tax ratio (1)	3.4%	2.3%
Effective income tax expense rate	23.8%	40.3%
After-tax margin (2)	4.8%	2.3%

(1) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) After-tax margin represents net income as a percentage of total revenue. G&A ratio represents general and administrative expenses as a percentage of total revenue.

CONSOLIDATED RESULTS

See table below, under "Summary of Significant Items," for details relating to significant non-run rate items.

NET INCOME AND OPERATING INCOME

Net income in the first quarter of 2019 amounted to $198 million, or $2.99 per diluted share, compared with $107 million, or $1.64 per diluted share, for the first quarter of 2018. The improvement was driven by an increase in operating income, which amounted to $280 million in the first quarter of 2019, compared with $222 million in the first quarter of 2018. The year-over-year improvement was mainly driven by declines in both the MCR and G&A ratios.

PREMIUM REVENUE

Premium revenue decreased $371 million in the first quarter of 2019, when compared with the first quarter of 2018. Member months declined 17%, partially offset by a per-member per-month ("PMPM") revenue increase of 9%.

Lower premium revenue was driven by decreases in Medicaid and Marketplace membership, partially offset by Medicaid and Marketplace premium rate increases.

MEDICAL CARE RATIO

Overall, the MCR decreased to 85.3% in the first quarter of 2019, from 86.1% in the first quarter of 2018. Excluding the $70 million benefit of the 2017 Marketplace CSR reimbursement recognized in first quarter of 2018, the MCR would have been 87.7% in the first quarter of 2018. The improvement in the first quarter of 2019 was mainly due to year-over-year improvement in the underlying performance across all of our programs.

PREMIUM TAX REVENUE AND EXPENSES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 3.4% in the first quarter of 2019, compared with 2.3% in the first quarter of 2018. The increase is attributed to the state of Michigan implementing an insurance provider assessment in 2019.

INVESTMENT INCOME AND OTHER REVENUE

Investment income and other revenue increased to $29 million in the first quarter of 2019, compared with $24 million in the first quarter of 2018, mainly due to improved annualized portfolio yields.

GENERAL AND ADMINISTRATIVE ("G&A") EXPENSES

The G&A expense ratio decreased to 7.3% in the first quarter of 2019, from 7.6% in the first quarter of 2018. This improvement was primarily the result of lower expenses and the timing of certain expenditures, which were partially offset by the impact associated with lower premium revenue.

HEALTH INSURER FEES

There are no health insurer fees ("HIF") expensed or reimbursed in 2019 due to the moratorium under Public Law No. 115-120. In the first quarter of 2018, the HIF amounted to $75 million, and HIF reimbursements amounted to $61 million.

RESTRUCTURING COSTS

In the first quarter of 2019, we incurred restructuring costs of $3 million, mainly in connection with our IT Restructuring Plan that commenced in the third quarter of 2018. In the first quarter of 2018, we incurred restructuring costs of $25 million related to our 2017 Restructuring Plan.

INTEREST EXPENSE

Interest expense was $23 million in the first quarter of 2019, compared with $33 million in the first quarter of 2018. As further described below in "Liquidity," we reduced the principal amount of outstanding debt by $46 million in the first quarter of 2019, and $759 million in the year ended December 31, 2018.

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $3 million and $7 million in the first quarter of 2019, and 2018, respectively. The decline in the first quarter of 2019 is due to repayment of our convertible senior notes throughout 2018 and in the first quarter of 2019. See further discussion in Notes to Consolidated Financial Statements, Note 7, "Debt."

OTHER (INCOME) EXPENSES, NET

In the first quarter of 2019, we recognized debt extinguishment gains of $3 million, and in the first quarter of 2018, we recognized debt extinguishment losses of $10 million in connection with convertible senior notes repayment transactions in both periods, and an exchange transaction in the first quarter of 2018. The gain in the first quarter of 2019 was attributed to a favorable mark to market valuation on the partial termination of the Call Spread Overlay executed in connection with the related debt extinguishment. See further discussion in Notes to Consolidated Financial Statements, Note 7, "Debt."

INCOME TAXES

The provision for income taxes was recorded at an effective rate of 23.8% in the first quarter of 2019, compared with 40.3% in the first quarter of 2018. The effective tax rate for 2019 differs from 2018 as a result of higher non-

deductible expenses in 2018, primarily related to the non-deductible HIF. The HIF is not applicable in 2019 due to the moratorium under Public Law No. 115-120.

SUMMARY OF SIGNIFICANT ITEMS

The table below summarizes the impact of certain items significant to our financial performance in the periods presented. The individual items presented below increase (decrease) income before income tax expense.

	Three Months Ended March 31,			
	2019		2018	
	Amount	Per Diluted Share (1)	Amount	Per Diluted Share (1)
Marketplace CSR subsidies, for 2017 dates of service	$ —	$ —	$ 70	$ 0.83
Restructuring costs	(3)	(0.03)	(25)	(0.30)
Gain (loss) on debt extinguishment	3	0.03	(10)	(0.15)
	$ —	$ —	$ 35	$ 0.38

(1) Except for permanent differences between GAAP and tax (such as certain expenses that are not deductible for tax purposes), per diluted share amounts are generally calculated at the statutory income tax rate of 22.6% and 22% for the first quarter of 2019 and 2018, respectively

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums. Our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our Health Plans segment is the MCR, which represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Margin for our Health Plans segment is referred to as “Medical Margin.” Medical Margin amounted to $581 million in the first quarter of 2019, and $601 million in the first quarter of 2018. Management’s discussion and analysis of the changes in the individual components of Medical Margin follows.

See Notes to Consolidated Financial Statements, Note 11, “Segments,” for more information on our reportable segments.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 14 states and the Commonwealth of Puerto Rico. As of March 31, 2019, these health plans served approximately 3.4 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals, including Marketplace members, most of whom receive government premium subsidies.

TRENDS AND UNCERTAINTIES

Decline in Membership and Premium Revenue

Medicaid. As reported throughout 2018, our Medicaid contracts in New Mexico and in all but two regions in Florida terminated in late 2018 and early 2019. As a result, our Medicaid membership has decreased to 94,000 members in the aggregate in those states as of March 31, 2019, from 468,000 members as of December 31, 2018. During 2019, we continue to serve Medicare and Marketplace members in both Florida and New Mexico, as well as Medicaid members in two regions in Florida. In addition, our Medicaid membership has declined further in Puerto Rico as a result of the entry of more manage care organizations to that market late last year. We served approximately 207,000 members in Puerto Rico as of March 31, 2019, compared with 252,000 members as of

December 31, 2018. As a result of these market changes, we expect our Medicaid revenues to decrease in 2019.

Marketplace. We estimate that our 2019 Marketplace end-of-year enrollment will range from 270,000 to 280,000 members. This enrollment is lower than the 332,000 members enrolled as of March 31, 2019, due to expected attrition. Consequently, we expect our Marketplace revenues to decrease in 2019 compared with 2018.

Status of Upcoming Contract Reprocurements

Medicaid. In November 2018, our Texas health plan submitted two separate RFP responses: one with regard to the Texas ABD program, known in Texas as the STAR+PLUS program; and the other with regard to the Texas TANF and CHIP programs, known in Texas as the STAR and CHIP programs. We expect the STAR+PLUS award to be announced in the second quarter of 2019, with an effective date of June 1, 2020. We expect the STAR and CHIP awards to be announced in the third quarter of 2019, with an effective date of September 1, 2020. As of March 31, 2019, the membership of our Texas health plan under the existing STAR+PLUS contract was 86,000 members. We estimate annualized premium revenues of approximately $1,650 million in 2019 under our existing STAR+PLUS contract. As of March 31, 2019, the membership of our Texas health plan under the existing STAR and CHIP contracts was 120,000 members. We estimate annualized premium revenues of approximately $310 million in 2019 under our existing STAR and CHIP contracts.

We have received information that the Medicaid contracts of our Ohio and California health plans may be subject to RFP in late 2019 and 2020, respectively. A loss of any of our Texas, Ohio, or California Medicaid contracts would have a material adverse effect on our business, financial condition, cash flows, and results of operations.

Medicaid-Medicare Plans ("MMPs"). In late April 2019, CMS approved the California Medicaid agency's request for a three-year extension of its duals demonstration program, through December 31, 2022. We estimate annualized premium revenues of approximately $180 million in 2019 under our California MMP program.

The current authority for our MMP programs in Illinois and Ohio ends December 31, 2019. In March 2019, the Illinois Medicaid agency submitted a request to CMS for a one-year extension of its duals demonstration program, through December 31, 2020, with a possible three-year extension through 2022. We estimate annualized premium revenues of approximately $100 million in 2019 under our Illinois MMP program. In July 2018, the Ohio Medicaid agency submitted a request to Centers for Medicare and Medicaid Services ("CMS") for a three-year extension of its duals demonstration program, through December 31, 2022. We estimate annualized premium revenues of approximately $570 million in 2019 under our Ohio MMP program.

Pressures on Medicaid Funding

Due to states' budget challenges and political agendas at both the state and federal levels, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal or state spending on the Medicaid program, constitute a fundamental change to the federal role in health care and, if enacted, could have a material adverse effect on our business, financial condition, cash flows and results of operations. These proposals include elements such as the following, as well as numerous other potential changes and reforms:

- Ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis;
- Requiring Medicaid beneficiaries to work; and
- Limiting the amount of lifetime benefits for Medicaid beneficiaries.

ACA and the Marketplace

As a result of the election of President Trump, the Republican party's control of the Senate and the former Republican party's control of the House, several changes have been made to the provisions of the ACA, including reduced funding. Accordingly, the future of the ACA and its underlying programs are subject to continuing and substantial uncertainty, making long-term business planning difficult. In December 2018, in a case brought by the state of Texas and nineteen other states, a federal judge in Texas struck down the ACA based on his determination that the ACA's individual mandate is unconstitutional and, since that mandate cannot be separated from the rest of the ACA, the judge ruled that the rest of the ACA is also unconstitutional. The decision has been appealed to the U.S. Court of Appeals for the Fifth Circuit. Other proposed changes and reforms to the ACA have included, or may include the following:

- Prohibiting the federal government from operating Marketplaces;
- Eliminating the advanced premium tax credits, and cost sharing reductions for low income individuals who purchase their health insurance through the Marketplaces;
- Expanding and encouraging the use of private health savings accounts;
- Providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans, or short-term health insurance;
- Establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; and
- Allowing insurers to sell insurance across state lines.

Any final, not-appealable determination that the ACA is unconstitutional, or the passage of any of these changes or other reforms, would have a material adverse effect on our business, financial condition, cash flows and results of operations.

MEMBERSHIP

The following tables set forth our Health Plans membership as of the dates indicated:

	March 31, 2019	December 31, 2018	March 31, 2018
Ending Membership by Program:			
Temporary Assistance for Needy Families ("TANF") and Children's Health Insurance Program ("CHIP")	2,016,000	2,295,000	2,435,000
Medicaid Expansion	596,000	660,000	662,000
Aged, Blind or Disabled ("ABD")	352,000	406,000	411,000
Total Medicaid	2,964,000	3,361,000	3,508,000
Medicare-Medicaid Plan ("MMP") – Integrated [1]	56,000	54,000	56,000
Medicare Special Needs Plans ("Medicare")	41,000	44,000	44,000
Total Medicare	97,000	98,000	100,000
Total Medicaid and Medicare	3,061,000	3,459,000	3,608,000
Marketplace	332,000	362,000	453,000
	3,393,000	3,821,000	4,061,000
Ending Membership by Health Plan:			
California	600,000	608,000	656,000
Florida [2]	144,000	313,000	414,000
Illinois	219,000	224,000	151,000
Michigan	369,000	383,000	388,000
New Mexico [2]	27,000	222,000	250,000
Ohio	295,000	302,000	328,000
Puerto Rico	207,000	252,000	316,000
South Carolina	126,000	120,000	117,000
Texas	377,000	423,000	476,000
Washington	815,000	781,000	779,000
Other [3]	214,000	193,000	186,000
	3,393,000	3,821,000	4,061,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) As reported throughout 2018, our Medicaid contracts in New Mexico and in all but two regions in Florida terminated in late 2018 and early 2019. During 2019, we continue to serve Medicare and Marketplace members in both Florida and New Mexico, as well as Medicaid members in two regions in Florida.
(3) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, MCR and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended March 31, 2019						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	6.2	$ 1,173	$ 189.36	$ 1,022	$ 165.05	87.2%	$ 151
Medicaid Expansion	1.8	664	369.62	594	330.45	89.4	70
ABD	1.1	1,167	1,068.43	1,042	953.48	89.2	125
Total Medicaid	9.1	3,004	330.75	2,658	292.60	88.5	346
MMP	0.2	388	2,355.29	333	2,026.83	86.1	55
Medicare	0.1	163	1,284.70	133	1,047.78	81.6	30
Total Medicare	0.3	551	1,889.47	466	1,600.84	84.7	85
Total Medicaid and Medicare	9.4	3,555	379.19	3,124	333.26	87.9	431
Marketplace	1.0	397	393.53	247	244.61	62.2	150
	10.4	$ 3,952	$ 380.59	$ 3,371	$ 324.65	85.3%	$ 581

	Three Months Ended March 31, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.4	$ 1,373	$ 185.14	$ 1,272	$ 171.56	92.7%	$ 101
Medicaid Expansion	2.0	752	372.75	641	317.46	85.2	111
ABD	1.2	1,254	1,014.23	1,155	934.55	92.1	99
Total Medicaid	10.6	3,379	316.69	3,068	287.56	90.8	311
MMP	0.2	357	2,137.88	305	1,824.21	85.3	52
Medicare	0.1	157	1,188.97	131	994.81	83.7	26
Total Medicare	0.3	514	1,718.61	436	1,457.75	84.8	78
Total Medicaid and Medicare	10.9	3,893	354.94	3,504	319.48	90.0	389
Marketplace	1.4	430	312.87	218	158.40	50.6	212
	12.3	$ 4,323	$ 350.25	$ 3,722	$ 301.55	86.1%	$ 601

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid Program

Our Medicaid Medical Margin increased $35 million, or 11%, in the first quarter of 2019 when compared with the first quarter of 2018, mainly due to lower MCRs in the TANF and ABD programs, which more than offset the impact of declining Medicaid premium revenue. Medicaid premium revenue decreased $375 million in the first quarter of 2019 mainly due to the loss in membership in connection with the termination of our Medicaid contracts in New Mexico and in all but two regions in Florida in late 2018 and early 2019, partially offset by increases in other markets. The improved MCRs in TANF and ABD were principally driven by lower pharmacy costs resulting from re-contracted pharmacy benefits management and our continued focus on medical cost management.

The Medical Margin of our Medicaid Expansion program declined due to lower premium revenue in California and higher inpatient and outpatient fee for service costs in California and Ohio. The decline in Expansion premium in California mainly resulted from the rate reduction we received in July 2018. As noted above, we expect lower Medicaid premium revenue throughout 2019, when compared with 2018.

Medicare Program

Our Medicare Medical Margin increased $7 million, or 9%, in the first quarter of 2019, when compared with the first quarter of 2018, mainly due to a slight improvement in the MCR. Premiums continue to increase and are higher

compared to the prior year, mainly due to increased premium revenues tied to risk scores that are more commensurate with the acuity of our population.

Marketplace Program

The Marketplace Medical Margin decreased $62 million in the first quarter of 2019, when compared with the first quarter of 2018, mainly due to a $70 million benefit of the 2017 Marketplace CSR reimbursement recognized in first quarter of 2018, and a $33 million decrease in premium revenue. The CSR benefit related to 2017 dates of service and was recognized following the federal government's confirmation that the reconciliation would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied. Lower Marketplace premium revenue was driven by a decrease in membership of over 20%, partially offset by premium rate increases. As noted above, we expect Marketplace premium revenue to be lower in 2019, when compared with 2018.

The MCR for the Marketplace program amounted to 62.2% in the first quarter of 2019, compared with 50.6% in the first quarter of 2018. Excluding the benefit of the 2017 Marketplace CSR reimbursement recognized in first quarter of 2018, the MCR for the first quarter of 2018 would have been approximately 66.8%. The improved MCR was driven by the impact of rate increases and increased premiums tied to risk scores, partially offset by the impact of higher acuity membership.

FINANCIAL PERFORMANCE BY HEALTH PLAN

The following tables summarize member months, premium revenue, medical care costs, MCR, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Medicaid and Medicare

	Three Months Ended March 31, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.7	$ 499	$ 299.83	$ 448	$ 269.33	89.8%	$ 51
Florida	0.4	162	387.48	127	303.05	78.2	35
Illinois	0.7	227	348.04	185	282.70	81.2	42
Michigan	1.1	395	363.04	326	299.99	82.6	69
Ohio	0.9	590	659.09	537	600.07	91.0	53
Puerto Rico	0.6	102	165.02	90	145.38	88.1	12
South Carolina	0.4	136	363.14	115	308.87	85.1	21
Texas	0.6	599	902.56	532	801.53	88.8	67
Washington	2.4	614	258.41	586	246.69	95.5	28
Other [1] [2]	0.6	231	370.26	178	285.13	77.0	53
	9.4	$ 3,555	$ 379.19	$ 3,124	$ 333.26	87.9%	$ 431

	Three Months Ended March 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 494	$ 272.61	$ 412	$ 227.31	83.4%	$ 82
Florida	1.0	382	351.58	345	317.41	90.3	37
Illinois	0.5	141	298.17	122	257.50	86.4	19
Michigan	1.1	376	336.64	331	296.19	88.0	45
New Mexico (2)	0.7	319	466.17	310	453.30	97.2	9
Ohio	0.9	551	576.60	460	481.26	83.5	91
Puerto Rico	1.0	186	193.13	174	181.39	93.9	12
South Carolina	0.3	122	348.08	104	297.52	85.5	18
Texas	0.7	562	809.90	519	747.53	92.3	43
Washington	2.3	584	256.66	574	252.41	98.3	10
Other (1)	0.6	176	314.93	153	273.36	86.8	23
	10.9	$ 3,893	$ 354.94	$ 3,504	$ 319.48	90.0%	$ 389

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.
(2) In 2019, "Other" includes the New Mexico health plan. The New Mexico health plan's Medicaid contract terminated on December 31, 2018, and therefore its 2019 results are not individually significant to our consolidated operating results.

Health Plans Segment Financial Data — Marketplace

	Three Months Ended March 31, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.1	$ 56	$ 342.00	$ 33	$ 201.46	58.9%	$ 23
Florida	0.2	61	421.17	26	177.31	42.1	35
Michigan	—	10	467.25	5	211.50	45.3	5
Ohio	—	30	853.87	15	448.51	52.5	15
Texas	0.6	148	306.36	109	226.36	73.9	39
Washington	—	47	711.60	29	435.90	61.3	18
Other (1)	0.1	45	476.11	30	314.70	66.1	15
	1.0	$ 397	$ 393.53	$ 247	$ 244.61	62.2%	$ 150

	Three Months Ended March 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 49	$ 253.93	$ 31	$ 162.64	64.0 %	$ 18
Florida	0.2	45	271.12	(16)	(95.60)	(35.3)	61
Michigan	0.1	13	224.11	9	144.16	64.3	4
New Mexico	0.1	34	438.67	19	246.50	56.2	15
Ohio	0.1	26	403.44	17	262.87	65.2	9
Texas	0.7	229	308.74	146	196.89	63.8	83
Washington	—	39	526.36	30	405.40	77.0	9
Other (2)	—	(5)	NM	(18)	NM	NM	13
	1.4	$ 430	$ 312.87	$ 218	$ 158.40	50.6 %	$ 212

(1) "Other" includes the New Mexico, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results in 2019.

(2) "Other" includes the Utah and Wisconsin health plans, where we did not participate in the Marketplace in 2018. Therefore, the ratios for 2018 periods are not meaningful (NM).

Health Plans Segment Financial Data — Total

	Three Months Ended March 31, 2019						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 555	$ 303.64	$ 481	$ 263.20	86.7%	$ 74
Florida	0.6	223	396.13	153	270.76	68.4	70
Illinois	0.7	227	348.04	185	282.70	81.2	42
Michigan	1.1	405	365.09	331	298.25	81.7	74
Ohio	0.9	620	666.41	552	594.38	89.2	68
Puerto Rico	0.6	102	165.02	90	145.38	88.1	12
South Carolina	0.4	136	363.14	115	308.87	85.1	21
Texas	1.2	747	651.67	641	559.49	85.9	106
Washington	2.4	661	270.72	615	251.83	93.0	46
Other [1] [2]	0.7	276	384.08	208	288.99	75.2	68
	10.4	$ 3,952	$ 380.59	$ 3,371	$ 324.65	85.3%	$ 581

	Three Months Ended March 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 543	$ 270.80	$ 443	$ 221.03	81.6%	$ 100
Florida	1.2	427	340.91	329	262.65	77.0	98
Illinois	0.5	141	298.17	122	257.50	86.4	19
Michigan	1.2	389	331.08	340	288.68	87.2	49
New Mexico [2]	0.8	353	463.33	329	431.94	93.2	24
Ohio	1.0	577	565.62	477	467.41	82.6	100
Puerto Rico	1.0	186	193.13	174	181.39	93.9	12
South Carolina	0.3	122	348.08	104	297.52	85.5	18
Texas	1.4	791	551.28	665	463.37	84.1	126
Washington	2.3	623	265.20	604	257.25	97.0	19
Other [1]	0.6	171	305.94	135	240.95	78.8	36
	12.3	$ 4,323	$ 350.25	$ 3,722	$ 301.55	86.1%	$ 601

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.
(2) In 2019, "Other" includes the New Mexico health plan. The New Mexico health plan's Medicaid contract terminated on December 31, 2018, and therefore its 2019 results are not individually significant to our consolidated operating results.

OTHER

The Other segment includes the historical results of the Medicaid management information systems ("MMIS") and behavioral health subsidiaries that were sold in the fourth quarter of 2018, as well as certain corporate amounts not allocated to the Health Plans segment. Prior to the fourth quarter of 2018, the MMIS subsidiary was reported as a stand-alone segment. Beginning in 2019, we no longer report service revenue or cost of service revenue as a result of the sales of the MMIS and behavioral health subsidiaries noted above.

FINANCIAL OVERVIEW

The Other segment Service Margin in the first quarter of 2018 was insignificant.

LIQUIDITY AND FINANCIAL CONDITION

LIQUIDITY

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

We maintain liquidity at two levels: 1) the regulated health plan subsidiaries; and 2) the parent company. Our regulated health plan subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated health plan subsidiaries is in the form of cash, cash equivalents, and investments.

When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plan subsidiaries is generally paid in the form of dividends to our parent company to be used for general corporate purposes. The regulated health plan subsidiaries paid $289 million in such dividends to the parent company in the first quarter of 2019. No such dividends were paid in the first quarter of 2018. With regard to capital contributions, the parent company contributed capital of $80 million in the first quarter of 2018, to satisfy statutory net worth requirements. No such contributions were required in the first quarter of 2019.

Cash, cash equivalents and investments at the parent company amounted to $443 million and $170 million as of March 31, 2019, and December 31, 2018, respectively. The increase in 2019 was mainly due to cash dividends received from our regulated health plan subsidiaries, and proceeds from a draw-down under the Term Loan facility, partially offset by a partial principal repayment of our outstanding 1.125% Convertible Notes.

Investments

After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding variable rate securities, for which interest rates are periodically reset). Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels.

Our restricted investments are invested principally in certificates of deposit and U.S. Treasury securities; we have the ability to hold such restricted investments until maturity. All of our unrestricted investments are classified as current assets.

Cash Flow Activities

Our cash flows are summarized as follows:

	Three Months Ended March 31,		
	2019	2018	Change
	(In millions)		
Net cash provided by operating activities	$ 249	$ 394	$ (145)
Net cash provided by investing activities	171	145	26
Net cash used in financing activities	(48)	(5)	(43)
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	$ 372	$ 534	$ (162)

Operating Activities

We typically receive capitation payments monthly, in advance of payments for medical claims; however, state or federal payors may decide to adjust their payment schedules which could positively or negatively impact our

reported cash flows from operating activities in any given period. State or federal payors may delay our premium payments, or they may prepay the following month's premium payment.

Net cash provided by operations for the first quarter of 2019 was $249 million, compared with $394 million for the first quarter of 2018. This decrease in cash flow of $145 million was due to settlements with government agencies, mainly related to CSR payments in 2019, timing of CMS Medicare premium receipts in 2018, the use of cash associated with declines in Medicaid and Marketplace membership, partially offset by a net benefit from timing differences in other current assets and liabilities.

Investing Activities

Net cash provided by investing activities was $171 million in the first quarter of 2019, compared with $145 million in the first quarter of 2018, an increase in cash flow of $26 million. The year over year improvement was primarily due to higher proceeds from sales and maturities of investments, net of purchases, in the first quarter of 2019, largely driven by cash flow needs associated with our financing activities, as described below.

Financing Activities

Net cash used in financing activities was $48 million in the first quarter of 2019, compared with $5 million in the first quarter of 2018, a decrease in cash flow of $43 million. The year over year decline was mainly due to $149 million in net cash paid for partial principal repayment of the 1.125% Convertible Notes and partial settlement of the related 1.125% Conversion Option, 1.125% Call Option and 1.125% Warrants in the first quarter of 2019. These settlements were partially offset by proceeds received from a $100 million draw-down under the Term Loan facility.

FINANCIAL CONDITION

We believe that our cash resources, our borrowing capacity available under our Credit Agreement as discussed further below in "Future Sources and Uses of Liquidity—Future Sources," and internally generated funds will be sufficient to support our operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months.

On a consolidated basis, at March 31, 2019, our working capital was $2,439 million, compared with $2,216 million at December 31, 2018. At March 31, 2019, our cash and investments amounted to $4,834 million, compared with $4,629 million at December 31, 2018.

Regulatory Capital and Dividend Restrictions

Each of our HMO subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulations. Such statutes, regulations and capital requirements also restrict the timing, payment and amount of dividends and other distributions, loans or advances that may be paid to us as the sole stockholder. To the extent our HMO subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus (net assets) requirement, for these subsidiaries was approximately $1,020 million at March 31, 2019, and $1,040 million at December 31, 2018. Our HMO subsidiaries were in compliance with these minimum capital requirements as of both dates.

Under applicable regulatory requirements, the amount of dividends that may be paid through the remainder of 2019 by our HMO subsidiaries without prior approval by regulatory authorities as of March 31, 2019, is approximately $123 million in the aggregate. Our HMO subsidiaries can pay dividends over this amount, but only after approval is granted by the regulatory authorities.

Debt Ratings

Our 5.375% Notes and 4.875% Notes are rated "BB-" by Standard & Poor's, and "B2" by Moody's Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs.

Financial Covenants

Our Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Agreement.

Credit Facility Financial Covenants	Required Per Agreement	As of March 31, 2019
Net leverage ratio	<4.0x	1.0x
Interest coverage ratio	>3.5x	14.7x

In addition, the indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. As of March 31, 2019, we were in compliance with all covenants under the Credit Agreement and the indentures governing our outstanding notes.

Capital Plan Progress

In the first quarter of 2019, we repaid $46 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants.

In April 2019, we repaid an additional $128 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to terminate the respective portion of the related 1.125% Call Option and 1.125% Warrants. Following these transactions, the remaining principal amount outstanding of our 1.125% Convertible Notes is $78 million. In addition, we have received a conversion notice for $7 million principal amount that will be settled in August 2019.

FUTURE SOURCES AND USES OF LIQUIDITY

Future Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes.

Credit Agreement Borrowing Capacity. As of March 31, 2019, we had available borrowing capacity of $500 million under the Term Loan, following our draw down of $100 million in the first quarter of 2019. We drew down an additional $120 million under the Term Loan in April 2019, further reducing borrowing capacity by that amount permanently. Under the Term Loan facility, we may request up to ten advances, each in a minimum principal amount of $50 million, until July 31, 2020. In addition, we have available borrowing capacity of $498 million under our Credit Facility. See further discussion in the Notes to Consolidated Financial Statements, Note 7, “Debt.”

Savings from the IT Restructuring Plan. Management is focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we began a plan to restructure our information technology department (the “IT Restructuring Plan”) in 2018. In early 2019, we have entered into services agreements with Infosys Limited under which Infosys manages certain of our information technology services. We expect the IT Restructuring Plan to be completed by the end of 2019. We currently estimate that this plan will reduce annualized run-rate expenses by approximately $15 million to $20 million in the first full year, increasing to approximately $30 million to $35 million by the end of the fifth full year. Such savings, if achieved, would reduce Other segment general and administrative expenses in our consolidated statements of income. Further details are described in the Notes to Consolidated Financial Statements, Note 10, “Restructuring Costs.”

Future Uses

Regulatory Capital Requirements and Dividend Restrictions. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

1.125% Convertible Notes. The fair value of the 1.125% Convertible Notes was $716 million as of March 31, 2019, which amount reflects both the principal amount outstanding and the fair value of the 1.125% Conversion Option. Refer to the Notes to Consolidated Financial Statements, Note 7, "Debt," for a detailed discussion of the 1.125% Convertible Notes, including recent transactions. The 1.125% Convertible Notes are convertible by the holders within one year of the current balance sheet date until they mature; therefore, they are reported in current portion of long-term debt. If conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the applicable indenture. We have sufficient available cash, combined with borrowing capacity available under our Credit Agreement, to fund conversions should they occur.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2018, was disclosed in our 2018 Annual Report on Form 10-K.

Other than the financing transactions described in the Notes to Consolidated Financial Statements, Note 7, "Debt," there were no significant changes to this previously filed information outside the ordinary course of business during the first quarter of 2019.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, "Medical Claims and Benefits Payable," for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the first quarter of 2019, to our disclosure reported in "Critical Accounting Estimates" in our Annual Report on Form 10-K for the year ended December 31, 2018.

- *Contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."

- *Quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."

- *Goodwill and intangible assets, net.* There have been no significant changes, during the first quarter of 2019, to our disclosure reported in "Critical Accounting Estimates" in our Annual Report on Form 10-K for the year ended December 31, 2018.

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2019, the fair value of our fixed income investments would decrease by approximately $13 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, "Fair Value Measurements," and Note 5, "Investments."

Borrowings under our Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. As of March 31, 2019, $100 million was outstanding under the Term Loan facility of the Credit Agreement. For further information, see Notes to Consolidated Financial Statements, Note 7, "Debt."

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures. Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms.

Changes in Internal Control Over Financial Reporting. There has been no change in our internal control over financial reporting during the fiscal quarter ended March 31, 2019 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 12, "Commitments and Contingencies."

RISK FACTORS

Certain risks may have a material adverse effect on our business, financial condition, cash flows, results of operations, or stock price, and you should carefully consider them before making an investment decision with respect to our securities. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in "Risk Factors," in our Annual Report on Form 10-K for the year ended December 31, 2018. The risk factors described in our 2018 Annual Report on Form 10-K are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, results of operations, or stock price.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended March 31, 2019, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
January 1 - January 31	1,011	$ 133.04	—	$ —
February 1 - February 28	—	$ —	—	$ —
March 1 - March 31	48,228	$ 137.88	—	$ —
Total	49,239	$ 137.78	—	

(1) During the three months ended March 31, 2019, we withheld 49,239 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

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INDEX TO EXHIBITS

Exhibit No.	Title	Method of Filing
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
101.INS	XBRL Taxonomy Instance Document.	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document.	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: April 30, 2019

/s/ JOSEPH M. ZUBRETSKY

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Dated: April 30, 2019

/s/ THOMAS L. TRAN

Thomas L. Tran
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2019 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: April 30, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Thomas L. Tran, certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2019 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: April 30, 2019

/s/ Thomas L. Tran

Thomas L. Tran

Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2019 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: April 30, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2019 (the "Report"), I, Thomas L. Tran, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: April 30, 2019

/s/ Thomas L. Tran

Thomas L. Tran
Chief Financial Officer and Treasurer

2018 MHI Form 10-K

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2018

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒		Accelerated filer	☐
Non-accelerated filer	☐	(Do not check if a smaller reporting company)	Smaller reporting company	☐
Emerging growth company	☐			

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2018, the last business day of our most recently completed second fiscal quarter, was approximately $6,018.8 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2018).

As of February 15, 2019, approximately 62,460,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2019 Annual Meeting of Stockholders to be held on May 8, 2019, are incorporated by reference into Part III of this Form 10-K, to the extent described therein.

MOLINA HEALTHCARE, INC. 2018 FORM 10-K

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(a) Incorporated by reference to "Executive Compensation" in the 2019 Proxy Statement.
(b) Incorporated by reference to "Security Ownership of Certain Beneficial Owners and Management" in the 2019 Proxy Statement.
(c) Incorporated by reference to "Related Party Transactions" and "Corporate Governance and Board of Directors Matters — Director Independence" in the 2019 Proxy Statement.
(d) Incorporated by reference to "Fees Paid to Independent Registered Public Accounting Firm" in the 2019 Proxy Statement.

FORWARD LOOKING STATEMENTS

This Annual Report on Form 10-K (this "Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Readers are cautioned not to place undue reliance on any forward-looking statements, as forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly due to numerous known and unknown risks and uncertainties. Those known risks and uncertainties include, but are not limited to, the risk factors identified in the section of this Form 10-K titled "Risk Factors," as well as the following:

- *the numerous political, judicial and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including the ultimate outcome on appeal of the Texas et al. v. U.S. et al. matter;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk adjustment requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment;*
- *effective management of the Company's medical costs;*
- *the Company's ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of the Company's efforts to retain existing or awarded government contracts, including the success of any requests for proposal protest filings or defenses;*
- *the success of the Company's profit improvement and sustainability initiatives, including the timing and amounts of the benefits realized, and administrative and medical cost savings achieved;*
- *the Company's ability to manage its operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of its care management initiatives;*
- *the Company's receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *the Company's ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *the Company's estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion medical cost corridor, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and the Company's ability to recognize revenue amounts associated therewith;*
- *the Company's ability to successfully recognize the intended cost savings and other intended benefits of outsourcing certain services and functions to third parties, and its ability to manage the risk that such third parties may not perform contracted functions and services in a timely, satisfactory and compliant manner;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of the Company's health plan in Puerto Rico, including the resolution of the debt crisis and the effect of the PROMESA law, and the impact of any future significant weather events;*

- *the success and renewal of the Company's duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across the Company's health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, eligibility redeterminations, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits, reviews, comment letters, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to the Company's provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;*
- *changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings, including litigation involving the ACA to which we ourselves are not a direct party;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of the Company's California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize the Company's expansion and growth, repay the Company's outstanding indebtedness at maturity and meet its liquidity needs, including the interest expense and other costs associated with such financing;*
- *the Company's failure to comply with the financial or other covenants in its credit agreement or the indentures governing its outstanding notes;*
- *the sufficiency of the Company's funds on hand to pay the amounts due upon conversion or maturity of its outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care industry;*
- *increases in government surcharges, taxes, and assessments;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm;*
- *the unexpected loss of the leadership of one or more of our senior executives; and*
- *increasing competition and consolidation in the Medicaid industry.*

Each of the terms "Molina Healthcare, Inc." "Molina Healthcare," "Company," "we," "our," and "us," as used herein, refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

OVERVIEW

ABOUT MOLINA HEALTHCARE

Molina Healthcare, Inc., a FORTUNE 500, multi-state healthcare organization, arranges for the delivery of health care services to individuals and families who receive their care through the Medicaid and Medicare programs, and through the state insurance marketplaces (the "Marketplace").

Through our locally operated health plans in 14 states and the Commonwealth of Puerto Rico, we served approximately 3.8 million members as of December 31, 2018. These health plans are operated by our respective wholly owned subsidiaries in those states and in the Commonwealth of Puerto Rico, each of which is licensed as a health maintenance organization ("HMO").

Molina was founded in 1980 as a provider organization serving low-income families in Southern California. We were originally organized in California as a health plan holding company and reincorporated in Delaware in 2002.

2018 EXECUTIVE SUMMARY

Following Molina's internal restructuring in mid-2017, the board of directors appointed an experienced industry leader, Joe Zubretsky, as its CEO in November 2017. Mr. Zubretsky made significant changes to the executive management team throughout 2018 by recruiting new, experienced leaders of finance, health plan operations, health plan services, strategic planning and corporate development, and human resources.

We have embarked on a deliberate turn-around strategy aimed at margin recovery and sustainability, pursuit of targeted growth opportunities, enhancement of our talent and culture to align with our strategic initiatives, and development of the future capabilities needed to address the evolving healthcare environment.

We believe that management has demonstrated the effectiveness of this strategy by its accomplishments in 2018, which have included, among others:

- Improving the efficiency of our administrative cost profile;
- Strengthening our balance sheet by reducing our outstanding indebtedness;
- Revamping the contract procurement process;
- Realigning management incentive programs with our strategic objectives;
- Divesting non-core businesses; and
- Producing strong financial results, which have exceeded our initial and revised guidance and expectations.

The following table illustrates the year-over-year improvement in our operating results:

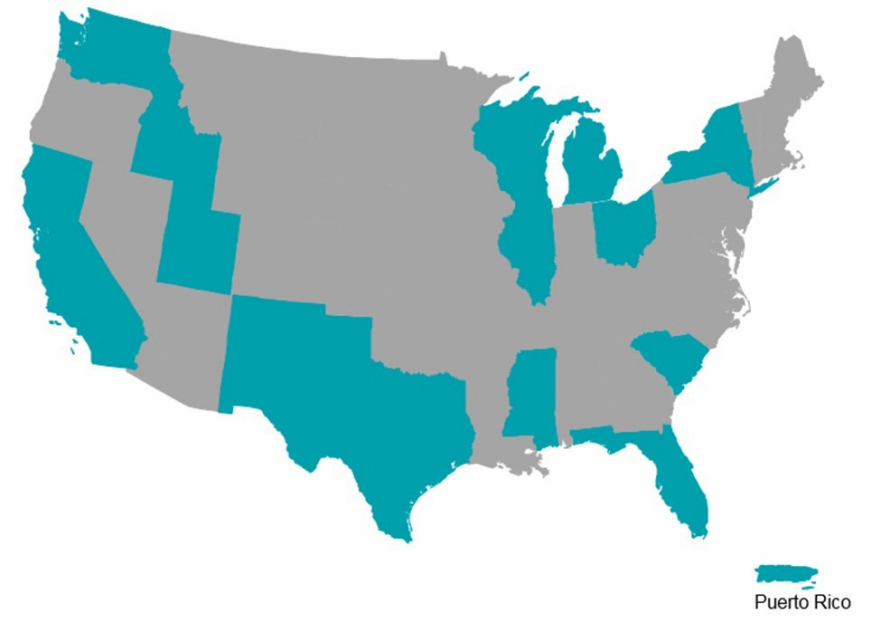
	2018	2017
	(Dollars in millions, except per-share amounts)	
Total Revenue	**$18,890**	**$19,883**
Medical Care Ratio ("MCR") [1]	**85.9%**	**90.6%**
Pre-Tax Margin [2]	**5.3%**	**(3.1)%**
After-Tax Margin [2]	**3.7%**	**(2.6)%**
Net Income (Loss) per Diluted Share	**$10.61**	**$(9.07)**

(1) Medical care ratio represents medical care costs as a percentage of premium revenue.

(2) Pre-tax margin represents net income (loss) before income taxes as a percentage of total revenue. After-tax margin represents net income (loss) as a percentage of total revenue.

OUR BUSINESS FOOTPRINT TODAY

As of December 31, 2018, our health plans operated in 14 states and the Commonwealth of Puerto Rico. This footprint includes the five largest Medicaid markets—California, Florida, New York, Ohio, and Texas.



OUR SEGMENTS

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. Our Other segment includes the historical results of the Pathways behavioral health subsidiary, which we sold in the fourth quarter of 2018, and certain corporate amounts not allocated to the Health Plans segment. Effective in the fourth quarter of 2018, we reclassified the historical results relating to our Molina Medicaid Solutions ("MMS") segment, which we sold in the third quarter of 2018, to the Other segment. Previously, results for MMS were reported in a stand-alone segment. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition and divestiture activity, and changing laws and regulations. Therefore, these reportable segments may change in the future.

Refer to Notes to Consolidated Financial Statements, Note 18, "Segments," for segment revenue and profit information, and Note 2, "Significant Accounting Policies" for revenue information by health plan.

MEMBERSHIP BY PROGRAM

	As of December 31,		
	2018	**2017**	**2016**
Temporary Assistance for Needy Families ("TANF") and Children's Health Insurance Program ("CHIP")	2,295,000	2,457,000	2,536,000
Medicaid Expansion	660,000	668,000	673,000
Aged, Blind or Disabled ("ABD")	406,000	412,000	396,000
Total Medicaid	3,361,000	3,537,000	3,605,000
Medicare-Medicaid Plan ("MMP") - Integrated	54,000	57,000	51,000
Medicare Special Needs Plans	44,000	44,000	45,000
Total Medicare	98,000	101,000	96,000
Total Medicaid and Medicare	3,459,000	3,638,000	3,701,000
Marketplace	362,000	815,000	526,000
	3,821,000	4,453,000	4,227,000

MEMBERSHIP BY HEALTH PLAN

	As of December 31,		
	2018	2017	2016
California	608,000	746,000	683,000
Florida	313,000	625,000	553,000
Illinois	224,000	165,000	195,000
Michigan	383,000	398,000	391,000
New Mexico	222,000	253,000	254,000
Ohio	302,000	327,000	332,000
Puerto Rico	252,000	314,000	330,000
South Carolina	120,000	116,000	109,000
Texas	423,000	430,000	337,000
Washington	781,000	777,000	736,000
Other [1]	193,000	302,000	307,000
	3,821,000	4,453,000	4,227,000

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

MISSION

Molina's mission is to provide quality health care services to financially vulnerable families and individuals who are covered by government programs.

STRATEGY

Our strategy focuses on the following four key areas, which are described in detail below: margin recovery and sustainability, growth opportunities, talent and culture, and future capabilities.

MARGIN RECOVERY AND SUSTAINABILITY

We are executing a comprehensive, short-term plan designed to restore margins through expense reductions, operating improvements, execution of managed care fundamentals, and divestiture of non-strategic assets. In addition, we are working to enhance our balance sheet by implementing a disciplined approach to capital management.

We are simplifying our provider networks. We are terminating or renegotiating high-cost providers, narrowing networks in certain geographies, evaluating stop-loss thresholds and carve-outs, implementing value-based contracting, and evaluating ancillary services and pharmacy benefit management pricing and operations. In addition, we have exited substantially all direct delivery operations.

We are striving to improve the effectiveness of utilization review and care management. Areas of focus include specialist referrals, pre-authorization, concurrent review, high acuity populations and high utilizers of services, emergency room utilization, and behavioral and medical integration.

We are addressing at-risk revenues and risk adjustment. We seek to more effectively engage in state rate setting, improve Medicare Star Ratings, increase retention of quality revenue withholds, and focus on coding and documentation to achieve risk scores commensurate with the acuity of our population.

We are working to improve our claims payment function. The key areas of improvement we are focusing on include provider experience, payment accuracy, and oversight of claims fraud, waste and abuse.

We are evaluating and outsourcing certain elements of our information technology and management function. We seek to standardize our administrative platform, streamline operations and procedures, evaluate potential co-sourcing and/or outsource operational components, and consolidate data warehousing and data mining capabilities.

GROWTH OPPORTUNITIES

Our immediate goal is to win re-procurements of state contracts and to capitalize on opportunities to achieve measured growth. We see numerous opportunities for growth in our legacy state health plans and programs. We have already experienced some success in the pursuit of new revenue and the defense of existing revenue:

- In May 2018, our Washington health plan was selected by the Washington State Health Care Authority to enter into a managed care contract for the eight remaining regions of the state's Apple Health Integrated Managed Care program, in addition to the two regions previously awarded to us. As of December 31, 2018, we served approximately 751,000 Medicaid members in Washington, which represented premium revenue of approximately $2,035 million in the year ended December 31, 2018.

- In June 2018, our Florida health plan was awarded comprehensive Medicaid Managed Care contracts by the Florida Agency for Health Care Administration in Regions 8 and 11 of the Florida Statewide Medicaid Managed Care Invitation to Negotiate. Under the new contracts, effective January 1, 2019, we serve approximately 98,000 Medicaid members in those regions, which represented premium revenue of approximately $462 million in the year ended December 31, 2018. As of December 31, 2018, we served a total of 272,000 Medicaid members in Florida, which represented premium revenue of approximately $1,479 million in the year ended December 31, 2018.

- In July 2018, our Puerto Rico health plan was selected by the Puerto Rico Health Insurance Administration to be one of the organizations to administer the Commonwealth's new Medicaid Managed Care contract. As of December 31, 2018, we served approximately 252,000 members under the new contract, which represents a reduction in membership compared with 320,000 members served as of September 30, 2018. The new contract commenced on November 1, 2018 and has a three-year term with an optional one year extension. The Puerto Rico health plan's premium revenue amounted to $696 million in the year ended December 31, 2018.

- Our Mississippi health plan commenced operations on October 1, 2018 and served approximately 26,000 Medicaid members as of December 31, 2018. In December 2018, our Mississippi health plan was awarded a contract by the Mississippi Division of Medicaid for the Children's Health Insurance Program ("CHIP"). Services under the new three-year contract were initially set to begin July 1, 2019; however, the start date is now pending the outcome of a protest of the contract awards.

Now that our margin recovery efforts have been successful and margin sustainability is well under way, we expect to expand our focus on growth opportunities in new markets.

TALENT AND CULTURE

We intend to drive our strategic initiatives by evolving to a more accountable and performance-driven culture with the right talent in the right jobs. We believe that the success we have had in recruiting new leaders to our current senior executive team has given us a strong start and we are optimistic about this initiative.

FUTURE CAPABILITIES

We are focused on building future capabilities needed to address the evolving healthcare environment and competitive pressures. We believe that key future differentiating capabilities include, but are not limited to, population health management, complex care management, advanced value-based contracting, advanced data analytics, and improved member experience. We are creating a road-map designed to meet these market demands by developing the people, processes, and technologies we require to build these capabilities.

OUR BUSINESS

MEDICAID

Overview

Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage ("FMAP"). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all jurisdictions except Puerto Rico is currently approximately 60%, and currently ranges from a federally established FMAP floor of 50% to as high as 76%. As a result of Hurricane Maria, the FMAP for the Commonwealth of Puerto Rico was temporarily raised from 55% to 100% until late in the third quarter of 2019.

We participate in the following Medicaid programs:

- Temporary Assistance for Needy Families ("TANF") - This is the most common Medicaid program. It primarily covers low-income families with children.
- Medicaid Aged, Blind or Disabled ("ABD") - ABD programs cover low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries typically use more services than those served by other Medicaid programs because of their critical health issues.
- Children's Health Insurance Program ("CHIP") - CHIP is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.
- Medicaid Expansion - In states that have elected to participate, Medicaid Expansion provides eligibility to nearly all low-income individuals under age 65 with incomes at or below 138% of the federal poverty line.

Our state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal ("RFP") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Status of Contract Re-procurements

In November 2018, our Texas health plan submitted two separate RFP responses: one with regard to the Texas ABD program, known in Texas as the Star Plus program; and the other with regard to the Texas TANF and CHIP programs, known in Texas as the Star program. We expect the Star Plus award to be announced in the second quarter of 2019, with an effective date of June 1, 2020. We expect the Star award to be announced in the third quarter of 2019, with an effective date of September 1, 2020. As of December 31, 2018, the membership of our Texas health plan under the existing Star Plus contract was 87,000 members, and the related premium revenues for 2018 were $1,605 million. As of December 31, 2018, the membership of our Texas health plan under the existing Star contract was 122,000 members, and the related premium revenues for 2018 were $316 million.

We have received information that the Medicaid contracts of both our Ohio and California health plans may be subject to RFP either in late 2019 or early 2020. A loss of any of our Texas, Ohio, or California Medicaid contracts would have a material adverse effect on our business, financial condition, cash flows, and results of operations.

In January 2018, we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. A hearing was held on our judicial protest on October 17, 2018, and our protest was rejected. We filed an appeal with the New Mexico Court of Appeals on January 28, 2019. We are continuing to manage the business in run-off until the determination of these further appeals or our decision not to pursue our appeal rights. As of December 31, 2018, we served approximately 196,000 Medicaid members in New Mexico, and Medicaid premium revenue amounted to $1,181 million in the year ended December 31, 2018. Our New Mexico health plan continues to serve Medicare and Marketplace members, but, effective January 1, 2019, no longer has Medicaid members.

Member Enrollment and Marketing

Most states allow eligible Medicaid members to select the Medicaid plan of their choice. This opportunity to choose a plan is almost always afforded to the member at the time of first enrollment and, at a minimum, annually thereafter. In some of our states, a substantial majority of new Medicaid members voluntarily select a plan with the remainder subject to the auto-assignment process described below, while in other states less than half of new members voluntarily choose a plan.

Our Medicaid health plans may benefit from auto-assignment of individuals who do not choose a plan, but for whom participation in managed care programs is mandatory. Each state differs in its approach to auto-assignment, but one or more of the following criteria is typical in auto-assignment algorithms: a Medicaid beneficiary's previous enrollment with a health plan or experience with a particular provider contracted with a health plan, enrolling family members in the same plan, a plan's quality or performance status, a plan's network and enrollment size, awarding all auto-assignments to a plan with the lowest bid in a county or region, and equal assignment of individuals who do not choose a plan in a specified county or region.

Our Medicaid marketing efforts are regulated by the states in which we operate, each of which imposes different requirements for, or restrictions on, Medicaid sales and marketing. These requirements and restrictions are revised from time to time. None of the jurisdictions in which we operate permit direct sales by Medicaid health plans.

MEDICARE

Overview

Medicare Advantage. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services ("CMS"). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month ("PMPM") premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition. Since 2006, Medicare beneficiaries have had the option of selecting a prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

Medicare-Medicaid Plans, or MMPs. Over 10 million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as MMPs. We operate MMPs in six states.

Contracts

We enter into Medicare and MMP contracts with CMS, in partnership with each state's department of health and human services. Such contracts typically have terms of one to two years.

Status of Contract Renewals - MMP

MMP premium revenues for the California, Illinois, and Ohio health plans, whose duals demonstration programs currently expire on December 31, 2019, amounted to $189 million, $81 million, and $529 million, respectively, in the year ended December 31, 2018.

- *California MMP*. In 2018, the state submitted a one-year extension of its duals demonstration program with CMS, through December 31, 2020, and is currently in negotiations with CMS to extend the program for three years, through December 31, 2022.
- *Illinois MMP*. We believe the state is likely moving toward a three-year extension of its duals demonstration program with CMS. This potential extension is currently pending review with the state's new administration.
- *Ohio MMP.* The state has submitted a three-year extension of its duals demonstration program with CMS, through December 31, 2022.

Member Enrollment and Marketing

Our Medicare members may be enrolled through auto-assignment, as described above under "Medicaid - Member Enrollment and Marketing," or by enrolling in our plans with the assistance of insurance agents employed by Molina,

outside brokers, or via the Internet.

Our Medicare marketing and sales activities are regulated by CMS and the states in which we operate. CMS has oversight over all marketing materials used by Medicare Advantage plans, and in some cases has imposed advance approval requirements. CMS generally limits sales activities to those conveying information regarding benefits, describing the operations of our managed care plans, and providing information about eligibility requirements.

We employ our own insurance agents and contract with independent, licensed insurance agents to market our Medicare Advantage products. We have continued to expand our use of independent agents because the cost of these agents is largely variable and we believe the use of independent, licensed agents is more conducive to the shortened Medicare selling season and the open enrollment period. The activities of our independent, licensed insurance agents are also regulated by CMS. We also use direct mail, mass media and the Internet to market our Medicare Advantage products.

MARKETPLACE

Overview

Effective January 1, 2014, the ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase federally subsidized health insurance. We offer Marketplace plans in many of the states where we offer Medicaid health plans. Our plans allow our Medicaid members to stay with their providers as they transition between Medicaid and the Marketplace. Additionally, they remove financial barriers to quality care and keep members' out-of-pocket expenses to a minimum. In 2019, we participate in the Marketplace in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin.

Contracts

We enter into contracts with CMS annually for the state Marketplace programs. These contracts have a one-year term ending on December 31 and must be renewed annually.

Member Enrollment and Marketing

Our Marketplace members enroll in our plans with the assistance of insurance agents employed by Molina, outside brokers, vendors, direct to consumer marketing and via the Internet.

While our Marketplace sales activities are regulated by CMS (such as eligibility determinations), our marketing activities are regulated by the individual states in which we operate. Some states require us to obtain prior approval of our marketing materials, others simply require us to provide them with copies of our marketing materials, and some states do not request our marketing materials. We are able to freely contact our own members and provide them with marketing materials as long as those materials are fair and do not discriminate.

Our Marketplace sales and marketing strategy is to provide high quality, affordable, compliant and consumer centric Marketplace products through a variety of distribution channels. Our Marketplace products are displayed on the Federally Facilitated Marketplace (“FFM”) and the State Based Marketplace (“SBM”) in the states in which we participate in the Marketplace. We also contract with independent, licensed insurance agents to market our Marketplace products. The activities of our independently licensed insurance agents are also regulated by both CMS and the departments of insurance in the states in which we participate. Our sales cycle typically peaks during the annual Open Enrollment Period (“OEP”) as defined and regulated by CMS and applicable FFM and SBM.

For 2019, we are currently estimating that our Marketplace end-of-year membership will range from 250,000-275,000. This estimated membership is lower than the 362,000 enrollment as of December 31, 2018, despite our return to Utah and Wisconsin, and we expect our Marketplace revenues to decrease in 2019 as a result.

BASIS FOR PREMIUM RATES

Medicaid

Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business, and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members’ health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state. The amount of the premiums paid to our health plans may vary substantially between states and among various government

programs. For the year ended December 31, 2018, Medicaid program PMPM premium revenues ranged as follows: TANF and CHIP ranged from $130.00 to $340.00; Medicaid Expansion ranged from $290.00 to $520.00; and ABD ranged from $520.00 to $1,630.00.

Medicare

Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment. Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs. For the year ended December 31, 2018, Medicare program PMPM premium revenues ranged as follows: Medicare Advantage ranged from $590.00 to $1,370.00; and MMP ranged from $1,390.00 to $3,250.00.

Marketplace

For Marketplace, we develop each state's premium rates during the spring of each year for policies effective in the following calendar year. Premium rates are based on our estimates of projected member utilization, medical unit costs, member risk acuity, member risk transfer, and administrative costs, with the intent of realizing a target pretax percentage profit margin. Our actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval. For the year ended December 31, 2018, Marketplace program PMPM premium revenues ranged from $250.00 to $660.00.

PREMIUM REVENUE BY PROGRAM

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
TANF and CHIP	$ 5,508	$ 5,554	$ 5,403
Medicaid Expansion	2,884	3,150	2,952
ABD	5,231	5,135	4,666
Total Medicaid	13,623	13,839	13,021
MMP	1,443	1,446	1,321
Medicare	631	601	558
Total Medicare	2,074	2,047	1,879
Total Medicaid and Medicare	15,697	15,886	14,900
Marketplace	1,915	2,968	1,545
	$ 17,612	$ 18,854	$ 16,445

LEGISLATIVE AND POLITICAL ENVIRONMENT

PRESSURES ON MEDICAID FUNDING

Due to states' budget challenges and political agendas at both the state and federal levels, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal or state spending on the Medicaid program, constitute a fundamental change to the federal role in health care and, if enacted, could have a material adverse effect on our business, financial condition, cash flows and results of operations. These proposals include elements such as the following, as well as numerous other potential changes and reforms:

- Ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers;

- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis;
- Requiring Medicaid beneficiaries to work; and
- Limiting the amount of lifetime benefits for Medicaid beneficiaries.

AFFORDABLE CARE ACT

As a result of the election of President Trump, the GOP control of the Senate and the former GOP control of the House, several changes have been made to the provisions of the ACA, including reduced funding. Accordingly, the future of the ACA and its underlying programs are subject to continuing and substantial uncertainty, making long-term business planning exceedingly difficult. In December 2018, in a case brought by the state of Texas and nineteen other states, a federal judge in Texas struck down the ACA based on his determination that the ACA's individual mandate is unconstitutional and, since that mandate cannot be separated from the rest of the ACA, the judge ruled that the rest of the ACA is also unconstitutional. The decision has been appealed to the U.S. Court of Appeals for the Fifth Circuit. Other proposed changes and reforms to the ACA have included, or may include the following:

- Prohibiting the federal government from operating Marketplaces;
- Eliminating the advanced premium tax credits, and cost sharing reductions for low income individuals who purchase their health insurance through the Marketplaces;
- Expanding and encouraging the use of private health savings accounts;
- Providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans, or short-term health insurance;
- Establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; and
- Allowing insurers to sell insurance across state lines.

Any final, not-appealable determination that the ACA is unconstitutional, or the passage of any of these changes or other reforms, would have a material adverse effect on our business, financial condition, cash flows and results of operations.

OPERATIONS

QUALITY

Our long-term success depends, to a significant degree, on the quality of the services we provide. As of December 31, 2018, 11 of our health plans were accredited by the National Committee for Quality Assurance ("NCQA"), including the Multicultural Health Care Distinction, which is awarded to organizations that meet or exceed NCQA's rigorous requirements for multicultural health care.

The table below presents our health plans' NCQA status, as well as their current scores as part of the Medicare Star Ratings, which measures the quality of Medicare plans across the country using a 5-star rating system.

We believe that these objective measures of quality are important to state Medicaid agencies, as a growing number of states link reimbursement and patient assignment to quality scores. Additionally, Medicare pays quality bonuses to health plans that achieve high quality.

State	NCQA Health Plan Accreditation	NCQA Multicultural Healthcare Distinction	NCQA Health Insurance Plans Rating 2018-2019 (Medicaid)	Medicare Star Rating 2019
California	Marketplace – Accredited Medicaid – Accredited	Marketplace & Medicaid	3.5 ★★★½☆	3.5 ★★★½☆
Florida	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.5 ★★★½☆	3.5 ★★★½☆
Illinois	Medicaid – Accredited	Medicaid	3.0 ★★★☆☆	not applicable
Michigan	Marketplace – Accredited Medicaid – Accredited	Marketplace & Medicaid	3.5 ★★★½☆	3.0 ★★★☆☆
New Mexico	Marketplace – Accredited	—	not applicable	3.0 ★★★☆☆
Ohio	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.5 ★★★½☆	2.5 ★★½☆☆ (Part D Only)
Puerto Rico	not applicable	Medicaid	not applicable	not applicable
South Carolina	Medicaid – Commendable	Medicaid	3.0 ★★★☆☆	not applicable
Texas	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.0 ★★★☆☆	3.5 ★★★½☆
Utah	Medicaid – Accredited	Medicaid	3.5 ★★★½☆	3.5 ★★★½☆
Washington	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.5 ★★★½☆	3.5 ★★★½☆
Wisconsin	Medicaid – Commendable	Medicaid	3.5 ★★★½☆	3.0 ★★★☆☆

PROVIDER NETWORKS

We arrange health care services for our members through contracts with a vast network of providers, including independent physicians and physician groups, hospitals, ancillary providers, and pharmacies. We strive to ensure that our providers have the appropriate expertise and cultural and linguistic experience.

The quality, depth and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members, to gain insight into the needs of both our members and our providers.

Physicians

We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive care services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals

We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, capitation, and case rates.

Ancillary Providers

Our ancillary agreements provide coverage of medically-necessary care, including laboratory services, home health, physical, speech and occupational therapy, durable medical equipment, radiology, ambulance and transportation services, and are reimbursed on a capitation and fee-for-service basis.

Pharmacy

We outsource pharmacy benefit management services, including claims processing, pharmacy network contracting, rebate processing and mail and specialty pharmacy fulfillment services.

The following table provides the details of consolidated medical care costs by type for the periods indicated:

	Year Ended December 31,								
	2018			2017			2016		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
	(In millions, except PMPM amounts)								
Fee-for-service	$ 11,278	$ 232.15	74.5%	$ 12,682	$ 229.63	74.3%	$ 10,993	$ 217.84	74.4%
Pharmacy	2,138	44.01	14.1	2,563	46.40	15.0	2,213	43.84	15.0
Capitation	1,184	24.38	7.8	1,360	24.63	8.0	1,218	24.13	8.2
Other [1]	537	11.05	3.6	468	8.48	2.7	350	6.94	2.4
Total	$ 15,137	$ 311.59	100.0%	$ 17,073	$ 309.14	100.0%	$ 14,774	$ 292.75	100.0%

(1) "Other" includes all medically related administrative costs, certain provider incentive costs, provider claims, and other health care expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses.

MEDICAL MANAGEMENT

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. We believe this model has proved to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, information technology, and centralized services.

Utilization Management

We continuously review utilization patterns with the intent to optimize quality of care and to ensure that appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use predictive modeling that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management

We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs such as the following:

- *Disease Management Programs.* We develop specialized disease management programs that address the particular health care needs of our members. Our member assessment process evaluates the individual needs of the members and ensures that the appropriate level of services and support are provided to address the physical, behavioral and social determinants of health. This comprehensive and customized approach is designed to address our members' individual goals and improve their overall quality of life. For example, our comprehensive maternity programs are designed to improve pregnancy outcomes and enhance member satisfaction. "*breathe with ease!*" is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15.

- *Educational Programs.* Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and

methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate members on the use of primary care physicians, emergency rooms, and nurse call centers.

- *Pharmacy Management Programs*. Our pharmacy programs are designed with the goal to be a trusted partner in improving member health and healthcare affordability. We do this by strategically partnering with the physicians and other healthcare providers who treat our members. This collaboration results in drug formularies and clinical initiatives that promote improved patient care. We employ full-time pharmacists and pharmacy technicians who work closely with providers to educate them on our formulary products, clinical programs and the importance of cost-effective care.

INFORMATION TECHNOLOGY

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our members and providers also depend upon our information systems for enrollment, primary care and specialist physician roster access, membership verifications, claims status, and other information.

We have partnered with third parties to support our information technology systems. This makes our operations vulnerable to adverse effects if such third parties fail to perform adequately. On February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. As a result of the agreement, we anticipate reducing our administrative expenses and improving the reliability of our information technology functions, while aiming to maintain targeted levels of service and operating performance. A segment of the infrastructure services will be provided on the Company's premises, while other portions of the infrastructure services will be performed at Infosys facilities. Infosys will provide us with services required to migrate those information technology infrastructure operations that will be performed at Infosys facilities. As the infrastructure services currently performed by the Company are transitioned to Infosys, we expect to eliminate certain positions in our information technology group. Some of the employees in our information technology group may become employees of Infosys. The initial term of this agreement with Infosys is three years, commencing on February 4, 2019. We have the right to extend the agreement for up to two additional renewal terms of one year each.

CENTRALIZED SERVICES

We provide certain centralized medical and administrative services to our subsidiaries pursuant to administrative services agreements that include, but are not limited to, information technology, product development and administration, underwriting, claims processing, customer service, certain care management services, human resources, legal, marketing, purchasing, risk management, actuarial, underwriting, finance, accounting, legal and public relations.

COMPETITIVE CONDITIONS AND ENVIRONMENT

We face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, quality scores, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Medicaid

The Medicaid managed care industry is subject to ongoing changes as a result of health care reform, business consolidations and new strategic alliances. We compete with national, regional, and local Medicaid service providers, principally on the basis of size, location, quality of the provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., Aetna Inc., and other large not-for-profit health care organizations. Competition can vary considerably from state to state.

Medicare

While we expect to see strong growth in the Medicare program in coming years, the market is highly competitive across the country, with large competitors, such as UnitedHealth Group Incorporated, Humana Inc., and Aetna Inc., holding significant market share.

Marketplace

Low-income members who receive government subsidies comprise the vast majority of Marketplace membership, which is served by a limited number of health plans. Our primary competitor for low-income Marketplace membership is Centene Corporation.

REGULATION

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

HIPAA

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (“HIPAA”). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, such as claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

We enforce an internal HIPAA compliance program, which we believe complies with HIPAA privacy and security regulations, and have dedicated resources to monitor compliance with this program.

Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

FRAUD AND ABUSE LAWS AND THE FALSE CLAIMS ACT

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as “fraud and abuse” laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements.

Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, upcoding, payments made to excluded providers, improper

marketing, and the violation of patient privacy rights. In particular, there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices, particularly in the Medicare program. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change.

The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action.

LICENSING AND SOLVENCY

Our health plans are licensed by the insurance departments in the states in which they operate, except our New York HMO, which is licensed as a prepaid health services plan by the New York State Department of Health, and our California HMO, which is licensed by the California Department of Managed Health Care.

Our health plans are subject to stringent requirements to maintain a minimum amount of statutory capital determined by statute or regulation, and restrictions that limit their ability to pay dividends to us. For further information, refer to the Notes to Consolidated Financial Statements, Note 17, "Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions."

OTHER INFORMATION

EMPLOYEES

As of December 31, 2018, we had approximately 11,000 employees. Our employee base is multicultural and reflects the diverse membership we serve.

AVAILABLE INFORMATION

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. The Company also maintains corporate offices in New York City, New York.

You can access our website at *www.molinahealthcare.com* to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Form 10-K or any other SEC filings.

RISK FACTORS

You should carefully consider the risks described below and all of the other information set forth in this Form 10-K, including our consolidated financial statements and accompanying notes. These risks and other factors may affect our forward-looking statements, including those we make in this annual report or elsewhere, such as in press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. The risks described below are not the only risks facing our Company. Additional risks that we are unaware of, or that we currently believe are not material, may also become important factors that

adversely affect our business. If any of the following risks actually occurs, our business, financial condition, results of operations, and future prospects could be materially and adversely affected. In that event, among other effects, the trading price of our common stock could decline, and you could lose part or all of your investment.

Risks Related to Our Business

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed on favorable terms or at all, our premium revenues could be materially reduced and our operating results could be negatively impacted.

We currently derive our premium revenues from health plans that operate in 14 states and the Commonwealth of Puerto Rico. Measured by premium revenue by health plan, our top four health plans were in California, Ohio, Texas, and Washington, with aggregate premium revenue of $10,143 million, or approximately 58% of total premium revenue, in the year ended December 31, 2018. If we are unable to continue to operate in any of our existing jurisdictions, or if our current operations in any portion of those jurisdictions are significantly curtailed or terminated entirely, our revenues could decrease materially.

Many of our government contracts for the provision of managed care programs to people receiving government assistance are effective only for a fixed period of time and may be extended for an additional period of time if the contracting entity or its agent elects to do so. When such contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that the contracts will be renewed or extended. For example, our previous Medicaid contract with the Florida Agency for Health Care Administration ("AHCA") expired on December 31, 2018, as of which date the Florida health plan served approximately 272,000 Medicaid members. In June 2018, our Florida health plan was awarded a comprehensive Medicaid Managed Care contract by AHCA, effective January 1, 2019, for two regions in Florida (which consisted of approximately 98,000 Medicaid members as of December 31, 2018), as opposed to the eight regions covered by our previous contract.

As yet another example, our New Mexico health plan's Medicaid contract with the New Mexico Human Services Department ("HSD") expired on December 31, 2018. In January 2018, we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. A hearing was held on our judicial protest on October 17, 2018, and our protest was rejected. We filed an appeal with the New Mexico Court of Appeals on January 28, 2019. We are continuing to manage the business in run-off until the determination of these further appeals or our decision not to pursue our appeal rights. As of December 31, 2018, we served approximately 196,000 Medicaid members in New Mexico, and Medicaid premium revenue amounted to $1,181 million in the year ended December 31, 2018. Our New Mexico health plan continues to serve Medicare and Marketplace members, but, effective January 1, 2019, no longer has Medicaid members.

In any bidding process, our health plans may face competition from numerous other health plans, many with greater financial resources and greater name recognition than we have. For example, in November 2018, our Texas health plan submitted RFP responsive bids under the following two programs:

- The Texas Health and Human Service Commission ("HHSC") currently contracts with five STAR+PLUS (or "ABD") plans: Anthem, Cigna, Centene, United Healthcare, and Molina. Our Texas health plan served a total of approximately 87,000 STAR+PLUS members as of December 31, 2018. We expect the new Texas STAR+PLUS contracts to be awarded in the second quarter of 2019, and to become effective June 1, 2020.
- The HHSC currently contracts with many STAR (or "TANF" and "CHIP") plans, including Molina. Our Texas health plan served a total of approximately 122,000 STAR members as of December 31, 2018. We expect the new Texas STAR contracts to be awarded in the third quarter of 2019, and to become effective September 1, 2020.

If the RFP responsive bids of our Texas health plan are not successful, or if our Texas health plan's contracts with HHSC are not renewed, or if they are renewed but coverage is reduced, our revenues would be materially and adversely impacted.

Even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or, in extreme cases, could result in a net loss. Furthermore, our government contracts contain certain provisions regarding, among other things, eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and information reporting, quality assurance and timeliness of claims payment, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

If any of our governmental contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business and reputation may be adversely impacted, and our financial position, results of

operations or cash flows could be materially and adversely affected. In addition, we may be unable to support the carrying amount of goodwill we have recorded for the applicable business, because its fair value is based on estimated future cash flows.

If we lose contracts that constitute a significant amount of our revenue, we will lose the administrative cost efficiencies that are inherent in a large revenue base. In such circumstances, we may not be able to reduce fixed costs proportionally with our lower revenue, and the financial impact of lost contracts may exceed the net income ascribed to those contracts.

We are currently able to spread the cost of centralized services over a large revenue base. Many of our administrative costs are fixed in nature, and will be incurred at the same level regardless of the size of our revenue base. If we lose contracts that constitute a significant amount of our revenue, we may not be able to reduce the expense of centralized services in a manner that is proportional to that loss of revenue. In such circumstances, not only will our total dollar margins decline, but our percentage margins, measured as a percentage of revenue, will also decline. This loss of cost efficiency, and the resulting stranded administrative costs, could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

If, in the interests of maintaining or improving longer term profitability, we decide to exit voluntarily certain state contractual arrangements, make changes to our provider networks, or make changes to our administrative infrastructure, we may incur short- to medium-term disruptions to our business that could materially reduce our premium revenues and our net income.

Decisions that we make with regard to retaining or exiting our portfolio of state and federal contracts, and changes to the manner in which we serve the members attached to those contracts, could generate substantial expenses associated with the run out of existing operations and the restructuring of those operations that remain. Such expenses could include, but would not be limited to, goodwill and intangible asset impairment charges, restructuring costs, additional medical costs incurred due to the inability to leverage long-term relationships with medical providers, and costs incurred to finish the run out of businesses that have ceased to generate revenue.

If we are unable to successfully execute our profit maintenance and improvement initiatives and our restructuring plans, or if we fail to realize the anticipated benefits of those initiatives and plans, our business, cash flows, financial position, or results of operations could be materially and adversely affected.

In August 2017, we announced the implementation of a comprehensive restructuring and profitability improvement plan (the "2017 Restructuring Plan"). The 2017 Restructuring Plan included the streamlining of our organizational structure, including the elimination of over 2,000 positions, the re-design of certain core operating processes, the remediation of high cost provider contracts, the restructuring of our direct delivery operations, and the review of our vendor base in an attempt to insure that we were partnering with the lowest cost, most effective, vendors. Since the inception of the 2017 Restructuring Plan in August 2017 through December 31, 2018, we have reported restructuring and separation costs of $271 million under the 2017 Restructuring Plan.

In addition, in the second half of 2017, we launched several profit maintenance and improvement initiatives. We pursued additional profit maintenance and improvement initiatives throughout 2018, and have begun to implement a plan to outsource certain functions of our information technology department. As a part of that plan, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers.

Our restructuring plan and profit improvement initiatives create numerous uncertainties, including the effect of the initiatives and plan on our business, operations, revenues, and profitability, potential disruptions to our business as a result of management's attention to the initiatives and plan, uncertainty regarding the potential amount and timing of future cost savings associated with the initiatives and plan or problems experienced as a result of the outsourcing of our information technology infrastructure services, and the potential negative impact of the initiatives and plan on employee morale. The success of the initiatives and plan will depend, in part, on factors that are beyond our control, including reliance on third parties as is the case with our agreement with Infosys. Accordingly, we can provide no assurance that the goals of the initiatives and plan will be fully achieved. Failure in this regard could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

A failure to accurately estimate incurred but not paid medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves

for such incurred but not paid ("IBNP") medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, is negatively impacted by the more limited experience we have had with those newer lines of business or populations.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than previously estimated, our earnings in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

We are subject to retroactive adjustment to our Medicaid premium revenue as a result of retroactive risk adjustment; retroactive changes to contract terms and the resolution of differing interpretations of those terms; the difficulty of estimating performance-based premium; and retroactive adjustments to "blended" premium rates to reflect the actual mix of members captured in those blended rates.

The complexity of some of our Medicaid contract provisions, imprecise language in those contracts, the desire of state Medicaid agencies in some circumstances to retroactively adjust for the acuity of the medical needs of our members; and state delays in processing rate changes, can create uncertainty around the amount of revenue we should recognize.

A current example of exposure to this risk is in California. In the third and fourth quarters of 2018, we recognized adjustments of $57 million and $24 million, respectively, mainly related to the retroactive reinstatement of the Medicaid Expansion risk corridor requirement by the California Department of Health Care Services, mainly for the state fiscal years ended June 2017 and 2018. The risk corridor provision mandates a minimum loss ratio ("MLR") of 85% and a maximum MLR of 95%. The total impact of these adjustments resulted in a reduction to premium revenue totaling approximately $81 million in the year ended December 31, 2018.

Any circumstance such as those described above could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to accurately predict and effectively manage our medical care costs, our operating results could be materially and adversely affected.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio of 85.9%, for the year ended December 31, 2018 had been one percentage point higher, or 86.9%, our net income per diluted share for the year ended December 31, 2018 would have been approximately $8.54 rather than our actual net income per diluted share of $10.61, a difference of $2.07.

Many factors may affect our medical care costs, including:

- the level of utilization of health care services,
- changes in the underlying risk acuity of our membership,
- unexpected patterns in the annual flu season,
- increases in hospital costs,
- increased incidences or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage,
- increased maternity costs,
- payment rates that are not actuarially sound,

- changes in state eligibility certification methodologies,
- relatively low levels of hospital and specialty provider competition in certain geographic areas,
- increases in the cost of pharmaceutical products and services,
- changes in health care regulations and practices,
- epidemics,
- new medical technologies, and
- other various external factors.

Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we are unable to collect health insurer fee ("HIF") reimbursement for 2018 from our state partners, our business, cash flows, financial position, or results of operations could be materially and adversely affected.

Because Medicaid is a government funded program, Medicaid health plans must request reimbursement for the HIF from respective state partners to offset the impact of this tax. When states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. The 2018 HIF assessment, related to our Medicaid business, was $257 million, with an expected tax gross-up effect from the reimbursement of the assessment of approximately $72 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF was approximately $329 million. As of December 31, 2018, we have collected $188 million of this total, with reimbursements receivable of $141 million. The delay or failure of our state partners to reimburse us in full for the 2018 HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2018, the carrying amounts of goodwill and intangible assets, net, amounted to $143 million, and $47 million, respectively.

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Such events or circumstances may include experienced or expected operating cash-flow deterioration or losses, significant losses of membership, loss of state funding, loss of state contracts, and other factors. Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss and adjusted if necessary for the impact of tax-deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit. Our reporting units consist of our individual health plans.

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

An event or events could occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net. For example, if the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states. If such state health plans have recorded goodwill and intangible assets, net, the contract loss would result in a non-cash impairment charge. Such a non-cash impairment charge could have a material adverse impact on our financial results.

We operate in an uncertain political and judicial environment which creates uncertainties with regard to the sources and amounts of our revenues, volatility with regard to the amount of our medical costs, and vulnerability to unforeseen programmatic or regulatory changes.

As a result of the election of President Trump, the GOP control of the Senate and the former GOP control of the House, several changes have been made to the provisions of the ACA, including reduced funding. Accordingly, the future of the ACA and its underlying programs are subject to continuing and substantial uncertainty, making long-

term business planning exceedingly difficult. In December 2018, in a case brought by the state of Texas and nineteen other states, a federal judge in Texas struck down the ACA based on his determination that the ACA's individual mandate is unconstitutional and, since that mandate cannot be separated from the rest of the ACA, the judge ruled that the rest of the ACA is also unconstitutional. The decision has been appealed to the U.S. Court of Appeals for the Fifth Circuit. Any final, not-appealable determination that the ACA is unconstitutional would have a material adverse effect on our business, financial condition, cash flows and results of operations.

We are unable to predict with any degree of certainty whether the ACA will be modified or repealed in its entirety, and if it is repealed, what it will be replaced with; nor are we able to predict when any such changes, if enacted, would become effective.

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following: ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers; reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults; changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis; requiring Medicaid beneficiaries to work; limiting the amount of lifetime benefits for Medicaid beneficiaries; prohibiting the federal government from operating Marketplaces; eliminating the advanced premium tax credits, and cost sharing reductions for low income individuals who purchase their health insurance through the Marketplaces; expanding and encouraging the use of private health savings accounts; providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans, or short-term health insurance (Short-Term Medical or STM plans); establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; allowing insurers to sell insurance across state lines; and numerous other potential changes and reforms. Changes to or the repeal of the ACA, or the adoption of new health care regulatory laws, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A reversal of the Medicaid Expansion would have a negative impact on our revenues.

In the states that have elected to participate, the ACA provided for the expansion of the Medicaid program to offer eligibility to nearly all individuals under age 65 with incomes at or below 138% of the federal poverty line. Since January 1, 2014, several of our health plans have participated in the Medicaid Expansion program under the ACA. At December 31, 2018, our membership included approximately 660,000 Medicaid Expansion members, or 17% of our total membership. If the Medicaid Expansion is reversed by repeal of the ACA or otherwise, we could lose this membership, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our participation in the Marketplace creates certain risks which could adversely impact our business, financial position, and results of operations.

The ACA authorized the creation of marketplace insurance exchanges (the "Marketplace"), allowing individuals and small groups to purchase federally subsidized health insurance. As of December 31, 2018, we participated in the individual Marketplace in seven states which represented approximately 9% of our total membership. For 2019, we are currently estimating that our Marketplace end-of-year membership will range from 250,000-275,000. This estimated membership is lower than the 362,000 enrollment as of December 31, 2018, despite our return to Utah and Wisconsin, and we expect our Marketplace revenues to decrease in 2019 as a result.

A number of larger commercial insurance plans, including Humana Inc., have discontinued their participation in the Marketplace. The perceived instability and impending changes in the Marketplace could further promote reduced participation among the uninsured. Further, the withdrawal of cost sharing subsidies and/or premium tax credits, the elimination of the individual mandate to purchase health insurance in December 2017, the use of special enrollment periods, or any announcement that some or all of our health plans will be leaving the Marketplace, could additionally impact Marketplace enrollment. These market and political dynamics may increase the risk that our Marketplace products will be selected by individuals who have a higher risk profile or utilization rate than we anticipated when we established the pricing for our Marketplace products, leading to financial losses.

The Medicare-Medicaid Duals Demonstration Pilot Programs could be discontinued or altered, resulting in a loss of premium revenue.

To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligibles"), and to deliver services to these individuals in a more financially efficient manner, under the direction of CMS some

states implemented demonstration pilot programs to integrate Medicare and Medicaid services for the dual eligibles. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans ("MMPs"). We operate MMPs in six states: California, Illinois, Michigan, Ohio, South Carolina, and Texas. At December 31, 2018, our membership included approximately 54,000 integrated MMP members, representing just over 1% of our total membership. However, the capitation payments paid to us for dual eligibles are significantly higher than the capitation payments for other members, representing 8% of our total premium revenues in 2018. If the states running the MMP pilot programs conclude that the demonstration pilot programs are not delivering better coordinated care and reduced costs, they could decide to discontinue or substantially alter such programs, resulting in a reduction to our premium revenues.

Continuing changes in health care laws, and in the health care industry, make it difficult to develop actuarially sound rates.

Comprehensive changes to the U.S. health care system make it more difficult for us to manage our business, and increase the likelihood that the assumptions we make with respect to our future operations and results will prove to be inaccurate. The continuing pace of change has made it difficult for us to develop actuarially sound rates because we have limited historical information on which to develop these rates. In the absence of significant historical information to develop actuarial rates, we must make certain assumptions. These assumptions may subsequently prove to be inaccurate. For example, rates of utilization could be significantly higher than we projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, our lack of actuarial experience for a particular program, region, or population, could cause us to set our reserves at an inadequate level.

Our health plans operate with very low profit margins, and small changes in operating performance or slight changes to our accounting estimates will have a disproportionate impact on our reported net income.

A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost-plus and performance-based reimbursement programs. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are potentially subject to differing interpretations by ourselves and the relevant government agency with whom we contract. If the applicable government agency disagrees with our interpretation or implementation of a particular contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to such government agency. Any interpretation of these contract provisions by the applicable governmental agency that varies from our interpretation and implementation of the provision, or that is inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. If we are unsuccessful in achieving the stated performance measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

If we are unable to deliver quality care, and maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay to such providers and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, cash flows, or results of operations.

The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

Introduction of new high cost specialty drugs and sudden costs spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our capitation rates are not adequate to cover the actual pharmacy costs, which jeopardizes the overall actuarial soundness of our rates. Bearing the high costs of new specialty drugs or the high cost inflation of generic drugs without an appropriate rate adjustment or other reimbursement mechanism has an adverse impact on our financial condition and results of operations. For example, the FDA approved the first drug to treat patients with spinal muscular atrophy, Spinraza, in December 2016. After this approval, the distributor of Spinraza announced that one dose will have a list price of $125,000, which means the drug will cost between $650,000 and $750,000 to cover the five or six doses required in the first year, and approximately $375,000 annually thereafter, presumably for the life of the patient. The inordinate cost of Spinraza was not contemplated in the development of our 2017 capitation rates. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. Although we will continue to work with state Medicaid agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends, there can be no assurance that we will always be successful.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plans are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

Further, when a state implements new programs to determine eligibility, establishes new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care health plans. Whenever a state effects an eligibility redetermination for any reason, there is generally a reduction in Medicaid membership associated with that exercise which could have an adverse effect on our premium revenues and results of operations.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have a material adverse effect on our business, membership, cash flows, or results of operations.

Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount per member per month to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Due to insolvency or other circumstances, such providers may be unable or unwilling to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability or unwillingness of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care, as well as potential loss of members. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures or practical regulatory considerations may force us to pay such claims even when we have no legal obligation to do so; or we have already paid claims to a delegated provider and such payments cannot be recouped when the delegated provider becomes insolvent. Liabilities incurred or losses suffered as a result of provider insolvency could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid, Medicare, and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures. As discussed below, such budgetary pressures are particularly intense in the Commonwealth of Puerto Rico. State budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

We are unable to determine how any future congressional spending cuts will affect Medicare and Medicaid reimbursement. We believe there will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one or more of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Furthermore, a state or commonwealth undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state in which we operate a health plan does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

The Commonwealth of Puerto Rico may fail to pay the premiums of our Puerto Rico health plan, which could negatively impact our business, financial condition, cash flows, or results of operations.

The government of Puerto Rico continues to struggle with major fiscal and liquidity challenges. The extreme financial difficulties faced by the Commonwealth may make it very difficult for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2018, our Puerto Rico health plan served approximately 252,000 members, and had recognized premium revenue of approximately $147 million in the fourth quarter of 2018. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Large-scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.

Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions. For example, natural disasters, such as a major earthquake or wildfire in California, or a major hurricane affecting Florida, Puerto Rico, South Carolina or Texas, could have a significant impact on the health of a large number of our covered members. Other conditions that could impact our members include a virulent influenza season or epidemic, or newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikungunya virus, conditions for which vaccines may not exist, are not effective, or have not been widely administered.

In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction. All of these conditions, and others, could have a significant impact on the health of the population of wide-spread areas. We seek to set our IBNP reserves appropriately to account for anticipatable spikes in utilization, such as for the flu season. However, if one of our health plan states were to experience a large-scale natural disaster, a viral epidemic or pandemic, a significant terrorism attack, or some other large-scale event affecting the health of a large number of our members, our covered medical expenses in that state would rise, which could have a material adverse effect on our business, cash flows, financial condition, or results of operations.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets in, and conduct most of our operations through, our direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of ordinary dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. In general, our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare ordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the ordinary dividend. We received $288 million, $245 million, and $100 million in dividends from our regulated health plan subsidiaries during 2018, 2017 and 2016, respectively. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2018 and 2017, without approval of the regulatory authorities, were approximately $126 million and $85 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our Company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our senior notes or credit agreement ("Credit Agreement").

Our use and disclosure of personally identifiable information and other non-public information, including protected health information, is subject to federal and state privacy and security regulations, and our

failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations including, but not limited to, HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of personally identifiable information ("PII"), including protected health information ("PHI"). HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities and business associates, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, PII, or non-public information, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal penalties, divert management's time and energy, and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, upcoding, payments made to excluded providers, improper marketing, and the violation of patient privacy rights. In particular, there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices, particularly in the Medicare program. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal

health care programs as a result of an investigation arising out of such action. We have been the subject of *qui tam* actions in the past and other *qui tam* actions may be filed against us in the future. If we are subject to liability under a *qui tam* or other actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, the new business would fail. We also could be required by the state or commonwealth to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our start-up costs.

Even if we are successful in establishing a profitable health plan in a new jurisdiction, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing jurisdiction will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis, or at all, the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new jurisdiction, or expanding a health plan in an existing jurisdiction could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, stock price, and result in our inability to maintain compliance with applicable stock exchange listing requirements.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses.

We have identified material weaknesses in our internal control over financial reporting in the past, which have subsequently been remediated. If additional material weaknesses in our internal control over financial reporting are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results.

Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are unable to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the New York Stock Exchange, SEC, or other regulatory authorities which would require additional financial and management resources.

This Form 10-K reflects management's conclusion regarding the effectiveness of our disclosure controls and procedures and internal control over financial reporting as of December 31, 2018. See Item 9A, “Controls and Procedures–Management’s Evaluation of Disclosure Controls and Procedures and Management’s Report on Internal Control Over Financial Reporting.”

We are dependent on the leadership of our chief executive officer and other executive officers and key employees.

In late 2017, the board hired Joe Zubretsky as our chief executive officer. Mr. Zubretsky, in turn, has hired other senior level executives. Under the leadership and direction of Mr. Zubretsky, our executive team has launched a vigorous turnaround plan, including many profit improvement initiatives. Our turnaround plan and operational improvements are highly dependent on the efforts of Mr. Zubretsky and our other key executive officers and

employees. The loss of their leadership, expertise, and experience could negatively impact our operations. Our ability to replace them or any other key employee may be difficult and may take an extended period of time because of the limited number of individuals in the health care industry who have the breadth and depth of skills and experience necessary to operate and lead a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain, or motivate these personnel. If we are unsuccessful in recruiting, retaining, managing, and motivating such personnel, our business, financial condition, cash flows, or results of operations may be adversely affected.

We face various risks inherent in the government contracting process that could materially and adversely affect our business and profitability, including periodic routine and non-routine reviews, audits, and investigations by government agencies.

We are subject to various risks inherent in the government contracting process. These risks include routine and non-routine governmental reviews, audits, and investigations, and compliance with government reporting requirements. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our government contracts, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

If we sustain a cyber-attack or suffer privacy or data security breaches that disrupt our information systems or operations, or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. To ensure information security, we have implemented controls to protect the confidentiality, integrity and availability of this data and the systems that store and transmit such data. However, our information technology systems and safety control systems are subject to a growing number of threats from computer programmers, hackers, and other adversaries that may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause damage, security issues, or shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit security vulnerabilities. Because the techniques used to circumvent, gain access to, or sabotage security systems can be highly sophisticated and change frequently, they often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world. We may be unable to anticipate these techniques or implement adequate preventive measures, resulting in potential data loss and damage to our systems. Our systems are also subject to compromise from internal threats such as improper action by employees including malicious insiders, vendors, counterparties, and other third parties with otherwise legitimate access to our systems. Our policies, employee training (including phishing prevention training), procedures and technical safeguards may not prevent all improper access to our network or proprietary or confidential information by employees, vendors, counterparties, or other third parties. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, or other similar events that could negatively affect our systems and our and our members' data.

Moreover, we face the ongoing challenge of managing access controls in a complex environment. The process of enhancing our protective measures can itself create a risk of systems disruptions and security issues. Given the breadth of our operations and increasing sophistication of cyberattacks, a particular incident could occur and persist for an extended period of time before being detected. The extent of a particular cyberattack and the steps that we may need to take to investigate the attack may take a significant amount of time before such an investigation could be completed and full and reliable information about the incident is known. During such time, the extent of any harm or how best to remediate it might not be known, which could further increase the risks, costs, and consequences of a data security incident. In addition, our systems must be routinely updated, patched, and upgraded to protect against known vulnerabilities. The volume of new software vulnerabilities has increased substantially, as has the importance of patches and other remedial measures. In addition to remediating newly identified vulnerabilities, previously identified vulnerabilities must also be updated. We are at risk that cyber attackers exploit these known

vulnerabilities before they have been addressed. The complexity of our systems and platforms that we operate, the increased frequency at which vendors are issuing security patches to their products, our need to test patches, and in some instances, coordinate with third-parties before they can be deployed, all could further increase our risks. The increased use of mobile devices and other technologies can heighten these and other risks.

Furthermore, certain aspects of the security of various technologies are unpredictable or beyond our control. For example, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. The security of these services will depend in part on Infosys's ability to perform the contracted functions and services, including with respect to data security, in a timely, satisfactory, and compliant manner. The Infosys transaction will require us to devote significant resources to transition from our existing systems infrastructure, and if we are unable to successfully execute and manage this transition, any movement of data during the transition may enhance the information management and data security risks we currently face.

The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. We may need to expend significant additional resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. Further, our remediation efforts may be delayed or complicated as a result of our desire to cooperate with law enforcement agencies. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us (including but not limited to material fines, damages, consent orders, penalties and/or remediation costs, mandatory disclosure to the media and regulators, or enforcement proceedings), damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could require us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, requiring us to implement additional or different programs and systems, or making it more difficult to predict future results. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Potential divestitures of businesses or product lines may materially adversely affect our business, financial condition, cash flows, or results of operations.

As a part of our business strategy, we continually review our products and business lines across all geographies to identify opportunities for performance improvement. Depending on the particular circumstances, we may determine that a divestiture of one or more businesses or product lines would be the best means to further our plan to improve and sustain profitability and enhance our focus on the execution of our business plan. For example, in late 2018 we sold two of our former wholly owned subsidiaries: Molina Information Systems, LLC d/b/a Molina Medicaid Solutions, and Pathways Health and Community Support LLC.

Divestitures involve risks, including: difficulties in the separation of operations, services, products and personnel; the diversion of management's attention from other business concerns; the disruption of our business; the potential loss of key employees; the retention of uncertain contingent liabilities related to the divested business or product line; and the failure of our efforts to divest any such business or product line on the terms and time frames desired by management, or at all. Furthermore, we may be unsuccessful in finding a replacement for any lost revenue or

income previously derived from the divested business or product line. In addition, divestitures may result in significant impairment charges, including those related to goodwill and other intangible assets, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition, cash flows and ability to bid for, and continue to participate in, certain programs.

Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine compliance with performance standards and to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect or correct inaccurate or incomplete encounter data and have been, and continue to be exposed to, operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

We have experienced challenges in obtaining complete and accurate encounter data, due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could adversely affect the premium rates we receive and how membership is assigned to us and subject us to financial penalties, which could have a material adverse effect on our results of operations, financial condition, cash flows and our ability to bid for, and continue to participate in, certain programs.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, update, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our members and providers also depend upon our information systems for enrollment, primary care and specialist physician roster access, membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected.

We have partnered with third parties to support our information technology systems. This makes our operations vulnerable to adverse effects if such third parties fail to perform adequately. For example, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. If Infosys or any licensor or vendor of any technology which is integral to our operations were to become insolvent or otherwise fail to support the technology sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. On an ongoing basis, we evaluate the ability of our existing operations to support our current and future business needs and to maintain our compliance requirements. As a result, we periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives, industry trends and recently enacted regulations, and changes in our system platforms. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. Any inability or failure by us or our vendors to properly maintain information management systems; any failure to efficiently and effectively consolidate our information systems, including to renew technology, maintain technology currency, keep pace with evolving industry standards or eliminate redundant or obsolete applications; or any inability or failure to successfully update or expand processing capability or develop new capabilities to meet our business needs, could result in operational disruptions, loss of existing members, providers, and customers, difficulty in attracting new members, providers, and customers, disputes with members, providers, and customers, regulatory or other legal or compliance problems, and significant increases in administrative expenses and/or other adverse consequences. If for any reason there is a business continuity interruption resulting in loss of access to or availability of data, we may, among other things,

not be able to meet the full demands of our customers and, in turn, our business, results of operations, financial condition and cash flow could be adversely impacted.

Moreover, business acquisitions require transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our systems, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake or wildfire.

Our corporate headquarters is located in Long Beach, California. In addition, some of our health plans' claims are processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake and wildfires than most other parts of the United States. If a major earthquake or wildfire were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. If there is a major Southern California earthquake or wildfire, there can be no assurances that our disaster recovery plan will be successful or that the business operations of our health plans, including those that are remote from any such event, would not be substantially impacted.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including provider disputes, employment related disputes, health care regulatory law-based litigation, breach of contract actions, *qui tam* or False Claims Act actions, and securities class actions. If we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Successful claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

We cannot predict the outcome of any lawsuit. Some of the liabilities related to litigation that we may incur may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us. The litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations and service providers. Our health plans compete for members principally on the basis of size, location, and quality of provider network; benefits supplied; quality of service; and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to us. Many other organizations with which we compete, including large commercial plans and other service providers, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our business, or may lose business to third parties.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Some of these third-parties also have direct access to our systems. For example, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. Our arrangements with third party vendors and service providers such as Infosys may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data or the information and data relating to our members or customers. We are also at risk of a data security incident involving a vendor or third party, which could result in a breakdown of such third party's data protection

processes or cyber-attackers gaining access to our infrastructure through the third party. To the extent that a vendor or third party suffers a data security incident that compromises its operations, we could incur significant costs and possible service interruption, which could have an adverse effect on our business and operations. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures or incidents under applicable business associate agreements or other applicable outsourcing agreements. Any contractual remedies and/or indemnification obligations we may have for vendor or service provider failures or incidents may not be adequate to fully compensate us for any losses suffered as a result of any vendor's failure to satisfy its obligations to us or under applicable law. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk, including significant cybersecurity risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or could result in sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs and/or experience significant disruption to our operations in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our members or customers and, in turn, our business, financial condition, and results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms, unanticipated costs or expenses, or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could have a material adverse effect on our business, financial condition, cash flows, and results of operations.

We are subject to a number of risks in connection with our decision to enter into a master services agreement with Infosys for the management of certain of our information technology infrastructure functions.

On February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers.

Given the scope of services that will be provided by Infosys, the transition of services presents considerable execution risk inherent to large scale strategic and operational initiatives, including, among others, with respect to the efficient and secure transfer of information and data and the management of our workforce, which will require us to coordinate with Infosys and monitor the transition. We have incurred costs and will continue to incur costs and devote substantial resources during the transition to prepare for Infosys's services. If we are unable to efficiently, effectively and successfully carry out the transition of our information technology infrastructure activities to Infosys in a coordinated and timely manner, including securely transferring information and data between the parties, such failures or delays in the start of Infosys's services could materially impact the amount of the intended cost savings and other intended benefits of the Infosys transaction.

The success of our business will depend in part on Infosys's ability to perform the contracted functions and services, including with respect to data security, in a timely, satisfactory, and compliant manner. To protect our expectations regarding Infosys' performance, the agreement has minimum service levels that Infosys must meet or exceed. In the event of an expiration of our agreement with Infosys or upon termination of the agreement for any reason, we have the right to obtain disengagement assistance from Infosys to facilitate the transition of the infrastructure services from Infosys to another supplier or back to the Company itself. We would be required to pay for any disengagement assistance based on a combination of pre-determined charges and hourly fees for services for which there is no pre-determined charge. We retain the right to terminate the agreement with Infosys, in whole or in part, for, among other things, cause, convenience, and, if certain criteria are met, a change in the control of Infosys. However, we will be required to pay varying termination charges if we terminate the agreement for certain reasons other than for cause. Depending upon the circumstances of the termination, the termination charge may be material.

Furthermore, changes in Infosys's operations, security posture or vulnerabilities, financial condition, or other matters outside of our control could adversely affect the provision of their services to the Company. If we experience a loss or disruption in the provision of any of these functions or services, or they are not performed in a timely, satisfactory or compliant manner, we may not fully achieve anticipated cost savings or other expected benefits of the transaction; we may be subject to regulatory enforcement actions; we may be vulnerable to security breaches that threaten the security and confidentiality of our information and data; we may not be able to meet the full demands of our customers and members or be subject to claims against us by our members and providers; and we may have difficulty in finding alternate providers in a timely manner on terms and conditions favorable to us upon expiration or termination of the agreement, or at all. Furthermore, the contractual remedies and indemnification obligations for Infosys's failures may not fully compensate us for any losses suffered as a result of Infosys's failure to satisfy its obligations to us. Any of the foregoing could have a material and adverse impact on our business.

Our substantial indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of any variable rate debt, and prevent us from meeting our obligations under our outstanding indebtedness.

We have a significant amount of indebtedness. As of December 31, 2018, our total indebtedness was approximately $1,458 million, including lease financing obligations. As of December 31, 2018, we also had $493 million available for borrowing under our Credit Facility. On January 31, 2019, we entered into a Sixth Amendment to the Credit Agreement that provides for a delayed draw term loan facility in an aggregate principal amount of $600 million (the "Term Loan"), under which we may request up to ten advances, each in a minimum principal amount of $50 million, until 18 months after January 31, 2019.

Our substantial indebtedness could have significant consequences, including:

- increasing our vulnerability to adverse economic, industry, or competitive developments;
- requiring a substantial portion of our cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund operations, make capital expenditures, and pursue future business opportunities;
- exposing us to the risk of increased interest rates to the extent of any future borrowings, including borrowings under our Credit Agreement, at variable rates of interest;
- making it more difficult for us to satisfy our obligations with respect to our indebtedness, including our Credit Agreement and our outstanding senior notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indenture governing our outstanding senior notes and the agreements governing such other indebtedness;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product and service development, debt service requirements, acquisitions, and general corporate or other purposes; and
- limiting our flexibility in planning for, or reacting to, changes in our business or market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged and who, therefore, may be able to take advantage of opportunities that our substantial indebtedness may prevent us from exploiting.

The terms of our debt impose, and will impose, restrictions on us that may affect our ability to successfully operate our business and our ability to make payments on our outstanding senior notes.

The indentures governing our outstanding senior notes and the Credit Agreement governing our revolving Credit Facility and Term Loan contain various covenants that could materially and adversely affect our ability to finance our future operations or capital needs and to engage in other business activities that may be in our best interest. These covenants limit our ability to, among other things:

- incur additional indebtedness or issue certain preferred equity;
- pay dividends on, repurchase, or make distributions in respect of our capital stock, prepay, redeem, or repurchase certain debt or make other restricted payments;
- make certain investments;
- create certain liens;
- sell assets, including capital stock of restricted subsidiaries;
- enter into agreements restricting our restricted subsidiaries' ability to pay dividends to us;
- consolidate, merge, sell, or otherwise dispose of all or substantially all of our assets;

- enter into certain transactions with our affiliates; and
- designate our restricted subsidiaries as unrestricted subsidiaries.

All of these covenants may restrict our ability to pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, such as prevailing economic conditions and changes in regulations, and if such events occur, we cannot be sure that we will be able to comply. A breach of these covenants could result in a default under the indentures for our outstanding senior notes and/or the Credit Agreement governing our Credit Facility and Term Loan including, as a result of cross default provisions and, in the case of our Credit Agreement, permit the lenders to cease making loans to us. If there were an event of default under the indentures governing our outstanding senior notes and/or the Credit Agreement governing our Credit Facility and Term Loan, holders of such defaulted debt could cause all amounts borrowed under these instruments to be due and payable immediately. Our assets or cash flow may not be sufficient to repay borrowings under our outstanding debt instruments in the event of a default thereunder.

In addition, the restrictive covenants in the Credit Agreement governing our Credit Facility and Term Loan require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests will depend on our ongoing financial and operating performance, which, in turn, will be subject to economic conditions and to financial, market, and competitive factors, many of which are beyond our control.

If our operating performance declines, we may be required to obtain waivers from the lenders under our Credit Agreement governing our Credit Facility and Term Loan, from the holders of our outstanding senior notes or from the holders of other obligations, to avoid defaults thereunder. For example, in February 2017, to avoid default under our Credit Agreement as a result of our failure to comply with certain financial covenants therein applicable to the three months ended December 31, 2016, we sought, and obtained, a waiver of such defaults by the required lenders under our Credit Agreement.

If we are not able to obtain such waivers, our creditors could exercise their rights upon default, and we could be forced into bankruptcy or liquidation.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments, including our Credit Agreement, and the indentures governing our outstanding senior notes, may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which would harm our ability to incur additional indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies may increase our future borrowing costs and reduce our access to capital.

There can be no assurance that any rating assigned by the rating agencies to our debt or our corporate rating will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, future circumstances relating to the basis of the rating, such as adverse changes, so warrant. In 2017, both Moody's and Standard and Poor's downgraded our debt ratings. In February 2018, both S&P and Moody's downgraded our corporate and debt ratings further to BB- and B3, respectively, with modest negative impact on future borrowing cost. A further lowering or withdrawal of the ratings assigned to our debt securities by rating agencies would likely increase our future borrowing costs and reduce our access to capital, which could have a materially adverse impact on our business, financial condition, cash flows, or results of operations.

Risks Related to Our Common Stock

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock/units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock/units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150 million shares of common stock and 20 million shares of preferred stock. As of December 31, 2018, approximately 62 million shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our Company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval of such state regulatory agencies.

Further, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock.

PROPERTIES

As of December 31, 2018, the Health Plans segment leased a total of 66 facilities. We own a 186,000 square-foot office building in Troy, Michigan, a 24,000 square-foot mixed use facility in Pomona, California, and a 26,700 square foot data center in Albuquerque, New Mexico. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we continue to periodically evaluate our employee and operational growth prospects to determine if additional space is required, and where it would be best located.

LEGAL PROCEEDINGS

Refer to the Notes to Consolidated Financial Statements, Note 17, “Commitments and Contingencies—Legal Proceedings,” for a discussion of legal proceedings.

MARKET FOR REGISTRANT’S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

STOCK REPURCHASE PROGRAMS

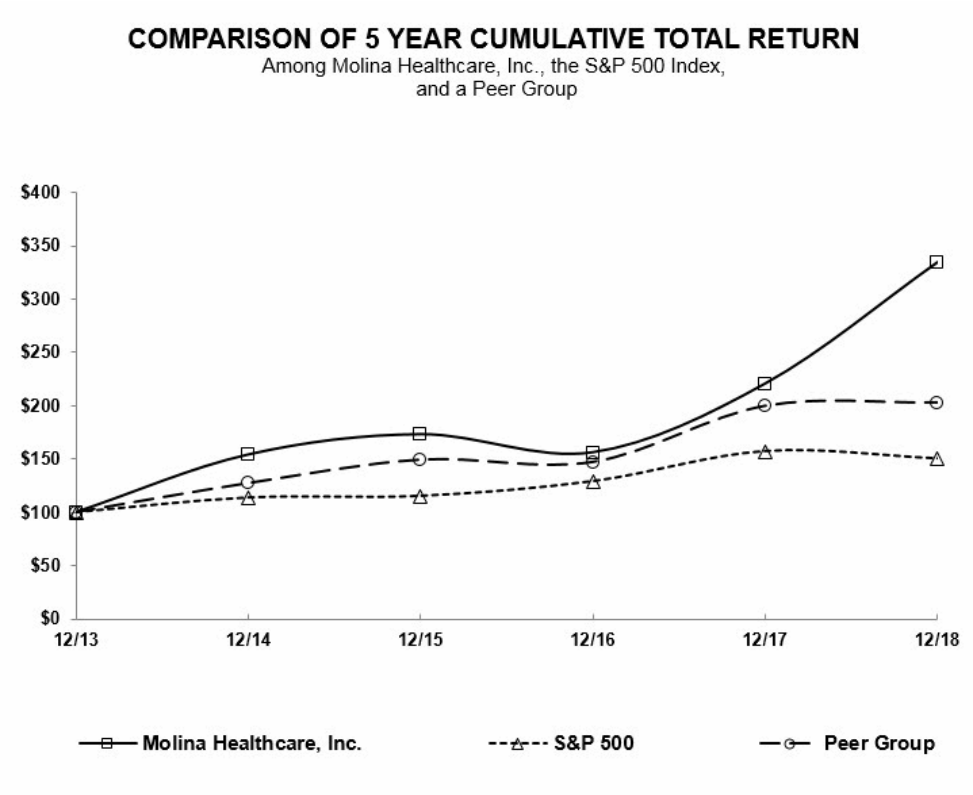
Purchases of common stock made by us, or on our behalf during the quarter ended December 31, 2018, including shares withheld by us to satisfy our employees’ income tax obligations, are set forth below:

	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
October 1 — October 31	—	$ —	—	$ —
November 1 — November 30	—	$ —	—	$ —
December 1 — December 31	—	$ —	—	$ —
	—	$ —	—	

STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be “soliciting materials” or to be “filed” with the U.S. Securities and Exchange Commission (“SEC”) (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that we specifically incorporate it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor’s Corporation Composite 500 Index (the “S&P 500”) and a peer group index for the five-year period from December 31, 2013 to December 31, 2018. The comparison assumes $100 was invested on December 31, 2013, in our common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.



The peer group index consists of Centene Corporation (CNC), Cigna Corporation (CI), DaVita HealthCare Partners, Inc. (DVA), Humana Inc. (HUM), Magellan Health, Inc. (MGLN), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).

STOCK TRADING SYMBOL AND DIVIDENDS

Our common stock is listed on the New York Stock Exchange under the trading symbol “MOH.” As of February 15, 2019, there were 14 holders of record of our common stock.

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business operations. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Additionally, the indentures governing our outstanding senior notes and the Credit Agreement governing the revolving Credit Facility and Term Loan contain various covenants that limit our ability to pay dividends on our common stock.

Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see the Notes to Consolidated Financial Statements, Note 17, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

SELECTED FINANCIAL DATA

	Year Ended December 31,				
	2018	2017	2016	2015	2014
	(In millions, except per-share data, percentages and membership)				
Premium revenue	$ 17,612	$ 18,854	$ 16,445	$ 13,261	$ 9,035
Total revenue	$ 18,890	$ 19,883	$ 17,782	$ 14,178	$ 9,667
Operating income (loss)	$ 1,131	$ (555)	$ 306	$ 387	$ 193
Income (loss) before income taxes	$ 999	$ (612)	$ 205	$ 322	$ 135
Net income (loss)	$ 707	$ (512)	$ 52	$ 143	$ 62
Basic net income (loss) per share [1]	$ 11.57	$ (9.07)	$ 0.93	$ 2.75	$ 1.33
Diluted net income (loss) per share [1]	$ 10.61	$ (9.07)	$ 0.92	$ 2.58	$ 1.29
Weighted average shares outstanding:					
Basic	61.1	56.4	55.4	52.2	46.9
Diluted	66.6	56.4	56.2	55.6	48.3
Operating Statistics:					
Medical care ratio [2]	85.9%	90.6 %	89.8%	88.9%	89.4%
G&A ratio [3]	7.1%	8.0 %	7.8%	8.1%	7.9%
Effective income tax expense (benefit) rate	29.2%	(16.4)%	74.8%	55.5%	53.8%
Pre-tax margin [3]	5.3%	(3.1)%	1.2%	2.3%	1.4%
After-tax margin [3]	3.7%	(2.6)%	0.3%	1.0%	0.6%
Ending Membership by Government Program:					
Medicaid	3,361,000	3,537,000	3,605,000	3,235,000	2,541,000
Medicare	98,000	101,000	96,000	93,000	67,000
Marketplace	362,000	815,000	526,000	205,000	15,000
	3,821,000	4,453,000	4,227,000	3,533,000	2,623,000

(1) Source data for calculations in thousands.
(2) Medical care ratio represents medical care costs as a percentage of premium revenue.
(3) G&A ratio represents general and administrative expenses as a percentage of total revenue. Pre-tax margin represents net income (loss) before income taxes as a percentage of total revenue. After-tax margin represents net income (loss) as a percentage of total revenue.

	December 31,				
	2018	2017	2016	2015	2014
	(In millions)				
Balance Sheet Data:					
Cash and cash equivalents	$ 2,826	$ 3,186	$ 2,819	$ 2,329	$ 1,539
Total assets	7,154	8,471	7,449	6,576	4,435
Medical claims and benefits payable	1,961	2,192	1,929	1,685	1,201
Long-term debt, including current portion [1]	1,458	2,169	1,645	1,609	887
Total liabilities	5,507	7,134	5,800	5,019	3,425
Stockholders' equity	1,647	1,337	1,649	1,557	1,010

(1) Also includes lease financing obligations.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS ("MD&A")

OVERVIEW

Molina Healthcare, Inc., a FORTUNE 500, multi-state healthcare organization, arranges for the delivery of health care services to individuals and families who receive their care through the Medicaid and Medicare programs, and through the state insurance marketplaces (the "Marketplace"). Through our locally operated health plans in 14 states and the Commonwealth of Puerto Rico, we served approximately 3.8 million members as of December 31, 2018. These health plans are operated by our respective wholly owned subsidiaries in those states and in the Commonwealth of Puerto Rico, each of which is licensed as a health maintenance organization ("HMO").

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. Our Other segment includes the historical results of the Pathways behavioral health subsidiary, which we sold in the fourth quarter of 2018, and certain corporate amounts not allocated to the Health Plans segment. Effective in the fourth quarter of 2018, we reclassified the historical results relating to our Molina Medicaid Solutions ("MMS") segment, which we sold in the third quarter of 2018, to the Other segment. Previously, results for MMS were reported in a stand-alone segment.

2018 HIGHLIGHTS

In summary, we produced pretax earnings of $999 million and net income of $707 million for the full year ending December 31, 2018, resulting in an after-tax margin of 3.7%. These results include, on a consolidated basis, a medical cost ratio ("MCR") of 85.9% and a general and administrative ("G&A") expense ratio of 7.1%. The improved performance in 2018 across all of our programs, health plans, operating metrics, and the actions we took with respect to capital management, are summarized below.

Program Performance. The improved performance in 2018 demonstrates the effectiveness of our margin recovery and sustainability plan.

- Our Medicaid program, with $13.6 billion in premium revenue, ended the year with a 90.0% MCR, both improved when compared with 2017. Several factors contributed to this result, including our ability to manage medical costs, our success in executing on a variety of profit improvement initiatives, including network contracting, front-line utilization management, and retaining increased levels of revenue at risk for quality scores.

- Our Medicare program also delivered improved results in 2018 when compared to 2017. We earned premium revenues of $2.1 billion in 2018 and attained an MCR of 84.5%. We believe we have proved our ability to manage high-acuity members who have complex medical conditions and co-morbidities, and we believe we have proved to be proficient at managing long-term services and supports benefits, an important and fast-growing benefit across all of our products. Additionally, we increased revenues tied to member risk scores to be more commensurate with the acuity of our membership.

- Our Marketplace program was a significant contributor to our results in 2018, with approximately $1.9 billion in premium revenue and an MCR of 58.9%. In 2017 and prior years, the performance in our Marketplace program was challenged, and we executed corrective pricing actions of nearly 60% in 2018 to improve our results. Our prices were competitive, even with the significant increases over 2017; which enabled us to retain higher membership in 2018 than we expected. Lastly, execution of the core managed care fundamentals that are also applicable to our other programs, and an increase in revenues tied to member risk scores to be commensurate with the acuity of our membership, also helped to produce the results that we attained.

Health Plan Performance. In summary, we believe our health plan portfolio is performing well. In 2017, more than 25% of our premium revenue related to plans that were not profitable. In 2018, all these plans were profitable. We significantly improved the performance and balance of our locally operated health plans in 2018. Our largest health plans from a membership standpoint (going forward in 2019)–California, Ohio, Michigan, Texas, and Washington– continued to perform well. Florida and New Mexico were challenges due to contract losses, but performed well considering they faced the run-off of large proportions of membership and revenues. Additionally, our Washington health plan began to improve its profitability midway through 2018 and we believe is now well-positioned to improve its pretax margins on an expanded revenue base.

Operational Improvements. We implemented operational improvements that enabled us to gain operating efficiencies. We continued to improve our G&A cost profile, managing to a G&A expense ratio of 7.1% for the full year of 2018, which is a 90 basis-point improvement compared to 2017. We reduced our core business workforce by more than 800 full-time equivalents, or nearly 7% from the beginning of the year. More importantly, we continued to invest in the business. We improved the performance of our core processes: claims, payment integrity, member and provider services and a host of others, all of which create lasting effects. Finally, in 2018, we set the stage for ongoing improvement by making significant progress on a variety of outsourcing initiatives, including the recently announced outsourcing of certain information technology infrastructure functions to Infosys, which will benefit us in 2019 and beyond.

Balance Sheet and Capital Management. Our improved operating performance in 2018 allowed our business to dividend approximately $300 million to the parent company. We deployed approximately $1.2 billion to retire convertible debt and repay the outstanding amount drawn on our revolving Credit Facility. This reduced earnings per share volatility and lowered our debt-to-capital ratio to approximately 47%.

FINANCIAL SUMMARY

	Year Ended December 31,		
	2018	2017	2016
	(Dollars in millions, except per-share amounts)		
Premium revenue	$ 17,612	$ 18,854	$ 16,445
Premium tax revenue	417	438	468
Health insurer fees reimbursed	329	—	292
Investment income and other revenue	125	70	38
Medical care costs	15,137	17,073	14,774
General and administrative expenses	1,333	1,594	1,393
Premium tax expenses	417	438	468
Health insurer fees	348	—	217
Restructuring and separation costs	46	234	—
Impairment losses	—	470	—
Loss on sales of subsidiaries, net of gain	(15)	—	—
Operating income (loss)	1,131	(555)	306
Interest expense	115	118	101
Other expenses (income), net	17	(61)	—
Income tax expense (benefit)	292	(100)	153
Net income (loss)	707	(512)	52
Net income (loss) per diluted share	$ 10.61	$ (9.07)	$ 0.92
Operating Statistics:			
Ending total membership	3,821,000	4,453,000	4,227,000
Medical care ratio [1]	85.9%	90.6 %	89.8%
G&A ratio [2]	7.1%	8.0 %	7.8%
Premium tax ratio [1]	2.3%	2.3 %	2.8%
Effective income tax expense (benefit) rate	29.2%	(16.4)%	74.8%
After-tax margin [2]	3.7%	(2.6)%	0.3%

(1) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) G&A ratio represents general and administrative expenses as a percentage of total revenue. After-tax margin represents net income (loss) as a percentage of total revenue.

CONSOLIDATED RESULTS

See tables below, under "Summary of Significant Items," for details relating to significant non-run rate items, such as impairment losses, restructuring costs and material out of period adjustments to premiums or medical care costs.

NET INCOME AND OPERATING INCOME

2018 vs. 2017

Net income amounted to $707 million, or $10.61 per diluted share in 2018, compared with a net loss of $512 million, or $9.07 per diluted share in 2017. The year-over-year improvement was mainly driven by a decline in the medical care ratio ("MCR") and the general and administrative (G&A) expense ratio. Additionally, results for 2017 reflect $704 million in impairment losses and restructuring costs, or $8.87 per diluted share.

2017 vs. 2016

Net loss was $512 million, or $9.07 per diluted share in 2017 compared with net income of $52 million, or $0.92 per diluted share in 2016. The substantial decline in 2017 was mainly due to $704 million in impairment losses and restructuring costs, as mentioned above.

PREMIUM REVENUE

2018 vs. 2017

Premium revenue decreased $1,242 million in 2018 when compared with 2017. Lower premium revenue was mainly driven by a decrease in Marketplace membership, and lower premiums in Medicaid, including retroactive California Medicaid Expansion risk corridor adjustments, partially offset by Marketplace premium rate increases.

2017 vs. 2016

Premium revenue increased $2,409 million in 2017 when compared with 2016, due to a 10% increase in membership, mainly in Marketplace, and a 5% increase in the overall premium revenue PMPM.

PREMIUM TAX REVENUE AND EXPENSES

2018 vs. 2017

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) remained consistent in 2018 when compared to 2017 and was 2.3% in both years. The decrease in expense is consistent with the decline in premiums.

2017 vs. 2016

The premium tax ratio decreased to 2.3% in 2017 from 2.8% in 2016, mainly due to the significant revenue growth at our Florida health plan in 2017 and 2016, which operates in a state with no premium tax, and growth in MMP revenue. The Medicare portion of MMP revenue is not subject to premium tax.

INVESTMENT INCOME AND OTHER REVENUE

2018 vs. 2017

Investment income and other revenue increased to $125 million in 2018, compared with $70 million in 2017, primarily for two reasons. First, investment income increased due to improved annualized portfolio yields and higher average invested assets in 2018. In addition, other revenue increased in 2018 due to administrative services fees earned by our Washington health plan, following that state's decision to transition the management of Medicaid pharmacy benefits to an administrative services-based arrangement in 2018.

2017 vs. 2016

Investment income and other revenue increased to $70 million in 2017 compared with $38 million in 2016, mainly due to an increase in average invested assets.

MEDICAL CARE RATIO ("MCR")

2018 vs. 2017

Overall, the MCR improved to 85.9% in 2018, from 90.6% in 2017. Excluding the retroactive California Medicaid Expansion risk corridor adjustments, and the combined benefit of the 2017 Marketplace risk adjustment and CSR

benefit, the MCR for 2018 would have been 86.3%. Excluding several, substantial out-of-period items that are discussed further below, the MCR for 2017 would have been 89.3%. The improvement was due to a decrease in the MCRs across our Medicaid, Medicare and Marketplace programs.

2017 vs. 2016

The medical care ratio increased to 90.6% in 2017, from 89.8% in 2016. Our 2017 medical care ratio was burdened by substantial unfavorable out-of-period items, including $150 million of medical margin deterioration resulting from unfavorable prior period claims development, the related need to replenish margins for adverse development in our liability for medical claims and benefits payable, increased reserves for premiums we expect to repay to state Medicaid agencies, and approximately $90 million of unfavorable Marketplace items, most notably the lack of CSR reimbursement in the fourth quarter of 2017. Absent these items, our medical care ratio for 2017 would have been approximately 89.3%.

GENERAL AND ADMINISTRATIVE ("G&A") EXPENSES

2018 vs. 2017

The G&A expense ratio improved to 7.1% in 2018 compared with 8.0% in 2017. This year-over-year improvement was primarily the result of continued G&A cost containment, partially offset by decreased leverage resulting from the decline in premium revenues.

2017 vs. 2016

The G&A expense ratio increased to 8.0% in 2017 compared with 7.8% in 2016 due to increased spending related to growth in our Marketplace membership, partially offset by the benefit of increased leverage resulting from the associated increase in premium revenues.

HEALTH INSURER FEES ("HIF")

Health insurer fees amounted to $348 million, and health insurer fees reimbursed amounted to $329 million in 2018. There were no HIF expensed or reimbursed in 2017 due to the moratorium under the Consolidated Appropriations Act of 2016. A new moratorium will be in effect in 2019.

IMPAIRMENT LOSSES

In the year ended December 31, 2017, we recorded impairment losses relating to goodwill and intangible assets, net, of $470 million. These losses included $269 million recorded in the Health Plans segment, and $201 million recorded in the Other segment, relating to our recently divested Pathways and Molina Medicaid Solutions subsidiaries.

RESTRUCTURING AND SEPARATION COSTS

In 2018, we incurred restructuring and separation costs of $46 million, including $37 million of additional costs related to implementation of our restructuring and profit improvement plan in 2017 (the "2017 Restructuring Plan"), and $9 million related to our IT restructuring plan that was commenced in 2018. In 2017, we incurred restructuring and separation costs of $234 million as a result of the implementation of our 2017 Restructuring Plan.

LOSS ON SALES OF SUBSIDIARIES, NET OF GAIN

Molina Medicaid Solutions. We closed on the sale of Molina Medicaid Solutions ("MMS") to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million. As a result of this transaction, we recognized a pretax gain, net of transaction costs, of $37 million. The gain, net of income tax expense, was $28 million.

Pathways. We closed on the sale of our Pathways behavioral health subsidiary to Pyramid Health Holdings, LLC on October 19, 2018, for a nominal purchase price. As a result of this transaction, we recognized a pretax loss of $52 million. The loss, net of income tax benefit, was $32 million.

INTEREST EXPENSE

2018 vs. 2017

Interest expense decreased to $115 million for the year ended December 31, 2018, compared with $118 million for the year ended December 31, 2017. As further described below in “Liquidity,” we reduced the principal amount of outstanding debt by $759 million in 2018.

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $22 million and $32 million, and $31 million for the years ended December 31, 2018, 2017, and 2016 respectively. See further discussion in Notes to Consolidated Financial Statements, Note 11, “Debt.”

2017 vs. 2016

Interest expense increased to $118 million for the year ended December 31, 2017, compared with $101 million for the year ended December 31, 2016. The increase was due primarily to our issuance of $330 million aggregate principal amount of senior notes (the “4.875% Notes”) due June 15, 2025, and $300 million borrowed under our Credit Facility in the third quarter of 2017.

OTHER EXPENSES (INCOME), NET

In 2018, we recorded other expenses of $17 million, primarily due to the loss on debt extinguishment resulting from our 1.125% Convertible Notes repayments and the 1.625% Convertible Notes exchange. These transactions are described further in Notes to Consolidated Financial Statements, Note 11, “Debt.” In early 2017, we received a $75 million fee in connection with a terminated Medicare acquisition.

INCOME TAXES

2018 vs. 2017

Income tax expense amounted to $292 million in 2018, or 29.2% of pretax income, compared with an income tax benefit of $100 million in 2017, or 16.4% of the pretax loss.

The effective tax rate for 2018 differs from 2017 mainly due to: 1) the reduction in the federal statutory rate from 35% to 21% under the Tax Cuts and Jobs Act of 2017 (“TCJA”); and 2) higher non-deductible expenses in 2018, primarily related to the non-deductible HIF, as a percentage of pre-tax income (loss). The HIF was not applicable in 2017 due to the 2017 HIF moratorium.

The revaluation of deferred tax assets in connection with the TJCA resulted in $54 million additional income tax expense in the year ended December 31, 2017. In addition, the effective tax benefit rate for 2017 was less than the statutory tax benefit due to the relatively large amount of reported expenses that were not deductible for tax purposes, primarily relating to goodwill impairment losses and separation costs.

2017 vs. 2016

The income tax benefit amounted to $100 million in 2017, or 16.4% of the pretax loss, compared with an income tax expense of $153 million in 2016, or 74.8% of pretax income.

As discussed above, the effective tax benefit rate in 2017 was impacted by a revaluation of deferred tax assets and relatively large amounts of nondeductible expenses. The effective tax rate of 74.8% in 2016 mainly reflected the relatively large impact of the non-deductible HIF expenses relative to pretax income.

SUMMARY OF SIGNIFICANT ITEMS

The tables below summarize the impact of certain items significant to our financial performance in the periods presented. The individual items presented below increase (decrease) income (loss) before income tax expense (benefit).

	Year Ended December 31, 2018	
	Amount	Per Diluted Share [1]
	(In millions)	
Retroactive California Medicaid Expansion risk corridor	$ (81)	$ (0.95)
Marketplace risk adjustment, for 2017 dates of service	56	0.66
Marketplace CSR subsidies, for 2017 dates of service	81	0.95
Loss on sales of subsidiaries, net of gain	(15)	(0.05)
Restructuring costs	(46)	(0.54)
Loss on debt extinguishment	(22)	(0.29)
	$ (27)	$ (0.22)

	Year Ended December 31, 2017	
	Amount	Per Diluted Share [1]
	(In millions)	
Termination of CSR subsidy payments for the fourth quarter of 2017	$ (73)	$ (0.82)
Marketplace adjustments related to risk adjustment, CSR subsidies, and other items for 2016 dates of service	(47)	(0.52)
Change in Marketplace premium deficiency reserve for 2017 dates of service	30	0.33
Impairment losses	(470)	(6.01)
Restructuring and separation costs	(234)	(2.86)
Loss on debt extinguishment	(14)	(0.24)
Fee received for terminated Medicare acquisition	75	0.84
	$ (733)	$ (9.28)

(1) Except for permanent differences between GAAP and tax (such as certain expenses that are not deductible for tax purposes), per diluted share amounts are generally calculated at the statutory income tax rate of 22% for 2018, and 37% for 2017.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums. Our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our Health Plans segment is the MCR, which represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Margin for our Health Plans segment is referred to as “Medical Margin,” and for Other, as “Service Margin.” Management’s discussion and analysis of the changes in the individual components of Medical Margin and Service Margin follows.

See Notes to Consolidated Financial Statements, Note 18, “Segments,” for more information.

SEGMENT SUMMARY

	2018	2017	2016
	(In millions)		
Medical Margin [1]	$ 2,475	$ 1,781	$ 1,671
Service Margin [2]	43	29	54
Total Margin	$ 2,518	$ 1,810	$ 1,725
MCR	85.9%	90.6%	89.8%

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.

HEALTH PLANS SEGMENT

RECENT DEVELOPMENTS

For a description of recent renewals of Medicaid contracts, see *Item 1. Business—Strategy—Growth Opportunities.*

TRENDS AND UNCERTAINTIES

For descriptions of "Status of Contract Re-procurements," and other developments see *Item 1. Business—Our Business—Medicaid, Medicare and Marketplace*.

For discussions of "Pressures on Medicaid Funding," and "ACA and the Marketplace," see *Item 1. Business—Legislative and Political Environment*.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, MCR and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Year Ended December 31, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	29.4	$ 5,508	$ 187.04	$ 4,908	$ 166.66	89.1%	$ 600
Medicaid Expansion	8.1	2,884	356.81	2,587	320.11	89.7	297
ABD	5.0	5,231	1,049.26	4,763	955.22	91.0	468
Total Medicaid	42.5	13,623	320.43	12,258	288.31	90.0	1,365
MMP	0.7	1,443	2,192.58	1,241	1,885.59	86.0	202
Medicare	0.5	631	1,180.46	511	955.81	81.0	120
Total Medicare	1.2	2,074	1,738.85	1,752	1,468.77	84.5	322
Total Medicaid and Medicare	43.7	15,697	359.14	14,010	320.53	89.2	1,687
Marketplace	4.9	1,915	392.97	1,127	231.33	58.9	788
	48.6	$ 17,612	$ 362.54	$ 15,137	$ 311.59	85.9%	$ 2,475

	Year Ended December 31, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	30.2	$ 5,554	$ 183.75	$ 5,111	$ 169.09	92.0%	$ 443
Medicaid Expansion	8.1	3,150	388.42	2,674	329.73	84.9	476
ABD	4.9	5,135	1,050.41	4,863	994.80	94.7	272
Total Medicaid	43.2	13,839	320.16	12,648	292.61	91.4	1,191
MMP	0.7	1,446	2,177.72	1,317	1,982.36	91.0	129
Medicare	0.5	601	1,143.63	493	939.67	82.2	108
Total Medicare	1.2	2,047	1,722.47	1,810	1,523.15	88.4	237
Total Medicaid and Medicare	44.4	15,886	357.68	14,458	325.53	91.0	1,428
Marketplace	10.8	2,968	274.47	2,615	241.84	88.1	353
	55.2	$ 18,854	$ 341.39	$ 17,073	$ 309.14	90.6%	$ 1,781

	Year Ended December 31, 2016						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	30.2	$ 5,403	$ 179.21	$ 4,950	$ 164.18	91.6%	$ 453
Medicaid Expansion	7.8	2,952	378.58	2,475	317.37	83.8	477
ABD	4.7	4,666	991.24	4,277	908.39	91.6	389
Total Medicaid	42.7	13,021	305.28	11,702	274.33	89.9	1,319
MMP	0.6	1,321	2,160.94	1,141	1,866.93	86.4	180
Medicare	0.5	558	1,063.44	515	981.36	92.3	43
Total Medicare	1.1	1,879	1,653.73	1,656	1,457.67	88.1	223
Total Medicaid and Medicare	43.8	14,900	340.28	13,358	305.03	89.6	1,542
Marketplace	6.7	1,545	231.38	1,416	212.17	91.7	129
	50.5	$ 16,445	$ 325.87	$ 14,774	$ 292.75	89.8%	$ 1,671

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid Program

2018 vs. 2017

Our Medicaid Medical Margin improved $174 million, or 15%, in 2018 when compared with 2017. This improvement was mainly due to an improvement in the MCR from 91.4% to 90.0%, partially offset by a slight decline in premiums. Medicaid premiums declined slightly, mainly due to a carve-out of pharmacy benefits for all Medicaid membership in Washington effective July 1, 2018, $81 million in retroactive California Medicaid Expansion risk corridor adjustments, and a decline in TANF and CHIP membership, partially offset by the impact of rate increases in certain markets and increased quality incentive premium revenue.

Excluding recognition of the retroactive California Medicaid Expansion risk corridor adjustments, the Medicaid MCR would have been 89.4% in 2018, or 200 basis points lower compared with 2017. The improvement in MCR was mainly attributable to improvements in the MCR for TANF and CHIP, primarily at our Illinois, California and Texas health plans, and improvement in the MCR for ABD, due to several actions, including improved network contracting and our management of high acuity members. We also benefited from net favorable prior year claims development in 2018, compared with net unfavorable claims development in 2017. Partially offsetting these improvements was an increase in the MCR for Medicaid Expansion. The increase was due to the retroactive California risk corridor adjustments and the premium reduction we received in California in July 2017. Despite an increase in MCR in 2018, Medicaid Expansion has generally performed well because rate adequacy has trended favorably, and membership is concentrated in our higher performing health plans, particularly California, Michigan, and Washington.

2017 vs. 2016

Medicaid Medical Margin decreased $128 million, or 10%, in 2017 when compared with 2016, mainly due to an increase in the MCR from 89.9% to 91.4%, partially offset by an increase in premiums. Medicaid premiums increased $818 million, or 6%, in 2017 when compared with 2016, mainly due to enrollment growth in Medicaid Expansion and ABD, and higher average premium PMPM in TANF, CHIP and ABD.

The increase in the Medicaid MCR was mainly attributed to a deterioration in ABD medical costs most notably in Michigan, New Mexico and Texas, and an increase in Expansion MCR, principally driven by reduced premium rates in California.

Medicare Program

2018 vs. 2017

The Medicare Medical Margin increased $85 million in 2018, or 36%, when compared with 2017 due mainly to an improvement in the MCR.

The overall MCR for the combined Medicare programs decreased to 84.5% in 2018, from 88.4% in 2017. The improvement in 2018 was due to improved medical management of high-acuity members and long-term services and supports benefits, in addition to increased premium revenue tied to risk scores that is more commensurate with the acuity of our population.

2017 vs. 2016

The Medicare Medical Margin increased slightly in 2017 when compared with 2016, due mainly to an increase in premiums, partially offset by an increase in the MCR. MMP and Medicare enrollment and premium combined grew by approximately 9% in 2017 compared with 2016. The MCR for this membership increased 30 basis points from 2016 to 2017.

Marketplace Program

2018 vs. 2017

The Marketplace Medical Margin increased $435 million in 2018, or 123%, when compared to 2017, due mainly to an improvement in the MCR, partially offset by a $1,053 million decrease in premiums. The lower Marketplace premium revenue was driven by a nearly 60% decrease in membership, partially offset by premium rate increases. As previously disclosed, we increased premium rates and reduced our Marketplace presence effective January 1, 2018, as part of our overall program to improve profitability.

The MCR for the Marketplace program improved to 58.9% in 2018, from 88.1% in 2017. Excluding the combined benefit of the 2017 Marketplace risk adjustment and CSR benefit recognized in 2018, the MCR in 2018 would have been 65.0%. Excluding the changes in Marketplace premium deficiency reserves for 2017 dates of service, the MCR would have been 89.1% for 2017. The year over year improvement is mainly due to the overall program to improve profitability, as discussed above, as well as increased premium revenue tied to risk scores more that is commensurate with the acuity of our population.

2017 vs. 2016

The Marketplace Medical Margin increased by $224 million in 2017, almost double that of 2016, due to an increase in premiums and a reduction in the MCR. The increase in Marketplace premium revenue was driven by a 60% increase in membership in 2017 compared with 2016.

The Marketplace MCR improved to 88.1% in 2017 compared with 91.7% in 2016. Excluding the changes in Marketplace premium deficiency reserves for 2017 dates of service, the MCR would have been 89.1% for 2017. Despite a decrease in the MCR in 2017 compared with 2016, our Marketplace program still failed to meet expectations in 2017.

FINANCIAL PERFORMANCE BY HEALTH PLAN

The following tables summarize member months, premium revenue, medical care costs, MCR, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Medicaid and Medicare

	Year Ended December 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.1	$ 1,931	$ 273.59	$ 1,724	$ 244.21	89.3%	$ 207
Florida	4.2	1,517	360.98	1,414	336.43	93.2	103
Illinois	2.5	793	322.87	670	272.61	84.4	123
Michigan	4.5	1,550	344.42	1,303	289.53	84.1	247
New Mexico	2.6	1,241	474.10	1,140	435.65	91.9	101
Ohio	3.7	2,277	608.29	2,001	534.59	87.9	276
Puerto Rico	3.7	696	186.59	636	170.45	91.4	60
South Carolina	1.4	495	351.38	429	304.85	86.8	66
Texas	2.7	2,296	839.70	2,092	765.12	91.1	204
Washington	9.1	2,178	240.42	1,999	220.72	91.8	179
Other [1]	2.2	723	329.06	602	273.55	83.1	121
	43.7	$ 15,697	$ 359.14	$ 14,010	$ 320.53	89.2%	$ 1,687

	Year Ended December 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.4	$ 2,392	$ 321.46	$ 2,117	$ 284.53	88.5%	$ 275
Florida	4.3	1,522	350.15	1,461	335.97	96.0	61
Illinois	2.1	593	286.69	638	308.41	107.6	(45)
Michigan	4.6	1,545	334.22	1,360	294.15	88.0	185
New Mexico	2.9	1,258	439.95	1,166	407.94	92.7	92
Ohio	3.9	2,130	544.98	1,894	484.66	88.9	236
Puerto Rico	3.8	732	190.13	691	179.65	94.5	41
South Carolina	1.4	445	328.41	412	304.04	92.6	33
Texas	2.8	2,150	769.82	1,978	708.20	92.0	172
Washington	8.9	2,445	275.64	2,143	241.55	87.6	302
Other [1]	2.3	674	292.92	598	259.85	88.7	76
	44.4	$ 15,886	$ 357.68	$ 14,458	$ 325.53	91.0%	$ 1,428

	Year Ended December 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.4	$ 2,247	$ 304.83	$ 1,900	$ 257.72	84.5%	$ 347
Florida	4.1	1,348	329.58	1,227	299.94	91.0	121
Illinois	2.3	603	258.72	568	243.71	94.2	35
Michigan	4.7	1,517	324.18	1,339	286.00	88.2	178
New Mexico	2.8	1,245	440.63	1,162	411.30	93.3	83
Ohio	3.9	1,927	490.71	1,718	437.56	89.2	209
Puerto Rico	4.0	726	180.65	694	172.57	95.5	32
South Carolina	1.3	378	296.58	320	250.97	84.6	58
Texas	2.9	2,182	744.65	1,926	657.38	88.3	256
Washington	8.1	2,146	263.50	1,936	237.66	90.2	210
Other [1]	2.3	581	264.52	568	258.77	97.8	13
	43.8	$ 14,900	$ 340.28	$ 13,358	$ 305.03	89.6%	$ 1,542

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

Health Plans Segment Financial Data — Marketplace

	Year Ended December 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.6	$ 219	$ 325.84	$ 125	$ 187.37	57.5%	$ 94
Florida	0.6	273	498.66	99	181.52	36.4	174
Michigan	0.2	51	250.69	31	150.11	59.9	20
New Mexico	0.3	115	403.55	74	260.29	64.5	41
Ohio	0.3	111	477.03	78	334.32	70.1	33
Texas	2.7	948	356.06	593	222.89	62.6	355
Washington	0.2	183	664.48	140	506.07	76.2	43
Other [1]	—	15	NM	(13)	NM	NM	28
	4.9	$ 1,915	$ 392.97	$ 1,127	$ 231.33	58.9%	$ 788

	Year Ended December 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.7	$ 309	$ 185.88	$ 231	$ 138.61	74.6%	$ 78
Florida	3.6	1,046	293.35	1,009	283.17	96.5	37
Michigan	0.3	51	180.26	38	135.64	75.2	13
New Mexico	0.3	110	349.50	84	264.14	75.6	26
Ohio	0.2	86	363.24	81	340.44	93.7	5
Texas	2.6	663	250.08	517	195.20	78.1	146
Washington	0.5	163	317.39	156	304.74	96.0	7
Other [1]	1.6	540	340.13	499	314.21	92.4	41
	10.8	$ 2,968	$ 274.47	$ 2,615	$ 241.84	88.1%	$ 353

	Year Ended December 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.8	$ 131	$ 166.01	$ 129	$ 164.35	99.0%	$ 2
Florida	2.6	590	228.65	538	208.53	91.2	52
Michigan	—	10	232.88	6	154.32	66.3	4
New Mexico	0.2	60	287.37	47	223.85	77.9	13
Ohio	0.1	40	348.06	29	254.78	73.2	11
Texas	1.4	279	208.48	184	137.13	65.8	95
Washington	0.3	76	272.48	79	284.87	104.5	(3)
Other [1]	1.3	359	271.04	404	304.22	112.2	(45)
	6.7	$ 1,545	$ 231.38	$ 1,416	$ 212.17	91.7%	$ 129

(1) "Other" includes the Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results. We terminated Marketplace operations at these plans effective January 1, 2018, so the ratios for 2018 periods are not meaningful (NM).

Health Plans Segment Financial Data — Total

	Year Ended December 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.7	$ 2,150	$ 278.13	$ 1,849	$ 239.28	86.0%	$ 301
Florida	4.8	1,790	376.84	1,513	318.58	84.5	277
Illinois	2.5	793	322.87	670	272.61	84.4	123
Michigan	4.7	1,601	340.35	1,334	283.47	83.3	267
New Mexico	2.9	1,356	467.17	1,214	418.44	89.6	142
Ohio	4.0	2,388	600.62	2,079	522.89	87.1	309
Puerto Rico	3.7	696	186.59	636	170.45	91.4	60
South Carolina	1.4	495	351.38	429	304.85	86.8	66
Texas	5.4	3,244	601.23	2,685	497.75	82.8	559
Washington	9.3	2,361	252.92	2,139	229.13	90.6	222
Other [1]	2.2	738	336.86	589	268.17	79.6	149
	48.6	$ 17,612	$ 362.54	$ 15,137	$ 311.59	85.9%	$ 2,475

	Year Ended December 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	9.1	$ 2,701	$ 296.68	$ 2,348	$ 257.86	86.9%	$ 353
Florida	7.9	2,568	324.56	2,470	312.18	96.2	98
Illinois	2.1	593	286.69	638	308.41	107.6	(45)
Michigan	4.9	1,596	325.43	1,398	285.11	87.6	198
New Mexico	3.2	1,368	430.97	1,250	393.67	91.3	118
Ohio	4.1	2,216	534.56	1,975	476.39	89.1	241
Puerto Rico	3.8	732	190.13	691	179.65	94.5	41
South Carolina	1.4	445	328.41	412	304.04	92.6	33
Texas	5.4	2,813	516.84	2,495	458.50	88.7	318
Washington	9.4	2,608	277.93	2,299	245.01	88.2	309
Other (1)	3.9	1,214	312.20	1,097	282.06	90.3	117
	55.2	$ 18,854	$ 341.39	$ 17,073	$ 309.14	90.6%	$ 1,781

	Year Ended December 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	8.2	$ 2,378	$ 291.41	$ 2,029	$ 248.70	85.3%	$ 349
Florida	6.7	1,938	290.56	1,765	264.60	91.1	173
Illinois	2.3	603	258.72	568	243.71	94.2	35
Michigan	4.7	1,527	323.36	1,345	284.82	88.1	182
New Mexico	3.0	1,305	430.15	1,209	398.49	92.6	96
Ohio	4.0	1,967	486.66	1,747	432.36	88.8	220
Puerto Rico	4.0	726	180.65	694	172.57	95.5	32
South Carolina	1.3	378	296.58	320	250.97	84.6	58
Texas	4.3	2,461	576.69	2,110	494.41	85.7	351
Washington	8.4	2,222	263.80	2,015	239.21	90.7	207
Other (1)	3.6	940	266.98	972	275.92	103.3	(32)
	50.5	$ 16,445	$ 325.87	$ 14,774	$ 292.75	89.8%	$ 1,671

(1) "Other" includes the Idaho, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

OTHER

Molina Medicaid Solutions. We closed on the sale of Molina Medicaid Solutions ("MMS") to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million. As a result of this transaction, we recognized a pretax gain, net of transaction costs, of $37 million. The gain, net of income tax expense, was $28 million.

Pathways. We closed on the sale of our Pathways behavioral health subsidiary to Pyramid Health Holdings, LLC on October 19, 2018, for a nominal purchase price. As a result of this transaction, we recognized a pretax loss of $52 million. The loss, net of income tax benefit, was $32 million.

FINANCIAL OVERVIEW

The year over year changes in service margin in 2018 and 2017 were insignificant to our consolidated results of operations.

As discussed further in the Notes to Consolidated Financial Statements, Note 8, “Goodwill and Intangible Assets, Net,” in the year ended December 31, 2017, we recorded goodwill impairment losses of $162 million for Pathways, and $28 million for MMS, and intangible assets, net impairment losses of $11 million for Pathways.

LIQUIDITY AND FINANCIAL CONDITION

LIQUIDITY

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

We maintain liquidity at two levels: 1) the regulated health plan subsidiaries; and 2) the parent company. Our regulated health plan subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated health plan subsidiaries is in the form of cash, cash equivalents, and investments.

When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plan subsidiaries is generally paid in the form of dividends to our parent company to be used for general corporate purposes. The regulated health plan subsidiaries paid $288 million, $245 million, and $100 million in such dividends to the parent company in 2018, 2017 and 2016, respectively. Additionally, our unregulated subsidiaries paid $10 million, $41 million, and $1 million in dividends to the parent in 2018, 2017 and 2016, respectively. Conversely, the parent company contributed capital of $145 million, $370 million, and $338 million in 2018, 2017 and 2016, respectively, to our regulated health plan subsidiaries to satisfy statutory net worth requirements.

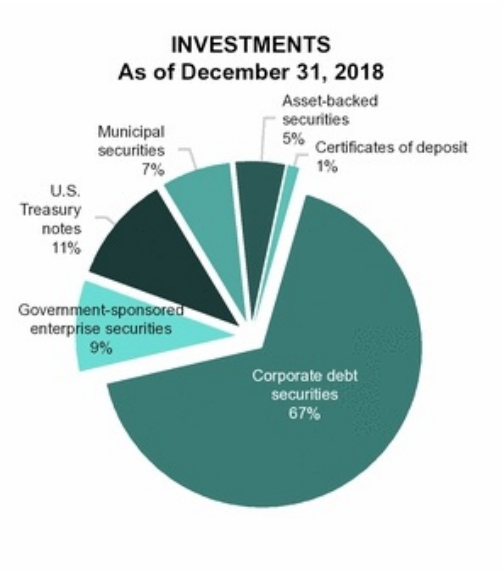
Cash, cash equivalents and investments at the parent company amounted to $170 million and $696 million as of December 31, 2018 and 2017, respectively. The decrease in 2018 was mainly attributed to cash paid to reduce the principal amount of outstanding debt, partially offset by net cash dividends received from our subsidiaries.

Investments

After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels.

Our restricted investments are invested principally in certificates of deposit and U.S. Treasury securities; we have the ability to hold such restricted investments until maturity. All of our unrestricted investments are classified as current assets and are presented in the table below.



Cash Flow Activities

Our cash flows are summarized as follows:

	Year Ended December 31,				
	2018	2017	2016	2017 to 2018 Change	2016 to 2017 Change
			(In millions)		
Net cash (used in) provided by operating activities	$ (314)	$ 804	$ 673	$ (1,118)	$ 131
Net cash provided by (used in) investing activities	1,143	(1,062)	(206)	2,205	(856)
Net cash (used in) provided by financing activities	(1,193)	636	19	(1,829)	617
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	$ (364)	$ 378	$ 486	$ (742)	$ (108)

Operating Activities

We typically receive capitation payments monthly, in advance of payments for medical claims; however, state or federal payors may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. State or federal payors may delay our premium payments, or they may prepay the following month's premium payment.

2018 vs. 2017

Net cash used in operating activities was $314 million in 2018 compared with $804 million of net cash provided in 2017, a decrease in cash of $1,118 million, due to the following factors:

- The timing effect of premium receipts and other revenues negatively impacted our cash flows from operating activities by $633 million on a year-over-year comparative basis. This impact was mainly related to the timing of premiums received at our California, Illinois, Michigan, Ohio, and Washington health plans.
- The decline in medical claims and benefits payable, mainly resulting from reduced Marketplace membership in Florida, Utah, Washington and Wisconsin decreased cash flows from operations by $489 million.
- Settlements with government agencies decreased our cash flows by $915 million on a year-over-year comparative basis, primarily due to payments in the third quarter of 2018, including risk transfer payments associated with our Marketplace health plans.

- The declines discussed above were partially offset by the improved operating performance in our health plans, driven mainly by lower medical care costs.

2017 vs. 2016

Net cash provided by operating activities was $804 million in 2017, compared with $673 million of net cash provided in 2016, an increase in cash of $131 million, due to the following factors:

- The timing effect of premium receipts and other revenues, mainly in our California, Florida, Illinois, and Washington health plans, favorably impacted our cash flows from operating activities by $325 million on a year-over-year comparative basis.
- This improvement was partially offset by: 1) a decrease in cash flows associated with the settlements with government agencies of approximately $132 million, mainly related to provisions that mandate medical cost floors or medical corridors; and 2) a decline in our operating performance.

Investing Activities

2018 vs. 2017

Net cash provided by investing activities was $1,143 million in 2018, compared with $1,062 million of net cash used in 2017, an increase in cash of $2,205 million. The year over year improvement was primarily due to higher proceeds from sales and maturities of investments, net of purchases, in 2018, largely driven by cash flow needs associated with our financing activities, as described below.

2017 vs. 2016

Net cash used in investing activities was $1,062 million in 2017, compared with $206 million of net cash used in 2016, a decrease in cash of $856 million. More cash was used in investing activities in 2017 primarily due to $768 million of increased purchases of investments as a result of the 2017 financing transactions described below, and $207 million decreased proceeds from sales and maturities of investments.

Financing Activities

2018 vs. 2017

Net cash used in financing activities was $1,193 million in 2018, compared with $636 million of net cash provided in 2017, a decrease in cash of $1,829 million, due to the following factors:

- $300 million repayment of the Credit Facility in 2018;
- $847 million net payments for partial repayment of the 1.125% Convertible Notes, and partial settlements of the related 1.125% Conversion Option, 1.125% Call Option and 1.125% Warrants in 2018; and
- $64 million principal repayment of 1.625% Convertible Notes in 2018; partially offset by
- $625 million of proceeds from the issuance of the 4.875% Notes and borrowings under the Credit Facility in 2017.

2017 vs. 2016

Cash provided by financing activities was $636 million in 2017, compared with $19 million of net cash provided in 2016, an increase in cash of $617 million. In 2017, cash inflows included $325 million for the net proceeds from our issuance of the 4.875% Notes, and borrowings under our Credit Facility, with no comparable activity in 2016.

FINANCIAL CONDITION

We believe that our cash resources, borrowing capacity available under our Credit Agreement as discussed further below in “Future Sources and Uses of Liquidity—Future Sources,” and internally generated funds will be sufficient to support our operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months.

On a consolidated basis, at December 31, 2018, our working capital was $2,216 million compared with $1,954 million at December 31, 2017. At December 31, 2018, our cash and investments amounted to $4,629 million, compared with $6,000 million of cash and investments at December 31, 2017.

Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by our unregulated parent and subsidiaries. For more information, see the *Liquidity* discussion presented earlier in this section of the MD&A.

Debt Ratings

Our 5.375% Notes and 4.875% Notes are rated “BB-” by Standard & Poor’s, and “B3” by Moody’s Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs.

Financial Covenants

Our Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Agreement.

Credit Agreement Financial Covenants	Required Per Agreement	As of December 31, 2018
Net leverage ratio	<4.0x	1.1x
Interest coverage ratio	>3.5x	13.6x

In addition, the terms of our 4.875% Notes, 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. As of December 31, 2018, we were in compliance with all covenants under the Credit Agreement and the indentures governing our outstanding notes.

Capital Plan Progress

In the year ended December 31, 2018, we have reduced the principal amount of our outstanding debt by $759 million.

In the fourth quarter of 2018, we repaid $62 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to partially terminate the related 1.125% Call Option and 1.125% Warrants.

In the third quarter of 2018, we repaid $140 million aggregate principal amount of our 1.125% Convertible Notes and entered into privately negotiated termination agreements to partially terminate the related 1.125% Call Option and 1.125% Warrants. In addition, we converted the remaining $64 million aggregate principal amount of our 1.625% Convertible Notes for cash and 0.6 million shares of our common stock. We also terminated our bridge credit agreement in the third quarter of 2018.

In the second quarter of 2018, we repaid $300 million outstanding under our Credit Facility. In addition, we repaid $96 million aggregate principal amount of our 1.125% Convertible Notes, and entered into privately negotiated termination agreements to partially terminate the related 1.125% Call Option and 1.125% Warrants.

In the first quarter of 2018, we exchanged $97 million aggregate principal amount and accrued interest of our 1.625% Convertible Notes for 1.8 million shares of our common stock.

FUTURE SOURCES AND USES OF LIQUIDITY

Future Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. For more information on our regulatory capital requirements and dividend restrictions, refer to Notes to Consolidated Financial Statements, Note 17, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions,” and Note 20, “Condensed Financial Information of Registrant—Note C - Dividends and Capital Contributions.”

Borrowing Capacity and Debt Financing. On January 31, 2019, we entered into a Sixth Amendment to the Credit Agreement that provides for a delayed draw term loan facility in an aggregate principal amount of $600 million (the “Term Loan”), under which we may request up to ten advances, each in a minimum principal amount of $50 million,

until 18 months after January 31, 2019. In addition, we have available borrowing capacity of $493 million under our Credit Facility. See further discussion in the Notes to Consolidated Financial Statements, Note 11, “Debt.”

Savings from Restructuring Plans. Our new executive team has focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we implemented a plan to restructure our information technology department (the “IT Restructuring Plan”) in the third quarter of 2018. As a part of that plan, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. We expect the IT Restructuring Plan to be completed by the end of 2019. We currently estimate that the IT Restructuring Plan will reduce annualized run-rate expenses by approximately $15 million to $20 million in the first full year, increasing up to approximately $30 million to $35 million by the end of the fifth full year. Such savings, if achieved, would reduce Other segment “General and administrative expenses” in our consolidated statements of operations.

Under the restructuring plan we implemented in 2017 (the “2017 Restructuring Plan”), we achieved savings in our Health Plans and Other segments, which have reduced both “General and administrative expenses” and “Medical care costs” reported in our consolidated statements of operations. The following table illustrates the run-rate savings realized under the 2017 Restructuring Plan:

Run-Rate Savings Realized by Reportable Segment	Health Plans	Other	Total
		(In millions)	
General and administrative expenses	$ 60	$ 93	$ 153
Medical care costs	168	23	191
	$ 228	$ 116	$ 344

Further details of the restructuring plans, including costs associated with such plans, are described in the Notes to Consolidated Financial Statements, Note 15, “Restructuring and Separation Costs.”

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering.

Future Uses

Regulatory Capital Requirements and Dividend Restrictions. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with minimum statutory capital requirements.

1.125% Convertible Notes. The fair value of the 1.125% Convertible Notes was $732 million as of December 31, 2018, which includes both the principal amount outstanding and the fair value of the 1.125% Conversion Option. Refer to the Notes to Consolidated Financial Statements, Note 11, “Debt,” for a detailed discussion of our convertible notes, including recent transactions. The 1.125% Convertible Notes are convertible by the holders within one year of December 31, 2018, until they mature; therefore, they are reported in current portion of long-term debt. If conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the applicable indenture. We have sufficient available cash, combined with borrowing capacity available under our Credit Agreement (including the Term Loan described above), to fund conversions should they occur.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting estimates relate to:

- *Medical claims and benefits payable.* See discussion below, and refer to the Notes to Consolidated Financial Statements, Notes 2, “Significant Accounting Policies,” and 10, “Medical Claims and Benefits Payable” for more information.

- *Contractual provisions that may adjust or limit revenue or profit.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”
- *Quality incentives.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”
- *Goodwill and intangible assets, net.* At December 31, 2018, goodwill and intangible assets, net, represented approximately 3% of total assets and 12% of total stockholders’ equity, compared with 3% and 19%, respectively, at December 31, 2017. For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies,” and Note 8, “Goodwill and Intangible Assets, Net.”

MEDICAL CARE COSTS
MEDICAL CLAIMS AND BENEFITS PAYABLE

Medical care costs are recognized in the period in which services are provided and include amounts that have been paid by us through the reporting date, as well as estimated medical claims and benefits payable for costs that have been incurred but not paid by us as of the reporting date. Medical care costs include, among other items, fee-for-service claims, pharmacy benefits, capitation payments to providers, and various other medically-related costs. We use judgment to determine the appropriate assumptions for determining the required estimates.

Under fee-for-service claims arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of hospital and physician services. Pharmacy benefits represent payments for members' prescription drug costs, net of rebates from drug manufacturers. We estimate pharmacy rebates earned based on historical and current utilization of prescription drugs and contract terms. Capitation payments represent monthly contractual fees paid to physicians and other providers on a per-member, per-month basis, who are responsible for providing medical care to members, which could include medical or ancillary costs like dental, vision and other supplemental health benefits. Such capitation costs are fixed in advance of the periods covered and are not subject to significant accounting estimates. Due to insolvency or other circumstances, such providers may be unable to pay claims they have incurred with third parties in connection with referral services provided to our members. Depending on states’ laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Based on our current assessment, such losses have not been and are not expected to be significant. Other medical care costs include all medically-related administrative costs, certain provider incentive costs, provider claims, and other health care expenses. See further discussion of provider claims in Notes to Consolidated Financial Statements, Note 17, “Commitments and Contingencies.” Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. Additionally, we include an estimate for the cost of settling claims incurred through the reporting date in our medical claims and benefits payable liability.

The following table provides the details of our medical claims and benefits payable as of the dates indicated.

	December 31,		
	2018	2017	2016
	(In millions)		
Fee-for-service claims incurred but not paid (“IBNP”)	$ 1,562	$ 1,717	$ 1,352
Pharmacy payable	115	112	112
Capitation payable	52	67	37
Other	232	296	428
	$ 1,961	$ 2,192	$ 1,929

(1) “Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. As of December 31, 2018, 2017, and 2016, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $107 million, $122 million and $225 million, respectively.

The determination of our liability for fee-for-service claims incurred but not paid ("IBNP") is particularly important to the determination of our financial position and results of operations in any given period and requires the application of a significant degree of judgment by our management.

As a result, the determination of IBNP is subject to an inherent degree of uncertainty. Our IBNP claims reserve represents our best estimate of the total amount we will ultimately pay with respect to claims incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on several factors.

The factors we consider when estimating our IBNP include, without limitation:

- claims receipt and payment experience (and variations in that experience),
- changes in membership,
- provider billing practices,
- health care service utilization trends,
- cost trends,
- product mix,
- seasonality,
- prior authorization of medical services,
- benefit changes,
- known outbreaks of disease or increased incidence of illness such as influenza,
- provider contract changes,
- changes to Medicaid fee schedules, and
- the incidence of high dollar or catastrophic claims.

Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fourth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2018 that would result if we change our completion factors for the fourth through the twelfth months preceding December 31, 2018, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in millions.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 554
(4)%	369
(2)%	185
2%	(185)
4%	(369)
6%	(554)

For the three months of service immediately prior to the reporting date, actual claims paid are a less reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on a blend of estimated completion factors and trended PMPM cost estimates. The PMPM costs estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, pharmacy utilization and other relevant factors.

The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2018 that would result if we alter our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in millions.

(Decrease) Increase in Trended Per Member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (185)
(4)%	(124)
(2)%	(62)
2%	62
4%	124
6%	185

The following per-share amounts are based on a combined federal and state statutory tax rate of 22%, and 67 million diluted shares outstanding for the year ended December 31, 2018. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2018, net income for the year ended December 31, 2018 would increase or decrease by approximately $72 million, or $1.08 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2018, net income for the year ended December 31, 2018 would increase or decrease by approximately $24 million, or $0.36 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $360 million, or $5.41 per diluted share, and $121 million, or $1.81 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, changes in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $72 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse development in our claim payments for which the base actuarial model is not intended to and does not account. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP, and averages between 8% to 10% of IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled, changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded.

The use of a consistent methodology (including a consistent provision for adverse claims development) in estimating our liability for medical claims and benefits payable minimizes the degree to which the estimate of that liability at the close of one period may materially differ compared to our actual experience and affect consolidated

results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. For example, any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate, to the extent that replenishment of reserves is not equal to the benefit recognized due to the absence of adverse development. Conversely, in the presence of adverse claims development, the financial impact of recording claims expense in the current period that is related to dates of service in the prior period will be compounded by the need to replenish the provision for adverse development.

The development of our IBNP estimate is a continuous process that we monitor and update monthly as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported and may be required to do so again in the future. Any significant increases to prior period claim reserves would materially decrease reported earnings for the period in which the adjustment is made.

There are many related factors working in conjunction with one another that determine the accuracy of our estimates, some of which are qualitative in nature rather than quantitative. Therefore, we are seldom able to quantify the impact that any single factor has on a change in estimate. Given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, changes in estimates involving trended PMPM costs will almost always be accompanied by changes in estimates involving completion factors, and vice versa. In such circumstances, changes in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. Such reinsurance coverage does not relieve us of our primary obligation to our policyholders. We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs.

Refer to the Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies,” and Note 10, “Medical Claims and Benefits Payable,” for additional information regarding the specific factors used to determine our changes in estimates of IBNP, as well as a table presenting the components of the change in our medical claims and benefits payable, for all periods presented in the accompanying consolidated financial statements.

CONTRACTUAL OBLIGATIONS

In the table below, we present our contractual obligations as of December 31, 2018. Some of the amounts included in this table are based on management’s estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table.

Additionally, we have a variety of other contractual agreements related to acquiring services used in our operations. However, we believe these other agreements do not contain material non-cancelable commitments.

	Total [1]	2019	2020-2021	2022-2023	2024 and after
			(In millions)		
Medical claims and benefits payable	$ 1,961	$ 1,961	$ —	$ —	$ —
Principal amount of debt [2]	1,282	—	252	700	330
Amounts due government agencies	967	967	—	—	—
Lease financing obligations	411	19	39	42	311
Interest on long-term debt	253	57	108	65	23
Operating leases	147	46	58	28	15
Purchase commitments	8	5	3	—	—
	$ 5,029	$ 3,055	$ 460	$ 835	$ 679

(1) As of December 31, 2018, we have recorded approximately $20 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Notes to Consolidated Financial Statements, Note 13, "Income Taxes."

(2) Represents the principal amounts due on our 1.125% Convertible Notes due 2020, 5.375% Notes due 2022, and our 4.875% Notes due 2025.

Commitments and Contingencies. We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in the Notes to Consolidated Financial Statements, Note 17, "Commitments and Contingencies."

INFLATION

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

COMPLIANCE COSTS

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk relating changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2018, the fair value of our fixed income investments would decrease by approximately $14 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to the Notes to Consolidated Financial Statements, Note 4, "Fair Value Measurements," Note 5, "Investments," and Note 9, "Restricted Investments."

Borrowings under our Credit Agreement, including both the Credit Facility and the Term Loan, bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. As of December 31, 2018, no amounts were outstanding under the Credit Facility. See Notes to Consolidated Financial Statements, Note 11, “Debt,” for more information.

FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

	Year Ended December 31,		
	2018	2017	2016
	(In millions, except per-share data)		
Revenue:			
Premium revenue	$ 17,612	$ 18,854	$ 16,445
Service revenue	407	521	539
Premium tax revenue	417	438	468
Health insurer fees reimbursed	329	—	292
Investment income and other revenue	125	70	38
Total revenue	18,890	19,883	17,782
Operating expenses:			
Medical care costs	15,137	17,073	14,774
Cost of service revenue	364	492	485
General and administrative expenses	1,333	1,594	1,393
Premium tax expenses	417	438	468
Health insurer fees	348	—	217
Depreciation and amortization	99	137	139
Restructuring and separation costs	46	234	—
Impairment losses	—	470	—
Total operating expenses	17,744	20,438	17,476
Loss on sales of subsidiaries, net of gain	(15)	—	—
Operating income (loss)	1,131	(555)	306
Other expenses, net:			
Interest expense	115	118	101
Other expenses (income), net	17	(61)	—
Total other expenses, net	132	57	101
Income (loss) before income tax expense (benefit)	999	(612)	205
Income tax expense (benefit)	292	(100)	153
Net income (loss)	$ 707	$ (512)	$ 52
Net income (loss) per share:			
Basic	$ 11.57	$ (9.07)	$ 0.93
Diluted	$ 10.61	$ (9.07)	$ 0.92
Weighted average shares outstanding:			
Basic	61	56	55
Diluted	67	56	56

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Net income (loss)	$ 707	$ (512)	$ 52
Other comprehensive (loss) income:			
Unrealized investment (loss) gain	(3)	(5)	3
Less: effect of income taxes	(1)	(2)	1
Other comprehensive (loss) income, net of tax	(2)	(3)	2
Comprehensive income (loss)	$ 705	$ (515)	$ 54

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2018	2017
	(In millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,826	$ 3,186
Investments	1,681	2,524
Restricted investments	—	169
Receivables	1,330	871
Prepaid expenses and other current assets	149	239
Derivative asset	476	522
Total current assets	6,462	7,511
Property, equipment, and capitalized software, net	241	342
Goodwill and intangible assets, net	190	255
Restricted investments	120	119
Deferred income taxes	117	103
Other assets	24	141
	$ 7,154	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,961	$ 2,192
Amounts due government agencies	967	1,542
Accounts payable and accrued liabilities	390	366
Deferred revenue	211	282
Current portion of long-term debt	241	653
Derivative liability	476	522
Total current liabilities	4,246	5,557
Long-term debt	1,020	1,318
Lease financing obligations	197	198
Other long-term liabilities	44	61
Total liabilities	5,507	7,134
Stockholders' equity:		
Common stock, $0.001 par value per share; 150 million shares authorized; outstanding: 62 million shares at December 31, 2018 and 60 million shares at December 31, 2017	—	—
Preferred stock, $0.001 par value per share; 20 million shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	643	1,044
Accumulated other comprehensive loss	(8)	(5)
Retained earnings	1,012	298
Total stockholders' equity	1,647	1,337
	$ 7,154	$ 8,471

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
Balance at January 1, 2016	56	$ —	$ 803	$ (4)	$ 758	$ 1,557
Net income	—	—	—	—	52	52
Other comprehensive income, net	—	—	—	2	—	2
Share-based compensation	1	—	36	—	—	36
Tax benefit from share-based compensation	—	—	2	—	—	2
Balance at December 31, 2016	57	—	841	(2)	810	1,649
Net loss	—	—	—	—	(512)	(512)
Exchange of 1.625% Convertible Notes	3	—	161	—	—	161
Other comprehensive loss, net	—	—	—	(3)	—	(3)
Share-based compensation	—	—	42	—	—	42
Balance at December 31, 2017	60	—	1,044	(5)	298	1,337
Net income	—	—	—	—	707	707
Adoption of Topic 606	—	—	—	—	6	6
Adoption of ASU 2018-02	—	—	—	(1)	1	—
Partial termination of 1.125% Warrants	—	—	(550)	—	—	(550)
Exchange of 1.625% Convertible Notes	2	—	108	—	—	108
Conversion of 1.625% Convertible Notes	—	—	4	—	—	4
Other comprehensive loss, net	—	—	—	(2)	—	(2)
Share-based compensation	—	—	37	—	—	37
Balance at December 31, 2018	62	$ —	$ 643	$ (8)	$ 1,012	$ 1,647

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Operating activities:			
Net income (loss)	$ 707	$ (512)	$ 52
Adjustments to reconcile net income (loss) to net cash (used in) provided by operating activities:			
Depreciation and amortization	127	178	182
Deferred income taxes	(6)	(94)	22
Share-based compensation	27	46	26
Non-cash restructuring charges	17	60	—
Amortization of convertible senior notes and lease financing obligations	22	32	31
Loss on sales of subsidiaries, net of gain	15	—	—
Loss on debt extinguishment	22	14	—
Impairment losses	—	470	—
Other, net	4	21	16
Changes in operating assets and liabilities:			
Receivables	(530)	103	(348)
Prepaid expenses and other current assets	6	(56)	(69)
Medical claims and benefits payable	(226)	263	226
Amounts due government agencies	(574)	341	473
Accounts payable and accrued liabilities	45	(12)	(4)
Deferred revenue	(21)	(34)	92
Income taxes	51	(16)	(26)
Net cash (used in) provided by operating activities	(314)	804	673
Investing activities:			
Purchases of investments	(1,444)	(2,697)	(1,929)
Proceeds from sales and maturities of investments	2,445	1,759	1,966
Purchases of property, equipment and capitalized software	(30)	(86)	(176)
Net cash received from sale of subsidiaries	190	—	—
Net cash paid in business combinations	—	—	(48)
Other, net	(18)	(38)	(19)
Net cash provided by (used in) investing activities	1,143	(1,062)	(206)
Financing activities:			
Repayment of credit facility	(300)	—	—
Repayment of principal amount of 1.125% Convertible Notes	(298)	—	—
Cash paid for partial settlement of 1.125% Conversion Option	(623)	—	—
Cash received for partial settlement of 1.125% Call Option	623	—	—
Cash paid for partial termination of 1.125% Warrants	(549)	—	—
Repayment of principal amount of 1.625% Convertible Notes	(64)	—	—
Proceeds from senior notes offerings, net of issuance costs	—	325	—
Proceeds from borrowings under credit facility	—	300	—
Other, net	18	11	19
Net cash (used in) provided by financing activities	(1,193)	636	19
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(364)	378	486
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	3,290	2,912	2,426
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 2,926	$ 3,290	$ 2,912

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(continued)

	Year Ended December 31,		
	2018	**2017**	**2016**
	(In millions)		
Supplemental cash flow information:			
Cash paid during the period for:			
Income taxes	$ 240	$ 7	$ 153
Interest	$ 93	$ 78	$ 66
Schedule of non-cash investing and financing activities:			
1.625% Convertible Notes exchange transaction:			
Common stock issued in exchange for 1.625% Convertible Notes	$ 131	$ 193	$ —
Component of 1.625% Convertible Notes allocated to additional paid-in capital, net of income taxes	(23)	(32)	—
Net increase to additional paid-in capital	$ 108	$ 161	$ —
Common stock used for stock-based compensation	$ (6)	$ (22)	$ (8)
Details of sales of subsidiaries:			
Decrease in carrying amount of assets	$ (327)	$ —	$ —
Decrease in carrying amount of liabilities	85	—	—
Transaction costs	(15)	—	—
Cash received from buyers	242	—	—
Loss on sale of subsidiaries, net of gain	$ (15)	$ —	$ —
Details of business combinations:			
Fair value of assets acquired	$ —	$ —	$ (186)
Fair value of liabilities assumed	—	—	28
Payable to seller	—	—	8
Amounts advanced for acquisitions	—	—	102
Net cash paid in business combinations	$ —	$ —	$ (48)
Details of change in fair value of derivatives, net:			
Gain (loss) on 1.125% Call Option	$ 577	$ 255	$ (107)
(Loss) gain on 1.125% Conversion Option	(577)	(255)	107
Change in fair value of derivatives, net	$ —	$ —	$ —

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces (the "Marketplace"). We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. Our Other segment includes the historical results of the Pathways behavioral health subsidiary, which we sold in the fourth quarter of 2018, and certain corporate amounts not allocated to the Health Plans segment. Effective in the fourth quarter of 2018, we reclassified the historical results relating to our Molina Medicaid Solutions ("MMS") segment, which we sold in the third quarter of 2018, to the Other segment. Previously, results for MMS were reported in a stand-alone segment.

We operate health plans in 14 states and the Commonwealth of Puerto Rico. As of December 31, 2018, these health plans served approximately 3.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization ("HMO").

Our state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal ("RFP") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Recent Developments – Health Plans Segment

Mississippi Health Plan. Our Mississippi health plan commenced operations on October 1, 2018 and served approximately 26,000 Medicaid members as of December 31, 2018. In December 2018, our Mississippi health plan was awarded a contract by the Mississippi Division of Medicaid for the Children's Health Insurance Program ("CHIP"). Services under the new three-year contract were initially set to begin July 1, 2019; however, the start date is now pending the outcome of a protest of the contract awards.

Puerto Rico Health Plan. In July 2018, our Puerto Rico health plan was selected by the Puerto Rico Health Insurance Administration to be one of the organizations to administer the Commonwealth's new Medicaid Managed Care contract. As of December 31, 2018, we served approximately 252,000 members under the new contract, which represents a reduction in membership compared with 320,000 members served as of September 30, 2018. The new contract commenced on November 1, 2018 and has a three-year term with an optional one year extension. The Puerto Rico health plan's premium revenue amounted to $696 million in the year ended December 31, 2018.

Florida Health Plan. In June 2018, our Florida health plan was awarded comprehensive Medicaid Managed Care contracts by the Florida Agency for Health Care Administration in Regions 8 and 11 of the Florida Statewide Medicaid Managed Care Invitation to Negotiate. Under the new contracts, effective January 1, 2019, we serve approximately 98,000 Medicaid members in those regions, which represented premium revenue of approximately $462 million in the year ended December 31, 2018. As of December 31, 2018, we served a total of 272,000 Medicaid members in Florida, which represented premium revenue of approximately $1,479 million in the year ended December 31, 2018.

Washington Health Plan. In May 2018, our Washington health plan was selected by the Washington State Health Care Authority to enter into a managed care contract for the eight remaining regions of the state's Apple Health Integrated Managed Care program, in addition to the two regions previously awarded to us. As of December 31, 2018, we served approximately 751,000 Medicaid members in Washington, which represented premium revenue of approximately $2,035 million in the year ended December 31, 2018.

New Mexico Health Plan. In January 2018, we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. A hearing was held on our judicial protest on

October 17, 2018, and our protest was rejected. We filed an appeal with the New Mexico Court of Appeals on January 28, 2019. We are continuing to manage the business in run-off until the determination of these further appeals or our decision not to pursue our appeal rights. As of December 31, 2018, we served approximately 196,000 Medicaid members in New Mexico, and Medicaid premium revenue amounted to $1,181 million in the year ended December 31, 2018. Our New Mexico health plan continues to serve Medicare and Marketplace members, but, effective January 1, 2019, no longer has Medicaid members.

Recent Developments – Other

Molina Medicaid Solutions. We closed on the sale of Molina Medicaid Solutions ("MMS") to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million. As a result of this transaction, we recognized a pretax gain, net of transaction costs, of $37 million. The gain, net of income tax expense, was $28 million.

Pathways. We closed on the sale of our Pathways behavioral health subsidiary to Pyramid Health Holdings, LLC on October 19, 2018, for a nominal purchase price. As a result of this transaction, we recognized a pretax loss of $52 million. The loss, net of income tax benefit, was $32 million.

Presentation and Reclassification

We have reclassified certain amounts in the 2017 and 2016 consolidated statements of cash flows to conform to the 2018 presentation, relating to the presentation of restricted cash and cash equivalents. The reclassification is a result of our adoption of Accounting Standards Update ("ASU") 2016-18, *Restricted Cash* effective January 1, 2018. See Note 2, "Significant Accounting Policies," for further information, including the amount reclassified.

We have combined certain line items in the accompanying consolidated balance sheets. For all periods presented, we have combined the presentation of:

- Income taxes refundable with "Prepaid expenses and other current assets;"
- Income taxes payable with "Accounts payable and accrued liabilities;" and
- Goodwill, and intangible assets, net to a single line.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., and its subsidiaries. As of December 31, 2018, we were no longer a party to any variable interest entities following the termination of certain agreements earlier in the year and in the fourth quarter of 2018. Such variable interest entities were insignificant. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable of our Health Plans segment;
- Health plans' contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plans' quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Settlements under risk or savings sharing programs;
- The assessment of long-lived and intangible assets, and goodwill, for impairment;
- The determination of reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Certain of our significant accounting policies are discussed within the note to which they specifically relate.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in "Restricted investments" in the accompanying consolidated balance sheets.

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Cash and cash equivalents	$ 2,826	$ 3,186	$ 2,819
Restricted cash and cash equivalents, non-current	100	95	93
Restricted cash and cash equivalents, current	—	9	—
Total cash, cash equivalents, and restricted cash and cash equivalents presented in the consolidated statements of cash flows	$ 2,926	$ 3,290	$ 2,912

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income (loss). The cost of securities sold is determined using the specific-identification method.

Our investment policy requires that all of our investments have final maturities of 10 years or less (excluding variable rate securities where interest rates may be periodically reset), and that the average maturity be three years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our investments, see Note 4, "Fair Value Measurements," Note 5, "Investments," and Note 9, "Restricted Investments."

Long-Lived Assets, including Intangible Assets

Long-lived assets consist primarily of property, equipment, capitalized software (see Note 7, "Property, Equipment, and Capitalized Software, Net"), and intangible assets resulting from acquisitions. Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at fair value and are then amortized on a straight-line basis over their expected useful lives, generally between five and 15 years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators, including the ability of our health plan subsidiaries to obtain the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment. Refer to Note 8, "Goodwill and Intangible Assets, Net", for further details.

Goodwill and Business Combinations

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Such events or circumstances may include experienced or expected operating cash-flow deterioration or losses, significant losses of membership, loss of state funding, loss of state contracts, and other factors. Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss and adjusted if necessary for the impact of tax-deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit. Our reporting units consist of our individual health plans.

During the fourth quarter of 2018, we changed the date of our annual impairment testing of goodwill from December 31 to October 1. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value, we perform the quantitative assessment.

We may also elect to bypass the qualitative assessment and proceed directly to the quantitative assessment. The dynamic economic and political environments in which we operate may necessitate the performance of a quantitative test to prove that goodwill is not impaired. If performing a quantitative assessment, we generally estimate the fair values of our reporting units by applying the income approach, using discounted cash flows. For the annual impairment test, the base year in the reporting units' discounted cash flows is derived from the annual financial budgeting cycle, for which the planning process commences in the fourth quarter of the year. When computing discounted cash flows, we make assumptions about a wide variety of internal and external factors, and consider what the reporting unit's selling price would be in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free cash flow (including significant assumptions about membership, premium rates, health care and operating cost trends, contract renewal and the procurement of new contracts, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. When determining the discount rate, we consider the overall level of inherent risk of the reporting unit, and the expected rate an outside investor would expect to earn. As part of a quantitative assessment, we may also apply the asset liquidation method to estimate the fair value of individual reporting units, which is computed as total assets minus total liabilities, excluding intangible assets and deferred taxes. Finally, we apply a market approach to reconcile the value of our reporting units to our consolidated market value. Under the market approach, we consider publicly traded comparable company information to determine revenue and earnings multiples which are used to estimate our reporting units' fair values. The assumptions used are consistent with those used in our long-range business plan and annual planning process. However, if these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected.

Accounting for acquisitions requires us to recognize separately from goodwill the assets acquired and the liabilities assumed at their acquisition date fair values. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Upon the conclusion of the final determination of the values of assets acquired or liabilities assumed, or one year after the date of acquisition, whichever comes first, any subsequent adjustments are recorded within our consolidated statements of operations. Refer to Note 8, "Goodwill and Intangible Assets, Net", for further details.

Revenue Recognition

We adopted ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)* effective January 1, 2018, using the modified retrospective approach. The insurance contracts of our Health Plans segment are excluded from the scope of Topic 606 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts. The cumulative effect of initially applying the guidance, relating entirely to the contracts of our recently divested MMS subsidiary, resulted in an immaterial impact to beginning retained earnings as of January 1, 2018. Such impact is presented in the accompanying consolidated statement of stockholders' equity.

Premium Revenue

Premium revenue is generated from our Health Plans segment contracts, including agreements with other managed care organizations for which we operate as a subcontractor. Premium revenue is generally received based on per

member per month ("PMPM") rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. The state Medicaid programs and the federal Medicare program periodically adjust premiums. Additionally, many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is earned under such provisions.

The following table summarizes premium revenue by geography for the periods indicated:

	Year Ended December 31,					
	2018		2017		2016	
	Amount	% of Total	Amount	% of Total	Amount	% of Total
	(Dollars in millions)					
California	$ 2,150	12.2%	$ 2,701	14.3%	$ 2,378	14.4%
Florida	1,790	10.2	2,568	13.6	1,938	11.8
Illinois	793	4.5	593	3.1	603	3.7
Michigan	1,601	9.1	1,596	8.5	1,527	9.3
New Mexico	1,356	7.7	1,368	7.3	1,305	7.9
Ohio	2,388	13.6	2,216	11.8	1,967	12.0
Puerto Rico	696	3.9	732	3.9	726	4.4
South Carolina	495	2.8	445	2.4	378	2.3
Texas	3,244	18.4	2,813	14.9	2,461	15.0
Washington	2,361	13.4	2,608	13.8	2,222	13.5
Other [1]	738	4.2	1,214	6.4	940	5.7
	$ 17,612	100.0%	$ 18,854	100.0%	$ 16,445	100.0%

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid Program

Medical Cost Floors (Minimums), and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $103 million and $135 million at December 31, 2018 and December 31, 2017, respectively, to amounts due government agencies. Approximately $87 million and $96 million of the liability accrued at December 31, 2018 and December 31, 2017, respectively, relates to our participation in Medicaid Expansion programs.

In the third and fourth quarters of 2018, we recognized adjustments of $57 million and $24 million, respectively, mainly related to the retroactive reinstatement of the Medicaid Expansion risk corridor requirement by the California Department of Health Care Services, mainly for the state fiscal years ended June 2017 and 2018. The risk corridor provision mandates a minimum loss ratio ("MLR") of 85% and a maximum MLR of 95%. The total impact of these adjustments resulted in a reduction to premium revenue totaling approximately $81 million in the year ended December 31, 2018.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at December 31, 2018 and December 31, 2017.

Profit Sharing and Profit Ceiling. Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at December 31, 2018 and December 31, 2017.

Retroactive Premium Adjustments. State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare Program

Risk Adjusted Premiums: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and CMS practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjusted premiums and Medicare Part D settlements were insignificant at December 31, 2018 and December 31, 2017.

Minimum MLR: Additionally, federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations. Aggregate balance sheet amounts related to the Medicare Minimum MLR were insignificant at December 31, 2018 and December 31, 2017.

Marketplace Program

Risk adjustment: Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score, and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of operations. As of December 31, 2018, and December 31, 2017, the Marketplace risk adjustment payable amounted to $466 million and $917 million, respectively.

Minimum MLR: The ACA has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations. Aggregate balance sheet amounts related to the Marketplace Minimum MLR were insignificant at December 31, 2018 and December 31, 2017.

Quality Incentives

At many of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2018 are not known, we have no reason to believe that the adjustments to prior periods noted below are not indicative of the potential future changes in our estimates as of December 31, 2018.

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Maximum available quality incentive premium - current period	$ 182	$ 150	$ 147
Amount of quality incentive premium revenue recognized in current period:			
Earned current period	$ 133	$ 97	$ 104
Earned prior periods	31	10	47
Total	$ 164	$ 107	$ 151
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.9%	0.6%	0.9%

A summary of the categories of amounts due government agencies is as follows:

	December 31,	
	2018	2017
	(In millions)	
Medicaid program:		
Medical cost floors and corridors	$ 103	$ 135
Other amounts due to states	81	71
Marketplace program:		
Risk adjustment	466	917
Cost sharing reduction	183	275
Other	134	144
	$ 967	$ 1,542

Medical Care Costs and Medical Claims and Benefits Payable

Medical care costs are recognized in the period in which services are provided and include amounts that have been paid by us through the reporting date, as well as estimated medical claims and benefits payable for costs that have been incurred but not paid by us as of the reporting date. Medical care costs include, among other items, fee-for-service claims, pharmacy benefits, capitation payments to providers, and various other medically-related costs. We use judgment to determine the appropriate assumptions for determining the required estimates.

Under fee-for-service claims arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of hospital and physician services. Pharmacy benefits represent payments for members' prescription drug costs, net of rebates from drug manufacturers. We estimate pharmacy rebates earned based on historical and current utilization of prescription drugs and contract terms. Capitation payments represent monthly contractual fees paid to physicians and other providers on a per-member, per-month basis, who are responsible for providing medical care to members, which could include medical or ancillary costs like dental, vision and other supplemental health benefits. Such capitation costs are fixed in advance of the periods covered and are not subject to significant accounting estimates. Due to insolvency or other circumstances, such providers may be unable to pay claims they have incurred with third parties in connection with referral services provided to our members. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Based on our current assessment, such losses have not been and are not expected to be significant. Other medical care costs include all medically-related administrative costs, certain provider incentive costs, provider claims, and other health care expenses. See further discussion of provider claims in Note 17, "Commitments and Contingencies." Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. Additionally, we include an estimate for the cost of settling claims incurred through the reporting date in our medical claims and benefits payable liability.

The following table provides the details of our consolidated medical care costs for the periods indicated:

	Year Ended December 31,								
	2018			2017			2016		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
	(In millions, except PMPM amounts)								
Fee-for-service	$ 11,278	$ 232.15	74.5%	$ 12,682	$ 229.63	74.3%	$ 10,993	$ 217.84	74.4%
Pharmacy	2,138	44.01	14.1	2,563	46.40	15.0	2,213	43.84	15.0
Capitation	1,184	24.38	7.8	1,360	24.63	8.0	1,218	24.13	8.2
Other	537	11.05	3.6	468	8.48	2.7	350	6.94	2.4
Total	$ 15,137	$ 311.59	100.0%	$ 17,073	$ 309.14	100.0%	$ 14,774	$ 292.75	100.0%

The determination of our liability for fee-for-service claims incurred but not paid ("IBNP") is particularly important to the determination of our financial position and results of operations in any given period and requires the application of a significant degree of judgment by our management.

As a result, the determination of IBNP is subject to an inherent degree of uncertainty. Our IBNP claims reserve represents our best estimate of the total amount we will ultimately pay with respect to claims incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on several factors. The factors we consider when estimating our IBNP include, without limitation:

- claims receipt and payment experience (and variations in that experience),
- changes in membership,
- provider billing practices,
- health care service utilization trends,
- cost trends,
- product mix,
- seasonality,
- prior authorization of medical services,
- benefit changes,
- known outbreaks of disease or increased incidence of illness such as influenza,
- provider contract changes,
- changes to Medicaid fee schedules, and
- the incidence of high dollar or catastrophic claims.

Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fourth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

For the three months of service immediately prior to the reporting date, actual claims paid are a less reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on a blend of estimated completion factors and trended PMPM cost estimates. The PMPM costs estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, pharmacy utilization and other relevant factors.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse development in our claim payments for which the base actuarial model is not intended to and does not account. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP, and averages between 8% to 10% of IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled, changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development.

The development of our IBNP estimate is a continuous process that we monitor and update monthly as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported and may be required to do so again in the future. Any significant increases to prior period claim reserves would materially decrease reported earnings for the period in which the adjustment is made.

There are many related factors working in conjunction with one another that determine the accuracy of our estimates, some of which are qualitative in nature rather than quantitative. Therefore, we are seldom able to quantify the impact that any single factor has on a change in estimate. Given the variability inherent in the reserving

process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. Such reinsurance coverage does not relieve us of our primary obligation to our policyholders. We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. Reinsurance premiums amounted to $16 million, $20 million and $30 million for the years ended December 31, 2018, 2017, and 2016, respectively. Reinsurance recoveries amounted to $33 million, $24 million and $65 million for the years ended December 31, 2018, 2017, and 2016, respectively. Reinsurance recoverable of $31 million, $16 million, and $61 million, as of December 31, 2018, 2017, and 2016, respectively, is included in “Receivables” in the accompanying consolidated balance sheets.

Marketplace Cost Share Reduction (“CSR”)

In the year ended December 31, 2018, we recognized a benefit of approximately $81 million in reduced medical care costs related to 2017 dates of service, as a result of the federal government’s confirmation that the reconciliation of 2017 Marketplace CSR subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. No premium deficiency reserves were recorded as of December 31, 2018 and 2017.

Taxes Based on Premiums

Health Insurer Fee (“HIF”). The federal government under the ACA imposes an annual fee, or excise tax, on health insurers for each calendar year. The HIF is based on a company’s share of the industry’s net premiums written during the preceding calendar year and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Within our Medicaid program, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment or payment from a state to reimburse us for the HIF, and such HIF revenue is recognized ratably throughout the year. The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there were no health insurer fees reimbursed, nor health insurer fees incurred, in 2017.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expenses in the consolidated statements of operations.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. Treasury securities. Concentration of credit risk with respect to accounts receivable is limited because our payors consist principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans primarily as a direct contractor with the states (or Commonwealth), and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements Adopted

Revenue Recognition (Topic 606). See discussion above, in "Revenue Recognition."

Comprehensive Income. In February 2018, the Financial Accounting Standards Board ("FASB") issued ASU 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income.* ASU 2018-02 allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act ("TCJA"), which was enacted on December 22, 2017. ASU 2018-02 is effective beginning January 1, 2019; we early adopted this ASU effective January 1, 2018. The effect of applying the guidance resulted in an immaterial impact to beginning retained earnings, as presented in the accompanying consolidated statements of stockholders' equity.

Restricted Cash. In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which requires us to include in our consolidated statements of cash flows the changes in the balances of cash, cash equivalents, restricted cash and restricted cash equivalents. We adopted ASU 2016-18 on January 1, 2018. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption resulted in a $104 million and $93 million reclassification of restricted cash and cash equivalents from "Investing activities," to the beginning and ending balances of cash and cash equivalents in our consolidated statements of cash flows for the years ended December 31, 2017 and 2016, respectively. There was no impact to our consolidated statements of operations, balance sheets, or stockholders' equity. The reconciliation of cash and cash equivalents to cash, cash equivalents, and restricted cash and cash equivalents is presented at the beginning of this note.

Recent Accounting Pronouncements Not Yet Adopted

Software Licenses. In August 2018, the FASB issued ASU 2018-15, *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract,* which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. ASU 2018-15 is effective beginning January 1, 2020 and can be applied either retrospectively or prospectively to all implementation costs incurred after the date of adoption; early adoption is permitted. We are evaluating the effect of this guidance.

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument's contractual life. ASU 2016-13 is effective beginning January 1, 2020 and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted. We are in the early stages of evaluating the effect of this guidance.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by:

- ASU 2017-03, *Transition and Open Effective Date Information;*
- ASU 2018-01, *Leases (Topic 842): Land Easement Practical Expedient for Transition to Topic 842;*
- ASU 2018-10, *Codification Improvements to Topic 842, Leases; and*
- ASU 2018-11, *Leases (Topic 842): Targeted Improvements.*

Under Topic 842, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both financing and operating leases. Topic 842 also requires new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. We will adopt Topic 842 effective January 1, 2019, using the modified retrospective method. Under this method, we will recognize the cumulative effect of initially applying the standard as an adjustment to the opening balance of retained earnings on January 1, 2019. In addition, we have elected the transition option provided under ASU 2018-11, which allows entities to continue to apply the legacy guidance in Topic 840, *Leases*, including its disclosure requirements, in the comparative periods presented in the year of adoption.

Under Topic 842, we will record right-of-use assets and liabilities relating primarily to leases of office space for administrative and health plan operations. Specifically, on January 1, 2019, we expect to record operating lease right-of-use assets of approximately $80 million to $90 million, and operating lease liabilities of approximately $90 million to $100 million. In addition, in connection with the transition provisions relating to failed sale-leaseback transactions, we expect to record finance lease right-of-use assets of approximately $230 million to $240 million; record finance lease liabilities of approximately $230 million to $240 million; reduce property, equipment, and capitalized software net, by approximately $75 million to $95 million; reduce lease financing obligations by approximately $195 million to $205 million; and record an increase of approximately $80 million to $100 million to opening retained earnings.

3. Net Income (Loss) Per Share

The following table sets forth the calculation of basic and diluted net income (loss) per share:

	Year Ended December 31,		
	2018	2017	2016
	(In millions, except net income (loss) per share)		
Numerator:			
Net income (loss)	$ 707	$ (512)	$ 52
Denominator:			
Shares outstanding at the beginning of the period	59.3	55.8	55.1
Weighted-average number of shares issued:			
Exchange of 1.625% Convertible Notes [1]	1.4	0.1	—
Conversion of 1.625% Convertible Notes [1]	0.2	—	—
Stock-based compensation	0.2	0.5	0.3
Denominator for basic net income (loss) per share	61.1	56.4	55.4
Effect of dilutive securities:			
1.125% Warrants [1]	4.8	—	0.5
1.625% Convertible Notes [1]	0.4	—	—
Stock-based compensation	0.3	—	0.3
Denominator for diluted net income (loss) per share	66.6	56.4	56.2
Net income (loss) per share: [2]			
Basic	$ 11.57	$ (9.07)	$ 0.93
Diluted	$ 10.61	$ (9.07)	$ 0.92
Potentially dilutive common shares excluded from calculations: [1]			
1.125% Warrants [1]	—	1.9	—
1.625% Convertible Notes [1]	—	0.4	—
Stock-based compensation	—	0.3	—

(1) For more information regarding the 1.625% Convertible Notes, refer to Note 11, “Debt.” For more information and definitions regarding the 1.125% Warrants, refer to Note 14, “Stockholders' Equity.” The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income (loss) per share because to do so would have been anti-dilutive.
(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices for identical securities in active markets.

Level 2 — Directly or Indirectly Observable Inputs. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management’s best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments consist primarily of derivative financial instruments.

The derivatives include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2018, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, “Derivatives,” the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the years ended December 31, 2018, and 2017.

Our financial instruments measured at fair value on a recurring basis at December 31, 2018, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,123	$ —	$ 1,123	$ —
U.S. Treasury notes	181	—	181	—
Government-sponsored enterprise securities (GSEs)	163	—	163	—
Municipal securities	114	—	114	—
Asset-backed securities	82	—	82	—
Certificates of deposit	14	—	14	—
Other	4	—	4	—
Subtotal - current investments	1,681	—	1,681	—
1.125% Call Option derivative asset	476	—	—	476
Total assets	$ 2,157	$ —	$ 1,681	$ 476
1.125% Conversion Option derivative liability	$ 476	$ —	$ —	$ 476
Total liabilities	$ 476	$ —	$ —	$ 476

Our financial instruments measured at fair value on a recurring basis at December 31, 2017, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,588	$ —	$ 1,588	$ —
U.S. Treasury notes	388	—	388	—
GSEs	253	—	253	—
Municipal securities	141	—	141	—
Asset-backed securities	117	—	117	—
Certificates of deposit	37	—	37	—
Subtotal - current investments	2,524	—	2,524	—
Corporate debt securities	101	—	101	—
U.S. Treasury notes	68	—	68	—
Subtotal - current restricted investments	169	—	169	—
1.125% Call Option derivative asset	522	—	—	522
Total assets	$ 3,215	$ —	$ 2,693	$ 522
1.125% Conversion Option derivative liability	$ 522	$ —	$ —	$ 522
Total liabilities	$ 522	$ —	$ —	$ 522

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	December 31, 2018		December 31, 2017	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
		(In millions)		
5.375% Notes	$ 694	$ 674	$ 692	$ 730
4.875% Notes	326	301	325	329
1.125% Convertible Notes [1],[2]	240	732	496	1,052
Credit Facility [2]	—	—	300	300
1.625% Convertible Notes [2]	—	—	157	220
	$ 1,260	$ 1,707	$ 1,970	$ 2,631

(1) The fair value of the 1.125% Conversion Option derivative liability (the embedded cash conversion option), which is included in the fair value amounts presented above, amounted to $476 million and $522 million as of December 31, 2018 and 2017, respectively. See further discussion at Note 11, “Debt,” and Note 12, “Derivatives.”

(2) For more information on debt repayments in the year ended December 31, 2018, refer to Note 11, “Debt.”

5. Investments

We consider all of our investments classified as current assets to be available-for-sale. The following tables summarize our current investments as of the dates indicated:

	December 31, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,131	$ —	$ 8	$ 1,123
U.S. Treasury notes	181	—	—	181
GSEs	164	—	1	163
Municipal securities	115	—	1	114
Asset-backed securities	83	—	1	82
Certificates of deposit	14	—	—	14
Other	4	—	—	4
Total current investments	$ 1,692	$ —	$ 11	$ 1,681

	December 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,591	$ 1	$ 4	$ 1,588
U.S. Treasury notes	389	—	1	388
GSEs	255	—	2	253
Municipal securities	142	—	1	141
Asset-backed securities	117	—	—	117
Certificates of deposit	37	—	—	37
Subtotal - current investments	2,531	1	8	2,524
Corporate debt securities	101	—	—	101
U.S. Treasury notes	68	—	—	68
Subtotal - current restricted investments	169	—	—	169
	$ 2,700	$ 1	$ 8	$ 2,693

The contractual maturities of our current investments as of December 31, 2018 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,000	$ 997
Due after one year through five years	692	684
	$ 1,692	$ 1,681

As discussed further in Note 11, “Debt,” the 4.875% Notes’ indenture required us to hold a portion of the net proceeds from their issuance in a segregated account to be used to settle the conversion of the 1.625% Convertible Notes. Prior to September 30, 2018, this account was reported as a current asset, entitled “Restricted investments,” in the accompanying consolidated balance sheets. Because this account was used to settle the conversion of the 1.625% Convertible Notes in the third quarter of 2018, current restricted investments, as of December 31, 2018, was reduced to zero.

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the years ended December 31, 2018, 2017 and 2016 were insignificant.

We have determined that unrealized losses at December 31, 2018 and 2017 are temporary in nature, because the change in market value for these securities resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2018.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 509	$ 3	285	$ 412	$ 5	298
GSEs	—	—	—	127	1	76
Municipal securities	—	—	—	87	1	90
Asset backed securities	—	—	—	68	1	52
	$ 509	$ 3	285	$ 694	$ 8	516

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2017.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,297	$ 3	561	$ 94	$ 1	69
U.S. Treasury notes	470	1	89	—	—	—
GSEs	173	1	69	95	1	47
Municipal securities	—	—	—	38	1	48
	$ 1,940	$ 5	719	$ 227	$ 3	164

6. Receivables

Receivables consist primarily of amounts due from government agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is insignificant. Any amounts determined to be uncollectible are charged to expense when such determination is made.

	December 31,	
	2018	2017
	(In millions)	
Premiums and other receivables	855	695
Pharmacy administrative services receivables	179	—
Pharmacy rebate receivables	155	154
Health insurer fee reimbursement receivables	141	22
	$ 1,330	$ 871

7. Property, Equipment, and Capitalized Software, Net

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years.

Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years.

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2018	2017
	(In millions)	
Capitalized software	$ 373	$ 417
Furniture and equipment	231	289
Building and improvements	154	161
Land	16	16
Total cost	774	883
Less: accumulated amortization - capitalized software	(320)	(308)
Less: accumulated depreciation and amortization - building and improvements, furniture and equipment	(213)	(233)
Total accumulated depreciation and amortization	(533)	(541)
Property, equipment, and capitalized software, net	$ 241	$ 342

The following table presents all depreciation and amortization recognized in our consolidated statements of operations, whether the item appears as depreciation and amortization, or as cost of service revenue.

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Recorded in depreciation and amortization:			
Amortization of capitalized software	$ 42	$ 64	$ 62
Depreciation of property and equipment	36	42	45
Amortization of intangible assets	21	31	32
Subtotal	99	137	139
Recorded in cost of service revenue:			
Amortization of capitalized software	19	28	22
Amortization of deferred contract costs	9	13	21
Subtotal	28	41	43
Total depreciation and amortization recognized	$ 127	$ 178	$ 182

8. Goodwill and Intangible Assets, Net

Goodwill

The following table presents the changes in the carrying amounts of goodwill, by segment, for the year ended December 31, 2018. The 2017 goodwill impairment losses were reported as “Impairment losses” in the accompanying consolidated statements of operations. See Note 18, “Segments,” for a discussion of the change in our reportable segments in 2018.

	Health Plans	Other	Total
		(In millions)	
Historical goodwill, gross	$ 445	$ 233	$ 678
Accumulated impairment losses at December 31, 2017	(302)	(190)	(492)
Balance, December 31, 2017	143	43	186
Sale of subsidiary	—	(43)	(43)
Balance, December 31, 2018	$ 143	$ —	$ 143
Accumulated impairment losses at December 31, 2018	$ 302	$ 190	$ 492

Impairment Analysis Results

2018. We performed a qualitative goodwill assessment of our reporting units, which resulted in no goodwill impairment losses in the year ended December 31, 2018.

2017 – Health Plans Segment. We performed quantitative goodwill assessments using the discounted cash flows and asset liquidation methods, which resulted in Health Plans segment goodwill impairment losses of $244 million in the year ended December 31, 2017, primarily due to the following:

- Medicaid contract terminations announced in early 2018 at our Florida and New Mexico health plans; and
- Future cash flow projections insufficient to produce an estimated fair value in excess of the Illinois health plan's carrying amount.

2017 – Other Segment. Our recently divested Molina Medicaid Solutions and Pathways businesses are reported in the Other segment. The quantitative goodwill assessments of these reporting units, using the discounted cash flows method, resulted in goodwill impairment losses of $190 million in the year ended December 31, 2017, primarily due to the following:

- Management's conclusion that Molina Medicaid Solutions would provide fewer future benefits for its support of the Health Plans segment; and
- Management's conclusion that Pathways would not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected.

2016. We performed a quantitative goodwill assessment of our reporting units using the discounted cash flows method, which resulted in no impairment losses in the year ended December 31, 2016.

Intangible Assets, Net

The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Carrying Amount
		(In millions)	
Intangible assets:			
Contract rights and licenses	$ 201	$ 162	$ 39
Provider networks	20	12	8
Balance at December 31, 2018	$ 221	$ 174	$ 47
Intangible assets:			
Contract rights and licenses	$ 201	$ 141	$ 60
Provider networks	20	11	9
Balance at December 31, 2017	$ 221	$ 152	$ 69

Based on the balances of our identifiable intangible assets as of December 31, 2018, we estimate that our intangible asset amortization will be approximately $18 million in 2019, $14 million in 2020, $5 million in 2021, and $3 million in 2022 and 2023. For a presentation of our intangible assets by reportable segment, refer to Note 18, "Segments."

Impairment Analysis Results

2018. No impairment charges relating to intangible assets were recorded in the year ended December 31, 2018. See Note 15, "Restructuring and Separation Costs," for a description of certain long-lived assets written off in 2018, in connection with our 2017 Restructuring Plan.

2017 – Health Plans Segment. As a result of the impairment indicators described above for the Florida and New Mexico reporting units of the Health Plans segment in 2017, we performed undiscounted cash flows analyses of the reporting units, which resulted in Health Plans segment intangible asset impairment losses of $25 million in the year ended December 31, 2017.

2017 – Other Segment. As a result of management's conclusion that Pathways would not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected, we computed an undiscounted cash flows analysis of reporting units, which resulted in Other segment intangible asset impairment losses of $11 million.

2016. No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the year ended December 31, 2016.

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. Treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulation in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as "Restricted investments" in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. The following table presents the balances of restricted investments:

	December 31,	
	2018	2017
	(In millions)	
Florida	$ 32	$ 31
New Mexico	43	43
Ohio	12	12
Puerto Rico	10	10
Other	23	23
Total Health Plans segment	$ 120	$ 119

The contractual maturities of our held-to-maturity restricted investments, which are carried at amortized cost, which approximates fair value, as of December 31, 2018 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 105	$ 105
Due after one year through five years	15	15
	$ 120	$ 120

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated.

	December 31,		
	2018	2017	2016
	(In millions)		
Fee-for-service claims incurred but not paid ("IBNP")	$ 1,562	$ 1,717	$ 1,352
Pharmacy payable	115	112	112
Capitation payable	52	67	37
Other	232	296	428
	$ 1,961	$ 2,192	$ 1,929

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. Non-risk provider payables amounted to $107 million, $122 million and $225 million, as of December 31, 2018, 2017, and 2016, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were (more) less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Medical claims and benefits payable, beginning balance	$ 2,192	$ 1,929	$ 1,685
Components of medical care costs related to:			
Current period	15,478	17,037	14,966
Prior periods [1]	(341)	36	(192)
Total medical care costs	15,137	17,073	14,774
Change in non-risk provider payables	13	(106)	58
Payments for medical care costs related to:			
Current period	13,671	15,130	13,304
Prior periods	1,710	1,574	1,284
Total paid	15,381	16,704	14,588
Medical claims and benefits payable, ending balance	$ 1,961	$ 2,192	$ 1,929

(1) Includes the 2018 benefit of the 2017 Marketplace CSR reimbursement of $81 million.

The following tables provide information about incurred and paid claims development as of December 31, 2018, as well as cumulative claims frequency and the total of incurred but not paid claims liabilities. The cumulative claim frequency is measured by claim event, and includes claims covered under capitated arrangements.

	Incurred Claims and Allocated Claims Adjustment Expenses					
Benefit Year	2016	2017	2018	Total IBNP	Cumulative number of reported claims
	(Unaudited)	(Unaudited)			
			(In millions)		
2016	$ 15,064	$ 15,093	$ 15,057	$ 18	105
2017		17,037	16,728	57	119
2018			15,478	1,477	105
			$ 47,263	$ 1,552	

Cumulative Paid Claims and Allocated Claims Adjustment Expenses

Benefit Year	2016	2017	2018
	(Unaudited)	(Unaudited)	
		(In millions)	
2016	$ 13,403	$ 14,952	$ 15,039
2017		15,130	16,752
2018			13,671
			$ 45,462

The following table represents a reconciliation of claims development to the aggregate carrying amount of the liability for medical claims and benefits payable.

	2018
	(In millions)
Incurred claims and allocated claims adjustment expenses	$ 47,263
Less: cumulative paid clams and allocated claims adjustment expenses	(45,462)
All outstanding liabilities before 2016	10
Non-risk provider payables and other	150
Medical claims and benefits payable	$ 1,961

Our estimates of medical claims and benefits payable recorded at December 31, 2017, 2016 and 2015 developed favorably (unfavorably) by approximately $341 million, $(36) million and $192 million in 2018, 2017 and 2016, respectively.

The favorable prior year development recognized in 2018 includes a benefit of approximately $81 million in reduced medical care costs relating to Marketplace CSR subsidies for 2017 dates of service. The remainder of the favorable prior period development was primarily due to lower than expected utilization of medical services by our Medicaid and Marketplace members and improved operating performance. The differences between our original estimates in 2017 and the ultimate costs in 2018 were not discernable until additional information was provided to us in 2018 and the effect became clearer over time as claim payments were processed.

The unfavorable prior year development in 2017 was primarily due to higher than expected costs for settling certain claims with certain providers in states where we had recently commenced operations, such as in Illinois and Puerto Rico, or had instituted significant changes due to provider contract changes, such as in Florida and New Mexico. The differences between our original estimates in 2016 and the ultimate costs in 2017 were not discernable until additional information was provided to us in 2017 and the effect became clearer over time as claim payments were processed.

The favorable prior year development we recognized in 2016 was primarily due to reprocessing a significant number of claims in 2016 for provider submission of claims that were not compliant with new diagnostic coding requirements instituted in late 2015; several high-dollar claims at our New Mexico health plan that were settled for amounts lower than we initially estimated; recoveries on certain outpatient facility claims at our Washington health plan; and lower than expected claims costs for Medicaid Expansion members that were new to our California health plan in 2015. The differences between our original estimates in 2015 and the ultimate costs in 2016 were not discernable until additional information was provided to us in 2016 and the effect became clearer over time as claim payments were processed.

11. Debt

As of December 31, 2018, contractual maturities of debt for the years ending December 31 were as follows. All amounts represent the principal amounts of the debt instruments outstanding.

	Total	2019	2020	2021	2022	2023	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ —	$ 700	$ —	$ —
4.875% Notes	330	—	—	—	—	—	330
1.125% Convertible Notes	252	—	252	—	—	—	—
	$ 1,282	$ —	$ 252	$ —	$ 700	$ —	$ 330

All of our debt is held at the parent which is reported, for segment purposes, in "Other." The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets:

	December 31,	
	2018	2017
	(In millions)	
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 241	$ 499
1.625% Convertible Notes, net of unamortized discount	—	157
Lease financing obligations	1	1
Debt issuance costs	(1)	(4)
	241	653
Non-current portion of long-term debt:		
5.375% Notes	700	700
4.875% Notes	330	330
Credit Facility	—	300
Debt issuance costs	(10)	(12)
	1,020	1,318
Lease financing obligations	197	198
	$ 1,458	$ 2,169

Interest cost recognized relating to our convertible senior notes, the 1.125% Convertible Notes and the 1.625% Convertible Notes, was as follows:

	Years Ended December 31,		
	2018	2017	2016
		(In millions)	
Contractual interest at coupon rate	$ 6	$ 11	$ 11
Amortization of the discount	21	32	30
	$ 27	$ 43	$ 41

Credit Agreement

In January 2017, we entered into an amended Credit Agreement, which provides for an unsecured $500 million revolving credit facility (the "Credit Facility"). The Credit Facility has a term of five years and all amounts outstanding (other than the Term Loan, as described below) will be due and payable on January 31, 2022. In May 2018, we repaid the $300 million outstanding borrowings under the Credit Facility. As of December 31, 2018, no amounts were outstanding under the Credit Facility, and outstanding letters of credit amounting to $7 million reduced our remaining borrowing capacity under the Credit Facility to $493 million.

Borrowings under our Credit Agreement, including both the Credit Facility and the Term Loan, bear interest based, at our election, on a base rate or other defined rate, plus in each case the applicable margin. In addition to interest

payable on the principal amount of indebtedness outstanding from time to time under the Credit Agreement, we are required to pay a quarterly commitment fee.

Subsequent Event

On January 31, 2019, we entered into a Sixth Amendment to the Credit Agreement that provides for the following:

- A delayed draw term loan facility in an aggregate principal amount of $600 million (the "Term Loan"), under which we may request up to ten advances, each in a minimum principal amount of $50 million, until 18 months after January 31, 2019 ("Delayed Draw Commitment Period"). The Term Loan will amortize in quarterly installments, commencing on the last day of the first fiscal quarter after the Delayed Draw Commitment Period, equal to the principal amount of the Term Loan outstanding on the last day of the Delayed Draw Commitment Period multiplied by an amortization payment percentage ranging from 1.25% to 2.50% (depending on the applicable fiscal quarter) for each fiscal quarter. We will pay a delayed draw ticking fee in an amount equal to 37.5 basis points (0.375%) per annum of the undrawn amount of the Term Loan commencing on January 31, 2019, and continuing until the last day of the Delayed Draw Commitment Period, payable quarterly. All amounts outstanding under the Term Loan will be due and payable on January 31, 2024;
- Addition of definitions for various terms that apply to the Term Loan; and
- Various other amendments relating to the administration of the Credit Agreement.

In addition, effective as of January 31, 2019, Molina Pathways, LLC was automatically and unconditionally released as a guarantor under the Credit Agreement. As a result, as of January 31, 2019, no guarantors were parties to the Credit Agreement.

The Credit Agreement contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of December 31, 2018, we were in compliance with all financial and non-financial covenants under the Credit Agreement and other long-term debt.

5.375% Notes due 2022

We have $700 million aggregate principal amount of senior notes (the "5.375% Notes") outstanding as of December 31, 2018, which are due November 15, 2022, unless earlier redeemed. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15. As noted above, effective January 31, 2019, none of our subsidiaries is a guarantor of the 5.375% Notes.

The 5.375% Notes are senior unsecured obligations of Molina and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina. The 5.375% Notes contain customary non-financial covenants and change in control provisions.

4.875% Notes due 2025

We have $330 million aggregate principal amount of senior notes (the "4.875% Notes") outstanding as of December 31, 2018, which are due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. As noted above, effective January 31, 2019, none of our subsidiaries is a guarantor of the 4.875% Notes.

The 4.875% Notes are senior unsecured obligations of Molina, respectively, and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

1.125% Cash Convertible Senior Notes due 2020

In the second, third and fourth quarters of 2018, we entered into privately negotiated note purchase agreements with certain holders of our outstanding 1.125% cash convertible senior notes due January 15, 2020 (the "1.125% Convertible Notes"). In each case, the difference between the principal amount extinguished and our cash payments primarily represented the settlement of the 1.125% Convertible Notes' embedded cash conversion option feature at fair value (which is a derivative liability we refer to as the 1.125% Conversion Option). Activity during the year was as follows:

- In the fourth quarter of 2018, we repaid $62 million aggregate principal amount of the 1.125% Convertible Notes, plus accrued interest, for a total cash payment of $202 million.
- In the third quarter of 2018, we repaid $140 million aggregate principal amount of the 1.125% Convertible Notes, plus accrued interest, for a total cash payment of $483 million.
- In the second quarter of 2018, we repaid $96 million aggregate principal amount of the 1.125% Convertible Notes, plus accrued interest, for a total cash payment of $228 million.

In the year ended December 31, 2018, we have recorded an aggregate net loss on debt extinguishment of $12 million for the 1.125% Convertible Notes purchases, primarily relating to the acceleration of the debt discount. This loss is reported in “Other expenses (income), net” in the accompanying consolidated statements of operations. No common shares were issued in connection with these transactions.

In connection with each of the 1.125% Convertible Notes purchases, we also entered into privately negotiated termination agreements with each of the counterparties in 2018, to partially terminate the Call Spread Overlay, defined and further discussed in Notes 12, “Derivatives,” and 14, “Stockholders' Equity.” The net cash proceeds from the Call Spread Overlay partial termination transactions partially offset the cash paid to settle the 1.125% Convertible Notes.

Following the transactions described above, we have $252 million aggregate principal amount of 1.125% Convertible Notes outstanding at December 31, 2018. Interest is payable semiannually in arrears on January 15 and July 15. The 1.125% Convertible Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Convertible Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Convertible Notes is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Convertible Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date. Holders may convert their 1.125% Convertible Notes only under the following circumstances:

- During any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- During the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Convertible Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- Upon the occurrence of specified corporate events; or
- At any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Convertible Notes are convertible by the holders within one year of December 31, 2018, until they mature; therefore, they are reported in current portion of long-term debt.

Concurrent with the issuance of the 1.125% Convertible Notes, the 1.125% Conversion Option was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the 1.125% Conversion Option settles or expires. This initial liability simultaneously reduced the carrying value of the 1.125% Convertible Notes’ principal amount (effectively an original issuance discount), which is amortized to the principal amount through the recognition of non-cash interest expense over the expected life of the debt. The effective interest rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued is approximately 6%. As of December 31, 2018, the 1.125% Convertible Notes have a remaining amortization period of one year, and their ‘if-converted’ value exceeded their principal amount by approximately $581 million and $406 million as of December 31, 2018 and 2017, respectively.

1.625% Convertible Senior Notes due 2044

Conversion. On July 11, 2018, we announced notice of our election to redeem the remaining $64 million aggregate principal amount of the 1.625% convertible senior notes due 2044 (the “1.625% Convertible Notes”) on August 20, 2018 (the “Redemption Date”), pursuant to the terms of the indenture. Also pursuant to the indenture, the 1.625% Convertible Notes were convertible until August 17, 2018, at a conversion rate of 17.2157 shares of our common stock per $1,000 principal amount equal to the settlement amount (as defined in the related indenture), or approximately $58.09 per share of our common stock. At December 31, 2017, the equity component of the 1.625% Convertible Notes, including the impact of deferred taxes, was $12 million.

Through August 17, 2018, we received conversion notices from substantially all of the remaining holders of the 1.625% Convertible Notes outstanding. Under the conversions, we paid cash for the remaining $64 million aggregate principal amount and delivered 0.6 million shares of our common stock to the converting holders on the settlement dates in September 2018.

Exchange. In March 2018, we entered into separate, privately negotiated, synthetic exchange agreements with certain holders of our outstanding 1.625% Convertible Notes, under which we exchanged $97 million aggregate principal amount and accrued interest for 1.8 million shares of our common stock. We recorded a loss on debt extinguishment, including transaction fees, of $10 million, primarily relating to the inducement premium paid to the bondholders, which is recorded in "Other expenses (income), net" in the accompanying consolidated statements of operations. We did not receive any proceeds from the transaction.

In December 2017, we entered into separate, privately negotiated, synthetic exchange agreements with certain holders of our outstanding 1.625% Convertible Notes, under which we exchanged $141 million aggregate principal amount and accrued interest for 2.6 million shares of our common stock. We recorded a loss on debt extinguishment, including transaction fees, of $14 million, primarily relating to the inducement premium paid to the bondholders, which is recorded in "Other expenses (income), net" in the accompanying consolidated statements of operations. We did not receive any proceeds from the transaction.

Cross-Default Provisions

The indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

Bridge Credit Agreement

In January 2018, we entered into a bridge credit agreement with several banks, which was subsequently terminated in August 2018.

Lease Financing Obligations

Molina Center and Ohio Exchange. In 2013, we entered into a sale-leaseback transaction for the Molina Center and our Ohio health plan office building located in Columbus, Ohio, also known as the Ohio Exchange. Based on certain lease terms, we retained continuing involvement with these leased properties. Rent increases 3% per year through the initial term, which expires in 2038. The lease provides for six five-year renewal options, with renewal rent to be the higher of the 3% annual escalator or the then-fair market value.

6th and Pine. Also in 2013, we entered into a construction and lease transaction for two office buildings in Long Beach, California ("6th and Pine"). Due to our participation in the construction project, we retained continuing involvement in the properties. Rent increases 3.4% per year through the initial term, which expires in 2029. The lease provides for two five-year renewal options, with renewal rent to be determined based on the then-fair market value.

Because of our continuing involvement in the leasing transactions, as noted above, the sale of these properties did not qualify for sales recognition and we remain the owner of the properties under these leases for accounting purposes as of December 31, 2018. The assets are therefore included in our consolidated balance sheets, and are depreciated over their remaining useful lives. The lease financing obligations are amortized over the initial lease terms, such that there will be no gain or loss recorded if the leases are not extended beyond their expiration dates. Payments under the leases adjust the lease financing obligations, and the imputed interest is recorded to interest expense in our consolidated statements of operations. Aggregate interest expense under these leases amounted to $17 million in each of the years ended December 31, 2018, 2017 and 2016. For information regarding the future minimum lease obligations, refer to Note 17, "Commitments and Contingencies" and Note 2, "Significant Accounting Policies," Recent Accounting Pronouncements Not Yet Adopted, *Leases*.

12. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	December 31, 2018	December 31, 2017
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 476	$ 522
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 476	$ 522

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, and reported in "Other expenses (income), net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Convertible Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the "1.125% Call Option") and warrant transactions (collectively, the "1.125% Warrants"), with certain of the initial purchasers of the 1.125% Convertible Notes (the "Counterparties"). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

In the second, third and fourth quarters of 2018, in connection with the 1.125% Convertible Notes purchases (described in Note 11, "Debt"), we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased.

- In the fourth quarter of 2018, this resulted in our receipt of $146 million for the settlement of the 1.125% Call Option (which is a derivative asset), and the payment of $130 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $16 million from the Counterparties.
- In the third quarter of 2018, this resulted in our receipt of $343 million for the settlement of the 1.125% Call Option, and the payment of $306 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $37 million from the Counterparties.
- In the second quarter of 2018, this resulted in our receipt of $134 million for the settlement of the 1.125% Call Option, and the payment of $113 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $21 million from the Counterparties.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, "Fair Value Measurements."

As of December 31, 2018, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within twelve months of December 31, 2018, as described in Note 11, "Debt."

13. Income Taxes

Income tax expense (benefit) is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the HIF, goodwill impairment, certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by the HIF in 2017, given the 2017 HIF moratorium. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The TCJA, in part, reduced the U.S. federal corporate tax rate from 35% to 21% effective January 1, 2018. TCJA's change in the federal rate required that we revalue deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally the new 21% federal corporate tax rate plus applicable state tax rate. We applied the guidance in SEC Staff Accounting Bulletin No. 118 when accounting for the enactment-date effects of the TCJA in 2017 and throughout 2018.

As of December 31, 2017, we recorded a provisional amount of $54 million for the revaluation of deferred tax assets and liabilities because we had not yet completed our accounting for all of the enactment-date income tax effects of the TJCA under ASC 740, *Income Taxes.* Upon further analysis of certain aspects of the TCJA and refinement of our calculations in the year ended December 31, 2018, we reduced this provisional amount by $4 million, which is included as a component of income tax expense in the accompanying consolidated statement of operations. As of December 31, 2018, the accounting for all of the enactment-date income tax effects of the TCJA is complete.

Income tax expense (benefit) consisted of the following:

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Current:			
Federal	$ 272	$ (9)	$ 134
State	18	3	3
Foreign	8	—	(6)
Total current	298	(6)	131
Deferred:			
Federal	(3)	(85)	19
State	(3)	(9)	2
Foreign	—	—	1
Total deferred	(6)	(94)	22
Income tax expense (benefit)	$ 292	$ (100)	$ 153

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate is as follows:

	Year Ended December 31,		
	2018	2017	2016
Statutory federal tax (benefit) rate	21.0 %	(35.0)%	35.0 %
State income provision (benefit), net of federal	1.2	(0.7)	1.6
Nondeductible health insurer fee ("HIF")	7.3	—	37.0
Nondeductible compensation	0.7	2.8	3.1
Nondeductible goodwill impairment	—	6.6	—
Worthless stock deduction	(1.0)	—	—
Revaluation of net deferred tax assets	(0.4)	8.8	—
Change in purchase agreement that increased tax basis in assets	—	—	(2.2)
Other	0.4	1.1	0.3
Effective tax (benefit) rate	29.2 %	(16.4)%	74.8 %

Our effective tax rate is based on expected income (loss), statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, foreign, and local tax laws.

Deferred tax assets and liabilities are classified as non-current. Significant components of our deferred tax assets and liabilities as of December 31, 2018 and 2017 were as follows:

	December 31,	
	2018	2017
	(In millions)	
Accrued expenses	$ 32	$ 15
Reserve liabilities	7	11
Other accrued medical costs	12	16
Net operating losses	16	27
Fixed assets and intangibles	30	23
Unearned premiums	9	19
Lease financing obligation	30	30
Tax credit carryover	12	15
Other	3	3
Valuation allowance	(28)	(41)
Total deferred income tax assets, net of valuation allowance	123	118
Prepaid expenses	(6)	(6)
Basis in debt	—	(9)
Total deferred income tax liabilities	(6)	(15)
Net deferred income tax asset	$ 117	$ 103

At December 31, 2018, we had state net operating loss carryforwards of $332 million, which begin expiring in 2027.

At December 31, 2018, we had California research and development and enterprise zone tax credit carryovers of $14 million, which will begin to expire in 2024.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2018, $28 million of deferred tax assets did not satisfy the recognition criteria. Therefore, we decreased our valuation allowance by $13 million, from $41 million at December 31, 2017, to $28 million as of December 31, 2018.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the United States, Puerto Rico, and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will

be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Gross unrecognized tax benefits at beginning of period	$ (13)	$ (11)	$ (9)
Increases in tax positions for current year	(9)	(1)	(1)
Increases in tax positions for prior years	—	(4)	(1)
Decreases in tax positions for prior years	—	3	—
Lapse in statute of limitations	2	—	—
Gross unrecognized tax benefits at end of period	$ (20)	$ (13)	$ (11)

The total amount of unrecognized tax benefits at December 31, 2018, 2017 and 2016 that, if recognized, would affect the effective tax rates is $18 million, $12 million, and $9 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $3 million due to the expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2018, 2017 and 2016 were insignificant.

We may be subject to federal examination for calendar years 2015 through 2017. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local, and Puerto Rico tax examinations for years before 2014. We are not aware of any material adjustments that may be proposed.

14. Stockholders' Equity

1.625% Convertible Notes

Conversion. As described in Note 11, “Debt,” we issued 0.6 million shares of our common stock in connection with the conversion of the 1.625% Convertible Notes in the third quarter of 2018.

Exchange. As described in Note 11, “Debt,” we issued 1.8 million shares and 2.6 million shares of our common stock in connection with the exchange of the 1.625% Convertible Notes in March 2018 and December 2017, respectively.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 12, “Derivatives,” in 2013, we issued 13.5 million warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, if the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income (Loss) Per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Following the transactions described below, 6.2 million of the 1.125% Warrants remain outstanding.

As described in Note 12, “Derivatives,” in the second, third and fourth quarters of 2018, we entered into privately negotiated termination agreements with each of the Counterparties to terminate the respective portion of the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes repaid. In each case, additional paid-in capital was reduced for the same amount paid to the Counterparties for the termination of the 1.125% Warrants.

- In the fourth quarter of 2018, we paid $130 million to the Counterparties for the termination of 1.5 million of the 1.125% Warrants outstanding.
- In the third quarter of 2018, we paid $306 million to the Counterparties for the termination of 3.4 million of the 1.125% Warrants outstanding.

- In the second quarter of 2018, we paid $113 million to the Counterparties for the termination of 2.4 million of the 1.125% Warrants outstanding.

Share-Based Compensation

At December 31, 2018, we had employee equity incentives outstanding under our 2011 Equity Incentive Plan ("2011 Plan"). The 2011 Plan provides for the award of restricted stock ("RSAs"), performance stock ("PSAs"), performance stock units ("PSUs"), stock options and stock bonuses to the company's officers, employees, directors, consultants, advisers, and other service providers. The 2011 Plan provides for the issuance of up to 4.5 million shares of common stock.

In connection with the 2011 Plan and employee stock purchase plan, approximately 365,000 shares and 857,000 shares of common stock were purchased or vested, net of shares used to settle employees' income tax obligations, during the years ended December 31, 2018, and 2017, respectively.

Except as noted below, we record share-based compensation as "General and administrative expenses" in the accompanying consolidated statements of operations. Total share-based compensation expense was as follows:

	Year Ended December 31,					
	2018		2017		2016	
	(In millions)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
RSAs, PSAs and PSUs	$ 17	$ 17	$ 39	$ 35	$ 20	$ 17
Employee stock purchase plan and stock options	10	9	7	5	6	5
	$ 27	$ 26	$ 46	$ 40	$ 26	$ 22

RSAs, PSAs and PSUs are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Certain PSUs may vest in their entirety at the end of three-year performance periods, if their performance conditions are met. We generally recognize expense for RSAs, PSAs and PSUs on a straight-line basis.

Activity for such awards in the year ended December 31, 2018 is summarized below:

	RSAs	PSAs	PSUs	Total Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2017	401,804	84,762	91,828	578,394	$ 58.35
Granted	363,740	—	214,952	578,692	75.38
Vested	(192,609)	(32,929)	—	(225,538)	59.08
Forfeited	(173,140)	(48,701)	(105,397)	(327,238)	63.69
Unvested balance as of December 31, 2018	399,795	3,132	201,383	604,310	$ 71.50

As of December 31, 2018, there was $35 million of total unrecognized compensation expense related to unvested RSAs, PSAs and PSUs, which we expect to recognize over a remaining weighted-average period of 2.6 years, 0.2 years and 2.0 years, respectively. This unrecognized compensation cost assumed an estimated forfeiture rate of 16.1% for non-executive employees as of December 31, 2018, based on actual forfeitures over the last 4 years.

The total grant date fair value of awards granted and vested is presented in the following table:

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Granted:			
RSAs	$ 28	$ 20	$ 19
PSAs	—	—	15
PSUs	16	16	—
	$ 44	$ 36	$ 34
Vested:			
RSAs	$ 15	$ 23	$ 22
PSAs	3	15	—
PSUs	—	9	—
	$ 18	$ 47	$ 22

During the year ended December 31, 2017, the vesting of 133,957 RSAs, 153,574 PSAs and 139,272 PSUs was accelerated in connection with the termination of our former Chief Executive Officer and former Chief Financial Officer in May 2017. The incremental charge relating to this acceleration, or $23 million, is reported in “Restructuring and separation costs” in the accompanying consolidated statements of operations. This amount is included in the 2017 “Pretax Charges” in the table above.

Stock Options. Stock option awards generally have an exercise price equal to the fair market value of our common stock on the date of grant, vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant. Stock option activity for the year ended December 31, 2018 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In millions)	(Years)
Stock options outstanding as of December 31, 2017	405,000	$ 64.79		
Granted	—	—		
Exercised	—	—		
Stock options outstanding as of December 31, 2018	405,000	64.79	$ 21	8.5
Stock options exercisable and expected to vest as of December 31, 2018	405,000	64.79	$ 21	8.5
Exercisable as of December 31, 2018	155,000	60.69	$ 9	8.0

The weighted-average grant date fair value per share of stock options awarded in 2017 was $41.43. We estimate the fair value of each stock option award on the grant date using the Black-Scholes option pricing model. To determine the fair value of the stock options awarded in 2017 we applied a risk-free interest rate of 2.3%, expected volatility of 38.4%, dividend yield of 0% and expected life of 8.4 years. No stock options were granted in 2018 and 2016.

Also as of December 31, 2018, there was $9 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.8 years. The total intrinsic value of options exercised during the years ended December 31, 2017, and 2016 was $2 million, and $1 million, respectively. No stock options were exercised in 2018. The following is a summary of information about stock options outstanding and exercisable at December 31, 2018:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$33.02	30,000	4.2	$ 33.02	30,000	$ 33.02
$67.33	375,000	8.9	67.33	125,000	67.33
	405,000			155,000	

Employee Stock Purchase Plan. Under our employee stock purchase plan ("ESPP"), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2018, 2017, and 2016, the inputs to this model were as follows: risk-free interest rates of approximately 0.4% to 1.9%; expected volatilities ranging from approximately 31% to 44%, dividend yields of 0%, and an average expected life of 0.5 years. We issued approximately 216,000, 351,000 and 410,000 shares of our common stock under the ESPP during the years ended December 31, 2018, 2017, and 2016, respectively. The 2011 ESPP provides for the issuance of up to three million shares of common stock.

15. Restructuring and Separation Costs

Restructuring and separation costs are reported by the same name in the accompanying consolidated statements of operations.

IT Restructuring Plan

Following the 2017 Restructuring Plan noted below, our new executive team has focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we began the implementation of a plan to restructure our information technology department (the "IT Restructuring Plan") in the third quarter of 2018. On February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers.

Expected Costs

In addition to $9 million incurred in the last half of 2018, we expect to incur approximately $11 million for the IT Restructuring Plan in 2019. We expect such costs to consist primarily of one-time termination benefits and other costs in the Other segment. We expect the IT Restructuring Plan to be completed by the end of 2019.

Costs Incurred

We have incurred expenses under the IT Restructuring Plan as follows:

	Year Ended December 31, 2018		
	One-Time Termination Benefits	Other Restructuring Costs	
		Consulting Fees	Total
	(In millions)		
Other	$ 7	$ 2	$ 9

Reconciliation of Liability

For those restructuring costs that require cash settlement (such as one-time termination benefits and consulting fees), the following table presents a roll-forward of the accrued liability, which is reported in "Accounts payable and

accrued liabilities" in the accompanying consolidated balance sheets.

	One-Time Termination Benefits	Other Restructuring Costs	Total
	(In millions)		
Accrued as of December 31, 2017	$ —	$ —	$ —
Charges	7	2	9
Cash payments	(2)	(1)	(3)
Accrued as of December 31, 2018	$ 5	$ 1	$ 6

2017 Restructuring Plan

Following a management-initiated, broad operational assessment in early 2017, our board of directors approved, and we committed to, a comprehensive restructuring and profitability improvement plan in June 2017 (the "2017 Restructuring Plan"). Key activities under this plan to date have included:

- Streamlining of our organizational structure to eliminate redundant layers of management, consolidate regional support services, and other staff reductions to improve efficiency and the speed and quality of decision making;
- Re-design of core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology, to achieve more effective and cost-efficient outcomes;
- Remediation of high-cost provider contracts and enhancement of high quality, cost-effective networks;
- Restructuring, including selective exits, of direct delivery operations; and
- Partnering with the lowest-cost, most effective vendors.

Costs Incurred

In our 2017 Annual Report on Form 10-K, we reported that we had incurred approximately $234 million of costs associated with the 2017 Restructuring Plan in 2017. In the year ended December 31, 2018, we incurred an additional $37 million in such costs, primarily resulting from a write-off of costs associated with a terminated utilization and care management project that was inconsistent with the goals of the 2017 Restructuring Plan. We also recorded nominal amounts for one-time termination benefits, and true-ups of certain lease contract termination costs recorded in 2017. As of December 31, 2018, we had incurred $271 million in total costs under the 2017 Restructuring Plan. We completed all activities under the 2017 Restructuring Plan in 2018, with the exception of the cash settlement of lease termination liabilities. We expect to continue to settle those liabilities through 2025, unless the leases are terminated sooner.

The following table presents the major types of such costs by segment. Current and long-lived assets include current and non-current capitalized project costs, and capitalized software determined to be unrecoverable.

	Year Ended December 31, 2018					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ —	$ (1)	$ —	$ 12	$ 11
Other	—	5	20	1	—	26
	$ —	$ 5	$ 19	$ 1	$ 12	$ 37

	Year Ended December 31, 2017					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 33	$ 16	$ —	$ 24	$ 73
Other	36	34	45	44	2	161
	$ 36	$ 67	$ 61	$ 44	$ 26	$ 234

As of December 31, 2018, we had incurred cumulative restructuring costs under the 2017 Restructuring Plan as follows:

			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 33	$ 15	$ —	$ 36	$ 84
Other	36	39	65	45	2	187
	$ 36	$ 72	$ 80	$ 45	$ 38	$ 271

Reconciliation of Liability

For those restructuring and separation costs that require cash settlement (primarily separation costs not including equity incentives, termination benefits, consulting fees and contract termination costs), the following table presents a roll-forward of the accrued liability, which is reported primarily in “Accounts payable and accrued liabilities” in the accompanying consolidated balance sheets. Certain contract termination cost accruals are non-current, recorded in “Other long-term liabilities.”

	Separation Costs - Former Executives	One-Time Termination Benefits	Other Restructuring Costs	Total
	(In millions)			
Accrued as of December 31, 2017	$ 2	$ 11	$ 35	$ 48
Adjustments	—	(1)	11	10
Charges	—	6	2	8
Cash payments	(2)	(15)	(31)	(48)
Accrued as of December 31, 2018	$ —	$ 1	$ 17	$ 18

16. Employee Benefits

We sponsor defined contribution 401(k) plans that cover substantially all employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We generally match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plans amounted to $36 million, $43 million, and $36 million in the years ended December 31, 2018, 2017, and 2016, respectively.

We also have a non-qualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

17. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. The National Association of Insurance Commissioners ("NAIC"), has adopted rules which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital ("RBC") rules which may vary from state to state. All of the states in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states. Regulators in some states may also enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. As of December 31, 2018, our health plans had aggregate statutory capital and surplus of approximately $2,388 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,040 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2018. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $2,262 million at December 31, 2018, and $1,691 million at December 31, 2017. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $170 million and $696 million as of December 31, 2018 and 2017, respectively.

Legal Proceedings

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Steamfitters Local 449 Pension Plan v. Molina Healthcare, Inc., et al. On October 5, 2018, the Steamfitters Local 449 Pension Plan filed its first amended class action securities complaint in the Central District Court of California against the Company and its former executive officers, J. Mario Molina, John C. Molina, Terry P. Bayer, and Rick Hopfer, Case 2:18-cv-03579. The amended complaint purports to seek recovery on behalf of all persons or entities who purchased Molina common stock between October 31, 2014, and August 2, 2017, for alleged violations under Sections 10(b) and 20(a) of the Securities Exchange Act of 1934, as amended, and Rule 10b-5 promulgated thereunder. The plaintiff alleges the defendants misled investors regarding the scalability of the Company's administrative infrastructure during the identified class period. On December 13, 2018, the Court granted the Company's motion to dismiss in its entirety and closed the case. On January 9, 2019, plaintiffs appealed to the United States Court of Appeals for the Ninth Circuit. Plaintiff's opening brief is due April 10, 2019, the Company's response is due May 10, 2019, and Plaintiff's reply is due May 31, 2019. Oral argument will likely occur within 9-12 months after the briefing is completed. The Company believes it has meritorious defenses to the alleged claims and intends to defend the matter vigorously. At this time, we are not able to estimate a possible loss or range of loss that

may result from this matter or to determine whether such loss, if any, would have a material adverse effect on our financial condition, results of operations, or cash flows.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid, Medicare, and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures.

Lease Obligations

We lease administrative facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2026. Facility lease terms generally range from five to 10 years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under operating leases and lease financing obligations consist of the following amounts:

	Lease Financing Obligations	Operating Leases	Total
		(In millions)	
2019	$ 19	$ 46	$ 65
2020	19	34	53
2021	20	24	44
2022	21	16	37
2023	21	12	33
Thereafter	311	15	326
	$ 411	$ 147	$ 558

Rental expense related to operating leases amounted to $62 million, $75 million, and $64 million for the years ended December 31, 2018, 2017, and 2016, respectively. The amounts reported in "Lease Financing Obligations" above represent our contractual lease commitments for the properties described in Note 11, "Debt" under the subheading "Lease Financing Obligations."

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered in the primary care institutions that we manage. In addition, we also carry errors and omissions insurance for all Molina entities.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

18. Segments

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. Our Other segment includes the historical results of the Pathways behavioral health subsidiary, which we sold in the fourth quarter of 2018, and certain corporate amounts not allocated to the Health Plans segment. Effective in the fourth quarter of 2018, we reclassified the

historical results relating to our Molina Medicaid Solutions ("MMS") segment, which we sold in the third quarter of 2018, to the Other segment. Previously, results for MMS were reported in a stand-alone segment.

Refer to Note 1, "Organization and Basis of Presentation," for further details on the sales of Pathways and MMS.

We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition and divestiture activity, and changing laws and regulations. Therefore, these reportable segments may change in the future.

Description of Earnings Measures for Reportable Segments

Margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Margin for our Health Plans segment is referred to as "Medical margin," which represents the amount earned by the segments after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the segments. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker.

	Health Plans	Other	Consolidated
		(In millions)	
2018			
Total revenue	$ 18,471	$ 419	18,890
Margin	2,475	43	2,518
Goodwill, and intangible assets, net	190	—	190
Total assets	6,165	989	7,154
2017			
Total revenue	$ 19,352	$ 531	$ 19,883
Margin	1,781	29	1,810
Goodwill, and intangible assets, net	212	43	255
Total assets	6,347	2,124	8,471
2016			
Total revenue	$ 17,234	$ 548	$ 17,782
Margin	1,671	54	1,725
Goodwill, and intangible assets, net	513	247	760
Total assets	5,897	1,552	7,449

The following table reconciles margin by segment to consolidated income (loss) before income tax expense (benefit):

	Year Ended December 31,		
	2018	2017	2016
		(In millions)	
Margin:			
Health Plans	$ 2,475	$ 1,781	$ 1,671
Other	43	29	54
Total margin	2,518	1,810	1,725
Add: other operating revenues [1]	871	508	798
Less: other operating expenses [2]	(2,243)	(2,873)	(2,217)
Less: loss on sales of subsidiaries, net of gain	(15)	—	—
Operating income (loss)	1,131	(555)	306
Less: other expenses, net	132	57	101
Income (loss) before income tax expense (benefit)	$ 999	$ (612)	$ 205

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, investment income and other revenue.
(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, impairment losses, and restructuring and separation costs.

19. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2018 and 2017.

	For The Quarter Ended			
	March 31, 2018	June 30, 2018	Sept. 30, 2018	December 31, 2018
	(In millions, except per-share data)			
Total revenue	$ 4,646	$ 4,883	$ 4,697	$ 4,664
Margin	615	673	566	664
Gain (loss) on sales of subsidiaries	—	—	37	(52)
Restructuring and separation costs	25	8	5	8
Net income	107	202	197	201
Net income per share [1]:				
Basic	$ 1.79	$ 3.29	$ 3.22	$ 3.24
Diluted	$ 1.64	$ 3.02	$ 2.90	$ 3.01

	For The Quarter Ended			
	March 31, 2017	June 30, 2017	Sept. 30, 2017	December 31, 2017
	(In millions, except per-share data)			
Total revenue	$ 4,904	$ 4,999	$ 5,031	$ 4,949
Margin	546	254	564	446
Impairment losses	—	72	129	269
Restructuring and separation costs	—	43	118	73
Net income (loss)	77	(230)	(97)	(262)
Net income (loss) per share [1]:				
Basic	$ 1.38	$ (4.10)	$ (1.70)	$ (4.59)
Diluted	$ 1.37	$ (4.10)	$ (1.70)	$ (4.59)

(1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method and is based on the weighted-average common share equivalents outstanding during each quarter. Accordingly, the sum of the quarterly net income (loss) per share may not agree to the total for the year. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income (loss) per share because to do so would be anti-dilutive.

20. Condensed Financial Information of Registrant

The condensed balance sheets as of December 31, 2018 and 2017, and the related condensed statements of operations, comprehensive income (loss) and cash flows for each of the three years in the period ended December 31, 2018 for our parent company Molina Healthcare, Inc. (the "Registrant"), are presented below.

Condensed Balance Sheets

	December 31,	
	2018	2017
	(In millions, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 70	$ 504
Investments	100	192
Restricted investments	—	169
Receivables	2	2
Due from affiliates	90	148
Prepaid expenses and other current assets	47	103
Derivative asset	476	522
Total current assets	785	1,640
Property, equipment, and capitalized software, net	176	223
Goodwill and intangible assets, net	13	15
Investments in subsidiaries	2,768	2,306
Deferred income taxes	39	17
Advances to related parties and other assets	40	32
	$ 3,821	$ 4,233
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 4	$ 3
Accounts payable and accrued liabilities	223	178
Current portion of long-term debt	241	653
Derivative liability	476	522
Total current liabilities	944	1,356
Long-term debt	1,020	1,318
Lease financing obligations	197	198
Other long-term liabilities	13	24
Total liabilities	2,174	2,896
Stockholders' equity:		
Common stock, $0.001 par value; 150 million shares authorized; outstanding:		
62 million shares at December 31, 2018 and 60 million shares at December 31, 2017	—	—
Preferred stock, $0.001 par value; 20 million shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	643	1,044
Accumulated other comprehensive loss	(8)	(5)
Retained earnings	1,012	298
Total stockholders' equity	1,647	1,337
	$ 3,821	$ 4,233

See accompanying notes.

Condensed Statements of Operations

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Revenue:			
Management fees	$ 1,138	$ 1,317	$ 1,062
Investment income and other revenue	17	16	16
Total revenue	1,155	1,333	1,078
Expenses:			
Medical care costs	8	16	73
General and administrative expenses	1,007	1,082	899
Depreciation and amortization	69	93	95
Restructuring and separation costs	35	153	—
Impairment losses	—	39	—
Total operating expenses	1,119	1,383	1,067
Gain on sale of subsidiary	37	—	—
Operating income (loss)	73	(50)	11
Interest expense	114	117	101
Other expense (income)	17	(61)	—
Loss before income tax (benefit) expense and equity in net earnings (losses) of subsidiaries	(58)	(106)	(90)
Income tax (benefit) expense	(14)	8	(24)
Net loss before equity in net earnings (losses) of subsidiaries	(44)	(114)	(66)
Equity in net earnings (losses) of subsidiaries	751	(398)	118
Net income (loss)	$ 707	$ (512)	$ 52

Condensed Statements of Comprehensive Income (Loss)

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Net income (loss)	$ 707	$ (512)	$ 52
Other comprehensive (loss) income:			
Unrealized investment (loss) gain	(3)	(5)	3
Less: effect of income taxes	(1)	(2)	1
Other comprehensive (loss) income, net of tax	(2)	(3)	2
Comprehensive income (loss)	$ 705	$ (515)	$ 54

See accompanying notes.

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
Operating activities:			
Net cash provided by operating activities	$ 118	$ 166	$ 55
Investing activities:			
Capital contributions to subsidiaries	(145)	(370)	(386)
Dividends received from subsidiaries	298	286	101
Purchases of investments	(136)	(331)	(115)
Proceeds from sales and maturities of investments	388	156	188
Purchases of property, equipment and capitalized software	(22)	(67)	(125)
Net cash received from sale of subsidiaries	242	—	—
Change in amounts due to/from affiliates	6	(49)	(18)
Other, net	—	—	6
Net cash provided by (used in) investing activities	631	(375)	(349)
Financing activities:			
Repayment of credit facility	(300)	—	—
Repayment of principal amount of 1.125% Convertible Notes	(298)	—	—
Cash paid for partial settlement of 1.125% Conversion Option	(623)	—	—
Cash received for partial settlement of 1.125% Call Option	623	—	—
Cash paid for partial termination of 1.125% Warrants	(549)	—	—
Repayment of principal amount of 1.625% Convertible Notes	(64)	—	—
Proceeds from senior notes offerings, net of issuance costs	—	325	—
Proceeds from borrowings under credit facility	—	300	—
Other, net	19	11	20
Net cash (used in) provided by financing activities	(1,192)	636	20
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(443)	427	(274)
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	513	86	360
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 70	$ 513	$ 86

See accompanying notes.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

The Registrant was incorporated in 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for three other state health plans. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to our subsidiaries pursuant to administrative services agreements that include, but are not limited to, information technology, product development and administration, underwriting, claims processing, customer service, certain care management services, human

resources, legal, marketing, purchasing, risk management, actuarial, underwriting, finance, accounting, legal and public relations. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2018, 2017, and 2016 for these services amounted to $1,137 million, $1,317 million, and $1,062 million, respectively, and are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Dividends and Capital Contributions

When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries.

For all periods presented, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund business combinations. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

21. Supplemental Condensed Consolidating Financial Information

On November 10, 2015, the Parent issued $700 million aggregate principal amount of the 5.375% Notes in a private placement to institutional investors. The 5.375% Notes were registered with the SEC in September 2016. Pursuant to the terms of the indenture governing the 5.375% Notes (the "Indenture"), the 5.375% Notes are required to be guaranteed by each of the Parent's existing and future direct and indirect domestic restricted subsidiaries that guarantee the Parent's Credit Agreement. At the time of issuance, there were two subsidiaries of the Parent that guaranteed the Notes: MMS and Molina Medical Management, Inc. ("MMM").

On November 1, 2015, the Parent acquired all of the outstanding ownership interests of Pathways Health and Community Support LLC ("Pathways"). As a result of that acquisition, and pursuant to the terms of the Indenture, effective February 16, 2016, Pathways and 15 of its subsidiaries were added as guarantors of the 5.375% Notes. Subsequently, effective January 3, 2017, MMM and 14 Pathways subsidiaries were released as guarantors of the 5.375% Notes, leaving MMS, Pathways, and Molina Pathways, LLC as the only subsidiary guarantors. MMS and Pathways were released as guarantors effective September 30, 2018, and October 19, 2018, respectively, in connection with their divestitures. Accordingly, as of December 31, 2018, Molina Pathways, LLC was the sole wholly owned subsidiary guarantor of the 5.375% Notes, on a full and unconditional basis. As discussed in Note 11, "Debt," effective as of January 31, 2019, Molina Pathways, LLC was released as a guarantor of the 5.375% Notes.

For all periods presented, the following condensed consolidating financial statements present Molina Healthcare, Inc. (as "Parent Issuer"), Molina Pathways, LLC (as "Other Guarantor"), the subsidiary non-guarantors (as "Non-Guarantors") and "Eliminations," according to the guarantor structure as assessed as of and for the year ended December 31, 2018.

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Year Ended December 31, 2018				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 1,155	$ 3	$ 18,884	$ (1,152)	$ 18,890
Expenses:					
Medical care costs	8	—	15,129	—	15,137
Cost of service revenue	—	—	364	—	364
General and administrative expenses	1,007	4	1,474	(1,152)	1,333
Premium tax expenses	—	—	417	—	417
Health insurer fees	—	—	348	—	348
Depreciation and amortization	69	—	30	—	99
Restructuring and separation costs	35	—	11	—	46
Total operating expenses	1,119	4	17,773	(1,152)	17,744
Gain (loss) on sales of subsidiaries	37	(52)	—	—	(15)
Operating income (loss)	73	(53)	1,111	—	1,131
Interest expense	114	—	1	—	115
Other expense	17	—	—	—	17
(Loss) income before income tax (benefit) expense	(58)	(53)	1,110	—	999
Income tax (benefit) expense	(14)	(11)	317	—	292
Net (loss) income before equity in net earnings (losses) of subsidiaries	(44)	(42)	793	—	707
Equity in net earnings (losses) of subsidiaries	751	(5)	—	(746)	—
Net income (loss)	$ 707	$ (47)	$ 793	$ (746)	$ 707

	Year Ended December 31, 2017				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Revenue:					
Total revenue	$ 1,333	$ 2	$ 19,904	$ (1,356)	$ 19,883
Expenses:					
Medical care costs	16	—	17,058	(1)	17,073
Cost of service revenue	—	—	492	—	492
General and administrative expenses	1,082	2	1,865	(1,355)	1,594
Premium tax expenses	—	—	438	—	438
Depreciation and amortization	93	—	44	—	137
Restructuring and separation costs	153	—	81	—	234
Impairment losses	39	—	431	—	470
Total operating expenses	1,383	2	20,409	(1,356)	20,438
Operating loss	(50)	—	(505)	—	(555)
Total other expenses, net	56	—	1	—	57
Loss before income taxes	(106)	—	(506)	—	(612)
Income tax expense (benefit)	8	—	(108)	—	(100)
Net loss before equity in net (losses) earnings of subsidiaries	(114)	—	(398)	—	(512)
Equity in net (losses) earnings of subsidiaries	(398)	(164)	8	554	—
Net loss	$ (512)	$ (164)	$ (390)	$ 554	$ (512)

	Year Ended December 31, 2016				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Revenue:					
Total revenue	$ 1,078	$ —	$ 17,786	$ (1,082)	$ 17,782
Expenses:					
Medical care costs	73	—	14,702	(1)	14,774
Cost of service revenue	—	—	485	—	485
General and administrative expenses	899	2	1,573	(1,081)	1,393
Premium tax expenses	—	—	468	—	468
Health insurer fees	—	—	217	—	217
Depreciation and amortization	95	—	44	—	139
Total operating expenses	1,067	2	17,489	(1,082)	17,476
Operating income (loss)	11	(2)	297	—	306
Total other expenses, net	101	—	—	—	101
(Loss) income before income taxes	(90)	(2)	297	—	205
Income tax (benefit) expense	(24)	(1)	178	—	153
Net (loss) income before equity in earnings of subsidiaries	(66)	(1)	119	—	52
Equity in net earnings of subsidiaries	118	2	—	(120)	—
Net income	$ 52	$ 1	$ 119	$ (120)	$ 52

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Year Ended December 31, 2018				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net income (loss)	$ 707	$ (47)	$ 793	$ (746)	$ 707
Other comprehensive loss, net of tax	(2)	—	(2)	2	(2)
Comprehensive income (loss)	$ 705	$ (47)	$ 791	$ (744)	$ 705

	Year Ended December 31, 2017				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net loss	$ (512)	$ (164)	$ (390)	$ 554	$ (512)
Other comprehensive loss, net of tax	(3)	—	(2)	2	(3)
Comprehensive loss	$ (515)	$ (164)	$ (392)	$ 556	$ (515)

	Year Ended December 31, 2016				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net income	$ 52	$ 1	$ 119	$ (120)	$ 52
Other comprehensive income, net of tax	2	—	1	(1)	2
Comprehensive income	$ 54	$ 1	$ 120	$ (121)	$ 54

CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2018				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
ASSETS					
Current assets:					
Cash and cash equivalents	$ 70	$ 2	$ 2,754	$ —	$ 2,826
Investments	100	—	1,581	—	1,681
Receivables	2	—	1,328	—	1,330
Due from (to) affiliates	90	7	(97)	—	—
Prepaid expenses and other current assets	47	29	73	—	149
Derivative asset	476	—	—	—	476
Total current assets	785	38	5,639	—	6,462
Property, equipment, and capitalized software, net	176	—	65	—	241
Goodwill and intangible assets, net	13	—	177	—	190
Restricted investments	—	—	120	—	120
Investment in subsidiaries, net	2,768	(5)	—	(2,763)	—
Deferred income taxes	39	—	78	—	117
Other assets	40	—	5	(21)	24
	$ 3,821	$ 33	$ 6,084	$ (2,784)	$ 7,154
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 4	$ —	$ 1,957	$ —	$ 1,961
Amounts due government agencies	—	—	967	—	967
Accounts payable and accrued liabilities	223	—	167	—	390
Deferred revenue	—	—	211	—	211
Current portion of long-term debt	241	—	—	—	241
Derivative liability	476	—	—	—	476
Total current liabilities	944	—	3,302	—	4,246
Long-term debt and lease financing obligations	1,217	—	20	(20)	1,217
Other long-term liabilities	13	—	32	(1)	44
Total liabilities	2,174	—	3,354	(21)	5,507
Total stockholders' equity	1,647	33	2,730	(2,763)	1,647
	$ 3,821	$ 33	$ 6,084	$ (2,784)	$ 7,154

CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2017				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
ASSETS					
Current assets:					
Cash and cash equivalents	$ 504	$ —	$ 2,682	$ —	$ 3,186
Investments	192	—	2,332	—	2,524
Restricted investments	169	—	—	—	169
Receivables	2	—	869	—	871
Due from (to) affiliates	148	2	(150)	—	—
Prepaid expenses and other current assets	103	2	150	(16)	239
Derivative asset	522	—	—	—	522
Total current assets	1,640	4	5,883	(16)	7,511
Property, equipment, and capitalized software, net	223	—	119	—	342
Goodwill and intangible assets, net	15	—	240	—	255
Restricted investments	—	—	119	—	119
Investment in subsidiaries, net	2,306	75	—	(2,381)	—
Deferred income taxes	17	—	101	(15)	103
Other assets	32	—	110	(1)	141
	$ 4,233	$ 79	$ 6,572	$ (2,413)	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 3	$ —	$ 2,189	$ —	$ 2,192
Amounts due government agencies	—	—	1,542	—	1,542
Accounts payable and accrued liabilities	178	1	188	(1)	366
Deferred revenue	—	—	282	—	282
Current portion of long-term debt	653	—	16	(16)	653
Derivative liability	522	—	—	—	522
Total current liabilities	1,356	1	4,217	(17)	5,557
Long-term debt and lease financing obligations	1,516	—	—	—	1,516
Deferred income taxes	—	—	15	(15)	—
Other long-term liabilities	24	—	37	—	61
Total liabilities	2,896	1	4,269	(32)	7,134
Total stockholders' equity	1,337	78	2,303	(2,381)	1,337
	$ 4,233	$ 79	$ 6,572	$ (2,413)	$ 8,471

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Year Ended December 31, 2018				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by (used in) operating activities	$ 118	(2)	(430)	—	$ (314)
Investing activities:					
Purchases of investments	(136)	—	(1,308)	—	(1,444)
Proceeds from sales and maturities of investments	388	—	2,057	—	2,445
Purchases of property, equipment and capitalized software	(22)	—	(8)	—	(30)
Net cash received from sales of subsidiaries	242	—	(52)	—	190
Capital contributions to subsidiaries	(145)	—	145	—	—
Dividends received from subsidiaries	298	—	(298)	—	—
Change in amounts due to/from affiliates	6	4	(10)	—	—
Other, net	—	—	(18)	—	(18)
Net cash provided by investing activities	631	4	508	—	1,143
Financing activities:					
Repayment of credit facility	(300)	—	—	—	(300)
Repayment of principal amount of 1.125% Convertible Notes	(298)	—	—	—	(298)
Cash paid for partial settlement of 1.125% Conversion Option	(623)	—	—	—	(623)
Cash received for partial settlement of 1.125% Call Option	623	—	—	—	623
Cash paid for partial termination of 1.125% Warrants	(549)	—	—	—	(549)
Repayment of principal amount of 1.625% Convertible Notes	(64)	—	—	—	(64)
Other, net	19	—	(1)	—	18
Net cash used in financing activities	(1,192)	—	(1)	—	(1,193)
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(443)	2	77	—	(364)
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	513	—	2,777	—	3,290
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 70	$ 2	$ 2,854	$ —	$ 2,926

	Year Ended December 31, 2017				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 166	—	638	—	$ 804
Investing activities:					
Purchases of investments	(331)	—	(2,366)	—	(2,697)
Proceeds from sales and maturities of investments	156	—	1,603	—	1,759
Purchases of property, equipment and capitalized software	(67)	—	(19)	—	(86)
Capital contributions to subsidiaries	(370)	2	368	—	—
Dividends received from subsidiaries	286	—	(286)	—	—
Change in amounts due to/from affiliates	(49)	(2)	51	—	—
Other, net	—	—	(38)	—	(38)
Net cash used in investing activities	(375)	—	(687)	—	(1,062)
Financing activities:					
Proceeds from senior notes offerings, net of issuance costs	325	—	—	—	325
Proceeds from borrowings under credit facility	300	—	—	—	300
Other, net	11	—	—	—	11
Net cash provided by financing activities	636	—	—	—	636
Net increase (decrease) in cash, cash equivalents, and restricted cash and cash equivalents	427	—	(49)	—	378
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	86	—	2,826	—	2,912
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 513	$ —	$ 2,777	$ —	$ 3,290

	Year Ended December 31, 2016				
	Parent Issuer	Other Guarantor	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by (used in) operating activities	$ 55	(1)	619	—	$ 673
Investing activities:					
Purchases of investments	(115)	—	(1,814)	—	(1,929)
Proceeds from sales and maturities of investments	188	—	1,778	—	1,966
Purchases of property, equipment and capitalized software	(125)	—	(51)	—	(176)
Net cash paid in business combinations	—	—	(48)	—	(48)
Capital contributions to subsidiaries	(386)	7	379	—	—
Dividends received from subsidiaries	101	—	(101)	—	—
Change in amounts due to/from affiliates	(18)	(6)	24	—	—
Other, net	6	—	(25)	—	(19)
Net cash (used in) provided by investing activities	(349)	1	142	—	(206)
Financing activities:					
Other, net	20	—	(1)	—	19
Net cash provided by (used in) financing activities	20	—	(1)	—	19
Net increase (decrease) in cash, cash equivalents, and restricted cash and cash equivalents	(274)	—	760	—	486
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	360	—	2,066	—	2,426
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 86	$ —	$ 2,826	$ —	$ 2,912

CONTROLS AND PROCEDURES

MANAGEMENT'S EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures, as defined in Rule 13a-15(e) and Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the Exchange Act), that are designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is accumulated and communicated to our management, including our principal executive officer and principal financial officer or persons performing similar functions, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management is required to apply its judgment in evaluating the cost-benefit relationship of any possible controls and procedures.

Under the supervision and with the participation of our management, including our chief executive officer and our chief financial officer, we carried out an evaluation of the effectiveness of our disclosure controls and procedures as of the end of the period covered by this Form 10-K pursuant to Rule 13a-15(b) and Rule 15d-15(b) of the Exchange Act. Based on this evaluation, our chief executive officer and our chief financial officer concluded that our disclosure controls and procedures were effective as of December 31, 2018, at the reasonable assurance level. In addition, management concluded that our consolidated financial statements included in this Annual Report on Form 10-K are fairly stated in all material respects in accordance with U.S. generally accepted accounting principles ("GAAP") for each of the periods presented herein.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets, (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors, and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on our financial statements.

Internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements prepared for external purposes in accordance with GAAP. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of the effectiveness of our internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management concluded that we maintained effective internal control over financial reporting as of December 31, 2018, based on criteria described in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO").

Ernst & Young, LLP, the independent registered public accounting firm who audited our Consolidated Financial Statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2018, that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the Board of Directors of Molina Healthcare, Inc.

Opinion on Internal Control over Financial Reporting

We have audited Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Molina Healthcare, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2018 and 2017 and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and our report dated February 19, 2019, expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 19, 2019

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the Board of Directors of Molina Healthcare, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity and cash flows, for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 19, 2019, expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ ERNST & YOUNG LLP

We have served as the Company's auditor since 2000.

Los Angeles, California
February 19, 2019

OTHER INFORMATION

Principal Accounting Officer Designation

Maurice S. Hebert was designated as our Principal Accounting Officer for purposes of the Securities Exchange Act of 1934, as amended, effective as of February 19, 2019. There is no family relationship between or among Mr. Hebert and any director, executive officer, or person nominated or chosen by the Company to become an executive officer of the Company, and there are no transactions that would be required to be reported pursuant to Item 404(a) of Regulation S-K. For further information, see “Directors, Executive Officers, and Corporate Governance” below.

Amendments to Certificate of Incorporation and Bylaws

On February 18, 2019, in response to feedback from our institutional stockholders, our Board of Directors approved amendments to the Company's Certificate of Incorporation, as amended, in order to declassify our Board of Directors over a three-year period. The amendments will be submitted for adoption by our stockholders at our 2019 annual meeting of stockholders.

In connection with the amendments, our Board of Directors approved an amendment and restatement of the Company’s Bylaws that affected a number of changes. The amendment and restatement deleted Section 3.3(c) of the Bylaws, which provided that any director may be removed at any time only for cause by an affirmative vote of the holders of two-thirds of the shares then entitled to vote in the election of directors. Delaware corporate law provides that, unless otherwise provided in the certificate of incorporation, members of a board that is classified may be removed only for cause. Accordingly, as long as our Board of Directors remains classified, members of the Board will be removable for cause by the holders of a majority of our outstanding shares entitled to vote at an election of directors. If the proposed amendments to the Certificate of Incorporation are adopted by our stockholders, when the Board has ceased to be classified after the three year phase-in period, members of the Board will be removable with or without cause by the holders of a majority of our outstanding shares entitled to vote at an election of directors.

The amendment and restatement also amended the following provisions of the Bylaws:

- Section 2.4, which relates to making available a list of stockholders in connection with stockholder meetings, in order to conform to applicable provisions of the Delaware General Corporation Law; and

- Section 5.1, in order to delete the requirement that the executive officers of the company include a Chief Operating Officer.

The Sixth Amended and Restated Bylaws of the company, which reflect the above amendments, became effective upon approval by our Board of Directors. A copy of the Sixth Amended and Restated Bylaws of the Company is included as Exhibit 3.3 hereto and is incorporated herein by reference.

Amended and Restated Change in Control Severance Plan

On February 18, 2019, our Board of Directors approved an amendment and restatement of the Company’s Change in Control Severance Plan (the “Original Plan”), as set forth in the Molina Healthcare, Inc. Amended and Restated Change in Control Severance Plan (the “Amended and Restated Plan”).

The Amended and Restated Plan provides that all employees with positions of vice president and above, including our named executive officers, are eligible to receive certain separation benefits in the event of a qualifying termination of employment within two years following a change in control of the Company. The Amended and Restated Plan left unchanged the provisions of the Original Plan providing that senior vice presidents and above would be entitled to receive two times (2x) their base salary, vice presidents would be entitled to receive one times (1x) their base salary, and all participants would be entitled to receive a prorated target bonus for the year of termination and accelerated vesting of all of their time-based equity awards.

The Amended and Restated Plan amends the accelerated vesting provision with respect to performance-based equity compensation that participants were eligible to receive under the Original Plan. Pursuant to the Original Plan, participants would have been entitled to full vesting of all performance-based equity compensation. The Amended and Restated Plan provides that the participant’s performance-based equity compensation shall become vested based upon the greater of: (1) target performance, based on the assumption that such target performance had been achieved, or (2) the projected final achievement of the performance metric through the measurement period, provided that where applicable, such projected final achievement shall be based on straight-line extrapolation of actual achievement (as of the termination date) through the end of the respective performance metric period; except

to the extent vesting is determined by reference to any completed fiscal year, then actual performance for such completed fiscal year shall be used.

In addition, the Amended and Restated Plan amends the post-termination continued healthcare and life insurance benefit that participants were eligible to receive under the Original Plan. The Original Plan provided that, in the event of a qualifying termination, participants would be entitled to continued health care, dental, and life insurance benefits under the Company's applicable benefits programs for 24 months following the date of termination, and would be eligible for COBRA continuation coverage following such period. The Amended and Restated Plan provides that if the participant elects continued healthcare coverage under COBRA, the Company will, for a period of up to 18 months following the participant's termination of employment, subsidize a portion of the participant's COBRA premiums in an amount equal to the difference between the full cost for such COBRA coverage and the amount that the participant would be required to pay for such coverage as an active employee. The Amended and Restated Plan does not provide a continued life insurance benefit.

The Amended and Restated Plan makes certain additional changes to the Original Plan, including the addition of a clawback provision that would allow the Company to recoup severance benefits paid or provided to a participant who violates the nondisparagement, confidentiality, or nonsolicitation provisions set forth therein.

The named executive officers are entitled to receive such separation benefits under the Amended and Restated Plan only to the extent that such separation benefits would be in addition to or in excess of the benefits provided under their employment/change of control agreements.

The foregoing summary of the Amended and Restated Plan does not purport to be complete and is subject to, and qualified in its entirety by, the full text of the Amended and Restated Plan. A copy of the Amended and Restated Plan is included as Exhibit 10.1 hereto and is incorporated herein by reference.

DIRECTORS, EXECUTIVE OFFICERS, AND CORPORATE GOVERNANCE

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
Joseph M. Zubretsky	62	President and Chief Executive Officer
Thomas L. Tran	62	Chief Financial Officer
Jeff D. Barlow	56	Chief Legal Officer and Corporate Secretary
James E. Woys	60	Executive Vice President, Health Plan Services
Mark L. Keim	53	Executive Vice President, Strategic Planning, Corporate Development & Transformation
Pamela S. Sedmak	57	Executive Vice President, Health Plan Operations
Maurice S. Hebert	56	Chief Accounting Officer

Mr. Zubretsky has served as President and Chief Executive Officer since November 6, 2017. He served as the President and Chief Executive Officer of The Hanover Insurance Group, Inc. from June 2016 to October 2017. Prior to that, Mr. Zubretsky served almost nine years at Aetna, Inc., where he most recently served as Chief Executive Officer of Healthagen Holdings, a group of healthcare services and information technology companies at Aetna, from January 2015 to October 2015. Prior to that, he served as a Senior Executive Vice President leading Aetna's National Businesses from 2013 to 2014, and served as Aetna's Chief Financial Officer from 2007 to 2013. None of the entities where Mr. Zubretsky was previously employed is a parent, subsidiary, or other affiliate of the Company.

Mr. Tran has served as Chief Financial Officer since June 2018. He served as the Chief Financial Officer and Chief Operating Officer of Sentry Data Systems from 2014 to 2018. Prior to that, Mr. Tran served as Chief Financial Officer of WellCare Health Plans from 2008 to 2014. None of the entities where Mr. Tran was previously employed is a parent, subsidiary, or other affiliate of the Company.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010.

Mr. Woys has served as Executive Vice President, Health Plan Services since May 2018. Mr. Woys spent 30 years at Health Net where he most recently served as the Executive Vice President and Chief Financial and Operating

Officer. None of the entities where Mr. Woys was previously employed is a parent, subsidiary, or other affiliate of the Company.

Mr. Keim has served as Executive Vice President, Strategic Planning, Corporate Development and Transformation since January 2018. Most recently, he served as executive vice president of corporate development and strategy for The Hanover Insurance Group. Prior to The Hanover Insurance Group, Mr. Keim spent six years with Aetna where he led major strategic initiatives. Before Aetna, he was senior vice president of strategy and business development at GE Capital. None of the entities where Mr. Keim was previously employed is a parent, subsidiary, or other affiliate of the Company.

Ms. Sedmak has served as Executive Vice President, Health Plan Operations since February 2018. Ms. Sedmak brings more than 25 years of Medicaid managed care leadership experience in operations, strategy, and finance. Most recently, she was a senior adviser at McKinsey & Company, serving clients in the health care services and global corporate finance practice areas. Prior to McKinsey, she served as president and CEO for Aetna Medicaid/Dual Eligibles. Before Aetna, Ms. Sedmak held C-level leadership positions at Blue Cross and Blue Shield of Minnesota, CareSource and General Electric. None of the entities where Ms. Sedmak was previously employed is a parent, subsidiary, or other affiliate of the Company.

Mr. Hebert has served as Chief Accounting Officer since September 2018. He joins the Company from Tufts Health Plan, where he served as Senior Vice President of Finance from 2016 to 2018. Prior to that, Mr. Hebert served as Chief Accounting Officer at WellCare Health Plans from 2010 to 2016. None of the entities where Mr. Hebert was previously employed is a parent, subsidiary, or other affiliate of the Company.

Each executive officer serves at the pleasure of the board of directors.

The remaining information called for by Item 10 of Form 10-K is incorporated by reference to “Election of Directors,” “Corporate Governance and Board of Directors Matters,” and “Section 16(a) Beneficial Ownership Reporting Compliance” in our definitive proxy statement for our 2019 Annual Meeting of Stockholders.

EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) The consolidated financial statements and exhibits listed below are filed as part of this Form 10-K.

(1) The financial statements included in Financial Statements and Supplementary Data, above, are filed as part of this annual report.

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 19th day of February, 2019.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Zubretsky **Joseph M. Zubretsky**	Chief Executive Officer, President and Director (Principal Executive Officer)	February 19, 2019
/s/ Thomas L. Tran **Thomas L. Tran**	Chief Financial Officer and Treasurer (Principal Financial Officer)	February 19, 2019
/s/ Maurice S. Hebert **Maurice S. Hebert**	Chief Accounting Officer (Principal Accounting Officer)	February 19, 2019
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	February 19, 2019
/s/ Daniel Cooperman **Daniel Cooperman**	Director	February 19, 2019
/s/ Charles Z. Fedak **Charles Z. Fedak**	Director	February 19, 2019
/s/ Steven J. Orlando **Steven J. Orlando**	Director	February 19, 2019
/s/ Ronna E. Romney **Ronna E. Romney**	Director	February 19, 2019
/s/ Richard M. Schapiro **Richard M. Schapiro**	Director	February 19, 2019
/s/ Dale B. Wolf **Dale B. Wolf**	Chairman of the Board	February 19, 2019
/s/ Richard C. Zoretic **Richard C. Zoretic**	Director	February 19, 2019

INDEX TO EXHIBITS

The following exhibits, which are furnished with this Annual Report on Form 10-K (this "Form 10-K") or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Form 10-K may contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Form 10-K not misleading.

Number	Description	Method of Filing
2.1	Membership Interest Purchase Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Healthcare, Inc.	Filed as Exhibit 2.1 to registrant's Form 8-K filed September 8, 2015.
2.2	Amendment to Membership Interest Purchase Agreement, dated as of October 30, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Pathways, LLC, as assignee of all rights and obligations of Molina Healthcare, Inc.	Filed as Exhibit 2.2 to registrant's Form 10-K filed February 26, 2016.
2.3	Membership Interest Purchase Agreement, dated as of October 19, 2018, by and among Pyramid Health Holdings, LLC, Molina Pathways, LLC, and Molina Healthcare, Inc.**	Filed as Exhibit 2.1 to registrant's Form 10-Q filed November 1, 2018.
2.4	Purchase and Sale Agreement, dated as of June 26, 2018, by and between Molina Healthcare, Inc. and DXC Technology Company**	Filed as Exhibit 2.1 to registrant's Form 8-K filed June 27, 2018.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Certificate of Amendment to Certificate of Incorporation	Filed as Appendix A to registrant's Definitive Proxy Statement on Form DEF 14A filed March 25, 2013.
3.3	Sixth Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed herewith.
4.1	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.2	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.3	Indenture, dated as of September 5, 2014, by and between Molina Healthcare, Inc. and U.S. Bank National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014.
4.4	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014.
4.5	First Supplemental Indenture, dated as of September 16, 2014, by and between Molina Healthcare, Inc. and the U.S. Bank National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014.
4.6	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014.
4.7	Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.8	Form of 5.375% Senior Notes due 2022	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.9	Form of Guarantee pursuant to Indenture, dated as of November 10, 2015, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.

Number	Description	Method of Filing
4.10	First Supplemental Indenture, dated as of February 16, 2016, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 18, 2016.
4.11	Indenture, dated June 6, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee.	Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
4.12	Form of Notes (included in Exhibit 4.1 to registrant's Form 8-K filed June 6, 2017).	Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
4.13	Form of Guarantees (included in Exhibit 4.1 to registrant's Form 8-K filed June 6, 2017).	Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
*10.1	Molina Healthcare, Inc. Amended and Restated Change in Control Severance Plan	Filed herewith.
*10.2	2011 Equity Incentive Plan	Filed as Exhibit 10.8 to registrant's Form 10-K filed February 26, 2014.
*10.3	2011 Employee Stock Purchase Plan	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2015.
*10.4	2011 Equity Incentive Plan - Form of Stock Option Agreement (Director)	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 4, 2017.
*10.5	2011 Equity Incentive Plan - Form of Restricted Stock Award Agreement (Employee)	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 4, 2017.
*10.6	2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 1 (Executive Officer)	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 4, 2017.
*10.7	2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 2 (Executive Officer)	Filed as Exhibit 10.5 to registrant's Form 10-Q filed May 4, 2017.
*10.8	Employment Agreement with Jeff Barlow dated June 14, 2013	Filed as Exhibit 10.3 to registrant's Form 8-K filed June 14, 2013.
*10.9	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed as Exhibit 10.16 to registrant's Form 10-K filed February 28, 2013.
*10.10	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
*10.11	Employment Agreement, dated October 9, 2017, by and between Molina Healthcare, Inc. and Joseph M. Zubretsky.	Filed as Exhibit 10.1 to registrant's Form 8-K filed October 10, 2017.
*10.12	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
*10.13	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.
10.14	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.
10.15	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.16	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.17	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.18	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.19	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.
10.20	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013.
10.21	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013.

Number	Description	Method of Filing
10.22	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013.
10.23	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013.
10.24	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013.
10.25	Guarantor Joinder Agreement, dated February 16, 2016, by and among the guarantors party thereto and SunTrust Bank, as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 18, 2016.
10.26	Purchase Agreement, dated May 22, 2017, by and among the Company, the guarantors party thereto and SunTrust Robinson Humphrey, Inc., as representative of the several initial purchasers named in Schedule A thereto.	Filed as Exhibit 1.1 to registrant's Form 8-K filed May 23, 2017.
10.27	Commitment Letter, dated December 4, 2017, by and among Molina Healthcare, Inc., SunTrust Bank and SunTrust Robinson Humphrey, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed December 7, 2017.
10.28	Amended and Restated Commitment Letter, dated as of January 2, 2018, by and among Molina Healthcare, Inc., SunTrust Bank, SunTrust Robinson Humphrey, Inc., Barclays Bank PLC, MUFG, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Morgan Stanley Senior Funding, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 2, 2018.
10.29	Bridge Credit Agreement, dated as of January 2, 2018, by and among Molina Healthcare, Inc., as the Borrower, Molina Information Systems, LLC, Molina Pathways LLC and Pathways Health and Community Support LLC, as the Guarantors, SunTrust Bank, Barclays Bank PLC, The Bank of Tokyo-Mitsubishi UFJ, Ltd., Bank of America, N.A., and Morgan Stanley Senior Funding, Inc., as Lenders, and SunTrust Bank, as Administrative Agent.	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 2, 2018.
10.30	Capitated Medical Group/IPA Provider Services Agreement, effective May 1, 2013, by and between Molina Healthcare of California and Pacific Healthcare IPA	Filed as Exhibit 10.42 to registrant's Form 10-K filed February 26, 2016.
10.31	Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to Molina Healthcare of California Group/IPA Provider Services Agreement(s), effective September 26, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed as Exhibit 10.43 to registrant's Form 10-K filed February 26, 2016.
10.32	Capitated Financial Alignment Demonstration Amendment to Molina Healthcare of California Group/IPA Provider Services Agreement, effective as of July 1, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed as Exhibit 10.44 to registrant's Form 10-K filed February 26, 2016.
10.33	Offer Letter, dated May 4, 2018, by and between Molina Healthcare, Inc. and Thomas L. Tran.	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 24, 2018.
10.34	Sixth Amendment to Credit Agreement, dated as of January 31, 2019, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacity as Administrative Agent, including the amended and restated Credit Agreement attached as Exhibit A thereto, the amended and restated Schedule I to the Credit Agreement attached as Exhibit B thereto and the amended and restated Exhibit 2.5 to the Credit Agreement attached as Exhibit C thereto.	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 31, 2019.
10.35	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2018)	Filed as Exhibit 10.2 to registrant's Form 10-Q filed August 1, 2018.
+10.36	Master Services Agreement for Information Technology Services, dated February 4, 2019, by and between Molina Healthcare, Inc. and Infosys Limited.	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.

Number	Description	Method of Filing
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
101.INS	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

** Certain schedules and exhibits to this agreement have been omitted in accordance with Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule and/or exhibit will be furnished to the Securities and Exchange Commission upon request.

\+ Portions of this exhibit have been omitted pursuant to a request for confidential treatment filed with the Securities and Exchange Commission under Rule 24b-2. The omitted confidential material has been filed separately. The location of the redacted confidential information is indicated in the exhibit as “[redacted]”.

SIXTH AMENDED AND RESTATED

BYLAWS

OF

MOLINA HEALTHCARE, INC.

a Delaware corporation

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SIXTH AMENDED AND RESTATED BYLAWS
OF
MOLINA HEALTHCARE, INC.

ARTICLE I

OFFICES

Section 1.1 Registered Office. The registered office of the Corporation shall be maintained in the County of New Castle, State of Delaware, and the registered agent in charge thereof is Corporation Service Company.

Section 1.2 Other Offices. The Corporation may also have offices and keep the books and records of the Corporation, except as may otherwise be required by law, at such other places both within and outside the State of Delaware as the Board of Directors of the Corporation (the "Board of Directors") may from time to time determine or the business of the Corporation may require.

ARTICLE II

STOCKHOLDERS' MEETINGS

Section 2.1 Place of Meetings. All meetings of the stockholders, whether annual or special, shall be held at an office of the Corporation or at such other place, within or outside the State of Delaware, as may be fixed from time to time by the Board of Directors.

Section 2.2 Annual Meetings.

(a) The annual meeting of the stockholders shall be held at such date and time as shall be designated from time to time by the Board of Directors and stated in the notice of annual meeting, at which such stockholders shall elect members to the Board of Directors and transact such other business as may properly be brought before such meeting. Nominations of persons for election to the Board of Directors of the Corporation and the proposal of business to be considered by the stockholders may be made at an annual meeting of stockholders (i) pursuant to the Corporation's notice of meeting of stockholders, (ii) by or at the direction of the Board of Directors, (iii) by any stockholder of the Corporation who was a stockholder of record at the time of giving of notice provided for in Section 2.2(b) or, if applicable, Section 2.13, who is entitled to vote at such meeting and who complied with the notice procedures set forth in Section 2.2(b) or Section 2.13, as applicable. In lieu of holding an annual meeting of stockholders at a designated place, the Board of Directors may, in its sole discretion, determine that any annual meeting of stockholders may be held solely by means of remote communication, pursuant to Section 2.12.

(b) (1) At an annual meeting of the stockholders, only such business as shall have been properly brought before such meeting shall be conducted. For nominations or other business to be properly brought before an annual meeting by a stockholder pursuant to Section 2.2(c) of these Amended and Restated Bylaws (these “Bylaws”), (i) such stockholder must have given timely notice thereof in writing to the Secretary of the Corporation; (ii) such other business must be a proper matter for stockholder action under the General Corporation Law of the State of Delaware; (iii) if such stockholder, or the beneficial owner on whose behalf any such nomination or proposal is made (such stockholder or beneficial owner, a “Holder”), has provided the Corporation with a Solicitation Notice (as such term is hereinafter defined), such Holder must, in the case of a nomination or nominations, have delivered a proxy statement and form of proxy to holders of a percentage of the Corporation's voting shares reasonably believed by such Holder to be sufficient to elect the nominee or nominees proposed to be nominated by such stockholder, and must, in either case, have

included in such materials the Solicitation Notice or, in the case of a proposal, have delivered a proxy statement and form of proxy to holders of at least the percentage of the Corporation's voting shares required under applicable law to carry any such proposal; and (iv) if no Solicitation Notice relating thereto has been timely provided pursuant to this Section 2.2(b), the Holder proposing such nomination or business must not have solicited a number of proxies sufficient to have required the delivery of such a Solicitation Notice under this Section 2.2. To be timely, a stockholder's notice shall be delivered to the Secretary of the Corporation at the principal executive offices of the Corporation not later than the close of business on the ninetieth (90th) day nor earlier than the close of business on the one hundred twentieth (120th) day prior to the first anniversary of the preceding year's annual meeting of the stockholders; provided, however, that in the event that the date of the annual meeting is scheduled more than thirty (30) days prior to the anniversary of the preceding year's annual meeting, notice by the stockholder, to be timely, must be so delivered not earlier than the close of business on the one hundred twentieth (120th) day prior to such annual meeting and not later than the close of business on the later of the ninetieth (90th) day prior to such annual meeting or the tenth (10th) day following the day on which public announcement of the date of such meeting is first made. In no event shall the public announcement of an adjournment of an annual meeting of the stockholders commence a new time period for the giving of a stockholder's notice as described above (the "Stockholder's Notice").

(2) The Stockholder's Notice shall set forth:

(i) as to each person that the stockholder proposes to nominate for election or reelection as a director:

(A) all information relating to such person that is required to be disclosed in solicitations of proxies for the election of directors in an election contest or is otherwise required, in each case pursuant to Regulation 14A under the Securities Exchange Act of 1934, as amended (the "1934 Act") (including such person's written consent to being named in the proxy statement as a nominee and to serving as a director if elected);

(B) a description of all direct and indirect compensation and other material monetary agreements, arrangements and understanding during the past three years, and any other material relationships, between or among the stockholder and its affiliates and associates, or others acting in concert therewith, on the one hand, and each proposed nominee, and each proposed nominee's respective affiliates and associates, and others acting in concert therewith, on the other hand, including, without limitation, all information that would be required to be disclosed pursuant to Item 404 of Regulation S-K if the stockholder making the nomination or on whose behalf the nomination is made, or any affiliate or associate thereof or any person acting in concert therewith, were the "registrant" for purposes of Item 404 and the nominee were a director or executive officer of such registrant;

(C) a list of all positions held by any proposed nominee as an officer or director of any competitor (as defined for purposes of Section 8 of the Clayton Antitrust Act of 1914, as amended, within the three (3) years preceding the submission of the Stockholder Notice; and

(D) a completed and signed questionnaire, representation and agreement required by subsection 2.2(f) (and the Corporation may require any proposed nominee to furnish such other information as may be reasonably required by the Corporation to determine the eligibility of the proposed nominee to serve as an independent director of the Corporation or that could be material to a reasonable stockholder's understanding of the independence or lack thereof, of the nominee);

(ii) as to any other business that such stockholder proposes to bring before the meeting:

(A) a brief description of the business desired to be brought before such meeting, the text of the proposal or business (including the text of any resolutions proposed for consideration and in the event that such business includes a proposal to amend the Bylaws of the Corporation, the language

of the proposed amendment), the reasons for conducting such business at the meeting and any material interest in such business of such Holder, if any, on whose behalf such proposal is made; and

(B) a description of all agreements, arrangements and understandings, direct and indirect, between such Holder and any other person or persons (including their names), in connection with the proposal of such business.

(iii) as to the Holder, and if the Holder is an entity, as to each director, executive officer, managing member or control person of such entity (each such individual and control person, a "control person"):

(A) the name and address of such Holder and control person, as applicable;

(B) the following information regarding the ownership interests of the Holder and control persons, as applicable, which shall be supplemented not later than 10 days after the record date for the meeting to disclose such interests as of the record date:

(1) the class and number of shares of the Corporation that are owned beneficially and of record by the Holder and by any control person;

(2) a description of any agreement, arrangement or understanding (including, without limitation, any derivative or short positions, profit interests, options, hedging transactions, and borrowed or loaned shares) that has been entered into as of the date of the stockholder's notice by, or on behalf of such Holder or control person, the effect or intent of which is to mitigate loss, manage risk or benefit from changes in the share price of any class or series of the Corporation's stock, or maintain, increase or decrease the voting power of the Holder or control person with respect to shares of the Corporation (any such agreement, arrangement or understanding, a "Derivative Instrument");

(3) a description of any proxy, contract, arrangement, understanding, or relationship with respect to a nomination or other business between or among such Holder, any of its affiliates or associates, and any others acting in concert with any of the foregoing, including in the case of a nomination, the nominee or pursuant to which such Holder has a right or obligation to vote any shares of any security of the Corporation;

(4) a description of the terms of and number of shares subject to any short interest in any security of the Corporation (for purposes of this Section 2.2(b), a person shall be deemed to have a short interest in a security if such person directly or indirectly, through any contract, arrangement, understanding, relationship or otherwise, has the opportunity to profit or share in any profit derived from any decrease in the value of the subject security);

(5) a description of any proportionate interest in shares of the Corporation or Derivative Instruments held, directly or indirectly, by a general or limited partnership or limited liability company or similar entity in which such Holder or any control person is a general partner or, directly or indirectly, beneficially owns an interest in a general partner, is the manager, managing member or directly or indirectly owns an interest in the manager or managing member of a limited liability company or similar entity;

(6) a description of the terms of and number of shares subject to any performance-related fees (other than an asset-based fee) to which such Holder or control person is entitled based on any increase or decrease in the value of shares of the Corporation or Derivative Instruments, if any, as of the date of such notice;

(7) a description of the terms of and number of shares subject to any arrangements, rights, or other interests described in Sections 2.2(b)(iii)(B)(2)-(6) held by members of such Holder's or control person's immediate family sharing the same household; and

(8) any other information relating to the Holder or control person, or any person who would be considered a participant in a solicitation with such Holder or control person that would be required to be disclosed in a proxy statement or other filings required to be made in connection with solicitations of proxies for, as applicable, the proposal and/or for the election of directors in a contested election pursuant to Section 14 of the 1934 Act and the rules and regulations thereunder;

(iv) a representation that the stockholder is a holder of record of stock of the Corporation entitled to vote at such meeting and intends to vote or cause to be voted its stock at the meeting and intends to appear in person or by proxy at the meeting to propose such business or nomination; and

(v) whether either such Holder intends (or is part of a group that intends) to deliver a proxy statement and form of proxy to holders of, in the case of a nomination or nominations, a sufficient number of holders of the Corporation's voting shares to elect such nominee or nominees or, in the case of the proposal, at least the percentage of the Corporation's voting shares required under applicable law to carry the proposal (an affirmative statement of such intent, a "Solicitation Notice").

For purposes of these Bylaws, the term "affiliate" or "affiliates" and "associate" or "associates" shall have the meanings ascribed thereto under the General Rules and Regulations under the 1934 Act.

(c) Notwithstanding anything in the second sentence of Section 2.2(b(1) of these Bylaws to the contrary, in the event that the number of directors to be elected to the Board of Directors of the Corporation is increased effective after the time period for which nominations would otherwise be due under Section 2.2(b) and there is no public announcement naming all of the nominees for director or specifying the size of the increased Board of Directors made by the Corporation at least one hundred (100) days prior to the first anniversary of the preceding year's annual meeting, a stockholder's notice required by Section 2.2 (b) shall also be considered timely, but only with respect to nominees for any new positions created by such increase, if it shall be delivered to the Secretary at the principal executive offices of the Corporation not later than the close of business on the tenth (10th) day following the day on which such public announcement is first made by Corporation.

(d) Notwithstanding the foregoing provisions of this Section 2.2, in order to include information with respect to a stockholder proposal in the proxy statement and form of proxy for a stockholders' meeting pursuant to Rule 14a-8 under the 1934 Act, stockholders must provide notice as required by the regulations promulgated under the 1934 Act. Nothing in these Bylaws shall be deemed to affect any rights of stockholders to request inclusion of proposals in the Corporation proxy statement pursuant to Rule 14a-8 under the 1934 Act.

(e) For purposes of this Section 2.2, "public announcement" shall mean disclosure in a press release reported by the Dow Jones News Service, Associated Press or comparable national news service or in a document publicly filed by the Corporation with the Securities and Exchange Commission pursuant to Section 13, 14 or 15(d) of the 1934 Act.

(f) To be eligible to be a nominee for election or reelection by a stockholder pursuant to Section 2.2(b) or by an Eligible Stockholder pursuant to Section 2.13, a person must complete and deliver (in accordance with the time periods prescribed for delivery of notice under Section 2.2(b) or Section 2.13, as applicable), to the Secretary at the principal offices of the Corporation a written questionnaire providing the information requested about the background and qualifications of such person and the background of any other person or entity on whose behalf the nomination is being made and a written representation and agreement (the questionnaire, representation, and agreement to be in the form provided by the Secretary upon written request) of such person that such person:

(1) is not and will not become a party to:

(i) any agreement, arrangement or understanding with, and has not given any commitment or assurance to, any person or entity as to how the person, if elected as a director of the Corporation, will act or vote on any issue or question (a "Voting Commitment") that has not been disclosed to the Corporation, or

(ii) any Voting Commitment that could limit or interfere with the person's ability to comply, if elected as a director of the Corporation, with the person's fiduciary duties under applicable law,

(2) is not and will not become a party to any agreement, arrangement or understanding with any person or entity other than the Corporation with respect to any direct or indirect compensation, reimbursement, or indemnification in connection with service or action as a director that has not been disclosed to the Corporation, and

(3) would be in compliance, if elected as a director of the Corporation, and will comply with all applicable publicly disclosed corporate governance, conflict of interest, confidentiality, and stock ownership and trading policies and guidelines of the Corporation.

Section 2.3 Notice of Annual Meeting. Written notice of the annual meeting stating the place, date and time of the meeting, shall be given not less than ten nor more than sixty days before the date of the meeting to each stockholder entitled to vote at such meeting. If mailed, notice is given when deposited in the United States mail, postage prepaid, directed to the stockholder at his address as it appears on the records of the Corporation. In lieu of holding an annual meeting of stockholders at a designated place, the Board of Directors may, in its sole discretion, determine that any annual meeting of stockholders may be held solely by means of remote communication in accordance with Section 2.12.

Section 2.4 Stockholders' List. The Corporation shall prepare, at least ten (10) days before every meeting of stockholders, a complete list of the stockholders entitled to vote at the meeting; provided, however, if the record date for determining the stockholders entitled to vote is less than ten (10) days before the meeting date, the list shall reflect the stockholders entitled to vote as of the tenth day before the meeting date, arranged in alphabetical order, and showing the address of each stockholder and the number of shares registered in the name of each stockholder. The Corporation shall not be required to include electronic mail addresses or other electronic contact information on such list. Such list shall be open to the examination of any stockholder for any purpose germane to the meeting for a period of at least ten (10) days prior to the meeting: (i) on a reasonably accessible electronic network, provided that the information required to gain access to such list is provided with the notice of the meeting, or (ii) during ordinary business hours, at the Corporation's principal place of business. In the event that the Corporation determines to make the list available on an electronic network, the Corporation may take reasonable steps to ensure that such information is available only to stockholders of the Corporation. If the meeting is to be held at a place, then a list of stockholders entitled to vote at the meeting shall be produced and kept at the time and place of the meeting during the whole time thereof, and may be examined by any stockholder who is present. If the meeting is to be held solely by means of remote communication, then such list shall also be open to the examination of any stockholder during the whole time of the meeting on a reasonably accessible electronic network, and the information required to access such list shall be provided with the notice of the meeting.

Section 2.5 Special Meetings.

(a) Pursuant to the Certificate of Incorporation, special meetings of the stockholders of the Corporation for any purpose or purposes may be called at any time by the President or Chief Executive Officer of the Corporation, the Chairperson of the Board of Directors, the Board of Directors or by a committee of the Board of Directors which has been duly designated by the Board of Directors and the powers and authority of which, as provided in a resolution of the Board of Directors or in the Bylaws of the Corporation,

include the power to call such meetings. Such special meetings may not be called by any other person or persons.

(b) If a special meeting is properly called by any person or persons other than the Board of Directors, the request shall be in writing, specifying the general nature of the business proposed to be transacted, and shall be delivered personally or sent by registered mail or by telegraphic or other facsimile transmission to the Secretary of the Corporation. No business may be transacted at such special meeting, otherwise than specified in such notice or as resolved by the Board of Directors. The Board of Directors shall determine the time and place of such special meeting, which shall be held not less than thirty- five (35) nor more than one hundred twenty (120) days after the date of the receipt of the request. Upon determination of the time and place of the meeting, the Secretary shall cause notice to be given to the stockholders entitled to vote, in accordance with the provisions of Section 2.6 of these Bylaws. If the notice is not given within one hundred (100) days after the receipt of the request, the person or persons properly requesting the meeting may set the time and place of the meeting and give the notice. Nothing contained in this paragraph (b) shall be construed as limiting, fixing, or affecting the time when a meeting of stockholders called by action of the Board of Directors may be held.

(c) Nominations of persons for election to the Board of Directors may be made at a special meeting of stockholders at which directors are to be elected pursuant to the Corporation's notice of meeting (i) by or at of the direction of the Board of Directors or (ii) provided that the Board of Directors has determined that directors shall be elected at such meeting, by any stockholder of the Corporation who is a stockholder of record at the time of giving notice provided for in these Bylaws who shall be entitled to vote at the meeting and who complies with the notice procedures set forth in this Section 2.5(c). In the event the Corporation calls a special meeting of stockholders for the purpose of electing one or more directors to the Board of Directors, any such stockholder may nominate a person or persons (as the case may be), for election to such position(s) as specified in the Corporation's notice of meeting, if a Stockholder's Notice (as provided pursuant to Section 2.2(b) of these Bylaws) shall be delivered to the Secretary at the principal executive offices of the Corporation not earlier than the close of business on the one hundred twentieth (120th) day prior to such special meeting and not later than the close of business on the later of the ninetieth (90th) day prior to such meeting or the tenth (10th) day following the day on which public announcement is first made of the date of the special meeting and of the nominees proposed by the Board of Directors to be elected at such meeting. In no event shall the public announcement of an adjournment of a special meeting commence a new time period for the giving of a stockholder's notice as described above.

Section 2.6 Notice of Special Meetings. Written notice of a special meeting, stating the place, date and hour of the meeting and the purpose or purposes for which the meeting is called, shall be given not less than ten nor more than sixty days before the date of the meeting to each stockholder entitled to vote at such meeting. If mailed, notice is given when deposited in the United States mail, postage prepaid, directed to the stockholder at his address as it appears on the records of the Corporation. In lieu of holding a special meeting of stockholders at a designated place, the Board of Directors may, in its sole discretion, determine that any special meeting of stockholders may be held solely by means of remote communication in accordance with Section 2.12.

Section 2.7 Quorum; Adjournment. The holders of a majority of the shares issued and outstanding and entitled to vote thereat, present in person or represented by proxy, shall be requisite and shall constitute a quorum at all meetings of the stockholders for the transaction of business except as otherwise provided by statute, by the Certificate of Incorporation or by these Bylaws. If, however, such quorum shall not be present or represented at any meeting of the stockholders, the chairman of the meeting or, in the absence of such person, any officer entitled to preside at or act as secretary of such meeting, or the stockholders entitled to vote thereat, present in person or represented by proxy, shall have the power to adjourn the meeting from time to time, without notice other than announcement at the

meeting, of the place, date and hour of the adjourned meeting, until a quorum shall again be present or represented by proxy. At the adjourned meeting at which a quorum shall be present or represented by proxy, the Corporation may transact any business which might have been transacted at the original meeting. If the adjournment is for more than thirty (30) days, or if after the adjournment, a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each stockholder of record entitled to vote at the meeting. Shares of its own stock belonging to the Corporation or to another corporation, if a majority of the shares entitled to vote in the election of directors of such other corporation is held, directly or indirectly, by the Corporation, shall neither be entitled to vote nor be counted for quorum purposes; provided, however, that the foregoing shall not limit the right of the Corporation to vote stock, including, without limitation, its own stock, held by it in a fiduciary capacity.

Section 2.8 Conduct of Business. (a) Only persons who are nominated in accordance with the procedures set forth in Section 2.2 or Section 2.5 shall be eligible to serve as directors and only such business shall be conducted at a meeting of stockholders as shall have been brought before the meeting in accordance with the procedures set forth in Section 2.2 or 2.5. Except as otherwise provided by law, the Chairman of the meeting shall have the power and duty to determine whether a nomination or any business proposed to be brought before the meeting was made, or proposed, as the case may be, in accordance with the procedures set forth in these Bylaws and, if any proposed nomination or business is not in compliance with these Bylaws, to declare that such defective proposal or nomination shall not be presented for stockholder action at the meeting and shall be disregarded. Notwithstanding the foregoing provisions of this Section 2.8, unless otherwise required by law, if the stockholder (or a qualified representative of the stockholder) does not appear at the annual or special meeting of stockholders of the Corporation to present a nomination or proposed business, such nomination shall be disregarded and such proposed business shall not be transacted, notwithstanding that proxies in respect of such vote may have been received by the Corporation.

(b) At every meeting of the stockholders, the President or, in his or her absence, such other person as may be appointed by the Board of Directors, shall act as chairman of the meeting. The Secretary of the Corporation or, in his or her absence, such other person as designated by the chairman of the meeting, shall act as secretary of the meeting. The chairman of the meeting shall call the meeting to order, establish the agenda, and conduct the business of the meeting in accordance therewith or, at the chairman's discretion, it may be conducted otherwise in accordance with the wishes of the stockholders in attendance. The date and time of the opening and closing of the polls for each matter upon which the stockholders will vote at the meeting shall be announced at the meeting. The chairman shall also conduct the meeting in an orderly manner, rule on the precedence of, and procedure on, motions and other procedural matters, and exercise discretion with respect to such procedural matters with fairness and good faith toward all those entitled to take part. Without limiting the foregoing, the chairman of the meeting may (a) restrict attendance at any time to bona fide stockholders of record and their proxies and other persons as invited by the chairman or Board of Directors, (b) restrict use of audio or video recording devices at the meeting, and (c) impose reasonable limits on the amount of time taken up at the meeting on discussion in general or on remarks by any one stockholder. Should any person in attendance become unruly or obstruct the meeting proceedings, the chairman shall have the power to have such person removed from the meeting. Notwithstanding anything in the Bylaws to the contrary, no business shall be conducted at a meeting except in accordance with the procedures set forth in this Section 2.8.

Section 2.9 Voting. When a quorum is present at any meeting, and subject to the provisions of the General Corporation Law of the State of Delaware, the Certificate of Incorporation or by these Bylaws or any other applicable law or the rules of any stock exchange on which the Corporation's shares are listed in respect of the vote that shall be required for a specified action, the vote of the holders of a majority of the shares having voting power, present in person or represented by proxy and entitled to vote on such matter, shall decide any question brought before such meeting, unless the question is one upon which, by

express provision of the General Corporation Law of the State of Delaware or of the Certificate of Incorporation or of these Bylaws or of such other applicable law or the rules of any stock exchange on which the Corporation's shares are listed, a different vote is required in which case such express provision shall govern and control the decision of such question. Each stockholder shall have one vote for each share of stock having voting power registered in his name on the books of the Corporation, except as otherwise provided in the Certificate of Incorporation.

Section 2.10 Proxies.

(a) Each stockholder entitled to vote at a meeting of stockholders or to express consent or dissent to corporate action in writing without a meeting may authorize another person or persons to act for him by proxy, but no such proxy shall be voted or acted upon after three years from its date, unless the proxy provides for a longer period.

(b) A stockholder may issue a valid proxy by (i) executing a written authorization therefor identifying the person or persons authorized to act for such stockholder by proxy or (ii) transmitting or authorizing the transmission of a telegram, cablegram or other means of electronic transmission, provided that the telegram, cablegram or other means of electronic transmission either sets forth or is submitted with information from which it can be determined that the telegram, cablegram or other electronic transmission was authorized by the stockholder. A copy, facsimile transmission or other reliable reproduction of a written or electronically-transmitted proxy authorized by this Section 2.10 may be substituted for or used in lieu of the original writing or electronic transmission. Each proxy shall be delivered to the inspectors of election prior to or at the meeting.

Section 2.11 Inspectors. Either the Board of Directors or, in the absence of designation of inspectors by the Board of Directors, the chairman of any meeting of the stockholders may, in its or such person's discretion, appoint one (1) or more inspectors to act at any meeting of the stockholders. Each inspector, before discharging his or her duties, shall take and sign an oath faithfully to execute the duties of inspector with strict impartiality and according to the best of his or her ability. Such inspectors shall perform such duties as shall be specified by the Board of Directors or the chairman of the meeting. Inspectors need not be Stockholders, employees, officers or directors of the Corporation. No director or nominee for the office of director shall be appointed as any such inspector.

Section 2.12 Meetings by Remote Communication. If authorized by the Board of Directors, and subject to such guidelines and procedures as the Board may adopt, stockholders and proxy holders not physically present at a meeting of stockholders may, by means of remote communication, participate in the meeting and be deemed present in person and vote at the meeting, whether such meeting is to be held at a designated place or solely by means of remote communication, provided that (i) the Corporation shall implement reasonable measures to verify that each person deemed present and permitted to vote at the meeting by means of remote communication is a stockholder or proxy holder, (ii) the Corporation shall implement reasonable measures to provide such stockholders and proxy holders a reasonable opportunity to participate in the meeting and to vote on matters submitted to the stockholders, including an opportunity to read or hear the proceedings of the meeting substantially concurrently with such proceedings, and (iii) if any stockholder or proxy holder votes or takes other action at the meeting by means of remote communication, a record of such vote or other action shall be maintained by the Corporation.

Section 2.13 Proxy Access for Director Nominations.

(a) The Corporation shall include in its proxy statement and/or on its form of proxy or ballot (collectively, "proxy materials") for an annual meeting of stockholders the name of, and the Required Information (as defined below) relating to, any nominee for election or reelection to the Board who satisfies the eligibility requirements in this Section 2.13 (a "Stockholder Nominee") and who is identified in a

Stockholder Notice that complies with Section 2.2(b)(2) and that in addition complies with Section 2.13(f) and that is timely delivered pursuant to Section 2.13(g) by a stockholder on behalf of one or more beneficial owners (such stockholder or beneficial owner, a "Holder"), but in no case more than twenty (20) Holders, who:

(1) elect(s) at the time of delivering the Stockholder Notice to have such Stockholder Nominee included in the Corporation's proxy materials,

(2) as of both the date of the Stockholder Notice, and the record date for determining stockholders entitled to vote at the annual meeting of stockholders, (A) own(s) (as defined below in Section 2.13(c)) a number of shares that represents at least 3% of the outstanding shares of the Corporation entitled to vote in the election of directors as of the most recent date for which such amount is disclosed in any filing by the Corporation with the SEC prior to the submission of the Stockholder Notice (the "Required Shares") and (B) has or have owned (as defined below in Section 2.13(c)) continuously the Required Shares (as adjusted for any stock splits, stock dividends, or similar events) for at least the three (3)-year period preceding the date of the Stockholder Notice, and must continue to hold the Required Shares through the annual meeting date, and

(3) satisfies or satisfy the additional requirements in these Bylaws (such Holder or Holders collectively, an "Eligible Stockholder"). For the avoidance of doubt, in the event of a nomination by a group of Holders, any and all requirements and obligations for an individual Eligible Stockholder set forth in this Section 2.13, including the minimum holding period, shall apply to each member of such group, provided that the Required Shares shall be owned by the group of Holders in the aggregate. Should any Holder withdraw from a group of Holders constituting an Eligible Stockholder at any time prior to the annual meeting of stockholders, the remaining Holders shall be deemed to own only the shares owned by the remaining members of the group in determining if the Holders continue to constitute an Eligible Stockholder.

(b) For purposes of satisfying the ownership requirement under Section 2.13(a):

(1) the outstanding shares of the Corporation owned by one or more Holders may be aggregated, provided that the number of Holders whose ownership of shares is aggregated for such purpose shall not exceed twenty (20), and

(2) a group of funds under common management and investment control shall be treated as one Holder.

(c) For purposes of this Section 2.13, an Eligible Stockholder "owns" only those outstanding shares of the Corporation as to which the Holder possesses both;

(1) the full voting and investment rights pertaining to the shares and

(2) the full economic interest in (including the opportunity for profit and risk of loss on) such shares;

provided that the number of shares calculated in accordance with clauses (1) and (2) shall not include any shares:

(i) sold by such Holder or any of its affiliates in any transaction that has not been settled or closed,

(ii) borrowed by such Holder or any of its affiliates for any purposes or purchased by such Holder or any of its affiliates pursuant to an agreement to resell, or

(iii) subject to any option, warrant, forward contract, swap, contract of sale, other derivative or similar agreement entered into by such Holder or any of its affiliates, whether any such instrument or agreement is to be settled with shares or with cash based on the notional amount or value of

outstanding shares of the Corporation, in any such case which instrument or agreement has, or is intended to have, the purpose or effect of:

(A) reducing in any manner, to any extent or at any time in the future, such Holder's or any of its affiliates' full right to vote or direct the voting of any such shares, and/or

(B) hedging, offsetting, or altering to any degree gain or loss arising from the full economic ownership of such shares by such Holder or affiliate.

A Holder "owns" shares held in the name of a nominee or other intermediary so long as the Holder retains the right to instruct how the shares are voted with respect to the election of directors and possesses the full economic interest in the shares. A Holder's ownership of shares shall be deemed to continue during any period in which the Holder has delegated any voting power by means of a proxy, power of attorney, or other instrument or arrangement that is revocable at any time by the Holder. A Holder's ownership of shares shall be deemed to continue during any period in which the Holder has loaned such shares provided that the Holder has the power to recall such loaned shares on no more than five (5) business days' notice and recalls such loaned shares back to its own possession not more than five (5) business days after being notified that its Stockholder Nominee will be included in the Corporation's proxy material for the relevant annual meeting and holds the recalled shares through date of the annual meeting. The terms "owned," "owning" and other variations of the word "own" shall have correlative meanings. Whether outstanding shares of the Corporation are "owned" for these purposes shall be determined by the Board. For purposes of this Section 2.13, the term "affiliate" or "affiliates" shall have the meaning ascribed thereto under the General Rules and Regulations under the 1934 Act.

(d) No Holder may be a member of more than one group of Holders constituting an Eligible Stockholder under this Section 2.13 per each annual meeting of stockholders.

(e) For purposes of this Section 2.13, the "Required Information" that the Corporation will include in its proxy materials is:

(1) the information concerning the Stockholder Nominee and the Eligible Stockholder that is required to be disclosed in the Corporation's proxy materials by the applicable requirements of the 1934 Act and the rules and regulations thereunder; and

(2) if the Eligible Stockholder so elects, a written statement of the Eligible Stockholder, not to exceed 500 words, in support of its Stockholder Nominee, which must be provided at the same time as the Stockholder Notice for inclusion in the Corporation's proxy materials for the annual meeting (the "Statement").

Notwithstanding anything to the contrary contained in this Section 2.13, the Corporation may omit from its proxy materials any information, including all or a portion of any Statement, if the Corporation in good faith believes such information (A) is not true and correct in all material respects or omits to state a material statement necessary to make the statements therein not misleading; (B) directly or indirectly impugns character, integrity or personal reputation of, or directly or indirectly makes charges concerning improper, illegal or immoral conduct or associations, without factual foundation, with respect to, any person; or (C) would violate any applicable law or regulation. Nothing in this Section 2.13 shall limit the Corporation's ability to solicit against and include in its proxy materials its own statements relating to any Eligible Stockholder or Stockholder Nominee.

(f) The Stockholder Notice shall set forth the information required under Section 2.2(b) (2) of these Bylaws and in addition shall set forth:

(1) a copy of the Schedule 14N that has been or concurrently is filed with the Securities and Exchange Commission under Rule 14a-18 under the 1934 Act;

(2) the details of any relationship not disclosed in the Schedule 14N that existed within the past three years and that would have been described pursuant to Item 6(e) of Schedule 14N (or any successor item) if it existed on the date of submission of the Schedule 14N;

(3) an executed written agreement by the Eligible Stockholder addressed to the Corporation, setting forth the following additional agreements, representations, and warranties:

(i) a representation and warranty as to the number of shares of the Corporation it owns and has owned (as defined in Section 2.13(c)) continuously for at least three years as of the date of the Stockholder Notice and an agreement to continue to own the Required Shares through the date of the annual meeting, which statement shall also be included in the written statements set forth in Item 4 of the Schedule 14N filed by the Eligible Stockholder with the Securities and Exchange Commission, and a representation and warranty that it intends to continue to satisfy the eligibility requirements described in this Section 2.13 through the date of the annual meeting;

(ii) the Eligible Stockholder's agreement to provide written statements from the record holder and intermediaries as required under Section 2.13(h) verifying the Eligible Stockholder's continuous ownership of the Required Shares, such statements to be delivered within five (5) business days after the date of the Stockholder Notice and as of the business day immediately preceding the date of the annual meeting;

(iii) the Eligible Stockholder's representation and agreement that the Eligible Stockholder (including each member of any group of Holders that together is an Eligible Stockholder under this Section 2.13):

(A) did not acquire the Required Shares with the intent to change or influence control at the Corporation, and does not presently have such intent,

(B) has not nominated and will not nominate for election to the Board at the annual meeting any person other than the Stockholder Nominee(s) being nominated pursuant to this Section 2.13,

(C) has not engaged and will not engage in a, and has not been and will not be a "participant" in another person's, "solicitation" within the meaning of Rule 14a-1(l) under the 1934 Act (or any successor rules), in support of the election of any individual as a director at the annual meeting other than its Stockholder Nominee or a nominee of the Board, and

(D) will not distribute to any Stockholder any form of proxy for the annual meeting other than the form distributed by the Corporation; and

(iv) the Eligible Stockholder's agreement to:

(A) assume all liability stemming from any legal or regulatory violation arising out of any statements or communications made by the Eligible Stockholder to the Corporation, its stockholders or any other persons in connection with the nomination or election of directors, including, without limitation, the Stockholder Notice,

(B) indemnify and hold harmless (jointly with all other group members, in the case of a group member) the Corporation and each of its directors, officers and employees, individually against any liability, loss, damages, expenses or other costs (including attorneys' fees) incurred in connection with any threatened or pending action, suit or proceeding, whether legal, administrative or investigative, against the Corporation or any of its directors, officers or employees arising out of the Eligible Stockholder's actions, including the provision of any information in the Stockholder Notice or any other communication by the Eligible Stockholder (including with respect to any group member) with the Corporation, in connection with any nomination submitted by the Eligible Stockholder pursuant to this Section 2.13,

(C) in the event that any information in the Stockholder Notice, or any other communication by the Eligible Stockholder (including with respect to any group member) with the Corporation, its stockholders or any other person in connection with the nomination or election ceases to be true and correct in all material respects or omits to state a material fact necessary to make the statements made therein not misleading, or the Eligible Stockholder (including any group member) discovers that it has failed to continue to satisfy the eligibility requirements described in this Section 2.13, promptly (and in any event within 48 hours of discovering such misstatement, omission or failure to satisfy eligibility) notify the Corporation and any other recipient of such misstatement or omission and of the information required to correct the misstatement or omission, or of such failure to satisfy eligibility;

(D) comply with all other laws and regulations applicable to the Eligible Stockholder in connection with any solicitation in connection with the annual meeting,

(E) file all materials described below in Section 2.13(h)(3) with the Securities and Exchange Commission, regardless of whether any such filing is required under Regulation 14A under the 1934 Act or whether any exemption from filing is available for such materials under Regulation 14A, and

(F) provide to the Corporation prior to the annual meeting such additional information as may be reasonably requested by the Corporation in order for the Corporation to comply with its disclosure obligations under applicable law, determine the Eligible Stockholder's satisfaction of the requirements of this Section 2.13 and ascertain the Stockholder Nominee's eligibility for nomination pursuant to this Section 2.13; and

(4) in the case of a nomination by a group of Holders that together is an Eligible Stockholder, the designation by all group members of one group member that is authorized to act on behalf of all such members with respect to the nomination and matters related thereto, including any withdrawal of the nomination.

The information and documents required by this Section 2.13(f) shall be: (i) provided with respect to and executed by each Holder whose shares are aggregated for purposes of constituting an Eligible Stockholder, in the case of a group; and (ii) provided with respect to the persons specified in Instruction 1 to Items 6(c) and (d) of Schedule 14N (or any successor item) in the case of a Stockholder Nominee or group member that is an entity. The Stockholder Notice shall be deemed submitted on the date on which all of the information and documents referred to in this Section 2.13(f) (other than such information and documents contemplated to be provided after the date the Stockholder Notice is provided) have been delivered to or, if sent by mail, received by the Secretary of the Corporation.

(g) To be timely under this Section 2.13, the Stockholder Notice must be received by the secretary of the Corporation not later than the close of business on the 120th day nor earlier than the close of business on the 150th day prior to the first anniversary of the date the definitive proxy statement was first released to Stockholders in connection with the preceding year's annual meeting of stockholders; provided, however, that in the event that the date of the annual meeting is scheduled more than thirty (30) days prior to or more than sixty (60) days following the anniversary of the preceding year's annual meeting, the Stockholder Notice, to be timely, must be so delivered not earlier than the close of business on the one hundred twentieth (120th) day prior to such annual meeting and not later than the close of business on the later of the ninetieth (90th) day prior to such annual meeting or the tenth (10th) day following the day on which public announcement of the date of such annual meeting is first made. In no event shall any adjournment or postponement of an annual meeting, or the announcement thereof, commence a new time period for the giving of the Stockholder Notice as described above.

(h) An Eligible Stockholder (or in the case of a group, each Holder whose shares are aggregated for purposes of constituting an Eligible Stockholder) must:

(1) within five (5) business days after the date of the Stockholder Notice, and on the last business day immediately prior to the date of the annual meeting, provide one (1) or more written statements from the record holder(s) of the Required Shares and from each intermediary through which the Required Shares are or have been held, in each case during the requisite three-year holding period, verifying that the Eligible Stockholder owns, and has owned continuously for the preceding three (3) years, the Required Shares,

(2) include in the written statements provided pursuant to Item 4 of Schedule 14N filed with the Securities and Exchange Commission a statement certifying that it owns and continuously has owned, as defined in Section 2.13(c), the Required Shares for at least three (3) years,

(3) file with the Securities and Exchange Commission any solicitation or other communication relating to the annual meeting at which any Stockholder Nominee will be nominated, regardless of whether any such filing is required under Regulation 14A under the 1934 Act or whether any exemption from filing is available for such solicitation or other communication under Regulation 14A, and

(4) as to any group of funds whose shares are aggregated for purposes of constituting an Eligible Stockholder, within five (5) business days after the date of the Stockholder Notice, provide documentation reasonably satisfactory to the Corporation that demonstrates that the funds are under common management and investment control.

(i) Within the time period specified in Section 2.13(g) for delivery of the Stockholder Notice, a Stockholder Nominee must deliver to the Secretary of the Corporation the questionnaire, representation and agreement set forth in Section 2.2(f). At the request of the Corporation, the Stockholder Nominee must promptly, but in any event within five (5) business days of such request, submit any additional completed and signed questionnaires required of the Corporation's directors and provide to the Corporation such other information as it may reasonably request in order for the Corporation to comply with its disclosure obligations under applicable law, determine the Eligible Stockholder's satisfaction of the requirements of this Section 2.13 or ascertain the Stockholder Nominee's eligibility for nomination pursuant to this Section 2.13. The Corporation may request such additional information as necessary to permit the Board to determine if each Stockholder Nominee is independent under the listing standards of the principal U.S. exchange upon which the shares of the Corporation are listed, any applicable rules of the Securities and Exchange Commission and any publicly disclosed standards used by the Board in determining and disclosing the independence of the Corporation's directors.

(j) Notwithstanding anything to the contrary contained in this Section 2.13, the Corporation may omit from its proxy materials any Stockholder Nominee, and such nomination shall be disregarded and no vote on such Stockholder Nominee will occur, notwithstanding that proxies in respect of such vote may have been received by the Corporation, and a stockholder may not, after the last day on which a Stockholder Notice would be timely, cure in any way any defect preventing the nomination of the Stockholder Nominee, if:

(1) the Secretary of the Corporation receives notice pursuant to Section 2.2(b) of these Bylaws that a stockholder intends to nominate a person for election to the Board, which stockholder does not elect to have its nominee(s) included in the Corporation's proxy materials pursuant to this Section 2.13,

(2) (A) the Eligible Stockholder materially breaches any of its agreements set forth in the Stockholder Notice, (B) the Board of Directors, acting in good faith, determines that the Eligible Stockholder has provided representations and warranties or other information to the Company in connection with such nomination (including without limitation in the Stockholder Notice) that was untrue, or ceases to be true, in any material respect or omitted, or omits, to state a material fact necessary to make the statements made therein not misleading, or (C) the Stockholder Nominee withdraws his or her consent or becomes unwilling or unable to serve on the Board or any material violation or breach occurs of the obligations, agreements, representations or warranties of the Stockholder Nominee provided for herein,

(3) the Eligible Stockholder withdraws its nomination,

(4) the Board of Directors, acting in good faith, after consultation with outside counsel, determines that such Stockholder Nominee's nomination or election to the Board would result in the Corporation violating or failing to be in compliance with the Corporation's bylaws or certificate of incorporation or any applicable law, rule, regulation to which the Corporation is subject, including any rules or regulations of any stock exchange on which the Corporation's securities are traded, or

(5) the Stockholder Nominee (A) is not independent under the listing standards of the principal U.S. exchange upon which the shares of the Corporation are listed, any applicable rules of the Securities and Exchange Commission, and any publicly disclosed standards used by the Board in determining and disclosing the independence of the Corporation's directors, (B) does not qualify as independent under the audit committee independence requirements set forth in the rules of the principal U.S. exchange on which shares of the Corporation are listed, or as a "non-employee director" under Rule 16b-3 under the 1934 Act (or any successor provision), (C) is or has been, within the past three years, an officer or director of a competitor, as defined in Section 8 of the Clayton Antitrust Act of 1914, as amended, (D) is a named subject of a pending criminal proceeding (excluding traffic violations and other minor offenses) or has been convicted in a criminal proceeding within the past ten years, or (E) is or has been subject to any order, judgement, decree, event or circumstance specified in Rule 506(d)(1) under the Securities Act of 1933, as amended (or successor Rule), such that the exemption under Rule 506 (or successor Rule) would be unavailable to the Corporation were the Stockholder Nominee a member of the Board.

(k) Notwithstanding anything to the contrary contained in this Section 2.13, the Board may declare a nomination to be invalid (and shall do so in the case of paragraphs 2.13(k)(2) and (3) below), and such nomination shall be disregarded and no vote on such Stockholder Nominee will occur, notwithstanding that proxies in respect of such vote may have been received by the Corporation, if:

(1) the Board of Directors, acting in good faith, determines that the Eligible Stockholder has failed to continue to satisfy the eligibility requirements described in this Section 2.13;

(2) the Eligible Stockholder or the designated lead group member, as applicable, or any qualified representative thereof, does not appear at the meeting of stockholders to present the nomination submitted pursuant to this Section 2.13, or

(3) the Eligible Stockholder withdraws its nomination.

(l) The number of Stockholder Nominees appearing in the Corporation's proxy materials with respect to an annual meeting of stockholders (including any Stockholder Nominee whose name was submitted for inclusion in the Corporation's proxy materials but who is nominated by the Board as a Board nominee), together with any nominees who were previously elected to the Board as Stockholder Nominees at any of the preceding two (2) annual meetings and who are re-nominated for election at such annual meeting by the Board and any Stockholder Nominee who was qualified for inclusion in the Corporation's proxy materials but whose nomination is subsequently withdrawn, shall not exceed (the "Maximum Number") the greater of (i) two (2) or (ii) 20% of the number of directors in office as of the last day on which a Stockholder Notice may be delivered pursuant to this Section 2.13 with respect to the annual meeting, or if such amount is not a whole number, the closest whole number below 20%. In the event that the number of Stockholder Nominees submitted by Eligible Stockholders pursuant to this Section 2.13 exceeds this Maximum Number, each Eligible Stockholder will select one Stockholder Nominee for inclusion in the Corporation's proxy materials until the Maximum Number is reached, going in order of the number (largest to smallest) of shares of the Corporation each Eligible Stockholder disclosed as owned in its respective Stockholder Notice submitted to the Corporation. If the Maximum Number is not reached after each Eligible Stockholder has selected one Stockholder Nominee, this selection process will continue as many times as necessary, following the same order each time, until the Maximum Number is reached. In the event that one or more vacancies for any

reason occurs on the Board after the deadline set forth in Section 2.13(g) but before the date of the annual meeting, and the Board resolves to reduce its size in connection therewith, the Maximum Number shall be calculated based on the number of directors as so reduced.

(m) Any Stockholder Nominee who is included in the Corporation's proxy materials for a particular annual meeting of Stockholders but either (i) withdraws from or becomes ineligible or unavailable for election at the annual meeting, or (ii) does not receive at least 25% of the votes cast in favor of the Stockholder Nominee's election, will be ineligible to be a Stockholder Nominee pursuant to this Section 2.13 for the next two annual meetings.

(n) This Section 2.13 provides the exclusive method for a stockholder to include nominees for election to the Board in the Corporation's proxy materials.

(o) The interpretation of, and compliance with, any provision of this Section 2.13, including the representations, warranties and covenants contained herein, shall be determined by the Board or, in the discretion of the Board, one or more of its designees, in each case acting reasonably and in good faith.

ARTICLE III

DIRECTORS

Section 3.1 General Powers. The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors which may exercise all such powers of the Corporation and do all such acts and things as are not, by the General Corporation Law of the State of Delaware nor by the Certificate of Incorporation nor by these Bylaws, directed or required to be exercised or done by the stockholders.

Section 3.2 Number and Qualifications of Directors.

(a) The number of directors which shall constitute the whole Board of Directors shall be no less than seven and no more than eleven; provided that until changed by resolution of the Board of Directors, the number of directors shall be fixed at eleven. Except as otherwise required by applicable law, the Certificate of Incorporation or Section 3.3 of this Article III, a nominee for director shall be elected by the affirmative vote of a majority of the votes cast with respect to such director, provided that nominees for director shall be elected by the vote of a plurality of the votes cast at any meeting of stockholders for which, as of a date that is ten (10) days in advance of the date on which the Corporation files its definitive proxy statement with the Securities and Exchange Commission (regardless of whether thereafter revised or supplemented), the number of nominees for director exceeds the number of directors to be elected, as determined by the Secretary of the Corporation. For purposes of this Section 3.2, a majority of the votes cast means that the number of shares voted "for" a director exceeds the number of votes cast "against" that director. The following shall not be votes cast: (a) a share whose ballot is marked as withheld; (b) a share otherwise present at the meeting but for which there is an abstention; and (c) a share otherwise present at the meeting as to which a shareholder gives no authority or direction.

If an incumbent director is not elected due to a failure to receive a majority of the votes cast as described above, and his or her successor is not otherwise elected and qualified, such director shall tender his or her offer to resign to the Secretary of the Corporation promptly following the certification of the election results. Within ninety (90) days after the date of the certification of the election results, (i) the Corporate Governance and Nominating Committee will make a recommendation to the Board of Directors on whether to accept or reject the resignation, or whether other action should be taken and (ii) the Board of Directors will act on such committee's recommendation and publicly disclose its decision and the rationale behind it, provided that any director who tenders his or her offer to resign shall not participate in either the Corporate Governance and Nominating Committee's or Board of Directors' deliberations regarding the offer to resign,

and if a quorum of the Corporate Governance and Nominating Committee cannot be met without the presence of the directors who did not receive a majority of the votes cast, then the Board of Directors shall appoint a committee of independent directors to consider the resignation offers and recommend to the Board of Directors whether to accept or reject the resignations, or whether other action should be taken. Directors need not be stockholders.

Section 3.3 Vacancies; Resignation and Removal of Directors.

(a) If the office of any director or directors becomes vacant by reason of death, resignation, retirement, disqualification, removal from office, or otherwise, or a new directorship is created, the Board of Directors shall choose a successor or successors, or a director to fill the newly created directorship, who shall hold office for the unexpired term (in the case of a vacancy) or until the next election of directors (in the case of a new directorship).

(b) Any director of the Corporation may at any time resign by giving written notice to the Board of Directors, the Chairman of the Board, the President or the Secretary of the Corporation. Such resignation shall take effect upon receipt thereof by the Corporation, or such later time specified therein; and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

Section 3.4 Place of Meetings. The Board of Directors may hold its meetings inside or outside of the State of Delaware, at the office of the Corporation or at such other places as they may from time to time determine, or as shall be fixed in the respective notices or waivers of notice of such meetings.

Section 3.5 Compensation of Directors. Directors who are not at the time also a salaried officer or employee of the Corporation or any of its subsidiaries may receive such stated salary for their services and/or such fixed sums and expenses of attendance for attendance at each regular or special meeting of the Board of Directors as may be established by resolution of the Board; provided that nothing herein contained shall be construed to preclude any director from serving the Corporation in any other capacity and receiving compensation therefor. Members of special or standing committees may be allowed like compensation for attending committee meetings. Each director, whether or not a salaried officer or employee of the Corporation or any of its subsidiaries, shall be entitled to receive from the Corporation reimbursement for the reasonable expenses incurred by such person in connection with the performance of such person's duties as a director.

Section 3.6 Regular Meetings. Regular meetings of the Board of Directors shall be held at such times and places as the Board shall from time to time by resolution determine, except that the annual meeting of the Board to elect officers of the Corporation for the ensuing year shall be held within ten (10) days after the annual meeting of stockholders. If any day fixed for a regular meeting shall be a legal holiday under the laws of the place where the meeting is to be held, then the meeting which would otherwise be held on that day shall be held at the same hour on the next succeeding business day.

Section 3.7 Special Meetings. Special meetings of the Board of Directors may be held at any time on the call of the President or at the request in writing of a majority of the directors. Notice of any such meeting, unless waived, shall be given to directors personally, by telephone, by first-class United States mail, postage prepaid or by facsimile or electronic transmission to each director at his or her address as the same appears on the records of the Corporation not later than two days prior to the day on which such meeting is to be held if such notice is delivered personally, by telephone or by facsimile or electronic transmission, and not less than four days prior to the day on which the meeting is to be held if such notice is by first-class United States mail, provided, however, that notice of any such special meeting need not be given to any such member who shall, either before or after such special meeting, submit a signed waiver of such notice or who shall attend such meeting without protesting, prior to or at its commencement, the lack of such notice to such member. . If the Secretary shall fail or refuse to give such

notice, then the notice may be given by the President or any one of the directors calling the meeting. Any such meeting may be held at such place as the Board may fix from time to time or as may be specified or fixed in such notice or waiver thereof. Any meeting of the Board of Directors shall be a legal meeting without any notice thereof having been given, if all the directors shall waive notice or be present thereat, and no notice of a meeting shall be required to be given to any director who shall attend such meeting without protesting, prior to or at its commencement, the lack of such notice to such member.. Notice of any adjourned meeting of the Board of Directors need not be given to any director in attendance.

Section 3.8 Action Without Meeting; Use of Communications Equipment.

(a) Any action required or permitted to be taken at any meeting of the Board of Directors or any committee thereof may be taken without a meeting if all members of the Board or of such committee, as the case may be, consent to such action in writing or by electronic transmission and such written consent or electronic transmissions are filed with the minutes of proceedings of the Board of Directors.

(b) Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

Section 3.9 Quorum and Manner of Acting.

(a) Except as otherwise provided in these Bylaws, a majority of the total number of directors as at the time specified as provided in the Bylaws shall constitute a quorum at any regular or special meeting of the Board of Directors. Except as otherwise provided by statute, by the Certificate of Incorporation or by these Bylaws, the vote of a majority of the directors present at any meeting at which a quorum is present shall be the act of the Board of Directors. In the absence of a quorum, a majority of the directors present may adjourn the meeting from time to time until a quorum shall be present. .

(b) The Board of Directors may adopt such rules and regulations not inconsistent with the provisions of these Bylaws for the conduct of its meetings and management of the affairs of the Corporation as the Board may deem to be proper. In the absence of the Chairman of the Board, such person designated by the Board shall preside at Board meetings.

ARTICLE IV

EXECUTIVE AND OTHER COMMITTEES

Section 4.1 Executive Committee. The Board of Directors may, by resolution adopted by a majority of the entire Board of Directors, designate annually three (3) or more of the directors to constitute members or alternate members of an Executive Committee, which Executive Committee shall have and may exercise, between the meetings of the Board of Directors, all of the powers and authority of the Board of Directors in the management of the business and affairs of the Corporation, including, without limitation, if such Executive Committee is so empowered and authorized by resolution adopted by a majority of the entire Board of Directors, the power and authority to declare a dividend and to authorize the issuance of stock, and may authorize the seal of the Corporation to be affixed to all papers which may require it, except that such Executive Committee shall not have such power or authority in reference to:

(a) amending the Certificate of Incorporation or these Bylaws;

(b) adopting an agreement of merger or consolidation involving the Corporation;

(c) recommending to the stockholders the sale, lease or exchange of all or substantially all of the property and assets of the Corporation;

(d) recommending to the stockholders a dissolution of the Corporation or a revocation of a dissolution;

(e) taking any action related to the approval or determination of any matter in connection with any business combination;

(f) filling vacancies on the Board of Directors or on any committee of the Board of Directors, including, but not limited to, the Executive Committee; or

(g) amending or repealing any resolution of the Board of Directors which by its terms may be amended or repealed only by the Board of Directors.

The Board of Directors shall have the power at any time to change the membership of the Executive Committee, to fill all vacancies in it and to discharge it, either with or without cause.

Section 4.2 Other Committees. The Board of Directors may, by resolution adopted by a majority of the entire Board of Directors (except to the extent prohibited by law), designate from among the directors one or more other committees, each of which shall have such authority of the Board of Directors as may be specified in the resolution of the Board of Directors designating such committee; provided that no committee shall have the power or authority in reference to the matters described in Section 4.1(a) through 4.1(g) above. A majority of all of the members of such committee may determine its action and fix the time and place of its meetings, unless the Board of Directors shall otherwise provide. The Board of Directors shall have the power at any time to change the membership of, to fill all vacancies in and to discharge any such committee, either with or without cause. The committees shall keep regular minutes of their proceedings and report the same to the Board of Directors when required.

Section 4.3 Procedure; Meeting; Quorum. Regular meetings of the Executive Committee or of any other committee of the Board of Directors, of which no notice shall be necessary, may be held at such times and places as shall be fixed by resolution adopted by a majority of the members thereof. Special meetings of the Executive Committee or any other committee of the Board of Directors shall be called at the request of any member thereof. Notice of each special meeting of the Executive Committee or of any other committee of the Board of Directors shall be delivered personally, by telephone, by first-class United States mail, postage prepaid or by facsimile or electronic transmission to each member thereof not later than one day prior to the day on which such meeting is to be held if such notice is delivered personally, by telephone or by facsimile or electronic transmission and not less than four days prior to the day on which such meeting is to be held if such notice is delivered by first-class United States mail; provided, however, that notice of any such special meeting need not be given to any such member who shall, either before or after such special meeting, submit a signed waiver of such notice or who shall attend such meeting without protesting, prior to or at its commencement, the lack of such notice to such member. Any special meeting of the Executive Committee or any other committee of the Board of Directors shall be a valid meeting without any notice thereof having been given if all of the members thereof shall waive notice or be present thereat without protesting, prior to or at its commencement, the lack of such notice to such member. Notice of any adjourned meeting of any committee of the Board of Directors need not be given to any director in attendance. Each of the Executive Committee and each other committee of the Board of Directors may adopt such rules and regulations that are not inconsistent with the provisions of law, the Certificate of Incorporation or these Bylaws for the conduct of its meetings as the Executive Committee or each other committee of the Board of Directors, as the case may be, may deem to be proper. A majority of the members of the Executive Committee or of any other committee of the Board of Directors shall constitute a quorum for the transaction of business at any meeting thereof, and the vote of a majority of the members thereof present at any meeting thereof at which such a quorum is present shall be the act of the Executive Committee or such other committee, as the case may be. Each of the Executive Committee and each other committee of

the Board of Directors shall keep written minutes of its proceedings and shall report on such proceedings to the Board of Directors.

ARTICLE V

OFFICERS

Section 5.1 Executive Officers. The executive officers of the Corporation shall be a President and Chief Executive Officer, a Chief Financial Officer, a Chief Legal Officer, a Treasurer, a Secretary, and such number of executive vice presidents, if any, as the Board of Directors may determine. One person may hold any number of said offices.

Section 5.2 Election, Term of Office and Eligibility. The executive officers of the Corporation shall be elected annually by the Board of Directors, and new or additional officers may be elected at any meeting of the Board. Each officer, except such officers as may be appointed in accordance with the provisions of Section 5.3, shall hold office until the next annual election of officers or until his or her death, resignation or removal. None of the other officers need be members of the Board.

Section 5.3 Subordinate Officers. The Board of Directors may appoint a Controller, such vice presidents, assistant secretaries, assistant treasurers and such other officers, and such agents as the Board may determine, to hold office for such period and with such authority and to perform such duties as the Board may from time to time determine. The Board may, by specific resolution, empower the Chief Executive Officer of the Corporation or the Executive Committee to appoint any such subordinate officers or agents.

Section 5.4 Removal. The President, Chief Executive Officer, Chief Financial Officer, Chief Legal Officer, Chief Operating Officer, Treasurer, Secretary, and any executive vice president may be removed at any time, either with or without cause, but only by the affirmative vote of the majority of the total number of directors as at the time specified by the Bylaws. Any subordinate officer appointed pursuant to Section 5.3 may be removed at any time, either with or without cause, by the majority vote of the directors present at any meeting of the Board or by any committee or officer empowered to appoint such subordinate officers.

Section 5.5 Chairman of the Board. The Chairman of the Board shall, if present, preside at meetings of the Board of Directors. The Chairman of the Board shall be a member of the Board of Directors.

Section 5.6 The President. The President shall be the chief executive officer of the Corporation. He shall have executive authority to see that all orders and resolutions of the Board of Directors are carried into effect and, subject to the control vested in the Board of Directors by statute, by the Certificate of Incorporation, or by these Bylaws, shall administer and be responsible for the management of the business and affairs of the Corporation. He shall in general perform all duties incident to the office of the president and such other duties as from time to time may be assigned to him by the Board of Directors.

Section 5.7 Other Executive Officers and Executive Vice Presidents. In the event of the absence or disability of the President, the other executive officers of the Corporation, in the order designated, or in the absence of any designation, then in the order of their election, shall perform the duties of the President. The other officers and executive vice presidents of the Corporation shall also perform such other duties as from time to time may be assigned to them by the Board of Directors or by the President of the Corporation.

Section 5.8 The Secretary. The Secretary shall:

(a) Keep the minutes of the meetings of the stockholders and of the Board of Directors;

(b) See that all notices are duly given in accordance with the provisions of these Bylaws or as required by law;

(c) Be custodian of the records and of the seal of the Corporation and see that the seal or a facsimile or equivalent thereof is affixed to or reproduced on all documents, the execution of which on behalf of the Corporation under its seal is duly authorized;

(d) Have charge of the stock record books of the Corporation;

(e) In general, perform all duties incident to the office of Secretary, and such other duties as are provided by these Bylaws and as from time to time are assigned to him by the Board of Directors or by the chief executive officer of the Corporation.

Section 5.9 The Treasurer. The Treasurer shall:

(a) Receive and be responsible for all funds of and securities owned or held by the Corporation and, in connection therewith, among other things: keep or cause to be kept full and accurate records and accounts for the Corporation; deposit or cause to be deposited to the credit of the Corporation all moneys, funds and securities so received in such bank or other depositary as the Board of Directors or an officer designated by the Board may from time to time establish; and disburse or supervise the disbursement of the funds of the Corporation as may be properly authorized.

(b) Render to the Board of Directors at any meeting thereof, or from time to time whenever the Board of Directors or the chief executive officer of the Corporation may require, financial and other appropriate reports on the condition of the Corporation;

(c) In general, perform all the duties incident to the office of Treasurer and such other duties as from time to time may be assigned to him by the Board of Directors or by the chief executive officer of the Corporation.

Section 5.10 Salaries. The salaries of the officers shall be fixed from time to time by the Board of Directors, and no officer shall be prevented from receiving such salary by reason of the fact that he is also a director of the Corporation.

Section 5.11 Delegation of Duties. In case of the absence of any officer of the Corporation or for any other reason which may seem sufficient to the Board of Directors, the Board of Directors may, for the time being, delegate his powers and duties, or any of them, to any other officer or to any director.

ARTICLE VI

SHARES OF STOCK

Section 6.1 Regulation. Subject to the terms of any contract of the Corporation, the Board of Directors may make such rules and regulations as it may deem expedient concerning the issue, transfer, and registration of certificates for shares of the stock of the Corporation, including the issue of new certificates for lost, stolen or destroyed certificates, and including the appointment of transfer agents and registrars.

Section 6.2 Stock Certificates. The shares of the Corporation shall be represented by certificates, provided that the Board of Directors may provide by resolution or resolutions that some or all of any class or series of its stock shall be uncertificated shares; provided, however, that no such resolution shall apply to shares represented by a certificate until such certificate is surrendered to the Corporation. Every holder of stock of the Corporation represented by certificates, and, upon written request to the

Corporation's transfer agent or registrar, any holder of uncertificated shares, shall be entitled to have a certificate, in such form as may be prescribed by law and by the Board of Directors, certifying the number and class of shares owned by him in the Corporation. Certificates for shares of the stock of the Corporation shall be respectively numbered serially for each class of stock, or series thereof, as they are issued, shall be impressed with the corporate seal or a facsimile thereof, and shall be signed by the President or other executive officer, and by the Secretary or Treasurer, or an Assistant Secretary or an Assistant Treasurer, provided that such signatures may be facsimiles on any certificate countersigned by a transfer agent other than the Corporation or its employee. Each certificate shall exhibit the name of the Corporation, the class (or series of any class) and number of shares represented thereby, and the name of the holder. Each certificate shall be otherwise in such form as may be prescribed by the Board of Directors.

Section 6.3 Restriction on Transfer of Securities. A restriction on the transfer or registration of transfer of securities of the Corporation may be imposed either by the Certificate of Incorporation or by these Bylaws or by an agreement among any number of security holders or among such holders and the Corporation. No restriction so imposed shall be binding with respect to securities issued prior to the adoption of the restriction unless the holders of the securities are parties to an agreement or voted in favor of the restriction.

A restriction on the transfer of securities of the Corporation is permitted by this Section if it:

(a) Obligates the holder of the restricted securities to offer to the Corporation or to any other holders of securities of the Corporation or to any other person or to any combination of the foregoing a prior opportunity, to be exercised within a reasonable time, to acquire the restricted securities; or

(b) Obligates the Corporation or any holder of securities of the Corporation or any other person or any combination of the foregoing to purchase the securities which are the subject of an agreement respecting the purchase and sale of the restricted securities; or

(c) Requires the Corporation or the holders of any class of securities of the Corporation to consent to any proposed transfer of the restricted securities or to approve the proposed transferee of the restricted securities; or

(d) Prohibits the transfer of the restricted securities to designated persons or classes of persons; and such designation is not manifestly unreasonable; or

(e) Restricts transfer or registration of transfer in any other lawful manner.

Unless noted conspicuously on the security, a restriction, even though permitted by this Section, is ineffective except against a person with actual knowledge of the restriction.

Section 6.4 Transfer of Shares. Except as otherwise established by rules and regulations adopted by the Board of Directors, and subject to applicable law, shares of stock may be transferred on the books of the Corporation: (i) in the case of shares represented by a certificate, by the surrender to the Corporation or its transfer agent of the certificate representing such shares properly endorsed or accompanied by a written assignment or power of attorney properly executed, and with such proof of authority or authenticity of signature as the Corporation or its transfer agent may reasonably require; and (ii) in the case of uncertificated shares, upon the receipt of proper transfer instructions from the registered owner thereof. Except as may be otherwise required by law, the Certificate of Incorporation or the Bylaws, the Corporation shall be entitled to treat the record holder of stock as shown on its books as the owner of such stock for all purposes, including the payment of dividends and the right to vote with respect to such stock, regardless of any transfer, pledge or other disposition of such stock until the shares have been transferred on the books of the Corporation in accordance with the requirements of these Bylaws.

Section 6.5 Fixing Date for Determination of Stockholders of Record.

(a) In order that the Corporation may determine the stockholders entitled to notice of or to vote at any meeting of stockholders or any adjournment thereof, the Board of Directors may fix a record date, which record date shall not precede the date upon which the resolution fixing the record date is adopted by the Board of Directors, and which record date shall not be more than sixty (60) nor less than ten (10) days before the date of such meeting. If no record is fixed by the Board of Directors, the record date for determining stockholders entitled to notice of or to vote at a meeting of stockholders shall be at the close of business on the day next preceding the day on which notice is given, or, if notice is waived, at the close of business on the day next preceding the day on which the meeting is held. A determination of stockholders of record entitled to notice of or to vote at a meeting of stockholders shall apply to any adjournment of the meeting; providing, however, that the Board of Directors may fix a new record date for the adjourned meeting.

(b) In order that the Corporation may determine the stockholders entitled to receive payment of any dividend or other distribution or allotment of any rights or the stockholders entitled to exercise any rights in respect of any change, conversion or exchange of stock, or for the purpose of any other lawful action, the Board of Directors may fix a record date, which record date shall not precede the date upon which the resolution fixing the record date is adopted, and which record date shall be not more than sixty days prior to such action. If no record date is fixed, the record date for determining stockholders for any such purpose shall be at the close of business on the day on which the Board of Directors adopts the resolution relating thereto.

Section 6.6 Lost Certificate. Any stockholder claiming that a certificate representing shares of stock has been lost, stolen or destroyed may make an affidavit or affirmation of the fact and, if the Board of Directors so requires, advertise the same in a manner designated by the Board, and give the Corporation a bond of indemnity in form and with security for an amount satisfactory to the Board (or an officer or officers designated by the Board), whereupon a new certificate may be issued of the same tenor and representing the same number, class and/or series of shares as were represented by the certificate alleged to have been lost, stolen or destroyed.

ARTICLE VII

BOOKS AND RECORDS

Section 7.1 Location. The books, accounts and records of the Corporation may be kept at such place or places within or outside the State of Delaware as the Board of Directors may from time to time determine.

Section 7.2 Inspection. The books, accounts, and records of the Corporation shall be open to inspection by any member of the Board of Directors at all times; and open to inspection by the stockholders at such times, and subject to such regulations as the Board of Directors may prescribe, except as otherwise provided by statute.

Section 7.3 Corporate Seal. The corporate seal shall contain two concentric circles between which shall be the name of the Corporation and the word "Delaware" and in the center shall be inscribed the words "Corporate Seal."

ARTICLE VIII

DIVIDENDS AND RESERVES

Section 8.1 Dividends. The Board of Directors of the Corporation, subject to any restrictions contained in the Certificate of Incorporation and other lawful commitments of the Corporation, may declare and pay dividends upon the shares of its capital stock either out of the surplus of the Corporation, as defined in and computed in accordance with the General Corporation Law of the State of Delaware, or in case there shall be no such surplus, out of the net profits of the Corporation for the fiscal year in which the dividend is declared and/or the preceding fiscal year. If the capital of the Corporation, computed in accordance with the General Corporation Law of the State of Delaware, shall have been diminished by depreciation in the value of its property, or by losses, or otherwise, to an amount less than the aggregate amount of the capital represented by the issued and outstanding stock of all classes having a preference upon the distribution of assets, the Board of Directors of the Corporation shall not declare and pay out of such net profits any dividends upon any shares of any classes of its capital stock until the deficiency in the amount of capital represented by the issued and outstanding stock of all classes having a preference upon the distribution of assets shall have been repaired.

Section 8.2 Reserves. The Board of Directors of the Corporation may set apart, out of any of the funds of the Corporation available for dividends, a reserve or reserves for any proper purpose and may abolish any such reserve.

ARTICLE IX

MISCELLANEOUS PROVISIONS

Section 9.1 Fiscal Year. The fiscal year of the Corporation shall end on the 31st day of December of each year.

Section 9.2 Depositories. The Board of Directors or an officer designated by the Board shall appoint banks, trust companies, or other depositories in which shall be deposited from time to time the money or securities of the Corporation.

Section 9.3 Checks, Drafts and Notes. All checks, drafts, or other orders for the payment of money and all notes or other evidences of indebtedness issued in the name of the Corporation shall be signed by such officer or officers or agent or agents as shall from time to time be designated by resolution of the Board of Directors or by an officer appointed by the Board.

Section 9.4 Contracts and Other Instruments. The Board of Directors may authorize any officer or agent to enter into any contract or execute and deliver any instrument in the name and on behalf of the Corporation and such authority may be general or confined to specific instances.

Section 9.5 Notices. In addition to other means of notice permitted herein, whenever under the provisions of the statutes or of the Certificate of Incorporation or of these Bylaws notice is required to be given to any director or stockholder, it shall not be construed to mean personal notice, but such notice may be given in writing, by mail, by depositing the same in a post office or letter box, in a postpaid sealed wrapper, or by delivery to a telegraph company, addressed to such director or stockholder at such address as appears on the records of the Corporation, or, in default of other address, to such director or stockholder at the General Post Office in the City of Dover, Delaware, and such notice shall be deemed to be given at the time when the same shall be thus mailed or delivered to a telegraph company.

Section 9.6 Waivers of Notice. Whenever any notice is required to be given under the provisions of the statutes or of the Certificate of Incorporation or of these Bylaws, a waiver thereof in writing signed by the person or persons entitled to said notice, whether before or after the time stated

therein, shall be deemed equivalent to notice. Attendance of a person at a meeting shall constitute a waiver of notice of such meeting, except when the person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the stockholders, directors or members of a committee of directors need be specified in any written waiver of notice.

Section 9.7 Stock in Other Corporations. Any shares of stock in any other Corporation which may from time to time be held by this Corporation may be represented and voted at any meeting of shareholders of such Corporation by the President or other executive officer, or by any other person or persons thereunto authorized by the Board of Directors, or by any proxy designated by written instrument of appointment executed in the name of this Corporation by its President or an executive officer. Shares of stock belonging to the Corporation need not stand in the name of the Corporation, but may be held for the benefit of the Corporation in the individual name of the Treasurer or of any other nominee designated for the purpose by the Board of Directors. Certificates for shares so held for the benefit of the Corporation shall be endorsed in blank or have proper stock powers attached so that said certificates are at all times in due form for transfer, and shall be held for safekeeping in such manner as shall be determined from time to time by the Board of Directors.

Section 9.8 Indemnification.

(a) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to, or is otherwise involved in, any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was a director or an officer of the Corporation, against all judgments, fines, amounts paid in settlement and other liability and loss suffered, and all expenses (including, without limitation, attorneys' fees) reasonably incurred thereby in connection with such action, suit or proceeding to the fullest extent permitted by the General Corporation Law of the State of Delaware and any other applicable law as from time to time in effect. Such right of indemnification shall include the right to payment of expenses incurred in defending any proceeding in advance of final disposition of such proceeding upon tendering of any undertaking to repay such expenses required by law as a condition to advancement of such expenses, and shall not be deemed to be exclusive of any rights to which any such director or officer may otherwise be entitled. The foregoing provisions of this Section 9.8(a) shall be deemed to be a contract between the Corporation and each director and officer of the Corporation serving in such capacity at any time while this Section 9.8(a) is in effect, and any repeal or modification thereof shall not affect any right or obligation then existing with respect to any state of facts then or theretofore existing or any action, suit or proceeding theretofore or thereafter brought or threatened based in whole or in part upon any such state of facts. Notwithstanding the first sentence of Section 9.8(a), except as otherwise provided in Section 9.8(c), the Corporation shall be required to indemnify a person in connection with a proceeding (or part thereof) commenced by such person only if the commencement of such proceeding (or part thereof) by the person was authorized in the specific case by the Board of Directors.

(b) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to, or is otherwise involved in, any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was an employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another Corporation, partnership, joint venture, trust or other enterprise, against all judgments, fines, amounts paid in settlement and other liability and loss suffered, and all expenses (including, without limitation, attorneys' fees) reasonably incurred thereby in connection with such action, suit or proceeding to the extent permitted by and in the manner set forth in and permitted by the General Corporation Law of the State of Delaware and any other applicable law as from time to time in effect. Such right of indemnification may include the right to payment of expenses incurred in defending any proceeding

in advance of final disposition of such proceeding upon tendering of any undertaking to repay such expenses required by the board of directors as a condition to advancement of such expenses, and shall not be deemed to be exclusive of any other rights to which any such person may otherwise be entitled. Notwithstanding the first sentence of Section 9.8(b), except as otherwise provided in Section 9.8(c), the Corporation shall be required to indemnify a person in connection with a proceeding (or part thereof) commenced by such person only if the commencement of such proceeding (or part thereof) by the person was authorized in the specific case by the Board of Directors.

(c) If a claim under subsection (a) or (b) of this Section is not paid in full by the Corporation within thirty days after a written claim has been received by the Corporation, the claimant may at any time thereafter bring suit against the Corporation to recover the unpaid amount of the claim and, if successful in whole or in part, the claimant shall also be entitled to be paid the expense of prosecuting such claim. It shall be a defense to any action (other than an action brought to enforce a claim for expenses incurred in defending any proceeding in advance of its final disposition where the required undertaking has been tendered to the Corporation) that the claimant has failed to meet a standard of conduct which makes it permissible under Delaware law for the Corporation to indemnify the claimant for the amount claimed, but the burden of proving such defense shall be on the Corporation. Neither the failure of the Corporation (including its Board of Directors, independent legal counsel, or its stockholders) to have made a determination prior to the commencement of such action that indemnification of the claimant is permissible in the circumstances because he has met such standard of conduct, nor an actual determination by the Corporation (including its Board of Directors, independent legal counsel, or its stockholders) that the claimant has not met such standard of conduct, nor the termination of any proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall be a defense to the action or create a presumption that the claimant has failed to meet the required standard of conduct.

(d) The right to indemnification and the payment of expenses incurred in defending a proceeding in advance of its final disposition conferred in this Section shall not be exclusive of any other right which any person may have or hereafter acquire under any statute, provision of the Certificate of Incorporation, bylaw, agreement, vote of stockholders or disinterested directors or otherwise.

(e) The Corporation may maintain insurance, at its expense, to protect itself and any director, officer, employee or agent of the Corporation or another Corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss, whether or not the Corporation would have the power to indemnify such person against such expense, liability or loss under Delaware law.

(f) To the extent that any director, officer, employee or agent of the Corporation is by reason of such position, or a position with another entity at the request of the Corporation, a witness in any proceeding, he shall be indemnified against all costs and expenses actually and reasonably incurred by him or on his behalf in connection therewith.

(g) Any amendment, repeal or modification of any provision of this Section by the stockholders or the directors of the Corporation shall not adversely affect any right or protection of a director or officer of the Corporation with respect to any action or omission occurring prior to the time of such amendment, repeal or modification.

Section 9.9 Amendment of Bylaws.

(a) The stockholders, by the affirmative vote of the holders of a majority of the stock issued and outstanding and having voting power may, at any annual or special meeting if notice of such alteration or amendment of the Bylaws is contained in the notice of such meeting, adopt, amend, or repeal these Bylaws, and alterations or amendments of Bylaws made by the stockholders shall not be altered or amended by the Board of Directors.

(b) The Board of Directors, by the affirmative vote of a majority of the whole Board, may adopt, amend, or repeal these Bylaws at any meeting, except as provided in the above paragraph. Bylaws made by the Board of Directors may be altered or repealed by the stockholders.

ARTICLE X

EXCLUSIVE FORUM

Section 10.1 Exclusive Forum. Unless the Corporation consents in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware shall, to the fullest extent permitted by law, be the sole and exclusive forum for (1) any derivative action or proceeding brought on behalf of the Corporation, (2) any action asserting a claim of breach of a fiduciary duty owed by any director, officer, or other employee of the Corporation to the Corporation or the Corporation's stockholders, (3) any action asserting a claim against the Corporation or any director, officer, or other employee of the Corporation arising pursuant to any provision of the Delaware General Corporation Law, or the Corporation's Certificate of Incorporation or Bylaws (as either may be amended from time to time) or (4) any action asserting a claim against the Corporation, or any director, officer, or other employee of the Corporation governed by the internal affairs doctrine.

* * * * *

SECRETARY'S CERTIFICATE

ADOPTION

OF

SIXTH AMENDED AND RESTATED BYLAWS

OF

MOLINA HEALTHCARE, INC.

I, the undersigned, do hereby certify:

1. That I am the duly appointed and acting Secretary of Molina Healthcare, Inc., a Delaware corporation (the "Company").

2. That the foregoing Sixth Amended and Restated Bylaws of the Company were adopted by the Board of Directors of the Company (the "Board") by unanimous written consent of the Board effective February 18, 2019.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 18th day of February, 2019.

/s/ Jeff D. Barlow
Jeff. D. Barlow, Secretary

MOLINA HEALTHCARE, INC.

AMENDED AND RESTATED CHANGE IN CONTROL SEVERANCE PLAN

(As Amended and Restated as of February 18, 2019)

I. INTRODUCTION

Molina Healthcare, Inc. considers the maintenance of a sound management to be essential to protecting and enhancing the best interests of the Company and its stockholders. Thus, the Company recognizes that the possibility of a Change in Control may exist from time to time, and that this possibility, and the uncertainty and questions it may raise among management, may result in the departure or distraction of management personnel to the detriment of the Company and its stockholders. Accordingly, the Company has determined that appropriate steps should be taken to encourage the continued attention and dedication of members of the Company's management to their assigned duties without the distraction which may arise from the possibility of a Change in Control.

The Company's Change in Control Severance Plan was originally effective as of May 3, 2017, and is hereby amended and restated effective as of February 18, 2019 (the "Effective Date"). This Amended and Restated Change in Control Severance Plan (this "Plan") does not alter the status of Participants as at-will employees of the Company. Just as Participants remain free to leave the employ of the Company at any time, so too does the Company retain its right to terminate the employment of Participants without notice, at any time, for any reason, except to the extent otherwise provided in a written employment agreement between the Company and the Participant.

However, the Company believes that, both prior to and at the time a Change in Control is anticipated or occurring, it is necessary to have the continued attention and dedication of Participants to their assigned duties without distraction, and this Plan is intended as an inducement for Participants' willingness to continue to serve as employees of the Company (subject, however, to either party's right to terminate such employment at any time). Therefore, should a Participant still be an employee of the Company at the time of a Change in Control, the Company agrees that such Participant shall receive the severance benefits hereinafter set forth in the event the Participant's employment with the Company terminates under the circumstances described below.

II. DEFINITIONS

As used herein the following words and phrases shall have the following respective meanings unless the context clearly indicates otherwise.

(a) Affiliate. Any entity which controls, is controlled by, or is under common control with the Company.

(b) Annual Base Salary. The Participant's annual base salary paid or payable, including any base salary that is subject to deferral, to the Participant by the Company or any of its Affiliates at the rate in effect (or required to be in effect before any diminution that is a basis of the Participant's termination for Good Reason) on the Date of Termination or immediately prior to the Change in Control if the Participant's annual base salary was higher at such time.

(c) Annual Bonus. The Participant's target annual bonus.

(d) Applicable Multiple.

(i) With respect to any Participant who is at or above the level of Senior Vice President, two (2).

(ii) With respect to any Participant who is at or above the level of Vice President, but below the level of Senior Vice President, one (1).

(iii) With respect to any Participant, other than a Participant identified in clause (i) or (ii) of this Section 2(d), one (1).

(e) Board. The Board of Directors of the Company.

(f) Cause. With respect to any Participant:

(i) the Participant's willful engaging in illegal conduct or gross misconduct which is materially and demonstrably injurious to the Company;

(ii) the Participant's material violation of any policy or code of conduct of the Company or any of its Affiliates, and failure to correct (if possible) following notification of such violation;

(iii) the Participant's unauthorized use or disclosure of confidential information or trade secrets;

(iv) the Participant's engaging in competition with the Company;

(v) any material breach by the Participant of his or her fiduciary duty to the Company; or

(vi) the willful and continued failure of the Participant to perform substantially the Participant's duties with the Company or one of its Affiliates to the extent, degree and level of performance as expected of the Participant (other than any such failure resulting from incapacity due to physical or mental illness), after a written demand for substantial performance is delivered to the Participant by the Board or the Chief Executive Officer of the Company which specifically identifies the manner in which the Board or Chief Executive Officer believes that the Participant has not substantially performed the Participant's duties.

(g) Change in Control. The occurrence of any of the following events after the Effective Date:

(i) the acquisition (other than by an Excluded Person), directly or indirectly, in one or more transactions, by any person or by any group of persons, within the meaning of Section 13(d) or 14(d) of the Exchange Act, of beneficial ownership (within the meaning of Rule 13d-3 of the Exchange Act) of more than fifty percent (50%) of either the outstanding shares of common stock or the combined voting power of the Company's outstanding voting securities entitled to vote generally, whether or not the acquisition was previously approved by the existing directors, other than an acquisition that complies with clause (x) of paragraph (ii);

(ii) consummation of a reorganization, merger, or consolidation of the Company or the sale or other disposition of all or substantially all of the Company's assets unless, (x) immediately following such event, all or substantially all of the stockholders of the Company immediately prior to such event own, directly or indirectly, more than fifty percent (50%) of the then outstanding voting securities of the resulting company (including without limitation, a corporation which as a result of such event owns the Company or all or substantially all of the Company's assets either directly or indirectly through one or more subsidiaries);

(iii) the complete liquidation or dissolution of the Company; or

(iv) a change in the composition of a majority of the directors on the Company's Board within twelve (12) months if not approved by a majority of the pre-existing directors.

A transaction shall not constitute a Change in Control if its sole purpose is to change the state of the Company's incorporation or to create a holding company that will be owned in substantially the same proportions by the persons who held the Company's securities immediately before such transaction.

(h) Code. The Internal Revenue Code of 1986, as amended from time to time.

(i) Committee. The Compensation Committee of the Board.

(j) Company. Molina Healthcare, Inc., a Delaware corporation, and any successor thereto.

(k) Date of Termination. The Date of Termination shall mean:

(i) except in the case of the Participant's termination of employment by reason of death or Disability, the date of receipt of the Notice of Termination by the Company or the Participant, as the case may be, or such later date specified in the Notice of Termination, as the case may be;

(ii) if the Participant's employment is terminated by reason of death, the date of death; or

(iii) if the Participant's employment is terminated by reason of Disability, the thirtieth (30th) day after receipt of such Notice of Termination by the Participant.

Notwithstanding the foregoing, in no event shall the Date of Termination occur until the Participant experiences a "separation from service" within the meaning of Section 409A, and the date on which such separation from service takes place shall be the "Date of Termination."

(l) Disability. A condition such that the Participant by reason of physical or mental disability becomes entitled to benefits under the Company's long-term disability plan.

(m) Effective Date. The Effective Date shall be as defined in the introductory section hereof.

(n) Employee. Any full-time, regular employee of the Company or any of its Subsidiaries whose employment is not the subject of a collective bargaining agreement, including any such employees who may be on a leave of absence approved by the Company or any of its Subsidiaries, respectively.

(o) ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time.

(p) Exchange Act. The Securities Exchange Act of 1934.

(q) Excluded Person. "Excluded Person" means:

(i) any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act;

(ii) the Company;

(iii) an employee benefit plan (or related trust) sponsored or maintained by the Company or its successor; or

(iv) any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than fifteen percent (15%) of the common stock of the Company on the Effective Date (or any affiliate, successor, heir, descendant, or related party of or to such person).

(r) Good Reason. The occurrence of any one (1) or more of the following, without the express written consent of the Participant:

(i) the Participant's position, authority, duties or responsibilities are materially diminished from those in effect during the ninety (90)-day period immediately preceding a Change in Control (whether or not occurring solely as a result of the Company ceasing to be a publicly traded entity);

(ii) a material reduction in the Participant's (x) Annual Base Salary or (y) total annual compensation opportunity, from such total annual compensation opportunity as in effect during the ninety (90)-day period immediately prior to the Change in Control, or as the same may be increased from time to time;

(iii) the Company requires the Participant regularly to perform such Participant's duties of employment beyond a fifty (50) mile radius from the location of the Participant's employment immediately prior to the Change in Control; or

(iv) a material breach by the Company of the terms of a Participant's written employment agreement.

In order to invoke a termination of employment for Good Reason, the Participant shall provide a Notice of Termination pursuant to Section 7.4 to the Company's Chief Legal Officer of the existence of one or more of the conditions described in clauses (i) through (iv) within ninety (90) days following the initial existence of such condition or conditions, specifying in reasonable detail the conditions constituting Good Reason (hereinafter, "Notice of Good Reason"), and the Company shall have thirty (30) days following receipt of such written notice (the "Cure Period") during which it may remedy the condition. In the event that the Company fails to remedy the condition constituting Good Reason during the applicable Cure Period, the effective date of the Participant's Termination of Employment shall be as specified in such notice, but in no event later than thirty (30) days thereafter. The Participant's mental or physical incapacity following the occurrence of an event described above in clauses (i) through (iv) shall not affect the Participant's ability to terminate employment for Good Reason and the Participant's death following delivery of a Notice of Good Reason shall not affect the Participant's estate's entitlement to Separation Benefits provided hereunder.

(s) Notice of Termination.

(i) In the case of the Company, a written notice that (x) indicates the basis under the Plan for termination and (y) to the extent applicable, sets forth in reasonable detail the facts and circumstances claimed to provide a basis for termination of the Participant's employment under the Plan, as indicated. The failure by the Company to set forth in the Notice of Termination any fact or circumstance that contributes to a showing of Good Reason or Cause shall not waive any right of the Company hereunder or preclude the Company, respectively, from asserting such fact or circumstance in enforcing the Company's respective rights hereunder.

(ii) In the case of a Participant, a notice from a Participant to the Company that shall indicate the specific termination provision or provisions of the Plan relied upon and shall set forth in reasonable detail the facts and in the case of a Notice of Termination for Good Reason, the circumstances claimed to provide a basis for termination for Good Reason. Such Notice of Termination for Good Reason must be given no later than ninety (90) days from the initial existence of the condition and shall provide for a date of termination not less than thirty (30) nor more than sixty (60) days after the date such Notice of Termination for Good Reason is delivered to and acknowledged by the General Counsel of the Company.

(t) Participant. An individual who qualifies to participate in this Plan pursuant to Section 3.1.

(u) Qualifying Termination. At any time following a Change in Control and prior to the second (2^{nd}) anniversary of the Change in Control, the Participant's employment with the Company or any of its Subsidiaries is terminated (i) involuntarily by the Company for any reason other than Cause, death, or Disability; or (ii) by the Participant for Good Reason.

(v) Section 409A. Section 409A of the Code, and the rules and regulations issued thereunder.

(w) Separation Benefits. The benefits described in Sections 4.2(a)(iii), (iv) and (v) and Sections 4.2(b) and 4.2(c) that are provided to qualifying Participants under the Plan.

(x) Subsidiary. Any corporation, limited liability company, or any other entity in which the Company, directly or indirectly, holds a majority of the voting power of such corporation's, limited liability company's, or such other entity's outstanding equity interests.

III. ELIGIBILITY

3.1 Participation. Each Employee (a) who has a position of Vice President or above, or (b) who has a position lower than Vice President, but has been designated in writing as a Participant by the Committee or the Board, shall be a Participant in this Plan. Notwithstanding the foregoing, if a Participant who is eligible to participate in this Plan has entered into an agreement with the Company that provides for benefits in the event of a termination of employment following a Change in Control, such Participant shall be entitled to receive Separation Benefits (or any other benefits under the Plan) only to the extent that such Separation Benefits are in addition to or in excess of the benefits provided under such Participant's agreement with the Company.

3.2 Duration of Participation. The Committee may remove an Employee as a Participant by providing written notice of removal to such Employee; provided that no such removal shall be effective (a) during the two (2) year period following a Change in Control, (b) if effectuated prior to a Change in Control, but after a letter of intent with respect to such Change in Control has been entered into between the Company and a third party or (c) at such time as the Participant is entitled to payment of a Separation Benefit or any other amounts payable under the Plan. In addition, a Participant shall cease to be a Participant in the Plan as a result of an amendment or termination of the Plan complying with Article VI of the Plan, or when the Participant ceases to be an Employee or no longer qualifies as a Participant under Section 3.1, unless, at the time the Participant ceases to be an Employee or no longer qualifies as a Participant under Section 3.1, such Participant is entitled to payment of a Separation Benefit or any other amounts payable under the Plan or there has been an event or occurrence constituting Good Reason that would enable the Participant to terminate employment and receive a Separation Benefit. A Participant entitled to payment of a Separation Benefit or any other amounts payable under the Plan shall remain a Participant in the Plan until the full amount of the Separation Benefit and any other amounts payable under the Plan have been paid to the Participant.

IV. SEPARATION BENEFITS

4.1 Terminations of Employment which Give Rise to Separation Benefits under this Plan. Provided that a Participant is in compliance with the terms of this Plan and satisfies all conditions herein, such Participant shall be entitled to Separation Benefits as set forth in Section 4.2 below if the Participant experiences a Qualifying Termination. For purposes of this Plan, any purported termination by the Company or by the Participant shall be communicated by written Notice of Termination to the other in accordance with Section 7.4 hereof and, to the extent applicable, Section 2(s) hereof.

4.2 Separation Benefits.

(a) If a Participant experiences a Qualifying Termination, then the Company shall pay to the Participant, in a lump sum in cash on the sixtieth (60^{th}) day after the Date of Termination (or on such earlier date as may be required by applicable law), subject to the Participant's compliance with Section 4.2(e) below, the aggregate of the following amounts which benefits, except as provided in Section 7.3 below, shall be in addition to any other benefits to which the Participant is entitled other than by reason of this Plan:

(i) unpaid salary with respect to any paid time off accrued but not taken as of the Date of Termination;

(ii) accrued but unpaid salary through the Date of Termination;

(iii) any earned but unpaid annual incentive bonuses from the fiscal year immediately preceding the year in which the Date of Termination occurs (unless (x) such annual incentive bonus is "nonqualified deferred compensation" within the meaning of Section 409A, in which case such bonus shall be paid at the time that bonuses with respect to such fiscal year are or otherwise would be paid in accordance with the terms of the applicable plan or (y) the Participant has made an irrevocable election under any deferred compensation arrangement subject to Section 409A to defer any portion of such annual incentive bonuses, in which case any such deferred bonuses shall be paid in accordance with such election);

(iv) an amount equal to the Applicable Multiple times the Participant's Annual Base Salary; and

(v) an amount equal to the Participant's Annual Bonus for the year in which the Participant's employment is terminated based on the assumption that target performance had been achieved, and based on the number of entire months of such year that have elapsed through the date of the Participant's termination of employment as a fraction of twelve (12).

(b) If the Participant's employment is terminated under circumstances which entitle the Participant to Separation Benefits under this Section 4.2 and the Participant and the Participant's eligible dependents are eligible for extended continued health care, dental and/or vision coverage under the Company's benefit plans ("COBRA Coverage") as required by Code Section 4980B, then, if the Participant complies with all terms and conditions of the applicable plans, timely and properly elects COBRA Coverage and timely pays the applicable COBRA contributions for the elected COBRA Coverage, except as provided below, for a period of eighteen (18) months following the Date of Termination (the "Benefit Continuation Period"), the Company shall pay directly to the applicable plans or, to the extent paid by the Participant, reimburse Participant, an amount equal to the difference between the full cost for such COBRA Coverage and the amount the Participant would be required to pay for such coverage as an active employee. Such payment shall be paid (or reimbursed) and reported as taxable compensation to the Participant and shall be subject to applicable tax withholding. Notwithstanding the above, if the Participant becomes employed by another employer and becomes eligible for health care, dental and/or vision coverage under another employer-provided plan before the end of the Benefit Continuation Period, the Company will cease the premium reimbursements and/or payments described above for the corresponding COBRA Coverage.

(c) If the Participant is entitled to Separation Benefits under this Plan and notwithstanding anything to the contrary in any equity incentive, stock option, stock appreciation right (SAR), performance units, phantom stock awards, or deferred compensation plan or retirement plan or agreements, then:

(i) all outstanding time-vesting Company equity or equity-based awards held by the Participant shall immediately vest in full;

(ii) all outstanding performance-vesting Company equity or equity-based awards held by the Participant shall immediately vest based upon the greater of: (1) target performance, based on the assumption that such target performance had been achieved, or (2) the projected final achievement of the performance metric through the measurement period, provided that where applicable, such projected final achievement shall be based on straight-line extrapolation of actual achievement (as of the Date of Termination) through the end of the respective performance

metric period; except to the extent vesting is determined by reference to any completed fiscal year, then actual performance for such completed fiscal year shall be used; and

(iii) the Participant (or his personal representative if applicable) shall be permitted to exercise any of the Participant's vested stock options/SARs until the earlier of: (1) one (1) year after the Participant's termination of employment, and (2) the term of such unexercised stock options, warrants, or SARs.

(d) Except as provided in Section 4.2(b) and Section 7.3, the Participant shall not be required to mitigate the amount of any payment provided for in this Section 4.2 by seeking other employment or otherwise, nor shall the amount of any payment or benefit provided for in this Section 4.2 be reduced by any compensation earned by the Participant as the result of employment by another employer or by retirement benefits paid by the Company after the Date of Termination, or otherwise, or by any set-off, counterclaim, recoupment, or other claim, right or action the Company may have against the Participant or others.

(e) All Severance Benefits are conditioned on the Participant's continuing compliance with this Plan and the Company's policies. All Severance Benefits are also conditioned on, and in consideration for, the following actions being completed no later than sixty (60) days following the Participant's termination of employment: the Participant's execution (and effectiveness) of a release of claims and covenant not to sue substantially in the form provided in Exhibit A, any revocation period required by law has run, and the Participant has not revoked the release of claims and covenant not to sue. In the event a Participant fails to return such release within such time period, or revokes the release, the Participant shall forfeit his Severance Benefits hereunder. In the event that the period for consideration or revocation overlaps two (2) tax years, any payment of Severance Benefits under Section 4.2(a) due hereunder shall not commence until the later tax year.

4.3 Limitation on Payments.

(a) Anything in this Plan to the contrary notwithstanding, in the event it shall be determined that any payment or distribution made, or benefit provided, by the Company to or for the benefit of the Participant under this Plan or any other agreement between the Company and the Participant or plan of the Company would constitute a "parachute payment" as defined in Section 280G of the Code, then the benefits payable pursuant to this Plan shall be reduced so that the aggregate present value of all payments in the nature of compensation to (or for the benefit of) the Participant which are contingent on a change of control (as defined in Section 280G(b)(2)(A) of the Code) is One Dollar ($1.00) less than the amount which the Participant could receive without being considered to have received any parachute payment (the amount of this reduction in the benefits payable is referred to herein as the "Excess Amount"). The determination of the amount of any reduction required by this Section 4.3(a) shall be made by a nationally recognized tax counsel selected by the Company, and such determination shall be conclusive and binding on the parties hereto.

(b) Notwithstanding the provisions of Section 4.3(a), if it is established, pursuant to a final determination of a court or an Internal Revenue Service proceeding which has been finally and conclusively resolved, that an Excess Amount was received by the Participant from the Company, then the Participant shall be obligated to repay such Excess Amount to the Company on demand (but no less than ten (10) days after written demand is received by the Participant).

V. SUCCESSOR TO COMPANY

This Plan shall inure to the benefit of and be binding upon the Company and its successors and assigns. The Company shall require any corporation, entity, individual, or other person who is the successor (whether direct or indirect by purchase, merger, consolidation, reorganization or otherwise) to all or substantially all the business and/or assets of the Company to expressly assume and agree to perform, by a

written agreement in form and in substance satisfactory to the Company, all of the obligations of the Company under this Plan. It is a condition of this Plan, and all rights of each person eligible to receive benefits under this Plan shall be subject hereto, that no right or interest of any such person in this Plan shall be assignable or transferable in whole or in part, except by operation of law, including, but not by way of limitation, lawful execution, levy, garnishment, attachment, pledge, bankruptcy, alimony, child support or qualified domestic relations order.

VI. DURATION, AMENDMENT AND TERMINATION

6.1 Duration. Unless earlier terminated pursuant to Section 6.2, if a Change in Control has not occurred, this Plan shall expire three (3) years from the Effective Date; provided, that upon each annual anniversary of the Effective Date (each such annual anniversary a "Renewal Date"), the Plan shall be extended for an additional year, unless pursuant to a resolution adopted by the Board prior to the Renewal Date the Company determines not to so extend the Plan. If a Change in Control occurs while this Plan is in effect, this Plan shall continue in full force and effect for at least two (2) years following such Change in Control, and shall not terminate or expire until after all Participants who become entitled to any payments or benefits hereunder shall have received such payments and benefits in full.

6.2 Amendment or Termination. The Company reserves the right to amend, modify, suspend or terminate the Plan at any time by action of a majority of the Board; provided that no such amendment, modification, suspension or termination that has the effect of reducing or diminishing the right of any Participant shall be effective without the written consent of such Participant for a period of two (2) years following the Change in Control if adopted after a Change in Control or in anticipation of a Change in Control. Any amendment, modification, suspension or termination of this Plan adopted after a Change in Control or in anticipation of a Change in Control shall not affect the right of any Participant to payments or benefits to be paid or provided as a result of events that occur prior to the second anniversary of the Change in Control.

6.3 Procedure for Extension, Amendment or Termination. Any extension, amendment or termination of this Plan by the Board in accordance with this Article VI shall be made by action of the Board in accordance with the Company's charter documents and applicable law.

VII. MISCELLANEOUS

7.1 Default in Payment. Any payment not made within ten (10) days after it is due in accordance with this Plan shall thereafter bear interest, compounded annually, at the U.S. prime rate from time to time then in effect.

7.2 No Assignment. No interest of any Participant or spouse of any Participant or any other beneficiary under this Plan, or any right to receive payment hereunder, shall be subject in any manner to sale, transfer, assignment, pledge, attachment, garnishment, or other alienation or encumbrance of any kind, nor may such interest or right to receive a payment or distribution be taken, voluntarily or involuntarily, for the satisfaction of the obligations or debts of, or other claims against, a Participant or spouse of a Participant or other beneficiary, including for alimony.

7.3 Effect on Other Plans, Agreements and Benefits. Except to the extent expressly set forth herein, any benefit or compensation to which a Participant is entitled under any agreement between the Participant and the Company or any of its Subsidiaries or under any plan maintained by the Company or any of its Subsidiaries in which the Participant participates or participated shall not be modified or lessened in any way, but shall be payable according to the terms of the applicable plan or agreement. Notwithstanding the foregoing, any benefits received by a Participant pursuant to this Plan shall be in lieu of any severance benefits to which the Participant would otherwise be entitled under any general severance policy or other severance plan maintained by the Company and, upon consummation of a

Change in Control, Participants in this Plan shall in no event be entitled to participate in any such severance policy or other severance plan maintained by the Company.

7.4 Notice. For the purpose of this Plan, notices and all other communications provided for in this Plan shall be in writing and shall be deemed to have been duly given when actually delivered or mailed by United States registered mail, return receipt requested, postage prepaid, addressed to the Company's Chief Legal Officer at the Company's corporate headquarters address, and to the Participant (at the last address of the Participant on the Company's books and records).

7.5 Employment Status. This Plan does not constitute a contract of employment or impose on the Participant or the Company any obligation for the Participant to remain an Employee or change the status of the Participant's employment or the policies of the Company and its Affiliates regarding termination of employment, nor does it alter or exterminate the agreement that employment is at-will.

7.6 Nondisparagement; Confidentiality. On the Effective Date and thereafter, the Participant agrees that the Participant will not disparage the Company or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. The Participant further agrees that he/she will not direct anyone to make any disparaging oral or written remarks to any third parties. During the Participant's employment and following the Participant's termination of employment for any reason, the Participant agrees to not use or disclose the confidential information or trade secrets of the Company. Notwithstanding the foregoing, nothing herein or in the release of claims described in Section 4.2(e) above is intended to or shall prevent any Participant from communicating directly with, cooperating with, or providing information (including trade secrets) in confidence to, any federal, state or local government regulator (including, but not limited to, the U.S. Securities and Exchange Commission, the U.S. Commodity Futures Trading Commission, or the U.S. Department of Justice) for the purpose of reporting or investigating a suspected violation of law.

7.7 Nonsolicitation. During the Participant's employment with Company and for twelve (12) months after the Participant's termination of employment and payment of the Severance Benefits hereunder, the Participant shall not, directly or indirectly, either as an individual or as an employee, agent, consultant, advisor, independent contractor, general partner, officer, director, stockholder, investor, lender, or in any other capacity whatsoever, of any person, firm, corporation, or partnership, (i) induce or attempt to induce any person who at the time of such inducement or hire is an employee of the Company (or who was, within six (6) months prior to such inducement or hire, an employee) to perform work or service for any other person or entity other than the Company, or (ii) through the use of confidential information or trade secrets, solicit customers, suppliers, or clients of the Company to reduce or discontinue their business with the Company or to engage in business with any competing entity.

7.8 Clawback. Compensation and benefits payable under Sections 4.2(a)(iv), 4.2(a)(v), 4.2(b) and 4.2(c) are subject to a right of recoupment by the Company in the event of a violation of the provisions of Sections 7.6 and 7.7, as provided in this Section 7.8. The Company may seek recovery of any and all compensation and benefits paid under Sections 4.2(a)(iv), 4.2(a)(v), 4.2(b) and 4.2(c) from a Participant during the period commencing twelve (12) months immediately prior to such violation. The Company shall have the right to sue for repayment, and enforce the repayment through the reduction or cancellation of outstanding equity awards.

7.9 Plan Administration. This Plan shall be administered by the Committee; provided that in the event of an impending Change in Control, the Committee may appoint a person (or persons) independent of the third-party effectuating the Change in Control to be the Committee effective upon the occurrence of a Change in Control and such Committee shall not be removed or modified following a Change in Control, other than at its own initiative (the "Independent Committee"). Except as otherwise provided in this Plan, the decision of the Committee (including the Independent Committee) upon all matters within the scope

of its authority shall be conclusive and binding on all parties, provided that in the event that no Independent Committee is appointed, any determination by the Committee of whether "Cause" or "Good Reason" exists shall be subject to de novo review.

7.10 Unfunded Plan Status. This Plan is intended to be an unfunded plan maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, within the meaning of Section 401 of ERISA. All payments pursuant to the Plan shall be made from the general funds of the Company and no special or separate fund shall be established or other segregation of assets made to assure payment. No Participant or other person shall have under any circumstances any interest in any particular property or assets of the Company as a result of participating in the Plan. Notwithstanding the foregoing, the Company may (but shall not be obligated to) create one (1) or more grantor trusts, the assets of which are subject to the claims of the Company's creditors, to assist it in accumulating funds to pay its obligations under the Plan.

7.11 Withholding Taxes. All payments made under this Plan shall be subject to reduction to reflect taxes required to be withheld by law.

7.12 Validity and Severability. The invalidity or unenforceability of any provision of this Plan shall not affect the validity or enforceability of any other provision of this Plan, which shall remain in full force and effect, and any prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

7.13 Section 409A.

(a) General. This Plan is intended to be exempt from the requirements of Section 409A and shall in all respects be administered in accordance with the "short-term deferral" exception in the regulations promulgated under Section 409A. In no event may the Participant, directly or indirectly, designate the calendar year of any payment under this Plan.

(b) In-Kind Benefits and Reimbursements. Notwithstanding anything to the contrary in this Plan, all reimbursements and in-kind benefits provided under this Plan shall be made or provided in accordance with the requirements of the regulations promulgated under Section 409A, including, where applicable, the requirement that (i) any reimbursement is for expenses incurred during the Participant's lifetime (or during a shorter period of time specified in this Plan); (ii) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during a calendar year may not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other calendar year, except, if such benefits consist of the reimbursement of expenses referred to in Section 105(b) of the Code, a maximum, if provided under the terms of the plan providing such medical benefit, may be imposed on the amount of such reimbursements over some or all of the period in which such benefit is to be provided to the Participant as described in Treasury Regulation Section 1.409A-3(i)(1)(iv)(B); (iii) the reimbursement of an eligible expense will be made no later than the last day of the calendar year following the year in which the expense is incurred, provided that the Participant shall have submitted an invoice for such fees and expenses at least ten (10) days before the end of the calendar year next following the calendar year in which such fees and expenses were incurred; and (iv) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit.

(c) Delay of Payments. Notwithstanding any other provision of this Plan to the contrary, if the Participant is considered a "specified employee" for purposes of Section 409A (as determined by the Company in accordance with Section 409A), any payment that constitutes nonqualified deferred compensation within the meaning of Section 409A that is otherwise due to the Participant under this Plan during the six-month period following the Participant's separation from service (as determined in accordance with Section 409A) on account of the Participant's separation from

service shall be accumulated and paid to the Participant on the first (1st) business day after the date that is six (6) months following the Participant's separation from service (the "Delayed Payment Date"). The Participant shall be entitled to interest (at the applicable rate in effect for the month in which the separation from service occurs) on any cash payments so delayed from the scheduled date of payment to the Delayed Payment Date. If the Participant dies during the postponement period, the amounts and entitlements delayed on account of Section 409A shall be paid to the personal representative of the Participant's estate on the first to occur of the Delayed Payment Date or thirty (30) days after the date of the Participant's death.

7.14 Governing Law. The validity, interpretation, construction and performance of this Plan shall in all respects be governed by the laws of Delaware, without reference to principles of conflict of law, except to the extent pre-empted by federal law.

EXHIBIT A

Form of Release of Claims and Covenant Not To Sue

In consideration of the payments and other benefits that Molina Healthcare, Inc., a Delaware corporation (the "Company"), is providing to _____ ("Employee") under the Company's Change in Control Severance Plan, the Employee, on his/her own behalf and on behalf of Employee's representatives, agents, heirs and assigns, waives, releases, discharges and promises never to assert any and all claims, demands, actions, costs, rights, liabilities, damages or obligations of every kind and nature, whether known or unknown, suspected or unsuspected that Employee ever had, now have or might have as of the date of Employee's termination of employment with the Company against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, attorneys, insurers, successors, or assigns (including all such persons or entities that have a current and/or former relationship with the Company) for any claims arising from or related to Employee's employment with the Company, its parent or any of its affiliates and subsidiaries and the termination of that employment.

These released claims also specifically include, but are not limited to, any claims arising under any federal, state and local statutory or common law, such as (as amended and as applicable) Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, the Americans With Disabilities Act, the Employee Retirement Income Security Act, the Family Medical Leave Act, the Equal Pay Act, the Fair Labor Standards Act, the Industrial Welfare Commission's Orders, the California Fair Employment and Housing Act, the California Constitution, the California Government Code, the California Labor Code and any other federal, state or local constitution, law, regulation or ordinance governing the terms and conditions of employment or the termination of employment, and the law of contract and tort and any claim for attorneys' fees.

Furthermore, the Employee acknowledges that this waiver and release is knowing and voluntary and that the consideration given for this waiver and release is in addition to anything of value to which Employee was already entitled. Employee acknowledges that there may exist facts or claims in addition to or different from those which are now known or believed by Employee to exist. Nonetheless, this Agreement extends to all claims of every nature and kind whatsoever, whether known or unknown, suspected or unsuspected, past or present. Employee also expressly waives the provisions of California Civil Code section 1542, which provides: "A general release does not extend to claims which the creditor does not know or suspect to exist in his/her favor at the time of executing the release, which if known by him/her must have materially affected his/her settlement with the debtor." With respect to the claims released in the preceding sentences, the Employee will not initiate or maintain any legal action or proceeding of any kind against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, successors, or assigns (including all such persons or entities that have a current or former relationship with the Company), for the purpose of obtaining any personal relief, nor assist or participate in any such proceedings, including any proceedings brought by any third parties (except as otherwise required or permitted by law). The Employee further acknowledges that he/she has been advised by this writing that:

he/she should consult with an attorney prior to executing this release;

he/she has at least [twenty-one (21) or forty-five (45) days, as required under applicable law] within which to consider this release;

he/she has up to seven (7) days following the execution of this release by the parties to revoke the release; and

this release shall not be effective until such seven (7) day revocation period has expired.

Employee agrees that the release set forth above shall be and remain in effect in all respects as a complete general release as to the matters released.

EMPLOYEE

_____

[Name]

Date:

Certain information in this exhibit has been omitted and filed separately with the Securities and Exchange Commission. Confidential treatment has been requested with respect to the omitted portions in accordance with Rule 24b-2 of the Securities Exchange Act of 1934, as amended. Omitted portions of this exhibit are marked by "[redacted]".

Master Services Agreement

For Information Technology Services

between

MOLINA HEALTHCARE, INC.

and

INFOSYS LIMITED

COMPANY CONFIDENTIAL

CONTENTS

TABLE OF SCHEDULES

THIS AGREEMENT is made on February 4, 2019:

BETWEEN:

(1) **MOLINA HEALTHCARE, INC.**, a Delaware corporation, whose headquarters is at 200 Oceangate, Long Beach, CA 90802, USA ("**Molina**"); and

(2) **INFOSYS LIMITED,** a limited liability company registered in India (company number L85110KA1981PLC013115), whose registered office is at Electronics City, Hosur Road, Bangalore, 560 100, India (the "**Service Provider**").

INTRODUCTION:

(A) Molina has conducted a wide-ranging strategic review of its technology requirements for information technology. Following the review, Molina identified a number of key criteria that would define a successful relationship between Molina and the chosen suppliers.

(B) In order to implement Molina's strategic requirements, Molina issued a Request for Proposal in August 2018 ("**RFP**") to the chosen suppliers.

(C) The Service Provider responded to the RFP with the RFP Proposal in August 2018.

(D) Molina and the Service Provider engaged in a period of negotiations in relation to this Agreement based on the RFP Proposal.

(E) Following discussions with the Service Provider in connection with the RFP Proposal, Molina has selected the Service Provider to be a provider of services to Molina for the benefit of all the Molina Companies.

(F) Molina has entered into, and may from time to time enter into, multiple contracts with multiple suppliers for the supply of different elements of Molina's information technology requirements. This Agreement concerns the Services only.

(G) Molina requires its various suppliers to co–operate with each other and with Molina to achieve an end–to–end service for Molina.

(H) The Service Provider has agreed to supply the Services to Molina for the benefit of all the Molina Companies on the terms of this Agreement.

THE PARTIES AGREE as follows:

PART ADEFINITIONS AND INTERPRETATION

1. **DEFINITIONS**

In this Agreement, capitalized words and phrases shall have the meanings given in paragraph 1 of Schedule 1 (*Definitions and Interpretation*) to this Agreement.

2. **INTERPRETATION**

This Agreement shall be construed in accordance with paragraph 2 of Schedule 1 (*Definitions and Interpretation*) to this Agreement.

PART B THE TERM AND EXTENSION OF TERM

3. THE TERM

3.1 Subject to Clause 4 (Extension of the Term), the Term shall:

(a) commence on the Effective Date; and

(b) expire at 11.59 pm and 59 seconds (Pacific time) on the Expiry Date, unless terminated earlier in accordance with Clause 51 (*Termination of the Entire Agreement for Cause*), Clause 54 (*Termination for Continued Force Majeure*) or Clause 55 (*Termination for Convenience*).

4. EXTENSION OF THE TERM

4.1 Molina may extend the term for a maximum of two (2) additional periods of twelve (12) months each.

4.2 If Molina wishes to extend the Term, it shall give notice of its request to extend the Term in writing to the Service Provider at least two (2) months prior to the then-current Expiry Date ("**Renewal Notice**").

4.3 Each extension of the Term pursuant to Clause 4.2 shall be referred to as an "**Extended Term**" for the purposes of this Clause 4 (*Extension of the Term*).

4.4 Each Renewal Notice shall specify the date, in accordance with Clause 4.1, on which the Term shall expire.

4.5 The Charges applicable to each Extended Term shall be determined in accordance with Schedule 3 (*Pricing and Invoicing*).

4.6 Molina and the Service Provider shall meet to discuss the Renewal Notice no later than two (2) weeks after the date the Renewal Notice is received.

4.7 The Service Provider acknowledges that it has not been given any assurance nor has the Service Provider any legitimate expectation that the Term will be extended.

PART C AGREEMENT STRUCTURE AND FORMALITIES

5. STRUCTURE OF THE MASTER SERVICES AGREEMENT

5.1 Master Services Agreement

This Agreement:

(a) sets out the terms on which the Service Provider shall provide the Services or procure the provision of the Services to Molina, Molina Companies; and

(b) describes how the relationship between Molina and the Service Provider will be managed.

6. NOT USED

7. FLOW-THROUGH OF CHANGES

7.1 Except where expressly stated otherwise in this Agreement, each requirement in this Agreement for the Parties to agree on a matter shall be construed as a reference to Molina and the Service Provider agreeing on the matter, and it shall not be necessary for the purposes of this Agreement to obtain the agreement of any other Molina Company or any Service Provider Company on that matter.

PART D WARRANTIES AND EXCLUSIVITY

8. WARRANTIES, REPRESENTATIONS AND COVENANTS

8.1 Service Provider's General Warranties

The Service Provider hereby warrants, represents and covenants to Molina as follows:

(a) Authorization

The Service Provider has all the requisite power and authority to enter into this Agreement.

(b) Performance

The Service Provider shall have all the necessary licenses and consents and Resources it requires in order to deliver the Services as and when required to fulfill all of its obligations under this Agreement and each Project Work Order, except Software, Hardware and licenses and consents that Molina is required to provide as a Molina Responsibility.

(c) Execution

Execution of this Agreement by the Service Provider does not and will not violate any Applicable Law and does not and will not constitute a default under or breach of any of the Service Provider's existing or future obligations.

(d) Compliance

The Service Provider shall comply with Applicable Law in relation to this Agreement. Changes to Applicable Law shall be implemented in accordance with the Change Control Process.

(e) Inducements to Molina

The Service Provider has not violated any Applicable Law or any Policy regarding the offering of unlawful inducements in connection with this Agreement.

(f) Inducements from Third Parties

The Service Provider has not received any payment or other benefit from any Third Party (except for any arms' length payments made for goods or services provided) in return for the Service Provider introducing that Third Party to Molina or in return for subcontracting part of the Services to that Third Party.

(g) No Exclusive Deals

As of the Effective Date, the Service Provider has no agreements in place under or in relation to this Agreement that would have the effect of preventing a supplier from providing goods or services to Molina other than through the Service Provider or

have the effect of requiring the Service Provider to use only one supplier of any kind of goods or services for the purposes of providing Services to Molina.

(h) Quality of Code

(i) The Service Provider shall develop all Source Code and any associated graphical user interfaces that it develops under this Agreement or a Project Work Order:

(A) in accordance with Good Industry Practice;

(B) in accordance with all applicable Policies and Molina conventions that have been notified by Molina to the Service Provider, including any conventions relating to development language, naming conventions for modules, subroutines, variables and constants and use of interfaces, modules and subroutines; and

(C) in accordance with applicable Third Party Software supplier guidelines, including any style guides, to the extent that the Third Party Software supplier guidelines do not conflict with any Molina conventions.

(ii) The Service Provider agrees that Molina shall be entitled to engage an expert Third Party to conduct an independent assessment of Source Code quality if in Molina's opinion the Service Provider has failed to comply with any of the terms in this Clause 8.1(h).

8.2 Warranties given at the Effective Date

Subject to Clause 8.4, each of the representations and warranties in Clauses 8.1(a), 8.1(c), 8.1(e) and 8.1(f) shall be given at the Effective Date only.

8.3 Warranties of a Continuing Nature

Each of the representations, warranties and covenants in Clause 8.1 (other than those referred to in Clause 8.2) shall be of a continuing nature, and shall be deemed to have been repeated on each day throughout the Term and thereafter for as long as any Services under this Agreement remain to be performed during an Exit Period.

8.4 Warranties Repeated on Execution of Project Work Order

Each of the representations, warranties and covenants in Clause 8.1 (including those referred to in Clause 8.2) shall be deemed to have been repeated on the date on which each Project Work Order is executed, and shall apply as repeated as if references in those representations, warranties and covenants to this Agreement were references to that Project Work Order.

8.5 The RFP Proposal and Due Diligence

(a) The Service Provider represents and warrants that the RFP Proposal was created and submitted in good faith and the Service Provider represents and warrants that the

contents of the RFP Proposal are true and accurate in all material respects based on the information available to the Service Provider at the date the RFP Proposal was submitted to Molina**.**

(b) The Service Provider represents and warrants to Molina that it:

(i) has satisfied itself as to the risks, contingencies and circumstances relating to the performance of the Services and its other obligations under this Agreement before entering into this Agreement;

(ii) has reviewed and considered all information provided by Molina in relation to this Agreement and all other information that is accessible to the Service Provider and that the Service Provider ought reasonably to consider in relation to its performance of this Agreement, including data concerning existing volumes, service performance and other metrics made available to Service Provider during the diligence process relating to this Agreement;

(iii) has made all necessary enquiries of Molina that the Service Provider ought reasonably to consider in relation to its performance of this Agreement;

(iv) has reviewed the Services and determined the Charges having regard to all of the Services to be provided under this Agreement; and

(v) will have no claim against Molina, or relief from any of its obligations under this Agreement, or any right to increase the Charges, in each case, in respect of any risk, contingency or other circumstance that the Service Provider failed to identify or consider during the course of the Service Provider's due diligence activities unless caused by fraudulent misrepresentation or fraudulent omission by Molina or any Molina Company.

(c) Molina represents and warrants to the Service Provider that the Service Provider is entitled to rely upon the content of the responses by Molina to any enquiries made by the Service Provider as set out in Clause 8.5(b)(iii) above, in each case solely to the extent of such responses and without limiting the Service Provider's need to make additional enquiries as may be required to resolve conflicting information provided by Molina or for the Service Provider to conduct diligence in accordance with Good Industry Practice (e.g., a general or high-level response by Molina shall not relieve the Service Provider of responsibility for enquiring about information at a level of detail that a reasonably prudent service provider would seek when acting in accordance with Good Industry Practice); provided, however, that where such responses by Molina are or appear to be conflicting, so long has Molina has acted in good faith in providing such responses, it is the responsibility of the Service Provider and not of Molina to identify and to make additional enquiries to resolve such conflict to the satisfaction of the Service Provider.

8.6 Capability

The Service Provider represents and warrants to Molina that it has carefully reviewed the Services and that it has all necessary skill, resources, experience and technical capacity to deliver all of the Services in accordance with this Agreement.

8.7 Molina Warranties, Representations and Covenants

Molina hereby warrants, represents and covenants to the Service Provider as follows:

(a) Authorization

Molina has all requisite power and authority to enter into this Agreement and to fulfill all of its obligations under this Agreement.

(b) Execution

Execution of this Agreement by Molina does not and will not violate any Applicable Law and does not and will not constitute a default under or breach of any of Molina's existing or future obligations.

(c) Compliance

Performance of this Agreement by Molina does not and will not violate any Applicable Law that is binding on Molina as a healthcare insurance company and recipient of the Services.

(d) Licenses

Molina shall have all the necessary licenses and consents it requires in order to grant the Service Provider the rights to Use Molina IP in accordance with Clause 29 (*Intellectual Property Rights*).

8.8 Warranties given at the Effective Date

Each of the representations, warranties and covenants in Clause 8.7(a) and Clause 8.7(b) shall be given at the Effective Date only.

8.9 Warranties of a Continuing Nature

The representation, warranty and covenant in Clause 8.7(c) shall be of a continuing nature, and shall be deemed to have been repeated on each day throughout the Term and thereafter for as long as any obligations under this Agreement remain to be performed after the expiry or termination of this Agreement.

8.10 Warranties Repeated on Execution of Project Work Order

Each of the representations, warranties and covenants in Clause 8.7 (including those referred to in Clause 8.8) shall be deemed to have been repeated on the date on which each Project Work Order is executed, and shall apply as repeated as if references in those representations, warranties and covenants to this Agreement were references to that Project Work Order.

8.11 Compliance with Import/Export Laws

(a) The Parties agree to comply with all Applicable Laws with respect to the export and import of Systems, Materials, data, information and technologies ("**Controlled Items**"), including those of the U.S. and with applicable embargoes/sanctions which the U.S. may impose from time to time ("**Import/Export Laws**").

(b) Except as provided in Clause 8.11(c) or where it is prohibited by any Import/Export Law, the Service Provider shall be responsible for, and shall notify Molina of, the export and import of all Controlled Items provided or procured by Service Provider in connection with the provision of the Services, including for determining and obtaining all relevant export and import authorizations.

(c) Molina shall be responsible for the export of all Controlled Items that it is required under this Agreement or any Project Work Order to provide to the Service Provider in order for the Service Provider to provide the Services.

(d) In circumstances where a Party (the "**Responsible Party**") is responsible for the import or export of any Controlled Items, the other Party agrees to cooperate with the Responsible Party, reasonably and in good faith, through the import/export process, including but not limited to providing information available to the other Party so that the Responsible Party may:

(i) determine all relevant import and export authorizations; and

(ii) export and import the Controlled Items.

(e) The Parties acknowledge that Import/Export Laws may include restrictions on access by citizens of third countries, wherever located, to certain U.S. source Controlled Items.

(f) The Service Provider shall:

(i) ensure that none of the Service Provider Personnel is on the United States Denied/Restricted Party List (DRPL) as notified by the U.S. Department of Commerce, or is considered a national of any country under US embargo or anti-terrorism export controls; and

(ii) ensure that no Service Provider Person is an individual who, if he or she were to have access to any Controlled Items in connection with the Services, would cause Molina to contravene any Import/Export Law (whether as a result of a deemed export or re-export or otherwise).

8.12 Ethical Business Practices

(a) The Service Provider represents, warrants and covenants to Molina that:

(i) in undertaking the activities contemplated by this Agreement, the Service Provider has complied with, and will continue to comply with, the Molina

Anti-Corruption Policy (and the Service Provider acknowledges that it has been provided with a copy of that Policy prior to the Effective Date), all applicable laws, regulations and industry codes and good business ethics including without limitation the Foreign Corrupt Practices Act of the United States, the OECD Convention on Combating Bribery of Foreign Public Officials in International Business Transactions and the Bribery Act 2010, and all other applicable laws, regulations and industry codes prohibiting bribery and other forms of corruption in the public and private sectors, and shall not take any action or make any payment in contravention of any such laws, regulations or industry codes or any other Applicable Law;

(ii) neither the Service Provider, any Service Provider Company nor any of its or their directors, officers, employees, agents or partners shall directly or indirectly offer, promise, give or authorize the giving of any financial or other advantage, or anything else of value to any official or employee of any government, government department or agency, enterprise owned in whole or in part by any government or government department or agency, public international organization, political party, or any other public or regulatory organization that may recommend, purchase, pay for, reimburse, authorize, approve or supply a product or service sold by Molina (the persons covered by this provision are referred to in this Agreement as "Government Officials") or to any other person or entity at the request of or with the assent or acquiescence of a Government Official, for the purpose of obtaining or retaining business for Molina, securing any other business advantage for Molina or influencing any act or decision in connection with the activities of the Service Provider contemplated by this Agreement;

(iii) neither the Service Provider, any Service Provider Company nor any of its or their directors, officers, employees, agents or partners shall directly or indirectly offer, promise, give or authorize the giving of any financial or other advantage, or anything else of value, to any person including an officer, employee, agent or representative of another company or organization to induce such person or another person to breach a duty to his or her employer or improperly perform any work-related activity or reward such person or another person for breaching a duty to his or her employer or improperly performing any work-related activity; and

(iv) neither the Service Provider, any Service Provider Company nor any of its or their directors, officers, employees, agents or partners (a) has made prior to the Effective Date any payment, authorization, promise or gift as described in sub-Clauses (ii) or (iii) above; (b) is a Government Official or (c) will become a Government Official without prior written notice to Molina.

(b) The Service Provider shall notify Molina promptly in the event that any of the information contained in the Anti-Corruption Questionnaire is rendered untrue or incomplete as a result of future developments.

(c) Upon each anniversary of the Effective Date an authorized signatory of the Service Provider shall sign and submit to Molina a certification in a form provided by Molina confirming that the Service Provider is in full compliance with this Clause 8.12 and that the Anti-Corruption Questionnaire is still accurate and complete or clearly indicating any changes thereto.

(d) The Service Provider shall ensure that each Service Provider Company and Subcontractor complies with the Service Provider's obligations under this Clause 8.12.

9. NO EXCLUSIVITY

9.1 The Service Provider is not granted exclusive supplier status by this Agreement for services of the same or a similar nature as the Services (including any future additions to or expansions of the Services) to Molina or any Molina Company.

9.2 Molina may, and any Molina Company may, at any time, obtain from a Third Party or a Molina Company or perform itself, services of the same or a similar nature as the Services.

9.3 This Agreement does not give the Service Provider or any Service Provider Company any right to a minimum level or volume of Services or Charges.

9.4 Molina makes no commitment to use the Service Provider for the provision of any Services or to incur any Charges.

9.5 Nothing in this Clause 9 affects Molina's obligation to pay for those Services actually consumed or utilized in accordance with this Agreement or any Project Work Order, or affects any other express payment obligation of Molina under this Agreement or any Project Work Order.

PART E THE SERVICES

10. MOLINA GROUP

The Services are provided for the benefit of Molina and the other Molina Companies under this Agreement.

11. TRANSITION

11.1 The Parties shall comply with their respective obligations set out in Schedule 4 (*Transition and Transformation*).

11.2 The Service Provider shall ensure that each Transition Milestone set out in the Transition Plans is Achieved by the corresponding Milestone Date.

11.3 The Service Provider's obligation to Achieve each Transition Milestone, and Molina's remedies under this Clause 11 (*Transition*) for any failure by the Service Provider to Achieve a Transition Milestone are subject to Clause 60 (*Excusing Causes*).

11.4 If a Transition Milestone that is a Delivery Credit Milestone is not Achieved by the relevant Milestone Date (or such other period as the Parties may agree in writing), the Service Provider shall credit a Delivery Credit to Molina, which shall be credited in the same manner as Service Credits in accordance with Schedule 3 (*Pricing and Invoicing*). The amount of each Delivery Credit shall be determined in accordance with Schedule 4 (*Transition and Transformation*).

11.5 If a Transition Milestone applicable to any Wave is not Achieved within [redacted] of the relevant Milestone Date, Molina may, without prejudice to its other rights and remedies:

(a) postpone the Service Commencement Date for the Services in that Wave, and in any subsequent Wave, either to a certain date or until the Transition Milestone has been Achieved;

(b) move all or part of the Services in that Wave, and in any subsequent Wave, to a later Wave; and/or

(c) remove from the scope of this Agreement all or part of the Services in that Wave, and in any subsequent Wave, in one, more than one, or all Countries.

12. STRUCTURE OF THE SERVICES

12.1 The Services include:

(a) the Run Services;

(b) the Project Services;

(c) the services described elsewhere in, as applicable, this Agreement and any Project Work Order; and

(d) all other activities, responsibilities and obligations that are an inherent or necessary part of the Services described in Clauses 12.1(a)-(c) above, provided that in each case such other activities, responsibilities and obligations contemplated in this Clause 12.1(d) are (i) not expressly being retained by Molina pursuant to this Agreement or (ii) with respect to those Services being provided under the applicable Statement of Work (and without limiting the Service Provider's obligations under another Statement or Work or PWO), identified as being outside the scope of Services set out in the applicable Statement of Work or PWO.

12.2 The Run Services shall be provided under this Agreement, without the need for the Parties to enter into any Project Work Order, and are described in the Statement(s) of Work.

12.3 The Project Services shall be provided under Project Work Orders, and are described in the Projects Statement of Work. Clause 13 (*Project Work Orders*) describes Project Work Orders, the process by which the terms of Project Work Orders shall be agreed and the contents and legal effect of each Project Work Order.

13. PROJECT WORK ORDERS

13.1 Introductory

(a) This Clause 13 (*Project Work Orders*) describes the process by which the terms of Project Work Orders shall be agreed, and the contents and legal effect of each Project Work Order.

(b) Each Project Work Order shall be substantially in the form attached at Appendix 2-D to Schedule 2 (*Statement of Work*).

(c) Each Project Work Order shall be executed by a Molina Company (acting by those persons authorized by Molina from time to time) and a Service Provider Company.

13.2 Agreement of Project Work Orders

(a) Each Project Work Order shall be agreed in accordance with the process set out in the Projects Statement of Work.

(b) Except as provided in Clause 13.2(c), a Project Work Order may be entered into during the Term but not after the end of the Term.

(c) A Project Work Order may be entered into during the twelve (12) month period following the end of the Term, but only:

(i) with the approval of the Head of IS Vendor and Supplier Management; and

(ii) if it is Linked to a Project Work Order that was entered into during the Term.

13.3 Effect of Project Work Orders

(a) Each Project Work Order shall constitute a contract between the Molina PWO Party and the Service Provider PWO Party, separate from and in addition to this Agreement.

(b) Each Project Work Order shall incorporate the terms of this Agreement. Except for references to Molina in Clauses 29.3(a) and 29.3(a) (in respect of which Molina and not the Molina PWO Party shall accrue all rights), if any provision of this Master Services Agreement provides that a Party shall have a right, remedy or claim, or shall be subject to an obligation or liability, that provision, as incorporated into a Project Work Order, shall confer that right, remedy or claim or impose that obligation or liability on the Molina PWO Party (in the case of rights, remedies or claims of, or obligations or liabilities on, Molina) and on the Service Provider PWO Party (in the case of rights, remedies or claims of, or obligations or liabilities on, the Service Provider), in respect of that Project Work Order.

(c) The Service Provider shall procure the performance by each Service Provider PWO Party of its obligations under each Project Work Order.

(d) Molina shall procure the performance by each Molina PWO Party of its obligations each Project Work Order.

(e) Nothing in this Clause 13.3 shall relieve Molina or the Service Provider of any of its obligations under this Agreement in respect of any Project Work Order, including the Service Provider's obligation to provide the Services and Molina's obligation to pay the Charges, but:

(i) performance by Molina of an activity under this Agreement in respect of a Project Work Order shall discharge the Molina PWO Party from its corresponding obligation to perform that activity under the Project Work Order; and

(ii) performance by the Service Provider of an activity under this Agreement in respect of a Project Work Order shall discharge the Service Provider PWO Party from its corresponding obligation to perform that activity under the Project Work Order.

13.4 Services under a Project Work Order

(a) The Services to be provided under each Project Work Order are:

(i) the services, functions, roles and responsibilities set out in the Project Work Order itself; and

(ii) the services, functions, roles and responsibilities set out in any software development lifecycle or methodology expressly referenced in the Project Work Order.

13.5 Linked Project Work Orders

(a) In this Agreement, a Project Work Order ("**Project Work Order A**") is Linked to another Project Work Order ("**Project Work Order B**") (and Project Work Order B is also Linked to Project Work Order A) if:

(i) any of the Deliverables of Project Work Order A, or any derivative works or Modified versions of any of those Deliverables, are Input Deliverables for Project Work Order B;

(ii) any of the Deliverables of Project Work Order A, or any derivative works or Modified versions of any of those Deliverables, are Input Deliverables for a Project Work Order that is Linked to Project Work Order B;

(iii) both of the following conditions are satisfied:

(A) any of the Deliverables of Project Work Order A, or any derivative works or Modified versions of any of those Deliverables, are Input Deliverables (or the equivalent of Input Deliverables) for an agreement with a Third Party; and

(B) any of the Deliverables (or the equivalent of Deliverables) of that agreement, or any derivative works or Modified versions of any of any of those Deliverables, are Input Deliverables for Project Work Order B; or

(iv) Project Work Order A expressly states that it is 'Linked' to Project Work Order B.

14. PROVISION OF THE SERVICES

14.1 The Service Provider shall provide, or shall procure the provision by Service Provider Companies of, the Services to Molina and the Molina Companies.

14.2 Each of the Service Provider and Molina has the rights and obligations allocated to it in each Statement of Work.

14.3 The Service Provider or the Service Provider PWO Party (as applicable) shall provide the Services with effect from the following dates:

(a) in the case of the Run Services, each Service Commencement Date, as set out in Schedule 4 (*Transition and Transformation*); and

(b) in the case of the Project Services under each Project Work Order, the commencement date for the Project Services under that Project Work Order.

14.4 The Service Provider shall provide the Services and perform all its other obligations under this Agreement in a manner that at all times complies with:

(a) the provisions referred to in Clause 13.4 (in the case of the Project Services);

(b) subject to Clause 14.5 and if the relevant Project Work Order expressly contemplates the applicability of the associated detail in the Service Provider Technical Solution to the Services set out in such Project Work Order, the Service Provider Technical Solution; and

(c) the Policies, as notified by Molina to the Service Provider in writing from time to time.

14.5 Except to the extent the provisions of this Agreement or the applicable Project Work Order expressly contemplate that an obligation in an SoW is subject to the related detail set out in Schedule 21 (*Service Provider Technical Solution*), Service Provider shall not be entitled to rely on any provision of Schedule 21 (*Service Provider Technical Solution*), whether expressed as an assumption, a dependency or otherwise, as limiting or reducing any of its obligations under:

(a) any other provision of this Agreement (including under any provision of any Schedule other than Schedule 21 (*Service Provider Technical Solution*)); or

(b) any Project Work Order.

15. SERVICE DELIVERY LOCATIONS

15.1 The Service Provider shall provide the Run Services only from Approved Service Delivery Locations.

15.2 If any Project Work Order provides that the Service Provider must provide the Project Services under that Project Work Order (or some of those Services) at or from a particular Molina Location or Approved Service Delivery Location, or Molina requires the Service Provider to provide any Catalogue Item at or from a particular Molina Location or Approved Service Delivery Location, the Service Provider shall provide those Project Services or that Catalogue Item at or from that Molina Location or Approved Service Delivery Location.

15.3 If any Project Work Order does not include a provision as described in Clause 15.2, or includes such a provision only in respect of certain Project Services under that Project Work Order, then the Service Provider may provide the Project Services under that Project Work Order, or the Project Services not covered by such a provision, from any Approved Service Delivery Location but not from any other location.

15.4 Molina may, by written notice to the Service Provider, remove any Approved Service Delivery Location from Schedule 10 (*Approved Service Delivery Locations*) (and that location shall cease to be an Approved Service Delivery Location) if:

(a) the Service Provider commits a material breach of this Agreement that is wholly or mainly due to the Approved Service Delivery Location, and, if that breach is capable of remedy, that breach is not remedied within twenty (20) Business Days (or such other period as may be agreed by the Parties); or

(b) that Approved Service Delivery Location does not comply with any Policy and is not or cannot be made to be compliant with that Policy within twenty (20) Business Days.

15.5 Clause 50 (*Service Relocation*) shall apply if Molina removes any Approved Service Delivery Location under Clause 15.4.

16. **SOFTWARE REQUIREMENTS**

16.1 The Service Provider shall be responsible for installing, operating and maintaining, at its own expense, the Service Provider Software utilized in the performance of the Services.

16.2 The Service Provider shall provide the following to Molina together with any Deliverable required to be provided under this Agreement or any Project Work Order that is, or that includes, any Software that has been created or developed by the Service Provider in the performance of the Services (including any Modification to any such Software) (a "**Customized Software Deliverable**"):

(a) all Source Code in respect of the Customized Software Deliverable;

(b) copies of all:

(i) Service Provider Software that is embedded in the Customized Software Deliverable;

(ii) Service Provider Software that is necessary to Use, Modify, support or maintain or continue to develop the Customized Software Deliverable, except where such Service Provider Software is owned by a Third Party and the Agreement or relevant Project Work Order expressly sets outs that that Molina will have to obtain the copies of that Service Provider Software from such Third Party;

(iii) other Service Provider Software that the Parties have agreed will be provided to Molina;

(iv) Third Party Software in respect of which Molina has requested the Service Provider to assist it in obtaining licenses under Clause 16.8(d); and

(v) Third Party Software that the Service Provider has incorporated into a Customized Software Deliverable.

(c) full details of the Customized Software Deliverable, including full name and version details, the type of media on which the Customized Software Deliverable is provided, any backup command or Software used to create the Customized Software Deliverable provided, any compression used on the Customized Software Deliverable, any archive hardware used in relation to the Customized Software Deliverable and details of the operating system on which the Customized Software Deliverable runs;

(d) any password and encryption details necessary to access the Source Code to the Customized Software Deliverable that the Service Provider is required to provide under this Clause 16.2;

(e) a directory listing of the media on which the Customized Software Deliverable is provided;

(f) design information in respect of the Customized Software Deliverable, including module names and functionality; and

(g) the name and contact details of the Service Provider Personnel who Molina may contact if it has any queries regarding the Customized Software Deliverable.

16.3 The Service Provider shall promptly provide Molina with any additional information that Molina may reasonably request in order to be able to Use, reproduce, Modify, build, compile, install, enhance or support any Customized Software Deliverable.

16.4 The Service Provider may not incorporate any Service Provider Software, any Third Party Software or any Open Source Software (including any Modification to any Service Provider Software, Third Party Software or Open Source Software made in the course of providing the Services) (the "Software Materials") into any Molina Work Product, any Customized Software Deliverable or any of Molina's Applications or other Systems unless the Service Provider has all the necessary licenses and consents it requires in order to grant to Molina the rights described in Clause 29 (*Intellectual Property Rights*) and:

(a) the Software Materials were already incorporated in Materials provided by Molina to the Service Provider for the Service Provider to Modify;

(b) the Software Materials' inclusion is expressly set out in a Statement of Work or a Project Work Order as an exception to the obligation set out in this Clause 16.4;

(c) the Software Materials' inclusion is approved via the Change Control Process; or

(d) in the case of Open Source Software, the Open Source Software is Approved Open Source Software.

16.5 In order to ensure compliance with Clause 16.4, the Service Provider shall use Software tools in accordance with Good Industry Practice to detect the presence of Open Source Software.

16.6 The Service Provider may not, without the prior written permission of Molina or in accordance with the Policies, create any dependency between the Use, Modification, development, maintenance or support of any Customized Software Deliverable or any of Molina's Applications or other Systems and:

(a) any Service Provider IP;

(b) any Software, Materials or data the Intellectual Property Rights in which (or some of them) are owned by any Third Party; or

(c) any services, assets or facilities that are not under Molina's control and which Molina does not enjoy a perpetual, irrevocable, transferrable, sublicenseable, royalty-free, fully paid up right to use to the extent necessary for the proper operation of the Customized Software Deliverable, Molina Application or other System.

In this Clause 16.6, to "create a dependency" means the Customized Software Deliverable, Molina Application or other System (as applicable), cannot be Used, Modified, developed or supported without one of the items listed in Clauses 16.6(a), 16.6(b) or 16.6(c).

16.7 The Service Provider shall ensure that all Service Provider Software, Third Party Software and Open Source Software that are incorporated into any Molina Work Product, any Customized Software Deliverable or any of Molina's Applications or other Systems are clearly identified, either in the Source Code in respect of the Molina Work Product or Customized Software Deliverable or as otherwise agreed between the Parties, as being Service Provider Software, Third Party Software or Open Source Software (as the case may be).

16.8 The Service Provider shall:

(a) obtain the prior written approval of Molina in respect of all Systems used in the creation or development of Molina Work Product created for Regulated Systems;

(b) not use any System in the creation or development of Molina Work Product created for Regulated Systems that has not been approved by Molina in accordance with Clause 16.8(a);

(c) obtain for the benefit of Molina and the other Molina Companies, at the Service Provider's cost (unless expressly stated as a Molina Responsibility), a license, on terms that are at least as favorable as those in Clause 29.4 (or such other terms as may be agreed by the Parties in writing) in respect of any Third Party Software incorporated into any Molina Work Product or any Customized Software Deliverable;

(d) if requested by Molina, assist Molina in obtaining (including introducing Molina to the relevant Third Party), at Molina's cost, a license for Molina and the other Molina Companies to Use any Third Party Software approved by Molina in accordance with Clause 16.8(a) on, to the extent agreed by the applicable Third Party licensor, the standard license terms offered by the relevant Third Party licensor;

(e) obtain for the benefit of Molina and the other Molina Companies, at the Service Provider's cost, a license to Use any Software, Materials and data, and any services, assets or facilities, owned by any Third Party and on which the Use, Modification, development, maintenance or support of any Customized Software Deliverable becomes dependent as a result of any action taken by the Service Provider in breach of Clauses 16.6(b) or 16.6(c); and

(f) wherever possible, use applications and tools that are generally commercially available in the creation and development of Molina Work Product.

17. SERVICE LEVELS

17.1 The Service Levels are set out in Schedule 6 (*Service Levels and Service Credits*).

17.2 Without limiting the Service Provider's obligations to provide the Services in accordance with the quality standards in Clause 19 (*Quality*), the Service Provider must ensure that the Services at all times meet or exceed the Service Levels.

17.3 If Service Level Default occurs, the Service Provider shall do any or all of the following (as directed by Molina):

(a) prior to the end of the month following the month in which the failure (or, as applicable, the last failure) occurred (or within such shorter period as may be specified in Schedule 6 (*Service Levels and Service Credits*)), perform a Root Cause Analysis to identify the cause of such failure and provide Molina with a written report identifying the root cause of the failure, the consequences of the failure and the Service Provider's procedures for correcting the failure and for ensuring that the failure does not occur again in the future, in each case as further set out in Schedule 6 (*Service Levels and Service Credits*); and

(b) correct any fault or defect in the Systems (other than Systems that Molina is responsible for providing and maintaining, in each case as expressly stated in the applicable Statement of Work or Project Work Order) or processes used by the Service Provider to provide the Services which gave rise to the failure so that the same fault or defect does not reoccur.

17.4 The Service Provider is responsible for ensuring that performance against each of the Service Levels is capable of being measured and reported, and that performance is measured and reported, in accordance with this Agreement.

17.5 If the Service Provider does not measure or report performance against any Service Level in any month in which the Service Provider is required to measure and report performance as set out in Schedule 6 (*Service Levels and Service Credits*), then the Service Provider shall be deemed to have failed to meet that Service Level and all the normal consequences of such a failure shall apply including crediting Service Credits in accordance with Clause 18 (*Service Credits*).

18. SERVICE CREDITS

18.1 If a Service Level Default occurs, the Service Provider shall credit Molina Service Credits in accordance with Schedule 6 (*Service Levels and Service Credits*).

18.2 The Service Credits that the Service Provider must credit to Molina shall be credited, reported, applied and calculated in accordance with the method set out in Schedule 6 (*Service Levels and Service Credits*).

18.3 The Service Provider must automatically credit Service Credits against the Charges in accordance with Schedule 3 (*Pricing and Invoicing*).

18.4 The Service Provider acknowledges and agrees that the credit of any Service Credit by the Service Provider is a one-time price adjustment (without the need to adjust the Charges in Schedule 3 (*Pricing and Invoicing*)) to reflect the fact that Molina was not provided the quality of Service that it contracted to receive. A Service Credit is therefore not an estimate of the loss or damage suffered by Molina as a result of the Service Provider's failure to deliver the Services to meet a Service Level.

18.5 If Molina brings an action based on the same circumstances that gave rise to the payment of Service Credits then any award of damages shall be reduced by the amount of the Service Credit to reflect the Service Credits already credited.

18.6 Service Credits are not Molina's sole or exclusive remedy in relation to:

(a) any failure by the Service Provider to meet the Service Levels; or

(b) breach of, or failure to perform, this Agreement by the Service Provider.

18.7 Subject to Clause 18.5, Molina is not precluded from claiming general damages should Service Credits not fully compensate Molina for its recoverable loss.

19. QUALITY

19.1 The Service Provider shall perform its obligations under this Agreement in accordance with Good Industry Practice.

19.2 The Parties shall have the rights and obligations allocated to them in Schedule 14 (*Molina Policies*).

20. TRAINING

20.1 The Service Provider shall train the Service Provider Personnel about Molina Policies and on regulatory matters impacting on Molina. In the case of regulatory matters, the Service Provider shall train the Service Provider Personnel in accordance with Molina's interpretation of such regulatory matters that it notifies to the Service Provider in writing, and, if Molina does not notify the Service Provider of any interpretation, the Service Provider shall train the Service Provider Personnel about regulatory matters impacting on Molina in accordance with Good Industry Practice.

20.2 Molina may provide materials, including speaker notes and handouts, for use in the training sessions referred to in Clause 20.1, and the Service Provider shall ensure that these materials are used in those training sessions, including in such manner as Molina may specify.

20.3 The Service Provider shall bear all of its own costs related to the staging and running of the training sessions referred to in Clause 20.1.

20.4 Molina shall have the right to attend training sessions referred to in Clause 20.1. The Service Provider shall, promptly upon request by Molina, provide Molina with copies of all materials presented or distributed to Service Provider Personnel attending training sessions referred to in Clause 20.1.

20.5 If Molina discovers that the Service Provider is not performing its obligations under Clause 20.1 in accordance with Good Industry Practice, or that the training sessions under Clause 20.1 are otherwise deficient in any material respect, then, without prejudice to any of Molina's other remedies under this Agreement, the Parties may agree that until the Service Provider has remedied that failure or those deficiencies:

(a) Molina may require all Service Provider Personnel to attend training sessions run by or on behalf of Molina on the matters referred to in Clause 20.1;

(b) the Service Provider shall bear all of its own costs related to the attendance by Service Provider Personnel at those training sessions (including travel and living expenses); and

(c) Molina shall not be liable to pay any amounts to the Service Provider in respect of the time spent by any Service Provider Personnel in attending any of those training sessions.

20.6 Molina may, in circumstances other than those described in Clause 20.5, require Service Provider Personnel to attend training sessions run by or on behalf of Molina on the matters referred to in Clause 20.1. Molina shall reimburse the Service Provider's reasonable travel and living expenses incurred in complying with this Clause 20.6.

21. MUTUAL ASSISTANCE AND COOPERATION

The Parties shall have the rights and obligations allocated to them in Schedule 17 (*Mutual Assistance and Cooperation*).

PART F CHANGE

22. THE RELEVANT CHANGE MANAGEMENT PROCESS

The Parties shall have the rights and obligations as set out in Schedule 9 (*Change*).

23. TECHNOLOGY DEVELOPMENT AND ASSET REFRESH

23.1 Continuous Improvement

(a) The Service Provider shall proactively plan for and identify opportunities to improve the Services and, in so doing, shall advise Molina of each such opportunity that is identified for consideration and possible implementation.

(b) The Service Provider shall, in addition to any requirements to reduce the Charges as set out in Schedule 3 (*Pricing and Invoicing*), proactively plan for and identify opportunities to reduce the Charges further (without compromising the quality of the Services) and, in so doing, shall advise Molina of each such opportunity that is identified for consideration and possible implementation.

23.2 Technological Flexibility

(a) The Service Provider shall, where practicable, employ technology platforms, systems and solutions to provide the Services that have the ability to interface and interoperate with industry standard technology platforms and systems.

(b) Notwithstanding and in addition to Clause 23.2(a), all interfaces that are required to be prepared and developed by the Service Provider under this Agreement or any Project Work Order must, where practicable and unless otherwise mandated by Molina, be prepared and developed:

(i) using open standards and open communications protocols;

(ii) in accordance with the Service Provider's then current development, interface and interoperability methodologies;

(iii) using applications and Software tools that are generally available in the market (if any), rather than bespoke applications or Software tools created for the purpose of developing a specific interface unless otherwise agreed between the Parties; and

(iv) in accordance with Good Industry Practice in the Software development industry and any specific practices recommended, and publications issued (including recommendations on the use of application programming interfaces) by the vendor of the platforms, Systems and solutions that the interfaces are designed to connect.

PART G SECURITY, BUSINESS CONTINUITY AND INCIDENT MANAGEMENT

24. SECURITY

24.1 The Service Provider shall comply with its obligations in relation to security set out in the Policies and each Statement of Work.

24.2 The Service Provider understands and acknowledges that Molina is a covered entity and/or business associates subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and any regulations promulgated thereunder (collectively the "HIPAA Rules") and that Service Provider creates, receives, maintains, and/or transmits Protected Health Information ("PHI") in providing Services on behalf of Molina. The Parties agree to enter into the Business Associate Agreement set forth in Schedule 24 (*Certain Security Requirements*).

24.3 The Service Provider understands and acknowledges that Molina is a Qualified Health Plan which participates in state and federal health insurance exchanges which involve the use and disclosure of Personally Identifiable Information ("PII"). The Service Provider agree to comply with applicable state and federal law with respect to safeguarding such PII. The Parties agree to abide by the requirements set forth in Schedule 24 which is incorporated herein by reference. The Service Provider shall access or use Molina's Systems only for the purpose of performing the Services and for no other purpose whatsoever.

24.4 The Service Provider understands and acknowleges that Molina is subject to other state and federal laws regulating the privacy and confidentiality of personal information, including, but not limited to, the Gramm-Leach-Bliley Act ("GLBA"), Title 42 Part 2 pertaining to the confidentiality of Substance Abuse Disorder Information, and 42 CFR 431.00 et seq., pertaining to the Confidentiality of Medicaid Participant information, and the California Consumer Privacy Act ("CCPA").

24.5 When accessing or using Molina's Systems the Service Provider shall, and shall procure that such of the Service Provider Personnel who have access to Molina's Systems in connection with the performance of the Services shall, comply with all Policies relating to security of Molina's Systems.

24.6 The Service Provider shall ensure that all the Service Provider Personnel are granted access to Molina's Confidential Information and any of Molina's Systems only on a need-to-access basis which shall be restricted to such access as is necessary to perform the Services. Such Service Provider Personnel granted access shall be bound by written confidentiality obligations no less restrictive than those set out in this Agreement (which obligations may, in respect of each Service Provider Person, be set out in that Service Provider Person's terms of employment or in a separate non-disclosure agreement) and shall be informed by the Service Provider of the confidentiality obligations in this Agreement.

24.7 The Service Provider shall ensure that no Service Provider Company and, to the extent any of the following events arise from any failure by the Service Provider to fulfill its obligations under this Agreement, that no Third Party:

(a) suspends, interrupts or discontinues Molina's (or any Molina Company's) use of Molina's Systems;

(b) erases, destroys, corrupts or modifies any of the Molina Data without the consent or knowledge of Molina;

(c) is, at any time, unable to locate definitively any media, device or equipment on which Molina Data is stored; or

(d) bypasses any internal or external security measure in order to obtain access to the relevant Molina Systems or Molina Data without the consent or knowledge of Molina.

24.8 The Service Provider shall notify Molina as soon as it becomes aware of any actual or suspected breaches of this Clause 24 (*Security*). Molina shall be entitled to investigate, or engage a third party to investigate on its behalf, any actual or alleged breaches (and the Service Provider shall fully cooperate) and the Service Provider shall, as soon as practicable and to extent such actual or alleged breaches are rectifiable by the Service Provider, rectify any breaches identified. The costs of any such investigation, cooperation, and of any rectification of failures by the Service Provider to comply with this Clause 24 (*Security*), shall be borne by the Service Provider; provided, however, that Molina shall be responsible for such costs to the extent (a) the Service Provider is not responsible for the actions of the applicable Third Party as set out in Clause 24.7, (b) the breach was caused by Molina, (c) the breach was caused by an Other Service Provider whose contract with Molina or whose related activities are not being administered or managed by the Service Provider or any of its Affiliates, or (d) the breach was caused by an Other Service Provider whose contract with Molina or whose related activities are being managed by the Service Provider and such breach was not directly caused by Service Provider's failure to properly manage or administer such Other Service Provider.

24.9 The Service Provider shall notify Molina as soon as it becomes aware of any actual or suspected vulnerability in the security of any of Molina's Systems (whether or not those vulnerabilities are, or result from, a breach of this Agreement by the Service Provider).

25. BUSINESS CONTINUITY MANAGEMENT AND DISASTER RECOVERY

25.1 In addition to the Service Provider's obligations set out in Schedule 23 (*Business Continuity and Disaster Recovery*), the Service Provider shall implement, test and maintain disaster recovery and business continuity procedures in respect of its own Systems and facilities used to provide the Services, in accordance with Good Industry Practice.

26. MAJOR INCIDENTS

26.1 In the event of a Major Incident, the Service Provider shall:

(a) comply with its obligations in this Agreement and the Policies according to the nature and impact of that Major Incident;

(b) take Appropriate Actions to mitigate any adverse effects of the Major Incident on the Services; and

(c) take Appropriate Actions to ensure that the steps taken by the Service Provider in managing and resolving the Major Incident do not add any further disruptions to the impact of the Major Incident on the Services.

26.2 If a Major Incident is caused or contributed to by, or is otherwise connected to, the Services or Deliverables that the Service Provider has provided under this Agreement or any Project Work Order, the Service Provider shall:

(a) take Appropriate Actions to assign personnel from its Incident Response Team to manage and resolve the Major Incident (before assigning BAU Personnel); and

(b) to the extent that it is unable to assign personnel from its Incident Response Team in accordance with Clause 26.2(a), take Appropriate Actions to:

(i) assign BAU Personnel to manage and resolve the Major Incident; and

(ii) back-fill the roles of any BAU Personnel assigned in accordance with Clause 26.2(b)(i).

26.3 Subject to Clause 26.4 and without prejudice to Clause 60 (*Excusing Causes*) and Clause 61 (Force Majeure), the Service Provider shall not be liable for a failure to perform its obligations under this Agreement (other than any of its obligations under this Clause 26 (*Major Incidents*)) if and to the extent that the failure resulted from:

(a) an action or step taken by the Service Provider in managing and resolving a Major Incident which Molina directed the Service Provider to take; or

(b) BAU Personnel being assigned to manage and resolve a Major Incident in accordance with this Clause 26 (*Major Incidents*) and, as a result, being unavailable to perform the Services.

26.4 The Service Provider shall not be entitled to relief under Clause 26.3 to the extent that:

(a) the Major Incident occurred as a result of a breach by the Service Provider of any of its obligations under this Agreement or a negligent act or omission on the part of the Service Provider; or

(b) the Service Provider fails to comply with its obligations under Clause 26.1.

26.5 The Service Provider's obligations under this Agreement in relation to the management and resolution of a Major Incident apply irrespective of whether the Parties have agreed on the Service Provider's liability in relation to that Major Incident or any action or step to be taken in managing or resolving the Major Incident, and the Service Provider may not

refuse to perform those obligations on the grounds that the Parties have not reached such agreement.

26.6 In circumstances where a Major Incident was not caused by an act or omission of the Service Provider (or of a Service Provider Company), or by the Service Provider's breach of any of its obligations under this Agreement, to the extent the Service Provider's compliance with this Clause 26 causes it to incur demonstrable and material costs in addition to those it incurs in complying with its obligations under this Agreement, the Parties shall agree any adjustment to the Charges in accordance with the Change Control Process.

26.7 The Service Provider shall:

(a) maintain a plan for responding to Major Incidents using the Incident Response Team and shall test this plan on an annual basis;

(b) ensure that a member of the Incident Response Team is available at all times to respond to a Major Incident, irrespective of when or where the Major Incident occurs;

(c) maintain an up-to-date call-out list containing names, roles and contact details (including mobile and home phone numbers) of all members of the Incident Response Team;

(d) identify a manager and single point of contact on the Incident Response Team;

(e) cooperate with Other Service Providers to share such call-out lists for each Incident Response Team;

(f) recommend to Molina that a Major Incident be declared as a result of an event or crisis within the Service Provider's own organization; and

(g) participate in formal reviews and assessments of all Major Incidents to capture learning and improvements to the Services arising out of the Major Incident including retrospectively processing such Major Incidents in accordance with this Agreement and the Policies.

27. VIRUS AND HARMFUL CODE PROTECTION

27.1 Service Provider Responsibility

(a) Subject to Clause 27.1(c), the Service Provider must ensure that it does not introduce, or, by failing to comply with its obligations under this Agreement, permit the introduction of, any computer program virus, drop dead device, Trojan horse, time bomb, back door device, or other code that is harmful, destructive, disabling or which assists in or enables unauthorized access to, or use or modification of, any of Molina's Systems or associated data or otherwise disrupts or impairs the normal operation of any of Molina's Systems ("**Harmful Code**") into any Molina Work Product or in any Customized Software Deliverable.

(b) The Service Provider must take Appropriate Actions to ensure that no Harmful Code is introduced into any of Molina's Systems by the Service Provider or any of its Subcontractors.

(c) The Service Provider will not be in breach of the provisions of Clause 27.1(a) in circumstances where Materials provided to it by Molina or Other Service Providers already contain Harmful Code, except where the Service Provider's obligations under this Agreement or a Project Work Order in relation to the Customized Software Deliverable include an obligation to eliminate such Harmful Code.

27.2 Molina Responsibility

Molina shall implement and enforce its own internal policies as they apply to virus protection.

27.3 Procedure if Harmful Code is Found

If any Harmful Code is found by the Service Provider to have been introduced into any Molina Work Product, any Customized Software Deliverable or any of Molina's Systems:

(a) the Service Provider must report that fact to Molina as soon as the Service Provider becomes aware of it and provide all information reasonably requested by Molina and which it is capable of providing in relation to the Harmful Code, its manner of introduction and the effect the Harmful Code has had or is likely to have;

(b) the Service Provider shall cooperate fully with Molina and its Third Party suppliers in taking the necessary remedial action to eliminate the Harmful Code and shall itself take Appropriate Actions to prevent re–occurrence (including implementing appropriate policies and processes to prevent further occurrences);

(c) if so directed by Molina, the Service Provider shall, at its own cost (except in circumstances where Clause 27.3(d) applies), take Appropriate Actions to remove the Harmful Code from all Molina Work Product, Customized Software Deliverables and Molina Systems (or such of them as Molina may specify) but shall in all cases remedy any consequences of the introduction, execution or proliferation of the Harmful Code, whether by way of removing the Harmful Code or creating a Workaround; and

(d) Molina shall bear the cost of the Service Provider removing Harmful Code in accordance with this Clause 27.3 if (i) the Harmful Code was introduced by Molina or a Third Party acting on Molina's behalf or (ii) the Service Provider is not responsible for the actions of the applicable Third Party as set out in Clause 24.7, in each case unless the Service Provider is required to remove the Harmful Code as part of the Services or under another agreement with a Molina Company.

PART H FACILITIES AND SAFETY, HEALTH AND ENVIRONMENT

28. SITE SYSTEMS AND ACCESS TO MOLINA FACILITIES

28.1 The Service Provider may install Site Systems only in accordance with the terms set out in Schedule 13 (*Access to Molina Facilities*).

28.2 Molina shall give the Service Provider the access to the Molina Facilities as is required by Schedule 13 (*Access to Molina Facilities*) and each Project Work Order and each Party shall have the rights and obligations in relation to accessing the Molina Facilities as set out in Schedule 13 (*Access to Molina Facilities*) or in a Project Work Order.

28.3 Molina's Discretion

The Service Provider may install Site Systems at Molina Facilities only with Molina's prior written consent, which may be given or refused in Molina's absolute discretion. Molina consents to the continuing installation of Site Systems that are already installed at Molina Facilities as at the Effective Date, and consents to the installation of those Site Systems that are specifically included in the Agreement, a Project Work Order or a Transition Project.

28.4 Quality and Compliance

The Service Provider shall procure that all Site Systems comply and remain compliant with all applicable Policies until removed from Molina Facilities.

28.5 Compatibility

The Service Provider shall procure that the Site Systems and the Services are at all times compatible with the technical standards set out in the Policies.

28.6 Installation, Removal and Use

(a) The Service Provider shall, in reasonable time:

(i) provide Molina with the information and instructions necessary to enable appropriately skilled Molina personnel to prepare each Molina Facility for the delivery and installation of the Site Systems; and

(ii) deliver the Site Systems to, and install them at, Molina Facilities.

(b) When a Site System ceases to be used in the provision of the Services, the Service Provider shall promptly disconnect that System, make good any damage caused by the disconnection (unless otherwise instructed by Molina) and remove it from the relevant Molina Facility, provided that where the Site System is an Exit System, the Service Provider shall take no action to remove that Site System from the relevant Molina Facility unless Molina gives its written consent, which it shall not unreasonably withhold.

(c) The Service Provider shall not use the Site Systems other than for the provision of the Services without first obtaining Molina's written consent.

(d) If a Site System is removed from a Molina Facility, the Service Provider shall promptly securely erase all Molina Data and Molina Confidential Information from that Site System in accordance with the Policies and with Molina's written consent.

PART I INTELLECTUAL PROPERTY, CONFIDENTIALITY AND DATA PROTECTION

29. INTELLECTUAL PROPERTY RIGHTS

29.1 Ownership of Pre–existing Intellectual Property Rights

(a) This Agreement shall not assign or otherwise transfer any Intellectual Property Rights existing as at the Effective Date.

(b) Neither Party shall contest ownership of all or part of the other Party's pre–existing Intellectual Property Rights.

29.2 License of Molina IP and Molina Work Product

(a) Molina shall retain all right, title and interest in and to the Molina IP, including all Intellectual Property Rights therein.

(b) Subject to this Clause 29.2, the Service Provider and the Approved Subcontractors are hereby granted (in each case, to the extent necessary and for the sole purpose of providing the Services):

(i) a world–wide, fully paid–up, non–exclusive license to Use the Molina IP; and

(ii) a right to use the Molina–owned Systems, and, to the extent permitted under the relevant lease, Molina–leased Systems.

(c) The Molina IP shall be made available to the Service Provider in such form and on such media as exists at the Effective Date and for Molina IP provided after the Effective Date in such form and on such media as may be agreed between the Parties.

(d) Neither the Service Provider nor the Approved Subcontractors shall be permitted to Use the Molina IP for the benefit of any entities other than Molina Companies without the prior written consent of Molina, which may be withheld at Molina's sole discretion.

(e) The license granted under this Clause 29.2 shall take effect from the date that the Molina IP is first provided to the Service Provider or the Approved Subcontractors.

(f) The right to use the Molina–owned or leased Systems under this Clause 29.2 shall take effect from the following date:

(i) in the case of each System that is required to be used by the Service Provider or the Approved Subcontractors in the provision of the Run Services, the applicable Service Commencement Date; and

(ii) in the case of each System that is required to be used by the Service Provider or the Approved Subcontractors in the provision of the Project Services, the commencement of the applicable Project Work Order (or, if the System is

required to be used in relation to more than one Project Work Order, the first commencement of any such Project Work Order).

(g) The license granted under this Clause 29.2 shall terminate:

(i) in respect of a particular item of the Molina IP, on the date that item ceases to be Used in performance of the Services, in which event the Service Provider shall (to the extent the Molina IP is, or comprises, Confidential Information) promptly comply with Clause 32 (*Return of Confidential Information*) in respect of that item; and

(ii) in total, on the date on which this Agreement has expired or been terminated and the Service Provider has completed the performance of all of its obligations under all Project Work Orders (including its obligations under Schedule 8 (*Termination Assistance and Exit*) in respect of all Project Work Orders that are terminated).

(h) The right to use the Molina–owned or leased Systems under this Clause 29.2 shall terminate on the date on which this Agreement has expired or been terminated and the Service Provider has completed the performance of all of its obligations under all Project Work Orders (including its obligations under Schedule 8 (*Termination Assistance and Exit*) in respect of all Project Work Orders that are terminated).

29.3 Rights in Molina Work Product

(a) Subject to Clause 29.1, Clause 29.3(b), and Clause 29.3(c), Molina shall own all right, title and interest (including ownership of all Intellectual Property Rights, patentable inventions and patents thereon) in and to Molina Work Product. This Agreement memorializes that it was the Parties' intent before commencement of the Molina Work Product that the Molina Work Product was to be a work made for hire within the meaning of the Copyright Act, 17 U.S.C. § 101 et seq. and all other applicable intellectual property laws, owned by Molina. The Service Provider acknowledges that, for the purposes of the foregoing, the Work Product shall be considered "works made for hire" under all applicable copyright laws.

(b) To the extent that any of the rights, title and interest referred to in Clause 29.3(a) do not vest in Molina by operation of law, the Service Provider hereby irrevocably assigns, transfers and conveys to Molina with full title guarantee and, when applicable, shall procure that any of its Affiliates or Subcontractors irrevocably assign, transfer and convey to Molina with full title guarantee, without further consideration, all such rights, title and interest (including Intellectual Property Rights) and such assignment shall be an assignment (in respect of any copyright subsisting therein) of future copyright pursuant the Copyright Act, 17 U.S.C. § 101 et seq. and all other applicable intellectual property laws.

(c) If a Deliverable, or any other Software or Materials specifically created or developed by the Service Provider for Molina and required to be delivered to Molina in the

course of providing the Services, incorporates Service Provider IP (including any Modification of pre-existing Service Provider IP):

(i) that Deliverable, Software or Materials as a whole shall be treated for the purposes of this Agreement as Molina Work Product, and not as a Modification of the incorporated Service Provider IP; but

(ii) that incorporated Service Provider IP shall remain treated as Service Provider IP, and nothing in this Agreement shall assign or otherwise transfer any Intellectual Property Rights in that incorporated Service Provider IP.

(d) With respect to any moral rights in any of the Molina Work Product, the Service Provider shall procure, and shall procure that any Affiliates of the Service Provider and any Subcontractors procure, that all applicable moral rights shall not be asserted by the holder of such rights.

29.4 License of Service Provider IP

(a) Subject to Clause 29.3 and this Clause 29.4, the members of the Service Provider Group shall retain all right, title and interest in and to the Service Provider IP, including all Intellectual Property Rights therein.

(b) The Service Provider hereby grants to each Molina Company, for its benefit and for the benefit of its contractors and agents, a perpetual, irrevocable, world-wide, fully paid-up, non-exclusive, transferable license (with the right to sublicense) to Use and Modify all Service Provider IP that is:

(i) incorporated within any Deliverable or Molina Work Product by the Service Provider or any Subcontractor (whether solely or jointly with Molina or any Third Party);

(ii) otherwise necessary for the Use of any Molina Work Product or any Deliverable;

(iii) necessary for the ongoing support, maintenance, Modification or development of any Molina Work Product or any Deliverable; or

(iv) integrated into any other Systems that are transferred to Molina or a Successor Supplier on termination or expiry of this Agreement (in whole or in part).

(c) Clause 29.4(b) applies to Service Provider IP irrespective of whether the use made of the Service Provider IP by the Service Provider in providing the Services was in compliance with, or in breach of, this Agreement.

(d) Other than in the case specified in Clause 29.4(e)(i) or for the purpose specified in Clause 29.4(e)(ii), or as otherwise expressly provided in this Agreement, and subject always to Clause 29.4(f), nothing in this Agreement shall be construed to give Molina, a Molina Company or an Other Service Provider the right to use any

Embedded Service Provider IP in a manner unconnected with the Application or System in connection with which the Embedded Service Provider IP is provided.

(e) For the purpose of Clause 29.4(d):

(i) the case specified in this Clause is: if another provision of this Agreement or a Project Work Order provides, or the specifications applicable to the Application or System or to the Deliverable in which the Embedded Service Provider IP is incorporated provide, for that Service Provider IP to be used other than in connection with that Application or System; and

(ii) the purpose specified in this Clause is: achieving interoperability with that Application or System.

(f) Clause 29.4(d) shall not apply in respect of any Embedded Service Provider IP if the Service Provider does not comply with Clause 16.4 or 16.7 in respect of that Embedded Service Provider IP.

(g) The Service Provider hereby grants to each Molina Company, for its benefit and for the benefit of its contractors and agents, during the Term (including the term of any Project Work Order that continues after the end of the Term, and any Exit Period), a world–wide, fully paid–up, non–exclusive license to Use the Service Provider IP (other than Service Provider IP subject to the license under Clause 29.4(b)) to the extent necessary to receive the Services.

(h) The Service Provider hereby grants to each Molina Company for the benefit of the Other Service Providers, during the Term (including the term of any Project Work Order that continues after the end of the Term and any Exit Period), a world–wide, fully paid–up, non–exclusive license to Use the Service Provider IP (other than Service Provider IP subject to the license under Clause 29.4(b)) to the extent necessary to enable those Other Service Providers to interact with the Service Provider or to enable the Other Service Provider's services to interface with the Services.

(i) Molina shall ensure that the Other Service Providers comply with the license granted pursuant to Clause 29.4(h).

(j) The licenses granted under this Clause 29.4 above shall take effect from the date on which the Service Provider IP that is the subject of the license is first used by, or on behalf of, the Service Provider to provide the Services or incorporated into any Deliverable or any Molina Work Product or becomes necessary for the Use of any Deliverable or any Molina Work Product.

(k) If a Service Provider Method is incorporated within Molina's business processes or practices:

(i) by or on behalf of the Service Provider;

(ii) by or on behalf of Molina, on the Service Provider's recommendation; or

(iii) by or on behalf of Molina as a result of Molina having learned to perform the Service Provider Method in the course of receiving the Services during the Term,

then the Service Provider hereby grants to each Molina Company, for its benefit and for the benefit of its contractors and agents (in connection with the provision of services to a Molina Company), a perpetual, irrevocable, world-wide, fully paid-up, non-exclusive, transferable license (with the right to sublicense) to conduct its business and operate its processes and practices incorporating the Service Provider Method. For the avoidance of doubt, Molina shall comply with its obligations set out in Clause 30 (*Confidentiality*) with respect to Service Provider Methods except as the disclosure thereof may be permitted as set out in this Clause 29.4(k).

(l) In each case where the Service Provider grants a license under this Clause 29.4 for the benefit of a contractor or agent of any Molina Company or any Other Service Provider, that contractor, agent or Other Service Provider may exercise its rights under that license for the sole purpose of providing goods, services and Software to the Molina Companies.

29.5 Protection of each Party's Rights

(a) Except to the extent contemplated in this Agreement, the Service Provider shall not at any time do anything or cause anything to be done that would prejudice Molina's right, title and interest in any of the Intellectual Property Rights vested in Molina pursuant to this Agreement.

(b) Except to the extent contemplated in this Agreement, Molina shall not at any time do anything or cause anything to be done that would prejudice the Service Provider's right, title and interest in any Intellectual Property Rights vested in the Service Provider pursuant to this Agreement.

(c) Each Party agrees to, at the claiming Party's reasonable expense, do all things reasonably necessary to confirm the ownership of the subject matter and Intellectual Property Rights therein as contemplated in this Clause 29 (*Intellectual Property Rights*), including executing or procuring the execution of documents or taking other reasonable actions as necessary to perfect ownership or otherwise to give full effect to the licenses granted pursuant to this Clause 29 (*Intellectual Property Rights*).

(d) Neither Party shall be permitted to use any trademarks of the other Party for any purpose except with the express written permission of the owner of the trade marks.

30. CONFIDENTIALITY

30.1 In this Clause 30 (*Confidentiality*), the "**Disclosing Party**" means the Party making a disclosure of Confidential Information to the other Party (the "**Receiving Party**").

30.2 The Receiving Party shall, and shall procure that its Subcontractors shall:

(a) keep the Confidential Information confidential;

(b) not disclose the Confidential Information to any person, other than in accordance with Clauses 30.3 to 30.5 or Clause 30.7, unless it first obtains the written consent of the Disclosing Party; and

(c) not use the Confidential Information other than for the Permitted Purposes.

30.3 Each Party and its Subcontractors may disclose Confidential Information to:

(a) each other and their respective employees and Authorized Persons; and

(b) its auditors to the extent reasonably required for such appointment and the exercise by the auditor of its audit obligations.

30.4 Without limiting Clause 30.3, Molina may disclose Confidential Information (other than Service Provider Commercially Sensitive Information) to:

(a) Successor Suppliers to the extent set out in the Exit Plan or Schedule 8 (*Termination Assistance and Exit*);

(b) any Step-In Agent appointed pursuant to Clause 48 (*Step-In*) to the extent reasonably required for such appointment and the exercise by the Step-In Agent of its step-in obligations, provided such Step-In Agent enters into an Agreed Form NDA;

(c) any Other Service Provider to the extent required to enable the Other Service Provider to interact with the Service Provider or to enable the Other Service Provider's services to interface with the Services; and

(d) without limiting Clause 30.10, any Regulatory Authority (or any Person that is an Affiliate of, or acting at the behest of, a Regulatory Authority) to which Molina or any Molina Company is obligated to provide services pursuant to a contract with such Regulatory Authority or Person.

30.5 The Receiving Party may disclose Confidential Information to Third Parties (including, if the Receiving Party is Molina, any Step-in Agent, Successor Supplier or Other Service Provider) only if those Third Parties have entered into a non-disclosure agreement for the benefit of the Disclosing Party containing confidentiality terms no less stringent than those set out in this Agreement (which may take the form of an Agreed Form NDA) or to those that are subject to professional obligations preventing disclosure.

30.6 The Receiving Party shall be liable to the Disclosing Party if any person to whom the Receiving Party disclosed Confidential Information does not comply with this Clause 30 (*Confidentiality*) or the non-disclosure agreement in favor of the Disclosing Party described in Clause 30.5 above.

30.7 The Receiving Party may disclose any information relating to the services or transactions under this Agreement and Confidential Information where disclosure is required by law,

by a court of competent jurisdiction or by a regulatory body or stock exchange with authority over its business or securities, provided that, where permitted by law, the Receiving Party gives the Disclosing Party as much notice of the disclosure as is practicable so that the Disclosing Party may seek a protective order. The compelled disclosure described in the preceding sentence shall not otherwise alter or affect the confidential nature of the Confidential Information.

30.8 The obligations contained in Clauses 30.2 to 30.7 do not apply to any Confidential Information which:

(a) is at the date of this Agreement in, or at any time after the date of this Agreement comes into, the public domain other than through the Receiving Party's breach of this Agreement;

(b) can be shown by the Receiving Party to the reasonable satisfaction of the Disclosing Party to have been known by the Receiving Party before disclosure to the Receiving Party;

(c) has been developed by the Receiving Party independently, without reference to any Confidential Information provided by or otherwise obtained from the Disclosing Party (or another member of its Group) or its contractors; or

(d) subsequently comes lawfully into the possession of the Receiving Party from a Third Party without restriction as to disclosure or use.

30.9 Nothing in this Clause 30 (*Confidentiality*) or any other obligation of confidence arising under this Agreement or at law or in equity shall restrict in any way the use (including disclosure) or enjoyment by Molina of any Service Provider IP (in accordance with any license terms) that Molina is authorized to use or enjoy under this Agreement.

30.10 Each Party may disclose to any Regulatory Authority a breach by the other of this Agreement where such Party has an obligation to disclose that breach to a Regulatory Authority.

30.11 Subject to Clause 30.3, Clause 30.4 and Clause 30.7, in no event shall either Party's Confidential Information be provided to other persons who are, or who work for, a competitor of such Party without that Party's prior written consent.

30.12 If the Receiving Party commits a breach of this Clause 30 (*Confidentiality*), the Disclosing Party shall be entitled to seek the remedies afforded it in equity or at law for breach of confidence, in addition to the remedies available to it for breach of contract.

30.13 Molina shall be entitled to disclose the terms of this Agreement (other than Schedule 21 (*Service Provider Technical Solution*) and the Charges) and any Project Work Orders to any Third Party who Molina wishes to engage to provide Replacement Services, provided that the identity of the Service Provider and the identities of Service Provider Personnel are anonymized in that disclosure. Nothing in this Clause 30.13 shall prevent Molina from disclosing to any such Third Party that the Service Provider is the provider of any Services, provided that Molina does not also disclose that the terms of this Agreement or any Project

Work Order are the terms on which the Service Provider has agreed to provide those Services.

30.14 The Receiving Party shall promptly notify the Disclosing Party of any facts known to the Receiving Party concerning any accidental or unauthorized access, disclosure or use, or accidental or unauthorized loss, damage or destruction of Confidential Information by any current or former employee, contractor, agent, or subcontractor of the Receiving Party.

31. USE OF CONFIDENTIAL INFORMATION AND MOLINA DATA

31.1 The Service Provider must not examine or analyze the contents of any Molina Confidential Information or Molina Data disclosed to the Service Provider in the performance of its obligations under this Agreement except as necessary for the performance of those obligations. PHI, PII and other Personal Data subject to privacy and confidentiality requirements pursuant to Applicable Law, as applicable, shall be only be used and disclosed by the Service Provider in accordance the attached Business Associate Agreement and applicable law. The Service Provider shall continue to safeguard any such information even after the Molina Confidential Information is disclosed to unauthorized individuals or subject to unauthorized access.

31.2 The Service Provider shall keep any Molina Confidential Information and Molina Data which is in electronic form separate from information in relation to any Third Party in such a way that it can only be accessed by specified authorized individuals who must enter an appropriately secured password or similar security control to gain access.

31.3 The Service Provider shall keep any Molina Confidential Information and Molina Data which is in paper form separate from information in relation to any Third Party in such a way that it can only be accessed by specified authorized individuals who must use an appropriate restricted key or similar security control to gain access.

32. RETURN OF CONFIDENTIAL INFORMATION

32.1 The Receiving Party must promptly on request from the Disclosing Party:

(a) return to the Disclosing Party;

(b) destroy and certify in writing to the Disclosing Party the destruction of; or

(c) destroy and permit an employee of the Disclosing Party to witness the destruction of,

all the Disclosing Party's Confidential Information in the Receiving Party's possession or control, except as set out in Clause 57.5.

32.2 The Receiving Party may retain one copy of any notes and other records that it is required by law to retain.

32.3 Either Party may retain information that it is required to disclose in order to comply with any of those reporting obligations set out in Clause 30.7.

33. **ANNOUNCEMENTS AND PUBLICITY**

33.1 The Service Provider may not disclose to any existing or potential customer (whether in any marketing materials addressed to a specific customer or its customers generally, in a response to a 'request for information', 'request for proposal' or similar document, or otherwise) any information regarding the existence or subject matter of this Agreement.

33.2 Molina shall be entitled to disclose the termination or expiry of this Agreement (in whole or in part), and the basis of the termination or expiry, to potential Successor Suppliers and such other Third Parties as Molina has reasonable grounds for notifying of the termination or expiry (except to the extent that the Parties agree in a confidential settlement agreement that this information will not be disclosed).

34. **DATA PROTECTION AND DATA PRIVACY**

34.1 In this Clause 34 (*Data Protection and Data Privacy*):

(a) **Data Protection Laws** means all Applicable Laws (including HIPAA and HITECH), and any laws, rules, regulations, regulatory guidance, and regulatory requirements relating to personal information, personally identifiable information, Personal Data, non-public information, or protected health information (whether enacted by the United States, any State or other jurisdiction thereof, or any other government or regulatory agency) in relation to: (a) data protection; (b) privacy; (c) restrictions on, or requirements in respect of, the processing of Personal Data of any kind, including protected health information; and (d) actions required to be taken in respect of unauthorized or accidental access to or use or disclosure of Personal Data;

(b) data is **Personal Data** for the purposes of this Agreement if:

(i) it relates to natural persons and its processing, under or in connection with this Agreement, is subject to any Data Protection Laws, including Data Breach Notification laws, that apply to data about legal persons as well as data about natural persons;

(ii) it is PHI; or

(iii) it includes any of the following information and its processing, under or in connection with this Agreement, is subject to any U.S. federal or state law or regulation: name, address, telephone number, fax number, social security number, DEA number, other government issued identifier, credit card information, medical insurance identifiers, IP addresses, e-mail addresses and information relating to the past, present or future health or condition (physical or mental) of an individual;

(c) **Data Safeguards** means administrative, technical and physical safeguards that protect against threats or hazards to the integrity and security of, the unauthorized or accidental destruction, loss, alteration or use of, and the unauthorized access to, In-scope Personal Data and that comply with (i) the requirements set out in

Schedule 24 (Certain Security Requirements), (ii) Good Industry Practice, and (iii) the requirements set out in each applicable Statement of Work;

(d) **In-Scope Personal Data** means any Personal Data that is processed by the Service Provider in the course of providing the Services or performing its other obligations under this Agreement.

34.2 Each of the Service Provider and Molina shall, at all times, comply with its obligations under all Data Protection Laws and all applicable Molina Policies in connection with this Agreement. It is the parties' understanding that Molina is the data controller and the Service Provider is the data processor under this Agreement.

34.3 The Service Provider shall not be entitled to use or otherwise process any In-Scope Personal Data for any purpose other than to provide the Services and to perform its other obligations under this Agreement.

34.4 The Service Provider shall:

(a) Process In-Scope Personal Data only on and in accordance with the written instructions of Molina, which instructions may be given specifically in writing or, to the extent not inconsistent with those specific instructions, may be contained in Molina Policies;

(b) promptly notify Molina upon becoming aware of any errors or inaccuracies in any In-Scope Personal Data;

(c) ensure that, except as otherwise instructed in writing by Molina or required by Applicable Law, any copies of In-Scope Personal Data in the possession or under the control of the Service Provider, any Subcontractor or any Service Provider Personnel are permanently destroyed when they are no longer required for the performance of the Service Provider's obligations under this Agreement;

(d) provide access to In-Scope Personal Data only to Service Provider Personnel who: (i) need to have access to the data in order to carry out their roles in the performance of the Service Provider's obligations under this Agreement; (ii) have been appropriately trained on the requirements of Data Protection Laws applicable to the processing, care and handling of the data; and (iii) are subject to contractual or statutory obligations of confidentiality in respect of the In-Scope Personal Data; and

(e) subject to Clause 34.11, give the Molina Companies such co–operation, assistance and information and execute all documents as they may reasonably request to assist them to comply with their obligations under any Data Protection Laws insofar as they relate to any In-Scope Personal Data, and co–operate and comply with the directions or decisions of any competent data protection or privacy authority, or any other relevant regulatory authority, in relation to such data, and, in each case, within such time to assist Molina Companies to meet any time limit imposed by Data

Protection Laws or by the data protection or privacy authority, or such other relevant regulatory authority,.

34.5 In respect of In-Scope Personal Data the processing of which is subject to any Applicable Law that prohibits or restricts (a) the transfer of that In-Scope Personal Data to any country or territory or (b) the processing of that In-Scope Personal Data in any country or territory, the Service Provider shall not transfer or Process that In-Scope Personal Data in contravention of any such prohibition or restriction, except where the transfer merely continues, and is carried out in all material respects in the same way as, a transfer which was carried on between Molina Companies before the Effective Date (unless another provision of this Agreement requires that transfer to cease).

34.6 The Service Provider shall:

(a) at all times have in place (and keep Molina Companies' Corporate Privacy Official informed in writing of the identity of) a Service Provider Person who is responsible for assisting Molina Companies in responding to enquiries received from data subjects or any competent data protection or privacy authority, or any other relevant regulatory authority;

(b) ensure that the Service Provider Person referred to in Clause 34.6(a) always responds promptly and reasonably to the enquiries referred to in that Clause, taking full account of the relevant requirements of Data Protection Laws as to timely response; and

(c) take no steps in relation to any enquiry as referred to in Clause 34.6(a) except on the written instructions of the applicable Molina Company.

34.7 The Service Provider shall:

(a) not disclose or transfer any In-Scope Personal Data to any third party, except for a disclosure or transfer:

(i) made on the written instructions of Molina;

(ii) to a Subcontractor in accordance with Clause 34.7(b); or

(iii) to the extent required by Applicable Law or any other provision of this Agreement;

(b) in respect of any processing of In-Scope Personal Data by a Subcontractor:

(i) comply with the provisions of Clause 63 (*Subcontracting*);

(ii) ensure that the Subcontractor's processing is carried out under a written contract imposing on the Subcontractor equivalent obligations as are imposed on the Service Provider under this Clause 34 (*Data Protection and Data Privacy*);

(iii) procure that the Subcontractor performs and observes those obligations; and

(iv) if Molina so requests, procure that the Subcontractor enters into a written contract with Molina (or a Molina Company nominated by Molina), imposing on the Subcontractor the same obligations as are imposed on the Service Provider under this Clause 34 (*Data Protection and Data Privacy*).

The Service Provider understands and agrees that it is not authorized to respond to any requests for In-Scope Personal Data, whether made by a regulatory authority, data subject, or any other party, unless the Service Provider is explicitly authorized by Molina or the response is legally required under a subpoena or similar legal document issued by a government agency that compels disclosure by the Service Provider.

34.8 The Service Provider:

(a) shall adopt, implement, maintain, and comply with the Data Safeguards, including, as part of the Data Safeguards, security procedures and practices to prevent the unauthorized or accidental access to or destruction, loss, modification, use or disclosure of In-Scope Personal Data;

(b) warrants to Molina that the Service Provider has written security policies, procedures and practices that comply with the Service Provider's data security obligations under Data Protection Laws;

(c) shall maintain and enforce the Data Safeguards at each Approved Service Delivery Location and each other facility from which the Service Provider provides the Services, and with respect to any and all networks that process In-scope Personal Data;

(d) shall immediately notify Molina in writing: (i) if it cannot comply with any term of the Agreement regarding the Services that affects the privacy or security of Molina Data or In-Scope Personal Data (and if this occurs, the Service Provider shall remedy the noncompliance in accordance with the Agreement, and Molina shall be entitled to suspend transmission of such information to the Service Provider and suspend the portion of the Services involving the impacted Molina Data or In-Scope Personal Data until such gap or weakness is eliminated to Molina's satisfaction); (ii) of any request for access to any In-Scope Personal Data received from an individual who is (or claims to be) the subject of the data and enforcing a regulatory granted right; or (iii) of any request for access to any In-Scope Personal Data received by the Service Provider from any government official (including any data protection agency or law enforcement agency) or from other third parties, other than those set forth in this Agreement; and

(e) shall review and revise the Data Safeguards from time to time in accordance with prevailing Good Industry Practice and as reasonably requested by Molina (and shall promptly provide details of such revised Data Safeguards to Molina in writing upon request), provided that any changes to the Data Safeguards:

(i) will not alter or modify the Service Provider's ability to meet its obligations under this Agreement or alter the nature of any Services;

(ii) will not in any way weaken, compromise or alter the confidentiality and security of In-scope Personal Information; and

(iii) will be implemented at no additional cost to Molina.

34.9 Security Breach Response.

(a) Upon becoming aware of any unauthorized or accidental access to or use or disclosure of any In-Scope Personal Data which is in the Service Provider's custody or control, or the Service Provider having reasonable belief that any such access, use or disclosure has occurred or is at risk of occurring (which shall include, without limitation, the loss of or the inability to locate definitively any media, device or equipment on which In-Scope Personal Data is or may be stored), the Service Provider shall:

(i) notify Molina without delay, and in any event within twenty-four (24) hours, providing reasonable detail of the impact on Molina of the access, use or disclosure and the corrective action taken and to be taken by the Service Provider;

(ii) subject to Clause 34.11, promptly take all necessary and appropriate corrective action to mitigate and to remedy the underlying causes of the access, use or disclosure;

(iii) take any action pertaining to the access, use or disclosure required by Applicable Law including, without limitation, at the request of Molina, providing notices to data subjects whose Personal Data may have been affected, whether or not such notice is required by Applicable Law; and

(iv) if the access, use or disclosure would permit access to a data subject's financial information or lead to a reasonable risk of identity theft or fraud, the Service Provider shall provide, for a reasonable period of time of not less than one (1) year, credit monitoring services for any such data subjects.

(b) Except where the Service Provider is not responsible for the actions of the applicable Third Party as set out in Clause 24.7, the Service Provider shall be responsible for all of the following costs and expenses resulting from any unauthorized or accidental access to or use or disclosure of any In-Scope Personal Data which is in the Service Provider's custody or control, regardless of whether such costs and expenses are incurred by or on behalf of the Service Provider or by or on behalf of Molina:

(i) the cost of providing notice of the event to affected individuals;

(ii) the cost of providing required notice to government agencies, credit bureaus, media and/or other required entities;

(iii) the cost of providing individuals affected by the event with credit monitoring (including identity theft insurance) and credit protection services designed to prevent fraud associated with identity theft crimes for a specific period not to exceed twelve (12) months, except to the extent Applicable Law specifies a longer period for such credit protection services, in which case such longer period shall then apply;

(iv) the cost of providing reasonable call center support for such affected individuals for a specific period not less than ninety (90) days, except to the extent Applicable Law specifies a longer period of time for such call center support, in which case such longer period shall then apply;

(v) the fees associated with computer forensics work required to investigate the event;

(vi) non-appealable fines or penalties assessed by governments or regulators;

(vii) the costs or fees associated with any obligations imposed by Applicable Law, in addition to the costs, expenses and fees defined herein; and

(viii) any other costs and expenses to undertake any other action the Parties hereto agree to be an appropriate response to the circumstances in which the unauthorized or accidental access to or use or disclosure of any In-Scope Personal Data occurs.

34.10 Molina:

(a) is responsible, in its own right and on behalf of the other Molina Companies, for instructing the Service Provider to take such steps in the processing of Personal Data on behalf of Molina Companies as are reasonably necessary for the performance of the Service Provider's obligations under this Agreement; and

(b) authorizes the Service Provider, to the extent permitted by Data Protection Laws, to provide equivalent instructions to the Subcontractors on behalf of Molina.

34.11 The costs and expenses incurred by the Service Provider in complying with Clauses 34.4(e), 34.9(a)(ii), 34.9(a)(iii) and 34.9(a)(iv) shall be borne:

(a) by the Service Provider in cases where the action required to be taken by the Service Provider results from a breach of this Agreement or any negligent, willful or fraudulent act or omission of the Service Provider, any Subcontractor or any Service Provider Personnel; and

(b) by Molina in other cases.

PART J CONTRACT ADMINISTRATION AND HR

35. CONTRACT MANAGEMENT PORTAL

35.1 The Service Provider shall maintain a contract management intranet site (the "**Contract Management Portal**") in accordance with the requirements set out in this Agreement.

35.2 The Contract Management Portal shall act as the main tool for the Service Provider to report Service performance.

35.3 The Contract Management Portal shall contain an interface to the Service Provider's various monitoring tools to enable Molina to review performance against Service Levels at any time by means of the Contract Management Portal.

35.4 The Contract Management Portal shall be the main data repository for all information generated by the Service Provider related to this Agreement and the Service Provider shall ensure that it is updated to ensure that the information is accurate and it reflects the nature of the Services at any given time.

35.5 The Service Provider shall ensure that the Contract Management Portal contains:

(a) conformed copies of this Agreement and all Project Work Orders updated regularly to reflect all Change Notices;

(b) scanned counterparts of all Change Notices signed by each Party (or PWO Party as applicable);

(c) scanned counterparts of all Project Work Orders signed by each Party (or PWO Party as applicable);

(d) copies of the current and all historic Reports, including all Reports related to performance against the Service Levels;

(e) copies of the current and all historic invoices;

(f) the Exit Plan;

(g) the information that the Service Provider is required to provide to Molina during the Term under the Exit Plan or Schedule 8 (*Termination Assistance and Exit*) (and the Service Provider shall update this information in the Contract Management Portal whenever the Exit Plan itself is updated); and

(h) copies of all current proposals and responses to Change Notices and such other information referred to in Schedule 3 (*Pricing and Invoicing*).

36. GOVERNANCE

The Parties shall have the rights and obligations allocated to them in relation to governance, contract management and reporting as set out in Schedule 7 (*Governance*).

37. **POLICIES**

The Parties shall have the rights and obligations allocated to them in Schedule 14 (*Molina Policies*).

38. **AUDIT AND INFORMATION ACCESS**

38.1 Molina may, from time to time, notify the Service Provider of appropriate persons ("**Representatives**") including Molina employees and other representatives, auditors, any Software Auditor and any Regulatory Authority (including any person acting on behalf of such Regulatory Authority), who are to have access rights to those portions of the sites from which the Service Provider and Subcontractors provide, manage and administer the Services.

38.2 The Service Provider shall (and except to the extent otherwise agreed in writing by both the chief information officer and the chief information security officer of Molina, shall procure that the Subcontractors shall) allow the Representatives, for the purposes set out in Clause 38.4 and on the production of satisfactory evidence of identity and authority:

(a) access to each of those sites, the records and supporting documents referred to in Clauses 38.9 and 38.10, the relevant Service Provider Personnel (or Subcontractor personnel) and Systems (including operational records and manuals relating to Molina but excluding the general corporate financial books and ledgers of the Service Provider and any data to the extent it relates to any other customer of the Service Provider) and any other information in relation to the Services as requested by those Representatives; and

(b) reasonable facilities at each of those sites at all reasonable times during normal working hours at the relevant site, including facilities to print or copy information required.

38.3 Molina shall give the Service Provider not less than twenty (20) Business Days' prior written notice of an audit under Clause 38.2 except in cases where:

(a) Molina conducts an audit under Clause 38.6(a)(i), in which case it shall be entitled to conduct an audit upon giving the Service Provider not less than ten (10) Business Days' notice; or

(b) Molina conducts an audit under Clause 38.6(a)(ii), in which case it shall be entitled to conduct an audit upon giving the Service Provider such prior notice as is reasonably practicable in the circumstances and that the Regulatory Authority permits Molina to give (which the Service Provider acknowledges may be no prior notice at all).

38.4 The purposes referred to in Clause 38.2 are:

(a) to inspect the records and supporting documents referred to in Clauses 38.9 and 38.10;

(b) for Molina or any duly appointed agent and/or any Regulatory Authority or any Software Auditor to inspect Records, documents, files, computer data and other material in relation to the Services to enable Molina to fulfill its responsibilities to that Regulatory Authority or to any Software Vendor;

(c) to assess whether the Service Provider is performing its obligations in this Agreement;

(d) to carry out surveys of risk for the purposes of the Molina Group insurance cover;

(e) to review the integrity of Molina's Confidential Information and to make inspections, audits and tests for the purpose of conducting the internal and external audits of the Molina Group, and making reports as required by any Regulatory Authority;

(f) to verify the Service Provider's compliance with its obligations under Clauses 24 (*Security*), 25 (*Business Continuity Management and Disaster Recovery*) and 34 (*Data Protection and Data Privacy*) and Schedules 23 (*Business Continuity Management and Disaster Recovery*) and 14 (*Molina Policies*);

(g) to conduct any risk assessment in relation to the delivery of the Services that Molina may wish to undertake to assess the possible impact of the delivery of the Services on Molina's business; and

(h) to comply with the requirements of any Regulatory Authority or a Software Auditor or for any purpose reasonably determined by Molina to ensure Molina's compliance with Applicable Law.

38.5 Any audit (other than those conducted by a Regulatory Authority), whether referenced in this Clause or any other provision of this Agreement, shall be subject to the following limitations:

(a) subject to Clause 38.6, Molina may not conduct an audit more than once in any twelve (12)-month period;

(b) use of a material competitor as an auditor under this Agreement shall be subject to the Service Provider's prior written approval;

(c) all audit results and records disclosed solely as a result of the audit shall be held as Service Provider's Confidential Information and may only be used for purposes permitted by this Agreement;

(d) Molina and any auditor conducting any such audit shall at all times comply with the reasonable security and confidentiality guidelines of the Service Provider with respect to the audit.

38.6 Clause 38.5(a) is subject to the following:

(a) nothing in Clause 38.5(a) limits the number of audits that Molina may conduct in circumstances where:

(i) Molina knows or has reasonable grounds to believe that the Service Provider is not complying with any of its obligations under this Agreement; or

(ii) the audit is carried out by, on behalf of, or at the request or direction of, a Regulatory Authority;

(b) any audit that falls under Clause 38.6(a) shall be in addition to the single audit that Molina is permitted to conduct in each twelve (12)-month period under Clause 38.5(a);

(c) if any sites, records, documents, personnel or Systems that the Service Provider is required to make available to Molina during an audit are not available to Molina during any audit, Molina may repeat that audit on one or more occasions until the sites, records, documents, personnel or Systems (as the case may be) have been made available in accordance with this Agreement; and

(d) Molina may conduct audits more frequently than those permitted by this Clause 38 (*Audit and Information Access*) provided such additional audits are agreed in accordance with the Change Control Process.

38.7 The Service Provider warrants and represents that there is no legal or regulatory impediment or any other restriction of any kind imposed upon the Service Provider or, as far as the Service Provider is aware, any Subcontractor that would prevent Molina or any of its Representatives from accessing any of the Service Provider's or Subcontractor's sites to carry out audits in accordance with this Clause 38 (*Audit and Information Access*). In the event it is discovered or determined that any Subcontractor would prevent Molina or any of its Representatives from accessing any of the Service Provider's or Subcontractor's sites to carry out audits in accordance with this Clause 38 (*Audit and Information Access*), the Service Provider promptly secure such access as set out in Clause 38.2, and the Service Provider shall not be relieved of its obligations set out in this Clause 38 (*Audit and Information Access*).

38.8 The Service Provider shall, as soon as practicable after becoming aware of an impediment or restriction of the type referred to in Clause 38.7, provide Molina with written notice of such impediment or restriction and offer Molina alternative ways to exercise its rights under this Clause 38 that were affected by the impediment or restriction.

38.9 The Service Provider shall at all times operate a system of accounting in relation to, and maintain complete and accurate records of, and adequate supporting documents for, its Charges (and those of the members of the Service Provider Group) incurred in performing its obligations under this Agreement and the amounts invoiced to Molina under this Agreement, in accordance with GAAP.

38.10 The Service Provider shall maintain its records of its Charges (and those of the other members of the Service Provider Group) in accordance with GAAP in a manner and to a level of detail sufficient to demonstrate to an experienced financial auditor the calculation of the Charges under Schedule 3 (*Pricing and Invoicing*). The Service Provider shall retain

these records and supporting documents for as long as Services continue to be provided under this Agreement and then for as long as is required by Applicable Law.

38.11 The Service Provider shall, at the Service Provider's cost to the extent the required changes are the result of Service Provider's breach of this Agreement, implement any formal directions or instructions given by any Regulatory Authority arising from an audit under Clause 38.6(a)(ii) in accordance with any time periods stipulated by such Regulatory Authority, and if no time periods are stipulated, as soon as reasonably practicable. If a Regulatory Authority makes a recommendation that is specifically for the benefit of Molina and (a) has no application or benefit for other Service Provider customers, then the implementation of such recommendation shall be at Molina's cost and (b) such recommendation by its nature requires an implementation that is specific to Molina, then the aspects of such implementation that are specific to Molina shall be at Molina's cost except to the extent the Service Provider is responsible for such costs as set out in the first sentence of this Clause 38.11.

38.12 Molina may, instead of conducting an audit at a Service Provider or Subcontractor site in accordance with this Clause 38 (*Audit and Information Access*), request the Service Provider to furnish Molina with such information as Molina may reasonably specify and to which Representatives would have been entitled to have access had Molina conducted such an audit. The Service Provider shall promptly comply with any request by Molina under this Clause 38.12, and shall provide the requested information to Molina in such form and format as Molina may reasonably specify. Nothing in this Clause 38.12 limits Molina's rights to conduct an audit under this Clause 38 (*Audit and Information Access*).

38.13 Controls Audit Reports

(a) Within five (5) Business Days after a written request from Molina, the Service Provider shall, at its cost, procure that Molina is provided with an audit report in the form of one of the following (a "**Controls Audit Report**"):

(i) a SOC 1, Type II report prepared in accordance with the American Institute of Certified Public Accountants (AICPA) Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization;

(ii) a report prepared in accordance with the International Standards for Assurance Engagements (ISAE) No. 3402, Assurance Reports on Controls at a Service Organization; or

(iii) an Assurance Report on Controls of Contract Services prepared in accordance with Auditing and Assurance Practice Committee Statement No. 86**.**

(b) Each Controls Audit Report shall be prepared by the Service Provider's independent accountants reasonably acceptable to Molina and shall be a multi-client audit covering the Service Provider's common processes for the Services and Region specified by Molina.

(c) With regard to each such Controls Audit Report, the Service Provider, at its cost, shall provide Molina with any relevant certification, report and other documentation requested by Molina, including, but not limited to, Early Warning Reports and Bridging Letters.

(d) The Service Provider shall ensure that Molina is timely informed of the details (including the period covered) and timing of the availability of such Control Audit Reports and any change of the foregoing.

(e) At Molina's written request, and at Molina's cost, the Service Provider shall request its appointed independent accountants to undertake a review of the Service Provider's controls in accordance with the applicable standards above in respect of the Services to be provided under this Agreement, where such controls are not covered by the Controls Audit Report. The Service Provider shall make available to Molina a copy of the reports produced in accordance with this Clause as soon as they are completed.

(f) The Service Provider shall cooperate with Molina and the independent accountants to determine the scope and control objective requirements for each Controls Audit Report where applicable to that report.

(g) If any Controls Audit Report identifies any deficiencies, the Service Provider shall, at the request of and in consultation with Molina, plan and implement any necessary corrective measures in a timely manner.

38.14 The Service Provider shall at all times hold and maintain ISO 9000/20000 Certifications in relation to the Approved Service Delivery Locations.

38.15 The Service Provider shall upon Molina's request, assist Molina with its audit of Molina's Sarbanes-Oxley (SOX) oriented internal control processes and implement such modifications as Molina may direct, at Molina's cost.

39. HR OBLIGATIONS

The Parties shall comply with their respective obligations set out in Schedule 15 (*HR Matters and Key Personnel*).

PART K PAYMENT

40. CHARGES

40.1 Except where any provision of this Agreement provides otherwise, Molina shall pay to the Service Provider, or shall procure the payment by Molina Companies to the Service Provider of, the Charges that have been correctly invoiced to Molina in accordance with Schedule 3 (*Pricing and Invoicing*), in accordance with the timeframes as set out in Schedule 3 (*Pricing and Invoicing*).

40.2 The Service Provider acknowledges that the Charges, and the activities for which the Service Provider is entitled to invoice Molina, are set out in Schedule 3 (*Pricing and Invoicing*). Except to the extent the provisions of the applicable SoW or the applicable Project Work Order expressly contemplate that an obligation in such SoW or such Project Work Order, as applicable, is subject to the related detail set out in Schedule 21 (*Service Provider Technical Solution*), the Service Provider shall not be entitled to rely on any provision of Schedule 21 (*Service Provider Technical Solution*), whether expressed as an assumption, a dependency or otherwise, as creating any entitlement for the Service Provider to charge, or any obligation on Molina to pay, any amounts of any kind in respect of the performance of the Services; provided, however, that the Service Provider may rely on the provisions of Schedule 21 (*Service Provider Technical Solution*) with respect to the interpretation of obligations of the Service Provider set out in Schedule 21 (*Service Provider Technical Solution*) that are not otherwise set out in this Agreement.

41. LATE PAYMENT

If either Party fails to pay any undisputed sum, or any disputed sum which is subsequently determined not to have been disputed in good faith, by the due date for payment (as set out in Schedule 3 (*Pricing and Invoicing*)), the other Party may charge the paying Party interest at the Agreed Interest Rate on the sum from the due date for payment until the date upon which the obligation of the paying Party to pay the sum is discharged (whether before or after judgment).

42. INVOICES

The Service Provider shall invoice Molina for the Charges from the relevant Charges Commencement Date (and not before that date), in accordance with the procedures in Schedule 3 (*Pricing and Invoicing*).

43. TAXATION

43.1 The Charges do not include any taxes, duties, levies, fees or similar charges of any jurisdiction that may be assessed or imposed in connection with the transactions contemplated by this Agreement. Molina will pay all Taxes imposed on the provision of Services to Molina. The Service Provider will invoice said Taxes in accordance with Schedule 3 (*Pricing and Invoicing*). The invoicing location and beneficiary locations for

the Molina entities receiving the Services shall be those locations set out in, as applicable, this Agreement or the applicable Project Work Order.

43.2 Each Party will bear sole responsibility for Taxes based upon its own income, employment taxes of its own employees, agents or subcontractors, and for any assessments or taxes on any real or personal property it owns, leases or otherwise acquires. Molina is not responsible for Taxes based on the Service Provider's gross receipts including, but not limited to, any corporate business taxes.

43.3 Molina and the Service Provider will cooperate to segregate the charges into:

(a) those for taxable Services;

(b) those for non-taxable or exempt Services;

(c) those for which a sales, use, excise, gross receipts, value-added or other similar tax has already been paid; and

(d) those for which the Service Provider functions merely as a paying agent for Molina or a Molina Company that otherwise are non-taxable or have previously been subject to tax.

43.4 In the event that any payment in respect of any invoice is subject by Applicable Law to any withholding tax:

(a) Molina (or the applicable Molina Company, as applicable) may make payment to the Service Provider of the amount owing less a deduction for such withholding tax and account to the relevant taxation authority for the appropriate withholding tax;

(b) payment of such net sum to the Service Provider and of the withholding tax to the relevant taxation authority will constitute full settlement of the sums owing pursuant to the relevant invoice;

(c) Molina or the applicable Molina Company will send the tax receipt or will provide evidence that may be reasonably required to establish the payment of the relevant withholding tax immediately upon payment of such taxes or upon request, whichever occurs earlier; and

(d) the Service Provider will, on request from Molina (or the applicable Molina Company, as applicable), provide a declaration of tax residence on the prescribed forms and obtain certification by the relevant taxation authority in order to confirm the applicability and availability of any reduced rate of withholding tax pursuant to the provisions of any relevant double taxation treaties.

43.5 If applicable, with respect to Taxes-related notices, assessments, audits, and proceedings:

(a) the Parties and their duly appointed representative will cooperate in order to negotiate, resolve, settle or contest any liability for Taxes attributable to any transaction or payment contemplated by this Agreement. Molina will cooperate with

the reasonable requests of the Service Provider and its representatives with respect to any audit by a taxing authority or any other proceeding covered by this Clause 43.5(a).

(b) if Molina receives notice of any asserted Taxes-related liability ("**Asserted Tax Liability**"), Molina will promptly give notice thereof (a "**Tax Claims Notice**") to the Service Provider. The Tax Claims Notice will describe the Asserted Tax Liability in reasonable detail, and will indicate the amount thereof. The Service Provider will not be liable to Molina under this Clause 43.5(b) for such claim.

(c) Molina will reasonably cooperate with the Service Provider taking all action in connection with contesting any such claim as the Service Provider may reasonably request in writing from time to time provided that within thirty (30) days after the related Tax Claims Notice has been delivered by Molina to the Service Provider, the Service Provider requests within thirty (30) days in writing that such claim be contested.

(d) the Service Provider will promptly notify Molina in writing upon receipt by the Service Provider (or by a Service Provider Company) of notice of any sales or use Taxes-related assessment or adjustments applicable to Molina's purchase of services that may affect any liability for Taxes of Molina. The Service Provider and the Service Provider Companies will cooperate with the reasonable requests of Molina and its representatives with respect to any Taxes-related assessment by a taxing authority or any other administrative or judicial proceeding covered by this Clause 43.5(d). Molina will be responsible for any Taxes of the sort contemplated in this Clause 43.5(d) to the extent Molina is responsible for such Taxes under Clause 43.1; provided, however, that Service Provider will be responsible for any interest or penalties directly resulting from its delay or failures.

(e) the Service Provider and Molina will cooperate with each other in connection with:

(i) the preparation and filing of any Taxes-related returns of the respective Parties, and

(ii) any audit examination or other proceeding by any government taxing authority of or with respect to the returns referred to in Clause 43.5(e)(i).

(f) Such cooperation will include, without limitation, the furnishing or making available of records, books of account or other materials of the Parties necessary or helpful for the defense against the assertions of any taxing authority as to any Taxes-related audit, Asserted Tax Liability or for the preparation of Taxes-related returns filed by the Parties. Each Party will also provide access to employees of the other Party for purposes of contesting any jointly agreed Taxes-related audit or Asserted Tax Liability or for the preparation of Taxes-related returns filed by the Parties. For purposes of clarity, each Party shall have full control over its own tax returns and any government audits of its finances or taxes, and (a) the Service Provider shall have no obligation under this Clause 43.5(f) to share the confidential information of

its other customers and (b) Molina shall have no obligation under this Clause 43.5(f) to share the confidential information of its other suppliers, its customers, or its members.

43.6 If any transaction or payment contemplated by this Agreement is exempt from any Tax or Taxes noted on an invoice, Molina will provide the Service Provider with a valid exemption certificate or other evidence of such exemption in a form reasonably acceptable to the Service Provider. Each Party will cooperate with the other in minimizing applicable Taxes.

PART L CONTINUING PROTECTIONS FOR MOLINA

44. MOST VALUED CLIENT

44.1 Disasters

If a disaster occurs that would trigger the Service Provider's disaster recovery or business continuity plans and, as a result, the Service Provider has to allocate scarce Resources between accounts, the Service Provider must, acting reasonably, treat Molina no less favorably than other similarly situated clients receiving similar services to the Services on a like–for–like basis, having regard to the overall circumstances and commercial agreement with each of its customers.

44.2 Dialogue with Senior Management

The Service Provider must, on reasonable prior notice, allow Molina access to the Service Provider's senior management (including the Service Provider's senior-most Regional Account Executive) to discuss the Service Provider's performance under this Agreement as and when reasonably requested by Molina.

44.3 Service Consistency

The Service Provider shall:

(a) manage the delivery of the Services, and its relationship with Molina, in a consistent manner;

(b) use the same systems, processes and tools in the provision of the Services that are provided in different jurisdictions, except where otherwise set out in this Agreement; and

(c) procure that all members of the Governance Boards are authorized and empowered to take all decisions necessary in connection with the day–to–day provision of the Services as required.

44.4 New Technologies to Deliver the Services

(a) If the Service Provider has developed or is in the process of developing a new product or technology during the Term that could be used to deliver the Services in a materially more efficient way, it shall, subject to Applicable Law and any confidentiality restrictions that may exist, use reasonable efforts to keep Molina informed of:

(i) the product or technology and the development progress of the product or technology;

(ii) the benefits to Molina of that product or technology; and

(iii) whether that product or technology has been implemented elsewhere and if so, the benefits and problems associated with that implementation.

(b) If the Service Provider implements a product or technology for the first time and that product or technology could be used to deliver the Services, the Service Provider shall, where the Service Provider Delivery Lead is aware (acting proactively) and subject to any confidentiality restrictions that may exist, use reasonable efforts to keep Molina informed of:

(i) the implementation progress;

(ii) the benefits to Molina of that product or technology; and

(iii) the benefits and problems associated with the implementation.

(c) The Service Provider shall, on an annual basis, subject to Applicable Law and any confidentiality restrictions that may exist, use reasonable efforts to advise Molina of those future technology skills which the Service Provider believes will be required by Molina's employees to adapt to changes in technology which the Service Provider intends to employ. In connection with the foregoing, the Service Provider shall discuss with Molina how those future technology skills could address Molina's business needs.

45. REFERENCE CLIENT

45.1 In this Clause 45 (*Reference Client*), a "**Qualifying Deal**" is a potential infrastructure outsourcing, or application development or application maintenance outsourcing, transaction in the healthcare sector (or a transaction with infrastructure outsourcing as a significant component) between the Service Provider and a potential customer in the healthcare or healthcare payor industry (whether that customer is an existing customer or a new customer) (a "**Potential Customer**"), under which the aggregate annual spending under the potential contract (when considering global spending) is anticipated by the Service Provider to exceed [redacted].

45.2 The Service Provider shall on at least two (2) occasions in each Contract Year (provided there are at least two (2) Qualifying Deals in any Contract Year, and if not then as many as there are), before submitting a proposal (a " **Tender**") for those Qualifying Deals, notify Molina specifying the identity of the Potential Customer (unless it would be either an actionable breach of confidence or breach of agreement for the Service Provider to do so) and give Molina the option to be listed as a reference client in the Tender.

45.3 If Molina states, in response to the invitation in Clause 45.2, that it wishes to be listed as a reference client in a Tender the Service Provider must list Molina as a reference client.

45.4 The Service Provider shall not disclose any specific information in relation to this Agreement or in relation to its relationship with Molina to the Potential Customer, but may provide a general description of the Services and the geographical coverage and provide the name and address of the Molina contact as provided by the GCC and invite the Potential Customer to make contact with the Molina contact as provided by the GCC.

45.5 Molina shall respond to any query from a Potential Customer in good faith.

45.6 Subject to Clause 45.7, the Service Provider agrees that Molina may disclose the Confidential Information of the Service Provider to any Potential Customer but only to the extent that it is relevant and necessary to give the Potential Customer a full and fair assessment of the Service Provider's performance under this Agreement.

45.7 Molina shall enter into an Agreed Form NDA with any Potential Customer prior to disclosing any Confidential Information of the Service Provider. If the Potential Customer refuses to enter into an Agreed Form NDA in accordance with this Clause 45.7, Molina shall, subject to Clause 30 (*Confidentiality*), not disclose any of the Service Provider's Confidential Information to that Potential Customer.

46. BENCHMARKING

The Parties shall have the rights and obligations allocated to them in Schedule 5 (*Benchmarking*).

PART M WHAT HAPPENS WHEN A PARTY FAILS TO PERFORM

47. ADVANCE WARNING

47.1 The Service Provider shall notify and provide full details to Molina in writing as soon as it becomes aware of, any event or occurrence, actual or threatened, which materially affects or would materially affect the Service Provider's ability to provide the Services or perform any of its other obligations under this Agreement.

48. STEP-IN

48.1 Instigation of Step-In

(a) Molina may by notice in writing appoint a Step-In Agent to perform the Services or any part of the Services if:

(i) the Service Provider has committed a breach of this Agreement that would entitle Molina to terminate this Agreement at law or pursuant to the specific termination rights set out in Clause 51.1(a) (subject to the same right to remedy as is set out in that Clause 51.1(a)), Clause 51.1(b), Clause 51.1(c), Clause 51.1(d) or Clause 51.1(f), or there is a reasonable probability on the merits that such a breach of the nature stated in the termination clauses referenced above will be committed;

(ii) the Service Provider has committed a breach of a Project Work Order that would entitle Molina to terminate that Project Work Order at law or pursuant to the specific termination rights set out in Clause 52.1(a) (subject to the same right to remedy as is set out in that Clause 52.1(a)), Clause 52.1(b) or Clause 52.1(c), or there is a reasonable probability on the merits that such a breach of the nature stated in the termination clauses referenced above will be committed,

(the circumstances described in Clause 48.1(a)(i) and Clause 48.1(a)(ii) each being a "**Step-In Event**" and together being the "**Step-In Events**").

(b) Molina's right under Clause 48.1(a) is referred to in this Clause as its right to step in.

(c) In the circumstances described in Clause 48.1(a)(i), Molina may exercise its right to step in in respect of the affected Services and any Project Work Order.

(d) In the circumstances described in Clause 48.1(a)(ii), Molina may exercise its right to step in only in respect of the Project Work Order referred to in that Clause and any Project Work Order that is Linked to that Project Work Order.

(e) Molina shall give the Service Provider notice of the proposed Step-In Agent prior to appointing that Step-In Agent and shall reasonably consider any objections that the Service Provider may have in relation to any proposed Step-In Agent, but Molina is entitled to appoint any Step-In Agent it considers appropriate.

(f) If Molina exercises its right in Clause 48.1(a) to step in in circumstances where it is reasonably likely that a Step-In Event will occur (but such Step-In Event has not actually yet occurred), Molina shall, prior to exercising its right to step in, give the Service Provider five (5) Business Days (starting on the day after issue of Molina's notice under Clause 48.1(a)) to demonstrate to the reasonable satisfaction of Molina that such a breach will not be committed. If the Service Provider demonstrates to the reasonable satisfaction of Molina that the breach will not be committed, Molina will not exercise its right to step in in respect of that breach.

48.2 The Step-In Process

(a) Prior to appointing a Step-In Agent, Molina shall ask the Service Provider:

(i) whether Molina should engage the Step-In Agent on a time and materials basis or on a fixed fee basis; and

(ii) for how long Molina should engage the Step-In Agent,

and shall attempt to incorporate the recommendations given by the Service Provider above into Molina's agreement with the Step-In Agent together with a right to terminate on one month's notice and if these terms cannot be obtained, Molina shall take Appropriate Action to secure reasonable terms.

(b) Prior to exercising its step in rights, Molina shall procure that the Step-In Agent enters into an Agreed Form NDA.

(c) If the contract appointing a Step-In Agent needs to be renewed then Clause 48.2(a) above shall apply in relation to that renewal.

(d) Molina shall deliver written notice to the Service Provider ("**Step-In Notice**") specifying the date by which the Step-In Agent shall commence, which date shall not be less than seven (7) Business Days following the date of the Step-In Notice.

(e) The Step-In Notice shall include details of the Step-In Agent, details of the Services over which the right of step in is being exercised and such information as Molina is able to provide in relation to how the Step-In Agent intends to perform its activities.

48.3 The Step-Out Process

(a) Molina may elect to cease exercising its right to step in at any time by giving written notice to the Service Provider.

(b) Molina's right to step in will cease when condition (i) below has been satisfied, either of conditions (ii) and (iii) below (as applicable) has also been satisfied and either of conditions (iv) and (v) below has also been satisfied:

(i) the event giving rise to Molina's right to step in has ceased and/or has been resolved or remedied;

(ii) the Service Provider has demonstrated to Molina's reasonable satisfaction that the event giving rise to Molina's right to step in will not reoccur, or, if a reoccurrence does occur, that a reasonable mitigation plan is in place, and that the Service Provider is able to resume performance of the Services in accordance with this Agreement;

(iii) in cases of reasonable likelihood of the Step-In Events occurring the Service Provider has demonstrated to Molina's reasonable satisfaction that the breach referred to in those Clauses will not occur;

(iv) in circumstances where a Step-In Agent has been appointed, the contract between Molina and the Step-In Agent has expired;

(v) in circumstances where a Step-In Agent is appointed under terms which are obtained in compliance with Clause 48.2(a) and that contract has not expired and the Service Provider undertakes in writing to bear any costs and expenses incurred by Molina in terminating any contract between Molina and the Step-In Agent prior to its expiry date.

(c) On cessation of Molina's right to step in pursuant to Clause 48.3(b), or Molina electing to cease exercising its right to step in pursuant to Clause 48.3(a), Molina shall deliver written notice to the Service Provider ("**Step-Out Notice**") specifying the indicative date by which it plans to conclude such action, which date shall not be less than fourteen (14) Business Days following the date of the Step-Out Notice. In the event Molina exercises its right to step-in under this Agreement, the Parties shall discuss such matter and developments relating thereto as part of the meetings of the Operational Review Board.

(d) The Service Provider shall, during the exercise of Molina's right of step-in, develop a plan to demonstrate to Molina how it will resume the proper performance of the Services ("**Step-Out Plan**"), and shall, as soon as it is prepared and following receipt of a Step-Out Notice, provide that Step-Out Plan to Molina.

(e) Molina shall be entitled to comment on the Step-Out Plan and the Service Provider shall make all reasonable efforts to incorporate into the Step-Out Plan any comments that Molina may make. Responsibility for the Step-Out Plan and delivery of the Services remains with the Service Provider and accordingly the Service Provider is not obligated to accept any of Molina's suggestions. Acceptance by Molina of the Step-Out Plan does not mean that Molina waives any rights it may have if the Service Provider is unable to perform any of its obligations in accordance with the terms of this Agreement after the Step-Out Date.

(f) Following receipt and review of the Step-Out Plan, unless Molina decides to exercise its right to terminate this Agreement or a Project Work Order for the breach giving rise to the right to step in, Molina shall either:

(i) confirm the date for resumption of the affected Services by the Service Provider as set out in the Step-Out Notice; or

(ii) revise the date to reflect the time to implement the Step-Out Plan and the state of readiness of the Service Provider ("Step-Out Date").

(g) Once the date for the resumption of the affected Service is fixed, the Service Provider shall devote the necessary resources to implement the Step-Out Plan such that delivery of the affected Services is restored to the Service Levels, and that the affected Services are delivered in accordance with all other provisions of this Agreement, from the Step-Out Date.

(h) Where Molina serves a notice of termination of this Agreement, or of any Project Work Order in respect of which Molina exercises its right to step in, for any reason, or the Initial Term or any Extended Term expires during the exercise by Molina of a right to step in, Molina's right to step in shall continue until the earlier of the Step-Out Date and the completion by the Service Provider of its obligations under Schedule 8 (*Termination Assistance and Exit*).

(i) The exercise by Molina of its right to step in and its decision to step out shall be without prejudice to any other rights or remedies of Molina.

(j) During any period of step-in Molina and the Service Provider shall meet weekly to discuss progress toward remedying or resolving the relevant Step-In Event, including deciding whether or not the Services can be returned to the Service Provider.

48.4 Liability issues relating to the Step-In Process

(a) If Molina exercises its right to step in, and the Service Levels for the Services the subject of Molina's right to step in are not met while Molina is exercising its right to step in, then the Service Provider shall not be liable for failing to meet such Service Levels to the extent that it was prevented from meeting such Service Levels by Molina's exercise of its right to step in.

(b) By exercising its right to step in Molina shall not, and shall not be deemed to, assume any obligation to resolve the event giving rise to Molina's right to step in or relieve the Service Provider of any obligation or liability in relation to that event or relieve the Service Provider of any of its other obligations or liabilities under this Agreement; provided, however, that to the extent Molina steps-in under this Clause 48 (*Step-In*) to take control of any Service Provider activity necessary to the Service Provider's performance of the Services in accordance with this Agreement, the Service Provider's obligations to continue to perform affected Services after such step-in by Molina shall be limited accordingly until Molina steps-out in accordance with this Agreement; provided, however, that the foregoing shall not limit the Service Provider's liability for its breaches of the Agreement giving rise to such step-in by Molina, including such liability for Loses suffered by Molina during the step-in

period in connection with Molina's engaging in self-help to mitigate or to remediate the failures by the Service Provider to perform its obligaitons hereunder.

(c) For a period of six (6) months, Molina or a Step-In Agent may instruct the Service Provider to procure that certain Service Provider Personnel cease the provision of Services under any Project Work Order that is charged on a Time & Materials basis in respect of which Molina exercises its right to step in.

(d) For up to six (6) months after the date Molina actually stepped-in to perform the Services as contemplated in this Clause 48 (*Step-In*), Molina shall not be liable to pay the Charges in respect of those Run Services for which Molina exercises its right to step in for as long as Molina is exercising its right to step in.

(e) The Service Provider shall be liable for Molina's costs incurred as a result of the exercise of its right to step in, including any Step-In Agent's charges (the "**Step-In Costs**"), to the extent that those Step-In Costs exceed the Charges that Molina is not liable to pay pursuant to Clause 48.4(c) or Clause 48.4(d); provided, however, that without limiting Molina's rights to pursue additional damages under this Agreement, the Service Provider's obligation to reimburse Molina for Step-In Costs or to pay Step-In Costs directly shall not exceed [redacted].

(f) Each Party shall take Appropriate Actions to minimize Step-In Costs.

(g) Subject to any necessary restrictions that the Service Provider must make to protect the confidentiality of the Service Provider's other customers (in circumstances where it is providing the Services from a facility that it uses for other customers) or the Service Provider IP, and provided that the Step-In Agent complies with the Service Provider's reasonable security and health and safety policies, the Service Provider shall provide any Step–In Agent with such assistance, co–operation and information in relation to the Services, and such access to the Service Provider's Systems as is necessary for the Step-In Agent to properly perform its role or as Molina or the Step-In Agent may request.

(h) If the Step-Out Date shall not have occurred by the date six (6) months after the date Molina actually stepped-in to perform the Services as contemplated in this Clause 48 (*Step-In*), Molina shall have the option to terminate this Agreement or the affected Services pursuant to Clause 51.1(c) (*Performance-Related Failures*) upon notice to the Service Provider.

48.5 Assistance with Appointment of Step-In Agent

The Service Provider must provide Molina with reasonable cooperation, information and assistance as reasonably requested by Molina in the preparation for the appointment of a Step-In Agent (including any assistance in the conduct of any request for proposal process in relation to that appointment).

49. ENHANCED CO–OPERATION

49.1 Molina may, in circumstances where Molina has the right to step in as set out in Clause 48.1, nominate its employees, agents, advisors or contractors, to oversee the Service Provider or any of its Subcontractors implicated in the circumstances giving rise to the right to step in as set out in Clause 48.1 ("**Consultants**").

49.2 If Molina exercises its rights under Clause 48 (*Step-In*) in respect of any Services, Molina may not exercise its rights under this Clause 49.1 (*Enhanced Co–Operation*) in respect of the same Services until after the Step-Out Date. For the purposes of this Clause 49.2, the same Services provided from or received in different Countries shall be considered different Services.

49.3 The Consultants shall be given full access to all information (other than information related to the Charges and the Service Provider's internal cost base including the cost of performing the Services) that is available to all of the Key Persons and that is related to the performance of the Services that are affected by the event giving rise to Molina's rights in this Clause and shall be able to make suggestions related to any element of the performance of the Services.

49.4 The Service Provider shall comply with all written directions of the Consultants and shall reasonably consider all suggestions of the Consultants but is not obliged to follow any suggestions given by the Consultants.

49.5 If the Service Provider does follow a suggestion of a Consultant, then the Service Provider shall be fully responsible for all consequences that flow from the suggestion as if it were the Service Provider's own suggestion. The Service Provider shall not be liable for delay, damage or loss to the extent caused directly by the Consultant (and not by the Service Provider acting on the Consultant's suggestions) or by the Service Provider complying with an express written direction of the Consultant.

49.6 By exercising its rights under this Clause, Molina shall not, and shall not be deemed to, assume any obligation to resolve the event giving rise to Molina's rights under this Clause or relieve the Service Provider of any obligation or liability in relation to that event.

49.7 The duration of any secondment shall be at Molina's reasonable discretion.

49.8 The Service Provider shall be responsible for paying an amount equal to [redacted] for each Consultant (in the case of a Consultant who is an employee of Molina) or the [redacted] (in the case of a Consultant who is a contractor or agent of Molina) for the duration of the secondment but shall not be liable for [redacted]; provided, however, that without limiting Molina's rights to pursue additional damages under this Agreement, the Service Provider's obligation to reimburse Molina in connection with such secondment shall not exceed [redacted].

49.9 The exercise by Molina of its rights in this Clause 49.1 (*Enhanced Cooperation*) shall be without prejudice to any other rights or remedies of Molina including the right to step in following the completion of the secondment referred to in this Clause 49.1 (*Enhanced Cooperation*).

50. SERVICE RELOCATION

50.1 If Molina notifies the Service Provider that it proposes to remove any Approved Service Delivery Location from Schedule 10 (*Approved Service Delivery Locations*) in accordance with Clause 15.4 and the Service Provider is at that time providing Services from that Approved Service Delivery Location the Service Provider may, within twenty (20) Business Days, submit to Molina a written response explaining why, having used all reasonable endeavors, it would not be able to move the provision of the Services from the Approved Service Delivery Location as proposed by Molina.

50.2 If the Service Provider does not submit a response within twenty (20) Business Days or Molina notifies in writing that it does not accept the Service Provider's response under Clause 50.1, the Service Provider shall:

(a) submit to Molina a project plan (which shall include a detailed impact assessment) for moving the location from which those Services are delivered to an Approved Service Delivery Location (a "**Service Relocation Plan**"); and

(b) upon Molina's approval of the Service Relocation Plan (not to be unreasonably withheld or delayed), implement the Service Relocation Plan in accordance with its terms, subject to such modifications as Molina may reasonably require.

50.3 The Service Relocation Plan shall incorporate such provisions of the Exit Plan as are relevant to the relocation of the Services from the former Approved Service Delivery Location to the replacement Approved Service Delivery Location.

50.4 The costs of implementation of a Service Relocation Plan ("**Service Relocation Costs**") shall be borne as follows:

(a) if the removal referred to in Clause 50.1 was effected by Molina exercising its rights under Clause 15.4(a), or by Molina exercising its rights under Clause 15.4(b) (other than as described in Clause 50.4(b)), the Service Relocation Costs shall be borne by the Service Provider; and

(b) if the removal referred to in Clause 50.1 was effected by Molina exercising its rights under Clause 15.4(b) in circumstances where the Approved Service Delivery Location did not comply with a Policy because of a change in that Policy, the Service Relocation Costs shall be borne by Molina.

51. TERMINATION OF THE ENTIRE AGREEMENT FOR CAUSE

51.1 Molina's Rights to Terminate for Cause

Molina may terminate this Agreement by notice to the Service Provider on or at any time after the occurrence of any of the following events:

(a) Material Breach

A material breach of this Agreement (whether or not a repudiatory breach, and whether or not a single material breach or multiple breaches that in aggregate are material), including a breach of any Project Work Order that is (or is when viewed with other breaches as an aggregate) a material breach of this Agreement, and, if the material breach is capable of being remedied, the Service Provider failing to remedy the material breach within twenty (20) Business Days (or such longer period as may be agreed) starting on the Business Day after receipt of notice from Molina giving particulars of the breach and requiring the Service Provider to remedy the breach.

(b) Persistent Breach

A failure by the Service Provider to perform an obligation under this Agreement or any Project Work Order (whether or not a repudiatory breach) that has been, or that is substantially similar to failures that have been, repeated sufficiently often to collectively amount to a material breach, provided that:

(i) Molina has previously notified the Service Provider Delivery Lead (via formal notice, written correspondence, or during a meeting of the Operational Review Board (and a Party subsequently memorializes such discussion in writing within a reasonable time under the circumstances)) on one or more occasions that if the same or substantially similar breach occurs again, Molina may exercise its rights under this Clause, and the first such notification occurred at least twenty (20) Business Days prior to Molina's termination of the applicable Services pursuant to this Clause 51.1(b)(i); and

(ii) the breach referred to in a notice submitted under Clause 51.1(b)(i) did in fact occur again.

(c) Performance-Related Failures

Without limiting Molina's rights under Clause 51.1(a) and Clause 51.1(b):

(i) for any four (4) consecutive months, the Service Credits that the Service Provider must credit in each such month equals the At Risk Amount;

(ii) Service Provider commits a breach of a kind permitting Molina to terminate this Agreement or certain Services pursuant to Clause 48.4.

(iii) without prejudice to the Service Provider's right to argue that Service Credits are not applicable due to the application of Clause 60 (*Excusing Causes*), the Service Provider withholds Service Credits or Delivery Credits in circumstances where the Service Provider has an obligation to credit such Service Credits or Delivery Credits pursuant to Clause 11 (*Transition*) in the case of Delivery Credits or Clause 18 (*Service Credits*) in the case of Service Credits, and Service Provider fails to pay Molina such amounts (or issue Molina a credit note for such amounts) within ten (10) Business Days after any Molina demand that such amount be paid or credited to Molina.

(d) Regulatory Sanction

An act or omission of the Service Provider which is in breach of this Agreement or any Project Work Order resulting in:

(i) any of the following:

(A) any Regulatory Authority subjecting Molina to a prohibition or restriction on the carrying on of its business;

(B) a Regulatory Authority subjecting Molina to a fine or similar penalty;

(C) a Regulatory Authority subjecting Molina to public censure; or

(D) any Regulatory Authority making a formal finding that it has observed a condition in relation to the business or operations of any Molina Company that the Regulatory Authority considers to be objectionable (including the issue of an FDA Form 483, as replaced from time to time, or the equivalent in any jurisdiction) and requires that condition to be rectified;

(ii) any Regulatory Authority withdrawing any license required for Molina or any member of the Molina Group to carry on its business or any part of its business, or imposing any conditions on any such license; or

(iii) any Regulatory Authority notifying Molina that if Molina fails to remedy the act or omission, or if the act or omission recurs, it will or will be likely to take the action referred to in Clause 51.1(d)(i) or Clause 51.1(d)(ii), so long as Molina shall have promptly informed the Service Provider that the applicable Regulatory Authority has so notified Molina.

The Parties acknowledge and agree that, for the purposes of determining whether the Service Provider breached this Agreement, Molina's right to terminate this Agreement pursuant to this Clause 51.1(d) shall not be construed as expanding the Service Provider's obligations to comply with Applicable Law as otherwise set out in this Agreement.

(e) Specific Failures

The Service Provider is in material breach of Clauses 24 (*Security*), 29 (*Intellectual Property Rights*), 30 (*Confidentiality*) or 34 (*Data Protection and Data Privacy*) (whether or not such breach is a material breach of this Agreement) and such breach:

(i) is not capable of remedy; or

(ii) is capable of remedy and the Service Provider fails to remedy the breach within twenty (20) Business Days starting on the Business Day after receipt of notice from Molina giving particulars of the breach and requiring the Service Provider to remedy the breach.

(f) For security breach

(i) The Service Provider is in breach of Clause 24 (*Security*), Clause 30 (*Confidentiality*) or Clause 34 (*Data Protection and Data Privacy*) and as a result:

(A) Molina is required to notify a Regulatory Authority and/or affected data subjects of such breach;

(B) there is a material adverse impact on Molina's reputation;

(C) the Service Provider is unable to locate definitively, for a period of longer than fifteen (15) days, any media, device or equipment on which Molina Data is stored;

(D) a third party gains unauthorized access to any Molina System or any Molina Data; or

(E) any of the events described in Clause 51.1(d) occur.

(g) For exhaustion of liability cap

The sum of the damages that the Service Provider has already paid and the damages that the Service Provider is ordered in a final ruling by a court of competent jurisdiction or agrees to pay but has not paid, to Molina under or in connection with this Agreement, exceed fifty percent (50%) of an applicable limit under Clause 58.4 (i.e., either or both of the limits set out in Clause 58.4(b)(i) and Clause 58.4(b)(ii)) unless Molina and the Service Provider agree in writing to increase that limit such that those damages no longer exceed that percentage of that limit.

(h) For violation of ethical requirements

The Service Provider commits a material breach of Clause 8.12.

(i) For Failure to complete Transition

The Service Provider fails to Achieve the Final Transition Milestone within sixty (60) days after its Milestone Date.

(j) Termination of the Entire Agreement for a Failed Benchmark

If the Service Provider fails to implement the findings of a Final Benchmark Report under paragraph 9.6 of Schedule 5 (*Benchmarking*).

51.2 Right of Molina to Terminate for Change of Control

(a) Molina may terminate this Agreement, without any payment or penalty, by giving at least three (3) months' notice to the Service Provider at any time if the person that acquires Control of the Service Provider is:

(i) a Molina Competitor;

(ii) an entity that does not comply with Molina's Code of Conduct, as amended from time to time in accordance with Schedule 9 (*Change*), or with whom Molina could not contract without breaching that policy;

(iii) an Excluded Supplier;

(iv) an entity with a financial standing that is materially worse than that of the Service Provider; or

(v) an entity whose Control of the Service Provider will, or is likely, on the basis of an objective analysis, to lead to a material detrimental impact on the provision of the Services or damage to the reputation of Molina or any other Molina Company.

(b) The Service Provider shall give Molina notice of any acquisition of Control of the Service Provider as soon as practicable (taking into account any restrictions imposed by Applicable Law) and in any event within thirty (30) Business Days after the acquisition.

51.3 Right of both Parties to Terminate for Insolvency

Either Party may terminate this Agreement by notice to the other Party on or at any time after the occurrence of any of the following:

(a) the other Party being unable to pay its debts as they fall due; or

(b) the taking of any of the following steps by the other Party or any other person:

(i) the presentation of a petition for winding up the other Party (and, where the petition is presented by a person other than the other Party, that petition not being struck out or withdrawn within fourteen (14) days);

(ii) the application for an order or tabling of an effective resolution for winding up the other Party (and, where the application is made or resolution tabled by a person other than the other Party, that application or resolution not being struck out or withdrawn within fourteen (14) days);

(iii) the application for an order or application for the appointment of a liquidator, receiver (including an administrative receiver), administrator, trustee or similar officer in respect of the other Party (and, where the application is made by a person other than the other Party, that application not being struck out or withdrawn within fourteen (14) days);

(iv) an execution creditor, encumbrancer, receiver (including an administrative receiver) or similar officer taking possession of the whole or any part of the other Party's property, assets or undertaking; or

(v) the other Party making a composition with its creditors generally (other than for the purpose of a solvent reorganization, solvent arrangement or solvent scheme).

51.4 Right for Service Provider to Terminate Agreement

(a) If, at any time, the total amount of undisputed Charges that are overdue for payment exceeds the amount of the Charges for the previous three (3) full calendar months:

(i) the Service Provider may give Molina written notice, for the attention of each of Head of IS Vendor and Supplier Management:

(A) requiring payment of the undisputed amounts within fifteen (15) days of receipt of such notice by Molina; and

(B) notifying Molina that it will exercise its rights to terminate if payment is not received within fifteen (15) days of receipt of that notice.

(ii) If Molina does not pay the amounts set out in any notice served pursuant to Clause 51.4(a) within the period set out in that notice, the Service Provider may terminate this Agreement by giving written notice to Molina. If Molina pays the Charges set out in the notice prior to the date of termination specified in the further notice, then the notice shall automatically be deemed rescinded and the Agreement shall not terminate, but this shall not affect the Service Provider's ability to levy late payment charges in accordance with Clause 41 (*Late Payment*).

(iii) The continued non-payment of the same Charges shall constitute a single occasion of non-payment for the purposes of this Clause.

(b) The Service Provider may terminate this Agreement by giving written notice to Molina if Molina is in material breach of Clauses 29 (*Intellectual Property Rights*) or 30 (*Confidentiality*) and, if the breach is capable of remedy, fails to remedy the breach within twenty (20) Business Days starting on the Business Day after receipt of notice from the Service Provider giving particulars of the breach and requiring Molina to remedy the breach.

(c) For the purposes of Clause 51.4(b), a breach by Molina of Clause 29 (*Intellectual Property Rights*) is not material unless it causes irreparable damage to the Service Provider's business for which damages would not provide an adequate remedy.

(d) In circumstances where the Service Provider terminates this Agreement under Clause 51.4(a) or Clause 51.4(b), the Service Provider may also terminate all Project Work Orders (but not some of them only), by giving fourteen (14) days' written notice to Molina.

52. TERMINATION OF A PROJECT WORK ORDER FOR CAUSE

52.1 Termination by Molina

Molina may terminate any Project Work Order by notice to the Service Provider on or at any time after the occurrence of any of the following events:

(a) Material Breach

A material breach of that Project Work Order (whether or not a repudiatory breach, and whether or not a single material breach or multiple breaches that are in aggregate material) and, if the material breach is capable of being remedied, the Service Provider failing to remedy the material breach within twenty (20) Local Business Days (or such longer period as may be agreed) starting on the Local Business Day after receipt of notice from Molina giving particulars of the breach and requiring the Service Provider to remedy the breach.

(b) Persistent Breach

A failure by the Service Provider to perform an obligation under that Project Work Order (whether or not a repudiatory breach) that has been, or that is substantially similar to failures that have been, repeated sufficiently often to collectively amount to a material breach provided that Molina has previously notified the Service Provider that if the failure or a substantially similar failure is repeated Molina may wish to terminate the Project Work Order.

(c) Late Delivery

The Service Provider fails to Achieve the Final Milestone under a Project Work Order within twenty (20) Business Days after its Milestone Date, except to the extent the applicable Project Work Order sets outs shorter timeframe.

(d) Termination of Linked Project Work Order

Molina terminates any Project Work Order that is Linked to that Project Work Order in accordance with this Clause 52 (*Termination of a Project Work Order for Cause*), or becomes entitled to do so (whether or not Molina actually exercises that right).

(e) Termination of MSA

Molina terminates this Agreement in accordance with Clause 51 (*Termination of the Entire Agreement for Cause*), or becomes entitled to do so (whether or not Molina actually exercises that right).

52.2 Right for Service Provider to Terminate for Non–Payment of Charges

(a) If Molina fails to pay any undisputed Charges under any Project Work Order when due under this Agreement, the Service Provider may give Molina notice of its intention to terminate that Project Work Order if payment is not received within twenty (20) Local Business Days of that notice.

(b) If Molina does not pay the Charges set out in any notice served pursuant to Clause 52.2(a) within the period set out in that notice, the Service Provider may

terminate the Project Work Order specified in that notice by giving a further ten (10) Local Business Days' written notice to Molina. If Molina pays the Charges set out in the further notice prior to the date of termination specified in the notice, then the notice shall automatically be deemed rescinded and the Project Work Order shall not terminate, but this shall not affect the Service Provider's ability to levy late payment charges in accordance with Clause 41 (*Late Payment*).

(c) Without limiting Clause 51.4(b), nothing in this Clause entitles the Service Provider to terminate this Agreement or any Project Work Order other than the Project Work Order referred to in Clauses 52.2(a) and 52.2(b).

52.3 Right of both Project Work Order Parties to Terminate for Insolvency

Either PWO Party may terminate a Project Work Order by notice to the other PWO Party on or at any time after the occurrence of any of the following:

(a) the other PWO Party being unable to pay its debts as they fall due; or

(b) the taking of any of the following steps by the other PWO Party or any other person:

(i) the presentation of a petition for winding up the other PWO Party (and, where the petition is presented by a person other than the other PWO Party, that petition not being struck out or withdrawn within fourteen (14) days);

(ii) the application for an order or tabling of an effective resolution for winding up the other PWO Party (and, where the application is made or resolution tabled by a person other than the other PWO Party, that application or resolution not being struck out or withdrawn within fourteen (14) days);

(iii) the application for an order or application for the appointment of a liquidator, receiver (including an administrative receiver), administrator, trustee or similar officer in respect of the other PWO Party (and, where the application is made by a person other than the other PWO Party, that application not being struck out or withdrawn within fourteen (14) days);

(iv) an execution creditor, encumbrancer, receiver (including an administrative receiver) or similar officer taking possession of the whole or any part of the other PWO Party's property, assets or undertaking; or

(v) the other PWO Party making a composition with its creditors generally (other than for the purpose of a solvent reorganization, solvent arrangement or solvent scheme).

53. PARTIAL TERMINATION

53.1 Where this Agreement gives Molina the right to terminate this Agreement in its entirety, Molina may instead elect to terminate this Agreement in respect of:

(a) any or all of the Sub-Towers affected by the events, facts or circumstances giving rise to Molina's right to terminate;

(b) any or all of the Service Elements affected by the events, facts or circumstances giving rise to Molina's right to terminate; or

(c) a combination of (a) and (b).

53.2 Without limiting Clause 51 (*Termination of the Entire Agreement for Cause*) or Clause 53.1, if any of the events referred to in Clause 53.3 occur in respect of any Sub-Tower or Service Element, Molina may terminate this Agreement in respect of that Sub-Tower or Service Element by notice to the Service Provider on or at any time after the occurrence of that event.

53.3 The events are:

(a) Material Breach

A material breach of this Agreement in the context of that Sub-Tower or Service Element (whether or not a repudiatory breach, whether or not a single material breach or multiple breaches that in the aggregate are material, and whether or not a material breach of this Agreement as a whole) and, if the material breach is capable of being remedied, the Service Provider failing to remedy the material breach within twenty (20) Business Days (or such longer period as may be agreed) starting on the Business Day after receipt of notice from Molina giving particulars of the breach and requiring the Service Provider to remedy the breach.

(b) Persistent Breach

A failure by the Service Provider to perform an obligation in relation to that Sub-Tower or Service Element (whether or not a repudiatory breach) that has been, or that is substantially similar to failures that have been, repeated sufficiently often to collectively amount to a material breach provided that Molina has previously notified the Service Provider Delivery Lead (via formal notice, written correspondence, or during a meeting of the Operational Review Board (and a Party subsequently memorializes such discussion in writing within a reasonable time under the circumstances)) on one or more occasions that if the failure or a substantially similar failure is repeated Molina may wish to terminate this Agreement or that Sub-Tower or that Service Element, and the first such notification occurred at least twenty (20) Business Days prior to Molina's termination of the applicable Services pursuant to this Clause 53.3(b).

53.4 Nothing in Clause 53.2:

(a) shall be construed as meaning that the events referred to in Clause 53.3 are not also material breaches of this Agreement as a whole or would not have a materially adverse impact on the use or enjoyment of the Services as a whole; or

(b) shall prevent Molina from exercising its rights under Clause 51 (*Termination of the Entire Agreement for Cause*) in circumstances where it is entitled to do so as a result of the events referred to in Clause 53.3.

53.5 In the case of partial termination as contemplated by Clause 53.1, Clause 53.2 or Clause 53.3, the Change Control Process shall be used to modify this Agreement to account for the partial termination. Molina may terminate the entire Agreement (under Clauses 53.1 or 53.2) for the reason giving rise to the termination right, at any time up to the execution of the relevant Change Notice that shall modify this Agreement with respect to such partial termination.

54. TERMINATION FOR CONTINUED FORCE MAJEURE

54.1 If the Service Provider is excused from the performance of any of the Services by reason of a Force Majeure Event in accordance with Clause 61 (Force Majeure) for a period of thirty (30) or more consecutive days, then Molina may, on written notice to the Service Provider, terminate any portion of this Agreement or any Project Work Order so affected that it would have been entitled to terminate in accordance with Clause 53 (*Partial Termination*).

54.2 In the case of partial termination as contemplated by Clause 54.1 in circumstances where any terminated Service does not have a separately identifiable Charge that relates specifically to that Service:

(a) the Change Control Process shall be used to modify this Agreement or the Project Work Order (as the case may be) to adjust the Charges for the partial termination as well as other changes strictly necessary to reflect the partial termination;

(b) if the Parties cannot agree (after exhausting all of the available escalation levels forming part of Schedule 7 (*Governance*)) to an adjustment to the Charges following notice of a partial termination, then this Agreement or the Project Work Order (as the case may be) shall terminate in whole; and

(c) Molina may terminate the entire Agreement or the Project Work Order (as the case may be) at any time up to the execution of the relevant Change Notice that shall modify this Agreement or the Project Work Order.

55. TERMINATION FOR CONVENIENCE

55.1 Termination of MSA for Convenience

(a) Molina may terminate this Agreement, in whole or in respect of one or more Services, for convenience by giving:

(i) not less than six (6) months' prior written notice to the Service Provider, in the case of a termination of this Agreement in whole; and

(ii) not less than three (3) months' prior written notice to the Service Provider, in the case of a termination of this Agreement in respect of one or more Services,

(b) Termination of this Agreement by Molina under Clause 55.1 shall not entitle Molina or the Service Provider to terminate any Project Work Order under Clause 52 (*Termination of a Project Work Order for Cause*).

55.2 Termination of Project Work Order for Convenience

Molina shall be entitled to terminate any Project Work Order at any time for convenience by giving three (3) months' written notice to the Service Provider.

56. THE EFFECTIVE DATE OF TERMINATION

56.1 The Termination Date shall be determined by the Party terminating this Agreement or the Project Work Order and shall be set out in the termination notice.

56.2 If a Termination Date is not included in the termination notice, the Termination Date shall, except in the case of notice under Clause 55 (*Termination for Convenience*), be forty-five (45) Business Days from the date the termination notice is received.

56.3 The Service Provider's obligation to deliver the Services does not cease on the Termination Date. The Service Provider must continue to deliver the Services in accordance with this Agreement to the extent required under Schedule 8 (*Termination Assistance and Exit*).

56.4 Molina is not required to exhaust all or any part of the Dispute Resolution Procedure before exercising a right to terminate this Agreement.

57. CONSEQUENCES OF TERMINATION

57.1 No Right to an Injunction

(a) The only remedy that the Service Provider shall have in relation to the wrongful termination of this Agreement or a Project Work Order by Molina is damages.

(b) Without limiting Clause 57.1(a), the Service Provider shall have no right to an injunction or similar relief or remedy restraining Molina from terminating this Agreement or a Project Work Order.

(c) The Service Provider must not refuse to provide the Services or suspend the provision of the Services following any notice of termination issued by Molina and in particular the Service Provider must not refuse to meet its obligations under the Exit Plan even if it is pursuing a claim against Molina that it has wrongfully repudiated this Agreement.

57.2 Damages and Termination not Exclusive

(a) If this Agreement is terminated by either Party for breach by the other Party, the terminating Party may, in addition to terminating the Agreement, claim damages for that breach irrespective of the reason for terminating the Agreement.

(b) If this Agreement is terminated by Molina under Clause 51 (*Termination of the Entire Agreement for Cause*) or Clause 53 (*Partial Termination*), Molina shall be entitled

to recover damages in respect of losses resulting from the termination of this Agreement, as well as damages in respect of losses resulting from any breach of this Agreement.

(c) If this Agreement is terminated by the Service Provider under Clause 51 (*Termination of the Entire Agreement for Cause*), the Service Provider shall be entitled to recover damages in respect of losses resulting from the termination of this Agreement, as well as damages in respect of losses resulting from any breach of this Agreement.

(d) If any Project Work Order is terminated by either PWO Party for breach by the other PWO Party, the terminating PWO Party may, in addition to terminating the Project Work Order, claim damages for that breach irrespective of the reason for terminating the Project Work Order.

(e) If a Project Work Order is terminated by Molina under Clause 52 (*Termination of a Project Work Order for Cause*), Molina shall be entitled to recover damages in respect of losses resulting from the termination of the Project Work Order, as well as damages in respect of losses resulting from any breach of the Project Work Order.

(f) If a Project Work Order is terminated by the Service Provider under Clause 52 (*Termination of a Project Work Order for Cause*), the Service Provider shall be entitled to recover damages in respect of losses resulting from the termination of that Project Work Order, as well as damages in respect of losses resulting from any breach of that Project Work Order.

57.3 Rights in addition to right to termination at law

(a) The Service Provider may not terminate this Agreement other than as expressly provided in Clause 51.3 and Clause 51.4, but nothing in this Clause restricts the Service Provider's right to rescind this Agreement for fraudulent misrepresentation by Molina.

(b) Neither the Service Provider nor the applicable Service Provider PWO Party may terminate any Project Work Order other than as expressly provided in Clause 52.2 and Clause 52.3, but nothing in this Clause restricts the right of the Service Provider or the applicable Service Provider PWO Party to rescind a Project Work Order for fraudulent misrepresentation by Molina.

57.4 Termination Assistance

Molina and the Service Provider each has the rights and obligations allocated to it in Schedule 8 (*Termination Assistance and Exit*) in relation to preparation for, and the consequences of, expiry or termination (in whole or in part) of this Agreement or a Project Work Order.

57.5 Return and Treatment of Confidential Information

On termination or expiry of this Agreement, each Party agrees that:

(a) it must continue to keep confidential the other Party's Confidential Information in accordance with Clause 30 (*Confidentiality*); and

(b) its rights to use and disclose the other Party's Confidential Information cease other than:

(i) in relation to information any Party (including Subcontractors) is required to disclose in order to comply with any of those reporting obligations set out in Clause 30.7;

(ii) to the extent use and disclosure of Confidential Information is necessary in order to make use of the license rights granted pursuant to Clause 29 (*Intellectual Property Rights*); and

(iii) in relation to disclosures required to be made by either Party in order to carry out their respective obligations as set out in Schedule 8 (*Termination Assistance and Exit*).

57.6 Other Consequences of Termination

(a) Expiry or termination of this Agreement does not affect a Party's accrued rights and obligations at the time of expiry or termination.

(b) Without prejudice to Clause 52.1(e), expiry or termination of this Agreement shall not result in the automatic expiry or termination of any Project Work Order.

(c) The provisions of Clauses 1 (Definitions), 2 (Interpretation), 8.11, 29 (Intellectual Property Rights), 30 (Confidentiality), 31 (Use of Confidential Information and Molina Data), 32 (Return of Confidential Information), 33 (Announcements and Publicity), 34 (Data Protection and Data Privacy), 39 (HR Obligations), 40 (Charges), 41 (Late Payment), 42 (Invoices), 43 (Taxation), 57.2, 57.3, 57.4, 57.5, 57.6, 58(Indemnification, Liability), 60 (Excusing Causes), 61 (Force Majeure), 66 (Further Assurance), 67 (Third Party Beneficiaries), 69 (Entire Agreement), 70 (Waiver), 71 (No Partnership), 72 (Severability), 73 (Counterparts), 74 (Dispute Resolution and Dispute Management) and 75 (Governing Law and Jurisdiction) and any other Clauses where the context requires it to survive shall survive expiry or termination of this Agreement or of any Project Work Order for any reason.

(d) Clauses 13.3(c) and 13.3(d) shall survive expiry or termination of this Agreement for as long as any Project Work Order remains in force.

(e) The provisions of the Schedules will survive expiry or termination of this Agreement for any reason to the extent that and for so long as they are referred to in Clauses which survive.

(f) Molina's obligation to pay Charges properly incurred prior to the date of expiry or termination of this Agreement, or of termination of the Project Work Order in respect

of which those Charges are payable, shall survive the expiry or termination of this Agreement and that Project Work Order.

(g) If this Agreement is terminated by Molina pursuant to Clause 55 (*Termination for Convenience*), then Molina shall pay the applicable early termination fee as set forth in, as applicable, Schedule 3 (*Pricing and Invoicing*) or the applicable Project Work Order.

PART N INDEMNIFICATION, LIMITATION OF LIABILITY AND EXCUSING CAUSES

58. **INDEMNIFICATION, LIABILITY**.

58.1 Indemnification by the Service Provider.

The Service Provider will, at its sole cost and expense, defend, indemnify and keep indemnified, and hold harmless Molina and the Molina Companies and each of their respective officers, directors, employees, contractors, agents, representatives, successors and assigns (each an "**Molina Indemnified Party**") from any and all Losses of a Third Party alleged, incurred, or awarded to or payable in settlement with such Third Party, in each case arising out of a claim by a Third Party, to the extent caused by:

(a) An IPR Claim Against Molina, in each case except to the extent such IPR Claim Against Molina results from:

(i) the Service Provider complying with Molina's specifications or other requirements, but only if those specifications or requirements mandated the specific act or acts of infringement or alleged infringement on which the IPR Claim is based;

(ii) Molina IP or any materials or resources provided by or on behalf of Molina or any Molina Companies and used in a manner permitted by this Agreement;

(iii) modifications made by or on behalf of Molina or any Molina Companies by any person (other than modifications made by or on behalf of the Service Provider or any Service Provider Companies) of the Services, Software, System, Materials or Modifications that are the subject of the IPR Claim Against Molina, but only if such Services, Software, System, Materials or Modifications, without that modification, would not have resulted in the infringement or alleged infringement on which the IPR Claim is based;

(iv) use or combination (other than by or on behalf of the Service Provider) of the Services, Software, System, Materials or Modifications that are the subject of the IPR Claim Against Molina, with items not provided by or on behalf of the Service Provider or its Subcontractors and absent such use or combination such Services, Software, System, Materials or Modifications would not have resulted in the infringement or alleged infringement on which the IPR Claim Against the Service Provider is based;

(v) refusal to use corrections and enhancements provided by the Service Provider at no additional cost, where:

(A) those corrections and enhancements could have been implemented without disruption to Molina's business; and

(B) the act or acts of infringement or alleged infringement on which the IPR Claim Against Molina is based would not have occurred if the corrections and enhancements had been implemented; or

(vi) use by a Third Party of the Services, Software System, Materials or Modifications that are the subject of the IPR Claim Against Molina in a manner where such use by Molina would have constituted a breach of this Agreement;

(a) a violation of or non-compliance with Applicable Law by the Service Provider or any Subcontractor except to the extent such violation or non-compliance by Service Provider resulted from:

(i) a breach of this Agreement by the Molina or any Molina Company;

(ii) violation or non-compliance with Applicable Law (including obligations that Molina may have under Data Protection Laws by virtue of its role as a data controller or other similar concepts under applicable Data Protection Laws) by Molina or any Molina Company; or

(iii) the Service Provider's compliance with Molina's written instructions on how to comply with a particular Applicable Law, to the extent the only plausible manner in which the Service Provider could have complied with such instruction resulted in such violation of or non-compliance with Applicable Law;

(b) breaches of the Service Provider's obligations with respect to Clause 30 (*Confidentiality*);

(c) death or bodily injury, or the damage, loss or destruction of real or tangible personal property of Third Parties (including employees of any Molina Company, Service Provider Company, or their respective subcontractors) resulting from the acts or omissions (including breach of contract or negligence) of the Service Provider, or any Service Provider Personnel, agents and/or representatives or any of the personnel of the foregoing;

(d) any Taxes, interest, penalties or other amounts assessed against Molina that are the obligation of the Service Provider pursuant to 43 (*Taxation*); or

(e) the gross negligence, willful misconduct or fraud of the Service Provider, any Service Provider Company, or any Subcontractor.

58.2 Indemnification by Molina

Molina will, at its sole cost and expense, defend, indemnify and keep indemnified, and hold harmless the Service Provider and the Service Provider Companies and each of their respective officers, directors, employees, contractors, agents, representatives, successors and assigns (each a "Service Provider Indemnified Party") from any and all Losses of a

Third Party alleged, incurred, or awarded to or payable in settlement with such Third Party, in each case arising out of a claim by a Third Party, to the extent caused by:

(a) an IPR Claim Against the Service Provider, in each case except to the extent such IPR Claim Against the Service Provider results from:

(i) Molina complying with the Service Provider's specifications or other requirements, but only if those specifications or requirements mandated the specific act or acts of infringement or alleged infringement on which the IPR Claim Against the Service Provider is based;

(ii) Service Provider IP or any materials or resources provided by or on behalf of Service Provider or any Service Provider Companies and used in a manner permitted by this Agreement;

(iii) modifications made by or on behalf of the Service Provider by any person (other than modifications made by or on behalf of Molina or any Molina Companies) of any Molina IP, Software or Third Party Software that are the subject of the IPR Claim Against the Service Provider, but only if such Molina IP, Software or Third Party Software, without that modification, would not have resulted in the infringement or alleged infringement on which the IPR Claim is based;

(iv) refusal to use corrections and enhancements provided by Molina at no additional cost, where:

(A) those corrections and enhancements could have been implemented without disruption to Service Provider's business; and

(B) the act or acts of infringement or alleged infringement on which the IPR Claim Against the Service Provider is based would not have occurred if the corrections and enhancements had been implemented; or

(v) use of the Molina IP, Software or Third Party Software that are the subject of the IPR Claim Against the Service Provider in connection with the provision of services to any party other than the Molina Companies;

(b) a violation of or non-compliance with Applicable Law by Molina, in each case except to the extent such violation or non-compliance by Molina resulted from:

(i) a breach of this Agreement by the Service Provider or any Service Provider Company; or

(ii) violation or non-compliance with Applicable Law (including obligations that the Service Provider may have under Data Protection Laws by virtue of its role as a data processor or other similar concepts under applicable Data Protection Laws) by the Service Provider or any Service Provider Company;

(c) breaches of Molina's obligations with respect to Clause 30 (*Confidentiality*);

(d) death or bodily injury, or the damage, loss or destruction of real or tangible personal property of Third Parties (including employees of any Molina Company, Service Provider Company and/or their respective subcontractors) resulting from the acts or omissions (including breach of contract or negligence) of Molina or Molina Companies, agents and/or representatives or any of the personnel of the foregoing;

(e) any Taxes, interest, penalties or other amounts assessed against the Service Provider that are the obligation of Molina pursuant to Clause 43 (*Taxation*); or

(f) use of any Service Provider IP other than as authorized and for use as part of the Services (or as may be permitted following the expiration or termination of this Agreement or the applicable Services, as applicable).

58.3 Indemnification Procedures.

(a) The following procedures shall apply if any third-party Claim is commenced against any Molina Indemnified Party or Service Provider Indemnified Party (the "**Indemnified Party**"):

(i)Notice of such Claim will be given to the other Party (the "**Indemnifying Party**") as promptly as practicable.

(ii)If, after such notice, the Indemnifying Party acknowledges that the terms of this Agreement apply with respect to such Claim, then subject to Clause 58.3(a)(vii) and except where Clause 58.3(a)(viii) applies, the Indemnifying Party will be entitled, if it so elects, in a notice promptly delivered to the Indemnified Party, but in no event less than ten (10) days prior to the date on which a response to such Claim is due or as soon as reasonably practicable if notice of the Claim was given with less than ten (10) days to respond to the Claim, to immediately take control of the defense and investigation of such Claim and to employ and engage attorneys reasonably acceptable to the Indemnified Party to handle and defend the same, at the Indemnifying Party's sole cost and expense.

(iii)No settlement of a Claim that involves a remedy other than the payment of money by the Indemnifying Party will be entered into without the consent of the Indemnified Party which is not to be unreasonably withheld.

(iv)After notice by the Indemnifying Party to the Indemnified Party of its election to assume full control of the defense of any such Claim (excluding those instances where the Indemnified Party has the option to retain control of the defense of the applicable claim), the Indemnifying Party will not be liable to the Indemnified Party for any legal expenses incurred thereafter by such Indemnified Party in connection with the defense of that Claim.

(v)If the Indemnifying Party does not assume full control over the defense of a Claim subject to such defense as provided in this Clause 58.3(a), the

Indemnifying Party may participate in such defense, at its sole cost and expense, and the Indemnified Party will have the right to defend the Claim in such manner as it may deem appropriate, at the reasonable cost and expense (including attorneys' fees) of the Indemnifying Party.

(vi) The Indemnified Party will, at the Indemnifying Party's cost and expense, cooperate in all reasonable respects with the Indemnifying Party and its attorneys in the investigation, trial and defense of such Claim and any appeal arising therefrom.

(vii) The Indemnified Party may, at its own cost and expense, participate, through its attorneys or otherwise, in such investigation, trial and defense of such Claim and any appeal arising therefrom.

(viii) If an Indemnified Party is entitled to indemnification in respect of a Claim (in accordance with Clause 58), and liability in connection with that Claim is subject to a liability cap set out in Clause 58.4, the Indemnified Party will be entitled, if it so elects, in a notice promptly delivered to the Indemnifying Party, but in no event less than ten (10) days prior to the date on which a response to such Claim is due or as soon as reasonably practicable if notice of the Claim was given with less than ten (10) days to respond to the Claim, to immediately take control of the defense and investigation of such Claim and to employ and engage attorneys reasonably acceptable to the Indemnified Party to handle and defend the same, at the Indemnifying Party's sole cost and expense, provided that if the Indemnified Party assumes control of the defense of a Claim in accordance with this Clause 58.3(a)(viii), the Indemnified Party:

(A) shall comply with its obligations to mitigate under Clause 58.8 (No Double Recovery; Duty to Mitigate Damages) with respect to losses incurred in connection with the Claim and the defense of the Claim; and

(B) may only enter into a settlement of a Claim concerning the payment of money with a complete release of all Indemnified Parties' liability, and shall not without the consent of the Indemnifying Party, in its discretion, enter into any settlement of a Claim that involves an admission of liability by or on behalf of the Indemnifying Party, or involves any other remedy except the payment of money.

(b) If an IPR Claim against an Indemnified Party is made, in addition to the obligations of the Indemnifying Party set out in Clause 58.3(a), the Indemnifying Party (i) may, at the Indemnifying Party's cost and expense, procure for itself and the Indemnified Party, as the case may be, the right to continue using infringing items and (ii) may, in the Indemnifying Party's discretion, (A) substitute or modify any affected item so as to avoid the infringement, (B) replace any part of any affected item with a non–infringing item or remove any or part of the affected item so long as such modification or removal results in the affected item offering equivalent or better features and

functionality to the infringing items, or (C) if substitution or modification in line with the above is not practicable, Indemnifying Party may remove the affected item (and the Indemnified Party shall cease using it) and refund the amounts paid for such item; provided, however, that in the event the Indemnifying Party exercises the option set out in clause (C) above, (I) such provision shall not be construed as relieving the Indemnifying Party exercising such option from any of its obligations under this Agreement, regardless of whether the performance of such obligations are affected by actions taken by the Indemnifying Party excercising such option and (II) the Indemnifying Party exercising such option shall bear any incremental costs and expenses incurred by the Indemnified Party as a result of the exercise of such option to the extent such incremental costs relate to changes implemented by or on behalf of the Indemnified Party to mitigate the effects of the Indemnifying Party's exercising such option. Where the Indemnifying Party addresses the applicable IPR Claim via clause (ii) of the preceding sentence, the Parties shall memorialize the change to the Service Provider Technical Solution via a Change Notice in an amendment to this Agreement.

58.4 Limitations Caps.

(a) References in this Clause 58.4 to Charges paid or payable (as specified below in this Clause 58.4) by Molina as the basis for calculating a limitation of liability under this Agreement will be the aggregate of all such Charges under this Agreement (including Charges paid or payable pursuant to Project Work Orders), but excluding VAT or other taxes that are payable by Molina in connection with the Services. Molina will have the sole right to recover damages and assert all rights, and exercise all options, under this Agreement on behalf of and for the benefit of Molina Companies. The Service Provider will have the sole right to recover damages and assert all rights, and exercise all options, under this Agreement on behalf of and for the benefit of the Service Provider Companies.

(b) Service Provider's Liability Caps

(i) General Liability Cap.

Except as set forth in Clause 58.6 and Clause 58.4(b)(ii), the Service Provider's total liability under this Agreement (whether the liability is in contract, in tort, breach of warranty, negligence, strict liability or otherwise) for any claim or Losses under this Agreement will under no circumstances exceed an amount equal to the greater of:

(A) [redacted]; and

(B) [redacted],

[redacted].

Amounts that apply against the limitation of liability set out in this Clause 58.4(b)(i) shall not apply against any other limitation of liability or damages cap set out in this Agreement.

(ii) Security Incident Liability Cap.

Except as set forth in Clause 58.6, the Service Provider's total liability under this Agreement (whether the liability is in contract, in tort, breach of warranty, negligence, strict liability or otherwise) for (x) liability arising from any cause of action arising from breach by the Service Provider of Clause 34 (*Data Protection and Data Privacy*), (y) the Service Provider's responsibility for certain costs and expenses as set out in Clause 34.9 (Security Breach Response.), and (z) the Service Provider's obligation of the Service Provider to indemnify Molina pursuant to Attachment 24A (*Business Associate Agreement*) to Schedule 24 (*Certain Security Requirements*), as applicable, will under no circumstances exceed an amount equal to the greater of:

(A) [redacted]; and

(B) [redacted],

[redacted].

Amounts that apply against the limitation of liability set out in this Clause 58.4(b)(ii) shall not apply against any other limitation of liability or damages cap set out in this Agreement.

(c) Molina's Liability Cap

Except as set forth in Clause 58.6, Molina's total liability in the aggregate under this Agreement (whether the liability is in contract, in tort, breach of warranty, negligence, strict liability or otherwise) for any claim or Losses under this Agreement will under no circumstances exceed:

(A) [redacted]; and

(B) [redacted],

[redacted].

58.5 **Consequential Damages Exclusion**.

(a) EXCEPT AS SET OUT IN CLAUSE 58.5(b) AND CLAUSE 58.6, IN NO EVENT, WHETHER IN CONTRACT OR IN TORT (INCLUDING BREACH OF WARRANTY, NEGLIGENCE AND STRICT LIABILITY), WILL EITHER PARTY BE LIABLE TO THE OTHER FOR LOST REVENUE, LOST PROFIT, LOSS OF GOODWILL, LOSS OF ANTICIPATED SAVINGS, LOSS OF BUSINESS, OR CONSEQUENTIAL, INDIRECT, SPECIAL, EXEMPLARY,

PUNITIVE OR INCIDENTAL DAMAGES EVEN IF SUCH PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES IN ADVANCE.

(b) Notwithstanding Clause 58.5(a) the following will be recoverable damages that apply against the caps on liability set forth in Clause 58.4 as applicable to the extent that they result directly from either Party's failure to perform in accordance with this Agreement:

(i) the reasonable cost of researching, procuring, purchasing, installing, testing and implementing alternative Systems and/or services used in whole or partial substitution for the Services;

(ii) the reasonable cost of restoring lost or corrupted data (including recreating data in circumstances where the data is no longer reasonably available in the form in which it existed at the time of the loss or corruption), provided that the data has been backed up by or on behalf of Molina in accordance with a reasonable back-up policy (but that proviso does not apply to the extent the Service Provider is responsible for backing up that data under this Agreement and has failed to do so in accordance with this Agreement);

(iii) fines payable by Molina or any Molina Company as a result of the Service Provider's breach of this Agreement;

(iv) the reasonable cost of implementing and performing work-arounds;

(v) the reasonable cost of replacing lost, stolen or damaged goods or materials;

(vi) the reasonable cost of procuring replacement services, or services designed to rectify defects in the Services from an alternate source; and

(vii) additional wages, overtime, fees and expenses (including reasonable travel and lodging) incurred by Molina Companies in:

(A) appointing advisors to advise upon the impact and consequences of the Service Provider's breach, including legal and compliance professionals;

(B) investigating the circumstances of the Service Provider's breach, whether such investigation is conducted by Molina or by a third party on Molina's behalf;

(C) performing or rectifying, or engaging a Third Party to perform or rectify, the Services that the Service Provider has failed to perform; and

(D) managing a Third Party's or the Service Provider's investigation, performance or rectification of the Services that the Service Provider has failed to perform.

58.6 **Exceptions**

(a) In each case subject to Clause 58.6(x), liability arising from the following will not be subject to any cap in Clause 58.1 and the disclaimer in Clause 58.5(a) will not apply with respect to:

(i) death or bodily injury or physical or real property damage caused by a Party or its personnel;

(ii) Molina's obligation to pay the Charges;

(iii) any Charge Deductions;

(iv) the cost of procuring any license for any Software incorporated into Molina Work Product or System that the Service Provider should have procured, but did not procure, for Molina's benefit under any provision of this Agreement;

(v) the breach by either Party of the obligations contained in Clause 29 (*Intellectual Property Rights*) or Clause 30 (*Confidentiality*);

(vi) [redacted];

(vii) [redacted];

(viii) [redacted];

(ix) [redacted];

(x) liability arising from the intentional cessation by the Service Provider of any of its obligations under this Agreement;

(xi) liability arising from willful misconduct by either Party or members of its Group;

(xii) liability arising from the fraud of either Party or members of its Group;

(xiii) liability arising from gross negligence of either Party or members of its Group; and

(xiv) the extent such limitation or exclusion is not permitted by Applicable Law.

(b) If a claim or event of any sort that is contemplated by this Clause 58.6 is one with respect to which both (i) the provisions of Clause 58.4(b)(ii) are set out as applying to limit the amount Service Provider's liability and (ii) any other provision of this Clause 58.6 applies, then Clause 58.4(b)(ii) shall be deemed not to apply, and the Service Provider's liability with respect to such claim or event shall be unlimited in the manner otherwise contemplated in this Clause 58.6. For example, in the event the Service Provider breaches Clause 34 (*Data Protection and Data Privacy*) as a result of the [redacted] of [redacted], then [redacted] shall be deemed not to apply,

and the Service Provider's liability with respect to such claim or event shall be [redacted].

58.7 **Open Negotiation**

Molina and the Service Provider have freely and openly negotiated this Agreement, including the pricing, with the knowledge that the liability of the Parties is to be limited in accordance with the provisions of this Agreement.

58.8 **No Double Recovery; Duty to Mitigate Damages**

In the event of any set of circumstances that results in both Service Credits (or Delivery Credits) and Molina incurring a Loss, an amount equal to the Service Credits (or Delivery Credits, as applicable) paid by the Service Provider in connection with such circumstances will be deducted from the Losses recoverable by Molina pursuant to this Agreement. In no event will any of the provisions in this Agreement be interpreted to allow recovery for the same Losses more than once. Each Party has a duty to mitigate the damages and losses that would otherwise be recoverable from the other Party pursuant to this Agreement to the extent required under the law governing this Agreement, as set out in Clause 75.1.

59. **INSURANCE**

59.1 In this Clause, unless the context otherwise requires:

(a) "**Insurance**" means each of the policies of insurance which the Service Provider is required to maintain pursuant to this Agreement and "**Insurances**" means all such policies of insurance collectively;

(b) "**Insurance Limits**" means the monetary amounts set out in Clause 59.2;

(c) "**Insurer**" means the persons providing the Insurance; and

(d) **"Prudent Service Provider**" means in respect of the Insurances a prudent supplier, in a similar industry and of similar size and financial strength as the Service Provider, providing services of a type and size similar to those undertaken by the Service Provider under this Agreement.

59.2 The Service Provider shall, during the Term and at its expense, have and maintain in force the following insurance coverages (including tail coverage of at least 1 year for any claims-made policies, if such claims-made policies are not maintained for 1 year after the conclusion of this Agreement):

(a) Employer's Liability Insurance, including coverage for occupational injury, illness and disease, and other similar social insurance with the minimum limits in amount equal to the greater of (i) the minimum limits required by Applicable Law and (ii) [redacted];

(b) Worker's Compensation Insurance, including coverage for occupational injury, illness, and disease, and other similar social insurance with minimum limits in

accordance with the laws of the country, state, or territory exercising jurisdiction over the employee;

(c) Commercial General Liability Insurance, including Products, Completed Operations, on an occurrence basis, of [redacted] per occurrence and an aggregate limit of [redacted]. This coverage shall name Molina and each other Molina Company as additional insureds, to the extent allowable by law, as set out in Clause 59.11;

(d) Auto Liability Insurance as required by local law and, in any event and in addition, automobile bodily injury and property damage liability insurance covering owned, non-owned and hired automobiles, the limits of which shall not be less than [redacted] combined single limit per occurrence;

(e) Commercial Crime Insurance, in an amount not less than [redacted] per occurrence and in the aggregate covering the theft of money, securities and other tangible property belonging to Molina by a Service Provider employee, while performing the Services for Molina, and with Molina added as Loss Payee under said Policy;

(f) Professional Liability Insurance (specifically, Cyber Insurance that includes both Network Security and Privacy Liability) covering the Service Provider's liability for claims due to an act, error, omission or negligence in the performance of the Service under this Agreement, with a limit of [redacted] per claim with an aggregate limit of [redacted];

(g) in the event Services include handling funds from Customer employees and/or members, the Service Provider shall provide proof of Fidelity Bonds and Crime Insurance with a [redacted] limit covering losses resulting from employee dishonesty, fraudulence, and/or theft;

(h) cybersecurity insurance in amounts equal to the greater of (i) with industry standard limits and (ii) a minimum [redacted] limit of liability; and

(i) Umbrella Liability Insurance with a minimum limit of [redacted] per occurrence and in the aggregate, in excess of the insurance coverage described in Clause 59.2(b) and Clause 59.2(d) provided that Molina shall not require the Service Provider to evidence such insurance in jurisdictions that do not permit non-admitted insurance.

59.3 The Insurances shall cover the liability of the Service Provider.

59.4 The Insurance Limits must be maintained as per the limits above.

59.5 These stated Insurance coverages:

(a) shall be maintained with excesses or deductibles no greater than those that would be assumed by a Prudent Service Provider; and

(b) shall not be subject to any exclusions other than those that are typical in all the circumstances and would be accepted by a Prudent Service Provider.

59.6 The Insurances shall be maintained with insurers or reinsurers that have a Rating in Best's Rating Guide of A (A) or higher (or equivalent rating agency).

59.7 If the General Liability Insurer disputes any bodily injury, death or property insurance claim by the Service Provider arising out of this Agreement and to which Molina is also named in such action, the Service Provider shall so notify Molina in writing.

59.8 The Service Provider shall give Molina at least thirty (30) days' prior written notice if any Insurance will be cancelled.

59.9 Molina may elect (but shall not be obliged), after giving thirty (30) days' written notice and an opportunity to cure to the Service Provider, to purchase any Insurance which the Service Provider is required to maintain pursuant to this Agreement but has failed to maintain in full force and effect, and Molina shall be entitled to recover the reasonable premium and other reasonable costs incurred in connection therewith as a debt due from the Service Provider.

59.10 The Service Provider shall provide before the Effective Date, and within ten (10) Business Days after the renewal of every stated Insurance, a certificate of insurance from the insurance brokers who arranged the Insurances addressed to Molina evidencing that such Insurance is in effect as of the Effective Date as at each renewal date.

59.11 Provision Specific to Commercial General Liability Insurance

(a) The Service Provider shall ensure that Molina and each member of the Molina Group shall be added and maintained as an additional insured for claims against Molina and members of the Molina Group from any person (other than Molina's own employees) resulting from the negligence of the Service Provider and any Service Provider Personnel in the course of this Agreement and for which the Service Provider is itself insured under that Insurance subject to the terms and conditions of the policy.

(b) The Commercial General Liability Insurance shall provide that each insured party shall be insured for its own insurable interest, and separately from any other insured party.

(c) The Service Provider shall endeavor to give at least thirty (30) days' prior written notice to Molina if any Insurer proposes to cancel that Insurance.

59.12 It is acknowledged by the parties that should any local custom or Applicable Law in any jurisdiction require or have the effect of requiring any amendment to the provisions of, or the obligations imposed by this Clause 59 in respect of that jurisdiction, the necessary amendments to this Clause 59 shall be agreed between the parties (such amendments applying in relation to that jurisdiction only) and recorded in this Agreement with respect to that jurisdiction.

59.13 Waiver of Subrogation.

The Service Provider waives all rights of recovery against Molina and the Molina Companies and its and their officers, directors, employees, agents, and other representatives for any loss, damage, or injury of any nature whatsoever to the Service Provider unless the loss, damage or injury was caused by the negligence or willful misconduct of Molina and the Molina Companies and its and their officers, directors, employees, agents and other representatives. The Service Provider will obtain from the Service Provider's insurance carriers waivers of the subrogation rights under the respective policies for commercial general liability and auto liability.

60. EXCUSING CAUSES

60.1 This Clause 60 (*Excusing Causes*) and Clause 61 (Force Majeure) set out:

(a) the only bases on which the Service Provider shall be excused from liability for a failure to perform (or delay in performing) its obligations under this Agreement, and the conditions to which that excuse is subject; and

(b) the Service Provider's only remedies in respect of Molina's failure to perform the Molina Responsibilities (but without prejudice to the Service Provider's right to terminate this Agreement under Clause 51 (*Termination of the Entire Agreement for Cause*)).

Any reference to Service Provider in this Clause 60 shall be read as including a reference to any member of the Service Provider Group.

60.2 Subject to Clause 60.5, the Service Provider shall not be liable for any failure to perform (or any delay in performing) any of its obligations under this Agreement (including the Service Levels) if and to the extent that the Service Provider can reasonably demonstrate that the failure or delay results from:

(a) a failure or delay by Molina, Molina Companies, or Other Service Providers (other than those Other Service Providers whose contract with Molina or whose related activities are not being administered or managed by the Service Provider or any of its Affiliates, to the extent the failure or delay by the applicable Other Service Provider results from the Service Provider's improper administration, improper management, or other breach of this Agreement by the Service Provider) in performing any Molina Responsibility; or

(b) the Service Provider acting in accordance with an express instruction by Molina, provided that:

(i) the instruction was issued by an employee or other representative of Molina with at least apparent authority; and

(ii) the instruction was not manifestly issued in error

(each, an "Excusing Cause").

60.3 The provision by Service Provider or any other member of the Service Provider Group of other services to Molina other than the Services, where the provision of such other services adversely affects the Services, shall not amount to an Excusing Cause, provided that it is neither (a) a breach of the applicable agreement between Molina or any member of the Molina Group, on one hand, and the Service Provider or any member of the Service Provider Group, on the other hand, for which Molina or any member of the Molina Group is liable nor (b) an event for which Molina or the applicable member of the Molina Group is responsible in a manner which, under the terms of the applicable agreement, results in the Service Provider or the applicable member of the Service Provider Group being relieved of its obligation to perform its obligations under such agreement.

60.4 The Service Provider shall:

(a) notify Molina in writing, and in a form that complies with the requirements of Clause 60.4(b) (an "**Excusing Cause Notice**"), as soon as practicable after becoming aware of an Excusing Cause which has led, is leading or is likely to lead to a failure or delay in the Service Provider performing its obligations under this Agreement;

(b) provide Molina with full details of, in each case as soon as is practicable under the circumstances:

(i) the precise nature of the Excusing Cause and the actual or potential delay or failure;

(ii) the specific obligations that are impacted by the Excusing Cause and how the Excusing Cause prevents or delays the performance of those obligations;

(iii) if the Service Provider seeks relief from Service Levels, the specific Service Levels in respect of which the Service Provider seeks relief and the reasons why the Excusing Cause impacts the Service Provider's ability to meet those Service Levels;

(iv) the specific actions the Service Provider requires Molina to take in order for the Service Provider to resume performance of the Services in accordance with this Agreement; and

(v) the specific actions the Service Provider will to take in order for the Service Provider to mitigate the effect of the Excusing Cause and resume performance of the Services in accordance with this Agreement;

(c) use all reasonable endeavors to continue to perform the affected obligations in accordance with this Agreement notwithstanding the occurrence of any Excusing Cause; and

(d) comply with its obligations under this Agreement that relate to the management and resolution of the effects of the Excusing Cause (including, without limitation, its obligations under Clauses 24 (*Security*) to Clause 27 (*Virus and Harmful Code Protection*)).

60.5 If the Service Provider

(a) fails to comply with Clause 60.4; or

(b) submits an Excusing Cause Notice that does not comply with any of the requirements of Clause 60.4(b),

the Service Provider shall not be excused from liability under Clause 60.2 to the extent that compliance with Clause 60.4 would have mitigated, or would have enabled Molina to mitigate, the effects of the Excusing Cause.

60.6 Where an Excusing Cause contributed to a failure by the Service Provider to meet a Milestone, the Milestone Date for that Milestone (and Molina's obligation to make payment in respect of any Payment Milestone corresponding to that Milestone) shall be automatically extended (without the need for Agreement Change) by a period of time equal to the delay caused by the Excusing Cause (which the Parties acknowledge may not necessarily be exactly the same as the period for which the Excusing Cause itself persisted).

60.7 If an Agreement Change has been made in respect of an Excusing Cause in accordance with Schedule 9 (*Change*), which may include an adjustment to the Charges, the Service Provider is not entitled to any other relief in respect of that Excusing Cause except as set out in the relevant agreed Change Notice.

60.8 Where the Parties cannot agree an Agreement Change to give effect to the adjustment to the Charges, either Party shall be entitled to initiate the Fast-Track Dispute Resolution Procedure, subject to Clause 60.12 and Clause 60.13.

60.9 Where there is a dispute under Clause 60.11, the Independent Expert shall be called upon to determine, and shall provide a formal report (the "Expert Report") specifying:

(a) whether there is an entitlement to a change to the Charges due to an Excusing Cause; and/or

(b) how the Charges should be adjusted based on the Excusing Cause.

60.10 The Independent Expert shall determine the matters set out in Clause 60.9 by confirming all the relevant circumstances, including having regard to the following factors:

(a) whether there has in fact been an Excusing Cause within the meaning of Clause 60; and

(b) if there has been an Excusing Cause, the consequence of all the Excusing Causes in the relevant month is that the Service Provider had to expend more than 160 hours of Service Provider Personnel time in additional effort to perform the Services.

60.11 If the Independent Expert determines these criteria are met, then the Service Provider shall be entitled to adjust the Charges. If an Excusing Cause results directly in any delay in the Service Provider achieving a Milestone, and that delay results directly in the Service Provider incurring additional costs which it is unable to mitigate despite having used

reasonable efforts to do so, the Service Provider shall be entitled to recover those costs from Molina. Where the Service Provider has incurred costs beyond the Delivery Credit amounts provided for above, nothing in this Clause 60.11 shall be taken as preventing the Service Provider in recovering any such amounts by way of damages in accordance with Clause 60.14.

60.12 A claim by a Party ("**Claiming Party**") under this Agreement for damages shall not be defeated because of the fault of the Claiming Party suffering the damage, but the damages recoverable by the Claiming Party in respect of that claim shall be reduced to the extent that the Claiming Party is responsible for the situation giving rise to the claim.

60.13 The acts, delays, failures or omissions of Molina referred to in this Clause 60 shall be deemed to include the acts, delays, failures or omissions of members of the Molina Group.

60.14 Any sums recoverable as an Excusing Cause under the provisions of this Clause 60 (*Excusing Causes*) shall be counted towards the liability cap under Clause 58.4(c) (*Molina's Liability Cap*) and shall be subject to the provisions of Clause 58 (*Indemnification, Liability*), save that the provisions of Clause 58.5(a) relating to loss of profits and loss of revenue shall not apply to the extent that the sums recoverable by the Service Provider are for additional Service Provider Personnel, which shall be charged for in accordance with Appendix 3A (Resource Rates) to Schedule 3 (*Pricing and Invoicing*).

61. FORCE MAJEURE

61.1 Neither Party shall be liable to the other for any breach or delay in performance of its obligations under this Agreement (including the Service Provider's obligation to perform the Services in accordance with the Service Levels) if and to the extent that the breach or delay is caused by a Force Majeure Event.

61.2 The failure of any Subcontractor to perform any obligation owed to Molina shall constitute a Force Majeure Event with respect to the Service Provider's performance of the Services only if and to the extent that the failure by the Subcontractor is itself caused by a Force Majeure Event.

61.3 When a Force Majeure Event has occurred, the non-performing Party shall be excused from further performance of the obligations affected for as long as the circumstances prevail and the non-performing Party continues to use its reasonable endeavors to recommence performance whenever and to whatever extent reasonably possible. Any Party so delayed in its performance shall promptly notify the other Party, and describe at a reasonable level of detail the circumstances causing such delay.

61.4 If a Force Majeure Event causes the Service Provider to allocate limited resources between or among the Service Provider's customers, the Service Provider shall not unreasonably place Molina in lower priority to any other similarly affected customers of the Service Provider. Except as may be required by Applicable Law, in no event shall the Service Provider redeploy or reassign any Key Personnel to another account solely as a result of the occurrence of a Force Majeure Event.

61.5 If the Service Provider is excused from the performance of the Services pursuant to this Clause 61 (Force Majeure) and, as a result, the performance of the Services is substantially prevented, hindered, degraded or delayed for more than thirty (30) consecutive days then, without limiting any other rights it may have, at any time prior to the Service Provider's recommencement of such Services, Molina may terminate this Agreement pursuant to Clause 54.1.

61.6 Notwithstanding any other provision of this Agreement, where the provision of the Services or part thereof is prevented or affected by a Force Majeure Event, then Molina's obligation to pay the Charges shall, to the extent to which those Charges relate to that part of the Services which is so prevented or materially affected, be reduced by such an amount as represents the smallest divisible and separately identifiable portion of the Charges as set out in Schedule 3 (*Pricing and Invoicing*) that relates to and fully covers the suspended Services, until the Service Provider resumes full performance of that part of the Services in accordance with the terms of this Agreement.

PART O ASSIGNMENT AND SUBCONTRACTING

62. ASSIGNMENT; CERTAIN SERVICE PROVIDER FINANCING ARRANGEMENTS

62.1 This Agreement will be binding upon and inure to the benefit of the Parties hereto and their respective successors and permitted assigns.

62.2 Neither Party may assign any of its rights or obligations under this Agreement, by operation of law or otherwise, without the prior written consent of the other Party, which consent will not be unreasonably withheld or delayed. Notwithstanding the foregoing, on written notice to the Service Provider, Molina may assign this Agreement to:

(a) any Molina Company

(b) the successor in a merger of Molina or any Molina Company in which Molina or that Molina Company is not the surviving entity;

(c) any person that acquires Control of Molina or of any Molina Company; or

(d) any person that acquires all or substantially all of Molina's or any Molina Company's assets.

63. SUBCONTRACTING

63.1 The Service Provider shall be entitled to subcontract its obligations under this Agreement to an Approved Subcontractor without notice to Molina, but only for the specific Services and Approved Service Delivery Locations specifically listed against each of the Approved Subcontractors in Schedule 11(*Approved Subcontractors*).

63.2 Where an Approved Subcontractor is an Affiliate of the Service Provider and after entering into a Subcontract ceases to be an Affiliate of the Service Provider, the relevant Approved Subcontractor's status as an Approved Subcontractor shall be automatically revoked unless the Service Provider seeks and obtains Molina's further approval to the continuation of such Subcontract in accordance with Clause 63.3.

63.3 The Service Provider shall require the prior written approval of Molina (which will not be unreasonably withheld or delayed) to subcontract any of its obligations under this Agreement other than to Approved Subcontractors.

63.4 In relation to all proposed Subcontracts, the Service Provider shall promptly:

(a) provide Molina with an explanation as to why the Services are required to be subcontracted and provide Molina with the reasons why a particular Subcontractor is proposed;

(b) give Molina written details of each material amendment to any Subcontract; and

(c) inform Molina in writing of the termination of any Subcontract.

63.5 In relation to each Subcontract to which the Service Provider is a party it shall ensure that:

(a) the Subcontract does not include a provision which would entitle any other party to the Subcontract to terminate it, or cause its automatic termination, on or as a result of the expiry or termination (in whole or in part) of this Agreement;

(b) the Service Provider is entitled to transfer its rights and obligations under the Subcontract to Molina or a Successor Supplier on expiry or termination (in whole or in part) of this Agreement, that no conditions are attached to such entitlement and that, following any such assignment, Molina or the Successor Supplier is entitled to make full use of the subject matter of the Subcontract for the benefit of Molina; and

(c) except to the extent that Molina expressly agrees otherwise in writing, the Subcontract shall contain obligations of the Subcontractor which are no less onerous than those in Clauses 24 (*Security*), 25 (*Business Continuity Management and Disaster Recovery*), 26 (*Major Incidents*), 27 (*Virus and Harmful Code Protection*), 29 (*Intellectual Property Rights*), 30 (*Confidentiality*), 37 (*Policies*), 38 (*Audit and Information Access*), 39 (*HR Obligations*), 48 (*Step-In*), 50 (*Service Relocation*), 62 (*Assignment*), 63 (*Subcontracting*) and 64 (*Disposal of a Molina Company*).

63.6 The Service Provider shall at all times have in place and make full use of an effective selection and monitoring process designed to validate that the Subcontractors have sufficient quality management and control standards and procedures in place to provide reasonable assurance that they will perform and observe their obligations under the Subcontracts.

63.7 Notwithstanding the grant of any Subcontract, the Service Provider is responsible to Molina for the performance and observance of all its obligations under this Agreement and, subject to the limitation of liabilities in Clause 58 (*Indemnification, Liability*), for the consequences of any negligent acts or omissions of the Subcontractor arising in connection with this Agreement.

63.8 All of the obligations, prohibitions and requirements in this Agreement that are applicable to the Service Provider shall in so far as applicable to the sub-contracted Services be equally applicable to Subcontractors. The express reference to a Subcontractor in any provision of this Agreement is for emphasis only and shall not mean that the absence of an express reference to a Subcontractor in another provision means that that provision does not apply to a Subcontractor.

64. DISPOSAL OF A MOLINA COMPANY

64.1 If Molina or any Molina Company transfers a Molina Company or any part of its business or operations that receive the Services to another entity that is not part of the Molina Group, then Molina may remove the transferred business or operations of Molina or the Molina Company from the scope of this Agreement.

64.2 The Charges in respect of the Run Services shall be adjusted in accordance with Schedule 3 (*Pricing and Invoicing*) to reflect removal of a Molina Company or part of the business of Molina or a Molina Company from this Agreement.

64.3 The Service Provider shall, at Molina's cost, comply with the provisions of Schedule 8 (*Termination Assistance and Exit*) in relation to the removed Molina Company or business or operations.

64.4 The Service Provider shall, if requested by Molina, provide the Services to the entity that acquired the Molina Company or business or operations removed from the scope of the Agreement pursuant to this Agreement for a reasonable period designated by Molina which may be up to and including the end of the Term.

65. THIRD PARTY ADMINISTRATION

65.1 Molina may appoint a Third Party (other than a direct competitor of the Service Provider) to administer or manage this Agreement, or to perform Molina's obligations under this Agreement, on behalf of Molina (a "**Third Party Manager**"), and the Service Provider shall provide all cooperation and assistance reasonably required by Molina to allow that Third Party Manager to administer or manage this Agreement, or perform Molina's obligations under this Agreement, as appropriate, provided that this does not materially increase the Service Provider's costs of providing the Services and provided that Molina provides reasonable (and, in any event, not less than thirty (30) Business Days) prior written notice to the Service Provider of the appointment of the Third Party Manager, including reasonable details of the scope of the Third Party Manager's authority as Molina's manager.

65.2 Molina shall at all times remain responsible for the performance of its obligations and liabilities under this Agreement and for the acts or omissions of any Third Party Manager, and shall not in any event take the position that an act or omission of such Third Party was outside the scope of its authority.

65.3 The Service Provider shall, at Molina's request, enter into an Agreed Form NDA with each Third Party Manager.

65.4 Molina shall, at the Service Provider's request, ensure that each Third Party Manager enters into an Agreed Form NDA with the Service Provider.

65.5 Molina shall disclose to each Third Party Manager only such of the Service Provider's Confidential Information as is reasonably necessary for that Third Party Manager to perform its functions in administering or managing this Agreement.

PART P MISCELLANEOUS PROVISIONS

66. FURTHER ASSURANCE

66.1 The Service Provider and Molina shall each, to the extent that it is reasonably able to do so and at the other Party's cost, execute all documents and do all acts and things reasonably required by the other Party to give effect to the terms of this Agreement and the Service Provider shall procure that the Subcontractors do so.

66.2 Throughout the Term, the Service Provider shall ensure that each Key Person and other of its, and its Subcontractors', employees as may be required by Molina execute such agreements, acknowledgements or undertakings as is required by Applicable Law.

67. THIRD PARTY BENEFICIARIES

This Agreement is for the sole benefit of the Parties and their permitted assigns and each Party intends that this Agreement shall not benefit, or create any right or cause of action in or on behalf of, any person or entity other than the Parties and their permitted assigns.

68. NOTICES

68.1 A notice under or in connection with this Agreement shall be in writing, in English and delivered personally or sent by registered first class post (and registered air mail if overseas) or sent by facsimile to the Party due to receive the notice to the address specified in Clause 68.2 and marked for the attention of the representative of the receiving Party specified in Clause 68.4.

68.2 The address referred to in Clause 68.1 is:

(a) in the case of notices to Molina to:

Molina Healthcare, Inc.
Chief Legal Officer
300 University Avenue, Suite 100
Sacramento, CA 95825

With a copy to:

Molina Healthcare, Inc.
Chief Information Officer
200 E. Oceangate, Suite 100
Long Beach, CA 90802

(b) in the case of notices to the Service Provider to:

General Counsel
Infosys Ltd
2400 N Glenville Dr
Richardson, TX 75082

With a copy to:

Michael [redacted]
AVP & Group Manager, Client Services
2400 N Glenville Dr
Richardson, TX 75082

68.3 Unless there is evidence that it was received earlier, a notice under this Agreement is deemed given:

(a) if delivered personally, when left at the address referred to in Clause 68.2;

(b) if sent by mail other than air mail, two Business Days after it is posted;

(c) if sent by air mail, five Business Days after it is posted; and

(d) if sent by facsimile, at the time of sending provided that the sender's facsimile machine provides confirmation of error-free transmission to the correct number.

68.4 The representative for each Party is as follows:

(a) for (1) a notice to terminate this Agreement or a Project Work Order, in each case whether in whole or in part; (2) a notice that the sending Party is seeking or intends to seek a remedy or order from a court or other tribunal; (3) a notice that the sending Party is making or intends to make a claim under any indemnity; (4) a Step-In Notice or a notice by Molina exercising its rights under Clause 49 (*Enhanced Co–Operation*); or (5) a notice alleging a breach of this Agreement or a Project Work Order by the receiving Party or a member of its Group:

(i) Chief Legal Officer (with a copy to the Chief Information Officer) (if the receiving Party is Molina); and

(ii) General Counsel (with a copy to AVP & Group Manager, Client Services) (if the receiving Party is the Service Provider);

(b) for a notice that Schedule 7 (*Governance*) provides should be sent to a particular representative of the receiving Party, that representative; and

(c) for all other notices:

(i) Chief Information Officer (with a copy to the Chief Legal Officer) (if the receiving Party is Molina); and

(ii) Michael [redacted] (with a copy to General Counsel) (if the receiving Party is the Service Provider).

68.5 Either Party may change its representative for the purposes of Clauses 68.4(a), 68.4(b) or 68.4(c) by notifying that representative's counterpart under Clause 68.4. Either Party may change its address for the purposes of Clause 68.2 in accordance with Clause 68.4(c).

69. **ENTIRE AGREEMENT**

69.1 This Agreement, and any other documents incorporated into this Agreement, constitutes the entire understanding between the Parties with respect to its subject matter, and supersedes all prior proposals, marketing materials, negotiations, representations (whether negligently or innocently made), agreements and other written or oral communications between the Parties with respect to the subject matter of this Agreement.

70. **WAIVER**

70.1 A failure to exercise or delay in exercising a right or remedy provided by this Agreement or by law does not constitute a waiver of the right or remedy or a waiver of other rights or remedies.

70.2 No single or partial exercise of a right or remedy provided by this Agreement or by law prevents a further exercise of the right or remedy or the exercise of another right or remedy.

70.3 No waiver of any breach of this Agreement, and no course of dealing between the Parties, will be construed as a waiver of any subsequent breach of this Agreement.

70.4 Except where otherwise explicitly agreed, all remedies in this Agreement are cumulative and not exclusive of any other remedy or right in this Agreement or at Law or in equity.

70.5 Where there is a failure or delay by the Service Provider to meet any Milestone or any other obligation where a time period is stipulated and Molina does not exercise its rights in a timely manner then any delay in enforcing its rights shall not constitute a waiver of rights by Molina. If the Service Provider has not met a Milestone or time related obligation and Molina has not exercised its rights in a timely manner, then Molina does not need to issue any notice other than any notice stipulated in this Agreement prior to enforcing its available remedies.

70.6 Without prejudice to the generality of Clauses 70.1 to 70.5, the Service Provider accepts and agrees that:

(a) because the continued and uninterrupted provision of the Services is of importance to Molina, Molina may elect not to exercise its rights or remedies provided by this Agreement or by law immediately upon those rights or remedies becoming exercisable, and may continue to pay the Charges and/or attempt to negotiate an agreement, arrangement, settlement or compromise with the Service Provider in circumstances where those rights or remedies are exercisable;

(b) the Service Provider shall not be entitled to claim that, by reason of such delay in exercising its rights or remedies, continued payment or attempted negotiation, Molina is prevented from exercising any of its rights or remedies provided by this Agreement or by law (whether based on waiver, estoppel, laches or any other legal principle or theory) provided that the foregoing shall not be construed as a waiver; and

(c) in circumstances where the Service Provider fails to perform any obligation under this Agreement, the acceptance by Molina of different, partial or late performance of that obligation, or the agreement by Molina to any plan for the remedy of that failure, shall not prejudice any of Molina's rights or remedies provided by this Agreement or by law in respect of that failure (whether based on waiver, estoppel, laches or any other legal principle or theory) or an express or implied election by Molina to affirm this Agreement.

71. **NO PARTNERSHIP**

No provision of this Agreement creates a partnership between the Parties or makes a Party the agent of another Party for any purpose. Neither the Service Provider nor Molina has any authority to bind, to contract in the name of or to create a liability for such other Party in any way or for any purpose. No Service Provider personnel shall obtain the status of or otherwise be considered a Molina employee by virtue of their activities under this Agreement. The rights and obligations of Molina under this Agreement may be exercised or performed by one or more Molina Company.

72. **SEVERABILITY**

72.1 The provisions contained in each Clause of and Schedule to this Agreement are enforceable independently of each other and the validity of this Agreement will not be affected if any Clause of or Schedule to this Agreement (or part thereof) is invalid or otherwise unenforceable.

72.2 If a Clause of or Schedule to this Agreement (or any part thereof) is void, but would be enforceable if any part of the provision was deleted, the provision in question will apply with such deletion, but only to the extent that the meaning of the provision is not altered by that deletion.

73. **COUNTERPARTS**

This Agreement may be executed in any number of counterparts, each of which when executed and delivered is an original, but all the counterparts together constitute the same document.

74. **DISPUTE RESOLUTION AND DISPUTE MANAGEMENT**

74.1 Subject to Clause 74.2, Schedule 7 (*Governance*) shall apply to any dispute, controversy, claim or proceeding arising out of or in connection with this Agreement (a "**Dispute**") and the Parties shall have the rights and obligations relating to dispute resolution and management as set out in Schedule 7 (*Governance*).

74.2 There are separate and specific dispute resolution provisions in Schedule 9 (*Change*) that deal with failures to agree certain aspects of Agreement Change.

74.3 Any provision of this Agreement which requires one Party to provide information to the other Party shall apply to any given information, notwithstanding that that information may

be pertinent to an actual or potential Dispute or prejudicial to either Party's position in any actual or potential Dispute or otherwise. Neither Party shall be entitled to withhold or delay the provision of such information on the grounds that it is pertinent to an actual or potential Dispute or prejudicial to either Party's position in any actual or potential Dispute or otherwise. This Clause 74.3 shall not be construed as a Party's waiving its protections under attorney-client privilege or the attorney work product doctrine under Applicable Law.

74.4 If either Party brings any claim against the other in which fraud is not pleaded, and the pleading Party subsequently discovers evidence that suggests fraud on the part of the other Party (or in the case of the Service Provider, its Subcontractors), the pleading Party shall be entitled to amend its pleadings accordingly and the other Party may not argue that the pleading Party is not so entitled.

75. GOVERNING LAW AND JURISDICTION

75.1 This Agreement is governed by, construed in accordance with, and enforced under the substantive Law of the State of New York, without giving any effect to any contrary choice of law or conflict of law provision or rule (whether of the State of New York or any other jurisdiction). Any claim or action brought by a Party in connection with this Agreement, or any part hereof, will be brought in the appropriate federal or state court located in the State of New York, New York County, and the Parties irrevocably consent to the exclusive jurisdiction of such courts. The United Nations Convention on Contracts for the International Sale of Goods and New York conflict of Law rules do not apply to this Agreement or its subject matter. In any action relating to this Agreement, each of the Parties irrevocably waives the right to trial by jury.

75.2 Either Party may refer any Judgment Payment Dispute relating to this Agreement for binding arbitration conducted by a single arbitrator in accordance with the AAA Commercial Arbitration Rules, then in effect, in Long Beach, California. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law or award punitive damages. The arbitrator shall have no authority to review the basis for or the substantive merits of the Judgment Payment Dispute, and the arbitrator's purview shall instead be limited to the enforcement of the Judgement Payment Dispute. Each Party shall bear its own costs and expenses in connection with such arbitration, including attorneys' fees, and the Parties shall equally bear the arbitrator's fees and expenses. The Parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction.

EXECUTED BY THE PARTIES:

EXECUTED by)
MOLINA HEALTHCARE, INC.)
)
through its duly authorized person,)
)
)
Signature: _____)
Name: _____)
Title: _____)

EXECUTED by)
INFOSYS LIMITED)
)
through its duly authorized person,)
)
)
Signature: _____)
Name: _____)
Title: _____)

SCHEDULE 1

DEFINITIONS AND INTERPRETATION

1. DEFINITIONS AND INTERPRETATION

1.1 In the Agreement capitalized terms shall have the meaning given to them in this Schedule 1 (*Definitions and Interpretation*) and as otherwise determined in the Agreement.

2. IN THE AGREEMENT (UNLESS THE CONTEXT REQUIRES OTHERWISE):

2.1 the words "including", "include", "for example", "in particular" and words of similar effect shall not be deemed to limit the general effect of the words which precede them and "including", "include" and "for example" shall be continued to have the words "but not limited to" following them;

2.2 reference to any agreement, contract, document or deed shall be construed as a reference to it as varied, supplemented or novated from time to time;

2.3 reference to a party shall be construed to include its successors and permitted assigns or transferees;

2.4 words importing persons shall include natural persons, bodies corporate, un incorporated associations and partnerships (whether or not any of them have separate legal personality);

2.5 words importing the singular shall include the plural and vice versa;

2.6 words importing any one gender shall include other genders;

2.7 the headings, index and front sheet are all for reference only and shall be ignored when construing the Agreement;

2.8 references to a clause, schedule, paragraph or appendix are references to the clause, schedule, paragraph or appendix of, or to, the Agreement;

2.9 reference to any legislative provision shall be deemed to include any statutory instrument, by law, regulation, rule, subordinate or delegated legislation or order and rules and regulations which are made under it and any subsequent re-enactment or amendment of the same;

2.10 if this Agreement is translated and there is any conflict, ambiguity or inconsistency between the English language version and the translated version, then the English version shall prevail;

2.11 if there is any conflict, ambiguity or inconsistency between the parts of the Agreement, then the following order of precedence shall apply and the document higher in the order of precedence will prevail and represent the binding obligation of the Parties:

(a) the clauses;

(b) the schedules;

(c) the appendices; and

(d) the annexes.

2.12 If there is a conflict or inconsistency between any provision of this Agreement and any provision of a Project Work Order, the provision of this Agreement shall prevail. A variation of the terms of this Agreement as they apply to any Project Work Order, properly made in accordance with Clause 13.3(f), is not a conflict or inconsistency for the purposes of this paragraph 2.12.

2.13 If there is a conflict or inconsistency between any provision of Schedule 21 (*Service Provider Technical Solution*) and any other provision or any document incorporated into or attached to this Agreement (including any provision of any other Schedule), that other provision will prevail and represent the binding obligation on the Parties.

2.14 No provision of Schedule 21 (*Service Provider Technical Solution*) shall in any way affect the interpretation of any other provision of this Agreement, and no obligation of the Service Provider under any other provision of this Agreement shall be interpreted having regard to any provision of Schedule 21 (*Service Provider Technical Solution*).

2.15 "**person**" includes any individual, corporation, partnership, firm, joint venture (whether incorporated or not), trust, government or governmental body, authority, agency or unincorporated organization or association of persons;

2.16 an obligation to "**procure**" a result shall mean that the result a Party is required to procure shall be achieved;

2.17 "**day**", "**month**" and "**year**" means a calendar day, a calendar month and a calendar year, respectively

2.18 a restriction or obligation on the Service Provider is to be construed so as to require the Service Provider to abide by the restriction or comply with the obligation and procure that all Service Provider Personnel and Subcontractors do likewise;

2.19 the Service Provider "**remedying**" a breach or default, or a breach or default being "**remedied**" means that the Service Provider must:

(a) correct all technical, procedural and management errors and failings (other than those errors or failings of Molina or its Third Party contractors, but excluding any member of the Service Provider Group or any Subcontractor or any of their respective Third Party contractors) that caused or contributed to the breach or default, so that any similar breach or default will not occur in the future; and

(b) restore the affected services or activities (other than those for which the Service Provider has no responsibility under this Agreement) so that they are provided or performed in all respects in accordance with this Agreement;

2.20 the Service Provider having to keep, maintain, store or hold information, Data, records or Materials under this Agreement without a reference to the length of time for which it must be kept, maintained, stored or held is an obligation to keep, maintain, store or hold that information, Data, records or Materials for seven (7) years from the later of the date of its creation or the date it is processed, stored or transmitted under this Agreement;

2.21 a material breach of this agreement includes an anticipatory breach (as that term is defined at common law) which would, if the breach that is anticipated occurred, be a material breach; and

2.22 "**24x7x365**" means 24 hours a day, 365 days a year (or 366 days in a leap year), that is to say, at all times.

2.23 Whether one Project Work Order is "**Linked**" to another Project Work Order shall be determined in accordance with Clause 13.5.

2.24 A reference in this Agreement to this Agreement includes each Project Work Order unless the context requires otherwise, but this does not apply to references to the termination of this Agreement or any right of either Party to terminate this Agreement.

2.25 An obligation to take "**Appropriate Actions**" to achieve any result is an obligation to take such actions as a party acting in a determined, prudent and reasonable manner would take to achieve that result if it were in that party's own interests to achieve that result, taking into account all relevant circumstances and the cost of taking a particular action.

2.26 The headings in this Agreement and the names given to defined terms are for convenience only, and do not affect the interpretation of this Agreement.

2.27 All documents, notices, correspondence and information required to be produced under this Agreement shall be in English, unless this Agreement expressly provides otherwise.

2.28 If there is any discrepancy between an English language word or series of words and a word or series of words used in any other language relating to the same subject matter, then, to the extent of such discrepancy only, the meaning of the English language word or series of words shall prevail.

2.29 All words and phrases used in this Agreement (whether capitalized or not) shall bear their ordinary meaning unless they are defined as having a particular meaning or required to be construed in a particular manner.

2.30 Each of the conditions, terms, representations and warranties in this Agreement are to be construed independently of the others.

2.31 The inclusion of provisions in the Agreement stating that a particular obligation must be performed at no cost or no charge to Molina (or similar words) should not be taken to conclusively mean that other obligations without similar wording are necessarily subject to additional charges.

2.32 The actions and omissions of the employees, agents, contractors, officers, or attorneys of the Service Provider or a Subcontractor shall be deemed to be the actions of the Service Provider or the Subcontractor as the case may be (and in the case of the Subcontractor the Service Provider shall be liable to Molina for such actions or omissions), and the Service Provider shall be vicariously liable for all such actions and omissions, irrespective of whether:

(a) the Service Provider or Subcontractor authorized the actions or omissions; or

(b) the actions or omissions were willful, deliberate, illegal or fraudulent in connection with the performance of the Services; or

(c) the actions or omissions were in contravention of instructions.

2.33 The actions and omissions of the employees, agents, contractors, officers, or attorneys of Molina shall be deemed to be the actions of Molina, and Molina shall be vicariously liable for all such actions and omissions, irrespective of whether:

(a) Molina authorized the actions or omissions; or

(b) the actions or omissions were willful, deliberate, illegal or fraudulent in connection with the receipt of the Services; or

(c) the actions or omissions were in contravention of instructions.

2.34 Where a provision of this Agreement requires Molina or the Service Provider to procure, ensure or cause the performance of an obligation under a Project Work Order by a Molina Company or a Service Provider Company, or a contractor or agent of Molina, the Service Provider, a Molina Company or a Service Provider Company:

(a) the obligation to so procure, ensure or cause the performance of such obligation shall not be discharged by any amendment or variation to the Project Work Order, or any waiver, forbearance, relaxation, indulgence or delay by either party under the Project Work Order;

(b) the Party obligated to so procure, ensure or cause the performance of such obligation shall remain the primary obligor with respect to procuring, ensuring or causing the performance of such obligation; and

(c) to the extent that any such obligation is amended or varied from time to time, the obligation of Molina or the Service Provider, as the case may be, to procure, ensure or cause the performance of such obligation by such Molina Company or Service Provider Company shall extend to such amended or varied obligation.

3. **IN THIS AGREEMENT**

"**Acceptance**" means that Molina confirms in writing via a Milestone Acceptance Certificate, that the Acceptance Criteria has been fully satisfied in respect of the relevant Acceptance Tests and "**Accept**" and "**Accepted**" shall be construed accordingly;

"**Achieved**", in respect of a Milestone, means that all of the Deliverables corresponding to that Milestone have been Passed and "**Achievement**" shall be construed accordingly;

"**AD Service Provider**" means each Other Service Provider that carries out development (including Modification) and/or integration of Software for Molina or any other Molina Company from time to time;

"**Affected Services**" means the identified Services influenced or touched by an external factor;

"**Affiliate**" means, in relation to a Party, each entity that it Controls or is under common Control with that Party;

"**Agreed Cost Standards**" means the standards specified in Schedule 3 (*Pricing and Invoicing*), which are to be applied to any proposed Charge Adjustment, Benchmarking Adjustments and/or one-off fees resulting from an Agreement Change during the Term;

"**Agreed Form Non-Disclosure Agreement**" or "**Agreed Form NDA**" means an agreement in the form of Schedule 19 (*Agreed Form Non-Disclosure Agreement*);

"**Agreed Interest Rate**" is the rate of [redacted];

"**Agreement**" means these terms and conditions of this Master Services Agreement which include the recitals, the attached schedules, appendices and annexes, together with any Statements of Work or Project Work Orders and any incorporated documents (and, as the context requires, shall include the same as they are incorporated into a Statement of Work or Project Work Order in conjunction with the terms of such Statement of Work or Project Work Order);

"**Agreement Change**" means an MSA Change or a Project Change including any of the Schedules and the Appendices to the Schedules, or any other document incorporated into this Agreement or any Project Work Order, but does not include any change to any of the Policies (the term "**Change**" shall have the same meaning);

"**Aggregated Amount Invoiced**" has the meaning given in Schedule 3 (*Pricing and Invoicing*);

"**Agile Delivery Model**" refers to the Agile software development methodology;

"**Allocation**" means the amount or portion of a resource assigned to a recipient;

"**Allocation of Pool Percentage**" means the portion of the Pool Percentage Available for Allocation allocated to a given Service Level in Appendix 3-A (*Service Level Matrix*);

"**AM Service Provider**" means each Other Service Provider that carries out the maintenance, management and/or operation of Software for Molina or any other Molina Company from time to time;

"**Analysis**" means the detailed examination of the elements or structure of something complex to understand its nature or to determine its essential features;

"**Annual Invoice**" means the annual Charges accrued in each Contract Year;

"**Applicable Law**" means:

(a) laws, rules, regulations, regulatory guidance and regulatory requirements; and

(b) any form of secondary legislation, resolution, policy, guideline, concession or case law of the relevant jurisdiction having the force of law;

in each case, that are relevant to the provision, receipt or use of the Services;

"**Application**" means any Software whether owned by or licensed to Molina, including associated configuration and parameterization and all associated data created or processed by such Software;

"**Approved Service Delivery Locations**" means the locations (including the locations of a Subcontractor) approved by Molina for delivery of the Services and listed in Schedule 10 (*Approved Service Delivery Locations*) from time to time;

"**Approved Subcontractors**" means those Subcontractors listed in Schedule 11 (*Approved Subcontractors*);

"**Asserted Tax Liability**" has the meaning given in Clause 43.5(b);

"**Assets**" means Software, Systems, Materials and all other assets that are involved in the delivery of the Services or otherwise used in relation to this Agreement;

"**Asset Register**" means the register of the Intellectual Property Rights, systems and other assets used by the Service Provider to provide the Services and perform its obligations under the Agreement;

"**Asset Transfer Expenses**" has the meaning given in Schedule 3 (*Pricing and Invoicing*);

"**Assumption**" means a statement of fact on which the provision of the Services, including the Deliverables, under a Project Work Order is dependent, as set out in that Project Work Order;

"**At Risk Amount**" means the [redacted];

"**At Risk Percentage**" has the meaning given in Schedule 6 (*Service Levels and Service Credits*);

"**Authorized User**" means a user of Services within and outside of Molina, including but not limited to Molina Healthcare, Third Parties, customers, contractors, Molina divested entities, and joint ventures;

"**Authorized Persons**" means, in relation to either Party, any director, officer, employee, representative or professional adviser (such as lawyers, accountants and consultants) of a Party (or in the case of Molina, of a Molina Company, and in the case of Service Provider, a Service Provider Company), to whom disclosure of Confidential Information is necessary to fulfil the Permitted Purpose and in relation to professional advisers only those who have entered into agreements containing confidentiality terms no less stringent than those set out in this Agreement or are subject to professional obligations no less stringent than those in this Agreement;

"**Average Amount**" has the meaning given within Schedule 6 (*Service Levels and Service Credits*);

"**Baselines**" has the meaning given in Schedule 3 (*Pricing and Invoicing*);

"**Baseline Unit**" means the benchmark that is used as a foundation for measuring or comparing current and past values as it relates to the Services;

"**Baselining Period**" has the meaning given to it in Paragraph 9 of Schedule 6 (*Service Levels and Service Credits*);

"**BAU Personnel**" means Service Provider Personnel who are not part of the Service Provider's Incident Response Team and who are involved in the provision of the Services on a day–to–day basis;

"**BCP/DR Plan**" means the business continuity and disaster recovery plan set out in or required by Schedule 23 ;

"**Benchmarking Threshold**" an amount, as determined on a Service Bundle by Service Bundle basis, that is [redacted].

"**Benchmarking Adjustment**" means a reduction in the Charges in accordance with paragraph 9 of Schedule 5 (*Benchmarking*);

"**Benchmarking Process**" has the meaning given in paragraph 3.1 of Schedule 5 (*Benchmarking*);

"**Benchmarking Termination Fee**" means [redacted] of the fee that would be payable by Molina as a Termination for Convenience fee had Molina terminated pursuant to Clause 55 (*Termination for Convenience*) of the Agreement;

"**Business Continuity Plan**" means the BC/DR Plan;

"**Business Days**" means those days deemed by Molina to be standard working days according to Molina's business operations and designated holidays both globally and within a given jurisdiction (e.g., Region, country, city). For the avoidance of doubt, weekends, public holidays, and Service Provider-designated holidays shall not be considered Business Days unless otherwise designated by Molina;

"**Change Control Process**" means the process for agreeing Agreement Changes, as described in Schedule 9 (*Change*); (the term "**Change Procedure**" shall have the same meaning);

"**Change Management**" means the process for controlling the lifecycle of all changes to Applications, reports, contractual documents, and any other Services, Deliverables, or work products under this Agreement. The primary objective of Change Management is to enable beneficial changes to be made, with minimum disruption to IT services and Applications in accordance with the Molina Change Management policy;

"**Change Notice**" means the formal record of an Agreement Change constituting the complete statement of the required amendment to this Agreement or a Project Work Order, and Charge Adjustments or one-off fees or any combination of the two relating to this Agreement or Project Work Order, which, in the case of an MSA Change shall be in substantially the same form as the template contained at Appendix 9C (*Change Notice*) to

Schedule 9 (*Change*), and in the case of a Project Change, shall be a Project Change Request that is executed by both Parties and that attaches a conformed copy of the relevant Project Work Order;

"**Change of Control**" means a change in Control of the Service Provider, other than a listing on a recognized stock exchange;

"**Change Request**" or "**CR**" has the meaning given in paragraph 6.2 of Schedule 9 (*Change*);

"**Change Start Date**" means the date on which an Agreement Change takes effect;

"**Charge Adjustment**" means an increase or decrease to the Charges, an additional Charge, a one-off fee or the removal of an existing Charge, in accordance with the Change Control Process;

"**Charge Deductions**" means Service Credits, and Delivery Credits;

"**Charges**" means the charges set out in and/or calculated pursuant to Schedule 3 (*Pricing and Invoicing*);

"**Charges Commencement Date**" means, in respect of each Service, the date on which the Service Provider is entitled to commence issuing Official Invoices in respect of such Service, as set out in Appendix 3-A of Schedule 3 (*Pricing and Invoicing*);

"**Claim**" means any demand, or any civil, criminal, administrative, or investigative claim, action, or proceeding (including arbitration), or any allegation, in each case, made, asserted, commenced or threatened by a third party, including any demand, or any civil, criminal, administrative or investigative claim, action, proceeding, or any allegation made, asserted, commenced or threatened by any Regulatory Authority;

"**Claiming Party**" has the meaning given in Clause 60.12;

"**Co-Location Data Centers**" means a data center facility in which a business can rent space for servers and other computing hardware and where the building, cooling, power, bandwidth, and physical security are provided;

"**Compute Capacity**" means the physical or logical allocation of storage or processing power;

"**Confidential Information**" means this Agreement and all information of a confidential nature that is marked with a restrictive legend of the disclosing Party (or a member of its Group), or that is clearly identified as confidential at the time of disclosure, or that is manifestly of a confidential nature, disclosed (by whatever means, directly or indirectly) by either Party (or the disclosing Party's subcontractors, agents, consultants or employees) to the other Party (or that receiving Party's subcontractors, agents, consultants or employees) and which relates to the disclosing Party's (or any member of its Group's) business, including any information of a confidential nature relating to the products, operations, processes,

plans, intentions, product information, market opportunities or business affairs of the Party making the disclosure or its contractors, suppliers, customers, clients or other contacts;

"**Configuration Management Database**" means a repository that acts as a data warehouse for information technology installations and that holds data relating to the configuration of IT assets;

"**Consents**" means all approvals, consents, licenses, permissions and authorizations required from any government or similar body or any regulatory authority;

"**Consultants**" has the meaning given in Clause 49.1;

"**Continuous Process Improvement**" means the ongoing effort to improve products, services, or processes;

"**Contract Year** " means the period starting on the Effective Date and ending on the first anniversary of that date, and each successive period of twelve (12) months thereafter;

"**Control**" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Party, whether through the ownership of voting securities, by contract, or otherwise, and "Controls" and "Controlled" shall be construed accordingly;

"**Controlled Items**" has the meaning given in Clause 8.11(a);

"**Controls Audit Report**" has the meaning given in Clause 38.13

"**Converged IT**" means grouped information technology (IT) components in a single, optimized computing package, including servers, data storage devices, networking equipment and software for IT infrastructure management, automation, and orchestration;

"**Critical Service Levels**" or "**CSLs**" means the Service Levels identified as such in Schedule 6 (*Service Levels and Service Credits*) or any Local Agreement or Services Order;

"**Core Working Hours**" means the hours that the Service Provider is expected to provide support and availability to Molina counterparts

"**Customer**" means the person or organization that buys or received goods or services from Molina;

"**Customer Precise Equipment**" means a telephone, terminal, router or associated equipment located at Molina premises connected with carrier's telecommunication circuits;

"**Customized Software Deliverable**" has the meaning given in Clause 16.2;

"**Data**" means Molina Data and Service Provider Data;

"**Data Definition Language**" means a syntax similar to a computer programming language for defining data structures, especially database schemas;

"**Data Enrichment**" means the method of preparing data so that it is ready for analysis and exploitation;

"**Data Network**" means a digital telecommunications network which allows access points (nodes) to share resources and data through data switching, system control, and interconnection transmission;

"**Data Protection Laws**" has the meaning given in Clause 34.1(a);

"**Debugging**" means the process of finding and resolving defects or problems within a computer program that prevent correct operation of computer software or a system;

"**Dedicated Equipment**" means the Assets used by the Service Provider to perform the Terminating Services and for no other purpose;

"**Default**" means, in relation to this Agreement, any act, statement or omission on the part of the Party in breach of this Agreement or any tortious act or omission in connection with, or in relation to, the subject matter of a transaction under this Agreement in respect of which the Party in breach is liable to the other in contract or the Party that committed the tortious act is liable to the other in tort.

"**Delay Payments**" means payments due from the Service Provider to Molina pursuant to Schedule 4 (*Transition and Transformation*) and/or as set out in any Services Order or Local Agreement;

"**Deliverable**" means each System, document or other item or deliverable that the Service Provider delivers or is required to deliver under this Agreement, a Project Work Order or Transition Project, and includes any such System, document or other item or deliverable that is a Modified form or a derivative work of, or that incorporates, an Input Deliverable;

"**Delivery Credit Milestone**" means any Transition Milestones which, if the Service Provider fails to achieve it, will result in the payment of Delivery Credits by the Service Provider as set out in Schedule 4 (*Transition and Transformation*);

"**Delivery Credits**" means credits against the amounts that must be paid or credited to Molina by the Service Provider if the Service Provider fails to meet a Delivery Credit Milestone in accordance with, as applicable, Schedule 4 (*Transition and Transformation*) or the applicable Project Work Order;

"**Delivery Date**" means the date on which a Deliverable is required to be delivered to Molina by the Service Provider, as set out in, as applicable, Schedule 4 (*Transition and Transformation*) or the applicable Project Work Order;

"**Deployment Plan**" means the plan that defines the sequence of steps or activities that must be carried out to execute change in the target environment;

"**Depot Services**" means the services performed on end user devices requiring exchange, repair, shipping, receiving, or storage as detailed within Exhibit 2-C (End User Services);

"**Disaster**" means an unplanned event affecting services or Systems which prevents Molina from providing critical business functions, and the resulting interruption is causing or is likely to cause: material financial losses to any Molina Company; legal or regulatory compliance failure; and/or loss of life or creation of patient safety risks;

"**Disaster Recovery**" means the documented processes, or set of technical procedures, to Recover the impacted part of the Systems, following a Disaster, and includes the Restoration of:

(a) Services, so that they are provided in accordance with all Molina requirements specified in this Agreement; and

(b) Systems so that they are provided in accordance with all applicable specifications;

"**Disaster Recovery Plan**" means a BCP/DR Plan;

"**Disaster Recovery Services Management**" means the management of the delivery of Services as they relate to Disaster Recovery;

"**Disclosing Party**" has the meaning given in Clause 30.1;

"**Dispute**" has the meaning given in Clause 74.1;

"**Dispute Resolution Procedure**" has the meaning given in Schedule 7 (*Governance*);

"**Divested Affiliate**" means any entity that was a member of Molina's Group as at the Commencement Date but which ceases to be a member of Molina's Group at any time during the Term;

"**Due Date**" has the meaning given within Schedule 3 (*Pricing and Invoicing*);

"**Effective Date**" means the date that this Agreement was entered into;

"**Embedded Service Provider IP**" means any Service Provider IP that is incorporated within a Deliverable;

"**Emergency Software**" or "**Patches**" means releases that contain files to a small number of urgent problems;

"**End User**" means, in respect of any Service, the employees, officers, agents and contractors of a Molina Company or of an External User;

"**Endpoint Encryption Services**" means the services used to encrypt the end user devices in order to protect the data and ensure regulatory compliance;

"**Enhancements**" means changes or additions, other than New Versions or Modifications, to the Software (or any constituent parts thereof) that improve or add new functions;

"**Equipment**" means any and all computing, networking and communications equipment procured, provided, operated, supported, or used by a party or its Personnel or users in connection with the Services, including:

(a) mainframe, midrange, server and distributed computing equipment and associated attachments, features, accessories, peripheral devices, and cabling;

(b) personal computers, laptop computers, terminals, workstations, personal data devices and associated attachments, features, accessories, printers, multi-functional printers, peripheral or network devices, and cabling; and

(c) voice, data, video and wireless telecommunications, network and monitoring equipment and associated attachments, features, accessories, peripheral devices, cell phones and cabling;

"**Excusing Cause**" has the meaning given in Clause 60.2;

"**Existing Service Provider**" means an entity providing services to be substituted by all or part of the Services;

"**Exit Criteria**" means the criteria to be satisfied to demonstrate that the Acceptance Tests have been successful completed;

"**Exit Milestone**" means a state of affairs as described in the Exit Plan;

"**Exit Milestone Date**" means the date by which the associated Exit Milestone must have been achieved, as specified in the Exit Plan;

"**Exit Period**" has the meaning given in Schedule 8 (*Termination Assistance and Exit*);

"**Exit Plan**" means each plan that the Service Provider is required to make available and maintain under Schedule 8 (*Termination Assistance and Exit*);

"**Expected Service Level Target**" means the higher performance requirement of Service Provider as detailed within Schedule 6 (*Service Levels and Service Credits*);

"**Expiry Date**" means the Initial Expiry Date or, if this Agreement is extended in accordance with Clause 4 (Extension of the Term), the date set out in the most recent Renewal Notice from time to time;

"**Extended Term**" has the meaning given in Clause 4.3;

"**External Users**" means any third party with whom Molina has a research, marketing or development or collaboration or supply relationship (that is related to the core business of Molina) that is not a Molina Company and that Molina nominates to receive any of the Services;

"**Facilities**" or "**Facility**" means all Approved Locations;

"**Fail**" means that a Deliverable has not Passed, and "Failed" shall be interpreted accordingly;

"**Fair Market Price**" means the median of the market range of prices for services against which the Benchmarker compares the Benchmarked Services;

"**FDA**" means the U.S. Food and Drug Administration;

"**Financial Responsibility Matrix**" has the meaning given in Schedule 3 (*Pricing and Invoicing*);

"**Final Milestone**" means the final Milestone under a Project Work Order;

"**Final Payment Milestone**" means the final Payment Milestone under a Project Work Order;

"**Final Transition Milestone**" means the Milestone labeled as such in Schedule 4 (*Transition and Transformation*) or the Detailed Transition Plan;

"**First Call Resolution**" means properly addressing the end user's need the first time they call, thereby eliminating the need for the end user to follow up with a second call;

"**First Go Live Date**" means the first date the Service Provider assumes operational responsibility for the performance of the Services.

"**Fixed Fee**" means those Charges that are set at a fixed and defined amount and are not subject to adjustment except as otherwise specified in Schedule 3 (*Pricing and Invoicing*) or a Work Order under the Agreement;

"**Flexible Asset Resource Unit**" means the units of measurement for the delivery of resources applicable to the Services which is only for provision of any Equipment, Software, systems or other commodities and appliances for which distinct volumes are measured and charging rates or other charging mechanisms apply. The particular Resource Units applicable under the Agreement shall be set forth in Schedule 3 (*Pricing and Invoicing*) of the Agreement;

"**Force Majeure Event**" means:

(a) fire, flood, earthquake, tsunami, element of nature or act of God;

(b) war, explosion, acts or threatened acts of terrorism, riot, civil disorder, rebellion or revolution;

(c) epidemic or pandemic directly affecting a Party's personnel;

(d) actions of government that prevent a Party from performing its obligations, or transport or communication services or energy supply within a country becoming generally unavailable for reasons outside the Party's control,

but in each case only if and to the extent that the non-performing Party is without fault in causing the breach or delay, and the breach or delay could not have been prevented without unreasonable expense by reasonable precautions and measures and cannot reasonably be circumvented by the non-performing Party at its expense through the use of alternate sources, work around plans or other means. A strike or other employment dispute of either Party's personnel that affects only such Party's employees shall not be deemed a Force Majeure Event for that Party;

"**FTE**" means full time equivalent;

"**Function-as-a-Service**" or "**FaaS**" means a category of cloud computing services that provides a platform allowing customers to develop, run, and manage application functionalities without the complexity of building and maintaining the infrastructure typically associated with developing and launching an application;

"**Go Live**" means assumption by the Service Provider of operational responsibility for the performance of the Services;

"**Go Live Date**" means a date on which the Service Provider actually assumes operational responsibility for the performance of the Services;

"**Go Live Milestone**" means a Milestone by which the Service Provider is to Go Live, as specified in Schedule 4 (*Transition and Transformation*) or any Services Order;

"**Good Industry Practice**" means in respect of each individual Service that level of skill, care, prudence, judgment, foresight, integrity and diligence that would be reasonably expected of a global market leading provider of services similar to the Services;

"**Governance Board**" or "**Governance Body**" means a committee described in and established pursuant to Schedule 7 (*Governance*);

"**Group**" means either or both of the Molina Group and the Service Provider Group as the context requires;

"**Hardware**" means a physical item of computer equipment, including laptops, desktops and tablet devices, servers and network and communications equipment, as well as peripherals that can be connected to a computer including keyboards, mice, monitors and printers;

"**Harmful Code**" has the meaning given in Clause 27.1(a);

"**Import/Export Laws**" has the meaning given in Clause 8.11(a);

"**Incident**" means any event which is not part of the standard operation of any System and which causes, or may cause, an interruption or a reduction of the quality of that System;

"**Incident Detection, Analysis and Response**" means the process to determine whether the incident is occurring, analyze the nature of the incident, notify stakeholders of the occurrence, and develop a mitigation plan;

"**Incident Management**" means the process for managing the lifecycle of all Incidents. The primary objective of Incident Management is to return the Application to full operation as quickly as possible;

"**Incident Response Team**" means the Service Provider's team responsible for the resolution of Major Incidents;

"**Incident Triage and Escalation**" means the first post-detection incident response process to structure a mitigation plan;

"**Indemnified Party**" has the meaning given in Clause 58.3;

"**Indemnifying Party**" has the meaning given in Clause 58.3;

"**Independent Expert**" means a Third Party that is agreed by the Parties to serve as an independent expert with respect to the matters set out in Clause 60 (*Excusing Causes*) of the Agreement;

"**Information Security Policy**" means the security-related policies as set out in Schedule 24 (*Certain Security Requirements*) to the Agreement;

"**Information Technology Service Management**" means the entirety of activities – directed by policies, organized and structured in processes and supporting procedures – that are performed by an organization to design, plan, deliver, operate and control information technology (IT) services offered to customers;

"**Infrastructure**" means the basic, underlying framework or features of a system or organization;

"**Initial Expiry Date**" means the date three (3) years after the Effective Date;

"**Initial Term**" means the period commencing on the Effective Date and ending on the Initial Expiry Date;

"**Innovation Fund**" has the meaning given within Schedule 3 (*Pricing and Invoicing*);

"**Innovation Fund Rate Card**" has the meaning given in Schedule 3 (*Pricing and Invoicing*);

"**Input Deliverable**" means a System or a Material that has been created by Molina, an Other Service Provider or by the Service Provider, identified as such in a Project Work Order;

"**In-Scope Personal Data**" has the meaning given in Clause 34.1(d);

"**Insurance**" and "**Insurances**" have the meaning given in Clause 59.1(a);

"**Insurance Limits**" has the meaning given in Clause 59.1(b);

"**Insurer**" has the meaning given in Clause 59.1(c);

"**Integration Testing**" means the phase in software testing in which individual software modules are combined and tested as a group;

"**Intellectual Property Rights**" or "**IPR**" means patents, registered designs, trademarks and service marks (whether registered or not), copyright, database right, design right and moral right, in each case existing in any jurisdiction in the world, and other property rights in other jurisdictions that grant similar rights as the foregoing, including those subsisting

in inventions, drawings, performances, software, databases, semiconductor topographies, business names, goodwill and the style of presentation of goods and services and in applications for the protection thereof;

"**IPR Claim**" means an IPR Claim against Molina or an IPR Claim against the Service Provider as the case may be;

"**IPR Claim Against Molina**" means any claim against Molina or another Molina Company or to which Molina or another Molina Company is joined that alleges infringement of a Third Party's Intellectual Property Right however arising as a result of or in connection with the provision or authorized use of:

(a) the Services;

(b) any Software, System or Materials made available by the Service Provider or a Subcontractor to any Molina Company in connection with this Agreement; or

(c) any System, Software and/or Modification created by the Service Provider or a Subcontractor,

provided, in the case where the Intellectual Property Right is a patent, that that patent had been filed in a country that was a signatory to the Patent Cooperation Treaty as at the date on which the Services, Software, Materials, System or Modification was provided to Molina (or, where such provision occurred on more than one date, on the latest such date);

"**IPR Claim Against the Service Provider**" means any claim against the Service Provider or another Service Provider Company or to which the Service Provider or another Service Provider Company is joined that alleges infringement of a Third Party's Intellectual Property Right however arising as a result of or in connection with the provision or authorized use of:

(a) any Molina IP (other than Molina IP created or Modified by the Service Provider in the performance of the Services);

(b) any use mandated by Molina, as set out in any Project Work Order, of any Software owned or licensed by Molina in accordance with the instructions of Molina; or

(c) any Third Party Software provided by Molina to the Service Provider for the Service Provider to use in the performance of the Services,

provided, in the case where the Intellectual Property Right is a patent, that: (i) in the case of (a) or (c), that patent had been filed in a country that was a signatory to the Patent Cooperation Treaty as at the date on which the Molina IP or Third Party Software (as the case may be) was provided to the Service Provider (or, where such provision occurred on more than one date, on the latest such date); and (ii) in the case of (b), that patent had been filed in a country that was a signatory to the Patent Cooperation Treaty as at the date on which the Project Work Order was executed;

"**Judgment Payment Dispute**" means any dispute, difference, controversy or claim between a judgment creditor and judgment debtor with respect to any money (including interest and costs) due under an unsatisfied judgment, including: (i) a failure to pay on demand any sum of money remaining due under a judgment on or after the date on which that sum becomes due; and (ii) the inability or unwillingness of the judgment debtor to pay the outstanding portion of the judgment sum within the time demanded, but excluding any dispute about the formal validity or substantive merits of the judgment.

"**Key Performance Indicators**" or "**KPIs**" means the Service Levels identified as such in Schedule 6 (*Service Levels and Service Credits*) or any Local Agreement or Services Order;

"**Key Person**" means a person occupying a Key Service Provider Position from time to time including but not limited to those listed in Appendix 15A (Key Personnel) to Schedule 15 (*HR Matters and Key Personnel*) or, in respect of a Project Work Order, in the relevant Project Work Order, in each case as amended from time to time in accordance with the provisions of Schedule 15 (*HR Matters and Key Personnel*), and "Key Personnel" shall be interpreted accordingly;

"**Key Service Provider Position**" means a position or role within the Service Provider Group that is considered by Molina critical to the support of Services and which positions or roles are identified in Appendix 15A (Key Personnel) to Schedule 15 (*HR Matters and Key Personnel*), or, in respect of a Project Work Order, in the relevant Project Work Order, in each case as amended from time to time in accordance with the provisions of Schedule 15 (*HR Matters and Key Personnel*);

"**Laws**" means any applicable law, statute, by law, regulation, order, regulatory policy (including any requirement or notice of any regulatory body), guidance or industry code of practice, rule of court or directives, delegated or subordinate legislation in force from time to time;

"**Level 1**" means a category of Services which resolve Requests and Incidents which are known issues which can be resolved through the use of Knowledge Base articles or other previously created documentation;

"**Level 2**" means a category of Services which resolve Requests and Incidents which are known issues which require further triage, investigation, and in some cases configuration changes beyond what is performed at Level 1;

"**Level 3**" means a category of Services which resolve Requests and Incidents which are not known issues which require code changes or interfacing with a Third Party;

"**Linked Project**" means each group of Project Work Orders that are Linked to one another (and, in the case of a Project Work Order that is not Linked to any other Project Work Order, that Project Work Order is itself a Project);

"**Local Business Day**" means, in respect of any act to be performed under this Agreement or any Project Work Order, a day on which banks are open for general non-automated business in the country in or from which that act is required to be performed;

"**Losses**" means any and all damages, fines, penalties, deficiencies, losses, liabilities (including settlements and judgments) and expenses (including interest, court costs, reasonable fees and expenses of attorneys, accountants and other experts or other reasonable fees and expenses of litigation or other proceedings or of any claim, default or assessment);

"**Major Enhancement**" means an Application activity or set of activities within the scope of Services or related to the Services that requires more than 200 hours of effort;

"**Major Incident**" means any Incident that Molina declares to be a Major Incident in accordance with the Policies, and may include, without limitation: (i) hostile code attacks; (ii) denial of service attacks; (iii) physical destruction of key elements of Molina's Systems, Applications or information stored in electronic form; and (iv) hacking (whether external or internal);

"**Master Services Agreement**" or "**MSA**" means this Agreement;

"**Material**" means any material in whatever form (including documentary, magnetic, electronic, graphic or digitized), including any methodologies, processes, reports, specifications, business rules or requirements, user manuals, user guides, operations manuals, training materials and instructions;

"**Measurement Period**" means the period of time in respect of the Service Provider's performance against the Service Levels will be measured, and in the absence of anything to the contrary will be a calendar month;

"**Milestone**" means:

(a) a milestone associated with the Project Services and identified in a Project Work Order; or

(b) a milestone associated with a Transition Project and identified in the applicable Transition Plan;

"**Milestone Acceptance Certificate**" means a certificate issued by Molina confirming that a Milestone has been Achieved;

"**Milestone Achievement Date**" means the date on which a Milestone is actually Achieved;

"**Milestone Charge**" means the monetary amount which is associated with the respective Milestone which Molina is responsible for paying to Service Provider upon Acceptance of that Milestone;

"**Milestone Date**" means a date identified in a Project Work Order or Transition Plan by which one or more Deliverables must have been Passed by Molina;

"**Milestone Payments**" means the percentage of the fee of the project that the client pays over the course of the project for the Service Provider delivering identified Milestones;

"**Minimum Service Level Target**" means the minimum service level in respect of each Service Level set out in Schedule 6 (*Service Levels and Service Credits*) or any Services Order or Local Agreement;

"**Minor Enhancement**" means an Application activity or set of activities within the scope of Services or related to the Services that requires less than or equal to [redacted]of effort;

"**Modify**" means to add to, enhance, reduce, change, vary or create a derivative work of and "Modification" and "Modified" have corresponding meanings;

"**Molina Authorized Representative**" means the employee or officer of Molina who is designated by Molina from time to time as its representative, and of whom the Service Provider has been notified in writing;

"**Molina Change Management Policy**" means the Molina policy document of this name as may be updated from time to time;

"**Molina Company**" means a member of the Molina Group;

"**Molina Competitor**" means any enterprise that is involved in the healthcare or health plan industry;

"**Molina Data**" means data relating to the business, customers or operations (including the operation and performance of the Services) of any member of the Molina Group, whether generated or produced:

(a) by or for Molina;

(b) by the Service Provider or any Subcontractor in or in relation to the provision of the Services; or

(c) automatically by any Software or Systems,

and shall include all derivatives of and Modifications to any such information;

"**Molina Environment**" means the combination of hardware, software, telecommunications links and other material (or any of its constituent parts) made available by Molina or as used by or interfaced to by the Service Provider;

"**Molina Facilities**" means:

(a) those facilities identified in Schedule 13 (*Access to Molina Facilities*); and

(b) those facilities identified in any Project Work Order as facilities that are required to be provided by Molina in order for the Service Provider to perform the Services under that Project Work Order;

"**Molina Group**" means Molina and its Affiliates from time to time;

"**Molina Indemnified Party**" has the meaning given in Clause 58.1;

"**Molina IP**" means the Molina Software, Molina Materials, Molina Work Product and Molina Data and any other resources or items provided to the Service Provider by or for Molina or any other Molina Company at any time to perform the Services and includes any Modifications to the same;

"**Molina Location**" means each location set out in Schedule 18 (*Countries, Regions and Molina Locations*) and each other location from which any Molina Company carries on any business or operations from time to time;

"**Molina Materials**" means any Materials owned by Molina or any other Molina Company that are used by the Service Provider or any Subcontractor to perform the Services, and includes any Modifications to such Materials;

"**Molina Premises**" means premises owned, controlled or occupied by Molina or a member of Molina's Group which are made available for use by the Service Provider or its Sub-Contractors for the provision of the Services (or any of them) on the terms set out in the Agreement or any separate agreement or license;

"**Molina Responsibilities**" means:

(a) the obligations of Molina in respect of the Services and Deliverables provided by the Service Provider pursuant to a Project Work Order as expressly set out in that Project Work Order;

(b) the obligations of Molina as expressly set out in Schedule 16 (*Dependencies*);

(c) the obligations of Molina as set out in Appendix 13A (*Resources Schedule*) of Schedule 13 (*Access to Molina Facilities*);

(d) the obligations of Molina as set out in the Financial Responsibility Matrix; and

(e) the obligations of Molina as set out in any Exit Plan; and

(f) any obligation of Molina set out in the Agreement;

"**Molina Service Leads**" means the IT managers and leads for the individual services under each Tower;

"**Molina Sites**" means the Molina locations at which the services will be delivered;

"**Molina Software**" means any Software owned by Molina or any other Molina Company which is used by the Service Provider or any Subcontractor to perform the Services, and includes any Modifications to the same;

"**Molina PWO Party**" means, in respect of any Project Work Order, the Molina Company that is a party to that Project Work Order in accordance with Clause 13 (*Project Work Orders*);

"**Molina Work Product**" means:

(a) any Deliverables (other than any Service Provider IP incorporated in any Deliverable);

(b) any Modifications to the Molina IP;

(c) to the extent permitted by the terms of any governing Third Party Software licenses, any Modifications to any such Third Party Software; and

(d) any other Software or Materials specifically created or developed by the Service Provider for Molina and required to be delivered to Molina in the course of providing the Services,

together with all copies made thereof, that are developed or otherwise created pursuant to this Agreement, whether solely or jointly by the Service Provider, the Subcontractors or any other Third Parties;

"**Modifications**" means any maintenance releases, modifications or revisions other than Enhancements or New Versions to the Software that correct defects, support new releases of the operation system on which the Software operates, support new input/output devices or provide other incidental updates and corrections;

"**Monitoring Interval**" means the period of time in which a Service Level is measured, as detailed within Schedule 3 (*Service Levels and Service Credits*);

"**Monthly Charges**" means, for any given month, the total invoice amount for all Charges for all Services provided by Service Provider under this Agreement;

"**Monthly Invoice**" means the invoice for all Monthly Charges for the Services;

"**Monthly Performance Report**" means the report provided by Service Provider to Molina each month to verify Service Provider's performance and the supporting data, calculation, and analysis performed by Service Provider to develop such report;

"**MSA Change**" means a change to any of the terms of this Agreement, including any of the Schedules and the Appendices to the Schedules, or any other document incorporated into this Agreement, but does not include any change to any of the Policies or a Project Change;

"**Network**" means a group of two or more devices that can communicate, usually comprised of a number of different computer systems connected by physical and/or wireless connections;

"**Network Equipment**" means physical devices required for communication and interaction between devices on a computer network;

"**New Version**" means any new version of the Software which from time to time is publicly marketed and made available for purchase by the Service Provider in the course of its or its Sub Contractors' normal business where the purchase or operation of the new version does not require the purchaser already to possess a version of the Software;

"**Nonconformity**" means an incidence of a Deliverable not meeting the Assurance Criteria;

"**Official Invoice**" means the invoice issued by the Service Provider each month in accordance with Schedule 3 (*Pricing and Invoicing*);

"**Offshore Ratio**" means the number of supplier resources supporting from offshore to the total number of supplier resources supporting the Molina engagement;

"**Off the shelf Packages**" means standard, "shrink wrap" or "clickwrap" Software packages generally available from Third Parties or from Sub Fs (other than members of the Service Provider's Group);

"**Open Source Software**" means Software that is licensed by a Third Party on terms that place restrictions on the terms on which any Software incorporating that Software or derived from that Software may be licensed, sold or distributed, or which require a person licensing, selling or distributing Software incorporating or derived from that Software to grant any right to any person, including without limitation any Software licensed under the GNU General Public License (GPL), the GNU Lesser General Public License (LGPL) or any other license issued or approved by the Free Software Foundation or the Open Source Initiative;

"**Operational Change**" means any activity involving the introduction, updating, modification, or retirement of a System or Application, including any planned activity that has an impact or potential impact on the availability or performance of a System or Application;

"**Operational Loss**" means any Losses as a result of any overpayment, underpayment, incorrect payment or non-payment by the Service Provider or resulting from a default on the part of the Service Provider pursuant to its performance of the Services;

"**Operational Review Board**" has the meaning set out in Schedule 7 (*Governance*).

"**Other Service Provider**" means each other provider of services, Software or goods to any Molina Company and any Software Vendor;

"**Other Services**" means services provided by the Other Service Providers;

"**Outline Transition Plan**" has the meaning given to it in Schedule 4 (*Transition and Transformation*);

"**Parties**" means Molina and the Service Provider, and "**Party**" means either of them;

"**Pass**" shall mean confirmation from Molina that a Deliverable does not materially deviate from the applicable requirements set out in the relevant Project Work Order and meets the applicable Assurance Criteria, as evidenced by the issue by Molina of an Assurance Certificate, and "**Passed**" shall be interpreted accordingly;

"**Patching**" means the action of performing non-Release level changes, including electronic software updates ("**ESUs**"), software action requests ("**SARs**"), and service packs (i.e., cumulative releases ("**CUMs**")) or their equivalent in Applications;

"**Payment Milestone**" means a Milestone the Achievement of which results in certain Charges (or a portion of those Charges) becoming payable to the Service Provider;

"**Performance Category**" means the category in which Service Levels are grouped within Appendix 6-A (*Service Level Matrix*);

"**Performance Management**" has the meaning given within Schedule 6 (*Service Levels and Service Credits*);

"**Period**" means each calendar month during the Term;

"**Permitted Purposes**" means the performance of the relevant Party's obligations under this Agreement, and, where the relevant person is Molina it also means:

(a) the receipt and use of the Services; and

(b) the provision of services to (or within) the Molina Group and the procurement of services from Third Parties and Other Service Providers;

"**Personal Data**" has the meaning given in Clause 34.1(b);

"**Personnel**" means Service Provider Personnel;

"**Policy**" means all policies, procedures and standards adopted by Molina or any other Molina Company from time to time;

"**Policy Change**" means a change to a Policy or the implementation of a new Policy;

"**Policy Change Effective Date**" has the meaning given in Schedule 9 (*Change*);

"**Policy Change Notice**" has the meaning given in Schedule 9 (*Change*);

"**Pool Percentage Available for Allocation**" has the meaning given in Schedule 6 (*Service Levels and Service Credits*);

"**Prior Damages**" means, when calculating the liability cap available in respect of a particular claim or cause of action, all damages paid by, plus all damages awarded against, the Party seeking to rely on that liability cap to limit its liability, in respect of all prior claims and causes of action that accrued against that liability cap;

"**Problem**" means:

(a) a cause of one or more Incidents;

(b) a reoccurring service disruption in an Application;

(c) a single service disruption in an Application where such disruption is expected to reoccur; or

(d) a major disruption to Molina's IT environment;

"**Problem Management**" means the process for managing the lifecycle of all Problems. The primary objective of Problem Management is to return the Application to full operation without recurrence of the Problem or associated Incidents;

"**Procedures Manual**" means the list of specific methods employed to express policies in action in day-to-day operations of the organization;

"**Productive Hours**" means the hours during which resources from the supplier would be productively working;

"**Project**" is an activity or set of activities within the scope of Services or related to the Services that requires more than 200 hours of effort. A Project may be a Chargeable Project or Non-Chargeable Project depending on whether it fits the applicable definition;

"**Project Change**" means a change to any of the terms of any Project Work Order, or any other document incorporated into any Project Work Order, but does not include any change to any of the Policies;

"**Project Charges**" means the Charges payable for Project Services, as set out in Schedule 3 (*Pricing and Invoicing*);

"**Project Services**" means those services provided by a Service Provider Group Company to a Molina Company under a Project Work Order, as set out in Clause 13.4;

"**Project Support**" means support provided by the Service Provider to deliver the services;

"**Project Statement of Work**" means the Services Order which is agreed between the parties for a separate Project;

"**Project Work Order**" or "**PWO**" means an agreement between Molina (or a Molina Company) and the Service Provider (or a Service Provider Company) in a form agreed by the Parties, made and constituted in accordance with Clause 13 (Project Work Orders);

"**Prudent Service Provider**" has the meaning given in Clause 59.1(d);

"**Quarter**" means January to March (inclusive), April to June (inclusive), July to September (inclusive) and October to December (inclusive);

"**Rate Card**" means the rate card set out in Schedule 3 (*Pricing and Invoicing*);

"**Receiving Party**" has the meaning given in Clause 30.1;

"**Record**" means recorded information, regardless of medium or characteristics, made or received by an organization that is evidence of its operations;

"**Regulated System**" means any System that is, or that is required to be, subject to Validation and/or Qualification;

"**Regulatory Authority**" means any authority, agency or other body with regulatory jurisdiction over any Molina Company or any business conducted by any Molina Company from time to time;

"**Regulatory Change**" means any change to an Applicable Law;

"**Regulatory Change Effective Date**" has the meaning given in paragraph 5.2 of Schedule 9 (*Change*);

"**Related Documentation**" means, with respect to Software and Software development tools, all materials, documentation, specifications, technical manuals, user manuals, flow diagrams, file descriptions and other written information that describes the function and use of such Software or Software development tools, as applicable;

"**Release**" means one or a series of Operational Changes to be implemented on a specific date;

"**Relief Event**" means a failure by Molina to comply with an Molina Responsibility;

"**Replacement Services**" means services similar to the Services (or part of the Services) that are provided in replacement for the Services (or part of the Services) following the termination (including partial termination) or expiry of this Agreement or any Project Work Order;

"**Replacement Service Provider**" means any Third Party supplier of Replacement Services appointed by Molina or Molina, as the case may be;

"**Reports**" means the reports that the Service Provider is required to produce as set out in Schedule 7 (*Governance*);

"**Representatives**" has the meaning given in Clause 38.1;

"**Renewal Notice**" has the meaning given in Clause 4.2;

"**Required Service Levels**" means the Service Levels identified as such in Schedule 6 (*Service Levels and Service Credits*) or any Services Order or Local Agreement;

"**Resolution**" means the act of fixing an Incident such that its original or similar symptoms are no longer present for the reporting user or system and "**Resolve**" and "**Resolved**" shall be construed accordingly. Such incidents or requests are agreed to be Resolved as per schedule 3 and its related Appendices;

"**Resource Baseline**" means the assumed quantity of an individual Resource Unit that may be consumed or utilized in each month as specified in Appendix 3-A to Schedule 3 (*Pricing and Invoicing*);

"**Resource Rates**" means the daily rates for Service Provider Personnel set out in Appendix 3-A to Schedule 3 (*Pricing and Invoicing*);

"**Resource Units**" means the units of resource set out in Appendix 3-A to Schedule 3 (*Pricing and Invoicing*) that are counted to measure the use of, or demand for, each Service or part of a Service (as defined in Appendix 3-A to Schedule 3 (*Pricing and Invoicing*));

"**Resource Unit Data Source**" has the meaning given within Schedule 3 (*Pricing and Invoicing*);

"**Resource Unit Rates**" has the meaning given within Schedule 3 (*Pricing and Invoicing*);

"**Resource Unit Record**" means the records of all Resource Units within the Resource Unit Data Source;

"**Resources**" means personnel, facilities, Systems, procedures, electronic communications and network management processes and other resources;

"**Responsible Party**" has the meaning given in Clause 8.11(d);

"**RFP**" has the meaning given in paragraph (B) of the Introduction to this Agreement;

"**RFP Proposal**" means the Service Provider's response to the RFP, which the Service Provider provided to Molina in August 2018;

"**Root Cause Analysis**" or "**RCA**" means the analysis of the underlying cause of an Incident, Problem, unsuccessful Operational Change or Release from which effective actions can be defined to Resolve and prevent reoccurrence;

"**RRC**" or "**Reduced Resource Credit**" means a credit against the Base Charges, at the rates stated in Appendix 3-A to Schedule 3 (*Pricing and Invoicing*), for the consumption or utilization of Resource Units in the performance of the related Service during any month less than anticipated by the applicable Resource Baseline;

"**Run Services**" means the services described in Schedule 2 to this Agreement;

"**Sarbanes-Oxley**" or "**SOX**" means the Sarbanes-Oxley Act of 2002;

"**Security Policy**" means Molina's security policy, guidelines and requirements notified to the Service Provider;

"**Security Service Catalog**" means the comprehensive list of IT security services maintained by Molina;

"**Service Bundle**" means each of the following groupings of the Services:

(a) core infrastructure (as described in Schedule 2);

(b) end user services (as described in Schedule 2);

(c) security (as described in Schedule 2); and

(d) any other Service or grouping of Services identified in a Change Notice or SoW, as applicable, as constituting a "service bundle" apart from those listed in clauses (a) through (c) above.

"**Service Catalog**" means a list of pre-defined Deliverables that may be ordered by Molina from the Service Provider in accordance with Schedule 2 (*Service Description*);

"**Service Commencement Date**" means each date on which the Service Provider is required to commence the provision of certain Run Services, as set out in Schedule 4 (*Transition and Transformation*);

"**Service Credits**" means the credit against the Charges (of an amount calculated in accordance with Schedule 6 (*Service Levels and Service Credits*)) to be applied by the Service Provider if it fails to meet or exceed one or more Service Levels (and "**Service Level Credits**" shall have the same meaning);

"**Service Element**" means each Service (or group of Services) identified as a 'Service Element' in the applicable Statement of Work;

"**Service Failure**" means a failure to meet any of the Service Levels and/or any other failure to provide any of the Services in accordance with the Agreement;

"**Service Fees**" means Charges which are incurred for the delivery of Services according to Schedule 3 (*Pricing and Invoicing*);

"**Service Level**" or "**Service Levels**" means the service levels set out in Schedule 6 (*Service Levels and Service Credits*) or any Services Order or Local Agreement;

"**Service Level Component**" means an aspect of a Service Level which defines the requirement for that Service Level, as included in Appendix 3-A (Service Level Matrix);

"**Service Level Default**" has the meaning given in Schedule 6 (*Service Levels and Service Credits*);

"**Service Level Matrix**" has the meaning given in Schedule 6 (*Service Levels and Service Credits*);

"**Service Level Performance**" means, in respect of each Service Level or Key Performance Indicator (KPI), the Service Provider's actual performance of the Services against such Service Level or KPI in the relevant Period;

"**Service Level Report**" shall have the meaning set out in Schedule 6 (*Service Levels and Service Credits*);

"**Service Level Target**" means the minimum level of performance for a Service Level;

"**Service Provider**" means the entity which is contracted via the Agreement to provide the Services;

"**Service Provider Authorized Representative**" means the employee or officer of the Service Provider who is designated by the Service Provider from time to time as its representative, and of whom Molina has been notified in writing;

"**Service Provider Commercially Sensitive Information**" means:

(a) financial information relating to the Service Provider's profits;

(b) Service Provider Data;

(c) information that is confidential to the Service Provider's other customers;

"**Service Provider Company**" means a member of the Service Provider Group;

"**Service Provider Data**" means data relating to the business, customers or operations of any Service Provider Company, whether generated or produced by any Software or Systems during the course of delivering the Services and shall include all derivatives and Modifications to any such information but does not include Molina Data;

"**Service Provider Delivery Lead**" has the meaning set out in Schedule 7 (*Governance*);

"**Service Provider Group**" means the Service Provider and its Affiliates from time to time;

"**Service Provider Indemnified Party**" has the meaning given in Clause 58.2;

"**Service Provider IP**" means the Service Provider Software, Service Provider Materials, Service Provider Data, Service Provider Methods and any Modifications to any of the same;

"**Service Provider Materials**" means any Material made available by the Service Provider (or any member of the Service Provider Group) and/or used by or on behalf of the Service Provider to perform the Services and including any Modifications to the same;

"**Service Provider Methods**" means any methods, processes and business rules that are used by or on behalf of the Service Provider to perform the Services and the performance of which would, without a license from the Service Provider or any Service Provider Company or Subcontractor, infringe any Intellectual Property Right of the Service Provider or any Third Party;

"**Service Provider Personnel**" means employees and contractors, and employees of Subcontractors, of the Service Provider and each Service Provider Group company engaged in the provision of the Services and "Service Provider Person" shall be interpreted accordingly;

"**Service Provider Premises**" means any premises in the possession or control of the Service Provider or any Sub Contractor (which are not Molina Premises) from which the Services are delivered, in whole or in part or in which records relating to the Services are kept;

"**Service Provider Software**" means any Software (and any Modifications to that Software) made available by the Service Provider (or by any other Service Provider Company) and/or used by or on behalf of the Service Provider to perform the Services (for purposes of clarity, Service Provider Software does not include Molina Software);

"**Service Provider PWO Party**" means, in respect of any Project Work Order, the Service Provider Company that is a party to that Project Work Order in accordance with Clause 13 (Project Work Orders);

"**Service Provider Technical Solution**" means Schedule 21 (*Service Provider Technical Solution*);

"**Service Relocation Costs**" has the meaning given in Clause 50.4;

"**Service Relocation Plan**" has the meaning given in Clause 50.2(a);

"**Service Remedies**" shall have the meaning given to it in Schedule 6 (*Service Levels and Service Credits*);

"**Service Request**" means a request from an Authorized User for information, or advice, or for a standard change or for access to an IT Service, such as to reset a password or to provide standard IT services for a new Authorized User;

"**Service Tower**" means an individual tower as defined by scope Exhibits for which Services are provided (e.g. Infrastructure, Applications, End User Services);

"**Services**" means:

(a) the Catalog Services;

(b) the Run Services;

(c) the Project Services;

(d) the Transition Services;

(e) during an Exit Period, the Termination Assistance; and

(f) the performance of all other obligations of the Service Provider under this Agreement.

"**Severity**" means:

(a) Severity 1 - Critical (Tier 1 Application Outage/Data Center Outage that has Impact);

(b) Severity 2 - High (a large number/region of users are impacted/Financials missing Month End Close Business Process/Microsoft O365 outage). Tier 1 Applications Degraded Performance - Intermittent Outage, Errors or user impacting latency;

(c) Severity 3 - Medium (Some Users are impacted or some functionality is impacted/User productivity impacted);

(d) Severity 4 - Low (Content issue on website/Some users are unable to log in, but most users are able to access the website);

(e) Severity 5 - Information (monitoring issues/no impact to users, website degraded performance/redundancy impaired);

"**Site**" means an Molina owned location at which Service Provider provides Services according to the Agreement;

"**Site Systems**" means those Systems owned or leased by the Service Provider that the Service Provider needs to install at any Molina Facility in order to deliver the Services;

"**Skill Grade**" means each grade of Service Provider Personnel set out in Appendix 3-A of Schedule 3 (*Pricing and Invoicing*);

"**Software**" means the versions of any applications, programs, operating system software, computer software languages, utilities and Related Documentation, in whatever form or media, including the tangible media upon which such applications, programs, operating system software, computer software languages, utilities and Related Documentation are recorded or printed, together with all corrections, improvements, Modifications, updates and releases thereof;

"**Software Auditor**" means an auditor representing the Federation Against Software Theft or the Business Software Alliance or equivalent body that may from time to time audit or review the type and manner of use of any Software by any Molina Company;

"**Software Components**" means software programs, code, routines and sub routines that perform specific functions, that are independent copyright works and are used by or on behalf of the Service Provider in the development of the Bespoke Software but that pre date or are not created specifically for the purposes of the Agreement;

"**Software Vendor**" means a Third Party from which Molina or the Service Provider licenses any Software;

"**Solvency Ratio**" means the outcome of the following equation: net borrowings net of cash / EBITDA;

"**Source Code**" means Software in an eye-readable form and in such a form that it can be compiled or interpreted into equivalent object code or byte code, together with all technical information and documentation necessary for the Use, reproduction, Modification, build, compilation, installation, enhancement and support of Software without recourse to any other document, materials or person;

"**Stage**" means each discrete stage set out in the Projects Statement of Work;

"**Statement of Work**" or "**SoW**" means each statement of work set out in Schedule 2 (*Statements of Work*);

"**Start Time**" means, for the purposes of determining a response time, when a ticket is opened in respect of an Incident;

"**Step-In Agent**" means Molina or a Third Party appointed by Molina pursuant to Clause 48.1 (*Instigation of Step-In*);

"**Step-In Costs**" has the meaning given in Clause 48.4(e);

"**Step-In Event**" has the meaning given in Clause 48.1(a);

"**Step-In Notice**" has the meaning given in Clause 48.2(d);

"**Step-Out Date**" has the meaning given in Clause 48.3(f)(ii);

"**Step-Out Notice**" has the meaning given in Clause 48.3(c);

"**Step-Out Plan**" has the meaning given in Clause 48.3(d);

"**Subcontract**" means a contract between the Service Provider and a Subcontractor;

"**Subcontractor**" means a subcontractor of the Service Provider of any Service Provider Company, appointed (directly or indirectly) to perform any of the Service Provider's obligations under this Agreement;

"**Sub-Tower**" means each group of Services forming the entirety of a Statement of Work;

"**Successor Supplier**" means any Third Party or Molina Company that provides Replacement Services;

"**Supporting**" or "**Support Services**" means the activities required for successful execution of a product, program, or process;

"**System**" or "**Systems**" means an interconnected grouping of manual or electronic processes, Equipment, Hardware, Firmware, protocols and Software and associated attachments, features, accessories, peripherals and cabling, and all additions, modifications, substitutions, upgrades or enhancements to the extent a party has financial or operational responsibility for such System or System components under this Agreement;

"**System of Record**" means the System which is Molina's authoritative source for a particular function, process, or data;

"**Tax**" and "**Taxation**" mean all sales, use, property, ad valorem, value added or similar taxes;

"**Tax Authority**" or "**Tax Authorities**" means any government, state or municipality, or any local, state, federal, national or other fiscal, revenue, customs, or excise authority, body or official anywhere in the world, authorized to levy Tax;

"**Tax Claims Notice**" has the meaning given in Clause 43.5(b);

"**Term**" means the term of this Agreement which is determined by Clause 3 (Term) and Clause 4 (Extension of the Term);

"**Terminating Services**" means:

(a) in respect of a termination of this Agreement or a PWO in whole or in part, those Services for which a Party has issued a formal notification of termination but which continue to be provided during an Exit Period; and

(b) in respect of the expiry of this Agreement or the termination of this Agreement in whole, all of the Services;

"**Termination Assistance**" means the assistance the Service Provider shall provide Molina in order for the Service Provider to transfer responsibility for delivery, performance and management of the Terminating Services, as set out in Schedule 8 (*Termination Assistance and Exit*) and each Exit Plan;

"**Termination Assistance Period**" means a period of time commencing upon the earlier of Service of a notice to terminate or when requested by Molina;

"**Termination Date**" means the date on which any notice of termination of this Agreement or a Project Work Order takes effect, as determined in accordance with Clause 56 (*The Effective Date of Termination*);

"**Termination for Convenience**" means the termination of the contract by Molina at any time with or without giving any justification;

"**the Act**" means the Employment Rights Act 1996 (as amended);

"**Third Party**" means a person that is not a Party, a Molina Company, a Service Provider Company or a Subcontractor;

"**Third Party Agreements**" means the agreement between Molina or the Service Provider and a third party;

"**Third Party Manager**" has the meaning given in Clause 65.1;

"**Third Party Software**" means any Software other than Molina Software and Service Provider Software, and related Material that is otherwise used in the performance of the Services and includes Software provided under license or lease that is used to provide the Services;

"**Threat Management**" means protecting a business from security threats, including computer security and information security;

"**Tollgate**" means the checkpoints specified as such in a Transition Plan;

"**Traditional Delivery Model**" refers to the waterfall software development methodology;

"**Transfer**" means the transfer of the provision of any Services from the Service Provider to Molina or a Successor Supplier on the termination (in whole or in part) or expiry of this Agreement or any Project Work Order;

"**Transfer Fee**" means the Charges associated with transferring an asset as detailed within the Wind-Down Expenses;

"**Transformation Deliverables**" means those Deliverables that are generated as an output of the Transformation Services;

"**Transformation Period**" means in respect of each Transformation Project, the period commencing on the start of the Transformation Services to the date of Acceptance of the final Transformation Milestone;

(a) Transformation Plan" means either the Outline Transformation Plan or the Detailed Transformation Plan;

(b) Transformation Services" means the services that relate to paragraph 7 of Schedule 4 (*Transition and Transformation*);

"**Transition Deliverables**" means those Deliverables that are generated as an output of the Transition Services;

"**Transition Charges**" means the charges for Transition set out in a Project Work Order for each relevant Transition Project;

"**Transition Milestone**" means a Milestone relating to Service Provider's obligations to complete certain Transition Services on specified dates in accordance with the Transition Plan;

"**Transition Period**" means the period from the Commencement Date to the final Go Live Date;

"**Transition Plan**" means the plan for the conduct of each Transition Project, as set out in, as applicable, the Initial Transition Plan, the Detailed Transition Plan, and, as applicable, a Project Work Order entered into in connection with the applicable Transition Project;

"**Transition Project**" means each project to be completed by the Service Provider in connection with Transition, as set out in the Detailed Transition Plan or the Service Provider Technical Solution, as applicable;

"**Transition Services**" means the services, functions, roles and responsibilities to be performed by the Service Provider under each Transition Project, in accordance with Schedule 4 (*Transition and Transformation*) and each Project Work Order for each Transition Project;

"**Trend Identification**" means assessing tickets or events in order to identify a common Root Cause among multiple, repetitive issues;

"**Triage**" means the process of assessing an issue to determine the appropriate Severity, Priority, and ownership group in order to carry the issue to resolution;

"**Unified Communication**" means the Services associated with providing enterprise communications infrastructure;

"**Unified Compute**" means the Services associated with providing Security, Storage, Network, and Compute;

"**Unit Testing**" means the process of testing individual units of an Application to ensure proper functioning and fulfilment of requirements;

"**Unplanned Downtime**" means downtime that occurs as a result of a failure (for example, a hardware failure or a system failure caused by improper server configuration);

"**Upgrade**" means any update, upgrade, enhancement or change to an Application or System including a Patch or Release;

"**Use**" means to load, execute, display and perform (and to copy for these purposes);

"**User**" means the equivalent of "**Authorized User**";

"**User Acceptance Testing**" means the last phase of Software testing process in which users ensure that the Software meets business process requirements;

"**VIP User**" means a user as identified in Schedule 14 (*Molina Policies*);

"**Voice Network**" means a group of technologies for the delivery of voice communications and multimedia sessions over Internet Protocol (IP) networks;

"**Volume Discounts**" means the discount percentages Service Provider shall credit Molina based on incremental aggregate (for that Contract Year) Monthly Charge dollars invoiced by and paid to the Service Provider under this Agreement, not inclusive of Transition Charges, or Approved Out-of-Pocket Expenses, in accordance with Schedule 3 (*Pricing and Invoicing*);

"**Vulnerability**" means a Security flaw or weakness in a System which may cause such System to be open to a cyber-attack;

"**Wave**" means each group of Services the provision of which, or the provision of which to one or more Molina Companies or in one or more Countries, is to commence together, as set out in Schedule 4 (*Transition and Transformation*);

"**Work Order**" means a written agreement between Molina and Service Provider for the performance of projects;

"**Workaround**" means a method of restoring:

(a) access to the affected System; and

(b) the affected System to the functionality and performance required by the applicable specifications, without necessarily Resolving the underlying Problem;

"**Working Day**" means a period of eight (8) hours in the United States, or 8.8 hours offshore; and

"**Year**" means each consecutive twelve (12) month period commencing on the Effective Date and each anniversary of the Effective Date and the terms; and "**First Year**", "**Second Year**" etc., and so forth shall be construed accordingly.

SCHEDULE 2

SERVICE DESCRIPTION

CONTENTS

1. **DEFINITIONS**

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) to this Agreement.

2. **INTRODUCTION; SERVICES DESCRIPTION STRUCTURE**

This Schedule sets out the description of the Services. The Services descriptions have been arranged in the following manner:

(a) certain Services requirements of general applicability to all Services are set out in this Schedule 2; and

(b) the following Appendices to this Schedule set out Services in a grouped manner:

(i) Appendix 2-A (*Infrastructure*);

(ii) Appendix 2-B (*Security Services*);

(iii) Appendix 2-C (*End User Services*); and

(iv) Appendix 2-D (*Pro Forma Project Work Order*).

3. **SERVICES REQUIREMENTS OF GENERAL APPLICATION**

3.1 **The Service Provider shall perform its obligations pursuant to the Agreement, including the performance of the Services as set out in this Schedule and the Appendices hereto, in accordance with the following:**

(a) With respect to any Service performed in accordance with this agreement under which Molina is to provide services specifically directed toward the State of Texas Medicaid program (or its regulatory bodies, administrative agencies, health plans, or any member of any such health plan) or with respect to the Texas marketplace, the Service provider shall ensure that (i) its performance of such Service in accordance with the Agreement shall occur at locations [redacted] and (ii) no Confidential Information of Molina (including any confidential information of the State of Texas (or its regulatory bodies, administrative agencies, health plans, or any member of such health plan) or information that relates to the Texas marketplace) shall be [redacted]. For purposes of clarity, the Parties agree that Services model described in the Agreement (including the Schedules thereto) as of the Effective Date are in compliance with the foregoing restrictions as of the Effective Date].

CONTENTS

1. **INTRODUCTION**

1.1 This Appendix 2-A (*Infrastructure*) Services forms part of the Agreement. All terms and conditions of the Agreement shall apply to this Appendix 2-A and any attachments hereto.

2. **DATA CENTER REQUIREMENTS**

2.1 Service Provider shall coordinate where applicable with Molina or Molina's Datacenter provider for service described in this section. Service Provide will provide hands and feet support for infrastructure components (compute, storage, network, backup) only.

2.2 Service Provider shall be responsible for fulfillment of the requirements specified as Service Provider's in this Exhibit.

General Requirements

2.3 All data center supporting Equipment shall and maintained according to the respective manufacturers' specifications.

2.4 Service Provider shall support Molina server architecture, including "hot aisle" and "cold aisle" cabinet configurations and environmentally friendly cooling design (e.g., "free air" /open-air cooling if applicable based on proposed Data Center Co-Lo facility locations), where possible.

2.5 Service Provider shall service each data center per Molina's requirement.

2.6 Service Provider shall provide remote access to equipment that will meet Molina's security standards.

2.7 Service Provider shall use existing web-based monitoring System for the environmental variables in any data center available to Molina.

3. **DATA CENTER SERVICES**

3.1 Service Provider shall provide and where required, coordinate with Molina's team or its Third Party suppliers to provide all the data center Services described herein, including:

Receiving and Staging Services

3.2 Service Provider shall stage all Equipment, including:

(a) Dockside pickup and relocation;

(b) Setting up racks;

(c) Power distribution units;

(d) Routers;

(e) Switches;

(f) Fiber cabling to storage/tape; and

(g) Other necessary data center components.

Installation Services

3.3 Service Provider shall perform cabinet installations with necessary power, cooling, network, and redundancy requirements, including:

(a) Coordinating with other vendors as required;

(b) Rack mounting servers and networking Equipment in Molina specified rack locations;

(c) Performing basic router and firewall configuration and routing to allow servers to be network accessible and ensuring routers are placed in the appropriate virtual local area networks, including demilitarized zones;

(d) Configuring all servers to a network accessible state;

(e) Coordinating with network Service Providers for all circuit installations (e.g., internet, primary office, disaster recovery site, and home office), and cross-connects required to reach target devices;

(f) Ensuring new Equipment is powered up within two (2) business days of receipt, or as agreed with Molina, and acceptance by the Data Center;

(g) Providing patch, panel, cabling, device, and power labeling documentation for all Molina Equipment with name and power source indications;

(h) Planning and installing Equipment, including cabling, consumables and any and all other Equipment required to support the installation;

(i) Using Molina's existing vendor for cabling, consumables and any and all other Equipment required to support the installation; and

(j) Testing, returning, and managing replacement of non-performing Equipment and/or Software as per Service Provider support contractual terms.

LAN Operations Services

3.4 Service Provider shall monitor and manage per Molina requirements the data center local area network (LAN) as an end-to-end Service, from the wide area network (carrier demarcation point) to each installed Molina device, including:

(a) Provide network management and monitoring services per Molina requirements, including ensuring the proper operation (as per performance SLAs) and full functionality for all ports.

Data Center to Data Center WAN Operations Services

3.5 Service Provider shall monitor and manage the data center WAN per Molina requirements as an end-to-end Service in conjunction with the local Service Provider(s), from the external internet connection to the Local Area Network, including:

(a) Monitoring quality-of-Service mechanisms across any Service Provider Services or other telecommunications Agreements, to support data, voice and video traffic as well as latency and jitter sensitive applications to all Molina sites;

(b) Monitoring and providing real time network capacity reports;

(c) Monitoring, supporting, and otherwise ensuring the proper operation of internal and external domain name Service (DNS) and dynamic host configuration protocol (DHCP) Services per Molina specifications;

(d) Monitoring, supporting, and otherwise ensuring the proper operation (as per performance SLAs) of internal and external firewalls, demilitarized zones, load balancer, and other security and privacy related network components;

(e) Ensuring high availability of WAN Services, including:

(i) High availability and performance (as per performance SLAs) of WAN Equipment;

(ii) High availability and performance (as per performance SLAs) of load balanced WAN links;

(f) Performing quarterly performance and failover tests of WAN links as directed by Molina as per BC/DR plan testing; and

(g) Performing monthly performance and failover tests of regional WAN links as directed by Molina in addition to any BC/DR plan testing.

General Services

4. GENERAL REQUIREMENTS – SERVER, STORAGE, DATABASE, AND NETWORK

General Requirements

4.1 Service Provider shall be responsible for fulfillment of the requirements specified as Service Provider's in this Exhibit.

4.2 Service Provider shall perform activities across all of Molina's technology and business partners, including Molina's Service Desk, other Service Provider teams, Third Party Sub-contractors or other third parties as required by Molina.

4.3 Service Provider shall support Molina with respect to its in project that are in-flight as of the Effective Date, in each case in accordance with the in-flight project support provisions as set out in the Service Provider Technical Solution.

Services Requirements

4.4 Service Provider shall adhere to all Molina's server, storage, database, and network requirements, including:

(a) Complying with or improving (subject to Molina's approval) Molina's current and future Equipment, Software, and network architecture technical specifications as necessary to deliver the Services.

(b) Following all Molina policies including but not limited to Molina change management policies and approved Service Provider policies as applicable.

(c) Ensuring resources are available and staff is properly and continuously trained to provide appropriate levels of SME coverage and support.

(d) Ensuring that, to the extent possible and as approved by Molina, tools utilized by Service Provider to perform the Services shall be commercially available (e.g., shrink-wrap Software) and non-proprietary technologies; and, in those instances where it is not possible to utilize commercially available technologies, gaining Molina approval prior to implementing such tools.

(e) Ensuring Service Provider Services comply with all local and regional regulatory requirements including but not limited to privacy, data retention, encryption, financial, auditing, and security.

(f) Ensuring Service Provider Services are consistent with the Master Services Agreement, and adhere to all Molina policies related to provided services.

(g) Following all original equipment manufacturer (OEM) standards and industry best practices.

(h) Ensuring that all equipment is maintained according to manufacturer specified guidelines, and maintains Service Provider device support coverage.

(i) Notifying Molina on major events and incidents as per Molina’s notification procedure, until resolution.

(j) Coordinating with teams, as agreed upon between Parties, to support, maintain, and troubleshoot server, storage, database, and network equipment (e.g., file/print servers, local servers, switches, routers, access points) at remote and campus sites.

(k) Using existing documentation and updating (within forty-eight (48) hours of all changes) to provide required Molina documentation including site-specific information, such as diagrams of LANs and Customer Premise Equipment (CPE), hardware configurations, Software releases, and routing tables.

Administrative Services

4.5 Service Provider shall administer and be responsible for access to and access control for Molina's server, storage, database, and network environments, including:

(a) Maintaining privileged System accounts including but not limited to administrator and root, access control strings, and delegating access to Molina Authorized Users upon request per Molina policies.

(b) Administering IDs to ensure that only those privileges and authorities required for such IDs are provided to personnel, per Molina specifications and policies, and provide notifications to Molina every time an ID is administered.

(c) Recording the activities of all users, including privileged System accounts, for eighteen (18) months, and providing such records (e.g., domain administrator logs, System logs, etc.) to Molina within forty-eight (48) hours, as permitted by local and regional regulatory specifications. In the event of a security breach, Service Provider to provide such records within two (2) hours.

(d) Assigning and managing access permissions (including role-based access) associated with user IDs.

(e) Assigning and managing access rights to all System-wide objects within Service Provider's scope of responsibilities.

(f) Reporting Unauthorized Users for management review and action per Molina's security policy.

(g) Rescinding access privileges upon termination or request by authorized Molina personnel.

(h) Proactively auditing activity records to identify any deviation from practice and immediately raising awareness of any deviations to Molina, per Molina requirements.

(i) Obtaining appropriate authorization prior to granting non-expiring password in accordance with Molina's information security policies.

(j) Logging into infrastructure using standard admin access tools, as specified as Appendix 6-D (Tools Inventory).

(k) Logging into servers using network accounts where possible and using local admin account as a last resort.

(l) Maintaining control of master passwords in accordance to Molina’s policies and specifications.

Installation, Provisioning, and Retirement Services

4.6 Service Provider shall deploy, provision, and retire Systems in server, storage, database, and network environments, including:

(a) Providing sufficient space, in existing Molina’s Data Center using its existing contracts / facilities temporary and long term, to house any and all Molina, Service Provider, or Third Party Equipment.

(b) Staging Equipment, including:

(i) Dockside pickup and relocation,

(ii) Setting up racks,

(iii) Power distribution units,

(iv) Switches, controllers, WAN optimization devices, routers, access points, hubs, firewalls, and other network Equipment,

(v) Other necessary components, and

(vi) Network connections.

(c) Support the installation of Equipment, including cabling, consumables and any and all other Equipment and/or Software required to support the installation.

(d) Testing, returning, and managing replacement of non-performing and/or unused Equipment and/or Software as per Service Provider support contractual terms.

(e) Provisioning infrastructure services, including Systems, virtual machines, network access layer, load balancers, and security policies, to meet application deployment readiness

(f) Executing the retirement and replacement of Equipment, including:

(i) Purging data and Software per Molina policies and procedures.

(ii) Upgrading any Molina Equipment that is intended to be redeployed, according to Molina specifications.

(iii) For Molina Equipment at end of lease, taking such steps as are necessary to return such leased Equipment to lessors in accordance with lessor guidelines and requirements.

(iv) Preparation for disposal of any Equipment that shall not be redeployed, according to Molina policies, and contacting Molina or its Third Party supplier, as applicable, to schedule disposal.

(v) Scheduling test and turn-up of sites utilizing Molina Equipment following Molina confirmation of the installation of access and Equipment.

(vi) For Molina-owned, Service Provider-managed Equipment, ensuring refresh procedures are carried out according to the defined refresh plans, per Molina approval.

(vii) For Service Provider-owned Equipment only, ensuring refresh procedures are carried out according to agreed upon refresh plans (proposed by Service Provider).

(viii) Verifying remote connectivity and access to equipment.

Monitoring and Resolution Services

4.7 Service Provider shall monitor for and respond to issues with servers, storage, and database performance (or degradation thereof) twenty-four (24) hours per day every day of every year including:

(a) Performing proactive, reactive, and real-time troubleshooting to effectively identify potential incidents, and attempting to eliminate incidents before they occur.

(b) Monitoring and managing the Infrastructure for Service degradation including detecting, isolating, diagnosing and recommending corrective actions, including Systems capacity reporting.

(c) Monitoring the performance and availability of the Services from an end user perspective (for example, monitoring performance at the input and output ("**IO**") path level from a server to associated storage as a means of identifying and subsequently resolving congestion from the back end of a System to the end user).

(d) Using Molina approved tools that incorporate machine learning (where applicable) and dynamic performance thresholds (minimum and maximum) based on requirements from Molina, provide automated alarms and indication of incidents when mutually agreed upon thresholds are exceeded (e.g., utilization parameters, memory limits).

(e) Implementing a method (as approved by Molina) for automatically detecting and creating an incident ticket for any issue, with automated resolution capability.

(f) Following, reporting, and executing corrective action procedures approved by Molina.

(g) Reporting overall availability, key performance metrics, device trends, one-off and recurring issues, corrective action recommendations, Third Party performance metrics, and other key System attributes indicated by Molina on a daily, weekly, and monthly basis, including historical data.

Support Services

4.8 Service Provider shall perform support Services for Molina's server, storage, database, and network environments, including:

(a) Performing Equipment and Software maintenance in accordance with manufacturer warranty and Molina requirements.

(b) Correcting incidents associated with failure or degradation of the performance of Equipment and Software, and providing break-fix support, advice and assistance in accordance with manufacturer warranty and Molina requirements.

(c) Performing System remediation to ensure compliance to Molina standards such that non-standard alterations to Systems are identified during Service calls and remediated upon Molina approval.

(d) In the event Service Provider must replace Equipment and/or Software in order to conduct a repair, restoring the environment to the previous state including configuration and data, and providing Equipment and/or Software that is an identical or an improved model, as per Molina approval.

Operations Services

4.9 Service Provider shall operate Molina server (physical and virtual), storage, database, and network environments, including:

(a) Performing necessary System administration, including but not limited to:

(i) Performing patching (application/OS layer/hardware) as per Molina defined schedule, including but not limited to bug-fixes, security issues, and firmware.

(ii) Performing proactive, reactive, and real-time troubleshooting to effectively identify potential incidents, and attempting to eliminate incidents before they occur.

(iii) Supporting, creating, testing, and implementing scripts.

(b) Performing health check on all environments to generate compliance, usage and capacity reports on a daily basis, and provide long-term capacity reporting and forecasting trends, including but not limited to fail-over tests.

(c) Installing Equipment and infrastructure Software and customizing infrastructure Software, including writing scripts, customizations, and interfaces; loading applications; or other activities as required to ensure the proper operation of all Equipment and Software.

(d) Managing file Systems, including optimizing logical and physical attributes.

(e) Running or terminating utilities to minimize the impact to Molina end users.

(f) Configuring and reconfiguring Equipment and Software as required or requested by Molina, including any required Third Party support.

(g) Modifying infrastructure Software to provide interfaces between Molina Systems while maintaining any existing special user interfaces.

(h) Engaging third parties (as approved by Molina) necessary to complete the requests within the defined Service Level, including but not limited to the following tasks:

(i) Connecting with relevant third parties when an incident arises.

(ii) Working with relevant third parties until incidents are resolved.

(iii) Communicating with relevant third parties to understand the root cause of an incident.

(iv) Collaborating with relevant third parties to implement a solution that will prevent future incidents from occurring.

(v) Following up with relevant third parties to implement a workaround.

(vi) Following up with relevant third parties to understand when a fix will be available, and informing Molina accordingly.

(i) Following the completion of the Transition, the Service Provider will perform patch implementation work as part of the Services using Service Provider Personnel, utilizing the patch baseline and backlog to be shared by Molina within two (2) weeks after the Effective Date. In the event Molina seeks to materially alter the backlog patch management plan and process (as used by Molina as of the Effective Date or, to the extent applicable, as modified pursuant to the Detailed Transition Plan), the Service Provider may propose to implement such changes via a chargeable Project to accelerate the application of patches and reduce the backlog. With the exception of planned patches that were not implemented on-time based on Service Provider's error or omission, the risks associated with security and operational vulnerabilities created by the backlog of unapplied patches remains with Molina. The Service Provider will be excused from its obligations to meet Service Levels to the extent a Service failure results from the backlog of unapplied available patches, in each case except to the extent that the reason the applicable patch was not applied is the result of Service Provider's error, omission or delay.

Back-up and Recovery Services

4.10 Service Provider shall administer and monitor back-up and recovery Services, including but not limited to:

(a) Backup report management to include access, bundling, de-duplication, replication, retention, splitting, encryption, distribution, and backups.

(b) Back-up processes, procedures, schedules and timeframes in compliance with Molina specifications (for example OS file Systems and OS System image, Molina exclusion lists at the Service Level, etc.) including off-site production mirrors.

(c) Online report management to include access, indexing, retention, distribution, archiving, viewing, splitting, and backup Systems that include multiple tier viewing Systems.

(d) Recovery procedures, including online, partial or other recovery procedures.

(e) Supporting on and off-site retention per Molina policies.

(f) Performing on-going (per Molina's schedule) inter-site transfers of secure data in case of disaster.

(g) Performing ad-hoc backups on demand.

(h) Performing full or partial recovery on demand (and as required by any regulatory requirements).

(i) Managing exclusion lists (as directed and/or provided by Molina policy) at the server level.

(j) Configuring and scheduling backup and recovery tools.

(k) Developing for Molina approval and implementing data migration, archival, backup, catalogue maintenance, and retention management procedures.

(l) Implementing and ensuring the successful completion of backup procedures, including installing and configuring components, testing restoration integrity, scheduling backups, and executing on-demand backups.

(m) Implementing and ensuring the successful completion of archival procedures, including installing and configuring components, scheduling archival processes, and executing on-demand archivals.

(n) Implementing and ensuring the successful completion of recovery procedures, including online, partial, or other recovery procedures.

5. **SERVER SERVICES**

Operations Services

5.1 Service Provider shall operate Molina server environments (physical and virtual), including:

(a) Managing file transfer with third parties including but not limited to FTP, SFTP.

(b) Implementing and testing high availability and load balancing for Servers (e.g., server farms).

5.2 Service Provider shall schedule and monitor approved jobs as per Molina approved schedule. Service Provider shall escalate any issues leading to delays, failure or schedule conflicts of jobs to relevant technical teams following appropriate ticketing and escalation processes.

5.3 Service Provider shall perform following tasks related to enterprise scheduling

(a) Monitoring batch processing jobs utilizing Molina approved and/or provided tools and complying with all Molina standards, procedures, and time frames.

(b) Implementing processing schedules to meet Molina's guidelines and fulfill the Services.

(c) Informing/escalating to the relevant teams for Resolving scheduling conflicts, enhancing critical path and otherwise integrating the schedules in accordance with all Molina policies and as necessary to deliver Services.

(d) Running, monitoring, and maintaining processing tasks (including production, development, quality assurance and other processing tasks) according to the established schedules.

(e) Completing processing within Molina specified and Service Provider published time frames, in the approved sequence, and fulfilling requests for expedited and/or special processing needs by Authorized Users, while achieving successful batch throughput, according to Molina specifications.

(f) Assisting relevant teams in Performing trend analysis to highlight production problems; planning and implementing solutions to remediate and prevent issues proactively.

(g) Providing Molina with proactive and timely notifications and updates on any issues that may affect the completion of batch jobs.

(h) Providing access to Third Party suppliers to schedule and monitor jobs per Molina's guidelines.

(i) Service Provider to repair and resolve abnormal batch terminations when possible using SOPs (including Molina and/or application team provided SOPs), communicating terminations to Molina Authorized Users and performing job restarts with Molina's acknowledgement and approval.

(j) Configuration and management of lights out interfaces (e.g., iLOs)

5.4 Virtualization Services – in addition to other requirements for all servers above, Service Provider shall perform further operational tasks, functions, and activities related to Molina's virtual server environment, including:

(a) Performing physical to virtual migrations as directed by Molina.

(b) Supporting, creating, testing, upgrading, and monitoring host servers.

(c) Supporting, creating, testing, upgrading and monitoring guest servers.

(d) Supporting, creating, testing and monitoring remote, virtual application presentation, or other servers in Molina's environment, including:

(i) Maintaining and managing published virtual applications.

(ii) Performing workload management of virtualized environment.

(iii) Managing guest balancing optimization

(iv) Managing application administrative roles.

(v) Managing and reporting on usage (e.g., license utilization or other key indicators), performance forecasting, and other metrics identified to Service Provider by Molina.

6. STORAGE AND DATABASE SERVICES

Operations Services

6.1 Service Provider shall support storage and database environments per Molina policy, including:

(a) Modifying infrastructure Software to provide interfaces between Molina Systems while maintaining any existing special user interfaces.

(b) Managing Molina's capacity quotas and notifying authorized internal or external users and end users per Molina's specifications.

(c) Managing storage in a manner that maintains the availability and protects the integrity of such data to meet Molina requirements, including:

(i) Managing, monitoring, optimizing and controlling storage performance including but not limited to multiple tiers.

(ii) Ensuring that storage Systems are optimized per original equipment manufacturer ("**OEM**") recommendations and best practices.

(iii) Allocating, de-allocating, and re-allocating storage as required or requested by Molina.

(iv) Migrating data as required or requested by Molina.

(v) Recommending and implementing Molina security practices (e.g., logical unit masking) to prevent unauthorized storage access.

(vi) Managing and enforcing Molina data retention policies.

(d) Supporting and ensuring access to environments, including administrative activities required to add or delete access.

(e) Planning and coordinating Software moves between environments (development, quality assurance, test, and production) as required to meet Molina specified timelines and to meet the Service Levels.

(f) Managing remote function call (RFC) interfaces to ensure that all Systems are operating correctly and are fully functional.

(g) Providing data recovery assistance for problem resolution and contingency testing.

(h) Providing testing support for Molina Application development Projects including:

(i) Operating and loading development, test, and staging environments.

(ii) Testing test plans and scripts; generating, loading and refreshing test data; unit testing; System testing; integration testing; regression testing; performance testing; stress testing and supporting user acceptance testing (UAT).

(i) Providing guidance and coordination for all activities during Software installations and routine maintenance including interfacing with and, as appropriate, managing Molina groups, Other Service Providers and other relevant groups.

(j) Participating in incident and crisis management activities including interfacing with and, as appropriate, managing Molina groups, Third Party suppliers and other relevant groups.

(k) Managing and installing Software and customizing Software, including writing scripts, customizations, interfaces, or other activities as required to ensure the proper operation of all Equipment and Software.

(l) Interfacing with Molina to ensure storage is available and provisioned on time.

(m) Promoting objects from pre-production to production.

(n) Performing update activities, at the direction of Molina, including:

(i) Installing and/or applying patches and/or fixes based on Molina security standards.

(ii) Performing database management Systems (DBMS) upgrades as directed by Molina.

(o) Performing database optimization and tuning support activities per Molina requirements including:

(i) Assisting development teams in optimizing SQL statements (indexes, selects, etc.).

(ii) Assisting development teams in optimizing the database.

(iii) Implementing database Application schema and/or changes.

(iv) Managing and, upon approval from Molina, correcting System and DBMS performance issues.

(v) Recommending and implementing database reorganization strategies.

(vi) Tuning database Application level performance (e.g., SQL/Oracle Query optimization, NoSQL, Hadoop).

(vii) Reporting database capacity constraints and growth requirements when internal thresholds are exceeded, as thresholds are defined on an ongoing basis in various monitoring tools.

(viii) Tuning database System level performance (e.g., performance ratios, I/O load balancing, memory buffers).

(ix) Updating database clusters.

(x) Managing workloads.

(xi) Adding and/or removing nodes.

Back-up and Recovery Services

6.2 Service Provider shall perform all back-up and recovery Services for the storage and database environment, including but not limited to:

(a) Implementing procedures for recycling media regularly, managing media replacement, and recopying media to provide data integrity and quality.

(b) Implementing procedures for encrypting media per Molina specifications.

(c) Implementing procedures for recopying storage media as necessary to minimize errors.

(d) Implementing procedures for retrieving backed-up and archived storage media (onsite or offsite) as requested by Molina, and if not otherwise requested by Molina, as required to support the Services.

(e) Implementing a procedure for retrieving randomly selected backed-up and archived data sets, as specified by Molina and representing a significant amount of data, on a regular basis as a test and verifying that the data can be restored in a usable fashion.

(f) Monitoring and providing a monthly report to Molina on the number and types of back-up failures and storage System usage parameters.

(g) Developing and implementing plans to eliminate back-up failures as required or requested by Molina.

7. DATABASE SERVICES

Environment Control and Scheduling Services

7.1 Service Provider shall perform job management activities across all environments (e.g., production, test, development) including:

(a) Characterizing the workload of production jobs.

(b) Designing and managing concurrent queues.

(c) Creating and maintaining concurrent job schedules.

(d) Monitoring concurrent job schedule execution.

8. NETWORK INFRASTRUCTURE SERVICES

Services Requirements

8.1 Service Provider shall be responsible for fulfillment of the requirements specified as Service Provider's in this Exhibit, including:

(a) Maintaining and updating (as required to document changes in Molina's Network) Molina's repository of Molina's Network topology, applications, connectivity, projected traffic flows, and performance data/documentation based upon Molina provided information and Molina-specified requirements.

(b) Validating network design including hardware, software and network platforms and utilizing Molina-provided testing and troubleshooting criteria.

(c) Maintaining and updating documentation provided by Molina with regard to the network addressing plans, logical network device assignments and logical parameters for network management connectivity to Molina's network.

(d) Assisting in auditing Molina's transport network and Customer Premise Equipment (CPE) devices using Molina provided documentation.

Monitoring and Resolution Services

8.2 Service Provider shall monitor for and provide Incident resolution Services for Molina's network on a twenty-four (24) hours per day and three hundred sixty-five (365) days per year basis, including:

(a) Monitoring and reporting regularly on the WAN performance (quality of Service indicators), and forecasting recommendations to Molina for capacity add and business justification, and coordinating with WAN service provider for non-Molina managed routers.

(b) Monitoring quality of Service reports that contain all information required by Molina (e.g., load indicators per location, CPU utilization, access link load, LAN segment load, router availability, traffic volume).

(c) Providing proactive surveillance and monitoring Services for all Molina sites, including:

(i) Providing fault reference information to Molina.

(ii) Providing trouble shooting results, including but not limited to packet capture analysis.

(iii) Dispatching faults to the appropriate entities.

(iv) Providing periodic updates to Molina on the progress of fault resolution.

(v) Minimizing the number of duplicate cases opened and recommending process changes to consolidate duplicates.

(d) Monitoring and monthly report generation for voice over IP ("**VoIP**") usage and quality of Service with executive summary, location of equipment, voice quality indicators, and performance indicators.

Support Services

8.3 Service Provider shall perform support Services for Molina's LAN, WAN, and perimeter environments, including:

(a) Resolving incidents, performing change requests, performing Service Requests, and maintaining reports.

Operations Services

8.4 Service Provider shall operate Molina LAN, WAN, and perimeter environments and perform required activities, including:

(a) Dispatching spares, and/or field Services engineers to Molina Sites if replacement parts, or on-site repair or technical support are needed.

(b) Supporting Molina network Services including:

(i) Third Party suppliers in transporting voice, data, and video protocol from the LAN to the WAN and perimeter environments and between sites.

(ii) Secure internet communications and terminations per Molina specifications and standards.

(iii) High availability and load balancing of network ports as designated by Molina, and maintaining, as need Molina's firewall and load balancing configurations.

(c) Supporting wireless local area network ("**WLAN**") Services and devices in Molina Sites including:

(i) Securing WLAN access points for internal Molina users per Molina's standards.

(ii) Securing WLAN access points for guest (non-Molina) users per Molina's standards.

(iii) Periodically reviewing usage data and the performing of Service optimization for employee-level Services (remote access dial plans, network bandwidth etc.).

(d) Utilizing a Molina-provided database of specific information regarding the logical address configuration(s) of the Service Provider Customer Premise Equipment (CPE) and Molina Equipment and associated Software specifications, including:

(i) Administering changes made to access lists, device passwords, and using secured community strings for simple network management protocol ("**SNMP**") access.

(ii) Performing configuration changes due to maintenance and moves, adds, changes, deletes or similar changes in the database and reloading router configurations from the database and initiating Software updates to Molina Equipment with prior notification to Molina.

(iii) Performing switch, wireless controller, and wireless access point upgrades and configuration, standardized (to Molina specification).

(iv) Performing router, load balancer, and WAN optimization device upgrades and configuration, standardized (to Molina specification).

(v) Performing firewall and other perimeter device upgrades and configuration, standardized (to Molina specification)

(e) Implementing Molina's videoconferencing traffic within the network by:

(i) Ensuring dedicated access for video and a predetermined bandwidth per Molina policies.

(ii) Connecting videoconferencing devices and supporting endpoints.

(f) Providing WAN operational support regarding the internal Molina Network, including:

(i) Maintaining the secure perimeter structure to comply with Molina's security policy.

(ii) Monitoring internet access points of presence in multiple geographically diverse data center sites.

(iii) Administering IP address management System (e.g., DNS, and DHCP).

(iv) Procuring via Molina's procurement team, resizing and decommissioning network circuits and access points as per Molina requirements.

(g) Administering quality-of-Service mechanisms, across telecommunications paths to support data, voice and video traffic as well as latency and jitter sensitive applications to Molina.

(h) Coordinating dispatch of support specialists as necessary to provide Authorized Users with operational and technical support and to meet required Service Levels.

(i) Coordinating install, move, add and change of data and voice Services with Molina, Service Service Provider, and Third Party suppliers.

(j) Coordinating PBX/Voice Mail/CMS backups of the voice equipment, and maintaining backup logs according to Molina processes.

(k) Performing Network Equipment loads and configuration.

(l) Implementing work around and resolution activities with Molina, Service Provider, and Third Party suppliers as required.

(m) Collaborating with Third-Party Service and maintenance suppliers as necessary to keep voice and data Equipment and Software in good working order.

(n) Coordinating dispatch of support specialists (Molina, Service Provider, and Third Party supplier) as necessary to resolve Network Incidents or Problems.

(o) Participating in Third Party supplier management Services:

(i) Incident management with Carriers including triage and restoration Services.

(ii) Coordination of Root Cause Analysis (RCA) process with Carriers.

(iii) Participation in monthly review forums with Carriers.

(iv) Coordination of dispatch Services and/or contact relevant Third Party supplier(s) when Problems cannot be resolved remotely.

(v) Verifying restoration of availability following Incidents with Data Network, Voice Network and/or Network Equipment.

(vi) Support Molina with managing existing Third Party supplier service levels to ensure proper problem acknowledgment, and status responses.

9. TELEPHONY

9.1 Service Provider shall provide for the administration of Molina's Voice Network infrastructure, as well as provide telephony managed Services to all in-scope Molina sites.

(a) Supporting Voice telephony Services including:

(i) Coordinating with existing Voice/Telephony Service Provider for inbound/outbound national and international calls.

(ii) Voice mail, including:

(A) Customizable user level voice mail account options, including user greetings, notifications delivered to external phone Systems, fast forwarding and reversing settings, message skipping, enterprise and group message delivery, message sending, forwarding.

(B) Interfacing with Molina's internal communications groups to coordinate enterprise voicemail broadcasts and ensure compliance with internal communications standards.

(C) Ensuring an easy-to-use, intuitive interface for setting user level voice mail account options and making user training available as required.

(iii) Enforcing Molina's security policy including sensible password rules.

(iv) Fixed-to-Mobile call direction.

(v) Desk sharing (user specific Services) and number portability.

(b) Providing access to all statutory geographic specific emergency Services, including 911, 999, 112, and location origination tracking.

(c) Reviewing all transport Service Provider charges.

(d) Validating that only valid toll charges have been applied to Molina.

(e) Reviewing and reporting abuses of long distance Services.

(f) Investigating whenever Molina exceeds Molina designated thresholds and coordinating activities with the transport Service Provider, including conferencing charges (e.g., bridge calls).

(g) Monitoring and reporting toll usage and toll fraud, and proposing cost savings opportunities (e.g., VoIP vs. traditional PSTN)

(h) Monitoring end user usage to detect termination of potentially unresolved calls due to issues such as poor audio quality.

(i) Managing Molina applications used for video conferencing (e.g., Cisco WebEx, Slack, etc.).

(j) Working with Molina approved Third Party suppliers for managing tele/video conferencing on ad hoc basis as required by Molina.

(k) Monitoring telephony circuit usage and provide recommendations on capacity changes and/or decommission.

(l) Recovering extension numbers upon receiving notices of termination, long-term disability, retirements, and other notices from HR.

(m) Complying with all Molina policies regarding international, federal, and state regulations.

(n) Complying with all Molina policies regarding federal and state "**Do not Call**" regulations.

(o) The Service Provider shall perform and administer voice systems, including participation in:

(i) Incident resolution,

(ii) Package administration,

(iii) Supplier (OEM) coordination,

(iv) Root cause analysis,

(v) Change management,

(vi) Operating System (OS) and patch management, and

(vii) Capacity planning.

(p) The Service Provider shall manage Cisco UCCE contact center technology platform, including IVR for agent routing, skilling, and delivery of Omni-channel contact interactions and administer voice systems, including:

(i) Reskilling/routing management as needed by business demand

(ii) Maintaining business open / close hours rules, including holiday exceptions

(iii) Maintaining FAD agent desktop technology/upstream works gadgets for agent interactions, and other technologies defined

(iv) Building and maintaining CUIC and other reporting mechanisms on demand for business need

(v) Recommending upgrade/patch/break-fix as needed

(q) The Service Provider shall manage contact center productivity tools like the NICE suite, including:

(i) Voice analytics

(ii) Engage call recording

(iii) IEX workforce management

(r) Implementing voice links against different PBX's and Network elements.

(s) Supporting integration with any Molina specified call center technology applications

(t) Operating Molina’s voice telephony environment, and perform required activities, including:

(u) Passively monitoring each conference by utilizing monitoring tools that allow the operator to view conference statistics (e.g., packet loss, jitter etc.) without being an active participant in the meeting via audio or video

(v) Monitoring Customer Premise Equipment (CPE) interfaces within the Service boundary in-band and out-of-band

(i) Performing diagnostic testing of CPE interfaces and isolate, sectionalizing and identifying faults as being physical or logical in nature

(ii) Identifying sites that are trending toward or operating above threshold levels so that Molina can consider network upgrades or changes

(iii) Working with Molina in reviewing the exception analyses and performance capacity reviews

(iv) Maintaining the performance Capacity Management performance thresholds

(w) Coordinating with remote field Services teams to performing Install, Move, Add, Change and De-Install (IMACD) Services.

(x) Installing Equipment, consumables and all other equipment and/or Software required to support the Services

(y) Supporting the retirement and replacement of equipment, including:

(i) Purging data and Software per Molina requirements and specifications.

(z) Participating in Third Party supplier management Services:

(i) Escalation of Carrier performance issues.

(ii) Incident Management with Carriers include triage and restoration Services.

(iii) Coordinating Root Cause Analysis (RCA) process with Carriers.

(iv) Participating in monthly review forums with Carriers.

(v) Coordinating dispatch Services and/or contact relevant Third Party supplier(s) when Problems cannot be resolved remotely.

(vi) Verifying restoration of availability following Incidents with Data Network, Voice Network and/or Network Equipment.

10. BUSINESS CONTINUITY PLANNING

10.1 The Service Provider shall comply with BCP/DR policies in Schedule 14 (*Molina Policies*) and Schedule 23 (*Business Continuity and Disaster Planning*) of the Agreement, and additionally Service Provider shall test all redundant infrastructure devices in alignment with Molina patching schedule and coordinate maintenance windows to minimize business impact.

10.2 For each incident with business impact, Service Provider shall notify Molina management as per Molina tiered notification requirements.

11. DISASTER RECOVERY

11.1 Service Provider shall comply with BCP/DR policies in Schedule 14 (*Policies and Procedures*) and Schedule 23 (*Business Continuity and Disaster Planning*) of the Agreement, and additionally Service Provider shall support Disaster Recovery Services Management so as to reduce IT related risk to Molina's' business as it pertains to other Service Provider responsibilities and including:

(a) Participate with all other teams as required, both internal to Service Provider and to Molina, to provide all disaster recovery management and recovery of Services herein.

(b) Follow a prioritized Service list based on a business impact analysis review and approval for the Service recovery class, as provided by Molina.

(c) Working with Molina on the creation of recovery plans, including developing Services and plans.

(d) Monitoring, tracking, and reporting, with Molina teams, updates to Disaster Recovery environments and Disaster Recovery testing environments, as required, and based on all approved Changes.

(e) Reporting DR metrics as specified by Molina.

(f) Escalating any questions or issues to Molina.

(g) Processing recovery classification requests for updating Configuration Management Database ("**CMDB**") with approved classification indicators (as identified in a Molina approved business impact assessment).

(h) Documenting all disaster recovery procedures according to Molina specifications, policies and procedures.

(i) Updating and archiving DR documentation as required by Molina.

(j) Assisting with all documentation related to disaster recovery management and recovery in a centralized location according to Molina specifications policies and procedures.

(k) Participating in Projects to on-board new or upgrading applications and Services into Disaster Recovery Services program as specified by Molina.

(l) Notifying Molina and coordinating updates to disaster recovery plans and documentation for applications and Services marked for retirement.

(m) Executing the disaster management and recovery plans and activities according to Molina specified criteria for exercise/testing, including:

(i) Validating the disaster management and recovery plans as required by Molina.

(ii) Participating in disaster simulation exercise with Molina once per year.

(iii) Participating in disaster simulation exercise with Molina as dictated by individual state requirements and per Molina instructions.

12. DATA CENTER REQUIREMENTS (CONDITIONAL)

12.1 The Data Center requirements captured in this section only applies if the Service Provider provides the data center (owned or Co-Lo) at any point during the life of the contract.

(a) Service Provider shall, in as many locations as necessary (pursuant to Molina policies, regulations, end user considerations, latency considerations, etc.), provide data center Services in data centers with a minimum rating of "tier 3" as defined by TIA-942

(www.upsite.com) data center standards, or the latest published standards of a similar nature approved by Molina, that, at a minimum, enables compliance with the Service Levels.

(b) Service Provider shall provide Molina with a geographical map of the environment surrounding the proposed Data Center Co-Lo facility locations that contains information including but not limited to any historical natural disasters, and proximity to major public cloud suppliers locations.

(c) Each Data Center facility will provide certification/documentation proving compliance with all required standards and industry conventions, at a minimum to include SSAE16 and ISO 27001 standards.

(d) Service Provider shall provide secure contiguous space in a facility that meets Molina architectural requirements.

(e) All facilities hardware (electrical, mechanical and environmental) shall be supported by valid maintenance contracts.

(f) Service Provider shall provide functional phone lines, not dependent on shared infrastructure.

(g) Service Provider shall provide internet access for Molina personnel.

(h) Service Provider shall ensure the distance to the telecommunications room from all Molina Equipment will be in accordance with manufacturer specification and leading practices based on cable utilized (e.g., UTP fiber).

(i) Service Provider shall provide Molina with a work area, power, network access and phones for Molina to perform on-site activities related to Molina Equipment within 24 hours of communicated arrival at Service Provider provided facility.

(j) Service Provider shall provide sufficient space to meet all server requirements including application, storage and networking (voice and data).

(k) Data center walls and entry points shall be of solid and secure construction with a minimum use of windows and complete facility reinforcement using code recommended bracing Systems.

(l) Service Provider shall provide a Data Center capacity plan each year on the anniversary of the commencement date and will plan any future capacity upgrades for contiguous space, servers, storage, and network equipment.

(m) A fire suppression System shall be utilized in accordance with Molina requirements.

(n) Providing sufficient physical storage, temporary and long term, to house any and all Molina, Service Provider, or Third Party Equipment.

Power Systems

(o) Primary power shall be available through correctly sized circuits to support maximum device loads (both startup and running).

(p) All high voltage and low voltage wiring shall be installed and maintained according to all applicable IEEE, IEC, NEMA and TIA/EIA standards.

(q) Dual independently pathed and separately ingressed electrical and network feeds shall be maintained into all cabinets and Equipment (where supported), and other secure areas from the electrical grid.

(r) Service Provider shall ensure that all standard 120/220/380 volt device redundant power connections are provided.

(s) Each data center (i) shall be equipped with a backup generator with a fuel tank capacity and fuel delivery arrangement large enough to ensure running at full load for at least 7 days, or as specified by Molina BCP/DR policies and requirements, and that supports the entire data center, including but not limited to critical Services such as HVAC, lighting; (ii) shall meet all disaster recovery and business continuity requirements; and (iii) shall have a running failover test successfully performed quarterly.

(t) Redundant power connections shall be made available as per Molina requirements.

(u) Redundant power shall be supplied by the backup generator as per Molina requirements.

(v) Providing continuous power of fifteen (15) minutes, or as specified by Molina BCP/DR policies, to ensure successful power transfers between uninterruptable power supplies and other back-up Systems.

(w) Uninterruptable power Systems and surge protection shall be in place to prevent power surges and ensure seamless failover to the generator.

(x) Standard ground fault interrupter switching shall be maintained for all premises meeting Molina requirements.

Telecommunication Systems

(y) Service Provider shall verify that dual, independently pathed, and separately ingressed telecommunication (both voice and data) circuits shall be utilized which are engineered to provide full carrier diversity at the local level.

(z) Service Provider shall maintain the capability to increase / decrease access, port speed, and quality of Service mechanisms integrated with Molina's network environment, all as requested by Molina.

Cable Management

(aa) Service Provider shall, with respect to each Data Center, utilize either 'access flooring' or 'overhead cable management Systems' for all new and existing cable and power distribution conduits, piping, and other carrier Systems (which shall all be in accordance with and approved pursuant to local building, electrical and code regulations, in addition to Molina requirements).

(bb) Latest IEEE/EIA/TIA industry cable standards shall be followed in all instances.

(cc) All cables shall be organized, easily traceable, and appropriately dressed, to meet Molina's needs, and the Service Provider shall provide photographic evidence following each change.

(dd) Cables shall be properly organized and located below the raised floor or in overhead cable trays.

HVAC

(ee) Service Provider shall ensure that redundant air handling equipment is installed to ensure that in no case, including in the event of a single unit failure, either head or roof, the temperature shall remain within an acceptable range in all locations within the data center and shall not exceed 26 degrees Celsius.

(ff) Service Provider shall cause air handling equipment to produce the necessary tons of air based on wattages per square foot for electronic equipment and free space to maintain an average temperature of 21 degrees Celsius in all locations within the data center.

(gg) Service Provider to cause water detection and humidity detection devices to be installed around all air conditioning and other environmental units (and any other possible water entry points).

13. **RESPONSIBILITY MATRIX**

The Service Provider shall perform the Services in a manner which complies with the responsibility matrix set out below. The table below is a RACI matrix in which:

- R corresponds to "responsible" – the Party indicated is responsible for doing work as needed to complete the task;
- A corresponds to "accountable" – the Party indicated is responsible for the correct completion of the task, which may be carried out through advance planning, oversight, or post-completion verification
- C corresponds to "consulted" – the Party indicated is one whose opinions are to be solicited by the other parties indicated with an R or A
- I corresponds to "informed" – the Party indicated is to be kept up to date by the other parties indicated with an R or A

Service	Detailed Task Description	Molina	Infosys
Documentation – SOPs, Procedures	Maintain documentation related to operational activities (escalation instructions, contingencies, etc.)		RA
Policies & Procedures	Review and approve documentation related to operational activities (escalation instructions, contingencies, etc.)	RA	
Incident management	Incident handling and Coordination		RA
New Tools & Technology	Propose new or alternate technology solutions for Molina Review	C	RA
New Tools & Technology	Approve the proposed new or alternate technology solutions	RA	
Monitoring, reporting	Proactive response to automated alerts, take action within established SLA's for availability, response times, etc.		RA
Monitoring, reporting	Periodic review of activities that were performed as a result of direct response to alerts.	C	RA
Monitoring, reporting	Review systems logs (manual or via automation tools) and report on anomalies and concerns.		RA
System Administration	Install, Update and Configure system software.		RA
System Administration	Inform Molina team regarding upcoming critical patches and plan/schedule new upgrade/patch rollout.		RA
Audit & compliance	Deliver evidence for requests for information, such as from regular formal audit reviews.	C	RA
Incident and Problem Management	Resolve incidents per agreed upon SLA's, etc. Perform troubleshooting and any necessary escalation within appropriate groups.	C	RA
Incident and Problem Management	Perform root cause analysis and deliver report.	C	RA
Incident and Problem Management	Handle escalations with 3rd party vendors within parameters of established maintenance/support contracts.	C	RA
Incident and Problem Management	Send out regular updates to keep Molina informed on current status.		RA
Incident and Problem Management	Handle problem management tasks (e.g. root cause analysis, follow-up fixes, etc.) as directed by Molina.		RA
Incident and Problem Management	Conduct performance analyses as required, per incident or otherwise (e.g. study based on reported trends or user experience, etc.).		RA
Access Management	Manage and maintain access to infrastructure management systems.	C	RA
Trending and capacity planning	Harness and extend monitoring and reporting capabilities, producing regular meaningful projections for Molina review. Includes resource usage as well as regular build activities.	C	RA
Trending and capacity planning	For all managed technologies, deliver regular report on system capacity and projections based on recent usage and/or growth trends.		RA
Change requests	Create, properly document, and execute changes in strict adherence with Molina change control processes		RA
Change requests	Report on changes and attend regular Change Advisory Board meetings	C	RA

Molina IT standards and policies	Adhere with any standards and policies set by Molina across services, providing feedback on standards and policies.	C	RA
Process improvement	Assess current processes and propose new recommendations that maximize efficiency, consistency, and accuracy of service/task delivered.		RA
Disaster recovery Maintenance, Management, and Testing	Execute annual DR testing activities including documentation of tests.	C	RA
	Update DR documentation as necessary.		
	Service systems dedicated to DR (in accordance to technology specific indications as listed in other areas).		
License Management	Report on license usage and inventory status to establish awareness towards renewals, etc. within established time frame for advance notice.		RA
Licenses Management	Procuring and renewing licenses	RA	
Asset Management	Document and maintain accurate inventory of all hardware at covered data centres and branches.		RA
Asset Management	Reports on supported hardware warranty status establish awareness towards renewals, etc. within established time frame for advance notice.		RA
Innovation and architecture	Work closely with Molina technical governance team, to support Molina innovation initiatives such as Proof Of Concepts for new technologies, via architecture assessments, test implementations, test documentation, and provide recommendations and feedback.		
Innovation and architecture	Provide Molina with operationalization plans for new technology.	C	RA
Third party management	Work with 3rd Party vendor for Problem resolution	C	RA
Third party management	Implement 3rd party vendor performance reporting	RA	
Third party management	Work with Vendors on enablement, communicate processes and procedures in operational interactions	C	RA
Third party management	Work with Vendors on contractual interactions	AR	
Third party management	Vendor Escalation management	A	R

CONTENTS

1. **INTRODUCTION**

1.1 This is Appendix 2-B (*Security Services*) Services forms part of the Agreement. All terms and conditions of the Agreement shall apply to this Appendix and any attachments hereto.

1.2 Service Provider shall provide 24x7x365 security monitoring and real time security analytics with escalation to and coordination with Molina teams as required.

1.3 Service Provider shall recommend improvements to Molina security technologies and processes, provide documentable assurance reports, and implement intelligent automation where possible to help improve Molina's security posture.

1.4 Service Provider shall work within [redacted] environment and tools including but not limited to [redacted].

1.5 Service Provider shall support identity management process and supporting Tools.

2. **MANAGED SECURITY SERVICES**

Services Requirements

2.1 Service Provider shall adhere to all Molina security requirements, including:

(a) Enforcing all current and future Molina policies and procedures as communicated to Service Provider.

(b) Ensuring Services comply with all local and regional regulatory requirements applicable to the Services in accordance with the Agreement, including but not limited to privacy, data retention, encryption, financial, auditing, and security.

(c) Ensuring all Molina policies are adhered to and auditing such adherence as required by Molina regulatory and compliance policies.

(d) Complying with Molina's technical Security specifications.

(e) Following all OEM standards and industry best practices for security incident management.

(f) Creating and maintaining all documentation related to security incident management policies, procedures, Equipment, and Software in accordance with all requirements communicated to Service Provider from Molina, including:

(i) Maintaining and reporting on log of incident types.

(ii) Maintaining and reporting on incident identification plans, including responsibility and routing matrices between Molina and Service Provider.

(iii) Maintaining and reporting on incident response plans, including normal prioritization and response processes, responsibility matrices between Molina and Service Provider, and response procedures to non-typical incidents.

(iv) Maintaining and updating, as required by Molina, incident run books.

(v) Maintaining and updating Service Provider contact lists and rosters.

(vi) Maintaining and updating incident escalation processes.

(vii) Maintaining and reporting on a log of threat types (e.g., Trojan, Key logger, Hacktivism).

(viii) Maintaining and reporting on threat classification plans.

(ix) Maintaining and reporting on vulnerability service levels and other metrics as defined by Molina in accordance with Molina policies.

(x) Maintaining and updating vulnerability response plans as defined by Molina.

Administrative Services

2.2 Service Provider shall administer and provide access controls and auditing for Molina's security incident management environment at Molina's directions according to Molina's auditing policies and standards as indicated in Schedule 14 (*Molina Policies*), including:

(a) Maintaining ownership of privileged system accounts and delegating access to authorized users upon a request per Molina policies. This will include but is not limited to (i) using PAM for managing local admin access on all workstations and servers, and (ii) the use of a privileged access control system for system accounts, administrative (i.e. Domain accounts) accounts, and (iii) DBA accounts.

(b) Administering IDs to ensure that only those privileges and authorities required for such IDs are provided to personnel, per Molina specifications.

(c) Recording the activities of all users, including privileged system accounts, and providing such records (e.g., domain administrator logs, system logs, etc.) to Molina as permitted by local and regional regulatory specifications.

(d) Reporting unauthorized users for management review and action per Molina policies.

(e) Rescinding access privileges upon termination or request by authorized Molina personnel.

Monitoring and Resolution Services

2.3 Service Provider shall monitor Molina's environment to identify potential security incidents, including:

(a) Allowing Molina application and infrastructure teams to initiate on-demand vulnerability scans on applications, databases, and servers during development activities occurring within the application development or project lifecycle.

(b) Providing access to Systems and Equipment as required by Molina teams. Molina retains the ownership of the software and execution function for scanning.

(c) Scanning Molina technology for indicators of vulnerability, missing patches, and misconfigurations, including but not limited to:

(i) Scanning web applications for indicators of vulnerability, missing patches, misconfigurations.

(ii) Scanning applications and infrastructure components for indicators of vulnerability, missing patches, and misconfigurations.

(iii) Scanning databases for indicators of vulnerability, missing patches, and misconfigurations.

(iv) Scanning physical infrastructure components (e.g., servers, routers, switches, wireless controllers, non-superseded Microsoft patches, and operating systems such as Linux, Unix, and Windows) for indicators of vulnerability, missing patches, and misconfigurations.

(v) Scanning mobile devices for indicators of vulnerability, missing patches, and misconfigurations.

(vi) Scanning Molina's code based solutions for indicators of vulnerability, missing patches, misconfigurations. This includes but not limited for the scanning of source code for any custom developed changes to applications and systems to identify malformed code.

(d) Performing infrastructure, database, application, and operating system penetration tests as required by regulatory requirements in accordance with the Agreement. Molina may conduct these with 3rd parties to the Service Provider and will require support and timely remediation of any identified issues of concern.

(e) Providing the capability to allow Molina to perform on-demand and independent scans. Molina may conduct these with 3rd parties to the Service Provider and will require support and timely remediation of any identified issues of concern.

(f) Providing scan results consultation, remediation guidance and recommendations when needed by Molina. The cadence for this work and reporting will be determined by Molina, but likely to involve weekly activities.

Support Services

2.4 Service Provider shall perform all security incident, threat, and vulnerability management support services, in accordance with Molina's policies (i.e. Incident Response Plan) including:

(a) Supporting Molina regarding a security incident, threat, phishing attempt or vulnerability being identified.

(b) Investigating active incidents and alerts.

(c) Containing and resolving security incidents and events assigned to Service Provider based on a Molina approved security incident prioritization process.

(d) Handling false positives.

(e) Rule tuning.

(f) Supporting triage of a security incidents or escalating appropriately as defined in Molina's incident escalation process.

(g) Supporting containment, eradication, and recovery services for security incidents.

(h) Gathering evidence of security incidents for future investigation and analysis.

(i) Coordinating with Molina to investigate the origin of security incidents.

(j) Recommending and executing Molina approved post event remediation activities.

(k) Participating in post mortem reviews as per Molina processes.

(l) Monitoring, triaging, investigating and responding to incidents and/or security events on the PhishMe triage platform, including but not limited to:

(i) Active incident and alert investigation based on PhishMe inbox emails.

(ii) Proper classification and remediation of non-malicious emails.

(iii) Incident tracking.

(iv) Remediation and support of incidents/events.

(v) Rule and recipe creation/tuning.

(vi) Escalation of incidents as per Molina requirements.

(vii) Documenting lessons learned from each security incident handled, making data available to Molina upon request and make recommendations for where Molina can improve its security posture.

(m) Coordinating with Molina approved Third Party software vendors to gather security threat and vulnerability intelligence.

Consult with Molina CDC L2/L3 resources on containment and eradication strategy for priority zero and priority 1 incidents.

(n) Providing on-demand vulnerability information to collaborate with Molina defined security and incident response teams (e.g., for zero day attacks, supervisory control and data acquisition ("**SCADA**") exploits, threat management processes and services), including:

(i) Building an internal threat intelligence program for threats that Service Provider detects that are targeted at Molina Systems.

(ii) Associating vulnerability information to Molina defined risk levels and ratings.

(iii) Communicating information and risk levels to Molina stakeholders as defined.

Operations Services

2.5 Service Provider shall perform all security incident management operations services, including:

(a) Security incident monitoring, identification, and response.

(b) Triage tickets raised by the Symantec Managed Service as possible incidents.

(c) Support for 3rd party audits and performance of audit of controls in accordance with regulatory requirements such as HIPAA Security Rule and NIST SP 800-53.

(d) Performing quality reviews, with Molina, of security incident processes.

(e) Participating in security incident management simulations and exercises.

(f) Reporting on security incident statistics, trends, and lessons learned.

(g) Recommending enhancements to proactively avoid vulnerabilities.

(h) Recommending security incident and vulnerability management process improvements for Molina review and approval.

(i) Recommending updates to patches or other security measures to proactively avoid future security incidents.

(j) Assisting with deployment of patches or other security measures.

(k) Support the analysis of trends in threats and incidents (e.g., spikes in network activity, root cause analyses for repeat offenders, patient zero analysis for worm activity, account lockouts).

(l) Ensuring that retention schedule complies with Molina requirements.

(m) Support vulnerability management activities on hosts, network devices and off-the-shelf applications that can be found in:

(i) OS software

(ii) Firmware

(iii) Commercial applications.

(iv) Custom-written and partner-written applications.

(v) Misconfigured security safeguards.

(vi) Unauthorized applications. Service Provider will assist with removal of unauthorized applications upon notification from Molina of their presence.

(n) Service Provider shall support Molina's security information and event management (SIEM) environment in a manner that meets all Molina requirements, including:

(i) Support tuning activities to avoid false positives.

(ii) Providing log management capabilities, including:

(A) Maintaining chain of custody on data.

(B) Support the ability to search log data, run reports, specify data retention periods, and specify compression of log data.

(C) Maintaining ability to offload and store log data to an external data store (e.g., NAS, SAN).

CONTENTS

1. **INTRODUCTION**

1.1 This is Appendix 2-C (*End User Services*) forms part of the Agreement. All terms and conditions of the Agreement shall apply to this Appendix.

2. **GENERAL SERVICE DESK SERVICES**

2.1 Service Provider shall provide Service Desk services in accordance with this Attachment, which Services shall be the single Level 1 point of contact for Users regarding tickets, which include events that cause or may cause an interruption or reduction of Services, as well as for requests for information and requests for Services relating to all of Molina's IT Services.

2.2 Service Provider shall provide 24x7 hours of operation Sunday through Saturday of each week in the following languages: English.

2.3 Service Provider shall staff twenty-four (24) hours per day every day of every year a single point of contact for internal and external Users through a country-specific, central telephone number capable of routing callers to the appropriate Service Provider Personnel in the most efficient manner practicable (a "**Service Desk**").

2.4 Service Provider shall manage the Service Desk and the ticket management process including:

(a) Recording issues and work orders in a Molina approved ticketing System.

(b) Performing contact prioritization and regularly (as directed by Molina and based upon Molina-provided Priority level definitions) informing Users of ticket status.

(c) Providing Users with a ticket reference number associated with such issue or work order until such Users agree it is resolved.

(d) Transferring the ticket per Molina approved escalation criteria and procedures to another Service Provider support group (e.g., server support) or another Third Party (if allowed pursuant to Molina approved procedures) as required.

(e) If unresolved within a Molina specified and approved timeframe, transferring tickets to a higher level of support, per Molina standards and processes.

(f) Maintaining incident ownership for the resolution and closure of the ticket even if support is performed by others, per the requirements set forth by the Service Levels in Appendix 6-A (Service Level Matrix).

(g) Performing First Call troubleshooting and Resolution ("**FCR**") of tickets, including but not limited to password resets, e-mail, office productivity tools, logon issues, shrink-wrap Software, custom applications (including complying with Molina provided scripts) and other First Call Resolution issues directed by Molina.

(h) Resolving issues related to the Services.

(i) Ensuring Service Desk personnel possess the appropriate customer service and technical skills and qualifications to provide technical Service Desk Services, including effective oral and written communication skills and a customer-focused attitude (e.g., correct, polite, helpful, understanding, clear and understandable language speaking, listening and writing skills) with specific requirements to be determined during Transition.

(j) Ensuring Service Desk personnel have ongoing adequate training and documentation to stay current on new products, Services, Equipment, Software and technologies used by Molina.

(k) Providing Level 1 support for all Molina IT environments, including:

(i) Equipment, including but not limited to desktops, laptops, mobile devices.

(ii) Infrastructure, including but not limited to voice and data network and Systems.

(iii) Applications, including but not limited to productivity tools and business applications.

(l) For those incidents which cannot be resolved by the Service Desk, Service Provider shall escalate to the appropriate Level 2 or 3 teams, whether Molina, Service Provider, or Third Party.

(m) Defining a methodology for interfacing with Molina Level 2 and 3 support teams or external teams required to resolve an issue or provide a workaround.

(n) Receiving phone calls, chats, and web-based incident submissions.

(o) Complying with applicable regulations and data privacy laws and Molina policies relating thereto.

(p) Providing self-help (self-service) support, including:

(i) A web-based ticketing system (approved by Molina) including automated ticket registration by Users and capabilities for Users and Authorized Users to check status of specific tickets or groups of tickets based on Molina provided access control lists.

(ii) Providing and updating a list of frequently asked questions (FAQs) and potential workarounds as approved by Molina and in compliance with Molina requirements.

(iii) Create knowledge articles subject to Molina review and consideration for approval.

(q) Complying with Molina requirements to accommodate Molina provided and Molina administered surveying and sentiment analysis, including providing a compatible call recording capability:

(i) Jointly developing user survey questions and ratings with Molina.

(ii) Conducting monthly satisfaction surveys and reporting on results and resolution time metrics.

(iii) Following up with Users on all negative surveys and sentiment analysis scoring and providing Molina a detailed plan within ten (10) days after completion of the survey or sentiment analysis to correct the causes of such dissatisfaction.

(iv) Complying with all performance management requirements associated with surveys and sentiment analysis.

(r) Ensuring security processes are in place such that Service Desk calls are authenticated and users are correctly identified.

(s) Identifying opportunities to improve Service Desk Services (e.g., automation, self-service, etc.) and making recommendations to Molina.

Technical Requirements

2.5 Service Provider shall support Molina in integrating Molina's information technology Service management ("**ITSM**") tools with Service Provider's and Service Provider's third parties' Systems (as directed by Molina) in a manner that ensures end-to-end Service management and seamless integration from an end user's perspective.

2.6 Service Provider shall accommodate multiple technology channels (inbound or outbound) to communicate with the Users (e.g., phone calls, chats, web-based), including:

(a) Providing automatic call distributor ("**ACD**") capabilities and reporting capabilities, all of which meet Molina specifications.

(b) Pre-screening and appropriately routing caller based upon issue.

2.7 Service Provider shall perform chat Services in accordance with Molina specifications that will include the following:

(a) Access to Molina chat Software to initiate chat sessions with Service Provider help desk personnel.

2.8 Service Provider shall provide Molina consultation regarding technology requirements (DSL, cable, etc.) when standard secure connectivity (e.g., VPN) is not available.

2.9 Service Provider shall provide Molina with forward looking view of advances in contact channels such that planning and implementing new contact channels may be considered for implementation on an annual basis according to Molina annual planning cycle.

Ticket Management

2.10 Service Provider shall perform ticket and ticket management, including:

(a) For each Service Request or ticket reported, assigning a unique ticket number for tracking.

(b) Assigning ticket Priority Levels to all tickets as defined by Molina's policies, procedures, and Service Level agreements as specified in this Agreement.

(c) Maintaining ownership of the ticket (regardless of disposition and in a manner that provides a seamless experience for all Users) through closure.

(d) Providing Resolution for tickets the Service Desk owns, including, and in accordance with the Service Levels in Appendix 6-A (*Service Level Matrix*):

(i) Updating the ticket work log with all relevant status updates and troubleshooting steps taken.

(ii) Providing root cause analysis activities and proposing changes to the environment to eliminate future tickets from being reported when possible; creating relevant knowledge articles and/or contributing to existing knowledge base.

(e) Engaging appropriate support teams for resolution in order to meet Service Level targets in accordance with the Service Levels in Appendix 6-A (*Service Level Matrix*).

(f) Integrating the Service Desk with Molina's functions, tools, and processes.

(g) Supporting Molina as required in identifying, reviewing, tracking and communicating patterns and trends that are causing issues and escalating trends to appropriate groups as needed.

(i) Obtain open lines of communication with appropriate escalation groups such that status and remediation from escalated pattern and trends can be communicated to Molina.

(h) Providing special or very important person (VIP) Users (as designated by Molina) with priority service including accelerated response time for issues and access to the trouble System and ticket escalation.

(i) Providing 24x7 support and VIP User support Service, including:

(A) Meetings setup and associated support

(B) MAC computer support

(C) Mobile device support

(D) WebEx and telepresence troubleshooting

(E) Special event support (e.g., annual shareholders meeting)

(F) Wireless access support, printing, and other technology support

(G) Traveling with Molina executives (as per Molina directions) to provide technology support. Any travel, lodging & boarding expenses incurred for VIP support will be borne by Molina, in each case subject to the provisions of the Agreement regarding reimbursement of Service Provider expenses.

(ii) Allowing Molina to reasonably nominate, at its sole discretion, VIP Users who will require VIP User support Services.

(iii) Verifying that tickets to the Service Desk from VIP Users are recognized as such at the receipt of the ticket to provide VIP Users with the response from the Service Desk specified in the Service Levels.

(iv) Notifying Molina using the approved process of all tickets generated from the VIP Users, including ticket status and other details as directed by Molina.

(i) Closing tickets with defined category levels for reporting, analysis and tracking ticket results for process and knowledge improvement.

(j) Proactively confirming with the affected User(s) that the problem has been satisfactorily resolved and closing the ticket after driving the ticket to complete resolution.

(k) Ensuring that tickets are closed (pursuant to actual resolution of tickets) within the defined Service Level targets as specified within the Service Levels in Appendix 6-A (Service Level Matrix).

(l) Provide the ability to discern and open additional tickets when a User(s) communicates a new issue arising from a closure contact.

2.11 Service Provider shall provide a Service Desk with that is in compliance with Molina processes for Service delivery and Service management, and is ITIL-conformant.

User Complaint Management

2.12 Service Provider shall respond to Users as well as Molina teams expressing concerns with Service provided during a call or otherwise, including:

(a) Working with Molina in defining the procedures to be followed when complaints are raised, including:

(i) Logging, tracking and reporting complaint remediation.

(ii) Ensuring Molina is aware of complaints that may have financial or reputation implications.

(iii) Ensuring corrective actions are completed at all levels of Service Desk personnel.

(iv) Ensuring appropriate changes to processes are put in place.

(v) Providing written communication to the User(s) logging the complaint, as appropriate.

Escalation Management

2.13 Service Provider shall escalate identified ticket resolution issues to the appropriate Molina management team(s) or support partners for tickets where the Molina team(s) owns the resolution activity, including:

(a) Tracking tickets and ensuring that Service Provider provides periodic updates and ticket status, including:

(i) Working with Molina in defining the criteria to escalate for a lack of ticket updates by the Service Provider teams.

(ii) Maintaining and updating Molina's contact, VIP, and escalation lists on a regular basis.

2.14 Working with Molina to define the escalation process based on Molina business requirements, including but not limited to "internal warm transfers" or "external warm transfers."

2.15 Service Provider shall ensure User(s) can be transferred to appropriate Molina Supervisor or equivalent based on the defined escalation process.

Communication

2.16 Service Provider shall support Molina-provided methods and tools to announce outages, un-scheduled downtime and/or special announcements affecting Users (including any outages, un-scheduled downtime, and/or special announcements related to Third Party Services).

2.17 Service Provider shall notify Molina management wherever reasonably possible when Service Level targets related to issue resolution are at risk of being missed; this is above and beyond the reporting requirement as specified in Schedule 6 (*Service Levels and Service Credits*).

2.18 Service Provider shall promote self-help (Self-Service) support and educated Users to increase adoption of self-help (Self-Service) support.

Knowledge Management

2.19 Service Provider shall compile lists of knowledge articles where recommended solutions can be made available to the Service Desk and Users to increase the ability to resolve tickets.

2.20 Service Provider shall provide knowledge articles in a format for publication on Molina's internal Systems and/or contribute knowledge articles in Molina Service Management tools (e.g., ServiceNow)

2.21 Service Provider shall identify members on the Service Provider's team(s) to act as subject matter experts (SME) to:

(a) Increase First Call Resolution (FCR).

(b) Identify problems needing attention by higher level support teams.

(c) Provide training to Service Desk teammates.

(d) Provide quality reviews of new knowledge, training, processes.

Reporting / SLA Management

2.22 Service Provider shall comply with Molina's monthly Service Level tracking and reporting requirements.

2.23 Service Provider shall provide real-time and ad-hoc reporting as required by Molina, including:

(a) Providing daily status report on Molina daily production status call including the previous 24-hour significant issues, remediation of significant issues and any extra-ordinary ticket volume. This reporting will be compliant with Molina requirements, in accordance with the Service Levels in Appendix 6-A (*Service Level Matrix*).

2.24 Service Provider shall participate in weekly Molina IT infrastructure and business application deployment conference calls, including:

(a) Providing feedback on ticket trends related to deployments.

(b) Proactively informing Molina on User issues related to active deployments.

(c) Proactively informing Molina of backlogs or pending items that may impact the Services and proposing means to reduce such backlogs or mitigate such pending items.

2.25 Service Provider shall provide ad-hoc individual ticket root cause analysis (RCA) and closed loop corrective actions in regards to issues raised by Molina.

Molina Satisfaction

(a) Service Provider shall leverage Molina-provided sentiment analysis and customer satisfaction survey tools as the foundation for delivering, measuring, and improving ongoing Services.

(b) Service Provider shall utilize results from sentiment analysis and customer survey to initiate a review process to determine the reason and remediation for those results.

(c) Service Provider shall develop survey parameters and content, which in each case shall be subject to Molina's prior written approval:

(i) Targeted users – any User that contacts the survey desk for assistance.

(ii) Intervals – how often Users will be surveyed.

(iii) Invitation rate – the number of surveys that Molina may be subject to in a specified period.

(iv) Expiration period – the time period during which the User may respond to the survey before it expires.

Quality Management and Continuous Improvement

2.26 Service Provider shall support process improvement initiatives or activities as required by Molina.

2.27 Service Provider shall provide internal coaching and share lessons learned among Service Provider team members to promote Service improvements.

2.28 Service Provider shall proactively conduct incident analysis per the parameters outlined by Molina.

2.29 Service Provider shall proactively conduct knowledge analysis.

2.30 Service Provider shall facilitate advisory board events, including but not limited to meetings, calls, requests for information, as required by Molina.

2.31 Service Provider shall deploy best-in-class industry leading Service Desk quality management practices in compliance with Molina certification requirements, which will be subject to Molina audit requirements.

Business Continuity

2.32 The Service Provider shall comply with BCP/DR policies in Schedule 14 (*Molina Policies*) and Schedule 23 (*Business Continuity and Disaster Recovery*) of the Master Services Agreement, as part of which Service Provider shall develop a business continuity plan to ensure uninterrupted Service Desk Services during a disaster or outage for Molina review and consideration for approval. During an outage or disaster, Service Levels will not apply unless the Disaster Recovery Plan specifies otherwise; provided, however, that the Service Levels shall apply in any event where the Disaster Recovery Plan was enacted in response to a breach of the Agreement by the Service Provider (as opposed to being enacted in response to a Force Majeure Event).

2.33 The Service Provider shall comply with BCP/DR policies in Schedule 14 (*Molina Policies*) and Schedule 23 (*Business Continuity and Disaster Recovery*) of the Master Services Agreement, as part of which Service Provider shall develop a Disaster Recovery Plan for an outage of Service Desk Services for Molina review and consideration for approval. During any outage or disaster, Service Levels will not apply unless the Disaster Recovery Plan specifies otherwise; provided, however, that the Service Levels shall apply in any event where the Disaster Recovery Plan was enacted in response to a breach of the Agreement by the Service Provider (as opposed to being enacted in response to a Force Majeure Event).

2.34 Service Provider shall notify Molina management of unresolved tickets relevant to a disaster recovery situation within a Molina specific time frame, including:

(a) Advising Molina of the impact, initial assessment and recommended actions to maintain and restore Services.

2.35 Molina must be notified if calls are switched between locations within a timeframe agreed with Molina of a declared disaster recovery situation, per Molina policies.

3. GENERAL END USER COMPUTING SERVICES

General End User Computing Services

3.1 Service Provider shall perform the in-scope Services for the in-scope Equipment as designated by Section 1 of the TSD.

3.2 Service Provider shall provide and manage life-cycle Services including asset management, installation management, license management reporting, warranty support using existing Molina's contracts, recovery, redeployment, preparation for disposal, and on-site support for Equipment while complying with Molina specified processes and policies or working with Molina designated Third Parties.

Services Requirements

3.3 Service Provider shall perform image deployment Services that adhere to all Molina End User Computing requirements, including:

(a) Complying with or improving (subject to Molina's review and consideration for approval) Molina's current and future Equipment and Software technical specifications, including changes and refreshes of technology (hardware, components, or Software) by Equipment and Software Service Providers. Changes will be completed within Molina guidelines, at or before due date and in compliance with Molina change management process.

(b) Coordinating with internal or Third Party Service Providers to provide remote "hands and feet" support for network and local file and print server issues.

(c) As applicable, managing and integrating with Service Providers of Equipment for effective roadmap plans and resolution of technical issues, in in accordance with the Service Levels in Appendix 6-A (*Service Level Matrix*).

Administrative Services

3.4 Service Provider shall administer, manage, and execute requests for Molina Equipment, and software submitted by Molina Users in accordance with Molina policies and procedures, including:

(a) Verifying User entitlement to the requested Molina Equipment or software and advising Molina management on any non-conformance issues relating to entitlement.

(b) Providing life-cycle support from procurement to end-of-life disposal, including:

(i) Validating entitlements to, sourcing, installing, tracking, recovering, redeploying and disposing of assets.

Deployment and Retirement Services

3.5 Service Provider shall provide or oversee, as appropriate, all installations, de-installations, cascades, moves, adds, changes and deletions (IMACDs) for all Molina Equipment, Software, and related Services at designated Molina Sites, including:

(a) Coordinating, planning, and scheduling IMACDs with all affected IT functions, Molina Personnel, Third Party contractors and Users (whether the function is included within the Services provided by Service Provider, as a Molina-retained function, or a Third Party) to achieve high-quality execution of the IMACDs, (including scheduling and dispatching of appropriate Molina, Service Provider and/or Third Party Contractor technicians) to meet Service Levels and to minimize business impact on Users and any operational interruption to Molina.

(b) On receiving and verifying a valid IMACD request, performing all necessary pre-work before an IMACD is executed.

(c) Communicating with Users if there is any issue with an IMACD request.

(d) Providing a mechanism for expedited handling of IMACDs and Project IMACDs that are of high business Priority to Molina, such that all IMACDs are completed within the required timeframe.

(e) Creating and documenting the processes to enable IMACD execution for each Molina Software and/or Equipment component, and obtain Molina's approval for such processes and documentation.

(f) As applicable, conducting or confirming a Site survey to determine the location of the IMACD and coordinate any special requirements at the location.

(g) Providing the necessary technical support to complete the IMACD, including on-site support during normal business hours for Molina Locations identified by Molina in Molina's sole discretion.

(h) Remotely conducting all IMACDs for Molina Equipment and Software where practicable.

(i) Confirming that all Molina Equipment, Software, parts, Network, cabling, or any other Services necessary to execute the IMACD will be available as of the date scheduled for the IMACD.

(j) Confirming the new and/or existing configuration of Molina Equipment and Software associated with performing the IMACD. Service Provider will conform to configurations approved by Molina.

(k) Confirming the installation and/or de-installation procedures associated with performing the IMACD, including backup, contingency, and test procedures.

(l) Coordinating the scheduling and dispatching of appropriate technicians, including Third-Party Service Providers.

(m) Coordinating with Molina so that as required, Molina can place orders for the installation of Equipment.

(n) Providing depot Services using Molina's existing depots in support of IMACD activity for Equipment.

(o) Supporting Third-Party Service Providers in the execution of IMACDs, and coordinating such activities with the applicable Molina personnel or Third-Party Service Providers.

(p) Performing any required backup procedures in accordance with Molina policies and processes.

(q) De-installing and re-installing any existing Equipment, Software, or other related Services as necessary to execute the IMACD.

(r) For multiple Users sharing workstations:

(i) Supporting workstation sharing among multiple Users.

(ii) Supporting multiple accounts on single workstations.

(iii) Making available the User-specific Software configurations of all installed Applications.

(s) Confirming correct implementation of the IMACD with the designated Molina personnel as appropriate.

(t) Coordinating Molina's Third party vendors for disposal, in accordance with Molina policies and procedures.

(u) Supporting Molina in monitoring Molina satisfaction and Service Levels throughout the IMACD activity and following the delivery.

(v) Tracking the IMACD request from initiation to completion, using the Molina System defined to track IMACD activity.

(w) Providing a single point of contact for Users and the Service Desk for activities associated with each individual IMACD.

(x) Providing close coordination and support to the Service Desk for all matters pertaining to IMACD requests and status reports.

(y) Performing IMACDs for Service Provider Personnel without additional charge to Molina, and without including such IMACDs when comparing actual IMACD volume to any Resource Baseline.

(z) Updating the Molina System of record to reflect any new information upon completion of the IMACD and/or as specified by Molina.

3.6 Service Provider shall assist User with migration of data from the malfunctioning unit to the replacement unit, assist with any required application installation and/or configurations, and perform gathering and migration of data for Molina Equipment.

3.7 Service Provider shall provide support to the User in order to enable the data to be copied, and send any necessary media that facilitates the copying of data along with the replacement. Service Provider shall ensure that, after any User Equipment changes, Users have all functionality provided on prior Equipment, that all data has been migrated from the prior Equipment to the new Equipment, all applications have been migrated and updated if appropriate (per Molina specifications), and that all such Equipment changes are fully tested according to Molina specifications.

3.8 Service Provider shall develop and execute managed refresh plans for Molina Equipment (subject to review and consideration for approval by Molina), including developing contingency plans and out-of-warranty repair processes.

3.9 Service Provider shall coordinate efforts with Third Party service and maintenance Service Providers as necessary to keep EUC Equipment and Software in good working order, and perform these responsibilities regardless of the Party (Service Provider or Molina) that has financial responsibility for the underlying asset and maintenance expenses.

3.10 Service Provider shall perform all maintenance of Molina Equipment and Software in accordance with Molina change management procedures, and schedule this maintenance to minimize disruption to Molina's business.

3.11 Service Provider shall coordinate recovery activities for Molina Equipment and Software (e.g., lost and stolen assets) in accordance with all Molina policies (including IT security policies).

3.12 Service Provider shall provide such maintenance as necessary to keep the assets in good operating condition and in accordance with the manufacturer's specifications, or other Agreements as applicable, so that such assets will qualify for the manufacturer's standard maintenance plan upon sale or return to a lessor. Service Provider will provide support with enhanced SLA expectations for response per Molina specifications.

Support Services

3.13 Service Provider shall perform all support Services, including:

(a) Notifying Molina IT of outages related to Service Provider's Services.

(b) Providing break-fix support, advice and assistance in accordance with manufacturer warranties.

Providing advanced notification in accordance with Molina policies for any planned or unplanned down time, including planned preventative maintenance.

(c) Providing IT walk-up support for locations as identified by Molina and according to agreed specifications.

(d) Providing remote or dispatched support by qualified specialists as necessary or requested by Molina in all Molina locations.

(e) Providing Depot support by qualified specialists as necessary for Molina locations where remote or dispatched service is not required (as directed by Molina). In those cases where Service Provider Personnel are not qualified to perform dispatched, depot, or remote support, Service Provider shall manage, dispatch, and maintain financial responsibility for qualified third party technicians.

(f) Correcting all incidents associated with failure or degradation of the performance of Molina Equipment and Software.

(g) Integrating across areas (including local support organizations) to support a seamless IT environment across all Molina teams and Molina's Third Party Contractors and external business connections.

(h) Implementing patches (only to Molina approved patch levels) and applying Molina approved Software updates, including maintaining the capability to test new patches and Software updates.

(i) Assisting with connectivity to Molina's network environments, including but not limited to remote and off-site personnel accessing the Molina internal networks and applications.

(j) Performing System remediation to ensure compliance to Molina standards such that non-standard alterations to systems are identified during service calls and remediated upon Molina approval.

(k) In the event of Molina Equipment failure, coordinating with Third Party Contractors to determine root cause, appropriate fix, and warranty and expense implications.

(l) Creating and maintaining support knowledge articles and documentation in the Molina knowledge base.

(m) Creating and maintaining Site and Molina Equipment inventory lists in the Molina System of Record.

(n) Supporting (by phone, on the ground, or with training manuals as appropriate) to enable the correct use of Molina Equipment and Software and of related technologies and services.

Operations Services

3.14 Service Provider shall perform all operations Services and provide related reports as dictated by Molina, including:

(a) Testing all non-performing Molina Equipment and Software.

(b) Returning all non-performing Molina Equipment and Software to the warranty provider.

(c) Replacing all non-performing Molina Equipment and Software under warranty.

(d) Repairing all non-performing Molina Equipment and Software that is not under warranty.

(e) Managing Molina Third Party Contractors to resolve issues with non-performing Molina Equipment and Software within Molina's required timelines.

3.15 As directed by Molina, Service Provider shall maintain, control and report an inventory of spare Molina Equipment at Molina locations and provisioning such devices as necessary to Users.

3.16 Service Provider shall provide End Point Encryption Services using existing Molina provided tools/solutions.

Delivery and Staging

3.17 The Service Provider’s responsibilities include the following:

(a) Providing Depot Services using Molina’s existing depots in support of IMACD activity.

(b) Preparing and coordinating the shipping and receiving of Molina Equipment and Software that are delivered in accordance with procurement orders from Molina.

(c) Receiving Molina Equipment as necessary at Molina Sites.

(d) Verifying that all contents of the delivery are included according to the procurement order.

(e) As appropriate and required, notifying representatives from Molina, the Service Provider or any Third-Party Service Providers that the order has been received, as well as completing and forwarding any required paperwork associated with verifying the receipt and contents of the order to the appropriate Molina, Service Provider, or Third-Party Service Provider personnel.

(f) Providing timely input into Molina Systems to provide accurate billing and order/inventory management.

(g) After receipt at the initial Site, moving or shipping all Molina Equipment and Software (if necessary) to the staging Site (and a location within the Site) on a

scheduled delivery date that is agreed to with the appropriate User or Third-Party Service Provider.

(h) Arranging and preparing for shipping to and from Sites, as required.

(i) Verifying that the Molina Equipment and Software are stored in a secure area and are not subject to undue heat, cold, or dampness.

(j) Providing all logistics Services (provisioning, Site preparation, etc.) associated with the movement of Molina Equipment or Software from Third-Party Service Providers to staging facilities.

(k) After the Molina Equipment and/or Software has reached its final staging destination and prior to its actual installation, the Service Provider has the following responsibilities (as necessary based on an agreed installation date and plan):

(i) Unloading, uncrating, and/or removing the packaging that was used to ship and contain the product.

(ii) Assembling and/or testing the product, including assembling a complete or partial configuration, if required by the agreed installation plan.

(iii) Providing the specific configuration required to complete the assembly and/or installation of the Molina Equipment and Software.

(iv) Using the Molina standard deployment tools and configuration for the underlying Molina Equipment and/or Software for all new Molina Equipment and Software, unless otherwise approved by Molina.

(v) Preparing and delivering quality review processes to the Service Provider's personnel or Third-Party Service Provider in electronic format and/or paper copy as needed.

(vi) Providing all parts and materials necessary for proper assembly and installation of Molina Equipment, Software and Services, exclusive of electrical power and environmental resources and any other materials specifically agreed with Molina or a Third-Party Service Provider.

(vii) Coordinating with all Third-Party Service Providers that are supplying peripheral or ancillary Molina Equipment or Software.

Patch and Software Distribution Support

3.18 Service Provider shall perform all patch and Software distribution operations Services, including:

(a) Performing Software distribution and patch management.

(b) Supporting patch distribution services for multiple operating system configurations.

(c) Determining patch distribution schedules and methods, according to Molina policies and procedures.

(d) Providing ongoing notification processes to Service Desk services, informing them of patches and patch schedules.

(e) Reporting patch and Software distribution status and progress against planned or advertised schedules, and providing risk mitigation plans where exceptions arise, per Molina requirements.

(f) Implementing a method and a process for testing patch and Software releases prior to general deployment, including testing and, where necessary, coordinating the testing certification of patches within Molina Equipment.

(g) Obtaining Equipment, Software and BIOS inventory, including reporting on historical PC and BIOS inventory information for Software license verification.

Back-up and Recovery Services

3.19 Service Provider shall support Molina's back-up and recovery activities, including:

(a) Supporting the configuring and scheduling backup and recovery tools.

(b) Supporting the development of data migration, archival, backup, and retention management procedures.

(c) Supporting the implementation and management of backup procedures, including installing and configuring components, scheduling backups, and executing on-demand backups.

(d) Supporting the implementation and management of archival procedures, including installing and configuring components, scheduling archival processes, and executing on-demand archrivals.

(e) Supporting the implementation of recovery procedures, including online, partial, or other recovery procedures, per Molina policies and processes.

End User Training

3.20 Service Provider shall perform end user training related to the Services, including:

(a) Providing train-the-trainer training and associated documentation for products and Services delivered by Service Provider.

(b) Providing end users with feature overview and product update documentation, and user guide documentation whenever Service Provider Software releases are implemented.

(c) Providing computer-based, documentation-based, and/or web-based orientation training for end users, inclusive of all new Service Provider Equipment, Service Provider Software, and/or Service Provider Services, pending Molina's approval.

4. **ENDPOINT SECURITY**

Host-Based Firewalls

4.1 Service Provider shall provide backup and recovery firewall policies and configurations.

Host-based Intrusion Protection System (IPS)

4.2 Service Provider shall support global IPS on end user devices across Molina assets.

4.3 Service Provider shall monitor all IPS devices from the central logging System, and provide appropriate response to health alerts.

4.4 Service Provider shall review IPS rule updates, determine risk and recommend priority for deployment for Molina's review and approval.

Endpoint Detection and Response (EDR) Solution

4.5 Service Provider shall be responsible for the proper installation of security Software distribution. Service Provider shall deploy approved product updates in the case of individual Software distribution(s).

4.6 Service Provider shall provide hands and feet or remote support services for non-contained Molina Equipment in the event of suspicious activities and issues on hosts and endpoints at Molina corporate locations.

Antivirus and Malware Protection for Endpoints

4.7 Service Provider shall be responsible for the proper installation of security Software distribution of such production as antivirus. Service Provider shall deploy antivirus patterns in the case of individual Software distribution(s).

5. **RESPONSIBILITY MATRIX**

The Service Provider shall perform the Services in a manner which complies with the responsibility matrix set out below. The table below is a RACI matrix in which:

- R corresponds to "responsible" – the Party indicated is responsible for doing work as needed to complete the task;
- A corresponds to "accountable" – the Party indicated is responsible for the correct completion of the task, which may be carried out through advance planning, oversight, or post-completion verification
- C corresponds to "consulted" – the Party indicated is one whose opinions are to be solicited by the other parties indicated with an R or A
- I corresponds to "informed" – the Party indicated is to be kept up to date by the other parties indicated with an R or A

#	Activity	Detail	Sub-Activity	Molina	Infosys	Third Party
1	General	Act as first point of contact to support user IT related incidents/ service requests through phone call, chat and web tickets.	Provide end user facing 24x7 IT Service Desk support in English	I,C	R	
2			Provide initial training to Infosys on functions, features and configuration of all the Molina supported environment (IT Infrastructure and Business Applications)	R	A	
3			Provide existing documentation on Molina's Service Desk tools and processes to Infosys	R	A	
4			Respond to contacts via Telephone, Chat and Web Portal	I,C	R	
5			Resolve Incidents, escalate to resolver group as applicable to meet Service Level Targets	I,C	R	
6			Ensure that all staff are fully trained and experienced in the resolution of first time fixes and ensure that service levels are achieved	I,C	A, R	
7			Ensure that all Service Desk staff are familiar with Molina’s relevant policies and procedures	I,C	A, R	
8			Develop, document and maintain the Service Desk operational procedures for each of the Services/Sub-Services defined in the SoW	I,C	R	
9			Implement quality management practices in compliance with Molina requirements	I,C	R	
10			Continuously identify and implement opportunities for improvement	I,C	R	
11			Identify and report trends in incidents and requests and propose solutions to reduce overall cost	I,C	R	

#	Activity	Detail	Sub-Activity	Molina	Infosys	Third Party
12	***Incident Management***	Troubleshoot and resolve L1 incidents and escalate to respective L2/ L3 resolver groups where resolution is not possible within Molina defined timeframe	Establish/ Define Incident classification by priority	A,R	C,I	
13			Establish Incident workflow, escalation, communication and reporting processes that help to achieve required Service Levels	I,C	RA	
14			Review and approve Incident classification, prioritization and workflow, communication, escalation and reporting processes	R	A	
15			Molina to extend ITSM & other operational tools to Infosys as is the case in the current business	R	I,C	
16			Manage entire Incident lifecycle including detection, escalation, diagnosis, status reporting, repair and recovery	I,C	R	
17			Provide a satisfactory response to each contact made, providing the End User at all times with a clear method of resolving the Incident or Service Request	I,C	R	
18			Initiate the process of ticket closure so that the closure notices can be routed automatically to the end-user	I,C	R	
19			Resolve incidents at first contact, otherwise escalate to appropriate Level 2 resolver groups within Infosys or to other resolution groups in other Parties	I,C	R	I
20			Determine the allocation to other resolver groups of Incidents that cannot be resolved on first contact	I,C	R	
21			Troubleshoot Incidents using the relevant knowledge databases (e.g. KEDB and CMDB), knowledge articles provided by other Parties	I,C	R	
22			Document and update solutions to Resolved Incidents in knowledge database for Service Desk continual improvement	I,C	R	
23			Manage efficient workflow of Incidents including the involvement of third parties and initiate broadcast of outages in accordance with Molina's approved procedures	I,C	R	I,C

#	Activity	Detail	Sub-Activity	Molina	Infosys	Third Party
24	Verify acceptance of resolution by contacting the End-User to confirm through any channel (Phone/Email/Chat) and record results. Ticket closure does not occur until End User confirmation is completed and recorded	I,C	R			
25	Service Desk owns each Incident through to resolution, to the satisfaction of the user, regardless of OEM and Component ownership	I,C	R	I,C		
26	Capture data required for KPIs pertaining to volumes for all Incident types such as by hour per day; Service Desk call/chats abandonment rate, telephone call/Chats lengths, time-to-answer rates for telephone calls/chats, etc.,	I,C	R			
27	Categorize, prioritize and log all Service Desk contacts along with resolution activities in the ITSM Tool (Service Now).	I,C	R			
28	Collate Incident information from End Users regarding suggested improvements to the Infosys's Services	I,C	R			
29	Ensure that resolution of Service Desk contacts are based on priority and impact levels as defined and agreed by both Molina and Infosys	I,C	R			
30	For Major Incidents, the service desk will initiate the incident management process and assign the tickets to the respective resolver groups	I,C	R	I		

#	Activity	Detail	Sub-Activity	Molina	Infosys	Third Party
31	***Service Request Management***	Resolve service requests and escalate to respective L2/ L3 resolver groups where the required rights, skill set are not available with L1 team for resolution.	Identify and document Service Request priority types, response and Resolution targets for all the standard Service Requests	I,C	A,R	
32			Extend ITSM system to Infosys to document, manage and track all Service Desk communication and Service Requests and inquiries regardless of the means by which the Service Request is submitted (e.g., telephone, web)	R	I,C	
33			Log and prioritize all Service Requests based on service catalog	I,C	R	
34			Where Service Requests are non-standard, proactively manage these calls with resolver groups to track that they are resolved within service standards	I,C	R	
35			Log all non-standard Service Requests that cannot be handled by the Service Desk and hand over to the appropriate parties to fulfill	I,C	R	I, C
36			Manage all standard Service Request escalations in accordance with the agreed procedures	I,C	R	
37			Work closely with all resolver groups & service delivery partners to proactively identify additional standard Service Requests. Agree the take-on of these with Molina ensuring that they are fully documented in the Knowledge Management Repository, and the Service Desk staff are appropriately briefed and trained	I,C	R	C
38	***Knowledge Management***	Identify opportunity for creation of Service Desk/ user facing knowledge articles and support in creation of the same in specified format.	Co-ordinate and maintain knowledge management repository for all Service Desk issues, including knowledge articles containing first time fixes & standard Service Requests, and with auditable access to Molina	I,C	R	
39			Maintain a list of all resolutions (Incident & Request) that can and should be resolved by the Infosys at first contact.	I,C	R	
40			Work closely with all service delivery partners and resolver groups to continuously identify suitable resolutions, first time fixes for the knowledge management repository	I,C	R	C

#	Activity	Detail	Sub-Activity	Molina	Infosys	Third Party
41	***Customer Satisfaction Management***	Leverage Molina-provided sentiment analysis and customer satisfaction survey tools as the foundation for delivering, measuring, reporting, and improving ongoing Services.	Collate, analyze results, and tabulate trends from returned CSAT and sentiment analysis surveys	I,C	R	
42			Provide performance reports as requested by Molina on a regular basis categorized by service and resolver group	I,C	R	
43			Review the results of the satisfaction process with Molina and work with Molina and other Third parties to assimilate feedback into continuous improvement processes	I,C	R	C
44			Log, track and report user complaint, initiate remediation and implement the required corrective actions across process and personnel	I,C	R	
45			Identify opportunities for continuous improvement within the Infosys Services, agree with Molina and implement	I,C	R	
46	***Service Level Management***	Monitor and track adherence to Molina SLAs and share pre-defined, ad-hoc reports with Molina as requested.	Manage and meet Service Level Targets as defined and agreed by both Molina and Infosys	I,C	R	
47			Share Service Level reports with Molina at pre-agreed frequency	I,C	R	
48			Meet with Molina every 6 months to suggest changes to Service Levels including new Service Levels and increase in Service Levels that the Infosys believes would benefit Molina	I,C	R	
49	***Technical Requirements***	*Support in integrating Molina's infrastructure with Infosys and its third parties' systems (as directed by Molina) in a manner that ensures end-to-end Service management and seamless integration from an end user's perspective.*	Own and manage the IT infrastructure deployed at Infosys delivery center	I,C	A, R	
50			Provide the required data connectivity bandwidth	I,C	R	
51			Multi-Channel Services hosted on ServiceNow platforms	R	I,C	
52			Provide pre-screening and automatic call distributor (“ACD”) capabilities along with provision for call reporting capabilities.	I,C	R	
53			Provision and provide technical support for the local desktops and monitors and the required hardware such as Head Sets deployed within the Molina ODC	I,C	R	

Activity	RACI	
	Infosys	Molina
Desktop Engineering		
Deployment of Operating System, SW packages and patches on the end client machines using MS SCCM	RA	IC
Upgrade and maintenance of the Standard Operating Environments (SOEs)	RA	IC
Coordination with third party vendors for the Third Party tools integration with Molina AD, ADFS DHCP etc.	RA	IC
Manage and Maintain the Self- Help portal and User Account management	RA	I
Management of the Service Request system for any kind of HW or SW IMAC requests	RA	I
Creation, Deletion and update of User accounts through AD	RA	IC
Manage and Maintain SW License Inventory using the ServiceNow & MS SCCM tools	RA	I
Endpoint Antivirus Management on the end user devices	RA	I
End Point Hard Disk Encryption Management	RA	IC
Standard Operating Environment Image to be maintained as per the Industry best practices and Molina Business requirements	RA	CI
Scheduled upgrade of the Reference point with the security Patches, HW drivers and applications (including third party applications)	RA	CI
Third party vendor Coordination for HW Imaging, Asset Disposal, HW Inventory Management	RA	CI
HW Inventory Management using ServiceNow ITSM tool	RA	I
Remotely control the End User devices for Incident resolution using existing Molina Bomgar tool	RA	I
To deploy the OS & SW packages and as per the user accounts	RA	I
Support the Microsoft operating systems currently deployed on desktop and Laptops for Molina users (Win 7 and Win 10)	RA	I
Provide necessary Microsoft patches/service for desktops and laptops as required	RA	CI
Provide the Application Packaging services as per the requests raised by Molina Application Team (MSI packages)	RA	I
Provide application installer files for packaging	I	RA
Testing the Application Packages in the Test environment before deployment	RA	CI
Provide test scenarios for business applications	C	RA
Deployment of Software Patches, Application Packages to Molina End Devices within Molina's intranet.	RA	I

Mobile Device Management (MDM)

	RACI	
Activity	Infosys	Molina
MDM service request management	RA	I
Support for self-service portal and tool	RA	I
Maintenance of Communication templates related to MDM service	RA	I
Support for specific tasks such as allow/deny access, enable/disable particular capability	RA	I
Administration of the MDM service platform	RA	CI
To provide resolution for the MDM service environment related incidents and service tickets	RAC	I
Manage Documentation – Provide FAQs, User guides, Standard Operating Procedures (SOPs),	RA	CI
Resolution of the device enrollment and enrollment related issues	RA	CI
To perform device status monitoring and dashboard administration	RA	I
MDM incident and service tickets resolution	RA	I
Modify/New policy information for specific user groups or devices.	RA	CI
Application onboarding process definition and support	RA	I
Support for MDM service related processes and compliance	RA	CI
Compliance of the MDM service solution with security guidelines provided Molina Enterprise Security Framework	RA	CI
Monitor Mobile Iron for Enterprise solution system parameters	RA	CI
Maintaining inventory data of devices, users, status, last connect.	RA	I
Document and track the device management life cycle of standard end user devices	RA	CI
Generate Status report on ticket (incident/service request) resolution	RA	CI

Field Support Services

	RACI	
Activity	Infosys	Molina
Coordination with OEM vendors for break-fix and AMC related matters	RA	CI
Escorting OEM/Vendor team at Customer site	RA	CI
Local incident Resolution	RA	CI
Desktop field services (Repair, swap)	RA	CI
Break fix and Hard IMAC	RA	CI
Provide tech bars support at Dedicated sites	RA	CI
Coordination with Purchase for refilling of stock	RA	CI
Physical verification and reconciliation for HW	RA	CI
Manual Image, patch installation on low bandwidth network machines	RA	CI
Connection of Machine to network and establish remote connectivity with offshore	RA	CI
Desk-side/onsite repair (component swap)	RA	CI
Desktop/Laptop and parts inventory update and asset up keep	RA	CI
Physical device/asset decommissioning	RA	CI
Consumable Replacement (spare acquisition)	A	RCI

APPENDIX 2-D

PRO FORMA

PROJECT WORK ORDER

This Project Work Order, between [***Molina entity***] ("**Molina PWO Party**") and [***Service Provider entity***] ("**Service Provider PWO Party**") is entered into pursuant to the Master Services Agreement between [***Molina MSA Party***] and [***Service Provider MSA Party***] effective [***date***] (the "**MSA**"). The terms and conditions of the MSA, the Schedules and the Appendices thereto, are hereby incorporated into this Project Work Order and subject to any variations to such terms and conditions set out below.

Molina Reference Number: [●]	**Service Provider Reference Number: [●]**

The parties hereto, each by a duly authorized representative, have executed this Project Work Order as of the date set out below and this Project Work Order is effective as of the Commencement Date:	
[*Molina Entity*]: [●]	**[*Service Provider Entity*]: [●]**
By:	By:
Signed:	Signed:
Title:	Title:
Date:	Date:

Where Molina Head of IS Vendor and Supplier Management signature is required:
[*Molina Entity*]: [●]
By:
Signed:
Title: Molina Head of IS Vendor and Supplier Management
Date:

1	Project Name / Program Name

2	Project Managers
	Molina Project Manager
	Service Provider Project Manager

3	Commencement Date		
	Day	**Month**	**Year**

4.1	Project Description

4.2	Risks
	The following description of business and/or operational risks associated with this Project is intended for operational use only, is not legally binding, neither does it affect, waiver or amend any of the rights or obligations set out in this Project Work Order:

5	Stage and Description
	[Stage Name and Description]
	[Stage Name and Description]
	[Stage Name and Description]
	[Stage Name and Description]
	[Stage Name and Description]

6	Molina Requirements

7	Acceptance Criteria

8	**Molina Personnel Authorized to sign off that Acceptance Criteria have been met in respect of each Stage or Deliverable**
	Name of Person authorized to sign off Deliverables/Stages on behalf of the Molina PWO Party

9	**Charging Mechanism**	**Select One Only**	**Complete paragraph:**
	Role Based Time and Materials		11
	Capped Time and Materials		12
	Fixed Price		13

10	**Invoice Currency**
	[USD]

11	**Role Based Time and Materials**								
	Name ***[Note: Name may sometimes be required where identity of person is important to Molina.]***	**Skill Grade**	**Home Location**	**Work Location**	**Language**	**Resource Unit Rate**	**Start Date**	**End Date**	**Estimated Cost**

12.1	Capped Time and Materials – Estimate		
	Month	**Estimated Charges incurred by Service Provider in that Month**	**Estimate of Time Based Payment Amount**
	[Month]		
	[Month]		
	[Month]		
	...		
	Total Estimated Charges for the PWO		

12.2		Capped Time and Materials			
	Stage	**Payment Milestone / Decision Point**	**Date**	**Estimated Retained Amount**	**T&M Cap per Stage**
	[Stage]	Milestone 1			
		Milestone 2			
		Milestone 3			
		....			
		Final Payment Milestone			
		Totals – [Stage]			
		Authority To Proceed			
	[Stage]	Milestone 4			
		Milestone 5			
		Milestone 6			
		....			
		Final Payment Milestone			
		Totals – [Stage]			
		Authority To Proceed			
	[Stage]	Milestone 7			
		Milestone 8			
		Milestone 9			
		...			
		Final Payment Milestone			
		Totals – [Stage]			
	[Stage]	Milestone 10			
		Milestone 11			
		Milestone 12			
		...			
		Final Payment Milestone			
		Authority To Proceed			
		Totals – [Stage]			

	[Stage]	Milestone 13			
		Milestone 14			
		Milestone 15			
		...			
		Final Payment Milestone			
		Authority To Proceed			
		Totals – [Stage]			

12.3	**Capped Time and Materials – Resource Profile from Quote**		
	Skill Grade	**Number of Individuals**	**Home Location**

12.4	**Project Structure**
	[Include arrangements describing how Service Provider Personnel will be structured and managed]

13	Fixed Price				
	Stage	**Payment Milestone / Decision Point**	**Date**	**Estimated Retained Amount**	**T&M Cap per Stage**
	[Stage]	Milestone 1			
		Milestone 2			
		Milestone 3			
		....			
		Final Payment Milestone			
		Totals – [Stage]			
		Authority To Proceed			
	[Stage]	Milestone 4			
		Milestone 5			
		Milestone 6			
		....			
		Final Payment Milestone			
		Totals – [Stage]			
		Authority To Proceed			
	[Stage]	Milestone 7			
		Milestone 8			
		Milestone 9			
		...			
		Final Payment Milestone			
		Totals – [Stage]			
	[Stage]	Milestone 10			
		Milestone 11			
		Milestone 12			
		...			
		Final Payment Milestone			
		Authority To Proceed			
		Totals – [Stage]			
	[Stage]	Milestone 13			
		Milestone 14			
		Milestone 15			
		...			
		Final Payment Milestone			
		Authority To Proceed			
		Totals – [Stage]			

14 Deliverables									
Stage	**Deliverable**	**Input / Output**	**If Input, does it contain Molina Requirements (Y/N)?**	**Document Version Number**	**Acceptance Criteria**	**Delivery Date**	**Milestone Number**	**Milestone Date**	**Payment Milestone (Y/N)?**

16	Molina Responsibilities	Date Required

17	Molina Locations and Approved Service Delivery Location

18	Additional Service Provider Key Personnel for this Project Work Order	
	Name	Title

19	Assumptions

20	Other Service Providers

21	Service Provider Software

22	Third Party Software

23	Open Source Software

23	Site Systems

24	Molina Software to be provided by Molina

25	Project Governance

26	Molina Policies
	[Note: Identify which non-mandatory Molina Policies do <u>not</u> apply to this Project Work Order]

27	Additional Terms and Conditions	
	Molina Legal Approval	
	Name:	Title:
	Date:	Signed:
	Service Provider	
	Name:	Title:
	Date:	Signed:

29	Linked Project Work Orders
	The following Project Work Orders are Linked to this Project Work Order:

SCHEDULE 3 PRICING AND INVOICING

CONTENTS

1. **Definitions**

1.1 All terms and conditions of the Agreement will apply to Schedule 3 and any Appendices hereto, and capitalized terms not defined in Schedule 3 will have the meanings given to them in the Agreement. Section references used herein will refer to the applicable section in Schedule 3, except as otherwise set forth herein.

2. **Introduction**

2.1 This Schedule sets out the requirements as to pricing and invoicing with which the Service Provider must comply in connection with the Services.

2.2 No other Charges

The Service Provider shall not be entitled to impose or pass on any fees, charges, taxes, duties or expenses for the Services unless there is a specific charge set out in this Schedule or unless specifically permitted to do so in this Agreement.

Notwithstanding any other provision of this Agreement, if there are no specific fees, charges or expenses identified within this Schedule for a particular activity which the Service Provider is required to perform under this Agreement, then the Charges already incorporate a fee, charge or expense for that activity. The absence of a specific fee, charge or expense for a particular activity does not mean that, and may not be used to support any argument that, the particular activity does not form part of the Services.

Without limiting the paragraphs of this Section 2.2 set out above, the Service Provider shall provide or have provided all of the Systems (and be responsible for all of the costs of provisioning, commissioning, maintaining, refreshing (to the extent sent out in the applicable SoW) and installing those Systems), licenses, contracts, premises (other than the facilities to be provided by Molina as set out in Schedule 15 (Access to Molina Facilities)), personnel, consumables, peripherals, processing and storage capacity and all other resources, capital and skills necessary to provide the Services (unless any such activities are a Molina Responsibility) and to procure the performance of all of the Service Provider's obligations set out in the Agreement, for the Charges.

2.3 Late Payment Interest

The Service Provider shall be entitled to invoice Molina for accrued late payment interest at the Agreed Interest Rate in accordance with Clause 41 (Late Payment) of the Agreement.

2.4 General Principles

Subject to Section 10, the Charges for all Services are inclusive of all disbursements, administrative expenses, allowances and other costs and expenses incurred in, or in connection with, the provision of the Services, including the cost of:

(a) connectivity required by any Service Provider Person to enable that Service Provider Person to perform his or her duties in relation to the Project Services;

(b) personal tools required by the Service Provider Person to enable that Service Provider Person to perform his or her duties in relation to the Services, unless any such tools are described as Molina's responsibility in Appendix 3-A-1. (Financial Responsibility Matrix), Schedule 13 (Access to Molina Facilities), Schedule 16 (Dependencies), or as Molina Responsibility in a Project Work Order;

(c) all necessary employment visas required to work in a country for an extended period and other permits, licenses (except Software licenses) and consents necessary for any Service Provider Person to carry out any work in any location;

(d) overhead and organizational infrastructure for a Service Provider Person needed to deliver the Services (including human resources, finance, tax and legal functions or services);

(e) any translation to or from English of documentation required to perform, or to report performance of, any of the Services; and

(f) in the case of Project Charges, the performance of all the activities set out in the Projects Statement of Work.

3. **Agreed Cost Standards**

3.1 Introduction

The determination of whether Charge Adjustments may be made, the amount of any Charge Adjustments, and the calculation of Charges for Project Services shall be made in accordance with the principles set out in this Section 3. The Service Provider shall ensure that the Charges (and its preparation of the Charges) at all times comply with the Agreed Costs Standards.

3.2 Interaction with Benchmarking

The Agreed Cost Standards do not in any way limit or affect the outcomes of the Benchmarking Process. The Agreed Cost Standards shall not require the Service Provider to adjust the Charges where it does not agree to do so under the Benchmarking Process. Any adjustments to the Charges following the Benchmarking Process shall be made in accordance with the Agreed Cost Standards.

3.3 Enforcement and Verification

The Service Provider shall provide a confidential letter addressed to the members of the Head of IS Vendor and Service Provider Management, no later than 14 Business Days after the end of each Contract Year, to state that each Charge Adjustment assessed and invoiced in that Contract Year was assessed and invoiced in accordance with the Agreed Cost Standards.

3.4 The Agreed Costs Standards

Principle of Fairness – All Charge Adjustments and Charges for Project Services shall be fair and reasonable both to Molina and the Service Provider.

Principle of Proportionality – Subject to the principles that follow, all Charge Adjustments, Benchmarking Adjustments and Charges for Project Services shall be in proportion to the increase or decrease in the costs and/or risk that the Service Provider requires to deliver the Services.

Principle of Similar Charging Methodology – The methodology for calculating Charge Adjustments shall be based wherever practical upon the same methodology as applies to the Charges.

Principle of Auditable Pricing – The Service Provider may not impose any Charge for Project Services or make any Charge Adjustment unless that adjustment is supported by reasonable supporting documentary evidence. Not all the supporting evidence need be disclosed to Molina but it must be sufficient to allow Molina to make a meaningful assessment of the reasons for any Charge Adjustment or Charge for Project Services. However, all supporting evidence, whether disclosed to Molina or not, must be maintained in such a form as to allow an auditor or other expert appointed pursuant to Clause 38 (*Audit and Information Access*) of this Agreement to conduct an audit referred to in that Clause.

4. **Appendices**

4.1 The following Appendices are attached to Schedule 3 and shall apply to the Exhibits, as applicable:

(a) Appendix 3-A. (Pricing Matrix) sets forth the pricing framework, matrix and constructs for all functions.

(b) Appendix 3-A-1. (Financial Responsibility Matrix) sets forth whether Service Provider or Molina shall be financially responsible for the expenses associated with Personnel, Software, Equipment, Facilities, Systems and other expenditures related to the provision of Services during the SOW Term.

(c) Appendix 3-A-2. (Transition Charges) sets forth the charges associated with Transition Services, which shall be invoiced on a Fixed Fee, per milestone basis.

(d) Appendix 3-A-3 (Termination Charges) sets forth charges in the event of Termination for Convenience.

(e) Appendix 3-A-4. (Volume Discounts) sets forth the discount percentages Service Provider shall credit Molina based on all Services provided by Service Provider in a given period.

(f) Appendix 3-A-5. (Invoicing Structure) sets forth the invoice structure to be used by the Service Provider.

(g) Appendix 3-A-6. (Infrastructure Pricing) sets forth the Resource Units and corresponding Infrastructure Monthly Charges that are chargeable to the Molina for in-scope Infrastructure Services.

(h) Appendix 3-A-7. (Security Pricing) sets forth the Security Monthly Charges that are chargeable to the Molina for in-scope Security Services.

(i) Appendix 3-A-8. (EUS Pricing) sets forth the Resource Units and corresponding End User Services Monthly Charges that are chargeable to the Molina for in-scope End User Services.

(j) Appendix 3-A-9. (Applications Development Committed Capacity) sets forth the approved roles for Service Provider Personnel performing in-scope Services and the corresponding resource rates based on a committed capacity model.

(k) Appendix 3-A-10. (Application Test Committed Capacity) sets forth the approved roles for Service Provider Personnel performing in-scope Services and the corresponding resource rates based on a committed capacity model.

(l) Appendix 3-A-11. (Application Support Pricing Matrix) sets forth the Application categories and the corresponding Application Support Monthly Charges that are chargeable to Molina for Application Support Services for such Application category.

(m) Appendix 3-A-12. (Resource Unit Definitions) sets forth the definitions for Resource Units as indicated in other pricing worksheets.

(n) Appendix 3-A-13. (Supplemental Rate Card) sets forth the approved roles and rates for Service Provider personnel to be used in cases of Supplemental Project Charges

"**Resource Unit Rates**" shall mean the rates on which the Service Fees shall be calculated,

4.2 Unless expressly agreed otherwise in a SOW, there shall be no increase to the Resource Unit Rates during the Term of the Agreement, and for the avoidance of doubt, there shall be no increase to the Resource Unit Rates as a result of exchange rate movements or inflation.

5. **Intentionally Omitted**

6. **On-Going Services Charges**

6.1 For ongoing services set forth in Appendices 3-A-6 (Infrastructure), 3-A-7 (Security Services), and 3-A-7 (End User Services), the total allowable Charges for each Resource Unit shall be calculated as A x B, where:

6.2 A = the Resource Unit Rate for such Resource Unit.

6.3 Certain Resource Unit Rates incorporate annual productivity improvements as set forth in Appendices 3-A-6 (Infrastructure), and 3-A-7 (End User Services).

6.4 B = the total actual volume of such Resource Unit in the applicable month, subject to the following:

(a) Service Provider shall not invoice for more than one Resource Unit if a device or Service fits within the definition of more than one Resource Unit.

(b) In the event that a device or Service fits within the definition of more than one Resource Unit, the Parties will refer the matter to the applicable Operational Review Board to determine which Resource Unit applies to such device or Service.

(c) Where the volume of Resource Units is not cumulative (as determined by Molina) (e.g., FTE hours is a cumulative Resource Unit and desktops supported is a non-cumulative Resource Unit), the volume of Resource Units shall be calculated as the average daily volume of the number of Resource Units for the Period. For cumulative Resource Unit, the volume of Resource Units shall be calculated as on the end of the month.

(d) For a period of three months from the First Go Live Date of the Agreement and until such time the actual Resource Unit count is determined, invoicing shall be based on the Baseline Units, as set out in the Summary of Projected Charges tab of appendix 4 B (Pricing Matrix) as "Projected Monthly Service Volumes". Thereafter, once the actual count is completed, a retrospective adjustment shall be carried out to the charges in the subsequent invoice. In such case, Service Provider shall not retrospectively adjust charges for services related Resource Units for which the actual count is within [redacted] of the Baseline Unit count. Molina and Service Provider will complete joint inventory tracking during transition period.

(e) For the fourth and subsequent months, the parties shall agree the actual volume of any Resource Unit, for the purposes of invoicing within the first 10 days after the month for which the invoice had to be raised. In the event the parties do not agree within 10 days the invoicing will be done based on the last invoiced volume count of Resource Units, and when agreement is reached, any variation shall be credited against the subsequent invoice.

(f) The term "Resource Unit Data Source" means a database or repository designated by Molina as the repository of all Resource Unit Records that shall track chargeable Resource Units. No Resource Unit Record may be added to the Resource Unit Data Source without Molina's prior agreement. No Resource Unit Record will be deemed a chargeable Resource Unit for a month unless (i) it is listed in the Resource Unit Data Source and (ii) Service Provider provided Services (other than removal) with respect to such Resource Unit Record during a month.

(g) For avoidance of doubt, the Resource Unit Data Source is for invoicing purposes only and omission of an item from the Resource Unit Data Source shall not affect or reduce Service Provider's responsibility under Schedule 2 (Services) and/or the Exhibits thereto to provide Services with respect to that item.

(h) In the event that an item designated as a Resource Unit is replaced by a new item, the Parties will refer the matter to the applicable Operational Review Board (i) to designate an existing Resource Unit that will be associated with such replacement item, (ii) to determine that the replacement item is not relevant for pricing purposes (and thus will not be counted when determining the number of Resource Units), or (iii) to determine that providing Services with respect to the new item requires a new Resource Unit, in which case Service Provider will submit a new Charges proposal to perform Services with regard to such item pursuant to Schedule 2 (Services) or an amendment, as determined by Molina.

(i) In the event of a change in the amount of a Resource Unit, any change of [redacted] (or such other percentage as the parties specify in the Agreement) of the total amount of such Resource Unit will result in the completion of a formal Change Request.

6.5 The total allowable On-Going Services Charges for Services in connection with a Service Tower shall be the sum of all On-Going Services Charges for Resource Units associated with such Service Tower.

6.6 Service Provider shall measure and report to Molina monthly on the number and type of Resource Units actually utilized by Molina.

6.7 To the extent the Service Provider is responsible for Hardware and Software refresh as set out in the applicable SoW, such refresh shall be at no additional Charge in accordance with the Services, except, in each case subject to agreement by Molina and Service Provider, to the extent Molina requires an accelerated refresh of Molina Hardware and Software in addition to (a) refresh as set out in the SoW or (b) refresh as may be required for Service Provider to fulfil its obligations set out in the Agreement.

6.8 Service Provider may only begin charging Molina for On-Going Service Charges for a Service when all corresponding Transition Milestones for that Service are met.

7. Supplemental Project Charges

7.1 For a project priced on a time and materials basis outside the scope of Services, the formula for calculating such "Supplemental Project Charges" for each Project Rate for each month shall be calculated as (D x E), where:

(a) D = the Supplemental Project Rate set forth in Appendix 3-A-13 (Supplemental Rate Card), as applicable in such month, or such lower rate as may be specified in the applicable project statement of work.

(b) E = Number of Project Productive Hours provided by Service Provider Personnel in the role associated with such Supplemental Project Rate during such month.

7.2 The total allowable Supplemental Project Charges in connection with a project statement of work priced on a time and materials basis shall be the sum of all Supplemental Project Charges for each Supplemental Project Rate associated with such project statement of work without any supplemental amounts, up-charges, or any other fee.

7.3 For a project statement of work priced on a basis other than time and materials, the Charges shall be set forth in such project statement of work.

8. **Transition Charges**

8.1 All Charges for Services performed by Service Provider under Schedule 4 (Transition and Transformation) shall be as set forth in Appendix 3-A-2 (Transition Charges); such Charges shall be fixed, regardless of actual effort undertaken and shall be invoiced by Service Provider to Molina on a Fixed Fee basis in accordance with Appendix 4-B (Milestones).

8.2 For the avoidance of doubt, all costs in connection with providing Transition Services shall be Service Provider's responsibility and include but are not limited to:

(a) Service Provider Equipment costs

(b) Training and on-boarding of resources that shall become Service Provider Personnel to charge Productive Hours

(c) Travel and expense costs

(d) All Service Provider Equipment, Software and Systems inherent to delivering Transition Services and achieving Service Provider commitments

(e) Costs associated with providing System access, as specified in the Appendix 4-B-1 (Financial Responsibility Matrix)

(f) Expense associated with integration of Systems as required by Service Provider to provide Services under the SOW

(g) Expense associated with the migration of data between Systems (e.g., the transfer of tickets to new queues)

(h) Service Provider’s costs associated with knowledge transfer

(i) Any other costs associated with modifying the Services as they are performed on the SOW Effective Date

8.3 If Service Provider fails to achieve acceptance of a Milestone for Transition by its Milestone Date, Service Provider shall be liable for delay payments in accordance with Schedule 4 (Transition and Transformation). The applicable Transition Fee less that total amount of the Delay Payment shall be considered to be the “Adjusted Transition Fee” for that Transition. The total amount of the Adjusted Transition Fee for a Transition may be invoiced by the Service Provider upon Acceptance of the final Transition Milestone for that Transition in accordance with Schedule 4 (Transition and Transformation).

8.4 In the event that Go Live for any Transition does not occur on the relevant Milestone Date any costs incurred by Service Provider shall be borne by the Service Provider and the Transition Charges shall not vary.

9. **Discounts**

Volume Discount. At the end of each annual period, Service Provider shall reimburse Molina an amount calculated as K x L = M, where:

(a) K = discount percentage as determined pursuant to Appendix 4-B-4 (Volume Discounts) as applicable to the Charges for such period.

(b) L = the total On-Going Services Charges, Committed Capacity Charges, and Supplemental Project Charges for such period

(c) M = Discount amount due Molina for such period.

(d) Volume Discounts and any additional discounts shall be applied, simultaneously with the issuing of the last invoice of each Contract Year.

10. **Inflation Adjustments and Foreign Exchange**

All inflationary adjustments, indexation and foreign exchange risk shall be incorporated into the Resource Unit Rates for the Term of the Agreement (including any renewal terms). Commencing on the second anniversary of the Effective Date, and again as of each anniversary of the Effective Date thereafter during the Term, the Service Provider may notify Molina that Supplier wishes to implement a CPI adjustment on the Project Rates; provided however, that (i) onsite Project Rates will not increase by more than the lesser of (a) [redacted] and (b) the Consumer Price Index for All Urban Consumers (CPI-U) as released by the U.S. Department of Labor, Bureau of Labor Statistics for the year prior to the date on which the applicable adjustment is made in accordance with this paragraph and (ii) offshore Project Rates will not increase by more than the lesser of (a) [redacted] and (b) the All India Consumer Price Index for Urban Non-Manual Employees CPI(UNME) (http://Mospi_New/site/home.aspx) for the year prior to the date on which the applicable adjustment is made in accordance with this paragraph. Any adjustment to the Project Rates as set out in this paragraph shall be prospective and shall apply as of the applicable anniversary of the Effective Date.

11. **Invoices and Payments**

11.1 All invoices shall be in accordance with the MSA and Schedule 3. Unless otherwise specified, the Service Provider shall submit invoices on a monthly basis in respect of the Services provided in the immediately preceding month. Service Provider may provide separate invoices by Service Bundle. Molina shall pay properly submitted and valid invoices within [redacted] days of the date on which Molina receives the relevant invoice ("Due Date"). Service Provider will provide invoices to Molina in accordance to a mutually agreed Form of Invoice. The Service Provider shall ensure for each invoice:

(a) Specifies the period to which the invoice relates;

(b) Specifies the Services to which the invoice relates;

(c) Sets out the calculations used to reach the amount of the Charges that are being invoiced;

(d) Separately itemizes any expense or taxes said to be payable by Molina;

(e) Specifies the Service Provider's tax number;

(f) Specifies the relevant purchase order number; and

(g) Contains any other information reasonably required by Molina, from time to time.

11.2 Service Provider shall perform all services and record all Productive Hours within the Molina system of record for Third Parties.

11.3 The Service Provider shall maintain complete and accurate records of, and supporting documents for, the amounts billable to and payments made by Molina under the Agreement in accordance with generally accepted accounting principles, applied on a consistent basis, for a minimum period of seven (7) years (unless a longer period is required by law or regulation in which case such longer period shall be deemed to apply) following the end of the Term or the Termination Assistance Period, whichever is the later

11.4 The Service Provider will provide Molina with all such documentation and other information as Molina may reasonably require with respect to each invoice to verify its accuracy and compliance with the provisions of the Agreement.

11.5 Without prejudice to paragraph 9.4, Molina may at any time require the Service Provider to provide with every invoice a schedule of supporting information relating to that invoice.

11.6 Without prejudice to any Milestone Payments, if the Service Provider does not invoice Molina within 120 days of the end of the month in which such Services were performed, the Service Provider shall be deemed to have waived its right to be paid for such Services.

12. **Disputed Invoices**

12.1 If there is a dispute about any Charge in an invoice that is raised before an invoice is issued, no Charge reflecting the amount in dispute shall be included within an invoice.

12.2 Molina may dispute any Charges appearing in an invoice, provided it does so on reasonable grounds and provides a written explanation of those grounds to the Service Provider. Upon receipt of Molina’s written explanation, the Service Provider shall initiate the Fast-Track Dispute Resolution Procedure and the parties shall resolve the dispute using that procedure. If Service Provider has concerns about delays in payment of undisputed amounts resulting from this process, Service Provider may raise such concerns as part of the meetings of the applicable Operational Review Board.

12.3 If a Charge based on a disputed amount that was raised by Molina prior to the issue of an invoice appears in an invoice, or if Molina disputes any Charges appearing in an invoice in accordance with this Section 11, Molina may reject the entire invoice. If Molina does so, and there remain any undisputed amounts in the rejected invoice:

(a) the Service Provider shall reissue (within five (5) Business Days) the invoice without the amounts in dispute; and

(b) the time that Molina has to pay the undisputed amounts shall be calculated, in accordance with Section 9.1, from the date the second (and undisputed) invoice is received (provided the Service Provider reissues the invoice).

12.4 The Service Provider may provide a separate invoice to reflect the Charges in dispute in order to document the disputed Charges (a "Holding Invoice"). Molina has no obligation to pay any Charges in a Holding Invoice until the dispute is resolved.

13. **Service Credits**

13.1 If the Service Provider is liable to allow any Molina Company any Service Credits:

(a) those Service Credits shall be issued as a credit note, which Service Provider shall identify as applicable only as a credit credited against the Charges in a future invoice issued by the Service Provider to Molina for the Services; or

(b) if there are no further invoices to be issued by the Service Provider, or if no further invoice is issued by the Service Provider within sixty (60) days from the date on which the Service Credits are incurred, the Service Provider shall pay an amount equal to those Service Credits to Molina as a liquidated sum within thirty (30) days from receipt of written notice from Molina.

13.2 If the Service Provider is liable to allow any Molina Company any Service Credits, and Local Services Agreements have been entered into pursuant to the Agreement, Molina shall specify the Local Services Agreement(s) in respect of which Molina requires the Service Provider to issue the Service Credit, and the amount of the Service Credit which Molina requires to be allocated to each Local Services Agreement. Such amounts shall be credited to the relevant Molina LSA Party in accordance with the preceding paragraph.

14. **Delivery Credits**

14.1 If the Service Provider is liable to allow any Molina Company any Delivery Credits:

(a) those Delivery Credits shall be issued as a credit note, which Service Provider shall identify as applicable as a credit against the Charges in a future invoice issued by the Service Provider to Molina for the Services; or

(b) if there are no further invoices to be issued by the Service Provider, or if no further invoice is issued by the Service Provider within sixty (60) days from the date on which the Delivery Credits are incurred, the Service Provider shall pay an amount equal to those Delivery Credits to Molina as a liquidated sum within thirty (30) days from receipt of written notice from Molina.

14.2 If the Service Provider is liable to allow any Molina Company any Delivery Credits, and Local Services Agreements have been entered into pursuant to the Agreement, Molina shall specify the Local Services Agreement(s) in respect of which Molina requires the Service Provider to issue the Delivery Credit, and the amount of the Delivery Credit which Molina

requires to be allocated to each Local Services Agreement. Such amounts shall be credited to the relevant Molina LSA Party in accordance with preceding paragraph.

15. **Expenses**

Save as provided in this paragraph, the Service Provider shall not be entitled to charge nor to invoice Molina for travel and/or accommodation costs or other expenses incurred in the provision of the Services. Accordingly, such Service Provider expenses are not separately reimbursable by Molina unless, on a case by case basis for unusual expenses, Molina has agreed in advance and in writing to reimburse the Service Provider for a particular expense and such expenses are incurred in accordance with Molina's travel and expenses policy as updated by Molina from time to time and provided that:

(a) The expense is a necessary (as determined by Molina) part of satisfying a requirement the Services and is incurred by the Service Provider during providing Services;

(b) The amount charged to Molina is no greater than the actual documented cost incurred by the Service Provider;

(c) The amount charged is supported by an original proof of purchase.

(d) The amount of any travel and/or living expenses charged to Molina is no greater than the travel and/or living expenses cap communicated to the Service Provider by Molina; and

(e) The amount charged was not incurred as part of participation in scheduled governance meetings as contemplated by schedule 7 (Governance).

16. **Financial Responsibility for Non-Service Expenses**

16.1 Appendix 3-A-1 (Financial Responsibility Matrix) indicates whether Service Provider or Molina is financially responsible for:

(a) Personnel,

(b) Software,

(c) Equipment, and

(d) Facilities.

16.2 Where responsibility is indicated as being Service Provider's responsibility, the Service Fees include all costs related to the provision of such service, Software, Equipment or other item.

17. **Additional Commitments by Service Provider**

17.1 As of the Service Commencement Date, the Service Provider shall fully fund an innovation fund (the “Innovation Fund”) in an amount totalling [redacted]. After the total Charges under this Agreement have exceeded [redacted], then additional amounts shall accrue in the Innovation Fund monthly at the [redacted] of the monthly Charges.

17.2 Amounts in the Innovation Fund may be used only to fund time and materials projects in connection with the Services under this Agreement by the application of Service Provider Personnel time against the Innovation Fund using the applicable rates listed in Appendix 3-A-13 with a [redacted] discount. In order to use the Innovation Fund, the applicable Project Work Order shall state that it will be funded by the Innovation Fund.

17.3 Amounts in the Innovation Fund must be used during the Term and will be utilized on a first-in-first-out basis (i.e., the amounts first accrued will be treated as the first spent). Amounts that are not used the Term shall be treated as expired, and shall no longer be available. For purposes of clarity, the balance of the Innovation Fund may not be utilized as a credit or set-off against amounts due under the Agreement (other than Project Work Orders expressly agreed to be Innovation Fund Project Work Orders), and any unused amounts will not be paid out in the form of cash or any similar remuneration. Amounts accrued in the Innovation Fund may be used only as described herein.

18. **Transformation Credit**

18.1 If the Service Provider fails to achieve Acceptance of all of the following (collectively, the "Transformation Milestones"), each of which is a Milestone, by the close of business hours at Molina's corporate headquarters on the date that is [redacted] after the Service Commencement Date (which is the applicable Milestone Date), then Service Provider shall pay the applicable Monthly Transformation Credit on the first day of each calendar month until the Aggregate Transformation Credit is paid in full:

(a) Migration of Non-production Servers – [redacted] which the Service Provider is to prepare pursuant to Section 7 (*Transformation*) of Schedule 4 (*Transition and Transformation*) have been Accepted by Molina for lift and shift type of migration;

(b) Migration of Production Servers – [redacted] which the Service Provider is to prepare pursuant to Section 7 (*Transformation*) of Schedule 4 (*Transition and Transformation*) have been Accepted by Molina for lift and shift type of migration].

The volume of VMs that are pertinent for the percentages set out in the Transformation Milestones above will be finalized at the end of assessment phase, in accordance with Schedule 4 (*Transition and Transformation*).

18.2 For the avoidance of doubt, in the event the Service Provider fails to achieve all of the Transformation Milestones by the applicable Milestone Date, the Service Provider shall pay the entirety of the Aggregate Transformation Credit to Molina even if the Service Provider later completes all of the Transformation Milestones before the Service Provider pays to Molina the final Monthly Transformation Credit.

18.3 The Service Provider shall pay each Monthly Transformation Credit to Molina as a Service Credit, as contemplated in paragraph 13.1.

18.4 "Monthly Transformation Credit" means (a) with respect to the first such amount payable by the Service Provider, [redacted] and (b) with respect to each such amount payable by

the Service Provider thereafter, [redacted]. “Aggregate Transformation Credit” means [redacted].

APPENDIX 3A – PRICING MATRIX

[See Attached]

Exhibits to Schedule C and Supplemental Materials (Pricing Matrix)

Appendix 3-A

Pricing Workbook Instructions		
Table 1. Instructions		
1	Suppliers to fill ONLY cells in PURPLE	
2	Commercials are based on information provided in RFP/Client Document	
3	The charges are specified in USD currency	
4	Count of devices for the purpose of determining actual units for invoicing, will happen on 1st of every month.	
Table 2. Appendix Table of Contents		
Pricing Matrix:		
Appendix Reference	**Appendix Title**	**Description**
Appendix 3-A	Pricing Matrix Summary	Sets forth the pricing framework, matrix and constructs for all functions.
Appendix 3-A-1	Financial Responsibility Matrix (FRM)	Sets forth whether Supplier or Molina shall be financially responsible for the expenses associated with Personnel, Software, Equipment, Facilities, Systems and other expenditures related to the provision of Services during the SOW Term.
Appendix 3-A-2	Transition Charges	Sets forth the charges associated with Transition Services, which shall be invoiced on a Fixed Fee, per milestone basis.
Appendix 3-A-3	Termination Charges	Sets forth charges in the event of Termination for Convenience.
Appendix 3-A-4	Volume Discounts	Sets forth the discount percentages Supplier shall credit Molina based on all Services provided by Supplier in a given period.
Appendix 3-A-5	Invoicing Structure	Sets forth the invoice structure to be used by the Supplier.
Appendix 3-A-6	Infrastructure Pricing	Sets forth the Resource Units and corresponding Unified Compute Monthly Charges that are chargeable to the Molina for in-scope Infrastructure Services.
Appendix 3-A-7	Security Pricing	Sets forth the Security Monthly Charges that are chargeable to the Molina for in-scope Security Services.
Appendix 3-A-8	EUS Pricing	Sets forth the Resource Units and corresponding End User Services Monthly Charges that are chargeable to the Molina for in-scope End User Services.
Appendix 3-A-12	Resource Unit Definitions	Sets forth the definitions for Resource Units as indicated in other pricing worksheets.
Appendix 3-A-13	Supplemental Rate Card	Sets forth the approved roles and rates for Supplier personnel to be used in cases of Supplemental Project Charges
Appendix 3-A-14	Molina Requirements	Sets forth the list of requirements expected of Molina in the case that they are not met, may have qualitative or financial implications.
Pricing Changes:		
Tab Reference	**Tab Title**	**Description**
EUS Steady State	[redacted]	Details the changes in pricing for [redacted].
EUS Transition	[redacted]	Details the changes in pricing for [redacted].
Core Infra Steady State	[redacted]	Details the changes in pricing for [redacted].
Core Infra Transition	[redacted]	Details the changes in pricing for [redacted].
Security Steady State	[redacted]	Details the changes in pricing for [redacted].
Security Transition	[redacted]	Details the changes in pricing for [redacted].

Summary Results

Molina-Owned Assets																					
		Year 1 TCO	Year 2 TCO	Year 3 TCO	Year 4 TCO	Year 5 TCO	Year 1 Units	Year 2 Units	Year 3 Units	Year 4 Units	Year 5 Units	Units	Year 1 Pricing	Year 2 Pricing	Year 3 Pricing	Year 4 Pricing	Year 5 Pricing	Year 1 Productivity	Year 2 Productivity	Year 3 Productivity	Year 4 Productivity	Year 5 Productivity
1. Infrastructure																					
Server Services (MHI)																					
	Physical (Non-Virtualized) Servers	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Physical (Virtualized) Servers	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	VM Ware ESX Virtualization	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Others (Nutanix)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Storage Services																					
	SAN/NAS Storage	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	SAN-Only	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	NAS-Only	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Object	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Storage Services - Remote																					
	NAS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Optimization Appliance	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Backup Technology/Hardware																					
	Appliance Count	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Storage Capacity	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Data Throughput	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Network Hardware																					
	Access Point	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Switches	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Routers	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Firewalls and other Perimeter Device	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Load Balancers	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Other Devices	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	LAN Controllers	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Meraki Gateways	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Meraki Remote Z1	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Data Circuits	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Voice Circuits	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Gateways (Analog/Fax)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Network Software	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Voice Gateways	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
DB Services																					
	DR	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Production	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Non-Production	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Middleware																					
	SQL Server	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Oracle ODA	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
	Oracle Exadata	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
	Oracle PCA	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					

Molina-Owned Assets																					
Netezza	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
WebLogic	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Jump Servers	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
IIS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
MariaDB	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
MySQL	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Oracle Server	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Citrix	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
ADFS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
BizTalk	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Exchange	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Cloudera - does not yet factor Cloud	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Pivotal (Hortonworks)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Active Directory	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Delphix	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Data Collection Tools/Software																					
Asset Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Collaboration	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Configuration Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Data Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Endpoint Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Hypervisor	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Load Balancing	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Operations Monitoring/Metircs	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
QA	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Security	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Service Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Storage & Backup	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Other Supplier Charges																					
Other Charges (Supplier to Specify)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Single Service Pricing (See Infrastructure Pricing Tab)						Single Service Pricing									
2. Security Services																					
Security Services	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Single Service Pricing (See Security Pricing Tab)						Single Service Pricing									
3. End User Services																					
Level 1 Service Desk																					
End Users (Corporate Offices)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
End Users (VIP)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
End User Computing																					
Desktops	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Laptops	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Tablets	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Desktop Phones	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Mobile Phones	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
End Users (White Glove Service)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
End User Supported Software																					
Utility and Device	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Development	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Network Application/Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Molina-Owned Assets								
Content Authoring and Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Data Management and Query	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Information Exchange	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Security and Protection	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Industry-Specific	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Business Function	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Operating Environment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Education and Reference	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Finance	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Other	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]
Other Supplier Charges								
Other Charges (Supplier to Specify)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] [redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]	[redacted] [redacted] [redacted] [redacted] [redacted]

	Transition Charges				
Transition Fees (All Towers)	**2018**	**2019**	**2020**	**2021**	**2022**
Infrastructure Transition Fees	$-	$-	$-	$-	$-
EUS Transition Fees	$-	$-	$-	$-	$-
Security Transition Fees	$-	$-	$-	$-	$-
Total Transition Fees	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

	Termination Charges				
Termination Fees (All Towers)	**2019**	**2020**	**2021**	**2022**	**2023**
Infrastructure Termination Fees	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
EUS Termination Fees	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Security Termination Fees	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total Termination Fees	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Cost of Transformation						
	2019 Cost of Transformation	**2020 Cost of Transformation**	**2021 Cost of Transformation**	**2022 Cost of Transformation**	**2023 Cost of Transformation**	**5 Years Total**
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Discount	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Net Price	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Financial Responsibility Matrix

Facilities	Asset and Expense Allocation: Capital / Expense / Lease Cost			
	Current Assets	**Refresh**	**Upgrade / Enhance**	**Growth**
Client Facilities	[redacted]	[redacted]	[redacted]	[redacted]
Supplier Facilities	[redacted]	[redacted]	[redacted]	[redacted]
Data telecommunications service and access fees	[redacted]	[redacted]	[redacted]	[redacted]
Telecommunication circuit provisioning	[redacted]	[redacted]	[redacted]	[redacted]
Long-Distance Phone Calls	[redacted]	[redacted]	[redacted]	[redacted]
Local Phone Calls	[redacted]	[redacted]	[redacted]	[redacted]
Use of Office Space	[redacted]	[redacted]	[redacted]	[redacted]
Use of Office Supplies	[redacted]	[redacted]	[redacted]	[redacted]
Use of Other Office Equipment	[redacted]	[redacted]	[redacted]	[redacted]
All Resource Categories				
Supplier Staff on Client Premises				
Long-Distance Phone Calls	[redacted]	N/A	N/A	N/A
Local Phone Calls	[redacted]	N/A	N/A	N/A
Use of Office Space	[redacted]	N/A	N/A	N/A
Use of Office Supplies	[redacted]	N/A	N/A	N/A
Use of Other Office Equipment	[redacted]	N/A	N/A	N/A

Key

Client	Client financially responsible
Supplier	Supplier financially responsible

Approved Supplier Facilities	Pursuant to Section [TBD - Supplier Facilities] the following locations are approved for the provision of Services					
	Location 1	**Location 2**	**Location 3**	**Location 4**	**Location 5**	**Location 6**
Primary Contact Phone Number	91 80 285 20261	91 172 669 8000				
Address Line 1	Infosys Ltd.	Infosys Ltd.	Infosy Ltd.			
Address Line 2	Electronics City, Hosur Road	Plot# I-3, IT City, Sector 83 Alpha, SAS Nagar	604 Pine Avenue			
Address Line 3	Bengaluru	Mohali	Long beach			
State/Province	Karnataka	Punjab	CA 90802			
Routing Number						
Country	India	India	USA			

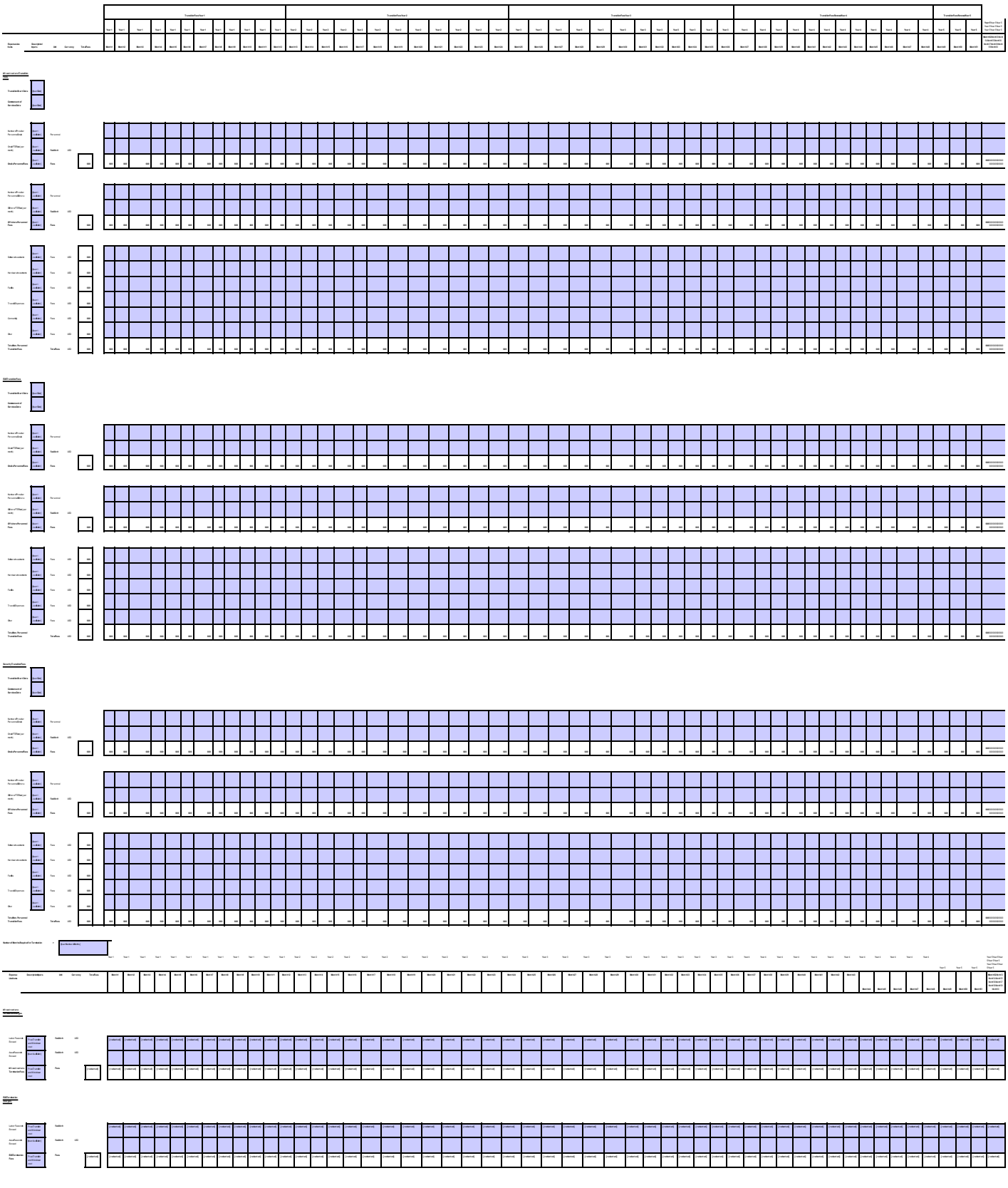
Software	Asset Allocation: License / Lease Cost					Contract Expenses
Resource Category:	**Current License**	**Replacement SW**	**SW Currency**	**Release/Upgrade**	**Growth**	**Maintenance**
Infrastructure at Supplier Facilities						
All basic personal computer Software	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]

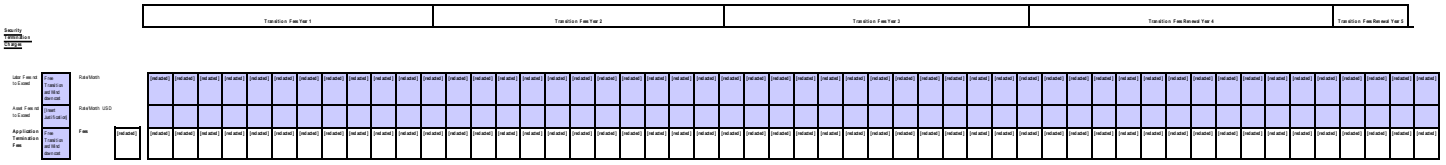
All application development Software tools	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]
All server, networking, and management Software	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]
All other Software	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]
Infrastructure at Client Facilities						
All basic personal computer Software	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]
All application development Software tools	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]
All server, networking, and management Software	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]
All remote access (e.g. Citrix) Software	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]
All other Software	[redacted]	[redacted]	n / n-1	[redacted]	[redacted]	[redacted]

Facilities	**Asset and Expense Allocation: Capital / Expense / Lease Cost**				**Key**	
Equipment	**Asset Allocation: Capital / Lease Cost**					**Contract Expenses**
Resource Categories	**Current Assets**	**Refresh**	**Cycle**	**Upgrade / Enhance**	**Growth**	**Maintenance**
Infrastructure at Supplier Facilities						
All personal computing Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
All telecommunications Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
All server, networking, and management Equipment (Public Cloud / Traditional)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
All server, networking, and management Equipment (Private Cloud)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
All other Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Infrastructure at Client Facilities						
All personal computing Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
All telecommunications Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
All server, networking, and management Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
All other Equipment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Supplier Personnel	**Salary & Benefits**	**Travel**	**Training**	**Relocation**	**Staffing Incr. / Decr.**	**Severance**	**Retention Payments**
Transitioned Employees	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Transitioned Contractors	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Third-Party Service Contracts	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Supplemental Supplier Personnel	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Transition Fees




Transition Fees Year 1
Transition Fees Year 2
Transition Fees Year 3
Transition Fees Renewal Year 4
Transition Fees Renewal Year 5
Liter Fees to Exceed
Asset Fees to Exceed
Application Termination Fees
RateMath
RateMath USD
Fees
[redacted]

Discount Schedule				**% Discount**				
Total Incremantal Charges ($)				**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
				(1st 12 Months)	(2nd 12 Months)	(3rd 12 Months)	(4th 12 Months)	(5th 12 Months)
>	**0**	**and <**	**5,000,000**					
>	**5,000,000**	**and <**	**10,000,000**					
>	**10,000,000**	**and <**	**15,000,000**					
>	**15,000,000**	**and <**	**20,000,000**					
>	**20,000,000**	**and <**	**25,000,000**					
>	**25,000,000**	**and <**	**30,000,000**					
>	**30,000,000**	**and <**	**35,000,000**					
>	**35,000,000**	**and <**	**40,000,000**					
>	**40,000,000**	**and <**	**45,000,000**					
>	**45,000,000**	**and <**	**50,000,000**					
>	**50,000,000**	**and <**	**55,000,000**					
>	**55,000,000**	**and <**	**60,000,000**					
>	**60,000,000**	**and <**	**65,000,000**					
>	**65,000,000**	**and <**	**70,000,000**					
>	**70,000,000**	**and <**	**75,000,000**					
>	**75,000,000**	**and >**						

	Invoice Description	Services In Scope	Invoicing Entity Name	Invoicing Entity Country	Invoicing Entity State	Invoicing Entity City	Invoiced Entity	Invoiced Entity Country	Invoiced Entity State	Invoiced Entity City	Percentage of Total Fees	Frequency of Invoice	Currency of Pricing	Currency of Invoicing & Payment	Payment Receipt Entity
1. Infrastructure															
	Towards Server and DC Support services rendered for the month of < Month Invoiced>	Support	Infosys Limited	India	TamilNadu	Chennai	[redacted]	United States	Long Beach	California CA US 90801-5813	[redacted]	Monthly	USD	USD	Invoicing Entity
													USD	USD	Invoicing Entity
2. End User Services															
	Towards End User Devices and Softwares support services rendered for the month of < Month Invoiced>	Support	Infosys Limited	India	TamilNadu	Chennai	[redacted]	United States	Long Beach	California CA US 90801-5813	[redacted]	Monthly	USD	USD	Invoicing Entity
													USD	USD	Invoicing Entity
3. Security															
	Towards Infrastructure security support services rendered for the month of < Month Invoiced>	Support	Infosys Limited	India	TamilNadu	Chennai	[redacted]	United States	Long Beach	California CA US 90801-5813	[redacted]	Monthly	USD	USD	Invoicing Entity

Infrastrucutre Pricing

Note: Year 1 begins on the Commencement Date, after completion of Transition

All Resource Unit Rates in USD (United States Dollars)

Onshore/Offshore Ratios

Percentage Onshore:	
Onshore Location:	
Percentage Offshore:	
Offshore Location:	
RU Exceptions to Onshore Ratio	

Designated Service Tower	Measurement Unit	Units					Pricing					
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Year 5	
		(1st 12 Months)	(2nd 12 Months)	(3rd 12 Months)	(4th 12 Months)	(5th 12 Months)	(1st 12 Months)	(2nd 12 Months)	(3rd 12 Months)	(4th 12 Months)	(5th 12 Months)	
Molina Owned Assets		**Unit Count**	**Unit Count**	**Unit Count**	**Unit Count**	**Unit Count**	**Unit Price**	**Unit Price**	**Unit Price**	**Unit Price**	**Unit Price**	**Additional Pricing Guidance**
Server Services (MHI)												
Physical (Non-Virtualized) Servers	Servers per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Physical (Virtualized) Servers	Servers per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
VM Ware ESX Virtualization	Servers per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Others (Nutanix)	Servers per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Storage Services												
SAN/NAS Storage	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
SAN-Only	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
NAS-Only	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Object	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Storage Services - Remote												
NAS	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Optimization Appliance	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Backup Technology/Hardware												
Appliance Count	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
Storage Capacity	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Data Throughput	TB per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
Network Hardware												
Access Point	Units per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Switches	Units per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Routers	Units per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Firewalls and other Perimeter Device	Units per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Load Balancers	Units per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	

Other Devices	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
LAN Controllers	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Meraki Gateways	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Meraki Remote Z1	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Data Circuits	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Voice Circuits	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Gateways (Analog/Fax)	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Network Software	Releases per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Voice Gateways	Units per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
DB Services							
DR	Instances per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Production	Instances per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Non-Production	Instances per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Middleware							
SQL Server	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]					
Oracle ODA	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Oracle Exadata	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]

Designated Service Tower	Measurement Unit	Units	Pricing				
Oracle PCA	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Netezza	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
WebLogic	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Jump Servers	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
IIS	Servers per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
MariaDB	Instances per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
MySQL	Instances per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Oracle Server	Instances per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Citrix	Nodes per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
ADFS	Nodes per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
BizTalk	Nodes per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Exchange	Nodes per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Cloudera - does not yet factor Cloud	Nodes per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Pivotal (Hortonworks)	Nodes per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Active Directory	Domain components per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Delphix	OVA appliances per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Data Collection Tools/Software							
Asset Management	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Collaboration	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Configuration Management	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Data Management	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Endpoint Management	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Hypervisor	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Load Balancing	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Operations Monitoring/Metircs	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
QA	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Security	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Service Management	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Storage & Backup	Tools per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Other Supplier Charges							
Onsite Command Center	Single cost per year	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Azure Foundation & Implementation	Single cost per year	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]				

Azure Migration	Single cost per year	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]			

[redacted]

Onshore/Offshore Ratios

Percentage Onshore:	
Onshore Location:	
Percentage Offshore:	
Offshore Location:	
RU Exceptions to Onshore Ratio	

Security		**Services Charges**				
Total Charges		**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
		(1st 12 Months)	(2nd 12 Months)	(3rd 12 Months)	(4th 12 Months)	(5th 12 Months)
Item 1	[Security Managed Service]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Item 2						
Item 3						
Item 4						
Item 5						
Item 6						
Item 7						
Item 8						
Item 9						
Item 10						
Item 11						
Item 12						
Item 13						
Item 14						
Item 15						
Item 16						
Item 17						
Item 18						
Item 19						
Item 20						
Item 21						
Item 22						
Item 23						
Item 24						
Item 25						
Item 26						
Item 27						
Item 28						
Item 29						
Item 30						
Item 31						

Note: All Resource Unit Rates should be monthly and in USD

Onshore/Offshore Ratios

Service Desk

Percentage Onshore:	
Onshore Location:	
Percentage Offshore:	
Offshore Location:	
RU Exceptions to Onshore Ratio	

End User Services

Percentage Onshore:	
Location:	
Percentage Offshore:	
Offshore Location:	
RU Exceptions to Onshore Ratio	

	Units					Pricing					
Designated Service Tower	**Measurement Unit**	**Year 1** (1st 12 Months) **Unit Count**	**Year 2** (2nd 12 Months) **Unit Count**	**Year 3** (3rd 12 Months) **Unit Count**	**Year 4** (4th 12 Months) **Unit Count**	**Year 5** (5th 12 Months) **Unit Count**	**Year 1** (1st 12 Months) **Unit Price/Mo.**	**Year 2** (2nd 12 Months) **Unit Price/Mo.**	**Year 3** (3rd 12 Months) **Unit Price/Mo.**	**Year 4** (4th 12 Months) **Unit Price/Mo.**	**Year 5** (5th 12 Months) **Unit Price/Mo.**	**Additional Pricing Guidance**
Level 1 Service Desk (Model 1)												
End Users (Corporate Offices)	Users per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
End Users (VIP)	Users per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
End User Computing												
Desktops	Devices per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Laptops	Devices per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Tablets	Devices per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Desktop Phones	Devices per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
Mobile Phones	Devices per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
End Users (White Glove Service)	Users per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	
End User Supported Software												

Utility and Device	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Development	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Network Application/Management	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Content Authoring and Management	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Data Management and Query	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Information Exchange	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Security and Protection	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Industry-Specific	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Business Function	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Operating Environment	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Education and Reference	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Finance	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Other	Programs per month	[redacted] [redacted] [redacted] [redacted] [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]
Other Charges							
Other Supplier Charges	Single cost per year	[redacted] [redacted] [redacted] [redacted] [redacted]					
Other Supplier Charges	Single cost per year	[redacted] [redacted] [redacted] [redacted] [redacted]					
Other Supplier Charges	Single cost per year	[redacted] [redacted] [redacted] [redacted] [redacted]					

Resource Unit Definitions

End User Services	
End Users (Corporate Offices)	[redacted]
Level 1 Ticket	[redacted]
Level 2 Ticket	[redacted]
Desktops and Laptops	[redacted]
Mobile Devices	[redacted]
Desktop Phones	[redacted]
Infrastructure	
Physical (Non-Virtualized) Servers	[redacted]
Physical (Virtualized) Servers	[redacted]
Other (e.g., VM Ware ESX) Servers	
SAN / NAS / File Services	[redacted]
LAN Switches and other LAN Device	[redacted]
WAN Routers and other WAN Equipment	[redacted]
Firewalls and other Perimeter Device	[redacted]
Telephony Services	[redacted]
Security	[redacted]
Web Application Scanning	[redacted]
SQL Server	[redacted]
Oracle	[redacted]
Other	[redacted]

Supplemental
Rate Card

Note: [redacted]

Role	Role Description	Traditional	Offshore Agile	Near-Shore Agile
Server Admin	Responsible for Server issues, performs administration and routine support, execution of processes, services. Determines escalation to higher levels.	[redacted]	[redacted]	
Server SME	Subject Matter expert, highly skilled and is sought out by team members to advise, peer review, and has knowledge of all technology related products.Has ability to interact with clients at all levels including members of senior leadership.	[redacted]	[redacted]	
Infra Admin	Responsible for administration and routine support for Infrastructure, execution of processes and services. Determines escalation to higher levels.	[redacted]	[redacted]	
Infra SME	Subject Matter expert, highly skilled and is sought out by team members to advise, peer review, and has knowledge of all technology related products.Has ability to interact with clients at all levels including members of senior leadership.	[redacted]	[redacted]	
SQL Admin	Responsible for managing SQL related issues, performs administration and routine support, execution of processes, services. Determines escalation to higher levels.	[redacted]	[redacted]	
SQL SME	Subject Matter expert, highly skilled and is sought out by team members to advise, peer review, and has knowledge of all technology related products.Has ability to interact with clients at all levels including members of senior leadership.	[redacted]	[redacted]	
Oracle Admin	Responsible for managing Oracle related issues, performs administration and routine support, execution of processes, services. Determines escalation to higher levels.	[redacted]	[redacted]	
Oracle SME	Subject Matter expert, highly skilled and is sought out by team members to advise, peer review, and has knowledge of all technology related products.Has ability to interact with clients at all levels including members of senior leadership.	[redacted]	[redacted]	
Exadata Admin	Responsible for managing Exadata related issues, performs administration and routine support, execution of processes, services. Determines escalation to higher levels.	[redacted]	[redacted]	
Exadata SME	Subject Matter expert, highly skilled and is sought out by team members to advise, peer review, and has knowledge of all technology related products.Has ability to interact with clients at all levels including members of senior leadership. Provides expertise and hands on implementation in specific areas	[redacted]	[redacted]	
Network Data - Admin	Responsible for Installing, Maintaining and troubleshooting network and computer systems.Diagnosing and fixing problems or potential problems with the network and its hardware, software and systems. Monitoring network and systems to improve performance.	[redacted]	[redacted]	
Network Data - SME	Subject Matter expert, highly skilled and is sought out by team members to advise, peer review, and has knowledge of all technology related products. Provides expertise and hands on implementation in specific areas.	[redacted]	[redacted]	
Network Voice - Admin	Responsible for Installing, Maintaining and troubleshooting voice devices. Identifying and fixing problems or potential problems with the voice network and its hardware, software and systems. Monitoring voice systems to improve performance.	[redacted]	[redacted]	
Network Voice - SME	Subject Matter expert, highly skilled and is sought out by team members to advise, peer review, and has knowledge of all technology related products. Has ability to interact with clients at all levels including members of senior leadership. Provides expertise and hands on implementation in specific areas. Wide range of experience on design, implementation and support of Avaya & Cisco Unified Communication & Contact center technologies.	[redacted]	[redacted]	
Enterprise Architect	Design and implementation of systems to support the enterprise infrastructure. Ensuring all systems work at optimal levels and support the development of new technologies and system requirements. Manage, architect, and implement infrastructure components for the global enterprise to improve business processes and achieve significant cost reductions.	[redacted]	[redacted]	[redacted]
Project Manager	Managing very large complex project work with executive level clients to drive projects and business organisations toward achieving the intended business results	[redacted]	[redacted]	[redacted]
Program Manager	Managing complex, transformational programs with executive level clients to drive projects and business organizations toward achieving the intended business results	[redacted]	[redacted]	
Sr. Technology Architect	Design, manage, architect, and implement complex systems and components leveraging Digital Technolgies (Big data, Data Science, IOT, etc.)	[redacted]	[redacted]	[redacted]
Solution Architect	Design, architect, and implement components across technology stacks. Works as expert developer in critical project requirements	[redacted]	[redacted]	[redacted]
Sr. Analyst - Niche	Senior analyst with 3+ years of experience in developing/configuring systems and components across niche technologies areas such as - Big Data, IOT, Digital, COTS Products, QNXT, ERP, Full stack development (including MEAN/MERN, Web/Micro Services, Databases)	[redacted]	[redacted]	[redacted]

Analyst - Niche	Analyst with up to 3 years of experience in developing/configuring systems and components across niche technologies areas such as - Big Data, IOT, Digital,COTS Products, QNXT, ERP	[redacted]	[redacted]	[redacted]
Test Process Consultant	Setting up Test Maturity Assessment and development of roadmap for process improvements. Assist in the TCoE Transition for the Testing function of applications to Testing Center of Excellence Conduct automation feasibility for existing application portfolio and develop a roadmap and strategy for maturing the automation of the QA organization Provide leadership to Functional Testing teams providing testing services	[redacted]	[redacted]	[redacted]
Specialized Tester	Provide guidance for specialized test (Performance/ test data management/ test environment management/ security testing/ API testing) Act as dedicated (virtual) support for different specialized testing services mentioned above Analysis of business requirements for specialized testing services mentioned above Review of Test Plan & preparation of Test Cases for specialized testing services Report test results and defects detected for specialized testing services	[redacted]	[redacted]	[redacted]
Healthcare Industry Principal	Strategic Consulting, Product Evaluation and recommendation, Product fitment and gap analysis, Stakeholder Management, Plan and manage critical programs for product implementation and support. As a Design Thinking Coach – Plan, Lead and Conduct Design Thinking workshops to partner with stakeholders to identify, define and prototype solutions	[redacted]	[redacted]	[redacted]
Sr. Healthcare Consultant	Product Evaluation and recommendation, Product fitment and gap analysis, Stakeholder Management, Plan and manage critical programs for product implementation and support	[redacted]	[redacted]	[redacted]
Digital Strategist	Strategic consultant - helps create and deliver enterprise / regional digital strategies. Applies design thinking to business innovation, transforming outdated, vulnerable models into more sustainable and adaptable ones able to navigate the markets of tomorrow.	[redacted]		

Security	**Role**	**Traditional**	**Offshore Agile**	**Near-Shore Agile**
Sr. Admin	Configure Role Association Type focused on debug incidents related to user identity provisioning / de-provisioning, user account reconciliation, user authentication, authorization, and session management.	[redacted]	[redacted]	
Lead Developer	Daily monitoring and Ongoing maintenance, Config Mgmt. SoD and Policy Roll-out. Product Administration, Application Integration. Plug-in and Workflow customization. Web Access Mgmt	[redacted]	[redacted]	
Admin	Responsible for IAM Service Monitoring. User provisioning and administration tasks. Password management and operational reporting. Incident handling & Closure	[redacted]	[redacted]	
Consultant	Provide security design and vendor configuration reviews for project implementation, including SaaS and offsite hosting applications. Administration of Molina's information and data security policies and practices to ensure authorised users can readily access information and that the information is protected in terms of confidentiality, integrity and availability	[redacted]	[redacted]	
Security Mgr	Responsible for monitoring the security operations, implement security policies, regulations, rules, and norms and ensures that the IT environment is secure. Handle escalations. Participate on discussion with Molina. Participate in regular practiced drills for security incident response. SLA tracking, SLA monitoring. Share analysis report. Take appropriate action to respond to weekly/monthly reporting and alerted incidents	[redacted]	[redacted]	

Sr. Engineer	Engineering, implementing and monitoring security measures for the protection of computer systems, networks and information. Designing computer security architecture and developing detailed cyber security designs.	[redacted]	[redacted]	
SOC Lead	Lead and manage Security Operations Center. Primarily responsible for security event monitoring, management and response. Perform threat management, threat modeling, identify threat vectors and develop use cases for security monitoring.	[redacted]	[redacted]	
Sr. Analyst	Front lines fighting against cyber attacks and analyzing threats, implementing security measures as dictated by management. Stay up-to-date on the latest intelligence, including hackers' methodologies, in order to anticipate security breaches	[redacted]	[redacted]	
Sr. Engineer	Evaluate the security of applications through design and code reviews, adherence to application security standards, and application vulnerability assessments, Conduct web application security scans, analyze results for false positives, prioritize vulnerabilities, and research and propose remediation steps.	[redacted]	[redacted]	
Architect	Subject matter expert consultant role responsible for architecting, designing and implementing a variety of identity and access management solutions. Being the face of client delivery and managing client expectations day-to-day.	[redacted]	[redacted]	
Lead Developer	Responsible for the ongoing development, deployment, and support of the evolving IAM systems. The IAM System Developer identifies business needs, collects the requirements, provides project management and hands-on implementation support for new IAM applications, administers the IAM components and overall system, and resolves complex system problems.	[redacted]	[redacted]	
Lead Developer	The IAM BA/Lead Developer identifies business needs, collects the requirements, provides project management and hands-on implementation support for new IAM applications, administers the IAM components and overall system, and resolves complex system problems.	[redacted]	[redacted]	
Program Manager	Managing complex, transformational programs with executive level clients to drive projects and business organizations toward achieving the intended business results	[redacted]	[redacted]	
Senior Industry Consultant - Security		[redacted]	[redacted]	
Industry Consultant - Security		[redacted]	[redacted]	
Cloud Technology Roles		[redacted]	[redacted]	
Enterprise Architect		[redacted]	[redacted]	
Senior Technology Architect		[redacted]	[redacted]	
Technology Architect		[redacted]	[redacted]	
Lead Consultant		[redacted]	[redacted]	
Senior Consultant		[redacted]	[redacted]	

EUS	**Role**	**Traditional**	**Offshore Agile**	**Near-Shore Agile**
Desktop Engineer	Desktop Engineer responsible for all in scope end user device related issues that can be resolved remotely. Performs general preventative maintenance tasks.	[redacted]	[redacted]	
Field Services - Desktop Engineer	Desktop Engineer operating from customer site responsible for all in scope end user device related issues including IMAC. Performs general preventative maintenance tasks. Performs work in compliance within specified warranty requirements.	[redacted]	[redacted]	
Image Deployment	Responsible for Image deployment. Troubleshooting Image deployment issues. Sound knowledge of Image deployment through LANDesk/ SCCM	[redacted]	[redacted]	
L2 Service Desk	Responsible for handling application and installation related issues, logging all incidents and requests; triaging, and follow up on pending issues. Provides basic application support and responsible for installation desk activities	[redacted]	[redacted]	

Service Desk - English	Responsible for handling issues from users through Call/ mail/ web, logging all incidents and requests; triaging, and follow up on pending issues. Creates a positive customer support experience by providing necessary and accurate information consistently. Provides support for basic/ SOP based issues.			[redacted]
Service Desk Lead	Service Desk Lead responsible for ensuring SLA adherence, consistent performance, monitoring high priority tickets, review Service desk analyst performance			[redacted]
Service Desk Manager	Responsible for monitoring the overall Service desk operations, reviewing team performance, ensuring Service Desk readiness. Handle escalations. Participate on discussion with Molina. SLA tracking, SLA monitoring. Share analysis report. Take appropriate action to respond to weekly/monthly reporting and alerted incidents			[redacted]
Software dist & Patching	Responsible for Software distribution and Patch Management. Troubleshooting Software distribution and patching issues. Sound knowledge of Software distribution and patching through LANDesk/ SCCM	[redacted]	[redacted]	
Tools & Automation Roles				
Senior Architect		[redacted]	[redacted]	
Technology Arhcitect		[redacted]	[redacted]	
Principal Consultant		[redacted]	[redacted]	
Lead Consultant		[redacted]	[redacted]	
Senior Consultant		[redacted]	[redacted]	
[As needed Supplier Added Role 7]				
[As needed Supplier Added Role 8]				
[As needed Supplier Added Role 9]				
[As needed Supplier Added Role 10]				

Molina Requirements

All pricing indicated within this Appendix 3-A (Pricing Matrix) is assumed as the Supplier's bid. Supplier may indicate any exception to pricing with regards to Molina requirements to the delivery of services below.

#	Requirement	Qualitative Implication(s)	Potential Financial Impact
1			
2			
3			
4			
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11			
12			
13			
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20			
21			
22			
23			

[redacted][1]

[1] Sixteen (16) pages have been redacted in their entirety.

SCHEDULE 4 TRANSITION AND TRANSFORMATION

CONTENTS

1. **DEFINITIONS**

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*).

2. **INTRODUCTION; CHARGES**

This Schedule 4 (*Transition and Transformation*) sets the process for transferring responsibility for the performance of the Services to the Service Provider in readiness for Go Live. No Charges shall be payable by Molina in connection with the Transition Services.

3. **PERFORMANCE OF TRANSITION SERVICES**

3.1 The Service Provider shall provide the Transition Services and the Transition Deliverables in accordance with the Transition Plan or as set out in a Services Order or Local Agreement and, in any event, so as to achieve the Milestones by the Milestone Dates;

3.2 The Service Provider shall perform such other tasks and provide such other outputs as are required to achieve the Milestones by the Milestone Dates, and so that the Service Provider is ready to perform the Services in accordance with the terms of the Agreement from the Go Live Date(s); and

3.3 The Service Provider shall perform the activities described in paragraphs 3.1 and 3.2 above causing only minimal and non-adverse impact to Molina and its other service providers.

3.4 Subject to paragraph 3.5 below, the Service Provider shall effect the transition to it of the Services and shall be in a position to provide the Services in accordance with the terms of the Agreement from the Service Commencement Date(s). Service Provider shall manage and be responsible for the Transition Services and shall comply with its obligations under the Transition Plan.

3.5 The Service Provider shall execute all Transition Services and Molina will be responsible for any Molina Responsibilities in relation to the Transition Services that are identified in the relevant Transition Plan.

3.6 The Service Provider shall manage issues and risks during the period of transition and escalate any issues and risks to Molina as appropriate.

3.7 Throughout the period of transition, and without limiting Service Provider’s obligations under the Agreement, Service Provider shall comply with all relevant Molina policies and standards, including network and data security requirements provided to the Service Provider in writing.

3.8 The Service Provider shall provide a written description of the Service Provider's solution during Transition Period in accordance with the timescale agreed in the Transition Plan. For the avoidance of doubt, the solution will supplement and not in any way reduce the scope of the Services or conflict with any provision of this Agreement.

3.9 The Service Provider shall promptly notify Molina if it reasonably believes it will not be able to meet its obligations under this schedule.

3.10 In the event of a delay during transition due to fault of the Service Provider, any costs incurred by the Service Provider shall be borne by the Service Provider, and any costs incurred by Molina to the extent such costs would otherwise constitute damages that Molina is permitted to recover under the Agreement shall be borne by Service Provider.

4. **TRANSITION TEAM**

4.1 Service Provider shall assign a Transition Services team headed by an experienced transition manager ("Service Provider Transition Lead") who shall be a member of the program team until steady-state implementation is complete.

4.2 The Service Provider Transition Lead shall be responsible for developing the Transition Plan and managing all Transition Services covered within this Schedule 4.

4.3 The Transition Services team shall perform all functions, tasks, and responsibilities to plan and execute a successful and smooth transition, including:

(a) program administration and management for all Transition Services for Service Provider and Molina;

(b) establishing and documenting Service Provider's procedures for change management, communications, escalation, and Problem Management;

(c) maintaining and updating the Transition Plan;

(d) executing the Transition Plan; and

(e) managing to the Transition Plan through successful transition of the Services, including reporting to Molina on status, issues, and risks.

5. TRANSITION PLAN

5.1 Within 10 Working Days of the Commencement Date the Service Provider shall propose to Molina a high level Initial Transition Plan that describes in reasonable detail how it will affect the transition contemplated in this Schedule. The written "**Initial Transition Plan**" shall be subject to Molina's approval and, at minimum, shall include:

(a) a description of all Deliverables to be provided pursuant to Transition Services and specifying the date such Deliverables will be provided

(b) a description of the specific methods to be employed to perform the Transition Services and all resources required, both Service Provider Personnel and Molina personnel;

(c) a description of the "Current State" of Molina's environment and the anticipated "Steady State" of Molina's environment after the completion of Transition Services, and all significant changes anticipated to achieve such environment, including:

(i) proposed changes to delivery locations;

(ii) proposed changes to delivery methods, processes, standards, or approaches;

(iii) proposed changes to applications used to provide Services, including but not limited to Service Request Systems, Project request Systems, Incident Management Systems, monitoring tools and Systems, and programming tools and interfaces;

(iv) a detailed description of the efficiency levers and the impact to FTEs, tools, and assets. Such description shall also clearly describe any investments being made by Service Provider;

(v) the process, tools, and timing required to support current Molina Critical Service Levels and achieve the Critical Service Levels to be met by Service Provider; and

(vi) a description of all proposed Projects to be completed during the transition timeframe; and

(d) all other aspects and criteria relating to the transition contemplated in this Schedule as set out in the Service Provider Technical Solution as of the Effective Date (except to the extent the relevant provisions of the Service Provider Technical Solution has been amended by the Parties through an amendment to the Agreement, or as set out in a Change Notice executed in accordance with Schedule 9 (*Change*)).

5.2 Within ten (10) Working Days of Acceptance of the Initial Transition Plan, Service Provider shall propose to Molina a Detailed Transition Plan that describes in greater detail how it will affect the transition contemplated in this Schedule.

5.3 Once the Detailed Transition Plan has been Accepted by Molina it shall constitute the Transition Plan and shall, subject to paragraph 5.4 below, supersede and replace the Initial Transition Plan.

5.4 The written **"Detailed Transition Plan"** shall be subject to Molina's approval and sole discretion and, at minimum, shall include:

(a) a description of various items required for transition, including items related to Equipment, Software, Third Party Contracts, human resources transition, in-flight and pending Projects, Service Request Systems, and related applications, processes and technology;

(b) a detailed transition schedule for all Transition Services;

(c) a detail of all expected knowledge transfer activities;

(d) details of any transition testing to be performed;

(e) detailed planning to minimize downtime during transition;

(f) detailed and continuous issues and risk assessments and contingency planning activities; and

(g) a description of Exit Criteria that must be accomplished prior to wind-down of the Transition Services (**"Exit Criteria"**), which Exit Criteria shall include Molina's final confirmation that the transition Deliverables have been accepted and the Transition Milestones have been completed, all in accordance with the Detailed Transition Plan and the Agreement.

(h) a description of all major Transition Milestones, together with dates for the completion of such Transition Milestones is set forth in the Initial Transition Plan and, as applicable, the Service Provider Technical Solution.

5.5 Subject to paragraph 5.10, the Detailed Transition Plan shall not alter any Milestone Date, required Go Live Date or impose any obligations on Molina or give rise to any further dependencies or assumptions in excess of those set out in the Agreement, and any attempt to do so shall be void and deemed not incorporated into the Detailed Transition Plan.

5.6 Acceptance and approval of the Transition Services, the Transition Deliverables and the Service Provider's readiness to Go Live will be conducted in accordance with the Detailed Transition Plan and the Agreement (including, to the extent applicable, the Service Provider Technical Solution).

5.7 If the Service Provider does not achieve a Milestone by its Milestone Date, then Service Provider shall be liable to Molina for a Delay Payment as specified in paragraph 8 of this Schedule.

5.8 The provisions of paragraphs 5.6 and 5.7 shall be deemed revised to apply to any amended Milestone Dates where extensions of time have been granted or agreed, whatever the reason for such extensions of time including a Relief Event. The payment of Delay Payments operate as a price reduction to reflect the reduced value of the Transition Services to Molina. Accordingly, the parties agree that they are not in any way compensatory but instead operate as a price adjustment and the claiming and payment of these is without prejudice to any other right and remedies that Molina might have.

5.9 The parties will comply with their respective obligations set out in the Transition Plans.

5.10 Any changes to the Transition Plan must be agreed in writing between the parties in accordance with a Change Procedure.

6. TRANSITION SERVICES

6.1 Transition Services shall include activities necessary to complete the transition as detailed in the Transition Plan, including:

(a) creating and executing the Transition Plan and meeting all Transition Milestones;

(b) identifying and managing interdependencies of executing tasks during transition;

(c) performing required site readiness activities;

(d) identifying and onboarding resources required for Transition Services, both Service Provider’s and Molina’s resources;

(e) collecting, reviewing and confirming user onboarding and access requirements required for delivery of Services;

(f) verification and testing of transition changes, subject to Molina review and consideration for approval;

(g) validating migrated data;

(h) managing quality on all aspects of the transition including, but not limited to, documentation, knowledge transfer activities, quality gate reviews;

(i) establishing and executing governance model to be used during transition;

(j) monitoring, tracking and reporting against the various tasks which need to be completed by all teams;

(k) creating and executing a ramp-up plan that aligns with the Transition Plan;

(l) setup of post go-live and ongoing production support processes and organizations;

(m) providing information and data to Molina, and coordinating with and participating in (as requested by Molina), the completion of all applicable Exit Criteria; and

(n) updating the Technical Solution Document to reflect any changes in the delivery solution made and approved by Molina during the transition contemplated in this Schedule.

6.2 The Service Provider shall perform the Transition Services as set out in Appendix 4A (*Transition*).

7. **TRANSFORMATION**

7.1 Transformational Milestones are as set out in Appendix 4B (*Transformation*) and as agreed in writing by the Parties. These will be subject to Delay Payments if the Service Provider fails to achieve Milestones. The Service Provider shall transform the Services on a timeline approved by Molina and, in each case, (a) in accordance with Appendix 4B (*Transformation*), with the actual actions to be undertaken by the Service Provider being subject to Molina's written approval, and (b) as otherwise agreed by the Parties.

7.2 In addition to the above, from time to time, the Service Provider will recommend transformational initiatives over the duration of contract to further improve Molina operating efficiency, reliability, scale, speed to delivery, and customer satisfaction while reducing costs, including at a minimum all aspects and criteria relating to transformation as set out in the Service Provider Technical Solution as of the Effective Date (except to the extent the relevant provisions of the Service Provider Technical Solution has been amended by the Parties through an amendment to the Agreement, or as set out in a Change Notice executed in accordance with Schedule 9 (*Change*)). Service Provider shall demonstrate through governance meetings how these initiatives might be integrated to ongoing operations and for bringing new ideas and approaches to Molina in support of their transformation.

7.3 *Transformational Initiatives for Infrastructure*

Project Scope: Any project less than [redacted] will be supported / executed by [redacted]; to the extent it does not [redacted]. Any additional project effort will be via separate SOW. These hours will be [redacted].

During Transition, the Parties will evaluate the progress of existing projects, assess what work remains to be completed and make a plan for completion using business as usual resources or the Innovation fund, any other commercial means. Alterations to schedule or scope will be implemented through CR. The transformational initiatives include but are not limited to:

(a) [redacted];

(b) [redacted];

(c) [redacted];

(d) [redacted];

(e) Service Provider will also provide support of projects related to current, on-going transformation efforts; such support will consist of attending meetings, providing data, and similar tasks (provided that such support shall be provided on a time and material basis or as a chargeable Project to the extent that the support constitutes out-of-scope activities); the parties will refer concerns over the level of support requested to the Operational Review Board.

(f) improve incident and event frameworks, integrate problem management into development and support lifecycles, and enhance visibility into issues, impacts and resolution;

(g) [redacted];

(h) [redacted];

(i) [redacted].

8. **WIND-DOWN OF TRANSITION SERVICES**

8.1 Service Provider shall notify Molina when it believes it has completed the Transition Services. Service Provider shall document and demonstrate that the Deliverables and Transition Milestones constituting Exit Criteria have been fulfilled.

8.2 Upon Molina's confirmation of completion, Service Provider shall commence the orderly cessation and removal of tasks and materials specific to the Transition Services, with minimal disruption to Molina's operations or Service Provider's ongoing Services.

8.3 If the Service Provider does not successfully achieve Acceptance of the Exit Criteria for:

(a) any Transition completion by the applicable Milestone Date by more than [redacted], then the Service Provider shall be liable to pay to Molina the sum of $[redacted] for

each week of delay (or part week of delay) capped at $[redacted] until such Exit Criteria are Accepted.

8.4 The provisions of paragraph 8.3 shall apply to any amended Milestone Dates where extensions of time have been granted or agreed, whatever the reason for such extensions of time including a Relief Event.

8.5 The payment of Delay Payments operates as a price reduction to reflect the reduced value of the Transition Services to Molina. Accordingly, the parties agree that they are not in any way compensatory but instead operate as a price adjustment and the claiming and payment of these is without prejudice to any other right and remedies that Molina might have.

APPENDIX 4A

TRANSITION

Proposed Tools and Timeline for Implementation

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Commitments for Day 1 and Outcomes for Day 30, 60, 90, 120, and Beyond

While the overall transformation will be presented separately, this section will particularly deal with what we would propose/look after under the day to day operations or as separately priced project once we complete the transition [redacted].

Below we have presented some of the activities that we are intended to take once the transition is over. These are indicative and may or may be completely relevant depending upon the observations after the transition phase.

[redacted]. This will be discussed and agreed with Molina, followed by the detailed implementation plan.

[redacted]

Transition Milestones & Dependencies

Transition Milestones

The table below details the critical milestones we propose for the transition.

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 1. Transition Milestones

Transition Plan

We recognize Molina's desire for an efficient, effective and risk-free transition of this very important strategic initiative. While in today's world IT services have been industrialized to the extent where combination of technology and process can ensure [redacted]. It is the combination of structured processes, leverage of in-house tools specifically for [redacted].

[redacted].

Based on our understanding of your evaluation criteria, [redacted].

Service Provider's key transition design principles used to develop the plan are: [redacted].

Figure 1. Key Transition Design Principles

Transition Wave Plan

We have customized our patented [redacted]. We have designed a right aligned transition which provides Molina with a right balance between speed to value, appetite-for-risk and people management and quality planning considerations. The transition timeline is based on the [redacted].

Our proposed transition solution for Molina is based on: [redacted]

Service Transition Timeline

The following diagrams depicts overall Service Transition [redacted]

Figure 2. Overall Transition Timeline

Transition Contingency Plan

Infosys Transition Center of Expertise (TCOE) has successfully completed in excess of [redacted] without a failed transition. Infosys TCOE is committed to bringing to bear any resources and leadership required to ensure successful completion of the transition.

However, in the unlikely event that the [redacted]. Because this plan is likely to have [redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Table 2. **Quality Check points**

In addition to the quality assurance [redacted].

Each member in this team is personally incentivized to continuously improve the way we approach transition. Therefore, our methodology is constantly evolving to incorporate new knowledge and best practices.

Our methodology is based on [redacted].

Figure 3. End-to-End Transition Methodology

Transition is, as mentioned above, the [redacted].

Figure 4. Service Execution Work Stream Approach

[redacted].

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 3. Pre-Planning Activities

[redacted].

Transition Planning

The transition planning phase clearly details the plan to successfully execute the remaining phases of transition. It is a collaborative effort between Infosys and Molina to [redacted] making transition a success.

Following table specifies activities performed by [redacted]:

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 4. Transition Planning Activities

Knowledge Transfer (KT)

Knowledge Transfer (KT) is approached top down from business knowledge down to technical knowledge; the knowledge is landed in teams comprised of functional, technical and domain experts.

There are several ways in which [redacted].

Key Knowledge transfer activities, deliverables and acceptance criteria are listed below**:** [redacted].

Figure 5. Knowledge Transfer – Activities, Deliverables and Acceptance Criteria

Secondary Support (SS)

The Secondary Support phase of the [redacted].

Figure 6. Secondary Support – Activities, Deliverables and Acceptance Criteria

Primary Support (PS)

The main objective of Primary Support phase is to [redacted]. During this phase, [redacted] if the need arises.

Key primary phase activities, deliverables and acceptance criteria are listed below: [redacted]

Figure 7. Primary Support – Activities, Deliverables and Acceptance Criteria

[redacted]

- Pre-process Training:

[redacted]

- Onsite Knowledge Transfer:

[redacted]

- Offshore Knowledge Transfer Training:

[redacted]

- Parallel Run/Primary Support:

During this phase:

- [redacted]
  - This phase ensures that [redacted].
  - Also ensures that quality of service is maintained at highest level, right from the start of engagement. Parallel run volume ramp-up and communication strategy will be finalized during process definition stage.

Transition Governance Structure

A key factor to the success of any major transition program is effective governance. Infosys believes in bringing everybody to the table through robust, yet transparent, leadership and governance. [redacted]. In line with our transition approach, we will have Transition Leads [redacted].

Figure 8. Transition Governance Model

Infosys recommends [redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Table 5. Transition Management Functions

Transition Metrics

The following Metrics will be reported as part of the Transition Status Report. During Transition planning the methodology for reporting these statistics [redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Table 6. Transition Metrics

Transition Meetings

The proposed governance structure will be supported by a comprehensive governance schedule that will facilitate the clear direction of the transition program and ensure clear, unambiguous communication across all levels of the governance structure. Given the multiple threads that that need to be managed, we recommend [redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Table 7. Meeting Cadence

Reporting during transition will be centralized and managed from the TMO.

[redacted]

The following table shows the resource [redacted]. There will be weekly reporting to reflect progress against the Staffing Plan.

[redacted]

Figure 9. Resource Ramp Up

Transition Staffing
[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
[redacted]	[redacted]			[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]

Table 8. Transition Roles and Responsibilities

Requirements on Molina Personnel

Approximate maximum effort required per day from Molina personnel [redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Table 9. Requirements on Molina Personnel

[redacted]. It introduces unnecessary risks to make process, standards and tool changes in the midst of a services transition.
It is recognized that [redacted].

Other Information on Transition

Transition Risks and Mitigation Process

Infosys follows a structured Risk Management framework. Risk management is a key focus area under our core transition approach strategy. The objective of this framework is to identify and develop mitigation plans for potential risks which may impact the success of the engagement. The following diagram illustrates the Risk Management Framework:

[redacted]

Figure 10. **Risk Management Framework**

The refinement of risks already identified will be carried out via a joint risk workshop prior to the commencement of transition during the planning phase. This risk register will be a running document and inputs to this will get added be the based on risks identified by Molina and Infosys during the transition execution process.

We have dedicated focus at the program level to manage the risk mitigation plan and report findings, risk management is pushed down to each and every work stream and cluster lead/transition lead.

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Table 10. Transition Risk Management

Transition Risks and Mitigations

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 11. Transition Risks

Transition Enablement (Cross Functional) Teams
[redacted]

Infrastructure
[redacted]

IT Service Process
[redacted]

Access and On Boarding
[redacted]

Policies and Procedures
[redacted]

SLA Tools
[redacted]

APPENDIX 4B

TRANSFORMATION

Core Infrastructure Transformation

While the overall transformations will be presented / discussed in the session for "***Transformational Initiatives***", this section will particularly deal with operational transformation ideas under day-to-day operations. The idea is to understand and take over the operations in its existing shape, identify / document the gaps and take the services to the next level.

Below we have presented some of the operational transformations that we intend to start working post takeover of services. These are indicative based on our current understanding of Molina infrastructure landscape. Once, we have more details of the landscape, we will refine these as appropriate.

This will be [redacted].

The transformation activities are explained below with the potential benefits:

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]
		[redacted]
	[redacted]	[redacted]
		[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
		[redacted]
		[redacted]
	[redacted]	[redacted]
	[redacted]	[redacted]
		[redacted]
	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
		[redacted]
		[redacted]

Contact Center Transformation

[redacted]

The aforesaid areas, can be planned for long term objectives as each one of them takes significant amount of time and requires a detailed analysis in the current setup as part of the [redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Table 12. [redacted]

Figure 11. [redacted]

[redacted]

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

Table 13. [redacted]

Infosys recommends [redacted]
To implement [[redacted]

- Analysis

Infosys will [redacted]

Figure 12. [redacted]

[redacted]

Figure 13. [redacted]

Once all meta data information is collected, [redacted].
[redacted]

Figure 14. [redacted]

[redacted]

Figure 15. [redacted]

- Migrate

  [redacted]

  Co-ordinating across the stakeholders requires a multi-tier/multi-party governance - domain level execution, program board level and executive level, driven from a centralised command center to deliver a frictionless workflow.

[redacted]

Figure 16. [redacted]

[redacted]

Figure 17. [redacted]

[redacted]

Figure 18. [redacted]

[redacted]

Figure 19. [redacted]

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Below table depicts [redacted]

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 14. [redacted]

Transformational Initiatives

As per our discussion with Molina as part of different meetings and sessions, we understand the importance of [redacted].
This section will detail [redacted]:
[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]		[redacted]	[redacted]	

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted]

[redacted]	[redacted]	[redacted]

Table 15. [redacted]

[redacted]

Figure 20. [redacted]

[redacted]

Figure 21. [redacted]

[redacted]

Figure 22. [redacted]

[redacted]

Figure 23. [redacted]

[redacted]

1.1.1.1 Timeline for Implementation

Timelines for implementation of our approach is as depicted in the diagram below: [redacted]

Figure 24. Implementation Timeline

The above approach and timelines is considering the fact [redacted]

[redacted]

1.1.2 [Redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

1.1.2.1 [redacted]

Cloud computing benefits organizations by giving them the ability to trade capital expense for variable expense, gain advantage from massive economies of scale, make agile capacity decisions, increase business speed and agility, stop spending money running and maintaining data centers, and go global quickly. At the same time, cloud adoption represents a major IT transformation, a shift in culture and a new way of financing your infrastructure. Cloud introduces a significant shift in how technology is procured, used, and managed. It presents new cost and security challenges, requiring governance and control across the organization. And it also needs a proactive team to take ownership and direction of the migration process. [redacted]

Figure 25. [redacted]

[redacted]

*1.1.2.2 **[redacted]***

Figure 26. [redacted]

[redacted]

*1.1.2.3 **[redacted]***

[redacted]

[redacted]

Figure 27. [redacted]

[redacted]

Figure 28. [redacted]

[redacted]

The below diagram provides [redacted].

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Table 16. [redacted]

[redacted]

1.1.2.1 [redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

Figure 29. [redacted]

[redacted]

Figure 30. [redacted]

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

Figure 31. [redacted]

[redacted]

Figure 32. [redacted]

[redacted]

Figure 33. [redacted]

[redacted]

Figure 34. [redacted]

[redacted]

Figure 35. [redacted]

[redacted]

Figure 36. [redacted]

[redacted]

Figure 37. [redacted]

[redacted]

Figure 38. [redacted]

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 17. [redacted]

SCHEDULE 5

BENCHMARKING

CONTENTS

1. **DEFINITIONS**

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) to this Agreement.

2. **INTRODUCTION**

This Schedule defines the way in which Benchmarking shall be implemented under the Agreement.

3. **BENCHMARKING GENERALLY**

3.1 Each Benchmarking shall comprise a mutually agreed objective measurement, applicable metrics and comparison process that compares the Charges with the price of services that are:

(a) substantially similar to the Benchmarked Services (as defined below) in scope, specification, volume and geographical coverage, time period and provided on similar terms and conditions;

(b) provided by outsourcing service providers substantially similar to the Service Provider; and

(c) provided to outsourcing services clients substantially similar to Molina,

(the "**Benchmarking Process**").

3.2 The Service Provider shall cooperate with Molina in relation to any Benchmarking.

4. **SELECTION OF BENCHMARKER**

4.1 Molina shall have the right to select any of the following as the **"Benchmarker"** to conduct the Benchmarking Process:

(a) Gartner;

(b) ISG; or

(c) Maturity.

4.2 As an alternative to Molina selecting the Benchmarker under paragraph 4.1, the Parties may jointly agree to select another provider of benchmarking services to conduct the Benchmarking Process. Nothing in this paragraph 4.2 limits Molina's right to make a selection under paragraph 4.1.

4.3 The Parties shall enter into an agreement with the Benchmarker (the "**Benchmarking Agreement**"), in substantially the same form as Appendix 5A (*Agreed Form Tri-Partite Benchmarking Agreement*).

5. **TIMING**

5.1 Molina may engage in Benchmarking in respect of any Service Bundle only after six (6) months following the end of Transition of that Service Bundle. No Service Bundle shall be benchmarked more than twice during the Term.

5.2 Molina may notify the Service Provider that it wishes to conduct a Benchmarking by providing the Service Provider with thirty (30) days' written notice of its intention to do so (the "**Benchmarking Notice**").

6. **PROCESS**

6.1 Each Benchmarking Notice shall set out:

(a) the Service Bundle and associated Resource Rates in respect of which Molina wishes to conduct the Benchmarking (the "**Benchmarked Services**"); and

(b) the identity of the Benchmarker Molina has chosen in accordance with paragraph 4.1 above.

6.2 Throughout the Benchmarking, all instructions to the Benchmarker will be given solely by Molina and shall be disclosed to the Service Provider and will be consistent with and relate to the topics agreed pursuant to paragraph 6.3 below.

6.3 Molina, the Service Provider and the Benchmarker shall in good faith agree to the methodology that will be used to conduct or support the specific Benchmarking and the normalization processes that will be applied, including, without limitation, at least four (4) comparable outsourcing transactions (not counting this Agreement) to allow a valid Benchmarking to be conducted (the "**Benchmarking Methodology**").

6.4 Where during the Term, the Parties and a Benchmarker agree a Benchmarking Methodology and apply that Benchmarking Methodology, that Benchmarking Methodology shall, unless otherwise agreed, be valid for all future Benchmarkings for the Services that are part of the Benchmarked Services.

6.5 The Service Provider shall cooperate to facilitate the Benchmarking and shall reasonably meet with Molina and the Benchmarker prior to and throughout the Benchmarking.

6.6 The Benchmarker shall conduct the Benchmarking in a manner that does not unreasonably interfere with the Service Provider's ongoing service operations.

6.7 The Parties shall agree a timetable for the Benchmarking that provides for the Benchmarking to be completed as soon as reasonably practicable and sets a deadline by which the Benchmarking must be complete and the Benchmarking Report must be delivered to the Parties (the "**Report Deadline**").

6.8 The fees, costs and expenses of any Benchmarker shall be borne by Molina, and each Party shall bear its own costs of compliance with this Schedule.

7. **BENCHMARKING REPORT**

7.1 Within ten (10) days after the completion of the Benchmarking but in any event no later than the Report Deadline, the Benchmarker shall deliver to Molina and the Service Provider

the final results of the Benchmarking in a written report, including any supporting documentation required to interpret or validate the report (the "**Benchmarking Report**").

7.2 Within thirty (30) days following the date of the issuance of a Benchmarking Report:

(a) Molina and the Service Provider shall review the Benchmarking Report results; and

(b) the Parties and the Benchmarker shall review the Benchmarking Report and the Benchmarking Methodology to confirm that the Benchmarking Process was followed.

7.3 If either Party has reason to believe that the Benchmarking Report contains material errors, it shall notify the Benchmarker of the information being contested along with such documentation as is necessary to support the claim and copy the other Party on all such correspondence.

8. FINAL BENCHMARKING REPORT

8.1 The Benchmarker shall review any claims made by a Party pursuant to paragraph 7.3 and meet with both Parties to address any such matters and make any necessary adjustments to its findings prior to the Benchmarking Report being considered final (the "**Final Benchmarking Report**").

8.2 If there is any dispute between the Service Provider and Molina in relation to the application of the Benchmarking Process or the determinations of the Benchmarker in the Final Benchmarking Report then the matter shall be referred to the Operational Review Board.

9. CONSEQUENCES OF FINAL BENCHMARKING REPORT

9.1 If a Final Benchmarking Report indicates that the Charges attributable to the Benchmarked Services exceed the Benchmark Threshold, then the remainder of this paragraph 9 shall apply.

9.2 In this paragraph 9, the "**Benchmark Difference**" ("**BD**") shall be calculated, in monetary terms, as follows:
BD = X – B

Where:

X = the Charges applicable in the Contract Year in which the Final Benchmarking Report is issued (or, if the Contract Year is not complete, the estimated Charges based on the actual Charges invoiced at the time of the Final Benchmarking Report); and

B = the Benchmark Threshold.

9.3 The Service Provider shall, by no later than ten (10) Business Days following the date on which the Final Benchmarking Report is issued, provide written notice to Molina:

(a) setting out how the Service Provider proposes to address the Benchmark Difference; and

(b) providing an assurance from the Service Provider that this proposal complies with the Agreed Cost Standards.

9.4 Molina shall, by no later than ten (10) Business Days following receipt by it of a written notice under paragraph 9.3, provide written notice to the Service Provider stating whether Molina agrees that the proposal in that notice complies with the Agreed Cost Standards.

9.5 If:

(a) the Service Provider does not provide written notice in accordance with paragraph 9.3 within the timeframe specified in that paragraph; or

(b) Molina notifies the Service Provider under paragraph 9.4 that it does not agree with the Service Provider's proposal under paragraph 9.3,

then Molina may terminate the Agreement immediately upon notice to the Service Provider, with payment of the Benchmarking Termination Fee.

9.6 [redacted] agreed by the Parties pursuant to this Schedule shall be [redacted] and shall be incorporated as an amendment to Schedule 3 (*Pricing and Invoicing*) without the need for an Agreement Change.

9.7 A Benchmarking shall not in any circumstances result in an increase in any of the Charges or any of the rates by which the Charges are calculated.

APPENDIX 5A

AGREED FORM TRI-PARTITE BENCHMARKING AGREEMENT

TRI-PARTITE BENCHMARKING AGREEMENT

1) **[MOLINA]**
2) **[SUPPLIER]**
3) **[BENCHMARKER]**

THIS AGREEMENT is made on [●]
BETWEEN:
[●] ("**Molina**");
[●] (the "**Supplier**"); and
[●] (the "**Benchmarker**"),
(hereinafter each of the above shall be referred to individually as a "**Party**" and collectively as the "**Parties**").
AND CONSISTS OF THE FOLLOWING:

- This Agreement.
- Attachment 1 – The Terms of Reference.
- Attachment 2 – Confidentiality Agreement.
- Attachment 3 – Schedule 2 (*Statements of Work*) and Schedule 6 (*Service Levels and Service Credits*) of the Master Services Agreement and all Statements of Work.
- Attachment 4 – Types of Benchmark Data.
- Attachment 5 – Benchmarking Steering Group.
- Attachment 6 – The Benchmarking Charges.
- Attachment 7 – Description of Comprehensive Benchmark.
- Attachment 8 – Benchmark Plan.

(collectively, all of the above shall be referred to as the "**Benchmarking Agreement**").

WHEREAS:

(A) Molina and the Supplier entered into the framework Master Services Agreement dated [●] (the "**Master Services Agreement**").
(B) The Parties have agreed to enter into this Benchmarking Agreement to govern the conduct of the Benchmark Process as and when invoked by Molina (pursuant to the Master Services Agreement).
(C) The Benchmark Process shall, depending on the Benchmarked Services, determine the Fair Market Price.
(D) The Benchmarker is instructed by Molina, as the client of the Benchmarker, to carry out each Benchmark.

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions:

In this Benchmarking Agreement the following words and phrases have the meanings set out below unless a contrary intention appears:
"**Affiliate**" means in relation to a Party, each entity that it Controls or is under common Control with that Party;

"**Benchmark**" means the application of the Benchmark Process in order to identify the Fair Market Price for the Benchmarked Services;
"**Benchmark Data**" means the data submitted by Molina and the Supplier to the Benchmarker as validated by the Benchmarker as set out in Attachment 4 (*Types of Benchmark Data*);
"**Benchmark Deliverables**" means the Initial Benchmark Report and the Final Benchmark Report;
"**Benchmark Milestones**" means the dates set out in the Benchmark Plan by which certain deliverables and obligations as set out in the Benchmark Plan must be met;
"**Benchmark Notice**" means the notice issued by Molina to the Supplier and the Benchmarker invoking the Benchmark Process in relation to the Benchmarked Services set out in the notice;
"**Benchmark Plan**" means the plan set out in Attachment 8 (*Benchmark Plan*) pursuant to which the Benchmark will be performed;
"**Benchmark Process**" means the Benchmarker's methodology, database and corresponding process, as set out in Attachment 7 (*Description of Comprehensive Benchmark*), to be followed in accordance with the Benchmarker's standard practice as amended in accordance with this Benchmarking Agreement;
"**Benchmarked Services**" means the services provided under the Master Services Agreement or any Statement of Work and/or Resource Rates in respect of which Molina wishes to conduct the Benchmark, as identified by Molina in a Benchmark Notice;
"**Benchmarker Materials**" means the tools, methodologies, questionnaires, responses, proprietary research and data, software, software documentation and other materials (other than Party Materials) generated by the Benchmarker in the course of performing the Benchmark in each case, whether in hard copy, electronically or otherwise, together with all intellectual property rights in the Benchmarker Materials;
"**Benchmarking Charges**" means the agreed upon payment for the Benchmarking Services, comprising the applicable fees set out in Attachment 6 (*The Benchmarking Charges*);
"**Benchmarking Services**" means the services as set out and referred to in this Benchmarking Agreement and provided by the Benchmarker in order to perform the Benchmark;
"**Benchmarking Steering Group**" means the group comprised of no more than four named representatives (or their deputies) from each of the Benchmarker, the Supplier and Molina. The members of the Benchmarking Steering Group as at the date of this Benchmarking Agreement are listed in Attachment 5 (*Benchmarking Steering Group*);
"**Business Days**" means those days deemed by Molina to be standard working days according to Molina's business operations and designated holidays both globally and within a given jurisdiction;
"**Comparable Services**" means the services provided by the Peers that the Benchmarker selects for comparison with the Benchmarked Services;

"**Comparative Suppliers**" means the service providers (no fewer than four) considered by the Benchmarker to be within the Supplier's peer group at the time of the Benchmark;
"**Confidential Information**" has the meaning given to it in Clause 5.1;
"**Control**" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Party, whether through the ownership of voting securities, by contract, or otherwise and "**Controls**" shall be construed accordingly;
"**Expiry Date**" means four (4) years from the date of this Benchmarking Agreement, unless extended in accordance with Clause 4.2;
"**Fair Market Price**" means the median of the market range of prices for services against which the Benchmarker compares the Benchmarked Services;
"**Final Benchmark Report**" means the Benchmarker's final written report setting forth the Fair Market Price, including all supporting calculations, mapping matrices, agreed assumptions and documentation (including an explanation of any Normalization in different Benchmarks during the term of this Benchmarking Agreement) to the extent allowable by the Benchmarker's non-disclosure agreements, that will be provided by the Benchmarker simultaneously to Molina and the Supplier in hardcopy format (or as agreed by the Benchmarking Steering Group);
"**Financial / Contract Questionnaire**" or "**FCQ**" means the financial / contract questionnaire used by the Benchmarker in connection with the Benchmark;
"**Good Industry Practice**" means in respect of each individual Benchmarking Service that level of skill, care, prudence, judgement, foresight, integrity and diligence that would be reasonably expected of a global market leading provider of services similar to the Benchmarking Services;
"**Initial Benchmark Report**" means the initial output from the Benchmark Process, including all supporting calculations, mapping matrices, agreed assumptions and documentation (including any explanation of any Normalization in different Benchmarks during the term of this Benchmarking Agreement), to the extent allowable by any confidentiality obligations of the Benchmarker, that will be provided by the Benchmarker simultaneously to Molina and the Supplier in hardcopy format (or as agreed by the Benchmarking Steering Group) during the initial Benchmark Report review meeting;
"**Molina Group**" means Molina and its Affiliates from time to time;
"**Molina Group Company**" means a member of the Molina Group;
"**Normalization**" means the process by which the Benchmarker adjusts each of the Peer Group Data as part of the Benchmark Process to match the Benchmarked Services and the Benchmark Data in order to enable a "like for like" comparison between the Benchmarked Services and the Peer Group Data for the purpose of the Benchmark, and "**Normalized**" shall be construed accordingly;
"**Normalization Factor**" means an individual component of normalization which adjusts for a specific aspect of service, scope, terms, volume or charge, including the

scope of services, volume of services, technical constraints, service levels and any onshore/offshore requirements;
"**Party Materials**" has the meaning given to it in Clause 10.7;
"**Peer**" and "**Peers**" shall mean a member or members of the Peer Group respectively;
"**Peer Group**" means the group of Comparative Suppliers selected by the Benchmarker in connection with the performance of the Benchmark;
"**Peer Group Data**" means the data related to the Peer Group held by the Benchmarker and used during the Benchmark Process;
"**Personal Data**" means information which relates to or would identify an individual;
"**Resource Rates**" means the daily rates for Supplier personnel, as set out in the Master Services Agreement or any Statement of Work;
"**Review Period**" has the meaning given to it in Clause 3.7;
"**Standard Collection Templates**" means the standard collection templates set out in Attachment 4 (*Types of Benchmark Data*);
"**Statement of Work**" means a statement of work for Services under the Master Services Agreement;
"**Supplier Group**" means the Supplier and its Affiliates from time to time;
"**Supplier Group Company**" means a member of the Supplier Group; and
"**Terms of Reference**" and "**ToR**" means the description of the way in which the Benchmark will be conducted as described in Attachment 1 (*The Terms of Reference*).

1.2 Headings are for convenience only and shall not affect the interpretation of this Benchmarking Agreement.

1.3 References to the singular include the plural and vice versa, and references to one gender include the other gender.

1.4 Any reference to persons includes natural persons, firms, partnerships, limited liability partnerships, companies, corporations, unincorporated associations, local authorities, governments, states, foundations and trusts (in each case, whether or not having separate legal personality) and any agency of any of the above.

1.5 In the event of any conflict between this Benchmarking Agreement and the terms of any other consultancy and/or professional service agreement executed between the Benchmarker and the Supplier or Molina relating to the subject of this Benchmarking Agreement, the terms of this Benchmarking Agreement shall take precedence unless otherwise agreed in writing after the date of this Benchmarking Agreement.

2. INTRODUCTION

2.1 Molina and the Supplier have agreed in the Master Services Agreement that a Benchmark may be carried out from time to time and have agreed to appoint the Benchmarker to perform the Benchmarks as and when required pursuant to the Master Services Agreement.

2.2 The Benchmark Process shall be commenced by Molina issuing the Supplier and the Benchmarker a Benchmarking Notice, in accordance with the Master Services Agreement.

2.3 The Benchmark Notice shall set out the number of Benchmarks that shall be performed and the Benchmarked Services that shall be the subject of those Benchmarks.

2.4 A single Final Benchmark Report shall be prepared by the Benchmarker for all of the Benchmarks invoked in the same Benchmark Notice.

2.5 The Benchmarker is not granted exclusive supplier status by this Benchmarking Agreement.

2.6 This Agreement does not give to the Benchmarker any right to a minimum level or volume of services or revenue.

3. PROVISION OF BENCHMARKING SERVICES

3.1 The Benchmarker shall undertake the Benchmarks in respect of the Benchmarked Services when requested by Molina by means of a Benchmark Notice.

3.2 The Benchmarker shall perform the Benchmark in accordance with the terms of this Benchmarking Agreement and the Benchmark Plan. Notwithstanding anything else in this Benchmarking Agreement, the Benchmark Milestones in the Benchmark Plan must be met for each Benchmark irrespective of any discussions about errors or failures to meet the Benchmark Process.

3.3 Molina and the Supplier shall meet their respective obligations by the dates set out in the Benchmark Plan.

3.4 The Benchmarker shall deliver a copy of any correspondence between the Benchmarker and either of Molina or the Supplier to all Parties at the same time except where stated otherwise in this Benchmarking Agreement.

3.5 The Benchmarker shall undertake the Benchmark in such a way so as to cause minimum disruption to the business of Molina and the Supplier during the performance of its obligations under this Benchmarking Agreement.

3.6 Following completion of the Benchmark (which shall be no later than the date determined by the Benchmark Plan), the Benchmarker shall promptly provide each of Molina and the Supplier with an Initial Benchmark Report and shall present such Initial Benchmark Report to the Parties at a workshop or meeting within five (5) Business Days of completing the Benchmark.

3.7 Within thirty (30) days following the issuance of the Initial Benchmark Report (the "**Review Period**"), Molina and the Supplier shall identify any errors or omissions of fact or failures to comply with the Benchmark Process that they individually reasonably believe may have been made in compiling the Initial Benchmark Report or clarification (to aid understanding) that may be necessary to the Initial Benchmark Report. Molina and the Supplier shall set out in reasonable detail their reasons and supporting data for why the findings should be amended or reviewed and provide that information to the Benchmarker and the other Party.

3.8 The Benchmarker shall take account of any submissions made by the Parties during the Review Period and shall provide a written explanation in respect of any decision to accept or reject any correction, clarification or comments from any Party, but the Benchmarker is not obliged to make any clarification or apply any comments from any Party in the Final Benchmark Report.

3.9 The Benchmarker shall produce a Final Benchmark Report within two (2) weeks following the end of the Review Period.

3.10 The Final Benchmark Report shall be final and binding upon the Parties except to the extent that there is fraud, a manifest error of fact or material failure by the Benchmarker to follow the Benchmark Process which impacts the validity of the Final Benchmark Report.

3.11 If the Final Benchmark Report contains findings that were not contained in the Initial Benchmark Report and those findings do not relate to any of the submissions made by a Party pursuant to Clause 3.8, then the Final Benchmark Report shall be considered as an Initial Benchmark Report and the steps in Clauses 3.7 to 3.10 shall be repeated, however the Review Period shall be seven (7) days only and the Benchmarker shall produce a Final Benchmark Report within seven (7) days following the end of that Review Period.

4. CONTRACT TERM

4.1 This Benchmarking Agreement shall commence on the date of this Benchmarking Agreement and expire at 11:59 pm and 59 seconds Pacific Time on the Expiry Date, unless terminated earlier in accordance with Clause 4.4, Clause 4.5 and Clause 4.6.

4.2 Molina may extend the term of this Agreement, as a single extension of two (2) years, by giving notice of the extension in writing to the Benchmarker and the Supplier at least three (3) months prior to the Expiry Date.

4.3 The Benchmarker acknowledges that it has not been given any assurance nor has the Benchmarker any legitimate expectation that the term of this Benchmarking Agreement will be extended under Clause 4.2.

4.4 Molina may decide to terminate this Benchmarking Agreement for convenience without penalty or charge, subject to Clause 4.9 and Clause 4.10.

4.5 Each Party may terminate this Benchmarking Agreement by giving written notice to the other Parties if any other Party is in material breach of any of its obligations under this Benchmarking Agreement and either that breach is incapable of remedy or the other Party shall have failed to remedy that breach within twenty (20) Business Days after receiving written notice requiring it to remedy that breach.

4.6 Without limiting Clause 4.5, Molina may terminate this Benchmarking Agreement by giving written notice to the other Parties, if the steps in Clauses 3.7 to 3.10 have been repeated two or more times pursuant to Clause 3.11.

4.7 Any term of this Benchmarking Agreement that by its nature extends beyond the expiry or earlier termination of this Benchmarking Agreement remains in effect until fulfilled, and shall apply to respective successors and assignees.

4.8 If this Benchmarking Agreement is terminated during the conduct of a Benchmark but prior to completion of the Benchmark Process due to material breach by a Party other than the Benchmarker, the Benchmarker shall be entitled to issue an invoice to reflect all the work performed up to the date that the termination takes effect.

4.9 If Molina decides to terminate this Benchmarking Agreement for convenience pursuant to Clause 4.4, or this Benchmarking Agreement or the Master Services Agreement is terminated for the breach of either Molina or the Supplier, then Molina shall give the

Supplier and the Benchmarker at least ten (10) Business Days' written notice ("**Termination Notice**").

4.10 If the Termination Notice is received during the conduct of a Benchmark, the Benchmarker shall use its best efforts to redeploy the consultants deployed on that Benchmark. The only amounts Molina shall be liable to pay in relation to the termination for convenience exercised during the conduct of a Benchmark is:

(a) an amount equal to the value of the work performed to the date of the expiry of the Termination Notice; and

(b) any outstanding Benchmarking Charges related to the period between the expiry of the Termination Notice and the end of the Benchmark Process which Benchmarking Charges shall be reduced on a pro rata basis to reflect the number and seniority of the consultants redeployed and when they were redeployed.

5. EXCHANGE OF INFORMATION

5.1 All information exchanged by the Parties pursuant to this Benchmarking Agreement or in relation to the Benchmark Process, including, without limitation, the Benchmark Data and the Benchmark Deliverables and the Benchmarker Materials (the "**Confidential Information**") is confidential and each Party shall comply with the confidentiality terms set out in Attachment 2 (*Confidentiality Agreement*). The provisions in Attachment 2 (*Confidentiality Agreement*) are without prejudice to, and shall not limit, any other confidentiality agreements or understandings between any of the Parties.

5.2 The Parties will not publicize the terms of this Benchmarking Agreement, or the relationship, in any advertising, marketing, promotional or any other materials without prior written consent of the other Parties, except as may be required by law.

5.3 The Benchmarker may use the information and data provided under this Benchmarking Agreement only for the purpose of performing a Benchmark under this Benchmarking Agreement and as provided for in Clause 5.4.

5.4 The Benchmarker may include Molina's data and the Supplier's data provided in Attachment 3 (*Schedule 2 and Schedule 6 of the Global Framework Agreement and all SOWs*) and Attachment 4 (*Types of Benchmark Data*) in the Benchmarker's database and such data:

(a) may be used only by the Benchmarker for future consulting and benchmarking engagements in compliance with this Clause 5 and Clause 10; and

(b) shall be coded by the Benchmarker to preserve the Supplier's, Molina's and other third parties' anonymity.

5.5 Except for the data retained in accordance with Clause 5.4 and any other information that the Benchmarker is required by law to retain, on the completion of each Benchmark undertaken by the Benchmarker under this Benchmarking Agreement, the Benchmarker shall return to the Supplier and Molina all information (whether in hard or soft form) provided by those Parties, respectively, during the course of the Benchmark, or on request confirm that all such information has been destroyed.

6. BENCHMARKING CHARGES

6.1 Molina shall pay the Benchmarking Charges for the Benchmarking Services in accordance with the provisions of this Clause 6 (Benchmarking Charges).

6.2 The Benchmarker shall issue an invoice to Molina for the Benchmarking Charges (including any agreed travel and subsistence expenses referred to in Clause 6.7) payable in accordance with Clause 6.8.

6.3 Except for expenses as specified in Clause 6.7 below and the relevant taxes as required by applicable law, the Benchmarking Charges will constitute the entire fee due to the Benchmarker from Molina for completion of the Benchmarking Services provided hereunder.

6.4 The Benchmarker shall invoice out-of-pocket expenses related to reasonable travel and subsistence, where the need for incurring such expenses has been pre-agreed with Molina, (and such expenses are not included in the Benchmarking Charges). The Benchmarker will invoice monthly for any agreed travel and subsistence expenses incurred in the prior month, in accordance with the terms of Clause 10.2 and Clause 6.2.

6.5 The Benchmarker shall be entitled to issue invoices for the Benchmarking Charges in accordance with the terms of Clause 10.2 and Clause 6.2 and in the following stages:

(a) [30]% on the receipt of the Benchmark Notice; and

(b) [70]%, ten (10) Business Days after delivery of the Final Benchmark Report.

6.6 Payment of the Benchmarking Charges will be due from Molina within sixty (60) days of the date on which Molina receives the relevant invoice.

6.7 [Without prejudice to its other rights and remedies, the Benchmarker may charge, and Molina shall pay, interest, accruing daily from the due date to the date of actual payment, on any overdue amounts owed by Molina under this Benchmarking Agreement at the rate of [●] percent ([●]%) per annum.]

7. BENCHMARKER AND BENCHMARKER PERSONNEL

7.1 Each of the Benchmarker, Molina and the Supplier is an independent contractor and this Benchmarking Agreement does not create an agency relationship between any of the Parties.

7.2 None of the Parties assumes liability or responsibility for any of the other Party's personnel.

7.3 Each Party will:

(a) ensure it and its personnel are in compliance with all laws, regulations, ordinances and licensing requirements that apply to its activities under this Benchmarking Agreement;

(b) be responsible for the supervision, control, compensation, withholdings, health and safety of its personnel; and

(c) inform the other Parties if one of their former employees will be assigned work under this Benchmarking Agreement, such assignment to be subject to the relevant Party's approval.

8. ON PREMISES GUIDELINES

8.1 Access to Premises. If the Benchmarker is required to enter onto the premises of another Party, the Benchmarker will ensure that its personnel assigned to work on the Supplier's or Molina's premises will comply with all notices and requirements regarding security and other matters that are made known to the Benchmarker and its personnel.

8.2 If the Benchmarker is required to enter onto the premises of another Party it shall:

(a) maintain a current and complete list of the names of the Benchmarker personnel working on the premises;

(b) obtain from the Supplier or Molina, as applicable, a valid identification badge for each member of its personnel and ensure that it is displayed to gain access to and while on the relevant Party's premises;

(c) comply with Molina's and Supplier's (as applicable) health and safety requirements;

(d) ensure that each person with regular access to the Supplier's and Molina's premises complies with all parking restrictions and with vehicle registration requirements if any;

(e) at the Supplier's or Molina's reasonable request, remove its personnel from the Supplier's and/or Molina's premises, as applicable, and not reassign such personnel to work on those premises; and

(f) promptly notify the Supplier or Molina, as applicable, upon completion or termination of any assignment on a Party's premises and return the relevant Party's identification badge. Upon the relevant Party's request, the Benchmarker will provide documentation to verify compliance with this Clause 8.2(f).

8.3 General Business Activity Restrictions. If the Benchmarker is required to enter onto the premises of another Party it:

(a) will not conduct any business activities (such as interviews, hirings, dismissals or personal solicitations) or other activities that are not reasonably related to the provision of the Benchmarking Services on the Party's premises;

(b) will not conduct any of its own personnel training, except for on-the-job training on the Party's premises;

(c) will not attempt to participate in the benefit plans or activities of the Party on whose premises they are providing the Benchmark;

(d) will not send or receive any mail through the Party's mail systems that is unrelated to the provision of the Benchmark;

(e) will not sell, advertise or market any products or distribute printed, written or graphic materials on the Party's premises without the Party's written permission; and

(f) will remain in authorized areas only (limited to the work locations, cafeterias, rest rooms and, in the event of a medical emergency, the Party's medical facilities).

8.4 The Benchmarker will promptly notify the affected Party of any accident or security incidents involving loss of or misuse of or damage to the Party's intellectual or physical assets, physical altercations, assaults, or harassment and provide the Party with a copy of any accident or incident report involving the above. The Benchmarker shall co-ordinate with the Party any necessary access to the Party's premises during non-regular working hours.

9. WARRANTIES

9.1 The Parties make the following ongoing representations and warranties:

(a) each Party warrants that it has the right to enter into this Benchmarking Agreement and that, in the performance of its obligations under this Benchmarking Agreement, it will comply, at its own expense, with any law, regulation or ordinance to which it is or becomes subject;

(b) each of Molina and the Supplier warrants that the information it individually contributes for the purposes of the Benchmark does not infringe any privacy, publicity, reputation or intellectual property right of a third party;

(c) the Benchmarker warrants that the Benchmark Deliverables, the Benchmark Process and the Benchmark Data do not infringe any privacy, publicity, reputation or intellectual property right of a third party (except where such infringement is due to the information provided by Molina or the Supplier, as applicable);

(d) the Benchmarker warrants that the Benchmark Process and the production of the Benchmark Deliverables will be performed using reasonable care and skill and in accordance with Good Industry Practice;

(e) each Party warrants that it will not use, disclose, or transfer across borders any information that is processed for the Parties that includes Personal Data, except to the extent necessary to perform the Benchmark under this Benchmarking Agreement;

(f) each Party warrants that, as relevant to its rights and obligations under this Benchmarking Agreement, it will comply with all applicable data privacy laws and regulations, it will implement and maintain appropriate technical and other protections for the Personal Data, and it will co-operate fully with the other Parties' reasonable requests for access to, correction of, and destruction of Personal Data in its possession;

(g) each of the Parties warrants that it has no agreement, settlement, order, award or understanding (outside this Benchmarking Agreement) that would prejudice the outcome of the Benchmark or that would have the effect of preventing the Benchmarker carrying out any Benchmark or from preparing a complete and accurate Initial Benchmark Report or Final Benchmark Report;

(h) each of the Parties warrants that it is not aware of any agreement, settlement, order, award or understanding that would prevent the Benchmarker from considering any information in the Benchmarker's possession and applying that information for the purposes of a Benchmark;

(i) the Benchmarker warrants that, as of the date of this Benchmarking Agreement, there are a sufficient number of Peers to enable a Benchmark to be conducted; and

(j) the Benchmarker warrants that it shall follow and comply with the Benchmarker's methodology set out in Attachment 7 (*Description of Comprehensive Benchmark*).

9.2 THERE ARE NO WARRANTIES BY EITHER PARTY, EXPRESS OR IMPLIED (INCLUDING THOSE WARRANTIES OR CONDITIONS OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE), OTHER THAN THOSE SET FORTH IN THIS BENCHMARKING AGREEMENT.

10. INTELLECTUAL PROPERTY

10.1 The Benchmarker shall retain sole and exclusive ownership of the Benchmarker Materials.

10.2 The Benchmarker shall own the intellectual property rights in the format and presentation of the Benchmark Deliverables but Molina shall own that part of the Benchmark Deliverables that document, reproduce or represent information provided by, and relating to, Molina and the Supplier shall own that part of the Benchmark Deliverables that document, reproduce or represent information provided by, and relating to, the Supplier.

10.3 With respect to any Benchmarking Services performed by the Benchmarker, the Parties acknowledge that:

(a) the contents of the Initial Benchmark Report and Final Benchmark Report (and other deliverables) are based upon information which is proprietary to the Benchmarker and contained in the Benchmarker's proprietary database as well as information which is proprietary to Molina and the Supplier; and

(b) except for Molina's data and the Supplier's data, the contents of the Benchmarker's database and any copyright or database rights or other intellectual property rights in the Benchmarker's database belong to the Benchmarker solely.

10.4 Molina grants the Benchmarker a worldwide, non-exclusive, royalty-free, paid-up perpetual license to use Molina's data provided in Attachment 3 (*Schedule 2 and Schedule 6 of the Master Services Agreement and all SOWs*) and Attachment 4 (*Types of Benchmark Data*):

(a) for the purposes of carrying out its obligations under this Benchmarking Agreement; and

(b) for the purpose set out in Clause 5.4,

provided that, in each case, the Benchmarker complies with Clause 5, Clause 10 and its obligations of confidence both in equity and as set out in this Benchmarking Agreement and in any confidentiality agreement between the Benchmarker and any of the Parties.

10.5 The Supplier grants the Benchmarker a worldwide, non-exclusive, royalty-free, paid-up perpetual license to use the Supplier's data provided in Attachment 3 (*Schedule 2 and Schedule 6 of the Master Services Agreement and all SOWs*) and Attachment 4 (*Types of Benchmark Data*):

(a) for the purposes of carrying out its obligations under this Benchmarking Agreement; and

(b) for the purpose set out in Clause 5.4,

provided that, in each case, the Benchmarker complies with Clause 5, Clause 10 and its obligations of confidence both at equity and as set out in this Benchmarking Agreement or in any other confidentiality agreement between the Benchmarker and any of the Parties.

10.6 A Party shall retain its intellectual property rights in all proprietary materials that the Party supplies to the Benchmarker. In particular, Molina and the Supplier retain sole and exclusive ownership of their respective information provided in Attachment 3 (*Schedule 1 and Schedule 7 of the Global Framework Agreement and all SOWs*) and Attachment 4 (*Types of Benchmark Data*).

10.7 If a Party provides the Benchmarker with materials owned by or licensed to that Party (the "**Party Materials**"), that Party grants to the Benchmarker a non-exclusive, royalty-free, paid-up license to use the Party Materials for the purpose of fulfilling its obligations under this Benchmarking Agreement.

10.8 To the extent that any of the rights, title and interest in any materials do not vest by operation of law in the Party that this Clause 10 (*Intellectual Property*) indicates should own that material, then the Party that owns that material by operation of law hereby irrevocably assigns, transfers and conveys to the Party (which for copyright shall be an assignment of future rights) that this Clause 10 (*Intellectual Property*) indicates should own the material, without further consideration, all such rights, title and interest.

10.9 The Parties shall not be restricted in their use of ideas, concepts, know-how, data and techniques acquired or learned in the course of a Benchmark, provided that the Parties shall not use or disclose any of the other Parties' Confidential Information.

11. USE OF DELIVERABLES

11.1 The Benchmarker grants to the Supplier (and the Supplier Group) and Molina (and the Molina Group), for each of their internal purposes only, a worldwide, non-exclusive,

royalty-free, perpetual license to use, reproduce, display, distribute copies of, and prepare derivative works of the Benchmark Deliverables.

11.2 No Party shall make the Benchmark Deliverables available, in whole or in part, to any person outside that Party or quote excerpts from the Benchmark Deliverables to any such person, without the prior written consent of the other Parties, except that the Supplier and Molina may make the Benchmark Deliverables available to other Supplier Group Companies and Molina Group Companies respectively for internal purposes only.

11.3 Notwithstanding the foregoing, each Party may disclose the Benchmark Deliverables to:

(a) its external professional advisers as reasonably required in relation to this Benchmarking Agreement; and

(b) any governmental or competent regulatory authority as required by law or regulation.

12. LIMITATION OF LIABILITY

12.1 None of the Parties excludes or limits its liability for fraud or for death or personal injury caused by its negligence or that of its employees, agents or sub-contractors or for any breach of the confidentiality or intellectual property provisions set out in this Benchmarking Agreement. No limit on liability shall apply to claims for loss and/or damage relating to breach of confidentiality in Clause 5 (*Exchange of Information*).

12.2 Subject to Clause 12.1, the Benchmarker's liability to another Party and that other Party's liability to the Benchmarker under or in connection with this Benchmarking Agreement, whether arising from negligence, breach of contract or otherwise, in respect of all the events that give rise to a liability, is limited in aggregate to an amount equivalent to the Benchmarking Charges paid or payable by Molina under this Benchmarking Agreement.

12.3 The liability of Molina to the Supplier and the liability of the Supplier to Molina under or in connection with this Benchmarking Agreement, whether arising from negligence, breach of contract or otherwise shall be dealt with and addressed under the Master Services Agreement. Molina and the Supplier shall not be liable to each other separately under this Benchmarking Agreement for loss or damage that can be recovered under the Master Services Agreement.

12.4 The Benchmarker shall not be liable to any other Party, and those other Parties shall not be liable to the Benchmarker, for events arising out or in relation to this Benchmarking Agreement for (a) loss of profits, revenues or contracts, business interruption, loss or corruption of data or (b) indirect, special or consequential loss or damage, even if that loss was reasonably foreseeable and whether arising from negligence, breach of contract or otherwise.

13. GENERAL

13.1 Amendments

This Benchmarking Agreement may be amended only by a written agreement of all the Parties specifically referencing this Benchmarking Agreement, which written agreement has been duly signed by authorized representatives of each of the Parties.

13.2 Assignment

(a) If the Master Services Agreement is transferred (in accordance with the provisions of the Master Services Agreement), then this Benchmarking Agreement may similarly be transferred to the same counterpart.

(b) Subject to Clause 13.2(a), no Party will assign its rights or delegate or subcontract its duties under this Benchmarking Agreement to any other Party or third party or affiliate without the prior written consent of the other Parties, such consent not to be unreasonably delayed or withheld. Any unauthorized assignment of this Benchmarking Agreement is null and void.

13.3 Law and Jurisdiction

This Benchmarking Agreement and the performance of the Benchmarking Services and other transactions under this Benchmarking Agreement will be governed by and construed in accordance with the substantive law of the State of New York, without giving any effect to any contrary choice of law or conflict of law provision or rule (whether of the State of New York or any other jurisdiction). Any claim or action brought by a Party in connection with this Benchmarking Agreement, or any part hereof, will be brought in the appropriate federal or state court located in the State of New York, New York County, and the Parties irrevocably consent to the exclusive jurisdiction of such courts. The United Nations Convention on Contracts for the International Sale of Goods and New York conflict of law rules do not apply to this Benchmarking Agreement or its subject matter. In any action relating to this Benchmarking Agreement, each of the Parties irrevocably waives the right to trial by jury.

13.4 Communications

All communications between the Parties regarding this Benchmarking Agreement will be conducted through the Parties' representatives as specified in Attachment 5 (*Benchmarking Steering Group*) or as otherwise agreed by the Parties.

13.5 Counterparts

This Benchmarking Agreement may be signed in one or more counterparts, each of which will be deemed to be an original and all of which when taken together will constitute the same agreement. Any copy of this Benchmarking Agreement made by reliable means (for example, photocopy or facsimile) is considered an original.

13.6 Freedom of Action

This Benchmarking Agreement is non-exclusive and any of the Parties may design, develop, manufacture, acquire or market competitive products or services.

13.7 **Prior Communications**

This Benchmarking Agreement, and any other documents incorporated into this Agreement, constitutes the entire understanding between the Parties with respect to its subject matter, and supersedes all prior proposals, marketing materials, negotiations, representations (whether negligently or innocently made), agreements and other written or oral communications between the Parties with respect to the subject matter of this Agreement.

13.8 **Severability**

If any term in this Benchmarking Agreement is found by competent judicial authority to be unenforceable in any respect, the validity of the remainder of this Benchmarking Agreement will be unaffected, provided that such unenforceability does not materially affect the Parties' rights under this Benchmarking Agreement.

13.9 **Waiver**

An effective waiver under this Benchmarking Agreement must be in writing signed by the Parties waiving their right. A waiver by any Party of any instance of another Party's non-compliance with any obligation or responsibility under this Benchmarking Agreement will not be deemed a waiver of subsequent instances.

Attachment 1
Terms of Reference

Introduction

These Terms of Reference (hereinafter "**ToR**") set out the principles and processes which the Benchmarker, with the assistance of Molina and the Supplier will provide as part of the Benchmarking Services.

Governance

Project Management

The Parties shall agree, within five (5) Business Days of receipt of a Benchmark Notice from Molina, upon a project management system to be utilized to manage the Benchmarking Services in respect of that Benchmark Notice. This project management system will incorporate, at a minimum, roles and responsibilities, key milestones and decision points, a meeting system, data exchange and repository provisions, and an agenda structure. A failure to agree any project management system shall not delay the conduct of the Benchmark that shall be carried out, irrespective of whether a project management system is agreed by the Parties. If the Parties do not agree within a timeframe that would not delay the Benchmark, the Benchmarker may amend the Benchmark Process as needed to specify its preferred project management system, which the Parties shall thereafter utilize.

Review Meetings

The Benchmarking Steering Group will review benchmark project progress and status [every two weeks] from the date of the execution of this Benchmarking Agreement.

Communications

All material communications relating to any Benchmark shall be shared between all the Parties except where explicitly stated otherwise in this Benchmarking Agreement.

The Benchmark Process

The Benchmark Process will be conducted by the Benchmarker in accordance with the requirements as set out within this Benchmarking Agreement. In the event the Parties agree to request that the Benchmarker address matters that the Parties agree do not relate to the Benchmark Process, the terms of that engagement shall be as agreed by the Parties.

Benchmark Scope and Period

A Benchmark relates to identifying the Fair Market Price for the Benchmarked Services.

When providing the Benchmark, the Benchmarker may not, without the consent of both the Supplier and Molina, take into consideration any elements other than the ones stated in this Benchmarking Agreement.

Benchmark Approach

The Benchmarker shall follow the Benchmark Process.

The Parties shall complete the Standard Collection Templates and the FCQ.

The Benchmarker shall invite the Supplier and Molina to make individual confidential disclosures to the Benchmarker regarding the items they each believe the Benchmarker should take into consideration in its approach to Normalization.

Following the confidential disclosures made to the Benchmarker, the Benchmarker shall consider the submissions made by both Parties and, within five (5) Business Days, provide its feedback in writing to Molina and the Supplier. The Parties shall, within two (2) Business Days of receiving the feedback, meet to review the Benchmarker's feedback. The Benchmarker shall, following the meeting, confirm in writing its decision to include or disregard any disclosure from a Party that may be a combination of any of the following:

- the disclosure is not a price driver and so should not be considered for the purpose of the Benchmark;
- the disclosure is a price driver, but the Benchmarker can take the disclosure into account through the Benchmarker's Standard Collection Templates without Normalization;
- the disclosure is a price driver, it is not included in the Standard Collection Templates, but is subject to Normalization and so can be included within the Benchmark; and
- the disclosure is a price driver, but cannot be Normalized and so the price impact must be agreed between Molina and the Supplier separately from the Benchmark.

The Benchmarker is not obliged to accept any comments from any Party but shall provide a written explanation in respect of any decision to include or disregard any disclosure from a Party to the Party concerned.
The Benchmarker shall consider the Comparable Services provided by each of the Peers in carrying out the Benchmark.
The Benchmarker shall validate the Benchmark Data for clarity, completeness and lack of ambiguity and the Benchmark Data shall be used as part of the Normalization.
The Benchmarker shall select Peers for the Peer Group. The Benchmarker will provide a Peer Group for review and comment by the Benchmarking Steering Group and the Benchmarker will present its reasons for selecting the members of the Peer Group by providing contextual information about the Peer Group members to the Benchmarking Steering Group (to the extent it is able to, taking into account any confidentiality obligations owed to those Peer Group members). The Benchmarker is not obliged to accept any comments from any Party but shall provide an explanation in respect of any decision to include or disregard any comments from a Party to the Party concerned.
The Benchmarker will not share with either Party the identities of the Peer Group companies or the underlying proprietary algorithms supporting the Normalization Factors, but the Initial Benchmark Report and the Final Benchmark Report will contain a summary explanation of the Normalization applied by the Benchmarker.

Resources

Molina and the Supplier shall provide the Benchmarker with such information and data as is reasonably required for the conduct of a Benchmark.
Both the Supplier and Molina shall provide, as a minimum, a named individual as the 'template lead' for each of the Standard Collection Templates included in the Benchmark. This person (or a delegated nominee during periods of absence) shall be available throughout the Benchmark to assist the Benchmarker with the speedy and accurate execution of the

Benchmark. In practice, this is likely to be a single individual from each of the Supplier and Molina, with support from subject matter experts as appropriate.
The Benchmarker will provide a primary point of contact for both of the Supplier and Molina.

Ongoing Adjustments

The Parties recognize that while the Benchmark Process is being undertaken the Benchmarked Services may be subject to change in respect of scope, volumes or terms under the Master Services Agreement and that such changes may impact the Benchmark Data.
If there is a material change to any of the Benchmark Data prior to the issue of the Final Benchmark Report, then either the Supplier or Molina may notify the other that it believes that the change would impact the Benchmark Process and the determination of the Fair Market Price for the Benchmarked Services.
If the Supplier and Molina both agree that the change would impact the Benchmark Process, then the Benchmarker shall, at a time to be jointly selected by Molina and the Supplier, take into account the adjusted information. If both the Supplier and Molina agree that the change would impact the Benchmark Process but cannot agree on the timing of a referral to the Benchmarker, the Benchmarker shall be consulted and determine the most efficient time to consider the adjusted information.
If Molina or the Supplier cannot agree that a change would result in the Fair Market Price for the Benchmarked Services, then either Party may elect to refer the matter to the Benchmarker to take the information into account in determining the Fair Market Price. If the Benchmarker levies an additional charge to remodel the Benchmark Data, then that charge shall be paid for by Molina, unless the Benchmarker confirms that the change has led to an adjustment in the Fair Market Price for the Benchmarked Services.

Attachment 2

Conditions for Exchange of Confidential Information

The mutual objective of the Parties under this Benchmarking Agreement is to provide protection for Confidential Information (referred to in this **Attachment** as "**Information**"), while maintaining their ability to conduct their respective business activities. The following terms apply when one Party (the "**Discloser**") discloses Information to any other Party (the "**Recipient**"). This Agreement applies only to the Information disclosed by the Discloser in connection with the Benchmarker performing a Benchmark of the Master Services Agreement.

1. Disclosure

Information will be disclosed either:

(a) in writing;
(b) by delivery of items;
(c) by initiation of access to Information, such as may be in a data base; or
(d) by oral or visual presentation.

Information should be marked with a restrictive legend of the Discloser. If Information is not marked with such legend or is disclosed orally, the Information must be identified as confidential at the time of disclosure unless it is obvious from the context that the Information is confidential.

2. Obligations

The Recipient agrees to:

(a) use the same care and discretion to avoid disclosure, publication or dissemination of the Discloser's Information as it uses with its own similar information that it does not wish to disclose, publish or disseminate; and
(b) use the Discloser's Information for the purpose for which it was disclosed or otherwise for the benefit of the Discloser.

3. Confidentiality Period

Information disclosed under this Benchmarking Agreement will be subject to these confidentiality obligations for as long as the Information remains of a confidential nature.

4. Exceptions to Obligations

(a) The Recipient may disclose, publish, disseminate, and use Information that is:
  (i) already in its possession without obligation of confidentiality;
  (ii) developed independently;
  (iii) obtained from a source other than the Discloser without obligation of confidentiality;
  (iv) publicly available when received, or subsequently becomes publicly available through no fault of the Recipient; or
  (v) disclosed by the Discloser to another without obligation of confidentiality.
(b) The Recipient may disclose, publish, disseminate, and use the ideas, concepts, know-how and techniques, related to the Recipient's business activities, which are

in the Discloser's Information and retained in the memories of Recipient's employees who have had access to the Information under this Benchmarking Agreement. Nothing in this paragraph gives the Recipient the right to disclose, publish, or disseminate:

(i) the source of Information;
(ii) any financial, statistical or personnel data of the Discloser; or
(iii) the business plans of the Discloser.

(c) The Recipient may disclose Information:

(i) if the Benchmarker is the Recipient, to its employees who have a need to know;
(ii) if Molina is the Recipient, to the Molina Group, and their employees;
(iii) if the Supplier is the recipient, to the Supplier Group and their employees;
(iv) in accordance with paragraphs 4(a), (b), (d) and (e); and
(v) any other third party with the Discloser's prior written consent.

Before disclosure to any of the third parties described in paragraph 4(c)(v), the Recipient will have a written agreement with the third party sufficient to require that party to treat Information in accordance with this Benchmarking Agreement.

(d) Molina and the Supplier may disclose, publish, disseminate and use the Benchmark Deliverables in accordance with Clause 11.

(e) The Recipient may disclose Information to the extent required by law. However, the Recipient will give the Discloser prompt notice to allow the Discloser a reasonable opportunity to seek a protective order.

5. Disclaimers

The Discloser will not be liable for any damages arising out of the use of Information disclosed under this Benchmarking Agreement (and this Benchmarking Agreement only).

Neither this Benchmarking Agreement nor any disclosure of Information made under it grants the Recipient any right or license under any trademark, copyright or patent now or subsequently owned or controlled by the Discloser.

6. General

The receipt of Information under this Benchmarking Agreement will not in any way limit the Recipient from:

(a) providing to others products or services which may be competitive with products or services of the Discloser;
(b) providing products or services to others who compete with the Discloser; or
(c) assigning its employees in any way it may choose.

Attachment 3
Schedule 2 and Schedule 6 of the Master Services Agreement, and all SOWs
[●]

Attachment 4

Types of Benchmark Data

The Benchmark Data is the data collected in the attached templates.

[●]

Attachment 5
Benchmarking Steering Group Members
[●]

Attachment 6
Benchmarking Charges
[●]

Attachment 7
Description of the Benchmark Process
[●]

Attachment 8
Benchmark Plan

The detailed Benchmark Plan is set out below.

[●]

Attachment 9
Supplier Competitors

[●]	[●]

IN WITNESS WHEREOF, this Benchmarking Agreement has been signed by the duly authorized representatives of each of the Parties.

EXECUTED BY THE PARTIES:

EXECUTED by

[MOLINA]

)

by its duly authorized person)

)

)

)

)

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EXECUTED by

[SUPPLIER])

by its duly authorized person)

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EXECUTED by

[BENCHMARKER])

by its duly authorized person)

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SCHEDULE 6

SERVICE LEVELS AND SERVICE CREDITS

SCHEDULE 6

SERVICE LEVELS AND SERVICE CREDITS

CONTENTS

1. **DEFINITIONS**

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*).

2. **INTRODUCTION**

2.1 References.

All references in this Schedule to Sections and Appendices shall be to Sections and Appendices in this Schedule unless another reference is provided.

2.2 Completion.

No activity will be deemed to have been processed or completed for purposes of any Service Level unless Service Provider has correctly, accurately, and properly completed such activity in accordance with the Agreement and the Procedures Manual.

2.3 Reports.

All reports required under this Schedule shall be provided pursuant to Schedule 7 (Governance).

3. **APPENDICES**

3.1 The following Appendices are attached to this Schedule, are incorporated by reference herein and shall apply to all Services under this SOW, as applicable:

3.2 Appendix 6-A (*Service Level Matrix*) sets forth the definitions, descriptions, Service Level Requirements, and calculation methods associated with Service Levels.

(a) Each Service Level shall have a detailed description, Service Level Requirement, and calculation method as specified in Appendix 6-A (*Service Level Matrix*).

(b) Each Service Level shall have an Allocation of Pool Percentage as specified in Appendix 6-A (*Service Level Matrix*) and as described below, which shall be used to determine the applicable Service Level Credit due by Service Provider to Molina in the event of a Service Level Default relative to that Service Level. Molina may allocate the Pool Percentage Available for Allocation across all Service Levels, with an Allocation of Pool Percentage to each Service Level.

4. **SCHEDULE 6 GENERAL TERMS**

4.1 This Schedule 6 sets forth the Service Levels and other performance requirements that Service Provider is required to achieve in performing the Services and describes the method for calculating credits for Service Provider's failure to meet a Service Level Requirement in the applicable reporting frequency (the "Service Level Credits") that Service Provider shall credit on the next monthly invoice of Molina after such Service Level Credit is reported.

4.2 Service Level Matrix is mandatory and shall apply to all Services. All Service Levels shall have the components (collectively the "Service Level Components") specified by Molina in Appendix 6-A (Service Level Matrix).

4.3 Additionally, Project Service Levels shall apply to Services if specified in a Project Statement of Work. All Project Service Levels shall have the Service Level Components specified by Molina in Project Statements of Work.

4.4 Subject to paragraph 5.3, each Service Level will come into effect on the Service Commencement Date for the SOW, and the Service Provider shall monitor and report its performance against that Service Level from that date, save that, for the purposes of this schedule, Service Level Credits shall only accrue in respect of Service Level Defaults, with effect from the date specified for that Service Level as the "Service Level Commencement Date" in the Service Level Matrix.

4.5 Except as otherwise specified, all references to hours will be to business hours during a calendar day; and all references to days, months, and quarters will be to calendar days, calendar months, and calendar quarters, respectively, unless otherwise specified.

4.6 All references to time will be to local time at the site at which the Service is being received. It will not be based on Service Provider headquarters or Molina headquarters time.

4.7 The objectives of the Service Levels are to ensure that the Services are of a consistently high quality, delivered to time and budget and meet the requirements of Molina.

5. MEASUREMENT AND REPORTS

5.1 The methodology set out in this schedule will support the Service Level methodology cycle of agreeing, monitoring, reporting, and improving the delivery of the Services to the Molina.

5.2 Service Provider shall provide, implement, maintain, and support tools required or appropriate to measure and report on its performance of the Services against the Service Levels, and make them available to Molina on or before the applicable Service Level Commencement Date.

5.3 For any Service Level other than those that Molina has designated as not subject to Baselining in the columns titled "Subject to Baselining" in the Service Level Matrix prior to the Service Level Commencement Date of the SOW, the Service Provider shall be given a period of four (4) months following the relevant Service Level Commencement Date during which:

(a) Service Provider will not be subject to Service Level Defaults;

(b) Service Provider will report actual Service Level performance; and

(c) Service Provider will use the four (4) month baselining period to meet the Expected Service Level Target, and

after the four (4) month baselining period, the Service Provider will become subject to Service Level Defaults, as defined in this schedule.

5.4 Service Provider shall provide detailed supporting information for each report as reasonably requested by Molina.

5.5 The raw data and detailed supporting information related to each Service Level report shall be deemed Confidential Information and shall be the property of Molina.

5.6 Regardless of data source, Service Provider is solely responsible for the underlying collection, measurement, and analysis of data pertaining to the Services and related Service Levels as reflected in any Service Level reports. Molina will make available the tools listed in Appendix 6-D, if any, for use by the Service Provider in the collection, measurement and analysis of the Service Levels, for which the Service Provider is responsible. The Service Provider shall make underlying data available to Molina by request.

5.7 Failure to submit Service Level reports when due, or to properly report performance with respect to any particular Service Level for any Monitoring Interval, shall be a Service Level Default for that Service Level.

5.8 For the avoidance of doubt, Molina retains the right to conduct its own reporting, which does not absolve the Service Provider of its responsibility under this clause; Molina retains the right to challenge if the Service Provider's reporting conflicts with Molina's reporting. Notwithstanding any other provision of this Agreement, in the event of a discrepancy between Molina's reporting and the Service Provider's reporting, the Parties will refer the matter to the Operational Review Board for resolution.

5.9 Failure to properly measure performance with respect to any Service Level for any thirty (30) day period will be deemed to be a Service Level Default with respect to such Service Level for such thirty (30) day period.

5.10 Service Provider shall prepare and submit for each Period of the SOW Term an accurate and complete Monthly Performance Report meeting Molina's requirements, that shows the performance of all Service Levels; Service Provider shall submit the Monthly Performance Report to Molina no later than seven (7) Business Days after the close of each such Period.

(a) The Monthly Performance Report shall include a set of online accessible reports to verify Service Provider Service Level Performance and compliance with the Service Levels. The reported metrics shall be in a report format as designated by Molina and calculated according to the System of Record as laid out in the Appendix 6-A (Service Level Matrix). Service Provider shall make such information available to Molina online on a 24 x 7 basis (excluding mutually-agreed-upon maintenance windows) using commonly available technology. Service Provider shall provide to Molina as part of Service Provider's "**Monthly Performance Reports**", a set of soft-copy reports to verify Service Provider's performance and compliance with the Service Levels. A hard-copy report shall be made available at Molina's request.

(b) Service Provider is required to keep updated documentation of Services and how they are completed and shall be made accessible at Molina's request.

5.11 In circumstances where the time allowed by a Service Level for an activity to be completed (such as the response to, or resolution of, an incident or problem) continues beyond the end of the Period in which that Service Level is measured, such activity shall be included in the Period during which Service Provider is to complete the activity within the time allowed for the applicable Service Level.

6. SERVICE LEVEL DEFAULTS AND CREDITS

6.1 In addition to the other items deemed a Service Level Default hereunder, a "**Service Level Default**" shall be deemed to have occurred for a given Service Level when:

(a) For a Critical Service Level, Service Provider fails to meet the applicable Expected Service Level Target and in the immediately previous [redacted] there have been at least [redacted] other months where the Service Provider's performance failed to meet such Expected Service Level Target and that the failure is the [redacted] or more such failure in a rolling [redacted] month period (an "**Expected Service Level Default**");

(b) For a Critical Service Level, Service Provider fails to meet the applicable Minimum Service Level Target in respect to any month (a "**Minimum Service Level Default**");

(c) The Parties agree to a Service Level with respect to the Key Performance Indicators, as follows: If Service Provider fails to meet the applicable Minimum Service Level Target for [redacted] or more Key Performance Indicators in the same month it will be a Service Level Default. With respect to this particular Service Level, the allocation of the Pool Percentage shall not exceed [redacted]; or

(d) For any Service Level, Service Provider fails to provide an accurate and complete Monthly Performance Report, in which case such failure shall be deemed a Service Level Default with respect to such Service Levels for such Period, if Service Provider has access to necessary data for such measurement. Service Provider shall promptly notify Molina if Service Provider does not have access to necessary data for such measurement.

6.2 In respect of each SOW, the Service Provider's performance shall be measured and reported on separately and the calculation of any Service Level Credits payable in respect of any SOW, shall be calculated and operated on a per SOW basis. Each SOW has a separate Service Level Matrix applicable to it.

6.3 A "**Service Level Credit**" shall be applied to the relevant Monthly Invoice by Service Provider to Molina for any Service Level Default with respect to a Service Level in accordance with the following:

(a) Service Level Credits shall apply with effect from the Service Level Commencement Date as specified in Appendix 6-A (*Service Level Matrix*).

(b) Service Provider shall promptly notify Molina (no later than five (5) Business Days after the end of each Period) in writing if Molina becomes entitled to a Service Level Credit. Concurrent with delivering each Monthly Invoice, Service Provider shall deliver within the Monthly Performance Report a comprehensive report identifying any Service Level Defaults and corresponding Service Level Credits to which Molina is entitled at the time of such Monthly Invoice.

The formula for Service Level Credit calculation is
Service Level Credit = A x B x C; Where:
A = The At-Risk Fees
B = The At-Risk Percentage
C = The Allocation of Pool Percentage for the Service Level for which the Service Level Default occurred as shown in Appendix 6-A (*Service Level Matrix*).

For example, assume that Service Provider fails to meet the Service Level Requirement for a Service Level. Assume Service Provider's At-Risk Fees for the month in which the Service Level Default occurred was [redacted] and that the At-Risk Percentage was [redacted].

Additionally, assume that the Allocation of Pool Percentage is [redacted]. The Service Level Credit due to Molina for such Service Level Default would be computed as follows:
A = the At-Risk Fees [redacted]
[redacted]
B = The At-Risk Percentage [redacted]
[redacted]
C = The Allocation of Pool Percentage for the Service Level for which the Service Level Default occurred as shown in Appendix 6-A (*Service Level Matrix*) to this Schedule [redacted]
= [redacted] the amount of the Service Level Credit).

6.4 The "**At-Risk Fees**" for a given SOW shall be the total Charges for the Period, excluding taxes, Project Charges (except to the extent the applicable Project Work Order specifies that the Charges payable with respect to the applicable Project shall be included in the At-Risk Fees) and pass-through expenses to be reimbursed by Molina under the Agreement.

6.5 The "**At-Risk Percentage**" for this SOW shall be [redacted].

6.6 The "**Pool Percentage Available for Allocation**" for a given SOW shall [redacted], which shall be allocable across all Service Levels as per Appendix 6-A (*Service Level Matrix*).

6.7 There shall be a cap on the "Allocation of Pool Percentage" for any Service Level under this SOW [redacted] (except the allocation contemplated in paragraph 6.1(c) regarding KPIs, which shall be capped at [redacted]), except that Molina may elect, at its sole discretion, up to two Service Levels to each have an allocation of greater than [redacted] and less than or equal to [redacted].

6.8 Service Level Credits shall be subject to acceleration ("**Service Level Credit Acceleration**"). For Critical Service Levels, there shall be an increasing level of Service

Level Credits if there is a consecutive recurring Minimum Service Level Default for the same Critical Service Level in consecutive Periods. For a second consecutive Minimum Service Level Default for a given Critical Service Level, there shall be an increase of [redacted] in the Service Level Credit payable, relative to the original Service Level Credit that would have otherwise been payable without the application of Service Level Credit Acceleration, for that Period. For a third consecutive Minimum Service Level Default, there shall be an increase of [redacted] in the Service Level Credit payable, relative to the original Service Level Credit, for that Period. For a fourth consecutive Minimum Service Level Default, there shall be an increase of [redacted] in the Service Level Credit payable, relative to the original Service Level Credit, for that Period. For example, if a Critical Service Level has the Service Level Credit Allocation of Pool Percentage set as [redacted], and if the Service Provider has a Minimum Service Level Default for that Critical Service Level, then in the first such instance, the corresponding Service Level Credit shall be computed using a Service Level Credit Allocation Percentage of [redacted]. However, if the Service Provider has a consecutively recurring Minimum Service Level Default for that Critical Service Level, then in the second such instance the Service Level Credit Allocation of Pool Percentage shall be increased to [redacted] of the previous month's Service Level Credit Allocation of Pool Percentage. In this example, in the second month the Service Level Credits shall be computed using a Service Level Credit Allocation Percentage of [redacted] ([redacted]) rather than [redacted].

6.9 If [redacted] has occurred [redacted]. If a [redacted], Molina shall have the right to [redacted].

6.10 In no event shall the amount of Service Level Credits credited to Molina with respect to all Service Level Defaults occurring in a single Period exceed, in total, the At-Risk Amount.

6.11 The total amount of Service Level Credits with respect to Service Level Defaults occurring each Period, shall be reflected on the subsequent Monthly Invoice detailing the timing of the Service Level Default.

6.12 Service Provider acknowledges and agrees that the Service Level Credits shall not be deemed or construed to be liquidated damages or a sole and exclusive remedy or in derogation of any other rights and remedies, which Molina has under the Agreement, at law or in equity. Notwithstanding any language to the contrary contained herein, if Molina receives monetary damages from Service Provider because of Service Provider's failure to meet a Service Level, Service Provider shall be entitled to set-off against such damages any Service Level Credits paid for the failure giving rise to such recovery.

6.13 If Molina elects to waive in writing a Service Level Credit, such waiver shall not be considered a waiver of the Service Level Default or other rights and remedies available to Molina in connection with the Agreement, including rights to seek to recover damage and to exercise termination rights, unless otherwise expressly stated in such written waiver.

6.14 "**Minimum Event Quantity**" applies to a Critical Service Level or a Key Performance Indicator where a small number of occurrences in the measurement pool can result in a missed Service Level, except where the measured tasks are binary (either 0% or 100%) and the Service Level

has been set accordingly. The Minimum Event Quantity for a particular Target Service Level or a Critical Service Level is the quantity of occurrences in the measurement pool that would allow Service Provider to attain the Service Level even though there was one occurrence not meeting the applicable Critical Service Level or Key Performance Indicator.

7. CHANGES TO SERVICE LEVELS

7.1 In accordance with the agreed upon Change Procedure and not more than once in the period of ninety (90) days:

(a) Molina may modify or delete existing Service Levels.

(b) Molina may re-distribute the Service Level Credit Allocation Percentage.

(c) Molina may demote Critical Service Levels to Key Performance Indicators or promote Key Performance Indicators to Critical Service Levels.

7.2 Regarding the deletion of one or more Service Levels, there shall be no corresponding change in Service Fees as described in Schedule 3 (Pricing and Invoicing). Regarding the modification or addition of one or more Service Levels, the modification or addition shall be subject to a related change in the Charges for the Services measured by the applicable Service Level.

7.3 Any change (including but not limited to additions, modifications, or deletions) to Service Levels shall take effect thirty (30) calendar days after written notice of such change has been received by Service Provider.

7.4 Each notice shall include an updated Appendix 6-A (*Service Level Matrix*) applicable to the change made as specified above.

8. ROOT CAUSE ANALYSIS

8.1 In addition to any Service Level Credits that may be due, Service Provider shall investigate and perform a Root Cause Analysis of each Service Level Default and provide Molina with a commercially reasonable and operationally viable written plan to permanently correct such root cause within thirty (30) calendar days of such occurrence to improve Service Provider's performance with respect to such Service Level and prevent Service Level Defaults in the future.

(a) Service Provider shall promptly implement such plan once it has been approved by Molina.

(b) Successful execution and completion of such plan is subject to approval by Molina. In the event of such plan not being satisfactorily completed or the root cause of the Service Level Default not being resolved according to Molina standards, Molina reserves the rights to ask Service Provider for re-submission of the plan to address resolution of such issues.

(c) Service Provider agrees that (i) failure to implement the plan shall be treated as a new Service Level Default regarding the same Service Level to which the Root Cause

Analysis relates, with such new Service Level Default being deemed to have occurred with respect to the Period in which Service Provider was due to delivery to Molina the applicable Root Cause Analysis and remediation plan, and (ii) such Service Level Default shall apply regardless of whether a Service Level Credit was incurred because of the initial Service Level Default.

9. **ANNUAL REVIEW AND CONTINUOUS IMPROVEMENT**

9.1 The parties agree that the Service Levels shall be subject to continuous improvement and shall be modified as described below.

9.2 Beginning on the one-year anniversary of the Service Level Commencement Date, and annually thereafter, the parties shall adjust each Service Level using the method described below:

(a) The parties will review:

(i) The then-current Service Level Performance for Service Levels.

(ii) The percentage difference between the average Service Level Performance and the Service Level Requirement for the duration of the previous Contract Year.

(iii) The original Service Level Requirement as of the SOW Effective Date.

(iv) Generally available information regarding industry-wide service levels and performance requirements for similar services.

(v) Improved performance capabilities, including those associated with advances in technology and methods used to provide the Services.

(b) Consistent with and using the information identified in the foregoing:

(i) The parties shall attempt in good faith to agree on an improved Service Level Requirement for each of the Service Levels, based on the information collected. For avoidance of doubt, such improvement may be either an increase or decrease in the Service Level Requirement, as based on the metric applicable to perfect performance for the Service Level.

(ii) If the parties fail to agree, then:

(A) The Service Level Requirement will be reset based on averaging (i) the average of the Service Level Performance [redacted] of the previous Contract Year in which Service Provider had its highest level of performance (such average is the "Average Amount"), with (ii) the then-current Service Level Requirement, but only if the actual results for each of [redacted] the then current Service Level Requirement.

For example, assume that the current Service Level Requirement is [redacted]

[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]

[redacted].

(B) Notwithstanding the abovementioned, no single increase or decrease in a Service Level Requirement for any Contract Year may exceed [redacted].

For example, assume that the current Service Level Requirement is at [redacted].
[redacted].
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]

(iii) Minimum Service Levels:

(A) Each Minimum Service Level Target shall be reset by adding to the Minimum Service Level Target being adjusted a sum equal to [redacted] of the difference between [redacted] and [redacted] Minimum Service Level Target.

(B) [redacted].

10. ADDING OR MODIFYING NEW SERVICE LEVELS

10.1 If the Parties agree that it is appropriate between yearly adjustment periods to establish or baseline a new or modified Service Level, such Service Level shall be baselined during a period of stable activity, as determined at the reasonable discretion of Molina, as follows:

(a) Molina shall identify and communicate in writing to the Service Provider the applicable Service Level Components for such new Service Level.

(b) The Service Provider shall report to Molina its actual performance relative to that Service Level for the previous three (3) consecutive Periods, such that:

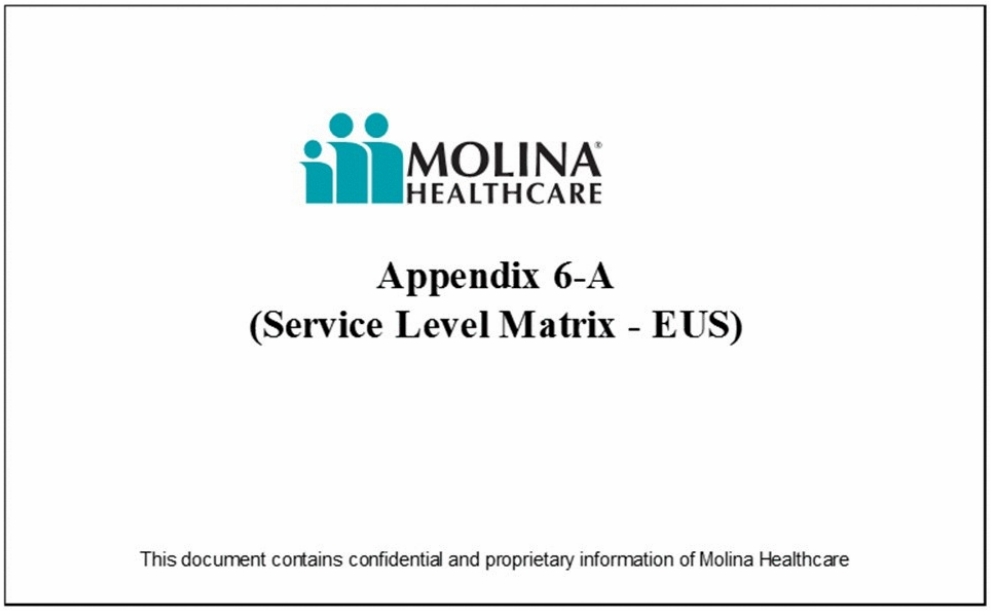
(i) No Service Defaults shall be deemed to have occurred and no Service Level Credits shall be enforced for such Service Level during the Baselining Period.

(ii) The Service Level Target shall be set as the Service Provider's average actual Service Level performance during the Baselining Period, and the Service Level shall be added and incorporated into the Service Level Matrix, with the start of the subsequent Period established as the Service Level Commencement Date.

(iii) Unless otherwise specified within the Service Level Matrix, the Baselining Period shall consist of three (3) consecutive Periods; in no case shall the Baselining Period exceed six (6) months

APPENDIX 6-A – SERVICE LEVEL MATRIX

[See Attached]


MOLINA
HEALTHCARE
Appendix 6-A
(Service Level Matrix - EUS)
This document contains confidential and proprietary information of Molina Healthcare

INTRODUCTION

This Appendix sets forth the following:

For Service Levels:
- The Allocation of Pool Percentage associated with each Performance Category
- The Service Level Credit Allocation Percentage associated with each Service Level within a Performance Category
- The timing regarding the commencement of obligations for reporting and credits for each Service Level
- The measurement period for each Service Level
- Flags identifying whether the Supplier agrees to the mentioned metrics
- The rationale behind Supplier's agreement/disagreement with the assigned metrics

For KPIs:
- The timing regarding the commencement of obligations for each KPI
- The measurement period for each KPI
- Flags identifying whether the Supplier agrees to the mentioned metrics
- The rationale behind Supplier's agreement/disagreement with the assigned metrics

INSTRUCTIONS

Suppliers to provide their point of view on best-in-class SLA framework, definition of priorities and SLA targets.
Please confirm in column O if you agree with the metrics and update comments (if any) in column P

Pool Percentage for Allocation:

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
1	Critical Service Level	First Contact Resolution	Measures the percentage of calls and chats resolved on first contact FCR is for Level 1 resolvable incidents and service requests based on the SOP & KB articles. It excludes third party, hardware, desk side related issues. We will mutually define & agree upon resolvable incidents & service requests. FCR roadmap: Day 1: 75%, Day 30: 80% Day 60: 82%: Day 90:85%	Service Level = A / B	A = number of calls or chats resolved during a User's first contact with the Service Desk	B = the total of all calls and chats to the Service Desk	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	FCR is for Level 1 resolvable incidents and service requests based on the SOP & KB articles. It excludes third party, hardware, desk side related issues. We will mutually define & agree upon resolvable incidents & service requests. FCR roadmap: Day 1: 75%, Day 30: 80% Day 60: 82%: Day 90:85%

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
2	Critical Service Level	Same Day Resolution	Measures the percentage of calls and chats resolved during same day with the Service Desk Same day resolution is for 24 hours' ticket resolution. This is for Level 1 resolvable issues based on SOPs, which couldn't be solved on the call and requires additional offline steps/coordination with resolver group. This excludes complex Level 2/Level 3 (based on deeper analysis), third party, hardware, desk side related issues. Roadmap: Day 1: 75%, Day 30: 80% Day 60: 82%: Day 90:85%	Service Level = A / B	A = number of calls and chats resolved during same day	B = the total of all calls and chats to the Service Desk	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	Same day resolution is for 24 hours' ticket resolution. This is for Level 1 resolvable issues based on SOPs, which couldn't be solved on the call and requires additional offline steps/coordination with resolver group. This excludes complex Level 2/Level 3 (based on deeper analysis), third party, hardware, desk side related issues. Roadmap: Day 1: 75%, Day 30: 80% Day 60: 82%: Day 90:85%
3	Critical Service Level	Mean Time to Resolve (MTTR)	Measures the average time from when an incident is reported until the incident is resolved Excludes the time a ticket is waiting user input	Service Level = A / B	A = the total amount of time taken to resolve the cases	B = the total number of all cases resolved	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	Excludes the time a ticket is waiting user input

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
4	Critical Service Level	Average Speed of Answer (ASA)	Measures the period of time a call or chat has been waiting prior to being answered by a Service Desk agent The measurement criteria and exclusions such as (i) Non-applicability for days where call or chat volumes are less than 100, (ii) Non-applicability during Major incidents or abnormal volumes, etc. will have to be defined.	Service Level = A / B	A = the total amount of time all calls and chats have been waiting prior to being answered by a Service Desk agent	B = the total number of calls and chats	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	The measurement criteria and exclusions such as (i) Non-applicability for days where call or chat volumes are less than 100, (ii) Non-applicability during Major incidents or abnormal volumes, etc. will have to be defined.
5	Critical Service Level	Abandonment Rate	Measures the percentage of calls and chats that are abandoned.	Service Level = A / B	A = number of calls and chats abandoned	B = the total of all calls and chats to the Service Desk	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	
6	Critical Service Level	IMACD Completion	Measures the percentage of IMACD requests that are completed within the specified time frame.	Service Level = A / B	A = the number of IMACDs completed within the designated timeframe	B = the total of all IMACDs	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	Except dispatch locations. Service Catalogue to be defined and agreed with Molina.
7	Critical Service Level	Customer Satisfaction Survey	Measures the satisfaction of the Customer through surveying.	TBD	TBD	TBD	[redacted]	[redacted]	[redacted]	[redacted]	As determined by Molina	Monthly	Yes	Survey questionnaire, SLA calculation and measurement methodology will have to be mutually defined and agreed. The SLA targets will be baselined prior to finalizing the targets. Applicable to service desk calls / chats only.
8	Critical Service Level	Sentiment Analysis	Measures the satisfaction of the Customer through sentiment analysis of both calls and chats.	TBD	TBD	TBD	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	Infosys will develop a Emoji based survey mechanism

	~~Critical Service Level~~	~~Response Time (Priority 1)~~	~~Measures the number of seconds or cycles it takes an End-User to connect with Supplier's contact center representative for priority 1 incidents.~~	~~Service Level = A / B~~	~~A = the number of cases responded to within the designated timeframe~~	~~B = the total number of all cases~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~Redundant SLA, covered as part of Infra SLAs~~

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
~~Critical Service Level~~	~~Response Time (Priority 2)~~	~~Measures the number of seconds or cycles it takes an End-User to connect with Supplier's contact center representative for priority 2 incidents.~~	~~Service Level = A / B~~	~~A = the number of cases responded to within the designated timeframe~~	~~B = the total number of all cases~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~Redundant SLA, covered as part of Infra SLAs~~
~~Critical Service Level~~	~~Response Time (Priority 3)~~	~~Measures the number of seconds or cycles it takes an End-User to connect with Supplier's contact center representative for priority 3 incidents.~~	~~Service Level = A / B~~	~~A = the number of cases responded to within the designated timeframe~~	~~B = the total number of all cases~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~SLA to be baselined prior to finalizing.~~
~~Critical Service Level~~	~~Response Time (Priority 4)~~	~~Measures the number of seconds or cycles it takes an End-User to connect with Supplier's contact center representative for priority 4 incidents.~~	~~Service Level = A / B~~	~~A = the number of cases responded to within the designated timeframe~~	~~B = the total number of all cases~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~SLA to be baselined prior to finalizing.~~
~~Critical Service Level~~	~~Resolution Time (Priority 1)~~	~~Measures the time elapsed from the initiation of the Service Desk Incident until the Priority 1 Incident is fixed.~~	~~Service Level = A / B~~	~~A = the number of cases resolved within the designated timeframe~~	~~B = the total number of all cases~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~This is for remote desktop support only while other issues will be covered under the different resolver group~~
~~Critical Service Level~~	~~Resolution Time (Priority 2)~~	~~Measures the time elapsed from the initiation of the Service Desk Incident until the Priority 2 Incident is fixed.~~	~~Service Level = A / B~~	~~A = the number of cases resolved within the designated timeframe~~	~~B = the total number of all cases~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~This is for remote desktop support only while other issues will be covered under the different resolver group~~
9	Critical Service Level	Resolution Time (Priority 3)	Measures the time elapsed from the initiation of the Service Desk Incident until the Priority 3 Incident is fixed.	Service Level = A / B	A = the number of cases resolved within the designated timeframe	B = the total number of all cases	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	
10	Critical Service Level	Resolution Time (Priority 4)	Measures the time elapsed from the initiation of the Service Desk Incident until the Priority 4 Incident is fixed.	Service Level = A / B	A = the number of cases resolved within the designated timeframe	B = the total number of all cases	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	

~~	~~KPI~~	~~Backlog (Priority 1)~~	~~Measures the average age of all Priority 1 cases.~~	~~Service Level = A~~	~~A = the average age of cases for the designated priority level~~	~~N/A~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~Should not be applicable~~
~~	~~KPI~~	~~Backlog (Priority 2)~~	~~Measures the average age of all Priority 2 cases.~~	~~Service Level = A~~	~~A = the average age of cases for the designated priority level~~	~~N/A~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~Should not be applicable~~
11	KPI	Backlog (Priority 3)	Measures the average age of all Priority 3 cases.	Service Level = A	A = the average age of cases for the designated priority level	N/A	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	For tickets for which Infosys has assumed primary responsibility

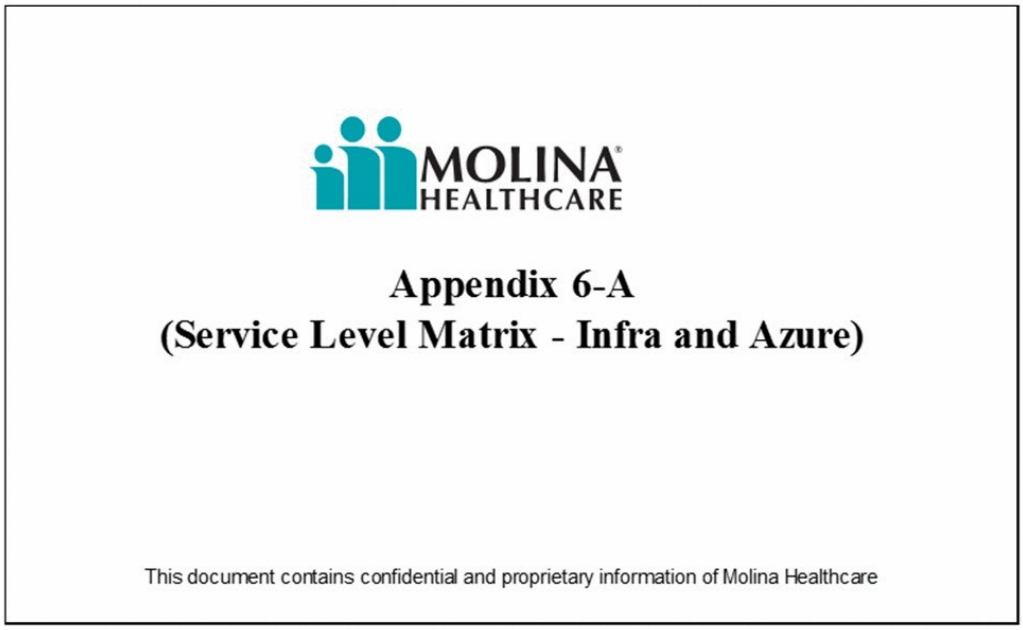
250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
12	KPI	Backlog (Priority 4)	Measures the average age of all Priority 4 cases.	Service Level = A	A = the average age of cases for the designated priority level	N/A	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	For tickets for which Infosys has assumed primary responsibility
	~~KPI~~	~~Case Chase/Follow-up (Priority 1)~~	~~Measures the average follow-up time of Priority 1 case requests~~	~~Service Level = A / B~~	~~A = the total time to execute case follow-up for the designated priority level~~	~~B = the total number of case follow-ups for the designated priority level~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	~~Should not be applicable~~
	~~KPI~~	~~Case Chase/Follow-up (Priority 2)~~	~~Measures the average follow-up time of Priority 2 case requests~~	~~Service Level = A / B~~	~~A = the total time to execute case follow-up for the designated priority level~~	~~B = the total number of case follow-ups for the designated priority level~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	
13	KPI	Case Chase/Follow-up (Priority 3)	Measures the average follow-up time of Priority 3 case requests	Service Level = A / B	A = the total time to execute case follow-up for the designated priority level	B = the total number of case follow-ups for the designated priority level	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	For tickets for which Infosys has assumed primary responsibility
14	KPI	Case Chase/Follow-up (Priority 4)	Measures the average follow-up time of Priority 4 case requests	Service Level = A / B	A = the total time to execute case follow-up for the designated priority level	B = the total number of case follow-ups for the designated priority level	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	For tickets for which Infosys has assumed primary responsibility
	~~KPI~~	~~Customer Case Update (Priority 1)~~	~~The average time required for updates and escalation execution.~~	~~Service Level = A / B~~	~~A = the total time for updates and escalation execution for the designated priority level~~	~~B = the total number of updates and escalation executions for the designated priority level~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	
	~~KPI~~	~~Customer Case Update (Priority 2)~~	~~The average time required for updates and escalation execution.~~	~~Service Level = A / B~~	~~A = the total time for updates and escalation execution for the designated priority level~~	~~B = the total number of updates and escalation executions for the designated priority level~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	
	~~KPI~~	~~Customer Case Update (Priority 3)~~	~~The average time required for updates and escalation execution.~~	~~Service Level = A / B~~	~~A = the total time for updates and escalation execution for the designated priority level~~	~~B = the total number of updates and escalation executions for the designated priority level~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	
	~~KPI~~	~~Customer Case Update (Priority 4)~~	~~The average time required for updates and escalation execution.~~	~~Service Level = A / B~~	~~A = the total time for updates and escalation execution for the designated priority level~~	~~B = the total number of updates and escalation executions for the designated priority level~~	[redacted]	[redacted]	[redacted]	[redacted]	~~Each case~~	~~Monthly~~	~~Yes~~	
15	KPI	Hierarchical Escalation	Measures the average time required for the initial response to a management escalation.	Service Level = A / B	A = the total time required for the initial response to a management escalation.	A = the total number of initial responses to management escalations	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	Molina to revert

16	KPI	Duplicate Incidents	Measures the percentage of cases for which there are duplicate records.	Service Level = A / B	A = the number of cases for which there are duplicate records	B = the total number of cases	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
17	KPI	Average Contact Handle Time	Measures the total time that an agent spends on an inbound contact, including talk time, chat time, wrap time, and after call or after chat work time (ACW).	Service Level = A / B	A = the total time that agents spend on inbound contacts	B = the total number of inbound contacts	[redacted]	[redacted]	[redacted]	[redacted]	Each case	Monthly	Yes	
18	Critical Service Level	Installation of Emergency Software or Patches	Percentage of End User Devices applied with Emergency Software or Patches for which the process was started immediately, and installed on those devices within the designated timeframe.	Service Level Achievement = A/B	A=Total number of Emergency Software/Patch installations required to be completed during the Measurement Period that are completed within the time allotted	B=Total number of Emergency Software/Patch installations required to be completed during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	Each patch or Software distribution to each Molina device	Monthly	Yes	Excludes devices not connected to network
19	KPI	Installation of Approved Software or Patches	Percentage of Approved Software or Patches installed on end user devices within the time allotted (as per Molina patching and installation scheduling requirements)	Service Level Achievement = A/B	A=Total number of Approved Software/Patch installations required to be completed during the Measurement Period that are completed within the time allotted	B=Total number of Approved Software/Patch installations required to be completed during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	Each patch or Software distribution to each Molina device	Monthly	Yes	Excludes devices not connected to network
20	KPI	VIP Incident Response	All tickets raised by or on behalf of a VIP are acknowledged to the customer by an analyst attending/remote intervention	Service Level Achievement = A/B	A = the number of VIP Incidents responded to within the designated timeframe	B = the total number of all VIP Incidents	[redacted]	[redacted]	[redacted]	[redacted]				Applicable at Corporate Offices
21	KPI	VIP Incident Resolution	All tickets raised by or on behalf of a VIP are resolved to the customer by an analyst attending/remote intervention	Service Level Achievement = A/B	A = the number of VIP Incidents resolved within the designated timeframe	B = the total number of VIP Incidents	[redacted]	[redacted]	[redacted]	[redacted]				Applicable at Corporate Offices


MOLINA
HEALTHCARE
Appendix 6-A
(Service Level Matrix - Infra and Azure)
This document contains confidential and proprietary information of Molina Healthcare

INTRODUCTION

This Appendix sets forth the following:

For Service Levels:
- The Allocation of Pool Percentage associated with each Performance Category
- The Service Level Credit Allocation Percentage associated with each Service Level within a Performance Category
- The timing regarding the commencement of obligations for reporting and credits for each Service Level
- The measurement period for each Service Level
- Flags identifying whether the Supplier agrees to the mentioned metrics
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For KPIs:
- The timing regarding the commencement of obligations for each KPI
- The measurement period for each KPI
- Flags identifying whether the Supplier agrees to the mentioned metrics
- The rationale behind Supplier's agreement/disagreement with the assigned metrics

INSTRUCTIONS

Suppliers to provide their point of view on best-in-class SLA framework, definition of priorities and SLA targets.
Please confirm in column O if you agree with the metrics and update comments (if any) in column P

Pool Percentage for Allocation

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
1	Critical Service Level	Database Cluster Availability	Measures the percentage availability of Database Clusters (with redundancy within the site) in Data Centers 1. This SLA is applicable for Platinum category application having more than 2 nodes per clusters. 2. AppDynamincs will be used for application performance monitoring 3. On Azure, the SLA's will reamin same for services taken as IaaS. For PaaS DB services, MS Azure specific SLA will be applicable as contracted.	Service Level = (B - A) / B	A = number of minutes of Unplanned Downtime for database clusters during the Measurement Period. "A" shall not include Unplanned Downtime as long as all database clusters remain available and are capable of taking workload. "A" shall include Unplanned Downtime if any of the four following conditions applies: 1. More than one node in a cluster is in downstate 2. Loss of connectivity to the database 3. Performance degradation of application due to database issue. 4. SQLs running longer due to optimizer plan change resulting in partial loss of functionality to the application.	B = number of minutes of planned operation for all database clusters that experienced any Unplanned Downtime during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	This is not applicable to for Azure Cloud as the oracle Exadata is running on private cloud. SQL DB Availability is covered as part of Azure SLA: https://azure.microsoft.com/en-us/support/legal/sla/	[redacted]	Each minute	Monthly	Yes	1. This SLA is applicable for Platinum category application having more than 2 nodes per clusters. 2. AppDynamincs will be used for application performance monitoring 3. On Azure, the SLA's will reamin same for services taken as IaaS. For PaaS DB services, MS Azure specific SLA will be applicable as contracted.
2	Critical Service Level	Response Time (Priority 1)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 1 incidents responded to within the designated timeframe or less.	B = number of Priority 1 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Infosys IIMSS will be configured to send automated aknowledgement alerts.	[redacted]	Each incident	Monthly	Yes	
3	Critical Service Level	Response Time (Priority 2)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 2 incidents responded to within the designated timeframe or less	B = number of Priority 2 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Infosys IIMSS will be configured to send automated aknowledgement alerts.	[redacted]	Each incident	Monthly	Yes	Volumes for P2 tickets is almost 5 tickets per day hence keeping SLA lower than P1s.

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
4	Critical Service Level	Resolution Time (Priority 1)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 1 incidents resolved within the designated timeframe.	B = number of Priority 1 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	For the issues related to Azure platform, MS provodes the following SLAs with Azure Rapid response Contract. This contract needs to be established between Molina & MS or Infosys & MS. With Rapid response contract- response SLA is 15 min. With Azure premimum support contract- response SLA is 1 hour there is no resolution SLA commited by MS.	[redacted]	Each incident	Monthly	Yes	
5	Critical Service Level	Resolution Time (Priority 2)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 2 incidents resolved within the designated timeframe.	B = number of Priority 2 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	For the issues related to Azure platform, MS provodes the following SLAs with Azure Rapid response Contract. This contract needs to be established between Molina & MS or Infosys & MS. With Rapid response contract- response SLA is 15 min. With Azure premimum support contract- response SLA is 1 hour there is no resolution SLA commited by MS.	[redacted]	Each incident	Monthly	Yes	

6	Critical Service Level	Installation of Emergency Software or Patches	Percentage of Emergency Software or Patches for which the process was started immediately, and installed on Infrastructure within the designated timeframe. 1. Inclusions : Devices reporting to AD, persistent machines and DMZ devices 2. Exclusions : Pooled, EoL and in-progress decomm mchines 3. Applies to day-0 patches 4. Implementation timelines will be mutually agreed	Service Level Achievement = A/B	A=Total number of Emergency Software/Patch installations required to be completed during the Measurement Period that are completed within the time allotted	B=Total number of Emergency Software/Patch installations required to be completed during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each patch or Software distribution to each Molina device	Monthly	Yes	1. Inclusions : Devices reporting to AD, persistent machines and DMZ devices 2. Exclusions : Pooled, EoL and in-progress decomm mchines 3. Applies to day-0 patches 4. Implementation timelines will be mutually agreed

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
7	Critical Service Level	Network Infrastructure Availability	Measures the percentage availability of Production Network Infrastructure	Service Level = (B - A) / B	A = number of minutes of Unplanned Downtime for all Production Network Infrastructure resources during the Measurement Period. "A" shall not include Unplanned Downtime as long as all server clusters (including Infrastructure and storage), and network paths remain available and are capable of taking workload.	B = number of minutes of planned operation for all Production Network resources that experienced any Unplanned Downtime during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	This is covered as part of Azure SLA: https://azure.microsoft.com/en-us/support/legal/sla/	[redacted]	Each minute	Monthly	Yes	1. Applicable to the On prem DC Networks 2. For Azure, MS SLA will be applicable as contracted.
8	Critical Service Level	Azure Services Availability	Microsoft's commitments for uptime and connectivity	https://azure.microsoft.com/en-us/support/legal/sla/	-	-	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Microsoft makes service levels commitments to customers in the SLA, which will be applicable to Molina as well. Details on specific services are listed on https://azure.microsoft.com/en-us/support/legal/sla/. As per the terms of Cloud Service Provider ("CSP") agreement between Microsoft and Infosys - In case of any Azure Services SLA breach for Azure Services procured through Infosys CSP, Infosys will escalate the claim to Microsoft for review. Microsoft will review the claim according to the standard SLA review process. Microsoft will then apply any credit due on Infosys's next billing reconciliation report and Infosys will then credit Molina for the SLA claim that Microsoft has paid Infosys for the SLA credit. Molina is eligible for credits not to exceed the total monthly Subscription price.	[redacted]	Each incident	Monthly	Yes	

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
9	KPI	Backup Infrastructure Availability	Measures the percentage availability of the backup infrastructure	Service Level = (B - A) / B	A = number of minutes of Unplanned Downtime for all backup infrastructure during the Measurement Period.	B = number of minutes of planned operation for backup infrastructure that experienced any Unplanned Downtime during the Measurement Period. B shall not include minutes of planned operation of the backup infrastructure unless the it was unavailable.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	This is covered as part of Azure SLA: https://azure.microsoft.com/en-us/support/legal/sla/	[redacted]	Each minute	Monthly	Yes	For Azure, backup is a paas service and availability of paas services will shared by MS as per the contract.
10	KPI	Stand-Alone Device Availability	Measures the aggregate availability of the in-scope stand-alone devices 1. Assumption : Branch office location devices are protected by the secured and controlled facility. 2. All WAP devices except those in Corporate offices (bldg 200/300) in Long Beach are excluded 3. Exclusions : End-user and EoL Devices	Service Level = (B - A) / B	A = number of minutes of Unplanned Downtime for all stand-alone devices located outside a Data Center during the Measurement Period.	B = number of minutes of planned operation for all stand-alone devices located outside a Data Center that experienced any Unplanned Downtime during the Measurement Period. B shall not include minutes of planned operation for a stand-alone device unless the device was unavailable.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	This is covered as part of Azure SLA: https://azure.microsoft.com/en-us/support/legal/sla/	[redacted]	Each minute	Monthly	Yes	1. Assumption : Branch office location devices are protected by the secured and controlled facility. 2. All WAP devices except those in Corporate offices (bldg 200/300) in Long Beach are excluded 3. Exclusions : End-user and EoL Devices
11	~~KPI~~	~~Communication Time~~	~~Measures the percentage of incidents where the incident was communicated with business impact and technical description of what is being investigated, to appropriate business partners and technical teams within the appropriate amount of time.~~	~~Service Level = A / B~~	~~A = number of incidents communicated in within the designated timeframe or less.~~	~~B = number of incidents opened during the Measurement Period.~~	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	~~Each incident~~	~~Monthly~~	~~Yes~~	~~Applicable only for the P1/P2 incidents and as per the agreed business communication plans~~

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
12	KPI	Response Time (Priority 3)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 3 incidents responded to within the designated timeframe.	B = number of Priority 3 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
13	KPI	Response Time (Priority 4)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 4 incidents responded to within the designated timeframe.	B = number of Priority 4 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
14	KPI	Resolution Time (Priority 3)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 3 incidents resolved within the designated timeframe.	B = number of Priority 3 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
15	KPI	Resolution Time (Priority 4)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 4 incidents resolved within the designated timeframe.	B = number of Priority 4 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
16	KPI	Root Cause Analysis Time	Measures the percentage of Priority 1 and 2 incidents that receive a final root cause analysis within the designated timeframe. Pending responses from third party suppliers are acceptable	Service Level = A / B	A = number of Priority 1 and Priority 2 incidents that meet the Root Cause Analysis Time within the designated timeframe	A = number of Priority 1 and Priority 2 incidents resolved during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
17	KPI	Batch Job Commencement	Measures the percentage of batch jobs failures where the failure was responded to (following SOP guidelines) within the designated timeframe. Response only to respective teams according SOP & Communication Matrix	Service Level = A / B	A = number of batch job failures during the Measurement Period that were responded to within the designated timeframe or less	B = number of batch job failures during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each instance	Monthly	Yes	Response only to respective teams according SOP & Communication Matrix

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
18	KPI	Successful Completion of Backup and Recovery	Measures the percentage of successfully completed backup and recovery jobs. >2 consecutive backup failures will be considered breach failure in service level	Service Level = A / B	A = the sum of (x) number of tests of backup data that show that the backup was complete, accurate and accessible plus (y) the number of complete, accurate and otherwise successful restorations of backed-up data during the Measurement Period.	B = number of tests of backup data plus the number of restorations of backed-up data performed during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each test of backup data or each restoration of backed-up data	Monthly	Yes	Molina to revert with metric data >2 consecutive backup failures will be considered breach failure in service level
19	KPI	Infrastructure Capacity Provisioning	Measure of Capacity provisioning requests completed within the time allotted. This metric measures number of succesful completion of catalogue requests for provisioning	Service Level Achievement = A/B	A=Total number of Infrastructure Capacity provisioning requests required to be completed during the Measurement Period that are completed within the time allotted	B=Total number of Infrastructure Capacity provisioning requests required to be completed during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Infra Provisioning on Azure can be fully automated to improve the service request completion time	[redacted]	Each request	Monthly	Yes	Catalogue with defined timelines to be created in ServicNow. This metric measures number of succesful completion of catalogue requests for provisioning
20	KPI	Installation of Approved Software or Patches	Percentage of Approved Software or Patches installed on Infrastructure within the time allotted (as per Molina patching and installation scheduling requirements)	Service Level Achievement = A/B	A=Total number of Approved Software/Patch installations required to be completed during the Measurement Period that are completed within the time allotted	B=Total number of Approved Software/Patch installations required to be completed during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each patch or Software distribution to each Molina device	Monthly	Yes	Need to evaluate the pending patches with the new approved patches to agree on the standards.
21	KPI	Contract Management	Measures the percentage of Contract Change Order, Invoices Correct and On-Time (calculated on number of lines). This will be applicable for Infosys contracts only. All documents recalled for corrections post approvals will be considered for defaults.	Service Level = (B - A) / B	A = number of line items on any contract change order or invoice which are incorrect (or all lines if such invoice or contract is provided to Molina after a Molina-communicated due date).	B = number of line items on all invoices and change orders in the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each line item	Monthly	Yes	

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
22	KPI	Reporting	Measures the Supplier's ability to deliver reports to Molina according to the planned and/or scheduled cadence. Only for the agreed and pre defined report formats.	Service Level = A / B	A = number of reports completed by Supplier within the scheduled reporting cadence as defined by Molina	B = number of reports scheduled to be completed during the Measurement Period by Supplier	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each report	Monthly	Yes	Only for the agreed and pre defined format
23	KPI	Documentation	Completion of all scheduled documentation revisions and drafts as defined by Molina. Following list of documents will form a part of this list: 1. Ops Manual/Run book 2. Process Manual 3. SOPs	Service Level = A / B	A = number of documents drafted or updated by Supplier within the scheduled document update window as mutually agreed between Molina and Supplier	B = number of documents scheduled to be completed during the Measurement Period by Supplier	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each report	Monthly	Yes	Need to clarifiy on the list and type of scheduled documents. Following list of documents will form a part of this list: 1. Ops Manual/Run book 2. Process Manual 3. SOPs
24	~~KPI~~	~~Security Review~~	~~Measures the performance of all security reviews within specified timeframes~~	~~Service Level = B / A~~	~~A = number of security reviews required by Molina (or Supplier's standards) during the Measurement Period.~~	~~B = number of security reviews completed during the Measurement Period.~~	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	~~Each security review~~	~~Monthly~~	~~Yes~~	~~To be discussed~~ Will be included in Security SLA Matrix
25	KPI	Capacity Reporting	Measures the number of Infra Capacity Events not reported within one business day. Events include : CPU Utilization, Memory Utilization, Disk Capacity, Network Bandwidth, SAN/NAS Storage Capacity, beyond defined thresholds.	Service Level = A/B	A = number of instances in which the threshold breaches ocurred but not reported	B = number of instances in which the threshold breaches occurred	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each month	Monthly	Yes	

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	On-Prem Infra			On-Azure Infra			Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
							Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage						
26	KPI	File Recovery / Restoration	Measure of restoration requests where the restore is initiated is that are completed with the allotted time. This has to be a measure of success or failure of restoration.	Service Level Achievement = A/B	A=Total number of restoration requests initiated and completed succesfully	B=Total number of restoration requests during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each request	Monthly	Yes	Proposed : This has to be a measure of success or failure of restoration.
27	KPI	Account Provisioning Error Rates	Percentage of Account Provisioning (including de-Provisioning) requests processed incorrectly to total number of requests by type	Service Level Achievement = A/B	A=Total number of Account Provisioning and De-Provisioning requests processed incorrectly during the Measurement Period	B=Total number of Account Provisioning and De-Provisioning requests received during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each request	Monthly	Yes	Account provisioning needs to be clarified. How is Molina measuring this currently?
28	KPI	Emergency Account de-provisioning Error Rates	Percentage of Emergency Account de-provisioning requests processed incorrectly to total number Emergency Account de-provisioning requests	Service Level Achievement = A/B	A=Total number of Emergency Account de-provisioning requests processed incorrectly during the Measurement Period	B=Total number of Emergency Account de-provisioning requests received during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each request	Monthly	Yes	Account provisioning needs to be clarified. How is Molina measuring this currently?
29	KPI	Customer Satisfaction	Infosys will use ELF (Engagement Level Feedback) mechanism to collect and report customer satisfaction.				[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each report	Quarterly	Yes	Overlaps with the EUC customer satisfaction survey. What is current survey mechanism being used by Molina? Can be part of CVS Survey conducted by Infosys.


MOLINA
HEALTHCARE
Appendix 6-A
(Service Level Matrix - Security Services)
This document contains confidential and proprietary information of Molina Healthcare

INTRODUCTION

This Appendix sets forth the following:

For Service Levels:
- The Allocation of Pool Percentage associated with each Performance Category

- The Service Level Credit Allocation Percentage associated with each Service Level within a Performance Category
- The timing regarding the commencement of obligations for reporting and credits for each Service Level
- The measurement period for each Service Level
- Flags identifying whether the Supplier agrees to the mentioned metrics
- The rationale behind Supplier's agreement/disagreement with the assigned metrics

For KPIs:
- The timing regarding the commencement of obligations for each KPI
- The measurement period for each KPI
- Flags identifying whether the Supplier agrees to the mentioned metrics
- The rationale behind Supplier's agreement/disagreement with the assigned metrics

INSTRUCTIONS

Suppliers to provide their point of view on best-in-class SLA framework, definition of priorities and SLA targets.
Please confirm in column O if you agree with the metrics and update comments (if any) in column P

Service Level Category - Incidents	Definition	Examples
Priority 1 (P1)	Incident with potential for short-term or immediate impact to business critical assets or that could result in the breach of highly sensitive/confidential business information or VIP information	P1 by Impact - Virus outbreak impacting the entire business unit, DDoS attacks
		P1 by risk – APT data exfiltration with potential highly sensitive data. Reputational and financial probability. Unauthorized access to company critical systems/data
Priority 2 (P2)	Incident with potential for short-term or immediate impact to medium criticality business assets or IT Systems or that could result in the breach of medium sensitivity information or VIP information includes time-sensitive employee	P2 by Impact - Malware, Phishing attacks impacting large number of business or IT users, Application Access Outage impacting a large number of users
		P2 by risk - Potential medium sensitive data exfiltration that shall result in financial or reputational loss
Priority 3 (P3)	Possible incident involving non-critical systems. Includes employee investigations that are not time sensitive. Long-term investigations involving extensive research and/or detailed forensic work.	Malware, Phishing attacks impacting smaller number of business or IT users, potential low sensitive data exfiltration that shall result in financial or reputational loss, Outages impacting a small number of users
Priority 4 (P4)	Application or personal procedure unusable, where a workaround is available or a repair is possible.	Same as above but impacting a individual users, non-critical assets, low priority

Pool Percentage for Allocation

				250%						On-Azure Infra								
#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
1	Critical Service Level	Triage Investigation for CDC	Measurs the percetage of alerts for which the alert triaging process was started witin the appopriate amount of time for a security event.	Service Level = A / B	A = number of alerts that were generated within the designated timeframe or less	A = number of alerts for which the traigae process was started and initial priority assignedwithin the designated timeframe or less	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each alert	Monthly	Yes	Applicable to CDC Incident Response services
2	Critical Service Level	Alert Notification Response Time (Priority 0, 1) for CDC	Measures the percentage of True Postive Priority 1 incidents where the incident was assigned to a security analyst within the appropriate amount of time from the time a security event was assiged as a priority 1.	Service Level = A / B	A = number of True Postive Priority 1 incidents where the incident was assigned to a security analyst within the designated timeframe or less	B = number of True Postive Priority 1 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services
3	Critical Service Level	Alert Notification Response Time(Priority 2) for CDC	Measures the percentage of True Postive Priority 2 incidents where the incident was assigned to a security analyst within the appropriate amount of time from the time a security event was assiged as a priority 2	Service Level = A / B	A = number of True Postive Priority 2 incidents where the incident was assigned to a security analyst within the designated timeframe or less	B = number of True Postive Priority 2 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services
4	Critical Service Level	Target for Recommendations /workarounds (Priority 0) for CDC	Measures the percentage of True Postive Priority 1 incidents where the incident recommendations /workarounds was provided within the appropriate amount of time from the time a security event was assiged as a priority 1	Service Level = A / B	A = number of True Postive Priority 1 incidents where the incident containment was initiated within the designated timeframe.	B = number of True Postive Priority 1 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services. Exeption
5	Critical Service Level	Target for Recommendations /workarounds (Priority 1) for CDC	Measures the percentage of True Postive Priority 1 incidents where the incident recommendations /workarounds was provided within the appropriate amount of time from the time a security event was assiged as a priority 1	Service Level = A / B	A = number of True Postive Priority 1 incidents where the incident containment was initiated within the designated timeframe.	B = number of True Postive Priority 1 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services. Exeption

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	On-Azure Infra: Minimum Service Level Target	On-Azure Infra: Expected Service Level Target	On-Azure Infra: Allocation of Pool Percentage	Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
6	Critical Service Level	Target for Recommendations /workarounds (Priority 2) for CDC	Measures the percentage of True Postive Priority 2 incidents where the incident recommendations /workarounds was provided within the appropriate amount of time from the time a security event was assigned as a priority 2	Service Level = A / B	A = number of True Postive Priority 2 incidents where the incident containment was initiated within the designated timeframe.	B = number of True Postive Priority 2 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services
7	KPI	Alert Notification Response Time (Priority 3) for CDC	Measures the percentage of True Postive Priority 3 incidents where the incident was assigned to a security analyst within the appropriate amount of time from the time a security event was assigned as a priority 3	Service Level = A / B	A = number of True Postive Priority 3 incidents where the incident was assigned to a security analyst within the designated timeframe or less	B = number of True Postive Priorit 3 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services
8	KPI	Alert Notification Response Time (Priority 4) for CDC	Measures the percentage of True Postive Priority 4 incidents where the incident was assigne to a security analyst within the appropriate amount of time from the time a security event was assigned as a priority 4	Service Level = A / B	A = number of True Postive Priority 4 incidents where the incident was assigned to a security analyst within the designated timeframe or less	B = number of True Postive Priority 4 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services
9	KPI	Target for Recommendations /workarounds (Priority 3) for CDC	Measures the percentage of True Postive Priority 3 incidents where the incident recommendations /workarounds was provided within the appropriate amount of time from the time a security event was assigned as a priority 3.	Service Level = A / B	A = number of True Postive Priority 3 incidents where the incident containment was initiated within the designated timeframe.	B = number of True Postive Priority 3 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services
10	KPI	Target for Recommendations /workarounds (Priority 4) for CDC	Measures the percentage of True Postive Priority 4 incidents where the incident recommendations /workarounds was provided within the appropriate amount of time from the time a security event was assigned as a priority 4.	Service Level = A / B	A = number of True Postive Priority 4 incidents where the incident containment was initiated within the designated timeframe.	B = number of True Postive Priority 4 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	Not applicable	Not applicable	Not applicable	Not applicable	[redacted]	Each incident	Monthly	Yes	Applicable to CDC Incident Response services

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	On-Azure Infra: Minimum Service Level Target	On-Azure Infra: Expected Service Level Target	On-Azure Infra: Allocation of Pool Percentage	Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
11	Critical Service Level	Response Time (Critical Severtiy Vulnerability) for UVM	Measures the percentage of critical severity vulnerability identified by scanning using any technology means is reported to the system or application owner for appopriate remediation.	Service Level = A / B	A = number of critical serverity vulnerabities reported where the vulnerabiity was reported within the designated timeframe or less	B = number of critical serverity vulnerabities detected within during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each vulnerability on infrastructure or application	Monthly	Yes	Applicable to application and infrastrcture vulnerability management services. Exceptions - Zero Day vulnerabilities
12	Critical Service Level	Response Time (High Severity Vulnerability) for UVM	Measures the percentage of High severity vulnerability identified by scanning using any technology means is brought to the notice of system or application owner for appopriate remediation.	Service Level = A / B	A = number of high serverity vulnerabities reported where the vulnerabiity was reported within the designated timeframe or less	B = number of high serverity vulnerabities detected within during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each vulnerability on infrastructure or application	Monthly	Yes	Applicable to application and infrastrcture vulnerability management services. Exceptions - Zero Day vulnerabilities
13	Critical Service Level	Response Time (Priority 1) for global security services	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 1 incidents responded to within the designated timeframe or less.	B = number of Priority 1 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Infosys IIMSS will be configured to send automated aknowledgement alerts.	[redacted]	Each incident	Monthly	Yes	
14	Critical Service Level	Response Time (Priority 2) for global security services	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 2 incidents responded to within the designated timeframe or less	B = number of Priority 2 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Infosys IIMSS will be configured to send automated aknowledgement alerts.	[redacted]	Each incident	Monthly	Yes	Volumes for P2 tickets is almost 5 tickets per day hence keeping SLA lower than P1s.
15	Critical Service Level	Resolution Time (Priority 1) for global security services	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 1 incidents resolved within the designated timeframe.	B = number of Priority 1 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	For the issues related to Azure platform, MS provodes the following SLAs with Azure Rapid response Contract. This contract needs to be established between Molina & MS or Infosys & MS. With Rapid response contract- response SLA is 15 min. With Azure premimum support contract- response SLA is 1 hour there is no resolution SLA commited by MS.	[redacted]	Each incident	Monthly	Yes	

250%

										On-Azure Infra								
#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
16	Critical Service Level	Resolution Time (Priority 2) for global security services	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 2 incidents resolved within the designated timeframe.	B = number of Priority 2 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	For the issues related to Azure platform, MS provodes the following SLAs with Azure Rapid response Contract. This contract needs to be established between Molina & MS or Infosys & MS. With Rapid response contract-response SLA is 15 min. With Azure premimum support contract-response SLA is 1 hour there is no resolution SLA commited by MS.	[redacted]	Each incident	Monthly	Yes	
17	Critical Service Level	Installation of Emergency Software or Patches	Percentage of Emergency Software or Patches for which the process was started immediately, and installed on Infrastructure within the designated timeframe. 1. Inclusions : Devices reporting to AD, persistent machines and DMZ devices 2. Exclusions : Pooled, EoL and in-progress decomm mchines 3. Applies to day-0 patches 4. Implementation timelines will be mutually agreed	Service Level Achievement = A/B	A=Total number of Emergency Software/Patch installations required to be completed during the Measurement Period that are completed within the time allotted	B=Total number of Emergency Software/Patch installations required to be completed during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each patch or Software distribution to each Molina device	Monthly	Yes	1. Inclusions : Devices reporting to AD, persistent machines and DMZ devices 2. Exclusions : Pooled, EoL and in-progress decomm mchines 3. Applies to day-0 patches 4. Implementation timelines will be mutually agreed
18	KPI	Response Time (Priority 3) for global security services	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 3 incidents responded to within the designated timeframe.	B = number of Priority 3 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	On-Azure Infra: Minimum Service Level Target	On-Azure Infra: Expected Service Level Target	On-Azure Infra: Allocation of Pool Percentage	Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
19	KPI	Response Time (Priority 4) for global security services	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.	Service Level = A / B	A = number of Priority 4 incidents responded to within the designated timeframe.	B = number of Priority 4 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
20	KPI	Resolution Time (Priority 3) for global security services	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 3 incidents resolved within the designated timeframe.	B = number of Priority 3 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
21	KPI	Resolution Time (Priority 4) for global security services	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.	Service Level = A / B	A = number of Priority 4 incidents resolved within the designated timeframe.	B = number of Priority 4 incidents opened during the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
22	KPI	Root Cause Analysis Time for global security services	Measures the percentage of Priority 1 and 2 incidents that receive a final root cause analysis within the designated timeframe. Pending responses from third party suppliers are acceptable	Service Level = A / B	A = number of Priority 1 and Priority 2 incidents that meet the Root Cause Analysis Time within the designated timeframe	A = number of Priority 1 and Priority 2 incidents resolved during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each incident	Monthly	Yes	
23	KPI	Installation of Approved Software or Patches for global security services	Percentage of Approved Software or Patches installed on Infrastructure within the time allotted (as per Molina patching and installation scheduling requirements)	Service Level Achievement = A/B	A=Total number of Approved Software/Patch installations required to be completed during the Measurement Period that are completed within the time allotted	B=Total number of Approved Software/Patch installations required to be completed during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each patch or Software distribution to each Molina device	Monthly	Yes	Need to evaluate the pending patches with the new approved patches to agree on the standards.

250%

#	Type	Service Level Name	Description / Overview	Formula	Formula Variable - A	Formula Variable - B	Minimum Service Level Target	Expected Service Level Target	Allocation of Pool Percentage	On-Azure Infra: Minimum Service Level Target	On-Azure Infra: Expected Service Level Target	On-Azure Infra: Allocation of Pool Percentage	Comments for Azure SLA deviations / Changes	Service Level Commencement Date	Monitoring Requirement	Measurement Period	Agree?	Comments
24	KPI	Contract Management for global security services	Measures the percentage of Contract Change Order, Invoices Correct and On-Time (calculated on number of lines). This will be applicable for Infosys contracts only. All documents recalled for corrections post approvals will be considered for defaults.	Service Level = (B - A) / B	A = number of line items on any contract change order or invoice which are incorrect (or all lines if such invoice or contract is provided to Molina after a Molina-communicated due date).	B = number of line items on all invoices and change orders in the Measurement Period.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each line item	Monthly	Yes	
25	KPI	Reporting for global security services	Measures the Supplier's ability to deliver reports to Molina according to the planned and/or scheduled cadence. Only for the agreed and pre defined report formats.	Service Level = A / B	A = number of reports completed by Supplier within the scheduled reporting cadence as defined by Molina	B = number of reports scheduled to be completed during the Measurement Period by Supplier	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each report	Monthly	Yes	Only for the agreed and pre defined format
26	KPI	Account Provisioning Error Rates for global security services	Percentage of Account Provisioning (including de-Provisioning) requests processed incorrectly to total number of requests by type	Service Level Achievement = A/B	A=Total number of Account Provisioning and De-Provisioning requests processed incorrectly during the Measurement Period	B=Total number of Account Provisioning and De-Provisioning requests received during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each request	Monthly	Yes	Account provisioning needs to be clarified. How is Molina measuring this currently?
27	KPI	Emergency Account de-provisioning Error Rates for global security services	Percentage of Emergency Account de-provisioning requests processed incorrectly to total number Emergency Account de-provisioning requests	Service Level Achievement = A/B	A=Total number of Emergency Account de-provisioning requests processed incorrectly during the Measurement Period	B=Total number of Emergency Account de-provisioning requests received during the Measurement Period	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	Each request	Monthly	Yes	Account provisioning needs to be clarified. How is Molina measuring this currently?

SCHEDULE 7 GOVERNANCE

CONTENTS

1. **INTRODUCTION**

1.1 This Schedule 7 (*Governance*) sets out certain governance processes and procedures with which the parties shall comply.

1.2 Capitalized terms used but not defined in this Schedule and its Appendices shall have the meanings given in Schedule 1 (*Definitions and Interpretation*). Paragraph references used herein will refer to the applicable paragraph in this Schedule 7, except as otherwise set forth herein.

2. **APPENDICES**

2.1 The following Appendices are attached to this Schedule 7:

(a) Appendix 7-A (*Meeting Requirements*) sets forth the cadence of meetings held periodically between Molina and Service Provider.

(b) Appendix 7-B (*Reporting Requirements*) sets forth reporting requirements described further below and elsewhere in this Schedule.

3. **GOVERNANCE PROCESSES AND PROCEDURES**

3.1 The Governance organization defines the key roles and responsibilities for Molina, the Service Provider, and other relevant third-party vendors. The program structure/governance model under this Schedule is comprised of a four-tier structure for the management of the relationship between the parties under this Agreement:

(a) Executive Steering Committee;

(b) IT Core Leadership Team;

(c) Multi-Service Provider Operational Committee; and

(d) Operational Review Board.

4. **GOVERNANCE DEFINITIONS**

4.1 **"Executive Steering Committee"** means the committee described in paragraph 5.

4.2 **"IT Core Leadership Team"** means the committee described in paragraph 6.

4.3 **"Molina CIO"** means the role described in paragraph 5.

4.4 **"Molina - Commercial Lead(s)"** means the role described in paragraph 7.

4.5 **"Molina - Delivery Lead(s)"** means the role described in paragraph 7.

4.6 **"Molina Procurement Lead"** means the role described in paragraph 5.

4.7 **"Multi-Service Provider Operational Committee"** means the committee described in paragraph 7.

4.8 **"Operational Review Board"** means the committee described in paragraph 8.

4.9 **"Service Provider Account Executive"** means the role described in paragraph 5.

4.10 **"Service Provider Delivery Lead"** means the role described in paragraph 6.

4.11 **"Service Provider Operational Team Lead"** means the role described in paragraph 7.

5. **EXECUTIVE STEERING COMMITTEE**

5.1 Purpose. The purpose of the Executive Steering Committee is to manage the overall strategic direction of the relationship between Molina and Service Provider to ensure alignment with the broader direction of the business.

5.2 Members. The members of the Executive Steering Committee shall consist of:

(a) Molina EVP of Health Plan Services, CIO, and/or their respective peers and proxies;

(b) Molina Procurement Lead;

(c) Molina VP, Vendor Management;

(d) Service Provider Account Executive; and

(e) a CIO Service Provider Peer-Level Representative.

5.3 Meetings. The Service Provider Account Executive shall be responsible for developing and, as directed by the Molina CIO, revising the meeting agenda and presentation materials for meetings. The Executive Steering Committee shall meet on an ad hoc basis if called by the Molina CIO, but in no case less than two (2) times each calendar year, unless Molina elects to meet less frequently.

5.4 Oversight. The Molina CIO and Molina Procurement Lead shall be authorized to set the strategic direction for the relationship between the Parties and shall meet to discuss, processes, risks and potential remedies, as well as any commercial implications of the foregoing.

(a) The Molina CIO shall be responsible for setting the overall strategic direction in consultation with the Molina EVP of Health Plan Services.

(b) The Service Provider Account Executive shall be responsible for implementing and executing the overall strategy set by Molina, and escalating issues that may affect the overall strategy.

(c) The Service Provider Account Executive shall be responsible for communicating to the IT Core Leadership Team the high-level strategy as directed by the Executive Steering Committee.

(d) The Service Provider Account Executive shall be responsible for overseeing the performance and status of all active Project(s), and escalating significant issues and risks to the Molina CIO.

5.5 Strategic Relationships. The Service Provider Account Executive shall:

(a) Prepare and present high-level trend analysis to the Molina CIO, including relating to Molina's and Service Provider's behavior patterns, process requests, and synergy opportunities for Molina with other customers of Service Provider.

(b) Present value-add business opportunities and innovations to Molina for review and consideration for approval.

5.6 Portfolio and Financial Management. The Service Provider Account Executive shall inform the Molina CIO of Services volume forecasts, resource allocation, audits, and applicable invoices for approval.

5.7 Contract Management. The Service Provider Account Executive shall be responsible for communicating to the Executive Steering Committee any Service Provider-proposed contract changes and for providing a risk analysis for review and consideration for approval by the Executive Steering Committee.

5.8 Reporting and Communication. The Service Provider Account Executive shall:

(a) Conduct a performance assessment and deliver to the Molina CIO for review a summary of the performance of the Services for review and consideration for approval; and

(b) Be responsible for communicating the monthly performance reviews made by the Multi-Service Provider Operational Committee to the Executive Steering Committee.

6. IT CORE LEADERSHIP TEAM

6.1 Purpose. The purpose of the IT Core Leadership Team is to provide Molina executive leadership a forum for discussing Molina's strategic vision, and receiving Service Provider input on that vision

6.2 Members. The members of the IT Core Leadership Team shall consist of:

(a) Molina CIO and his/her proxies;

(b) Molina IT Core Leadership Team;

(c) Molina Procurement Lead;

(d) Molina VP, Vendor Management; and

(e) Service Provider Delivery Lead.

6.3 Meetings. The Service Provider Delivery Lead shall be responsible for developing and (as directed by the Molina CIO) revising the meeting agenda and presentation materials for meetings, to be submitted prior to the meetings. The IT Core Leadership Team shall meet on an ad hoc basis if called by the Molina CIO, but in no case less than one (1) time each calendar quarter.

6.4 The IT Core Leadership Team shall focus on topics such as, but not limited to, reviewing Molina IT's overall performance trends, assessing ability to meet the needs of its customers, and identifying opportunities for improved performance and commercial outcomes.

6.5 Oversight. The IT Core Leadership Team shall make recommendations to the Executive Steering Committee about the strategic direction of Molina IT, and shall implement strategies as directed by the Executive Steering Committee.

(a) The IT Core Leadership Team shall be responsible for advising and counseling the Multi-Service Provider Operational Review Board.

(b) The IT Core Leadership Team shall act as the first level of issue resolution for issues escalated by the Multi-Service Provider Operational Committee.

(c) The Service Provider Delivery Lead shall be responsible for assisting and counseling Service Provider Operational Team Lead(s) and the Molina Delivery Lead(s) as required.

(d) The Service Provider Delivery Lead is responsible for ensuring that the Multi-Service Provider Operational Committee and Operational Review Board adhere to all operational processes.

6.6 Portfolio Management. The Service Provider Delivery Lead shall provide a complete financial review of the Services for the review and consideration for approval of the respective Molina Commercial Lead(s).

(a) The Service Provider Delivery Lead shall be responsible for reviewing all Services volume forecasts from the Molina Delivery Lead(s) and Service Provider Operational Team Lead(s).

(b) The Service Provider Delivery Lead shall be responsible for the analysis, preparation, review, and reporting to Molina of forecasts, resource plans, baseline volumes, and summaries of any associated impacts to the Services (including Service Levels), for review, revision (as directed by Molina Procurement Lead), and approval by the Molina Commercial Lead(s)

7. MULTI-SERVICE PROVIDER OPERATIONAL COMMITTEES

7.1 Purpose. The purpose of the Multi-Service Provider Operational Committee is to provide integrated governance in instances whereby Service Provider is providing support under

multiple towers and/or Service Provider is one of multiple service providers supporting a single tower.

7.2 Members. The members of the Multi-Service Provider Operational Committee shall consist of:

(a) Molina Delivery Lead(s);

(b) Molina Commercial Lead(s);

(c) Molina Delivery Executives for Other Service Providers;

(d) Service Provider Delivery Lead;

(e) Service Provider Operational Team Lead(s); and

(f) Other Service Provider Personnel as Required.

7.3 Meetings. The Service Provider Delivery Lead shall be responsible for developing and (as directed by the Molina Delivery Lead) revising the meeting agenda and presentation materials for meetings, to be submitted prior to the meetings. The Multi-Service Provider Operational Committee(s) shall meet on an ad hoc basis if called by the Molina Delivery Lead, but in no case less than one (1) time each calendar month.

7.4 Oversight. The Multi-Service Provider Operational Committee shall maintain the quality of end-to-end service delivery within each tower, and shall implement strategies as directed by the IT Core Leadership Team.

(a) The Multi-Service Provider Operational Committee shall be responsible for advising and counseling the Operational Review Board.

(b) The Multi-Service Provider Operational Committee shall act as the first level of issue resolution for issues arising from multiple Service Providers operating within the same tower.

(c) Service Provider Delivery Lead(s) shall be responsible for assisting and counseling Service Provider Operational Team Lead(s) and the Molina Delivery Lead(s) as required.

(d) Service Provider Delivery Lead(s) are responsible for ensuring that the Operational Review Board adheres to all operational processes.

7.5 Portfolio Management. Service Provider Delivery Lead(s) shall provide a work portfolio and performance review of the Service Provider contracts for the review and consideration for approval of the respective Molina Commercial Lead(s).

(a) Service Provider Delivery Lead(s) shall be responsible for reviewing all Services volume forecasts from the Molina Delivery Lead(s) and Service Provider Operational Team Lead(s).

(b) Service Provider Delivery Lead(s) shall be responsible for reviewing issues and risks related to Services with the Molina Delivery Lead(s), Lead Commercial Manager and the Operations Steering Committee.

(c) Service Provider Delivery Lead(s) shall be responsible for supporting the Molina Delivery Lead(s) and the Service Provider Operational Team Lead(s) (e.g., on applicable application of resources, audits, etc.).

(d) Service Provider Delivery Lead(s) shall be responsible for the analysis, preparation, review, and reporting to Molina of forecasts, resource plans, baseline volumes, and summaries of any associated impacts to the Services (including Service Levels), for review, revision (as directed by Molina Commercial Lead(s)), and approval by the Molina Commercial Lead(s), including:

(i) Reporting and Communication. The Service Provider Delivery Lead, with the consultation of the Service Provider Operating Team Lead(s), shall provide to the Molina Delivery Lead(s) monthly performance reviews, including operations, metric achievement, and trends.

(ii) Service Level and Consequence Management. The Service Provider Delivery Lead, in the consultation of the Molina Delivery Lead(s) and Service Provider Operational Team Lead(s), shall review actual performance against the requirements of the applicable Services, and shall submit the results of such review for review and consideration for approval by the Molina CIO.

7.6 Molina Commercial Lead(s) and Molina Delivery Lead(s) shall have the right to add, modify, or remove Service Levels and Key Performance Indicators in accordance with Schedule 6 (*Service Levels and Service Credits*).

8. OPERATIONAL REVIEW BOARDS

8.1 Purpose. The purpose of the Operational Review Board is to oversee and manage contracted Services to ensure that all the Services are delivered according to contracted Service Provider obligations.

8.2 Members. The members of an Operational Review Board for each Services tower shall consist of:

(a) Molina Delivery Lead(s);

(b) Molina Commercial Lead(s);

(c) Molina VP, Vendor Management;

(d) Service Provider Delivery Lead;

(e) Service Provider Operational Team Lead(s); and

(f) Other Service Provider Personnel as Required.

8.3 Meetings. Service Provider Operating Team Lead(s) shall be responsible for developing and revising (as directed by the Molina Delivery Lead(s)) the meeting agenda and presentation materials for meetings, to be submitted prior to the meetings. The Operational Review Board(s) shall meet on an ad hoc basis if called by the Molina Delivery Lead(s), but in no case less than one (1) time each calendar month.

8.4 Oversight. Service Provider Operating Team Lead(s) shall be responsible for day-to-day oversight of operations, and shall report any findings for review and consideration for approval by the Molina Delivery Lead(s) / Molina Commercial Lead(s), which oversight activities shall include the following:

(a) Ensuring compliance with all Molina's onboarding requirements set forth on Schedule 4 (*Transition and Transformation*) or as otherwise directed by Molina and providing a report to Molina Delivery Lead(s) and Molina Commercial Lead(s) in such level of detail as directed by Molina;

(b) Ensuring operational process adherence;

(c) Managing risk and mitigation strategies;

(d) Identifying and managing issues applicable to the relevant Services; and

(e) Presenting any issues, risks, or concerns to the Molina Delivery Lead(s) / Molina Commercial Lead(s).

8.5 Strategic Relationships. Service Provider Operating Team Lead(s) shall identify opportunities to optimize Services through standardizations, and report any findings for review and consideration by the Molina Delivery Lead(s).

8.6 Portfolio and Financial Management. Service Provider Operating Team Lead(s) shall perform portfolio and financial management activities (and shall report any findings for the review and consideration for approval by the Molina Delivery Lead(s) / Molina Commercial Lead(s)), including the following:

(a) Reviewing applicable Services forecasts;

(b) Coordinating and allocating resources applicable to the relevant Services;

(c) Supporting audits;

(d) Processing invoices applicable to the relevant Services; and

(e) Providing general reporting applicable to the relevant Services, including weekly and monthly activity status.

8.7 Contract Management. Service Provider Operating Team Lead(s) shall submit proposed amendments to Services for review and consideration for approval by the appropriate Molina Commercial Lead(s).

8.8 Service Level and Consequence Management. Service Provider Operating Team Lead(s) shall manage quality applicable to the relevant Services.

(a) Service Provider Operating Team Lead(s) shall be responsible for monitoring performance against Service Levels and Services obligations, and reviewing any issues or risks (and proposed mitigation plans) with the Molina Delivery Lead(s) / Molina Commercial Lead(s).

8.9 Project Delivery. Service Provider Operating Team Lead(s) shall be responsible for ensuring that Service Provider delivers Projects on time and within budgets.

(a) Service Provider Operating Team Lead(s) shall be responsible for managing risk on a function, process, and project basis.

9. REPORTING

9.1 The Service Provider shall provide the reports set out in Appendix 7-B (*Reporting Requirements*) and the Agreement. Each report shall be provided by the Service Provider with effect from the "Services Commencement Date" as indicated in Appendix 7-B (*Reporting Requirements*) at the frequency specified therein.

9.2 The Service Provider shall provide to Molina such other information or reports relating to the Services as are reasonably requested by Molina and the Service Provider shall provide such information or reports within five (5) Business Days of such request.

10. BACKGROUND CHECKS

10.1 The Service Provider shall screen all Service Provider Personnel prior to their being assigned to the Services and / or entering any Molina Premises. The Service Provider will be responsible for all costs associated with the screening process. The screening process shall include, but not be limited to:

(a) Completion of the Service Provider's application process for Service Provider Personnel, which, at a minimum, shall provide for references, employment history, and disclosure of criminal convictions, where allowed by law;

(b) Reference checks, including at least three (3) previous employers, if possible; and

(c) Save as provided in paragraph 10.3 below, a criminal background check conducted by a reputable consumer reporting agency utilizing the highest industry standards that include, at a minimum, a complete criminal records search and a sex offender registry check.

10.2 The Service Provider shall provide evidence of having performed these checks in relation to any assigned Service Provider Personnel within a reasonable time period following request by Molina.

10.3 The Service Provider must allow for adequate time for background checks to be performed prior to onboarding any new resources.

APPENDIX 7A – MEETING REQUIREMENTS

[See Attached]

APPENDIX 7B – REPORTING REQUIREMENTS

[See Attached]

APPENDIX 7-A MEETING REQUIREMENTS

[redacted]	Executive Steering Committee	IT Core Leadership Team	Multi-Service Provider Operational Committee	Operational Review Board
Details				
Frequency:	Semi-Annual (Calendar Year)	Quarterly (Calendar Year)	Monthly	Monthly
Molina Participants				
Participant #1:	EVP of Health Plan Services	Molina CIO	Molina Delivery Lead(s)	Molina Delivery Lead(s)
Participant #2:	Molina CIO	Molina IT Core Leadership Team	Molina Commercial Lead(s)	Molina Commercial Lead(s)
Participant #3:	Molina Procurement Lead	Molina Procurement Lead	Delivery Executives for Other Service Providers	VP, Vendor Management
Participant #4:	VP, Vendor Management	VP, Vendor Management		
Participant #5:				
Supplier Participants				
Participant #1:	Service Provider Account Executive	Service Provider Delivery Lead	Service Provider Delivery Lead	Service Provider Delivery Lead
Participant #2:	CIO Service Provider Peer-Level Representative		Service Provider Operational Team Lead(s)	Service Provider Operational Team Lead(s)
Participant #3:			Other Service Provider Personnel as Required	Other Service Provider Personnel as Required
Responsibilities				

	Executive Steering Committee	IT Core Leadership Team	Multi-Service Provider Operational Committee	Operational Review Board
Strategic Alignment	- Provide strategic direction on where the organization is heading - Understand Molina business priorities - Understand how business priorities influence IT priorities - Manage enterprise-level risks, issues, and decisions that impact IT (and vice-versa)	- Discuss business initiatives that could impact the current environment - Own IT Roadmap - Understand business initiatives - Managed cross-IT priorities, risks, issues, and decisions	- Maintain quality of end-to-end service delivery within each Service Tower - Coordinate service integration across the IT ecosystem - Manage cross-supplier dependencies, and tower priorities, risks, issues, and decisions	- Oversee and manage contracted Services to ensure that all the Services are delivered according to contracted Service Provider obligations.
Performance Review	- Review executive summary performance reports; discuss trends - Review critical issues escalated by other governance forums	- Review summary performance reports and Service Levels since the last forum; discuss trends - Review critical issues escalated by other governance forums - Review recommendations for service improvement - Review transition and transformation performance	- Review overall supplier performance and aggregate service level performance - Discuss the overall 30/60/90 days plan	- Discuss any key service tickets or critical issues during the month - Review recommendations regarding service improvement from performance review meetings
Financial Review	- Review relevant summary commercial reports including budgets	- Review financial summary reports (invoice, payment, budget variations, etc.) relative to the IT bucket - Review recommendations from benchmarking activities and other audits when applicable - Review relevant summary commercial reports - Review usage and application of Innovation Fund	- Review the monthly, quarterly and annual forecast, and resource plan - Review performance issues, which have company-wide commercial impact	- Review the monthly, quarterly and annual forecast, and resource plan - Review performance issues, which have company-wide commercial impact - Review the variance to the forecasted / budget expenses - Resolve escalated issues related to invoice payment and service credits / earn backs from regional meetings

	Executive Steering Committee	IT Core Leadership Team	Multi-Service Provider Operational Committee	Operational Review Board
Contract Management	- Approve contract changes escalated from IT Core Leadership Team Review - Optimize benefit Molina is receiving from its supplier relationships	- Approve contract changes escalated from Supplier Operational Review		- Review performance issues, which have company-wide contractual impact - Review recent contract changes or change order, and discuss upcoming contract expirations / terminations
Continuous Improvement of Services	- Set directions for performance improvement - Review the innovation and service optimization ideas - Review progress of optimization and service innovations programs	- Review a summary of continuous improvement plans and programs - Review submissions for performance improvement and set direction - Review the innovation plans	- Sorting out ways to enhance end-to-end delivery in a multi-supplier environment	- Review performance and identifying root causes of any performance issues
Risk Management	- Discuss any audit issues/findings - Provide guidance on significant enterprise risks and interdependencies - Provide final approval for contract exit plans, business continuity plan, disaster recovery and technology refresh plan	- Discuss any audit issues/findings - Provide guidance on significant program risks and interdependencies - Provide final approval for contract exit plans, business continuity plan, disaster recovery and technology refresh plan	- Review issues & risks related to Tower services and project order - Review issues related to attrition of staff and key personnel	- Review issues & risks related to individual services and project order - Review issues related to attrition of staff and key personnel

	Executive Steering Committee	IT Core Leadership Team	Multi-Service Provider Operational Committee	Operational Review Board
Issue & Dispute Resolution	- Provide resolution for issues and disputes that require executive attention	- Resolve any issues escalated by Multi-Service Provider Operational Committee - Authorize closure of open issues that are discussed within this forum	- Escalate the unresolved issues to the IT Core Leadership Team for guidance - Report to the IT Core Leadership Team any significant results / findings related to repetitive SLA breach, recurring contract change orders or scope creep, recurring invoicing issues, customer satisfaction survey results, supplier audit results, and benchmarking results - Manage issues and disputes that arise due to multi-supplier dependencies	- Escalate the unresolved issues to the IT Core Leadership Team for guidance - Report to the IT Core Leadership Team any significant results / findings related to repetitive SLA breach, recurring contract change orders or scope creep, recurring invoicing issues, customer satisfaction survey results, supplier audit results, and benchmarking results

APPENDIX 7-B
REPORTING REQUIREMENTS

APPENDIX 7-B REPORTING REQUIREMENTS

Report Name	Summary of Required Report Data Elements	Effective Date	Reporting Frequency
Resource Attrition	Overall Resourcing statistics for Attrition, and Headcount as it relates to the Service Provider personnel supporting Molina	One (1) month after Statement of Work Effective Date	Quarterly
Asset Inventory	Asset and configuration information including: o Expiring support o Licenses o Maintenance o Certificates o Warranties o Recommendations on course of action needed • Asset changes from previous report • Decommissioned applications • Identification of all third party assets • Forecasted asset changes	One (1) month after Statement of Work Commencement Date	Monthly
Project Management Status	• Schedule • Project Deliverables and Milestones • Issues and risks • Changes • Tasks • Next steps	One (1) month after Statement of Work Commencement Date	Monthly
Monthly Performance Report	As required by Schedule 6 (*Service Levels and Service Credits*)	As required by Schedule 6 (*Service Levels and Service Credits*)	As required by Schedule 6 (*Service Levels and Service Credits*)
Annual Service Level Report	Information required under paragraph 9 (*Annual Review and Continuous Improvement*) of Schedule 6 (*Service Levels and Service Credits*)	One year anniversary of Commencement date of Services	Annually
Project Management Status	• Schedule • Project Deliverables and Milestones • Issues and risks • Changes • Tasks • Next steps • Cost	Commencement date of Services	Weekly
Molina Designated Systems Operations	Reporting daily (live or on demand using monitoring tools) to indicate the performance of Molina designated Systems	Commencement date of Services	Daily, On-Request

Report Name	Summary of Required Report Data Elements	Effective Date	Reporting Frequency
Disaster Recovery Plans	• Updates and changes to Disaster Recovery Plan • Updates and changes to relevant infrastructure • Number of disaster recovery plans per Service in place vs. targets and criticality of Services	Commencement date of Services	Annual
Disaster Recovery Test	• Number of tests performed and the results achieved • A comparison of the results to the measures and goals identified in the Disaster Recovery Plan per Service • A report on the feedback from Molina supplier Management Office as to the adequacy of continuity for their respective areas • A plan and a schedule to remedy any gaps revealed during testing	Commencement date of Services	Annual
Capacity Service Analysis	• Capacity service analysis. Provide plans for peak season volumes. • Reporting on defined key elements of capacity on • Service and resource levels to include: • Resource capacity levels • Service capacity levels • Data center capacity levels • Mid-term and long term trending and capacity forecasts	Commencement date of Services	Monthly
Operational Matrices	• Report on operational metrics as of commencement per the Service Level Matrix	Commencement date of Services	Monthly
Incident Report	Summary report for the reporting period detailing: • Number of Incidents opened • Incident resolution – elapsed time average and maximum • Range, mean, and median time for Incident resolution by service. Include metrics in Daily Dashboard as a MTD total • Major Incident summary Key issues relating to the Incident • Number of Incidents during the month, grouped by severity, service, and appropriate classification • Detailed description, including timing of activities and duration of each Incident • Trend analysis of the Incidents reported during the thirteen (13) most recent months • Knowledge article usage	Commencement date of Services	Monthly

Report Name	Summary of Required Report Data Elements	Effective Date	Reporting Frequency
Problem Report	Summary report for the reporting period displaying: • Key issues relating to Problem • Number of Problems during the month, grouped by severity, service, and appropriate classification • Detailed description, including timing of activities and duration of each Problem • Reduction in Incidents over time • Timely production of Root Cause Analysis • Aging of Problems	Commencement date of Services	Monthly
Change Management Requests	Change management requests, status, estimates for completion, etc. Include metrics in Daily Dashboard as a MTD total.	Commencement date of Services	Monthly, On Request
Security Audit Reports	Security audit reports, to be determined	Commencement date of Services	As required
Security Events Report	Summary report for the reporting period in encrypted format displaying: • Number of events by types of attacks or misuse; • Identified source of attacker and destination	Commencement date of Services	Weekly
Financial Reporting	• Required billing information in format requested • Financial reporting as requested	Commencement date of Services	As required in accordance with the Agreement.
Opportunity Analysis	• Identifying, analyzing, and recommending areas of opportunity for cost savings or business improvement • Suggestions for innovation in IT and business operations	Commencement date of Services	Quarterly
Audit Responses	•Service Provider Certifications •Service Provider Audit Reports	Commencement date of Services	As required in accordance with the Agreement.
Contract Scorecard	•Service Provider results vs Target metrics	Commencement date of Services	Monthly

Lift, Shift and Enhance for End-User Services (EUS): Workflows, including State-Specific Requirements: Workflows for Service Desk and any State-Specific Requirements: Monitoring and Reporting:

Service Provider shall provide customized reports at a frequency as desired by Molina. The format and frequency of reports will be customized to Molina's requirements and will clearly depict a comparison of actual performance against the contracted service levels.

Infosys generates performance reports at three levels:

#	Level	Report Type
1	Agent Level	• Transaction Quality • AHT / Productivity • Escalations

#	Level	Report Type
2	Process Level	• Process quality • Average Speed of Answer (ASA) percentage • Abandoned Call Rate percentage • First Contact Resolution percentage • Same Day Resolution percentage • Ticket Resolution time percentage • At First Level resolution percentage • Mean Time to Resolve (MTTR) • Response Time (P1, P2, P3, P4) • Resolution Time (P1, P2, P3, P4) • Backlog (P1, P2, P3, P4) • Case Chase/ Follow-up/ Update (P1, P2, P3, P4) • Customer satisfaction score • Sentiment Analysis • Customer complaints • Production hours • Process AHT • Attrition • Capacity plans/ Seat utilization calibration

#	Level	Report Type
3	Organization Level	• Service levels • Hierarchical Escalation • Attrition Reports • C-SAT Reports

These reports will be referenced during performance feedback sessions and will be utilized by Service Provider and Molina to map improvements and set targets.

Lift, Shift and Enhance for End-User Services (EUS): Fundamentals for Transformation: Security Operations: Security Operations Model: Reporting Requirements:

SOC team will create daily/weekly/monthly reports and share the update with Molina team. The reports that will be shared with Molina are as follows

Area	Frequency	Target Stakeholders	Report Example
Operational Reporting	Weekly	Infra leads, App Leads, SOC Manager/team, CSIRT team	• Total alerts, true positive alerts with incidence severity, status of alerts (open/closed) • Correlation rules Alerts, incidents, cases and event reports

Area	Frequency	Target Stakeholders	Report Example
Trend Reporting	Monthly	SOC Manager, IT Managers	• Administrative changes Trends • Point solutions like AV, IPS, FW trends • Traffic Trends (services, ports, users) • Vulnerabilities and Threats • SLAs
Executive Reporting	Monthly, Quarterly	Program Manager, CISO, SOC Manager	• Attack categories and distribution • Incidents summary and remediation trends • Risk and compliance status overview • Service performance and enhancements (if any) • SLAs
Incident and Service Status reporting	Daily, Weekly	SOC Manager	• Incidents by Priority • Incident by Stages • Incidents by Age • Incident Trend by Priority • SLA Compliance/breaches • Average Incident response time by priority • Ad-Hoc Report delivery

Area	Frequency	Target Stakeholders	Report Example
Compliance Reports	On-Demand	Compliance Auditors	• Access and Change Validation • Administrative Activities
Ad-Hoc report	On-Demand	Need basis	• Any available report
Incident Alerts	As per notification and escalation matrix	SOC Manager, Concerned Stakeholders	• Correlated Rules Alerts • Manual Analysis Alerts • Reporting Analysis

Below are few sample reports that Infosys uses.

[Redacted]

Illustrative SOC Reports

[Redacted]

Illustrative Dashboards

[Redacted]

Lift, Shift and Enhance for End-User Services (EUS): Engagement Level Security and Security Operations: Security Operations: Scope of Work: Reporting:

Service Provider's SOC team will create daily/weekly/monthly reports and share the update with Molina team. The reports that will be shared with Molina are as follows:

Area	Frequency	Target Stakeholders	Report Example
Incident and Service Status reporting	Daily, Weekly	Infra leads, App Leads, SOC Manager/team, CSIRT team	▪ Total alerts, true positive alerts ▪ Incidents by Priority ▪ Incident by Stages ▪ Incidents by Age ▪ Incident Trend by Priority ▪ Average Incident response time by priority ▪ Ad-Hoc Report delivery ▪ Correlation rules Alerts, incidents, cases and event reports

Area	Frequency	Target Stakeholders	Report Example
Trend Reporting	Monthly	SOC Manager, IT Managers	▪ Administrative changes Trends ▪ Point solutions like AV, IPS, FW trends ▪ Traffic Trends (services, ports, users) ▪ Vulnerabilities and Threats ▪ SLA reporting
Executive Reporting	Monthly, Quarterly	Program Manager, CISO, SOC Manager	▪ Attack categories and distribution ▪ Incidents summary and remediation trends ▪ Risk and compliance status overview ▪ Service performance and enhancements (if any) ▪ SLAs
Compliance Reports	On-Demand	Compliance Auditors	▪ Based on on-demand requirements
Ad-Hoc report	On-Demand	Need basis	▪ Based on on-demand requirements

Lift, Shift and Enhance for End-User Services (EUS): Engagement Level Security and Security Operations: Security Operations: Identity and Access Management: Reporting:

Following table provides list of reports / KPIs that Service Provider shall provider for identity and access management support:

#	Report Parameter / KPI	Description / Action Item
1	Availability	Ensure availability of IAM systems and provide weekly / monthly report for the same in addition to live availability status (live availability is dependent on available monitoring systems)
2	Incident Count / Service Requests vs. Status	Adhere to SLAs
3	Top 10 IAM Incident Categories vs. Volume	With process optimization or automation, show decrease in incident numbers in same category
4	SOX Reports	Convert Ad-hoc / manual report generation into automated report generation over time for SOX queries
5	Audit Reports	Convert manual audit report generation into automated report generation over time
6	Operations Reports	Automate report generation for operational efficiency such as for data discrepancy over time
7	Usage Reports	Provide reports on usage of identity and access management system, password reset, progress of access certification cycle, etc. and monitor performance of environment vs. available capacity
8	Privilege Usage Reports	Provide reports for privilege access usage through available tools (Bomgar PAM and available analytics system)
9	Weekly / Monthly Trend Reports	Provide weekly / monthly trends for incidents, problems, service requests, availability, usage, etc.
10	Dashboard	Provide dashboard summarizing no of active users, key activities, key automation activities, etc. in addition to weekly / monthly trends

SCHEDULE 8

TERMINATION ASSISTANCE AND EXIT

CONTENTS

1. DEFINITIONS

1.1 Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) of this Agreement.

1.2 The express reference in this Schedule to both Molina (or a Molina Company) and a Successor Supplier is for convenience only, and does not affect the interpretation of any other reference to a Successor Supplier.

2. INTRODUCTION

2.1 This Schedule describes the responsibilities of both Parties in relation to the termination (in whole or in part) or expiry of this Agreement or the termination of one or more Services, including the obligations of the Service Provider to provide assistance, information and cooperation, and establishes the means by which the Service Provider will be remunerated for providing Termination Assistance.

2.2 Where in this Schedule or in an Exit Plan, Molina is given a right, that right shall also be given to each Successor Supplier (but only to be exercised for the benefit of Molina) and both Molina and the Successor Supplier shall be entitled to exercise that right (but, in the case of the Successor Supplier, that right shall only be exercised for the benefit of Molina). Only Molina may enforce any such rights, and may also do so on behalf of any Successor Supplier.

2.3 Where in this Schedule or in an Exit Plan, Molina has an obligation to fulfil, that obligation may be fulfilled by either Molina or a Successor Supplier, and fulfilment of an obligation by a Successor Supplier shall discharge Molina's obligation. The Service Provider shall have no cause of action against any Successor Supplier for any failure of Molina or the Successor Supplier to meet any obligations set out in this Schedule or in the Exit Plan. Molina shall at all times be responsible to the Service Provider for fulfilling the obligations of Molina and any Successor Supplier under this Schedule or in an Exit Plan.

2.4 No Successor Supplier shall have any cause of action against the Service Provider for any failure of the Service Provider to meet any obligations set out in this Schedule or in an Exit Plan (and Molina agrees to procure the same). The Service Provider shall at all times be responsible to Molina for fulfilling its obligations under this Schedule and each Exit Plan.

2.5 The Service Provider and Molina shall perform their respective obligations under this Schedule in accordance with any applicable Exit Plan.

2.6 Where there is a full or partial termination of the Run Services, the Service Provider's obligations to provide the Project Services pursuant to any Project Work Order shall be unaffected unless Molina separately terminates any relevant Project Work Order.

3. EXIT PERIOD

3.1 This Schedule:

(a) sets out a framework governance process to be adopted and applied during any Exit Period; and

(b) provides that it is the Service Provider's responsibility to prepare and maintain the Exit Plan and describes the process to be applied in preparing and maintaining the Exit Plan.

3.2 The Service Provider must provide Molina with Termination Assistance during each Exit Period in accordance with the terms of this Schedule and the Exit Plans applicable to the Terminating Services.

3.3 The Exit Plan may be used more than once, as there may be more than one Exit Period. The Exit Plan may also be used over a single Exit Period to phase out Services in multiple stages over time.

3.4 There shall be a period (each, an "**Exit Period**") in respect of:

(a) the termination of this Agreement by either Party (for whatever reason);

(b) each partial termination of this Agreement, including the termination of one or more of the Services; and

(c) the expiry of the Term.

3.5 Each Exit Period shall commence in accordance with paragraph 3.6 and shall continue until the responsibility for delivering the Terminating Services has transferred to the Successor Supplier or Successor Suppliers in accordance with the terms of this Schedule and the Exit Plan.

3.6 An Exit Period shall commence on each of the following dates:

(a) the date on which either Party gives notice of termination of this Agreement (including partial termination of this Agreement by Molina); and

(b) the date falling nine (9) months prior to the then-current Expiry Date.

3.7 Subject to paragraphs 3.8 to 3.11, the duration of each Exit Period shall be of such duration as may be agreed in the Exit Plan. The Exit Plan shall provide for an Exit Period of sufficient duration to transfer responsibility for the Terminating Services to the Successor Supplier or Successor Suppliers.

3.8 Molina may, in its sole discretion, extend any Exit Period one or more times by giving not less than thirty (30) days' written notice to the Service Provider, as may be necessary in order to ensure a smooth, efficient and minimum-risk Transfer. Subject to paragraph 3.10, the aggregate duration of an Exit Period, including all extensions, under this paragraph 3.8 shall not exceed twenty-four (24) months unless the parties mutually agree otherwise in writing.

3.9 Molina may, in its sole discretion, shorten any Exit Period by giving written notice to the Service Provider specifying the earlier date on which the Exit Period will end, provided that such notice must be given no later than thirty (30) days before the date specified by Molina and in the event of expiry of the Term cannot take effect sooner than the end of the then-current Term.

3.10 The Exit Period shall be extended if (a) the Service Provider fails to achieve any Milestone, Delivery Date or other time-related obligation set out in the Exit Plan and (b) Molina has provided prior written notice to Service Provider of such failure. The length of the extension to the Exit Period shall be equivalent in Business Days to the delays caused by the Service Provider.

3.11 An Exit Period commencing under paragraph 3.6(b) shall end automatically if Molina subsequently issues a Renewal Notice under Clause 4 (*Extension of the Term*) and the Parties agree that there shall be an Extended Term; in such event, Molina will be responsible for the Service Provider's reasonable out-of-pocket expenses, incurred at the time the Renewal Notice is issued, in relation to such Exit Period at the time of the Renewal Notice.

3.12 The provisions of this Agreement (including without limitation the Service Provider's obligation to provide the Services and Molina's obligation to pay the Charges (including Termination Assistance Charges)) shall remain in full force during each Exit Period, subject to the Exit Plan.

4. QUALITY OF TRANSFER

4.1 The Service Provider shall provide the Termination Assistance in accordance with the terms of this Schedule.

4.2 The Service Provider shall perform its obligations under this Schedule in such a way as to:

(a) facilitate a smooth and orderly Transfer; and

(b) minimize disruption and cause no material impact to any Services or to Molina's business or operations (other than scheduled downtime and ramp-down of Services provided for in the Exit Plan).

4.3 The Service Provider shall reasonably cooperate with each Successor Supplier and Molina shall procure that each Successor Supplier shall reasonably cooperate with the Service Provider.

4.4 The Service Provider shall continue to perform the Services up to the end of each Exit Period in accordance with this Agreement, including the Service Levels, except to the extent that an agreed Exit Plan expressly provides to the contrary.

4.5 The Parties acknowledge that this Schedule and any Exit Plan cannot and do not include all of Molina's and the Successor Suppliers' specific requirements related to a Transfer. Accordingly, during an Exit Period, the Service Provider shall, in addition to performing the obligations expressly set out in this Schedule and in the Exit Plan, provide such assistance as is necessary or ancillary to the performance of those obligations, in relation to the Services or the Termination Assistance.

4.6 During an Exit Period, the Service Provider shall provide Molina and each Successor Supplier, as necessary, with reasonable access to the locations from which it delivers the Services, provided:

(a) any such access does not interfere with the Service Provider's ability to provide the Services or Termination Assistance;

(b) in the case of access by a Successor Supplier, the Successor Supplier complies with the Service Provider's reasonable security requirements; and

(c) in the case of access by a Successor Supplier, Molina has procured the execution of an Agreed Form NDA by the Successor Supplier.

5. TERMINATION ASSISTANCE

5.1 Termination Assistance to be provided by the Service Provider shall include all those matters set out in the Exit Plan and the following obligations:

(a) notifying Subcontractors of procedures to be followed during the Transfer process;

(b) providing assistance and expertise as necessary to identify all material operational and business processes provided specifically for Molina and used by the Service Provider or any Subcontractor in providing the relevant Services, which may include, at Molina's reasonable request, the presentation of such processes to Molina, the Successor Suppliers and other designees;

(c) providing and coordinating assistance to Molina in notifying the relevant members of Service Provider Personnel of the procedures to be followed during the Transfer process;

(d) providing details of work volumes and staffing requirements over the preceding twelve (12) months;

(e) providing a listing of the Service Provider Personnel engaged in the delivery of the Services, in sufficient detail to determine their applicability to the Transfer process and ongoing operation and support of the Replacement Services;

(f) providing Molina with reasonable access to Service Provider Personnel performing (or who were performing) the Services and to a Service Provider representative familiar with the provision of the Services in order that these Service Provider Personnel will answer Molina's questions;

(g) providing Molina with copies of all documented operations, procedures and tools that are used or followed by the Service Provider in performing the Services;

(h) providing to Molina the plans and status of current and pending projects and other work in progress and all other information required for continuity during the Exit Period to minimize the disruption to the Services and Molina's business;

(i) providing for the orderly hand-off of ongoing projects and other work in progress as may be requested by Molina;

(j) providing key support contact details for Subcontractor personnel under contracts which are agreed to be assigned or novated to Molina under paragraph 12;

(k) providing assistance and expertise as reasonably necessary to examine all governance arrangements and reports in place for the provision of the Services;

(l) assisting in the execution of a parallel operation involving certain Services being provided by the Service Provider, Molina and the Successor Suppliers until the end of the Exit Period; and

(m) providing any further assistance requested by Molina with a view to allowing the Services to continue with minimal interruption or without material adverse effect following the termination or expiry of this Agreement and with a view to facilitating the orderly transfer of responsibility for and conduct of the Services to Molina or its Successor Supplier.

5.2 The first activities that the Service Provider must complete as part of the first phase of the Exit Plan shall include the preparation of a risk matrix highlighting all of the anticipated risk elements associated with the Transfer and in particular those areas where particular focus and attention is required. The Service Provider must include appropriate mitigating factors to help manage that risk. The Exit Plan must be modified and enhanced by the Service Provider to address all risks identified, and in particular must reflect all of the mitigating factors identified.

6. LIABILITY AND LEGAL PROCESS

6.1 If during any Exit Period:

(a) the Service Provider fails or unreasonably refuses to provide to Molina (within a required time period) any information is material in the context of the assistance that the Service Provider is reasonably required to provide (whether expressly under this Agreement or in any Exit Plan or in order to meet an obligation set out in this Agreement or in any Exit Plan); and

(b) such failure or refusal remains uncured for ten (10) days following receipt of written notice of such failure or refusal,

then the failure or refusal shall be treated as a material breach of this Agreement by the Service Provider.

6.2 If the Service Provider is in material breach of this Agreement by virtue of operation of this paragraph 6, Molina shall be afforded the following remedies in addition to its other remedies under this Agreement and at law:

(a) Molina may, in its sole discretion, elect to commence a new Exit Period;

(b) if the Agreement was not terminated for cause, Molina may then elect to treat the Agreement as if it were terminated for cause; and

(c) Molina may publicize the material breach to the Successor Suppliers with full details of that breach to explain any consequential delays and impact on the Transfer.

7. EXIT PLANS

7.1 With effect from the Effective Date, the Parties shall comply with the obligations set out in the Exit Plan, as amended from time to time in accordance with this Schedule.

7.2 The Service Provider shall make available to Molina, on the Contract Management Portal or such other location as may be agreed between the Parties, an Exit Plan within three (3) months of the Effective Date, to reflect the state of the Services after Transition. If the Service Provider does not produce an Exit Plan within the time period stipulated in this paragraph 7.2, Molina

may elect, at its cost, to produce an Exit Plan and the Service Provider shall provide reasonable assistance in the preparation of such Exit Plan.

7.3 Amendments to the Exit Plan that in any way change the substance of either Party's obligations shall not bind the Parties unless agreed pursuant to the Change Control Process.

7.4 The Service Provider shall keep the Exit Plan up to date and ensure that it reflects all changes to the Services and means of delivering the Services. The Service Provider shall maintain the Exit Plan so that it is sufficiently flexible to enable the partial termination of the Services.

7.5 The Service Provider shall conduct a thorough review of the latest Exit Plan at least annually and shall make available to the Operational Review Board an up to date version of the latest Exit Plan, together with a written statement of currency, confirming the Exit Plan is up to date, within sixty (60) days of this annual review. The Service Provider shall include all information required in the Exit Plan in the Contract Management Portal (or such other location as may be agreed between the Parties), and that the Exit Plan is capable of implementation in accordance with this Agreement. In support of the annual review, the Service Provider shall provide anonymized and where necessary redacted examples of exit plans that it has implemented to the extent such plans are available to demonstrate to Molina that the Exit Plan is fit for purpose and in line with current best practice deployed within the Service Provider.

7.6 Amendments to the Exit Plan that are made pursuant to paragraphs 7.4 and 7.5 need not be made pursuant to the Change Control Process.

7.7 The Service Provider shall ensure that the Service Provider is, at all times, able to commence the various processes described within the Exit Plan within seven (7) days.

7.8 The Exit Plan and its annual review shall at all times be available to Molina to view and print on the Contract Management Portal (or such other location as may be agreed between the Parties).

7.9 If the terms of the Exit Plan are incomplete, unclear or ambiguous, then they are to be interpreted and construed by reference to this Schedule.

7.10 The Exit Plan must at all times contain a description of the Services, focusing in particular on any cases where the Services as delivered may differ from the description of those Services in this Agreement.

7.11 The Exit Plan must clearly identify the dependencies on a Successor Supplier, and if any information or assistance is required from Molina the Exit Plan must clearly state what that information or assistance is and when it is required and what activity of the Service Provider is dependent on that information or assistance.

8. TERMINATION ASSISTANCE CHARGES

8.1 Molina shall pay for Termination Assistance as if those Services were Project Services and the Exit Plan were a Fixed Price Project Work Order. The Charges shall be as set out in the Exit Plan and Schedule 3 (*Pricing and Invoicing*).

8.2 Where the Service Provider has terminated this Agreement in accordance with Clauses 51.3 or 51.4 then Molina shall pay the Charges for Termination Assistance monthly in advance.

8.3 If any of the activities required in this Schedule can be performed by BAU Personnel without impacting the Services or are included within another obligation in this Agreement (that is not specifically expressed to be separately chargeable) then they shall be performed and charged for as part of the Base Charges.

8.4 If there are no specific fees, charges or expenses identified within this Schedule for a particular activity which the Service Provider is required to perform as part of the Termination Assistance, then the Charges for Termination Assistance already incorporate a fee, charge or expense for that activity. The absence of a specific fee, charge or expenses for a particular activity does not mean that, and should not be used to support any argument that, the particular activity does not form part of the Termination Assistance.

9. EXIT MANAGEMENT

9.1 The Service Provider shall identify one Key Person (the "**Exit Manager**") who shall, subject to approval by Molina, be dedicated to the management of Termination Assistance. The Exit Manager must have experience in managing the transition of services from one provider to another of similar scale and complexity.

9.2 The name of the Exit Manager shall be included within each Exit Plan and updated regularly.

9.3 If the Exit Manager does not become a Molina employee as may be required pursuant to Applicable Law, the Service Provider shall make the Exit Manager available to provide consulting services until the date falling six (6) months after the end of the Exit Period, and the Charges for such individual shall be determined in accordance with the Resource Rates or as otherwise agreed between the Parties.

9.4 The Service Provider shall ensure that a dedicated team is assigned to the Transfer over and above any 'business as usual' resources deployed. All members of the dedicated team assigned to the Transfer shall have experience in transitioning services from one supplier to another of a similar scale and complexity. The Charges for such team shall be determined in accordance with the Resource Rates or as otherwise agreed between the Parties. The CVs of the Exit Manager and each member of the dedicated team shall be appended to the Exit Plan.

10. EMPLOYMENT PROVISIONS

The exit-related provisions set out in Schedule 15 (*HR Matters and Key Personnel*) shall apply. Any employment-related provisions in this Schedule or in the Exit Plan shall operate independently of the obligations in Schedule 15 (*HR Matters and Key Personnel*) and the Parties shall meet their respective obligations set out in Schedule 15 (*HR Matters and Key Personnel*).

10.1 The operational requirements for transferring Assets to the Successor Suppliers shall be contained in an Exit Plan. It shall be the Service Provider's responsibility to ensure that all Assets owned by Molina and all Dedicated Equipment purchased by each Successor Supplier are safely shipped to the destination of Molina's or the Successor Supplier's choosing at Molina's request and at Molina's expense.

10.2 During the Exit Period, the Service Provider shall, offer to sell each individual item of Dedicated Equipment (such sale to be effective at the date that responsibility for providing the Replacement Services that requires the Dedicated Equipment transfers to a Successor Supplier). The offer shall be made, in respect of each item of Dedicated Equipment, to Molina or to such Successor Supplier as Molina may nominate. Molina (on its own behalf or on behalf of a nominated Successor Supplier) and each nominated Successor Supplier may, in its sole discretion, elect to accept the Service Provider's offer in respect of any or all of the Dedicated Equipment, and shall have no liability for failing to accept the offer in respect of any or all of the Dedicated Equipment.

10.3 The purchase price for each item of Dedicated Equipment that Molina or a Successor Supplier agrees to purchase shall be the fair market value.

10.4 During the Exit Period, the Service Provider may not delay or condition the provision of any Assets required in order to provide the Services (other than as expressly permitted in this Agreement) and in particular may not refuse to provide any Asset unless the Successor Supplier makes an election to purchase that Asset (whether Dedicated Equipment or not).

10.5 Molina may acquire Dedicated Equipment on the terms set out in a Project Work Order or in a Change Notice.

10.6 During the Exit Period, the Service Provider shall not sell, Refresh, upgrade or replace any Dedicated Equipment without obtaining Molina's written approval, other than in cases of (i) emergency replacement or repair where to do otherwise would impact on the delivery of the Services, or (ii) where otherwise set out as an obligation under the Agreement.

11. THIRD PARTY CONTRACTS

11.1 Each Exit Plan shall always contain provisions that require the Service Provider to:

(a) with respect to Third Party contracts that the Service Provider or any Subcontractor has entered into relating exclusively to the Services (including software licenses and other licenses of Intellectual Property Rights), transfer to Molina or a Successor Supplier (whether by assignment or novation), on the expiry or earlier termination (in whole or in part) of this Agreement, at no charge (other than on-going charges as consideration for the services or goods provided under those contracts), such of those Third Party contracts as Molina may request to be transferred; provided, however, that if a Third Party contract contains terms making transfer conditional on the payment of any additional charges, then those charges shall be allocated between the Parties in such proportions as they mutually agree;

(b) with respect to all other Third Party contracts:

(i) use all reasonable efforts to obtain the commitment of such Third Party vendor(s) to allow the Service Provider to transfer to Molina or a Successor Supplier (whether by assignment or novation), at no charge (other than on-going charges as consideration for the services or goods provided under those contracts), such of those Third Party contract(s) as Molina may request to be transferred;

(ii) use all reasonable efforts to exercise that right of transfer under each such Third Party contract that Molina has requested to be transferred and in respect of which the Service Provider obtains that commitment from the Third Party vendor(s); and

(iii) if the Service Provider is unable to obtain that commitment from the Third Party in connection with a contract that is needed for the continued performance of Replacement Services:

(A) notify Molina and provide Molina non-confidential information related to the Third Party's refusal to consent to the transfer; and

(B) propose a work-around solution, if feasible, that will enable the Successor Supplier to take the benefit of the services under the relevant contracts; and

(c) exercise its rights of transfer referred to in Clause 63.5(b) of the Agreement as requested by Molina.

11.2 To ensure that the Service Provider is able to comply with the transfer requirements set out in paragraph 12.1(a) above, the Service Provider shall use commercially reasonable efforts to include in each such Third Party contract a provision stating that such contract can be transferred to a Successor Supplier at no charge (apart from any ongoing charges payable under the Third Party contract as consideration for the services or goods provided under that contract) on the expiry or earlier termination (in whole or in part) of this Agreement.

11.3 With respect to the contracts covered by paragraph 12.1(a), the Service Provider shall use commercially reasonable efforts to procure that all such Third Party contracts include a right to extend or renew the term of those contracts for at least a further period of two (2) years, exercisable by Molina at the time of the transfer to Molina.

11.4 The Service Provider shall ensure that the Exit Plan contains at all times a complete list of the contracts entered into by any Service Provider Company for the performance of the Services, and that all such contracts are contained in the Contract Management Portal on:

(a) each and every date that the Exit Plan is first prepared and thereafter updated in accordance with paragraph 7; and

(b) the first day of the Exit Period and each day thereafter during the Exit Period.

12. INFORMATION

12.1 The Service Provider shall, at Molina's request:

(a) provide to Molina and/or any Successor Supplier; and

(b) maintain on the Contract Management Portal,

a full and up-to-date copy of the information required under the Exit Plan.

12.2 The Service Provider shall ensure that the Exit Plan shall contain a standard set of information requirements that must be provided by the Service Provider during the Exit Period to a Successor Supplier that will enable the Successor Supplier to fully understand how the Services are provided by the Service Provider.

12.3 The Service Provider shall update the information in the Contract Management Portal regularly during the Exit Period.

12.4 Molina shall be entitled to give potential Successor Suppliers access to copies of the information on the Contract Management Portal as part of any tender process and as part of any knowledge transfer process; provided, however, that Molina shall not give potential Successor Suppliers access to any of the following information:

(a) the Resource Rates;

(b) the Project Rates;

(c) descriptions of the Service Provider's technical architecture that are separate from descriptions of the Services or the technical architecture of Systems that are provided to, or for the benefit of, Molina as part of the Services;

(d) descriptions of the Service Provider's security policies that are separate from descriptions of the Services or the technical architecture of Systems that are provided to, or for the benefit of, Molina as part of the Services;

(e) whether the Service Provider achieved or missed any Service Levels (though actual Service performance may be shared by Molina);

(f) audit findings provided by the Service Provider to Molina in connection with the Services (except to the extent such findings relate to a security risk which the applicable Successor Supplier is being engaged by Molina to address); and

(g) except as contemplated in this Schedule (e.g., job shadowing and knowledge transfer in accordance with this Schedule), the names of Service Provider Personnel other than Subcontractors.

13. KNOWLEDGE TRANSFER

13.1 The Service Provider will transfer all Molina-related training materials to Molina and/or the Successor Supplier.

13.2 To facilitate the transfer of knowledge from the Service Provider to Molina or its Successor Supplier in order to enable Molina or the Successor Supplier to provide (and/or, in the case of Molina, receive) Replacement Services, the Service Provider shall explain to Molina and/or its Successor Supplier, in writing and by way of presentations, the operations, procedures and tools used to provide the Services, the Change Control Process and other standards and procedures.

13.3 This knowledge transfer may include Molina personnel shadowing Service Provider Personnel, and, if agreed between the parties, being seconded to the Service Provider, to facilitate the transfer of knowledge from the Service Provider to Molina or any Successor Supplier.

13.4 Subject to paragraph 14.5, the Service Provider shall:

(a) provide for transfer of knowledge required for the provision of the Services which may, as appropriate, include confidential information, records and documents including those referred to in the Exit Plan and all other relevant information, data, IPR or records in the Service Provider's and Subcontractors' possession or control

required by Molina or its Successor Supplier to provide the Replacement Services; and

(b) answer all reasonable questions from Molina or its Successor Supplier regarding the Services during the Exit Period.

13.5 Subject to Clause 29 of the Agreement (*Intellectual Property Rights*), paragraph 14.4 does not require the Service Provider to transfer or otherwise make available to Molina or to a Successor Supplier any:

(a) Service Provider IP that is not included or embedded in a Deliverable, and to which Molina would not have had access during the Term, provided that this exception shall not apply if it would prevent Molina or a Successor Supplier from being able to use any Molina Data; or

(b) Service Provider Commercially Sensitive Information.

14. FURTHER TENDERS

14.1 The Service Provider shall, at Molina's request, reasonably assist and cooperate with Molina and with any potential Successor Supplier prior to its appointment as a Successor Supplier, in any tender process conducted for the provision of all or part of the Terminating Services.

14.2 The Service Provider shall, at Molina's request, provide to Molina all copies of any information and data in the Service Provider's possession concerning Molina's business and technical requirements for the Run Services and the Project Services.

15. PROJECT WORK ORDER TERMINATION ASSISTANCE

15.1 If either Party gives notice to terminate a Project Work Order (for any reason), the Service Provider shall, as requested by Molina:

(a) provide reasonable knowledge transfer associated with the Deliverables, undertaken through co-working, show and tell or otherwise, by Service Provider Personnel co-located with the 'take-on' staff on Molina, Service Provider or Successor Supplier premises (as required by Molina);

(b) either as part of knowledge transfer or otherwise, provide training in the use of the Deliverables and any other Software required to be provided under the Project Work Order (including tools);

(c) for all licensed Software (Third Party or Servicer Provider Software), determine what is used, the identities of the licensor and licensee, and where the physical or electronic license copies are located;

(d) hand over Molina-owned licenses and provide other licenses necessary for Molina to use the Deliverables;

(e) where Deliverables were to have been provided in a language other than that in which they exist at the time of termination, complete any outstanding translation activities forming part of the terminated Project Work Order;

(f) physically transfer Deliverables to Molina environments, in a location determined by Molina;

(g) provide any and all Source Code that is associated with the Deliverables and required to be provided under this Agreement;

(h) migrate Source Code libraries into a Molina Source Code configuration control tool;

(i) hand over test data and stubs/harnesses specifically developed for the Deliverables; and

(j) support any verification activities for the above and correction of any outstanding issues.

SCHEDULE 9

CHANGE

CONTENTS

PART A GENERAL

1. Definitions

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) of this Agreement.

2. **Introduction**

2.1 Part A of this Schedule deals with changes to the Service Provider Technical Solution, changes to Policies, Regulatory Changes and the consequences of Molina's failure to perform its obligations under this Agreement.

2.2 Part B of this Schedule defines the processes for introducing and approving Agreement Changes.

2.3 Any decision or agreement resulting from the processes set out in this Schedule shall not be binding on the Parties unless:

(a) approved in accordance with the relevant level of authority set out in Schedule 7 (*Governance*); or

(b) where Schedule 7 (*Governance*) does not stipulate a relevant level of authority for any change, approved by duly authorized representatives of the Parties named in each draft Change Request.

2.4 Part C of this Schedule defines the processes for introducing and approving Charge Adjustments and one-off fees that arise in connection with an Agreement Change.

2.5 Part D of this Schedule sets out the procedure for resolving Change Disputes and Disputed Proposed Charges that arise in relation to the content of this Schedule.

3. **The Service Provider Technical Solution**

3.1 The Service Provider may change the Service Provider Technical Solution except as set out in this Schedule.

3.2 If the Parties expressly agree as part of any Agreement Change that the functionality provided by the Service Provider's solution may differ in any material respect from that described by the Service Provider Technical Solution, then the Parties shall record such agreement in a written addendum to the Service Provider Technical Solution and the Service Provider shall upload that addendum to the Contract Management Portal in the same section as the Service Provider Technical Solution.

3.3 Any change (a) to the functionality provided by the Service Provider Technical Solution or (b) to any aspect of the Service Provider Technical Solution which the Service Provider is not permitted to change unilaterally (as set out in paragraph 3.1), as applicable, shall not be effective unless and until an addendum is executed by authorized representatives of the Parties. Each such addendum must be uploaded to the Contract Management Portal within two (2) Business Days of being executed.

4. **Changes to Policies**

4.1 Molina may amend the Policies at any time without following the Agreement Change procedure as set out in Part B of this Schedule. Molina may not amend a Policy to deliberately single out or discriminate against the Service Provider.

4.2 A Policy Change is not an Agreement Change but may result in formal requests by either Party for an Agreement Change.

4.3 Molina shall notify the Service Provider in writing (which may be an e-mail notification) of each Policy Change ("**Policy Change Notice**"). Unless Molina specifies otherwise, the date on which the Policy Change shall become effective ("**Policy Change Effective Date**") shall be ten (10) Business Days from the date of the Policy Change Notice.

4.4 In circumstances where Molina specifies a Policy Change Effective Date under paragraph 4.3, Molina shall ensure that it gives the Service Provider reasonable time to comply with the Policy Change, taking into account the complexity of the Policy Change. The Service Provider acknowledges that in cases where the Policy Change is required by Applicable Law or by any Regulatory Authority, Molina may only allow the Service Provider as much time to implement the Policy Change as Applicable Law or the Regulatory Authority permits. Molina shall, at the Service Provider's request, discuss the Policy Change with the Service Provider.

4.5 The Service Provider shall comply with each Policy Change from the Policy Change Effective Date.

4.6 The Service Provider may, within ten (10) Business Days after the date of the Policy Change Notice (or within such other period as the Parties may agree in writing), issue a Change Request if it believes that a Policy Change requires a Charge Adjustment or the imposition of a one-off fee or a combination of both. In that case, paragraph 12.3(a) of this Schedule shall apply to the Policy Change, and any Charge Adjustment or one-off fee shall be processed and documented in the same manner as an Agreement Change.

4.7 Molina may make a Change Request if it believes that the Policy Change should result in an overall reduction in the Charges to Molina.

4.8 If either Party makes a request pursuant to paragraph 4.6 or 4.7, the Service Provider shall comply with the Policy Change immediately but any Charge Adjustment relating to the Policy

Change shall be processed and documented in the same manner as an Agreement Change in accordance with the principles in Part C of this Schedule.

5. **Regulatory Change**

5.1 A Regulatory Change may require an Agreement Change.

5.2 Either Party shall notify the other as soon as reasonably practicable after becoming aware of a Regulatory Change that could have an impact on the provision of the Services under this Agreement or any Project Work Order or impact either Party in meeting any of its obligations under this Agreement or any Project Work Order, together with the date on which that Regulatory Change will become effective ("**Regulatory Change Effective Date**").

5.3 The Service Provider shall comply with each Regulatory Change from the Regulatory Change Effective Date.

5.4 Except as provided in paragraph 12.2, there shall be no Charge Adjustment or one-off fees imposed on Molina in relation to a Regulatory Change or any Agreement Change resulting from a Regulatory Change.

PART B AGREEMENT CHANGE

6. Agreement Change

6.1 All Agreement Changes shall be made in accordance with the process set out in this Schedule.

6.2 An Agreement Change may be initiated by those persons authorized by Molina or by the Service Provider to do so from time to time, by issuing a written request to the other Party. A request to make an MSA Change shall be referred to as an "**MSA Change Request**" and a request to make a Project Change shall be referred to as a "**Project Change Request**", together being "**Change Requests**".

6.3 All Change Requests shall be submitted in such form as is specified by Molina from time to time. As at the Contract Effective Date, the format for:

(a) an MSA Change Request is as set out in Appendix 9A to this Schedule; and

(b) a Project Change Request is set as out in Appendix 9B to this Schedule, and shall attach a draft conformed copy of the Project Work Order, updated to include the changes proposed under the draft Project Change Request and all prior Agreement Changes affecting that PWO.

6.4 The Service Provider shall not take any action to implement the terms of a Change Request until the Parties have executed a Change Notice following the process set out in the remainder of this Schedule.

6.5 Molina shall only be liable to pay for costs or expenditure incurred by the Service Provider in taking any action to implement the terms of a Change Request, or for any proposed Charge Adjustment or one-off fees proposed in a Change Request, when the Change Request has been signed by Molina or otherwise determined in accordance with paragraphs 13.4 and 13.5.

7. MSA Change

7.1 Response to requests for MSA Change

(a) Following issuance of an MSA Change Request by either Party, the Service Provider shall provide Molina with an impact assessment for the proposed MSA Change, within the time period set out by the relevant Governance Body charged with the responsibility for the particular Change as set out in Schedule 7 (*Governance*) ("**relevant Governance Body**"), or, in the absence of any time period set out by the relevant Governance Body, within five (5) Business Days.

(b) All impact assessments submitted shall be reviewed by the relevant Governance Body, and during those reviews the Service Provider must:

(i) acting reasonably share any relevant experience it may have in relation to changes similar to the particular MSA Change in question, provided sharing that information would not require the Service Provider to breach any obligations of confidentiality that it owes to a third party;

(ii) discuss the impact assessment at the meeting of the relevant Governance Body;

(iii) outline any particular requirements and information that it will need in order to prepare a detailed Change Notice and the time that the Service Provider requires to prepare a Change Notice;

(iv) provide Molina with an indicative timetable within which the MSA Change could be implemented;

(v) give an explanation of its estimate of the net effect on the Charges and any required one-off fee;

(vi) identify any impact the Service Provider believes the proposed MSA Change may have on the services provided or Systems supported by any Other Service Provider, and any corresponding changes to any such services or Systems the Service Provider believes may be necessary or desirable if the proposed MSA Change is made; and

(vii) inform Molina if the Service Provider is unable to implement the MSA Change because one of the reasons in paragraph 11.1 applies and an explanation as to why one of those reasons applies.

(c) Discussions under paragraph 7.1(b) must be held within the time period set out by the relevant Governance Body, or, in the absence of any time period set out by the relevant Governance Body, within ten (10) Business Days of Molina either receiving an MSA Change Request issued by the Service Provider or issuing an MSA Change Request to the Service Provider and such discussions must result either in:

(i) agreement by the Parties, or, where Molina has discretion, a determination by Molina, not to proceed further with an MSA Change as a result of the MSA Change Request, and any such agreement or determination shall be recorded in the minutes of the relevant Governance Body; or

(ii) agreement by the Parties, or, where Molina has discretion, a determination by Molina, to proceed with the process set out below to reach agreement on an MSA Change as a result of the MSA Change Request (even if the Service Provider prepared and submitted the MSA Change Request but no longer wishes to proceed), and this agreement or determination (the "**Initial Change Approval**") shall be signed by Molina and recorded in the minutes of the relevant Governance Body.

(d) Following Initial Change Approval, the relevant Governance Body shall set out a timetable to reach agreement of the Change Notice, or, in absence of a timetable, the Change Notice shall be agreed within ten (10) Business Days from the date of such Initial Change Approval.

7.2 Submission of a Change Notice

The Service Provider must submit to Molina, as soon as reasonably possible but in no event later than ten (10) Business Days (or such longer period as may be agreed by the Parties) following Initial Change Approval, either:

(a) the Change Notice to which the Initial Change Approval relates, which shall be an irrevocable offer capable of acceptance by Molina and signed by an authorized representative of the Service Provider; or

(b) a draft Change Notice for agreement with Molina and an updated impact assessment.

7.3 Modification of the Change Notice

(a) If Molina does not agree with any aspect of the Change Notice, it shall notify the Service Provider of the matters with which it does not agree and it may provide a counter-proposal reflecting terms that are acceptable to Molina or request the Service Provider to make changes to its Change Notice or any combination of the two.

(b) If Molina and the Service Provider cannot agree on the terms of a Change Notice, the matters in dispute shall be referred for informal dispute resolution in accordance with paragraph 13.

7.4 Notification of Acceptance of Change Notice

(a) Molina shall, within a reasonable period of time after its receipt of the Change Notice (having regard to the proposed Change Start Date), notify the Service Provider as to whether or not it wishes to proceed with the implementation of the proposed MSA Change using the services of the Service Provider on the terms of the Change Notice.

(b) If Molina accepts the Change Notice (either as submitted by the Service Provider or as amended by agreement between the Parties in accordance with paragraph 10) then both Parties shall execute, as soon as possible thereafter, two copies of the Change Notice. The Service Provider and Molina shall each retain one copy of the executed Change Notice.

(c) Upon a Change Notice being executed by both the Service Provider and Molina, the Change Notice will be deemed to form a part of this Agreement and, in the case of an MSA Change applicable to a Project Work Order, that Project Work Order, and the Parties shall comply with the Change Notice accordingly.

7.5 Process Following Acceptance of Change Notice

(a) The Service Provider shall maintain a conformed copy of this Agreement reflecting all agreed Change Notices and make those conformed copies available to Molina on the Contract Management Portal within ten (10) Business Days of the Parties agreeing to a Change Notice.

(b) Further details of the Change Control Process may be agreed upon by the Parties.

7.6 Notification of Refusal to Proceed with a Change Notice

If, at any time prior to execution of a Change Notice, where Molina has discretion, Molina does not wish to proceed with a proposed MSA Change, Molina will notify the Service Provider of its decision, in which case the MSA Change Request shall be abandoned and neither Party shall be required to take any further steps in that regard.

8. **Project Change**

8.1 Subject to paragraph 8.2, within ten (10) Business Days (or such longer period as the Parties agree) after issuance of a Project Change Request by either Party, the Service Provider shall provide Molina with:

(a) the Service Provider's comments on the Project Change Request in the case of a Project Change Request submitted by Molina; or

(b) a final draft of the Project Change Request and conformed Project Work Order (updated to reflect the Project Change Request), which shall be an irrevocable offer capable of acceptance by Molina and signed by an authorized representative of the Service Provider.

8.2 Molina may, at its discretion, upon receipt of a Project Change Request from the Service Provider or when submitting a Project Change Request to the Service Provider, require the Service Provider to follow all or any part of the process described in paragraph 7 of this Schedule in relation to a Project Change Request, and references to an "MSA Change Request" in that paragraph shall, in relation to a Project Change Request and for the purposes of this paragraph 8, mean a reference to a Project Change Request.

8.3 The Service Provider shall not take any action to implement the terms of a Project Change Request until both Parties have executed an agreed Project Change Request following the process set out in the remainder of this Schedule.

8.4 Subject to paragraphs 13.4 and 13.5, unless otherwise agreed in advance and in writing, Molina shall not be liable for any costs or expenditure incurred by the Service Provider in taking any action to implement the terms of a proposed Project Change Request, and shall not be liable for any proposed Charge Adjustment or one-off fees proposed in a Project Change Request, unless and until it has been signed by Molina.

8.5 If, at any time prior to execution of a Project Change Request, Molina does not wish to proceed with a proposed Project Change, Molina will notify the Service Provider of its decision, in which case the Project Change Request shall be abandoned and neither Party shall be required to take any further steps in that regard.

8.6 The Service Provider shall maintain a conformed copy of each Project Work Order reflecting all agreed Project Change Requests and make those conformed copies available to Molina on the Contract Management Portal within ten (10) Business Days of the Parties agreeing to a Project Change Request.

8.7 Any Project Change that varies any terms of this Agreement as they apply to a Project Work Order shall be subject to Clause 13.3 (*Effect of Project Work Orders*) of this Agreement.

8.8 Any Change Notice for an Agreement Change that varies any terms of this Agreement must state whether that Agreement Change applies to any Project Work Orders in effect as at the effective date of the Agreement Change and, if so, which Project Work Orders.

8.9 If any Agreement Change as described in paragraph 8.8 applies to any Project Work Order, the Service Provider must also prepare a Change Notice in respect of the amendment to each such Project Work Order. Any such Agreement Change that affects the Charges under any Project Work Order shall be treated as a Charge Adjustment and shall be subject to Part C of this Schedule.

9. **Costs of Investigating and Agreeing Agreement Changes**

The Service Provider and Molina will each bear its own costs related to any investigations into a proposed Agreement Change and agreeing and preparing and negotiating a Change Request, impact assessment and Change Notice.

10. **Urgent Changes**

10.1 The Service Provider acknowledges that the appropriate Governance Board may designate certain Agreement Changes (including those resulting from Regulatory Changes) to be sufficiently urgent (an "**Urgent Change**") to require the timescales set out in this Schedule to be shortened.

10.2 The following is a non-exhaustive list of the types of Agreement Changes that will, in all circumstances, be Urgent Changes:

(a) required by a Regulatory Authority;

(b) requested by the CIO or an equivalent board level Molina Personnel; or

(c) necessitated by a Major Incident.

10.3 In the event of an Urgent Change, the Service Provider shall take Appropriate Actions:

(a) to mitigate the adverse effects of the Urgent Change on the Services and any other Agreement Changes;

(b) to ensure that the actions or steps taken by the Service Provider in managing and implementing the Urgent Change do not add any further disruptions to the impact of the Urgent Change on the Services or other Agreement Changes; and

(c) to assign appropriately qualified and experienced Service Provider Personnel to manage and conclude the Urgent Change as a priority.

11. **Agreement Change Compulsory**

The Service Provider shall not refuse to agree to any Agreement Change (other than disputes in relation to a Charge Adjustment which are addressed by Part C) unless to implement the Agreement Change:

(a) is not technically possible for a service provider adopting Good Industry Practice;

(b) the Service Provider, adopting Good Industry Practice, cannot reasonably implement the Agreement Change in the required timescale, in which case the Service Provider shall, within five (5) Business Days after receipt of a Change Request, notify Molina of the shortest timescale within which it could implement the Agreement Change;

(c) would or might reasonably cause the Service Provider to contravene Applicable Law; or

(d) would cause the Service Provider to miss or be delayed in meeting a Milestone, and Molina, having been notified in writing of that likelihood, does not respond to the Service Provider's notification.

PART C CHARGE ADJUSTMENT AND ONE-OFF FEES

12. **Changes to the Charges and One-Off Fees Resulting From Changes**

12.1 The Service Provider may propose a Charge Adjustment or the imposition of a one-off fee in connection with a Change Request only to the extent permitted under, and then only in accordance with, this paragraph 12.

12.2 Regulatory Changes

(a) The Service Provider shall bear all of its own costs incurred in order to comply with a Regulatory Change, including all of its costs related to any necessary Agreement Changes, except in cases where paragraph 12.2(c) applies.

(b) The Service Provider shall make no adjustment to the Charges to recover any costs from Molina as a result of a Regulatory Change (including any resulting Agreement Changes), except in cases where paragraph 12.2(c) applies.

(c) In cases where a Regulatory Change occurs that is a change in Applicable Law and that is binding on Molina and that requires:

(i) the Service Provider to acquire, Modify or otherwise enhance any Systems, Materials or Resources that are required under this Agreement to be dedicated exclusively to the provision of Services to Molina or to be reserved for Molina's exclusive use;

(ii) the Service Provider to create, Modify or otherwise enhance any Molina IP;

(iii) Services dedicated exclusively to Molina to be provided from a location other than the Approved Service Delivery Location agreed for a particular Service or as set out in a relevant Project Work Order; or

(iv) the Service Provider to adapt the performance of the Services,

either Party may make a Change Request to adjust the Charges under this Agreement and any Project Work Order affected by the Regulatory Change by such amount as represents the Service Provider's increased or reduced costs resulting from the Regulatory Change.

12.3 Policy Changes

(a) If a Policy Change is made due to a Regulatory Change then the provisions of paragraph 12.2 shall apply in relation to the costs of compliance with that Policy Change as if all references to Regulatory Change read Policy Change.

(b) In all other cases of a Policy Change, the Service Provider or Molina may seek to apply a Charge Adjustment or impose a one-off fee, if either Party can establish and justify the basis of those charges and fees in accordance with paragraph 4.6 or 4.7 of this Schedule.

PART D CHANGE DISPUTES

13. **Resolution of Change Disputes**

13.1 If the Service Provider and Molina cannot agree on any issue relating to a Change Request (a "**Change Dispute**"), then Clause 74 (*Dispute Resolution and Dispute Management*) shall apply.

13.2 Without prejudice to paragraph 13.1, if the only matter left to agree in relation to a Change Notice is whether a proposed Charge Adjustment or the imposition of a one-off fee (or a combination of both) is valid or is too high (a "**Disputed Proposed Charge**"), and:

(a) the Agreement Change was triggered by a Policy Change or a Regulatory Change; or

(b) the Agreement Change was not triggered by a Policy Change or a Regulatory Change, but Molina (acting through the Operational Review Board or such person as the Operational Review Board may nominate) issues a letter to the Service Provider stating that Molina, in its reasonable discretion, considers the Agreement Change to be urgent and requesting the Service Provider to proceed with the Change Notice,

the Parties shall, if Molina so requests, execute the Change Notice on a time and materials basis and shall commence the performance of the Change Notice.

13.3 Paragraphs 13.4 to 13.6 shall apply in cases where the Parties execute a Change Notice in the circumstances described in paragraph 13.2.

13.4 In the period of time between:

(a) the date on which the performance of the work to which the relevant Change Notice relates is properly authorized by Molina (whether by signing the Change Notice or otherwise in writing); and

(b) the time when the Change Dispute is resolved (either through determination of the Change Dispute or through agreement of the Disputed Proposed Charge),

the Service Provider shall be entitled to charge Molina on a time and materials basis, [redacted], for all work conducted in relation to the performance of its obligations under the Change Notice.

13.5 The final determination or agreement as to the Charge Adjustments or the imposition of a one-off fee (or a combination of both) relating to any Disputed Proposed Charge shall be applicable retrospectively with effect from the date of execution of the Change Notice, and any time and materials charges already paid to the Service Provider shall be deducted from amounts due to the Service Provider under the Change Notice, or, if no Charge Adjustments or imposition of a one-off fee (or a combination of both) are payable, shall be refunded to Molina by means of a credit note against the next month's Charges.

13.6 Molina may, at any stage during the Change Dispute or following determination of the Change Dispute, terminate the Change Notice and pay the Service Provider for all Services rendered under the Change Notice up to the date of termination at the applicable time and materials charges.

Appendix 9A

Template MSA Change Request

[Note: To Follow]

Appendix 9B

Template Project Change Request

[Note: To Follow]

Appendix 9C

Sample Change Notice

[Note: To Follow]

APPENDIX 9-A TEMPLATE MSA CHANGE REQUEST

Reference is made to the Master Services Agreement dated [***date***] and entered into between [***Molina MSA Party***] ("**Molina**") and [***Service Provider MSA Party***] ("**Service Provider**") (the "**Agreement**"). Unless otherwise defined herein, capitalized terms used in this MSA Change Request shall have the meanings ascribed to them in that Agreement.

PART A – CHANGE REQUEST

Change Request: ***CR*** **#:** **Date of Change Request Submission:**	
Change Request Title:	**Change Description:**
Change Request Type: **MSA Change** ***NB: An "MSA Change" means a change to any of the terms of the Agreement, including any of the Schedule or Appendices thereto, or any documents incorporated therein, but does <u>not</u> include any change to (i) any of the Policies (for which, see paragraph 4 of Schedule 9) or (ii) a Project Change (for which, see Appendix 9-B (Project Change Request)).***	
Requesting Group Contact(s):	**Responding Group Contact(s):**

Document Purpose:	▪ The written means by which authorized persons of Molina and Service Provider initiate an MSA Change. ▪ ***[Describe the nature of requested change]***

Request Overview (Complete with as much detail as possible)	
Summary of Requested Change	
Objectives / Goals	
Agreement Reference(s)	

Key Drivers *What are the key business objectives or other factors causing the Change Request?*	
Expected Impacts *What are the expected Impacts as a result of this Change Request?* *(i.e. Scope, Schedule, Cost, Other)*	
Dependencies	
Risks *Are there any risks identified?*	***Of Moving Ahead:*** ***Of NOT Moving Ahead:***

PART B – IMPACT ASSESSMENT

Change Request Impact Assessment: *CA #:* ***NB: To be completed by Service Provider in all cases.***	
Change Title:	**Change Description:**
Date of CR Impact Assessment Submission:	**Impact Assessment Version:**
Impact Assessment Prepared By:	

Document Purpose:	
Expected Results:	

A. Impact Assessment	
Assumptions	
Background	
Scope	
Schedule	
Service Provider Technical Solution	
Deliverables	
Transition Milestones	
Service Delivery Locations	
Project Work Order(s) Impacted Upon	
Molina Policies	
Service Level Impact?	
Third Parties	

A. Impact Assessment	
Dependencies on Molina or its Other Service Providers	
Systems	
Disaster Recovery and Business Continuity	
Molina Locations	
Contract Impacts or Other Reference(s)	
Risks	
Charges (on-going)	
Charges (One-Off Fees)	
Other matters reasonably considered by Service Provider to be relevant	

B. Molina Disposition[1]	
Decision:	**[ ] Reject CR [ ] Withdraw CR [ ] Initial Change Approval granted**
Approval Date:	
Molina Approver Name:	
Molina Approver Title:	
Molina Approver Signature:	

[1] Note: In the event Molina's disposition is to approve this document as completed, the next step is to begin developing the final form Change Notice as a separate document.

APPENDIX 9-B TEMPLATE PROJECT CHANGE REQUEST

PROJECT CHANGE REQUEST

This Project Change Request amends Project Work Order: ***[insert PWO Name]*** (Number: [●]) entered into between [***Molina PWO Party***] and [***Service Provider PWO Party***] on ***[date***], pursuant to a Master Services Agreement dated [***date***] and entered into between [***Molina MSA Party***] and [***Service Provider MSA Party***].

Project Change Request Form (For Summary Purposes Only)	
Initiation	
Project Change Request (Tracker Number)	***[PWO No. PCR XX]*** ***[(Tracker No. according to PCR Tracker)]***
Title:	***[Insert PWO Name]***
Originator:	***[Party requesting change]***
Sponsor:	***[Authorized person requesting change]***
Date of Initiation:	***[date]***
Priority	[High/Medium/Low]
Background and reason for Proposed Change	
[High-level background]	
Details of Proposed Change	
[Provide as much detail as is appropriate]	

AMENDED AND RESTATED PROJECT WORK ORDER

PROJECT WORK ORDER

[Attach a draft conformed copy of the Project Work Order, updated to include the changes proposed under this Project Change Request (and all prior Agreement Changes that affect the Project Work Order).]

[●]

APPENDIX 9-C

SAMPLE CHANGE NOTICE

CHANGE NOTICE [*NUMBER*]

This Change Notice ("Change Notice") amends Master Services Agreement dated [***date***] and entered into between [***Molina MSA Party***] ("**Molina**") and [***Service Provider MSA Party***] ("**Service Provider**") (the "**Agreement**"), as provided below. All terms and conditions of the Agreement not expressly modified herein, shall remain in full force and effect. All capitalized terms shall have the meaning ascribed to them in the Agreement unless otherwise defined herein.

This Change Notice is effective as of [***date***] ("**Change Notice Effective Date**").

1. ***[Include details of changes and any relevant attachments (in particular, the approved Change Request to which this Change Notice relates.]***
2.
3.

IN WITNESS WHEREOF, the Parties have caused this Change Notice [***number***] to be executed by their duly authorized representatives as of the day and year signed below.

[*MOLINA ENTITY*]. **[*SERVICE PROVIDER ENTITY*]**

Signature: _____ Signature: _____

Name: _____ Name: _____

Title: _____ Title: _____

Date: _____ Date: _____

SCHEDULE 10

APPROVED SERVICE DELIVERY LOCATIONS

1. Introduction

This Schedule 10 sets out the Approved Service Delivery Locations.

2. Approved Service Delivery Locations

Service Bundles	Approved Service Delivery Location (including address)
Infrastructure Security Service Desk & EUC	**Infosys Limited** Bengaluru Offshore Development Center Plot No. 26A Electronics City, Hosur Road **Bengaluru** 560 100, India Mohali Infosys Ltd Level 9 & 10, Landmark Plaza Building Plot No. A-40A, Industrial Focal Point, Phase VIII Extension, Industrial Area, SAS Nagar Mohali, Punjab – 160 059 Molina facilities set forth in Schedule 18
Service Desk	**Infosys BPO Limited** – Philippines Branch BGC Corporate Center #3030 11th Avenue corner 30th Street, 23rd Floor Bonifacio Global City, Taguig City Philippines – 1634 **Infosys BPM Limited** 5F Vector 2 Building, Northgate Cyberzone, Alabang, Muntinlupa City, Philippines 1781 **Molina Healthcare Inc.** 650 Pine Ave, Long Beach, CA 90802

SCHEDULE 11

APPROVED SUBCONTRACTORS

CONTENTS

1. **INTRODUCTION**

This Schedule sets forth the Approved Subcontractors for each of the Services listed below.

2. **APPROVED SUBCONTRACTORS**

Service	Approved Subcontractor
Hands and feet support	[redacted] (Molina's approval of this entity as an Approved Subcontractor is conditioned upon this entity's passing Molina's subcontractor review and vetting process before this entity performs any activities under the Agreement)

SCHEDULE 13

Access to MOLINA FACILITIES

CONTENTS

1. INTRODUCTION

1.1 This Schedule sets out the rights and obligations of the Parties in relation to the Molina Facilities.

1.2 In this Schedule, capitalized words and phrases shall have the meanings given to them in Schedule 1 (*Definitions and Interpretation*) to the Agreement.

2. ACCESS TO MOLINA FACILITIES

2.1 Molina shall provide the Service Provider at no charge, as is reasonably necessary for the Service Provider to perform the Services, with reasonable access to the Molina Facilities and those resources set out in Appendix 13A (*Resources Schedule*) to this Schedule.

2.2 Molina shall be responsible for:

(a) the physical security of the Molina Facilities;

(b) the environmental and operational planning and monitoring of the Molina Facilities;

(c) provision of equipment to assist in the installation and decommissioning of equipment, for example, lifting equipment, step ladders and pallet trucks;

(d) portable appliance testing (PAT testing) of all electrical equipment to ensure it complies with Molina standards; and

(e) any other facilities or equipment that Molina is required to provide in accordance with the Financial Responsibility Matrix or any other provision of the Agreement.

3. CHANGE TO OR RELOCATION OF THE MOLINA FACILITIES

3.1 Molina may modify the design, engineering and operating standards relating to the Molina Facilities provided that where any such modifications are made Molina shall:

(a) provide reasonable notice to the Service Provider of the forthcoming modifications;

(b) consult with the Service Provider prior to making such modifications to allow the Service Provider to advise of any impact such modifications may have on the Service Provider's ability to deliver the Services; and

(c) if the modifications will impact the Service Provider's ability to deliver the Services or have any material cost impact, initiate an Agreement Change to the Services or the Charges in accordance with the Change Control Process.

3.2 The Service Provider shall not make any improvements or changes involving structural, mechanical or electrical alterations to the Molina Facilities, except as may be permitted in the Agreement, without Molina's prior written approval. Any improvements to the Molina Facilities shall be the property of Molina.

3.3 Molina may upon reasonable notice direct the Service Provider to relocate to another Molina Facility or another portion of the same Molina Facility and where such a direction is given Molina shall provide the Service Provider with facilities in the new location that are comparable to the facilities provided in the previous location. If such relocation will impact the Service Provider's ability to deliver the Services or have any material cost impact, Molina shall initiate an Agreement Change to the Services or Charges in accordance with the Change Control Process.

4. SERVICE PROVIDER USE OF MOLINA FACILITIES

4.1 The Service Provider's use of the Molina Facilities shall not constitute or create a leasehold interest or any other enduring interest (whether legal or equitable) in the Molina Facilities.

4.2 The Parties acknowledge and agree that in the absence of any license agreement, the Service Provider (and its Subcontractors where relevant) shall have the use of such Molina Facilities as non-exclusive bare licensees and the Service Provider shall (and shall procure that its Subcontractors shall) vacate the same upon the expiry or earlier termination of the Agreement (or later to the extent Molina requests such later date to be the completion of Termination Assistance by the Service Provider).

4.3 The Service Provider shall use the Molina Facilities for the sole and exclusive purpose of performing the Services.

4.4 The Service Provider's usage of the Molina Facilities shall be in accordance with the Molina Policies and procedures set out in Schedule 14 (*Molina Policies*).

4.5 The Service Provider shall be responsible for any damage to the Molina Facilities caused by the Service Provider or its employees, agents or Subcontractors, except for normal wear and tear.

4.6 The Service Provider shall comply with any reasonable directions or decisions made and notified to it by Molina in respect of the Molina Facilities.

4.7 The Service Provider shall maintain up-to-date records of its usage of the Molina Facilities and the condition of those parts of the Molina Facilities used by the Service Provider, and shall respond to requests from Molina for such information in a prompt and accurate manner.

4.8 The Service Provider shall not connect any laptops or PCs to the Molina network, other than through a visitor LAN in accordance with Molina terms and conditions of use for that visitor LAN, unless otherwise agreed with Molina.

5. SERVICE PROVIDER PERSONNEL LOCATED AT MOLINA FACILITIES

5.1 The Service Provider shall provide Molina with a list of its personnel and Subcontractors that require access to any Molina Facility and shall maintain this list and provide updates on a regular basis.

5.2 Molina shall provide the Service Provider with the number of desks as outlined in Appendix 13A (*Resources Schedule*). The header row indicates the time period from which Molina shall make the desks available. Furthermore, Molina makes no affirmative commitment to the specific buildings or work locations from which it will provide the desks.

5.3 The Service Provider shall comply with Molina additional reasonable rules and regulations communicated in writing to the Service Provider regarding personal and professional conduct whilst at the Molina Facilities.

5.4 Where Service Provider Personnel or a Subcontractor employee fails to comply with procedures and Policies, Molina may request that the Service Provider remove the offender and the Service Provider shall comply with such request as soon as reasonably practicable.

6. MOLINA PROVIDED EQUIPMENT

6.1 At the Molina Facilities, Molina shall permit Service Provider Personnel access to the internet for the purpose of gaining access to the Service Provider network.

Appendix 13A

Resources Schedule

In relation to this Agreement, Molina shall make work space available to the relevant Service Provider Personnel at each Molina Facility as set out below:

#	Services	Molina Office Location	Track	# of FTEs
1.	Infrastructure Services	[redacted]	Infra Services	[redacted]
2.	Infrastructure Services	[redacted]	Datacenter Hands and Feet	[redacted]
3.	Infrastructure Services	[redacted]	Datacenter Hands and Feet	[redacted]
4.	Infrastructure Services	[redacted]	DR Management	[redacted]
5.	End User Services	[redacted]	EUS White Glove	[redacted]
6.	End User Services	[redacted]	EUS White Glove	[redacted]
7.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
8.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
9.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
10.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
11.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
12.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
13.	End User Services	[redacted]	EUS - Deskside Support	[redacted]2
14.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
15.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
16.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
17.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
18.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
19.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
20.	End User Services	[redacted]	EUS - Deskside Support	[redacted]
21.	Security Services	[redacted]	Security Services	[redacted]

SCHEDULE 14
MOLINA POLICIES

CONTENTS

1. DEFINITIONS

1.1 Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) of this Agreement.

2. INTRODUCTION

2.1 This Schedule:

(a) describes the global Policies that the Service Provider must adhere to in delivery of all Services undertaken in accordance with this Agreement; and

(b) describes the key human resources Policies that all Service Provider employees and representatives must adhere to when working at Molina Locations.

2.2 The human resources Policies provided are not an exhaustive list of policies, and all Service Provider Personnel and representatives are expected to follow and adhere to all site specific employment laws and regulations within the country of the Molina Location.

2.3 All Service Provider Personnel or representatives working on a Molina Location for more than five (5) Business Days must attend a site induction. During the site induction the local site policies and procedures will be made clear to the Service Provider Person/representative, who must adhere to these policies and procedures at all times while working at the Molina Location. Attendance of a site induction is also required in order for the Service Provider Person/representative to be issued with an access card to enable them to access the Molina Location.

2.4 If a Molina Policy has a more stringent standard than the equivalent Service Provider policy then the Service Provider shall comply with the Molina Policy. If a Service Provider policy requires a more stringent standard than the Molina Policy then the Service Provider shall apply its own more stringent standards.

2.5 If a Molina Policy is drafted as an internal policy containing instructions for Molina personnel (and is not, or contains sections that are not, drafted to apply to an external service provider), the Service Provider will comply with the intent and spirit of the Molina Policy and shall implement its own processes to achieve the result required by the Molina Policy, provided that result would be apparent to a service provider adopting Good Industry Practice. Without limiting the foregoing, if a Molina Policy sets out specific obligations to apply to external service providers, the Service Provider shall comply with such specific obligations.

3. MOLINA POLICIES

The following global Policies are to be adhered to by the Service Provider at all times. No standards, guidelines, processess, standard operating procedures, working practices and any

other control documents developed by the Service Provider to support the delivery of the Services may contradict these Policies.

(a) **Business Continuity Policies**

Document ID	Name	Version
BCM 11.0	Incident Command System Terms and Definitions	May 2, 2014
BCM 11.0	Business Interruption Incident Management	May 2016
BCM 11.0	Incident Command System References	May 2, 2014

(b) **Data Center Standard Operating Procedures (SOPs)**

Document ID	Name	Version
DCTS-SOP-201	Data Center Weekly Walkthrough	3/19/2018
DCTS-SOP-202	Mobile Data Destroyer Drive Destruction Procedure	2/20/2018
DCTS-SOP-203	Drive Erasure Procedure	2/2/2017
DCTS-SOP-205	Exporting Tapes for Iron Mountain Procedure	12/29/2016
DCTS-SOP-206	IT Hardware Requests for Shipment to Molina Sites Procedure	6/22/2018
DCTS-SOP-207	New Mexico Data Centre Receiving Procedure	8/23/2016
DCTS-SOP-208	Proof of Concept (POC) and Leased or Loaned Equipment Requests Procedure	6/21/2018
DCTS-SOP-209	Texas Data Center Receiving Procedure	5/21/2018
DCTS-SOP-210	Request for De-Installation of equipment in Molina Data Center’s [sic]	5/21/2018
DCTS-SOP-211	105 HD Shredder Drive Destruction Procedure	3/19/2018

(c) **Enterprise Infrastructure Services Policies**

Document ID	Name	Version
IS-10.20	Cybersecurity Policy	9/11/17
IS-10.50	Asset Management Policy	12/9/14
IS-50.20	Risk Management	6/2/17
IS-50.33	Software Development Life Cycle	6/30/16
IS-55.30	IT Service Incident Management	3/31/16
IS-56.10	Contingency Planning	3/31/16
IS-60.20	Facility Access Controls	5/30/17
IS-61.10	Workstation Use and Security	3/31/16
IS-61.20	Desktop/Laptop Security Standards	7/20/15
IS-61.50	Server Security	3/1/17
IS-65.00	Software Asset Management	9/1/15
IS-72.10	Data Integrity	3/31/16
IS-73.50	Patch Management Policy	12/11/14
IS-74.00	Firewall Configuration	12/12/14
IS-74.10	Transmission Security	3/31/16
IS-80.10	SharePoint Governance and Standards Policy	7/18/16
IS-80.11	Email Use and Security	3/1/17
IS-80.15	Active Directory Management Policy	3/3/15
IS-80.22	Mobile Devise Use	5/15/15
IS-80.25	Wireless Network Security	12/15/14
IS-80.30	Data Backup and Recovery Policy	3/1/17
IS-80.35	Database Security Policy	3/11/16
IS-80.51	Removable Media	3/31/16
IS-80.65	Media Reuse and Disposal	3/31/16

(d) **HIPAA Policies**

Document ID	Name	Version
HP-35	HIPAA TRANSACTIONS COMPLIANCE	03/01/18
HP-36	HIPAA CODE SETS COMPLIANCE	03/01/18
HP-43	PHYSICAL SECURITY	11/06/ 17
MHI HP-50	PRIVACY & SECURITY COUNCIL CHARTER	10/05/17
HP-23	USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND/OR PERSONALLY IDENTIFIABLE INFORMATION (Pil): MINIMUM NECESSARY	9/12/17

(e) **Incident Policies**

Document ID	Name	Version
NA	MIT Incident Management Prioritization Quick Reference	v1.3 June 2015
NA	MIT Major Incident Process	Version 2.0, Revised October 30, 2015

(f) **Service Management Policies**

Document ID	Name	Version
IS-50.30	Change Management	1/27/2016
IS-50.31	Configuration Management Policy	12/16/16
IS-50.32	Release and Deployment Management	12/14/16
IS-50.35	Problem Management Policy	11/21/2016
IS-50.55	Request Fulfillment Management Policy	12/16/16
IS-58.10	IT Strategic Sourcing and Staffing Policy	June 24th, 2016
IS-81.00	Cloud Security	7 /22/16

(g) **Other Policies**

Document ID	Name	Version
AD-03	Document Retention and Destruction Policy	10/27/2010
NA	Cloud Application Standards	1/5/2017
NA	IT Compliance Considerations	NA
NA	Information Security Incident Response Plan	Version 1.5
NA	Molina HealthCare Applied Cryptography Guidelines	Version 0.1
1.1	OIG/GSA Exclusion List Reporting	August 11, 2017
	PE Executive Support	3/2/2018
FAC.DC0.001	Physical Security and Access - Data Center and Equipment Rooms	10/13/14
	SOX 307 Reporting Up Policy	10/23/2010
CC-19	Anti-Bribery and Anti-Money Laundering Policy	March 5, 2015

SCHEDULE 15
HR MATTERS AND KEY PERSONNEL

CONTENTS

1. **DEFINITIONS AND INTERPRETATION**

1.1 Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (Definitions and Interpretation) to the Agreement**.**

1.2 The following defined terms used in this Schedule shall have the meanings specified below:

(a)"Molina Disability" shall have the meaning set forth in Paragraph 4.1.

(b)"Molina Leave of Absence" shall have the meaning set forth in Paragraph 4.1.

(c)"Molina Net Credited Service" shall mean a Designated Employee's total years of service with Molina, commencing with his/her date of hire and ending on his/her last date of employment with Molina, as may be adjusted for any breaks in service.

(d)"Designated Molina Employees" shall mean the employees identified by Molina on Appendix A.

(e)"Service Provider Benefit Plans" shall have the meaning set forth in Paragraph 6.3.

(f)"Service Provider Employment Date" shall mean the date on which each Transitioned Employee begins his/her employment with Service Provider, which date shall be on the Effective Date, except for any employee who is on a Molina Leave of Absence or Molina Disability on the Effective Date, in which case employment with Service Provider shall begin on the first Business Day following his/her return to active service with Molina at the end of such Molina Leave of Absence or Molina Disability; provided that in special circumstances any other Transitioned Employee may begin his/her employment with Service Provider on such date after the Effective Date as Molina and Service Provider may mutually agree.

(g)"Transitioned Employee" shall mean a Designated Employee who timely accepts Service Provider's offer of employment and commences employment with Service Provider in accordance with Paragraph 5.

2. **GENERAL PROVISIONS**

2.1 This Schedule describes the responsibilities of Molina and the Service Provider in relation to personnel at and before the relevant Service Commencement Dates, during the Term and on the termination, partial termination or reduction of any Services**. Certain additional obligations in relation to personnel are set out in the Exit Plan.**

2.2 Unless explicitly mentioned otherwise, where in this Schedule or in the Exit Plan, Molina is given a right (and that right shall also be given to any Successor Supplier), Molina or the Successor Supplier shall be entitled to exercise that right**.**

2.3 Unless explicitly mentioned otherwise, where in this Schedule or in the Exit Plan, Molina has an obligation to fulfill, that obligation may be fulfilled by either Molina or a Successor Supplier**.**

2.4 An obligation of the Service Provider in this Schedule or in the Exit Plan shall be construed to mean that the Service Provider must perform that obligation itself and must ensure that each and every Subcontractor performs that obligation to the extent that it is relevant**.**

3. PRE-COMMENCEMENT DATE WORK-SHADOWING

3.1 At Service Provider's request, prior to the relevant Service Commencement Date, the Service Provider may assign an agreed number of its employees, to be agreed with Molina, to "work-shadow" Molina's employees in order to understand Molina's business operations and to facilitate such transfer of knowledge and skills as will assist the Service Provider in providing the Services, provided that the Service Provider shall ensure that its assigned employees do not interfere with, hinder or restrict Molina's business operations and that the assigned employees will comply with all Molina's policies and procedures (as disclosed to the Service Provider or its personnel) while on Molina's premises**. Any such assigned employees shall at all times remain employees of the Service Provider and will be subject to the management and directions of the Service Provider during the period of the assignment.**

4. DESIGNATED EMPLOYEE HIRING REQUIREMENTS

4.1 Subject to the terms and conditions set forth in this Schedule, Service Provider shall extend offers of employment to all Designated Employees on Appendix A, regardless of whether any such Designated Employee is on an approved leave of absence as determined under any of Molina's leave of absence policies ("Molina Leave of Absence") or receiving benefits from Molina's Short-Term Disability Benefit Plan ("Molina Disability")**.**

5. DESIGNATED EMPLOYEE TRANSITION PROCESS

5.1 The process by which the Designated Employees shall become Transitioned Employees is as follows:

(a)As agreed to between Molina and Service Provider, Service Provider shall provide all Designated Employees with a general introduction package that has been reviewed by Molina and that shall include information regarding non-individualized terms and conditions of Service Provider's offer of employment and information regarding Service Provider, its general management values, policies and practices and its performance standards and business conduct requirements. Thereafter, Molina shall provide Service Provider with access to the Designated Employees for group informational meetings at such dates, times and frequency as Molina, in its sole discretion, may determine to be appropriate. Prior to any such meetings, the Parties shall work together to agree upon guidelines for the meetings.

(b)[redacted].

(c)[redacted].

(d)[redacted].

(e)[redacted].

(f)[redacted].

(g) Each Designated Employee who timely accepts Service Provider's offer of employment shall become a Transitioned Employee and shall commence employment with Service Provider on the Effective Date, which shall be his/her Service Provider Employment Date; provided, however, that (i) any Designated Employee who is on a Molina Leave of Absence or Molina Disability shall commence employment with Service Provider immediately following returning to work; (ii) Service Provider shall not be required to employ any such Designated Employee who does not return to work within twelve (12) months of the Effective Date, and (iii) Service Provider will use commercially reasonable efforts to obtain the transfer any H1-B visa held by a Designated Employee to Service Provider's sponsorship.

(h) Service Provider shall immediately inform Molina when any Designated Employee declines an offer of employment.

6. EMPLOYMENT OF TRANSITIONED EMPLOYEES

6.1 Service Provider shall not terminate any Transitioned Employee during the first [redacted] of his/her employment with Service Provider; provided, however, that Service Provider may terminate the employment of any Transitioned Employee for Cause (as that term is defined in Service Provider's policies, practices and procedures; and provided, further, that all decisions regarding the termination of any Transitioned Employee shall be the sole responsibility of Service Provider**.**

6.2 For a period of no less than [redacted] following each Transitioned Employee's Service Provider Employment Date, such Transitioned Employee shall be]:

(a) [redacted];

(b) [redacted];

(c) assigned to perform job responsibilities with Service Provider that are substantially similar job responsibilities assigned to the Transitioned Employee at Molina immediately prior to the Effective Date, unless mutually agreed upon between the Transitioned Employee, Molina and Service Provider; and

(d) permitted to work at the same work location as with Molina immediately prior to the Effective Date (including working remotely if there is no Molina location nearby) during the time the Transferred Employee is assigned to the Molina account.

6.3 **[redacted]**:

(a) [redacted];

(b) [redacted]

(c) [redacted].

6.4 **[redacted].**

6.5 Without limiting the obligations in Paragraph 6.2, any Transitioned Employee whose employment is terminated by **Service Provider** in the first [redacted] of his/her employment

with Service Provider, not for cause, shall be paid severance by Service Provider that is the greater of the severance payment calculated under, (a) Molina's severance plan or policy and a formula providing for base salary payments of four months for AVPs and Directors, three months for Managers and Supervisors and two months for all other positions, and (b) the applicable Service Provider severance plan or policy maintained by Service Provider; provided, however, that no Transferred Employee whose employment is terminated by Service Provider shall receive severance from Service Provider unless and until Service Provider obtains from such Transferred Employee a general release that includes as a releasee any "Predecessor Employer," and that term is defined within the general release generically in a manner that would reasonably be construed to include Molina**.** Severance for any Transferred Employee whose employment is terminated after the first [redacted] for a reason that qualifies him or her for severance under a Service Provider severance plan or policy that shall be calculated by recognizing both the Transferred Employee's Molina Net Credited Service and his/her service with Service Provider.

7. KEY PERSONNEL

7.1 The Service Provider shall ensure that each Key Service Provider Position is occupied by suitably qualified Service Provider Personnel, which may include Transitioned Employees, in accordance with this Paragraph 7 during the entire term of the Agreement, unless the written consent of Molina is first obtained or the Parties agree that such Key Service Provider Position is no longer required for the provision of the Services. [1] The designation of any Key Service Provider Position in addition to those set forth in Appendix A shall require agreement of the Parties.

7.2 Each Key Person shall be dedicated on a fulltime basis to the provision of the Services for the period set forth in Appendix A**.**

7.3 If any present or former Key Person breaches his/her confidentiality obligations entered into pursuant to Paragraph 8.2 below, then the Service Provider shall take steps so as to prevent any future breach of such obligations, including reviewing the processes to protect confidentiality information and/or removing the Key Person from his/her position, if still so engaged**.**

7.4 Paragraph 7.3 and any confidentiality agreement entered into pursuant to Paragraph 8.2 are without prejudice to the Service Provider's obligations of confidentiality under the Agreement and at law**.**

7.5 Service Provider shall ensure that no Key Person is removed from his/her specified role in the performance of the Service Provider's obligations under the Agreement for the duration of his/her designation as a Key Person unless:

(a)he/she resigns as an employee of the Service Provider or any relevant Subcontractor; or

(b)he/she dies; or

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[1] Note: Key Person designation already addressed in MSA and Schedule 1.

(c) he/she has become incapable of performing the essential functions of his/her position through illness or incapacity, or he/she is unavailable, due to family or medical leave or other leave which the Service Provider is legally obliged to provide, in each instance where such incapacity or unavailability lasts, or has been certified as being expected to last, for a consecutive period of more than 20 Business Days, and in such instance the removal shall be temporary, for the duration of the absence; or

(d) he/she has committed any act or omission with respect to which appropriate disciplinary action is to remove the Key Person from his/her specified role; or

(e) Molina requests a replacement pursuant to Paragraph 7.9; or

(f) the prior written consent of Molina is first obtained.

7.6 Before removing any Key Person in accordance with Paragraph 7.5 or appointing any person to a Key Service Provider Position, the Service Provider shall:

(a) notify Molina of the proposed removal or appointment;

(b) in the case of an appointment, provide Molina with a curriculum vitae of the proposed candidate and discuss the position with Molina and permit Molina, on request, to meet the proposed candidate; and

(c) to the extent that it is lawfully able to do so, provide Molina with such information as Molina requests in relation to the proposed removal or appointment.

7.7 No person shall be appointed to a Key Service Provider Position without Molina's prior written approval**.**

7.8 If a Key Person is to be replaced, the Service Provider shall ensure that a replacement who is acceptable to Molina is appointed as soon as practicable, that there is a handover period that is reasonable in the circumstances and that any adverse effects of the change of personnel on the performance of the Service Provider's obligations under the Agreement or on Molina's businesses are minimized**.** The Service Provider shall be responsible for all costs relating to such handover.

7.9 Molina may request that the Service Provider replace any Key Person if:

(a) the Key Person has become incapable of performing the essential functions of his/her position through illness or incapacity, or he/she is unavailable, due to family or medical leave or other leave which the Service Provider is legally obligated to provide, in each instance where such incapacity or unavailability lasts, or has been certified as being expected to last, for a consecutive period of more than 20 Business Days, and in such instance the replacement shall be temporary, for the duration of the absence; or

(b) the Key Person's performance or conduct is, in Molina's reasonable opinion, unsatisfactory or prejudicial to the working relationship between the Parties and the Services being provided, provided that:

(i) before making any such request Molina has consulted with the Service Provider, and the Service Provider and/or the Key Person did not remedy

any unsatisfactory performance and/or conduct within thirty (30) days after Molina's notice pursuant to this Paragraph 7.9(b); and

(ii) the proviso in this Paragraph 7.9 shall not apply if Molina has previously provided notice of any concerns relating to the Key Person in accordance with Paragraph 7.9(b)(i).

7.10 The Service Provider shall replace the Key Person as soon as reasonably practicable after conclusion of the processes set forth in Paragraph 7.9 and, in any event, no later than two (2) months after such notice, or within such longer period as is reasonably necessary as a result of circumstances which are beyond the reasonable control of the Service Provider**.** The replacement of a Key Person under this Paragraph 7.10 shall be carried out in accordance with the provisions of Paragraph 7.6 above.

7.11 If a Key Person is unavailable or unable to respond to the needs of his/her position for a significant period, and Molina so requests, the Service Provider shall promptly nominate an alternate. The alternate shall have all the authority of the relevant Key Person for so long as the Key Person remains unavailable or unable to respond, and Molina may require the replacement of the alternate in accordance with this Paragraph 7.

7.12 Molina may, by written notice to the Service Provider, request Service Provider to designate new or alternative Key Service Provider Positions, and such new or alternate Key Service Provider Positions will be agreed via the Change Control Process**.**

7.13 The Service Provider shall defend, indemnify, keep indemnified and hold harmless Molina and any Molina Company from any employment related liability arising from any withdrawal or removal of Key Personnel (including any associated termination of employment) pursuant to this Paragraph 7, except to the extent such liability results from any unlawful act or omission of Molina**.**

8. SERVICE PROVIDER PERSONNEL

8.1 The Service Provider shall ensure that Service Provider Personnel:

(a) have all the skills, experience, training, knowledge and linguistic fluency requisite to carry out the tasks allocated to them;

(b) are trained in connection with the provision of the Services in accordance with market standards and any particular and reasonable Molina requirements provided to the Service Provider;

(c) comply with any reasonable directions or decisions provided by Molina which are consistent with the Service Provider's obligations under the Agreement; and

(d) have the appropriate work authorizations in accordance with Applicable Law; and

(e) while performing the Services, comply with professional standards of behavior and with Molina's policies regarding personal and professional conduct, safety and security and any other policies and procedures as have from time to time been provided to the Service Provider or the relevant Subcontractor (including the Policies).

8.2 The Service Provider shall, subject to Applicable Law, ensure that the Service Provider Personnel:

(a) enter into, or have already entered into, a confidentiality agreement with the Service Provider obligating the Service Provider Personnel to comply with confidentiality obligations which cover the confidentiality obligations in the Agreement; and

(b) cooperate constructively with Molina or Molina personnel and third party personnel with whom they come into contact in the course of the provision of the Services.

8.3 If any of the Service Provider Personnel, in the reasonable opinion of Molina, do not at any time meet any of the requirements in Paragraphs 8.1 or 8.2, Molina shall so notify the Service Provider, and the Service Provider shall immediately review the matter and consult with Molina on its proposals to address Molina's concerns. Following this review and consultation and, in any event, within ten (10) Business Days after the notification is received, if Molina is not reasonably satisfied, Molina may require the Service Provider to, and the Service Provider shall, remove the relevant Service Provider Personnel from the performance of the Services. The requirement to remove such an individual shall not excuse the Service Provider from any obligation of the Service Provider contained in the Agreement.

8.4 In order to protect Molina's confidential and other proprietary information, the Key Service Provider Personnel shall not be assigned to or involved with the business or prospective business of any Molina Competitor while he/she is involved in the provision of the Services or for the twelve (12) months after his/her involvement with the Services ceases.

8.5 The Service Provider shall defend, indemnify, keep indemnified and hold harmless Molina from any employment related liability arising from any withdrawal or removal of Service Provider Personnel (including any associated termination of employment) pursuant to this Paragraph 8 except to the extent such liability results from any unlawful act or omission of Molina (including direction by Molina to act in an unlawful manner).

8.6 The Service Provider certifies that it is not named on the Specially Designated National ("**SDN**") list maintained by the US Office of Foreign Assets Control and shall ensure that none of the Service Provider Personnel:

(a) is named on the SDN list or on the United States Denied/Restricted Party List ("**DRPL**") maintained by the US Department of Commerce; or

(b) is considered a national of any country under US embargo or anti-terrorism export controls.

8.7 The Service Provider shall ensure that the Service Provider Personnel are appropriately vetted, including criminal and other background checks to the extent permitted by Applicable Law, and that no individual who does not meet the standards required by this Schedule or the Agreement is involved in the provision of the Services**.** Vetting shall be considered appropriate if they meet the Service Provider's and market standards for the role in question together with any specific requirements provided to the Service Provider in writing by Molina.

8.8 The Service Provider shall comply with all relevant employment, labor, immigration and work permit laws and regulations in respect of the Service Provider Personnel**.**

8.9 The Service Provider shall be and remain liable for all amounts due to or in respect of the Service Provider Personnel, including but not limited to salary and other emoluments, benefits, payroll taxes, and social security payments, subject to Molina's obligations in Paragraph 15**.**

8.10 Without limiting any other provisions of this Schedule, and if and to the extent applicable, Service Provider shall comply with United States Department of Labor regulations regarding:

(a)equal employment opportunity obligations of government contractors and subcontractors;

(b)employment by government contractors of Vietnam-era and disabled veterans;

(c)employment of disabled persons by government contractors and subcontractors;

(d)developing written affirmative action programs;

(e)certifying no segregated facilities;

(f)filing annual EEO-1 reports;

(g)utilizing minority-owned and female-owned business concerns; and

(h)any successor regulations thereto which are incorporated by reference herein.

9. STATUS, RESPONSIBILITY AND AUTHORIZATION

9.1 No Service Provider Personnel shall become employed by, or be deemed to be employed by any member of the Molina Group (before the termination, partial termination or reduction of the relevant Services) as a consequence of the provision of the Services (unless the Parties and the individual otherwise expressly agree in writing), and the Service Provider shall defend, indemnify, keep indemnified and hold harmless Molina and each Molina Company against all costs, losses and expenses arising out of or relating to any claim by any Service Provider Personnel that he/she has become an employee of Molina or any Molina Company or subcontractor of either, unless (a) he/she has become an employee of Molina or any Molina Company or subcontractor of either as a result of an offer of employment by Molina, a Molina Company or subcontractor of either, or (b) such liability results from any unlawful act or omission of Molina**.**

9.2 All Service Provider Personnel shall be deemed expressly authorized by the Service Provider to perform the Services, and all Key Persons shall be deemed expressly authorized by the Service Provider to communicate with Molina regarding the Services**.**

10. INCENTIVES

10.1 The Service Provider shall encourage and incentivize the Service Provider Personnel by appropriate means to maximize:

(a)the quality and efficiency (for the benefit of Molina) with which the Services are delivered; and

(b)Molina's satisfaction with the Services.

10.2 In relation to any incentive scheme or arrangement affecting one or more Key Persons, the Service Provider will give Molina an opportunity to provide input with respect to the performance targets of such Key Persons, and the Service Provider shall consider such input for such targets. The provisions of this Paragraph 10.2 are without prejudice to the generality of Paragraph 10.1 above.

11. EMPLOYEE RECORDS

11.1 The Service Provider shall maintain comprehensive, accurate and up-to-date employee records in relation to the Service Provider Personnel, including training records, roles performed and numbers of Service Provider Personnel and staff structure, which shall, subject to Applicable Laws, be available for inspection by Molina.

11.2 Without limiting Paragraph 11.1 above, the Service Provider shall maintain an up to date list of all Service Provider Personnel working on any Molina premises (for any length of time), listing, where relevant, immigration authorization and work permit status. This list will be provided to Molina within five (5) Business Days of any request.

12. CONTINUITY OF SERVICE PROVIDER PERSONNEL

12.1 The Service Provider shall make all reasonable efforts to maintain continuity in relation to Service Provider Personnel.

12.2 The Service Provider shall provide a quarterly report on the Service Provider Personnel turnover rate. If Molina notifies the Service Provider in writing that the turnover is not in line with Good Industry Practice, the Parties will meet to discuss the impact of the turnover rate on the provision of the Services, and the Service Provider shall, as soon as practicable or, in any event, within ten (10) Business Days, submit to Molina a proposal for reducing the turnover rate, to be discussed and agreed with Molina. Once agreed, the Service Provider will implement the proposal as soon as practicable.

13. ASSIGNMENT OF MOLINA STAFF

13.1 Any Molina employees will at all times remain employees of Molina and will be subject to the management and directions of Molina during the period of assignment.

13.2 Molina shall ensure that its assigned employees do not interfere with, hinder, restrict or prevent the Service Provider from meeting its obligations under the Agreement and that they comply with all Service Provider policies and procedures, as notified from time to time, while on Service Provider premises.

13.3 Prior to the expiry or termination of the Agreement, or the termination or partial termination of any Services (or where any such an event is reasonably likely to occur), the Service Provider will allow Molina or a Successor Supplier to assign an agreed number of their employees to the Service Provider in order to work-shadow the Service Provider Personnel to facilitate such transfer of knowledge and skills in relation to the Services as Molina shall consider to be necessary. Access by Successor Supplier personnel to Service Provider's premises or systems may be conditioned on the Successor Supplier executing a suitable confidentiality agreement.

14. **SERVICE PROVIDER ASSISTANCE**

14.1 At Molina's reasonable request, the Service Provider shall make available to Molina or a Successor Supplier for the continued support of the Services any Service Provider Personnel who do not transfer to Molina or a Successor Supplier for any reason, on a full or part time basis, as appropriate, for an agreed period following termination of the relevant part of the Services (or as otherwise required by Molina) in order to facilitate such transfer of knowledge and skills in relation to providing the Services to Molina's or a Successor Supplier's personnel, as shall be necessary to ensure, to Molina's satisfaction, uninterrupted continuity in the provision of the Services**. The Service Provider shall be entitled to charge for such continued support in accordance with the principles described in Schedule 8 (Termination Assistance and Exit).**

15. **LIABILITY AND INDEMNIFICATION**

15.1 Molina shall assume liability for all claims asserted by or on behalf of any Designated Employees arising out of their employment with Molina prior to their Service Provider Employment Date, including any termination of employment by Molina, and the Service Provider shall assume liability for all claims asserted by any Transitioned Employees arising out of their employment with or termination of employment from the Service Provider**.**

15.2 The Service Provider shall be fully responsible for and, unless prohibited by Applicable Law, shall defend, indemnify, keep indemnified and hold harmless Molina and each Molina Company against (a) all losses arising out of or relating to any claim or liability for any labor, employment or immigration related claim or any claim based on worker status brought against Molina or any Molina Company or any Molina subcontractor arising out of or in connection with any Service Provider Personnel, and (b) all costs, claims and liabilities arising out of or in relation to any of the foregoing (including costs and expenses, reasonable attorneys' fees and expenses), including with respect to any:

(a) alleged violation of federal, state, local, international or other laws or regulations or any common law protecting persons or members of a protected class or category, including without limitation laws or regulations prohibiting discrimination or harassment on the basis of a protected characteristic,

(b) alleged work-related injury, illness or death, except as may be covered by the Service Provider's workers' compensation plans,

(c) claim for payment of wages, or

(d) claim accrued employee pension or welfare benefits, except to the extent such claim arises in connection with a pension or benefit of a Transitioned Employee arising prior to the Service Provider Employment Date.

except to the extent such losses, costs, claims or liability results from any unlawful act or omission of Molina.

15.3 Molina shall indemnify and hold the Service Provider harmless, to the fullest extent permitted by applicable law, against any liability or expenses (including reasonable attorneys' fees and expenses) incurred or suffered by the Service Provider as a consequence of the Service Provider's being made a party or being threatened to be made a party to any action, suit or proceeding commenced by or on behalf of any Designated Employee arising out of or relating

to any act or omission by Molina or any employee or agent of Molina prior to the Effective Date with respect to any:

(a) alleged violation of federal, state, local, international or other laws or regulations or any common law protecting persons or members of a protected class or category, including without limitation laws or regulations prohibiting discrimination or harassment on the basis of a protected characteristic,

(b) alleged work-related injury, illness or death, except as may be covered by Molina's workers' compensation plan,

(c) claim for payment of wages, or

(d) claim for accrued employee pension or welfare benefit obligations;

except to the extent such losses, costs, claims or liability results from any unlawful act or omission of the Service Provider.

15.4 The provisions of this Paragraph 15 shall be in addition to any similar provisions contained in the Agreement and in other sections of this Schedule, and in the event of a conflict, the specific provision shall control over the general provision**.** The Parties shall follow the procedures set forth in the Agreement with respect to any claim for indemnification.

15.5 Each Party's indemnity obligations arising pursuant to this Paragraph 15 shall not be subject to, and shall not accrue against, any limitation of liability set out in the Agreement**.**

Appendix A
Key Personnel

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted] [redacted]		[redacted]			
[redacted]		[redacted] [redacted]			[redacted]	[redacted]	[redacted]
[redacted]		[redacted] [redacted]				[redacted]	[redacted]
[redacted]		[redacted] [redacted]			[redacted]	[redacted]	

SCHEDULE 16

DEPENDENCIES

CONTENTS

1. DEFINITIONS

1.1 Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) of this Agreement.

2. INTRODUCTION

2.1 This Schedule sets out the Molina Responsibilities and the date by which the Service Provider requires them to be completed.

Reference	Molina Responsibility	Due Date
DP1	Molina to provide access to all updated Inventories / CMDB / Asset Database (registers), Design Diagrams, Architecture Diagrams, Runbooks, Operating Manual, Operations policies and standards, Risk and Issues documents, Capacity Reporting methodology and reports, Vulnerability reports, CDC known error database, patching status reports, SLA/KRA/KPI Reporting, Quality check, 3rd Party contact information, 3rd Party contract details, required software tools and existing call / Service Desk ticket monitoring parameters that are required to perform the scope the services. IT inventories across Service Towers are aligned to the RU counts in the pricing sheet. Infosys would validate actual RU counts by the end of transition.	The start date for Transition as set out in the Detailed Transition Plan
DP2	Ensure that it has RTU (right to use) for the Service Provider to use the following Software in connection with the Service Provider's provision of the Services: Tools as set out in Appendix 6-D to Schedule 6.	45 days after the Effective Date
[redacted]	[redacted]	[redacted]
DP4	Molina's existing toll-free numbers will be leveraged for in-scope voice requirements (for general and VIP callers)	Final Go Live Date
[redacted]	[redacted]	[redacted]
DP6	Molina will provision required number of licenses for Service Provider Personnel, in a number subject to Molina's approval, to have access to ServiceNow (Access required - Fulfiller users, Planner Users, Worker User, Software Asset Management, Discovery), in each case as set out in the Detailed Transition Plan	The start date for Transition as set out in the Detailed Transition Plan
DP7	Molina will provide adequate seating facility to Service Provider Personnel onsite at Molina's office locations, in a number subject to Molina's approval, along with a Molina-imaged PC	Final Go Live Date
DP8	Molina will provide the applicable Service Provider Personnel, in a number subject to Molina's approval, access to the applicable Molina offices where such individual performs the Services	The start date for Transition as set out in the Detailed Transition Plan
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

DP13	• Molina will allow the use of collaboration tools like WebEx to conduct knowledge transfer sessions to transition team working from India delivery centers. All KT and some shadowing sessions will need to be recorded for later review. The recordings will be considered Molina property. • All backlog tickets carried forward from the current team into steady state will be excluded from SLA computation.	
DP14	Molina will assign technical resources to work with Infosys in order to set up remote connectivity with Infosys Bangalore/Chandigarh/Manila Offices.	One week before the start date for Transition as set out in the Detailed Transition Plan
DP15	• Molina to share the resource onboarding pre-requisite/process 10 business days before the start of the transition. • Molina to ensure Infosys designated resources are on-boarded in an expedited manner • Molina to provide VDI/Virtual Desktop/RSA/Remote Login capability to the On boarded resources • Infosys will provide complete list of resource names along with roles and location 10 days in advance to ensure proper onboarding during steady state • Infosys to ensure proper device availability for all resources offshore to meet Molina requirements as defined (Desktop, Laptops, Phones etc.,) before the resources are onboarded	The start date for Transition as set out in the Detailed Transition Plan
DP16	Approve draft transition plan, schedule and SME availability before the transition is commenced.	One week before the start date for Transition as set out in the Detailed Transition Plan

DP17	Share the details of the Molina SME's for each track and confirm the availability as per the KT Plan shared by Infosys. Infosys to share details of Infosys resources who will be participating in the KT sessions one day after contract signature	One week before the start date for Transition as set out in the Detailed Transition Plan
DP18	Molina to share details and ensure that there are adequate Underpinning Contracts/support arrangements with the OEM and Third party vendors (eg Microsoft, Oracle , IBM, ServiceNow, Cisco, etc) where there is an interdependency of services and deliverables.	During Transition Phase
DP19	Timely feedback (As per the transition plan) of Molina on the Infosys queries/deliverables/escalations during the overall Transition phase	During Transition Phase
DP20	Timely approvals during ARC/security council to bring in Infosys recommended tools IIMSS, ESM café and Cyber Gaze into Molina environment Molina will provide required infrastructure for installation of Infosys recommended tools (IIMSS, ESM café and Cyber Gaze) in Dev, QA and Production environment	The start date for Transition as set out in the Detailed Transition Plan
DP21	Provide access to Molina facilities, depots and logistic service providers	The start date for Transition as set out in the Detailed Transition Plan
DP22	Molina will ensure that every dispatch site is made accessible to the named and verified Infosys dispatch engineer along with a site contact	The start date for Transition as set out in the Detailed Transition Plan
DP23	During transition, Molina will be the single point of contact for any communication and will mediate on any issues or conflicts with any third party vendors.	During KT Phase
DP24	Third party contact information will be provided to Infosys team during KT phase. For e.g. WAN Link provider information, Third party asset disposal services etc	During KT Phase
DP25	All in-flight Infra projects will be assessed by Infosys as part of the transition and an approach for assisting in in-flights and taking over support as per the Statement of Work will mutually agree to by Infosys and Molina.	During KT Phase
[redacted]	[redacted]	[redacted]
DP27	Any other dependencies expressly set out in the Agreement as a responsibility of Molina e.g FRMor SOWs.	During Transition and Steady State

DP28	Molina will complete 50% of DR migration to Azure (based on # of VMs, storage and back-up) and the remaining work will be completed by Infosys.	Transition to steady state complete
DP29	• Infosys and Molina to provide organization holiday calendar before transition, to put the transition plan accordingly • Molina to provide vacation calendar/details of the Molina SMEs participating in KT sessions. The details to be provided before the transition commencement date, for transition planning	The start date for Transition as set out in the Detailed Transition Plan
DP30	Molina will assign SME(s) to provide requirements to build Business Service Assurance (BSA) use-cases during IIMSS implementation phase. The SME also will be responsible to get necessary approvals from Molina team (IT/Business) to enable IIMSS team build necessary interfaces, access to required tools and data. Molina will provide the priority of the applications that needs to be covered under BSA. Infosys IIMSS team will build BSA for 4 critical applications.	During steady state
DP31	Molina will provide OEM/third party support for End Of Life (EOL) hardware and software configuration items. This would be finalized during the Transition.	Transition to steady state complete

SCHEDULE 17

MUTUAL ASSISTANCE AND COOPERATION

CONTENTS

1. DEFINITIONS

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) to this Agreement.

2. INTRODUCTION

2.1 This Schedule deals with the interaction between the Service Provider and the Other Service Providers.

2.2 Nothing in this Schedule relieves the Service Provider of any of its obligations under this Agreement or any Project Work Order, or requires any Other Service Provider to perform any of the Service Provider's obligations under this Agreement or any Project Work Order.

2.3 The Service Provider shall enter into an Agreed Form Non-Disclosure Agreement with the Other Service Providers where requested to do so by Molina to facilitate the performance of its obligations under this Schedule.

3. MUTUAL ASSISTANCE

3.1 The Service Provider shall provide Molina and each Other Service Provider with reasonable cooperation and assistance as requested by each such party.

3.2 In particular, the Service Provider shall provide reasonable cooperation to each Other Service Provider in relation to the following matters (in each case, in so far as the matters set out below are relevant to the Services or any Deliverables, or to Systems, Software or services that relate to the Services or any Deliverables):

(a) change management and in particular any relevant change control process;

(b) problem management;

(c) service desk management;

(d) business continuity, technology refresh and disaster recovery planning;

(e) security of Molina Data, Applications and Systems (including Intellectual Property Rights);

(f) transfer and migration of Molina Data;

(g) data recovery and back–up procedures;

(h) operation and execution of production control and job schedules;

(i) database administration;

(j) configuration management;

(k) any handover processes;

(l) crisis management and escalation management;

(m) project management; and

(n) security of Service Provider Data and Systems (including Intellectual Property Rights therein).

3.3 In addition to the general obligations set out in paragraphs 3.1 and 3.2, the Service Provider shall:

(a) provide all the Other Service Providers with:

(i) the Service Provider's roles and accountabilities for its delivery of the Services, including organization charts, operating models and contact details, in particular to ensure that contact points and interfaces are understood;

(ii) reasonable knowledge transfer about Deliverables that have been developed by the Service Provider, and about the Services and the Systems supported or managed by the Service Provider under this Agreement, including difficulties and issues the Other Service Provider may encounter in working with those Deliverables, Services and Systems;

(iii) such information regarding the operating environment, system constraints and other operating parameters applicable to the Deliverables and the Services and the Systems supported or managed by the Service Provider under this Agreement as a service provider with reasonable technical skills and expertise would find reasonably necessary in order to perform its work; and

(iv) such information as is necessary to assist the Other Service Providers with interoperation of its services with the Deliverables and the Services and the Systems supported or managed by the Service Provider under this Agreement,

(b) provide cooperation, support, information and assistance to the Other Service Providers in a proactive, transparent and open way and in a spirit of trust and mutual confidence;

(c) where possible, work with the Other Service Providers to prepare, and then deliver services according to, a single, consolidated project plan incorporating all the milestones that the Service Provider and each Other Service Provider is required to achieve. If that is not possible, the Service Provider must at a minimum co-ordinate its project plans with those of the Other Service Providers to ensure that they are consistent, that dependencies between the Service Provider and the Other Service Providers are clearly identified and that milestones are aligned between project plans in order to ensure the optimal delivery of the Services and the Other Services to Molina;

(d) communicate appropriately and provide reasonable availability to communicate in order to reach mutual solutions where necessary;

(e) cooperate and assist with acceptance testing and any necessary quality assurance analysis;

(f) make itself available for a reasonable time after each Deliverable has Passed, to respond promptly to questions and problems raised by the Other Service Providers in connection with that Deliverable;

(g) cooperate with the Other Service Providers in identifying planned downtime, and cooperatively plan and communicate planned downtime so as to maximize benefit to Molina and minimize disruption to the services and to Molina's business;

(h) cooperate with the Other Service Providers to co-coordinate the scheduling and conducting of testing and the preparation of test scripts and test cases, and to review test results as applicable;

(i) where Incidents or Problems occur in relation to any Deliverable or any Services or any Systems supported or managed by the Service Provider under this Agreement, cooperate reasonably and in good faith with the Other Service Providers, to the extent that this is required, including:

(i) identifying what it would take to Resolve the Incident or Problem;

(ii) Resolving an Incident or fixing a Problem as expeditiously and cost effectively as possible and waiting until after the resolution of the relevant Incident or Problem to raise (or take any action in relation to) any dispute as to whether which Party or Other Service Provider is responsible, which Party or Other Service Provider should bear the cost of fixing the Incident or Problem or any associated legal issues;

(iii) providing prompt information where necessary; and

(iv) where Incidents or Problems occur that have multiple possible solutions (including Incidents or Problems that could be resolved through action by the Service Provider, whether alone or with the Other Service Providers), cooperate with Molina and/or the Other Service Providers to Resolve the Incident or Problem in the way that causes the least disruption and cost to Molina and complies with recognized industry standards and practices;

(j) promptly identify any inconsistencies, ambiguities or gaps between the Other Service Providers' respective accountabilities and responsibilities which impact (or may impact) upon the delivery of the services, and proactively engage the Other Service Providers to resolve any such inconsistencies, ambiguities or gaps;

(k) adopt standard processes to support end to end service delivery in collaboration with the Other Service Providers. Adoption of standard processes means that:

(i) the Service Provider shall actively participate in the design, development, introduction and operation of end to end service delivery processes, including by participation in multi-supplier governance meetings and working sessions as required; and

(ii) the Service Provider shall provide its own insight and experience as required to support end to end service delivery processes; and

(l) wherever possible, for a given concept adopt such standard terminology as is used already by Molina and the Other Service Providers and where no such standardized terminology exists, use recognized industry standard terminology wherever possible, in preference to terminology that describes the Service Provider's own products, services, tools and processes.

3.4 In addition to the obligations set out in paragraphs 3.1 to 3.3, the Service Provider shall, in relation to each AD Service Provider:

(a) in connection with each Project that relates to a project for the development of an Application:

(i) collaborate with the AD Service Provider in developing an estimate of the work required by the Service Provider to support a Project, based on input from Molina or the AD Service Provider and their requirements of the Service Provider; and

(ii) when reviewing Input Deliverables provided by the AD Service Provider, identify to both Molina and the AD Service Provider any issues that the Service Provider believes arise as a result of information obtained by reviewing the Input Deliverables;

(b) provide the AD Service Provider with reasonable information about the Systems supported or managed by the Service Provider under this Agreement in order to assist the AD Service Provider in developing Applications that will depend upon, be used in conjunction with or otherwise relate to those Systems; and

(c) proactively, and with cooperation and support from Molina in obtaining this information, in accordance with Good Industry Practice, obtain from the AD Service Provider all necessary information about the Applications being developed by the AD Service Provider and any related Third Party Software to be used in conjunction with the Deliverables or with the Applications being developed by the AD Service Provider, and use that information in the provision of the Services.

3.5 In addition to the obligations set out in paragraphs 3.1 to 3.3, the Service Provider shall, in relation to each AM Service Provider, provide such information about the Services and the Systems supported or managed by the Service Provider under this Agreement as the AM Service Provider may require in order to provide maintenance, management and/or operations services in relation to any Application that will depend upon, be used in conjunction with or otherwise relate to the Services or those Systems.

3.6 In addition to the obligations set out in paragraphs 3.1 to 3.3, the Service Provider shall, in relation to each Infrastructure Supplier:

(a) participate in any reasonable discussions requested by the other Infrastructure Supplier regarding the other Infrastructure Supplier's requirements;

(b) where necessary, provide reasonable assistance to the other Infrastructure Supplier in meeting its requirements; and

(c) ensure that the other Infrastructure Supplier is kept up-to-date with such information about the Deliverables and the Services and the Systems supported or managed by the Service Provider under this Agreement as is reasonably required by the Infrastructure Supplier.

3.7 If the Service Provider is not receiving the cooperation that it requires from any Other Service Provider and the lack of cooperation could impact on the Service Provider's ability to perform any of the Services, then the Service Provider shall promptly notify Molina. Molina shall procure

the mutual cooperation and assistance of the Other Service Provider as contemplated by this Agreement.

3.8 A dispute or uncertainty about the financial consequences of, or operational responsibility for an Incident or Problem does not entitle the Service Provider to delay the resolution of that Incident or Problem or to suspend or defer the performance of the Services or any Other Services.

3.9 The Service Provider shall provide to Molina, at Molina's request, information collected by the Service Provider or provided to the Service Provider about Molina's business, operations, Applications and Systems, as reasonably required by Molina, and Molina shall be entitled to share that information with each Other Service Provider for the purpose of that Other Service Provider providing services to the Molina Companies.

3.10 The Service Provider shall comply with the reasonable security and health and safety policies of each Other Service Provider if it is working on the site of that Other Service Provider.

3.11 Molina is responsible for informing the Service Provider of the identity of each Other Service Provider to whom the Service Provider is required to provide cooperation and assistance under this Schedule, including informing the Service Provider of the Applications for which each such AD Service Provider and AM Service Provider is responsible and the Systems for which each such Infrastructure Supplier is responsible.

4. OPERATIONAL LEVEL AGREEMENTS

4.1 In order to facilitate the smooth and effective delivery of services (including the Services) to Molina in a multi-vendor environment, Molina may require the Service Provider to enter into an operational level agreement ("Operational Level Agreement") with any Other Service Provider, as specified by Molina.

4.2 A change to any Operational Level Agreement and the re-allocation of responsibilities within any Operational Level Agreement shall be dealt with entirely between the Service Provider and the relevant Other Service Provider and shall not require an Agreement Change, in accordance with the provisions of this Agreement.

4.3 The principal purpose of each Operational Level Agreement shall be to clarify the relevant responsibilities, accountability, access and dependencies between the Service Provider and the relevant Other Service Provider in respect of services to be provided to Molina.

4.4 A copy of each Operational Level Agreement and each subsequent version thereof shall be published by the Service Provider on the Contract Management Portal promptly after it is signed.

SCHEDULE 18
MOLINA LOCATIONS

CONTENTS

1. **DEFINITIONS**

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) of this Agreement.

2. **INTRODUCTION**

This Schedule is divided into three sections and sets out the Molina Locations at which Molina operates and where the Service Provider shall provide the Services.

3. **MOLINA LOCATIONS SERVICE MATRIX**

The following table sets out the Molina Locations at which the Services shall be provided:

#	Address Suite	City	State	Postal Code	Type
1.	200 S. Main St	Corona	CA	92882	Office
2.	1607 W. Main St,	El Centro	CA	92243	Office
3.	1500 Hughes Way, Pod A	Long Beach	CA	90810-1870	Office
4.	604 Pine Ave (Press Telegram)	Long Beach	CA	90802-1329	Office
5.	650 Pine Ave (Meeker Baker)	Long Beach	CA	90802-1329	Office
6.	100 Oceangate, 15th Floor	Long Beach	CA	90802	Office
7.	300 Oceangate (300 Tower)	Long Beach	CA	90802	Office
8.	200 Oceangate, #100	Long Beach	CA	90802-4317	Office
9.	One Golden Shore Drive	Long Beach	CA	90802	Parking
10.	1151 Walnut Avenue	Ontario	CA	91761	Clinic
11.	887 E. 2nd Street	Pomona	CA	91766-2009	Clinic/Office
12.	35-800 Bob Hope Drive	Rancho Mirage	CA	92270	Office
13.	2180 Harvard St, #500	Sacramento	CA	95815	Office
14.	300 University Avenue, #100	Sacramento	CA	95825-6518	Office
15.	550 E. Hospitality Lane, #100	San Bernardino	CA	92408	Office
16.	9275 Sky Park Court, #350	San Diego	CA	92123	Office

#	Address Suite	City	State	Postal Code	Type
17.	222 West 6th Street, floors 6, 7, 8 &11	San Pedro	CA	90731	Office
18.	8300 N.W. 33rd Street, #400	Doral (Miami)	FL	33122-1940	Office
19.	8200 NW 33rd Street	Doral (Miami)	FL	33122	Office
20.	6622 SouthPoint Drive South, #450	Jacksonville	FL	32216	Office
21.	3450 Buschwood Park Drive, #200	Tampa Bay	FL	33618	Office
22.	950 Bannock St., Offices 1116 & 1117	Boise	ID	83702	Temp Office
23.	950 Bannock St., Office 1169	Boise	ID	83702	Temp Office
24.	9050 Overland, Suite 155	Boise	ID	83704	Office
25.	1520 Kensington Rd, #212	Oak Brook	IL	60523-2197	Office
26.	One West Old State Capitol Plaza, #300	Springfield	IL	62701	Office
27.	615 W. Lafayette Blvd., #500	Detroit	MI	48226	Office
28.	1321 S. Linden Road, #A	Flint	MI	48532	Office
29.	3196 Kraft Ave, #303	Grand Rapids	MI	49512	Office
30.	880 West Long Lake Rd	Troy	MI	48098-4504	Office
31.	188 E Capitol, Suites 600, 700, 800	Jackson	MS	39201	Office
32.	5610 Turing Dr SE	Albuquerque	NM	87106-9703	Data Center
33.	400 Tijeras Ave NW	Albuquerque	NM	87102	Office
34.	Kent Ave & 8th St	Albuquerque	NM	87102	Parking
35.	500 4th Street	Albuquerque	NM	87102	Parking
36.	5232 Witz Dr.	Clay	NY	13212	Office
37.	70 E 55th St., 8th Floor	New York	NY		Office
38.	819 South Salina St	Syracuse	NY	13202	Office
39.	1101 Erie Blvd East, Suite #100	Syracuse	NY	13210	Clinic

#	Address Suite	City	State	Postal Code	Type
40.	9987 Carver Rd, Suite 250	Blue Ash	OH	45242	Office
41.	25 Merchant St, #200	Cincinnati	OH	45246	Office
42.	3000 Corporate Exchange Dr	Columbus	OH	43231	Office
43.	6161 Oak Tree Blvd, #200	Independence (Cleveland)	OH	44131	Office
44.	6001 Woodland Ave	Cleveland	OH	44104	Office/Storage
45.	PR State Road 908, Km 0.4, Barrio tejas	Humacao	PR	791	Office
46.	111 Hostos Ave.	Ponce	PR	716	Office
47.	652 Munoz Rivera Ave, #300	San Juan	PR	918	Office
48.	654 Munoz Rivera Ave, #1600	San Juan	PR	918	Office
49.	Calle 25 de Julio St, #53, Urb. Villa Milagros	Yauco	PR	698	Office
50.	440 Knox Abbott Drive, #430	Cayce	SC	29033-4353	Office
51.	4105 Faber Place Drive, #120	N. Charleston	SC	29405	Office
52.	4316 South McColl Road	Edinburg	TX	78539-3160	Office
53.	445 Executive Center, #100	El Paso	TX	79902-1003	Office
54.	15115 Park Row, #110	Houston	TX	77084-4288	Office
55.	1660 N. Westridge Circle,	Irving	TX	75038	Office
56.	5605 MacArthur, #400	Irving	TX	75038-2693	Office
57.	6999 MacPherson Road, #213	Laredo	TX	78041-6450	Office
58.	1255 W. 15th St, #100	Plano	TX	75075	Office
59.	1232 Alma Rd.	Richardson	TX	75081	Data Center

#	Address Suite	City	State	Postal Code	Type
60.	84 NE Loop 410, #200	San Antonio	TX	78216-8419	Office
61.	7050 Union Park Center, #240	Midvale	UT	84047-4169	Office
62.	7070 Union Park Center	Midvale	UT	84047	Office
63.	3959 Pender Dr, Suite 240	Fairfax	VA	22030	Office
64.	4101 Cox Rd, #100	Glen Allen	VA	22408	Office
65.	21540 30th Drive SE 101, #400	Bothell	WA	98021	Office
66.	15 SW Everett Mall Way, #A	Everett	WA	98208-3230	Clinic
67.	1330 North Washington St, #4000	Spokane	WA	99201	Office
68.	19120 SE 34th St, 2nd floor	Vancouver	WA	98683	Office
69.	616 A Valley Mall Parkway	East Wenatchee	WA	98802	Office
70.	601 13th St NW, #800 North	Washington	WA DC	20005	Office
71.	11002 W. Park Place	Milwaukee	WI	53224	Office

SCHEDULE 19
AGREED FORM NON-DISCLOSURE AGREEMENT

Non-Disclosure Agreement

CONTENTS

THIS CONFIDENTIALITY AGREEMENT is made on [●]
BETWEEN:

(1) [●], a company registered in [●] (company number [●]), whose registered office is at [●] ("[●]"); and

(2) [●], a company registered in [●] (company number [●]), whose registered office is at [●] ("[●]").

Each of [●] and [●] is referred to in this Confidentiality Agreement as a "**Party**", and they are referred to collectively as the "**Parties**".

INTRODUCTION:

The Parties' mutual objective under this Confidentiality Agreement is to provide protection for confidential information ("**Information**") while maintaining their ability to conduct their respective business activities. Each Party agrees that the following terms apply when the disclosing Party (the "**Discloser**") discloses Information to the other, receiving Party (the "**Recipient**") which relates to or is acquired in consequence of either Party's engagement with ***[Molina Healthcare Entity]*** ("**Molina**") for [●].

For the avoidance of doubt the obligations under this Confidentiality Agreement will apply only with effect from the date of signature hereof.

THE PARTIES AGREE as follows:

1. DISCLOSURE

1.1 Information will be disclosed either:

a(in writing;

b(by delivery of items;

c(by initiation of access to Information, such as may be in a database; or

d(by oral or visual presentation.

1.2 Information should be marked with a restrictive legend of the Discloser. If Information is not marked with such legend or is disclosed orally, the Information will be identified as confidential at the time of disclosure. In any event, Information will be protected by this Confidentiality Agreement if by its nature it would reasonably be considered to be confidential even if it is not marked with a restrictive legend or identified as confidential at the time of disclosure.

2. **OBLIGATIONS**

2.1 The Recipient agrees to:

1(a) use the same care and discretion to avoid disclosure, publication or dissemination of the Discloser's Information as it uses with its own similar information that it does not wish to disclose, publish or disseminate; and

1(b) use the Discloser's Information solely for the purpose for which it was disclosed or otherwise for the benefit of the Discloser.

2.2 The Recipient may disclose Information to:

1(a) its employees who have a need to know, and employees of any legal entity that it controls, controls it, or with which it is under common control, who have a need to know. Control means to own or control, directly or indirectly, over 50% of voting shares;

1(b) employees of Molina who have a need to know and employees of any legal entity that Molina controls, controls Molina, or with which Molina is under common control, who have a need to know. Control means to own or control, directly or indirectly, over 50% of voting shares; and

1(c) any other party with the Discloser's prior written consent.

2.3 Before disclosure to other parties as described in Clause 2.2(c), the Recipient will have a written agreement with the party sufficient to require that party to treat Information in accordance with this Confidentiality Agreement.

2.4 The Recipient may disclose Information to the extent required by law. However, unless prohibited by law, the Recipient will give the Discloser prompt notice to allow the Discloser a reasonable opportunity to obtain a protective order.

2.5 Notwithstanding the Parties' obligations in this Clause 2, the Parties acknowledge that general ideas, concepts and know-how contained in the Discloser's Information may be retained in the unaided memories (meaning that part of the memory that cannot be controlled or influenced by a person) of the Recipient's employees who have had access to the Information in accordance with the terms of this Confidentiality Agreement. The Parties therefore agree that the Recipient shall not be in breach of this Confidentiality Agreement if the Recipient's employees who have had access to such Information use such retained general ideas, concepts and know-how in conducting the Recipient's business activities.

2.6 Nothing contained in Clause 2.5 gives the Recipient the right to disclose, publish or disseminate:

(a) the source of Information;

(b) any financial, statistical or personnel data of the Discloser; or

(c) the business plans of the Discloser.

Furthermore, neither Party shall use any ideas, concepts or know-how if such use involves the reproduction or reconstruction of any Information in such a form as may involve an infringement of the other Party's intellectual property rights.

3. CONFIDENTIALITY PERIOD

Information disclosed under this Confidentiality Agreement will be subject to this Confidentiality Agreement for ten (10) years following the initial date of disclosure.

4. EXCEPTIONS TO OBLIGATIONS

The Recipient may disclose, publish, disseminate and use Information that is:

(a) already in its possession without obligation of confidentiality;

(b) developed independently;

(c) obtained from a source other than the Discloser without obligation of confidentiality;

(d) publicly available when received, or subsequently becomes publicly available through no fault of the Recipient; or

(e) disclosed by the Discloser to another person without obligation of confidentiality.

5. DISCLAIMERS

5.1 The Discloser provides Information without warranties of any kind in favor of the Recipient.

5.2 The Discloser will not be liable to the Recipient for any damages arising out of the use of Information disclosed under this Confidentiality Agreement unless and except to the extent that such damages arise as a direct result of the Discloser providing information it did not have the right to provide.

5.3 Neither this Agreement nor any disclosure of Information made under it grants the Recipient any right or license under any trademark, copyright or patent now or subsequently owned or controlled by the Discloser.

6. GENERAL

6.1 This Agreement does not require either Party to disclose or to receive Information.

6.2 Neither Party may assign, or otherwise transfer, its rights or delegate its duties or obligations under this Confidentiality Agreement without prior written consent. Any attempt to do so is void.

6.3 The receipt of Information under this Confidentiality Agreement will not in any way limit the Recipient from:

(a) providing to others products or services which may be competitive with products or services of the Discloser;

(b) providing products or services to others who compete with the Discloser; or

(c) assigning its employees in any way it may choose.

6.4 The Recipient will comply with all applicable export and import laws and regulations provided that the Discloser has provided the applicable export control classification number so as to enable such compliance.

6.5 Only a written agreement signed by both Parties can modify this Confidentiality Agreement.

6.6 Either Party may terminate this Confidentiality Agreement by providing one month's written notice to the other. Any terms of this Confidentiality Agreement which by their nature extend beyond its termination remain in effect until fulfilled, and apply to respective successors and assignees.

7. ENTIRE AGREEMENT

This Confidentiality Agreement is the complete and exclusive agreement regarding the Parties' disclosures of Information, and replaces any prior oral or written communications between the Parties regarding these disclosures. By signing below for their respective enterprises, each Party agrees to the terms of this Confidentiality Agreement. Once signed, any reproduction of this Confidentiality Agreement made by reliable means (for example, photocopy or facsimile) is considered an original.

8. GOVERNING LAW AND JURISDICTION

This Confidentiality Agreement is governed by, construed in accordance with, and enforced under the substantive Law of the State of New York, without giving any effect to any contrary choice of law or conflict of law provision or rule (whether of the State of New York or any other jurisdiction). Any claim or action brought by a Party in connection with this Confidentiality Agreement, or any part hereof, will be brought in the appropriate federal or state court located in the State of New York, New York County, and the Parties irrevocably consent to the exclusive jurisdiction of such courts. The United Nations Convention on Contracts for the International Sale of Goods and New York conflict of law rules do not apply to this Agreement or its subject matter. In any action relating to this Confidentiality Agreement, each of the Parties irrevocably waives the right to trial by jury.

By signing below, both Parties agree to perform their obligations set out in this Confidentiality Agreement.

…….. ……..
For and on behalf of For and on behalf of
<insert company name> *<insert company name>*

<Name> *<Name>*
<Title> *<Title>*
<Date> *<Date>*
<E-mail address> *<E-Mail Address>*
<Telephone number> *<Telephone Number>*

SCHEDULE 21

SERVICE PROVIDER TECHNICAL SOLUTION

CONTENTS

1. **DEFINITIONS AND INTERPRETATION**

1.1 Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) to the Agreement**.**

2. **GENERAL PROVISIONS**

2.1 This Schedule sets out the Service Provider Technical Solution, as contemplated in the Agreement.

3. **SERVICE PROVIDER TECHNICAL SOLUTION**

See below.


MOLINA HEALTHCARE
Infosys
Navigate your next
Technical Solution Document – Technical Solution Overview and Current Mode of Operations

1 CONTENTS

1 INTRODUCTION

1.1 Overview of the Technical Solution Document (TSD)

Overview:
The Technical Solution Document (TSD), is an artefact detailing the various elements of the technical solution detailed in the entire document.

1.2 Definitions

Following are the definition of the terminologies used this document:

Terminology	Definition
TSD	Technical Solution Document
RFP	Request for Proposal
IIMSS	Infosys Infrastructure Management Solution Suite
ESM Café	Enterprise Service Management Café
DR	Disaster Recovery
BCP	Business Continuity Plan
FTE	Full Time Employee
SLA	Service Level Agreement
CSL	Critical Service Level
KPI	Key Performance Indicator

Table 1. List of Terminologies

2 TECHNICAL SOLUTION OVERVIEW

2.1 Current Mode of Operations

2.1.1 Current Delivery Locations

Infosys understands that Molina office at Long Beach, CA is the primary delivery location, from where the infrastructure services are provided apart from the EUC services where skilled staff are stationed on those locations.

SOW	Service Delivery Location #1	Service Delivery Location #2
Service Desk	Long Beach, CA	Bothell, WA
End User Services	102 Locations across 22 states of US & Puerto Rico with dedicated and dispatch services	
Infrastructure Services	NOC – Long Beach, CA	
Security Services	Long Beach, CA	

Table 2. Delivery Locations

The Molina's platform engineering area is divided into seven capability areas. A combined internal and contractor workforce of approximately 317 FTEs, are catering to these capability areas.

There are two Main Datacenter New Mexico (NM) and Co-Lo (Digital Reality) in Texas. Where prior services as Primary DC and later as Cold DR DC with exceptions to Telephony/Call Center services (with capacity limitations).

2.1.2 Current Assets, Layouts

2.1.2.1 Architecture Overview

2.1.2.2 Inventory of Molina IT Assets

[redacted]

Figure 1.[redacted]

Following is the Molina inventory detail and analysis done by Infrastructure technology tracks:

Server Inventory

[redacted]	[redacted]
[redacted]	[redacted]

Table 3. [redacted]

Network Inventory

[redacted]	[redacted]
[redacted]	[redacted]

Table 4. [redacted]

Storage and Backup Inventory

[redacted]	[redacted]
[redacted]	[redacted]

Table 5. [redacted]

Database Inventory

[redacted]	[redacted]
[redacted]	[redacted]

Table 6. [redacted]

Middleware Inventory

[redacted]	[redacted]
[redacted]	[redacted]

Table 7. [redacted]

EUC Inventory

[redacted]	[redacted]
[redacted]	[redacted]

Table 8. [redacted]

Service Desk Inventory

[redacted]	[redacted]
[redacted]	[redacted]

Table 9. [redacted]

2.1.3 Current Processes & Performance Standards

Current Processes

Process	Process Description
Business Continuity	This deals with the Business Continuity, in case, if there is any incident where normal business functions delivery is affected or at risk. The definition and policy with the handling procedure are understood and can be accommodated in the overall Infosys BCP solution.
Data Center SOPs	The supplied SOP's (201-211) are in general part of the best practices wherever Infosys deliver managed services operations. They largely deals with the material movement, DC access, Disk wipe procedure, DC walkthrough etc.
Enterprise Infrastructure Services Policies	As stated above, similarly for the infrastructure services policies are also part of the Infosys delivered managed services. We build upon the existing policies and keep the policies reviewed to ensure the adherence to the agreement shared with our customers.
HIPAA	Infosys is aware of the HIPAA requirement while working in the Health care sector. We understand the sensitivity of the health information and care that needs to be taken to ensure that they are only available for the authorized eyes only. Infosys agrees to abide by the terms set forth Molina's BAA.
Incident	The document provided gives quite good understanding of the Incident prioritization and thereafter Molina specific process to handle the designated Major Incident. Infosys may review this and mutually agree the changes so that it is best suitable for all stages of the engagement.
Service Management Policies	All the ITSM policies/Sourcing/SR/Security are not revised for more than 2 years. However, we believe these are derived out of the best practices and can be followed without review.
Additional Policies	We have gone through the additional policy documents shared namely, SOX, Document retention and destruction, VIP Support policy, Physical DC etc. are found to be in line with our understanding too. We will comply with these as well.

Table 10. Current Process

Current Performance Standards

We have analyzed the following documents such as Schedule 7 (Governance) and Appendix 6-A (Service Level Matrix) to understand the status of the Molina IT operations prior to the Effective Date. However, no service levels values, benchmarks were provided.

Infosys believes the Service levels and Governance both needs to be in place for progressive delivery of the performance standards. We are delighted to see that Molina review the service levels and performance against them on regular basis. It is also noted that the regular reports are reviewed and discussed by the respective governance group's viz., Operational Review Board, Multi-Supplier Operational Committee, IT Core Leadership Team and Executive Steering Committee. Moreover, the optimization also becomes the part of the discussion to ensure the continuous improvements are done over and above what is being reported and monitored.

Below are the Molina expected Infrastructure SLA's*:

Type	Service Level Name	Description / Overview
Critical Service Level (CSL)	Database Cluster Availability	Measures the percentage availability of Database Clusters (with redundancy within the site) in Data Centers
	Response Time (Priority 1)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.
	Response Time (Priority 2)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.
	Resolution Time (Priority 1)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.
	Resolution Time (Priority 2)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.
	Installation of Emergency Software or Patches	Percentage of Emergency Software or Patches for which the process was started immediately, and installed on Infrastructure within the designated timeframe.
	Network Infrastructure Availability	Measures the percentage availability of Production Network Infrastructure

Type	Service Level Name	Description / Overview
Key Performance Indicator (KPI)	Backup Storage Device Availability	Measures the percentage availability of the backup storage devices
	Stand-Alone Device Availability	Measures the aggregate availability of the in-scope stand-alone devices
	Communication Time	Measures the percentage of incidents where the incident was communicated with business impact and technical description of what is being investigated, to appropriate business partners and technical teams within the appropriate amount of time.
	Response Time (Priority 3)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.
	Response Time (Priority 4)	Measures the percentage of incidents where the incident was responded to within the appropriate amount of time.
	Resolution Time (Priority 3)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.
	Resolution Time (Priority 4)	Measures the percentage of incidents where the incident was resolved within the appropriate amount of time.
	Root Cause Analysis Time	Measures the percentage of Priority 1 and 2 incidents that receive a final root cause analysis within the designated timeframe. Pending responses from third party suppliers are acceptable
	Batch Job Commencement	Measures the percentage of batch jobs failures where the failure was responded to (following SOP guidelines) within the designated timeframe.
	Successful Completion of Backup and Recovery	Measures the percentage of successfully completed backup and recovery jobs.
	Infrastructure Capacity Provisioning	Measure of Capacity provisioning requests completed within the time allotted
	Installation of Approved Software or Patches	Percentage of Approved Software or Patches installed on Infrastructure within the time allotted (as per Molina patching and installation scheduling requirements)
	Contract Management	Measures the percentage of Contract Change Order, Invoices Correct and On-Time (calculated on number of lines).
	Reporting	Measures the Supplier's ability to deliver reports to Molina according to the planned and/or scheduled cadence
	Documentation	Completion of all scheduled documentation revisions and drafts as defined by Molina
	Security Review	Measures the performance of all security reviews within specified timeframes
	Capacity Reporting	Measures the number of CPU Capacity Events or Storage Capacity Events not reported within one business day.
	File Recovery / Restoration	Measure of restoration requests where the restore is initiated is that are completed with the allotted time
	Account Provisioning Error Rates	Percentage of Account Provisioning (including de-Provisioning) requests processed incorrectly to total number of requests by type
	Customer Satisfaction	Measures the percentage of Infrastructure stakeholders (as defined by Molina) who are satisfied with the Services (e.g., BAU, Continuous Improvement and Innovation).

Table 11. Current Performance Standards

*All SLA's are subject to due diligence

Infosys understands that Molina is already following these above mentioned service levels. However, Infosys would further like to understand the current adherence to these service levels achieved.

2.1.4 Current Tools and Licensing

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Table 12. [redacted]

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Table 14. [redacted]

2.1.4.1 Purpose and Scope

The primary purpose of these tools is to support various technology areas, mentioned in the latest tools data provided in ‘20181029_Attachment D _Tools and Technology_updates.xlsx’

Infosys is expected to support all these tools and agrees for the same. However, the license(s) of these tools remains with Molina, and Infosys need to support Molina, with periodic license updates to avoid any license renewal issues, from the time perspective.

Also, Molina has a strong preference for non-proprietary, commercially available tools but open for discussion and inclusion of any such tools, if it brings transformational value and thereby helps optimize the operations further.

2.1.4.2 PE/Telecom/Network Security

Platform Engineering (PE)

PE is part of Molina’s Infrastructure landscape construct, among the five core groups. The PE is further categorized into seven capability areas, namely:

- Solution Engineering
- Core Engineering
- IT Security and Identity Management
- Operations
- DB & Analytics Platform

- Quality Management
- Service and Relationship Management

The PE tools support, the following technology/process areas:

- Asset Management
- Collaboration
- Configuration Management
- Data Management
- Endpoint Management
- Hypervisor
- Operations Monitoring/Metrics
- QA
- Security – Access, Detection and Operations
- Service Management
- Storage and Backup
- Source Control Management

The details of the tools, as provided by Molina is already provided in the beginning of this section – Section 2.1.4

Telecom Tools

[redacted]

2.1.5 Current Challenges and Focus Areas (Please add other topics as appropriate)

2.1.5.1 Expansive and Highly Disparate Infrastructure Landscape

Based on our analysis of Molina's Infrastructure landscape, for the same work areas, multiple technologies, tools, multiple different versions of software(s) and hardware. [redacted].

The details around all these things have already been provided in various sections of this document.

2.1.5.2 Disaster Recovery/Business Continuity (DR/BC)

Infosys understands the following challenges and Infosys recommendations:

[redacted]

2.1.5.3 End-of-Life Devices Increasing Risk, Support Complexity, and Upkeep Costs

Infosys have performed analysis on the Molina infrastructure estate, as per the inventory provided, and following are the details by technology tracks where and how much devices have already reached end-of-life or reaching end of life by [redacted].

[redacted]

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Table 15. [redacted]

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Table 16. [redacted]

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Table 17. [redacted]

Storage:
The total number of storage arrays as per inventory are [redacted] with total storage capacity of [redacted].
(source: A-2 Storage Services and A-3 Storage Services – Remote worksheets in 27. Attachment B (Infrastructure Data) workbook)

[redacted]

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Table 18. [redacted]

End User Devices:
Following are the details of the end user devices (desktops and laptops) contributing to EOL:
(source: B-1 Desktops and Laptops in worksheets in 27. Attachment B (Infrastructure Data) workbook)

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 19. [redacted]

2.1.5.4 [redacted]

2.1.5.5 [redacted]

2.1.6 Other Information on Current State

Not applicable

2.2 Lift, Shift and Enhance for Core Infrastructure

2.2.1 Service Delivery Model, Processes, and Procedures

The graphic below visualized the governance committees which the Parties are to implement and participate in accordance with the Agreement, including Schedule 7 (*Governance*).

These governance models are defined in accordance to Molina's ask and agreed through 'Schedule 7' and 'Appendices 7-A and 7-B' documents related to Governance.

In addition to the robust governance structure, we also have a comprehensive delivery structure at multiple layers and with right SMEs and management coverage at onsite and offshore for seamless delivery of services.

This integrated managed services model is based on ITIL V3 framework, bringing in synergies between various teams, and **driving efficiencies, quality and productivity improvements and ownership of services**. While the teams will be organized by areas of expertise and core delivery, they will act as **one cohesive team for Molina Healthcare** acting in unison to deliver on time, on budget and on specifications.

The underlying core culture of the team will be to work in an entrepreneurial fashion that will support Molina's business requirements. **Integrated Service Delivery** model through its various levers will provide Molina Healthcare increased synergies and seamless operations across geographies, and portfolios that will ultimately lead to **superior service and reduced TCO**.

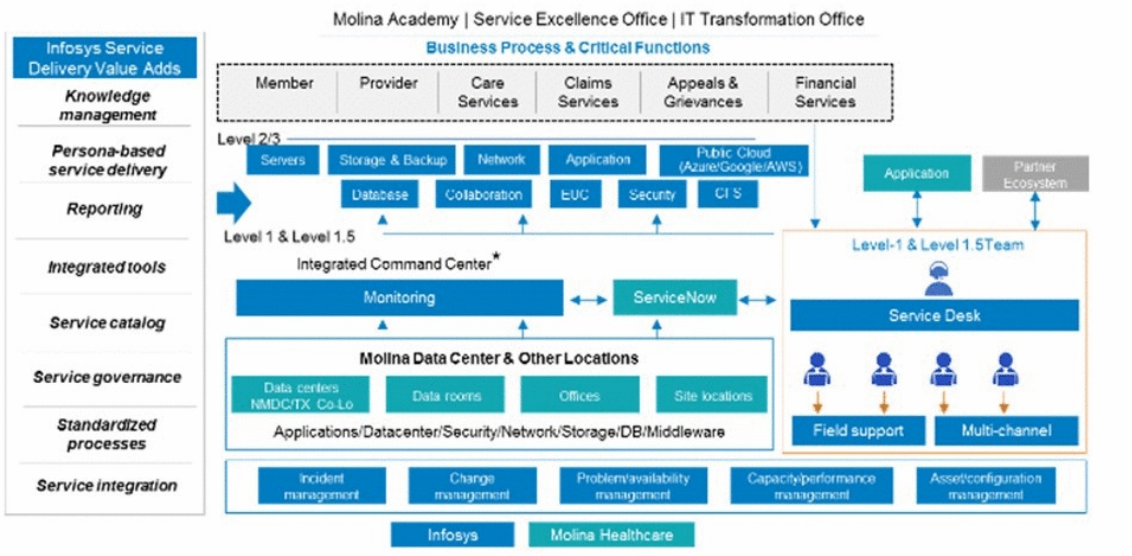

Figure 2.Steady State Integrated Service Delivery Model

Service Delivery Model for Infrastructure support to Molina Healthcare, is defined and aligned to the governance model given above, and caters to with the information required at all levels in the forms of reports and dashboards.

Below view, provide more details specific to infrastructure operations as part of the integrated service delivery model.

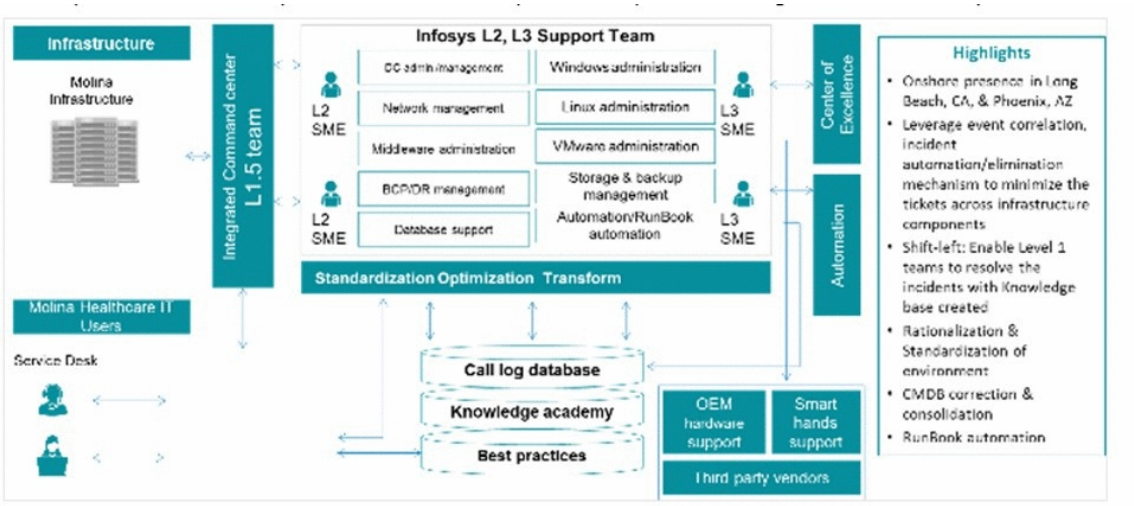

Figure 3.Infrastructure Operations

Following are the components of the proposed service model:

L1 - Global Service Desk:

Service Desk is the first point of contact for any IT support needs for Molina Healthcare round the clock - 24x7x365. Molina users can contact service desk via all current prevailing modes of communication viz., Web, Email, Phone etc. This layer provides an 'integrated' service for all IT needs, applications and infrastructure support.

Service Desk will be recording all the issues/requests coming to them in Molina's Service Now instance, and thus enables end users to track progress on their tickets directly in the ticketing tool.

L1.5 – Integrated Command Center Operations:

Command center will be completely responsible for monitoring the entire IT estate function that includes job scheduling, Monitoring, Managing. Additionally, playing the role of Major Incident Management Team. Command Center will also supplement the other IT operations team with performance and capacity management inputs.

This layer is entrusted with the responsibility of keeping a vigilant eye on Molina's infrastructure estate, leveraging existing monitoring tools like Splunk, SCOM, SolarWinds, etc. Infosys proposes to bring in Infosys Infrastructure Management Solution Suite (IIMSS), which would act as single pane of glass for this command center team, to monitor Molina's entire infrastructure estate, and take relevant actions for immediate resolution of tickets and alerts themselves or escalate to the L2/L3 teams to resolve any alert/issue that needs specific technical skills and detailed system knowledge.

Job management will also be a significant part of their day to day operations. Infosys will leverage existing Molina's job scheduling tool, Autosys for defining, scheduling and monitoring jobs on Unix/Windows systems. The job scheduling is done using Unix - Cron (or windows - AT) which is time based, it will fire the job based on the clock. We understand that all the batch sequences are already defined in Molina. Team will ensure the running of the jobs in order, thereafter ensure the completion and regular reporting. All the failures will be raised with the respective technical teams for further investigation. The standard actions will be part of the operating manual of the team to ensure the steps are taken before escalating further.

While Integrated Command Center will be based out of offshore and US locations, a part of the Security Operations Center (SOC) will also be based out of onsite/onshore location in USA. All the security logs data need to be located in the USA.

IIMSS is driven by the policy engine and inputs from estate monitoring tools to orchestrate, suppress, resolve and alert any incident proactively. It also offers best suggestions and course of actions by grouping the similar issues/incidents of past. IIMSS enables IT administrators, Infrastructure Operations team and other users of it to centrally manage the entire physical and virtual infrastructure, platforms and applications from a single interface.

Command Center team will be recording all such incidents in Molina's Service Now instance, and would be working round the clock – 24X7X365.

Figure 4.Integrated Command Center

Major Incident Manager (MIM) role **will be part of Command Center. MIM's are staffed 24 x 7 and will be deployed both at Onsite – Long Beach, CA and Offshore – India delivery locations Level 2 – Operations and Administration & Level 3 – Engineering, Optimization, and Design**

This layer is the core technical team comprising of L2 and L3 technical SMEs, who would resolve incident/service request for all ticket categories raised by Molina users or by Infosys Command Center team for alerts and issues.

Dedicated Level 2 operations team will have experienced technicians who will ensure day-to-day operation of the in-scope infrastructure components by responding to and resolving escalated incidents, executing change activities, performing proactive trend analysis, implementing routine changes and participating in transformational projects. This team will also be responsible for identifying, developing, and implementing scripts and knowledge base articles to enable the Command Center team to increase their first-pass resolution rate.

Dedicated Level 3 technical team for each tower will use their experience and expertise to design new solutions to solve Molina Healthcare's technical problems. They will provide technical leadership to projects within the environment and mentor their Level 2 counterparts.

Performance management and ongoing capacity planning/optimization will also be performed by this team. Finally, they will serve as a "backstop" for troubleshooting and problem resolution for the most complex issues.

Infrastructure team will comprise of Infosys technical support professionals both at onsite and offshore for the following technologies:

- Servers
- Storage and Backup
- Networks & Telephony
- Database
- Middleware
- Collaboration Services
- End User Computing and
- Infrastructure Security
- Tools
- Azure Cloud

L2/L3 teams will be using Molina's Service Now instances for working on the issues, and documenting the progress updates and resolution provided to the issue.

In addition, Infosys proposes a Core-Flex model at Level 2, where the core layer will be the staff deployed full time as per Molina's needs as elaborated in the proposal and flex layer is a readily deployable pool of trained Infosys staff that can be deployed anytime based on increase in demand from Molina Healthcare. The flex layer staff will be graduated from the proposed Molina academy, before being on-boarded.

Infosys will have hands and feet services for the Molina Datacenter locations. The Infosys hands and feet team will act in close collaboration with Infosys Global Service Desk (L1) team, and provide services, as shown in the Service Delivery Model above.

Delivery enablement functions

- **Service Delivery Office (SDO)**

The Infosys Service Delivery office will play the key role of working closely with the various Molina Healthcare managers and Infosys teams to understand their needs and define engagement structures that can deliver the most optimal value to Molina. The Service Delivery Office will be responsible for directing the overall engagement to align with business and IT goals associated with delivering services to Molina. The Service Delivery office will comprise of delivery managers and program managers who will play the oversight role and brings the necessary support needed for day-to-day execution teams.

- Service Level Management Office (SLMO)

Service Level Management office will monitor and implements process to measure various metrics governing the efficiency and efficacy of services provided. Service delivery and service level management office will be responsible for reporting health of service towers.

- **Service Excellence Office (SEO)**

As part of the integrated service delivery model, Infosys will set up a dedicated Service Excellence Office (SEO) for Molina, constituting dedicated team of experts with proven ITIL and infrastructure experience, interfacing with multiple service delivery groups within Infosys and other partners. The ultimate goal of the SEO is to provide operational excellence and drive continuous improvement, by focusing on the following areas:

- **Resolution Optimization**: Analyze incident data and identify candidate and to drive shift left of issue resolution on a continuous basis
- **Quality Oversight and Defect Management**: SEO focuses on reporting, analysis and action plans for service defects, such as miss-assigned incident records, incorrect diagnosis, and excessive resolution times resulting in reduced MTTR.
- **Service Management Optimization**: Variance and exception oriented reporting and analysis that helps to guide problem management efforts, as well as oversight of ticket coding accuracy and quality to maintain accurate information for data analysis and mining.
- **Cross Functional operational governance:** Drive process adoption and adherence across infrastructure towers by performing ongoing review of operational team's adherence to the cross functional service processes based on quality audits and process maturity results.
- **"Voice of the Customer":** A program designed around survey responses, and direct Molina feedback, to bring continual visibility and emphasis to the customer experience.
- **Industry Best-Practice Guidance:** Recommend industry best-practice standards and create a roadmap for implementation and/or achievement.
- **Multi-Dimensional Metric Methodology aligned with Molina's Business Goals:** Develop Value Map Control Plan, including a value map that establishes and rationalizes all measurements against a clearly stated Business Goal, and accompanying Critical Success Factors.
- **Molina Academy:**
- Infosys has devoted a special focus on Learning and Knowledge Management since its inception and has built an integrated approach to manage its knowledge capital. This structured KM approach focusing on improving the 'learnability' and continuous knowledge improvement will help improve the quality of the deliverables, meet and exceed Service Levels and enable Molina Healthcare stay ahead of the technology curve.

All Molina specific documents (policies, procedures, standards, configurations etc.,) that form the part of the onboarding documentation under Molina academy will be located within Molina networks and should reside at the locations (SharePoint, Shared Drives, etc.,) as per Molina policy. These documents will be reviewed and approved by Molina before they become part of Molina Academy.

While Molina Academy will store documents specific to Molina on Molina SharePoint, the Lex platform of Infosys will be accessible over Infosys and public internet as per Infosys current setup. Trainings on Lex are for upskilling and reskilling of the Infosys resources in technology, process and domain areas. These trainings are not Molina specific and do not contain Molina information.

- Other enablers of the delivery model:

One of the key differentiators of the operating model are the Infosys enabler teams that will be engaged on demand for any Molina Healthcare specific priority issues and Transformation initiatives.

Training & Certification: Infosys mandates every employee to undergo one domain, one technical and one process certification each year. There are several certifications created by Infosys Research team on infrastructure platforms, Azure, AWS, ITIL and ITSM processes, fund accounting, security lending and other financial services domain specific modules. This will ensure that the Infosys Molina Healthcare project team acquires skills across technologies, domains, and are able to scale up for any new requirements in the future.

Strategic Delivery Risk Management: Infosys will provide a delivery risk management professional to ensure early identification and management of risks across Molina Healthcare engagements through our proven Delivery Risk Management framework.

2.2.1.1 Service Delivery Process

Infosys understands that service delivery for Molina Healthcare engagement is key to success of the program, and is divided into following two aspects, for better understanding:

- Delivery model
- Key elements of service delivery process

Infosys will leverage Global Delivery Model (GDM) for Molina Healthcare engagement, with dedicated onsite, near-shore and offshore resources, focusing on infrastructure services that includes server administration and management, storage services (including remote storage services), network administration, database administration and management, end user services, infrastructure tools administration, infrastructure security services and aligned service management services.

Onsite service location will be Molina Healthcare office at Long Beach, California, near-shore location will be Infosys delivery center at Arizona and offshore delivery location will be Bengaluru/Chandigarh, India. Service Desk will operate from Infosys facilities at Manila, Philippines and Bengaluru, India.

Infosys Global Delivery Model will enable -

- Stricter compliance adherence for ‘qualified server environment’
- Infrastructure team integrated with Intelligent Command Center to provide effective support
- Standardized processes for Incident, Problem, and Change management processes
- Implement Infosys’s best practices from knowledge gained in executing similar projects
- Orchestration and automation bringing in operational improvements
- Infrastructure optimization recommendations and exercise reducing technical debt

Infosys, following the ITIL V3 guidelines will work towards delivering service(s) following a staged process, where certain activities may run in parallel as well.

Figure 5.Staged Service Delivery Process

Infosys Service Delivery Process will ensure following four critical elements of Service Delivery are always in play and help build more matured Service Delivery Ecosystem every day as the engagement runs with the baseline being set right from proposal stage (current stage) to day 1 of steady state.

Service Culture built on elements of leadership governance, direction and overall vision for this engagement. Here the governance mechanism, and the direction set during these governance sessions will play a critical role.

Employee Engagement of Infosys resources supporting Molina, where the resources have to undergo mandatory trainings from proposed Molina Academy before being on-boarded. Infosys resources will be trained for the technological changes, as appropriate during the engagement, relevant to the engagement. In addition, employees will be motivated through some fun-filled activities time to time, helping them enhance their team building and teamwork culture.

Service Quality, where Infosys in alignment to the proposed service delivery model will leverage strategies, service management processes and zero distance ideas, bringing in better quality of deliverables, adherence to agreed service levels with Molina and drive continuous service improvement process. This will help Molina realize their vision and objectives and serve as the firm foundation of partnership between Infosys and Molina Healthcare.

Enhanced End User Experience, where Infosys teams will work towards enhancing Molina end user experience, by understanding their issues, pain points for the services in scope, and will work towards providing the resolution/services for the same, in the best possible time and working towards adhering to the agreed service levels. Also, Infosys leadership will share the updates gained through joint governance sessions with Molina leadership time to time, and help design strategies for further improvement.

- **Major Incident Management Process:**

Major Incident Management is a critical part of service operations and Infosys is committed to ensure robust and proven process to handle major incidents, adhering to the agreed service levels, and addressing them with quality with minimal disruption to business and keeping relevant stakeholders informed through the resolution process.

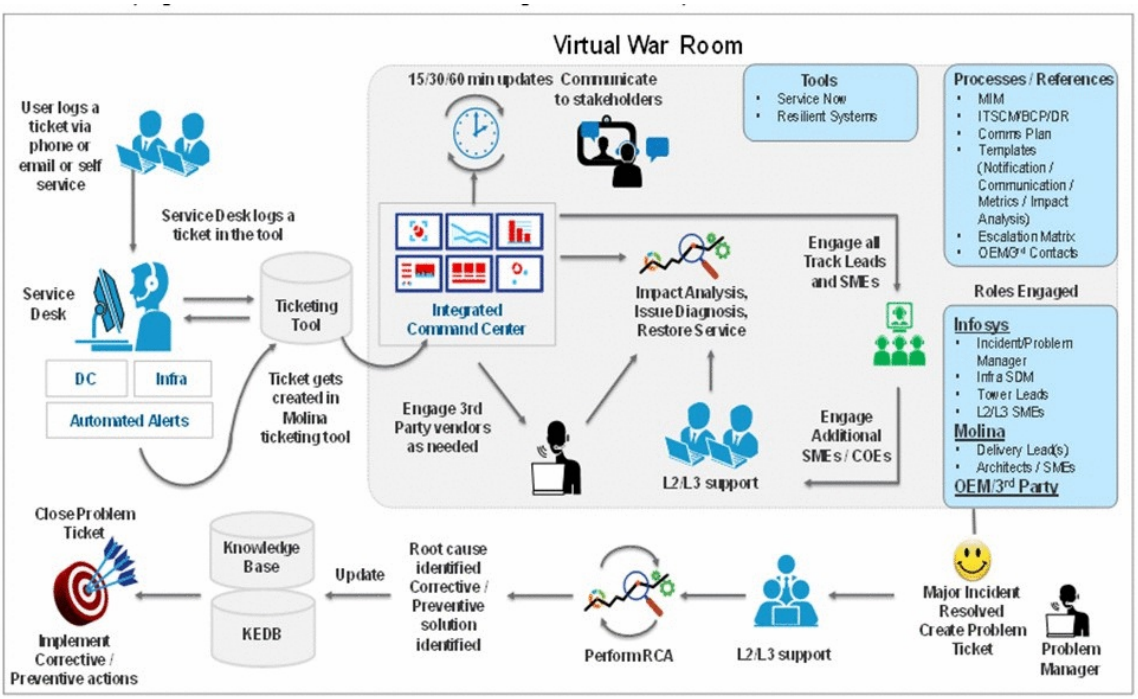

Figure 6.Major Incident Management Process

2.2.1.2 IMACD for Data Center Hardware

Infosys has extensive experience of providing IMACD services for data centers owned and managed by Infosys as well as owned by the client and managed by Infosys.

For IMACD services to Molina Data Centers, Infosys will have dedicated team in NMDC and Texas DC.

IMACD are of two types i.e. Hard IMACD and Soft IMACD. Hard IMACD services will be provided by local support resource (DC Partner or Infosys partner dispatch resource) whereas Infosys Remote Support Teams (Desk side/Service Desk /Infra) will resolve soft IMAC services remotely. Below is a typical checklist, which will be followed for equipment provisioning.

- Ensure availability of all equipment components and related peripherals with no visible sign of damage
- Assemble/Install hardware components and complete racking activities
- Attach all related components/peripherals and complete POST test
- Access equipment remotely via remote board (e.g. iLO, DRAC, etc) and start configuration
- Install and configure equipment as per its build plan/standard build process
- Test and confirm equipment accessibility and manageability
- Check and ensure all errors are clear. Perform a sanity check to ensure equipment has been built as per standard requirement
- Confirm equipment installations/readiness with the customer/stakeholder Teams
- Take sign-off from Stakeholders for equipment readiness
- Assist customer / stakeholder on equipment administration related requests (creating access, analyzing error logs, performance, etc.), Check and ensure no errors on the equipment.
- Take confirmation from stakeholder team on install completion and any test report

- Configure the equipment for its data backup and monitoring
- Make sure Equipment's are monitored as per requirement
- Take signoff from Stakeholders Team
- Update the Equipment Operations related documents and Update CMDB with equipment configuration details
- Handover equipment and all relevant documents to support team
- Ensure sign off and update stakeholders

Some common IMACD requests are as follows:

- Installation of New device
- Disposal of EOL or EOS devices
- Movement/change of device
- Installation of software's and applications which are not possible for remote installations

Infosys team will leverage the current technology, best practices to provide all in-scope services including IMACDs work through fully trained engineers. However, Infosys attention shall always be on reducing IMAC's by reducing dispatches and routing calls through / from Remote resolutions for a quick and permanent fix.

IMACD involves below activities:

- Develop and manage IMAC-D process, forms and checklist contained in the Operations Manual that will be used for each IMAC-D transaction
- Install, change or move devices upon request. Depending on the move, additional charges may apply
- Redeploy equipment when possible for efficient use according to the deployment criteria
- Preparation for disposal of any equipment that shall not be redeployed according to Molina policies.
- Maintain documentation for the delivery to include operational checklists for pre-installation, installation and post installation.

2.2.1.3 Hardware Break-Fix for Data Center Hardware

Following diagrams depicts how service recovery scenario due to 'server failure at datacenter (dispatch from OEM vendor assuming asset is under warranty)' would look like in an integrated manner:

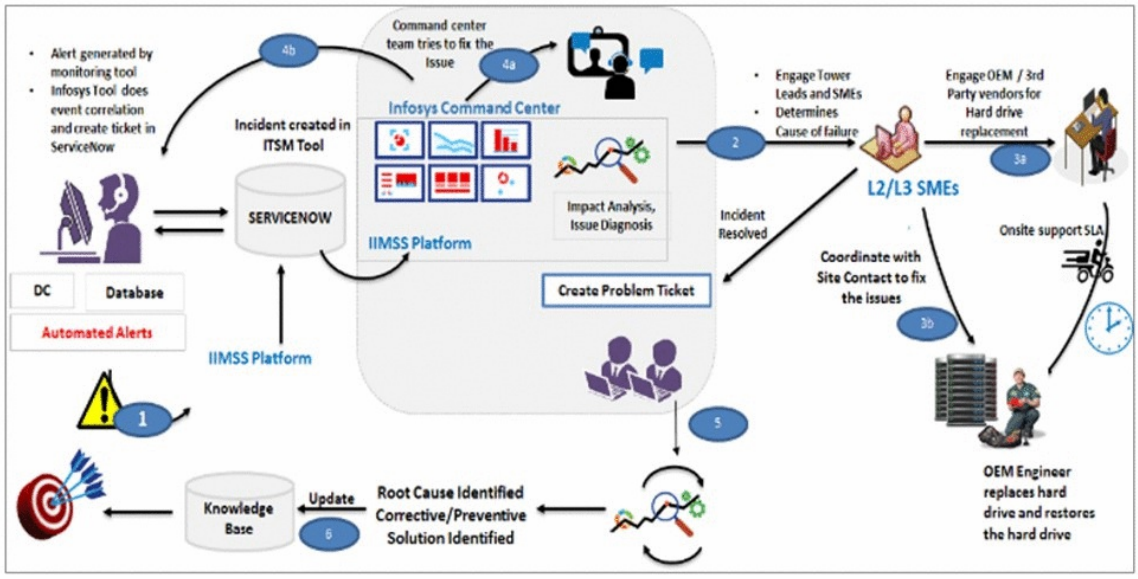

Figure 7.Service Recovery Process Example

The integrated command centre will be the central point for any pro-active incident resolution, which are identified from the monitoring systems. Command centre will cut across all our services for Molina. Command Centre team members will take the first attempts to resolve all pro-active incidents and will reach out / route the ticket to the respective L2/ L3 SME from applications and/or infrastructure teams for issues resolution (wherever necessary to be escalated).

In the scenario, once the root cause is identified as Asset part failure, the team will work with OEM / Third party vendor to replace the part if they are in warranty and extended support. In case the system is not in warranty, the team will try to bring the system up with spares and scavenge from the old systems.

2.2.1.4 Patch Management and Software Distribution

In order to ensure that the Molina environment is safeguard from known vulnerabilities, Infosys will ensure that appropriate patches received from various OEMs on the periodic basis are implemented following a thorough patch management process. Infosys will review existing patch management policy for datacenter infrastructure and end user devices and make the customization as per industry best practice.

The patch management process at a high level would remain the same for both the entities. However, the patch management for end user devices is described in the respective section (2.3.3.2). Infosys would further like to understand from Molina the frequency and prioritization of the patch assessment and implementation guidelines. Infosys will consider Molina patching policy as mandate and will follow the periodization matrix over the OEM default patch categorization.

The high-level patch management process is as follows:

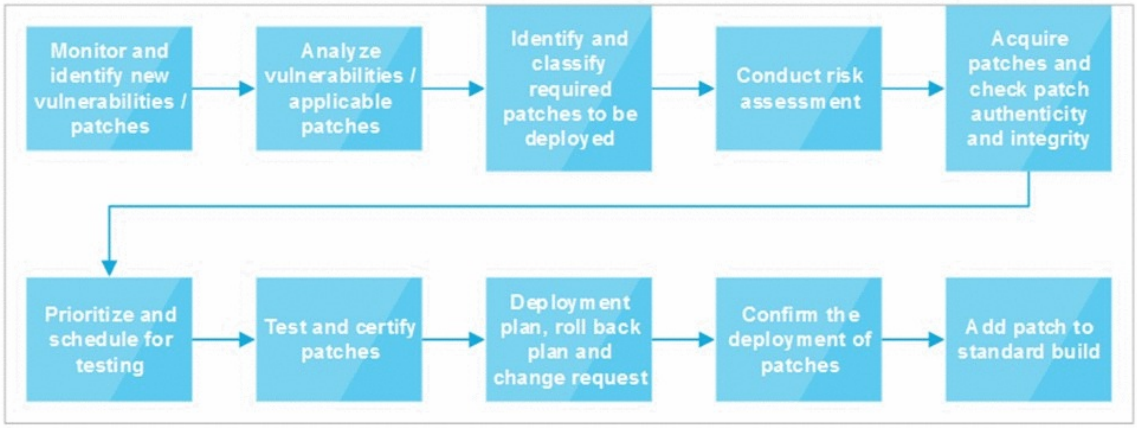

Figure 8.Patch Management Process

More details of the patch management process are as follows:

Vulnerability and patch identification and evaluation – In this stage, Infosys team will:

- Monitor and identify new vulnerabilities
- Analyze those identified vulnerabilities
- Identify and classify required patches
- Communicate patch requirements and
- Raise the patching request

Monitor and identify new vulnerabilities

- Infosys will monitor trusted sources for information on new vulnerabilities
- The patch update advisory will be checked on planned intervals for new patches

- Periodically (monthly) scan for the vulnerabilities
- Vulnerabilities are tracked and assessed for applicability to Molina's environment. As part of assurance, it will be validated if the vulnerabilities applicable to Molina are tracked and reported

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Table 20. [redacted]

- Analyze vulnerabilities
  - Infosys team will analyse vulnerabilities related to Molina systems/third party software's
  - Classification of a patch will specify a severity rating (in a range from "Low" to 'Critical'), which in turn will give rise to a timescale for implementation
  - Each asset is categorized based on the criticality, specified by the respective stakeholder's/application owner. It will be used to prioritize the assets and deployment of patches based on the risk assessment
  - Classification of a patch will be determined from analysis of associated vulnerabilities; in particular, the assessed risk to the systems / third party software(s). A risk assessment will allow Infosys to assess the severity of a vulnerability/patch.
  - Following factors are considered while conducting the risk assessment:
    - High value or high exposure assets impacted: increased risk
    - Assets historically attacked are impacted: increased risk
    - Mitigating controls already in place, or soon to be in place for all affected assets: decreased risk
    - Low risk of exposure for impacted assets: decreased risk
  - Time frame for implementation - Patch deployment status is tracked and reported as part of monthly vulnerability and patch management report
    - Patching for critical internet facing applications will be done in 7 days of patch release by OEM
    - Critical Patches rated as Critical / High will be done within 30 days
    - Non Critical Patches rated as Medium / Low will be done within 90 days
- Communicate patch requirements / patch reports

Here Infosys team will communicate the requirements in the form of patching request to the different application teams, that may be Infosys application teams or from other service providers. This will help the respective teams to analyze on the patching details and other essential information beforehand.

- Patch testing

In this process, the Infosys patch management team will be testing the identified patch(es) in the testing environment, and publish success or failure report. Upon successful testing, the patch is confirmed, ready for deployment. This will be done, in accordance to the defined patch test plan, which would have – testing scope, testing schedule and detailed test scripts.

- Resolve test issues

This is an optional step, and invoked in case any issue(s) is/are encountered during patch testing activity.

- Define patch deployment and roll back plan

The final patch deployment plan is drafted and appended in the change request. It is further, discussed and approved for deployment in all environments. Also, as a precautionary step, and as a good practice, a roll back plan is produced and appended to the same change request, to be leveraged in case, the patching activity is to be abandoned and environments are to be kept in the original state.

- Deploy patch

Post approval of the change request, the patch is applied, first in the lower environments and further into the production environment.

- Patch reporting

Post conclusion of the above activity, a report is published to respective stakeholders and a communication is sent to all stakeholders, about the completion of the activity, following Molina's communication guidelines. Infosys will ensure periodic communication is done to all impacted Molina, Infosys and other service provider stakeholders about the activity time to time from the initiation of the patching activity, to deployment to completion of the activity.

Emergency Patch Management (Zero day patches):

At times, depending on the type and extent of vulnerability and need of the hour, Infosys will go for an exception process and will follow the emergency patch management process. This will be done when the OEMs advice for the same, or the internal vulnerability assessment advices for the same.

In the overall patching exercise, Infosys will like to understand Molina's policy and guidelines, as mentioned in the beginning, as well as would like to have their involvement so that informed decisions are jointly taken and executed.

Following the completion of the Transition, Service Provider will use commercially reasonable efforts to reduce the backlog of unapplied patches using available capacity of business as usual Service Provider Personnel. Molina and Service Provider may implement a chargeable Project to accelerate the application of patches and reduce the backlog. The risks associated with vulnerabilities created by the backlog of unapplied patches remains with Molina. Service Provider will be excused from its obligations to meet Service Levels to the extent impacted by backlog of unapplied patches.

[redacted]

2.2.1.5 End-Point Protection

In order to ensure, and apart from the regular patching process, as described in the above section 2.2.1.5, end point protection is another critical action item and area of activity to safeguard the Molina environment.

In order to ensure that Molina estate is secured from the end-point protection perspective, following activities are performed:

- All images will be updated with the latest Symantec SEP client version once the same is rolled out/deployed in the environment. Molina will provide list of other core infra (compute) end point protection agents to be included as part of compute images by Infosys.
- Updated client version is pushed to the endpoints/servers
- Infosys team will ensure that all the machines in the Molina Healthcare estate are updated with the latest AV updates
- Non-compliant Molina machines will be reported to track for appropriate actions, in order to make them compliant in the near future, thereby minimize the risk
- Endpoint testing will also be made part of the DR test exercise for the Molina environment

- License utilization will also be monitored
- As part of the daily health checks, anti-virus versions update will be checked and reported
- All external certificate renewals will be managed by Molina while Infosys will manage the installations and distribution.

2.2.2 Delivery Locations (Onshore, Nearshore, Offshore) and Associated Services

2.2.2.1 Service Delivery Location Details by Towers (Address, Photos, and Security Details)

Infosys shall perform the Services from the Approved Service Delivery Locations, in accordance with the Agreement.

Security at Infosys:

Infosys has very comprehensive security policies that covers all employees, contractors, facilities etc. We have a corporate security architecture group, which governs overall security infrastructure across all our Development centers. Following are Information Security Details at Infosys facilities across locations.

Infosys Information Security Policy framework is aligned and certified to ISO 27001:2013 Information Security Standard. The information security framework is supported by a set of supplementary policies, procedures & standards aimed at achieving the enterprise level information security objectives. The Information Security Policy provides an overview of the below areas, details of which are provided below:

- Policy Framework
- Awareness and people security
- Risk Management
- Third-Party Risk Management
- Business security
- Physical and environmental security
- Endpoint security
- Network security
- Infrastructure security
- Database security
- Platform security
- Application Security
- Cloud security
- Security Architecture
- Malware protection
- Data Protection
- Security Configuration
- Security Testing
- Emerging tech security
- System development
- Security monitoring

2.2.2.2 [redacted]

2.2.2.3 Alignment to Molina Contractual Requirements

Infosys is fully aligned to contractual requirements in Exhibit 2-A. The redlined document has been submitted complying with Molina contractual requirements as deemed applicable.

2.2.3 Staffing, Hours of Operation, and On-Demand Sourcing

2.2.3.1 Staffing Breakdown by Tower and Skillset Details

Infosys operating model will be enabled by an operations team based across 3 locations – Long Beach, CA (USA), Bengaluru/Chandigarh (India), Manila (Philippines), and Bengaluru (India) to help meet the coverage and resiliency requirements. This will ensure adequate service continuity for all the business operations with a cohesive workforce, making time zone differences transparent to business users.

Following will be the Skillsets, capabilities and experience of the resources working across various core infrastructure towers. Level of expertise and years of experience will vary based on the role played by the resources:

SOW	Skill set / Responsibilities
Process Management	• Requirements Gathering (for addition/modification/retirement of services) • Measurement and reporting • Change Management and Training • Continuous service improvement Activities • Maintenance of the data accuracy in the Service Catalog through rigorous change control • Collect process KPIs and Report to all stakeholders periodically • Communicate Service Catalog changes to all stakeholders • Conduct end user surveys and collect feedback to identify improvement areas • Communicate Service Catalog changes to all stakeholders • Coordinate service review meetings and document corrective actions • Understand areas of improvements, create service improvement plans, analyze the impact of implementing the improvement • Raise RFCs for the identified improvement areas • Educate and Train all the stakeholders on the improvements made to the Service Catalog • Improve Business users' awareness of the services being provided through Catalog • Regular Maturity Assessment of ITIL processes • Co-ordination & Management of Processes • Service Integration (Multi-Vendor Environment)
Middleware	• Creating new services • Configuration of http settings and monitoring on web server • Create & configure Domain\cluster • Configuring a Web Server to Serve Content • Server configuration parameters administration • Configuring Request Processing for a Web Server • Setting up environment variable • Higher End Administration tasks • Configure LDAP interfaces • Create & Configure Work Managers • Configuring Web Server Security • Software install/re-install, patching and zone build • Installing a proxy server and configuring it with tomcat • Implementation of clustering and load balancing • Performance management & tuning
Database	• Database backup/restore, maintenance plans – strategies and tools – Full/Diff/Incremental/log/archive-log backups - litespeed, RMAN etc. • Experience in access control, security in DB area • Database monitoring, issue identification and troubleshooting • Querying Databases – joins, procedures along with knowledge of system objects – functions, views etc. • High Availability – Mirroring, replication, Log shipping, Failover cluster, Always On – experience in set-up, maintenance and support • Experience in Performance monitoring and improvement techniques, tools etc. • Capacity/License management • Performance tuning using EWR reports Query tuning • Experience in DR • Incident management/ problem management / Change management

SOW	Skill set / Responsibilities
Compute	• Windows Server (2008/2012/2016) administration • Windows servers and Cluster patching • Linux/Unix administration • Linux/Windows servers patching and hardening • Shell scripting and automation • Troubleshooting Incident and problems with windows/unix servers • Active directory administration and Group policy administration • Performing various troubleshooting and maintenance operations in Windows Server environments • VM Servers build & rebuild deploying the New VM from the Template and Cloning an existing • Hypervisor (Vmware/Vsphere/Hyper-V/etc.) administration • Redhat/Microsoft certified • Vendor coordination for hardware issues
Storage	• Knowledge of storage architecture and administration • Provisioning/DE provisioning LUNs • NAS file share creation/administration • Configuration of NAS and SAN replication • Brocade/Cisco San switch administration / Server to Storage Zoning and De-zoning • Unix scripting/automation • Troubleshooting multi pathing/Performance issues • Migration between arrays • Upgrade and patching • Coordination with vendor for Hardware issues • License/Capacity management • Fabric upgrades • Configure and manage local and remote replication • Participation in DR drills • Backup and Restore architecture • Virtual and agent based backup concepts and technologies • Hands-on backup tools (EMC Networker, Symantec Net backup, IBM TSM) • Configuration and implementation of Backup server, Backup devices. • Administering backup and restore jobs. • Knowledge on reporting tool such as DPA • Scripting for automation • Troubleshooting backup failures • Upgrade software versions/agents • Vendor coordination for break fix

SOW	Skill set / Responsibilities
Network (Data & Voice)	• Understanding of LAN & WAN Technologies • Understanding of Switching protocols, STP / RSTP / VTP • Experience on Cisco Switches–2960, 3650, 3750 , 3850 , 4500, 6500, 9300 , 9400, 9500 • Experience on Meraki Switches – MS120, MS210, MS225, MS250, MS350, MS410, MS425 • Understanding of Meraki Dashboard management, Troubleshooting utilities • Experience on Nexus 2K / 5K / 7K / 9K • Understanding on technologies like – VPC / VDC / VSS / Layer 3 Switching • Routing protocols – OSPF / BGP / IGRP / EIGRP. • CCNA R&S / CCNP certified • Basic understanding of VoIP, VoIP protocols like SIP, MGCP, MEGACO, H323 etc. • Experience on Cisco IPT products – CUCM, UCCX , Unity , Arc , CME, SRST , Cisco IP phones • Basic understanding of DHCP / DNS / AD to support Cisco Voice services • Configuration like, hunt group / pickup group / extension mobility / shared line config / Bulk tool operations / Auto registration / Time based call routing • Call flow designing and scripting for UCCX • CCNA Collaboration / CCNP Collaboration certified

Table 21. Skillset vs Responsibility

2.2.3.2 [redacted]

Figure 9.[redacted]

[redacted]

2.2.3.3 Infra On-Demand Sourcing Model (By Tower)

Infosys understands demand for infrastructure will be dynamic and varies based on business needs. Infosys has experience in handling such requirements based on our exposure to large number of clients. Below are different options, which will be leveraged, based on the requirement type and duration of the need(s)

Sourcing for the infra towers will be done using below options, as applicable:

- In Stock/Spare Capacity
- Lease/Loan
- Public Cloud (Azure)
- Outright purchase/procure

The decision on the approach will be based on following considerations:

Strategic considerations	Operational considerations
▪ Time to Market ▪ Technology Roadmap ▪ Scalability & Availability considerations ▪ Duration	▪ Ease of use/adoptability ▪ Role/Functions alignment ▪ Power/space constraints

Table 22. On-demand Sourcing model

In this sourcing model, Infosys will be working with Molina procurement/sourcing team for any procurement taking into consideration following aspects:

• Analyze Spend • Procure to Pay • Manage Suppliers	• Manage Contracts • Track Pipeline • Source

2.2.4 Day 1 and Year 1 Transformation (e.g., Migration, Consolidation, Layout)

2.2.4.1 Detailed Explanation of Transformation as Relates to Infrastructure (by Tower/Area)

See Schedule 4 to the Agreement for matters relating to transformation.

2.2.5 Flex Models (e.g., Scale Up, Scale Down, Migrate)

2.2.5.1 Solution Deep Dive

Infosys plans to provide the support for Molina's Infrastructure in a Global Delivery Model composed of resources at two locations: Onsite at Molina's office in Long Beach and Infosys Offshore DC (Bengaluru / Chandigarh).

Infosys also will have a Service Excellence Office as part of our delivery model, which will oversee the excellence in delivery including Continuous Service Improvement, Automations, ITIL Process Excellence and Service Transformation Strategies. This team will work with Molina on demand planning, re-skilling of resources.

2.2.5.2 Resource Supporting this Model

The support operations team is segregated by the functions and level of services as below:

- **Integrated Command Center team**: Infosys proposes a dedicated team for Molina Healthcare to provide integrated proactive monitoring across all functional towers and this team will be enabled by "Command Center" console of Infosys' IIMSS platform. Alerts through various monitoring tools will be integrated into the event management tool with auto-ticketing into proposed ITSM Suite. This team will be based out of Bengaluru/Chandigarh office
- **L2 / L3 teams**: This will be a tower / area wise team for each technology area (server administration and management, storage services, network administration, database administration and management, end user services, infrastructure tools administration, infrastructure security services and aligned service management services). This team comprises of [redacted] of resources skilled in L2 work and [redacted] skilled in L3 work which will primarily focus on managing operational changes.
- Infosys, through its COEs along with the operational teams, will work with Molina's architecture team to define future roadmaps for Molina's infrastructure, plan for transformation projects, create projects / resource plans and work on approvals from Molina management along with their architecture group.
- **Flex Team**: In addition to the code team above, for any new projects or transformations, Infosys will ensure an on-time ramp-up using a tested demand management process. These resources will ramp-up for any agreed project / transformation and will be there until the project completion.

Below is a view of the ramp-up process:

[redacted]

Figure 10.Resourcing Model

2.2.5.3 Required Commitment, Restrictions, and Limitations

In this section, we assume Molina wants to understand the requirements / commitments, which Infosys expects from Molina for this model to work.

Below are the things we expect from Molina for this model:

- Provide a 90-day rolling window for any large ramp-up (e.g. [redacted] resources) needed for onboarding resources for new projects / transformations. Infosys will define a process for this capacity management and work with Molina to identify demands on time.
- For individual ramp-ups for any niche work, Infosys expects a lead-time of [redacted] weeks for onsite and [redacted] weeks for offshore resource onboarding and [redacted] weeks for niche skill based out of offshore.
- In any outcome-based project executed by Infosys, Infosys will take complete ownership of onboarding the resources with the right skills. For any staff augmentation resources onboarding, Molina can conduct interviews and Infosys will define the process for this with Molina

2.2.5.4 [redacted]

Figure 11.[redacted]

2.3 Lift, Shift and Enhance for End-User Services (EUS)

End user support services as a function will collaborate closely with the Integrated Service Desk to deliver best-in-class services. Infosys views end user support as a holistic function wherein success is based on driving incident resolution and it is driven by Customer Experience. There are two levels of remote resolution. This is a major enabler to reducing cost and increasing customer satisfaction. Only if an end-user issue cannot be resolved remotely and there is need for physical access to the devices, as in the case of hardware break-fix or hard IMAC, the ticket will be assigned to desk-side support team (dedicated or dispatch). From that point on the desk-side support team will be responsible for resolving the issue and updating the ticket status. Our focus is to keep Dispatch at a minimum and drive high resolution through a combination of Self-service, Service Desk and Dedicated team members and proactive monitoring. The service desk is still the custodian of the ticket till it has been closed.

End-User Services section covers the below tracks:

- IT Service Desk
- Deskside & Walk up Support
- Desktop Engineering
- End user device management & Remote support

Operation Solution Highlights

- Tailored Delivery Model - 24x7 Support English, Support delivered from Manila, Philippines and Bengaluru (India)
- Walk-up services with dedicated technicians based out of 9 premium locations including [redacted]. [redacted] of the user base will be supported through [redacted] dedicated FTEs through walk-up desks, [redacted] of the user base will be supported through dispatch.
- Persona based Service delivery with focus on enhancing customer satisfaction through industry best practices and proven methodologies
- Differentiated support to end users based on their personas identified through ESM Café
- Real time service level monitoring and reporting (Emilia)
- Improved accountability through end-to-end ownership of tickets thereby reducing total support costs through a single point of contact, FCR-focused service desk
- Shift-left (deskilling) to drive higher resolution at the service desk
- Continuous Improvement through six sigma and process improvement initiatives
- Effective problem management and RCA based approach to identify and eliminate recurring issues that drive ticket volumes
- Knowledge Management

End User Service enhancement themes

Infosys will be working towards enhancing the End-user computing user experience. Some of key themes Infosys will be implementing to enhance end-user experience is given below

- Enhanced Persona based delivery through ESM Café.
- Enhancing Process/ Agent Efficiencies
- Extreme Knowledge Management Improvisation
- Self-Heal & Automated problem resolution for service desk and End user computing tracks
- Trend and Performance Analysis to enhance operational efficiencies using Infosys tools Emilia and IIMSS
- Standardization of service support in desktop engineering and smart hands support.

2.3.1 [redacted]

2.3.1.1 [redacted]

[redacted]

Figure 12.[redacted]

[redacted]

2.3.1.2 [redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

Figure 13. [redacted]

2.3.1.2.1 [redacted]

[redacted]

Figure 14. [redacted]

[redacted]

Figure 15. [redacted]

[redacted]

Continuous Improvement initiatives:

Infosys envisions Molina's L1 Service Desk landscape to evolve from its current state to a best in class industry standard which has a Next Gen contact center architecture, provides converged service management, aligned to business services and is based on one platform. The initiatives which will drive this transformation are:

- **Reduction in number of end user contacts:**
  - Using tools such as chat bots to automate and eliminate simple, standard or repetitive application and infrastructure ticket categories.
  - Using Service Now service catalog based auto-routing to assign tickets directly to the correct L2/ L3 resolver groups without Service Desk intervention
  - Promote self-service through ChatBot and by creation of FAQs for frequently occurring easily resolvable issues and proving users access to clear and concise "How to" knowledge artifacts
  - Keep Customers Informed (KCI) on the ticket progress through proactive status alerts through their preferred channel to reduce the status update related contacts, duplicate tickets.

- **Enhanced process efficiency and agent performance:**
  - Reduced handle times and handoffs through efficiency improvement projects based on Six Sigma and Lean methodologies
  - Dedicated quality analysts supporting action planning for improved customer experience
  - Improve agent utilization by analyzing aux code usage and staffing pattern intervention
  - Ongoing training programs targeted at improving agent' soft skills and customer handling skills

- **Shift Left of resolution to Service Desk:**
  - Conduct top trend analysis to identify issues which the Service Desk can resolve on First Contact
  - Conduct resolution reviews with the Level 2 teams and other resolver groups to identify opportunities and train Service Desk on recurring complex issues
  - Increase knowledge base contribution through regular updates to the knowledge base with new artefacts

- **Trend and performance analysis:**
  - Trend and Root Cause Analysis to be performed for top call drivers and all high severity incidents and repetitive lower severity incidents; Statistical tools and methods like Pareto, Fishbone, etc. to be used
  - Six Sigma trained resource to perform Root Cause Analysis (RCA) on customer complaints and escalations, and deep dive analysis for key metrics
  - Perform deep dive analysis for key metric trends

- **Continuous SLAs improvements:**

Infosys will implement a continuous improvement process for systemically improving service level targets annually. At the start of each service year, Infosys and Molina will jointly review the SLA performance/ trends for the past year and agree upon any changes in SLA parameters and measures. The initial plan will be to bring current Molina service levels to Industry Standards.

2.3.1.2.2 End-to-End Ownership of Incidents

Service Desk will act as the Single Point of Contact, and will own the ticket resolution End-to-End irrespective of the resolver group to which the ticket is escalated; the Service Desk will follow up and close the ticket in the committed time frame.

- User creates a ticket for a request/incident that is received at L1 Service Desk
- L1 Service Desk determines involvement of other Resolver Group(s); these could be Infosys, Molina or other third party Vendors groups
- Same ticket is transferred to the correct Resolver Group
- L1 Service Desk continuously monitors SLA's and keeps Molina User updated on the request status; RCA is updated in knowledge database

- Ticket is closed by the resolver and notification goes to the Service Desk and Molina end user
- Service Desk confirms resolution with Molina End User and closes the ticket.

Described below is the Level 1 end to end ticket ownership model.

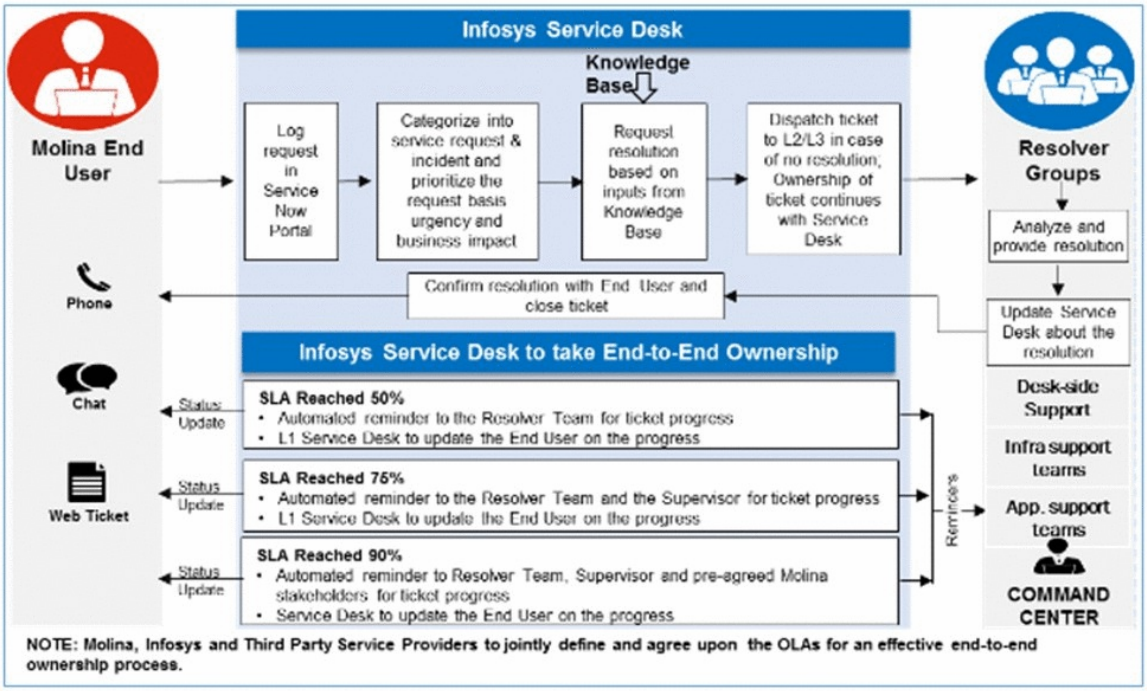

Figure 16. L1 End-to-end Ticket Flow

Apart from improving the resolution rate, ticket ownership will also drive enhanced end user satisfaction by keeping the users proactively informed regarding the status of their request/ ticket until closure.

2.3.1.2.3 Knowledge Management

We will implement a strong Knowledge Management process along with a comprehensive Knowledge Base for improved resolution at Service Desk.

- Have a knowledge management team comprising of Team Leads, SMEs, Quality Analysts and Service Desk Analysts who will take complete ownership of updating the knowledge articles
- Have a dedicated SME act as a Knowledge Manager who will be responsible for coordinating new entries or updates to current content to ensure the accuracy and quality of knowledge base entries, validate the knowledge relevance for retirement/archiving purposes and finally to publish and retire all reviewed knowledge entries
- Implement audit process for measuring effectiveness of the Knowledge Base to ensure accuracy and effectiveness
- Knowledge sharing sessions for all unique incidents and major issues
- Rewards and recognition for Service Desk team to contribute to knowledge base
- Implement a robust training program for the Service Desk Analyst to enable them to be effective and contribute towards continuous process improvement; training framework snapshot below:

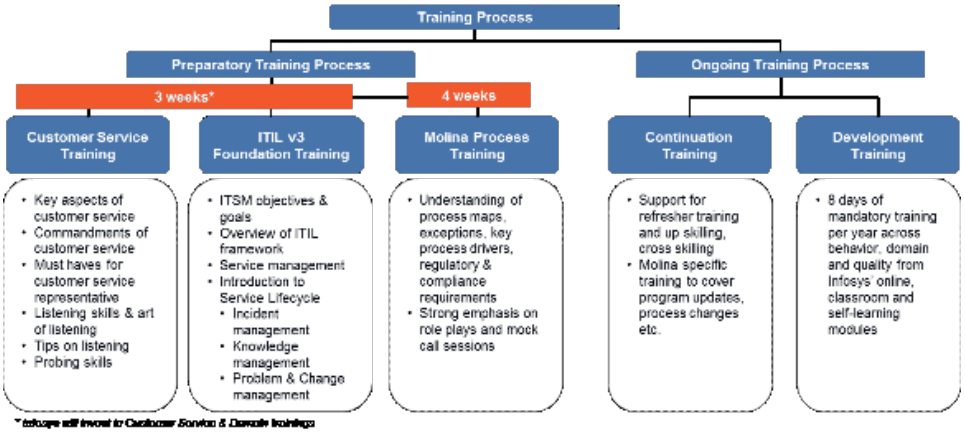

Figure 17. Training Process

The key areas to consider for efficient Knowledge Management include:

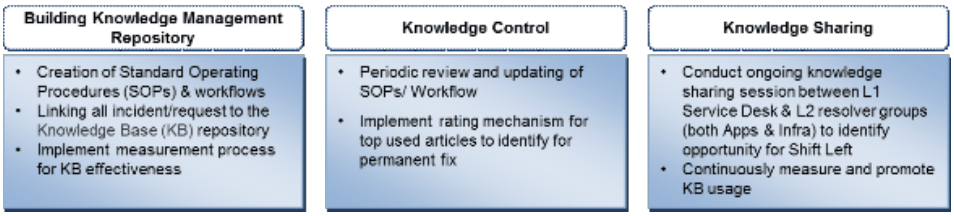

Figure 18.Key areas of Efficient KM

Infosys team will perform the following steps w.r.t Knowledge Management prior to go-live and then in an on-going manner.

- Knowledge Entry Review:
  - Accuracy and quality review which includes review of all published articles, articles currently in the Molina's Knowledge Database and all articles pending for retirement
  - This process also includes the review of archived/retired knowledge that can be used as baseline for knowledge entries

Process Owner: Infosys SMEs / Knowledge Manager

- Knowledge Entry Creation/Update Process
  - Identify gaps in Knowledge Base and create relevant knowledge articles; the knowledge articles will either be leveraged from Infosys existing centralized repository or created in coordination with Molina SME if it is client specific
  - Submit the content to Molina SMEs for review
  - Upon successful review, Infosys SME will create the knowledge article following the KM template and submit the entry to the knowledge manager for final review and feedback prior to publishing the knowledge entry

Process Owner: Infosys SMEs/ Knowledge Manager & Molina SMEs

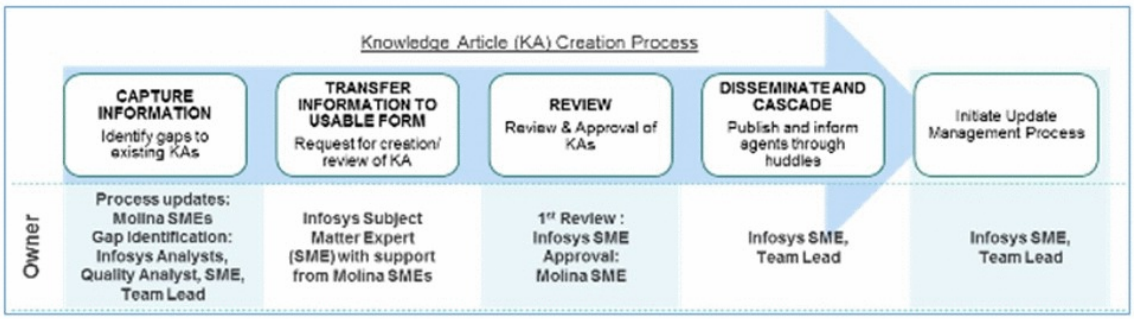

Figure 19. KA creation Process

- Knowledge Entry Publishing: Upon successful review of knowledge entries, the Knowledge Manager will publish the entry and will cascade the new update/new entry to the team. The Service Now Knowledge Management module provides workflow and approval process which can be switched on to enable quality checks before posting. The created article goes for review to Molina Knowledge Manager/ other leads for approvals though a defined workflow before the expiry in Service Now. Additional features like commenting, rating, tagging ensures that the knowledge is usable.

Process Owner: Infosys Knowledge Manager

- Knowledge Entry Retirement
  - Where it has been determined that the Knowledge Article can be retired, the Knowledge Management Team will archive the article from the Knowledge Management System and remove any links to the article from other Knowledge Articles
  - Team will publish the retirement of the Knowledge Article to all relevant stakeholders (details of Knowledge Articles retired from use are communicated via Monthly Reporting)
  - Knowledge entries will not contain an expiration date as the review and analysis of all knowledge entries will be done periodically; Identification of new processes will be the trigger of knowledge entry retirement

Process Owner: Infosys Knowledge Manager

We would require the following support from Molina to ensure the accuracy and effectiveness of the KB:

- Provide a Knowledge Manager who will validate and confirm the accuracy of the knowledge provided
- Review and provide inputs to update the knowledge article
- Make available to team, any updates/changes to the processes, new products and services added to the scope
- Communicate new offerings and changes to the scope to ensure readiness of the team to create and update the knowledge base

2.3.1.2.4 [redacted]

Figure 20. [redacted]

[redacted]

2.3.1.2.5 Escalation Management

A well-defined escalation procedure is must for seamless delivery of services. At the same time, care will be taken that each interaction needs to be maintained at the right levels of the organization hierarchy ensuring transparency to higher levels. Escalation matrix including timeframe for resolution will be jointly defined with Molina based on the governance structure. We will also work with Molina to facilitate transfer of Molina user(s) to appropriate Molina Supervisor or equivalent as applicable by incorporating the same into the escalation path.

A typical escalation path is illustrated in the table below:

Level	Unresolved Period
Team Manager	8 hours
Operations Manager	16 hours
Service Delivery Lead/ Client Partner	Over 48 hours

2.3.1.2.6 Monitoring and Reporting

We will utilize a combination of dedicated staffing such as Incident Manager, Real-Time/ MIS Analysts and tools such as Emilia for monitoring and reporting support.

Monitoring:

We will utilize Emilia, a robotic tool that mimics the role of both Incident Manager and RTA, and is responsible for managing the life cycle of all incidents and service request. It can be integrated with call center monitoring system and Service Now ITSM tool to monitor the critical environment for Service Desk.

The robot enables operations team to focus on their complex deliverables rather than queue and ticket monitoring/incident management tasks listed below. Its primary objective is to prevent incidents and service request to breach and minimize impact to business.

Real Time Analyst	Incident Management/Ticket Management
• Monitors Phone and Chat metric to ensure Service Levels are met • Reminds agents of callback to ensures alignment to user commitment; Alerts generated via callout, chat or desktop • It monitors real time status of agents such as agents on incorrect auxiliary code, long handle time, long after call work, agents about to go on break or lunch, etc., • It monitors calls and chat wait times • It monitors avail time and advises operations if they can go on team huddles, coaching, breaks • Runs and sends customized reports to operations for better governance • Quickly analyzes top call/chat drivers and inform operations	• Randomly assigns cases to available agent to avoid cherry picking and also alerts Team Leads of the assignment • Alerts operations if there are high priority tickets • Alerts operations of tickets about to breach (breach time can be customizable based on operations Service Levels and criteria) • Sends ticket reports to operations • Can implement Smart Ticket assignments • Can monitor alerts based on operations criteria

Table 23. Monitoring & Reporting

Reporting:

Infosys has the capability to report all aspects of operations. Besides standard Service Desk operations report related to staffed hours, quality scores, AHT, service levels, abandonment rate etc., we can provide customized reports as well, at a frequency as desired by Molina. The format and frequency of reports will be customized to Molina's requirements and will clearly depict a comparison of actual performance against the contracted service levels.

Infosys generates performance reports at three levels:

#	Level	Report Type
1	Agent Level	• Transaction Quality • AHT / Productivity • Escalations • Staffed Hours
2	Process Level	• Process quality • Average Speed of Answer (ASA) percentage • Abandoned Call Rate percentage • First Contact Resolution percentage • Same Day Resolution percentage • Ticket Resolution time percentage • At First Level resolution percentage • Mean Time to Resolve (MTTR) • Response Time (P1, P2, P3, P4) • Resolution Time (P1, P2, P3, P4) • Backlog (P1, P2, P3, P4) • Case Chase/ Follow-up/ Update (P1, P2, P3, P4) • Customer satisfaction score • Sentiment Analysis • Customer complaints • Production hours • Process AHT • Attrition • Capacity plans/ Seat utilization calibration
3	Organization Level	• Service levels • Hierarchical Escalation • Attrition Reports • C-SAT Reports

These reports are referenced during performance feedback sessions and will be utilized to map improvements and set targets.

2.3.1.2.7 Service Desk Channels

Infosys will support the all the technology channels (inbound, outbound) as provided in the Agreement (including each SoW and this document) to communicate with Molina users including phone calls, chats, web-based tickets. The service desk will use Molina's VDI for connecting to applications at Molina so that there is no data being moved.

2.3.1.2.8 [redacted]

[redacted]

Figure 21. [redacted]

[redacted]

Figure 22. [redacted]

[redacted]

2.3.1.2.9 [redacted]

[redacted]

[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]

2.3.1.2.10 Other Workflows

<Not Applicable>

2.3.1.3 IMACD for End-User Devices

Infosys's IMACD delivery model is categorized into two key stages for every IMACD request i.e. IMACD Pre-Execution and IMACD Execution. The pre-execution phase ensures sufficient checks and balances are in place to execute the IMACD, while the execution phase addresses user issues during the IMACD and ensures proper closure of the request.

Key activities performed as part of IMACDs will be:

- Provide and oversee, as appropriate, all installations, de-installations, cascades, moves, adds and Changes for all EUC Equipment, Software, and related Services at designated Customer Sites.
- Coordinate, plan, and schedule IMACDs with all affected IT functions (whether the function is included within the Services provided by Infosys, as a Customer-retained function, or a Third Party); and
- Coordinate all internal and external functions and activities to achieve high-quality execution of the IMACD, to meet Service Levels, and to minimize any operational interruption or disturbance to Molina

IMAC Pre-Execution

IMACD pre-execution will have the activities that will be done by Infosys to enable IMACD execution. The below are the key activities that will be performed by Infosys as part of IMACD Pre-Execution

- Document the IMACD process and get client approval
- Obtain list of Molina personnel authorized to approve these requests
- Work with authorized personnel to resolve any issues identified with the IMACD
- Co-ordinate with all third parties required to perform the IMACD and ensure availability
- Confirm that all hardware and software necessary to perform IMACD is available in the site

- Confirm the installation and de-installation procedures
- Test the device used for IMACD
- Co-ordinate with all stakeholders and schedule the IMACD.

IMAC Execution

- Infosys asset manager assigns a replacement device to the end user
- The pre-configured device with user specific image and core applications is checked, tested and will be provisioned from site stock room.
- If the site has no stock room (site having <10 users), the request for shipment of device from nearest site will be raised.
- The Device gets shipped to the user site.
- In case of sites with dedicated FTEs:
  - The dedicated support engineer will schedule a time with the user in order to perform the IMACD
- In case of dispatch sites:
  - Remote support team will work with user and schedule IMACD
  - Remote support team will arrange a dispatch engineer for the site on the same date or at best the next day based on user availability.
  - Dispatch engineer will travel to the site and perform IMACD

Following are the detailed activities that will be carried out during the IMACD execution. These are broken up across install, move, add and change.

Install

- Connecting a new system unit (e.g. notebook/desktop, network printer)
- Installing and connecting of directly attached peripheral devices that are a component of the standard configuration
- Testing of the system unit to verify the hardware and software functionality with a network connection, provided that the network infrastructure is available.
- Test additional hardware peripherals to verify proper functionality with the main system unit
- User briefing on new device
- Recovery of user data from one or more servers onto the new system within defined parameters
- Ship the old device back to OEM if required with Molina 3rd party contract.

Move

- Brief functional testing of the system.
- Removal of the system unit including directly attached peripheral devices.
- Packing (if necessary) of the equipment for dispatch/transportation from the user's current place of work to the user's destination place of work (within a location or between two locations).
- Unpacking (if necessary) and connecting the system unit and the directly attached peripheral devices.
- Taking back of packing materials and their conveyance within the Molina location to a place designated by Molina
- Testing of the system unit to verify the functionality of the hardware and software with a network connection, providing the network infrastructure is available.

Hardware Add

- Unpacking (if necessary) of new equipment
- Installation of an external device (external modem, hard disks, printers, scanners, monitors) and the associated device drivers.

Software Add

- Installation of an application or a software suite with integrated application (e.g. bespoke apps) from the approved supported software catalogue.
- Only software published to the user's SCCM profile shall be supported

Hardware Change

- Modification of an existing system unit by a hardware upgrade (adding of functionality) or hardware downgrade (removal of functionality), including the drivers, if necessary.
- Testing the system unit to ensure the functionality of the hardware and software and accessing of the network.

Software Change

- Modification of an existing software configuration according to the specified documents/work instructions, such as the creation of network icons.
- Testing the system unit to ensure the functionality of the hardware and software and accessing of the network.

Remove

- Removal of the system unit including the directly attached peripheral devices, packing and conveyance of these devices to a store specified by Molina with having the option of picking up /scrapping.
- Erasing of the data on the hard disk by predefined processes in the predetermined store.

Build

- Receive, inspect, and store inventory at central and regional warehouse
- Load, configure, and test standard software on to the workstation based on the standard “gold master” image via SCCM
- Configure network parameters, User ID and password settings, network printer defaults, and other similar base
- Add user specific software as specified
- Test completed workstations, laptops, or other devices included in the standard hardware list
- Apply asset tags and perform initial asset inventory scan (e.g. serial number capture) or enter configuration item (CI) information if required
- Manage, track, and report inventory status and completion status of systems in work to central Infosys asset register
- As required, repackage fully assembled hardware and bundled software using original packing materials or other available means), apply shipping labels, generate appropriate shipping documentation
- The build activity may be performed at the user desk or a designated space within the Molina premises, where services are being delivered.

Quality Control and Improvements:

Faults Analysis within the Team:

- Appearing problems and technician’s shortcomings are analyzed and corrected
- Fast feedback from the supervisor
- Information sharing within the whole team
- Corrective Actions Reports

Project IMACDs Additional Responsibilities

Infosys and Molina will continue to monitor the utilization of Deskside resources. If there is any project IMAC such as large deployments which are time bound and critical, and require additional effort for a short period of time then it will be classified as a Project IMAC. For locations where there is a dispatch support it will be priced based on actual effort spent completing the project task.

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Figure 23. [redacted]

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Figure 24. [redacted]

The effort for hardware break fix will be optimized by Infosys once transition to desktop as a Service model.

2.3.1.5 L1.5 (Smart Hands Support) /Remote “Hands & Feet”

The Field Services team will perform Smart Hands and Feet support for Incidents, service requests, change requests, installs, de-installs, moves, break-fix of equipment for server/ network equipment in remote locations.

Below is the broad list of activities that will be categorized as “Smart Hands” / “Remote Hands & Feet” in remote locations.

- Perform network and server equipment shut down and restarts. Rack and stack for servers, routers, switches and other IT equipment
- Un-racking of decommissioned IT equipment
- Configure remote management on servers, switches etc. as per the guidance from the remote infra L2 / L3 team
- Perform basic tasks like swapping out of a failed server disk / memory module etc. as per instructions from the remote infra team
- Coordinate with Infosys L3 team to troubleshoot various IT related issues
- Coordinate with remote team regarding any third party vendors related issues including replacements
- Liaison with local facility teams to coordinate access and other activities as instructed by Infosys L3 team.
- Liaison with users to understand issues and report back to Infosys L3 team
- Wireless Support – assist in testing and installation of Wireless Access Points
  - Documentation – recording of IT inventory & IT processes at local sites including updating layout diagrams, rack view of the datacentre etc. as requested.
- For Dispatch sites, we propose this to be a one-time activity during Knowledge Acquisition.

2.3.2 Deskside and Walkup Support (Exhibit 2-C)

2.3.2.1 [redacted]

Figure 25. [redacted]

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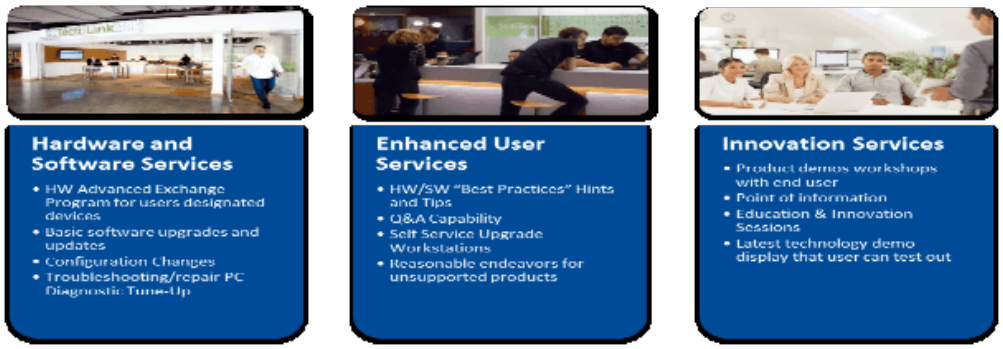
Continuous Improvements

- As shown in Figure below, Walk-Up services improves Molina employees' productivity and end user experience.



- As a result of the **continuous improvement** and the analysis of the operation of Walk-Up Service centers and new trends and technologies available in the near future. We would establish new products demos sessions, trainings on increasing Self-Service Services.

2.3.2.2 [redacted]

2.3.2.3 [redacted]

2.3.3 Desktop Engineering (Exhibit 2-C)

2.3.3.1 Solution

Infosys has vast experience in providing Desktop Engineering services for multiple enterprise customers across the globe. We will bring our Desktop engineering implementation and operation capabilities, lessons learnt, to cater Molina's benefit, with end to end service capabilities and ownership. Also we will analyze the scope during the DD/transition phase and enhance the service.

2.3.3.2 Patch Management and Software Distribution

Infosys as part of its services will provide Molina, support to End Users Software distribution, Software upgrades and updates through existing tool SCCM.

Desktop support team will provide support to Service desk for issues related to end user workstation issues. Using the Desktop engineering model, we will cater to services such as Software packaging, Software deployment, Software upgrades and updates

through SCCM which will help us to cater to the end user requests and maintain a stable operating environment which is secured and monitored effectively.

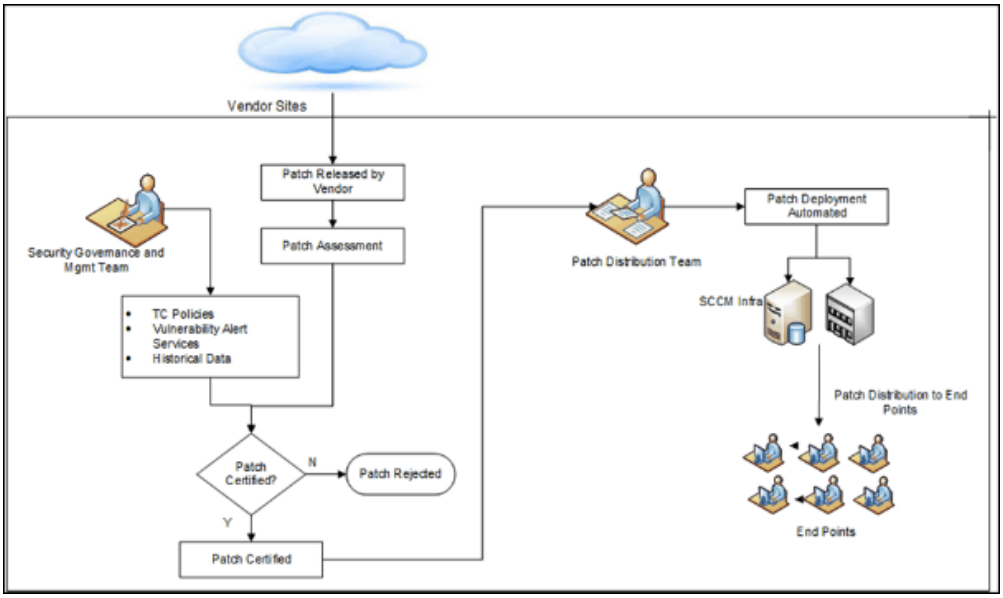
Patch Management

- Patch management service comprises of assessing threats and vulnerability, discovering new updates, Coordinate with Molina for patch qualification, Obtaining, testing and deploying required patches.

[redacted]

Figure 26. Patch Management Process

- We understand the significance of an effective patch management process as, in a network of hundreds of systems, all it takes is one machine to become compromised to open the door for multiple other machines to be compromised as well.
- Patch Management process not only plays a significant role in upholding enterprise security posture but is also treated as the solution for majority of security vulnerabilities. The key tenets of Infosys's Patch Management service are as follows:
  - Service Packs as a foundation of the patch strategy
  - Track the Product Lifecycle
  - Perform risk assessment using a Severity Rating System
  - Test updates before deployment
  - Patch prioritization and Scheduling



The Patches would be distributed using the existing SCCM in Molina environment. The team would take control of the end user equipment and distribute the patches as per scheduled releases. The OS and Application patches would be tested and then released for distribution by the security team. A periodic report will be generated for Molina capturing the total amount of Patches released and distributed in a stipulated times frame.

Key points to note are as follows:

- Patch Deployment will be done by Infosys.
- Identification of patches would be a joint function of the security teams at Molina and Infosys

- Patch Testing will be a collaborative process between Molina and Infosys.

Software Distribution

Infosys software distribution service apart from the distribution and deployment of the on-going patches and updates, Infosys will utilize Molina existing software distribution tool. Some of the Key activities include Deployment planning, deployment pilot test, deployment execution and coordination, monitoring and control.

Infosys will have a Software Distribution team for deployment and on-going patch and updates management utilizing Molina Automation's in SCCM tool. Key activities that we will perform as part of software distribution are.

- Establishing deployment plan for different user types
- Deployment process customization and coordination
- Software distribution to software repositories and clients
- Deployment pilot test
- Implementation of rollback plan

2.3.3.3 [redacted]

2.3.3.4 Desktop Management

Infosys will provide proactive management and testing of new hardware as part of an agreed roadmap of change with Molina.

- Molina and Infosys will review and evaluate new Hardware based on Molina's business requirements.
- Infosys will test the Hardware against the standard Molina Images before being introduced in to production
- Infosys will ensure that the changes to hardware models will be managed such that the hardware models are tested and qualified well before the current hardware reaches end of life or is not available for purchase.

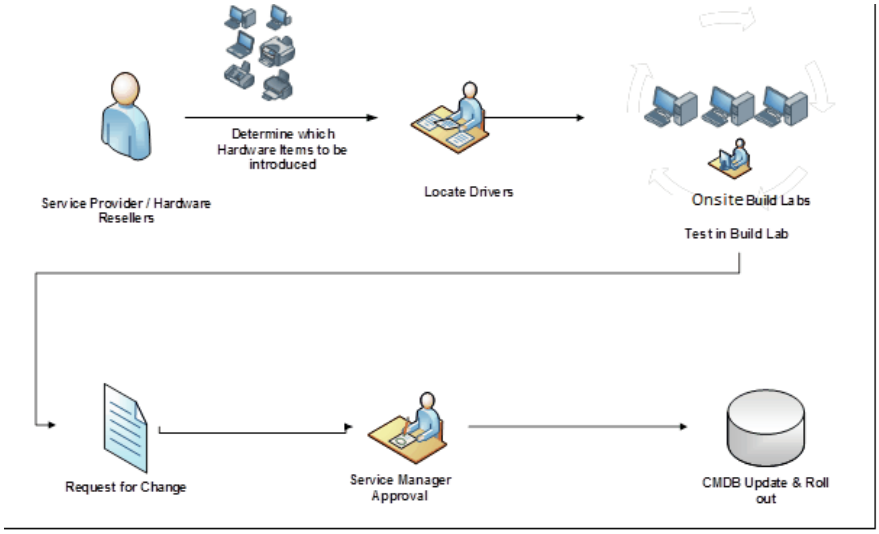


Figure 65.Desktop Management

2.3.3.5 Mobile Device Management

Infosys will support the existing MobileIron platform environment for the Enterprise mobile devices. Mobile Iron offers capabilities for mobile device management, mobile application management, mobile content management, secure access to cloud services and unified endpoint management.

Operate

- Provide support services for mobile devices which are in-scope.
- Provide lifecycle management services of mobile devices such as procurement to retirement

- Perform asset management services for mobile devices to the authorized users
- Perform CMDB updates and periodic reconciliation
- Perform patch management, device updates/fixes etc.
- Develop, maintain documentation and standard operating procedures
- Perform Install / uninstall / remote wipe etc. of applications and provide incident/ problem management services
- Conduct periodic audit to ensure adherence of Molina policies / procedures & compliance regulations.
- Provide support for mobile devices managed by other platforms if any, until all mobile devices are migrated to MobileIron.
- Report of audit, inventory & exceptions to Molina IT team on mutually agreed intervals

Continuous improvement

- Identify and propose integration methods for mobile applications
- Implement best practices for improved performance, problem isolation and troubleshooting
- Improve user experience
- Improve compliance of the devices and usage
- Perform stringent compliance management and identify / report security gaps
- Roll out new features and enhancement updates

2.3.4 End-User Device (EUD) Management and Remote Support Model (Exhibit 2-C)

Infosys will manage the Molina's IT assets throughout the life cycle from demand recognition and procurement to disposal using Molina's existing management processes and tools.

The Device Management Services includes the following Service Components:

- Device Lifecycle Management
- Asset Management

Device Lifecycle Management responsibilities

Infosys will:

- Use the Systems Management Toolset (SCCM) to install a Supported Image and core Software onto End Points as requested by Molina;
  - Perform End User state migration activities to ensure all data, Applications installed via the Software Distribution Service Component and locally stored preferences are transferred from one End Point to another;
  - Support the IMAC Service Component and Onsite Support Service Component as requested;
  - Perform quality assurance tests on all newly built or rebuilt End Points to ensure the following items are installed and operating as designed before the End Point is cleared for deployment:
    - All core Software as defined by Molina from time to time; and
    - All Software installed by the End User via the Software Distribution Service Component;
  - Provide Molina with reports detailing issues experienced/observed during the quality assurance steps outlined in this Service Component;
  - Record all issues experienced/observed during the quality assurance steps outlined in this Service Component to be able to provide such information to Molina on request;
  - Resolve any issues uncovered during quality assurance check before the End Point is cleared for deployment;
- Update the Asset Management Database (CMDB) for Tracking and Reporting Service Component;
- Configure End Points and update the CMBD with the unique identifier for the End Point and the date the End Point was built/rebuilt;
- Hand over the End Point to the Onsite Support team and update the CMBD with details about owner, status, detailed location amongst other specifically requested details from Molina;
- Being decommissioned:

- Ensure removal of the associated End Point AD Object from the Active Directory using the Active Directory Service Component;
- Ensure removal of the associated End Point AD Object from the Systems Management Tool using the Systems Management Toolset Service Component;
- Update the CMDB as described in the Tracking and Reporting Service Component;
- Engage Stock Management Service Components for Repair or Disposal if appropriate;
- Prepare End Point for redeployment and engage the Stock Management Service Component.

Asset Management responsibilities

Infosys will maintain a sufficient Stock of PC hardware and peripherals at Sites designated by Molina to meet the user demands through the End Point Provisioning, Re-provisioning and Decommissioning Service Component. Infosys will:

- Do Spares forecasting for the Break / Fix Services
- Manage Stock efficiently and only include Infosys supported/deployed End Points;
- Transfer Stock between any depots, Molina Facilities as necessary (leverage existing Molina shipment contract);
- Work with the Molina approved Hardware vendor(s) for fulfilment, warranty and non-warranty repair and disposal;
- Order equipment, receive equipment, check-in to inventory, apply Asset Tag, record model, type, serial number, date, status, and Stock location in the CMDB;
- Transfer to the Build Team and update the CMDB with new Molina locations and date moved as requested;
- Collect Hardware from Build Teams and update stock numbers when not in use; and
- Support the IMAC Service Component as requested.

Molina will own the Assets (Stocks, spares) and depots.

2.3.4.1 Remote Site Management

Infosys will leverage the existing BOMGAR tool of Molina to provide the remote support. Operational model for remote support is explained in section 1.1.2.

2.3.4.2 MDM, Cell Phone, and Hotspots Management

Solution summary

The key operational activities for devices are:

- Provide support services for mobile devices which are in-scope
- Provide lifecycle management services of mobile devices from procurement to retirement
- Perform asset management services for mobile devices to the authorized users
- Perform CMDB updates and periodic reconciliation
- Perform patch management, device updates/fixes etc.
- Develop, maintain documentation and standard operating procedures
- Perform Install / uninstall / remote wipe etc. of applications and provide incident/ problem management services
- Conduct periodic audit to ensure adherence of Molina policies / procedures & compliance
- Report of audit, inventory & exceptions to Molina IT team on a mutually agreed intervals
- Co-ordinate with 3rd party vendor / OEM for warranty replacements and/or disposal requirements

For Hotspots and bar code scanners: -

The operational activities include:

- Perform initial configuration of device and create device account in the Active Directory.
- Handle the needed certificates in rollout and updates processes.
- Resolve device errors and Authorized User issues including Incidents that need involvement of Third Parties (such as WLAN Access point provider). Re-build the device if it seems to be configured incorrectly.
- Handle communication with the external Hardware supplier.

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Table 24. [redacted]

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2.3.6 Network Operations Center

2.3.6.1 NOC Support Model

Infosys will be leveraging the intelligent command center to act as Network Operations Center (**NOC**). Molina will be able to proactively identify and resolve incidents before business is impacted through proactive monitoring by our Integrated Command Center.

Infosys will set up an Integrated Command Center (ICC) that will centralize support using unified processes, tools and technologies. The ICC will be staffed 24x7 to facilitate intelligent and timely action to "***catch the yellows before they become reds***". The ICC team will play a pivotal role in critical incident management and will be responsible for SOP-based resolution thereby reducing the number of incidents escalated to L2. by [redacted]:

- Monitor all events and correlate events to give actionable conditions
- Prioritized based on business impact
- Verified and enriched with extra state information and diagnostics
- If application performance problem, triaged to determine probable cause area
- Fix using run-book or route to appropriate team / co-ordinate with vendors
- Own the event and critical incident management process
- Reporting service level metrics on regular basis leveraging IIMSS

Figure 33.Integrated Command Center/NOC

Infosys integrated command center/NOC team will be leveraging IIMSS to perform L1.5 support for all the infrastructure tracks. Following IIMSS features will be leveraged to enhance the IT services across Infrastructure tracks

- Single and unified management solution/portal to help users request, manage, monitor and govern the Hybrid IT resources while providing agility and ensuring adherence to enterprise policies and processes
- To integrate, automate, and manage all its on premise, cloud resources and third-party cloud service providers (private/public, IaaS/PaaS/SaaS) in a central location
- Streamlined and disciplined monitoring across a hybrid IT landscape with a centralized data source for monitoring
- A single point of integration of alerts/alarms received from various monitoring tools into MOM (Monitors of Monitor) & other integration touch points
- A single point of correlated alerting, notification and reporting data source mechanism

- Proactively and predictively identify and resolve issues before the occurrence of a major outage incident
- Visibility of alerts and current tickets that are either assigned, being triaged or resolved
- Comprehensive reporting & dashboard capabilities based on various team reporting requirements including management and business teams
- Data analytics and Machine learning algorithms for incidents/service request to identify the recurring patterns for automations

Service Management Layer

Infosys will be having a service management layer overarching the integrated command center and service desk. Service management layer will have dedicated incident, change and problem managers who will take end to ownership of MIM, Incident, change and problem management functions. Following are key objectives and activities which will be managed and monitored by up by Incident, change and Problem manager's

Incident Manager

Objectives:

- Resolving Incidents within Established Service Times.
- Restore normalcy as quickly as possible.
- Ensure Customer Satisfaction.

Key Activities:

- Logging of incidents in the service management tool
- Prioritization and categorization of the incident
- Solve on the call if possible, else escalate it to the 2nd level / 3rd level support
- Ownership throughout the life cycle of the incident
- Knowledge base updates
- Analyzing incident trends
- Defining/updating KPI's
- Assisting the Major Incident Management Team
- Implement Lean methodologies through automation of certain tasks (where ever possible) and improve business value

Problem Manager

Objective:

- To prevent problems and resulting incidents from happening
- To eliminate recurring incidents
- To minimize the impact of incidents that cannot be prevented

Key Activities:

- Identifying the recurring incidents and work on a permanent solution
- Updating ServiceNow Known Error database, so further incidents can be resolved much more quickly
- Assist the Major Incident Management Team
- Closely work with Incident, Change, Event, Capacity and Performance Management processes
- Risk Management by identifying the vulnerabilities and performing the preventive actions
- Proactive Problem management through Continuous service improvement

Change Manager

Objectives:

- Respond to the customer's changing business requirements while maximizing value and reducing incidents, disruption and re-work
- Respond to the business and IT requests for change
- Clear and comprehensive release plans that enable Molina to align their activities with these plans.
- Building, installing, testing and deploying a release on schedule

- Identify specific Patch installation process

Key Activities:

- Categorization and prioritization of a change
- Validating the information provided by the change requester with Configuration Management, Test plan, Implementation plan, back out plan
- Driving the Change management board meetings
- Business Impact analysis on the change
- Authorization and coordination during implementation of the change
- Documentation and instruct Configuration management to update the CMDB
- Release building
- Release testing
- Release planning
- Release deployment
- Release documentation control

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Figure 36. [redacted]

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Figure 37. [redacted]

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2.4.2 Security Operations

Infosys engagement level controls with NIST Cybersecurity Framework

Infosys will follow NIST cyber security framework at an engagement level for supporting Molina's compliance mandates from outsourced managed services standpoint. Infosys internally is ISO27001 certified for all its delivery locations. From an engagement standpoint, Infosys will –

- Onboard and dedicated Information Security officer at offshore who will own –
- SOA and security controls documentation for Molina engagement
  - Work with Molina security team and align on the security controls, their design and operational aspects. These will be documented in the "Information Security HandBook_Molina Health Care".
  - Document a statement of applicability (SOA) to cross reference between controls, applicable services, processes, responsible parties, reporting and audit requirements, periodic assessment requirements.
- Security training for Infosys team engaged with Molina
  - Understand Molina requirements from security training for all resources who are going to work on the engagement.
  - Ensure that the training is undertaken by resources and records are maintained and updated in an on-going basis.
- Supporting Internal and external security audits for Molina-Infosys engagement
  - Create a calendar of internal and external audits, reviews, assessments by Infosys and Molina
  - Coordinate with internal and external stakeholders from Infosys and Molina perspective for such internal and external audits, reviews, assessments by Infosys and Molina
- Advisory and guidance to Infosys teams to meet Molina compliance requirements (SOA).
  - Provide continuous guidance to Infosys and Molina teams on meeting the stated and implicit needs for security control compliance requirements.
  - Addressing any gaps discovered as a part of any audit or assessment
- Report on KPIs
  - Align with Molina on reporting and KPI requirements
  - Ensure the committed reports and KPI reporting requirements are being adhered to and being met on a continuous basis.
- Infosys will explore with Molina on automating the security controls maintenance, change management and operational effectiveness by the usage of suitable eGRC tools.
- Infosys will create a statement of applicability of applicable controls – the SOA will be built by Infosys Information Security Officer and approved by Molina Security team. The applicable controls will be jointly arrived by referring to Molina security policy, compliance requirements, Infosys security policy and compliance requirements. The SOA will be a living document and will be updated as and when there is a change in the control design or implementation consideration. Future control requirement for Molina

- Infosys team engaged in this program will be responsible for ensuring that the security controls are designed, implemented, enhanced, supported. Each Infosys team will identify a security SPOC who be responsible for ensuring compliance to the SOA and associated compliance and reporting mandates

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Table 28. [redacted]

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Figure 44. [redacted]

Figure 45. [redacted]

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Figure 50. [redacted]

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Figure 51. [redacted]

Identify Key Objectives for Monitoring like the ones mentioned below:

- Identify gaps in the tools setup
- Improvement in alert noise
- Improved Dashboards and Reporting structure

Infosys will perform below Transition Activities for App and Infra support:

- Request for the latest details (repository, Inventory, Application owner details) of all the Infra and applications which are being monitored
- Take hand over of AppDynamics and Infra monitoring tools hardware details, software licenses and credentials of the servers forming the environment
- Analyze their on boarding process, approval process to perform new enhancements
- Get details of all the different application agents that are currently instrumented? (Java, .Net, PHP, Node.js etc.)
- Analyse current monitoring tools integration with event management tool and identify pain areas
- Create new account on Monitoring tools and deactivate old ones
- Understand all the SOP's, KB articles and process related documents
- Get details of all out of the box functionalities currently used and customized functions deployed in the monitoring tools
- Analyse default health rules and figure out any gaps in current setup
- Get application owner details for application which are getting monitored

From the tools leveraged in Molina, Infosys would analyse cases for redundancy and overlap of tools & functionality. After getting detailed information on Tools landscape, we can propose various idea to optimize the tools set by consolidating redundant tools.

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Figure 52. Sample Clarifications for tool rationalization

Tools Strategy During Cloud Migration Journey

Infosys understands that Molina will be embarking on the journey to migrate servers / applications to cloud in the upcoming years. This strategy will certainly have an impact on how the various monitoring and management tools would need to operate. Infosys will closely work with Molina architecture & security team in ensuring that appropriate strategies are defined to handle both the hybrid state of the environment with cloud & on premise existence and dedicated environments of only cloud or only on premise needs.

This strategy is anticipated to bring in the need for new tools to handle monitoring & management requirements in the cloud as well as the need for retiring / optimizing some of the existing tools. All changes related to Molina & Infosys tools will follow the defined release & change management processes including updating the necessary documentation of the tools.

2.5.2.2 Consolidation and optimization of existing tools

Solution Approach

- Rationalize current tools and extend the capability for tools optimization across businesses and eliminate redundant tools in consultation with Molina
- Deliver integrated and efficient operations to have robust tools and processes
- Optimized tools with applicable configuration and customization of monitoring solution to ensure long-term needs are fulfilled
- Integrate monitoring tools with IIMSS for event correlation

High-Level View of Integrated Monitoring environment with IIMSS Orchestration & Automation

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Figure 55. [redacted]

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Figure 56. [redacted]

- The proposed Strategic Governance Layer has been conceptualized to ensure overall governance to the service management initiative. This layer will be jointly owned by Infosys and Molina to ensure proper communication and effective governance. The strategic layer also follows a three-layer strategy, comprising of a Steering Committee, a Management Layer & an Operations Layer.
- The Operation Service Integration Layer will pursue policy and process adoptions and adherence as well as drive standardization of processes across the board (including multiple vendors). This layer will focus on process operations as well as develop various reports of varying complexities. Multiple reports will be generated to target specific audiences to give an overall dynamic snapshot of the environment health. Continuous Improvement activities will be spearheaded by the Service Excellence Office across the board and will ensure that process maturity within the organization continues to improve at a steady pace.
- Tools & Orchestration Layer will ensure integration of existing tools utilized by Molina and its vendors are appropriately integrated into ServiceNow. This will ensure seamless flow of information and enhanced governance of the infrastructure.
- **Tools & IP**

ITSM process transformation solutions are intended to be built on the ServiceNow platform: Incident, Problem, Knowledge, SLM, Service Catalog, Change Management & CMDB, Reporting and Dashboard.

Persona Based Services: Persona information available to Service Desk agent to ask relevant questions while interacting with Molina business users.

CXO Dashboards and Reports

- Leadership Dashboards will help making quick decision and analyse the health of IT operations at one glance
- Operations Dashboards – This will be designed for the operations team to help in operational efficiency and prioritize their work easily
- Trend Reports – These reports will give a snapshot view of how the performance has been for an organization over a period of time
- Snapshot View – This will be designed for various operations team to provide a glimpse of current health of operations

- **Consulting Enablers**

  - SIAM Maturity Assessment Framework

  Our varied and diverse experience in the SIAM space has enabled us to conceptualize and implement a comprehensive SIAM Maturity Assessment Framework which will help Molina gauge its existing infrastructure maturity levels. This framework consists of an assessment tool which utilizes a rating mechanism based on a detailed questionnaire and the results/scores are benchmarked against our defined maturity levels. The questionnaire encompasses all conceivable process within the ITSM space and hence this detailed and in depth analysis will enable Molina to accurately identify the processes that need a maturity level up. This, in turn, helps Infosys and Molina to focus a concerted effort on the pain areas and improve corresponding maturity levels. Along with a scorecard, Infosys will also provide action items and a roadmap to help Molina improve maturity levels across the spectrum.

  - Infosys SIAM Readiness Framework

  Infosys will also perform a SIAM Readiness Framework to gauge the effort and the pace in which the SIAM framework can be deployed across Molina environment. The multi-phased SIAM implementation approach will help us deploy process improvements at a much faster pace and hence save valuable time for Molina.

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Figure 57. SIAM Readiness Framework

- **Process Aids**

Infosys "iPrise" is an Infosys' proprietary set of processes required for different streams in Infrastructure Services. It Draws out best practices from world known process frameworks such as ITIL, CMMI, COBIT, ISO 27001, PMBok, etc. It is a collection of accelerated process designs using ready to use designs from the process repository. This set is used as a baseline to customize and develop Processes for IT Infrastructure Management set-ups. "Infosys i-PRISE" enables organizations to save time & effort required for defining processes and provides easy access to industry best practices. It acts as a catalyst for process definition and implementation. It includes detailed levels of various parts of a process such as sub – processes, roles & responsibilities, requirements for tools, KPIs and Metrics, etc.

Key areas where iPrise can contribute are:

- Enhancing existing processes and implement new capabilities to ensure core capabilities are defined
- Setup of Service Excellence Office to provide the overarching governance during the process setup and ensure its improvement.
- Ensure ITSM processes are defined, integrated, implemented and sustained. This will result in achieving processes with high end maturity level
- Once the processes are rolled out, process maturity assessments, quality audits, trainings and governance will ensure the maturity is maintained and improved.
- Rapid deployment of ITSM processes thereby saving significant time

Infosys recognizes and acknowledge Molina's current ITSM maturity state at Level 2 .Infosys's unique processes, frameworks and accelerators can help in reducing the short-comings. We will leverage our experience and Service Management Maturity Framework to improve the maturity of the processes at Molina.

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Figure 58. [redacted]

SIAM governance forums

Governance Forums	Frequency	Infosys Participants	Infosys Attendance
Service Excellence & Innovation Forum	Quarterly	Delivery Manager Engagement Manager	Mandatory
Commercial Review Forum	Quarterly On Need basis	Delivery Manager Engagement Manager	Mandatory
Service Review Forum	Monthly On Need basis	Delivery Manager Engagement Manager	Mandatory
Change Approval Board	Weekly	Infosys Change Coordinators / Initiators	Mandatory
Release Management Review Meeting	Weekly	Infosys Release coordinators / Initiators	Mandatory
Tower Operational Service Review Forum	Weekly	Tower Leads	Mandatory
Capacity Planning Forum	Monthly	Infosys Capacity Co-coordinators	Mandatory
Service Change Forum	Monthly	Tower Leads, Change Coordinators	Mandatory
Service Management Operational Governance Forum	Monthly	Tower Leads Delivery Manager	Mandatory
Service Design & Life cycle forum	Quarterly On Need basis	Delivery Manager	By Invitation
SIAM Project Forum	Monthly	Delivery Manager Project Manager	By Invitation

Integrated Performance Dashboards and Reporting

Infosys will maintain integrated IT Governance to build a seamless and service focused delivery structure. Based on our experience, we often notice that with dispersed data, IT Leadership often receives very different reports from each region, it's hard to get an end to end overview of the IT operation, or to perform data analysis resulting in what we often refer to as 'Water-Melon' Effect (Green from outside, red inside); where Individually each vendor or region might be performing well, but collectively business is not happy.

Infosys has handled multiple accounts with this scenario and helped our Customers overcome these challenges by having a robust and comprehensive multi-tier Governance structure.

Infosys' view on performance reporting focuses on enabling adequate visibility of performance of each Vendor/region/tower at various Organizational levels

- At Strategic layer, high level performance summary or a dashboard view on all Suppliers and a Management summary related reports are produced
- At Management Layer, the regular SLA reports as well as CSI reports are shared and discussed.
- At operational layer, multiple reports at various stages of each process are produced and verified

2.6.2 DR / BC for Supplier Services in-Scope of This Agreement

Infosys understands the criticality and relevance of DR and BCM for supplier services to ensure continuity of services to our clients / partners under any disaster scenario. Infosys can provide 100% confidence to Molina for continuation of services via its thorough DR/BCM corporate level framework, guidelines and teams.

Infosys has a detailed Business Continuity and Disaster Recovery plan called "Phoenix" at the Corporate Level, Location Level and each account Level. Redundancy has been built into all the essential infrastructure including office space, network connectivity, power, computing resources and personnel, and the same would be applicable for Molina engagement.

Infosys BCMS conforms to the requirements of ISO 22301. Infosys is certified for ISO 22301-certification standard effective February' 2013. The scope of the certification covers all Infosys India locations (including BPO locations).

The Business Continuity Management Plan is a comprehensive set of steps to be taken before, during, and after a disaster. The plan is documented, communicated and tested to ensure the continuity of business operations and availability of critical resources after disaster. This plan is made available at all of our Development Centers (DCs).

The BCMS Plans are driven systemically through the BCMS System, an in-house application for management of all the Business Continuity Plans and reviewed at least annually.

The BCMS system is used to develop the account level BCMS Plans and cover sections such as the account level BCMS team structure, Roles and responsibilities, Business Impact Analysis, Risk Assessment, recovery sites, Incident Management Workflow, Post Disaster Activities, Notification Directory, Tests and Exercises, Call Trees, Metrics to check on maturity tracking and compliance etc. This plan will be created for Molina as well and will go through an approval process before it gets baselined.

Tests and exercises are conducted at all three levels - Location, Function, Account. Once the Molina account level BCP gets created it will be tested as per the frequency updated in the test plan / agreed with Molina. Tests are conducted at least once a year by the Infosys Quality assurance team and BCM team.

These BCMS tests and exercises are planned to ensure the validation on the various BCMS strategies/controls in place. These are conducted to cover scenarios like unavailability of –

- IT Infrastructure
- Physical Infrastructure, and / or
- Human Resources

Any issues or deficiencies identified during these tests are captured as action item in an Infosys BCMS tracking tool and driven to closure with follow-ups and execution.

As in any other engagement, Molina account team will have few DRRs – Disaster Recovery Representatives on the floor, to take care of any disaster situation. These are resources from the project, and are trained by the Infosys BCMS team, on how to act during the disaster situation.

Degree of Assurance

- A minimum of **[redacted]** of the physical infrastructure is available as redundancy. Example – extra office space at Infosys DCs within the same city and / or another city
- A minimum of **[redacted]** of the IT infrastructure is available as redundancy. Example – Laptops, Desktops, VoiPs etc.

- Upon occurrence of a disaster affecting Infosys offshore facilities, Infosys will implement the plans and procedures stated to ensure business continuity

For Molina, it is envisaged that services will be delivered using a combination of resources at onsite and one or more of Infosys' development centers in India (Bengaluru and Chandigarh).

Following is the snapshot of the BCP/DR infrastructure for Molina is outlined below.

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2.6.2.1 Backup and Storage (Process, Data Residency)

Infosys will be accessing Molina infrastructure / tools / applications from offshore (Bengaluru / Chandigarh) through Molina VDI / Citrix connections. Infosys will not have any Molina data stored in any of the Infosys site and systems. Molina data will stay within Molina's Data Center and follow the agreed Molina DR/BCP. In case of any disaster at the Infosys service locations, Molina related data will not be affected since no data is stored within Infosys network / site.

2.6.2.2 Committed and On-Demand Equipment

From the current scope of work, Infosys understands the need to setup an Offshore ODC location, which will be setup in Bengaluru / Chandigarh for Molina. Following would be the committed equipment, to ensure steady execution of operations:

- Router – for network connectivity from Infosys ODC to Molina DC
- Laptops/Desktops – for all the on-boarded resources to carry out their work for Molina.
- VoiP Phones – for the resources to join direct meetings within the teams located globally, with the Molina stakeholders

2.6.2.3 Support Services

In order to ensure smooth and continuous operations and to meet any DR/BCP situation, Infosys has the following internal teams / sources to provide support services:

- Computers and Communication Department
- Quality Assurance Team
- Business Continuity Management team
- Infosys Development center facilities team
- Transport team

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Figure 59. [redacted]

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2.8.3.5.4 Reporting

Following table provides list of reports / KPIs we propose for effective IAM support.

#	Report Parameter / KPI	Description / Action Item
1	Availability	Ensure availability of IAM systems and provide weekly / monthly report for the same in addition to live availability status (live availability is dependent on available monitoring systems)
2	Incident Count / Service Requests vs. Status	Adhere to SLAs
3	Top 10 IAM Incident Categories vs. Volume	With process optimization or automation, show decrease in incident numbers in same category
4	SOX Reports	Convert Ad-hoc / manual report generation into automated report generation over time for SOX queries
5	Audit Reports	Convert manual audit report generation into automated report generation over time
6	Operations Reports	Automate report generation for operational efficiency such as for data discrepancy over time
7	Usage Reports	Provide reports on usage of identity and access management system, password reset, progress of access certification cycle, etc. and monitor performance of environment vs. available capacity
8	Privilege Usage Reports	Provide reports for privilege access usage through available tools (Bomgar PAM and available analytics system)
9	Weekly / Monthly Trend Reports	Provide weekly / monthly trends for incidents, problems, service requests, availability, usage, etc.
10	Dashboard	Provide dashboard summarizing no of active users, key activities, key automation activities, etc. in addition to weekly / monthly trends

2.8.3.5.5 Continuous improvement opportunities

Based on understanding of current state and overall application landscape at Molina, Infosys has identified key areas for improvement/ automation which will result into a streamlined end to end IAM solution.

2.8.3.5.5.1 IAM Manual Activities

As part of due diligence and transition phase, Infosys will work on listing complete inventory of manual activities related to Identity and Access Management support, and will work on automation of the ones resulting into higher number of incidents and service requests. Following table provides a brief list of manual activities which are generally encountered in a typical IAM program of similar scale.

#	Typical Manual Activities	Mitigation / Automation
1	Data Quality – discrepancies and inconsistency in data between source system, IDM system and target systems	Data quality analysis during implementation; Periodic data discrepancies reports and automated remediation of the same
2	Manual troubleshooting related to various access certifications	Log analytics; Automated troubleshooting; Verified process
3	System Management (including backup, storage, logs)	Automated operational management (such as automated log rotation, archival, purge)
4	Support to internal / external audit queries	Define requirement in alignment with audit teams; Enable solution for automated reporting of audit requirements
5	Incidents related to self-services including password reset	Provide self-services for account unlock, password expiry, etc.; Enable help desk / L1 support to resolve such incidents
6	Requests pending for approval	Enable delegated approvals using IDM system
7	Assign access in PAM system for local administrative rights or deployment rights for a short window	Automate on-demand privilege access management through process and technical optimizations

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2.8.3.6.4 Reporting

Security Infrastructure tools support team will create daily/weekly/monthly reports and share the update with Molina team. The reports that will be shared with Molina are as follows:

Area	Frequency	Target Stakeholders	Report Example
Operational Reporting	Weekly	Infra leads, App Leads, SOC Manager/team, CSIRT team	▪ Total incidents, problem, change tickets, status of tickets (open/closed) ▪ Weekly trends ▪ Any open issues
Trend Reporting	Monthly	SOC Manager, IT Managers	▪ Administrative changes Trends ▪ Point solutions like AV, IPS, FW trends ▪ Traffic Trends (services, ports, users) ▪ SLAs
Incident and Service Status reporting	Daily, Weekly	SOC Manager	▪ Incidents by Priority ▪ Incident by Stages ▪ Incidents by Age ▪ Incident Trend by Priority ▪ SLA Compliance/breaches ▪ Average Incident response time by priority ▪ Ad-Hoc Report delivery
Compliance Reports	On-Demand	Compliance Auditors	▪ Access and Change Validation ▪ Administrative Activities

2.8.3.6.5 Continuous improvement opportunities

Security Infrastructure tools support will continuously be looking for improvement opportunities and provide Molina with transformation ideas well. Some of the typical opportunities for improvement in supported, existing tools.

2.8.3.7 [redacted]

[redacted]

Figure 60. [redacted]

[redacted]

Figure 61. [redacted]

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Figure 62. [redacted]

2.8.3.7.1 [redacted]

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2.8.3.7.3 [redacted]

[redacted]

2.8.3.7.4 Reporting

Following table provides list of reports:

#	Report Parameter / KPI	Description / Action Item
1	Application Scan Vulnerability Report	After each scan completion, Infosys team will provide a report to Application owner to fix the identified vulnerabilities
2	Weekly Report	Provide insights of total number of applications or assets scanned in a week, total vulnerabilities identified, fixed and closed
3	Weekly Infrastructure Vulnerability Scan Report	Will be shared with IT Ops or Assets owners for their remediation action
4	Monthly Infrastructure Vulnerability Scan Report	This report will provide insights of cumulative scan performance and the left over vulnerabilities to be fixed
5	Yearly Infrastructure Vulnerability Scan Report	Toward end of year, a complete scan will be conducted to find out if there are still vulnerabilities exist

2.8.3.7.5 Continuous improvement opportunities

During the Steady State, Infosys will assess the possibilities of identifying opportunities for improvement. Some of such improvement ideas are:

- Vulnerability management life-cycle process assessment and improvements
- Vulnerability backlog clearing initiative for CVSS 7+ vulnerabilities
- Reporting of vulnerabilities by asset and application criticality matrix
- Bring in secure SDLC as a part of application development and release process

2.8.3.8 [redacted]

[redacted]

Figure 63. [redacted]

2.8.3.8.1 [redacted]

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2.8.3.8.3 [redacted]

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2.8.3.8.4 Reporting

Following table provides list of reports:

#	Report Parameter / KPI	Description / Action Item
1	Weekly Report	Provides Total number of Incidents and Requests serviced by Infosys team
2	SLA Report	This report will bring the view of how Infosys is performing against agreed SLA in handling incidents

2.8.3.8.5 Transformation ideas/initiatives

During the course of Steady State, if there are automation opportunities or Data Center to Cloud migration opportunities or Major upgrade initiatives, Infosys will be partnering to deliver the transformational initiatives.

2.8.3.9 [redacted]

[redacted]

Figure 64. [redacted]

2.8.3.10 [redacted]

[redacted]

2.8.3.10.1 [redacted]

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2.8.3.10.2 [redacted]

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Figure 103.[redacted]

2.8.3.10.3 [redacted]
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2.8.3.10.4 [redacted]
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Appendix

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Schedule 23

BUSINESS CONTINUITY AND DISASTER RECOVERY

CONTENTS

1. **DEFINITIONS**

1.1 Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (Definitions and Interpretation) to this Agreement. In this Schedule:

"**BCP/DR Tests**" means the tests performed to assess the success of the BCP/DR Plan(s). The test includes:

(a) participation in the planning sessions leading up to a test;

(b) executing Recovery activities which are the responsibility of the Service Provider;

(c) supporting Recovery activities which are the responsibility of any Other Service Provider;

(d) participating in post-test debriefs and reviews; and

(e) contribution to and execution of follow up actions, as part of the Disaster Action Log;

"**Disaster Action Log**" means a document that records all the open and closed actions that were identified as part of a response to:

(a) a Disaster;

(b) an audit, Risk Assessment, review, Planned Exercise or BCP/DR Test;

"**Disaster Recovery Service**" means:

(c) producing, implementing, maintaining and testing the BCP/DR Plan(s);

(d) managing and completing the activities as documented in the BCP/DR Plan(s) in the event of a Disaster and including performing Disaster Recovery; and

(e) fulfilling any obligations, set out in this Schedule 23 *(Business Continuity and Disaster Recovery)*;

"**Exercise and Test Report**" means a report that contains the results of a review, Planned Exercise or BCP/DR Test, and includes full details of the results, activities performed and evaluates the performance against agreed objectives and Service Levels;

"**Planned Exercise**" means reviewing a BCP/DR Plan(s) to ensure their viability and effectiveness, and alignment of each other BCP/DR Plan(s);

"**Recover**" means to recover a backup from backup media in accordance with the Recovery Point Objective as specified in this Schedule 23 *(Business Continuity Management and Disaster Recovery)* and "**Recovery**" shall be construed accordingly;

"**Recovery Point Objective**" or "**RPO**" means the point in time to which the data is restored using the last back up as set out in Appendix 23A (*BCP/DR Plan Requirements*);

"**Recovery Time Objective**" or "**RTO**" means the period of time from the invocation of a Disaster to when the System should be Restored as set out in Appendix 23A (*BCP/DR Plan Requirements*);

"**Remedy Plan**" means a document that describes the activities and resources needed to remediate issues identified in the Disaster Action Log, which may include changes required to the BCP/DR Plan(s);

"**Restore**" means to restore Services and the impacted part of the Systems to normal operation in accordance with the Service Levels and "**Restoration**" shall be construed accordingly;

"**Risk Assessment**" means an assessment to ensure that the Approved Service Delivery Locations and those Services and Systems delivered from the Approved Service Delivery Locations comply with the Molina Policies, and includes:

(a) identifying whether the likelihood of a Disaster has changed;

(b) identifying new threats, vulnerabilities, issues experienced and opportunities for improvement in relation to the continuity capabilities of Services and Systems in those Approved Service Delivery Locations;

(c) ensuring new, obsolete or modified processes are analyzed and classified by criticality;

(d) ensuring mapping between the Services and Systems delivered from the Approved Service Delivery Locations remains correct and is appropriately reflected within the configuration management database; and

(e) providing updates to any risk assessments conducted by or on behalf of Molina in relation to the Approved Service Delivery Locations, Services, Systems, or business processes;

"**Risk Assessment Report**" means a report that summarizes the results of the Risk Assessment, and includes details of:

(a) criticality of the Services and Systems to Molina;

(b) single points of failure, including potential issues caused by centralization or a lack of physical separation and geographic spread;

(c) amount of physical spare capacity available;

(d) interdependencies, including dependencies on Other Service Providers; and

(e) recommendations for improvement and/or plans as required by the remediation of issues, risks and deficiencies section of this Schedule.

"**Service Provider Disaster Coordinator**" means the Service Provider person serving as the point of contact concerning Disaster Recovery in the event of a Disaster.

2. PRINCIPLES

2.1 This Schedule sets out the Service Provider's obligations in relation to the BCP/DR Plan(s) and Disaster Recovery Service.

2.2 The Service Provider shall develop and maintain its BCP/DR Plan(s) in accordance with paragraphs 3 and 3.17 respectively.

2.3 In meeting the requirements set out in this Schedule, the Service Provider shall:

(a) take appropriate actions to minimize interruption to Molina business activities during a Disaster;

(b) manage all aspects concerning the ability to continuously provide Services according to the Service Levels, Recovery Time Objectives and Recovery Point Objectives; and

(c) deliver the ability to manage the Recovery and Restoration of Services and Systems following a Disaster with minimum impact on Molina.

2.4 The Service Provider shall manage the Service Provider resources required to meet the requirements set out in this Schedule for all Approved Service Delivery Locations.

2.5 The Service Provider shall:

(a) have a documented BCP/DR Plan(s) for (i) Approved Service Delivery Locations, and (ii) designated Systems (i.e., Systems used by Service Provider to provide the Services); and

(b) each year during the Term, provide written confirmation to Molina that the Service Provider has a documented BCP/DR Plan.

2.6 The Service Provider shall store the latest, up-to-date version of the BCP/DR Plan(s), Service Provider briefings to Molina, if any, on the BCP/DR Plan(s), and supporting documents produced by the Service Provider under this Schedule on the Contract Management Portal.

2.7 During an outage or disaster, Service Levels will not apply unless the Disaster Recovery Plan specifies otherwise; provided, however, that the Service Levels shall apply in any event where the Disaster Recovery Plan was enacted in response to a breach of the Agreement by the Service Provider (as opposed to being enacted in response to a Force Majeure Event).

3. SERVICE PROVIDER'S BCP/DR PLAN

3.1 Molina shall provide the Service Provider a prioritized list for the Recovery and Restoration of the Services.

3.2 The Service Provider shall develop, implement and maintain the BCP/DR Plan(s).

3.3 The BCP/DR Plan(s) shall be developed for (i) Approved Service Delivery Locations, and (ii) designated Systems in accordance with this paragraph 3, unless otherwise agreed or directed by Molina.

3.4 Each BCP/DR Plan shall cover reasonably foreseeable events (together with any other events agreed with Molina) and consequences including loss of designated Systems, loss of Services, loss of Systems provided by a Subcontractor, and total or partial loss of any single building or group of buildings for each relevant Service and designated System.

3.5 Each BCP/DR Plan shall provide for the following in the event of a Disaster:

(a) ensuring the safety of Service Provider Personnel and Molina Personnel (if applicable);

(b) minimizing potential economic/business loss to both the Service Provider and Molina;

(c) reducing disruptions to Services and Systems;

(d) ensuring organizational stability and reducing reliance on certain key individuals;

(e) minimizing decision-making and providing an orderly Recovery;

(f) minimizing the Service Provider's legal liability by adhering to Applicable Law as set out in the Agreement; and

(g) seeking to protect the Services and Systems containing Molina Data.

3.6 The BCP/DR Plan shall include details of the following:

(a) the events that may trigger a Disaster;

(b) communication channels;

(c) the detailed activities required to be taken by the Service Provider in the event of a Disaster to Restore impacted Services and Systems;

(d) the sequence of the activities required to Restore Services and designated Systems;

(e) the dependencies the Service Provider has on Molina and Other Service Providers in order for the Service Provider to complete the activities to Recover and Restore impacted Services and Systems;

(f) details about the prioritization of Recovery and Restoration activities to be performed in relation to the designated Systems and Services;

(g) resources involved in each activity in the BCP/DR Plan;

(h) the testing activities that will be completed after each activity;

(i) potential Workarounds which may be deployed in the event of a Disaster to partially or fully Recover and Restore Services and designated Systems; and

(j) the activities to failback a Service or designated Systems to its state before a Disaster occurred.

3.7 Each BCP/DR Plan shall comply with all relevant Molina Policies, Applicable Law and Good Industry Practice and shall conform to ISO 27001, and cover all Key Personnel, resources, Services and actions required to manage the required Disaster Recovery processes and achieve the RPO and RTO set out in Appendix 23A (BCP/DR Plan Requirements). Service Provider will use commercially reasonable efforts to support RTO and RPO as architected in the current Systems. If changes to the architecture or investment in Capital is required to achieve the RTO / RPO requirements listed in Appendix 23A, Molina will be responsible to fund these changes to the underlying systems, but as long as the service provider identifies these requirements promptly following the first DR test with Molina.

3.8 The Service Provider shall work with Subcontractors to ensure the BCP/DR Plan can be supported by Subcontractors as required.

3.9 The Service Provider shall:

(a) submit a draft of the BCP/DR Plan(s) that meets all of the requirements set out in this Schedule 23 (*Business Continuity and Disaster Recovery*) to Molina within 180 days after the Service Commencement Date; and

(b) update the BCP/DR Plan(s) within 10 Business Days after receiving notification from Molina that an update to the BCP/DR Plan(s) is required following a Planned Exercise with the details of the updates required, and at the Service Providers cost continue to update the BCP/DR Plan(s) until Molina provides approval or the Parties escalate the matter to the relevant Governance Board in accordance with Schedule 7 (*Governance*).

3.10 The Service Provider shall cause the BCP/DR Plans developed and, as applicable, implemented by it pursuant to this Schedule 23 to account for and to be coordinated with the Molina BCP/DR plan set out in Appendix 23B.

3.11 Molina shall approve or reject the BCP/DR Plan(s) within ten (10) Business Days of receipt of the draft BCP/DR Plan from the Service Provider. If Molina rejects the BCP/DR Plan(s) then Molina shall provide reasoning for the rejection to the Service Provider. Where Molina rejects a BCP/DR Plan, the Service Provider shall make all required changes in accordance with paragraph 3.12(b).

3.12 The Service Provider shall:

(a) co-operate with all Other Service Provider(s) and Molina in the development of BCP/DR Plan(s); and

(b) provide input into Other Service Providers' business continuity and disaster recovery plan(s) as reasonably requested by Molina.

3.13 The Service Provider shall define and provide evidence to Molina on how the BCP/DR Plan(s) will be coordinated with Other Service Providers' business continuity and disaster recovery plans.

3.14 The Service Provider shall perform reviews, Planned Exercises and BCP/DR Tests of the BCP/DR Plan(s) in accordance with paragraph 5, and the Service Provider shall provide evidence to Molina, in the form of an Exercise and Test Report, that the reviews, Planned Exercises and BCP/DR Tests were completed as per the review, Planned Exercise and BCP/DR Test schedule in accordance with paragraph 5.4.

3.15 If a Disaster occurs that would trigger a BCP/DR Plan and, as a result, the Service Provider has to allocate scarce Resources between accounts, the Service Provider must treat Molina no less favorably than other similarly situated clients receiving similar services to the Services on a like–for–like basis.

3.16 The Service Provider shall record the BCP/DR Plan(s) in the Contract Management Portal to ensure the BCP/DR Plan(s) are continuously available to Molina. The Service Provider shall produce and maintain a report, on the Contract Management Portal, that includes:

(a) a list of the BCP/DR Plan(s) in scope for the Service Provider;

(b) the date of the last update for each BCP/DR Plan;

(c) the date of the next scheduled review, Planned Exercise and BCP/DR Test; and

(d) any missed activities or performance gaps.

3.17 The Service Provider shall continuously review the BCP/DR Plans and make necessary updates to reflect the status of the Services, Recovery strategies, technical solutions and related Recovery (subject to approval by Molina to any amendments).

4. RECOVERY TIME OBJECTIVES AND RECOVERY POINT OBJECTIVES

4.1 All of the Services and designated Systems shall be maintained or Restored in accordance with the Recovery Time Objectives set out in Appendix 23A (*BCP/DR Plan Requirements*) and each BCP/DR Plan.

4.2 All agreed data shall be backed-up, maintained and Recovered in accordance with the Recovery Point Objectives set out in Appendix 23A (*BCP/DR Plan Requirements*) and each BCP/DR Plan.

4.3 The Service Provider shall reasonably co-operate and work together with Other Service Providers and Molina in implementing the Recovery Time Objectives, Recovery Point Objectives in accordance with the BCP/DR Plans.

5. REVIEWS, EXERCISES AND TESTING

5.1 General principles

(a) The BCP/DR Plan(s) shall be reviewed, exercised and tested in accordance with this paragraph 5.

(b) Reviews, Planned Exercises and BCP/DR Tests will be scheduled with consideration of seasonal business cycles, the number of processing systems or platforms involved and the time required to perform the review, Planned Exercise or BCP/DR Test and shall only be performed if approved by Molina. The Service Provider shall take appropriate actions to avoid reviews, Planned Exercises and BCP/DR Tests having an impact on the delivery of Services, unless specifically approved by Molina.

(c) In each Contract Year a Planned Exercise or a BCP/DR Test, will be scheduled for each System which is eligible for Disaster Recovery Service.

(d) The Service Provider shall develop the Planned Exercise and BCP/DR Test schedule of the BCP/DR Plan(s), Molina shall review the Planned Exercise and BCP/DR Test schedule with the Service Provider, and Molina shall approve the Planned Exercise and BCP/DR Test schedule. The Service Providers shall execute the Planned Exercise and BCP/DR Test as specified in the Planned Exercise and BCP/DR Test schedule approved by Molina. The approved Planned Exercise and BCP/DR Test schedule will be available on the Contract Management Portal.

(e) For all Planned Exercises and BCP/DR Tests, a scenario and detailed list of objectives will be developed and agreed between Molina and the Service Provider prior to the Planned Exercise or BCP/DR Test commencing. The Parties shall agree:

(i) scenarios which represent realistic Recovery parameters to ensure all components of the BCP/DR Plan(s) can be demonstrated, e.g., simulation of Recovery from losing a data center, Recovery of a business critical application environment;

(ii) objectives written in such a way that success criteria are clearly defined and understood and so that overall performance can be measured against those objectives; and

(iii) reporting format and content.

(f) Unless otherwise specified, Molina shall provide the facilities, operations, networks and equipment necessary for the Planned Exercises and BCP/DR Tests of the BCP/DR Plans.

(g) The Service Provider shall continue to provide the Services and Systems with minimal interruption in accordance with the Service Levels during the performance of the Planned Exercises or BCP/DR Tests of the BCP/DR Plans.

5.2 BCP/DR Plan reviews

(a) The Service Provider shall formally review the BCP/DR Plan(s) once a year, by:

(i) performing a structured walk-through of the BCP/DR Plans' capabilities; and

(ii) reviewing the BCP/DR Plan(s) to identify any perceived gaps and provide recommendations and rationale for amendments to the BCP/DR Plan(s).

(b) Following such a review, the Service Provider shall update the BCP/DR Plan(s) as necessary to comply with the requirements of this Schedule 23 (*Business Continuity and Disaster Recovery*).

5.3 BCP/DR Plan Planned BCP/DR Test

(a) As set out in paragraph 5.1(c), the Service Provider shall perform a BCP/DR Test of the BCP/DR Plan(s) once a year.

(b) The BCP/DR Test shall:

(i) test that all purposes of the BCP/DR Plan(s) are being achieved;

(ii) test the state of readiness of the organization to respond to and cope with a Disaster;

(iii) determine whether backup Data and documentation stored off-site are adequate to support the resumption of business operations and failback to the state of business operations before a Disaster;

(iv) determine whether the activities and operating procedures are adequate to support the resumption of business operations and failback to the state of business operations before a Disaster;

(v) determine whether the BCP/DR Plan(s) have been properly maintained to reflect annual resumption, Recovery and Restoration needs and failback to the state of business operations before a Disaster;

(vi) consider and test for exposure to new risks;

(vii) test that Service Provider Personnel are adequately trained for Disaster Recovery;

(viii) consider lessons learned from the occurrence of an Incident and test these against the current processes;

(ix) test against changes in technology and/or processes;

(x) test against the introduction of or change to any Applicable Law, to the extent the Service Provider is responsible for complying with Applicable Law as set out in the Agreement, or Molina Policies, in each case to the extent Molina has communicated the change and the impact to the Service Provider.; and

(xi) consider any changes to any Service and Systems.

(c) The Service Provider shall conduct an additional Planned Exercise following:

(i) an Agreement Change that requires a change to the BCP/DR Plan(s) or requires a different manner of implementation, including different people to implement the BCP/DR Plan(s);

(ii) subject to the Change Control Process a re-organization of Molina;

(iii) a re-organization of the Service Provider;

(iv) a Disaster; or

(v) an Incident where the associated BCP/DR Plan(s) or associated Disaster Recovery capabilities fails to maintain Services at the required level or fails to meet RTOs or agreed Service Levels.

(d) The Service Provider shall manage and coordinate the BCP/DR Test of the BCP/DR Plan(s).

(e) Following such a BCP/DR Test, the Service Provider shall update the BCP/DR Plan(s) as necessary to enable the execution of all activities in compliance with the requirements of this Schedule.

5.4 BCP/DR Plan Exercise and Test Reporting

(a) Within ten (10) Business Days following the completion of each BCP/DR Plan review, Planned Exercise or BCP/DR Test, the Service Provider shall prepare and communicate the Exercise and Test Report.

(b) Each Exercise and Test Report shall be stored on the Contract Management Portal.

(c) Where the agreed test objectives and/or Service Levels are not met, the remediation of issues, risks and deficiencies section, paragraph 8, of this Schedule 23 (*Business Continuity Management and Disaster Recovery*) shall apply.

6. CONTINUITY RISK MANAGEMENT

6.1 The Service Provider shall conduct Risk Assessments at least once per year for each Service Provider Approved Service Delivery Location where there are Systems or from where the Service Provider delivers Services.

6.2 The Service Provider shall prepare a Risk Assessment Report in relation to each Risk Assessment within ten (10) Business Days of completing each Risk Assessment.

7. AUDIT

7.1 Without limiting Clause 38 (*Audit and Information Access*) of the Agreement, Molina reserves the right to audit, with reasonable prior written notice, the Service Provider's adherence to the BCP/DR Plan(s) at any time.

7.2 At a minimum, the Service Provider shall make available to Molina for audit purposes, the most recent approved version of the:

(a) Risk Assessment Report;

(b) BCP/DR Plan(s);

(c) Exercise and Test Reports; and

(d) Disaster Action Log.

8. REMEDIATION OF ISSUES, RISKS AND DEFICIENCIES

8.1 If:

(a) Molina invokes a BCP/DR Plan(s) and the Service Provider has not met its obligations in relation to the BCP/DR Plan; or

(b) a Planned Exercise or BCP/DR Test fails to achieve stated objectives; or

(c) an audit under paragraph 7 of this Schedule 23 (*Business Continuity and Disaster Recovery*) or Clause 38 (*Audit and Information Access*) of the Agreement or Risk Assessment related to an event under paragraph 6 identifies that the Service Provider has failed to achieve stated objectives, and such failure is due to the fault of the Service Provider,

the Service Provider shall produce and share with Molina a Remedy Plan within ten (10) Business Days of the failed result, to remedy any deficiencies or risks identified.

8.2 Molina shall approve or reject the Remedy Plan within ten (10) Business Days of receipt from the Service Provider. If Molina rejects the Remedy Plan, Molina shall provide reasons for the rejection.

8.3 Where Molina rejects the Remedy Plan, the Service Provider shall revise the Remedy Plan taking into consideration all Molina's comments and within five (5) Business Days of Molina's rejection, re-submit the revised Remedy Plan to Molina to obtain Molina's approval in accordance with paragraphs 8.2 and 8.3.

8.4 Where Molina does not approve or reject the Remedy Plan or Molina rejects a revised Remedy Plan, the Parties shall escalate the Remedy Plan (or revised Remedy Plan) to the relevant Governance Board in accordance with Schedule 7 (*Governance*).

8.5 Where Molina approves the Remedy Plan, the Service Provider shall rectify non-compliant areas as per Molina's approved Remedy Plan. Should the Service Provider remain non-

compliant sixty (60) Business Days after Remedy Plan activities were due to be completed then the Parties shall escalate the matter to the relevant Governance Board in accordance with Schedule 7 (*Governance*) and Molina may require an additional audit, Risk Assessment, review, Planned Exercise and/or BCP/DR Test (as applicable) at the Service Provider's expense, for every subsequent thirty (30) Business Day period until the matter is resolved in accordance with the Remedy Plan.

9. SERVICE PROVIDER DISASTER COORDINATOR

9.1 The Service Provider shall appoint a Service Provider Disaster Coordinator who shall:

(a) be available 24 x 7 and have suitable experience;

(b) be responsible for maintaining the BCP/DR Plan(s);

(c) conduct and coordinate testing and reviews of the BCP/DR Plan(s);

(d) manage and coordinate the execution of the BCP/DR Plan(s) in the event of a Disaster;

(e) ensure all Service Provider Personnel and Service Provider Subcontractors have awareness of the obligations within the BCP/DR Plan(s);

(f) liaise with the Service Provider Subcontractors as required; and

(g) liaise with Molina as required by Molina.

10. DECLARATION OF A DISASTER

10.1 If the Service Provider becomes aware of a Disaster, the Service Provider shall notify Molina immediately.

10.2 Upon Molina instructing the Service Provider to invoke the BCP/DR Plan, Service Provider shall commence the processes and activities outlined in this Schedule 23 (*Business Continuity and Disaster Recovery*), and specifically those processes and activities in paragraph 10.4 of this Schedule 23 (*Business Continuity and Disaster Recovery*), and the BCP/DR Plan(s), immediately.

10.3 The Service Provider's Disaster Coordinator shall co-operate with all Other Service Provider's disaster coordinators and Molina's disaster coordinator and Molina personnel as required during a Disaster.

10.4 In the event Molina declares a Disaster the Service Provider shall:

(a) invoke, and execute the activities set out within, the relevant BCP/DR Plan(s) which cover the Services and Systems affected by the Disaster;

(b) mobilize and activate the teams necessary to facilitate the resumption of time-sensitive business operations;

(c) work with Other Service Providers as needed to support end-to-end Recovery of technologies, services and applications to a functional state;

(d) continually assess and report Incident impact in accordance with the BCP/DR Plan(s), extent of damage and disruption to the Services and Molina's business operations;

(e) organize and manage any meetings with Molina and Other Service Providers as necessary to keep them informed of the activities being undertaken by the Service Provider and the status of the Services;

(f) attend and contribute to any meetings organized by Molina;

(g) if applicable, co-ordinate the relocation and/or migration of operations and support functions from temporary recovery facilities to repaired or new facilities;

(h) participate in any post Disaster Recovery debriefs; and

(i) contribute to and execute follow-up actions to the extent that they require the Service Provider's knowledge related to the affected Services and Systems.

11. RECORDS AND LOGS

11.1 The Service Provider Disaster Coordinator shall maintain the Disaster Action Log for actions related to the BCP/DR Plan(s) as a result of any of the following:

(a) a Disaster; and

(b) an audit, Risk Assessment, review, Planned Exercise or BCP/DR Test of the BCP/DR Plan(s).

11.2 The Service Provider shall maintain the latest version of the Disaster Action Log, in the Contract Management Portal.

11.3 The Disaster Action Log shall be used during Recovery and Restoration activities to ensure that all actions for a particular plan are carried out and for evaluation purposes after the Disaster, or an audit, Risk Assessment, review, Planned Exercise and/or BCP/DR Test, to ensure lessons learned are noted and future BCP/DR Plans are amended accordingly as required by paragraph 8.

11.4 At a minimum, the Disaster Action Log shall cover:

(a) all actions carried out and the start/end times for each;

(b) reasons for taking such action;

(c) any delegation of actions;

(d) remote escalations;

(e) dependencies on Molina or Service Provider; and

(f) any deviations from defined BCP/DR Plans and operating procedures and any Workarounds implemented.

12. MANAGEMENT AND TRAINING

12.1 The Service Provider shall nominate a duly authorized Service Provider Person (who may be the same person as the Service Provider Disaster Coordinator) to be primarily responsible for Disaster Recovery Services, and for ensuring the Service Provider's compliance with this Schedule.

12.2 The Service Provider shall ensure that a key group of Service Provider Personnel at each Service Provider Approved Service Delivery Location where there are Systems or from where the Services are provided, are trained in all aspects of the Disaster Recovery Services and the Service Provider shall maintain training records showing the training received by and the attendance of such Service Provider Personnel. Such training records shall be available for inspection by Molina at any time.

12.3 The Service Provider shall ensure all Approved Subcontractors and key Service Provider Personnel required to deliver any Disaster Recovery Services have sufficient capability to meet the requirements stated within this Schedule or within any plan required under this Schedule.

12.4 The Service Provider shall provide Service Provider Personnel with immediate access to all relevant operating procedures and documentation relating to the Disaster Recovery Services in the event of a Disaster or where required to meet the obligations set out in this Schedule.

12.5 The Service Provider shall ensure that Service Provider Personnel are aware of, understand and comply with the obligations set out in this Schedule.

12.6 The Service Provider shall maintain a list of key contacts and notification operating procedures for Molina, Service Provider Personnel and Subcontractor Personnel relating to the Disaster Recovery Services.

13. CONTACT LIST

13.1 Molina shall produce, maintain and record, on the Contract Management Portal, the Molina contact list, which includes the Molina contacts to be notified in an event of a Disaster.

13.2 The Service Provider shall produce, maintain and record, on the Contract Management Portal, the Service Provider Personnel contact list, which includes the Service Provider Personnel contacts to be contacted in the event of a Disaster being declared.

14. USE OF SUBCONTRACTORS

14.1 In the event the Service Provider engages a Subcontractor for the provisioning and delivery of Disaster Recovery Services (e.g., recovery facility, recovery/replacement hardware and/or

staffing resources), the Service Provider shall be responsible for the management, oversight and performance of those Subcontractors in accordance with Clause 63 (*Subcontracting*) of the Agreement.

14.2 Molina reserves the right to review and either approve or reject the use of Subcontractors supporting the delivery of Disaster Recovery Services in accordance with Clause 63 (*Subcontracting*) of the Agreement.

APPENDIX 23A
BCP/DR PLAN REQUIREMENTS

[redacted]

APPENDIX 23B
MOLINA ENTERPRISE BCP/DR PLAN
See the attached.

MOLINA® HEALTHCARE

Enterprise Infrastructure Services

Molina Healthcare, Inc.
Disaster Recovery Plan

Version 09

Revised May 19, 2017

Document Control

Revision History

Date	Version	Description	Author
02/01/2013	1	Initial draft (based on MIT DRP, MMS DRP and QNXT 4.8 DRP documents).	Kurt Dufresne
02/07/2013	2	Further revisions to initial draft. Changed to version 02 to preserve content removed from version 01.	Kurt Dufresne
02/28/2013	3	Removed business continuity material and excessively specific sections.	Kurt Dufresne
07/19/2013	4	Iterative revisions.	Kurt Dufresne
08/26/2013	5	Revised structure of the document and selected content.	Kurt Dufresne
04/11/2014	6	Revisions based on Arizona-Texas data center migration.	Kurt Dufresne
12/03/2014	7	Revisions, minor edits, updated broken links.	Amelia Directo
04/26/2016	8	Annual revisions. Updated URLs. Added recent test results.	Kurt Dufresne
05/19/2017	9	Annual Revisions/Updates	Rajesh Sukumar

Approval

Date	Version	Approver
04/11/2014	6	So Ling Balschi

Distribution

The primary electronic copy of this plan is located on the Molina Healthcare, Inc. (MHI), disaster recovery (DR) SharePoint site:

http://mhi/sites/mit/eis/ServiceDelivery/MHI/DR%20Plans/MHI%20Overall%20DR%20Plan

A secondary electronic copy of this plan is stored on the RecoveryPlanner RPX site (login required):

https://rpx1-us.recoveryplanner.com/recoveryPlanner/

A hard copy is also retained at the DR Manager's desk:

Meeker Baker Building, 3rd Floor
650 Pine Avenue, Long Beach, CA

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Refer to Information Services Policy and Procedure, *IS 72.00, Data Classification*, for additional information and required handling procedures.

Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191), the HIPAA Privacy Final Rule, and the American Recovery and Reinvestment Act (ARRA) of 2009 require that covered entities protect the privacy and security of individually identifiable health information.

Protected health information (PHI) includes demographic information and other health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Molina Healthcare about members and patients. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

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1. Introduction

1.1 Objective

This Disaster Recovery Plan (DRP) is designed to provide immediate response and recovery procedures from major events that would result in the loss of critical processing capabilities at the Molina Healthcare, Inc., data center in Albuquerque, New Mexico. The DRP covers procedures which provide for a smooth transition of critical functions to an alternate location that facilitates the resumption of normal business operations.

The DRP is closely integrated with the business continuity plan (BCP), and provides for the recovery of information technology (IT) services that support the business processes covered in the BCP. Both the DRP and BCP are pursuant to Molina Information Services policy and procedure *IS-56.10 Contingency Planning*.

1.2 Scope

The DRP provides guidance and procedures to enable the timely recovery from unplanned crises and to facilitate an orderly transition of functions to the alternate location. This allows for smooth resumption of critical processing capabilities for Molina Healthcare, Inc., to restore services within the contractually required time period after a declared disaster.
This document serves as an overall IT DR plan. Detailed technical recovery procedures are also being developed for critical applications. These are essentially addenda to the overall DR plan. Refer to the list below for these procedural documents.

1.2.1 [redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

1.2.2 Application Tier

The Business Continuity Management (BCM) team conducted a business impact analysis (BIA) to identify critical business functions and gather information pertaining to the impact incurred by a disruption of these services. The BIA defined the tier classification as the period of time in which a business function needs to be restored. Four tier categories were specified.

[redacted]

IT systems support business processes, so this same tier stratification is used for IT systems. The recovery time objective (RTO) and recovery point objective (RPO) for a given application determine which tier classification it is assigned.

Recovery time objective is the duration of time within which a business process (or application) must be restored after a disaster or disruption in order to avoid unacceptable consequences associated with a break in business continuity.

Recovery point objective refers to the maximum allowable time frame between the last restorable data point and the time of disaster. Some of this data can be recovered by alternate means such as paper re-entry, batch re-runs, etc.

RTO and RPO vary according to the system and the business function it supports. Therefore, they may be found in the application-specific DR plan.

1.2.3 Application Recovery Priority

The order in which applications are restored is a function of their criticality and dependency relationships. Below is the recovery priority for applications with documented DR plans.

[redacted]

1.3 Plan Review

The IT DR Plan is a living document and therefore will be reviewed after any significant change to the infrastructure, processes, or related information, such as IT organizational structure. The DR plan will be reviewed at least annually.

1.4 DR Strategy

Core IT systems are located in Molina's primary data center in Albuquerque, New Mexico, and protected by a co-location/disaster recovery (DR) data center located in Richardson, Texas. Near real-time storage replication ensures that critical production data is available at the DR site. Production data backups are also copied to the DR site, providing a secondary data protection measure.

In the event of a disaster preventing application functionality at the primary data center, the Disaster Recovery Coordinator works with the IT infrastructure and application teams to coordinate the efforts needed to bring up the DR servers and connect them with the replicated data, according to the DR plan documentation. This documentation is available for on-site review upon request.

1.5 Testing Strategy

Having a DR Plan by itself does not prepare any business unit to cope with business interruption in an effective manner. The DR Plan must be tested regularly in order to ensure staff awareness and effectiveness in response to any business interruption. A scenario of the DR Plan is tested annually and the results documented. The DR Coordinator will coordinate the annual testing with other internal and external parties.

Any major change or modification to normal business procedures must be considered under DR and business continuity (BC) planning and its impact documented. In case there is substantial impact to the DR or BC Plan, the DR and the BC Plans must be appropriately updated and tested.

Refer to Appendix A for a summary of test results.

1.5.1 Test Date and Authorization

Disaster recovery testing is conducted at least once each calendar year to demonstrate Molina's ability to restore system functions at the DR data center. Tests are planned by the DR Coordinator to

take advantage of the regularly scheduled application maintenance window, where applicable. Testing may be internally conducted by IT, and may also involve business users.

Authorization to conduct DR tests is secured from the IT application owner in conjunction with the business. The Business Continuity Management team works with the business team to identify an agreeable date for the business, and the DR Coordinator then works with the IT application owner for confirmation. An email is solicited from the IT application owner granting approval. This approval is attached to the ticket submitted for the conduct of the test.

1.5.2 Test Location

Disaster recovery tests involve system administrators remotely accessing production systems in New Mexico and DR systems at the alternate site. Business users are also involved at their respective plan locations in their home states. Users may be accessing systems from their home or office, as individual circumstances warrant.

1.6 Definitions and Acronyms

1.6.1 Definitions

The following terms pertain to the DR plan.

Disaster, as defined for this document, is any unplanned major event or condition, whether environmental (e.g., fire, flood, tornado, earthquake, hurricane), mechanical (e.g., major equipment failure, sabotage, theft), loss of environmental systems (e.g., power, air conditioning), loss of telecommunications capability, or other damage to hardware, operating system, or physical plant, that results in a loss of major operations at the New Mexico data center, thereby preventing the normal scheduling and processing of business information. Acts of war are not covered in these procedures. For the purposes of this document, the disaster is assumed to be at the New Mexico Data Center in Albuquerque, New Mexico. Once a disaster has been declared, Molina Healthcare will work to restore services within the contractually required time period after the declaration of disaster.

Incident or **event** is a circumstance caused by any unexpected situation that disrupts the normal flow of critical operating processes or functions, thereby preventing and/or causing significant delay in the completion of scheduled activities or expected outcomes.

Incident Command System (ICS) – The Incident Command System (ICS) is a systematic tool used for the command, control, and coordination of emergency response operations of all types and complexities. ICS is a subcomponent of the National Incident Management System (NIMS), as released by the U.S. Department of Homeland Security in 2004. ICS is the overarching framework for managing incidents at Molina.

Incident Management Team (IMT) – The Incident Management Team is a group of operational leaders with the authority and ability to make decisions about controlling an incident on behalf of the organization.

Crisis Management Team (CMT) – The Crisis Management Team (CMT) is comprised of senior business leadership functioning as a planning and policy group. This team has the responsibility for the protection of the business, the staff, and the customers. It renders decisions about corporate policies, legalities and liabilities, ethical issues, brand image, approval of emergency funding, corporate communications, and interfacing with shareholders and the Board of Directors.

The **Disaster Recovery Team** (DRT) is assembled if a disaster occurs to manage IT disaster recovery (DR) activities. The composition of this team includes the infrastructure teams needed to recover IT systems at the secondary site.

The **Disaster Recovery Analyst**(s) (DRA) is (are) responsible for coordinating among the members of the DRT during recovery operations. The DRA is also responsible for periodic verification and updating of the DRP, as well as the coordination and oversight of DR tests.

The **Recovery Time Objective** (RTO) is the duration of time within which a business process must be restored after a disaster or disruption in order to avoid unacceptable consequences associated with a break in business continuity.

The **Recovery Point Objective** (RPO) refers to the maximum allowable time frame between the last restorable data point and the time of disaster. The RPO indicates the maximum amount of data loss that is permissible. Some of this data can be recovered by alternate means such as paper re-entry, batch re-runs, etc.

The **secondary** or **alternate site** is a data center providing usage on a system configuration that is compatible with that of the New Mexico Data Center, tailored to meet the requirements for disaster recovery.

Recovery procedures are documented actions necessary to respond to an incident and recover business operations to the alternate site.

Restoration procedures are documented actions necessary to restore processing and operations to the primary site where the disaster occurred.

1.6.2 List of Acronyms

Acronym	Description
ACS	Automatic Call Distribution
AT&T	American Telephone and Telegraph
BCP	Business Continuity Plan
BCM	Business Continuity Management
CIO	Chief Information Officer
CMT	Crisis Management Team
CTI	Computer Telephony Integration
DR	Disaster Recovery
DRA	Disaster Recovery Analyst
DRP	Disaster Recovery Plan
DRT	Disaster Recovery Team
EDI	Electronic Data Interchange
EMC	Company name or Electronic Media Claims
ESC	Electronic Submission of Claims or Error Status Codes

Acronym	Description
FAX	Facsimile; also known as the telephonic transmission of scanned-in hardcopy or printed materials
HIPAA	Health Insurance Portability and Accountability Act
HR	Human Resources
ICS	Incident Command System
IMT	Incident Management Team
IP	Internet Protocol
ISP	Internet Service Provider
IT	Information Technology
IVR	Interactive Voice Response
LAN	Local Area Network
MS	Microsoft
NAG	Network Access Gateway
NAS	Network Attached Storage
NOC	Network Operations Center
PC	Personal Computer
POS	Point of Sale or Place of Service or Point of Service
RPA	RecoverPoint Appliance
RPO	Recovery Point Objective
RRI	Recognition Research Inc., purchased by SunGard
RTO	Recovery Time Objective
SAN	Storage Area Network
SQL	Structured Query Language
TBD	To Be Determined
UAT	User Acceptance Testing
UPS	Uninterrupted Power Source
VAN	Value Added Network
VLAN	Virtual Local Area Network
VPN	Virtual Private Network
WAN	Wide Area Network

2. Data Center Overview

The business operations for Molina Healthcare, Inc., are supported by the New Mexico Data Center, and the Unitas Global Richardson Data Center.

2.1 New Mexico Data Center (DC01)

The Molina Healthcare Data Center (DC01) located in Albuquerque, New Mexico, is the primary production data center for all of Molina's IT infrastructure. DC01 is designed to support Molina's existing and future computing for all of the state health plans, Molina Medicaid Solutions, and internal Molina services.

At the 10,800 square foot New Mexico Data Center, Molina employs top-tier infrastructure components to ensure continued quality of service for our remote office locations. Telephony is provided by a Cisco infrastructure which provides VoIP, voicemail, call center functions, and instant messaging capabilities to users across the United States. WAN and Internet connectivity is provided on a Cisco-based network utilizing redundant 10 and 20 Mbps MPLS-based network connections to remote offices, direct OC-12 connections to the disaster recovery site and redundant 1 Gbps links to the Internet over multiple carriers. Partner network connectivity is provided via frame relay or MPLS and is segregated from Molina internal traffic via Cisco firewalls and Intrusion Detection Systems. Each rack is serviced by redundant feeds from separate UPS systems, with two power domains feeding racks to entirely separate utility or generator sources.

The New Mexico Data Center is protected by perimeter security features including video surveillance, alarms, and roaming security guards. Access to the building is available 24/7. Entrances to the building, the main computer room, and telecom service rooms are monitored by surveillance cameras and controlled by electronic badge access. Employees who have the required security access must utilize badges to gain access into the office space and other critical areas of the facility. All visitors are required to sign in and must be escorted at all times. Molina management reviews the authorized access list on a regular basis, and procedures are in place to modify the access list immediately if required.

The New Mexico Data Center is staffed by experienced Molina server engineering and network engineering personnel, and Critical Facilities Management team members. Figure 2-1 provides a visual representation of the DC01 floor plan.

Figure 2-1: [redacted]

2.2 Unitas Global Richardson Data Center (DC02)

Molina has contracted with Unitas Global for data center co-location services in the Unitas Global data center located in Richardson, Texas. The Unitas Global Richardson Data Center (DC02) is the disaster recovery data center for Molina's IT infrastructure and is designed to support Unitas Global Richardson's existing and future customer needs in a safe and secure environment. Molina's contract with Unitas Global Richardson includes the option for Remote Hands Services (technical services for physical, on-site support) at the data center for on-site coordination of hardware and support issues, with both Molina and subcontractors. Molina supports the infrastructure remotely for all platform areas, and sends personnel on-site when needed. Molina orchestrates the disaster recovery activities within the DC02 data center utilizing Molina staff, third party vendors, and assistance from Remote Hands Services, if needed.

At the 8,700 square foot Unitas Global Richardson Data Center (DC02), Molina employs top-tier infrastructure components to ensure continued quality of service for remote office locations. Telephony is provided by a Cisco infrastructure which provides VoIP, voicemail, call center functions and instant messaging capabilities to users across the United States. WAN and Internet connectivity are provided on a Cisco-based network utilizing redundant 1 Gbps WAN circuits to Molina's MPLS cloud, redundant 10 and 20 Mbps MPLS-based network connections to remote offices, dual 6 Gbps and 10 Gbps connections to the production site, and redundant 1 Gbps links to the Internet over multiple carriers. Partner network connectivity is provided via Frame-relay or MPLS and is segregated from Molina internal traffic via Cisco firewalls and Intrusion Detection Systems. Each rack is serviced by redundant feeds from separate UPS systems, with two power domains feeding racks to entirely separate utility or generator sources.

The Unitas Global Richardson Data Center (DC02) is protected by perimeter security features including video surveillance, alarms and roaming security guards. Entrances to the building, the main computer room and telecom service rooms are monitored by surveillance cameras and controlled by electronic badge access. All employees must badge into the office space and other critical areas of the facility to gain access. All visitors are required to sign in and must be escorted at all times. Unitas Global Richardson management reviews the authorized access list on a regular basis, and procedures are in place to modify the access list immediately if required.

Figure 2-2 provides a visual perspective of the DC02 data center environment floor space.

Figure 2-2: [redacted]

2.3 *Network Infrastructure*

The Molina corporate network provides network communications for these facilities. In case of a disaster at the New Mexico Data Center, data communications will be routed through the Unitas Global Richardson Data Center (Figures 2-3 and 2-4) to enable the recovery and continuation of business operations.

Figure 2-3: [redacted]

Figure 2-4: [redacted]

2.4 *Telephony Overview*

Molina uses several models of Cisco IP desk phones. Some other telephone types and models are also in use to a limited extent. The data behind the desk phone itself resides in both the primary data center and the DR data center. The network circuits carry both voice and data, and are protected by redundant circuits. If desk phones lose connectivity, the user's computer would lose access to the network as well because both use the same network lines.

Separate servers handle call control and call center functions. The servers are configured in geographically dispersed clusters, offering high availability with fully-automated failover between data centers.

Some call centers have undergone cross-training and perform call sharing, mutually supporting each other during normal operations. This also allows one site to take all calls for the other site in the event that the other site goes down.

The following diagram illustrates the Molina telephony architecture.

Figure 2-5: [redacted]

Figure 2-6: Telephony Acronyms

Acronym	Meaning
AW	Admin Workstation
CER	Cisco Emergency Responder
CTL	CenturyLink
CUBE	Cisco Unified Border Element
CUCM	Cisco Unified Communications Manager
CUIC	Cisco Unified Intelligence Center

Acronym	Meaning
CUSP	Cisco Unified SIP Proxy
CVP	Cisco Unified Customer Voice Portal
DID	Direct Inward Dialing
ELM	Enterprise License Manager
HDS	Historical Data Server
HSRP	Hot Standby Router Protocol
ICM	Intelligent Contact Management
MML	Man-Machine Language
MPLS	Multiprotocol Label Switching
MR-PG	Media Routing Peripheral Gateway
PG	Peripheral Gateway
PRI	Primary Rate Interface
PSTN	Public Switched Telephone Network
SIP	Session Initiation Protocol
TDM	Time-Division Multiplexing
TFN	Toll-Free Number
TFTP	Trivial File Transfer Protocol
TTS	Text-to-Speech
UCCE	Cisco Unified Contact Center Enterprise
UWF	Upstream Works for Finesse
VLAN	Virtual Local Area Network
VXML	VoiceXML
VZ	Verizon
XML	Extensible Markup Language

3. Data Handling and Protection

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets security standards for the protection of Electronic Protected Health Information (ePHI), which is commonly known as the Security Rule. All customer data is protected by a variety of methods including processes and policies that are defined into the way that ePHI is handled. Upon request, the full policies or procedures can be provided by Molina.

3.1 Data Backup

Data backups are performed on a server by server basis, so there are some variations based on what is requested. But daily and weekly backups are performed. Typically, a full backup is performed every weekend ("weekly" backup). An incremental backup is performed nightly ("daily" backup). The first weekly backup of the month is identified as the monthly backup.

Symantec NetBackup is currently the primary backup software tool in use. Each backup is retained on local disk storage at the primary data center for 35 days, and duplicated to identical storage at the DR site where it is also retained for 35 days. The "weekly" that occurs on the first weekend of the month is designated as the "monthly" backup. In addition to being duplicated to the DR site for 35 days, it is also duplicated to encrypted tape and sent off-site for secure storage.

The encrypted backup tapes are picked up for off-site secure storage by Iron Mountain. An Iron Mountain representative comes to the primary data center on Wednesdays to pick up tapes. The tapes are transported in secured containers. The individual signs in, validates the containers being picked up and signs them out. Bringing tapes back for restoration follows the same procedure. Retrieval of tapes may be expedited upon request. Backup tapes are retained for 10 years.

Test restores are randomly conducted to validate data integrity and the ability to restore from tapes. Application teams also frequently request restores of production data to non-production environments for development purposes, further validating the ability to successfully restore from tape.

Further information pertaining to backup and restore procedures:

[redacted]

Iron Mountain tape hand off procedures:

[redacted]

3.2 *Replication Process*

In addition to the NetBackup, EMC's RecoverPoint solution is also being used for critical production SQL Server databases to be able to do geographically dispersed replication of the databases online. EMC RecoverPoint provides a continuous remote replication technology that uses software to "split" application writes to send each write to the designated storage volumes and to RecoverPoint Appliances (RPAs) on the source side, which then sends the writes to remote RPAs. Replicated data is contained in a journal volume on the RPAs then written to target volumes on the remote site. All application data is maintained in a consistency group that retains write-order dependencies across all volumes in the consistency group. Repository volumes are used to retain configuration data and allow an RPA to assume replication for a failed RPA for high-availability purposes. RecoverPoint runs on an out-of-band RPA and combines continuous data-protection with broadband efficient technology allowing it to protect data remotely. This solution will limit the time frame for potential data loss.

3.3 *Microsoft Exchange Server*

Microsoft Outlook, part of the Microsoft Office suite, is the email and calendar software solution used across the Molina enterprise. Outlook leverages data on Microsoft Exchange Server. The Exchange Server environment is completely virtual. The primary Exchange virtual machines (VMs) are hosted in the New Mexico Data Center (DC01), and redundant servers are located in the Unitas Global Richardson Data Center (DC02). Employee mailboxes are hosted on Exchange mailbox databases in Database Availability Groups (DAGs), a multi-copy, high availability solution that spans across the two data centers. There are no Exchange servers at local sites.

Microsoft Exchange Server is highly resilient, and can be fully or partially failed over to DC02. It can be operated with any combination of components running in New Mexico or Texas. The mailbox servers are also protected by weekly full and daily differential backups. Molina Healthcare corporate IT services provides all backup and restoration functions.

4. Molina IT Organization

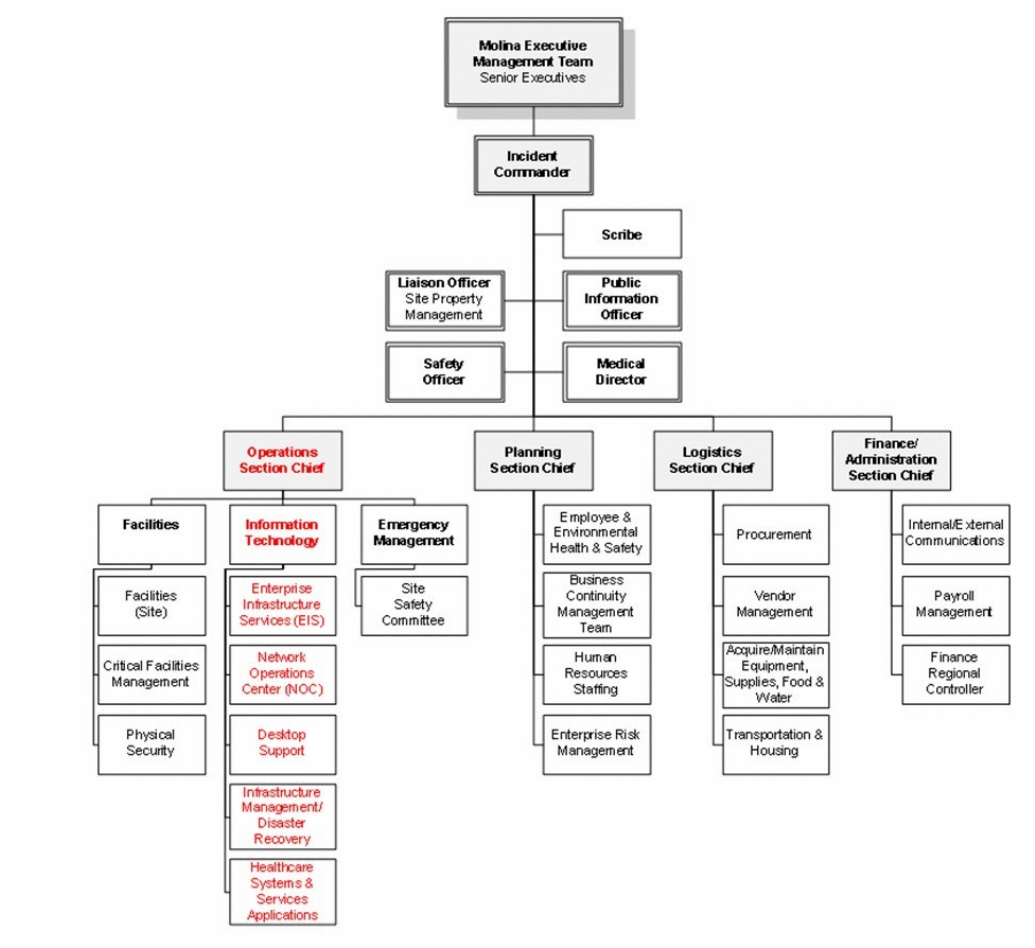
The below diagram represents the high-level functional organization of Molina's Enterprise Infrastructure Services (EIS) *as it pertains to disaster recovery*. The Disaster Recovery Team works with the Infrastructure as a Service (IaaS) and Platform as a Service (PaaS) Service Delivery and Service Operations groups for DR activities. DR testing and the invocation of the DR plan in an actual disaster situation primarily involve the Disaster Recovery Team working in concert with the IaaS and PaaS Service Operations teams.

Figure 4-1: [redacted]

5. DR Roles and Responsibilities

This section discusses the roles, responsibilities, and membership of the various teams involved in DR activities. Disaster recovery operations typically fall under the umbrella of the Incident Command System (ICS). The Disaster Recovery Team (DRT) is responsible for the recovery of IT systems in support of the Incident Management Team (IMT) and Business Continuity Team (BCT) recovering business functions.

Figure 5-1: IT Role in ICS Organization



5.1 Disaster Recovery Team (DRT)

5.1.1 DRT Responsibilities

Upon notification of a disaster, the Disaster Recovery Team (DRT) is responsible for all IT recovery efforts until completed. The overall role of the DRT is to analyze the damage to the primary data center and recommend the escalation to disaster status, if appropriate, in order to initiate the declaration process. The Disaster Recovery Analyst serves as a liaison between the EIS groups and coordinates IT recovery efforts. Responsibilities of the DRT and its members include the following:

- Contact the DR Coordinator to organize the movement of any and all materials and media required to the recovery location, including backup tapes, paper forms, and other hardware or software.
- Make the determination, depending on the extent of the damage, whether to begin the recovery effort at the affected facility or an alternate location.
- If the damage is extensive and restoration at the primary facility is not feasible, begin the process of moving to the alternate location.
- If necessary, coordinate logistics, including travel and lodging, for all employees involved in the recovery effort.
- Determine the status of the batch cycles, databases, backups, production deliverables, and the telecommunications network.
- Contact the DR Coordinator to determine the status of the DR environment needed for the recovery effort and assure appropriate priority is given to this validation.
- Implement the detailed recovery plan, including establishing priorities, as defined in the application disaster recovery documentation.
- The DRT will support recovery efforts throughout the recovery process. If recovery is at the alternate location, the DRT will also manage the transition to the alternate location.
- The DRT will support all restoration efforts at the operational sites and the New Mexico data center to move back from the alternate site once the disaster situation has passed.
- The DRT will also focus on the restoration of capabilities within the existing primary facility or determine the need for a new permanent facility location.

5.1.2 DRT Members

The membership of the DRT will vary depending upon the nature and extent of the disaster. Typical members include key staff drawn from within the Enterprise Infrastructure Services (EIS) organization, as shown below. If damage is localized, employees with specific expertise may also be included on the DRT.

- EIS Vice President
- EIS Associate Vice Presidents
- EIS Directors
- EIS Managers

- Disaster Recovery team

The IaaS Service Delivery and Service Operations groups each contain personnel with expertise in the traditional technology areas.

- Server Engineering
- Storage Engineering
- Backup and Restore Engineering
- Network Engineering
- Telephony Engineering
- Network Operations Center (NOC)
- Enterprise Service Desk

The PaaS Service Delivery and Service Operations groups each contain personnel with expertise in the following technology areas.

- Database Administration
- Business Automation Services
- Enterprise Monitoring Services

5.1.3 DRT Key Activities

The following outlines the key activities that take place after recognition of an incident or event and prior to a declaration of a disaster.

- Follow instructions when being notified of an incident or event.
- DRT will perform a business impact assessment of the IT infrastructure damage.
- Validate that the current version of the DR Plan is being referenced by all parties.
- Contact the HR manager for contact information if required.

The following outlines the key activities that take place during the initial 24 hours following the declaration of a disaster at the primary data center:

- NOC notifies DRT that a disaster has been declared.
- DRT arranges travel for DRT members and key personnel (if necessary).
- DRT and key personnel travel to the alternate site (if necessary).
- DRT begins redirecting network connections.
- DRT begins recovery of servers.
- DRT implements the recovery plan and verifies the application standup priority list.
- Key personnel set up operations units at the alternate site, as necessary.
- DRT conducts network verification to ensure performance at normal standards.
- DRT conducts system verification to ensure performance at normal standards.
- DRA notifies the DRT that systems are ready for production processing.

- Production operations resume at the alternate site.

5.2 Disaster Recovery Analyst (DRA)

The Disaster Recovery Analysts represent the leads at each site for both the recovery and restoration efforts, and serve as an overall lead.

5.2.1 DRA Responsibilities

The Disaster Recovery Analyst will coordinate all recovery and restoration activities at all sites through completion and provide updates to the DRT.

The DRA is responsible for the following activities:

- Coordinate and manage the DRAs for each site.
- Coordinate the failover of production to the alternate site.
- Assist with the recovery at the alternate site and the restoration of the operational facilities and the primary data center.
- Routinely report to the DRT the progress of restoration efforts, and communicate to any resources necessary for the successful restoration.
- Work with the DRT to coordinate the return of operations after a disaster to the recovered or new site when it is ready for production operations again.
- Assist with the recovery at the recovery site and the restoration of the permanent primary data center facility as necessary.
- Identify to the DRT the resources required for restoration of the permanent data center facility as necessary, including facility, hardware, software, personnel, and expendable supplies.
- Work with key members of the Molina Healthcare infrastructure and engineering teams to develop a detailed restoration plan for the restoration of the primary data center facility based on the findings of the DRT members.
- The DR Coordinator is responsible for supplying the DR Plan to all stakeholders, potential DRT members, and any other relevant parties upon the yearly update to this plan.

6. Communication Plan

The communication plan is the core portion of the Disaster Recovery and Business Continuity processes, as it serves to make sure that all of the parties are constantly updated on the status of the disaster and the recovery state. To do this Molina has some automated tools that help with the notification of a disaster, as well as with coordination of activities throughout the DR Lifecycle.

6.1 *Emergency Notification System*

Molina utilizes an automated notification system to send communication of events. The Molina Incident Notification System (MINS) is the vehicle to bring the DR teams together to start working on the recovery process. The system allows for the following:

- Creation of Users and Groups
- Multiple Notification Methods: Telephone, Email, SMS Text Message
- Managed Broadcasts
- Reporting: Broadcast, Ad Hoc

Messages may be broadcast to the entire company or designated groups, as appropriate. Notifications will typically be sent via email and telephone messages to staff participating in the disaster recovery procedures and other key stakeholders. The email or phone message will prompt the recipient to acknowledge receipt, which is then tracked. Emails from MINS will show the sender as Notifications@MolinaHealthcare.com.

6.2 *Status Emails*

Status emails may be sent as needed during the course of disaster recovery operations or testing. During testing, communications with the business users will be via MINS and initiated by the Business Continuity Management (BCM) team. The DR Coordinator will communicate with the infrastructure teams and the BCM team via email. The DR Coordinator will send status emails after milestone events, such as scheduled checkpoints, and at other times as required. Status emails will be sent more frequently if issues are encountered.

6.3 *Conference Bridges*

The Network Operations Center (NOC) will open a conference bridge upon disaster notification to serve as a focal communication outlet. During DR testing, two conference bridge lines will typically be opened for direct voice communications. The DR Coordinator and BCM team will each monitor one of the lines.

7. Disaster Identification and DR Plan Activation

Molina's DR plan addresses procedures for recovering from a disaster at the primary data center which renders one or more production applications unusable in the primary site.

Lower level system failures and localized system outages would be addressed through the normal production monitoring, notification, troubleshooting, and escalation procedures. As such, they would not normally warrant invocation of the DR plan. The DR plan would only be activated when a failure, whatever the cause, renders an application unusable in the primary data center. These failures may be procedurally categorized into two main types:

- A major disaster resulting in catastrophic damage to the primary data center.
- A technical issue that develops to the point where a decision is made to fail one or more applications over to the DR site.

A major disaster event at the primary data center would be quickly detected by Molina staff in New Mexico and/or the Network Operations Center (NOC) personnel who monitor systems 24 hours a day, seven days a week. The NOC would notify the Enterprise Service Desk and then follow the established troubleshooting, notification and escalation procedures to summon the appropriate on-call subject matter experts (SMEs). For complex issues, which certainly include a major disaster, the NOC would open a conference bridge to provide a central communication and collaboration venue. Damage assessment would be performed by the Critical Facilities Management team in New Mexico in conjunction with the IaaS Service Operations - Infrastructure staff located in New Mexico. Decisions would be made by senior management on how to meet the demands of the situation from within the framework of the Incident Command System (ICS). Data center recovery is beyond the scope of this document, but additional detail may be found in the primary data center Emergency Response Plan, available for on-site review upon request.

Since the probability of such a catastrophic event is very remote, a more realistic scenario would involve an issue that is detected and develops to the point where a decision is made to fail an application over to the DR site.

Detection of an incident or impending event affecting an application could be made by any number of Molina staff, but most likely, the NOC, the application support team, or a business user would be the first to identify it.

The ***Enterprise Service Desk*** is the single point of contact for reporting of all incidents. The initial response of any Molina employee or business user detecting an issue should be to call the Service Desk at [redacted]. The Service Desk technician will follow the established procedures to document, diagnose and remediate the issue.

If the Service Desk technician is unable to resolve the issue or determines that it is a Severity 1 incident and requires escalation, he or she will follow the prescribed procedures to notify the NOC [redacted].

If the NOC is the first to identify the issue, the NOC would also notify the Service Desk and proceed to follow the NOC's established triage, notification and escalation procedures, summoning the appropriate EIS and application on-call personnel. The NOC would open and maintain a bridge line for team collaboration.

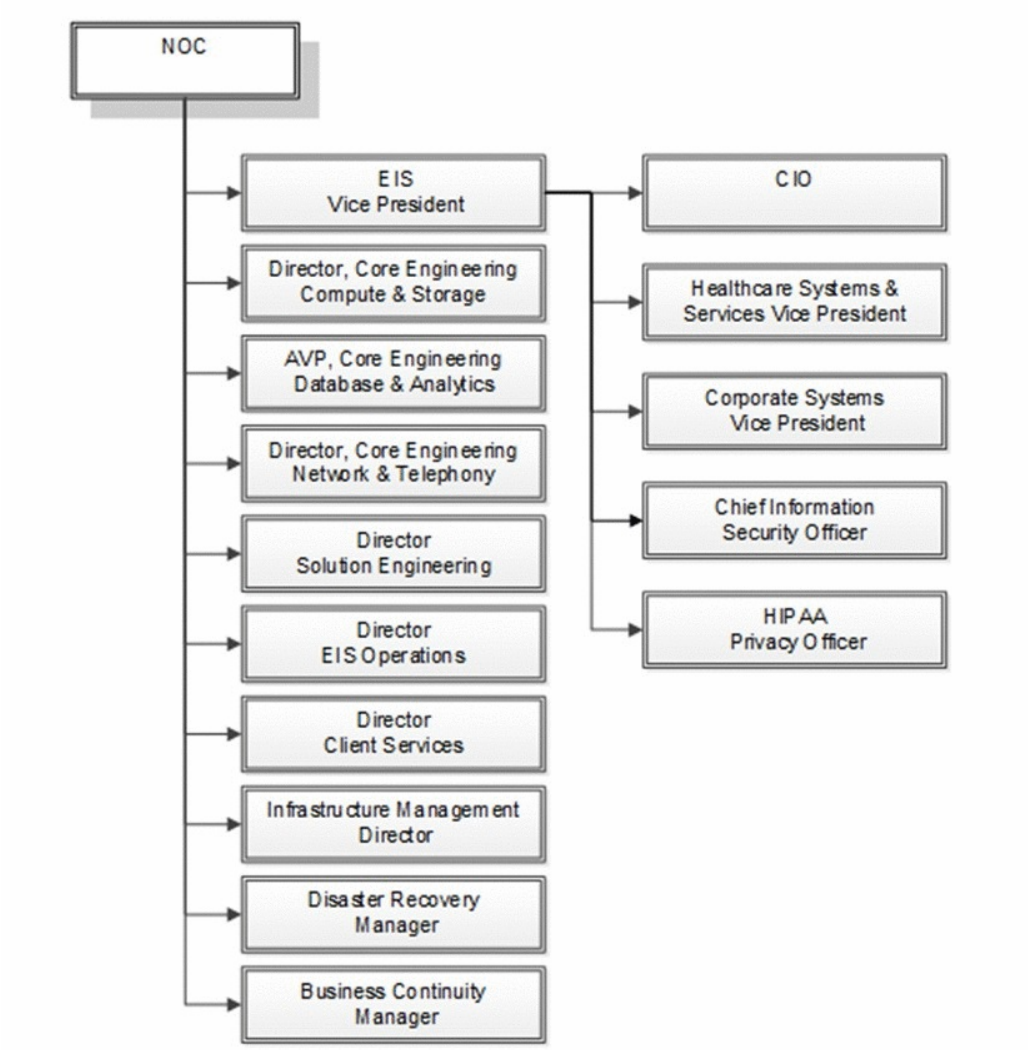
As part of the troubleshooting procedures, infrastructure and application management are notified and engaged. Management personnel would reach out to the business community as appropriate. The decision to fail over an application to the DR site is the outcome of collaboration between the infrastructure, application, and business teams. Failover execution does not necessarily involve the formal declaration of a disaster. Formal declaration of disaster can only be made by senior executive leadership.

7.1 [redacted]

[redacted] [1]

[1] two pages have been redacted in their entirety

Figure 7-1: Disaster Recovery Call Tree



Once the initial notification occurs, the Molina Network Operations Center (NOC) takes on the task of making sure that the DR communication flow is maintained, working with the DR Team.

Corporate Communications will work with the Public Relations department and site communications to address media, legislative and regulatory inquiries. The Public Relations department is the only group authorized to communicate with the media in cases of emergencies that impact the company.

7.2 Disaster Scenarios

The DR plan may be activated in the event of:

- A major disaster resulting in catastrophic damage to the primary data center.
- Damage or a technical issue of any type that renders an application unusable in the primary data center.

Recovery of the most critical systems should generally be achieved in [redacted]. Data loss could range from milliseconds for replicated data to [redacted] for systems restored from backup.

Transactions at the time of outage.

Data keyed in by a user (Molina employee or business user) that has not yet been backed up or replicated will be lost and will have to be re-entered per the department's manual procedures. Data replication is near real-time, however, there is a slight lag, so some data loss may occur. File transfers or batch processing in transit at the time of an outage may have to be re-sent.

Compromise of the integrity of production data.

If production data appears to have been lost, the replicated data in DR would be evaluated to determine if it were there. If it indeed was, the missing data would be restored to the production environment rather than failing over to the DR environment. For corruption of production data, the approach to restoration would be to restore from backup, not invoke the DR plan. Corrupt production data would be replicated to DR as corrupt data. If the backup is corrupt, it would be necessary to go to the latest clean backup copy.

Unscheduled system unavailability.

The most common reasons for unscheduled system unavailability would be a network outage or an application or hardware issue that would be handled by troubleshooting and resolving as a *production issue*, not invoking the DR plan. A production issue *could* possibly escalate into a major issue which could warrant executing the DR plan, as previously noted. Molina utilizes redundant network circuits from different vendors to mitigate the risk of a network outage. Failure of a vendor-managed circuit is outside of Molina's control.

Malicious acts

Molina's IT Security department has a Security Operations Center (SOC) that monitors systems for unusual activity around the clock. Processes and procedures are in place to prevent malicious acts and to remediate them when detected. The *Information Security Incident Response Plan* documents the steps to take for remediation. For *malicious acts* by internal workforce members, this includes engaging the individual's supervisor, and the Human Resources and HIPAA Program Management Office teams, in addition to the SOC's investigation. The individual will be closely monitored, and the user account will be disabled if necessary. Disciplinary measures, and possibly legal action, will be taken where appropriate. The workforce member's workload will be distributed among the other members of his or her team to ensure continuity of operations.

The SOC maintains constant vigilance for *malware* attacks. For suspected malware infections, the Computer Incident Response Team (CIRT) will investigate. For desktop or laptop computers, the infected device will be quarantined, a forensic analysis will be performed, and the computer will be reimaged. For servers, the infected server will also be quarantined, to include eviction from any cluster it may be a part of. Cluster resources will be distributed across the remaining nodes. If the scale of the malware intrusion warrants it, systems may be failed over to the DR site. In all malware incidents, the CIRT will conduct a thorough investigation.

7.3 Restoration to the Primary Site

Restoration mode is the return to normal operations of the actual production environment, either to the existing primary site or to a new facility. The procedures to restore operations to the primary data center are analogous to those followed to fail systems over to the DR site. Once the primary site is available, replication will be initiated from the DR site back to the primary site. Backup copies will also be sent to the primary site. At an agreed upon time, fail back procedures are executed. Restoration of the most critical systems should generally be accomplished in [redacted].

Appendix A: DR Test Results

Result details of the annual DR test are contained in a separate document.

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]

SCHEDULE 24

CERTAIN SECURITY REQUIREMENTS

CONTENTS

1. DEFINITONS

Capitalized terms used but not defined in this Schedule shall have the meanings given in Schedule 1 (*Definitions and Interpretation*) to this Agreement.

2. INTRODUCTION

2.1 This Schedule sets out certain security requirements with which the Service Provider must comply in connection with the Services.

2.2 Nothing in this Schedule relieves the Service Provider of any of its obligations under this Agreement or any Project Work Order, or requires any Other Service Provider to perform any of the Service Provider's obligations under this Agreement or any Project Work Order, including not limiting the Service Provider's obligation to comply with Policies as set out in this Agreement. Nothing in this Schedule, including references to principles or to evaluations of circumstances and practices by the Service Provider, shall relieve the Service Provider from performing any of its other obligations in the Agreement (including as may be set out in the Policies).

3. INFORMATION SECURITY OBLIGATIONS

3.1 The Service Provider shall designate a Security Official to oversee and direct the Service Provider's information security program and ensure that the information security obligations contained herein are adhered to.

3.2 The Service Provider shall have implemented and documented reasonable and appropriate administrative, technical, and physical safeguards to protect Molina Data and In-Scope Personal Data against accidental or unlawful destruction, alteration, unauthorized or improper disclosure or access. The Service Provider shall monitor access to, use and disclosure of Molina Data and In-Scope Personal Data whether in physical or electronic form. The Service Provider shall regularly test and monitor the effectiveness of its safeguards, controls, systems and procedures. The Service Provider shall periodically identify reasonably foreseeable internal and external risks to the security, confidentiality, integrity, and availability of Molina Data and In-Scope Personal Data, and ensure that these risks are addressed. The Service Provider shall use secure user identification and authentication protocols, including, but not limited to unique user identification, use of appropriate access controls, and strict measures to protect identification and authentication processes.

3.3 Prior to allowing any employee or contractor to access, use, transmit, store, modify, or process any Molina Data and In-Scope Personal Data, the Service Provider shall (i) conduct an appropriate background investigation of the individual (and receive an acceptable response),

(ii) require the individual to execute an enforceable confidentiality agreement that has at least as stringent requirements regarding In-Scope Personal Data as this Schedule, and (iii) provide the individual with appropriate privacy and security training. The Service Provider shall also monitor its workers for compliance with the security program requirements. Upon request following the unauthorized access to, or use or modification of, any Molina Data and In-Scope Personal Data, the Service Provider shall provide to Molina a list of all individuals who have (or have had) relevant access to the applicable data.

3.4 If the access, use, transmission, storage or processing of Molina Data and In-Scope Personal Data involves the transmission of In-Scope Personal Data, the Service Provider shall have implemented appropriate supplementary measures to protect such In-Scope Personal Data against the specific risks presented by such activity, including, but not limited to, the transmission of Molina Data and In-Scope Personal Data only in an encrypted format in accordance with the U.S. Department of Health and Human Services' Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals. If the In-Scope Personal Data is stored on systems with direct connections to wireless, insecure or public networks, the Service Provider shall encrypt all In-Scope Personal Data stored on such systems in accordance with the U.S. Department of Health and Human Services' Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals and as further described in the Annual Security Plan.

3.5 The Service Provider shall cause all portable or mobile devices or media (including, without limitation, laptop computers, removable hard disks, USB or flash drives, personal digital assistants (PDAs) or mobile phones, DVDs, CDs or computer tapes) used in connection with the provision of the Services to be encrypted in accordance with the U.S. Department of Health and Human Services' Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals. The Service Provider shall not store In-Scope Personal Data on any portable or mobile devices or media (including, without limitation, laptop computers, removable hard disks, USB or flash drives, personal digital assistants (PDAs) or mobile phones, DVDs, CDs or computer tapes) unless the In-Scope Personal Data is encrypted in accordance with the U.S. Department of Health and Human Services' Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals.

3.6 Upon Molina's request, the Service Provider shall provide Molina with information about the Service Provider's information security program. The Service Provider shall also submit to a review of its security program by Molina or its designees, which shall be carried out by Molina (or by an independent inspection company designated by Molina). The Service Provider shall reasonably cooperate with any such review. In the event that the review under such a review reveals material gaps or weaknesses in the Service Provider's security program, Molina shall

notify the Service Provider promptly and shall be entitled to suspend transmission of Molina Data and In-Scope Personal Data to the Service Provider and suspend the portion of the Services involving the impacted Molina Data and In-Scope Personal Data until such gap or weakness is eliminated to Molina's satisfaction.

3.7 The Service Provider shall promptly and thoroughly investigate all allegations, suspicions, and potential and actual discoveries of unauthorized or improper access to, use, modification, disclosure or destruction (collectively, a "Security Incident") of the Molina Data and In-Scope Personal Data, especially those involving In-Scope Personal Data, under the control of the Service Provider or Subcontractors. The Service Provider shall notify Molina promptly of any Security Incident, including Security Breaches, but no later than the sooner of (a) the notification requirement set out in the applicable BAA and (b) twenty-four (24) hours after it is discovered. Molina's designated form of BAA is set forth in Attachment 24A.

3.8 When the Service Provider ceases to perform Services for Molina or upon termination of the applicable data retention period specified in the Agreement or by Applicable Law for Molina Data and In-Scope Personal Data required to be retained by the Service Provider after termination of the Services, the Service Provider shall either (i) return such Molina Data and In-Scope Personal Data (and all media containing copies thereof) to Molina, or, at Molina's request, (ii) purge, delete and destroy the applicable Molina Data and In-Scope Personal Data. Electronic media containing Molina Data and In-Scope Personal Data shall be disposed of by the Service Provider in a manner that renders such Molina Data and In-Scope Personal Data unrecoverable. Upon written request, the Service Provider shall provide Molina with a certificate executed by an officer of the Service Provider to certify its compliance with this provision. If required by Applicable Law or by the Agreement, the Service Provider may retain an archival copy of such Molina Data and In-Scope Personal Data as and for the period required by the Applicable Law or Agreement. Such archival copy shall not be used or disclosed for any purpose except for disclosures to Molina upon request or as required by Applicable Law. All other terms and conditions of this Schedule shall survive for so long as the Service Provider has not returned such archival copy to Molina or securely destroyed it in accordance with this Schedule.

3.9 The Service Provider shall comply with the requirements set forth in Attachment 24B in connection with the Services.

310 The Service Provider shall comply with the requirements set forth in Attachment 24C in connection with the Services.

3.11 Without prejudice to anything else contained in the Agreement or this Schedule, the Service Provider shall at all times comply with Molina's Security Policies, as set out in Schedule 14 (*Molina Policies*) and with NIST SP800-53, NY DFS Cybersecurity and HIPAA.

Attachment 24A

Business Associate Agreement

[Note: See following pages

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "BAA"), effective Select Date (the "Effective Date"), is entered into by and between Infosys Ltd (the "Business Associate") and Molina Healthcare, Inc., its subsidiaries and affiliates (the "Company") (each a "Party" and collectively the "Parties").

WHEREAS, the Parties have engaged or intend to engage in one or more agreements (each, an "Agreement" and collectively, the "Agreements") which may require the use or disclosure of PHI in performance of services described in such Agreement or Agreements (the "Services") on behalf of the Company;

WHEREAS, the Parties are committed to complying with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and any regulations promulgated thereunder (collectively the "HIPAA Rules"); and

WHEREAS, this BAA, in conjunction with the HIPAA Rules, sets forth the terms and conditions pursuant to which protected health information (in any format) that is created, received, maintained, or transmitted by, the Business Associate from or on behalf of the Company, will be handled between the Business Associate and the Company and with third parties during the term of the Agreement(s) and after its termination.

NOW THEREFORE, the Parties agree as follows:

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the first party listed in the first paragraph of this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by the Business Associate to the Company under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1 Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by the Company to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2 Amendment. The Company may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. The Company may otherwise materially amend this BAA only after forty-five (45) business days prior written notice to the Business Associate and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the Business Associate's receipt of the Company's written notice to amend this BAA, the Company shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of the Company.

3. SCOPE OF USE AND DISCLOSURE

3.1 The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2 The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by the Company, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and

b. to provide Data Aggregation services relating to the Health Care Operations of the Company if required under the Agreement.

3.3 The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or

b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4 The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, the Company, is as between the parties, the sole property of the Company.

3.5 The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of the Company in each instance.

4. OBLIGATIONS OF THE BUSINESS ASSOCIATE

The Business Associate shall:

4.1 Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2 Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Company. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4 Promptly report to the Company any unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI, Breach of Unsecured PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such unauthorized use or disclosure, Breach of Unsecured PHI, or Security Incident. The Business Associate shall indemnify the Company against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5 The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify the Company of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to the Company shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that the Company is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach; and

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7 Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to the Company as necessary to satisfy the Company's obligations under 45 CFR 164.524.

4.8 Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by the Company pursuant to 45 CFR 164.526.

4.9 Maintain and make available to the Company, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy the Company's obligations under 45 CFR 164.528.

4.10 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of the Company available to the Company or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11 To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of the Company, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12 To the extent the Business Associate is to carry out one or more of the Company's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Company in the performance of such obligation(s).

5. MISCELLANEOUS

5.1 Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all third party claims, losses, damages, expenses or other liabilities (including reasonable attorney's fees) incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2 Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3 No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4 Governing Law and Venue. This BAA shall be governed by California law notwithstanding any conflicts of law provisions to the contrary. The venue shall be Los Angeles, California.

5.5 Notices. Any notices to be given hereunder to a Party shall be made via certified U.S. Mail or express courier to such Party's address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below:

If to Business Associate, to:	**If to the Company, to:**
Infosys Ltd	Molina Healthcare, Inc.
2400 N Glenville Dr	200 Oceangate, Suite 100
Richardson, TX 75082	Long Beach, CA 90802
Attn: General Counsel	Attn: Privacy Official
Fax:	Fax: 562-499-0789

6. TERM AND TERMINATION OF BAA

6.1 Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date the Company terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2 Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), the Company may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if the Business Associate has violated a material term of this BAA and fails to cure its breach within thirty (30) days after receiving written notice of the breach.

6.3 Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to the Company or, if agreed to by the Company, destroy all PHI received from the Company, or created, maintained, or received by Business Associate on behalf of the Company, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide the Company with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required By Law. If return or destruction of all PHI, and all copies of PHI, received from the Company, or created, maintained, or received by Business Associate on behalf of the Company, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and

b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4 Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

[Rest of page intentionally left blank]

INTENDING TO BE LEGALLY BOUND, the parties hereto have caused this BAA to be executed by their duly authorized representatives.

"Business Associate"	**"Company"**
_____ Signature	_____ Signature
_____ Print Name	**Timothy Zevnik** Print Name
_____ __ Title Date	**Privacy Official** __ Title Date

Attachment 24B

Certain Information Security Requirements

[Note: See following pages]

1. Network Security.

Contractor agrees at all times to maintain network security that–at a minimum –includes: network firewall provisioning, intrusion and threat detection, and regular third party vulnerability assessments upon request of the Client (no more frequently than once every six months). Contractor agrees to maintain network security that conforms to generally recognized industry standards and best practices that Contractor shall apply to its own network (refer to “12. Industry Standards”).

2. Application Security.

Contractor agrees at all times to provide, maintain, and support its software and subsequent updates, upgrades, and bug fixes such that the software is, and remains, secure from those vulnerabilities in accordance with industry practices or standards.

3. Data Security.

Contractor agrees to preserve the confidentiality, integrity and accessibility of Client data with administrative, technical and physical measures that conform to generally recognized industry standards and best practices that Contractor then applies to its own processing environment (refer to “12. Industry Standards”). Maintenance of a secure processing environment includes but is not limited to the timely application of patches, fixes and updates to operating systems and applications as provided by Contractor or open source support.

4. Data Storage.

Contractor agrees that any and all Client data will be stored, processed, and maintained solely on designated target servers and that no Client data at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Contractor's designated backup and recovery processes and encrypted (refer to “6. Data Encryption”).

5. Data Transmission.

Contractor agrees that any and all electronic transmission or exchange of system and application data with Client and/or any other parties expressly designated by Client shall take place via secure means (using HTTPS or SFTP or equivalent) and, if applicable, solely in accordance with Federal Information Processing Standard Publication 140-2 (“FIPS PUB 140-2”) and Section 7 (Data Re-Use).

6. Data Encryption.

Contractor agrees to store all Client backup data as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Contractor further agrees that any and all Client data defined as personally identifiable information under current legislation or regulations stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no

less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and FIPS PIB 140-2.

7. Data Re-Use.

Contractor agrees that any and all data exchanged shall be used expressly and solely for the purposes enumerated in the Current Agreement and this Addendum. Data shall not be distributed, repurposed or shared across other applications, environments, or business units of the Contractor. Contractor further agrees that no Client data of any kind shall be transmitted, exchanged or otherwise passed to other Contractors or interested parties except on a case-by-case basis as specifically agreed to in writing by the Client.

8. End of Agreement Data Handling.

Contractor agrees that upon termination of this Agreement and upon Client's written approval it shall erase, destroy, and render unrecoverable all Client data and certify in writing that these actions have been completed within thirty (30) days of the termination of this Agreement or within seven (7) days of the request of an agent of the Client, whichever shall come first. At a minimum, a "Clear" media sanitization is to be performed according to the standards enumerated by the National Institute of Standards and Technology ("NIST") Guidelines for Media Sanitization (SP800-88, Appendix A).

9. Security Breach Notification.

Contractor agrees to comply with all applicable laws that require the notification of Client, in the event of an unauthorized disclosure or breach of information or other events requiring notification. Client will then decide on further action including, but not limited to, notification to effected individuals or government entities. In the event of a breach of any of Contractor's security obligations, or other events requiring notification under applicable law, Contractor agrees to:

a. Notify the Client Chief Information Security Officer by telephone and email of such an event within twenty-four (24) hours of discovery;

b. Upon Client's prior written request, assume responsibility for informing all such individuals in accordance with applicable law; and

c. Indemnify, hold harmless and defend Client and its trustees, officers, and employees from and against any claims, damages, or other harm related to such event.

10. Right to Audit

The Client or a client-appointed audit firm ("Auditors") has the right to audit the Contractor and the Contractor's sub-contractors or affiliates that provide a service for the processing, transport or

storage of Client's data. Client will announce their intent to audit the Contractor by providing at a minimum of ten (10) business days' notice to the Contractor. This notice will go to the Contractor that this contract is executed with. A scope document along with a request for deliverables will be provided at the time of notification of an audit. If the documentation requested cannot be removed from the Contractor's premises, the Contractor will allow the Client or Auditors access to their site or share on the desktop screen in an audio-video conference. Where necessary, the Contractor will provide a personal site guide for the Client or Auditors while on site. If site visit is necessary, the Contractor will provide a private workspace on site with electrical and internet connectivity for data review, analysis and meetings. The Contractor will make necessary employees or contractors available for interviews in person or on the phone during the time frame of the audit.

In lieu of the Client or its appointed audit firm performing their own audit, if the Contractor has an external, independent audit firm that performs a certified SOC or HITRUST review, the Client has the right to review the controls tested as well as the results, and has the right to request additional controls to be added to the certified SOC or HITRUST review for testing the controls that have an impact on Client data. Audits will be at the Client's sole expense, except where the audit reveals material noncompliance with contract specifications, in which case the cost will be borne by the Contractor.

11. Contractor Warranty

Contractor (i) warrants that the services provided in this agreement will be in substantial conformity with the information provided in Contractor's response to the Client's Due Diligence/Security Assessment questionnaire and that Contractor's response to the Client's Due Diligence/Security Assessment questionnaire is accurate as of the date of such response; (ii) agrees to inform Client promptly of any material variation in operations from that reflected in the Contractor's response to the Client's Due Diligence/Security Assessment; and (iii) agrees that any material deficiency in operations from those as described in the Contractor's Response to the Client's Due Diligence/Security Assessment questionnaire will be deemed a material breach of this agreement.

12. Industry Standards

Generally recognized industry standards include but are not limited to the current standards and benchmarks set forth and maintained by the:

a. Center for Internet Security - http://www.cisecurity.org

b. Payment Card Industry/Data Security Standards ("PCI/DSS") - http://www.pcisecuritystandards.org/

c. National Institute for Standards and Technology (NIST 800-53) - http://csrc.nist.gov

d. Federal Information Security Management Act ("FISMA") - http://csrc.nist.gov

e. ISO/IEC 27000-series - http://www.iso27001security.com/

f. HIPAA and HITECH

g. Federal Risk and Authorization Management Program (“FedRamp”)

Attachment 24C

Certain Cybersecurity Requirements

[Note: See following pages]

1. Client is required by law to implement a Cybersecurity Program that, among other things:

A. protects the confidentiality, integrity, and availability of its Information Systems;

B. identifies and assesses internal and external cybersecurity risks that may threaten its Nonpublic Information stored on its Information Systems;

C. uses defensive infrastructure and implements policies and procedures to protect its Information Systems and Nonpublic Information from unauthorized access, use or malicious acts;

D. detects Cybersecurity Events;

E. responds to identified or detected Cybersecurity Events;

F. recovers and restores normal operations; and

G. fulfills applicable regulatory reporting obligations.

2. As part of its Cybersecurity Program, Client is also required by law to ensure the security of its Information Systems and Nonpublic Information accessible to or held by Third Party Service Providers ("TPSPs") such as Contractor. Therefore, TPSPs must have, and permit Client to audit via written request, the cybersecurity measures, safeguards and standards used by such TPSPs including, but not limited to, the policies, procedures and practices:

A. Delineating access controls, including Multi-Factor Authentication, to limit access to Client's Information Systems and Nonpublic Information accessible to or held by the TPSP;

B. Using encryption to protect Client's Nonpublic Information, in transit and at rest, accessible to or held by the TPSP;

C. Requiring notice to be provided to Client if a Cybersecurity Event threatens or affects Client's Information Systems or Nonpublic Information accessible to or held by the TPSP. Such notice must be provided to Client within seventy-two (72) hours from a determination that a Cybersecurity Event has occurred that is either of the following:

(i) Cybersecurity Events impacting Client of which notice is required to be provided to any government body, self-regulatory agency or any other supervisory body; or

(ii) Cybersecurity Events that have a reasonable likelihood of materially harming any material part of the normal operation(s) of Client; and

D. Ensuring the security of Client's Information Systems and Nonpublic Information accessible to or held by the TPSP.

Defined terms in this Attachment 24C:

"Affiliate" means any Person that controls, is controlled by or is under common control with another Person. For purposes of this subsection, control means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of stock of such Person or otherwise.

"Cybersecurity Program" means a program designed to protect the confidentiality, integrity and availability of the Covered Entity's Information Systems.

"Cybersecurity Event" means any act or attempt, successful or unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or information stored on such Information System.

"Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) Knowledge factors, such as a password; (2) Possession factors, such as a token or text message on a mobile phone; or (3) Inherence factors, such as a biometric characteristic.

"Nonpublic Information" means all electronic information that is not publicly available information and is:

(1) Business related information of Client the tampering with which, or unauthorized disclosure, access or use of which, would cause a material adverse impact to the business, operations or security of Client;

(2) Any information concerning an individual which because of name, number, personal mark, or other identifier can be used to identify such individual, in combination with any one or more of the following data elements: (i) social security number, (ii) drivers' license number or non-driver identification card number, (iii) account number, credit or debit card number, (iv) any security code, access code or password that would permit access to an individual's financial account; or (v) biometric records;

(3) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or an individual and that relates to (i) the past, present or future physical, mental or behavioral health or condition of any individual or a member of the individual's family, (ii) the provision of health care to any individual, or (iii) payment for the provision of health care to any individual.

"Information System" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic information, as well as any specialized system.

"Third Party Service Provider" ("TPSP") means an entity that (i) is not an affiliate of Client, (ii) provides services to Client, and (iii) maintains, processes or otherwise is permitted access to Nonpublic Information through its provision of services to Client.

All other provisions of the Agreement shall remain unchanged and in full force and effect.

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Healthcare Data Center, LLC	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Mississippi, Inc.	Mississippi
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of New York, Inc.	New York
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Oklahoma, Inc.*	Oklahoma
Molina Healthcare of Pennsylvania, Inc.*	Pennsylvania
Molina Healthcare of Puerto Rico, Inc.	Puerto Rico/Nevada
Molina Healthcare of South Carolina, Inc.	South Carolina
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Hospital Management, LLC	California
Molina Youth Academy*	California
Molina Medical Management, Inc.	California
Molina Holdings Corporation*	New York
Molina Clinical Services, LLC	Delaware
Molina Healthcare of Louisiana, Inc.*	Louisiana
Molina Healthcare of Nevada, Inc.*	Nevada
Molina Pathways, LLC	Delaware
Molina Pathways of Texas, Inc.+	Texas
Pathways Community Corrections, LLC	Delaware

* Non-operational entity

\+ Wholly owned subsidiary of Molina Pathways, LLC

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-204558) of Molina Healthcare, Inc.; and

(2) Registration Statement (Form S-8 No. 333-174912) pertaining to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan;

of our reports dated February 19, 2019, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2018.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 19, 2019

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-K for the period ended December 31, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: February 19, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Thomas L. Tran, certify that:

1. I have reviewed the report on Form 10-K for the period ended December 31, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 19, 2019

/s/ Thomas L. Tran

Thomas L. Tran

Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2018 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 19, 2019

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2018 (the "Report"), I, Thomas L. Tran, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 19, 2019

/s/ Thomas L. Tran

Thomas L. Tran
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended September 30, 2018

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2018

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).
Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of October 26, 2018, was approximately 62,389,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED September 30, 2018

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CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions, except per-share data) (Unaudited)			
Revenue:				
Premium revenue	$ 4,337	$ 4,777	$ 13,174	$ 14,165
Service revenue	130	130	391	390
Premium tax revenue	110	106	320	331
Health insurer fees reimbursed	83	—	248	—
Investment income and other revenue	37	18	93	48
Total revenue	4,697	5,031	14,226	14,934
Operating expenses:				
Medical care costs	3,790	4,220	11,362	12,822
Cost of service revenue	111	123	349	369
General and administrative expenses	311	383	998	1,227
Premium tax expenses	110	106	320	331
Health insurer fees	87	—	261	—
Depreciation and amortization	25	33	76	109
Restructuring and separation costs	5	118	38	161
Impairment losses	—	129	—	201
Total operating expenses	4,439	5,112	13,404	15,220
Gain on sale of subsidiary	37	—	37	—
Operating income (loss)	295	(81)	859	(286)
Other expenses, net:				
Interest expense	26	32	91	85
Other expenses (income), net	10	—	25	(75)
Total other expenses, net	36	32	116	10
Income (loss) before income tax expense (benefit)	259	(113)	743	(296)
Income tax expense (benefit)	62	(16)	237	(46)
Net income (loss)	$ 197	$ (97)	$ 506	$ (250)
Net income (loss) per share:				
Basic	$ 3.22	$ (1.70)	$ 8.32	$ (4.44)
Diluted	$ 2.90	$ (1.70)	$ 7.60	$ (4.44)

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions) (Unaudited)			
Net income (loss)	$ 197	$ (97)	$ 506	$ (250)
Other comprehensive income (loss):				
Unrealized investment gain (loss)	1	1	(5)	2
Less: effect of income taxes	—	1	(1)	1
Other comprehensive income (loss), net of tax	1	—	(4)	1
Comprehensive income (loss)	$ 198	$ (97)	$ 502	$ (249)

See accompanying notes.

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CONSOLIDATED BALANCE SHEETS

	September 30, 2018	December 31, 2017
	(In millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,814	$ 3,186
Investments	1,812	2,524
Restricted investments	—	169
Receivables	1,346	871
Prepaid expenses and other current assets	486	239
Derivative asset	843	522
Total current assets	7,301	7,511
Property, equipment, and capitalized software, net	264	342
Goodwill and intangible assets, net	195	255
Restricted investments	118	119
Deferred income taxes	143	103
Other assets	30	141
	$ 8,051	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 2,042	$ 2,192
Amounts due government agencies	1,030	1,542
Accounts payable and accrued liabilities	824	366
Deferred revenue	178	282
Current portion of long-term debt	296	653
Derivative liability	843	522
Total current liabilities	5,213	5,557
Long-term debt	1,019	1,318
Lease financing obligations	198	198
Other long-term liabilities	60	61
Total liabilities	6,490	7,134
Stockholders' equity:		
Common stock, $0.001 par value, 150 shares authorized; outstanding: 62 shares at September 30, 2018 and 60 shares at December 31, 2017	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	760	1,044
Accumulated other comprehensive loss	(10)	(5)
Retained earnings	811	298
Total stockholders' equity	1,561	1,337
	$ 8,051	$ 8,471

See accompanying notes.

CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
	(Unaudited)					
Balance at January 1, 2018	60	$ —	$ 1,044	$ (5)	$ 298	$ 1,337
Net income	—	—	—	—	107	107
Adoption of Topic 606	—	—	—	—	6	6
Adoption of ASU 2018-02	—	—	—	(1)	1	—
Exchange of 1.625% Notes	2	—	108	—	—	108
Other comprehensive loss, net	—	—	—	(6)	—	(6)
Share-based compensation	—	—	1	—	—	1
Balance at March 31, 2018	62	—	1,153	(12)	412	1,553
Net income	—	—	—	—	202	202
Partial termination of 1.125% Warrants	—	—	(113)	—	—	(113)
Other comprehensive income, net	—	—	—	1	—	1
Share-based compensation	—	—	15	—	—	15
Balance at June 30, 2018	62	—	1,055	(11)	614	1,658
Net income	—	—	—	—	197	197
Partial termination of 1.125% Warrants	—	—	(306)	—	—	(306)
Conversion of 1.625% Notes	—	—	4	—	—	4
Other comprehensive income, net	—	—	—	1	—	1
Share-based compensation	—		7	—	—	7
Balance at September 30, 2018	62	$ —	$ 760	$ (10)	$ 811	$ 1,561

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
	(Unaudited)					
Balance at January 1, 2017	57	$ —	$ 841	$ (2)	$ 810	$ 1,649
Net income	—	—	—	—	77	77
Other comprehensive income, net	—	—	—	1	—	1
Balance at March 31, 2017	57	—	841	(1)	887	1,727
Net loss	—	—	—	—	(230)	(230)
Share-based compensation	—	—	24	—	—	24
Balance at June 30, 2017	57	—	865	(1)	657	1,521
Net loss	—	—	—	—	(97)	(97)
Share-based compensation	—	—	5	—	—	5
Balance at September 30, 2017	57	$ —	$ 870	$ (1)	$ 560	$ 1,429

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2018	2017
	(In millions) (Unaudited)	
Operating activities:		
Net income (loss)	$ 506	$ (250)
Adjustments to reconcile net income (loss) to net cash (used in) provided by operating activities:		
Depreciation and amortization	104	139
Deferred income taxes	(32)	(68)
Share-based compensation	20	38
Non-cash restructuring costs	17	49
Amortization of convertible senior notes and lease financing obligations	18	24
Gain on sale of subsidiary	(37)	—
Loss on debt extinguishment	25	—
Impairment losses	—	201
Other, net	6	13
Changes in operating assets and liabilities:		
Receivables	(507)	(28)
Prepaid expenses and other current assets	(117)	(53)
Medical claims and benefits payable	(144)	549
Amounts due government agencies	(511)	122
Accounts payable and accrued liabilities	398	90
Deferred revenue	(55)	153
Income taxes	118	(22)
Net cash (used in) provided by operating activities	(191)	957
Investing activities:		
Purchases of investments	(1,202)	(1,894)
Proceeds from sales and maturities of investments	2,070	1,536
Purchases of property, equipment and capitalized software	(24)	(85)
Other, net	(23)	(33)
Net cash provided by (used in) investing activities	821	(476)
Financing activities:		
Repayment of credit facility	(300)	—
Repayment of principal amount of 1.125% Notes	(236)	—
Cash paid for partial settlement of 1.125% Conversion Option	(477)	—
Cash received for partial termination of 1.125% Call Option	477	—
Cash paid for partial termination of 1.125% Warrants	(419)	—
Repayment of principal amount of 1.625% Notes	(64)	—
Proceeds from senior notes offerings, net of issuance costs	—	325
Proceeds from borrowings under credit facility	—	300
Other, net	7	7
Net cash (used in) provided by financing activities	(1,012)	632
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(382)	1,113
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	3,290	2,912
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 2,908	$ 4,025

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Nine Months Ended September 30,	
	2018	2017
	(In millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (6)	$ (21)
Details of sale of subsidiary:		
Decrease in carrying amount of assets	$ (243)	$ —
Decrease in carrying amount of liabilities	59	—
Transaction costs	(12)	—
Receivable from buyer - recorded in prepaid expenses and other current assets	233	—
Gain on sale of subsidiary	$ 37	$ —
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 321	$ 158
Loss on 1.125% Conversion Option	(321)	(158)
Change in fair value of derivatives, net	$ —	$ —
1.625% Notes exchange transaction:		
Common stock issued in exchange for 1.625% Notes	$ 131	$ —
Component of 1.625% Notes allocated to additional paid-in capital, net of income taxes	(23)	—
Net increase to additional paid-in capital	$ 108	$ —

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

September 30, 2018

1. Organization and Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments, consisting of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

The Health Plans segment consists of health plans operating in 13 states and the Commonwealth of Puerto Rico. As of September 30, 2018, these health plans served approximately 4.0 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies' administration of their Medicaid programs, including business processing, information technology development and administrative services. The Other segment includes primarily our behavioral health and social services provider subsidiary (Pathways), and corporate amounts not allocated to other reportable segments.

Recent Developments – Health Plans Segment

New Mexico Health Plan. In our Annual Report on Form 10-K for 2017, we reported that we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. A hearing was held on our judicial protest on October 17, 2018, with a decision expected in the fourth quarter of 2018. Regardless of the court's decision on our protest, we would have further rights of appeal. We are continuing to manage the business in run-off until such time as a different outcome is determined. As of September 30, 2018, we served approximately 206,000 Medicaid members in New Mexico, which represented premium revenue of $891 million for the nine months ended September 30, 2018.

Puerto Rico Health Plan. In July 2018, our Puerto Rico health plan was selected by the Puerto Rico Health Insurance Administration to be one of the organizations to administer the Commonwealth's new Medicaid Managed Care contract. We expect to serve approximately 290,000 members under the new contract. The base contract runs for a period of three years with an optional one-year extension. As of September 30, 2018, we served approximately 320,000 Medicaid members in the East and Southwest regions of Puerto Rico, which represented premium revenue of $549 million for the nine months ended September 30, 2018.

Florida Health Plan. In June 2018, our Florida health plan was awarded comprehensive Medicaid Managed Care contracts by the Florida Agency for Health Care Administration (AHCA) in Regions 8 and 11 of the Florida Statewide Medicaid Managed Care Invitation to Negotiate. As of September 30, 2018, we served approximately 96,000 Medicaid members in those regions, which represented premium revenue of approximately $346 million for the nine months ended September 30, 2018. Services under the new contract are expected to begin on January 1, 2019. We will be serving both the Medicaid and long-term care populations in the two regions.

Washington Health Plan. In May 2018, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to enter into a managed care contract for the eight remaining regions of the state's Apple Health Integrated Managed Care program, in addition to the two regions previously awarded to us. We were

selected by HCA for the following regions: Greater Columbia, King, North Sound, Pierce, and Spokane beginning January 1, 2019; and Salish, Thurston-Mason, and Great Rivers beginning January 1, 2020. As of September 30, 2018, we served approximately 738,000 Medicaid members in Washington, which represented premium revenue of $1,558 million for the nine months ended September 30, 2018.

Recent Developments – Molina Medicaid Solutions Segment

We closed on the sale of Molina Medicaid Solutions (MMS) to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million, which we received on October 1, 2018. As a result of this transaction, we recognized a pretax gain, net of transaction costs, of $37 million. Refer to Note 11, "Segments," for further information.

Subsequent Event – Other Segment

On October 19, 2018, we sold our Pathways subsidiary to Pyramid Health Holdings, LLC for a nominal purchase price. We expect to record a loss on sale of subsidiary amounting to approximately $40 million, net of income tax benefits.

Presentation and Reclassification

We have reclassified certain amounts in the 2017 consolidated statement of cash flows to conform to the 2018 presentation, relating to the presentation of restricted cash and cash equivalents. The reclassification is a result of our adoption of Accounting Standards Update (ASU) 2016-18, *Restricted Cash* effective January 1, 2018. See Note 2, "Significant Accounting Policies," for further information, including the amount reclassified.

We have combined certain line items in the accompanying consolidated balance sheets. For all periods presented, we have combined the presentation of:

- Income taxes refundable with "Prepaid expenses and other current assets;"
- Income taxes payable with "Accounts payable and accrued liabilities;"
- Goodwill, and intangible assets, net to a single line; and
- Deferred contract costs with "Other assets."

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the nine months ended September 30, 2018 are not necessarily indicative of the results for the entire year ending December 31, 2018.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2017. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in our December 31, 2017 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our audited consolidated financial statements for the fiscal year ended December 31, 2017.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in non-current "Restricted investments" in the accompanying consolidated balance sheets.

	Nine Months Ended September 30,	
	2018	2017
	(In millions)	
Cash and cash equivalents	$ 2,814	$ 3,934
Restricted cash and cash equivalents	94	91
Total cash, cash equivalents, and restricted cash and cash equivalents presented in the statements of cash flows	$ 2,908	$ 4,025

Revenue Recognition

We adopted ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)* effective January 1, 2018, using the modified retrospective approach. The insurance contracts of our Health Plans segment, which segment constitutes the vast majority of our operations, are excluded from the scope of Topic 606 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts. The cumulative effect of initially applying the guidance, relating entirely to our Molina Medicaid Solutions segment contracts, resulted in an immaterial impact to beginning retained earnings, as presented in the accompanying consolidated statement of stockholders' equity. Topic 606 was only applied to service contracts that were not completed as of December 31, 2017. Refer to "Other segment" below for further information.

Health Plans segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into two broad categories discussed in further detail below: 1) "Contractual Provisions That May Adjust or Limit Revenue or Profit;" and 2) "Quality Incentives." Liabilities recorded for such provisions are included in "Amounts due government agencies" in the accompanying consolidated balance sheets.

1) Contractual Provisions That May Adjust or Limit Revenue or Profit:

Medicaid

- *Medical Cost Floors (Minimums), and Medical Cost Corridors:* Pursuant to certain contract provisions, a portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $198 million and $135 million at September 30, 2018 and December 31, 2017, respectively. Approximately $144 million and $96 million of this liability accrued at September 30, 2018 and December 31, 2017, respectively, relates to our participation in Medicaid Expansion programs. Refer to Note 12, "Commitments and Contingencies," for further information regarding the California Medicaid Expansion program.

- *Retroactive Premium Adjustments:* State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare

- *Minimum MLR:* The Affordable Care Act (ACA) has established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations. The payable for the Medicare Minimum MLR was not significant at September 30, 2018 and December 31, 2017.

Marketplace

- *Risk adjustment:* Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score, and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium

revenue in our consolidated statements of operations. As of September 30, 2018, and December 31, 2017, the Marketplace risk adjustment payable amounted to $390 million and $912 million, respectively.

- *Minimum MLR:* The ACA has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations. The payable for the Marketplace Minimum MLR was not significant at September 30, 2018 and December 31, 2017.

2) Quality Incentives:

At many of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2018 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30, 2018.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(Dollars in millions)			
Maximum available quality incentive premium - current period	$ 48	$ 36	$ 135	$ 113
Quality incentive premium revenue recognized in current period:				
Earned current period	$ 39	$ 24	$ 97	$ 72
Earned prior periods	9	3	32	9
Total	$ 48	$ 27	$ 129	81
Quality incentive premium revenue recognized as a percentage of total premium revenue	1.1%	0.6%	1.0%	0.6%

Other segment

Our Pathways subsidiary's revenue is all variable, and generally invoiced after services are rendered; customer payment follows invoicing. We concluded that there is no change to revenue recognition under Topic 606 for Pathways, and therefore no impact to retained earnings effective January 1, 2018. As discussed in Note 1, "Organization and Basis of Presentation," we sold Pathways on October 19, 2018.

Medical Care Costs - Marketplace Cost Share Reduction (CSR) Update

In the nine months ended September 30, 2018, we recognized a benefit of approximately $81 million in reduced medical expense related to 2017 dates of service, including $5 million in the third quarter of 2018, as a result of the federal government's confirmation that the reconciliation of 2017 Marketplace CSR subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is generally limited because our payors consist principally of the governments of each state in which our health plan subsidiaries operate.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by HIF in 2017 given the 2017 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including projected pretax earnings, the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The Tax Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. The TCJA, in part, reduced the U.S. federal statutory corporate income tax rate from 35% to 21% effective January 1, 2018. Accounting guidance allows filers a measurement period of one year from the enactment date to finalize the provisional valuation of deferred tax assets and liabilities. During the third quarter of 2018, we recognized approximately $4 million in adjustments to our provisional valuation of our deferred tax assets and liabilities recorded at December 31, 2017, and included these adjustments as a component of income tax expense from continuing operations, which decreased our effective tax rate by 150 basis points in the quarter. At September 30, 2018, we had not completed our accounting for the tax effects resulting from enactment of TCJA with respect to valuation of our deferred tax assets and liabilities. We will continue to refine our calculations as additional analysis is completed. In addition, our estimates may also be affected by expected future guidance on the tax law from the Internal Revenue Service and U.S. Treasury.

Recent Accounting Pronouncements Adopted

Revenue Recognition (Topic 606). See discussion above, in “Revenue Recognition.”

Comprehensive Income. In February 2018, the Financial Accounting Standards Board (FASB) issued ASU 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the TCJA. ASU 2018-02 is effective beginning January 1, 2019; we early adopted this ASU effective January 1, 2018. The effect of applying the guidance resulted in an immaterial impact to beginning retained earnings, as presented in the accompanying consolidated statement of stockholders’ equity.

Restricted Cash. In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which requires us to include in our consolidated statements of cash flows the changes in the balances of cash, cash equivalents, restricted cash and restricted cash equivalents. We adopted ASU 2016-18 on January 1, 2018. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption resulted in a $91 million reclassification of restricted cash and cash equivalents from “Investing activities,” to the beginning and ending balances of cash and cash equivalents in our consolidated statements of cash flows for the nine months ended September 30, 2017. There was no impact to our consolidated statements of operations, balance sheets, or stockholders’ equity. The reconciliation of cash and cash equivalents to cash, cash equivalents, and restricted cash and cash equivalents is presented at the beginning of this note.

Recent Accounting Pronouncements Not Yet Adopted

Software Licenses. In August 2018, the FASB issued ASU 2018-15, *Customer’s Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract,* which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. ASU 2018-15 is effective beginning January 1, 2020, and can be applied either retrospectively or prospectively to all implementation costs incurred after the date of adoption; early adoption is permitted. We are evaluating the effect of this guidance.

Callable Debt Securities. In March 2017, the FASB issued ASU 2017-08, *Premium Amortization on Purchased Callable Debt Securities*, which shortens the amortization period for certain callable debt securities held at a premium. Specifically, the amendments require the premium to be amortized to the earliest call date. ASU 2017-08 is effective beginning January 1, 2019, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted. We are evaluating the effect of this guidance.

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the

revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument's contractual life. ASU 2016-13 is effective beginning January 1, 2020, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted. We are evaluating the effect of this guidance.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by:

- ASU 2017-03, *Transition and Open Effective Date Information;*
- ASU 2018-01, *Leases (Topic 842): Land Easement Practical Expedient for Transition to Topic 842;*
- ASU 2018-10, *Codification Improvements to Topic 842, Leases; and*
- ASU 2018-11, *Leases (Topic 842): Targeted Improvements.*

Under Topic 842, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both financing and operating leases. Topic 842 also requires new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. We will adopt Topic 842 effective January 1, 2019, using the modified retrospective method. Under this method, we will recognize the cumulative effect of initially applying the standard as an adjustment to the opening balance of retained earnings on January 1, 2019. In addition, we have elected the transition option provided under ASU 2018-11, which allows entities to continue to apply the legacy guidance in Topic 840, *Leases*, including its disclosure requirements, in the comparative periods presented in the year of adoption.

Under Topic 842, we will record right-of-use assets and liabilities relating primarily to our long-term office operating leases. We have substantially completed the configuration of our lease database management system for the adoption of Topic 842. We do not currently expect the adoption of this guidance to have a material effect on our consolidated results of operations, financial condition or cash flows.

3. Net Income (Loss) per Share

The following table sets forth the calculation of basic and diluted net income (loss) per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions, except net income per share)			
Numerator:				
Net income (loss)	$ 197	$ (97)	$ 506	$ (250)
Denominator:				
Shares outstanding at the beginning of the period	61.3	56.5	59.3	55.8
Weighted-average number of shares issued:				
Exchange of 1.625% Notes (1)	—	—	1.3	—
Stock-based compensation	—	—	0.2	0.4
Denominator for basic net income per share	61.3	56.5	60.8	56.2
Effect of dilutive securities:				
1.125% Warrants (1)	5.6	—	5.0	—
1.625% Notes (1)	0.6	—	0.5	—
Stock-based compensation	0.4	—	0.3	—
Denominator for diluted net income per share	67.9	56.5	66.6	56.2
Net income (loss) per share: (2)				
Basic	$ 3.22	$ (1.70)	$ 8.32	$ (4.44)
Diluted	$ 2.90	$ (1.70)	$ 7.60	$ (4.44)
Potentially dilutive common shares excluded from calculations:				
1.125% Warrants (1)	—	2.3	—	1.3
1.625% Notes (1)	—	0.6	—	0.3
Stock-based compensation	—	0.2	—	0.3

(1) For more information and definitions regarding the 1.625% Notes, refer to Note 7, “Debt.” For more information and definitions regarding the 1.125% Warrants, refer to Note 9, “Stockholders' Equity.” The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income (loss) per share because to do so would be anti-dilutive.

(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of cash, cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to the three-tier fair value hierarchy. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 4, “Fair Value Measurements,” in our 2017 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability (see Note 8 “Derivatives,” for definitions and further information). These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of September 30, 2018, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. The 1.125% Call Option derivative asset and the 1.125% Conversion Option

derivative liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such derivative instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the nine months ended September 30, 2018.

Our financial instruments measured at fair value on a recurring basis at September 30, 2018, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,191	$ —	$ 1,191	$ —
U.S. treasury notes	221	221	—	—
Government-sponsored enterprise securities (GSEs)	170	170	—	—
Municipal securities	119	—	119	—
Asset-backed securities	92	—	92	—
Certificate of deposit	15	—	15	—
Other	4	—	4	—
Subtotal - current investments	1,812	391	1,421	—
1.125% Call Option derivative asset	843	—	—	843
Total assets	$ 2,655	$ 391	$ 1,421	$ 843
1.125% Conversion Option derivative liability	$ 843	$ —	$ —	$ 843
Total liabilities	$ 843	$ —	$ —	$ 843

Our financial instruments measured at fair value on a recurring basis at December 31, 2017, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,588	$ —	$ 1,588	$ —
U.S. treasury notes	388	388	—	—
GSEs	253	253	—	—
Municipal securities	141	—	141	—
Asset-backed securities	117	—	117	—
Certificates of deposit	37	—	37	—
Subtotal - current investments	2,524	641	1,883	—
Corporate debt securities	101	—	101	—
U.S. treasury notes	68	68	—	—
Subtotal - current restricted investments	169	68	101	—
1.125% Call Option derivative asset	522	—	—	522
Total assets	$ 3,215	$ 709	$ 1,984	$ 522
1.125% Conversion Option derivative liability	$ 522	$ —	$ —	$ 522
Total liabilities	$ 522	$ —	$ —	$ 522

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	September 30, 2018		December 31, 2017	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
	(In millions)			
5.375% Notes	$ 693	$ 711	$ 692	$ 730
1.125% Notes (1)	295	1,142	496	1,052
4.875% Notes	326	325	325	329
1.625% Notes (2)	—	—	157	220
Credit Facility (2)	—	—	300	300
	$ 1,314	$ 2,178	$ 1,970	$ 2,631

(1) The fair value of the 1.125% Conversion Option (the embedded cash conversion option), which is included in the fair value amounts presented above, amounted to $843 million and $522 million as of September 30, 2018, and December 31, 2017, respectively. See further discussion at Note 7, “Debt,” and Note 8, “Derivatives.”
(2) For more information on debt repayments in the nine months ended September 30, 2018, refer to Note 7, “Debt.”

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets to be available-for-sale. The following tables summarize our investments as of the dates indicated:

	September 30, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In millions)		
Corporate debt securities	$ 1,197	$ 1	$ 7	$ 1,191
U.S. treasury notes	222	—	1	221
GSEs	172	—	2	170
Municipal securities	121	—	2	119
Asset backed securities	93	—	1	92
Certificates of deposit	15	—	—	15
Other	4	—	—	4
	$ 1,824	$ 1	$ 13	$ 1,812

	December 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,591	$ 1	$ 4	$ 1,588
U.S. treasury notes	389	—	1	388
GSEs	255	—	2	253
Municipal securities	142	—	1	141
Asset-backed securities	117	—	—	117
Certificates of deposit	37	—	—	37
Subtotal - current investments	2,531	1	8	2,524
Corporate debt securities	101	—	—	101
U.S. treasury notes	68	—	—	68
Subtotal - current restricted investments	169	—	—	169
	$ 2,700	$ 1	$ 8	$ 2,693

The contractual maturities of our available-for-sale investments as of September 30, 2018 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,025	$ 1,023
Due after one year through five years	799	789
	$ 1,824	$ 1,812

As discussed further in Note 7, “Debt,” the 4.875% Notes’ indenture required us to hold a portion of the net proceeds from their issuance in a segregated account to be used to settle the conversion of the 1.625% Notes. Prior to September 30, 2018, this account was reported as a current asset, entitled “Restricted investments,” in the accompanying consolidated balance sheets. Because this account was used to settle the conversion of the 1.625% Notes in the third quarter of 2018, current restricted investments, as of September 30, 2018, was reduced to zero.

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and nine months ended September 30, 2018 and 2017 were insignificant.

We have determined that unrealized losses at September 30, 2018 and December 31, 2017, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of September 30, 2018:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 727	$ 4	460	$ 186	$ 3	127
U.S. Treasury notes	—	—	—	94	1	31
GSEs	—	—	—	127	2	68
Municipal securities	63	1	63	55	1	57
Asset backed securities	72	1	41	—	—	—
	$ 862	$ 6	564	$ 462	$ 7	283

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2017:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,297	$ 3	561	$ 94	$ 1	69
U.S. Treasury Notes	470	1	89	—	—	—
GSEs	173	1	69	95	1	47
Municipal securities	—	—	—	38	1	48
	$ 1,940	$ 5	719	$ 227	$ 3	164

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current “Restricted investments” in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

Our held-to-maturity restricted investments are carried at amortized cost, which approximates fair value. Held-to-maturity restricted investments as of September 30, 2018, are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 111	$ 111
Due after one year through five years	7	7
	$ 118	$ 118

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated:

	September 30, 2018	December 31, 2017
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,609	$ 1,717
Pharmacy payable	121	112
Capitation payable	48	67
Other	264	296
	$ 2,042	$ 2,192

“Other” medical claims and benefits payable includes amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. Non-risk provider payables amounted to $158 million and $122 million as of September 30, 2018 and December 31, 2017, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amounts by which our original estimate of medical claims and benefits payable at the beginning of the

period were (more) less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30,	
	2018	2017
	(In millions)	
Medical claims and benefits payable, beginning balance	$ 2,192	$ 1,929
Components of medical care costs related to:		
Current period	11,589	12,813
Prior periods	(227)	9
Total medical care costs	11,362	12,822
Change in non-risk provider payables	60	172
Payments for medical care costs related to:		
Current period	9,866	10,944
Prior periods	1,706	1,501
Total paid	11,572	12,445
Medical claims and benefits payable, ending balance	$ 2,042	$ 2,478

The differences between our original estimates and the amounts ultimately paid out for the most part relate to IBNP. Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because we establish the provision for adverse claims deviation and the accrued cost of settling claims on a consistent basis every quarter, the lower cost recognized in a subsequent period if such a provision proved unnecessary would be offset by the establishment of a similar provision during that same period.

Because the amount of our initial liability is an estimate, we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded.

Further, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at September 30, 2018 are as follows:

- Across all of our health plans, the inventory of unpaid claims increased significantly during the first half of 2017, then decreased in the last half of 2017 and into 2018. Changes in claims inventories impact the timing between date of service and the date of claim payment, increasing the volatility of our liability estimates.
- In June 2018, our Puerto Rico health plan implemented state prescribed claim billing requirements to ensure more accurate claims submissions. The billing requirements were more stringent and caused a significant number of claim denials. Although we expect providers to ultimately submit updated claims with the required information, the impact of the new billing requirements creates more uncertainty in our liability estimates.
- At our Florida health plan, a new clinical service system was implemented in the first quarter of 2018. This system impacted the reporting of inpatient authorizations used in our development of claims liabilities, which makes our liability estimates subject to more than the usual amount of uncertainty.
- We recently implemented a new process for increased quality review of claims payments in 11 of our health plans. While we do not anticipate this new process will impact the percentage of claims paid within the timely turnaround requirements, we believe it will have a minor impact on the timing of some paid claims. For this reason, our liability estimates in these 11 health plans are subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $227 million for the nine months ended September 30, 2018. This amount represents our estimate as of September 30, 2018, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2017, was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe these differences were due primarily to the following factors:

- The impact of the provision for adverse claims deviation and the accrued cost of settling claims as discussed above. Because we re-establish the provision for adverse claims deviation and the accrued cost of settling claims on a consistent basis every quarter, the impact of this item to medical care costs in the nine months ended September 30, 2018, results was minimal.
- Across all of our health plans, the inventory of unpaid claims increased significantly during the first half of 2017, then decreased in the last half of 2017. In hindsight, the impact of the changes in claims processing timing reduced our liabilities more than we had anticipated.
- December 2017 data from The Centers for Disease Control and Prevention indicated widespread influenza activity in several states in which we operate health plans. The additional liabilities established in consideration of increased claims related to a more severe influenza season turned out to be higher than our actual experience.
- In establishing our liability at December 31, 2017, we anticipated an increase in the utilization of medical services by Marketplace members concerned about the future of their healthcare coverage as a result of uncertainties related to high premium increases and issuer exits. This induced demand did not materialize to the degree we expected.

7. Debt

As of September 30, 2018, contractual maturities of debt were as follows. All amounts represent the principal amounts of the debt instruments outstanding.

	Total	2019	2020	2021	2022	2023	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ —	$ 700	$ —	$ —
4.875% Notes	330	—	—	—	—	—	330
1.125% Notes	314	—	314	—	—	—	—
	$ 1,344	$ —	$ 314	$ —	$ 700	$ —	$ 330

All of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets:

	September 30, 2018	December 31, 2017
	(In millions)	
Current portion of long-term debt:		
1.125% Notes, net of unamortized discount of $18 at September 30, 2018, and $51 at December 31, 2017	$ 296	$ 499
1.625% Notes, net of unamortized discount of $3 at December 31, 2017	—	157
Lease financing obligations	1	1
Debt issuance costs	(1)	(4)
	296	653
Non-current portion of long-term debt:		
5.375% Notes	700	700
4.875% Notes	330	330
Credit Facility	—	300
Debt issuance costs	(11)	(12)
	1,019	1,318
Lease financing obligations	198	198
	$ 1,513	$ 2,169

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions)			
Contractual interest at coupon rate	$ 1	$ 3	$ 5	$ 9
Amortization of the discount	5	8	18	24
	$ 6	$ 11	$ 23	$ 33

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (the Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. In May 2018, we repaid the $300 million outstanding borrowings under the Credit Facility. As of September 30, 2018, no amounts were outstanding under the Credit Facility, and outstanding letters of credit amounting to $6 million reduced our borrowing capacity under the Credit Facility to $494 million.

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee. Certain of our wholly owned subsidiaries guarantee our obligations under the Credit Facility. The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of September 30, 2018, we were in compliance with all financial and non-financial covenants under the Credit Facility and other long-term debt.

Bridge Credit Agreement

In January 2018, we entered into a bridge credit agreement with several banks, which was subsequently terminated in August 2018.

5.375% Notes due 2022

We have $700 million aggregate principal amount of senior notes (the 5.375% Notes) outstanding as of September 30, 2018, which are due November 15, 2022, unless earlier redeemed. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 5.375% Notes; such guarantees mirror those of the Credit Facility. See Note 13,

"Supplemental Condensed Consolidating Financial Information," for more information on the guarantors. The 5.375% Notes contain customary non-financial covenants and change in control provisions.

4.875% Notes due 2025

We have $330 million aggregate principal amount of senior notes (the 4.875% Notes) outstanding as of September 30, 2018, which are due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 4.875% Notes; such guarantees mirror those of the Credit Facility. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

1.125% Cash Convertible Senior Notes due 2020

In the second and third quarters of 2018, we entered into privately negotiated note purchase agreements with certain holders of our outstanding 1.125% cash convertible senior notes due January 15, 2020 (the 1.125% Notes).

In the third quarter of 2018, we repaid $140 million aggregate principal amount of the 1.125% Notes, plus accrued interest, for a total cash payment of $483 million. The $343 million difference between the principal amount extinguished and our cash payment primarily represents the settlement of the 1.125% Notes' embedded cash conversion option feature at fair value (which is a derivative liability we refer to as the 1.125% Conversion Option).

In the second quarter of 2018, we repaid $96 million aggregate principal amount of the 1.125% Notes, plus accrued interest, for a total cash payment of $228 million. As noted above, the $132 million difference between the principal amount extinguished and our cash payment primarily represents the settlement of the embedded cash conversion option feature at fair value.

In the nine months ended September 30, 2018, we have recorded a loss on debt extinguishment of $15 million for the 1.125% Notes purchases, including $10 million in the third quarter of 2018, primarily relating to the acceleration of the debt discount. This loss is reported in "Other expenses (income), net" in the accompanying consolidated statements of operations. No common shares were issued in connection with these transactions.

In connection with the 1.125% Notes purchases, we also entered into privately negotiated termination agreements with each of the counterparties in the second and third quarters of 2018, to partially terminate the Call Spread Overlay, defined and further discussed in Notes 8, "Derivatives," and 9, "Stockholders' Equity." The net cash proceeds from the Call Spread Overlay partial termination transactions partially offset the cash paid to settle the 1.125% Notes.

Following the transactions described above, we have $314 million aggregate principal amount of the 1.125% Notes outstanding at September 30, 2018. Interest is payable semiannually in arrears on January 15 and July 15. The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date. The 1.125% Notes are convertible by the holders within one year of the current balance sheet date until they mature; therefore, they are reported in current portion of long-term debt.

Concurrent with the issuance of the 1.125% Notes, the 1.125% Conversion Option was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the 1.125% Conversion Option fully settles or expires. This initial liability simultaneously reduced the carrying value of the 1.125% Notes' principal amount (effectively an original issuance discount), which is amortized to the principal amount through the recognition of non-cash interest expense over the expected life of the debt. The effective interest rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued is approximately 6%. As of September 30, 2018, the 1.125% Notes had a remaining amortization period of 1.3 years, and their 'if-converted' value exceeded their principal amount by approximately $626 million and $406 million as of September 30, 2018 and December 31, 2017, respectively.

1.625% Convertible Senior Notes due 2044

Conversion. On July 11, 2018, we announced notice of our election to redeem the remaining $64 million aggregate principal amount of the 1.625% convertible senior notes due 2044 (the 1.625% Notes) on August 20, 2018 (the Redemption Date), pursuant to the terms of the indenture. Also pursuant to the indenture, the 1.625% Notes were convertible until August 17, 2018, at a conversion rate of 17.2157 shares of our common stock per $1,000 principal amount equal to the settlement amount (as defined in the related indenture), or approximately $58.09 per share of our common stock.

Through August 17, 2018, we received conversion notices from substantially all of the remaining holders of the 1.625% Notes outstanding. Under the conversions, we paid cash for the remaining $64 million aggregate principal amount and delivered 0.6 million shares of our common stock to the converting holders on the settlement dates in September 2018.

Exchange. In March 2018, we entered into separate, privately negotiated, synthetic exchange agreements with certain holders of our outstanding 1.625% Notes, under which we exchanged $97 million aggregate principal amount and accrued interest for 1.8 million shares of our common stock. We recorded a loss on debt extinguishment, including transaction fees, of $10 million, primarily relating to the inducement premium paid to the bondholders, which is recorded in "Other expenses (income), net" in the accompanying consolidated statements of operations. We did not receive any proceeds from the transaction.

Cross-Default Provisions

The indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	September 30, 2018	December 31, 2017
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 843	$ 522
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 843	$ 522

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, and reported in "Other expenses (income), net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Notes due upon any conversion of such notes.

In the second and third quarters of 2018, in connection with the 1.125% Notes purchases (described in Note 7, "Debt"), we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Notes purchased. In the third quarter of 2018, this resulted in our receipt of $343 million for the settlement of the 1.125% Call Option (which is a derivative asset), and the payment of $306 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $37 million from the Counterparties.

In the second quarter of 2018, this resulted in our receipt of $134 million for the settlement of the 1.125% Call Option, and the payment of $113 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $21 million from the Counterparties.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, "Fair Value Measurements."

As of September 30, 2018, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within twelve months of September 30, 2018, as described in Note 7, "Debt."

9. Stockholders' Equity

1.625% Notes

Conversion. As described in Note 7, "Debt," we issued 0.6 million shares of our common stock in connection with the conversion of the 1.625% Notes in the third quarter of 2018.

Exchange. As described in Note 7, "Debt," we issued 1.8 million shares of our common stock in connection with the exchange of the 1.625% Notes in March 2018.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, "Derivatives," in 2013, we issued 13.5 million warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, if the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net Income (Loss) per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Following the transactions described below, 7.7 million of the 1.125% Warrants remain outstanding.

As described in Note 8, "Derivatives," in the second and third quarters of 2018, we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Notes purchased. In the third quarter of 2018, we paid $306 million to the Counterparties for the termination of 3.4 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in-capital for the same amount.

In the second quarter of 2018, we paid $113 million to the Counterparties for the termination of 2.4 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in capital for the same amount.

Share-Based Compensation

In connection with our equity incentive plans and employee stock purchase plan, approximately 281,000 shares of common stock vested or were purchased, net of shares used to settle employees' income tax obligations, during the nine months ended September 30, 2018.

Share-based compensation is generally recorded to "General and administrative expenses" in the accompanying consolidated statements of operations. Total share-based compensation expense for the three and nine months ended September 30, 2018, amounted to $7 million and $20 million, respectively. Total share-based compensation expense for the three months ended September 30, 2017, amounted to $3 million. Total share-based compensation expense for the nine months ended September 30, 2017, amounted to $38 million, of which $23 million was recorded to "Restructuring and separation costs" in the accompanying consolidated statements of operations.

As of September 30, 2018, there was $41 million of total unrecognized compensation expense related to unvested restricted stock awards (RSAs), performance stock awards (PSAs), and performance stock units (PSUs), which we expect to recognize over a remaining weighted-average period of 2.8 years, 0.4 years and 2.3 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 12.1% for non-executive employees as of September 30, 2018.

Also as of September 30, 2018, there was $11 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.0 years. No stock options were granted or exercised in the nine months ended September 30, 2018.

Activity for RSAs, PSAs and PSUs, for the nine months ended September 30, 2018, is summarized below:

	Restricted Stock Awards	Performance Stock Awards	Performance Stock Units	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2017	401,804	84,762	91,828	578,394	$ 58.35
Granted	353,618	—	212,926	566,544	73.85
Vested	(188,954)	(32,929)	—	(221,883)	57.87
Forfeited	(152,243)	(48,701)	(104,527)	(305,471)	63.67
Unvested balance, September 30, 2018	414,225	3,132	200,227	617,584	70.11

The aggregate fair values of RSAs, PSAs and PSUs granted and vested are presented in the following table:

	Nine Months Ended September 30,	
	2018	2017
	(In millions)	
Granted:		
Restricted stock awards	$ 26	$ 19
Performance stock units	16	16
	$ 42	$ 35
Vested:		
Restricted stock awards	$ 14	$ 21
Performance stock awards	3	15
Performance stock units	—	9
	$ 17	$ 45

10. Restructuring and Separation Costs

Restructuring and separation costs are reported by the same name in the accompanying consolidated statements of operations.

IT Restructuring

Following the 2017 Restructuring Plan noted below, our new executive team has focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we have begun to implement a plan to restructure our information technology department (the IT Restructuring) in the third quarter of 2018.

Expected Costs

In addition to $3 million incurred in the third quarter of 2018, we expect to incur approximately $6 million for the IT Restructuring in the fourth quarter of 2018. We expect such costs to consist primarily of one-time termination benefits and other costs in the Other segment. We will update the total estimated costs for the IT Restructuring in our 2018 Annual Report on Form 10-K.

Costs Incurred

We have incurred expenses under the IT Restructuring as follows:

	Three and Nine Months Ended September 30, 2018			
		Other Restructuring Costs		
	One-Time Termination Benefits	Consulting Fees	Contract Termination Costs	Total
		(In millions)		
Other	$ 2	$ 1	$ —	$ 3

Reconciliation of Liability

For those restructuring and separation costs that require cash settlement (one-time termination benefits and consulting fees), the following table presents a roll-forward of the accrued liability, which is reported in "Accounts payable and accrued liabilities" in the accompanying consolidated balance sheets.

	One-Time Termination Benefits	Other Restructuring Costs	Total
Accrued as of December 31, 2017	$ —	$ —	$ —
Charges	2	1	3
Cash payments	—	—	—
Accrued as of September 30, 2018	$ 2	$ 1	$ 3

2017 Restructuring Plan

Following a management-initiated, broad operational assessment in early 2017, our board of directors approved, and we committed to, a comprehensive restructuring and profitability improvement plan in June 2017 (the 2017 Restructuring Plan). Key activities under this plan to date have included:

- Streamlining of our organizational structure to eliminate redundant layers of management, consolidate regional support services, and other staff reductions to improve efficiency and the speed and quality of decision making;
- Re-design of core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology, to achieve more effective and cost-efficient outcomes;
- Remediation of high-cost provider contracts and enhancement of high quality, cost-effective networks;
- Restructuring, including selective exits, of direct delivery operations; and
- Partnering with the lowest-cost, most effective vendors.

Costs Incurred

In our 2017 Annual Report on Form 10-K, we reported that we had incurred substantially all of the costs associated with the 2017 Restructuring Plan in 2017, amounting to $234 million. In the nine months ended September 30, 2018, we incurred an additional $35 million in such costs, primarily as a result of our further evaluation and write-off of a utilization and care management project terminated because of its inconsistency with the goals of the 2017 Restructuring Plan. We also recorded nominal amounts for one-time termination benefits, true-ups of certain lease contract termination costs, and consulting fees recorded in 2017. As of September 30, 2018, we had incurred $269 million in total costs under the 2017 Restructuring Plan. We expect to complete all activities under the 2017 Restructuring Plan in 2018, with the exception of the cash settlement of lease termination liabilities. We expect to continue to settle those liabilities through 2025, unless the leases are terminated sooner.

The following tables present the major types of such costs by segment. Current and long-lived assets include current and non-current capitalized project costs, and capitalized software determined to be unrecoverable.

	Three Months Ended September 30, 2018				
		Other Restructuring Costs			
	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)				
Health Plans	$ —	$ —	$ —	$ 2	$ 2
	$ —	$ —	$ —	$ 2	$ 2

	Nine Months Ended September 30, 2018				
		Other Restructuring Costs			
	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)				
Health Plans	$ —	$ (1)	$ —	$ 10	$ 9
Other	5	20	1	—	26
	$ 5	$ 19	$ 1	$ 10	$ 35

	Three Months Ended September 30, 2017					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 27	$ 6	$ —	$ —	$ 33
Molina Medicaid Solutions	—	—	8	—	—	8
Other	—	23	35	16	3	77
	$ —	$ 50	$ 49	$ 16	$ 3	$ 118

	Nine Months Ended September 30, 2017					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 27	$ 6	$ —	$ —	$ 33
Molina Medicaid Solutions	—	—	8	—	—	8
Other	35	23	35	24	3	120
	$ 35	$ 50	$ 49	$ 24	$ 3	$ 161

As of September 30, 2018, we had incurred cumulative restructuring costs under the 2017 Restructuring Plan as follows:

			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 33	$ 15	$ —	$ 34	$ 82
Molina Medicaid Solutions	—	—	8	—	—	8
Other	36	39	57	45	2	179
	$ 36	$ 72	$ 80	$ 45	$ 36	$ 269

Reconciliation of Liability

For those restructuring and separation costs that require cash settlement (primarily separation costs, one-time termination benefits, consulting fees and contract termination costs), the following table presents a roll-forward of the accrued liability, which is reported in “Accounts payable and accrued liabilities” in the accompanying

consolidated balance sheets. The adjustments are due to true-ups of costs recorded in 2017.

	Separation Costs - Former Executives	One-Time Termination Benefits	Other Restructuring Costs	Total
		(In millions)		
Accrued as of December 31, 2017	$ 2	$ 11	$ 35	$ 48
Adjustments	—	(1)	10	9
Charges	—	6	2	8
Cash payments	(2)	(15)	(15)	(32)
Accrued as of September 30, 2018	$ —	$ 1	$ 32	$ 33

11. Segments

We have three reportable segments, consisting of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve. Refer to Note 1, “Organization and Basis of Presentation,” for a discussion of our recent divestiture of Pathways.

Recent Developments – Molina Medicaid Solutions Segment

We closed on the sale of MMS to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million, which we received on October 1, 2018. As a result of this transaction, we recognized a pretax gain, net of transaction costs, of $37 million.

Description of Earnings Measures for Reportable Segments

Margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” Medical margin represents the amount earned by the Health Plans segment after medical care costs are deducted from premium revenue. The medical care ratio represents medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

The following table presents total revenue by segment. Inter-segment revenue was insignificant for all periods presented.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions)			
Total revenue:				
Health Plans	$ 4,565	$ 4,899	$ 13,826	$ 14,538
Molina Medicaid Solutions	53	47	152	140
Other	79	85	248	256
Consolidated	$ 4,697	$ 5,031	$ 14,226	$ 14,934

The following table reconciles margin by segment to consolidated income (loss) before income taxes:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions)			
Margin:				
Health Plans	$ 547	$ 557	$ 1,812	$ 1,343
Molina Medicaid Solutions	14	5	26	13
Other	5	2	16	8
Total margin	566	564	1,854	1,364
Add: other operating revenues (1)	230	124	661	379
Add: gain on sale of subsidiary	37	—	37	—
Less: other operating expenses (2)	(538)	(769)	(1,693)	(2,029)
Operating income (loss)	295	(81)	859	(286)
Other expenses, net	36	32	116	10
Income (loss) before income taxes	$ 259	$ (113)	$ 743	$ (296)

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, and investment income and other revenue.
(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, restructuring and separation costs, and impairment losses.

12. Commitments and Contingencies

California Medicaid Expansion Risk Corridor

In October 2018, we entered into contract amendments with the California Department of Health Care Services that retroactively reinstated the Medicaid Expansion risk corridor requirement for the state fiscal year ended June 2017. This risk corridor mandates a minimum medical loss ratio (MLR) of 85% and a maximum MLR of 95%. The estimated impact of such requirement resulted in a reduction to 2016 and 2017 premium revenue totaling approximately $57 million, which we recognized in the quarter ended September 30, 2018.

Regulatory Capital Requirements and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations, and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $2,041 million at September 30, 2018, and $1,691 million at December 31, 2017. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company—Molina Healthcare, Inc.

As of September 30, 2018, our health plans had aggregate statutory capital and surplus of approximately $2,125 million compared with the estimated required minimum aggregate statutory capital and surplus of approximately $1,138 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2018. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

Legal Proceedings

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously collected revenues.

In the ordinary course of business we are involved in legal actions, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and reasonably estimable, but the outcome of legal actions is inherently uncertain and our estimates of such losses could change as a result of further developments of these matters. For certain pending matters, accruals have not been established because such matters have not progressed sufficiently through discovery or factual development to enable us to reasonably estimate a range of possible loss. An adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Steamfitters Local 449 Pension Plan v. Molina Healthcare, Inc., et al. On October 5, 2018, the Steamfitters Local 449 Pension Plan filed its first amended class action securities complaint in the Central District Court of California against the Company and its former executive officers, J. Mario Molina, John C. Molina, Terry P. Bayer, and Rick Hopfer, Case 2:18-cv-03579. The amended complaint purports to seek recovery on behalf of all persons or entities who purchased Molina common stock between October 31, 2014, and August 2, 2017, for alleged violations under Sections 10(b) and 20(a) of the Securities Exchange Act of 1934, as amended, and Rule 10b-5 promulgated thereunder. The plaintiff alleges the defendants misled investors regarding the scalability of the Company's administrative infrastructure during the identified class period. The Company believes it has meritorious defenses to the alleged claims and intends to defend the matter vigorously.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and Children's Health Insurance Program (CHIP) programs. The states and Commonwealth in which we operate our health plans regularly face significant budgetary pressures.

13. Supplemental Condensed Consolidating Financial Information

As discussed in Note 7, "Debt," we have outstanding $700 million aggregate principal amount of 5.375% Notes due November 15, 2022, unless earlier redeemed. At September 30, 2018, the 5.375% Notes were fully and unconditionally guaranteed by certain of our wholly owned subsidiaries on a joint and several basis, with exceptions considered customary for such guarantees.

For all periods presented, the following condensed consolidating financial statements present Molina Healthcare, Inc. (as "Parent Guarantor"), the subsidiary guarantors (as "Other Guarantors"), the subsidiary non-guarantors (as "Non-Guarantors") and "Eliminations", according to the guarantor structure as assessed as of and for the nine months ended September 30, 2018.

In connection with the divestiture of MMS described in Note 11, "Segments," MMS was released as an "Other Guarantor" effective September 30, 2018, and is reported in "Non-Guarantors" for all periods presented.

In connection with the sale of all of the membership interests of our wholly owned subsidiary Pathways Health and Community Support LLC (Pathways) described in Note 1, "Organization and Basis of Presentation," Pathways was released as an "Other Guarantor" effective October 19, 2018, leaving our wholly owned subsidiary Molina Pathways, LLC as the sole subsidiary guarantor as of that date.

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Three Months Ended September 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 273	$ —	$ 4,695	$ (271)	$ 4,697
Expenses:					
Medical care costs	(11)	—	3,801	—	3,790
Cost of service revenue	—	—	111	—	111
General and administrative expenses	243	1	338	(271)	311
Premium tax expenses	—	—	110	—	110
Health insurer fees	—	—	87	—	87
Depreciation and amortization	17	—	8	—	25
Restructuring and separation costs	3	—	2	—	5
Total operating expenses	252	1	4,457	(271)	4,439
Gain on sale of subsidiary	37	—	—	—	37
Operating income (loss)	58	(1)	238	—	295
Interest expense	26	—	—	—	26
Other expenses, net	10	—	—	—	10
Income (loss) before income taxes	22	(1)	238	—	259
Income tax (benefit) expense	(6)	—	68	—	62
Net income (loss) before equity in net earnings (losses) of subsidiaries	28	(1)	170	—	197
Equity in net earnings (losses) of subsidiaries	169	(2)	—	(167)	—
Net income (loss)	$ 197	$ (3)	$ 170	$ (167)	$ 197

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Three Months Ended September 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income (loss)	$ 197	$ (3)	$ 170	$ (167)	$ 197
Other comprehensive gain, net of tax	1	—	1	(1)	1
Comprehensive income (loss)	$ 198	$ (3)	$ 171	$ (168)	$ 198

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Three Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 380	$ (1)	$ 5,031	$ (379)	$ 5,031
Expenses:					
Medical care costs	3	—	4,217	—	4,220
Cost of service revenue	—	—	123	—	123
General and administrative expenses	244	—	518	(379)	383
Premium tax expenses	—	—	106	—	106
Depreciation and amortization	23	—	10	—	33
Restructuring and separation costs	77	—	41	—	118
Impairment losses	—	—	129	—	129
Total operating expenses	347	—	5,144	(379)	5,112
Operating income (loss)	33	(1)	(113)	—	(81)
Interest expense	32	—	—	—	32
Income (loss) before income taxes	1	(1)	(113)	—	(113)
Income tax expense (benefit)	9	(1)	(24)	—	(16)
Net loss before equity in net (losses) earnings of subsidiaries	(8)	—	(89)	—	(97)
Equity in net (losses) earnings of subsidiaries	(89)	(86)	8	167	—
Net loss	$ (97)	$ (86)	$ (81)	$ 167	$ (97)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE LOSS

	Three Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (97)	$ (86)	$ (81)	$ 167	$ (97)
Other comprehensive income, net of tax	—	—	—	—	—
Comprehensive loss	$ (97)	$ (86)	$ (81)	$ 167	$ (97)

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Nine Months Ended September 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 867	$ 2	$ 14,220	$ (863)	$ 14,226
Expenses:					
Medical care costs	(4)	—	11,366	—	11,362
Cost of service revenue	—	—	349	—	349
General and administrative expenses	762	3	1,096	(863)	998
Premium tax expenses	—	—	320	—	320
Health insurer fees	—	—	261	—	261
Depreciation and amortization	53	—	23	—	76
Restructuring and separation costs	28	—	10	—	38
Total operating expenses	839	3	13,425	(863)	13,404
Gain on sale of subsidiary	37	—	—	—	37
Operating income (loss)	65	(1)	795	—	859
Interest expense	90	—	1	—	91
Other expenses, net	25	—	—	—	25
(Loss) income before income taxes	(50)	(1)	794	—	743
Income tax expense	4	—	233	—	237
Net (loss) income before equity in net earnings (losses) of subsidiaries	(54)	(1)	561	—	506
Equity in net earnings (losses) of subsidiaries	560	(6)	—	(554)	—
Net income (loss)	$ 506	$ (7)	$ 561	$ (554)	$ 506

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Nine Months Ended September 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income (loss)	$ 506	$ (7)	$ 561	$ (554)	$ 506
Other comprehensive loss, net of tax	(4)	—	(4)	4	(4)
Comprehensive income (loss)	$ 502	$ (7)	$ 557	$ (550)	$ 502

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Nine Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 1,010	$ 1	$ 14,937	$ (1,014)	$ 14,934
Expenses:					
Medical care costs	10	—	12,812	—	12,822
Cost of service revenue	—	—	369	—	369
General and administrative expenses	799	2	1,440	(1,014)	1,227
Premium tax expenses	—	—	331	—	331
Depreciation and amortization	75	—	34	—	109
Restructuring and separation costs	120	—	41	—	161
Impairment losses	—	—	201	—	201
Total operating expenses	1,004	2	15,228	(1,014)	15,220
Operating income (loss)	6	(1)	(291)	—	(286)
Interest expense	85	—	—	—	85
Other income, net	(75)	—	—	—	(75)
Loss before income taxes	(4)	(1)	(291)	—	(296)
Income tax expense (benefit)	26	(1)	(71)	—	(46)
Net loss before equity in net (losses) earnings of subsidiaries	(30)	—	(220)	—	(250)
Equity in net (losses) earnings of subsidiaries	(220)	(152)	8	364	—
Net loss	$ (250)	$ (152)	$ (212)	$ 364	$ (250)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE LOSS

	Nine Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (250)	$ (152)	$ (212)	$ 364	$ (250)
Other comprehensive income, net of tax	1	—	1	(1)	1
Comprehensive loss	$ (249)	$ (152)	$ (211)	$ 363	$ (249)

CONDENSED CONSOLIDATING BALANCE SHEETS

	September 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 399	$ 2	$ 2,413	$ —	$ 2,814
Investments	106	—	1,706	—	1,812
Receivables	2	—	1,344	—	1,346
Due from (to) affiliates	63	(4)	(59)	—	—
Prepaid expenses and other current assets	293	—	193	—	486
Derivative asset	843	—	—	—	843
Total current assets	1,706	(2)	5,597	—	7,301
Property, equipment, and capitalized software, net	187	—	77	—	264
Goodwill and intangible assets, net	14	—	181	—	195
Restricted investments	—	—	118	—	118
Investment in subsidiaries, net	2,578	74	—	(2,652)	—
Deferred income taxes	48	—	95	—	143
Other assets	40	—	6	(16)	30
	$ 4,573	$ 72	$ 6,074	$ (2,668)	$ 8,051
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 4	$ —	$ 2,038	$ —	$ 2,042
Amounts due government agencies	—	—	1,030	—	1,030
Accounts payable and accrued liabilities	635	—	189	—	824
Deferred revenue	—	—	178	—	178
Current portion of long-term debt	296	—	—	—	296
Derivative liability	843	—	—	—	843
Total current liabilities	1,778	—	3,435	—	5,213
Long-term debt and lease financing obligations	1,217	—	16	(16)	1,217
Other long-term liabilities	17	—	43	—	60
Total liabilities	3,012	—	3,494	(16)	6,490
Total stockholders' equity	1,561	72	2,580	(2,652)	1,561
	$ 4,573	$ 72	$ 6,074	$ (2,668)	$ 8,051

CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 504	$ —	$ 2,682	$ —	$ 3,186
Investments	192	—	2,332	—	2,524
Restricted investments	169	—	—	—	169
Receivables	2	—	869	—	871
Due from (to) affiliates	148	(5)	(143)	—	—
Prepaid expenses and other current assets	103	16	136	(16)	239
Derivative asset	522	—	—	—	522
Total current assets	1,640	11	5,876	(16)	7,511
Property, equipment, and capitalized software, net	223	—	119	—	342
Goodwill and intangible assets, net	15	—	240	—	255
Restricted investments	—	—	119	—	119
Investment in subsidiaries, net	2,306	82	—	(2,388)	—
Deferred income taxes	17	—	101	(15)	103
Other assets	32	—	110	(1)	141
	$ 4,233	$ 93	$ 6,565	$ (2,420)	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 3	$ —	$ 2,189	$ —	$ 2,192
Amounts due government agencies	—	—	1,542	—	1,542
Accounts payable and accrued liabilities	178	14	174	—	366
Deferred revenue	—	—	282	—	282
Current portion of long-term debt	653	—	16	(16)	653
Derivative liability	522	—	—	—	522
Total current liabilities	1,356	14	4,203	(16)	5,557
Long-term debt and lease financing obligations	1,516	—	—	—	1,516
Deferred income taxes	—	—	15	(15)	—
Other long-term liabilities	24	1	37	(1)	61
Total liabilities	2,896	15	4,255	(32)	7,134
Total stockholders' equity	1,337	78	2,310	(2,388)	1,337
	$ 4,233	$ 93	$ 6,565	$ (2,420)	$ 8,471

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by (used in) operating activities	$ 451	$ 1	$ (643)	$ —	$ (191)
Investing activities:					
Purchases of investments	(136)	—	(1,066)	—	(1,202)
Proceeds from sales and maturities of investments	383	—	1,687	—	2,070
Purchases of property, equipment and capitalized software	(16)	—	(8)	—	(24)
Capital contributions to subsidiaries	(122)	—	122	—	—
Dividends from subsidiaries	268	—	(268)	—	—
Change in amounts due to/from affiliates	70	1	(71)	—	—
Other, net	—	—	(23)	—	(23)
Net cash provided by investing activities	447	1	373	—	821
Financing activities:					
Repayment of credit facility	(300)	—	—	—	(300)
Repayment of principal amount of 1.125% Notes	(236)	—	—	—	(236)
Cash paid for partial settlement of 1.125% Conversion Option	(477)	—	—	—	(477)
Cash received for partial termination of 1.125% Call Option	477	—	—	—	477
Cash paid for partial termination of 1.125% Warrants	(419)	—	—	—	(419)
Repayment of principal amount of 1.625% Notes	(64)	—	—	—	(64)
Other, net	7	—	—	—	7
Net cash used in financing activities	(1,012)	—	—	—	(1,012)
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(114)	2	(270)	—	(382)
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	513	—	2,777	—	3,290
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 399	$ 2	$ 2,507	$ —	$ 2,908

	Nine Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 215	$ —	$ 742	$ —	$ 957
Investing activities:					
Purchases of investments	(331)	—	(1,563)	—	(1,894)
Proceeds from sales and maturities of investments	148	—	1,388	—	1,536
Purchases of property, equipment and capitalized software	(67)	—	(18)	—	(85)
Capital contributions to subsidiaries	(363)	2	361	—	—
Dividends from subsidiaries	136	—	(136)	—	—
Change in amounts due to/from affiliates	(100)	—	100	—	—
Other, net	—	—	(33)	—	(33)
Net cash (used in) provided by investing activities	(577)	2	99	—	(476)
Financing activities:					
Proceeds from senior notes offerings, net of issuance costs	325	—	—	—	325
Proceeds from borrowings under credit facility	300	—	—	—	300
Other, net	7	—	—	—	7
Net cash provided by financing activities	632	—	—	—	632
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	270	2	841	—	1,113
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	86	—	2,826	—	2,912
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 356	$ 2	$ 3,667	$ —	$ 4,025

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

FORWARD-LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements included in this quarterly report, other than statements of historical fact, may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, or expected. Those known risks and uncertainties include, but are not limited to, the following:

- *the success of the Company's profit improvement and maintenance initiatives, including the timing and amounts of the benefits realized, and administrative and medical cost savings achieved;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare;"*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk adjustment requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment;*
- *effective management of the Company's medical costs;*
- *the Company's ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of the Company's efforts to retain existing or awarded government contracts, including the success of any protest filings or defenses;*
- *the Company's ability to manage its operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of its care management initiatives;*
- *the Company's ability to consummate and realize benefits from divestitures and acquisitions, including the recently consummated MMS and Pathways divestitures;*
- *the Company's receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *the Company's ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *the Company's estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion medical cost corridors in California, New Mexico, and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*

- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and the Company's ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of the Company's health plan in Puerto Rico, including the resolution of the debt crisis and the effect of the PROMESA law, and the impact of any future significant weather events;*
- *the success and renewal of the Company's duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across the Company's health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to the Company's provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;*
- *changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings, including litigation involving the ACA to which we ourselves are not a direct party;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of the Company's California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize the Company's expansion and growth, repay the Company's outstanding indebtedness at maturity and meet its liquidity needs, including the interest expense and other costs associated with such financing;*
- *the Company's failure to comply with the financial or other covenants in its credit agreement or the indentures governing its outstanding notes;*
- *the sufficiency of the Company's funds on hand to pay the amounts due upon conversion or maturity of its outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm;*
- *the unexpected loss of the leadership of one or more of our senior executives; and*
- *increasing competition and consolidation in the Medicaid industry;*

Readers should refer to the section entitled "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2017 for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This Quarterly Report on Form 10-Q and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2017.

ABOUT MOLINA HEALTHCARE

OUR MISSION IS TO PROVIDE QUALITY HEALTHCARE TO PEOPLE RECEIVING GOVERNMENT ASSISTANCE.

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments,

consisting of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

OVERVIEW - FINANCIAL SUMMARY

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions, except per-share amounts)			
Revenue:				
Premium revenue	$ 4,337	$ 4,777	$ 13,174	$ 14,165
Premium tax revenue	110	106	320	331
Health insurer fees reimbursed	83	—	248	—
Investment income and other revenue	37	18	93	48
Operating expenses:				
Medical care costs	3,790	4,220	11,362	12,822
General and administrative expenses	311	383	998	1,227
Premium tax expenses	110	106	320	331
Health insurer fees	87	—	261	—
Gain on sale of subsidiary	37	—	37	—
Operating income (loss)	295	(81)	859	(286)
Interest expense	26	32	91	85
Other expenses (income), net	10	—	25	(75)
Income tax expense (benefit)	62	(16)	237	(46)
Net income (loss)	197	(97)	506	(250)
Operating Statistics:				
Ending total membership	4.0	4.5	4.0	4.5
MCR [1]	87.4%	88.3 %	86.2%	90.5 %
G&A ratio [2]	6.6%	7.6 %	7.0%	8.2 %
Premium tax ratio [1]	2.5%	2.2 %	2.4%	2.3 %
Effective income tax rate	24.0%	14.6 %	31.9%	15.5 %
Net profit (loss) margin [2]	4.2%	(1.9)%	3.6%	(1.7)%
Net income (loss) per diluted share	$ 2.90	$ (1.70)	$ 7.60	$ (4.44)

(1) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) Net profit margin represents net income as a percentage of total revenue. G&A ratio represents general and administrative expenses as a percentage of total revenue.

CONSOLIDATED RESULTS

See tables below, under "Summary of Significant Items," for details relating to significant non-run rate items, such as impairment losses, restructuring costs and material out of period adjustments to premiums or medical care costs.

NET INCOME AND OPERATING INCOME

Net income for the third quarter of 2018 amounted to $197 million, or $2.90 per diluted share, compared with a net loss of $97 million, or $1.70 per diluted share for the third quarter of 2017. Operating income for the third quarter of 2018 amounted to $295 million, compared with an operating loss of $81 million in the third quarter of 2017. The

year-over-year improvement is mainly driven by a decline in the medical care ratio (MCR). Additionally, results for the third quarter of 2017 reflect $247 million in impairment and restructuring charges, or $3.16 per diluted share.

Net income for the nine months ended September 30, 2018 was $506 million, or $7.60 per diluted share, compared with a net loss of $250 million, or $4.44 per diluted share for the nine months ended September 30, 2017. Operating income for the nine months ended September 30, 2018 amounted to $859 million, compared with an operating loss of $286 million for the nine months ended September 30, 2017. The year-over-year improvement is mainly driven by a decline in the MCR. Additionally, results for the nine months ended September 30, 2017 reflect $362 million in impairment and restructuring charges, or $4.69 per diluted share.

PREMIUM REVENUE

Premium revenue decreased $440 million in the third quarter of 2018, when compared with the third quarter of 2017. Member months declined 11%, partially offset by a per-member per-month (PMPM) revenue increase of 2%. Lower premium revenue was driven by a decrease in Marketplace membership, partially offset by Marketplace premium rate increases. In addition, we recognized a $57 million reduction in revenues for a retroactive California Medicaid Expansion risk corridor for the state's 2017 fiscal year in the third quarter of 2018.

Premium revenue decreased $991 million in the nine months ended September 30, 2018, when compared with the nine months ended September 30, 2017. Member months declined 13%, partially offset by a revenue PMPM increase of 6%, primarily relating to Marketplace membership as noted above.

PREMIUM TAX REVENUE AND EXPENSES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.5% for the third quarter of 2018 compared with 2.2% for the third quarter of 2017; and 2.4% compared with 2.3% for the nine months ended September 30, 2018 and 2017, respectively. At our California health plan, the premium tax rate is based on the prior state fiscal year enrollment. Because the California health plan's enrollment and premium revenue have declined in 2018, premium taxes recognized in 2018 have driven a higher premium tax ratio in 2018.

INVESTMENT INCOME AND OTHER REVENUE

Investment income and other revenue increased to $37 million for the third quarter of 2018, compared with $18 million for the third quarter of 2017, and increased to $93 million for the nine months ended September 30, 2018, compared with $48 million for the nine months ended September 30, 2017. The current quarter and year-to-date increases were a result of two factors. First, investment income improved due to annualized portfolio yields, and, for the nine months ended September 30, 2018, we had higher average invested assets. In addition, other revenue increased in the third quarter and nine months ended September 30, 2018, due to administrative services fees earned in our Washington health plan following that state's decision to transition the management of Medicaid pharmacy benefits to an administrative services-based arrangement in 2018.

MEDICAL CARE RATIO (MCR)

Overall, the MCR decreased to 87.4% in the third quarter of 2018, from 88.3% in the third quarter of 2017. Excluding the retroactive California Medicaid Expansion risk corridor adjustment and a small benefit from the 2017 Marketplace cost sharing reduction (CSR), the MCR would have been 86.4% in the third quarter of 2018. Excluding the change in Marketplace premium deficiency reserve for 2017 dates of service, the MCR for the third quarter of 2017 would have been 89.0%. The improvement was mainly due to a decrease in the Medicaid and Marketplace MCRs, partially offset by an increase in the Medicare MCR.

Overall, the MCR improved to 86.2% for the nine months ended September 30, 2018, from 90.5% in the nine months ended September 30, 2017. Excluding adjustments for the retroactive California Medicaid Expansion risk corridor, and the combined benefit of the 2017 Marketplace risk adjustment and CSR reimbursement, the MCR for the nine months ended September 30, 2018 would have been 86.9%. Excluding the change in Marketplace premium deficiency reserve for 2017 dates of service, the MCR for the nine months ended September 30, 2017 would have been 90.2%. The improvement was due to a decrease in the MCRs across our Medicaid, Medicare and Marketplace plans.

GENERAL AND ADMINISTRATIVE (G&A) EXPENSES

The general and administrative (G&A) expense ratio decreased to 6.6% for the third quarter of 2018, from 7.6% for the third quarter of 2017, and decreased to 7.0% for the nine months ended September 30, 2018, from 8.2% for the

nine months ended September 30, 2017. This year-over-year improvement was primarily the result of continued G&A cost containment.

HEALTH INSURER FEES (HIF)

Health insurer fees amounted to $87 million and $261 million, and health insurer fees reimbursed amounted to $83 million and $248 million, in the third quarter of 2018 and the nine months ended September 30, 2018, respectively.

There were no HIF expensed or reimbursed in 2017 due to the HIF moratorium under the Consolidated Appropriations Act of 2016.

GAIN ON SALE OF SUBSIDIARY

We closed on the sale of Molina Medicaid Solutions (MMS) to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million, which we received on October 1, 2018. As a result of this transaction, we recognized a pretax gain, net of transaction costs, of $37 million, or $0.42 per diluted share in the third quarter of 2018.

INTEREST EXPENSE

Interest expense was $26 million for the third quarter of 2018, compared with $32 million for the third quarter of 2017. Interest expense was $91 million for the nine months ended September 30, 2018, compared with $85 million for the nine months ended September 30, 2017. As further described below in “Liquidity,” year to date we have reduced the principal amount of outstanding debt by $697 million.

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $5 million and $8 million in the third quarter of 2018 and 2017, respectively and $18 million and $24 million in the nine months ended September 30, 2018 and 2017, respectively. See further discussion in Notes to Consolidated Financial Statements, Note 7, “Debt.”

OTHER EXPENSES (INCOME), NET

In the three and nine months ended September 30, 2018, we recorded other expenses of $10 million and $25 million, respectively, due to the loss on debt extinguishment resulting from our 1.125% Notes repayments and the 1.625% Notes exchange. These transactions are described further in Notes to Consolidated Financial Statements, Note 7, “Debt.” In early 2017, we received a $75 million fee in connection with a terminated Medicare acquisition.

INCOME TAXES

The provision for income taxes was recorded at an effective rate of 24.0% for the third quarter of 2018, compared with a benefit of 14.6% for the third quarter of 2017, and 31.9% for the nine months ended September 30, 2018, compared with a benefit of 15.5% for the nine months ended September 30, 2017. The effective tax rate for 2018 differs from 2017 as a result of the reduction in the federal statutory rate from 35% to 21% under the TCJA and higher non-deductible expenses in 2018, primarily related to the non-deductible HIF, as a percentage of pre-tax income (loss). The HIF was not applicable in 2017 due to the 2017 HIF moratorium.

SUMMARY OF SIGNIFICANT ITEMS

The tables below summarize the impact of certain items significant to our financial performance in the periods presented. The individual items presented below increase (decrease) income (loss) before income tax expense (benefit).

	Three Months Ended September 30, 2018		Nine Months Ended September 30, 2018	
	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]
Retroactive California Medicaid Expansion risk corridor for the state fiscal year ended June 30, 2017	$ (57)	$ (0.65)	$ (57)	$ (0.67)
Marketplace risk adjustment, for 2017 dates of service	—	—	56	0.66
Marketplace CSR subsidies, for 2017 dates of service	5	0.06	81	0.95
Gain on sale of subsidiary	37	0.42	37	0.43
Restructuring costs [2]	(5)	(0.06)	(38)	(0.45)
Loss on debt extinguishment	(10)	(0.12)	(25)	(0.33)
	$ (30)	$ (0.35)	$ 54	$ 0.59

	Three Months Ended September 30, 2017		Nine Months Ended September 30, 2017	
	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]
Restructuring costs [2]	$ (118)	$ (1.39)	$ (161)	$ (1.92)
Impairment losses [3]	(129)	(1.77)	(201)	(2.77)
Change in Marketplace premium deficiency reserve for 2017 service dates	30	0.33	(40)	(0.45)
Termination fee received for terminated Medicare acquisition	—	—	75	0.84
	$ (217)	$ (2.83)	$ (327)	$ (4.30)

(1) Except for certain items that are not deductible for tax purposes, per diluted share amounts are generally calculated at the statutory income tax rates of 22% for 2018, and 37% for 2017.
(2) For more information, refer to Notes to Consolidated Financial Statements, Note 10, “Restructuring and Separation Costs.”
(3) In the nine months ended September 30, 2017, we recorded non-cash impairment losses for goodwill and intangibles, primarily relating to our Pathways subsidiary.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums, and our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the MCR, which represents medical care costs as a percentage of premium revenue. Therefore, the underlying margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” The service margin is equal to service revenue minus cost of service revenue. Management’s discussion and analysis of the changes in the individual components of medical margin and service margin follows.

SEGMENT SUMMARY

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2018	2017	2018	2017
	(In millions)			
Health Plans segment medical margin [1]	$ 547	$ 557	$ 1,812	$ 1,343
Molina Medicaid Solutions segment service margin [2]	14	5	26	13
Other segment service margin [2]	5	2	16	8
Total margin	$ 566	$ 564	$ 1,854	$ 1,364
Health Plans segment medical care ratio	87.4%	88.3%	86.2%	90.5%

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 13 states and the Commonwealth of Puerto Rico. As of September 30, 2018, these health plans served approximately 4.0 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Marketplace members, most of whom receive government premium subsidies.

RECENT DEVELOPMENTS

Renewal of Medicaid Contracts

Year to date in 2018, we renewed Medicaid contracts in Washington, Florida and Puerto Rico as follows:

- In May 2018, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to enter into a managed care contract for the eight remaining regions of the state's Apple Health Integrated Managed Care program, in addition to the two regions previously awarded to us. We were selected by HCA for the following regions: Greater Columbia, King, North Sound, Pierce, and Spokane beginning January 1, 2019; and Salish, Thurston-Mason, and Great Rivers beginning January 1, 2020. As of September 30, 2018, we served approximately 738,000 Medicaid members in Washington, which represented premium revenue of $1,558 million for the nine months ended September 30, 2018.

- In June 2018, our Florida health plan was awarded comprehensive Medicaid Managed Care contracts by the Florida Agency for Health Care Administration (AHCA) in Regions 8 and 11 of the Florida Statewide Medicaid Managed Care Invitation to Negotiate. As of September 30, 2018, we served approximately 96,000 Medicaid members in those regions, which represented premium revenue of approximately $346 million for the nine months ended September 30, 2018. Services under the new contract are expected to begin on January 1, 2019. We will be serving both the Medicaid and long-term care populations in the two regions.

- In July 2018, our Puerto Rico health plan was selected by the Puerto Rico Health Insurance Administration to be one of the organizations to administer the Commonwealth's new Medicaid Managed Care contract. We expect to serve approximately 290,000 members under the new contract. The base contract runs for a period of three years with an optional one-year extension. As of September 30, 2018, we served approximately 320,000 Medicaid members in the East and Southwest regions of Puerto Rico, which represented premium revenue of $549 million for the nine months ended September 30, 2018.

TRENDS AND UNCERTAINTIES

Upcoming Contract Reprocurements

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates; such dates are subject to change. Premium revenue is stated in millions.

State Health Plan	Medicaid Program(s)	Membership as of September 30, 2018	Premium Revenue Nine Months Ended September 30, 2018	Anticipated Award Date	Anticipated Effective Date
Texas	ABD, MMP	99,000	$ 1,460	Q2 2019	6/1/2020
Texas	TANF, CHIP	124,000	236	Q3 2019	9/1/2020

New Mexico Health Plan Update. In our Annual Report on Form 10-K for 2017, we reported that we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. A hearing was held on our judicial protest on October 17, 2018, with a decision expected in the fourth quarter of 2018. Regardless of the court's decision on our protest, we would have further rights of appeal. We are continuing to manage the business in run-off until such time as a different outcome is determined. As of September 30, 2018, we served approximately 206,000 Medicaid members in New Mexico, which represented premium revenue of $891 million for the nine months ended September 30, 2018.

Medicare-Medicaid Plans (MMP) Update. The current authority for three of our MMP programs, in California, Illinois and Ohio, ends December 31, 2019. In July 2018, the Ohio Medicaid agency submitted a request to Centers for Medicare and Medicaid Services (CMS) for a three-year extension of its duals demonstration program, through December 31, 2022. We estimate annualized premium revenues of approximately $690 million in 2018 under our Ohio MMP program.

In June 2018, the California Medicaid agency submitted a request to CMS for a one-year extension of its duals demonstration program, through December 31, 2020. We estimate annualized premium revenues of approximately $180 million in 2018 under our California MMP program.

As of October 31, 2018, the Illinois Medicaid agency had not yet submitted an extension request to CMS for its duals demonstration program. We estimate annualized premium revenues of approximately $80 million in 2018 under our Illinois MMP program.

Pressures on Medicaid Funding

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following:

- Ending the entitlement nature of Medicaid by capping future increases in federal health spending for these programs, and shifting more of the risk for health costs in the future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap");
- Requiring Medicaid beneficiaries to work;
- Limiting the amount of lifetime benefits for Medicaid beneficiaries; and
- Numerous other potential changes and reforms.

ACA and the Marketplace

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, are subject to substantial uncertainty. While we continue to monitor the current political and programmatic developments pertaining to the Marketplace, in 2018 we have taken various actions to improve our Marketplace operating performance. The action with the greatest impact to year-to-date results, effective January 1, 2018, was the significant increase to premium rates (averaging 58%).

We have entered into contracts to participate in nine Marketplace states, including the Utah and Wisconsin Marketplaces, effective January 2019.

MEMBERSHIP

The following tables set forth our Health Plans membership as of the dates indicated:

	September 30, 2018	December 31, 2017	September 30, 2017
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,436,000	2,457,000	2,451,000
Medicaid Expansion	664,000	668,000	662,000
Aged, Blind or Disabled (ABD)	415,000	412,000	411,000
Total Medicaid	3,515,000	3,537,000	3,524,000
Medicare-Medicaid Plan (MMP) – Integrated [1]	55,000	57,000	58,000
Medicare Special Needs Plans (Medicare)	45,000	44,000	44,000
Total Medicare	100,000	101,000	102,000
Total Medicaid and Medicare	3,615,000	3,638,000	3,626,000
Marketplace	384,000	815,000	877,000
	3,999,000	4,453,000	4,503,000
Ending Membership by Health Plan:			
California	623,000	746,000	751,000
Florida	395,000	625,000	641,000
Illinois	223,000	165,000	163,000
Michigan	394,000	398,000	399,000
New Mexico	234,000	253,000	256,000
Ohio	315,000	327,000	343,000
Puerto Rico	320,000	314,000	306,000
South Carolina	117,000	116,000	113,000
Texas	436,000	430,000	444,000
Washington	770,000	777,000	770,000
Other [2]	172,000	302,000	317,000
	3,999,000	4,453,000	4,503,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) "Other" includes the Idaho, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

Premiums by Program

The amount of the premiums paid to our health plans vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a PMPM basis, for the nine months ended September 30, 2018. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 340.00	$ 190.00
Medicaid Expansion	300.00	510.00	360.00
ABD	520.00	1,530.00	1,030.00
MMP – Integrated	1,360.00	3,190.00	2,170.00
Medicare	600.00	1,270.00	1,170.00
Marketplace	250.00	650.00	380.00

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, MCR and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended September 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.4	$ 1,379	$ 187.03	$ 1,228	$ 166.41	89.0%	$ 151
Medicaid Expansion	2.0	671	333.11	640	317.62	95.3	31
ABD	1.2	1,322	1,054.92	1,186	946.38	89.7	136
Total Medicaid	10.6	3,372	316.86	3,054	286.86	90.5	318
MMP	0.2	353	2,159.72	323	1,981.45	91.7	30
Medicare	0.1	156	1,157.71	121	895.25	77.3	35
Total Medicare	0.3	509	1,706.95	444	1,490.63	87.3	65
Total Medicaid and Medicare	10.9	3,881	354.70	3,498	319.63	90.1	383
Marketplace	1.2	456	394.02	292	252.61	64.1	164
	12.1	$ 4,337	$ 358.46	$ 3,790	$ 313.23	87.4%	$ 547

	Three Months Ended September 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.5	$ 1,392	$ 185.95	$ 1,242	$ 165.76	89.1%	$ 150
Medicaid Expansion	2.0	773	385.58	667	332.99	86.4	106
ABD	1.2	1,288	1,038.85	1,259	1,016.06	97.8	29
Total Medicaid	10.7	3,453	321.77	3,168	295.23	91.8	285
MMP	0.2	378	2,263.07	336	2,013.67	89.0	42
Medicare	0.1	163	1,231.61	126	951.01	77.2	37
Total Medicare	0.3	541	1,806.26	462	1,543.05	85.4	79
Total Medicaid and Medicare	11.0	3,994	362.04	3,630	329.08	90.9	364
Marketplace	2.7	783	301.72	590	227.22	75.3	193
	13.7	$ 4,777	$ 350.55	$ 4,220	$ 309.68	88.3%	$ 557

	Nine Months Ended September 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	22.3	$ 4,145	$ 186.12	$ 3,705	$ 166.35	89.4%	$ 440
Medicaid Expansion	6.1	2,184	359.37	1,957	322.01	89.6	227
ABD	3.7	3,864	1,034.25	3,550	950.11	91.9	314
Total Medicaid	32.1	10,193	317.70	9,212	287.10	90.4	981
MMP	0.5	1,077	2,173.90	941	1,899.26	87.4	136
Medicare	0.4	470	1,171.59	385	959.54	81.9	85
Total Medicare	0.9	1,547	1,725.71	1,326	1,479.06	85.7	221
Total Medicaid and Medicare	33.0	11,740	355.96	10,538	319.50	89.8	1,202
Marketplace	3.8	1,434	379.91	824	218.44	57.5	610
	36.8	$ 13,174	$ 358.42	$ 11,362	$ 309.12	86.2%	$ 1,812

	Nine Months Ended September 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	22.8	$ 4,185	$ 183.69	$ 3,861	$ 169.44	92.2%	$ 324
Medicaid Expansion	6.1	2,376	389.14	2,045	334.93	86.1	331
ABD	3.6	3,769	1,033.45	3,634	996.58	96.4	135
Total Medicaid	32.5	10,330	317.49	9,540	293.21	92.4	790
MMP	0.5	1,083	2,189.96	976	1,974.22	90.1	107
Medicare	0.4	449	1,142.68	369	939.21	82.2	80
Total Medicare	0.9	1,532	1,726.39	1,345	1,516.09	87.8	187
Total Medicaid and Medicare	33.4	11,862	354.88	10,885	325.66	91.8	977
Marketplace	8.4	2,303	276.27	1,937	232.31	84.1	366
	41.8	$ 14,165	$ 339.19	$ 12,822	$ 307.03	90.5%	$ 1,343

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid

The Medicaid MCR decreased to 90.5% in the third quarter of 2018, from 91.8% in the third quarter of 2017, and decreased to 90.4% for the nine months ended September 30, 2018, from 92.4% for the nine months ended September 30, 2017. Excluding recognition of the $57 million retroactive California Medicaid Expansion risk corridor adjustment, the Medicaid MCR would have been 89.0% in the third quarter of 2018, and 89.9% for the nine months ended September 30, 2018. The decreases were mainly due to improved performance for ABD and TANF and CHIP, partially offset by a decline in performance for Medicaid Expansion.

TANF and CHIP. The MCR for TANF and CHIP improved to 89.0% in the third quarter of 2018, from 89.1% in the third quarter of 2017; and improved to 89.4% for the nine months ended September 30, 2018, from 92.2% for the nine months ended September 30, 2017. The year over year improvement was primarily due to improved performance at our Illinois, California and Texas health plans, partially offset by a decline in performance at our New Mexico health plan.

Medicaid Expansion. The MCR for Medicaid Expansion was 95.3% in the third quarter of 2018, up from 86.4% in the third quarter of 2017, and was 89.6% for the nine months ended September 30, 2018, up from 86.1% for the nine months ended September 30, 2017. Excluding recognition of the $57 million retroactive California Medicaid Expansion risk corridor adjustment, the Medicaid Expansion MCR would have been 87.9% in the third quarter of 2018, and 87.3% for the nine months ended September 30, 2018. These increases were primarily due to the premium reduction we received in California in July 2017. Medicaid Expansion has generally performed well because rate adequacy has trended favorably, and membership is concentrated in our higher performing health plans, particularly California, Michigan, and Washington.

ABD. The MCR for ABD improved to 89.7% in the third quarter of 2018, compared with 97.8% in the third quarter of 2017; and improved to 91.9% for the nine months ended September 30, 2018, from 96.4% for the nine months ended September 30, 2017. The year-over-year improvement can be attributed to a number of actions, including our management of high acuity members.

Medicare and MMP

The overall MCR for the combined Medicare programs increased to 87.3% in the third quarter of 2018, from 85.4% in the third quarter of 2017, but improved to 85.7% for the nine months ended September 30, 2018, from 87.8% for the nine months ended September 30, 2017. The MCR increase in the third quarter of 2018 is mainly due to certain premium transfers between the MMP and Medicaid programs that had no impact on consolidated results, and higher inpatient costs in our MMP program. The improvement for the nine months ended September 30, 2018 was partly driven by the recognition of additional MMP at-risk revenue for dates of service in 2016 and 2017, resulting from ultimate settlements with CMS that were higher than the original estimates recognized in those periods. The Medicare business also benefited from favorable medical care trends and improved medical management of inpatient utilization for this population. Accurate and complete risk score documentation and effective management of chronic and high acuity conditions are critical to the successful management of this program.

Marketplace

Lower Marketplace premium revenue was driven by a decrease in membership of over 50%, partially offset by premium rate increases. As previously disclosed, we increased premium rates and reduced our Marketplace presence effective January 1, 2018, as part of our overall program to improve profitability.

The MCR for the Marketplace program decreased to 64.1% in the third quarter of 2018, from 75.3% in the third quarter of 2017; and improved to 57.5% in the nine months ended September 30, 2018, from 84.1% for the nine months ended September 30, 2017. Excluding the benefit of the 2017 Marketplace cost sharing reduction (CSR) reimbursement recognized in 2018, the MCR for the third quarter of 2018 would have been 65.3%. Excluding the combined benefit of the 2017 Marketplace risk adjustment and CSR reimbursement recognized in 2018, the MCR for the nine months ended September 30, 2018 would have been 65.7%. Excluding the changes in Marketplace premium deficiency reserves for 2017 dates of service, the MCR for the third quarter of 2017 would have been 79.1%, and 82.4% for the nine months ended September 30, 2017. The year over year improvement is mainly due to the overall program to improve profitability, as discussed above.

FINANCIAL PERFORMANCE BY STATE

The following tables summarize member months, premium revenue, medical care costs, MCR, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Medicaid and Medicare

	Three Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.7	$ 435	$ 249.00	$ 446	$ 255.22	102.5%	$ (11)
Florida	1.0	388	363.16	362	339.33	93.4	26
Illinois	0.7	207	312.72	182	274.98	87.9	25
Michigan	1.1	397	350.05	321	282.49	80.7	76
New Mexico	0.6	304	471.66	275	426.69	90.5	29
Ohio	0.9	584	624.84	532	568.93	91.1	52
Puerto Rico	1.0	179	189.65	162	171.96	90.7	17
South Carolina	0.4	124	354.53	112	318.56	89.9	12
Texas	0.7	577	848.47	525	772.14	91.0	52
Washington	2.3	511	226.77	444	197.04	86.9	67
Other [1]	0.5	175	334.29	137	261.49	78.2	38
	10.9	$ 3,881	$ 354.70	$ 3,498	$ 319.63	90.1%	$ 383

	Three Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.9	$ 601	$ 322.97	$ 563	$ 302.67	93.7%	$ 38
Florida	1.0	388	355.59	390	356.83	100.3	(2)
Illinois	0.5	137	287.69	138	289.36	100.6	(1)
Michigan	1.2	390	337.17	345	298.83	88.6	45
New Mexico	0.7	304	429.07	277	390.91	91.1	27
Ohio	0.9	549	560.06	483	492.61	88.0	66
Puerto Rico	1.0	191	202.59	159	168.25	83.1	32
South Carolina	0.3	113	332.48	101	297.74	89.6	12
Texas	0.7	541	778.50	506	728.19	93.5	35
Washington	2.3	612	276.73	522	236.11	85.3	90
Other [1]	0.5	168	294.99	146	256.99	87.1	22
	11.0	$ 3,994	$ 362.04	$ 3,630	$ 329.08	90.9%	$ 364

	Nine Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.3	$ 1,446	$ 270.63	$ 1,299	$ 243.14	89.8%	$ 147
Florida	3.2	1,147	356.15	1,069	331.93	93.2	78
Illinois	1.8	551	308.45	474	265.47	86.1	77
Michigan	3.4	1,161	343.08	983	290.26	84.6	178
New Mexico	2.0	936	469.19	875	438.70	93.5	61
Ohio	2.8	1,670	590.71	1,474	521.26	88.2	196
Puerto Rico	2.9	549	190.34	501	173.83	91.3	48
South Carolina	1.1	369	350.94	323	306.76	87.4	46
Texas	2.1	1,715	831.21	1,554	753.31	90.6	161
Washington	6.8	1,666	245.40	1,544	227.41	92.7	122
Other (1)	1.6	530	323.84	442	269.98	83.4	88
	33.0	$ 11,740	$ 355.96	$ 10,538	$ 319.50	89.8%	$ 1,202

	Nine Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.6	$ 1,771	$ 316.83	$ 1,586	$ 283.82	89.6%	$ 185
Florida	3.2	1,132	347.41	1,112	341.15	98.2	20
Illinois	1.6	447	284.18	492	312.54	110.0	(45)
Michigan	3.5	1,162	332.60	1,035	296.28	89.1	127
New Mexico	2.2	933	431.70	887	410.24	95.0	46
Ohio	2.9	1,598	541.56	1,434	486.02	89.7	164
Puerto Rico	2.9	553	190.99	513	177.01	92.7	40
South Carolina	1.0	329	325.43	301	298.43	91.7	28
Texas	2.1	1,592	760.76	1,468	701.32	92.2	124
Washington	6.7	1,835	275.60	1,603	240.83	87.4	232
Other (1)	1.7	510	292.93	454	261.01	89.1	56
	33.4	$ 11,862	$ 354.88	$ 10,885	$ 325.66	91.8%	$ 977

(1) "Other" includes the Idaho, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

Health Plans Segment Financial Data — Marketplace

	Three Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 49	$ 309.04	$ 37	$ 235.63	76.2%	$ 12
Florida	0.2	66	548.60	45	362.39	66.1	21
Michigan	—	12	233.51	7	145.13	62.1	5
New Mexico	0.1	28	419.20	18	249.33	59.5	10
Ohio	0.1	27	485.08	18	336.86	69.4	9
Texas	0.6	228	357.54	134	209.80	58.7	94
Washington	—	44	656.70	34	518.75	79.0	10
Other (1)	—	2	NM	(1)	NM	NM	3
	1.2	$ 456	$ 394.02	$ 292	$ 252.61	64.1%	$ 164

	Three Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.3	$ 88	$ 208.19	$ 63	$ 147.87	71.0%	$ 25
Florida	0.9	260	313.36	235	283.13	90.4	25
Michigan	—	14	212.08	10	150.24	70.8	4
New Mexico	0.1	29	383.58	20	269.28	70.2	9
Ohio	0.1	23	386.09	20	364.31	94.4	3
Texas	0.7	183	291.14	109	172.70	59.3	74
Washington	0.1	42	327.40	33	256.52	78.3	9
Other (1)	0.5	144	375.83	100	259.15	69.0	44
	2.7	$ 783	$ 301.72	$ 590	$ 227.22	75.3%	$ 193

	Nine Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.6	$ 171	$ 326.82	$ 89	$ 169.98	52.0%	$ 82
Florida	0.5	211	491.13	67	155.24	31.6	144
Michigan	0.1	40	248.24	23	145.38	58.6	17
New Mexico	0.2	93	426.07	55	247.57	58.1	38
Ohio	0.2	84	466.75	58	324.91	69.6	26
Texas	2.0	679	330.92	440	214.65	64.9	239
Washington	0.2	139	654.78	105	497.00	75.9	34
Other (1)	—	17	NM	(13)	NM	NM	30
	3.8	$ 1,434	$ 379.91	$ 824	$ 218.44	57.5%	$ 610

	Nine Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.2	$ 241	$ 193.33	$ 156	$ 124.32	64.3%	$ 85
Florida	2.8	821	296.14	758	273.55	92.4	63
Michigan	0.2	41	187.96	27	126.76	67.4	14
New Mexico	0.2	82	338.18	62	256.05	75.7	20
Ohio	0.2	68	365.35	64	346.93	95.0	4
Texas	2.1	517	252.32	351	171.57	68.0	166
Washington	0.4	123	315.95	128	327.51	103.7	(5)
Other (1)	1.3	410	333.05	391	316.86	95.1	19
	8.4	$ 2,303	$ 276.27	$ 1,937	$ 232.31	84.1%	$ 366

(1) "Other" includes the Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results. We terminated Marketplace operations at these plans effective January 1, 2018, so the ratios for 2018 periods are not meaningful (NM).

Health Plans Segment Financial Data — Total

	Three Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.9	$ 484	$ 253.96	$ 483	$ 253.60	99.9%	$ 1
Florida	1.2	454	382.20	407	341.70	89.4	47
Illinois	0.7	207	312.72	182	274.98	87.9	25
Michigan	1.1	409	345.28	328	276.88	80.2	81
New Mexico	0.7	332	466.63	293	409.68	87.8	39
Ohio	1.0	611	616.95	550	555.83	90.1	61
Puerto Rico	1.0	179	189.65	162	171.96	90.7	17
South Carolina	0.4	124	354.53	112	318.56	89.9	12
Texas	1.3	805	611.01	659	500.14	81.9	146
Washington	2.3	555	239.25	478	206.38	86.3	77
Other [1]	0.5	177	336.18	136	260.19	77.4	41
	12.1	$ 4,337	$ 358.46	$ 3,790	$ 313.23	87.4%	$ 547

	Three Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.2	$ 689	$ 301.64	$ 626	$ 273.90	90.8%	$ 63
Florida	1.9	648	337.40	625	325.09	96.4	23
Illinois	0.5	137	287.69	138	289.36	100.6	(1)
Michigan	1.2	404	330.27	355	290.63	88.0	49
New Mexico	0.8	333	424.61	297	378.98	89.3	36
Ohio	1.0	572	550.75	503	485.61	88.2	69
Puerto Rico	1.0	191	202.59	159	168.25	83.1	32
South Carolina	0.3	113	332.48	101	297.74	89.6	12
Texas	1.4	724	546.57	615	463.83	84.9	109
Washington	2.4	654	279.52	555	237.23	84.9	99
Other [1]	1.0	312	327.47	246	257.86	78.7	66
	13.7	$ 4,777	$ 350.55	$ 4,220	$ 309.68	88.3%	$ 557

	Nine Months Ended September 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.9	$ 1,617	$ 275.64	$ 1,388	$ 236.61	85.8%	$ 229
Florida	3.7	1,358	372.07	1,136	311.09	83.6	222
Illinois	1.8	551	308.45	474	265.47	86.1	77
Michigan	3.5	1,201	338.83	1,006	283.77	83.7	195
New Mexico	2.2	1,029	464.92	930	419.78	90.3	99
Ohio	3.0	1,754	583.29	1,532	509.52	87.4	222
Puerto Rico	2.9	549	190.34	501	173.83	91.3	48
South Carolina	1.1	369	350.94	323	306.76	87.4	46
Texas	4.1	2,394	581.74	1,994	484.70	83.3	400
Washington	7.0	1,805	257.82	1,649	235.59	91.4	156
Other [1]	1.6	547	334.26	429	262.27	78.5	118
	36.8	$ 13,174	$ 358.42	$ 11,362	$ 309.12	86.2%	$ 1,812

	Nine Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	6.8	$ 2,012	$ 294.26	$ 1,742	$ 254.67	86.5%	$ 270
Florida	6.0	1,953	323.86	1,870	310.09	95.7	83
Illinois	1.6	447	284.18	492	312.54	110.0	(45)
Michigan	3.7	1,203	324.12	1,062	286.35	88.3	141
New Mexico	2.4	1,015	422.25	949	394.66	93.5	66
Ohio	3.1	1,666	531.17	1,498	477.81	90.0	168
Puerto Rico	2.9	553	190.99	513	177.01	92.7	40
South Carolina	1.0	329	325.43	301	298.43	91.7	28
Texas	4.2	2,109	509.09	1,819	439.11	86.3	290
Washington	7.1	1,958	277.83	1,731	245.62	88.4	227
Other (1)	3.0	920	309.56	845	284.16	91.8	75
	41.8	$ 14,165	$ 339.19	$ 12,822	$ 307.03	90.5%	$ 1,343

(1) "Other" includes the Idaho, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

MEDICAL CARE COSTS BY TYPE

The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended September 30,					
	2018			2017		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,865	$ 236.74	75.6%	$ 3,196	$ 234.51	75.8%
Pharmacy	495	40.90	13.1	638	46.85	15.1
Capitation	297	24.52	7.8	342	25.07	8.1
Other	133	11.07	3.5	44	3.25	1.0
	$ 3,790	$ 313.23	100.0%	$ 4,220	$ 309.68	100.0%

	Nine Months Ended September 30,					
	2018			2017		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 8,471	$ 230.46	74.6%	$ 9,630	$ 230.58	75.1%
Pharmacy	1,645	44.76	14.5	1,904	45.60	14.8
Capitation	891	24.23	7.8	1,022	24.47	8.0
Other	355	9.67	3.1	266	6.38	2.1
	$ 11,362	$ 309.12	100.0%	$ 12,822	$ 307.03	100.0%

MOLINA MEDICAID SOLUTIONS

We closed on the sale of MMS to DXC Technology Company on September 30, 2018.

FINANCIAL OVERVIEW

The Molina Medicaid Solutions segment service margin for the third quarter of 2018 and 2017 and for the nine months ended September 30, 2018 and 2017, was insignificant.

OTHER

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

We sold our Pathways subsidiary on October 19, 2018. See further information in the Notes to Consolidated Financial Statements, Note 1. “Organization and Basis of Presentation.”

FINANCIAL OVERVIEW

The Other segment service margin for the third quarter of 2018 and 2017 and for the nine months ended September 30, 2018 and 2017, was insignificant.

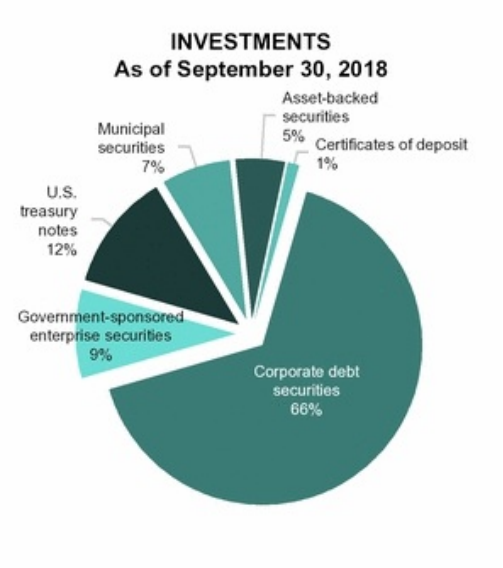
LIQUIDITY AND FINANCIAL CONDITION

INTRODUCTION

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our Health Plans segment regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

Our investments are classified as current assets, except for our held-to-maturity restricted investments, which are classified as non-current assets, and which are not included in the totals below. Our held-to-maturity restricted investments are invested principally in certificates of deposit and U.S. treasury securities.



MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2018, the fair value of our fixed income investments would decrease by approximately $16 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of September 30, 2018, no amounts were outstanding under the Credit Facility.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Nine Months Ended September 30,		
	2018	2017	Change
	(In millions)		
Net cash (used in) provided by operating activities	$ (191)	$ 957	$ (1,148)
Net cash provided by (used in) investing activities	821	(476)	1,297
Net cash (used in) provided by financing activities	(1,012)	632	(1,644)
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	$ (382)	$ 1,113	$ (1,495)

Operating Activities

We typically receive capitation payments monthly, in advance of payments for medical claims; however, state or federal payors may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. State or federal payors may delay our premium payments, or they may prepay the following month’s premium payment.

Net cash used in operations for the nine months ended September 30, 2018, was $191 million, compared with $957 million of net cash provided for the nine months ended September 30, 2017. The year over year decline was mainly due to the following:

- The timing effect of premium receipts and other revenues negatively impacted our cash flows from operating activities by $687 million on a year-over-year comparative basis. This impact was mainly related to the timing of premiums received at our California, Florida, Ohio, and Washington health plans.
- The decline in medical claims and benefits payable, mainly resulting from reduced Marketplace membership in Florida, Utah, Washington and Wisconsin decreased cash flows from operations by $693 million.
- Settlements with government agencies decreased our cash flows by $633 million on a year-over-year comparative basis, primarily due to payments in the third quarter of 2018, including risk transfer payments associated with our Marketplace health plans.
- The declines discussed above were partially offset by favorable timing differences in the settlement of various operating expenses, including the health insurer fee (HIF). The HIF payable of $348 million was paid on October 1, 2018, after receiving certain related state reimbursements. These favorable timing differences benefited our cash flows by $308 million on a year-over-year comparative basis.

Investing Activities

Net cash provided by investing activities was $821 million for the nine months ended September 30, 2018, compared with $476 million of net cash used in investing activities for the nine months ended September 30, 2017. The year over year improvement is primarily due to higher proceeds from sales and maturities of investments, net of purchases, for the nine months ended September 30, 2018, largely driven by cash flow needs associated with our financing activities, as described below.

Financing Activities

Net cash used in financing activities was $1,012 million for the nine months ended September 30, 2018, compared with $632 million of net cash provided by financing activities for the nine months ended September 30, 2017. The year over year decline was mainly due to the following:

- $300 million repayment of the Credit Facility in 2018;

- $236 million partial principal repayment of the 1.125% Notes in 2018;
- $477 million cash paid for partial settlement of the 1.125% Conversion Option in 2018;
- $419 million cash paid for partial termination of the 1.125% Warrants in 2018;
- $64 million principal repayment of 1.625% Notes in 2018; and
- $625 million of proceeds from the sale of the 4.875% Notes and borrowings under the Credit Facility in 2017.

These uses of cash were partially offset by $477 million of cash received in the nine months ended September 30, 2018 for a partial settlement of the 1.125% Call Option.

FINANCIAL CONDITION

We believe that our cash resources, our borrowing capacity available under our Credit Facility as discussed further below in "Future Sources and Uses of Liquidity—Future Sources," and internally generated funds will be sufficient to support operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months.

On a consolidated basis, at September 30, 2018, our working capital was $2,088 million, compared with $1,954 million at December 31, 2017. At September 30, 2018, our cash and investments amounted to $4,746 million, compared with $6,000 million at December 31, 2017.

Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company—Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $505 million as of September 30, 2018, or $390 million when adjusted for the timing of the HIF payment and the proceeds received from the sale of MMS, both of which occurred on October 1, 2018. Parent company cash, cash equivalents and investments amounted to $696 million as of December 31, 2017. The decrease is mainly attributed to reductions in the principal amount of outstanding debt, partially offset by net cash paid to the parent company by our subsidiaries.

In the nine months ended September 30, 2018, the regulated health plan subsidiaries paid $258 million in dividends to the parent, and our unregulated subsidiaries paid $10 million in dividends to the parent. In the nine months ended September 30, 2018, the parent company contributed capital of $122 million to our regulated health plan subsidiaries to satisfy statutory net worth requirements.

Debt Ratings

Our 5.375% Notes are rated "BB-" by Standard & Poor's, and "B3" by Moody's Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs.

Financial Covenants

Our Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Facility.

Credit Facility Financial Covenants	Required Per Agreement	As of September 30, 2018
Net leverage ratio	<4.0x	1.2x
Interest coverage ratio	>3.5x	10.8x

In addition, the indentures governing the 4.875% Notes, the 5.375% Notes and the 1.125% Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. As of September 30, 2018, we were in compliance with all covenants under the Credit Facility and the indentures governing our outstanding notes.

Capital Plan Progress

Year to date, we have reduced the principal amount of outstanding debt by $697 million.

In the third quarter of 2018, we repaid $140 million aggregate principal amount of our 1.125% Notes and entered into privately negotiated termination agreements to partially terminate the related 1.125% Call Option and 1.125% Warrants. In addition, we converted the remaining $64 million aggregate principal amount of our 1.625% Notes for

cash and 0.6 million shares of our common stock. Additionally, we terminated our bridge credit agreement in the third quarter of 2018.

In the second quarter of 2018, we repaid $300 million outstanding under our Credit Facility. In addition, we repaid $96 million aggregate principal amount of our 1.125% Notes, and entered into privately negotiated termination agreements to partially terminate the related 1.125% Call Option and 1.125% Warrants.

In the first quarter of 2018, we exchanged $97 million aggregate principal amount and accrued interest of our 1.625% Notes for 1.8 million shares of our common stock.

FUTURE SOURCES AND USES OF LIQUIDITY

Future Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. For more information on our regulatory capital requirements and dividend restrictions, refer to Notes to Consolidated Financial Statements, Note 12, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

Borrowing Capacity and Debt Financing. We have available borrowing capacity of $494 million under our Credit Facility. See further discussion in the Notes to Consolidated Financial Statements, Note 7, “Debt.”

Sale of MMS. We closed on the sale of Molina Medicaid Solutions (MMS) to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million, which we received on October 1, 2018.

Savings from Restructuring Plans. Our new executive team has focused on a margin recovery plan that includes identification and implementation of various profit improvement initiatives. To that end, we have begun to implement a plan to restructure our information technology department (the IT Restructuring) in the third quarter of 2018. As we further implement the IT Restructuring in the fourth quarter of 2018, we will report estimates of anticipated future savings in our 2018 Annual Report on Form 10-K.

Under the restructuring plan we implemented in 2017 (the 2017 Restructuring Plan), we have achieved savings in our Health Plans and Other segments of approximately $230 million since the plan’s inception through September 30, 2018. These savings have reduced both “General and administrative expenses” and “Medical care costs” reported in our consolidated statements of operations.

Further details of our restructuring plans, including costs associated with such plans, are described in the Notes to Consolidated Financial Statements, Note 10, “Restructuring and Separation Costs.”

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered and the use of proceeds will be provided at the time of an offering.

Future Uses

Regulatory Capital Requirements and Dividend Restrictions. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

1.125% Notes. Refer to the Notes to Consolidated Financial Statements, Note 7, “Debt,” for a detailed discussion of our convertible notes, including recent transactions. The principal amount of our 1.125% Notes is convertible into cash prior to its maturity date under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger, which is $53.00 per share. The 1.125% Notes met this trigger in the quarter ended September 30, 2018, and are convertible to cash through at least December 31, 2018. In addition, they are convertible by the holders within one year of the current balance sheet date until they mature; therefore, they are reported in current portion of long-term debt. If conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the relevant indentures. We have sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund conversions should they occur.

HIF. The HIF payable of $348 million was paid on October 1, 2018.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2017, was disclosed in our 2017 Annual Report on Form 10-K.

As of September 30, 2018, the principal amount of debt outstanding was $1,344 million, compared with $2,041 million reported at December 31, 2017. Refer to the Notes to Consolidated Financial Statements, Note 7, “Debt,” for a description of debt repayments in 2018.

As of December 31, 2017, we reported operating lease obligations of $262 million. Of this total, approximately $49 million related to the Molina Medicaid Solutions and Pathways subsidiaries. As noted in the Notes to Consolidated Financial Statements, Note 1, “Organization and Basis of Presentation,” these subsidiaries were recently sold; therefore, such lease obligations are no longer obligations of Molina Healthcare.

Other than these items, there were no significant changes to this previously filed information outside the ordinary course of business during the nine months ended September 30, 2018.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, “Medical Claims and Benefits Payable,” for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the nine months ended September 30, 2018, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2017.

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Goodwill and intangible assets, net.* As result of the divestiture of MMS on September 30, 2018, the carrying amount of goodwill was reduced by $43 million; therefore, goodwill and intangible assets, net, represented approximately 2% of total assets and 12% of stockholders’ equity as of September 30, 2018, compared with 3% and 19%, respectively, at December 31, 2017. Other than the divestiture of MMS, there have been no significant changes during the nine months ended September 30, 2018, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2017.

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures. Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company’s “disclosure controls and procedures” (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the “Exchange Act”)), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC’s rules and forms.

Changes in Internal Control Over Financial Reporting. There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2018 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 12, “Commitments and Contingencies.”

RISK FACTORS

Certain risks may have a material adverse effect on our business, financial condition, cash flows, results of operations, or stock price, and you should carefully consider them before making an investment decision with respect to our securities. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in “Risk Factors,” in our Annual Report on Form 10-K for the year ended December 31, 2017. The risk factors described in our 2017 Annual Report on Form 10-K are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, results of operations, or stock price.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended September 30, 2018, including shares withheld by us to satisfy our employees’ income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
July 1 - July 31	105	$ 97.94	—	$ —
August 1 - August 31	243	$ 134.01	—	$ —
September 1 - September 30	—	$ —	—	$ —
Total	348	$ 123.13	—	

(1) During the three months ended September 30, 2018, we withheld 348 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

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INDEX TO EXHIBITS

Exhibit No.	Title	Method of Filing
2.1	Membership Interest Purchase Agreement, dated as of October 19, 2018, by and among Pyramid Health Holdings, LLC, Molina Pathways, LLC, and Molina Healthcare, Inc.*	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
101.INS	XBRL Taxonomy Instance Document.	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document.	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Certain schedules and exhibits to this agreement have been omitted in accordance with Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule and/or exhibit will be furnished to the Securities and Exchange Commission upon request.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: November 1, 2018

/s/ JOSEPH M. ZUBRETSKY

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Dated: November 1, 2018

/s/ THOMAS L. TRAN

Thomas L. Tran
Chief Financial Officer and Treasurer
(Principal Financial Officer)

Execution Version

MEMBERSHIP INTERESTS PURCHASE AGREEMENT

by and between

PYRAMID HEALTH HOLDINGS, LLC,

as Purchaser,

MOLINA PATHWAYS, LLC,

as Seller,

and

MOLINA HEALTHCARE, INC.,

as Parent,

October 19, 2018

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EXHIBITS

SCHEDULES

MEMBERSHIP INTERESTS PURCHASE AGREEMENT

This **MEMBERSHIP INTERESTS PURCHASE AGREEMENT** (this "Agreement"), dated as of October 19, 2018, is made and entered into by and between Pyramid Health Holdings, LLC, a Delaware limited liability company ("Purchaser"), and Molina Pathways, LLC, a Delaware limited liability company ("Seller"). Molina Healthcare, Inc., a Delaware corporation ("Parent"), is a party hereto for purposes of Sections 6.02(b), 6.08, 6.10, 6.11, 6.12, 6.13, 6.15, 6.16 and 6.18 and Articles 8 and 9.

RECITALS

WHEREAS, Seller owns beneficially and of record all of the issued and outstanding membership interests (the "Interests") of Pathways Health and Community Support LLC, a Delaware limited liability company (the "Company");

WHEREAS, Seller desires to sell to Purchaser, and Purchaser desires to purchase from Seller, all of the Interests upon the terms and subject to the conditions hereinafter set forth; and

WHEREAS, the parties hereto desire to enter into, or to cause their applicable Affiliates to enter into, the Transaction Documents, and to perform or cause such Affiliates to perform their obligations thereunder as further described herein.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual covenants contained herein and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, and intending to be legally bound, the parties hereto agree as follows:

ARTICLE 1
CERTAIN DEFINITIONS

Section 1.01 Certain Definitions. As used in this Agreement, the following terms have the respective meanings set forth below.

"ACA" has the meaning ascribed thereto in Section 4.20(h).

"Accounts Receivable" means the accounts receivable of the Business in accordance with the Company Accounting Principles.

"Acquisition Proposal" means any offer, proposal or indication of interest (other than an offer, proposal or indication of interest by Purchaser or its Affiliates) contemplating or otherwise relating to any transaction or series of related transactions involving any:

(a) merger, consolidation, share exchange, business combination, issuance of securities, direct or indirect acquisition of securities, recapitalization, tender offer, exchange offer or other similar transaction (collectively, "Business Combinations") in which: (i) a Person or "group" (as defined in the Securities Exchange Act of 1934, as amended and the rules promulgated thereunder) of Persons directly or indirectly acquires beneficial or record ownership

of securities representing more than 15% of the outstanding shares of any class of voting securities of the Company; or (ii) the Company issues securities representing more than 15% of the outstanding shares of any class of voting securities of the Company to any Person or "group" of Persons other than Parent or an Affiliate thereof, in each case, other than any Business Combination in which a Person or "group" of Persons directly acquires beneficial or record ownership of securities of Parent;

(b) sale, lease, license, exchange, transfer, acquisition or disposition of any assets by the Company or its Subsidiaries that constitute or account for: (i) 15% or more of the consolidated net revenues of the Company and its Subsidiaries, consolidated net income of the Company and its Subsidiaries or consolidated book value of the Company and its Subsidiaries; or (ii) 15% or more of the fair market value of the assets of the Company and its Subsidiaries, in each case, other than (x) in the ordinary course of business, or (y) pursuant to the express terms of this Agreement; or

(c) liquidation or dissolution of the Company.

"Adjusted Balance Sheet" shall have the meaning specified in Section 2.05.

"Affiliate" of any Person, means any other Person that, directly or indirectly, through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, such first Person. As used in this definition, the term "control," including the correlative terms "controlled by" and "under common control with," means the possession, directly or indirectly, of the power to direct or cause the direction of management or policies (whether through ownership of Equity Securities, by Contract or otherwise).

"Agreement" has the meaning ascribed thereto in the Preamble.

"Allocation Schedule" has the meaning ascribed thereto in Section 6.04(e).

"Assets" has the meaning ascribed thereto in Section 4.10(a).

"Balance Sheet" has the meaning ascribed thereto in Section 4.07(a).

"Business" means the business engaged in by the Company and its Subsidiaries as presently conducted.

"Business Day" means a day, other than a Saturday or Sunday or any other day on which commercial banking institutions in New York, New York are not open for the transaction of normal banking business.

"Closing" has the meaning ascribed thereto in Section 3.01.

"Closing Cash" means the cash and cash equivalents of the Company and its Subsidiaries as of the Closing Date, including any deposits in transit, less any outstanding checks, bank overdrafts, book overdrafts or other negative cash balances, calculated consistently with the Company Accounting Principles.

"Closing Date" has the meaning ascribed thereto in Section 3.01.

"Code" means the Internal Revenue Code of 1986, as amended, and the rules and regulations issued thereunder.

"Company" has the meaning ascribed thereto in the Recitals.

"Company Accounting Principles" has the meaning ascribed thereto in Section 4.07(a).

"Company Confidential Information" has the meaning ascribed thereto in Section 6.13(a).

"Company Disclosure Schedule" means the disclosure schedule and exhibits thereto that have been delivered to Purchaser concurrently with the execution and delivery of this Agreement.

"Confidentiality Agreement" means that certain Mutual Nondisclosure Agreement, dated May 3, 2018, by and between Parent and Atar Capital, LLC.

"Continuing Employees" has the meaning ascribed thereto in Section 6.05(a).

"Contract" means any written or oral agreement, contract, subcontract, lease, indenture, note, guaranty, option, warranty, purchase order, license, sublicense, insurance policy or legally binding arrangement, commitment, obligation or undertaking of any nature (and all amendments, modifications, restatements, or supplements thereto).

"Covered Entities" has the meaning ascribed thereto in Section 4.16(a).

"Data Room" has the meaning ascribed thereto in Section 9.04.

"Deductible" has the meaning ascribed thereto in Section 8.04(e).

"Dispute Accountant" means an independent accounting firm mutually selected by Purchaser and Seller.

"Employee Benefit Plan" means each (a) "employee benefit plan," as defined in Section 3(3) of ERISA and (b) incentive, profit-sharing, stock option, stock purchase, equity-based, employment, consulting, vacation or other leave, change of control, transaction, retention, severance, deferred compensation, medical, dental, vision, retiree medical, disability, flexible spending, cafeteria, retirement, fringe benefit or other compensation or benefit plan, policy, program or agreement, in each case established, sponsored, maintained or contributed by the Company or its Subsidiaries, or with respect to which the Company or any of its Subsidiaries has or may have any actual or contingent liability or obligation, in each case with respect to its current or former employees, directors and/or independent contractors.

"End Date" has the meaning ascribed thereto in Section 7.01(b).

"Environmental Laws" means all Laws relating to pollution or protection of the environment (including ambient air, surface water, groundwater, soils or subsurface strata), the preservation or reclamation of natural resources, the protection of human health as it relates to exposure to Hazardous Materials or the use, generation, management, handling, transport, treatment, presence, disposal, storage or release of Hazardous Materials.

"Equity Securities" means, if a Person is a corporation, shares of capital stock of such corporation and, if a Person is a form of entity other than a corporation, ownership interests in such form of entity, whether membership interests, partnership interests or otherwise, and in either case any options, warrants, or any other interests convertible into or exchangeable or exercisable for the purchase of any such shares or ownership interests.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"ERISA Affiliate" of any entity means any trade or business that is, or at any relevant time was, together with such entity, treated as a "single employer" under Section 414(b), 414(c) or 414(m) of the Code and/or Section 4001(b)(1) of ERISA.

"Existing Performance Bonds" has the meaning ascribed thereto in Section 6.06.

"Federal Privacy Regulations" means the regulations contained in 45 C.F.R. §§ 160 and 164, as amended.

"Federal Security Regulations" means the regulations contained in 45 C.F.R. §§ 160 and 164, as amended.

"Federal Transaction Regulations" means the regulations contained in 45 C.F.R. §§ 160 and 162, as amended.

"Final Closing Cash" shall have the meaning specified in Section 2.03(b).

"Final Closing Cash Statement" shall have the meaning specified in Section 2.03(b).

"Financial Statements" has the meaning ascribed thereto in Section 4.07.

"Fraud" means (a) with respect to Seller, the actual fraud of Seller with respect to the representations and warranties made pursuant to Article 4 (as modified by the Company Disclosure Schedule), which involves a knowing and intentional misrepresentation of a fact material to the transactions contemplated by this Agreement, with the intent of deceiving Purchaser or its Affiliates and upon which Purchaser or such Affiliates has relied to its detriment (as opposed to any fraud claim based on constructive knowledge, negligent misrepresentation or a similar theory) under applicable tort laws and (b) with respect to Purchaser, the actual fraud of Purchaser with respect to the representations and warranties made pursuant to Article 5, which involves a knowing and intentional misrepresentation of a fact material to the transactions contemplated by this Agreement, with the intent of deceiving Seller or its Affiliates and upon which Seller or such Affiliates has relied to its detriment (as opposed to any fraud claim based on constructive knowledge, negligent misrepresentation or a similar theory) under applicable tort laws.

"Fraud Claims" has the meaning ascribed thereto in Section 4.27.

"Fundamental Purchaser Representations" means, collectively, the representations and warranties contained in Section 5.01 (Organization and Good Standing), Section 5.02 (Authority), clause (a) of Section 5.03 (No Conflicts), and Section 5.10 (Brokers).

"Fundamental Seller Representations" means, collectively, the representations and warranties contained in Section 4.01 (Organization and Good Standing), Section 4.02 (Authority), clause (a) of Section 4.03 (No Conflicts), Section 4.05 (Title to Interests), clauses (a) and (b) of Section 4.06 (Capitalization), and Section 4.25 (Brokers).

"GAAP" means generally accepted accounting principles as in effect in the United States on the date of this Agreement, applied in a manner consistent with the Company Accounting Principles.

"General Cap Amount" has the meaning ascribed thereto in Section 8.04(a).

"Governing Documents" means the legal document(s) by which any Person (other than an individual) establishes its legal existence or which govern its internal affairs, in each case, as amended to date. For example, the "Governing Documents" of a corporation are its articles or certificate of incorporation and by-laws, and the "Governing Documents" of a limited liability company are its articles of organization and its operating agreement or limited liability company agreement.

"Government Program" means any Federal Healthcare Program or any health care program or health care reimbursement or participation agreement between the Company or any of its Subsidiaries and any Governmental Authority or any contractor of such Governmental Authority.

"Governmental Authority" means any federal, state or local government, court, tribunal or arbitral body (whether private or governmental) of competent jurisdiction, administrative agency, commission or board, or other governmental, quasi-governmental authority (including self-regulatory organization) or regulatory authority or instrumentality of the United States or any other country or any other state, county, municipality or other governmental division of any country.

"Hazardous Materials" means any chemical, material, substance, waste, pollutant or contaminant (a) that is regulated, defined, listed or identified under any Environmental Law as a "hazardous waste," "hazardous substance" or "toxic substance" or (b) that is or contains petroleum or petroleum constituents or byproducts, toxic mold, biohazards, radioactive materials, asbestos-containing materials, urea formaldehyde foam insulation, polychlorinated biphenyl or radon gas.

"Health Plan" has the meaning ascribed thereto in Section 4.20(h).

"Healthcare Laws" means applicable Laws relating to or governing health care, insurance fraud or abuse or the licensure, certification, qualification or authority to provide healthcare items and services, including the following statutes: the Federal Anti-Kickback Statute (42

U.S.C. § 1320a-7b), the Stark Law (42 U.S.C. § 1395nn), the Federal False Claims Act (31 U.S.C. §§ 3729, et seq.), the Federal Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), the Federal Program Fraud Civil Remedies Act (31 U.S.C. § 3801 et seq.) and the Federal Health Care Fraud Law (18 U.S.C. § 1347); and the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), as amended by the Health Information Technology for Economic and Clinical Health Act (Pub. L. No. 111-5) and their implementing regulations (collectively, "HIPAA").

"Indebtedness" means, with respect to the Company and each of its Subsidiaries, at any applicable date, (a) all obligations for borrowed money or extensions of credit of the Company or such Subsidiaries, (b) all obligations evidenced by bonds, debentures, notes or other similar instruments, commercial paper or debt securities of the Company or such Subsidiaries, (c) all obligations under interest rate or non-U.S. currency swaps, hedges, caps, collars, options, futures or similar instruments of the Company or such Subsidiaries for the purpose of managing interest rate and/or non-U.S. exchange rate, (d) all obligations of the Company or such Subsidiaries for the deferred purchase price of any property or services (other than trade accounts payable and accrued expenses reflected as accounts payable or accrued expenses in the Balance Sheet or incurred after the date thereof in the ordinary course of business), including earnouts, payments under non-compete agreements and seller notes owed by the Company or its Subsidiaries, (e) all obligations for borrowed money of the Company or such Subsidiaries secured by a Lien, (f) all obligations of the Company or such Subsidiaries under leases which are required to be, in accordance with GAAP, recorded as capital leases, and (g) all interest, principal, prepayment penalties, premiums, fees or expenses due or owing by the Company or such Subsidiaries in respect of any item listed in clauses (a) through (f) above.

"Indemnifying Party" has the meaning ascribed thereto in Section 8.01(a).

"Indemnity Notice" has the meaning ascribed thereto in Section 8.04(a).

"Insurance Policies" has the meaning ascribed thereto in Section 4.23.

"Intellectual Property" means all domestic and international intellectual property rights, whether registered or unregistered, including, without limitation (a) patents, applications for patents, patent disclosures and inventions, together with all reissues, continuations, continuations-in-part, revisions, divisional, extensions and re-examinations, (b) trade secrets and confidential, proprietary business and technical information, (c) copyright registrations, applications for copyright registrations and unregistered copyrights and works of authorship (including software), (d) trademarks and service marks, logos, business names, corporate names and trade names, together with all goodwill associated therewith and all registrations, applications for registration, and renewals for any of the foregoing, (e) trade secrets and other confidential information and know-how that derive economic value from not being generally known to, and not being readily available through lawful means by another Person, (f) Internet web site addresses, domain names and URLs and (g) any other proprietary or similar rights relating to any of the foregoing.

"Intercompany Accounts" means any intercompany accounts, balances, payables, receivables or indebtedness between Parent or any of its Subsidiaries (excluding the Company

and its Subsidiaries), on the one hand, and any of the Company or its Subsidiaries, on the other hand.

"Interests" has the meaning ascribed thereto in the Recitals.

"IRS" means the United States Internal Revenue Service.

"Laws" means all laws, statutes, acts, ordinances, rules, rules of common law, regulations, directives, legally binding policies or guidance, treaties, codes, rulings, Orders, certification standards, accreditation standards, Permits, decisions or other directives or requirements of any Governmental Authority.

"Lease" has the meaning ascribed thereto in Section 4.11(b).

"Leased Real Property" has the meaning ascribed thereto in Section 4.11(b).

"Liability" means any liability or obligation of any nature whatsoever, whether known or unknown, whether asserted or unasserted, whether absolute or contingent, whether accrued or unaccrued, whether liquidated or unliquidated, and whether due or to become due.

"Lien" means any mortgage, pledge, lien, charge, claim, equitable interest, option, proxy, pledge, right of first refusal or first offer, security interest, deed of trust, hypothecation, easement, encroachment, right of way, voting trust, voting agreement and any other encumbrance of any kind, including, without limitation, any restriction on voting, transfer, receipt of income, or exercise of any other attribute of ownership.

"Loss" means all damages, awards, losses, Liabilities, obligations, claims, payments, fines, penalties, interest, costs and expenses (including reasonable attorneys' fees, court costs and other reasonable professional fees and expenses and any amounts paid in settlement).

"Maple Star Colorado" means Maple Star Colorado, a non-profit corporation incorporated under the laws of the State of Colorado.

"Material Adverse Effect" means any event, change, circumstance, effect or other matter that has had or would reasonably be expected to have, with or without notice, lapse of time or both, (a) a material adverse effect on the business assets, properties, liabilities, condition (financial or otherwise), operating results or operations of the Company and its Subsidiaries, taken as a whole, or (b) the ability of Parent and the Seller to perform their respective obligations under this Agreement or to consummate the transactions contemplated by this Agreement; provided, that the impact of the following shall not be taken into account in determining whether there has been or would be a Material Adverse Effect: (a) changes in conditions in the industry in which the Company and its Subsidiaries operate; (b) changes in conditions in the United States or global economy, capital or financial markets generally, including, without limitation, changes in interest or exchange rates; (c) changes in legal, tax, accounting, regulatory, political or business conditions that, in each case, generally affect the industry in which the Company and its Subsidiaries participate; (d) acts of war, sabotage or terrorism (including any escalation or general worsening of any such acts of war, sabotage or terrorism) in the United States or any other country; (e) earthquakes, hurricanes, tsunamis, tornadoes, floods, mudslides, wild fires or

other natural disasters, weather conditions and other force majeure events in the United States or any other country; (f) any failure, in and of itself, by the Company or its Subsidiaries to meet any forecast, projection or estimate (it being understood that any material adverse effect giving rise to such failure may be taken into account in determining whether there has been a Material Adverse Effect); (g) acts by Parent, Seller, the Company or its Subsidiaries carried out at the express written request of Purchaser; (h) the taking of any action expressly required by the terms of this Agreement; or (i) the announcement, pendency or consummation of the transactions contemplated by this Agreement; except, with respect to clauses (a), (b), (c), (d), and (e), to the extent any such matter materially and disproportionately affects the Company and its Subsidiaries compared to other companies operating in the industries in which the Company and its Subsidiaries operate.

"Material Contracts" has the meaning ascribed thereto in Section 4.09(b).

"Membership Interest Assignment and Assumption Agreement" means the Membership Interest Assignment and Assumption Agreement, to be entered into as of the Closing Date, by and between Purchaser and Seller, substantially in the form attached hereto as Exhibit A.

"Mutual Release" means the Mutual Release, to be entered into as of the Closing Date, by and between Seller and the Company, substantially in the form attached hereto as Exhibit B.

"Order" means any judgment, award, decision, order, decree, writ, injunction, assessment, ruling, subpoena or verdict entered or issued by any Governmental Authority.

"Owned Real Property" has the meaning ascribed thereto in Section 4.11(a).

"Parent" has the meaning ascribed thereto in the Preamble.

"Parent Confidential Information" has the meaning ascribed thereto in Section 6.13(b).

"Per-Claim Basket" has the meaning ascribed thereto in Section 8.04(c).

"Permit" means any permit, license, franchise, qualification, certification, accreditation, approval, certificate, consent, provider number or other registration, authorization or exemption by or of a Governmental Authority.

"Permitted Liens" means (a) statutory mechanics', carriers', workmen's, repairmen's, vendors', suppliers', warehousemen's or other like or statutory Liens arising or incurred in the ordinary course of business for amounts not yet due or which are being contested in good faith by appropriate Proceedings; (b) Liens for Taxes, special assessments and other governmental or quasi-governmental charges that are not yet delinquent or that are being contested in good faith by appropriate Proceedings and for which adequate reserves have been made with respect thereto in accordance with GAAP; (c) with respect to Real Property, easements, covenants, conditions, restrictions, reservations, rights of way, encroachments and/or other similar matters or imperfections affecting or encumbering title to any Real Property; provided, that no such item described in this clause (c) individually or in the aggregate materially impairs the current use or occupancy of the Real Property subject thereto; (d) Liens incurred or deposits or pledges made in the ordinary course of business in connection with, or to secure payment of, workers'

compensation, unemployment insurance, old age pension programs mandated under applicable Laws or other social security regulations; (e) zoning, building and other land use entitlements, regulations or restrictions regulating the development, use or occupancy of Real Property; provided, that no such item described in this clause (e) materially impairs the current use or occupancy of the Real Property subject thereto; (f) the interests of, and Liens and encumbrances on the interests of, the lessors and sublessors of any Leased Real Property, and Liens and encumbrances on easements, licenses, rights of use, rights of access, rights of way and other non-fee estates, interests and/or rights in property arising from the provisions of such agreements or benefiting or created by any superior estate, right, or interest in such nonfee estates and (g) the Lien described on Section 1.01 of the Company Disclosure Schedule.

"Person" means an individual, sole proprietorship, partnership, corporation, limited liability company, joint stock company, unincorporated organization or association, trust, joint venture, association or other organization, whether or not a legal entity or a Governmental Authority.

"Pre-Closing Insurable Event" means any event or circumstance that occurred prior to the Closing and that was insurable under the Insurance Policies, but is not insured under the Insurance Policies because it was not properly reported to the applicable insurer prior to the Closing, and including without limitation, any and all related to general liability, workers compensation, property, umbrella liability and owned, hired, rented and/or other non-owned vehicles.

"Post-Closing Tax Period" means any Tax period beginning after the Closing Date and that portion of any Straddle Period beginning after the Closing Date.

"Pre-Closing Tax Period" means any Tax period ending on or prior to the Closing Date and that portion of any Straddle Period ending on (and including) the Closing Date.

"Proceeding" means any lawsuit, litigation, arbitration, mediation, action or other proceeding by or before any Governmental Authority.

"Proprietary Information" has the meaning ascribed thereto in Section 4.12(c).

"Protected Health Information" has the meaning ascribed thereto by HIPAA and the implementing rules found in 45 CFR § 160.103.

"Purchase Price" has the meaning ascribed thereto in Schedule 2.02.

"Purchaser" has the meaning ascribed thereto in the Preamble.

"Purchaser 401(k) Plan" has the meaning ascribed thereto in Section 6.05(a).

"Purchaser Indemnified Party" has the meaning ascribed thereto in Section 8.02.

"Real Property" means the Owned Real Property and the Leased Real Property.

"Reference Date" has the meaning ascribed thereto in Section 4.08.

"Related Person" has the meaning ascribed thereto in Section 4.27.

"Remedies Exception" means: (a) applicable bankruptcy, insolvency, reorganization, moratorium, fraudulent transfer and other Laws of general application, heretofore or hereafter enacted or in effect, affecting the rights and remedies of creditors generally; and (b) general principles of equity, including good faith and fair dealing, regardless of whether in a proceeding at equity or at Law.

"Representatives" means, with respect to a Person, the directors, officers, employees, agents, Affiliates and representatives of such Person.

"Restricted Names" has the meaning ascribed thereto in Section 6.10.

"Restricted Person" has the meaning ascribed thereto in Section 6.12(a).

"Retention Bonus Agreements" means those retention bonus letter agreements, dated December 29, 2017, by and between Seller, Parent and each of the Retention Bonus Holders.

"Retention Bonus Amounts" means the aggregate amounts payable to the Retention Bonus Holders under and pursuant to the Retention Bonus Agreements.

"Retention Bonus Holders" has the meaning ascribed thereto in Section 6.05(c).

"Section 336 Elections" has the meaning ascribed thereto in Section 6.04(e).

"Section 336 Forms" means all returns, documents, statements, and other forms that are required to be submitted to any federal, state, local or foreign Tax Authority in connection with a Section 336 Election (including, without limitation, any "statement of section 336 election" and IRS Form 8023, together with any schedules or attachments thereto, that are required pursuant to Treasury Regulations under Code Section 336(e), as applicable).

"Securities Act" means the Securities Act of 1933, as amended.

"Seller" has the meaning ascribed thereto in the Preamble.

"Seller 401(k) Plan" has the meaning ascribed thereto in Section 4.20(c).

"Seller Group" has the meaning ascribed thereto in Section 9.15.

"Seller Indemnified Party" has the meaning ascribed thereto in Section 8.03.

"Seller's Knowledge" means, when referring to the "knowledge" of Seller or the Company, or any similar phrase or qualification based on knowledge of Seller or the Company, the present, actual knowledge of any of Craig Bass, Allen Wolfenbarger and/or Bart Beattie, after reasonable inquiry of their direct reports.

"Solvent" means, with respect to any Person, that: (a) the assets of such Person, at a present fair saleable valuation, exceeds the sum of its debts (including contingent and unliquidated debts); (b) the present fair saleable value of the assets of such Person exceeds the

amount that will be required to pay such Person's probable Liability on its existing debts as they become absolute and matured; (c) such Person has adequate capital to carry on its business; and (d) such Person does not intend or believe it will incur debts beyond its ability to pay as such debts mature. In computing the amount of contingent or unliquidated Liabilities at any time, such Liabilities will be computed at the amount which, in light of all the facts and circumstances existing at such time, represents the amount that can reasonably be expected to become actual or matured Liabilities.

"Straddle Period" means any Tax period beginning on or prior to and ending after the Closing Date.

"Subsidiary" means, with respect to any Person, as of the date of any determination, any other Person as to which such Person owns, directly or indirectly, or otherwise controls, more than fifty percent (50%) of the voting shares or other similar interests or the sole general partner interest or managing member or similar interest. For purposes of this Agreement, "Subsidiary" shall include, Maple Star Colorado, College Community Services, a California nonprofit corporation, and Maple Star Oregon, Inc., an Oregon nonprofit corporation.

"Substitute Performance Bonds" has the meaning ascribed thereto in Section 6.06.

"Surviving Seller Representations" means, collectively, the Fundamental Seller Representations and the representations and warranties contained in Section 4.19 (Taxes).

"Target Closing Cash" shall have the meaning specified in Schedule 2.02.

"Tax" or "Taxes" means (a) any federal, state, local or foreign income, gross receipts, property, sales, use, license, franchise, employment, severance, stamp, occupation, windfall profits, environmental, customs duties, capital stock, profits, social security (or similar, including FICA), unemployment, sales, use, disability, real property, personal property, escheat, unclaimed property, registration, value added, estimated, payroll, premium, withholding, alternative or added minimum, ad valorem, transfer or excise tax, or any other tax of any kind or any fee or charge in the nature of (or similar to) taxes (including any of the foregoing), together with any interest or penalty or addition to tax, whether disputed or not and (b) any liability for the payment of any amounts of the type described in clause (a) as a result of being a member of an affiliated, consolidated, combined or unitary group, as a result of any tax sharing, tax allocation or tax indemnity agreement, arrangement or understanding, as a result of entity level taxes on entities which are disregarded entities or passthrough entities for federal income tax purposes or as a result of being liable for another Person's taxes as a transferee or successor, by Contract or otherwise.

"Tax Authority" shall mean any Governmental Authority, having or purporting to exercise jurisdiction with respect to any Tax.

"Tax Matter" has the meaning ascribed thereto in Section 6.04(j).

"Tax Purchase Price" has the meaning ascribed thereto in Section 6.04(d).

"Tax Refunds" has the meaning ascribed thereto in Section 6.04(c).

"Tax Return" means any return, report, declaration, claim for refund, information return or other document relating to Taxes, including any related or supporting schedule, statement or information thereto, any attachment thereto, and including any amendment thereof.

"Third Party Claim" has the meaning ascribed thereto in Section 8.04(b).

"Transaction Documents" means the Membership Interest Assignment and Assumption Agreement, the Mutual Release, the Transition Services Agreement and each other document to be executed by the parties hereto at the Closing.

"Transfer Taxes" has the meaning ascribed thereto in Section 6.03.

"Transition Services Agreement" means that certain Transition Services Agreement, to be entered into as of the Closing Date, by and between Parent and Purchaser, substantially in the form attached hereto as Exhibit C.

"Treasury Regulations" means the Treasury Regulations promulgated under the Code.

"United States" means the United States of America.

ARTICLE 2
PURCHASE AND SALE

Section 2.01 Purchase and Sale of the Interests. Upon the terms and subject to the conditions of this Agreement, at the Closing, Seller agrees to sell, convey, assign and transfer to Purchaser, and Purchaser agrees to purchase from Seller, all right, title and interest in and to the Interests, free and clear of all Liens (except for restrictions on transfer imposed by federal or state securities Laws).

Section 2.02 Purchase Price. Upon the terms and subject to the conditions of this Agreement, in consideration of the sale, conveyance, assignment and transfer of all right, title and interest in and to the Interests to Purchaser pursuant to Section 2.01 and the rights and benefits conferred herein, at the Closing, (a) Purchaser will pay or cause to be paid to Seller the Purchase Price in immediately available funds, and (b) Seller shall leave an estimated amount of Closing Cash equal to the Target Closing Cash on the Adjusted Balance Sheet.

Section 2.03 Cash Reconciliation.

(a) Final Closing Cash. By no later than October 26, 2018, Purchaser shall deliver to Seller a statement (the "Final Closing Cash Statement") of the amount of the Closing Cash (the "Final Closing Cash").

(b) Review by Seller; Dispute Resolution.

(i) Seller will be afforded a period of ten (10) Business Days to review the Final Closing Cash Statement and the calculation of the Final Closing Cash during which period Seller and its advisors shall have reasonable access, during normal business hours, to the relevant personnel and books and records of the Company and its Subsidiaries

related to the Final Closing Cash Statement and calculation of the Final Closing Cash. At or before the end of such ten (10) Business Day period, Seller will either accept the Final Closing Cash Statement and the calculation of the Final Closing Cash (in which case the calculation of the Final Closing Cash delivered by Purchaser above will be final, conclusive and binding on the parties), or notify Purchaser in writing that Seller disputes the Final Closing Cash Statement and the calculation of the Final Closing Cash. Within a further period of another five (5) Business Days, the parties will attempt to resolve in good faith any disputed items.

(ii) Failing such resolution, either Seller or Purchaser may refer the disputed items for resolution by the Dispute Accountant. The parties hereto shall direct the Dispute Accountant to deliver to Purchaser and Seller, within fifteen (15) days after reference of the matter, a written report setting forth its calculation of the Final Closing Cash, which shall be consistent with the terms of this Agreement and final, conclusive and binding upon the parties. The costs and expenses of the Dispute Accountant shall be allocated evenly between Purchaser and Seller.

(c) Adjustment Payment. After the Final Closing Cash Statement and the calculation of the Final Closing Cash become final, conclusive and binding upon the parties as provided above, then, within five (5) Business Days:

(i) If the Final Closing Cash is greater than the Target Closing Cash, then Purchaser will wire transfer to Seller the difference in immediately available funds.

(ii) If the Final Closing Cash is less than the Target Closing Cash, then Seller will wire transfer to Purchaser the difference in immediately available funds.

Section 2.04 Withholding. Purchaser or the Company, as applicable, shall be entitled to deduct and withhold, or cause to be deducted and withheld, from any amounts payable pursuant to this Agreement such amounts as are required to be deducted and withheld under the Code or any other applicable Law with respect to the making of such payment; provided, however, that (a) before making any such deduction or withholding, Purchaser or the Company, as applicable, shall give Seller notice of the intention to make such deduction or withholding (such notice, which shall include the authority, basis and method of calculation for the proposed deduction or withholding, shall be given at least a commercially reasonable period of time before such deduction or withholding), (b) Purchaser or the Company, as applicable, shall cooperate with Seller to the extent reasonable in efforts to obtain reduction of or relief from such deduction or withholding and (c) Purchaser or the Company, as applicable, shall timely remit to the appropriate Tax Authority any and all amounts so deducted or withheld and timely file all Tax Returns and provide to Seller such information statements and other documents required to be filed or provided under applicable Tax law. To the extent that amounts are so withheld and paid over or deposited with the relevant Tax Authority by Purchaser or the Company in accordance with the foregoing, such withheld amounts shall be treated for all purposes of this Agreement as having been paid to the Person in respect of whom such deduction and withholding was made. Notwithstanding the foregoing, no deduction or withholding under the Code shall be made from the consideration otherwise payable to Seller pursuant to this Agreement if Seller provides to

Purchaser at the Closing a complete IRS Form W-9 and a statement made in accordance with Treasury Regulations Section 1.1445-2(b).

Section 2.05 Adjusted Balance Sheet. Attached as Exhibit D is an unaudited consolidated balance sheet of the Company and its Subsidiaries as of September 30, 2018, as adjusted to give effect to (a) the distribution of Cash by the Company to Seller at or on the day prior to the Closing, and (b) the settlement or cancellation of Intercompany Accounts, deferred tax liabilities and deferred tax assets at Closing (the "Adjusted Balance Sheet").

ARTICLE 3
CLOSING

Section 3.01 Closing. Upon the terms and subject to the satisfaction or waiver of the conditions contained in this Agreement, the closing of the transactions contemplated hereby (the "Closing") shall be effected (a) by electronic mail and overnight courier service, or by physical exchange of documentation at the offices of Latham & Watkins LLP, located at 355 South Grand Avenue, Suite 100, Los Angeles, CA 90071, on October 19, 2018, or (b) at such other time and place as the parties hereto shall mutually agree. The date on which the Closing occurs is referred to as the "Closing Date".

Section 3.02 Delivery and Actions by Seller at Closing. At or prior to the Closing, Seller shall deliver, or shall cause to be delivered, to Purchaser:

(a) a certificate in form and substance reasonably satisfactory to Purchaser, dated as of the Closing Date and duly executed and delivered by Seller, certifying as to Seller's, Parent's and the Company's satisfaction of the conditions set forth in Sections 3.05(a) and 3.05(b).

(b) a completed IRS Form W-9 for Parent duly executed by Parent and accompanied by an affidavit dated as of the Closing Date from Parent, sworn under penalty of perjury and in form and substance required under the Treasury Regulations issued pursuant to Section 1445 of the Code stating that Parent is not a "foreign person" as defined in Section 1445 of the Code;

(c) written resignations in form and substance reasonably acceptable to Purchaser effective as of the Closing from each director of the Company and each of its Subsidiaries in their capacity as such;

(d) an executed signature page of Seller or its Affiliates, as the case may be, of each Transaction Document to which Seller or such Affiliates, as the case may be, is a party; and

(e) a certificate, dated as of the Closing Date, signed by the Secretary or other authorized officer of Seller, attesting and certifying to the completion of all necessary limited liability company action by Seller to execute and deliver this Agreement and the Transaction Documents to which it is a party and to consummate the transactions contemplated hereby and thereby, and including copies of all resolutions required in connection with this Agreement and the Transaction Documents.

Section 3.03 Delivery and Actions by Purchaser at Closing. At or prior to the Closing, Purchaser shall deliver, or shall cause to be delivered, to Seller:

(a) an executed signature page of Purchaser or its Affiliates, as the case may be, of each Transaction Document to which Purchaser or such Affiliates, as the case may be, is a party;

(b) the Purchase Price in accordance with Section 2.02; and

(c) a certificate, dated as of the Closing Date, signed by the Secretary or other authorized officer of Purchaser, attesting to the completion of all necessary limited liability company action by Purchaser to execute and deliver this Agreement and the Transaction Documents to which it is a party and to consummate the transactions contemplated hereby and thereby, and including all limited liability company resolutions required in connection with this Agreement and the Transaction Documents.

Section 3.04 Conditions to Obligations of Seller. The obligations of Seller under this Agreement to sell the Interests and to consummate the transactions contemplated hereby are subject to the satisfaction, on or prior to the Closing, of the following conditions, unless waived (to the extent such conditions can be waived) in writing by Seller:

(a) Accuracy of Representations and Warranties. Each of (i) the representations and warranties of Purchaser contained in Article 5 (other than the Fundamental Purchaser Representations) shall be true and correct in all material respects (without giving effect to any limitation as to materiality or material adverse effect set forth therein) on and as of the date of this Agreement and as of the Closing, as though made at and as of Closing (other than such representations and warranties expressly made as of an earlier date, which representations and warranties shall be true and correct as of such earlier date), except where the failure of such representations and warranties to be so true and correct, individually or in aggregate with other such failures, has had or would reasonably be expected to have a material adverse effect on Purchaser's ability to consummate the transactions contemplated hereby and (ii) the Fundamental Purchaser Representations shall be true and correct in all material respects on and as of the date of this Agreement and as of the Closing, as though made at and as of Closing.

(b) Performance of Obligations. Purchaser shall have performed or complied in all material respects with all agreements, obligations and covenants required to be performed by it under this Agreement on or as of the Closing Date.

(c) No Restraint. No provisions of any applicable Law or Order shall be in effect, and no Proceeding shall be pending or overtly threatened by or before any Governmental Authority, that would reasonably be expected to enjoin, prevent, restrain or delay consummation of any of the transactions contemplated hereby or by the Transaction Documents, declare unlawful any of the transactions contemplated hereby or by the Transaction Documents or cause any of the transactions contemplated hereby or by the Transaction Documents to be rescinded following consummation.

(d) Deliveries. Purchaser shall have delivered, or caused to be delivered, to Seller the funds, documents, certificates and other instruments required under Section 3.03.

Section 3.05 Conditions to Obligations of Purchaser. The obligations of Purchaser under this Agreement to purchase the Interests and to consummate the transactions contemplated

hereby are subject to the satisfaction, on or prior to the Closing, of the following conditions, unless waived (to the extent such conditions can be waived) in writing by Purchaser:

(a) Accuracy of Representations and Warranties. Each of (i) the representations and warranties of Seller contained in Article 4 (other than the Fundamental Seller Representations) shall be true and correct in all respects (without giving effect to any limitation as to materiality or Material Adverse Effect set forth therein) on and as of the date of this Agreement and as of the Closing, as though made at and as of Closing (other than such representations and warranties expressly made as of an earlier date, which representations and warranties shall be true and correct as of such earlier date), except where the failure of such representations and warranties to be so true and correct, individually or in the aggregate with any other such failures, have not had, and would not reasonably be expected to have, a Material Adverse Effect, and (ii) the Fundamental Seller Representations shall be true and correct in all material respects on and as of the date of this Agreement and as of the Closing, as though made at and as of Closing.

(b) Performance of Obligations. Each of Seller, Parent and the Company shall have performed or complied in all material respects with all agreements, obligations and covenants required to be performed by it under this Agreement on or as of the Closing Date.

(c) No Material Adverse Effect. From the date of this Agreement through the Closing Date, no event, occurrence, change, development, effect, condition, state of facts or circumstance shall have occurred or arisen that, individually or in combination with any other event, occurrence, change, development, effect, condition, state of facts or circumstance, has had or would reasonably be expected to have a Material Adverse Effect.

(d) No Restraint. No provisions of any applicable Law or Order shall be in effect, and no Proceeding shall be pending or overtly threatened by or before any Governmental Authority, that would reasonably be expected to enjoin, prevent, restrain or delay consummation of any of the transactions contemplated hereby or by the Transaction Documents, declare unlawful any of the transactions contemplated hereby or by the Transaction Documents or cause any of the transactions contemplated hereby or by the Transaction Documents to be rescinded following consummation.

(e) Deliveries. Seller shall have delivered, or caused to be delivered, to Purchaser the documents, certificates and other instruments required under Section 3.02.

ARTICLE 4
REPRESENTATIONS AND WARRANTIES OF SELLER

Subject to the qualifications set forth in the applicable sections or subsections of the Company Disclosure Schedule (it being understood and agreed that the disclosure of any item in the Company Disclosure Schedule shall be deemed to have been disclosed with respect to other representations or warranties in this Article 4 if the relevance of such disclosure to such other representations or warranties in this Article 4 is readily apparent on its face), Seller hereby represents and warrants to Purchaser as of the date hereof and as of the Closing as follows:

Section 4.01 Organization and Good Standing. Seller is a limited liability company, duly formed, validly existing and in good standing under the Laws of the State of Delaware. Each of the Company and its Subsidiaries is a corporation or limited liability company, duly organized, validly existing and in good standing under the Laws of its jurisdiction of organization, which jurisdiction is listed on Section 4.01 of the Company Disclosure Schedule, and has the requisite corporate or limited liability company power and authority to carry on its business as presently conducted and to own, lease and operate its properties. Each of the Company and its Subsidiaries is duly qualified to do business and is in good standing in each jurisdiction listed on Section 4.01 of the Company Disclosure Schedule, which are all of the jurisdictions in which the property owned, leased or operated by it or the nature of the business conducted by it makes such qualification and good standing necessary, except where the failure to be so qualified and in good standing has not had a Material Adverse Effect. The Company has made available to Purchaser correct and complete copies of the Governing Documents of the Company and each of its Subsidiaries. Section 4.01 of the Company Disclosure Schedule sets forth a true, complete and accurate list of all of the Company's Subsidiaries.

Section 4.02 Authority. Each of Seller and the Company has the requisite limited liability company power and authority to execute and deliver this Agreement and the Transaction Documents to which it is a party, to perform its obligations hereunder and thereunder and to consummate the transactions contemplated hereby and thereby. The execution, delivery and performance by Seller and the Company of this Agreement and the Transaction Documents to which it is party and the consummation of the transactions contemplated hereby and thereby have been duly authorized by all necessary limited liability company action on the part of Seller and the Company. Each of this Agreement and the Transaction Documents to which Seller or the Company is a party has been, or will be as of the Closing, duly executed and delivered by Seller or the Company, as applicable, and, assuming the due authorization, execution and delivery by the other parties hereto or thereto, constitutes or will constitute a legal, valid and binding obligation of Seller or the Company, as applicable, enforceable against Seller or the Company, as applicable, in accordance with its terms, subject to the Remedies Exception.

Section 4.03 No Conflicts. Assuming the consents, approvals, Orders and authorizations of, and registrations, declarations and filings with, and notices to, the Governmental Authorities and other Persons referenced on Section 4.04 of the Company Disclosure Schedule are obtained, given, and made at the time required under applicable Law or applicable Material Contract, neither the execution or delivery of this Agreement nor any Transaction Document by Seller or the Company, nor the consummation by Seller or the Company of the transactions contemplated hereby and thereby will: (a) conflict with, contravene or constitute a violation of (whether after the giving of notice, lapse of time or both) the Governing Documents of Seller, the Company or any of its Subsidiaries; (b) contravene, conflict with or constitute a material violation or breach of the terms or conditions of, or constitute (whether after the giving of notice, lapse of time or both) a material default under, any Material Contract; (c) contravene, conflict with or constitute a violation of (whether after the giving of notice, lapse of time or both) any Law or Order to which Seller, the Company or its Subsidiaries are subject in any material respect; or (d) result in the creation or imposition of any Lien (other than a Permitted Lien) upon any Interests or any Assets.

Section 4.04 Consents. No consent, approval, Order or authorization of, or registration, declaration or filing with, or notice to, any Governmental Authority or any other Person or under any Material Contract is required to be obtained or made by Seller, the Company or any of its Subsidiaries in connection with the authorization, execution, delivery and performance of this Agreement or any Transaction Document to which it is a party, as applicable, or in connection with the consummation of the transactions contemplated hereby and thereby, other than as set forth on Section 4.04 of the Company Disclosure Schedule.

Section 4.05 Title to Interests. Seller is the sole record and beneficial owner of the Interests free and clear of all Liens other than restrictions on transfer arising under applicable federal and state securities Laws.

Section 4.06 Capitalization.

(a) Section 4.06(a)(i) of the Company Disclosure Schedule sets forth (i) the number of authorized Equity Securities of the Company and each of its Subsidiaries, and (ii) a complete and correct list of the issued and outstanding Equity Securities of the Company and each of its Subsidiaries, including the name of the record and beneficial owner thereof and the number of Equity Securities held thereby. Except as set forth on Section 4.06(a)(i) of the Company Disclosure Schedule, neither the Company nor any of its Subsidiaries owns or otherwise holds, directly or indirectly, any Equity Securities in any Person. All of the outstanding Equity Securities of each of the Company's Subsidiaries are owned by the Company or another Subsidiary free and clear of all Liens (other than Liens arising under applicable securities Laws that are released no later than the Closing).

(b) All of the Equity Securities of the Company and each of its Subsidiaries have been duly authorized and validly issued, and are fully paid and non-assessable. All of the Interests are owned beneficially and of record by Seller and all of the Equity Securities of each Subsidiary of the Company are directly or indirectly owned beneficially and of record by the Company. There are no outstanding (i) Equity Securities or other securities of the Company or any of its Subsidiaries directly or indirectly convertible into or exchangeable for Equity Securities of the Company or any of its Subsidiaries; (ii) options, warrants, calls, subscriptions or other rights to directly or indirectly acquire from the Company or any of its Subsidiaries or other obligations of the Company or any of its Subsidiaries to issue, any Equity Securities of the Company or any of its Subsidiaries; or (iii) agreements to which Parent or any of its Subsidiaries (including the Company or any of its Subsidiaries) is a party containing profit participation or phantom equity features with respect to the Company or any of its Subsidiaries. There are no outstanding obligations (contingent or otherwise) of the Company or any of its Subsidiaries to repurchase, redeem or otherwise acquire or retire any of its Equity Securities or any warrants or option or other rights to acquire any Equity Securities of the Company or any of its Subsidiaries. There are no statutory or contractual equityholder preemptive or similar rights, rights of first refusal or registration rights with respect to the Equity Securities of the Company or any of its Subsidiaries. There are no agreements, commitments or understandings with respect to the voting or transfer of the Equity Securities or other securities of the Company or any of its Subsidiaries.

(c) Neither the Company nor any of its Subsidiaries has violated any applicable federal or state securities Laws or any preemptive or similar rights created by statute, organizational document or agreement in connection with the offer, sale or issuance of any of the Equity Securities of the Company or any of its Subsidiaries. There is no Liability for, or obligation with respect to, the payment of dividends, distributions or similar participation interests declared or accumulated but unpaid with respect to any Equity Securities of the Company or any of its Subsidiaries, and there are no restrictions of any kind which prevent the payment of the foregoing by the Company or any of its Subsidiaries.

Section 4.07 Financial Statements.

(a) Annexed to Section 4.07(a)(i) of the Company Disclosure Schedule are true, correct and complete copies of (i) the unaudited consolidated balance sheets of the Company and its Subsidiaries, as of December 31, 2017 and 2016 and the related unaudited consolidated statements of income for the years then ended and (ii) the unaudited consolidated balance sheet of the Company and its Subsidiaries, as of September 30, 2018 (the "Balance Sheet") and the related unaudited consolidated statement of income for the nine (9) months then ended (collectively, the "Financial Statements"). Except as set forth therein and except as set forth on Section 4.07(a) of the Company Disclosure Schedule, the Financial Statements (x) have been prepared in accordance with the accounting principles set forth on Schedule 4.07(a) (the "Company Accounting Principles") and consistent with past practices, except that the interim Financial Statements described in clause (ii) immediately above are subject to the absence of footnotes and to normal year-end adjustments (which will not be material individually or in the aggregate), (y) fairly present, in all material respects, the consolidated financial position and results of operations of the Company and its Subsidiaries in accordance with the Company Accounting Principles at the respective dates set forth therein and for the respective periods covered thereby, and (z) are consistent with the books and records of the Company and its Subsidiaries. Since December 31, 2017, there has been no change in any accounting principles, policies, methods or practices of the Company and its Subsidiaries except as set forth on Section 4.07(a)(ii) of the Company Disclosure Schedule.

(b) Neither the Company nor any of its Subsidiaries has any Liabilities required to be accrued on a balance sheet in accordance with GAAP, except (i) as and to the extent specifically accrued for or reserved against in the Balance Sheet, (ii) Liabilities which have arisen after the date of the Balance Sheet in the ordinary course of business consistent with past practice (none of which results from, arises out of, relates to, is in the nature of, or was caused by any breach of contract, breach of warranty, tort, infringement or violation of Law), (iii) executory obligations under Contracts (other than Liabilities relating to any breach, or any fact or circumstance that, with notice, lapse of time or both, would result in a breach, thereof by the Company or any of its Subsidiaries), (iv) Liabilities that would not reasonably be expected to be material to the Company and its Subsidiaries taken as a whole and (v) Liabilities specifically set forth on Section 4.07(b) of the Company Disclosure Schedule.

(c) Neither the Company nor any of its Subsidiaries is responsible for any of the obligations or Liabilities of Maple Star Colorado that are specified in detail on Section 4.07(c) of the Company Disclosure Schedule.

Section 4.08 Absence of Certain Developments. Except as set forth on Section 4.08 of the Company Disclosure Schedule, since December 31, 2017 (the "Reference Date") through the date of this Agreement, (a) the Company and its Subsidiaries have conducted their business in all material respects in the ordinary course of business consistent with past practice, (b) there has not been a Material Adverse Effect, and (c) none of Parent, Seller, the Company nor any of the Company's Subsidiaries has taken any action that, if taken after the date of this Agreement, would constitute a breach of any of the covenants set forth in Section 6.15.

Section 4.09 Material Contracts.

(a) Section 4.09(a) of the Company Disclosure Schedule sets forth, as of the date of this Agreement, a true, complete and accurate list (by reference to the applicable subsection hereof) of the following types of undischarged Contracts to which the Company or any of its Subsidiaries are bound or are a party (excluding any Employee Benefit Plan):

(i) indentures, credit agreements, security agreements, mortgages, guarantees, promissory notes and Contracts relating to or evidencing Indebtedness of the Company or any of its Subsidiaries;

(ii) each Contract that contains a covenant not to compete or a material exclusivity requirement or otherwise prohibits the Company or its Subsidiaries or any of their respective present or future Affiliates from competing with or engaging in any business activity anywhere in the world or soliciting for employment, hiring or employing any Person in any geographic location;

(iii) all partnership agreements, limited liability company agreements, joint venture agreements or similar Contracts;

(iv) each Contract relating to the acquisition or sale of a business (or all or substantially all of the assets thereof) by the Company or any of its Subsidiaries;

(v) each Contract involving the settlement of any Proceeding or threatened Proceeding involving payments by the Company or any of its Subsidiaries in excess of Three Hundred Thousand Dollars ($300,000);

(vi) except for indemnity Contracts (or other similar contracts) relating to the Existing Performance Bonds, any Contract the primary purpose of which is to provide for the indemnification of a third party by any of the Company and its Subsidiaries;

(vii) each Contract that contains a most favored nation or similar provision in favor of any counterparty or that obliges the Company to purchase or otherwise obtain any product or service exclusively from a single party;

(viii) each Contract involving or expected to involve payments of more than Three Hundred Thousand Dollars ($300,000), in the aggregate, in any calendar year to or by the Company or any of its Subsidiaries; and

(ix) each Contract not required to be disclosed pursuant to any of the other subsections of this Section 4.09(a) that provided for revenue (on a consolidated basis) to the Company and its Subsidiaries in excess of Three Hundred Thousand Dollars ($300,000) for the twelve (12) month period ended on the date hereof.

(b) Each Contract listed or required to be listed on Section 4.09(a) of the Company Disclosure Schedule (collectively, the "Material Contracts") is, in all material respects, in full force and effect, is valid, binding and enforceable in accordance with its terms, subject in each case to the Remedies Exception and any termination of such Material Contracts expressly provided under this Agreement or the Transaction Documents. Neither the Company or its Subsidiaries nor, to Seller's Knowledge, any other party to any Material Contract has materially violated or breached, or committed any material default under, nor, to Seller's Knowledge, has any event occurred within the last three (3) years which with the giving of notice or the passage of time or both would constitute a material breach or default by the Company or any of its Subsidiaries or any other party under any Material Contract. True, complete and accurate copies of the Material Contracts, together with all modifications and amendments thereto, previously have been delivered or made available to Purchaser, or, to the extent any of such Material Contracts are oral, Section 4.09(a) of the Company Disclosure Schedule contains a description of the material terms thereof. Neither Seller, the Company nor any of its Subsidiaries has, in the last three (3) years, received any written notice regarding any material violation or breach of, or material default under, any such Material Contract.

Section 4.10 Title to Assets; No Liens.

(a) Except as set forth on Section 4.10(a) of the Company Disclosure Schedule, each of the Company and its Subsidiaries has good and marketable title to, or a valid leasehold interest in or the right to use, all of the tangible assets and property used or held in and necessary for the conduct of the Business, as presently conducted (collectively, the "Assets"), free and clear of all Liens (except Permitted Liens). The Assets, together with the services to be provided pursuant to the Transition Services Agreement, the insurance policies of Parent or its Subsidiaries, the two (2) servers to be delivered by Seller to Purchaser pursuant to Section 6.10, the "Pathways" name and logo and the name "Pathways by Molina", are all of the assets and property that are necessary to enable the Business of the Company and its Subsidiaries to be conducted immediately after the Closing in the same manner as the Business of the Company and its Subsidiaries have been conducted since the Reference Date and in accordance with the terms of their Contracts.

(b) All material items of tangible personal property owned or leased by the Company or any its Subsidiaries are in good operating condition and repair, ordinary wear and tear excepted, and are suitable for the purposes for which they are presently being used.

Section 4.11 Real Property.

(a) Section 4.11(a)(i) of the Company Disclosure Schedule sets forth, as of the date of this Agreement, a complete list of the addresses of all real property owned in fee by the Company or any of its Subsidiaries as of the date of this Agreement (the "Owned Real Property"). With respect to each Owned Real Property: (i) either the Company or one (1) of its

Subsidiaries has good and insurable title in fee simple to each parcel of Owned Real Property, free and clear of all Liens except for Permitted Liens; (ii) there are no outstanding options, rights of first offer or rights of first refusal to purchase the Owned Real Property or any portion thereof or interest therein; and (iii) except as set forth on Section 4.11(f) of the Company Disclosure Schedule, no Person other than the Company or its Subsidiaries, as applicable, has any right to use, occupy or lease any of the Owned Real Property (other than any right pursuant to a Permitted Lien). Seller has made available to Purchaser copies of all material reports, surveys, plans, books, and records relating to the business of owning, operating, maintaining and/or managing the Owned Real Property, including, but not limited to, all accounting, financial, tax, sales, maintenance and similar records, each of which pertain to Owned Real Property, in each case to the extent in Seller's and/or its Affiliates' possession or control (the "Real Property Documents"). The Real Property Documents constitute all material documents which are in Seller's and its Affiliates' possession or control. For purposes of the preceding representation, "material documents" means one (1) or more documents which would put a reasonable person on notice that a material defective condition, violation of or termination of an easement or other material adverse impact on appurtenant rights, land use change, claim or potential claim, or other material problem with the ownership, use, operation or management of the Owned Real Property exists or is threatened and such material problem is reasonably estimated to cost One Hundred Thousand Dollars ($100,000.00) or more to repair or remediate or correct.

(b) Section 4.11(b) of the Company Disclosure Schedule sets forth, as of the date of this Agreement, a complete list of all leases of real property (such real property, the "Leased Real Property") to which the Company or any of its Subsidiaries is currently a party as a tenant or occupant (together with all amendments, extensions, and renewals with respect thereto, each a "Lease"). A true, correct and complete copy of each such written Lease (including all amendments and other modifications), as in the Company's possession, has been made available to Purchaser prior to the date hereof. With respect to each Leased Real Property, the Company's or its applicable Subsidiary's possession and quiet enjoyment under the applicable Lease has not been disturbed.

(c) The Real Property comprises all of the real property that is used by the Company or its Subsidiaries in the Business. No condemnation Proceeding or similar Proceeding is pending or, to Seller's Knowledge, threatened in writing with respect to any part or interest in any Owned Real Property or, to Seller's Knowledge, Leased Real Property. Except as set forth on Section 4.11(c) of the Company Disclosure Schedule, to Seller's Knowledge, all of the Real Property is in good operating condition and repair, subject only to ordinary wear and tear, and is sufficient for the operation of the Business as currently conducted. To Seller's Knowledge, there are no facts or conditions affecting the Real Property that would reasonably be expected to materially interfere with the current use and occupancy of such Real Property or the operation of the Business as currently conducted. To Seller's Knowledge, there are no material violations of any Laws, Permits or certificates of occupancy affecting any of the Real Property. During the last three (3) years, neither the Company nor any of its Subsidiaries has received any notice from any insurance company or board of fire underwriters of any defects or inadequacies that would reasonably be expected to materially adversely affect the insurability of any Real Property or requesting the performance of any material work or alteration with respect to any Real Property. To Seller's Knowledge, no event has occurred that would reasonably be expected to result in the termination or material impairment of presently available access from adjoining public or private

streets or ways or in the discontinuation of presently available sewer, water, electric, gas, telephone or other utilities or services for any Real Property. The Company and/or the Subsidiaries have all certificates of occupancy, licenses, and Permits as necessary for the lawful operation of the Real Property in the manner as currently operated.

(d) Each Lease is legal, valid and binding on the Company or its applicable Subsidiary and, to Seller's Knowledge, on the other parties thereto, and, to Seller's Knowledge, is in full force and effect, in accordance with its terms (subject to the Remedies Exception). The Leased Real Property is (i) used in a manner which is consistent and permitted by applicable zoning ordinances and other applicable Laws or regulations, (ii) is served by all water, sewer, electrical, telephone, drainage and other utilities required for normal operations of the business of the Company and its Subsidiaries, and (iii) is equipped with building systems which are adequate for the conduct of the business of the Company and its Subsidiaries as it presently is or has been conducted. During the last three (3) years, neither the Company nor any of its Affiliates has received written notice of any uncured violation of any Laws affecting any of the Leased Real Property, including any zoning regulation or ordinance (with respect to parking), building, fire, health or other Law. During the last three (3) years, neither the Company nor any of its Affiliates has received any written notice of any uncured violation of any declarations, restrictive covenants, or easements with respect to any Leased Real Property.

(e) The Company or its applicable Subsidiary has paid all rent and other amounts heretofore due and payable under each Lease (including any utility charges, common area maintenance charges, real property taxes or assessments payable by the Company or such Subsidiary under each Lease).

(f) Except as otherwise set forth in Section 4.11(f) of the Company Disclosure Schedule, neither the Company nor any of its Subsidiaries has leased, subleased, licensed or otherwise granted any Person the right to use or occupy the Real Property or any portion thereof.

(g) To Seller's Knowledge, no party is in breach or default under any Lease in any material respect and no event has occurred which, with notice or lapse of time, would constitute a breach or default under any Lease in any material respect.

Section 4.12 Intellectual Property.

(a) Section 4.12(a) of the Company Disclosure Schedule sets forth, as of the date of this Agreement, a true, complete and accurate list of the (i) patents and patent applications; (ii) trademark and service mark registrations and applications for registration thereof; (iii) copyright registrations and applications for registration thereof; and (iv) internet domain name registrations, in each case that are owned by the Company or any of its Subsidiaries, including for each item listed, as applicable, the owner, the jurisdiction, the application/serial number, the patent/registration number, the filing date, and the issuance/registration date. All such registrations and applications are valid and in full force and effect and the Company and its Subsidiaries have taken all reasonable actions required to maintain their validity and effectiveness.

(b) Except as set forth on Section 4.12(b) of the Company Disclosure Schedule, (i) there are no written and outstanding claims or allegations of infringement or unauthorized use of any third party Intellectual Property or technology that has been sent to the Company or any of its Subsidiaries, (ii) there have been no written and outstanding claims made against the Company or any of its Subsidiaries asserting the invalidity, misuse or unenforceability of any of the Intellectual Property owned by the Company or any of its Subsidiaries, (iii) during the three (3) years preceding the date of this Agreement, neither the Company nor any of its Subsidiaries has received any written notices of any infringement or misappropriation by, or conflict with, any third party with respect to any Intellectual Property (including any demand or request in writing that the Company or any of its Subsidiaries license any Intellectual Property rights from a third party in order to avoid infringement or misappropriation), (iv) during the three (3) years preceding the date of this Agreement, to Seller's Knowledge, the conduct of the Company's Business and that of its Subsidiaries have not materially infringed, misappropriated or conflicted with and does not materially infringe, misappropriate or conflict with any Intellectual Property rights of other Persons, (v) to Seller's Knowledge, the Company and all of its Subsidiaries has the right to use and license the Intellectual Property material to their Business, and (vi) to Seller's Knowledge, no third party is currently infringing, misappropriating, diluting or otherwise violating any Intellectual Property owned by the Company or any of its Subsidiaries that is material to the Business. To Seller's Knowledge, the transactions contemplated by this Agreement will not have an adverse effect on the Company's or any of its Subsidiaries right, title or interest in and to the Intellectual Property listed on Section 4.12(a) of the Company Disclosure Schedule and all of such Intellectual Property shall be owned or available for use by the Company and its Subsidiaries on identical terms and conditions immediately after the Closing.

(c) The Company and its Subsidiaries have taken all industry standard and commercially reasonable security measures (i) to safeguard and maintain the secrecy and confidentiality of the Intellectual Property owned by the Company and/or its Subsidiaries that comprises trade secrets or other confidential information that is material to the Business ("Proprietary Information") and, to Seller's Knowledge, there has not been any release, publication, disclosure or other dissemination of such Proprietary Information except as permitted under agreements between the Company (or any of its Subsidiaries) or third parties that contain confidentiality or non-disclosure provisions with respect to such Proprietary Information.

Section 4.13 Litigation. Except as set forth on Section 4.13 of the Company Disclosure Schedule, there is no material Proceeding pending, or to Seller's Knowledge, threatened against the Company or any of its Subsidiaries. Except as set forth on Section 4.13 of the Company Disclosure Schedule, there are no material Proceedings pending or threatened by the Company or any of its Subsidiaries that would reasonably be expected to result in a material Liability or obligation of the Company or any of its Subsidiaries. Neither the Company nor any of its Subsidiaries, nor any of their businesses or assets, is subject to any outstanding Order.

Section 4.14 Compliance with Laws.

(a) The Company and each of its Subsidiaries are, and have been during the last three (3) years, in compliance in all material respects with all Laws related to the conduct, ownership, use, occupancy or operation of its Business and the Assets.

(b) Except as set forth on Section 4.14(b)(i) of the Company Disclosure Schedule, neither the Company nor any of its Subsidiaries has received any written notice or other communication from a Governmental Authority during the last three (3) years or, to Seller's Knowledge, been subject to any audit or investigation by a Governmental Authority which alleges or asserts that the Company or any such Subsidiary has violated any Laws in any material respect. There is no material audit, claim, action, suit, investigation or administrative or other legal Proceeding pending or, to Seller's Knowledge, threatened against the Company or any of its Subsidiaries relating to the Company's or such Subsidiary's participation in any Government Program or private third party payment program. Except as forth on Section 4.14(b)(ii) of the Company Disclosure Schedule, during the last three (3) years, no single Government Program or single private third party payment program has requested or, to Seller's Knowledge, threatened any recoupment, refund or set-off from the Company or any of its Subsidiaries in excess of One Hundred Thousand Dollars ($100,000) in the aggregate other than in the ordinary course of business.

Section 4.15 Healthcare Matters.

(a) The Company and its Subsidiaries are, and have been during the last three (3) years, in compliance in all material respects with all Healthcare Laws. During the last three (3) years, neither the Company nor any of its Subsidiaries has received any written notice from any Governmental Authority regarding any actual or alleged violation in any material respect of, or failure to be in compliance in any material respect with, any Healthcare Laws.

(b) (i) The Company and each of its Subsidiaries possesses all material Permits required by applicable Healthcare Laws necessary for the operation of the Business; (ii) the Company and each of its Subsidiaries has been, during the last three (3) years, in compliance in all material respects with such Permits, and all of such Permits are valid and in full force and effect; (iii) there is no action or investigation by or before any Governmental Authority pending or, to Seller's Knowledge, threatened against the Company or any of its Subsidiaries to revoke, suspend, or otherwise materially restrict any such Permit; (iv) neither the Company nor any of its Subsidiaries has received, during the last three (3) years, any written notice from any Governmental Authority regarding any actual or alleged material violation of, or failure to be in compliance in all material respects with, any such Permit or any revocation, withdrawal, suspension, cancellation or termination of any such Permit; and (v) the Company and each of its Subsidiaries has filed all material reports (or corrected in or supplemented such reports by a subsequent filing) and maintained and retained all records required by applicable Healthcare Laws pertaining to all of its respective material Permits. The Permits are renewable by their terms or in the ordinary course of business consistent with past practice, without the need to comply with any special qualification procedures or to pay any material fines or penalties other than routine filing fees.

(c) None of the Company, any of the Company's Subsidiaries, or any of their respective directors, officers or managing employees has been during the last three (3) years or is currently suspended, excluded or debarred from contracting with any Governmental Authority or from participating in any Federal Health Care Program (as defined in 42 USC § 1320a-7b(f)) or, to Seller's Knowledge, is subject to an investigation or Proceeding by any Governmental Authority that has resulted in or would reasonably be expected to result in such suspension,

exclusion, or debarment; nor has the Company or any of its Subsidiaries or, to Seller's Knowledge, any of their respective directors, officers or managing employees, received written notice of any impending or potential exclusion or listing. Neither the Company nor any of its Subsidiaries has been, during the last three (3) years, subject to sanction pursuant to 15 U.S.C. § 41 et seq. or 42 U.S.C. § 1320a-7a or 1320a-8, or been charged with or convicted of a crime described at 42 U.S.C. § 1320a-7b, and no such sanction or Proceeding is pending or, to Seller's Knowledge, threatened.

(d) To Seller's Knowledge, none of the Company's or any of its Subsidiaries' respective professionals and personnel have, during the last three (3) years: (i) been excluded, suspended, debarred, or terminated from participation in any Government Program or prohibited from contracting with the federal government, (ii) been included on any federal or state exclusion list, including the Office of Inspector General's List of Excluded Individuals (LEIE), the System Award Management (SAM) excluded parties list, and any state Medicaid exclusion list, (iii) had a professional license or certification, Drug Enforcement Administration registration (as applicable), Government Program provider status, suspended, terminated, restricted or revoked, or (iv) had staff privileges at any health care facility suspended, restricted, terminated, or revoked for a reason relating to patient care.

(e) The Company has conducted all billing and collection practices in material compliance with all Healthcare Laws and the conditions for participation, contracts, rules, regulations, and requirements of all Government Programs in all material respects.

(f) There is no material Proceeding, investigation or survey pending or, to Seller's Knowledge, threatened by any third-party payor programs with respect to any program conducted by the Company or its Subsidiaries.

Section 4.16 HIPAA Matters.

(a) Each business, entity or component of any entity owned or controlled by the Company or any of its Subsidiaries that is a health plan, healthcare clearinghouse or healthcare provider, as such terms are defined in the Federal Privacy Regulations (collectively, the "Covered Entities") or is a Business Associate (as such term is defined in the Federal Privacy Regulations), is, and during the last three (3) years has been, in compliance in all material respects with the administrative simplification section of HIPAA, the Federal Privacy Regulations, the Federal Security Regulations, the Breach Notification Rule, the Federal Electronic Transaction Regulations, or applicable state privacy laws. Without limiting the generality of the foregoing, each of the Company and its Subsidiaries is, and during the last three (3) years has been, in compliance in all material respects with 45 C.F.R. § 164.308(a)(1)(ii)(A).

(b) Except to the extent listed on Section 4.16(b)of the Company Disclosure Schedule, neither Company nor any of its Subsidiaries has received during the last three (3) years any written notice or communication alleging any non-compliance, unauthorized use or disclosure, successful security incident or breach of Protected Health Information under HIPAA or any state law and has not notified any person or any Governmental Authority with respect to such incident or breach. The Company has not previously been and is not currently subject to

any audit, inquiry, proceeding, investigation or enforcement action by any Governmental Authority related to Protected Health Information.

(c) To Seller's Knowledge, there has been no material breach by a Business Associate of any Business Associate Agreement or any violation by a Business Associate of HIPAA, the Federal Transaction Regulations, the Federal Privacy Regulations, the Federal Security Regulations, or corresponding state Laws.

(d) Except as set forth on Section 4.16(d) of the Company Disclosure Schedule, neither the Company nor any of its Subsidiaries has experienced a Breach of Unsecured Protected Health Information as defined by HIPAA, for which Breach notification was required under HIPPA.

Section 4.17 Permits. The Company and its Subsidiaries hold and have at all times during the last three (3) years held, and are operating and have at all times during the last three (3) years been operating in compliance in all material respects with, all Permits necessary for the conduct, ownership, use, occupancy or operation of their Business and/or the Assets, including all Permits required pursuant to the Material Contracts. Section 4.17 of the Company Disclosure Schedule sets forth, as of the date of this Agreement, a correct and complete list of all such material Permits of the Company and its Subsidiaries and complete and correct copies thereof have been made available to Purchaser. Such material Permits are in full force and effect and have not been revoked, suspended, canceled or terminated.

Section 4.18 Environmental Matters. Each of the Company and its Subsidiaries have at all times been in material compliance with all applicable Environmental Law. Neither the Company nor any of its Subsidiaries has received, during the last three (3) years, any written notice of any material violation of, or material Liability under, any Environmental Laws. The Company and its Subsidiaries have all material Permits which are required to be held by them under applicable Environmental Laws for the operation of the Business and has made available to Purchaser true and complete copies of all such Permits. To Seller's Knowledge, there are no material Proceedings or investigations by any Governmental Authority pending or threatened against or affecting the Company or its Subsidiaries related to Environmental Laws. Neither the Company nor any of its Subsidiaries has treated, stored, disposed of, arranged for the disposal of, transported, handled, or released any Hazardous Materials in violation of or in a manner which would reasonably be expected to form the basis of material Liability under any applicable Environmental Laws. To Seller's Knowledge, other than as could not reasonably be expected to result in a material Liability of the Company or its Subsidiaries, there has been no release, spill, emission, dumping, injection, pouring, deposit, disposal, discharge, dispersal or leaching into or through the environment or within any building, structure, facility or fixture, of any Hazardous Materials, at, on or under the Owned Real Property or any other property currently or previously owned, leased or operated by the Company or its Subsidiaries. Neither the Company nor any of its Subsidiaries has entered into any consent decree or agreement or is subject to any Order imposing any material Liability or material requirement under any applicable Environmental Law. All environmental assessments, studies or compliance audits which contain material information relating to the Company or its Subsidiaries including, without limitation, with respect to its or their current or former operations, the Owned Real Property or any other property currently or previously owned, leased or operated by the Company or its Subsidiaries

and are in the possession of or, to Seller's Knowledge, were initiated by Seller or the Company, have been made available to Purchaser. Except for the representations and warranties contained in this Section 4.18 and Section 4.17, Seller makes no representations or warranties relating to Environmental Laws or Hazardous Materials.

Section 4.19 Employee Matters.

(a) No collective bargaining agreement or similar agreement with any labor union is currently in effect with respect to any employee of the Company or any of its Subsidiaries, and neither the Company nor any of its Subsidiaries is presently negotiating any collective bargaining agreement in respect of any employee of the Company or any of its Subsidiaries. No organizational effort is presently being made or, to Seller's Knowledge, threatened by or on behalf of any labor union with respect to employees of the Company or any of its Subsidiaries. No strike, lockout, shutdown, slowdown, picketing or unfair labor practice charge (whether or not resolved) has occurred at any time during the last three (3) years or is pending or threatened against the Company or any of its Subsidiaries.

(b) Except as set forth on Section 4.19(b) of the Company Disclosure Schedule, each of the Company and its Subsidiaries is and has been in compliance in all material respects with all Laws which relate to employment matters, employment practices and terms and conditions of employment, including without limitation wages, benefits, hours, overtime, discrimination, equal opportunity, harassment, immigration, disability, affirmative action, leaves of absence, rest periods, meal breaks, workers' compensation, unemployment insurance, occupational health and safety and the collection and payment of withholding and/or social contribution Taxes and similar Taxes, plant closings, mass layoffs and relocations. During the last three (3) years, (i) there has been no claim, arbitration, mediation, charge, or litigation against the Company or any of its Subsidiaries relating to any employment or labor matter, and (ii) there has been no audit, investigation, or examination of the Company or any of its Subsidiaries by any Governmental Authority regarding any employment or labor matter. Neither the Company nor any of its Subsidiaries is, and has ever been, a party to or otherwise bound by any judgment, citation, decree or Order by any Governmental Authority relating to employees or employment practices. Each of the Company and each of its Subsidiaries has timely paid in full to each current or former employee or, if not past due, adequately accrued in accordance with GAAP all wages, salaries, commissions, bonuses, benefits and other compensation due to or on behalf of such employees. Except as would not reasonably be expected to have a Material Adverse Effect, each of the Company and each of its Subsidiaries has during the last three (3) years properly classified in accordance with the requirements of all applicable Laws all of its service providers either as an "employee" or "independent contractor" and as exempt or non-exempt from overtime requirements and has made all appropriate filings in connection with services provided by, and compensation paid to, such service providers. Further, to Seller's Knowledge, no employee of the Company and its Subsidiaries is in any respect in violation of any term of any employment agreement, nondisclosure agreement, common law nondisclosure obligation, fiduciary duty, noncompetition agreement, restrictive covenant or similar obligation with or to the Company or any Subsidiary.

(c) During the ninety (90) days prior to the date of this Agreement, neither the Company nor any of its Subsidiaries has engaged in or effectuated any "plant closing" or

employee "mass layoff" (in each case, as defined in the Worker Adjustment Retraining and Notification Act of 1988, as amended, or any similar state or local statute, rule or regulation) affecting any site of employment or one (1) or more facilities or operating units within any site of employment or facility of the Company or any of its Subsidiaries.

Section 4.20 Employee Benefit Plans.

(a) Section 4.20(a) of the Company Disclosure Schedule lists, as of the date of this Agreement, all Employee Benefit Plans. With respect to each Employee Benefit Plan, the Company has made available to Purchaser correct, current and complete copies, as applicable, of (i) each written plan document (including any amendments thereto) and descriptions of all material terms of any such plan that is not in writing; (ii) the most recent summary plan description; (iii) any trust documents or funding arrangements relating thereto (including group insurance contracts); (iv) the three (3) most recent annual reports with accompanying schedules and attachments, filed with the IRS; (v) the nondiscrimination testing results for the last three (3) plan years; and (vi) material correspondence from any Governmental Authority with respect to any Employee Benefit Plan within the past three (3) years.

(b) Except as set forth on Section 4.20(b) of the Company Disclosure Schedule, with respect to each Employee Benefit Plan: (i) such Employee Benefit Plan has been operated and administered in compliance, in all material respects, with its terms and all applicable Law (including but not limited to ERISA and the Code); (ii) there are no pending or, to Seller's Knowledge, threatened claims against, by or on behalf of any Employee Benefit Plan (other than routine claims for benefits); (iii) no audits, inquiries, reviews, Proceedings, claims, or demands are pending with any Governmental Authority; (iv) all premiums, contributions, or other payments required to have been made by Law or under the terms of any Employee Benefit Plan or any contract or agreement relating thereto as of the Closing Date have been made (or, to the extent not yet due, properly accrued on the Balance Sheet in accordance with the terms of the Employee Benefit Plan and all applicable Laws); and (v) there have been no acts or omissions by the Company, any Subsidiary or any ERISA Affiliate that have given or would give rise to any material fines, penalties, Taxes or related charges under Sections 502(c), 502(i), 502(l), 502(m) or 4071 of ERISA or Section 511 or Chapter 43 of the Code, or under any other applicable Law, for which the Company, any Subsidiary or any ERISA Affiliate may be liable.

(c) Each Employee Benefit Plan that is intended to be qualified under Section 401(a) of the Code and in which any employee of the Company or any of its Subsidiaries participates (each, a "Seller 401(k) Plan") (i) has received a favorable determination or opinion letter or advisory letter from the IRS; (ii) has pending or has time remaining in which to file an application for such a determination from the IRS; or (iii) may rely upon a prototype opinion letter or a volume submitter advisory letter from the IRS. To Seller's Knowledge, no event has occurred that would reasonably be expected to cause the loss of such qualified status.

(d) Except as would not reasonably be expected to result in material liability to Seller or the Company, no non-exempt prohibited transaction (within the meaning of Section 406 of ERISA or Section 4975 of the Code) has occurred with respect to any Employee Benefit Plan.

(e) No Employee Benefit Plan is or was, and none of the Company, any of its Subsidiaries or any of their respective ERISA Affiliates contributes to, has within the preceding six (6) years contributed to, or has any obligation or Liability with respect to, (i) a "multiemployer plan" (within the meaning of Section 3(37) of ERISA); (ii) a pension plan subject to Title IV or Section 302 of ERISA or Section 412 of the Code; (iii) a "multiple employer plan" (within the meaning of Section 413(c) of the Code); or (iv) a "multiple employer welfare arrangement" (within the meaning of Section 3(40) of ERISA).

(f) Neither Seller, the Company nor any of its Subsidiaries is obligated under any Employee Benefit Plan or otherwise to provide medical or death benefits with respect to any current or former employee of the Company, any Subsidiary or their predecessors after termination of employment, except as required under Section 4980B of the Code or Part 6 of Title I of ERISA or other applicable law.

(g) Seller, the Company and their ERISA Affiliates have each complied in all material respects with the notice and continuation coverage requirements, and all other requirements, of Section 4980B of the Code and Parts 6 and 7 of Title I of ERISA, and the regulations thereunder.

(h) Seller, the Company and each Employee Benefit Plan that is a "group health plan" as defined in Section 733(a)(1) of ERISA (each, a "Health Plan") is and has at all times been in compliance, in all material respects, with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("ACA"), and to Seller's Knowledge no condition or circumstance exists, that would reasonably be expected to subject Seller, the Company or any Health Plan to penalties or excise taxes under Code Section 4980D or 4980H or any other provision of the ACA.

(i) Each Employee Benefit Plan that is a "nonqualified deferred compensation plan" (within the meaning of Section 409A(d)(1) of the Code) subject to Section 409A of the Code satisfies, in all material respects, in form and operation the requirements of Sections 409A(a)(2), 409A(a)(3) and 409A(a)(4) of the Code and the guidance thereunder (and has satisfied such requirements over the past three (3) years or, if later, for the entire period during which Section 409A of the Code has applied to such Employee Benefit Plan), and no additional material Tax under Section 409A(a)(1)(B) of the Code has been or would reasonably be expected to be incurred by a participant in any such Employee Benefit Plan.

(j) Neither the execution and delivery of this Agreement, nor the consummation of the transactions contemplated hereby, either alone or in combination with another event (whether contingent or otherwise) (i) will give rise to any "excess parachute payment" under Section 280G of the Code; or (ii) except as set forth on Section 4.20(j) of the Company Disclosure Schedule, (x) will accelerate the vesting, funding or time of payment of any compensation or other benefit due by the Company or any of its Subsidiaries to any employee, director or individual independent contractor of the Company or any of its Subsidiaries or (y) will increase the amount or value of any payment, compensation or benefit to any employee, director or individual independent contractor of the Company or any of its Subsidiaries.

(k) Except with respect to any Employee Benefit Plan listed on Section 4.20(a) of the Company Disclosure Schedule, there are no obligations of the Company or its Subsidiaries under

any deferred compensation arrangement or phantom stock arrangement or any "success fees" or bonuses, or severance payments or employee change of control payments payable or to be payable to employees of the Company or its Subsidiaries arising solely from or otherwise triggered solely by the closing of the transactions contemplated hereby (including the employer portion of employment Taxes imposed on the Company or its Subsidiaries with respect to such payments).

(l) Except as set forth on Section 4.20(l) of the Company Disclosure Schedule, there are no obligations of the Company or its Subsidiaries with respect to any Employee Benefit Plan that is subject to Title IV of ERISA and not funded in accordance with ERISA.

(m) Neither the Company nor its Subsidiaries is party to, nor is it otherwise obligated under, any contract, plan or arrangement that provides for a "gross-up," make-whole or similar payment in respect of any Taxes that may become payable under Section 409A or Section 4999 of the Code.

Section 4.21 Taxes.

Except as set forth on Section 4.21 of the Company Disclosure Schedule:

(a) Each of the Company and its Subsidiaries has duly and timely filed or caused to be timely filed with the appropriate Tax Authority all material Tax Returns required to be filed by, or with respect to, each such entity. All such Tax Returns are true, correct and complete in all material respects. All material Taxes due and owing by any of the Company or its Subsidiaries (whether or not shown on any Tax Return) have been timely paid in full. There are no Liens for material Taxes on any asset of any of the Company or any of its Subsidiaries, other than Permitted Liens. No written claim has ever been made by a Governmental Authority in which the Company or any of its Subsidiaries does not file Tax Returns that the Company or such Subsidiary, as applicable, is or may be subject to taxation by, or required to file Tax Returns in, such jurisdiction. Each of the Company and its Subsidiaries has timely withheld and paid to the appropriate Governmental Authority all material Taxes required to have been withheld and paid in connection with amounts owing to any employee, independent contractor, creditor, stockholder, limited liability company member, or other third party.

(b) No deficiencies for material Taxes with respect to the Company or its Subsidiaries have been claimed, proposed or assessed in writing by any Tax Authority, which deficiencies have not yet been finally settled. There are no audits, investigations, assessments, Proceedings, claims or other actions by a Tax Authority for or relating to any material Liability in respect of Taxes of the Company or its Subsidiaries in process, pending or threatened in writing.

(c) No extension or waiver of the statute of limitations in respect of any material Taxes is currently in effect, nor has any request been made in writing for any such extension or waiver.

(d) None of the Company or any of its Subsidiaries is a party to any Tax sharing, Tax allocation, Tax indemnity or similar agreement, other than customary commercial Contracts entered into in the ordinary course of business the primary purpose of which does not relate to the sharing, allocation or indemnification of any Tax.

(e) Except as set forth on Section 4.21(e) of the Company Disclosure Schedules, from and after January 1, 2014, none of the Company or any of its Subsidiaries (i) has been a member of an affiliated group of corporations within the meaning of Section 1504 of the Code or a member of or participant in any group or fiscal unity within the meaning of any similar provision of Law to which the Company or any of its Subsidiaries may be subject, other than the affiliated group of which Parent is the common parent or (ii) has any Liability for the Taxes of any Person (other than the Company or any of its Subsidiaries) under Treasury Regulations Section 1.1502-6 (or any similar provision of Law) as a transferee or successor, by Contract or otherwise.

(f) Neither the Company nor any of its Subsidiaries has participated in any "listed transaction" within the meaning of Treasury Regulations Section 1.6011-4.

(g) Neither the Company nor any of its Subsidiaries will be required to include any item of income in, or exclude any item of deduction from, taxable income for any taxable period (or portion thereof) beginning after the Closing Date as a result of any (i) change in method of accounting for a taxable period ending on or prior to the Closing Date; (ii) "closing agreement" as described in Section 7121 of the Code (or any corresponding or similar provision of state, local or non-U.S. income Tax law) executed on or prior to the Closing Date; (iii) intercompany transaction or excess loss account described in Treasury Regulations under Section 1502 of the Code (or any corresponding or similar provision of state, local or non-U.S. income Tax law); (iv) any use of an improper method of accounting for a taxable period ending on or prior to the Closing Date; (v) installment sale or open transaction disposition made on or prior to the Closing Date; (vi) prepaid amount or deferred revenue received on or prior to the Closing Date; (vii) election under Section 108(i) of the Code; or (viii) election under Section 965(h) of the Code (or any similar provision of any Legal Requirement) or otherwise pursuant to Section 965 of the Code.

(h) Within the past three (3) years, none of the Company or any of its Subsidiaries has distributed stock of another Person nor had its stock distributed by another Person in a transaction that was purported or intended to be governed in whole or in part by Sections 355 or 361 of the Code.

(i) Notwithstanding anything herein to the contrary, (i) no representations or warranties are made with respect to Taxes for any Post-Closing Tax Period and (ii) no representation or warranty is made by Seller, the Company or its Subsidiaries with respect to the existence, amount, usability or any other aspect of any Tax attributes of the Company and its Subsidiaries, including net operating losses, capital loss carryforwards, Tax credit carryforwards, asset bases or depreciation periods.

(j) Neither the Company nor any Subsidiary has (i) a permanent establishment or otherwise has an office or fixed place of business outside of the United States or (ii) a source of income in a jurisdiction other than the country in which it is organized. Each of the Company and each of its Subsidiaries has correctly classified those individuals performing services as common law employees, leased employees, independent contractors or agents of the Company outside of the United States.

Section 4.22 Intercompany Obligations. Except as set forth on Section 4.22(a) of the Company Disclosure Schedule or otherwise expressly permitted by this Agreement, (a) neither Parent nor any of its Subsidiaries (excluding the Company and its Subsidiaries) is a party to any Contract with the Company or any of its Subsidiaries and (b) since December 31, 2017, neither the Company nor any of its Subsidiaries has made any payment to or received any payment from Parent or any of its Subsidiaries (other than the Company or any of its Subsidiaries). Neither Parent nor any of its Subsidiaries (excluding the Company and its Subsidiaries) has any direct or indirect interest in (i) any customer, supplier or other business relationship of the Company or any of its Subsidiaries or (ii) any assets or property used by the Company or any of its Subsidiaries (including any Intellectual Property).

Section 4.23 Insurance Policies. Section 4.23 of the Company Disclosure Schedule sets forth, as of the date of this Agreement, a true, complete and accurate (a) list of all insurance policies to which the Company or any of its Subsidiaries is a party, including those which provide coverage to or for the benefit of or with respect to the Company or any of its Subsidiaries or any director, officer, employee, manager, independent contractor, consultant, leased employee or other service provider of the Company or any of its Subsidiaries in his or her capacity as such (the "Insurance Policies"), indicating in each case the type of coverage, name of the insured, the insurer, the expiration date of each policy and the amount of coverage, and (b) list of any and all claims that have been submitted under any of the Insurance Policies at any time during the last three (3) years (the "Claims History"). True, complete and accurate copies of all such Insurance Policies and the Claims History have been provided or made available to Purchaser. Each Insurance Policy is in full force and effect and shall remain in full force and effect in accordance with its terms and following the Closing as respects accidents, events, happenings, injuries, claims, conduct and occurrences relating to the businesses of the Company and its Subsidiaries prior to the Closing, is provided by a financially solvent carrier and has not been subject to any lapse in coverage. The Company and each of its Subsidiaries are current in all premiums or other payments due under the Insurance Policies and have otherwise complied in all material respects with all of their obligations under each Insurance Policy. The Company and each of its Subsidiaries have given timely notice to the insurer of all claims that may be insured thereby under any Insurance Policy. During the last three (3) years, neither the Company nor any of its Subsidiaries has been refused any insurance by, nor has coverage been limited by, any insurance carrier with which the Company or any of its Subsidiaries has carried insurance or any other insurance carrier to which the Company or any of its Subsidiaries has applied for insurance.

Section 4.24 Bank Accounts. Section 4.24 of the Company Disclosure Schedule is a true, complete and accurate list of each bank or financial institution in which the Company or any of its Subsidiaries has an account, safe deposit box or lockbox, or maintains a banking, custodial, trading or similar relationship, the number of each such account or box, and the names of all persons authorized to draw thereon or having signatory power or access thereto.

Section 4.25 Brokers. No Person is or will be entitled to a broker's, finder's, investment banker's, financial advisor's or similar fee from the Company or its Subsidiaries in connection with this Agreement or any of the transactions contemplated hereby.

Section 4.26 Accounts Receivable. All Accounts Receivable reflected on the Balance Sheet, and all Accounts Receivable of the Business acquired by the Company and its Subsidiaries or arising subsequent to September 30, 2018, but before the date hereof, (a) have been acquired or have arisen only in the ordinary course of business, and (b) to Seller's Knowledge, are collectible in the face value thereof using normal collection procedures (net of the reserve for doubtful accounts set forth in the Balance Sheet). The reserve for doubtful accounts contained in the Balance Sheet has been determined consistent with past practices of the Company and in conformity with the Company Accounting Principles. This Section 4.26 is not intended as a warranty of collectability of any Account Receivable reflected on the Balance Sheet or that Purchaser will realize any minimum amount from collection of the Accounts Receivable.

Section 4.27 Exclusivity of Representations. Except for the representations and warranties contained in Article 4 (as modified by the Company Disclosure Schedule) or Section 9.16, none of the Company, Parent, Seller or any other Person makes or has made any other representation or warranty, expressed or implied, at law or in equity, with respect to Parent, Seller, the Company, its Subsidiaries, the Interests or any of the Company's or its Subsidiaries' respective businesses, assets, liabilities, operations, prospects, or condition (financial or otherwise), and each of Parent and Seller disclaims any other representations or warranties, whether made by Parent, Seller, the Company, its Subsidiaries or any of their respective Affiliates, direct or indirect equityholders, officers, directors, employees, agents or Representatives (collectively, "Related Persons"), and no Related Person has any authority, express or implied, to make any representations, warranties or agreements not specifically set forth in this Agreement and subject to the limited remedies herein provided. Except for the representations and warranties contained in this Article 4 (as modified by the Company Disclosure Schedule) or in Section 9.16, each of Parent and Seller (directly and on behalf of all Related Persons) hereby disclaims all liability and responsibility for any representation, warranty, projection, forecast, statement, or information made, communicated, or furnished (whether orally or in writing, in any data room relating to the transactions contemplated hereby, in management presentations, functional "break-out" discussions, responses to questions or requests submitted by or on behalf of Purchaser or in any other form in consideration or investigation of the transactions contemplated hereby) to Purchaser or its Affiliates or Representatives (including any opinion, information, forecast, projection, or advice that may have been or may be provided to Purchaser or its Affiliates or Representatives by Parent, Seller, the Company or any Related Person). Except for the representations and warranties contained in this Article 4 (as modified by the Company Disclosure Schedule) or in Section 9.16, none of Parent, Seller, the Company or any Related Person has made or makes any representation or warranty to Purchaser or its Affiliates or Representatives regarding: (a) merchantability or fitness of any assets of the Company or its Subsidiaries for any particular purpose; (b) the nature or extent of any liabilities of the Company or its Subsidiaries; (c) the prospects of the business of the Company and its Subsidiaries; (d) the probable success or profitability of the Company or its Subsidiaries; or (e) the accuracy or completeness of any confidential information memoranda, documents, projections, material, statement, data, or other information (financial or otherwise) provided to Purchaser or its Affiliates or made available to Purchaser and its Representatives in any "data rooms," "virtual data rooms," management presentations or in any other form in expectation of, or in connection with, the transactions contemplated hereby, or in respect of any other matter or thing whatsoever. Notwithstanding anything herein or in any Transaction

Document to the contrary, (i) nothing in this Section 4.27 or any other provision of this Agreement or any Transaction Document shall limit or modify the representations and warranties set forth in this Article 4 or Section 9.16 or the right of Purchaser to rely thereon, and (ii) Purchaser retains all rights and remedies with respect to claims based on Fraud ("Fraud Claims").

ARTICLE 5
REPRESENTATIONS AND WARRANTIES OF PURCHASER

Purchaser hereby represents and warrants to Seller as of the date hereof and as of the Closing as follows:

Section 5.01 Organization and Good Standing. Purchaser is a limited liability company, duly organized, validly existing and in good standing under the Laws of the State of Delaware.

Section 5.02 Authority. Purchaser has the requisite limited liability company power and authority to execute and deliver this Agreement and the Transaction Documents to which it is a party, to perform its obligations hereunder and thereunder and to consummate the transactions contemplated hereby and thereby. The execution, delivery and performance by Purchaser of this Agreement and the Transaction Documents to which it is party and the consummation of the transactions contemplated hereby and thereby have been duly authorized by all necessary limited liability company action on the part of Purchaser. Each of this Agreement and the Transaction Documents to which Purchaser is a party has been, or will be as of the Closing, duly executed and delivered by Purchaser and, assuming the due authorization, execution and delivery by the other parties hereto or thereto, constitutes or will constitute a legal, valid and binding obligation of Purchaser, enforceable against Purchaser in accordance with its terms, subject to the Remedies Exception.

Section 5.03 No Conflict. Assuming the consents, approvals, Orders and authorizations of, and registrations, declarations and filings with, and notices to, the Governmental Authorities and other Persons referenced in Section 5.04 are obtained, given, and made at the time required under applicable Law, neither the execution or delivery of this Agreement nor any Transaction Document by Purchaser, nor the consummation by Purchaser of the transactions contemplated hereby or thereby will: (a) conflict with, contravene or constitute a violation of (whether after the giving of notice, lapse of time or both) the Governing Documents of Purchaser; (b) constitute a material default under, or an event which would (or would reasonably be expected to) result in, any right of notice, modification, acceleration, payment, suspension, withdrawal, cancellation or termination under, or release any party thereto from its obligations under, or otherwise materially affect the rights or benefits of Purchaser under, any material contract to which Purchaser is a party or material Permit; or (c) contravene, conflict with or constitute a violation of (whether after the giving of notice, lapse of time or both) any Law or Order to which Purchaser is subject in any material respect.

Section 5.04 Consents. No consent, approval, Order or authorization of, or registration, declaration or filing with, or notice to, any Governmental Authority or under any material contract to which Purchaser is a party is required to be obtained or made by Purchaser in

connection with the execution and delivery of this Agreement or any Transaction Document or in connection with the consummation of the transactions contemplated hereby and thereby, other than consents, notifications or filings which, if not obtained or made, would not reasonably be expected to prevent Purchaser from consummating the transactions contemplated by this Agreement.

Section 5.05 Litigation. There are no Proceedings pending or, to the knowledge of Purchaser, threatened against or affecting Purchaser, which would reasonably adversely affect the ability of Purchaser to consummate the transactions contemplated by this Agreement.

Section 5.06 Investment. Purchaser is purchasing the Interests for investment for its own account and not with a view to, or for sale in connection with, any distribution of the Interests in violation of federal and state securities Laws. Purchaser is an "accredited investor" as defined in Regulation D promulgated under the Securities Act and has sufficient knowledge and experience in financial and business matters so as to be capable of evaluating the merits and risks of its investment in the Interests and is capable of bearing the economic risks of such investment. Purchaser acknowledges that the Interests have not been registered under the Securities Act or any state or foreign securities Laws and that the Interests may not be sold, transferred, offered for sale, pledged, hypothecated or otherwise disposed of unless such sale, transfer, offer, pledge, hypothecation or other disposition is pursuant to the terms of an effective registration statement under the Securities Act and are registered under any applicable state or foreign securities Laws or pursuant to an exemption from registration under the Securities Act and any applicable state or foreign securities Laws.

Section 5.07 Solvency. Purchaser is not entering the transactions contemplated by this Agreement with actual intent to hinder, delay or defraud either present or future creditors. Assuming (a) the accuracy of the representations and warranties set forth in Article 4, (b) that any estimates or projections of the Company and its Subsidiaries provided to Purchaser have been prepared in good faith based upon assumptions that were and continue to be reasonable and (c) compliance by Seller of its obligations set forth herein and in the Transaction Documents immediately after giving effect to the transactions contemplated by this Agreement, each of Purchaser and its Subsidiaries will be Solvent.

Section 5.08 Brokers. No Person is or will be entitled to a broker's, finder's, investment banker's, financial advisor's or similar fee from Purchaser in connection with this Agreement or any of the transactions contemplated hereby.

Section 5.09 Acknowledgement. Except for the specific representations and warranties expressly made by Seller in Article 4 (as modified by the Company Disclosure Schedule) or by Parent in Section 9.16: (a) Purchaser acknowledges and agrees that (i) none of the Company, Seller, Parent or any other Person is making or has made any representation or warranty, expressed or implied, at law or in equity, in respect of the Company, its Subsidiaries, or any of the Company's or its Subsidiaries' respective businesses, assets, liabilities, operations, prospects, or condition (financial or otherwise), including with respect to merchantability or fitness for any particular purpose of any assets, the nature or extent of any liabilities, the prospects of the business of the Company and its Subsidiaries, the effectiveness or the success of any operations, or the accuracy or completeness of any confidential information memoranda,

documents, projections, material or other information (financial or otherwise) regarding the Company or any of its Subsidiaries furnished to Purchaser or its Representatives or made available to Purchaser and its Representatives in any "data rooms," "virtual data rooms," management presentations or in any other form in expectation of, or in connection with, the transactions contemplated hereby, or in respect of any other matter or thing whatsoever, and (ii) no Representative of Seller, Parent the Company, any of its Subsidiaries or any other Person has any authority, express or implied, to make any representations, warranties or agreements not specifically set forth in this Agreement and subject to the limited remedies herein provided; (b) Purchaser specifically disclaims that it is relying upon or has relied upon any such other representations or warranties that may have been made by any Person, and acknowledges and agrees that the Company, Seller, Parent and each of their Representatives have specifically disclaimed and do hereby specifically disclaim any such other representation or warranty made by any Person; (c) Purchaser specifically disclaims any obligation or duty by Seller, Parent, the Company or any other Person to make any disclosures of fact not required to be disclosed pursuant to the specific representations and warranties set forth in Article 4 or Section 9.16 (either as information expressly required to be provided by such representations of warranties or as qualifications to such representations and warranties required to make them accurate statements); and (d) Purchaser is acquiring the Company subject only to the specific representations and warranties set forth in Article 4 and Section 9.16. Notwithstanding anything expressed or implied herein or in any Transaction Document to the contrary, (i) nothing in this Section 5.09 or any other provision of this Agreement or any Transaction Document shall limit or modify the representations and warranties set forth in Article 4 and Section 9.16 of the Agreement or the right of Purchaser to rely thereon, and (ii) Purchaser retains all rights and remedies with respect to Fraud Claims.

ARTICLE 6
COVENANTS AND AGREEMENTS

Section 6.01 [Reserved].

Section 6.02 Post-Closing Access; Preservation of Records.

(a) From and after the Closing until the seventh (7^{th}) anniversary of the Closing Date, Purchaser will make or cause to be made available to Seller and its Representatives (i) at Seller's sole cost and expense, all books, records and documents (including, for purposes of this Section 6.02(a), Tax Returns) of the Company and its Subsidiaries, and (ii) access to the management team and all facilities of the Company, in each case to the extent relating to the conduct of the ongoing business and operations of the Company and its Subsidiaries, and (iii) any and all incident reports relating to claims that have been filed or could be filed under any of the Company's Insurance Policies, in each case upon reasonable written request, during regular business hours, as may be reasonably necessary for, among other things: (A) investigating, settling, preparing for the defense or prosecution of, defending or prosecuting any Proceeding by or before any court or other Governmental Authority; (B) preparing reports to Governmental Authorities; or (C) such other purposes for which access to such documents is believed in good faith by Seller to be reasonably necessary, including preparing and delivering any accounting or other statement provided for under this Agreement or otherwise, preparing Tax Returns or responding to or disputing any Tax inquiry, audit or assessment; provided, however, that such

access will not interfere with the normal operations of the Company and its Subsidiaries. Notwithstanding anything in this Agreement to the contrary, none of Purchaser, the Company or any of its Subsidiaries shall be under any obligation under this Section 6.02(a) to disclose to Seller or its Representatives (A) any information the disclosure of which is restricted by Law, (B) any information that would result in the disclosure of any trade secrets or competitively sensitive information, or (C) any information that would adversely affect the attorney-client privilege or other evidentiary privileges of the Company or any of its Subsidiaries or (D) any information related to or requested in connection with any dispute related to, or indemnification claim under, this Agreement or the Transaction Documents (in which event the provisions of Section 8.05 and/or the applicable rules of discovery will apply in lieu of this Section 6.02(a)); provided, however, that, in the case of foregoing clauses (A) or (C), Purchaser and Seller shall use commercially reasonable efforts to enter into common interest or other arrangements to allow for the disclosure of such information in compliance with this Section 6.02(a). For a period of seven (7) years after the Closing Date, Purchaser will use commercially reasonable efforts to cause the Company and its Subsidiaries to maintain and preserve all such Tax Returns, books, records and documents relating to the conduct of the business and operations of the Company and its Subsidiaries prior to the Closing Date, in each case, in the ordinary course consistent with the past practices of the Company and its Subsidiaries.

(b) From and after the Closing until the seventh (7^{th}) anniversary of the Closing Date, Seller and Parent will make or cause to be made available to Purchaser, its Affiliates and their respective Representatives (at Purchaser's sole cost and expense), all books, records and documents (including, for purposes of this Section 6.02(b), Tax Returns but only to the extent such Tax Returns relate to the Company and its Subsidiaries and are not the consolidated income Tax Returns of Seller, Parent or their Affiliates) of the Company and its Subsidiaries to the extent relating to the conduct of the business and operations of the Company and its Subsidiaries prior to the Closing Date solely upon reasonable written request, during regular business hours, as may be reasonably necessary for: (i) investigating, settling, preparing for the defense or prosecution of, defending or prosecuting any Proceeding by or before any court or other Governmental Authority; (ii) preparing reports to Governmental Authorities; or (iii) such other purposes for which access to such documents is believed in good faith by Purchaser to be reasonably necessary, including preparing and delivering any accounting or other statement provided for under this Agreement or otherwise, preparing Tax Returns or responding to or disputing any Tax inquiry, audit or assessment; provided, however, that (x) access to such books, records, and documents will not interfere with the normal operations of Seller or Parent and (y) Seller and Parent shall be entitled, in their respective sole discretion, to redact or otherwise withhold any such books, records, documents or other information that is not related solely to the business and operations of the Company and its Subsidiaries. Notwithstanding anything in this Agreement to the contrary, neither Seller nor Parent shall be under any obligation under this Section 6.02(b) to disclose to Purchaser or its Representatives (A) any information the disclosure of which is restricted by Law, (B) any information that would result in the disclosure of any trade secrets or competitively sensitive information, (C) any information that would adversely affect the attorney-client privilege or other evidentiary privileges of Purchaser or Parent or (D) any information related to or requested in connection with any dispute related to, or indemnification claim under, this Agreement or the Transaction Documents (in which event the provisions of Section 8.05 and/or the applicable rules of discovery will apply in lieu of this Section 6.02(b)); provided, however, that, in the case of foregoing clauses (A) or (C), Seller and Purchaser shall

use commercially reasonable efforts to enter into common interest or other arrangements to allow for the disclosure of such information in compliance with this Section 6.02(b). For a period of seven (7) years after the Closing Date, Seller and Parent will use commercially reasonable efforts to maintain and preserve all such Tax Returns, books, records and documents relating to the conduct of the business and operations of the Company and its Subsidiaries prior to the Closing Date, in each case, in the ordinary course consistent with the past practices of Seller and Parent.

Section 6.03 Transfer Taxes. All transfer, documentary, sales, use, stamp, registration and other such Taxes, and all conveyance fees, recording charges and other fees and charges (including any penalties and interest) incurred in connection with the consummation of the transactions contemplated by this Agreement ("Transfer Taxes") shall be split equally by Seller and Purchaser. Seller and Purchaser (and their respective Affiliates) shall reasonably cooperate in preparing and filing all Tax Returns relating to such Taxes, fees and charges.

Section 6.04 Tax Matters.

(a) Tax Periods Ending on or Prior to the Closing Date and Straddle Periods – Tax Returns.

(i) Seller shall prepare or cause to be prepared and file or cause to be filed all income Tax Returns of the Company and its Subsidiaries for all periods ending on or prior to the Closing Date that are required to be filed after the Closing Date and all income Tax Returns of the Company and its Subsidiaries for any Straddle Period, and the Company shall pay or cause to be paid all Taxes due with respect to such Tax Returns to the extent such Taxes relate to Pre-Closing Tax Periods. All such Tax Returns shall be prepared in a manner consistent with the past practice of the Company and its Subsidiaries; provided, that such Tax Returns shall, as applicable, reflect the Section 336 Elections and the allocation of the Tax Purchase Price as required pursuant to this Section 6.04. With respect to any income Tax Returns for a Straddle Period, Seller shall provide a copy of such Tax Return to Purchaser for its review at least ten (10) days prior to the due date (taking into account any extension) for the filing of such Tax Returns and shall make any changes reasonably requested by Purchaser.

(ii) Purchaser shall file all other Tax Returns, and shall pay or cause to be paid all Taxes due with respect to such Tax Returns and any Taxes related to the Post-Closing Tax Period of any Tax Returns relating to the Straddle Period prepared pursuant to clause (i) above. All Tax Returns relating to a Straddle Period shall be prepared in a manner consistent with the past practice of the Company and its Subsidiaries; provided, that such Tax Returns shall, as applicable, reflect the Section 336 Elections and the allocation of the Tax Purchase Price as required pursuant to this Section 6.04. Purchaser shall provide a copy of such Tax Returns to Seller for Seller's review at least ten (10) days prior to the due date (taking into account any extension) for the filing of such Tax Returns and shall make any changes reasonably requested by Purchaser.

(b) Limitation on Actions. Without the prior written consent of Seller, which consent shall not be unreasonably withheld, neither Purchaser nor any of its Affiliates (including after

Closing, the Company or its Subsidiaries) shall (i) make, revoke or amend any election relating to Taxes of the Company or its Subsidiaries with respect to or relating to a Pre-Closing Tax Period or Straddle Period, (ii) take any action outside the ordinary course of business on the Closing Date after the Closing that would result in any increased liability for Taxes for Seller or Parent, (iii) file, re-file or amend any Tax Return relating to any Pre-Closing Tax Period, (iv) waive or extend the statute of limitations relating to any Pre-Closing Tax Period or (v) make any voluntary disclosure, amnesty or similar filing in respect of Taxes relating to any Pre-Closing Tax Period.

(c) Tax Refunds. Any Tax refunds with respect to income Taxes that are received by Purchaser, the Company or its Subsidiaries and any amounts credited or applied against any income Tax (including any interest paid or credited by a Governmental Authority with respect thereto) to which Purchaser, the Company, or its Subsidiaries becomes entitled that relate to a Pre-Closing Tax Period ("Tax Refunds") shall be for the account of Seller, and Purchaser shall pay to Seller any such Tax Refund within ten (10) days after receipt or entitlement thereto.

(d) Section 336 Elections. Purchaser (and to the extent necessary, the Company) and Seller (and its Affiliates) jointly shall make timely and irrevocable elections under either Section 336 of the Code or Section 336(e) of the Code with respect to Purchaser's acquisition of the Company and the Subsidiaries listed on Schedule 6.04(d) and, if permissible, similar elections under any applicable state and local Tax laws (collectively, the "Section 336 Elections"). Purchaser and Seller shall not take any action that would cause the Section 336 Elections to be invalid, and shall take no position contrary thereto unless required pursuant to a determination as defined in Section 1313(a) of the Code or any similar provision of any state, foreign or local Law. Purchaser shall deliver to Seller all the Section 336 Forms properly completed in accordance with all applicable Laws no less than fifteen (15) days before the date such Section 336 Forms are required to be filed and Seller shall duly execute and timely file such forms. Seller and Purchaser agree that the Tax Purchase Price as defined in Section 6.04(e) for each applicable Subsidiary of the Company (plus other relevant items) will be allocated to the assets of such Subsidiary for which a Section 338 Election is made in accordance with Section 6.04(e). Seller and Purchaser shall file (and Purchaser shall cause the Company and its Subsidiaries to file and Seller shall cause its applicable Affiliates to file) all Tax Returns (including amended returns and claims for refund) and information reports in a manner consistent with such allocation.

(e) Allocation of Tax Purchase Price. Purchaser and Seller acknowledge that the purchase and sale of the Interests will be treated as a purchase and sale of the assets of the Company for federal and state income tax purposes. The Purchase Price and any liability or other amount included in the amount realized by Seller or cost basis to Purchaser with respect to the transactions contemplated by this Agreement (the "Tax Purchase Price") shall be allocated as set forth in the schedule described below (the "Allocation Schedule"). Within seventy-five (75) days following the Closing Date, Purchaser shall deliver to Seller the Purchaser's proposed Allocation Schedule with respect to the Company and each applicable Subsidiary of the Company that is eligible for a Section 336 Election or is treated as disregarded as a pass-through or disregarded entity for federal income tax purposes. The Allocation Schedule shall specify Purchaser's determination of how the Tax Purchase Price allocated to the Company and each applicable Subsidiary shall be allocated among each designated class of assets of such applicable

Subsidiary as defined in Treasury Regulation Section 1.338-6(b)(2) and/or in accordance with Treasury Regulation Section 1.1060-1 and applicable Law. Purchaser shall reflect any reasonable comments made by Seller within fifteen (15) days after the receipt of the draft Allocation Schedule. Seller and Purchaser shall work together in good faith to resolve any disputes regarding the Allocation Schedule. If the Purchaser and Seller are unable to agree on the Allocation Schedule within thirty (30) days after the delivery by Seller of its comments to the Allocation Schedule, then each of Purchaser and Seller may prepare its own Allocation Schedule in a manner each believes appropriate. Any adjustment to or redetermination of the Tax Purchase Price shall be made consistently with the Allocation Schedule and shall be taken into account by Purchaser and Seller in carrying out the provisions of this Section 6.04(e). The parties shall make consistent use of the allocation per the Allocation Schedule (to the extent the parties agree on the Allocation Schedule) for all Tax purposes and in all filings, declarations and reports with the IRS and other Tax Authorities in respect thereof except pursuant to a final determination (within the meaning of Section 1313(a) of the Code or corresponding provision of state, local or foreign Tax law). In any Proceeding involving a Tax Authority related to the determination of any Tax, neither Purchaser nor Seller shall contend or represent that such agreed upon allocation is not correct.

(f) Certain Elections. Seller shall not make an election pursuant to Treasury Regulation Section 1.1502-36(d)(6)(i)(A).

(g) Tax Contests. (a) Purchaser, the Company and its Subsidiaries, on the one hand, and Seller and its Affiliates, on the other hand, shall promptly notify each other upon receipt by such party of written notice of any inquiries, claims, assessments, audits or similar events with respect to Taxes relating to a Pre-Closing Tax Period (any such inquiry, claim, assessment, audit or similar event, a "Tax Matter"). Any failure to so notify the other party of any Tax Matter shall not relieve such other party of any liability with respect to such Tax Matters except to the extent such party was actually prejudiced as a result thereof.

(h) Seller shall have sole control of the conduct of all Tax Matters, including any settlement or compromise thereof, provided, however, that Seller shall keep Purchaser reasonably informed of the progress of any Tax Matter relating to a Straddle Period and shall consult with Purchaser in the settlement of any Tax Matter that would reasonably be expected to impact the Taxes of the Companies or its Subsidiaries in a Post-Closing Tax Period.

Section 6.05 Employee Matters.

(a) Effective as of the Closing and thereafter, Purchaser and its Affiliates shall recognize, or shall cause the Company or its Subsidiaries to recognize, each Continuing Employee's employment or service with the Company and its Subsidiaries (including any current or former Affiliate or any predecessor) prior to the Closing for purposes of determining eligibility for participation, vesting and entitlement of the Continuing Employee under all employee benefit plans maintained by the Company, its Subsidiaries, Purchaser or an Affiliate of Purchaser, including vacation plans or arrangements, 401(k) or other retirement plans and any severance or welfare plans (excluding equity compensation arrangements and benefit accrual under any defined benefit plan), except to the extent such recognition would result in a duplication of benefits. In addition, and without limiting the generality of the foregoing,

Purchaser shall (or shall cause one (1) of its Affiliates to) use commercially reasonable efforts to: (i) cause each Continuing Employee to be immediately eligible to participate, without any waiting time, in any and all such plans; (ii) cause any pre-existing conditions or limitations, eligibility waiting periods, actively at work requirements, evidence of insurability requirements or required physical examinations under any health or similar plan of the Company, its Subsidiaries, Purchaser or an Affiliate of Purchaser to be waived with respect to Continuing Employees and their eligible dependents, except to the extent that any waiting period, exclusions or requirements still applied to such Continuing Employee under the comparable Employee Benefit Plan in which such Continuing Employee participated immediately before the Closing; and (iii) credit each Continuing Employee with all deductible payments, co-payments and other out-of-pocket expenses incurred by such Continuing Employee and his or her covered dependents under the medical, dental, pharmaceutical or vision benefit plans of the Company or its Subsidiaries prior to the Closing during the plan year in which the Closing occurs for the purpose of determining the extent to which such Continuing Employee has satisfied the deductible, co-payments, or maximum out-of-pocket requirements applicable to such Continuing Employee and his or her covered dependents for such plan year under any medical, dental, pharmaceutical or vision benefit plan of the Company, its Subsidiaries, Purchaser or an Affiliate of Purchaser, as if such amounts had been paid in accordance with such plan.

(b) Effective as of the Closing Date, each employee of the Company or its Subsidiaries shall cease to be participating employees in the Seller 401(k) Plan, and each employee of the Company or its Subsidiaries who continues in employment with Purchaser or any of its Affiliates after the Closing Date (collectively, the "Continuing Employees") shall cease to participate in the Seller 401(k) Plan and, as soon as practicable after the Closing Date, Purchaser shall establish or designate a defined contribution retirement plan which is qualified or eligible for qualification under Section 401(a) of the Code (the "Purchaser 401(k) Plan"). Each Continuing Employee shall become eligible to participate, as soon as practicable after the Closing Date, in the Purchaser 401(k) Plan. Purchaser agrees that each Continuing Employee who receives an "eligible rollover distribution" (within the meaning of Section 402(c)(4) of the Code) from the Seller 401(k) Plan shall be eligible to rollover such distribution (including loans) to the Purchaser 401(k) Plan.

(c) At or following the Closing, Seller or an Affiliate of Seller shall pay to the Company, and the Company shall pay to each of the individuals listed on Section 6.05(c) of the Company Disclosure Schedule (the "Retention Bonus Holders"), the Retention Bonus Amounts in accordance with the terms and conditions set forth in the applicable Retention Bonus Agreement (including, without limitation, any requirement that the applicable Retention Bonus Holder timely execute and deliver, and not revoke, a release of claims against the Company, Seller and each of their respective Affiliates).

(d) Notwithstanding anything herein to the contrary, Purchaser and Seller acknowledge and agree that all provisions contained in this Section 6.05 are included for the sole benefit of Purchaser and the Company, and that nothing in this Agreement, whether express or implied, (i) shall be treated as an amendment or other modification of any Employee Benefit Plan; (ii) shall limit the right of Purchaser, the Company or any of their respective Affiliates to amend, terminate or otherwise modify any Employee Benefit Plan or other employee benefit plan, agreement or other arrangement following the Closing Date; or (iii) shall confer upon any

Person who is not a party to this Agreement (including any current or former director, officer, employee or independent contractor of the Company or any of its Subsidiaries, or any participant in any Employee Benefit Plan or other employee benefit plan, agreement or other arrangement (or any dependent or beneficiary thereof)), any right to continued or resumed employment or recall, any right to compensation or benefits, or any third-party beneficiary or other right of any kind or nature whatsoever.

Section 6.06 Performance Bonds. On the Closing Date, Purchaser shall obtain performance bonds or letters of credit on behalf of the Company and its Subsidiaries (collectively, the "Substitute Performance Bonds"), which Substitute Performance Bonds will be effective as of Closing, in full substitute for all performance bonds or letters of credit listed in Section 6.06 of the Company Disclosure Schedule (collectively, the "Existing Performance Bonds"), and Seller shall obtain the release of the Company from any and all obligations under any of the Existing Performance Bonds and related contractual obligations in connection therewith. In the event Purchaser does not obtain any Substitute Performance Bond by the Closing Date, Purchaser shall indemnify and hold the Seller Indemnified Parties harmless from and against any and all Losses based upon or arising from the related Existing Performance Bond to the extent the matter or occurrence giving rise to such Loss occurred after the Closing.

Section 6.07 Use of Names. Except as provided in Section 6.14, as soon as reasonably practicable (and in no event more than ninety (90) days) after the Closing, Purchaser shall cause the Company and each of its Subsidiaries to cease any and all usage of the names of Seller or its Affiliates in their respective businesses and to remove and cease to use all of the signage, logos, trademarks and service marks of Seller or such Affiliates. Purchaser shall cause the Company and each of its Subsidiaries not to use any business name that is confusingly similar with any trademarks, trade names, brand names, logos, slogans or domain names of Seller or its Affiliates.

Section 6.08 Termination of Intercompany Accounts. At or prior to the Closing, Parent and Seller shall cause all Intercompany Accounts to be, at Parent and Seller's option, settled and/or cancelled without any further Liability or any adverse Tax consequences to the Company or any of its Subsidiaries.

Section 6.09 Servers. At Closing, Seller shall make available to Purchaser for transportation the servers and related infrastructure dedicated to the Company and its Subsidiaries that are located at Seller or its Affiliates' facility in Albuquerque, New Mexico, and the co-location center used by Seller or its Affiliates in Richardson, Texas, and which shall not contain any Protected Health Information that is not related solely to the business of the Company and its Subsidiaries. Within ninety (90) days of Closing, Purchaser shall, at its cost, transport such servers and related infrastructure to a location of its choice.

Section 6.10 Restricted Names. Parent shall not, and shall cause its Subsidiaries not to, use, license or permit any third party to use, any name, slogan, logo or trademark which is the same as or confusingly similar to any of the names, trademarks or service marks included in the Intellectual Property owned or used by the Company and/or any Subsidiary ("Restricted Names"). Notwithstanding anything in this Agreement to the contrary, Purchaser agrees that Seller may continue to use the Restricted Names for the following purposes: (a) for reference to the historical relationship between Seller and its Affiliates, on the one hand, and the Company

and/or any Subsidiary, on the other hand, (b) for retention of any books, records or other materials for internal archival purposes only, and (c) for compliance with applicable Laws including in connection with any corporate filings and documents filed by Seller or any of its Affiliates with any Governmental Authority on or after the Closing Date.

Section 6.11 Payment of Certain Amounts. In the event Seller, Parent or any of their respective Affiliates shall receive any instruments of payment of any accounts receivable, notes receivable or other receivables of the Company and/or any of its Subsidiaries, such Person shall forthwith deliver such instruments to Purchaser, endorsed where necessary, without recourse, in favor of Purchaser.

Section 6.12 Non-Solicitation.

(a) In order to protect the value of the Company and its Subsidiaries, for a period of twenty four (24) months after the Closing, Parent shall not, and shall cause its Subsidiaries not to, without the prior written consent of Purchaser, directly or indirectly, solicit to employ or engage or actually employ any individual that served as an employee of the Company or any of its Subsidiaries at any time during the twelve (12) month period prior to the Closing Date, other than any of the individuals listed on Section 6.12 of the Company Disclosure Schedule (each, a "Restricted Person"); provided, that this Section 6.12(a) shall not be construed to prohibit Seller, Parent or any of Parent's Subsidiaries from (i) engaging in general solicitations for employees in the ordinary course of business, including placing general advertisements for employees in newspapers, periodicals or other media of general circulation, so long as such solicitations are not directed toward Restricted Persons, (ii) soliciting to employ employees, including Restricted Persons, through recruiting firms, placement agencies, and similar businesses so long as such recruiting firms, placement agencies, and similar businesses are not instructed by Seller, Parent or any of Parent's Subsidiaries to target Restricted Persons, or (iii) soliciting to employ or actually employing any Restricted Person more than six (6) months after such Restricted Person's employment or engagement with the Company or any of its Subsidiaries is terminated.

(b) Acknowledgements; Remedies. Each of Seller and Parent acknowledges and agrees that (i) the covenants and agreements set forth in this Section 6.12 were a material inducement to Purchaser to enter into this Agreement and to perform its obligations hereunder, (ii) Purchaser and its stakeholders would not obtain the benefit of the bargain set forth in this Agreement as specifically negotiated by the parties hereto if Seller, Parent or any of their respective Subsidiaries breached any provisions of this Section 6.12 (iii) the Purchase Price is sufficient consideration to make the covenants and agreements set forth herein enforceable, (iv) the length of time and scope of the covenants set forth in this Section 6.12 are reasonable given the benefits Seller and Parent will directly or indirectly receive hereunder, (v) each of Seller and Parent are familiar with all the non-solicitation provisions contained in this Section 6.12 and are fully aware of their respective obligations hereunder, and (vi) neither Seller nor Parent will challenge the reasonableness of the time, scope or other provisions of this Section 6.12 in any Proceeding, regardless of who initiates such Proceeding. Each of Seller and Parent further acknowledges and agrees that irreparable injury would result to Purchaser if Seller, Parent or any of their respective Subsidiaries breaches any of the terms of this Section 6.12, and that in the event of an actual or threatened breach by Seller, Parent or any of their respective Subsidiaries of any of the provisions contained in this Section 6.12, Purchaser may have no adequate remedy at

Law. Each of Seller and Parent accordingly agrees that in the event of any actual or threatened breach by Seller, Parent or any of their respective Subsidiaries of any of the provisions contained in this Section 6.12, Purchaser shall be entitled to seek injunctive and other equitable relief without (A) posting any bond or other security and (B) showing that monetary damages are an inadequate remedy. Nothing contained herein shall be construed as prohibiting Purchaser from pursuing any other remedies available to it for such breach or threatened breach, including the recovery of any damages that it is able to prove. Each of Seller and Parent shall cause its Subsidiaries to comply with this Section 6.12, and shall be liable for any breach by any of its Subsidiaries of this Section 6.12.

Section 6.13 Confidentiality.

(a) Except as otherwise provided herein or in the Transaction Documents, after the Closing Date, Parent shall, and shall cause its Subsidiaries to, keep secret and retain in confidence, and Parent shall not, and shall cause its Subsidiaries not to, use for the benefit of Parent or any of Parent's Subsidiaries, or others, all confidential or proprietary information exclusively relating to the Company or its Subsidiaries and that is not already generally available to the public, including, without limitation, trade secrets, pricing policies, marketing plans or strategies, business acquisition plans, and inventions and research projects, in each case, exclusively relating to the Company and its Subsidiaries (the "Company Confidential Information"). Notwithstanding, the foregoing, the Company Confidential Information shall not include information (i) that is or becomes generally available to the public other than as a result of a disclosure by Parent or any Subsidiary of Parent in breach of this Section 6.13(a), (ii) used or disclosed by Parent or any Subsidiary of Parent in connection with a bona fide dispute with Purchaser or its Affiliates, and (iii) lawfully acquired by Parent or any Subsidiary of Parent after the Closing from sources that were not known by Parent or any Subsidiary of Parent to be prohibited from disclosing such information by a legal, contractual or fiduciary obligation. If Parent or any Subsidiary of Parent is requested or required (by Law or stock exchange requirement or by oral question or request for information or documents in any legal proceeding, interrogatory, subpoena, civil investigative demand, or similar process) to disclose any Company Confidential Information, to the extent reasonably practicable, such Person shall notify Purchaser promptly of the request or requirement so that Purchaser may seek, at its sole cost and expense, an appropriate protective order or waive compliance with the provisions of this Section 6.13(a). If, in the absence of a protective order or the receipt of a waiver hereunder, Parent or any Subsidiary of Parent is, on the advice of counsel, compelled to disclose any Company Confidential Information to any tribunal or other Person, such Person may disclose the Company Confidential Information to the tribunal or other Person, provided that such disclosing Person shall use its commercially reasonable efforts to obtain, at the request and expense of Purchaser, an order or other assurance that confidential treatment shall be accorded to such portion of the Company Confidential Information required to be disclosed as Purchaser shall designate.

(b) Except as otherwise provided herein or in the Transaction Documents, after the Closing Date, Purchaser shall, and shall cause its Subsidiaries to, keep secret and retain in confidence, and Purchaser shall not, and shall cause its Subsidiaries not to, use for the benefit of Purchaser or any of its Subsidiaries, or others, all confidential or proprietary information exclusively relating to Parent or its Subsidiaries (other than the Company and its Subsidiaries) and that is not already generally available to the public, including, without limitation, trade

secrets, pricing policies, marketing plans or strategies, business acquisition plans, and inventions and research projects, in each case, exclusively relating to Parent and its Subsidiaries (other than the Company and its Subsidiaries) (the "Parent Confidential Information"). Notwithstanding, the foregoing, the Parent Confidential Information shall not include information (i) that is or becomes generally available to the public other than as a result of a disclosure by Purchaser or any of its Subsidiaries in breach of this Section 6.13(b), (ii) used or disclosed by Purchaser or its Subsidiaries in connection with a bona fide dispute with Seller or its Affiliates, and (iii) lawfully acquired by Purchaser or its Subsidiaries after the Closing from sources that were not known by Purchaser or such Subsidiaries to be prohibited from disclosing such information by a legal, contractual or fiduciary obligation. If Purchaser or any of its Subsidiaries is requested or required (by Law or stock exchange requirement or by oral question or request for information or documents in any legal proceeding, interrogatory, subpoena, civil investigative demand, or similar process) to disclose any Parent Confidential Information, to the extent reasonably practicable, such Person shall notify Parent promptly of the request or requirement so that Parent may seek, at its sole cost and expense, an appropriate protective order or waive compliance with the provisions of this Section 6.13(b). If, in the absence of a protective order or the receipt of a waiver hereunder, Purchaser or any of its Subsidiaries is, on the advice of counsel, compelled to disclose any Parent Confidential Information to any tribunal or other Person, such Person may disclose the Parent Confidential Information to the tribunal or other Person, provided that such disclosing Person shall use its commercially reasonable efforts to obtain, at the request and expense of Parent, an order or other assurance that confidential treatment shall be accorded to such portion of the Parent Confidential Information required to be disclosed as Parent shall designate.

Section 6.14 Regulatory Approvals; Consents; Notices; Filings.

(a) Each of Purchaser and Seller shall use its commercially reasonable efforts to (i) take, or cause to be taken, all appropriate action, and do, or cause to be done, all things necessary, proper or advisable under any applicable Law to consummate and make effective the transactions contemplated by this Agreement as promptly as reasonably practicable, (ii) obtain from Governmental Authorities any consents or Orders required to be obtained or made by Purchaser, Seller or any of their respective Affiliates in connection with the authorization, execution and delivery of this Agreement and the Transaction Documents and the consummation of the transactions contemplated hereby and thereby, (iii) provide the notices required to be made by Purchaser, Seller or any of their respective Affiliates under or with respect to any Laws in connection with the authorization, execution and delivery of this Agreement and the Transaction Documents and the consummation of the transactions contemplated hereby or thereby, and to pay any fees due of it in connection with such applications or filings, as promptly as is reasonably practicable, (iv) comply at the earliest practicable date with any request under or with respect to any Laws for additional information, documents or other materials received by Purchaser, Seller or any of their respective Affiliates from any Governmental Authority in connection with such applications or filings or the other transactions contemplated by this Agreement and (v) coordinate and cooperate with, and give due consideration to, all reasonable additions, deletions or changes suggested in connection with, making any filing under or with respect to any Laws. Each of Purchaser and Seller shall, and shall cause its respective Affiliates to, furnish to the other party all information reasonably necessary for any such filing to be made in connection with the transactions contemplated by this Agreement. Seller shall, or shall cause

the Company and its Subsidiaries to, give promptly such notice to third parties and use commercially reasonable efforts to obtain such third party consents as are required under Material Contracts or material Permits held by the Company or its Subsidiaries in connection with the transactions contemplated by this Agreement.

(b) For a period ending upon the earlier of (i) the ninety (90) day anniversary of the Closing, and (ii) the date on which all such notices have been filed and such consents have been obtained, Purchaser shall be permitted to use the "Molina" name solely as reasonably necessary in connection with Purchaser's efforts to file the notices and obtain the consents identified in Part I(a) (Pre-Closing Consents) and Part I(c) (Pre-Closing Notice) in Section 4.04 of the Company Disclosure Schedule, and Parent shall reasonably cooperate with Purchaser and its Subsidiaries in connection with making such filings and obtaining such consents.

(c) Notwithstanding anything to the contrary contained herein, (i) except for routine filing fees, nothing in this Agreement shall require Purchaser or Seller to expend money to a third party in exchange for any consent or approval, and (ii) any consent, approval, Order or authorization of, or registration, declaration or filing with, or notice to, any Governmental Authority or any other Person or under any Material Contract required to be obtained or made by Seller, the Company, any of its Subsidiaries or Purchaser in connection with the Closing, including, without limitation, those notices and consents set forth on Section 4.04 of the Company Disclosure Schedule, is at Purchaser's own risk, and none of Parent, Seller or their respective Affiliates shall be responsible for any Losses or any disruption to the operation of the Business resulting therefrom.

Section 6.15 Conduct of the Business.

(a) Except (x) as otherwise contemplated by this Agreement, (y) as consented to in writing by Purchaser (which consent shall not be unreasonably withheld, delayed or conditioned) or (z) as provided on Section 6.15 of the Company Disclosure Schedule, from and after the date hereof until the earlier of the Closing or the termination of this Agreement in accordance with its terms, Seller and Parent shall cause each of the Company and its Subsidiaries to (i) use commercially reasonable efforts to conduct the Business only in the ordinary course of business consistent with past practice, (ii) pay all Indebtedness, Taxes and other obligations when due, except for amounts subject to a bona fide dispute by the Company or its Subsidiaries, (iii) make purchases of goods and services required for the normal operation of the Business in the ordinary course of business consistent with past practice, (iv) pay for payables and other Liabilities in the ordinary course of business consistent with past practice, and (v) use commercially reasonable efforts to collect receivables in the ordinary course of business consistent with past practice.

(b) Without limiting the generality of Section 6.15(a), and except (i) as otherwise contemplated by this Agreement or the Transaction Documents, (ii) as otherwise required by Contract or applicable Law, (iii) as consented to by Purchaser (which consent shall not be unreasonably withheld, delayed or conditioned) or (iv) as provided on Section 6.15 of the Company Disclosure Schedule, from the date of this Agreement and until the earlier of the Closing or the termination of this Agreement in accordance with its terms, Seller and Parent shall cause the Company and each of its Subsidiaries not to:

(i) make any material change in any method of accounting or accounting practice, policy or procedure, other than as required by GAAP;

(ii) amend its Governing Documents;

(iii) (A) declare, set aside, make or pay any dividend or other distribution or payments (whether in cash, stock or property or any combination thereof) in respect of any of its Equity Securities (except for the distribution of cash referenced in the Adjusted Balance Sheet); or (B) redeem or otherwise acquire any of its Equity Securities, issue, sell or otherwise dispose any of its Equity Securities or grant any Person any right or option to acquire (including upon conversion, exchange, or exercise) any Equity Securities;

(iv) merge or consolidate with any business or any corporation, partnership, limited liability company, association or other business organization or division thereof, acquire all or substantially all of the assets of any Person or make any loans, advances or capital contributions to, or any investments in, any Persons;

(v) sell, lease, license or otherwise transfer any material assets or properties of the Company or any of its Subsidiaries, other than in the ordinary course of business consistent with past practice;

(vi) adopt a plan of complete or partial liquidation, dissolution, merger, consolidation, recapitalization or other reorganization, or taken any action for the appointment of a receiver, administrator, trustee or similar officer;

(vii) enter into, amend or terminate a Material Contract other than (A) in order to comply with applicable Law, (B) any termination at the expiration of its stated term, or (C) in the ordinary course of business consistent with past practice;

(viii) except as required by the terms of any Employee Benefit Plan in existence on the date of this Agreement, increase the compensation or benefits of any employee, director or individual independent contractor of the Company or any of its Subsidiaries (other than, in each case, in the ordinary course of business consistent with past practice);

(ix) enter into, adopt or amend, in any material respect, any Employee Benefit Plan in any manner except as required by applicable Law;

(x) authorize, or make any commitment with respect to, any capital expenditures that are, in the aggregate, in excess of Two Hundred Fifty Thousand Dollars ($250,000), or fail to make capital expenditures consistent with the budget set forth in Section 6.15(b)(x) of the Company Disclosure Schedule;

(xi) make any capital investment in, any loan to, or any acquisition of the securities or assets of, any Person or business;

(xii) (A) create, incur, assume, forgive, guarantee or modify any Indebtedness (other than draws under revolving lines of credit existing on the date hereof in the ordinary course of business consistent with past practice), (B) enter into any off-balance sheet

financing arrangement, or (C) make any loans or advances of money other than to employees of the Company or its Subsidiaries in the ordinary course of business consistent with past practice;

(xiii) settle any Proceeding involving payment by the Company or any of its Subsidiaries in an amount in excess of One Hundred Thousand Dollars ($100,000);

(xiv) transfer, assign, or grant any license or sublicense of any rights under or with respect to any Intellectual Property other than in the ordinary course of business consistent with past practice;

(xv) permit the lapse of any existing insurance policy relating to the Business or Assets;

(xvi) except for the settlement or cancellation of Intercompany Accounts as provided in Section 6.08, make any payment to (whether as a distribution, fee, expense reimbursement or otherwise) or on behalf of Parent or any of its Subsidiaries (other than the Company or any of its Subsidiaries);

(xvii) make any material Tax election, prepare any Tax Returns in a manner which is materially inconsistent with the past practices of the Company or such Subsidiary of the Company with respect to the treatment of items on such Tax Returns, incur any material Liability for Taxes other than in the ordinary course of business consistent with past practice, file an amended Tax Return, file a claim for refund of material Taxes of the Company or such Subsidiary of the Company outside of the ordinary course of business, make any voluntary disclosure regarding Taxes to any Governmental Authority, or settle any claim relating to Taxes; or

(xviii) enter into any agreement, understanding or commitment by the Company or any of its Subsidiaries to do any of the foregoing.

Section 6.16 Notification of Certain Matters. Each of Seller and Purchaser hereto shall promptly notify the other party hereto in writing upon the occurrence of any event that has caused: (a) any representation or warranty of the notifying party or its Affiliates contained in this Agreement to be untrue or inaccurate in any material respect as of the time made under this Agreement; or (b) any failure of the notifying party to comply with or satisfy any covenant or agreement to be complied with or satisfied by it under this Agreement, in each case, if such failure to be true or accurate or failure to comply has caused or would reasonably be expected to cause any condition to the obligations of the notified party to effect the transactions contemplated by this Agreement not to be satisfied.

Section 6.17 Access to Information; Confidentiality.

(a) From and after the date hereof until the earlier of the Closing or the termination of this Agreement in accordance with its terms, Seller, upon request, shall permit Purchaser and its Representatives to have reasonable access during normal business hours upon reasonable notice to the Company's and its Subsidiaries' facilities, the individual listed on Section 6.17 of the Company Disclosure Schedule and the business, financial, legal, tax, compensation and other data and information solely concerning the Company's and its

Subsidiaries' affairs and operations as Purchaser deems reasonably necessary or advisable; provided that (i) such access does not unreasonably interfere with normal operations or customer or employee relations of the Company and its Subsidiaries or Affiliates, (ii) access to such data and information may be provided by making such data and information available in the Data Room and (iii) such access shall be at Purchaser's sole cost and expense. All requests for such access shall be made to such Representatives of Seller as Seller shall designate. It is further agreed that neither Purchaser nor its Representatives shall (and Purchaser shall not permit any of its Representatives to) contact any of the employees, customers or other material business relations of the Company or its Subsidiaries in connection with the transactions contemplated by this Agreement, whether in person or by telephone, mail or other means of communication, without the specific prior authorization of Seller. Any such access shall be subject to the following additional limitations: (x) such access shall be subject to restrictions under applicable Law; and (y) such access shall not require disclosure of information that is a trade secret or competitively sensitive or subject to attorney-client or other evidentiary privilege.

(b) The parties acknowledge that an Affiliate of Purchaser and Parent have previously executed the Confidentiality Agreement, which Confidentiality Agreement shall continue to be in full force and effect in accordance with its terms, and Purchaser shall hold, and cause its Representatives to hold, any Evaluation Material (as defined in the Confidentiality Agreement) confidential in accordance with the terms of the Confidentiality Agreement. Effective upon the Closing, the Confidentiality Agreement shall terminate.

Section 6.18 Exclusivity. From and after the date hereof until the earlier of the Closing or the termination of this Agreement, neither Seller nor Parent shall (and Seller and Parent shall cause their respective Affiliates, officers, directors, managers, employees, attorneys, accountants, consultants, financial advisors, and other agents not to), directly or indirectly: (a) solicit, initiate or knowingly encourage (including by way of furnishing any information relating to the Company and its Subsidiaries), or knowingly induce or knowingly take any other action which would reasonably be expected to lead to the making, submission or announcement of, any proposal or inquiry that constitutes, or would reasonably be likely to lead to, an Acquisition Proposal; (b) other than informing Persons of the provisions contained in this Section 6.18, enter into, continue or participate in any discussions or any negotiations regarding any Acquisition Proposal or otherwise take any action to knowingly facilitate or knowingly induce any effort or attempt to make or implement an Acquisition Proposal; (c) approve, endorse, recommend or enter into any Acquisition Proposal or any letter of intent, memorandum of understanding or Contract contemplating an Acquisition Proposal or requiring the Company or Seller or Parent to abandon or terminate its obligations under this Agreement; or (d) agree, resolve or commit to do any of the foregoing. Seller and Parent agree to notify Purchaser within two (2) Business Days if any Person makes any proposal, offer, inquiry or contact with respect to an Acquisition Proposal and provide Purchaser with a description of the material terms and conditions thereof, including the identity of such Person. Seller and Parent shall immediately cease and cause to be terminated any existing discussions with any Person (other than Purchaser) concerning any proposal relating to an Acquisition Proposal. With respect to the Persons with whom discussions or negotiations have been terminated, Seller and Parent shall use their respective reasonable best efforts to obtain the return or destruction of, in accordance with the terms of any applicable confidentiality agreement, any confidential information previously furnished to any such Person by Seller or

Parent or any of their respective officers, directors, managers, employees, attorneys, accountants, consultants, financial advisors or other agents.

Section 6.19 Lease Guarantees. After the Closing, (a) Purchaser shall reasonably cooperate with Parent and Seller to cause Parent to be released from all obligations arising after the Closing under any guarantees entered into by Parent in connection with a Lease as soon as reasonably practicable after the Closing and (b) Purchaser shall indemnify and hold the Seller Indemnified Parties harmless from and against any and all Losses based upon or arising from any such guarantee to the extent the matter or occurrence giving rise to such Loss occurred after the Closing.

ARTICLE 7
TERMINATION

Section 7.01 Termination. This Agreement may be terminated and the transactions contemplated by this Agreement abandoned at any time prior to the Closing:

(a) by mutual written consent of Purchaser and Seller;

(b) by either Purchaser or Seller, if the Closing shall not have been consummated on or before October 19, 2018 (the "End Date"); provided, however, that the right to terminate this Agreement under this Section 7.01(b) shall not be available to any such party whose failure to fulfill any obligation under this Agreement has been the cause of, or resulted in, the failure of the Closing to occur on or prior to the End Date;

(c) by Purchaser, if at any time there is a breach of or inaccuracy in any representation or warranty set forth in Article 4 (and including specifically any of those contained in Section 4.08) or any failure to perform in any respect any covenant or agreement to be complied with or performed by Seller, Parent or the Company pursuant to the terms of this Agreement such that the conditions set forth in Sections 3.05(a) or 3.05(b) would not be satisfied (treating such time as if it were the Closing for purposes of this Section 7.01(c)), which breach, inaccuracy or failure to perform cannot be cured by the End Date or has not been cured within fifteen (15) days following the receipt by Seller of written notice thereof from Purchaser or any shorter period of time that remains between the date Purchaser delivers written notice of such breach and the End Date; provided, however, that Purchaser may not terminate this Agreement pursuant to this Section 7.01(c) if such inaccuracy or breach was primarily caused by the failure of Purchaser to perform in any material respect any of the covenants or agreements to be performed by it prior to the Closing; or

(d) by Seller, if at any time there is a breach of or inaccuracy in any representation or warranty set forth in Article 5 or any failure to perform in any respect any covenant or agreement to be complied with or performed by Purchaser pursuant to the terms of this Agreement such that the conditions set forth in Sections 3.04(a) or 3.04(b) would not be satisfied (treating such time as if it were the Closing for purposes of this Section 7.01(d)), which breach, inaccuracy or failure to perform cannot be cured by the End Date or has not been cured within fifteen (15) days following the receipt by Purchaser of written notice thereof from Seller or any shorter period of time that remains between the date Seller delivers written notice of such

breach and the End Date; provided, however, that Seller may not terminate this Agreement pursuant to this Section 7.01(d) if such inaccuracy or breach was primarily caused by the failure Seller, Parent, or the Company to perform in any material respect any of the covenants or agreements to be performed by it prior to the Closing; or

(e) by either Purchaser or Seller, if any Governmental Authority shall have issued a permanent injunction or other Order prohibiting the consummation of the transactions contemplated by this Agreement and such permanent injunction or other Order shall have become final and non-appealable.

Section 7.02 Effect of Termination. If this Agreement is terminated pursuant to Section 7.01 by a party hereto, written notice thereof shall be given by such party to the other party or parties, specifying the provision pursuant to which such termination is made and, upon delivery thereof, all rights, and obligations of the parties hereunder shall terminate and no party hereto shall have any Liability to the other party or parties, except for obligations of the parties hereto in Section 6.01 (Public Announcements), Section 7.02 (Effect of Termination) and Article 9 (Miscellaneous), and the Confidentiality Agreement, which shall survive the termination of this Agreement in accordance with their terms. Notwithstanding anything to the contrary contained in this Agreement or the Transaction Documents, termination of this Agreement pursuant to Section 7.01 shall not release any party hereto from any Liability for any willful breach by such party of the terms and provisions of this Agreement prior to such termination or limit or restrict the availability of specific performance or other injunctive relief to the extent that specific performance or such other relief is available to a party hereunder.

ARTICLE 8
SURVIVAL; INDEMNIFICATION

Section 8.01 Survival of Representations and Warranties.

(a) The representations and warranties contained in Section 9.16 and Articles 4 and 5 shall survive the Closing and shall terminate on January 19, 2020; provided, that the Surviving Seller Representations and the Fundamental Purchaser Representations shall survive the Closing until the expiration of the applicable statute of limitations. Any written claim for indemnification under Section 8.02(b), Section 8.02(c) or Section 8.03(b) may be given at any time prior to January 19, 2020, and, from and after such date, no claim for such indemnification may be made hereunder. Any written claim for indemnification under Section 8.02(d) may be given at any time prior to the date that all of the Proceedings subject to such indemnification have been resolved, and, from and after such date, no claim for such indemnification may be made hereunder. Notwithstanding the foregoing, if a written claim for indemnification is made hereunder prior to the end of the applicable survival period, such indemnification shall survive, solely in relation to such claim, until such claim is resolved. Any party providing indemnification pursuant to this Article 8 is referred to herein as an "Indemnifying Party" and any Person entitled to indemnification pursuant to Section 8.02 or Section 8.03 is referred to herein as an "Indemnified Party".

(b) It is the express intent of the parties to this Agreement that, to the extent the survival of the representations and warranties in this Agreement (and the associated right to bring

a claim for a breach of such representations and warranties) is shorter than the statute of limitations that would otherwise have been applicable to such representations or warranties, by contract, the applicable statute of limitations with respect to such representations or warranties (and the associated right to bring a claim for a breach of such representations and warranties) are hereby reduced so they end at the end of the applicable survival period specified in Section 8.01(a).

Section 8.02 Indemnification by Parent. Effective as of the Closing, Parent and Seller, jointly and severally, shall indemnify and hold Purchaser, its Affiliates (including, after the Closing, the Company and its Subsidiaries) and each of their respective Representatives (each such Person, a "Purchaser Indemnified Party") harmless from and against any and all Losses based upon or arising from:

(a) any breach of any representation or warranty made by Seller pursuant to Article 4 or by Parent pursuant to Section 9.16;

(b) any failure by Seller or Parent to perform any of its respective covenants or agreements contained herein (and including in particular those contained in Section 6.15);

(c) any Pre-Closing Insurable Event; and

(d) any Proceedings pending against the Company or any of its Subsidiaries as of the Closing, and including without limitation those matters described in Section 4.13, Section 4.14(b), Section 4.16(b) and Section 4.20(b) of the Company Disclosure Schedule.

Section 8.03 Indemnification by Purchaser. Effective as of the Closing, Purchaser shall indemnify and hold Seller, its Affiliates and each of their respective Representatives (each such Person, a "Seller Indemnified Party") harmless from and against any and all Losses based upon or arising from:

(a) any breach of any representation or warranty made by Purchaser pursuant to Article 5; and

(b) any failure by Purchaser to perform any of its covenants or agreements contained herein.

Section 8.04 Additional Provisions Regarding Indemnification and Insurance Obligations. Notwithstanding Section 8.02 and Section 8.03, the rights to indemnification pursuant to the provisions of Section 8.02 and Section 8.03 are subject to the following limitations:

(a) The maximum aggregate Liability of Parent and Seller to all Purchaser Indemnified Parties taken together for Losses for any claims for indemnification pursuant to Section 8.02 (other than Section 8.02(d)) shall be limited to an amount equal to Ten Million Dollars ($10,000,000) (collectively, the "General Cap Amount"). For purposes of clarification, in no event shall any Losses for which the Purchaser Indemnified Parties are indemnified pursuant to Section 8.02(d) count against the General Cap Amount.

(b) The maximum aggregate Liability of Purchaser to all Seller Indemnified Parties taken together for Losses for any claims for indemnification pursuant to Section 8.03 shall be limited to an amount equal to the General Cap Amount.

(c) Parent and Seller shall not be liable for Losses for any individual claim for indemnification pursuant to Section 8.02(a) (other than as a result of breaches of the Surviving Seller Representations) unless the amount of Losses for such claim for indemnification against Seller pursuant to Section 8.02(a) (other than as a result of breaches of the Surviving Seller Representation) shall exceed Fifty Thousand Dollars ($50,000) (the "Per-Claim Basket"), and then for such Losses from the first dollar. For purposes of the preceding sentence, multiple claims for indemnification based upon the same act, event, omission or set of facts shall be deemed a single individual claim.

(d) Purchaser shall not be liable for Losses for any individual claim for indemnification pursuant to Section 8.03(a) (other than as a result of a breach of a Fundamental Purchaser Representation) unless the amount of Losses for such claim for indemnification against Purchaser pursuant to Section 8.03(a) (other than as a result of a breach of a Fundamental Purchaser Representation) shall exceed the Per-Claim Basket, and then for such Losses from the first dollar. For purposes of the preceding sentence, multiple claims for indemnification based upon the same act, event, omission or set of facts shall be deemed a single individual claim.

(e) Parent and Seller shall not be liable for Losses for any claims for indemnification pursuant to Section 8.02(a) (other than as a result of breaches of the Surviving Seller Representations) unless the total of all Losses for claims for indemnification against Parent pursuant to Section 8.02(a) (other than as a result of a breach of a Surviving Seller Representation and Losses excluded under Section 8.04(c)) shall exceed Five Hundred Thousand Dollars ($500,000) in the aggregate (the "Deductible"), and then only for such Losses to the extent they exceed such amount.

(f) Purchaser shall not be liable for Losses for any claims for indemnification pursuant to Section 8.03(a) (other than as a result of breach of the Fundamental Purchaser Representations) unless the total of all Losses for claims for indemnification against Seller pursuant to Section 8.03(a) (other than as a result of a breach of a Fundamental Purchaser Representation and Losses excluded under Section 8.04(d)) shall exceed the Deductible, and then only for such Losses to the extent they exceed such amount.

(g) No Indemnifying Party shall be liable to an Indemnified Party hereunder for (i) any punitive damages, except where such damages are recovered by a third party from an Indemnified Party in connection with Losses indemnified hereunder or (ii) any lost profits, diminution of value, consequential damages, special damages, incidental damages, indirect damages, exemplary damages or other unforeseen damages, except where such damages are recovered by a third party from an Indemnified Party in connection with Losses indemnified hereunder. In no event shall any multiples or similar valuation methodology (whether based on "multiple of profits," "multiple of earnings," "multiple of cash flows" or similar terms) be used in calculating the amount of any Losses.

(h) No Indemnified Party shall be entitled to recover for a Loss under Section 8.02 or Section 8.03 to the extent that such Indemnified Party has recovered such Loss under (i) unaffiliated third-party insurance held by, or for the benefit of, such Indemnified Party, or (ii) the Insurance Policies. In the event that an Indemnified Party receives insurance proceeds from unaffiliated third-party insurance with respect to any matter for which it was previously indemnified pursuant to this Article 8, such Indemnified Party shall promptly remit such insurance proceeds to the Indemnifying Party. Each Indemnified Party covenants and agrees to use commercially reasonable efforts to seek recovery of any amounts available under (A) third-party insurance held by, or for the benefit of, such Indemnified Party and (B) any other insurance applicable to Indemnified losses, including, but without limitation, the Insurance Policies.

(i) For the avoidance of doubt, and notwithstanding any term or provision to the contrary, (i) effective as of the Closing, all insurance coverage owned or held by Parent or its Subsidiaries, including but without limitation the Insurance Policies, shall be cancelled and terminated in respect of all accidents, events, happenings, injuries, claims, conduct and occurrences relating to the Business commencing or taking place after the Closing, and (ii) this Agreement is not intended as an assignment or attempted assignment of any policy of insurance or as a contract of insurance and shall not be construed to waive any right or remedy of Parent or its Subsidiaries in respect of any insurance policy or any other contract or policy of insurance, except to the extent such assignment is permitted by the terms of such policy in accordance with applicable Law and Parent has agreed to such assignment. Notwithstanding the foregoing, this Agreement is intended as an assignment of insurance rights to Company and its Subsidiaries and each of their insured persons and entities and their successors-in-interest and respective permitted assignees under the Insurance Policies, and otherwise in respect of insurance applicable to any Losses indemnified hereunder, to the extent allowed by applicable Law and as necessary to fully establish their rights to obtain coverage under the such insurance as respects accidents, events, happenings, injuries, claims, conduct and occurrences relating to the Business prior to the Closing.

(j) Upon and after becoming aware of any event which is reasonably likely to give rise to Losses subject to indemnification hereunder, each Indemnified Party shall use commercially reasonable efforts to mitigate the Losses arising from such events, including incurring costs only to the minimum extent necessary to remedy the event which gives rise to Losses.

(k) Parent and Seller shall have no obligation under this Article 8 to indemnify any Purchaser Indemnified Party with respect to (i) any Loss that is a Liability to the extent reflected the calculation of the Purchase Price; or (ii) any Loss to the extent such Loss does not exceed the amount of any reserves for such Loss as reflected in the Balance Sheet.

(l) The amount of any recovery by the Indemnified Party pursuant to this Article 8 shall be reduced by any foreign, federal, state and/or local Tax benefits actually realized by such Indemnified Party.

(m) Notwithstanding anything to the contrary in this Agreement, no Purchaser Indemnified Party shall have any claim for indemnification (and no Purchaser Indemnified Party

shall be indemnified) for Loss under this Article 8 to the extent such Loss relates to Taxes attributable to a Post-Closing Tax Period.

(n) For Tax purposes, the parties agree to treat all payments made under this Article 8 as adjustments to the Purchase Price.

Section 8.05 Indemnification Procedures; Third Party Claims; Tax Claims.

(a) An Indemnified Party shall give the Indemnifying Party prompt written notice of any matter which an Indemnified Party has determined has given or would give rise to a right of indemnification under this Agreement (other than a Third Party Claim), within twenty (20) Business Days of such determination (an "Indemnity Notice"); provided, however, that the failure to give an Indemnity Notice shall not waive an Indemnified Party's right to indemnification, except to the extent the Indemnifying Party is prejudiced by the Indemnified Party's failure to give notice or such Indemnity Notice is given after the expiration of the applicable survival period.

(b) If any claim, demand or Proceeding is brought by a Person who is not a party to this Agreement or an Affiliate thereof (a "Third Party Claim") against an Indemnified Party, and if such party intends to seek indemnification with respect thereto pursuant to this Article 8, such Indemnified Party shall promptly, but in any event within twenty (20) Business Days after the Indemnified Party learns of the existence of the Third Party Claim, notify the Indemnifying Party in writing of the Third Party Claim; provided, however, that no delay on the part of the Indemnified Party in notifying the Indemnifying Party will relieve the Indemnifying Party from any obligation hereunder except to the extent the Indemnifying Party is prejudiced by the Indemnified Party's failure to give notice or such Indemnity Notice is given after the expiration of the applicable survival period. The Indemnified Party will deliver to the Indemnifying Party, promptly after the Indemnified Party's receipt thereof, copies of all documents relating to the Third Party Claim and notices and documents relating to the Third Party Claim received by the Indemnified Party.

(c) The Indemnifying Party will have the right to participate in or assume the defense of the Third Party Claim with counsel of its choice reasonably satisfactory to the Indemnified Party, so long as the Indemnifying Party delivers written notice to the Indemnified Party of its election to assume the defense of the Third Party Claim; provided, however, that Parent shall be deemed to have delivered such notice with respect to Proceedings indemnified under Section 8.02(d). Should the Indemnifying Party so elect to assume the defense of a Third Party Claim, the Indemnifying Party shall not be liable to the Indemnified Party for any legal or other expenses subsequently incurred by the Indemnified Party in connection with the defense thereof. If the Indemnifying Party is conducting the defense of the Third Party Claim in accordance with the provisions above, the Indemnified Party, at its sole cost and expense, may retain separate counsel, and participate in the defense of the Third Party Claim, it being understood that the Indemnifying Party will control such defense. To the extent the Indemnifying Party has not assumed the defense of such Third Party Claim pursuant to this Section 8.05(c), the Indemnified Party will (upon delivering written notice to such effect to the Indemnifying Party) have the right to undertake the defense of such Third Party Claim. Each party shall fully cooperate with the other party in such defense and make available to the party undertaking the defense of the Third

Party Claim employees, witnesses, pertinent records, materials and information in such party's possession or under such party's control relating to such Third Party Claim as may be requested by the party undertaking the defense of the Third Party Claim. If an Indemnified Party fails to comply with the immediately preceding sentence, such Indemnified Party's right to indemnification under this Article 8 shall be waived to the extent such failure prejudices the Indemnifying Party.

(d) Notwithstanding anything in this Section 8.05 to the contrary, neither the Indemnifying Party nor the Indemnified Party shall, without the written consent of the other party (which consent shall not be unreasonably delayed, withheld or conditioned), settle, compromise or discharge any Third-Party Claim or admit any Liability or permit a default or consent to entry of any judgment with respect to any Third Party Claim; provided that if the Indemnifying Party assumes the defense of any Third Party Claim, the Indemnifying Party shall be permitted to settle, compromise or discharge such Third Party Claim without the Indemnified Party's consent if such settlement, compromise or discharge (i) by its terms unconditionally releases the Indemnified Party from all Liability (other than an amount equal to the Deductible) in connection with such Third Party Claim, (ii) does not include an admission of wrongdoing or misconduct by the Indemnified Party, and (iii) does not impose any injunctive against the Indemnified Party.

(e) Notwithstanding anything in this Section 8.05 to the contrary, the foregoing provisions of Section 8.05 shall not apply to claims for indemnification for Losses pursuant to Section 8.02 solely with respect to breaches of the representations, warranties and covenants set forth in Section 4.19 (Taxes), Section 6.03 (Transfer Taxes) and Section 6.04 (Tax Matters). Parent shall have the sole right to control, defend and settle any audit, other administrative proceeding or inquiry or judicial proceeding involving the income Tax Return of Parent or its Subsidiaries. Except as otherwise provided in this Section 8.05(e), if a claim for Taxes is made against Purchaser by any Tax Authority and if Purchaser intends to seek indemnity with respect thereto under Section 8.02, Purchaser shall promptly furnish written notice to Parent of such claim. Parent shall have thirty (30) days after receipt of such notice to notify Purchaser of its intent to undertake, conduct, and control (through counsel of its own choosing and at its own expense) the settlement or defense thereof, and Purchaser and the Company and their respective Affiliates shall cooperate in connection therewith. If Purchaser or the Company fails to comply with the immediately preceding sentence, Purchaser and the Company's right to indemnification under this Article 8 shall be waived to the extent such failure prejudices the Parent. If within thirty (30) days after the receipt of Purchaser's notice of a claim of indemnity hereunder, Parent does not notify Purchaser that Parent elects (at its cost and expense) to undertake the defense thereof, or gives such notice and thereafter fails to contest such claim in good faith, Purchaser shall have the right to contest, settle, or compromise such claim and Purchaser shall not thereby waive any right to indemnification for such claim under this Agreement; provided, however, that neither Purchaser nor the Company shall pay or settle any such claim without the prior written consent of Parent, which consent shall not be unreasonably withheld. Nothing contained herein shall compel Parent or Seller to disclose any of its income Tax Returns to Purchaser or provide Purchaser the right to see or review such income Tax Returns.

Section 8.06 Exclusive Remedy. Subject to Section 9.10 and except for claims based on Fraud, notwithstanding anything to the contrary contained in this Agreement, the remedies

expressly set forth in this Article 8 shall be the sole and exclusive remedy for the parties hereto and the other Indemnified Parties for any breach of any representation, warranty, covenant or other provision contained in this Agreement or otherwise relating to the subject matter of this Agreement. In furtherance of the foregoing, each party hereto (on behalf of itself and the other Indemnified Parties) hereby waives, to the fullest extent permitted under Law, any and all rights, claims and causes of action for any breach of any representation, warranty, covenant, agreement or provision set forth herein or otherwise relating to the subject matter of this Agreement such party or other Indemnified Parties may have against the other party and each of its Affiliates and Representatives arising under or based upon any Law, except in the case of Fraud, pursuant to the express indemnification provisions set forth in this Article 8 or pursuant to the provisions of Section 9.10.

ARTICLE 9
MISCELLANEOUS

Section 9.01 Entire Agreement; Assignment. This Agreement, together with the Transaction Documents, contains the entire agreement of the parties hereto with respect to the subject matter hereof and the Confidentiality Agreement and supersedes all other prior agreements between such parties and their respective Representatives in respect of such subject matter. Neither this Agreement nor any rights or obligations hereunder may be assigned by any party hereto without the prior written consent of the other parties hereto. Notwithstanding the foregoing: (a) Seller may assign all of its rights and obligations hereunder to Parent without the consent of Purchaser; provided, that such assignment shall not relieve Seller of any of its obligations hereunder; and (b) Purchaser may, without the consent of Seller or Parent, assign (by operation of law or otherwise) or otherwise transfer its rights and obligations hereunder to any Affiliate of Purchaser; provided, that such assignment shall not relieve Purchaser of any of its obligations hereunder. Subject to the foregoing, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, successors, permitted assigns and legal representatives.

Section 9.02 Notices. All notices, consents, requests, instructions, approvals and other communications provided for in this Agreement shall be in writing and shall be deemed validly given upon personal delivery or one (1) Business Day after being sent by nationally recognized overnight courier service or on the date of transmission if sent by e-mail (subject to automated confirmation of receipt), at the following address or e-mail address, or at such other address or e-mail address as a party may designate to the other parties:

If to Purchaser:

Pyramid Health Holdings, LLC
c/o Atar Capital, LLC
1999 Avenue of the Stars, Suite 2810
Los Angeles, CA 90067
Attention: Cyrus Nikou
E-mail: cnikou@atarcapital.com

with a copy (which shall not constitute notice) to:

Dykema Gossett LLP
333 South Grand Avenue, Suite 2100
Los Angeles, CA 90071
Attn: Thomas M. Cleary
E-mail: tcleary@dykema.com

If to Seller:

Molina Pathways, LLC
200 Oceangate, Suite 100
Long Beach, CA 90802
Attn: Jeff Barlow and Burt Park
E-mail: jeffrey.barlow@molinahealthcare.com;
burt.park@molinahealthcare.com

with a copy (which shall not constitute notice) to:

Latham & Watkins LLP
355 South Grand Avenue, Suite 101
Los Angeles, CA 90071-1560
Attn: David A. Zaheer
E-mail: david.zaheer@lw.com

or to such other address as the Person to whom notice is given may have previously furnished to the other in writing in the manner set forth above.

Section 9.03 **Governing Law**. This Agreement, and all claims or causes of action (whether in contract or tort) that may be based upon, arise out of or relate to this Agreement, or the negotiation, execution or performance of this Agreement (including any claim or cause of action based upon, arising out of or related to any representation or warranty made in or in connection with this Agreement or as an inducement to enter into this Agreement), shall be governed by the internal Laws of the State of Delaware, without giving effect to any Law that would cause the Laws of any jurisdiction other than the State of Delaware to be applied.

Section 9.04 **Construction; Interpretation**. The name assigned to this Agreement and the article and section captions used herein are for convenience of reference only and shall not affect the interpretation or construction hereof. Whenever the context requires, the gender of all words used in this Agreement includes the masculine, feminine, and neuter. All references to Articles and Sections refer to articles and sections of this Agreement. The terms "herein", "hereunder", "hereof" and words of like import refer to this entire Agreement instead of just the provision in which they are found. Unless the context otherwise requires: (a) a reference to a document includes all amendments or supplements to, or replacements or novations of, that document; (b) the use of the term "including" means "including, without limitation"; (c) the word "or" shall be disjunctive but not be exclusive; (d) unless expressly provided otherwise, the measure of a period of one (1) month or year for purposes of this Agreement shall be that date of the following month or year corresponding to the starting date; provided, that if no corresponding date exists, the measure shall be that date of the following month or year

corresponding to the next day following the starting date (for example, one (1) month following February 18 is March 18, and one (1) month following March 31 is May 1); (e) a reference to an entity includes any successor entity, whether by way of merger, amalgamation, consolidation or other business combination; (f) reference to a word defined hereunder shall apply equally to both the singular and plural forms of the term defined; and (g) a reference to "$" or "dollars" means the lawful currency of the United States. The language used in this Agreement shall be deemed to be the language chosen by the parties hereto to express their mutual intent, and no rule of strict construction shall be applied against any party hereto. For purposes of Article 4, information shall be deemed to have been "made available" to Purchaser only if such information was posted to the electronic data room maintained by Cain Brothers & Company, LLC in connection with the transactions contemplated hereby (the "Data Room") in a manner accessible and reviewable by Purchaser at least one (1) Business Day prior to the date of this Agreement.

Section 9.05 Company Disclosure Schedule. Neither the specification of any dollar amount in the representations or warranties contained in this Agreement nor the inclusion of any specific item in the Company Disclosure Schedule hereto is intended to imply that such amounts, or higher or lower amounts of the items so included or other items, are or are not material or that such fact or matter would with any other fact or matter, individually or in the aggregate, have a Material Adverse Effect.

Section 9.06 Parties in Interest. This Agreement shall be binding upon and inure solely to the benefit of each party hereto and its successors and permitted assigns and nothing in this Agreement, express or implied, is intended to or shall confer upon any other Person any rights, benefits or remedies of any nature whatsoever under or by reason of this Agreement.

Section 9.07 Severability. If any term or other provision of this Agreement is invalid, illegal or unenforceable, all other provisions of this Agreement shall remain in full force and effect so long as the economic or legal substance of the transactions contemplated hereby is not affected in any manner materially adverse to any party hereto.

Section 9.08 Counterparts; Signatures. This Agreement may be executed in one (1) or more counterparts, each of which shall be deemed to be an original, but all of which shall constitute one (1) and the same agreement. Delivery of an executed counterpart of a signature page to this Agreement by scanned pages shall be effective as delivery of a manually executed counterpart to this Agreement.

Section 9.09 Jurisdiction; Venue; Waiver of Jury Trial. ANY LEGAL ACTION OR PROCEEDING WITH RESPECT TO THIS AGREEMENT (INCLUDING PURSUANT TO SECTION 9.10) SHALL BE BROUGHT IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE AND ANY STATE APPELLATE COURT THEREFROM WITHIN THE STATE OF DELAWARE (OR, IF THE COURT OF CHANCERY OF THE STATE OF DELAWARE DECLINES TO ACCEPT JURISDICTION OVER A PARTICULAR MATTER, ANY FEDERAL COURT WITHIN THE STATE OF DELAWARE OR, IN THE EVENT FEDERAL COURT WITHIN THE STATE OF DELAWARE DECLINES TO ACCEPT JURISDICTION OVER A PARTICULAR MATTER, ANY STATE COURT WITHIN THE STATE OF DELAWARE). BY EXECUTION AND DELIVERY OF THIS AGREEMENT, EACH PARTY HEREBY ACCEPTS FOR ITSELF AND IN RESPECT OF ITS PROPERTY,

GENERALLY AND UNCONDITIONALLY, THE EXCLUSIVE JURISDICTION OF THE AFORESAID COURTS. EACH PARTY HERETO HEREBY IRREVOCABLY CONSENTS TO THE SERVICE OF PROCESS OUT OF ANY OF THE AFOREMENTIONED COURTS IN ANY ACTION OR PROCEEDING BY THE MAILING OF COPIES THEREOF TO SUCH PARTY BY REGISTERED OR CERTIFIED MAIL, POSTAGE PREPAID, RETURN RECEIPT REQUESTED, TO SUCH PARTY AT ITS ADDRESS SPECIFIED IN SECTION 9.02, OR BY ANY OTHER METHOD PERMITTED BY LAW. THE PARTIES HERETO HEREBY IRREVOCABLY WAIVE TRIAL BY JURY IN ANY LEGAL ACTION OR PROCEEDING OR COUNTERCLAIM (WHETHER BASED ON CONTRACT, TORT, STATUTE OR OTHERWISE) ARISING OUT OF OR RELATING TO THIS AGREEMENT, THE TRANSACTIONS CONTEMPLATED HEREBY OR THE ACTIONS OF SUCH PARTY IN THE NEGOTIATION, ADMINISTRATION, PERFORMANCE AND ENFORCEMENT HEREOF, AND EACH OF THE PARTIES HEREBY IRREVOCABLY WAIVES ANY OBJECTION, INCLUDING, WITHOUT LIMITATION, ANY OBJECTION TO THE LAYING OF VENUE OR BASED ON THE GROUNDS OF FORUM NON CONVENIENS, WHICH IT MAY NOW OR HEREAFTER HAVE TO THE BRINGING OF ANY SUCH ACTION OR PROCEEDING IN SUCH RESPECTIVE JURISDICTIONS.

Section 9.10 Remedies. The parties hereto agree that irreparable damage could occur if any provision of this Agreement were not performed in accordance with the terms hereof and that such parties shall be entitled, without posting a bond or similar indemnity, to seek an injunction to prevent breaches of this Agreement, or specific performance of the terms and provisions hereof, in addition to any other remedy to which they are entitled at law or in equity.

Section 9.11 Further Assurances. In connection with this Agreement and the transactions contemplated hereby, each party hereto shall execute and deliver any additional documents and instruments and perform any additional acts that may be necessary or appropriate to effectuate and perform the provisions of this Agreement and such transactions.

Section 9.12 Failure or Indulgence Not Waiver. No failure or delay on the part of any party hereto in the exercise of any right hereunder shall impair such right or be construed to be a waiver of, or acquiescence in, any breach of any representation, warranty or agreement herein, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or any other right. All rights and remedies existing under this Agreement are cumulative to, and not exclusive of, any rights or remedies otherwise available.

Section 9.13 Amendments. This Agreement may not be amended, supplemented or otherwise modified except in a written instrument executed by Purchaser and Seller. No provision of this Agreement may be waived except in a written instrument executed by the party waiving such provision. Any written waiver shall be limited to those items specifically waived therein and shall not be deemed to waive any future breaches or violations or other non-specified breaches or violations unless, and to the extent, expressly set forth therein.

Section 9.14 Fees and Expenses. Except as otherwise expressly provided in this Agreement, all fees, charges and expenses incurred in connection with this Agreement and the transactions contemplated hereby shall be paid by the party incurring such fees, charges or expenses.

Section 9.15 Provision Respecting Legal Representation. Each of the parties to this Agreement hereby agrees, on its own behalf and on behalf of its Representatives, that Latham & Watkins LLP may serve as counsel to Seller and its Affiliates (individually and collectively, the "Seller Group"), on the one hand, and the Company or its Subsidiaries, on the other hand, in connection with the negotiation, preparation, execution and delivery of this Agreement, the Transaction Documents and the consummation of the transactions contemplated hereby or thereby, and that, following consummation of such transactions, Latham & Watkins LLP may serve as counsel to the Seller Group or any Representative of the Seller Group, in connection with any litigation, claim or obligation arising out of or relating to this Agreement, the Transaction Documents or the transactions contemplated hereby or thereby notwithstanding such prior representation of the Company or its Subsidiaries and each of the parties hereto hereby consents thereto and waives any conflict of interest arising therefrom, and each of such parties shall cause any Affiliate thereof to consent to waive any conflict of interest arising from such representation.

Section 9.16 Parent Representations. Parent hereby represents and warrants to Purchaser as of the date hereof and as of the Closing as follows:

(a) Parent is a corporation, duly formed, validly existing and in good standing under the Laws of the State of Delaware.

(b) Parent has the requisite corporate power and authority to execute and deliver this Agreement and the Transaction Documents to which it is a party, to perform its obligations hereunder and thereunder and to consummate the transactions contemplated hereby and thereby.

[Signature page follows.]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the day and year first above written.

PYRAMID HEALTH HOLDINGS, LLC

By: /s/ Cyrus Nikou
Cyrus Nikou
Manager

MOLINA PATHWAYS, LLC

By: /s/ Thomas L. Tran
Name: Thomas L. Tran
Title: Chief Financial Officer

FOR PURPOSES OF SECTIONS 6.02(b), 6.08, 6.10, 6.11, 6.12, 6.13, 6.15, 6.16 AND SECTION 6.18 AND ARTICLES 8 AND 9:

MOLINA HEALTHCARE, INC.

By: /s/ Thomas L. Tran
Name: Thomas L. Tran
Title: Chief Financial Officer

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: November 1, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Thomas L. Tran, certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: November 1, 2018

/s/ Thomas L. Tran

Thomas L. Tran
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2018 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: November 1, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2018 (the "Report"), I, Thomas L. Tran, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: November 1, 2018

/s/ Thomas L. Tran

Thomas L. Tran
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended June 30, 2018

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2018

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).
Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of July 27, 2018, was approximately 61,762,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED June 30, 2018

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CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions, except per-share data) (Unaudited)			
Revenue:				
Premium revenue	$ 4,514	$ 4,740	$ 8,837	$ 9,388
Service revenue	127	129	261	260
Premium tax revenue	106	114	210	225
Health insurer fees reimbursed	104	—	165	—
Investment income and other revenue	32	16	56	30
Total revenue	4,883	4,999	9,529	9,903
Operating expenses:				
Medical care costs	3,850	4,491	7,572	8,602
Cost of service revenue	118	124	238	246
General and administrative expenses	335	405	687	844
Premium tax expenses	106	114	210	225
Health insurer fees	99	—	174	—
Depreciation and amortization	25	37	51	76
Impairment losses	—	72	—	72
Restructuring and separation costs	8	43	33	43
Total operating expenses	4,541	5,286	8,965	10,108
Operating income (loss)	342	(287)	564	(205)
Other expenses (income), net:				
Interest expense	32	27	65	53
Other expense (income), net	5	—	15	(75)
Total other expenses (income), net	37	27	80	(22)
Income (loss) before income tax expense (benefit)	305	(314)	484	(183)
Income tax expense (benefit)	103	(84)	175	(30)
Net income (loss)	$ 202	$ (230)	$ 309	$ (153)
Net income (loss) per share:				
Basic	$ 3.29	$ (4.10)	$ 5.10	$ (2.74)
Diluted	$ 3.02	$ (4.10)	$ 4.68	$ (2.74)

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(Amounts in millions) (Unaudited)			
Net income (loss)	$ 202	$ (230)	$ 309	$ (153)
Other comprehensive income (loss):				
Unrealized investment gain (loss)	1	—	(6)	1
Less: effect of income taxes	(1)	—	(1)	—
Other comprehensive income (loss), net of tax	2	—	(5)	1
Comprehensive income (loss)	$ 204	$ (230)	$ 304	$ (152)

See accompanying notes.

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CONSOLIDATED BALANCE SHEETS

	June 30, 2018	December 31, 2017
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,392	$ 3,186
Investments	2,176	2,524
Restricted investments	80	169
Receivables	1,148	871
Prepaid expenses and other current assets	344	239
Derivative asset	657	522
Assets held for sale	230	—
Total current assets	8,027	7,511
Property, equipment, and capitalized software, net	276	342
Goodwill and intangible assets, net	201	255
Restricted investments	117	119
Deferred income taxes	114	103
Other assets	28	141
	$ 8,763	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,920	$ 2,192
Amounts due government agencies	1,746	1,542
Accounts payable and accrued liabilities	754	366
Deferred revenue	193	282
Current portion of long-term debt	484	653
Derivative liability	657	522
Liabilities held for sale	66	—
Total current liabilities	5,820	5,557
Long-term debt	1,019	1,318
Lease financing obligations	198	198
Other long-term liabilities	68	61
Total liabilities	7,105	7,134
Stockholders' equity:		
Common stock, $0.001 par value, 150 shares authorized; outstanding: 62 shares at June 30, 2018 and 60 shares at December 31, 2017	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	1,055	1,044
Accumulated other comprehensive loss	(11)	(5)
Retained earnings	614	298
Total stockholders' equity	1,658	1,337
	$ 8,763	$ 8,471

See accompanying notes.

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CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
			(In millions)			
			(Unaudited)			
Balance at January 1, 2018	60	$ —	$ 1,044	$ (5)	$ 298	$ 1,337
Net income	—	—	—	—	309	309
Adoption of Topic 606	—	—	—	—	6	6
Adoption of ASU 2018-02	—	—	—	(1)	1	—
Partial termination of 1.125% Warrants	—	—	(113)	—	—	(113)
1.625% Convertible Notes exchange transaction	2	—	108	—	—	108
Other comprehensive loss, net	—	—	—	(5)	—	(5)
Share-based compensation	—	—	16	—	—	16
Balance at June 30, 2018	62	$ —	$ 1,055	$ (11)	$ 614	$ 1,658

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2018	2017
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net income (loss)	$ 309	$ (153)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:		
Depreciation and amortization	73	96
Impairment losses	—	72
Deferred income taxes	(6)	(41)
Share-based compensation	13	35
Non-cash restructuring costs	17	—
Amortization of convertible senior notes and lease financing obligations	13	16
Loss on debt extinguishment	15	—
Other, net	4	7
Changes in operating assets and liabilities:		
Receivables	(315)	(32)
Prepaid expenses and other current assets	(181)	(38)
Medical claims and benefits payable	(267)	148
Amounts due government agencies	205	642
Accounts payable and accrued liabilities	349	(18)
Deferred revenue	(42)	(32)
Income taxes	127	(30)
Net cash provided by operating activities	314	672
Investing activities:		
Purchases of investments	(914)	(1,636)
Proceeds from sales and maturities of investments	1,335	874
Purchases of property, equipment and capitalized software	(14)	(60)
Other, net	(9)	(24)
Net cash provided by (used in) investing activities	398	(846)
Financing activities:		
Repayment of credit facility	(300)	—
Repayment of 1.125% Convertible Notes	(89)	—
Cash paid for partial settlement of 1.125% Conversion Option	(134)	—
Cash received for partial termination of 1.125% Call Option	134	—
Cash paid for partial termination of 1.125% Warrants	(113)	—
Proceeds from senior notes offerings, net of issuance costs	—	325
Other, net	(1)	8
Net cash (used in) provided by financing activities	(503)	333
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	209	159
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	3,290	2,912
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 3,499	$ 3,071

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Six Months Ended June 30,	
	2018	2017
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (6)	$ (21)
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 135	$ 173
Loss on 1.125% Conversion Option	(135)	(173)
Change in fair value of derivatives, net	$ —	$ —
1.625% Convertible Notes exchange transaction:		
Common stock issued in exchange for 1.625% Convertible Notes	$ 131	$ —
Component of 1.625% Convertible Notes allocated to additional paid-in capital, net of income taxes	(23)	—
Net increase to additional paid-in capital	$ 108	$ —

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

June 30, 2018

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

The Health Plans segment consists of health plans operating in 13 states and the Commonwealth of Puerto Rico. As of June 30, 2018, these health plans served approximately 4.1 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies' administration of their Medicaid programs, including business processing, information technology development and administrative services. The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Recent Developments – Health Plans Segment

Puerto Rico Health Plan. In July 2018, our Puerto Rico health plan was selected by the Puerto Rico Health Insurance Administration to be one of the organizations to administer the Commonwealth's new Medicaid Managed Care contract. Services under the new contract, currently expected to begin on November 1, 2018, would cover the entire island. The base contract runs for a period of three years with an optional one year extension. As of June 30, 2018, we served approximately 326,000 Medicaid members in the East and Southwest regions of Puerto Rico, which represented premium revenue of $370 million for the six months ended June 30, 2018.

Florida Health Plan. In June 2018, our Florida health plan was awarded comprehensive Medicaid Managed Care contracts by the Florida Agency for Health Care Administration (AHCA) in Regions 8 and 11 of the Florida Statewide Medicaid Managed Care Invitation to Negotiate. As of June 30, 2018, we served approximately 96,000 Medicaid members in those regions, which represented premium revenue of approximately $232 million for the six months ended June 30, 2018. Services under the new contract are expected to begin on January 1, 2019. We will be serving both the Medicaid and long-term care populations in the two regions.

Washington Health Plan. In May 2018, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to enter into a managed care contract for the eight remaining regions of the state's Apple Health Integrated Managed Care program, in addition to the two regions previously awarded to us. We were selected by HCA for the following regions: Greater Columbia, King, North Sound, Pierce, and Spokane beginning January 1, 2019; and Salish, Thurston-Mason, and Great Rivers beginning January 1, 2020. As of June 30, 2018, we served approximately 742,000 Medicaid members in Washington, which represented premium revenue of $1,083 million for the six months ended June 30, 2018.

Recent Developments – Molina Medicaid Solutions Segment

In June 2018, we entered into a definitive agreement to sell Molina Medicaid Solutions (MMS) to DXC Technology Company. The divestiture, expected to close in the third quarter of 2018, is subject to the satisfaction of customary

closing conditions and the receipt of certain third party consents and regulatory approvals. Refer to Note 11, “Segments,” for further information.

Presentation and Reclassification

We have reclassified certain amounts in the 2017 consolidated statement of cash flows to conform to the 2018 presentation, relating to the presentation of restricted cash and cash equivalents. The reclassification is a result of our adoption of Accounting Standards Update (ASU) 2016-18, *Restricted Cash* effective January 1, 2018. See Note 2, “Significant Accounting Policies,” for further information, including the amount reclassified.

We have combined certain line items in the accompanying consolidated balance sheets. For all periods presented, we have combined the presentation of:

- Income taxes refundable with “Prepaid expenses and other current assets;”
- Income taxes payable with “Accounts payable and accrued liabilities;”
- Goodwill, and intangible assets, net to a single line; and
- Deferred contract costs with “Other assets.”

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the six months ended June 30, 2018 are not necessarily indicative of the results for the entire year ending December 31, 2018.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2017. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in our December 31, 2017 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our audited consolidated financial statements for the fiscal year ended December 31, 2017.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in non-current “Restricted investments” in the accompanying consolidated balance sheets.

	Six Months Ended June 30,	
	2018	2017
	(In millions)	
Cash and cash equivalents	$ 3,392	$ 2,979
Restricted cash and cash equivalents	98	92
Cash and cash equivalents reported in assets held for sale	9	—
Total cash, cash equivalents, and restricted cash and cash equivalents presented in the statements of cash flows	$ 3,499	$ 3,071

Revenue Recognition

We adopted ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)* effective January 1, 2018, using the modified retrospective approach. The insurance contracts of our Health Plans segment, which segment constitutes the vast majority of our operations, are excluded from the scope of Topic 606 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts. The cumulative effect of initially applying the guidance, relating entirely to our Molina Medicaid Solutions segment contracts, resulted in an immaterial impact to beginning retained earnings, as presented in the accompanying consolidated statement of stockholders' equity. Topic 606 was only applied to service contracts that were not completed as of December 31, 2017. Refer to "Molina Medicaid Solutions segment" and "Other segment" below for further information.

Health Plans segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into two broad categories discussed in further detail below: 1) "Contractual Provisions That May Adjust or Limit Revenue or Profit;" and 2) "Quality Incentives." Liabilities recorded for such provisions are included in "Amounts due government agencies" in the accompanying consolidated balance sheets.

1) Contractual Provisions That May Adjust or Limit Revenue or Profit:

Medicaid

- *Medical Cost Floors (Minimums), and Medical Cost Corridors:* A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $144 million and $135 million at June 30, 2018 and December 31, 2017, respectively. Approximately $97 million and $96 million of the liability accrued at June 30, 2018 and December 31, 2017, respectively, relates to our participation in Medicaid Expansion programs. Refer to Note 12, "Commitments and Contingencies," for further information regarding the California Medicaid Expansion program.

- *Retroactive Premium Adjustments:* State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare

- *Minimum MLR:* Federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Marketplace

- *Risk adjustment:* Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score, and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of operations. As of June 30, 2018, and December 31, 2017, the Marketplace risk adjustment payable amounted to $1,159 million and $912 million, respectively. Refer to Note 12, "Commitments and Contingencies," for further information regarding recent developments in the Marketplace risk adjustment program.

- *Minimum MLR:* The Affordable Care Act (ACA) has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

2) Quality Incentives:

At many of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2018 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2018.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(Dollars in millions)			
Maximum available quality incentive premium - current period	$ 47	$ 39	$ 87	$ 77
Quality incentive premium revenue recognized in current period:				
Earned current period	$ 34	$ 29	$ 58	$ 48
Earned prior periods	12	1	23	6
Total	$ 46	$ 30	$ 81	54
Quality incentive premium revenue recognized as a percentage of total premium revenue	1.0%	0.6%	0.9%	0.6%

Molina Medicaid Solutions segment

MMS is under contract with Medicaid agencies in six states and the U.S. Virgin Islands. Our existing contracts have terms that currently extend to 2018 through 2025, before renewal options. As of June 30, 2018, the aggregate amount of service revenue relating to unsatisfied performance obligations amounted to approximately $638 million.

Business process outsourcing services are billed immediately following the end of the month in which such services are performed, with payment received soon thereafter. Payments for the design, development and implementation (DDI) of Medicaid management information systems milestones are received following our performance, and the customer's acceptance, of the milestone deliverable. However, recognition of DDI revenue is deferred until the system 'go-live' date, and is amortized over the initial contract hosting period.

Other segment

Our Pathways behavioral health subsidiary's revenue is all variable, and generally invoiced after services are rendered; customer payment follows invoicing. We have concluded that there is no change to revenue recognition under Topic 606 for our Pathways behavioral health subsidiary, and therefore no impact to retained earnings effective January 1, 2018.

The following table presents the opening and closing balances of receivables, deferred contract costs (contract assets), and deferred revenue (contract liabilities) from contracts with customers, by segment.

	June 30, 2018	December 31, 2017
	(In millions)	
Receivables:		
Molina Medicaid Solutions	$ 34	$ 30
Other	40	44
Deferred contract costs (contract assets) – Molina Medicaid Solutions	109	101
Deferred revenue (contract liabilities) – Molina Medicaid Solutions	39	49

Medical Care Costs - Marketplace Cost Share Reduction (CSR) Update

During the first half of 2018, we recognized a benefit of approximately $76 million in reduced medical expense related to 2017 dates of service as a result of the federal government's confirmation that the reconciliation of 2017 Marketplace CSR subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed

a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by HIF in 2017 given the 2017 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including projected pretax earnings, the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The Tax Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. The TCJA, in part, reduced the U.S. federal statutory corporate income tax rate from 35% to 21% effective January 1, 2018. Accounting guidance allows filers one year subsequent to the end of the tax year to finalize the valuation of deferred tax assets and liabilities. At June 30, 2018, we had not completed our accounting for the tax effects resulting from enactment of TCJA with respect to valuation of our deferred tax assets and liabilities. We will continue to make and refine our calculations as additional analysis is completed. In addition, our estimates may also be affected as we gain a more thorough understanding of the tax law based on expected future guidance from the Internal Revenue Service and U.S. Treasury.

Recent Accounting Pronouncements Adopted

Revenue Recognition (Topic 606). See discussion above, in “Revenue Recognition.”

Comprehensive Income. In February 2018, the Financial Accounting Standards Board (FASB) issued ASU 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the TCJA. ASU 2018-02 is effective beginning January 1, 2019; we early adopted this ASU effective January 1, 2018. The effect of applying the guidance resulted in an immaterial impact to beginning retained earnings, as presented in the accompanying consolidated statement of stockholders’ equity.

Restricted Cash. In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which requires us to include in our consolidated statements of cash flows the changes in the balances of cash, cash equivalents, restricted cash and restricted cash equivalents. We adopted ASU 2016-18 on January 1, 2018. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption resulted in a $92 million reclassification of restricted cash and cash equivalents from “Investing activities” to the beginning and ending balances of cash and cash equivalents in our consolidated statements of cash flows for the six months ended June 30, 2017. There was no impact to our consolidated statements of operations, balance sheets, or stockholders’ equity. The reconciliation of cash and cash equivalents to cash, cash equivalents and restricted cash and cash equivalents is presented at the beginning of this note.

Recent Accounting Pronouncements Not Yet Adopted

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument’s contractual life. ASU 2016-13 is effective beginning January 1, 2020, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted. We are evaluating the effect of this guidance.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information* and ASU 2018-10, *Codification Improvements to Topic 842, Leases*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity’s balance sheet for both financing and operating leases. For leases with a term of 12 months or less, an entity may elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing,

and uncertainty of cash flows pertaining to an entity's leases. ASU 2016-02 must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. Under this guidance, we will record right of use assets and liabilities relating primarily to our long-term office leases. We are currently updating the configuration of our lease database management system for the adoption of Topic 842; we do not currently expect the adoption of this guidance to have a material effect on our consolidated results of operations, financial condition or cash flows.

3. Net Income (Loss) per Share

The following table sets forth the calculation of basic and diluted net income (loss) per share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions, except net income per share)			
Numerator:				
Net income (loss)	$ 202	$ (230)	$ 309	$ (153)
Denominator:				
Shares outstanding at the beginning of the period	61	56	59	56
Weighted-average number of shares issued:				
1.625% Exchange (1)	—	—	2	—
Denominator for basic net income per share	61	56	61	56
Effect of dilutive securities:				
1.625% Convertible Notes (1)	1	—	—	—
1.125% Warrants (1)	5	—	5	—
Denominator for diluted net income per share	67	56	66	56
Net income (loss) per share: (2)				
Basic	$ 3.29	$ (4.10)	$ 5.10	$ (2.74)
Diluted	$ 3.02	$ (4.10)	$ 4.68	$ (2.74)
Potentially dilutive common shares excluded from calculations:				
1.125% Warrants (1)	—	2	—	1

(1) For more information and definitions regarding the 1.625% Exchange and the 1.625% Convertible Notes, refer to Note 7, "Debt." For more information regarding the 1.125% Warrants, refer to Note 9, "Stockholders' Equity." The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income (loss) per share because to do so would be anti-dilutive. For the three and six months ended June 30, 2017, the 1.125% Warrants were not included in diluted shares outstanding because to do so would have been anti-dilutive.

(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of cash, cash equivalents and other current assets and current liabilities (not including derivatives, the current portion of long-term debt, and certain accounts reported in assets and liabilities held for sale) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to the three-tier fair value hierarchy. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 4, "Fair Value Measurements," in our 2017 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of June 30, 2018, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 8, "Derivatives," the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such derivative instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the six months ended June 30, 2018.

Our financial instruments measured at fair value on a recurring basis at June 30, 2018, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,382	$ —	$ 1,382	$ —
U.S. treasury notes	330	330	—	—
Government-sponsored enterprise securities (GSEs)	207	207	—	—
Municipal securities	136	—	136	—
Asset-backed securities	99	—	99	—
Certificate of deposit	19	—	19	—
Other	3	—	3	—
Subtotal - current investments	2,176	537	1,639	—
Corporate debt securities	55	—	55	—
U.S. treasury notes	25	25	—	—
Subtotal - current restricted investments	80	25	55	—
1.125% Call Option derivative asset	657	—	—	657
Total assets	$ 2,913	$ 562	$ 1,694	$ 657
1.125% Conversion Option derivative liability	$ 657	$ —	$ —	$ 657
Total liabilities	$ 657	$ —	$ —	$ 657

Our financial instruments measured at fair value on a recurring basis at December 31, 2017, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,588	$ —	$ 1,588	$ —
U.S. treasury notes	388	388	—	—
GSEs	253	253	—	—
Municipal securities	141	—	141	—
Asset-backed securities	117	—	117	—
Certificates of deposit	37	—	37	—
Subtotal - current investments	2,524	641	1,883	—
Corporate debt securities	101	—	101	—
U.S. treasury notes	68	68	—	—
Subtotal - current restricted investments	169	68	101	—
1.125% Call Option derivative asset	522	—	—	522
Total assets	$ 3,215	$ 709	$ 1,984	$ 522
1.125% Conversion Option derivative liability	$ 522	$ —	$ —	$ 522
Total liabilities	$ 522	$ —	$ —	$ 522

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the amount due under our Credit Facility was classified as a Level 3 financial instrument, because certain inputs used to determine its fair value were not observable. The carrying amount of the amount due under the Credit Facility as of December 31, 2017, approximated its fair value because the Credit Facility's interest rate is a variable rate that approximates rates currently available to us.

	June 30, 2018		December 31, 2017	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
		(In millions)		
5.375% Notes	$ 693	$ 706	$ 692	$ 730
1.125% Convertible Notes [1]	420	1,099	496	1,052
4.875% Notes	326	320	325	329
1.625% Convertible Notes	63	107	157	220
Credit Facility	—	—	300	300
	$ 1,502	$ 2,232	$ 1,970	$ 2,631

(1) The fair value of the 1.125% Conversion Option (the embedded cash conversion option) amounted to $657 million and $522 million as of June 30, 2018, and December 31, 2017, respectively. See further discussion at Note 7, "Debt," and Note 8, "Derivatives."

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets (including restricted investments) to be available-for-sale. Our 4.875% Notes, as further discussed in Note 7, "Debt," contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as "Restricted investments" in the accompanying consolidated balance sheets. Such proceeds, while

restricted as to their use and held in a segregated deposit account, are available-for-sale based upon our contractual liquidity requirements.

The following tables summarize our investments as of the dates indicated:

	June 30, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,390	$ —	$ 8	$ 1,382
U.S. treasury notes	331	—	1	330
GSEs	209	—	2	207
Municipal securities	138	—	2	136
Asset backed securities	100	—	1	99
Certificates of deposit	19	—	—	19
Other	3	—	—	3
Subtotal - current investments	2,190	—	14	2,176
Corporate debt securities	55	—	—	55
U.S. treasury notes	25	—	—	25
Subtotal - current restricted investments	80	—	—	80
	$ 2,270	$ —	$ 14	$ 2,256

	December 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,591	$ 1	$ 4	$ 1,588
U.S. treasury notes	389	—	1	388
GSEs	255	—	2	253
Municipal securities	142	—	1	141
Asset-backed securities	117	—	—	117
Certificates of deposit	37	—	—	37
Subtotal - current investments	2,531	1	8	2,524
Corporate debt securities	101	—	—	101
U.S. treasury notes	68	—	—	68
Subtotal - current restricted investments	169	—	—	169
	$ 2,700	$ 1	$ 8	$ 2,693

The contractual maturities of our available-for-sale investments as of June 30, 2018 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,356	$ 1,354
Due after one year through five years	914	902
	$ 2,270	$ 2,256

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and six months ended June 30, 2018 and 2017 were insignificant.

We have determined that unrealized losses at June 30, 2018 and December 31, 2017, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of June 30, 2018:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 959	$ 7	535	$ 116	$ 1	72
U.S. Treasury notes	224	1	52	—	—	—
GSEs	—	—	—	113	2	56
Municipal securities	81	1	79	40	1	52
Asset backed securities	90	1	59	—	—	—
	$ 1,354	$ 10	725	$ 269	$ 4	180

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2017:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,297	$ 3	561	$ 94	$ 1	69
U.S. Treasury Notes	470	1	89	—	—	—
GSEs	173	1	69	95	1	47
Municipal securities	—	—	—	38	1	48
	$ 1,940	$ 5	719	$ 227	$ 3	164

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current “Restricted investments” in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

Our held-to-maturity restricted investments are carried at amortized cost, which approximates fair value. Such investments amounted to $117 million at June 30, 2018, and mature in one year or less.

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated:

	June 30, 2018	December 31, 2017
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,510	$ 1,717
Pharmacy payable	116	112
Capitation payable	49	67
Other	245	296
	$ 1,920	$ 2,192

“Other” medical claims and benefits payable includes amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. Non-risk provider payables amounted to $158 million and $122 million as of June 30, 2018 and December 31, 2017, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amounts by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30,	
	2018	2017
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 2,192	$ 1,929
Components of medical care costs related to:		
Current period	7,794	8,633
Prior periods	(222)	(31)
Total medical care costs	7,572	8,602
Change in non-risk provider payables	56	(114)
Payments for medical care costs related to:		
Current period	6,248	6,883
Prior periods	1,652	1,457
Total paid	7,900	8,340
Medical claims and benefits payable, ending balance	$ 1,920	$ 2,077

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because we establish the provision for adverse claims deviation and the accrued cost of settling claims on a consistent basis every quarter, the lower cost recognized in a subsequent period if such a provision proved unnecessary would be offset by the establishment of a similar provision during that subsequent period.

Because the amount of our initial liability is an estimate, we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The differences between our original estimates and the amounts ultimately paid out for the most part relate to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at June 30, 2018 are as follows:

- Across all of our health plans, the inventory of unpaid claims increased significantly during the first half of 2017, then decreased in the last half of 2017 and into 2018. Changes in claims inventories impact the timing between date of service and the date of claim payment, increasing the volatility of our liability estimates.
- In June 2018, our Puerto Rico health plan implemented state prescribed claim billing requirements to ensure more accurate claims submissions. The billing requirements were more stringent and caused a significant number of claim denials. Although we expect providers to ultimately submit updated claims with

the required information, the impact of the new billing requirements create more uncertainty in our liability estimates.

- At our Florida health plan, a new clinical service system was implemented in the first quarter of 2018. This system impacted the reporting of inpatient authorizations used in our development of claims liabilities, which makes our liability estimates subject to more than the usual amount of uncertainty.
- We recently implemented a new process for increased quality review of claims payments in nine of our health plans. While we do not anticipate this new process will impact the percentage of claims paid within the timely turnaround requirements, we believe it will have a minor impact on the timing of some paid claims. For this reason, our liability estimates in the nine health plans are subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $222 million for the six months ended June 30, 2018. This amount represents our estimate as of June 30, 2018, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2017, was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- The impact of the provision for adverse claims deviation and the accrued cost of settling claims as discussed above. Because we re-establish the provision for adverse claims deviation and the accrued cost of settling claims on a consistent basis every quarter, the impact of this item on the first half of 2018 results was minimal.
- Across all of our health plans, the inventory of unpaid claims increased significantly during the first half of 2017, then decreased in the last half of 2017. In hindsight, the impact of the changes in claims processing timing reduced our liabilities more than we had anticipated.
- December 2017 data from The Centers for Disease Control and Prevention indicated widespread influenza activity in several states in which we operate health plans. The additional liabilities established in consideration of increased claims related to a more severe influenza season turned out to be higher than our actual experience.
- In establishing our liability at December 31, 2017, we anticipated an increase in the utilization of medical services by Marketplace members concerned about the future of their healthcare coverage as a result of uncertainties related to high premium increases and issuer exits. This induced demand did not materialize to the degree we expected.

7. Debt

All of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets:

	June 30, 2018	December 31, 2017
	(In millions)	
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 422	$ 499
1.625% Convertible Notes, net of unamortized discount	63	157
Lease financing obligations	1	1
Debt issuance costs	(2)	(4)
	484	653
Non-current portion of long-term debt:		
5.375% Notes	700	700
4.875% Notes	330	330
Credit Facility	—	300
Debt issuance costs	(11)	(12)
	1,019	1,318
Lease financing obligations	198	198
	$ 1,701	$ 2,169

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions)			
Contractual interest at coupon rate	$ 2	$ 3	$ 4	$ 6
Amortization of the discount	6	8	13	16
	$ 8	$ 11	$ 17	$ 22

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. In May 2018, we repaid all outstanding borrowings under the Credit Facility. As of June 30, 2018, no amounts were outstanding under the Credit Facility, and outstanding letters of credit amounting to $6 million reduced our borrowing capacity under the Credit Facility to $494 million.

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee. The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of June 30, 2018, we were in compliance with all financial and non-financial covenants under the Credit Facility and other long-term debt.

Bridge Credit Agreement

In January 2018, we entered into a bridge credit agreement (Bridge Credit Agreement) with several banks. Under the Bridge Credit Agreement, we may borrow up to $550 million to: (i) satisfy conversions of our 1.125% Convertible Notes; (ii) satisfy and/or refinance indebtedness incurred to satisfy conversion of the 1.125% Convertible Notes; (iii) repay or refinance our Credit Facility; and (iv) pay fees and expenses in connection with the foregoing. Subject to the satisfaction of certain conditions, the remaining amount of any borrowing may be used for general corporate purposes.

Borrowings under the Bridge Credit Agreement are reduced by the following:

- Any future debt and/or equity transactions including term loans, but excluding any Credit Facility drawing (excluding transactions with proceeds used for working capital purposes and acquisition financings up to $300 million); and
- On August 20, 2018 (the first put date for the 1.625% Convertible Notes), the Bridge Credit Agreement shall permanently be reduced by the greater of $150 million; and the principal amount of the 1.625% Convertible Notes that are exchanged into equity or otherwise defeased on or prior to that date.

The Bridge Credit Agreement matures on January 1, 2019 and, subject to the satisfaction of certain conditions, we may elect to extend twice the initial maturity date by a period of six months each. The amount available for borrowing under the Bridge Credit Agreement at June 30, 2018, was $550 million.

Borrowings under the Bridge Credit Agreement bear interest based, at our election, at a base rate or an adjusted LIBOR rate, plus in each case the applicable margin. Our wholly owned subsidiaries that guarantee our obligations under the indenture governing the 4.875% Notes, the 5.375% Notes, and the Credit Facility have jointly and severally guaranteed our obligations under the Bridge Credit Agreement.

The Bridge Credit Agreement contains usual and customary (a) affirmative covenants for credit facilities of this type which are substantially similar to those contained in the Credit Facility, (b) negative covenants consistent with those contained in the 4.875% Notes and (c) events of default for credit facilities of this type which are substantially similar to those contained in the 4.875% Notes.

4.875% Notes due 2025

We have outstanding $330 million aggregate principal amount of senior notes (4.875% Notes) due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. Guarantees under the 4.875% Notes mirror those of the Credit Facility. See Note 13, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

The 4.875% Notes contain a limitation on the use of proceeds which required us to deposit a portion of the net proceeds from their issuance into a segregated deposit account. These funds may be used by us as follows:

- On or prior to August 20, 2018, to:
    - Redeem, repurchase, repay, tender for, or acquire for value all or any portion of our 1.625% Convertible Notes, defined and discussed further below, or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes and/or
    - Pay any interest due on all or any portion of the 4.875% Notes.
- On or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that we are obligated to repurchase; and
- Subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited in the indenture governing the 4.875% Notes.

The investments that constitute the segregated funds are current assets reported as “Restricted investments” in the accompanying consolidated balance sheets. As a result of the 1.625% Exchange described below, approximately $94 million of such investments were transferred to unrestricted current investments in the first quarter of 2018. As of June 30, 2018, the balance of current restricted investments was $80 million.

5.375% Notes due 2022

We have outstanding $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 5.375% Notes. Such guarantees mirror those of the Credit Facility. See Note 13, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors. The 5.375% Notes contain customary non-financial covenants and change in control provisions.

1.125% Cash Convertible Senior Notes due 2020

In June 2018, we entered into two separate, privately negotiated note purchase agreements with certain holders of our outstanding 1.125% cash convertible senior notes due January 15, 2020 (1.125% Convertible Notes). In these transactions, we repaid $96 million aggregate principal amount of the 1.125% Convertible Notes, plus accrued interest, for an aggregate cash payment of $228 million. The $132 million difference between the principal amount extinguished and our cash payment represents primarily the settlement of the fair value of the 1.125% Convertible Notes’ embedded cash conversion option feature (which is a derivative liability we refer to as the 1.125% Conversion Option). In addition, we recorded a loss on debt extinguishment of $5 million, primarily relating to the acceleration of the debt discount, which is recorded in “Other expenses (income), net” in the accompanying consolidated statements of operations. No common shares were issued in connection with these transactions.

Also in June 2018, in connection with the 1.125% Notes purchases, we entered into privately negotiated termination agreements with each of the counterparties to partially terminate the Call Spread Overlay, defined and further discussed in Notes 8, “Derivatives,” and 9, “Stockholders' Equity.”

Following the transactions described above, we have outstanding $454 million aggregate principal amount of 1.125% Convertible Notes. Interest is payable semiannually in arrears on January 15 and July 15.

The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Convertible Notes is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Convertible Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended June 30, 2018; therefore, they are convertible into cash and are reported in current portion of long-term debt as of June 30, 2018.

The 1.125% Conversion Option was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the 1.125% Conversion Option settles or expires. The effective interest rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued is approximately 6%. As of June 30,

2018, the 1.125% Convertible Notes had a remaining amortization period of 1.5 years. The 1.125% Convertible Notes' if-converted value exceeded their principal amount by approximately $503 million and $406 million as of June 30, 2018 and December 31, 2017, respectively.

1.625% Convertible Senior Notes due 2044

In March 2018, we entered into separate, privately negotiated, synthetic exchange agreements (1.625% Exchange) with certain holders of our outstanding 1.625% convertible senior notes due 2044 (1.625% Convertible Notes). In this transaction, we exchanged $97 million aggregate principal amount and accrued interest for 1.8 million shares of our common stock. We recorded a loss on debt extinguishment, including transaction fees, of $10 million for the transaction, primarily relating to the inducement premium paid to the bondholders, which is recorded in "Other expenses (income), net" in the accompanying consolidated statements of operations. We did not receive any proceeds from the 1.625% Exchange.

On July 11, 2018, we announced notice of our election to redeem the remaining $64 million aggregate principal amount of the 1.625% Convertible Notes on August 20, 2018 (the Redemption Date). Pursuant to the terms of the indenture, the 1.625% Convertible Notes will be redeemed for cash equal to 100% of the principal amount plus accrued and unpaid interest to, but excluding the Redemption Date (the Redemption Price).

Also pursuant to the indenture, the 1.625% Convertible Notes may be converted until August 17, 2018, at a conversion rate of 17.2157 shares of our common stock per $1,000 principal amount, or approximately $58.09 per share of our common stock. Upon conversion, we will pay cash for the principal and, if applicable, deliver shares of our common stock to the converting holders in an amount per $1,000 principal amount equal to the settlement amount (as defined in the related indenture). After August 17, 2018, holders will be entitled only to the Redemption Price.

Because the 1.625% Convertible Notes are convertible within 12 months, they are reported in current portion of long-term debt as of June 30, 2018.

From the issuance date in 2014, the expected life of the 1.625% Convertible Notes has been approximately four years, ending on the first date we may redeem the 1.625% Convertible Notes in August 2018. As of June 30, 2018, the 1.625% Convertible Notes had a remaining amortization period of 0.1 years. The effective interest rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued is approximately 5%. The outstanding 1.625% Convertible Notes' if-converted value exceeded their principal amount at June 30, 2018 and December 31, 2017 by approximately $39 million and $50 million, respectively. At June 30, 2018 and December 31, 2017, the equity component of the 1.625% Convertible Notes, including the impact of deferred taxes, was $5 million and $12 million, respectively.

Cross-Default Provisions

The indentures governing the 4.875% Notes, the 5.375% Notes, the 1.125% Convertible Notes and the 1.625% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	June 30, 2018	December 31, 2017
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 657	$ 522
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 657	$ 522

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, and reported in "Other expenses (income), net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

In June 2018, in connection with the 1.125% Convertible Notes purchases (described in Note 7, “Debt”), we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased. This resulted in our receipt of $134 million for the settlement of the 1.125% Call Option (which is a derivative asset), and the payment of $113 million for the partial termination of the 1.125% Warrants, for an aggregate net cash receipt of $21 million from the Counterparties.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, “Fair Value Measurements.”

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, “Fair Value Measurements.”

As of June 30, 2018, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within twelve months of June 30, 2018, as described in Note 7, “Debt.”

9. Stockholders' Equity

1.625% Exchange

As described in Note 7, “Debt,” we issued 1.8 million shares of our common stock in connection with the 1.625% Exchange in March 2018.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, “Derivatives,” in 2013, we issued 13.5 million warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, if the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income (Loss) per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

As described in Note 8, “Derivatives,” in June 2018, we entered into privately negotiated termination agreements with each of the Counterparties to partially terminate the Call Spread Overlay, in notional amounts corresponding to the aggregate principal amount of the 1.125% Convertible Notes purchased. We paid $113 million to the Counterparties for the termination of 2.4 million of the 1.125% Warrants outstanding, which resulted in a reduction of additional paid-in capital for the same amount. Following this transaction, 11.1 million of the 1.125% Warrants remain outstanding.

Share-Based Compensation

In connection with our equity incentive plans and employee stock purchase plan, approximately 276,000 shares of common stock vested or were purchased, net of shares used to settle employees’ income tax obligations, during the six months ended June 30, 2018.

We record share-based compensation as “General and administrative expenses” in the accompanying consolidated statements of operations. As of June 30, 2018, there was $46 million of total unrecognized compensation expense

related to unvested restricted stock awards (RSAs), performance stock awards (PSAs), and performance stock units (PSUs), which we expect to recognize over a remaining weighted-average period of 3.1 years, 0.7 years and 2.6 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 10.8% for non-executive employees as of June 30, 2018.

Also as of June 30, 2018, there was $12 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.3 years. No stock options were granted or exercised in the six months ended June 30, 2018.

Activity for RSAs, PSAs and PSUs, for the six months ended June 30, 2018, is summarized below:

	Restricted Stock Awards	Performance Stock Awards	Performance Stock Units	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2017	401,804	84,762	91,828	578,394	$ 58.35
Granted	346,491	—	211,969	558,460	73.43
Vested	(183,595)	(32,929)	—	(216,524)	57.04
Forfeited	(124,690)	(48,701)	(101,320)	(274,711)	63.38
Unvested balance, June 30, 2018	440,010	3,132	202,477	645,619	69.69

The aggregate fair values of RSAs, PSAs and PSUs granted and vested are presented in the following table:

	Six Months Ended June 30,	
	2018	2017
	(In millions)	
Granted:		
Restricted stock awards	$ 25	$ 19
Performance stock units	16	16
	$ 41	$ 35
Vested:		
Restricted stock awards	$ 14	$ 20
Performance stock awards	3	15
Performance stock units	—	9
	$ 17	$ 44

10. Restructuring and Separation Costs

Following a management-initiated, broad operational assessment in early 2017, our board of directors approved, and we committed to, a comprehensive restructuring and profitability improvement plan in June 2017 (the 2017 Restructuring Plan). Key activities under this plan to date have included:

- Streamlining of our organizational structure to eliminate redundant layers of management, consolidate regional support services, and other staff reductions to improve efficiency and the speed and quality of decision making;
- Re-design of core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology, to achieve more effective and cost-efficient outcomes;
- Remediation of high-cost provider contracts and enhancement of high quality, cost-effective networks;
- Restructuring, including selective exits, of direct delivery operations; and
- Partnering with the lowest-cost, most effective vendors.

Costs Incurred

In our 2017 Annual Report on Form 10-K, we reported that we had incurred substantially all of the costs associated with the 2017 Restructuring Plan in 2017, amounting to $234 million. In the first half of 2018, we incurred an

additional $33 million in such costs, primarily as a result of our further evaluation and write-off of a utilization and care management project terminated because of its inconsistency with the goals of the 2017 Restructuring Plan. We also recorded nominal amounts for one-time termination benefits, true-ups of certain lease contract termination costs, and consulting fees recorded in 2017. As of June 30, 2018, we had incurred $267 million in total costs under the 2017 Restructuring Plan; we expect to complete all activities under the 2017 Restructuring Plan in 2018, with the exception of the cash settlement of lease termination liabilities. We expect to continue to settle those liabilities through 2025, unless the leases are terminated sooner.

Restructuring and separation costs are reported by the same name in the accompanying consolidated statements of operations. The following tables present the major types of such costs by segment. Current and long-lived assets include current and non-current capitalized project costs, and capitalized software determined to be unrecoverable.

	Three Months Ended June 30, 2018				
		Other Restructuring Costs			
	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)				
Health Plans	$ (1)	$ —	$ —	$ 9	$ 8
	$ (1)	$ —	$ —	$ 9	$ 8

	Six Months Ended June 30, 2018				
		Other Restructuring Costs			
	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)				
Health Plans	$ —	$ (1)	$ —	$ 8	$ 7
Other	5	20	1	—	26
	$ 5	$ 19	$ 1	$ 8	$ 33

	Three Months and Six Months Ended June 30, 2017					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Other	$ 35	$ —	$ —	$ 8	$ —	$ 43
	$ 35	$ —	$ —	$ 8	$ —	$ 43

As of June 30, 2018, we had incurred cumulative restructuring costs under the 2017 Restructuring Plan as follows:

			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 33	$ 15	$ —	$ 32	$ 80
Molina Medicaid Solutions	—	—	8	—	—	8
Other	36	39	57	45	2	179
	$ 36	$ 72	$ 80	$ 45	$ 34	$ 267

Reconciliation of Liability

For those restructuring and separation costs that require cash settlement (primarily separation costs, one-time termination benefits, consulting fees and contract termination costs), the following table presents a roll-forward of

the accrued liability, which is reported in "Accounts payable and accrued liabilities" in the accompanying consolidated balance sheets. The adjustments are due to true-ups of costs recorded in 2017.

	Separation Costs - Former Executives	One-Time Termination Benefits	Other Restructuring Costs	Total
		(In millions)		
Accrued as of December 31, 2017	$ 2	$ 11	$ 35	$ 48
Adjustments	—	(1)	8	7
Charges	—	6	2	8
Cash payments	(2)	(15)	(13)	(30)
Accrued as of June 30, 2018	$ —	$ 1	$ 32	$ 33

11. Segments

We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Recent Developments – Molina Medicaid Solutions Segment

In late 2017, as part of the 2017 Restructuring Plan, management decided to pursue the divestiture of MMS.

In June 2018, we entered into a definitive agreement to sell Molina Medicaid Solutions (MMS) to DXC Technology Company. The divestiture, expected to close in the third quarter of 2018, is subject to the satisfaction of customary closing conditions and the receipt of certain third party consents and regulatory approvals. We expect the net cash selling price for the equity interests of MMS to approximate $220 million after certain adjustments.

As of June 30, 2018, Molina Medicaid Solutions' major classes of assets and liabilities were as follows:

	(In millions)
Cash and cash equivalents	$ 9
Receivables and prepaid expenses	41
Goodwill and property, equipment, and capitalized software, net	70
Deferred contract costs and other assets	110
Total assets held for sale	$ 230

Accounts payable and accrued and other liabilities	$ 27
Deferred revenue	39
Total liabilities held for sale	$ 66

Description of Earnings Measures for Reportable Segments

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the amount earned by the Health Plans segment after medical care costs are deducted from premium revenue. The medical care ratio represents medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

The following table presents total revenue by segment. Inter-segment revenue was insignificant for all periods presented.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions)			
Total revenue:				
Health Plans	$ 4,752	$ 4,868	$ 9,261	$ 9,639
Molina Medicaid Solutions	48	47	99	93
Other	83	84	169	171
Consolidated	$ 4,883	$ 4,999	$ 9,529	$ 9,903

The following table reconciles gross margin by segment to consolidated income (loss) before income taxes:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions)			
Gross margin:				
Health Plans	$ 664	$ 249	$ 1,265	$ 786
Molina Medicaid Solutions	4	4	12	8
Other	5	1	11	6
Total gross margin	673	254	1,288	800
Add: other operating revenues [1]	242	130	431	255
Less: other operating expenses [2]	(573)	(671)	(1,155)	(1,260)
Operating income (loss)	342	(287)	564	(205)
Other expenses (income), net	37	27	80	(22)
Income (loss) before income taxes	$ 305	$ (314)	$ 484	$ (183)

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, and investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, impairment losses, and restructuring and separation costs.

12. Commitments and Contingencies

Marketplace Risk Adjustment Program

On July 7, 2018, the Centers for Medicare and Medicaid Services (CMS) announced that a February 28, 2018 ruling in the U.S. District Court for the District of New Mexico prevents CMS from making further collections or payments under the risk adjustment program, including amounts for the 2017 benefit year, until the litigation is resolved. In light of a contrary decision by the U.S. District Court for the District of Massachusetts, the government moved the New Mexico district court to reconsider its decision, and CMS is currently awaiting the court's ruling. On July 30, 2018, CMS published in the Federal Register the final rule that reissues, with additional policy explanation, the risk adjustment methodology that CMS had previously established. Due to the reissuance of the rule, the risk adjustment program for the 2017 benefit year will proceed, with solely a one-month delay — from August 2018 to September 2018 — in collection settlement.

As reported in Note 2, "Significant Accounting Policies," our Marketplace risk adjustment payable amounted to $1,159 million as of June 30, 2018, and is reported in "Amounts due government agencies" in the accompanying consolidated balance sheets.

California Medicaid Expansion Risk Corridor

In the second quarter of 2018, California health plans participating in the Medicaid Expansion program received unofficial and unverified information that CMS did not approve premium rates for the state fiscal year ended June 30, 2017. It is our understanding that, as a condition of approving the rates, CMS may require the application of a risk corridor similar to the risk corridor that was in effect for periods prior to July 2016. The risk corridor for that prior period applied a minimum medical loss ratio (MLR) of 85% and a maximum MLR of 95%. It is our understanding that the state of California is currently evaluating what actions it will take, if any, with respect to the 2016-2017 rates

and risk corridor issue. The potential impact of retroactively reinstating a minimum MLR requirement, if effected, would be a reduction to premium revenue relating to 2016 and 2017. Such an adjustment for these prior periods, if effected, could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Regulatory Capital Requirements and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations, and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $2,008 million at June 30, 2018, and $1,691 million at December 31, 2017. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company—Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to approximately $350 million and $696 million as of June 30, 2018 and December 31, 2017, respectively.

As of June 30, 2018, our health plans had aggregate statutory capital and surplus of approximately $2,152 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,180 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2018. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

Legal Proceedings

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously collected revenues.

In the ordinary course of business we are involved in legal actions, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and reasonably estimable, but the outcome of legal actions is inherently uncertain and our estimates of such losses could change as a result of further developments of these matters. For certain pending matters, accruals have not been established because such matters have not progressed sufficiently through discovery or factual development to enable us to reasonably estimate a range of possible loss. An adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Steamfitters Local 449 Pension Plan v. Molina Healthcare, Inc, et al. On April 27, 2018, the Steamfitters Local 449 Pension Plan filed a class action securities complaint in the Central District Court of California against the Company and its former executive officers, J. Mario Molina, John C. Molina, Terry P. Bayer, and Rick Hopfer, Case 2:18-cv-03579. The complaint purports to seek recovery on behalf of all persons or entities who purchased Molina common stock between October 31, 2014, and August 2, 2017, for alleged violations under Sections 10(b) and 20(a) of the Securities Exchange Act and Rule 10b-5 promulgated thereunder. The plaintiff alleges the defendants misled investors regarding the scalability of the Company's administrative infrastructure during the identified class period. The Company believes it has meritorious defenses to the alleged claims and intends to defend the matter vigorously.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and Children's Health Insurance Program (CHIP) programs. The states and Commonwealth in which we operate our health plans regularly face significant budgetary pressures.

13. Supplemental Condensed Consolidating Financial Information

As discussed in Note 7, "Debt," we have outstanding $700 million aggregate principal amount of 5.375% Notes due November 15, 2022, unless earlier redeemed. The 5.375% Notes were registered in September 2016, and are fully

and unconditionally guaranteed by certain of our wholly owned subsidiaries on a joint and several basis, with exceptions considered customary for such guarantees.

For all periods presented, the following condensed consolidating financial statements present Molina Healthcare, Inc. (as "Parent Guarantor"), the subsidiary guarantors (as "Other Guarantors"), the subsidiary non-guarantors (as "Non-Guarantors") and "Eliminations", according to the guarantor structure as assessed as of and for the six months ended June 30, 2018.

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Three Months Ended June 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 261	$ 49	$ 4,834	$ (261)	$ 4,883
Expenses:					
Medical care costs	3	—	3,847	—	3,850
Cost of service revenue	—	44	74	—	118
General and administrative expenses	252	3	341	(261)	335
Premium tax expenses	—	—	106	—	106
Health insurer fees	—	—	99	—	99
Depreciation and amortization	18	—	7	—	25
Restructuring and separation costs	(1)	—	9	—	8
Total operating expenses	272	47	4,483	(261)	4,541
Operating (loss) income	(11)	2	351	—	342
Interest expense	31	—	1	—	32
Other expenses, net	5	—	—	—	5
(Loss) income before income taxes	(47)	2	350	—	305
Income tax expense	1	1	101	—	103
Net (loss) income before equity in net earnings (losses) of subsidiaries	(48)	1	249	—	202
Equity in net earnings (losses) of subsidiaries	250	(1)	—	(249)	—
Net income	$ 202	$ —	$ 249	$ (249)	$ 202

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 202	$ —	$ 249	$ (249)	$ 202
Other comprehensive gain, net of tax	2	—	2	(2)	2
Comprehensive income	$ 204	$ —	$ 251	$ (251)	$ 204

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Three Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 289	$ 51	$ 4,952	$ (293)	$ 4,999
Expenses:					
Medical care costs	3	—	4,488	—	4,491
Cost of service revenue	—	43	81	—	124
General and administrative expenses	258	7	433	(293)	405
Premium tax expenses	—	—	114	—	114
Depreciation and amortization	25	—	12	—	37
Impairment losses	—	—	72	—	72
Restructuring and separation costs	43	—	—	—	43
Total operating expenses	329	50	5,200	(293)	5,286
Operating (loss) income	(40)	1	(248)	—	(287)
Interest expense	27	—	—	—	27
(Loss) income before income taxes	(67)	1	(248)	—	(314)
Income tax benefit	(14)	—	(70)	—	(84)
Net (loss) income before equity in net losses of subsidiaries	(53)	1	(178)	—	(230)
Equity in net losses of subsidiaries	(177)	(64)	—	241	—
Net loss	$ (230)	$ (63)	$ (178)	$ 241	$ (230)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Three Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (230)	$ (63)	$ (178)	$ 241	$ (230)
Other comprehensive income, net of tax	—	—	—	—	—
Comprehensive loss	$ (230)	$ (63)	$ (178)	$ 241	$ (230)

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Six Months Ended June 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 594	$ 101	$ 9,426	$ (592)	$ 9,529
Expenses:					
Medical care costs	7	—	7,565	—	7,572
Cost of service revenue	—	87	151	—	238
General and administrative expenses	519	7	753	(592)	687
Premium tax expenses	—	—	210	—	210
Health insurer fees	—	—	174	—	174
Depreciation and amortization	36	—	15	—	51
Restructuring and separation costs	25	—	8	—	33
Total operating expenses	587	94	8,876	(592)	8,965
Operating income	7	7	550	—	564
Interest expense	64	—	1	—	65
Other expenses, net	15	—	—	—	15
(Loss) income before income taxes	(72)	7	549	—	484
Income tax expense	10	2	163	—	175
Net (loss) income before equity in net earnings (losses of subsidiaries	(82)	5	386	—	309
Equity in net earnings (losses) of subsidiaries	391	(4)	—	(387)	—
Net income	$ 309	$ 1	$ 386	$ (387)	$ 309

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Six Months Ended June 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 309	$ 1	$ 386	$ (387)	$ 309
Other comprehensive loss, net of tax	(5)	—	(5)	5	(5)
Comprehensive income	$ 304	$ 1	$ 381	$ (382)	$ 304

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Six Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 630	$ 99	$ 9,809	$ (635)	$ 9,903
Expenses:					
Medical care costs	7	—	8,595	—	8,602
Cost of service revenue	—	85	161	—	246
General and administrative expenses	555	14	910	(635)	844
Premium tax expenses	—	—	225	—	225
Depreciation and amortization	52	—	24	—	76
Impairment losses	—	—	72	—	72
Restructuring and separation costs	43	—	—	—	43
Total operating expenses	657	99	9,987	(635)	10,108
Operating loss	(27)	—	(178)	—	(205)
Interest expense	53	—	—	—	53
Other income, net	(75)	—	—	—	(75)
Loss before income taxes	(5)	—	(178)	—	(183)
Income tax expense (benefit)	17	—	(47)	—	(30)
Net loss before equity in net losses of subsidiaries	(22)	—	(131)	—	(153)
Equity in net losses of subsidiaries	(131)	(66)	—	197	—
Net loss	$ (153)	$ (66)	$ (131)	$ 197	$ (153)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE LOSS

	Six Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (153)	$ (66)	$ (131)	$ 197	$ (153)
Other comprehensive income, net of tax	1	—	1	(1)	1
Comprehensive loss	$ (152)	$ (66)	$ (130)	$ 196	$ (152)

CONDENSED CONSOLIDATING BALANCE SHEETS

	June 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 235	$ 2	$ 3,155	$ —	$ 3,392
Investments	105	—	2,071	—	2,176
Restricted investments	80	—	—	—	80
Receivables	2	—	1,146	—	1,148
Due from (to) affiliates	68	(6)	(62)	—	—
Prepaid expenses and other current assets	62	—	282	—	344
Derivative asset	657	—	—	—	657
Assets held for sale	—	230	—	—	230
Total current assets	1,209	226	6,592	—	8,027
Property, equipment, and capitalized software, net	196	—	80	—	276
Goodwill and intangible assets, net	14	—	187	—	201
Restricted investments	—	—	117	—	117
Investment in subsidiaries, net	2,761	76	—	(2,837)	—
Deferred income taxes	33	—	99	(18)	114
Other assets	39	—	5	(16)	28
	$ 4,252	$ 302	$ 7,080	$ (2,871)	$ 8,763
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 2	$ —	$ 1,918	$ —	$ 1,920
Amounts due government agencies	—	—	1,746	—	1,746
Accounts payable and accrued liabilities	211	—	543	—	754
Deferred revenue	—	—	193	—	193
Current portion of long-term debt	484	—	—	—	484
Derivative liability	657	—	—	—	657
Liabilities held for sale	—	66	—	—	66
Total current liabilities	1,354	66	4,400	—	5,820
Long-term debt	1,217	—	16	(16)	1,217
Deferred income taxes	—	18	—	(18)	—
Other long-term liabilities	23	1	44	—	68
Total liabilities	2,594	85	4,460	(34)	7,105
Total stockholders' equity	1,658	217	2,620	(2,837)	1,658
	$ 4,252	$ 302	$ 7,080	$ (2,871)	$ 8,763

CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 504	$ 28	$ 2,654	$ —	$ 3,186
Investments	192	—	2,332	—	2,524
Restricted investments	169	—	—	—	169
Receivables	2	30	839	—	871
Due from (to) affiliates	148	(6)	(142)	—	—
Prepaid expenses and other current assets	103	14	138	(16)	239
Derivative asset	522	—	—	—	522
Total current assets	1,640	66	5,821	(16)	7,511
Property, equipment, and capitalized software, net	223	33	86	—	342
Goodwill and intangible assets, net	15	43	197	—	255
Restricted investments	—	—	119	—	119
Investment in subsidiaries, net	2,306	82	—	(2,388)	—
Deferred income taxes	17	—	101	(15)	103
Other assets	32	103	7	(1)	141
	$ 4,233	$ 327	$ 6,331	$ (2,420)	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 3	$ —	$ 2,189	$ —	$ 2,192
Amounts due government agencies	—	1	1,541	—	1,542
Accounts payable and accrued liabilities	178	40	148	—	366
Deferred revenue	—	49	233	—	282
Current portion of long-term debt	653	—	16	(16)	653
Derivative liability	522	—	—	—	522
Total current liabilities	1,356	90	4,127	(16)	5,557
Long-term debt	1,516	—	—	—	1,516
Deferred income taxes	—	15	—	(15)	—
Other long-term liabilities	24	2	36	(1)	61
Total liabilities	2,896	107	4,163	(32)	7,134
Total stockholders' equity	1,337	220	2,168	(2,388)	1,337
	$ 4,233	$ 327	$ 6,331	$ (2,420)	$ 8,471

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Six Months Ended June 30, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by operating activities	$ 49	$ 9	$ 256	$ —	$ 314
Investing activities:					
Purchases of investments	(136)	—	(778)	—	(914)
Proceeds from sales and maturities of investments	303	—	1,032	—	1,335
Purchases of property, equipment and capitalized software	(9)	(3)	(2)	—	(14)
Capital contributions to subsidiaries	(117)	—	117	—	—
Dividends from subsidiaries	60	(10)	(50)	—	—
Change in amounts due to/from affiliates	75	1	(76)	—	—
Other, net	—	(14)	5	—	(9)
Net cash provided (used in) by investing activities	176	(26)	248	—	398
Financing activities:					
Repayment of credit facility	(300)	—	—	—	(300)
Repayment of 1.125% Convertible Notes	(89)	—	—	—	(89)
Cash paid for partial settlement of 1.125% Conversion Option	(134)	—	—	—	(134)
Cash received for partial termination of 1.125% Call Option	134	—	—	—	134
Cash paid for partial termination of 1.125% Warrants	(113)	—	—	—	(113)
Other, net	(1)	—	—	—	(1)
Net cash used in financing activities	(503)	—	—	—	(503)
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(278)	(17)	504	—	209
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	513	28	2,749	—	3,290
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 235	$ 11	$ 3,253	$ —	$ 3,499

	Six Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by operating activities	$ 90	$ 44	$ 538	$ —	$ 672
Investing activities:					
Purchases of investments	(330)	—	(1,306)	—	(1,636)
Proceeds from sales and maturities of investments	127	—	747	—	874
Purchases of property, equipment and capitalized software	(45)	(9)	(6)	—	(60)
Capital contributions to subsidiaries	(238)	2	236	—	—
Dividends from subsidiaries	120	—	(120)	—	—
Change in amounts due to/from affiliates	(34)	2	32	—	—
Other, net	—	(13)	(11)	—	(24)
Net cash used in investing activities	(400)	(18)	(428)	—	(846)
Financing activities:					
Proceeds from senior notes offerings, net of issuance costs	325	—	—	—	325
Other, net	8	—	—	—	8
Net cash provided by financing activities	333	—	—	—	333
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	23	26	110	—	159
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	86	6	2,820	—	2,912
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 109	$ 32	$ 2,930	$ —	$ 3,071

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

FORWARD-LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements included in this quarterly report, other than statements of historical fact, may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, or expected. Those known risks and uncertainties include, but are not limited to, the following:

- *the success of the Company's profit improvement and maintenance initiatives, including the timing and amounts of the benefits realized, and administrative and medical cost savings achieved;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare;"*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk adjustment requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment;*
- *effective management of the Company's medical costs;*
- *the Company's ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of the Company's efforts to retain existing or awarded government contracts, including those in New Mexico and Texas, and those for Regions 8 and 11 in Florida, including the success of any protest filings or defenses;*
- *the Company's ability to manage its operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of its care management initiatives;*
- *the Company's ability to consummate and realize benefits from divestitures and acquisitions, including the timely closing of the MMS divestiture;*
- *the Company's receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *the Company's ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *the Company's estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*

- *the Medicaid expansion medical cost corridors in California, New Mexico, and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and the Company's ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of the Company's health plan in Puerto Rico, including the resolution of the debt crisis and the effect of the PROMESA law, and the impact of any future significant weather events;*
- *the success and renewal of the Company's duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across the Company's health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to the Company's provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;*
- *changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings, including litigation involving the ACA to which we ourselves are not a direct party;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of the Company's California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize the Company's expansion and growth, repay the Company's outstanding indebtedness at maturity and meet its liquidity needs, including the interest expense and other costs associated with such financing;*
- *the Company's failure to comply with the financial or other covenants in its credit agreements or the indentures governing its outstanding notes;*
- *the sufficiency of the Company's funds on hand to pay the amounts due upon conversion or maturity of its outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm;*
- *the unexpected loss of the leadership of one or more of our senior executives; and*
- *increasing competition and consolidation in the Medicaid industry;*

Readers should refer to the section entitled "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2017 for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This Quarterly Report on Form 10-Q and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2017.

ABOUT MOLINA HEALTHCARE

OUR MISSION IS TO PROVIDE QUALITY HEALTHCARE TO PEOPLE RECEIVING GOVERNMENT ASSISTANCE.

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

OVERVIEW

KEY PERFORMANCE INDICATORS

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions, except per-share amounts)			
Ending total membership	4.1	4.7	4.1	4.7
Premium revenue	$ 4,514	$ 4,740	$ 8,837	$ 9,388
Health Plans segment medical margin (1)	$ 664	$ 249	$ 1,265	$ 786
Operating income (loss)	$ 342	$ (287)	$ 564	$ (205)
Net income (loss)	$ 202	$ (230)	$ 309	$ (153)
Net income (loss) per diluted share	$ 3.02	$ (4.10)	$ 4.68	$ (2.74)
Diluted weighted average shares outstanding	66.7	56.2	66.0	56.1
Adjusted net income (loss) per diluted share*	$ 3.08	$ (4.01)	$ 4.80	$ (2.55)
EBITDA*	$ 370	$ (243)	$ 616	$ (40)
Operating Statistics:				
MCR (2)	85.3%	94.8 %	85.7%	91.6 %
G&A ratio (3)	6.9%	8.1 %	7.2%	8.5 %
Premium tax ratio (2)	2.3%	2.4 %	2.3%	2.3 %
Effective income tax rate	33.8%	26.8 %	36.2%	16.0 %
Net profit (loss) margin (3)	4.1%	(4.6)%	3.2%	(1.5)%

(1) Medical margin is equal to premium revenue minus medical care costs.
(2) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(3) G&A ratio represents general and administrative expenses as a percentage of total revenue. Net profit margin represents net income as a percentage of total revenue.

Non-GAAP Financial Measures

We use non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures.

See further information regarding non-GAAP measures in the “Supplemental Information” section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this report are designated with an asterisk (*).

CONSOLIDATED RESULTS

Three Months Ended June 30, 2018 Compared with Three Months Ended June 30, 2017

Net income for the second quarter of 2018 was $202 million, compared with a net loss of $230 million for the second quarter of 2017. Net income per diluted share was $3.02 for the second quarter of 2018, compared with net loss per diluted share of $4.10 reported for the second quarter of 2017.

Premium revenue decreased approximately 5%, or $226 million, in the second quarter of 2018, when compared with the second quarter of 2017. Member months declined 14%, partially offset by a PMPM revenue increase of 9%. Lower premium revenue was driven by a decrease in Marketplace membership, partially offset by Marketplace premium rate increases.

Overall, the medical care ratio improved to 85.3%, from 94.8% in the second quarter of 2017. See further discussion below in “Financial Performance by Program.”

Medical margin increased 167% in the second quarter of 2018, compared with the second quarter of 2017.

The general and administrative (G&A) expense ratio decreased to 6.9%, from 8.1% in the second quarter of 2017. Excluding the impact of Marketplace broker commissions and exchange fees in both periods, the G&A ratio decreased to 6.2%, from 6.7% in the second quarter of 2017. This year-over-year improvement was primarily the result of our efforts to reduce G&A costs under the 2017 Restructuring Plan.

Six Months Ended June 30, 2018 Compared with Six Months Ended June 30, 2017

Net income for the six months ended June 30, 2018 was $309 million, compared with a net loss of $153 million for the six months ended June 30, 2017. Net income per diluted share was $4.68 in the six months ended June 30, 2018, compared with net loss per diluted share of $2.74 reported in the six months ended June 30, 2017.

Premium revenue decreased approximately 6%, or $551 million, in the six months ended June 30, 2018, when compared with the six months ended June 30, 2017. Member months declined 13%, partially offset by a revenue PMPM increase of 7%, primarily relating to Marketplace membership as noted above.

Overall, the medical care ratio improved to 85.7%, from 91.6% in the six months ended June 30, 2017. See further discussion below in “Financial Performance by Program.”

Medical margin increased 61% in the six months ended June 30, 2018, compared with the six months ended June 30, 2017.

Approximately $8 million ($0.10 per diluted share) and $33 million ($0.39 per diluted share) of restructuring costs were recognized in the second quarter and six months ended June 30, 2018, respectively. For more information, refer to Notes to Consolidated Financial Statements, Note 10, “Restructuring and Separation Costs.”

Approximately $5 million ($0.06 per diluted share) and $15 million ($0.21 per diluted share) loss on debt extinguishment was recognized in the second quarter and six months ended June 30, 2018, respectively. For more information, refer to Notes to Consolidated Financial Statements, Note 7, “Debt.”

As presented in the table below, in the second quarter and six months ended June 30, 2017, we recorded significant medical care costs relating to prior year dates of service in excess of historical expectations, and Marketplace-related premium deficiency reserves and changes in estimates for prior year dates of service. In addition, we recorded significant impairment losses and restructuring costs under the 2017 Restructuring Plan.

Renewal of Medicaid Contracts

Year to date in 2018, we renewed Medicaid contracts in Washington, Florida and Puerto Rico as follows:

- In May 2018, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to enter into a managed care contract for the eight remaining regions of the state’s Apple Health Integrated Managed Care program, in addition to the two regions previously awarded to us. We were selected by HCA for the following regions: Greater Columbia, King, North Sound, Pierce, and Spokane beginning January 1, 2019; and Salish, Thurston-Mason, and Great Rivers beginning January 1, 2020. As of June 30, 2018, we served approximately 742,000 Medicaid members in Washington, which represented premium revenue of $1,083 million for the six months ended June 30, 2018.

- In June 2018, our Florida health plan was awarded comprehensive Medicaid Managed Care contracts by the Florida Agency for Health Care Administration (AHCA) in Regions 8 and 11 of the Florida Statewide Medicaid Managed Care Invitation to Negotiate. As of June 30, 2018, we served approximately 96,000 Medicaid members

in those regions, which represented premium revenue of approximately $232 million for the six months ended June 30, 2018. Services under the new contract are expected to begin on January 1, 2019. We will be serving both the Medicaid and long-term care populations in the two regions.

- In July 2018, our Puerto Rico health plan was selected by the Puerto Rico Health Insurance Administration to be one of the organizations to administer the Commonwealth's new Medicaid Managed Care contract. Services under the new contract, currently expected to begin on November 1, 2018, would cover the entire island. The base contract runs for a period of three years with an optional one year extension. As of June 30, 2018, we served approximately 326,000 Medicaid members in the East and Southwest regions of Puerto Rico, which represented premium revenue of $370 million for the six months ended June 30, 2018.

Capital Plan Progress

In the second quarter of 2018, we repaid $300 million outstanding under the revolving credit facility. In addition, we repaid $96 million aggregate principal amount of our 1.125% Notes, and entered into privately negotiated termination agreements to partially terminate the related 1.125% Call Option and 1.125% Warrants. In the first quarter of 2018, we exchanged $97 million aggregate principal amount and accrued interest of our 1.625% Convertible Notes for 1.8 million shares of our common stock. Year to date, we have reduced the principal amount of outstanding debt by $493 million.

Sale of Molina Medicaid Solutions Segment

In June 2018, we entered into a definitive agreement to sell Molina Medicaid Solutions (MMS) to DXC Technology Company. The divestiture, expected to close in the third quarter of 2018, is subject to the satisfaction of customary closing conditions and the receipt of certain third party consents and regulatory approvals. We expect the net cash selling price for the equity interests of Molina Medicaid Solutions to approximate $220 million after certain adjustments.

Summary of Significant Items

The tables below summarize the impact of certain items significant to our financial performance in the periods presented. The individual items presented below increase (decrease) income before income tax expense.

	Three Months Ended June 30, 2018		Six Months Ended June 30, 2018	
	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]
	(In millions, except per diluted share amounts)			
Marketplace risk adjustment, for 2017 dates of service	$ 79	$ 0.92	$ 56	$ 0.66
Marketplace cost sharing reduction (CSR) subsidies, for 2017 dates of service	6	0.07	76	0.90
Restructuring costs	(8)	(0.10)	(33)	(0.39)
Loss on debt extinguishment	(5)	(0.06)	(15)	(0.21)
	$ 72	$ 0.83	$ 84	$ 0.96

	Three Months Ended June 30, 2017		Six Months Ended June 30, 2017	
	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]
	(In millions, except per diluted share amounts)			
Impairment losses	$ (72)	$ (1.01)	$ (72)	$ (1.02)
Losses at behavioral health subsidiary exclusive of impairment	(8)	(0.09)	(12)	(0.14)
Medical care costs related to prior year dates of service that were in excess of historical expectations	(85)	(0.95)	(74)	(0.84)
Marketplace adjustments related to risk adjustment, CSR, and other items for 2016 dates of service	(44)	(0.49)	(47)	(0.53)
Marketplace premium deficiency reserve for 2017 dates of service	(78)	(0.87)	(70)	(0.79)
Restructuring and separation costs	(43)	(0.68)	(43)	(0.68)
Fee received for terminated acquisition	—	—	75	0.84
	$ (330)	$ (4.09)	$ (243)	$ (3.16)

(1) Except for certain items that are not deductible for tax purposes, per diluted share amounts are generally calculated at the statutory income tax rates of 22% for 2018, and 37% for 2017.

TRENDS AND UNCERTAINTIES

MEDICAID CONTRACT RE-PROCUREMENT

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates; such dates are subject to change. Premium revenue is stated in millions.

State Health Plan	Medicaid Program(s)	Membership as of June 30, 2018	Premium Revenue Six Months Ended June 30, 2018	Anticipated Award Date	Anticipated Effective Date
Texas	ABD, MMP	99,000	$ 966	Q2 2019	6/1/2020
Texas	TANF, CHIP	127,000	159	Q1 2019	1/1/2020

New Mexico Health Plan Update. In our Annual Report on Form 10-K for 2017, we reported that we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. We filed a brief in support of our judicial protest on July 20, 2018, with proposed protest hearing dates set for September 2018, and a decision expected in or around October 2018. In the interim, a temporary stay allows us to participate in the readiness review process for the new contract award. We are continuing to manage the business in run-off until such time as a different outcome is determined.

Ohio Health Plan MMP Update. In July 2018, the Ohio Medicaid agency submitted a request to Centers for Medicare and Medicaid Services (CMS) for a three-year extension of the MyCare Ohio Duals Demonstration program, through December 31, 2022. The current authority for the program ends December 31, 2019. We estimate annualized premium revenues of approximately $680 million in 2018 under the Ohio MMP program.

PRESSURES ON MEDICAID FUNDING

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following:

- Ending the entitlement nature of Medicaid by capping future increases in federal health spending for these programs, and shifting more of the risk for health costs in the future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee

basis (a “per capita cap”);

- Requiring Medicaid beneficiaries to work;
- Limiting the amount of lifetime benefits for Medicaid beneficiaries; and
- Numerous other potential changes and reforms.

ACA AND THE MARKETPLACE

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, are subject to substantial uncertainty. Effective January 1, 2018, we have:

- Exited the Utah and Wisconsin Marketplaces. We are currently evaluating the re-entry into these markets in 2019;
- Reduced the scope of our Washington state Marketplace participation;
- Increased premiums averaging 58%;
- Mitigated our exposure to uncertainties relating to cost share reduction (CSR) funding and reconciliation; and
- Adjusted broker commissions to market rates.

Effective January 2019, we have filed rates in nine Marketplace states, including the Utah and Wisconsin Marketplaces.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums, and our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio (MCR). The MCR represents medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” The service margin is equal to service revenue minus cost of service revenue. Management’s discussion and analysis of the changes in the individual components of medical margin and service margin follows.

SEGMENT SUMMARY

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions)			
Health Plans segment medical margin [1]	$ 664	$ 249	$ 1,265	$ 786
Molina Medicaid Solutions segment service margin [2]	4	4	12	8
Other segment service margin [2]	5	1	11	6
	673	254	$ 1,288	$ 800
Health Plans segment medical care ratio	85.3%	94.8%	85.7%	91.6%

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 13 states and the Commonwealth of Puerto Rico. As of June 30, 2018, these health plans served approximately 4.1 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Marketplace members, most of whom receive government premium subsidies.

BUSINESS OVERVIEW

Health Plans Membership

The following tables set forth our Health Plans membership as of the dates indicated:

	June 30, 2018	December 31, 2017	June 30, 2017
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,464,000	2,457,000	2,517,000
Medicaid Expansion	675,000	668,000	678,000
Aged, Blind or Disabled (ABD)	415,000	412,000	408,000
Total Medicaid	3,554,000	3,537,000	3,603,000
Medicare-Medicaid Plan (MMP) – Integrated [1]	55,000	57,000	54,000
Medicare Special Needs Plans (Medicare)	45,000	44,000	44,000
Total Medicare	100,000	101,000	98,000
Total Medicaid and Medicare	3,654,000	3,638,000	3,701,000
Marketplace	409,000	815,000	949,000
	4,063,000	4,453,000	4,650,000
Ending Membership by Health Plan:			
California	639,000	746,000	766,000
Florida	398,000	625,000	672,000
Illinois	219,000	165,000	163,000
Michigan	397,000	398,000	414,000
New Mexico	241,000	253,000	266,000
Ohio	320,000	327,000	351,000
Puerto Rico	326,000	314,000	322,000
South Carolina	114,000	116,000	112,000
Texas	450,000	430,000	465,000
Washington	776,000	777,000	788,000
Other [2]	183,000	302,000	331,000
	4,063,000	4,453,000	4,650,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) "Other" includes the Idaho, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

Premiums by Program

The amount of the premiums paid to our health plans vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a per member per month (PMPM) basis, for the six months ended June 30, 2018. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 330.00	$ 190.00
Medicaid Expansion	320.00	500.00	370.00
ABD	530.00	1,510.00	1,020.00
MMP – Integrated	1,360.00	3,180.00	2,180.00
Medicare	690.00	1,300.00	1,180.00
Marketplace	250.00	650.00	370.00

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, medical care ratio and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended June 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.5	$ 1,393	$ 186.18	$ 1,205	$ 161.13	86.5%	$ 188
Medicaid Expansion	2.1	761	372.04	676	330.83	88.9	85
ABD	1.3	1,288	1,033.34	1,209	969.27	93.8	79
Total Medicaid	10.9	3,442	319.52	3,090	286.89	89.8	352
MMP	0.1	367	2,224.30	313	1,893.91	85.1	54
Medicare	0.2	157	1,168.40	133	989.33	84.7	24
Total Medicare	0.3	524	1,751.49	446	1,488.85	85.0	78
Total Medicaid and Medicare	11.2	3,966	358.23	3,536	319.37	89.2	430
Marketplace	1.2	548	440.93	314	253.04	57.4	234
	12.4	$ 4,514	$ 366.57	$ 3,850	$ 312.68	85.3%	$ 664

	Three Months Ended June 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.6	$ 1,391	$ 182.47	$ 1,315	$ 172.48	94.5%	$ 76
Medicaid Expansion	2.1	786	383.07	689	335.26	87.5	97
ABD	1.2	1,285	1,053.89	1,245	1,020.85	96.9	40
Total Medicaid	10.9	3,462	317.79	3,249	298.10	93.8	213
MMP	0.1	361	2,217.44	333	2,050.20	92.5	28
Medicare	0.2	148	1,126.14	126	963.34	85.5	22
Total Medicare	0.3	509	1,730.91	459	1,565.65	90.5	50
Total Medicaid and Medicare	11.2	3,971	354.87	3,708	331.36	93.4	263
Marketplace	2.8	769	267.37	783	272.37	101.9	(14)
	14.0	$ 4,740	$ 336.98	$ 4,491	$ 319.29	94.8%	$ 249

	Six Months Ended June 30, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	14.9	$ 2,766	$ 185.66	$ 2,477	$ 166.32	89.6%	$ 289
Medicaid Expansion	4.1	1,513	372.39	1,317	324.19	87.1	196
ABD	2.5	2,542	1,023.83	2,364	951.99	93.0	178
Total Medicaid	21.5	6,821	318.11	6,158	287.22	90.3	663
MMP	0.3	724	2,180.86	618	1,858.87	85.2	106
Medicare	0.3	314	1,178.58	264	992.05	84.2	50
Total Medicare	0.6	1,038	1,735.05	882	1,473.30	84.9	156
Total Medicaid and Medicare	22.1	7,859	356.59	7,040	319.43	89.6	819
Marketplace	2.6	978	373.67	532	203.34	54.4	446
	24.7	$ 8,837	$ 358.40	$ 7,572	$ 307.11	85.7%	$ 1,265

	Six Months Ended June 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	15.3	$ 2,793	$ 182.58	$ 2,619	$ 171.25	93.8%	$ 174
Medicaid Expansion	4.1	1,603	390.88	1,378	335.88	85.9	225
ABD	2.4	2,481	1,030.68	2,375	986.54	95.7	106
Total Medicaid	21.8	6,877	315.39	6,372	292.22	92.7	505
MMP	0.3	705	2,152.75	640	1,954.15	90.8	65
Medicare	0.3	286	1,097.36	243	933.20	85.0	43
Total Medicare	0.6	991	1,685.72	883	1,502.36	89.1	108
Total Medicaid and Medicare	22.4	7,868	351.35	7,255	323.98	92.2	613
Marketplace	5.7	1,520	264.77	1,347	234.62	88.6	173
	28.1	$ 9,388	$ 333.68	$ 8,602	$ 305.74	91.6%	$ 786

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Overall

Medical care costs as a percent of premium revenue improved to 85.3% in the second quarter of 2018, from 94.8% in the second quarter of 2017. Excluding the Marketplace risk adjustments and cost sharing reduction (CSR) adjustments relating to prior year dates of service in both periods noted in the tables above in "Overview—Consolidated Results," the overall medical care ratio would have been 87.0% in the second quarter of 2018, and 93.9% in the second quarter of 2017.

Medical care costs as a percent of premium revenue improved to 85.7% in the six months ended June 30, 2018, from 91.6% in the six months ended June 30, 2017. Excluding the Marketplace risk adjustments and CSR adjustments relating to prior year dates of service in both periods, the overall medical care ratio would have been 87.1% in the six months ended June 30, 2018, and 91.2% in the six months ended June 30, 2017.

Medicaid

TANF and CHIP. The medical care ratio for TANF and CHIP improved to 86.5% in the second quarter of 2018, from 94.5% in the second quarter of 2017; and was 89.6% in the six months ended June 30, 2018, down from 93.8% in the six months ended June 30, 2017. The year over year improvement was primarily due to improved performance at our Illinois and Puerto Rico health plans.

Medicaid Expansion. The medical care ratio for Medicaid Expansion was 88.9% in the second quarter of 2018, up from 87.5% in the second quarter of 2017, and was 87.1% in the six months ended June 30, 2018, up from 85.9% in the six months ended June 30, 2017. These increases were primarily due to the premium reduction we received

in California in July 2017. Medicaid Expansion has generally performed well because rate adequacy has trended favorably, and membership is concentrated in our higher performing health plans, particularly California, Michigan, and Washington.

ABD. The medical care ratio for ABD improved to 93.8% in the second quarter of 2018, compared with 96.9% in the second quarter of 2017; and was 93.0% in the six months ended June 30, 2018, down from 95.7% in the six months ended June 30, 2017. The year over year improvement can be attributed to our continued advancement on key, high acuity management fundamentals.

Medicare and MMP

The medical care ratio for the combined Medicare programs improved to 85.0% in the second quarter of 2018, from 90.5% in the second quarter of 2017; and was 84.9% in the six months ended June 30, 2018, down from 89.1% in the six months ended June 30, 2017. This improvement was partly driven by the recognition of additional MMP at-risk revenue for dates of service in 2016 and 2017, because at-risk revenue is often recognized long after medical services have been provided. The Medicare business also benefited from favorable medical care trends and improved medical management of inpatient utilization for this population. Accurate and complete risk score documentation and effective management of chronic and high acuity conditions are critical to the successful management of this program for the rest of the year.

Marketplace

Lower Marketplace premium revenue was driven by a decrease in membership of over 50%, offset by premium rate increases. As previously disclosed, we increased premium rates and reduced our Marketplace presence effective January 1, 2018, as part of our overall program to improve profitability.

The medical care ratio for the Marketplace program decreased to 57.4% in the second quarter of 2018, from 101.9% in the second quarter of 2017; and was 54.4% in the six months ended June 30, 2018, down from 88.6% in the six months ended June 30, 2017.

Excluding the Marketplace risk adjustments and CSR adjustments relating to prior year dates of service in both periods, the Marketplace medical care ratio would have been 68.4% in the second quarter of 2018, compared with 96.3% in second quarter of 2017, and would have been 66.0% in the six months ended June 30, 2018, compared with 86.2% in the six months ended June 30, 2017.

FINANCIAL PERFORMANCE BY STATE

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Medicaid and Medicare

	Three Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR	Medical Margin
California	1.8	$ 517	$ 289.80	$ 441	$ 247.36	85.4%	$ 76
Florida	1.2	377	353.81	362	339.31	95.9	15
Illinois	0.6	203	311.60	170	261.59	84.0	33
Michigan	1.2	388	342.45	331	292.20	85.3	57
New Mexico	0.7	313	469.88	290	435.36	92.7	23
Ohio	1.0	535	571.08	482	514.57	90.1	53
Puerto Rico	0.9	184	188.26	165	168.20	89.3	19
South Carolina	0.4	123	350.22	107	304.20	86.9	16
Texas	0.7	576	835.66	510	740.55	88.6	66
Washington	2.2	571	252.61	526	232.49	92.0	45
Other [1]	0.5	179	322.99	152	274.59	85.0	27
	11.2	$ 3,966	$ 358.23	$ 3,536	$ 319.37	89.2%	$ 430

	Three Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.9	$ 598	$ 318.89	$ 539	$ 287.36	90.1%	$ 59
Florida	1.1	380	347.20	370	337.92	97.3	10
Illinois	0.5	149	289.51	174	336.76	116.3	(25)
Michigan	1.1	390	333.26	358	305.40	91.6	32
New Mexico	0.8	321	443.13	311	428.58	96.7	10
Ohio	1.0	529	536.90	489	496.41	92.5	40
Puerto Rico	0.9	179	184.28	189	194.42	105.5	(10)
South Carolina	0.4	111	326.57	102	304.14	93.1	9
Texas	0.7	524	752.01	473	679.43	90.3	51
Washington	2.2	618	276.90	546	244.58	88.3	72
Other (1)	0.6	172	294.15	157	268.91	91.4	15
	11.2	$ 3,971	$ 354.87	$ 3,708	$ 331.36	93.4%	$ 263

	Six Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	3.6	$ 1,011	$ 281.14	$ 853	$ 237.26	84.4%	$ 158
Florida	2.2	759	352.68	707	328.26	93.1	52
Illinois	1.1	344	305.94	292	259.87	84.9	52
Michigan	2.3	764	339.56	662	294.19	86.6	102
New Mexico	1.4	632	468.00	600	444.44	95.0	32
Ohio	1.9	1,086	573.87	942	497.75	86.7	144
Puerto Rico	1.9	370	190.68	339	174.74	91.6	31
South Carolina	0.7	245	349.15	211	300.87	86.2	34
Texas	1.4	1,138	822.72	1,029	744.05	90.4	109
Washington	4.5	1,155	254.64	1,100	242.48	95.2	55
Other (1)	1.1	355	318.94	305	273.97	85.9	50
	22.1	$ 7,859	$ 356.59	$ 7,040	$ 319.43	89.6%	$ 819

	Six Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	3.7	$ 1,170	$ 313.76	$ 1,023	$ 274.42	87.5%	$ 147
Florida	2.2	744	343.29	722	333.23	97.1	22
Illinois	1.1	310	282.66	354	322.63	114.1	(44)
Michigan	2.3	772	330.34	690	295.02	89.3	82
New Mexico	1.5	629	432.98	610	419.65	96.9	19
Ohio	2.0	1,049	532.35	951	482.73	90.7	98
Puerto Rico	1.9	362	185.40	354	181.24	97.8	8
South Carolina	0.7	216	321.85	200	298.79	92.8	16
Texas	1.4	1,051	751.94	962	687.96	91.5	89
Washington	4.4	1,223	275.05	1,081	243.18	88.4	142
Other (1)	1.2	342	291.93	308	262.97	90.1	34
	22.4	$ 7,868	$ 351.35	$ 7,255	$ 323.98	92.2%	$ 613

(1) "Other" includes the Idaho, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

Health Plans Segment Financial Data — Marketplace

	Three Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 73	$ 426.16	$ 21	$ 117.92	27.7%	$ 52
Florida	0.1	100	698.31	38	269.86	38.6	62
Michigan	—	15	288.67	7	146.97	50.9	8
New Mexico	—	31	418.82	18	247.06	59.0	13
Ohio	—	31	518.64	23	381.46	73.6	8
Texas	0.7	222	330.12	160	238.72	72.3	62
Washington	0.2	56	787.80	41	572.48	72.7	15
Other [1]	—	20	NM	6	NM	NM	14
	1.2	$ 548	$ 440.93	$ 314	$ 253.04	57.4%	$ 234

	Three Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.5	$ 81	$ 186.90	$ 67	$ 154.23	82.5%	$ 14
Florida	0.9	269	284.60	317	336.78	118.3	(48)
Michigan	0.1	16	204.15	10	135.89	66.6	6
New Mexico	—	31	367.98	23	266.91	72.5	8
Ohio	—	24	377.94	27	404.20	106.9	(3)
Texas	0.7	177	247.49	129	180.92	73.1	48
Washington	0.2	44	317.42	49	359.87	113.4	(5)
Other [1]	0.4	127	304.00	161	383.02	126.0	(34)
	2.8	$ 769	$ 267.37	$ 783	$ 272.37	101.9%	$ (14)

	Six Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.4	$ 122	$ 334.47	$ 52	$ 141.73	42.4%	$ 70
Florida	0.3	145	468.36	22	73.13	15.6	123
Michigan	0.1	28	254.69	16	145.49	57.1	12
New Mexico	0.1	65	429.19	37	246.77	57.5	28
Ohio	0.1	57	458.48	40	319.53	69.7	17
Texas	1.4	451	318.93	306	216.83	68.0	145
Washington	0.2	95	653.89	71	486.90	74.5	24
Other [1]	—	15	NM	(12)	NM	NM	27
	2.6	$ 978	$ 373.67	$ 532	$ 203.34	54.4%	$ 446

	Six Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.9	$ 153	$ 185.68	$ 93	$ 112.20	60.4%	$ 60
Florida	1.9	561	288.81	523	269.48	93.3	38
Michigan	0.2	27	177.12	17	116.21	65.6	10
New Mexico	0.1	53	317.10	42	249.90	78.8	11
Ohio	0.1	45	356.20	44	339.26	95.2	1
Texas	1.4	334	235.07	242	171.07	72.8	92
Washington	0.3	81	310.26	95	362.78	116.9	(14)
Other (1)	0.8	266	313.77	291	342.88	109.3	(25)
	5.7	$ 1,520	$ 264.77	$ 1,347	$ 234.62	88.6%	$ 173

(1) "Other" includes the Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results. We terminated Marketplace operations at these plans effective January 1, 2018, so the ratios for 2018 periods are not meaningful (NM).

Health Plans Segment Financial Data — Total

	Three Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 590	$ 301.73	$ 462	$ 236.04	78.2%	$ 128
Florida	1.3	477	394.38	400	331.13	84.0	77
Illinois	0.6	203	311.60	170	261.59	84.0	33
Michigan	1.2	403	340.08	338	285.78	84.0	65
New Mexico	0.7	344	464.90	308	416.99	89.7	36
Ohio	1.0	566	567.96	505	506.66	89.2	61
Puerto Rico	0.9	184	188.26	165	168.20	89.3	19
South Carolina	0.4	123	350.22	107	304.20	86.9	16
Texas	1.4	798	585.50	670	492.23	84.1	128
Washington	2.4	627	268.84	567	242.80	90.3	60
Other (1)	0.5	199	360.90	158	285.65	79.1	41
	12.4	$ 4,514	$ 366.57	$ 3,850	$ 312.68	85.3%	$ 664

	Three Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.4	$ 679	$ 294.09	$ 606	$ 262.34	89.2%	$ 73
Florida	2.0	649	318.21	687	337.39	106.0	(38)
Illinois	0.5	149	289.51	174	336.76	116.3	(25)
Michigan	1.2	406	325.38	368	295.06	90.7	38
New Mexico	0.8	352	435.34	334	411.83	94.6	18
Ohio	1.0	553	527.14	516	490.75	93.1	37
Puerto Rico	0.9	179	184.28	189	194.42	105.5	(10)
South Carolina	0.4	111	326.57	102	304.14	93.1	9
Texas	1.4	701	495.93	602	426.41	86.0	99
Washington	2.4	662	279.21	595	251.16	90.0	67
Other [1]	1.0	299	298.29	318	316.89	106.2	(19)
	14.0	$ 4,740	$ 336.98	$ 4,491	$ 319.29	94.8%	$ 249

	Six Months Ended June 30, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	4.0	$ 1,133	$ 286.07	$ 905	$ 228.44	79.9%	$ 228
Florida	2.5	904	367.18	729	296.29	80.7	175
Illinois	1.1	344	305.94	292	259.87	84.9	52
Michigan	2.4	792	335.59	678	287.23	85.6	114
New Mexico	1.5	697	464.11	637	424.58	91.5	60
Ohio	2.0	1,143	566.77	982	486.79	85.9	161
Puerto Rico	1.9	370	190.68	339	174.74	91.6	31
South Carolina	0.7	245	349.15	211	300.87	86.2	34
Texas	2.8	1,589	567.95	1,335	477.43	84.1	254
Washington	4.7	1,250	267.01	1,171	250.05	93.6	79
Other [1]	1.1	370	333.35	293	263.24	79.0	77
	24.7	$ 8,837	$ 358.40	$ 7,572	$ 307.11	85.7%	$ 1,265

	Six Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	4.6	$ 1,323	$ 290.56	$ 1,116	$ 245.02	84.3%	$ 207
Florida	4.1	1,305	317.53	1,245	303.09	95.5	60
Illinois	1.1	310	282.66	354	322.63	114.1	(44)
Michigan	2.5	799	321.10	707	284.24	88.5	92
New Mexico	1.6	682	421.11	652	402.27	95.5	30
Ohio	2.1	1,094	521.57	995	473.95	90.9	99
Puerto Rico	1.9	362	185.40	354	181.24	97.8	8
South Carolina	0.7	216	321.85	200	298.79	92.8	16
Texas	2.8	1,385	491.46	1,204	427.48	87.0	181
Washington	4.7	1,304	276.99	1,176	249.79	90.2	128
Other [1]	2.0	608	301.11	599	296.58	98.5	9
	28.1	$ 9,388	$ 333.68	$ 8,602	$ 305.74	91.6%	$ 786

(1) "Other" includes the Idaho, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

MEDICAL CARE COSTS BY TYPE

The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended June 30,					
	2018			2017		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,861	$ 232.40	74.4%	$ 3,348	$ 238.04	74.5%
Pharmacy	567	46.05	14.7	650	46.23	14.5
Capitation	282	22.89	7.3	356	25.29	7.9
Other	140	11.34	3.6	137	9.73	3.1
	$ 3,850	$ 312.68	100.0%	$ 4,491	$ 319.29	100.0%

	Six Months Ended June 30,					
	2018			2017		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 5,606	$ 227.38	74.1%	$ 6,434	$ 228.68	74.8%
Pharmacy	1,150	46.66	15.2	1,266	45.00	14.7
Capitation	594	24.09	7.8	680	24.17	7.9
Other	222	8.98	2.9	222	7.89	2.6
	$ 7,572	$ 307.11	100.0%	$ 8,602	$ 305.74	100.0%

PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.3% in the second quarter of 2018 compared with 2.4% in the second quarter of 2017 and 2.3% in both the six months ended June 30, 2018 and 2017.

HEALTH INSURER FEES (HIF)

Health insurer fees reimbursed amounted to $104 million and $165 million, and health insurer fees amounted to $99 million and $174 million, in the second quarter of 2018 and the six months ended June 30, 2018, respectively. In the second quarter of 2018, we recognized revenue related to the reimbursement of Medicaid health insurer fees from New Mexico, New York, and Puerto Rico, because we received adequate documentation of the intent to reimburse such fees.

There were no HIF reimbursed or expensed in 2017 due to the HIF moratorium under the Consolidated Appropriations Act of 2016.

MOLINA MEDICAID SOLUTIONS

The Molina Medicaid Solutions segment provides support to state government agencies' administration of their Medicaid programs, including business processing, information technology development and administrative services.

In June 2018, we entered into a definitive agreement to sell Molina Medicaid Solutions (MMS) to DXC Technology Company. The divestiture, expected to close in the third quarter of 2018, is subject to the satisfaction of customary closing conditions and the receipt of certain third party consents and regulatory approvals.

FINANCIAL OVERVIEW

The Molina Medicaid Solutions segment service margin for the second quarter of 2018 and 2017 and for the six months ended June 30, 2018 and 2017, was insignificant.

OTHER

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

FINANCIAL OVERVIEW

The Other segment service margin for the second quarter of 2018 and 2017 and for the six months ended June 30, 2018 and 2017, was insignificant.

OTHER CONSOLIDATED INFORMATION

GENERAL AND ADMINISTRATIVE EXPENSES

The G&A ratio decreased to 6.9% in the second quarter of 2018, compared with 8.1% in the second quarter of 2017. The G&A ratio decreased to 7.2% for the six months ended June 30, 2018, compared with 8.5% for the six months ended June 30, 2017. Refer to the discussion above, in "Consolidated Results."

IMPAIRMENT LOSSES

No impairment losses were recorded in the first half of 2018.

In the second quarter of 2017, we recorded $72 million in non-cash impairment losses for goodwill and intangibles, primarily relating to our Pathways subsidiary. In the course of developing the 2017 Restructuring Plan, we determined that future benefits to be derived from Pathways (including integration with our health plans) would be less than previously anticipated.

RESTRUCTURING AND SEPARATION COSTS

See Notes to Consolidated Financial Statements, Note 10, "Restructuring and Separation Costs."

INTEREST EXPENSE

Interest expense was $32 million for the second quarter of 2018, compared with $27 million for the second quarter of 2017. Interest expense was $65 million for the six months ended June 30, 2018, compared with $53 million for the six months ended June 30, 2017. As further described below in "Liquidity," year to date we have reduced the principal amount of outstanding debt by $493 million.

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $6 million and $8 million in the second quarter of 2018 and 2017, respectively and $13 million and $16 million in the six months ended June 30, 2018 and 2017, respectively. See further discussion in Notes to Consolidated Financial Statements, Note 7, "Debt."

OTHER EXPENSES (INCOME), NET

In the six months ended June 30, 2018, we recorded other expenses of $15 million due to the loss on debt extinguishment resulting from our 1.125% Convertible Notes repayments and the 1.625% Exchange. These transactions are described further in Notes to Consolidated Financial Statements, Note 7, "Debt." In February of 2017, we received a $75 million fee in connection with a terminated Medicare acquisition.

INCOME TAXES

The provision for income taxes was recorded at an effective rate of 33.8% for the second quarter of 2018, compared with a benefit of 26.8% for the second quarter of 2017, and 36.2% for the six months ended June 30, 2018, compared with a benefit of 16.0% for the six months ended June 30, 2017. The effective tax rate for 2018 differs from 2017 as a result of the reduction in the federal statutory rate from 35% to 21% under the TCJA, combined with higher non-deductible expenses in 2018 primarily related to the non-deductible HIF as a percentage of pre-tax income (loss). The HIF was not applicable in 2017 due to the 2017 HIF moratorium.

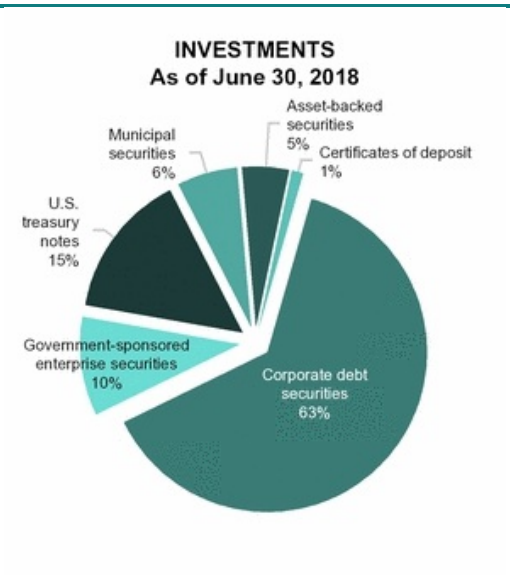
LIQUIDITY AND FINANCIAL CONDITION

INTRODUCTION

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our Health Plans segment regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

Our investments are classified as current assets, except for our held-to-maturity restricted investments, which are classified as non-current assets, and which are not included in the totals below. Our held-to-maturity restricted investments are invested principally in certificates of deposit and U.S. treasury securities.



Investment income increased to $42 million for the six months ended June 30, 2018, compared with $22 million for the six months ended June 30, 2017, primarily due to increases in our average invested assets, and in our annualized portfolio yield.

MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2018, the fair value of our fixed income investments would decrease by approximately $19 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of June 30, 2018, no amounts were outstanding under the Credit Facility.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Six Months Ended June 30,		
	2018	2017	Change
	(In millions)		
Net cash provided by operating activities	$ 314	$ 672	$ (358)
Net cash provided by (used in) investing activities	398	(846)	1,244
Net cash (used in) provided by financing activities	(503)	333	(836)
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	$ 209	$ 159	$ 50

Operating Activities

Net cash provided by operating activities decreased $358 million in the six months ended June 30, 2018, compared with the six months ended June 30, 2017. Increased net income of $462 million was offset by the following:

Receivables and deferred revenue. The aggregate year-over-year change in receivables and deferred revenue reduced cash flows from operations by $293 million. Cash flows from operations in each period were impacted by the timing of premium receipts, including health insurer fees (HIF) to be reimbursed in 2018. In general, state or federal payors may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, state or federal payors may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In 2018, the year-over-year effect of the timing of premiums received at our California, Florida, Ohio, and Washington health plans negatively impacted our cash flows from operating activities. In 2017, no receivables were recorded for the HIF due to the moratorium in that year.

Prepaid expenses and other current assets, and accounts payable and accrued liabilities. Each of these accounts increased significantly in the six months ended June 30, 2018, primarily due to amounts recorded in connection with the reinstatement of the HIF in 2018, with no comparable activity in 2017.

Medical claims and benefits payable. In the six months ended June 30, 2018, the change in medical claims and benefits payable decreased cash flows from operations by $415 million, primarily due to the decline in reserves resulting from reduced Marketplace membership in Florida, Utah, Washington and Wisconsin.

Amounts due government agencies. While amounts due government agencies increased $205 million in the six months ended June 30, 2018, this increase was less than the increase experienced in the six months ended June 30, 2017, resulting in a year over year reduction in cash flows from operations of $437 million. This decrease was primarily due to a decline in the amounts accrued for Marketplace CSR subsidies year over year.

Investing Activities

Investing activities were a source of cash of $398 million in the six months ended June 30, 2018, and a use of cash of $846 million in the six months ended June 30, 2017. This was primarily due to reduced purchases of investments and higher proceeds from sales and maturities of investments in the six months ended June 30, 2018, largely a result of the financing activities described below.

Financing Activities

Net cash used in financing activities increased $836 million in the six months ended June 30, 2018 compared with the six months ended June 30, 2017. The increase in cash used in the six months ended June 30, 2018 was due to the following:

- $300 million repayment the Credit Facility;
- $89 million repayment of the 1.125% Convertible Notes;
- $134 million cash paid for partial settlement of the 1.125% Conversion Option; and
- $113 million cash paid for partial termination of the 1.125% Warrants.

These uses of cash were partially offset by $134 million cash received for the settlement of a portion of the 1.125% Call Option. In the six months ended June 30, 2017, we received proceeds of $325 million from the sale of the 4.875% Notes.

FINANCIAL CONDITION

We believe that our cash resources, our borrowing capacity available under our Bridge Credit Agreement and Credit Facility as discussed further below in "Future Sources and Uses of Liquidity—Future Sources," and internally generated funds will be sufficient to support operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months.

On a consolidated basis, at June 30, 2018, our working capital was $2,207 million, compared with $1,954 million at December 31, 2017. At June 30, 2018, our cash and investments amounted to $5,767 million, compared with $6,000 million at December 31, 2017.

Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company—Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $350 million and $696 million as of June 30, 2018 and December 31, 2017, respectively.

Debt Ratings. Our 5.375% Notes are rated "BB-" by Standard & Poor's, and "B3" by Moody's Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs.

Financial Covenants. Our Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Facility.

Credit Facility Financial Covenants	Required Per Agreement	As of June 30, 2018
Net leverage ratio	<4.0x	1.4x
Interest coverage ratio	>3.5x	9.7x

In addition, the indentures governing the 4.875% Notes, the 5.375% Notes, the 1.125% Convertible Notes and the 1.625% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. Our Bridge Credit Agreement contains customary non-financial covenants. As of June 30, 2018, we were in compliance with all covenants under the Credit Facility, our Bridge Credit Agreement and the indentures governing our outstanding notes.

FUTURE SOURCES AND USES OF LIQUIDITY

Future Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. In the six months ended June 30, 2018, the regulated health plan subsidiaries paid $50 million in dividends to the parent, and the unregulated subsidiaries paid $10 million in dividends to the parent. In July 2018, the regulated health plan subsidiaries paid $60 million in dividends to the parent. For more information on our regulatory capital requirements and dividend restrictions, refer to Notes to Consolidated Financial Statements, Note 12, "Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions."

Borrowing Capacity and Debt Financing. We have available borrowing capacity of $550 million under our Bridge Credit Agreement (which amount is subject to the use of proceeds restrictions set forth in the Bridge Credit Agreement), and $494 million under our Credit Facility. In addition, we have adequate cash held in a restricted

account available to satisfy the redemption or conversion cash payments applicable to the $64 million principal balance outstanding under our 1.625% Convertible Notes, when they are redeemed or converted in the third quarter of 2018. See further discussion in the Notes to Consolidated Financial Statements, Note 7, “Debt.”

Sale of MMS. We expect the net cash selling price for the equity interests of MMS to approximate $220 million after certain adjustments. See further discussion in the Notes to Consolidated Financial Statements, Note 1, “Basis of Presentation.”

2017 Restructuring Plan. As previously disclosed, we estimate that the 2017 Restructuring Plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. This estimate includes run-rate savings of approximately $10 million relating to actions taken in the first quarter of 2018. We expect the cost savings to reduce both “General and administrative expenses” and “Medical care costs” reported in our consolidated statements of operations. The following table illustrates our estimates of run-rate savings associated with the 2017 Restructuring Plan, which have not changed significantly since our estimate at December 31, 2017. Such savings will be offset, through the end of 2018, by the costs referred to in the Notes to Consolidated Financial Statements, Note 10, “Restructuring and Separation Costs.”

Estimated Savings Expected to be Realized by Reportable Segment	Health Plans	Other	Total
		(In millions)	
General and administrative expenses	$65	$92 to $152	$157 to $217
Medical care costs	$126 to $166	$17	$143 to $183
	$191 to $231	$109 to $169	$300 to $400

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered and the use of proceeds will be provided at the time of an offering.

Future Uses

Regulatory Capital Requirements and Dividend Restrictions. In the six months ended June 30, 2018, the parent company contributed capital of $117 million to our regulated health plan subsidiaries to satisfy statutory net worth requirements.

Convertible Senior Notes. Refer to the Notes to Consolidated Financial Statements, Note 7, “Debt,” for a detailed discussion of our convertible senior notes, including recent transactions.

- 1.625% Convertible Notes. On July 11, 2018, we announced notice of our election to redeem the remaining $64 million aggregate principal amount of the 1.625% Convertible Notes on August 20, 2018 (the Redemption Date). Pursuant to the terms of the indenture, the 1.625% Convertible Notes will be redeemed for cash equal to 100% of the principal amount plus accrued and unpaid interest to, but excluding the Redemption Date (the Redemption Price).

  Also pursuant to the indenture, the 1.625% Convertible Notes may be converted until August 17, 2018, at a conversion rate of 17.2157 shares of our common stock per $1,000 principal amount, or approximately $58.09 per share of our common stock. Upon conversion, we will pay cash for the principal and, if applicable, deliver shares of our common stock to the converting holders in an amount per $1,000 principal amount equal to the settlement amount (as defined in the related indenture). After August 17, 2018, holders will be entitled only to the Redemption Price. As noted above, we have adequate cash held in a restricted account available to satisfy the redemption or conversion cash payments applicable to the $64 million principal balance outstanding under our 1.625% Convertible Notes, when they are redeemed or converted in the third quarter of 2018.
- 1.125% Convertible Notes. The principal amount of our 1.125% Convertible Notes is convertible into cash prior to its maturity date under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The stock price trigger for the 1.125% Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended June 30, 2018, and are convertible to cash through at least September 30, 2018. Because the 1.125% Convertible Notes may be converted into cash within 12 months, the $420 million carrying amount is reported in current portion of long-term debt as of June 30, 2018. If conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the relevant indentures. We have sufficient available cash, combined with borrowing capacity available under our Credit Facility and Bridge Credit Agreement, to fund conversions should they occur.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2017, was disclosed in our 2017 Annual Report on Form 10-K. Other than the financing transactions noted in the Notes to Consolidated Financial Statements, Note 7, “Debt,” there were no material changes to this previously filed information outside the ordinary course of business during the six months ended June 30, 2018.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, “Medical Claims and Benefits Payable,” for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the six months ended June 30, 2018, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2017.

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Goodwill and intangible assets, net.* There have been no significant changes during the six months ended June 30, 2018, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2017.

SUPPLEMENTAL INFORMATION

FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

EBITDA*

We believe that earnings before interest, taxes, depreciation and amortization (EBITDA*) is helpful in assessing our ability to meet the cash demands of our operating units.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In millions)			
Net income (loss)	$ 202	$ (230)	$ 309	$ (153)
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	33	44	67	90
Interest expense	32	27	65	53
Income tax expense (benefit)	103	(84)	175	(30)
EBITDA*	$ 370	$ (243)	$ 616	$ (40)

ADJUSTED NET INCOME (LOSS)* AND ADJUSTED NET INCOME (LOSS) PER SHARE*

We believe that adjusted net income (loss)* and adjusted net income (loss) per diluted share* are helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income (loss), which we believe to be the most comparable GAAP measure, to adjusted net income (loss)*.

	Three Months Ended June 30,				Six Months Ended June 30,			
	2018		2017		2018		2017	
	(In millions, except diluted per-share amounts)							
Net income (loss)	$ 202	$ 3.02	$ (230)	$ (4.10)	$ 309	$ 4.68	$ (153)	$ (2.74)
Adjustment:								
Amortization of intangible assets	5	0.08	8	0.14	10	0.16	17	0.30
Income tax effect [1]	(1)	(0.02)	(3)	(0.05)	(2)	(0.04)	(6)	(0.11)
Amortization of intangible assets, net of tax effect	4	0.06	5	0.09	8	0.12	11	0.19
Adjusted net income (loss)*	$ 206	$ 3.08	$ (225)	$ (4.01)	$ 317	$ 4.80	$ (142)	$ (2.55)

(1) Income tax effect of adjustments calculated at the blended federal and state statutory tax rates of 22% and 37% for 2018 and 2017, respectively.

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures. Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms.

Changes in Internal Control Over Financial Reporting. There has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2018 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 12, "Commitments and Contingencies."

RISK FACTORS

Certain risks may have a material adverse effect on our business, financial condition, cash flows, results of operations, or stock price, and you should carefully consider them before making an investment decision with respect to our securities. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in "Risk Factors," in our Annual Report on Form 10-K for the year ended December 31, 2017. The risk factors described in our 2017 Annual Report on Form 10-K are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, results of operations, or stock price.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended June 30, 2018, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
April 1 - April 30	2,528	$ 81.18	—	$ —
May 1 - May 31	—	$ —	—	$ —
June 1 - June 30	4,096	$ 85.46	—	$ —
Total	6,624	$ 83.83	—	

(1) During the three months ended June 30, 2018, we withheld 6,624 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

INDEX TO EXHIBITS

Exhibit No.	Title	Method of Filing
2.1	Purchase and Sale Agreement, dated as of June 26, 2018, by and between Molina Healthcare, Inc. and DXC Technology Company*	Filed as Exhibit 2.1 to registrant's Form 8-K filed June 27, 2018.
3.1	Fifth Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 8-K filed May 7, 2018.
10.1	Offer Letter, dated May 4, 2018, by and between Molina Healthcare, Inc. and Thomas L. Tran.	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 24, 2018.
10.2	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2018)	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
101.INS	XBRL Taxonomy Instance Document.	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document.	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Certain schedules and exhibits to this agreement have been omitted in accordance with Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule and/or exhibit will be furnished to the Securities and Exchange Commission upon request.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: August 1, 2018

/s/ JOSEPH M. ZUBRETSKY

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Dated: August 1, 2018

/s/ THOMAS L. TRAN

Thomas L. Tran
Chief Financial Officer and Treasurer
(Principal Financial Officer)

MOLINA HEALTHCARE, INC.

AMENDED AND RESTATED

DEFERRED COMPENSATION PLAN (2018)

This Deferred Compensation Plan (the "Plan") is amended and restated effective for amounts earned and deferred on or after January 1, 2018 (the "Restatement"), by MOLINA HEALTHCARE, INC., a Delaware corporation (the "Company") with reference to the following:

A. The Company originally established a Deferred Compensation Plan for key employees, effective September 1, 1999 (the "Original Plan"). The Original Plan was amended on March 29, 2001.

B. As a result of the adoption of section 409A of the Internal Revenue Code of 1986 (the "Code"), the Original Plan was frozen effective at midnight on December 31, 2004.

C. This Plan was implemented effective January 1, 2005 to replace the Original Plan with a new plan that complies with the requirements of Code section 409A and the related Treasury Regulations (and other guidance from the Internal Revenue Service) thereunder (collectively, the "409A Requirements") and amended and restated as of October 1, 2013, and subsequently amended November 14, 2013, October 29, 2014, September 1, 2016, and November 7, 2017.

D. This Plan was established to provide key employees of the Company and its subsidiaries a tax deferred, capital accumulation program. The Plan is intended to provide benefits to a select group of management or highly compensated personnel in order to attract and retain the highest quality executives. The Company does not intend for this to be a qualified plan within the meaning of Sections 401(a) and 501(a) of the Code. This Plan is intended to be an unfunded plan for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Company contributions and voluntary compensation deferrals shall be held in a "Rabbi Trust," as that term is defined in Revenue Procedure 92-64, 1992-2 C.B. 422.

E. This Plan is hereby amended and restated to clarify certain provisions of the Plan.

NOW, THEREFORE, the Company hereby adopts this Plan on the following terms and conditions:

1. Definitions. Whenever used in this Plan, the following words and phrases shall have the meaning set forth below, unless a different meaning is expressly provided or plainly required by the context in which the words or phrases are used:

1.1. Beneficiary means a person designated by a Participant to receive Plan benefits in the event of the Participant's death.

1.2. Board means the Board of Directors of the Company and its successors.

1.3. Change in Control means, a Change in Ownership, a Change in the Effective Control, a Change in Assets or a termination of the Plan and distribution of compensation deferred hereunder within twelve (12) months after any of the foregoing events. For purposes of this Section, "Company" shall include (i) the company for which a Participant is performing services at the time of the Change in Control, (ii) the company liable for the payment of the deferred compensation (or all companies liable if more than one company is liable), or a company that is a majority shareholder of a company identified in

(i) or (ii), or any company in a chain of companies in which each company is a majority shareholder of another company in the chain, ending in a company identified in (i) or (ii). The events described in this section will not be considered to occur, with respect to an employee of a participating entity, if a participating entity is sold and the employee of the participating entity continues employment with Molina Healthcare, Inc., or any other participating entity which is considered as a single employer with Molina Healthcare, Inc. under Section 414(b) or (c) of the Code subsequent to such sale. The events described in this section have the following meanings:

a. Change in Ownership means the acquisition of stock by any one person or persons acting in concert (a "group") of the Company, that when added to the stock of the person or group constitutes more than 50% of the total fair market value or total voting power of the stock of the Company. The acquisition of additional stock by any person or group who are already considered to own more than 50% of the stock of the Company shall not constitute a change in ownership of the Company. An increase in the percentage of stock owned by any person or group, as result of a transaction in which the Company acquires its stock in exchange for property will be treated as an acquisition of stock for purposes of this section.

b. Change in the Effective Control means the occurrence of any of the following events, despite the fact that the Company has not undergone a Change in Ownership as described above:

    i. The acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of ownership of stock of the Company possessing 35% or more of the total voting power of the stock, except if such acquisition is the result of a change in "record ownership" and not a change in "beneficial ownership;"

    ii. The replacement of a majority of the Company's board of directors during any 12-month period by directors whose appointment or election is not endorsed by a majority of the members of the Company's board of directors prior to the date of the appointment or election; or

    iii A transaction between the Company and another company resulting in a Change in Control.

    iv. Provided that this section shall not apply to the acquisition of additional control of the Company by any person or group, if that person or group is considered to effectively control the Company prior to the acquisition

c. Change in Assets means the acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of assets from the Company, that have a total gross fair market value equal to, or more than, 40% of the total gross fair market value of all the assets of the Company immediately prior to such acquisition or acquisitions. A transfer of assets by the Company will not be treated as a Change in Assets if the assets are transferred to any of the following (determined immediately after the transfer):

    i. A shareholder of the Company (as determined, immediately before the asset transfer) in exchange for or with respect to its stock;

    ii. An entity, 50% or more of the total value or voting power of which is owned directly or indirectly by the Company;

iii. A person or group that owns, directly or indirectly, 50% or more of the total value or voting power of all the outstanding stock of the Company; or

iv. An entity, at least 50% of the total value or voting power of which is owned, directly or indirectly, by a person described in (iii).

For purposes of this subsection (c), the gross fair market value of assets is the value of the assets of the Company or the value of the assets being disposed of with regard to any liabilities associated with such assets. If assets are transferred to an entity that is controlled by the shareholders of the transferring company immediately after the transfer, there is no Change in Control.

1.4. Company means MOLINA HEALTHCARE, INC., a Delaware corporation.

1.5. Company Stock means shares of stock issued by the Company.

1.6. Disability or Disabled means with respect to a Participant (i) the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months, or (ii) the receipt of income replacement benefits for a period of not less than three (3) months under an accident and health plan covering employees of the Company or a Subsidiary, by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months.

1.7. The original Effective Date of this Plan means January 1, 2005. The Effective Date of this Restatement shall mean January 1, 2018.

1.8. Key Employee means an employee of the Company or a Subsidiary, who is (A) a member of a select group of management or highly compensated employees within the meaning of §2520.104-23 of the Department of Labor ERISA Regulations, (B) projected to receive Plan Year Compensation (base pay plus bonus), plus amounts deferred to any 401(k) plan, deferred compensation plan, or cafeteria plan maintained by the Company, of $200,000 or more and (C) designated by the Plan Committee as a Key Employee.

1.9. Participant means (A) a Key Employee who timely files a Written Election pursuant to Section 2.3, below, and (B) a former Employee who, at the time of his Separation from Service, death, or Disability, retains, or whose beneficiary retains, benefits earned under the Plan in accordance with its terms. A Participant is considered an Active Participant in the Plan (even if the Participant no longer satisfies the requirements of Section 1.8(B) but subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee) until the Participant separates from service under the terms of this Plan.

1.10. Plan means the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2018) evidenced by this document and the Trust Agreement previously established in connection herewith.

1.11. Plan Committee means the individuals appointed by the Board from time to time to administer the Plan as provided herein.

1.12. Plan Year means the calendar year.

1.13. Plan Year Compensation means the total taxable income (other than Share Awards) paid to an Active Participant by the Company or a Subsidiary during any Plan Year, or portion thereof in which he is a Participant in this Plan, as reflected on a Key Employee's form W-2.

1.14. Separation from Service. A separation from service with the Company or a Subsidiary, provided such separation constitutes a “separation from service” under Treasury Regulation Section 1.409A-1(h).

1.15. Share Awards means shares of Company Stock which are awarded to a Participant as an employee by the Company or a Subsidiary.

1.16. Specified Employee means a "key employee" of the Company (taking into account the Subsidiaries), as defined in section 416(i) of the Code without regard to paragraph five (5) thereof.

1.17. Subsidiary means any entity in which the Company owns not less than 80% of the outstanding voting interests.

1.18. Trust Agreement means the grantor trust established in connection with this Plan between the Company as grantor and the Trustee.

1.19. Trustee means Union Bank of California and any successor institutional trustee named to succeed such Trustee under the terms of the Trust Agreement established in connection with this Plan.

1.20. Unforeseeable Financial Emergency means: (i) an illness or accident of the Participant or beneficiary, the Participant's or beneficiary's spouse, or the Participant's or beneficiary's dependent; (ii) the loss of the Participant's or beneficiary's property due to casualty; or (iii) other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant or beneficiary. Determination of whether a Participant has incurred an Unforeseeable Financial Emergency shall be made by the Plan Committee, in accordance with the requirements of Section 409A of the Code and any guidance issued thereunder.

2. Participation.

2.1. Eligibility. An employee of the Company or a Subsidiary is eligible to participate in this Plan upon meeting the criteria for Key Employee specified in Section 1.8. Any Key Employee who was a Participant in the Original Plan and who continued in the employ of the Company or a Subsidiary on the effective date of the Restatement will continue to be a Participant in this Plan, subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee thereafter.

2.2. Entry Date. An employee of the Company or a Subsidiary who met the eligibility requirement specified in Section 2.1 as of the Effective Date of this Plan Restatement is a Participant in the Plan as of the Effective Date. Newly eligible employees of the Company or a Subsidiary who have met the enrollment requirements under Section 2.3 of the Plan shall commence participation in the Plan within thirty (30) days of their date of hire. An employee of the Company or a Subsidiary who meets the eligibility requirements specified in Section 2.1 but fails to meet the requirements in accordance with Section 2.3 within the period required, shall become a Participant in this Plan on the first day of the next Plan Year following submission of a Written Election form as specified in Section 2.3.

2.3. Written Election by Participant. As a condition to participation in the Plan, each newly eligible Employee shall complete, sign and return to the Plan Committee a Written Election within thirty (30) days after the date the Participant becomes eligible to participate in the Plan. Annual enrollment shall be in December each year for the following Plan Year. Each Participant shall submit a Written Election prior to the first day of the Plan Year in which he or she will be a Participant.

a. Such Written Election shall be made on the form presented to the Participant by the Plan Committee and shall set forth:

i. his election to participate in this Plan under the terms hereof;

ii. the amount of Plan Year Compensation the Participant has determined to defer under the Plan for the Plan Year, pursuant to Section 3.1 below;

iii. the investment vehicles into which the Participant desires to have his Account attributable to deferral of Plan Year Compensation invested, as provided in Section 3.5 below, and the percentage of such Account allocated to each elected investment vehicle;

iv. the date on which his benefit is to be distributed which is the earliest of: (a) the date specified for an In-Service Withdrawal; (b) an Unforeseeable Financial Emergency; (c) the later of (i) when he separates from service with the Company or a Subsidiary for any reason or (ii) a date subsequent to his termination of employment specified by the Participant;

v. the form in which his benefit is to be distributed upon an In-Service Withdrawal, Separation from Service, Disability or death.

b. A Participant must provide a separate Written Election for each subsequent Plan Year that specifies the percentage of the Plan Year Compensation that Participant has determined to defer for each such Plan Year. Such Written Election is only effective for the Plan Year for which the election is made and if no Written Election to defer Plan Year Compensation is executed in relation to a subsequent Plan Year, no Plan Year Compensation will be deferred for such subsequent Plan Year. Any election of the amount of Plan Year Compensation to defer for a given Plan Year shall be irrevocable on and after the first day of the Plan Year for which the election was made.

c. A Participant may change the investment vehicle(s) in which the Participant desires to have that portion of the Participant's Account attributable to Plan Year Compensation and investment income invested and the percentage of the Participant's Account allocated to each investment vehicle by completing and submitting any form or forms required by the Company. Changes in investment vehicle(s) will be made as of the applicable business day (or as soon as practicable thereafter) following the date that the change is requested.

d. Notwithstanding the foregoing, the Trustee shall, at the direction of the Plan Committee, have the duty and authority to invest the trust assets and funds in accordance with the terms of the Trust Agreement, and all rights associated with the trust assets shall be exercised by the Trustee as designated by the Plan Committee and shall in no event be exercisable by or be settled upon Participants or their Beneficiaries.

e. A Participant may change the date or form of distribution by submitting a new Written Election to the Company, provided that the following conditions are met:

i. That such election may not take effect until at least twelve (12) months after the date on which the election is made;

ii. In the case of an election related to a payment other than a payment on account of death, disability or the occurrence of a financial hardship, such payment must be deferred for a period of not less than five (5) years from the date such payment would have otherwise been made, and

iii. Any election related to a payment at a specified time or pursuant to a fixed schedule may not be made less than twelve (12) months prior to the date of the first scheduled payment.

iv. Such election may be made among the payment options set forth in Section 5.4.

2.4. Duration of Participation. Any Key Employee who has become a Participant at any time shall remain a Participant, even though he is no longer an Active Participant, until his entire benefit under the terms of the Plan has been paid to him (or to his Beneficiary in the event of his death), at which time he ceases to be a Participant.

2.5. Maintenance of Records. The annual Designation of Participants by the Plan Committee shall be maintained in the corporate minute book. The Written Elections by Participants shall be maintained in the corporate records with all other files pertaining to this Plan by the Plan Committee.

3. Contributions and Allocation.

3.1 Participant Contributions. A Participant may elect to defer a portion of (i) up to 75% of Plan Year Compensation constituting base pay and (ii) up to 100% of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay). For a Participant's initial Plan Year of participation, the minimum deferral percentage for base pay and bonus pay must be 3% for each such component. For succeeding years of participation, a Participant may not defer an amount less than the minimum percentage established from year to year by the Plan Committee. A written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of Plan Year Compensation constituting base pay the Participant has chosen to defer. A separate written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay) the Participant has chosen to defer. Once a Participant's contributions for a Plan Year reach the Participant's elected percentage, such Participant shall not be allowed to defer additional portions of such Participant's Plan Year Compensation for the remainder of the Plan Year. Any amounts in excess of the Participant's elected percentage inadvertently deferred shall be refunded to the Participant as soon as practicable.

3.2. Company Contributions. The Company may, subject to the sole discretion of its Board of Directors, make contributions for the Participants, reserving the right to discriminate among the Participants in the amount or percentage of contributions made in any Plan Year.

3.3. Allocation of Participant Contributions. All amounts which a Participant elects to defer under the terms of this Plan shall be allocated to his Account as of the last business day of each month. Each such Participant Deferral Account shall be credited with earnings as provided in Section 3.5 below.

3.4. Allocation of Company Contributions. Any amounts contributed by the Company on behalf of a Participant under Section 3.2 above shall be allocated to the Company Contribution Account of each Participant. Each such Company Contribution Account shall be credited with earnings as provided in Section 3.5 below.

3.5 Credited Earnings. The Account of each Participant (which includes such Participant's Participant Deferral Account established under Section 3.1 and such Participant's Company Contribution Account established under Section 3.2) shall be credited as of each applicable business day with the actual earnings on the investments allocated to the Participant's Account.

3.6. Funding. The assets of the Plan shall be held under the Trust Agreement (a "grantor trust") designated in Section 8. As such, the Plan is intended to be an unfunded plan for purposes of the requirements of ERISA and the Code.

Notwithstanding the provisions under the terms of the Plan that amounts contributed to this Plan, plus earnings thereon, shall be allocated to separate Accounts of Participants, all such amounts credited to such individual Accounts shall remain the general assets of the Company, and as such shall remain subject to the claims of the general creditors of the Company. This Plan and the related Trust Agreement do not create, nor does any employee, Participant or Beneficiary have, any right with respect to any specific assets of the Company or the Plan.

4. Vesting of Accounts. The Participant Deferral Accounts and the Company Contribution Account of each Participant shall be 100% vested in such Participant at all times.

5. Types of Benefits.

5.1. Separation from Service Benefit. A Participant's Separation from Service Benefit is the unpaid balance of his Accounts which equals the total of all contributions made by the Participant and the Company allocated to his Account and all earnings credited to his Account in accordance with the terms of the Plan and the Trust Agreement, less any distributions already paid.

5.2. Disability Benefit. If a Participant becomes Disabled as defined in Section 1.6 above, the Company will pay his Separation from Service Benefit, calculated under Section 5.1, in the applicable form elected by the Participant in his Written Election.

A Participant who believes he has suffered a Disability within the meaning of Section 1.6 shall make application to the Plan Committee, on a form prescribed by the Plan Committee, for a determination of whether he is Disabled under the terms of Section 1.6. The Participant shall make such written application to the Plan Committee on or after the date which is at least five (5) consecutive months following the date he first suffered the impairment under consideration. Any determination by the Plan Committee that a Disability exists under the provisions of Section 1.6 shall be effective only after the date the Disability has existed for six (6) consecutive months. All determinations made by the Plan Committee shall be final, and no Participant shall be considered Disabled for any purpose whatsoever under the provisions of this Plan if determined not to be Disabled by the Plan Committee under the procedures set forth in this Section.

The Plan Committee shall notify each Participant who has made application under this Section 5.2, in writing, of its determination within three (3) months of the date the Plan Committee receives the Participant's application hereunder. The Participant shall cooperate in providing any information to the Plan Committee which it requires in making its determination, including, but not limited to, access to the Participant's medical records, direct

contact with his physician, and physical examination by a physician selected by the Company. Any Participant who does not fully cooperate shall be deemed not Disabled by the Plan Committee and so notified.

5.3. Death Benefit.

a. If a Participant dies after a distribution has commenced or if the Company has not purchased a life insurance contract in connection with the Participant's Separation from Service Benefit, the Company will continue the payments of such distribution otherwise due to the Participant to his designated Beneficiary, in the applicable form elected by the Participant in his Written Election.

b. If a Participant dies while still employed by the Company or a Subsidiary and the Company has purchased a life insurance contract in connection with such Participant's Separation from Service Benefit, the Company will pay the Participant's designated Beneficiary the greatest of: (i) twice the Participant's base salary upon initial eligibility for the Plan; (ii) $500,000; or (iii) if the Participant was a Participant prior to January 1, 2018, the amount specified under the Plan prior to such date, in the applicable form elected by the Participant in his Written Election.

5.4. In-Service Withdrawal. A Participant may designate a year in the future for receipt of an In-Service Withdrawal with respect to the Participant's contribution for a given Plan Year. Such withdrawal may be paid while the Participant remains employed with the Company or a Subsidiary. Initial designations made with respect to the 2018 Plan Year in accordance with Section 2.3(a)(iv) (as may be subsequently modified under Section 2.3(b)) shall include Credited Earnings attributable to such Participant Contribution. The In-Service Withdrawal will be paid in a lump sum unless the Participant elects to receive substantially equal annual installments from two (2) to five (5) years, commencing no earlier than three (3) years after the Plan Year during which such Participant Contributions are made; provided, however, that a Participant may make a subsequent deferral election with respect to any initial In-Service Withdrawal election made under this Plan subject to the following requirements:

a. the Participant must deliver to the Company a written election not later than twelve (12) months prior to the date the payment is scheduled to be paid;

b. the payments that are subject to the election must be delayed at least five (5) years from the date the payments would have otherwise been made; and

c. the election will not take effect until at least twelve (12) months after the election is made.

5.5. Unforeseeable Financial Emergency Benefit. A Participant may request a portion of his Separation from Service Benefit as an Unforeseeable Financial Emergency Benefit at any time by providing the Plan Committee, to its satisfaction, with a written request, proof of an Unforeseeable Financial Emergency, and proof that all other financial resources have been explored and utilized to: (i) receive a partial or full payout from the Plan and/or (ii) suspend any deferrals required to be made by a Participant. The amount of an Unforeseeable Financial Emergency Benefit shall be limited to the lesser of the amount needed for the financial hardship or such Participant's Separation from Service Benefit. If a Participant receives a distribution as a result of an Unforeseeable Financial Emergency, such Participant may not participate in the Plan during the Plan Year following the year of the hardship distribution.

6. Distributions.

6.1. Form of Benefits. The Company shall pay benefits in the form associated with Type of Benefit elected by the Participant, and, to the extent a Type of Benefit may be distributed in various forms, the Company shall pay benefits in the form elected by the Participant. The forms of benefits associated with the Types of Benefits are the following:

a. Separation from Service Benefit, Disability Benefit, and Death Benefit shall be paid in (i) one lump sum; (ii) 5 yearly installments; (iii) 10 yearly installments; or (iv) 15 yearly installments;

b. In-Service Withdrawal shall be paid as provided in Section 5.4 above; and

c. Unforeseeable Financial Emergency Benefit shall be paid in one lump sum.

6.2. Commencement of Payments. The Company will pay, or begin to pay, the Types of Benefits under this Plan to the Participant in accordance with the following:

a. Separation from Service Benefit, Disability Benefit, and Death Benefit payments shall commence no later than sixty-five (65) days following the date on which the Participant retires, terminates service, becomes disabled, or dies;

b. In-Service Withdrawal payments shall commence on the date designated by the Participant on his Written Election pursuant to Section 2.3, provided that such payments are from Participant Contributions that have been in such Participant's Participant Deferral Account for at least two years;

c. Unforeseeable Financial Emergency Benefit payments shall commence no later than sixty-five (65) days after a request for an Unforeseeable Financial Emergency Benefit is approved by the Plan Committee.

6.3. Domestic Relations Order. In the event the Plan Committee receives a Domestic Relations Order from a potential Alternate Payee, the Plan Committee shall notify the Participant whose benefit is the subject of such order and provide him/her with information concerning the Plan's procedures for administering Qualified Domestic Relations Orders ("QDROs"). Unless and until the order is set aside, the following provisions shall apply:

a. The Plan Committee shall within a reasonable time determine whether the order is a QDRO and shall notify the Participant whose benefit is the subject of the order, of its determination. The Plan Committee may designate a representative to carry out its duties under this provision.

b. Nothing in this Section shall be deemed to allow payment under a QDRO to an Alternate Payee of any benefit which would violate Section 409A of the Code and the regulations thereunder.

c. QDRO definitions. For purposes of Section 6.3 the following definitions and rules shall apply:

i. Alternate Payee means any spouse, former spouse, child or other dependent of a Participant who is recognized by a QDRO as having a right to receive all, or a portion of, the benefits payable under this Plan with respect to the Participant.

ii. Domestic Relations Order means any judgment, decree, or order (including approval of a property settlement agreement) which:

(1) relates to the provision of child support, alimony payments, or marital property rights to a spouse, child, or other dependent of a Participant; and

(2) is made pursuant to a state domestic relations law (including a community property law).

iii. Qualified Domestic Relations Order means any Domestic Relations Order meeting the requirements for a Qualified Domestic Relations Order under Code section 414(p), which satisfies any additional criteria under policies established by the Plan Committee.

6.4 Limited Cashout. Notwithstanding any Written Election made by the Participant, if, upon the Participant's Separation from Service, such Participant's accrued benefit under the Plan (and any other deferred compensation plan required to be aggregated with this Plan) does not exceed the then-current limit under Section 402(g)(1)(B) of the Code, the Company shall immediately distribute such Participant's accrued benefit under the Plan in a single lump sum payment to the Participant (or the Beneficiary, if the Participant is deceased), provided that such distribution results in a termination and complete liquidation of such Participant's interest under the Plan (and any other deferred compensation plan required to be aggregated by this Plan).

Notwithstanding sections 6.2 and 7.3, distributions to a Specified Employee shall not commence earlier than six (6) months after the date such Specified Employee experiences a Separation from Service (or, if earlier, the date of death of the employee).

7. Amendment, Termination of Plan, Change in Control.

7.1. Amendment. The Company reserves the right to amend the Plan at any time by resolution of the Plan Committee. The Plan Committee will determine the effective date of any such amendment. The amendment may not deprive any Participant or Beneficiary of any portion of a benefit under the terms of this Plan at the time of the amendment.

7.2. Termination of Plan. The Company reserves the right to terminate the Plan under the following circumstances:

a. The Plan Committee may resolve to terminate the Plan provided that:

i. all arrangements of the same type (account balance plans, nonaccount balance plans, separation pay plans or other arrangements) are terminated with respect to all participants;

ii no payments other than those otherwise payable under the terms of the Plan absent a termination of the Plan are made within twelve (12) months of the termination of the arrangement;

iii. all payments are made within twenty-four (24) moths of the termination of the arrangement; and

iv. the Company does not adopt a new arrangement that would be aggregated with any terminated arrangement under the plan aggregation rules at any time for a period of five years following the date of termination of the arrangement.

b. The Plan Committee may terminate the Plan and make payments to the Participants at any time during the twelve (12) months following a change in control of the corporation;

c. A corporate dissolution taxed under Section 331, or with the approval of a bankruptcy court pursuant to 11 U.S.C. §503(b)(l)(A), provided that the amounts deferred under the Plan are included in the Participants' gross incomes by the latest of:

i. the calendar year in which the Plan termination occurs,

ii. the calendar year in which the amount is no longer subject to a substantial risk of forfeiture, or

iii. the first calendar year in which the payment is administratively practicable.

7.3. Change in Control. In the event of a Change in Control, the Company shall, as soon as possible, but in no event later than ten days after the Change in Control, notify the Trustee, and the Trustee or its agent shall immediately calculate the Separation from Service Benefit of each affected Participant and distribute such amounts to the Participant or Beneficiary in a lump sum as soon as administratively feasible after the Change in Control, but in no event later than the last day of the year in which the Change in Control occurs. If the Company fails to notify the Trustee as specified in this section, the Trustee may act upon notification of the "Change of Control" obtained in an alternate manner. The Trustee shall incur no liability to any person for any action taken pursuant to such notification and in conformity with the terms of the Plan.

8. Benefits Not Funded. Participants and Beneficiaries have the status of unsecured creditors of the Company, and the Plan constitutes a mere promise by the Company to make benefit payments in the future. A Participant's or Beneficiary's interest in the Plan is an unsecured claim against the general assets of the Company, and neither the Participant nor a Beneficiary has any right against the account until the Plan has distributed the benefit. All amounts credited to an account are the general assets of the Company and may be disposed of or used by the Company in such manner as it determines.

Notwithstanding the first paragraph of this Section 8, the Company will make deposits to a trust pursuant to a Trust Agreement, a copy of which is attached, as provided above. Such Trust Agreement created by the Company is intended to be a grantor trust, and any assets held by such trust to assist the Company in meeting its obligations under the Plan will conform to the terms of the model trust, as described in Revenue Procedure 92-64, 1992-2 C.B. 422, promulgated by the Internal Revenue Service. The Company will make a transfer of cash to the trust annually in the amount necessary to pay the deferred compensation required.

It is the intention of the parties that this Plan and the accompanying Trust Agreement shall constitute an unfunded arrangement maintained for the purpose of providing deferred compensation for a select group of management or highly compensated employees for purposes of Title I of ERISA.

9. Administration.

9.1. Plan Committee. The Plan shall be administered by the Plan Committee. The Plan Committee shall have full authority and power to administer and construe the Plan, subject to applicable requirements of law. Without limiting the generality of the foregoing, the Plan Committee shall have the powers indicated in the foregoing Sections of the Plan and the following additional powers and duties:

a. To make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan;

b. To interpret the Plan and to decide all questions concerning the Plan;

c. To determine the amount and the recipient of any payments to be made under the Plan;

d. To designate and value any investments deemed held in the Accounts; and

e. To make all other determinations and to take all other steps necessary or advisable for the administration of the Plan.

All decisions made by the Plan Committee pursuant to the provisions of the Plan shall be made in its sole discretion and shall be final; conclusive, and binding upon all parties.

9.2. Delegation of Duties. The Plan Committee may delegate such of its duties and may engage such experts and other persons as it deems appropriate in connection with administering the Plan. The Plan Committee shall be fully protected in any action taken, in good faith, in reliance upon any opinions or reports furnished them by any such experts or other persons.

9.3. Indemnification of Committee. The Company agrees to indemnify and to defend to the fullest extent permitted by law any person serving as a member of the Plan Committee, and each employee of the Company or any of its affiliates appointed by the Plan Committee to carry out duties under this Plan, against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

9.4. Liability. To the extent permitted by law, neither the Plan Committee nor any other person shall incur any liability for any acts or for any failure to act except for liability arising out of such person's own willful misconduct or willful breach of the Plan.

9.5. Claims Review Procedure.

a. A claim for benefits may be filed, in writing, with the Plan Committee. A written disposition of a claim shall be furnished to the claimant within a reasonable time after the claim for benefits is filed. In the event a claim for benefits is denied, the Plan Committee shall provide the claimant with the reasons for denial.

b. A claimant whose claim for benefits was denied may file for a review of such denial, with the Plan Committee, no later than 60 days after he has received written notification of the denial.

c. The Plan Committee shall give a request for review a full and fair review. If the claim for benefits is denied upon completion of a full and fair review, notice of such denial shall be provided to the claimant within 60 days after the Plan Committee's receipt of such written claim for review. This 60-day period may be extended in the event of special circumstances. Such special circumstances shall be communicated to the claimant in writing within the 60-day period. If there is an extension, a decision shall be made as soon as possible, but not later than 120 days after receipt by the Plan Committee of such claim for review.

d. If benefits are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of a state, the claims procedure relating to these benefits may provide for review. If so, that company, service, or organization will be the entity to which claims are addressed.

10. General Provisions

10.1. Designation of Beneficiary. Each Participant shall designate, in writing, prior to the date he first becomes a Participant in the Plan, one or more beneficiaries to receive his benefit under the provisions of Section 5.3. The Participant shall file the written designation with the Plan Committee. The Participant may revoke a previous beneficiary designation by filing a new written beneficiary designation with the Plan Committee.

In any event, if a Participant or Beneficiary who has designated another Beneficiary is divorced, all beneficiary designations executed prior to the effective date of the dissolution of marriage (or other decree or order entered under applicable state law) are automatically revoked under the terms of this Section 10.1. In such event, the Participant or Beneficiary may designate one or more Beneficiaries in accordance with the terms of this Section 10.1. If none is made following the effective date of the dissolution of the marriage, the individual's benefit shall pass under the laws of intestate succession and the terms of the next following paragraph.

If a Participant fails to file a valid designation of beneficiary with the Plan Committee under the provisions of this Section 10.1, or if a designated Beneficiary fails to survive to receive any or all payments due hereunder, then the death benefit payable under this Plan shall be payable to the Participant's (or the Beneficiary's) spouse; if no spouse survives, then to the Participant's (or Beneficiary's) children, with equal shares among living children and with the living descendants of a deceased child receiving equal portions of the deceased child's share; in the absence of spouse or descendants, to the Participant's (or Beneficiary's) parents; and in the absence of spouse, descendants or parents, to the Participant's (or Beneficiary's) brothers and sisters, with the living descendants of a deceased brother and those of a deceased sister receiving equal portions of the deceased brother's or sister's share; in the absence of any of the persons named herein, to the Participant's (or Beneficiary's) estate.

For purposes of this Section 10.1, the term "descendant" means all persons who are descended from the person referred to either by birth to or legal adoption by such person, and "child" or "children" includes adopted children.

10.2. Benefits Not Assignable. The rights of each Participant are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment, or garnishment by creditors of the Participant or any Beneficiary. Neither the Participant nor Beneficiary may assign, transfer or pledge the benefits under this Plan. Any attempt to assign, transfer or pledge a Participant's benefits under this Plan is void.

10.3. Benefit. This Plan constitutes an agreement between the Company and each of the Participants which is binding upon and inures to the Company, its successors and assigns and upon the Participant and his heirs and legal representatives.

10.4. Headings. The headings of the Articles and Sections of this Plan are included for purposes of convenience only, and shall not affect the construction or interpretation of any of it provisions.

10.5. Notices. All notices, requests, demands, and other communications under this Plan shall be in writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the third day after mailing if mailed to the party to whom notice is to be given, by first class mail, registered or certified (return receipt requested), postage prepaid, and properly addressed to the last known address to each party as set forth on the first page thereof. Any party may change its address for purposes of this Section by giving the other parties written notice of the new address in the manner set forth above.

10.6. No Loans. The Plan does not permit any loans to be made to any Participant or Beneficiary.

10.7. Gender Usage. The use of the masculine gender includes the feminine gender for all purposes of this Plan.

10.8. Expenses. Costs of administration of the Plan shall be paid by the Company.

IN WITNESS WHEREOF, the Company has executed this Amended and Restated Deferred Compensation Plan (2018) on July 16, 2018, effective as of the Effective Date.

MOLINA HEALTHCARE, INC.

By: /s/ *Joseph M. Zubretsky*

Name: Joseph M. Zubretsky

Title: Chief Executive Officer

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: August 1, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Thomas L. Tran, certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 1, 2018

/s/ Thomas L. Tran

Thomas L. Tran
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2018 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 1, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2018 (the "Report"), I, Thomas L. Tran, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 1, 2018

/s/ Thomas L. Tran

Thomas L. Tran
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended March 31, 2018

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2018

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of April 25, 2018, was approximately 61,685,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q

FOR THE QUARTERLY PERIOD ENDED March 31, 2018

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CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2018	2017
	(In millions, except per-share data) (Unaudited)	
Revenue:		
Premium revenue	$ 4,323	$ 4,648
Service revenue	134	131
Premium tax revenue	104	111
Health insurer fees reimbursed	61	—
Investment income and other revenue	24	14
Total revenue	4,646	4,904
Operating expenses:		
Medical care costs	3,722	4,111
Cost of service revenue	120	122
General and administrative expenses	352	439
Premium tax expenses	104	111
Health insurer fees	75	—
Depreciation and amortization	26	39
Restructuring and separation costs	25	—
Total operating expenses	4,424	4,822
Operating income	222	82
Other expenses (income), net:		
Interest expense	33	26
Other expense (income), net	10	(75)
Total other expenses (income), net	43	(49)
Income before income tax expense	179	131
Income tax expense	72	54
Net income	$ 107	$ 77
Net income per share:		
Basic	$ 1.79	$ 1.38
Diluted	$ 1.64	$ 1.37

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2018	2017
	(Amounts in millions) (Unaudited)	
Net income	$ 107	$ 77
Other comprehensive (loss) income:		
Unrealized investment (loss) gain	(7)	1
Less: effect of income taxes	—	—
Other comprehensive (loss) income, net of tax	(7)	1
Comprehensive income	$ 100	$ 78

See accompanying notes.

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CONSOLIDATED BALANCE SHEETS

	March 31, 2018	December 31, 2017
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,729	$ 3,186
Investments	2,444	2,524
Restricted investments	77	169
Receivables	950	871
Prepaid expenses and other current assets	411	239
Derivative asset	585	522
Total current assets	8,196	7,511
Property, equipment, and capitalized software, net	318	342
Goodwill and intangible assets, net	250	255
Restricted investments	120	119
Deferred income taxes	114	103
Other assets	135	141
	$ 9,133	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 2,023	$ 2,192
Amounts due government agencies	1,714	1,542
Accounts payable and accrued liabilities	713	366
Deferred revenue	404	282
Current portion of long-term debt	566	653
Derivative liability	585	522
Total current liabilities	6,005	5,557
Long-term debt	1,318	1,318
Lease financing obligations	198	198
Other long-term liabilities	59	61
Total liabilities	7,580	7,134
Stockholders' equity:		
Common stock, $0.001 par value, 150 shares authorized; outstanding: 62 shares at March 31, 2018 and 60 shares at December 31, 2017	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	1,153	1,044
Accumulated other comprehensive loss	(12)	(5)
Retained earnings	412	298
Total stockholders' equity	1,553	1,337
	$ 9,133	$ 8,471

See accompanying notes.

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CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
			(In millions)			
			(Unaudited)			
Balance at January 1, 2018	60	$ —	$ 1,044	$ (5)	$ 298	$ 1,337
Net income	—	—	—	—	107	107
Adoption of Topic 606	—	—	—	—	6	6
Adoption of ASU 2018-02	—	—	—	—	1	1
1.625% Convertible Notes exchange transaction	2	—	108	—	—	108
Other comprehensive loss, net	—	—	—	(7)	—	(7)
Share-based compensation	—	—	1	—	—	1
Balance at March 31, 2018	62	$ —	$ 1,153	$ (12)	$ 412	$ 1,553

See accompanying notes.

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CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2018	2017
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net income	$ 107	$ 77
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	37	49
Deferred income taxes	(6)	(5)
Share-based compensation	6	6
Non-cash restructuring costs	17	—
Amortization of convertible senior notes and lease financing obligations	7	8
Loss on debt extinguishment	10	—
Other, net	2	3
Changes in operating assets and liabilities:		
Receivables	(83)	(32)
Prepaid expenses and other current assets	(239)	(12)
Medical claims and benefits payable	(163)	(3)
Amounts due government agencies	172	373
Accounts payable and accrued liabilities	319	50
Deferred revenue	130	146
Income taxes	78	59
Net cash provided by operating activities	394	719
Investing activities:		
Purchases of investments	(389)	(733)
Proceeds from sales and maturities of investments	543	433
Purchases of property, equipment and capitalized software	(4)	(26)
Increase in restricted investments held-to-maturity	—	(5)
Other, net	(5)	(6)
Net cash provided by (used in) investing activities	145	(337)
Financing activities:		
Cash paid for financing transaction fees	(5)	—
Proceeds from employee stock plans	—	1
Other, net	—	(2)
Net cash used in financing activities	(5)	(1)
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	534	381
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	3,290	2,912
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 3,824	$ 3,293

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Three Months Ended March 31,	
	2018	2017
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (5)	$ (6)
Details of change in fair value of derivatives, net:		
Gain (loss) on 1.125% Call Option	$ 63	$ (86)
(Loss) gain on 1.125% Conversion Option	(63)	86
Change in fair value of derivatives, net	$ —	$ —
1.625% Convertible Notes exchange transaction:		
Common stock issued in exchange for 1.625% Convertible Notes	$ 131	$ —
Component of 1.625% Convertible Notes allocated to additional paid-in capital, net of income taxes	(23)	—
Net increase to additional paid-in capital	$ 108	$ —

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

March 31, 2018

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

The Health Plans segment consists of health plans operating in 13 states and the Commonwealth of Puerto Rico. As of March 31, 2018, these health plans served approximately 4.1 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies' administration of their Medicaid programs, including business processing, information technology development and administrative services. The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Presentation and Reclassification

We have reclassified certain amounts in the 2017 consolidated statement of cash flows to conform to the 2018 presentation, relating to the presentation of restricted cash and cash equivalents. The reclassification is a result of our adoption of Accounting Standards Update (ASU) 2016-18, *Restricted Cash* effective January 1, 2018. See Note 2, "Significant Accounting Policies," for further information, including the amount reclassified.

We have combined certain line items in the accompanying consolidated balance sheets. For all periods presented, we have combined the presentation of:

- Income taxes refundable with "Prepaid expenses and other current assets;"
- Income taxes payable with "Accounts payable and accrued liabilities;"
- Goodwill, and intangible assets, net to a single line; and
- Deferred contract costs with "Other assets."

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the three

months ended March 31, 2018 are not necessarily indicative of the results for the entire year ending December 31, 2018.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2017. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in our December 31, 2017 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2017 audited consolidated financial statements.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in non-current "Restricted investments" in the accompanying consolidated balance sheets.

	Three Months Ended March 31,	
	2018	2017
	(In millions)	
Cash and cash equivalents	$ 3,729	$ 3,198
Restricted cash and cash equivalents	95	95
Total cash, cash equivalents, and restricted cash and cash equivalents presented in the statements of cash flows	$ 3,824	$ 3,293

Revenue Recognition

We adopted ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)* effective January 1, 2018, using the modified retrospective approach. The insurance contracts of our Health Plans segment, which segment constitutes the vast majority of our operations, are excluded from the scope of Topic 606 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts. The cumulative effect of initially applying the guidance, relating entirely to our Molina Medicaid Solutions segment contracts, resulted in an immaterial impact to beginning retained earnings, as presented in the accompanying consolidated statement of stockholders' equity. Topic 606 was only applied to service contracts that were not completed as of December 31, 2017. Refer to "Molina Medicaid Solutions segment" and "Other segment" below for further information.

Health Plans segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into two broad categories discussed in further detail below: 1) "Contractual Provisions That May Adjust or Limit Revenue or Profit;" and 2) "Quality Incentives." Liabilities recorded for such provisions are included in "Amounts due government agencies" in the accompanying consolidated balance sheets.

1) Contractual Provisions That May Adjust or Limit Revenue or Profit:

Medicaid

- *Medical Cost Floors (Minimums), and Medical Cost Corridors:* A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $148 million and $135 million at March 31, 2018 and December 31, 2017, respectively. Approximately $97 million and $96 million of the liability

accrued at March 31, 2018 and December 31, 2017, respectively, relates to our participation in Medicaid Expansion programs.

- *Retroactive Premium Adjustments:* State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare

- *Minimum MLR:* Federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Marketplace

- *Risk adjustment:* Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. As of March 31, 2018, and December 31, 2017 the Marketplace risk adjustment payable amounted to $1,129 million and $912 million, respectively.

- *Minimum MLR:* The ACA has established a Minimum MLR of 80% for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

2) Quality Incentives:

At many of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2018 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2018.

	Three Months Ended March 31,	
	2018	2017
	(Dollars in millions)	
Maximum available quality incentive premium - current period	$ 40	$ 38
Quality incentive premium revenue recognized in current period:		
Earned current period	$ 24	$ 19
Earned prior periods	11	5
Total	$ 35	$ 24
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.8%	0.5%

Molina Medicaid Solutions segment

Molina Medicaid Solutions is under contract with Medicaid agencies in six states and the U.S. Virgin Islands. Our existing contracts have terms that currently extend to 2018 through 2025, before renewal options. As of March 31, 2018, the aggregate amount of service revenue relating to unsatisfied performance obligations amounted to $571 million.

Business process outsourcing services are billed immediately following the end of the month in which such services are performed, with payment received soon thereafter. Payments for the design, development and implementation (DDI) of Medicaid management information systems milestones are received following our performance, and the

customer's acceptance, of the milestone deliverable. However, DDI revenue is deferred until the system 'go-live' date, and is amortized over the initial contract hosting period.

Other segment

Our Pathways behavioral health subsidiary's revenue is variable, and generally invoiced after services are rendered; customer payment follows invoicing. We have concluded that there is no change to revenue recognition under Topic 606 for our Pathways behavioral health subsidiary, and therefore no impact to retained earnings effective January 1, 2018.

The following table presents the opening and closing balances of receivables, deferred contract costs (contract assets), and deferred revenue (contract liabilities) from contracts with customers, by segment.

	March 31, 2018	December 31, 2017
	(In millions)	
Receivables:		
Molina Medicaid Solutions	$ 41	$ 30
Other	46	44
Deferred contract costs (contract assets) – Molina Medicaid Solutions	103	101
Deferred revenue (contract liabilities) – Molina Medicaid Solutions	41	49

Medical Care Costs - Marketplace Cost Share Reduction (CSR) Update

During the first quarter of 2018, we recognized a benefit of approximately $70 million in reduced medical expense related to 2017 dates of service as a result of the federal government's confirmation that the reconciliation of 2017 Marketplace CSR subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by HIF in 2017 given the 2017 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The Tax Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. The TCJA, in part, reduced the U.S. federal statutory corporate income tax rate from 35% to 21% effective January 1, 2018. Accounting guidance allows filers one year subsequent to the end of the tax year to finalize the valuation of deferred tax assets and liabilities. At March 31, 2018, we had not completed our accounting for the tax effects resulting from enactment of TCJA with respect to valuation of our deferred tax assets and liabilities. We will continue to make and refine our calculations as additional analysis is completed. In addition, our estimates may also be affected as we gain a more thorough understanding of the tax law based on expected future guidance from the Internal Revenue Service and U.S. Treasury.

Recent Accounting Pronouncements Adopted

Revenue Recognition (Topic 606). See discussion above, in "Revenue Recognition."

Comprehensive Income. In February 2018, the Financial Accounting Standards Board (FASB) issued ASU 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the TCJA. ASU 2018-02 is effective beginning January 1, 2019; we early adopted this ASU effective

January 1, 2018. The effect of applying the guidance resulted in an immaterial impact to beginning retained earnings, as presented in the accompanying consolidated statement of stockholders' equity.

Restricted Cash. In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which requires us to include in our consolidated statements of cash flows the balances of cash, cash equivalents, restricted cash and restricted cash equivalents. When these items are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Transfers between cash and cash equivalents and restricted cash and restricted cash equivalents are no longer presented in the statement of cash flows. We adopted ASU 2016-18 on January 1, 2018. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption resulted in a $95 million reclassification of restricted cash and cash equivalents from "Investing activities" to the beginning and ending balances of cash and cash equivalents in our consolidated statements of cash flows for the quarter ended March 31, 2017. There was no impact to our consolidated statements of income, balance sheets, or stockholders' equity. The reconciliation of cash and cash equivalents to cash, cash equivalents and restricted cash and cash equivalents is presented at the beginning of this note.

Recent Accounting Pronouncements Not Yet Adopted

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument's contractual life. ASU 2016-13 is effective for us beginning January 1, 2020, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted. We are evaluating the effect of this guidance.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both financing and operating leases. For leases with a term of 12 months or less, an entity may elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. ASU 2016-02 is effective for us beginning January 1, 2019, and must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. Under this guidance, we will record assets and liabilities relating primarily to our long-term office leases. We are currently updating the configuration of our lease database management system for the adoption of Topic 842, and we are in the early stages of computing the impact of Topic 842 on our consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of basic and diluted net income per share:

	Three Months Ended March 31,	
	2018	2017
	(In millions, except net income per share)	
Numerator:		
Net income	$ 107	$ 77
Denominator:		
Shares outstanding at the beginning of the period	59	56
Weighted-average number of shares issued:		
1.625% Exchange (1)	1	—
Denominator for basic net income per share	60	56
Effect of dilutive securities:		
Convertible senior notes (1)	1	—
1.125% Warrants (1)	4	—
Denominator for diluted net income per share	65	56
Net income per share: (2)		
Basic	$ 1.79	$ 1.38
Diluted	$ 1.64	$ 1.37

(1) For more information regarding the 1.625% Exchange and the convertible senior notes, refer to Note 7, “Debt.” For more information regarding the 1.125% Warrants, refer to Note 9, “Stockholders' Equity.” The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method.
(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of cash, cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to the three-tier fair value hierarchy. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 4, “Fair Value Measurements,” in our 2017 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of March 31, 2018, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 8, “Derivatives,” the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such derivative instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the three months ended March 31, 2018.

Our financial instruments measured at fair value on a recurring basis at March 31, 2018, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,618	$ —	$ 1,618	$ —
U.S. treasury notes	329	329	—	—
Government-sponsored enterprise securities (GSEs)	227	227	—	—
Municipal securities	131	—	131	—
Asset-backed securities	110	—	110	—
Certificate of deposit	27	—	27	—
Other	2	—	2	—
Subtotal - current investments	2,444	556	1,888	—
Corporate debt securities	66	—	66	—
U.S. treasury notes	11	11	—	—
Subtotal - current restricted investments	77	11	66	—
1.125% Call Option derivative asset	585	—	—	585
Total assets	$ 3,106	$ 567	$ 1,954	$ 585
1.125% Conversion Option derivative liability	$ 585	$ —	$ —	$ 585
Total liabilities	$ 585	$ —	$ —	$ 585

Our financial instruments measured at fair value on a recurring basis at December 31, 2017, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,588	$ —	$ 1,588	$ —
U.S. treasury notes	388	388	—	—
GSEs	253	253	—	—
Municipal securities	141	—	141	—
Asset-backed securities	117	—	117	—
Certificates of deposit	37	—	37	—
Subtotal - current investments	2,524	641	1,883	—
Corporate debt securities	101	—	101	—
U.S. treasury notes	68	68	—	—
Subtotal - current restricted investments	169	68	101	—
1.125% Call Option derivative asset	522	—	—	522
Total assets	$ 3,215	$ 709	$ 1,984	$ 522
1.125% Conversion Option derivative liability	$ 522	$ —	$ —	$ 522
Total liabilities	$ 522	$ —	$ —	$ 522

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the amount due under our Credit Facility is classified as a Level 3 financial instrument, because certain inputs used to determine its fair value are not observable. The carrying amount of the amount due under the Credit Facility approximates its fair value because the Credit Facility's interest rate is a variable rate that approximates rates currently available to us.

	March 31, 2018		December 31, 2017	
	Carrying Value	Fair Value	Carrying Value	Fair Value
	(In millions)			
5.375% Notes	$ 693	$ 694	$ 692	$ 730
1.125% Convertible Notes	502	1,111	496	1,052
4.875% Notes	326	307	325	329
Credit Facility	300	300	300	300
1.625% Convertible Notes	63	90	157	220
	$ 1,884	$ 2,502	$ 1,970	$ 2,631

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets (including restricted investments) to be available-for-sale. Certain of our senior notes, as further discussed in Note 7, "Debt," contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as "Restricted investments" in the accompanying consolidated balance sheets. Such proceeds, while restricted as to their use and held in a segregated deposit account, are available-for-sale based upon our contractual liquidity requirements.

The following tables summarize our investments as of the dates indicated:

	March 31, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,627	$ —	$ 9	$ 1,618
U.S. treasury notes	330	—	1	329
GSEs	229	—	2	227
Municipal securities	133	—	2	131
Asset backed securities	111	—	1	110
Certificates of deposit	27	—	—	27
Other	2	—	—	2
Subtotal - current investments	2,459	—	15	2,444
Corporate debt securities	66	—	—	66
U.S. treasury notes	11	—	—	11
Subtotal - current restricted investments	77	—	—	77
	$ 2,536	$ —	$ 15	$ 2,521

	December 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,591	$ 1	$ 4	$ 1,588
U.S. treasury notes	389	—	1	388
GSEs	255	—	2	253
Municipal securities	142	—	1	141
Asset-backed securities	117	—	—	117
Certificates of deposit	37	—	—	37
Subtotal - current investments	2,531	1	8	2,524
Corporate debt securities	101	—	—	101
U.S. treasury notes	68	—	—	68
Subtotal - current restricted investments	169	—	—	169
	$ 2,700	$ 1	$ 8	$ 2,693

The contractual maturities of our available-for-sale investments as of March 31, 2018 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,576	$ 1,573
Due after one year through five years	959	947
Due after five years through ten years	1	1
	$ 2,536	$ 2,521

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three months ended March 31, 2018 and 2017 were insignificant.

We have determined that unrealized losses at March 31, 2018 and December 31, 2017, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of March 31, 2018:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,276	$ 7	610	$ 93	$ 2	71
U.S. Treasury notes	364	1	81	—	—	—
GSEs	179	1	67	95	1	47
Municipal securities	85	1	97	38	1	46
Asset backed securities	97	1	60	—	—	—
	$ 2,001	$ 11	915	$ 226	$ 4	164

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2017:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,297	$ 3	561	$ 94	$ 1	69
U.S. Treasury Notes	470	1	89	—	—	—
GSEs	173	1	69	95	1	47
Municipal securities	—	—	—	38	1	48
	$ 1,940	$ 5	719	$ 227	$ 3	164

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current "Restricted investments" in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

The contractual maturities of our held-to-maturity restricted investments, which are carried at amortized cost, which approximates fair value, as of March 31, 2018, are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 117	$ 117
Due after one year through five years	3	3
	$ 120	$ 120

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated:

	March 31, 2018	December 31, 2017
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,586	$ 1,717
Pharmacy payable	127	112
Capitation payable	62	67
Other	248	296
	$ 2,023	$ 2,192

"Other" medical claims and benefits payable includes amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $146 million and $122 million as of March 31, 2018 and December 31, 2017, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amounts by which our original estimate of medical claims and benefits payable at the beginning of the

period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,	
	2018	2017
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 2,192	$ 1,929
Components of medical care costs related to:		
Current period	3,963	4,253
Prior periods	(241)	(142)
Total medical care costs	3,722	4,111
Change in non-risk provider payables	45	(96)
Payments for medical care costs related to:		
Current period	2,498	2,683
Prior periods	1,438	1,335
Total paid	3,936	4,018
Medical claims and benefits payable, ending balance	$ 2,023	$ 1,926
Benefit from prior period as a percentage of:		
Balance at beginning of period	11.0%	7.4%
Premium revenue, trailing twelve months	1.3%	0.8%
Medical care costs, trailing twelve months	1.4%	0.9%

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because we establish the provision for adverse claims deviation and the accrued cost of settling claims on a consistent basis every quarter, the lower cost recognized in a subsequent period if such a provision proved unnecessary would be offset by the establishment of a similar provision during that subsequent period.

Because the amount of our initial liability is an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The differences between our original estimates and the amounts ultimately paid out for the most part relate to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at March 31, 2018 are as follows:

- Across all of our health plans, the inventory of unpaid claims increased significantly during the first half of 2017, then decreased in the last half of 2017 and into 2018. Changes in claims inventories impact the timing between date of service and the date of claim payment, increasing the volatility of our liability estimates.
- According to The Centers for Disease Control and Prevention, and confirmed by our own claims experience, the influenza season was much more severe this year than last year in several states in which we operate health plans. Although we have established liabilities for additional expected claims related to influenza, our liability estimates are subject to more than the usual amount of uncertainty.

- At our Florida health plan a new clinical service system was implemented in the first quarter of 2018. This system impacted the reporting of inpatient authorizations used in our development of claims liabilities, which makes our liability estimates subject to more than the usual amount of uncertainty.
- We recently implemented a new process for increased quality review of claims payments in nine of our health plans. While we do not anticipate this new process will impact the percentage of claims paid within the timely turnaround requirements, we believe it will have a minor impact on the timing of some paid claims. For this reason, our liability estimates in the nine health plans are subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $241 million for the three months ended March 31, 2018. This amount represents our estimate as of March 31, 2018, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2017, was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- The impact of the provision for adverse claims deviation and the accrued cost of settling claims as discussed above. Because we re-establish the provision for adverse claims deviation and the accrued cost of settling claims on a consistent basis every quarter, the impact of this item on first quarter 2018 results was minimal.
- Across all of our health plans, the inventory of unpaid claims increased significantly during the first half of 2017, then decreased in the last half of 2017. In hindsight, the impact of the changes in claims processing timing reduced our liabilities more than we had anticipated.
- December 2017 data from The Centers for Disease Control and Prevention indicated widespread influenza activity in several states in which we operate health plans. The additional liabilities established in consideration of increased claims related to a more severe influenza season turned out to be conservative.
- In establishing our liability at December 31, 2017, we anticipated an increase in the utilization of medical services by Marketplace members concerned about the future of their healthcare coverage as a result of uncertainties related to high premium increases and issuer exits. This induced demand did not materialize to the degree we expected.

7. Debt

Substantially all of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets:

	March 31, 2018	December 31, 2017
	(In millions)	
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 505	$ 499
1.625% Convertible Notes, net of unamortized discount	63	157
Lease financing obligations	1	1
Debt issuance costs	(3)	(4)
	566	653
Non-current portion of long-term debt:		
5.375% Notes	700	700
4.875% Notes	330	330
Credit Facility	300	300
Debt issuance costs	(12)	(12)
	1,318	1,318
Lease financing obligations	198	198
	$ 2,082	$ 2,169

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended March 31,	
	2018	2017
	(In millions)	
Contractual interest at coupon rate	$ 2	$ 3
Amortization of the discount	7	8
	$ 9	$ 11

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. As of March 31, 2018, $300 million was outstanding under the Credit Facility, and outstanding letters of credit amounting to $6 million reduced our remaining borrowing capacity under the Credit Facility to $194 million.

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee. The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of March 31, 2018, we were in compliance with all financial and non-financial covenants under the Credit Facility and other long-term debt.

Bridge Credit Agreement

In January 2018, we entered into a bridge credit agreement (Bridge Credit Agreement) with several banks. Under the Bridge Credit Agreement, we may borrow up to $550 million to: (i) satisfy conversions of our 1.125% Convertible Notes; (ii) satisfy and/or refinance indebtedness incurred to satisfy conversion of the 1.125% Convertible Notes; (iii) repay or refinance our Credit Facility; and (iv) pay fees and expenses in connection with the foregoing. Subject to the satisfaction of certain conditions, the remaining amount of any borrowing may be used for general corporate purposes.

Borrowings under the Bridge Credit Agreement are reduced by the following:

- Any future debt and/or equity transactions including term loans, but excluding any Credit Facility drawing (excluding transactions with proceeds used for working capital purposes and acquisition financings up to $300 million); and
- On August 20, 2018 (the first put date for the 1.625% Convertible Notes), the Bridge Credit Agreement shall permanently be reduced by the greater of $150 million; and the principal amount of the 1.625% Convertible Notes that are exchanged into equity or otherwise defeased on or prior to that date.

The Bridge Credit Agreement matures on January 1, 2019 and, subject to the satisfaction of certain conditions, we may elect to extend twice the initial maturity date by a period of six months each. The amount available for borrowing under the Bridge Credit Agreement at March 31, 2018, was $550 million.

Borrowings under the Bridge Credit Agreement will bear interest based, at our election, at a base rate or an adjusted LIBOR rate, plus in each case the applicable margin. Our wholly owned subsidiaries that guarantee our obligations under the indenture governing the 4.875% Notes, the 5.375% Notes, and the Credit Facility have jointly and severally guaranteed our obligations under the Bridge Credit Agreement.

The Bridge Credit Agreement contains usual and customary (a) affirmative covenants for credit facilities of this type and substantially similar to those contained in the Credit Facility, (b) negative covenants consistent with those contained in the 4.875% Notes and (c) events of default for credit facilities of this type and substantially similar to those contained in the 4.875% Notes.

4.875% Notes due 2025

We have outstanding $330 million aggregate principal amount of senior notes (4.875% Notes) due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. Guarantees under the 4.875% Notes mirror those of the Credit Facility. See Note 13, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

The 4.875% Notes contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as “Restricted investments” in our consolidated balance sheets. These funds may be used by us as follows:

- On or prior to August 20, 2018, to:
  - Redeem, repurchase, repay, tender for, or acquire for value all or any portion of our 1.625% Convertible Notes, defined and discussed further below, or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes; and/or
  - Pay any interest due on all or any portion of the 4.875% Notes.
- On or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that we are obligated to repurchase; and
- Subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited in the indenture governing the 4.875% Notes.

The investments that constitute the segregated funds are current assets reported as “Restricted investments” in the accompanying consolidated balance sheets. As a result of the 1.625% Exchange described below, approximately $94 million of such investments were transferred to unrestricted current investments in the first quarter of 2018. As of March 31, 2018, the balance of current restricted investments was $77 million.

5.375% Notes due 2022

We have outstanding $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 5.375% Notes. Such guarantees mirror those of the Credit Facility. See Note 13, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors. The 5.375% Notes contain customary non-financial covenants and change in control provisions.

1.125% Cash Convertible Senior Notes due 2020

We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020 (1.125% Convertible Notes), unless earlier repurchased or converted. Interest is payable semiannually in arrears on January 15 and July 15.

The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Convertible Notes is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Convertible Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended March 31, 2018; therefore, they are convertible into cash and are reported in current portion of long-term debt as of March 31, 2018.

The 1.125% Convertible Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The effective interest rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued is approximately 6%. As of March 31, 2018, the 1.125% Convertible Notes had a remaining amortization period of 1.8 years. The 1.125% Convertible Notes’ if-converted value exceeded their principal amount by approximately $527 million and $406 million as of March 31, 2018 and December 31, 2017, respectively.

1.625% Convertible Senior Notes due 2044

In March 2018, we entered into separate, privately negotiated, synthetic exchange agreements (1.625% Exchange) with certain holders of our outstanding 1.625% convertible senior notes due 2044 (1.625% Convertible Notes). In this transaction, we exchanged $97 million aggregate principal amount and accrued interest for 1.8 million shares of our common stock. We recorded a loss on debt extinguishment, including transaction fees, of $10 million, for the transaction, primarily relating to the inducement premium paid to the bondholders, which is recorded in “Other

expenses (income), net" in the accompanying consolidated statements of income. We did not receive any proceeds from the 1.625% Exchange.

Following the 1.625% Exchange, we have outstanding $64 million aggregate principal amount of the 1.625% Convertible Notes. The initial conversion rate for the 1.625% Convertible Notes is 17.2157 shares of our common stock per $1,000 principal amount, or approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended March 31, 2018. However, on contractually specified dates beginning in August 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of March 31, 2018. As noted above, because the proceeds from the 4.875% Notes are initially restricted to payments upon conversion or redemption of the 1.625% Convertible Notes, such restricted investments are also classified as current in the accompanying consolidated balance sheets.

The expected life of the 1.625% Convertible Notes is approximately four years, beginning on the issuance date and ending on the first date we may redeem the 1.625% Convertible Notes in August 2018. As of March 31, 2018, the 1.625% Convertible Notes had a remaining amortization period of 0.4 years. The effective interest rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued is approximately 5%. The outstanding 1.625% Convertible Notes' if-converted value exceeded their principal amount at March 31, 2018 and December 31, 2017 by approximately $19 million and $50 million, respectively. At March 31, 2018 and December 31, 2017, the equity component of the 1.625% Convertible Notes, including the impact of deferred taxes, was $5 million and $12 million, respectively.

Cross-Default Provisions

The indentures governing the 4.875% Notes, the 5.375% Notes, the 1.125% Convertible Notes and the 1.625% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture.

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	March 31, 2018	December 31, 2017
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 585	$ 522
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 585	$ 522

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in "Other expenses (income), net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, “Fair Value Measurements.”

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, “Fair Value Measurements.”

As of March 31, 2018, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within twelve months of March 31, 2018, as described in Note 7, “Debt.”

9. Stockholders' Equity

1.625% Exchange

As described in Note 7, “Debt,” we issued 1.8 million shares of our common stock in connection with the 1.625% Exchange in March 2018.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, “Derivatives,” in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, when the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Share-Based Compensation

In connection with our equity incentive plans and employee stock purchase plan, approximately 127,000 shares of common stock vested or were purchased, net of shares used to settle employees’ income tax obligations, during the three months ended March 31, 2018.

We record share-based compensation as “General and administrative expenses” in the accompanying consolidated statements of income. As of March 31, 2018, there was $53 million of total unrecognized compensation expense related to unvested restricted stock awards (RSAs), performance stock awards (PSAs), and performance stock units (PSUs), which we expect to recognize over a remaining weighted-average period of 3.2 years, 0.9 years and 2.7 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 9.7% for non-executive employees as of March 31, 2018.

Also as of March 31, 2018, there was $13 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.5 years. No stock options were granted or exercised in the three months ended March 31, 2018.

Activity for RSAs, PSAs and PSUs, for the three months ended March 31, 2018, is summarized below:

	Restricted Stock Awards	Performance Stock Awards	Performance Stock Units	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2017	401,804	84,762	91,828	578,394	$ 58.35
Granted	321,798	—	188,455	510,253	72.46
Vested	(163,043)	(32,929)	—	(195,972)	55.16
Forfeited	(59,931)	(44,384)	(47,650)	(151,965)	62.99
Unvested balance, March 31, 2018	500,628	7,449	232,633	740,710	67.96

The total fair value of awards granted and vested is presented in the following table:

	Three Months Ended March 31,	
	2018	2017
	(In millions)	
Granted:		
Restricted stock awards	$ 23	$ 17
Performance stock units	14	—
	$ 37	$ 17
Vested:		
Restricted stock awards	$ 12	$ 10
Performance stock awards	3	6
	$ 15	$ 16

10. Restructuring and Separation Costs

Following a management-initiated, broad operational assessment in early 2017, our board of directors approved, and we committed to, a comprehensive restructuring and profitability improvement plan in June 2017 (the 2017 Restructuring Plan). Key activities under this plan to date have included:

- Streamlining of our organizational structure to eliminate redundant layers of management, consolidate regional support services, and other staff reductions to improve efficiency and the speed and quality of decision making;
- Re-design of core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology, to achieve more effective and cost-efficient outcomes;
- Remediation of high-cost provider contracts and enhancement of high quality, cost-effective networks;
- Restructuring, including selective exits, of direct delivery operations; and
- Partnering with the lowest-cost, most effective vendors.

Costs Incurred

In our 2017 Annual Report on Form 10-K, we reported that we had incurred substantially all of the costs associated with the 2017 Restructuring Plan in 2017, amounting to $234 million. In the first quarter of 2018, we incurred an additional $25 million in such costs, primarily as a result of our further evaluation of a utilization and care management project terminated because of its inconsistency with the goals of the 2017 Restructuring Plan. As a result, assets relating to this project were written off. In addition, we recorded nominal amounts for one-time termination benefits, and true-ups of consulting fees and contract termination costs recorded in 2017. We expect to complete all activities under the 2017 Restructuring Plan in 2018, with the exception of the settlement of lease termination liabilities. We expect to continue to settle those liabilities through 2025, unless the leases are terminated sooner.

Restructuring and separation costs are reported by the same name in the accompanying consolidated statements of income. The following tables present the major types of such costs by segment. Current and long-lived assets include current and non-current capitalized project costs, and capitalized software determined to be unrecoverable.

	Three Months Ended March 31, 2018				
		Other Restructuring Costs			
	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)				
Health Plans	$ 1	$ (1)	$ —	$ (1)	$ (1)
Other	5	20	1	—	26
	$ 6	$ 19	$ 1	$ (1)	$ 25

No restructuring costs were reported in the first quarter of 2017.

As of March 31, 2018, we had incurred cumulative restructuring costs under the 2017 Restructuring Plan as follows:

			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Current and Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 34	$ 15	$ —	$ 23	$ 72
Molina Medicaid Solutions	—	—	8	—	—	8
Other	36	39	57	45	2	179
	$ 36	$ 73	$ 80	$ 45	$ 25	$ 259

Reconciliation of Liability

For those restructuring and separation costs that require cash settlement (primarily separation costs, one-time termination benefits, consulting fees and contract termination costs), the following table presents a roll-forward of the accrued liability, which is reported in “Accounts payable and accrued liabilities” in the accompanying consolidated balance sheets. The adjustments are due to true-ups of consulting fees and contract termination costs recorded in 2017.

	Separation Costs - Former Executives	One-Time Termination Benefits	Other Restructuring Costs	Total
	(In millions)			
Accrued as of December 31, 2017	$ 2	$ 11	$ 35	$ 48
Adjustments	—	—	(1)	(1)
Charges	—	6	2	8
Cash payments	(2)	(12)	(9)	(23)
Accrued as of March 31, 2018	$ —	$ 5	$ 27	$ 32

11. Segments

We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” Medical margin represents the amount earned by the Health Plans segment after medical care costs are deducted from premium revenue. The medical care ratio represents medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure

of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

The following table presents total revenue by segment. Inter-segment revenue is insignificant for all periods presented.

	Three Months Ended March 31,	
	2018	2017
	(In millions)	
Total revenue:		
Health Plans	$ 4,509	$ 4,771
Molina Medicaid Solutions	51	46
Other	86	87
Consolidated	$ 4,646	$ 4,904

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Three Months Ended March 31,	
	2018	2017
	(In millions)	
Gross margin:		
Health Plans	$ 601	$ 537
Molina Medicaid Solutions	8	4
Other	6	5
Total gross margin	615	546
Add: other operating revenues (1)	189	125
Less: other operating expenses (2)	(582)	(589)
Operating income	222	82
Other expenses (income), net	43	(49)
Income before income taxes	$ 179	$ 131

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, and investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, and restructuring and separation costs.

12. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are operated by our wholly owned subsidiaries in the states in which our health plans operate, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,777 million at March 31, 2018, and $1,691 million at December 31, 2017. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments (excluding restricted investments) held by the parent company—Molina Healthcare, Inc. Such cash, cash equivalents and investments (excluding restricted investments) amounted to $706 million and $696 million as of March 31, 2018 and December 31, 2017, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states and Commonwealth in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states.

As of March 31, 2018, our health plans had aggregate statutory capital and surplus of approximately $1,904 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,181 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2018. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

Legal Proceedings

The health care and Medicaid-related business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and reasonably estimable, but the outcome of legal actions is inherently uncertain and our estimates of such losses could change as a result of further developments of these matters. For certain pending matters, accruals have not been established because such matters have not progressed sufficiently through discovery, and/or development of important factual information and legal issues is insufficient to enable us to estimate a range of possible loss, if any. An adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Steamfitters Local 449 Pension Plan v. Molina Healthcare, Inc, et al. On April 27, 2018, the Steamfitters Local 449 Pension Plan filed a class action securities complaint in the Central District Court of California against the Company and its former executive officers, J. Mario Molina, John C. Molina, Terry P. Bayer, and Rick Hopfer, Case 2:18-cv-03579. The complaint purports to seek recovery on behalf of all persons or entities who purchased Molina common stock between October 31, 2014 and August 2, 2017 for alleged violations under Sections 10(b) and 20(a) of the Securities Exchange Act and Rule 10b-5 promulgated thereunder. The plaintiff alleges the defendants misled investors regarding the scalability of the Company's administrative infrastructure during the identified class period. The Company believes it has meritorious defenses to the alleged claims and intends to defend the matter vigorously.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. The states and Commonwealth in which we operate our health plans regularly face significant budgetary pressures.

13. Supplemental Condensed Consolidating Financial Information

As discussed in Note 7, "Debt," we have outstanding $700 million aggregate principal amount of 5.375% Notes due November 15, 2022, unless earlier redeemed. The 5.375% Notes were registered in September 2016, and are fully and unconditionally guaranteed by certain of our wholly owned subsidiaries on a joint and several basis, with exceptions considered customary for such guarantees.

For all periods presented, the following condensed consolidating financial statements present Molina Healthcare, Inc. (as "Parent Guarantor"), the subsidiary guarantors (as "Other Guarantors"), the subsidiary non-guarantors (as "Non-Guarantors") and "Eliminations", according to the guarantor structure as assessed as of and for the three months ended March 31, 2018.

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Three Months Ended March 31, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 333	$ 52	$ 4,592	$ (331)	$ 4,646
Expenses:					
Medical care costs	4	—	3,718	—	3,722
Cost of service revenue	—	43	77	—	120
General and administrative expenses	267	4	412	(331)	352
Premium tax expenses	—	—	104	—	104
Health insurer fees	—	—	75	—	75
Depreciation and amortization	18	—	8	—	26
Restructuring and separation costs	26	—	(1)	—	25
Total operating expenses	315	47	4,393	(331)	4,424
Operating income	18	5	199	—	222
Interest expense	33	—	—	—	33
Other expenses, net	10	—	—	—	10
(Loss) income before income taxes	(25)	5	199	—	179
Income tax expense	9	1	62	—	72
Net (loss) income before equity in net losses of subsidiaries	(34)	4	137	—	107
Equity in net earnings (losses) of subsidiaries	141	(3)	—	(138)	—
Net income	$ 107	$ 1	$ 137	$ (138)	$ 107

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 107	$ 1	$ 137	$ (138)	$ 107
Other comprehensive loss, net of tax	(7)	—	(7)	7	(7)
Comprehensive income	$ 100	$ 1	$ 130	$ (131)	$ 100

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Three Months Ended March 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 341	$ 48	$ 4,857	$ (342)	$ 4,904
Expenses:					
Medical care costs	4	—	4,107	—	4,111
Cost of service revenue	—	42	80	—	122
General and administrative expenses	297	7	477	(342)	439
Premium tax expenses	—	—	111	—	111
Depreciation and amortization	27	—	12	—	39
Total operating expenses	328	49	4,787	(342)	4,822
Operating income (loss)	13	(1)	70	—	82
Interest expense	26	—	—	—	26
Other income, net	(75)	—	—	—	(75)
Income (loss) before income taxes	62	(1)	70	—	131
Income tax expense	31	—	23	—	54
Net income (losses) before equity in earnings (losses) of subsidiaries	31	(1)	47	—	77
Equity in net earnings (losses) of subsidiaries	46	(2)	—	(44)	—
Net income (loss)	$ 77	$ (3)	$ 47	$ (44)	$ 77

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income (loss)	$ 77	$ (3)	$ 47	$ (44)	$ 77
Other comprehensive income, net of tax	1	—	1	(1)	1
Comprehensive income (loss)	$ 78	$ (3)	$ 48	$ (45)	$ 78

CONDENSED CONSOLIDATING BALANCE SHEETS

	March 31, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 307	$ 27	$ 3,395	$ —	$ 3,729
Investments	399	—	2,045	—	2,444
Restricted investments	77	—	—	—	77
Receivables	2	41	907	—	950
Due from (to) affiliates	147	(5)	(142)	—	—
Prepaid expenses and other current assets	60	8	343	—	411
Derivative asset	585	—	—	—	585
Total current assets	1,577	71	6,548	—	8,196
Property, equipment, and capitalized software, net	206	30	82	—	318
Goodwill and intangible assets, net	15	43	192	—	250
Restricted investments	—	—	120	—	120
Investment in subsidiaries, net	2,531	79	—	(2,610)	—
Deferred income taxes	28	—	104	(18)	114
Other assets	41	105	5	(16)	135
	$ 4,398	$ 328	$ 7,051	$ (2,644)	$ 9,133
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 3	$ —	$ 2,020	$ —	$ 2,023
Amounts due government agencies	—	1	1,713	—	1,714
Accounts payable and accrued liabilities	151	40	522	—	713
Deferred revenue	—	41	363	—	404
Current portion of long-term debt	566	—	—	—	566
Derivative liability	585	—	—	—	585
Total current liabilities	1,305	82	4,618	—	6,005
Long-term debt	1,516	—	16	(16)	1,516
Deferred income taxes	—	18	—	(18)	—
Other long-term liabilities	24	1	34	—	59
Total liabilities	2,845	101	4,668	(34)	7,580
Total stockholders' equity	1,553	227	2,383	(2,610)	1,553
	$ 4,398	$ 328	$ 7,051	$ (2,644)	$ 9,133

CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 504	$ 28	$ 2,654	$ —	$ 3,186
Investments	192	—	2,332	—	2,524
Restricted investments	169	—	—	—	169
Receivables	2	30	839	—	871
Due from (to) affiliates	148	(6)	(142)	—	—
Prepaid expenses and other current assets	103	14	138	(16)	239
Derivative asset	522	—	—	—	522
Total current assets	1,640	66	5,821	(16)	7,511
Property, equipment, and capitalized software, net	223	33	86	—	342
Goodwill and intangible assets, net	15	43	197	—	255
Restricted investments	—	—	119	—	119
Investment in subsidiaries, net	2,306	82	—	(2,388)	—
Deferred income taxes	17	—	101	(15)	103
Other assets	32	103	7	(1)	141
	$ 4,233	$ 327	$ 6,331	$ (2,420)	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 3	$ —	$ 2,189	$ —	$ 2,192
Amounts due government agencies	—	1	1,541	—	1,542
Accounts payable and accrued liabilities	178	40	148	—	366
Deferred revenue	—	49	233	—	282
Current portion of long-term debt	653	—	16	(16)	653
Derivative liability	522	—	—	—	522
Total current liabilities	1,356	90	4,127	(16)	5,557
Long-term debt	1,516	—	—	—	1,516
Deferred income taxes	—	15	—	(15)	—
Other long-term liabilities	24	2	36	(1)	61
Total liabilities	2,896	107	4,163	(32)	7,134
Total stockholders' equity	1,337	220	2,168	(2,388)	1,337
	$ 4,233	$ 327	$ 6,331	$ (2,420)	$ 8,471

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CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Three Months Ended March 31, 2018				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by operating activities	$ 6	$ 9	$ 379	$ —	$ 394
Investing activities:					
Purchases of investments	(130)	—	(259)	—	(389)
Proceeds from sales and maturities of investments	5	—	538	—	543
Purchases of property, equipment and capitalized software	(1)	(2)	(1)	—	(4)
Capital contributions to subsidiaries	(80)	—	80	—	—
Change in amounts due to/from affiliates	(3)	(2)	5	—	—
Other, net	2	(6)	(1)	—	(5)
Net cash (used in) provided by investing activities	(207)	(10)	362	—	145
Financing activities:					
Cash paid for financing transaction fees	(5)	—	—	—	(5)
Net cash used in financing activities	(5)	—	—	—	(5)
Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents	(206)	(1)	741	—	534
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	513	28	2,749	—	3,290
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 307	$ 27	$ 3,490	$ —	$ 3,824

	Three Months Ended March 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by operating activities	$ 144	$ 21	$ 554	$ —	$ 719
Investing activities:					
Purchases of investments	—	—	(733)	—	(733)
Proceeds from sales and maturities of investments	92	—	341	—	433
Purchases of property, equipment and capitalized software	(18)	(5)	(3)	—	(26)
Decrease in restricted investments held-to-maturity	—	—	(5)	—	(5)
Capital contributions to subsidiaries	(106)	1	105	—	—
Dividends from subsidiaries	50	—	(50)	—	—
Change in amounts due to/from affiliates	(60)	2	58	—	—
Other, net	—	(6)	—	—	(6)
Net cash used in investing activities	(42)	(8)	(287)	—	(337)
Financing activities:					
Proceeds from employee stock plans	1	—	—	—	1
Other, net	(2)	—	—	—	(2)
Net cash used in financing activities	(1)	—	—	—	(1)
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	101	13	267	—	381
Cash, cash equivalents, and restricted cash and cash equivalents at beginning of period	86	6	2,820	—	2,912
Cash, cash equivalents, and restricted cash and cash equivalents at end of period	$ 187	$ 19	$ 3,087	$ —	$ 3,293

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

FORWARD-LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- *the success of the Company's profit improvement and maintenance initiatives, including the timing and amounts of the benefits realized, and administrative savings achieved;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare;"*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk transfer requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer;*
- *effective management of the Company's medical costs;*
- *the Company's ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the Company's ability to manage its operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of its care management initiatives;*
- *the Company's ability to consummate and realize benefits from acquisitions or divestitures;*
- *the Company's receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *the Company's ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *the Company's estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion cost corridors in California, New Mexico, and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and the Company's ability to recognize revenue amounts associated therewith;*

- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of the Company's health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under the Company's Medicaid contract, the effect of the PROMESA law, the impact of Hurricane Maria and the Company's efforts to better manage the health care costs of its Puerto Rico health plan;*
- *the success and renewal of the Company's duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across the Company's health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to the Company's provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;*
- *changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of the Company's California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize the Company's expansion and growth, repay the Company's outstanding indebtedness at maturity and meet its liquidity needs, including the interest expense and other costs associated with such financing;*
- *the Company's failure to comply with the financial or other covenants in its credit agreements or the indentures governing its outstanding notes;*
- *the sufficiency of the Company's funds on hand to pay the amounts due upon conversion or maturity of its outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm; and*
- *increasing competition and consolidation in the Medicaid industry;*

Readers should refer to the section entitled "Risk Factors" in each of our Annual Report on Form 10-K for the year ended December 31, 2017, and this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This Quarterly Report on Form 10-Q and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2017.

ABOUT MOLINA HEALTHCARE

OUR MISSION IS TO PROVIDE QUALITY HEALTHCARE TO PEOPLE RECEIVING GOVERNMENT ASSISTANCE.

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

KEY PERFORMANCE INDICATORS

	Three Months Ended March 31,	
	2018	2017
	(Dollar amounts in millions, except per-share amounts)	
Ending total membership	4.1	4.8
Premium revenue	$ 4,323	$ 4,648
Health Plans segment medical margin (1)	$ 601	$ 537
Operating income	$ 222	$ 82
Net income	$ 107	$ 77
Net income per diluted share	$ 1.64	$ 1.37
Diluted weighted average shares outstanding	65.2	56.2
Adjusted net income per diluted share*	$ 1.71	$ 1.47
EBITDA*	$ 246	$ 203
Operating Statistics:		
MCR (2)	86.1%	88.4%
G&A ratio (3)	7.6%	8.9%
Premium tax ratio (2)	2.3%	2.3%
Effective income tax expense rate	40.3%	41.6%
Net profit margin (3)	2.3%	1.6%

(1) Medical margin is equal to premium revenue minus medical care costs.
(2) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(3) G&A ratio represents general and administrative expenses as a percentage of total revenue. Net profit margin represents net income as a percentage of total revenue.

Non-GAAP Financial Measures

We use non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures.

See further information regarding non-GAAP measures in the “Supplemental Information” section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this report are designated with an asterisk (*).

CONSOLIDATED RESULTS

Three Months Ended March 31, 2018 Compared with Three Months Ended March 31, 2017

Net income for the first quarter of 2018 was $107 million, compared with net income of $77 million for the first quarter of 2017. Net income per diluted share was $1.64 for the first quarter of 2018 compared with $1.37 reported for the first quarter of 2017. Improved performance in the first quarter of 2018 resulted from improved medical and administrative cost efficiency.

Net income for the first quarter of 2018 included a net benefit of $35 million ($0.38 per diluted share) for certain items significant to our financial performance described below. Net income for the first quarter of 2017 included a benefit of $75 million ($0.84 per diluted share) for the receipt of an acquisition termination fee.

Premium revenue decreased approximately 7% when compared with the first quarter of 2017. Lower premium revenue was driven by a decrease in Marketplace membership of over 50%, partially offset by Marketplace premium rate increases. As previously disclosed, we have increased premium rates and reduced our Marketplace presence effective January 1, 2018, as part of our overall program to improve profitability.

Overall, the medical care ratio decreased to 86.1%, from 88.4% in the first quarter of 2017. Excluding the benefit of the 2017 CSR reimbursement, the consolidated medical care ratio was 87.7% in the first quarter of 2018.

- The medical care ratio for the Medicaid and Medicare programs combined decreased to 90.0%, from 91.0% in the first quarter of 2017. Improved performance at the Florida, Illinois, Ohio and South Carolina health plans, partially offset by a decline in performance at the Washington health plan, drove the decrease in the consolidated medical care ratio for Medicaid and Medicare combined. The 2017 CSR reimbursement had no impact on the medical care ratio for the Company's Medicaid and Medicare programs.

- The medical care ratio for the Marketplace operations was 50.6% for the first quarter of 2018. Excluding the impact of the 2017 Marketplace CSR adjustment noted below, the medical care ratio for Marketplace operations decreased to approximately 67%, from 75% in the first quarter of 2017. Improved profitability in Marketplace operations is primarily the result of premium increases implemented effective January 1, 2018.

The general and administrative (G&A) expense ratio decreased to 7.6%, from 8.9% in the first quarter of 2017. Excluding the impact of Marketplace broker commissions and exchange fees in both periods, the G&A ratio decreased to 6.8%, from 7.5% in the first quarter of 2017.This improvement is primarily the result of our efforts to reduce G&A costs under the 2017 Restructuring Plan.

We recognized a benefit of approximately $70 million ($0.83 per diluted share) in reduced medical expense related to 2017 dates of service as a result of the federal government's confirmation that the reconciliation of 2017 Marketplace CSR subsidies would be performed on an annual basis. In the fourth quarter of 2017, we had assumed a nine-month reconciliation of this item pending confirmation of the time period to which the 2017 reconciliation would be applied.

Approximately $25 million ($0.30 per diluted share) of restructuring costs were recognized in the first quarter, primarily relating to the write-off of prepaid and other assets in connection with the continuing re-design of core processes.

Approximately $10 million ($0.15 per diluted share) loss on debt extinguishment was recognized in the first quarter in connection with the issuance of 1.8 million common shares in exchange for $97 million principal amount of our 1.625% Convertible Notes.

The table below summarizes the impact of certain items significant to our financial performance in the periods presented. The individual items presented below increase (decrease) income before income tax expense.

	Three Months Ended March 31,			
	2018		2017	
	Amount	Per Diluted Share [1]	Amount	Per Diluted Share [1]
	(In millions, except per diluted share amounts)			
Reimbursement of Marketplace CSR subsidies, for 2017 dates of service	$ 70	$ 0.83	$ —	$ —
Restructuring costs	(25)	(0.30)	—	—
Loss on debt extinguishment	(10)	(0.15)	—	—
Fee received for terminated acquisition	—	—	75	0.84
	$ 35	$ 0.38	$ 75	$ 0.84

(1) Except for certain items that are not deductible for tax purposes, per diluted share amounts are generally calculated at statutory income tax rates of 22% and 37% for the first quarters of 2018 and 2017, respectively.

TRENDS AND UNCERTAINTIES

MEDICAID CONTRACT RE-PROCUREMENT

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates; such dates are subject to change. Premium revenue is stated in millions.

State Health Plan	Medicaid Program(s)	Membership as of March 31, 2018	Premium Revenue Three Months Ended March 31, 2018	Anticipated Award Date	Anticipated Effective Date
Puerto Rico	All	316,000	$ 186	Q2 2018	10/1/2018
Texas	ABD, MMP	99,000	479	Q3 2018	1/1/2020
Texas	TANF, CHIP	129,000	77	Q1 2019	1/1/2020
Washington (1)	All in 7 of 9 regions	606,000	444	Q2 2018	1/1/2019

(1) The re-procurement information presented for the Washington health plan includes all Medicaid membership in the following regions: Northeast, Northwest, Central and Southeast, Pierce County, King County, Olympic Peninsula, and West-Central. Five of the seven largest regions' contracts that are awarded will be effective January 1, 2019. The remaining two will be effective on January 1, 2020.

Florida and New Mexico RFP Update. In our Form 10-K Annual Report for 2017, we reported that we were selected by Florida's Medicaid agency to negotiate for a tentative award of a 2019 Medicaid contract in Region 11 of the state. We were selected for no other regions besides Region 11. On April 24, 2018, the state notified us that we were not awarded a contract for Region 11. While we protest the Florida RFP awards, we continue to evaluate our options for 2019 participation in the Florida Marketplace, which business has shown signs of improvement. Also in our Form 10-K for 2017, we reported that we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. We are pursuing a protest of the New Mexico RFP awards. Without a reversal of the RFP awards, our New Mexico health plan will be in run-off. Subject to future developments, we will continue to evaluate our business profile in New Mexico for 2019.

PRESSURES ON MEDICAID FUNDING

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following:

- Ending the entitlement nature of Medicaid by capping future increases in federal health spending for these programs, and shifting more of the risk for health costs in the future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap");
- Requiring Medicaid beneficiaries to work;
- Limiting the amount of lifetime benefits for Medicaid beneficiaries; and
- Numerous other potential changes and reforms.

ACA AND THE MARKETPLACE

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, are subject to substantial uncertainty. Effective January 1, 2018, we have:

- Exited the Utah and Wisconsin Marketplaces;
- Reduced the scope of our Washington state participation;
- Increased premiums averaging 58%

- Mitigated our exposure to uncertainties relating to cost share reduction (CSR) funding and reconciliation; and
- Adjusted broker commissions to market rates.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums, and our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio, ("MCR"). The medical care ratio represents medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. Management's discussion and analysis of the changes in the individual components of medical margin and service margin follows.

SEGMENT SUMMARY

	Three Months Ended March 31,	
	2018	2017
	(In millions)	
Health Plans segment medical margin [1]	$ 601	$ 537
Molina Medicaid Solutions segment service margin [2]	8	4
Other segment service margin [2]	6	5
	$ 615	$ 546
Health Plans segment medical care ratio	86.1%	88.4%

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 13 states and the Commonwealth of Puerto Rico. As of March 31, 2018, these health plans served approximately 4.1 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies.

BUSINESS OVERVIEW

Health Plans Membership

The following tables set forth our Health Plans membership as of the dates indicated:

	March 31, 2018	December 31, 2017	March 31, 2017
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,435,000	2,457,000	2,548,000
Medicaid Expansion	662,000	668,000	684,000
Aged, Blind or Disabled (ABD)	411,000	412,000	401,000
Total Medicaid	3,508,000	3,537,000	3,633,000
Medicare-Medicaid Plan (MMP) – Integrated [1]	56,000	57,000	55,000
Medicare Special Needs Plans (Medicare)	44,000	44,000	43,000
Total Medicare	100,000	101,000	98,000
Non-Marketplace	3,608,000	3,638,000	3,731,000
Marketplace	453,000	815,000	1,035,000
	4,061,000	4,453,000	4,766,000
Ending Membership by Health Plan:			
California	656,000	746,000	765,000
Florida	414,000	625,000	711,000
Idaho [2]	2,000	—	—
Illinois	151,000	165,000	194,000
Michigan	388,000	398,000	417,000
New Mexico	250,000	253,000	270,000
New York	32,000	32,000	34,000
Ohio	328,000	327,000	351,000
Puerto Rico	316,000	314,000	326,000
South Carolina	117,000	116,000	111,000
Texas	476,000	430,000	493,000
Utah	90,000	152,000	172,000
Washington	779,000	777,000	785,000
Wisconsin	62,000	118,000	137,000
	4,061,000	4,453,000	4,766,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) Idaho operations commenced January 1, 2018.

Premiums by Program

The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a per member per month (PMPM) basis, for the three months ended March 31, 2018. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 130.00	$ 330.00	$ 190.00
Medicaid Expansion	330.00	500.00	370.00
ABD	440.00	1,530.00	1,010.00
MMP – Integrated	1,320.00	3,200.00	2,140.00
Medicare	600.00	1,380.00	1,190.00
Marketplace	220.00	530.00	310.00

FINANCIAL OVERVIEW

In the first quarter of 2018, premium revenue decreased approximately 7%, or $325 million, when compared with the first quarter of 2017. Member months declined 13%, partially offset by a revenue PMPM increase of 6%. Medical margin increased 12% in the first quarter of 2018 compared with the first quarter of 2017.

Medical care costs as a percent of premium revenue decreased to 86.1% in the first quarter of 2018 from 88.4% in the first quarter of 2017. This improvement reflects improved performance and favorable medical cost trends that were partially offset by a lower mix of Marketplace revenue. On balance, inpatient and physician utilization as well as unit costs improved in the quarter, while pharmacy costs ran higher than expected. This netted to an overall favorable medical cost trend despite the higher pharmacy costs and approximately $18 million of above normal influenza-related expenses.

We have also started to see some of the early benefits from contracting efforts that we undertook last year in Florida, South Carolina and Texas, where we eliminated or renegotiated high cost provider contracts for in-patient, and ancillary services.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, medical care ratio and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended March 31, 2018						
	Member Months [1]	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR [2]	Medical Margin
TANF and CHIP	7.4	$ 1,373	$ 185.14	$ 1,272	$ 171.56	92.7%	$ 101
Medicaid Expansion	2.0	752	372.75	641	317.46	85.2	111
ABD	1.2	1,254	1,014.23	1,155	934.55	92.1	99
Total Medicaid	10.6	3,379	316.69	3,068	287.56	90.8	311
MMP	0.2	357	2,137.88	305	1,824.21	85.3	52
Medicare	0.1	157	1,188.97	131	994.81	83.7	26
Total Medicare	0.3	514	1,718.61	436	1,457.75	84.8	78
Non-Marketplace	10.9	3,893	354.94	3,504	319.48	90.0	389
Marketplace	1.4	430	312.87	218	158.40	50.6	212
	12.3	$ 4,323	$ 350.25	$ 3,722	$ 301.55	86.1%	$ 601

	Three Months Ended March 31, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.7	$ 1,402	$ 182.69	$ 1,304	$ 170.02	93.1%	$ 98
Medicaid Expansion	2.0	817	398.70	689	336.51	84.4	128
ABD	1.2	1,196	1,006.84	1,130	951.32	94.5	66
Total Medicaid	10.9	3,415	312.98	3,123	286.35	91.5	292
MMP	0.2	344	2,088.96	307	1,859.41	89.0	37
Medicare	0.1	138	1,068.20	117	902.67	84.5	21
Total Medicare	0.3	482	1,640.63	424	1,439.20	87.7	58
Non-Marketplace	11.2	3,897	347.84	3,547	316.62	91.0	350
Marketplace	2.9	751	262.16	564	196.72	75.0	187
	14.1	$ 4,648	$ 330.39	$ 4,111	$ 292.20	88.4%	$ 537

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid

TANF and CHIP. The medical care ratio for TANF and CHIP was 92.7% in the first quarter of 2018, a slight improvement from 93.1% in the first quarter of 2017. However, the current quarter results modestly underperformed our expectations due to high acuity inpatient cases in Washington, and higher behavioral health costs in New Mexico.

Medicaid Expansion. The medical care ratio for Medicaid Expansion was 85.2% in the first quarter of 2018, compared with 84.4% in the first quarter of 2017. This increase was primarily due to the premium reduction we received in California last July. Medicaid Expansion has performed well because rate adequacy has trended favorably, and membership is concentrated in our higher performing health plans, particularly, California, Michigan and Ohio.

ABD. The medical care ratio for ABD was 92.1% in the first quarter of 2018, compared with 94.5% in the first quarter of 2017. The year over year improvement can be attributed to our continued advancement on key, high acuity management fundamentals.

Medicare and MMP

The medical care ratio for the combined Medicare programs decreased to 84.8% in the first quarter of 2018, from 87.7% in the first quarter of 2017. Much of this improvement relates to the recognition of additional MMP at-risk revenue for dates of service in 2016 and 2017, because at-risk revenue is often recognized long after medical services have been provided. The Medicare business also benefited from favorable medical care trends and improved medical management of inpatient utilization for this population. Our Michigan health plan, which serves about 25% of our Medicare membership, has shown particular improvement in the first quarter of 2018. Accurate and complete risk score documentation and effective management of chronic and high acuity conditions are critical to the successful management of this program for the rest of the year.

Marketplace

Lower Marketplace premium revenue was driven by a decrease in membership of over 50%, partially offset by premium rate increases. As previously disclosed, we have increased premium rates and reduced our Marketplace presence effective January 1, 2018, as part of our overall program to improve profitability.

The medical care ratio for the Marketplace program decreased to 50.6% in the first quarter of 2018, from 75.0% in the first quarter of 2017. The lower medical care ratio in 2018 was the result of the premium increases implemented effective January 2018 and the 2017 Marketplace CSR adjustment described in "Consolidated Results" above. Absent the 2017 Marketplace CSR adjustment, the medical care ratio for our Marketplace program would have been approximately 67% in the first quarter of 2018.

FINANCIAL PERFORMANCE BY STATE

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Non-Marketplace

	Three Months Ended March 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 494	$ 272.61	$ 412	$ 227.31	83.4%	$ 82
Florida	1.0	382	351.58	345	317.41	90.3	37
Idaho [1]	—	4	960.33	4	977.00	101.8	—
Illinois	0.5	141	298.17	122	257.50	86.4	19
Michigan	1.1	376	336.64	331	296.19	88.0	45
New Mexico	0.7	319	466.17	310	453.30	97.2	9
New York	0.1	46	468.91	39	396.76	84.6	7
Ohio	0.9	551	576.60	460	481.26	83.5	91
Puerto Rico	1.0	186	193.13	174	181.39	93.9	12
South Carolina	0.3	122	348.08	104	297.52	85.5	18
Texas	0.7	562	809.90	519	747.53	92.3	43
Utah	0.3	92	339.71	77	284.61	83.8	15
Washington	2.3	584	256.66	574	252.41	98.3	10
Wisconsin	0.2	34	183.97	29	154.53	84.0	5
Other [2]	—	—	—	4	—	—	(4)
	10.9	$ 3,893	$ 354.94	$ 3,504	$ 319.48	90.0%	$ 389

	Three Months Ended March 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 572	$ 308.57	$ 484	$ 261.31	84.7%	$ 88
Florida	1.1	364	339.30	352	328.45	96.8	12
Idaho [1]	—	—	—	—	—	—	—
Illinois	0.6	161	276.58	180	310.08	112.1	(19)
Michigan	1.2	382	327.41	333	284.58	86.9	49
New Mexico	0.7	308	422.87	299	410.75	97.1	9
New York	0.1	46	441.19	42	409.63	92.8	4
Ohio	1.0	520	527.79	462	469.04	88.9	58
Puerto Rico	1.0	183	186.51	165	168.18	90.2	18
South Carolina	0.3	105	317.07	98	293.34	92.5	7
Texas	0.7	527	751.86	489	696.43	92.6	38
Utah	0.3	89	313.20	72	253.75	81.0	17
Washington	2.2	605	273.18	535	241.77	88.5	70
Wisconsin	0.2	33	165.40	27	135.91	82.2	6
Other [2]	—	2	—	9	—	—	(7)
	11.2	$ 3,897	$ 347.84	$ 3,547	$ 316.62	91.0%	$ 350

(1) Idaho operations commenced January 1, 2018.
(2) "Other" medical care costs include primarily medically related administrative costs at the parent company.

Health Plans Segment Financial Data — Marketplace

	Three Months Ended March 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 49	$ 253.93	$ 31	$ 162.64	64.0 %	$ 18
Florida	0.2	45	271.12	(16)	(95.60)	(35.3)	61
Michigan	0.1	13	224.11	9	144.16	64.3	4
New Mexico	0.1	34	438.67	19	246.50	56.2	15
Ohio	0.1	26	403.44	17	262.87	65.2	9
Texas	0.7	229	308.74	146	196.89	63.8	83
Utah [1]	—	(3)	NM	(10)	NM	NM	7
Washington	—	39	526.36	30	405.40	77.0	9
Wisconsin [1]	—	(2)	NM	(8)	NM	NM	6
Other	—	—	—	—	—	—	—
	1.4	$ 430	$ 312.87	$ 218	$ 158.40	50.6 %	$ 212

	Three Months Ended March 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.4	$ 72	$ 184.34	$ 26	$ 65.53	35.5%	$ 46
Florida	1.0	292	292.80	206	205.91	70.3	86
Michigan	0.1	11	149.23	6	95.92	64.3	5
New Mexico	0.1	22	265.06	19	232.50	87.7	3
Ohio	0.1	21	334.26	17	273.72	81.9	4
Texas	0.7	157	222.40	113	161.02	72.4	44
Utah	0.2	45	202.48	51	228.20	112.7	(6)
Washington	0.1	37	302.51	46	365.94	121.0	(9)
Wisconsin	0.2	94	453.39	81	389.80	86.0	13
Other	—	—	—	(1)	—	—	1
	2.9	$ 751	$ 262.16	$ 564	$ 196.72	75.0%	$ 187

(1) We terminated Marketplace operations at our Utah and Wisconsin health plans effective January 1, 2018, so the ratios for 2018 periods are not meaningful for those health plans.

Health Plans Segment Financial Data — Total

	Three Months Ended March 31, 2018						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 543	$ 270.80	$ 443	$ 221.03	81.6%	$ 100
Florida	1.2	427	340.91	329	262.65	77.0	98
Idaho	—	4	960.33	4	977.00	101.8	—
Illinois	0.5	141	298.17	122	257.50	86.4	19
Michigan	1.2	389	331.08	340	288.68	87.2	49
New Mexico	0.8	353	463.33	329	431.94	93.2	24
New York	0.1	46	468.91	39	396.76	84.6	7
Ohio	1.0	577	565.62	477	467.41	82.6	100
Puerto Rico	1.0	186	193.13	174	181.39	93.9	12
South Carolina	0.3	122	348.08	104	297.52	85.5	18
Texas	1.4	791	551.28	665	463.37	84.1	126
Utah	0.3	89	328.83	67	246.78	75.0	22
Washington	2.3	623	265.20	604	257.25	97.0	19
Wisconsin	0.2	32	172.09	21	110.91	64.4	11
Other	—	—	—	4	—	—	(4)
	12.3	$ 4,323	$ 350.25	$ 3,722	$ 301.55	86.1%	$ 601

	Three Months Ended March 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.2	$ 644	$ 286.92	$ 510	$ 227.19	79.2%	$ 134
Florida	2.1	656	316.86	558	269.33	85.0	98
Idaho	—	—	—	—	—	—	—
Illinois	0.6	161	276.58	180	310.08	112.1	(19)
Michigan	1.3	393	316.80	339	273.36	86.3	54
New Mexico	0.8	330	406.90	318	392.72	96.5	12
New York	0.1	46	441.19	42	409.63	92.8	4
Ohio	1.1	541	516.00	479	457.14	88.6	62
Puerto Rico	1.0	183	186.51	165	168.18	90.2	18
South Carolina	0.3	105	317.07	98	293.34	92.5	7
Texas	1.4	684	486.96	602	428.55	88.0	82
Utah	0.5	134	264.73	123	242.57	91.6	11
Washington	2.3	642	274.74	581	248.40	90.4	61
Wisconsin	0.4	127	311.30	108	264.53	85.0	19
Other	—	2	—	8	—	—	(6)
	14.1	$ 4,648	$ 330.39	$ 4,111	$ 292.20	88.4%	$ 537

MEDICAL CARE COSTS BY TYPE

The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended March 31,					
	2018			2017		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,745	$ 222.38	73.8%	$ 3,086	$ 219.32	75.1%
Pharmacy	583	47.25	15.6	616	43.76	15.0
Capitation	312	25.28	8.4	324	23.06	7.9
Other	82	6.64	2.2	85	6.06	2.0
	$ 3,722	$ 301.55	100.0%	$ 4,111	$ 292.20	100.0%

PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.3% in both the first quarter of 2018 and 2017.

HEALTH INSURER FEES (HIF)

Health insurer fees reimbursed amounted to $61 million, and health insurer fees amounted to $75 million, in the first quarter of 2018. Approximately $10 million of revenue related to the reimbursement of Medicaid health insurer fees from New Mexico, New York and Puerto Rico was not recognized in the first quarter of 2018 because as of March 31, 2018 we had not received adequate documentation of the intent to reimburse such fees.

There were no HIF reimbursed or expensed in 2017 due to the HIF moratorium under the Consolidated Appropriations Act of 2016.

MOLINA MEDICAID SOLUTIONS

The Molina Medicaid Solutions segment provides support to state government agencies' administration of their Medicaid programs, including business processing, information technology development and administrative services.

FINANCIAL OVERVIEW

The Molina Medicaid Solutions segment service margin for the three months ended March 31, 2018 and 2017, was insignificant.

OTHER

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

FINANCIAL OVERVIEW

The Other segment service margin for the three months ended March 31, 2018 and 2017, was insignificant.

OTHER CONSOLIDATED INFORMATION

GENERAL AND ADMINISTRATIVE EXPENSES

The G&A ratio decreased to 7.6% for the first quarter of 2018, compared with 8.9% for the first quarter of 2017. Refer to discussion above, in "Consolidated Results."

DEPRECIATION AND AMORTIZATION

Depreciation and amortization, as a percentage of total revenue, was 0.6% and 0.8% in the first quarter of 2018 and 2017, respectively.

RESTRUCTURING AND SEPARATION COSTS

See Notes to Consolidated Financial Statements, Note 10, “Restructuring and Separation Costs.”

INTEREST EXPENSE

Interest expense was $33 million for the first quarter of 2018, compared with $26 million for the first quarter of 2017. Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $7 million and $8 million in the first quarter of 2018 and 2017, respectively. See further discussion in Notes to Consolidated Financial Statements, Note 7, “Debt.”

OTHER EXPENSES (INCOME), NET

In the first quarter of 2018, we recorded other expenses of $10 million due to the loss on debt extinguishment resulting from our 1.625% Exchange. The 1.625% Exchange is described further in Notes to Consolidated Financial Statements, Note 7, “Debt.” In the first quarter of 2017, we received a $75 million fee in connection with a terminated Medicare acquisition transaction.

INCOME TAXES

The provision for income taxes was recorded at an effective rate of 40.3% for the first quarter of 2018, compared with 41.6% for the first quarter of 2017. The effective tax rate for 2018 is lower than 2017 as a result of the reduction in the federal statutory rate from 35% to 21% under the TCJA, combined with higher non-deductible expenses in 2018 primarily related to the non-deductible HIF. The HIF was not applicable in 2017 due to the 2017 HIF moratorium.

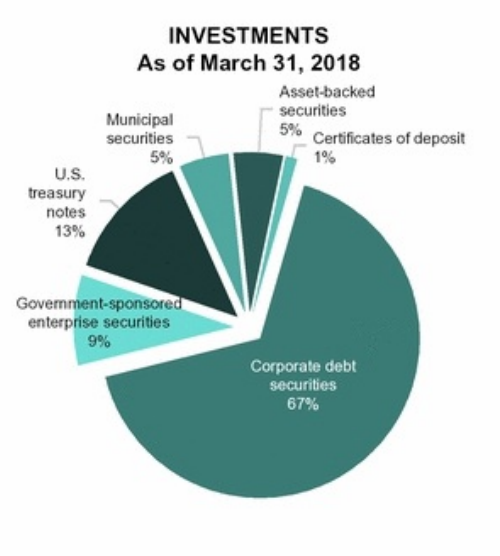
LIQUIDITY AND FINANCIAL CONDITION

INTRODUCTION

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our Health Plans segment regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

Our investments are classified as current assets, except for our held-to-maturity restricted investments, which are classified as non-current assets, and which are not included in the totals below. Our held-to-maturity restricted investments are invested principally in certificates of deposit and U.S. treasury securities.



Investment income increased to $19 million for the three months ended March 31, 2018, compared with $10 million for the three months ended March 31, 2017, primarily due to the increase in invested assets.

MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2018, the fair value of our fixed income investments would decrease by approximately $21 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of March 31, 2018, $300 million was outstanding under the Credit Facility.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Three Months Ended March 31,		
	2018	2017	Change
	(In millions)		
Net cash provided by operating activities	$ 394	$ 719	$ (325)
Net cash provided by (used in) investing activities	145	(337)	482
Net cash used in financing activities	(5)	(1)	(4)
Net increase in cash, cash equivalents, and restricted cash and cash equivalents	$ 534	$ 381	$ 153

Operating Activities

Net cash provided by operating activities decreased $325 million in the first quarter of 2018, compared with the first quarter of 2017, primarily due to the following:

Prepaid expenses and other current assets, and accounts payable and accrued liabilities. Each of these accounts increased significantly in the first quarter of 2018, primarily due to amounts recorded in connection with the reinstatement of the HIF in 2018; such increase in accounts payable and accrued liabilities was largely offset by the increase in prepaid expenses and other current assets.

Medical claims and benefits payable. In the first quarter of 2018, the change in medical claims and benefits payable decreased cash flows from operations by $160 million, primarily due to a decline in reserves as a result of reduced Marketplace membership in Florida, Utah and Wisconsin.

Amounts due government agencies. While amounts due government agencies increased $172 million in the first quarter of 2018, this increase was less than the increase experienced in the first quarter of 2017, resulting in a year over year decrease of cash flows from operations of $201 million. This decrease was primarily due to a decline in the amounts accrued for Marketplace CSR subsidies year over year.

Investing Activities

Investing activities were a source of cash of $145 million in the first quarter of 2018, and a use of cash of $337 million in the first quarter of 2017, primarily due to reduced purchases of investments and higher proceeds from sales and maturities of investments, in the first quarter of 2018.

Financing Activities

Net cash used in financing activities increased $4 million in the first quarter of 2018 compared with the first quarter of 2017, due to cash paid for financing transaction fees, including the 1.625% Exchange and our Bridge Credit Agreement, in the first quarter of 2018.

FINANCIAL CONDITION

We believe that our cash resources, our borrowing capacity available under our Bridge Credit Agreement and Credit Facility as discussed further below in “Future Sources and Uses of Liquidity—Sources,” and internally generated funds will be sufficient to support operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months.

On a consolidated basis, at March 31, 2018, our working capital was $2,191 million, compared with $1,954 million at December 31, 2017. At March 31, 2018, our cash and investments amounted to $6,372 million, compared with $6,000 million at December 31, 2017.

Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments (excluding restricted investments) held by the parent company—Molina Healthcare, Inc. Such cash, cash equivalents and investments (excluding restricted investments) amounted to $706 million and $696 million as of March 31, 2018 and December 31, 2017, respectively.

Debt Ratings. Our 5.375% Notes are rated "BB-" by Standard & Poor's, and "B3" by Moody's Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs.

Financial Covenants. Our Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Facility.

Credit Facility Financial Covenants	Required Per Agreement	As of March 31, 2018
Net leverage ratio	<4.0x	2.7x
Interest coverage ratio	>3.5x	6.9x

In addition, the indentures governing the 4.875% Notes, the 5.375% Notes, the 1.125% Convertible Notes and the 1.625% Convertible Notes contain cross-default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. As of March 31, 2018, we were in compliance with all covenants under the Credit Facility and the indentures governing our outstanding notes.

FUTURE SOURCES AND USES OF LIQUIDITY

Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. In the first quarter of 2018, we did not receive dividends from our subsidiaries. In the first quarter of 2017, we received $50 million in dividends from our regulated health plan subsidiaries. See further discussion in Notes to Consolidated Financial Statements, Note 12, "Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions."

Borrowing Capacity and Debt Financing. We have available borrowing capacity of $550 million under our Bridge Credit Agreement (which amount is subject to the use of proceeds restrictions set forth in the Bridge Credit Agreement), and $194 million under our Credit Facility. We have adequate cash held in a restricted account available to repay the $64 million principal balance outstanding under our 1.625% Convertible Notes, if noteholders exercise their conversion or put rights in 2018. See further discussion in the Notes to Consolidated Financial Statements, Note 7, "Debt."

2017 Restructuring Plan. As previously disclosed, we estimate that the 2017 Restructuring Plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. This estimate includes run-rate savings of approximately $10 million relating to actions taken in the first quarter of 2018. We expect the cost savings to reduce both "General and administrative expenses" and "Medical care costs" reported in our consolidated statements of income. The following table illustrates our estimates of run-rate savings associated with the 2017 Restructuring Plan, which have not changed significantly since our estimate at December 31, 2017. Such savings will be offset, through the end of 2018, by the costs referred to below in "*Uses*."

Estimated Savings Expected to be Realized by Reportable Segment	Health Plans	Other	Total
		(In millions)	
General and administrative expenses	$65	$92 to $152	$157 to $217
Medical care costs	$126 to $166	$17	$143 to $183
	$191 to $231	$109 to $169	$300 to $400

Credit Facility. Refer to Notes to Consolidated Financial Statements, Note 7, "Debt," for a detailed discussion of our Credit Facility.

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Uses

Regulatory Capital Requirements and Dividend Restrictions. In the first quarter of 2018 and 2017, the parent company contributed capital of $80 million and $106 million, respectively, to our health plans subsidiaries to satisfy statutory net worth requirements. For more information on our regulatory capital requirements and dividend restrictions, refer to Notes to Consolidated Financial Statements, Note 12, “Commitments and Contingencies.”

2017 Restructuring Plan. Refer to Notes to Consolidated Financial Statements, Note 10, “Restructuring and Separation Costs,” for a detailed discussion and update of the 2017 Restructuring Plan, including costs incurred in the first quarter of 2018.

Convertible Senior Notes. Refer to the Notes to Consolidated Financial Statements, Note 7, “Debt,” for a detailed discussion of our Convertible Senior Notes. The principal amounts of both our 1.625% Convertible Notes and our 1.125% Convertible Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.625% Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this trigger in the quarter ended March 31, 2018. However, on contractually specified dates beginning in August 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of March 31, 2018. As described above, we have adequate cash held in a restricted account available to repay the 1.625% Convertible Notes, if noteholders exercise their conversion or put rights in 2018.

The stock price trigger for the 1.125% Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended March 31, 2018, and are convertible to cash through at least June 30, 2018. Because the 1.125% Convertible Notes may be converted into cash within 12 months, the $550 million carrying amount is reported in current portion of long-term debt as of March 31, 2018. For economic reasons related to the trading market for our 1.125% Convertible Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Convertible Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Convertible Notes may elect to convert the notes to cash. If conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the relevant indentures. We have sufficient available cash, combined with borrowing capacity available under our Credit Facility and Bridge Credit Agreement, to fund conversions should they occur.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2017, was disclosed in our 2017 Annual Report on Form 10-K. Other than the Bridge Credit Agreement we executed in January 2018, and the 1.625% Exchange in March 2018, there were no material changes to this previously filed information outside the ordinary course of business during the three months ended March 31, 2018. Refer to Notes to Consolidated Financial Statements, Note 7, “Debt,” for further information on the transactions noted above.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, "Medical Claims and Benefits Payable," for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the three months ended March 31, 2018, to our disclosure reported in "Critical Accounting Estimates" in our Annual Report on Form 10-K for the year ended December 31, 2017.

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."

- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."

- *Goodwill and intangible assets, net.* There have been no significant changes during the three months ended March 31, 2018, to our disclosure reported in "Critical Accounting Estimates" in our Annual Report on Form 10-K for the year ended December 31, 2017.

SUPPLEMENTAL INFORMATION

FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

EBITDA*

We believe that earnings before interest, taxes, depreciation and amortization (EBITDA*) is helpful in assessing our ability to meet the cash demands of our operating units.

	Three Months Ended March 31,	
	2018	2017
	(In millions)	
Net income	$ 107	$ 77
Adjustments:		
Depreciation, and amortization of intangible assets and capitalized software	34	46
Interest expense	33	26
Income tax expense	72	54
EBITDA*	$ 246	$ 203

ADJUSTED NET INCOME* AND ADJUSTED NET INCOME PER SHARE*

We believe that adjusted net income* and adjusted net income per diluted share* are helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net income*.

	Three Months Ended March 31,			
	2018		2017	
	(In millions, except diluted per-share amounts)			
Net income	$ 107	$ 1.64	$ 77	$ 1.37
Adjustment:				
Amortization of intangible assets	5	0.08	9	0.16
Income tax effect [1]	(1)	(0.01)	(3)	(0.06)
Amortization of intangible assets, net of tax effect	4	0.07	6	0.10
Adjusted net income*	$ 111	$ 1.71	$ 83	$ 1.47

(1) Income tax effect of adjustments calculated at the blended federal and state statutory tax rates of 22% and 37% for the first quarters of 2018 and 2017, respectively.

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms.

Changes in Internal Control Over Financial Reporting. There has been no change in our internal control over financial reporting during the fiscal quarter ended March 31, 2018 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 12, "Commitments and Contingencies."

RISK FACTORS

Certain risks may have a material adverse effect on our business, financial condition, cash flows, results of operations, or stock price, and you should carefully consider them before making an investment decision. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in "Risk Factors," in our Annual Report on Form 10-K for the year ended December 31, 2017. The risk factors described in our 2017 Annual Report on Form 10-K are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, results of operations, or stock price.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended March 31, 2018, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
January 1 - January 31	2,705	$ 91.83	—	$ —
February 1 - February 28	17,365	$ 90.63	—	$ —
March 1 - March 31	48,853	$ 72.36	—	$ —
Total	68,923	$ 77.73	—	

(1) During the three months ended March 31, 2018, we withheld 68,923 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

INDEX TO EXHIBITS

Exhibit No.	Title	Method of Filing
3.1	Fourth Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 8-K filed March 2, 2018.
10.1	Amended and Restated Commitment Letter, dated as of January 2, 2018, by and among Molina Healthcare, Inc., SunTrust Bank, SunTrust Robinson Humphrey, Inc., Barclays Bank PLC, MUFG, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Morgan Stanley Senior Funding, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 2, 2018.
10.2	Bridge Credit Agreement, dated as of January 2, 2018, by and among Molina Healthcare, Inc., as the Borrower, Molina Information Systems, LLC, Molina Pathways LLC and Pathways Health and Community Support LLC, as the Guarantors, SunTrust Bank, Barclays Bank PLC, The Bank of Tokyo-Mitsubishi UFJ, Ltd., Bank of America, N.A., and Morgan Stanley Senior Funding, Inc., as Lenders, and SunTrust Bank, as Administrative Agent.	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 2, 2018.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
101.INS	XBRL Taxonomy Instance Document.	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document.	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: April 30, 2018

/s/ JOSEPH M. ZUBRETSKY

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Dated: April 30, 2018

/s/ JOSEPH W. WHITE

Joseph W. White
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: April 30, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph W. White, certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2018 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: April 30, 2018

/s/ Joseph W. White

Joseph W. White
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2018 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: April 30, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2018 (the "Report"), I, Joseph W. White, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: April 30, 2018

/s/ Joseph W. White

Joseph W. White
Chief Financial Officer and Treasurer

2017 MHI Form 10-K

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2017

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒		Accelerated filer	☐
Non-accelerated filer	☐	(Do not check if a smaller reporting company)	Smaller reporting company	☐
Emerging growth company	☐			

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2017, the last business day of our most recently completed second fiscal quarter, was approximately $2,952.7 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2017).

As of February 23, 2018, approximately 59,727,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2018 Annual Meeting of Stockholders to be held on May 2, 2018, are incorporated by reference into Part III of this Form 10-K, to the extent described therein.

MOLINA HEALTHCARE, INC. 2017 FORM 10-K

CROSS-REFERENCE INDEX

(a) Incorporated by reference to "Executive Compensation" in the 2018 Proxy Statement.
(b) Incorporated by reference to "Security Ownership of Certain Beneficial Owners and Management" in the 2018 Proxy Statement.
(c) Incorporated by reference to "Related Party Transactions" and "Corporate Governance and Board of Directors Matters — Director Independence" in the 2018 Proxy Statement.
(d) Incorporated by reference to "Fees Paid to Independent Registered Public Accounting Firm" in the 2018 Proxy Statement.

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FORWARD LOOKING STATEMENTS

This Annual Report on Form 10-K (this "Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly due to numerous known and unknown risks and uncertainties. Those known risks and uncertainties include, but are not limited to, the risk factors identified in the section of this Form 10-K titled "Risk Factors," as well as the following:

- *the success of our profit improvement and maintenance initiatives, including the timing and amounts of the benefits realized, and administrative savings achieved;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare;"*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk transfer requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, the adequacy of agreed rates, and potential disruption associated with market withdrawal from Utah, Wisconsin, or other states;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer, risk corridors, and reinsurance;*
- *effective management of our medical costs;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of our efforts to retain existing government contracts, including those in Florida, New Mexico, Puerto Rico, Texas, and Washington, including the success of any protest filings;*
- *our ability to manage our operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our ability to consummate and realize benefits from acquisitions or divestitures;*
- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion cost corridors in California, New Mexico, and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, the effect of the PROMESA law, the impact of Hurricane Maria and our efforts to better manage the health care costs of our Puerto Rico health plan;*

- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to our provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of our California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *our failure to comply with the financial or other covenants in our credit agreement, our bridge credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of our funds on hand to pay the amounts due upon conversion or maturity of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm; and*
- *increasing competition and consolidation in the Medicaid industry*.

Each of the terms "Molina Healthcare,Inc." "Molina Healthcare," "Company," "we," "our," and "us," as used herein, refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

ABOUT MOLINA HEALTHCARE

Molina Healthcare, Inc. provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our health plans operating across the nation and in the Commonwealth of Puerto Rico, we serve approximately 4.5 million members.

2017 was a year of great change for Molina Healthcare. On May 2, 2017, after several disappointing quarters in which we continued to underperform relative to our own internal financial metrics and to the managed care sector as a whole, the board terminated the employment of Dr. J. Mario Molina, our former president and chief executive officer, and John C. Molina, our former chief financial officer. Our former chief accounting officer, Joseph W. White, was promoted to chief financial officer and interim president and chief executive officer, while the board launched a search for a permanent president and chief executive officer. Effective as of November 6, 2017, Joseph M. Zubretsky was named as president and chief executive officer of Molina Healthcare. Over the past ten months, the executive management team has been largely restructured.

2017

(Dollars in millions, except per-share amounts)

Total Revenue	Net Loss per Diluted Share	Adjusted Net Loss Per Share*
$19,883	($9.07)	($8.72)
Net Loss Margin	**EBITDA***	**Ending Membership**
(2.6)%	($329)	4,453,000

Non-generally accepted accounting principles (Non-GAAP) financial measures referred to in this Form 10-K are designated with an asterisk (*). For more information, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations (MD&A)—Non-GAAP Financial Measures,” and “MD&A—Supplemental Information.”

OUR MISSION

Our mission is to provide quality healthcare to people receiving government assistance.

OUR BUSINESS STRATEGY

We are building a plan to improve and sustain profitability

Our margin recovery and sustainability plan is designed to:

- Restore margins through operational improvements and managed care fundamentals
- Optimize the revenue base for profitability and future revenue growth
- Enhance balance sheet and capital management discipline

Restore margins through operational improvements and managed care fundamentals

In 2017, we changed leadership, restructured our workforce to better meet the needs of our business, and improved our cost structure. As described further below in “Consolidated Results–Fiscal Year 2017 Financial Summary,” and in the Notes to the Consolidated Financial Statements, Note 15, “Restructuring and Separation Costs,” in 2017 we implemented a comprehensive restructuring and profitability improvement plan that will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. As of December 31, 2017, we achieved $235 million of these run-rate reductions on an annualized basis.

We have reconfigured our organization. By reducing the workforce and number of management layers, and increasing management’s span of control, we have achieved significant savings.

We are simplifying our provider networks. We are terminating or renegotiating high-cost providers, narrowing networks in certain geographies, evaluating stop-loss thresholds and carve-outs, implementing value-based

contracting, evaluating ancillary services and pharmacy benefit management pricing and operations, and we have exited direct delivery operations.

We are improving the effectiveness of utilization review and care management. Areas of focus include specialist referrals, pre-authorization, concurrent review, high acuity populations and high utilizers of services, emergency room utilization and behavioral and medical integration.

We are addressing at-risk revenues and risk adjustment. We seek to more effectively engage in state rate setting, improve STAR ratings, increase retention of quality revenue withholds, and focus on coding and documentation to achieve risk scores commensurate with the acuity of our population.

We are improving our claims payment function. The key areas of improvement will include provider experience, payment accuracy and oversight of claims fraud, waste and abuse.

We are evaluating information technology and management. We seek to standardize the administrative platform, streamline operations and procedures, evaluate potential co-sourcing and/or outsource operational components, and consolidate data warehousing and data mining capabilities.

Optimize revenue base for profitability and future revenue growth

We will focus on defending existing revenue.

- In early 2018, we received the disappointing news that we were unsuccessful in defending all of our New Mexico Medicaid business and most of our Florida Medicaid business during state re-procurements.
    - We will lodge the necessary protests and appeals to ensure that we have exhausted every avenue available to us for retaining the managed care contracts currently held by our Florida and New Mexico health plans.
    - In addition, we have taken significant steps to improve our RFP response process to better articulate and present the Molina value proposition. Steps we have taken include marshaling more internal and external resources to support the RFP process, engaging a broader and deeper array of subject matter experts, infusing more local market knowledge into the process, and retaining outside experts in Medicaid procurement to pre-score our proposals and conduct mock reviews.
- We have also experienced some success in the pursuit of new revenue and the defense of existing revenue:
    - In May 2017, our Washington health plan was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North-Central region of the state's Apple Health Integrated Managed Care Program. The new contract commenced January 1, 2018.
    - In June 2017, Molina Healthcare of Mississippi, Inc. was awarded a Medicaid Coordinated Care Contract for the statewide administration of the Mississippi Coordinated Access Network (MississippiCAN). The operational start date for the program is currently scheduled for October 1, 2018, pending the completion of a readiness review. The initial term of the contract is through June 2020, with options to renew annually for up to two additional years.
    - In August 2017, our Illinois health plan was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the state's three current managed care programs into one program. The contract began January 1, 2018, and will continue for four years with options to renew annually for up to four additional years.

We will consider opportunistic revenue growth opportunities only if specific parameters are met. Such parameters include a positive regulatory environment, manageable competitive forces, network viability, the ability to leverage scale and operations, and a scalable population.

We will continue to identify opportunities for significant performance improvement. The under-performing geographies and lines of business we have identified are under intense review for performance improvement to ensure that every product and geography contributes to the portfolio.

We have taken decisive action with respect to our Affordable Care Act (ACA) Marketplace products. Effective January 1, 2018, we have:

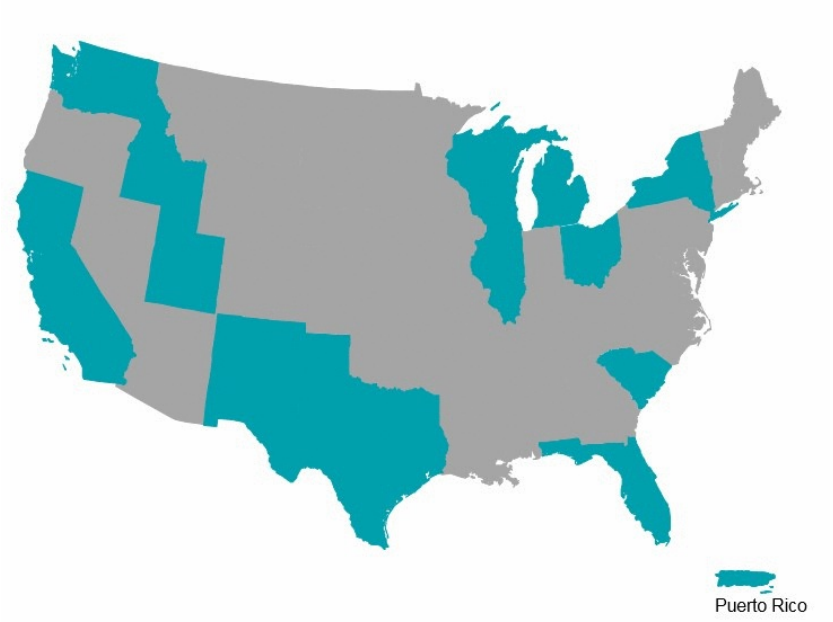
- Exited the Utah and Wisconsin Marketplaces;
- Reduced the scope of our Washington state Marketplace participation;
- Increased premiums averaging 58%; and
- Mitigated our exposure to uncertainties relating to cost sharing reduction (CSR) funding and reconciliation.

Enhance balance sheet and capital management discipline

We are taking steps to improve reserving accuracy, increase tangible net equity, reduce the cost of borrowing, maximize the dividend capacity of our subsidiaries, maximize parent company liquidity and cash flow, deploy excess capital in a balanced manner, and reduce the optionality in our capital structure.

OUR CORE BUSINESS FOOTPRINT TODAY

As of December 31, 2017, our health plan footprint included the five largest Medicaid markets.



OUR SEGMENTS

We manage our operations through three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition and divestiture activity, and changing laws and regulations. Therefore, these reportable segments may change in the future.

Business and financial overviews for our reportable segments are provided in “MD&A—Reportable Segments.”

Refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies” for revenue information by state health plan, and Note 20, “Segment Information,” for segment revenue, profit and total assets information.

COMPETITIVE CONDITIONS AND ENVIRONMENT

We face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, quality scores, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

For further competitor information specific to each of our reportable segments, refer to "MD&A—Reportable Segments."

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

NON-GAAP FINANCIAL MEASURES

We use non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures.

See further information regarding non-GAAP measures in the "Supplemental Information" section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this Form 10-K are designated with an asterisk (*).

KEY PERFORMANCE INDICATORS

(Dollars in millions except per-share amounts, membership in millions)

	Year Ended December 31,		
	2017	2016	2015
Ending total membership	4.5	4.2	3.5
Premium revenue	$ 18,854	$ 16,445	$ 13,261
Health Plans segment medical margin (1)	$ 1,781	$ 1,671	$ 1,467
Operating (loss) income	$ (555)	$ 306	$ 387
Net (loss) income	$ (512)	$ 52	$ 143
Net (loss) income per diluted share	$ (9.07)	$ 0.92	$ 2.58
Diluted weighted average shares outstanding	56.5	56.3	55.6
Adjusted net (loss) income per diluted share*	$ (8.72)	$ 1.28	$ 2.78
EBITDA*	$ (329)	$ 467	$ 508
Operating Statistics:			
Medical care ratio (2)	90.6 %	89.8%	88.9%
G&A ratio (3)	8.0 %	7.8%	8.1%
Premium tax ratio (2)	2.3 %	2.8%	2.9%
Effective income tax (benefit) expense rate	(16.4)%	74.8%	55.5%
Net (loss) profit margin (3)	(2.6)%	0.3%	1.0%

(1) Medical margin is equal to premium revenue minus medical costs.
(2) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(3) G&A ratio represents general and administrative expenses as a percentage of total revenue. Net (loss) profit margin represents net (loss) income as a percentage of total revenue.

See discussion of Key Performance Indicators in the “Consolidated Results” and “Reportable Segments” sections of this MD&A.

CONSOLIDATED RESULTS

FISCAL YEAR 2017 FINANCIAL SUMMARY

- Net loss per diluted share was $9.07 in 2017 compared with net income per diluted share of $0.92 in 2016.
- Adjusted net loss per diluted share* was $8.72 in 2017 compared with adjusted net income per diluted share* of $1.28 in 2016.
- The medical care ratio increased to 90.6% in 2017, from 89.8% in 2016.
- The general and administrative ratio increased to 8.0% in 2017, from 7.8% in 2016.
- We recorded a $73 million charge as a result of the federal government’s decision to stop paying cost sharing reduction rebates (CSRs) to health plans beginning in the fourth quarter of 2017. We believe we are legally entitled to those payments, and will pursue all available means to collect them.
- We recorded $47 million in charges for Marketplace changes in estimates, including risk adjustment and CSRs, related to 2016 dates of service that were estimated at December 31, 2016, and finalized during the second quarter of 2017.
- We recognized the $30 million release of the Marketplace-related premium deficiency reserve we had established as of December 31, 2016.

- We incurred non-cash impairment losses of $470 million in 2017. These losses included $269 million, primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management's determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago.

  Also during 2017, we recorded impairment losses of $28 million for our Molina Medicaid Solutions segment because management determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment than previously anticipated. In addition, we recorded impairment losses of $173 million for our Other segment, primarily relating to our Pathways business, because management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected.
- We incurred restructuring and separation costs of $234 million in 2017 as a result of the implementation of our restructuring and profit improvement plan in 2017 (the 2017 Restructuring Plan). As previously disclosed, we estimate that our 2017 Restructuring Plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. As of December 31, 2017, we achieved $235 million of these run-rate reductions by the elimination of administrative costs (some of which are classified as medical care costs) on an annualized basis. As of December 31, 2017 we had also achieved an undetermined amount of medical care cost savings on an annualized basis through the re-negotiation of various medical provider contracts and the restructuring of our direct delivery operations. We expect to have more visibility into the actual value of these medical care cost savings later in 2018. We incurred substantially all of the costs associated with the 2017 Restructuring Plan in 2017.
- We incurred $14 million in expenses, including transaction fees, relating to our exchange of equity for $141 million face value of our 1.625% convertible senior notes.
- We recognized $75 million of other income for fees we received in connection with the termination of a proposed Medicare acquisition in early 2017.
- We recognized approximately $54 million in additional tax expense during the fourth quarter, due to the revaluation of our deferred tax assets as a result of the Tax Cuts and Jobs Act of 2017.

The following table summarizes significant items affecting 2017 financial results (in millions, except per diluted share amounts).

	Year Ended December 31, 2017	
	Amount	Per Diluted Share [1]
Termination of CSR subsidy payments for the fourth quarter of 2017	$ 73	$ 0.82
Marketplace adjustments related to risk adjustment, CSR subsidies, and other items for 2016 dates of service	47	0.52
Change in Marketplace premium deficiency reserve for 2017 dates of service	(30)	(0.33)
Impairment losses	470	6.01
Restructuring and separation costs	234	2.86
Loss on debt extinguishment	14	0.24
Fee received for terminated Medicare acquisition	(75)	(0.84)
	$ 733	$ 9.28

(1) Amounts shown are before considering revaluation of related deferred tax assets as a result of the *Tax Cuts and Jobs Act of 2017*, as applicable. Except for certain items that are not deductible for tax purposes, per diluted share amounts are generally calculated at a statutory income tax rate of 37%, which is in excess of the effective tax rate recorded in our consolidated statements of operations.

TRENDS AND UNCERTAINTIES

Medicaid Contract Re-Procurement

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates; such dates are subject to change. Premium revenue is stated in millions.

Health Plan	Medicaid Program(s)	Membership as of December 31, 2017	Premium Revenue Year Ended December 31, 2017	Anticipated Award Date	Anticipated Effective Date
Puerto Rico	All	314,000	$ 732	Q2 2018	10/1/2018
Texas	ABD, MMP	100,000	$ 1,814	Q3 2018	1/1/2020
Washington [1]	All in 7 of 9 regions	574,000	$ 1,861	Q2 2018	1/1/2019

(1) The re-procurement information presented for the Washington health plan includes all Medicaid membership in the following regions: Northeast, Northwest, Central and Southeast, Pierce County, King County, Olympic Peninsula, and West-Central. Five of the seven largest regions' contracts that are awarded will be effective January 1, 2019. The remaining two will be effective on January 1, 2020.

Florida Health Plan. On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served approximately 360,000 Medicaid members in Florida, which represented approximately $1,486 million premium revenue for the year ended December 31, 2017. This decision does not affect the Florida health plan's current contracts with AHCA, which run through December 31, 2018. We recorded impairment losses in connection with this event. Refer to the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," for further information regarding all impairment losses recorded in 2017.

New Mexico Health Plan. In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico, which represented approximately $1,205 million premium revenue for the year ended December 31, 2017. This decision does not affect the New Mexico plan's current contract with HSD which runs through December 31, 2018. We recorded impairment losses in connection with this event.

Illinois Health Plan. In August 2017, our Illinois health plan was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the state's three current managed care programs into one program. The contract began January 1, 2018, and will continue for four years with options to renew annually for up to four additional years.

Washington Health Plan. In May 2017, our Washington health plan was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North-Central region of the state's Apple Health Integrated Managed Care Program. The new contract commenced January 1, 2018.

Pressures on Medicaid Funding

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following:

- Ending the entitlement nature of Medicaid by capping future increases in federal health spending for these programs, and shifting more of the risk for health costs in the future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap");

- Requiring Medicaid beneficiaries to work;
- Limiting the amount of lifetime benefits for Medicaid beneficiaries; and
- Numerous other potential changes and reforms.

ACA and the Marketplace

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, is subject to substantial uncertainty. Effective January 1, 2018, we have:

- Exited the Utah and Wisconsin Marketplaces;
- Reduced the scope of our Washington state Marketplace participation;
- Increased premiums averaging 58%;
- Mitigated our exposure to uncertainties relating to cost sharing reduction (CSR) funding and reconciliation; and
- Adjusted broker commissions to market rates.

As a result of these actions, we estimate that our ACA Marketplace membership will decline to approximately 300,000 members by the end of 2018, from 815,000 members as of December 31, 2017.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums. Our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio ("MCR"). The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. Management's discussion and analysis of the changes in the individual components of medical margin and service margin follows.

SEGMENT SUMMARY

	2017	2016	2015
		(In millions)	
Health Plans segment medical margin [1]	$ 1,781	$ 1,671	$ 1,467
Molina Medicaid Solutions segment service margin [2]	16	21	55
Other segment service margin [2]	13	33	5
	$ 1,810	$ 1,725	$ 1,527
Health Plans segment medical care ratio	90.6%	89.8%	88.9%

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.

HEALTH PLANS

BUSINESS OVERVIEW

- 97.3% of total revenue in 2017
- 96.9% of total revenue in 2016
- Employees: approximately 5,300

Our Industry

Medicaid. Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and supports to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all jurisdictions is currently about 59%, and ranges from a federally established FMAP floor of 50% to as high as 75%.

We participate in the following Medicaid programs:

- Temporary Assistance for Needy Families, or TANF - The most common Medicaid program, covers primarily low-income families with children.
- Aged, Blind or Disabled, or ABD - Medicaid ABD programs cover low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries typically use more services than those served by other Medicaid programs because of their critical health issues.
- Children's Health Insurance Program, or CHIP - A joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.
- Medicaid Expansion - In states that have elected to participate, Medicaid Expansion provides eligibility to nearly all low-income individuals under age 65 with incomes at or below 138% of the federal poverty line.

Marketplace. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in California, Florida, Michigan, New Mexico, Ohio, Texas and Washington. As previously announced, we exited the Utah and Wisconsin ACA Marketplaces effective January 1, 2018.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services (CMS). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (PMPM) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

Medicare-Medicaid Plans, or MMPs. Approximately nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to

deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as MMPs. We operate MMPs in six states.

Significant Trends and Developments

Refer to the discussion above, in the "Consolidated Results," and also below, in "Financial Performance by Program" sections of this MD&A.

Competition

The Medicaid managed care industry is subject to ongoing changes as a result of health care reform, business consolidations and new strategic alliances. We compete with national, regional, and local Medicaid service providers, principally on the basis of size, location, quality of provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., and Aetna Inc. Competition can vary considerably from state to state.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, such as claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

Regulatory Capital Requirements and Dividend Restrictions. Our health plans are subject to stringent minimum capitalization requirements that limit their ability to pay dividends to us. For further information, refer to the Notes to Consolidated Financial Statements, Note 19, "Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions."

Quality

Our long-term success depends, in large part, on the quality of the services we provide. As of December 31, 2017, 11 of our 13 health plans were accredited by the National Committee for Quality Assurance (NCQA), including the Multicultural Health Care Distinction, which is awarded to organizations that meet or exceed its rigorous requirements for multicultural health care.

The table below presents our health plans' NCQA status, as well as their scores as part of the CMS 2017 Star Ratings, which measures the quality of Medicare plans across the country using a 5-star rating system.

We believe that these objective measures of quality are important to state Medicaid agencies, as a growing number of states link reimbursement and patient assignment to quality scores. Additionally, Medicare pays quality bonuses to health plans that achieve high quality.

State	NCQA Health Plan Accreditation	NCQA Multicultural Healthcare Distinction	NCQA Health Insurance Plan Rating 2017-2018 (Medicaid)	Medicare Star Rating 2018
California	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.0 ★★★☆☆	3.0 ★★★☆☆
Florida	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.0 ★★★☆☆	3.0 ★★★☆☆
Illinois	Medicaid – Accredited	Medicaid	3.0 ★★★☆☆	not applicable
Michigan	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.5 ★★★½☆	3.0 ★★★☆☆
New Mexico	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.0 ★★★☆☆	3.0 ★★★☆☆
Ohio	Marketplace – Accredited Medicaid – Accredited	Marketplace & Medicaid	3.5 ★★★½☆	2.5 ★★½☆☆ (Part D Only)
South Carolina	Medicaid – Commendable	Medicaid	3.0 ★★★☆☆	not applicable
Texas	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.5 ★★★½☆	3.0 ★★★☆☆
Utah	Medicaid – Commendable	Medicaid	3.5 ★★★½☆	3.5 ★★★½☆
Washington	Marketplace – Accredited Medicaid – Commendable	Marketplace & Medicaid	3.5 ★★★½☆	3.0 ★★★☆☆
Wisconsin	Medicaid – Commendable	Medicaid	3.5 ★★★½☆	3.5 ★★★½☆

Programs and Services

As of December 31, 2017, the Health Plans segment consisted of health plans operating in 12 states and the Commonwealth of Puerto Rico. These health plans served approximately 4.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. The contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

Basis for our Premium Rates

Medicaid. Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members' health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Medicare. Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment. Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to

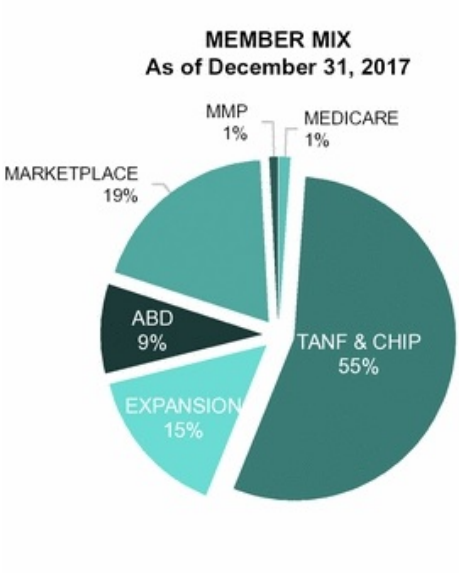
federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

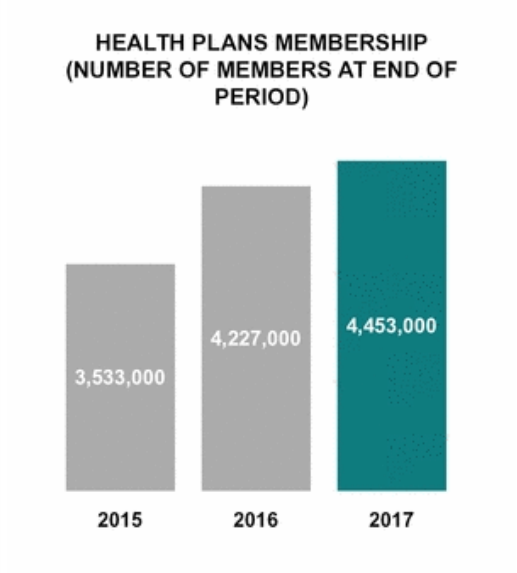
Marketplace. For our Marketplace plans, we develop premium rates during the spring of each year for policies effective in the following calendar year. Premium rates are based on our estimates of projected member utilization, medical unit costs, member risk acuity, member risk transfer, and administrative costs, with the intent of realizing a target pretax percentage profit margin. Our actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval.

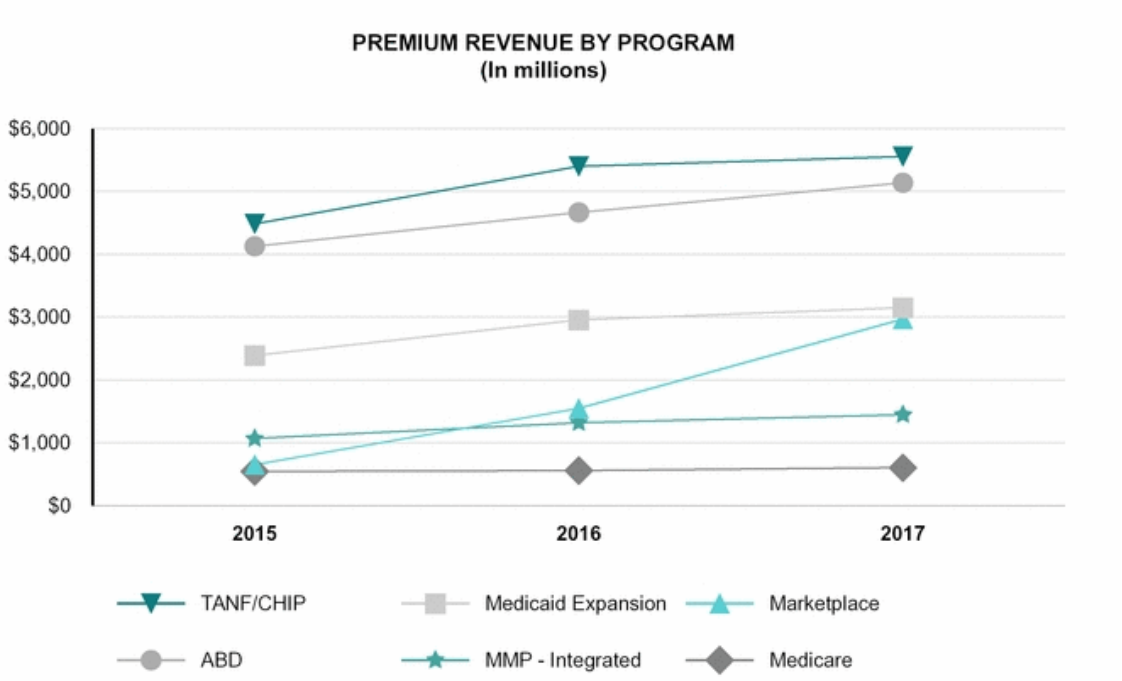
Premiums by Program

The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a PMPM basis, for the year ended December 31, 2017. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 110.00	$ 290.00	$ 180.00
Marketplace	180.00	480.00	270.00
Medicaid Expansion	320.00	510.00	390.00
ABD	380.00	1,460.00	1,050.00
MMP – Integrated	1,290.00	3,230.00	2,180.00
Medicare	940.00	1,250.00	1,140.00






PREMIUM REVENUE BY PROGRAM
(In millions)
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
2015
2016
2017
TANF/CHIP
Medicaid Expansion
Marketplace
ABD
MMP - Integrated
Medicare

Membership by Program and Health Plan

The following tables set forth our health plans' membership as of the dates indicated:

	As of December 31,		
	2017	**2016**	**2015**
Ending Membership by Program:			
TANF and CHIP	2,457,000	2,536,000	2,312,000
Marketplace	815,000	526,000	205,000
Medicaid Expansion	668,000	673,000	557,000
ABD	412,000	396,000	366,000
MMP – Integrated	57,000	51,000	51,000
Medicare	44,000	45,000	42,000
	4,453,000	4,227,000	3,533,000
Ending Membership by Health Plan:			
California	746,000	683,000	620,000
Florida [(1)]	625,000	553,000	440,000
Illinois	165,000	195,000	98,000
Michigan	398,000	391,000	328,000
New Mexico [(2)]	253,000	254,000	231,000
New York [(3)]	32,000	35,000	—
Ohio	327,000	332,000	327,000
Puerto Rico	314,000	330,000	348,000
South Carolina	116,000	109,000	99,000
Texas	430,000	337,000	260,000
Utah	152,000	146,000	102,000
Washington	777,000	736,000	582,000
Wisconsin	118,000	126,000	98,000
	4,453,000	4,227,000	3,533,000

(1) On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served a total of approximately 360,000 Medicaid members in Florida.

(2) In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico.

(3) The New York health plan was acquired on August 1, 2016.

FINANCIAL OVERVIEW

2017 Compared with 2016

In 2017, a 10% increase in membership, and a 5% increase in revenue PMPM, resulted in increased premium revenue of 15%, or $2.4 billion, when compared with 2016.

The medical care ratio increased to 90.6% in 2017, from 89.8% in 2016. Medical margin (measured in absolute dollars) increased 7% in 2017 over 2016. Our 2017 medical care ratio of 90.6% was burdened by substantial unfavorable out-of-period items, including:

- Approximately $150 million of medical margin deterioration resulting from unfavorable prior period claims development, the related need to replenish margins for adverse development in our liability for medical claims and benefits payable, and increased reserves for premiums we expect to repay to state Medicaid agencies; and
- Approximately $90 million of unfavorable Marketplace items, most notably the lack of CSR reimbursement in the fourth quarter of 2017.

Absent these items, our medical care ratio for 2017 would have been approximately 89.3%.

2016 Compared with 2015

In 2016, a 27% increase in membership, partially offset by a 3% decrease in revenue PMPM, resulted in increased premium revenue of 24%, or $3.2 billion, when compared with 2015.

The medical care ratio increased to 89.8% in 2016, from 88.9% in 2015. The increase in our medical care ratio was driven primarily by Marketplace membership. Medical margin (measured in absolute dollars) increased 14% in 2016 over 2015. The medical care ratio of all of our programs excluding Marketplace decreased by 10 basis points between 2015 and 2016, as decreasing margins in Medicaid Expansion (where we saw a 300 basis point increase in our medical care ratio) were offset by improved margins in other programs. Consolidated medical care costs measured on a PMPM basis decreased approximately 3% in 2016 when compared with 2015.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Year Ended December 31, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	30.2	$ 5,554	$ 183.75	$ 5,111	$ 169.09	92.0%	$ 443
Medicaid Expansion	8.1	3,150	388.42	2,674	329.73	84.9	476
ABD	4.9	5,135	1,050.41	4,863	994.80	94.7	272
Total Medicaid	43.2	13,839	320.16	12,648	292.61	91.4	1,191
MMP	0.7	1,446	2,177.72	1,317	1,982.36	91.0	129
Medicare	0.5	601	1,143.63	493	939.67	82.2	108
Total Medicare	1.2	2,047	1,722.47	1,810	1,523.15	88.4	237
Core operations	44.4	15,886	357.68	14,458	325.53	91.0	1,428
Marketplace	10.8	2,968	274.47	2,615	241.84	88.1	353
	55.2	$ 18,854	$ 341.39	$ 17,073	$ 309.14	90.6%	$ 1,781

	Year Ended December 31, 2016						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	30.2	$ 5,403	$ 179.21	$ 4,950	$ 164.18	91.6%	$ 453
Medicaid Expansion	7.8	2,952	378.58	2,475	317.37	83.8	477
ABD	4.7	4,666	991.24	4,277	908.39	91.6	389
Total Medicaid	42.7	13,021	305.28	11,702	274.33	89.9	1,319
MMP	0.6	1,321	2,160.94	1,141	1,866.93	86.4	180
Medicare	0.5	558	1,063.44	515	981.36	92.3	43
Total Medicare	1.1	1,879	1,653.73	1,656	1,457.67	88.1	223
Core operations	43.8	14,900	340.28	13,358	305.03	89.6	1,542
Marketplace	6.7	1,545	231.38	1,416	212.17	91.7	129
	50.5	$ 16,445	$ 325.87	$ 14,774	$ 292.75	89.8%	$ 1,671

	Year Ended December 31, 2015					
	Member Months [1]	Premium Revenue		Medical Care Costs		
		Total	PMPM	Total	PMPM	MCR [2]	Medical Margin
TANF and CHIP	25.5	$ 4,483	$ 175.64	$ 4,122	$ 161.50	92.0%	$ 361
Medicaid Expansion	5.9	2,389	408.51	1,931	330.18	80.8	458
ABD	4.3	4,124	966.83	3,784	887.27	91.8	340
Total Medicaid	35.7	10,996	308.54	9,837	276.05	89.5	1,159
MMP	0.5	1,066	2,040.08	974	1,863.93	91.4	92
Medicare	0.5	546	1,069.17	502	982.50	91.9	44
Total Medicare	1.0	1,612	1,560.08	1,476	1,428.18	91.5	136
Core operations	36.7	12,608	343.80	11,313	308.51	89.7	1,295
Marketplace	2.6	653	252.58	481	185.85	73.6	172
	39.3	$ 13,261	$ 337.79	$ 11,794	$ 300.43	88.9%	$ 1,467

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

2017 TRENDS

Medicaid TANF, CHIP and ABD. TANF represented approximately 40% of our total Medicaid revenue in 2017, with a medical care ratio of 92.0%. Keys to the cost-effective delivery of care to TANF members include:

- Effective utilization controls and care management, particularly with respect to high-risk pregnancies; and
- Reducing unit costs of high-cost providers.

Our ABD program represented approximately 37% of our total Medicaid revenue in 2017, with a medical care ratio of 94.7%. Keys to the cost-effective delivery of care to ABD members include:

- Improved care management and coordination of services for high acuity populations, focusing on the integration of behavioral and physical health services;
- Targeting high risk members for care management intervention and more comprehensive documentation of medical conditions; and
- Improved management of community and other long-term care services for members in this program.

Medicaid Expansion. Medicaid Expansion represented approximately 23% of our total Medicaid revenue in 2017, with a medical care ratio of 84.9%. This program continues to contribute favorably to our overall profitability and was responsible for approximately 40% of our total Medicaid medical margin for 2017. While premiums and margins for Medicaid Expansion have been declining in recent years, the rating environment appears to have stabilized.

Marketplace. The Marketplace 2017 medical care ratio was 88.1%. As noted above, the Marketplace program was burdened in 2017 by a net $90 million unfavorable impact from various Marketplace CSR, risk adjustment and premium deficiency reserve items. In response to profitability challenges, effective January 1, 2018, we exited the Marketplaces entirely in Utah and Wisconsin while also limiting our presence in Washington. Also effective January 1, 2018, we increased Marketplace premium rates by an average of 58%.

2017 Compared with 2016

Medicaid TANF and CHIP. The performance of TANF and CHIP was very consistent between 2017 and 2016, with flat enrollment, a premium revenue increase of approximately 3%; and an increase in the medical care ratio to 92.0% in 2017, from 91.6% in 2016.

Medicaid ABD. ABD enrollment grew approximately 4% in 2017 compared with 2016, while premium revenue grew by approximately 10%. The medical care ratio for our ABD membership deteriorated to 94.7% in 2017, from 91.6% in 2016. The deterioration in medical cost performance was most notable in Michigan, New Mexico and Texas.

Medicaid Expansion. Medicaid Expansion enrollment grew approximately 4% in 2017 compared with 2016, while premium revenue grew by approximately 7%. The medical care ratio for our Medicaid Expansion membership deteriorated to 84.9% in 2017 from 83.8% in 2016. Reduced premium rates in California were the primary driver of declining performance in 2017.

MMP and Medicare. MMP and Medicare enrollment and premium combined grew by approximately 9% in 2017 compared with 2016. The medical care ratio for this membership increased 30 basis points from 2016 to 2017.

Marketplace. Marketplace enrollment increased over 60% in 2017 compared with 2016, while premium revenue increased over 90%. Despite a decrease in the medical care ratio of 360 basis points in 2017 compared with 2016, our Marketplace program still failed to meet expectations in 2017.

2016 Compared with 2015

Medicaid TANF, CHIP and ABD. TANF, CHIP and ABD revenue increased in 2016 when compared with 2015, due to health plan acquisitions in late 2015 and 2016, as well as inclusion of a full year of Puerto Rico operations in 2016 (Puerto Rico began operations effective April 1, 2015). The slight decline in the medical care ratio for these programs on a consolidated basis when comparing 2016 with 2015 is not significant given normal margin fluctuations observed when performance is reviewed at this level of detail.

Medicaid Expansion. Member months increased 33% in 2016, when compared with 2015, as a result of membership growth in all states. Lower premium revenue PMPM more than offset lower medical costs PMPM, leading to an increase in the consolidated medical care ratio for the Medicaid Expansion program. Medicaid Expansion medical care ratios increased in Illinois, Michigan, New Mexico and Ohio.

MMP and Medicare. Membership and revenue increased on a consolidated basis for the MMP and Medicare programs when comparing 2016 with 2015. The medical care ratio for these programs, in the aggregate, decreased due to higher margins for the MMP program.

*Marketplace. O*ur Marketplace program performed poorly in 2016. The medical care ratio of our Marketplace membership increased to 91.7% in 2016, from 73.6% in 2015. This decline in profitability was the result of lower premium revenue PMPM, the recording of a $30 million premium deficiency reserve at December 31, 2016, and higher medical costs PMPM.

The poor performance of our Marketplace program in 2016 was exacerbated by the federal government's failure to pay amounts owed to our health plans under the Marketplace risk corridor program. We believe our health plans are owed approximately $76 million in Marketplace risk corridor payments for 2016 dates of service, but have not recorded any amounts associated with this claim.

FINANCIAL PERFORMANCE BY STATE HEALTH PLAN

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Core Operations (Medicaid and Medicare Combined)

	Year Ended December 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.4	$ 2,392	$ 321.46	$ 2,117	$ 284.53	88.5%	$ 275
Florida	4.3	1,522	350.15	1,461	335.97	96.0	61
Illinois	2.1	593	286.69	638	308.41	107.6	(45)
Michigan	4.6	1,545	334.22	1,360	294.15	88.0	185
New Mexico	2.9	1,258	439.95	1,166	407.94	92.7	92
New York [1]	0.4	181	449.85	170	424.17	94.3	11
Ohio	3.9	2,130	544.98	1,894	484.66	88.9	236
Puerto Rico [1]	3.8	732	190.13	691	179.65	94.5	41
South Carolina	1.4	445	328.41	412	304.04	92.6	33
Texas	2.8	2,150	769.82	1,978	708.20	92.0	172
Utah	1.1	355	316.44	290	258.96	81.8	65
Washington	8.9	2,445	275.64	2,143	241.55	87.6	302
Wisconsin	0.8	131	168.64	107	136.84	81.1	24
Other [2]	—	7	—	31	—	—	(24)
	44.4	$ 15,886	$ 357.68	$ 14,458	$ 325.53	91.0%	$ 1,428

	Year Ended December 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.4	$ 2,247	$ 304.83	$ 1,900	$ 257.72	84.5%	$ 347
Florida	4.1	1,348	329.58	1,227	299.94	91.0	121
Illinois	2.3	603	258.72	568	243.71	94.2	35
Michigan	4.7	1,517	324.18	1,339	286.00	88.2	178
New Mexico	2.8	1,245	440.63	1,162	411.30	93.3	83
New York [1]	0.2	82	446.72	79	431.73	96.6	3
Ohio	3.9	1,927	490.71	1,718	437.56	89.2	209
Puerto Rico [1]	4.0	726	180.65	694	172.57	95.5	32
South Carolina	1.3	378	296.58	320	250.97	84.6	58
Texas	2.9	2,182	744.65	1,926	657.38	88.3	256
Utah	1.1	344	297.68	296	256.31	86.1	48
Washington	8.1	2,146	263.50	1,936	237.66	90.2	210
Wisconsin	1.0	142	165.95	106	123.44	74.4	36
Other [2]	—	13	—	87	—	—	(74)
	43.8	$ 14,900	$ 340.28	$ 13,358	$ 305.03	89.6%	$ 1,542

	Year Ended December 31, 2015						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	6.9	2,163	$ 314.73	$ 1,901	$ 276.57	87.9%	$ 262
Florida	2.4	802	333.18	801	333.02	100.0	1
Illinois	1.2	398	329.48	367	303.72	92.2	31
Michigan	3.4	1,068	318.95	901	268.91	84.3	167
New Mexico	2.7	1,226	450.16	1,097	402.85	89.5	129
New York [1]	—	—	—	—	—	—	—
Ohio	4.0	2,025	500.15	1,710	422.43	84.5	315
Puerto Rico [1]	3.2	567	178.31	505	158.80	89.1	62
South Carolina	1.3	348	267.25	278	213.30	79.8	70
Texas	3.0	1,918	639.47	1,778	592.95	92.7	140
Utah	1.1	318	293.42	285	263.18	89.7	33
Washington	6.6	1,586	241.84	1,454	221.75	91.7	132
Wisconsin	0.9	148	157.14	113	120.06	76.4	35
Other [2]	—	41	—	123	—	—	(82)
	36.7	$ 12,608	$ 343.80	$ 11,313	$ 308.51	89.7%	$ 1,295

Health Plans Segment Financial Data — Marketplace

	Year Ended December 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.7	$ 309	$ 185.88	$ 231	$ 138.61	74.6%	$ 78
Florida	3.6	1,046	293.35	1,009	283.17	96.5	37
Michigan	0.3	51	180.26	38	135.64	75.2	13
New Mexico	0.3	110	349.50	84	264.14	75.6	26
Ohio	0.2	86	363.24	81	340.44	93.7	5
Texas	2.6	663	250.08	517	195.20	78.1	146
Utah	0.9	180	215.93	178	213.33	98.8	2
Washington	0.5	163	317.39	156	304.74	96.0	7
Wisconsin	0.7	360	477.53	327	433.98	90.9	33
Other [2]	—	—	—	(6)	—	—	6
	10.8	$ 2,968	$ 274.47	$ 2,615	$ 241.84	88.1%	$ 353

	Year Ended December 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.8	$ 131	$ 166.01	$ 129	$ 164.35	99.0%	$ 2
Florida	2.6	590	228.65	538	208.53	91.2	52
Michigan	—	10	232.88	6	154.32	66.3	4
New Mexico	0.2	60	287.37	47	223.85	77.9	13
Ohio	0.1	40	348.06	29	254.78	73.2	11
Texas	1.4	279	208.48	184	137.13	65.8	95
Utah	0.7	103	166.21	127	204.14	122.8	(24)
Washington	0.3	76	272.48	79	284.87	104.5	(3)
Wisconsin	0.6	256	363.54	282	399.51	109.9	(26)
Other [2]	—	—	—	(5)	—	—	5
	6.7	$ 1,545	$ 231.38	$ 1,416	$ 212.17	91.7%	$ 129

	Year Ended December 31, 2015						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.2	$ 37	$ 179.77	$ 25	$ 124.68	69.4%	$ 12
Florida	1.7	397	229.85	280	162.04	70.5	117
Michigan	—	4	212.70	2	124.35	58.5	2
New Mexico	0.1	11	242.42	9	185.13	76.4	2
Ohio	0.1	10	399.81	8	290.81	72.7	2
Texas	0.1	45	286.78	31	197.41	68.8	14
Utah	0.1	16	221.00	15	202.41	91.6	1
Washington	—	19	369.59	16	301.94	81.7	3
Wisconsin	0.3	114	403.08	102	362.28	89.9	12
Other [2]	—	—	—	(7)	—	—	7
	2.6	$ 653	$ 252.58	$ 481	$ 185.85	73.6%	$ 172

Health Plans Segment Financial Data — Total

	Year Ended December 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	9.1	$ 2,701	$ 296.68	$ 2,348	$ 257.86	86.9%	$ 353
Florida	7.9	2,568	324.56	2,470	312.18	96.2	98
Illinois	2.1	593	286.69	638	308.41	107.6	(45)
Michigan	4.9	1,596	325.43	1,398	285.11	87.6	198
New Mexico	3.2	1,368	430.97	1,250	393.67	91.3	118
New York [1]	0.4	181	449.85	170	424.17	94.3	11
Ohio	4.1	2,216	534.56	1,975	476.39	89.1	241
Puerto Rico [1]	3.8	732	190.13	691	179.65	94.5	41
South Carolina	1.4	445	328.41	412	304.04	92.6	33
Texas	5.4	2,813	516.84	2,495	458.50	88.7	318
Utah	2.0	535	273.55	468	239.49	87.5	67
Washington	9.4	2,608	277.93	2,299	245.01	88.2	309
Wisconsin	1.5	491	320.71	434	283.14	88.3	57
Other [2]	—	7	—	25	—	—	(18)
	55.2	$ 18,854	$ 341.39	$ 17,073	$ 309.14	90.6%	$ 1,781

	Year Ended December 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	8.2	$ 2,378	$ 291.41	$ 2,029	$ 248.70	85.3%	$ 349
Florida	6.7	1,938	290.56	1,765	264.60	91.1	173
Illinois	2.3	603	258.72	568	243.71	94.2	35
Michigan	4.7	1,527	323.36	1,345	284.82	88.1	182
New Mexico	3.0	1,305	430.15	1,209	398.49	92.6	96
New York [1]	0.2	82	446.72	79	431.73	96.6	3
Ohio	4.0	1,967	486.66	1,747	432.36	88.8	220
Puerto Rico [1]	4.0	726	180.65	694	172.57	95.5	32
South Carolina	1.3	378	296.58	320	250.97	84.6	58
Texas	4.3	2,461	576.69	2,110	494.41	85.7	351
Utah	1.8	447	251.63	423	238.03	94.6	24
Washington	8.4	2,222	263.80	2,015	239.21	90.7	207
Wisconsin	1.6	398	255.30	388	248.28	97.2	10
Other [2]	—	13	—	82	—	—	(69)
	50.5	$ 16,445	$ 325.87	$ 14,774	$ 292.75	89.8%	$ 1,671

	Year Ended December 31, 2015						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.1	$ 2,200	$ 310.86	$ 1,926	$ 272.22	87.6%	$ 274
Florida	4.1	1,199	289.95	1,081	261.49	90.2	118
Illinois	1.2	398	329.48	367	303.72	92.2	31
Michigan	3.4	1,072	318.47	903	268.27	84.2	169
New Mexico	2.8	1,237	446.47	1,106	398.98	89.4	131
New York (1)	—	—	—	—	—	—	—
Ohio	4.1	2,035	499.52	1,718	421.61	84.4	317
Puerto Rico (1)	3.2	567	178.31	505	158.80	89.1	62
South Carolina	1.3	348	267.25	278	213.30	79.8	70
Texas	3.1	1,963	621.97	1,809	573.32	92.2	154
Utah	1.2	334	288.83	300	259.32	89.8	34
Washington	6.6	1,605	242.82	1,470	222.36	91.6	135
Wisconsin	1.2	262	213.95	215	176.01	82.3	47
Other (2)	—	41	—	116	—	—	(75)
	39.3	$ 13,261	$ 337.79	$ 11,794	$ 300.43	88.9%	$ 1,467

(1) The New York health plan was acquired on August 1, 2016. Our Puerto Rico health plan began serving members on April 1, 2015.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

MEDICAL CARE COSTS BY TYPE

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. The following table provides the details of consolidated medical care costs by type for the periods indicated (dollars in millions except PMPM amounts):

	Year Ended December 31,								
	2017			2016			2015		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 12,682	$ 229.63	74.3%	$ 10,993	$ 217.84	74.4%	$ 8,572	$ 218.35	72.7%
Pharmacy	2,563	46.40	15.0	2,213	43.84	15.0	1,610	41.01	13.7
Capitation	1,360	24.63	8.0	1,218	24.13	8.2	982	25.02	8.3
Direct delivery	73	1.33	0.4	78	1.55	0.5	128	3.26	1.1
Other	395	7.15	2.3	272	5.39	1.9	502	12.79	4.2
	$ 17,073	$ 309.14	100.0%	$ 14,774	$ 292.75	100.0%	$ 11,794	$ 300.43	100.0%

PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.3% in 2017, 2.8% in 2016, and 2.9% in 2015. The decreases in the premium tax ratio were primarily due to the significant revenue growth at our Florida health plan in 2017 and 2016, which operates in a state with no premium tax, and growth in MMP revenue. The Medicare portion of MMP revenue is not subject to premium tax.

HEALTH INSURER FEES (HIF)

The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there were no health insurer fees reimbursed, nor health insurer fees incurred, in 2017.

HIF reimbursed, as a percentage of premium revenue, was consistent at 1.8% in 2016 and 2015.

IMPAIRMENT LOSSES

In 2017, we incurred $269 million of impairment losses related to our Health Plans segment, primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management's determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago.

MOLINA MEDICAID SOLUTIONS

BUSINESS OVERVIEW

- 1.0% of total revenue in 2017
- 1.1% of total revenue in 2016
- Employees: approximately 1,200

Programs and Services

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with Medicaid agencies in six states, and the U.S. Virgin Islands. Our existing state Medicaid management information system (MMIS) contracts have terms that currently extend to 2018 through 2025, before renewal options.

Competition and Regulation

Molina Medicaid Solutions competes with large MMIS vendors, such as DXC Technology Company, Conduent, Inc. and CNSI. Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance.

FINANCIAL OVERVIEW

2017 Compared with 2016

The year over year change in service margin was insignificant to our consolidated results of operations.

As discussed further in the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," in 2017 we recorded goodwill impairment losses of $28 million.

2016 Compared with 2015

Service margin declined $34 million in 2016 compared with 2015, primarily due to increased service costs associated with legacy state contracts that were re-procured.

OTHER

BUSINESS OVERVIEW

- 1.7% of total revenue in 2017
- 2.0% of total revenue in 2016
- Employees: Corporate – approximately 7,100; Pathways – approximately 6,000

Programs and Services

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

We acquired the outstanding ownership interests in Pathways Health and Community Support, LLC (Pathways), formerly known as Providence Human Services, LLC, in late 2015. Substantially all of Pathways' revenue is derived from contracts with state or local government agencies and government intermediaries, the majority of which are negotiated fee-for-service arrangements.

FINANCIAL OVERVIEW

2017 Compared with 2016

Service margin declined $20 million in 2017 compared with 2016, due primarily to reduced revenues as a result of the termination of operations in selected markets, and increased professional labor benefit expenses.

As discussed further in the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," in 2017 we recorded impairment losses primarily relating to our Pathways subsidiary, of $162 million for goodwill and $11 million for intangible assets.

2016 Compared with 2015

Service margin was $33 million in 2016 and insignificant in 2015. The service margin in 2015 was insignificant because our acquisition of Pathways was not completed until the fourth quarter of 2015.

OTHER CONSOLIDATED INFORMATION

GENERAL AND ADMINISTRATIVE EXPENSES

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") was 8.0% in 2017, 7.8% in 2016, and 8.1% in 2015. Our general and administrative ratio has been relatively constant since the phase-in of the ACA Medicaid Expansion and Marketplace programs beginning in 2014.

DEPRECIATION AND AMORTIZATION

Depreciation and amortization amounted to 0.9%, 1.0% and 0.8% of total revenue for the years ended December 31, 2017, 2016 and 2015, respectively.

RESTRUCTURING AND SEPARATION COSTS

For a comprehensive discussion of our 2017 Restructuring Plan, refer to "Liquidity and Financial Condition—Future Sources and Uses of Liquidity," in this MD&A, and Notes to Consolidated Financial Statements, Note 15, "Restructuring and Separation Costs."

INTEREST EXPENSE

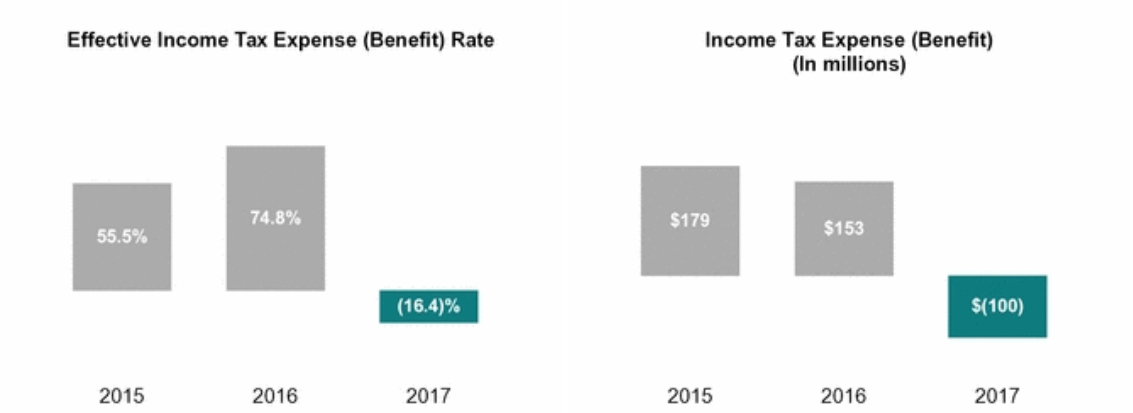
Interest expense increased to $118 million for the year ended December 31, 2017, compared with $101 million for the year ended December 31, 2016. The increase was due primarily to our issuance of $330 million aggregate principal amount of senior notes (the 4.875% Notes) due June 15, 2025, and $300 million borrowed under our

Credit Facility in the third quarter of 2017. For further details regarding debt financing transactions, please refer to the Notes to Consolidated Financial Statements, Note 11, “Debt.”

Interest expense increased to $101 million for the year ended December 31, 2016, compared with $66 million for the year ended December 31, 2015. The increase was due primarily to our issuance of $700 million aggregate principal amount of senior notes (the 5.375% Notes) due November 15, 2022, in the fourth quarter of 2015.

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $32 million, $31 million and $30 million for the years ended December 31, 2017, 2016, and 2015, respectively.

INCOME TAXES



The revaluation of deferred tax assets in connection with the *Tax Cuts and Jobs Act of 2017* resulted in $54 million additional income tax expense in the year ended December 31, 2017 ($0.95 per diluted share). In addition, the effective tax benefit for 2017 is less than the statutory tax benefit due to the relatively large amount of reported expenses that are not deductible for tax purposes, primarily relating to goodwill impairment losses and separation costs.

The decrease in income before taxes in 2016 compared with 2015, combined with the relatively large amount of reported expenses that are not deductible for tax purposes, resulted in an effective tax rate in excess of 70% for the full year 2016, compared with 55.5% for 2015.

LIQUIDITY AND FINANCIAL CONDITION

INTRODUCTION

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

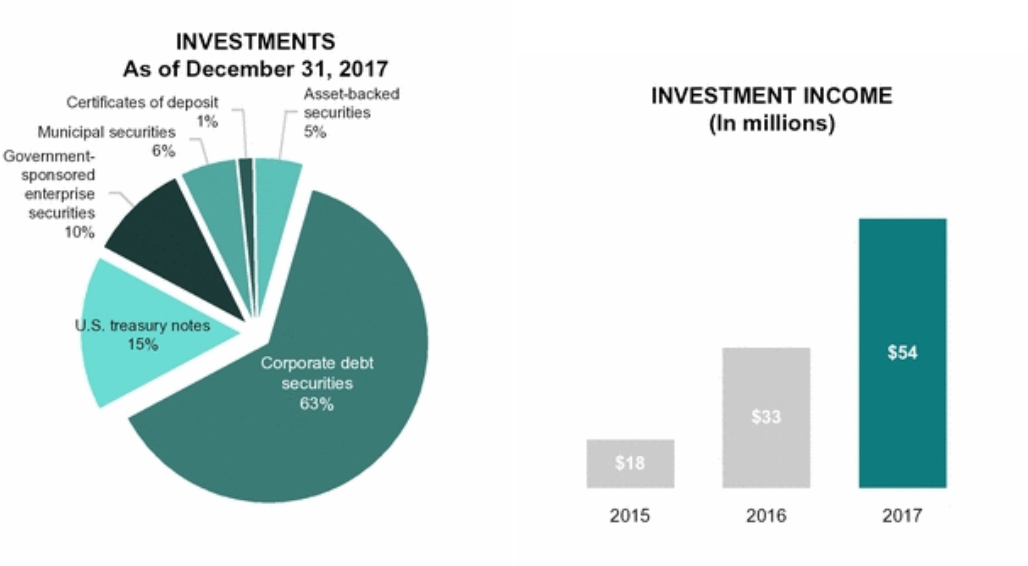
Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or

less (excluding variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels.

Our non-current restricted investments are invested principally in certificates of deposit and U.S. treasury securities; we have the ability to hold our non-current restricted investments until maturity. We also maintain certain funds from the issuance of our 4.875% Notes in a segregated deposit account, a current asset reported as “Restricted investments” in the accompanying consolidated balance sheets. Such investments, while restricted as to their use and held in a segregated deposit account, are classified as available-for-sale based upon our contractual liquidity requirements.

All of our unrestricted investments are classified as current assets and are presented in the table below.



Investment income increased in 2017 compared with 2016, and in 2016 compared with 2015, primarily due to the increase in invested assets in each of 2017 and 2016. See further discussion below in “Liquidity.”

MARKET RISK

Our earnings and financial position are exposed to financial market risk relating changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2017, the fair value of our fixed income investments would decrease by approximately $24 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to the Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” Note 5, “Investments,” and Note 9, “Restricted Investments, Non-current.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of December 31, 2017, $300 million was outstanding under the Credit Facility.

In January 2018, we entered into a bridge credit agreement (Bridge Credit Agreement) with several banks. Under the Bridge Credit Agreement, the banks agreed to lend us up to $550 million to be used to: (i) satisfy conversions of

our 1.125% Convertible Notes; (ii) satisfy and/or refinance indebtedness incurred to satisfy conversion of the 1.125% Convertible Notes; (iii) repay or refinance our Credit Facility; (iv) pay fees and expenses in connection with the foregoing; and, subject to the satisfaction of specified conditions, for general corporate purposes. Borrowings under the Bridge Credit Agreement will bear interest based, at our election, at a base rate or an adjusted LIBOR rate, plus in each case the applicable margin. No amounts are currently outstanding under the Bridge Credit Agreement.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Year Ended December 31,				
	2017	2016	2015	2016 to 2017 Change	2015 to 2016 Change
	(In millions)				
Net cash provided by operating activities	$ 804	$ 673	$ 1,125	$ 131	$ (452)
Net cash used in investing activities	(1,073)	(202)	(1,420)	(871)	1,218
Net cash provided by financing activities	636	19	1,085	617	(1,066)
Net increase in cash and cash equivalents	$ 367	$ 490	$ 790	$ (123)	$ (300)

Operating Activities

2017 Compared with 2016

Net cash provided by operating activities was $804 million in 2017 compared with $673 million in 2016, an increase of $131 million, due to the following factors:

The combined effect of our 2017 net loss and adjustments to cash provided by operating activities, which included non-cash impairment losses of $470 million and non-cash restructuring charges of $60 million, resulted in a $114 million use of cash.

Receivables and deferred revenue. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. In general, states may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In the current year, the net effect of the timing of premiums received at our California, Florida, Illinois, and Washington health plans positively impacted our cash flows from operating activities in the amount of $325 million.

Amounts due government agencies. While amounts due government agencies increased $340 million in 2017, this increase was less than the increase experienced in 2016, resulting in a decrease to cash flows from operations of $132 million. This decrease was due primarily to a decline in the amounts accrued for Health Plans segment programs that mandate medical cost floors or medical cost corridors, under which a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. This decrease was partially offset by increased Marketplace risk adjustment accruals.

2016 Compared with 2015

Net cash provided by operating activities was $673 million in 2016, compared with $1,125 million in 2015, a decrease of $452 million. This decrease was due primarily to a $91 million decrease in net income, and the following factors:

Receivables and deferred revenue. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. In general, states may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In the current year, the net effect of the timing of premiums received at our California and Illinois health plans negatively impacted our cash flows from operating activities.

Medical claims and benefits payable. In 2016, the change in medical claims and benefits payable reduced cash flows from operations by $256 million, primarily because membership and related medical costs grew at a higher rate in 2015 than in 2016, resulting in a lower year-over-year change in 2016.

Amounts due government agencies. In 2016, the change in amounts due government agencies, when compared with the change in 2015, increased cash flows from operations by $271 million, due primarily to increased accruals for Marketplace risk adjustments.

Investing Activities

2017 Compared with 2016

Net cash used in investing activities was $1,073 million in 2017, compared with $202 million in 2016, an increase of $871 million. More cash was used in investing activities in 2017 primarily due to $789 million of increased purchases of investments as a result of the 2017 financing transactions described below, and $195 million decreased proceeds from sales and maturities of investments.

2016 Compared with 2015

Net cash used in investing activities was $202 million in 2016, compared with $1,420 million in 2015, a decrease of $1,218 million. Less cash was used in investing activities in 2016 primarily due to $840 million increased proceeds from sales and maturities of investments, and a reduction in cash paid in business combinations of $402 million in 2016, compared with 2015.

Financing Activities

2017 Compared with 2016

Cash provided by financing activities was $636 million in 2017, compared with $19 million in 2016. In 2017, cash inflows included $325 million for the net proceeds from our issuance of 4.875% Notes, and borrowings of $300 million under our Credit Facility, with no comparable activity in 2016.

2016 Compared with 2015

Cash provided by financing activities was $19 million in 2016, compared with $1,085 million in 2015. In 2015, we received net proceeds from our fiscal 2015 offerings of the 5.375% Notes amounting to $689 million, and common stock amounting to $373 million, with no comparable activity in 2016.

FINANCIAL CONDITION

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at December 31, 2017, our working capital was $1,954 million compared with $1,418 million at December 31, 2016. At December 31, 2017, our cash and investments amounted to $6,000 million, compared with $4,689 million of cash and investments at December 31, 2016.

Debt Ratings. Our 5.375% Notes and 4.875% Notes are rated “BB-” by Standard & Poor’s, and “B3” by Moody’s Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

Financial Covenants. Our Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Facility.

Credit Facility Financial Covenants	Required Per Agreement	As of December 31, 2017
Net leverage ratio	<4.0x	3.1x
Interest coverage ratio	>3.5x	6.7x

In addition, the terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures. As of December 31, 2017, we were in compliance with all covenants under the Credit Facility.

FUTURE SOURCES AND USES OF LIQUIDITY

Sources

Parent Cash and Cash Equivalents. Cash, cash equivalents and investments held by the parent company—Molina Healthcare, Inc.—amounted to $696 million as of December 31, 2017.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. We received $245 million, $100 million, and $125 million in dividends from our regulated health plan subsidiaries in 2017, 2016, and 2015, respectively. We received $41 million, $1 million and $17 million in dividends from our unregulated subsidiaries during 2017, 2016 and 2015, respectively. See further discussion in the Notes to Consolidated Financial Statements, Note 19, "Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions," and Note 22, "Condensed Financial Information of Registrant—Note C - Dividends and Capital Contributions."

Borrowing Capacity and Debt Financing. We have available borrowing capacity of $550 million under our Bridge Credit Agreement (which amount is subject to the use of proceeds restrictions set forth in its terms), and $194 million under our Credit Facility. On June 6, 2017, we completed the private offering of $330 million aggregate principal amount of the 4.875% Notes. As a result of the proceeds from this transaction, we have adequate cash held in a restricted account available to repay the $161 million principal balance outstanding under our 1.625% Convertible Notes, if noteholders exercise their conversion or put rights in 2018. See further discussion in the Notes to Consolidated Financial Statements, Note 11, "Debt," for further information.

2017 Restructuring Plan. As previously disclosed, we estimate that our 2017 Restructuring Plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. As of December 31, 2017, we achieved $235 million of these run-rate reductions by the elimination of administrative costs (some of which are classified as medical care costs) on an annualized basis. As of December 31, 2017 we had also achieved an undetermined amount of medical care cost savings on an annualized basis through the re-negotiation of various medical provider contracts and the restructuring of our direct delivery operations. We expect to have more visibility into the actual value of these medical care cost savings later in 2018. We incurred substantially all of the costs associated with the 2017 Restructuring Plan in 2017. The following table illustrates our current estimates of run-rate savings associated with the 2017 Restructuring Plan:

Estimated Savings Expected to be Realized by Reportable Segment	Health Plans	Other	Total
		(In millions)	
General and administrative expenses	$65	$92 to $152	$157 to $217
Medical care costs	$126 to $166	$17	$143 to $183
	$191 to $231	$109 to $169	$300 to $400

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Uses

Regulatory Capital Requirements. In 2017, 2016, and 2015, we contributed capital of $370 million, $338 million, and $320 million, respectively, to our health plans subsidiaries to satisfy statutory net worth requirements. For a comprehensive discussion of this topic, refer to the Notes to Consolidated Financial Statements, Note 19, "Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions."

Convertible Senior Notes. Refer to the Notes to Consolidated Financial Statements, Note 11, "Debt," for a detailed discussion of our Convertible Senior Notes. Both our 1.625% Convertible Notes and our 1.125% Convertible Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.625% Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this trigger in the quarter ended December 31, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of December 31, 2017. As described above, we have adequate cash held in a restricted account available to repay the 1.625% Convertible Notes, if noteholders exercise their conversion or put rights in 2018.

The stock price trigger for the 1.125% Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended December 31, 2017, and are convertible to cash through at least March 31, 2018. Because the 1.125% Convertible Notes may be converted into cash within 12 months, the $550 million carrying amount is reported in current portion of long-term debt as of December 31, 2017. For economic reasons related to the trading market for our 1.125% Convertible Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Convertible Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Convertible Notes may elect to convert the notes to cash. If conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the relevant indentures. We have sufficient available cash, combined with borrowing capacity available under our Credit Facility and Bridge Credit Agreement, to fund conversions should they occur.

Exchange Offers. We may from time to time seek to retire or purchase material amounts of our outstanding debt through cash purchases and/or exchanges for equity securities, in open market purchases, privately negotiated transactions or otherwise. For example, on December 7, 2017, we announced that on December 6, 2017 we priced a synthetic exchange transaction with a limited number of holders of our 1.625% Convertible Notes pursuant to which we agreed to repurchase from such noteholders an aggregate of $141 million principal amount of our 1.625% Convertible Notes and simultaneously issue to such noteholders an aggregate of 2.6 million shares of our common stock registered under the shelf registration statement described above. Future repurchases or exchanges, if any, will depend on prevailing market conditions, our liquidity requirements, contractual restrictions and other factors.

CONTRACTUAL OBLIGATIONS

In the table below, we present our contractual obligations as of December 31, 2017. Some of the amounts included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table.

Additionally, we have a variety of other contractual agreements related to acquiring services used in our operations. However, we believe these other agreements do not contain material non-cancelable commitments.

	Total [1]	2018	2019-2020	2021-2022	2023 and after
			(In millions)		
Medical claims and benefits payable	$ 2,192	$ 2,192	$ —	$ —	$ —
Principal amount of debt [2]	2,041	—	550	1,000	491
Amounts due government agencies	1,542	1,542	—	—	—
Lease financing obligations	410	17	37	39	317
Interest on long-term debt	428	73	140	119	96
Operating leases	262	67	109	52	34
Purchase commitments	11	6	5	—	—
	$ 6,886	$ 3,897	$ 841	$ 1,210	$ 938

(1) As of December 31, 2017, we have recorded approximately $13 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Notes to Consolidated Financial Statements, Note 13, "Income Taxes."

(2) Represents the principal amounts due on our 5.375% Notes due 2022, 1.125% Convertible Notes due 2020, 4.875% Notes due 2025, Credit Facility due 2022, and our 1.625% Convertible Notes due 2044. The amounts in the table reflect the 1.625% Convertible Notes' contractual maturity date in 2044; however, on specified dates beginning in 2018, holders of the 1.625% Convertible Notes may convert, or may require us to repurchase some or all of the 1.625% Convertible Notes, as described in the Notes to Consolidated Financial Statements, Note 11, "Debt."

Commitments and Contingencies. We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in the Notes to Consolidated Financial Statements, Note 19, "Commitments and Contingencies."

INFLATION

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

COMPLIANCE COSTS

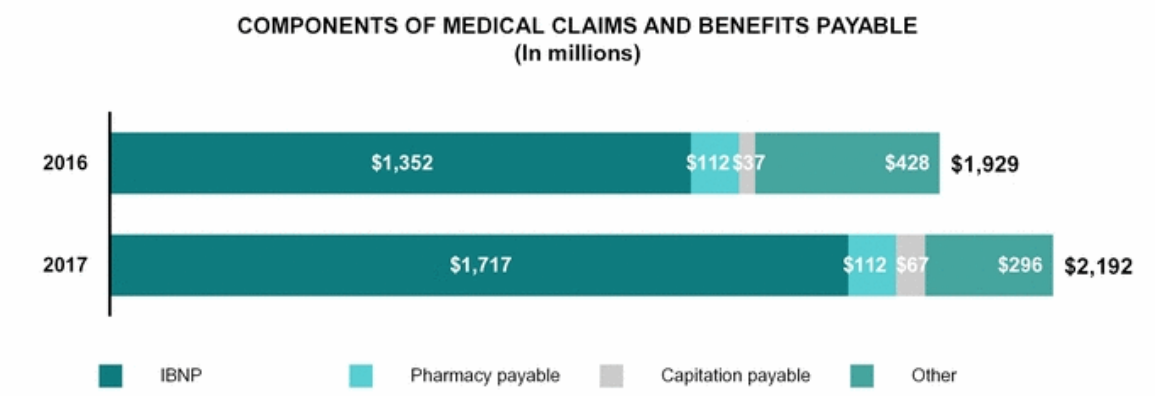
Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable.* See discussion below, and refer to the Notes to Consolidated Financial Statements, Note 10, "Medical Claims and Benefits Payable."
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Health Plans segment quality incentives.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Goodwill and intangible assets, net.* See discussion below, and refer to the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net."

MEDICAL CLAIMS AND BENEFITS PAYABLE - HEALTH PLANS SEGMENT



"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. As of December 31, 2017 and 2016, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $122 million and $225 million, respectively.

The determination of our liability for medical claims and benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for medical claims and benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not yet paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the graph above, our estimated IBNP liability represented $1,717 million of our total medical claims and benefits payable of $2,192 million as of December 31, 2017.

The factors we consider when estimating our IBNP include, without limitation:

- claims receipt and payment experience (and variations in that experience),
- changes in membership,
- provider billing practices,
- health care service utilization trends,
- cost trends,
- product mix,
- seasonality,
- prior authorization of medical services,

- benefit changes,
- known outbreaks of disease or increased incidence of illness such as influenza,
- provider contract changes,
- changes to Medicaid fee schedules, and
- the incidence of high dollar or catastrophic claims.

Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2017 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2017, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in millions.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 527
(4)%	351
(2)%	176
2%	(176)
4%	(351)
6%	(527)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2017 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in millions.

(Decrease) Increase in Trended Per Member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (263)
(4)%	(176)
(2)%	(88)
2%	88
4%	176
6%	263

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 56 million diluted shares outstanding for the year ended December 31, 2017. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2017, net income for the year ended December 31, 2017 would increase or decrease by approximately $55 million, or $0.98 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2017, net income for the year ended December 31, 2017 would increase or decrease by approximately $28 million, or $0.49 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $276 million, or $4.90 per diluted share, and $138 million, or $2.45 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, changes in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $55 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse development in our claims payments for which the base actuarial model is not intended to and does not account. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled, changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development.

We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date.

The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, changes in estimates involving trended PMPM costs will almost always be accompanied by changes in estimates involving completion factors, and vice versa. In such circumstances, changes in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Refer to the Notes to Consolidated Financial Statements, Note 10, “Medical Claims and Benefits Payable,” for additional information regarding the specific factors used to determine our changes in estimates of IBNP, as well as a table presenting the components of the change in our medical claims and benefits payable, for all periods presented in the accompanying consolidated financial statements.

GOODWILL AND INTANGIBLE ASSETS, NET

At December 31, 2017, goodwill and intangible assets, net, represented approximately 3% of total assets and 19% of total stockholders’ equity, compared with 10% and 46%, respectively, at December 31, 2016.

In the year ended December 31, 2017, we recorded impairment losses relating to goodwill and intangible assets, net, of $470 million. These losses included $269 million primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management’s determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan’s future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago. Also during 2017, we recorded impairment losses of $28 million for our Molina Medicaid Solutions segment because management determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment. In addition, we recorded impairment losses of $173 million for our Other segment, primarily relating to our Pathways business, because management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected.

Goodwill

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Such events or circumstances may include experienced or expected operating cash-flow deterioration or losses, significant loss of membership, loss of state funding, loss of state contracts, and other factors.

We conduct our required annual impairment testing of goodwill during the fourth quarter of each year for each of our reporting units that have recorded goodwill. Our reporting units comprise our health plan subsidiaries, and our Molina Medicaid Solutions and Pathways subsidiaries. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value, we perform the quantitative assessment. We may also elect to bypass the qualitative assessment and proceed directly to the quantitative assessment. We believe that the dynamic economic and political environments in which we operate often necessitate the performance of the quantitative test to prove that goodwill is not impaired on an annual basis. As of December 31, 2017, we performed qualitative impairment tests for our Michigan, Washington and Wisconsin health plans; based on these tests, we do not believe that it is more likely than not that the carrying value of these reporting units would exceed their estimated fair values.

As of December 31, 2017, we performed quantitative impairment tests for our Florida, Illinois, New Mexico, New York and South Carolina health plans, and our Molina Medicaid Solutions subsidiary.

We estimated the fair values of our reporting units using the higher of the income approach using discounted cash flows, or the asset liquidation method. For the annual impairment test, the base year in the reporting units’ discounted cash flows is derived from the most recent annual financial budgeting cycle, for which the planning process commences in the fourth quarter of the year. When computing discounted cash flows, we make assumptions about a wide variety of internal and external factors, and consider what the reporting unit’s selling price would be in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. When determining the discount rate, we consider the overall level of inherent risk of the reporting unit, and the expected rate an outside investor would expect to earn. The asset liquidation method is computed as total assets minus total liabilities, excluding intangible assets and liabilities.

Key assumptions in our cash flow projections, including changes in membership, premium rates, health care and operating cost trends, and contract renewals and the procurement of new contracts, are consistent with those used in our long-range business plan and annual planning process. If these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected.

Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss, and adjusted if necessary for the impact of tax deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit.

For our South Carolina health plan and our Molina Medicaid Solutions subsidiary, whose goodwill was not impaired as of December 31, 2017, their estimated fair values exceeded their carrying amounts by 46% and 9%, respectively. The Molina Medicaid Solutions' reporting unit recorded a goodwill impairment loss as of September 30, 2017; therefore its estimated fair value did not substantially exceed its carrying amount as of December 31, 2017.

Refer to Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," for further details on the goodwill impairment losses recorded in 2017.

No goodwill impairment charges were recorded in the years ended December 31, 2016, or 2015.

Intangible Assets

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators, including the ability of our health plan subsidiaries to obtain the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

Refer to Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," for further details on the intangible impairment losses recorded in 2017.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2016, or 2015.

SUPPLEMENTAL INFORMATION

FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

EBITDA*

We believe that EBITDA* is particularly helpful in assessing our ability to meet the cash demands of our operating units. The following table reconciles net (loss) income, which we believe to be the most comparable GAAP measure, to EBITDA*.

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Net (loss) income	$ (512)	$ 52	$ 143
Adjustments:			
Depreciation, and amortization of intangible assets and capitalized software	165	161	120
Interest expense	118	101	66
Income tax (benefit) expense	(100)	153	179
EBITDA*	$ (329)	$ 467	$ 508

ADJUSTED NET (LOSS) INCOME* AND ADJUSTED NET (LOSS) INCOME PER SHARE*

We believe that adjusted net (loss) income* and adjusted net (loss) income per diluted share* are very helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net (loss) income, which we believe to be the most comparable GAAP measure, to adjusted net (loss) income*.

	Year Ended December 31,					
	2017		2016		2015	
	(In millions, except diluted per-share amounts)					
	Amount	Per share	Amount	Per share	Amount	Per share
Net (loss) income	$ (512)	$ (9.07)	$ 52	$ 0.92	$ 143	$ 2.58
Adjustment:						
Amortization of intangible assets	30	0.55	32	0.57	18	0.32
Income tax effect [1]	(11)	(0.20)	(12)	(0.21)	(7)	(0.12)
Amortization of intangible assets, net of tax effect	19	0.35	20	0.36	11	0.20
Adjusted net (loss) income*	$ (493)	$ (8.72)	$ 72	$ 1.28	$ 154	$ 2.78

(1)Income tax effect of adjustments calculated at the blended federal and state statutory tax rate of 37%.

OTHER FINANCIAL DATA

SELECTED FINANCIAL DATA

(In millions, except per-share amounts)

	Year Ended December 31,				
	2017	2016	2015	2014	2013
Statements of Operations Data:					
Revenue:					
Premium revenue [1]	$ 18,854	$ 16,445	$ 13,261	$ 9,035	$ 6,179
Service revenue [2]	521	539	253	210	205
Premium tax revenue	438	468	397	294	172
Health insurer fees reimbursed [1]	—	292	244	108	—
Investment income and other revenue	70	38	23	20	33
Total revenue	19,883	17,782	14,178	9,667	6,589
Operating expenses:					
Medical care costs	17,073	14,774	11,794	8,076	5,380
Cost of service revenue [2]	492	485	193	157	161
General and administrative expenses	1,594	1,393	1,146	765	666
Premium tax expenses	438	468	397	294	172
Health insurer fee	—	217	157	89	—
Depreciation and amortization	137	139	104	93	73
Impairment losses	470	—	—	—	—
Restructuring and separation costs	234	—	—	—	—
Total operating expenses	20,438	17,476	13,791	9,474	6,452
Operating (loss) income	(555)	306	387	193	137
Other expenses, net:					
Interest expense	118	101	66	57	52
Other (income) expense, net	(61)	—	(1)	1	4
Total other expenses, net	57	101	65	58	56
(Loss) income from continuing operations before income taxes	(612)	205	322	135	81
Income tax (benefit) expense	(100)	153	179	73	36
(Loss) income from continuing operations	(512)	52	143	62	45
Income from discontinued operations, net of tax benefit [3]	—	—	—	—	8
Net (loss) income	$ (512)	$ 52	$ 143	$ 62	$ 53
Basic net (loss) income per share: [4]					
(Loss) income from continuing operations	$ (9.07)	$ 0.93	$ 2.75	$ 1.34	$ 0.98
(Loss) income from discontinued operations	—	—	—	(0.01)	0.18
Basic net (loss) income per share	$ (9.07)	$ 0.93	$ 2.75	$ 1.33	$ 1.16
Diluted net (loss) income per share: [4]					
(Loss) income from continuing operations	$ (9.07)	$ 0.92	$ 2.58	$ 1.30	$ 0.96
(Loss) income from discontinued operations	—	—	—	(0.01)	0.17
Diluted net (loss) income per share	$ (9.07)	$ 0.92	$ 2.58	$ 1.29	$ 1.13
Weighted average shares outstanding:					
Basic	56	55	52	47	46
Diluted	56	56	56	48	47

(1) The Centers for Medicare and Medicaid Services (CMS) incorporates the Health Insurer Fee (HIF) in our Medicare and

Marketplace premium rates. We have therefore reclassified such amounts in our consolidated statements of operations to premium revenue, from health insurer fees reimbursed, for all applicable periods presented. The amounts reclassified from health insurer fees reimbursed to premium revenue for years ended December 31, 2016, 2015, and 2014, amounted to $53 million, $20 million and $12 million, respectively.

(2) Service revenue and cost of service revenue include revenue and costs generated by our Pathways subsidiary, which was acquired on November 1, 2015.

(3) Income from discontinued operations is presented net of income tax benefit, which was insignificant in 2017, 2016, 2015 and 2014 and $10, in 2013, respectively.

(4) Source data for calculations in thousands.

	December 31,				
	2017	2016	2015	2014	2013
Balance Sheet Data:					
Cash and cash equivalents	$ 3,186	$ 2,819	$ 2,329	$ 1,539	$ 936
Total assets	8,471	7,449	6,576	4,435	2,988
Long-term debt, including current portion [1]	2,169	1,645	1,609	887	770
Total liabilities	7,134	5,800	5,019	3,425	2,095
Stockholders' equity	1,337	1,649	1,557	1,010	893

(1) Includes long-term debt and lease financing obligations.

STOCK REPURCHASE PROGRAMS

Purchases of common stock made by us, or on our behalf during the quarter ended December 31, 2017, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share [1]	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
October 1 — October 31	163	$ 68.76	—	$ —
November 1 — November 30	—	$ —	—	$ —
December 1 — December 31	12,699	$ 73.83	—	$ —
	12,862	$ 73.77	—	

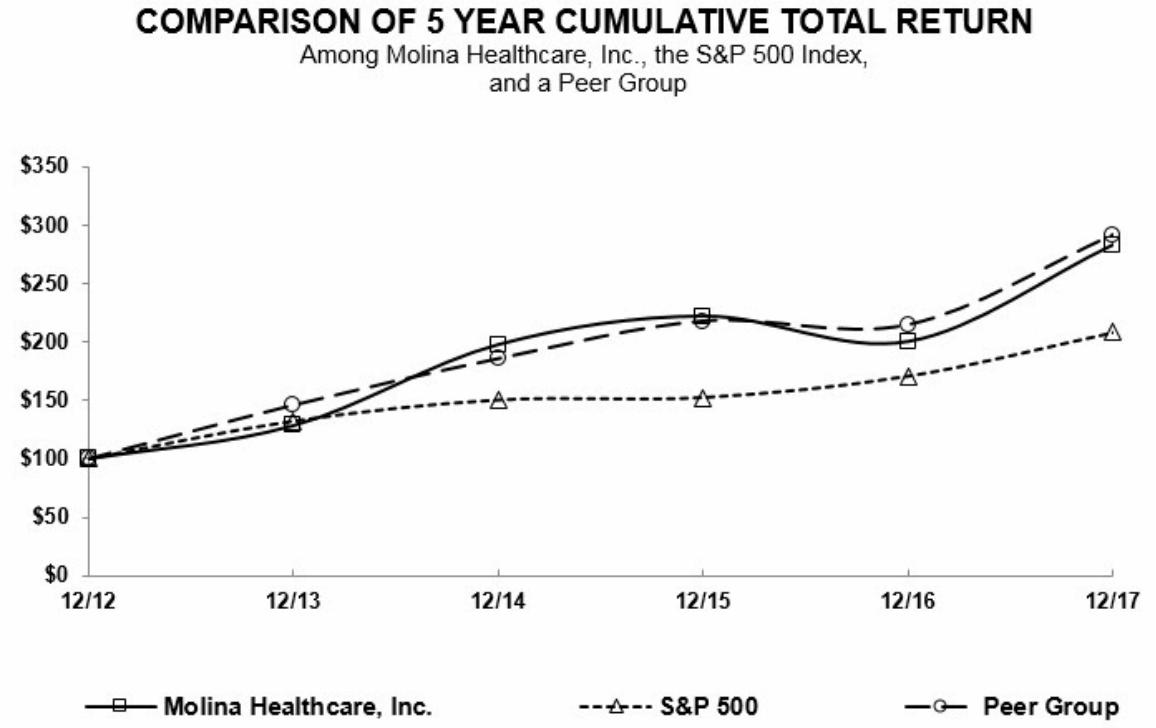
(1) During the quarter ended December 31, 2017, we withheld 12,862 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the U.S. Securities and Exchange Commission (SEC) (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that we specifically incorporate it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (S&P 500) and a peer group index for the five-year period from December 31, 2012 to December 31, 2017. The comparison assumes $100 was invested on December 31, 2012, in our common stock and in each of the foregoing indices and

assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.



The peer group index consists of Centene Corporation (CNC), Cigna Corporation (CI), DaVita HealthCare Partners, Inc. (DVA), Humana Inc. (HUM), Magellan Health, Inc. (MGLN), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).

STOCK PRICE RANGE AND DIVIDENDS

Our common stock is listed on the New York Stock Exchange under the trading symbol “MOH.” As of February 23, 2018, there were 34 holders of record of our common stock.

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business operations. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Additionally, the indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain various covenants that limit our ability to pay dividends on our common stock.

Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

PROPERTIES

As of December 31, 2017, the Health Plans segment leased a total of 71 facilities, the Molina Medicaid Solutions segment leased a total of 13 facilities and the Other segment leased a total of 260 facilities. We own a 186,000 square-foot office building in Troy, Michigan and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. We own a 26,700 square foot data center in Albuquerque, New Mexico and 42 properties in Pennsylvania, which are primarily residential housing facilities, under our Other segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operational growth prospects to determine if additional space is required, and where it would be best located.

EMPLOYEES

As of December 31, 2017, we had approximately 20,000 employees. Our employee base is multicultural and reflects the diverse membership we serve.

AVAILABLE INFORMATION

Dr. C. David Molina founded our Company in 1980 as a provider organization serving low-income families in Southern California. We were originally organized in California as a holding company for our initial health plan and reincorporated in Delaware in 2002. Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

You can access our website at *www.molinahealthcare.com* to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Form 10-K or any other SEC filings.

RISK FACTORS

You should carefully consider the risks described below and all of the other information set forth in this Form 10-K, including our consolidated financial statements and accompanying notes. These risks and other factors may affect our forward-looking statements, including those we make in this annual report or elsewhere, such as in press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. The risks described below are not the only risks facing our Company. Additional risks that we are unaware of, or that we currently believe are not material, may also become important factors that adversely affect our business. If any of the following risks actually occurs, our business, financial condition, results of operations, and future prospects could be materially and adversely affected. In that event, among other effects, the trading price of our common stock could decline, and you could lose part or all of your investment.

Risks Related to Our Business

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed on favorable terms or at all, our premium revenues could be materially reduced and our operating results could be negatively impacted.

We currently derive our premium revenues from 13 state health plans and our health plan in the Commonwealth of Puerto Rico. Measured by ending membership by health plan as of December 31, 2017, our top four health plans were in Washington, California, Florida, and Texas, with an aggregate of 2,578,000 members, or approximately 58% of total membership. If we are unable to continue to operate in any of our existing jurisdictions, or if our current operations in any portion of those jurisdictions are significantly curtailed or terminated entirely, our revenues could decrease materially.

Many of our government contracts for the provision of managed care programs to people receiving government assistance are effective only for a fixed period of time and may be extended for an additional period of time if the contracting entity or its agent elects to do so. When such contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that the contracts will be renewed or extended. For example, our current Medicaid contract with the Florida Agency for Health Care Administration (“AHCA”) expires on December 31, 2018. As of December 31, 2017, our Florida health plan served approximately 360,000 Medicaid members. On February 1, 2018, AHCA notified our Florida health plan that it was only granted the opportunity to bid on a post-December 31, 2018 managed care contract for a single region in Florida (which consisted of approximately 59,000 Medicaid members as of December 31, 2017), as opposed to the eight regions covered by our existing contract. As yet another example, our New Mexico health plan’s current Medicaid contract with the New Mexico Human Services Department (“HSD”) will also expire on December 31, 2018. On January 8, 2018, HSD notified our New Mexico health plan that it had not been selected to bid on a post December 31, 2018 managed care contract. Our New Mexico health plan served approximately 224,000 Medicaid members as of December 31, 2017. We have filed a protest with regard to HSD’s decision, and as appropriate we will pursue all protest rights and rights of appeal with regard to AHCA’s decision. However, there can be no assurances that any

protest filing in either New Mexico or Florida will be successful, and as a result we may lose the applicable Medicaid membership as of the end of 2018.

In any bidding process, our health plans may face competition from numerous other health plans, many with greater financial resources and greater name recognition than we have. For example, the following three health plans have upcoming requests for proposal, or RFPs:

- The Texas Health and Human Service Commission (HHSC) currently contracts with five STAR+PLUS (ABD) plans: Anthem, Cigna, Centene, United Healthcare and Molina. Our Texas health plan served a total of approximately 430,000 members as of December 31, 2017. The Texas STAR+PLUS RFP was issued on December 4, 2017, proposals are due March 6, 2018, and the new contracts that are awarded will be effective January 1, 2020 through August 31, 2022. If the RFP responsive bid of our Texas health plan is not successful, or if our Texas health plan's contract with HHSC is not renewed, or if it is renewed but coverage is reduced, our revenues would be materially and adversely impacted.
- The Washington State Health Care Authority (HCA) currently contracts with five Apple Health plans: Anthem, Community Health Plan of Washington, Centene, United Healthcare and Molina. Our Washington health plan served a total of approximately 777,000 members as of December 31, 2017. The Washington Fully Integrated Managed Care RFP issued on February 16, 2018, is the third of three re-procurement RFPs for all Medicaid lives in Washington state. Proposals for the third and final RFP are due April 12, 2018, and five of the seven largest regions contracts that are awarded will be effective January 1, 2019. The remaining two will be effective on January 1, 2020. The HCA has indicated that fewer than five MCOs will be awarded re-procurement contracts in three of the seven remaining regions. If the RFP responsive bid of our Washington health plan is not successful, or if our Washington health plan's contract with HCA is not renewed, or if it is renewed but coverage is reduced, our revenues would be materially and adversely impacted.
- The Puerto Rico Health Insurance Administration (ASES) currently contracts with five Government Health plans: First Medical, MMM and its subsidiary PMC, Triple-S, and Molina. Our Puerto Rico health plan had approximately 314,000 members as of December 31, 2017. The Puerto Rico Government Health Plan RFP was issued on February 9, 2018, proposals are due May 25, 2018, and the new contracts that are awarded will be effective October 1, 2018 through June 30, 2021, with a one-year option to June 30, 2022. If the RFP responsive bid of our Puerto Rico health plan is not successful, or if our Puerto Rico health plan's contract with ASES is not renewed, or if it is renewed but coverage is reduced, our revenues would be materially and adversely impacted.

Even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or, in extreme cases, could result in a net loss. Furthermore, our government contracts contain certain provisions regarding, among other things, eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and information reporting, quality assurance and timeliness of claims payment, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

If any of our governmental contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business and reputation may be adversely impacted, and our financial position, results of operations or cash flows could be materially and adversely affected. In addition, we may be unable to support the carrying amount of goodwill we have recorded for the applicable business, because its fair value estimated future cash flows.

If our attempts to retain our contracts in Florida and/or New Mexico are not successful, of if we lose other contracts that constitute a significant amount of our revenue, we will lose the administrative cost efficiencies that are inherent in a large revenue base. In such circumstances, we may not be able to reduce fixed costs proportionally with our lower revenue, and the financial impact of lost contracts may exceed the net income ascribed to those contracts.

We are currently able to spread the cost of centralized services over a large revenue base. Many of our administrative costs are fixed in nature, and will be incurred at the same level regardless of the size of our revenue base. If our attempts to retain our contracts in Florida and /or New Mexico are not successful, or if we lose other contracts that constitute a significant amount of our revenue, we may not be able to reduce the expense of centralized services in a manner that is proportional to that loss of revenue. In such circumstances, not only will our total dollar margins decline, but our percentage margins, measured as a percentage of revenue, will also decline. This loss of cost efficiency, and the resulting stranded administrative costs, could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

If, in the interests of maintaining or improving longer term profitability, we decide to exit voluntarily certain state contractual arrangements, make changes to our provider networks, or make changes to our administrative infrastructure, we may incur short- to medium-term disruptions to our business that could materially reduce our premium revenues and our net income.

Decisions that we make with regard to retaining or exiting our portfolio of state and Federal contracts, and changes to the manner in which we serve the members attached to those contracts, could generate substantial expenses associated with the run out of existing operations and the restructuring of those of operations that remain. Such expense could include, but would not be limited to, goodwill and intangible asset impairment charges, restructuring costs, additional medical costs incurred due to the inability to leverage long-term relationships with medical providers, and costs incurred to finish the run out of businesses that have ceased to generate revenue.

If we are unable to successfully execute our profit maintenance and improvement initiatives and our restructuring plans, or if we fail to realize the anticipated benefits of those initiatives and plans, our business, cash flows, financial position, or results of operations could be materially and adversely affected.

In August 2017, we announced the implementation of a comprehensive restructuring and profitability improvement plan. The restructuring plan includes the streamlining of our organizational structure, the re-design of certain core operating processes, the remediation of high cost provider contracts, the restructuring of our direct delivery operations, and the review of our vendor base in an attempt to insure that we are partnering with the lowest cost, most effective, vendors. As part of the restructuring plan, we reduced our corporate and health plans workforce by approximately 16%. For the year ended December 31, 2017, we reported restructuring and separation costs of $234 million.

In addition, in the second half of 2017, we launched several profit maintenance and improvement initiatives. We anticipate pursuing additional profit maintenance and improvement initiatives throughout 2018.

Our restructuring plan and profit improvement initiatives create numerous uncertainties, including the effect of the initiatives and plan on our business, operations, revenues, and profitability, potential disruptions to our business as a result of management's attention to the initiatives and plan, uncertainty regarding the potential amount and timing of future cost savings associated with the initiatives and plan, and the potential negative impact of the initiatives and plan on employee morale. The success of the initiatives and plan will depend, in part, on factors that are beyond our control. Accordingly, we can provide no assurance that the goals of the initiatives and plan will be fully achieved. Failure in this regard could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such IBNP medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, is negatively impacted by the more limited experience we have had with those populations.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

We are subject to retroactive adjustment to our Medicaid premium revenue as a result of retroactive risk adjustment; retroactive changes to contract terms and the resolution of differing interpretations of those terms; the difficulty of estimating performance-based premium; and retroactive adjustments to "blended" premium rates to reflect the actual mix of members captured in those blended rates.

The complexity of some of our Medicaid contract provisions; imprecise language in those contracts, the desire of state Medicaid agencies in some circumstances to retroactively adjust for the acuity of the medical needs of our members; and state delays in processing rate changes can create uncertainty around the amount of revenue we should recognize.

For example, in February 2017, the New Mexico Human Services Department (HSD) notified us that it had disallowed certain medically related administrative expenses and other items in the computation of its Medicaid Expansion risk corridor; this corridor was effective January 1, 2014, through December 31, 2016. As a result of this action, income before taxes at the New Mexico health plan was reduced by $45 million for the year ended December 31, 2016. Of this amount, $29 million related to dates of service prior to 2016.

A current example of exposure to this risk is in California, where the state Medicaid agency is several years behind in its reconciliation and settlement with us of the difference between expenses that it has paid on our behalf to providers of long term services and supports, and the amounts that it has withheld from our premium for those expenses; and has yet to share with us certain premium rates related to July 2017 through December 2017.

Any circumstance such as those described above could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to accurately predict and effectively manage our medical care costs, our operating results could be materially and adversely affected.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio of 90.6%, for the year ended December 31, 2017 had been one percentage point higher, or 91.6%, our net loss per diluted share for the year ended December 31, 2017 would have been approximately $11.17 rather than our actual net loss per diluted share of $9.07, a difference of $2.10.

Many factors may affect our medical care costs, including:

- the level of utilization of health care services,
- unexpected patterns in the annual flu season,
- increases in hospital costs,
- increased incidences or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage,
- increased maternity costs,
- payment rates that are not actuarially sound,
- changes in state eligibility certification methodologies,
- relatively low levels of hospital and specialty provider competition in certain geographic areas,
- increases in the cost of pharmaceutical products and services,
- changes in health care regulations and practices,
- epidemics,
- new medical technologies, and
- other various external factors.

Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we are unable to collect health insurer fee (HIF) reimbursement from our state partners, our business, cash flows, financial position, or results of operations could be materially and adversely affected.

Because Medicaid is a government funded program, Medicaid health plans must request reimbursement for the HIF from respective state partners to offset the impact of this tax. When states reimburse us for the amount of the HIF,

that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. Based on our previous years' experience, we expect to ultimately recognize revenue sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2018. However, we are uncertain as to the timing of such reimbursements. We expect this HIF assessment, related to our Medicaid business, to be approximately $232 million, with an expected tax effect from the reimbursement of the assessment of approximately $63 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $295 million. The delay or failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2017, the carrying amounts of goodwill and intangible assets, net, amounted to $186 million, and $69 million, respectively.

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss, and adjusted if necessary for the impact of tax deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit.

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

Key assumptions in our cash flow projections, including changes in membership, premium rates, health care and operating cost trends, and contract renewals and the procurement of new contracts, are consistent with those used in our long-range business plan and annual planning process. If these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected.

An event or events could occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net. For example, if the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states. If such state health plans have recorded goodwill and intangible assets, net, the contract loss would result in a non-cash impairment charge. Additionally, if we are unable to procure new state MMIS contracts, the outcome of our goodwill impairment tests could be adversely affected and result in a non-cash impairment charge. Such a non-cash impairment charge could have a material adverse impact on our financial results.

We incurred non-cash impairment losses of $470 million in 2017. These losses included $269 million, primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management's determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago.

Also during 2017, we recorded impairment losses of $28 million for our Molina Medicaid Solutions segment because management determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment than previously anticipated. In addition, we recorded impairment losses of $173 million for our Other segment, primarily relating to our Pathways business, because management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected.

We operate in an unstable political environment which creates uncertainties with regard to the sources and amounts of our revenues, volatility with regard to the amount of our medical costs, and vulnerability to unforeseen programmatic or regulatory changes.

As a result of the election of President Trump and the GOP control of both houses of Congress, the future of the ACA and its underlying programs are subject to substantial uncertainty, making long-term business planning exceedingly difficult. We are unable to predict with any degree of certainty whether the ACA will be modified or repealed in its entirety, and if it is repealed, what it will be replaced with; nor are we able to predict when any such changes, if enacted, would become effective.

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following: ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers; reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults; changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap"); requiring Medicaid beneficiaries to work; limiting the amount of lifetime benefits for Medicaid beneficiaries; prohibiting the federal government from operating Marketplaces; eliminating the advanced premium tax credits, and cost sharing reductions for low income individuals who purchase their health insurance through the Marketplaces; expanding and encouraging the use of private health savings accounts; providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans; establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; allowing insurers to sell insurance across state lines; and numerous other potential changes and reforms. Changes to or the repeal of the ACA, or the adoption of new health care regulatory laws, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A reversal of the Medicaid Expansion would have a negative impact on our revenues.

In the states that have elected to participate, the ACA provided for the expansion of the Medicaid program to offer eligibility to nearly all individuals under age 65 with incomes at or below 138% of the federal poverty line. Since January 1, 2014, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have participated in the Medicaid Expansion program under the ACA. At December 31, 2017, our membership included approximately 668,000 Medicaid Expansion members, or 15% of our total membership. If the Medicaid Expansion is reversed by repeal of the ACA or otherwise, we could lose this membership, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our participation in the Marketplace creates certain risks which could adversely impact our business, financial position, and results of operations.

The ACA authorized the creation of marketplace insurance exchanges (the "Marketplace"), allowing individuals and small groups to purchase federally subsidized health insurance. As of December 31, 2017, we participated in the individual Marketplace in nine states and our Marketplace membership represented 19% of our total membership, or approximately 815,000 members. In an effort to reduce our exposure to the risks related to the Marketplace, we implemented premium increases averaging 58% effective January 1, 2018 and we exited the Marketplace in Utah and Wisconsin. These market exits and price increases have resulted in substantially lower Marketplace membership.

A number of larger commercial insurance plans, including Humana Inc., have discontinued their participation in the Marketplace. The perceived instability and impending changes in the Marketplace could further promote reduced participation among the uninsured. Further, the withdrawal of cost sharing subsidies and/or premium tax credits, the elimination of the individual mandate to purchase health insurance in December 2017, the use of special enrollment periods, or any announcement that some or all of our health plans will be leaving the Marketplace for 2018, could additionally impact Marketplace enrollment. These market and political dynamics may increase the risk that our Marketplace products will be selected by individuals who have a higher risk profile or utilization rate than we anticipated when we established the pricing for our Marketplace products, leading to financial losses.

The Medicare-Medicaid Duals Demonstration Pilot Programs could be discontinued or altered, resulting in a loss of premium revenue.

To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligibles"), and to deliver services to these individuals in a more financially efficient manner, under the direction of CMS some states implemented demonstration pilot programs to integrate Medicare and Medicaid services for dual eligibles.

The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states: California, Illinois, Michigan, Ohio, South Carolina, and Texas. At December 31, 2017, our membership included approximately 57,000 integrated MMP members, representing just over 1% of our total membership. However, the capitation payments paid to us for dual eligibles are significantly higher than the capitation payments for other members, representing 8% of our total premium revenues in 2017. If the states running the MMP pilot programs conclude that the demonstration pilot programs are not delivering better coordinated care and reduced costs, they could decide to discontinue or substantially alter such programs, resulting in a reduction to our premium revenues.

Continuing changes in health care laws, and in the health care industry, make it difficult to develop actuarially sound rates.

Comprehensive changes to the U.S. health care system make it more difficult for us to manage our business, and increase the likelihood that the assumptions we make with respect to our future operations and results will prove to be inaccurate. The continuing pace of change has made it difficult for us to develop actuarially sound rates because we have limited historical information on which to develop these rates. In the absence of significant historical information to develop actuarial rates, we must make certain assumptions. These assumptions may subsequently prove to be inaccurate. For example, rates of utilization could be significantly higher than we projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, our lack of actuarial experience for a particular program, region, or population, could cause us to set our reserves at an inadequate level.

Our health plans segment operates with very low profit margins, and small changes in operating performance or slight changes to our accounting estimates will have a disproportionate impact on our reported net income.

A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost-plus and performance-based reimbursement programs. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are potentially subject to differing interpretations by ourselves and the relevant government agency with whom we contract. If the applicable government agency disagrees with our interpretation or implementation of a particular contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to such government agency. Any interpretation of these contract provisions by the applicable governmental agency that varies from our interpretation and implementation of the provision, or that is inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. If we are unsuccessful in achieving the stated performance measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

If we are unable to deliver quality care, and maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay to such providers and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, cash flows, or results of operations.

The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

Introduction of new high cost specialty drugs and sudden costs spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our capitation rates are not adequate to cover the actual pharmacy costs, which jeopardizes the overall actuarial soundness of our rates. Bearing the high costs of new specialty drugs or the high cost inflation of generic drugs without an appropriate rate adjustment or other reimbursement mechanism has an adverse impact on our financial condition and results of operations. For example, Gilead priced a new hepatitis C drug, Sovaldi, at $84,000 per standard course of therapy in 2014. With the advent of Sovaldi in early 2014, the cost of the drug was generally not factored into our 2014 capitation rates which undermined the actuarial soundness of those rates. Further, the relatively high incidence of hepatitis C in Medicaid populations coupled with the exorbitant cost of Sovaldi created a public health and public financing problem across the country. More recently, the FDA approved the first drug to treat patients with spinal muscular atrophy, Spinraza, in December 2016. After this approval, the distributor of Spinraza announced that one dose will have a list price of $125,000, which means the drug will cost between $650,000 and $750,000 to cover the five or six doses required in the first year, and approximately $375,000 annually thereafter, presumably for the life of the patient. The inordinate cost of Spinraza was not contemplated in the development of our 2017 capitation rates. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. Although we will continue to work with state Medicaid agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends, there can be no assurance that we will always be successful.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plans are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have a material adverse effect on our business, cash flows, or results of operations.

Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Due to insolvency or other circumstances, such providers may be unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so; or we have already paid claims to a delegated provider and such payments cannot be recouped when the

delegated provider becomes insolvent. Liabilities incurred or losses suffered as a result of provider insolvency could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures. As discussed below, such budgetary pressures are particularly intense in the Commonwealth of Puerto Rico. State budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

We are unable to determine how any future congressional spending cuts will affect Medicare and Medicaid reimbursement. We believe there will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one or more of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Furthermore, a state or commonwealth undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state in which we operate a health plan does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

The Commonwealth of Puerto Rico may fail to pay the premiums of our Puerto Rico health plan, which could negatively impact our business, financial condition, cash flows, or results of operations.

The government of Puerto Rico continues to struggle with major fiscal and liquidity challenges. The extreme financial difficulties faced by the Commonwealth may make it very difficult for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2017, our Puerto Rico health plan served approximately 314,000 members, and had recognized premium revenue of approximately $179 million in the fourth quarter of 2017, or approximately $60 million per month. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In February 2018, ASES issued an RFP in connection with a new island-wide re-procurement for Medicaid. In the event we do not participate in the re-procurement, or if the responsive bid of our Puerto Rico health plan is unsuccessful, our current contract with ASES will expire without renewal as of December 31, 2018. Our exit from the Commonwealth may result in disruptions to our business, and cause us to incur stranded overhead costs.

Large-scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.

Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions. For example, natural disasters, such as a major earthquake in Los Angeles or Cascadia, or a major hurricane in Florida or South Carolina, could have a significant impact on the health of a large number of our covered members. Other conditions that could impact our members include a virulent influenza season or epidemic, or newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikungunya virus, conditions for which vaccines may not exist, are not effective, or have not been widely administered.

In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction. All of these conditions, and others, could have a significant impact on the health of the population of wide-spread areas. We seek to set our IBNP reserves appropriately to account for anticipatable spikes in utilization, such as for the flu season. However, if one of our health plan states were to experience a large-scale natural disaster, a viral epidemic or pandemic, a significant terrorism attack, or some other large-scale event affecting the health of a large number of our members, our covered medical expenses in that state would rise, which could have a material adverse effect on our business, cash flows, financial condition, or results of operations.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets in, and conduct most of our operations through, our direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. We received $245 million, $100 million, and $125 million in dividends from our regulated health plan subsidiaries during 2017, 2016 and 2015, respectively. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2017 and 2016, without approval of the regulatory authorities, were approximately $85 million and $201 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our senior notes or revolving credit facility (Credit Facility).

Our use and disclosure of personally identifiable information and other non-public information, including protected health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations including, but not limited to, HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of personally identifiable information (PII), including protected health information, or PHI. HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities and business associates, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when

submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, PII, or non-public information, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal penalties, divert management's time and energy, and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, upcoding, payments made to excluded providers, improper marketing, and the violation of patient privacy rights. In particular, there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices, particularly in the Medicare program. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services (HHS), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. We have been the subject of *qui tam* actions in the past and other *qui tam* actions may be filed against us in the future. If we are subject to liability under a *qui tam* or other actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process

claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, the new business would fail. We also could be required by the state or commonwealth to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our start-up costs.

Even if we are successful in establishing a profitable health plan in a new jurisdiction, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing jurisdiction will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis, or at all, the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new jurisdiction, or expanding a health plan in an existing jurisdiction could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, stock price, and result in our inability to maintain compliance with applicable stock exchange listing requirements.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses.

We have identified material weaknesses in our internal control over financial reporting in the past, which have subsequently been remediated. If additional material weaknesses in our internal control over financial reporting are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results.

Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are unable to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the New York Stock Exchange, SEC, or other regulatory authorities which would require additional financial and management resources.

This Form 10-K reflects management's conclusion regarding the effectiveness of our disclosure controls and procedures and internal control over financial reporting as of December 31, 2017. See “Management and Auditor’s Reports - Management’s Evaluation of Disclosure Controls and Procedures and Management’s Report on Internal Control Over Financial Reporting.”

We are dependent on the leadership of our new chief executive officer and other executive officers and key employees.

In May 2017, our board of directors terminated both our former chief executive officer and our former chief financial officer. On November 6, 2017, following an intensive six month executive search effort, the board hired Mr. Joseph Zubretsky as our new chief executive officer. Mr. Zubretsky, in turn, has hired other senior level executives. Under the leadership and direction of Mr. Zubretsky, our executive team has launched a vigorous turnaround plan, including many profit improvement initiatives. Our turnaround plan and operational improvements are highly dependent on the efforts of Mr. Zubretsky and our other key executive officers and employees. The loss of their leadership, expertise, and experience could negatively impact our operations. Our ability to replace them or any other key employee may be difficult and may take an extended period of time because of the limited number of individuals in the health care industry who have the breadth and depth of skills and experience necessary to operate and lead a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain, or motivate these personnel. If we are unsuccessful in recruiting, retaining, managing, and motivating such personnel, our business, financial condition, cash flows, or results of operations may be adversely affected.

We face various risks inherent in the government contracting process that could materially and adversely affect our business and profitability, including periodic routine and non-routine reviews, audits, and investigations by government agencies.

We are subject to various risks inherent in the government contracting process. These risks include routine and non-routine governmental reviews, audits, and investigations, and compliance with government reporting requirements. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our government contracts, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

If we sustain a cyber-attack or suffer privacy or data security breaches that disrupt our information systems or operations, or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. To ensure information security, we have implemented controls to protect the confidentiality, integrity and availability of this data and the systems that store and transmit such data. However, our information technology systems and safety control systems are subject to a growing number of threats from computer programmers, hackers, and other adversaries that may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause damage, security issues, or shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit security vulnerabilities. Because the techniques used to circumvent, gain access to, or sabotage security systems can be highly sophisticated and change frequently, they often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world. We may be unable to anticipate these techniques or implement adequate preventive measures, resulting in potential data loss and damage to our systems. Our systems are also subject to compromise from internal threats such as improper action by employees including malicious insiders, vendors, counterparties, and other third parties with otherwise legitimate access to our systems. Our policies, employee training (including phishing prevention training), procedures and technical safeguards may not prevent all improper access to our network or proprietary or confidential information by employees, vendors, counterparties, or other third parties. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, or other similar events that could negatively affect our systems and our and our members' data.

Moreover, we face the ongoing challenge of managing access controls in a complex environment. The process of enhancing our protective measures can itself create a risk of systems disruptions and security issues. Given the breadth of our operations and increasing sophistication of cyberattacks, a particular incident could occur and persist for an extended period of time before being detected. The extent of a particular cyberattack and the steps that we may need to take to investigate the attack may take a significant amount of time before such an investigation could be completed and full and reliable information about the incident is known. During such time, the extent of any harm or how best to remediate it might not be known, which could further increase the risks, costs, and consequences of a data security incident. In addition, our systems must be routinely updated, patched, and upgraded to protect against known vulnerabilities. The volume of new software vulnerabilities has increased substantially, as has the importance of patches and other remedial measures. In addition to remediating newly identified vulnerabilities, previously identified vulnerabilities must also be updated. We are at risk that cyber attackers exploit these known vulnerabilities before they have been addressed. The complexity of our systems and platforms that we operate, the increased frequency at which vendors are issuing security patches to their products, our need to test patches, and in some instances, coordinate with third-parties before they can be deployed, all could further increase our risks. The increased use of mobile devices and other technologies can heighten these and other risks. Furthermore, certain aspects of the security of various technologies are unpredictable or beyond our control.

The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. We may need to expend significant additional resources in the future to continue to protect

against potential security breaches or to address problems caused by such attacks or any breach of our systems. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us (including but not limited to material fines, damages, consent orders, penalties and/or remediation costs, mandatory disclosure to the media and regulators, or enforcement proceedings), damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could require us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, requiring us to implement additional or different programs and systems, or making it more difficult to predict future results. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Potential divestitures of businesses or product lines may materially adversely affect our business, financial condition, cash flows, or results of operations.

As a part of our business strategy, we continually review our products and business lines across all geographies to identify opportunities for performance improvement. Depending on the particular circumstances, we may determine that a divestiture of one or more businesses or product lines would be the best means to further our plan to improve and sustain profitability and enhance our focus on the execution of our business plan. Divestitures involve risks, including: difficulties in the separation of operations, services, products and personnel; the diversion of management's attention from other business concerns; the disruption of our business; the potential loss of key employees; the retention of uncertain contingent liabilities related to the divested business or product line; and the failure of our efforts to divest any such business or product line on the terms and time frames desired by management, or at all. Furthermore, we may be unsuccessful in finding a replacement for any lost revenue or income previously derived from the divested business or product line. In addition, divestitures may result in significant impairment charges, including those related to goodwill and other intangible assets, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition, cash flows and ability to bid for, and continue to participate in, certain programs.

Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine compliance with performance standards and to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect or correct inaccurate or incomplete encounter data and have been, and continue to be exposed to, operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

We have experienced challenges in obtaining complete and accurate encounter data, due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could

adversely affect the premium rates we receive and how membership is assigned to us and subject us to financial penalties, which could have a material adverse effect on our results of operations, financial condition, cash flows and our ability to bid for, and continue to participate in, certain programs.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, update, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our members and providers also depend upon our information systems for enrollment, primary care and specialist physician roster access, membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. On an ongoing basis, we evaluate the ability of our existing operations to support our current and future business needs and to maintain our compliance requirements. As a result, we periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives, industry trends and recently enacted regulations, and changes in our system platforms. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences.

Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our systems, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, some of our health plans' claims are processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. If there is a major Southern California earthquake, there can be no assurances that our disaster recovery plan will be successful or that the business operations of all our health plans and our Molina Medicaid Solutions segment, including those that are remote from any such event, would not be substantially impacted.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, health care regulatory law-based litigation, breach of contract actions, intellectual property infringement actions, and securities class actions. If we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of our clinics or caused by one of our employees. Given the significant amount of some medical malpractice awards and settlements, the medical malpractice insurance that we maintain may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

We cannot predict the outcome of any lawsuit. Some of the liabilities related to litigation that we may incur may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us. The litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations and service providers. Our health plans segment competes for members principally on the basis of size, location and quality of provider network; benefits supplied; quality of service; and reputation. Our Molina Medicaid Solutions segment competes for government contracts principally on the basis of cost, quality of service, expertise, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to us. Many other organizations with which we compete, including large commercial plans and other service providers, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our business, or may lose business to third parties.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Some of these third-parties also have direct access to our systems. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data or the information and data relating to our members or customers. We are also at risk of a data security incident involving a vendor or third party, which could result in a breakdown of such third party's data protection processes or cyber-attackers gaining access to our infrastructure through the third party. To the extent that a vendor or third party suffers a data security incident that compromises its operations, we could incur significant costs and possible service interruption, which could have an adverse effect on our business and operations. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures or incidents under applicable business associate agreements or other applicable outsourcing agreements. Any contractual remedies and/or indemnification obligations we may have for vendor or service provider failures or incidents may not be adequate to fully compensate us for any losses suffered as a result of any vendor's failure to satisfy its obligations to us or under applicable law. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk, including significant cybersecurity risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs and/or disruption to our operations in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our members or customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our substantial indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of any variable rate debt, and prevent us from meeting our obligations under our outstanding indebtedness.

We have a significant amount of indebtedness. As of December 31, 2017, our total indebtedness was approximately $2,169 million, including lease financing obligations. As of December 31, 2017, we also had $194 million available for borrowing under our Credit Facility. In addition, as of January 2, 2018, we had $550 million available under our Bridge Credit Agreement, subject to the use of proceeds conditions set forth therein.

Our substantial indebtedness could have significant consequences, including:

- increasing our vulnerability to adverse economic, industry, or competitive developments;
- requiring a substantial portion of our cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund operations, make capital expenditures, and pursue future business opportunities;
- exposing us to the risk of increased interest rates to the extent of any future borrowings, including borrowings under our Credit Facility, at variable rates of interest;
- making it more difficult for us to satisfy our obligations with respect to our indebtedness, including our Credit Facility and our outstanding senior notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indenture governing our outstanding senior notes and the agreements governing such other indebtedness;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product and service development, debt service requirements, acquisitions, and general corporate or other purposes; and
- limiting our flexibility in planning for, or reacting to, changes in our business or market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged and who, therefore, may be able to take advantage of opportunities that our substantial indebtedness may prevent us from exploiting.

The terms of our debt impose, and will impose, restrictions on us that may affect our ability to successfully operate our business and our ability to make payments on our outstanding senior notes.

The indentures governing our outstanding senior notes and the credit agreement governing our Credit Facility contain various covenants that could materially and adversely affect our ability to finance our future operations or capital needs and to engage in other business activities that may be in our best interest. These covenants limit our ability to, among other things:

- incur additional indebtedness or issue certain preferred equity;
- pay dividends on, repurchase, or make distributions in respect of our capital stock, prepay, redeem, or repurchase certain debt or make other restricted payments;
- make certain investments;
- create certain liens;
- sell assets, including capital stock of restricted subsidiaries;
- enter into agreements restricting our restricted subsidiaries' ability to pay dividends to us;
- consolidate, merge, sell, or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates; and
- designate our restricted subsidiaries as unrestricted subsidiaries.

All of these covenants may restrict our ability to pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, such as prevailing economic conditions and changes in regulations, and if such events occur, we cannot be sure that we will be able to comply. A breach of these covenants could result in a default under the indentures for our outstanding senior notes and/or the credit agreement

governing our Credit Facility and the Bridge Credit Agreement including, as a result of cross default provisions and, in the case of our Credit Facility and our Bridge Credit Agreement, permit the lenders to cease making loans to us. If there were an event of default under the indentures governing our outstanding senior notes and/or the credit agreement governing our Credit Facility, holders of such defaulted debt could cause all amounts borrowed under these instruments to be due and payable immediately. Our assets or cash flow may not be sufficient to repay borrowings under our outstanding debt instruments in the event of a default thereunder.

In addition, the restrictive covenants in the credit agreement governing our Credit Facility require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests will depend on our ongoing financial and operating performance, which, in turn, will be subject to economic conditions and to financial, market, and competitive factors, many of which are beyond our control.

If our operating performance declines, we may be required to obtain waivers from the lenders under our Credit Facility, from the holders of our outstanding senior notes or from the holders of other obligations, to avoid defaults thereunder. For example, in February 2017, to avoid default under our Credit Facility as a result of our failure to comply with certain financial covenants therein applicable to the three months ended December 31, 2016, we sought, and obtained, a waiver of such defaults by the required lenders under our Credit Facility.

If we are not able to obtain such waivers, our creditors could exercise their rights upon default, and we could be forced into bankruptcy or liquidation.

We may not have the funds necessary to pay the amounts due upon conversion or required repurchase of our outstanding notes, and our indebtedness may contain limitations on our ability to pay the amounts due upon conversion or required repurchase.

As of December 31, 2017, the aggregate outstanding principal amount of our 1.125% cash convertible senior notes due January 15, 2020 (1.125% Convertible Notes), and our 1.625% convertible senior notes due 2044 (1.625% Convertible Notes) was $550 million and $161 million, respectively. Both our 1.125% Convertible Notes and our 1.625% Convertible Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended December 31, 2017, and are convertible to cash through at least March 31, 2018. Because the 1.125% Convertible Notes may be converted into cash within 12 months, their carrying amount is reported in current portion of long-term debt as of December 31, 2017. For economic reasons related to the trading market for our 1.125% Convertible Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Convertible Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Convertible Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Convertible Notes may elect to convert the notes to cash.

The stock price trigger for the 1.625% Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended December 31, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of December 31, 2017.

If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

In addition, in the event of a change in control or the termination in trading of our stock, each holder of our 1.125% Convertible Notes and our 1.625% Convertible Notes would have the right to require us to purchase some or all of their notes at a purchase price in cash equal to 100% of the principal amount of the notes, plus any accrued and unpaid interest.

Our ability to comply with the conversion or repurchase obligations under our 1.125% Convertible Notes and our 1.625% Convertible Notes will depend on the extent to which we have cash or financing available to satisfy such obligations and may also be limited by law, by regulatory authority, or by agreements governing our future indebtedness. The indentures for the 1.125% Convertible Notes and the 1.625% Convertible Notes provide that it would be an event of default if we do not make the cash payments due upon conversion or required repurchase of the notes. The occurrence of an event of default under one or both of these indentures may also constitute an event of default under our Credit Facility, our Bridge Credit Agreement and under our other indebtedness we may have

outstanding at such time. Any such default could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments, including our Credit Facility and Bridge Credit Agreement, and the indentures governing our outstanding senior notes, may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which would harm our ability to incur additional indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies may increase our future borrowing costs and reduce our access to capital.

There can be no assurance that any rating assigned by the rating agencies to our debt or our corporate rating will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, future circumstances relating to the basis of the rating, such as adverse changes, so warrant. During 2017, both Moody's and Standard and Poor's downgraded our debt ratings. In February 2018, both Moody's and S&P downgraded our corporate and debt ratings further to BB- and B3, respectively, with modest negative impact on future borrowing cost. A further lowering or withdrawal of the ratings assigned to our debt securities by rating agencies would likely increase our future borrowing costs and reduce our access to capital, which could have a materially adverse impact on our business, financial condition, cash flows, or results of operations.

If federal spending on the Medicaid program is reduced, populations served by Molina Medicaid Solutions could decline and our revenues could be materially reduced.

As noted above, some of the ACA modifications considered involve significantly reduced federal spending on the Medicaid program. Among the proposals being considered include reversing the ACA's expansion of Medicaid, and changing Medicaid to a state block grant program, possibly including a per capita cap. An end to Medicaid Expansion could lower the populations served by Molina Medicaid Solutions. Changing Medicaid to a state block grant program would turn control of the program to states and cap what the federal government spends on Medicaid each year. Fixed state block grants could mean states will cut benefits or force beneficiaries to take on more cost-sharing. If Medicaid Expansion were reversed and the funding of Medicaid capped, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida. If we are unable to continue to operate in any of those six jurisdictions, or if our current operations in any of those jurisdictions are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater

financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. If our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. In addition, we may be unable to support the carrying amount of goodwill we have recorded for this business, because its fair value estimated future cash flows. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business could be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our business may be adversely affected by the transition from traditional fee-for-service to Medicaid managed care.

To reduce expenses, a number of state Medicaid programs are expected to pursue the transition from a fee-for-service focus of their Medicaid programs to a Medicaid managed care focus. A shift in Medicaid payment models from fee-for-service to managed care will require a concomitant shift in the focus of MMIS. In connection with such a transition, MMIS must also make a transition from a system built around claims adjudication to one that performs analytics and can be used to manage Medicaid population health outcomes. If our Molina Medicaid Solutions segment is unable to accomplish this transition, our business, financial condition, cash flows, or results of operations may be adversely affected.

Risks Related to Our Common Stock

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of

common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150 million shares of common stock and 20 million shares of preferred stock. As of December 31, 2017, approximately 60 million shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Further, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock.

LEGAL PROCEEDINGS

Refer to the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Legal Proceedings,” for a discussion of legal proceedings.

MANAGEMENT AND AUDITOR’S REPORTS

MANAGEMENT’S EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures, as defined in Rule 13a-15(e) and Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the Exchange Act), that are designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is accumulated and communicated to our management, including our principal executive officer and principal financial officer or persons performing similar functions, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management is required to apply its judgment in evaluating the cost-benefit relationship of any possible controls and procedures.

Under the supervision and with the participation of our management, including our chief executive officer and our chief financial officer, we carried out an evaluation of the effectiveness of our disclosure controls and procedures as of the end of the period covered by this Form 10-K pursuant to Rule 13a-15(b) and Rule 15d-15(b) of the Exchange Act. Based on this evaluation and after consideration of the remediation of the two material weaknesses in our internal control over financial reporting described below, our chief executive officer and our chief financial officer concluded that, our disclosure controls and procedures were effective as of December 31, 2017, at the reasonable assurance level. In addition, management concluded that our consolidated financial statements included in this Annual Report on Form 10-K are fairly stated in all material respects in accordance with U.S. generally accepted accounting principles (GAAP) for each of the periods presented herein.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets, (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors, and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on our financial statements.

Internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements prepared for external purposes in accordance with GAAP. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of the effectiveness of our internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

After consideration of the remediation of the two material weaknesses described below, management concluded that we maintained effective internal control over financial reporting as of December 31, 2017, based on criteria described in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Ernst & Young, LLP, the independent registered public accounting firm who audited our Consolidated Financial Statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis. The Company determined that a material weakness in its internal control over financial reporting existed at December 31, 2016, and an additional material weakness existed at September 30, 2017. The following describes those material weaknesses and their remediation.

Material Weakness as of December 31, 2016

As disclosed in our Annual Report on Form 10-K for the year ended December 31, 2016, our management determined that as of December 31, 2016 a material weakness existed in our internal control over financial reporting relating to the operation of an element of its process for calculating the amount owed to California by its California health plan. More specifically, a Medicaid Expansion contract amendment executed in the fourth quarter of 2016 changed the medical loss ratio corridor formula and such amendment was not initially considered in determining the liability. As a result, we understated net income by $44 million for the year ended December 31, 2016, which is material to our consolidated results for the year ended December 31, 2016. This amount was corrected prior to the issuance of our consolidated financial statements as of and for the year ended December 31, 2016.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of December 31, 2016, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

We have executed a remediation plan to address this material weakness. The remediation efforts we have implemented included the development of robust protocols to ensure that the control relating to the review of a

contractual amendment affecting the computation of the Medicaid Expansion medical loss ratio corridor for our California health plan will operate as designed.

We have tested the operating effectiveness of the historical control, and new controls subsequent to implementation and, as a result, believe these measures have remediated the material weakness as of December 31, 2016 identified above and strengthened our internal control over financial reporting for the computation of our California Medicaid Expansion medical loss ratio corridor.

Material Weakness as of September 30, 2017

As disclosed in our Quarterly Report on Form 10-Q for the three months ended September 30, 2017, our management determined that as of September 30, 2017, a material weakness existed in our internal control over financial reporting relating to the design and operating effectiveness of our internal control for our interim goodwill impairment tests for our Pathways subsidiary and Molina Medicaid Solutions segment. Specifically, spreadsheet formula errors in our valuation model, and errors made in the calculation of impairment losses recorded, were not detected in our review procedures. As a result, we initially miscalculated the goodwill impairment in the three months ended September 30, 2017. The impairment calculation was corrected prior to the filing of our unaudited consolidated financial statements as of and for the three and nine months ended September 30, 2017.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of September 30, 2017, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

We have implemented a remediation plan to address this material weakness. The remediation efforts included: enhancement of the design of the controls relating to the computation and rigor of review of the goodwill impairment tests; engagement of additional subject matter experts to support the valuation calculations, key assumptions and review process; and development of new review controls that operate at an appropriate level of precision to prevent or detect potential material errors within the valuation calculations.

We have tested the operating effectiveness of the new controls subsequent to implementation and, as a result, believe these measures have remediated the material weakness as of September 30, 2017, identified above and strengthened our internal control over financial reporting for our interim goodwill impairment tests for our Pathways subsidiary and Molina Medicaid Solutions segment.

Changes in Internal Control over Financial Reporting

Except as described above, management did not identify any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2017, that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the Board of Directors of Molina Healthcare, Inc.

Opinion on Internal Control over Financial Reporting

We have audited Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Molina Healthcare, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2017 and 2016, the related consolidated statements of operations, comprehensive (loss) income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2017, and the related notes and our report dated March 1, 2018, expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 1, 2018

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the Board of Directors of Molina Healthcare, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2017 and 2016, and the related consolidated statements of operations, comprehensive (loss) income, stockholders' equity and cash flows, for each of the three years in the period ended December 31, 2017, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the consolidated financial position of the Company as of December 31, 2017 and 2016, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2017, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated March 1, 2018, expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ ERNST & YOUNG LLP

We have served as the Company's auditor since 2000.

Los Angeles, California

March 1, 2018

AUDITED FINANCIAL STATEMENTS AND NOTES

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	Year Ended December 31,		
	2017	2016	2015
	(In millions, except per-share data)		
Revenue:			
Premium revenue	$ 18,854	$ 16,445	$ 13,261
Service revenue	521	539	253
Premium tax revenue	438	468	397
Health insurer fees reimbursed	—	292	244
Investment income and other revenue	70	38	23
Total revenue	19,883	17,782	14,178
Operating expenses:			
Medical care costs	17,073	14,774	11,794
Cost of service revenue	492	485	193
General and administrative expenses	1,594	1,393	1,146
Premium tax expenses	438	468	397
Health insurer fees	—	217	157
Depreciation and amortization	137	139	104
Impairment losses	470	—	—
Restructuring and separation costs	234	—	—
Total operating expenses	20,438	17,476	13,791
Operating (loss) income	(555)	306	387
Other expenses, net:			
Interest expense	118	101	66
Other income, net	(61)	—	(1)
Total other expenses, net	57	101	65
(Loss) income before income tax (benefit) expense	(612)	205	322
Income tax (benefit) expense	(100)	153	179
Net (loss) income	$ (512)	$ 52	$ 143
Net (loss) income per share:			
Basic	$ (9.07)	$ 0.93	$ 2.75
Diluted	$ (9.07)	$ 0.92	$ 2.58
Weighted average shares outstanding:			
Basic	56	55	52
Diluted	56	56	56

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE (LOSS) INCOME

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Net (loss) income	$ (512)	$ 52	$ 143
Other comprehensive (loss) income:			
Unrealized investment (loss) gain	(5)	3	(5)
Less: effect of income taxes	(2)	1	(2)
Other comprehensive (loss) income, net of tax	(3)	2	(3)
Comprehensive (loss) income	$ (515)	$ 54	$ 140

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2017	2016
	(In millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,186	$ 2,819
Investments	2,524	1,758
Restricted investments	169	—
Receivables	871	974
Income taxes refundable	54	39
Prepaid expenses and other current assets	185	131
Derivative asset	522	267
Total current assets	7,511	5,988
Property, equipment, and capitalized software, net	342	454
Deferred contract costs	101	86
Intangible assets, net	69	140
Goodwill	186	620
Restricted investments	119	110
Deferred income taxes	103	10
Other assets	40	41
	$ 8,471	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 2,192	$ 1,929
Amounts due government agencies	1,542	1,202
Accounts payable and accrued liabilities	366	385
Deferred revenue	282	315
Current portion of long-term debt	653	472
Derivative liability	522	267
Total current liabilities	5,557	4,570
Long-term debt	1,318	975
Lease financing obligations	198	198
Deferred income taxes	—	15
Other long-term liabilities	61	42
Total liabilities	7,134	5,800
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 60 shares at December 31, 2017 and 57 shares at December 31, 2016	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	1,044	841
Accumulated other comprehensive loss	(5)	(2)
Retained earnings	298	810
Total stockholders' equity	1,337	1,649
	$ 8,471	$ 7,449

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
			(In millions)			
Balance at January 1, 2015	50	$ —	$ 396	$ (1)	$ 615	$ 1,010
Net income	—	—	—	—	143	143
Other comprehensive loss, net	—	—	—	(3)	—	(3)
Common stock offering, including issuance costs	6	—	373	—	—	373
Share-based compensation	—	—	26	—	—	26
Tax benefit from share-based compensation	—	—	8	—	—	8
Balance at December 31, 2015	56	—	803	(4)	758	1,557
Net income	—	—	—	—	52	52
Other comprehensive income, net	—	—	—	2	—	2
Share-based compensation	1	—	36	—	—	36
Tax benefit from share-based compensation	—	—	2	—	—	2
Balance at December 31, 2016	57	—	841	(2)	810	1,649
Net loss	—	—	—	—	(512)	(512)
Other comprehensive loss, net	—	—	—	(3)	—	(3)
1.625% Convertible Notes exchange transaction	3	—	161	—	—	161
Share-based compensation	—	—	42	—	—	42
Balance at December 31, 2017	60	$ —	$ 1,044	$ (5)	$ 298	$ 1,337

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Operating activities:			
Net (loss) income	$ (512)	$ 52	$ 143
Adjustments to reconcile net (loss) income to net cash provided by operating activities:			
Depreciation and amortization	178	182	126
Impairment losses	470	—	—
Deferred income taxes	(94)	22	(7)
Share-based compensation	46	26	23
Non-cash restructuring charges	60	—	—
Amortization of convertible senior notes and lease financing obligations	32	31	30
Loss on debt extinguishment	14	—	—
Other, net	21	16	19
Changes in operating assets and liabilities:			
Receivables	103	(348)	56
Prepaid expenses and other current assets	(56)	(69)	(35)
Medical claims and benefits payable	263	226	482
Amounts due government agencies	341	473	202
Accounts payable and accrued liabilities	(12)	(4)	84
Deferred revenue	(34)	92	24
Income taxes	(16)	(26)	(22)
Net cash provided by operating activities	804	673	1,125
Investing activities:			
Purchases of investments	(2,718)	(1,929)	(1,923)
Proceeds from sales and maturities of investments	1,771	1,966	1,126
Purchases of property, equipment and capitalized software	(86)	(176)	(132)
(Increase) decrease in restricted investments held-to-maturity	(12)	4	(6)
Net cash paid in business combinations	—	(48)	(450)
Other, net	(28)	(19)	(35)
Net cash used in investing activities	(1,073)	(202)	(1,420)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	325	—	689
Proceeds from borrowings under credit facility	300	—	—
Proceeds from common stock offering, net of issuance costs	—	—	373
Proceeds from employee stock plans	19	18	18
Cash paid for financing transaction fees	(7)	—	—
Other, net	(1)	1	5
Net cash provided by financing activities	636	19	1,085
Net increase in cash and cash equivalents	367	490	790
Cash and cash equivalents at beginning of period	2,819	2,329	1,539
Cash and cash equivalents at end of period	$ 3,186	$ 2,819	$ 2,329

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(continued)

	Year Ended December 31,		
	2017	**2016**	**2015**
	(In millions)		
Supplemental cash flow information:			
Cash paid during the period for:			
Income taxes	$ 7	$ 153	$ 197
Interest	$ 78	$ 66	$ 38
Schedule of non-cash investing and financing activities:			
1.625% convertible notes exchange transaction:			
Issuance of common stock in exchange for 1.625% Convertible Notes	$ 193	$ —	$ —
Component of 1.625% Convertible Notes allocated to additional paid-in capital, net of income taxes	(32)	—	—
Net increase to additional paid-in capital	$ 161	$ —	$ —
Common stock used for stock-based compensation	$ (22)	$ (8)	$ (15)
Details of business combinations:			
Fair value of assets acquired	$ —	$ (186)	$ (389)
Fair value of liabilities assumed	—	28	41
Payable to seller	—	8	—
Amounts advanced for acquisitions	—	102	(102)
Net cash paid in business combinations	$ —	$ (48)	$ (450)
Details of change in fair value of derivatives, net:			
Gain (loss) on 1.125% Call Option	$ 255	$ (107)	$ 45
(Loss) gain on 1.125% Conversion Option	(255)	107	(45)
Change in fair value of derivatives, net	$ —	$ —	$ —

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed healthcare to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

As of December 31, 2017, the Health Plans segment consisted of health plans operating in 12 states and the Commonwealth of Puerto Rico. These health plans served approximately 4.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. The contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. See below for further information regarding our Florida and New Mexico Medicaid contracts.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with Medicaid agencies in six states, and the U.S. Virgin Islands.

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

2017 and Recent Developments – Health Plans Segment

Florida Health Plan. On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served approximately 360,000 Medicaid members in Florida, which represented approximately $1,486 million premium revenue for the year ended December 31, 2017. This decision does not affect the Florida health plan's current contracts with AHCA, which run through December 31, 2018. We recorded impairment charges in connection with this event. Refer to Note 8, "Goodwill and Intangible Assets, Net," for further information.

New Mexico Health Plan. In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico, which represented approximately $1,205 million premium revenue for the year ended December 31, 2017. This decision does not affect the New Mexico plan's current contract with HSD which runs through December 31, 2018. We recorded impairment charges in connection with this event. Refer to Note 8, "Goodwill and Intangible Assets, Net," for further information.

Illinois Health Plan. In August 2017, our Illinois health plan was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the state's three current managed care programs into one

program. The contract began January 1, 2018, and will continue for four years with options to renew annually for up to four additional years.

Mississippi Health Plan. In June 2017, Molina Healthcare of Mississippi, Inc. was awarded a Medicaid Coordinated Care Contract for the statewide administration of the Mississippi Coordinated Access Network (MississippiCAN). The operational start date for the program is currently scheduled for October 1, 2018, pending the completion of a readiness review. The initial term of the contract is through June 2020, with options to renew annually for up to two additional years.

Washington Health Plan. In May 2017, our Washington health plan was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North-Central region of the state's Apple Health Integrated Managed Care Program. The new contract commenced January 1, 2018.

Terminated Medicare Acquisition. In August 2016, we entered into agreements with each of Aetna Inc. and Humana Inc. to acquire certain assets related to their Medicare Advantage business. In February 2017, our agreements with each of Aetna and Humana were terminated by the parties pursuant to the terms of the agreements, under which we received an aggregate termination fee of $75 million from Aetna and Humana in the first quarter of 2017. This fee is reported in "Other income, net" in the accompanying consolidated statements of operations.

Impairment Losses

Refer to Note 8, "Goodwill and Intangible Assets, Net," for a discussion of goodwill and intangible assets impaired in 2017.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 18, "Variable Interest Entities (VIEs)," for more information regarding these variable interest entities. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments.

Presentation and Reclassification

The Centers for Medicare and Medicaid Services (CMS) incorporates the Health Insurer Fee (HIF) in our Medicare and Marketplace premium rates. We have therefore reclassified such amounts in our consolidated statements of operations to premium revenue, from health insurer fees reimbursed, for all applicable periods presented. The amounts reclassified from health insurer fees reimbursed to premium revenue for years ended December 31, 2016, and 2015, amounted to $53 million and $20 million, respectively.

Use of Estimates

The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable of our Health Plans segment;
- Health plan contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Molina Medicaid Solutions segment revenue and cost recognition;
- Settlements under risk or savings sharing programs;
- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and

- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Certain of our significant accounting policies are discussed within the note to which they specifically relate.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net (loss) income. The cost of securities sold is determined using the specific-identification method.

Our investment policy requires that all of our investments have final maturities of 10 years or less (excluding variable rate securities where interest rates may be periodically reset), and that the average maturity be three years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our current and non-current investments, see Note 4, "Fair Value Measurements," Note 5, "Investments," and Note 9, "Restricted Investments, Non-current."

Long-Lived Assets, including Intangible Assets

Long-lived assets consist primarily of property, equipment, capitalized software (see Note 7, "Property, Equipment, and Capitalized Software, Net"), and intangible assets (see Note 8, "Goodwill and Intangible Assets, Net").

Deferred Contract Costs

Direct costs associated with our Molina Medicaid Solutions contracts, other than software-related costs for which we apply the guidance for internal-use software, are expensed as incurred unless corresponding revenue is deferred. We defer recognition of any contingent revenue until the contingency has been removed. If revenue is deferred, direct costs relating to delivered service elements are deferred as well, and recognized on a straight-line basis over the period of revenue recognition.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Business Combinations

Accounting for acquisitions requires us to recognize separately from goodwill the assets acquired and the liabilities assumed at their acquisition date fair values. Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Upon the conclusion of the final determination of the values of assets acquired or

liabilities assumed, or one year after the date of acquisition, whichever comes first, any subsequent adjustments are recorded within our consolidated statements of operations.

Premium Revenue - Health Plans

Premium revenue is generated primarily from our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. Premium revenue is generally received based on per member per month (PMPM) rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. The state Medicaid programs and the federal Medicare program periodically adjust premiums. Additionally, many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is earned under such provisions.

The following table summarizes premium revenue for the periods indicated:

	Year Ended December 31,					
	2017		2016		2015	
	Amount	% of Total	Amount	% of Total	Amount	% of Total
	(Dollars in millions)					
California	$ 2,701	14.3%	$ 2,378	14.4%	$ 2,200	16.6%
Florida	2,568	13.6	1,938	11.8	1,199	9.1
Illinois	593	3.1	603	3.7	398	3.0
Michigan	1,596	8.5	1,527	9.3	1,072	8.1
New Mexico	1,368	7.3	1,305	7.9	1,237	9.3
New York	181	1.0	82	0.5	—	—
Ohio	2,216	11.8	1,967	12.0	2,035	15.3
Puerto Rico	732	3.9	726	4.4	567	4.3
South Carolina	445	2.4	378	2.3	348	2.6
Texas	2,813	14.9	2,461	15.0	1,963	14.8
Utah	535	2.8	447	2.7	334	2.5
Washington	2,608	13.8	2,222	13.5	1,605	12.1
Wisconsin	491	2.6	398	2.4	262	2.0
Other	7	—	13	0.1	41	0.3
	$ 18,854	100.0%	$ 16,445	100.0%	$ 13,261	100.0%

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $135 million and $272 million at December 31, 2017 and December 31, 2016, respectively, to amounts due government agencies. Approximately $96 million and $244 million of the liability accrued at December 31, 2017 and December 31, 2016, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at December 31, 2017 and December 31, 2016.

Profit Sharing and Profit Ceiling. Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at December 31, 2017 and December 31, 2016.

Retroactive Premium Adjustments. State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare

Risk Adjustment: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and CMS practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjustment premiums and Medicare Part D settlements were insignificant at December 31, 2017 and December 31, 2016.

Minimum MLR: Additionally, federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described below, and, for receivables, when collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	December 31, 2017			
	Current Benefit Year	Prior Benefit Years	Total	December 31, 2016
	(In millions)			
Risk adjustment	$ (912)	$ —	$ (912)	$ (522)
Reinsurance	—	10	10	55
Risk corridor	—	—	—	(1)
Minimum MLR	(2)	—	(2)	(1)

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of operations.
- Reinsurance: This program was designed to provide reimbursement to insurers for high cost members and ended December 31, 2016; we expect to settle the outstanding receivable balance in the first quarter of 2018.
- Risk corridor: This program was intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by CMS, and ended December 31, 2016; all outstanding payable balances were settled in the third quarter of 2017. We are owed, but have not recorded $128 million in risk corridor payments from CMS related to benefit year 2016 and 2015.

Additionally, the ACA established a Minimum MLR of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2017 are not known, we have no reason to believe that the adjustments to prior periods noted below are not indicative of the potential future changes in our estimates as of December 31, 2017.

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Maximum available quality incentive premium - current period	$ 150	$ 147	$ 118
Amount of quality incentive premium revenue recognized in current period:			
Earned current period	$ 97	$ 104	$ 66
Earned prior periods	10	47	13
Total	$ 107	$ 151	$ 79
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.6%	0.9%	0.6%

Medical Care Costs - Health Plans

Expenses related to medical care services are captured in the following categories:

Fee-for-service expenses. Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.

Pharmacy expenses. All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

Capitation expenses. Many of our primary care physicians and a small number of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

Direct delivery expenses. All costs associated with our direct delivery of medical care are separately identified.

Other medical expenses. All medically related administrative costs, certain provider incentive costs, and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2017, 2016, and 2015, medically related administrative costs were $554 million, $488 million, and $398 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in millions, except PMPM amounts):

	Year Ended December 31,								
	2017			2016			2015		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 12,682	$ 229.63	74.3%	$ 10,993	$ 217.84	74.4%	$ 8,572	$ 218.35	72.7%
Pharmacy	2,563	46.40	15.0	2,213	43.84	15.0	1,610	41.01	13.7
Capitation	1,360	24.63	8.0	1,218	24.13	8.2	982	25.02	8.3
Direct delivery	73	1.33	0.4	78	1.55	0.5	128	3.26	1.1
Other	395	7.15	2.3	272	5.39	1.9	502	12.79	4.2
Total	$ 17,073	$ 309.14	100.0%	$ 14,774	$ 292.75	100.0%	$ 11,794	$ 300.43	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. For further information, see Note 10, “Medical Claims and Benefits Payable.”

We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. Such reinsurance coverage does not relieve us of our primary obligation to our policyholders. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Health Insurer Fee (HIF). The federal government under the ACA imposes an annual fee, or excise tax, on health insurers for each calendar year. The HIF is based on a company’s share of the industry’s net premiums written during the preceding calendar year, and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Within our Medicaid program, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment or payment from a state to reimburse us for the HIF; such HIF revenue is recognized ratably throughout the year. The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there were no health insurer fees reimbursed, nor health insurer fees incurred, in 2017.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expenses in the consolidated statements of operations.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. We recorded a premium deficiency reserve to “Medical claims and benefits payable” on our accompanying consolidated balance sheets relating to our Marketplace program of $30 million as of December 31, 2016. No premium deficiency reserves are recorded as of December 31, 2017.

Marketplace Cost Share Reduction (CSR) Update

In the fourth quarter of 2017, the federal government ceased payments of Marketplace CSR subsidies, which resulted in additional medical care costs of approximately $73 million in 2017.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments, non-current are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited because our payors consist principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans primarily as a direct contractor with the states (or Commonwealth), and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements

Comprehensive Income. In February 2018, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017. ASU 2018-02 also requires certain disclosures about stranded tax effects. ASU 2018-02 is effective beginning January 1, 2019; we early adopted this ASU effective January 1, 2018, with no material impact to our financial condition, results of operations or cash flows. We are currently evaluating the required disclosures.

Goodwill Impairment. In January 2017, FASB issued ASU 2017-04, *Simplifying the Test for Goodwill Impairment*, which eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment loss. Instead, an impairment loss is measured as the excess of the carrying amount of the reporting unit, including goodwill, over the fair value of the reporting unit. ASU 2017-04 is effective beginning January 1, 2020; we early adopted ASU 2017-04 as of June 30, 2017, in connection with the interim assessment of our Pathways subsidiary. See further discussion at Note 8, “Goodwill and Intangible Assets, Net.”

Restricted Cash. In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which will require us to include in our consolidated statements of cash flows the balances of cash, cash equivalents, restricted cash and restricted cash equivalents. When these items are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Transfers between cash and cash equivalents and restricted cash and restricted cash equivalents will no longer be presented in the statement of cash flows. ASU 2016-18 is effective beginning January 1, 2018. We are currently evaluating the classification changes that will be required in our presentation of the consolidated statements of cash flows.

Stock Compensation. In March 2016, the FASB issued ASU 2016-09, *Improvements to Employee Share-Based Payment Accounting*, which amends ASC Topic 718, *Compensation – Stock Compensation*. ASU 2016-09 simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income

taxes, forfeitures, statutory tax and classification in the statement of cash flows. We adopted ASU 2016-09 on January 1, 2017; such adoption did not significantly impact our consolidated financial statements. In addition, the prior period presentation in the statement of cash flows was not adjusted because such adjustments were insignificant.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. ASU 2016-02 is effective beginning January 1, 2019, and must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Under this guidance, we will record assets and liabilities relating primarily to our long-term office leases. We are in the early stages of evaluating the effect to our consolidated financial statements.

Financial Instruments. In January 2016, the FASB issued ASU 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*, which will require public business entities to use the exit price notion when measuring the fair value of financial instruments for disclosure purposes. Also, entities will have to assess the realizability of a deferred tax asset related to an available-for-sale debt security in combination with the entity's other deferred tax assets. Effective on January 1, 2018, ASU 2016-01 is applied prospectively with a cumulative-effect adjustment to beginning retained earnings as of the beginning of the first reporting period in which the guidance is adopted. We have determined that there will be no impact to beginning retained earnings; we are in the process of determining the changes to required disclosures.

Revenue Recognition. In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606).* We intend to adopt this standard and the related modifications on January 1, 2018, using the modified retrospective approach. Under this approach, the cumulative effect of initially applying the guidance will be reflected as an adjustment to beginning retained earnings.

We have determined that the insurance contracts of our Health Plans segment, which segment constitutes the vast majority of our operations, are excluded from the scope of Topic 606 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts.

For our Molina Medicaid Solutions segment, we have determined that revenue for contracts that include design, development and implementation (DDI) of Medicaid management information systems shall be deferred until the system 'go-live' date, and then generally recognized on a straight-line basis over the hosting period. This approach is similar to our historical revenue recognition methodology, with two exceptions. First, revenues contingent upon a state's acceptance of DDI and other services were previously deferred until the contingency was removed. Under Topic 606, we have determined that such revenues are appropriately recognized at the system 'go-live' date as noted above, resulting in a slight acceleration of revenue under Topic 606. Second, contract extensions were previously considered a single unit of account with the original contracts. Under Topic 606, contract extensions are considered to be standalone contracts, so revenues previously deferred over the original contract plus extension periods are now recognized over the original contract period, resulting in slightly accelerated revenue recognition. Cost of service revenue continues to be recognized in a manner consistent with the corresponding revenue recognition. As a result, the cumulative adjustment to retained earnings associated with the adoption of Topic 606 effective January 1, 2018, is insignificant for our Molina Medicaid Solutions segment.

For our Pathways behavioral health and social services provider, which is reported in the Other segment, there is no substantive change to revenue recognition under Topic 606, and therefore no impact to retained earnings effective January 1, 2018.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a significant impact on our present or future consolidated financial statements.

3. Net (Loss) Income per Share

The following table sets forth the calculation of basic and diluted net (loss) income per share:

	December 31,		
	2017	2016	2015
	(In millions, except net (loss) income per share)		
Numerator:			
Net (loss) income	$ (512)	$ 52	$ 143
Denominator:			
Shares outstanding at the beginning of the period	56	55	49
Weighted-average number of shares issued:			
Common stock offering	—	—	3
Denominator for basic net (loss) income per share	56	55	52
Effect of dilutive securities:			
Share-based compensation	—	—	1
Convertible senior notes [1]	—	—	1
1.125% Warrants [1]	—	1	2
Denominator for diluted net (loss) income per share	56	56	56
Net (loss) income per share: [2]			
Basic	$ (9.07)	$ 0.93	$ 2.75
Diluted	$ (9.07)	$ 0.92	$ 2.58
Potentially dilutive common shares excluded from calculations: [1]			
1.125% Warrants	2	—	—
1.625% Notes	1	—	—

(1) For more information regarding the convertible senior notes, refer to Note 11, “Debt.” For more information regarding the 1.125% Warrants, refer to Note 14, “Stockholders' Equity.” The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Potentially dilutive common shares were not included in the computation of diluted net loss per share for the year ended December 31, 2017, because to do so would have been anti-dilutive.

(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs. Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include derivative financial instruments.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2017, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the years ended December 31, 2017, and 2016.

Our financial instruments measured at fair value on a recurring basis at December 31, 2017, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,588	$ —	$ 1,588	$ —
U.S. treasury notes	388	388	—	—
Government-sponsored enterprise securities (GSEs)	253	253	—	—
Municipal securities	141	—	141	—
Asset-backed securities	117	—	117	—
Certificates of deposit	37	—	37	—
Subtotal - current investments	2,524	641	1,883	—
Corporate debt securities	101	—	101	—
U.S. treasury notes	68	68	—	—
Subtotal - current restricted investments	169	68	101	—
1.125% Call Option derivative asset	522	—	—	522
Total assets measured at fair value on a recurring basis	$ 3,215	$ 709	$ 1,984	$ 522
1.125% Conversion Option derivative liability	$ 522	$ —	$ —	$ 522
Total liabilities measured at fair value on a recurring basis	$ 522	$ —	$ —	$ 522

Our financial instruments measured at fair value on a recurring basis at December 31, 2016, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,179	$ —	$ 1,179	$ —
U.S. treasury notes	84	84	—	—
GSEs	231	231	—	—
Municipal securities	142	—	142	—
Asset-backed securities	69	—	69	—
Certificates of deposit	53	—	53	—
Subtotal - current investments	1,758	315	1,443	—
1.125% Call Option derivative asset	267	—	—	267
Total assets measured at fair value on a recurring basis	$ 2,025	$ 315	$ 1,443	$ 267
1.125% Conversion Option derivative liability	$ 267	$ —	$ —	$ 267
Total liabilities measured at fair value on a recurring basis	$ 267	$ —	$ —	$ 267

There were no current restricted investments as of December 31, 2016.

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the amount due under our Credit Facility is classified as a Level 3 financial instrument, because certain inputs used to determine its fair value are not observable. As of December 31, 2017, the carrying value of the amount due under the Credit Facility approximates it fair value because of the recency of this borrowing during the third quarter of 2017.

	December 31, 2017		December 31, 2016	
	Carrying Value	Fair Value	Carrying Value	Fair Value
		(In millions)		
5.375% Notes	$ 692	$ 730	$ 691	$ 714
1.125% Convertible Notes	496	1,052	471	792
4.875% Notes	325	329	—	—
Credit Facility	300	300	—	—
1.625% Convertible Notes	157	220	284	344
	$ 1,970	$ 2,631	$ 1,446	$ 1,850

5. Investments

We consider all of our investments, and our restricted investments that are classified as current assets, to be available-for-sale. As described further in Note 11, “Debt,” we maintain certain funds from the issuance of our 4.875% Notes in a segregated deposit account, a current asset reported as “Restricted investments” in the accompanying consolidated balance sheets. Such investments, while restricted as to their use and held in a segregated deposit account, are classified as available-for-sale based upon our contractual liquidity requirements.

The following tables summarize our investments as of the dates indicated:

	December 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In millions)		
Corporate debt securities	$ 1,591	$ 1	$ 4	$ 1,588
U.S. Treasury notes	389	—	1	388
GSEs	255	—	2	253
Municipal securities	142	—	1	141
Asset-backed securities	117	—	—	117
Certificates of deposit	37	—	—	37
Subtotal - current investments	2,531	1	8	2,524
Corporate debt securities	101	—	—	101
U.S. treasury notes	68	—	—	68
Subtotal - restricted investments, current	169	—	—	169
	$ 2,700	$ 1	$ 8	$ 2,693

	December 31, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In millions)		
Corporate debt securities	$ 1,180	$ 1	$ 2	$ 1,179
U.S. treasury notes	84	—	—	84
GSEs	232	—	1	231
Municipal securities	143	—	1	142
Asset-backed securities	69	—	—	69
Certificates of deposit	53	—	—	53
	$ 1,761	$ 1	$ 4	$ 1,758

There were no current restricted investments as of December 31, 2016.

The contractual maturities of our available-for-sale investments as of December 31, 2017 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,722	$ 1,721
Due after one year through five years	972	966
Due after five years through ten years	6	6
	$ 2,700	$ 2,693

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the years ended December 31, 2017, 2016 and 2015 were insignificant.

We have determined that unrealized losses at December 31, 2017 and 2016 are temporary in nature, because the change in market value for these securities resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2017.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 1,297	$ 3	561	$ 94	$ 1	69
U.S. Treasury notes	470	1	89	—	—	—
GSEs	173	1	69	95	1	47
Municipal securities	—	—	—	38	1	48
	$ 1,940	$ 5	719	$ 227	$ 3	164

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2016.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 542	$ 2	378	$ —	$ —	—
GSEs	198	1	73	—	—	—
Municipal securities	101	1	129	—	—	—
	$ 841	$ 4	580	$ —	$ —	—

6. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is insignificant. Any amounts determined to be uncollectible are charged to expense when such determination is made. The information below is presented by segment.

	December 31,	
	2017	2016
	(In millions)	
California	$ 208	$ 180
Florida	42	97
Illinois	91	134
Michigan	56	60
New Mexico	71	57
New York	21	26
Ohio	94	82
Puerto Rico	32	37
South Carolina	13	11
Texas	61	79
Utah	18	19
Washington	69	71
Wisconsin	19	33
Other	2	1
Total Health Plans segment	797	887
Molina Medicaid Solutions segment	30	34
Other segment	44	53
	$ 871	$ 974

7. Property, Equipment, and Capitalized Software, Net

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years.

The costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period, and the amortization is recorded within the heading “Cost of service revenue.”

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2017	2016
	(In millions)	
Capitalized software	$ 417	$ 443
Furniture and equipment	289	301
Building and improvements	161	159
Land	16	16
	883	919
Less: accumulated amortization - capitalized software	(308)	(259)
Less: accumulated depreciation and amortization - building and improvements, furniture and equipment	(233)	(206)
	(541)	(465)
Property, equipment, and capitalized software, net	$ 342	$ 454

The following table presents all depreciation and amortization recorded in our consolidated statements of operations, whether the item appears as depreciation and amortization, or as cost of service revenue.

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Recorded in depreciation and amortization:			
Amortization of capitalized software	$ 64	$ 62	$ 37
Depreciation of property and equipment	42	45	50
Amortization of intangible assets	31	32	17
	137	139	104
Recorded in cost of service revenue:			
Amortization of capitalized software	28	22	15
Amortization of deferred contract costs	13	21	6
	41	43	21
Other	—	—	1
	$ 178	$ 182	$ 126

8. Goodwill and Intangible Assets, Net

Goodwill

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is tested for impairment on an annual basis and more frequently if impairment indicators are present. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value, we perform the quantitative assessment. We may also elect to bypass the qualitative assessment and proceed directly to the quantitative assessment.

We estimated the fair values of our reporting units using the higher of the income approach using discounted cash flows, or the asset liquidation method. For the annual impairment test, the base year in the reporting units' discounted cash flows is derived from the most recent annual financial budgeting cycle, for which the planning process commences in the fourth quarter of the year. When computing discounted cash flows, we make assumptions about a wide variety of internal and external factors, and consider what the reporting unit's selling price would be in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations,

capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. When determining the discount rate, we consider the overall level of inherent risk of the reporting unit, and the expected rate an outside investor would expect to earn. The asset liquidation method is computed as total assets minus total liabilities, excluding intangible assets and liabilities.

We apply the market approach for certain reporting units to reconcile the value of all of our reporting units to our consolidated market value. Under the market approach, we consider publicly traded comparable company information to determine revenue and earnings multiples which are used to estimate our reporting units' fair values.

Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss, and adjusted if necessary for the impact of tax deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit.

The following table presents the changes in the carrying amounts of goodwill for the year ended December 31, 2017. The 2017 goodwill impairment losses are recorded to the segments as indicated in following table, and reported as "Impairment losses" in the accompanying consolidated statements of operations.

	Health Plans	Molina Medicaid Solutions	Other	Total
		(In millions)		
Historical goodwill	$ 445	$ 71	$ 162	$ 678
Accumulated impairment losses at December 31, 2016	(58)	—	—	(58)
Balance, December 31, 2016	387	71	162	620
Impairment losses, year ended December 31, 2017	(244)	(28)	(162)	(434)
Balance, December 31, 2017	$ 143	$ 43	$ —	$ 186
Accumulated impairment losses at December 31, 2017	$ 302	$ 28	$ 162	$ 492

2017 Impairment Analysis

Health Plans Segment

On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served approximately 360,000 Medicaid members in Florida, which represented approximately $1,486 million premium revenue for the year ended December 31, 2017. Because we expect the Florida health plan to have significantly reduced cash flows following the contract termination currently expected on December 31, 2018, its entire goodwill balance was impaired, amounting to $124 million, in the fourth quarter of 2017.

In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico, which represented approximately $1,205 million premium revenue for the year ended December 31, 2017. Because we do not expect the New Mexico health plan to have cash flows following the contract termination currently expected on December 31, 2018, its entire goodwill balance was impaired, amounting to $74 million, in the fourth quarter of 2017.

When we conducted the annual impairment evaluation of the goodwill of our Illinois health plan, the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. This was primarily due to the Illinois health plan's current profit profile, which does not support the purchase prices paid for certain membership acquired years ago. As a result, we recorded a goodwill impairment loss of approximately $45 million in the fourth quarter of 2017. When we conducted the annual impairment evaluation of the goodwill of our New York health plan, the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. As a result, we recorded goodwill impairment losses amounting to $1 million in the fourth quarter of 2017.

Molina Medicaid Solutions Segment

As described in Note 15, "Restructuring and Separation Costs," in the third quarter of 2017 we wrote off certain costs capitalized at our Molina Medicaid Solutions segment that supported our Health Plans segment provider information management processes. Although the intercompany revenues recorded by Molina Medicaid Solutions under this arrangement were insignificant on a consolidated basis, the termination of such revenue resulted in a

triggering event for an interim goodwill impairment analysis of this reporting unit in the third quarter of 2017. In the Molina Medicaid Solutions' discounted cash flow model, we incorporated significant estimates and assumptions related to future periods, such as intercompany business support opportunities and prospects for new Medicaid management information systems contracts. Because management has determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment, the test resulted in a fair value less than Molina Medicaid Solutions' carrying amount; therefore, we recorded a goodwill impairment loss for the difference, or $28 million, in the third quarter of 2017.

Other Segment

In the course of developing the 2017 Restructuring Plan in the second quarter of 2017, we determined that future benefits to be derived from our Pathways subsidiary, including the integration of its operations with our Health Plans segment, would be less than previously anticipated. In addition, poorer than expected year-to-date operating results, as well as lower projections of operating results for periods in the near term at our Pathways subsidiary, led us to conclude that a triggering event for an interim impairment analysis had occurred in the second quarter of 2017. Further, in the third quarter of 2017, management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected. Therefore, we conducted an additional interim impairment analysis.

We estimated Pathways' fair value using discounted cash flows, incorporating significant estimates and assumptions related to future periods. Such estimates included anticipated client census which drives service revenue; the likelihood of future benefits to be derived from Pathways (including integration with our health plans); current prospects relating to the behavioral services labor market which drives cost of service revenue; and anticipated capital expenditures. The tests in each of the quarters ended June 30, 2017, and September 30, 2017, resulted in a fair value less than Pathways' carrying amount; therefore, we recorded impairment losses for the difference. The Pathways goodwill impairment losses amounted to $101 million in the third quarter of 2017, and $59 million in the second quarter of 2017. In the second quarter of 2017, we also recorded a goodwill impairment loss of $2 million for a separate subsidiary in the Other segment.

2016 and 2015 Impairment Analysis

No impairment charges relating to goodwill were recorded in the years ended December 31, 2016, and 2015.

Intangible Assets, Net

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at fair value and are then amortized on a straight-line basis over their expected useful lives, generally between five and 15 years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators, including the ability of our health plan subsidiaries to obtain the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

Based on the balances of our identifiable intangible assets as of December 31, 2017, we estimate that our intangible asset amortization will be $21 million in 2018, $18 million in 2019, $14 million in 2020, $5 million in 2021, and $3 million in 2022. For a presentation of our goodwill and intangible assets by reportable segment, refer to Note 20, "Segment Information."

The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Carrying Amount
		(In millions)	
Intangible assets:			
Contract rights and licenses	$ 201	$ 141	$ 60
Provider networks	20	11	9
Balance at December 31, 2017	$ 221	$ 152	$ 69
Intangible assets:			
Contract rights and licenses	$ 267	$ 148	$ 119
Customer relationships	25	24	1
Provider networks	34	14	20
Balance at December 31, 2016	$ 326	$ 186	$ 140

2017 Impairment Analysis

During 2017, we noted the impairment indicators described above for the Florida health plan, New Mexico health plan, and Pathways.

Health Plans Segment

In the fourth quarter of 2017, prior to the goodwill impairment test noted above, we assessed the Florida health plan's primary definite-lived intangible assets (contract rights and provider networks) for impairment, using undiscounted cash flows expected over the asset's remaining useful life. Such undiscounted cash flows indicated impairment; therefore, the plan's estimated fair value, determined as noted above, indicated that its carrying amount exceeded its fair value. This resulted in impairment losses of $15 million in the fourth quarter of 2017.

In the fourth quarter of 2017, prior to the goodwill impairment test noted above, we assessed the New Mexico health plan's primary definite-lived intangible asset (contract rights) for impairment, using undiscounted cash flows expected over the asset's remaining useful life. Such undiscounted cash flows indicated impairment; therefore, the plan's estimated fair value, determined as noted above, indicated that its carrying amount exceeded its fair value. This resulted in impairment losses of $10 million in the fourth quarter of 2017.

Other Segment

In the second quarter of 2017, prior to the goodwill impairment tests noted above, we assessed Pathways' definite-lived intangible assets (customer relationships and contract licenses) for impairment, using undiscounted cash flows expected over the longest remaining useful life of the assets tested. Such undiscounted cash flows indicated impairment; therefore, Pathways' estimated fair value, determined as noted above, indicated that its carrying amount exceeded its fair value. This resulted in impairment losses of $11 million in the second quarter of 2017.

2016 and 2015 Impairment Analysis

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2016, and 2015.

9. Restricted Investments, Non-current

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulation in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current "Restricted investments" in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. The following table presents the balances of restricted investments:

	December 31,	
	2017	2016
	(In millions)	
Florida	$ 31	$ 22
New Mexico	43	43
Ohio	12	12
Puerto Rico	10	10
Other	23	23
Total Health Plans segment	$ 119	$ 110

The contractual maturities of our held-to-maturity restricted investments, which are carried at amortized cost, which approximates fair value, as of December 31, 2017 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 115	$ 115
Due after one year through five years	4	4
	$ 119	$ 119

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	December 31,		
	2017	2016	2015
	(In millions)		
Fee-for-service claims incurred but not paid (IBNP)	$ 1,717	$ 1,352	$ 1,191
Pharmacy payable	112	112	88
Capitation payable	67	37	140
Other	296	428	266
	$ 2,192	$ 1,929	$ 1,685

“Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. Non-risk provider payables amounted to $122 million, $225 million and $167 million, as of December 31, 2017, 2016 and 2015, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were less (more) than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Medical claims and benefits payable, beginning balance	$ 1,929	$ 1,685	$ 1,201
Components of medical care costs related to:			
Current period	17,037	14,966	11,935
Prior periods	36	(192)	(141)
Total medical care costs	17,073	14,774	11,794
Change in non-risk provider payables	(106)	58	48
Payments for medical care costs related to:			
Current period	15,130	13,304	10,448
Prior periods	1,574	1,284	910
Total paid	16,704	14,588	11,358
Medical claims and benefits payable, ending balance	$ 2,192	$ 1,929	$ 1,685

Reinsurance recoverables of $16 million, $61 million, and $46 million, as of December 31, 2017, 2016, and 2015, respectively, are included in "Receivables" in the accompanying consolidated balance sheets.

The following tables provide information about incurred and paid claims development as of December 31, 2017, as well as cumulative claims frequency and the total of incurred but not paid claims liabilities. The cumulative claim frequency is measured by claim event, and includes claims covered under capitated arrangements.

	Incurred Claims and Allocated Claims Adjustment Expenses				
Benefit Year	2015 (1)	2016	2017	Total IBNP	Cumulative number of reported claims
			(In millions)		
2015	$ 12,113	$ 11,928	$ 11,939	$ 6	84
2016		15,064	15,093	46	109
2017			17,037	1,665	114
			$ 44,069	$ 1,717	

	Cumulative Paid Claims and Allocated Claims Adjustment Expenses		
Benefit Year	2015 (1)	2016	2017
		(In millions)	
2015	$ 10,615	$ 11,906	$ 11,932
2016		13,403	14,952
2017			15,130
			$ 42,014

The following table represents a reconciliation of claims development to the aggregate carrying amount of the liability for medical claims and benefits payable.

	2017
	(In millions)
Incurred claims and allocated claims adjustment expenses	$ 44,069
Less: cumulative paid clams and allocated claims adjustment expenses	(42,014)
Non-risk provider payables and other	137
Medical claims and benefits payable	$ 2,192

(1) Data presented for this calendar year is required supplementary information, which is unaudited.

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is IBNP. Our IBNP, as included in medical claims and benefits payable, represents our best estimate of the total

amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Indeed, the amount we paid out during 2017 in satisfaction of our liability for medical claims and benefits payable at December 31, 2016, was in excess of the amount originally accrued. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology (including a consistent provision for adverse claims development) in estimating our liability for medical claims and benefits payable minimizes the degree to which the overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period.

Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. For example, any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate, to the extent that replenishment of reserves is not equal to the benefit recognized due to the absence of adverse development.

Conversely, in the presence of adverse claims development, the financial impact of recording claims expense in the current period that is related to dates of service in the prior period will be compounded by the need to replenish the provision for adverse development.

As noted above, the amounts ultimately paid out in 2017 for dates of service in 2016 and prior were in excess of the liability we had established for medical and claims and benefits payable at December 31, 2016. In contrast, the amounts we paid out for prior period dates of service in 2016 and 2015 were less than the liabilities we had established at the end of the previous years. In all three years, the differences between our original estimates and the amounts ultimately paid out for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

2017

We recognized unfavorable prior period claims development in the amount of $36 million for the year ended December 31, 2017. This amount represented the extent to which our initial estimate of medical claims and benefits payable at December 31, 2016, was less than the amount that was ultimately paid out in satisfaction of that liability; but does not include additional amounts expensed to re-establish the margin for adverse development. We believe this underestimation was due primarily to the following:

- Inaccurate adjudication of provider claims at our Florida, Illinois, New Mexico and Puerto Rico health plans that created substantial payment backlogs which we were unable to adequately measure when we estimated our liability at December 31, 2016.

We believe that the most significant uncertainties relating to our estimated IBNP liability at December 31, 2017, are as follows:

- At our Florida health plan, the inventory of unpaid claims increased significantly during the first two quarters of 2017, then dropped in the third quarter and fourth quarters of 2017. Changes in claim inventories impact the timing between dates of service and the dates claims are paid, making our liability estimates subject to more than the usual amount of uncertainty.
- At our Illinois health plan, in 2017 we paid a large number of claims that had previously been denied and were subsequently disputed by providers. We have also established a liability for additional expected claims

resulting from provider disputes. This has created some distortion in the claims payment patterns, making our liability estimates subject to more than the usual amount of uncertainty.

- At our California health plan, adjustments to our inpatient authorization process have improved the timeliness of paying inpatient claims, making our liability estimates subject to more than the usual amount of uncertainty.
- In 2017 we implemented a new process for increased quality review of claims payments in six of our health plans. While we do not anticipate this new process will impact the percentage of claims paid within the timely turnaround requirements, we believe it will have a minor impact on the timing of some paid claims. For this reason, our liability estimates in the six health plans are subject to more than the usual amount of uncertainty.
- At our Puerto Rico health plan, Hurricane Maria had a significant impact on both utilization of services and our ability to process claims payments in Puerto Rico. For these reasons, we believe our liability estimates are subject to more than the usual amount of uncertainty.
- December 2017 data from the Centers for Disease Control and Prevention have indicated widespread influenza activity in several states in which we operate health plans. Although we have established liabilities for additional expected claims related to influenza, our liability estimates are subject to more than the usual amount of uncertainty.

2016

We recognized favorable prior period claims development in the amount of $192 million for the year ended December 31, 2016. This amount represented the extent to which our initial estimate of medical claims and benefits payable at December 31, 2015, was more than the amount that was ultimately paid out in satisfaction of that liability. We believe this overestimation was due primarily to the following:

- A new version of diagnostic codes was required for all claims with dates of service on October 1, 2015, and later. As a result, payment was delayed or denied for a significant number of claims due to provider submission of claims with diagnostic codes that were no longer valid. Once providers were able to submit claims with the correct diagnostic codes, our actual costs were ultimately less than expected.
- At our New Mexico health plan, we overestimated the impact of several pending high-dollar claims, and our actual costs were ultimately less than expected.
- At our Washington health plan, we overpaid certain outpatient facility claims in 2015 when the state converted to a new payment methodology. We did not include an estimate in our December 31, 2015, reserves for this potential recovery.
- At our California health plan, we enrolled approximately 55,000 new Medicaid Expansion members in 2015. For these new members, our actual costs were ultimately less than expected.

2015

We recognized favorable prior period claims development in the amount of $141 million for the year ended December 31, 2015. This amount represented the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe this overestimation was due primarily to the following:

- At our Ohio and California health plans, approximately 61,000 and 100,000 members, respectively, were enrolled in the new Medicaid expansion program during 2014. Also in Ohio, approximately 17,000 members were enrolled in the new MMP program in 2014. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.

- At our New Mexico health plan, the state implemented a retroactive increase to the provider fee schedules in mid-2014. As a result, many claims that were previously settled were reopened, and subject to, additional payment. Because our reserving methodology is most accurate when claims payment patterns are consistent and predictable, the payment of additional amounts on claims that in some cases had been settled more than six months before added a substantial degree of complexity to our liability estimation process. Due to the difficulties in addressing that added complexity, liabilities recorded as of December 31, 2014 were in excess of amounts ultimately paid.

- At our Washington health plan, we collected amounts in 2015 related to certain claims paid in 2013. Such collections were not anticipated in our reserves as of December 31, 2014.

11. Debt

As of December 31, 2017, contractual maturities of debt for the years ending December 31 were as follows. All amounts represent the principal amounts of the debt instruments outstanding.

	Total	2018	2019	2020	2021	2022	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ —	$ —	$ 700	$ —
1.125% Convertible Notes	550	—	—	550	—	—	—
4.875% Notes	330	—	—	—	—	—	330
Credit Facility	300	—	—	—	—	300	—
1.625% Convertible Notes (1)	161	—	—	—	—	—	161
	$ 2,041	$ —	$ —	$ 550	$ —	$ 1,000	$ 491

(1) The 1.625% Convertible Notes have a contractual maturity date in 2044. However, on contractually specified dates beginning in 2018, holders may convert, or may require us to repurchase some or all of the 1.625% Convertible Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets (in millions):

	December 31,	
	2017	2016
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 499	$ 477
1.625% Convertible Notes, net of unamortized premium and discount	157	—
Lease financing obligations	1	1
Debt issuance costs	(4)	(6)
	653	472
Non-current portion of long-term debt:		
5.375% Notes	700	700
4.875% Notes	330	—
Credit Facility	300	—
1.625% Convertible Notes, net of unamortized premium and discount	—	286
Debt issuance costs	(12)	(11)
	1,318	975
Lease financing obligations	198	198
	$ 2,169	$ 1,645

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Years Ended December 31,		
	2017	2016	2015
		(In millions)	
Contractual interest at coupon rate	$ 11	$ 11	$ 11
Amortization of the discount	32	30	29
	$ 43	$ 41	$ 40

Bridge Credit Agreement

In January 2018, we entered into a bridge credit agreement (Bridge Credit Agreement) with several banks. Under the Bridge Credit Agreement, the banks agreed to lend us up to $550 million to be used to: (i) satisfy conversions of our 1.125% Convertible Notes; (ii) satisfy and/or refinance indebtedness incurred to satisfy conversion of the 1.125% Convertible Notes; (iii) repay or refinance our Credit Facility; (iv) pay fees and expenses in connection with the foregoing; and, subject to the satisfaction of specified conditions, for general corporate purposes.

Borrowings under the Bridge Credit Agreement are reduced by the following:

- Any future debt and/or equity transactions:
    - Including term loans, but excluding any Credit Facility drawing; and
    - Excluding transactions with proceeds used for working capital purposes and acquisition financings up to $300 million.
- On August 1, 2018 (the put date for the 1.625% Convertible Notes), the Bridge Credit Agreement shall permanently be reduced by the greater of:
    - $150 million; and
    - The principal amount of the 1.625% Convertible Notes that are exchanged into equity prior to that date.

The Bridge Credit Agreement matures on January 1, 2019 and, subject to the satisfaction of certain conditions, we may elect to extend twice the initial maturity date by a period of six months each.

Borrowings under the Bridge Credit Agreement will bear interest based, at our election, at a base rate or an adjusted LIBOR rate, plus in each case the applicable margin. Our wholly owned subsidiaries that guarantee our obligations under the indenture governing the 4.875% Notes, the 5.375% Notes, and the Credit Facility have jointly and severally guaranteed our obligations under the Bridge Credit Agreement.

The Bridge Credit Agreement contains usual and customary (a) affirmative covenants for credit facilities of this type and substantially similar to those contained in the Credit Facility, (b) negative covenants consistent with those contained in the 4.875% Notes and (c) events of default for credit facilities of this type and substantially similar to those contained in the 4.875% Notes.

4.875% Notes due 2025

On June 6, 2017, we completed the private offering of $330 million aggregate principal amount of senior notes (4.875% Notes) due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 4.875% Notes; subsidiary guarantors are defined under the Credit Facility, as described below. See Note 23, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors. The 4.875% Notes contain customary non-financial covenants and change of control provisions. At December 31, 2017, we were in compliance with all covenants under the 4.875% Notes.

The 4.875% Notes and the guarantees described above are senior unsecured obligations of Molina and the guarantors, respectively, and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina and the guarantors.

A portion of the proceeds from the issuance of the 4.875% Notes are required to be maintained in a segregated deposit account, which may be used as follows:

- On or prior to August 20, 2018, to:
    - Redeem, repurchase, repay, tender for, or acquire for value all or any portion of our 1.625% Convertible Notes, defined and discussed further below, or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes; and/or
    - Pay any interest due on all or any portion of the 4.875% Notes.
- On or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that we are obligated to repurchase; and
- Subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited in the indenture governing the 4.875% Notes.

The investments that constitute the segregated funds are current assets reported as “Restricted investments” in the accompanying consolidated balance sheets. As a result of the 1.625% Exchange transaction described below, approximately $157 million of such investments were transferred to unrestricted current investments in the fourth quarter of 2017. As of December 31, 2017, the balance of current restricted investments was $169 million.

5.375% Notes due 2022

We have outstanding $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 5.375% Notes; subsidiary guarantors are defined under the Credit Facility, as described below. The 5.375% Notes contain customary non-financial covenants and change in control provisions. At December 31, 2017, we were in compliance with all covenants under the 5.375% Notes.

The 5.375% Notes and the guarantees described above are senior unsecured obligations of Molina and the guarantors, respectively, and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina and the guarantors.

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (Credit Facility), referred to as the First Amendment. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. As of December 31, 2017, $300 million was outstanding under the Credit Facility. Also as of December 31, 2017, outstanding letters of credit amounting to $6 million reduced our remaining borrowing capacity under the Credit Facility to $194 million.

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee. The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of December 31, 2017, we were in compliance with all financial and non-financial covenants under the Credit Facility.

During 2017, we entered into several amendments to the Credit Facility which provided for, or modified the following:

- Automatic and unconditional release of all subsidiaries that were guarantors immediately prior to January 3, 2017, from their obligations as guarantors, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC;
- The definition of the earnings measure used in the financial covenant computations;
- The definition of specified cash, to permit cash that is either subject to customary escrow arrangements or held in a segregated account to be netted from the Credit Facility’s consolidated net leverage ratio if the use of the cash is limited to the repayment of other indebtedness;
- The definition of consolidated adjusted EBITDA, to permit the add-back of certain restructuring charges and cost savings subject to certain limitations, and the definition of the consolidated interest coverage ratio to include, when calculating such ratio, consolidated interest expense “paid in cash” only; and
- The list of indebtedness exceptions to include the new Bridge Credit Agreement discussed above.

1.125% Cash Convertible Senior Notes due 2020

We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020 (1.125% Convertible Notes), unless earlier repurchased or converted. Interest is payable semiannually in arrears on January 15 and July 15. The 1.125% Convertible Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Convertible Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Convertible Notes is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of

1.125% Convertible Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date. Holders may convert their 1.125% Convertible Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events; or
- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended December 31, 2017; therefore, they are convertible into cash and are reported in current portion of long-term debt as of December 31, 2017.

The 1.125% Convertible Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Convertible Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Convertible Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Convertible Notes at an effective rate of approximately 6%. As of December 31, 2017, the 1.125% Convertible Notes have a remaining amortization period of 2.0 years. The 1.125% Convertible Notes' if-converted value exceeded their principal amount by approximately $406 million and $182 million as of December 31, 2017 and December 31, 2016, respectively.

1.625% Convertible Senior Notes due 2044

In December 2017, we entered into separate, privately negotiated, synthetic exchange agreements (1.625% Exchange) with certain holders of our outstanding 1.625% convertible senior notes due 2044 (1.625% Convertible Notes). In this transaction, we exchanged $141 million aggregate principal amount and accrued interest for 2.6 million shares of our common stock. We recorded a loss on debt extinguishment, including transaction fees, of $14 million, for the transaction, primarily relating to the inducement premium paid to the bondholders, which is recorded in "Other expenses, net," in the accompanying consolidated statement of operations. We did not receive any proceeds under the 1.625% Exchange.

Following the 1.625% Exchange, we have outstanding $161 million aggregate principal amount of the 1.625% Convertible Notes. Interest is payable semiannually in arrears on February 15 and August 15. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Convertible Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Convertible Notes outstanding is less than $100 million.

The 1.625% Convertible Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Convertible Notes is 17.2157 shares of our common stock per $1,000 principal amount, or approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Convertible Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ended on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended December 31, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of December 31, 2017. As noted above, because the proceeds from the 4.875% Notes are initially restricted to payments upon conversion or redemption of the 1.625% Convertible Notes, such restricted investments are also classified as current in the accompanying consolidated balance sheets.

We may not redeem the 1.625% Convertible Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Convertible Notes, except for the 1.625% Convertible Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Convertible Notes will equal 100% of the principal amount of the 1.625% Convertible Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Convertible Notes may require us to repurchase some or all of the 1.625% Convertible Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Convertible Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Convertible Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Convertible Notes resulted in a debt discount that is amortized back to the 1.625% Convertible Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the 1.625% Convertible Notes in August 2018. As of December 31, 2017, the 1.625% Convertible Notes have a remaining amortization period of 0.6 years. This has resulted in our recognition of interest expense on the 1.625% Convertible Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Convertible Notes' if-converted value exceeded their principal amount at December 31, 2017 by approximately $50 million, and did not exceed their principal amount at December 31, 2016. At December 31, 2017 and 2016, the equity component of the 1.625% Convertible Notes, including the impact of deferred taxes, was $12 million and $23 million, respectively.

Cross-Default Provisions

The terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures.

Lease Financing Obligations

As a result of our continuing involvement in the leasing transactions described below, we are the "accounting owner" of the properties under the leases. The assets are therefore included in our consolidated balance sheets, and are depreciated over their remaining useful lives. The lease financing obligations are amortized over the initial lease terms, such that there will be no gain or loss recorded if the leases are not extended beyond their expiration dates. Payments under the leases adjust the lease financing obligations, and the imputed interest is recorded to interest expense in our consolidated statements of operations. Aggregate interest expense under these leases amounted to $17 million in each of the years ended December 31, 2017, 2016 and 2015. For information regarding the future minimum lease obligations, refer to Note 19, "Commitments and Contingencies."

Molina Center and Ohio Exchange. In 2013, we entered into a sale-leaseback transaction for the Molina Center and our Ohio health plan office building located in Columbus, Ohio, also known as the Ohio Exchange. The sale of these properties did not qualify for sales recognition, because certain lease terms resulted in our continuing involvement with these leased properties. Rent increases 3% per year through the initial term, which expires in 2038. The lease provides for six five-year renewal options, with renewal rent to be the higher of the 3% annual escalator or the then-fair market value.

6th and Pine. Also in 2013, we entered into a construction and lease transaction for two office buildings in Long Beach, California (6th and Pine). Due to our participation in the construction project, we retained continuing involvement in the properties. Rent increases 3.4% per year through the initial term, which expires in 2029. The lease provides for two five-year renewal options, with renewal rent to be determined based on the then-fair market value.

Debt Commitment Letter

In connection with the terminated Medicare acquisition described in Note 1, "Basis of Presentation," we entered into a debt commitment letter with Barclays Bank PLC (Barclays) in August 2016. Under this debt commitment letter, Barclays agreed to lend us up to $400 million, subject to satisfaction of certain conditions, including consummation of the terminated Medicare acquisition. The debt commitment letter automatically terminated in February 2017 upon termination of the Medicare acquisition.

12. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

		December 31,	
	Balance Sheet Location	2017	2016
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 522	$ 267
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 522	$ 267

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, and reported in other income, net. Gains and losses from our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, "Fair Value Measurements."

As of December 31, 2017, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within twelve months of December 31, 2017, as described in Note 11, "Debt."

13. Income Taxes

The (benefit) provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the HIF, goodwill impairment, certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by the HIF in 2017, given the 2017 HIF moratorium. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The Tax Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. The TCJA, in part, reduces the U.S. federal corporate tax rate from 35% to 21% effective January 1, 2018. TCJA's change in the federal rate requires that we revalue deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally the new 21% federal corporate tax rate plus applicable state tax rate. At December 31, 2017, we have not completed our accounting for the tax effects of enactment of the TCJA; however, we have made a reasonable estimate of the effects on our existing deferred tax balances and we recognized a provisional deferred federal income tax expense of $54 million, which is included as a reduction of income tax benefit for the year ended December 31, 2017. We will continue to make and refine our calculations as additional analysis is completed. In addition, our estimates may also be affected as we gain a more thorough understanding of the tax law based on expected future guidance from the Internal Revenue Service and U.S. Treasury.

The (benefit) provision for income taxes consisted of the following:

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Current:			
Federal	$ (9)	$ 134	$ 172
State	3	3	8
Foreign	—	(6)	6
Total current	(6)	131	186
Deferred:			
Federal	(85)	19	(10)
State	(9)	2	4
Foreign	—	1	(1)
Total deferred	(94)	22	(7)
	$ (100)	$ 153	$ 179

In 2017, the income tax benefit of $100 million is net of $54 million in deferred income tax expense as a result of the revaluation of net deferred tax assets in connection with the TCJA.

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate is as follows:

	Year Ended December 31,		
	2017	2016	2015
Statutory federal tax (benefit) rate	(35.0)%	35.0 %	35.0%
State income provision (benefit), net of federal	(0.7)	1.6	2.4
Nondeductible health insurer fee (HIF)	—	37.0	17.0
Nondeductible compensation	2.8	3.1	0.6
Nondeductible goodwill impairment	6.6	—	—
Revaluation of net deferred tax assets	8.8	—	—
Change in purchase agreement that increased tax basis in assets	—	(2.2)	—
Other	1.1	0.3	0.5
Effective tax (benefit) rate	(16.4)%	74.8 %	55.5%

Our effective tax rate is based on expected (loss) income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, foreign, and local tax laws.

During 2016, and 2015, excess tax benefits from share-based compensation amounted to $2 million and $8 million, respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital. Effective 2017, excess tax benefits are no longer recorded through additional paid-in capital but rather through the income statement as an income tax benefit pursuant to ASU 2016-09.

Deferred tax assets and liabilities are classified as non-current. Significant components of our deferred tax assets and liabilities as of December 31, 2017 and 2016 were as follows:

	December 31,	
	2017	2016
	(In millions)	
Accrued expenses	$ 15	$ 22
Reserve liabilities	11	28
Other accrued medical costs	16	5
Net operating losses	27	13
Fixed assets and intangibles	23	—
Unrealized losses	2	1
Unearned premiums	19	27
Lease financing obligation	30	38
Deferred compensation	1	6
Tax credit carryover	15	7
Valuation allowance	(41)	(16)
Total deferred income tax assets, net of valuation allowance	118	131
Prepaid expenses	(6)	(9)
Fixed assets and intangibles	—	(104)
Basis in debt	(9)	(23)
Total deferred income tax liabilities	(15)	(136)
Net deferred income tax asset (liability)	$ 103	$ (5)

At December 31, 2017, we had state net operating loss carryforwards of $578 million, which begin expiring in 2018.

At December 31, 2017, we had California research and development and enterprise zone tax credit carryovers of $14 million, which will begin to expire in 2024. In 2017, we generated federal research and development and other tax credit carryovers of $4 million, which will expire in 2038.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary

differences. We have determined that as of December 31, 2017, $41 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state net operating loss and credit carryforwards. Therefore, we increased our valuation allowance by $25 million, from $16 million at December 31, 2016, to $41 million as of December 31, 2017.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the United States, Puerto Rico, and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Gross unrecognized tax benefits at beginning of period	$ (11)	$ (9)	$ (3)
Increases in tax positions for current year	(1)	(1)	(1)
Increases in tax positions for prior years	(4)	(1)	(5)
Decreases in tax positions for prior years	3	—	—
Gross unrecognized tax benefits at end of period	$ (13)	$ (11)	$ (9)

The total amount of unrecognized tax benefits at December 31, 2017, 2016 and 2015 that, if recognized, would affect the effective tax rates is $12 million, $9 million, and $7 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $2 million due to the expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2017, 2016 and 2015 were insignificant.

We may be subject to federal examination for calendar years 2014 through 2016. We are under examination, or may be subject to examination, in Puerto Rico and certain state and local jurisdictions, with the major state jurisdictions being California, Michigan, and Illinois for the years 2009 through 2016.

14. Stockholders' Equity

1.625% Exchange

As described in Note 11, “Debt,” we issued 2.6 million shares of our common stock in connection with the 1.625% Exchange in December 2017.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 12, “Derivatives,” in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net (Loss) Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Share-Based Compensation

At December 31, 2017, we had employee equity incentives outstanding under our 2011 Equity Incentive Plan (2011 Plan). The 2011 Plan provides for the award of restricted shares and units, performance shares and units, stock options and stock bonuses to the company's officers, employees, directors, consultants, advisers, and other service providers. The 2011 Plan provides for the issuance of up to 4.5 million shares of common stock.

In connection with the 2011 Plan and employee stock purchase plan, approximately 857,000 shares of common stock were purchased or vested, net of shares used to settle employees' income tax obligations, during the year ended December 31, 2017.

Except as noted below, we record share-based compensation as "General and administrative expenses" in the accompanying consolidated statements of operations. Total share-based compensation expense was as follows:

	Year Ended December 31,					
	2017		2016		2015	
	(In millions)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock and performance awards	$ 39	$ 35	$ 20	$ 17	$ 19	$ 13
Employee stock purchase plan and stock options	7	5	6	5	4	3
	$ 46	$ 40	$ 26	$ 22	$ 23	$ 16

Restricted stock awards. Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. We recognize expense for these awards on a straight-line basis. Stock option awards generally have an exercise price equal to the fair market value of our common stock on the date of grant, vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

RSAs, PSAs and PSUs activity for the year ended December 31, 2017 is summarized below:

	Restricted Stock Awards	Performance Stock Awards	Performance Stock Units	Total Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2016	577,244	345,656	—	922,900	$ 58.15
Granted	395,946	—	231,100	627,046	57.34
Vested	(424,556)	(260,894)	(139,272)	(824,722)	57.78
Forfeited	(146,830)	—	—	(146,830)	53.89
Unvested balance as of December 31, 2017	401,804	84,762	91,828	578,394	$ 58.35

As of December 31, 2017, there was $19 million of total unrecognized compensation expense related to unvested restricted stock awards (RSAs), performance stock awards (PSAs) and performance stock units (PSUs), which we expect to recognize over a remaining weighted-average period of 2.2 years, 0.4 years and 1.6 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 11.8% for non-executive employees as of December 31, 2017, which is based on actual forfeitures over the last 4 years. Also as of December 31, 2017, there was $15 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.8 years.

The total fair value of awards granted and vested is presented in the following table:

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Granted:			
Restricted stock awards	$ 20	$ 19	$ 17
Performance stock awards	—	15	11
Performance stock units	16	—	—
	$ 36	$ 34	$ 28
Vested:			
Restricted stock awards	$ 23	$ 22	$ 23
Performance stock awards	15	—	16
Performance stock units	9	—	—
	$ 47	$ 22	$ 39

During the year ended December 31, 2017, the vesting of 133,957 RSAs, 153,574 PSAs and 139,272 PSUs was accelerated in connection with the termination of our former Chief Executive Officer (CEO) and former Chief Financial Officer (CFO) in May 2017. The incremental charge relating to this acceleration, or $23 million, is reported in “Restructuring and separation costs” in the accompanying consolidated statements of operations. This amount is included in the 2017 “Pretax Charges” in the table above. See Note 15, “Restructuring and Separation Costs” for further discussion.

Stock Options. Stock option activity for the year ended December 31, 2017 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In millions)	(Years)
Stock options outstanding as of December 31, 2016	90,000	$ 24.93		
Granted	375,000	67.33		
Exercised	(60,000)	20.88		
Stock options outstanding as of December 31, 2017	405,000	64.79	$ 5	9.5
Stock options exercisable and expected to vest as of December 31, 2017	405,000	64.79	$ 5	9.5
Exercisable as of December 31, 2017	30,000	33.02	$ 1	5.2

The weighted-average grant date fair value per share of stock options awarded in 2017 was $41.43. We estimate the fair value of each stock option award on the grant date using the Black-Scholes option pricing model. To determine the fair value of the stock options awarded in 2017 we applied a risk-free interest rate of 2.3%, expected volatility of 38.4%, dividend yield of 0% and expected life of 8.4 years. No stock options were granted in 2016 and 2015.

The total intrinsic value of options exercised during the years ended December 31, 2017, 2016, and 2015 was $2 million, $1 million, and $6 million, respectively. The following is a summary of information about stock options outstanding and exercisable at December 31, 2017:

	Options Outstanding			Options Exercisable	
	Number Outstanding	Weighted Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
Range of Exercise Prices					
$33.02	30,000	5.2	$ 33.02	30,000	$ 33.02
$67.33	375,000	9.9	67.33	—	—
	405,000			30,000	

Employee Stock Purchase Plan. Under our employee stock purchase plan (ESPP), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2017, 2016, and 2015, the inputs to this model were as follows: risk-free interest rates of approximately 0.1% to 1.1%; expected volatilities ranging from approximately 30% to 40%, dividend yields of 0%, and an average expected life of 0.5 years. We issued approximately 351,000, 410,000 and 302,000 shares of our common stock under the ESPP during the years ended December 31, 2017, 2016, and 2015, respectively. The 2011 ESPP provides for the issuance of up to three million shares of common stock.

15. Restructuring and Separation Costs

Following a management-initiated, broad operational assessment in early 2017, designed to improve our profitability and expand our core Medicaid business, in June 2017, we accelerated the implementation of a comprehensive restructuring and profitability improvement plan (the 2017 Restructuring Plan). Under the 2017 Restructuring Plan, we have taken the following actions:

1. We have streamlined our organizational structure, including the elimination of redundant layers of management, the consolidation of regional support services, and other reductions to our workforce, to improve efficiency as well as the speed and quality of our decision-making.

2. We re-designed core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology to achieve more effective and cost efficient outcomes.

3. We are remediating high cost provider contracts and building around high quality, cost-effective networks.

4. We restructured our existing direct delivery operations.

5. We reviewed our vendor base to ensure that we are partnering with the lowest-cost, most-effective vendors.

In addition to costs incurred under the 2017 Restructuring Plan, we have recorded costs associated with the separation of our former CEO and former CFO, described in further detail below.

Costs Incurred

2017 Restructuring Plan

Restructuring costs in 2017 consisted primarily of one-time termination benefits, write-offs of long-lived assets (primarily capitalized software, and leasehold improvements and other assets relating to restructured direct delivery operations), consulting fees, and contract termination costs (including office leases and other contracts).

We previously anticipated that we would incur costs under the 2017 Restructuring Plan in 2018. However, we incurred substantially all costs relating to this plan in 2017, or approximately $234 million. Such costs are presented, by type and reportable segment, below. Since the initiation of our 2017 Restructuring Plan in the second quarter of 2017, the range of total estimated costs increased by approximately $50 million due primarily to non-cash write-offs of certain capitalized software in connection with the re-design of core processes. Such write-offs were

not included in our initial total cost estimates, but as our evaluation of core operating processes proceeded in the third quarter, we determined that certain projects were inconsistent with our future operating goals and were therefore written off.

In addition, in the second quarter of 2017, we reported that we expected restructuring costs to relate only to the Health Plans and Other segments. In the third quarter of 2017, however, we wrote off certain costs capitalized at our Molina Medicaid Solutions segment that supported our Health Plans segment provider information management processes. These processes are now subject to re-design under the 2017 Restructuring Plan.

Separation Costs

On May 2, 2017, we terminated the employment of our former CEO and CFO without cause. Under their amended and restated employment agreements, they were each entitled to receive 400% of their base salary, a prorated termination bonus (150% of base salary for the former CEO and 125% of base salary for the former CFO), full vesting of equity compensation, and a cash payment for health and welfare benefits. We recorded separation costs of $36 million primarily related to these former executives under FASB ASC Topic 712, *Nonretirement and Postemployment Benefits*. Of this total, $23 million related to the acceleration of their share-based compensation, as further discussed in Note 14, “Stockholders' Equity.” Employee separation costs were insignificant in 2016 and 2015.

Restructuring and separation costs are reported in “Restructuring and separation costs” in the accompanying consolidated statements of operations. The following tables present the major types of such costs by segment. Long-lived assets include capitalized software, intangible assets and furniture, fixtures and equipment.

	Year Ended December 31, 2017					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
	(In millions)					
Health Plans	$ —	$ 33	$ 16	$ —	$ 24	$ 73
Molina Medicaid Solutions	—	—	8	—	—	8
Other	36	34	37	44	2	153
	$ 36	$ 67	$ 61	$ 44	$ 26	$ 234

Reconciliation of Liability

For those restructuring and separation costs that require cash settlement (primarily separation costs not including equity incentives, termination benefits, consulting fees and contract termination costs), the following table presents a roll-forward of the accrued liability, which is reported primarily in “Accounts payable and accrued liabilities” in the accompanying consolidated balance sheets. Certain contract termination cost accruals are non-current, recorded in “Other long-term liabilities.”

	Separation Costs - Former Executives	One-Time Termination Benefits	Other Restructuring Costs	Total
	(In millions)			
Accrued as of December 31, 2016	$ —	$ —	$ —	$ —
Charges	13	66	71	150
Cash payments	(11)	(55)	(36)	(102)
Accrued as of December 31, 2017	$ 2	$ 11	$ 35	$ 48

16. Employee Benefits

We sponsor defined contribution 401(k) plans that cover substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We generally match up to the first 4% of compensation contributed by employees. Expense

recognized in connection with our contributions to the 401(k) plans totaled $43 million, $36 million, and $27 million in the years ended December 31, 2017, 2016, and 2015, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

17. Related Party Transactions

As described in Note 15, “Restructuring and Separation Costs,” we terminated the employment of Dr. J. Mario Molina and John C. Molina without cause in May 2017. In addition, Dr. Molina resigned his board directorship in December 2017, and John C. Molina resigned his board directorship on February 23, 2018.

As of December 31, 2017, we held a receivable of $5 million in connection with the termination of the provider and other services agreements with Dr. Molina’s professional corporation in Michigan. Such agreements are described in further detail in Note 18, “Variable Interest Entities (VIEs).”

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. Molina and Mr. Molina. Under the terms of this provider agreement, the California health plan pays Pacific for medical care services that Pacific provides to health plan members. For the years ended December 31, 2017 and 2016, the amounts the California health plan paid to Pacific Healthcare were insignificant. For 2015, the California health plan paid Pacific approximately $1 million.

18. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) constitute medical provider groups originally created to advance our direct delivery business. JMMPC’s primary shareholder is Dr. J. Mario Molina, who was formerly both Molina’s CEO, and a member of our board of directors. When JMMPC was created, we concluded that we were the primary beneficiary of the JMMPC VIE because we had the power to direct the activities (excluding clinical decisions) that most significantly affected JMMPC’s economic performance, and the obligation to absorb losses or right to receive benefits that were potentially significant to the VIE, under the agreements described below. Because we were its primary beneficiary, we consolidated JMMPC as of December 31, 2017 and 2016.

In 2017, we made the strategic decision to restructure our direct delivery business. Effective September 30, 2017, we terminated our relationship with JMMPC in Florida, Michigan, New Mexico, Washington, and Utah. Therefore, the agreements among JMMPC, our wholly owned subsidiary Molina Medical Management, Inc. (MMM), and the Florida, Michigan, New Mexico, Washington and Utah health plans were terminated effective September 30, 2017.

In early January 2018, the agreements among JMMPC, MMM, and our California health plan terminated. In connection with the termination of the agreements in California, MMM entered into an asset purchase agreement with JMMPC, under which MMM sold various clinic and other assets to JMMPC for approximately $2 million. In addition, our California health plan entered into a new provider agreement with JMMPC. Following the termination of the agreements noted above, we will no longer have a) the power to direct the activities that most significantly affect JMMPC’s economic performance, or b) the obligation to absorb losses or right to receive benefits that are potentially significant to JMMPC.

JMMPC’s assets were available to settle only JMMPC’s obligations, and JMMPC’s creditors had no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2017, JMMPC had total assets of $8 million, and total liabilities of $8 million. As of December 31, 2016, JMMPC had total assets of $18 million, and total liabilities of $18 million. The health plans were parties to primary care services agreements with JMMPC, under which the health plans paid $119 million, $122 million, and $117 million to JMMPC for such services in the years ended December 31, 2017, 2016, and 2015, respectively. These agreements directed our health plans to either fund JMMPC’s operating deficits, or be reimbursed for JMMPC’s operating surpluses, such that JMMPC would derive no profits or losses. MMM was a party to services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services, and medical supplies to JMMPC. In the years ended December 31, 2017, 2016, and 2015, JMMPC paid $50 million, $55 million and $69 million, respectively, to MMM for such services. The

administrative services charged under these agreements were reviewed annually to assure that JMMPC would operate at break-even.

New Markets Tax Credit

In 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC (Wells Fargo), its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC (Investment Fund), and certain of Wells Fargo's affiliated Community Development Entities (CDEs), in connection with our participation in the federal government's New Markets Tax Credit Program (NMTC). The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period, which ends in the fourth quarter of 2018.

As a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $6 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $16 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $21 million to our New Mexico data center subsidiary. We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, that we are the primary beneficiary of the VIE, and we have included it in our consolidated financial statements.

19. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,691 million at December 31, 2017, and $1,492 million at December 31, 2016. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $696 million and $264 million as of December 31, 2017 and 2016, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states.

As of December 31, 2017, our health plans had aggregate statutory capital and surplus of approximately $1,777 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,186 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2017. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Legal Proceedings

The health care and Medicaid-related business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain

matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

States' Budgets

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures. For example, the government of Puerto Rico continues to struggle with major fiscal and liquidity challenges. The extreme financial difficulties faced by the Commonwealth may make it very difficult for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2017, our Puerto Rico health plan served approximately 314,000 members and recorded premium revenue of approximately $732 million for the year ended December 31, 2017. As of February 23, 2018, the Commonwealth is current with its premium payments.

Operating Leases

We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2027. Facility lease terms generally range from five to 10 years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under operating leases and lease financing obligations consist of the following amounts:

	Lease Financing Obligations	Operating Leases	Total
		(In millions)	
2018	$ 17	$ 67	$ 84
2019	18	65	83
2020	19	44	63
2021	19	30	49
2022	20	22	42
Thereafter	317	34	351
	$ 410	$ 262	$ 672

Rental expense related to operating leases amounted to $75 million, $64 million, and $44 million for the years ended December 31, 2017, 2016, and 2015, respectively. The amounts reported in "Lease Financing Obligations" above represent our contractual lease commitments for the properties described in Note 11, "Debt" under the subheading "Lease Financing Obligations."

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered in the primary care institutions that we manage. In addition, we also carry errors and omissions insurance for all Molina entities.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues

of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

20. Segment Information

We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

Our reportable segments are consistent with how we currently manage our business and view the markets we serve. The Health Plans segment consists of our health plans. Our health plans are operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
2017				
Total revenue	$ 19,352	$ 187	$ 344	$ 19,883
Gross margin [1]	1,781	16	13	1,810
Depreciation and amortization [2]	126	43	9	178
Goodwill, and intangible assets, net	212	43	—	255
Total assets	6,347	219	1,905	8,471
2016				
Total revenue	17,234	195	353	17,782
Gross margin [1]	1,671	21	33	1,725
Depreciation and amortization [2]	122	45	15	182
Goodwill, and intangible assets, net	513	72	175	760
Total assets	5,897	267	1,285	7,449
2015				
Total revenue	13,917	195	66	14,178
Gross margin [1]	1,467	55	5	1,527
Depreciation and amortization [2]	95	25	6	126
Goodwill, and intangible assets, net	393	73	175	641
Total assets	4,707	213	1,656	6,576

(1) In connection with the reclassification of Medicare and Marketplace health insurer fees to premium revenue, from health insurer fees reimbursed, amounts differ from amounts previously reported as follows: the Health Plans segment gross

margin for the years ended December 31, 2016 and 2015 increased $53 million, and $20 million, respectively. The Consolidated gross margin increased by the same amounts.

(2) Depreciation and amortization reported in accompanying consolidated statements of cash flows.

The following table reconciles gross margin by segment to consolidated (loss) income before income tax (benefit) expense:

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Gross margin:			
Health Plans	$ 1,781	$ 1,671	$ 1,467
Molina Medicaid Solutions	16	21	55
Other	13	33	5
Total gross margin	1,810	1,725	1,527
Add: other operating revenues (1)	508	798	664
Less: other operating expenses (2)	(2,873)	(2,217)	(1,804)
Operating (loss) income	(555)	306	387
Other expenses, net	57	101	65
(Loss) income before income tax (benefit) expense	$ (612)	$ 205	$ 322

(1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, impairment losses, and restructuring and separation costs.

21. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2017 and 2016.

	For The Quarter Ended			
	March 31, 2017	June 30, 2017	Sept. 30, 2017	December 31, 2017
	(In millions, except per-share data)			
Total revenue	$ 4,904	$ 4,999	$ 5,031	$ 4,949
Gross margin	546	254	564	446
Impairment losses	—	72	129	269
Restructuring and separation costs	—	43	118	73
Net income (loss)	77	(230)	(97)	(262)
Net income (loss) per share [1]:				
Basic	$ 1.38	$ (4.10)	$ (1.70)	$ (4.59)
Diluted	$ 1.37	$ (4.10)	$ (1.70)	$ (4.59)

	For The Quarter Ended			
	March 31, 2016	June 30, 2016	Sept. 30, 2016	December 31, 2016
	(In millions, except per-share data)			
Total revenue	$ 4,343	$ 4,359	$ 4,546	$ 4,534
Gross margin [2]	434	466	471	354
Net income (loss)	24	33	42	(47)
Net income (loss) per share [1]:				
Basic	$ 0.44	$ 0.58	$ 0.77	$ (0.85)
Diluted	$ 0.43	$ 0.58	$ 0.76	$ (0.85)

(1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income (loss) per share because to do so would be anti-dilutive.

(2) The Centers for Medicare and Medicaid Services (CMS) incorporates the Health Insurer Fee (HIF) in our Medicare and Marketplace premium rates. We have therefore reclassified such amounts in our consolidated statements of operations to premium revenue, from health insurer fees reimbursed, for all applicable periods presented. As a result, gross margin amounts differ from amounts previously reported as follows: for the quarters ended March 31, June 30, September 30, and December 31, 2016, gross margin increased $14 million, $12 million, $14 million, and $13 million, respectively.

22. Condensed Financial Information of Registrant

The condensed balance sheets as of December 31, 2017 and 2016, and the related condensed statements of operations, comprehensive (loss) income and cash flows for each of the three years in the period ended December 31, 2017 for our parent company Molina Healthcare, Inc. (the Registrant), are presented below.

Condensed Balance Sheets

	December 31,	
	2017	2016
	(In millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 504	$ 86
Investments	192	178
Restricted investments	169	—
Receivables	2	2
Income taxes refundable	16	17
Due from affiliates	148	104
Prepaid expenses and other current assets	87	58
Derivative asset	522	267
Total current assets	1,640	712
Property, equipment, and capitalized software, net	223	301
Goodwill and intangible assets, net	15	58
Investments in subsidiaries	2,306	2,609
Deferred income taxes	17	10
Advances to related parties and other assets	32	48
	$ 4,233	$ 3,738
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 3	$ 1
Accounts payable and accrued liabilities	178	146
Current portion of long-term debt	653	472
Derivative liability	522	267
Total current liabilities	1,356	886
Senior notes	1,318	975
Lease financing obligations	198	198
Deferred income taxes	—	11
Other long-term liabilities	24	19
Total liabilities	2,896	2,089
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding:		
60 shares at December 31, 2017 and 57 shares at December 31, 2016	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	1,044	841
Accumulated other comprehensive loss	(5)	(2)
Retained earnings	298	810
Total stockholders' equity	1,337	1,649
	$ 4,233	$ 3,738

See accompanying notes.

Condensed Statements of Operations

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Revenue:			
Management fees	$ 1,317	$ 1,062	$ 914
Investment income and other revenue	16	16	17
Total revenue	1,333	1,078	931
Expenses:			
Medical care costs	16	73	55
General and administrative expenses	1,082	899	797
Depreciation and amortization	93	95	82
Impairment losses	39	—	—
Restructuring and separation costs	153	—	—
Total operating expenses	1,383	1,067	934
Operating (loss) income	(50)	11	(3)
Interest expense	117	101	66
Other income	(61)	—	—
Loss before income taxes and equity in net income of subsidiaries	(106)	(90)	(69)
Income tax expense (benefit)	8	(24)	(21)
Net loss before equity in net income of subsidiaries	(114)	(66)	(48)
Equity in net (loss) income of subsidiaries	(398)	118	191
Net (loss) income	$ (512)	$ 52	$ 143

Condensed Statements of Comprehensive (Loss) Income

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Net (loss) income	$ (512)	$ 52	$ 143
Other comprehensive (loss) income:			
Unrealized investment (loss) gain	(5)	3	(5)
Less: effect of income taxes	(2)	1	(2)
Other comprehensive (loss) income, net of tax	(3)	2	(3)
Comprehensive (loss) income	$ (515)	$ 54	$ 140

See accompanying notes.

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2017	2016	2015
	(In millions)		
Operating activities:			
Net cash provided by operating activities	$ 166	$ 55	$ 113
Investing activities:			
Capital contributions to subsidiaries	(370)	(386)	(770)
Dividends received from subsidiaries	286	101	142
Purchases of investments	(352)	(115)	(244)
Proceeds from sales and maturities of investments	168	188	118
Purchases of property, equipment and capitalized software	(67)	(125)	(91)
Change in amounts due to/from affiliates	(49)	(18)	(68)
Other, net	—	6	—
Net cash used in investing activities	(384)	(349)	(913)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	325	—	689
Proceeds from borrowings under credit facility	300	—	—
Proceeds from common stock offering, net of issuance costs	—	—	373
Proceeds from employee stock plans	19	18	18
Cash paid for financing transaction fees	(7)	—	—
Other, net	(1)	2	5
Net cash provided by financing activities	636	20	1,085
Net increase (decrease) in cash and cash equivalents	418	(274)	285
Cash and cash equivalents at beginning of year	86	360	75
Cash and cash equivalents at end of year	$ 504	$ 86	$ 360

See accompanying notes.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

The Registrant was incorporated in 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for three other state health plans. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2017, 2016, and 2015 for these services amounted to $1,317 million, $1,062 million, and $914 million, respectively, and are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would

be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Dividends and Capital Contributions

When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries.

For all periods presented, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund business combinations. Such amounts have been recorded as an increase in investment in the respective subsidiaries, net of insignificant returns of capital.

Note D - Related Party Transactions

The Registrant's related party transactions are described in Note 17, "Related Party Transactions."

23. Supplemental Condensed Consolidating Financial Information

As discussed in Note 11, “Debt,” we have outstanding $700 million aggregate principal amount of 5.375% Notes due November 15, 2022, unless earlier redeemed. The 5.375% Notes were registered in September 2016, and are fully and unconditionally guaranteed by certain of our wholly owned subsidiaries on a joint and several basis, with exceptions considered customary for such guarantees.

All guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC and Pathways Health and Community Support LLC, were automatically and unconditionally released as guarantors of our amended Credit Facility, the 5.375% Notes, and the 4.875% Notes.

For all periods presented, the following condensed consolidating financial statements present Molina Healthcare, Inc. (as “Parent Guarantor”), the subsidiary guarantors (as “Other Guarantors”), the subsidiary non-guarantors (as “Non-Guarantors”) and “Eliminations,” according to the guarantor structure as assessed as of and for the year ended December 31, 2017.

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Year Ended December 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 1,333	$ 194	$ 19,712	$ (1,356)	$ 19,883
Expenses:					
Medical care costs	16	—	17,058	(1)	17,073
Cost of service revenue	—	171	321	—	492
General and administrative expenses	1,082	17	1,850	(1,355)	1,594
Premium tax expenses	—	—	438	—	438
Depreciation and amortization	93	1	43	—	137
Impairment losses	39	28	403	—	470
Restructuring and separation costs	153	8	73	—	234
Total operating expenses	1,383	225	20,186	(1,356)	20,438
Operating loss	(50)	(31)	(474)	—	(555)
Interest expense	117	—	1	—	118
Other income	(61)	—	—	—	(61)
Loss before income taxes	(106)	(31)	(475)	—	(612)
Income tax expense (benefit)	8	(21)	(87)	—	(100)
Net loss before equity in earnings of subsidiaries	(114)	(10)	(388)	—	(512)
Equity in net earnings of subsidiaries	(398)	(156)	—	554	—
Net loss	$ (512)	$ (166)	$ (388)	$ 554	$ (512)

	Year Ended December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 1,078	$ 202	$ 17,584	$ (1,082)	$ 17,782
Expenses:					
Medical care costs	73	—	14,702	(1)	14,774
Cost of service revenue	—	174	311	—	485
General and administrative expenses	899	16	1,559	(1,081)	1,393
Premium tax expenses	—	—	468	—	468
Health insurer fees	—	—	217	—	217
Depreciation and amortization	95	1	43	—	139
Total operating expenses	1,067	191	17,300	(1,082)	17,476
Operating income	11	11	284	—	306
Total other expenses, net	101	—	—	—	101
(Loss) income before income taxes	(90)	11	284	—	205
Income tax (benefit) expense	(24)	3	174	—	153
Net (loss) income before equity in earnings of subsidiaries	(66)	8	110	—	52
Equity in net earnings of subsidiaries	118	1	—	(119)	—
Net income	$ 52	$ 9	$ 110	$ (119)	$ 52

	Year Ended December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 931	$ 195	$ 13,980	$ (928)	$ 14,178
Expenses:					
Medical care costs	55	—	11,740	(1)	11,794
Cost of service revenue	—	140	53	—	193
General and administrative expenses	797	31	1,245	(927)	1,146
Premium tax expenses	—	—	397	—	397
Health insurer fees	—	—	157	—	157
Depreciation and amortization	82	1	21	—	104
Total operating expenses	934	172	13,613	(928)	13,791
Operating (loss) income	(3)	23	367	—	387
Total other expenses, net	66	—	(1)	—	65
(Loss) income before income taxes	(69)	23	368	—	322
Income tax (benefit) expense	(21)	7	193	—	179
Net (loss) income before equity in earnings of subsidiaries	(48)	16	175	—	143
Equity in net earnings of subsidiaries	191	(1)	—	(190)	—
Net income	$ 143	$ 15	$ 175	$ (190)	$ 143

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE (LOSS) INCOME

	Year Ended December 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net loss	$ (512)	$ (166)	$ (388)	$ 554	$ (512)
Other comprehensive loss, net of tax	(3)	—	(2)	2	(3)
Comprehensive loss	$ (515)	$ (166)	$ (390)	$ 556	$ (515)

	Year Ended December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net income	$ 52	$ 9	$ 110	$ (119)	$ 52
Other comprehensive income, net of tax	2	—	1	(1)	2
Comprehensive income	$ 54	$ 9	$ 111	$ (120)	$ 54

	Year Ended December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net income	$ 143	$ 15	$ 175	$ (190)	$ 143
Other comprehensive loss, net of tax	(3)	—	(3)	3	(3)
Comprehensive income	$ 140	$ 15	$ 172	$ (187)	$ 140

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
ASSETS					
Current assets:					
Cash and cash equivalents	$ 504	$ 28	$ 2,654	$ —	$ 3,186
Investments	192	—	2,332	—	2,524
Restricted investments	169	—	—	—	169
Receivables	2	30	839	—	871
Income tax refundable	16	(8)	46	—	54
Due from (to) affiliates	148	(6)	(142)	—	—
Prepaid expenses and other current assets	87	22	92	(16)	185
Derivative asset	522	—	—	—	522
Total current assets	1,640	66	5,821	(16)	7,511
Property, equipment, and capitalized software, net	223	33	86	—	342
Deferred contract costs	—	101	—	—	101
Goodwill and intangible assets, net	15	43	197	—	255
Restricted investments	—	—	119	—	119
Investment in subsidiaries, net	2,306	82	—	(2,388)	—
Deferred income taxes	17	—	101	(15)	103
Other assets	32	2	7	(1)	40
	$ 4,233	$ 327	$ 6,331	$ (2,420)	$ 8,471
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 3	$ —	$ 2,189	$ —	$ 2,192
Amounts due government agencies	—	1	1,541	—	1,542
Accounts payable and accrued liabilities	178	40	148	—	366
Deferred revenue	—	49	233	—	282
Current portion of long-term debt	653	—	16	(16)	653
Derivative liability	522	—	—	—	522
Total current liabilities	1,356	90	4,127	(16)	5,557
Long-term debt	1,516	—	—	—	1,516
Deferred income taxes	—	15	—	(15)	—
Other long-term liabilities	24	2	36	(1)	61
Total liabilities	2,896	107	4,163	(32)	7,134
Total stockholders' equity	1,337	220	2,168	(2,388)	1,337
	$ 4,233	$ 327	$ 6,331	$ (2,420)	$ 8,471

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
ASSETS					
Current assets:					
Cash and cash equivalents	$ 86	$ 6	$ 2,727	$ —	$ 2,819
Investments	178	—	1,580	—	1,758
Receivables	2	34	938	—	974
Income tax refundable	17	4	18	—	39
Due from (to) affiliates	104	(5)	(99)	—	—
Prepaid expenses and other current assets	58	30	43	—	131
Derivative asset	267	—	—	—	267
Total current assets	712	69	5,207	—	5,988
Property, equipment, and capitalized software, net	301	46	107	—	454
Deferred contract costs	—	86	—	—	86
Goodwill and intangible assets, net	58	73	629	—	760
Restricted investments	—	—	110	—	110
Investment in subsidiaries, net	2,609	246	—	(2,855)	—
Deferred income taxes	10	—	—	—	10
Other assets	48	3	6	(16)	41
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 1	$ —	$ 1,928	$ —	$ 1,929
Amounts due government agencies	—	—	1,202	—	1,202
Accounts payable and accrued liabilities	146	34	205	—	385
Deferred revenue	—	40	275	—	315
Current portion of long-term debt	472	—	—	—	472
Derivative liability	267	—	—	—	267
Total current liabilities	886	74	3,610	—	4,570
Long-term debt	1,173	—	16	(16)	1,173
Deferred income taxes	11	39	(35)	—	15
Other long-term liabilities	19	1	22	—	42
Total liabilities	2,089	114	3,613	(16)	5,800
Total stockholders' equity	1,649	409	2,446	(2,855)	1,649
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Year Ended December 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 166	83	555	—	$ 804
Investing activities:					
Purchases of investments	(352)	—	(2,366)	—	(2,718)
Proceeds from sales and maturities of investments	168	—	1,603	—	1,771
Purchases of property, equipment and capitalized software	(67)	(11)	(8)	—	(86)
Increase in restricted investments	—	—	(12)	—	(12)
Capital contributions to subsidiaries	(370)	2	368	—	—
Dividends received from subsidiaries	286	(25)	(261)	—	—
Change in amounts due to/from affiliates	(49)	1	48	—	—
Other, net	—	(28)	—	—	(28)
Net cash used in by investing activities	(384)	(61)	(628)	—	(1,073)
Financing activities:					
Proceeds from senior notes offering, net of issuance costs	325	—	—	—	325
Proceeds from borrowings under credit facility	300	—	—	—	300
Proceeds from employee stock plans	19	—	—	—	19
Cash paid for financing transaction fees	(7)	—	—	—	(7)
Other, net	(1)	—	—	—	(1)
Net cash provided by financing activities	636	—	—	—	636
Net increase (decrease) in cash and cash equivalents	418	22	(73)	—	367
Cash and cash equivalents at beginning of period	86	6	2,727	—	2,819
Cash and cash equivalents at end of period	$ 504	$ 28	$ 2,654	$ —	$ 3,186

	Year Ended December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 55	48	570	—	$ 673
Investing activities:					
Purchases of investments	(115)	—	(1,814)	—	(1,929)
Proceeds from sales and maturities of investments	188	—	1,778	—	1,966
Purchases of property, equipment and capitalized software	(125)	(29)	(22)	—	(176)
Decrease in restricted investments	—	—	4	—	4
Net cash paid in business combinations	—	(5)	(43)	—	(48)
Capital contributions to subsidiaries	(386)	7	379	—	—
Dividends received from subsidiaries	101	—	(101)	—	—
Change in amounts due to/from affiliates	(18)	(2)	20	—	—
Other, net	6	(26)	1	—	(19)
Net cash (used in) provided by investing activities	(349)	(55)	202	—	(202)
Financing activities:					
Proceeds from employee stock plans	18	—	—	—	18
Other, net	2	—	(1)	—	1
Net cash provided by financing activities	20	—	(1)	—	19
Net (decrease) increase in cash and cash equivalents	(274)	(7)	771	—	490
Cash and cash equivalents at beginning of period	360	13	1,956	—	2,329
Cash and cash equivalents at end of period	$ 86	$ 6	$ 2,727	$ —	$ 2,819

	Year Ended December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 113	51	961	—	$ 1,125
Investing activities:					
Purchases of investments	(244)	—	(1,679)	—	(1,923)
Proceeds from sales and maturities of investments	118	—	1,008	—	1,126
Purchases of property, equipment and capitalized software	(91)	(20)	(21)	—	(132)
Decrease in restricted investments	—	5	(11)	—	(6)
Net cash paid in business combinations	—	(174)	(276)	—	(450)
Capital contributions to subsidiaries	(770)	236	534	—	—
Dividends received from subsidiaries	142	—	(142)	—	—
Change in amounts due to/from affiliates	(68)	(63)	131	—	—
Other, net	—	(35)	—	—	(35)
Net cash used in investing activities	(913)	(51)	(456)	—	(1,420)
Financing activities:					
Proceeds from senior notes offerings, net of issuance costs	689	—	—	—	689
Proceeds from common stock offering, net of issuance costs	373	—	—	—	373
Proceeds from employee stock plans	18	—	—	—	18
Other, net	5	—	—	—	5
Net cash provided by financing activities	1,085	—	—	—	1,085
Net increase in cash and cash equivalents	285	—	505	—	790
Cash and cash equivalents at beginning of period	75	13	1,451	—	1,539
Cash and cash equivalents at end of period	$ 360	$ 13	$ 1,956	$ —	$ 2,329

DIRECTORS, EXECUTIVE OFFICERS, AND CORPORATE GOVERNANCE

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
Joseph M. Zubretsky	61	President and Chief Executive Officer
Joseph W. White	59	Chief Financial Officer
Jeff D. Barlow	55	Chief Legal Officer and Corporate Secretary
Pamela S. Sedmak	56	Executive Vice President, Health Plan Operations
Mark L. Keim	52	Executive Vice President, Strategic Planning, Corporate Development & Transformation
Lisa A. Rubino	60	Senior Vice President, Medicare and Duals Integration

Mr. Zubretsky has served as President and Chief Executive Officer since November 6, 2017. He joins the Company from The Hanover Insurance Group, Inc., where he served as its President and Chief Executive Officer from June 2016 to October 2017. Prior to that, Mr. Zubretsky served almost nine years at Aetna, Inc., where he most recently served as Chief Executive Officer of Healthagen Holdings, a group of healthcare services and information technology companies at Aetna, from January 2015 to October 2015. Prior to that, he served as a Senior Executive Vice President leading Aetna's National Businesses from 2013 to 2014, and served as Aetna's Chief Financial Officer from 2007 to 2013. None of the entities where Mr. Zubretsky was previously employed is a parent, subsidiary or other affiliate of the Company.

Mr. White has served as Chief Financial Officer since May 2, 2017. Prior to that, Mr. White had served as Chief Accounting Officer since 2007. Mr. White also served as our Interim President and Chief Executive Officer from May 2, 2017 to November 6, 2017.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010.

Ms. Sedmak has served as Executive Vice President, Health Plan Operations since February 2018. Ms. Sedmak brings more than 25 years of Medicaid managed care leadership experience in operations, strategy, and finance. Most recently, she was a senior adviser at McKinsey & Company, serving clients in the health care services and global corporate finance practice areas. Prior to McKinsey, she served as president and CEO for Aetna Medicaid/Dual Eligibles. Before Aetna, Ms. Sedmak held C-level leadership positions at Blue Cross and Blue Shield of Minnesota, CareSource and General Electric. None of the entities where Ms. Sedmak was previously employed is a parent, subsidiary or other affiliate of the Company.

Mr. Keim has served as Executive Vice President, Strategic Planning, Corporate Development and Transformation since January 2018. Most recently, he served as executive vice president of corporate development and strategy for The Hanover Insurance Group. Prior to The Hanover Insurance Group, Mr. Keim spent six years with Aetna where he led major strategic initiatives. Before Aetna, he was senior vice president of strategy and business development at GE Capital. None of the entities where Mr. Keim was previously employed is a parent, subsidiary or other affiliate of the Company.

Ms. Rubino has served as our Senior Vice President, Medicare & Duals Integration since 2013. From 2012 to 2013, Ms. Rubino served as Senior Vice President of Health Plans, Western Region. From 2007 to 2012, Ms. Rubino served as the President of Molina Healthcare of California.

Each executive officer serves at the pleasure of the board of directors.

The remaining information called for by Item 10 of Form 10-K is incorporated by reference to "Election of Directors," "Corporate Governance and Board of Directors Matters," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2018 Annual Meeting of Stockholders.

EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) The consolidated financial statements and exhibits listed below are filed as part of this Form 10-K.

(1) The financial statements included in Financial Statements and Supplementary Data, above, are filed as part of this annual report.

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 1st day of March, 2018.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Zubretsky **Joseph M. Zubretsky**	Chief Executive Officer, President and Director (Principal Executive Officer)	March 1, 2018
/s/ Joseph W. White **Joseph W. White**	Chief Financial Officer and Treasurer (Principal Financial Officer)	March 1, 2018
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	March 1, 2018
/s/ Daniel Cooperman **Daniel Cooperman**	Director	March 1, 2018
/s/ Charles Z. Fedak **Charles Z. Fedak**	Director	March 1, 2018
/s/ Steven J. Orlando **Steven J. Orlando**	Director	March 1, 2018
/s/ Ronna E. Romney **Ronna E. Romney**	Director	March 1, 2018
/s/ Richard M. Schapiro **Richard M. Schapiro**	Director	March 1, 2018
/s/ Dale B. Wolf **Dale B. Wolf**	Chairman of the Board	March 1, 2018

INDEX TO EXHIBITS

The following exhibits, which are furnished with this Annual Report on Form 10-K (this "Form 10-K") or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Form 10-K may contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Form 10-K not misleading.

Number	Description	Method of Filing
2.1	Membership Interest Purchase Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Healthcare, Inc.	Filed as Exhibit 2.1 to registrant's Form 8-K filed September 8, 2015.
2.2	Amendment to Membership Interest Purchase Agreement, dated as of October 30, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Pathways, LLC, as assignee of all rights and obligations of Molina Healthcare, Inc.	Filed as Exhibit 2.2 to registrant's Form 10-K filed February 26, 2016.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Certificate of Amendment to Certificate of Incorporation	Filed as Appendix A to registrant's Definitive Proxy Statement on Form DEF 14A filed March 25, 2013.
3.3	Third Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 10-Q filed July 30, 2014.
4.1	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.2	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.3	Indenture, dated as of September 5, 2014, by and between Molina Healthcare, Inc. and U.S. Bank National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014.
4.4	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014.
4.5	First Supplemental Indenture, dated as of September 16, 2014, by and between Molina Healthcare, Inc. and the U.S. Bank National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014.
4.6	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014.
4.7	Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.8	Form of 5.375% Senior Notes due 2022	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.9	Form of Guarantee pursuant to Indenture, dated as of November 10, 2015, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.10	First Supplemental Indenture, dated as of February 16, 2016, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 18, 2016.
4.11	Indenture, dated June 6, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee.	Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.

Number	Description	Method of Filing
4.12	Form of Notes (included in Exhibit 4.1 to registrant's Form 8-K filed June 6, 2017).	Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
4.13	Form of Guarantees (included in Exhibit 4.1 to registrant's Form 8-K filed June 6, 2017).	Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
*10.1	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2018)	Filed herewith.
*10.2	2011 Equity Incentive Plan	Filed as Exhibit 10.8 to registrant's Form 10-K filed February 26, 2014.
*10.3	2011 Employee Stock Purchase Plan	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2015.
*10.4	Molina Healthcare, Inc. Change in Control Severance Plan (2017)	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 4, 2017.
*10.5	2011 Equity Incentive Plan - Form of Stock Option Agreement (Director)	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 4, 2017.
*10.6	2011 Equity Incentive Plan - Form of Restricted Stock Award Agreement (Employee)	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 4, 2017.
*10.7	2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 1 (Executive Officer)	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 4, 2017.
*10.8	2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 2 (Executive Officer)	Filed as Exhibit 10.5 to registrant's Form 10-Q filed May 4, 2017.
*10.9	Amended and Restated Employment Agreement with Joseph W. White, dated June 5, 2017, and effective as of May 2, 2017.	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 7, 2017.
*10.10	Employment Agreement with Jeff Barlow dated June 14, 2013	Filed as Exhibit 10.3 to registrant's Form 8-K filed June 14, 2013.
*10.11	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
*10.12	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed as Exhibit 10.16 to registrant's Form 10-K filed February 28, 2013.
*10.13	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
*10.14	Waiver and Release Agreement, dated June 24, 2017, by and between J. Mario Molina and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K/A filed June 28, 2017.
*10.15	Waiver and Release Agreement, dated June 26, 2017, by and between John Molina and Molina Healthcare, Inc.	Filed as Exhibit 10.2 to registrant's Form 8-K/A filed June 28, 2017.
*10.16	Employment Agreement, dated October 9, 2017, by and between Molina Healthcare, Inc. and Joseph M. Zubretsky.	Filed as Exhibit 10.1 to registrant's Form 8-K filed October 10, 2017.
*10.17	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
*10.18	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.
10.19	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.
10.20	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.21	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.22	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.23	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.24	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.

Number	Description	Method of Filing
10.25	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013.
10.26	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013.
10.27	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013.
10.28	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013.
10.29	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013.
10.30	Credit Agreement, dated as of June 12, 2015, by and among Molina Healthcare, Inc., Molina Information Systems, LLC, Molina Medical Management, Inc., certain lenders named on the signature pages thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2015.
10.31	First Amendment to Credit Agreement, dated as of January 3, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank, including the amended and restated Credit Agreement attached as Exhibit A thereto	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 3, 2017.
10.32	Second Amendment to Credit Agreement, dated as of February 15, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 17, 2017.
10.33	Guarantor Joinder Agreement, dated February 16, 2016, by and among the guarantors party thereto and SunTrust Bank, as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 18, 2016.
10.34	Third Amendment to Credit Agreement, dated as of May 19, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacities as Administrative Agent, Issuing Bank and Swingline Lender.	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 22, 2017.
10.35	Purchase Agreement, dated May 22, 2017, by and among the Company, the guarantors party thereto and SunTrust Robinson Humphrey, Inc., as representative of the several initial purchasers named in Schedule A thereto.	Filed as Exhibit 1.1 to registrant's Form 8-K filed May 23, 2017.
10.36	Fourth Amendment to Credit Agreement, dated as of August 29, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacities as Administrative Agent, Issuing Bank and Swingline Lender.	Filed as Exhibit 10.1 to registrant's Form 8-K filed September 1, 2017.
10.37	Commitment Letter, dated December 4, 2017, by and among Molina Healthcare, Inc., SunTrust Bank and SunTrust Robinson Humphrey, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed December 7, 2017.
10.38	Form of Fifth Amendment to Credit Agreement, dated as of December 19, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacities as Administrative Agent, Issuing Bank and Swingline Lender.	Filed as Exhibit 10.1 to registrant's Form 8-K filed December 26, 2017.
10.39	Amended and Restated Commitment Letter, dated as of January 2, 2018, by and among Molina Healthcare, Inc., SunTrust Bank, SunTrust Robinson Humphrey, Inc., Barclays Bank PLC, MUFG, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Morgan Stanley Senior Funding, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 2, 2018.

Number	Description	Method of Filing
10.40	Bridge Credit Agreement, dated as of January 2, 2018, by and among Molina Healthcare, Inc., as the Borrower, Molina Information Systems, LLC, Molina Pathways LLC and Pathways Health and Community Support LLC, as the Guarantors, SunTrust Bank, Barclays Bank PLC, The Bank of Tokyo-Mitsubishi UFJ, Ltd., Bank of America, N.A., and Morgan Stanley Senior Funding, Inc., as Lenders, and SunTrust Bank, as Administrative Agent.	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 2, 2018.
10.41	Capitated Medical Group/IPA Provider Services Agreement, effective May 1, 2013, by and between Molina Healthcare of California and Pacific Healthcare IPA	Filed as Exhibit 10.42 to registrant's Form 10-K filed February 26, 2016.
10.42	Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to Molina Healthcare of California Group/IPA Provider Services Agreement(s), effective September 26, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed as Exhibit 10.43 to registrant's Form 10-K filed February 26, 2016.
10.43	Capitated Financial Alignment Demonstration Amendment to Molina Healthcare of California Group/IPA Provider Services Agreement, effective as of July 1, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed as Exhibit 10.44 to registrant's Form 10-K filed February 26, 2016.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
101.INS	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

MOLINA HEALTHCARE, INC.

AMENDED AND RESTATED

DEFERRED COMPENSATION PLAN (2018)

This Deferred Compensation Plan (the "Plan") is amended and restated effective for amounts earned and deferred on or after January 1, 2018 (the "Restatement"), by MOLINA HEALTHCARE, INC., a Delaware corporation (the "Company") with reference to the following:

A. The Company originally established a Deferred Compensation Plan for key employees, effective September 1, 1999 (the "Original Plan"). The Original Plan was amended on March 29, 2001.

B. As a result of the adoption of section 409A of the Internal Revenue Code of 1986 (the "Code"), the Original Plan was frozen effective at midnight on December 31, 2004.

C. This Plan was implemented effective January 1, 2005 to replace the Original Plan with a new plan that complies with the requirements of Code section 409A and the related Treasury Regulations (and other guidance from the Internal Revenue Service) thereunder (collectively, the "409A Requirements") and amended and restated as of October 1. 2013, and subsequently amended November 14, 2013, October 29, 2014 and September 1, 2016.

D. This Plan was established to provide key employees of the Company and its subsidiaries a tax deferred, capital accumulation program. The Plan is intended to provide benefits to a select group of management or highly compensated personnel in order to attract and retain the highest quality executives. The Company does not intend for this to be a qualified plan within the meaning of Sections 401(a) and 501(a) of the Code. This Plan is intended to be an unfunded plan for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Company contributions and voluntary compensation deferrals shall be held in a "Rabbi Trust," as that term is defined in Revenue Procedure 92-64, 1992-2 C.B. 422.

E. This Plan is hereby amended and restated to incorporate the prior amendments to the Plan, to provide for installment payments from in-service accounts and to modify the minimum death benefit under the Plan.

NOW, THEREFORE, the Company hereby adopts this Plan on the following terms and conditions:

1. Definitions. Whenever used in this Plan, the following words and phrases shall have the meaning set forth below, unless a different meaning is expressly provided or plainly required by the context in which the words or phrases are used:

1.1. Beneficiary means a person designated by a Participant to receive Plan benefits in the event of the Participant's death.

1.2. Board means the Board of Directors of the Company and its successors.

1.3. Change in Control means, a Change in Ownership, a Change in the Effective Control, a Change in Assets or a termination of the Plan and distribution of compensation deferred hereunder within twelve (12) months after any of the foregoing events. For purposes of this Section, "Company" shall include (i) the company for which a Participant is performing services at the time of the Change in Control, (ii) the company liable for the payment of the deferred compensation (or all companies liable if more than one company is liable), or a company that is a majority shareholder of a company identified in (i) or (ii), or any company in a chain of companies in which each company is a majority shareholder of another company in the chain, ending in a company identified in (i) or (ii). The events described in this section will not be considered to occur, with respect to an employee of a participating entity, if a participating entity is sold and the employee of the participating entity continues employment with the Company subsequent to the sale. The events described in this section have the following meanings:

a. Change in Ownership means the acquisition of stock by any one person or persons acting in concert (a "group") of the Company, that when added to the stock of the person or group constitutes more than 50% of the total fair market value or total voting power of the stock of the Company. The acquisition of additional stock by any person or group who are already considered to own more than 50% of the stock of the Company shall not constitute a change in ownership of the Company. An increase in the percentage of stock owned by any person or group, as result of a transaction in which the Company acquires its stock in exchange for property will be treated as an acquisition of stock for purposes of this section.

b. Change in the Effective Control means the occurrence of any of the following events, despite the fact that the Company has not undergone a Change in Ownership as described above:

i. The acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of ownership of stock of the Company possessing 35% or more of the total voting power of the stock, except if such acquisition is the result of a change in "record ownership" and not a change in "beneficial ownership;"

ii. The replacement of a majority of the Company's board of directors during any 12-month period by directors whose appointment or election is not endorsed by a majority of the members of the Company's board of directors prior to the date of the appointment or election; or

iii A transaction between the Company and another company resulting in a Change in Control.

iv. Provided that this section shall not apply to the acquisition of additional control of the Company by any person or group, if that person or group is considered to effectively control the Company prior to the acquisition.

c. Change in Assets means the acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of assets from the Company, that have a total gross fair market value equal to, or more than, 40% of the total gross fair market value of all the assets of the Company immediately prior to such acquisition or acquisitions. A transfer of assets by the Company will not be treated as a Change in Assets if the assets are transferred to any of the following (determined immediately after the transfer):

i. A shareholder of the Company (as determined, immediately before the asset transfer) in exchange for or with respect to its stock;

ii. An entity, 50% or more of the total value or voting power of which is owned directly or indirectly by the Company;

iii. A person or group that owns, directly or indirectly, 50% or more of the total value or voting power of all the outstanding stock of the Company; or

iv. An entity, at least 50% of the total value or voting power of which is owned, directly or indirectly, by a person described in (iii).

For purposes of this subsection (c), the gross fair market value of assets is the value of the assets of the Company or the value of the assets being disposed of with regard to any liabilities associated with such assets. If assets are transferred to an entity that is controlled by the shareholders of the transferring company immediately after the transfer, there is no Change in Control.

1.4. Company means MOLINA HEALTHCARE, INC., a Delaware corporation.

1.5. Company Stock means shares of stock issued by the Company.

1.6. Disability or Disabled means with respect to a Participant (i) the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months, or (ii) the receipt of income replacement benefits for a period of not less than three (3) months under an accident and health plan covering employees of the Company, by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months.

1.7. The original Effective Date of this Plan means January 1, 2005. The Effective Date of this Restatement shall mean January 1, 2018.

1.8. Key Employee means an employee of the Company or a Subsidiary, who is (A) a member of a select group of management or highly compensated employees within the meaning of §2520.104-23 of the Department of Labor ERISA Regulations, (B) projected to receive Plan Year Compensation (base pay plus bonus), plus amounts deferred to any 401(k) plan, deferred compensation plan, or cafeteria plan maintained by the Company, of $200,000 or more and (C) designated by the Plan Committee as a Key Employee.

1.9. Participant means (A) a Key Employee who timely files a Written Election pursuant to Section 2.3, below, and (B) a former Employee who, at the time of his Separation from Service, death, or Disability, retains, or whose beneficiary retains, benefits earned under the Plan in accordance with its terms. A Participant is considered an Active Participant in the Plan (even if the Participant no longer satisfies the requirements of Section 1.8(B) but subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee) until the Participant separates from service under the terms of this Plan.

1.10. Plan means the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2018) evidenced by this document and the Trust Agreement previously established in connection herewith.

1.11. Plan Committee means the individuals appointed by the Board from time to time to administer the Plan as provided herein.

1.12. Plan Year means the calendar year.

1.13. Plan Year Compensation means the total taxable income (other than Share Awards) paid to an Active Participant by the Company or a Subsidiary during any Plan Year, or portion thereof in which he is a Participant in this Plan, as reflected on a Key Employee's form W-2.

1.14. Separation from Service. A separation from service with the Company, provided such separation constitutes a "separation from service" under Treasury Regulation Section 1.409A-1(h).

1.15. Share Awards means shares of Company Stock which are awarded to a Participant as an employee by the Company.

1.16. Specified Employee means a "key employee" of the Company, as defined in section 416(i) of the Code without regard to paragraph five (5) thereof.

1.17. Subsidiary means any entity in which the Company owns not less than 80% of the outstanding voting interests.

1.18. Trust Agreement means the grantor trust established in connection with this Plan between the Company as grantor and the Trustee.

1.19. Trustee means Union Bank of California and any successor institutional trustee named to succeed such Trustee under the terms of the Trust Agreement established in connection with this Plan.

1.20. Unforeseeable Financial Emergency means: (i) an illness or accident of the Participant or beneficiary, the Participant's or beneficiary's spouse, or the Participant's or beneficiary's dependent; (ii) the loss of the Participant's or beneficiary's property due to casualty; or (iii) other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant or beneficiary. Determination of whether a Participant has incurred an Unforeseeable Financial Emergency shall be made by the Plan Committee, in accordance with the requirements of Section 409A of the Code and any guidance issued thereunder.

2. Participation.

2.1. Eligibility. An employee of the Company or a Subsidiary is eligible to participate in this Plan upon meeting the criteria for Key Employee specified in Section 1.8. Any Key Employee who was a Participant in the Original Plan and who continued in the employ of the Company on the effective date of the Restatement will continue to be a Participant in this Plan, subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee thereafter.

2.2. Entry Date. An employee of the Company or a Subsidiary who met the eligibility requirement specified in Section 2.1 as of the Effective Date of this Plan Restatement is a Participant in the Plan as of the Effective Date. Newly eligible employees of the Company who have met the enrollment requirements under Section 2.3 of the Plan shall commence participation in the Plan within thirty (30) days of their date of hire. An employee of the Company or a Subsidiary who meets the eligibility requirements specified in Section 2.1 but fails to meet the requirements in accordance with Section 2.3 within the period required, shall become a Participant in this Plan on the first day of the next Plan Year following submission of a Written Election form as specified in Section 2.3.

2.3. Written Election by Participant. As a condition to participation in the Plan, each newly eligible Employee shall complete, sign and return to the Plan Committee a Written Election within thirty (30) days after the date the Participant becomes eligible to participate in the Plan. Annual enrollment shall be in December each year for the following Plan Year. Each Participant shall submit a Written Election prior to the first day of the Plan Year in which he or she will be a Participant.

a. Such Written Election shall be made on the form presented to the Participant by the Plan Committee and shall set forth:

i. his election to participate in this Plan under the terms hereof;

ii. the amount of Plan Year Compensation the Participant has determined to defer under the Plan for the Plan Year, pursuant to Section 3.1 below;

iii. the investment vehicles into which the Participant desires to have his Account attributable to deferral of Plan Year Compensation invested, as provided in Section 3.5 below, and the percentage of such Account allocated to each elected investment vehicle;

iv. the date on which his benefit is to be distributed which is the earliest of: (a) the date specified for an In-Service Withdrawal; (b) an Unforeseeable Financial Emergency; (c) the later of (i) when he separates from service with the Company for any reason or (ii) a date subsequent to his termination of employment specified by the Participant;

v. the form in which his benefit is to be distributed upon an In-Service Withdrawal, Separation from Service, Disability or death.

b. A Participant must provide a separate Written Election for each subsequent Plan Year that specifies the percentage of the Plan Year Compensation that Participant has determined to defer for each such Plan Year. Such Written Election is only effective for the Plan Year for which the election is made and if no Written Election to defer Plan Year Compensation is executed in relation to a subsequent Plan Year, no Plan Year Compensation will be deferred for such subsequent Plan Year. Any election of the amount of Plan Year Compensation to defer for a given Plan Year shall be irrevocable on and after the first day of the Plan Year for which the election was made.

c. A Participant may change the investment vehicle(s) in which the Participant desires to have that portion of the Participant's Account attributable to Plan Year Compensation and investment income invested and the percentage of the Participant's Account allocated to each investment vehicle by completing and submitting any form or forms required by the Company. Changes in investment vehicle(s) will be made as of the applicable business day (or as soon as practicable thereafter) following the date that the change is requested.

d. Notwithstanding the foregoing, the Trustee shall, at the direction of the Plan Committee, have the duty and authority to invest the trust assets and funds in accordance with the terms of the Trust Agreement, and all rights associated with the trust assets shall be exercised by the Trustee as designated by the Plan Committee and shall in no event be exercisable by or be settled upon Participants or their Beneficiaries.

e. A Participant may change the date or form of distribution by submitting a new Written Election to the Company, provided that the following conditions are met:

i. That such election may not take effect until at least twelve (12) months after the date on which the election is made;

ii. In the case of an election related to a payment other than a payment on account of death, disability or the occurrence of a financial hardship, such payment must be deferred for a period of not less than five (5) years from the date such payment would have otherwise been made, and

iii. Any election related to a payment at a specified time or pursuant to a fixed schedule may not be made less than twelve (12) months prior to the date of the first scheduled payment.

iv. Such election may be made among the payment options set forth in Section 5.4.

2.4. Duration of Participation. Any Key Employee who has become a Participant at any time shall remain a Participant, even though he is no longer an Active Participant, until his entire benefit under the terms of the Plan has been paid to him (or to his Beneficiary in the event of his death), at which time he ceases to be a Participant.

2.5. Maintenance of Records. The annual Designation of Participants by the Plan Committee shall be maintained in the corporate minute book. The Written Elections by Participants shall be maintained in the corporate records with all other files pertaining to this Plan by the Plan Committee.

3. Contributions and Allocation.

3.1 Participant Contributions. A Participant may elect to defer a portion of (i) up to 75% of Plan Year Compensation constituting base pay and (ii) up to 100% of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay). For a Participant's initial Plan Year of participation, the minimum deferral percentage for base pay and bonus pay must be 3% for each such component. For succeeding years of participation, a Participant may not defer an amount less than the minimum percentage established from year to year by the Plan Committee. A written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of Plan Year Compensation constituting base pay the Participant has chosen to defer. A separate written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay) the Participant has chosen to defer. Once a Participant's contributions for a Plan Year reach the Participant's elected percentage, such Participant shall not be allowed to defer additional portions of such Participant's Plan Year Compensation for the remainder of the Plan Year. Any amounts in excess of the Participant's elected percentage inadvertently deferred shall be refunded to the Participant as soon as practicable.

3.2. Company Contributions. The Company may, subject to the sole discretion of its Board of Directors, make contributions for the Participants, reserving the right to discriminate

among the Participants in the amount or percentage of contributions made in any Plan Year.

3.3. Allocation of Participant Contributions. All amounts which a Participant elects to defer under the terms of this Plan shall be allocated to his Account as of the last business day of each month. Each such Participant Deferral Account shall be credited with earnings as provided in Section 3.5 below.

3.4. Allocation of Company Contributions. Any amounts contributed by the Company on behalf of a Participant under Section 3.2 above shall be allocated to the Company Contribution Account of each Participant. Each such Company Contribution Account shall be credited with earnings as provided in Section 3.5 below.

3.5 Credited Earnings. The Account of each Participant (which includes such Participant's Participant Deferral Account established under Section 3.1 and such Participant's Company Contribution Account established under Section 3.2) shall be credited as of each applicable business day with the actual earnings on the investments allocated to the Participant's Account.

3.6. Funding. The assets of the Plan shall be held under the Trust Agreement (a "grantor trust") designated in Section 8. As such, the Plan is intended to be an unfunded plan for purposes of the requirements of ERISA and the Code.

Notwithstanding the provisions under the terms of the Plan that amounts contributed to this Plan, plus earnings thereon, shall be allocated to separate Accounts of Participants, all such amounts credited to such individual Accounts shall remain the general assets of the Company, and as such shall remain subject to the claims of the general creditors of the Company. This Plan and the related Trust Agreement do not create, nor does any employee, Participant or Beneficiary have, any right with respect to any specific assets of the Company or the Plan.

4. Vesting of Accounts. The Participant Deferral Accounts and the Company Contribution Account of each Participant shall be 100% vested in such Participant at all times.

5. Types of Benefits.

5.1. Separation from Service Benefit. A Participant's Separation from Service Benefit is the unpaid balance of his Accounts which equals the total of all contributions made by the Participant and the Company allocated to his Account and all earnings credited to his Account in accordance with the terms of the Plan and the Trust Agreement, less any distributions already paid.

5.2. Disability Benefit. If a Participant becomes Disabled as defined in Section 1.6 above, the Company will pay his Separation from Service Benefit, calculated under Section 5.1, in the applicable form elected by the Participant in his Written Election.

A Participant who believes he has suffered a Disability within the meaning of Section 1.6 shall make application to the Plan Committee, on a form prescribed by the Plan Committee, for a determination of whether he is Disabled under the terms of Section 1.6. The Participant shall make such written application to the Plan Committee on or after the date which is at least five (5) consecutive months following the date he first suffered the impairment under consideration. Any determination by the Plan Committee that a Disability exists under the provisions of Section 1.6 shall be effective only after the date the Disability has existed for six (6) consecutive months. All determinations made by the Plan Committee shall be final, and no Participant shall be considered Disabled for any purpose whatsoever under the provisions of this Plan if determined not to be Disabled by the Plan Committee under the procedures set forth in this Section.

The Plan Committee shall notify each Participant who has made application under this Section 5.2, in writing, of its determination within three (3) months of the date the Plan Committee receives the Participant's application hereunder. The Participant shall cooperate in providing any information to the Plan Committee which it requires in making its determination, including, but not limited to, access to the Participant's medical records, direct contact with his physician, and physical examination by a physician selected by the Company. Any Participant who does not fully cooperate shall be deemed not Disabled by the Plan Committee and so notified.

5.3. Death Benefit.

a. If a Participant dies after a distribution has commenced or if the Company has not purchased a life insurance contract in connection with the Participant's Separation from Service Benefit, the Company will continue the payments of such distribution otherwise due to the Participant to his designated Beneficiary, in the applicable form elected by the Participant in his Written Election.

b. If a Participant dies while still employed by the Company and the Company has purchased a life insurance contract in connection with such Participant's Separation from Service Benefit, the Company will pay the Participant's designated Beneficiary the greatest of: (i) twice the Participant's base salary upon initial eligibility for the Plan; (ii) $500,000; or (iii) if the Participant was a Participant prior to January 1, 2018, the amount specified under the Plan prior to such date, in the applicable form elected by the Participant in his Written Election.

5.4. In-Service Withdrawal. A Participant may designate a year in the future for receipt of an In-Service Withdrawal with respect to the Participant's contribution for a given Plan Year. Such withdrawal may be paid while the Participant remains employed with the Company. Initial designations made with respect to the 2018 Plan Year in accordance with Section 2.3(a)(iv) (as may be subsequently modified under Section 2.3(b)) shall include Credited Earnings attributable to such Participant Contribution. The In-Service Withdrawal will be paid in a lump sum unless the Participant elects to receive substantially equal annual installments from two (2) to five (5) years, commencing no earlier than three (3) years after the Plan Year during which such Participant Contributions are made; provided, however, that a Participant may make a subsequent deferral election with respect to any initial In-Service Withdrawal election made under this Plan subject to the following requirements:

a. the Participant must deliver to the Company a written election not later than twelve (12) months prior to the date the payment is scheduled to be paid;

b. the payments that are subject to the election must be delayed at least five (5) years from the date the payments would have otherwise been made; and

c. the election will not take effect until at least twelve (12) months after the election is made.

5.5. Unforeseeable Financial Emergency Benefit. A Participant may request a portion of his Separation from Service Benefit as an Unforeseeable Financial Emergency Benefit at any time by providing the Plan Committee, to its satisfaction, with a written request, proof of an Unforeseeable Financial Emergency, and proof that all other financial resources have been explored and utilized to: (i) receive a partial or full payout from the Plan and/or (ii) suspend any deferrals required to be made by a Participant. The amount of an Unforeseeable Financial Emergency Benefit shall be limited to the lesser of the amount needed for the financial hardship or such Participant's Separation from Service Benefit. If a Participant receives a distribution as a result of an Unforeseeable Financial Emergency, such Participant may not participate in the Plan during the Plan Year following the year of the hardship distribution.

6. Distributions.

6.1. Form of Benefits. The Company shall pay benefits in the form associated with Type of Benefit elected by the Participant, and, to the extent a Type of Benefit may be distributed in various forms, the Company shall pay benefits in the form elected by the Participant. The forms of benefits associated with the Types of Benefits are the following:

a. Separation from Service Benefit, Disability Benefit, and Death Benefit shall be paid in (i) one lump sum; (ii) 5 yearly installments; (iii) 10 yearly installments; or (iv) 15 yearly installments;

b. In-Service Withdrawal shall be paid as provided in Section 5.4 above; and

c. Unforeseeable Financial Emergency Benefit shall be paid in one lump sum.

6.2. Commencement of Payments. The Company will pay, or begin to pay, the Types of Benefits under this Plan to the Participant in accordance with the following:

a. Separation from Service Benefit, Disability Benefit, and Death Benefit payments shall commence no later than sixty-five (65) days following the date on which the Participant retires, terminates service, becomes disabled, or dies;

b. In-Service Withdrawal payments shall commence on the date designated by the Participant on his Written Election pursuant to Section 2.3, provided that such payments are from Participant Contributions that have been in such Participant's Participant Deferral Account for at least two years;

c. Unforeseeable Financial Emergency Benefit payments shall commence no later than sixty-five (65) days after a request for an Unforeseeable Financial Emergency Benefit is approved by the Plan Committee.

6.3. Domestic Relations Order. In the event the Plan Committee receives a Domestic Relations Order from a potential Alternate Payee, the Plan Committee shall notify the Participant whose benefit is the subject of such order and provide him/her with information concerning the Plan's procedures for administering Qualified Domestic Relations Orders ("QDROs"). Unless and until the order is set aside, the following provisions shall apply:

a. The Plan Committee shall within a reasonable time determine whether the order is a QDRO and shall notify the Participant whose benefit is the subject of the order, of its determination. The Plan Committee may designate a representative to carry out its duties under this provision.

b. Nothing in this Section shall be deemed to allow payment under a QDRO to an Alternate Payee of any benefit which would violate Section 409A of the Code and the regulations thereunder.

c. QDRO definitions. For purposes of Section 6.3 the following definitions and rules shall apply:

i. Alternate Payee means any spouse, former spouse, child or other dependent of a Participant who is recognized by a QDRO as having a right to receive all, or a portion of, the benefits payable under this Plan with respect to the Participant.

ii. Domestic Relations Order means any judgment, decree, or order (including approval of a property settlement agreement) which:

(1) relates to the provision of child support, alimony payments, or marital property rights to a spouse, child, or other dependent of a Participant; and

(2) is made pursuant to a state domestic relations law (including a community property law).

iii. Qualified Domestic Relations Order means any Domestic Relations Order meeting the requirements for a Qualified Domestic Relations

Order under Code section 414(p), which satisfies any additional criteria under policies established by the Plan Committee.

6.4 Limited Cashout. Notwithstanding any Written Election made by the Participant, if, upon the Participant's Separation from Service, such Participant's accrued benefit under the Plan (and any other deferred compensation plan required to be aggregated with this Plan) does not exceed the then-current limit under Section 402(g)(1)(B) of the Code, the Company shall immediately distribute such Participant's accrued benefit under the Plan in a single lump sum payment to the Participant (or the Beneficiary, if the Participant is deceased), provided that such distribution results in a termination and complete liquidation of such Participant's interest under the Plan (and any other deferred compensation plan required to be aggregated by this Plan).

Notwithstanding sections 6.2 and 7.3, distributions to a Specified Employee shall not commence earlier than six (6) months after the date such Specified Employee experiences a Separation from Service (or, if earlier, the date of death of the employee).

7. Amendment, Termination of Plan, Change in Control.

7.1. Amendment. The Company reserves the right to amend the Plan at any time by resolution of the Plan Committee. The Plan Committee will determine the effective date of any such amendment. The amendment may not deprive any Participant or Beneficiary of any portion of a benefit under the terms of this Plan at the time of the amendment.

7.2. Termination of Plan. The Company reserves the right to terminate the Plan under the following circumstances:

a. The Plan Committee may resolve to terminate the Plan provided that:

i. all arrangements of the same type (account balance plans, nonaccount balance plans, separation pay plans or other arrangements) are terminated with respect to all participants;

ii no payments other than those otherwise payable under the terms of the Plan absent a termination of the Plan are made within twelve (12) months of the termination of the arrangement;

iii. all payments are made within twenty-four (24) moths of the termination of the arrangement; and

iv. the Company does not adopt a new arrangement that would be aggregated with any terminated arrangement under the plan aggregation rules at any time for a period of five years following the date of termination of the arrangement.

b. The Plan Committee may terminate the Plan and make payments to the Participants at any time during the twelve (12) months following a change in control of the corporation;

c. A corporate dissolution taxed under Section 331, or with the approval of a bankruptcy court pursuant to 11 U.S.C. §503(b)(l)(A), provided that the amounts deferred under the Plan are included in the Participants' gross incomes by the latest of:

i. the calendar year in which the Plan termination occurs,

ii. the calendar year in which the amount is no longer subject to a substantial risk of forfeiture, or

iii. the first calendar year in which the payment is administratively practicable.

7.3. Change in Control. In the event of a Change in Control, the Company shall, as soon as possible, but in no event later than ten days after the Change in Control, notify the Trustee, and the Trustee or its agent shall immediately calculate the Separation from Service Benefit of each Participant and distribute such amounts to the Participant or Beneficiary in a lump sum within thirty (30) days of the notification. If the Company fails to notify the Trustee as specified in this section, the Trustee may act upon notification of the "Change of Control" obtained in an alternate manner. The Trustee shall incur no liability to any person for any action taken pursuant to such notification and in conformity with the terms of the Plan.

8. Benefits Not Funded. Participants and Beneficiaries have the status of unsecured creditors of the Company, and the Plan constitutes a mere promise by the Company to make benefit payments in the future. A Participant's or Beneficiary's interest in the Plan is an unsecured claim against the general assets of the Company, and neither the Participant nor a Beneficiary has any right against the account until the Plan has distributed the benefit. All amounts credited to an account are the general assets of the Company and may be disposed of or used by the Company in such manner as it determines.

Notwithstanding the first paragraph of this Section 8, the Company will make deposits to a trust pursuant to a Trust Agreement, a copy of which is attached, as provided above. Such Trust Agreement created by the Company is intended to be a grantor trust, and any assets held by such trust to assist the Company in meeting its obligations under the Plan will conform to the terms of the model trust, as described in Revenue Procedure 92-64, 1992-2 C.B. 422, promulgated by the Internal Revenue Service. The Company will make a transfer of cash to the trust annually in the amount necessary to pay the deferred compensation required.

It is the intention of the parties that this Plan and the accompanying Trust Agreement shall constitute an unfunded arrangement maintained for the purpose of providing deferred compensation for a select group of management or highly compensated employees for purposes of Title I of ERISA.

9. Administration.

9.1. Plan Committee. The Plan shall be administered by the Plan Committee. The Plan Committee shall have full authority and power to administer and construe the Plan, subject to applicable requirements of law. Without limiting the generality of the foregoing, the Plan Committee shall have the powers indicated in the foregoing Sections of the Plan and the following additional powers and duties:

a. To make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan;

b. To interpret the Plan and to decide all questions concerning the Plan;

c. To determine the amount and the recipient of any payments to be made under the Plan;

d. To designate and value any investments deemed held in the Accounts; and

e. To make all other determinations and to take all other steps necessary or advisable for the administration of the Plan.

All decisions made by the Plan Committee pursuant to the provisions of the Plan shall be made in its sole discretion and shall be final; conclusive, and binding upon all parties.

9.2. Delegation of Duties. The Plan Committee may delegate such of its duties and may engage such experts and other persons as it deems appropriate in connection with administering the Plan. The Plan Committee shall be fully protected in any action taken, in good faith, in reliance upon any opinions or reports furnished them by any such experts or other persons.

9.3. Indemnification of Committee. The Company agrees to indemnify and to defend to the fullest extent permitted by law any person serving as a member of the Plan Committee, and each employee of the Company or any of its affiliates appointed by the Plan Committee to carry out duties under this Plan, against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

9.4. Liability. To the extent permitted by law, neither the Plan Committee nor any other person shall incur any liability for any acts or for any failure to act except for liability arising out of such person's own willful misconduct or willful breach of the Plan.

9.5. Claims Review Procedure.

a. A claim for benefits may be filed, in writing, with the Plan Committee. A written disposition of a claim shall be furnished to the claimant within a reasonable time after the claim for benefits is filed. In the event a claim for benefits is denied, the Plan Committee shall provide the claimant with the reasons for denial.

b. A claimant whose claim for benefits was denied may file for a review of such denial, with the Plan Committee, no later than 60 days after he has received written notification of the denial.

c. The Plan Committee shall give a request for review a full and fair review. If the claim for benefits is denied upon completion of a full and fair review, notice of such denial shall be provided to the claimant within 60 days after the Plan Committee's receipt of such written claim for review. This 60-day period may be extended in the event of special circumstances. Such special circumstances shall be communicated to the claimant in writing within the 60-day period. If there is an extension, a decision shall be made as soon as possible, but not later than 120 days after receipt by the Plan Committee of such claim for review.

d. If benefits are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of a state, the claims procedure relating to these benefits may provide for review. If so, that company, service, or organization will be the entity to which claims are addressed.

10. General Provisions

10.1. Designation of Beneficiary. Each Participant shall designate, in writing, prior to the date he first becomes a Participant in the Plan, one or more beneficiaries to receive his benefit under the provisions of Section 5.3. The Participant shall file the written designation with the Plan Committee. The Participant may revoke a previous beneficiary designation by filing a new written beneficiary designation with the Plan Committee.

In any event, if a Participant or Beneficiary who has designated another Beneficiary is divorced, all beneficiary designations executed prior to the effective date of the dissolution of marriage (or other decree or order entered under applicable state law) are automatically revoked under the terms of this Section 10.1. In such event, the Participant or Beneficiary may designate one or more Beneficiaries in accordance with the terms of this Section 10.1. If none is made following the effective date of the dissolution of the marriage, the individual's benefit shall pass under the laws of intestate succession and the terms of the next following paragraph.

If a Participant fails to file a valid designation of beneficiary with the Plan Committee under the provisions of this Section 10.1, or if a designated Beneficiary fails to survive to receive any or all payments due hereunder, then the death benefit payable under this Plan shall be payable to the Participant's (or the Beneficiary's) spouse; if no spouse survives, then to the Participant's (or Beneficiary's) children, with equal shares among living children and with the living descendants of a deceased child receiving equal portions of

the deceased child's share; in the absence of spouse or descendants, to the Participant's (or Beneficiary's) parents; and in the absence of spouse, descendants or parents, to the Participant's (or Beneficiary's) brothers and sisters, with the living descendants of a deceased brother and those of a deceased sister receiving equal portions of the deceased brother's or sister's share; in the absence of any of the persons named herein, to the Participant's (or Beneficiary's) estate.

For purposes of this Section 10.1, the term "descendant" means all persons who are descended from the person referred to either by birth to or legal adoption by such person, and "child" or "children" includes adopted children.

10.2. Benefits Not Assignable. The rights of each Participant are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment, or garnishment by creditors of the Participant or any Beneficiary. Neither the Participant nor Beneficiary may assign, transfer or pledge the benefits under this Plan. Any attempt to assign, transfer or pledge a Participant's benefits under this Plan is void.

10.3. Benefit. This Plan constitutes an agreement between the Company and each of the Participants which is binding upon and inures to the Company, its successors and assigns and upon the Participant and his heirs and legal representatives.

10.4. Headings. The headings of the Articles and Sections of this Plan are included for purposes of convenience only, and shall not affect the construction or interpretation of any of it provisions.

10.5. Notices. All notices, requests, demands, and other communications under this Plan shall be in writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the third day after mailing if mailed to the party to whom notice is to be given, by first class mail, registered or certified (return receipt requested), postage prepaid, and properly addressed to the last known address to each party as set forth on the first page thereof. Any party may change its address for purposes of this Section by giving the other parties written notice of the new address in the manner set forth above.

10.6. No Loans. The Plan does not permit any loans to be made to any Participant or Beneficiary.

10.7. Gender Usage. The use of the masculine gender includes the feminine gender for all purposes of this Plan.

10.8. Expenses. Costs of administration of the Plan shall be paid by the Company.

IN WITNESS WHEREOF, the Company has executed this Amended and Restated Deferred Compensation Plan (2018) on November 7, 2017, effective as of the Effective Date.

MOLINA HEALTHCARE, INC.

By: _____
Joseph White
Chief Financial Officer

EXHIBIT 12.1

MOLINA HEALTHCARE, INC.

COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES

	Year Ended December 31,				
	2017	**2016**	**2015**	**2014**	**2013**
	(Dollars in millions)				
Earnings:					
(Loss) income before income taxes, continuing operations	$ (612)	$ 205	$ 322	$ 135	$ 81
Add fixed charges:					
Interest expense, including amortization of debt discount	118	101	66	57	52
Estimated interest portion of rental expense	11	12	8	5	4
Total fixed charges	129	113	74	62	56
Total earnings available for fixed charges	$ (483)	$ 318	$ 396	$ 197	$ 137
Fixed charges from above:	$ 129	$ 113	$ 74	$ 62	$ 56
Ratio of Earnings to Fixed Charges [1]	—	2.8	5.4	3.2	2.4
Total rent expense	$ 75	$ 64	$ 44	$ 32	$ 25
Interest factor	14%	18%	18%	16%	16%
Interest component of rental expense	$ 11	$ 12	$ 8	$ 5	$ 4

(1) Earnings were inadequate to cover fixed charges by $612 million for the year ended December 31, 2017.

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Iowa, Inc.*	Iowa
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Mississippi, Inc.*	Mississippi
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of New York, Inc.	New York
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Oklahoma, Inc.*	Oklahoma
Molina Healthcare of Pennsylvania, Inc.*	Pennsylvania
Molina Healthcare of Puerto Rico, Inc.	Puerto Rico/Nevada
Molina Healthcare of South Carolina, LLC	South Carolina
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Hospital Management, LLC	California
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Youth Academy*	California
Molina Medical Management, Inc.	California
Molina Holdings Corporation*	New York
Molina Clinical Services, LLC	Delaware
Molina Healthcare of Louisiana, Inc.*	Louisiana
Molina Healthcare of Nevada, Inc.*	Nevada
Molina Pathways, LLC	Delaware
Molina Pathways of Texas, Inc.+	Texas
Pathways Health and Community Support LLC+	Delaware
AmericanWork, Inc.-	Delaware
Children's Behavioral Health, Inc.-	Pennsylvania
Choices Group, Inc.-	Delaware
College Community Services-	California
Dockside Services, Inc.-	Indiana
Family Preservation Services, Inc.-	Virginia

EXHIBIT 21.1

Family Preservation Services of Florida, Inc.-	Florida
Family Preservation Services of North Carolina, Inc.-	North Carolina
Family Preservation Services of Washington D.C., Inc.-	District of Columbia
Family Preservation Services of West Virginia, Inc.-	West Virginia
Maple Star Nevada, Inc.-	Nevada
Maple Star Oregon, Inc.-	Oregon
Pathways Community Corrections, Inc.-	Delaware
Camelot Care Centers, Inc.>	Illinois
Pathways Community Services LLC-	Delaware
Pathways Community Services LLC-	Pennsylvania
Pathways of Massachusetts LLC-	Delaware
Pathways of Washington, Inc.-	Washington
Pathways of Arizona, Inc.-	Arizona
Pathways of Idaho LLC-	Delaware
Pathways of Delaware, Inc.-	Delaware
Pathways of Maine, Inc.-	Maine
Pathways of Oklahoma, Inc.-	Oklahoma
Pathways Community Support of Texas, Inc.-	Texas
Transitional Family Services, Inc.-	Georgia
Pathways Human Services, LLC.-*	Delaware
The RedCo Group, Inc.-	Pennsylvania
Raystown Developmental Services, Inc./	Pennsylvania

* Non-operational entity

\+ Wholly owned subsidiary of Molina Pathways, LLC

\- Wholly owned subsidiary of Pathways Health and Community Support LLC

/ Wholly owned subsidiary of The RedCo Group, Inc.

> Wholly owned subsidiary of Pathways Community Corrections, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-204558) of Molina Healthcare, Inc.;
(2) Registration Statement (Form S-4 No. 333-213136) of Molina Healthcare, Inc.;
(3) Registration Statement (Form S-8 No. 333-174912) pertaining to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan;
(4) Registration Statements (Forms S-8 No. 333-138552, No. 333-153246, and No. 333-170571) pertaining to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and
(5) Registration Statement (Form S-8 No. 333-108317) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan and 2002 Employee Stock Purchase Plan;

of our reports dated March 1, 2018, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2017.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 1, 2018

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-K for the period ended December 31, 2017 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant’s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant’s internal control over financial reporting that occurred during the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant’s internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant’s auditors and to the audit committee of the registrant’s board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant’s ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant’s internal control over financial reporting.

Dated: March 1, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky
Chief Executive Officer, President and Director

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph W. White, certify that:

1. I have reviewed this annual report on Form 10-K for the period ended December 31, 2017 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: March 1, 2018

/s/ Joseph W. White

Joseph W. White
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2017 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 1, 2018

/s/ Joseph M. Zubretsky

Joseph M. Zubretsky

Chief Executive Officer, President and Director

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2017 (the "Report"), I, Joseph W. White, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 1, 2018

/s/ Joseph W. White

Joseph W. White
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended September 30, 2017

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2017

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of October 27, 2017, was approximately 57,094,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED September 30, 2017

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CROSS-REFERENCE INDEX

FINANCIAL STATEMENTS

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(In millions, except per-share data) (Unaudited)			
Revenue:				
Premium revenue	$ 4,777	$ 4,191	$ 14,165	$ 12,215
Service revenue	130	133	390	408
Premium tax revenue	106	127	331	345
Health insurer fee revenue	—	85	—	251
Investment income and other revenue	18	10	48	29
Total revenue	5,031	4,546	14,934	13,248
Operating expenses:				
Medical care costs	4,220	3,748	12,822	10,930
Cost of service revenue	123	119	369	362
General and administrative expenses	383	343	1,227	1,034
Premium tax expenses	106	127	331	345
Health insurer fee expenses	—	55	—	163
Depreciation and amortization	33	36	109	102
Impairment losses	129	—	201	—
Restructuring and separation costs	118	—	161	—
Total operating expenses	5,112	4,428	15,220	12,936
Operating (loss) income	(81)	118	(286)	312
Other expenses, net:				
Interest expense	32	26	85	76
Other income, net	—	—	(75)	—
Total other expenses, net	32	26	10	76
(Loss) income before income tax (benefit) expense	(113)	92	(296)	236
Income tax (benefit) expense	(16)	50	(46)	137
Net (loss) income	$ (97)	$ 42	$ (250)	$ 99
Net (loss) income per share:				
Basic	$ (1.70)	$ 0.77	$ (4.44)	$ 1.79
Diluted	$ (1.70)	$ 0.76	$ (4.44)	$ 1.77

CONSOLIDATED STATEMENTS OF COMPREHENSIVE (LOSS) INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(Amounts in millions) (Unaudited)			
Net (loss) income	$ (97)	$ 42	$ (250)	$ 99
Other comprehensive income:				
Unrealized investment gain (loss)	1	(3)	2	10
Less: effect of income taxes	1	(2)	1	3
Other comprehensive (loss) income, net of tax	—	(1)	1	7
Comprehensive (loss) income	$ (97)	$ 41	$ (249)	$ 106

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	September 30, 2017	December 31, 2016
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,934	$ 2,819
Investments	1,787	1,758
Restricted investments	326	—
Receivables	1,002	974
Income taxes refundable	60	39
Prepaid expenses and other current assets	174	131
Derivative asset	425	267
Total current assets	7,708	5,988
Property, equipment, and capitalized software, net	397	454
Deferred contract costs	97	86
Intangible assets, net	101	140
Goodwill	430	620
Restricted investments	117	110
Deferred income taxes	62	10
Other assets	42	41
	$ 8,954	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 2,478	$ 1,929
Amounts due government agencies	1,324	1,202
Accounts payable and accrued liabilities	485	385
Deferred revenue	468	315
Current portion of long-term debt	782	472
Derivative liability	425	267
Total current liabilities	5,962	4,570
Long-term debt	1,317	975
Lease financing obligations	198	198
Deferred income taxes	—	15
Other long-term liabilities	48	42
Total liabilities	7,525	5,800
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 57 shares at September 30, 2017 and at December 31, 2016	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	870	841
Accumulated other comprehensive loss	(1)	(2)
Retained earnings	560	810
Total stockholders' equity	1,429	1,649
	$ 8,954	$ 7,449

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2017	2016
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net (loss) income	$ (250)	$ 99
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Depreciation and amortization	139	135
Impairment losses	201	—
Deferred income taxes	(68)	20
Share-based compensation, including accelerated share-based compensation	38	24
Non-cash restructuring charges	49	—
Amortization of convertible senior notes and lease financing obligations	24	23
Other, net	13	14
Changes in operating assets and liabilities:		
Receivables	(28)	(427)
Prepaid expenses and other assets	(53)	(116)
Medical claims and benefits payable	549	168
Amounts due government agencies	122	503
Accounts payable and accrued liabilities	90	1
Deferred revenue	153	157
Income taxes	(22)	32
Net cash provided by operating activities	957	633
Investing activities:		
Purchases of investments	(1,896)	(1,444)
Proceeds from sales and maturities of investments	1,538	1,512
Purchases of property, equipment and capitalized software	(85)	(143)
(Increase) decrease in restricted investments held-to-maturity	(10)	4
Net cash paid in business combinations	—	(48)
Other, net	(21)	(12)
Net cash used in investing activities	(474)	(131)
Financing activities:		
Proceeds from senior notes offering, net of issuance costs	325	—
Proceeds from borrowings under credit facility	300	—
Proceeds from employee stock plans	11	10
Other, net	(4)	1
Net cash provided by financing activities	632	11
Net increase in cash and cash equivalents	1,115	513
Cash and cash equivalents at beginning of period	2,819	2,329
Cash and cash equivalents at end of period	$ 3,934	$ 2,842

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Nine Months Ended September 30,	
	2017	2016
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (21)	$ (8)
Details of change in fair value of derivatives, net:		
Gain (loss) on 1.125% Call Option	$ 158	$ (60)
(Loss) gain on 1.125% Conversion Option	(158)	60
Change in fair value of derivatives, net	$ —	$ —
Details of business combinations:		
Fair value of assets acquired	$ —	$ (186)
Fair value of liabilities assumed	—	28
Purchase price amounts accrued/received	—	8
Reversal of amounts advanced to sellers in prior year	—	102
Net cash paid in business combinations	$ —	$ (48)

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

September 30, 2017

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

The Health Plans segment consists of health plans operating in 12 states and the Commonwealth of Puerto Rico. As of September 30, 2017, these health plans served approximately 4.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs, including business processing, information technology development and administrative services.

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Recent Developments — Health Plans Segment

Illinois Health Plan. In August 2017, Molina Healthcare of Illinois, Inc. was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the State's three current managed care programs into one program. The contract begins January 1, 2018, for four years with options to renew annually for up to four additional years.

Mississippi Health Plan. In June 2017, Molina Healthcare of Mississippi, Inc. was awarded a Medicaid Coordinated Care Contract for the statewide administration of the Mississippi Coordinated Access Network (MississippiCAN). The operational start date for the program is currently scheduled for October 1, 2018, pending the completion of a readiness review. The initial term of the contract is through June 2020, with options to renew annually for up to two additional years.

Washington Health Plan. In May 2017, Molina Healthcare of Washington, Inc. was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North Central region of the state's Apple Health Integrated Managed Care Program. The start date for the new contract is scheduled for January 1, 2018.

Terminated Medicare Acquisition. In August 2016, we entered into agreements with each of Aetna Inc. and Humana Inc. to acquire certain assets related to their Medicare Advantage business. The transaction was subject to closing

conditions including the completion of the proposed acquisition of Humana by Aetna (the Aetna-Humana Merger). In January 2017, the U.S. District Court for the District of Columbia granted the request for relief made by the U.S. Department of Justice in its civil antitrust lawsuit against Aetna and Humana, to prohibit the Aetna-Humana Merger. In February 2017, our agreements with each of Aetna and Humana were terminated by the parties pursuant to the terms of the agreements. Under the termination agreements, we received an aggregate termination fee of $75 million from Aetna and Humana in the first quarter of 2017, which is reported in "Other income, net" in the accompanying consolidated statements of operations.

New York Health Plan. In August 2016, we closed on our acquisition of the outstanding equity interests of Today's Options of New York, Inc., which now operates as Molina Healthcare of New York, Inc. The purchase price allocation was completed, and the final purchase price adjustments were recorded, in the first quarter of 2017. Such adjustments were insignificant, and the final cash purchase price was $38 million.

Impairment Losses

Molina Medicaid Solutions segment. In the third quarter of 2017, we recorded a non-cash goodwill impairment loss of $28 million. See Note 10, "Impairment Losses."

Other segment. In the third quarter of 2017, we recorded a non-cash goodwill impairment loss of $101 million for our Pathways subsidiary. In the second quarter of 2017, we recorded non-cash goodwill and intangible assets impairment losses of $72 million, primarily for our Pathways subsidiary. See Note 10, "Impairment Losses."

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2017.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2016. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2016 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2016 audited consolidated financial statements.

2. Significant Accounting Policies

Certain of our significant accounting policies are discussed within the note to which they specifically relate.

Revenue Recognition – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into two broad categories discussed in further detail below: 1) "Contractual Provisions That May Adjust or Limit Revenue or Profit;" and 2) "Quality Incentives."

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), and Medical Cost Corridors: A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $119 million and $272 million at September 30, 2017 and December 31, 2016, respectively, to "Amounts due government agencies." Approximately $82 million and $244 million of the liability accrued at September 30, 2017 and December 31, 2016, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, our health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at September 30, 2017 and December 31, 2016.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at September 30, 2017 and December 31, 2016.

Retroactive Premium Adjustments: State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare

Risk Adjustment: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (measured as a member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and the Centers for Medicare & Medicaid Services (CMS) practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjustment premiums and Medicare Part D settlements were insignificant at September 30, 2017 and December 31, 2016.

Minimum MLR: Additionally, federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described below, and, for receivables, when collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	September 30, 2017			December 31, 2016
	Current Benefit Year	Prior Benefit Years	Total	
	(In millions)			
Risk adjustment	$ (655)	$ —	$ (655)	$ (522)
Reinsurance	—	10	10	55
Risk corridor	—	—	—	(1)
Minimum MLR	(27)	—	(27)	(1)

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of operations.

- Reinsurance: This program was designed to provide reimbursement to insurers for high cost members and ended December 31, 2016; we expect to settle the outstanding receivable balance in 2017.

- Risk corridor: This program was intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by CMS, and ended December 31, 2016; all outstanding balances were settled as of September 30, 2017.

Additionally, the ACA established a Minimum MLR of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2017 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30, 2017.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(Dollars in millions)			
Maximum available quality incentive premium - current period	$ 36	$ 33	$ 113	$ 114
Quality incentive premium revenue recognized in current period:				
Earned current period	$ 24	$ 26	$ 72	$ 80
Earned prior periods	3	—	9	54
Total	$ 27	$ 26	$ 81	134
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.6%	0.6%	0.6%	1.1%

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), goodwill impairment, certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by HIF in 2017 given the 2017 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. We assume a full-year CSR reconciliation (see further information below) in the premium deficiency reserve calculation for the Marketplace program. We recorded a premium deficiency reserve to “Medical claims and benefits payable” on our accompanying consolidated balance sheets relating to our Marketplace program of $30 million as of December 31, 2016, which increased to $100 million as of June 30, 2017, and then decreased to $70 million as of September 30, 2017. If a nine-month CSR reconciliation had been included in the computation rather than a full year, the premium deficiency reserve would have increased by $55 million, to $125 million as of September 30, 2017. The theoretical $55 million increase to the premium deficiency reserve is less than the potential fourth quarter 2017 impact described below, or $85 million, because such adjustment only recognizes the potential CSR impact to the extent it would have created a deficiency in premiums at September 30, 2017.

Marketplace Cost Share Reduction (CSR) Update

Our third quarter results do not include any potential impact from the October 12, 2017, direction to Centers for Medicare and Medicaid Services (CMS) from Acting Department of Health and Human Services Secretary Hargan to cease payment of Marketplace CSR subsidies. At September 30, 2017, we had a total of approximately $220 million in excess CSR subsidies, recorded as a payable to CMS. This payable represents the extent to which payments received by us from CMS exceeded our estimate of the actual cost of member subsidies incurred by us through September 30, 2017.

We expect to incur approximately $85 million in unreimbursed expense associated with the cessation of CSR subsidies in the fourth quarter of 2017. It has been the practice of CMS to perform a reconciliation on an annual basis of CSR subsidies paid to all health plans against the actual costs incurred by the health plans. Were such a reconciliation to be performed for the full calendar year of 2017—consistent with past practice—we would be able to offset nearly all of the $85 million expense incurred in the fourth quarter against the excess amounts received prior to September 30, 2017. However, should CMS transition to a nine month reconciliation period ending September 30, 2017—the last month for which CSR subsidies have been paid—the absence of CSR subsidy reimbursement would reduce income before income tax expense by approximately $85 million in the fourth quarter of 2017.

Recent Accounting Pronouncements

Goodwill Impairment. In January 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-04, *Simplifying the Test for Goodwill Impairment*, which eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment loss. Instead, an impairment loss is measured as the excess of the carrying amount of the reporting unit, including goodwill, over the fair value of the reporting unit. ASU 2017-04 is effective beginning January 1, 2020; we early adopted ASU 2017-04 as of June 30, 2017, in connection with the interim assessment of our Pathways subsidiary. See further discussion at Note 10, “Impairment Losses.”

Restricted Cash. In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which will require us to include in our consolidated statements of cash flows the balances of cash, cash equivalents, restricted cash and restricted cash equivalents. When these items are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Transfers between cash and cash equivalents and restricted cash and restricted cash equivalents will no longer be presented in the statement of cash flows. ASU 2016-18 is effective beginning January 1, 2018; early adoption is permitted. We are currently evaluating the changes that will be required in our consolidated statements of cash flows.

Stock Compensation. In March 2016, the FASB issued ASU 2016-09, *Improvements to Employee Share-Based Payment Accounting*, which amends ASC Topic 718, *Compensation – Stock Compensation*. ASU 2016-09 simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, statutory tax and classification in the statement of cash flows. We adopted ASU 2016-09 in the first quarter of 2017; such adoption did not significantly impact our consolidated financial statements. In addition, the prior period presentation in the statement of cash flows was not adjusted because such adjustments were insignificant.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity’s balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity’s leases. ASU 2016-02 is effective for us beginning January 1, 2019, and must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. Under this guidance, we will record assets and liabilities relating primarily to our long-term office leases. We are evaluating the effect to our consolidated financial statements.

Revenue Recognition. In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606).* We intend to adopt this standard and the related modifications on January 1, 2018, using the modified retrospective approach. Under this approach, the cumulative effect of initially applying the guidance will be reflected as an adjustment to beginning retained earnings.

We have determined that the insurance contracts of our Health Plans segment, which segment constitutes the vast majority of our operations, are excluded from the scope of Topic 606 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts.

For our Molina Medicaid Solutions segment, we have reevaluated our earlier assessment and determined that revenue for contracts that include design, development and implementation of Medicaid managed care systems shall be deferred until the system 'go-live' date, and then generally recognized on a straight-line basis over the hosting period. This approach is consistent with the FASB/IASB Joint Transition Resource Group for Revenue Recognition view for entities that provide software as a service solution, and similar to our historical revenue recognition methodology. We are continuing to evaluate the existence of customers' rights with regard to renewal options and whether such rights may constitute separate performance obligations. We expect that cost of service revenue will generally be recognized in a manner consistent with the corresponding revenue recognition.

We believe the cumulative adjustment to retained earnings associated with the adoption of Topic 606 effective January 1, 2018, will be insignificant for both our Molina Medicaid Solutions and Other segments.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a significant impact on our present or future consolidated financial statements.

3. Net (Loss) Income per Share

The following table sets forth the calculation of basic and diluted net (loss) income per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(In millions, except net income per share)			
Numerator:				
Net (loss) income	$ (97)	$ 42	$ (250)	$ 99
Denominator:				
Denominator for basic net (loss) income per share	57	56	56	55
Effect of dilutive securities:				
1.125% Warrants [1]	—	—	—	1
Denominator for diluted net (loss) income per share	57	56	56	56
Net (loss) income per share: [2]				
Basic	$ (1.70)	$ 0.77	$ (4.44)	$ 1.79
Diluted	$ (1.70)	$ 0.76	$ (4.44)	$ 1.77
Potentially dilutive common shares excluded from calculations:				
1.125% Warrants [1]	2	—	2	—
1.625% Notes [1]	1	—	—	—

(1) For more information regarding the 1.125% Warrants, refer to Note 9, "Stockholders' Equity." For more information regarding the 1.625% Notes, refer to Note 7, "Debt." The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Potentially dilutive common shares were not included in the computation of diluted net loss per share in the three and nine months ended September 30, 2017, because to do so would have been anti-dilutive.
(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of cash, cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the

relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to the three-tier fair value hierarchy. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 5, "Fair Value Measurements," in our 2016 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of September 30, 2017, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 8, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the nine months ended September 30, 2017.

Our financial instruments measured at fair value on a recurring basis at September 30, 2017, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,162	$ —	$ 1,162	$ —
Government-sponsored enterprise securities (GSEs)	220	220	—	—
Municipal securities	131	—	131	—
Asset-backed securities	125	—	125	—
U.S. treasury notes	121	121	—	—
Certificates of deposit	28	—	28	—
Subtotal - current investments	1,787	341	1,446	—
Corporate debt securities	229	—	229	—
U.S. treasury notes	97	97	—	—
Subtotal - current restricted investments	326	97	229	—
1.125% Call Option derivative asset	425	—	—	425
Total assets	$ 2,538	$ 438	$ 1,675	$ 425
1.125% Conversion Option derivative liability	$ 425	$ —	$ —	$ 425
Total liabilities	$ 425	$ —	$ —	$ 425

Our financial instruments measured at fair value on a recurring basis at December 31, 2016, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,179	$ —	$ 1,179	$ —
GSEs	231	231	—	—
Municipal securities	142	—	142	—
Asset-backed securities	69	—	69	—
U.S. treasury notes	84	84	—	—
Certificates of deposit	53	—	53	—
Subtotal - current investments	1,758	315	1,443	—
1.125% Call Option derivative asset	267	—	—	267
Total assets	$ 2,025	$ 315	$ 1,443	$ 267
1.125% Conversion Option derivative liability	$ 267	$ —	$ —	$ 267
Total liabilities	$ 267	$ —	$ —	$ 267

There were no current restricted investments as of December 31, 2016.

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the amount due under our Credit Facility is classified as a Level 3 financial instrument, because certain inputs used to determine its fair value are not observable. As of September 30, 2017, the carrying value of the amount due under the Credit Facility approximates it fair value because of the recency of this borrowing during the third quarter of 2017.

	September 30, 2017		December 31, 2016	
	Carrying Value	Fair Value	Carrying Value	Fair Value
	(In millions)			
5.375% Notes	$ 692	$ 726	$ 691	$ 714
1.125% Convertible Notes	489	927	471	792
4.875% Notes	325	324	—	—
Credit Facility	300	300	—	—
1.625% Convertible Notes	292	373	284	344
	$ 2,098	$ 2,650	$ 1,446	$ 1,850

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets (including restricted investments) to be available-for-sale. Certain of our senior notes, as further discussed in Note 7, “Debt,” contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as “Restricted investments” in the accompanying consolidated balance sheets. Such proceeds, while restricted as to their use and held in a segregated deposit account, are available-for-sale based upon our contractual liquidity requirements.

The following tables summarize our investments as of the dates indicated:

	September 30, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,162	$ 1	$ 1	$ 1,162
GSEs	221	—	1	220
Municipal securities	132	—	1	131
Asset-backed securities	125	—	—	125
U.S. treasury notes	121	—	—	121
Certificates of deposit	28	—	—	28
Subtotal - current investments	1,789	1	3	1,787
Corporate debt securities	229	—	—	229
U.S. treasury notes	97	—	—	97
Subtotal - current restricted investments	326	—	—	326
	$ 2,115	$ 1	$ 3	$ 2,113

	December 31, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,180	$ 1	$ 2	$ 1,179
GSEs	232	—	1	231
Municipal securities	143	—	1	142
Asset-backed securities	69	—	—	69
U.S. treasury notes	84	—	—	84
Certificates of deposit	53	—	—	53
	$ 1,761	$ 1	$ 4	$ 1,758

There were no current restricted investments as of December 31, 2016.

The contractual maturities of our available-for-sale investments as of September 30, 2017 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,154	$ 1,153
Due after one year through five years	944	943
Due after five years through ten years	17	17
	$ 2,115	$ 2,113

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and nine months ended September 30, 2017 and 2016 were insignificant.

We have determined that unrealized losses at September 30, 2017 and December 31, 2016, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of September 30, 2017:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 783	$ 1	314	$ —	$ —	—
GSEs	—	—	—	58	1	20
Municipal securities	97	1	116	—	—	—
	$ 880	$ 2	430	$ 58	$ 1	20

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2016:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 542	$ 2	378	$ —	$ —	—
GSEs	198	1	73	—	—	—
Municipal securities	101	1	129	—	—	—
	$ 841	$ 4	580	$ —	$ —	—

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulation in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current “Restricted investments” in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

The contractual maturities of our held-to-maturity restricted investments, which are carried at amortized cost, which approximates fair value, as of September 30, 2017 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 100	$ 100
Due after one year through five years	17	17
	$ 117	$ 117

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated:

	September 30, 2017	December 31, 2016
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,681	$ 1,352
Pharmacy payable	125	112
Capitation payable	57	37
Other	615	428
	$ 2,478	$ 1,929

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. Non-risk provider payables amounted to $403 million and $225 million as of September 30, 2017 and December 31, 2016, respectively.

Reinsurance recoverables of $16 million and $72 million as of September 30, 2017 and 2016, respectively, are included in "Receivables" in the accompanying consolidated balance sheets.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amounts by which our original estimate of medical claims and benefits payable at the beginning of the period were less (more) than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30,	
	2017	2016
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 1,929	$ 1,685
Components of medical care costs related to:		
Current period	12,813	11,120
Prior periods	9	(190)
Total medical care costs	12,822	10,930
Change in non-risk provider payables	172	70
Payments for medical care costs related to:		
Current period	10,944	9,536
Prior periods	1,501	1,278
Total paid	12,445	10,814
Medical claims and benefits payable, ending balance	$ 2,478	$ 1,871
Benefit from prior period as a percentage of:		
Balance at beginning of period	(0.5)%	11.3%
Premium revenue, trailing twelve months	— %	1.2%
Medical care costs, trailing twelve months	(0.1)%	1.3%

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single

factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

Prior period development of our estimate as of December 31, 2016, through September 30, 2017, was unfavorable by $9 million, which is substantially less than the favorable prior period development of $190 million we recognized for the same period in the prior year. Further, the unfavorable development through September 30, 2017, was less than the 8% to 10% favorable development we typically expect.

We believe that the most significant uncertainties surrounding our IBNP estimates at September 30, 2017 are as follows:

- At our Florida health plan, the inventory of unpaid claims increased significantly during the first two quarters of 2017, and then dropped in the third quarter. For this reason, the timing between the dates of service and the dates claims are paid will be impacted, making our liability estimates subject to more than the usual amount of uncertainty.
- At our Illinois health plan, in 2017 we paid a large number of claims that had previously been denied and were subsequently disputed by providers. We have also established a liability for additional expected claims resulting from provider disputes. This has created some distortion in the claims payment patterns, making our liability estimates subject to more than the usual amount of uncertainty.
- At our California health plan, we adjusted our inpatient authorization process. As a result, due to the expected increase in authorized inpatient stays, our liability estimates are subject to more than the usual amount of uncertainty.
- At our Illinois and New York health plans, we implemented a new process for increased quality review of claims payments. While we do not anticipate this new process will impact the percentage of claims paid within the timely turnaround requirements, we believe it will have a minor impact on the timing of some paid claims. For this reason, our liability estimates in these two health plans are subject to more than the usual amount of uncertainty.
- At our Puerto Rico health plan, Hurricane Maria had a significant impact on both utilization of services and our ability to process claims payments in Puerto Rico. For these reasons, we believe our liability estimates are subject to more than the usual amount of uncertainty.

7. Debt

Substantially all of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets (in millions):

	September 30, 2017	December 31, 2016
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 494	$ 477
1.625% Convertible Notes, net of unamortized premium and discount	293	—
Lease financing obligations	1	1
Debt issuance costs	(6)	(6)
	782	472
Non-current portion of long-term debt:		
5.375% Notes	700	700
4.875% Notes	330	—
Credit Facility	300	—
1.625% Convertible Notes, net of unamortized premium and discount	—	286
Debt issuance costs	(13)	(11)
	1,317	975
Lease financing obligations	198	198
	$ 2,297	$ 1,645

4.875% Notes due 2025

On June 6, 2017, we completed the private offering of $330 million aggregate principal amount of senior notes (4.875% Notes) due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. According to their terms, the guarantees under the 4.875% Notes mirror those of the Credit Facility, defined and described below. See Note 16, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

The 4.875% Notes contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as “Restricted investments” in our consolidated balance sheets. These funds may be used by us as follows:

- On or prior to August 20, 2018, to:
  - Redeem, repurchase, repay, tender for, or acquire for value all or any portion of our 1.625% Convertible Notes, defined and discussed further below, or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes; and/or
  - Pay any interest due on all or any portion of the 4.875% Notes.
- On or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that we are obligated to repurchase; and
- Subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited in the indenture governing the 4.875% Notes.

5.375% Notes due 2022

We have outstanding $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. According to their terms, the guarantees under the 5.375% Notes mirror those of the Credit Facility, defined and described below. See Note 16, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors.

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (Credit Facility), referred to as the First Amendment. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. As of September 30, 2017, $300 million was outstanding under the Credit Facility, and we were in compliance with all financial and non-financial covenants under the Credit Facility. Also as of September 30, 2017, outstanding letters of credit amounting to $6 million reduced our remaining borrowing capacity under the Credit Facility to $194 million.

In addition to increasing amounts available to borrow under the Credit Facility and extending its term, the First Amendment provided that all guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC, were automatically and unconditionally released from their obligations as guarantors of the Credit Facility and the 5.375% Notes.

The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. In February 2017, we entered into a second amendment to the Credit Facility (the Second Amendment) which modified the Credit Facility's definition of the earnings measure used in the financial covenant computations to a) allow us to receive credit for risk corridor payments owed to, but not received or accrued by us during 2016; and b) account for the difference between the amount of actual risk transfer payments made or accrued by us during 2016, and the amount of risk transfer payments that would have been due under the federal government's proposed 2018 risk adjustment payment transfer formula.

In May 2017, we entered into a third amendment to the Credit Facility (the Third Amendment) which modified the Credit Facility's definition of specified cash, to permit cash that is either subject to customary escrow arrangements or held in a segregated account to be netted from the Credit Facility's consolidated net leverage ratio if the use of the cash is limited to the repayment of other indebtedness. The Third Amendment also adds a carve-out to the Credit Facility's negative pledge covenant to allow for the escrow arrangements and segregated accounts.

In August 2017, we entered into a fourth amendment to the Credit Facility (the Fourth Amendment). The Fourth Amendment modified the definition of consolidated adjusted EBITDA to permit the add-back of certain restructuring charges and cost savings subject to certain limitations, and modified the definition of the consolidated interest coverage ratio to include, when calculating such ratio, consolidated interest expense "paid in cash" only.

Convertible Senior Notes

We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020 (1.125% Convertible Notes), unless earlier repurchased or converted. We also have outstanding $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044 (1.625% Convertible Notes), unless earlier repurchased, redeemed, or converted. The 1.125% Convertible Notes are convertible entirely into cash, and the 1.625% Convertible Notes are convertible partially into cash, each prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended September 30, 2017; therefore, they are convertible into cash and are reported in current portion of long-term debt as of September 30, 2017.

The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended September 30, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of September 30, 2017. As noted above, because the proceeds from the 4.875% Notes are initially restricted to payments upon conversion or redemption of the 1.625% Convertible Notes, such restricted investments are also classified as current in the accompanying consolidated balance sheets.

Cross-Default Provisions

The terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures.

Debt Commitment Letter

In connection with the terminated Medicare Acquisition, we entered into a debt commitment letter with Barclays Bank PLC (Barclays) in August 2016. Under this debt commitment letter, Barclays agreed to lend us up to $400 million, subject to satisfaction of certain conditions, including consummation of the terminated Medicare Acquisition. The debt commitment letter automatically terminated in February 2017 as a result of the termination of this transaction. The costs associated with the debt commitment letter and its termination were reimbursed as described in Note 1, "Basis of Presentation–*Health Plans Segment Recent Developments*."

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	September 30, 2017	December 31, 2016
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 425	$ 267
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 425	$ 267

Our derivative financial instruments do not qualify for hedge treatment; therefore, the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, and reported in "Other income, net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, "Fair Value Measurements."

As of September 30, 2017, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within twelve months of September 30, 2017, as described in Note 7, "Debt."

9. Stockholders' Equity

Stockholders' equity decreased $220 million during the nine months ended September 30, 2017 compared with stockholders' equity at December 31, 2016. The decrease was due primarily to the net loss of $250 million, partially offset by $29 million related to employee stock transactions in the nine months ended September 30, 2017.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, "Derivatives," in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, when the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net (Loss) Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Stock Incentive Plans

In connection with our equity incentive plans and employee stock purchase plan, approximately 702,000 shares of common stock vested or were purchased, net of shares used to settle employees' income tax obligations, during the nine months ended September 30, 2017.

Except as noted below, we record share-based compensation as "General and administrative expenses" in the accompanying consolidated statements of operations. Restricted stock awards (RSAs), performance stock awards (PSAs) and performance stock units (PSUs) activity for the nine months ended September 30, 2017 is summarized below:

	Restricted Stock Awards	Performance Stock Awards	Performance Stock Units	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2016	577,244	345,656	—	922,900	$ 58.15
Granted	386,273	—	231,100	617,373	57.16
Vested	(391,680)	(260,894)	(139,272)	(791,846)	57.78
Forfeited	(69,346)	—	—	(69,346)	54.37
Unvested balance, September 30, 2017	502,491	84,762	91,828	679,081	57.61

The total fair value of RSAs granted during the nine months ended September 30, 2017 and 2016 was $19 million and $18 million, respectively. The total fair value of RSAs which vested during the nine months ended September 30, 2017 and 2016 was $21 million and $22 million, respectively.

No PSAs were granted during the nine months ended September 30, 2017. The total fair value of PSAs granted during the nine months ended September 30, 2016 was $15 million. The total fair value of PSAs which vested during the nine months ended September 30, 2017 was $15 million. No PSAs vested during the nine months ended September 30, 2016.

The total fair value of PSUs granted during the nine months ended September 30, 2017 was $16 million. The total fair value of PSUs which vested during the nine months ended September 30, 2017 was $9 million. There were no PSUs granted or vested in 2016.

During the nine months ended September 30, 2017, the vesting of 133,957 RSAs, 153,574 PSAs and 139,272 PSUs was accelerated in connection with the termination of our former Chief Executive Officer (CEO) and former Chief Financial Officer (CFO) in May 2017. Share-based compensation expense of $38 million was recorded during the nine months ended September 30, 2017, of which $23 million was recorded to "Restructuring and separation costs" in the accompanying consolidated statements of operations. See Note 11, "Restructuring and Separation Costs" for further discussion. We recorded share-based compensation expense of $24 million in the nine months ended September 30, 2016.

As of September 30, 2017, there was $27 million of total unrecognized compensation expense related to unvested RSAs, PSAs, and PSUs, which we expect to recognize over a remaining weighted-average period of 2.2 years and 1.9 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 4.5% for non-executive employees as of September 30, 2017.

10. Impairment Losses

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is subject to an annual impairment test. We are required to test at least annually for impairment, or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analysis. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing.

An impairment loss is measured as the excess of the carrying amount of the reporting unit, including goodwill, over the fair value of the reporting unit. We estimate the fair values of our reporting units using discounted cash flows. We apply our weighted average cost of capital (WACC) as the best estimate to discount future estimated cash flows to present value. The WACC is based on externally available data considering market participants' cost of equity and debt, and capital structure. In addition, we apply a terminal growth rate that corresponds to the reporting unit's long-term growth prospects.

In the discounted cash flow analyses, we must make assumptions about a wide variety of internal and external factors, and consider the price that would be received to sell the reporting unit as a whole in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates.

Molina Medicaid Solutions Segment

As described in Note 11, "Restructuring and Separation Costs," in the third quarter of 2017 we wrote off certain costs capitalized at our Molina Medicaid Solutions segment that supported our Health Plans segment provider information management processes to be re-designed. Although the intercompany revenues recorded by Molina Medicaid Solutions under this arrangement were insignificant on a consolidated basis, the termination of such revenue resulted in a triggering event for an interim goodwill impairment analysis of this segment in the third quarter of 2017. In the Molina Medicaid Solutions' discounted cash flow model, we incorporated significant estimates and assumptions related to future periods, such as intercompany business support opportunities and prospects for new Medicaid management information systems contracts. Because management has determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment, the test resulted in a fair value less than Molina Medicaid Solutions' carrying amount; therefore, we recorded a goodwill impairment loss for the difference, or $28 million, in the third quarter of 2017.

Other Segment

In the course of developing the Restructuring Plan in the second quarter of 2017, we determined that future benefits to be derived from our Pathways subsidiary, including the integration of its operations with our Health Plans segment, would be less than previously anticipated. In addition, poorer than expected year-to-date operating results, as well as lower projections of operating results for periods in the near term at our Pathways subsidiary, led us to conclude that a triggering event for an interim impairment analysis had occurred in the second quarter of 2017.

In the third quarter of 2017, management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected. Therefore, we conducted an additional interim impairment analysis.

Intangible assets. In the second quarter of 2017, we evaluated Pathways' finite-lived intangible assets (customer relationships and contract licenses) for impairment, using undiscounted cash flows expected over the longest remaining useful life of the assets tested. Because the undiscounted cash flows over the remaining useful life were less than Pathways' carrying amount, the intangible assets were impaired. We recorded an impairment loss for the carrying amount of the intangible assets, or $11 million, in the second quarter of 2017.

Goodwill. As noted above, we estimated Pathways' fair value using discounted cash flows, incorporating significant estimates and assumptions related to future periods. Such estimates included anticipated client census which drives service revenue; the likelihood of future benefits to be derived from Pathways (including integration with our health plans); current prospects relating to the behavioral services labor market which drives cost of service revenue; and anticipated capital expenditures. The tests in each of the three months ended June 30, 2017, and September 30, 2017, resulted in a fair value less than Pathways' carrying amount; therefore, we recorded an

impairment loss for the difference. The Pathways goodwill impairment losses amounted to $101 million in the third quarter of 2017, and $59 million in the second quarter of 2017. In the second quarter of 2017, we also recorded a goodwill impairment loss of $2 million for a separate subsidiary in the Other segment that did not pass its impairment test.

There were no impairments of intangible assets or goodwill during 2016.

The goodwill impairment losses are recorded to the segments as indicated in following table, and reported as “Impairment losses” in the accompanying consolidated statements of operations.

	Health Plans	Molina Medicaid Solutions	Other	Total
		(In millions)		
Historical goodwill	$ 445	$ 71	$ 162	$ 678
Accumulated impairment losses at December 31, 2016	(58)	—	—	(58)
Balance, December 31, 2016	387	71	162	620
Impairment losses, three months ended June 30, 2017	—	—	(61)	(61)
Impairment losses, three months ended September 30, 2017	—	(28)	(101)	(129)
Balance, September 30, 2017	$ 387	$ 43	$ —	$ 430
Accumulated impairment losses at September 30, 2017	$ 58	$ 28	$ 162	$ 248

11. Restructuring and Separation Costs

Following a management-initiated, broad operational assessment in early 2017, designed to improve our profitability and expand our core Medicaid business, in June 2017, we accelerated the implementation of a comprehensive restructuring and profitability improvement plan (the Restructuring Plan). Under the Restructuring Plan, we are taking the following actions:

1. We have streamlined our organizational structure, including the elimination of redundant layers of management, the consolidation of regional support services, and other reductions to our workforce, to improve efficiency as well as the speed and quality of our decision-making.
2. We are re-designing core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology to achieve more effective and cost efficient outcomes.
3. We are remediating high cost provider contracts and building around high quality, cost-effective networks.
4. We are restructuring our existing direct delivery operations.
5. We are reviewing our vendor base to ensure that we are partnering with the lowest-cost, most-effective vendors.
6. Throughout this process, we are taking precautions to ensure that our actions do not impede our ability to continue to deliver quality health care, retain existing managed care contracts, and to secure new managed care contracts.

In addition to costs incurred under the Restructuring Plan, we have recorded costs associated with the separation of our former CEO and former CFO, described in further detail below.

Expected Costs

We estimate that total pre-tax costs associated with the restructuring plan will be approximately $70 million to $90 million in the fourth quarter of 2017, with an additional $20 million to $40 million to be incurred in 2018. Since the initiation of our Restructuring Plan in the second quarter of 2017, the range of total estimated costs have increased by approximately $50 million due primarily to non-cash write-offs of certain capitalized software in connection with the re-design of core processes. Such write-offs were not included in our initial total cost estimates, but as our evaluation of core operating processes proceeded in the third quarter, we determined that certain projects were inconsistent with our future operating goals and were therefore written off.

In addition, in the second quarter of 2017, we reported that we expected restructuring costs to relate only to the Health Plans and Other segments. In the third quarter of 2017, however, we wrote off certain costs capitalized at our Molina Medicaid Solutions segment that supported our Health Plans segment provider information management

processes to be re-designed. In addition, we now expect to incur consulting fees in connection with the review of Molina Medicaid Solutions' core operating processes.

The following table illustrates our estimates of the total costs, by segment and major type of cost, that we expect to incur under the Restructuring Plan, and includes costs incurred through September 30, 2017. We expect the Restructuring Plan to be completed by the end of 2018.

Estimated Costs Expected to be Incurred by Reportable Segment	Health Plans	Molina Medicaid Solutions	Other	Total
		(In millions)		
Termination benefits	$30 to $35	—	$30 to $35	$60 to $70
Other restructuring costs	$40 to $45	$10	$110 to $115	$160 to $170
	$70 to $80	$10	$140 to $150	$220 to $240

Costs Incurred

Restructuring Plan

Restructuring costs incurred to date consist primarily of termination benefits, write-offs of capitalized software due to the re-design of our core operating processes, restructuring of our direct delivery operations, and consulting fees.

Separation Costs

On May 2, 2017, we terminated the employment of our former CEO and CFO without cause. Under their amended and restated employment agreements, they were each entitled to receive 400% of their base salary, a prorated termination bonus (150% of base salary for the former CEO and 125% of base salary for the former CFO), full vesting of equity compensation, and a cash payment for health and welfare benefits. We recorded separation costs of $35 million primarily related to these former executives under FASB ASC Topic 712, *Nonretirement and Postemployment Benefits*. Of this total, $23 million related to the acceleration of their share-based compensation, as further discussed in Note 9, "Stockholders' Equity." Employee separation costs were insignificant in 2016.

Restructuring and separation costs are reported in "Restructuring and separation costs" in the accompanying consolidated statements of operations. The following tables present the major types of such costs by segment. Long-lived assets include capitalized software, intangible assets and furniture, fixtures and equipment.

	Three Months Ended September 30, 2017					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
			(In millions)			
Health Plans	$ —	$ 27	$ 6	$ —	$ —	$ 33
Molina Medicaid Solutions	—	—	8	—	—	8
Other	—	23	35	16	3	77
	$ —	$ 50	$ 49	$ 16	$ 3	$ 118

	Nine Months Ended September 30, 2017					
			Other Restructuring Costs			
	Separation Costs - Former Executives	One-Time Termination Benefits	Write-offs of Long-lived Assets	Consulting Fees	Contract Termination Costs	Total
			(In millions)			
Health Plans	$ —	$ 27	$ 6	$ —	$ —	$ 33
Molina Medicaid Solutions	—	—	8	—	—	8
Other	35	23	35	24	3	120
	$ 35	$ 50	$ 49	$ 24	$ 3	$ 161

Reconciliation of Liability

For those restructuring and separation costs that require cash settlement (primarily separation costs, termination benefits and consulting fees), the following table presents a roll-forward of the accrued liability, which is reported in "Accounts payable and accrued liabilities" in the accompanying consolidated balance sheets:

	Separation Costs - Former Executives	One-Time Termination Benefits	Other Restructuring Costs	Total
		(In millions)		
Accrued as of December 31, 2016	$ —	$ —	$ —	$ —
Charges	12	50	27	89
Cash payments	(1)	(9)	(14)	(24)
Accrued as of September 30, 2017	$ 11	$ 41	$ 13	$ 65

12. Segment Information

We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
Three Months Ended September 30, 2017				
Total revenue [1]	$ 4,899	$ 47	$ 85	$ 5,031
Gross margin	557	5	2	564
Impairment losses	—	(28)	(101)	(129)
Restructuring and separation costs	(33)	(8)	(77)	(118)
Nine Months Ended September 30, 2017				
Total revenue [1]	$ 14,538	$ 140	$ 256	$ 14,934
Gross margin	1,343	13	8	1,364
Impairment losses	—	(28)	(173)	(201)
Restructuring and separation costs	(33)	(8)	(120)	(161)
Three Months Ended September 30, 2016				
Total revenue [1]	$ 4,412	$ 48	$ 86	$ 4,546
Gross margin	443	6	8	457
Impairment losses	—	—	—	—
Restructuring and separation costs	—	—	—	—
Nine Months Ended September 30, 2016				
Total revenue [1]	$ 12,835	$ 146	$ 267	$ 13,248
Gross margin	1,285	17	29	1,331
Impairment losses	—	—	—	—
Restructuring and separation costs	—	—	—	—
Total assets				
September 30, 2017	$ 7,031	$ 233	$ 1,690	$ 8,954
December 31, 2016	5,897	267	1,285	7,449
Goodwill and intangible assets, net				
September 30, 2017	$ 488	$ 43	$ —	$ 531
December 31, 2016	513	72	175	760

(1) Total revenue consists primarily of premium revenue, premium tax revenue and health insurer fee revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments. Inter-segment revenue is insignificant for all periods presented.

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(In millions)			
Gross margin:				
Health Plans	$ 557	$ 443	$ 1,343	$ 1,285
Molina Medicaid Solutions	5	6	13	17
Other	2	8	8	29
Total gross margin	564	457	1,364	1,331
Add: other operating revenues [1]	124	222	379	625
Less: other operating expenses [2]	(769)	(561)	(2,029)	(1,644)
Operating (loss) income	(81)	118	(286)	312
Other expenses, net	32	26	10	76
(Loss) income before income taxes	$ (113)	$ 92	$ (296)	$ 236

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses, depreciation and amortization, impairment losses, and restructuring and separation costs.

13. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are operated by our wholly owned subsidiaries in the states in which our health plans operate, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,696 million at September 30, 2017, and $1,492 million at December 31, 2016. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments (excluding restricted investments) held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments (excluding restricted investments) amounted to $391 million and $264 million as of September 30, 2017 and December 31, 2016, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states.

As of September 30, 2017, our health plans had aggregate statutory capital and surplus of approximately $1,828 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,113 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2017. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

Legal Proceedings

The health care and Medicaid-related business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties

associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and reasonably estimable, but the outcome of legal actions is inherently uncertain and our estimates of such losses could change as a result of further developments of these matters. For certain pending matters, accruals have not been established because such matters have not progressed sufficiently through discovery, and/or development of important factual information and legal issues is insufficient to enable us to estimate a range of possible loss, if any. An adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Marketplace Risk Corridor Program. On January 19, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, Case Number 1:55-cv-01000-UNJ, on behalf of our health plans seeking recovery from the federal government of approximately $52 million in Marketplace risk corridor payments for calendar year 2015. Based upon current estimates, we believe our health plans are also owed approximately $76 million in Marketplace risk corridor payments from the federal government for calendar year 2016. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid Marketplace risk corridor payments as of September 30, 2017. We have fully recognized all liabilities due to the federal government that we have incurred under the Marketplace risk corridor program, and have paid all amounts due to the federal government as required.

Rodriguez v. Providence Community Corrections. On October 1, 2015, seven individuals, on behalf of themselves and all others similarly situated, filed a complaint in the District Court for the Middle District of Tennessee, Nashville Division, Case No. 3:15-cv-01048 (the Rodriquez Litigation), against Providence Community Corrections, Inc. (now known as Pathways Community Corrections, Inc., or PCC). Rutherford County, Tennessee formerly contracted with PCC for the administration of misdemeanor probation, which involved the collection of court costs and fees from probationers. The complaint alleges, among other things, that PCC illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay such amounts. The plaintiffs in the Rodriguez Litigation seek alleged compensatory, treble, and punitive damages, plus attorneys' fees, for alleged federal and state constitutional violations, as well as alleged violations of the Racketeer Influenced and Corrupt Organization Act. PCC's agreement with Rutherford County terminated effective March 31, 2016. On November 1, 2015, one month after the Rodriguez Litigation commenced, we acquired PCC from The Providence Service Corporation (Providence) pursuant to a membership interest purchase agreement. In September 2016, the parties to the Rodriguez Litigation accepted a mediation proposal for settlement pursuant to which PCC and Rutherford County would pay the plaintiffs $14 million and $3 million, respectively. The parties are in the process of finalizing the settlement agreement. We expect to recover the full amount of the settlement under the indemnification provisions of the membership interest purchase agreement with Providence.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. On October 22, 2015, the Relator filed a third amended complaint, seeking general and compensatory damages, treble damages, civil penalties, plus interest and attorneys' fees. On July 11, 2016, the District Court dismissed with prejudice the third amended complaint, without leave to amend. On September 23, 2016, the plaintiff filed an appeal with the Ninth Circuit Court of Appeals. The appeal has been fully briefed by the parties and we are awaiting the Court's decision.

States' Budgets

From time to time, the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. Until July 4, 2017, the state of Illinois operated without a budget for its current fiscal year. As of September 30, 2017, our Illinois health plan served approximately 163,000 members, and recognized premium revenue of approximately $447 million in the nine months ended September 30, 2017. As of September 30, 2017, the state of Illinois owed us approximately $220 million for certain March through September 2017 premiums.

On May 3, 2017, Puerto Rico's financial oversight board filed for a form of bankruptcy in the U.S. District Court in Puerto Rico under Title III of PROMESA. The Title III provision allows for a court debt restructuring process similar to U.S. bankruptcy protection. To the extent such bankruptcy results in our failure to receive payment of amounts due under our Medicaid contract with the Commonwealth or the inability of the Commonwealth to extend our Medicaid contract at the end of its current term, such bankruptcy could have a material adverse effect on our business, financial condition, cash flows, or results of operations. As of September 30, 2017, the plan served approximately 306,000 members and recorded premium revenue of approximately $553 million in the nine months ended September 30, 2017. As of October 27, 2017, the Commonwealth was current with its premium payments.

14. Related Party Transactions

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina and John C. Molina, who are members of our board of directors. Under the terms of this provider agreement, the California health plan pays Pacific for medical care Pacific provides to health plan members. For the three and nine months ended September 30, 2017 and 2016, the amounts paid to Pacific were insignificant.

Refer to Note 15, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

15. Variable Interest Entities (VIEs)

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created to further advance our direct delivery business. Effective September 30, 2017, we terminated our relationship with JMMPC in Florida, Michigan, Washington, and Utah. Therefore, the agreements described below, for all of our health plans other than those in California and New Mexico, were terminated effective September 30, 2017.

JMMPC's primary shareholder is Dr. J. Mario Molina, who is a member of our board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. JMMPC also provides certain specialty referral services to our California health plan members through a contracted provider network. The health plans had entered into primary care services agreements with JMMPC, under which the health plans paid $29 million and $31 million to JMMPC for health care services provided in the three months ended September 30, 2017 and 2016, respectively, and $89 million and $92 million for the nine months ended September 30, 2017 and 2016, respectively. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), had also entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. For the three months ended September 30, 2017 and 2016, JMMPC paid $12 million and $13 million to MMM for clinic administrative services, respectively. For the nine months ended September 30, 2017 and 2016, JMMPC paid $38 million and $40 million, respectively, to MMM for clinic administrative services.

As of September 30, 2017, we determined that JMMPC is a VIE, and that we are its primary beneficiary. We reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we had the power to direct the activities (excluding clinical decisions) that most significantly affected JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that were potentially significant to the VIE, under the agreements described above. Because we were its primary beneficiary, we consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of September 30, 2017, JMMPC had total assets of $20 million, and total liabilities of $24 million. As of December 31, 2016, JMMPC had total assets of $18 million, and total liabilities of $18 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities.

16. Supplemental Condensed Consolidating Financial Information

The 5.375% Notes described in Note 7, “Debt,” are fully and unconditionally guaranteed by certain of our 100% owned subsidiaries on a joint and several basis, with certain exceptions considered customary for such guarantees. The 5.375% Notes and the guarantees are effectively subordinated to all of our and our guarantors’ existing and future secured debt to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock, if any, of our subsidiaries that do not guarantee the 5.375% Notes.

As discussed in Note 7, “Debt,” the First Amendment to the Credit Facility provided that all guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC, were automatically and unconditionally released from their obligations as guarantors under the Credit Facility and the 5.375% Notes.

The following condensed consolidating financial statements present Molina Healthcare, Inc. (as parent guarantor), the subsidiary guarantors, the subsidiary non-guarantors and eliminations, according to the guarantor structure as assessed at the most recent balance sheet date, September 30, 2017.

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Three Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 380	$ 47	$ 4,983	$ (379)	$ 5,031
Expenses:					
Medical care costs	3	—	4,217	—	4,220
Cost of service revenue	—	42	81	—	123
General and administrative expenses	244	(1)	519	(379)	383
Premium tax expenses	—	—	106	—	106
Depreciation and amortization	23	1	9	—	33
Impairment losses	—	28	101	—	129
Restructuring and separation costs	77	8	33	—	118
Total operating expenses	347	78	5,066	(379)	5,112
Operating income (loss)	33	(31)	(83)	—	(81)
Interest expense	32	—	—	—	32
Income (loss) before income taxes	1	(31)	(83)	—	(113)
Income tax expense (benefit)	9	(10)	(15)	—	(16)
Net loss before equity in net losses of subsidiaries	(8)	(21)	(68)	—	(97)
Equity in net losses of subsidiaries	(89)	(77)	—	166	—
Net loss	$ (97)	$ (98)	$ (68)	$ 166	$ (97)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE LOSS

	Three Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (97)	$ (98)	$ (68)	$ 166	$ (97)
Other comprehensive loss, net of tax	—	—	—	—	—
Comprehensive loss	$ (97)	$ (98)	$ (68)	$ 166	$ (97)

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Three Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 274	$ 48	$ 4,498	$ (274)	$ 4,546
Expenses:					
Medical care costs	19	—	3,730	(1)	3,748
Cost of service revenue	—	42	77	—	119
General and administrative expenses	223	(4)	397	(273)	343
Premium tax expenses	—	—	127	—	127
Health insurer fee expenses	—	—	55	—	55
Depreciation and amortization	25	2	9	—	36
Total operating expenses	267	40	4,395	(274)	4,428
Operating income	7	8	103	—	118
Interest expense	26	—	—	—	26
(Loss) income before income taxes	(19)	8	103	—	92
Income tax expense	4	—	46	—	50
Net (loss) income before equity in net earnings of subsidiaries	(23)	8	57	—	42
Equity in net earnings of subsidiaries	65	—	—	(65)	—
Net income	$ 42	$ 8	$ 57	$ (65)	$ 42

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 42	$ 8	$ 57	$ (65)	$ 42
Other comprehensive loss, net of tax	(1)	—	(1)	1	(1)
Comprehensive income	$ 41	$ 8	$ 56	$ (64)	$ 41

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Nine Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 1,010	$ 146	$ 14,792	$ (1,014)	$ 14,934
Expenses:					
Medical care costs	10	—	12,812	—	12,822
Cost of service revenue	—	127	242	—	369
General and administrative expenses	799	13	1,429	(1,014)	1,227
Premium tax expenses	—	—	331	—	331
Depreciation and amortization	75	1	33	—	109
Impairment losses	—	28	173	—	201
Restructuring and separation costs	120	8	33	—	161
Total operating expenses	1,004	177	15,053	(1,014)	15,220
Operating income (loss)	6	(31)	(261)	—	(286)
Interest expense	85	—	—	—	85
Other income, net	(75)	—	—	—	(75)
Loss before income taxes	(4)	(31)	(261)	—	(296)
Income tax expense (benefit)	26	(10)	(62)	—	(46)
Net loss before equity in net losses of subsidiaries	(30)	(21)	(199)	—	(250)
Equity in net losses of subsidiaries	(220)	(143)	—	363	—
Net loss	$ (250)	$ (164)	$ (199)	$ 363	$ (250)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE LOSS

	Nine Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (250)	$ (164)	$ (199)	$ 363	$ (250)
Other comprehensive income, net of tax	1	—	1	(1)	1
Comprehensive loss	$ (249)	$ (164)	$ (198)	$ 362	$ (249)

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Nine Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 786	$ 147	$ 13,099	$ (784)	$ 13,248
Expenses:					
Medical care costs	50	—	10,881	(1)	10,930
Cost of service revenue	—	130	232	—	362
General and administrative expenses	659	5	1,153	(783)	1,034
Premium tax expenses	—	—	345	—	345
Health insurer fee expenses	—	—	163	—	163
Depreciation and amortization	70	5	27	—	102
Total operating expenses	779	140	12,801	(784)	12,936
Operating income	7	7	298	—	312
Interest expense	76	—	—	—	76
(Loss) income before income taxes	(69)	7	298	—	236
Income tax (benefit) expense	(24)	(1)	162	—	137
Net (loss) income before equity in earnings of subsidiaries	(45)	8	136	—	99
Equity in net earnings of subsidiaries	144	3	—	(147)	—
Net income	$ 99	$ 11	$ 136	$ (147)	$ 99

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Nine Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 99	$ 11	$ 136	$ (147)	$ 99
Other comprehensive income, net of tax	7	—	6	(6)	7
Comprehensive income	$ 106	$ 11	$ 142	$ (153)	$ 106

CONDENSED CONSOLIDATING BALANCE SHEETS

	September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 356	$ 58	$ 3,520	$ —	$ 3,934
Investments	35	—	1,752	—	1,787
Restricted investments	326	—	—	—	326
Receivables	2	25	975	—	1,002
Income taxes refundable	2	—	58	—	60
Due from (to) affiliates	203	(5)	(198)	—	—
Prepaid expenses and other current assets	65	20	89	—	174
Derivative asset	425	—	—	—	425
Total current assets	1,414	98	6,196	—	7,708
Property, equipment, and capitalized software, net	261	37	99	—	397
Deferred contract costs	—	97	—	—	97
Goodwill and intangible assets, net	55	43	433	—	531
Restricted investments	—	—	117	—	117
Investment in subsidiaries, net	2,625	95	—	(2,720)	—
Deferred income taxes	10	—	96	(44)	62
Other assets	50	2	6	(16)	42
	$ 4,415	$ 372	$ 6,947	$ (2,780)	$ 8,954
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ —	$ —	$ 2,478	$ —	$ 2,478
Amounts due government agencies	—	—	1,324	—	1,324
Accounts payable and accrued liabilities	227	40	218	—	485
Deferred revenue	—	52	416	—	468
Current portion of long-term debt	782	—	—	—	782
Derivative liability	425	—	—	—	425
Total current liabilities	1,434	92	4,436	—	5,962
Long-term debt	1,515	—	16	(16)	1,515
Deferred income taxes	12	32	—	(44)	—
Other long-term liabilities	25	1	22	—	48
Total liabilities	2,986	125	4,474	(60)	7,525
Total stockholders' equity	1,429	247	2,473	(2,720)	1,429
	$ 4,415	$ 372	$ 6,947	$ (2,780)	$ 8,954

CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 86	$ 6	$ 2,727	$ —	$ 2,819
Investments	178	—	1,580	—	1,758
Receivables	2	34	938	—	974
Income tax refundable	17	4	18	—	39
Due from (to) affiliates	104	(5)	(99)	—	—
Prepaid expenses and other current assets	58	30	43	—	131
Derivative asset	267	—	—	—	267
Total current assets	712	69	5,207	—	5,988
Property, equipment, and capitalized software, net	301	46	107	—	454
Deferred contract costs	—	86	—	—	86
Goodwill and intangible assets, net	58	73	629	—	760
Restricted investments	—	—	110	—	110
Investment in subsidiaries, net	2,609	246	—	(2,855)	—
Deferred income taxes	10	—	—	—	10
Other assets	48	3	6	(16)	41
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 1	$ —	$ 1,928	$ —	$ 1,929
Amounts due government agencies	—	—	1,202	—	1,202
Accounts payable and accrued liabilities	146	34	205	—	385
Deferred revenue	—	40	275	—	315
Current portion of long-term debt	472	—	—	—	472
Derivative liability	267	—	—	—	267
Total current liabilities	886	74	3,610	—	4,570
Long-term debt	1,173	—	16	(16)	1,173
Deferred income taxes	11	39	(35)	—	15
Other long-term liabilities	19	1	22	—	42
Total liabilities	2,089	114	3,613	(16)	5,800
Total stockholders' equity	1,649	409	2,446	(2,855)	1,649
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by operating activities	$ 215	$ 81	$ 661	$ —	$ 957
Investing activities:					
Purchases of investments	(333)	—	(1,563)	—	(1,896)
Proceeds from sales and maturities of investments	150	—	1,388	—	1,538
Purchases of property, equipment and capitalized software	(67)	(10)	(8)	—	(85)
Increase in restricted investments held-to-maturity	—	—	(10)	—	(10)
Capital contributions to/from subsidiaries	(363)	2	361	—	—
Dividends to/from subsidiaries	136	—	(136)	—	—
Change in amounts due to/from affiliates	(100)	—	100	—	—
Other, net	—	(21)	—	—	(21)
Net cash (used in) provided by investing activities	(577)	(29)	132	—	(474)
Financing activities:					
Proceeds from senior notes offering, net of issuance costs	325	—	—	—	325
Proceeds from borrowings under credit facility	300	—	—	—	300
Proceeds from employee stock plans	11	—	—	—	11
Other, net	(4)	—	—	—	(4)
Net cash provided by financing activities	632	—	—	—	632
Net increase in cash and cash equivalents	270	52	793	—	1,115
Cash and cash equivalents at beginning of period	86	6	2,727	—	2,819
Cash and cash equivalents at end of period	$ 356	$ 58	$ 3,520	$ —	$ 3,934

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 43	$ 34	$ 556	$ —	$ 633
Investing activities:					
Purchases of investments	(114)	—	(1,330)	—	(1,444)
Proceeds from sales and maturities of investments	103	—	1,409	—	1,512
Purchases of property, equipment and capitalized software	(102)	(23)	(18)	—	(143)
Decrease in restricted investments held-to-maturity	—	—	4	—	4
Net cash paid in business combinations	—	(5)	(43)	—	(48)
Capital contributions to/from subsidiaries	(221)	7	214	—	—
Dividends to/from subsidiaries	50	—	(50)	—	—
Change in amounts due to/from affiliates	(12)	4	8	—	—
Other, net	6	(19)	1	—	(12)
Net cash (used in) provided by investing activities	(290)	(36)	195	—	(131)
Financing activities:					
Proceeds from employee stock plans	10	—	—	—	10
Other, net	2	—	(1)	—	1
Net cash provided by (used in) financing activities	12	—	(1)	—	11
Net (decrease) increase in cash and cash equivalents	(235)	(2)	750	—	513
Cash and cash equivalents at beginning of period	360	13	1,956	—	2,329
Cash and cash equivalents at end of period	$ 125	$ 11	$ 2,706	$ —	$ 2,842

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

FORWARD-LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- *the success of our previously announced restructuring plan, including the timing and amounts of the benefits realized;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including any potential repeal and replacement of the law, amendment of the law, or move to state block grants for Medicaid;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk transfer requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, the adequacy of agreed rates, and potential disruption associated with market withdrawal from Utah, Wisconsin, or other states;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer, risk corridors, and reinsurance;*
- *effective management of our medical costs;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the payment of all amounts due to our Illinois health plan following the resolution of the Illinois budget impasse;*
- *the success of our efforts to retain existing managed care contracts, including those in Florida, New Mexico, Puerto Rico, and Texas, and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;*
- *any adverse impact resulting from the significant changes to our executive leadership team and the rightsizing of our workforce;*
- *the impact of our decision to exit the Utah and Wisconsin ACA Marketplace markets effective December 31, 2017;*
- *our ability to manage our operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our ability to consummate and realize benefits from acquisitions or divestitures;*
- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*

- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion cost corridors in California, New Mexico, and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, the effect of the PROMESA law, the impact of Hurricane Maria and our efforts to better manage the health care costs of our Puerto Rico health plan;*
- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom, including any potential demand by the state of New Mexico to recover purportedly underpaid premium taxes;*
- *changes with respect to our provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings;*
- *the relatively small number of states in which we operate health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *our failure to comply with the financial or other covenants in our credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of our funds on hand to pay the amounts due upon conversion or maturity of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm; and*
- *increasing competition and consolidation in the Medicaid industry;*

Readers should refer to the section entitled “Risk Factors” in each of our Annual Report on Form 10-K for the year ended December 31, 2016, our Quarterly Reports on Form 10-Q for the quarters ended March 31, 2017 and June 30, 2017, and this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This quarterly report and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management’s Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2016.

ABOUT MOLINA HEALTHCARE

OUR MISSION IS TO PROVIDE QUALITY HEALTHCARE TO PEOPLE RECEIVING GOVERNMENT ASSISTANCE.

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

KEY PERFORMANCE INDICATORS

Non-GAAP Financial Measures

We use non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures.

See further information regarding non-GAAP measures in the "Supplemental Information" section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this report are designated with an asterisk (*).

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(Dollar amounts in millions, except per-share amounts)			
Net (loss) income	$ (97)	$ 42	$ (250)	$ 99
Net (loss) income per diluted share	$ (1.70)	$ 0.76	$ (4.44)	$ 1.77
MCR (1)	88.3 %	89.4%	90.5 %	89.5%
G&A ratio (2)	7.6 %	7.6%	8.2 %	7.8%
Premium tax ratio (1)	2.2 %	2.9%	2.3 %	2.7%
Effective tax rate	14.6 %	54.0%	15.5 %	58.0%
Net profit margin (2)	(1.9)%	0.9%	(1.7)%	0.7%
EBITDA*	$ (42)	$ 160	$ (82)	$ 430
Adjusted net (loss) income*	$ (93)	$ 47	$ (235)	$ 114
Adjusted net (loss) income per diluted share*	$ (1.62)	$ 0.85	$ (4.17)	$ 2.03

(1) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) G&A ratio represents general and administrative expenses as a percentage of total revenue. Net profit margin represents net income as a percentage of total revenue.

CONSOLIDATED RESULTS

Three Months Ended September 30, 2017 Compared with Three Months Ended September 30, 2016

Net loss per diluted share was $1.70 for the third quarter of 2017 compared with net income per diluted share of $0.76 reported for the third quarter of 2016. Adjusted net loss per diluted share* was $1.62 in the third quarter of 2017, compared with adjusted net income per diluted share* of $0.85 in the third quarter of 2016. Loss before income tax benefit for the third quarter of 2017 was $113 million.

- Medical care costs measured as a percentage of premium revenue (the "medical care ratio") declined to 88.3% in the third quarter of 2017 from 89.4% in the third quarter of 2016 and from 94.8% in the second quarter of 2017. Improved medical cost performance in the third quarter of 2017 was the result of:
    - Improved sequential performance at our Illinois, New Mexico, Ohio, Puerto Rico, Texas, and Washington health plans, exclusive of the Marketplace program.
    - Improved performance of our Marketplace program, including a reduction to the premium deficiency reserve of $30 million ($0.33 per diluted share, net of tax). The reserve, which was $100 million at June 30, 2017, decreased to $70 million as of September 30, 2017.
- General and administrative costs, measured as a percentage of total revenue (the "administrative cost ratio"), were 7.6% in the third quarter of 2017, consistent with the third quarter of 2016, and 50 basis points lower than the second quarter of 2017. Excluding Marketplace broker commission and exchange fees, the administrative cost ratio decreased 30 basis points from the third quarter of 2016.

Restructuring costs and the impairment of certain purchased intangible assets increased loss before income tax benefit in the third quarter of 2017 by approximately $247 million. Specifically:

- We recorded $118 million ($1.39 per diluted share, net of tax) of restructuring costs in the third quarter of 2017. Restructuring costs incurred to date consist primarily of termination benefits, write-offs of capitalized software due to the re-design of our core operating processes, restructuring of our direct delivery operations, and consulting fees.
- We recorded $129 million ($1.77 per diluted share, net of tax) in non-cash goodwill impairment losses for our Pathways behavioral health subsidiary and our Molina Medicaid Solutions (MMS) segment. In the third quarter of 2017, management determined that neither business will provide future benefits relating to the integration of their operations with the Health Plans segment to the extent previously expected.

The table below summarizes the impact of certain items significant to our financial performance in the periods presented.

Summary of Significant Items Affecting 2017 Financial Results

	Three Months Ended September 30, 2017		Nine Months Ended September 30, 2017	
	(In millions, except per diluted share amounts)			
	Amount	Per Diluted Share (1)	Amount	Per Diluted Share (1)
Restructuring and separation costs	$ 118	$ 1.39	$ 161	$ 1.92
Impairment losses	129	1.77	201	2.77
Change in Marketplace premium deficiency reserve for 2017 service dates	(30)	(0.33)	40	0.45
Termination fee received for terminated Medicare acquisition	—	—	(75)	(0.84)
	$ 217	$ 2.83	$ 327	$ 4.30

(1) Except for certain items that are not deductible for tax purposes, per diluted share amounts are generally calculated at our statutory income tax rate of 37%, which is in excess of the effective tax rate recorded in our consolidated statements of operations.

Marketplace Cost Share Reduction (CSR) Update

Our third quarter results do not include any potential impact from the October 12, 2017, direction to Centers for Medicare and Medicaid Services (CMS) from Acting Department of Health and Human Services Secretary Hargan to cease payment of Marketplace CSR subsidies. At September 30, 2017, we had a total of approximately $220 million in excess CSR subsidies, recorded as a payable to CMS. This payable represents the extent to which payments received by us from CMS exceeded our estimate of the actual cost of member subsidies incurred by us through September 30, 2017.

We expect to incur approximately $85 million in unreimbursed expense associated with the cessation of CSR subsidies in the fourth quarter of 2017. It has been the practice of CMS to perform a reconciliation on an annual

basis of CSR subsidies paid to all health plans against the actual costs incurred by the health plans. Were such a reconciliation to be performed for the full calendar year of 2017—consistent with past practice—we would be able to offset nearly all of the $85 million expense incurred in the fourth quarter against the excess amounts received prior to September 30, 2017. However, should CMS transition to a nine month reconciliation period ending September 30, 2017—the last month for which CSR subsidies have been paid—the absence of CSR subsidy reimbursement would reduce income before income tax expense by approximately $85 million in the fourth quarter of 2017.

Nine Months ended September 30, 2017 Compared with Nine Months Ended September 30, 2016

Net loss per diluted share was $4.44 in the nine months ended September 30, 2017 compared with net income per diluted share of $1.77 reported for the nine months ended September 30, 2016. Adjusted net loss per diluted share* was $4.17 in the nine months ended September 30, 2017, compared with adjusted net income per diluted share* of $2.03 in the nine months ended September 30, 2016. Loss before income tax benefit for the nine months ended September 30, 2017 was $296 million. Results for the nine months ended September 30, 2017, were affected by the significant items presented in the table, and as further described, above. In total, these adjustments increased pretax loss in the nine months ended September 30, 2017 by $327 million.

RESTRUCTURING AND PROFIT IMPROVEMENT PLAN UPDATE

As previously disclosed, we estimate that our restructuring plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. We have already achieved $200 million of these run-rate reductions on an annualized basis, which will take full effect no later than January 1, 2018. Our third quarter results include approximately $10 million of these reductions. All savings targets discussed in regards to the restructuring plan represent annualized run-rate savings that we expect to achieve during the year following the indicated implementation date. We expect one-time costs associated with the restructuring plan to exceed the benefits realized in 2017 due to the upfront payment of implementation costs and the delayed benefit of full savings until the beginning of 2018.

TRENDS AND UNCERTAINTIES

ACA and the Marketplace

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, are subject to substantial uncertainty. We have taken the following steps in regards to our participation in the ACA Marketplace in 2018:

1. As previously announced, we will exit the Utah and Wisconsin ACA Marketplaces effective December 31, 2017.
2. In our remaining Marketplace plans, we are increasing 2018 premiums by 55% to take into account the absence of cost sharing reduction (CSR) subsidies and other risks related to ACA Marketplace uncertainties.
3. We have reduced the scope of our 2018 participation in the state of Washington Marketplace.
4. We continue to monitor the current political and programmatic developments pertaining to the ACA Marketplace.

Medicaid Contract Re-Procurement

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates; such dates are subject to change. Premium revenue is stated in millions.

State Health Plan	Medicaid Program(s)	Membership as of September 30, 2017	Premium Revenue Nine Months Ended September 30, 2017	Anticipated Award Date	Anticipated Effective Date
Florida	All	355,000	$ 1,105	Q2 2018	1/1/2019
New Mexico	All	225,000	893	Q1 2018	1/1/2019
Texas	ABD	87,000	1,065	Q3 2018	9/1/2019
Texas	CHIP	24,000	31	Q4 2017	9/1/2018

Illinois Health Plan. In August 2017, Molina Healthcare of Illinois, Inc. was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the State's three current managed care programs into one program. The contract begins January 1, 2018, for four years with options to renew annually for up to four additional years.

Washington Health Plan. In May 2017, Molina Healthcare of Washington, Inc. was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North Central region of the state's Apple Health Integrated Managed Care Program. The start date for the new contract is scheduled for January 1, 2018.

REPORTABLE SEGMENTS

How We Assess Performance

We derive our revenues primarily from health insurance premiums, and our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio, or MCR. The medical care ratio represents medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. Management's discussion and analysis of the changes in the individual components of gross margin, by reportable segment, is presented in the "Health Plans—Financial Overview," "Molina Medicaid Solutions—Financial Overview," and "Other—Financial Overview" sections of this MD&A.

SEGMENT SUMMARY

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(In millions)			
Segment gross margin:				
Health Plans medical margin [1]	$ 557	$ 443	$ 1,343	$ 1,285
Molina Medicaid Solutions service margin [2]	5	6	13	17
Other [2]	2	8	8	29
Total segment gross margin	564	457	1,364	1,331
Other operating revenues [3]	124	222	379	625
Other operating expenses [4]	(769)	(561)	(2,029)	(1,644)
Operating (loss) income	(81)	118	(286)	312
Other expenses, net	32	26	10	76
(Loss) income before income tax expense	(113)	92	(296)	236
Income tax (benefit) expense	(16)	50	(46)	137
Net (loss) income	$ (97)	$ 42	$ (250)	99

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.
(3) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.
(4) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses, depreciation and amortization, impairment losses, and restructuring and separation costs.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 12 states and the Commonwealth of Puerto Rico. As of September 30, 2017, these health plans served approximately 4.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies.

BUSINESS OVERVIEW

Recent Developments — Health Plans Segment

Refer to Notes to Consolidated Financial Statements, Note 1, “Basis of Presentation.”

Health Plans Membership

The following tables set forth our Health Plans membership as of the dates indicated:

	September 30, 2017	December 31, 2016	September 30, 2016
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,451,000	2,536,000	2,529,000
Marketplace	877,000	526,000	568,000
Medicaid Expansion	662,000	673,000	658,000
Aged, Blind or Disabled (ABD)	411,000	396,000	395,000
Medicare-Medicaid Plan (MMP) – Integrated [1]	58,000	51,000	51,000
Medicare Special Needs Plans (Medicare)	44,000	45,000	45,000
	4,503,000	4,227,000	4,246,000
Ending Membership by Health Plan:			
California	751,000	683,000	683,000
Florida	641,000	553,000	563,000
Illinois	163,000	195,000	195,000
Michigan	399,000	391,000	387,000
New Mexico	256,000	254,000	253,000
New York	33,000	35,000	37,000
Ohio	343,000	332,000	339,000
Puerto Rico	306,000	330,000	331,000
South Carolina	113,000	109,000	109,000
Texas	444,000	337,000	352,000
Utah	160,000	146,000	150,000
Washington	770,000	736,000	716,000
Wisconsin	124,000	126,000	131,000
	4,503,000	4,227,000	4,246,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.

Premiums by Program

The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a per member per month (PMPM) basis, for the nine months ended September 30, 2017. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 310.00	$ 180.00
Marketplace	190.00	470.00	280.00
Medicaid Expansion	320.00	510.00	390.00
ABD	380.00	1,480.00	1,030.00
MMP – Integrated	1,250.00	3,280.00	2,190.00
Medicare	960.00	1,260.00	1,140.00

FINANCIAL OVERVIEW

In the third quarter of 2017, premium revenue increased approximately 14%, or $586 million, when compared with the third quarter of 2016. Member months grew 8% while revenue PMPM increased 6%. Medical care costs as a percent of premium revenue decreased to 88.3% in the third quarter of 2017 from 89.4% in the third quarter of 2016. Medical margin increased 26% in the third quarter of 2017 from the third quarter of 2016.

In the nine months ended September 30, 2017, premium revenue increased approximately 16%, or $1,950 million, when compared with the nine months ended September 30, 2016. Member months grew 11% while revenue PMPM increased 5%. Medical care costs as a percent of premium revenue increased to 90.5% in the nine months ended September 30, 2017 from 89.5% in the nine months ended September 30, 2016. Medical margin increased 5% in the nine months ended September 30, 2017 from the nine months ended September 30, 2016.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, medical care ratio and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended September 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.5	$ 1,392	$ 185.95	$ 1,242	$ 165.76	89.1%	$ 150
Medicaid Expansion	2.0	773	385.58	667	332.99	86.4	106
ABD	1.2	1,288	1,038.85	1,259	1,016.06	97.8	29
Total Medicaid	10.7	3,453	321.77	3,168	295.23	91.8	285
MMP	0.2	378	2,263.07	336	2,013.67	89.0	42
Medicare	0.1	163	1,231.61	126	951.01	77.2	37
Total Medicare	0.3	541	1,806.26	462	1,543.05	85.4	79
Excluding Marketplace	11.0	3,994	362.04	3,630	329.08	90.9	364
Marketplace	2.7	783	301.72	590	227.22	75.3	193
	13.7	$ 4,777	$ 350.55	$ 4,220	$ 309.68	88.3%	$ 557

	Three Months Ended September 30, 2016						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.6	$ 1,373	$ 180.74	$ 1,246	$ 164.04	90.8%	$ 127
Medicaid Expansion	2.0	763	386.98	642	325.68	84.2	121
ABD	1.1	1,186	1,008.28	1,094	929.93	92.2	92
Total Medicaid	10.7	3,322	309.19	2,982	277.55	89.8	340
MMP	0.2	334	2,165.26	280	1,818.75	84.0	54
Medicare	0.1	136	1,019.19	134	1,003.85	98.5	2
Total Medicare	0.3	470	1,633.62	414	1,440.73	88.2	56
Excluding Marketplace	11.0	3,792	343.68	3,396	307.84	89.6	396
Marketplace	1.7	399	238.86	352	210.38	88.1	47
	12.7	$ 4,191	$ 329.88	$ 3,748	$ 295.01	89.4%	$ 443

	Nine Months Ended September 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	22.8	$ 4,185	$ 183.69	$ 3,861	$ 169.44	92.2%	$ 324
Medicaid Expansion	6.1	2,376	389.14	2,045	334.93	86.1	331
ABD	3.6	3,769	1,033.45	3,634	996.58	96.4	135
Total Medicaid	32.5	10,330	317.49	9,540	293.21	92.4	790
MMP	0.5	1,083	2,189.96	976	1,974.22	90.1	107
Medicare	0.4	449	1,142.68	369	939.21	82.2	80
Total Medicare	0.9	1,532	1,726.39	1,345	1,516.09	87.8	187
Excluding Marketplace	33.4	11,862	354.88	10,885	325.66	91.8	977
Marketplace	8.4	2,303	276.27	1,937	232.31	84.1	366
	41.8	$ 14,165	$ 339.19	$ 12,822	$ 307.03	90.5%	$ 1,343

	Nine Months Ended September 30, 2016						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	22.5	$ 3,999	$ 177.60	$ 3,646	$ 161.93	91.2%	$ 353
Medicaid Expansion	5.8	2,184	376.98	1,850	319.38	84.7	334
ABD	3.5	3,466	987.20	3,173	903.85	91.6	293
Total Medicaid	31.8	9,649	303.23	8,669	272.46	89.9	980
MMP	0.5	989	2,160.14	867	1,894.38	87.7	122
Medicare	0.4	396	1,015.14	385	986.40	97.2	11
Total Medicare	0.9	1,385	1,633.26	1,252	1,476.57	90.4	133
Excluding Marketplace	32.7	11,034	337.76	9,921	303.72	89.9	1,113
Marketplace	5.1	1,181	231.69	1,009	197.77	85.4	172
	37.8	$ 12,215	$ 323.44	$ 10,930	$ 289.41	89.5%	$ 1,285

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid: TANF/CHIP, Medicaid Expansion and ABD

The medical care ratios of the combined TANF/CHIP, Medicaid Expansion and ABD programs increased to 91.8% in the third quarter of 2017, from 89.8% in the third quarter of 2016. Margin pressures at the California health plan (primarily due to reduced Medicaid Expansion premium rates effective July 1, 2017), the Florida health plan; and the Illinois health plan more than offset improved performance at the Washington health plan.

The medical care ratios of the combined TANF/CHIP, Medicaid Expansion and ABD programs increased to 92.4% in the nine months ended September 30, 2017, from 89.9% in the nine months ended September 30, 2016. For the nine months ended September 30, 2017, margin pressures at the Florida, Illinois, New Mexico and Texas health plans more than offset improved performance at the Washington health plan. Financial results for the Texas health plan in 2016 benefited from the recognition of $44 million of quality revenue related to 2015 and 2014.

MMP and Medicare

The medical care ratio for these programs, in the aggregate, decreased in the third quarter of 2017 when compared with the third quarter of 2016, and also in the nine months ended September 30, 2017, compared with the nine months ended September 30, 2016. Utilization of inpatient and pharmacy services among our Medicare members has been subdued for the first nine months of 2017.

Marketplace

Marketplace member months increased 64% in the nine months ended September 30, 2017, when compared with the nine months ended September 30, 2016, as a result of membership growth primarily in California, Florida and Texas.

The medical care ratio for the Marketplace program decreased to 75.3% in the third quarter of 2017, from 88.1% in the third quarter of 2016. Absent a $30 million reduction to a previously established premium deficiency reserve, the medical care ratio for our Marketplace program would have been approximately 79% in the third quarter of 2017. The medical care ratio of the Marketplace program for the nine months ended September 30, 2017 was 84.1%, and generally consistent with the medical care ratio reported for the same period in 2016.

FINANCIAL PERFORMANCE BY STATE

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

Health Plans Segment Financial Data — Non-Marketplace

	Three Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.9	$ 601	$ 322.97	$ 563	$ 302.67	93.7%	$ 38
Florida	1.0	388	355.59	390	356.83	100.3	(2)
Illinois	0.5	137	287.69	138	289.36	100.6	(1)
Michigan	1.2	390	337.17	345	298.83	88.6	45
New Mexico	0.7	304	429.07	277	390.91	91.1	27
New York (3)	0.1	43	435.00	41	413.02	94.9	2
Ohio	0.9	549	560.06	483	492.61	88.0	66
Puerto Rico	1.0	191	202.59	159	168.25	83.1	32
South Carolina	0.3	113	332.48	101	297.74	89.6	12
Texas	0.7	541	778.50	506	728.19	93.5	35
Utah	0.2	89	318.98	71	254.99	79.9	18
Washington	2.3	612	276.73	522	236.11	85.3	90
Wisconsin	0.2	34	175.77	27	141.78	80.7	7
Other (4)	—	2	—	7	—	—	(5)
	11.0	$ 3,994	$ 362.04	$ 3,630	$ 329.08	90.9%	$ 364

	Three Months Ended September 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.8	$ 575	$ 310.64	$ 493	$ 266.81	85.9%	$ 82
Florida	1.0	335	323.98	317	305.71	94.4	18
Illinois	0.6	163	275.26	145	244.86	89.0	18
Michigan	1.2	385	335.34	335	291.69	87.0	50
New Mexico	0.7	323	451.06	293	409.24	90.7	30
New York (3)	0.1	32	427.40	30	403.71	94.5	2
Ohio	1.0	492	497.08	417	421.95	84.9	75
Puerto Rico	1.0	184	183.46	167	167.44	91.3	17
South Carolina	0.3	102	312.28	94	285.97	91.6	8
Texas	0.7	534	728.84	484	662.79	90.9	50
Utah	0.3	83	288.59	71	242.77	84.1	12
Washington	2.0	546	264.01	500	241.49	91.5	46
Wisconsin	0.3	35	166.82	26	125.86	75.4	9
Other (4)	—	3	—	24	—	—	(21)
	11.0	$ 3,792	$ 343.68	$ 3,396	$ 307.84	89.6%	$ 396

	Nine Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.6	$ 1,771	$ 316.83	$ 1,586	$ 283.82	89.6%	$ 185
Florida	3.2	1,132	347.41	1,112	341.15	98.2	20
Illinois	1.6	447	284.18	492	312.54	110.0	(45)
Michigan	3.5	1,162	332.60	1,035	296.28	89.1	127
New Mexico	2.2	933	431.70	887	410.24	95.0	46
New York (3)	0.3	135	444.77	128	421.58	94.8	7
Ohio	2.9	1,598	541.56	1,434	486.02	89.7	164
Puerto Rico	2.9	553	190.99	513	177.01	92.7	40
South Carolina	1.0	329	325.43	301	298.43	91.7	28
Texas	2.1	1,592	760.76	1,468	701.32	92.2	124
Utah	0.8	267	315.35	219	258.64	82.0	48
Washington	6.7	1,835	275.60	1,603	240.83	87.4	232
Wisconsin	0.6	101	170.64	80	136.04	79.7	21
Other (4)	—	7	—	27	—	—	(20)
	33.4	$ 11,862	$ 354.88	$ 10,885	$ 325.66	91.8%	$ 977

	Nine Months Ended September 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.5	$ 1,603	$ 291.20	$ 1,411	$ 256.41	88.1%	$ 192
Florida	3.0	974	322.69	892	295.43	91.6	82
Illinois	1.8	466	266.11	414	236.39	88.8	52
Michigan	3.6	1,136	323.08	1,013	288.13	89.2	123
New Mexico	2.1	974	460.71	873	412.92	89.6	101
New York (3)	0.1	32	427.40	30	403.71	94.5	2
Ohio	2.9	1,444	489.63	1,286	435.99	89.0	158
Puerto Rico	3.0	535	176.44	516	170.46	96.6	19
South Carolina	0.9	273	288.93	232	245.13	84.8	41
Texas	2.2	1,650	744.71	1,466	662.01	88.9	184
Utah	0.9	255	293.33	221	253.79	86.5	34
Washington	6.0	1,576	261.23	1,431	237.20	90.8	145
Wisconsin	0.7	107	165.53	78	120.82	73.0	29
Other (4)	—	9	—	58	—	—	(49)
	32.7	$ 11,034	$ 337.76	$ 9,921	$ 303.72	89.9%	$ 1,113

Health Plans Segment Financial Data — Marketplace

	Three Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.3	$ 88	$ 208.19	$ 63	$ 147.87	71.0%	$ 25
Florida	0.9	260	313.36	235	283.13	90.4	25
Michigan	—	14	212.08	10	150.24	70.8	4
New Mexico	0.1	29	383.58	20	269.28	70.2	9
Ohio	0.1	23	386.09	20	364.31	94.4	3
Texas	0.7	183	291.14	109	172.70	59.3	74
Utah	0.3	49	241.65	31	155.13	64.2	18
Washington	0.1	42	327.40	33	256.52	78.3	9
Wisconsin	0.2	95	527.17	70	385.65	73.2	25
Other [3]	—	—	—	(1)	—	—	1
	2.7	$ 783	$ 301.72	$ 590	$ 227.22	75.3%	$ 193

	Three Months Ended September 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.3	$ 37	$ 185.04	$ 30	$ 140.10	75.7%	$ 7
Florida	0.6	159	253.16	145	231.78	91.6	14
Michigan	—	2	221.84	2	132.62	59.8	—
New Mexico	0.1	15	290.63	11	220.32	75.8	4
Ohio	—	9	307.24	7	215.01	70.0	2
Texas	0.4	63	189.85	41	121.06	63.8	22
Utah	0.1	23	142.10	33	208.48	146.7	(10)
Washington	0.1	23	307.55	21	300.71	97.8	2
Wisconsin	0.1	68	375.60	64	357.60	95.2	4
Other (3)	—	—	—	(2)	—	—	2
	1.7	$ 399	$ 238.86	$ 352	$ 210.38	88.1%	$ 47

	Nine Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.2	$ 241	$ 193.33	$ 156	$ 124.32	64.3%	$ 85
Florida	2.8	821	296.14	758	273.55	92.4	63
Michigan	0.2	41	187.96	27	126.76	67.4	14
New Mexico	0.2	82	338.18	62	256.05	75.7	20
Ohio	0.2	68	365.35	64	346.93	95.0	4
Texas	2.1	517	252.32	351	171.57	68.0	166
Utah	0.7	135	209.43	135	209.13	99.9	—
Washington	0.4	123	315.95	128	327.51	103.7	(5)
Wisconsin	0.6	275	469.44	260	443.41	94.5	15
Other (3)	—	—	—	(4)	—	—	4
	8.4	$ 2,303	$ 276.27	$ 1,937	$ 232.31	84.1%	$ 366

	Nine Months Ended September 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	0.6	$ 104	$ 177.57	$ 74	$ 124.29	70.0%	$ 30
Florida	2.0	473	237.37	409	205.37	86.5	64
Michigan	—	7	213.35	5	138.37	64.9	2
New Mexico	0.2	42	264.76	32	201.73	76.2	10
Ohio	0.1	28	322.36	20	232.44	72.1	8
Texas	1.1	202	196.45	133	128.97	65.7	69
Utah	0.4	75	160.33	91	194.78	121.5	(16)
Washington	0.2	58	281.80	48	235.78	83.7	10
Wisconsin	0.5	192	357.80	200	373.94	104.5	(8)
Other (3)	—	—	—	(3)	—	—	3
	5.1	$ 1,181	$ 231.69	$ 1,009	$ 197.77	85.4%	$ 172

Health Plans Segment Financial Data — Total

	Three Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.2	$ 689	$ 301.64	$ 626	$ 273.90	90.8%	$ 63
Florida	1.9	648	337.40	625	325.09	96.4	23
Illinois	0.5	137	287.69	138	289.36	100.6	(1)
Michigan	1.2	404	330.27	355	290.63	88.0	49
New Mexico	0.8	333	424.61	297	378.98	89.3	36
New York (1)	0.1	43	435.00	41	413.02	94.9	2
Ohio	1.0	572	550.75	503	485.61	88.2	69
Puerto Rico	1.0	191	202.59	159	168.25	83.1	32
South Carolina	0.3	113	332.48	101	297.74	89.6	12
Texas	1.4	724	546.57	615	463.83	84.9	109
Utah	0.5	138	286.39	102	212.91	74.3	36
Washington	2.4	654	279.52	555	237.23	84.9	99
Wisconsin	0.4	129	345.63	97	259.66	75.1	32
Other (2)	—	2	—	6	—	—	(4)
	13.7	$ 4,777	$ 350.55	$ 4,220	$ 309.68	88.3%	$ 557

	Three Months Ended September 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.1	$ 612	$ 298.05	$ 523	$ 254.11	85.3%	$ 89
Florida	1.6	494	297.24	462	277.79	93.5	32
Illinois	0.6	163	275.26	145	244.86	89.0	18
Michigan	1.2	387	334.25	337	290.16	86.8	50
New Mexico	0.8	338	440.12	304	396.35	90.1	34
New York [1]	0.1	32	427.40	30	403.71	94.5	2
Ohio	1.0	501	491.51	424	415.87	84.6	77
Puerto Rico	1.0	184	183.46	167	167.44	91.3	17
South Carolina	0.3	102	312.28	94	285.97	91.6	8
Texas	1.1	597	559.98	525	493.07	88.1	72
Utah	0.4	106	236.31	104	230.53	97.6	2
Washington	2.1	569	265.48	521	243.49	91.7	48
Wisconsin	0.4	103	262.32	90	231.86	88.4	13
Other [2]	—	3	—	22	—	—	(19)
	12.7	$ 4,191	$ 329.88	$ 3,748	$ 295.01	89.4%	$ 443

	Nine Months Ended September 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	6.8	$ 2,012	$ 294.26	$ 1,742	$ 254.67	86.5%	$ 270
Florida	6.0	1,953	323.86	1,870	310.09	95.7	83
Illinois	1.6	447	284.18	492	312.54	110.0	(45)
Michigan	3.7	1,203	324.12	1,062	286.35	88.3	141
New Mexico	2.4	1,015	422.25	949	394.66	93.5	66
New York [1]	0.3	135	444.77	128	421.58	94.8	7
Ohio	3.1	1,666	531.17	1,498	477.81	90.0	168
Puerto Rico	2.9	553	190.99	513	177.01	92.7	40
South Carolina	1.0	329	325.43	301	298.43	91.7	28
Texas	4.2	2,109	509.09	1,819	439.11	86.3	290
Utah	1.5	402	269.48	354	237.20	88.0	48
Washington	7.1	1,958	277.83	1,731	245.62	88.4	227
Wisconsin	1.2	376	319.57	340	289.24	90.5	36
Other [2]	—	7	—	23	—	—	(16)
	41.8	$ 14,165	$ 339.19	$ 12,822	$ 307.03	90.5%	$ 1,343

	Nine Months Ended September 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR	Medical Margin
California	6.1	$ 1,707	$ 280.21	$ 1,485	$ 243.64	86.9%	$ 222
Florida	5.0	1,447	288.74	1,301	259.60	89.9	146
Illinois	1.8	466	266.11	414	236.39	88.8	52
Michigan	3.6	1,143	322.08	1,018	286.77	89.0	125
New Mexico	2.3	1,016	447.07	905	398.22	89.1	111
New York (1)	0.1	32	427.40	30	403.71	94.5	2
Ohio	3.0	1,472	484.82	1,306	430.14	88.7	166
Puerto Rico	3.0	535	176.44	516	170.46	96.6	19
South Carolina	0.9	273	288.93	232	245.13	84.8	41
Texas	3.3	1,852	570.65	1,599	492.79	86.4	253
Utah	1.3	330	246.78	312	233.14	94.5	18
Washington	6.2	1,634	261.91	1,479	237.15	90.5	155
Wisconsin	1.2	299	252.45	278	235.25	93.2	21
Other (2)	—	9	—	55	—	—	(46)
	37.8	$ 12,215	$ 323.44	$ 10,930	$ 289.41	89.5%	$ 1,285

(1) The New York health plan was acquired on August 1, 2016.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

MEDICAL CARE COSTS BY TYPE

The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended September 30,					
	2017			2016		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 3,196	$ 234.51	75.8%	$ 2,799	$ 220.29	74.7%
Pharmacy	638	46.85	15.1	567	44.65	15.1
Capitation	342	25.07	8.1	302	23.83	8.1
Direct delivery	18	1.37	0.4	21	1.66	0.5
Other	26	1.88	0.6	59	4.58	1.6
	$ 4,220	$ 309.68	100.0%	$ 3,748	$ 295.01	100.0%

	Nine Months Ended September 30,					
	2017			2016		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 9,630	$ 230.58	75.1%	$ 8,156	$ 215.96	74.6%
Pharmacy	1,904	45.60	14.8	1,621	42.93	14.8
Capitation	1,022	24.47	8.0	901	23.86	8.3
Direct delivery	62	1.50	0.5	55	1.46	0.5
Other	204	4.88	1.6	197	5.20	1.8
	$ 12,822	$ 307.03	100.0%	$ 10,930	$ 289.41	100.0%

PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.2% in the third quarter of 2017 compared with 2.9% in the third quarter of 2016 and 2.3% in the nine months

ended September 30, 2017, compared with 2.7% in the nine months ended September 30, 2016. This decline was primarily due to the temporary suspension of a Michigan HMO use tax effective January 1, 2017, which was partially offset by a higher California premium tax rate effective July 1, 2016, and significant revenue growth at our Florida health plan, which operates in a state with no premium tax.

HEALTH INSURER FEE (HIF) REVENUE AND EXPENSES

The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there are no HIF revenues or expenses in 2017.

MOLINA MEDICAID SOLUTIONS

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs, including business processing, information technology development and administrative services.

FINANCIAL OVERVIEW

The Molina Medicaid Solutions segment service margin for the third quarter of 2017 and 2016, and for the nine months ended September 30, 2017 and 2016, was insignificant.

As discussed further in Notes to Consolidated Financial Statements, Note 10, “Impairment Losses,” we recorded a goodwill impairment charge of $28 million, reported in our consolidated statements of operations as “Impairment losses.”

OTHER

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

FINANCIAL OVERVIEW

The Other segment service margin for the third quarter of 2017 and 2016, and for the nine months ended September 30, 2017 and 2016, was insignificant.

As discussed further in Notes to Consolidated Financial Statements, Note 10, “Impairment Losses,” in the second quarter of 2017 we recorded impairment losses, primarily relating to our Pathways subsidiary, of $61 million for goodwill and $11 million for intangible assets, or $72 million in the aggregate. In the third quarter of 2017, we recorded a further goodwill impairment loss relating to the Pathways subsidiary, of $101 million.

OTHER CONSOLIDATED INFORMATION

GENERAL AND ADMINISTRATIVE EXPENSES

The G&A ratio was 7.6% for both the third quarter of 2017 and 2016. The G&A ratio increased to 8.2% for the nine months ended September 30, 2017, compared with 7.8% for the nine months ended September 30, 2016. Refer to discussion above, in “Consolidated Results.”

DEPRECIATION AND AMORTIZATION

Depreciation and amortization, as a percentage of total revenue, was 0.7% and 0.8% in the nine months ended September 30, 2017 and 2016, respectively.

IMPAIRMENT LOSSES

See Notes to Consolidated Financial Statements, Note 10, “Impairment Losses.”

RESTRUCTURING AND SEPARATION COSTS

See Notes to Consolidated Financial Statements, Note 11, “Restructuring and Separation Costs.”

INTEREST EXPENSE

Interest expense was $32 million for the third quarter of 2017, compared with $26 million for the third quarter of 2016. Interest expense was $85 million for the nine months ended September 30, 2017, compared with $76 million for the nine months ended September 30, 2016. Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $8 million for both the third quarter of 2017 and 2016, and $24 million and $23 million in the nine months ended September 30, 2017 and 2016, respectively. We expect interest expense to continue to increase in future periods as a result of our recent $330 million offering of 4.875% Notes, and borrowings under the Credit Facility. See further discussion in Notes to Consolidated Financial Statements, Note 7, “Debt.”

OTHER INCOME, NET

As described in Notes to Consolidated Financial Statements, Note 1, “Basis of Presentation,” in February 2017, we received an aggregate termination fee of $75 million for the terminated Medicare Acquisition. This amount is reported in “Other income, net” in our consolidated statements of operations.

INCOME TAXES

The (benefit) provision for income taxes was recorded at an effective rate of 14.6% for the third quarter of 2017, compared with 54.0% for the third quarter of 2016, and an effective rate of 15.5% for the nine months ended September 30, 2017 compared with 58.0% for the nine months ended September 30, 2016. The significant change in the effective tax rate was primarily a result of pretax losses in 2017 combined with significant nondeductible expenses (primarily, separation costs and goodwill impairment) and the 2017 HIF moratorium as described above in “Health Plans—Health Insurer Fee (HIF) Revenue and Expenses.”

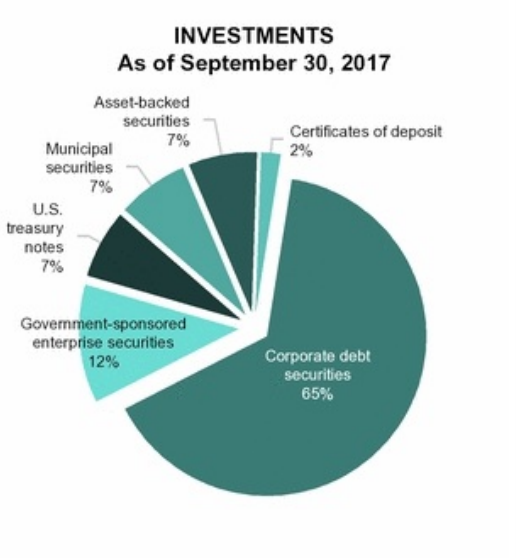
LIQUIDITY AND FINANCIAL CONDITION

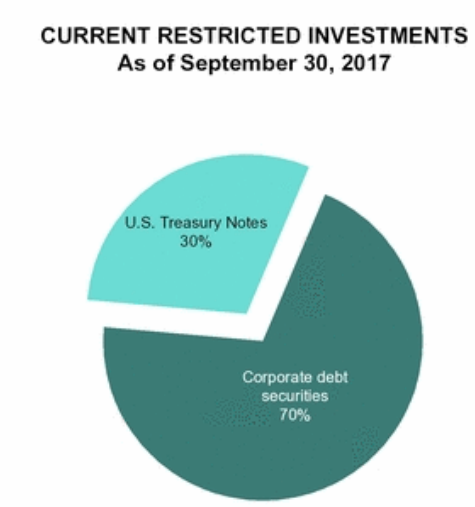
INTRODUCTION

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our Health Plans segment regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

Our investments are classified as current assets, except for our held-to-maturity restricted investments, which are classified as non-current assets, and which are not included in the totals below. Our held-to-maturity restricted investments are invested principally in certificates of deposit and U.S. treasury securities.





Investment income increased to $37 million for the nine months ended September 30, 2017, compared with $25 million for the nine months ended September 30, 2016, primarily due to the increase in invested assets.

MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2017, the fair value of our fixed income investments would decrease by approximately $25 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of September 30, 2017, $300 million was outstanding under the Credit Facility.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Nine Months Ended September 30,		
	2017	2016	Change
	(In millions)		
Net cash provided by operating activities	$ 957	$ 633	$ 324
Net cash used in investing activities	(474)	(131)	(343)
Net cash provided by financing activities	632	11	621
Net increase in cash and cash equivalents	$ 1,115	$ 513	$ 602

Operating Activities

Cash provided by operating activities increased $324 million in the nine months ended September 30, 2017 compared with the nine months ended September 30, 2016. The change in net (loss) income, partially offset by the effect of adjustments to reconcile net loss to net cash provided by operating activities, reduced cash provided by operating activities by $169 million. This change was more than offset by the aggregate of the following changes:

Medical claims and benefits payable. In 2017, the change in medical claims and benefits payable increased cash flows from operations by $381 million, primarily due to additional accruals relating to increased membership in 2017.

Receivables and deferred revenue. In 2017, the aggregate change in receivables and deferred revenue increased cash flows from operations by $395 million. Cash flows from operations in each period were impacted by the timing of premium revenues receipts. In general, state or federal payors may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, state or federal payors may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period.

Amounts due government agencies. In 2017, the change in amounts due government agencies decreased cash flows from operations by $381 million, primarily due to payments in the third quarter of 2017.

Investing Activities

Net cash used in investing activities increased $343 million in the nine months ended September 30, 2017 compared with the nine months ended September 30, 2016, primarily due to higher purchases of investments, net of sales and maturities, in the current year.

Financing Activities

Net cash provided by financing activities increased $621 million in the nine months ended September 30, 2017 compared with the nine months ended September 30, 2016, due to proceeds received from the 4.875% Notes offering and borrowings under the Credit Facility.

FINANCIAL CONDITION

We believe that our cash resources, combined with borrowing capacity available under our Credit Facility, as discussed further below in "Future Sources and Uses of Liquidity—Sources", and internally generated funds will be sufficient to support costs under the Restructuring Plan, operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at September 30, 2017, our working capital was $1,746 million, compared with $1,418 million at December 31, 2016. At September 30, 2017, our cash and investments amounted to $6,166 million, compared with $4,689 million at December 31, 2016.

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "B2" by Moody's Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

Financial Covenants. Our Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios, presented below, are computed as defined by the terms of the Credit Facility.

Credit Facility Financial Covenants	Required Per Agreement	As of September 30, 2017
Net leverage ratio	<4.0x	2.5x
Interest coverage ratio	>3.5x	8.8x

In addition, the terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures. As of September 30, 2017, we were in compliance with all covenants under the Credit Facility.

FUTURE SOURCES AND USES OF LIQUIDITY

Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. In the nine months ended September 30, 2017 and 2016, we received $100 million and $50 million, respectively, in dividends from our regulated health plan subsidiaries. We received $36 million in dividends from our unregulated subsidiaries in the nine months ended September 30, 2017. See further discussion in Notes to Consolidated Financial Statements, Note 13, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

Restructuring Plan. As previously disclosed, we estimate that our restructuring plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. We have already achieved $200 million of these run-rate reductions on an annualized basis, which will take full effect no later than January 1, 2018. All savings targets discussed in regards to the restructuring plan represent annualized run-rate savings that we expect to achieve during the year following the indicated implementation date. We expect one-time costs associated with the restructuring plan to exceed the benefits realized in 2017 due to the upfront payment of implementation costs and the delayed benefit of full savings until the beginning of 2018. We expect the cost savings to reduce both “General and administrative expenses” and “Medical care costs” reported on our consolidated statements of operations.

The following table illustrates our estimates of run-rate savings associated with the restructuring plan. Such savings will be offset, through the end of 2018, by the costs noted below in “*Uses*.” Following 2018, the savings will be offset by approximately $20 million in run-rate expenses resulting from the implementation of restructuring plan initiatives.

Estimated Savings Expected to be Realized by Reportable Segment	Health Plans	Other	Total
		(In millions)	
General and administrative expenses	$50	$120 to $140	$170 to $190
Medical care costs	$110 to $190	$20	$130 to $210
	$160 to $240	$140 to $160	$300 to $400

Credit Facility. Refer to Notes to Consolidated Financial Statements, Note 7, “Debt,” for a detailed discussion of our Credit Facility. In August 2017, we drew against the Credit Facility in the amount of $300 million.

4.875% Notes. The 4.875% Notes contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as “Restricted investments” in our consolidated balance sheets. See further discussion in Notes to Consolidated Financial Statements, Note 7, “Debt.”

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Uses

Restructuring. We recorded $118 million of restructuring costs in the third quarter of 2017. Restructuring costs incurred to date consist primarily of termination benefits, write-offs of capitalized software due to the re-design of our core operating processes, restructuring of our direct delivery operations, and consulting fees. Under the restructuring plan, and also including separation costs to former executives, we have made cash payments of $24 million in the nine months ended September 30, 2017, and have accrued a liability of $65 million for future payments as of September 30, 2017.

We estimate that total pre-tax costs associated with the restructuring plan will be approximately $70 million to $90 million in the fourth quarter of 2017, with an additional $20 million to $40 million to be incurred in 2018. We currently estimate that a majority of the costs we expect to incur in the fourth quarter of 2017 will be settled in cash. The costs we incur associated with the restructuring plan are reported in “Restructuring and separation costs” in our consolidated statements of operations.

Estimated Costs Expected to be Incurred by Reportable Segment	Health Plans	Molina Medicaid Solutions	Other	Total
		(In millions)		
Termination benefits	$30 to $35	—	$30 to $35	$60 to $70
Other restructuring costs	$40 to $45	$10	$110 to $115	$160 to $170
	$70 to $80	$10	$140 to $150	$220 to $240

Regulatory Capital Requirements and Dividend Restrictions. For more information on our regulatory capital requirements and dividend restrictions, refer to Notes to Consolidated Financial Statements, Note 13, “Commitments and Contingencies.”

States’ Budgets. From time to time, the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. Until July 4, 2017, the state of Illinois operated without a budget for its current fiscal year. As of September 30, 2017, our Illinois health plan served approximately 163,000 members, and recognized premium revenue of approximately $447 million in the nine months ended September 30, 2017. As of October 27, 2017, the state of Illinois owed us approximately $220 million for certain March through September 2017 premiums.

On May 3, 2017, Puerto Rico’s financial oversight board filed for a form of bankruptcy in the U.S. District Court in Puerto Rico under Title III of PROMESA. The Title III provision allows for a court debt restructuring process similar to U.S. bankruptcy protection. To the extent such bankruptcy results in our failure to receive payment of amounts due under our Medicaid contract with the Commonwealth or the inability of the Commonwealth to extend our Medicaid contract at the end of its current term, such bankruptcy could have a material adverse effect on our business, financial condition, cash flows, or results of operations. As of September 30, 2017, the plan served approximately 306,000 members and recorded premium revenue of approximately $553 million in the nine months ended September 30, 2017. As of October 27, 2017, the Commonwealth was current with its premium payments.

Convertible Notes. We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Convertible Notes. We also have outstanding $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Convertible Notes. We refer to the 1.125% Convertible Notes and 1.625% Convertible Notes collectively as the Convertible Notes. The 1.125% Convertible Notes are convertible entirely into cash, and the 1.625% Convertible Notes are convertible partially into cash, each prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended September 30, 2017; therefore, they are convertible into cash and are reported in current portion of long-term debt as of September 30, 2017.

The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended September 30, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of September 30, 2017. As noted above, because the proceeds from the 4.875% Notes are initially restricted to payments upon conversion or redemption of the 1.625% Convertible Notes, such restricted investments are also classified as current in the accompanying consolidated balance sheets.

For economic reasons related to the trading market for our Convertible Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our Convertible Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our Convertible Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our Convertible Notes may elect to convert the notes to cash.

We currently have sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2016, was disclosed in our 2016 Annual Report on Form 10-K.

As described further in the Notes to Consolidated Financial Statements, Note 7 “Debt,” on June 6, 2017, we completed the private offering of $330 million aggregate principal amount of senior notes (4.875% Notes) due June 15, 2025. In addition, in the third quarter of 2017, we borrowed $300 million under our Credit Facility.

Other than the transactions described above, there were no material changes to this previously filed information outside the ordinary course of business during the nine months ended September 30, 2017.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, “Medical Claims and Benefits Payable,” for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the nine months ended September 30, 2017, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2016.

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Molina Medicaid Solutions segment revenue and cost recognition*. There have been no significant changes during the nine months ended September 30, 2017, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2016.

- *Goodwill and intangible assets, net.* Please refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies,” regarding our adoption of Accounting Standards Update No. 2017-04 as of June 30, 2017, which has simplified the test for goodwill impairment. In the third quarter of 2017, we

recorded impairment charges of $129 million for goodwill, and in the second quarter of 2017, we recorded impairment charges of $61 million for goodwill and $11 million for intangible assets, or $72 million in the aggregate. Such charges are reported in the accompanying consolidated statements of operations as “Impairment losses.” At September 30, 2017, goodwill and intangible assets, net, represented approximately 6% of total assets and 37% of total stockholders’ equity, compared with 10% and 46%, respectively, at December 31, 2016. Refer to Notes to Consolidated Financial Statements, Note 10, “Impairment Losses.”

SUPPLEMENTAL INFORMATION

FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

EBITDA*

We believe that earnings before interest, taxes, depreciation and amortization (EBITDA*) is helpful in assessing our ability to meet the cash demands of our operating units.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2017	2016	2017	2016
	(In millions)			
Net (loss) income	$ (97)	$ 42	$ (250)	$ 99
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	39	42	129	118
Interest expense	32	26	85	76
Income tax (benefit) expense	(16)	50	(46)	137
EBITDA*	$ (42)	$ 160	$ (82)	$ 430

ADJUSTED NET (LOSS) INCOME* AND ADJUSTED NET (LOSS) INCOME PER SHARE*

We believe that adjusted net (loss) income* and adjusted net (loss) income per diluted share* are helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net (loss) income*.

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2017		2016		2017		2016	
	(In millions, except diluted per-share amounts)							
Net (loss) income	$ (97)	$ (1.70)	$ 42	$ 0.76	$ (250)	$ (4.44)	$ 99	$ 1.77
Adjustment:								
Amortization of intangible assets	7	0.13	9	0.15	24	0.43	24	0.42
Income tax effect (1)	(3)	(0.05)	(4)	(0.06)	(9)	(0.16)	(9)	(0.16)
Amortization of intangible assets, net of tax effect	4	0.08	5	0.09	15	0.27	15	0.26
Adjusted net (loss) income*	$ (93)	$ (1.62)	$ 47	$ 0.85	$ (235)	$ (4.17)	$ 114	$ 2.03

(1) Income tax effect of adjustments calculated at the blended federal and state statutory tax rate of 37%.

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our interim chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), were not effective at the reasonable assurance level because of the material weakness in our internal control over financial reporting described below. Notwithstanding the material weakness described below, management has concluded that our consolidated financial statements included in this interim report on Form 10-Q are fairly stated in all material respects in accordance with U.S. generally accepted accounting principles (GAAP) for each of the periods presented herein.

Existence of a Material Weakness in Internal Control as of September 30, 2017

During the quarter ended September 30, 2017, we determined that a material weakness existed in our internal control over financial reporting relating to the design and operating effectiveness of our internal control for our interim goodwill impairment tests for our Pathways subsidiary and Molina Medicaid Solutions segment. Specifically, spreadsheet formula errors in our valuation model, and errors made in the calculation of impairment losses recorded, were not detected in our review procedures. As a result, we initially miscalculated the goodwill impairment in the three and nine months ended September 30, 2017. The impairment calculation was corrected prior to the filing of our unaudited consolidated financial statements as of and for the three and nine months ended September 30, 2017.

Remediation Plan for Material Weakness

We will implement a remediation plan developed to address this material weakness as of September 30, 2017. The remediation efforts we intend to implement include the enhancement of the design of the controls relating to the computation and rigor of review of the goodwill impairment tests. The enhancement of the controls will include the engagement of additional subject matter experts to support the valuation calculations, key assumptions and review process. In addition, we intend to develop new review controls that operate at an appropriate level of precision to prevent or detect potential material errors within the valuation calculations. We believe these measures will remediate the material weakness identified above and will strengthen our internal control over financial reporting for the computation of reporting unit fair value and potential consequent goodwill impairment. We are currently targeting to complete the implementation of the control enhancements during the fourth quarter of 2017. We will test the operating effectiveness of the control enhancements subsequent to implementation. If the remedial measures described above are insufficient to address the material weakness described above, or are not implemented timely, or additional deficiencies arise in the future, material misstatements in our interim or annual financial statements may occur in the future and could have the effects described in "Risk Factors," in our Annual Report on Form 10-K for the year ended December 31, 2016.

Changes in Internal Control Over Financial Reporting: Except as described above, management did not identify any change in our internal control over financial reporting during the fiscal quarter ended September 30, 2017 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

Existence of a Material Weakness in Internal Control as of December 31, 2016

As disclosed in our Annual Report on Form 10-K for the year ended December 31, 2016, our management assessed the effectiveness of our internal control over financial reporting as of December 31, 2016, based on the framework set forth in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

We determined that a material weakness existed in our internal control over financial reporting relating to the operation of an element of our process for calculating the amount owed to California by our California health plan. More specifically, a Medicaid Expansion contract amendment executed in the fourth quarter of 2016 changed the medical loss ratio corridor formula and such amendment was not initially considered in determining the liability. As a result, we understated net income by $44 million for the year ended December 31, 2016, which was material to our consolidated results for the year ended December 31, 2016. This amount was corrected prior to the issuance of our consolidated financial statements as of and for the year ended December 31, 2016.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of December 31, 2016, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

Remediation Plan for Material Weakness

We are executing the remediation plan developed to address the material weakness reported as of December 31, 2016. The remediation efforts we have implemented include the development of robust protocols to ensure that the control, relating to the review of a contractual amendment affecting the computation of the Medicaid Expansion medical loss ratio corridor for our California health plan, is operating as designed. We believe these measures will remediate the material weakness identified above and will strengthen our internal control over financial reporting for the computation of our California Medicaid Expansion medical loss ratio corridor. We currently are targeting to complete the implementation of the control enhancements during 2017. We will test the ongoing operating effectiveness of the control enhancements subsequent to implementation, and consider the material weakness remediated after the applicable remedial control enhancements operate effectively for a sufficient period of time. If the remedial measures described above are insufficient to address the material weakness described above, or are not implemented timely, or additional deficiencies arise in the future, material misstatements in our interim or annual financial statements may occur in the future and could have the effects described in “Risk Factors” in our Annual Report on Form 10-K for the year ended December 31, 2016.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 13, “Commitments and Contingencies.”

RISK FACTORS

Certain risks may have a material adverse effect on our business, financial condition, cash flows, results of operations, or stock price, and you should carefully consider them before making an investment decision. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in “Risk Factors,” in our Annual Report on Form 10-K for the year ended December 31, 2016 and our Quarterly Reports on Form 10-Q for the quarters ended March 31, 2017 and June 30, 2017. The risk factors described in our 2016 Annual Report on Form 10-K and our Quarterly Reports on Form 10-Q for the quarters ended March 31, 2017 and June 30, 2017, are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, results of operations, or stock price.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended September 30, 2017, including shares withheld by us to satisfy our employees’ income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
July 1 - July 31	665	$ 69.18	—	$ —
August 1 - August 31	285	$ 57.03	—	$ —
September 1 - September 30	—	$ —	—	$ —
Total	950	$ 65.54	—	

(1) During the three months ended September 30, 2017, we withheld 950 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

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INDEX TO EXHIBITS

Exhibit No.	Title
10.1	Employment Agreement, dated October 9, 2017, by and between Molina Healthcare, Inc. and Joseph M. Zubretsky. Filed as Exhibit 10.1 to registrant's Form 8-K filed October 10, 2017.
31.1	Certification of Interim Chief Executive Officer and Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Interim Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: November 5, 2017

/s/ JOSEPH W. WHITE

Joseph W. White
Interim Chief Executive Officer
(Principal Executive Officer)

Dated: November 5, 2017

/s/ JOSEPH W. WHITE

Joseph W. White
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph W. White, certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2017 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. I am responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under my supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under my supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report my conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. I have disclosed, based on my most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: November 5, 2017

/s/ Joseph W. White

Joseph W. White
Interim Chief Executive Officer
Chief Financial Officer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2017 (the "Report"), I, Joseph W. White, Interim Chief Executive Officer and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: November 5, 2017

/s/ Joseph W. White

Joseph W. White
Interim Chief Executive Officer
Chief Financial Officer

MHI Form 10-Q for the Period Ended June 30, 2017

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2017

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of July 28, 2017, was approximately 57,118,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED June 30, 2017

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CROSS-REFERENCE INDEX

FINANCIAL STATEMENTS

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(In millions, except per-share data) (Unaudited)			
Revenue:				
Premium revenue	$ 4,740	$ 4,029	$ 9,388	$ 8,024
Service revenue	129	135	260	275
Premium tax revenue	114	109	225	218
Health insurer fee revenue	—	76	—	166
Investment income and other revenue	16	10	30	19
Total revenue	4,999	4,359	9,903	8,702
Operating expenses:				
Medical care costs	4,491	3,594	8,602	7,182
Cost of service revenue	124	116	246	243
General and administrative expenses	405	351	844	691
Premium tax expenses	114	109	225	218
Health insurer fee expenses	—	50	—	108
Depreciation and amortization	37	34	76	66
Impairment losses	72	—	72	—
Restructuring and separation costs	43	—	43	—
Total operating expenses	5,286	4,254	10,108	8,508
Operating (loss) income	(287)	105	(205)	194
Other expenses (income), net:				
Interest expense	27	25	53	50
Other income, net	—	—	(75)	—
Total other expenses (income), net	27	25	(22)	50
(Loss) income before income tax (benefit) expense	(314)	80	(183)	144
Income tax (benefit) expense	(84)	47	(30)	87
Net (loss) income	$ (230)	$ 33	$ (153)	$ 57
Net (loss) income per share:				
Basic	$ (4.10)	$ 0.58	$ (2.74)	$ 1.02
Diluted	$ (4.10)	$ 0.58	$ (2.74)	$ 1.01

CONSOLIDATED STATEMENTS OF COMPREHENSIVE (LOSS) INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(Amounts in millions) (Unaudited)			
Net (loss) income	$ (230)	$ 33	$ (153)	$ 57
Other comprehensive income:				
Unrealized investment gain	—	4	1	13
Less: effect of income taxes	—	2	—	5
Other comprehensive income, net of tax	—	2	1	8
Comprehensive (loss) income	$ (230)	$ 35	$ (152)	$ 65

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2017	December 31, 2016
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,979	$ 2,819
Investments	2,192	1,758
Restricted investments	325	—
Receivables	1,006	974
Income taxes refundable	68	39
Prepaid expenses and other current assets	159	131
Derivative asset	440	267
Total current assets	7,169	5,988
Property, equipment, and capitalized software, net	449	454
Deferred contract costs	93	86
Intangible assets, net	112	140
Goodwill	559	620
Restricted investments	118	110
Deferred income taxes	36	10
Other assets	47	41
	$ 8,583	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 2,077	$ 1,929
Amounts due government agencies	1,844	1,202
Accounts payable and accrued liabilities	375	385
Deferred revenue	284	315
Current portion of long-term debt	773	472
Derivative liability	440	267
Total current liabilities	5,793	4,570
Senior notes	1,017	975
Lease financing obligations	198	198
Deferred income taxes	—	15
Other long-term liabilities	54	42
Total liabilities	7,062	5,800
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 57 shares at June 30, 2017 and at December 31, 2016	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	865	841
Accumulated other comprehensive loss	(1)	(2)
Retained earnings	657	810
Total stockholders' equity	1,521	1,649
	$ 8,583	$ 7,449

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2017	2016
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net (loss) income	$ (153)	$ 57
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Depreciation and amortization	96	89
Impairment losses	72	—
Deferred income taxes	(41)	39
Share-based compensation, including accelerated share-based compensation	35	16
Amortization of convertible senior notes and lease financing obligations	16	15
Other, net	7	11
Changes in operating assets and liabilities:		
Receivables	(32)	(415)
Prepaid expenses and other assets	(38)	(143)
Medical claims and benefits payable	148	82
Amounts due government agencies	642	509
Accounts payable and accrued liabilities	(18)	147
Deferred revenue	(32)	(119)
Income taxes	(30)	(10)
Net cash provided by operating activities	672	278
Investing activities:		
Purchases of investments	(1,636)	(974)
Proceeds from sales and maturities of investments	874	812
Purchases of property, equipment and capitalized software	(60)	(102)
(Increase) decrease in restricted investments held-to-maturity	(10)	5
Net cash paid in business combinations	—	(8)
Other, net	(13)	(6)
Net cash used in investing activities	(845)	(273)
Financing activities:		
Proceeds from senior notes offering, net of issuance costs	325	—
Proceeds from employee stock plans	11	10
Other, net	(3)	1
Net cash provided by financing activities	333	11
Net increase in cash and cash equivalents	160	16
Cash and cash equivalents at beginning of period	2,819	2,329
Cash and cash equivalents at end of period	$ 2,979	$ 2,345

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Six Months Ended June 30,	
	2017	2016
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (21)	$ (7)
Details of change in fair value of derivatives, net:		
Gain (loss) on 1.125% Call Option	$ 173	$ (148)
(Loss) gain on 1.125% Conversion Option	(173)	148
Change in fair value of derivatives, net	$ —	$ —
Details of business combinations:		
Fair value of assets acquired	$ —	$ (131)
Purchase price amounts accrued/received	—	21
Reversal of amounts advanced to sellers in prior year	—	102
Net cash paid in business combinations	$ —	$ (8)

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

June 30, 2017

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

The Health Plans segment consists of health plans operating in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of June 30, 2017, these health plans served approximately 4.7 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs, including business processing, information technology development and administrative services.

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Restructuring Plan

We recorded $43 million in restructuring and separation costs in the second quarter of 2017 related primarily to contractually required termination benefits paid to our former chief executive officer (CEO) and chief financial officer (CFO). Also included in these costs are consulting fees incurred for the development and implementation of our corporate restructuring initiatives. See Note 11, "Restructuring and Separation Costs."

Recent Developments — Health Plans Segment

Direct Delivery. On August 2, 2017, we announced plans to restructure our direct delivery operations.

Mississippi Health Plan. In June 2017, Molina Healthcare of Mississippi, Inc. was awarded a Medicaid Coordinated Care Contract for the statewide administration of the Mississippi Coordinated Access Network (MississippiCAN). The contract begins July 1, 2017, for three years with options to renew annually for up to two additional years. The operational start date for the program is currently scheduled for July 1, 2018, pending the completion of a readiness review.

Washington Health Plan. In May 2017, Molina Healthcare of Washington, Inc. was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North Central region of the state's Apple Health Integrated Managed Care Program. The start date for the new contract is scheduled for January 1, 2018.

Terminated Medicare Acquisition. In August 2016, we entered into agreements with each of Aetna Inc. and Humana Inc. to acquire certain assets related to their Medicare Advantage business. The transaction was subject to closing conditions including the completion of the proposed acquisition of Humana by Aetna (the Aetna-Humana Merger). In January 2017, the U.S. District Court for the District of Columbia granted the request for relief made by the U.S. Department of Justice in its civil antitrust lawsuit against Aetna and Humana, to prohibit the Aetna-Humana Merger. In February 2017, our agreements with each of Aetna and Humana were terminated by the parties pursuant to the terms of the agreements. Under the termination agreements, we received an aggregate termination fee of $75 million from Aetna and Humana in the first quarter of 2017, which is reported in "Other income, net."

New York Health Plan. In August 2016, we closed on our acquisition of the outstanding equity interests of Today's Options of New York, Inc., which now operates as Molina Healthcare of New York, Inc. The purchase price allocation was completed, and the final purchase price adjustments were recorded, in the first quarter of 2017. Such adjustments were insignificant, and the final purchase price was $38 million.

Recent Developments — Other Segment

Pathways subsidiary. In the second quarter of 2017, we recorded non-cash goodwill and intangible assets impairment losses of $72 million, related primarily to our Pathways subsidiary. See Note 10, "Impairment Losses."

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2017.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2016. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2016 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2016 audited consolidated financial statements.

2. Significant Accounting Policies

Certain of our significant accounting policies are discussed within the note to which they specifically relate.

Revenue Recognition – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into two broad categories discussed in further detail below: 1) "Contractual Provisions That May Adjust or Limit Revenue or Profit;" and 2) "Quality Incentives."

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), and Medical Cost Corridors: A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $136 million and $272 million at June 30, 2017 and December 31, 2016, respectively, to "Amounts due government agencies." Approximately $114 million and $244 million of the liability accrued at June 30, 2017 and December 31, 2016, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, our health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at June 30, 2017 and December 31, 2016.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at June 30, 2017 and December 31, 2016.

Retroactive Premium Adjustments: State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare

Risk Adjustment: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (measured as a member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and Centers for Medicare & Medicaid Services (CMS) practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjustment premiums and Medicare Part D settlements were insignificant at June 30, 2017 and December 31, 2016.

Minimum MLR: Additionally, federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described below, and, for receivables, when collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	June 30, 2017			December 31, 2016
	Current Benefit Year	Prior Benefit Years	Total	
	(In millions)			
Risk adjustment	$ (502)	$ (546)	$ (1,048)	$ (522)
Reinsurance	—	57	57	55
Risk corridor	—	(1)	(1)	(1)
Minimum MLR	(3)	(2)	(5)	(1)

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of operations.

- Reinsurance: This program was designed to provide reimbursement to insurers for high cost members and ended December 31, 2016; we expect to settle the outstanding receivable balance in 2017.

- Risk corridor: This program was intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by CMS, and ended December 31, 2016; we expect to settle the outstanding payable balance in 2017.

Additionally, the ACA established a Minimum MLR of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We

recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2017 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2017.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(Dollars in millions)			
Maximum available quality incentive premium - current period	$ 39	$ 41	$ 77	$ 81
Quality incentive premium revenue recognized in current period:				
Earned current period	$ 29	$ 36	$ 48	$ 54
Earned prior periods	1	49	6	54
Total	$ 30	$ 85	$ 54	108
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.6%	2.1%	0.6%	1.3%

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), goodwill impairment, certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by HIF in 2017 given the 2017 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. We recorded a premium deficiency reserve to “Medical claims and benefits payable” on our accompanying consolidated balance sheets relating to our Marketplace program of $30 million as of December 31, 2016, which increased to $100 million as of June 30, 2017.

Recent Accounting Pronouncements

Goodwill Impairment. In January 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-04, *Simplifying the Test for Goodwill Impairment*, which eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment loss. Instead, an impairment loss is measured as the excess of the carrying amount of the reporting unit, including goodwill, over the fair value of the reporting unit. ASU 2017-04 is effective beginning January 1, 2020; we have early adopted ASU 2017-04 as of June 30, 2017, in connection with the assessment of our Pathways subsidiary. See further discussion at Note 10, “Impairment Losses.”

Restricted Cash. In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which will require us to include in our consolidated statements of cash flows the balances of cash, cash equivalents, restricted cash and

restricted cash equivalents. When these items are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Transfers between cash and cash equivalents and restricted cash and restricted cash equivalents will no longer be presented in the statement of cash flows. ASU 2016-18 is effective beginning January 1, 2018; early adoption is permitted. We intend to early adopt ASU 2016-18 as of December 31, 2017, and are currently evaluating the effect to our consolidated statements of cash flows.

Stock Compensation. In March 2016, the FASB issued ASU 2016-09, *Improvements to Employee Share-Based Payment Accounting*, which amends ASC Topic 718, *Compensation – Stock Compensation*. ASU 2016-09 simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, statutory tax and classification in the statement of cash flows. We adopted ASU 2016-09 in the first quarter of 2017; such adoption did not significantly impact our consolidated financial statements. In addition, the prior period presentation in the statement of cash flows was not adjusted because such adjustments were insignificant.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. ASU 2016-02 is effective for us beginning January 1, 2019, and must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. Under this guidance, we will record assets and liabilities relating primarily to our long-term office leases, and are currently evaluating the effect to our consolidated financial statements.

Revenue Recognition. In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606).* We intend to adopt this standard and the related modifications on January 1, 2018, using the modified retrospective approach. Under this approach, the cumulative effect of initially applying the guidance will be reflected as an adjustment to beginning retained earnings.

We have determined that the insurance contracts of our Health Plans segment, which comprises the majority of our operations, are excluded from the scope of ASU 2014-09 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts.

For our Molina Medicaid Solutions segment, we have determined that certain service revenue and cost of service revenue will no longer be deferred and recognized over the service delivery period. Rather, service revenue will be recognized based on the expected cost plus gross margin method, and cost of service revenue will be recognized as incurred. As of June 30, 2017, we expect the cumulative adjustment for historical periods through June 30, 2017 to increase retained earnings by no more than $50 million. This estimate will be updated in each quarterly and annual report until adoption. We expect the cumulative adjustment, if any, relating to our Other segment to be insignificant.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a significant impact on our present or future consolidated financial statements.

3. Net (Loss) Income per Share

The following table sets forth the calculation of basic and diluted net (loss) income per share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(In millions, except net income per share)			
Numerator:				
Net (loss) income	$ (230)	$ 33	$ (153)	$ 57
Denominator:				
Denominator for basic net (loss) income per share	56	55	56	55
Effect of dilutive securities:				
1.125% Warrants (1)	—	—	—	1
Denominator for diluted net (loss) income per share	56	55	56	56
Net (loss) income per share: (2)				
Basic	$ (4.10)	$ 0.58	$ (2.74)	$ 1.02
Diluted	$ (4.10)	$ 0.58	$ (2.74)	$ 1.01
Potentially dilutive common shares excluded from calculations:				
1.125% Warrants (1)	2	—	1	—

(1) For more information regarding the 1.125% Warrants, refer to Note 9, “Stockholders' Equity.” The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net (loss) income per share because to do so would be anti-dilutive. For the three and six months ended June 30, 2017, the 1.125% Warrants were excluded from diluted shares outstanding because to do so would have been anti-dilutive.

(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy defined by GAAP. For a description of the methods and assumptions that we use to a) estimate the fair value; and b) determine the classification according to the fair value hierarchy for each financial instrument, see Note 5, “Fair Value Measurements,” in our 2016 Annual Report on Form 10-K.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of June 30, 2017 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 8, “Derivatives,” the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the six months ended June 30, 2017.

Our financial instruments measured at fair value on a recurring basis at June 30, 2017, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,386	$ —	$ 1,386	$ —
U.S. treasury notes	263	263	—	—
Government-sponsored enterprise securities (GSEs)	241	241	—	—
Municipal securities	140	—	140	—
Asset-backed securities	128	—	128	—
Certificates of deposit	34	—	34	—
Subtotal - current investments	2,192	504	1,688	—
Corporate debt securities	228	—	228	—
U.S. treasury notes	97	97	—	—
Subtotal - current restricted investments	325	97	228	—
1.125% Call Option derivative asset	440	—	—	440
Total assets	$ 2,957	$ 601	$ 1,916	$ 440
1.125% Conversion Option derivative liability	$ 440	$ —	$ —	$ 440
Total liabilities	$ 440	$ —	$ —	$ 440

Our financial instruments measured at fair value on a recurring basis at December 31, 2016, were as follows:

	Total	Quoted Market Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
		(In millions)		
Corporate debt securities	$ 1,179	$ —	$ 1,179	$ —
U.S. treasury notes	84	84	—	—
GSEs	231	231	—	—
Municipal securities	142	—	142	—
Asset-backed securities	69	—	69	—
Certificates of deposit	53	—	53	—
Subtotal - current investments	1,758	315	1,443	—
1.125% Call Option derivative asset	267	—	—	267
Total assets	$ 2,025	$ 315	$ 1,443	$ 267
1.125% Conversion Option derivative liability	$ 267	$ —	$ —	$ 267
Total liabilities	$ 267	$ —	$ —	$ 267

There were no current restricted investments as of December 31, 2016.

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table.

	June 30, 2017		December 31, 2016	
	Carrying Value	Fair Value	Carrying Value	Fair Value
	(In millions)			
5.375% Notes	$ 692	$ 745	$ 691	$ 714
1.125% Convertible Notes	483	976	471	792
4.875% Notes	325	333	—	—
1.625% Convertible Notes	289	386	284	344
	$ 1,789	$ 2,440	$ 1,446	$ 1,850

5. Investments

Available-for-Sale Investments

We consider all of our investments classified as current assets (including restricted investments) to be available-for-sale. Certain of our senior notes, as further discussed in Note 7, “Debt,” contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as “Restricted investments” in the accompanying consolidated balance sheets. Such proceeds, while restricted as to their use and held in a segregated deposit account, are available-for-sale based upon our contractual liquidity requirements.

The following tables summarize our investments as of the dates indicated:

	June 30, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,387	$ 1	$ 2	$ 1,386
U.S. treasury notes	263	—	—	263
GSEs	242	—	1	241
Municipal securities	140	—	—	140
Asset-backed securities	128	—	—	128
Certificates of deposit	34	—	—	34
Subtotal - current investments	2,194	1	3	2,192
Corporate debt securities	227	1	—	228
U.S. treasury notes	97	—	—	97
Subtotal - current restricted investments	324	1	—	325
Total	$ 2,518	$ 2	$ 3	$ 2,517

	December 31, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,180	$ 1	$ 2	$ 1,179
U.S. treasury notes	84	—	—	84
GSEs	232	—	1	231
Municipal securities	143	—	1	142
Asset-backed securities	69	—	—	69
Certificates of deposit	53	—	—	53
Total - current investments	$ 1,761	$ 1	$ 4	$ 1,758

There were no current restricted investments as of December 31, 2016.

The contractual maturities of our available-for-sale investments as of June 30, 2017 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,301	$ 1,301
Due after one year through five years	1,194	1,193
Due after five years through ten years	23	23
Total	$ 2,518	$ 2,517

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and six months ended June 30, 2017 and 2016 were insignificant.

We have determined that unrealized losses at June 30, 2017 and December 31, 2016, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of June 30, 2017:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 913	$ 2	418	$ —	$ —	—
GSEs	247	1	101	—	—	—
Total - current investments	$ 1,160	$ 3	519	$ —	$ —	—

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2016:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 542	$ 2	378	$ —	$ —	—
GSEs	198	1	73	—	—	—
Municipal securities	101	1	129	—	—	—
Total - current investments	$ 841	$ 4	580	$ —	$ —	—

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulation in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as non-current “Restricted investments” in the accompanying consolidated balance sheet. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

The contractual maturities of our held-to-maturity restricted investments, which are carried at amortized cost, which approximates fair value, as of June 30, 2017 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 100	$ 100
Due after one year through five years	18	17
	$ 118	$ 117

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	June 30, 2017	December 31, 2016
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,478	$ 1,352
Pharmacy payable	121	112
Capitation payable	45	37
Other	433	428
	$ 2,077	$ 1,929

“Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. Non-risk provider payables amounted to $111 million and $225 million as of June 30, 2017 and December 31, 2016, respectively.

Reinsurance recoverables of $65 million and $83 million as of June 30, 2017 and 2016, respectively, are included in “Receivables” in the accompanying consolidated balance sheets.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30,	
	2017	2016
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 1,929	$ 1,685
Components of medical care costs related to:		
Current period	8,633	7,371
Prior periods	(31)	(189)
Total medical care costs	8,602	7,182
Change in non-risk provider payables	(114)	24
Payments for medical care costs related to:		
Current period	6,883	5,885
Prior periods	1,457	1,240
Total paid	8,340	7,125
Medical claims and benefits payable, ending balance	$ 2,077	$ 1,766
Benefit from prior period as a percentage of:		
Balance at beginning of period	1.6%	11.3%
Premium revenue, trailing twelve months	0.2%	1.3%
Medical care costs, trailing twelve months	0.2%	1.4%

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated in the table above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2017 and 2016 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

While prior period development of our estimate as of December 31, 2016, through June 30, 2017, was favorable by $31 million, that amount is substantially less than the favorable prior period development of $189 million we recognized for the same period in the prior year. Further, favorable development through June 30, 2017, was less than the 8% to 10% we typically expect.

We believe that the most significant uncertainties surrounding our IBNP estimates at June 30, 2017 are as follows:

- In the first half of 2017, our Marketplace enrollment across all health plans increased by over 400,000 members. Due to limited insight into the cost patterns associated with this large number of new Marketplace members, our liability estimates for these members are subject to more than the usual amount of uncertainty.
- At our Florida health plan, claims receipts increased significantly over the last few months due to an increase in the receipt of secondary claims, many of which are not our liability. These claims will either be denied or will have very small paid amounts. For this reason, claims denial rates, amounts paid per claim and other claims indicators will be impacted, making our liability estimates subject to more than the usual amount of uncertainty.

- At our Illinois health plan, we paid a large number of claims in the first half of 2017 that had previously been denied and were subsequently disputed by providers. This has created some distortion in the claims payment patterns, making our liability estimates subject to more than the usual amount of uncertainty.
- At our California health plan, we adjusted our inpatient authorization process. As a result, due to the expected increase in authorized inpatient stays, our liability estimates are subject to more than the usual amount of uncertainty.
- At our New Mexico health plan, a fee schedule reduction for a large provider has created some distortion in the claims payment patterns, making our liability estimates subject to more than the usual amount of uncertainty.

7. Debt

Substantially all of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets (in millions):

	June 30, 2017	December 31, 2016
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ 488	$ 477
1.625% Convertible Notes, net of unamortized premium and discount	291	—
Lease financing obligations	1	1
Debt issuance costs	(7)	(6)
	773	472
Non-current portion of long-term debt, reported as "Senior notes":		
5.375% Notes	700	700
4.875% Notes	330	—
1.625% Convertible Notes, net of unamortized premium and discount	—	286
Debt issuance costs	(13)	(11)
	1,017	975
Lease financing obligations	198	198
	$ 1,988	$ 1,645

4.875% Notes due 2025

On June 6, 2017, we completed the private offering of $330 million aggregate principal amount of senior notes (4.875% Notes) due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. According to their terms, the guarantees under the 4.875% Notes mirror those of the Credit Facility, defined and described below. See Note 16, "Supplemental Condensed Consolidating Financial Information," for more information on the guarantors. The 4.875% Notes contain customary non-financial covenants and change of control provisions.

The 4.875% Notes contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as "Restricted investments" in our consolidated balance sheets. These funds may be used by us as follows:

- On or prior to August 20, 2018, to:
  - Redeem, repurchase, repay, tender for, or acquire for value all or any portion of our 1.625% Convertible Notes, defined and discussed further below, or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes; and/or
  - Pay any interest due on all or any portion of the 4.875% Notes.
- On or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that we are obligated to repurchase; and

- Subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited in the indenture governing the 4.875% Notes.

5.375% Notes due 2022

We have outstanding $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. According to their terms, the guarantees under the 5.375% Notes mirror those of the Credit Facility, defined and described below. See Note 16, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors.

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (Credit Facility), referred to as the First Amendment. As of June 30, 2017, outstanding letters of credit amounting to $6 million reduced our borrowing capacity under the Credit Facility to $494 million. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. As of June 30, 2017, no amounts were outstanding under the Credit Facility.

In addition to increasing amounts available to borrow under the Credit Facility and extending its term, the First Amendment provided that all guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC, were automatically and unconditionally released from their obligations as guarantors of the Credit Facility and the 5.375% Notes.

The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. In February 2017, we entered into a second amendment to the Credit Facility (the Second Amendment) which modified the Credit Facility’s definition of the earnings measure used in the financial covenant computations to a) allow us to receive credit for risk corridor payments owed to, but not received or accrued by us during 2016; and b) account for the difference between the amount of actual risk transfer payments made or accrued by us during 2016, and the amount of risk transfer payments that would have been due under the federal government’s proposed 2018 risk adjustment payment transfer formula.

In May 2017, we entered into a third amendment to the Credit Facility (the Third Amendment) which modified the Credit Facility’s definition of specified cash, to permit cash that is either subject to customary escrow arrangements or held in a segregated account to be netted from the Credit Facility’s consolidated net leverage ratio if the use of the cash is limited to the repayment of other indebtedness. The Third Amendment also adds a carve-out to the Credit Facility’s negative pledge covenant to allow for the escrow arrangements and segregated accounts. At June 30, 2017, we were in compliance with all financial and non-financial covenants under the Credit Facility.

Convertible Senior Notes

We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Convertible Notes. We also have outstanding $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Convertible Notes. The 1.125% Convertible Notes are convertible entirely to cash, and the 1.625% Convertible Notes are convertible partially to cash, each prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended June 30, 2017; therefore, they are convertible into cash and are reported in current portion of long-term debt as of June 30, 2017.

The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended June 30, 2017. On contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of this conversion feature, the 1.625% Convertible Notes are reported in current portion of long-term debt as of June 30, 2017. As noted above, because the proceeds from the 4.875% Notes are initially restricted to payments upon conversion or redemption of the 1.625% Convertible Notes, such restricted investments are also classified as current in the accompanying consolidated balance sheets.

Cross-Default Provisions

The terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures.

Debt Commitment Letter

In connection with the Terminated Medicare Acquisition, we entered into a debt commitment letter with Barclays Bank PLC (Barclays) in August 2016. Under this debt commitment letter, Barclays agreed to lend us up to $400 million, subject to satisfaction of certain conditions, including consummation of the Terminated Medicare Acquisition. The debt commitment letter automatically terminated in February 2017 as a result of the termination of this transaction. The costs associated with the debt commitment letter and its termination were reimbursed as described in Note 1, "Basis of Presentation–*Health Plans Segment Recent Developments*."

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the accompanying consolidated balance sheets:

	Balance Sheet Location	June 30, 2017	December 31, 2016
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 440	$ 267
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 440	$ 267

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, and reported in "Other income, net." Gains and losses for our derivative financial instruments are presented individually in the accompanying consolidated statements of cash flows, "Supplemental cash flow information."

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, "Fair Value Measurements."

As of June 30, 2017, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within 12 months of June 30, 2017, as described in Note 7, "Debt."

9. Stockholders' Equity

Stockholders' equity decreased $128 million during the six months ended June 30, 2017 compared with stockholders' equity at December 31, 2016. The decrease was due primarily to the net loss of $153 million, partially offset by $24 million related to employee stock transactions in the six months ended June 30, 2017, which are described further below.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, "Derivatives," in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, when the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net (Loss) Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Stock Incentive Plans

In connection with our equity incentive plans and employee stock purchase plan, approximately 692,000 shares of common stock vested or were purchased, net of shares used to settle employees' income tax obligations, during the six months ended June 30, 2017.

Restricted stock awards (RSAs), performance stock awards (PSAs) and performance stock units (PSUs) activity for the six months ended June 30, 2017 is summarized below:

	Restricted Stock Awards	Performance Stock Awards	Performance Stock Units	Total	Weighted Average Grant Date Fair Value
Unvested balance, December 31, 2016	577,244	345,656	—	922,900	$ 58.15
Granted	377,076	—	231,100	608,176	56.98
Vested	(380,812)	(260,894)	(139,272)	(780,978)	57.63
Forfeited	(58,643)	—	—	(58,643)	54.48
Unvested balance, June 30, 2017	514,865	84,762	91,828	691,455	57.57

The total fair value of RSAs granted during the six months ended June 30, 2017 and 2016 was $19 million and $17 million, respectively. The total fair value of RSAs which vested during the six months ended June 30, 2017 and 2016 was $20 million and $21 million, respectively.

No PSAs were granted during the six months ended June 30, 2017. The total fair value of PSAs granted during the six months ended June 30, 2016 was $15 million. The total fair value of PSAs which vested during the six months ended June 30, 2017 was $15 million. No PSAs vested during the six months ended June 30, 2016.

The total fair value of PSUs granted during the six months ended June 30, 2017 was $16 million. The total fair value of PSUs which vested during the six months ended June 30, 2017 was $9 million. There were no PSUs granted or vested in 2016.

During the six months ended June 30, 2017, the vesting of 133,957 RSAs, 153,574 PSAs and 139,272 PSUs was accelerated in connection with the termination of our former Chief Executive Officer (CEO) and former Chief Financial Officer (CFO) in May 2017. Share-based compensation expense of $35 million was recorded during the six months ended June 30, 2017, of which $23 million was recorded to "Restructuring and separation costs" in the accompanying consolidated statements of operations. See Note 11, "Restructuring and Separation Costs" for further discussion. Share-based compensation expense of $16 million was recorded to "General and administrative expenses" in the six months ended June 30, 2016.

As of June 30, 2017, there was $32 million of total unrecognized compensation expense related to unvested RSAs, including those with market and performance conditions, and unvested PSUs, which we expect to recognize over a remaining weighted-average period of 2.5 years and 2.1 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 3.3% for non-executive employees as of June 30, 2017.

10. Impairment Losses

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is subject to an annual impairment test. Refer to Note 2, “Significant Accounting Policies,” for a discussion of our adoption of ASU 2017-04, *Simplifying the Test for Goodwill Impairment*. We are required to test at least annually for impairment, or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analysis. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing.

An impairment loss is measured as the excess of the carrying amount of the reporting unit, including goodwill, over the fair value of the reporting unit. We estimate the fair values of our reporting units using discounted cash flows. In the discounted cash flow analyses, we must make assumptions about a wide variety of internal and external factors, and consider the price that would be received to sell the reporting unit as a whole in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates.

In the course of developing our restructuring and profitability improvement plan, discussed further in Note 11, “Restructuring and Separation Costs,” we determined that future benefits to be derived from Pathways, including integration with our health plans, would be less than previously anticipated. In addition, poorer than expected year-to-date operating results and lower projections of operating results for periods in the near term led us to conclude that a triggering event for an interim impairment analysis had occurred in the second quarter of 2017.

Intangible Assets. We first evaluated Pathways’ finite-lived intangible assets (customer relationships and contract licenses) for impairment, using undiscounted cash flows expected over the longest remaining useful life of the assets tested. See below for a description of the estimates and assumptions used in the cash flow model. Because the undiscounted cash flows over the remaining useful life were less than Pathways’ carrying amount, the intangible assets were impaired. We recorded an impairment loss for the carrying amount of the intangible assets, or $11 million, in the second quarter of 2017.

Goodwill. We next tested Pathways’ goodwill for impairment. As described above, we estimated Pathways’ fair value using discounted cash flows, incorporating significant estimates and assumptions related to future periods. Such estimates included anticipated client census which drives service revenue; management’s determination that future benefits to be derived from Pathways (including integration with our health plans) will be less than previously anticipated; current prospects relating to the behavioral services labor market which drives cost of service revenue; and anticipated capital expenditures. In addition, we applied our weighted average cost of capital (WACC) as the best estimate to discount future estimated cash flows to present value. The WACC was based on externally available data considering market participants’ cost of equity and debt, and capital structure. We applied a terminal growth rate that corresponds to Pathways’ long-term growth prospects. The test resulted in a fair value less than Pathways’ carrying amount; therefore, we recorded an impairment loss for the difference, or $59 million, in the second quarter of 2017. In addition to the Pathways impairment loss, we recorded an impairment loss of $2 million for a separate subsidiary’s goodwill that did not pass the impairment test. Both impairment losses were recorded to the Other segment, and reported as “Impairment losses” in the accompanying consolidated statements of operations.

There were no impairments of intangible assets or goodwill during 2016.

The following table presents the balances of goodwill as of June 30, 2017 and December 31, 2016:

	Health Plans	Molina Medicaid Solutions	Other	Total
		(In millions)		
Historical goodwill	$ 445	$ 71	$ 162	$ 678
Accumulated impairment losses at December 31, 2016	(58)	—	—	(58)
Balance, December 31, 2016	387	71	162	620
Impairment losses	—	—	(61)	(61)
Balance, June 30, 2017	$ 387	$ 71	$ 101	$ 559
Accumulated impairment losses at June 30, 2017	$ (58)	$ —	$ (61)	$ (119)

11. Restructuring and Separation Costs

Following a management-initiated, broad operational assessment in early 2017, designed to improve our profitability and expand our core Medicaid business, in June 2017, we accelerated the implementation of a comprehensive restructuring and profitability improvement plan (the Restructuring Plan). Under the Restructuring Plan, we are taking the following actions:

1. We are streamlining our organizational structure, including the elimination of redundant layers of management, the consolidation of regional support services, and other reductions to our workforce, to improve efficiency as well as the speed and quality of our decision-making.

2. We are re-designing core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology to achieve more effective and cost efficient outcomes.

3. We are remediating high cost provider contracts and building around high quality, cost-effective networks.

4. We are restructuring our existing direct delivery operations.

5. We are reviewing our vendor base to ensure that we are partnering with the lowest-cost, most-effective vendors.

6. Throughout this process, we are taking precautions to ensure that our actions do not impede our ability to continue to deliver quality health care, retain existing managed care contracts, and to secure new managed care contracts.

In addition to costs incurred under the Restructuring Plan, in the second quarter of 2017 we recorded costs associated with the separation of our former CEO and former CFO, described in further detail below.

All restructuring and separation costs incurred in the six months ended June 30, 2017, are reported in “Restructuring and separation costs” in the accompanying consolidated statements of operations, and are included in the Other segment because they represent corporate costs not allocated to the other reportable segments.

Separation Costs

Separation costs–ongoing benefit arrangements for former executives. We entered into amended and restated employment agreements with our former CEO and former CFO in 2016. On May 2, 2017, their employment was terminated without cause. Under the amended and restated employment agreements, they were each entitled to receive 400% of their base salary, a prorated termination bonus (150% of base salary for the former CEO and 125% of base salary for the former CFO), full vesting of equity compensation, and a cash payment for health and welfare benefits. During the second quarter of 2017, we recorded charges of $35 million for severance primarily related to these former executives. Of this total, $23 million related to the acceleration of their share-based compensation, as further discussed in Note 9, “Stockholders' Equity.” Employee separation costs were insignificant in 2016.

Separation costs–one-time benefit arrangement for workforce reduction. As part of the Restructuring Plan, we are reducing our corporate and health plans workforce by approximately 10%, or 1,500 full-time-equivalent employees. This workforce rightsizing, which represents 7% of the total number of our employees, is expected to be completed by the end of 2017. Affected employees will be offered severance and outplacement assistance. Our board of

directors approved the reduction in our workforce under the Restructuring Plan effective July 27, 2017; as such no amounts were accrued for this termination plan as of June 30, 2017.

Other Restructuring Costs

In the six months ended June 30, 2017, we incurred approximately $8 million in other restructuring costs including primarily consulting fees relating to the operational assessment and restructuring initiatives described above.

The following table summarizes the year-to-date activities related to our Restructuring Plan, the reserve for which is reported in "Accounts payable and accrued liabilities" in the consolidated balance sheets:

	Separation Costs–Former Executives	Other Restructuring Costs	Total
		(In millions)	
Accrued restructuring and separation costs as of December 31, 2016	$ —	$ —	$ —
Costs recognized	35	8	43
Cash payments	(1)	(2)	(3)
Other adjustments–acceleration of share-based compensation	(23)	—	(23)
Accrued restructuring and separation costs as of June 30, 2017	$ 11	$ 6	$ 17

Expected Costs

We estimate that total pre-tax costs associated with the Restructuring Plan will be approximately $130 million to $150 million for the second half of 2017, with an additional $40 million to be incurred in 2018. We expect these costs to relate only to the Health Plans and Other segments. Other restructuring costs will include primarily consulting fees; costs associated with the restructuring of our direct delivery operations including lease terminations and accelerated depreciation and amortization; and restructuring of various corporate business functions.

The following table illustrates our estimates of costs associated with the Restructuring Plan, which we expect to be completed by the end of 2018, by segment and major type of cost:

Estimated Costs Expected to be Incurred by Reportable Segment	Health Plans	Other	Total
		(In millions)	
Separation costs–one-time benefit arrangement for a workforce reduction	$25 to $30	$35 to $40	$60 to $70
Other restructuring costs	$55 to $60	$55 to $60	$110 to $120
	$80 to $90	$90 to $100	$170 to $190

12. Segment Information

We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
Three Months Ended June 30, 2017				
Total revenue [1]	$ 4,868	$ 47	$ 84	$ 4,999
Gross margin	249	4	1	254
Impairment losses	—	—	(72)	(72)
Restructuring and separation costs	—	—	(43)	(43)
Six Months Ended June 30, 2017				
Total revenue [1]	9,639	93	171	9,903
Gross margin	786	8	6	800
Impairment losses	—	—	(72)	(72)
Restructuring and separation costs	—	—	(43)	(43)
Three Months Ended June 30, 2016				
Total revenue [1]	4,223	46	90	4,359
Gross margin	435	5	14	454
Impairment losses	—	—	—	—
Restructuring and separation costs	—	—	—	—
Six Months Ended June 30, 2016				
Total revenue [1]	8,424	98	180	8,702
Gross margin	842	11	21	874
Impairment losses	—	—	—	—
Restructuring and separation costs	—	—	—	—
Total Assets				
June 30, 2017	6,732	240	1,611	8,583
December 31, 2016	5,897	267	1,285	7,449
Goodwill, and Intangible Assets, Net				
June 30, 2017	498	72	101	671
December 31, 2016	513	72	175	760

(1) Total revenue consists primarily of premium revenue, premium tax revenue and health insurer fee revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments. Inter-segment revenue is insignificant for all periods presented.

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(In millions)			
Gross margin:				
Health Plans	$ 249	$ 435	$ 786	$ 842
Molina Medicaid Solutions	4	5	8	11
Other	1	14	6	21
Total gross margin	254	454	800	874
Add: other operating revenues (1)	130	195	255	403
Less: other operating expenses (2)	(671)	(544)	(1,260)	(1,083)
Operating (loss) income	(287)	105	(205)	194
Other expenses (income), net	27	25	(22)	50
(Loss) income before income taxes	$ (314)	$ 80	$ (183)	$ 144

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses, depreciation and amortization, impairment losses, and restructuring and separation costs.

13. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,526 million at June 30, 2017, and $1,492 million at December 31, 2016. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments (excluding restricted investments) held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments (excluding restricted investments) amounted to $165 million and $264 million as of June 30, 2017 and December 31, 2016, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states.

As of June 30, 2017, our health plans had aggregate statutory capital and surplus of approximately $1,662 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,118 million. Primarily as a result of the recognition of Marketplace-related premium deficiency reserves discussed in Note 2, “Significant Accounting Policies,” certain of our health plans did not meet the minimum capital requirements on June 30, 2017. We intend to remedy the deficiencies to the satisfaction of our departments of insurance prior to the filing of the statutory financial statements on August 15, 2017. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

Legal Proceedings

The health care and Medicaid-related business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Marketplace Risk Corridor Program. On January 19, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, Case Number 1:55-cv-01000-UNJ, on behalf of our health plans seeking recovery from the federal government of approximately $52 million in Marketplace risk corridor payments for calendar year 2015. Based upon current estimates, we believe our health plans are also owed approximately $76 million in Marketplace risk corridor payments from the federal government for calendar year 2016, and a further nominal amount for calendar year 2014. Our lawsuit seeks recovery of all of these unpaid amounts. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid Marketplace risk corridor payments as of June 30, 2017. We have fully recognized all liabilities due to the federal government that we have incurred under the Marketplace risk corridor program, and have paid all amounts due to the federal government as required.

Rodriguez v. Providence Community Corrections. On October 1, 2015, seven individuals, on behalf of themselves and all others similarly situated, filed a complaint in the District Court for the Middle District of Tennessee, Nashville Division, Case No. 3:15-cv-01048 (the Rodriquez Litigation), against Providence Community Corrections, Inc. (now known as Pathways Community Corrections, Inc., or PCC). Rutherford County, Tennessee formerly contracted with PCC for the administration of misdemeanor probation, which involved the collection of court costs and fees from probationers. The complaint alleges, among other things, that PCC illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay such amounts. The plaintiffs in the Rodriguez Litigation seek alleged compensatory, treble, and punitive damages, plus attorneys' fees, for alleged federal and state constitutional violations, as well as alleged violations of the Racketeer Influenced and Corrupt Organization Act. PCC's agreement with Rutherford County terminated effective March 31, 2016. On November 1, 2015, one month after the Rodriguez Litigation commenced, we acquired PCC from The Providence Service Corporation (Providence) pursuant to a membership interest purchase agreement. In September 2016, the parties to the Rodriguez Litigation accepted a mediation proposal for settlement pursuant to which PCC and Rutherford County would pay the plaintiffs $14 million and $3 million, respectively. The parties are in the process of finalizing the settlement agreement. We expect to recover the full amount of the settlement under the indemnification provisions of the membership interest purchase agreement with Providence.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. On October 22, 2015, the Relator filed a third amended complaint, seeking general and compensatory damages, treble damages, civil penalties, plus interest and attorneys' fees. On July 11, 2016, the District Court dismissed with prejudice the third amended complaint, without leave to amend. On September 23, 2016, the plaintiff filed an appeal with the Ninth Circuit Court of Appeals. The appeal has been fully briefed by the parties and we are awaiting the Court's decision.

States' Budgets

From time to time the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. Until July 4, 2017, the state of Illinois operated without a budget for its current fiscal year. As of June 30, 2017, our Illinois health plan served approximately 163,000 members, and recognized premium revenue of approximately $310 million in the first half of 2017. As of July 28, 2017, the state of Illinois owed us approximately $116 million for certain March, April, May and June 2017 premiums.

On May 3, 2017, Puerto Rico's financial oversight board filed for a form of bankruptcy in the U.S. District Court in Puerto Rico under Title III of PROMESA. The Title III provision allows for a court debt restructuring process similar to U.S. bankruptcy protection. To the extent such bankruptcy results in our failure to receive payment of amounts due under our Medicaid contract with the Commonwealth or the inability of the Commonwealth to extend our Medicaid contract at the end of its current term, such bankruptcy could have a material adverse effect on our business, financial condition, cash flows, or results of operations. As of June 30, 2017, the plan served approximately 322,000 members and recorded premium revenue of approximately $362 million in the first half of 2017. As of July 28, 2017, the Commonwealth was current with its premium payments.

14. Related Party Transactions

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina and John C. Molina, who are members of our board of directors. Under the terms of this provider agreement, the California health plan pays Pacific for medical care Pacific provides to health plan members. For the three and six months ended June 30, 2017 and 2016, the amounts paid to Pacific were insignificant.

Refer to Note 15, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

15. Variable Interest Entities (VIEs)

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created to further advance our direct delivery business. On August 2, 2017, we announced plans to restructure our direct delivery operations.

JMMPC's primary shareholder is Dr. J. Mario Molina, who is a member of our board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. JMMPC also provides certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our California, Florida, New Mexico, Utah, and Washington health plans. These health plans had entered into primary care services agreements with JMMPC, under which the health plans paid $29 million and $31 million to JMMPC for health care services provided in the three months ended June 30, 2017 and 2016, respectively. For the six months ended June 30, 2017 and 2016, the health plans paid JMMPC $60 million and $61 million, respectively. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), had also entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC operated at break even, ensuring the availability of quality care and access for our health plan members. The services agreements further provided that the administrative fees charged to JMMPC by MMM were reviewed annually to assure the achievement of this goal. For each of the three months ended June 30, 2017 and 2016, JMMPC paid $13 million to MMM for clinic administrative services. For the six months ended June 30, 2017 and 2016, JMMPC paid $26 million and $27 million, respectively, to MMM for clinic administrative services.

As of June 30, 2017, we determined that JMMPC is a VIE, and that we are its primary beneficiary. We reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we had the power to direct the activities (excluding clinical decisions) that most significantly affected JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that were potentially significant to the VIE, under the agreements described above. Because we were its primary beneficiary, we consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of

Molina Healthcare, Inc. As of June 30, 2017, JMMPC had total assets of $17 million, and total liabilities of $18 million. As of December 31, 2016, JMMPC had total assets of $18 million, and total liabilities of $18 million.

Our maximum exposure to loss as a result of our involvement with JMMPC was generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities.

16. Supplemental Condensed Consolidating Financial Information

The 5.375% Notes described in Note 7, "Debt," are fully and unconditionally guaranteed by certain of our 100% owned subsidiaries on a joint and several basis, with certain exceptions considered customary for such guarantees. The 5.375% Notes and the guarantees are effectively subordinated to all of our and our guarantors' existing and future secured debt to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock, if any, of our subsidiaries that do not guarantee the 5.375% Notes.

As discussed in Note 7, "Debt," the First Amendment to the Credit Facility provided that all guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC, were automatically and unconditionally released from their obligations as guarantors under the Credit Facility and the 5.375% Notes.

The following condensed consolidating financial statements present Molina Healthcare, Inc. (as parent guarantor), the subsidiary guarantors, the subsidiary non-guarantors and eliminations, according to the guarantor structure as assessed at the most recent balance sheet date, June 30, 2017.

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Three Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Revenue:					
Total revenue	$ 289	$ 51	$ 4,952	$ (293)	$ 4,999
Expenses:					
Medical care costs	3	—	4,488	—	4,491
Cost of service revenue	—	43	81	—	124
General and administrative expenses	258	7	433	(293)	405
Premium tax expenses	—	—	114	—	114
Depreciation and amortization	25	—	12	—	37
Impairment losses	—	—	72	—	72
Restructuring and separation costs	43	—	—	—	43
Total operating expenses	329	50	5,200	(293)	5,286
Operating (loss) income	(40)	1	(248)	—	(287)
Interest expense	27	—	—	—	27
(Loss) income before income taxes	(67)	1	(248)	—	(314)
Income tax benefit	(14)	—	(70)	—	(84)
Net (loss) income before equity in net losses of subsidiaries	(53)	1	(178)	—	(230)
Equity in net losses of subsidiaries	(177)	(64)	—	241	—
Net loss	$ (230)	$ (63)	$ (178)	$ 241	$ (230)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE LOSS

	Three Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (230)	$ (63)	$ (178)	$ 241	$ (230)
Other comprehensive loss, net of tax	—	—	—	—	—
Comprehensive loss	$ (230)	$ (63)	$ (178)	$ 241	$ (230)

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Three Months Ended June 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 261	$ 47	$ 4,311	$ (260)	$ 4,359
Expenses:					
Medical care costs	19	—	3,575	—	3,594
Cost of service revenue	—	23	93	—	116
General and administrative expenses	219	24	368	(260)	351
Premium tax expenses	—	—	109	—	109
Health insurer fee expenses	—	—	50	—	50
Depreciation and amortization	23	1	10	—	34
Total operating expenses	261	48	4,205	(260)	4,254
Operating (loss) income	—	(1)	106	—	105
Interest expense	25	—	—	—	25
(Loss) income before income taxes	(25)	(1)	106	—	80
Income tax (benefit) expense	(12)	(1)	60	—	47
Net (loss) income before equity in net earnings of subsidiaries	(13)	—	46	—	33
Equity in net earnings of subsidiaries	46	1	—	(47)	—
Net income	$ 33	$ 1	$ 46	$ (47)	$ 33

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 33	$ 1	$ 46	$ (47)	$ 33
Other comprehensive income, net of tax	2	—	2	(2)	2
Comprehensive income	$ 35	$ 1	$ 48	$ (49)	$ 35

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

	Six Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 630	$ 99	$ 9,809	$ (635)	$ 9,903
Expenses:					
Medical care costs	7	—	8,595	—	8,602
Cost of service revenue	—	85	161	—	246
General and administrative expenses	555	14	910	(635)	844
Premium tax expenses	—	—	225	—	225
Depreciation and amortization	52	—	24	—	76
Impairment losses	—	—	72	—	72
Restructuring and separation costs	43	—	—	—	43
Total operating expenses	657	99	9,987	(635)	10,108
Operating loss	(27)	—	(178)	—	(205)
Interest expense	53	—	—	—	53
Other income, net	(75)	—	—	—	(75)
Loss before income taxes	(5)	—	(178)	—	(183)
Income tax expense (benefit)	17	—	(47)	—	(30)
Net loss before equity in net losses of subsidiaries	(22)	—	(131)	—	(153)
Equity in net losses of subsidiaries	(131)	(66)	—	197	—
Net loss	$ (153)	$ (66)	$ (131)	$ 197	$ (153)

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE LOSS

	Six Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net loss	$ (153)	$ (66)	$ (131)	$ 197	$ (153)
Other comprehensive income, net of tax	1	—	1	(1)	1
Comprehensive loss	$ (152)	$ (66)	$ (130)	$ 196	$ (152)

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Six Months Ended June 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 512	$ 99	$ 8,601	$ (510)	$ 8,702
Expenses:					
Medical care costs	31	—	7,151	—	7,182
Cost of service revenue	—	88	155	—	243
General and administrative expenses	436	9	756	(510)	691
Premium tax expenses	—	—	218	—	218
Health insurer fee expenses	—	—	108	—	108
Depreciation and amortization	45	3	18	—	66
Total operating expenses	512	100	8,406	(510)	8,508
Operating (loss) income	—	(1)	195	—	194
Interest expense	50	—	—	—	50
(Loss) income before income taxes	(50)	(1)	195	—	144
Income tax (benefit) expense	(28)	(1)	116	—	87
Net (loss) income before equity in earnings of subsidiaries	(22)	—	79	—	57
Equity in net earnings of subsidiaries	79	3	—	(82)	—
Net income	$ 57	$ 3	$ 79	$ (82)	$ 57

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Six Months Ended June 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 57	$ 3	$ 79	$ (82)	$ 57
Other comprehensive income, net of tax	8	—	7	(7)	8
Comprehensive income	$ 65	$ 3	$ 86	$ (89)	$ 65

CONDENSED CONSOLIDATING BALANCE SHEETS

	June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 109	$ 32	$ 2,838	$ —	$ 2,979
Investments	56	—	2,136	—	2,192
Restricted investments	325	—	—	—	325
Receivables	2	30	974	—	1,006
Income taxes refundable	7	1	60	—	68
Due from (to) affiliates	137	(6)	(131)	—	—
Prepaid expenses and other current assets	70	21	68	—	159
Derivative asset	440	—	—	—	440
Total current assets	1,146	78	5,945	—	7,169
Property, equipment, and capitalized software, net	297	47	105	—	449
Deferred contract costs	—	93	—	—	93
Goodwill and intangible assets, net	56	72	543	—	671
Restricted investments	—	—	118	—	118
Investment in subsidiaries, net	2,597	181	—	(2,778)	—
Deferred income taxes	10	(43)	79	(10)	36
Other assets	55	2	6	(16)	47
	$ 4,161	$ 430	$ 6,796	$ (2,804)	$ 8,583
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ —	$ —	$ 2,077	$ —	$ 2,077
Amounts due government agencies	—	—	1,844	—	1,844
Accounts payable and accrued liabilities	170	35	170	—	375
Deferred revenue	—	49	235	—	284
Current portion of long-term debt	773	—	—	—	773
Derivative liability	440	—	—	—	440
Total current liabilities	1,383	84	4,326	—	5,793
Long-term debt	1,215	—	16	(16)	1,215
Deferred income taxes	10	—	—	(10)	—
Other long-term liabilities	32	1	21	—	54
Total liabilities	2,640	85	4,363	(26)	7,062
Total stockholders' equity	1,521	345	2,433	(2,778)	1,521
	$ 4,161	$ 430	$ 6,796	$ (2,804)	$ 8,583

CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 86	$ 6	$ 2,727	$ —	$ 2,819
Investments	178	—	1,580	—	1,758
Receivables	2	34	938	—	974
Income tax refundable	17	4	18	—	39
Due from (to) affiliates	104	(5)	(99)	—	—
Prepaid expenses and other current assets	58	30	43	—	131
Derivative asset	267	—	—	—	267
Total current assets	712	69	5,207	—	5,988
Property, equipment, and capitalized software, net	301	46	107	—	454
Deferred contract costs	—	86	—	—	86
Goodwill and intangible assets, net	58	73	629	—	760
Restricted investments	—	—	110	—	110
Investment in subsidiaries, net	2,609	246	—	(2,855)	—
Deferred income taxes	10	—	—	—	10
Other assets	48	3	6	(16)	41
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 1	$ —	$ 1,928	$ —	$ 1,929
Amounts due government agencies	—	—	1,202	—	1,202
Accounts payable and accrued liabilities	146	34	205	—	385
Deferred revenue	—	40	275	—	315
Current portion of long-term debt	472	—	—	—	472
Derivative liability	267	—	—	—	267
Total current liabilities	886	74	3,610	—	4,570
Long-term debt	1,173	—	16	(16)	1,173
Deferred income taxes	11	39	(35)	—	15
Other long-term liabilities	19	1	22	—	42
Total liabilities	2,089	114	3,613	(16)	5,800
Total stockholders' equity	1,649	409	2,446	(2,855)	1,649
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Six Months Ended June 30, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by operating activities	$ 90	$ 44	$ 538	$ —	$ 672
Investing activities:					
Purchases of investments	(330)	—	(1,306)	—	(1,636)
Proceeds from sales and maturities of investments	127	—	747	—	874
Purchases of property, equipment and capitalized software	(45)	(9)	(6)	—	(60)
Increase in restricted investments held-to-maturity	—	—	(10)	—	(10)
Capital contributions to/from subsidiaries	(238)	2	236	—	—
Dividends to/from subsidiaries	120	—	(120)	—	—
Change in amounts due to/from affiliates	(34)	2	32	—	—
Other, net	—	(13)	—	—	(13)
Net cash used in investing activities	(400)	(18)	(427)	—	(845)
Financing activities:					
Proceeds from senior notes offerings, net of issuance costs	325	—	—	—	325
Proceeds from employee stock plans	11	—	—	—	11
Other, net	(3)	—	—	—	(3)
Net cash provided by financing activities	333	—	—	—	333
Net increase in cash and cash equivalents	23	26	111	—	160
Cash and cash equivalents at beginning of period	86	6	2,727	—	2,819
Cash and cash equivalents at end of period	$ 109	$ 32	$ 2,838	$ —	$ 2,979

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Six Months Ended June 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash (used in) provided by operating activities	$ (21)	$ 20	$ 279	$ —	$ 278
Investing activities:					
Purchases of investments	(67)	—	(907)	—	(974)
Proceeds from sales and maturities of investments	67	—	745	—	812
Purchases of property, equipment and capitalized software	(73)	(19)	(10)	—	(102)
Decrease in restricted investments held-to-maturity	—	—	5	—	5
Net cash paid in business combinations	—	(1)	(7)	—	(8)
Capital contributions to/from subsidiaries	(106)	2	104	—	—
Dividends to/from subsidiaries	50	—	(50)	—	—
Change in amounts due to/from affiliates	(13)	2	11	—	—
Other, net	5	(12)	1	—	(6)
Net cash used in investing activities	(137)	(28)	(108)	—	(273)
Financing activities:					
Proceeds from employee stock plans	10	—	—	—	10
Other, net	2	—	(1)	—	1
Net cash provided by (used in) financing activities	12	—	(1)	—	11
Net (decrease) increase in cash and cash equivalents	(146)	(8)	170	—	16
Cash and cash equivalents at beginning of period	360	13	1,956	—	2,329
Cash and cash equivalents at end of period	$ 214	$ 5	$ 2,126	$ —	$ 2,345

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

FORWARD LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- *the success of the Restructuring Plan, including the timing of the benefits realized;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including any potential repeal and replacement of the law, amendment of the law, or move to state block grants for Medicaid;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk transfer requirements, the potential for disproportionate enrollment of higher acuity members, the withdrawal of cost sharing subsidies and/or premium tax credits, the adequacy of agreed rates, and potential disruption associated with market withdrawal;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer, risk corridors, and reinsurance;*
- *effective management of our medical costs;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the payment of all amounts due to our Illinois health plan following the resolution of the Illinois budget impasse;*
- *the success of our efforts to retain existing government contracts, including those in Florida, Illinois, New Mexico, Puerto Rico, and Texas, and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;*
- *any adverse impact resulting from the significant changes to our executive leadership team and the rightsizing of our workforce;*
- *the impact of our decision to exit the Utah and Wisconsin ACA Marketplace markets effective December 31, 2017;*
- *our ability to manage our operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our ability to consummate and realize benefits from acquisitions or divestitures;*

- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion cost corridors in California, New Mexico, and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, the effect of the PROMESA law, and our efforts to better manage the health care costs of our Puerto Rico health plan;*
- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *the continuation and renewal of the government contracts of our health plans, Molina Medicaid Solutions, and Pathways, and the terms under which such contracts are renewed;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom, including any potential demand by the state of New Mexico to recover purportedly underpaid premium taxes;*
- *changes with respect to our provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings;*
- *the relatively small number of states in which we operate health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *our failure to comply with the financial or other covenants in our credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of our funds on hand to pay the amounts due upon conversion or maturity of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm; and*
- *increasing competition and consolidation in the Medicaid industry;*

Investors should refer to the section entitled “Risk Factors” in each of our Annual Report on Form 10-K for the year ended December 31, 2016, our Quarterly Report on Form 10-Q for the quarter ended March 31, 2017, and this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2016.

ABOUT MOLINA HEALTHCARE

OUR MISSION IS TO PROVIDE QUALITY HEALTHCARE TO PEOPLE RECEIVING GOVERNMENT ASSISTANCE.

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

OUR GOAL IS TO ACHIEVE OUR MISSION WHILE IMPROVING THE FINANCIAL STRENGTH OF OUR ORGANIZATION.

KEY PERFORMANCE INDICATORS

Non-GAAP Financial Measures

We use non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures.

See further information regarding non-GAAP measures in the "Supplemental Information" section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this report are designated with an asterisk (*).

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(Dollar amounts in millions, except per-share amounts)			
Net (loss) income	$ (230)	$ 33	$ (153)	$ 57
Net (loss) income per diluted share	$ (4.10)	$ 0.58	$ (2.74)	$ 1.01
MCR (1)	94.8 %	89.2%	91.6 %	89.5%
G&A ratio (2)	8.1 %	8.1%	8.5 %	7.9%
Premium tax ratio (1)	2.4 %	2.6%	2.3 %	2.6%
Effective tax rate	26.8 %	59.8%	16.0 %	60.7%
Net profit margin (2)	(4.6)%	0.7%	(1.5)%	0.7%
EBITDA*	$ (243)	$ 144	$ (40)	$ 270
Adjusted net (loss) income*	$ (225)	$ 38	$ (142)	$ 67
Adjusted net (loss) income per diluted share*	$ (4.01)	$ 0.67	$ (2.55)	$ 1.18

(1) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) G&A ratio represents general and administrative expenses as a percentage of total revenue. Net profit margin represents net income as a percentage of total revenue.

CONSOLIDATED RESULTS

Three Months Ended June 30, 2017 Compared with Three Months Ended June 30, 2017

- Net loss per diluted share was $4.10 in the second quarter of 2017 compared with net income per diluted share of $0.58 reported for the second quarter of 2016. Adjusted net loss per diluted share* was $4.01 in the second quarter of 2017, compared with adjusted net income per diluted share of $0.67 in the second quarter of 2016. Loss before income tax benefit for the second quarter of 2017 was $314 million.

- Certain significant items contributed $330 million to the loss before income tax benefit. See further discussion of these items in the table below, in "Health Plans—Financial Performance by Program," and "Other Consolidated Information."

- The medical care ratio increased to 94.8% in the second quarter of 2017 compared to 89.2% in the second quarter of 2016. See further discussion below in "Reportable Segments—Health Plans—Financial Overview."

The following table summarizes the impact of the significant items:

Summary of Significant Items Affecting 2017 Financial Results

	Three Months Ended June 30, 2017		Six Months Ended June 30, 2017	
	(In millions, except per diluted share amounts)			
	Amount	Per Diluted Share (1)	Amount	Per Diluted Share (1)
Impairment losses	$ 72	$ 1.01	$ 72	$ 1.02
Losses at behavioral health subsidiary exclusive of impairment	8	0.09	12	0.14
Medical care costs related to prior year service dates that were in excess of historical expectations	85	0.95	74	0.84
Marketplace adjustments related to risk transfer, cost sharing subsidies, and other items for 2016 service dates	44	0.49	47	0.53
Marketplace premium deficiency reserve for 2017 service dates	78	0.87	70	0.79
Restructuring and separation costs	43	0.68	43	0.68
Termination fee received for Terminated Medicare acquisition	—	—	(75)	(0.84)
	$ 330	$ 4.09	$ 243	$ 3.16

(1) Except for certain items that are not deductible for tax purposes, per diluted share amounts are generally calculated at our statutory income tax rate of 37%, which is in excess of the effective tax rate recorded in our consolidated statements of operations.

Certain significant items increased loss before income tax benefit in the second quarter of 2017 by approximately $330 million. Specifically:

- We recorded $72 million in non-cash impairment losses for goodwill and intangibles, primarily relating to our Pathways subsidiary. In the course of developing our restructuring and profitability improvement plan, we determined that future benefits to be derived from Pathways (including integration with our health plans) will be less than previously anticipated. While such impairment losses have a short-term impact on profitability, there is no impact to our cash flows. Pathways experienced operating losses of $8 million for the quarter ended June 30, 2017 and $12 million for the six months ended June 30, 2017.
- Medical care costs related to 2016 service dates were significantly in excess of what the Company usually experiences for out-of-period claims development, particularly at the Florida, Illinois, New Mexico, and Puerto Rico health plans. In total, we experienced out-of-period claims development that was approximately $85 million higher than expected at December 31, 2016.

- We recorded $44 million for Marketplace changes in estimates, including risk transfer and cost sharing subsidies, related to 2016 service dates. Liabilities for risk transfer payments and cost sharing subsidies that were estimated at December 31, 2016 were finalized during the second quarter of 2017.
- Loss before income tax benefit increased by $78 million as a result of an increase to the premium deficiency reserve established for the Marketplace program. The reserve, which was $22 million at March 31, 2017, increased to $100 million as of June 30, 2017. Based upon revenue and cost trends observed in the second quarter of 2017, we now believe that Marketplace performance in the second half of 2017 will fall substantially short of previous expectations. Marketplace performance has been most disappointing in Florida, Utah, Washington, and Wisconsin.
- We recorded $43 million in restructuring and separation costs in the second quarter of 2017 related primarily to contractually required termination benefits paid to our former chief executive officer and chief financial officer. Also included in these costs are consulting fees incurred for the development and implementation of our corporate restructuring initiatives. See below in “Liquidity and Financial Condition—Future Sources and Uses of Liquidity,” and Notes to Consolidated Financial Statements, Note 11, “Restructuring and Separation Costs,” for further information.

Six Months ended June 30, 2017 Compared with Six Months Ended June 30, 2016

Net loss per diluted share was $2.74 in the first half of 2017 compared with net income per diluted share of $1.01 reported for the first half of 2016. Adjusted net loss per diluted share* was $2.55 in the first half of 2017, compared with adjusted net income per diluted share* of $1.18 in the first half of 2016. Loss before income tax benefit for the first half of 2017 was $153 million. These results were affected by several out-of-period adjustments as presented in the table, and as further described, above. In total, these adjustments increased pretax loss in the first half of 2017 by $243 million.

RESTRUCTURING AND PROFIT IMPROVEMENT PLAN

As a result of our poor operating performance and catalyzed by our change in management, we accelerated the implementation of a comprehensive restructuring and profitability improvement plan (the Restructuring Plan). Under the Restructuring Plan, we are taking the following actions:

1. We are streamlining our organizational structure, including the elimination of redundant layers of management, the consolidation of regional support services, and other reductions to our workforce, to improve efficiency as well as the speed and quality of our decision-making.
2. We are re-designing core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology to achieve more effective and cost efficient outcomes.
3. We are remediating high cost provider contracts and building around high quality, cost-effective networks.
4. We are restructuring our existing direct delivery operations.
5. We are reviewing our vendor base to ensure that we are partnering with the lowest-cost, most-effective vendors.
6. Throughout this process, we are taking precautions to ensure that our actions do not impede our ability to continue to deliver quality health care, retain existing managed care contracts, and to secure new managed care contracts.

ACTION PLAN—2018 MARKETPLACE PERFORMANCE

In addition to the Restructuring Plan, we are taking these further steps to improve profitability in 2018:

1. We are exiting the Utah and Wisconsin ACA Marketplaces effective December 31, 2017. For the three months ended June 30, 2017, these two health plans reported a total of $127 million in Marketplace premium revenue (16% of consolidated Marketplace premium revenue), and a combined Marketplace medical care ratio of 128%.
2. In our remaining Marketplace plans, we are increasing 2018 premiums by 55%. The increase takes into account the absence of cost sharing reduction subsidies. Had we assumed that cost sharing reduction subsidies would be funded for 2018, the premium increase would have been 30%.
3. We are also reducing the scope of our 2018 participation in the Washington Marketplace.
4. We continue to closely monitor the current political and programmatic developments pertaining to our 2018 participation in other Marketplace states, and subject to those developments, will withdraw from 2018 participation as may be necessary.

TRENDS AND UNCERTAINTIES

ACA and the Marketplace

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, are subject to substantial uncertainty. We continue to advocate for federal policies to stabilize the Marketplace program.

Medicaid Contract Re-Procurement

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates. Such dates are subject to change and, in some cases, not yet known to us. Premium revenue is stated in millions.

State Health Plan	Medicaid Program(s)	Membership as of June 30, 2017	Premium Revenue Six Months Ended June 30, 2017	Anticipated Award Date	Anticipated Effective Date
Florida	All	359,000	$ 726	Q1 2018	1/1/2019
Illinois	All	159,000	259	Q3 2017	1/1/2018
New Mexico	All	234,000	605	Q1 2018	1/1/2019
Puerto Rico	All	322,000	362	Q1 2018	7/1/2018
Texas	All	191,000	920	Q3 2018	9/1/2019
Texas	CHIP	25,000	21	Q4 2017	9/1/2018

Washington Health Plan. As discussed in Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," in May 2017, Molina Healthcare of Washington, Inc. was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North Central region of the state's Apple Health Integrated Managed Care Program. The start date for the new contract is scheduled for January 1, 2018.

REPORTABLE SEGMENTS

How We Assess Performance

We derive our revenues primarily from health insurance premiums, and our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio, or MCR. The medical care ratio represents medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. Management's discussion and analysis of the changes in the individual components of gross

margin, by reportable segment, is presented in the “Health Plans—Financial Overview,” “Molina Medicaid Solutions—Financial Overview,” and “Other—Financial Overview” sections, respectively, of this MD&A.

SEGMENT SUMMARY

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(In millions)			
Segment gross margin:				
Health Plans medical margin [1]	$ 249	$ 435	$ 786	$ 842
Molina Medicaid Solutions service margin [2]	4	5	8	11
Other [2]	1	14	6	21
Total segment gross margin	254	454	800	874
Other operating revenues [3]	130	195	255	403
Other operating expenses [4]	(671)	(544)	(1,260)	(1,083)
Operating (loss) income	(287)	105	(205)	194
Other expenses (income), net	27	25	(22)	50
(Loss) income before income tax expense	(314)	80	(183)	144
Income tax (benefit) expense	(84)	47	(30)	87
Net (loss) income	$ (230)	$ 33	$ (153)	57

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.
(3) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.
(4) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses, depreciation and amortization, impairment losses, and restructuring and separation costs.

HEALTH PLANS

The Health Plans segment consists of health plans operating in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of June 30, 2017, these health plans served approximately 4.7 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies.

BUSINESS OVERVIEW

Recent Developments — Health Plans Segment

Refer to Notes to Consolidated Financial Statements, Note 1, “Basis of Presentation.”

Health Plans Membership

The following tables set forth our Health Plans membership as of the dates indicated:

	June 30, 2017	December 31, 2016	June 30, 2016
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,517,000	2,536,000	2,500,000
Marketplace	949,000	526,000	597,000
Medicaid Expansion	678,000	673,000	654,000
Aged, Blind or Disabled (ABD)	408,000	396,000	387,000
Medicare-Medicaid Plan (MMP) – Integrated [1]	54,000	51,000	51,000
Medicare Special Needs Plans (Medicare)	44,000	45,000	44,000
	4,650,000	4,227,000	4,233,000
Ending Membership by Health Plan:			
California	766,000	683,000	680,000
Florida	672,000	553,000	565,000
Illinois	163,000	195,000	201,000
Michigan	414,000	391,000	393,000
New Mexico	266,000	254,000	251,000
New York [2]	34,000	35,000	—
Ohio	351,000	332,000	341,000
Puerto Rico	322,000	330,000	336,000
South Carolina	112,000	109,000	105,000
Texas	465,000	337,000	367,000
Utah	167,000	146,000	151,000
Washington	788,000	736,000	709,000
Wisconsin	130,000	126,000	134,000
	4,650,000	4,227,000	4,233,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) The New York health plan was acquired on August 1, 2016.

Premiums by Program

The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a per member per month (PMPM) basis, for the six months ended June 30, 2017. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 320.00	$ 180.00
Marketplace	180.00	440.00	270.00
Medicaid Expansion	320.00	510.00	390.00
ABD	370.00	1,490.00	1,030.00
MMP – Integrated	1,220.00	3,250.00	2,150.00
Medicare	910.00	1,240.00	1,100.00

FINANCIAL OVERVIEW

In the second quarter of 2017, premium revenue increased approximately 18%, or $711 million, when compared with the second quarter of 2016. Member months grew 11% while revenue PMPM increased 7%. Medical care costs as a percent of premium revenue increased to 94.8% in the second quarter of 2017 from 89.2% in the second quarter of 2016. Medical margin decreased 43% in the second quarter of 2017 from the second quarter of 2016.

In the six months ended June 30, 2017, premium revenue increased approximately 17%, or $1,364 million, when compared with the six months ended June 30, 2016. Member months grew 13% while revenue PMPM increased 4%. Medical care costs as a percent of premium revenue increased to 91.6% in the six months ended June 30, 2017 from 89.5% in the six months ended June 30, 2016. Medical margin decreased 7% in the six months ended June 30, 2017 from the six months ended June 30, 2016.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, medical care ratio and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended June 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.6	$ 1,391	$ 182.47	$ 1,315	$ 172.48	94.5%	$ 76
Medicaid Expansion	2.1	786	383.07	689	335.26	87.5	97
ABD	1.2	1,285	1,053.89	1,245	1,020.85	96.9	40
Total Medicaid	10.9	3,462	317.79	3,249	298.10	93.8	213
MMP	0.1	361	2,217.44	333	2,050.20	92.5	28
Medicare	0.2	148	1,126.14	126	963.34	85.5	22
Total Medicare	0.3	509	1,730.91	459	1,565.65	90.5	50
Excluding Marketplace	11.2	3,971	354.87	3,708	331.36	93.4	263
Marketplace	2.8	769	267.37	783	272.37	101.9	(14)
	14.0	$ 4,740	$ 336.98	$ 4,491	$ 319.29	94.8%	$ 249

	Three Months Ended June 30, 2016						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.5	$ 1,302	$ 173.57	$ 1,202	$ 160.26	92.3%	$ 100
Medicaid Expansion	1.9	742	378.19	634	323.56	85.6	108
ABD	1.2	1,168	991.38	1,038	881.80	88.9	130
Total Medicaid	10.6	3,212	301.86	2,874	270.27	89.5	338
MMP	0.2	315	2,093.29	270	1,792.78	85.6	45
Medicare	0.2	129	997.44	127	974.30	97.7	2
Total Medicare	0.4	444	1,584.77	397	1,412.96	89.2	47
Excluding Marketplace	11.0	3,656	334.86	3,271	299.67	89.5	385
Marketplace	1.8	373	206.88	323	178.79	86.4	50
	12.8	$ 4,029	$ 316.72	$ 3,594	$ 282.54	89.2%	$ 435

	Six Months Ended June 30, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	15.3	$ 2,793	$ 182.58	$ 2,619	$ 171.25	93.8%	$ 174
Medicaid Expansion	4.1	1,603	390.88	1,378	335.88	85.9	225
ABD	2.4	2,481	1,030.68	2,375	986.54	95.7	106
Total Medicaid	21.8	6,877	315.39	6,372	292.22	92.7	505
MMP	0.3	705	2,152.75	640	1,954.15	90.8	65
Medicare	0.3	286	1,097.36	243	933.20	85.0	43
Total Medicare	0.6	991	1,685.72	883	1,502.36	89.1	108
Excluding Marketplace	22.4	7,868	351.35	7,255	323.98	92.2	613
Marketplace	5.7	1,520	264.77	1,347	234.62	88.6	173
	28.1	$ 9,388	$ 333.68	$ 8,602	$ 305.74	91.6%	$ 786

	Six Months Ended June 30, 2016						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	14.9	$ 2,626	$ 176.00	$ 2,400	$ 160.85	91.4%	$ 226
Medicaid Expansion	3.8	1,421	371.82	1,208	316.13	85.0	213
ABD	2.4	2,280	976.58	2,079	890.71	91.2	201
Total Medicaid	21.1	6,327	300.19	5,687	269.86	89.9	640
MMP	0.3	655	2,157.55	587	1,932.73	89.6	68
Medicare	0.3	260	1,013.04	251	977.35	96.5	9
Total Medicare	0.6	915	1,633.08	838	1,494.92	91.5	77
Excluding Marketplace	21.7	7,242	334.74	6,525	301.61	90.1	717
Marketplace	3.4	782	228.19	657	191.62	84.0	125
	25.1	$ 8,024	$ 320.17	$ 7,182	$ 286.57	89.5%	$ 842

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid: TANF/CHIP, Medicaid Expansion and ABD

The medical care ratios of the combined TANF/CHIP, Medicaid Expansion and ABD programs increased to 93.8% in the second quarter of 2017, from 89.5% in the second quarter of 2016.

As noted above, medical care costs recognized in the second quarter of 2017 for services delivered in 2016 were significantly in excess of what we usually experience for out-of-period claims development. Favorable run-out of our reported in "Medical claims and benefits payable" as of December 31, 2016, was $85 million less than our typical experience, and was reflected in higher medical care costs for the quarter. This development was most notable at our Florida, Illinois, New Mexico, and Puerto Rico health plans. Additionally, those same health plans experienced higher than expected current period medical care costs.

The medical care ratios of the combined TANF/CHIP, Medicaid Expansion and ABD programs increased to 92.7% in the six months ended June 30, 2017, from 89.9% in the six months ended June 30, 2016, primarily due to the reasons noted above for the increased medical care ratio in the second quarter of 2017.

MMP and Medicare

The medical care ratio for these programs, in the aggregate, increased in the second quarter of 2017 when compared with the second quarter of 2016. However, for the six months ended June 30, 2017, compared with the six months ended June 30, 2016, the aggregated medical care ratio for these two programs decreased.

Marketplace

The medical care ratio for the Marketplace program increased to 101.9% in the second quarter of 2017, from 86.4% in the second quarter of 2016.

The medical care ratio for the Marketplace program increased to 88.6% in the six months ended June 30, 2017, from 84.0% in the six months ended June 30, 2016.

In the second quarter of 2017, we recorded an increase to the premium deficiency reserve established for the Marketplace program. The reserve, which was $22 million at March 31, 2017, increased to $100 million as of June 30, 2017. In addition, we recorded $44 million for Marketplace changes in estimates, including risk transfer and cost sharing subsidies, related to 2016 service dates. Liabilities for risk transfer payments and cost sharing subsidies that were estimated at December 31, 2016 were finalized during the second quarter of 2017.

In the first half of 2016, adjustments related to 2015 dates of service reduced Marketplace pretax income by approximately $68 million.

Member months increased 68% in the second quarter of 2017, when compared with the second quarter of 2016, as a result of membership growth primarily in California, Florida and Texas.

FINANCIAL PERFORMANCE BY STATE

The ongoing poor performance at our Florida, Illinois, New Mexico and Puerto Rico health plans in 2017 all contributed to our disappointing financial performance in the second quarter of 2017. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR	Medical Margin
California	2.4	$ 679	$ 294.09	$ 606	$ 262.34	89.2%	$ 73
Florida	2.0	649	318.21	687	337.39	106.0	(38)
Illinois	0.5	149	289.51	174	336.76	116.3	(25)
Michigan	1.2	406	325.38	368	295.06	90.7	38
New Mexico	0.8	352	435.34	334	411.83	94.6	18
New York [1]	0.1	46	457.96	45	442.16	96.5	1
Ohio	1.0	553	527.14	516	490.75	93.1	37
Puerto Rico	0.9	179	184.28	189	194.42	105.5	(10)
South Carolina	0.4	111	326.57	102	304.14	93.1	9
Texas	1.4	701	495.93	602	426.41	86.0	99
Utah	0.5	130	258.10	129	255.00	98.8	1
Washington	2.4	662	279.21	595	251.16	90.0	67
Wisconsin	0.4	120	303.59	135	342.43	112.8	(15)
Other [2]	—	3	—	9	—	—	(6)
	14.0	$ 4,740	$ 336.98	$ 4,491	$ 319.29	94.8%	$ 249

	Three Months Ended June 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 554	$ 268.95	$ 493	$ 239.63	89.1%	$ 61
Florida	1.8	464	273.90	426	251.69	91.9	38
Illinois	0.6	154	256.17	137	227.71	88.9	17
Michigan	1.2	369	312.18	334	282.86	90.6	35
New Mexico	0.8	342	451.72	305	403.52	89.3	37
New York [1]	—	—	—	—	—	—	—
Ohio	1.0	483	473.91	433	424.87	89.7	50
Puerto Rico	1.0	170	169.04	175	173.49	102.6	(5)
South Carolina	0.3	87	277.22	71	226.27	81.6	16
Texas	1.1	635	571.14	499	448.23	78.5	136
Utah	0.5	110	240.26	106	233.12	97.0	4
Washington	2.1	559	264.40	500	236.32	89.4	59
Wisconsin	0.4	99	244.88	96	235.88	96.3	3
Other [2]	—	3	—	19	—	—	(16)
	12.8	$ 4,029	$ 316.72	$ 3,594	$ 282.54	89.2%	$ 435

	Six Months Ended June 30, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	4.6	$ 1,323	$ 290.56	$ 1,116	$ 245.02	84.3%	$ 207
Florida	4.1	1,305	317.53	1,245	303.09	95.5	60
Illinois	1.1	310	282.66	354	322.63	114.1	(44)
Michigan	2.5	799	321.10	707	284.24	88.5	92
New Mexico	1.6	682	421.11	652	402.27	95.5	30
New York [1]	0.2	92	449.48	87	425.72	94.7	5
Ohio	2.1	1,094	521.57	995	473.95	90.9	99
Puerto Rico	1.9	362	185.40	354	181.24	97.8	8
South Carolina	0.7	216	321.85	200	298.79	92.8	16
Texas	2.8	1,385	491.46	1,204	427.48	87.0	181
Utah	1.0	264	261.42	252	248.77	95.2	12
Washington	4.7	1,304	276.99	1,176	249.79	90.2	128
Wisconsin	0.8	247	307.50	243	302.95	98.5	4
Other [2]	—	5	—	17	—	—	(12)
	28.1	$ 9,388	$ 333.68	$ 8,602	$ 305.74	91.6%	$ 786

	Six Months Ended June 30, 2016						
	Member Months	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR	Medical Margin
California	4.0	$ 1,095	$ 271.14	$ 962	$ 238.30	87.9%	$ 133
Florida	3.4	953	284.53	839	250.58	88.1	114
Illinois	1.2	303	261.43	269	232.06	88.8	34
Michigan	2.4	756	316.18	681	285.13	90.2	75
New Mexico	1.5	678	450.62	601	399.17	88.6	77
New York (1)	—	—	—	—	—	—	—
Ohio	2.0	971	481.44	882	437.35	90.8	89
Puerto Rico	2.0	351	172.98	349	171.95	99.4	2
South Carolina	0.6	171	276.61	138	223.58	80.8	33
Texas	2.2	1,255	575.87	1,074	492.65	85.5	181
Utah	0.9	224	252.08	208	234.46	93.0	16
Washington	4.1	1,065	260.05	958	233.84	89.9	107
Wisconsin	0.8	196	247.57	188	236.92	95.7	8
Other (2)	—	6	—	33	—	—	(27)
	25.1	$ 8,024	$ 320.17	$ 7,182	$ 286.57	89.5%	$ 842

(1) The New York health plan was acquired on August 1, 2016.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

MEDICAL CARE COSTS BY TYPE

The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended June 30,					
	2017			2016		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 3,348	$ 238.04	74.5%	$ 2,620	$ 206.01	72.9%
Pharmacy	650	46.23	14.5	529	41.59	14.7
Capitation	356	25.29	7.9	304	23.87	8.5
Direct delivery	22	1.54	0.5	18	1.39	0.5
Other	115	8.19	2.6	123	9.68	3.4
	$ 4,491	$ 319.29	100.0%	$ 3,594	$ 282.54	100.0%

	Six Months Ended June 30,					
	2017			2016		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 6,434	$ 228.68	74.8%	$ 5,357	$ 213.77	74.6%
Pharmacy	1,266	45.00	14.7	1,054	42.05	14.7
Capitation	680	24.17	7.9	599	23.87	8.3
Direct delivery	44	1.56	0.5	34	1.36	0.5
Other	178	6.33	2.1	138	5.52	1.9
	$ 8,602	$ 305.74	100.0%	$ 7,182	$ 286.57	100.0%

PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.4% in the second quarter of 2017 compared with 2.6% in the second quarter of 2016 and 2.3% in the six months ended June 30, 2017, compared with 2.6% in the six months ended June 30, 2016. This decline was primarily due to the temporary suspension of a Michigan HMO use tax effective January 1, 2017 which was partially offset by a higher California premium tax rate effective July 1, 2016, and significant revenue growth at our Florida health plan, which operates in a state with no premium tax.

HEALTH INSURER FEE (HIF) REVENUE AND EXPENSES

The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there are no HIF revenues or expenses in 2017.

MOLINA MEDICAID SOLUTIONS

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs, including business processing, information technology development and administrative services.

FINANCIAL OVERVIEW

The Molina Medicaid Solutions segment service margin for the second quarter of 2017 and 2016 and for the six months ended June 30, 2017 and 2016 was insignificant.

OTHER

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Substantially all of Pathways' revenue is derived from contracts with state or local government agencies and government intermediaries, the majority of which are negotiated fee-for-service arrangements. A significant number of these contracts allow the payer to terminate the contract immediately with or without cause.

FINANCIAL OVERVIEW

The Other segment service margin for the second quarter of 2017 and 2016 and for the six months ended June 30, 2017 and 2016 was insignificant.

In the course of developing the Restructuring Plan, as discussed further in Notes to Consolidated Financial Statements, Note 11, "Restructuring and Separation Costs," we determined that future benefits to be derived from Pathways, including integration with our health plans, would be less than previously anticipated. In addition, poorer than expected year-to-date operating results and lower projections of operating results for periods in the near term led us to conclude that a triggering event for an interim impairment analysis had occurred in the second quarter of 2017.

For the Other segment in total, we recorded impairment charges of $61 million for goodwill and $11 million for intangible assets, or $72 million in the aggregate, reported in our consolidated statements of operations as "Impairment losses."

OTHER CONSOLIDATED INFORMATION

GENERAL AND ADMINISTRATIVE EXPENSES

The G&A ratio was 8.1% in both the second quarter of 2017 and 2016. The G&A ratio increased to 8.5% for the six months ended June 30, 2017, compared with 7.9% for the six months ended June 30, 2016. The year to date G&A ratio increased over 2016 primarily due to costs associated with increased Marketplace enrollment in 2017 and the reduction to revenue as a result of the 2017 Health Insurer Fee (HIF) moratorium.

DEPRECIATION AND AMORTIZATION

Depreciation and amortization, as a percentage of total revenue, was 0.8% in the six months ended June 30, 2017 and 2016.

IMPAIRMENT LOSSES

See Notes to Consolidated Financial Statements, Note 10, “Impairment Losses.”

RESTRUCTURING AND SEPARATION COSTS

See Notes to Consolidated Financial Statements, Note 11, “Restructuring and Separation Costs.”

INTEREST EXPENSE

Interest expense was $27 million for the second quarter of 2017, compared with $25 million for the second quarter of 2016. Interest expense increased to $53 million for the six months ended June 30, 2017, from $50 million for the six months ended June 30, 2016. Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $8 million and $7 million for second quarter of 2017 and 2016, respectively and $16 million and $15 million the six months ended June 30, 2017 and 2016, respectively. We expect interest expense to continue to increase in future periods as a result of our recent $330 million offering of 4.875% Notes. See further discussion in Notes to Consolidated Financial Statements, Note 7, “Debt.”

OTHER INCOME, NET

As described in Notes to Consolidated Financial Statements, Note 1, “Basis of Presentation,” in February 2017, we received an aggregate termination fee of $75 million for the Terminated Medicare Acquisition. This amount is reported in “Other income, net” in our consolidated statements of operations.

INCOME TAXES

The (benefit) provision for income taxes was recorded at an effective rate of 26.8% for the second quarter of 2017, compared with 59.8% for the second quarter of 2016, and an effective rate of 16.0% for the six months ended June 30, 2017 compared with 60.7% for the six months ended June 30, 2016. The significant change in the effective tax rate was primarily a result of pretax losses in 2017 combined with significant nondeductible expenses (primarily, compensation and goodwill impairment) and the 2017 HIF moratorium as described above in “Health Plans—Health Insurer Fee (HIF) Revenue and Expenses.”

LIQUIDITY AND FINANCIAL CONDITION

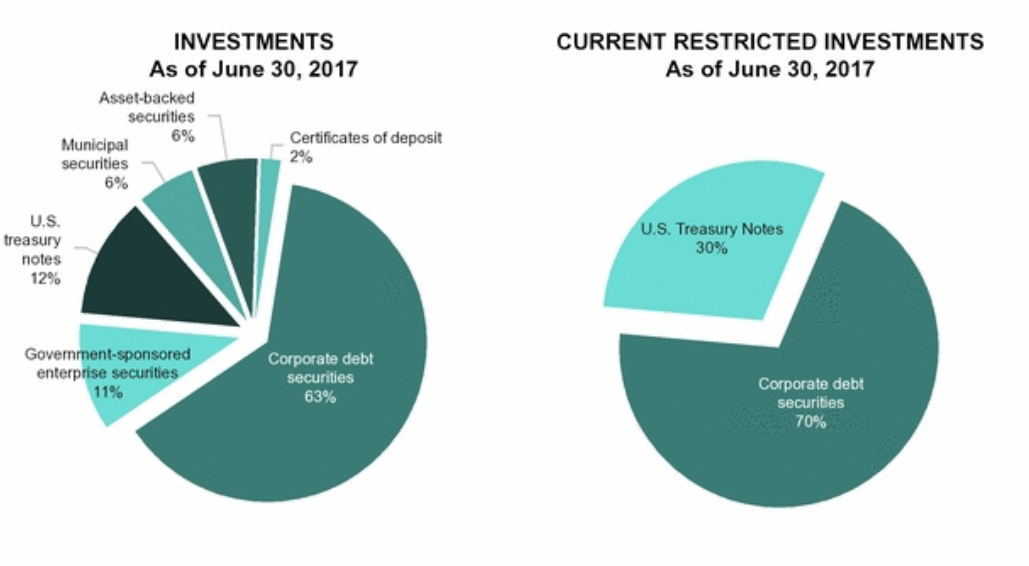
INTRODUCTION

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our Health Plans segment regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest

cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

Our investments are classified as current assets, except for our held-to-maturity restricted investments, which are classified as non-current assets, and which are not included in the totals below. Our held-to-maturity restricted investments are invested principally in certificates of deposit and U.S. treasury securities.



Investment income increased to $22 million for the six months ended June 30, 2017, compared with $16 million for the six months ended June 30, 2016, primarily due to the increase in invested assets.

MARKET RISK

Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2017, the fair value of our fixed income investments would decrease by approximately $27 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of June 30, 2017, no amounts were outstanding under the Credit Facility.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Six Months Ended June 30,		
	2017	2016	Change
	(In millions)		
Net cash provided by operating activities	$ 672	$ 278	$ 394
Net cash used in investing activities	(845)	(273)	(572)
Net cash provided by financing activities	333	11	322
Net increase in cash and cash equivalents	$ 160	$ 16	$ 144

Operating Activities

Cash provided by operating activities increased $394 million in the six months ended June 30, 2017 compared with the six months ended June 30, 2016. The change in net (loss) income, plus the effect of adjustments to reconcile net loss to net cash provided by operating activities, reduced cash provided by operating activities by $195 million. This change was more than offset by the aggregate of the following changes:

Receivables and deferred revenue. In 2017, the aggregate change in receivables and deferred revenue increased cash flows from operations by $470 million. Cash flows from operations in each period were impacted by the timing of premium revenues receipts. In general, state or federal payors may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, state or federal payors may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in a any given period. In 2017, the year-over-year effect of the timing of premiums received at our California, Florida, Michigan, Ohio, Texas and Washington health plans positively impacted our cash flows from operating activities.

Amounts due government agencies. In 2017, the change in amounts due government agencies increased cash flows from operations by $133 million, due primarily to additional accruals for ACA Marketplace risk transfer payments.

Accounts payable and accrued liabilities. In 2017, the change in accounts payable and accrued liabilities decreased cash flows from operations by $165 million. In 2016, accounts payable and accrued liabilities increased $147 million, primarily due to the HIF payable at June 30, 2016. As of June 30, 2017, there is no comparable accrual because of the HIF moratorium.

Investing Activities

Net cash used in investing activities increased $572 million in the six months ended June 30, 2017 compared with the six months ended June 30, 2016, primarily due to higher purchases of investments, net of sales and maturities, in the current year.

Financing Activities

Net cash provided by financing activities increased $322 million in the six months ended June 30, 2017 compared with the six months ended June 30, 2016, due to proceeds received from the 4.875% Notes offering.

FINANCIAL CONDITION

We believe that our cash resources, combined with borrowing capacity available under our Credit Facility, as discussed further below in "*Future Sources and Uses of Liquidity — Sources*", and internally generated funds will be sufficient to support costs under the Restructuring Plan, operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at June 30, 2017, our working capital was $1,376 million, compared with $1,418 million at December 31, 2016. At June 30, 2017, our cash and investments amounted to $5,616 million, compared with $4,689 million at December 31, 2016.

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "Ba3" by Moody's Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

Financial Covenants. Our Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio, as follows:

Credit Facility Financial Covenants	Required Per Agreement	As of June 30, 2017
Net leverage ratio	<4.0x	3.3x
Interest coverage ratio	>3.5x	4.5x

In addition, the terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures. As of June 30, 2017, we were in compliance with all covenants under the Credit Facility.

FUTURE SOURCES AND USES OF LIQUIDITY

Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. In the six months ended June 30, 2017 and 2016, we received $120 million and $50 million, respectively, in dividends from our regulated health plan subsidiaries. See further discussion in Notes to Consolidated Financial Statements, Note 13, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

Restructuring Plan. In total, we estimate that the Restructuring Plan will reduce annualized run-rate expenses by approximately $300 million to $400 million upon its completion in late 2018. $200 million of these run-rate reductions, which are a result of staff reductions, will be in place by December 2017, and therefore will fully contribute to our 2018 results. Since the close of the second quarter, we have already achieved $55 million of our annualized run-rate reduction target as a result of staff reductions taken on July 27th. All savings targets discussed in regards to the Restructuring Plan represent annualized run-rate savings that we expect to achieve during the year following the indicated implementation date. One-time costs associated with the Restructuring Plan are expected to exceed the benefits realized in 2017 due to the upfront payment of implementation costs and the delayed benefit of full savings until the beginning of 2018. We expect the cost savings to reduce both “General and administrative expenses” and “Medical care costs” reported on our consolidated statements of operations.

The following table illustrates our estimates of run-rate savings associated with the Restructuring Plan. Such savings will be offset, through the end of 2018, by the costs noted below in “*Future Sources and Uses of Liquidity—Uses*.” Following 2018, the savings will be offset by approximately $20 million in run-rate expenses resulting from the implementation of Restructuring Plan initiatives.

Estimated Savings Expected to be Realized by Reportable Segment	Health Plans	Other	Total
		(In millions)	
General and administrative expenses	$50	$120 to $140	$170 to $190
Medical care costs	$110 to $190	$20	$130 to $210
	$160 to $240	$140 to $160	$300 to $400

Credit Facility. Refer to Notes to Consolidated Financial Statements, Note 7, “Debt,” for a detailed discussion of our Credit Facility. We intend to borrow approximately $300 million under the Credit Facility in early August 2017.

4.875% Notes. The 4.875% Notes contain a limitation on the use of proceeds which required us to deposit the net proceeds from their issuance into a segregated deposit account, a current asset reported as “Restricted investments” in our consolidated balance sheets. See further discussion in Notes to Consolidated Financial Statements, Note 7, “Debt.”

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more

offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Uses

Restructuring. We estimate that total pre-tax costs associated with the Restructuring Plan will be approximately $130 million to $150 million for the second half of 2017, with an additional $40 million to be incurred in 2018. The costs we incur associated with the Restructuring Plan will be reported in "Restructuring and separation costs" in our consolidated statements of operations.

Estimated Costs Expected to be Incurred by Reportable Segment	Health Plans	Other	Total
		(In millions)	
Separation costs–one-time benefit arrangement for a workforce reduction	$25 to $30	$35 to $40	$60 to $70
Other restructuring costs	$55 to $60	$55 to $60	$110 to $120
	$80 to $90	$90 to $100	$170 to $190

Regulatory Capital Requirements and Dividend Restrictions. For more information on our regulatory capital requirements and dividend restrictions, refer to Notes to Consolidated Financial Statements, Note 13, "Commitments and Contingencies."

States' Budgets. From time to time the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. Until July 4, 2017, the state of Illinois operated without a budget for its current fiscal year. As of June 30, 2017, our Illinois health plan served approximately 163,000 members, and recognized premium revenue of approximately $310 million in the first half of 2017. As of July 28, 2017, the state of Illinois owed us approximately $116 million for certain March, April, May and June 2017 premiums.

On May 3, 2017, Puerto Rico's financial oversight board filed for a form of bankruptcy in the U.S. District Court in Puerto Rico under Title III of PROMESA. The Title III provision allows for a court debt restructuring process similar to U.S. bankruptcy protection. To the extent such bankruptcy results in our failure to receive payment of amounts due under our Medicaid contract with the Commonwealth or the inability of the Commonwealth to extend our Medicaid contract at the end of its current term, such bankruptcy could have a material adverse effect on our business, financial condition, cash flows, or results of operations. As of June 30, 2017, the plan served approximately 322,000 members and recorded premium revenue of approximately $362 million in the first half of 2017. As of July 28, 2017, the Commonwealth was current with its premium payments.

Convertible Notes. We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Convertible Notes. We also have outstanding $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Convertible Notes. We refer to the 1.125% Convertible Notes and 1.625% Convertible Notes collectively as the Convertible Notes. The 1.125% Convertible Notes are convertible entirely to cash, and the 1.625% Convertible Notes are convertible partially to cash, each prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended June 30, 2017; therefore, they are convertible into cash and are reported in current portion of long-term debt as of June 30, 2017.

The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended June 30, 2017. On contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of this conversion feature, the 1.625% Convertible Notes are reported in current portion of long-term debt as of June 30, 2017. As noted above, because the proceeds from the 4.875% Notes are initially restricted to payments upon conversion or redemption of the 1.625% Convertible Notes, such restricted investments are also classified as current in the accompanying consolidated balance sheets.

For economic reasons related to the trading market for our Convertible Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our Convertible Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our Convertible Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our Convertible Notes may elect to convert the notes to cash.

We currently have sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2016, was disclosed in our 2016 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the six months ended June 30, 2017. For additional information regarding our long-term debt, including maturity dates, refer to Notes to Consolidated Financial Statements, Note 7, “Debt.”

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, “Medical Claims and Benefits Payable,” for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the six months ended June 30, 2017, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2016.

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Molina Medicaid Solutions segment revenue and cost recognition*. There have been no significant changes during the six months ended June 30, 2017, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2016.

- *Goodwill and intangible assets, net.* Please refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies,” regarding our adoption of Accounting Standards Update No. 2017-04 as of June 30, 2017, which has simplified the test for goodwill impairment. We recorded impairment charges of $61 million for goodwill and $11 million for intangible assets, or $72 million in the aggregate, reported in the accompanying consolidated statements of operations as “Impairment losses.” At June 30, 2017, goodwill and intangible assets, net, represented approximately 8% of total assets and 44% of total stockholders’ equity, compared with 10% and 46%, respectively, at December 31, 2016. Refer to Notes to Consolidated Financial Statements, Note 10, “Impairment Losses.”

SUPPLEMENTAL INFORMATION

FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

EBITDA*

We believe that earnings before interest, taxes, depreciation and amortization (EBITDA*) is helpful in assessing our ability to meet the cash demands of our operating units.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
	(In millions)			
Net (loss) income	$ (230)	$ 33	$ (153)	$ 57
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	44	39	90	76
Interest expense	27	25	53	50
Income tax (benefit) expense	(84)	47	(30)	87
EBITDA*	$ (243)	$ 144	$ (40)	$ 270

ADJUSTED NET (LOSS) INCOME* AND ADJUSTED NET (LOSS) INCOME PER SHARE*

We believe that adjusted net (loss) income* and adjusted net (loss) income per diluted share* are helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net (loss) income*.

	Three Months Ended June 30,				Six Months Ended June 30,			
	2017		2016		2017		2016	
	(In millions, except diluted per-share amounts)							
Net (loss) income	$ (230)	$ (4.10)	$ 33	$ 0.58	$ (153)	$ (2.74)	$ 57	$ 1.01
Adjustment:								
Amortization of intangible assets	8	0.14	8	0.14	17	0.30	15	0.27
Income tax effect [1]	(3)	(0.05)	(3)	(0.05)	(6)	(0.11)	(5)	(0.10)
Amortization of intangible assets, net of tax effect	5	0.09	5	0.09	11	0.19	10	0.17
Adjusted net (loss) income*	$ (225)	$ (4.01)	$ 38	$ 0.67	$ (142)	$ (2.55)	$ 67	$ 1.18

(1) Income tax effect of adjustments calculated at the blended federal and state statutory tax rate of 37%.

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our interim chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), were not effective at the reasonable assurance level because of the material weakness in our internal control over financial reporting described below. Notwithstanding the material weakness described below, management has concluded that our consolidated financial statements included in this interim report on Form 10-Q are fairly stated in all material

respects in accordance with U.S. generally accepted accounting principles (GAAP) for each of the periods presented herein.

Existence of a Material Weakness in Internal Control as of December 31, 2016

As disclosed in our Annual Report on Form 10-K for the year ended December 31, 2016, our management assessed the effectiveness of our internal control over financial reporting as of December 31, 2016, based on the framework set forth in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

We determined that a material weakness existed in our internal control over financial reporting relating to the operation of an element of our process for calculating the amount owed to California by our California health plan. More specifically, a Medicaid Expansion contract amendment executed in the fourth quarter of 2016 changed the medical loss ratio corridor formula and such amendment was not initially considered in determining the liability. As a result, we understated net income by $44 million for the year ended December 31, 2016, which was material to our consolidated results for the year ended December 31, 2016. This amount was corrected prior to the issuance of our consolidated financial statements as of and for the year ended December 31, 2016.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of December 31, 2016, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

Remediation Plan for Material Weakness

We are executing the remediation plan developed to address the material weakness reported as of December 31, 2016. The remediation efforts we have implemented include the development of robust protocols to ensure that the control, relating to the review of a contractual amendment affecting the computation of the Medicaid Expansion medical loss ratio corridor for our California health plan, is operating as designed. We believe these measures will remediate the material weakness identified above and will strengthen our internal control over financial reporting for the computation of our California Medicaid Expansion medical loss ratio corridor. We currently are targeting to complete the implementation of the control enhancements during 2017. We will test the ongoing operating effectiveness of the control enhancements subsequent to implementation, and consider the material weakness remediated after the applicable remedial control enhancements operate effectively for a sufficient period of time. If the remedial measures described above are insufficient to address the material weakness described above, or are not implemented timely, or additional deficiencies arise in the future, material misstatements in our interim or annual financial statements may occur in the future and could have the effects described in “Risk Factors” in our Annual Report on Form 10-K for the year ended December 31, 2016.

Changes in Internal Control Over Financial Reporting: Except as described above, management did not identify any change in our internal control over financial reporting during the fiscal quarter ended June 30, 2017 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 13, “Commitments and Contingencies.”

RISK FACTORS

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in “Risk Factors,” in our Annual Report on Form 10-K for the year ended December 31, 2016 and our Quarterly Report on Form 10-Q for the quarter ended March 31, 2017. The risk factors described herein, and in our 2016 Annual Report on Form 10-K and our Quarterly Report on Form 10-Q for the quarter ended March 31, 2017, are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

The Restructuring Plan may be disruptive, and we may not fully realize the anticipated benefits.

As discussed herein, we recently initiated a comprehensive Restructuring Plan to improve our profitability and operational efficiency. As part of that Restructuring Plan, we are re-designing core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology. We are also streamlining our organization structure, including eliminating redundant layers of management. Finally, we are reducing our workforce by approximately 10%, or 1,400 full-time-equivalent positions. While we expect to benefit from the implementation of the Restructuring Plan, estimates of cost savings are inherently uncertain, and we may not be able to achieve these cost savings, or the expected operating efficiencies, within the periods we have projected, or at all. Restructuring activities may also result in a loss of continuity or institutional knowledge, inefficiency, depressed employee morale, and litigation during transitional periods and thereafter. Internal restructurings can also require a significant amount of time and focus from management and other employees, which may divert attention from our ongoing business operations. In addition, our implementation of the Restructuring Plan will require significant upfront costs. Our estimate of the costs necessary to achieve the cost savings we have identified may prove to be inaccurate, and any increase in such costs may affect our ability to achieve our anticipated cost savings within the period we have projected, or at all. If the Restructuring Plan fails to achieve all of the anticipated benefits, our business, financial condition, cash flows, or results of operations could be materially and adversely affected.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2016, the carrying amounts of goodwill and intangible assets, net, amounted to $620 million, and $140 million, respectively. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives. For the reasons described below, as of June 30, 2017 the carrying amounts of goodwill and intangible assets, net, had declined to $559 million, and $112 million, respectively.

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is subject to an annual impairment test. We are required to test at least annually for impairment, or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. We estimate the fair values of our reporting units using discounted cash flows.

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets.

In the discounted cash flow analyses, we must make assumptions about a wide variety of internal and external factors, and consider the price that would be received to sell the reporting unit as a whole in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free

cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. If these assumptions differ from actual results, the outcome of our impairment tests could be adversely affected.

Based on our impairment tests, we recorded $72 million in non-cash impairment losses for goodwill and intangibles, primarily relating to our Pathways subsidiary. In the course of developing our restructuring and profitability improvement plan, we determined that future benefits to be derived from Pathways (including integration with our health plans) will be less than previously anticipated.

We cannot accurately predict the amount and timing of any future impairment charges. Additional events could occur that would cause us to further revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net. For example, if the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states. If such state health plans have recorded goodwill and intangible assets, net, the contract loss could result in a non-cash impairment charge. Additionally, if we are unable to procure new state MMIS contracts, the outcome of our goodwill impairment tests could be adversely affected and result in a non-cash impairment charge. Such a non-cash impairment charge could have a material adverse impact on our financial results.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended June 30, 2017, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
April 1 - April 30	12,389	$ 45.60	—	$ —
May 1 - May 31	223,661	$ 62.45	—	$ —
June 1 - June 30	—	$ —	—	$ —
Total	236,050	$ 61.56	—	

(1) During the three months ended June 30, 2017, we withheld 236,050 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

INDEX TO EXHIBITS

Exhibit No.	Title
4.1	Indenture, dated June 6, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee. Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
4.2	Form of 4.875% Senior Notes due 2025. Included in Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
4.3	Form of Guarantees in connection with Indenture dated June 6, 2017. Included in Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017.
10.1	Third Amendment to Credit Agreement dated as of May 19, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacities as Administrative Agent, Issuing Bank and Swingline Lender. Filed as Exhibit 10.1 to registrant's Form 8-K filed May 22, 2017.
10.2	Amended and Restated Employment Agreement with Joseph W. White, dated June 5, 2017, and effective as of May 2, 2017. Filed as Exhibit 10.1 to registrant's Form 8-K filed June 7, 2017.
10.3	Waiver and Release Agreement, dated June 24, 2017, by and between J. Mario Molina and Molina Healthcare, Inc. Filed as Exhibit 10. 1 to registrant's Form 8-K filed June 28, 2017.
10.4	Waiver and Release Agreement, dated June 26, 2017, by and between John Molina and Molina Healthcare, Inc. Filed as Exhibit 10.2 to registrant's Form 8-K filed June 28, 2017.
10.5	Purchase Agreement, dated May 22, 2017, by and among the Company, the guarantors party thereto and SunTrust Robinson Humphrey, Inc., as representative of the several initial purchasers named in Schedule A thereto. Filed as Exhibit 1.1 to registrant's Form 8-K filed May 23, 2017.
31.1	Certification of Interim Chief Executive Officer and Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Interim Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: August 2, 2017

/s/ JOSEPH W. WHITE

Joseph W. White
Interim Chief Executive Officer
(Principal Executive Officer)

Dated: August 2, 2017

/s/ JOSEPH W. WHITE

Joseph W. White
Chief Financial Officer and Treasurer
(Principal Financial Officer)

MOLINA HEALTHCARE, INC.

THE GUARANTORS PARTY HERETO

$330,000,000

4.875% Senior Notes due 2025

INDENTURE

Dated as of June 6, 2017

U.S. BANK NATIONAL ASSOCIATION

as Trustee

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INDENTURE

This INDENTURE dated as of June 6, 2017, is by and among Molina Healthcare, Inc., a Delaware corporation (the "***Company***"), the Guarantors (as defined herein) party hereto from time to time and U.S. Bank National Association, a national banking association, as trustee (the "***Trustee***").

RECITALS OF THE COMPANY

A. The Company has duly authorized the execution and delivery of this Indenture to provide for the issuance of 4.875% Senior Notes due 2025 issued on the date hereof (the "***Initial Notes***").

B. All things and acts necessary to make this Indenture the legal, valid and binding obligation of the Company have been done.

RECITALS OF THE GUARANTORS

A. Each of the Guarantors is a Subsidiary of the Company and desires to make the Subsidiary Guarantees provided for herein.

B. All things and acts necessary to make this Indenture the legal, valid and binding obligation of each of the Guarantors have been done.

NOW, THEREFORE, THIS INDENTURE WITNESSETH:

For, and in consideration of the premises and the purchase of the Notes by the Holders (as defined herein) thereof, the Company, the Guarantors and the Trustee mutually covenant and agree, for the equal and ratable benefit of the Holders of the Notes, as follows:

ARTICLE 1

DEFINITIONS AND INCORPORATION BY REFERENCE

Section 1.01 Definitions.

For all purposes of this Indenture, except as otherwise expressly provided or unless the context otherwise requires:

"***Additional Notes***" means any additional 4.875% Senior Notes due 2025 issued from time to time after the Issue Date under the terms of this Indenture other than pursuant to Sections 2.08, 2.09, 2.12, 3.06 or 9.05 of this Indenture.

"***Affiliate***" of any specified Person means any other Person directly or indirectly controlling or controlled by or under direct or indirect common control with such specified Person. For purposes of this definition, "***control***," as used with respect to any Person, means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of such Person, whether through the ownership of voting securities, by agreement or otherwise. For purposes of this definition, the terms "***controlling***," "***controlled by***" and "***under common control with***" have correlative meanings.

"***Agent***" means any Note Registrar, co-registrar, Paying Agent or additional paying agent.

"***Appendix***" has the meaning specified in Section 2.01 of this Indenture.

"***Applicable Premium***" means the greater of:

(1) 1.0% of the principal amount of the Notes being redeemed; or

(2) the excess of:

(a) the present value at such Redemption Date of (i) the Redemption Price of the Notes at June 15, 2020 *plus* (ii) all remaining required interest payments due on the Notes through, but not including, June 15, 2020 (excluding accrued but unpaid interest to the Redemption Date), computed using a discount rate equal to the Treasury Rate as of such Redemption Date *plus* 50 basis points; over

(b) the then outstanding principal amount of the Notes.

The Company shall calculate or cause the Applicable Premium to be calculated.

"***Applicable Procedures***" means, with respect to any transfer, redemption or exchange of or for beneficial interests in any Global Note, the rules and procedures of the Depositary that apply to such transfer, redemption or exchange.

"***Attributable Debt***" means, as of any date upon which a determination of the amount thereof shall be computed, as of any particular time, the present value, calculated using a rate of interest implicit in such transaction determined in accordance with GAAP, of the obligation of a lessee for rental payments during the remaining term of any lease (including any period for which such lease has been extended or may, at the option of the lessor, be extended).

"***Bankruptcy Law***" means Title 11, U.S. Code or any similar federal or state law for the relief of debtors, or the law of any other jurisdiction relating to bankruptcy, insolvency, winding up, liquidation, reorganization or relief of debtors.

"***Beneficial Owner***" has the meaning assigned to such term in Rule 13d-3 and Rule 13d-5 under the Exchange Act, except that in calculating the beneficial ownership of any particular "person" (as that term is used in Section 13(d)(3) of the Exchange Act), such "person" will be deemed to have beneficial ownership of all securities that such "person" has the right to acquire by conversion or exercise of other securities, whether such right is currently exercisable or is exercisable only upon the occurrence of a subsequent condition.

"***Board of Directors***" means:

(1) with respect to a corporation, the board of directors of the corporation or any committee thereof duly authorized to act on behalf of such board;

(2) with respect to a partnership, the Board of Directors of the general partner of the partnership;

(3) with respect to a limited liability company, the managing member or members or any controlling committee or managing members thereof; and

(4) with respect to any other Person, the board or committee of such Person serving a similar function.

"***Board Resolution***" of a Person means a copy of a resolution certified by the secretary or an assistant secretary (or individual performing comparable duties) of the applicable Person to have been duly adopted by the Board of Directors of such Person and to be in full force and effect on the date of such certification, and delivered to the Trustee.

"***Business Day***" means any day other than a Legal Holiday.

"***Capital Lease Obligation***" means, at the time any determination is to be made, the amount of the liability in respect of a capital lease that would at that time be required to be capitalized on a balance sheet in accordance with GAAP as in effect on the date of this Indenture. In the event of a change under GAAP (or the application thereof) requiring all leases to be capitalized, only those leases that would result or would have resulted in Capital Lease Obligations on the date of this Indenture (assuming for purposes hereof that they were in existence on the date of this Indenture) shall be considered Capital Lease Obligations and all calculations and deliverables under this Indenture shall be made in accordance therewith.

"***Capital Stock***" means:

(1) in the case of a corporation, corporate stock;

(2) in the case of an association or business entity, any and all shares, interests, participations, rights or other equivalents (however designated) of corporate stock;

(3) in the case of a partnership or limited liability company, partnership or membership interests (whether general or limited); and

(4) any other interest or participation that confers on a Person the right to receive a share of the profits and losses of, or distributions of assets of, the issuing Person.

"***Cash Equivalents***" means:

(1) United States dollars;

(2) securities issued or directly and fully guaranteed or insured by the United States government or any agency or instrumentality of the United States government (*provided* that the full faith and credit of the United States is pledged in support of those securities) having maturities of not more than 24 months from the date of acquisition;

(3) certificates of deposit and Eurodollar time deposits with maturities of 12 months or less from the date of acquisition, bankers' acceptances with maturities not exceeding 12 months and overnight bank deposits, in each case, with any lender party to the Credit Agreement or with any domestic commercial bank having capital and surplus in excess of $250.0 million;

(4) repurchase obligations with a term of not more than thirty days for underlying securities of the types described in clauses (2) and (3) above entered into with any financial institution meeting the qualifications specified in clause (3) above;

(5) commercial paper rated at least A1 by S&P or at least P1 by Moody's (or reasonably equivalent ratings of another internationally recognized ratings agency) and in each case maturing within 12 months after the date of acquisition;

(6) readily marketable direct obligations issued by any state of the United States or any political subdivision with a rating of AA or higher from S&P or Aa3 or higher from Moody's (or reasonably equivalent ratings of another internationally recognized ratings agency) with maturities of 24 months or less from the date of acquisition;

(7) Indebtedness issued by Persons with a rating of A or higher from S&P or A2 or higher from Moody's (or reasonably equivalent ratings of another internationally recognized ratings agency) in each case with maturities not exceeding 24 months from the date of acquisition; and

(8) money market funds substantially all of the assets of which constitute Cash Equivalents of the kinds described in clauses (1) through (7) of this definition.

"***Change of Control***" means the occurrence of any of the following:

(1) the direct or indirect sale, transfer, conveyance or other disposition (other than by way of merger or consolidation), in one or a series of related transactions, of all or substantially all of the properties or assets of the Company and its Consolidated Subsidiaries, taken as a whole, to any "person" or "group" (as such terms are used in Sections 13(d) and 14(d) of the Exchange Act);

(2) the consummation of any transaction (including, without limitation, any merger or consolidation) the result of which is that any "person" or "group" (as defined above) becomes the Beneficial Owner, directly or indirectly, of more than 50% of the Voting Stock of the Company, measured by voting power rather than number of shares; or

(3) the approval by the holders of Capital Stock of the Company of any plan or proposal for the liquidation or dissolution of the Company (whether or not otherwise in compliance with the provisions of this Indenture).

Notwithstanding the foregoing, a transaction will not be deemed to involve a Change of Control under clause (2) above if (i) the Company becomes a direct or indirect Wholly Owned Subsidiary of a holding company and (ii) the direct or indirect holders of the Voting Stock of such holding company immediately following that transaction are substantially the same as the holders of the Company's Voting Stock immediately prior to that transaction.

"***Code***" means the U.S. Internal Revenue Code of 1986, as amended.

"***Company***" means Molina Healthcare, Inc., a Delaware corporation, and any successor thereto.

"***Company Order***" means a written order signed in the name of the Company by an Officer and delivered to the Trustee or, with respect to Sections 2.02, 2.09, 2.12 and 9.05, any other employee of the Company named in an Officer's Certificate delivered to the Trustee.

"***Consolidated Subsidiary***" means a Subsidiary of the Company, the accounts of which are consolidated with those of the Company in accordance with GAAP.

"***Consolidated Total Assets***" means, as of the most recent balance sheet date referenced in the financial statements that have been filed with the SEC or delivered in accordance with Section 4.09 immediately preceding the date on which any determination is being made, the total assets of the Company and its Consolidated Subsidiaries calculated in accordance with GAAP.

"***Corporate Trust Office of the Trustee***" shall be at the address of the Trustee specified in Section 12.02 hereof, or such other address as to which the Trustee may give notice to the Company.

"***Credit Agreement***" means that certain Credit Agreement, dated as of June 12, 2015, by and among the Company, the other loan parties party thereto, the lenders party thereto and SunTrust Bank, as administrative agent, including any related notes, guarantees, collateral documents, instruments and agreements executed in connection therewith, and, in each case, as amended, restated, modified, renewed, refunded, replaced (whether upon or after termination or otherwise) or refinanced (including by means of sales of debt securities to institutional investors) in whole or in part from time to time.

"***Credit Facilities***" means one or more debt facilities or agreements (including, without limitation, the Credit Agreement), note purchase agreements, indentures or commercial paper facilities, in each case with banks or other institutional lenders or investors providing for revolving credit loans, term loans, receivables financing (including through the sale of receivables to such lenders or to special purpose entities formed to borrow from such lenders against such receivables), debt securities or letters of credit, in each case, as amended, restated, modified, renewed, refunded, replaced or refinanced (including any agreement to extend the maturity thereof and adding additional borrowers or guarantors and by means of sales of debt securities to institutional investors) in whole or in part from time to time under the same or any other agent, lender or group of lenders, underwriter or group of underwriters and including increasing the amount of available borrowings thereunder.

"***Custodian***" means, with respect to the Notes issuable or issued in whole or in part in global form, the Person specified in Section 2.05 as Custodian with respect to the Notes, and any and all successors thereto appointed as custodian hereunder and having become such pursuant to the applicable provisions of this Indenture.

"***Default***" means any event that is, or with the passage of time or the giving of notice or both would be, an Event of Default.

"***Definitive Note***" means a certificated Note registered in the name of the Holder thereof and issued in accordance with Sections 2.08 or 2.12 hereof, in substantially the form of Exhibit 1 to the Appendix (as defined herein) except that such Note shall not bear the Global Note legend set forth in Exhibit 1 to the Appendix and shall not have the "Schedule of Exchanges of Interests in Global Note" attached thereto.

"***Depositary***" means, with respect to the Notes issuable or issued in whole or in part in global form, the Person specified in Section 2.05 hereof as the Depositary with respect to the Notes, and any and all successors thereto appointed as Depositary hereunder and having become such pursuant to the applicable provisions of this Indenture.

"***Disqualified Stock***" means any Capital Stock that, by its terms (or by the terms of any security into which it is convertible, or for which it is exchangeable, in each case at the option of the holder of the Capital Stock), or upon the happening of any event, matures or is mandatorily redeemable, pursuant to a sinking fund obligation or otherwise, or redeemable at the option of the holder of the Capital Stock, in whole or in part, on or prior to the date that is 91 days after the date on which the Notes mature; *provided*,

however, that only the portion of Capital Stock which so matures or is mandatorily redeemable, is so convertible or exchangeable at the option of the holder thereof or is so redeemable at the option of the holder thereof prior to such date shall be deemed to be Disqualified Stock; *provided*, *further*, *however*, that if such Capital Stock is issued to any employee or to any plan for the benefit of employees of the Company or its Subsidiaries or by any such plan to such employees, such Capital Stock shall not constitute Disqualified Stock solely because it may be required to be repurchased by the Company in order to satisfy applicable statutory or regulatory obligations or as a result of such employee's termination, death or disability; *provided*, *further*, that any class of Capital Stock of such Person that by its terms authorizes such Person to satisfy its obligations thereunder by delivery of Capital Stock that is not Disqualified Stock shall not be deemed to be Disqualified Stock.

"***dollars***" and the sign "***$***" mean the lawful money of the United States of America.

"***Equity Interests***" means Capital Stock and all warrants, options or other rights to acquire Capital Stock (but excluding any debt security that is convertible into, or exchangeable for, Capital Stock).

"***Equity Offering***" means (i) a public or private sale of Capital Stock (other than Disqualified Stock) of the Company or (ii) a public or private sale of Capital Stock (other than Disqualified Stock) of a direct or indirect parent entity of the Company (to the extent the net proceeds therefrom are contributed to the common equity capital of the Company), in each case, other than to a Subsidiary of the Company or pursuant to a registration statement on Form S-8 (or any successor form) under the Securities Act or any similar offering in any other jurisdiction or otherwise issuable under any employee benefit plan of the Company or such parent entity of the Company, as the case may be.

"***Exchange Act***" means the Securities Exchange Act of 1934, as amended.

"***Funded Debt***" means all indebtedness for the repayment of money borrowed, whether or not evidenced by a bond, debenture, note or similar instrument or agreement, having a final maturity of more than 12 months after the date of its creation or having a final maturity of less than 12 months after the date of its creation but by its terms being renewable or extendable beyond 12 months after such date at the option of the borrower. For the purpose of determining "***Funded Debt***" of any Person, there shall be excluded any particular indebtedness if, on or prior to the final maturity thereof, there shall have been deposited with the proper depositary in trust the necessary funds for the payment, redemption or satisfaction of such indebtedness.

"***GAAP***" means generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board of the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or in such other statements by such other entity as have been approved by a significant segment of the accounting profession, which are in effect from time to time.

"***Global Note***" has the meaning specified in the Appendix.

"***Government Securities***" means securities that are:

(1) direct obligations of the United States of America for the timely payment of which its full faith and credit is pledged; or

(2) obligations of a Person controlled or supervised by and acting as an agency or instrumentality of the United States of America or a member of the European Union, the timely

payment of which is unconditionally guaranteed as a full faith and credit obligation by the United States of America, which, in each case, are not callable or redeemable at the option of the issuer thereof, and shall also include a depository receipt issued by a bank (as defined in Section 3(a)(2) of the Securities Act) as custodian with respect to any such Government Securities or a specific payment of principal of or interest on any such Government Securities held by such custodian for the account of the holder of such depository receipt; *provided, however*, that (except as required by law) such custodian is not authorized to make any deduction from the amount payable to the holder of such depository receipt from any amount received by the custodian in respect of the Government Securities or the specific payment of principal of or interest on the Government Securities evidenced by such depository receipt.

"***Guarantee***" means a guarantee other than by endorsement of negotiable instruments for collection in the ordinary course of business, direct or indirect, in any manner, including, without limitation, by way of a pledge of assets or through letters of credit or reimbursement agreements in respect thereof, of all or any part of any Indebtedness. The terms "***Guaranteed***" and "***Guarantees***" have a corresponding meaning.

"***Guarantor***" means any Subsidiary that executes a Subsidiary Guarantee in accordance with the provisions of this Indenture and its respective successors and assigns.

"***Hedging Obligations***" means, with respect to the Company or any of its Consolidated Subsidiaries, the obligations of such Person under (a) interest rate swap agreements (whether from fixed to floating or from floating to fixed), interest rate cap agreements and interest rate collar agreements, (b) other agreements or arrangements designed to manage interest rates or interest rate risk and (c) other agreements or arrangements designed to protect such Person against fluctuations in currency exchange rates or commodity prices.

"***Holder***" means a Person in whose name a Note is registered in the Note Register.

"***Indebtedness***" means any indebtedness for money borrowed, with respect to any specified Person, which, in accordance with GAAP, would be reflected on such specified Person's most recent balance sheet date referenced in the financial statements immediately preceding the date on which such indebtedness for money borrowed is determined.

"***Indenture***" means this instrument, as originally executed or as it may from time to time be supplemented or amended in accordance with Article 9 hereof.

"***Initial Notes***" has the meaning specified in the first recital of this Indenture.

"***Initial Purchasers***" means SunTrust Robinson Humphrey, Inc., Barclays Capital Inc., J.P. Morgan Securities LLC, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Morgan Stanley & Co. LLC, Wells Fargo Securities, LLC and MUFG Securities Americas Inc.

"***Interest Payment Dates***" shall have the meaning set forth in paragraph 1 of each Note.

"***Issue Date***" means June 6, 2017.

"***Legal Holiday***" means Saturday, Sunday or other day on which banking institutions in The City of New York, the city in which the Corporate Trust Office of the Trustee is located or the jurisdiction of the place of payment are authorized or obligated by law, regulation or executive order to close.

"***Lien***" means, with respect to any asset or property, a mortgage, pledge, security interest or other lien or encumbrance in respect of such asset or property.

"***Moody's***" means Moody's Investors Service, Inc. or any successor to the ratings agency business thereof.

"***Notes***" means the Initial Notes and any Additional Notes. The Initial Notes and any Additional Notes shall be treated as a single class for all purposes of this Indenture, including waivers, amendments, redemptions and offers to purchase, and unless the context otherwise requires, all references to the Notes shall include the Initial Notes and any Additional Notes.

"***Offering Memorandum***" means the final Offering Memorandum dated May 22, 2017 relating to the Notes.

"***Officer***" means, with respect to the Company, the Chairman of the Board, Chief Executive Officer (including, if applicable, any interim Chief Executive Officer), Chief Financial Officer, President, Chief Accounting Officer, Chief Legal Officer, any Executive Vice President, Senior Vice President or Vice President, the Treasurer or the Secretary of the Company and, with respect to a Guarantor, the President, Chief Financial Officer, Chief Operating Officer, any Vice President or the Secretary of such Guarantor.

"***Officer's Certificate***" means a certificate signed by an Officer of the Company.

"***Opinion of Counsel***" means a written opinion from legal counsel which meets the requirements of Section 12.05 hereof. The counsel may be an employee of or counsel to the Company.

"***Person***" means an individual, corporation, partnership, limited liability company, joint venture, association, joint-stock company, trust, unincorporated organization or any other entity or organization, including a government or political subdivision or an agency or instrumentality thereof.

"***Predecessor Note***" of any particular Note means every previous Note evidencing all or a portion of the same Indebtedness as that evidenced by such particular Note; and any Note authenticated and delivered under Section 2.09 in lieu of a lost, destroyed or stolen Note shall be deemed to evidence the same Indebtedness as the lost, destroyed or stolen Note.

"***Principal Property***" means, with respect to any Person, all of such Person's interests in any kind of property or asset (including the capital stock in and other securities of any other Person), except such as the Board of Directors by resolution determines in good faith (taking into account, among other things, the materiality of such property to the business, financial condition and earnings of the Company and its Consolidated Subsidiaries taken as a whole) not to be material to the business of the Company and its Consolidated Subsidiaries, taken as a whole.

"***Redemption Date***," when used with respect to any Note to be redeemed, shall mean the date specified for redemption of such Note in accordance with the terms of such Note and this Indenture.

"***Redemption Price***," when used with respect to any Note to be redeemed, means the price at which it is to be redeemed pursuant to the terms of such Note and this Indenture.

"***Regular Record Date***" for the interest payable on any Interest Payment Date means the applicable date specified as a "***Record Date***" on the face of the Note.

"***Responsible Officer***," when used with respect to the Trustee, means any officer within the corporate trust department of the Trustee (or any successor group of the Trustee) with direct responsibility for the administration of this Indenture and also means, with respect to a particular corporate trust matter relating to this Indenture, any other officer to whom such matter is referred because of his or her knowledge of and familiarity with the particular subject, and who shall have direct responsibility for the administration of this Indenture.

"***S&P***" means Standard & Poor's Ratings Service, a division of The McGraw Hill Companies, Inc., or any successor to the ratings agency business thereof.

"***SEC***" means the Securities and Exchange Commission.

"***Securities Act***" means the Securities Act of 1933, as amended.

"***Significant Subsidiary***" means any Subsidiary that would be a "significant subsidiary" as defined in Article 1, Rule 1-02 of Regulation S-X, promulgated pursuant to the Securities Act, as such regulation is in effect on the Issue Date.

"***Special Record Date***" for the payment of any Defaulted Interest on the Notes means a date fixed by the Company pursuant to Section 2.14 hereof.

"***Stated Maturity***" means, with respect to any installment of interest or principal on any series of Indebtedness, the date on which the payment of interest or principal was scheduled to be paid in the original documentation governing such Indebtedness, and will not include any contingent obligations to repay, redeem or repurchase any such interest or principal prior to the date originally scheduled for the payment thereof.

"***Subsidiary***" means, with respect to any specified Person:

(1) any corporation, association or other business entity of which more than 50% of the total voting power of shares of Capital Stock entitled (without regard to the occurrence of any contingency) to vote in the election of directors, managers or trustees of the corporation, association or other business entity is at the time owned or controlled, directly or indirectly, by that Person or one or more of the other Subsidiaries of that Person (or a combination thereof); and

(2) any partnership (a) the sole general partner or the managing general partner of which is such Person or a Subsidiary of such Person or (b) the only general partners of which are that Person or one or more Subsidiaries of that Person (or any combination thereof).

"***Subsidiary Guarantee***" means a Guarantee by each Guarantor of the Company's obligations under this Indenture and on the Notes, executed pursuant to the provisions of this Indenture.

"***TIA***" means the Trust Indenture Act of 1939, as amended, and the rules and regulations thereunder.

"***Trade Payables***" means, with respect to any Person, any accounts payable or any other indebtedness or monetary obligation to trade creditors, physicians, hospitals, health maintenance organizations or other health care providers created, assumed or Guaranteed by such Person or any of its Subsidiaries arising in the ordinary course of business in connection with the acquisition of goods and services.

"***Treasury Rate***" means, as of any Redemption Date, the yield to maturity at the time of computation of United States Treasury securities with a constant maturity (as compiled and published in the most recent Federal Reserve Statistical Release H.15 (519) which has become publicly available at least two Business Days prior to the Redemption Date (or, if such Statistical Release is no longer published, any publicly available source of similar market data)) most nearly equal to the period from the Redemption Date to June 15, 2020; *provided*, *however*, that if the period from the redemption date to June 15, 2020 is not equal to the constant maturity of a United States Treasury security for which a weekly average yield is given, the Treasury Rate shall be obtained by linear interpolation (calculated to the nearest one-twelfth of a year) from the weekly average yields of United States Treasury securities for which such yields are given, except that if the period from the Redemption Date to June 15, 2020 is less than one year, the weekly average yield on actually traded United States Treasury securities adjusted to a constant maturity of one year shall be used. We will (a) calculate the Treasury Rate as of the second Business Day preceding the applicable Redemption Date and (b) prior to such Redemption Date file with the trustee an Officer's Certificate setting forth the Treasury Rate and showing the calculation of each in reasonable detail.

"***Trustee***" means the Person named as the "Trustee" in the first paragraph of this Indenture until a successor Trustee shall have become such pursuant to the applicable provisions of this Indenture, and thereafter "Trustee" shall mean such successor Trustee.

"***Uniform Commercial Code***" or "***UCC***" means the New York Uniform Commercial Code as in effect from time to time.

"***Voting Stock***" of any Person as of any date means the Capital Stock of such Person that is at the time entitled to vote in the election of the Board of Directors of such Person.

"***Wholly Owned Subsidiary***" means any Subsidiary all of the outstanding voting securities of which (other than directors' qualifying shares or shares required by applicable law or regulation to be held by a Person other than the Company or another Subsidiary of the Company) shall at the time be owned or controlled, directly or indirectly, by the Company or one or more Wholly Owned Subsidiaries, or by the Company and one or more Wholly Owned Subsidiaries, or any similar business organization which is so owned or controlled.

Section 1.02 Other Definitions.

Term	Defined in Section
"1.625% Convertible Notes"	4.05
"Acceleration Notice"	6.02
"Change of Control Offer"	4.08
"Change of Control Purchase Date"	4.08
"Change of Control Purchase Price"	4.08
"Defaulted Interest"	2.14
"DTC"	2.05
"Event of Default"	6.01
"losses"	7.07
"Note Register"	2.05
"Note Registrar"	2.05
"Offer Amount"	3.08(c)(2)
"Offer Period"	3.08(d)
"Paying Agent"	2.05
"Purchase Date"	3.08(d)
"Purchase Price"	3.08(c)(2)
"Sale and Leaseback Transaction"	4.04(a)

Section 1.03 Incorporation by Reference of Trust Indenture Act.

(a) Whenever this Indenture refers to a provision of the TIA, the provision is incorporated by reference in and made a part of this Indenture.

(b) All other terms used in this Indenture that are defined by the TIA, defined by TIA reference to another statute or defined by SEC rule under the TIA and not otherwise defined herein have the meanings so assigned to them either in the TIA, by another statute or SEC rule, as applicable.

Section 1.04 Rules of Construction.

(a) Unless the context otherwise requires:

(1) a term has the meaning assigned to it;

(2) an accounting term not otherwise defined herein has the meaning assigned to it in accordance with GAAP;

(3) "or" is not exclusive;

(4) words in the singular include the plural, and in the plural include the singular;

(5) unless otherwise indicated, all references in this Indenture to "Articles," "Sections" and other subdivisions are to the designated Articles, Sections and subdivisions of this Indenture as originally executed;

(6) the words "herein," "hereof" and "hereunder" and other words of similar import refer to this Indenture as a whole and not to any particular Article, Section or other subdivision;

(7) "including" means "including without limitation";

(8) provisions apply to successive events and transactions; and

(9) references to sections of or rules under the Securities Act, the Exchange Act or the TIA shall be deemed to include substitute, replacement or successor sections or rules adopted by the SEC from time to time thereunder.

ARTICLE 2

THE NOTES

Section 2.01 Form Generally.

Provisions relating to the Initial Notes are set forth in the Rule 144A / Regulation S Appendix attached hereto (the "***Appendix***"), which is hereby incorporated in, and expressly made part of, this Indenture. The Initial Notes and the Trustee's certificate of authentication shall be substantially in the form of Exhibit 1 to the Appendix, which is hereby incorporated in, and expressly made a part of, this Indenture. The Notes may have notations, legends or endorsements required by law, stock exchange rule, agreements to which the Company is subject, if any, or usage (*provided* that any such notation, legend or endorsement is in a form reasonably acceptable to the Company). Each Note shall be dated the date of its authentication. The terms of the Notes set forth in the Appendix and exhibits thereto are part of the terms of this Indenture.

Section 2.02 Execution, Authentication, Delivery and Dating.

Two Officers shall sign the Notes for the Company by manual, facsimile or electronic signature. If an Officer whose signature is on a Note no longer holds that office at the time a Note is authenticated, the Note shall nevertheless be valid.

A Note shall not be valid until authenticated by the manual signature of the Trustee. The signature shall be conclusive evidence that the Note has been authenticated under this Indenture.

At any time and from time to time after the execution and delivery of this Indenture, the Company may deliver Notes executed by the Company to the Trustee for authentication, together with a Company Order for the authentication and delivery of such Notes; and the Trustee in accordance with such Company Order shall authenticate and deliver such Notes.

On the Issue Date, the Company shall deliver the Initial Notes in the aggregate principal amount of $330,000,000 executed by the Company to the Trustee for authentication, together with a Company Order directing the Trustee to authenticate the Notes and certifying that all conditions precedent to the issuance of Notes contained herein have been fully complied with, and the Trustee in accordance with such Company Order shall authenticate and deliver such Initial Notes. At any time and from time to time after the Issue Date, the Company may deliver Additional Notes executed by the Company to the Trustee for authentication, together with a Company Order for the authentication and delivery of such Additional Notes, directing the Trustee to authenticate the Additional Notes and certifying that all conditions

precedent to the issuance of Additional Notes contained herein have been fully complied with, and the Trustee in accordance with such Company Order shall authenticate and deliver such Additional Notes.

The Trustee shall receive a Company Order, an Officer's Certificate and an Opinion of Counsel that it may reasonably require in connection with the authentication of Notes. Such Company Order shall specify the amount of Notes to be authenticated and the date on which the original issue of Notes is to be authenticated. Each Note shall be dated the date of its authentication.

No Note shall be entitled to any benefit under this Indenture or be valid or obligatory for any purpose unless there appears on such Note a certificate of authentication substantially in the form provided for in the applicable exhibit to the Appendix, duly executed by the Trustee by manual signature of an authorized signatory, and such certificate upon the applicable Note shall be conclusive evidence, and the only evidence, that such Note has been duly authenticated and delivered hereunder and is entitled to the benefits of this Indenture.

In case the Company, pursuant to Article 5 of this Indenture, shall be consolidated or merged with or into another Person (whether or not the Company is the surviving Person) or shall sell, transfer, convey, lease or otherwise dispose of its properties and assets substantially as an entirety to any Person, and the successor Person resulting from such consolidation, or surviving such merger, or into which the Company shall have been merged, or the Person which shall have received a conveyance, transfer, lease or other disposition as aforesaid, shall have executed a supplemental indenture hereto with the Trustee pursuant to Article 5 of this Indenture, any of the Notes authenticated or delivered prior to such consolidation, merger, sale, transfer, conveyance, lease or other disposition may, from time to time, at the request of the successor Person, be exchanged for other Notes executed in the name of the successor Person with such changes in phraseology and form as may be appropriate, but otherwise in substance of like tenor as the Notes surrendered for such exchange and of like principal amount; and the Trustee, upon a Company Order of the successor Person, shall authenticate and deliver Notes as specified in such request for the purpose of such exchange. If Notes shall at any time be authenticated and delivered in any new name of a successor Person pursuant to this Section in exchange or substitution for or upon registration of transfer of any Notes, such successor Person, at the option of the Holders but without expense to them, shall provide for the exchange of all Notes at the time outstanding for Notes authenticated and delivered in such new name.

Section 2.03 [Reserved].

Section 2.04 Amount of Notes.

The aggregate principal amount of Notes which may be authenticated and delivered under this Indenture is unlimited. The Notes may have notations, legends or endorsements required by law, stock exchange rules or usage. The Notes shall be in minimum denominations of $2,000 and integral multiples of $1,000 in excess of $2,000.

Except as provided in the Appendix and Exhibits hereto, all Notes shall be substantially identical except as to the date from which interest shall accrue and except as may otherwise be provided in any indenture supplemental hereto.

If any of the terms of the Notes are established by action taken pursuant to a Board Resolution, a copy of any appropriate record of such action shall be certified by the Secretary or an Assistant Secretary of the Company and delivered to the Trustee at or prior to the delivery of the Officer's Certificate setting forth the terms of the Notes.

Section 2.05 Note Registrar and Paying Agent.

The Company shall maintain, with respect to the Notes, an office or agency where Notes may be presented for registration of transfer or for exchange ("***Note Registrar***") and an office or agency where Notes may be presented for payment ("***Paying Agent***") in the United States. The Note Registrar shall keep a register (the "***Note Register***") of the Notes and of their transfer and exchange. The Company may appoint one or more co-registrars and one or more additional paying agents. The term "***Note Registrar***" includes any co-registrar and the term "***Paying Agent***" includes any additional paying agent. The Company may change any Paying Agent or Note Registrar without notice to any Holder. The Company shall notify the Trustee in writing of the name and address of any Agent not a party to this Indenture. If the Company fails to appoint or maintain another entity as Note Registrar or Paying Agent, the Trustee shall act as such. The Company or any of its Consolidated Subsidiaries may act as Paying Agent or Note Registrar.

The Company initially appoints The Depository Trust Company ("***DTC***") to act as Depositary with respect to the Global Notes.

The Company initially appoints the Trustee to act as Note Registrar and Paying Agent and to act as Custodian with respect to the Global Notes, and the Trustee hereby agrees so to initially act.

Section 2.06 Paying Agent to Hold Money in Trust.

The Company shall require each Paying Agent (other than the Trustee) to agree in writing that the Paying Agent will hold in trust, for the benefit of Holders or the Trustee, all money held by the Paying Agent for the payment of principal of, premium, if any, or interest on the Notes, and will notify the Trustee of any default by the Company in making any such payment. While any such default continues, the Trustee may require a Paying Agent to pay all funds held by it relating to the Notes to the Trustee. The Company at any time may require a Paying Agent to pay all funds held by it to the Trustee. Upon payment over to the Trustee, the Paying Agent (if other than the Company or a Consolidated Subsidiary) shall have no further liability for such funds. If the Company or a Consolidated Subsidiary acts as Paying Agent, it shall segregate and hold in a separate trust fund for the benefit of the Holders all funds held by it as Paying Agent. Upon any Event of Default under Section 6.01(f) or (h) hereof relating to the Company, the Trustee shall automatically serve as Paying Agent for the Notes.

In the event that the Paying Agent receives funds in advance of any due date, the Paying Agent shall be entitled to invest such funds in the U.S. Bank Money Market Deposit Account or any substantially similar successor account, any earnings on which shall be for the account of the Company.

Section 2.07 Holder Lists.

The Trustee shall preserve in as current a form as is reasonably practicable the most recent list available to it of the names and addresses of all Holders and shall otherwise comply with TIA § 312(a). If the Trustee is not the Note Registrar, the Company shall furnish or cause to be furnished to the Trustee at least seven Business Days before each Interest Payment Date and at such other times as the Trustee may request in writing, a list in such form and as of such date as the Trustee may reasonably require of the names and addresses of the Holders and the Company shall otherwise comply with TIA § 312(a).

Section 2.08 Registration; Registration of Transfer and Exchange.

Upon surrender for registration of transfer of any Notes at an office or agency of the Company designated pursuant to Section 4.02 hereof for such purpose, and subject to the provisions of Section 2.2 to the Appendix, the Company shall execute, and the Trustee shall authenticate and deliver, in the name of the designated transferee or transferees, one or more new Notes of any authorized denominations, of a like aggregate principal amount. The Company shall not charge a service charge for any registration of transfer or exchange, but the Company may require payment of a sum sufficient to pay all taxes, assessments or other governmental charges that may be imposed in connection with the transfer or exchange of the Notes from the Holder requesting such transfer or exchange (other than any exchange of a temporary Note for a permanent Note not involving any change in ownership or any exchange pursuant to Sections 2.12, 3.06 or 9.05 hereof, not involving any transfer).

At the option of the Holders, Notes may be exchanged for other Notes of any authorized denomination or denominations of like aggregate principal amount and tenor, upon surrender of the Notes to be exchanged at such office or agency. Whenever any Notes are so surrendered for exchange, the Company shall execute, and the Trustee shall authenticate and deliver, the certificated Notes which the Holder making the exchange is entitled to receive.

All Notes issued upon any registration of transfer or exchange of Notes shall be the valid obligations of the Company, evidencing the same debt, and entitled to the same benefits under this Indenture, as the Notes surrendered upon such registration of transfer or exchange.

Every Note presented or surrendered for registration of transfer or for exchange shall be duly endorsed, or be accompanied by a written instrument of transfer in form satisfactory to the Company and the Note Registrar duly executed, by the Holder thereof or his or her attorney duly authorized in writing.

The Company shall not be required (i) to issue, register the transfer of or exchange any Notes during a period beginning 15 days before any selection of Notes to be redeemed or during the period between a Record Date and the next succeeding Interest Payment Date or (ii) to register the transfer of or exchange any Note so selected for redemption, in whole or in part, except the unredeemed portion of any Note being redeemed in part.

Section 2.09 Replacement Notes.

If any mutilated Note is surrendered to the Trustee or the Company and the Trustee and the Company receives evidence to their satisfaction of the destruction, loss or theft of any Note, the Company shall issue and, upon receipt of a Company Order, the Trustee shall authenticate a replacement Note. If required by the Trustee or the Company, the Holder of such Note shall provide indemnity that is sufficient, in the judgment of the Trustee to protect the Trustee, any of its Agents and any authenticating agent and in the judgment of the Company to protect the Company, the Trustee, any Agent and any authenticating agent from any loss that any of them may suffer in connection with such replacement. If required by the Company, such Holder shall reimburse the Company for its reasonable expenses in connection with such replacement.

Every replacement Note issued in accordance with this Section 2.09 shall be the valid obligation of the Company, evidencing the same debt as the destroyed, lost or stolen Note, and shall be entitled to all of the benefits of this Indenture equally and proportionately with all other Notes duly issued hereunder.

Section 2.10 Outstanding Notes.

The Notes outstanding at any time shall be the entire principal amount of Notes represented by all of the Global Notes and Definitive Notes authenticated by the Trustee except for those cancelled by it, those delivered to it for cancellation, those subject to reductions in beneficial interests in a Global Note effected by the Trustee in accordance with the provisions hereof, and those described in this Section 2.10 as not outstanding. Except as set forth in Section 2.11 hereof, a Note shall not cease to be outstanding because the Company or an Affiliate of the Company holds the Note.

If a Note is replaced pursuant to Section 2.09 hereof, it shall cease to be outstanding unless the Trustee receives proof satisfactory to it that the replaced Note is held by a bona fide purchaser.

If the principal amount of any Note is considered paid under Section 4.01 hereof, it shall cease to be outstanding and interest on it shall cease to accrue.

If the Paying Agent (other than the Company, a Subsidiary or an Affiliate of any thereof) holds, on a Redemption Date, a Purchase Date or a maturity date, funds sufficient to pay Notes payable on that date, then on and after that date such Notes shall be deemed to be no longer outstanding and shall cease to accrue interest.

Section 2.11 Treasury Notes.

In determining whether the Holders of the required principal amount of Notes have concurred in any direction, waiver or consent, Notes owned by the Company, or by any Affiliate of the Company, shall be disregarded and deemed not to be outstanding, except that for the purpose of determining whether the Trustee shall be protected in relying on any such direction, waiver or consent, only Notes that a Responsible Officer of the Trustee knows are so owned shall be so disregarded.

Section 2.12 Temporary Notes.

Until certificates representing Notes are ready for delivery, the Company may prepare and, upon receipt of a Company Order in accordance with Section 2.02 hereof, the Trustee shall authenticate temporary Notes. Temporary Notes shall be substantially in the form of Definitive Notes but may have variations that the Company considers appropriate for temporary Notes and as shall be reasonably acceptable to the Trustee. Without unreasonable delay, the Company shall prepare and the Trustee shall authenticate Global Notes or Definitive Notes in exchange for temporary Notes, as applicable. After preparation of Definitive Notes, the temporary Note will be exchangeable for Definitive Notes upon surrender of the temporary Notes.

Holders of temporary Notes shall be entitled to all of the benefits of this Indenture as permanent Notes.

Section 2.13 Cancellation.

The Company at any time may deliver Notes to the Trustee for cancellation. The Note Registrar and Paying Agent shall forward to the Trustee any Notes surrendered to them for registration of transfer, exchange or payment. The Trustee and no one else shall cancel all Notes surrendered for registration of transfer, exchange, payment, replacement or cancellation and shall dispose of cancelled Notes in accordance with its customary procedures (subject to the record retention requirements of the Exchange Act or other applicable laws) unless by written order, signed by an Officer of the Company, the Company directs them to be returned to it.

Certification of the disposal of all cancelled Notes shall be delivered to the Company from time to time upon request. The Company may not issue new Notes to replace Notes that it has paid or that have been delivered to the Trustee for cancellation.

Section 2.14 Payment of Interest; Defaulted Interest.

Interest on any Note which is payable, and is punctually paid or duly provided for, on any Interest Payment Date shall be paid to the person in whose name such Note (or one or more Predecessor Notes) is registered at the close of business on the Regular Record Date for such interest.

If the Company defaults in a payment of interest on the Notes which is payable ("***Defaulted Interest***"), it shall pay the Defaulted Interest in any lawful manner *plus*, to the extent lawful, interest payable on the Defaulted Interest, to the Persons who are Holders on a subsequent Special Record Date, in each case at the rate provided in the Notes. The Company shall notify the Trustee in writing of the amount of Defaulted Interest proposed to be paid on the Notes and the date of the proposed payment. The Company shall fix or cause to be fixed each such Special Record Date and payment date, *provided* that no such Special Record Date shall be less than 10 days prior to the related payment date for such Defaulted Interest. At least 15 days before the Special Record Date, the Company (or, upon the written request of the Company delivered at least 5 Business Days before such notice is to be mailed (or such other period acceptable to the Trustee), the Trustee in the name and at the expense of the Company) shall mail or cause to be mailed to Holders a notice that states the Special Record Date, the related payment date and the amount of such interest to be paid.

Subject to the foregoing provisions of this Section 2.14 and Section 2.08 hereof, each Note delivered under this Indenture upon registration of transfer of or in exchange for or in lieu of any other Note shall carry the rights to interest accrued and unpaid, and to accrue, which were carried by such other Note.

Section 2.15 CUSIP or ISIN Numbers.

The Company in issuing the Notes may use "CUSIP" and/or "ISIN" numbers (if then generally in use), and, if so, the Trustee shall use "CUSIP" and/or "ISIN" numbers in notices of redemption or Offers to Purchase as a convenience to Holders; *provided*, *however*, that any such notice may state that no representation is made as to the correctness of such numbers either as printed on the Notes or as contained in any notice of a redemption or notice of a Change of Control Offer and that reliance may be placed only on the other identification numbers printed on the Notes, and any such redemption or Change of Control Offer shall not be affected by any defect in or omission of such numbers. The Company shall promptly notify the Trustee of any change in the "CUSIP" and/or "ISIN" numbers.

Section 2.16 Additional Notes.

The Company shall be entitled to issue Additional Notes under this Indenture from time to time after the Issue Date, which shall have identical terms as the Initial Notes issued on the Issue Date, other than with respect to the date of issuance and issue price and first payment of interest. The Initial Notes issued on the Issue Date and any Additional Notes shall be treated as a single class for all purposes under this Indenture, including directions, waivers, amendments, consents, redemptions and offers to purchase; *provided, however*, that a separate CUSIP and/or ISIN number (if then generally in use) will be issued for the Additional Notes, unless the Notes and such Additional Notes are treated as fungible for U.S. federal income tax purposes.

With respect to any Additional Notes, the Company shall set forth in a Board Resolution and an Officer's Certificate, a copy of each of which shall be delivered to the Trustee, the following information:

(1) the aggregate principal amount of such Additional Notes to be authenticated and delivered pursuant to this Indenture; and

(2) the issue price, the issue date and the CUSIP and/or ISIN number of such Additional Notes.

Section 2.17 Record Date.

The record date for purposes of determining the identity of Holders of Notes entitled to vote or consent to any action by vote or consent or permitted under this Indenture shall be determined as provided for in TIA § 316(c).

Section 2.18 Persons Deemed Owners.

Prior to due presentment of a Note for registration of transfer, the Company, the Trustee and any agent of the Company or the Trustee may treat the person in whose name such Note is registered as the owner of such Note for the purpose of receiving payment of principal of and (subject to Sections 2.07 and 2.13 hereof) interest on such Note and for all other purposes whatsoever, whether or not such Note be overdue, and neither the Company, the Trustee nor any agent of the Company or the Trustee shall be affected by notice to the contrary.

None of the Company, the Trustee, any Paying Agent or the Note Registrar will have any responsibility or liability for any aspect of the records relating to or payments made on account of beneficial ownership interests of a Note in global form or for maintaining, supervising or reviewing any records relating to such beneficial ownership interests.

Notwithstanding the foregoing, nothing herein shall prevent the Company, the Trustee or any agent of the Company or the Trustee from giving effect to any written certification, proxy or other authorization furnished by the Depositary or impair, as between the Depositary and its participants, the operation of customary practices of the Depositary governing the exercise of the rights of a holder of a beneficial interest in any Global Note.

Section 2.19 Computation of Interest.

Interest on the Notes will be computed on the basis of a 360-day year comprised of twelve 30-day months. Interest on the Initial Notes will accrue from June 6, 2017. If any Interest Payment Date falls on a day that is a Legal Holiday, the required payment will be made on the next succeeding Business Day and no interest on such payment will accrue in respect of the delay.

ARTICLE 3

REDEMPTION AND PREPAYMENT

Section 3.01 Notices to Trustee.

Except as set forth in Paragraph 5 of the reverse side of the form of the Notes set forth in Exhibit 1 to the Appendix, the Company will not be entitled to redeem the Notes at its option prior to their Stated Maturity.

If the Company elects to redeem Notes, it shall furnish to the Trustee, at least 30 days but not more than 60 days before a Redemption Date, an Officer's Certificate setting forth (a) the applicable section of this Indenture and the Notes pursuant to which the redemption shall occur, (b) the Redemption Date, (c) the principal amount of Notes to be redeemed, (d) the Redemption Price and (e) any conditions to such redemption.

Section 3.02 Selection of Notes to Be Redeemed.

(a) If less than all of the Notes are to be redeemed at any time, the Trustee will select the Notes for redemption as follows:

(1) if the Notes are listed on any national securities exchange, in compliance with the requirements of the principal national securities exchange on which the Notes are listed; or

(2) if the Notes are not listed on any national securities exchange, based on a method that most nearly approximates a pro rata basis unless otherwise required by law or Depository requirements.

In the event of partial redemption, the particular Notes to be redeemed shall be selected, unless otherwise provided herein, not less than 30 nor more than 60 days prior to the Redemption Date by the Trustee from the outstanding Notes not previously called for redemption.

(b) The Trustee shall promptly notify the Company in writing of the Notes selected for redemption and, in the case of any Note selected for partial redemption, the principal amount thereof to be redeemed. Notes and portions of Notes selected shall be in minimum denominations of $2,000 and integral multiples of $1,000 in excess thereof; except that if all of the Notes of a Holder are to be redeemed, the entire outstanding amount of Notes held by such Holder, even if not an integral multiple of $1,000, shall be redeemed. Except as provided in the preceding sentence, provisions of this Indenture that apply to Notes called for redemption also apply to portions of Notes called for redemption.

Section 3.03 Notice of Redemption.

At least 30 days but not more than 60 days prior to a Redemption Date, the Company shall deliver or cause to be delivered by electronic transmission (for Notes held in book-entry form) or first class mail, a notice of redemption to each Holder whose Notes are to be redeemed at such Holder's registered address appearing in the Note Register, except that redemption notices may be delivered more than 60 days prior to a Redemption Date if the notice is issued in connection with a satisfaction and discharge or defeasance, in each case, pursuant to Article 8 hereof.

The notice shall identify the Notes to be redeemed and shall state:

(a) the Redemption Date;

(b) the appropriate method for calculation of the Redemption Price, but need not include the Redemption Price itself; the actual Redemption Price shall be set forth in an Officer's Certificate delivered to the Trustee no later than two (2) Business Days prior to the Redemption Date;

(c) if any Note is being redeemed in part, the portion of the principal amount of such Note to be redeemed and that, after the Redemption Date upon surrender of such Note, if applicable, a new Note or Notes in principal amount equal to the unredeemed portion shall be issued upon cancellation of the original Note;

(d) the name and address of the Paying Agent;

(e) that Notes called for redemption must be surrendered to the Paying Agent to collect the Redemption Price;

(f) that, unless the Company defaults in making such redemption payment, interest on Notes called for redemption ceases to accrue on and after the Redemption Date;

(g) the applicable section of this Indenture pursuant to which the Notes called for redemption are being redeemed;

(h) that no representation is made as to the correctness of the CUSIP and/or ISIN numbers, if any, listed in such notice or printed on the Notes; and

(i) any conditions to such redemption.

At the Company's request, the Trustee shall provide the notice of redemption in the Company's name and at its expense; *provided*, *however*, that the Company shall have delivered to the Trustee, at least 45 days (or such shorter period as may be acceptable to the Trustee) prior to the Redemption Date, an Officer's Certificate requesting that the Trustee provide such notice (in the name and at the expense of the Company) and setting forth the information to be stated in such notice as provided in this Section 3.03.

Section 3.04 Effect of Notice of Redemption.

Once notice of redemption is delivered in accordance with Section 3.03 hereof, Notes called for redemption shall become irrevocably due and payable on the Redemption Date at the Redemption Price.

Any redemption of the Notes may, at the Company's discretion, be subject to one or more conditions precedent. In addition, if such redemption or notice is subject to satisfaction of one or more conditions precedent, such notice shall state that, in the Company's discretion, the Redemption Date may be delayed until such time as any or all of such conditions shall be satisfied (or waived by the Company in its sole discretion), or such redemption may not occur and such notice may be rescinded in the event that any or all such conditions shall not have been satisfied (or waived by the Company in its sole discretion) by the Redemption Date, or by the Redemption Date so delayed.

Section 3.05 Deposit of Redemption Price.

On or prior to 11:00 a.m. Eastern time on any Redemption Date, the Company shall deposit with the Trustee or with the Paying Agent (or, if the Company or any of its Consolidated Subsidiaries is the Paying Agent, shall segregate and hold in trust) money sufficient to pay the Redemption Price of and, if applicable, accrued and unpaid interest on all Notes to be redeemed on that date. The Trustee or the Paying Agent shall promptly, and in any event within two (2) Business Days after the Redemption Date, return to the Company any money deposited with the Trustee or the Paying Agent by the Company in excess of the amounts necessary to pay the Redemption Price of, and accrued and unpaid interest, if any, on, all Notes to be redeemed, and any outstanding fees and expenses of the Trustee.

If the Company complies with the provisions of the preceding paragraph, on and after the Redemption Date, interest shall cease to accrue on the Notes or the portions of Notes called for purchase or redemption in accordance with Section 3.08 hereof, whether or not such Notes are presented for payment. If a Note is redeemed on or after a Regular Record Date but on or prior to the related Interest Payment Date, then any accrued and unpaid interest, if any, shall be paid to the Person in whose name such Note was registered at the close of business on such Regular Record Date. If any Note called for redemption shall not be so paid upon surrender for redemption because of the failure of the Company to comply with the preceding paragraph, interest shall be paid on the unpaid principal from the Redemption Date up to and including such date as such principal is paid, and to the extent lawful on any interest not paid on such unpaid principal, in each case at the rate provided in the Notes and in Section 4.01 hereof.

Section 3.06 Notes Redeemed in Part.

Upon surrender of a Note that is redeemed in part, the Company shall issue and, upon receipt of a Company Order in accordance with Section 2.02 hereof, the Trustee shall authenticate for the Holder at the expense of the Company a new Note equal in principal amount to the unredeemed portion of the Note surrendered.

Section 3.07 Mandatory Redemption.

Except as set forth in Section 4.08, the Company shall not be required to make mandatory redemption or sinking fund payments with respect to, or offer to purchase, the Notes.

Section 3.08 Change of Control Offer.

(a) In the event that, pursuant to Section 4.08 hereof, the Company shall be required to commence a Change of Control Offer, it shall follow the procedures specified below.

(b) The Company shall cause a notice of the Change of Control Offer to be sent at least once to the Dow Jones News Service or similar business news service in the United States.

(c) The Company shall commence the Change of Control Offer by sending, by first-class mail (or electronic transmission), with a copy to the Trustee, to each Holder at such Holder's address appearing in the Note Register, a notice the terms of which shall govern the Change of Control Offer stating:

(1) that the Change of Control Offer is being made pursuant to this Section 3.08 and Section 4.08, that a Change of Control has occurred, and the circumstances and relevant facts regarding the Change of Control;

(2) the principal amount of Notes required to be purchased pursuant to Section 4.08 (the "***Offer Amount***"), the purchase price set forth in Section 4.08 (the "***Purchase Price***"), the Offer Period and the Purchase Date (each as defined below);

(3) that all Notes timely tendered and not withdrawn shall be accepted for payment;

(4) that any Note not tendered or accepted for payment shall continue to accrue interest;

(5) that, unless the Company defaults in making such payment, any Note accepted for payment pursuant to the Change of Control Offer shall cease to accrue interest after the Purchase Date;

(6) that Holders electing to have a Note purchased pursuant to a Change of Control Offer may elect to have Notes purchased equal to $2,000 or in integral multiples of $1,000 in excess of $2,000 only;

(7) that Holders electing to have a Note purchased pursuant to any Change of Control Offer shall be required to surrender the Note, with the form entitled "Option of Holder to Elect Purchase" on the reverse of the Note completed, or transfer by book-entry transfer, to the Company, the Depositary, if appointed by the Company, or a Paying Agent at the address specified in the notice before the close of business on the third Business Day before the Purchase Date;

(8) that Holders shall be entitled to withdraw their election if the Company, the Depositary or the Paying Agent, as the case may be, receives, not later than the expiration of the Offer Period, a telegram, facsimile transmission or letter setting forth the name of the Holder, the principal amount of the Note (or portions thereof) the Holder delivered for purchase and a statement that such Holder is withdrawing its election to have such Note purchased;

(9) [Reserved];

(10) that Holders whose Notes are purchased in part shall be issued new Notes equal in principal amount to the unpurchased portion of the Notes surrendered (or transferred by book-entry transfer); and

(11) any other procedures the Holders must follow in order to tender their Notes (or portions thereof) for payment and the procedures that Holders must follow in order to withdraw an election to tender Notes (or portions thereof) for payment.

(d) The Change of Control Offer shall remain open for a period of at least 30 days but no more than 60 days following its commencement, except to the extent that a longer period is required by applicable law (the "***Offer Period***"). No later than five (5) Business Days (and in any event, no later than the 60th day following the Change of Control) after the termination of the Offer Period (the "***Purchase Date***"), the Company shall purchase the Offer Amount or, if less than the Offer Amount has been tendered, all Notes tendered in response to the Change of Control Offer. Payment for any Notes so purchased shall be made in the same manner as interest payments are made. The Company shall publicly announce the results of the Change of Control Offer on or as soon as practicable after the Purchase Date.

(e) On or prior to the Purchase Date, the Company shall, to the extent lawful:

(1) accept for payment, the Offer Amount of Notes or portions of Notes properly tendered and not withdrawn pursuant to the Change of Control Offer, or if less than the Offer Amount has been tendered, all Notes tendered;

(2) deposit with the Paying Agent funds in an amount equal to the Purchase Price in respect of all Notes or portions of Notes properly tendered and not withdrawn; and

(3) deliver or cause to be delivered to the Trustee the Notes properly accepted together with an Officer's Certificate stating the aggregate principal amount of Notes or portions of Notes being purchased by the Company and that such Notes or portions thereof were accepted for payment by the Company in accordance with the terms of this Section 3.08.

(f) The Paying Agent (or the Company, if acting as the Paying Agent) shall promptly (and in any event, not later than 60 days from the date of the Change of Control) deliver or wire transfer to each tendering Holder the Purchase Price deposited with the Paying Agent by the Company (or, if all the Notes are then in global form, make such payment through the facilities of DTC). In the event that any portion of the Notes surrendered is not purchased by the Company, the Company shall promptly execute and issue a new Note in a principal amount equal to such unpurchased portion of the Notes surrendered, and, upon receipt of a Company Order in accordance with Section 2.02 hereof, the Trustee shall authenticate and deliver (or cause to be transferred by book-entry) such new Note to such Holder, in a principal amount equal to any unpurchased portion of the Notes surrendered; *provided*, *however*, that each such new Note shall be in a principal amount of $2,000 or an integral multiple of $1,000 in excess of $2,000. Any Note not so accepted shall be promptly mailed or delivered by the Company to the Holder thereof.

(g) If the Purchase Date is after a Regular Record Date and on or before the related Interest Payment Date, any accrued and unpaid interest shall be paid to the Person in whose name a Note is registered at the close of business on such Regular Record Date.

(h) The Company shall comply, to the extent applicable, with the requirements of Rule 14e-1 under the Exchange Act and any other securities laws and regulations thereunder to the extent those laws and regulations are applicable in connection with the Change of Control Offer. To the extent that the provisions of any securities laws or regulations conflict with Section 4.08, this Section 3.08 or other provisions of this Indenture, the Company shall comply with applicable securities laws and regulations and shall not be deemed to have breached its obligations under Section 4.08, this Section 3.08 or such other provision by virtue of such compliance.

Other than as specifically provided in this Section 3.08, any purchase pursuant to this Section 3.08 shall be made in accordance with the provisions of Sections 3.01 through 3.06 hereof.

ARTICLE 4

COVENANTS

Section 4.01 Payment of Notes.

The Company shall pay or cause to be paid the principal of, premium, if any, and interest on, the Notes on the dates and in the manner provided in this Indenture and the Notes. Principal, premium, if any, and interest shall be considered paid on the date due if the Paying Agent, if other than the Company or a Consolidated Subsidiary thereof, holds as of 11:00 a.m. Eastern Time on the due date money

deposited by the Company in immediately available funds and designated for and sufficient to pay all principal, premium, if any, and interest then due. Such Paying Agent shall return to the Company promptly, and in any event, no later than five (5) Business Days following the date of payment, any money (including accrued interest) that exceeds such amount of principal, premium, if any, and interest paid on the Notes. If a payment date is a Legal Holiday at a place of payment, payment may be made at that place on the next succeeding day that is not a Legal Holiday, and no interest shall accrue on such payment for the intervening period.

The Company shall pay interest (including post-petition interest in any proceeding under any Bankruptcy Law) on overdue principal and premium, if any, from time to time on demand at a rate per annum equal to the rate of interest then in effect; it shall pay interest (including post-petition interest in any proceeding under any Bankruptcy Law) on overdue installments of interest (without regard to any applicable grace periods), from time to time on demand at the same rate to the extent lawful.

Section 4.02 Maintenance of Office or Agency.

(a) The Company shall maintain an office or agency (which may be an office or drop facility of the Trustee or an Affiliate of the Trustee, Note Registrar or co-registrar) where Notes may be presented or surrendered for registration of transfer or for exchange and where notices and demands to or upon the Company in respect of the Notes and this Indenture may be made. The Company shall give prompt written notice to the Trustee of the location, and any change in the location, of such office or agency. If at any time the Company shall fail to maintain any such required office or agency or shall fail to furnish the Trustee with the address thereof, such presentations, surrenders, notices and demands may be made at the Corporate Trust Office of the Trustee, and the Company hereby appoints the Trustee as its agent to receive all such presentations, surrenders, notices and demands.

(b) The Company may also from time to time designate one or more other offices or agencies where the Notes may be presented or surrendered for any or all such purposes and may from time to time rescind such designations. The Company shall give prompt written notice to the Trustee of any such designation or rescission and of any change in the location of any such other office or agency.

(c) The Company hereby designates the Corporate Trust Office of the Trustee, as one such office, drop facility or agency of the Company in accordance with Section 2.05 hereof.

Section 4.03 Limitation Upon Liens.

(a) So long as any Notes remain outstanding, the Company will not, and will not permit any Consolidated Subsidiary to, issue, assume or guarantee any Indebtedness that is secured by a Lien upon or with respect to any Principal Property, or on any shares of Capital Stock of any Consolidated Subsidiary that owns a Principal Property (unless all obligations and indebtedness thereby secured are held by, and the related Lien is granted to, the Company or a Consolidated Subsidiary) unless

(i) the Notes are secured by a Lien equally and ratably with (or prior to) any and all other obligations and Indebtedness secured by such Lien, or

(ii) the aggregate principal amount of all Indebtedness secured by such a Lien of the Company or a Consolidated Subsidiary then outstanding, together with all Attributable Debt of the Company and its Consolidated Subsidiaries in respect of Sale and Leaseback Transactions (other than Sale and Leaseback Transactions permitted by Section 4.04) then outstanding would not exceed the greater of (x) 10% of Consolidated Total Assets and (y) $850.0 million;

(b) The provisions of Section 4.03(a) shall not prevent, restrict or apply to the following Liens (collectively, "*Permitted Liens*"), and Indebtedness secured by one or more Permitted Liens shall be excluded in any computation of Indebtedness secured by a Lien pursuant the foregoing clause (ii) of Section 4.03(a):

(i) Liens existing as of the Issue Date on any property or assets owned or leased by the Company or any Consolidated Subsidiary;

(ii) Liens on property or assets of, or on any shares of stock or Indebtedness of, any Person existing at the time such Person becomes a Consolidated Subsidiary and not created in contemplation of such event;

(iii) Liens (A) on any property or assets or shares of stock existing at the time of acquisition thereof (including acquisition through merger or consolidation) and not created in contemplation of such event or to secure the payment of all or any part of the purchase price or construction cost thereof, or (B) to secure any Indebtedness incurred prior to, at the time of or within 270 days after the later of acquisition of such property or assets or shares of stock or Indebtedness or the completion of any such construction and the commencement of operation of such property, for the purpose of financing all or any part of the purchase price or construction cost thereof;

(iv) Liens on any property or assets to secure all or any part of the cost of acquisition, development, operation, construction, alteration, repair, lease, design, installation or improvement of all or any part of such property or assets, or to secure Indebtedness (including Capital Lease Obligations) incurred prior to, at the time of or within 270 days after the completion of such acquisition, development, operation, construction, alteration, repair, lease, design, installation or improvement, whichever is later, for the purpose of financing all or any part of such cost;

(v) Liens in favor of, or which secure Indebtedness owing to, the Company or a Consolidated Subsidiary;

(vi) Liens arising from the assignment of monies due and to become due under contracts between the Company or any Consolidated Subsidiary and the United States of America, any State, Commonwealth, Territory or possession thereof or any agency, department, instrumentality or political subdivision of any thereof; or Liens in favor of the United States of America, any State, Commonwealth, Territory or possession thereof or any agency, department, instrumentality or political subdivision of any thereof, to secure progress, advance or other payments pursuant to any contract or provision of any statute, or pursuant to the provisions of any contract not directly or indirectly in connection with securing Indebtedness;

(vii) any deposit or pledge as security for the performance of any statutory obligations, bid, tender, contract, lease, government contract, performance bond or undertaking not made directly or indirectly in connection with the securing of Indebtedness; any deposit or pledge with any governmental agency required or permitted to qualify the Company or any Consolidated Subsidiary to conduct business, to maintain self-insurance or to obtain the benefits of any law pertaining to worker's compensation, unemployment insurance, pensions, social security or similar matters, or to obtain any stay or discharge in any legal or administrative proceedings; landlord's, mechanics', worker's, repairmen's, materialmen's, warehousemen's and other like liens imposed by law and securing obligations that are not yet overdue by more than 30 days or are being contested in good faith, and deposits or pledges to obtain releases thereof; any

security interest created in connection with the sale, discount or guarantee of notes, chattel mortgages, leases, accounts receivable, trade acceptances or other paper, or contingent repurchase obligations, arising out of sales of merchandise in the ordinary course of business; liens for taxes, assessments or other government charges or claims that are not yet delinquent or being contested in good faith; any deposit or pledge in connection with appeal or surety bonds; or other deposits or pledges similar to those referred to in this clause (vii);

(viii) judgment Liens; and Liens arising by reason of any attachment, decree or order of any court or other governmental authority, so long as any appropriate legal proceedings which may have been initiated for review of such attachment, decree or order shall not have been finally terminated or so long as the period within which such proceedings may be initiated shall not have expired;

(ix) Liens created after the date of this Indenture on property leased to or purchased by the Company or any Consolidated Subsidiary after that date and securing, directly or indirectly, obligations issued by a State, a Territory or a possession of the United States of America, or any political subdivision of any of the foregoing, or the District of Columbia, to finance the cost of acquisition or cost of construction of such property;

(x) survey exceptions, easements, zoning restrictions, licenses, title restrictions, rights-of-way and similar encumbrances on real property imposed by law or incurred or granted by the Company or any Consolidated Subsidiary in the ordinary course of business that do not secure any material monetary obligations and do not materially interfere with the ordinary conduct of business of the Company and its Consolidated Subsidiaries, taken as a whole;

(xi) Liens upon real or personal property leased after the date of this Indenture in the ordinary course of business by the Company or any Consolidated Subsidiary in favor of the lessor created at the inception of the lease transaction, securing obligations of the Company or those of any Consolidated Subsidiary under or in respect of such lease and extending to or covering only the property subject to such lease and improvements thereon;

(xii) minor imperfections in title that do not materially interfere with the ordinary conduct of business of the Company and its Consolidated Subsidiaries, taken as a whole;

(xiii) Liens securing indebtedness or any other obligations under the Credit Agreement and/or Hedging Obligations related thereto;

(xiv) Liens created in connection with the depositing of the proceeds from the Notes in a separate deposit account as set forth in Section 4.05;

(xv) Liens arising from Uniform Commercial Code financing statement filings regarding leases entered into by the Company or any of its Consolidated Subsidiaries in the ordinary course of business;

(xvi) licenses, leases or subleases and other intellectual property rights granted to others not interfering in any material respect with the business of the Company or any Consolidated Subsidiary of the Company;

(xvii) Liens in the nature of normal and customary rights of setoff upon deposits of cash in favor of banks or other depository institutions;

(xviii) Liens of a collection bank arising in the ordinary course of business under Section 4-210 of the Uniform Commercial Code in effect in the relevant jurisdiction covering only the items being collected upon;

(xix) Liens solely on any cash earnest money deposits made by the Company or any of its Consolidated Subsidiaries in connection with any letter of intent or purchase agreement permitted by this Indenture;

(xx) Liens in favor of customs and revenue authorities arising as a matter of law to secure payment of customs duties in connection with the importation of goods; and

(xxi) any extension, renewal, substitution or replacement (or successive extensions, renewals, substitutions or replacements), as a whole or in part, of any Lien referred to in subparagraphs (i) through (xx) above or the Indebtedness secured thereby; *provided* that (A) such extension, renewal, substitution or replacement Lien shall be limited to all or any part of the same property or assets or shares of stock that secured the Lien extended, renewed, substituted or replaced (plus improvements, accessions, after-acquired property, proceeds or dividends or distributions in respect thereof and any other property or assets not then constituting a Principal Property) and (B) to the extent, if any, that the Indebtedness secured by such Lien at such time is increased, the amount of such increase shall not be excluded from Indebtedness under any computation under this Section 4.03.

Debt created by the Company or any Consolidated Subsidiary shall not be cumulated with a guarantee of the same Indebtedness by the Company or any other Consolidated Subsidiary for the same financial obligation.

Section 4.04 Limitation on Sale and Leaseback Transactions.

(a) So long as any Notes remain outstanding, the Company will not itself, and will not permit any Consolidated Subsidiary to, enter into any arrangement after the date of this Indenture with any Person (not including the Company or any Consolidated Subsidiary) which provides for the leasing by the Company or any such Consolidated Subsidiary of any Principal Property which was or is owned by the Company or such Consolidated Subsidiary (except for temporary leases of not more than three years), which property has been or is to be sold or transferred to such Person more than 120 days after the later of (i) the date on which such Principal Property has been acquired by the Company or such Consolidated Subsidiary and (ii) the date of completion of construction and commencement of full operation thereof by the Company or any Consolidated Subsidiary (a "***Sale and Leaseback Transaction***").

(b) The foregoing limitation shall not apply to any Sale and Leaseback Transaction if:

(i) the net proceeds to the Company or such Consolidated Subsidiary from such sale or transfer is equal to or exceeds the fair value (as determined by the Board of Directors of the Company) of the Principal Property so leased,

(ii) the Company or such Consolidated Subsidiary could incur Indebtedness secured by a Lien on the Principal Property to be leased pursuant to Section 4.03 in an amount equal to the Attributable Debt with respect to such Sale and Leaseback Transaction without equally and ratably securing the Notes or

(iii) the Company, within 120 days after the effective date of any such Sale and Leaseback Transaction, applies an amount equal to the fair value (as determined by the Board of Directors of the Company) of the Principal Property so sold and leased back at the time of entering into such arrangement (as determined by the Company) to

(A) the prepayment or retirement of Funded Debt (including securities constituting Funded Debt) of the Company; or

(B) the acquisition of additional real property for the Company or any Consolidated Subsidiary.

(c) A Sale and Leaseback Transaction shall not include any such arrangement for financing air, water or noise pollution control facilities or sewage or solid waste disposal facilities or involving industrial development bonds which are tax-exempt pursuant to Section 103 of the United States Internal Revenue Code, as amended (or which receive similar tax treatment under any subsequent amendments thereto or successor laws thereof).

Section 4.05 Limitation on Use of Proceeds.

(a) No later than 10 Business Days after the Issue Date, the Company will deposit the net proceeds from the Initial Notes into a newly-formed segregated deposit account in the name of the Company, and such net proceeds will be invested (and may be reinvested) in cash and Cash Equivalents. Amounts contained in such account will be used by the Company

(i) on or prior to August 20, 2018, to (a) redeem, repurchase, repay, tender for, or acquire or retire for value (whether through one or more tender offers, open market repurchases, redemptions or similar transactions) all or any portion of the Company's 1.625% Convertible Senior Notes due 2044 (the "***1.625% Convertible Notes***") or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes pursuant to the requirements contained in the indenture governing the 1.625% Convertible Notes, and/or (b) make any interest payments due on all or any portion of the Initial Notes,

(ii) on or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that the Company is obligated to repurchase pursuant to the requirements contained in the indenture governing the 1.625% Convertible Notes and

(iii) subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited by this Indenture, subject to the Company complying with clauses (i) or (ii) of this Section 4.05(a) prior to any such amounts being used or applied in accordance with this clause (iii). For payments made pursuant to Section 4.05(a)(i) or, to the extent applicable, Section 4.05(a)(ii), amounts permitted to be released from the segregated account shall include amounts necessary to pay principal, any accrued and unpaid interest due on the date of any redemption, repurchase, repayment, tender, acquisition or retirement for value or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes, premiums (including tender premiums) and fees and expenses incurred in connection therewith.

(b) Prior to release of proceeds of the Initial Notes from the segregate account pursuant to clauses (i) and (ii) of Section 4.05(a), the Company shall deliver to the Trustee an Officer's Certificate certifying that the proposed use of proceeds from such segregated account is in compliance with this

Section 4.05. No such Officer's Certificate shall be required in the event funds are released from such segregated account pursuant to Section 4.05(a)(iii).

Section 4.06 Compliance Certificates.

(a) The Company shall deliver to the Trustee, within 90 days after the end of each fiscal year, commencing with the fiscal year ending December 31, 2017, an Officer's Certificate stating that a review of the activities of the Company and its Subsidiaries during the preceding fiscal year (or, with respect to the first such certificate, the period from the Issue Date to December 31, 2017), has been made under the supervision of the signing Officer with a view to determining whether the Company and the Guarantors have kept, observed, performed and fulfilled their obligations under this Indenture, and further stating, as to such Officer signing such certificate, that to the best of his or her knowledge the Company and the Guarantors have kept, observed, performed and fulfilled each and every covenant contained in this Indenture and none is in default in the performance or observance of any of the terms, provisions and conditions of this Indenture (or, if a Default or Event of Default shall have occurred, describing all such Defaults or Events of Default of which he or she may have knowledge and what action the Company is taking or proposes to take with respect thereto) and that to the best of his or her knowledge no event has occurred and remains in existence by reason of which payments on account of the principal of, premium, if any, or interest on the Notes is prohibited or if such event has occurred, a description of the event and what action the Company is taking or proposes to take with respect thereto.

(b) The Company shall deliver to the Trustee, within 30 days after becoming aware thereof, written notice in the form of an Officer's Certificate of any event that with the giving of notice and/or the lapse of time would become an Event of Default, its status and what action the Company is taking or proposes to take with respect thereto.

Section 4.07 Waiver of Certain Covenants.

The Company may omit in any particular instance to comply with any term, provision or condition set forth in Section 4.03 or Section 4.04 with respect to the Notes if the Holders of at least a majority in principal amount of the outstanding Notes shall either waive such compliance in such instance or generally waive compliance with such term, provision or condition, but no such waiver shall extend to or affect such term, provision or condition, except to the extent so expressly waived, and, until such waiver shall become effective, the obligations of the Company and the duties of the Trustee in respect of any such term, provision or condition shall remain in full force and effect.

Section 4.08 Repurchase at the Option of Holders Upon a Change of Control.

(a) Except as provided in Section 4.08(c), upon the occurrence of a Change of Control, each Holder of the Notes shall have the right to require the Company to repurchase all or any part (equal to $2,000 or an integral multiple of $1,000 in excess thereof) of such Holder's Notes pursuant to an offer (the "***Change of Control Offer***") at a purchase price (the "***Change of Control Purchase Price***") equal to 101% of the principal amount of the Notes to be repurchased, plus accrued and unpaid interest, to, but not including, the repurchase date specified by the Company in the notice referred to below (subject to the right of Holders of record on the relevant Record Date to receive interest due on the relevant Interest Payment Date).

(b) Except as provided in Section 4.08(c) or (d), within 30 days following any Change of Control, the Company shall send a notice to each Holder of the Notes, by first-class mail at such Holder's address appearing in the Note Register, or, in the case of Notes held in book-entry form, by electronic

transmission in accordance with the applicable procedures of the Depositary, with a copy to the Trustee, stating:

(i) that a Change of Control has occurred (or, with respect to a notice sent in advance of a Change of Control, is expected to occur) and a Change of Control Offer is being made pursuant to this Section 4.08 and that all Notes timely tendered will be accepted for payment;

(ii) the Change of Control Purchase Price and the repurchase date (the "***Change of Control Purchase Date***"), which will be, subject to any contrary requirements of applicable law, a Business Day no earlier than 30 days nor later than 60 days from the date the notice is mailed;

(iii) the circumstances and relevant facts regarding the Change of Control; and

(iv) the procedures, determined by the Company consistent with this Indenture, that Holders of the Notes must follow in order to tender their Notes (or portions thereof) for payment, and the procedures that Holders of the Notes must follow in order to withdraw an election to tender Notes (or portions thereof) for payment.

(c) The Company will not be required to make a Change of Control Offer following a Change of Control if:

(i) A third party makes the Change of Control Offer in the manner, at the times and otherwise in compliance with the requirements set forth in this Indenture applicable to a Change of Control Offer made by the Company and purchases all Notes validly tendered and not withdrawn under such Change of Control Offer, or

(ii) notice of redemption in respect of all of the outstanding Notes has been given pursuant to Section 3.03.

(d) A Change of Control Offer may be made in advance of, or conditioned upon, a Change of Control if a definitive agreement is in place.

(e) On the Change of Control Payment Date, the Company shall (i) accept for payment on a pro rata basis Notes or portions thereof properly tendered pursuant to the applicable Change of Control Offer; (ii) deposit with the Paying Agent the Change of Control Purchase Price in respect of all Notes or portions thereof so accepted; and (iii) deliver, or cause to be delivered, to the Trustee all Notes or portions thereof so accepted together with an Officer's Certificate specifying the Notes or portions thereof accepted for payment by the Company. The Paying Agent shall promptly disburse to the holders of Notes so accepted payment in an amount equal to the purchase price, and the Trustee shall promptly authenticate upon receipt of a Company Order and send (or cause to be transferred by book entry) to such holders a new Note equal in principal amount to any unpurchased portion of the Note surrendered; *provided* that each Note purchased and each new Note issued shall be in a minimum principal amount of $2,000 or integral multiples of $1,000 in excess thereof.

(f) Subject to applicable escheat laws, the Trustee and the Paying Agent shall return to the Company any cash that remains unclaimed, together with interest or dividends, if any, thereon, held by them for the payment of the Change of Control Purchase Price; *provided*, *however*, that, (x) to the extent that the aggregate amount of cash deposited by the Company pursuant to subclause (ii) of clause (e) above exceeds the aggregate Change of Control Purchase Price of the Notes or portions thereof to be

purchased, then the Trustee shall hold such excess for the Company and (y) unless otherwise directed by the Company in writing, promptly after the Business Day following the Change of Control Purchase Date the Trustee shall return any such excess to the Company together with interest, if any, thereon.

(g) The Company will comply, to the extent applicable, with the requirements of Section 14(e) of the Exchange Act, and any other securities laws or regulations in connection with the repurchase of Notes pursuant to a Change of Control Offer. To the extent that the provisions of any securities laws or regulations conflict with the provisions of this covenant, the Company will comply with the applicable securities laws and regulations and will not be deemed to have breached the Company's obligations under this covenant by virtue of this compliance.

(h) If Holders of not less than 90% in aggregate principal amount of the outstanding Notes validly tender and do not withdraw such Notes in a Change of Control Offer and the Company, or any third party making a Change of Control Offer in lieu of the Company as described above, purchases all of the Notes validly tendered and not withdrawn by such Holders, the Company will have the right, upon not less than 30 nor more than 60 days' prior notice, given not more than 30 days following such purchase pursuant to the Change of Control Offer described above, to redeem all Notes that remain outstanding following such purchase at a Redemption Price in cash equal to the applicable Change of Control payment plus, to the extent not included in the Change of Control payment, accrued and unpaid interest to, but not including, the Redemption Date.

Section 4.09 Reports to Holders.

(a) Notwithstanding that the Company may not be subject to the reporting requirements of Section 13 or 15(d) of the Exchange Act, if not filed electronically with the SEC through EDGAR (or any successor system), the Company will provide to the Trustee and the Holders of the Notes, within 15 days of the time periods specified in the SEC's rules and regulations with respect to a non-accelerated filer (after giving effect to any grace period provided by Rule 12b-25 under the Exchange Act):

(i) all quarterly and annual financial information that would be required to be contained in a filing with the SEC on Forms 10-Q and 10-K if the Company were required to file such Forms, including a "Management's Discussion and Analysis of Financial Condition and Results of Operations" and, with respect to the annual information only, a report on the annual financial statements by the Company's independent registered public accounting firm; and

(ii) all current reports that would be required to be filed with the SEC on Form 8-K if the Company were required to file such reports. The requirement for the Company to provide information may be satisfied by posting such reports, documents and information on its website within the time periods specified herein.

(b) To the extent any information is not provided within the time periods specified in Section 4.09(a) and such information is subsequently provided, the Company will be deemed to have satisfied its obligations with respect thereto at such time and any Default or Event of Default with respect thereto shall be deemed to have been cured.

(c) In addition, the Company and the Guarantors have agreed that, for so long as any Notes remain outstanding, if at any time the Company is not subject to Section 13 or Section 15(d) of the Exchange Act, they will furnish to the Holders and prospective investors, upon their request, the information required to be delivered pursuant to Rule 144A(d)(4) under the Securities Act. Delivery of any reports, information and documents to the Trustee pursuant to this Section 4.09(a) is for informational

purposes only and the Trustee's receipt of such shall not constitute actual or constructive notice of any information contained therein or determinable from information contained therein, including the Company's compliance with any of its covenants pursuant to this Article 4 (as to which the Trustee is entitled to rely exclusively on Officer's Certificates).

Section 4.10 Taxes.

The Company shall pay, and shall cause each of its Subsidiaries to pay, prior to delinquency, all material taxes, assessments and governmental levies, except such as are being contested in good faith and by appropriate proceedings or where the failure to effect such payment is not adverse in any material respect to the Holders.

Section 4.11 Stay, Extension and Usury Laws.

The Company covenants (to the extent that it may lawfully do so) that it shall not at any time insist upon, plead, or in any manner whatsoever claim or take the benefit or advantage of, any stay, extension or usury law wherever enacted, now or at any time hereafter in force, that may affect the covenants or the performance of this Indenture; and the Company (to the extent that it may lawfully do so) hereby expressly waives all benefit or advantage of any such law, and covenants that it shall not, by resort to any such law, hinder, delay or impede the execution of any power herein granted to the Trustee, but shall suffer and permit the execution of every such power as though no such law has been enacted.

Section 4.12 Corporate Existence.

Subject to Article 5 hereof, the Company shall do or cause to be done all things necessary to preserve and keep in full force and effect (i) its corporate existence, and the corporate, partnership or other existence of each Subsidiary, in accordance with the respective organizational documents (as the same may be amended from time to time) of the Company or any such Subsidiary and (ii) the rights (charter and statutory), licenses and franchises of the Company and its Subsidiaries; *provided*, *however*, that the Company shall not be required to preserve any such right, license or franchise, or the corporate, partnership or other existence of any Subsidiary, if the Board of Directors shall determine that the preservation thereof is no longer desirable in the conduct of the business of the Company and its Subsidiaries, taken as a whole, and that the loss thereof is not adverse in any material respect to the Holders of the Notes, or that such preservation is not necessary in connection with any transaction not prohibited by this Indenture.

ARTICLE 5

SUCCESSORS

Section 5.01 Merger, Consolidation or Sale of Assets.

(a) The Company may not, directly or indirectly, consolidate or merge with or into another Person (whether or not the Company is the surviving Person) or sell, assign, transfer, convey, lease or otherwise dispose of all or substantially all of its properties or assets in one or more related transactions, to another Person, unless:

(1) either:

(A) the Company is the surviving Person; or

(B) the Person formed by or surviving any such consolidation or merger (if other than the Company) or to which such sale, assignment, transfer, lease, conveyance or other disposition has been made is an entity organized or existing under the laws of the United States of America, any state thereof or the District of Columbia; *provided* that, if such entity is not a corporation, a co-obligor of the Notes is a corporation;

(2) the Person formed by or surviving any such consolidation or merger (if other than the Company) or the Person to which such sale, assignment, transfer, conveyance or other disposition has been made assumes by supplemental indenture and joinders all the obligations of the Company under the Notes and this Indenture pursuant to agreements in form satisfactory to the Trustee;

(3) immediately after such transaction no Default or Event of Default exists; and

(4) the Company shall deliver, or cause to be delivered, to the Trustee, in form satisfactory to the Trustee, an Officer's Certificate and an Opinion of Counsel, each stating that such transaction or series of transactions and the supplemental indenture, if any, in respect thereto comply with this Section 5.01 and that all conditions precedent herein provided for relating to such transaction or series of transactions have been satisfied.

(b) The sale, assignment, transfer, lease, conveyance or other disposition of all or substantially all of the properties or assets of one or more Subsidiaries of the Company, which properties or assets, if held by the Company instead of such Subsidiaries, would constitute all or substantially all of the properties or assets of the Company on a consolidated basis, shall be deemed to be the transfer of all or substantially all of the properties or assets of the Company.

(c) Upon any transaction or series of transactions that are of the type described in, and are effected in accordance with, conditions described in this Section 5.01, the surviving entity shall succeed to, and be substituted for, and may exercise every right and power of, the Company or the Guarantor, as applicable, under this Indenture and the Notes with the same effect as if such surviving entity had been named as the Company or the Guarantor, as applicable, of the Notes; and when a surviving entity duly assumes all of the obligations and covenants of the Company or the Guarantor, as applicable, pursuant to this Indenture, the Notes and the Subsidiary Guarantee, the Company or the Guarantor, as applicable, or any other predecessor Person shall be relieved of such obligations.

(d) Section 5.01(a) will not apply to any sale, assignment, transfer, conveyance, lease or other disposition of assets between or among the Company or any of its Consolidated Subsidiaries. Clause (3) of Section 5.01(a) will not apply to (1) any merger or consolidation of the Company or a Guarantor with or into another Guarantor for any purpose or (2) the merger of the Company or a Guarantor with or into an Affiliate solely for the purpose of reincorporating the Company or such Guarantor, as the case may be, in another jurisdiction under the laws of the United States, any state of the United States or the District of Columbia so long as the amount of Indebtedness of the Company and its Consolidated Subsidiaries is not increased thereby.

Section 5.02 Successor Corporation Substituted.

The Person formed by or surviving any consolidation or merger described in Section 5.01 (if other than the Company) or the Person to which any sale, assignment, transfer, conveyance or other disposition described in Section 5.01 has been made, as applicable, shall succeed to, and be substituted

for, and may exercise every right and power of the Company under this Indenture and the Notes; *provided*, *however*, that the predecessor entity shall not be released from any of the obligations or covenants under this Indenture, including with respect to the payment of the Notes in the case of:

(a) a sale, transfer, assignment, conveyance or other disposition (unless such sale, transfer, assignment, conveyance or other disposition is of all or substantially all of the assets of the Company, taken as a whole), or

(b) a lease.

ARTICLE 6

DEFAULTS AND REMEDIES

Section 6.01 Events of Default.

"***Event of Default***" with respect to the Notes, wherever used herein, means any one of the following events which shall have occurred and be continuing:

(a) default in the payment of any installment of interest upon any Note as and when it becomes due and payable, and continuance of such default for a period of 30 days;

(b) default in the payment of all or any part of the principal of or premium, if any, on any Note as and when it becomes due and payable either at Stated Maturity, upon any redemption, by declaration or otherwise;

(c) failure to comply with Section 4.09 for 120 days after either the Trustee notifies the Company of the failure or the Holders of at least 25% in principal amount of the outstanding Notes affected by the failure notify us and the Trustee of the failure;

(d) default in the performance, or breach, of any covenant or warranty of the Company contained in the Notes or in this Indenture (other than a covenant or warranty a default in the performance or breach of which is elsewhere in this Section 6.01 specifically dealt with or which has been expressly included in this Indenture solely for the benefit of the Notes), and continuance of such default or breach for a period of 90 days after the date on which written notice specifying such default or breach and requiring the Company to remedy the same and stating that such notice is a "Notice of Default" hereunder shall have been given to the Company by the Trustee, or to the Company and the Trustee by the Holders of at least 25% in principal amount of the outstanding Notes affected by the failure;

(e) failure by the Company to make any payment, on or before the end of the applicable grace period, after the maturity of any Indebtedness of the Company with an aggregate principal amount then outstanding in excess of $100.0 million or the acceleration of Indebtedness of the Company with an aggregate principal amount then outstanding in excess of $100.0 million as a result of a default with respect to such Indebtedness, and such Indebtedness, in either case, is not discharged or such acceleration shall not have been cured, waived, rescinded or annulled within a period of 30 days after there shall have been given, by registered or certified mail, to the Company by the Trustee or to the Company and the Trustee by the Holders of at least 25% in principal amount of the outstanding Notes affected by the failure, a written notice specifying such failure to pay or acceleration and requiring the Company to cause such acceleration to be cured, waived, rescinded or annulled or to cause such Indebtedness to be discharged and stating that such notice is a "Notice of Default" hereunder;

(f) the entry by a court having jurisdiction in the premises of (i) a decree or order for relief in respect of the Company in an involuntary case or proceeding under any applicable federal or state bankruptcy, insolvency, reorganization or other similar law or (ii) a decree or order adjudging the Company a bankrupt or insolvent, or approving as properly filed a petition seeking reorganization, arrangement, adjustment or composition of or in respect of the Company under any applicable federal or state law, or appointing a custodian, receiver, liquidator, assignee, trustee, sequestrator or other similar official of the Company or for all or any substantial part of its property, or ordering the winding-up or liquidation of its affairs, and the continuance of such decree or order for relief or any such other decree or order unstayed and in effect for a period of 90 consecutive days;

(g) the Subsidiary Guarantee by any of the Guarantors ceases to be, or is asserted in writing by the Company or such Guarantor not to be, in full force and effect or enforceable in accordance with its terms (except as contemplated or permitted by the terms of the Subsidiary Guarantee or this Indenture);

(h) the commencement by the Company or any Guarantor of a voluntary case or proceeding under any applicable federal or state bankruptcy, insolvency reorganization or other similar law, or of any other case or proceeding to be adjudicated a bankrupt or insolvent, or the consent by it to the entry of a decree or order for relief in respect of the Company in an involuntary case or proceeding under any such law, or the filing by it of a petition or answer or consent seeking reorganization or relief under any applicable federal or state law, or the consent by it to the filing of such petition or to the appointment of or taking possession by a custodian, receiver, liquidator, assignee, trustee, sequestrator or similar official of the Company or for all or any substantial part of its property, or the making by it of a general assignment for the benefit of creditors; or

(i) any other Event of Default provided with respect to the Notes.

Section 6.02 Acceleration.

If any Event of Default (other than those of the type described in Section 6.01(f) or (h)) occurs and is continuing, the Trustee may or the Holders of at least 25% in aggregate principal amount of outstanding Notes may, declare the principal, premium, if any, and accrued and unpaid interest, if any, of all the outstanding Notes, to be due and payable by notice in writing to the Company and the Trustee specifying the respective Event of Default and that such notice is a notice of acceleration (the "***Acceleration Notice***"), and the same shall become immediately due and payable.

In the case of an Event of Default specified in Section 6.01(f) or (h) the principal, premium, if any, and accrued and unpaid interest, if any, of all of the outstanding Notes shall become due and payable immediately without any further action or notice on the part of the Trustee or the Holders.

The Holders of at least a majority in aggregate principal amount of the outstanding Notes by notice to the Trustee and the Company may rescind and annul any declaration of acceleration if the rescission would not conflict with any judgment or decree and if all existing Events of Default have been cured or waived except nonpayment of principal, premium or interest that has become due solely because of the acceleration. No such rescission shall affect any subsequent Default or impair any right consequent thereto.

Section 6.03 Other Remedies.

If an Event of Default occurs and is continuing, the Trustee may pursue any available remedy to collect the payment of principal, premium, if any, and interest on the Notes or to enforce the performance of any provision of the Notes or this Indenture.

The Trustee may maintain a proceeding even if it does not possess any of the Notes or does not produce any of them in the proceeding. A delay or omission by the Trustee or any Holder in exercising any right or remedy accruing upon an Event of Default shall not impair the right or remedy or constitute a waiver of or acquiescence in the Event of Default. All remedies shall be cumulative to the extent permitted by law.

Section 6.04 Waiver of Defaults.

(a) The Holders of at least a majority in aggregate principal amount of the Notes then outstanding by notice to the Trustee may on behalf of the Holders of all of the Notes waive any existing Default or Event of Default and its consequences under this Indenture, except a continuing Default or Event of Default in the payment of interest on, or the principal of, the Notes.

(b) Upon any waiver of a Default or Event of Default, such Default shall cease to exist, and any Event of Default arising therefrom shall be deemed cured for every purpose of this Indenture but no such waiver shall extend to any subsequent or other Default or Event of Default or impair any right consequent thereon.

Section 6.05 Control by Majority.

Subject to Sections 7.01 (including the Trustee's receipt of the security or indemnification described in Section 7.01(e)), 7.02(f) and 7.07 hereof, in case an Event of Default shall occur and be continuing, the Holders of at least a majority in aggregate principal amount of the Notes then outstanding shall have the right to direct the time, method and place of conducting any proceeding for any remedy available to the Trustee or exercising any trust or power conferred on the Trustee with respect to the Notes.

Section 6.06 Limitation on Suits.

No Holder of a Note may pursue any remedy with respect to this Indenture or the Notes unless:

(a) such Holder has previously given to the Trustee written notice of a continuing Event of Default or the Trustee receives the notice from the Company;

(b) Holders of at least 25% in aggregate principal amount of the Notes then outstanding make a written request to the Trustee to pursue the remedy;

(c) such Holder or Holders offer to the Trustee security or indemnity reasonably satisfactory to the Trustee against any loss, liability or expense;

(d) the Trustee does not comply with such request within 60 days after receipt of the request and the offer of security or indemnity; and

(e) during such 60-day period, Holders of a majority in aggregate principal amount of the then outstanding Notes do not give the Trustee a direction inconsistent with such request.

The preceding limitations shall not apply to a suit instituted by a Holder for enforcement of payment of principal of, and premium, if any, or interest on, a Note on or after the respective due dates for such payments set forth in such Note.

A Holder may not use this Indenture to affect, disturb or prejudice the rights of another Holder or to obtain a preference or priority over another Holder.

Section 6.07 Rights of Holders to Receive Payment.

Notwithstanding any other provision of this Indenture (including Section 6.06), the right of any Holder to receive payment of principal, premium, if any, and interest on the Notes held by such Holder, on or after the respective due dates expressed in the Notes (including in connection with a Change of Control Offer), or to bring suit for the enforcement of any such payment on or after such respective dates, shall not be impaired or affected without the consent of such Holder.

Section 6.08 Collection Suit by Trustee.

If an Event of Default specified in Section 6.01(a) or (b) occurs and is continuing, the Trustee is authorized to recover judgment in its own name and as trustee of an express trust against the Company for the whole amount of principal of, premium, if any, and interest then due and owing (together with interest on overdue principal and, to the extent lawful, interest) and such further amount as shall be sufficient to cover the costs and expenses of collection, including the reasonable compensation, expenses, disbursements and advances of the Trustee, its agents and counsel.

Section 6.09 Trustee May File Proofs of Claim.

The Trustee shall be authorized to file such proofs of claim and other papers or documents as may be necessary or advisable in order to have the claims of the Trustee (including any claim for the reasonable compensation, expenses, disbursements and advances of the Trustee, its agents and counsel) and the Holders allowed in any judicial proceedings relative to the Company (or any other obligor upon the Notes), its assets or its property and shall be entitled and empowered to collect, receive and distribute any money or other property payable or deliverable on any such claims and any custodian in any such judicial proceeding is hereby authorized by each Holder to make such payments to the Trustee, and in the event that the Trustee shall consent to the making of such payments directly to the Holders, to pay to the Trustee any amount due to it for the reasonable compensation, expenses, disbursements and advances of the Trustee, its agents and counsel, and any other amounts due the Trustee under Section 7.07 hereof. To the extent that the payment of any such compensation, expenses, disbursements and advances of the Trustee and its agents and counsel, and any other amounts due the Trustee under Section 7.07 hereof out of the estate in any such proceeding, shall be denied for any reason, payment of the same shall be secured by a Lien on, and shall be paid out of, any and all distributions, moneys, securities and any other properties that the Holders may be entitled to receive in such proceeding whether in liquidation or under any plan of reorganization or arrangement or otherwise. Nothing herein contained shall be deemed to authorize the Trustee to authorize or consent to or accept or adopt on behalf of any Holder any plan of reorganization, arrangement, adjustment or composition affecting the Notes or the rights of any Holder, or to authorize the Trustee to vote in respect of the claim of any Holder in any such proceeding.

Section 6.10 Priorities.

If the Trustee collects any money pursuant to this Article 6, it shall pay out the money in the following order:

First: to the Trustee, its agents and attorneys for amounts due under Section 7.07 hereof, including payment of all compensation, expenses and liabilities incurred, and all advances made, by the Trustee and the costs and expenses of collection;

Second: to Holders for amounts due and unpaid on the Notes for principal, premium, if any, and interest ratably, without preference or priority of any kind, according to the amounts due and payable on the Notes for principal, premium, if any, and interest, respectively; and

Third: to the Company or to such party as a court of competent jurisdiction shall direct.

The Trustee may fix a record date and payment date for any payment to Holders pursuant to this Section 6.10.

Section 6.11 Undertaking for Costs.

In any suit for the enforcement of any right or remedy under this Indenture or in any suit against the Trustee for any action taken or omitted by it as a Trustee, a court in its discretion may require the filing by any party litigant in such suit of an undertaking to pay the costs of such suit, and the court in its discretion may assess reasonable costs, including reasonable attorneys' fees and expenses, against any party litigant in such suit, having due regard to the merits and good faith of the claims or defenses made by the party litigant. This Section 6.11 shall not apply to a suit by the Trustee, a suit by the Company, a suit by a Holder pursuant to Section 6.07 hereof, or a suit by Holders of more than 10% in principal amount of the then-outstanding Notes.

ARTICLE 7

TRUSTEE

Section 7.01 Duties of Trustee.

(a) If an Event of Default has occurred and is continuing, the Trustee shall exercise such of the rights and powers vested in it by this Indenture, and use the same degree of care and skill in its exercise, as a prudent Person would exercise or use under the circumstances in the conduct of such Person's own affairs.

(b) Except during the continuance of an Event of Default:

(1) the duties of the Trustee shall be determined solely by the express provisions of this Indenture and the Trustee need perform only those duties that are specifically set forth in this Indenture and no others, and no implied covenants or obligations shall be read into this Indenture against the Trustee; and

(2) in the absence of bad faith on its part, the Trustee may conclusively rely, as to the truth of the statements and the correctness of the opinions expressed therein, upon certificates or opinions furnished to the Trustee and conforming to the requirements of this Indenture. However, in the case of certificates or opinions specifically required by any provision herein to be furnished to it, the Trustee shall examine the certificates and opinions to determine whether or not they conform to the requirements of this Indenture (but need not confirm or investigate the accuracy of mathematical calculations or other facts stated therein).

(c) The Trustee may not be relieved from liabilities for its own negligent action, its own negligent failure to act, or its own willful misconduct, except that:

(1) this paragraph does not limit the effect of paragraph (b) of this Section 7.01;

(2) the Trustee shall not be liable for any error of judgment made in good faith by a Responsible Officer, unless it is proved that the Trustee was negligent in ascertaining the pertinent facts; and

(3) the Trustee shall not be liable with respect to any action it takes or omits to take in good faith in accordance with a direction received by it pursuant to Section 6.05 hereof.

(d) Whether or not therein expressly so provided, every provision of this Indenture that in any way relates to the Trustee is subject to paragraphs (a), (b), (c) and (e) of this Section 7.01.

(e) No provision of this Indenture shall require the Trustee to expend or risk its own funds or incur any liability. The Trustee shall be under no obligation to exercise any of the rights or powers vested in it by this Indenture at the request or direction of any Holders pursuant to this Indenture, unless such Holders shall have offered to the Trustee security or indemnity satisfactory to the Trustee against any loss, liability or expense which might be incurred by it in compliance with such request or direction.

(f) The Trustee shall not be liable for interest on any money received by it except as the Trustee may agree in writing with the Company. Money or property held in trust by the Trustee need not be segregated from other funds or property except to the extent required by law.

(g) The Trustee shall have no duty to calculate or verify the calculations of the Applicable Premium.

Section 7.02 Rights of Trustee.

(a) The Trustee may conclusively rely upon any document believed by it to be genuine and to have been signed or presented by the proper Person.

(b) Before the Trustee acts or refrains from acting, it may require an Officer's Certificate or an Opinion of Counsel or both. The Trustee shall not be liable for any action it takes or omits to take in good faith in reliance on such Officer's Certificate or Opinion of Counsel. The Trustee may consult with counsel of its selection and the advice of such counsel or any Opinion of Counsel shall be full and complete authorization and protection from liability in respect of any action taken, suffered or omitted by it hereunder in good faith and in reliance thereon.

(c) The Trustee shall not be liable for any action it takes or omits to take in good faith that it believes to be authorized or within the rights or powers conferred upon it by this Indenture.

(d) Unless otherwise specifically provided in this Indenture, any demand, request, direction or notice from the Company shall be sufficient if signed by an Officer of the Company.

(e) The Trustee shall not be deemed to have notice of any Default or Event of Default unless a Responsible Officer of the Trustee has actual knowledge thereof or unless written notice of any event which is in fact such a Default or Event of Default is received by a Responsible Officer of the Trustee at the Corporate Trust Office of the Trustee from the Company or the Holders of at least 25% in aggregate principal amount of the outstanding Notes, and such notice references the specific Default or Event of Default, the Notes and this Indenture.

(f) The Trustee shall not be required to give any bond or surety in respect of the performance of its power and duties hereunder.

(g) The Trustee shall have no duty to inquire as to the performance of the Company's covenants herein.

(h) The Trustee may execute any of the trusts or powers hereunder or perform any duties hereunder either directly or by or through agents or attorneys and the Trustee shall not be responsible for any misconduct or negligence on the part of any agent or attorney appointed with due care by it hereunder.

(i) [Reserved].

(j) In no event shall the Trustee be responsible or liable for special, indirect, or consequential loss or damage of any kind whatsoever (including, but not limited to, loss of profit) irrespective of whether the Trustee has been advised of the likelihood of such loss or damage and regardless of the form of action.

(k) [Reserved].

(l) The rights, privileges, protections, immunities and benefits given to the Trustee, including, without limitation, its right to be indemnified, are extended to, and shall be enforceable by, the Trustee in each of its capacities hereunder, and each agent, custodian and other Person employed to act hereunder by or on behalf of the Trustee.

(m) The Trustee shall not be bound to make any investigation into the facts or matters stated in any resolution, certificate, statement, instrument, opinion, report, notice, request, direction, consent, order, bond, debenture, note, other evidence of indebtedness or other paper or document, but the Trustee, in its discretion, may make such further inquiry or investigation into such facts or matters as it may see fit, and, if the Trustee shall determine to make such further inquiry or investigation, it shall be entitled to examine the books, records and premises of the Company, personally or by agent or attorney at the sole cost of the Company and shall incur no liability or additional liability of any kind by reason of such inquiry or investigation.

(n) None of the provisions of this Indenture shall require the Trustee to expend or risk its own funds or otherwise to incur any liability, financial or otherwise, in the performance of any of its duties hereunder, or in the exercise of any of its rights or powers if it shall have reasonable grounds for believing that repayment of such funds or indemnity satisfactory to it against such risk or liability is not assured to it.

Section 7.03 Individual Rights of Trustee.

The Trustee in its individual or any other capacity may become the owner or pledgee of Notes and may otherwise deal with the Company or any Affiliate of the Company with the same rights it would have if it were not Trustee. However, in the event that the Trustee acquires any conflicting interest within the meaning of the TIA it must eliminate such conflict within 90 days, apply to the SEC for permission to continue as Trustee or resign. Any Agent may do the same with like rights and duties. The Trustee shall also be subject to Sections 7.10 and 7.11 hereof.

Section 7.04 Trustee's Disclaimer.

The Trustee shall not be responsible for and makes no representation as to the validity or adequacy of this Indenture or the Notes, it shall not be accountable for the Company's use of the proceeds from the Notes or any money paid to the Company or upon the Company's direction under any provision of this Indenture, it shall not be responsible for the use or application of any money received by any Paying Agent other than the Trustee, and it shall not be responsible for any statement or recital herein or any statement in the Notes or any other document in connection with the sale of the Notes or pursuant to this Indenture other than its certificate of authentication and any other certificate or other document executed by the Trustee and delivered to the Company.

Section 7.05 Notice of Defaults.

If a Default or Event of Default occurs and is continuing and if it is known to a Responsible Officer of the Trustee, the Trustee shall mail to Holders a notice of the Default or Event of Default within 90 days after such Default or Event of Default becomes known to a Responsible Officer. Except in the case of a Default or Event of Default in payment of principal of, premium, if any, or interest on any Note, the Trustee may withhold the notice if and so long as a Responsible Officer in good faith determines that withholding the notice is in the interests of the Holders.

Section 7.06 Reports by Trustee to Holders.

Within 60 days after each May 15 beginning with the May 15 following the Issue Date, and for so long as Notes remain outstanding, the Trustee shall mail to the Holders a brief report dated as of such reporting date that complies with TIA § 313(a) (but if no event described in TIA § 313(a) has occurred within the twelve months preceding the reporting date, no report need be transmitted). The Trustee also shall comply with TIA § 313(b)(2). The Trustee shall also transmit by mail all reports as required by TIA § 313(c).

A copy of each report at the time of its mailing to the Holders shall be mailed to the Company and filed with the SEC and each stock exchange on which the Notes are listed in accordance with TIA § 313(d). The Company shall promptly notify the Trustee when the Notes are listed on any stock exchange and any delisting thereof.

Section 7.07 Compensation and Indemnity.

The Company shall pay to the Trustee from time to time compensation for its acceptance of this Indenture and services hereunder. The Trustee's compensation shall not be limited by any law on compensation of a trustee of an express trust. The Company shall reimburse the Trustee promptly upon request for all reasonable disbursements, advances and expenses incurred or made by it in addition to the compensation for its services. Such expenses shall include the reasonable compensation, disbursements and expenses of the Trustee's agents and counsel.

The Company, and the Guarantors, shall, jointly and severally, indemnify the Trustee, its directors, officers, employees, agents and any predecessor Trustee against any and all losses, claims, damages, penalties, fines, liabilities or expenses, including incidental and out-of-pocket expenses and reasonable attorneys' fees and expenses (for purposes of this Article, "***losses***") incurred by it arising out of or in connection with the acceptance or administration of its duties under this Indenture, including the costs and expenses of enforcing this Indenture against the Company (including this Section 7.07) and defending itself against any claim (whether asserted by the Company or any Holder or any other Person) or liability in connection with the exercise or performance of any of its powers or duties hereunder, except to the extent such losses have been determined to have been caused by its own negligence or willful misconduct. The Trustee shall notify the Company promptly of any claim of which a Responsible Officer has received written notice and for which it may seek indemnity. Failure by the Trustee to so notify the Company shall not relieve the Company of its obligations under this Section 7.07. The Company shall defend the claim, and the Trustee shall cooperate in the defense. The Trustee may have separate counsel if the Trustee has been reasonably advised by counsel that it is advisable for the Trustee to engage separate counsel, and the Company shall pay the reasonable fees and expenses of such counsel. Neither the Company nor any Guarantor need pay for any settlement made without the Company's consent, which consent shall not be unreasonably withheld. Neither the Company nor any Guarantor need pay any expense or indemnify against any loss incurred by the Trustee through the Trustee's own willful misconduct or gross negligence, as determined by a final non-appealable order of a court of competent jurisdiction not subject to appeals.

The obligations of the Company and the Guarantors under this Section 7.07 shall survive the satisfaction and discharge of this Indenture, the resignation or removal of the Trustee and payment in full of the Notes.

To secure the Company's and Guarantors' payment obligations in this Section, the Trustee shall have a Lien prior to the Notes on all money or property held or collected by the Trustee, except that held in trust to pay principal, premium, if any, and interest on particular Notes. Such Lien shall survive the satisfaction and discharge of this Indenture and the resignation and removal of the Trustee hereunder.

When the Trustee incurs expenses or renders services after an Event of Default specified in Section 6.01(f) or (h) hereof occurs, the expenses and the compensation for the services (including the fees and expenses of its agents and counsel) are intended to constitute expenses of administration under any Bankruptcy Law.

Section 7.08 Replacement of Trustee.

A resignation or removal of the Trustee and appointment of a successor Trustee shall become effective only upon the successor Trustee's acceptance of appointment as provided in this Section 7.08.

The Trustee may resign in writing at any time upon 30 days' prior notice to the Company and be discharged from the trust hereby created by so notifying the Company. The Holders of a majority in aggregate principal amount of the then outstanding Notes may remove the Trustee by so notifying the Trustee and the Company in writing. The Company may remove the Trustee if:

(a) the Trustee fails to comply with Section 7.10 hereof;

(b) the Trustee is adjudged bankrupt or insolvent or an order for relief is entered with respect to the Trustee under any Bankruptcy Law;

(c) a custodian or public officer takes charge of the Trustee or its property; or

(d) the Trustee becomes incapable of acting.

If the Trustee resigns or is removed or if a vacancy exists in the office of Trustee for any reason (the Trustee in such event being referred to herein as the retiring Trustee), the Company shall promptly appoint a successor Trustee.

Within one year after the successor Trustee takes office, the Holders of a majority in principal amount of the then outstanding Notes may appoint a successor Trustee to replace the successor Trustee appointed by the Company.

If a successor Trustee does not take office within 30 days after the retiring Trustee resigns or is removed, the retiring Trustee, the Company, or the Holders of at least 10% in aggregate principal amount of the then outstanding Notes may, at the expense of the Company, petition any court of competent jurisdiction for the appointment of a successor Trustee.

If the Trustee, after written request by any Holder who has been a Holder for at least six months, fails to comply with Section 7.10 hereof, such Holder may petition any court of competent jurisdiction for the removal of the Trustee and the appointment of a successor Trustee.

A successor Trustee shall deliver a written acceptance of its appointment to the retiring Trustee and to the Company and enter into a supplemental indenture with the retiring Trustee and the Company in which it assumes the rights, powers and duties of the Trustee under this Indenture. Thereupon, the resignation or removal of the retiring Trustee shall become effective, and the successor Trustee shall have all the rights, powers and duties of the Trustee under this Indenture. The successor Trustee shall mail a notice of its succession to the Holders. Subject to the Lien provided for in Section 7.07 hereof, the retiring Trustee shall promptly transfer all property held by it as Trustee to the successor Trustee; *provided*, *however*, that all sums owing to the Trustee hereunder shall have been paid. Notwithstanding replacement of the Trustee pursuant to this Section 7.08, the Company's obligations under Section 7.07 hereof shall continue for the benefit of the retiring Trustee.

In the case of an appointment hereunder of a separate or successor Trustee with respect to the Notes, the Company, any retiring Trustee and each successor or separate Trustee with respect to the Notes shall execute and deliver a supplemental indenture hereto (1) which shall contain such provisions as shall be deemed necessary by the Company or retiring Trustee or desirable to confirm that all the rights, powers, trusts and duties of any retiring Trustee with respect to the Notes have been assumed by a successor Trustee and in the case where any retiring Trustee is retiring only with respect to some of the Notes that the rights, powers, trusts and duties of any retiring Trustee with respect to the Notes as to which any such retiring Trustee is not retiring shall continue to be vested in such retiring Trustee and (2) that shall add to or change any of the provisions of this Indenture as shall be necessary to provide for or facilitate the administration of the trusts hereunder by more than one Trustee, it being understood that nothing herein or in such supplemental indenture shall constitute such Trustee co-trustees of the same trust and that each such separate, retiring or successor Trustee shall be Trustee of a trust or trusts hereunder separate and apart from any trust or trusts hereunder administered by any such other Trustee.

Section 7.09 Successor Trustee by Merger, etc.

If the Trustee consolidates, merges or converts into, or transfers all or substantially all of its corporate trust business to, another corporation or banking association, the successor corporation or

banking association without any further act shall, if such successor corporation or banking association is otherwise eligible hereunder, be the successor Trustee.

Section 7.10 Eligibility; Disqualification.

There shall at all times be a Trustee hereunder that is a Person organized and doing business under the laws of the United States of America or of any state thereof that is authorized under such laws to exercise corporate trustee power, that is subject to supervision or examination by federal or state authorities and that has a combined capital and surplus of at least $50.0 million (or a wholly owned subsidiary of a bank or trust company, or of a bank holding company, the principal subsidiary of which is a bank or trust company having a combined capital and surplus of at least $50.0 million) as set forth in its most recent published annual report of condition.

This Indenture shall always have a Trustee who satisfies the requirements of TIA § 310(a)(1), (2) and (5). The Trustee is subject to TIA § 310(b).

Section 7.11 Preferential Collection of Claims Against Company.

The Trustee is subject to TIA § 311(a), excluding any creditor relationship listed in TIA § 311(b). A Trustee who has resigned or been removed shall be subject to TIA § 311(a) to the extent indicated therein.

ARTICLE 8

SATISFACTION AND DISCHARGE OF THE INDENTURE AND DEFEASANCE

Section 8.01 Satisfaction and Discharge of Notes; Discharge of Indenture.

This Indenture will be discharged and will cease to be of further effect as to all Notes issued hereunder when:

(a) all outstanding Notes previously authenticated and delivered (other than destroyed, lost or stolen Notes that have been replaced or Notes that are paid pursuant to Section 4.01 or Notes for whose payment money or Notes have theretofore been held in trust and thereafter repaid to the Company, as provided in Section 8.05) have been delivered to the Trustee for cancellation and the Company has paid all sums payable by it hereunder; or

(b) all of the Notes not theretofore delivered to the Trustee for cancellation mature within one year, or the Notes have become due and payable by reason of the mailing of a notice of redemption or otherwise, and (A) the Company irrevocably deposits or causes to be deposited with the Trustee as trust funds in trust solely for the benefit of the Holders of such Notes, funds (including money, Government Securities or any combination thereof) in amounts as will be sufficient in the good faith opinion of the Company without consideration of any reinvestment of any interest thereon, to pay and discharge the entire indebtedness on such Notes not already delivered to the Trustee for cancellation, for principal of and interest on the Notes to maturity or redemption, as the case may be, and to pay all other sums payable by it hereunder, together with irrevocable instructions from the Company directing the Trustee to apply such funds to the payment thereof at maturity or redemption, as the case may be, (B) no Default or Event of Default with respect to the Notes shall have occurred and be continuing on the date of such deposit, (C) such deposit will not result in a breach or violation of, or constitute a default under, this Indenture or any other agreement or instrument to which the Company is a party or by which it is bound and (D) the

Company has delivered to the Trustee an Officer's Certificate and an Opinion of Counsel, in each case stating that all conditions precedent provided for herein relating to the satisfaction and discharge of the outstanding Notes and this Indenture have been complied with.

With respect to the foregoing clauses (a) and (b), the Company's obligations under Section 7.07 shall survive. With respect to the foregoing clause (b), the Company's obligations in Sections 2.01, 2.02, 2.05, 2.06, 2.07, 2.08, 2.09, 2.10, 4.01, 4.02, 7.08, 7.09, 8.04, 8.05 and 8.06 shall survive until the Notes are no longer outstanding. After any such irrevocable deposit, this Indenture shall cease to be of any further effect (except as otherwise expressly provided herein) and the Trustee upon request shall acknowledge in writing the satisfaction and discharge of the Company's obligations under the Notes and this Indenture with respect to the Notes except for those surviving obligations specified above.

Section 8.02 Legal Defeasance.

Except as otherwise provided for in the Notes, the Company will be deemed to have paid and will be discharged from any and all obligations in respect of the Notes on the 91st day after the date of the deposit referred to in clause (a) of this Section 8.02, and the provisions of this Indenture will no longer be in effect with respect to the Notes, and the Trustee, at the expense of the Company, shall execute such instruments reasonably requested by the Company acknowledging the same if:

(a) the Company has irrevocably deposited or caused to be irrevocably deposited with the Trustee (or another Trustee satisfying the requirements of Section 7.10) and conveyed all right, title and interest to the Trustee for the benefit of the Holders of Notes, under the terms of an irrevocable trust agreement in form and substance satisfactory to the Trustee as trust funds in trust, specifically pledged to the Trustee for the benefit of such Holders of Notes for payment of the principal of and interest, if any, on the Notes, and dedicated solely to, the benefit of such Holders, in and to (1) money in an amount, (2) Government Securities that, through the payment of interest and principal in respect thereof in accordance with their terms, will provide, not later than one day before the due date of any payment referred to in this clause (a), money in an amount or (3) a combination thereof in an amount sufficient, in the opinion of a nationally recognized firm of independent public accountants expressed in a written certification thereof delivered to the Trustee, to pay and discharge, without consideration of the reinvestment of such interest and after payment of all federal, state and local taxes or other charges and assessments in respect thereof payable by the Trustee, the principal of and interest on the outstanding Notes on the Stated Maturity of such principal or interest; *provided* that the Trustee shall have been irrevocably instructed to apply such money or the proceeds of such Government Securities to the payment of such principal and interest with respect to the Notes;

(b) the Company has delivered to the Trustee either (x) an Opinion of Counsel to the effect that Holders of Notes will not recognize income, gain or loss for United States federal income tax purposes as a result of the Company's exercise of its option under this Section 8.02 and will be subject to United States federal income tax on the same amount and in the same manner and at the same times as would have been the case if such option had not been exercised, which Opinion of Counsel shall be based upon (and accompanied by a copy of) a ruling of the Internal Revenue Service to the same effect unless there has been a change in applicable federal income tax law after the Issue Date of such Notes such that a ruling is no longer required or (y) a ruling received from the Internal Revenue Service to the same effect as the aforementioned Opinion of Counsel;

(c) immediately after giving effect to such deposit, on a pro forma basis, no Default or Event of Default with respect to the Notes shall have occurred and be continuing on the date of such deposit or,

insofar as Sections 6.01(f) and 6.01(h) are concerned, to the Company's knowledge, will occur and be continuing at any time during the period ending on the 91st day after such date of such deposit; and

(d) the Company has delivered to the Trustee an Officer's Certificate and an Opinion of Counsel, in each case stating that all conditions precedent provided for herein relating to the defeasance contemplated by this Section 8.02 have been complied with.

Notwithstanding the foregoing, prior to the end of the 91-day period referred to in clause (c) of this Section 8.02, none of the Company's obligations under this Indenture with respect to the Notes shall be discharged. Subsequent to the end of such 91-day period with respect to this Section 8.02, the Company's obligations in 2.01, 2.02, 2.08, 2.09, 8.04, 8.05 and 8.06 and the rights, powers, trusts, duties and immunities of the Trustee hereunder shall survive such satisfaction and discharge until the Notes are no longer outstanding, and thereafter, the Company's obligations to the Trustee under Section 7.07 shall survive.

After any such irrevocable deposit, this Indenture shall cease to be of any further effect (except as otherwise expressly provided herein) and the Trustee upon request shall acknowledge in writing the discharge of the Company's obligations under the Notes and this Indenture with respect to the Notes except for those surviving obligations in the immediately preceding paragraph.

Section 8.03 Defeasance of Certain Obligations.

Except as otherwise provided for in the Notes, the Company and the Guarantors may omit to comply with any term, provision or condition set forth in Sections 4.03, 4.04, 4.06, 4.08, 4.09, and 5.01 and clause (d) of Section 6.01 and a breach with respect to Sections 4.03, 4.04, 4.06, 4.08, 4.09 and 5.01 and clause (d) of Section 6.01 shall be deemed not to be an Event of Default, in each case with respect to the outstanding Notes, and the Guarantors (including any Subsidiary of the Company who becomes a guarantor under the Credit Agreement subsequent to the date of this Indenture and who otherwise would be required to provide a Subsidiary Guarantee hereunder) shall be deemed to have been discharged from their obligations with respect to all Subsidiary Guarantees if:

(a) with reference to this Section 8.03, the Company has irrevocably deposited or caused to be irrevocably deposited with the Trustee (or another trustee satisfying the requirements of Section 7.10) and conveyed all right, title and interest to the Trustee for the benefit of the Holders of Notes, under the terms of an irrevocable trust agreement in form and substance satisfactory to the Trustee as trust funds in trust, specifically pledged to the Trustee for the benefit of such Holders of Notes for payment of the principal of and interest, if any, on the Notes, and dedicated solely to, the benefit of such Holders, in and to (A) money in an amount, (B) Government Securities that, through the payment of interest and principal in respect thereof in accordance with their terms, will provide, not later than one day before the due date of any payment referred to in this clause (i), money in an amount or (C) a combination thereof in an amount sufficient, in the opinion of a nationally recognized firm of independent public accountants expressed in a written certification thereof delivered to the Trustee, to pay and discharge, without consideration of the reinvestment of such interest and after payment of all federal, state and local taxes or other charges and assessments in respect thereof payable by the Trustee, the principal of and interest on the outstanding Notes on the Stated Maturity of such principal or interest; *provided* that the Trustee shall have been irrevocably instructed to apply such money or the proceeds of such Government Securities to the payment of such principal and interest with respect to the Notes;

(b) the Company has delivered to the Trustee an Opinion of Counsel to the effect that the Holders of Notes will not recognize income, gain or loss for United States federal income tax purposes as

a result of such deposit and defeasance of such covenants and Events of Default and will be subject to United States federal income tax on the same amount and in the same manner and at the same times as would have been the case if such deposit and defeasance had not occurred;

(c) immediately after giving effect to such deposit on a pro forma basis, no Default or Event of Default with respect to the Notes shall have occurred and be continuing on the date of such deposit or, insofar as Sections 6.01(f) and 6.01(h) are concerned, to the Company's knowledge, will occur and be continuing at any time during the period ending on the 91st day after such date of such deposit;

(d) if the Notes are then listed on a national Notes exchange, the Company has delivered to the Trustee an Opinion of Counsel to the effect that the Notes will not be delisted as a result of such deposit, defeasance and discharge; and

(e) the Company has delivered to the Trustee an Officer's Certificate and an Opinion of Counsel, in each case stating that all conditions precedent provided for herein relating to the defeasance contemplated by this Section 8.03 have been complied with.

Section 8.04 Application of Trust Money.

Subject to Section 8.06, the Trustee or Paying Agent shall hold in trust money or Government Securities deposited with it pursuant to Section 8.01, 8.02 or 8.03, as the case may be, and shall apply the deposited money and the money from Government Securities in accordance with the Notes and this Indenture to the payment of principal of and interest on the Notes; but such money need not be segregated from other funds except to the extent required by law.

Section 8.05 Repayment to Company.

Subject to Sections 7.08, 8.01, 8.02 and 8.03, the Trustee and the Paying Agent shall promptly pay to the Company upon request set forth in an Officer's Certificate any excess money held by them at any time and thereupon shall be relieved from all liability with respect to such money. The Trustee and the Paying Agent shall pay to the Company upon request any money held by them with respect to the Notes for the payment of principal or interest that remains unclaimed for two years; *provided* that the Trustee or Paying Agent before being required to make any payment may cause to be published at the expense of the Company once in a newspaper of general circulation in The City of New York or mail to each Holder of Notes entitled to such money at such Holder's address (as set forth in the Note Register) notice that such money remains unclaimed and that after a date specified therein (which shall be at least 30 days from the date of such publication or mailing) any unclaimed balance of such money then remaining will be repaid to the Company. After payment to the Company, Holders of Notes entitled to such money must look to the Company or the Guarantors, as the case may be, for payment as general creditors unless an applicable law designates another Person, and all liability of the Trustee and such Paying Agent with respect to such money shall cease.

Section 8.06 Reinstatement.

If the Trustee or Paying Agent is unable to apply any money or Government Securities in accordance with Section 8.01, 8.02 or 8.03, as the case may be, by reason of any legal proceeding or by reason of any order or judgment of any court or governmental authority enjoining, restraining or otherwise prohibiting such application, the Company's obligations under this Indenture and the Notes shall be revived and reinstated as though no deposit had occurred pursuant to Section 8.01, 8.02 or 8.03, as the case may be, until such time as the Trustee or Paying Agent is permitted to apply all such money or

Government Securities in accordance with Section 8.01, 8.02 or 8.03, as the case may be; *provided* that, if the Company has made any payment of principal of or interest on any Notes because of the reinstatement of its obligations, the Company shall be subrogated to the rights of the Holders of such Notes to receive such payment from the money or Government Securities held by the Trustee or Paying Agent.

ARTICLE 9

AMENDMENT, SUPPLEMENT AND WAIVER

Section 9.01 Without Consent of Holders of Notes.

Notwithstanding Section 9.02, the Company, each of the Guarantors (except no existing Guarantor need execute a supplemental indenture with respect to clause (g) below) and the Trustee may amend or supplement this Indenture, the Notes or any Subsidiary Guarantee without notice to or the consent of any Holder:

(a) to cure any ambiguity, defect, inconsistency, omission or mistake;

(b) to comply with Article 5;

(c) to evidence and provide for the acceptance of appointment hereunder by a successor trustee;

(d) to provide for uncertificated Notes in addition to or in place of certificated Notes;

(e) to add to the covenants of the Company for the protection of the Holders of Notes, to add any additional Events of Default with respect to the Notes, or to surrender any right or power conferred upon the Company;

(f) to convey, transfer, assign, mortgage or pledge to the Trustee as security for the Notes any property or assets;

(g) to allow any Guarantor to execute a supplemental indenture in respect of a Subsidiary Guarantee;

(h) to release Guarantors in compliance with Section 10.05;

(i) to secure the Notes, including pursuant to the requirements of Section 4.03;

(j) to conform this text of this Indenture, the Notes or any Subsidiary Guarantee to any provision of the "Description of Notes" section of the Offering Memorandum to the extent that the Trustee has received an Officer's Certificate stating that such text constitutes an unintended conflict with the corresponding provision in such "Description of Notes";

(k) to comply with requirements of any securities depository with respect to the notes;

(l) to establish the terms of Notes as permitted by Section 3.01;

(m) to make any change that, in the good faith opinion of the Board of Directors of the Company, does not materially and adversely affect the rights of any Holder;

(n) to provide for the assumption of the Company's or a Guarantor's obligations to holders of the Notes and Subsidiary Guarantees in the case of a merger or consolidation or sale of all or substantially all of the Company's or such Guarantor's assets, as applicable; or

(o) to provide for or confirm the issuance of Additional Notes otherwise permitted to be incurred by this Indenture.

Section 9.02 With Consent of Holders of Notes.

Subject to Sections 6.04 and 6.07 and without prior notice to the Holders, the Company, each of the Guarantors and the Trustee may amend or supplement this Indenture and the Notes with the written consent of the Holders of a majority in principal amount of the Notes then outstanding (voting as one class), and the Holders of a majority in principal amount of the Notes then outstanding (voting as one class) by written notice to the Trustee may waive future compliance by the Company with any provision of this Indenture or the Notes.

Notwithstanding the provisions of this Section 9.02, without the consent of each Holder affected, an amendment, supplement or waiver, including a waiver pursuant to Section 6.04, may not:

(a) extend the Stated Maturity of the principal of, or any installment of principal or interest on, any Note;

(b) reduce the principal amount of or rate of interest on any Note, or any amount payable upon redemption thereof, except as provided in this Indenture or the Notes;

(c) change any place or currency of payment of principal of or interest on any Note;

(d) impair the right to institute suit for the enforcement of any payment on or after the Stated Maturity on any Note;

(e) reduce the percentage or principal amount of outstanding Notes the consent of whose Holders is necessary to modify or amend this Indenture or to waive compliance with certain provisions of or certain Defaults under this Indenture;

(f) waive an uncured default in the payment of principal of or interest on any Note; or

(g) modify any of the provisions of this Section 9.02, except to increase any such percentage or to provide that certain other provisions of this Indenture cannot be modified or waived without the consent of the Holder of each outstanding Note affected thereby.

It shall not be necessary for the consent of the Holders under this Section 9.02 to approve the particular form of any proposed amendment, supplement or waiver, but it shall be sufficient if such consent approves the substance thereof.

After an amendment, supplement or waiver under this Section 9.02 becomes effective, the Company shall mail to the Holders affected thereby a notice briefly describing the amendment, supplement or waiver. The Company will mail supplemental indentures to Holders upon request. Any failure of the Company to mail such notice, or any defect therein, shall not, however, in any way impair or affect the validity of any such supplemental indenture or waiver.

Section 9.03 Action by Holders; Record Dates.

Whenever in this Indenture it is provided that the Holders of a specified principal amount of the outstanding Notes may take any action (including the making of any demand or request, the giving of any notice, consent or waiver or the taking of any other action), the fact that at the time of taking any such action the Holders of such specified amount have joined therein may be evidenced (a) by any instrument or any number of instruments of similar tenor executed by such Holders in person or by agent or proxy appointed in writing, or (b) the record of the Holders voting in favor thereof at any meeting of the Holders duly called, or (c) any combination of such instrument or instruments and any such record of such a meeting of the Holders.

Subject to the provisions of Sections 7.02 and 12.06, proof of the execution of any instrument by a Holder or its agent or proxy shall be sufficient if the ownership of the Notes shall be proved by (a) the Note Register or by a certificate of the Registrar; or (b) in accordance with such reasonable rules and regulations as may be prescribed by the Trustee or in any other manner which the Trustee may deem sufficient.

The Company may, but shall not be obligated to, fix a record date for the purpose of determining the Holders entitled to consent to any amendment, supplement or waiver. If a record date is fixed, then, notwithstanding the first paragraph of this Section 9.03, those Persons who were Holders at such record date (or their duly designated proxies) and only those Persons shall be entitled to consent to such amendment, supplement or waiver or to revoke any consent previously given, whether or not such Persons continue to be Holders after such record date. No such consent shall be valid or effective for more than 90 days after such record date.

After an amendment, supplement or waiver becomes effective, it shall bind every Holder of Notes unless it is of the type described in the second paragraph of Section 9.02. In case of an amendment or waiver of the type described in the second paragraph of Section 9.02, the amendment or waiver shall bind each Holder who has consented to it and every subsequent Holder of a Note that evidences the same indebtedness as the Note of the consenting Holder.

Section 9.04 Revocation and Effect of Consents.

Until an amendment, supplement or waiver becomes effective, a consent to it by a Holder is a continuing consent by the Holder and every subsequent Holder of a Note or portion of a Note that evidences the same debt as the Note of the consenting Holder, even if notation of the consent is not made on any Note. However, any such Holder or subsequent Holder may revoke the consent as to its Note or portion of its Note. Such revocation shall be effective only if the Trustee receives the notice of revocation before the date the amendment, supplement or waiver becomes effective. An amendment, supplement or waiver shall become effective on receipt by the Trustee of written consents from the Holders of the requisite percentage in principal amount of the outstanding Notes.

Section 9.05 Notation on or Exchange of Notes.

If an amendment, supplement or waiver changes the terms of a Note, the Trustee may require the Holder to deliver such Note to the Trustee. At the Company's expense, the Trustee may place an appropriate notation on such Note about the changed terms and return it to the Holder, and the Trustee may place an appropriate notation on any Note thereafter authenticated. Alternatively, if the Company or the Trustee so determines, the Company in exchange for such Note shall issue and the Trustee shall

authenticate a new Note that reflects the changed terms. Failure to make the appropriate notation, or issue a new Note, shall not affect the validity and effect of such amendment, supplement or waiver.

Section 9.06 Trustee to Sign Amendments, etc.

The Trustee shall be provided with, and shall be fully protected in relying upon, an Officer's Certificate and an Opinion of Counsel stating that the execution of any amendment, supplement or waiver authorized pursuant to this Article Nine is authorized or permitted by this Indenture and that it will be valid and binding upon the Company, subject to customary exceptions. Subject to the preceding sentence, the Trustee shall sign such amendment, supplement or waiver if the same does not adversely affect the rights, duties, liabilities or immunities of the Trustee. The Trustee may, but shall not be obligated to, execute any such amendment, supplement or waiver that affects the Trustee's own rights, duties or immunities under this Indenture or otherwise.

ARTICLE 10

SUBSIDIARY GUARANTEE

Section 10.01 Subsidiary Guarantees.

Subject to this Article 10, each of the Guarantors hereby agrees, jointly and severally, to unconditionally guarantee to each Holder of a Note authenticated and delivered by the Trustee and to the Trustee and its successors and assigns, irrespective of the validity and enforceability of this Indenture, the Notes or the obligations of the Company hereunder or thereunder, that: (a) the principal of and interest on the Notes will be promptly paid in full when due, whether at Stated Maturity, by acceleration, redemption, purchase or otherwise, and (b) all other obligations of the Company to the Holders or the Trustee under this Indenture and the Notes will be fully and punctually performed within the grace period set forth in Section 6.01(d), if applicable. Failing payment when due of any amount so guaranteed or any performance so guaranteed for whatever reason, the Guarantors shall be jointly and severally obligated to pay the same immediately. Each Guarantor agrees that this is a guarantee of payment and not a guarantee of collection.

The Guarantors hereby agree that their obligations hereunder shall be unconditional, irrespective of the validity, regularity or enforceability of the Notes or this Indenture, the absence of any action to enforce the same, any waiver or consent by any Holder of the Notes with respect to any provisions hereof or thereof, the recovery of any judgment against the Company, any action to enforce the same or any other circumstance which might otherwise constitute a legal or equitable discharge or defense of a guarantor. Each Guarantor hereby waives diligence, presentment, demand of payment, filing of claims with a court in the event of insolvency or bankruptcy of the Company, any right to require a proceeding first against the Company, protest, notice and all demands whatsoever and covenant that this Subsidiary Guarantee shall not be discharged except by complete performance of the obligations contained in the Notes and this Indenture.

If any Holder or the Trustee is required by any court or otherwise to return to the Company, the Guarantors or any custodian, trustee, liquidator or other similar official acting in relation to either the Company or the Guarantors, any amount paid by either to the Trustee or such Holder, this Subsidiary Guarantee, to the extent theretofore discharged, shall be reinstated in full force and effect.

Each Guarantor agrees that it shall not be entitled to any right of subrogation in relation to the Holders of Notes in respect of any obligations guaranteed hereby until payment in full of all obligations

guaranteed hereby. Each Guarantor further agrees that, as between the Guarantors, on the one hand, and the Holders and the Trustee, on the other hand, (x) the maturity of the obligations guaranteed hereby may be accelerated as provided in Article 6 for the purposes of this Subsidiary Guarantee, notwithstanding any stay, injunction or other prohibition preventing such acceleration in respect of the obligations guaranteed hereby, and (y) in the event of any declaration of acceleration of such obligations as provided in Article 6, such obligations (whether or not due and payable) shall forthwith become due and payable by such Guarantor for the purpose of this Subsidiary Guarantee. The Guarantors shall have the right to seek contribution from any non-paying Guarantor so long as the exercise of such right does not impair the rights of the Holders under the Subsidiary Guarantee.

In case any provision of any Subsidiary Guarantee shall be invalid, illegal or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

Each payment to be made by a Guarantor in respect of its Subsidiary Guarantee shall be made without set-off, counterclaim, reduction or diminution of any kind or nature.

As used in this Section 10.01, the term "***Trustee***" shall also include each of the Paying Agent, Registrar and Transfer Agent, as applicable.

Section 10.02 Limitation on Guarantors Liability.

Each Guarantor and, by its acceptance of Notes, each Holder hereby confirms that it is the intention of all such parties that the Subsidiary Guarantee of such Guarantor not constitute a fraudulent transfer or conveyance for purposes of any Bankruptcy Law, the Uniform Fraudulent Conveyance Act, the Uniform Fraudulent Transfer Act or any similar federal or state law to the extent applicable to any Subsidiary Guarantee. To effectuate the foregoing intention, the Trustee, the Holders and the Guarantors hereby irrevocably agree that the obligations of such Guarantor will be limited so that, after giving effect to such maximum amount and all other contingent and fixed liabilities of such Guarantor that are relevant under such laws, and after giving effect to any collections from, rights to receive contribution from or payments made by or on behalf of any other Guarantor in respect of the obligations of such other Guarantor under this Article 10, will not result in the obligations of such Guarantor under its Subsidiary Guarantee constituting a fraudulent transfer or conveyance.

Section 10.03 Execution and Delivery of Subsidiary Guarantee.

To evidence its Subsidiary Guarantee set forth in Section 10.01, each Guarantor hereby agrees that the Notes shall bear a notation substantially in the form annexed hereto as Exhibit A stating that such Notes are guaranteed by the Guarantors in accordance with this Article 10 and may be released upon the terms and conditions set forth in this Indenture.

Each Guarantor hereby agrees that its Subsidiary Guarantee set forth in Section 10.01 shall remain in full force and effect notwithstanding any failure to endorse on each Note a notation of such Subsidiary Guarantee.

If an Officer of a Guarantor whose signature is on this Indenture no longer holds that office at the time the Trustee authenticates the Note on which a Subsidiary Guarantee is endorsed, such Subsidiary Guarantee shall be valid nevertheless.

The delivery of any Note by the Trustee, after the authentication thereof hereunder, shall constitute due delivery of the Subsidiary Guarantees set forth in this Indenture on behalf of the Guarantors.

In the event that a Subsidiary of the Company (other than a Guarantor) becomes a guarantor under the Credit Agreement subsequent to the date of this Indenture, the Company shall cause such Subsidiary to become a Guarantor and to execute a supplemental indenture and Subsidiary Guarantee within 10 Business Days of the date when such event occurs.

Section 10.04 Guarantors May Consolidate, etc., on Certain Terms.

Except as otherwise provided in Section 10.05, no Guarantor may consolidate with or merge with or into (unless such Guarantor is the surviving Person) another Person unless:

(a) subject to Section 10.05, the Person formed by or surviving any such consolidation or merger (if other than a Guarantor or the Company) unconditionally assumes all of the obligations of such Guarantor under the Notes and this Indenture pursuant to a supplemental indenture on the terms set forth herein or therein; and

(b) immediately after giving effect to such transaction, no Default or Event of Default shall have occurred and be continuing; *provided*, *however*, that this requirement shall not apply to any consolidation or merger of a Guarantor with or into the Company or another Guarantor.

In case of any such consolidation or merger, and upon the assumption by the successor Person, by supplemental indenture, executed and delivered to the Trustee and satisfactory in form to the Trustee, of the due and punctual performance of all of the covenants and conditions of this Indenture to be performed by the Guarantor, such successor Person shall succeed to and be substituted for the Guarantor with the same effect as if it had been named herein as a Guarantor and such predecessor Guarantor shall be discharged from its obligations under the Notes and this Indenture.

Except as set forth in Articles 4 and 5, and notwithstanding clauses (a) and (b) above, nothing contained in this Indenture or in any of the Notes shall prevent any consolidation or merger of a Guarantor with or into the Company or another Guarantor, or shall prevent any sale or conveyance of the property of a Guarantor as an entirety or substantially as an entirety to the Company or another Guarantor.

Section 10.05 Release.

To the extent that a Guarantor is released as a guarantor under the Credit Agreement or the Credit Agreement is refinanced without such Guarantor being a guarantor under the new credit facility, or in the event the Credit Agreement is otherwise terminated, then such Guarantor (in the event of a termination of the Credit Agreement, all Guarantors) will be automatically and unconditionally released and discharged of any obligations under its Subsidiary Guarantee, without the consent of any Holder:

(a) to the same extent that such Guarantor was released and relieved of any obligations under the Credit Agreement;

(b) concurrently with any direct or indirect sale, issuance, exchange, disposition, conveyance or transfer (by merger or otherwise) of any Equity Interests of such Guarantor following which such Guarantor is no longer a Subsidiary of the Company, or of all or substantially all the assets of such Guarantor (determined on a consolidated basis for such Guarantor and its Subsidiaries), in accordance

with the applicable provisions of this Indenture following which such Guarantor is no longer a Subsidiary of the Company; or

(c) upon the Company exercising its legal defeasance or covenant defeasance options pursuant to Section 8.02 or 8.03 or the Company's obligations under this Indenture being discharged in accordance with Section 8.01 and the Notes.

Upon delivery by the Company to the Trustee of an Officer's Certificate and an Opinion of Counsel to the effect that such release has occurred in accordance with the provisions of this Indenture, the Trustee shall execute any documents reasonably requested by the Company in order to evidence the release of any Guarantor from its obligations under its Subsidiary Guarantee.

Any Guarantor not released from its obligations under its Subsidiary Guarantee shall remain liable for the full amount of the principal of and interest on the Notes and for the other obligations of any Guarantor under this Indenture as provided in this Article 10.

Section 10.06 Benefits Acknowledged.

Each Guarantor acknowledges that it will receive direct and indirect benefits from the financing arrangements contemplated by this Indenture, that it has received adequate value and fair consideration and that the Guarantee and waivers made by it pursuant to its Subsidiary Guarantee are knowingly made in contemplation of such benefits.

ARTICLE 11

[RESERVED]

ARTICLE 12

MISCELLANEOUS

Section 12.01 [Reserved].

Section 12.02 Notices.

Any notice or communication by the Company or the Trustee to the other is duly given if in writing and delivered in person or mailed by first class mail (registered or certified, return receipt requested), facsimile transmission or overnight air courier guaranteeing next-day delivery, to the other's address:

If to the Company:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Attention: Joseph W. White, Chief Financial Officer
Telecopier No.: (562) 499-0612

If to the Trustee:

U.S. Bank National Association
633 West Fifth Street, 24th Floor
Los Angeles, CA 90071
Attention: Paula Oswald
Telecopier No.: (213) 615-6197

The Company or the Trustee, by notice to the other, may designate additional or different addresses for subsequent notices or communications.

All notices and communications (other than those sent to the Trustee) shall be deemed to have been duly given: at the time delivered by hand, if personally delivered; five Business Days after being deposited in the mail, postage prepaid, if mailed; when receipt acknowledged, if sent by facsimile transmission; and the next Business Day after timely delivery to the courier, if sent by overnight air courier guaranteeing next-day delivery. All notices and communications to the Trustee shall be deemed duly given and effective only upon receipt.

Any notice or communication to a Holder shall be mailed by first class mail, certified or registered, return receipt requested, or by overnight air courier guaranteeing next-day delivery to its address shown on the Note Register or, if required or permitted by Section 3.03 or 3.08(c), by electronic transmission.

Failure to mail a notice or communication to a Holder or any defect in it shall not affect its sufficiency with respect to other Holders.

If a notice or communication is mailed or delivered in the manner provided above within the time prescribed, it is duly given, whether or not the addressee receives it.

If the Company sends a notice or communication to Holders, it shall mail a copy to the Trustee and each Agent at the same time.

The Trustee agrees to accept and act upon instructions or directions pursuant to this Indenture sent by unsecured e-mail, pdf, facsimile transmission or other similar unsecured electronic methods, *provided*, *however*, that the Trustee shall have received an incumbency certificate listing persons designated to give such instructions or directions and containing specimen signatures of such designated persons, which such incumbency certificate shall be amended and replaced whenever a person is to be added or deleted from the listing. If the Company elects to give the Trustee e-mail or facsimile instructions (or instructions by a similar electronic method) and the Trustee in its discretion elects to act upon such instructions, the Trustee's understanding of such instructions shall be deemed controlling. The Trustee shall not be liable for any losses, costs or expenses arising directly or indirectly from the Trustee's reliance upon and compliance with such instructions notwithstanding such instructions conflict with or are inconsistent with a subsequent written instruction. The Company agrees to assume all risks arising out of the use of such electronic methods to submit instructions and directions to the Trustee, including without limitation the risk of the Trustee acting on unauthorized instructions, and the risk or interception and misuse by third parties.

Notwithstanding any other provision of this Indenture or any Note, where this Indenture or any Note provides for notice of any event (including any notice of redemption or purchase) to a Holder of a Global Note (whether by mail or otherwise), such notice shall be sufficiently given if given to DTC (or its designee) pursuant to the standing instructions from DTC or its designee.

Section 12.03 Communication by Holders of Notes with Other Holders of Notes.

Holders may communicate pursuant to TIA § 312(b) with other Holders with respect to their rights under this Indenture or the Notes. The Company, the Trustee, the Note Registrar and anyone else shall have the protection of TIA § 312(c).

Section 12.04 Certificate and Opinion as to Conditions Precedent.

Upon any request or application by the Company to the Trustee to take any action under any provision of this Indenture, the Company shall furnish to the Trustee:

(a) an Officer's Certificate in form reasonably satisfactory to the Trustee (which shall include the statements set forth in Section 12.05 hereof) stating that, in the opinion of the signer, all conditions precedent and covenants, if any, provided for in this Indenture relating to the proposed action have been complied with; and

(b) an Opinion of Counsel in form reasonably satisfactory to the Trustee (which shall include the statements set forth in Section 12.05 hereof) stating that, in the opinion of such counsel, all such conditions precedent and covenants have been complied with.

Section 12.05 Statements Required in Certificate or Opinion.

Each certificate or opinion with respect to compliance with a condition or covenant provided for in this Indenture (other than a certificate provided pursuant to TIA § 314(a)(4)) shall comply with the provisions of TIA § 314(e) and shall include:

(a) a statement that the Person making such certificate or opinion has read such covenant or condition;

(b) a brief statement as to the nature and scope of the examination or investigation upon which the statements or opinions contained in such certificate or opinion are based;

(c) a statement that, in the opinion of such Person, he or she has made such examination or investigation as is necessary to enable such Person to express an informed opinion as to whether or not such covenant or condition has been complied with; and

(d) a statement as to whether or not, in the opinion of such Person, such condition or covenant has been complied with.

With respect to matters of fact, an Opinion of Counsel may rely on an Officer's Certificate, certificates of public officials or reports or opinions of experts.

Section 12.06 Rules by Trustee and Agents.

The Trustee may make reasonable rules for action by or at a meeting of Holders. The Note Registrar or Paying Agent may make reasonable rules and set reasonable requirements for its functions.

Section 12.07 No Personal Liability of Directors, Officers, Incorporators, Employees or Stockholders.

None of the Company's nor its Subsidiaries' directors, officers, employees, incorporators, members, partners or stockholders, as such, shall have any liability for any obligations of the Company or the Guarantors under the Notes, this Indenture, the Subsidiary Guarantees, or for any claim based on, in respect of, or by reason of, such obligations or their creation. Each Holder of Notes by accepting a Note waives and releases all such liability. The waiver and release are part of the consideration for issuance of the Notes.

Section 12.08 Governing Law.

THE LAWS OF THE STATE OF NEW YORK SHALL GOVERN AND BE USED TO CONSTRUE THIS INDENTURE AND THE NOTES WITHOUT GIVING EFFECT TO APPLICABLE PRINCIPLES OF CONFLICTS OF LAW TO THE EXTENT THAT THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION WOULD BE REQUIRED THEREBY.

Section 12.09 No Adverse Interpretation of Other Agreements.

This Indenture may not be used to interpret any other indenture, loan or debt agreement of the Company or its Subsidiaries or of any other Person. Any such indenture, loan or debt agreement may not be used to interpret this Indenture.

Section 12.10 Successors.

All covenants and agreements of the Company in this Indenture and the Notes shall bind its successors. All covenants and agreements of the Trustee in this Indenture shall bind its successors.

Section 12.11 Severability.

In case any provision in this Indenture or in the Notes shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

Section 12.12 Counterpart Originals.

The parties may sign any number of copies of this Indenture. The exchange of copies of this Indenture and of signature pages by facsimile or pdf transmission shall constitute effective execution and delivery of this Indenture as to the parties hereto. Each signed copy shall be an original, but all of them together shall represent one and the same agreement.

Section 12.13 Table of Contents, Headings, etc.

The Table of Contents, Cross-Reference Table and Headings in this Indenture have been inserted for convenience of reference only, are not to be considered a part of this Indenture and shall in no way modify or restrict any of the terms or provisions hereof.

Section 12.14 [Reserved].

Section 12.15 Waiver of Jury Trial.

EACH OF THE COMPANY, THE GUARANTORS AND THE TRUSTEE HEREBY IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY LEGAL PROCEEDING ARISING OUT OF OR RELATING TO THIS INDENTURE, THE NOTES OR THE TRANSACTION CONTEMPLATED HEREBY.

Section 12.16 Force Majeure.

In no event shall the Trustee be responsible or liable for any failure or delay in the performance of its obligations hereunder arising out of or caused by, directly or indirectly, forces beyond its control, including, without limitation, strikes, work stoppages, accidents, acts of war or terrorism, civil or military disturbances, nuclear or natural catastrophes or acts of God, and interruptions, loss or malfunctions of utilities, communications or computer (software and hardware) services; it being understood that the Trustee shall use reasonable efforts which are consistent with accepted practices in the banking industry to resume performance as soon as practicable under the circumstances.

Section 12.17 USA Patriot Act.

The parties hereto acknowledge that in accordance with Section 326 of the USA Patriot Act, the Trustee, like all financial institutions and in order to help fight the funding of terrorism and money laundering, is required to obtain, verify, and record information that identifies each person or legal entity that establishes a relationship or opens an account with the Trustee. The parties to this Indenture agree that they will provide the Trustee with such information as it may request in order for the Trustee to satisfy the requirements of the USA Patriot Act.

[Signatures on following page]

IN WITNESS WHEREOF, the parties have caused this Indenture to be duly executed.

Dated June 6, 2017

Company:

MOLINA HEALTHCARE, INC.

By: _____
Name:
Title:

Guarantors:

MOLINA INFORMATION SYSTEMS, LLC

By: _____
Name:
Title:

MOLINA PATHWAYS, LLC

By: _____
Name:
Title:

PATHWAYS HEALTH AND COMMUNITY SUPPORT LLC

By: _____
Name:
Title:

Dated June 6, 2017

Trustee:

U.S. BANK NATIONAL ASSOCIATION

By: _____
Name:
Title:

PROVISIONS RELATING TO INITIAL NOTES

1. Definitions

1.1 Definitions.

For the purposes of this Appendix the following terms shall have the meanings indicated below:

"Certificated Note" means a certificated Initial Note (other than a Global Note) bearing, if required, the restricted notes legend set forth in Section 2.2(e) of this Appendix.

"Distribution Compliance Period," with respect to any Notes, means the period of 40 consecutive days beginning on and including the later of (i) the day on which such Notes are first offered to Persons other than distributors (as defined in Regulation S under the Securities Act) in reliance on Regulation S and (ii) the issue date with respect to such Notes.

"Notes Custodian" means the custodian with respect to a Global Note (as appointed by the Depositary), or any successor Person thereto and shall initially be the Trustee.

"Purchase Agreement" means (1) with respect to the Initial Notes issued on the Issue Date, the Purchase Agreement dated May 22, 2017, among the Company, the Guarantors and SunTrust Robinson Humphrey, Inc., as representative of the Initial Purchasers, and (2) with respect to each issuance of Additional Notes, the purchase agreement or underwriting agreement among the Company, the Guarantors and the Persons purchasing such Additional Notes.

"QIB" means a "qualified institutional buyer" as defined in Rule 144A.

"Transfer Restricted Notes" means Notes that bear or are required to bear the legend relating to restrictions on transfer relating to the Securities Act set forth in Section 2.2(e) hereto.

1.2 Other Definitions.

Term	Defined in Section
"Agent Members"	2.1(b)
"Clearstream"	2.1(a)
"Euroclear"	2.1(a)
"Global Notes"	2.1(a)
"Regulation S"	2.1(a)
"Regulation S Global Note"	2.1(a)
"Rule 144A"	2.1(a)
"Rule 144A Global Note"	2.1(a)

1.3 Capitalized terms used in this Appendix, but not defined, have the meanings ascribed to such terms in the Indenture to which this Appendix is attached.

2. The Notes.

2.1 (a) Form and Dating. The Initial Notes shall be offered and sold by the Company pursuant to a Purchase Agreement. The Initial Notes shall be resold initially only to (i) QIBs in reliance on Rule 144A under the Securities Act ("Rule 144A") and (ii) Persons other than U.S. Persons (as defined in Regulation S) in reliance on Regulation S under the Securities Act ("Regulation S"). Initial Notes may thereafter be transferred to, among others, QIBs and purchasers in reliance on Regulation S, subject to the restrictions on transfer set forth herein. Initial Notes initially resold pursuant to Rule 144A shall be issued initially in the form of one or more permanent global Notes in definitive, fully registered form (collectively, the "Rule 144A Global Note"); and Initial Notes initially resold pursuant to Regulation S shall be issued initially in the form of one or more global Notes in fully registered form (collectively, the "Regulation S Global Note"), in each case without interest coupons and with the global Notes legend and the restricted notes legend set forth in Exhibit 1 hereto, which shall be deposited on behalf of the purchasers of the Initial Notes represented thereby with the Notes Custodian and registered in the name of the Depositary or a nominee of the Depositary, duly executed by the Company and authenticated by the Trustee as provided in the Indenture. Except as set forth in the immediately succeeding paragraph, beneficial ownership interests in the Regulation S Global Note shall be held only through the Euroclear Bank S.A./N.V., as operator of the Euroclear System ("Euroclear") and Clearstream Banking S.A. ("Clearstream") (as indirect participants in the Depositary) and shall not be exchangeable for interests in the Rule 144A Global Note or any other Note prior to the expiration of the Distribution Compliance Period and then, after the expiration of the Distribution Compliance Period, may be exchanged for interests in a Rule 144A Global Note only upon certification in the form attached hereto as Exhibit 3 or otherwise in a form reasonably satisfactory to the Trustee that beneficial ownership interests in such Regulation S Global Note are owned either by non-U.S. persons or U.S. persons who purchased such interests in a transaction that is exempt from the registration requirements under the Securities Act.

Prior to the expiration of the Distribution Compliance Period, beneficial interests in Regulation S Global Notes may be exchanged for interests in Rule 144A Global Notes if (1) such exchange occurs in connection with a transfer of Notes in compliance with Rule 144A and (2) the transferor of the beneficial interest in the Regulation S Global Note first delivers to the Trustee a written certificate (in a form substantially similar to that attached hereto as Exhibit 2) to the effect that the beneficial interest in the Regulation S Global Note is being transferred (a) to a Person who the transferor reasonably believes to be a QIB that is purchasing for its own account or the account of a QIB in a transaction meeting the requirements of Rule 144A, and (b) in accordance with all applicable securities laws of the States of the United States and other jurisdictions.

Beneficial interests in a Rule 144A Global Note may be transferred to a Person who takes delivery in the form of an interest in a Regulation S Global Note, whether before or after the expiration of the Distribution Compliance Period, subject to Applicable Procedures, only if the transferor first delivers to the Trustee a written certificate (in a form substantially similar to that attached hereto as Exhibit 2) to the effect that such transfer is being made in accordance with Rule 903 or 904 of Regulation S or Rule 144 (if applicable).

The Rule 144A Global Note and the Regulation S Global Note are collectively referred to herein as "Global Notes." The aggregate principal amount of the Global Notes may from time to time be increased or decreased by adjustments made on the records of the Trustee and the Depositary or its nominee as hereinafter provided.

(b) Book-Entry Provisions. This Section 2.1(b) shall apply only to a Global Note deposited with or on behalf of the Depositary.

The Company shall execute and the Trustee shall, in accordance with this Section 2.1(b), authenticate and deliver initially one or more Global Notes that (a) shall be registered in the name of the Depositary or the nominee of the Depositary and (b) shall be delivered by the Trustee to the Depositary or pursuant to the Depositary's instructions or held by the Trustee as custodian for the Depositary. The Company has entered into a letter of representations with the Depositary in the form provided by the Depositary and the Trustee and each Agent are hereby authorized to act in accordance with such letter and Applicable Procedures.

Members of, or participants in, the Depositary ("Agent Members") shall have no rights under the Indenture with respect to any Global Note held on their behalf by the Depositary or by the Trustee as the custodian of the Depositary or under such Global Note, and the Company, the Trustee and any agent of the Company or the Trustee shall be entitled to treat the Depositary as the absolute owner of such Global Note for all purposes whatsoever. Notwithstanding the foregoing, nothing herein shall prevent the Company, the Trustee or any agent of the Company or the Trustee from giving effect to any written certification, proxy or other authorization furnished by the Depositary or impair, as between the Depositary and its Agent Members, the operation of customary practices of such Depositary governing the exercise of the rights of a holder of a beneficial interest in any Global Note.

(c) Certificated Notes. Except as provided in this Section 2.1, Section 2.2 or 2.3, owners of beneficial interests in Global Notes shall not be entitled to receive physical delivery of Certificated Notes.

2.2 Transfer and Exchange.

(a) Transfer and Exchange of Certificated Notes. When Certificated Notes are presented to the Note Registrar with a request:

(x) to register the transfer of such Certificated Notes; or

(y) to exchange such Certificated Notes for an equal principal amount of Certificated Notes of other authorized denominations,

the Note Registrar shall register the transfer or make the exchange as requested if its reasonable requirements for such transaction are met; *provided*, *however*, that the Certificated Notes surrendered for transfer or exchange:

(i) shall be duly endorsed or accompanied by a written instrument of transfer in form reasonably satisfactory to the Company and the Note Registrar, duly executed by the Holder thereof or its attorney duly authorized in writing; and

(ii) if such Certificated Notes are required to bear a restricted notes legend, they are being transferred or exchanged pursuant to an effective registration statement under the Securities Act, pursuant to Section 2.2(b) or pursuant to clause (A), (B) or (C) below, and are accompanied by the following additional information and documents, as applicable:

(A) if such Certificated Notes are being delivered to the Note Registrar by a Holder for registration in the name of such Holder, without transfer, a certification from such Holder to that effect; or

(B) if such Certificated Notes are being transferred to the Company, a certification to that effect; or

(C) if such Certificated Notes are being transferred (x) pursuant to an exemption from registration in accordance with Rule 144A, Regulation S or Rule 144 under the Securities Act; or (y) in reliance upon another exemption from the requirements of the Securities Act: (i) a certification to that effect (in the form set forth on the reverse of the Note) and (ii) if the Company so requests, an Opinion of Counsel or other evidence reasonably satisfactory to the Company as to the compliance with the restrictions set forth in the legend set forth in Section 2.2(e)(i).

(b) Restrictions on Transfer of a Certificated Note for a Beneficial Interest in a Global Note. A Certificated Note may not be exchanged for a beneficial interest in a Rule 144A Global Note or a Regulation S Global Note except upon satisfaction of the requirements set forth below. Upon receipt by the Trustee of a Certificated Note, duly endorsed or accompanied by appropriate instruments of transfer, in form satisfactory to the Trustee, together with:

(i) certification, in a form substantially similar to that attached hereto as Exhibit 2, that such Certificated Note is either (A) being transferred to a QIB in accordance with Rule 144A or (B) being transferred after expiration of the Distribution Compliance Period by a Person who initially purchased such Note in reliance on Regulation S to a buyer who elects to hold its interest in such Note in the form of a beneficial interest in the Regulation S Global Note; and

(ii) written instructions directing the Trustee to make, or to direct the Notes Custodian to make, an adjustment on its books and records with respect to such Rule 144A Global Note (in the case of a transfer pursuant to clause (b)(i)(A)) or Regulation S Global Note (in the case of a transfer pursuant to clause (b)(i)(B)) to reflect an increase in the aggregate principal amount of the Notes represented by the Rule 144A Global Note or Regulation S Global Note, as applicable, such instructions to contain information regarding the Depositary account to be credited with such increase,

then the Trustee shall cancel such Certificated Note and cause, or direct the Notes Custodian to cause, in accordance with the standing instructions and procedures existing between the Depositary and the Notes Custodian, the aggregate principal amount of Notes represented by the Rule 144A Global Note or Regulation S Global Note, as applicable, to be increased by the aggregate principal amount of the Certificated Note to be exchanged and shall credit or cause to be credited to the account of the Person specified in such instructions a beneficial interest in the Rule 144A Global Note or Regulation S Global Note, as applicable, equal to the principal amount of the Certificated Note so cancelled. If no Rule 144A Global Notes or Regulation S Global Notes, as applicable, are then outstanding, the Company shall issue and the Trustee shall authenticate, upon receipt of a Company Order, a new Rule 144A Global Note or Regulation S Global Note, as applicable, in the appropriate principal amount.

(c) Transfer and Exchange of Global Notes.

(i) The transfer and exchange of Global Notes or beneficial interests therein shall be effected through the Depositary, in accordance with the Indenture (including applicable restrictions on transfer set forth herein, if any) and the procedures of the Depositary therefor. A transferor of a beneficial interest in a Global Note shall deliver to the Note Registrar a written order given in accordance with the Depositary's procedures containing information regarding the participant account of the Depositary to be credited with a beneficial interest in the Global Note. The Note Registrar shall, in accordance with such instructions instruct the Depositary to credit to the account of the Person specified in such instructions a

beneficial interest in the Global Note and to debit the account of the Person making the transfer the beneficial interest in the Global Note being transferred.

(ii) If the proposed transfer is a transfer of a beneficial interest in one Global Note to a beneficial interest in another Global Note, the Note Registrar shall reflect on its books and records the date and an increase in the principal amount of the Global Note to which such interest is being transferred in an amount equal to the principal amount of the interest to be so transferred, and the Note Registrar shall reflect on its books and records the date and a corresponding decrease in the principal amount of the Global Note from which such interest is being transferred.

(iii) Notwithstanding any other provisions of this Appendix (other than the provisions set forth in Section 2.3), a Global Note may not be transferred as a whole except by the Depositary to a nominee of the Depositary or by a nominee of the Depositary to the Depositary or another nominee of the Depositary or by the Depositary or any such nominee to a successor Depositary or a nominee of such successor Depositary.

(iv) In the event that a Global Note is exchanged for Certificated Notes pursuant to Section 2.3 of this Appendix, such Notes may be exchanged only in accordance with such procedures as are substantially consistent with the provisions of this Section 2.2 (including the certification requirements set forth on the reverse of the Initial Notes (as set forth in Exhibit 2, hereto) intended to ensure that such transfers comply with Rule 144A, Regulation S or another applicable exemption under the Securities Act, as the case may be) and such other procedures as may from time to time be adopted by the Company.

(d) Restrictions on Transfer of Regulation S Global Notes. Subject to Section 2.1(a), during the Distribution Compliance Period, beneficial ownership interests in Regulation S Global Notes may only be sold, pledged or transferred in accordance with the Applicable Procedures and only (i) to the Company, (ii) in an offshore transaction in accordance with Regulation S (other than a transaction resulting in an exchange for an interest in another Regulation S Global Note) or (iii) pursuant to an effective registration statement under the Securities Act, in each case in accordance with any applicable securities laws of any State of the United States.

(e) Legend.

(i) Except as permitted by the following paragraph (ii), each Note certificate evidencing the Global Notes (and all Notes issued in exchange therefor or in substitution thereof), in the case of Notes offered otherwise than in reliance on Regulation S shall bear a legend in substantially the following form:

> THIS NOTE (OR ITS PREDECESSOR) WAS ORIGINALLY ISSUED IN A TRANSACTION EXEMPT FROM REGISTRATION UNDER THE UNITED STATES SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT"), AND THIS NOTE MAY NOT BE OFFERED, SOLD OR OTHERWISE TRANSFERRED IN THE ABSENCE OF SUCH REGISTRATION OR AN APPLICABLE EXEMPTION THEREFROM. EACH PURCHASER OF THIS NOTE IS HEREBY NOTIFIED THAT THE SELLER OF THIS NOTE MAY BE RELYING ON THE EXEMPTION FROM THE PROVISIONS OF SECTION 5 OF THE SECURITIES ACT PROVIDED BY RULE 144A THEREUNDER.
>
> THE HOLDER OF THIS NOTE AGREES FOR THE BENEFIT OF THE COMPANY THAT (A) THIS NOTE MAY BE OFFERED, RESOLD, PLEDGED OR OTHERWISE TRANSFERRED, ONLY (I) TO THE COMPANY, (II) IN THE UNITED STATES TO A PERSON WHOM THE

SELLER REASONABLY BELIEVES IS A QUALIFIED INSTITUTIONAL BUYER (AS DEFINED IN RULE 144A UNDER THE SECURITIES ACT) IN A TRANSACTION MEETING THE REQUIREMENTS OF RULE 144A, (III) TO AN INSTITUTIONAL "ACCREDITED INVESTOR" WITHIN THE MEANING OF RULE 501(a) (1), (2), (3), (7) AND (8) UNDER THE SECURITIES ACT THAT IS AN INSTITUTIONAL INVESTOR ACQUIRING THE NOTE FOR ITS OWN ACCOUNT OR FOR THE ACCOUNT OF SUCH AN INSTITUTIONAL "ACCREDITED INVESTOR," IN EACH CASE IN A MINIMUM PRINCIPAL AMOUNT OF $250,000, (IV) OUTSIDE THE UNITED STATES IN AN OFFSHORE TRANSACTION IN ACCORDANCE WITH RULE 904 UNDER THE SECURITIES ACT, (V) PURSUANT TO AN EXEMPTION FROM REGISTRATION UNDER THE SECURITIES ACT PROVIDED BY RULE 144 THEREUNDER (IF AVAILABLE) OR (VI) PURSUANT TO AN EFFECTIVE REGISTRATION STATEMENT UNDER THE SECURITIES ACT, IN EACH OF CASES (I) THROUGH (VI) IN ACCORDANCE WITH ANY APPLICABLE SECURITIES LAWS OF ANY STATE OF THE UNITED STATES, AND (B) THE HOLDER WILL, AND EACH SUBSEQUENT HOLDER IS REQUIRED TO, NOTIFY ANY PURCHASER OF THIS NOTE FROM IT OF THE RESALE RESTRICTIONS REFERRED TO IN (A) ABOVE.

Each certificate evidencing a Note offered in reliance on Regulation S shall, in addition to the foregoing, bear a legend in substantially the following form:

THIS NOTE (OR ITS PREDECESSOR) WAS ORIGINALLY ISSUED IN A TRANSACTION ORIGINALLY EXEMPT FROM REGISTRATION UNDER THE U.S. SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT"), AND MAY NOT BE TRANSFERRED IN THE UNITED STATES OR TO, OR FOR THE ACCOUNT OR BENEFIT OF, ANY U.S. PERSON EXCEPT PURSUANT TO AN AVAILABLE EXEMPTION FROM THE REGISTRATION REQUIREMENTS OF THE SECURITIES ACT AND ALL APPLICABLE STATE SECURITIES LAWS. TERMS USED ABOVE HAVE THE MEANINGS GIVEN TO THEM IN REGULATION S UNDER THE SECURITIES ACT.

Each Certificated Note shall also bear the following additional legend:

IN CONNECTION WITH ANY TRANSFER, THE HOLDER WILL DELIVER TO THE COMPANY AND THE NOTE REGISTRAR SUCH CERTIFICATES AND OTHER INFORMATION AS THEY MAY REASONABLY REQUIRE TO CONFIRM THAT THE TRANSFER COMPLIES WITH THE FOREGOING RESTRICTIONS.

(ii) Upon any sale or transfer of a Transfer Restricted Note (including any Transfer Restricted Note represented by a Global Note) pursuant to Rule 144 under the Securities Act, the Note Registrar shall permit the transferee thereof to exchange such Transfer Restricted Note for a Certificated Note that does not bear the legend set forth above and rescind any restriction on the transfer of such Transfer Restricted Note, if the transferor thereof certifies in writing to the Note Registrar that such sale or transfer was made in reliance on Rule 144 (such certification to be in the form set forth on the reverse of the Note).

(f) Cancellation or Adjustment of Global Note. At such time as all beneficial interests in a Global Note have been exchanged for Certificated Notes, redeemed, purchased or cancelled, such Global Note shall be returned to the Depositary for cancellation or retained and cancelled by the Trustee. At any time prior to such cancellation, if any beneficial interest in a Global Note is exchanged for Certificated

Notes, redeemed, purchased or cancelled, the principal amount of Notes represented by such Global Note shall be reduced and an adjustment shall be made on the books and records of the Trustee (if it is then the Notes Custodian for such Global Note) with respect to such Global Note, by the Trustee or the Notes Custodian, to reflect such reduction.

(g) No Obligation of the Trustee.

(i) The Trustee shall have no responsibility or obligation to any beneficial owner of a Global Note, a member of, or a participant in the Depositary or other Person with respect to the accuracy of the records of the Depositary or its nominee or of any participant or member thereof, with respect to any ownership interest in the Notes or with respect to the delivery to any participant, member, beneficial owner or other Person (other than the Depositary) of any notice (including any notice of redemption) or the payment of any amount, under or with respect to such Notes. All notices and communications to be given to the Holders and all payments to be made to Holders under the Notes shall be given or made only to or upon the order of the registered Holders (which shall be the Depositary or its nominee in the case of a Global Note). The rights of beneficial owners in any Global Note shall be exercised only through the Depositary subject to the applicable rules and procedures of the Depositary. The Trustee may rely and shall be fully protected in relying upon information furnished by the Depositary with respect to its members, participants and any beneficial owners. Neither the Trustee nor any Agent shall have responsibility for any actions taken or not taken by the Depositary.

(ii) The Trustee shall have no obligation or duty to monitor, determine or inquire as to compliance with any restrictions on transfer imposed under the Indenture or under applicable law with respect to any transfer of any interest in any Note (including any transfers between or among Depositary participants, members or beneficial owners in any Global Note) other than to require delivery of such certificates and other documentation or evidence as are expressly required by, and to do so if and when expressly required by, the terms of the Indenture, and to examine the same to determine substantial compliance as to form with the express requirements hereof.

2.3 Certificated Notes.

(a) A Global Note deposited with the Depositary or with the Trustee as Notes Custodian for the Depositary pursuant to Section 2.1 shall be transferred to the beneficial owners thereof in the form of Certificated Notes in an aggregate principal amount equal to the principal amount of such Global Note, in exchange for such Global Note, only if such transfer complies with Section 2.2 hereof and (i) the Depositary notifies the Company that it is unwilling or unable to continue as depository for such Global Note and the Depositary fails to appoint a successor depository or if at any time such depository ceases to be a “clearing agency” registered under the Exchange Act, in either case, and a successor depository is not appointed by the Company within 90 days of such notice, or (ii) an Event of Default has occurred and is continuing or (iii) the Company, in its sole discretion, notifies the Trustee in writing that it elects to cause the issuance of Certificated Notes under the Indenture (although Regulation S Global Notes at the Company’s election pursuant to this clause may not be exchanged for Certificated Notes prior to (a) the expiration of the Distribution Compliance Period and (b) the receipt of any certificates required under the provisions of Regulation S).

(b) Any Global Note that is transferable to the beneficial owners thereof pursuant to this Section 2.3 shall be surrendered by the Depositary to the Trustee located at its principal corporate trust office to be so transferred, in whole or from time to time in part, without charge, and the Trustee shall authenticate and deliver, upon such transfer of each portion of such Global Note, an equal aggregate

principal amount of Certificated Notes of authorized denominations. Any portion of a Global Note transferred pursuant to this Section 2.3 shall be executed, authenticated and delivered only in minimum denominations of $2,000 principal amount and any integral multiple of $1,000 in excess thereof and registered in such names as the Depositary shall direct. Any Certificated Note delivered in exchange for an interest in the Transfer Restricted Note shall, except as otherwise provided by Section 2.2(e) hereof, bear the restricted notes legend and certificated notes legend set forth in Exhibit 1 hereto.

(c) Subject to the provisions of Section 2.3(b) hereof, the registered Holder of a Global Note shall be entitled to grant proxies and otherwise authorize any Person, including Agent Members and Persons that may hold interests through Agent Members, to take any action which a Holder is entitled to take under the Indenture or the Notes.

(d) In the event of the occurrence of one of the events specified in Section 2.3(a) hereof, the Company shall promptly make available to the Trustee a reasonable supply of Certificated Notes in definitive, fully registered form without interest coupons. In the event that such Certificated Notes are not issued, the Company expressly acknowledges, with respect to the right of any Holder to pursue a remedy pursuant to the Indenture, including, without limitation, pursuant to Section 6.05, the right of any beneficial owner of Notes to pursue such remedy with respect to the portion of the Global Note that represents such beneficial owner's Notes as if such Certificated Notes had been issued.

EXHIBIT 1
to Rule 144A / Regulation S Appendix

[FORM OF FACE OF INITIAL NOTE]
[Global Notes Legend]

UNLESS THIS CERTIFICATE IS PRESENTED BY AN AUTHORIZED REPRESENTATIVE OF THE DEPOSITORY TRUST COMPANY, A NEW YORK CORPORATION ("DTC"), NEW YORK, NEW YORK, TO THE COMPANY OR ITS AGENT FOR REGISTRATION OF TRANSFER, EXCHANGE OR PAYMENT, AND ANY CERTIFICATE ISSUED IS REGISTERED IN THE NAME OF CEDE & CO. OR SUCH OTHER NAME AS IS REQUESTED BY AN AUTHORIZED REPRESENTATIVE OF DTC (AND ANY PAYMENT IS MADE TO CEDE & CO., OR TO SUCH OTHER ENTITY AS IS REQUESTED BY AN AUTHORIZED REPRESENTATIVE OF DTC) ANY TRANSFER, PLEDGE OR OTHER USE HEREOF FOR VALUE OR OTHERWISE BY OR TO ANY PERSON IS WRONGFUL INASMUCH AS THE REGISTERED OWNER HEREOF, CEDE & CO., HAS AN INTEREST HEREIN.

TRANSFERS OF THIS GLOBAL NOTE SHALL BE LIMITED TO TRANSFERS IN WHOLE, BUT NOT IN PART, TO NOMINEES OF DTC OR TO A SUCCESSOR THEREOF OR SUCH SUCCESSOR'S NOMINEE AND TRANSFERS OF PORTIONS OF THIS GLOBAL NOTE SHALL BE LIMITED TO TRANSFERS MADE IN ACCORDANCE WITH THE RESTRICTIONS SET FORTH IN THE INDENTURE REFERRED TO ON THE REVERSE HEREOF.

[[FOR REGULATION S GLOBAL NOTE ONLY] UNTIL 40 DAYS AFTER THE LATER OF COMMENCEMENT OR COMPLETION OF THE OFFERING, AN OFFER OR SALE OF SECURITIES WITHIN THE UNITED STATES BY A DEALER (AS DEFINED IN THE SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT")) MAY VIOLATE THE REGISTRATION REQUIREMENTS OF THE SECURITIES ACT IF SUCH OFFER OR SALE IS MADE OTHERWISE THAN IN ACCORDANCE WITH RULE 144A THEREUNDER.]

[Restricted Notes Legend]

THIS NOTE (OR ITS PREDECESSOR) WAS ORIGINALLY ISSUED IN A TRANSACTION EXEMPT FROM REGISTRATION UNDER THE UNITED STATES SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT"), AND THIS NOTE MAY NOT BE OFFERED, SOLD OR OTHERWISE TRANSFERRED IN THE ABSENCE OF SUCH REGISTRATION OR AN APPLICABLE EXEMPTION THEREFROM. EACH PURCHASER OF THIS NOTE IS HEREBY NOTIFIED THAT THE SELLER OF THIS NOTE MAY BE RELYING ON THE EXEMPTION FROM THE PROVISIONS OF SECTION 5 OF THE SECURITIES ACT PROVIDED BY RULE 144A THEREUNDER.

THE HOLDER OF THIS NOTE AGREES FOR THE BENEFIT OF THE COMPANY THAT (A) THIS NOTE MAY BE OFFERED, RESOLD, PLEDGED OR OTHERWISE TRANSFERRED, ONLY (I) TO THE COMPANY, (II) IN THE UNITED STATES TO A PERSON WHOM THE SELLER REASONABLY BELIEVES IS A QUALIFIED INSTITUTIONAL BUYER (AS DEFINED IN RULE 144A UNDER THE SECURITIES ACT) IN A TRANSACTION MEETING THE REQUIREMENTS OF RULE 144A, (III) TO AN INSTITUTIONAL "ACCREDITED INVESTOR" WITHIN THE MEANING OF RULE 501(a) (1), (2), (3), (7) AND (8) UNDER THE SECURITIES ACT THAT IS AN INSTITUTIONAL INVESTOR ACQUIRING THE NOTE FOR ITS OWN ACCOUNT OR

FOR THE ACCOUNT OF SUCH AN INSTITUTIONAL "ACCREDITED INVESTOR," IN EACH CASE IN A MINIMUM PRINCIPAL AMOUNT OF $250,000, (IV) OUTSIDE THE UNITED STATES IN AN OFFSHORE TRANSACTION IN ACCORDANCE WITH RULE 904 UNDER THE SECURITIES ACT, (V) PURSUANT TO AN EXEMPTION FROM REGISTRATION UNDER THE SECURITIES ACT PROVIDED BY RULE 144 THEREUNDER (IF AVAILABLE) OR (VI) PURSUANT TO AN EFFECTIVE REGISTRATION STATEMENT UNDER THE SECURITIES ACT, IN EACH OF CASES (I) THROUGH (VI) IN ACCORDANCE WITH ANY APPLICABLE SECURITIES LAWS OF ANY STATE OF THE UNITED STATES, AND (B) THE HOLDER WILL, AND EACH SUBSEQUENT HOLDER IS REQUIRED TO, NOTIFY ANY PURCHASER OF THIS NOTE FROM IT OF THE RESALE RESTRICTIONS REFERRED TO IN (A) ABOVE.

[[FOR REGULATION S GLOBAL NOTE ONLY] THIS NOTE (OR ITS PREDECESSOR) WAS ORIGINALLY ISSUED IN A TRANSACTION ORIGINALLY EXEMPT FROM REGISTRATION UNDER THE U.S. SECURITIES ACT OF 1933, AS AMENDED (THE "SECURITIES ACT"), AND MAY NOT BE TRANSFERRED IN THE UNITED STATES OR TO, OR FOR THE ACCOUNT OR BENEFIT OF, ANY U.S. PERSON EXCEPT PURSUANT TO AN AVAILABLE EXEMPTION FROM THE REGISTRATION REQUIREMENTS OF THE SECURITIES ACT AND ALL APPLICABLE STATE SECURITIES LAWS. TERMS USED ABOVE HAVE THE MEANINGS GIVEN TO THEM IN REGULATION S UNDER THE SECURITIES ACT.]

[Certificated Notes Legend]

IN CONNECTION WITH ANY TRANSFER, THE HOLDER WILL DELIVER TO THE NOTE REGISTRAR SUCH CERTIFICATES AND OTHER INFORMATION AS THE COMPANY MAY REASONABLY REQUIRE TO CONFIRM THAT THE TRANSFER COMPLIES WITH THE FOREGOING RESTRICTIONS.

4.875% Senior Notes due 2025

CUSIP _____
ISIN _____

No. _____

$

MOLINA HEALTHCARE, INC.

promises to pay to [CEDE & CO., INC.]* or registered assigns, the principal sum of _____ Dollars ($_____) [as may be increased or decreased as set forth on the attached Schedule of Exchanges of Interests in Global Note] on June 15, 2025.

Interest Payment Dates: June 15 and December 15, commencing December 15, 2017.

Record Dates: June 1 and December 1.

Dated: _____, 20__

* Only applicable if there is a Global Note.

IN WITNESS WHEREOF, the Company has caused this Note to be signed manually or by facsimile by its duly authorized officers.

MOLINA HEALTHCARE, INC.

By: _____
Name:
Title:

By: _____
Name:
Title:

This Trustee Certificate of Authentication is for one of the Notes referred to in the within-mentioned Indenture.

U.S. BANK NATIONAL ASSOCIATION, as Trustee

By: _____
Authorized Signatory

Dated: _____ ___, 20____

[FORM OF REVERSE SIDE OF INITIAL NOTE]
4.875% Senior Notes due 2025

Capitalized terms used herein shall have the meanings assigned to them in the Indenture referred to below unless otherwise indicated.

1. ***Interest.*** Molina Healthcare, Inc., a Delaware corporation (the "***Company***"), promises to pay interest on the principal amount of this Note at 4.875% per annum until maturity. The Company shall pay interest semi-annually on June 15 and December 15 of each year, or if any such day is not a Business Day, on the next succeeding Business Day (each an "***Interest Payment Date***") and no interest shall accrue on such payment as the result of such delay. Interest shall accrue from the most recent date to which interest has been paid on the Notes (or one or more Predecessor Notes) or, if no interest has been paid, from June 6, 2017. The Company shall pay interest (including post-petition interest in any proceeding under any Bankruptcy Law) on overdue principal and premium, if any, from time to time at a rate per annum equal to the rate of interest under the Indenture and this Note; it shall pay interest (including post-petition interest in any proceeding under any Bankruptcy Law) on overdue installments of interest (without regard to any applicable grace periods), from time to time at the same rate to the extent lawful. Interest shall be computed on the basis of a 360-day year of twelve 30-day months.

2. ***Method of Payment.*** The Company shall pay interest on the Notes (except Defaulted Interest) to the Persons in whose name this Note (or one or more Predecessor Notes) is registered at the close of business on the June 1 or December 1 next preceding the Interest Payment Date, even if such Notes are cancelled after such record date and on or before such Interest Payment Date, except as provided in Section 2.14 of the Indenture with respect to Defaulted Interest. The Notes shall be payable as to principal, premium, if any, and interest at the office or agency of the Company maintained for such purpose, or, at the option of the Company, payment of interest may be made by check mailed to the Holders at their addresses set forth in the Note Register; *provided*, *however*, that payment by wire transfer of immediately available funds shall be required with respect to principal of and interest and premium, if any, on, all Global Notes and all other Notes the Holders of which shall have provided wire transfer instructions to the Company or the Paying Agent. Such payment shall be in such coin or currency of the United States of America as at the time of payment is legal tender for payment of public and private debts.

3. ***Paying Agent and Note Registrar.*** Initially, U.S. Bank National Association, the Trustee under the Indenture, shall act as Paying Agent and Note Registrar. The Company may change any Paying Agent or Note Registrar without notice to any Holder. The Company or any of its Consolidated Subsidiaries may act in any such capacity.

4. ***Indenture.*** The Company issued the Notes under an Indenture dated as of June 6, 2017 (the "***Indenture***") among the Company, the Guarantors and the Trustee. The terms of the Notes include those stated in the Indenture and those made part of the Indenture by reference to the Trust Indenture Act of 1939, as amended (15 U.S. Code §§ 77aaa-77bbbb). The Notes are subject to all such terms, and Holders are referred to the Indenture and such Act for a statement of such terms. To the extent any provision of this Note conflicts with the express provisions of the Indenture, the provisions of the Indenture shall govern and be controlling.

5. ***Optional Redemption.***

(a) Except pursuant to clauses (b), (c) and (d) of this paragraph 5, the Notes shall not be redeemable at the option of the Company prior to June 15, 2020.

(b) Prior to June 15, 2020, the Company may on any one or more occasions redeem all or a part of the Notes, upon not less than 30 nor more than 60 days' notice, at a Redemption Price equal to 100% of the principal amount of the Notes redeemed, plus the Applicable Premium as of, and accrued and unpaid interest, if any, to, but not including, the Redemption Date (subject to the rights of Holders of Notes on the relevant record date to receive interest due on the relevant interest payment date).

"***Applicable Premium***" means the greater of:

(1) 1.0% of the principal amount of the Notes being redeemed; or

(2) the excess of:

(A) the present value at such Redemption Date of (i) the Redemption Price of the Notes at June 15, 2020 *plus* (ii) all required remaining interest payments due on the Notes through, but not including, June 15, 2020 (excluding accrued but unpaid interest to the Redemption Date), computed using a discount rate equal to the Treasury Rate as of such Redemption Date *plus* 50 basis points; over

(B) the then outstanding principal amount of the Notes.

The Company shall calculate or cause the Applicable Premium to be calculated.

(c) Prior to June 15, 2020, the Company may on any one or more occasions redeem up to 40% of the aggregate principal amount of the Notes (calculated after giving effect to any issuance of Additional Notes), upon not less than 30 nor more than 60 days' notice, with the net cash proceeds of one or more Equity Offerings at a redemption price of 104.875% of the principal amount thereof, plus accrued and unpaid interest, if any, to the Redemption Date (subject to the right of holders of record on the relevant Record Date to receive interest due on the relevant Interest Payment Date); *provided* that (i) at least 60% of the aggregate principal amount of the Notes (calculated after giving effect to any issuance of Additional Notes) originally issued remains outstanding immediately after each such redemption and (ii) the redemption occurs within 180 days after the closing of the related Equity Offering.

(d) On or after June 15, 2020, the Company may on any one or more occasions redeem all or a part of the Notes, upon not less than 30 nor more than 60 days' notice, at the redemption prices (expressed as a percentage of principal amount of the Notes) set forth below, plus accrued and unpaid interest, if any, to, but not including, the Redemption Date (subject to the rights of Holders of Notes on the relevant Record Date to receive interest due on the relevant Interest Payment Date), if redeemed during the twelve-month period beginning on June 15 of the years indicated below:

Year	Percentage
2020	102.438%
2021	101.219%
2022 and thereafter	100.000%

6. ***Mandatory Redemption.*** Except as set forth in Sections 4.08 of the Indenture, the Company shall not be required to make mandatory redemption or sinking fund payments with respect to the Notes.

7. ***Repurchase at Option of Holder.***

(a) Upon the occurrence of a Change of Control, Article 3 and Section 4.08 of the Indenture shall apply to the extent applicable.

8. ***Notice of Redemption.*** Notice of redemption shall be mailed at least 30 days but not more than 60 days before the Redemption Date to each Holder whose Notes are to be redeemed at its registered address. Notes in denominations larger than $2,000 may be redeemed in part but only in integral multiples of $1,000 in excess of $2,000, unless all of the Notes held by a Holder are to be redeemed. Unless the Company defaults in the payment of the Redemption Price, interest shall cease to accrue on the Notes or portions thereof called for redemption on the applicable Redemption Date.

9. ***Denominations, Transfer, Exchange.*** The Notes are in registered form without coupons in minimum denominations of $2,000 and integral multiples of $1,000 in excess of $2,000. The transfer of Notes may be registered and Notes may be exchanged as provided in the Indenture. The Note Registrar and the Trustee may require a Holder, among other things, to furnish appropriate endorsements and transfer documents and the Company may require a Holder to pay any taxes and fees required by law or permitted by the Indenture. The Company need not exchange or register the transfer of any Note or portion of a Note selected for redemption, except for the unredeemed portion of any Note being redeemed in part. Also, the Company need not exchange or register the transfer of any Notes for a period of 15 days before a selection of Notes to be redeemed or during the period between a Record Date and the corresponding Interest Payment Date.

10. ***Persons Deemed Owners.*** The registered Holder of a Note may be treated as its owner for all purposes.

11. ***Amendment, Supplement and Waiver.*** The Indenture, Notes or Subsidiary Guarantees may be amended or supplemented as provided in the Indenture.

12. ***Defaults and Remedies.*** The Events of Default relating to the Notes are defined in Section 6.01 of the Indenture. If any Event of Default occurs and is continuing, the Trustee or the Holders of at least 25% in aggregate principal amount of the then outstanding Notes may declare the principal, premium, if any, and accrued and unpaid interest of all the outstanding Notes to be due and payable immediately. Notwithstanding the foregoing, in the case of an Event of Default arising from certain events of bankruptcy or insolvency described in the Indenture, all outstanding Notes shall become due and payable immediately without further action or notice. Subject to certain limitations, Holders of at least a majority in aggregate principal amount of the then outstanding Notes may direct the Trustee in its exercise of any trust or power.

The Holders of at least a majority in aggregate principal amount of the Notes then outstanding by notice to the Trustee may on behalf of the Holders of all of the Notes waive any existing Default or Event of Default and its consequences under the Indenture, except a continuing Default or Event of Default in the payment of interest on, or the principal of, the Notes, and rescind any acceleration and its consequences with respect to the Notes.

The Company is required to deliver to the Trustee annually a statement regarding compliance with the Indenture, and the Company is required within 30 days of becoming aware of any Default or Event of Default, to deliver to the Trustee a statement specifying such Default or Event of Default.

13. ***Trustee Dealings with Company.*** Subject to certain limitations, the Trustee in its individual or any other capacity may become the owner or pledgee of Notes and may otherwise deal with the Company or any Affiliate of the Company with the same rights it would have if it were not Trustee.

14. ***No Recourse Against Others.*** None of the Company's nor its Subsidiaries' directors, officers, employees, incorporators, members, partners or stockholders, as such, shall have any liability for any obligations of the Company or the Guarantors under the Notes, this Indenture, the Subsidiary Guarantees, or for any claim based on, in respect of, or by reason of, such obligations or their creation. Each Holder of Notes by accepting a Note waives and releases all such liability. The waiver and release are part of the consideration for issuance of the Notes.

15. ***Authentication.*** This Note shall not be valid until authenticated by manual signature of the Trustee or an authenticating agent.

16. ***Abbreviations.*** Customary abbreviations may be used in the name of a Holder or an assignee, such as: TEN COM (= tenants in common), TEN ENT (= tenants by the entireties), JT TEN (= joint tenants with right of survivorship and not as tenants in common), CUST (= Custodian), and U/G/M/A (= Uniform Gifts to Minors Act).

17. ***CUSIP and ISIN Numbers.*** The Company has caused CUSIP and ISIN numbers to be printed on the Notes and has directed the Trustee to use CUSIP and ISIN numbers in notices of redemption as a convenience to Holders. No representation is made as to the accuracy of such numbers either as printed on the Notes or as contained in any notice of redemption and reliance may be placed only on the other identification numbers placed thereon.

18. ***Governing Law.*** THE LAWS OF THE STATE OF NEW YORK SHALL GOVERN AND BE USED TO CONSTRUE THIS NOTE WITHOUT GIVING EFFECT TO APPLICABLE PRINCIPALS OF CONFLICTS OF LAW TO THE EXTENT THAT THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION WOULD BE REQUIRED THEREBY.

The Company shall furnish to any Holder upon written request and without charge a copy of the Indenture. Requests may be made to:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Attention: Joseph W. White, Chief Financial Officer
Telecopier No.: (562) 499-0612

EXHIBIT 2
to Rule 144A / Regulation S Appendix

ASSIGNMENT/TRANSFER FORM

To assign and transfer this Note, fill in the form below:

I or we assign and transfer this Note to _____

(Print or type assignee's name, address and zip code)

_____

(Insert assignee's soc. sec. or tax I.D. No.)

and irrevocably appoint _____ agent to transfer this Note on the books of the Company. The agent may substitute another to act for him.

Date: _____ Your Signature: _____

(Sign exactly as your name appears on the other side of this Note.)

In connection with any transfer of this Note occurring prior to the date which is the date following the expiration of the applicable holding period set forth in Rule 144(d) of the Securities Act of 1933, as amended (the "***Securities Act***"), of this Note, the undersigned confirms that it has not utilized any general solicitation or general advertising in connection with such transfer, is making such transfer in accordance with the applicable securities laws of the States of the United States and other jurisdictions and is making such transfer pursuant to one of the following:

CHECK ONE BOX BELOW

☐ (1) to the Company; or

☐ (2) in the United States to a person whom the seller reasonably believes is a "qualified institutional buyer" (as defined in Rule 144A under the Securities Act) in a transaction meeting the requirements of Rule 144A; or

☐ (3) to an institutional "accredited investor" within the meaning of Rule 501(a) (1), (2), (3), (7) and (8) under the Securities Act that is an institutional investor acquiring the note for its own account or for the account of such an institutional "accredited investor," in each case in a minimum principal amount of $250,000; or

☐ (4) outside the United States in an offshore transaction in accordance with Rule 904 under the Securities Act; or

☐ (5) pursuant to an exemption from registration under the Securities Act provided by Rule 144 thereunder (if available); or

☐ (6) pursuant to an effective registration statement under the Securities Act.

Unless one of the boxes is checked, the Trustee shall refuse to register the Note evidenced by this certificate in the name of any person other than the registered holder thereof; *provided*, *however*, that if box (5) is checked, the Trustee shall be entitled to require, prior to registering any such transfer of this Note, such legal opinions, certifications and other information as the Company have reasonably requested to confirm that such transfer is being made pursuant to an exemption from, or in a transaction not subject to, the registration requirements of the Securities Act, such as the exemption provided by Rule 144 under such Act.

Signature

Signature Guarantee:

Signature must be guaranteed

Signature

Signatures must be guaranteed by an "eligible guarantor institution" meeting the requirements of the Note Registrar, which requirements include membership or participation in the Security Transfer Agent Medallion Program ("STAMP") or such other "signature guarantee program" as may be determined by the Note Registrar in addition to, or in substitution for, STAMP, all in accordance with the Securities Exchange Act of 1934, as amended.

TO BE COMPLETED BY PURCHASER IF (2) ABOVE IS CHECKED.

The undersigned represents and warrants that it is purchasing this Note for its own account or an account with respect to which it exercises sole investment discretion and that it and any such account is a "qualified institutional buyer" within the meaning of Rule 144A under the Securities Act, and is aware that the sale to it is being made in reliance on Rule 144A and acknowledges that it has received such information regarding the Company as the undersigned has requested pursuant to Rule 144A or has determined not to request such information and that it is aware that the transferor is relying upon the undersigned's foregoing representations in order to claim the exemption from registration provided by Rule 144A.

Date: _____

_____

Name:

Title:

Name of Entity:

Notice: To be executed by an executive officer

[TO BE ATTACHED TO GLOBAL NOTES]

SCHEDULE OF EXCHANGES OF INTERESTS IN GLOBAL NOTE

The following exchanges of a part of this Global Note for an interest in another Global Note or for a Definitive Note, or exchanges of a part of another Global Note or Definitive Note for an interest in this Global Note, have been made:

Date of Exchange	Amount of decrease in Principal Amount of this Global Note	Amount of increase in Principal Amount of this Global Note	Principal Amount of this Global Note following such decrease (or increase)	Signature of authorized signatory of Trustee or Note Custodian

OPTION OF HOLDER TO ELECT PURCHASE

If you want to elect to have this Note purchased by the Company pursuant to Section 4.08 of the Indenture, check the box below:

☐ Section 4.08

If you want to elect to have only part of the Note purchased by the Company pursuant to Section 4.08 of the Indenture, state the amount you elect to have purchased: $_____.

Date: _____

Your signature: _____
(Sign exactly as your name appears on the Note)

Tax Identification No.:
_____

SIGNATURE GUARANTEE

_____
Signatures must be guaranteed by an "eligible guarantor institution" meeting the requirements of the Note Registrar, which requirements include membership or participation in the Security Transfer Agent Medallion Program ("***STAMP***") or such other "signature guarantee program" as may be determined by the Note Registrar in addition to, or in substitution for, STAMP, all in accordance with the Securities Exchange Act of 1934, as amended.

EXHIBIT 3
to Rule 144A / Regulation S Appendix

FORM OF NON-U.S. BENEFICIAL OWNERSHIP
CERTIFICATION BY EUROCLEAR OR CLEARSTREAM

[Date]

U.S. Bank National Association
633 West Fifth Street, 24th Floor
Los Angeles, CA 90071
Fax: (213) 615-6197

Re: 4.875% Senior Notes due 2025 (the "Notes") of Molina Healthcare, Inc. (the "***Company***")

Reference is hereby made to the Indenture, dated as of June 6, 2017 (as amended and supplemented from time to time, the "***Indenture***"), among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. Capitalized terms used but not defined herein shall have the meanings given them in the Indenture.

This is to certify with respect to $_____ principal amount of the Notes that, except as set forth below, we have received in writing, by tested telex or by electronic transmission, from member organizations appearing in our records as persons being entitled to a portion of such principal amount (our "***Member Organizations***") certifications with respect to such portion, that such portion is beneficially owned by (a) non-U.S. person(s) or (b) U.S. person(s) who purchased the portion beneficially owned by such U.S. person(s) in transactions that did not require registration under the Securities Act of 1933, as amended (the "***Act***"). As used in this paragraph the term "U.S. person" has the meaning given to it by Regulation S under the Act.

We further certify:

(i) that we are not making available herewith for exchange (or, if relevant, exercise of any rights or collection of any interest) any portion of the Regulation S Global Note excepted in such certifications; and

(ii) that as of the date hereof we have not received any notification from any of our Member Organizations to the effect that the statements made by such Member Organizations with respect to any portion of the part submitted herewith for exchange (or, if relevant, exercise of any rights or collection of any interest) are no longer true and cannot be relied upon as the date hereof.

We understand that this certification is required in connection with certain securities laws of the United States. In connection therewith, if administrative or legal proceedings are commenced or threatened in connection with which this certification is or would be relevant, we irrevocably authorize you or the Company to produce this certification to any interested party in such proceedings.

Dated: _____, 20__

Yours faithfully,
[Euroclear or Clearstream Luxembourg]

By: _____

EXHIBIT A

FORM OF NOTATION OF GUARANTEE

For value received, each Guarantor (which term includes any successor Person under the Indenture), jointly and severally, unconditionally guarantees, to the extent set forth in, and subject to the provisions of, the Indenture, dated as of June 6, 2017 (the "***Indenture***"), among Molina Healthcare, Inc., as issuer (the "***Company***"), the Guarantors listed on the signature pages thereto and U.S. Bank National Association, as trustee (the "***Trustee***"), (a) the due and punctual payment of the principal of, premium, if any, and interest on the Notes, whether at maturity, by acceleration, redemption or otherwise, the due and punctual payment of interest on overdue principal and premium, if any, and, to the extent permitted by law, interest and the due and punctual performance of all other obligations of the Company to the Holders or the Trustee all in accordance with the terms of the Indenture and (b) in case of any extension of time of payment or renewal of any Notes or any of such other obligations, that the same will be promptly paid in full when due or performed in accordance with the terms of the extension or renewal, whether at stated maturity, by acceleration or otherwise. The obligations of the Guarantors to the Holders of Notes and to the Trustee pursuant to the Subsidiary Guarantee and the Indenture are expressly set forth in Article 10 of the Indenture and reference is hereby made to the Indenture for the precise terms of the Guarantee. This Subsidiary Guarantee is subject to release as and to the extent set forth in Sections 8.02, 8.03 and 10.05 of the Indenture. Each Holder of a Note, by accepting the same agrees to and shall be bound by such provisions. Capitalized terms used herein and not defined are used herein as so defined in the Indenture.

MOLINA HEALTHCARE, INC.

By: _____
Name:
Title:

MOLINA PATHWAYS, LLC

By: _____
Name:
Title:

PATHWAYS HEALTH AND COMMUNITY SUPPORT LLC

By: _____
Name:
Title:

THIRD AMENDMENT TO CREDIT AGREEMENT

THIS THIRD AMENDMENT TO CREDIT AGREEMENT, dated as of May 19, 2017 (this "Amendment"), is entered into among Molina Healthcare, Inc., a Delaware corporation (the "Borrower"), the Guarantors party hereto, the Lenders party hereto, and SunTrust Bank, in its capacity as Administrative Agent (the "Administrative Agent"). Capitalized terms used herein and not otherwise defined shall have the meanings ascribed thereto in the Credit Agreement (as defined below).

RECITALS

WHEREAS, the Borrower, the Guarantors, the Lenders and the Administrative Agent are parties to that certain Credit Agreement, dated as of June 12, 2015 (as amended, restated, supplemented or otherwise modified from time to time, the "Credit Agreement"); and

WHEREAS, the Borrower has requested, and the Required Lenders have agreed, to amend the Credit Agreement as set forth herein.

NOW, THEREFORE, in consideration of the agreements contained herein and in the Credit Agreement, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

AGREEMENT

1. Amendments to the Credit Agreement.

1.1 The definition of Specified Cash in Section 1.1 of the Credit Agreement is amended to read as follows:

"Specified Cash" shall mean cash of the Borrower that constitutes, and Permitted Investments of the Borrower that are made with, the net cash proceeds of Indebtedness permitted to be incurred under Section 7.1 (the "Specified Indebtedness"), that are either (a) subject to customary escrow arrangements between the Borrower and the holders of such Specified Indebtedness prior to their use for one of the following purposes: (i) refinancing, tendering for, or otherwise redeeming or repaying Indebtedness of the Borrower or its Restricted Subsidiaries or (ii) to finance any Permitted Acquisition that has been identified in writing to the Administrative Agent with a closing date that is not later than 365 days after the incurrence of such Specified Indebtedness or (b) held in a segregated account of the Borrower and subject to a covenant in the documentation for such Specified Indebtedness that restricts the use of such cash or Permitted Investments of the Borrower to the limited purpose of (i) refinancing, tendering for, or otherwise redeeming or repaying Indebtedness of the Borrower or its Restricted Subsidiaries or (ii) paying interest on the Specified Indebtedness; provided, that if such cash or Permitted Investments no longer satisfy the conditions in this clause (b), they shall cease to constitute Specified Cash hereunder.

1.2 Section 7.2 of the Credit Agreement is amended to delete the "and" after clause (h), to insert an "and" after clause (i) and to add a new clause (j) to read as follows:

(j) customary escrow arrangements and segregated accounts (to the extent such segregated account is deemed to have incurred an encumbrance in connection with any covenants applicable to the proceeds contained in such segregated account), in each case, permitted by the definition of Specified Cash.

2 . Effectiveness; Conditions Precedent. This Amendment shall be effective as of the date hereof, upon receipt by the Administrative Agent of this Amendment, duly executed by the Borrower, the Guarantors, the Required Lenders and the Administrative Agent.

3. Amendment is a "Loan Document". This Amendment shall be deemed to be, and is, a Loan Document and all references to a "Loan Document" in the Credit Agreement and the other Loan Documents (including, without limitation, all such references in the representations and warranties in the Credit Agreement and the other Loan Documents) shall be deemed to include this Amendment.

4. Representations and Warranties; No Default. Each Loan Party hereby represents and warrants to the Administrative Agent, each Lender, the Swingline Lender and the Issuing Bank that, (a) the representations and warranties of each Loan Party contained in the Credit Agreement, any other Loan Document, or any document furnished at any time under or in connection with the Credit Agreement or any other Loan Document, are true and correct in all material respects (other than any representation and warranty that is expressly qualified by materiality, in which case such representation and warranty is true and correct in all respects) on and as of the date hereof, except to the extent that such representations and warranties specifically refer to an earlier date, in which case they are true and correct in all material respects (other than any representation and warranty that is expressly qualified by materiality, in which case such representation and warranty is true and correct in all respects) as of such earlier date and (b) no Default or Event of Default exists.

5. Reaffirmation of Obligations. Each Loan Party (a) acknowledges and consents to all of the terms and conditions of this Amendment, (b) affirms all of its obligations under the Loan Documents (as amended by this Amendment) and (c) agrees that this Amendment and all documents, agreements and instruments executed in connection with this Amendment do not operate to reduce or discharge such Loan Party's obligations under the Loan Documents (except to the extent such obligations are modified pursuant to this Amendment).

6. No Other Changes. Except as modified hereby, all of the terms and provisions of the Loan Documents shall remain in full force and effect and nothing herein shall limit or waive any right, power or remedy of the Administrative Agent or the Lenders under the Loan Documents.

7. Counterparts; Delivery. This Amendment may be executed in counterparts, and all of said counterparts taken together shall be deemed to constitute one and the same instrument. Delivery of an executed counterpart of a signature page of this Amendment by facsimile transmission or by any other electronic imaging means (including .pdf), shall be effective as delivery of a manually executed counterpart of this Amendment.

8. Fees and Expenses. The Borrower agrees to pay all reasonable out-of-pocket fees and expenses of the Administrative Agent in connection with the preparation, execution and delivery of this Amendment, including without limitation the reasonable fees and expenses of Moore & Van Allen, PLLC, counsel to the Administrative Agent.

9. Governing Law. THIS AMENDMENT AND ANY CLAIMS, CONTROVERSY, DISPUTE OR CAUSE OF ACTION (WHETHER IN CONTRACT OR TORT OR OTHERWISE) BASED UPON, ARISING OUT OF OR RELATING TO THIS AMENDMENT AND THE TRANSACTIONS CONTEMPLATED HEREBY SHALL BE CONSTRUED IN ACCORDANCE WITH AND BE GOVERNED BY THE LAW (WITHOUT GIVING EFFECT TO THE CONFLICT OF LAW PRINCIPLES THEREOF EXCEPT FOR SECTIONS 5-1401 AND 5-1402 OF THE NEW YORK GENERAL OBLIGATIONS LAW) OF THE STATE OF NEW YORK.

[SIGNATURE PAGES FOLLOW]

IN WITNESS WHEREOF, the parties hereto have caused this Third Amendment to Credit Agreement to be duly executed as of the date first above written.

BORROWER:

MOLINA HEALTHCARE, INC.
a Delaware corporation

By: _____
Name: Joseph W. White
Title: Chief Financial Officer and
interim President and Chief Executive Officer

GUARANTORS:

MOLINA INFORMATION SYSTEMS, LLC,
a California limited liability company

By: _____
Name: Joseph W. White
Title: Chief Financial Officer

MOLINA PATHWAYS, LLC,
a Delaware limited liability company

By: _____
Name: Joseph W. White
Title: Chief Financial Officer

PATHWAYS HEALTH AND COMMUNITY SUPPORT LLC,
a Delaware limited liability company

By: _____
Name: Joseph W. White
Title: Vice President

ADMINISTRATIVE AGENT:

SUNTRUST BANK,
as Administrative Agent

By: _____
Name:
Title:

LENDERS:

SUNTRUST BANK,
as Issuing Bank, as Swingline Lender and as a Lender

By: _____
Name:
Title:

BANK OF AMERICA, N.A.

By: _____
Name:
Title:

WELLS FARGO BANK, NATIONAL ASSOCIATION.

By: _____
Name:
Title:

BOKF, N.A. dba BANK OF ALBUQUERQUE

By: _____
Name:
Title:

EAST WEST BANK

By: _____
Name:
Title:

MUFG UNION BANK, N.A.

By: _____
Name:
Title:

UBS AG, STAMFORD BRANCH

By: _____
Name:
Title:

U.S. BANK NATIONAL ASSOCIATION

By: _____
Name:
Title:

BARCLAYS BANK PLC

By: _____
Name:
Title:

JPMORGAN CHASE BANK, N.A.

By: _____
Name:
Title:

MORGAN STANLEY SENIOR FUNDING, INC.

By: _____
Name:
Title:

AMENDED AND RESTATED EMPLOYMENT AGREEMENT

This Amended and Restated Employment Agreement (this "**Agreement**") is entered into on June 5, 2017, effective as of May 2, 2017 (the "**Effective Date**"), between Joseph White (the "**Executive**") and Molina Healthcare, Inc. (the "**Employer**").

RECITALS

The Employer desires to establish its right to the services of the Executive in the capacities described below, on the terms and conditions hereinafter set forth, and the Executive is willing to accept such employment on such terms and conditions. The parties hereto have previously entered into an Amended and Restated Change in Control Agreement dated as of December 31, 2009 (the "**Change in Control Agreement**"), which shall continue in effect as modified hereby. The parties hereto have also previously entered into an Employment Agreement dated as of June 14, 2013 (the "**Existing Agreement**"), and this Agreement supersedes the Existing Agreement.

The parties desire to amend and restate the Existing Agreement on the terms set forth below.

NOW, THEREFORE, in consideration of the above premises and the following mutual covenants and conditions, the parties agree as follows:

1. Employment. The Employer shall employ the Executive as its Chief Financial Officer and as its interim President and Chief Executive Officer, and the Executive hereby accepts such employment on the following terms and conditions. The Executive shall serve as the interim President and Chief Executive Officer during the period beginning May 2, 2017 and continuing until the Employer's Board of Directors (the "**Board**") appoints a permanent President and Chief Executive Officer or otherwise removes the Executive from the position of interim President and Chief Executive Officer (such period, the "**Interim CEO Term**"). The Executive understands and agrees that he or she is an at-will employee, and the Executive and the Employer can, and shall have the right to, terminate the employment relationship at any time for any or no reason, with or without notice, and with or without cause, subject to the payment provisions contained in Paragraph 7 of this Agreement. Nothing contained in this Agreement or any other agreement shall alter the at-will relationship. In the event that the Executive ceases to be employed by the Employer for any reason, the Executive shall tender his or her resignation from all positions he or she holds with the Employer, effective on the date his or her employment is terminated.

2. Duties. The Executive shall work for the Employer in a full-time capacity. The Executive shall, during the term of this Agreement, have the duties, responsibilities, powers, and authority customarily associated with the position of Chief Financial Officer. In addition, the Executive shall, during the Interim CEO Term, have the duties, responsibilities, powers, and authority customarily associated with the position of interim President and Chief Executive Officer. During the Interim CEO Term, the Executive shall report to and follow the direction of the Board. Following the expiration of the Interim CEO Term, the Executive, in his position as Chief Financial Officer, shall report to and follow the direction of, the Chief Executive Officer of the Employer. In addition to, or in lieu of, the foregoing, the Executive also shall perform such other and unrelated

services and duties as may be assigned to him from time to time by the Employer. The Executive shall diligently, competently, and faithfully perform all duties, and shall devote his or her entire business time, energy, attention, and skill to the performance of duties for the Employer or its affiliates and will use his or her best efforts to promote the interests of the Employer. Notwithstanding the foregoing, the Executive shall be permitted to (i) engage in charitable and community affairs, and (ii) make direct investments of any character in any non-competing business or businesses and to manage such investments (but not be involved in the day-to-day operations of any such business); provided, in each case, and in the aggregate, that such activities do not interfere with the performance of the Executive's duties hereunder.

3. Executive Loyalty. Except as otherwise permitted by Paragraph 2, the Executive shall devote all of his or her time, attention, knowledge, and skill solely and exclusively to the business and interests of the Employer, and the Employer shall be entitled to all benefits and profits arising from or incident to any and all work, services, and advice of the Executive. The Executive expressly agrees that during the term of this Agreement, he or she shall not engage, directly or indirectly, as a partner, officer, director, member, manager, stockholder, advisor, agent, employee, or in any other form or capacity, in any other business similar to that of the Employer.

4. Term of Employment. This Agreement shall be effective as of the Effective Date and shall continue in effect until terminated in accordance with Paragraph 6, provided that Executive shall only hold the position of interim President and Chief Executive Officer for the Interim CEO Term, and the termination of such Interim CEO Term shall not in and of itself be deemed to constitute a termination of the Executive's employment or termination of his services which would otherwise entitle the Executive to receive any termination compensation or benefits under this Agreement.

5. Compensation.

A. The Employer shall pay the Executive (i) an annual base salary of $650,000 (the "**Base Salary**") with respect to Executive's position as Chief Financial Officer, payable in substantially equal installments in accordance with the Employer's payroll policy from time to time in effect and (ii) during the Interim CEO Term, an additional special salary of $100,000 per month with respect to Executive's position as interim President and Chief Executive Officer. The Executive's Base Salary and monthly special salary shall be subject to any payroll or other deductions as may be required to be made pursuant to law, government order, or by agreement with, or consent of, the Executive. The Compensation Committee of the Board shall review at least annually the Executive's Base Salary for possible increase and may, in its sole discretion and in accordance with applicable rules and regulations of the Securities and Exchange Commission and the New York Stock Exchange, periodically adjust the Executive's Base Salary.

B. The Executive shall be eligible to earn annual performance and/or discretionary bonuses as determined each year at the discretion of the Compensation Committee of the Board. The Executive shall be entitled to participate in all bonus or incentive plans applicable to the senior executives of the Employer. Bonus compensation earned and payable pursuant hereto shall be paid in the calendar year following the fiscal year for which the bonus is earned, and in no event shall such payment be made later than December 31 of such following calendar year.

C. The Executive shall be eligible, at the discretion of the Compensation Committee of the Board, for grants of equity compensation pursuant to an equity compensation agreement. Any equity compensation will be granted under and subject to the terms and conditions of an equity compensation plan of the Employer as then in effect.

D. During the term of this Agreement, the Employer shall include the Executive in any 401(k), deferred compensation, savings plan, life insurance, disability insurance, medical, dental or health insurance, paid time off, and other benefit plans or programs maintained by the Employer for the benefit of its executives. The Executive acknowledges and agrees that certain fringe benefits may be subject to income tax withholding and reporting to the extent required by the Internal Revenue Code of 1986, as amended (the "**Code**").

E. The Employer shall reimburse the Executive for all reasonable and approved business expenses, provided the Executive submits paid receipts or other documentation acceptable to the Employer and as required by the Internal Revenue Service to qualify as ordinary and necessary business expenses under the Code.

F. The Employer and the Executive each acknowledge that amounts paid under this Paragraph 5 are subject to any policy on the recovery of compensation (i.e., a so-called "clawback policy"), as may be adopted by the Employer, and as thereafter amended from time to time, in order to comply with applicable law.

6. Termination. The Executive's services shall terminate upon the first to occur of the following events:

A. Upon the Executive's date of death or the date the Executive is given written notice that he or she has been determined to be disabled by the Board. For purposes of this Agreement, the Executive shall be deemed to be disabled if the Executive, as a result of illness or incapacity, shall be unable to perform substantially his or her required duties for a period of four (4) consecutive months or for any aggregate period of six (6) months in any twelve (12) month period.

B. On the date the Employer provides the Executive with written notice that he or she is being terminated for "Cause." For purposes of this Agreement, the Executive shall be deemed terminated for "**Cause**" if the Employer terminates the Executive after the Executive:

(1) shall be indicted or convicted of, or admitted, plea bargained, or entered a plea of no contest or nolo contendere to, any felony or any other act involving fraud, theft, misappropriation, dishonesty, or embezzlement;

(2) shall have committed intentional acts that materially impair the goodwill or business of the Employer or cause material damage to its property, goodwill, or business;

(3) shall have refused to, or willfully failed to, perform his or her material duties hereunder; or

(4) shall have engaged in conduct that constitutes a breach of any fiduciary duty or duty of loyalty owed to the Employer or its affiliates; or

(5) shall have violated any state or federal securities laws,

provided, however, that to the extent the event giving rise to Cause is susceptible to cure, the Employer shall not terminate the Executive's employment hereunder unless the Executive has not, within thirty (30) days following receipt of notice of termination from the Employer (which notice shall set forth in reasonable detail the specific conduct of the Executive that constitutes Cause and the specific provisions of this Agreement on which the Employer relies) taken all reasonable steps to cure such event giving rise to Cause.

Any voluntary termination by the Executive in anticipation of a termination for Cause under this subparagraph B, or a separation for other than Cause at a time when grounds for termination for Cause exist, shall be deemed a termination for Cause.

C. On the date the Employer terminates the Executive's employment for any reason, other than a reason otherwise set forth in this Paragraph 6.

D. On the date the Executive terminates his or her employment for "Good Reason." For purposes of this Agreement, "**Good Reason**" means:

(1) the assignment to the Executive of any duties materially inconsistent in any respect with Paragraph 2 of this Agreement, or any other action by the Employer that results in a material diminution in the Executive's authority, duties or responsibilities, provided, however, that in no event shall the termination or removal of the Executive from his position as interim President and Chief Executive Officer constitute Good Reason hereunder;

(2) any material diminution in the Executive's Base Salary or bonus opportunity;

(3) any material change in the geographic location of the Executive's principal place of employment; or

(4) any material breach of this Agreement by the Employer.

A termination of employment by the Executive for Good Reason shall be effectuated by giving the Employer written notice ("**Notice of Termination for Good Reason**") of the termination within thirty (30) days of the event constituting Good Reason setting forth in reasonable detail the specific conduct of the Employer that constitutes Good Reason and the specific provisions of this Agreement on which the Executive relies. A termination of employment by the Executive

for Good Reason shall be effective on the thirtieth (30th) day following the date when the Notice of Termination for Good Reason is given, unless the Employer cures the condition or event constituting Good Reason within thirty (30) days following receipt of the Executive's Notice of Termination for Good Reason.

E. On the date the Executive resigns for any reason other than a reason set forth in this Paragraph 6, provided that the Executive shall give the Employer thirty (30) days written notice prior to such date of his or her intention to so resign and provided further, that notwithstanding such notice period, the Employer may elect to terminate the Executive's employment at any time prior to the expiration of such notice period, so long as Employer pays the Executive that which would otherwise be due for the notice period.

7. Compensation Upon Termination.

A. If the Executive's services are terminated for any reason, the Executive shall be entitled to his or her salary through his or her final date of active employment plus any accrued but unused vacation pay. The Executive also shall be entitled to any benefits mandated under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or required under the terms of any death, insurance, or retirement plan, program, or agreement provided by the Employer and to which the Executive is a party or in which the Executive is a participant, including, but not limited to, any short-term or long-term disability plan or program, if applicable.

B. If the Executive's services are terminated pursuant to Paragraph 6C or 6D other than within twelve (12) months following a Change in Control Event (as defined in Paragraph 7C below), and the Executive complies with the release requirements set forth in Paragraph 7E, the Executive shall be entitled to receive, in addition to the payments and benefits set forth in Paragraph 7A, the following payments and benefits: (1) an amount equal to one hundred percent (100%) of the Executive's Base Salary then in effect as of the date of his or her termination of employment; (2) a pro rata portion of the Termination Bonus for the year in which the Executive's employment is terminated, based on the number of entire months of such year that have elapsed through the date of the Executive's termination of employment as a fraction of twelve (12); (3) a cash payment of $50,000 for health and welfare benefits; and (4) notwithstanding any provision in the applicable award agreement(s) to the contrary, any non-vested restricted shares awarded pursuant to Paragraph 5C of this Agreement, which shares would otherwise have vested based solely upon the lapse of time, shall immediately vest on the Executive's last day of employment, and any non-vested restricted shares awarded pursuant to Paragraph 5C of this Agreement, the restrictions on which shares would lapse based upon the failure to satisfy, as of the Executive's last day of employment, the relevant performance conditions associated with such shares, shall be forfeited. The term "**Termination Bonus**" shall mean an amount equal to one hundred percent (100%) of the Executive's Base Salary then in effect.

C. If the Executive's services are terminated pursuant to Paragraph 6C or 6D within twelve (12) months following a Change in Control Event, and the Executive complies with the release requirements in Paragraph 7E, the Executive shall be entitled to receive all of the payments and benefits set forth in Section 2 of the Change in Control Agreement and, if applicable,

under Section IV of the Change in Control Severance Plan. For purposes of this Agreement, "**Change in Control Event**" shall have the meaning of Change in Control as defined in Section 1(b) of the Change in Control Agreement and in Section 2(g) of the Change in Control Severance Plan, as applicable. The definitions of "Cause," "Disability" and "Good Reason" set forth in Paragraph 6 of this Agreement shall control the Executive's eligibility for severance under Section 2 of the Change in Control Agreement, and, if applicable, under Section IV of the Change in Control Severance Plan.

D. The Executive shall have no duty to mitigate damages and none of the payments provided in this Paragraph 7 shall be reduced by any amounts earned or received by the Executive from a third party at any time. Notwithstanding anything to the contrary in Paragraph 7C, if, in connection with a Change in Control Event, the Executive voluntarily enters a new written employment agreement with the Employer or the successor entity, the Executive will no longer be entitled to the payments and benefits under Paragraph 7C.

E. The Executive shall be entitled to the payments set forth in Paragraphs 7B or 7C above, if and as applicable, provided he or she signs the Form of Release of Claims and Covenant Not To Sue attached as Exhibit A to the Change in Control Agreement. The Executive must sign and tender (and not revoke) the release as described above not later than sixty (60) days following the Executive's last day of employment, or such earlier date as required by the Employer, and if the Executive fails or refuses to do so, the Executive shall forfeit the right to such termination compensation as would otherwise be due and payable. If the severance payments are otherwise subject to Section 409A of the Code, subject to Paragraph 15, they shall be paid on the first pay period following the date that is sixty (60) days after the Executive's employment terminates. If the payments are not otherwise subject to Section 409A of the Code, they shall be paid on the first pay period after the release becomes effective.

8. Confidentiality. The Executive will not at any time (whether during or after his or her employment with the Employer), unless compelled by lawful process, disclose or use for his or her own benefit or purposes or the benefit or purposes of any other person, firm, partnership, joint venture, association, corporation or other business organization, entity or enterprise other than the Employer and any of its subsidiaries or affiliates, any trade secrets, or other confidential data or information relating to customers, development programs, costs, marketing, trading, investment, sales activities, promotion, credit and financial data, financing methods, or plans of the Employer or of any subsidiary or affiliate of the Employer (collectively, "**Confidential Information**"); provided that the foregoing shall not apply to information which is not unique to the Employer or which is generally known to the industry or the public other than as a result of the Executive's breach of this covenant. The Executive agrees that upon termination of his or her employment with the Employer for any reason, he or she will return to the Employer immediately all memoranda, books, papers, plans, information, letters and other data, and all copies thereof or therefrom, in any way relating to the business of the Employer and its affiliates, except that he or she may retain personal notes, notebooks and diaries that do not contain confidential information of the type described in the preceding sentence. The Executive further agrees that he or she will not retain or use for his or her account at any time any trade names, trademark or other proprietary business designation used or owned in connection with the business of the Employer or its affiliates.

Notwithstanding anything herein to the contrary, the Executive is hereby notified, in accordance with the Defend Trade Secrets Act of 2016, that the Executive will not be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that: (a) is made (i) in confidence to a federal, state, or local government official, either directly or indirectly, or to an attorney; and (ii) solely for the purpose of reporting or investigating a suspected violation of law; or (b) is made in a complaint or other document that is filed under seal in a lawsuit or other proceeding. The Executive is further notified that if he or she files a lawsuit for retaliation by the Employer for reporting a suspected violation of law, the Executive may disclose the Employer's trade secrets to his or her attorney and use the trade secret information in the court proceeding if the Executive (a) files any document containing the trade secret under seal; and (b) does not disclose the trade secret, except pursuant to court order. Further, notwithstanding anything in this Agreement to the contrary, nothing contained herein prohibits the Executive from reporting, without the prior authorization of the Employer and without notifying the Employer, possible violations of federal law or regulation to the United States Securities and Exchange Commission, the United States Department of Justice, the United States Congress or other governmental agency having apparent supervisory authority over the business of the Employer, or making other disclosures that are protected under the whistleblower provisions of Federal law or regulation.

9. Non-Solicitation and Non-Disparagement

A. Non-Solicitation (Employees). During the Executive's employment with the Employer and for twelve (12) months after the Executive's date of termination, the Executive shall not, directly or indirectly, either as an individual or as an employee, agent, consultant, advisor, independent contractor, general partner, officer, director, stockholder, investor, lender, or in any other capacity whatsoever, of any person, firm, corporation, or partnership, induce or attempt to induce, or hire, any person, who at the time of such inducement or hire is an employee of the Employer (or who was, within the six (6) months prior to such inducement or hire, an employee) to perform work or service for any other person or entity other than the Employer.

B. Non-Solicitation (Customers). During the Executive's employment with the Employer and for twelve (12) months after the Executive's date of termination, the Executive shall not, directly or indirectly: (i) contact or solicit, or direct any person, firm, corporation, association or other entity to contact or solicit, any of the Employer's customers for the purpose of providing any products and/or services that are the same as or similar to the products and services provided by the Employer to its customers during the term of the Executive's employment; or (ii) divert or attempt to divert, for his or her direct or indirect benefit, or for the benefit of any other person, firm, corporation, association or other entity, the business of any customer of the Employer; or (iii) influence or attempt to influence any customer of the Employer to transfer its business to the Executive or any person, firm, corporation, association or other entity; or (iv) in any other manner knowingly interfere with, disrupt or attempt to disrupt the relationship of the Employer with any of its customers, and in each of (i) through (iv) if such activities post termination of employment involve the use of trade secrets or other Confidential Information, as defined in Paragraph 8, of the Employer. In addition, the Executive will not disclose the identity of any such customers to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever.

C. Nondisparagement. The Executive agrees that he or she will not disparage the Employer or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. The Executive further agrees that he or she will not direct anyone to make any disparaging oral or written remarks to any third parties.

D. Inventions. The Executive recognizes and agrees that all ideas, inventions, patents, copyrights, copyright designs, trade secrets, trademarks, processes, discoveries, enhancements, software, source code, catalogues, prints, business applications, plans, writings, and other developments or improvements and all other intellectual property and proprietary rights and any derivative work based thereon (the "**Inventions**") made, conceived, or completed by the Executive, alone or with others, during the term of his or her employment, whether or not during working hours, that are within the scope of the Employer's business operations or that relate to any of the Employer's work or projects (including any and all inventions based wholly or in part upon ideas conceived during the Executive's employment with the Employer), are the sole and exclusive property of the Employer. The Executive further agrees that (1) he or she will promptly disclose all Inventions to the Employer and hereby assigns to the Employer all present and future rights he or she has or may have in those Inventions, including without limitation those relating to patent, copyright, trademark or trade secrets; and (2) all of the Inventions eligible under the copyright laws are "work made for hire." At the request of the Employer, the Executive will do all things deemed by the Employer to be reasonably necessary to perfect title to the Inventions in the Employer and to assist in obtaining for the Employer such patents, copyrights or other protection as may be provided under law and desired by the Employer, including but not limited to executing and signing any and all relevant applications, assignments or other instruments. The Executive hereby irrevocably designates and appoints the Employer and its duly authorized officers and agents as the Executive's agents and attorneys-in-fact to act for and on the Executive's behalf and instead of the Executive, to execute and file any documents and to do all other lawfully permitted acts to further the above purposes with the same legal force and effect as if executed by the Executive, and the Executive acknowledges that this designation and appointment constitutes an irrevocable power of attorney and is coupled with an interest. Notwithstanding the foregoing, pursuant to Sections 2870 and 2872 of the California Labor Code, the Employer hereby notifies the Executive that the provisions of this Paragraph 9D shall not apply to any Inventions for which no equipment, supplies, facility or trade secret information of the Employer was used and which were developed entirely on the Executive's own time, unless (1) the Invention relates (i) to the business of the Employer, or (ii) to actual or demonstrably anticipated research or development of the Employer, or (2) the Invention results from any work performed by the Executive for the Employer. A copy of Code Sections 2870 and 2872 will be made available to the Executive upon his or her request.

10. Notices. All notices and other communications hereunder shall be in writing and shall be deemed delivered and effective upon the earliest of (a) personal delivery, (b) electronic confirmation of a facsimile transmission received in its entirety at the applicable facsimile number indicated below with a confirmatory copy sent for overnight delivery the next business day by recognized overnight commercial courier service (such as Federal Express), with all charges prepaid or charged to the sender's account, to the applicable address set forth below or (c) delivery by recognized overnight courier service, with all charges prepaid or charged to the sender's account,

to the applicable address set forth below or at such other address as shall be specified in writing in accordance with this Paragraph:

If to the Executive, to:

Joseph White
3521 Loma View Drive
Altadena, CA 91001

If to Employer, to:

Molina Healthcare, Inc.
Attention: Chief Legal Officer
200 Oceangate, Suite 100
Long Beach, CA 90802
Facsimile No: 916-646-4572

11. Waiver of Breach. A waiver by the Employer of a breach of any provision of this Agreement by the Executive shall not operate or be construed as a waiver or estoppel of any subsequent breach by the Executive. No waiver shall be valid unless in writing and signed by an authorized officer of the Employer.

12. Assignment. This Agreement is personal in its nature and neither of the parties hereto shall, without the consent of the other, assign or transfer this Agreement or any rights or obligations hereunder; provided, however, that, in the event of a merger, consolidation, or transfer or sale of all or substantially all of the assets of the Employer with or to any other individual(s) or entity, this Agreement shall, subject to the provisions hereof, be binding upon and inure to the benefit of such successor and such successor shall discharge and perform all the promises, covenants, duties, and obligations of the Employer hereunder.

13. Entire Agreement. This Agreement sets forth the entire and final agreement and understanding of the parties and contain all of the agreements made between the parties with respect to the subject matter hereof. This Agreement supersedes any and all other agreements, either oral or in writing, between the parties hereto, with respect to the subject matter hereof, including the Existing Agreement; provided, however, that the Change in Control Agreement shall remain in effect as modified hereby. No change or modification of this Agreement shall be valid unless in writing and signed by the Employer and the Executive.

14. Severability. If any provision of this Agreement shall be found invalid or unenforceable for any reason, in whole or in part, then such provision shall be deemed modified, restricted, or reformulated to the extent and in the manner necessary to render the same valid and enforceable, or shall be deemed excised from this Agreement, as the case may require, and this Agreement shall be construed and enforced to the maximum extent permitted by law, as if such provision had been originally incorporated herein as so modified, restricted, or reformulated or as if such provision had not been originally incorporated herein, as the case may be. The parties further

agree to seek a lawful substitute for any provision found to be unlawful; provided, that, if the parties are unable to agree upon a lawful substitute, the parties desire and request that a court or other authority called upon to decide the enforceability of this Agreement modify those restrictions in this Agreement that, once modified, will result in an agreement that is enforceable to the maximum extent permitted by the law in existence at the time of the requested enforcement.

15. Section 409A.

A. The Employer and the Executive intend that the payments and benefits provided for in this Agreement either be exempt from Section 409A of the Code, or be provided in a manner that complies with Section 409A of the Code, and any ambiguity herein shall be interpreted so as to be consistent with the intent of this Paragraph 15. In no event whatsoever shall the Employer be liable for any additional tax, interest or penalty that may be imposed on the Executive by Code Section 409A or damages for failing to comply with Section 409A. Notwithstanding anything contained herein to the contrary, all payments and benefits under Paragraph 7 of this Agreement shall be paid or provided only at the time of a termination of the Executive's employment that constitutes a "separation from service" from the Employer within the meaning of Section 409A of the Code and the regulations and guidance promulgated thereunder (determined after applying the presumptions set forth in Treas. Reg. Section 1.409A-1(h)(1)). Further, if at the time of the Executive's termination of employment with the Employer, the Executive is a "specified employee" as defined in Section 409A of the Code as determined by the Employer in accordance with Section 409A of the Code, and the deferral of the commencement of any payments or benefits otherwise payable hereunder as a result of such termination of employment is necessary in order to prevent any accelerated or additional tax under Section 409A of the Code, then the Employer will defer the commencement of the payment of any such payments or benefits hereunder (without any reduction in payments or benefits ultimately paid or provided to the Executive) until the date that is at least six (6) months following the Executive's termination of employment with the Employer (or the earliest date permitted under Section 409A of the Code), whereupon the Employer will pay the Executive a lump-sum amount equal to the cumulative amounts that would have otherwise been previously paid to the Executive under this Agreement during the period in which such payments or benefits were deferred.

B. Notwithstanding anything to the contrary in this Agreement, in-kind benefits and reimbursements provided under this Agreement during any calendar year shall not affect in-kind benefits or reimbursements to be provided in any other calendar year, other than an arrangement providing for the reimbursement of medical expenses referred to in Section 105(b) of the Code, and are not subject to liquidation or exchange for another benefit. Notwithstanding anything to the contrary in this Agreement, reimbursement requests must be timely submitted by the Executive and, if timely submitted, reimbursement payments shall be promptly made to the Executive following such submission, but in no event later than December 31st of the calendar year following the calendar year in which the expense was incurred. In no event shall the Executive be entitled to any reimbursement payments after December 31st of the calendar year following the calendar year in which the expense was incurred. This subparagraph B shall only apply to in-kind benefits and reimbursements that would result in taxable compensation income to the Executive.

C. In the event that following the date hereof the Employer or the Executive reasonably determines that any compensation or benefits payable under this Agreement may be subject to Section 409A of the Code, the Employer and the Executive shall work together to adopt such amendments to this Agreement or adopt other policies or procedures (including amendments, policies and procedures with retroactive effect), or take any other commercially reasonable actions necessary or appropriate to (x) exempt the compensation and benefits payable under this Agreement from Section 409A of the Code and/or preserve the intended tax treatment of the compensation and benefits provided with respect to this Agreement or (y) comply with the requirements of Section 409A of the Code and related Department of Treasury guidance.

16. Execution of Agreement. This Agreement may be executed in several counterparts, each of which shall be considered an original, but which when taken together, shall constitute one agreement.

17. Recitals. The recitals to this Agreement are incorporated herein as an integral part hereof and shall be considered as substantive and not precatory language.

18. Arbitration. Any controversy, claim or dispute between the parties relating to the Executive's employment or termination of employment, whether or not the controversy, claim or dispute arises under this Agreement, shall be resolved by arbitration in accordance with the Employment Arbitration Rules and Mediation Procedures ("**Rules**") of the American Arbitration Association through a single arbitrator in Los Angeles County, California selected in accordance with the Rules (provided, however, that any controversy or claim arising under Paragraphs 8 or 9 will be resolved, at the election of the Employer, either (i) under this Paragraph 18 or (ii) in accordance with Paragraph 19). The foregoing notwithstanding, claims for workers' compensation, unemployment compensation benefits or any other claims that, as a matter of law, the parties cannot agree to arbitrate shall not be covered by this Paragraph 18. A copy of the Rules will be provided to the Executive upon his or her written request to the Employer. The decision of the arbitrator shall be rendered within thirty (30) days of the close of the arbitration hearing and shall include written findings of fact and conclusions of law reflecting the appropriate substantive law. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof in the State of California. In reaching his or her decision, the arbitrator shall have no authority (a) to change or modify any provision of this Agreement, (b) to base any part of his or her decision on public policy arguments or the common law principle of constructive termination, or (c) to award punitive damages or any other damages not measured by the prevailing party's actual damages and may not make any ruling, finding or award that does not conform to this Agreement. The American Arbitration Association rules regarding discovery shall apply to arbitration under this Paragraph 18. Each party shall bear all of his or its own legal fees, costs and expenses of arbitration; provided, however, that the Employer shall be responsible for the costs of the arbitrator.

19. Governing Law. This Agreement shall be governed by, and construed in accordance with, the laws of the State of California, without reference to its conflict of law provisions. Furthermore, as to Paragraphs 8 or 9, the Executive agrees and consents to submit to personal jurisdiction in the state of California in any state or federal court of competent subject matter jurisdiction situated in Los Angeles County, California. The Executive further agrees that the sole

and exclusive venue for any suit arising out of, or seeking to enforce, the terms of Paragraphs 8 or 9 of this Agreement shall be in a state or federal court of competent subject matter jurisdiction situated in Los Angeles County, California, unless the Employer elects arbitration in accordance with Paragraph 18. In addition, the Executive waives any right to challenge in another court any judgment entered by such Los Angeles County court or to assert that any action instituted by the Employer in any such court is in the improper venue or should be transferred to a more convenient forum. **Further, the Executive waives any right he or she may otherwise have to a trial by jury in any action to enforce the terms of this Agreement.**

[Remainder of page intentionally left blank]

IN WITNESS WHEREOF, the parties have set their signatures on the date first written above.

MOLINA HEALTHCARE, INC.	EXECUTIVE:
/s/ Jeff D. Barlow	*/s/ Joseph White*
By: Jeff D. Barlow	Joseph White
Its: Chief Legal Officer	

Exhibit 10.1

WAIVER AND RELEASE AGREEMENT

This Waiver and Release Agreement ("**Agreement**" and/or "**Release**") is made by and between J. Mario Molina ("**Executive**"), on the one hand, and Molina Healthcare, Inc., a Delaware corporation (the "**Company**"), on the other hand (collectively, the "**Parties**").

WHEREAS, Executive and Company previously entered into that certain Second Amended and Restated Employment Agreement, dated as of March 16, 2016 (the "**Employment Agreement**"); and capitalized terms used but not defined herein shall have the meanings ascribed to them in the Employment Agreement;

WHEREAS, Executive's employment with Company was terminated without Cause under Section 6(b) of the Employment Agreement, effective May 2, 2017 ("**Termination Date**");

WHEREAS, under the Employment Agreement, Executive's receipt of certain severance benefits as a result of the termination of his employment is contingent on his execution of a general release and waiver of claims against Company, any revocation of release period provided by law has run, and Executive has not revoked the release of claims and covenant not to sue within such period;

WHEREAS, Executive and Company desire to resolve all outstanding matters with respect to Executive's employment with and separation of employment from Company; and

WHEREAS, Executive and Company desire to fully release all claims which Executive in any capacity may have or claim to have, including without limitation claims arising out of or in any way relating to Executive's employment with and separation of employment from Company.

NOW, THEREFORE, Executive and Company agree as follows:

1. Termination of Employment. Executive's employment with Company was terminated on the Termination Date. All positions Executive held with Company and any of its subsidiaries (whether as an employee, officer, director, consultant, committee member or otherwise) have ceased, except for his position as a director on the Board of Directors of Company (the "**Board of Directors**"). After the Termination Date, Executive shall have no employment duties or responsibilities to Company and no authority to act on its behalf (except solely for actions in Executive's capacity as a director on the Board of Directors, subject to all policies, guidelines and other provisions, in each case that now exist or that may be adopted from time to time, applicable to directors on the Board of Directors) or speak on its behalf (except solely for statements made in Executive's capacity as a director but only to the extent so authorized by Company). Executive will promptly sign all appropriate documents reasonably requested by Company to facilitate or reflect his separation from service from Company.

2. Payments and Benefits. As a result of the termination of Executive's employment with Company, Executive is entitled to receipt of payments under Section 6(b) of the Employment

Agreement, subject to satisfying the condition precedent set forth in Section 12 of the Employment Agreement that Executive shall have executed this Agreement and that any revocation of release period provided by law shall have expired without revocation by Executive within such period. The Parties agree that the actual amounts payable under Section 6(b) of the Employment Agreement (other than the Accrued Obligations, which are addressed in Section 3 below) are set forth below:

a. Cash Payment. Pursuant to Sections 6(b)(i)(1), (2) and (5) of the Employment Agreement, Executive will receive a cash payment equal to $5,690,000, subject to applicable withholding, which represents the sum of (i) $5,000,000, representing the amount equal to 400% of $1,250,000, which is Executive's Base Salary in effect as of the Termination Date ("**Base Salary**"), (ii) $625,000, representing the Pro Rata Bonus; and (iii) $65,000, representing eighteen months of health and welfare benefits as contemplated under Section 4(a) of the Employment Agreement (in lieu of any obligation of Company to continue to provide health and welfare benefit coverage to Executive). The cash payment described in this Section 2(a) shall be paid to Executive in accordance with the timing described in Section 6(b)(iii)(A) of the Employment Agreement, based on his status as a Specified Employee on the date of Executive's Separation from Service.

b. 401(k) Contributions. Consistent with Section 6(b)(i)(4) of the Employment Agreement, Executive is fully vested in his and Company's contributions to Executive's 401(k) plan account.

c. Equity Compensation. Pursuant to Section 6(b)(ii) of the Employment Agreement, Executive shall be entitled to one hundred percent vesting of all outstanding Equity Compensation previously granted to Executive pursuant to equity compensation agreements accepted by Executive as a condition to each such grant, as more particularly set forth on Attachment A, subject to applicable withholding. All such grants of Equity Compensation are set forth on Attachment A, and Executive does not hold or have rights to any Equity Compensation not listed on Attachment A. With respect to the Performance Stock Unit Awards granted on March 1, 2017, and in accordance with the applicable equity compensation agreement pursuant to which such grant was issued to Executive, Company shall deliver one share of common stock of Company for each Performance Stock Unit Award that vested as a result of Executive's termination of employment, subject to applicable withholding. All Equity Compensation listed on Attachment A shall continue to be governed by the terms of the applicable equity compensation plans and equity compensation agreements pursuant to which such grants were issued to Executive.

3. Accrued Obligations. The Parties acknowledge and agree that Company has paid or will pay Executive the following payments and benefits, subject to applicable withholding, which consist of the actual Accrued Obligations payable in accordance with Section 6(b)(i)(3) of the Employment Agreement, whether or not Executive signs this Agreement:

a. Base Salary, PTO and 2016 Incentive Compensation. Company has paid Executive a lump sum cash payment of $259,615.58, subject to applicable withholding, which represents the sum of (i) $57,692.35, representing his accrued but unpaid Base Salary as of the Termination Date, (ii) $201,923.23, representing his accrued but unused PTO as of the Termination Date and (iii) $0, representing his unpaid annual incentive compensation in respect of the 2016

fiscal year (it being agreed that all 2016 annual incentive compensation payable to Executive was paid by Company in March 2017). For the avoidance of doubt, the Parties acknowledge and agree that Executive had 336 hours of accrued but unused PTO as of the Termination Date.

b. Expense Reimbursement. Company has paid or will promptly reimburse Executive for all reasonable expenses incurred in connection with the performance of his duties under Section 1 of the Employment Agreement through the Termination Date in accordance with Company's expense reimbursement policies, subject to applicable withholding.

c. Vested Benefits. Company shall provide the vested benefits to which Executive is entitled, if any, as a result of the termination of his employment under the employee benefit plans and arrangements of Company described in Sections 4(a) and 4(c) through 4(f) of the Employment Agreement, subject to applicable withholding. For the avoidance of doubt, the Parties agree that these benefits consist solely of the following: (i) Non-Qualified Deferred Compensation Plan Account Balance of $5,663,625.62, to be distributed as a lump sum in accordance with the timing required by the terms of the Non-Qualified Deferred Compensation Plan and Code Section 409A; and (ii) Executive Disability Coverage paid through May 26, 2017.

4. General Release.

Executive, for himself and for his heirs, executors, administrators, successors, and assigns, does hereby irrevocably and unconditionally waive, release and forever discharge, Company, its past and present parents, subsidiaries, affiliates, divisions, predecessors, successors, and assigns, and its and their respective current and former employees, officers, directors and agents (collectively, the "**Released Parties**"), from any and all past or present claims, demands, causes of action, lawsuits, grievances, obligations, damages, expenses, attorneys' fees, and liabilities of whatever kind or nature, known or unknown (all hereinafter referred to as "**Claims**"), which he ever had, now has, or may hereafter claim to have had, against the Released Parties or any of them based on any events, facts or circumstances arising at any time on or before the date of this Agreement, including but not limited to claims that relate to Executive's service with Company and/or the separation from such service; provided that the foregoing release applies to current and former employees, officers, directors and agents only to the extent of Claims based on their actions (or failures to act) within the course or scope of their employment or service on the Board of Directors, as applicable, or otherwise made by reason of the fact that any such individual is or was an employee, officer, director or agent of Company, or is or was serving at the request of Company as a director, employee or agent of another company, partnership, joint venture, trust or other enterprise (this proviso, the "Claim Limitation Caveat"). Executive agrees that this general release of Claims includes, but is not limited to, (a) claims of race, age, gender, sexual orientation, religious or national origin discrimination or any other legally protected status under Title VII of the Civil Rights Act of 1964, as amended; the Civil Rights Act of 1991; the Age Discrimination in Employment Act of 1967, as amended ("**ADEA**"); and under any other federal, state or local laws, as amended; (b) claims based on any other federal, state or local laws, including but not limited to the Equal Pay Act; the Americans with Disabilities Act; the Americans with Disabilities Act Amendments Act; the Labor Management Relations Act; the Family and Medical Leave Act; the Employee Retirement Income Security Act ("**ERISA**"); the Sarbanes-Oxley Act of 2002, the Worker Adjustment and Retraining Notification Act (" **WARN**"); the California WARN Act; the California Fair Employment and Housing Act; the

California Labor Code; the California Family Rights Act, the California Industrial Welfare Commission Wage Orders; the California Constitution; and the California Government Code, as well as any amendments to those laws; (c) claims of disputed wages or entitlement to any other pay; (d) claims of wrongful discharge or retaliation; (e) claims of breach of any implied or express contract or covenant; (f) claims for violation of personnel policies, handbooks, or any covenant of good faith and fair dealing; (g) claims for promissory estoppel; (h) ERISA claims; (i) claims for wrongful denial of insurance or other benefits; (j) claims based on any public policy violation or on any tort, such as invasion of privacy, sexual harassment, defamation, fraud, misrepresentation and/or infliction of emotional distress; and (k) claims relating to Executive's service as a director on the Board of Directors or actions taken by the directors on the Board of Directors or any of them as directors. Execution of this Agreement by Executive operates as a complete bar and defense against any and all Claims that may be made by Executive against the Released Parties or any of them, subject to the Claim Limitation Caveat. Executive expressly understands that among the various claims and rights being waived by Executive in this Agreement are those arising under the ADEA, and in that regard Executive specifically acknowledges that Executive has read and understands the provisions of Section 9 below before signing this Agreement.

5. Exclusions from General Release; Protected Rights.

Notwithstanding anything to the contrary in Section 4 above, Executive is not prohibited from making or asserting: (a) Executive's rights under this Agreement and any claims arising from the breach of this Agreement by Company, including any claim for breach of Company's obligation to make the payments described in Sections 2 and 3 above; (b) any claims for unemployment compensation, workers' compensation or state disability insurance benefits pursuant to the terms of applicable state laws; (c) any claim for vested benefits under any Company-sponsored retirement or welfare benefit plan; (d) Executive's rights, if any, to indemnity and/or advancement of expenses pursuant to applicable state law, Company's articles, bylaws, or any indemnification agreement between Company and Executive; and/or to the protections of any director' and officers' liability policies of Company; (e) any right Executive may have to obtain contribution as permitted by law in the event of entry of judgment against Executive as a result of any act or failure to act for which Company and Executive are held jointly liable; (f) any claim that arises based on events or facts arising at any time after the date of execution of this Agreement (including any such claim arising under this Agreement or the Employment Agreement); and (g) any other right that may not be released by private agreement.

6. Protected Rights.

Nothing in this Agreement limits Executive's rights to file a charge with, or report possible violations of law or regulation to, or communicate with, any governmental agency or federal or state regulatory authority or self-regulatory organization, or to make other disclosures that are protected under any law or regulation, or to cooperate with any investigation or proceeding by any governmental agency, federal or state regulatory authority, or self-regulatory organization, or to receive an award for information provided to any securities regulatory agency or authority. If the Executive files a charge or participates in an investigative proceeding of the EEOC or another governmental agency relating to Company as described in this Section 6, or is otherwise made a party to any such proceedings or other proceedings of a type described in Section 4 hereof, Executive will not seek and will not accept any personal equitable or monetary relief in connection with such charge or investigative or other proceeding if the charge or proceeding pertains to a claim that is

released by this Agreement; provided, however, that this Agreement does not limit the Executive's right to receive an award for information provided to any governmental agencies under any whistleblower program. In addition, Executive acknowledges that an individual shall not be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that is made (a) in confidence to a federal, state, or local government official or to an attorney solely for the purpose of reporting or investigating a suspected violation of law, or (b) in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. Executive understands and acknowledges further that an individual who files a lawsuit for retaliation by an employer for reporting a suspected violation of law may disclose the trade secret to the attorney of the individual and use the trade secret information in the court proceeding, if the individual files any document containing the trade secret under seal and does not disclose the trade secret, except pursuant to court order. Notwithstanding the foregoing, under no circumstance is Executive authorized to disclose any attorney-client privileged information of Company or any of Company's attorney work product without Company's prior written consent or as otherwise expressly required by law. The exclusions and protections contained in this Section 6 override any language to the contrary in any other part of this Agreement.

7. Waiver of Unknown Claims.

It is Executive's intention (and Executive agrees) that Executive's execution of this Agreement will forever bar every claim, demand or cause of action it releases. Executive agrees that this Agreement shall constitute a complete defense to any such claim, demand or cause of action. Executive recognizes that Executive may have some claim, demand or cause of action against Company or any other Released Party which are part of the Claims that this Agreement releases of which Executive is unaware and unsuspecting which Executive is giving up by execution of this Agreement, but it is Executive's intention (and Executive agrees) that in executing this Agreement he shall be deprived of such claim, demand or cause of action and shall be prevented from asserting it against Company or any other Released Party. In furtherance of this intention, Executive expressly waives any and all rights and benefits conferred upon Executive by the provisions of Section 1542 of the California Civil Code (or any similar provision(s) of any other jurisdiction). Section 1542 provides:

> **"A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."**

8. Period for Review and Consideration of Agreement.

Executive confirms that he has been given until July 17, 2017 to review and consider this Agreement before signing it, which review period is at least twenty-one (21) days. Executive understands that he may use as much or as little of this period as he wishes prior to signing the Agreement. Executive and Company mutually agree to extend the deadline set forth in Section 12 of the Employment Agreement from July 1, 2017 (which is 60 days following Executive's Separation of Service) to July 17, 2017.

To accept this Agreement, Executive must return an executed copy of this Agreement to Molina Healthcare, Inc., Attn: Jeff Barlow, 200 Oceangate, Long Beach, CA 90802; fax: (916) 646-4572; email: Jeffrey.Barlow@molinahealthcare.com by 5:00 p.m. (Pacific) on July 17, 2017.

9. Revocation.

In order to comply with the Older Workers Benefits Protection Act (29 U.S.C. Section 626(f)) and effectuate the release by Executive of any potential claims under the ADEA, Executive agrees as follows. Executive specifically acknowledges that he is waiving and releasing any rights he may have under the ADEA in exchange for the consideration paid. Executive acknowledges that the consideration given for this waiver and release is in addition to anything of value to which he was already entitled. Executive has carefully reviewed this Agreement and understands the terms and conditions it contains. By entering into this Agreement Executive is giving up potentially valuable legal rights and he intends to be bound by all the terms and conditions set forth in this Agreement. Executive is entering into this Agreement freely, knowingly and voluntarily. Executive has been advised to consult, and has consulted, legal counsel before executing the Agreement. Executive does not waive any rights or claims that may arise from acts or events occurring after the date this Agreement is signed by Executive.

If this Agreement is signed by Executive and returned to Company within the time specified in Section 8 above, Executive may revoke this Agreement within seven (7) calendar days following the date on which Executive signs this Agreement. Accordingly, this Agreement shall not become effective or enforceable until the eighth (8th) calendar day after Executive signs this Agreement (the "**Effective Date**"). Revocation must be made by delivery of a written notice of revocation to Company in the manner described in Section 8 above by 5:00 p.m. Pacific on the seventh (7th) calendar day following the date on which Executive signs this Agreement.

If this Agreement is revoked within the seven (7)-day revocation period, none of the provisions of the Agreement shall be effective or enforceable.

10. Cooperation.

Executive will cooperate fully with Company and its counsel, upon their request, with respect to the defense, prosecution, or conduct of potential or pending proceedings (including without limitation any litigation, arbitration, regulatory proceeding, investigation, or governmental action) against, involving or on behalf of any Company entity that relates in whole or in part to events which transpired while Executive was employed with Company. Executive agrees to render such cooperation in a reasonably timely fashion and to provide Company personnel and counsel with the full benefit of his knowledge with respect to any such matter, and will make himself reasonably available at reasonable times and locations for interviews, depositions, or court appearances at the request of Company or its counsel. In seeking such cooperation, Company will take into account Executive's conflicting professional and personal commitments. Company agrees to compensate Executive at the rate of $300 per hour. for any cooperation required by and requested pursuant to this paragraph. Company acknowledges that Executive may have his personal counsel present for discovery or other adversarial proceedings at his own expense (except to the extent payment for counsel is provided under any applicable indemnification policy or director or officer insurance).

11. Acknowledgements.

Executive represents and agrees that he has been and is hereby advised to and had the opportunity to thoroughly discuss, and has discussed, all aspects of this Agreement with his attorney, and that he had a reasonable period of time within which to consider the Agreement, and that he has carefully read and fully understands all of the provisions of this Agreement, and that he is knowingly and voluntarily entering into this Agreement. Executive further acknowledges that Executive has no

right to any future employment by Company, and that except as set forth in Section 2 and 3 above, and except in connection with Executive's service as a director on the Board of Directors, as of the Termination Date, Executive is not entitled to any wages or compensation (including without limitation bonuses or incentive compensation), perquisites, other benefits, stock awards, stock options, stock appreciation rights, or other equity-based or cash-based awards from Company. Executive has not suffered any job-related illness or injury during employment with Company for which Executive has not already filed a claim, and Executive has disclosed to Company in writing any pending or previously filed claim relating to an on-the-job injury or illness, and the termination of Executive's employment by Company is not related to any such on-the-job injury or illness.

12. Withholding.

Company may withhold, or cause to be withheld, from any payments or benefits under this Agreement all amounts required to be withheld pursuant to federal, state or local tax laws.

13. Tax Matters.

Executive has not relied upon any representation, express or implied, made by Company or any of its representatives as to the tax consequences of this Agreement to Executive and Executive hereby releases the Released Parties from any and all liability to him or on behalf of him in connection with any such tax consequences. Executive agrees that any liability he incurs for federal, state or local tax payments or penalties on him arising from any portion of the payments made under the Employment Agreement or this Agreement shall be Executive's sole responsibility.

14. Assignment of Claims.

Executive hereby represents and warrants that he has not heretofore assigned or transferred or purported to assign or transfer to anyone or any entity any claims, assertions of claims, demands, actions, causes of action, or suits based upon, arising out of, pertaining to, concerning or connected with any other matters herein released.

15. Non-Admission of Liability.

It is understood and agreed by Executive that the payment of consideration to which reference is made in this Agreement does not constitute an admission or concession of liability by Company on account of any claim or potential claim by Executive.

16. No Current/Future Actions Filed; Covenant Not To Sue.

Executive represents and warrants that no type of administrative or legal action arising out of claims waived and/or released by this Agreement has been filed to date and that he will not sue or become party to any litigation arising out of claims waived or released by this Agreement. If Executive hereafter commences or becomes party to any action or proceeding against any Released Party based upon any of the claims waived and/or released by this Agreement, the Released Parties will be entitled to apply for an injunction to restrain such violation. This Agreement may be pleaded by the Released Parties as a defense, counterclaim or cross-claim in any such action or proceeding.

17. Dispute Resolution.

The Parties acknowledge that the provisions of Sections 22 and 23 of the Employment Agreement apply to disputes arising out of or relating to this Agreement and that, to the extent that any dispute subject to the provisions of Section 22 of the Employment Agreement would implicate the factors set forth in *Armendariz v. Foundation Health Psychare Services, Inc.*, 6 P.3d 669 (Cal. 2000) or its progeny to be applied, the Parties hereby agree and consent to their application, including the

requirement that Company shall pay all additional costs peculiar to the arbitration to the extent such costs would not otherwise be incurred in a court proceeding (for instance, Company will pay the arbitrator's fees to the extent they exceed court filing fees).

18. Entire Agreement.

Executive acknowledges that no promises or representations other than those set forth in this Agreement have been made to Executive to induce Executive to sign this Agreement, and that Executive only has relied on promises expressly stated herein. The Parties agree that nothing in this Agreement shall affect the provisions of the Employment Agreement that survive the termination of Executive's employment with Company. No amendments or modifications to this Agreement shall be binding unless made in a writing specifically referencing this Agreement and signed by Executive and Company.

19. Waiver.

The failure by either Party to insist upon strict compliance with any term or provision of this Agreement shall not operate or be construed as a waiver of such term or provision. The waiver by either Party of a breach of any term or provision of this Agreement must be in writing signed by such Party in order to be binding and, further, shall not operate or be construed as a waiver of a subsequent breach of the same provision by any Party or of the breach of any other term or provision of this Agreement.

20. Governing Law; Construction.

This Agreement shall be governed by, and construed and enforced in accordance with, the internal laws of the State of California, without regard to its conflict of laws provisions. The language of this Agreement shall not be construed for or against any particular party. The headings used herein are for reference only and shall not affect the construction of this Agreement.

21. Assignment; Binding Effect.

This Agreement is only assignable by Company (provided that no such assignment will relieve Company of its obligations under this Agreement to Executive). This Agreement shall be binding upon and inure to the benefit of each Party and its or his successors and assigns and, with respect to Executive, his spouse, heirs, legatees, executors, administrators, and representatives, and, with respect to the releases and waivers made herein, will inure to the benefit of the Released Parties.

22. Section 409A Provisions.

The provisions of Annex A to the Employment Agreement are hereby incorporated herein by reference as if fully set forth herein and shall apply to the payments made under this Agreement or the Employment Agreement, except as expressly set forth in this Agreement or the Employment Agreement.

23. Severability.

If any provision of this Agreement is held by a court of competent jurisdiction or arbitrator to be invalid, void or unenforceable, the remaining provisions shall, nevertheless, continue in full force and effect without being impaired or invalidated in any way, and the provision held to be invalid, void or unenforceable shall be deemed to be severed or limited, but only to the extent necessary to render the remaining portion of such provision and the remaining provisions of the Agreement enforceable to the maximum extent permitted by law.

24. Counterparts.

This Agreement may be executed in one or more counterparts, each of which shall constitute an original, and all of which shall constitute one instrument.

[SIGNATURES ON NEXT PAGE]

[SIGNATURES FOR WAIVER AND RELEASE AGREEMENT]

IN WITNESS WHEREOF, the undersigned execute this Agreement freely and voluntarily intending to be legally bound by it.

June 24, 2017

Executive

/s/ J. Mario Molina

J. Mario Molina

June 23, 2017

Molina Healthcare, Inc.

/s/ Jeff D. Barlow

By: Jeff D. Barlow
Its: Chief Legal Officer

Attachment A

Equity Awards

Award Number	Plan	Market Value on Vest Date	Accelerated Vesting Date	Tax Payment Method	Shares Released	Shares Traded For Taxes	Net Shares to be Issued
PS000134	2011	$ 59.75	5/2/2017	Trade	13,084	6,828	6,256
PS000129	2011	$ 59.75	5/2/2017	Trade	6,542	3,414	3,128
PS000094	2011	$ 59.75	5/2/2017	Trade	12,215	6,374	5,841
PS000089	2011	$ 59.75	5/2/2017	Trade	12,215	6,374	5,841
PS000084	2011	$ 59.75	5/2/2017	Trade	12,215	6,374	5,841
PS000079	2011	$ 59.75	5/2/2017	Trade	12,215	6,374	5,841
PS000104	2011	$ 59.75	5/2/2017	Trade	13,084	6,828	6,256
PS000119	2011	$ 59.75	5/2/2017	Trade	13,084	6,828	6,256
PS000109	2011	$ 59.75	5/2/2017	Trade	13,084	6,828	6,256
RA000442	2011	$ 59.75	5/2/2017	Trade	13,083	6,827	6,256
RA000442	2011	$ 59.75	5/2/2017	Trade	13,083	6,827	6,256
RA000365	2011	$ 59.75	5/2/2017	Trade	12,216	6,375	5,841
RA000527	2011	$ 59.75	5/2/2017	Trade	19,433	10,141	9,292
RA000527	2011	$ 59.75	5/2/2017	Trade	19,434	10,141	9,293
RA000527	2011	$ 59.75	5/2/2017	Trade	19,433	10,141	9,292
				TOTAL	**204,420**	**106,674**	**97,746**

Performance Stock Unit Awards

Award Number	Plan	Market Value on Vest Date	Accelerated Vesting Date	Tax Payment Method	Shares Released	Shares Traded For Taxes	Net Shares to be Issued
PS000144	2017	$ 68.16	5/10/2017	Trade	24,292	12,676	11,616
PS000139	2017	$ 68.16	5/10/2017	Trade	24,292	12,676	11,616
PS000149	2017	$ 68.16	5/10/2017	Trade	22,672	11,831	10,841
PS000154	2017	$ 68.16	5/10/2017	Trade	32,388	16,901	15,487
				TOTAL	**103,644**	**54,084**	**49,560**

Exhibit 10.2

WAIVER AND RELEASE AGREEMENT

This Waiver and Release Agreement ("**Agreement**" and/or "**Release**") is made by and between John Molina ("**Executive**"), on the one hand, and Molina Healthcare, Inc., a Delaware corporation(the "**Company**"), on the other hand (collectively, the "**Parties**").

WHEREAS, Executive and Company previously entered into that certain Second Amended and Restated Employment Agreement, dated as of March 16, 2016 (the "**Employment Agreement**"); and capitalized terms used but not defined herein shall have the meanings ascribed to them in the Employment Agreement;

WHEREAS, Executive's employment with Company was terminated without Cause under Section 6(b) of the Employment Agreement, effective May 2, 2017 ("**Termination Date**");

WHEREAS, under the Employment Agreement, Executive's receipt of certain severance benefits as a result of the termination of his employment is contingent on his execution of a general release and waiver of claims against Company, any revocation of release period provided by law has run, and Executive has not revoked the release of claims and covenant not to sue within such period;

WHEREAS, Executive and Company desire to resolve all outstanding matters with respect to Executive's employment with and separation of employment from Company; and

WHEREAS, Executive and Company desire to fully release all claims which Executive in any capacity may have or claim to have, including without limitation claims arising out of or in any way relating to Executive's employment with and separation of employment from Company.

NOW, THEREFORE, Executive and Company agree as follows:

1. Termination of Employment. Executive's employment with Company was terminated on the Termination Date. All positions Executive held with Company and any of its subsidiaries (whether as an employee, officer, director, consultant, committee member or otherwise) have ceased, except for his position as a director on the Board of Directors of Company (the "**Board of Directors**"). After the Termination Date, Executive shall have no employment duties or responsibilities to Company and no authority to act on its behalf (except solely for actions in Executive's capacity as a director on the Board of Directors, subject to all policies, guidelines and other provisions, in each case that now exist or that may be adopted from time to time, applicable to directors on the Board of Directors) or speak on its behalf (except solely for statements made in Executive's capacity as a director but only to the extent so authorized by Company). Executive will promptly sign all appropriate documents reasonably requested by Company to facilitate or reflect his separation from service from Company.

2. Payments and Benefits. As a result of the termination of Executive's employment with Company, Executive is entitled to receipt of payments under Section 6(b) of the Employment

Agreement, subject to satisfying the condition precedent set forth in Section 12 of the Employment Agreement that Executive shall have executed this Agreement and that any revocation of release period provided by law shall have expired without revocation by Executive within such period. The Parties agree that the actual amounts payable under Section 6(b) of the Employment Agreement (other than the Accrued Obligations, which are addressed in Section 3 below) are set forth below:

a. Cash Payment. Pursuant to Sections 6(b)(i)(1), (2) and (5) of the Employment Agreement, Executive will receive a cash payment equal to $4,040,000, subject to applicable withholding, which represents the sum of (i) $3,600,000, representing the amount equal to 400% of $900,000, which is Executive's Base Salary in effect as of the Termination Date ("**Base Salary**"), (ii) $375,000, representing the Pro Rata Bonus; and (iii) $65,000, representing eighteen months of health and welfare benefits as contemplated under Section 4(a) of the Employment Agreement (in lieu of any obligation of Company to continue to provide health and welfare benefit coverage to Executive). The cash payment described in this Section 2(a) shall be paid to Executive in accordance with the timing described in Section 6(b)(iii)(A) of the Employment Agreement , based on his status as a Specified Employee on the date of Executive's Separation from Service.

b. 401(k) Contributions. Consistent with Section 6(b)(i)(4) of the Employment Agreement, Executive is fully vested in his and Company's contributions to Executive's 401(k) plan account.

c. Equity Compensation. Pursuant to Section 6(b)(ii) of the Employment Agreement, Executive shall be entitled to one hundred percent vesting of all outstanding Equity Compensation previously granted to Executive pursuant to equity compensation agreements accepted by Executive as a condition to each such grant, as more particularly set forth on Attachment A, subject to applicable withholding. All such grants of Equity Compensation are set forth on Attachment A, and Executive does not hold or have rights to any Equity Compensation not listed on Attachment A. With respect to the Performance Stock Unit Awards granted on March 1, 2017, and in accordance with the applicable equity compensation agreement pursuant to which such grant was issued to Executive, Company shall deliver one share of common stock of Company for each Performance Stock Unit Award that vested as a result of Executive's termination of employment, subject to applicable withholding. All Equity Compensation listed on Attachment A shall continue to be governed by the terms of the applicable equity compensation plans and equity compensation agreements pursuant to which such grants were issued to Executive.

3. Accrued Obligations. The Parties acknowledge and agree that Company has paid or will pay Executive the following payments and benefits, subject to applicable withholding, which consist of the actual Accrued Obligations payable in accordance with Section 6(b)(i)(3) of the Employment Agreement, whether or not Executive signs this Agreement:

a. Base Salary, PTO and 2016 Incentive Compensation. Company has paid Executive a lump sum cash payment of $186,922.94, subject to applicable withholding, which represents the sum of (i) $41,538.43, representing his accrued but unpaid Base Salary as of the Termination Date, (ii) $145,384.51, representing his accrued but unused PTO as of the Termination

Date and (iii) $0, representing his unpaid annual incentive compensation in respect of the 2016 fiscal year (it being agreed that all 2016 annual incentive compensation payable to Executive was paid by Company in March 2017). For the avoidance of doubt, the Parties acknowledge and agree that Executive had 336 hours of accrued but unused PTO as of the Termination Date.

b. Expense Reimbursement. Company has paid or will promptly reimburse Executive for all reasonable expenses incurred in connection with the performance of his duties under Section 1 of the Employment Agreement through the Termination Date in accordance with Company's expense reimbursement policies, subject to applicable withholding.

c. Vested Benefits. Company shall provide the vested benefits to which Executive is entitled, if any, as a result of the termination of his employment under the employee benefit plans and arrangements of Company described in Sections 4(a) and 4(c) through 4(f) of the Employment Agreement, subject to applicable withholding. For the avoidance of doubt, the Parties agree that these benefits consist solely of the following: (i) Non-Qualified Deferred Compensation Plan Account Balance of $485,860.81, to be distributed in ten (10) annual installments in accordance with the timing required by the terms of the Non-Qualified Deferred Compensation Plan and Code Section 409A; and (ii) Executive Disability Coverage paid through May 26, 2017.

4. General Release.

Executive, for himself and for his heirs, executors, administrators, successors, and assigns, does hereby irrevocably and unconditionally waive, release and forever discharge, Company, its past and present parents, subsidiaries, affiliates, divisions, predecessors, successors, and assigns, and its and their respective current and former employees, officers, directors and agents (collectively, the "**Released Parties**"), from any and all past or present claims, demands, causes of action, lawsuits, grievances, obligations, damages, expenses, attorneys' fees, and liabilities of whatever kind or nature, known or unknown (all hereinafter referred to as "**Claims**"), which he ever had, now has, or may hereafter claim to have had, against the Released Parties or any of them based on any events, facts or circumstances arising at any time on or before the date of this Agreement, including but not limited to claims that relate to Executive's service with Company and/or the separation from such service; provided that the foregoing release applies to current and former employees, officers, directors and agents only to the extent of Claims based on their actions (or failures to act) within the course or scope of their employment or service on the Board of Directors, as applicable, or otherwise made by reason of the fact that any such individual is or was an employee, officer, director or agent of Company, or is or was serving at the request of Company as a director, employee or agent of another company, partnership, joint venture, trust or other enterprise (this proviso, the "Claim Limitation Caveat"). Executive agrees that this general release of Claims includes, but is not limited to, (a) claims of race, age, gender, sexual orientation, religious or national origin discrimination or any other legally protected status under Title VII of the Civil Rights Act of 1964, as amended; the Civil Rights Act of 1991; the Age Discrimination in Employment Act of 1967, as amended ("**ADEA**"); and under any other federal, state or local laws, as amended; (b) claims based on any other federal, state or local laws, including but not limited to the Equal Pay Act; the Americans with Disabilities Act; the Americans with Disabilities Act Amendments Act; the Labor Management Relations Act; the Family and Medical Leave Act; the Employee Retirement Income Security Act ("**ERISA**"); the Sarbanes-Oxley Act of 2002, the Worker Adjustment and Retraining Notification

Act ("**WARN**"); the California WARN Act; the California Fair Employment and Housing Act; the California Labor Code; the California Family Rights Act, the California Industrial Welfare Commission Wage Orders; the California Constitution; and the California Government Code, as well as any amendments to those laws; (c) claims of disputed wages or entitlement to any other pay; (d) claims of wrongful discharge or retaliation; (e) claims of breach of any implied or express contract or covenant; (f) claims for violation of personnel policies, handbooks, or any covenant of good faith and fair dealing; (g) claims for promissory estoppel; (h) ERISA claims; (i) claims for wrongful denial of insurance or other benefits; (j) claims based on any public policy violation or on any tort, such as invasion of privacy, sexual harassment, defamation, fraud, misrepresentation and/or infliction of emotional distress; and (k) claims relating to Executive's service as a director on the Board of Directors or actions taken by the directors on the Board of Directors or any of them as directors. Execution of this Agreement by Executive operates as a complete bar and defense against any and all Claims that may be made by Executive against the Released Parties or any of them, subject to the Claim Limitation Caveat. Executive expressly understands that among the various claims and rights being waived by Executive in this Agreement are those arising under the ADEA, and in that regard Executive specifically acknowledges that Executive has read and understands the provisions of Section 9 below before signing this Agreement.

5. Exclusions from General Release; Protected Rights.

Notwithstanding anything to the contrary in Section 4 above, Executive is not prohibited from making or asserting: (a) Executive's rights under this Agreement and any claims arising from the breach of this Agreement by Company, including any claim for breach of Company's obligation to make the payments described in Sections 2 and 3 above; (b) any claims for unemployment compensation, workers' compensation or state disability insurance benefits pursuant to the terms of applicable state laws; (c) any claim for vested benefits under any Company-sponsored retirement or welfare benefit plan; (d) Executive's rights, if any, to indemnity and/or advancement of expenses pursuant to applicable state law, Company's articles, bylaws, or any indemnification agreement between Company and Executive; and/or to the protections of any director' and officers' liability policies of Company; (e) any right Executive may have to obtain contribution as permitted by law in the event of entry of judgment against Executive as a result of any act or failure to act for which Company and Executive are held jointly liable; (f) any claim that arises based on events or facts arising at any time after the date of execution of this Agreement (including any such claim arising under this Agreement or the Employment Agreement); and (g) any other right that may not be released by private agreement.

6. Protected Rights.

Nothing in this Agreement limits Executive's rights to file a charge with, or report possible violations of law or regulation to, or communicate with, any governmental agency or federal or state regulatory authority or self-regulatory organization, or to make other disclosures that are protected under any law or regulation, or to cooperate with any investigation or proceeding by any governmental agency, federal or state regulatory authority, or self-regulatory organization, or to receive an award for information provided to any securities regulatory agency or authority. If the Executive files a charge or participates in an investigative proceeding of the EEOC or another governmental agency relating to Company as described in this Section 6, or is otherwise made a party to any such proceedings or other proceedings of a type described in Section 4 hereof, Executive will not seek and will not accept any personal equitable or monetary relief in connection with such

charge or investigative or other proceeding if the charge or proceeding pertains to a claim that is released by this Agreement; provided, however, that this Agreement does not limit the Executive's right to receive an award for information provided to any governmental agencies under any whistleblower program. In addition, Executive acknowledges that an individual shall not be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that is made (a) in confidence to a federal, state, or local government official or to an attorney solely for the purpose of reporting or investigating a suspected violation of law, or (b) in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. Executive understands and acknowledges further that an individual who files a lawsuit for retaliation by an employer for reporting a suspected violation of law may disclose the trade secret to the attorney of the individual and use the trade secret information in the court proceeding, if the individual files any document containing the trade secret under seal and does not disclose the trade secret, except pursuant to court order. Notwithstanding the foregoing, under no circumstance is Executive authorized to disclose any attorney-client privileged information of Company or any of Company's attorney work product without Company's prior written consent or as otherwise expressly required by law. The exclusions and protections contained in this Section 6 override any language to the contrary in any other part of this Agreement.

7. Waiver of Unknown Claims.

It is Executive's intention (and Executive agrees) that Executive's execution of this Agreement will forever bar every claim, demand or cause of action it releases. Executive agrees that this Agreement shall constitute a complete defense to any such claim, demand or cause of action. Executive recognizes that Executive may have some claim, demand or cause of action against Company or any other Released Party which are part of the Claims that this Agreement releases of which Executive is unaware and unsuspecting which Executive is giving up by execution of this Agreement, but it is Executive's intention (and Executive agrees) that in executing this Agreement he shall be deprived of such claim, demand or cause of action and shall be prevented from asserting it against Company or any other Released Party. In furtherance of this intention, Executive expressly waives any and all rights and benefits conferred upon Executive by the provisions of Section 1542 of the California Civil Code (or any similar provision(s) of any other jurisdiction). Section 1542 provides:

> **"A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."**

8. Period for Review and Consideration of Agreement.

Executive confirms that he has been given until July 17, 2017 to review and consider this Agreement before signing it, which review period is at least twenty-one (21) days. Executive understands that he may use as much or as little of this period as he wishes prior to signing the Agreement. Executive and Company mutually agree to extend the deadline set forth in Section 12 of the Employment Agreement from July 1, 2017 (which is 60 days following Executive's Separation of Service) to July 17, 2017.

To accept this Agreement, Executive must return an executed copy of this Agreement to Molina Healthcare, Inc., Attn: Jeff Barlow, 200 Oceangate, Long Beach, CA 90802; fax: (916) 646-4572; email: Jeffrey.Barlow@molinahealthcare.com by 5:00 p.m. Pacific on July 17, 2017.

9. Revocation.

In order to comply with the Older Workers Benefits Protection Act (29 U.S.C. Section 626(f)) and effectuate the release by Executive of any potential claims under the ADEA, Executive agrees as follows. Executive specifically acknowledges that he is waiving and releasing any rights he may have under the ADEA in exchange for the consideration paid. Executive acknowledges that the consideration given for this waiver and release is in addition to anything of value to which he was already entitled. Executive has carefully reviewed this Agreement and understands the terms and conditions it contains. By entering into this Agreement Executive is giving up potentially valuable legal rights and he intends to be bound by all the terms and conditions set forth in this Agreement. Executive is entering into this Agreement freely, knowingly and voluntarily. Executive has been advised to consult, and has consulted, legal counsel before executing the Agreement. Executive does not waive any rights or claims that may arise from acts or events occurring after the date this Agreement is signed by Executive.

If this Agreement is signed by Executive and returned to Company within the time specified in Section 8 above, Executive may revoke this Agreement within seven (7) calendar days following the date on which Executive signs this Agreement. Accordingly, this Agreement shall not become effective or enforceable until the eighth (8th) calendar day after Executive signs this Agreement (the "**Effective Date**"). Revocation must be made by delivery of a written notice of revocation to Company in the manner described in Section 8 above by 5:00 p.m. Pacific on the seventh (7th) calendar day following the date on which Executive signs this Agreement.

If this Agreement is revoked within the seven (7)-day revocation period, none of the provisions of the Agreement shall be effective or enforceable.

10. Cooperation.

Executive will cooperate fully with Company and its counsel, upon their request, with respect to the defense, prosecution, or conduct of potential or pending proceedings (including without limitation any litigation, arbitration, regulatory proceeding, investigation, or governmental action) against, involving or on behalf of any Company entity that relates in whole or in part to events which transpired while Executive was employed with Company. Executive agrees to render such cooperation in a reasonably timely fashion and to provide Company personnel and counsel with the full benefit of his knowledge with respect to any such matter, and will make himself reasonably available at reasonable times and locations for interviews, depositions, or court appearances at the request of Company or its counsel. In seeking such cooperation, Company will take into account Executive's conflicting professional and personal commitments. Company agrees to compensate Executive at the rate of $300 per hour. for any cooperation required by and requested pursuant to this paragraph. Company acknowledges that Executive may have his personal counsel present for discovery or other adversarial proceedings at his own expense (except to the extent payment for counsel is provided under any applicable indemnification policy or director or officer insurance).

11. Acknowledgements.

Executive represents and agrees that he has been and is hereby advised to and had the opportunity to thoroughly discuss, and has discussed, all aspects of this Agreement with his attorney, and that he had a reasonable period of time within which to consider the Agreement, and that he has carefully read and fully understands all of the provisions of this Agreement, and that he is knowingly and voluntarily entering into this Agreement. Executive further acknowledges that Executive has no

right to any future employment by Company, and that except as set forth in Section 2 and 3 above, and except in connection with Executive's service as a director on the Board of Directors, as of the Termination Date, Executive is not entitled to any wages or compensation (including without limitation bonuses or incentive compensation), perquisites, other benefits, stock awards, stock options, stock appreciation rights, or other equity-based or cash-based awards from Company. Executive has not suffered any job-related illness or injury during employment with Company for which Executive has not already filed a claim, and Executive has disclosed to Company in writing any pending or previously filed claim relating to an on-the-job injury or illness, and the termination of Executive's employment by Company is not related to any such on-the-job injury or illness.

12. Withholding.

Company may withhold, or cause to be withheld, from any payments or benefits under this Agreement all amounts required to be withheld pursuant to federal, state or local tax laws.

13. Tax Matters.

Executive has not relied upon any representation, express or implied, made by Company or any of its representatives as to the tax consequences of this Agreement to Executive and Executive hereby releases the Released Parties from any and all liability to him or on behalf of him in connection with any such tax consequences. Executive agrees that any liability he incurs for federal, state or local tax payments or penalties on him arising from any portion of the payments made under the Employment Agreement or this Agreement shall be Executive's sole responsibility.

14. Assignment of Claims.

Executive hereby represents and warrants that he has not heretofore assigned or transferred or purported to assign or transfer to anyone or any entity any claims, assertions of claims, demands, actions, causes of action, or suits based upon, arising out of, pertaining to, concerning or connected with any other matters herein released.

15. Non-Admission of Liability.

It is understood and agreed by Executive that the payment of consideration to which reference is made in this Agreement does not constitute an admission or concession of liability by Company on account of any claim or potential claim by Executive.

16. No Current/Future Actions Filed; Covenant Not To Sue.

Executive represents and warrants that no type of administrative or legal action arising out of claims waived and/or released by this Agreement has been filed to date and that he will not sue or become party to any litigation arising out of claims waived or released by this Agreement. If Executive hereafter commences or becomes party to any action or proceeding against any Released Party based upon any of the claims waived and/or released by this Agreement, the Released Parties will be entitled to apply for an injunction to restrain such violation. This Agreement may be pleaded by the Released Parties as a defense, counterclaim or cross-claim in any such action or proceeding.

17. Dispute Resolution.

The Parties acknowledge that the provisions of Sections 22 and 23 of the Employment Agreement apply to disputes arising out of or relating to this Agreement and that, to the extent that any dispute subject to the provisions of Section 22 of the Employment Agreement would implicate the factors set forth in *Armendariz v. Foundation Health Psychare Services, Inc.*, 6 P.3d 669 (Cal. 2000) or its progeny to be applied, the Parties hereby agree and consent to their application, including the

requirement that Company shall pay all additional costs peculiar to the arbitration to the extent such costs would not otherwise be incurred in a court proceeding (for instance, Company will pay the arbitrator's fees to the extent they exceed court filing fees).

18. Entire Agreement.

Executive acknowledges that no promises or representations other than those set forth in this Agreement have been made to Executive to induce Executive to sign this Agreement, and that Executive only has relied on promises expressly stated herein. The Parties agree that nothing in this Agreement shall affect the provisions of the Employment Agreement that survive the termination of Executive's employment with Company. No amendments or modifications to this Agreement shall be binding unless made in a writing specifically referencing this Agreement and signed by Executive and Company.

19. Waiver.

The failure by either Party to insist upon strict compliance with any term or provision of this Agreement shall not operate or be construed as a waiver of such term or provision. The waiver by either Party of a breach of any term or provision of this Agreement must be in writing signed by such Party in order to be binding and, further, shall not operate or be construed as a waiver of a subsequent breach of the same provision by any Party or of the breach of any other term or provision of this Agreement.

20. Governing Law; Construction.

This Agreement shall be governed by, and construed and enforced in accordance with, the internal laws of the State of California, without regard to its conflict of laws provisions. The language of this Agreement shall not be construed for or against any particular party. The headings used herein are for reference only and shall not affect the construction of this Agreement.

21. Assignment; Binding Effect.

This Agreement is only assignable by Company (provided that no such assignment will relieve Company of its obligations under this Agreement to Executive). This Agreement shall be binding upon and inure to the benefit of each Party and its or his successors and assigns and, with respect to Executive, his spouse, heirs, legatees, executors, administrators, and representatives, and, with respect to the releases and waivers made herein, will inure to the benefit of the Released Parties.

22. Section 409A Provisions.

The provisions of Annex A to the Employment Agreement are hereby incorporated herein by reference as if fully set forth herein and shall apply to the payments made under this Agreement or the Employment Agreement, except as expressly set forth in this Agreement or the Employment Agreement.

23. Severability.

If any provision of this Agreement is held by a court of competent jurisdiction or arbitrator to be invalid, void or unenforceable, the remaining provisions shall, nevertheless, continue in full force and effect without being impaired or invalidated in any way, and the provision held to be invalid, void or unenforceable shall be deemed to be severed or limited, but only to the extent necessary to render the remaining portion of such provision and the remaining provisions of the Agreement enforceable to the maximum extent permitted by law.

24. Counterparts.

This Agreement may be executed in one or more counterparts, each of which shall constitute an original, and all of which shall constitute one instrument.

[SIGNATURES ON NEXT PAGE]

[SIGNATURES FOR WAIVER AND RELEASE AGREEMENT]

IN WITNESS WHEREOF, the undersigned execute this Agreement freely and voluntarily intending to be legally bound by it.

June 26, 2017

Executive

/s/ John Molina

John Molina

June 23, 2017

Molina Healthcare, Inc.

/s/ Jeff D. Barlow

By: Jeff D. Barlow
Its: Chief Legal Officer

Attachment A

Equity Awards

Award Number	Plan	Market Value on Vest Date	Accelerated Vesting Date	Tax Payment Method	Shares Released	Shares Traded For Taxes	Net Shares to be Issued
PS000080	2011	$59.75	5/2/2017	Trade	4,034	2,105	1,929
PS000085	2011	$59.75	5/2/2017	Trade	4,034	2,105	1,929
PS000090	2011	$59.75	5/2/2017	Trade	4,034	2,105	1,929
PS000095	2011	$59.75	5/2/2017	Trade	4,034	2,105	1,929
PS000105	2011	$59.75	5/2/2017	Trade	6,600	3,444	3,156
PS000110	2011	$59.75	5/2/2017	Trade	6,600	3,444	3,156
PS000120	2011	$59.75	5/2/2017	Trade	6,600	3,444	3,156
PS000130	2011	$59.75	5/2/2017	Trade	3,300	1,722	1,578
PS000135	2011	$59.75	5/2/2017	Trade	6,600	3,444	3,156
RA000366	2011	$59.75	5/2/2017	Trade	4,034	2,105	1,929
RA000443	2011	$59.75	5/2/2017	Trade	6,600	3,444	3,156
RA000443	2011	$59.75	5/2/2017	Trade	6,600	3,444	3,156
RA000528	2011	$59.75	5/2/2017	Trade	6,680	3,486	3,194
RA000528	2011	$59.75	5/2/2017	Trade	6,680	3,486	3,194
RA000528	2011	$59.75	5/2/2017	Trade	6,681	3,487	3,194
				TOTAL	**83,111**	**43,370**	**39,741**

Performance Stock Unit Awards

Award Number	Plan	Market Value on Vest Date	Accelerated Vesting Date	Tax Payment Method	Shares Released	Shares Traded For Taxes	Net Shares to be Issued
PS000140	2011	$68.16	5/10/2017	Trade	8,350	4,358	3,992
PS000145	2011	$68.16	5/10/2017	Trade	8,350	4,358	3,992
PS000150	2011	$68.16	5/10/2017	Trade	7,794	4,067	3,727
PS000155	2011	$68.16	5/10/2017	Trade	11,134	5,810	5,324
				TOTAL	**35,628**	**18,593**	**17,035**

PURCHASE AGREEMENT

May 22, 2017

SUNTRUST ROBINSON HUMPHREY, INC.
As Representative of the Initial Purchasers
303 Peachtree Street, 10th Floor
Atlanta, GA 30308

Ladies and Gentlemen:

Molina Healthcare, Inc., a Delaware corporation (the "**Company**"), proposes to issue and sell to SunTrust Robinson Humphrey, Inc. ("**SunTrust**") and the other several Initial Purchasers named in Schedule A attached hereto (collectively, the "**Initial Purchasers**"), acting severally and not jointly, the respective amounts set forth in such Schedule A of $330,000,000 aggregate principal amount of the Company's 4.875% Senior Notes due 2025 (the "**Notes**") which will be unconditionally guaranteed jointly and severally on a senior basis as to principal, premium, if any, and interest (the "**Guarantees**") by the subsidiaries of the Company listed on the signature pages hereto (each individually, a "**Guarantor**" and collectively, the "**Guarantors**"). The Notes and the Guarantees attached thereto are herein collectively referred to as the "**Securities**". The Securities will be issued pursuant to an indenture, to be dated as of Closing Date (as defined below) (the "**Indenture**"), among the Company, the Guarantors and U.S. Bank National Association, as trustee (the "**Trustee**"). SunTrust has agreed to act as the representative of the several Initial Purchasers (the "**Representative**") in connection with the offering and sale of the Securities.

No later than ten business days after the Closing Date (as defined below), the Company will deposit the net proceeds from the issuance and sale of the Notes into a newly-formed segregated deposit account in the name of the Company, and such net proceeds will be invested (and may be reinvested) in cash and cash equivalents. Amounts contained in such account will be used by the Company (i) on or prior to August 20, 2018, to (a) redeem, repurchase, repay, tender for, or acquire or retire for value (whether through one or more tender offers, open market repurchases, redemptions or similar transactions) all or any portion of the Company's 1.625% Convertible Senior Notes due 2044 (the "**1.625% Convertible Notes**") or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes pursuant to the requirements contained in the indenture governing the 1.625% Convertible Notes, and/or (b) make any interest payments due on all or any portion of the Notes, (ii) on or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that the Company is obligated to repurchase pursuant to the requirements contained in the indenture governing the 1.625% Convertible Notes and (iii) subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited by the Indenture, subject to the Company complying with clauses (i) or (ii) prior to any such amounts being used or applied in accordance with this clause (iii). The issuance and sale of the Notes, the issuance of the Guarantees, the use of the net proceeds from the issuance and sale of the Notes as more fully described in the Pricing Disclosure Package (as defined below) and the Final Offering Memorandum (as defined

below) and the payment of transaction costs are referred to herein collectively, as the "**Transactions**." This Purchase Agreement (this "**Agreement**"), the Securities and the Indenture are referred to herein as the "**Transaction Documents**."

The Securities are to be offered and sold to or through the Initial Purchasers without being registered with the Securities and Exchange Commission (the "**Commission**") under the Securities Act of 1933 (as amended, the "**Securities Act**," which term, as used herein, includes the rules and regulations of the Commission promulgated thereunder), in reliance upon exemptions therefrom. Pursuant to the terms of the Securities and the Indenture, investors who acquire the Securities shall be deemed to have agreed that the Securities may only be resold or otherwise transferred, after the date hereof, if such Securities are registered for sale under the Securities Act or if an exemption from the registration requirements of the Securities Act is available (including the exemptions afforded by Rule 144A under the Securities Act ("**Rule 144A**") or Regulation S under the Securities Act ("**Regulation S**")). The Company agrees that the Initial Purchasers may resell, subject to the conditions set forth herein, all or a portion of the Securities to purchasers (the "**Subsequent Purchasers**") on the terms set forth in the Pricing Disclosure Package.

In connection with the sale of the Securities, the Company has prepared and delivered to each Initial Purchaser copies of a Preliminary Offering Memorandum, dated May 22, 2017 (the "**Preliminary Offering Memorandum**"). Prior to the time when the sales of the Securities were first made (the "**Time of Sale**"), the Company has prepared and delivered to each Initial Purchaser a Pricing Supplement, dated May 22, 2017 (the "**Pricing Supplement**"), describing the terms of the Securities, each for use by such Initial Purchaser in connection with its solicitation of offers to purchase the Securities. A copy of the Pricing Supplement is attached hereto as Schedule B-1. The Preliminary Offering Memorandum and the Pricing Supplement are herein referred to as the "**Pricing Disclosure Package**." Promptly after this Agreement is executed and delivered, the Company will prepare and deliver to each Initial Purchaser a final offering memorandum dated the date hereof (the "**Final Offering Memorandum**").

All references herein to the terms "**Pricing Disclosure Package**" and "**Final Offering Memorandum**" shall be deemed to mean and include all information filed under the Securities Exchange Act of 1934 (as amended, the "**Exchange Act**," which term, as used herein, includes the rules and regulations of the Commission promulgated thereunder) prior to the Time of Sale and incorporated by reference in the Pricing Disclosure Package (including the Preliminary Offering Memorandum) or the Final Offering Memorandum (as the case may be), and all references herein to the terms "**amend**," "**amendment**" or "**supplement**" with respect to the Final Offering Memorandum shall be deemed to mean and include all information filed under the Exchange Act after the Time of Sale that are deemed to be incorporated by reference in the Final Offering Memorandum.

The Company hereby confirms its agreements with the Initial Purchasers as follows:

SECTION 1. **Purchase, Sale and Delivery of the Securities.**

(a) Each of the Company and the Guarantors agrees to issue and sell to the several Initial Purchasers, all of the Securities, and subject to the conditions set forth herein and on the basis of the

representations, warranties, terms and agreements herein, the Initial Purchasers agree, severally and not jointly, to purchase from the Company and the Guarantors the aggregate principal amount of the Notes set forth opposite their names on Schedule A, at a purchase price of 99.0% of the principal amount thereof payable on the Closing Date.

(b) One or more certificates for the Securities in definitive form to be purchased by the Initial Purchasers shall be delivered to, and payment therefor shall be made at, the offices of Latham & Watkins LLP (or such other place as may be agreed to by the Company and SunTrust) at 9:00 a.m. New York City time, on June 6, 2017, or such other time and date as SunTrust shall designate by notice to the Company (the time and date of such closing are called the "**Closing Date**"). The Company hereby acknowledges that circumstances under which SunTrust may provide notice to postpone the Closing Date as originally scheduled include, but are in no way limited to, any determination by the Company or the Initial Purchasers to recirculate to investors copies of an amended or supplemented Offering Memorandum or a delay as contemplated by the provisions of Section 15 hereof.

(c) The Company shall deliver, or cause to be delivered, to SunTrust for the accounts of the several Initial Purchasers certificates for the Securities at the Closing Date against the irrevocable release of a wire transfer of immediately available funds for the amount of the purchase price therefor. The certificates for the Securities shall be in such denominations and registered in the name of Cede & Co., as nominee of The Depository Trust Company (the "**Depositary**"), and shall be made available for inspection on the business day preceding the Closing Date at a location in New York City, as SunTrust may designate. Time shall be of the essence, and delivery at the time and place specified in this Agreement is a further condition to the obligations of the Initial Purchasers.

(d) Each Initial Purchaser severally and not jointly represents and warrants to, and agrees with, the Company that:

(i) it will solicit offers for the Securities only (a) from, and will offer such Securities only to, persons who it reasonably believes are "qualified institutional buyers" within the meaning of Rule 144A ("**Qualified Institutional Buyers**") in transactions meeting the requirements of Rule 144A or (b) upon the terms and conditions set forth in Annex I to this Agreement;

(ii) it is an institutional "accredited investor" within the meaning of Rule 501(a)(1), (2), (3) or (7) under the Securities Act; and

(iii) it has not solicited offers for, or offered or sold, and will not solicit offers for, or offer to sell the Securities in any manner involving a public offering within the meaning of Section 4(a)(2) of the Securities Act.

SECTION 2. **Representations and Warranties of the Company and the Guarantors.** Each of the Company and the Guarantors, jointly and severally, hereby represents, warrants and covenants to each Initial Purchaser that, as of the date hereof and as of the Closing Date (references in this Section 2 to the "**Offering Memorandum**" are to (x) the Pricing Disclosure Package in the case of representations and

warranties made as of the date hereof and (y) the Final Offering Memorandum in the case of representations and warranties made as of the Closing Date):

(a) **The Pricing Disclosure Package and Offering Memorandum.** Neither the Pricing Disclosure Package, as of the Time of Sale, nor the Final Offering Memorandum, as of its date or (as amended or supplemented in accordance with Section 3(b) hereof, as applicable) as of the Closing Date, contains any untrue statement of a material fact or omits to state a material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading; provided that the Company and the Guarantors make no representation or warranty with respect to any statements or omissions made in reliance upon and in conformity with information relating to any Initial Purchaser furnished to the Company in writing by such Initial Purchaser through the Representative expressly for use in the Pricing Disclosure Package, the Final Offering Memorandum or amendment or supplement thereto, as the case may be, it being understood and agreed that only such information furnished by or on behalf of any Initial Purchaser consists of the information described as such in Section 7(b) hereof. The Company and the Guarantors have not distributed and will not distribute, prior to the later of the Closing Date and the completion of the Initial Purchasers' distribution of the Securities, any offering material in connection with the offering and sale of the Securities other than the Pricing Disclosure Package and the Final Offering Memorandum.

(b) **No Registration Required.** Assuming the accuracy of the representations and warranties of the Initial Purchasers set forth in Section 1 hereof and compliance by the Initial Purchasers with the procedures set forth in Section 5 hereof, it is not necessary in connection with the offer, sale and delivery of the Securities to the Initial Purchasers and to each Subsequent Purchaser in the manner contemplated by this Agreement and the Offering Memorandum to register the Securities under the Securities Act or to qualify the Indenture under the Trust Indenture Act of 1939 (as amended, the "**Trust Indenture Act**," which term, as used herein, includes the rules and regulations of the Commission promulgated thereunder).

(c) **Eligibility for Resale Under Rule 144A.** The Securities are eligible for resale pursuant to Rule 144A and will not be, at the Closing Date, of the same class as securities listed on a national securities exchange registered under Section 6 of the Exchange Act or quoted in a U.S. automated interdealer quotation system.

(d) **No Integration of Offerings.** None of the Company, its affiliates (as defined in Rule 501 under the Securities Act) (each, an "**Affiliate**"), or any person acting on its or any of their behalf (other than the Initial Purchasers, as to whom the Company makes no representation or warranty) has, directly or indirectly, solicited any offer to buy or offered to sell, or will, directly or indirectly, solicit any offer to buy or offer to sell, in the United States or to any United States citizen or resident, any security which is or would be integrated with the sale of the Securities in a manner that would require the Securities to be registered under the Securities Act.

(e) **No General Solicitation.** None of the Company, its Affiliates, or any person acting on its or any of their behalf (other than the Initial Purchasers, as to whom the Company makes no representation

or warranty) has engaged or will engage, in connection with the offering of the Securities, in any form of general solicitation or general advertising within the meaning of Rule 502 under the Securities Act other than by means of a Permitted General Solicitation (as defined below). With respect to those Securities sold in reliance upon Regulation S, (i) none of the Company, its Affiliates or any person acting on its or their behalf (other than the Initial Purchasers, as to whom the Company makes no representation or warranty) has engaged or will engage in any directed selling efforts within the meaning of Regulation S and (ii) each of the Company and its Affiliates and any person acting on its or their behalf (other than the Initial Purchasers, as to whom the Company makes no representation or warranty) has complied with and will comply with the offering restrictions set forth in Regulation S.

(f) **Company Additional Written Communications; Permitted General Solicitations.** The Company has not prepared, made, used, authorized, approved or distributed and will not prepare, make, use, authorize, approve or distribute (x) any written communication that constitutes an offer to sell or a solicitation of an offer to buy the Securities other than (i) the Pricing Disclosure Package, (ii) the Final Offering Memorandum and (iii) any electronic road show or other written communications other than any Permitted General Solicitation, in each case used in accordance with Section 3(b) hereof or (y) any general solicitation other than any such solicitation (i) listed on Schedule B-2 hereto or (ii) in accordance with Section 3(j) hereof (each such solicitation referred to in clause (i) and (ii), a "**Permitted General Solicitation**"). Each such communication or Permitted General Solicitation by the Company or its agents and representatives (other than the Initial Purchasers, in their capacity as such) pursuant to clause (iii) of the preceding sentence (each, a "**Company Additional Written Communication**"), when taken together with the Pricing Disclosure Package, did not as of the Time of Sale, and at the Closing Date will not, contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading; provided that this representation, warranty and agreement shall not apply to statements in or omissions from each such Company Additional Written Communication made in reliance upon and in conformity with information furnished to the Company in writing by any Initial Purchaser through the Representative expressly for use in any Company Additional Written Communication.

(g) **Incorporated Documents.** The documents incorporated or deemed to be incorporated by reference in the Offering Memorandum at the time they were or hereafter are filed with the Commission (collectively, the "**Incorporated Documents**") complied and will comply in all material respects with the requirements of the Exchange Act. Each such Incorporated Document, when taken together with the Pricing Disclosure Package, did not as of the Time of Sale, and at the Closing Date will not, contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading.

(h) **The Purchase Agreement.** This Agreement has been duly authorized, executed and delivered by the Company and the Guarantors.

(i) **The Indenture.** The Indenture has been duly authorized by the Company and the Guarantors and, at the Closing Date, will have been duly executed and delivered by the Company and the Guarantors and will constitute a valid and binding agreement of the Company and the Guarantors,

enforceable against the Company and the Guarantors in accordance with its terms, except as the enforcement thereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws relating to or affecting the rights and remedies of creditors or by general equitable principles.

(j) **The Notes and the Guarantees.** The Notes to be purchased by the Initial Purchasers from the Company will on the Closing Date be in the form contemplated by the Indenture, have been duly authorized for issuance and sale pursuant to this Agreement and the Indenture and, at the Closing Date, will have been duly executed by the Company and, when authenticated in the manner provided for in the Indenture and delivered against payment of the purchase price therefor, will constitute valid and binding obligations of the Company, enforceable in accordance with their terms, except as the enforcement thereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws relating to or affecting the rights and remedies of creditors or by general equitable principles, and will be entitled to the benefits of the Indenture. The Guarantees of the Notes on the Closing Date when issued will be in the respective forms contemplated by the Indenture and have been duly authorized for issuance pursuant to this Agreement and the Indenture; the Guarantees of the Notes, at the Closing Date, will have been duly executed by each of the Guarantors and, when the Notes have been duly executed and authenticated in the manner provided for in the Indenture and issued and delivered against payment of the purchase price therefor, the Guarantees of the Notes will constitute valid and binding agreements of the Guarantors, enforceable in accordance with their terms, except as the enforcement thereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws relating to or affecting the rights and remedies of creditors or by general equitable principles and will be entitled to the benefits of the Indenture.

(k) **Descriptions of the Transaction Documents.** Each Transaction Document conforms in all material respects to the description thereof contained in the Offering Memorandum.

(l) **No Material Adverse Change.** Since the date of the most recent financial statements of the Company included or incorporated in the Offering Memorandum (exclusive of any amendment or supplement thereto), (i) there has not been any change in the capital stock, long-term debt, notes payable or current portion of long-term debt of the Company or any of its subsidiaries, or any dividend or distribution of any kind declared, set aside for payment, paid or made by the Company on any class of capital stock, or any material adverse change, or any development involving a prospective material adverse change, in or affecting the business, properties, management, financial position, stockholders' equity, results of operations or prospects of the Company and its subsidiaries taken as a whole; (ii) neither the Company nor any of its subsidiaries has entered into any transaction or agreement that is material to the Company and its subsidiaries taken as a whole or incurred any liability or obligation, direct or contingent, that is material to the Company and its subsidiaries taken as a whole; and (iii) neither the Company nor any of its subsidiaries has sustained any material loss or interference with its business from fire, explosion, flood or other calamity, whether or not covered by insurance, or from any labor disturbance or dispute or any action, order or decree of any court or arbitrator or governmental or regulatory authority, except in each case as otherwise disclosed in the Offering Memorandum (exclusive of any amendment or supplement thereto).

(m) **Independent Accountants.** Ernst & Young LLP, which has issued its opinion with respect to the audited financial statements (including the related notes thereto) incorporated by reference in the Offering Memorandum is an independent registered public accounting firm with respect to the Company and its subsidiaries within the meaning of the applicable rules and regulations adopted by the Commission and the Public Company Accounting Oversight Board (United States) and as required by the Securities Act and the Exchange Act.

(n) **Preparation of the Financial Statements.** The financial statements, together with the related schedules and notes, included or incorporated by reference in the Offering Memorandum present fairly the financial position of the Company and its consolidated subsidiaries at the dates indicated and the statement of operations, stockholders' equity and cash flows of the Company and its consolidated subsidiaries for the periods specified; said financial statements have been prepared in conformity with generally accepted accounting principles as applied in the United States ("**GAAP**") applied on a consistent basis throughout the periods involved. The supporting schedules, if any, present fairly in accordance with GAAP the information required to be stated therein. The selected financial data and the summary financial information incorporated by reference in the Offering Memorandum present fairly the information shown therein and have been compiled on a basis consistent with that of the audited financial statements incorporated by reference therein. The interactive data in eXtensible Business Reporting Language incorporated by reference in the Offering Memorandum fairly present the information called for in all material respects and have been prepared in accordance with the Commission's rules and guidelines applicable thereto.

(o) **Incorporation and Good Standing.** The Company and each of its subsidiaries have been duly organized and are validly existing and in good standing under the laws of their respective jurisdictions of organization, are duly qualified to do business and are in good standing in each jurisdiction in which their respective ownership or lease of property or the conduct of their respective businesses requires such qualification, and have all power and authority necessary to own or hold their respective properties and to conduct the businesses in which they are engaged, except where the failure to be so duly organized, qualified or in good standing or have such power or authority would not, individually or in the aggregate, have a material adverse effect on the business, properties, management, financial position, stockholders' equity, results of operations or prospects of the Company and its subsidiaries taken as a whole or on the performance by each of the Company and the Guarantors of its obligations under each of the Transaction Documents to which it is a party (a "**Material Adverse Effect**"); other than the subsidiaries listed on Schedule C to this Agreement, the Company does not own or control, directly or indirectly, any corporation, association or other entity or 5% or more of the shares of capital stock or any other equity interest in any firm, partnership, joint venture, association or other entity.

(p) **Capitalization.** As of March 31, 2017, on a consolidated basis, after giving effect to the Transactions, the Company would have an authorized and outstanding capitalization as set forth in the section of the Offering Memorandum entitled "Capitalization"; all of the outstanding shares of capital stock, including the common stock (the "**Common Stock**"), of the Company have been duly authorized and validly issued and are fully paid and non-assessable, have been issued in compliance with all applicable securities laws and are not subject to any pre-emptive or similar rights; except as described in

the Offering Memorandum, there are no outstanding rights (including, without limitation, pre-emptive rights), warrants or options to acquire, or instruments convertible into or exchangeable for, any shares of capital stock or other equity interest in the Company or any of its subsidiaries, or any contract, commitment, agreement, understanding or arrangement of any kind relating to the issuance of any capital stock of the Company or any such subsidiary, any such convertible or exchangeable securities or any such rights, warrants or options; all the outstanding shares of capital stock or other equity interests of each subsidiary owned, directly or indirectly, by the Company have been duly and validly authorized and issued, are fully paid and non-assessable and are owned directly or indirectly by the Company, free and clear of any lien, charge, encumbrance, security interest, restriction on voting or any other claim of any third party.

(q) **No Termination of Agreements.** Except as otherwise disclosed in the Offering Memorandum, neither the Company nor any subsidiary has sent or received any communication regarding termination of, or intent not to renew, any of the contracts or agreements referred to or described in the Offering Memorandum, and no such termination or non-renewal has been threatened by the Company or any subsidiary or, to the knowledge of the Company and the Guarantors, any other party to any such contract or agreement, except in each such case for any termination or non-renewal that could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect.

(r) **No Material Actions or Proceedings.** Except as otherwise disclosed in the Offering Memorandum, there are no legal, governmental or regulatory investigations, actions, suits or proceedings pending to which the Company or any of its subsidiaries is or may be a party or to which any property of the Company or any of its subsidiaries is or may be the subject that, individually or in the aggregate, if determined adversely to the Company or any of its subsidiaries, could reasonably be expected to have a Material Adverse Effect; except as otherwise disclosed in the Offering Memorandum, to the knowledge of the Company and the Guarantors no such investigations, actions, suits or proceedings are threatened or contemplated by any governmental or regulatory authority.

(s) **Solvency.** Each of the Company and the Guarantors is, and immediately after the Closing Date will be, Solvent. As used herein, the term "**Solvent**" means, with respect to any person on a particular date, that on such date (i) the fair market value of the assets of such person is greater than the total amount of liabilities (including contingent liabilities) of such person, (ii) the present fair salable value of the assets of such person is greater than the amount that will be required to pay the probable liabilities of such person on its debts as they become absolute and matured, (iii) such person is able to realize upon its assets and pay its debts and other liabilities, including contingent obligations, as they mature and (iv) such person does not have unreasonably small capital.

(t) **Non-Contravention; No Authorizations or Approvals.** Neither the Company nor any of its subsidiaries is (i) in violation of its charter, bylaws or similar organizational document; (ii) in default, and no event has occurred that, with notice or lapse of time or both, would constitute such a default, in the due performance or observance of any term, covenant or condition contained in any indenture, mortgage, deed of trust, loan agreement, note, lease or other agreement or instrument to which the Company or any of its subsidiaries is a party or by which the Company or any of its subsidiaries is bound (including,

without limitation, the Company's $500 million revolving credit facility, 5.375% notes due 2022, 1.125% convertible notes due 2020 and the 1.625% Convertible Notes) or to which any of the property or assets of the Company or any of its subsidiaries is subject; or (iii) in violation of any law or statute or any judgment, order, rule or regulation of any court or arbitrator or governmental or regulatory authority, except, in the case of clauses (ii) and (iii) above, for any such default or violation that could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect. The execution, delivery and performance of the Transaction Documents by the Company and the Guarantors party thereto, and the issuance and delivery of the Securities, and consummation of the transactions contemplated hereby and thereby and by the Offering Memorandum have been duly authorized by all necessary corporate or limited liability company action and will not (i) conflict with or result in a breach or violation of any of the terms or provisions of, or constitute a default under, or result in the creation or imposition of any lien, charge or encumbrance upon any property or assets of the Company or any of its subsidiaries pursuant to, any indenture, mortgage, deed of trust, loan agreement, note, lease or other agreement or instrument to which the Company or any of its subsidiaries is a party or by which the Company or any of its subsidiaries is bound or to which any of the property or assets of the Company or any of its subsidiaries is subject, (ii) result in any violation of the provisions of the charter or by-laws or similar organizational documents of the Company or any of its subsidiaries or (iii) result in the violation of any law or statute or any judgment, order, rule or regulation of any court or arbitrator or governmental or regulatory authority. No consent, approval, authorization, order, registration or qualification of or with any court or arbitrator or governmental or regulatory authority is required for the execution, delivery and performance of the Transaction Documents by the Company and the Guarantors to the extent a party thereto, or the issuance and delivery of the Securities, or consummation of the transactions contemplated hereby and thereby and by the Offering Memorandum, other than as have been obtained or made by the Company and are in full force and effect under the Securities Act, applicable securities laws of the several states of the United States or provinces of Canada.

(u) **Related Party Transactions.** No relationship, direct or indirect, exists between or among the Company or any of its subsidiaries, on the one hand, and the directors, officers, stockholders, customers or suppliers of the Company or any of its subsidiaries, on the other, that is required by the Securities Act to be disclosed in a registration statement on Form S-1 which is not so disclosed in the Offering Memorandum.

(v) **Intellectual Property.** The Company and its subsidiaries own or possess adequate rights to use or can acquire on reasonable terms all material patents, patent applications, trademarks, service marks, trade names, trademark registrations, service mark registrations, copyrights, licenses and know-how (including trade secrets and other unpatented and/or unpatentable proprietary or confidential information, systems or procedures) (collectively, "Intellectual Property Rights") necessary for the conduct of their respective businesses; and the expected expiration of any of such Intellectual Property Rights would not have a Material Adverse Effect. Neither the Company nor any of its subsidiaries has received any notice of any claim of infringement of or conflict with any such Intellectual Property Rights of others.

(w) **All Necessary Permits, etc.** The Company and each subsidiary possess all licenses, certificates, permits and other authorizations issued by, and have made all declarations and filings with,

the appropriate federal, state, local or foreign governmental or regulatory authorities that are necessary for the ownership or lease of their respective properties or the conduct of their respective businesses as described in the Offering Memorandum, except where the failure to possess or make the same could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect; and except as otherwise disclosed in the Offering Memorandum, neither the Company nor any of its subsidiaries has received notice of any revocation or modification of any such license, certificate, permit or authorization.

(x) **Title to Properties.** Except as otherwise disclosed in the Offering Memorandum, the Company and its subsidiaries have good and marketable title in fee simple to, or have valid rights to lease or otherwise use, all items of real and personal property that are material to the respective businesses of the Company and its subsidiaries, in each case free and clear of all liens, encumbrances, claims and defects and imperfections of title except those that (i) do not materially interfere with the use made and proposed to be made of such property by the Company and its subsidiaries or (ii) could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect.

(y) **Tax Law Compliance.** The Company and its subsidiaries have paid all U.S. federal, state, local and foreign taxes which are due and payable (except assessments against which appeals have been or will be promptly taken in good faith and as to which adequate reserves have been provided in accordance with GAAP) and filed all U.S. federal and material state, local and foreign tax returns required to be filed through the date hereof; and except as otherwise disclosed in the Offering Memorandum, there is no tax deficiency that has been, or could reasonably be expected to be, asserted against the Company or any of its subsidiaries or any of their respective properties or assets except for any tax deficiencies that could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect.

(z) **Investment Company Act.** Neither the Company nor any Guarantor is, nor after giving effect to the offering and sale of the Securities and the application of the proceeds thereof, will be, required to register as an "investment company" or an entity "controlled" by an "investment company" within the meaning of the Investment Company Act of 1940, as amended, and the rules and regulations of the Commission thereunder.

(aa) **Insurance.** The Company and its subsidiaries have insurance covering their respective properties, operations, personnel and businesses, including business interruption insurance, which insurance is in amounts and insures against such losses and risks as are generally maintained by companies of established repute engaged in the same or similar businesses; and neither the Company nor any of its subsidiaries has (i) received notice from any insurer or agent of such insurer that capital improvements or other expenditures are required or necessary to be made in order to continue such insurance or (ii) any reason to believe that it will not be able to renew its existing insurance coverage as and when such coverage expires or to obtain similar coverage at reasonable cost from similar insurers as may be necessary to continue its business.

(bb) **No Stabilization or Manipulation.** None of the Company or any of the Guarantors has taken and none will take, directly or indirectly, any action designed to or that might be reasonably

expected to cause or result in stabilization or manipulation of the price of any security of the Company to facilitate the sale or resale of the Securities.

(cc) **Sarbanes-Oxley.** There is and has been no failure on the part of the Company or any of the Company's directors or officers, in their capacities as such, to comply with any provision of the Sarbanes-Oxley Act of 2002 and the rules and regulations promulgated in connection therewith (the "**Sarbanes-Oxley Act**"), including Section 402 related to loans and Sections 302 and 906 related to certifications.

(dd) **Internal Accounting Controls.** The Company and its subsidiaries maintain systems of "internal control over financial reporting" (as defined in Rule 13a-15(f) of the Exchange Act) that comply with the requirements of the Exchange Act and have been designed by, or under the supervision of, their respective principal executive and principal financial officers, or persons performing similar functions, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP, including, but not limited to internal accounting controls sufficient to provide reasonable assurance that (i) transactions are executed in accordance with management's general or specific authorizations; (ii) transactions are recorded as necessary to permit preparation of financial statements in conformity with GAAP and to maintain asset accountability; (iii) access to assets is permitted only in accordance with management's general or specific authorization; (iv) the recorded accountability for assets is compared with the existing assets at reasonable intervals and appropriate action is taken with respect to any differences; and (v) the interactive data in eXtensible Business Reporting Language included or incorporated by reference in the Offering Memorandum and the Pricing Disclosure Package fairly present the information called for in all material respects and are prepared in accordance with the Commission's rules and guidelines applicable thereto. Except as described in the Offering Memorandum, since the end of the Company's most recent audited fiscal year, there has been (i) no material weakness in the Company's internal control over financial reporting (whether or not remediated) and (ii) no change in the Company's internal control over financial reporting that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting (including any corrective actions with regard to significant deficiencies and material weaknesses). The Company's auditors and the Audit Committee of the Board of Directors of the Company have been advised of: (i) all significant deficiencies and material weaknesses in the design or operation of internal controls over financial reporting which are reasonably likely to adversely affect the Company's ability to record, process, summarize and report financial information; and (ii) any fraud, whether or not material, that involves management or other employees who have a significant role in the Company's internal controls over financial reporting.

(ee) **Disclosure Controls and Procedures.** The Company has established and maintains and evaluates "disclosure controls and procedures" (as such term is defined in Rules 13a-15 and 15d-15 under the Exchange Act) and "internal control over financial reporting" (as such term is defined in Rules 13a-15 and 15d-15 under the Exchange Act); such disclosure controls and procedures are designed to ensure that material information relating to the Company and its consolidated subsidiaries is made known to the Company's interim Chief Executive Officer and its Chief Financial Officer by others within the Company or any of its subsidiaries, and such disclosure controls and procedures are effective to perform the functions for which they were established; the Company's independent registered public accountants and

the Audit Committee of the Board of Directors of the Company have been advised of: (i) all significant deficiencies or material weaknesses, if any, in the design or operation of internal controls which could adversely affect the Company's ability to record, process, summarize and report financial data; and (ii) all fraud, if any, whether or not material, that involves management or other employees who have a role in the Company's internal controls; all "significant deficiencies" and "material weaknesses" (as such terms are defined in Rule 1-02(a)(4) of Regulation S-X under the Securities Act) of the Company, if any, have been identified to the Company's independent registered public accountants and are disclosed in the Offering Memorandum; the principal executive officer and principal financial officer of the Company have made all certifications required by the Sarbanes-Oxley Act and any related rules and regulations promulgated by the Commission, and the statements contained in each such certification are complete and correct; the Company, the subsidiaries and the Company's directors and officers are each in compliance in all material respects with all applicable effective provisions of the Sarbanes-Oxley Act and the rules and regulations of the Commission and the New York Stock Exchange (the "**NYSE**") promulgated thereunder.

(ff) **Margin Regulations.** The issuance, sale and delivery of the Securities will not violate Regulation T, Regulation U or Regulation X of the Board of Governors of the Federal Reserve System or any other regulation of such Board of Governors.

(gg) **Environmental Laws.** Except as otherwise disclosed in the Offering Memorandum, (i) the Company and its subsidiaries (A) are, and at all prior times were, in compliance with any and all applicable federal, state, local and foreign laws, rules, regulations, requirements, decisions and orders relating to the protection of human health or safety, the environment, natural resources, hazardous or toxic substances or wastes, pollutants or contaminants (collectively, "**Environmental Laws**"), (B) have received and are in compliance with all permits, licenses, certificates or other authorizations or approvals required of them under applicable Environmental Laws to conduct their respective businesses, and (C) have not received notice of any actual or potential liability under or relating to any Environmental Laws, including for the investigation or remediation of any disposal or release of hazardous or toxic substances or wastes, pollutants or contaminants, and have no knowledge of any event or condition that would reasonably be expected to result in any such notice, and (ii) there are no costs or liabilities associated with Environmental Laws of or relating to the Company or its subsidiaries, except in the case of each of (i) and (ii) above, for any such failure to comply, or failure to receive required permits, licenses or approvals, or cost or liability, as could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect; and (iii) except as otherwise disclosed in the Offering Memorandum, (A) there are no proceedings that are pending, or that are known to be contemplated, against the Company or any of its subsidiaries under any Environmental Laws in which a governmental entity is also a party, other than such proceedings regarding which it is reasonably believed no monetary sanctions of $100,000 or more will be imposed, (B) the Company and its subsidiaries are not aware of any issues regarding compliance with Environmental Laws, or liabilities or other obligations under Environmental Laws or concerning hazardous or toxic substances or wastes, pollutants or contaminants, that could reasonably be expected to have a Material Adverse Effect, and (C) none of the Company and its subsidiaries anticipates material capital expenditures relating to any Environmental Laws. Except as otherwise disclosed in the Offering Memorandum, there has been no storage, generation, transportation, handling, treatment,

disposal, discharge, emission, or other release of any kind of toxic wastes or hazardous substances, including, but not limited to, any naturally occurring radioactive materials, brine, drilling mud, crude oil, natural gas liquids and other petroleum materials, by, due to or caused by the Company or any of its subsidiaries (or, to the knowledge of the Company and the Guarantors, any other entity (including any predecessor) for whose acts or omissions the Company or any of its subsidiaries is or could reasonably be expected to be liable) upon any of the property now or previously owned or leased by the Company or any of its subsidiaries, or upon any other property, in violation of any Environmental Laws or in a manner or to a location that could reasonably be expected to give rise to any liability under the Environmental Laws, except for any violation or liability which could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect.

(hh) **ERISA.** Each employee benefit plan, within the meaning of Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**"), for which the Company or any member of its "Controlled Group" (defined as any organization which is a member of a controlled group of corporations within the meaning of Section 414 of the Internal Revenue Code of 1986, as amended (the "**Code**")) would have any liability (each, a "**Plan**") has been maintained in compliance with its terms and the requirements of any applicable statutes, orders, rules and regulations, including but not limited to ERISA and the Code except for any noncompliance which could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect; (i) no prohibited transaction, within the meaning of Section 406 of ERISA or Section 4975 of the Code, has occurred with respect to any Plan excluding transactions effected pursuant to a statutory or administrative exemption; (ii) for each Plan that is subject to the funding rules of Section 412 of the Code or Section 302 of ERISA, there has been no failure to satisfy the minimum funding standard of Section 412 of the Code, whether or not waived, and none is reasonably expected to occur; (iii) the fair market value of the assets of each Plan exceeds the present value of all benefits accrued under such Plan (determined based on those assumptions used to fund such Plan); (iv) no "reportable event" (within the meaning of Section 4043(c) of ERISA) has occurred or is reasonably expected to occur; and (v) neither the Company nor any member of the Controlled Group has incurred, nor reasonably expects to incur, any liability under Title IV of ERISA (other than contributions to the Plan or premiums to the Pension Benefit Guaranty Corporation, in the ordinary course and without default) in respect of a Plan (including a "multiemployer plan", within the meaning of Section 4001(a)(3) of ERISA).

(ii) **No Labor Disturbance.** No labor disturbance by or dispute with employees of the Company or any of its subsidiaries exists or, to the knowledge of the Company and the Guarantors, is contemplated or threatened and the Company is not aware of any existing or imminent labor disturbance by, or dispute with, the employees of any of its or its subsidiaries' principal suppliers, contractors or customers, except, in each case, as could not reasonably be expected to have a Material Adverse Effect.

(jj) **No Unlawful Payments.** None of the Company, any of its subsidiaries or, to the knowledge of the Company and the Guarantors, any director, officer, agent, employee, affiliate or other person acting on behalf of the Company or any of its subsidiaries is aware of or has taken any action, directly or indirectly, that would result in a violation by such persons of the Foreign Corrupt Practices Act of 1977, as amended, and the rules and regulations thereunder (the "**FCPA**"), including, without

limitation, making use of the mails or any means or instrumentality of interstate commerce corruptly in furtherance of an offer, payment, promise to pay or authorization of the payment of any money, or other property, gift, promise to give, or authorization of the giving of anything of value to any "foreign official" (as such term is defined in the FCPA) or any foreign political party or official thereof or any candidate for foreign political office, in contravention of the FCPA and the Company, its subsidiaries and, to the knowledge of the Company and the Guarantors, its affiliates have conducted their businesses in compliance with the FCPA and have instituted and maintain policies and procedures designed to ensure, and which are reasonably expected to continue to ensure, continued compliance therewith.

(kk) **No Conflict with Money Laundering Laws.** The operations of the Company and its subsidiaries are and have been conducted at all times in compliance with applicable financial recordkeeping and reporting requirements of the USA Patriot Act, the Bank Secrecy Act of 1970, as amended, the money laundering statutes of all jurisdictions, the rules and regulations thereunder and any related or similar rules, regulations or guidelines, issued, administered or enforced by any governmental agency (collectively, the "**Money Laundering Laws**"); and no action, suit or proceeding by or before any court or governmental agency, authority or body or any arbitrator or non-governmental authority involving the Company or any of its subsidiaries with respect to the Money Laundering Laws is pending or, to the knowledge of the Company and the Guarantors, threatened.

(ll) **No Conflict with Sanctions Laws.** Neither the Company nor any of its subsidiaries nor, to the knowledge of the Company and the Guarantors, any director, officer, agent, employee or affiliate of the Company or any of its subsidiaries is currently subject to any sanctions administered or enforced by the Office of Foreign Assets Control of the United States Treasury Department, the U.S. Department of Commerce, the U.S. Department of State, the United Nations Security Council, the European Union, Her Majesty's Treasury or any other relevant sanctions authority; and the Company will not directly or indirectly use the proceeds of the offering of the Securities contemplated hereby, or lend, contribute or otherwise make available such proceeds to any subsidiary, joint venture partner or other person or entity for the purpose of financing the activities of any person currently subject to any sanctions administered or enforced by such authorities.

(mm) **Forward-Looking Information.** No "forward-looking statement" (within the meaning of Section 27A of the Securities Act or Section 21E of the Exchange Act) contained in the Offering Memorandum has been made or reaffirmed without a reasonable basis or has been disclosed other than in good faith.

(nn) **Statistical and Market-Related Data.** Nothing has come to the attention of the Company that has caused the Company to believe that the statistical and market-related data included or incorporated by reference in the Offering Memorandum is not based on or derived from sources that are reliable and accurate in all material respects.

(oo) **USA Patriot Act.** The Company acknowledges that, in accordance with the requirements of the USA Patriot Act, the Initial Purchasers are required to obtain, verify and record information that identifies their respective clients, including the Company, which information may include the name and

address of their respective clients, as well as other information that will allow the Initial Purchasers to properly identify their respective clients.

(pp) **No Restrictive Agreements.** Except as otherwise disclosed in the Offering Memorandum, no subsidiary of the Company is currently prohibited, directly or indirectly, under any agreement or other instrument to which it is a party or is subject, from paying any dividends to the Company, from making any other distribution on such subsidiary's capital stock, from repaying to the Company any loans or advances to such subsidiary from the Company or from transferring any of such subsidiary's properties or assets to the Company or any other subsidiary of the Company.

(qq) **Health Care Law Filings and Licensure.** Except as set forth in or contemplated in the Offering Memorandum, all reports, documents, claims, notices or approvals required to be filed, obtained, maintained or furnished pursuant to any Health Care Law (as defined below) or as otherwise required by the Centers for Medicare & Medicaid Services, Medicare or Medicaid or similar state program (each a "**Government Program**"), or applicable state departments of insurance, health and/or public health or any other governmental authority, have been so filed, obtained, maintained or furnished, and all such reports, documents, claims and notices were complete and correct in all material respects on the date filed (or were corrected in or supplemented by a subsequent filing), except where the failure to do so could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect. Each of the Company and its subsidiaries which are licensed to conduct the business of health insurance or of a health maintenance organization is in current compliance with applicable deposit, reserve, risk based or other capital requirements imposed by each applicable state department of insurance. Additionally, the Company and each such subsidiary of the Company currently maintains all cash, marketable securities or other assets required to be retained by the Company or any of its subsidiaries pursuant to any applicable Health Care Laws, including any state statutory capital reserve requirements. None of the Company, its subsidiaries, nor, to the knowledge of the Company and the Guarantors, any officer, director, employee or other agent of the Company or any of its subsidiaries, has engaged on behalf of the Company or such subsidiary in any of the following: (i) knowingly and willfully making or causing to be made a false statement or representation of a material fact in any applications for any benefit or payment under a Government Program or from any third party (where applicable federal or state law prohibits such payments to third parties); (ii) knowingly and willfully making or causing to be made any false statement or representation of a material fact for use in determining rights to any benefit or payment under a Government Program or from any third party (where applicable federal or state law prohibits such payments to third parties); (iii) knowingly and willfully failing to disclose knowledge by a claimant of the occurrence of any event affecting the initial or continued right to any benefit or payment under a Government Program or from any third party (where applicable federal or state law prohibits such payments to third parties) on its own behalf or on behalf of another, with intent to secure such benefit or payment fraudulently; (iv) knowingly and willfully offering, paying, soliciting or receiving any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by a Government Program or plan or any third party (where applicable federal or state law prohibits such payments to third

parties), or (B) in return for purchasing, leasing or ordering or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service, or item for which payment may be made in whole or in part by a Government Program or plan or any third (where applicable federal or state law prohibits such payments to third parties).

(rr) **Government Programs and Health Care Laws.** To the extent required in connection with their respective businesses, each of the Company and its subsidiaries is in compliance with each of its contracts and all other conditions of participation in a Government Program in the state or states in which such entity operates except where failure to be in compliance could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect; neither the Company nor any of its subsidiaries is subject to any pending, or, to the knowledge of the Company and the Guarantors, threatened or contemplated action, audit or investigation which could reasonably be expected to result in a revocation, suspension, termination, restriction or non-renewal of any third party payor participation agreement or the Company's or any significant subsidiary's participation in any Government Program; and the Company and each significant subsidiary has been in compliance with all applicable Health Care Laws, except as set forth in or contemplated in the Offering Memorandum and except to the extent that failure to be in compliance could not reasonably be expected, individually or in the aggregate, to have a Material Adverse Effect. For purposes of this Agreement, "**Health Care Laws**" shall mean all federal, state and local laws governing managed care organizations, health maintenance organizations, health insurance or other risk bearing entity, for the payment of health care services, including, without limitation: (i) Titles XVIII and XIX of the Social Security Act, governing the Medicare and Medicaid programs and regulations pertaining thereto, and all state laws and regulations governing the Medicaid programs; (ii) Sections 1320a-7, 1320a-7a and 1320a-7b of Title 42 of the United States Code; (iii) the False Claims Act, 31 U.S.C. Sections 3729-3733; (iv) the Stark law, 42 U.S.C. § 1395nn; (v) the Federal Criminal False Claims Act, 18 U.S.C. § 287; (vi) the False Statements Relating to Health Care Matters statute, 18 U.S.C. § 1035; (vii) the Health Care Fraud statute, 18 U.S.C. § 1347; (viii) the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act and applicable state health care privacy and security laws; (ix) any fee-splitting statutes and corporate practice of medicine laws and regulations in the states in which the Company and each significant subsidiary operates a community clinic; and (x) any and all other similar laws, the regulations promulgated pursuant to each of (i) through (x), each as amended from time to time. The Company and each subsidiary have taken reasonable actions designed to ensure that they do not allow any individual with an ownership or control interest (as defined in 42 U.S.C. § 1320a-3(a)(3)) in the Company or any subsidiary or any officer, director or managing employee (as defined in 42 U.S.C. § 1320a-5(b)) of the Company or any subsidiary who would be a person excluded from participation in any federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)) as described in 42 U.S.C. § 1320a- 7(b)(8) to participate in any such federal health care program maintained by the Company or any significant subsidiary; and the Company and its significant subsidiaries have structured their respective business practices in a manner reasonably designed to comply with the federal and state laws regarding physician ownership of (or financial relationship with), and the referral to entities providing, healthcare related goods or services, and laws requiring disclosure of financial interests held by physicians in entities to which they may refer patients for the provisions of health care related goods and services, and the

Company reasonably believes that it is in material compliance with such laws. There are no proceedings that are pending, or that are known by the Company to be contemplated, against the Company or any of its subsidiaries under any Health Care Laws in which a governmental entity is also a party, other than such proceedings that could not reasonably be expected to have a Material Adverse Effect. Except as otherwise disclosed in the Offering Memorandum, neither the Company, nor any of its subsidiaries, has any material outstanding overpayments or refunds due under the Government Program contracts.

(ss) **Business with Cuba.** The Company has complied with all provisions of Section 517.075, Florida Statutes (Chapter 92-198, Laws of Florida) relating to doing business with the Government of Cuba or with any person or affiliate located in Cuba.

(tt) **Regulation S.** The Company, the Guarantors and their respective affiliates and all persons acting on their behalf (other than the Initial Purchasers, as to whom the Company and the Guarantors make no representation) have complied with and will comply with the offering restrictions requirements of Regulation S in connection with the offering of the Securities outside the United States and, in connection therewith, the Offering Memorandum will contain the disclosure required by Rule 902 under the Securities Act. The Company is a "reporting issuer", as defined in Rule 902 under the Securities Act.

(uu) **No Registration Rights.** Except as described in the Offering Memorandum, there are no contracts, agreements or understandings between the Company, any Guarantor and any person granting such person the right (other than rights that have been waived in writing or otherwise satisfied) to require the Company or any Guarantor to file a registration statement under the Securities Act with respect to any securities of the Company or any Guarantor owned or to be owned by such person or in any securities being registered pursuant to any other registration statement filed by the Company or any Guarantor under the Securities Act.

Any certificate signed by an officer of the Company or any Guarantor and delivered to the Initial Purchasers or to counsel for the Initial Purchasers shall be deemed to be a representation and warranty by the Company or such Guarantor to each Initial Purchaser as to the matters set forth therein.

SECTION 3. **Covenants of the Company and the Guarantors.** Each of the Company and the Guarantors, jointly and severally, further covenants and agrees with each Initial Purchaser as follows:

(a) **Copies of the Offering Memorandum.** The Company will furnish to the Initial Purchasers and to counsel for the Initial Purchasers, without charge, as many copies of the Pricing Disclosure Package and the Final Offering Memorandum and any amendments and supplements thereto as they shall reasonably request.

(b) **Final Offering Memorandum; Amendments and Supplements.** The Company will prepare and deliver to the Initial Purchasers the Final Offering Memorandum in the form approved by the Representative. The Company will not amend or supplement the Final Offering Memorandum prior to the Closing Date unless the Representative shall previously have been furnished a copy of the proposed amendment or supplement a reasonable period of time prior to the proposed use or filing, and shall not have reasonably objected to such amendment or supplement. Before making, preparing, using,

authorizing, approving or distributing any Company Additional Written Communication, the Company will furnish to the Representative a copy of such written communication for review and will not make, prepare, use, authorize, approve or distribute any such written communication to which the Representative reasonably objects.

(c) **Amendments and Supplements to the Final Offering Memorandum and Other Securities Act Matters.**

At any time prior to the Closing Date, if (i) any event occurs or condition exists as a result of which any of the Pricing Disclosure Package, as then amended or supplemented, would include any untrue statement of a material fact or omit to state any material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading or (ii) it is necessary to amend or supplement any of the Pricing Disclosure Package, to comply with applicable law, the Company and the Guarantors will immediately notify the Initial Purchasers thereof and will prepare and (subject to Section 3(a) hereof) provide to the Initial Purchasers such amendments or supplements to any of the Pricing Disclosure Package so that the statements in any of the Pricing Disclosure Package as so amended or supplemented will not, in the light of the circumstances under which they were made, be misleading or so that any of the Pricing Disclosure Package will comply with all applicable law.

Prior to the completion of the placement of the Securities by the Initial Purchasers with the Subsequent Purchasers, if any event occurs or condition exists as a result of which it is necessary to amend or supplement the Final Offering Memorandum, as then amended or supplemented, in order to make the statements therein, in the light of the circumstances when the Final Offering Memorandum is delivered to a Subsequent Purchaser, not misleading, or if in the judgment of the Representative or counsel for the Initial Purchasers it is otherwise necessary to amend or supplement the Final Offering Memorandum to comply with applicable law, the Company and the Guarantors agree to promptly prepare (subject to this Section 3) and provide at its own expense to the Initial Purchasers, amendments or supplements to the Final Offering Memorandum so that the statements in the Final Offering Memorandum as so amended or supplemented will not, in the light of the circumstances at the Closing Date and at the time of sale of the Securities, be misleading or so that the Final Offering Memorandum, as amended or supplemented, will comply with all applicable law.

The Company hereby expressly acknowledges that the indemnification and contribution provisions of Section 7 hereof are specifically applicable and relate to each offering memorandum, registration statement, prospectus, amendment or supplement referred to in this Section 3.

(d) **Use of Proceeds.** The Company shall apply the net proceeds from the sale of the Securities as described under the caption "Use of Proceeds" in the Pricing Disclosure Package.

(e) **The Depositary.** The Company will assist the Initial Purchasers and use commercially reasonable efforts to permit the Securities to be eligible for clearance and settlement through the facilities of the Depositary.

(f) **Additional Information.** So long as any of the Securities are "restricted securities" within the meaning of Rule 144(a)(3) under the Securities Act, at any time when the Company is not subject to Section 13 or 15(d) of the Exchange Act, for the benefit of holders and beneficial owners from time to time of the Securities, the Company shall furnish, at its expense, upon request, to holders and beneficial owners of the Securities and prospective purchasers of the Securities information satisfying the requirements of Rule 144A(d).

(g) **No Other Securities.** During the period of 60 days following the date hereof, the Company will not, without the prior written consent of SunTrust (which consent may be withheld at the sole discretion of SunTrust), directly or indirectly, sell, offer, contract or grant any option to sell, pledge, transfer or establish an open "put equivalent position" within the meaning of Rule 16a-1 under the Exchange Act, or otherwise dispose of or transfer, or announce the offering of, or file any registration statement under the Securities Act in respect of, any debt securities of the Company or securities exchangeable for or convertible into debt securities of the Company, except (i) as contemplated by this Agreement, (ii) for the vesting of or removal or lapse of restrictions on restricted stock or other awards under any employee benefit plan or agreement disclosed in the Offering Memorandum in accordance with the terms of such plan or agreement, and (iii) for the filing of any registration statement in respect of securities offered pursuant to the terms of any existing employee benefit plan or agreement disclosed in the Offering Memorandum, in each case without SunTrust's prior written consent.

(h) **Blue Sky Compliance.** Each of the Company and the Guarantors shall cooperate with the Representative and counsel for the Initial Purchasers to qualify or register (or to obtain exemptions from qualifying or registering) all or any part of the Securities for offer and sale under the securities laws of the several states of the United States, the provinces of Canada or any other jurisdictions designated by the Representative, shall comply with such laws and shall continue such qualifications, registrations and exemptions in effect so long as required for the distribution of the Securities. None of the Company or any of the Guarantors shall be required to qualify as a foreign corporation or to take any action that would subject it to general service of process in any such jurisdiction where it is not presently qualified or where it would be subject to taxation as a foreign corporation. The Company will advise the Representative promptly of the suspension of the qualification or registration of (or any such exemption relating to) the Securities for offering, sale or trading in any jurisdiction or any initiation or threat of any proceeding for any such purpose, and in the event of the issuance of any order suspending such qualification, registration or exemption, each of the Company and the Guarantors shall use its best efforts to obtain the withdrawal thereof at the earliest possible moment.

(i) **No Integration.** The Company agrees that it will not and will cause its Affiliates, directly or through any agent, not to make any offer or sale of securities of the Company of any class if, as a result of the doctrine of "integration" referred to in Rule 502 under the Securities Act, such offer or sale would render invalid the sale of the Securities pursuant hereto.

(j) **No General Solicitation or Directed Selling Efforts.** The Company agrees that it will not and will not permit any of its Affiliates or any other person acting on its or their behalf (other than the Initial Purchasers, as to which no covenant is given) to (i) solicit offers for, or offer or sell, the Securities

by means of any form of general solicitation or general advertising within the meaning of Rule 502(c) of Regulation D without the prior written consent of the Representative or in any manner involving a public offering within the meaning of Section 4(a)(2) of the Securities Act or (ii) engage in any directed selling efforts with respect to the Securities within the meaning of Regulation S, and the Company will and will cause all such persons to comply with the offering restrictions requirement of Regulation S with respect to the Securities.

(k) **Legended Securities.** Each certificate for a Security will bear the legend contained in "Notice to Investors" in the Preliminary Offering Memorandum for the time period and upon the other terms stated in the Preliminary Offering Memorandum.

(l) **No Resales.** The Company will not, and will not permit any of its affiliates (as defined in Rule 144A under the Securities Act) to, resell any of the Securities that have been acquired by any of them, other than pursuant to an effective registration statement under the Securities Act or in accordance with Rule 144 under the Securities Act.

(m) **Additional Issuer Information.** Subject to Section 3(b) hereof, prior to the completion of the placement of the Securities by the Initial Purchasers with the Subsequent Purchasers, the Company shall file, on a timely basis, with the Commission all reports and documents required to be filed under Section 13 or 15 of the Exchange Act. Additionally, at any time when the Company is not subject to Section 13 or 15 of the Exchange Act, for the benefit of holders and beneficial owners from time to time of the Securities, the Company shall furnish, at its expense, upon request, to holders and beneficial owners of the Securities and prospective purchasers of the Securities information satisfying the requirements of Rule 144A(d).

The Representative on behalf of the several Initial Purchasers, may, in its sole discretion, waive in writing the performance by the Company or any Guarantor of any one or more of the foregoing covenants or extend the time for their performance.

SECTION 4. **Conditions of the Obligations of the Initial Purchasers.** The obligations of the several Initial Purchasers to purchase and pay for the Securities shall be subject to the accuracy of the representations and warranties of the Company and the Guarantors in Section 2 hereof, in each case as of the date hereof and as of the Closing Date, as if made on and as of the Closing Date and to the timely performance by the Company of its covenants and other obligations hereunder, and to each of the following additional conditions:

(a) **Comfort Letters.** The Initial Purchasers shall have received on each of the date hereof and the Closing Date a letter, dated the date hereof or the Closing Date, as the case may be, in form and substance satisfactory to the Initial Purchasers and counsel to the Initial Purchasers, from Ernst & Young LLP, independent registered public accounting firm, containing statements and information of the type ordinarily included in accountants' "comfort letters" to underwriters with respect to the financial statements and certain financial information contained or incorporated in the Pricing Disclosure Package and Final Offering Memorandum; provided that the letter shall use a "cut-off date" within three days of

the date of such letter and that their procedures shall extend to financial information in the Final Offering Memorandum not contained or incorporated in the Pricing Disclosure Package. References to the Final Offering Memorandum in this paragraph with respect to either letter referred to above shall include any amendment or supplement thereto at the date of such letter.

(b) **No Material Adverse Change.** For the period from and after the date of this Agreement and prior to the Closing Date, no event or condition of a type described in Section 2(l) hereof shall have occurred or shall exist, the effect of which in the judgment of the Representative makes it impracticable or inadvisable to proceed with the offering, sale or delivery of the Securities on the terms and in the manner contemplated by this Agreement, the Pricing Disclosure Package and the Final Offering Memorandum.

(c) **No Ratings Agency Change.** For the period from and after the date of this Agreement and prior to the Closing Date, there shall not have occurred any downgrading, nor shall any notice have been given of any intended or potential downgrading or of any review for a possible change that does not indicate the direction of the possible change, in the rating accorded the Company or any of its subsidiaries or any of their securities or indebtedness by any "nationally recognized statistical rating organization" as such term is used by the Commission in Section 15E under the Exchange Act.

(d) **Opinion of Counsel for the Company.** On the Closing Date, the Initial Purchasers shall have received the favorable opinion, dated as of the Closing Date, of Boutin Jones Inc., counsel for the Company, in form and substance satisfactory to the Initial Purchasers and counsel to the Initial Purchasers, the form of which is attached as Exhibit A hereto.

(e) **Opinion of Chief Legal Officer.** On the Closing Date, the Initial Purchasers shall have received the favorable opinion, dated as of the Closing Date, of Jeffrey D. Barlow, the Company's Chief Legal Officer and Secretary, in form and substance satisfactory to the Initial Purchasers and counsel to the Initial Purchasers, the form of which is attached as Exhibit B hereto.

(f) **Opinion of Counsel for the Initial Purchasers.** On the Closing Date, the Initial Purchasers shall have received the favorable opinion, dated as of the Closing Date, of Latham & Watkins LLP, counsel for the Initial Purchasers, with respect to such matters as may be reasonably requested by the Initial Purchasers.

(g) **Officer's Certificate.** On the Closing Date, the Initial Purchasers shall have received a certificate, dated as of the Closing Date, executed by the Chief Executive Officer or Chief Financial Officer of the Company and each Guarantor, to the effect set forth in Sections 4(b) and 4(c) hereof, and further to the effect that: (i) the representations, warranties and covenants of the Company and the Guarantors set forth in Section 2 hereof were true and correct as of the date hereof and are true and correct as of the Closing Date with the same force and effect as though expressly made on and as of the Closing Date; and (ii) each of the Company and the Guarantors has complied with all the agreements and satisfied all the conditions on its part to be performed or satisfied at or prior to the Closing Date.

(h) **Indenture and Securities.** The Indenture shall have been duly executed and delivered by a duly authorized officer of the Company, each of the Guarantors and the Trustee, and the Securities shall

have been duly executed and delivered by a duly authorized officer of the Company and duly authenticated by the Trustee.

(i) **Use of Proceeds.** On the Closing Date, the Company shall place the net proceeds from the offering of the Securities in a segregated deposit bank account in the name of the Company, such net proceeds to be used as described under the caption "Use of Proceeds" in the Pricing Disclosure Package and the Final Offering Memorandum.

(j) **Additional Documents.** On or before the Closing Date, the Initial Purchasers and counsel for the Initial Purchasers shall have received such information, documents and opinions as they may reasonably request.

If any condition specified in this Section 4 is not satisfied or waived by the Representative when and as required to be satisfied, this Agreement may be terminated by the Representative by notice to the Company at any time on or prior to the Closing Date, which termination shall be without liability on the part of any party to any other party, subject to survival of the provisions referenced in Section 8 hereof.

SECTION 5. **Offer and Sale Procedures.** Each of the Initial Purchasers, on the one hand, and the Company and each of the Guarantors, on the other hand, hereby agree to observe the following procedures in connection with the offer and sale of the Securities:

(a) Offers and sales of the Securities will be made only by the Initial Purchasers or Affiliates thereof qualified to do so in the jurisdictions in which such offers or sales are made. Each such offer or sale of the Securities shall be made only to persons whom the offeror or seller reasonably believes to be Qualified Institutional Buyers or non-U.S. persons outside the United States to whom the offeror or seller reasonably believes offers and sales of the Securities may be made in reliance upon Regulation S upon the terms and conditions set forth in Annex I hereto, which Annex I is hereby expressly made a part hereof.

(b) Upon original issuance by the Company, and until such time as the same is no longer required under the applicable requirements of the Securities Act, the Securities (and all securities issued in exchange therefor or in substitution thereof) shall bear the following legend:

"THIS NOTE (OR ITS PREDECESSOR) WAS ORIGINALLY ISSUED IN A TRANSACTION EXEMPT FROM REGISTRATION UNDER THE UNITED STATES SECURITIES ACT OF 1933 (THE "SECURITIES ACT"),AND THIS NOTE MAY NOT BE OFFERED, SOLD OR OTHERWISE TRANSFERRED IN THE ABSENCE OF SUCH REGISTRATION OR AN APPLICABLE EXEMPTION THEREFROM. EACH PURCHASER OF THIS NOTE IS HEREBY NOTIFIED THAT THE SELLER OF THIS NOTE MAY BE RELYING ON THE EXEMPTION FROM THE PROVISIONS OF SECTION 5 OF THE SECURITIES ACT PROVIDED BY RULE 144A THEREUNDER.

THE HOLDER OF THIS NOTE AGREES FOR THE BENEFIT OF THE COMPANY THAT (A) THIS NOTE MAY BE OFFERED, RESOLD, PLEDGED OR OTHERWISE TRANSFERRED, ONLY (I) TO THE COMPANY, (II) IN THE UNITED STATES TO A

PERSON WHOM THE SELLER REASONABLY BELIEVES IS A QUALIFIED INSTITUTIONAL BUYER (AS DEFINED IN RULE 144A UNDER THE SECURITIES ACT) IN A TRANSACTION MEETING THE REQUIREMENTS OF RULE 144A, (III) TO AN INSTITUTIONAL "ACCREDITED INVESTOR" WITHIN THE MEANING OF RULE 501(a)(1), (2), (3), (7) AND (8) UNDER THE SECURITIES ACT THAT IS AN INSTITUTIONAL INVESTOR ACQUIRING THE NOTE FOR ITS OWN ACCOUNT OR FOR THE ACCOUNT OF SUCH AN INSTITUTIONAL "ACCREDITED INVESTOR," IN EACH CASE IN A MINIMUM PRINCIPAL AMOUNT OF $250,000 (IV) OUTSIDE THE UNITED STATES IN AN OFFSHORE TRANSACTION IN ACCORDANCE WITH RULE 904 OF THE SECURITIES ACT, (V) PURSUANT TO AN EXEMPTION FROM REGISTRATION UNDER THE SECURITIES ACT PROVIDED BY RULE 144 THEREUNDER (IF AVAILABLE) OR (VI) PURSUANT TO AN EFFECTIVE REGISTRATION STATEMENT UNDER THE SECURITIES ACT, IN EACH OF CASES (I) THROUGH (VI) IN ACCORDANCE WITH ANY APPLICABLE SECURITIES LAWS OF ANY STATE OF THE UNITED STATES, AND (B) THE HOLDER WILL, AND EACH SUBSEQUENT HOLDER IS REQUIRED TO, NOTIFY ANY PURCHASER OF THIS NOTE FROM IT OF THE RESALE RESTRICTIONS REFERRED TO IN (A) ABOVE."

Following the sale of the Securities by the Initial Purchasers to Subsequent Purchasers pursuant to the terms hereof, except as expressly set forth in Sections 7(b) and 7(d) hereof, the Initial Purchasers shall not be liable or responsible to the Company or the Guarantors for any losses, damages or liabilities suffered or incurred by the Company or the Guarantors for any reason, including any losses, damages or liabilities under the Securities Act, arising from or relating to any resale or transfer of any Security.

SECTION 6. **Payment of Expenses.**

(a) Whether or not the transactions contemplated in this Agreement are consummated or this Agreement is terminated, the Company and the Guarantors will pay or cause to be paid all costs, fees and expenses incident to the performance of its and the Guarantors' obligations under this Agreement and in connection with the transactions contemplated hereby, including, without limitation, (i) all expenses incident to the preparation, issuance and delivery of the Securities, (ii) all costs and expenses related to the issuance and delivery of the Securities to the Initial Purchasers, including any transfer or other taxes payable thereon, (iii) all fees, disbursements and expenses of the Company's counsel, the Company's accountants and other advisors (if any) in connection with the issuance and sale of the Securities and all other fees or expenses in connection with the preparation of the Pricing Disclosure Package, any Permitted General Solicitation and the Final Offering Memorandum and all amendments and supplements thereto, and the Transaction Documents, including all printing costs associated therewith, and the delivering of copies thereof to the Initial Purchasers, (iv) the fees and expenses of the Trustee, including the fees and disbursements of counsel for the Trustee in connection with the Indenture and the Securities, (v) all filing fees, attorneys' fees and expenses incurred by the Company, the Guarantors or the Initial Purchasers in connection with qualifying or registering (or obtaining exemptions from the qualification or registration of) all or any part of the Securities for offer and sale under the securities laws of the several states of the United States, the provinces of Canada or other jurisdictions designated by the Initial Purchasers

(including, without limitation, the cost of preparing, printing and mailing preliminary and final blue sky or legal investment memoranda and any related supplements to the Pricing Disclosure Package or the Final Offering Memorandum), (vi) any fees payable in connection with the rating of the Securities with the ratings agencies, (vii) any filing fees incident to, and any reasonable fees and disbursements of counsel to the Initial Purchasers in connection with the review by FINRA, if any, of the terms of the sale of the Securities (viii) all fees and expenses (including reasonable fees and expenses of counsel) of the Company and the Guarantors in connection with approval of the Securities by the Depositary for "book-entry" transfer, and the performance by the Company and the Guarantors of their respective other obligations under this Agreement and (ix) all costs and expenses relating to investor presentations, including any "road show" presentations undertaken in connection with the marketing of the offering of the Securities, including, without limitation, expenses associated with the production of road show slides and graphics and fees and expenses of any consultants engaged in connection with the road show presentations. It is understood, however, that except as provided in this Section 6 and Section 8 hereof, the Initial Purchasers shall pay their own expenses, including the fees and disbursements of their counsel.

(b) If the sale of the Securities provided for herein is not consummated because any condition to the obligations of the Initial Purchasers set forth in Section 5 hereof is not satisfied, because this Agreement is terminated pursuant to Section 8 hereof or because of any failure, refusal or inability on the part of the Company or the Guarantors to perform all obligations and satisfy all conditions on its part to be performed or satisfied hereunder other than by reason of a default by any of the Initial Purchasers, the Company and the Guarantors will reimburse the Initial Purchasers upon demand for all reasonable out-of-pocket expenses (including, without limitation, fees and disbursements of counsel, printing expenses, travel expenses, postage, facsimile and telephone charges) that shall have been incurred by them in connection with the proposed purchase, offering and sale of the Securities.

SECTION 7. **Indemnification.**

(a) **Indemnification by the Company and the Guarantors.** Each of the Company and the Guarantors, jointly and severally, agrees to indemnify and hold harmless each Initial Purchaser, its affiliates, directors, officers and employees, and each person, if any, who controls (within the meaning of Section 15 of the Securities Act or Section 20 of the Exchange Act) any Initial Purchaser against any and all losses, claims, damages, liabilities or expenses, joint or several, to which such Initial Purchaser, affiliate, director, officer, employee or controlling person may become subject, under the Securities Act, the Exchange Act or other federal or state statutory law or regulation, or at common law or otherwise (including in settlement of any litigation, if such settlement is effected with the written consent of the Company), insofar as such losses, claims, damages, liabilities or expenses (or actions in respect thereof as contemplated below) arise out of or are based upon any untrue statement or alleged untrue statement of a material fact contained or incorporated in the Preliminary Offering Memorandum, the Pricing Supplement, any Company Additional Written Communication, any Permitted General Solicitation or the Final Offering Memorandum (or any amendment or supplement thereto), or the omission or alleged omission therefrom of a material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading; and will reimburse each Initial Purchaser and each such affiliate, director, officer, employee or controlling person for any and all expenses (including the

fees and disbursements of counsel chosen by SunTrust) as such expenses are reasonably incurred by such Initial Purchaser or such affiliate, director, officer, employee or controlling person in connection with investigating, defending, settling, compromising or paying any such loss, claim, damage, liability, expense or action; provided, however, that the Company and the Guarantors will not be liable in any such case to the extent, but only to the extent, that any such loss, claim, damage, liability or expense arises out of or is based upon any untrue statement or alleged untrue statement or omission or alleged omission made in reliance upon and in conformity with written information relating to such Initial Purchaser and furnished to the Company by such Initial Purchaser through the Representative expressly for use in the Preliminary Offering Memorandum, the Pricing Supplement, any Company Additional Written Communication or the Final Offering Memorandum (or any amendment or supplement thereto). The indemnity agreement set forth in this Section 7(a) shall be in addition to any liabilities that the Company may otherwise have.

(b) **Indemnification by the Initial Purchasers.** Each Initial Purchaser agrees, severally and not jointly, to indemnify and hold harmless the Company, each Guarantor, each of their respective affiliates, directors, officers and each person, if any, who controls the Company or any Guarantor within the meaning of Section 15 of the Securities Act or Section 20 of the Exchange Act, against any and all losses, claims, damages, liabilities or expenses, as incurred, to which the Company, any Guarantor or any such affiliate, director, officer or controlling person may become subject, under the Securities Act, the Exchange Act, or other federal or state statutory law or regulation, or at common law or otherwise (including in settlement of any litigation, if such settlement is effected with the written consent of such Initial Purchaser), insofar as such loss, claim, damage, liability or expense (or actions in respect thereof as contemplated below) arises out of or is based upon any untrue statement or alleged untrue statement of a material fact contained or incorporated in the Preliminary Offering Memorandum, the Pricing Supplement, any Company Additional Written Communication or the Final Offering Memorandum (or any amendment or supplement thereto), or the omission or alleged omission therefrom of a material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading, in each case to the extent, but only to the extent, that such untrue statement or alleged untrue statement or omission or alleged omission was made in the Preliminary Offering Memorandum, the Pricing Supplement, any Company Additional Written Communication or the Final Offering Memorandum (or any amendment or supplement thereto), in reliance upon and in conformity with written information relating to such Initial Purchaser and furnished to the Company by such Initial Purchaser through the Representative expressly for use therein; and to reimburse the Company, any Guarantor and each such director or controlling person for any and all expenses (including the fees and disbursements of counsel) as such expenses are reasonably incurred by the Company, any Guarantor or such director or controlling person in connection with investigating, defending, settling, compromising or paying any such loss, claim, damage, liability, expense or action. Each of the Company and the Guarantors hereby acknowledges that the only information that the Initial Purchasers through the Representative have furnished to the Company expressly for use in the Preliminary Offering Memorandum, the Pricing Supplement, any Company Additional Written Communication or the Final Offering Memorandum (or any amendment or supplement thereto) are the statements set forth in the fourth paragraph, the third sentence of the sixth paragraph and the seventh paragraph under the caption “Plan of Distribution” in the Preliminary Offering Memorandum and the Final Offering Memorandum. The indemnity agreement set

forth in this Section 7(b) shall be in addition to any liabilities that each Initial Purchaser may otherwise have.

(c) **Notices and Procedures.** Promptly after receipt by any person to whom indemnity may be available under this Section 7 (the "**indemnified party**") of notice of the commencement of any action, such indemnified party will, if a claim in respect thereof is to be made against any person from whom indemnity may be sought under this Section 7 (the "**indemnifying party**"), notify such indemnifying party in writing of the commencement thereof; provided that the failure to so notify such indemnifying party will not relieve such indemnifying party from any liability which it may have to such indemnified party under this Section 7 except to the extent that it has been materially prejudiced by such failure (through the forfeiture of substantive rights and defenses) and shall not relieve such indemnifying party from any liability that such indemnifying party may have to such indemnified party other than under this Section 7. In case any such action is brought against any indemnified party and such indemnified party notifies the relevant indemnifying party of the commencement thereof, such indemnifying party will be entitled to participate therein and, to the extent that it may wish, to assume the defense thereof, jointly with any other indemnifying party similarly notified, with counsel reasonably satisfactory to such indemnified party; provided, however, if the defendants in any such action (including impleaded parties) include both the indemnified party and the indemnifying party and the indemnified party shall have concluded that a conflict may arise between the positions of the indemnifying party and the indemnified party in conducting the defense of any such action or that there may be legal defenses available to it and/or other indemnified parties which are different from or additional to those available to the indemnifying party, the indemnified party or parties shall have the right to select separate counsel to assume such legal defenses and to otherwise participate in the defense of such action on behalf of such indemnified party or parties. After notice from the indemnifying party to such indemnified party of its election so to assume the defense thereof and approval by the indemnified party of counsel appointed to defend such action, the indemnifying party will not be liable to such indemnified party under this Section 7 for any legal or other expenses other than reasonable costs of investigation, subsequently incurred by such indemnified party in connection with the defense thereof, unless (i) the indemnified party shall have employed separate counsel in accordance with the proviso to the immediately preceding sentence (it being understood, however, that the indemnifying party shall not be liable for the expenses of more than one separate counsel (together with local counsel (in each jurisdiction)), which shall be selected by SunTrust (in the case of counsel representing the Initial Purchasers or their related persons), representing the indemnified parties who are parties to such action), (ii) the indemnifying party shall not have employed counsel satisfactory to the indemnified party to represent the indemnified party within a reasonable time after notice of commencement of the action or (iii) such indemnifying party has authorized the employment of counsel for such indemnified party at the expense of the indemnifying party. After such notice from an indemnifying party to an indemnified party, such indemnifying party will not be liable for the costs and expenses of any settlement of such action effected by such indemnified party without the written consent of such indemnifying party. Notwithstanding the foregoing sentence, if at any time an indemnified party shall have requested an indemnifying party to reimburse the indemnified party for fees and expenses of counsel as contemplated by (i), (ii) or (iii) of the third sentence of this paragraph, the indemnifying party agrees that it shall be liable for any settlement of any proceeding effected without its written consent if

(x) such settlement is entered into more than 30 days after receipt by such indemnifying party of the aforesaid request and (y) such indemnifying party shall not have reimbursed the indemnified party in accordance with such request prior to the date of such settlement. An indemnifying party will not, without the prior written consent of the indemnified party, settle or compromise or consent to the entry of any judgment in any pending or threatened claim, action, suit or proceeding in respect of which indemnification may be sought hereunder (whether or not the indemnified party or any other person that may be entitled to indemnification hereunder is a party to such claim, action, suit or proceeding) unless such settlement, compromise or consent (i) includes an unconditional release of the indemnified party and such other persons from all liability arising out of such claim, action, suit or proceeding and (ii) does not include any statements as to or any findings of fault, culpability or failure to act by or on behalf of any indemnified party.

(d) **Contribution.** If the indemnification provided for in this Section 7 is held to be unavailable to or otherwise insufficient, for any reason, to hold harmless an indemnified party in respect of any losses, claims, damages, liabilities or expenses referred to therein, then each indemnifying party shall contribute to the aggregate amount paid or payable by such indemnified party, as incurred, as a result of any losses, claims, damages, liabilities or expenses referred to therein (i) in such proportion as is appropriate to reflect the relative benefits received by the Company and the Guarantors, on the one hand, and the Initial Purchasers, on the other hand, from the offering of the Securities pursuant to this Agreement or (ii) if the allocation provided by clause (i) above is not permitted by applicable law, in such proportion as is appropriate to reflect not only the relative benefits referred to in clause (i) above but also the relative fault of the Company and the Guarantors, on the one hand, and the Initial Purchasers, on the other hand, in connection with the statements or omissions which resulted in such losses, claims, damages, liabilities or expenses, as well as any other relevant equitable considerations. The relative benefits received by the Company and the Guarantors, on the one hand, and the Initial Purchasers, on the other hand, in connection with the offering of the Securities pursuant to this Agreement shall be deemed to be in the same respective proportions as the total net proceeds from the offering of the Securities pursuant to this Agreement (before deducting expenses) received by the Company, and the total discount received by the Initial Purchasers bear to the aggregate initial offering price of the Securities. The relative fault of the Company and the Guarantors, on the one hand, and the Initial Purchasers, on the other hand, shall be determined by reference to, among other things, whether any such untrue or alleged untrue statement of a material fact or omission or alleged omission to state a material fact relates to information supplied by the Company and the Guarantors, on the one hand, or the Initial Purchasers, on the other hand, and the parties' relative intent, knowledge, access to information and opportunity to correct or prevent such statement or omission. The amount paid or payable by a party as a result of the losses, claims, damages, liabilities and expenses referred to above shall be deemed to include, any legal or other fees or expenses reasonably incurred by such party in connection with investigating or defending any action or claim. The provisions set forth in subclauses (a) and (b) of this Section 7 with respect to notice of commencement of any action shall apply if a claim for contribution is to be made under this Section 7; provided, however, that no additional notice shall be required with respect to any action for which notice has been given under Section 7(c) hereof for purposes of indemnification. The Company, the Guarantors and the Initial Purchasers agree that it would not be just and equitable if contribution pursuant to this Section 7 were determined by pro rata allocation

(even if the Initial Purchasers were treated as one entity for such purpose) or by any other method of allocation which does not take account of the equitable considerations referred to in this Section 7. Notwithstanding the provisions of this Section 7, no Initial Purchaser shall be required to contribute any amount in excess of the discount received by such Initial Purchaser in connection with the Securities distributed by it. No person guilty of fraudulent misrepresentation (within the meaning of Section 11 of the Securities Act) shall be entitled to contribution from any person who was not guilty of such fraudulent misrepresentation. The Initial Purchasers' obligations to contribute pursuant to this Section 7 are several, and not joint, in proportion to their respective commitments as set forth opposite their names in Schedule A. For purposes of this Section 7, each affiliate, director, officer and employee of an Initial Purchaser and each person, if any, who controls an Initial Purchaser within the meaning of the Securities Act and the Exchange Act shall have the same rights to contribution as such Initial Purchaser, and each director of the Company or any Guarantor, and each person, if any, who controls the Company or any Guarantor within the meaning of the Securities Act and the Exchange Act shall have the same rights to contribution as the Company and the Guarantors.

SECTION 8. **Termination of this Agreement.** The Representative may terminate this Agreement with respect to the Notes by notice to the Company at any time on or prior to the Closing Date in the event that the Company shall have failed, refused or been unable to perform in any material respect all obligations and satisfy in any material respect all conditions on its part to be performed or satisfied hereunder at or prior thereto or if, at any time: (i) trading or quotation in any of the Company's securities shall have been suspended or limited by the Commission or by the NYSE, or trading in securities generally on either the Nasdaq Stock Market or the NYSE shall have been suspended or limited, or minimum or maximum prices shall have been generally established on any of such quotation system or stock exchange by the Commission or FINRA; (ii) there has been a material disruption in commercial banking or securities settlement, payment or clearance services in the United States; (iii) a general banking moratorium shall have been declared by any of federal or New York authorities; (iv) there shall have been (A) an outbreak or escalation of hostilities between the United States and any foreign power, (B) an outbreak or escalation of any other insurrection or armed conflict involving the United States, (C) the occurrence of any other calamity or crisis involving the United States or (D) any change in general economic, political or financial conditions which has an effect on the U.S. financial markets that, in the case of any event described in this clause (iv), in the sole judgment of the Representative, makes it impracticable or inadvisable to proceed with the offer, sale and delivery of the Securities as disclosed in the Pricing Disclosure Package or the Final Offering Memorandum, exclusive of any amendment or supplement thereto; or (v) in the judgment of the Representative there shall have occurred or exist any event or condition a type described in Section 2(l) hereof or any other loss, event or other calamity of such character as in the judgment of the Representative may interfere materially with the conduct of the business and operations of the Company regardless of whether or not such loss shall have been insured. Any termination pursuant to this Section 8 shall be without liability on the part of (i) the Company or any Guarantor to any Initial Purchaser, except that the Company and the Guarantors shall be obligated to reimburse the expenses of the Initial Purchasers pursuant to Section 6 hereof, (ii) any Initial Purchaser to the Company or any Guarantor, or (iii) any party hereto to any other party except that the provisions of Section 7 hereof shall at all times be effective and shall survive such termination.

SECTION 9. **Notices.** All communications hereunder shall be in writing and, if sent to any of the Initial Purchasers, shall be delivered or sent by mail or transmitted and confirmed in writing by any standard form of telecommunication to SunTrust Robinson Humphrey, Inc., 3333 Peachtree Road, 10th Floor, Atlanta, GA 30326, Facsimile: 404-926-5248, Attention: High Yield Syndicate, with a copy to Latham & Watkins LLP, 885 Third Avenue, New York, NY 10022, Attention: Michael Benjamin and if sent to the Company, shall be delivered or sent by mail, telex or facsimile transmission and confirmed in writing to the Company at 200 Oceangate, Suite 100, Long Beach, California 90802, Facsimile: 562-499-0612, Attention: Joseph W. White, Chief Financial Officer and Interim President and Chief Executive Officer, with a copy to Boutin Jones Inc., 555 Capitol Mall, Suite 1500, Sacramento, California 95814, Facsimile: 916-441-7597, Attention: Iain Mickle.

SECTION 10. **Successors.** This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and the officers and directors and any controlling persons referred to herein, and the affiliates of each Initial Purchaser referred to in Section 7 hereof. Nothing in this Agreement is intended or shall be construed to give any other person any legal or equitable right, remedy or claim under or in respect of this Agreement or any provision contained herein. No Subsequent Purchaser of the Securities from any Initial Purchaser shall be deemed to be a successor merely by reason of such purchase.

SECTION 11. **Authority of the Representative.** Any action by the Initial Purchasers hereunder may be taken by SunTrust on behalf of the Initial Purchasers, and any such action taken by SunTrust shall be binding upon the Initial Purchasers.

SECTION 12. **Partial Unenforceability.** The invalidity or unenforceability of any section, paragraph or provision of this Agreement shall not affect the validity or enforceability of any other section, paragraph or provision hereof. If any section, paragraph or provision of this Agreement is for any reason determined to be invalid or unenforceable, there shall be deemed to be made such minor changes (and only such minor changes) as are necessary to make it valid and enforceable.

SECTION 13. **Governing Law; Consent to Jurisdiction.** THIS AGREEMENT AND ANY CLAIM, CONTROVERSY OR DISPUTE ARISING UNDER OR RELATED TO THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK APPLICABLE TO AGREEMENTS MADE AND TO BE PERFORMED IN SUCH STATE WITHOUT REGARD TO CONFLICTS OF LAW PRINCIPLES THEREOF.

Any legal suit, action or proceeding arising out of or based upon this Agreement or the transactions contemplated hereby ("**Related Proceedings**") may be instituted in the federal courts of the United States of America located in the City and County of New York or the courts of the State of New York in each case located in the City and County of New York (collectively, the "**Specified Courts**"), and each party irrevocably submits to the exclusive jurisdiction (except for suits, actions, or proceedings instituted in regard to the enforcement of a judgment of any Specified Court in a Related Proceeding, as to which such jurisdiction is non-exclusive) of the Specified Courts in any Related Proceeding. Service of any process, summons, notice or document by mail to such party's address set forth above shall be effective service of

process for any Related Proceeding brought in any Specified Court. The parties irrevocably and unconditionally waive any objection to the laying of venue of any Specified Proceeding in the Specified Courts and irrevocably and unconditionally waive and agree not to plead or claim in any Specified Court that any Related Proceeding brought in any Specified Court has been brought in an inconvenient forum.

SECTION 14. **Waiver of Jury Trial.** Each of the Company and the Guarantors hereby irrevocably and unconditionally waives trial by jury in any legal action or proceeding relating to this Agreement.

SECTION 15. **Defaulting Initial Purchasers.** If any of the several Initial Purchasers shall fail or refuse to purchase the Securities that it or they have agreed to purchase hereunder on the Closing Date, and the aggregate number of Securities which such defaulting Initial Purchaser or Initial Purchasers agreed but failed or refused to purchase does not exceed 10% of the aggregate number of the Securities to be purchased on such date, the non-defaulting Initial Purchasers shall be obligated to purchase the Securities that such defaulting Initial Purchaser or Initial Purchasers agreed but failed to purchase on the Closing Date (the "**Remaining Securities**") in the respective proportions that the principal amount of the Securities set opposite the name of each non-defaulting Initial Purchaser in Schedule A hereto bears to the total number of the Securities set opposite the names of all the non-defaulting Initial Purchasers in Schedule A, or in such other proportions as may be specified by the Initial Purchasers with the consent of the non-defaulting Initial Purchasers; provided, however, that the non-defaulting Initial Purchasers shall not be obligated to purchase any of the Securities on the Closing Date if the total amount of Securities which the defaulting Initial Purchaser or Initial Purchasers agreed but failed or refused to purchase on such date exceeds 10% of the total amount of Securities to be purchased on the Closing Date, and no non-defaulting Initial Purchaser shall be obligated to purchase more than 110% of the amount of Notes that it agreed to purchase on the Closing Date pursuant to this Agreement. If the foregoing maximums are exceeded, the non-defaulting Initial Purchasers, or those other purchasers satisfactory to the Initial Purchasers who so agree, shall have the right, but not the obligation, to purchase, in such proportion as may be agreed upon among them, all the Remaining Securities. If the non-defaulting Initial Purchasers or other Initial Purchasers satisfactory to the Initial Purchasers do not elect to purchase the Remaining Securities, this Agreement shall terminate without liability of any party to any other party except that the provisions of Sections 6 and 8 hereof shall at all times be effective and shall survive such termination. In any such case either the Initial Purchasers or the Company shall have the right to postpone the Closing Date, as the case may be, but in no event for longer than seven days in order that the required changes, if any, to the Final Offering Memorandum or any other documents or arrangements may be effected.

As used in this Agreement, the term "**Initial Purchaser**" shall be deemed to include any person substituted for a defaulting Initial Purchaser under this Section 15. Any action taken under this Section 15 shall not relieve any defaulting Initial Purchaser from liability in respect of any default of such Initial Purchaser under this Agreement.

SECTION 16. **No Advisory or Fiduciary Responsibility.** Each of the Company and the Guarantors acknowledges and agrees that: (i) the purchase and sale of the Securities pursuant to this Agreement, including the determination of the offering price of the Securities and any related discounts and commissions, is an arm's-length commercial transaction between the Company and the Guarantors, on

the one hand, and the several Initial Purchasers, on the other hand, and the Company and the Guarantors are capable of evaluating and understanding and understand and accept the terms, risks and conditions of the transactions contemplated by this Agreement; (ii) in connection with each transaction contemplated hereby and the process leading to such transaction each Initial Purchaser is and has been acting solely as a principal and is not the agent or fiduciary of the Company, the Guarantors or their respective affiliates, stockholders, creditors or employees or any other party; (iii) no Initial Purchaser has assumed or will assume an advisory or fiduciary responsibility in favor of the Company and the Guarantors with respect to any of the transactions contemplated hereby or the process leading thereto (irrespective of whether such Initial Purchaser has advised or is currently advising the Company and the Guarantors on other matters) or any other obligation to the Company and the Guarantors except the obligations expressly set forth in this Agreement; (iv) the several Initial Purchasers and their respective affiliates may be engaged in a broad range of transactions that involve interests that differ from those of the Company and the Guarantors, and the several Initial Purchasers have no obligation to disclose any of such interests by virtue of any fiduciary or advisory relationship; and (v) the Initial Purchasers have not provided any legal, accounting, regulatory or tax advice with respect to the offering contemplated hereby, and the Company and the Guarantors have consulted their own legal, accounting, regulatory and tax advisors to the extent they deemed appropriate.

This Agreement supersedes all prior agreements and understandings (whether written or oral) between the Company, the Guarantors and the several Initial Purchasers, or any of them, with respect to the subject matter hereof. The Company and the Guarantors hereby waive and release, to the fullest extent permitted by law, any claims that the Company and the Guarantors may have against the several Initial Purchasers with respect to any breach or alleged breach of fiduciary duty.

SECTION 17. **Survival.** The respective indemnities, rights of contribution, agreements, representations, warranties and other statements of the Company, the Guarantors, their respective officers and the several Initial Purchasers set forth in or made pursuant to this Agreement will remain in full force and effect, regardless of any investigation made by or on behalf of any Initial Purchaser, the Company, any Guarantor or any of their partners, officers or directors or any controlling person, as the case may be, and will survive delivery of and payment for the Securities sold hereunder and any termination of this Agreement.

SECTION 18. **Miscellaneous.**

(a) **Entire Agreement.** This Agreement constitutes the entire agreement of the parties to this Agreement and supersedes all prior written or oral and all contemporaneous oral agreements, understandings and negotiations with respect to the subject matter hereof.

(b) **Counterparts.** This Agreement may be executed in two or more counterparts, each one of which shall be an original, with the same effect as if the signatures thereto and hereto were upon the same instrument. Delivery of an executed counterpart of a signature page to this Agreement by telecopier, facsimile or other electronic transmission (i.e., a “pdf” or “tif”) shall be effective as delivery of a manually executed counterpart thereof.

(c) **Amendments and Waivers.** No amendment or waiver of any provision of this Agreement, nor any consent or approval to any departure therefrom, shall in any event be effective unless the same shall be in writing and signed by the parties hereto.

(d) **Headings.** The headings herein are included for convenience of reference only and are not intended to be part of, or to affect the meaning or interpretation of, this Agreement.

[Signature Pages Follow]

If the foregoing is in accordance with your understanding, please indicate your acceptance of this Agreement by signing in the space provided below.

Very truly yours,

MOLINA HEALTHCARE, INC.

By: _____
Name:
Title:

MOLINA INFORMATION SYSTEMS, LLC,
as Guarantor

By: _____
Name:
Title:

MOLINA PATHWAYS, LLC,
as Guarantor

By: _____
Name:
Title:

PATHWAYS HEALTH AND COMMUNITY SUPPORT LLC,
as Guarantor

By: _____
Name:
Title:

The foregoing Agreement is hereby confirmed and accepted by the Initial Purchasers as of the date first above written.

SUNTRUST ROBINSON HUMPHREY, INC.
Acting on behalf of itself and as the
Representative of the several Initial
Purchasers

By: SunTrust Robinson Humphrey, Inc.

By: _____
Name:
Title:

SCHEDULE A

Initial Purchasers	Aggregate Principal Amount of Securities to be Purchased
SunTrust Robinson Humphrey, Inc.	$ 66,000,000
Barclays Capital Inc.	49,500,000
J.P. Morgan Securities LLC	49,500,000
Merrill Lynch, Pierce, Fenner & Smith Incorporated	49,500,000
Morgan Stanley & Co. LLC	49,500,000
Wells Fargo Securities, LLC	49,500,000
MUFG Securities Americas Inc.	16,500,000
Total	$ 330,000,000

SCHEDULE B-1

PRICING SUPPLEMENT

Supplement Dated May 22, 2017 to
Preliminary Offering Memorandum Dated May 22, 2017

$330,000,000

Molina Healthcare, Inc.
4.875% Senior Notes due 2025

This Supplement is qualified in its entirety by reference to the Preliminary Offering Memorandum dated May 22, 2017 (the "Preliminary Offering Memorandum"). The information in this Supplement updates and supersedes any information in the Preliminary Offering Memorandum that is inconsistent or prepared based on assumptions that are inconsistent with the information below.

The notes have not been registered under the federal securities laws or the securities laws of any state. The initial purchasers named below are offering the notes only to persons reasonably believed to be qualified institutional buyers under Rule 144A and to persons outside the United States under Regulation S. See "Notice to Investors" in the Preliminary Offering Memorandum for additional information about eligible offerees and transfer restrictions. Investing in the notes involves risks that are described in the "Risk Factors" section beginning on page 11 of the Preliminary Offering Memorandum.

Unless otherwise indicated, terms used but not defined herein have the meaning assigned to such terms in the Preliminary Offering Memorandum.

Other information (including financial information) presented in the Preliminary Offering Memorandum is deemed to have changed to the extent affected by the changes and other information described below.

Issuer:	Molina Healthcare, Inc.
Rating: [1]	Ba3/BB

[1] A securities rating is not a recommendation to buy, sell or hold securities and may be subject to revision or withdrawal at any time. Credit ratings are subject to change depending on financial and other factors.

Title of Securities:	4.875% Senior Notes due 2025
Aggregate Principal Amount:	$330,000,000
Gross Proceeds to Issuer:	$330,000,000
Final Maturity Date:	June 15, 2025
Issue Price:	100.0%, plus accrued interest, if any, from June 6, 2017
Coupon:	4.875%
Yield to Maturity:	4.875%
Spread to Benchmark Treasury:	+272 bps
Benchmark Treasury:	UST 2.125% due May 15, 2025
Interest Payment Dates:	June 15 and December 15
Record Dates:	June 1 and December 1
First Interest Payment Date:	December 15, 2017
Optional Redemption:	At any time prior to June 15, 2020, some or all of the notes at a price equal to 100% of the principal amount of the notes redeemed, plus accrued and unpaid interest, if any, to (but not including) the redemption date, plus an applicable "make-whole premium" as described in the Preliminary Offering Memorandum. On and after June 15, 2020, in whole at any time or in part from time to time, at the following redemption prices (expressed as a percentage of principal amount), plus accrued and unpaid interest, if any, to (but not including) the redemption date if redeemed during the 12-month period commencing on June 15 of the years set forth below:

Year	Price
2020	102.438%
2021	101.219%
2022 and thereafter	100.000%

Joint Book-Running Managers:	SunTrust Robinson Humphrey, Inc. Barclays Capital Inc. J.P. Morgan Securities LLC Merrill Lynch, Pierce, Fenner & Smith Incorporated Morgan Stanley & Co. LLC Wells Fargo Securities, LLC

Co-Manager:	MUFG Securities Americas Inc.
Trade Date:	May 22, 2017
Settlement Date:	June 6, 2017 (T+10)
	The Company expects that delivery of the notes will be made against payment therefor on or about the tenth business day following the date of confirmation of orders with respect to the notes (this settlement cycle being referred to as "T+10"). Under Rule 15c6-1 of the Exchange Act, trades in the secondary market generally are required to settle in three business days, unless the parties to any such trade expressly agree otherwise. Accordingly, purchasers who wish to trade the notes before the notes are delivered will be required, by virtue of the fact that the notes initially will settle in T+10, to specify an alternative settlement cycle at the time of any such trade to prevent a failed settlement. Purchasers of the notes who wish to trade the notes before their delivery should consult their own advisor.
Distribution:	144A and Regulation S
CUSIP/ISIN Numbers:	144A CUSIP: 60855R AH3 144A ISIN: US60855RAH30 Regulation S CUSIP: U60868 AB9 Regulation S ISIN: USU60868AB96

The information presented in the Preliminary Offering Memorandum is deemed to have changed to the extent affected by the changes described herein.

This material is confidential and is for your information only and is not intended to be used by anyone other than you. This information does not purport to be a complete description of these securities or the offering. Please refer to the Preliminary Offering Memorandum for a complete description.

This communication is being distributed in the United States solely to persons reasonably believed to be qualified institutional buyers, as defined in Rule 144A under the Securities Act of 1933, as amended, and outside the United States solely to non-U.S. persons as defined under Regulation S.

This communication is not an offer to sell the securities and it is not a solicitation of an offer to buy the securities in any jurisdiction where the offering is prohibited, where the person making the offer is not qualified to do so, or to any person who cannot legally be offered the securities.

SCHEDULE B-2

1. Press release of the Company dated May 22, 2017 relating to the announcement of the offering of the Securities.

2. Press release of the Company dated May 22, 2017 relating to the pricing of the offering of the Securities.

SCHEDULE C

SUBSIDIARIES

NAME	JURISDICTION
Molina Healthcare Data Center, Inc.^	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California\	California
Molina Healthcare of California Partner Plan, Inc.\	California
Molina Healthcare of Florida, Inc.\	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.\	Illinois
Molina Healthcare of Iowa, Inc. *	Iowa
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.\	Michigan
Molina Healthcare of Mississippi, Inc.*	Mississippi
Molina Healthcare of New Mexico, Inc.\	New Mexico
Molina Healthcare of New York, Inc.\	New York
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.\	Ohio
Molina Healthcare of Oklahoma, Inc.*	Oklahoma
Molina Healthcare of Pennsylvania, Inc.*	Pennsylvania
Molina Healthcare of Puerto Rico, Inc.\	Puerto Rico/Nevada
Molina Healthcare of South Carolina, LLC\	South Carolina
Molina Healthcare of Texas, Inc.\	Texas
Molina Healthcare of Texas Insurance Company^	Texas
Molina Healthcare of Utah, Inc.\	Utah
Molina Healthcare of Virginia, Inc.^	Virginia
Molina Healthcare of Washington, Inc.\	Washington
Molina Healthcare of Wisconsin, Inc.\	Wisconsin
Molina Health Plan Management, Inc.<	New York
Molina Hospital Management, Inc.^	California
Molina Information Systems, LLC, dba Molina Medicaid Solutions^	California

Molina Youth Academy*	California
Molina Medical Management, Inc. ^	California

NAME	JURISDICTION
Molina Holdings Corporation*	New York
Molina Clinical Services LLC^	Delaware
Molina Healthcare of Louisiana, Inc.*	Louisiana
Molina Healthcare of Nevada, Inc.*	Nevada
Molina Pathways, LLC<	Delaware
Molina Pathways of Texas, Inc.+^	Texas
Integrated Care Alliance, LLC (Synergy Partners, L.L.C.)+^	Michigan
Pathways Health and Community Support LLC+<	Delaware
AmericanWork, Inc.-^	Delaware
Children's Behavioral Health, Inc.-^	Pennsylvania
Choices Group, Inc.-^	Delaware
College Community Services-^	California
Dockside Services, Inc.-^	Indiana
Family Preservation Services, Inc.-^	Virginia
Family Preservation Services of Florida, Inc.-^	Florida
Family Preservation Services of North Carolina, Inc.-^	North Carolina
Family Preservation Services of Washington D.C., Inc.-^	District of Columbia
Family Preservation Services of West Virginia, Inc.-^	West Virginia
Maple Star Nevada, Inc.-^	Nevada
Maple Star Oregon, Inc.-^	Oregon
Pathways Community Corrections, Inc.-^	Delaware
Camelot Care Centers, Inc.>^	Illinois
Pathways Community Services LLC-^	Delaware
Pathways Community Services LLC-^	Pennsylvania
Pathways of Massachusetts LLC-^	Delaware
Pathways of Washington, Inc.-^	Washington
Pathways of Arizona, Inc.-^	Arizona
Pathways of Idaho LLC-^	Delaware
Pathways of Delaware, Inc.-^	Delaware
Pathways of Maine, Inc.-^	Maine
Pathways of Oklahoma, Inc.-^	Oklahoma

Pathways Community Support of Texas, Inc.-^	Texas
Transitional Family Services, Inc.-^	Georgia
Pathways Human Services, LLC.*-	Delaware

NAME	JURISDICTION
The RedCo Group, Inc.-^	Pennsylvania
Raystown Developmental Services, Inc./^	Pennsylvania

* Non-operational entity
< Holding company
\ Operating health plan
^ Operating, not a health plan
\+ Wholly owned subsidiary of Molina Pathways, LLC
~ Partially owned subsidiary of Molina Medical Management, Inc.
\- Wholly owned subsidiary of Pathways Health and Community Support LLC
/ Wholly owned subsidiary of The RedCo Group, Inc.
> Wholly owned subsidiary of Pathways Community Corrections, Inc.

EXHIBIT A

Opinion of counsel for the Company to be delivered pursuant to Section 4 of the Purchase Agreement.

(i) The Company has been duly incorporated and is validly existing as a corporation in good standing under the laws of the jurisdiction of its incorporation. The Company has full corporate power and authority to own, lease and operate its properties and to conduct its business as described in the Pricing Disclosure Package and the Final Offering Memorandum and to enter into and perform its obligations under the Transaction Documents to which it is a party.

(ii) Each Guarantor has been duly formed/organized and is validly existing as a corporation or limited liability company, as applicable, in good standing under the laws of the jurisdiction of its formation/organization, has corporate or limited liability company, as applicable, power and authority to own, lease and operate its properties and to conduct its business as described in the Pricing Disclosure Package and the Final Offering Memorandum and to enter into and perform its obligations under the Transaction Documents to which it is a party.

(iii) The Purchase Agreement has been duly authorized, executed and delivered by the Company and each Guarantor.

(iv) The Indenture has been duly authorized, executed and delivered by the Company and each Guarantor and (assuming the due authorization, execution and delivery thereof by the Trustee) is a valid and binding agreement of the Company and each Guarantor, enforceable against the Company and each Guarantor in accordance with its terms, except as the enforcement thereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws relating to or affecting the rights and remedies of creditors or by general equitable principles.

(v) The Notes are in the form contemplated by the Indenture, have been duly authorized by the Company for issuance and sale pursuant to the Purchase Agreement and the Indenture and, when executed by the Company and authenticated by the Trustee in the manner provided in the Indenture (assuming the due authorization, execution and delivery of the Indenture by the Trustee) and delivered against payment of the purchase price therefor, will constitute valid and binding obligations of the Company, enforceable against the Company in accordance with their terms, except as the enforcement thereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws relating to or affecting enforcement of the rights and remedies of creditors or by general equitable principles and will be entitled to the benefits of the Indenture.

(vi) The Guarantees are in the respective forms contemplated by the Indenture and have been duly authorized for issuance pursuant to the Purchase Agreement and the Indenture. The Guarantees have been duly executed by each of the Guarantors and, when the Notes have been authenticated in the manner provided for in the Indenture and delivered against payment of the purchase price therefor, will constitute valid and binding agreements of the Guarantors, enforceable in accordance with their terms, except as the enforcement thereof may be limited by bankruptcy, insolvency, reorganization, moratorium or other similar laws relating to or affecting the rights and remedies of creditors or by general equitable principles and will be entitled to the benefits of the Indenture.

(vii) The statements in the Pricing Disclosure Package and the Final Offering Memorandum under the captions "Description of Other Indebtedness," "Description of Notes," and "Material U.S. Federal Income Tax Consequences," insofar as such statements constitute matters of law, summaries of legal matters, documents or legal proceedings, or legal conclusions, have been reviewed by such counsel and fairly present and summarize, in all material respects, the matters referred to therein.

(viii) No consent, approval, authorization or other order of, or registration or filing with, any court or other governmental or regulatory authority or agency, is required for the execution, delivery and performance of the Transaction Documents by the Company and the Guarantors to the extent a party thereto, or the issuance and delivery of the Securities, or consummation of the transactions contemplated hereby and thereby and by the Pricing Disclosure Package and the Final Offering Memorandum, except such as have been obtained or made by the Company and are in full force and effect under the Securities Act, applicable state securities or blue sky laws.

(ix) The execution and delivery of the Transaction Documents by the Company and the Guarantors and the performance by the Company and the Guarantors to the extent a party thereto of their obligations thereunder (other than performance under the indemnification sections of the Purchase Agreement, as to which no opinion need be rendered): (i) will not result in any violation of the provisions of the charter or by-laws of the Company or any subsidiary; (ii) will not constitute a breach of, or Default or a breach under, or result in the creation or imposition of any lien, charge or encumbrance upon any property or assets of the Company or any of its subsidiaries pursuant to, that certain Credit Agreement, dated as of June 12, 2015, by and among the Company, the other loan parties party thereto, the lenders party thereto and SunTrust Bank, as administrative agent, or any other existing debt instrument that has been filed by the Company with the Commission; or (iii) will not result in any violation of any law, administrative regulation or administrative or court decree applicable to the Company or any subsidiary.

(x) Neither the Company nor any Guarantor is, or after receipt of payment for the Securities will be, an "investment company" within the meaning of Investment Company Act.

(xi) Assuming the accuracy of the representations, warranties and covenants of the Company and the Initial Purchasers contained herein, no registration of the Notes or the Guarantees under the Securities Act, and no qualification of an indenture under the Trust Indenture Act with respect thereto, is required in connection with the purchase of the Securities by the Initial Purchasers or the initial resale of the Securities by the Initial Purchasers in the manner contemplated by the Purchase Agreement and the Pricing Disclosure Package and the Final Offering Memorandum. Such counsel need express no opinion, however, as to when or under what circumstances any Notes initially sold by the Initial Purchasers may be reoffered or resold.

In rendering such opinion, such counsel may rely as to matters involving the application of laws of any jurisdiction other than the General Corporation Law of the State of Delaware, the laws of the State of California or the federal law of the United States, to the extent they deem proper and specified in such opinion, upon the opinion (which shall be dated the Closing Date shall be satisfactory in form and substance to the Initial Purchasers, shall expressly state that the Initial Purchasers may rely on such opinion as if it were addressed to them and shall be furnished to the Initial Purchasers) of other counsel of good standing whom they believe to be reliable and who are satisfactory to counsel for the Initial Purchasers; provided, however, that such counsel shall further state that they believe that they and the Initial Purchasers are justified in relying upon such opinion of other counsel, and as to matters of fact, to the extent they deem proper, on certificates of responsible officers of the Company and public officials; provided, further, that in rendering the "enforceability" opinions set forth in paragraphs (iv) through (vi) above, such counsel may assume that the outcome of the matters covered by such opinions shall be the same under the laws of the State of California as under the laws of the State of New York.

In addition, such counsel shall state that they have participated in conferences with officers and other representatives of the Company, representatives of the independent public or certified public accountants for the Company and with representatives of the Initial Purchasers at which the contents of the Pricing Disclosure Package and the Final Offering Memorandum and related matters were discussed and, although such counsel is not passing upon and does not assume any responsibility for the accuracy, completeness or fairness of the statements contained in the Pricing Disclosure Package or the Final Offering Memorandum (other than as specified above), on the basis of the foregoing, nothing has come to their attention which would lead them to believe that the Pricing Disclosure Package, as of the Time of Sale, or that the Final Offering Memorandum, as of its date or at the Closing Date, contained or contains an untrue statement of a material fact or omitted or omits to state a material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading

(it being understood that such counsel need express no belief as to the financial statements or other financial data derived therefrom, included in the Pricing Disclosure Package or the Final Offering Memorandum or any amendments or supplements thereto).

Exhibit A-4

EXHIBIT B

FORM OF OPINION OF JEFFREY D. BARLOW, CHIEF LEGAL OFFICER AND SECRETARY OF THE COMPANY

June 6, 2017

SunTrust Robinson Humphrey, Inc.
303 Peachtree Street, 10th Floor
Atlanta, GA 30308

as Representative of the several Initial Purchasers
named in Schedule A to the Purchase Agreement

Re: Molina Healthcare, Inc. – Issuance of $330,000,000 aggregate principal amount of 4.875% Senior Notes due 2025

Ladies and Gentlemen:

I am Chief Legal Officer and Secretary of Molina Healthcare, Inc., a Delaware corporation (the "Company"). This opinion is being delivered to you pursuant to Section 4(e) of the Purchase Agreement, dated May 22, 2017 (the "Purchase Agreement"), among the Company, the Guarantors party thereto and SunTrust Robinson Humphrey, Inc. (the "Representative"), as representative of the Initial Purchasers named therein (the "Initial Purchasers"), with respect to the Initial Purchasers' purchase of the Securities from the Company as provided in Section 1 of the Purchase Agreement. Capitalized terms used but not defined herein shall be used herein as defined in the Purchase Agreement.

In connection with rendering the opinions set forth herein, I have examined and relied on originals or copies, certified or otherwise identified to my satisfaction, of such corporate and other records, documents and other papers as I have deemed necessary or appropriate to examine for the purpose of this opinion.

In my examination I have assumed the genuineness of all signatures (including endorsements), the legal capacity of natural persons, the authenticity of all documents submitted to me as originals and the conformity to original documents of all documents submitted to me as certified or photostatic copies and the authenticity of the originals of such copies. In making my examination of documents executed by parties other than the Company or a Guarantor, I have assumed that such parties had the power, corporate or other, to enter into and perform all obligations under such documents and have also assumed the due authorization by all requisite action, corporate or other, and execution and delivery by such parties of such documents and the validity and binding effect thereof. As to any facts material to this opinion which I did not independently establish or verify, I have relied upon statements and representations of the Company and its subsidiaries and their respective officers and other representatives and of public officials.

Whenever a statement is qualified by "to my knowledge" or a similar phrase, it refers to my current actual knowledge after reasonable inquiry.

I am admitted to the Bar in the State of California. I express no opinion as to the laws of any jurisdiction other than (i) the laws of the State of California, (ii) the General Corporation Law of the State of Delaware and (iii) the federal laws of the United States of America to the extent specifically referred to herein.

Based upon the foregoing and subject to the limitations, qualifications, exceptions and assumptions set forth herein, I am of the opinion that:

(i) The Company has been duly incorporated and is validly existing as a corporation in good standing under the laws of the State of Delaware. Each of the Guarantors has been duly formed/organized and is validly existing as a corporation or limited liability company, as the case may be, in good standing under the laws of the State of California.

(ii) Each of the Company and the Guarantors has corporate or limited liability company power and authority, as the case may be, necessary to own, lease and operate its properties and to conduct its business as described in the Pricing Disclosure Package and the Final Offering Memorandum and to execute and deliver the Transaction Documents to which it is a party and perform its obligations thereunder.

(iii) Each of the Company and the Guarantors is duly qualified to transact business and is in good standing in each jurisdiction in which such qualification is required, whether by reason of the ownership or leasing of property or the conduct of business, except where the failure so to qualify or to be in good standing would not result in a Material Adverse Effect.

(iv) Each of the Purchase Agreement and the Indenture has been duly authorized, executed and delivered by each of the Company and the Guarantors.

(v) The Notes are in the form contemplated by the Indenture and have been duly authorized by the Company for issuance and sale pursuant to the Purchase Agreement and the Indenture. The Notes have been duly executed and delivered by the Company.

(vi) The Guarantees are in the respective forms contemplated by the Indenture and have been duly authorized for issuance pursuant to the Purchase Agreement and the Indenture. The Guarantees have been duly executed by each of the Guarantors.

(vii) To my knowledge, except as described in the Pricing Disclosure Package and the Final Offering Memorandum, there are not any legal, governmental, or regulatory investigation, action, suit, proceeding, inquiry or investigation, pending to which the Company or any subsidiary is a party, or to which the property of the Company or any subsidiary is subject, before or brought by any court or governmental agency or body, domestic or foreign, which, individually or in the aggregate, could reasonably be expected to result in a Material Adverse Effect, or which would reasonably be expected to materially and adversely affect the properties or assets thereof or the consummation of the transactions contemplated in the Purchase Agreement or the performance by each of the Company and the Guarantors of its obligations thereunder or under any other Transaction Document to which it is a party; and to my knowledge, no such

investigations, actions, suits or proceedings are threatened or contemplated by any governmental or regulatory authority or threatened by others.

(viii) The information in the Pricing Disclosure Package and the Final Offering Memorandum under "Description of Other Indebtedness" and "Description of Notes," to the extent that it constitutes matters of law, summaries of legal matters, legal proceedings or legal conclusions, and the information in the Pricing Disclosure Package and the Final Offering Memorandum (including the documents incorporated therein) under "We operate in an unstable political environment which creates uncertainties with regard to the sources and amounts of our revenues, volatility with regard to the amount of our medical costs, and vulnerability to unforeseen programmatic or regulatory changes.", "The Medicaid Expansion could be reversed.", "The Marketplace could be eliminated, or our continued participation in 2018 could become financially unsustainable.", "Puerto Rico's recent filing for bankruptcy may negatively impact the Commonwealth's ability to pay the amounts due under our Medicaid contract, which may negatively impact our business, financial condition, cash flows, or results of operations.", "If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.", "Our use and disclosure of personally identifiable information and other non-public information, including protected health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm." and "We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.", in each case under the caption "Risk Factors"; and "Management's Discussion and Analysis of Financial Condition and Results of Operations—Health Plans—Business Overview" has been reviewed by me and is correct in all material respects.

(ix) All descriptions in the Pricing Disclosure Package and the Final Offering Memorandum (including the documents incorporated therein) of contracts and other documents to which the Company or its subsidiaries are a party are accurate in all material respects.

(x) No filing with, or authorization, approval, consent, license, order, registration, qualification or decree of, any court or governmental authority or agency, domestic or foreign is necessary or required in connection with the due authorization, execution and delivery of the Transaction Documents or for the offering, issuance, sale or delivery of the Securities.

(xi) The execution, delivery and performance of the Transaction Documents and the consummation of the transactions contemplated in the Transaction Documents and in the Pricing Disclosure Package and the Final Offering Memorandum (including the issuance and sale of the Securities and the use of the proceeds from the sale of the Securities as described in the Pricing Disclosure Package and the Final Offering Memorandum under the caption "Use Of Proceeds") and compliance by each of the Company and the Guarantors with its obligations under the Transaction Documents to which it is a party do not and will not, whether with or without the giving of notice or lapse of time or both, conflict with or constitute a breach of, or default under, or result in the creation or imposition of any lien, charge or encumbrance upon any property or assets of the Company or any subsidiary pursuant to any contract, indenture, mortgage, deed of trust, loan or credit agreement, note, lease or any other agreement or instrument, known to me, to which

the Company or any subsidiary is a party or by which it or any of them may be bound, or to which any of the property or assets of the Company or any subsidiary is subject (except for such conflicts, breaches, defaults or liens, charges or encumbrances that would not have a Material Adverse Effect), nor will such action result in any violation of the provisions of the charter or by-laws of the Company or any subsidiary, or any applicable law, statute, rule, regulation, judgment, order, writ or decree, known to me, of any government, government instrumentality or court, domestic or foreign, having jurisdiction over the Company or any subsidiary or any of their respective properties, assets or operations.

(xii) Neither the Company nor any Guarantor is required, and upon the issuance and sale of the Securities as herein contemplated and the application of the net proceeds therefrom as described in the Pricing Disclosure Package and the Final Offering Memorandum, will be required, to register as an "investment company" under the Investment Company Act of 1940, as amended.

The Company is currently involved in the following legal matters:

Marketplace Risk Corridor Program. On January 19, 2017, the Company filed suit against the United States of America in the United States Court of Federal Claims, Case Number 1:55-cv-01000-UNJ, on behalf of the Company's health plans seeking recovery from the federal government of approximately $52 million in Marketplace risk corridor payments for calendar year 2015. Based upon current estimates, the Company believes its health plans are also owed approximately $90 million in Marketplace risk corridor payments from the federal government for calendar year 2016, and a further nominal amount for calendar year 2014. The lawsuit seeks recovery of all of these unpaid amounts.

Rodriguez v. Providence Community Corrections. On October 1, 2015, seven individuals, on behalf of themselves and all others similarly situated, filed a complaint in the District Court for the Middle District of Tennessee, Nashville Division, Case No. 3:15-cv-01048 (the Rodriquez Litigation), against Providence Community Corrections, Inc. (now known as Pathways Community Corrections, Inc., or PCC). Rutherford County, Tennessee formerly contracted with PCC for the administration of misdemeanor probation, which involved the collection of court costs and fees from probationers. The complaint alleges, among other things, that PCC illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay such amounts. The plaintiffs in the Rodriguez Litigation seek alleged compensatory, treble, and punitive damages, plus attorneys' fees, for alleged federal and state constitutional violations, as well as alleged violations of the Racketeer Influenced and Corrupt Organization Act. PCC's agreement with Rutherford County terminated effective March 31, 2016. On November 1, 2015, one month after the Rodriguez Litigation commenced, the Company acquired PCC from The Providence Service Corporation (Providence) pursuant to a membership interest purchase agreement. In September 2016, the parties to the Rodriguez Litigation accepted a mediation proposal for settlement pursuant to which PCC would pay the plaintiffs $14 million. The parties are in the process of finalizing the settlement agreement. The Company expects to recover the full amount of the settlement under the indemnification provisions of the membership interest purchase agreement with Providence.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of

California Partner Plan, Inc., purportedly turned a “blind eye” to these unlawful practices. On October 22, 2015, the Relator filed a third amended complaint, seeking general and compensatory damages, treble damages, civil penalties, plus interest and attorneys’ fees. On July 11, 2016, the District Court dismissed with prejudice the third amended complaint, without leave to amend. On September 23, 2016, the plaintiff filed an appeal with the Ninth Circuit Court of Appeals. The plaintiff/appellant’s opening brief was filed March 6, 2017, and the defendant/appellee’s opening brief is due June 5, 2017.

Nothing has come to my attention that would lead me to believe that the Pricing Disclosure Package (except for financial statements and schedules and other financial data included therein or omitted therefrom, as to which I make no statement), at the Time of Sale, contained an untrue statement of a material fact or omitted to state a material fact necessary to make the statements therein, in the light of the circumstances under which they were made, not misleading or that the Final Offering Memorandum (except for financial statements and schedules and other financial data included therein or omitted therefrom, as to which I make no statement), at its date and at the date hereof, included or includes an untrue statement of a material fact or omitted or omits to state a material fact necessary in order to make the statements therein, in the light of the circumstances under which they were made, not misleading.

In rendering this opinion, I have relied as to matters of fact (but not as to legal conclusions), to the extent I have deemed proper, on certificates of responsible officers of the Company and public officials.

Very truly yours,

Jeff D. Barlow

Exhibit B-5

ANNEX I

Each Initial Purchaser understands that:

Such Initial Purchaser agrees that it has not offered or sold and will not offer or sell the Securities in the United States or to, or for the benefit or account of, a U.S. person (other than a distributor), in each case, as defined in Rule 902 of Regulation S (i) as part of its distribution at any time and (ii) otherwise until 40 days after the later of the commencement of the offering of the Securities pursuant hereto and the Closing Date, other than in accordance with Regulation S or another exemption from the registration requirements of the Securities Act. Such Initial Purchaser agrees that, during such 40-day restricted period, it will not cause any advertisement with respect to the Securities (including any "tombstone" advertisement) to be published in any newspaper or periodical or posted in any public place and will not issue any circular relating to the Securities, except such advertisements as are permitted by and include the statements required by Regulation S.

Such Initial Purchaser agrees that, at or prior to confirmation of a sale of Securities by it to any distributor, dealer or person receiving a selling concession, fee or other remuneration during the 40-day restricted period referred to in Rule 903 of Regulation S, it will send to such distributor, dealer or person receiving a selling concession, fee or other remuneration a confirmation or notice to substantially the following effect:

> "The Securities covered hereby have not been registered under the U.S. Securities Act of 1933, as amended (the "Securities Act"), and may not be offered and sold within the United States or to, or for the account or benefit of, U.S. persons (i) as part of your distribution at any time or (ii) otherwise until 40 days after the later of the date the Securities were first offered to persons other than distributors in reliance upon Regulation S and the Closing Date, except in either case in accordance with Regulation S under the Securities Act (or in accordance with Rule 144A under the Securities Act or to accredited investors in transactions that are exempt from the registration requirements of the Securities Act), and in connection with any subsequent sale by you of the Securities covered hereby in reliance on Regulation S under the Securities Act during the period referred to above to any distributor, dealer or person receiving a selling concession, fee or other remuneration, you must deliver a notice to substantially the foregoing effect. Terms used above have the meanings assigned to them in Regulation S under the Securities Act."

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph W. White, certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2017 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. I am responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under my supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under my supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report my conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. I have disclosed, based on my most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 2, 2017

/s/ Joseph W. White

Joseph W. White
Interim Chief Executive Officer
Chief Financial Officer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2017 (the "Report"), I, Joseph W. White, Interim Chief Executive Officer and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 2, 2017

/s/ Joseph W. White

Joseph W. White
Interim Chief Executive Officer
Chief Financial Officer

MHI Form 10-Q for the Period Ended March 31, 2017

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2017

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

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Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of April 28, 2017, was approximately 57,004,000.

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MOLINA HEALTHCARE, INC. FORM 10-Q
FOR THE QUARTERLY PERIOD ENDED March 31, 2017

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CROSS-REFERENCE INDEX

FINANCIAL STATEMENTS

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2017	2016
	(In millions, except per-share data) (Unaudited)	
Revenue:		
Premium revenue	$ 4,648	$ 3,995
Service revenue	131	140
Premium tax revenue	111	109
Health insurer fee revenue	—	90
Investment income and other revenue	14	9
Total revenue	4,904	4,343
Operating expenses:		
Medical care costs	4,111	3,588
Cost of service revenue	122	127
General and administrative expenses	439	340
Premium tax expenses	111	109
Health insurer fee expenses	—	58
Depreciation and amortization	39	32
Total operating expenses	4,822	4,254
Operating income	82	89
Other (income) expenses, net:		
Interest expense	26	25
Other income, net	(75)	—
Total other (income) expenses, net	(49)	25
Income before income tax expense	131	64
Income tax expense	54	40
Net income	$ 77	$ 24
Net income per share:		
Basic	$ 1.38	$ 0.44
Diluted	$ 1.37	$ 0.43

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2017	2016
	(Amounts in millions) (Unaudited)	
Net income	$ 77	$ 24
Other comprehensive income:		
Unrealized investment gain	1	9
Less: effect of income taxes	—	3
Other comprehensive income, net of tax	1	6
Comprehensive income	$ 78	$ 30

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	March 31, 2017	December 31, 2016
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,198	$ 2,819
Investments	2,056	1,758
Receivables	1,006	974
Income taxes refundable	—	39
Prepaid expenses and other current assets	142	131
Derivative asset	—	267
Total current assets	6,402	5,988
Property, equipment, and capitalized software, net	447	454
Deferred contract costs	89	86
Intangible assets, net	131	140
Goodwill	620	620
Restricted investments	115	110
Deferred income taxes	10	10
Derivative asset	181	—
Other assets	43	41
	$ 8,038	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,926	$ 1,929
Amounts due government agencies	1,575	1,202
Accounts payable and accrued liabilities	438	385
Deferred revenue	461	315
Income taxes payable	21	—
Current portion of long-term debt	1	472
Derivative liability	—	267
Total current liabilities	4,422	4,570
Senior notes	1,455	975
Lease financing obligations	198	198
Deferred income taxes	11	15
Derivative liability	181	—
Other long-term liabilities	44	42
Total liabilities	6,311	5,800
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 57 shares at March 31, 2017 and December 31, 2016	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	841	841
Accumulated other comprehensive loss	(1)	(2)
Retained earnings	887	810
Total stockholders' equity	1,727	1,649
	$ 8,038	$ 7,449

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2017	2016
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net income	$ 77	$ 24
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	49	44
Deferred income taxes	(5)	30
Share-based compensation	6	7
Amortization of convertible senior notes and lease financing obligations	8	8
Other, net	3	6
Changes in operating assets and liabilities:		
Receivables	(32)	(266)
Prepaid expenses and other assets	(12)	(202)
Medical claims and benefits payable	(3)	255
Amounts due government agencies	373	181
Accounts payable and accrued liabilities	50	205
Deferred revenue	146	(129)
Income taxes	59	(24)
Net cash provided by operating activities	719	139
Investing activities:		
Purchases of investments	(733)	(611)
Proceeds from sales and maturities of investments	433	348
Purchases of property, equipment and capitalized software	(26)	(46)
Increase in restricted investments	(7)	(4)
Net cash paid in business combinations	—	(2)
Other, net	(6)	1
Net cash used in investing activities	(339)	(314)
Financing activities:		
Proceeds from employee stock plans	1	—
Other, net	(2)	2
Net cash (used in) provided by financing activities	(1)	2
Net increase (decrease) in cash and cash equivalents	379	(173)
Cash and cash equivalents at beginning of period	2,819	2,329
Cash and cash equivalents at end of period	$ 3,198	$ 2,156

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Three Months Ended March 31,	
	2017	2016
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (6)	$ (7)
Details of change in fair value of derivatives, net:		
(Loss) gain on 1.125% Call Option	$ (86)	$ 3
Gain (loss) on 1.125% Conversion Option	86	(3)
Change in fair value of derivatives, net	$ —	$ —
Details of business combinations:		
Fair value of assets acquired	$ —	$ (134)
Purchase price amounts accrued/received	—	30
Reversal of amounts advanced to sellers in prior year	—	102
Net cash paid in business combinations	$ —	$ (2)

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (UNAUDITED)

March 31, 2017

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

The Health Plans segment consists of health plans in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of March 31, 2017, these health plans served approximately 4.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs, including business processing, information technology development and administrative services.

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Health Plans Segment Recent Developments

Proposed Medicare Acquisition. In August 2016, we entered into agreements with each of Aetna Inc. and Humana Inc. to acquire certain membership and assets related to their Medicare Advantage business (the Proposed Medicare Acquisition). The Proposed Medicare Acquisition was subject to closing conditions including the completion of the proposed acquisition of Humana by Aetna (the Aetna-Humana Merger). In January 2017, the U.S. District Court for the District of Columbia granted the request made by the U.S. Department of Justice in its civil antitrust lawsuit against Aetna and Humana, to prohibit the Aetna-Humana Merger. In February 2017, the Proposed Medicare Acquisition was terminated by the parties pursuant to the terms of the transaction. Under the termination agreement, we received an aggregate termination fee of $75 million from Aetna and Humana in the first quarter of 2017, which was recorded as other income.

New York Health Plan. On August 1, 2016, we closed on our acquisition of the outstanding equity interests of Today's Options of New York, Inc., which now operates as Molina Healthcare of New York, Inc. The purchase price allocation was completed, and the final purchase price adjustments were recorded in the first quarter of 2017. Such adjustments were insignificant, and the final purchase price was $38 million.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2017.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2016. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2016 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2016 audited consolidated financial statements.

2. Significant Accounting Policies

Revenue Recognition – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into two broad categories discussed in further detail below: 1) “Contractual Provisions That May Adjust or Limit Revenue or Profit;” and 2) “Quality Incentives.”

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), and Medical Cost Corridors: A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $262 million and $272 million at March 31, 2017 and December 31, 2016, respectively, to amounts due government agencies. Approximately $245 million and $244 million of the liability accrued at March 31, 2017 and December 31, 2016, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, our health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at March 31, 2017 and December 31, 2016.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at March 31, 2017 and December 31, 2016.

Retroactive Premium Adjustments: State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies. In the first quarter of 2016, we recorded a retroactive increase to Medicaid premium revenue of approximately $18 million relating to dates of service prior to 2016.

Medicare

Risk Adjustment: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (measured as a member risk score). We estimate our members’ risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members’ health status, risk scores and Centers for Medicare & Medicaid Services (CMS) practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjustment premiums and Medicare Part D settlements were insignificant at March 31, 2017 and December 31, 2016.

Minimum MLR: Additionally, federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described below, and, for receivables, when collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	March 31, 2017			December 31, 2016
	Current Benefit Year	Prior Benefit Years	Total	
	(In millions)			
Risk adjustment	$ (247)	$ (522)	$ (769)	$ (522)
Reinsurance	—	58	58	55
Risk corridor	—	(5)	(5)	(1)
Minimum MLR	(37)	(3)	(40)	(1)

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income.

- Reinsurance: This program was designed to provide reimbursement to insurers for high cost members and ended December 31, 2016; we expect to settle the outstanding receivable balance in 2017.

- Risk corridor: This program was intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by CMS, and ended December 31, 2016; we expect to settle the outstanding payable balance in 2017.

Additionally, the ACA established a Minimum MLR of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2017 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2017.

	Three Months Ended March 31,	
	2017	2016
	(In millions)	
Maximum available quality incentive premium - current period	$ 38	$ 40
Amount of quality incentive premium revenue recognized in current period:		
Earned current period	$ 19	$ 18
Earned prior periods	5	5
Total	$ 24	$ 23
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.5%	0.6%

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), certain compensation, and other general and administrative expenses. The effective tax rate in the first quarter of 2017 decreased significantly, compared with prior year levels, due primarily to the 2017 HIF moratorium.

The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. We recorded a premium deficiency reserve of $30 million as of December 31, 2016 relating to our Marketplace program, which decreased to $22 million as of March 31, 2017.

Recent Accounting Pronouncements

Goodwill Impairment. In January 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-04, *Simplifying the Test for Goodwill Impairment*, which eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. Instead, an impairment charge will be the excess of the carrying amount of the reporting unit, including goodwill, over the fair value of the reporting unit. ASU 2017-04 is effective beginning January 1, 2020; early adoption is permitted for annual and interim goodwill impairment testing dates after January 1, 2017. We intend to early adopt ASU 2017-04 and will apply the provisions of this standard in our interim or annual goodwill impairment tests subsequent to January 1, 2017. We are unable to quantify the impact of adoption to future quarters because the impact of this standard is dependent on the fair value of our reporting units at the time an impairment assessment is performed.

Stock Compensation. In March 2016, the FASB issued ASU 2016-09, *Improvements to Employee Share-Based Payment Accounting*, which amends ASC Topic 718, *Compensation – Stock Compensation*. ASU 2016-09 simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, statutory tax and classification in the statement of cash flows. We adopted ASU 2016-09 in the first quarter of 2017; such adoption did not significantly impact our consolidated financial statements in the first quarter of 2017. In addition, the prior period presentation in the statement of cash flows was not adjusted because such adjustments were insignificant. We are unable to quantify the impact of adoption to future quarters, however, because such impact is dependent on future stock prices which we cannot predict.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require

new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. ASU 2016-02 is effective for us beginning January 1, 2019 and must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. Under this guidance, we will record assets and liabilities relating primarily to our long-term office leases, and are currently evaluating the effect to our consolidated financial statements.

Revenue Recognition. In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*. We intend to adopt this standard and the related modifications on January 1, 2018, using the modified retrospective approach. Under this approach, the cumulative effect of initially applying the guidance will be reflected as an adjustment to beginning retained earnings.

We have determined that the insurance contracts of our Health Plans segment, which comprises the vast majority of our operations, are excluded from the scope of ASU 2014-09 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts.

For our Molina Medicaid Solutions segment, we have determined that certain service revenue and cost of service revenue will no longer be deferred and recognized over the service delivery period. Rather, service revenue will be recognized based on the expected cost plus gross margin method, and cost of service revenue will be recognized as incurred. As of March 31, 2017, we expect the cumulative adjustment for historical periods through March 31, 2017, to increase retained earnings by no more than $50 million. This estimate will be updated in each quarterly and annual report until adoption. We are currently quantifying the effect of adoption in connection with our Other segment.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a significant impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of basic and diluted net income per share:

	Three Months Ended March 31,	
	2017	2016
	(In millions, except net income per share)	
Numerator:		
Net income	$ 77	$ 24
Denominator:		
Denominator for basic net income per share	56	55
Effect of dilutive securities:		
Share-based compensation	—	1
1.125% Warrants [1]	—	1
Denominator for diluted net income per share	56	57
Net income per share: [2]		
Basic	$ 1.38	$ 0.44
Diluted	$ 1.37	$ 0.43

(1) For more information regarding the 1.125% Warrants, refer to Note 9, "Stockholders' Equity."
(2) Source data for calculations in thousands.

4. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs. Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include derivative financial instruments.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of March 31, 2017 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 8, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the three months ended March 31, 2017.

Our financial instruments measured at fair value on a recurring basis at March 31, 2017, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,353	$ —	$ 1,353	$ —
Government-sponsored enterprise securities (GSEs)	209	209	—	—
U.S. treasury notes	193	193	—	—
Municipal securities	152	—	152	—
Asset-backed securities	110	—	110	—
Certificates of deposit	39	—	39	—
Subtotal - current investments	2,056	402	1,654	—
1.125% Call Option derivative asset	181	—	—	181
Total assets measured at fair value on a recurring basis	$ 2,237	$ 402	$ 1,654	$ 181
1.125% Conversion Option derivative liability	$ 181	$ —	$ —	$ 181
Total liabilities measured at fair value on a recurring basis	$ 181	$ —	$ —	$ 181

Our financial instruments measured at fair value on a recurring basis at December 31, 2016, were as follows:

	Total	Level 1	Level 2	Level 3
	(In millions)			
Corporate debt securities	$ 1,179	$ —	$ 1,179	$ —
GSEs	231	231	—	—
U.S. treasury notes	84	84	—	—
Municipal securities	142	—	142	—
Asset-backed securities	69	—	69	—
Certificates of deposit	53	—	53	—
Subtotal - current investments	1,758	315	1,443	—
1.125% Call Option derivative asset	267	—	—	267
Total assets measured at fair value on a recurring basis	$ 2,025	$ 315	$ 1,443	$ 267
1.125% Conversion Option derivative liability	$ 267	$ —	$ —	$ 267
Total liabilities measured at fair value on a recurring basis	$ 267	$ —	$ —	$ 267

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table.

	March 31, 2017		December 31, 2016	
	Carrying Value	Fair Value	Carrying Value	Fair Value
	(In millions)			
5.375% Notes	$ 691	$ 726	$ 691	$ 714
1.125% Convertible Notes	477	705	471	792
1.625% Convertible Notes	287	321	284	344
	$ 1,455	$ 1,752	$ 1,446	$ 1,850

5. Investments

Available-for-Sale Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,354	$ 1	$ 2	$ 1,353
GSEs	210	—	1	209
U.S. treasury notes	193	—	—	193
Municipal securities	153	—	1	152
Asset-backed securities	110	—	—	110
Certificates of deposit	39	—	—	39
	$ 2,059	$ 1	$ 4	$ 2,056

	December 31, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,180	$ 1	$ 2	$ 1,179
GSEs	232	—	1	231
U.S. treasury notes	84	—	—	84
Municipal securities	143	—	1	142
Asset-backed securities	69	—	—	69
Certificates of deposit	53	—	—	53
	$ 1,761	$ 1	$ 4	$ 1,758

The contractual maturities of our investments as of March 31, 2017 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,151	$ 1,151
Due after one year through five years	872	870
Due after five years through ten years	36	35
	$ 2,059	$ 2,056

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three months ended March 31, 2017 and 2016 were insignificant.

We have determined that unrealized losses at March 31, 2017 and December 31, 2016, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2017:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 570	$ 2	341	$ —	$ —	—
GSEs	200	1	83	—	—	—
Municipal securities	84	1	101	—	—	—
	$ 854	$ 4	525	$ —	$ —	—

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2016:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 542	$ 2	378	$ —	$ —	—
GSEs	198	1	73	—	—	—
Municipal securities	101	1	129	—	—	—
	$ 841	$ 4	580	$ —	$ —	—

Held-to-Maturity Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulation in the various states in which we operate, or as needed in the event of insolvency of capitated providers. We have the ability to hold our restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates.

The contractual maturities of our restricted investments, which are designated as held-to-maturity and are carried at amortized cost, which approximates fair value, as of March 31, 2017 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 97	$ 97
Due after one year through five years	18	18
	$ 115	$ 115

6. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	March 31, 2017	December 31, 2016
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,425	$ 1,352
Pharmacy payable	133	112
Capitation payable	36	37
Other	332	428
	$ 1,926	$ 1,929

“Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $131 million and $225 million as of March 31, 2017 and December 31, 2016, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,	
	2017	2016
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 1,929	$ 1,685
Components of medical care costs related to:		
Current period	4,253	3,755
Prior periods	(142)	(167)
Total medical care costs	4,111	3,588
Change in non-risk provider payables	(96)	24
Payments for medical care costs related to:		
Current period	2,683	2,241
Prior periods	1,335	1,116
Total paid	4,018	3,357
Medical claims and benefits payable, ending balance	$ 1,926	$ 1,940
Benefit from prior period as a percentage of:		
Balance at beginning of period	7.4%	10.0%
Premium revenue, trailing twelve months	0.8%	1.2%
Medical care costs, trailing twelve months	0.9%	1.3%

Reinsurance recoverables of $67 million and $61 million as of March 31, 2017 and December 31, 2016, respectively, are included in receivables.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2017 and 2016 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at March 31, 2017 are as follows:

- In the first quarter of 2017, our Marketplace enrollment across all health plans increased over 500,000 members. Due to limited insight into the cost patterns associated with this large number of new Marketplace members, our liability estimates for these members are subject to more than the usual amount of uncertainty.
- At our Florida health plan, claims receipts increased significantly over the last few months due to an increase in the receipt of secondary claims, many of which are not our liability. These claims, known as COBA (coordination of benefits agreement) claims, will either be denied or will have very small paid amounts. For this reason, claims denial rates, amounts paid per claim and other claims indicators will be impacted, making our liability estimates subject to more than the usual amount of uncertainty.
- At our Illinois health plan, we paid a large number of claims in the first quarter of 2017 that had previously been denied and disputed by providers. This has created some distortion in the payment patterns, making our liability estimates subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $142 million for the three months ended March 31, 2017. This amount represents our estimate as of March 31, 2017, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2016 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Puerto Rico health plan, we increased the outpatient claims liability at December 31, 2016 due to a significant increase in pharmacy utilization, which typically indicates that outpatient costs will also be increasing. However, our actual outpatient costs were ultimately lower than our estimates.

- At our California health plan, we increased our claims liability at December 31, 2016 to reflect delays in the processing of paper claims. Subsequent adjudication of those claims has demonstrated that our actual additional claim costs were less than the additional amount we added to the December 31, 2016 liability estimate.
- At our Texas health plan, higher than expected claims recoveries caused our actual costs to be less than expected.

7. Debt

Substantially all of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets (in millions):

	March 31, 2017	December 31, 2016
Current portion of long-term debt:		
1.125% Convertible Notes, net of unamortized discount	$ —	$ 477
Lease financing obligations	1	1
Debt issuance costs	—	(6)
	1	472
Senior notes:		
5.375% Notes	700	700
1.125% Convertible Notes, net of unamortized discount	482	—
1.625% Convertible Notes, net of unamortized premium and discount	289	286
Debt issuance costs	(16)	(11)
	1,455	975
Lease financing obligations	198	198
	$ 1,654	$ 1,645

5.375% Notes due 2022

We have outstanding $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. According to their terms, the guarantees under the 5.375% Notes mirror those of the Credit Facility, defined and described below. See Note 14, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors.

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (Credit Facility), referred to as the First Amendment. As of March 31, 2017, outstanding letters of credit amounting to $6 million reduced our borrowing capacity under the Credit Facility to $494 million. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $650 million. As of March 31, 2017, no amounts were outstanding under the Credit Facility.

In addition to increasing amounts available to borrow under the Credit Facility and extending its term, the First Amendment provided that all guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC, were automatically and unconditionally released from their obligations as guarantors of the Credit Facility and the 5.375% Notes.

The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. In February 2017, we entered into a second amendment to the Credit Facility (the Second Amendment) which modified the Credit Facility’s definition of the earnings measure used in the financial covenant computations to a) allow us to receive credit for risk corridor payments owed to, but not received or accrued by us during 2016; and b) account for the difference between the amount of actual risk transfer payments made or accrued by us during 2016, and the amount of risk transfer payments that would have been due under the federal

government's proposed 2018 risk adjustment payment transfer formula. At March 31, 2017, we were in compliance with all financial and non-financial covenants under the Credit Facility.

Convertible Senior Notes

We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Convertible Notes. We also have outstanding $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Convertible Notes. The 1.125% Convertible Notes are convertible entirely to cash, and the 1.625% Convertible Notes are convertible partially to cash, each prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.125% Convertible Notes and the 1.625% Convertible Notes did not meet their respective stock price triggers in the quarter ended March 31, 2017; therefore, they were not convertible and were reported as non-current as of March 31, 2017.

The 1.625% Convertible Notes have a contractual maturity date in 2044; however, on contractually specified dates beginning in August 2018, holders may require us to repurchase some or all of the 1.625% Convertible Notes, or we may redeem any or all of the 1.625% Convertible Notes.

Cross Default Provisions

The terms of our 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures.

Debt Commitment Letter

In connection with the Proposed Medicare Acquisition, we entered into a debt commitment letter with Barclays Bank PLC (Barclays) in August 2016. Under this debt commitment letter, Barclays agreed to lend us up to $400 million, subject to satisfaction of certain conditions, including consummation of the Proposed Medicare Acquisition. The debt commitment letter automatically terminated in February 2017 as a result of the termination of the Proposed Medicare Acquisition. The costs associated with the debt commitment letter and its termination were reimbursed as described in Note 1, "Basis of Presentation–*Health Plans Segment Recent Developments*."

8. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	March 31, 2017	December 31, 2016
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ —	$ 267
	Non-current assets: Derivative asset	$ 181	$ —
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ —	$ 267
	Non-current liabilities: Derivative liability	$ 181	$ —

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other income, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Convertible Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions

(collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Convertible Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Convertible Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Convertible Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Convertible Notes due upon any conversion of such Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 4, “Fair Value Measurements.”

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Convertible Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 4, “Fair Value Measurements.”

As of March 31, 2017, the 1.125% Call Option and the 1.125% Conversion Option were classified as a non-current asset and non-current liability, respectively, because the 1.125% Convertible Notes were not convertible as of March 31, 2017, as described in Note 7, “Debt.”

9. Stockholders' Equity

Stockholders’ equity increased $78 million during the three months ended March 31, 2017 compared with stockholders’ equity at December 31, 2016. The increase was due to net income of $77 million and $1 million of other comprehensive income.

1.125% Warrants

In connection with the Call Spread Overlay transaction described in Note 8, “Derivatives,” in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. Under certain circumstances, beginning in April 2020, when the price of our common stock exceeds the strike price of the 1.125% Warrants, we will be obligated to issue shares of our common stock subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Stock Incentive Plans

In connection with our equity incentive plans and employee stock purchase plan, approximately 246,000 shares of common stock were purchased or vested, net of shares used to settle employees’ income tax obligations, during the three months ended March 31, 2017.

As of March 31, 2017, there was $39 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 2.4 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 3.8% for non-executive employees as of March 31, 2017.

Restricted and performance stock activity for the three months ended March 31, 2017 is summarized below:

	Restricted Shares	Performance Shares	Total	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2016	577,244	345,656	922,900	$ 58.15
Granted	351,214	—	351,214	49.51
Vested	(208,425)	(107,320)	(315,745)	51.88
Forfeited	(5,061)	—	(5,061)	63.71
Unvested balance as of March 31, 2017	714,972	238,336	953,308	57.02

The total fair value of restricted awards, including those with performance or market conditions, granted during the three months ended March 31, 2017 and 2016 was $17 million and $18 million, respectively. The total fair value of

restricted awards, including those with performance and market conditions, which vested during the three months ended March 31, 2017 and 2016 was $16 million and $32 million, respectively.

10. Segment Information

We have three reportable segments. These segments consist of our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. Our reportable segments are consistent with how we currently manage the business and view the markets we serve.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
Three Months Ended March 31, 2017				
Total revenue [1]	$ 4,771	$ 46	$ 87	$ 4,904
Gross margin	537	4	5	546
Three Months Ended March 31, 2016				
Total revenue [1]	4,201	52	90	4,343
Gross margin	407	6	7	420
Total Assets				
March 31, 2017	6,586	279	1,173	8,038
December 31, 2016	5,897	267	1,285	7,449

(1) Total revenue consists primarily of premium revenue, premium tax revenue and health insurer fee revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments. Inter-segment revenue is insignificant.

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Three Months Ended March 31,	
	2017	2016
	(In millions)	
Gross margin:		
Health Plans	$ 537	$ 407
Molina Medicaid Solutions	4	6
Other	5	7
Total gross margin	546	420
Add: other operating revenues [1]	125	208
Less: other operating expenses [2]	(589)	(539)
Operating income	82	89
Other (income) expenses, net	(49)	25
Income before income tax expense	$ 131	$ 64

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

11. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,527 million at March 31, 2017, and $1,492 million at December 31, 2016. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $273 million and $264 million as of March 31, 2017 and December 31, 2016, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states.

As of March 31, 2017, our health plans had aggregate statutory capital and surplus of approximately $1,722 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,100 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2017. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements.

Legal Proceedings

The health care and Medicaid-related business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Marketplace Risk Corridor Program. On January 19, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, Case Number 1:55-cv-01000-UNJ, on behalf of our health plans seeking recovery from the federal government of approximately $52 million in Marketplace risk corridor payments for calendar year 2015. Based upon current estimates, we believe our health plans are also owed approximately $90 million in Marketplace risk corridor payments from the federal government for calendar year 2016, and a further

nominal amount for calendar year 2014. Our lawsuit seeks recovery of all of these unpaid amounts. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid Marketplace risk corridor payments as of March 31, 2017. We have fully recognized all liabilities due to the federal government that we have incurred under the Marketplace risk corridor program, and have paid all amounts due to the federal government as required.

Rodriguez v. Providence Community Corrections. On October 1, 2015, seven individuals, on behalf of themselves and all others similarly situated, filed a complaint in the District Court for the Middle District of Tennessee, Nashville Division, Case No. 3:15-cv-01048 (the Rodriquez Litigation), against Providence Community Corrections, Inc. (now known as Pathways Community Corrections, Inc., or PCC). Rutherford County, Tennessee formerly contracted with PCC for the administration of misdemeanor probation, which involved the collection of court costs and fees from probationers. The complaint alleges, among other things, that PCC illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay such amounts. The plaintiffs in the Rodriguez Litigation seek alleged compensatory, treble, and punitive damages, plus attorneys' fees, for alleged federal and state constitutional violations, as well as alleged violations of the Racketeer Influenced and Corrupt Organization Act. PCC's agreement with Rutherford County terminated effective March 31, 2016. On November 1, 2015, one month after the Rodriguez Litigation commenced, we acquired PCC from The Providence Service Corporation (Providence) pursuant to a membership interest purchase agreement. In September 2016, the parties to the Rodriguez Litigation accepted a mediation proposal for settlement pursuant to which PCC would pay the plaintiffs $14 million. The parties are in the process of finalizing the settlement agreement. We expect to recover the full amount of the settlement under the indemnification provisions of the membership interest purchase agreement with Providence.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. On October 22, 2015, the Relator filed a third amended complaint, seeking general and compensatory damages, treble damages, civil penalties, plus interest and attorneys' fees. On July 11, 2016, the District Court dismissed with prejudice the third amended complaint, without leave to amend. On September 23, 2016, the plaintiff filed an appeal with the Ninth Circuit Court of Appeals. The plaintiff/appellant's opening brief was filed March 6, 2017, and the defendant/appellee's opening brief is due June 5, 2017.

States' Budgets

From time to time the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. For example, the state of Illinois is operating without a budget for its current fiscal year. As of March 31, 2017, our Illinois health plan served approximately 194,000 members, and recognized premium revenue of approximately $161 million in the first quarter of 2017. As of April 28, 2017, the state of Illinois owed us approximately $80 million for certain January, February and March 2017 premiums.

On May 3, 2017, Puerto Rico's financial oversight board filed for a form of bankruptcy in the U.S. District Court in Puerto Rico under Title III of PROMESA. The Title III provision allows for a court debt restructuring process similar to U.S. bankruptcy protection. To the extent such bankruptcy results in our failure to receive payment of amounts due under our Medicaid contract with the Commonwealth or the inability of the Commonwealth to extend our Medicaid contract at the end of its current term, such bankruptcy could have a material adverse effect on our business, financial condition, cash flows, or results of operations. As of March 31, 2017, the plan served approximately 326,000 members and recorded premium revenue of approximately $183 million in the first quarter of 2017. As of April 28, 2017, the Commonwealth is current with its premium payments.

Employment Agreements and Severance Payments

We entered into amended and restated employment agreements with our former Chief Executive Officer (CEO) and former Chief Financial Officer (CFO) in 2016. On May 2, 2017, their employment was terminated without cause. Under the amended and restated employment agreements, subject to such former executives signing a general waiver and release agreement, they are each entitled to receive 400% of their base salary, a prorated termination bonus (150% of base salary for the former CEO and 125% of base salary for the former CFO), full vesting of equity compensation, and a cash payment for health and welfare benefits.

12. Related Party Transactions

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina and John C. Molina. Under the terms of this provider agreement, the California health plan pays Pacific for medical care Pacific provides to health plan members. For the three months ended March 31, 2017 and 2016, the amounts paid to Pacific were insignificant.

Refer to Note 13, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

13. Variable Interest Entities (VIEs)

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, who is a member of our board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. JMMPC also provides certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our California, Florida, New Mexico, Utah and Washington health plans. These health plans have entered into primary care services agreements with JMMPC, under which the health plans paid $31 million to JMMPC for health care services provided in each of the quarters ended March 31, 2017 and 2016. JMMPC does not have agreements to provide professional medical services with any other entities.

Separately, the primary care services agreements direct our health plans to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described below mitigate the likelihood of significant operating deficits or surpluses, such payments are generally insignificant.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal. For the three months ended March 31, 2017 and 2016, JMMPC paid $13 million and $14 million, respectively, to MMM for clinic administrative services.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities (excluding clinical decisions) that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of March 31, 2017, JMMPC had total assets of $17 million, and total liabilities of $17 million. As of December 31, 2016, JMMPC had total assets of $18 million, and total liabilities of $18 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be insignificant to our consolidated operating results and cash flows for the foreseeable future.

14. Supplemental Condensed Consolidating Financial Information

The 5.375% Notes described in Note 7, "Debt," are fully and unconditionally guaranteed by certain of our 100% owned subsidiaries on a joint and several basis, with certain exceptions considered customary for such guarantees. The 5.375% Notes and the guarantees are effectively subordinated to all of our and our guarantors' existing and future secured debt to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock, if any, of our subsidiaries that do not guarantee the 5.375% Notes.

As discussed in Note 7, “Debt,” the First Amendment to the Credit Facility provided that all guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC, were automatically and unconditionally released from their obligations as guarantors under the Credit Facility and the 5.375% Notes.

The following condensed consolidating financial statements present Molina Healthcare, Inc. (as parent guarantor), the subsidiary guarantors, the subsidiary non-guarantors and eliminations, according to the guarantor structure as assessed at the most recent balance sheet date, March 31, 2017.

CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Three Months Ended March 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 341	$ 48	$ 4,857	$ (342)	$ 4,904
Expenses:					
Medical care costs	4	—	4,107	—	4,111
Cost of service revenue	—	42	80	—	122
General and administrative expenses	297	7	477	(342)	439
Premium tax expenses	—	—	111	—	111
Depreciation and amortization	27	—	12	—	39
Total operating expenses	328	49	4,787	(342)	4,822
Operating income (loss)	13	(1)	70	—	82
Interest expense	26	—	—	—	26
Other income, net	(75)	—	—	—	(75)
Income (loss) before income taxes	62	(1)	70	—	131
Income tax expense	31	—	23	—	54
Net income (loss) before equity in earnings of subsidiaries	31	(1)	47	—	77
Equity in net earnings of subsidiaries	46	(2)	—	(44)	—
Net income (loss)	$ 77	$ (3)	$ 47	$ (44)	$ 77

	Three Months Ended March 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 251	$ 52	$ 4,290	$ (250)	$ 4,343
Expenses:					
Medical care costs	12	—	3,576	—	3,588
Cost of service revenue	—	65	62	—	127
General and administrative expenses	217	(15)	388	(250)	340
Premium tax expenses	—	—	109	—	109
Health insurer fee expenses	—	—	58	—	58
Depreciation and amortization	22	2	8	—	32
Total operating expenses	251	52	4,201	(250)	4,254
Operating income	—	—	89	—	89
Interest expense	25	—	—	—	25
(Loss) income before income taxes	(25)	—	89	—	64
Income tax (benefit) expense	(16)	—	56	—	40
Net (loss) income before equity in earnings of subsidiaries	(9)	—	33	—	24
Equity in net earnings of subsidiaries	33	2	—	(35)	—
Net income	$ 24	$ 2	$ 33	$ (35)	$ 24

CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income (loss)	$ 77	$ (3)	$ 47	$ (44)	$ 77
Other comprehensive income, net of tax	1	—	1	(1)	1
Comprehensive income (loss)	$ 78	$ (3)	$ 48	$ (45)	$ 78

	Three Months Ended March 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 24	$ 2	$ 33	$ (35)	$ 24
Other comprehensive income, net of tax	6	—	5	(5)	6
Comprehensive income	$ 30	$ 2	$ 38	$ (40)	$ 30

CONDENSED CONSOLIDATING BALANCE SHEETS

	March 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 187	$ 19	$ 2,992	$ —	$ 3,198
Investments	86	—	1,970	—	2,056
Receivables	2	41	963	—	1,006
Due from (to) affiliates	155	(7)	(148)	—	—
Prepaid expenses and other current assets	53	22	67	—	142
Total current assets	483	75	5,844	—	6,402
Property, equipment, and capitalized software, net	294	47	106	—	447
Deferred contract costs	—	89	—	—	89
Goodwill and intangible assets, net	56	72	623	—	751
Restricted investments	—	—	115	—	115
Investment in subsidiaries, net	2,722	244	—	(2,966)	—
Deferred income taxes	10	—	—	—	10
Derivative asset	181	—	—	—	181
Other assets	50	3	6	(16)	43
	$ 3,796	$ 530	$ 6,694	$ (2,982)	$ 8,038
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ —	$ —	$ 1,926	$ —	$ 1,926
Amounts due government agencies	—	—	1,575	—	1,575
Accounts payable and accrued liabilities	187	39	212	—	438
Deferred revenue	—	48	413	—	461
Income taxes payable	17	(7)	11	—	21
Current portion of long-term debt	1	—	—	—	1
Total current liabilities	205	80	4,137	—	4,422
Long-term debt	1,653	—	16	(16)	1,653
Deferred income taxes	8	42	(39)	—	11
Derivative liability	181	—	—	—	181
Other long-term liabilities	22	1	21	—	44
Total liabilities	2,069	123	4,135	(16)	6,311
Total stockholders' equity	1,727	407	2,559	(2,966)	1,727
	$ 3,796	$ 530	$ 6,694	$ (2,982)	$ 8,038

	December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
ASSETS					
Current assets:					
Cash and cash equivalents	$ 86	$ 6	$ 2,727	$ —	$ 2,819
Investments	178	—	1,580	—	1,758
Receivables	2	34	938	—	974
Income tax refundable	17	4	18	—	39
Due from (to) affiliates	104	(5)	(99)	—	—
Prepaid expenses and other current assets	58	30	43	—	131
Derivative asset	267	—	—	—	267
Total current assets	712	69	5,207	—	5,988
Property, equipment, and capitalized software, net	301	46	107	—	454
Deferred contract costs	—	86	—	—	86
Goodwill and intangible assets, net	58	73	629	—	760
Restricted investments	—	—	110	—	110
Investment in subsidiaries, net	2,609	246	—	(2,855)	—
Deferred income taxes	10	—	—	—	10
Other assets	48	3	6	(16)	41
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 1	$ —	$ 1,928	$ —	$ 1,929
Amounts due government agencies	—	—	1,202	—	1,202
Accounts payable and accrued liabilities	146	34	205	—	385
Deferred revenue	—	40	275	—	315
Current portion of long-term debt	472	—	—	—	472
Derivative liability	267	—	—	—	267
Total current liabilities	886	74	3,610	—	4,570
Long-term debt	1,173	—	16	(16)	1,173
Deferred income taxes	11	39	(35)	—	15
Other long-term liabilities	19	1	22	—	42
Total liabilities	2,089	114	3,613	(16)	5,800
Total stockholders' equity	1,649	409	2,446	(2,855)	1,649
	$ 3,738	$ 523	$ 6,059	$ (2,871)	$ 7,449

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Three Months Ended March 31, 2017				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash provided by operating activities	$ 144	$ 21	$ 554	$ —	$ 719
Investing activities:					
Purchases of investments	—	—	(733)	—	(733)
Proceeds from sales and maturities of investments	92	—	341	—	433
Purchases of property, equipment and capitalized software	(18)	(5)	(3)	—	(26)
Increase in restricted investments	—	—	(7)	—	(7)
Capital contributions to/from subsidiaries	(106)	1	105	—	—
Dividends to/from subsidiaries	50	—	(50)	—	—
Change in amounts due to/from affiliates	(60)	2	58	—	—
Other, net	—	(6)	—	—	(6)
Net cash used in investing activities	(42)	(8)	(289)	—	(339)
Financing activities:					
Proceeds from employee stock plans	1	—	—	—	1
Other, net	(2)	—	—	—	(2)
Net cash used in financing activities	(1)	—	—	—	(1)
Net increase in cash and cash equivalents	101	13	265	—	379
Cash and cash equivalents at beginning of period	86	6	2,727	—	2,819
Cash and cash equivalents at end of period	$ 187	$ 19	$ 2,992	$ —	$ 3,198

	Three Months Ended March 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Operating activities:					
Net cash (used in) provided by operating activities	$ (38)	$ 23	$ 154	$ —	$ 139
Investing activities:					
Purchases of investments	(35)	—	(576)	—	(611)
Proceeds from sales and maturities of investments	10	—	338	—	348
Purchases of property, equipment and capitalized software	(28)	(14)	(4)	—	(46)
Increase in restricted investments	—	—	(4)	—	(4)
Net cash paid in business combinations	—	(1)	(1)	—	(2)
Capital contributions to/from subsidiaries	(36)	2	34	—	—
Change in amounts due to/from affiliates	23	(5)	(18)	—	—
Other, net	6	(5)	—	—	1
Net cash used in investing activities	(60)	(23)	(231)	—	(314)
Financing activities:					
Other, net	2	—	—	—	2
Net cash provided by financing activities	2	—	—	—	2
Net decrease in cash and cash equivalents	(96)	—	(77)	—	(173)
Cash and cash equivalents at beginning of period	360	13	1,956	—	2,329
Cash and cash equivalents at end of period	$ 264	$ 13	$ 1,879	$ —	$ 2,156

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

FORWARD LOOKING STATEMENTS

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- *the success of our profit improvement and cost-cutting initiatives;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including any potential repeal and replacement of the law, amendment of the law, or move to state block grants for Medicaid;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk transfer requirements, the potential for disproportionate enrollment of higher acuity members, the withdrawal of cost sharing subsidies and/or premium tax credits, the adequacy of agreed rates, and potential disruption associated with market withdrawal;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer, risk corridors, and reinsurance;*
- *management of our medical costs, including our ability to reduce over time the high medical costs commonly associated with new patient populations;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates in new plans, geographies, and programs where we have less experience with patient and provider populations, and also including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the resolution of the Illinois budget impasse and continued payment of all amounts due to our Illinois health plan;*
- *the success of our efforts to retain existing government contracts, including those in Illinois, Washington, Florida, Texas, and New Mexico, and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;*
- *the impact of the recent changes to our executive leadership team;*
- *our ability to manage growth, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our ability to consummate and realize benefits from acquisitions, and to integrate acquisitions;*

- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion cost corridors in California, New Mexico and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, any impact of Puerto Rico's filing for bankruptcy protection under the PROMESA law, payment of all amounts due under our Medicaid contract, the effect of the PROMESA law, and our efforts to better manage the health care costs of our Puerto Rico health plan;*
- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *the continuation and renewal of the government contracts of our health plans, Molina Medicaid Solutions, and Pathways, and the terms under which such contracts are renewed;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to our provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings;*
- *the relatively small number of states in which we operate health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *our failure to comply with the financial or other covenants in our credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of our funds on hand to pay the amounts due upon conversion or maturity of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm; and*
- *increasing competition and consolidation in the Medicaid industry*.

Investors should refer to the section entitled "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2016 and the section entitled "Risk Factors" in this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2016.

ABOUT MOLINA HEALTHCARE

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

OUR GOAL IS TO ACHIEVE OUR MISSION WHILE IMPROVING THE FINANCIAL STRENGTH OF OUR ORGANIZATION.

Non-GAAP Financial Measures

We use non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures.

See further information regarding non-GAAP measures in the "Supplemental Information" section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this report are designated with an asterisk (*).

How We Assess Performance

We derive our revenues primarily from health insurance premiums, and our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio, or MCR. The medical care ratio represents medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. Management's discussion and analysis of the changes in the individual components of gross margin, by reportable segment, is presented in the "Reportable Segments" section of this MD&A.

KEY PERFORMANCE INDICATORS

	Three Months Ended March 31,	
	2017	2016
	(Dollar amounts in millions, except per-share amounts)	
Net income	$ 77	$ 24
Net income per diluted share	$ 1.37	$ 0.43
MCR (1)	88.4%	89.8%
G&A ratio (2)	8.9%	7.8%
Premium tax ratio (1)	2.3%	2.6%
Effective tax rate	41.6%	61.7%
Net profit margin (2)	1.6%	0.6%
Net profit margin excluding acquisition termination fee (2)	0.6%	0.6%
EBITDA*	$ 203	$ 126
Adjusted net income*	$ 83	$ 29
Adjusted net income per diluted share*	$ 1.47	$ 0.51

(1) MCR represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) G&A ratio represents general and administrative expenses as a percentage of total revenue. Net profit margin represents net income as a percentage of total revenue. Net profit margin excluding acquisition termination fee represents net income excluding the acquisition termination fee (net of income taxes at our blended federal and state statutory tax rate of 37%), as a percentage of total revenue.

CONSOLIDATED RESULTS

First Quarter 2017 Compared with First Quarter 2016

Net income per diluted share increased to $1.37 in the first quarter of 2017 compared with $0.43 reported for the first quarter of 2016. Adjusted net income per diluted share* increased to $1.47 in the first quarter of 2017, compared with $0.51 in the first quarter of 2016. Income before income taxes increased $67 million to $131 million in the first quarter of 2017 from $64 million in the first quarter of 2016.

First quarter financial performance was affected by the following developments. See further discussion of these items below in “Health Plans—Financial Performance by Program,” and “Other Consolidated Information.”

- As previously reported, we received a payment of $75 million relating to the termination of a proposed Medicare acquisition, which was recorded as other income in the first quarter of 2017.
- The performance of our Marketplace program was consistent with management’s expectations. See below for further discussion regarding Marketplace premium deficiency reserves.
- The performance of our combined Medicaid and Medicare programs was consistent with management’s expectations, with the exception of the unfavorable prior-period development of medical claims liabilities in Illinois discussed below.
- The G&A ratio was 8.9% in the first quarter of 2017, compared with 7.8% in the first quarter of 2016.
- The effective tax rate in the first quarter of 2017, while consistent with our previously announced full year 2017 Outlook, dropped substantially from prior year levels due primarily to the 2017 HIF moratorium.

TRENDS AND UNCERTAINTIES

ACA and the Marketplace

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, are subject to substantial uncertainty. We are unable to predict with any degree of certainty whether the ACA will be modified or repealed in its entirety, and if it is repealed, what will replace it. Nor are we able to predict when any such changes, if enacted, would become effective.

We continue to advocate for federal policies to stabilize the Marketplace program. We have not committed to operating in the Marketplace in 2018.

Medicaid Contract Re-Procurement

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates. Such dates are subject to change and, in some cases, not yet known to us. Premium revenue is stated in millions.

State Health Plan	Medicaid Program(s)	Membership as of March 31, 2017	Premium Revenue Three Months Ended March 31, 2017	Anticipated Award Date	Anticipated Effective Date
Florida	All	358,000	$ 356	Q1 2018	1/1/2019
Illinois	All	189,000	92	Q3 2017	1/1/2018
New Mexico	All	236,000	297	Q1 2018	1/1/2019
Puerto Rico	All	326,000	183	Unknown	7/1/2018
Texas	ABD	86,000	347	Q4 2017	1/1/2019
Texas	CHIP	26,000	10	Q4 2017	9/1/2018
Washington	All - North Central Region	40,000	24	Q2 2017	1/1/2018

REPORTABLE SEGMENTS

SEGMENT SUMMARY

	Three Months Ended March 31, 2017	Three Months Ended March 31, 2016
	(In millions)	
Segment gross margin:		
Health Plans medical margin [1]	$ 537	$ 407
Molina Medicaid Solutions service margin [2]	4	6
Other [2]	5	7
Total segment gross margin	546	420
Other operating revenues [3]	125	208
Other operating expenses [4]	(589)	(539)
Operating income	82	89
Other (income) expenses, net	(49)	25
Income before income tax expense	131	64
Income tax expense	54	40
Net income	$ 77	$ 24

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.
(3) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.
(4) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

HEALTH PLANS

The Health Plans segment consists of health plans in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of March 31, 2017, these health plans served approximately 4.8 million

members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies.

RECENT DEVELOPMENTS

Refer to Notes to Consolidated Financial Statements, Note 1, “Basis of Presentation” and Note 11, “Commitments and Contingencies—Employment Agreements and Severance Payments.”

BUSINESS OVERVIEW

Health Plans Membership

The following tables set forth our Health Plans membership as of the dates indicated:

	March 31, 2017	December 31, 2016	March 31, 2016
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children’s Health Insurance Program (CHIP)	2,548,000	2,536,000	2,485,000
Marketplace	1,035,000	526,000	630,000
Medicaid Expansion	684,000	673,000	632,000
Aged, Blind or Disabled (ABD)	401,000	396,000	380,000
Medicare-Medicaid Plan (MMP) – Integrated [1]	55,000	51,000	50,000
Medicare Special Needs Plans (Medicare)	43,000	45,000	43,000
	4,766,000	4,227,000	4,220,000
Ending Membership by Health Plan:			
California	765,000	683,000	676,000
Florida	711,000	553,000	576,000
Illinois	194,000	195,000	206,000
Michigan	417,000	391,000	399,000
New Mexico	270,000	254,000	246,000
New York [2]	34,000	35,000	—
Ohio	351,000	332,000	336,000
Puerto Rico	326,000	330,000	339,000
South Carolina	111,000	109,000	102,000
Texas	493,000	337,000	380,000
Utah	172,000	146,000	151,000
Washington	785,000	736,000	672,000
Wisconsin	137,000	126,000	137,000
	4,766,000	4,227,000	4,220,000

(1) MMP members receive both Medicaid and Medicare coverage from Molina Healthcare.
(2) The New York health plan was acquired on August 1, 2016.

Premiums by Program

The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a per member per month (PMPM) basis, for the three months ended March 31, 2017. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 320.00	$ 180.00
Marketplace	150.00	450.00	260.00
Medicaid Expansion	310.00	520.00	400.00
ABD	360.00	1,510.00	1,010.00
MMP – Integrated	1,100.00	3,240.00	2,090.00
Medicare	840.00	1,200.00	1,070.00

FINANCIAL OVERVIEW

In the first quarter of 2017, premium revenue increased by approximately 16%, or $653 million, when compared with the first quarter of 2016. Member months grew by 14% while revenue PMPM increased by 2%.

Medical care costs as a percent of premium revenue decreased to 88.4% in the first quarter of 2017 from 89.8% in the first quarter of 2016. Medical margin increased 32% in the first quarter of 2017 over the first quarter of 2016.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, medical care ratio and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended March 31, 2017						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.7	$ 1,402	$ 182.69	$ 1,304	$ 170.02	93.1%	$ 98
Medicaid Expansion	2.0	817	398.70	689	336.51	84.4	128
ABD	1.2	1,196	1,006.84	1,130	951.32	94.5	66
Total Medicaid	10.9	3,415	312.98	3,123	286.35	91.5	292
MMP	0.2	344	2,088.96	307	1,859.41	89.0	37
Medicare	0.1	138	1,068.20	117	902.67	84.5	21
Total Medicare	0.3	482	1,640.63	424	1,439.20	87.7	58
Excluding Marketplace	11.2	3,897	347.84	3,547	316.62	91.0	350
Marketplace	2.9	751	262.16	564	196.72	75.0	187
	14.1	$ 4,648	$ 330.39	$ 4,111	$ 292.20	88.4%	$ 537

	Three Months Ended March 31, 2016						
	Member Months [1]	Premium Revenue		Medical Care Costs		MCR [2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.4	$ 1,324	$ 178.47	$ 1,198	$ 161.46	90.5%	$ 126
Medicaid Expansion	1.9	679	365.11	574	308.30	84.4	105
ABD	1.2	1,112	961.49	1,041	899.79	93.6	71
Total Medicaid	10.5	3,115	298.51	2,813	269.42	90.3	302
MMP	0.1	340	2,220.68	317	2,070.23	93.2	23
Medicare	0.1	131	1,029.10	124	980.49	95.3	7
Total Medicare	0.2	471	1,681.57	441	1,577.21	93.8	30
Excluding Marketplace	10.7	3,586	334.62	3,254	303.59	90.7	332
Marketplace	1.6	409	251.85	334	205.86	81.7	75
	12.3	$ 3,995	$ 323.73	$ 3,588	$ 290.74	89.8%	$ 407

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid: TANF/CHIP, Medicaid Expansion and ABD

The medical care ratios of the combined TANF/CHIP, Medicaid Expansion and ABD programs increased to 91.5% in the first quarter of 2017 from 90.3% in the first quarter of 2016. The medical care ratios of these programs for the first quarters of both 2017 and 2016 were affected by out-of-period items. During the first quarter of 2017, we recognized approximately $20 million of medical costs at the Illinois health plan related to dates of service in 2016. During the first quarter of 2016, we recognized approximately $18 million of revenue at the Florida health plan related to dates of service in 2015. Absent these items, the MCR for the combined Medicaid programs was approximately 91% for the first quarters of both 2017 and 2016. Although increases in the utilization of services by these members were modest between the first quarter of 2016 and 2017, pharmacy costs increased.

MMP and Medicare

The medical care ratio for these programs, in the aggregate, decreased in the first quarter of 2017 when compared to the first quarter of 2016, partially as a result of lower hospital utilization.

Marketplace

Member months increased 77% in the first quarter of 2017, when compared with the first quarter of 2016, as a result of membership growth primarily in California, Florida and Texas. The medical care ratios of the Marketplace program for the first quarters of both 2017 and 2016 were affected by out-of-period items. In the first quarter of 2017, we recognized a decrease to medical expense of $8 million as a result of a reduction to the premium deficiency reserve established for the Marketplace program at December 31, 2016. The reserve, which was $30 million at December 31, 2016, decreased to $22 million as of March 31, 2017. In the first quarter of 2016, we recognized out-of-period items that reduced medical margin by $30 million. Absent these items, the medical care ratio for the Marketplace program was approximately 76% for the first quarters of both 2017 and 2016.

FINANCIAL PERFORMANCE BY STATE

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended March 31, 2017						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.2	$ 644	$ 286.92	$ 510	$ 227.19	79.2%	$ 134
Florida	2.1	656	316.86	558	269.33	85.0	98
Illinois	0.6	161	276.58	180	310.08	112.1	(19)
Michigan	1.3	393	316.80	339	273.36	86.3	54
New Mexico	0.8	330	406.90	318	392.72	96.5	12
New York (1)	0.1	46	441.19	42	409.63	92.8	4
Ohio	1.1	541	516.00	479	457.14	88.6	62
Puerto Rico	1.0	183	186.51	165	168.18	90.2	18
South Carolina	0.3	105	317.07	98	293.34	92.5	7
Texas	1.4	684	486.96	602	428.55	88.0	82
Utah	0.5	134	264.73	123	242.57	91.6	11
Washington	2.3	642	274.74	581	248.40	90.4	61
Wisconsin	0.4	127	311.30	108	264.53	85.0	19
Other (2)	—	2	—	8	—	—	(6)
	14.1	$ 4,648	$ 330.39	$ 4,111	$ 292.20	88.4%	$ 537

	Three Months Ended March 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 541	$ 273.42	$ 469	$ 236.92	86.7%	$ 72
Florida	1.6	489	295.42	413	249.45	84.4	76
Illinois	0.6	149	267.10	132	236.76	88.6	17
Michigan	1.2	387	320.14	347	287.34	89.8	40
New Mexico	0.7	336	449.52	296	394.77	87.8	40
New York (1)	—	—	—	—	—	—	—
Ohio	1.0	488	489.14	449	450.11	92.0	39
Puerto Rico	1.0	181	176.85	174	170.43	96.4	7
South Carolina	0.3	84	275.97	67	220.78	80.0	17
Texas	1.1	620	580.81	575	538.91	92.8	45
Utah	0.4	114	264.62	102	235.88	89.1	12
Washington	2.0	506	255.41	458	231.18	90.5	48
Wisconsin	0.4	97	250.36	92	238.01	95.1	5
Other (2)	—	3	—	14	—	—	(11)
	12.3	$ 3,995	$ 323.73	$ 3,588	$ 290.74	89.8%	$ 407

(1) The New York health plan was acquired on August 1, 2016.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

MEDICAL CARE COSTS BY TYPE

The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended March 31,					
	2017			2016		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 3,086	$ 219.32	75.1%	$ 2,737	$ 221.77	76.3%
Pharmacy	616	43.76	15.0	525	42.53	14.6
Capitation	324	23.06	7.9	295	23.87	8.2
Direct delivery	22	1.58	0.5	16	1.34	0.5
Other	63	4.48	1.5	15	1.23	0.4
	$ 4,111	$ 292.20	100.0%	$ 3,588	$ 290.74	100.0%

PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.3% in the first quarter of 2017 compared with 2.6% in the first quarter of 2016. This decline was primarily due to the temporary suspension of a Michigan HMO use tax effective January 1, 2017 which was partially offset by a higher California premium tax rate effective July 1, 2016, and significant revenue growth at our Florida health plan, which operates in a state with no premium tax.

HEALTH INSURER FEE (HIF) REVENUE AND EXPENSES

The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there are no HIF revenues or expenses in 2017.

MOLINA MEDICAID SOLUTIONS

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs, including business processing, information technology development and administrative services.

FINANCIAL OVERVIEW

The Molina Medicaid Solutions segment service margin for the three months ended March 31, 2017 and 2016 was insignificant.

OTHER

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Substantially all of Pathways' revenue is derived from contracts with state or local government agencies and government intermediaries, the majority of which are negotiated fee-for-service arrangements. A significant number of these contracts allow the payer to terminate the contract immediately with or without cause.

FINANCIAL OVERVIEW

The Other segment service margin for the three months ended March 31, 2017 and 2016 was insignificant.

OTHER CONSOLIDATED INFORMATION

GENERAL AND ADMINISTRATIVE EXPENSES

The G&A ratio was 8.9% in the first quarter of 2017, compared with 7.8% in the first quarter of 2016. The G&A ratio increased over 2016 primarily due to: 1) increased investment in systems and infrastructure; 2) employee bonuses recorded in 2017 but not in 2016; 3) costs associated with increased Marketplace enrollment in 2017; and 4) the reduction to revenue as a result of the 2017 Health Insurer Fee (HIF) moratorium. We expect our 2017 G&A ratio to be negatively impacted by the severance payments due to our former chief executive officer and former chief financial officer. See Notes to Consolidated Financial Statements, Note 11, “Commitments and Contingencies—Employment Agreements and Severance Payments.”

DEPRECIATION AND AMORTIZATION

Depreciation and amortization, as a percentage of total revenue, was 0.8% in the first quarter of 2017 and 2016.

INTEREST EXPENSE

Interest expense was $26 million for the first quarter of 2017, compared with $25 million for the first quarter of 2016. Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $8 million for both the three months ended March 31, 2017 and 2016.

OTHER INCOME, NET

As described in Notes to Consolidated Financial Statements, Note 1, “Basis of Presentation,” in February 2017, the Proposed Medicare Acquisition was terminated by the parties pursuant to the terms of the transaction. Under the termination agreement, we received an aggregate termination fee of $75 million.

INCOME TAXES

The provision for income taxes was recorded at an effective rate of 41.6% for the first quarter of 2017, compared with 61.7% for the first quarter of 2016. The significant decline in the effective tax rate was primarily a result of 2017 HIF moratorium as described above in “Health Plans—Health Insurer Fee (HIF) Revenue and Expenses.” Management expects the effective tax rate to be approximately 42% for all of 2017.

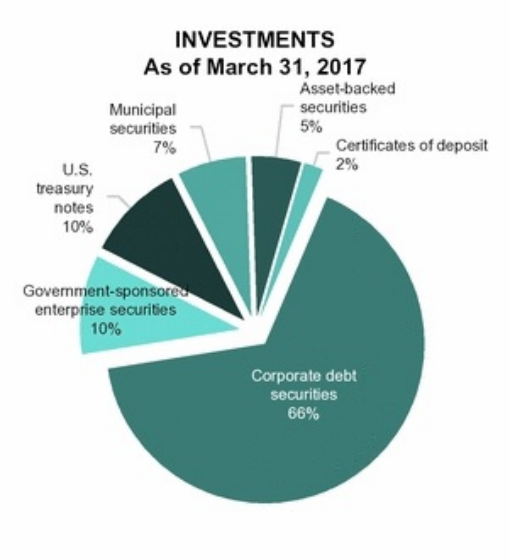
LIQUIDITY AND FINANCIAL CONDITION

INTRODUCTION

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our Health Plans segment regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

Our investments are classified as current assets, except for our restricted investments, which are classified as non-current assets, and which are not included in the totals below. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities. We have the ability to hold our restricted investments until maturity.



Investment income increased to $10 million for the three months ended March 31, 2017, compared with $8 million for the three months ended March 31, 2016, primarily due to the increase in invested assets.

MARKET RISK

Our earnings and financial position are exposed to financial market risk relating changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2017, the fair value of our fixed income investments would decrease by approximately $22 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Note 4, “Fair Value Measurements,” and Note 5, “Investments.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of March 31, 2017, no amounts were outstanding under the Credit Facility.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Three Months Ended March 31,		
	2017	2016	Change
	(In millions)		
Net cash provided by operating activities	$ 719	$ 139	$ 580
Net cash used in investing activities	(339)	(314)	(25)
Net cash (used in) provided by financing activities	(1)	2	(3)
Net increase (decrease) in cash and cash equivalents	$ 379	$ (173)	$ 552

Operating Activities

Cash provided by operating activities increased $580 million in the three months ended March 31, 2017 compared with the three months ended March 31, 2016, primarily due to the following:

Receivables and deferred revenue. In 2017, the aggregate change in receivables and deferred revenue increased cash flows from operations by $509 million. Cash flows from operations in each quarter were impacted by the timing premium revenues receipts. In general, state or federal payors may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, state or federal payors may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in a any given period. In the current quarter, the year-over-year effect of the timing of premiums received at our Florida, Michigan, Ohio, Texas and Washington health plans positively impacted our cash flows from operating activities.

Medical claims and benefits payable. In 2017, the change in medical claims and benefits payable reduced cash flows from operations by $258 million. Reserves for incurred but not paid claims (IBNP) grew at a faster rate in the first quarter of 2016 than in the first quarter of 2017. In addition to the change in IBNP, provider payables, including pass-through amounts, declined in the first quarter of 2017 compared with the first quarter of 2016 primarily due to the timing of payments.

Amounts due government agencies. In 2017, the change in amounts due government agencies increased cash flows from operations by $192 million, due primarily to additional accruals for ACA Marketplace risk transfer payments.

Investing Activities

Net cash used in investing activities increased $25 million in the three months ended March 31, 2017 compared with the three months ended March 31, 2016, primarily due to higher purchases of investments, net of sales and maturities, in the current year.

Financing Activities

There was no significant year over year change in financing activities.

FINANCIAL CONDITION

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at March 31, 2017, our working capital was $1,980 million, compared with $1,418 million at December 31, 2016. At March 31, 2017, our cash and investments amounted to $5,371 million, compared with $4,689 million at December 31, 2016.

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "Ba3" by Moody's Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

FUTURE SOURCES AND USES OF LIQUIDITY

Sources

Our Health Plans segment regulated subsidiaries generate significant cash flows from premium revenue, which we generally receive a short time before we pay for the related health care services. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity.

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. In the three months ended March 31, 2017, we received $50 million in dividends from our regulated health plan subsidiaries. In the three months ended March 31, 2016, we did not receive dividends from our subsidiaries. See further discussion in Note 11, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

Credit Facility. Refer to Note 7, “Debt,” for a detailed discussion of our Credit Facility.

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Uses

Regulatory Capital Requirements and Dividend Restrictions. For more information on our regulatory capital requirements and dividend restrictions, refer to Note 11, “Commitments and Contingencies.”

Acquisitions. In the year ended December 31, 2016, we paid $48 million for businesses or assets acquired in business combinations. Consistent with our business strategy, we will continue to evaluate acquisition opportunities.

States’ Budgets. From time to time the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. For example, the state of Illinois is operating without a budget for its current fiscal year. As of March 31, 2017, our Illinois health plan served approximately 194,000 members, and recognized premium revenue of approximately $161 million in the first quarter of 2017. As of April 28, 2017, the state of Illinois owed us approximately $80 million for certain January, February and March 2017 premiums.

On May 3, 2017, Puerto Rico’s financial oversight board filed for a form of bankruptcy in the U.S. District Court in Puerto Rico under Title III of PROMESA. The Title III provision allows for a court debt restructuring process similar to U.S. bankruptcy protection. To the extent such bankruptcy results in our failure to receive payment of amounts due under our Medicaid contract with the Commonwealth or the inability of the Commonwealth to extend our Medicaid contract at the end of its current term, such bankruptcy could have a material adverse effect on our business, financial condition, cash flows, or results of operations. As of March 31, 2017, the plan served approximately 326,000 members and recorded premium revenue of approximately $183 million in the first quarter of 2017. As of April 28, 2017, the Commonwealth is current with its premium payments.

CONTRACTUAL OBLIGATIONS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2016, was disclosed in our 2016 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the three months ended March 31, 2017. For further discussion and maturities of our long-term debt, refer to Note 7, “Debt.”

INFLATION

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care

cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

COMPLIANCE COSTS

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Notes to Consolidated Financial Statements, Note 6, “Medical Claims and Benefits Payable,” for a table that presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the three months ended March 31, 2017, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2016.

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies.”

- *Molina Medicaid Solutions segment revenue and cost recognition*. There have been no significant changes during the three months ended March 31, 2017, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2016.

- *Goodwill and intangible assets, net.* There have been no significant changes during the three months ended March 31, 2017, to our disclosure reported in “Critical Accounting Estimates” in our Annual Report on Form 10-K for the year ended December 31, 2016.

SUPPLEMENTAL INFORMATION

FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

EBITDA*

We believe that earnings before interest, taxes, depreciation and amortization (EBITDA*) is helpful in assessing our ability to meet the cash demands of our operating units.

	Three Months Ended March 31,	
	2017	2016
	(In millions)	
Net income	$ 77	$ 24
Adjustments:		
Depreciation, and amortization of intangible assets and capitalized software	46	37
Interest expense	26	25
Income tax expense	54	40
EBITDA*	$ 203	$ 126

ADJUSTED NET INCOME* AND ADJUSTED NET INCOME PER SHARE*

We believe that adjusted net income* and adjusted net income per diluted share* are helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net income*.

	Three Months Ended March 31,			
	2017		2016	
	(In millions, except diluted per-share amounts)			
Net income	$ 77	$ 1.37	$ 24	$ 0.43
Adjustment:				
Amortization of intangible assets	9	0.16	7	0.13
Income tax effect [1]	(3)	(0.06)	(2)	(0.05)
Amortization of intangible assets, net of tax effect	6	0.10	5	0.08
Adjusted net income*	$ 83	$ 1.47	$ 29	$ 0.51

(1) Income tax effect of adjustments calculated at the blended federal and state statutory tax rate of 37%.

CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our interim chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), were not effective at the reasonable assurance level because of the material weakness in our internal control over financial reporting described below. Notwithstanding the material weakness described below, management has concluded that our consolidated financial statements included in this interim report on Form 10-Q are fairly stated in all material respects in accordance with U.S. generally accepted accounting principles (GAAP) for each of the periods presented herein.

Existence of a Material Weakness in Internal Control as of December 31, 2016

As disclosed in our Annual Report on Form 10-K for the year ended December 31, 2016, our management assessed the effectiveness of our internal control over financial reporting as of December 31, 2016, based on the framework set forth in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

We determined that a material weakness existed in our internal control over financial reporting relating to the operation of an element of our process for calculating the amount owed to California by our California health plan. More specifically, a Medicaid Expansion contract amendment executed in the fourth quarter of 2016 changed the medical loss ratio corridor formula and such amendment was not initially considered in determining the liability. As a result, we understated net income by $44 million for the year ended December 31, 2016, which was material to our consolidated results for the year ended December 31, 2016. This amount was corrected prior to the issuance of our consolidated financial statements as of and for the year ended December 31, 2016.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of December 31, 2016, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

Remediation Plan for Material Weakness

We are executing the remediation plan developed to address the material weakness reported as of December 31, 2016. The remediation efforts we have implemented include the development of robust protocols to ensure that the control, relating to the review of a contractual amendment affecting the computation of the Medicaid Expansion medical loss ratio corridor for our California health plan, is operating as designed. We believe these measures will remediate the material weakness identified above and will strengthen our internal control over financial reporting for the computation of our California Medicaid Expansion medical loss ratio corridor. We currently are targeting to complete the implementation of the control enhancements during 2017. We will test the ongoing operating effectiveness of the control enhancements subsequent to implementation, and consider the material weakness remediated after the applicable remedial control enhancements operate effectively for a sufficient period of time. If the remedial measures described above are insufficient to address the material weakness described above, or are not implemented timely, or additional deficiencies arise in the future, material misstatements in our interim or annual financial statements may occur in the future and could have the effects described in “Risk Factors” in our Annual Report on Form 10-K for the year ended December 31, 2016.

Changes in Internal Control Over Financial Reporting: Except as described above, management did not identify any change in our internal control over financial reporting during the fiscal quarter ended March 31, 2017 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

LEGAL PROCEEDINGS

For information regarding legal proceedings, see Notes to Consolidated Financial Statements, Note 11, “Commitments and Contingencies.”

RISK FACTORS

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in “Risk Factors,” in our Annual Report on Form 10-K for the year ended December 31, 2016. The risk factors described herein, and in our 2016 Annual Report on Form 10-K, are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

The recent changes to our executive leadership team could prove disruptive to our operations and have adverse consequences for our business and operating results.

We recently had significant changes to our executive leadership team, and more changes could occur. On May 2, 2017, we announced the termination without cause of Joseph M. Molina, our President and Chief Executive Officer, and John C. Molina, our Chief Financial Officer, and the appointment of Joseph W. White as Chief Financial Officer and interim President and Chief Executive Officer. We expect that Dr. Molina and Mr. Molina will continue to serve as members of our board of directors.

Although the Board of Directors is conducting a search for a new President and Chief Executive Officer, there can be no assurance that we will be successful in identifying and retaining a suitable President and Chief Executive Officer in a timely fashion, or at all. It may also be more difficult for us to recruit and retain other managerial employees until a permanent President and Chief Executive Officer has been appointed. The recent changes to our executive leadership team could create uncertainty in the market and among our employees, business partners, and the various states with which we contract, and could make it more difficult for us to implement, or could delay the implementation of, our strategic initiatives, all of which could have a material adverse effect on our business, prospects, financial condition and operating results.

Puerto Rico’s recent filing for bankruptcy may negatively impact the Commonwealth’s ability to pay the amounts due under our Medicaid contract, which may negatively impact our business, financial condition, cash flows, or results of operations.

On May 3, 2017, Puerto Rico’s financial oversight board filed for a form of bankruptcy in the U.S. District Court in Puerto Rico under Title III of PROMESA. The Title III provision allows for a court debt restructuring process similar to U.S. bankruptcy protection. To the extent such bankruptcy results in our failure to receive payment of amounts due under our Medicaid contract with the Commonwealth or the inability of the Commonwealth to extend our Medicaid contract at the end of its current term, such bankruptcy could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

ISSUER PURCHASES OF EQUITY SECURITIES

Purchases of common stock made by us, or on our behalf during the quarter ended March 31, 2017, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
January 1 - January 31	14,147	$ 58.47	—	$ —
February 1 - February 28	511	$ 57.42	—	$ —
March 1 - March 31	114,777	$ 49.10	—	$ —
Total	129,435	$ 50.16	—	

(1) During the three months ended March 31, 2017, we withheld 129,435 shares of common stock under our 2011 Equity Incentive Plan to settle employee income tax obligations.

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INDEX TO EXHIBITS

Exhibit No.	Title
10.1	Molina Healthcare, Inc. Change in Control Severance Plan (2017)
10.2	2011 Equity Incentive Plan - Form of Stock Option Agreement (Director)
10.3	2011 Equity Incentive Plan - Form of Restricted Stock Award Agreement (Employee)
10.4	2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 1 (Executive Officer)
10.5	2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 2 (Executive Officer)
31.1	Certification of Interim Chief Executive Officer and Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Interim Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 4, 2017

/s/ JOSEPH W. WHITE

Joseph W. White
Interim Chief Executive Officer
(Principal Executive Officer)

Dated: May 4, 2017

/s/ JOSEPH W. WHITE

Joseph W. White
Chief Financial Officer and Treasurer
(Principal Financial Officer)

Exhibit 10.1

MOLINA HEALTHCARE, INC.

CHANGE IN CONTROL SEVERANCE PLAN

I. INTRODUCTION

Molina Healthcare, Inc. considers the maintenance of a sound management to be essential to protecting and enhancing the best interests of the Company and its stockholders. Thus, the Company recognizes that the possibility of a Change in Control may exist from time to time, and that this possibility, and the uncertainty and questions it may raise among management, may result in the departure or distraction of management personnel to the detriment of the Company and its stockholders. Accordingly, the Company has determined that appropriate steps should be taken to encourage the continued attention and dedication of members of the Company's management to their assigned duties without the distraction which may arise from the possibility of a Change in Control.

This Change in Control Severance Plan (this "Plan") shall be effective as of May 3, 2017 (the "Effective Date"). This Plan does not alter the status of Participants as at-will employees of the Company. Just as Participants remain free to leave the employ of the Company at any time, so too does the Company retain its right to terminate the employment of Participants without notice, at any time, for any reason.

However, the Company believes that, both prior to and at the time a Change in Control is anticipated or occurring, it is necessary to have the continued attention and dedication of Participants to their assigned duties without distraction, and this Plan is intended as an inducement for Participants' willingness to continue to serve as employees of the Company (subject, however, to either party's right to terminate such employment at any time). Therefore, should a Participant still be an employee of the Company at the time of a Change in Control, the Company agrees that such Participant shall receive the severance benefits hereinafter set forth in the event the Participant's employment with the Company terminates under the circumstances described below.

II. DEFINITIONS

As used herein the following words and phrases shall have the following respective meanings unless the context clearly indicates otherwise.

(a) Affiliate. Any entity which controls, is controlled by, or is under common control with the Company.

(b) Annual Base Salary. The Participant's annual base salary paid or payable, including any base salary that is subject to deferral, to the Participant by the Company or any of its Affiliates at the rate in effect (or required to be in effect before any diminution that is a basis of the Participant's

termination for Good Reason) on the Date of Termination or immediately prior to the Change in Control if the Participant's annual base salary was higher at such time.

(c) Annual Bonus. The Participant's fiscal year target bonus opportunity.

(d) Applicable Multiple.

(i) With respect to any Participant who is at or above the level of Senior Vice President, two (2).

(ii) With respect to any Participant who is at or above the level of Vice President, but below the level of Senior Vice President, one (1).

(iii) With respect to any Participant, other than a Participant identified in clause (i) or (ii) of this Section 2(d), one (1).

(e) Board. The Board of Directors of the Company.

(f) Cause. With respect to any Participant:

(i) the Participant's willful engaging in illegal conduct or gross misconduct which is materially and demonstrably injurious to the Company;

(ii) the Participant's material violation of any policy or code of conduct of the Company or any of its Affiliates, and failure to correct (if possible) following notification of such violation;

(iii) the Participant's unauthorized use or disclosure of confidential information or trade secrets;

(iv) the Participant's engaging in competition with the Company;

(v) any material breach by the Participant of his or her fiduciary duty to the Company; or

(vi) the willful and continued failure of the Participant to perform substantially the Participant's duties with the Company or one of its Affiliates to the extent, degree and level of performance as expected of the Participant (other than any such failure resulting from incapacity due to physical or mental illness), after a written demand for substantial performance is delivered to the Participant by the Board or the Chief Executive Officer of the Company which specifically identifies the manner in which the Board or Chief Executive Officer believes that the Participant has not substantially performed the Participant's duties.

(g) Change in Control. The occurrence of any of the following events after the Effective Date:

(i) the acquisition (other than by an Excluded Person), directly or indirectly, in one or more transactions, by any person or by any group of persons, within the meaning of Section 13(d) or 14(d) of the Exchange Act, of beneficial ownership (within the meaning of Rule 13d-3 of the Exchange Act) of more than fifty percent (50%) of either the outstanding shares of common stock or the combined voting power of the Company's outstanding voting securities entitled to vote generally, whether or not the acquisition was previously approved by the existing directors, other than an acquisition that complies with clause (x) of paragraph (ii);

(ii) consummation of a reorganization, merger, or consolidation of the Company or the sale or other disposition of all or substantially all of the Company's assets unless, (x) immediately following such event, all or substantially all of the stockholders of the Company immediately prior to such event own, directly or indirectly, more than fifty percent (50%) of the then outstanding voting securities of the resulting company (including without limitation, a corporation which as a result of such event owns the Company or all or substantially all of the Company's assets either directly or indirectly through one or more subsidiaries);

(iii) the complete liquidation or dissolution of the Company; or

(iv) a change in the composition of a majority of the directors on the Company's Board within twelve (12) months if not approved by a majority of the pre-existing directors.

A transaction shall not constitute a Change in Control if its sole purpose is to change the state of the Company's incorporation or to create a holding company that will be owned in substantially the same proportions by the persons who held the Company's securities immediately before such transaction.

(h) Code. The Internal Revenue Code of 1986, as amended from time to time.

(i) Committee. The Compensation Committee of the Board.

(j) Company. Molina Healthcare, Inc., a Delaware corporation, and any successor thereto.

(k) Date of Termination. The Date of Termination shall mean:

(i) except in the case of the Participant's termination of employment by reason of death or Disability, the date of receipt of the Notice of Termination by the Company or the Participant, as the case may be, or such later date specified in the Notice of Termination, as the case may be;

(ii) if the Participant's employment is terminated by reason of death, the date of death; or

(iii) if the Participant's employment is terminated by reason of Disability, the thirtieth (30th) day after receipt of such Notice of Termination by the Participant.

Notwithstanding the foregoing, in no event shall the Date of Termination occur until the Participant experiences a "separation from service" within the meaning of Section 409A, and the date on which such separation from service takes place shall be the "Date of Termination."

(l) Disability. A condition such that the Participant by reason of physical or mental disability becomes unable to perform Participant's normal duties for more than one-hundred eighty (180) days in the aggregate (excluding infrequent or temporary absence due to ordinary transitory illness) during any twelve (12)-month period.

(m) Effective Date. The Effective Date shall be as defined in the introductory section hereof.

(n) Employee. Any full-time, regular employee of the Company or any of its Subsidiaries whose employment is not the subject of a collective bargaining agreement, including any such employees who may be on a leave of absence approved by the Company or any of its Subsidiaries, respectively.

(o) ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time.

(p) Exchange Act. The Securities Exchange Act of 1934.

(q) Excluded Person. "Excluded Person" means:

(i) any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act;

(ii) the Company;

(iii) an employee benefit plan (or related trust) sponsored or maintained by the Company or its successor; or

(iv) any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than fifteen percent (15%) of the common stock of the Company on the Effective Date (or any affiliate, successor, heir, descendant, or related party of or to such person).

(r) Good Reason. The occurrence of any one (1) or more of the following, without the express written consent of the Participant:

(i) the Participant's position, authority, duties or responsibilities are materially diminished from those in effect during the ninety (90)-day period immediately preceding a Change in Control (whether or not occurring solely as a result of the Company ceasing to be a publicly traded entity);

(ii) a material reduction in the Participant's (x) Annual Base Salary or (y) total annual compensation opportunity, from such total annual compensation opportunity as in effect during the ninety (90)-day period immediately prior to the Change in Control, or as the same may be increased from time to time;

(iii) the Company requires the Participant regularly to perform such Participant's duties of employment beyond a fifty (50) mile radius from the location of the Participant's employment immediately prior to the Change in Control; or

(iv) a material breach by the Company of the terms of a Participant's written employment agreement.

In order to invoke a termination of employment for Good Reason, the Participant shall provide a Notice of Termination pursuant to Section 7.4 to the Company's Chief Legal Officer of the existence of one or more of the conditions described in clauses (i) through (iv) within ninety (90) days following the initial existence of such condition or conditions, specifying in reasonable detail the conditions constituting Good Reason (hereinafter, "Notice of Good Reason"), and the Company shall have thirty (30) days following receipt of such written notice (the "Cure Period") during which it may remedy the condition. In the event that the Company fails to remedy the condition constituting Good Reason during the applicable Cure Period, the effective date of the Participant's Termination of Employment shall be as specified in such notice, but in no event later than thirty (30) days thereafter. The Participant's mental or physical incapacity following the occurrence of an event described above in clauses (i) through (iv) shall not affect the Participant's ability to terminate employment for Good Reason and the Participant's death following delivery of a Notice of Good Reason shall not affect the Participant's estate's entitlement to Separation Benefits provided hereunder.

(s) Notice of Termination.

(i) In the case of the Company, a written notice that (x) indicates the basis under the Plan for termination and (y) to the extent applicable, sets forth in reasonable detail the facts and circumstances claimed to provide a basis for termination of the Participant's employment under the Plan, as indicated. The failure by the Company to set forth in the Notice of Termination any fact or circumstance that contributes to a showing of Good Reason or Cause shall not waive any right of the Company hereunder or preclude the Company, respectively, from asserting such fact or circumstance in enforcing the Company's respective rights hereunder.

(ii) In the case of a Participant, a notice from a Participant to the Company that shall indicate the specific termination provision or provisions of the Plan relied upon and shall set forth in reasonable detail the facts and in the case of a Notice of Termination for Good Reason, the circumstances claimed to provide a basis for termination for Good Reason. Such Notice of Termination for Good Reason must be given no later than ninety (90) days from the initial existence of the condition and shall provide for a date of termination not less than thirty (30) nor more than sixty (60) days after the date such Notice of Termination for Good Reason is delivered to and acknowledged by the General Counsel of the Company.

(t) Participant. An individual who qualifies to participate in this Plan pursuant to Section 3.1.

(u) Qualifying Termination. At any time following a Change in Control and prior to the second (2^{nd}) anniversary of the Change in Control, the Participant's employment with the Company or any of its Subsidiaries is terminated (i) involuntarily for any reason other than Cause, death, or Disability; or (ii) by the Participant for Good Reason.

(v) Section 409A. Section 409A of the Code, and the rules and regulations issued thereunder.

(w) Separation Benefits. The benefits described in Section 4.2 that are provided to qualifying Participants under the Plan.

(x) Subsidiary. Any corporation, limited liability company, or any other entity in which the Company, directly or indirectly, holds a majority of the voting power of such corporation's, limited liability company's, or such other entity's outstanding equity interests.

III. ELIGIBILITY

3.1 Participation. Each Employee (a) who has a position of Vice President or above, or (b) who has a position lower than Vice President, but has been designated in writing as a Participant by the Committee or the Board, shall be a Participant in this Plan. Notwithstanding the foregoing, if a Participant who is eligible to participate in this Plan has entered into an agreement with the Company that provides for benefits in the event of a termination of employment following a Change in Control, such Participant shall be entitled to receive Separation Benefits (or any other benefits under the Plan) only to the extent that such Separation Benefits are in addition to or in excess of the benefits provided under such Participant's agreement with the Company.

3.2 Duration of Participation. The Committee may remove an Employee as a Participant by providing written notice of removal to such Employee; provided that no such removal shall be effective (a) during the one (1) year period following a Change in Control, (b) if effectuated in connection with a potential Change in Control or (c) at such time as the Participant is entitled to

payment of a Separation Benefit or any other amounts payable under the Plan. In addition, a Participant shall cease to be a Participant in the Plan as a result of an amendment or termination of the Plan complying with Article VI of the Plan, or when the Participant ceases to be an Employee or no longer qualifies as a Participant under Section 3.1, unless, at the time the Participant ceases to be an Employee or no longer qualifies as a Participant under Section 3.1, such Participant is entitled to payment of a Separation Benefit or any other amounts payable under the Plan or there has been an event or occurrence constituting Good Reason that would enable the Participant to terminate employment and receive a Separation Benefit. A Participant entitled to payment of a Separation Benefit or any other amounts payable under the Plan shall remain a Participant in the Plan until the full amount of the Separation Benefit and any other amounts payable under the Plan have been paid to the Participant.

IV. SEPARATION BENEFITS

4.1 Terminations of Employment which Give Rise to Separation Benefits under this Plan. Provided that a Participant is in compliance with the terms of this Plan and satisfies all conditions herein, such Participant shall be entitled to Separation Benefits as set forth in Section 4.2 below if the Participant experiences a Qualifying Termination. For purposes of this Plan, any purported termination by the Company or by the Participant shall be communicated by written Notice of Termination to the other in accordance with Section 7.4 hereof and, to the extent applicable, Section 2(s) hereof.

4.2 Separation Benefits.

(a) If a Participant experiences a Qualifying Termination, then the Company shall pay to the Participant, in a lump sum in cash on the sixtieth (60^{th}) day after the Date of Termination, subject to the Participant's compliance with Section 4.2(e) below, the aggregate of the following amounts which benefits, except as provided in Section 7.3 below, shall be in addition to any other benefits to which the Participant is entitled other than by reason of this Plan:

(i) unpaid salary with respect to any paid time off accrued but not taken as of the Date of Termination;

(ii) accrued but unpaid salary through the Date of Termination;

(iii) any earned but unpaid annual incentive bonuses from the fiscal year immediately preceding the year in which the Date of Termination occurs (unless (x) such annual incentive bonus is "nonqualified deferred compensation" within the meaning of Section 409A, in which case such bonus shall be paid at the time that bonuses with respect to such fiscal year are or otherwise would be paid in accordance with the terms of the applicable plan or (y) the Participant has made an irrevocable election under any deferred compensation arrangement subject to

Section 409A to defer any portion of such annual incentive bonuses, in which case any such deferred bonuses shall be paid in accordance with such election);

(iv) an amount equal to the Applicable Multiple times the Participant's Annual Base Salary; and

(v) an amount equal to the Participant's Annual Bonus for the year in which the Participant's employment is terminated based on the number of entire months of such year that have elapsed through the date of the Participant's termination of employment as a fraction of twelve (12).

(b) If the Participant's employment is terminated under circumstances which entitle the Participant to Separation Benefits under this Section 4.2, for a period of twenty-four (24) months following the Date of Termination (the "Benefit Continuation Period"), the Company shall provide the Participant and the Participant's eligible dependents with extended continued health care, dental, and life insurance benefits under the Company's health care, dental and life insurance benefits programs ("Extended Health Coverage"), provided that the Participant complies with all terms and conditions of the applicable plans, including paying an amount equal to the applicable COBRA premiums contributions, based on the coverage elected by the Participant; and provided, further, that, if the Participant becomes reemployed with another employer and becomes eligible to receive health care, dental or life insurance benefits under another employer provided plan, such Extended Health Coverage shall cease. The Company shall pay to Participant an amount equal to the difference between the cost for Extended Health Coverage and the amount the Participant would be required to pay for such coverage as an active employee. Such payment shall be subject to applicable tax withholding. Following the end of the Benefit Continuation Period, the Participant shall be eligible for continued medical and dental coverage as required by Section 4980B of the Code or other applicable law, as if the Participant's employment with the Company had terminated as of the end of such Benefit Continuation Period.

(c) If the Participant is entitled to Separation Benefits under this Plan and notwithstanding anything to the contrary in any equity incentive, stock option, stock appreciation right (SAR), performance units, phantom stock awards, or deferred compensation plan or retirement plan or agreements, then (i) the Participant shall become immediately fully vested in all of the Participant's outstanding restricted stock, stock options, SARs, warrants, performance units, phantom stock, deferred compensation, retirement, or similar plans or agreements of the Company, and (ii) the Participant (or his personal representative if applicable) shall be permitted to exercise any of the Participant's vested stock options/SARs until the earlier of: (i) one (1) year after the Participant's termination of employment, and (ii) the term of such unexercised stock options, warrants, or SARs.

(d) Except as provided in Section 4.2(b), the Participant shall not be required to mitigate the amount of any payment provided for in this Section 4.2 by seeking other employment or otherwise, nor shall the amount of any payment or benefit provided for in this Section 4.2 be reduced by any compensation earned by the Participant as the result of employment by another employer or by retirement benefits paid by the Company after the Date of Termination, or otherwise, or by any set-off, counterclaim, recoupment, or other claim, right or action the Company may have against the Participant or others.

(e) All payments and benefits provided under this Section 4.2 are conditioned on the Participant's continuing compliance with this Plan and the Company's policies. All payments and benefits are also conditioned on, and in consideration for, the following actions being completed no later than sixty (60) days following the Participant's termination of employment: the Participant's execution (and effectiveness) of a release of claims and covenant not to sue substantially in the form provided in Exhibit A, any revocation period required by law has run, and the Participant has not revoked the release of claims and covenant not to sue. In the event a Participant fails to return such release within such time period, or revokes the release, the Participant shall forfeit his benefits hereunder. In the event that the period for consideration or revocation overlaps two (2) tax years, any payment due hereunder shall not commence until the later tax year.

4.3 Limitation on Payments.

(a) Anything in this Plan to the contrary notwithstanding, in the event it shall be determined that any payment or distribution made, or benefit provided, by the Company to or for the benefit of the Participant under this Plan or any other agreement between the Company and the Participant or plan of the Company would constitute a "parachute payment" as defined in Section 280G of the Code, then the benefits payable pursuant to this Plan shall be reduced so that the aggregate present value of all payments in the nature of compensation to (or for the benefit of) the Participant which are contingent on a change of control (as defined in Section 280G(b)(2)(A) of the Code) is One Dollar ($1.00) less than the amount which the Participant could receive without being considered to have received any parachute payment (the amount of this reduction in the benefits payable is referred to herein as the "Excess Amount"). The determination of the amount of any reduction required by this Section 4.3(a) shall be made by a nationally recognized tax counsel selected by the Company, and such determination shall be conclusive and binding on the parties hereto.

(b) Notwithstanding the provisions of Section 4.3(a), if it is established, pursuant to a final determination of a court or an Internal Revenue Service proceeding which has been finally and conclusively resolved, that an Excess Amount was received by the Participant from the Company, then such Excess Amount shall be deemed for all purposes to be a loan to the

Participant made on the date the Participant received the Excess Amount and the Participant shall be obligated to repay such Excess Amount to the Company on demand (but no less than ten (10) days after written demand is received by the Participant) together with interest on the Excess Amount at the "Applicable Federal Rate" (as defined in Section 1274(d) of the Code) from the date of the Participant's receipt of such Excess Amount until the date of such repayment.

V. SUCCESSOR TO COMPANY

This Plan shall inure to the benefit of and be binding upon the Company and its successors. The Company shall require any corporation, entity, individual, or other person who is the successor (whether direct or indirect by purchase, merger, consolidation, reorganization or otherwise) to all or substantially all the business and/or assets of the Company to expressly assume and agree to perform, by a written agreement in form and in substance satisfactory to the Company, all of the obligations of the Company under this Plan. It is a condition of this Plan, and all rights of each person eligible to receive benefits under this Plan shall be subject hereto, that no right or interest of any such person in this Plan shall be assignable or transferable in whole or in part, except by operation of law, including, but not by way of limitation, lawful execution, levy, garnishment, attachment, pledge, bankruptcy, alimony, child support or qualified domestic relations order.

VI. DURATION, AMENDMENT AND TERMINATION

6.1 Duration. Unless earlier terminated pursuant to Section 6.2, if a Change in Control has not occurred, this Plan shall expire three (3) years from the Effective Date; provided, that upon each annual anniversary of the Effective Date (each such annual anniversary a "Renewal Date"), the Plan shall be extended for an additional year, unless pursuant to a resolution adopted by the Board prior to the Renewal Date the Company determines not to so extend the Plan. If a Change in Control occurs while this Plan is in effect, this Plan shall continue in full force and effect for at least one (1) year following such Change in Control, and shall not terminate or expire until after all Participants who become entitled to any payments or benefits hereunder shall have received such payments and benefits in full.

6.2 Amendment or Termination. The Company reserves the right to amend, modify, suspend or terminate the Plan at any time by action of a majority of the Board; provided that no such amendment, modification, suspension or termination that has the effect of reducing or diminishing the right of any Participant shall be effective without the written consent of such Participant for a period of one (1) year following the Change in Control if adopted after a Change in Control or in anticipation of a Change in Control. Any amendment, modification, suspension or termination of this Plan adopted after a Change in Control or in anticipation of a Change in Control shall not affect the right of any Participant to payments or benefits to be paid or provided as a result of events that occur prior to the second anniversary of the Change in Control.

6.3 Procedure for Extension, Amendment or Termination. Any extension, amendment or termination of this Plan by the Board in accordance with this Article VI shall be made by action of the Board in accordance with the Company's charter documents and applicable law.

VII. MISCELLANEOUS

7.1 Default in Payment. Any payment not made within ten (10) days after it is due in accordance with this Plan shall thereafter bear interest, compounded annually, at the U.S. prime rate from time to time then in effect.

7.2 No Assignment. No interest of any Participant or spouse of any Participant or any other beneficiary under this Plan, or any right to receive payment hereunder, shall be subject in any manner to sale, transfer, assignment, pledge, attachment, garnishment, or other alienation or encumbrance of any kind, nor may such interest or right to receive a payment or distribution be taken, voluntarily or involuntarily, for the satisfaction of the obligations or debts of, or other claims against, a Participant or spouse of a Participant or other beneficiary, including for alimony.

7.3 Effect on Other Plans, Agreements and Benefits. Except to the extent expressly set forth herein, any benefit or compensation to which a Participant is entitled under any agreement between the Participant and the Company or any of its Subsidiaries or under any plan maintained by the Company or any of its Subsidiaries in which the Participant participates or participated shall not be modified or lessened in any way, but shall be payable according to the terms of the applicable plan or agreement. Notwithstanding the foregoing, any benefits received by a Participant pursuant to this Plan shall be in lieu of any severance benefits to which the Participant would otherwise be entitled under any general severance policy or other severance plan maintained by the Company and, upon consummation of a Change in Control, Participants in this Plan shall in no event be entitled to participate in any such severance policy or other severance plan maintained by the Company.

7.4 Notice. For the purpose of this Plan, notices and all other communications provided for in this Plan shall be in writing and shall be deemed to have been duly given when actually delivered or mailed by United States registered mail, return receipt requested, postage prepaid, addressed to the Company's Chief Legal Officer at the Company's corporate headquarters address, and to the Participant (at the last address of the Participant on the Company's books and records).

7.5 Employment Status. This Plan does not constitute a contract of employment or impose on the Participant or the Company any obligation for the Participant to remain an Employee or change the status of the Participant's employment or the policies of the Company and its Affiliates regarding termination of employment, nor does it alter or exterminate the agreement that employment is at-will.

7.6 Nondisparagement; Confidentiality. On the Effective Date and thereafter, the Participant agrees that the Participant will not disparage the Company or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. The Participant further agrees that he/she will not direct anyone to make any disparaging oral or written remarks to any third parties. During the Participant's employment and following the Participant's termination of employment for any reason, the Participant agrees to not use or disclose the confidential information or trade secrets of the Company.

7.7 Nonsolicitation. During the Participant's employment with Company and for twelve (12) months after the Participant's termination of employment and payment of the Severance Benefits hereunder, the Participant shall not, directly or indirectly, either as an individual or as an employee, agent, consultant, advisor, independent contractor, general partner, officer, director, stockholder, investor, lender, or in any other capacity whatsoever, of any person, firm, corporation, or partnership, (i) induce or attempt to induce, or hire, any person who at the time of such inducement or hire is an employee of the Company (or who was, within six (6) months prior to such inducement or hire, an employee) to perform work or service for any other person or entity other than the Company, or (ii) through the use of confidential information or trade secrets, solicit customers, suppliers, or clients of the Company to reduce or discontinue their business with the Company or to engage in business with any competing entity.

7.8 Plan Administration. This Plan shall be administered by the Committee; provided that in the event of an impending Change in Control, the Committee may appoint a person (or persons) independent of the third-party effectuating the Change in Control to be the Committee effective upon the occurrence of a Change in Control and such Committee shall not be removed or modified following a Change in Control, other than at its own initiative (the "Independent Committee"). Except as otherwise provided in this Plan, the decision of the Committee (including the Independent Committee) upon all matters within the scope of its authority shall be conclusive and binding on all parties, provided that in the event that no Independent Committee is appointed, any determination by the Committee of whether "Cause" or "Good Reason" exists shall be subject to de novo review.

7.9 Unfunded Plan Status. This Plan is intended to be an unfunded plan maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, within the meaning of Section 401 of ERISA. All payments pursuant to the Plan shall be made from the general funds of the Company and no special or separate fund shall be established or other segregation of assets made to assure payment. No Participant or other person shall have under any circumstances any interest in any particular property or assets of the Company as a result of participating in the Plan. Notwithstanding the foregoing, the Company may (but shall not be obligated to) create one (1) or more grantor trusts, the assets of

which are subject to the claims of the Company's creditors, to assist it in accumulating funds to pay its obligations under the Plan.

7.10 Withholding Taxes. All payments made under this Plan shall be subject to reduction to reflect taxes required to be withheld by law.

7.11 Validity and Severability. The invalidity or unenforceability of any provision of this Plan shall not affect the validity or enforceability of any other provision of this Plan, which shall remain in full force and effect, and any prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

7.12 Section 409A.

(a) General. This Plan is intended to be exempt from the requirements of Section 409A and shall in all respects be administered in accordance with the "short-term deferral" exception in the regulations promulgated under Section 409A. In no event may the Participant, directly or indirectly, designate the calendar year of any payment under this Plan.

(b) In-Kind Benefits and Reimbursements. Notwithstanding anything to the contrary in this Plan, all reimbursements and in-kind benefits provided under this Plan shall be made or provided in accordance with the requirements of the regulations promulgated under Section 409A, including, where applicable, the requirement that (i) any reimbursement is for expenses incurred during the Participant's lifetime (or during a shorter period of time specified in this Plan); (ii) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during a calendar year may not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other calendar year, except, if such benefits consist of the reimbursement of expenses referred to in Section 105(b) of the Code, a maximum, if provided under the terms of the plan providing such medical benefit, may be imposed on the amount of such reimbursements over some or all of the period in which such benefit is to be provided to the Participant as described in Treasury Regulation Section 1.409A-3(i)(1)(iv)(B); (iii) the reimbursement of an eligible expense will be made no later than the last day of the calendar year following the year in which the expense is incurred, provided that the Participant shall have submitted an invoice for such fees and expenses at least ten (10) days before the end of the calendar year next following the calendar year in which such fees and expenses were incurred; and (iv) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit.

(c) Delay of Payments. Notwithstanding any other provision of this Plan to the contrary, if the Participant is considered a "specified employee" for purposes of Section 409A (as determined by the Company in accordance with Section 409A), any payment that constitutes nonqualified deferred compensation within the meaning of Section 409A that is otherwise due to the Participant under this Plan during the six-month period following the Participant's separation

from service (as determined in accordance with Section 409A) on account of the Participant's separation from service shall be accumulated and paid to the Participant on the first (1st) business day after the date that is six (6) months following the Participant's separation from service (the "Delayed Payment Date"). The Participant shall be entitled to interest (at the applicable rate in effect for the month in which the separation from service occurs) on any cash payments so delayed from the scheduled date of payment to the Delayed Payment Date. If the Participant dies during the postponement period, the amounts and entitlements delayed on account of Section 409A shall be paid to the personal representative of the Participant's estate on the first to occur of the Delayed Payment Date or thirty (30) days after the date of the Participant's death.

7.13 Governing Law. The validity, interpretation, construction and performance of this Plan shall in all respects be governed by the laws of Delaware, without reference to principles of conflict of law, except to the extent pre-empted by federal law.

EXHIBIT A

Form of Release of Claims and Covenant Not To Sue

In consideration of the payments and other benefits that Molina Healthcare, Inc., a Delaware corporation (the "Company"), is providing to _____ ("Employee") under the Company's Change in Control Severance Plan, the Employee, on his/her own behalf and on behalf of Employee's representatives, agents, heirs and assigns, waives, releases, discharges and promises never to assert any and all claims, demands, actions, costs, rights, liabilities, damages or obligations of every kind and nature, whether known or unknown, suspected or unsuspected that Employee ever had, now have or might have as of the date of Employee's termination of employment with the Company against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, attorneys, insurers, successors, or assigns (including all such persons or entities that have a current and/or former relationship with the Company) for any claims arising from or related to Employee's employment with the Company, its parent or any of its affiliates and subsidiaries and the termination of that employment.

These released claims also specifically include, but are not limited to, any claims arising under any federal, state and local statutory or common law, such as (as amended and as applicable) Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, the Americans With Disabilities Act, the Employee Retirement Income Security Act, the Family Medical Leave Act, the Equal Pay Act, the Fair Labor Standards Act, the Industrial Welfare Commission's Orders, the California Fair Employment and Housing Act, the California Constitution, the California Government Code, the California Labor Code and any other federal, state or local constitution, law, regulation or ordinance governing the terms and conditions of employment or the termination of employment, and the law of contract and tort and any claim for attorneys' fees.

Furthermore, the Employee acknowledges that this waiver and release is knowing and voluntary and that the consideration given for this waiver and release is in addition to anything of value to which Employee was already entitled. Employee acknowledges that there may exist facts or claims in addition to or different from those which are now known or believed by Employee to exist. Nonetheless, this Agreement extends to all claims of every nature and kind whatsoever, whether known or unknown, suspected or unsuspected, past or present. Employee also expressly waives the provisions of California Civil Code section 1542, which provides: "A general release does not extend to claims which the creditor does not know or suspect to exist in his/her favor at the time of executing the release, which if known by him/her must have materially affected his/her settlement with the debtor." With respect to the claims released in the preceding sentences, the Employee will not initiate or maintain any legal action or proceeding of any kind against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, successors, or assigns (including all such persons or entities that have a current or former relationship with the Company), for the purpose of obtaining any personal relief, nor assist or participate in any such proceedings, including any proceedings brought by any third parties (except as otherwise required or permitted by law). The Employee further acknowledges that he/she has been advised by this writing that:

he/she should consult with an attorney prior to executing this release;

he/she has at least [twenty-one (21) or forty-five (45) days, as required under applicable law] within which to consider this release;

he/she has up to seven (7) days following the execution of this release by the parties to revoke the release; and

this release shall not be effective until such seven (7) day revocation period has expired.

Employee agrees that the release set forth above shall be and remain in effect in all respects as a complete general release as to the matters released.

EMPLOYEE

_____

[Name]

Date:

Exhibit 10.2

MOLINA HEALTHCARE, INC.

Notice of Grant of Stock Option

_____ (the "*Participant*") has been granted an option (the "*Option*") to purchase certain shares of Molina Healthcare, Inc. common stock, par value $0.001 per share (the "*Stock*"), pursuant to the Molina Healthcare, Inc. 2011 Equity Incentive Plan (the "*Plan*"). For purposes of this Option and the Stock Option Agreement incorporated herein by reference (the "*Option Agreement*"), the following terms shall have the following meanings:

Grant Date: **_____, ___**

Number of Option Shares: **_____ shares of Stock**

Exercise Price (per share): **$____**

Expiration Date: **_____, ____**

Tax Status of Option: **_____**

Vested Shares: Except as provided in the Option Agreement and provided that the Participant's Service has not terminated prior to any applicable date set forth below, the number of Vested Shares as of each date set forth below shall be:

Vesting Date	Vested Shares
Initial Vesting Date: _____, _____	**_____**
Plus:	
On each of the [second] and [third] anniversary of the Grant Date thereafter until all Option Shares are Vested Shares	**_____**

By their signatures below, the Company and the Participant each agree that the Option is governed by this Notice and by the provisions of the Plan and the Option Agreement, both of which are attached to and made a part of this document. The Participant acknowledges receipt of a copy of the Plan and the Option Agreement, represents that the Participant has read and is familiar with their provisions and hereby accepts the Option subject to all of their terms and conditions. This Notice may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same document.

MOLINA HEALTHCARE, INC.

_____

[Name]
[Title]

PARTICIPANT

_____

[Name]

ATTACHMENTS: Molina Healthcare, Inc. 2011 Equity Incentive Plan, as amended through the Grant Date, and Stock Option Agreement

Stock Option Agreement Under the
Molina Healthcare, Inc. 2011 Equity Incentive Plan

Pursuant to the Molina Healthcare, Inc. 2011 Equity Incentive Plan (the "*Plan*"), Molina Healthcare, Inc., a Delaware corporation (together with its successors, the "*Company*"), hereby grants to the Participant named in the Notice of Grant of Stock Option attached hereto (the "*Notice*") an option to purchase on such dates as specified herein, all or any part of the number of shares of Stock indicated in the Notice (the "*Option Shares*," and such shares once issued shall be referred to as the "*Issued Shares*," each as adjusted pursuant to Section 5 hereof), at the Exercise Price specified in the Notice, subject to the terms and conditions set forth in this Stock Option Agreement, the Notice and the Plan. All capitalized terms used herein and not otherwise defined shall have the respective meanings set forth in the Notice and the Plan (as applicable).

If this Option is designated as an Incentive Stock Option in the Notice, this Option is intended to qualify as an "*incentive stock option*" as defined in Section 422(b) of the Code. To the extent that any portion of this Option does not so qualify as an Incentive Stock Option or, if this Option is designated as a Non-Qualified Stock Option in the Notice, it shall be deemed a Non-Qualified Stock Option. The Participant should consult with the Participant's own tax advisor regarding the tax effects of this Option (and any requirements necessary to obtain favorable income tax treatment under Section 422 of the Code, including, but not limited to, the holding period requirements).

1. Vesting and Exercisability.

(a) No portion of this Option may be exercised until such portion shall have vested.

(b) Except as set forth below, this Option shall be exercisable at any time on and after the Initial Vesting Date and prior to the Expiration Date or earlier termination of the Option as provided herein and in the Plan, in an amount not to exceed the number of Vested Shares (determined at the time of exercise) less the number of shares previously acquired upon exercise of this Option. In no event shall this Option be exercisable for more than the Number of Option Shares.

(c) In the event that the Participant's Service terminates, this Option may thereafter be exercised, to the extent it was vested and exercisable on the date of such termination, until the date specified in Section 1 (d) hereof. Any portion of this Option that is not vested on the date of termination of the Service shall immediately expire and be null and void.

(d) Subject to the provisions of Section 6 hereof, once any portion of this Option becomes vested and exercisable, it shall continue to be exercisable by the Participant or his or her representatives and legatees as contemplated herein at any time or times prior to the earliest of: (i) the date which is: (A) twelve (12) months following the date on which the Participant's Service terminates due to death or Disability, or (B) three (3) months following the date on which the Participant's Service terminates if the termination is due to any other reason, or (ii) the Expiration Date; provided that, if the Participant's Service is terminated for "*Cause*" (as hereinafter defined), this Option shall terminate immediately and be null and void effective as of the date of the action

or inaction by the Participant that provided the Company "Cause" to terminate his or her employment. For purposes hereof, "*Cause*" shall mean, unless otherwise defined in Participant's employment agreement: (i) any material breach by the Participant of any agreement to which the Participant and the Company (or any Subsidiary Corporation) are parties, including, but not limited to, any agreement containing covenants not to compete and covenants relating to the protection of confidential information and proprietary rights of the Company (or any Subsidiary Corporation), which breach is not cured pursuant to the terms of such agreements, (ii) any act (other than retirement) or omission to act by the Participant which would reasonably be likely to have the effect of injuring the reputation, business or business relationships of the Company (or any Subsidiary Corporation) or on the Participant's ability to perform services for the Company (or any Subsidiary Corporation), (iii) the Participant's conviction (including any pleas of guilty or nolo contendere) of any crime (other than ordinary traffic violations) which impairs the Participant's ability to perform his or her duties, (iv) any material misconduct or willful and deliberate non-performance of duties by the Participant in connection with the business or affairs of the Company (or any Subsidiary Corporation), (v) the Participant's theft, dishonesty, misrepresentation or falsification of the Company's (or any Subsidiary Corporation's) documents or records, (vi) the Participant's improper use or disclosure of the Company's (or any Subsidiary Corporation's) confidential or proprietary information, or (vii) the Participant's use of the facilities or premises of the Company (or any Subsidiary Corporation) to conduct unlawful or unauthorized activities or transactions.

(e) If designated as an Incentive Stock Option in the Notice, the Participant understands that in order to obtain the benefits of an incentive stock option under Section 422 of the Code, subject to any amendments thereof, no sale or other disposition may be made of Issued Shares within the one (1)-year period after the day of issuance of such Issued Shares to him or her (i.e., the exercise date), nor within the two (2)-year period after the grant of this Option and further that this Option must be exercised, if and to the extent permitted hereunder, within three (3) months after termination of employment (or twelve (12) months in the case of Disability). If the Participant disposes of any such Issued Shares (whether by sale, gift, transfer or otherwise) within either of these periods, he or she agrees to notify the Company within thirty (30) days after such disposition. The Participant also agrees to provide the Company with any information concerning any such dispositions required by the Company for tax purposes. Further, to the extent that the aggregate Fair Market Value (determined as of the time that the applicable option is granted) of the shares of Stock with respect to which all Incentive Stock Options held by the Participant are exercisable for the first time during any calendar year (under all option plans of the Company, its Parent and/or its Subsidiaries) exceeds one hundred thousand dollars ($100,000), such Incentive Stock Options shall constitute Non-Qualified Stock Options. For purposes of this Section 1(e), Incentive Stock Options shall be taken into account in the order in which they were granted. If pursuant to the above, an Incentive Stock Option is treated as an Incentive Stock Option in part and a Non-Qualified Stock Option in part, the Participant may designate which portion of the Stock Option the Participant is exercising. In the absence of such designation, the Participant shall be deemed to have exercised the Incentive Stock Option portion of the Stock Option first.

2. Exercise of Option.

(a) The Participant may exercise this Option only by delivering an Option exercise notice (an "*Exercise Notice*") in substantially the form of Appendix A attached hereto to the Company's General Counsel or, if none, the Chief Executive Officer, indicating his or her election to purchase some or all of the Option Shares which have vested at the time of delivery of such Exercise Notice (which amount shall be specified in the Exercise Notice), accompanied by payment in full of the aggregate Exercise Price; provided that, such exercise shall in no event be effective before receipt by such officer of the Exercise Notice and the aggregate Exercise Price. Payment of the aggregate Exercise Price for the Option Shares elected to be purchased by the Participant may be made by one or more of the following methods:

(i) in cash, by certified or bank check, or other instrument acceptable to the Committee in U.S. funds payable to the order of the Company in an amount equal to the aggregate Exercise Price of such Option Shares;

(ii) if permitted by the Committee in its sole and absolute discretion, (y) through the delivery (or attestation to ownership) of shares of Stock with an aggregate Fair Market Value (as of the date such shares are delivered or attested to) equal to the aggregate Exercise Price and that have been purchased by the Participant on the open market or that have been held by the Participant for at least six (6) months and are not subject to restrictions under any plan of the Company, or (z) by the Participant delivering to the Company a properly executed Exercise Notice together with irrevocable instructions to a broker to promptly deliver to the Company cash or a check payable and acceptable to the Company in an amount equal to the aggregate Exercise Price; provided that, in the event the Participant chooses such payment procedure, the Participant and the broker shall comply with such procedures and enter into such agreements of indemnity and other agreements as the Committee shall prescribe as a condition of such payment procedure; or

(iii) a combination of the payment methods set forth in clauses (i) and (ii) above.

(b) Certificates for the Option Shares so purchased will be issued and delivered to the Participant upon compliance to the satisfaction of the Committee with all requirements under applicable laws, regulations or rules in connection with such issuance. Until the Participant shall have complied with the requirements hereof and of the Plan, including the withholding requirements set forth in Section 7 hereof, the Company shall be under no obligation to issue the Option Shares. The determination of the Committee as to such compliance shall be final and binding on the Participant. The Participant shall not be deemed to be the holder of, or to have any of the rights of a holder with respect to, any Issued Shares unless and until this Option shall have been exercised pursuant to the terms hereof and the Company shall have issued and delivered such Issued Shares to the Participant (as evidenced by an appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company.) Thereupon, the Participant shall have full dividend and other ownership rights with respect to such Issued Shares, subject to the terms of this Option Agreement and the Plan.

(c) The Company shall not be required to issue fractional shares upon the exercise of this Option.

3. Subject to Plan.

This Option is subject to all of the terms and conditions set forth in the Plan. Notwithstanding anything in this Option Agreement or the Notice to the contrary, to the extent of any conflict between the terms of the Plan, this Option Agreement and the Notice, the terms of the Plan shall control.

4. Transferability.

This Option is personal to the Participant and is not transferable by the Participant in any manner other than by will or by the laws of descent and distribution; provided that, if this Option is designated as a Non-Qualified Stock Option, this Option may also be transferred by the Participant, without consideration for the transfer, to members of his or her immediate family, to trusts for the benefit of such family members, to partnerships in which such family members are the only partners or to limited liability companies in which such family members are the only members (each a "*Permitted Transferee*"); provided that, the transferee agrees in writing with the Company to be bound by all of the terms and conditions of the Plan and this Option Agreement. This Option may be exercised during the Participant's lifetime only by the Participant (or by the Participant's legal representative or guardian in the event of the Participant's incapacity) or by a Permitted Transferee pursuant to this Section 4. The Participant may elect to designate a beneficiary by providing written notice of the name of such beneficiary to the Company and may revoke or change such designation at any time by filing written notice of revocation or change with the Company. Any such beneficiary may exercise the Participant's Option in the event of the Participant's death to the extent permitted herein. If the Participant does not designate a beneficiary or if the designated beneficiary predeceases the Participant, the executor of the Participant may exercise this Option to the extent permitted herein in the event of the Participant's death.

5. Adjustment Upon Changes in Capitalization.

If, as a result of any reorganization, recapitalization, reclassification, stock dividend, stock split, reverse stock split or other similar change in the Company's capital stock, the outstanding shares of Stock are increased or decreased or are exchanged for a different number or kind of shares or other securities of the Company, or additional shares or new or different shares or other securities of the Company or other non-cash assets are distributed with respect to such shares of Stock or other securities, or, if, as a result of any merger, consolidation or sale of all or substantially all of the assets of the Company, the outstanding shares of Stock are converted into or exchanged for a different number or kind of shares or other securities of the Company or any successor entity (or parent or subsidiary thereof), the Committee in its sole discretion shall make an appropriate or proportionate adjustment in the number and kind of shares or other securities subject to this Option and the Exercise Price, without changing the aggregate Exercise Price (i.e., the Exercise Price multiplied by the number of shares or other securities subject to this Option shall be the same both before and after any adjustment pursuant to this Section 5); provided that, the adjusted Exercise Price may not be less than the par value of the Stock. After any such adjustment, all references

herein to Stock or common stock shall be deemed to refer to the security that is subject to acquisition upon exercise of this Option. The adjustment by the Committee shall be final, binding and conclusive. No fractional shares of Stock shall be issued under the Plan resulting from any such adjustment, but the Committee in its discretion may either make a cash payment in lieu of fractional shares or round any resulting fractional share down to the nearest whole number.

6. Certain Transactions.

Upon the effectiveness of a Change in Control (as defined in the Plan), unless provision is made in connection with the Change in Control for the assumption of a Participant's outstanding Award granted hereunder, or the substitution of such Award with a new Award of the successor entity or parent thereof, with appropriate adjustment as to the number and kind of shares and, if appropriate, the per share exercise and/or repurchase prices, as provided in Section 4.2 of the Plan (the "Assumption"), such Award shall terminate and, if such Award is a Stock Option, the Participant shall be permitted to exercise such Stock Option to the extent that it is then vested and exercisable (after giving effect to the acceleration of vesting provided for in connection with the Change in Control, if any) for a period of at least ten (10) days prior to the date of such termination; provided that, the exercise of the portion of such Stock Option that becomes vested and exercisable in connection with the Change in Control, if any, shall be subject to and conditioned upon the effectiveness of the Change in Control. In addition, if no Awards are assumed or substituted for in an Assumption, this Plan shall terminate upon the effectiveness of such Change in Control. In the Committee's sole and absolute discretion, Award agreements may contain additional terms and conditions, not inconsistent with the foregoing, that will apply in the event a Change in Control occurs.

7. Withholding Taxes.

(a) Payment by Participant. The Participant shall, no later than the date as of which the exercise of this Option (or, if applicable, the issuance, in whole or in part, of any Issued Shares, the operation of any law, regulation or rule providing for the imputation of interest related to this Option or the lapsing of any restriction with respect to any Issued Shares) gives rise to taxable income and subjects the Company to a tax withholding obligation, authorize the Company to withhold from payroll and any other amounts payable to the Participant or pay to the Company or make arrangements satisfactory to the Committee for payment of any federal, state, foreign and local taxes required by law to be withheld with respect to such income.

(b) Payment in Stock. Subject to approval by the Committee, the Participant may elect to have the minimum tax withholding obligation satisfied, in whole or in part, by: (i) authorizing the Company to withhold from shares of Stock to be issued a number of shares of Stock with an aggregate Fair Market Value (as of the date the withholding is effected) that would satisfy the withholding amount due, or (ii) transferring to the Company shares of Stock owned by the Participant with an aggregate Fair Market Value (as of the date the withholding is effected) that would satisfy the withholding amount due. The Fair Market Value of any shares of Stock withheld or tendered to satisfy any such tax withholding obligation shall not exceed the amount determined by the applicable minimum statutory withholding rates.

8. Compliance with Legal Requirements.

The grant of this Option and the issuance of shares of Stock upon exercise of this Option shall be subject to compliance with all applicable requirements of federal, state and foreign law with respect to such securities. This Option may not be exercised if the issuance of shares of Stock upon exercise would constitute a violation of any applicable federal, state or foreign securities laws or other law or regulations or the requirements of any stock exchange or market system upon which the Stock may then be listed. In addition, this Option may not be exercised unless: (a) a registration statement under the Act shall at the time of exercise of this Option be in effect with respect to the shares issuable upon exercise, or (b) the shares issuable upon exercise of this Option may be issued in accordance with the terms of an applicable exemption from the registration requirements of the Act. The inability of the Company to obtain from any regulatory body having jurisdiction the authority, if any, deemed by the Company's legal counsel to be necessary to the lawful issuance and sale of any shares hereunder shall relieve the Company of any liability in respect of the failure to issue or sell such shares as to which such requisite authority shall not have been obtained. As a condition to the exercise of this Option, the Company may require the Participant to satisfy any qualifications that may be necessary or appropriate, to evidence compliance with any applicable law or regulation and to make any representation or warranty with respect thereto as may be requested by the Company.

9. Lock-up Provision.

The Participant and each Permitted Transferee agrees that, if the Company proposes to offer for sale any shares of Stock pursuant to a secondary offering and if requested by the Company and any underwriter engaged by the Company for a reasonable period of time specified by the Company or such underwriter following the effective date of the registration statement filed with respect to such offering, the Participant will not, directly or indirectly, offer, sell, pledge, contract to sell (including any short sale), grant any option to purchase, or otherwise dispose of any securities of the Company held by him or her (except for any securities sold pursuant to such registration statement) or enter into any "*Hedging Transaction*" (as defined below) relating to any securities of the Company held by him or her (including, without limitation, pursuant to Rule 144 under the Act or any successor or similar exemptive rule hereinafter in effect). Notwithstanding the foregoing, such period of time shall not exceed ninety (90) days. For purposes of this Section 9 "*Hedging Transaction*" means any short sale (whether or not against the box) or any purchase, sale or grant of any right (including, without limitation, any put or call option) with respect to any security (other than a broad-based market basket or index) that includes, relates to or derives any significant part of its value from the Stock.

10. Personal Data.

By signing the Notice, the Participant acknowledges and understands that in order to perform its requirements under this Option and the Plan, the Company may process personal data about the Participant, which may or may not be sensitive personal data. Such data includes, but is not limited to, the information provided in this Option, the Notice and any other correspondence received in connection with this Option and any changes thereto, other appropriate personal and financial data about the Participant and information about the Participant's participation in the Plan,

including the timing and extent to which this Option is exercised from time to time. Further, the Participant hereby authorizes the Company to process any such personal data, whether or not sensitive, and to transfer any such personal data outside the country in which Participant works or is employed, including to the United States. Participant acknowledges that the legal persons for whom the Participant's personal data are intended include the Company and any of its Subsidiaries, the outside plan administrator as selected by the Company from time to time and any other person or entity that the Company may find appropriate in its administration of the Plan. The Company hereby informs the Participant of his or her right to access and correction of his or her personal data by contacting the Company's local Human Resources representative.

11. Non-Solicitation.

By signing the Notice, the Participant acknowledges and agrees that during the period of Participant's Service with the Company (or any Subsidiary Corporation), and for a period of one (1) year after termination of Participant's Service for any reason, with or without Cause, Participant shall not directly or indirectly, either alone or in concert with others, solicit, entice, or encourage the hiring of any employee of the Company (or any Subsidiary Corporation) unless such person was involuntarily terminated or laid off by the Company (or any Subsidiary Corporation).

12. Confidentiality.

By signing the Notice, the Participant agrees to keep and maintain in strict confidence all confidential and proprietary information of the Company (or any Subsidiary Corporation) during and after the term of employment by the Company, and to never directly or indirectly make known, divulge, reveal, furnish, make available, or use any confidential information (except in the course of regular authorized duties on behalf of the Company or any Subsidiary Corporation). Participant's obligations of confidentiality hereunder shall survive termination of Participant's Service regardless of any actual or alleged breach by the Company (or any Subsidiary Corporation) in connection with such termination, until and unless any such confidential information shall have become, through no fault of Participant, generally known to the public or unless Participant is required by law to make disclosure (after giving the Company or any Subsidiary Corporation notice and an opportunity to contest such requirement). Participant's obligations under this Section are in addition to and not in limitation or preemption of all other obligations of confidentiality which Participant has to the Company under general legal or equitable principles. All documents and other property including or reflecting confidential information furnished to Participant by the Company or otherwise acquired or developed by the Company shall at all times be the property of the Company (or any Subsidiary Corporation). Upon termination of employment, Participant shall return to the Company (or any Subsidiary Corporation) any such documents or other property (including copies, summaries, or analyses of the foregoing) of the Company (or any Subsidiary Corporation) which are in Participant's possession, custody, or control.

13. Miscellaneous Provisions.

(a) Administration. All questions of interpretation concerning this Option Agreement shall be determined by the Committee. All determinations by the Committee shall be final and binding upon all persons having an interest in this Option.

(b) Employment Rights. The grant of this Option does not confer upon the Participant any right to continued Service with the Company or any Subsidiary Corporation or interfere in any way with the right of the Company or any Subsidiary Corporation to terminate the Participant's Service at any time. Payments you receive pursuant to this Option Agreement shall not be considered to be part of your compensation for purposes of determining benefits under any other employee benefit plan or arrangement provided by the Company or any subsidiary or affiliate thereto.

(c) Equitable Relief. The parties hereto agree and declare that legal remedies may be inadequate to enforce the provisions of this Option Agreement and that equitable relief, including specific performance and injunctive relief, may be used to enforce the provisions of this Option Agreement.

(d) Change and Modifications. The Committee may terminate or amend the Plan or this Option at any time; provided, that, except as provided in Section 3(c) of the Plan in connection with a Change in Control, no such termination or amendment may adversely affect this Option without the consent of the Participant unless such termination or amendment is necessary to comply with any applicable law, rule or regulation or, to the extent that this Option is designated as an Incentive Stock Option, is required to enable this Option to continue to qualify as an Incentive Stock Option.

(e) Governing Law. This Option Agreement shall be governed by and construed in accordance with the laws of the State of California without regard to conflict of laws principles thereof.

(f) Headings. The headings used herein are intended only for convenience in finding the subject matter and do not constitute part of the text of this Option Agreement and shall not be considered in the interpretation of this Option Agreement.

(g) Integrated Agreement. This Option Agreement, the Notice and the Plan constitute the entire understanding and agreement between the Participant and the Company with respect to the subject matter contained herein and supersedes any prior agreements, understandings, restrictions, representations or warranties among the Participant and the Company with respect to such subject matter except as provided for herein. To the extent contemplated herein, the provisions of this Option Agreement shall survive any exercise of this Option and shall remain in full force and effect.

(h) Saving Clause. If any provision of this Option Agreement shall be determined to be illegal or unenforceable, such determination shall in no manner affect the legality or enforceability of any other provision hereof.

(i) Notices. All notices, requests, consents and other communications shall be in writing and be deemed given when delivered personally, by telex or facsimile transmission, or two (2) days after deposit in the mail if mailed by first class registered or certified mail, postage prepaid, or one (1) business day after deposit with a nationally recognized overnight carrier. Notices

to the Company or the Participant shall be addressed to such address or addresses as may have been furnished by such party in writing to the other.

(j) Benefit and Binding Effect. This Option Agreement shall be binding upon and shall inure to the benefit of the parties hereto, their respective successors, permitted assigns, and legal representatives. The Company has the right to assign this Option Agreement and such assignee shall become entitled to all the rights of the Company hereunder to the extent of such assignment.

Appendix A
STOCK OPTION EXERCISE NOTICE

Molina Healthcare, Inc.
300 University Ave., Suite 100
Sacramento, California 95825
Fax: 916-646-4572

Date: _____

Pursuant to the terms of the Notice of Grant of Stock Option dated _____, ___ and the Stock Option Agreement granted pursuant to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and entered into by Molina Healthcare, Inc. and _____ (the Participant) on such date, I hereby exercise such Option by including herein or arranging for payment in the amount of $_____ representing the aggregate exercise price for _____ shares of Molina Healthcare, Inc. common stock, all of which have vested in accordance with the Notice of Grant of Stock Option. I hereby authorize withholding or otherwise will make adequate provision for federal, state, and local tax withholding obligations of the Company, if any, that arise in connection with the Option.

I acknowledge that the shares are being acquired in accordance with and subject to the terms, provisions and conditions of the Plan, the Notice of Grant of Stock Option and the Option Agreement, copies of which I have received and carefully read and understand, to all of which I hereby expressly assent.

Unless I otherwise direct you to deliver to me a physical share certificate, the electronic delivery instructions for the exercised shares are as follows:

Brokerage Firm: _____

DTC Participant Number: _____

Account Number: _____

Contact Name: _____

Contact Email Address: _____

Phone Number: _____

I hereby represent that I am purchasing the shares of common stock for my own account and not with a view to any sale or distribution thereof.

Sincerely yours,

_____

Name:

Exhibit 10.3

Molina Healthcare, Inc. 2011 Equity Incentive Plan
Restricted Stock Award Agreement

This RESTRICTED STOCK AWARD AGREEMENT (the "Agreement") effective as of _____, _____ is between Molina Healthcare, Inc., a Delaware corporation (the "Company"), and _____, an employee of the Company or one of its Affiliates (the "Grantee"), pursuant to and subject to the terms and conditions of the Molina Healthcare, Inc. 2011 Equity Incentive Plan (the "Plan"). The Company desires to award to the Grantee a number of shares of the Company's common stock, par value $.001 per share (the "Common Stock"), subject to certain restrictions as provided in this Agreement, in order to carry out the purpose of the Plan. The purpose of this Agreement is to evidence the terms and conditions of an award of restricted stock granted to the Grantee under the Plan.

Accordingly, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Company and the Grantee hereby agree as follows:

Section 1. Award of Restricted Stock.

Effective as of _____, _____ (the "Effective Date"), the Company grants to the Grantee a restricted stock award of _____ shares of Common Stock (the "Shares"), subject to the terms and conditions set forth in this Agreement and in accordance with the terms of the Plan (the "Restricted Stock Award").

Section 2. Rights with Respect to the Shares.

(a) Stockholder Rights. With respect to the Shares, the Grantee shall be entitled at all times on and after the date of issuance of the Shares to exercise the rights of a stockholder of Common Stock of the Company, including the right to vote the Shares and the right to receive dividends on the Shares as provided in Section 2(b) hereof, unless and until the Shares are forfeited pursuant to Section 3 hereof. However, the Shares shall be nontransferable and subject to a risk of forfeiture to the Company at all times prior to the dates on which such Shares become vested, and the restrictions with respect to the Shares lapse, in accordance with Section 3 of this Agreement.

(b) Dividends. As a condition to receiving the Shares under the Plan, the Grantee hereby agrees to defer the receipt of dividends paid on the Shares. Cash dividends or other cash distributions paid with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms, and conditions as the Shares to which they relate, shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary, and shall be forfeited in the event that the Shares with respect to which the dividends were paid are forfeited.

(c) Issuance of Shares. The Company shall cause the Shares to be issued in the Grantee's name or in a nominee name on the Grantee's behalf, either by book-entry registration or issuance of a stock certificate or certificates evidencing the Shares, which certificate or certificates shall be held by the Secretary of the Company or the stock transfer agent or brokerage service selected by the Secretary of the Company to provide such services for the Plan. The Shares shall be restricted from transfer and shall be subject to an appropriate stop-transfer order. If any certificate is issued, the certificate shall bear an appropriate legend referring to the restrictions applicable to the Shares. The Grantee hereby agrees to the retention by the Company of the Shares and, if a stock certificate is issued, the Grantee agrees to execute and deliver to the Company a blank stock power with respect to the Shares as a condition to the receipt of this Restricted Stock Award. After any Shares vest pursuant to Section 3 hereof, and following payment of the applicable withholding taxes pursuant to Section 6 of this Agreement, the Company shall promptly cause to be issued a certificate or certificates, registered in the Grantee's name, evidencing such vested whole Shares (less any Shares withheld to pay withholding taxes) and shall cause such certificate or certificates to be delivered to

the Grantee free of the legend and the stop-transfer order referenced above. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share at the time certificates evidencing the Shares are delivered to the Grantee.

Section 3. Vesting; Forfeiture.

(a) Vesting. Subject to the terms and conditions of this Agreement, one-fourth (1/4th) of the Shares shall vest, and the restrictions with respect to the Shares shall lapse, on each of the first, second, third, and fourth anniversaries of the Effective Date if the Grantee remains continuously employed by the Company or an Affiliate of the Company until such respective vesting dates.

(b) Forfeiture. If the Grantee ceases to be employed by the Company and all Affiliates of the Company for any reason prior to the vesting of the Shares pursuant to Section 3(a) hereof, Grantee's rights to all of the unvested Shares shall be immediately and irrevocably forfeited, including the right to vote such Shares and the right to receive dividends on such Shares.

(c) No Early Vesting. Unless otherwise determined by the Committee in its sole discretion, in no event will any of the Shares vest prior to their respective vesting dates set forth in Section 3(a) hereof.

Section 4. Restrictions on Transfer.

Until the Shares vest pursuant to Section 3 hereof, neither the Shares, nor any right with respect to the Shares under this Agreement, may be sold, assigned, transferred, pledged, hypothecated (by operation of law or otherwise) or otherwise conveyed or encumbered and shall not be subject to execution, attachment or similar process. Any attempted sale, assignment, transfer, pledge, hypothecation or other conveyance or encumbrance shall be void and unenforceable against the Company or any Affiliate of the Company.

Section 5. Distributions and Adjustments.

(a) If any Shares vest subsequent to any change in the number or character of the Common Stock of the Company through any stock dividend or other distribution, recapitalization, stock split, reverse stock split, reorganization, merger, consolidation, split-up, spin-off, combination, repurchase or exchange of shares or other securities of the Company, issuance of warrants or other rights to purchase shares of Common Stock or other securities of the Company or other similar corporate transaction or event such that an adjustment is determined by the Committee to be appropriate in order to prevent dilution or enlargement of the benefits or potential benefits intended to be made available under this Agreement, then the Committee shall, in such manner as it may deem equitable, in its sole discretion, adjust any or all of the number and type of such Shares.

(b) Any additional shares of Common Stock of the Company, any other securities of the Company and any other property distributed with respect to the Shares prior to the date or dates the Shares vest shall be subject to the same restrictions, terms and conditions as the Shares to which they relate and shall be promptly deposited with the Secretary of the Company or a custodian designated by the Secretary.

Section 6. Taxes.

(a) The Grantee acknowledges that the Grantee will consult with the Grantee's personal tax adviser regarding the income tax consequences of the grant of the Shares, payment of dividends on the Shares, the vesting of the Shares and any other matters related to this Agreement. In order to comply with all applicable federal, state, local or foreign income tax laws or regulations, the Company may take such action as it deems appropriate to ensure that all applicable federal, state, local or foreign payroll, withholding, income or other taxes, which are the Grantee's sole and absolute responsibility, are withheld or collected from the Grantee.

(b) In accordance with the terms of the Plan, and such rules as may be adopted by the Committee administering the Plan, the Grantee may elect to satisfy tax withholding obligations arising from the receipt of, or the lapse of restrictions relating to, the Shares by (i) delivering cash, check, bank draft, money order or wire transfer payable to the order of the Company, (ii) having the Company withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes, or (iii) delivering to the Company shares of Common Stock having a Fair Market Value equal to the amount of such taxes. The Company will not deliver any fractional Share but will pay, in lieu thereof, the Fair Market Value of such fractional Share. The Grantee's election must be made on or before the date that the amount of tax to be withheld is determined. If the Grantee does not make an election, the Company will withhold a portion of the Shares otherwise to be delivered having a Fair Market Value equal to the amount of such taxes.

Section 7. Non-Solicitation.

The Grantee acknowledges and agrees that during the period of Grantee's employment by the Company (or any Subsidiary), and for a period of one (1) year after termination of Grantee's Service Relationship for any reason, with or without Cause, Grantee shall not directly or indirectly, either alone or in concert with others, solicit, entice, or encourage the hiring of any employee of the Company (or any Subsidiary) unless such person was involuntarily terminated or laid off by the Company (or any Subsidiary).

Section 8. Confidentiality.

The Grantee agrees to keep and maintain in strict confidence all confidential and proprietary information of the Company (or any Subsidiary) during and after the term of employment by the Company, and to never directly or indirectly make known, divulge, reveal, furnish, make available, or use any confidential information (except in the course of regular authorized duties on behalf of the Company or any Subsidiary). Grantee's obligations of confidentiality hereunder shall survive termination of employment regardless of any actual or alleged breach by the Company (or any Subsidiary) in connection with such termination, until and unless any such confidential information shall have become, through no fault of Grantee, generally known to the public or unless Grantee is required by law to make disclosure (after giving the Company or any Subsidiary notice and an opportunity to contest such requirement). Grantee's obligations under this Section are in addition to and not in limitation or preemption of all other obligations of confidentiality which Grantee has to the Company under general legal or equitable principles. All documents and other property including or reflecting confidential information furnished to Grantee by the Company or otherwise acquired or developed by the Company shall at all times be the property of the Company (or any Subsidiary). Upon termination of employment, Grantee shall return to the Company (or any Subsidiary) any such documents or other property (including copies, summaries, or analyses of the foregoing) of the Company (or any Subsidiary) which are in Grantee's possession, custody, or control.

Section 9. Definitions.

Terms not defined in this Agreement shall have the meanings given to them in the Plan.

Section 10. Governing Law.

The internal law, and not the law of conflicts, of the State of California will govern all questions concerning the validity, construction and effect of this Agreement.

Section 11. Plan Provisions.

This Agreement is made under and subject to the provisions of the Plan, and all of the provisions of the Plan are also provisions of this Agreement. If there is a difference or conflict between the provisions of this Agreement and the provisions of the Plan, the provisions of the Plan will govern. By accepting this

Restricted Stock Award, the Grantee confirms that the Grantee has received a copy of the Plan and represents that the Grantee is familiar with the terms and provisions thereof, and hereby accepts this Restricted Stock Award subject to all the terms and provisions of the Plan.

Section 12. No Rights to Continue Service or Employment.

Nothing herein shall be construed as giving the Grantee the right to continue in the employ or to provide services to the Company or any Affiliate, whether as an employee or as a consultant or otherwise, or interfere with or restrict in any way the right of the Company or any Affiliate to discharge the Grantee, whether as an employee or consultant or otherwise, at any time, with or without cause. In addition, the Company or any Affiliate may discharge the Grantee free from any liability or claim under this Agreement.

Section 13. Entire Agreement.

This Agreement together with the Plan supersede any and all other prior understandings and agreements, either oral or in writing, between the parties with respect to the subject matter hereof and constitute the sole and only agreements between the parties with respect to said subject matter. All prior negotiations and agreements between the parties with respect to the subject matter hereof are merged into this Agreement. Each party to this Agreement acknowledges that no representations, inducements, promises or agreements, orally or otherwise, have been made by any party or by anyone acting on behalf of any party, which are not embodied in this Agreement or the Plan and that any agreement, statement or promise that is not contained in this Agreement or the Plan shall not be valid or binding or of any force or effect.

Section 14. Modification.

No change or modification of this Agreement shall be valid or binding upon the parties unless the change or modification is in writing and signed by the parties. Notwithstanding the preceding sentence, the Plan, this Agreement and the Restricted Stock Award may be amended, altered, suspended, discontinued or terminated to the extent permitted by the Plan.

Section 15. Shares Subject to Agreement.

The Shares shall be subject to the terms and conditions of this Agreement. Except as otherwise provided in Section 5, no adjustment shall be made for dividends or other rights for which the record date is prior to the issuance of the Shares. The Company shall not be required to deliver any Shares until the requirements of any federal or state securities or other laws, rules or regulations (including the rules of any securities exchange) as may be determined by the Committee to be applicable are satisfied.

Section 16. Severability.

In the event that any provision that is contained in the Plan or this Agreement is or becomes or is deemed to be invalid, illegal or unenforceable in any jurisdiction or would disqualify the Plan or this Agreement for any reason and under any law as deemed applicable by the Committee, the invalid, illegal or unenforceable provision shall be construed or deemed amended to conform to applicable laws, or if it cannot be so construed or deemed amended without, in the determination of the Committee, materially altering the purpose or intent of the Plan or this Agreement, such provision shall be stricken as to such jurisdiction or Shares, and the remainder of the Plan or this Agreement shall remain in full force and effect.

Section 17. Headings.

Headings are given to the sections and subsections of this Agreement solely as a convenience to facilitate reference. Such headings shall not be deemed in any way material or relevant to the construction or interpretation of this Agreement or any provision hereof.

Section 18. Grantee's Acknowledgments.

The Grantee hereby agrees to accept as binding, conclusive and final all decisions or interpretations of the Committee or the Board of Directors of the Company, as appropriate, upon any questions arising under the Plan or this Agreement. Any determination in this connection by the Company, including the Board of Directors of the Company or the Committee, shall be final, binding and conclusive. The obligations of the Company and the rights of the Grantee are subject to all applicable laws, rules and regulations.

Section 19. Parties Bound.

The terms, provisions and agreements that are contained in this Agreement shall apply to, be binding upon, and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives and permitted successors and assigns, subject to the limitation on assignment expressly set forth herein. This Agreement shall have no force or effect unless it is duly executed and delivered by the Company.

Section 20. Counterparts.

This Agreement may be executed in counterparts, each of which shall constitute an original, but both of which when taken together shall constitute a single contract. Delivery of an executed counterpart of a signature page of this Agreement by telecopy shall be effective as delivery of a manually executed counterpart of this Agreement.

IN WITNESS WHEREOF, each of the parties has executed this Agreement, in the case of the Company by its duly authorized officer, effective as of the day and year first above written.

MOLINA HEALTHCARE, INC.

By: _____
[Name]

Its: [Title]

Exhibit 10.4

MOLINA HEALTHCARE, INC.
2011 EQUITY INCENTIVE PLAN

PERFORMANCE STOCK UNIT AWARD AGREEMENT

THIS PERFORMANCE STOCK UNIT AWARD AGREEMENT (this "**Agreement**") dated _____, ___, by and between MOLINA HEALTHCARE, INC., a Delaware corporation (the "**Corporation**"), and _____ (the "**Participant**"), evidences the award of Performance Units (the **"Award**") granted by the Corporation to the Participant as to the number of Performance Units first set forth below.

Total Number of Performance Units:[1] **_____** **Award Date: _____**

Performance Periods for the respective installment of the Award:

[insert performance period applicable to each installment of the award, and number of performance units with respect to each installment]

Vesting[1,2] The Award shall vest and become nonforfeitable as provided in Section 2 of the attached Terms and Conditions of Performance Unit Award (the "**Terms**").

The Award is granted under the MOLINA HEALTHCARE, INC. 2011 EQUITY INCENTIVE PLAN AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2017 (the "**Plan**") and subject to the Terms attached to this Agreement (incorporated herein by this reference) and to the Plan. The grant of the Award is conditioned on the approval of the proposal in the 2017 proxy statement to amend and restate the Plan. The Award has been granted to the Participant in addition to, and not in lieu of, any other form of compensation otherwise payable or to be paid to the Participant. Capitalized terms are defined in the Plan if not defined herein. The parties agree to the terms of the Award set forth herein. The Participant acknowledges receipt of a copy of the Terms, the Plan, and the Prospectus for the Plan.

The Participant acknowledges and agrees that the Corporation may deliver, by electronic mail, the use of the Internet, including through the website of the agent appointed by the Committee to administer the Plan, the Corporation intranet web pages or otherwise, any information concerning the Corporation, this Award, the Plan, and any information required by the Securities Act of 1933, as amended, and the rules and regulations promulgated thereunder.

PARTICIPANT

_____

[Name]

MOLINA HEALTHCARE, INC.
a Delaware corporation

By: _____

[Name, Title]

1 Subject to adjustment under Section 4.2 of the Plan.

2 Subject to early termination under Section 10.7 of the Plan.

TERMS AND CONDITIONS OF PERFORMANCE UNIT AWARD

1. Performance Units.

Each Performance Unit constitutes an unfunded and unsecured promise of the Corporation to deliver up to two shares of the Corporation's common stock to the Participant (subject to adjustment as provided in Section 4.2 of the Plan) pursuant to the terms of this Agreement, subject to the vesting provisions in Exhibit A. The Performance Units shall be used solely as a device for the determination of the payment to eventually be made to the Participant if such Performance Units vest pursuant to Section 2. The Performance Units shall not be treated as property or as a trust fund of any kind.

2. Vesting.

Subject to Section 7, the installments of the Award shall vest and become nonforfeitable at the vesting percentage levels set forth in Exhibit A, based on the achievement of the Performance Goals established by the Committee and set forth on Exhibit A attached hereto for the respective Performance Periods. In the event that the respective performance condition with respect to each installment of the Award is achieved, the respective installment of the Award shall become unconditionally due. Subject to Section 7, any Performance Units subject to the Award that do not vest in accordance with Exhibit A shall terminate as of the last day of the respective Performance Period.

3. Continuance of Service.

Except as otherwise expressly provided in Section 7 below, the vesting schedule requires continued Service through each applicable vesting date as a condition to the vesting of the applicable installment of the Award and the rights and benefits under this Agreement; and Service for only a portion of any vesting period, even if a substantial portion, will not entitle the Participant to any proportionate vesting or avoid or mitigate a termination of rights and benefits upon or following a termination of Participant's Service as provided in Section 7 below or under the Plan for such vesting period (or for any later vesting period).

Nothing contained in this Agreement or the Plan constitutes an employment or service commitment by the Corporation, affects the contractual obligations pursuant to any employment or service commitment agreement if Participant is party to such agreement, or in the absence of such agreement affects Participant's status as an employee at will who is subject to termination without cause, confers upon the Participant any right to remain employed by or in service to the Corporation or any Subsidiary Corporation, interferes in any way with the right of the Corporation or any Subsidiary Corporation at any time to terminate Participant's Service, or affects the right of the Corporation or any Subsidiary Corporation to increase or decrease the Participant's other compensation or benefits. Nothing in this paragraph, however, is intended to adversely affect any independent contractual right of the Participant without his consent thereto.

4. Limitations on Rights Associated with Performance Units.

The Participant shall have no rights as a stockholder of the Corporation, no dividend rights and no voting rights with respect to the Performance Units and any shares of Common Stock underlying or issuable in respect of such Performance Units until such shares of Common Stock are actually issued to and held of record by the Participant. No adjustments will be made for dividends or other rights of a holder for which the record date is prior to the date of issuance of the stock certificate.

5. Restrictions on Transfer.

Unless otherwise determined by the Committee, neither the Award, nor any interest therein may be sold, assigned, transferred, pledged or otherwise disposed of, alienated or encumbered, either voluntarily or involuntarily. The transfer restrictions in the preceding sentence shall not apply to (a) transfers to the Corporation, or (b) transfers by will or the laws of descent and distribution.

6. Conversion of Performance Units; Issuance of Common Stock.

On or as soon as administratively practicable following the last day of the respective Performance Period, and in any event, no later than March 15 of the year following the year in which the vesting event occurs (which payment schedule is intended to comply with the "short-term deferral" exemption from the application of Section 409A of the Code), unless such payment is deferred in accordance with the terms and conditions of the Corporation's non-qualified compensation deferral plans, the Corporation shall deliver to the Participant the respective number of shares of Common Stock (either by delivering one or more certificates for such shares or by entering such shares in book entry form, as determined by the Corporation in its discretion) for the respective installment of the Performance Units (if any) that vest in accordance with Section 2, unless such Performance Units terminate prior to the given vesting date pursuant to Section 7. The Corporation's obligation to deliver shares of Common Stock with respect to any vested Performance Units is subject to the condition precedent that the Participant or other person entitled under the Plan to receive any shares with respect to the vested Performance Units deliver to the Corporation any representations or other documents or assurances required pursuant to Section 14 of the Plan. The Participant shall have no further rights with respect to any Performance Units that are paid or that are terminated pursuant to Section 7.

7. Effect of Change in Control or Termination of Employment.

7.1 Effect of Change in Control. In the event of a Change in Control, if, within two years following a Change in Control, the Participant's Service is terminated by the Corporation without Cause or the Participant terminates his employment for Good Reason, then the Performance Units shall become immediately 100% vested and the Corporation shall deliver to the Participant one share of Common Stock for each Performance Unit that vested as result of such termination.

7.2 Effect of Termination of Participant's Service. If the Participant's Service ceases the following rules shall apply (the last day that the Participant's Service is referred to as the Participant's "**Severance Date**"):

- other than as expressly provided below in this Section 7.2, the Participant's Performance Units, to the extent unvested on the Severance Date, shall terminate as of the Severance Date;

- in the event the Participant's Service is terminated by the Corporation without Cause or is terminated by the Participant for Good Reason, the vesting of the Performance Units shall be accelerated, and the Corporation shall deliver to the Participant one share of Common Stock for each Performance Unit that vested as result of such termination.

For purposes of this Agreement, the following terms shall have the following respective meanings.

"*Cause*" shall have the meaning given to such term in the Employment Agreement.

"Employment Agreement" shall mean the Second Amended and Restated Employment Agreement made as of _____, _____ between the Participant and the Corporation, as may be amended from time to time.

"*Good Reason*" shall have the meaning given to such term in the Employment Agreement.

If any unvested Performance Units are terminated hereunder, such Performance Units shall automatically terminate and be cancelled as of the applicable termination date without payment of any consideration by the Corporation and without any other action by the Participant, or the Participant's beneficiary or personal representative, as the case may be.

8. Adjustments Upon Specified Events.

The Committee may accelerate payment and vesting of the Performance Units in such circumstances as it, in its sole discretion, may determine. In addition, upon the occurrence of certain events relating to the Corporation's

stock contemplated by Section 4.2 of the Plan (including, without limitation, an extraordinary cash dividend on such stock), the Committee shall make adjustments in the number of Performance Units then outstanding and the number and kind of securities that may be issued in respect of the Award. No such adjustment shall be made with respect to any ordinary cash dividend paid on the Common Stock. Furthermore, the Committee shall adjust the performance measures and performance goals referenced in Exhibit A hereof to the extent (if any) it determines that the adjustment is necessary or advisable to preserve the intended incentives and benefits to reflect (1) any material change in corporate capitalization, any material corporate transaction (such as a reorganization, combination, separation, merger, acquisition, or any combination of the foregoing), or any complete or partial liquidation of the Corporation, (2) any change in accounting policies or practices, (3) the effects of any special charges to the Corporation's earnings, or (4) any other similar special circumstances.

9. Tax Withholding.

Subject to Section 16 of the Plan and such rules and procedures as the Committee may impose, upon any distribution of shares of Common Stock in respect of the Award, the Corporation shall automatically reduce the number of shares to be delivered by (or otherwise reacquire) the appropriate number of whole shares, valued at their then Fair Market Value, to satisfy any withholding obligations of the Corporation or its Subsidiary Corporations with respect to such distribution of shares at the minimum applicable withholding rates; provided, however, that the foregoing provision shall not apply in the event that the Participant has, subject to the approval of the Committee, made other provision in advance of the date of such distribution for the satisfaction of such withholding obligations. In the event that the Corporation cannot legally satisfy such withholding obligations by such reduction of shares, or in the event of a cash payment or any other withholding event in respect of the Award, the Corporation (or a Subsidiary Corporation) shall be entitled to require a cash payment by or on behalf of the Participant and/or to deduct from other compensation payable to the Participant any sums required by federal, state or local tax law to be withheld with respect to such distribution or payment.

10. Notices.

Any notice to be given under the terms of this Agreement shall be in writing and addressed to the Corporation at its principal office to the attention of the Secretary, and to the Participant at the Participant's last address reflected on the Corporation's records, or at such other address as either party may hereafter designate in writing to the other. Any such notice shall be given only when received, but if the Participant is no longer an employee of the Corporation, shall be deemed to have been duly given by the Corporation when enclosed in a properly sealed envelope addressed as aforesaid, registered or certified, and deposited (postage and registry or certification fee prepaid) in a post office or branch post office regularly maintained by the United States Government.

11. Plan.

The Award and all rights of the Participant under this Agreement are subject to, and the Participant agrees to be bound by, all of the terms and conditions of the provisions of the Plan, incorporated herein by reference. In the event of a conflict or inconsistency between the terms and conditions of this Agreement and of the Plan, the terms and conditions of the Plan shall govern. The Participant acknowledges having read and understood the Plan, the Prospectus for the Plan, and this Agreement. Unless otherwise expressly provided in other sections of this Agreement, provisions of the Plan that confer discretionary authority on the Committee do not (and shall not be deemed to) create any rights in the Participant unless such rights are expressly set forth herein or are otherwise in the sole discretion of the Committee so conferred by appropriate action of the Committee under the Plan after the date hereof.

12. Construction; Section 409A.

It is intended that the terms of the Award will not result in the imposition of any tax liability pursuant to Section 409A of the Code. This Agreement shall be construed and interpreted consistent with that intent. Notwithstanding any provision of this Agreement to the contrary, if the Participant is a "specified employee" as defined in Code Section 409A and, as a result of that status, any portion of the payments under this Agreement

would otherwise be subject to taxation pursuant to Code Section 409A, the Participant shall not be entitled to any payments upon a termination of his Service until the earlier of (i) the date which is six (6) months after his termination of Service for any reason other than death, or (ii) the date of the Participant's death; provided the first such payment thereafter shall include all amounts that would have been paid earlier but for such six (6) month delay. The Corporation and the Participant agree to act reasonably and to cooperate to amend or modify this Agreement to the extent reasonably necessary to avoid the imposition of the tax under Code Section 409A.

13. Entire Agreement; Applicability of Other Agreements.

This Agreement and the Plan together constitute the entire agreement and supersede all prior understandings and agreements, written or oral, of the parties hereto with respect to the subject matter hereof. The Plan and this Agreement may be amended pursuant to Section 17 of the Plan. Such amendment must be in writing and signed by the Corporation. The Corporation may, however, unilaterally waive any provision hereof in writing to the extent such waiver does not adversely affect the interests of the Participant hereunder, but no such waiver shall operate as or be construed to be a subsequent waiver of the same provision or a waiver of any other provision hereof. Notwithstanding the foregoing, if the Participant is subject to a written employment, change in control or similar agreement with the Corporation that is in effect as of the Participant's Severance Date and the Participant would be entitled under the express provisions of such agreement to greater rights with respect to accelerated vesting of the Award in connection with the termination of the Participant's employment in the circumstances, the provisions of such agreement shall control with respect to such vesting rights, and the corresponding provisions of this Agreement shall not apply.

14. Limitation on Participant's Rights.

Participation in this Plan confers no rights or interests other than as herein provided. This Agreement creates only a contractual obligation on the part of the Corporation as to amounts payable and shall not be construed as creating a trust. Neither the Plan nor any underlying program, in and of itself, has any assets. The Participant shall have only the rights of a general unsecured creditor of the Corporation (or applicable Subsidiary Corporation) with respect to amounts credited and benefits payable in cash, if any, with respect to the Performance Units, and rights no greater than the right to receive the Common Stock (or equivalent value) as a general unsecured creditor with respect to Performance Units, as and when payable thereunder.

15. Forfeiture and Corporation's Right to Recover Fair Market Value of Shares Received Pursuant to Performance Units.

If, at any time, the Board or the Committee, as the case may be, in its sole discretion determines that any action or omission by Participant constituted (a) wrongdoing that contributed to (i) any material misstatement in or omission from any report or statement filed by the Corporation with the U.S. Securities and Exchange Commission or (ii) a statement, certification, cost report, claim for payment, or other filing made under Medicare or Medicaid that was false, fraudulent, or for an item or service not provided as claimed, (b) intentional or gross misconduct, (c) a breach of a fiduciary duty to the Corporation or a Subsidiary Corporation, (d) fraud or (e) non-compliance with the Corporation's Code of Business Conduct and Ethics, policies or procedures to the material detriment of the Corporation, then in each such case, commencing with the first fiscal year of the Corporation during which such action or omission occurred, Participant shall forfeit (without any payment therefore) up to 100% of any Performance Units that have not been vested or settled and shall repay to the Corporation, upon notice to Participant by the Corporation, up to 100% of the Fair Market Value of the shares of Common Stock at the time such shares were delivered to the Participant pursuant to the Performance Units during and after such fiscal year. The Board or the Committee, as the case may be, shall determine in its sole discretion the date of occurrence of such action or omission, the percentage of the Performance Units that shall be forfeited and the percentage of the Fair Market Value of the shares of Common Stock delivered pursuant to the Performance Units that must be repaid to the Corporation.

16. Counterparts.

This Agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

17. Section Headings.

The section headings of this Agreement are for convenience of reference only and shall not be deemed to alter or affect any provision hereof.

18. Governing Law.

This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of California without regard to conflict of law principles thereunder.

EXHIBIT A

PERFORMANCE GOALS

[INSERT APPLICABLE PERFORMANCE GOALS.]

Exhibit 10.5

MOLINA HEALTHCARE, INC.
2011 EQUITY INCENTIVE PLAN

PERFORMANCE STOCK UNIT AWARD AGREEMENT

THIS PERFORMANCE STOCK UNIT AWARD AGREEMENT (this "**Agreement**") dated _____, ___, by and between MOLINA HEALTHCARE, INC., a Delaware corporation (the "**Corporation**"), and _____ (the "**Participant**"), evidences the award of Performance Units (the **"Award**") granted by the Corporation to the Participant as to the number of Performance Units first set forth below.

Total Number of Performance Units: _____ **Award Date: _____**

Performance Periods for the respective installment of the Award:

[insert performance period applicable to each installment of the award, and number of performance units with respect to each installment]

Vesting[1,2] The Award shall vest and become nonforfeitable as provided in Section 2 of the attached Terms and Conditions of Performance Unit Award (the "**Terms**").

The Award is granted under the MOLINA HEALTHCARE, INC. 2011 EQUITY INCENTIVE PLAN AMENDED AND RESTATED EFFECTIVE AS OF JANUARY 1, 2017 (the "**Plan**") and subject to the Terms attached to this Agreement (incorporated herein by this reference) and to the Plan. The grant of the Award is conditioned on the approval of the proposal in the 2017 proxy statement to amend and restate the Plan. The Award has been granted to the Participant in addition to, and not in lieu of, any other form of compensation otherwise payable or to be paid to the Participant. Capitalized terms are defined in the Plan if not defined herein. The parties agree to the terms of the Award set forth herein. The Participant acknowledges receipt of a copy of the Terms, the Plan, and the Prospectus for the Plan.

The Participant acknowledges and agrees that the Corporation may deliver, by electronic mail, the use of the Internet, including through the website of the agent appointed by the Committee to administer the Plan, the Corporation intranet web pages or otherwise, any information concerning the Corporation, this Award, the Plan, and any information required by the Securities Act of 1933, as amended, and the rules and regulations promulgated thereunder.

PARTICIPANT

_____

[Name]

MOLINA HEALTHCARE, INC.
a Delaware corporation

By: _____

[Name], [Title]

---

1 Subject to adjustment under Section 4.2 of the Plan.

2 Subject to early termination under Section 10.7 of the Plan.

TERMS AND CONDITIONS OF PERFORMANCE UNIT AWARD

1. Performance Units.

Each Performance Unit constitutes an unfunded and unsecured promise of the Corporation to deliver up to two shares of the Corporation's common stock to the Participant (subject to adjustment as provided in Section 4.2 of the Plan) pursuant to the terms of this Agreement, subject to the vesting provisions in Exhibit A. The Performance Units shall be used solely as a device for the determination of the payment to eventually be made to the Participant if such Performance Units vest pursuant to Section 2. The Performance Units shall not be treated as property or as a trust fund of any kind.

2. Vesting.

Subject to Section 7, the installments of the Award shall vest and become nonforfeitable at the vesting percentage levels set forth in Exhibit A, based on the achievement of the Performance Goals established by the Committee and set forth on Exhibit A attached hereto for the respective Performance Periods. In the event that the respective performance condition with respect to each installment of the Award is achieved, the respective installment of the Award shall become unconditionally due. Subject to Section 7, any Performance Units subject to the Award that do not vest in accordance with Exhibit A shall terminate as of the last day of the respective Performance Period.

3. Continuance of Service.

Except as otherwise expressly provided in Section 7 below, the vesting schedule requires continued Service through each applicable vesting date as a condition to the vesting of the applicable installment of the Award and the rights and benefits under this Agreement; and Service for only a portion of any vesting period, even if a substantial portion, will not entitle the Participant to any proportionate vesting or avoid or mitigate a termination of rights and benefits upon or following a termination of Participant's Service as provided in Section 7 below or under the Plan for such vesting period (or for any later vesting period).

Nothing contained in this Agreement or the Plan constitutes an employment or service commitment by the Corporation, affects the contractual obligations pursuant to any employment or service commitment agreement if Participant is party to such agreement, or in the absence of such agreement affects Participant's status as an employee at will who is subject to termination without cause, confers upon the Participant any right to remain employed by or in service to the Corporation or any Subsidiary Corporation, interferes in any way with the right of the Corporation or any Subsidiary Corporation at any time to terminate Participant's Service, or affects the right of the Corporation or any Subsidiary Corporation to increase or decrease the Participant's other compensation or benefits. Nothing in this paragraph, however, is intended to adversely affect any independent contractual right of the Participant without his consent thereto.

4. Limitations on Rights Associated with Performance Units.

The Participant shall have no rights as a stockholder of the Corporation, no dividend rights and no voting rights with respect to the Performance Units and any shares of Common Stock underlying or issuable in respect of such Performance Units until such shares of Common Stock are actually issued to and held of record by the Participant. No adjustments will be made for dividends or other rights of a holder for which the record date is prior to the date of issuance of the stock certificate.

5. Restrictions on Transfer.

Unless otherwise determined by the Committee, neither the Award, nor any interest therein may be sold, assigned, transferred, pledged or otherwise disposed of, alienated or encumbered, either voluntarily or involuntarily. The transfer restrictions in the preceding sentence shall not apply to (a) transfers to the Corporation, or (b) transfers by will or the laws of descent and distribution.

6. Conversion of Performance Units; Issuance of Common Stock.

On or as soon as administratively practicable following the last day of the respective Performance Period, and in any event, no later than March 15 of the year following the year in which the vesting event occurs (which payment schedule is intended to comply with the "short-term deferral" exemption from the application of Section 409A of the Code), unless such payment is deferred in accordance with the terms and conditions of the Corporation's non-qualified compensation deferral plans, the Corporation shall deliver to the Participant the respective number of shares of Common Stock (either by delivering one or more certificates for such shares or by entering such shares in book entry form, as determined by the Corporation in its discretion) for the respective installment of the Performance Units (if any) that vest in accordance with Section 2, unless such Performance Units terminate prior to the given vesting date pursuant to Section 7. The Corporation's obligation to deliver shares of Common Stock with respect to any vested Performance Units is subject to the condition precedent that the Participant or other person entitled under the Plan to receive any shares with respect to the vested Performance Units deliver to the Corporation any representations or other documents or assurances required pursuant to Section 14 of the Plan. The Participant shall have no further rights with respect to any Performance Units that are paid or that are terminated pursuant to Section 7.

7. Effect of Change in Control or Termination of Employment.

7.1 Effect of Change in Control. In the event of a Change in Control, if, within twelve (12) months following a Change in Control, the Participant's Service is terminated by the Corporation without Cause or the Participant terminates his employment for Good Reason, then the Performance Units shall become immediately 100% vested and the Corporation shall deliver to the Participant one share of Common Stock for each Performance Unit that vested as result of such termination.

7.2 Effect of Termination of Participant's Service. If the Participant's Service ceases for any reason (the last day that the Participant's Service is referred to as the Participant's "**Severance Date**"), the Participant's Performance Units, to the extent unvested on the Severance Date, shall terminate and be forfeited as of the Severance Date.

For purposes of this Agreement, the following terms shall have the following respective meanings.

"*Cause*" shall have the meaning given to such term in the Employment Agreement.

"Employment Agreement" shall mean the Employment Agreement made as of _____, ____, between the Participant and the Corporation, as may be amended from time to time.

"*Good Reason*" shall have the meaning given to such term in the Employment Agreement.

If any unvested Performance Units are terminated hereunder, such Performance Units shall automatically terminate and be cancelled as of the applicable termination date without payment of any consideration by the Corporation and without any other action by the Participant, or the Participant's beneficiary or personal representative, as the case may be.

8. Adjustments Upon Specified Events.

The Committee may accelerate payment and vesting of the Performance Units in such circumstances as it, in its sole discretion, may determine. In addition, upon the occurrence of certain events relating to the Corporation's stock contemplated by Section 4.2 of the Plan (including, without limitation, an extraordinary cash dividend on such stock), the Committee shall make adjustments in the number of Performance Units then outstanding and the number and kind of securities that may be issued in respect of the Award. No such adjustment shall be made with respect to any ordinary cash dividend paid on the Common Stock. Furthermore, the Committee shall adjust the performance measures and performance goals referenced in Exhibit A hereof to the extent (if any) it determines that the adjustment is necessary or advisable to preserve the intended incentives and benefits to reflect (1) any material

change in corporate capitalization, any material corporate transaction (such as a reorganization, combination, separation, merger, acquisition, or any combination of the foregoing), or any complete or partial liquidation of the Corporation, (2) any change in accounting policies or practices, (3) the effects of any special charges to the Corporation's earnings, or (4) any other similar special circumstances.

9. Tax Withholding.

Subject to Section 16 of the Plan and such rules and procedures as the Committee may impose, upon any distribution of shares of Common Stock in respect of the Award, the Corporation shall automatically reduce the number of shares to be delivered by (or otherwise reacquire) the appropriate number of whole shares, valued at their then Fair Market Value, to satisfy any withholding obligations of the Corporation or its Subsidiary Corporations with respect to such distribution of shares at the minimum applicable withholding rates; provided, however, that the foregoing provision shall not apply in the event that the Participant has, subject to the approval of the Committee, made other provision in advance of the date of such distribution for the satisfaction of such withholding obligations. In the event that the Corporation cannot legally satisfy such withholding obligations by such reduction of shares, or in the event of a cash payment or any other withholding event in respect of the Award, the Corporation (or a Subsidiary Corporation) shall be entitled to require a cash payment by or on behalf of the Participant and/or to deduct from other compensation payable to the Participant any sums required by federal, state or local tax law to be withheld with respect to such distribution or payment.

10. Notices.

Any notice to be given under the terms of this Agreement shall be in writing and addressed to the Corporation at its principal office to the attention of the Secretary, and to the Participant at the Participant's last address reflected on the Corporation's records, or at such other address as either party may hereafter designate in writing to the other. Any such notice shall be given only when received, but if the Participant is no longer an employee of the Corporation, shall be deemed to have been duly given by the Corporation when enclosed in a properly sealed envelope addressed as aforesaid, registered or certified, and deposited (postage and registry or certification fee prepaid) in a post office or branch post office regularly maintained by the United States Government.

11. Plan.

The Award and all rights of the Participant under this Agreement are subject to, and the Participant agrees to be bound by, all of the terms and conditions of the provisions of the Plan, incorporated herein by reference. In the event of a conflict or inconsistency between the terms and conditions of this Agreement and of the Plan, the terms and conditions of the Plan shall govern. The Participant acknowledges having read and understood the Plan, the Prospectus for the Plan, and this Agreement. Unless otherwise expressly provided in other sections of this Agreement, provisions of the Plan that confer discretionary authority on the Committee do not (and shall not be deemed to) create any rights in the Participant unless such rights are expressly set forth herein or are otherwise in the sole discretion of the Committee so conferred by appropriate action of the Committee under the Plan after the date hereof.

12. Construction; Section 409A.

It is intended that the terms of the Award will not result in the imposition of any tax liability pursuant to Section 409A of the Code. This Agreement shall be construed and interpreted consistent with that intent. Notwithstanding any provision of this Agreement to the contrary, if the Participant is a "specified employee" as defined in Code Section 409A and, as a result of that status, any portion of the payments under this Agreement would otherwise be subject to taxation pursuant to Code Section 409A, the Participant shall not be entitled to any payments upon a termination of his Service until the earlier of (i) the date which is six (6) months after his termination of Service for any reason other than death, or (ii) the date of the Participant's death; provided the first such payment thereafter shall include all amounts that would have been paid earlier but for such six (6) month delay. The Corporation and the Participant agree to act reasonably and to cooperate to amend or modify this Agreement to the extent reasonably necessary to avoid the imposition of the tax under Code Section 409A.

13. Entire Agreement; Applicability of Other Agreements.

This Agreement and the Plan together constitute the entire agreement and supersede all prior understandings and agreements, written or oral, of the parties hereto with respect to the subject matter hereof. The Plan and this Agreement may be amended pursuant to Section 17 of the Plan. Such amendment must be in writing and signed by the Corporation. The Corporation may, however, unilaterally waive any provision hereof in writing to the extent such waiver does not adversely affect the interests of the Participant hereunder, but no such waiver shall operate as or be construed to be a subsequent waiver of the same provision or a waiver of any other provision hereof. Notwithstanding the foregoing, if the Participant is subject to a written employment, change in control or similar agreement with the Corporation that is in effect as of the Participant's Severance Date and the Participant would be entitled under the express provisions of such agreement to greater rights with respect to accelerated vesting of the Award in connection with the termination of the Participant's employment in the circumstances, the provisions of such agreement shall control with respect to such vesting rights, and the corresponding provisions of this Agreement shall not apply.

14. Limitation on Participant's Rights.

Participation in this Plan confers no rights or interests other than as herein provided. This Agreement creates only a contractual obligation on the part of the Corporation as to amounts payable and shall not be construed as creating a trust. Neither the Plan nor any underlying program, in and of itself, has any assets. The Participant shall have only the rights of a general unsecured creditor of the Corporation (or applicable Subsidiary Corporation) with respect to amounts credited and benefits payable in cash, if any, with respect to the Performance Units, and rights no greater than the right to receive the Common Stock (or equivalent value) as a general unsecured creditor with respect to Performance Units, as and when payable thereunder.

15. Forfeiture and Corporation's Right to Recover Fair Market Value of Shares Received Pursuant to Performance Units.

If, at any time, the Board or the Committee, as the case may be, in its sole discretion determines that any action or omission by Participant constituted (a) wrongdoing that contributed to (i) any material misstatement in or omission from any report or statement filed by the Corporation with the U.S. Securities and Exchange Commission or (ii) a statement, certification, cost report, claim for payment, or other filing made under Medicare or Medicaid that was false, fraudulent, or for an item or service not provided as claimed, (b) intentional or gross misconduct, (c) a breach of a fiduciary duty to the Corporation or a Subsidiary Corporation, (d) fraud or (e) non-compliance with the Corporation's Code of Business Conduct and Ethics, policies or procedures to the material detriment of the Corporation, then in each such case, commencing with the first fiscal year of the Corporation during which such action or omission occurred, Participant shall forfeit (without any payment therefore) up to 100% of any Performance Units that have not been vested or settled and shall repay to the Corporation, upon notice to Participant by the Corporation, up to 100% of the Fair Market Value of the shares of Common Stock at the time such shares were delivered to the Participant pursuant to the Performance Units during and after such fiscal year. The Board or the Committee, as the case may be, shall determine in its sole discretion the date of occurrence of such action or omission, the percentage of the Performance Units that shall be forfeited and the percentage of the Fair Market Value of the shares of Common Stock delivered pursuant to the Performance Units that must be repaid to the Corporation.

16. Counterparts.

This Agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

17. Section Headings.

The section headings of this Agreement are for convenience of reference only and shall not be deemed to alter or affect any provision hereof.

18. Governing Law.

This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of California without regard to conflict of law principles thereunder.

EXHIBIT A

PERFORMANCE GOALS

[INSERT APPLICABLE PERFORMANCE GOALS.]

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph W. White, certify that:

1. I have reviewed the annual report on Form 10-Q for the period ended March 31, 2017 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. I am responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under my supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under my supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report my conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. I have disclosed, based on my most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 4, 2017

/s/ Joseph W. White

Joseph W. White
Interim Chief Executive Officer
Chief Financial Officer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2017 (the "Report"), I, Joseph W. White, Interim Chief Executive Officer and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 4, 2017

/s/ Joseph W. White

Joseph W. White
Interim Chief Executive Officer
Chief Financial Officer

2016 MHI Form 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2016

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2016, the last business day of our most recently completed second fiscal quarter, was approximately $2,077.8 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2016).

As of February 24, 2017, approximately 56,750,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2017 Annual Meeting of Stockholders to be held on May 3, 2017, are incorporated by reference into Part III of this Form 10-K, to the extent described therein.

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MOLINA HEALTHCARE, INC. 2016 FORM 10-K

CROSS-REFERENCE INDEX

(a) Incorporated by reference to "Executive Compensation" in the 2017 Proxy Statement.
(b) Incorporated by reference to "Security Ownership of Certain Beneficial Owners and Management" in the 2017 Proxy Statement.
(c) Incorporated by reference to "Related Party Transactions" and "Corporate Governance and Board of Directors Matters — Director Independence" in the 2017 Proxy Statement.
(d) Incorporated by reference to "Fees Paid to Independent Registered Public Accounting Firm" in the 2017 Proxy Statement.

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MOLINA HEALTHCARE, INC. 2016 FORM 10-K

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FORWARD LOOKING STATEMENTS

This Annual Report on Form 10-K ("Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly due to numerous known and unknown risks and uncertainties. Those known risks and uncertainties include, but are not limited to, the risk factors identified in the section of this report titled "Risk Factors," as well as the following:

- *the success of our profit improvement and cost-cutting initiatives;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including any potential repeal and replacement of the law, amendment of the law, or move to state block grants for Medicaid;*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk transfer requirements, the potential for disproportionate enrollment of higher acuity members, the withdrawal of cost sharing subsidies and/or premium tax credits, the adequacy of agreed rates, and potential disruption associated with market withdrawal;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer, risk corridors, and reinsurance;*
- *management of our medical costs, including our ability to reduce over time the high medical costs commonly associated with new patient populations;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates in new plans, geographies, and programs where we have less experience with patient and provider populations, and also including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the resolution of the Illinois budget impasse and continued payment of all amounts due to our Illinois health plan;*
- *the success of our efforts to retain existing government contracts, including those in Illinois, Washington, Florida, Texas, and New Mexico, and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;*
- *our ability to manage growth, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our ability to consummate and realize benefits from acquisitions, and to integrate acquisitions;*
- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion cost corridors in New Mexico and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*

- *the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, the effect of the PROMESA law, and our efforts to better manage the health care costs of our Puerto Rico health plan;*
- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *the continuation and renewal of the government contracts of our health plans, Molina Medicaid Solutions, and Pathways, and the terms under which such contracts are renewed;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to our provider contracts and the loss of providers;*
- *approval by state regulators of dividends and distributions by our health plan subsidiaries;*
- *changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;*
- *high dollar claims related to catastrophic illness;*
- *the favorable resolution of litigation, arbitration, or administrative proceedings;*
- *the relatively small number of states in which we operate health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *our failure to comply with the financial or other covenants in our credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of our funds on hand to pay the amounts due upon conversion of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm; and*
- *increasing competition and consolidation in the Medicaid industry.*

Each of the terms "Company," "Molina Healthcare," "we," "our," and "us," as used herein refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

ABOUT MOLINA HEALTHCARE

OUR VISION, MISSION, AND STRATEGY

We envision a future where everyone receives quality healthcare.

Our mission is to provide quality healthcare to people receiving government assistance.

We offer healthcare services for persons served by Medicaid, Medicare, the Children's Health Insurance Program (CHIP) and the Marketplace, and products to assist government agencies in their administration of the Medicaid program.

OUR GOAL IS TO ACHIEVE OUR MISSION WHILE IMPROVING THE FINANCIAL STRENGTH OF OUR ORGANIZATION

2016

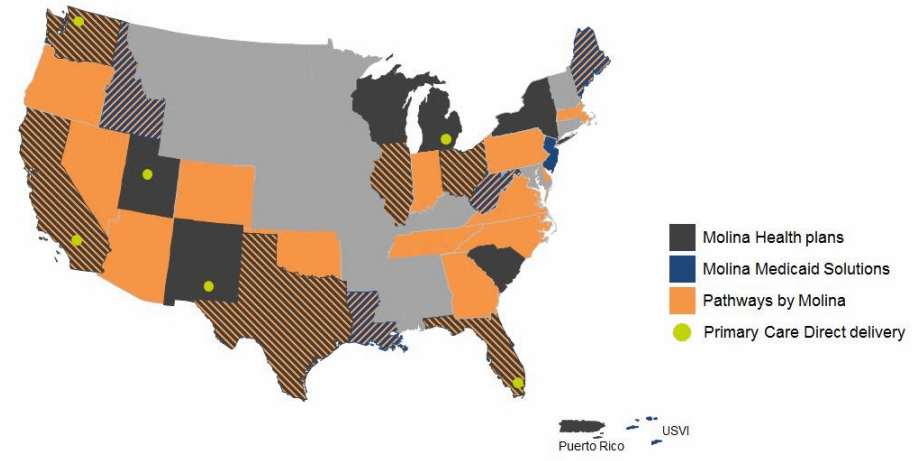
(Dollars in millions, except per-share amounts)

Total Revenue	Net Income per Diluted Share	Adjusted Net Income Per Share*
$17,782	$0.92	$1.28
Net Profit Margin	**EBITDA***	**Ending Membership**
0.3%	$467	4,227,000

Non-generally accepted accounting principles (GAAP) financial measures referred to in this report are designated with an asterisk (*). For more information, see "Management's Discussion and Analysis of Financial Condition and Results of Operations (MD&A)—Non-GAAP Financial Measures," and "MD&A—Supplemental Information."

OUR FOOTPRINT TODAY

Our health plan footprint includes the five largest Medicaid markets.



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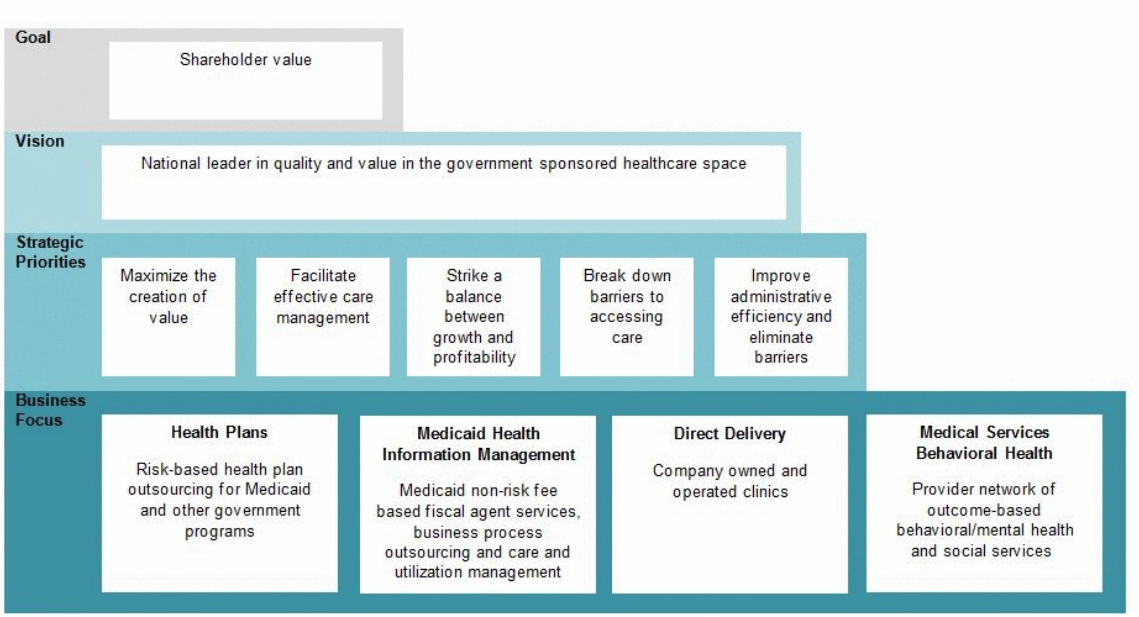
OUR BUSINESS STRATEGY



Significant accomplishments in support of our strategic growth initiatives during 2016 included:

- Medicaid contract acquisitions at our existing health plans in Illinois, Michigan and Washington that added approximately 221,000 Medicaid members in the first quarter of 2016.
- Acquisition of the outstanding equity interests of Molina Healthcare of New York, Inc., formerly known as Today's Options of New York, Inc., that added approximately 35,000 Medicaid members in the third quarter of 2016.

We believe that our strategy positions us well to respond to the following trends in Medicaid and Medicare:

- The transition of long-term care services for fee-for-service to managed care
- States' continued reliance on Medicaid
- Growth in Medicare driven by an aging population
- Increasing spend on home and community based services
- Further integration of medical and behavioral health services
- A growing focus on addressing the social determinants of health—social determinants are the conditions in the places where people live, learn, work, and play which affect a wide range of health risks and outcomes

We believe the key to our successful, sustained growth is to maintain our focus on our mission and adhere to the core competencies that give us an advantage over our competitors, including the ability to understand the needs of our members and the social and economic factors influencing their health.

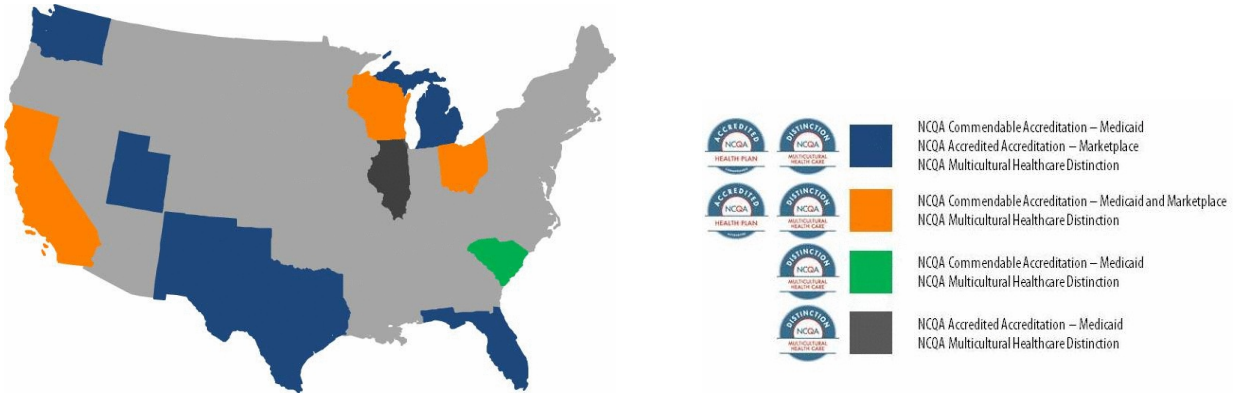
For example, attracting elderly and disabled Medicaid and Medicare beneficiaries to our health plans is a key part of our growth strategy, because these beneficiaries can especially benefit from our expertise in connecting our members to the right resources to help them maintain and improve their health.

Our long-term success also depends on the quality of the services we provide and the value that we create. We are a recognized quality leader, with 11 of our 13 Medicaid health plans currently accredited by the National Committee for Quality Assurance (NCQA). Nine of our health plans have been accredited for Marketplace as well. In addition, 11 of our 13 health plans have earned the Multicultural Health Care Distinction from NCQA, awarded to organizations that meet or exceed its rigorous requirements for multicultural health care.

In addition, in late 2016, we announced that all of our eligible health plans increased or maintained their scores as part of the Centers for Medicare & Medicaid Services' (CMS) 2017 Star Ratings, which measures the quality of Medicare plans across the country on a 5-star rating system.

We believe that these objective measures of quality are increasingly important to state Medicaid agencies as a growing number of states link reimbursement and patient assignment to quality scores. Additionally, Medicare pays quality bonuses to health plans that achieve high quality.

Based on the published results, Molina Healthcare of New Mexico was named the highest-rated Medicare plan in the state with a 4-star rating, while Molina Healthcare of Florida increased from 3 to 3.5 stars. Furthermore, Molina Healthcare of Michigan was rated the highest Medicare Dual-eligible Special Needs Plan (D-SNP) in the state with 3.5 stars. Other Molina health plans that retained their 3.5 Medicare star rating include Texas, Utah and Washington.



OUR SEGMENTS

We manage our operations through three reportable segments. These segments consist of our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment, which includes our behavioral health and social services subsidiary, Pathways. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition activity and changing laws and regulations. Therefore, these reportable segments may change in the future.

Business and financial overviews for our reportable segments are provided in "MD&A—Reportable Segments."

Refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies" for revenue information by state health plan, and Note 20, "Segment Information," for segment revenue, profit and total assets information.

COMPETITIVE CONDITIONS AND ENVIRONMENT

We face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, quality scores, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with

a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

For further competitor information specific to each of our reportable segments, refer to “MD&A—Reportable Segments.”

MANAGEMENT’S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (MD&A)

NON-GAAP FINANCIAL MEASURES

We use non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures.

See further information regarding non-GAAP measures in the “Supplemental Information” section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this report are designated with an asterisk (*).

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums, and our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio (“MCR”). The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” The service margin is equal to service revenue minus cost of service revenue. Management’s discussion and analysis of the changes in the individual components of gross margin, by reportable segment, is presented in the “Reportable Segments” section of this MD&A.

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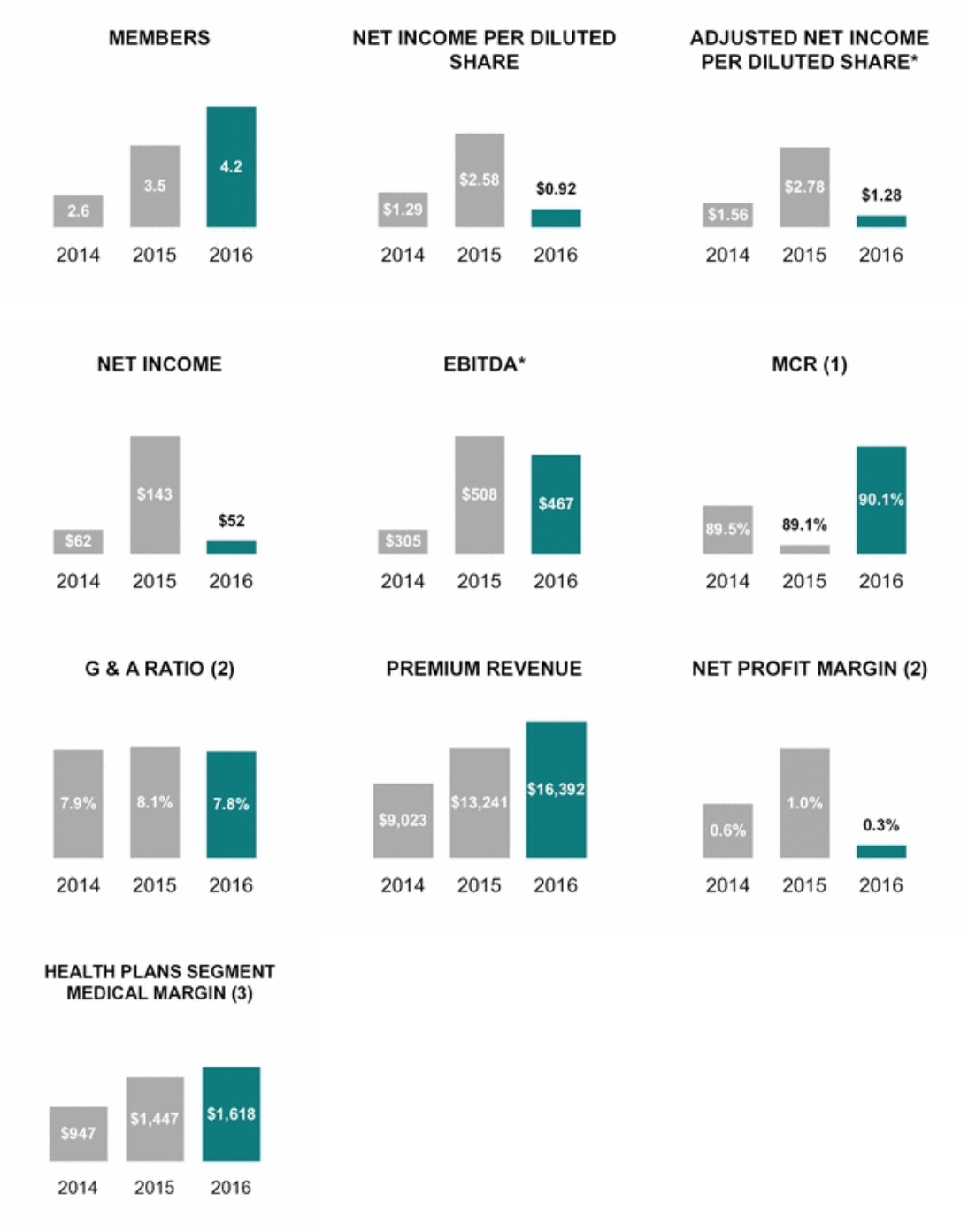
KEY PERFORMANCE INDICATORS

(Dollars and membership in millions, except per-share amounts)



(1) Medical care ratio represents medical care costs as a percentage of premium revenue.

(2) General and administrative expense ratio represents general and administrative expenses as a percentage of total revenue. Net profit margin represents net income as a percentage of total revenue.

(3) Medical margin is equal to premium revenue minus medical costs.

See discussion of Key Performance Indicators in the “Consolidated Results” and “Reportable Segments” sections of this MD&A.

CONSOLIDATED RESULTS

FISCAL YEAR 2016 FINANCIAL HIGHLIGHTS

- Net income per diluted share decreased to $0.92 in 2016 compared with $2.58 in 2015. Adjusted net income per diluted share* decreased to $1.28 in 2016 compared with $2.78 in 2015. The decrease in net income was primarily the result of the declining profitability of our Marketplace program.
- Strong enrollment growth generated approximately $16.4 billion of premium revenue, or 24% more premium revenue in 2016 compared with 2015. Enrollment growth was primarily due to increased Marketplace enrollment and the acquisition of Medicaid managed care membership.
- The medical care ratio increased to 90.1% in 2016, from 89.1% in 2015, due to lower Marketplace margins. The medical care ratio of our Marketplace program increased to 92.9% in 2016 from 73.8% in 2015.

MOLINA’S 2017 ACTION PLAN

We have identified the following areas of focus and related actions to execute in 2017:

1. **Stabilize Marketplace Performance:**

   We will continue to advocate for the immediate remediation of risk transfer methodologies that penalize comparatively efficient and affordable health plans like ours and, by extension, those individual consumers in need of affordable health insurance. In particular, we are recommending that the planned change to the Marketplace risk transfer methodology, which is currently scheduled to take effect on January 1, 2018, be brought forward in time and implemented immediately in 2017. Had that same planned methodology change been in effect in 2016, we estimate that our pre-tax income in 2016 would have been approximately $70 million higher.

   In January 2017, we filed suit on behalf of our health plans seeking recovery from the federal government of approximately $52 million in Marketplace risk corridor payments for calendar year 2015. Based upon current estimates, we believe our health plans are also owed approximately $90 million in Marketplace risk corridor payments from the federal government for calendar year 2016, and a further nominal amount for calendar year 2014. Our lawsuit seeks recovery of all of these unpaid amounts. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid Marketplace risk corridor payments as of December 31, 2016. We have fully recognized all liabilities due to the federal government that we have incurred under the Marketplace risk corridor program, and have paid all amounts due to the federal government as required.

2. **Improve Medicaid performance in Illinois, Ohio and Washington:**

   Inadequate premium rates limited profitability in Illinois, Ohio and Washington in 2016. Effective January 1, 2017, we received blended rate increases of approximately 5% in Illinois, 4% in Ohio and 4% in Washington. We expect improved profitability in all three plans in 2017 as a result of these rate increases and company-wide cost containment measures.

3. **Sustain the improvements achieved in Puerto Rico:**

   Results at our Puerto Rico health plan have improved in the second half of 2016, primarily as a result of management actions undertaken beginning in the spring of 2016. We expect the benefit of those actions to continue into 2017.

REPORTABLE SEGMENTS

SEGMENT SUMMARY

	2016	2015	2014
		(In millions)	
Segment gross margin:			
Health Plans medical margin [1]	$ 1,618	$ 1,447	$ 947
Molina Medicaid Solutions service margin [2]	21	55	53
Other [2]	33	5	—
Total segment gross margin	1,672	1,507	1,000
Other operating revenues [3]	851	684	434
Other operating expenses [4]	(2,217)	(1,804)	(1,241)
Operating income	306	387	193
Other expenses, net	101	65	58
Income before income tax expense	205	322	135
Income tax expense	153	179	73
Net income	$ 52	$ 143	$ 62

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.
(3) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.
(4) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

HEALTH PLANS

BUSINESS OVERVIEW

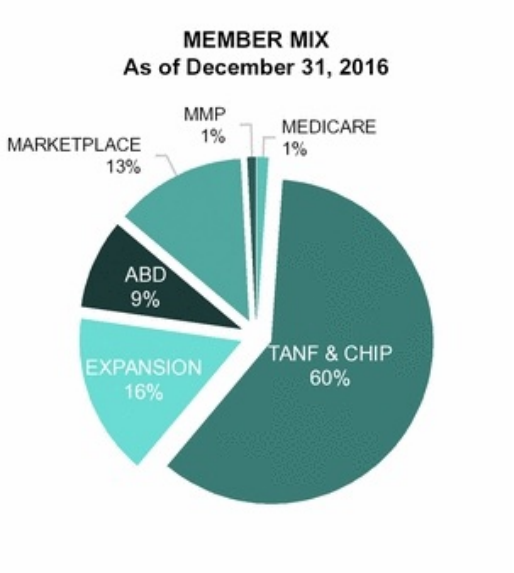
- 96.9% of total revenue in 2016
- 98.2% of total revenue in 2015
- Employees: Approximately 7,700

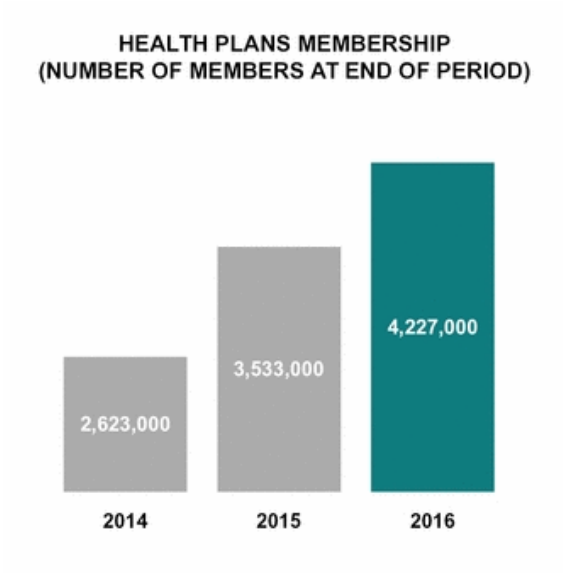
Programs and Services

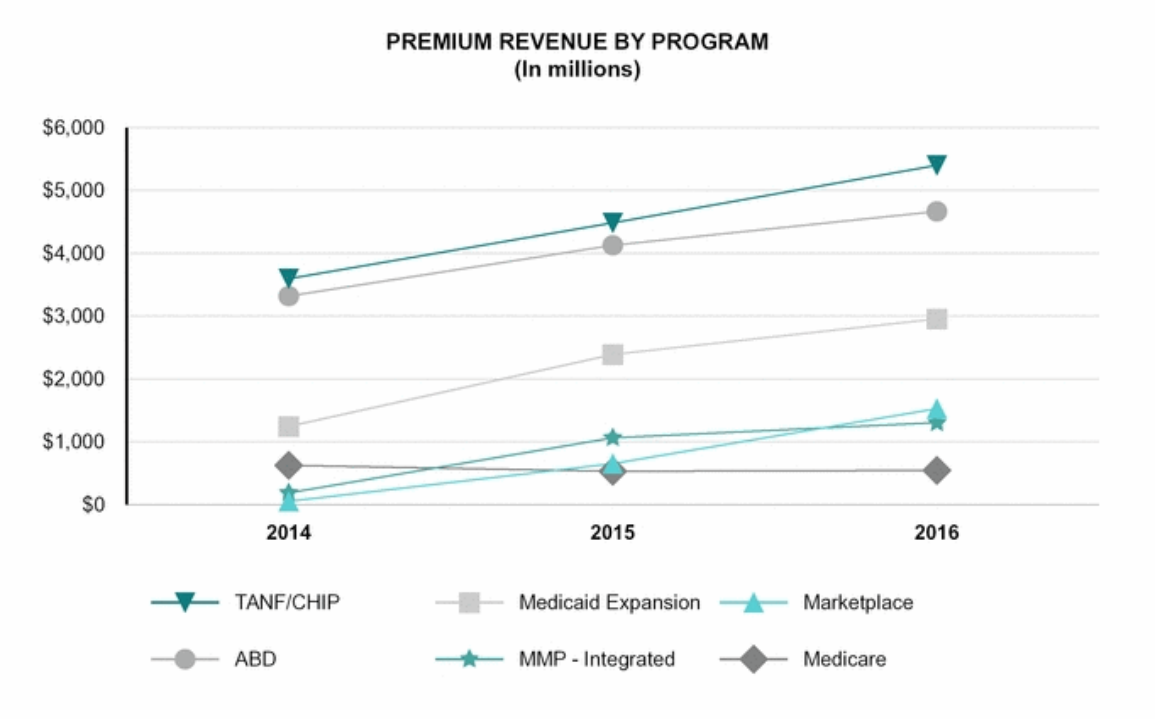
The Health Plans segment consists of health plans in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of December 31, 2016, these health plans served over 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.


MEMBER MIX
As of December 31, 2016
MMP
1%
MEDICARE
1%
MARKETPLACE
13%
ABD
9%
EXPANSION
16%
TANF & CHIP
60%


HEALTH PLANS MEMBERSHIP
(NUMBER OF MEMBERS AT END OF PERIOD)
2,623,000
3,533,000
4,227,000
2014
2015
2016


PREMIUM REVENUE BY PROGRAM
(In millions)
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
2014
2015
2016
TANF/CHIP
Medicaid Expansion
Marketplace
ABD
MMP - Integrated
Medicare

Membership by Health Plan and Program

The following tables set forth our Health Plans membership as of the dates indicated:

	As of December 31,		
	2016	**2015**	**2014**
Ending Membership by Health Plan:			
California	683,000	620,000	531,000
Florida	553,000	440,000	164,000
Illinois	195,000	98,000	100,000
Michigan	391,000	328,000	242,000
New Mexico	254,000	231,000	212,000
New York [1]	35,000	—	—
Ohio	332,000	327,000	347,000
Puerto Rico [2]	330,000	348,000	—
South Carolina	109,000	99,000	118,000
Texas	337,000	260,000	245,000
Utah	146,000	102,000	83,000
Washington	736,000	582,000	497,000
Wisconsin	126,000	98,000	84,000
	4,227,000	3,533,000	2,623,000
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,536,000	2,312,000	1,809,000
Medicaid Expansion	673,000	557,000	385,000
Marketplace	526,000	205,000	15,000
Aged, Blind or Disabled (ABD)	396,000	366,000	347,000
Medicare-Medicaid Plan (MMP) – Integrated [3]	51,000	51,000	18,000
Medicare Special Needs Plans (Medicare)	45,000	42,000	49,000
	4,227,000	3,533,000	2,623,000

(1) The New York health plan was acquired on August 1, 2016.
(2) The Puerto Rico health plan began serving members on April 1, 2015.
(3) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

Our Industry

Medicaid. Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and supports to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all jurisdictions is currently about 59%, and ranges from a federally established FMAP floor of 50% to as high as 75%.

We participate in the following Medicaid programs:

- TANF - TANF, the most common state-administered Medicaid, covers primarily low-income mothers and children.
- ABD - State-administered ABD programs cover low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries typically use more services than those served by other Medicaid programs because of their critical health issues.
- CHIP - CHIP is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.

- Medicaid Expansion - In states that have elected to participate, Medicaid Expansion provides eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line.

Marketplace. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois, New York, Puerto Rico and South Carolina.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by CMS. Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (PMPM) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

MMPs. Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as MMPs. We operate MMPs in six states.

Significant Trends and Developments

ACA. As a result of the election of President Trump and the GOP control of both houses of Congress, there is currently a great deal of discussion and debate about the repeal and replacement of the ACA. As a result, the future of the ACA and its underlying programs are subject to substantial uncertainty, making long-term business planning exceedingly difficult. We are unable to predict with any degree of certainty whether the ACA will be modified or repealed in its entirety, and if it is repealed, what it will be replaced with; nor are we able to predict when any such changes, if enacted, would become effective.

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following: ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers; reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults; changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap"); prohibiting the federal government from operating Marketplaces; eliminating the advanced premium tax credits, and cost-sharing reductions for low income individuals who purchase their health insurance through the Marketplaces; expanding and encouraging the use of private health savings accounts; providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans; establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; allowing insurers to sell insurance across state lines; and numerous other potential changes and reforms. Changes to or the repeal of the ACA, or the adoption of new health care regulatory laws, could have a material adverse effect on our business, financial condition, cash flows or results of operations.

Proposed Medicare Acquisition. In August 2016, we entered into substantially identical agreements with each of Aetna Inc. and Humana Inc. to acquire certain of their Medicare Advantage membership and other assets related to such Medicare Advantage business (the Proposed Medicare Acquisition), for cash. The Proposed Medicare Acquisition was subject to closing conditions including, but not limited to, the completion of the proposed acquisition of Humana by Aetna (the Aetna-Humana Merger). In January 2017, the U.S. District Court for the District of Columbia granted the request made by the U.S. Department of Justice in its civil antitrust lawsuit against Aetna and Humana, to prohibit the Aetna-Humana Merger (the District Court Order). In February 2017, the Proposed Medicare

Acquisition was terminated by the parties pursuant to the terms of the transaction. Under the termination agreement, we are entitled to receive from Aetna and Humana an aggregate termination fee of $75 million (the breakup fee). In addition, we are entitled to reimbursement of reasonable and documented out-of-pocket expenses incurred by us and our affiliates in connection with the Proposed Medicare Acquisition. We will record the breakup fee as other income in the first quarter of 2017.

Completed Acquisitions. Medicaid contract acquisitions at our existing health plans in Illinois, Michigan and Washington added approximately 221,000 Medicaid members in the first quarter of 2016. Acquisition of the outstanding equity interests of Molina Healthcare of New York, Inc., formerly known as Today's Options of New York, Inc., added approximately 35,000 Medicaid members in the third quarter of 2016.

Basis for our Premium Rates

Medicaid. Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members' health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Medicare. Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment. Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

Marketplace. For our Marketplace plans, we develop premium rates during the spring of each year for policies effective in the following calendar year. Premium rates are based on our estimates of projected member utilization, medical unit costs, member risk acuity, member risk transfer, and administrative costs, with the intent of realizing a target pretax percentage profit margin. Our actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval.

Premiums by Program

The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a PMPM basis, for the year ended December 31, 2016. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 400.00	$ 180.00
Medicaid Expansion	300.00	480.00	380.00
Marketplace	170.00	360.00	230.00
ABD	390.00	1,520.00	990.00
MMP – Integrated	1,240.00	3,240.00	2,130.00
Medicare	820.00	1,100.00	1,030.00

Competition

The Medicaid managed care industry is subject to ongoing changes as a result of health care reform, business consolidations and new strategic alliances. We compete with national, regional, and local Medicaid service providers, principally on the basis of size, location, quality of provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., and Aetna Inc. Competition can vary considerably from state to state.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

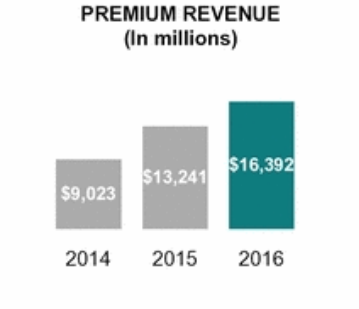
HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

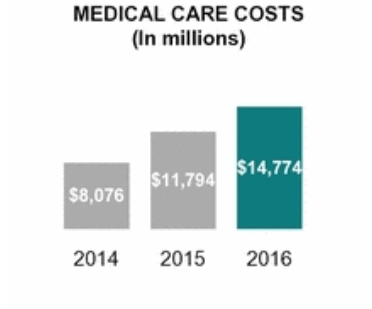
- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

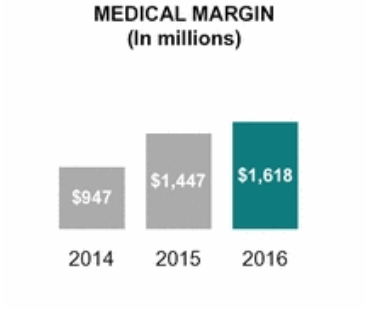
Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

Regulatory Capital Requirements and Dividend Restrictions. Our health plans are subject to stringent minimum capitalization requirements that limit their ability to pay dividends to us. For further information, refer to the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

FINANCIAL OVERVIEW







2016 Compared with 2015

In 2016, a 27% increase in membership, partially offset by a 3% decrease in revenue PMPM, resulted in increased premium revenue of 24%, or $3.2 billion, when compared with 2015. The decline in PMPM premium revenue was primarily the result of lower PMPM premiums for Medicaid Expansion membership and an increase in the percentage of our premium revenue derived from TANF and Marketplace membership.

The medical care ratio increased to 90.1% in 2016, from 89.1% in 2015. The increase in our medical care ratio was driven primarily by Marketplace membership. Medical margin (measured in absolute dollars) increased 12% in 2016 over 2015. The medical care ratio of all of our programs excluding Marketplace decreased by 10 basis points between 2015 and 2016, as decreasing margins in Medicaid Expansion (where we saw a 300 basis point increase in our medical care ratio) were offset by improved margins in other programs. Consolidated medical care costs measured on a PMPM basis decreased approximately 3% in 2016 when compared with 2015.

2015 Compared with 2014

In 2015, a 42% increase in membership and a 5% increase in revenue PMPM resulted in increased premium revenue of 47%, or over $4.2 billion, when compared with 2014.

Enrollment growth was primarily due to increased Medicaid expansion, increased Marketplace and integrated Medicare-Medicaid Plan (MMP) enrollment, and the start-up of the Puerto Rico health plan in April 2015.

Our medical margin increased nearly 53% in 2015 over 2014, and our consolidated medical care ratio decreased to 89.1% in 2015 from 89.5% in 2014.

FINANCIAL PERFORMANCE BY PROGRAM

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Year Ended December 31, 2016 [1]						
	Member Months[2]	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR[3]	Medical Margin
TANF and CHIP	30.2	$ 5,403	$ 179.21	$ 4,950	$ 164.18	91.6%	$ 453
Medicaid Expansion	7.8	2,952	378.58	2,475	317.37	83.8	477
Marketplace	6.7	1,525	228.44	1,416	212.17	92.9	109
ABD	4.7	4,666	991.24	4,277	908.39	91.6	389
MMP	0.6	1,303	2,131.97	1,141	1,866.93	87.6	162
Medicare	0.5	543	1,033.15	515	981.36	95.0	28
	50.5	$ 16,392	$ 324.82	$ 14,774	$ 292.75	90.1%	$ 1,618

	Year Ended December 31, 2015 [1]						
	Member Months[2]	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR[3]	Medical Margin
TANF and CHIP	25.5	$ 4,483	$ 175.64	$ 4,122	$ 161.50	92.0%	$ 361
Medicaid Expansion	5.9	2,389	408.51	1,931	330.18	80.8	458
Marketplace	2.6	652	251.96	481	185.85	73.8	171
ABD	4.3	4,124	966.83	3,784	887.27	91.8	340
MMP	0.5	1,063	2,034.51	974	1,863.93	91.6	89
Medicare	0.5	530	1,038.15	502	982.50	94.6	28
	39.3	$ 13,241	$ 337.28	$ 11,794	$ 300.43	89.1%	$ 1,447

(1) Year ended December 31, 2014 data not presented due to lack of comparability, because ACA-related programs began phasing in during 2014.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Medicaid TANF, CHIP and ABD. TANF, CHIP and ABD revenue increased in 2016 when compared with 2015, due to health plan acquisitions in late 2015 and 2016, as well as inclusion of a full year of Puerto Rico operations in 2016 (Puerto Rico began operations effective April 1, 2015). The slight decline in the medical care ratio for these programs on a consolidated basis when comparing 2016 with 2015 is not significant given normal margin fluctuations observed when performance is reviewed at this level of detail.

Medicaid Expansion. Member months increased 33% in 2016, when compared with 2015, as a result of membership growth in all states. Lower premium revenue PMPM more than offset lower medical costs PMPM, leading to an increase in the consolidated medical care ratio for the Medicaid Expansion program. Medicaid Expansion medical care ratios increased in Illinois, Michigan, New Mexico and Ohio.

In the fourth quarter of 2016, we recorded two adjustments to Medicaid Expansion revenue as a result of developments that encompassed the years ended December 31, 2014, 2015 and 2016. Both adjustments, noted below, involved changes to the method of calculation of amounts due back to the states. Under contract provisions that require us to spend certain minimum amounts on medical expenses for our Expansion members, we are required to refund to the states any shortfall of actual medical costs compared with required minimum medical costs.

- In the fourth quarter of 2016, our California health plan received a contract amendment from the California Department of Healthcare Services that allowed us to deduct certain tax expenses in the computation of its Medicaid Expansion minimum medical loss ratio; this minimum medical loss ratio was effective January 1, 2014, through June 30, 2016. As a result of this contract amendment, we increased premium revenue for the year ended December 31, 2016, by approximately $68 million, of which $35 million related to periods prior to 2016.
- In February 2017, the New Mexico Human Services Department (HSD) notified us that it has disallowed certain medically related administrative expenses and other items in the computation of its Medicaid Expansion risk corridor; this corridor was effective January 1, 2014, through December 31, 2016. Although we disagree with their contractual interpretations, we deferred premium revenue amounting to approximately $45 million for the year ended December 31, 2016, as a result of this communication, because such revenue is presently subject to refund or adjustment. Of this amount, $29 million relates to dates of service prior to 2016. At December 31, 2016, our aggregate Medicaid Expansion risk corridor payable to HSD is $145 million. We intend to appeal HSD's ruling on this matter.

Marketplace. The poor performance of our Marketplace program was very detrimental to our financial performance for the year ended December 31, 2016. In 2016, we estimate that our operating loss from the Marketplace program amounted to approximately $110 million, or $1.21 per diluted share. This operating loss includes the impact of a premium deficiency reserve of $30 million for our Marketplace contracts in California and Washington, which was recorded in the fourth quarter of 2016.

The decline in profitability in 2016 compared with 2015 was the result of lower premium revenue PMPM, the premium deficiency reserve noted above, and higher medical costs PMPM. Our Marketplace performance in 2016 continued to suffer from deficiencies in the Marketplace risk transfer methodology that we believe penalizes efficient and affordable health plans like ours and, as a result, those purchasing affordable Marketplace policies ultimately pay higher premiums.

Our 2016 Marketplace results were substantially lower than our expectations based upon our 2016 pricing model. Based upon actual 2016 enrollment, our 2016 Marketplace program was priced to produce income before income taxes of approximately $60 million for all of 2016. The $170 million difference in income before income taxes between our reported results and those we would have expected based upon our pricing model was due to the following factors:

- Risk transfer payments were approximately $325 million higher than anticipated in our pricing. Risk transfer payments amounted to 24% of total premium in 2016, compared with a pricing expectation of 9%.
- Although medical costs were $120 million lower than anticipated by our pricing model, we nevertheless incurred $325 million in additional risk transfer payments noted above.
- Other items increased income before income taxes by approximately $35 million compared with pricing expectations.

The difference between our actual results and those anticipated by our pricing model was exacerbated by the federal government's failure to pay amounts owed to our health plans under the Marketplace risk corridor program.

We believe our health plans are owed approximately $90 million in Marketplace risk corridor payments for 2016 dates of service, but have not recorded any amounts associated with this claim.

MMP and Medicare. Membership and revenue increased on a consolidated basis for the MMP and Medicare programs when comparing 2016 with 2015. The medical care ratio for these programs, in the aggregate, decreased due to higher margins for the MMP program.

FINANCIAL PERFORMANCE BY STATE HEALTH PLAN

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (dollars in millions except PMPM amounts):

	Year Ended December 31, 2016						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	8.2	$ 2,370	$ 290.50	$ 2,029	$ 248.70	85.6%	$ 341
Florida	6.7	1,926	288.73	1,765	264.60	91.6	161
Illinois	2.3	601	257.99	568	243.71	94.5	33
Michigan	4.7	1,520	321.93	1,345	284.82	88.5	175
New Mexico	3.0	1,304	429.81	1,209	398.49	92.7	95
New York [1]	0.2	82	446.72	79	431.73	96.6	3
Ohio	4.0	1,961	485.20	1,747	432.36	89.1	214
Puerto Rico [1]	4.0	726	180.65	694	172.57	95.5	32
South Carolina	1.3	378	296.54	320	250.97	84.6	58
Texas	4.3	2,454	575.01	2,110	494.41	86.0	344
Utah	1.8	444	249.56	423	238.03	95.4	21
Washington	8.4	2,218	263.36	2,015	239.21	90.8	203
Wisconsin	1.6	395	252.94	388	248.28	98.2	7
Other [2]	—	13	—	82	—	—	(69)
	50.5	$ 16,392	$ 324.82	$ 14,774	$ 292.75	90.1%	$ 1,618

	Year Ended December 31, 2015						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.1	$ 2,200	$ 310.89	$ 1,926	$ 272.22	87.6%	$ 274
Florida	4.1	1,199	289.85	1,081	261.49	90.2	118
Illinois	1.2	397	328.93	367	303.72	92.3	30
Michigan	3.4	1,067	317.15	903	268.27	84.6	164
New Mexico	2.8	1,237	446.27	1,106	398.98	89.4	131
New York [1]	—	—	—	—	—	—	—
Ohio	4.1	2,034	499.34	1,718	421.61	84.4	316
Puerto Rico [1]	3.2	567	178.31	505	158.80	89.1	62
South Carolina	1.3	348	267.25	278	213.30	79.8	70
Texas	3.1	1,961	621.37	1,809	573.32	92.3	152
Utah	1.2	331	286.22	300	259.32	90.6	31
Washington	6.6	1,602	242.36	1,470	222.36	91.7	132
Wisconsin	1.2	261	213.48	215	176.01	82.4	46
Other [2]	—	37	—	116	—	—	(79)
	39.3	$ 13,241	$ 337.28	$ 11,794	$ 300.43	89.1%	$ 1,447

	Year Ended December 31, 2014						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.6	$ 1,523	$ 270.51	$ 1,269	$ 225.37	83.3%	$ 254
Florida	1.1	439	397.79	419	379.95	95.5	20
Illinois	0.3	153	498.48	141	456.88	91.7	12
Michigan	2.8	781	278.68	661	235.81	84.6	120
New Mexico	2.5	1,076	435.17	996	402.92	92.6	80
New York (1)	—	—	—	—	—	—	—
Ohio	3.7	1,553	425.47	1,335	365.87	86.0	218
Puerto Rico (1)	—	—	—	—	—	—	—
South Carolina	1.5	381	260.72	323	220.89	84.7	58
Texas	3.0	1,318	442.32	1,197	401.81	90.8	121
Utah	1.0	310	310.64	285	286.43	92.2	25
Washington	5.5	1,305	236.27	1,219	220.75	93.4	86
Wisconsin	1.0	156	150.87	136	130.91	86.8	20
Other (2)	—	28	—	95	—	—	(67)
	28.0	$ 9,023	$ 322.68	$ 8,076	$ 288.84	89.5%	$ 947

(1) The New York health plan was acquired on August 1, 2016. Our Puerto Rico health plan began serving members on April 1, 2015.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

MEDICAL CARE COSTS BY TYPE

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. The following table provides the details of consolidated medical care costs by type for the periods indicated (dollars in millions except PMPM amounts):

	Year Ended December 31,								
	2016			2015			2014		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 10,993	$ 217.84	74.4%	$ 8,572	$ 218.35	72.7%	$ 5,673	$ 202.87	70.2%
Pharmacy	2,213	43.84	15.0	1,610	41.01	13.7	1,273	45.54	15.8
Capitation	1,218	24.13	8.2	982	25.02	8.3	748	26.77	9.3
Direct delivery	78	1.55	0.5	128	3.26	1.1	96	3.44	1.2
Other	272	5.39	1.9	502	12.79	4.2	286	10.22	3.5
	$ 14,774	$ 292.75	100.0%	$ 11,794	$ 300.43	100.0%	$ 8,076	$ 288.84	100.0%

PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) decreased to 2.8% in 2016, from 2.9% in 2015, primarily due to the significant revenue growth at our Florida health plan, which operates in a state with no premium tax, and growth in MMP revenue. The Medicare portion of MMP revenue is not subject to premium tax.

The premium tax ratio decreased to 2.9% in 2015, from 3.2% in 2014. This decrease was primarily due to the 2015 increase in MMP revenue.

HEALTH INSURER FEE (HIF) REVENUE AND EXPENSES

HIF revenue, as a percentage of premium revenue, increased slightly to 2.1% in 2016, compared with 2.0% in 2015. In 2015, our Puerto Rico health plan was not subject to the HIF because it was not operational during the previous year (2014). HIF revenue, as a percentage of premium revenue, was 1.3% in 2014. During 2015, we recognized approximately $20 million of HIF premium revenue meant to reimburse us for the cost of HIF expense recognized in 2014.

The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there will be no HIF revenue or expenses in 2017.

MOLINA MEDICAID SOLUTIONS

BUSINESS OVERVIEW

- 1.1% of total revenue in 2016
- 1.4% of total revenue in 2015
- Employees: Approximately 1,200

Programs and Services

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and provides drug rebate administration services in Florida. Our existing state MMIS contracts have terms that currently extend to 2018 through 2025, before renewal options.

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we actively participate in this market.

Competition and Regulation

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services, ACS (owned by Xerox Corporation), Computer Services Corporation, and CNSI. Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance.

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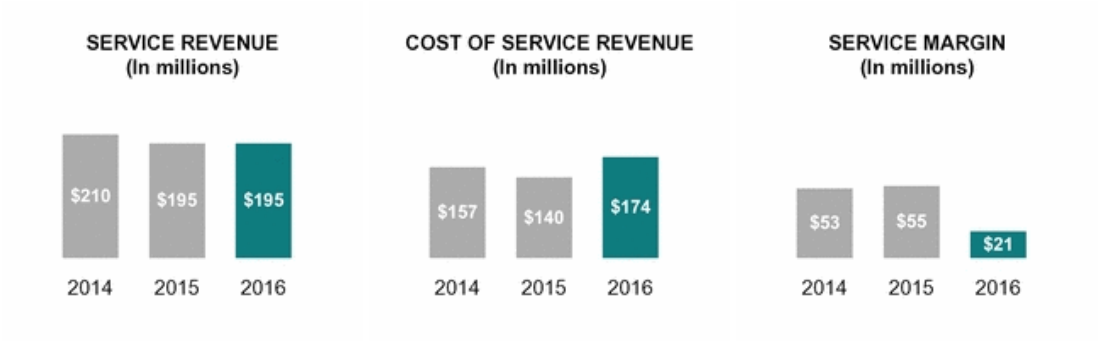
FINANCIAL OVERVIEW



2016 Compared with 2015

Service margin declined $34 million in 2016 compared with 2015, primarily due to increased service costs associated with legacy state contracts that were re-procured.

2015 Compared with 2014

Service revenue declined $15 million in 2015 compared with 2014, primarily due to an extension of the Idaho contract under which we are now amortizing certain deferred revenues over a longer term. Service margin increased slightly in 2015 compared with 2014.

OTHER

BUSINESS OVERVIEW

- 2.0% of total revenue in 2016
- 0.4% of total revenue in 2015
- Employees: Corporate – approximately 6,400. Pathways – approximately 5,500.

Programs and Services

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

We acquired the outstanding ownership interests in Pathways Health and Community Support, LLC (Pathways), formerly known as Providence Human Services, LLC, in the fourth quarter of 2015. Substantially all of Pathways' revenue is derived from contracts with state or local government agencies and government intermediaries, the majority of which are negotiated fee-for-service arrangements. A significant number of these contracts allow the payer to terminate the contract immediately with or without cause.

FINANCIAL OVERVIEW

2016 Compared with 2015

Service margin was $33 million in 2016 and insignificant in 2015. The service margin in 2015 was insignificant because our acquisition of Pathways was not completed until the fourth quarter of 2015.

OTHER CONSOLIDATED INFORMATION

GENERAL AND ADMINISTRATIVE EXPENSES

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") was 7.8% in 2016, 8.1% in 2015, and 7.9% in 2014. Our general and administrative ratio has been relatively constant since the phase-in of the ACA Medicaid Expansion and Marketplace programs beginning in 2014.

DEPRECIATION AND AMORTIZATION

Depreciation and amortization amounted to 1.0%, 0.8% and 1.4% of total revenue for the years ended December 31, 2016, 2015 and 2014, respectively.

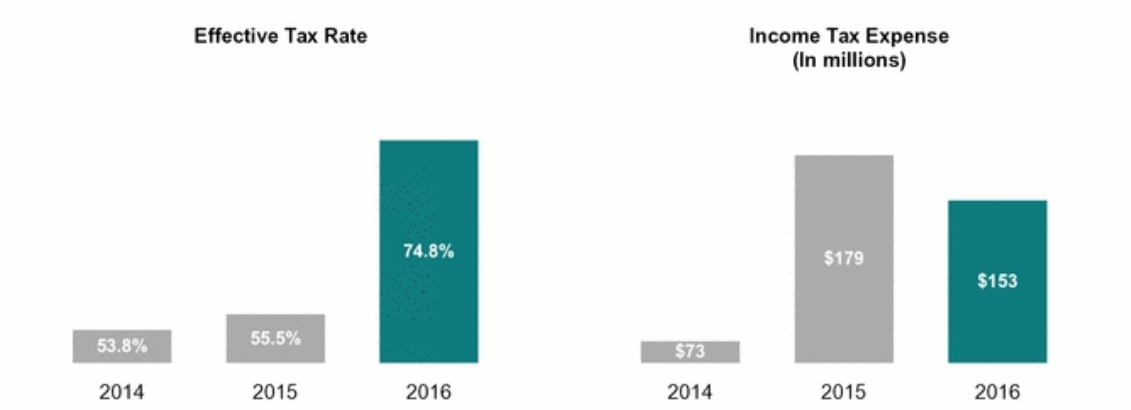
INTEREST EXPENSE

Interest expense increased to $101 million for the year ended December 31, 2016, compared with $66 million for the year ended December 31, 2015. The increase was due primarily to our issuance of $700 million aggregate principal amount of senior notes (the 5.375% Notes) due November 15, 2022, in the fourth quarter of 2015. For further details regarding this transaction, please refer to Notes to Consolidated Financial Statements, Note 12, "Debt."

Interest expense increased to $66 million for the year ended December 31, 2015, compared with $57 million for the year ended December 31, 2014. The increase was due primarily to our issuance of the 5.375% Notes in the fourth quarter of 2015.

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $31 million, $30 million and $27 million for the years ended December 31, 2016, 2015, and 2014, respectively.

INCOME TAXES



The health insurer fee that we pay to the federal government is not deductible for purposes of determining our income tax expense. The decrease in income before taxes in 2016 compared with 2015, combined with the relatively large amount of reported expenses that are not deductible for tax purposes, has resulted in an effective tax rate in excess of 70% for the full year 2016, compared with 55.5% for 2015.

The effective tax rate for 2015 was higher than 2014 primarily as a result of certain discrete tax benefits recorded in 2014 that were not recurring in 2015.

LIQUIDITY AND FINANCIAL CONDITION

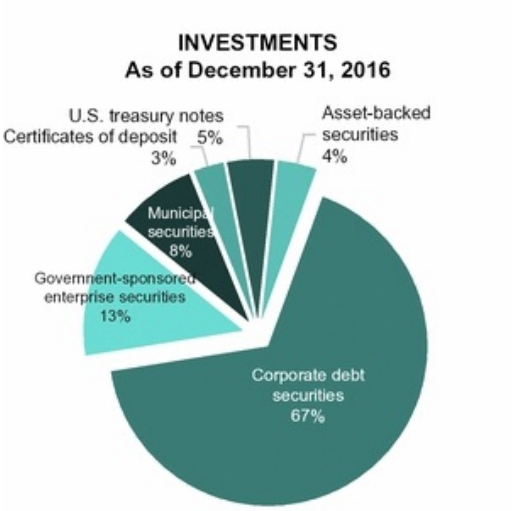
INTRODUCTION

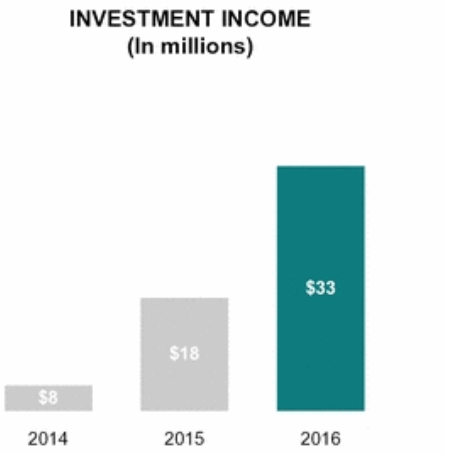
We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels.

All of our investments are classified as current assets, except for our restricted investments, which are classified as non-current assets, and which are not included in the totals below. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities; we have the ability to hold our restricted investments until maturity.





Investment income increased in 2016 compared with 2015, and in 2015 compared with 2014, primarily due to the increase in invested assets in each of 2016 and 2015. See further discussion below in “Liquidity.”

MARKET RISK

Our earnings and financial position are exposed to financial market risk relating changes in interest rates, and the resulting impact on investment income and interest expense.

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2016, the fair value of our fixed income investments would decrease by approximately $20 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to Note 5, “Fair Value Measurements,” Note 6, “Investments,” and Note 10, “Restricted Investments.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of December 31, 2016, no amounts were outstanding under the Credit Facility.

LIQUIDITY

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Year Ended December 31,				
	2016	2015	2014	2015 to 2016 Change	2014 to 2015 Change
	(In millions)				
Net cash provided by operating activities	$ 673	$ 1,125	$ 1,060	$ (452)	$ 65
Net cash used in investing activities	(202)	(1,420)	(536)	1,218	(884)
Net cash provided by financing activities	19	1,085	79	(1,066)	1,006
Net increase in cash and cash equivalents	$ 490	$ 790	$ 603	$ (300)	$ 187

Operating Activities

2016 Compared with 2015

Cash provided by operating activities was $673 million in 2016 compared with $1,125 million in 2015, a decrease of $452 million. This decrease was due primarily to a $91 million decrease in net income, and the following factors:

Receivables and deferred revenue. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. In general, states may delay our premium payments, which we record as a receivable, or they may prepay the following month’s premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In the current year, the net effect of the timing of premiums received at our California and Illinois health plans negatively impacted our cash flows from operating activities.

Medical claims and benefits payable. In 2016, the change in medical claims and benefits payable reduced cash flows from operations by $256 million, primarily because membership and related medical costs grew at a higher rate in 2015 than in 2016, resulting in a lower year-over-year change in 2016.

Amounts due government agencies. In 2016, the change in amounts due government agencies increased cash flows from operations by $271 million, due primarily to additional accruals for ACA Marketplace risk transfer payments. In addition to the impact of amounts due for Marketplace risk transfer, changes in this account relate primarily to Health Plans segment programs that contain medical cost floors or medical cost corridors. Under such programs, a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs.

2015 Compared with 2014

Cash provided by operating activities was $1,125 million in 2015, compared with $1,060 million in 2014, an increase of $65 million. This increase was primarily due to an $81 million increase in net income, and collection of premiums receivable at our California health plan in the first quarter of 2015. These increases were partially offset by our fourth quarter 2015 Medicaid expansion-related payment to the state of Washington’s Medicaid authority of $247 million, reflected in the change in amounts due to government agencies. In addition, the change in medical claims

and benefits payable reduced cash flows from operations by $49 million, primarily because membership and related medical costs grew at a higher rate in 2014 than in 2015, resulting in a lower year-over-year change in 2015.

Investing Activities

2016 Compared with 2015

Cash used in investing activities was $202 million in 2016, compared with $1,420 million in 2015, a decrease of $1,218 million. Cash flows from investing activities increased in 2016 due to $840 million increased proceeds from sales and maturities of investments, and a reduction in cash paid in business combinations of $402 million in 2016 compared with 2015.

2015 Compared with 2014

Cash used in investing activities was $1,420 million in 2015, compared with $536 million in 2014. This increase was due in part to higher purchases of investments, net of sales of maturities, amounting to $477 million, as a result of cash generated from 2015 financing activities, described below.

Financing Activities

2016 Compared with 2015

Cash provided by financing activities was $19 million in 2016, compared with $1,085 million in 2015. In 2015, we received net proceeds from our fiscal 2015 offerings of 5.375% Notes, amounting to $689 million, and common stock, amounting to $373 million, with no comparable activity in 2016.

2015 Compared with 2014

Cash provided by financing activities was $1,085 million in 2015, as described above. In 2014, cash flows from financing activities was $79 million, which included $123 million in net proceeds from our fiscal 2014 offering of 1.625% Notes, partially offset by $50 million paid to settle contingent consideration liabilities associated with our 2013 business acquisitions.

FINANCIAL CONDITION

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at December 31, 2016, our working capital was $1,418 million compared with $1,484 million at December 31, 2015. At December 31, 2016, our cash and investments amounted to $4,689 million, compared with $4,241 million of cash and investments at December 31, 2015.

Debt Ratings. Our 5.375% Notes are rated “BB” by Standard & Poor’s, and “Ba3” by Moody’s Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

FUTURE SOURCES AND USES OF LIQUIDITY

Sources

Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. We received $100 million and $125 million in dividends from our regulated health plan subsidiaries in 2016 and 2015, respectively. We received $1 million and $17 million in dividends from our unregulated subsidiaries during 2016 and 2015, respectively. We did not receive dividends from our subsidiaries in 2014. See further discussion in Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions,” and Note 22, “Condensed Financial Information of Registrant—Note C - Dividends and Capital Contributions.”

Credit Facility. Refer to Note 12, “Debt,” for a detailed discussion of our Credit Facility.

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Uses

Regulatory Capital Requirements. In 2016, 2015, and 2014, we contributed capital amounting to $338 million, $320 million, and $248 million, respectively, to our health plans subsidiaries to satisfy statutory net worth requirements. For a comprehensive discussion of this topic, refer to Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

Acquisitions. In 2016, 2015, and 2014, we paid $48 million, $450 million, and $44 million, respectively, for businesses or assets acquired in business combinations. Consistent with our business strategy, we will continue to evaluate acquisition opportunities.

States’ Budgets. From time to time, the states in which our health plans operate may delay premium payments. For example, the state of Illinois is currently operating without a budget for its current fiscal year. As of December 31, 2016, our Illinois health plan served approximately 195,000 members, and recognized premium revenue of approximately $601 million for the year ended December 31, 2016. As of February 24, 2017, the state of Illinois owed us approximately $68 million for certain October, November and December 2016 premiums.

In another example, the Commonwealth of Puerto Rico’s fiscal plan, issued on October 14, 2016, reported that current revenues are insufficient to support existing current operations and debt service. While the Commonwealth reports that it will prioritize health care spending, it stresses the need to address the cap on federal matching funds it receives for its participation in the Medicaid program. Among the fiscal issues expected to further exacerbate the Commonwealth’s current debt crisis is the depletion of ACA funds, estimated to occur in the Commonwealth’s fiscal year 2018. As of December 31, 2016, our Puerto Rico health plan served approximately 330,000 members and recorded premium revenue of approximately $726 million for the year ended December 31, 2016. As of February 24, 2017, the Commonwealth is current with its premium payments.

Convertible Senior Notes. Refer to Note 12, “Debt,” for a detailed discussion of our Convertible Senior Notes. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The stock price trigger for the 1.125% Notes is $53.00 per share. The 1.125% Notes met this trigger in the quarter ended December 31, 2016, and are convertible to cash through at least March 31, 2017. Because the 1.125% Notes may be converted into cash within 12 months, the $471 million carrying amount is reported in current portion of long-term debt as of December 31, 2016. For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash.

The stock price trigger for the 1.625% Notes is $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on February 24, 2017 was $48.83 per share. As of December 31, 2016, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

We have sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

CONTRACTUAL OBLIGATIONS

In the table below, we present our contractual obligations as of December 31, 2016. Some of the amounts included in this table are based on management’s estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table.

Additionally, we have a variety of other contractual agreements related to acquiring services used in our operations. However, we believe these other agreements do not contain material noncancelable commitments.

	Total [1]	2017	2018-2019	2020-2021	2022 and after
			(In millions)		
Medical claims and benefits payable	$ 1,929	$ 1,929	$ —	$ —	$ —
Principal amount of senior notes [2]	1,552	—	—	550	1,002
Amounts due government agencies	1,202	1,202	—	—	—
Lease financing obligations	427	17	35	38	337
Interest on long-term debt	376	49	98	85	144
Operating leases	267	63	107	54	43
Purchase commitments	20	10	10	—	—
	$ 5,773	$ 3,270	$ 250	$ 727	$ 1,526

(1) As of December 31, 2016, we have recorded approximately $11 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Notes to Consolidated Financial Statements, Note 14, “Income Taxes.”

(2) Represents the principal amounts due on our 5.375% Senior Notes due 2022, 1.125% Cash Convertible Senior Notes due 2020, and our 1.625% Convertible Senior Notes due 2044 (1.625% Notes). The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, as described in Notes to Consolidated Financial Statements, Note 12, “Debt.”

Commitments and Contingencies. We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies.”

INFLATION

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

COMPLIANCE COSTS

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

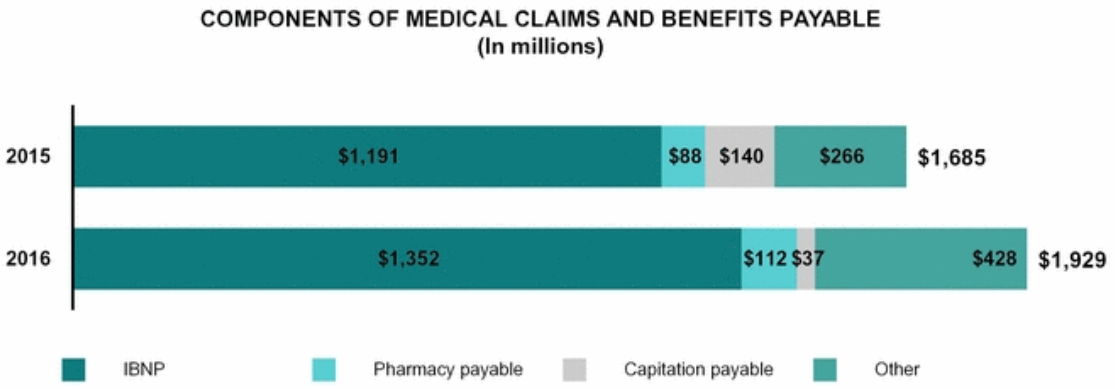
CRITICAL ACCOUNTING ESTIMATES

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable.* See discussion below, and refer to Notes to Consolidated Financial Statements, Note 11, “Medical Claims and Benefits Payable.”

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Health Plans segment quality incentives.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Molina Medicaid Solutions segment revenue and cost recognition.* For a comprehensive discussion of this topic, refer to Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Goodwill and intangible assets, net.* See discussion below, and refer to Notes to Consolidated Financial Statements, Note 9, "Goodwill and Intangible Assets."

MEDICAL CLAIMS AND BENEFITS PAYABLE - HEALTH PLANS SEGMENT



"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. As of December 31, 2016 and 2015, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $225 million and $167 million, respectively.

The determination of our liability for medical claims and benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for medical claims and benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the graph above, our estimated IBNP liability represented $1,352 million of our total medical claims and benefits payable of $1,929 million as of December 31, 2016.

The factors we consider when estimating our IBNP include, without limitation:

- claims receipt and payment experience (and variations in that experience),
- changes in membership,
- provider billing practices,
- health care service utilization trends,
- cost trends,
- product mix,
- seasonality,
- prior authorization of medical services,
- benefit changes,
- known outbreaks of disease or increased incidence of illness such as influenza,
- provider contract changes,
- changes to Medicaid fee schedules, and
- the incidence of high dollar or catastrophic claims.

Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse claims deviation, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2016 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2016, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in millions.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 462
(4)%	308
(2)%	154
2%	(154)
4%	(308)
6%	(462)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2016 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in millions.

(Decrease) Increase in Trended Per Member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (238)
(4)%	(158)
(2)%	(79)
2%	79
4%	158
6%	238

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 56 million diluted shares outstanding for the year ended December 31, 2016. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2016, net income for the year ended December 31, 2016 would increase or decrease by approximately $49 million, or $0.86 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2016, net income for the year ended December 31, 2016 would increase or decrease by approximately $25 million, or $0.44 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $243 million, or $4.32 per diluted share, and $125 million, or $2.22 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, changes in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $49 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse deviation in our claims payments for which the base actuarial model is not intended to and does not account. We refer to this additional liability as the provision for adverse claims deviation. The provision for adverse claims deviation is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled, changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims deviation.

We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date.

The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and

may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, changes in estimates involving trended PMPM costs will almost always be accompanied by changes in estimates involving completion factors, and vice versa. In such circumstances, changes in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Refer to Notes to Consolidated Financial Statements, Note 11, “Medical Claims and Benefits Payable,” for additional information regarding the specific factors used to determine our changes in estimates of IBNP, as well as a table presenting the components of the change in our medical claims and benefits payable, for all periods presented in the accompanying consolidated financial statements.

GOODWILL AND INTANGIBLE ASSETS, NET

At December 31, 2016, goodwill and intangible assets, net, represented approximately 10% of total assets and 46% of total stockholders’ equity, compared with 10% and 41%, respectively, at December 31, 2015.

Goodwill

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is subject to an annual impairment test. We are required to test at least annually for impairment, or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. Such events or circumstances may include experienced or expected operating cash-flow deterioration or losses, significant loss of membership, loss of state funding, loss of state contracts, and other factors.

We conduct our required annual impairment testing of goodwill during the fourth quarter. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analysis. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. We believe that the dynamic economic and political environments in which we operate often necessitate the performance of the quantitative test to prove that goodwill is not impaired on an annual basis.

Under the quantitative test we first measure the fair values of our reporting units and compare them to the carrying values of the respective units, including goodwill. Second, if the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared with the carrying amount of goodwill to determine the impairment charge, if any.

We estimate the fair values of our reporting units using discounted cash flows. In the discounted cash flow analyses, we must make assumptions about a wide variety of internal and external factors. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. We use a discount rate that corresponds to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate.

The fair value of our reporting units with significant goodwill generally exceeded carrying amounts substantially, by margins of greater than 100%. At December 31, 2016, the fair values of our Illinois health plan, Pathways subsidiary, and Molina Medicaid Solutions segment exceeded their carrying amounts by 42%, 54%, and 70%, respectively. The Illinois health plan acquired significant additional membership in 2016. As these members transition to managed care, we will continue to monitor the plan’s future health care costs and expected cash flows. At our Pathways subsidiary, we expect to leverage certain behavioral health capabilities to expand the revenue and

profit margin of our Health Plans segment. Since we acquired Pathways in late 2015, we continue to integrate its operations and develop intersegment services. At the Molina Medicaid Solutions segment, one of the factors considered in the discounted cash flow model is the procurement of new state MMIS contracts. Since our acquisition of this business in 2010, we have entered into three contracts to provide new or replacement MMIS. Our existing state MMIS contracts have terms that currently extend to 2018 through 2025, before renewal options.

Key assumptions in our cash flow projections, including changes in membership, premium rates, health care and operating cost trends, contract renewals and the procurement of new contracts, and synergies expectations relating to newly acquired businesses, are consistent with those used in our long-range business plan and annual planning process. If these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss.

Intangible Assets

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2016, 2015, or 2014.

SUPPLEMENTAL INFORMATION

FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

EBITDA*

We believe that EBITDA* is particularly helpful in assessing our ability to meet the cash demands of our operating units. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA*.

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Net income	$ 52	$ 143	$ 62
Adjustments:			
Depreciation, and amortization of intangible assets and capitalized software	161	120	114
Interest expense	101	66	57
Income tax expense	153	179	72
EBITDA*	$ 467	$ 508	$ 305

ADJUSTED NET INCOME* AND ADJUSTED NET INCOME PER SHARE*

We believe that adjusted net income* and adjusted net income per diluted share* is very helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net income*.

	Year Ended December 31,					
	2016		2015		2014	
	(In millions, except diluted per-share amounts)					
	Amount	Per share	Amount	Per share	Amount	Per share
Net income	$ 52	$ 0.92	$ 143	$ 2.58	$ 62	$ 1.29
Adjustment:						
Amortization of intangible assets	32	0.57	18	0.32	20	0.42
Income tax effect [1]	(12)	(0.21)	(7)	(0.12)	(7)	(0.15)
Amortization of intangible assets, net of tax effect	20	0.36	11	0.20	13	0.27
Adjusted net income*[2]	$ 72	$ 1.28	$ 154	$ 2.78	$ 75	$ 1.56

(1)Income tax effect of adjustments calculated at the blended federal and state statutory tax rate of 37%.

(2)Beginning in the first quarter of 2016, we revised our calculation of adjusted net income*. We no longer subtract “Amortization of convertible senior notes and lease financing obligations” from net income to arrive at adjusted net income*. We made this change because various capital transactions completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources of capital. We believe that this change enhances the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors. All periods presented conform to this presentation.

OTHER FINANCIAL DATA

SELECTED FINANCIAL DATA

(In millions, except per-share amounts)

	Year Ended December 31,				
	2016	2015	2014	2013	2012
Statements of Income Data:					
Revenue:					
Premium revenue	$ 16,392	$ 13,241	$ 9,023	$ 6,179	$ 5,544
Service revenue [1]	539	253	210	205	188
Premium tax revenue	468	397	294	172	159
Health insurer fee revenue	345	264	120	—	—
Investment income and other revenue	38	23	20	33	23
Total revenue	17,782	14,178	9,667	6,589	5,914
Operating expenses:					
Medical care costs	14,774	11,794	8,076	5,380	4,991
Cost of service revenue [1]	485	193	157	161	141
General and administrative expenses	1,393	1,146	765	666	519
Premium tax expenses	468	397	294	172	159
Health insurer fee expenses	217	157	89	—	—
Depreciation and amortization	139	104	93	73	63
Total operating expenses	17,476	13,791	9,474	6,452	5,873
Operating income	306	387	193	137	41
Other expenses, net:					
Interest expense	101	66	57	52	17
Other (income) expense, net	—	(1)	1	4	1
Total other expenses, net	101	65	58	56	18
Income from continuing operations before income taxes	205	322	135	81	23
Income tax expense	153	179	73	36	10
Income from continuing operations	52	143	62	45	13
Income (loss) from discontinued operations, net of tax expense (benefit) [2]	—	—	—	8	(3)
Net income	$ 52	$ 143	$ 62	$ 53	$ 10
Basic net income per share: [3]					
Income from continuing operations	$ 0.93	$ 2.75	$ 1.34	$ 0.98	$ 0.28
(Loss) income from discontinued operations	—	—	(0.01)	0.18	(0.07)
Basic net income per share	$ 0.93	$ 2.75	$ 1.33	$ 1.16	$ 0.21
Diluted net income per share: [3]					
Income from continuing operations	$ 0.92	$ 2.58	$ 1.30	$ 0.96	$ 0.27
(Loss) income from discontinued operations	—	—	(0.01)	0.17	(0.06)
Diluted net income per share	$ 0.92	$ 2.58	$ 1.29	$ 1.13	$ 0.21
Weighted average shares outstanding:					
Basic	55	52	47	46	46
Diluted	56	56	48	47	47

(1) Service revenue and cost of service revenue include revenue and costs generated by our Pathways subsidiary, which was acquired on November 1, 2015.

(2) Income (loss) from discontinued operations is presented net of income tax expense (benefit), which was insignificant in 2016, 2015 and 2014, and $(10), and $(1), in 2013 and 2012, respectively.

(3) Source data for calculations in thousands.

	December 31,				
	2016	2015	2014	2013	2012
Balance Sheet Data:					
Cash and cash equivalents	$ 2,819	$ 2,329	$ 1,539	$ 936	$ 796
Total assets	7,449	6,576	4,435	2,988	1,901
Long-term debt, including current portion [1]	1,645	1,609	887	770	261
Total liabilities	5,800	5,019	3,425	2,095	1,119
Stockholders' equity	1,649	1,557	1,010	893	782

(1) Includes senior notes, lease financing obligations, and other long-term debt.

STOCK REPURCHASE PROGRAMS

Purchases of common stock made by us, or on our behalf during the quarter ended December 31, 2016, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased [1]	Average Price Paid per Share [1]	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs [2]	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs [2]
October 1 — October 31	185	$ 58.32	—	$ 50,000,000
November 1 — November 30	329	$ 53.94	—	$ 50,000,000
December 1 — December 31	339	$ 52.69	—	$ 50,000,000
	853	$ 54.39	—	

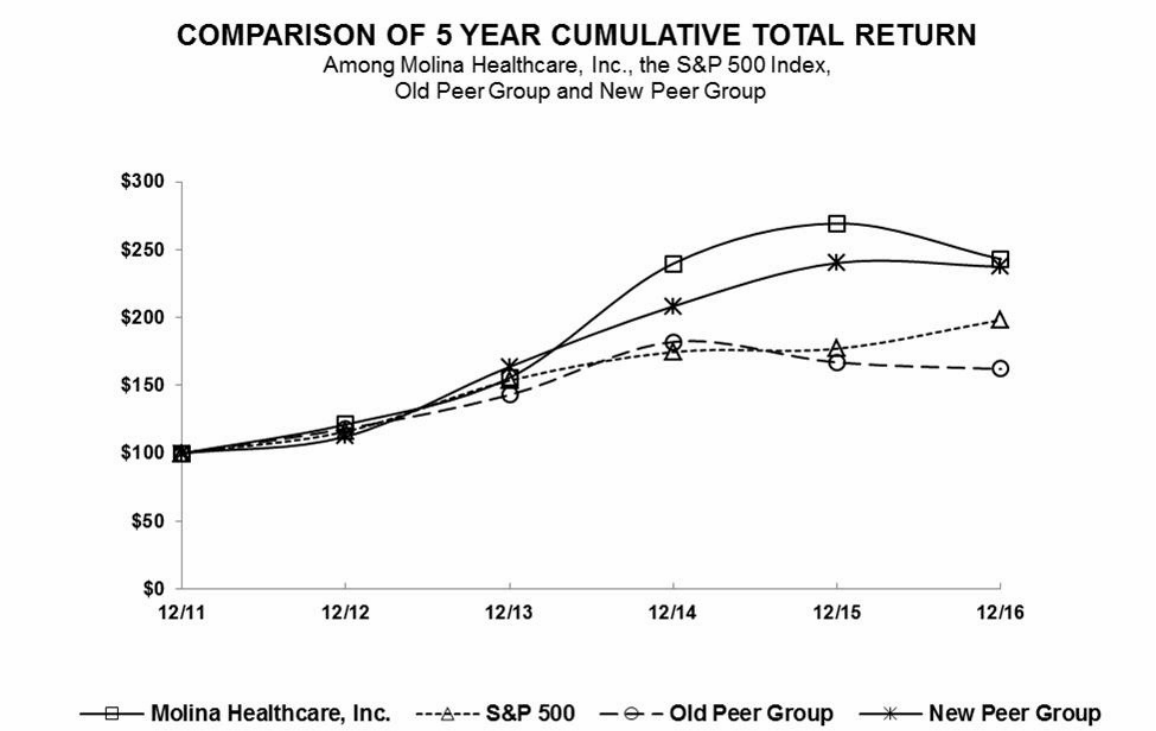
(1) During the quarter ended December 31, 2016, we withheld 853 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(2) In December 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. We did not repurchase any shares under this program, which expired without renewal on December 31, 2016.

STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the U.S. Securities and Exchange Commission (SEC) (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that we specifically incorporate it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (S&P 500) and a peer group index for the five-year period from December 31, 2011 to December 31, 2016. The comparison assumes $100 was invested on December 31, 2011, in our common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.



The old peer group index, used in last year's Annual Report on Form 10-K and also set forth above, consists of Brookdale Senior Living, Inc. (BKD), Catamaran Corporation (CTRX), Centene Corporation (CNC), Community Health Systems, Inc. (CYH), DaVita HealthCare Partners, Inc. (DVA), Health Net, Inc. (HNT), Kindred Healthcare, Inc. (KND), Laboratory Corporation of America Holdings (LH), Life Point Hospitals, Inc. (LPNT), Magellan Health, Inc. (MGLN), Omnicare, Inc. (OCR), Quest Diagnostics, Inc. (DGX), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).

The new peer group index consists of Centene Corporation (CNC), Cigna Corporation (CI), DaVita HealthCare Partners, Inc. (DVA), Humana Inc. (HUM), Magellan Health, Inc. (MGLN), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).

STOCK PRICE RANGE AND DIVIDENDS

Our common stock is listed on the New York Stock Exchange under the trading symbol “MOH.” As of February 24, 2017, there were approximately 120 holders of record of our common stock.

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business growth. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Additionally, the indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain various covenants that limit our ability to pay dividends on our common stock.

Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

PROPERTIES

As of December 31, 2016, the Health Plans segment leased a total of 89 facilities, the Molina Medicaid Solutions segment leased a total of 13 facilities and the Other segment leased a total of 289 facilities. We own a 186,000 square-foot office building in Troy, Michigan and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. We own a 26,700 square foot data center in Albuquerque, New Mexico and 40 properties in Pennsylvania, which are primarily residential housing facilities, under our Other segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operational growth prospects to determine if additional space is required, and where it would be best located.

EMPLOYEES

As of December 31, 2016, we had approximately 21,000 employees. Our employee base is multicultural and reflects the diverse membership we serve.

AVAILABLE INFORMATION

Dr. C. David Molina founded our Company in 1980 as a provider organization serving low-income families in Southern California. We were originally organized in California as a holding company for our initial health plan and reincorporated in Delaware in 2002. Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

You can access our website at *www.molinahealthcare.com* to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

RISK FACTORS

This Annual Report on Form 10-K and the documents we incorporate by reference in this report contain "forward-looking statements" as discussed in the Forward-Looking Statements section.

The risk factors below should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem insignificant may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Segment

We operate in an unstable political environment which creates uncertainties with regard to the sources and amounts of our revenues, volatility with regard to the amount of our medical costs, and vulnerability to unforeseen programmatic or regulatory changes.

As a result of the election of President Trump and the GOP control of both houses of Congress, there is currently a great deal of discussion and debate about the repeal and replacement of the ACA. As a result, the future of the ACA and its underlying programs are subject to substantial uncertainty, making long-term business planning exceedingly difficult. We are unable to predict with any degree of certainty whether the ACA will be modified or repealed in its entirety, and if it is repealed, what it will be replaced with; nor are we able to predict when any such changes, if enacted, would become effective.

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following: ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers; reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults; changing Medicaid to a state

block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap"); prohibiting the federal government from operating Marketplaces; eliminating the advanced premium tax credits, and cost-sharing reductions for low income individuals who purchase their health insurance through the Marketplaces; expanding and encouraging the use of private health savings accounts; providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans; establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; allowing insurers to sell insurance across state lines; and numerous other potential changes and reforms. Changes to or the repeal of the ACA, or the adoption of new health care regulatory laws, could have a material adverse effect on our business, financial condition, cash flows or results of operations.

The Medicaid Expansion could be reversed.

In the states that have elected to participate, the ACA provided for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Since January 1, 2014, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have participated in the Medicaid Expansion program under the ACA. At December 31, 2016, our membership included approximately 673,000 Medicaid Expansion members, or 16% of our total membership. If the Medicaid Expansion is reversed by repeal of the ACA, we could lose this membership, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The Marketplace could be eliminated, or our continued participation in 2018 could become financially unsustainable.

The ACA authorized the creation of marketplace insurance exchanges (the "Marketplace"), allowing individuals and small groups to purchase federally subsidized health insurance. We participate in the individual Marketplace in nine states. As of December 31, 2016, our Marketplace membership represented 13% of our total membership, or approximately 526,000 members. Our membership in 2017 is even higher, with 920,000 members as of January 31, 2017. The risk of material variances between actual results and our pricing assumptions is compounded by increased uncertainty created by competitors exiting the Marketplace, unknown impacts of legislative and/or regulatory changes, and changes to the risk transfer algorithm.

A number of larger commercial insurance plans, including most recently, Humana Inc., have announced their intention to discontinue their participation in the Marketplace. The perceived instability and impending changes in the Marketplace could further promote reduced participation among the uninsured. Further, the withdrawal of cost sharing subsidiaries and/or premium tax credits, the elimination of the individual mandate to purchase health insurance, the use of special enrollment periods, or any announcement that some or all of our health plans will be leaving the Marketplace for 2018, could additionally impact Marketplace enrollment. These market and political dynamics may increase the risk that our Marketplace products will be selected by individuals who have a higher risk profile or utilization rate than we anticipated when we established the pricing for our Marketplace products, leading to financial losses.

In addition, during 2016 our results were severely impacted by a risk transfer methodology that we believe penalizes comparatively efficient and affordable health plans like ours. That same flawed methodology is also in place for 2017 (although we are advocating for its immediate change). If we fail to accurately project the adverse impact of the risk transfer methodology, our results in 2017 could be adversely and materially affected.

The Medicare-Medicaid Duals Demonstration Pilot Programs could be discontinued or altered, resulting in a loss of premium revenue.

To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligibles"), and to deliver services to these individuals in a more financially efficient manner, under the direction of CMS some states implemented demonstration pilot programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states: California, Illinois, Michigan, Ohio, South Carolina, and Texas. At December 31, 2016, our membership included approximately 51,000 integrated MMP members, representing just over 1% of our total membership. However, the capitation payments paid to us for dual eligible is significantly higher than the capitation payments for other members, representing 8% of our total premium revenues in 2016. If the states running the MMP pilot programs conclude that the programs are not delivering better coordinated care and reduced cost, they could decide to discontinue the programs, or to substantially alter the programs, resulting in a reduction in our premium revenues.

Continuing changes in health care laws, and in the health care industry, make it difficult to develop actuarially sound rates.

Comprehensive changes to the U.S. health care system make it more difficult for us to manage our business, and increase the likelihood that the assumptions we make with respect to our future operations and results will prove to be inaccurate. The continuing pace of change has made it difficult for us to develop actuarially sound rates because we have limited historical information on which to develop these rates. In the absence of significant historical information to develop actuarial rates, we must make certain assumptions. These assumptions may subsequently prove to be inaccurate. For example, rates of utilization could be significantly higher than we projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, our lack of actuarial experience for a particular program, region, or population, could cause us to set our reserves at an inadequate level.

We are dependent upon a small number of state Medicaid contracts for the majority of our revenue.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Many of our government contracts are subject to periodic competitive bidding. In 2017, we expect to participate in a competitive bidding process in each of the states of Illinois, Washington, Florida, New Mexico and Texas. In such process, our health plans may face competition from numerous other health plans, many with greater financial resources and greater name recognition than we have. If the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states, and our premium revenues could be materially reduced as a result. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or, in extreme cases, could result in a net loss.

Because we derive our premium revenues from a relatively small number of state health plans, adverse changes in any one of the jurisdictions in which we operate could adversely impact our business, financial condition, cash flows, or results of operations.

We currently derive our premium revenues from 12 state health plans and our health plan in the Commonwealth of Puerto Rico. If we are unable to continue to operate in any of those jurisdictions, or if our current operations in any portion of the jurisdictions we are in are significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of jurisdictions could cause our revenue and profitability to change suddenly and unexpectedly in the event of an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic, an unexpected increase in utilization, general economic conditions, and similar factors in those jurisdictions. Our inability to continue to operate in any of the jurisdictions in which we currently operate, or a significant change in the nature of our existing operations, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our health plans segment operates with very low profit margins, and small changes in operating performance or slight changes to our accounting estimates will have a disproportionate impact on our reported net income.

A substantial portion of our premium revenues is subject to risks related to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost-plus and performance-based reimbursement programs.

A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost floors and corridors, administrative cost and profit ceilings, cost-plus reimbursement, premium stabilization programs, and profit-sharing arrangements. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are potentially subject to differing interpretations by ourselves and the relevant government agency with whom we contract. If the applicable government agency disagrees with our interpretation or implementation of a particular contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to the government agency. Any interpretation of these contract

provisions that varies from our interpretation and implementation of the provision, or that is inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. If we are unsuccessful in achieving the stated performance measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

If we are unable to deliver quality care, and maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state or commonwealth to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our start-up costs.

Even if we are successful in establishing a profitable health plan in a new state or commonwealth, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state or commonwealth will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis, or at all, the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or commonwealth, or expanding a health plan in

an existing state or commonwealth could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets—particularly operators of large commercial health plans—have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us, or at all, or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years, or that we will not complete acquisitions that turn out to be unfavorable. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. Problems that we may encounter in connection with our integration efforts include the following:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems and difficulties integrating the acquired businesses on our information technology platform,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

We are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. If we seek to acquire a business located in a state in which we do not already operate, we must obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

Introduction of new high cost specialty drugs and sudden costs spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our capitation rates are not adequate to cover the actual pharmacy costs, which jeopardizes the overall actuarial soundness of our rates. Bearing the high costs of new specialty drugs or the high cost inflation of generic drugs without an appropriate rate adjustment or other reimbursement mechanism adversely impacts our financial conditional and operational results. For example, Gilead priced a new hepatitis C drug, Sovaldi, at $84,000 per standard course of therapy in 2014. With the advent of Sovaldi in early 2014, the cost of the drug was generally not factored into our 2014 capitation rates which undermined the actuarial soundness of those rates. Further, the relatively high incidence of hepatitis C in Medicaid populations coupled with the exorbitant cost of Sovaldi created a public health and public financing problem across the country. More recently, the FDA approved the first drug to treat patients with spinal muscular atrophy, Spinraza, in December 2016. After this approval, the distributor of Spinraza announced that one dose will have a list price of $125,000, which means the drug will cost between $650,000 and $750,000 to cover the five or six doses required in the first year, and approximately $375,000 annually thereafter, presumably for the life of the patient. The inordinate cost of Spinraza was not contemplated in the development of our 2017 capitation rates. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and

changes in discounts. Although we will continue to work with state Medicaid agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends, there can be no assurance that we will always be successful.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plans are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have a material adverse effect on our business, cash flows, or results of operations.

Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Due to insolvency or other circumstances, such providers may be unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so; or we have already paid claims to a delegated provider and such payments cannot be recouped when the delegated provider becomes insolvent. Liabilities incurred or losses suffered as a result of provider insolvency could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Numerous circumstances might lead to inadequate premium rates, or to the inability of Medicaid agencies to pay us according to the terms of our contracts with those agencies.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures. As discussed below, such budgetary pressures are particularly intense in the Commonwealth of Puerto Rico. State budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

We are unable to determine how any future congressional spending cuts will affect Medicare and Medicaid reimbursement. We believe there will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one or more

of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Furthermore, a state or commonwealth undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state in which we operate a health plan does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

The Commonwealth of Puerto Rico may fail to pay the premiums of our Puerto Rico health plan, which could negatively impact our business, financial condition, cash flows, or results of operations.

The government of Puerto Rico continues to struggle with major fiscal and liquidity challenges. The extreme financial difficulties faced by the Commonwealth may make it impossible for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2016, our Puerto Rico health plan served approximately 330,000 members, and had recognized premium revenue of approximately $191 million in the fourth quarter of 2016, or approximately $64 million per month. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Pandemics, natural disasters and other health care emergencies may threaten our solvency.

Large-scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.

Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions. For example, natural disasters, such as a major earthquake in Los Angeles or Cascadia, or a major hurricane in Florida or South Carolina, could have a significant impact on the health of a large number of our covered members. Other conditions that could impact our members include an influenza epidemic, or newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikungunya virus, conditions for which vaccines may not exist, are not effective, or have not been widely administered. For example, the Zika virus is spreading at epidemic rates in Puerto Rico; a high incidence of Zika cases in Puerto Rico could increase our Puerto Rico's health plan's medical expenses beyond the amounts actuarially factored into its capitation rates.

In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction. All of these conditions, and others, could have a significant impact on the health of the population of wide-spread areas. We seek to set our IBNP reserves appropriately to account for anticipatable spikes in utilization, such as for the flu season. However, if one of our health plan states were to experience a large-scale natural disaster, a viral epidemic or pandemic, a significant terrorism attack, or some other large-scale event affecting the health of a large number of our members, our covered medical expenses in that state would rise, which could have a material adverse effect on our business, cash flows, financial condition, or results of operations.

We measure our performance and adjust our actions based upon financial estimates that are inherently subject to retroactive changes.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid" (IBNP) medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to duals, Medicaid expansion members, Marketplace members, or aged, blind or disabled Medicaid members, is negatively impacted by the more limited experience we have had with those populations.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

We are subject to retroactive adjustment to our Medicaid premium revenue as a result of retroactive risk adjustment; retroactive changes to contract terms and the resolution of differing interpretations of those terms; the difficulty of estimating performance-based premium; and retroactive adjustments to "blended" premium rates to reflect the actual mix of members captured in those blended rates.

The complexity of some of our Medicaid contract provisions; the desire of state Medicaid agencies in some circumstances to retroactively adjust for the acuity of the medical needs of our members; and state delays in processing rate changes can create uncertainty around the amount of revenue we should recognize.

For example, in February 2017, the New Mexico Human Services Department (HSD) notified us that it has disallowed certain medically related administrative expenses and other items in the computation of its Medicaid Expansion risk corridor; this corridor was effective January 1, 2014, through December 31, 2016. Although we disagree with their contractual interpretations, we deferred premium revenue amounting to approximately $45 million for the year ended December 31, 2016, as a result of this communication, because such revenue is presently subject to refund or adjustment. Of this amount, $29 million relates to dates of service prior to 2016.

In another example, in the fourth quarter of 2016, our California health plan received a contract amendment from the California Department of Healthcare Services that allowed us to deduct certain tax expenses in the computation of its Medicaid Expansion minimum medical loss ratio; this minimum medical loss ratio was effective January 1, 2014, through June 30, 2016. As a result of this contract amendment, we increased premium revenue for the year ended December 31, 2016, by approximately $68 million, of which $35 million related to periods prior to 2016.

Also in the fourth quarter of 2016, the Illinois Medicaid agency reduced our full year 2016 premium capitation payment by approximately $18 million as a result of a program wide risk adjustment that attempted to reduce revenue to health plans serving members with lower than average acuity and to transfer that premium revenue to health plans serving members with higher than average acuity.

In still another example, the California Medicaid agency has yet to share with us certain premium rates related to calendar year 2015 and 2016. We have also not reached agreement with the California Medicaid agency on the final aid category classifications for some members receiving long term services and supports. Since premium rates

vary significantly by aid category, any difference in classification of these members could result in substantial variances in premium revenue between our current estimates and the amounts ultimately realized. The state Medicaid agency in California is also several years behind in its reconciliation and settlement with us of the difference between expenses that it has paid on our behalf to providers of long term services and supports and the amounts that it has withheld from our premium for those expenses.

Any circumstance such as those described above could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to accurately predict and effectively manage our medical care costs, our operating results could be materially and adversely affected.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio of 90.1%, for the year ended December 31, 2016 had been one percentage point higher, or 91.1%, our net loss per diluted share for the year ended December 31, 2016 would have been approximately $0.93 rather than our actual net income per diluted share of $0.92, a difference of $1.85.

Many factors may affect our medical care costs, including:

- the level of utilization of health care services,
- unexpected patterns in the annual flu season,
- increases in hospital costs,
- increased incidences or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage,
- increased maternity costs,
- payment rates that are not actuarially sound,
- changes in state eligibility certification methodologies,
- relatively low levels of hospital and specialty provider competition in certain geographic areas,
- increases in the cost of pharmaceutical products and services,
- changes in health care regulations and practices,
- epidemics,
- new medical technologies, and
- other various external factors.

Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We operate in a highly regulated environment.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators

ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. We received $100 million and $125 million in dividends from our regulated health plan subsidiaries during 2016 and 2015, respectively. We did not receive any dividends from our regulated health plan subsidiaries during 2014, because significant growth across all of our health plans necessitated that the plans retain their cash to meet increasing net worth requirements. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2016 and 2015, without approval of the regulatory authorities, were approximately $201 million and $121 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under the senior notes or the revolving credit facility (Credit Facility).

Our use and disclosure of personally identifiable information and other non-public information, including protected health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations including, but not limited to, HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of personally identifiable information (PII), including protected health information, or PHI. HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities and business associates, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities for compliance with the HIPAA Privacy and Security Standards. Investigations of violations that indicate willful neglect, for which penalties are now mandatory, are statutorily required. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the civil monetary penalty fine paid by the violator.

HIPAA further requires covered entities to notify affected individuals "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach" if their unsecured PHI is subject to an unauthorized access, use, or disclosure. If a breach affects 500 patients or more, it must be reported to HHS and local media without unreasonable delay, and HHS will post the name of the breaching entity on its public website. If a breach affects fewer than 500 individuals, the covered entity must log it and notify HHS at least annually. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the American Recovery and Reinvestment Act of 2009, or ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. As required by ARRA, the Secretary of HHS has promulgated regulations implementing various provisions of the HITECH Act. The Final Omnibus Rule promulgated by HHS in January 2013, included the Final Breach Notification Rule as well as provisions that apply the HIPAA regulatory scheme to business associates. We anticipate that HHS will promulgate additional rules under the HITECH Act to implement provisions of the statute which were not addressed in the Final Omnibus Rule. The various requirements of the HITECH Act and the Final Omnibus Rule have different compliance dates, and in some cases, the applicable compliance date may depend on the publication of additional rules or guidance by HHS. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with such provisions. With respect to additional requirements that may be issued in the future by HHS, it is our intention to implement any such new requirements on or before the applicable compliance dates.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, PII, or non-public information, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal penalties, divert management's time and energy, and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, upcoding, payments made to excluded providers, improper marketing, and the violation of patient privacy rights. In particular, there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices, particularly in the Medicare program. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services (HHS), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. We have been the subject of *qui tam* actions in the past and other *qui tam* actions may be filed against us in the future. If we are subject to liability under a *qui tam* or other actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Risks Related to the Operation of Our Molina Medicaid Solutions Segment

We operate in an unstable political environment which creates uncertainties with regard to the sources and amounts of our revenues, volatility with regard to the amount of our medical costs, and vulnerability to unforeseen programmatic or regulatory changes.

If federal spending on the Medicaid program is reduced, populations served by Molina Medicaid Solutions could decline and our revenues could be materially reduced.

As noted above, some of the ACA modifications considered involve significantly reduced federal spending on the Medicaid program. Among the proposals being considered include reversing the ACA's expansion of Medicaid, and changing Medicaid to a state block grant program, possibly including a per capita cap. An end to Medicaid Expansion could lower the populations served by Molina Medicaid Solutions. Changing Medicaid to a state block grant program would turn control of the program to states and cap what the federal government spends on Medicaid each year. Fixed state block grants could mean states will cut benefits or force beneficiaries to take on more cost-sharing. If Medicaid Expansion were reversed and the funding of Medicaid capped, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida. If we are unable to continue to operate in any of those six jurisdictions, or if our current operations in any of those jurisdictions are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. If our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. In addition, we may be unable to support the carrying amount of goodwill we have recorded for this business, because its fair value estimated future cash flows. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business could be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various

procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our business may be adversely affected by the transition from traditional fee-for-service to Medicaid managed care.

To reduce expenses, a number of state Medicaid programs are expected to pursue the transition from a fee-for-service focus of their Medicaid programs to a Medicaid managed care focus. A shift in Medicaid payment models from fee-for-service to managed care will require a concomitant shift in the focus of MMIS. In connection with such a transition, MMIS must also make a transition from a system built around claims adjudication to one that performs analytics and can be used to manage Medicaid population health outcomes. If our Molina Medicaid Solutions segment is unable to accomplish this transition, our business, financial condition, cash flows, or results of operations may be adversely affected.

Risks Related to our General Business Operations

We have identified a material weakness in our internal control over financial reporting. If our remedial measures are insufficient to address this material weakness, or if additional material weaknesses or significant deficiencies in our internal control over financial reporting are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results, which could adversely affect our stock price and result in our inability to maintain compliance with applicable stock exchange listing requirements.

We concluded that there was a material weakness in our internal control over financial reporting as of December 31, 2016, because we determined that a material weakness existed in our internal control over financial reporting relating to the operation of an element of our process for calculating the amount owed to California by our California health plan. More specifically, a Medicaid Expansion contract amendment executed in the fourth quarter of 2016 changed the medical loss ratio corridor formula and such amendment was not initially considered in determining the liability. As a result, we understated net income by $44 million for the year ended December 31, 2016, which is material to our consolidated results for the year ended December 31, 2016. This amount was corrected prior to the issuance of our consolidated financial statements as of and for the year ended December 31, 2016.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis. Management evaluated our disclosure controls and procedures and internal control over financial reporting as of December 31, 2016, and concluded that our internal control over financial reporting was ineffective as of December 31, 2016. This Annual Report on Form 10-K reflects management's conclusion regarding the effectiveness of our disclosure controls and procedures and internal control over financial reporting as of December 31, 2016. See “Management and Auditor’s Reports - Management’s Evaluation of Disclosure Controls and Procedures and Management’s Report on Internal Control Over Financial Reporting.” The existence of this issue could adversely affect us, our reputation and investors' perception of us.

We are actively engaged in developing a remediation plan to address the material weakness reported as of December 31, 2016. The remediation efforts we expect to implement include the development of robust protocols to ensure that the control relating to the review of a contractual amendment affecting the computation of the Medicaid Expansion medical loss ratio corridor for our California health plan will operate as designed.

We believe these measures will remediate the material weakness identified above and will strengthen our internal control over financial reporting for the computation of our California Medicaid Expansion medical loss ratio corridor. We currently are targeting to complete the implementation of the control enhancements during 2017. We will test the ongoing operating effectiveness of the new controls subsequent to implementation, and consider the material weakness remediated after the applicable remedial controls operate effectively for a sufficient period of time.

If our remedial measures are insufficient to address the material weakness, or if additional material weaknesses or significant deficiencies in our internal control over financial reporting are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results, which could adversely affect our stock price and result in our inability to maintain compliance with applicable stock exchange listing requirements.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers and other key employees. The loss of their leadership, knowledge, and experience could negatively impact our operations. Our ability to replace any departed executive officer or key employee may be difficult and may take an extended period of time because of the limited number of individuals in the health care industry who have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain, or motivate these personnel. If we are unsuccessful in recruiting, retaining, managing, and motivating such personnel, our business, financial condition, cash flows, or results of operations may be adversely affected.

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

We expect to continue to grow our membership and to expand into other markets through acquisitions and other opportunities. Continued rapid growth could place a significant strain on our management and on our other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, or results of operations could be materially and adversely affected.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2016, the carrying amounts of goodwill and intangible assets, net, amounted to $620 million, and $140 million, respectively. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives.

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is subject to an annual impairment test. We are required to test at least annually for impairment, or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. We estimate the fair values of our reporting units using discounted cash flows.

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets.

Key assumptions in our cash flow projections, including changes in membership, premium rates, health care and operating cost trends, contract renewals and the procurement of new contracts, and synergies expectations relating to newly acquired businesses, are consistent with those used in our long-range business plan and annual planning process. If these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected.

An event or events could occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net. For example, if the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states. If such state health plans have recorded goodwill and intangible assets, net, the contract loss would result in a non-cash impairment charge. Additionally, if we are unable to procure new state MMIS contracts, or develop synergies relating to our Pathways acquisition, the outcome of our goodwill impairment tests could be adversely affected and result in a non-cash impairment charge. Such a non-cash impairment charge could have a material adverse impact on our financial results.

We face various risks inherent in the government contracting process that could materially and adversely affect our business and profitability, including periodic routine and non-routine reviews, audits, and investigations by government agencies.

We are subject to various risks inherent in the government contracting process. These risks include routine and non-routine governmental reviews, audits, and investigations, and compliance with government reporting requirements. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our government contracts, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs or MMIS contracts, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

If we sustain a cyber-attack or suffer privacy or data security breaches that disrupt our operations or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. Computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world, we may be unable to implement adequate preventive measures. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, acts of malicious insiders, or other similar events that could negatively affect our systems and our and our members' data. The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. We may need to expend significant additional resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could require us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, requiring us to implement additional or different programs and systems, or making it more difficult to predict future results. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. If there is a major Southern California earthquake, there can be no assurances that our disaster recovery plan will be successful or that the business operations of all our health plans and our Molina Medicaid Solutions segment, including those that are remote from any such event, would not be substantially impacted.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, health care regulatory law-based litigation, breach of contract actions, intellectual property infringement actions, and securities class actions. If we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of our clinics or caused by one of our employees. Given the significant amount of some medical malpractice awards and settlements, the medical malpractice insurance that we maintain may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

We cannot predict the outcome of any lawsuit. Some of the liabilities related to litigation that we may incur may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us. The litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations and service providers. Our health plans segment competes for members principally on the basis of size, location,

and quality of provider network, benefits supplied, quality of service, and reputation. Our Molina Medicaid Solutions segment competes for government contracts principally on the basis of cost, quality of service, expertise, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to us. Many other organizations with which we compete, including large commercial plans and other service providers, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our business, or may lose business to third parties.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are unable to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the New York Stock Exchange, SEC, or other regulatory authorities which would require additional financial and management resources.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data or the information and data relating to our members or customers. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk, including significant cybersecurity risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our members or customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our substantial indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of any variable rate debt, and prevent us from meeting our obligations under our outstanding indebtedness.

We have a significant amount of indebtedness. As of December 31, 2016, our total indebtedness was approximately $1,645 million, including lease financing obligations. As of December 31, 2016, we also had $494 million available for borrowing under our Credit Facility. Our substantial indebtedness could have significant consequences, including:

- increasing our vulnerability to adverse economic, industry, or competitive developments;
- requiring a substantial portion of our cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund operations, make capital expenditures, and pursue future business opportunities;
- exposing us to the risk of increased interest rates to the extent of any future borrowings, including borrowings under the Credit Facility, at variable rates of interest;
- making it more difficult for us to satisfy our obligations with respect to our indebtedness, including the Credit Facility and our outstanding senior notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indenture governing our outstanding senior notes and the agreements governing such other indebtedness;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product and service development, debt service requirements, acquisitions, and general corporate or other purposes; and
- limiting our flexibility in planning for, or reacting to, changes in our business or market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged and who, therefore, may be able to take advantage of opportunities that our substantial indebtedness may prevent us from exploiting.

Despite our high indebtedness level, we and our subsidiaries are able to incur substantial additional amounts of debt, including secured debt, which could further exacerbate the risks associated with our substantial indebtedness.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. Although the indentures governing our outstanding senior notes and the credit agreement governing the Credit Facility contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances, the amount of indebtedness that could be incurred in compliance with these restrictions could be substantial. As of December 31, 2016, we had approximately $494 million available for additional borrowing under our Credit Facility. In addition, the indentures governing our outstanding senior notes and the credit agreement governing our Credit Facility do not prevent us from incurring obligations that do not constitute prohibited indebtedness thereunder. If new debt is added to our and our subsidiaries' existing debt levels, the related risks that we now face would increase.

The terms of our debt impose, and will impose, restrictions on us that may affect our ability to successfully operate our business and our ability to make payments on our outstanding senior notes.

The indentures governing our outstanding senior notes and the credit agreement governing the Credit Facility contain various covenants that could materially and adversely affect our ability to finance our future operations or capital needs and to engage in other business activities that may be in our best interest. These covenants limit our ability to, among other things:

- incur additional indebtedness or issue certain preferred equity;
- pay dividends on, repurchase, or make distributions in respect of our capital stock, prepay, redeem, or repurchase certain debt or make other restricted payments;
- make certain investments;
- create certain liens;
- sell assets, including capital stock of restricted subsidiaries;
- enter into agreements restricting our restricted subsidiaries' ability to pay dividends to us;
- consolidate, merge, sell, or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates; and
- designate our restricted subsidiaries as unrestricted subsidiaries.

All of these covenants may restrict our ability to pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, such as prevailing economic conditions and changes in regulations, and if such events occur, we cannot be sure that we will be able to comply. A breach of these covenants could result in a default under the indentures for our outstanding senior notes and/or the credit agreement governing the Credit Facility including, as a result of cross default provisions and, in the case of the Credit Facility permit the lenders to cease making loans to us. If there were an event of default under the indentures governing our outstanding senior notes and/or the credit agreement governing the Credit Facility, holders of such defaulted debt could cause all amounts borrowed under these instruments to be due and payable immediately. Our assets or cash flow may not be sufficient to repay borrowings under our outstanding debt instruments in the event of a default thereunder.

In addition, the restrictive covenants in the credit agreement governing the Credit Facility require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests will depend on our ongoing financial and operating performance, which, in turn, will be subject to economic conditions and to financial, market, and competitive factors, many of which are beyond our control.

If our operating performance declines, we may be required to obtain waivers from the lenders under the Credit Facility, from the holders of our outstanding senior notes or from the holders of other obligations, to avoid defaults thereunder. For example, in February 2017, to avoid default under our Credit Facility as a result of our failure to comply with certain financial covenants therein applicable to the three months ended December 31, 2016, we sought, and obtained, a waiver of such defaults by the required lenders under our Credit Facility.

If we are not able to obtain such waivers, our creditors could exercise their rights upon default, and we could be forced into bankruptcy or liquidation.

We may not have the funds necessary to pay the amounts due upon conversion or required repurchase of our outstanding notes, and our indebtedness may contain limitations on our ability to pay the amounts due upon conversion or required repurchase.

In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Notes. In September 2014, we issued $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Notes. As of December 31, 2016, the aggregate outstanding principal amount of our 1.125% Notes and our 1.625% Notes was $550 million and $302 million, respectively. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The stock price trigger for the 1.125% Notes is $53.00 per share. The 1.125% Notes met this trigger in the quarter ended December 31, 2016, and are convertible to cash through at least March 31, 2017. Because the 1.125% Notes may be converted into cash within 12 months, the $471 million carrying amount is reported in current

portion of long-term debt as of December 31, 2016. For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash.

The stock price trigger for the 1.625% Notes is $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on February 24, 2017 was $48.83 per share. As of December 31, 2016, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

We have sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

In addition, in the event of a change in control or the termination in trading of our stock, each holder of our 1.125% Notes and our 1.625% Notes would have the right to require us to purchase some or all of their notes at a purchase price in cash equal to 100% of the principal amount of the notes, plus any accrued and unpaid interest.

In the event of conversions or required repurchases, we may not have enough available cash or be able to obtain financing at the time we are required to comply with our conversion or repurchase obligations. In addition, our ability to comply with these obligations may be limited by law, by regulatory authority, or by agreements governing our future indebtedness. The indentures for the 1.125% Notes and the 1.625% Notes provide that it would be an event of default if we do not make the cash payments due upon conversion or required repurchase of the notes. The occurrence of an event of default under one or both of these indentures may also constitute an event of default under our Credit Facility and under our other indebtedness we may have outstanding at such time. Any such default could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments, including the Credit Facility, and the indentures governing our outstanding senior notes, may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which would harm our ability to incur additional indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies may increase our future borrowing costs and reduce our access to capital.

There can be no assurance that any rating assigned by the rating agencies to our debt or our corporate rating will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, future circumstances relating to the basis of the rating, such as adverse changes, so warrant. A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies would likely increase our future borrowing costs and reduce our access to capital, which could have a materially adverse impact on our business, financial condition, cash flows or results of operations.

Risks Related to Our Common Stock

Members of the Molina family own a significant amount of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate owned or were entitled to receive upon certain events approximately 25% of our capital stock as of December 31, 2016. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election of directors, amendments to our charter, and any merger, consolidation, or sale of our company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150 million shares of common stock and 20 million shares of preferred stock. As of December 31, 2016, approximately 57 million shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Further, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock could impede a merger,

takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock.

LEGAL PROCEEDINGS

Refer to Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Legal Proceedings,” for a discussion of legal proceedings.

MANAGEMENT AND AUDITOR’S REPORTS

MANAGEMENT’S EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures, as defined in Rule 13a-15(e) and Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the Exchange Act), that are designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is accumulated and communicated to our management, including our principal executive officer and principal financial officer or persons performing similar functions, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management is required to apply its judgment in evaluating the cost-benefit relationship of any possible controls and procedures.

Under the supervision and with the participation of our management, including our chief executive officer and our chief financial officer, we carried out an evaluation of the effectiveness of our disclosure controls and procedures as of the end of the period covered by this report pursuant to Rule 13a-15(b) and Rule 15d-15(b) of the Exchange Act. Based on this evaluation, our chief executive officer and our chief financial officer concluded that, as of December 31, 2016, our disclosure controls and procedures were not effective at the reasonable assurance level because of the material weakness in our internal control over financial reporting described below. Notwithstanding the material weakness described below, management has concluded that our consolidated financial statements included in this Annual Report on Form 10-K are fairly stated in all material respects in accordance with U.S. generally accepted accounting principles (GAAP) for each of the periods presented herein.

MANAGEMENT’S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets, (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors, and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on our financial statements.

Internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements prepared for external purposes in accordance with GAAP. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of the effectiveness of our internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Our management has assessed the effectiveness of our internal control over financial reporting as of December 31, 2016, based on the framework set forth in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

The Company determined that a material weakness existed in its internal control over financial reporting relating to the operation of an element of its process for calculating the amount owed to California by its California health plan. More specifically, a Medicaid Expansion contract amendment executed in the fourth quarter of 2016 changed the medical loss ratio corridor formula and such amendment was not initially considered in determining the liability. As a result, we understated net income by $44 million for the year ended December 31, 2016, which is material to our consolidated results for the year ended December 31, 2016. This amount was corrected prior to the issuance of our consolidated financial statements as of and for the year ended December 31, 2016.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of December 31, 2016, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

Ernst & Young, LLP, the independent registered public accounting firm who audited our Consolidated Financial Statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which expressed an adverse opinion and is included herein.

Remediation Plan for Material Weakness

We are actively engaged in developing a remediation plan to address the material weakness reported as of December 31, 2016. The remediation efforts we expect to implement include the development of robust protocols to ensure that the control relating to the review of a contractual amendment affecting the computation of the Medicaid Expansion medical loss ratio corridor for our California health plan will operate as designed.

We believe these measures will remediate the material weakness identified above and will strengthen our internal control over financial reporting for the computation of our California Medicaid Expansion medical loss ratio corridor. We currently are targeting to complete the implementation of the control enhancements during 2017. We will test the ongoing operating effectiveness of the new controls subsequent to implementation, and consider the material weakness remediated after the applicable remedial controls operate effectively for a sufficient period of time.

If the remedial measures described above are insufficient to address the material weakness described above, or are not implemented timely, or additional deficiencies arise in the future, material misstatements in our interim or annual financial statements may occur in the future and could have the effects described in “Risk Factors.”

Changes in Internal Control over Financial Reporting

Except as described above, management did not identify any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2016, that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2016. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2016 and 2015, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated March 1, 2017 expressed an adverse opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 1, 2017

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the company's annual or interim financial statements will not be prevented or detected on a timely basis. The following material weakness has been identified and included in management's assessment. Management has identified a material weakness in the operating effectiveness of a management review control related to the Company's process for calculating the amount owed to California with respect to Medicaid Expansion at its California health plan. We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2016 and 2015 and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2016. This material weakness was considered in determining the nature, timing and extent of audit tests applied in our audit of the 2016 financial statements, and this report does not affect our report dated March 1, 2017, which expressed an unqualified opinion on those financial statements.

In our opinion, because of the effect of the material weakness described above on the achievement of the objectives of the control criteria, Molina Healthcare, Inc. has not maintained effective internal control over financial reporting as of December 31, 2016, based on the COSO criteria.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 1, 2017

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AUDITED FINANCIAL STATEMENTS AND NOTES

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2016	2015	2014
	(In millions, except per-share data)		
Revenue:			
Premium revenue	$ 16,392	$ 13,241	$ 9,023
Service revenue	539	253	210
Premium tax revenue	468	397	294
Health insurer fee revenue	345	264	120
Investment income and other revenue	38	23	20
Total revenue	17,782	14,178	9,667
Operating expenses:			
Medical care costs	14,774	11,794	8,076
Cost of service revenue	485	193	157
General and administrative expenses	1,393	1,146	765
Premium tax expenses	468	397	294
Health insurer fee expenses	217	157	89
Depreciation and amortization	139	104	93
Total operating expenses	17,476	13,791	9,474
Operating income	306	387	193
Other expenses, net:			
Interest expense	101	66	57
Other (income) expense, net	—	(1)	1
Total other expenses, net	101	65	58
Income before income tax expense	205	322	135
Income tax expense	153	179	73
Net income	$ 52	$ 143	$ 62
Basic net income (loss) per share:			
Continuing operations	$ 0.93	$ 2.75	$ 1.34
Discontinued operations	—	—	(0.01)
	$ 0.93	$ 2.75	$ 1.33
Diluted net income (loss) per share:			
Continuing operations	$ 0.92	$ 2.58	$ 1.30
Discontinued operations	—	—	(0.01)
	$ 0.92	$ 2.58	$ 1.29
Weighted average shares outstanding:			
Basic	55	52	47
Diluted	56	56	48

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Net income	$ 52	$ 143	$ 62
Other comprehensive income (loss):			
Unrealized investment gain (loss)	3	(5)	—
Less: effect of income taxes	1	(2)	—
Other comprehensive income (loss), net of tax	2	(3)	—
Comprehensive income	$ 54	$ 140	$ 62

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2016	2015
	(In millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,819	$ 2,329
Investments	1,758	1,801
Receivables	974	597
Income taxes refundable	39	13
Prepaid expenses and other current assets	131	192
Derivative asset	267	374
Total current assets	5,988	5,306
Property, equipment, and capitalized software, net	454	393
Deferred contract costs	86	81
Intangible assets, net	140	122
Goodwill	620	519
Restricted investments	110	109
Deferred income taxes	10	18
Other assets	41	28
	$ 7,449	$ 6,576
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,929	$ 1,685
Amounts due government agencies	1,202	729
Accounts payable and accrued liabilities	385	362
Deferred revenue	315	223
Current portion of long-term debt	472	449
Derivative liability	267	374
Total current liabilities	4,570	3,822
Senior notes	975	962
Lease financing obligations	198	198
Deferred income taxes	15	—
Other long-term liabilities	42	37
Total liabilities	5,800	5,019
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 57 shares at December 31, 2016 and 56 shares at December 31, 2015	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	841	803
Accumulated other comprehensive loss	(2)	(4)
Retained earnings	810	758
Total stockholders' equity	1,649	1,557
	$ 7,449	$ 6,576

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount				
	(In millions)					
Balance at January 1, 2014	46	$ —	$ 341	$ (1)	$ 553	$ 893
Net income	—	—	—	—	62	62
Convertible senior notes transactions, including issuance costs	2	—	22	—	—	22
Share-based compensation	2	—	30	—	—	30
Tax benefit from share-based compensation	—	—	3	—	—	3
Balance at December 31, 2014	50	—	396	(1)	615	1,010
Net income	—	—	—	—	143	143
Other comprehensive loss, net	—	—	—	(3)	—	(3)
Common stock offering, including issuance costs	6	—	373	—	—	373
Share-based compensation	—	—	26	—	—	26
Tax benefit from share-based compensation	—	—	8	—	—	8
Balance at December 31, 2015	56	—	803	(4)	758	1,557
Net income	—	—	—	—	52	52
Other comprehensive income, net	—	—	—	2	—	2
Share-based compensation	1	—	36	—	—	36
Tax benefit from share-based compensation	—	—	2	—	—	2
Balance at December 31, 2016	57	$ —	$ 841	$ (2)	$ 810	$ 1,649

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Operating activities:			
Net income	$ 52	$ 143	$ 62
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	182	126	134
Deferred income taxes	22	(7)	(2)
Share-based compensation	26	23	22
Amortization of convertible senior notes and lease financing obligations	31	30	27
Other, net	16	19	7
Changes in operating assets and liabilities:			
Receivables	(348)	56	(298)
Prepaid expenses and other current assets	(69)	(35)	(20)
Medical claims and benefits payable	226	482	531
Amounts due government agencies	473	202	470
Accounts payable and accrued liabilities	(4)	84	11
Deferred revenue	92	24	74
Income taxes	(26)	(22)	42
Net cash provided by operating activities	673	1,125	1,060
Investing activities:			
Purchases of investments	(1,929)	(1,923)	(953)
Proceeds from sales and maturities of investments	1,966	1,126	633
Purchases of property, equipment and capitalized software	(176)	(132)	(115)
Change in restricted investments	4	(6)	(34)
Net cash paid in business combinations	(48)	(450)	(44)
Other, net	(19)	(35)	(23)
Net cash used in investing activities	(202)	(1,420)	(536)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	—	689	123
Proceeds from common stock offering, net of issuance costs	—	373	—
Contingent consideration liabilities settled	—	—	(50)
Proceeds from employee stock plans	18	18	14
Principal payments on convertible senior notes	—	—	(10)
Other, net	1	5	2
Net cash provided by financing activities	19	1,085	79
Net increase in cash and cash equivalents	490	790	603
Cash and cash equivalents at beginning of period	2,329	1,539	936
Cash and cash equivalents at end of period	$ 2,819	$ 2,329	$ 1,539

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(continued)

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Supplemental cash flow information:			
Cash paid during the period for:			
Income taxes	$ 153	$ 197	$ 30
Interest	$ 66	$ 38	$ 29
Schedule of non-cash investing and financing activities:			
Convertible senior notes exchange transaction	$ —	$ —	$ 177
Increase in non-cash lease financing obligation	$ —	$ —	$ 14
Common stock used for stock-based compensation	$ (8)	$ (15)	$ (9)
Details of business combinations:			
Fair value of assets acquired	$ (186)	$ (389)	$ (52)
Fair value of liabilities assumed	28	41	—
Payable to seller	8	—	8
Amounts advanced for acquisitions	102	(102)	—
Net cash paid in business combinations	$ (48)	$ (450)	$ (44)
Details of change in fair value of derivatives, net:			
(Loss) gain on 1.125% Notes Call Option	$ (107)	$ 45	$ 143
Gain (loss) on 1.125% Notes Conversion Option	107	(45)	(143)
Change in fair value of derivatives, net	$ —	$ —	$ —

See accompanying notes.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed healthcare to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment, which includes our behavioral health and social services subsidiary, Pathways.

The Health Plans segment consists of health plans in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of December 31, 2016, these health plans served over 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and provides drug rebate administration services in Florida.

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Recent Developments – Health Plans Segment

Proposed Medicare Acquisition. In August 2016, we entered into substantially identical agreements with each of Aetna Inc. and Humana Inc. to acquire certain of their Medicare Advantage membership and other assets related to such Medicare Advantage business (the Proposed Medicare Acquisition), for cash. The Proposed Medicare Acquisition was subject to closing conditions including, but not limited to, the completion of the proposed acquisition of Humana by Aetna (the Aetna-Humana Merger). In January 2017, the U.S. District Court for the District of Columbia granted the request made by the U.S. Department of Justice in its civil antitrust lawsuit against Aetna and Humana, to prohibit the Aetna-Humana Merger (the District Court Order). In February 2017, the Proposed Medicare Acquisition was terminated by the parties pursuant to the terms of the transaction. Under the termination agreement, we are entitled to receive from Aetna and Humana an aggregate termination fee of $75 million (the breakup fee). In addition, we are entitled to reimbursement of reasonable and documented out-of-pocket expenses incurred by us and our affiliates in connection with the Proposed Medicare Acquisition. We will record the breakup fee as other income in the first quarter of 2017.

Completed acquisitions. See Note 4, "Business Combinations," for further information regarding Health Plans segment acquisitions completed during 2016.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 18, "Variable Interest Entities (VIEs)," for more information regarding these variable interest entities. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments.

Use of Estimates

The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable of our Health Plans segment;
- Health plan contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Molina Medicaid Solutions segment revenue and cost recognition;
- Settlements under risk or savings sharing programs;
- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Certain of our significant accounting policies are discussed within the note to which they specifically relate.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method.

Our investment policy requires that all of our investments have final maturities of 10 years or less (excluding variable rate securities where interest rates may be periodically reset), and that the average maturity be three years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our current and non-current investments, see Note 5, "Fair Value Measurements," Note 6, "Investments," and Note 10, "Restricted Investments."

Long-Lived Assets, including Intangible Assets

Long-lived assets consist primarily of property, equipment, capitalized software (see Note 8, "Property, Equipment, and Capitalized Software"), and intangible assets (see Note 9, "Goodwill and Intangible Assets").

Business Combinations

Accounting for acquisitions requires us to recognize separately from goodwill the assets acquired and the liabilities assumed at their acquisition date fair values. Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Upon the conclusion of the final determination of the values of assets acquired or liabilities assumed, or one year after the date of acquisition, whichever comes first, any subsequent adjustments are recorded to our consolidated statements of income. Refer to Note 4, "Business Combinations," for further details regarding our 2016 acquisitions.

Premium Revenue - Health Plans

Premium revenue is generated primarily from our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. Premium revenue is generally received based on per member per month (PMPM) rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. The state Medicaid programs and the federal Medicare program periodically adjust premiums. Additionally, many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is earned under such provisions.

The following table summarizes premium revenue for the periods indicated:

	Year Ended December 31,					
	2016		2015		2014	
	Amount	% of Total	Amount	% of Total	Amount	% of Total
	(Dollars in millions)					
California	$ 2,370	14.5%	$ 2,200	16.6%	$ 1,523	16.9%
Florida	1,926	11.7	1,199	9.0	439	4.9
Illinois	601	3.7	397	3.0	153	1.7
Michigan	1,520	9.3	1,067	8.1	781	8.7
New Mexico	1,304	7.9	1,237	9.3	1,076	11.9
New York	82	0.5	—	—	—	—
Ohio	1,961	12.0	2,034	15.4	1,553	17.2
Puerto Rico	726	4.4	567	4.3	—	—
South Carolina	378	2.3	348	2.6	381	4.2
Texas	2,454	15.0	1,961	14.8	1,318	14.6
Utah	444	2.7	331	2.5	310	3.4
Washington	2,218	13.5	1,602	12.1	1,305	14.5
Wisconsin	395	2.4	261	2.0	156	1.7
Direct delivery	13	0.1	37	0.3	28	0.3
	$ 16,392	100.0%	$ 13,241	100.0%	$ 9,023	100.0%

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $272 million and $214 million at December 31, 2016 and December 31, 2015, respectively, to amounts due government agencies. Approximately $244 million and $208 million of the liability accrued at December 31, 2016 and December 31, 2015, respectively, relates to our participation in Medicaid Expansion programs.

In February 2017, the New Mexico Human Services Department (HSD) notified us that it has disallowed certain medically related administrative expenses and other items in the computation of its Medicaid Expansion risk corridor; this corridor was effective January 1, 2014, through December 31, 2016. Although we disagree with their contractual interpretations, we deferred premium revenue amounting to approximately $45 million for the year ended December 31, 2016, as a result of this communication, because such revenue is presently subject to refund or adjustment. Of this amount, $29 million relates to dates of service prior to 2016. At December 31, 2016, our aggregate Medicaid Expansion risk corridor payable to HSD is $145 million. We intend to appeal HSD's ruling on this matter.

In the fourth quarter of 2016, our California health plan received a contract amendment from the California Department of Healthcare Services that allowed us to deduct certain tax expenses in the computation of its Medicaid Expansion minimum medical loss ratio; this minimum medical loss ratio was effective January 1, 2014, through June 30, 2016. As a result of this contract amendment, we increased premium revenue for the year ended December 31, 2016, by approximately $68 million, of which $35 million related to periods prior to 2016.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at December 31, 2016 and December 31, 2015.

Profit Sharing and Profit Ceiling. Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at December 31, 2016 and December 31, 2015.

Retroactive Premium Adjustments. In the first quarter of 2016, our Florida health plan recorded a retroactive increase to Medicaid premium revenue of approximately $18 million relating to dates of service prior to 2016.

Medicare

Risk Adjustment. Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and Centers for Medicare & Medicaid Services (CMS) practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjustment premiums and Medicare Part D settlements were insignificant at December 31, 2016 and December 31, 2015.

Minimum MLR. Additionally, federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for the Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations specifically define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Marketplace

Premium Stabilization Programs. The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably

estimable as described below, and, for receivables, collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	December 31, 2016			
	Current Benefit Year	Prior Benefit Years	Total	December 31, 2015
	(In millions)			
Risk adjustment	$ (522)	$ —	$ (522)	$ (214)
Reinsurance	51	4	55	36
Risk corridor	(1)	—	(1)	(10)
Minimum MLR	(1)	—	(1)	(3)

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. On June 30, 2016, CMS released the final update on risk transfer and reinsurance payments for the 2015 benefit year, and we adjusted our accruals accordingly. Our risk transfer payment was approximately $40 million more than our estimate as of December 31, 2015.
- Reinsurance: This program is designed to provide reimbursement to insurers for high cost members. Our health plans pay an annual contribution on a per-member basis, and are eligible for recoveries if claims for individual members exceed a specified threshold, up to a maximum amount. We recognize the assessments to fund the transitional reinsurance program as a reduction to premium revenue in our consolidated statements of income. We recognize recoveries under the reinsurance program as a reduction to medical care costs in our consolidated statements of income. This three-year program ended December 31, 2016.
- Risk corridor: This program is intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by CMS. Variances from the target amount exceeding certain thresholds may result in amounts due to or receivables due from CMS. Due to uncertainties as to the amount of federal funding available to support the risk corridor program, we do not recognize amounts receivable under this program. Our estimate of the unrecorded receivable for the Marketplace risk corridor amounted to approximately $142 million as of December 31, 2016. Of this total amount, $52 million relates to the 2015 benefit year and $90 million relates to the year ended December 31, 2016. All liabilities are recognized as incurred. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk corridor program as an adjustment to premium revenue in our consolidated statements of income. This three-year program ended December 31, 2016.

Additionally, the ACA established a Minimum MLR of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations specifically define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

During the second quarter of 2016, we were informed by the Texas Department of Health and Human Services that it will not recoup any quality revenue for calendar years 2014, 2015, and 2016. Therefore, we recognized previously deferred quality revenue amounting to approximately $51 million in the second quarter of 2016. Of the $51 million total adjustment, $44 million related to dates of service in 2015 and earlier.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2016 are not known, we have

no reason to believe that the adjustments to prior periods noted below are not indicative of the potential future changes in our estimates as of December 31, 2016, other than the Texas quality revenue recognized in the second quarter of 2016 described above.

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Maximum available quality incentive premium - current period	$ 147	$ 118	$ 90
Amount of quality incentive premium revenue recognized in current period:			
Earned current period	$ 104	$ 66	$ 40
Earned prior periods	47	13	4
Total	$ 151	$ 79	$ 44
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.9%	0.6%	0.5%

Medical Care Costs - Health Plans

Expenses related to medical care services are captured in the following categories:

Fee-for-service expenses. Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.

Pharmacy expenses. All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

Capitation expenses. Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

Direct delivery expenses. All costs associated with our direct delivery of medical care are separately identified.

Other medical expenses. All medically related administrative costs, certain provider incentive costs, and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2016, 2015, and 2014, medically related administrative costs were $488 million, $398 million, and $263 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in millions, except PMPM amounts):

	Year Ended December 31,								
	2016			2015			2014		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 10,993	$ 217.84	74.4%	$ 8,572	$ 218.35	72.7%	$ 5,673	$ 202.87	70.2%
Pharmacy	2,213	43.84	15.0	1,610	41.01	13.7	1,273	45.54	15.8
Capitation	1,218	24.13	8.2	982	25.02	8.3	748	26.77	9.3
Direct delivery	78	1.55	0.5	128	3.26	1.1	96	3.44	1.2
Other	272	5.39	1.9	502	12.79	4.2	286	10.22	3.5
Total	$ 14,774	$ 292.75	100.0%	$ 11,794	$ 300.43	100.0%	$ 8,076	$ 288.84	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. For further information, see Note 11, “Medical Claims and Benefits Payable.”

We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. Such reinsurance coverage does not relieve us of our primary obligation to our policyholders. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Health Insurer Fee (HIF). The federal government under the ACA imposes an annual fee, or excise tax, on health insurers for each calendar year. The HIF is based on a company’s share of the industry’s net premiums written during the preceding calendar year, and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Within our Medicaid program, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment or payment from a state to reimburse us for the HIF; such HIF revenue is recognized ratably throughout the year. The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there will be no HIF revenue or expenses in 2017.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expenses in the consolidated statements of income.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. In the fourth quarter of 2016, we recorded a premium deficiency reserve of $30 million for our Marketplace contracts in California and Washington. No premium deficiency reserve was recorded as of December 31, 2015.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element, and are therefore multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. If the deliverable has standalone value, the arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. Therefore, absent any contingencies as discussed in the following paragraph, or contract extensions, we would recognize all revenue associated with those contracts over the initial contract period. When a contract is extended, we generally consider the extension to be a continuation of the single unit of accounting; therefore, the deferred revenue as of the extension date is recognized prospectively over the new remaining term of the contract. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances, we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;

- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;
- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited because our payors consist principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans primarily as a direct contractor with the states (or Commonwealth), and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements Not Yet Adopted

Goodwill Impairment. In January 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-04, *Simplifying the Test for Goodwill Impairment*, which eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. Instead, impairment charges will be based on the first step in the two-step impairment test under Accounting Standards Codification (ASC) 350, *Intangibles - Goodwill and Other*. ASU 2017-04 is effective for us beginning January 1, 2020; early adoption is permitted for annual and interim goodwill impairment testing dates after January 1, 2017. We are evaluating the effect of this guidance.

Business Combinations. In January 2017, the FASB issued ASU 2017-01, *Clarifying the Definition of a Business*, which changes the definition of a business to assist entities with evaluating when a set of transferred assets and activities is considered a business. ASU 2017-01 is effective for us beginning January 1, 2018, and interim periods thereafter on a prospective basis. Adoption of this guidance may be significant to us depending on the size and nature of potential future acquisitions. For future Health Plans segment acquisitions under which the fair value of the assets acquired is concentrated in a single identifiable asset, such as contract rights, the acquisitions will be recorded as asset acquisitions rather than business combinations. The chief difference between an asset acquisition and a business combination is that goodwill only arises in business combinations.

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument's contractual life. ASU 2016-13 is effective for us beginning January 1, 2020, and must be adopted as a cumulative effect adjustment to retained earnings; early adoption is permitted. We are evaluating the effect of this guidance.

Stock Compensation. In March 2016, the FASB issued ASU 2016-09, *Improvements to Employee Share-Based Payment Accounting*, which amends ASC Topic 718, *Compensation – Stock Compensation*. ASU 2016-09 simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, statutory tax and classification in the statement of cash flows. We will adopt ASU 2016-09 in the first quarter of 2017. We are unable to quantify the impact of adoption, however, because such impact is dependent on future stock prices which cannot be predicted. However, we expect that adoption will not have a significant impact on net income, basic and diluted earnings per share, deferred tax assets and net cash from operations, or our effective tax rate.

Leases. In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. ASU 2016-02 is effective for us beginning January 1, 2019 and must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. Under this guidance, we will record assets and liabilities relating primarily to our long-term office leases, and are currently evaluating the effect to our consolidated financial statements.

Revenue Recognition. In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, as modified by:

- ASU 2015-14, *Deferral of the Effective Date*;
- ASU 2016-08, *Principal versus Agent Considerations (Reporting Revenue Gross versus Net)*;
- ASU 2016-10, *Identifying Performance Obligations and Licensing*;
- ASU 2016-12, *Narrow-Scope Improvements and Practical Expedients*;
- ASU 2016-20, *Technical corrections and improvements to Topic 606; and*
- ASU 2017-03, *Overall Transition and Open Effective Date Information*.

ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The new model requires an entity to recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required.

We have determined that our Health Plans segment, which comprises the vast majority of our operations, is excluded from the scope of ASU 2014-09, because the recognition of revenue under our Health Plans segment insurance contracts is dictated by other accounting standards governing insurers.

For our Molina Medicaid Solutions segment, we have determined that certain revenue and costs will no longer be deferred and recognized over the service delivery period. Rather, revenue will be recognized based on the expected cost plus gross margin method, and costs will be recognized as incurred. We are currently in the process of quantifying the impact to our consolidated financial position, results of operations, and cash flows.

Two adoption methods are permitted under ASU 2014-09. Under the full retrospective method, the financial statement adjustments are applied to each reporting period presented. Under the modified retrospective method, the cumulative effect of initially applying the guidance is reflected as an adjustment to beginning retained earnings as of the date of adoption. We intend to adopt this standard on January 1, 2018, using the modified retrospective approach.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not

have, or are not believed by management to have, a significant impact on our present or future consolidated financial statements.

Accounting Pronouncements Adopted

Short-Duration Contracts. In the fourth quarter of 2016, we adopted ASU 2015-09, *Disclosures about Short-Duration Contracts*, which requires additional disclosure on the liability for unpaid claims and claim adjustment expenses. It requires additional disclosure only and had an insignificant impact to our consolidated financial statements. The new disclosures are reported in Note 11, "Medical Claims and Benefits Payable."

3. Net Income per Share

The following table sets forth the calculation of basic and diluted net income per share:

	December 31,		
	2016	2015	2014
	(In millions, except net income per share)		
Numerator:			
Net income	$ 52	$ 143	$ 62
Denominator:			
Shares outstanding at the beginning of the period	55	49	46
Weighted-average number of shares issued:			
Common stock offering	—	3	—
Convertible senior notes	—	—	1
Denominator for basic net income per share	55	52	47
Effect of dilutive securities:			
Share-based compensation	—	1	—
Convertible senior notes [1]	—	1	1
1.125% Warrants [1]	1	2	—
Denominator for diluted net income per share	56	56	48
Net income per share: [2]			
Basic	$ 0.93	$ 2.75	$ 1.33
Diluted	$ 0.92	$ 2.58	$ 1.29
Potentially dilutive common shares excluded from calculations: [3]			
1.125% Warrants	—	—	13

(1) For more information regarding the convertible senior notes, refer to Note 12, "Debt." For more information regarding the 1.125% Warrants, refer to Note 15, "Stockholders' Equity."
(2) Source data for calculations in thousands.
(3) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the year ended December 31, 2014, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

4. Business Combinations

Health Plans Segment

In 2016, we closed on several business combinations in the Health Plans segment, consistent with our strategy to grow in our existing markets and expand into new markets. For all of these transactions, we applied the acquisition method of accounting, where the total purchase price was allocated, or preliminarily allocated, to tangible and intangible assets acquired, and liabilities assumed, based on their respective fair values. For the Health Plans acquisitions described below, except New York, only intangible assets were acquired. All of the transactions were funded using available cash, and acquisition-related costs were insignificant.

The individual transactions were as follows:

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. The final purchase price was approximately $30 million, and the Illinois health plan added approximately 50,000 Medicaid members as a result of this transaction.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. The final purchase price was approximately $12 million, and the Illinois health plan added approximately 18,000 Medicaid members as a result of this transaction.

On March 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Better Health Network, LLC. The final purchase price was approximately $15 million, and the Illinois health plan added approximately 28,000 Medicaid members as a result of this transaction.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. The final purchase price was approximately $31 million, and the Michigan health plan added approximately 68,000 Medicaid and MIChild members as a result of this transaction.

New York. On August 1, 2016, we closed on our acquisition of the outstanding equity interests of Today's Options of New York, Inc., which operates the Total Care Medicaid plan. The initial purchase price was approximately $38 million, and we now serve approximately 35,000 Medicaid members in upstate New York as a result of the transaction. The purchase price allocation was finalized, and final purchase price adjustments as provided in the stock purchase agreement were recorded, in the first quarter of 2017.

Washington. On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Columbia United Providers, Inc. The final purchase price was approximately $28 million, and the Washington health plan added approximately 57,000 Medicaid members as a result of this transaction.

For these acquisitions, we recorded goodwill to the Health Plans segment amounting to $96 million in the aggregate, which relates to future economic benefits arising from expected synergies to be achieved. Such synergies include use of our existing infrastructure to support the added membership. In general, the amount recorded as goodwill is deductible for income tax purposes.

For the transactions that closed on January 1, 2016 (a holiday), approximately $101 million of the purchase price consideration was funded to the sellers in December 2015, and was recorded to prepaid expenses and other assets as of December 31, 2015. Such amounts were reported in investing activities in the accompanying consolidated statements of cash flows for the year ended December 31, 2015.

The following table presents the intangible assets identified in the transactions described above. The weighted-average amortization period, in the aggregate, is 5.7 years.

	Fair Value (In millions)	Life (Years)
Intangible asset type:		
Contract rights - member list	$ 38	5
Provider network	7	10
	$ 45	

Other Segment

Pathways. On November 1, 2015, we acquired the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways). In 2016, we recorded a pre-acquisition contingent liability and corresponding indemnification asset in the amount of $14 million in connection with the Rodriguez Litigation matter defined and described further in Note 19, “Commitments and Contingencies.” Also in 2016, certain tax elections were made such that approximately 50% of the goodwill recorded in this transaction is deductible for income tax purposes. In the fourth quarter of 2016, the purchase price allocation was finalized, which included a $5 million increase to goodwill primarily in connection with certain tax-related gross-up payments.

5. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs. Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management’s best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include derivative financial instruments.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2016 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 13, “Derivatives,” the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the year ended December 31, 2016.

Our financial instruments measured at fair value on a recurring basis at December 31, 2016, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,179	$ —	$ 1,179	$ —
Government-sponsored enterprise securities (GSEs)	231	231	—	—
Municipal securities	142	—	142	—
U.S. treasury notes	84	84	—	—
Asset-backed securities	69	—	69	—
Certificates of deposit	53	—	53	—
Subtotal - current investments	1,758	315	1,443	—
1.125% Call Option derivative asset	267	—	—	267
Total assets measured at fair value on a recurring basis	$ 2,025	$ 315	$ 1,443	$ 267
1.125% Conversion Option derivative liability	$ 267	$ —	$ —	$ 267
Total liabilities measured at fair value on a recurring basis	$ 267	$ —	$ —	$ 267

Our financial instruments measured at fair value on a recurring basis at December 31, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,184	$ —	$ 1,184	$ —
GSEs	211	211	—	—
Municipal securities	185	—	185	—
U.S. treasury notes	78	78	—	—
Asset-backed securities	63	—	63	—
Certificates of deposit	80	—	80	—
Subtotal - current investments	1,801	289	1,512	—
1.125% Call Option derivative asset	374	—	—	374
Total assets measured at fair value on a recurring basis	$ 2,175	$ 289	$ 1,512	$ 374
1.125% Conversion Option derivative liability	$ 374	$ —	$ —	$ 374
Total liabilities measured at fair value on a recurring basis	$ 374	$ —	$ —	$ 374

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table.

	December 31, 2016		December 31, 2015	
	Carrying Value	Fair Value	Carrying Value	Fair Value
	(In millions)			
5.375% Notes	$ 691	$ 714	$ 689	$ 700
1.125% Convertible Notes	471	792	448	865
1.625% Convertible Notes	284	344	273	365
	$ 1,446	$ 1,850	$ 1,410	$ 1,930

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,180	$ 1	$ 2	$ 1,179
GSEs	232	—	1	231
Municipal securities	143	—	1	142
U.S. treasury notes	84	—	—	84
Asset-backed securities	69	—	—	69
Certificates of deposit	53	—	—	53
	$ 1,761	$ 1	$ 4	$ 1,758

	December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,189	$ —	$ 5	$ 1,184
GSEs	212	—	1	211
Municipal securities	186	—	1	185
U.S. treasury notes	78	—	—	78
Asset-backed securities	63	—	—	63
Certificates of deposit	80	—	—	80
	$ 1,808	$ —	$ 7	$ 1,801

The contractual maturities of our investments as of December 31, 2016 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 930	$ 930
Due after one year through five years	806	803
Due after five years through ten years	25	25
	$ 1,761	$ 1,758

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the years ended December 31, 2016, 2015 and 2014 were insignificant.

We have determined that unrealized gains and losses at December 31, 2016 and 2015 are temporary in nature, because the change in market value for these securities resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2016.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 542	$ 2	378	$ —	$ —	—
GSEs	198	1	73	—	—	—
Municipal securities	101	1	129	—	—	—
	$ 841	$ 4	580	$ —	$ —	—

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2015.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 825	$ 4	588	$ 119	$ 1	87
GSEs	182	1	77	—	—	—
Municipal securities	128	1	181	—	—	—
	$ 1,135	$ 6	846	$ 119	$ 1	87

7. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is insignificant. Any amounts determined to be uncollectible are charged to expense when such determination is made. The information below is presented by segment.

	December 31,	
	2016	2015
	(In millions)	
California	$ 180	$ 104
Florida	97	22
Illinois	134	35
Michigan	60	39
New Mexico	57	51
New York	26	—
Ohio	82	66
Puerto Rico	37	33
South Carolina	11	6
Texas	79	56
Utah	19	18
Washington	71	53
Wisconsin	33	22
Direct delivery and other	1	6
Total Health Plans segment	887	511
Molina Medicaid Solutions segment	34	37
Other segment	53	49
	$ 974	$ 597

8. Property, Equipment, and Capitalized Software

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years.

The costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period, and the amortization is recorded within the heading “Cost of service revenue.”

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2016	2015
	(In millions)	
Capitalized software	$ 443	$ 336
Furniture and equipment	301	250
Building and improvements	159	153
Land	16	16
	919	755
Less: accumulated amortization for capitalized software	(259)	(195)
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(206)	(167)
	(465)	(362)
Property, equipment, and capitalized software, net	$ 454	$ 393

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, or as cost of service revenue.

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Recorded in depreciation and amortization:			
Amortization of capitalized software	$ 62	$ 37	$ 41
Depreciation of property and equipment	45	50	34
Amortization of intangible assets	32	17	18
	139	104	93
Recorded in cost of service revenue:			
Amortization of capitalized software	22	15	18
Amortization of deferred contract costs	21	6	20
	43	21	38
Other	—	1	3
	$ 182	$ 126	$ 134

Molina Center. In 2011, we acquired two coterminous office buildings in Long Beach, California, known as the Molina Center. In 2013, we entered into a sale-leaseback transaction for the Molina Center. Due to our continuing involvement with the leased property, the sale did not qualify for sales recognition and we remain the “accounting owner” of the property. For further information, see Note 12, “Debt.” Sublease income from third party tenants of the Molina Center is reported as investment income and other revenue in our consolidated statements of income. As of December 31, 2016, future sublease income was insignificant.

9. Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is subject to an annual impairment test. We are required to test at least annually for impairment, or more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analysis. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing.

Under the quantitative test we first measure the fair values of our reporting units and compare them to the carrying values of the respective units, including goodwill. Second, if the fair value is less than the carrying value of the

reporting unit, then the implied value of goodwill would be calculated and compared with the carrying amount of goodwill to determine the impairment charge, if any.

We estimate the fair values of our reporting units using discounted cash flows. In the discounted cash flow analyses, we must make assumptions about a wide variety of internal and external factors. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates.

No impairment charges relating to goodwill were recorded in the years ended December 31, 2016, 2015, and 2014.

The following table presents the balances of goodwill as of December 31, 2016 and 2015. The Health Plans segment addition relates to the business combinations described in Note 4, “Business Combinations.” The Other segment addition relates to the final purchase price allocation adjustments for our Pathways acquisition in 2015.

	Health Plans	Molina Medicaid Solutions	Other	Total
		(In millions)		
Historical goodwill	$ 349	$ 71	$ 157	$ 577
Accumulated impairment losses	(58)	—	—	(58)
Balance, December 31, 2015	291	71	157	519
Acquisitions	96	—	—	96
Purchase price allocation adjustments	—	—	5	5
Balance at December 31, 2016	$ 387	$ 71	$ 162	$ 620

Intangible Assets. Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at fair value and are then amortized on a straight-line basis over their expected useful lives, generally between two and 15 years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset’s (or asset group’s) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2016, 2015, and 2014.

Based on the balances of our identifiable intangible assets as of December 31, 2016, we estimate that our intangible asset amortization will be $35 million in 2017, $33 million in 2018, $27 million in 2019, $19 million in 2020, and $8 million in 2021. For a presentation of our goodwill and intangible assets by reportable segment, refer to Note 20, “Segment Information.”

The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Carrying Amount
		(In millions)	
Intangible assets:			
Contract rights and licenses	$ 267	$ 148	$ 119
Customer relationships	25	24	1
Provider networks	34	14	20
Balance at December 31, 2016	$ 326	$ 186	$ 140
Intangible assets:			
Contract rights and licenses	$ 224	$ 120	$ 104
Customer relationships	25	23	2
Provider networks	27	11	16
Balance at December 31, 2015	$ 276	$ 154	$ 122

The changes in the carrying amounts of goodwill and intangible assets, at cost, in 2016 were due to the acquisitions described in Note 4, “Business Combinations.”

10. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited to specific purposes as required by regulation in the various states in which we operate, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. The following table presents the balances of restricted investments:

	December 31,	
	2016	2015
	(In millions)	
Florida	$ 22	$ 34
Illinois	3	—
Michigan	1	1
New Mexico	43	43
New York	9	—
Ohio	12	12
Puerto Rico	10	10
Texas	4	4
Utah	4	4
Wisconsin	1	1
Other	1	—
Total Health Plans segment	$ 110	$ 109

The contractual maturities of our restricted investments, which are designated as held-to-maturity and are carried at amortized cost, which approximates fair value, as of December 31, 2016 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 100	$ 100
Due after one year through five years	10	10
	$ 110	$ 110

11. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	December 31,		
	2016	2015	2014
	(In millions)		
Fee-for-service claims incurred but not paid (IBNP)	$ 1,352	$ 1,191	$ 871
Pharmacy payable	112	88	71
Capitation payable	37	140	28
Other	428	266	231
	$ 1,929	$ 1,685	$ 1,201

“Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $225 million, $167 million and $119 million, as of December 31, 2016, 2015 and 2014, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Medical claims and benefits payable, beginning balance	$ 1,685	$ 1,201	$ 670
Components of medical care costs related to:			
Current period	14,966	11,935	8,123
Prior periods	(192)	(141)	(46)
Total medical care costs	14,774	11,794	8,077
Change in non-risk provider payables	58	48	(32)
Payments for medical care costs related to:			
Current period	13,304	10,448	7,064
Prior periods	1,284	910	450
Total paid	14,588	11,358	7,514
Medical claims and benefits payable, ending balance	$ 1,929	$ 1,685	$ 1,201

Reinsurance recoverables of $61 million, $46 million, and $9 million, as of December 31, 2016, 2015, and 2014, respectively, are included in receivables.

The following tables provide information about incurred and paid claims development as of December 31, 2016, as well as cumulative claims frequency and the total of incurred but not paid claims liabilities. The information is inclusive of the New York health plan we acquired in 2016. The cumulative claim frequency is measured by claim event, and includes claims covered under capitated arrangements.

Incurred Claims and Allocated Claims Adjustment Expenses					
Benefit Year	2014 [1]	2015 [1]	2016	Total IBNP	Cumulative number of reported claims
			(In millions)		
2014	$ 8,284	$ 8,139	$ 8,138	$ 3	57
2015		12,113	11,928	22	83
2016			15,064	1,327	102
			$ 35,130	$ 1,352	

Cumulative Paid Claims and Allocated Claims Adjustment Expenses			
Benefit Year	2014 [1]	2015 [1]	2016
		(In millions)	
2014	$ 7,220	$ 8,123	$ 8,135
2015		10,615	11,906
2016			13,403
			$ 33,444

The following table represents a reconciliation of claims development to the aggregate carrying amount of the liability for medical claims and benefits payable.

	2016
	(In millions)
Incurred claims and allocated claims adjustment expenses	$ 35,130
Less: cumulative paid clams and allocated claims adjustment expenses	(33,444)
Non-risk provider payables and other	243
Medical claims and benefits payable	$ 1,929

(1) Data presented for these calendar years is required supplementary information, which is unaudited.

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is IBNP. Our IBNP, as included in medical claims and benefits payable, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under– or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any

absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in 2016, 2015, and 2014 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

2016

We believe that the most significant uncertainties relating to our IBNP estimates at December 31, 2016 are as follows:

- Our New York health plan acquisition closed on August 1, 2016, which added approximately 35,000 new members. Because these members are new to Molina and we have little insight into their claims history, our estimates of the liability we have incurred for services provided to these members are subject to more than the usual amount of uncertainty.
- At our Florida, New Mexico, Puerto Rico, Utah and Washington health plans, we overpaid certain inpatient and outpatient facility claims. We adjusted our claims payment history to reflect the claims payment pattern that would have occurred without these overpayments. For this reason, our liability estimates for these health plans are subject to more than the usual amount of uncertainty.
- Fluctuations in the volume of claims received in a paper format (rather than an electronic format) during the third quarter of 2016 have created more than the usual amount of uncertainty regarding our estimate of the liability for our California health plan.
- At our Illinois health plan, certain claims with dates of service in 2014 and 2015 were paid in December 2016. Because of these claims with unusually old dates of service, our liability estimate for the Illinois health plan is subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $192 million for the year ended December 31, 2016. This amount represents our estimate, as of December 31, 2016, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2015 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- A new version of diagnostic codes was required for all claims with dates of service on October 1, 2015, and later. As a result, payment was delayed or denied for a significant number of claims due to provider submission of claims with diagnostic codes that were no longer valid. Once providers were able to submit claims with the correct diagnostic codes, our actual costs were ultimately less than expected.
- At our New Mexico health plan, we overestimated the impact of several pending high-dollar claims, and our actual costs were ultimately less than expected.
- At our Washington health plan, we overpaid certain outpatient facility claims in 2015 when the state converted to a new payment methodology. We did not include an estimate in our December 31, 2015 reserves for this potential recovery.
- At our California health plan, we enrolled approximately 55,000 new Medicaid Expansion members in 2015. For these new members, our actual costs were ultimately less than expected.

2015

We recognized favorable prior period claims development in the amount of $141 million for the year ended December 31, 2015. This amount represented our estimate as of December 31, 2015, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio and California health plans, approximately 61,000 and 100,000 members, respectively, were enrolled in the new Medicaid expansion program during 2014. Also in Ohio, approximately 17,000 members were enrolled in the new MMP program in 2014. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.

- At our New Mexico health plan, the state implemented a retroactive increase to the provider fee schedules in mid-2014. As a result, many claims that were previously settled were reopened, and subject to, additional payment. Because our reserving methodology is most accurate when claims payment patterns are consistent and predictable, the payment of additional amounts on claims that in some cases had been settled more than six months before added a substantial degree of complexity to our liability estimation process. Due to the difficulties in addressing that added complexity, liabilities recorded as of December 31, 2014 were in excess of amounts ultimately paid.

- At our Washington health plan, we collected amounts in 2015 related to certain claims paid in 2013. Such collections were not anticipated in our reserves as of December 31, 2014.

2014

We recognized favorable prior period claims development in the amount of $46 million for the year ended December 31, 2014. This amount represented our estimate as of December 31, 2014, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2013 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio health plan, we entered new regions in the state, and a new product, ABD Kids, in July 2013. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.

- At our Michigan health plan, we overestimated the impact of certain unpaid potentially high-dollar claims. In addition, we overestimated the impact of the flu season on the outpatient claims for November and December 2013, which caused an overestimation in our outpatient reserve liability as of December 31, 2013.

12. Debt

As of December 31, 2016, contractual maturities of debt for the years ending December 31 are as follows:

	Total	2017	2018	2019	2020	2021	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ —	$ —	$ —	$ 700
1.125% Convertible Notes	550	—	—	—	550	—	—
1.625% Convertible Notes (1)	302	—	—	—	—	—	302
	$ 1,552	$ —	$ —	$ —	$ 550	$ —	$ 1,002

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on contractually specified dates beginning in 2018, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The principal amounts, unamortized discount (net of premium related to the 1.625% Notes), unamortized issuance costs, and net carrying amounts of debt were as follows:

	Principal Balance	Unamortized Discount	Unamortized Issuance Costs	Net Carrying Amount
		(In millions)		
December 31, 2016:				
5.375% Notes	$ 700	$ —	$ 9	$ 691
1.125% Convertible Notes	550	73	6	471
1.625% Convertible Notes	302	16	2	284
	$ 1,552	$ 89	$ 17	$ 1,446
December 31, 2015:				
5.375% Notes	$ 700	$ —	$ 11	$ 689
1.125% Convertible Notes	550	95	7	448
1.625% Convertible Notes	302	25	4	273
Other	1	—	—	1
	$ 1,553	$ 120	$ 22	$ 1,411

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Years Ended December 31,		
	2016	2015	2014
	(In millions)		
Contractual interest at coupon rate	$ 11	$ 11	$ 13
Amortization of the discount	30	29	26
	$ 41	$ 40	$ 39

Debt Commitment Letter

On August 2, 2016, in connection with the Proposed Medicare Acquisition, we entered into a debt commitment letter with Barclays Bank PLC (Barclays). The primary terms of the debt commitment letter provided that, subject to satisfaction of certain conditions, including consummation of the Proposed Medicare Acquisition, Barclays would provide us with debt financing up to $400 million. The debt commitment letter automatically terminated in February 2017 as a result of the termination of the Proposed Medicare Acquisition. See Note 1, “Basis of Presentation” for further discussion regarding the termination of the Proposed Medicare Acquisition.

5.375% Notes due 2022

On November 10, 2015, we completed the private offering of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. In September 2016, we completed a registration rights agreement to exchange the 5.375% Notes for registered notes having substantially identical terms, including guarantees. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15.

The 5.375% Notes contain customary non-financial covenants and change of control provisions. At December 31, 2016, we were in compliance with all financial covenants under the 5.375% Notes. Certain of our wholly owned subsidiaries jointly and severally guarantee our obligations under the 5.375% Notes. See Note 23, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors.

Credit Facility

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (the Credit Facility). Outstanding letters of credit amounting to $6 million reduce the borrowing capacity to $494 million. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $650 million.

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Certain of our wholly owned subsidiaries jointly and severally guarantee our obligations under the Credit Facility. The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. At December 31, 2016, we were not in compliance with the financial covenants under the Credit Facility. In February 2017, we entered into a Second Amendment to the Credit Facility (the Second Amendment). The Second Amendment modified the Credit Facility's definition of the earnings measure used in the covenant computations to: a) allow us to receive credit for risk corridor payments owed to, but not received or accrued by us during 2016; and b) account for the difference between the amount of actual risk transfer payments made or accrued by us during 2016, and the amount of risk transfer payments that would have been due to us under the federal government's proposed 2018 risk adjustment payment transfer formula. The Second Amendment also provides for a waiver by the lenders of our non-compliance with the Credit Facility debt covenants at December 31, 2016. As of December 31, 2016, no amounts were outstanding under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020

In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes (1.125% Notes) due January 15, 2020, unless earlier repurchased or converted.

Interest is payable semiannually in arrears on January 15 and July 15. The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date. Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events; or
- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes met the stock price trigger in the quarter ended December 31, 2016, and are convertible into cash through at least March 31, 2017. Because the 1.125% Notes may be converted to cash within 12 months, the $471 million carrying amount is reported in current portion of long-term debt as of December 31, 2016.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of December 31, 2016, the 1.125% Notes have a remaining amortization period of 3.0 years. The 1.125% Notes' if-converted value exceeded

their principal amount by approximately $182 million and $332 million as of December 31, 2016 and December 31, 2015, respectively.

1.625% Convertible Senior Notes due 2044

In September 2014, we issued $125 million principal amount of 1.625% convertible senior notes (1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Combined with the 1.625% Notes issued in an exchange transaction in 2014, the aggregate principal amount of 1.625% Notes issued was $302 million. Interest is payable semiannually in arrears on February 15 and August 15. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount, or approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of December 31, 2016, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is

approximately four years, beginning on the issuance date and ending on the first date we may redeem the 1.625% Notes in August 2018. As of December 31, 2016, the 1.625% Notes have a remaining amortization period of 1.6 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value did not exceed their principal amount at December 31, 2016, and exceeded their principal amount at December 31, 2015 by approximately $10 million. At December 31, 2016 and December 31, 2015, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $23 million.

Lease Financing Obligations

As a result of our continuing involvement in the leasing transactions described below, we are the "accounting owner" of the properties under the leases. The assets are therefore included in our consolidated balance sheets, and are depreciated over their remaining useful lives. The lease financing obligations are amortized over the initial lease terms, such that there will be no gain or loss recorded if the leases are not extended their expiration dates. Payments under the leases adjust the lease financing obligations, and the imputed interest is recorded to interest expense in our consolidated statements of income. Aggregate interest expense under these leases amounted to $17 million, $17 million and $16 million for the years ended December 31, 2016, 2015 and 2014, respectively. For information regarding the future minimum lease obligations, refer to Note 19, "Commitments and Contingencies."

Molina Center and Ohio Exchange. In 2013, we entered into a sale-leaseback transaction for the Molina Center and our Ohio health plan office building located in Columbus, Ohio, also known as the Ohio Exchange. The sale of these properties did not qualify for sales recognition, because certain lease terms resulted in our continuing involvement with these leased properties. Rent increases 3% per year through the initial term, which expires in 2038. The lease provides for six five-year renewal options, with renewal rent to be the higher of the 3% annual escalator or the then-fair market value.

6th and Pine. Also in 2013, we entered into a construction and lease transaction for two office buildings in Long Beach, California (6th and Pine). Due to our participation in the construction project, we retained continuing involvement in the properties. Rent increases 3.4% per year through the initial term, which expires in 2029. The lease provides for two five-year renewal options, with renewal rent to be determined based on the then-fair market value.

13. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	December 31, 2016	December 31, 2015
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 267	$ 374
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 267	$ 374

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants

strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Notes due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 5, "Fair Value Measurements."

As of December 31, 2016, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of December 31, 2016, as described in Note 12, "Debt."

14. Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the HIF, certain compensation, and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The provision for income taxes consisted of the following:

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Current:			
Federal	$ 134	$ 172	$ 72
State	3	8	3
Foreign	(6)	6	—
Total current	131	186	75
Deferred:			
Federal	19	(10)	—
State	2	4	(2)
Foreign	1	(1)	—
Total deferred	22	(7)	(2)
	$ 153	$ 179	$ 73

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate is as follows:

	Year Ended December 31,		
	2016	2015	2014
Statutory federal tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	1.6	2.4	0.4
Change in unrecognized tax benefits	0.5	0.9	(0.1)
Nondeductible health insurer fee (HIF)	37.0	17.0	22.9
Nondeductible compensation	3.1	0.6	(4.1)
Change in purchase agreement that increased tax basis in assets	(2.2)	—	—
Other	(0.2)	(0.4)	(0.3)
Effective tax rate	74.8 %	55.5 %	53.8 %

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, foreign, and local tax laws.

During 2014, the Internal Revenue Service (IRS) issued final regulations related to compensation deduction limitations applicable to certain health insurance issuers. Pursuant to these final regulations, we reversed amounts treated as nondeductible in 2013 and recognized a tax benefit during 2014.

During 2016, 2015, and 2014, excess tax benefits from share-based compensation amounted to $2 million, $8 million, and $3 million, respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital.

Deferred tax assets and liabilities are classified as non-current. Significant components of our deferred tax assets and liabilities as of December 31, 2016 and 2015 were as follows:

	December 31,	
	2016	2015
	(In millions)	
Accrued expenses	$ 22	$ 37
Reserve liabilities	28	14
Other accrued medical costs	5	5
Net operating losses	13	7
Unrealized losses	1	2
Unearned premiums	27	21
Lease financing obligation	38	35
Deferred compensation	6	8
Tax credit carryover	7	8
Valuation allowance	(16)	(9)
Total deferred income tax assets, net of valuation allowance	131	128
Prepaid expenses	(9)	(9)
Depreciation and amortization	(104)	(83)
Basis in debt	(23)	(18)
Total deferred income tax liabilities	(136)	(110)
Net deferred income tax (liability) asset - long term	$ (5)	$ 18

At December 31, 2016, we had state net operating loss carryforwards of $315 million, which begin expiring in 2018.

At December 31, 2016, we had California enterprise zone tax credit carryovers of $11 million, which will begin to expire in 2024.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2016, $16 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state net operating loss

carryforwards. Therefore, we increased our valuation allowance by $7 million, from $9 million at December 31, 2015, to $16 million as of December 31, 2016.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the United States, Puerto Rico, and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Gross unrecognized tax benefits at beginning of period	$ (9)	$ (3)	$ (8)
Increases in tax positions for current year	(1)	(1)	—
Increases in tax positions for prior years	(1)	(5)	(1)
Settlements	—	—	6
Gross unrecognized tax benefits at end of period	$ (11)	$ (9)	$ (3)

The total amount of unrecognized tax benefits at December 31, 2016, 2015 and 2014 that, if recognized, would affect the effective tax rates is $9 million, $7 million and $2 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $2 million due to the expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2016, 2015 and 2014 were insignificant.

We are under examination by the IRS for calendar year 2011 and may be subject to examination for calendar years 2012 through 2015. We are under examination, or may be subject to examination, in Puerto Rico and certain state and local jurisdictions, with the major state jurisdictions being California, Michigan, and Illinois for the years 2009 through 2015.

15. Stockholders' Equity

Common Stock Offering. In June 2015, we completed an underwritten public offering of 5,750,000 shares of our common stock, including the over-allotment option. Net of issuance costs, proceeds from the offering amounted to $373 million, or $64.90 per share, resulting in an increase to additional paid-in capital. We are using the proceeds to finance working capital needs, acquisitions, capital expenditures, and other general corporate activities.

1.125% Warrants. In connection with the Call Spread Overlay transaction described in Note 13, “Derivatives,” in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Programs. In December 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. We did not repurchase any shares under this program, which expired without renewal on December 31, 2016.

Stock Incentive Plans. At December 31, 2016, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan (2011 Plan); and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

The 2011 Plan provides for the award of restricted shares and units, performance shares and units, stock options and stock bonuses to the company's officers, employees, directors, consultants, advisers, and other service providers. The 2011 Plan provides for the issuance of up to 4.5 million shares of common stock.

Restricted share awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. We recognize expense for these awards on a straight-line basis. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

In connection with our equity incentive plans and employee stock purchase plan, approximately 674,000 shares of common stock were purchased or vested, net of shares used to settle employees' income tax obligations, during the year ended December 31, 2016.

Charged to general and administrative expenses, total share-based compensation expense was as follows:

	Year Ended December 31,					
	2016		2015		2014	
	(In millions)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock and performance awards	$ 20	$ 17	$ 19	$ 13	$ 19	$ 12
Employee stock purchase plan and stock options	6	5	4	3	3	2
	$ 26	$ 22	$ 23	$ 16	$ 22	$ 14

As of December 31, 2016, there was $29 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.7 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 4.7% for non-executive employees as of December 31, 2016. As of December 31, 2016, there was no unrecognized compensation expense related to unvested stock options.

Restricted stock. Restricted and performance stock activity for the year ended December 31, 2016 is summarized below:

	Restricted Shares	Performance Shares	Total Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2015	658,156	376,601	1,034,757	$ 46.68
Granted	300,007	226,010	526,017	63.84
Vested	(352,292)	—	(352,292)	42.06
Canceled	—	(256,955)	(256,955)	46.24
Forfeited	(28,627)	—	(28,627)	53.06
Unvested balance as of December 31, 2016	577,244	345,656	922,900	$ 58.15

The total fair value of restricted awards, including those with performance or market conditions, granted during the years ended December 31, 2016, 2015, and 2014 was $34 million, $28 million, and $25 million, respectively. The total fair value of restricted awards, including those with performance or market conditions, which vested during the years ended December 31, 2016, 2015, and 2014 was $22 million, $39 million, and $24 million, respectively.

Employee Stock Purchase Plan. Under our employee stock purchase plan (ESPP), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2016, 2015, and 2014, the inputs to this model were as follows: risk-free interest rates of approximately 0.1% to 0.5%; expected volatilities ranging from approximately 30% to 40%, dividend yields of 0%, and an average expected life of 0.5

years. We issued approximately 410,000, 302,000 and 327,000 shares of our common stock under the ESPP during the years ended December 31, 2016, 2015, and 2014, respectively. The 2011 ESPP provides for the issuance of up to three million shares of common stock.

Stock Options. No stock options were granted in 2016, 2015 and 2014, and stock options outstanding as of December 31, 2016 were insignificant. The total intrinsic value of options exercised during the years ended December 31, 2016, 2015, and 2014 was $1 million, $6 million, and $2 million, respectively.

16. Employee Benefits

We sponsor defined contribution 401(k) plans that cover substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We generally match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plans totaled $36 million, $27 million and $21 million in the years ended December 31, 2016, 2015, and 2014, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

17. Related Party Transactions

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina and John C. Molina. Under the terms of this provider agreement, the California health plan paid Pacific approximately $1 million in each of 2015 and 2014 for medical care provided to health plan members. Payments in 2016 were insignificant.

Refer to Note 18, “Variable Interest Entities (VIEs),” for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

18. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created to further advance our direct delivery business. JMMPC’s primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. JMMPC also provides certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal. For the years ended December 31, 2016, 2015 and 2014, JMMPC paid $55 million, $69 million and $11 million, respectively, to MMM for clinic administrative services provided by MMM to JMMPC.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to either fund JMMPC’s operating deficits, or receive JMMPC’s operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such amounts either paid to JMMPC or received by the health plans are generally insignificant. For the years ended December 31, 2016, 2015, and 2014, our health plans paid $122 million, $117 million and $32 million, respectively, to JMMPC for health care services provided by JMMPC to the health plans’ members.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities (excluding clinical decisions) that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or the right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2016, JMMPC had total assets of $18 million, and total liabilities of $18 million. As of December 31, 2015, JMMPC had total assets of $17 million, and total liabilities of $17 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be insignificant to our consolidated operating results and cash flows for the foreseeable future.

New Markets Tax Credit

In 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC (Wells Fargo), its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC (Investment Fund), and certain of Wells Fargo's affiliated Community Development Entities (CDEs), in connection with our participation in the federal government's New Markets Tax Credit Program (NMTC). The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

As a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $6 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $16 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $21 million to our New Mexico data center subsidiary.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, that we are the primary beneficiary of the VIE, and we have included it in our consolidated financial statements. Wells Fargo's contribution of $6 million is included in cash at December 31, 2016 and December 31, 2015 and the offsetting amount of Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

19. Commitments and Contingencies

Regulatory Capital Requirements and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,492 million at December 31, 2016, and $1,229 million at December 31, 2015. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $264 million and $612 million as of December 31, 2016 and 2015, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states.

As of December 31, 2016, our health plans had aggregate statutory capital and surplus of approximately $1,693 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,100 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2016. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Legal Proceedings

The health care and Medicaid-related business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Marketplace Risk Corridor Program. On January 19, 2017, we filed suit against the United States of America in the United States Court of Federal Claims, Case Number 1:55-cv-01000-UNJ, on behalf of our health plans seeking recovery from the federal government of approximately $52 million in Marketplace risk corridor payments for calendar year 2015. Based upon current estimates, we believe our health plans are also owed approximately $90 million in Marketplace risk corridor payments from the federal government for calendar year 2016, and a further nominal amount for calendar year 2014. Our lawsuit seeks recovery of all of these unpaid amounts. We have not recognized revenue, nor have we recorded a receivable, for any amount due from the federal government for unpaid Marketplace risk corridor payments as of December 31, 2016. We have fully recognized all liabilities due to the federal government that we have incurred under the Marketplace risk corridor program, and have paid all amounts due to the federal government as required.

Rodriguez v. Providence Community Corrections. On October 1, 2015, seven individuals, on behalf of themselves and all others similarly situated, filed a complaint in the District Court for the Middle District of Tennessee, Nashville Division, Case No. 3:15-cv-01048 (the Rodriquez Litigation), against Providence Community Corrections, Inc. (now known as Pathways Community Corrections, Inc., or PCC). Rutherford County, Tennessee formerly contracted with PCC for the administration of misdemeanor probation, which involved the collection of court costs and fees from probationers. The complaint alleges, among other things, that PCC illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay such amounts. The plaintiffs in the Rodriguez Litigation seek alleged compensatory, treble, and punitive damages, plus attorneys' fees, for alleged federal and state constitutional violations, as well as alleged violations of the Racketeer Influenced and Corrupt Organization Act. PCC's agreement with Rutherford County terminated effective March 31, 2016. On November 1, 2015, one month after the Rodriguez Litigation commenced, we acquired PCC from The Providence Service Corporation (Providence) pursuant to a membership interest purchase agreement. In September 2016, the parties to the Rodriguez Litigation accepted a mediation proposal for settlement pursuant to which PCC would pay the plaintiffs $14 million. The parties are in the process of finalizing the settlement agreement. We expect to recover the full amount of the settlement under the indemnification provisions of the membership interest purchase agreement with Providence.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. On October 22, 2015, the Relator filed a third amended complaint. On July 11, 2016, the District Court dismissed with prejudice the third amended complaint, without leave to amend. On

September 23, 2016, the plaintiff filed an appeal with the Ninth Circuit Court of Appeals. The plaintiff/appellant's opening brief is due March 6, 2017, and the defendant/appellee's opening brief is due April 5, 2017.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe that, pursuant to a settlement with the state, this matter will be dismissed against Molina Medicaid Solutions with no liability.

Hospital Management Contract. During the fourth quarter of 2015, we recorded a contract settlement charge of approximately $15 million as a result of our termination of a hospital management agreement.

States' Budgets

From time to time the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. For example, the state of Illinois is operating without a budget for its current fiscal year. It is unclear when or if the state's budget difficulties will be resolved. As of December 31, 2016, our Illinois health plan served approximately 195,000 members and recognized premium revenue of approximately $601 million for the year ended December 31, 2016. As of February 24, 2017, the state of Illinois owed us approximately $68 million for certain October, November and December 2016 premiums.

In another example, the Commonwealth of Puerto Rico's fiscal plan, issued on October 14, 2016, reported that current revenues are insufficient to support existing current operations and debt service. While the Commonwealth reports that it will prioritize health care spending, it stresses the need to address the cap on federal matching funds it receives for its participation in the Medicaid program. Among the fiscal issues expected to further exacerbate the Commonwealth's current debt crisis is the depletion of ACA funds, estimated to occur in the Commonwealth's fiscal year 2018. As of December 31, 2016, our Puerto Rico health plan served approximately 330,000 members and recorded premium revenue of approximately $726 million for the year ended December 31, 2016. As of February 24, 2017, the Commonwealth is current with its premium payments.

Operating Leases

We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2027. Facility lease terms generally range from five to 10 years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under operating leases and lease financing obligations consist of the following amounts:

	Lease Financing Obligations	Operating Leases	Total
		(In millions)	
2017	$ 17	$ 63	$ 80
2018	17	57	74
2019	18	50	68
2020	19	33	52
2021	19	21	40
Thereafter	337	43	380
	$ 427	$ 267	$ 694

Rental expense related to operating leases amounted to $64 million, $44 million, and $32 million for the years ended December 31, 2016, 2015, and 2014, respectively. The amounts reported in "Lease Financing Obligations" above represent our contractual lease commitments for the properties described in Note 12, "Debt" under the subheading "Lease Financing Obligations."

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered in the primary care institutions that we manage. In addition, we also carry errors and omissions insurance for all Molina entities.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Employment Agreements

In 2002, we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which were further amended and restated in 2016. These amended and restated employment agreements had an initial one-year term, and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay 400% of the executive's base salary then in effect and a prorated termination bonus (150% of base salary for the Chief Executive Officer and 125% of base salary for the Chief Financial Officer), in addition to full vesting of equity compensation, and a cash payment for health and welfare benefits.

In 2013, we entered into employment agreements with our Chief Operating Officer, Chief Accounting Officer, and Chief Legal Officer. These agreements continue until terminated by us, or the executive resigns. If the executive's employment is terminated by us without cause or the executive resigns for good reason, the executive will be entitled to receive one year's base salary and termination bonus, as defined, full vesting of time-based equity compensation, and a cash payment for health and welfare benefits.

Payment of the severance benefits described above is contingent upon the executive's signing a release agreement waiving claims against us. If the executives are terminated for cause, no further payments are due under the contracts.

20. Segment Information

We have three reportable segments. These segments consist of our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment, which includes our behavioral health and social services subsidiary, Pathways.

Our reportable segments are consistent with how we currently manage our business and view the markets we serve. The Health Plans segment consists of our health plans and our direct delivery business. Our health plans are operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
2016				
Total revenue [1]	$ 17,234	$ 195	$ 353	$ 17,782
Gross margin	1,618	21	33	1,672
Depreciation and amortization [2]	122	45	15	182
Goodwill, and intangible assets, net	513	72	175	760
Total assets	5,897	267	1,285	7,449
2015				
Total revenue [1]	13,917	195	66	14,178
Gross margin	1,447	55	5	1,507
Depreciation and amortization [2]	95	25	6	126
Goodwill, and intangible assets, net	393	73	175	641
Total assets	4,707	213	1,656	6,576
2014				
Total revenue [1]	9,449	210	8	9,667
Gross margin	947	53	—	1,000
Depreciation and amortization [2]	83	46	5	134
Goodwill, and intangible assets, net	286	75	—	361
Total assets	3,355	185	895	4,435

(1) Total revenue consists primarily of premium revenue, premium tax revenue and health insurer fee revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments.

(2) Depreciation and amortization reported in accompanying consolidated statements of cash flows.

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Gross margin:			
Health Plans	$ 1,618	$ 1,447	$ 947
Molina Medicaid Solutions	21	55	53
Other	33	5	—
Total gross margin	1,672	1,507	1,000
Add: other operating revenues [1]	851	684	434
Less: other operating expenses [2]	(2,217)	(1,804)	(1,241)
Operating income	306	387	193
Other expenses, net	101	65	58
Income before income tax expense	$ 205	$ 322	$ 135

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses, and depreciation and amortization.

21. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2016 and 2015.

	For The Quarter Ended			
	March 31, 2016	June 30, 2016	Sept. 30, 2016	December 31, 2016
	(In millions, except per-share data)			
Premium revenue	$ 3,995	$ 4,029	$ 4,191	$ 4,177
Service revenue	140	135	133	131
Operating income (loss)	89	105	118	(6)
Net income (loss)	24	33	42	(47)
Net income (loss) per share [1]:				
Basic	$ 0.44	$ 0.58	$ 0.77	$ (0.85)
Diluted	$ 0.43	$ 0.58	$ 0.76	$ (0.85)

	For The Quarter Ended			
	March 31, 2015	June 30, 2015	Sept. 30, 2015	December 31, 2015
	(In millions, except per-share data)			
Premium revenue	$ 2,971	$ 3,304	$ 3,377	$ 3,589
Service revenue	52	47	47	107
Operating income	82	116	113	76
Net income	28	39	46	30
Net income per share [1]:				
Basic	$ 0.58	$ 0.78	$ 0.84	$ 0.54
Diluted	$ 0.56	$ 0.72	$ 0.77	$ 0.52

(1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive.

22. Condensed Financial Information of Registrant

The condensed balance sheets as of December 31, 2016 and 2015, and the related condensed statements of income, comprehensive income and cash flows for each of the three years in the period ended December 31, 2016 for our parent company Molina Healthcare, Inc. (the Registrant), are presented below.

Condensed Balance Sheets

	December 31,	
	2016	2015
	(In millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 86	$ 360
Investments	178	252
Receivables	2	—
Income taxes refundable	17	7
Due from affiliates	104	86
Prepaid expenses and other current assets	58	46
Derivative asset	267	374
Total current assets	712	1,125
Property, equipment, and capitalized software, net	301	267
Goodwill and intangible assets, net	58	61
Investments in subsidiaries	2,609	2,205
Deferred income taxes	10	23
Advances to related parties and other assets	48	36
	$ 3,738	$ 3,717
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1	$ —
Accounts payable and accrued liabilities	146	157
Current portion of long-term debt	472	449
Derivative liability	267	374
Total current liabilities	886	980
Senior notes	975	962
Lease financing obligations	198	198
Deferred income taxes	11	—
Other long-term liabilities	19	20
Total liabilities	2,089	2,160
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding:		
57 shares at December 31, 2016 and 56 shares at December 31, 2015	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	841	803
Accumulated other comprehensive loss	(2)	(4)
Retained earnings	810	758
Total stockholders' equity	1,649	1,557
	$ 3,738	$ 3,717

See accompanying notes.

Condensed Statements of Income

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Revenue:			
Management fees	$ 1,062	$ 914	$ 692
Investment income and other revenue	16	17	14
Total revenue	1,078	931	706
Expenses:			
Medical care costs	73	55	46
General and administrative expenses	899	797	583
Depreciation and amortization	95	82	73
Total operating expenses	1,067	934	702
Operating income (loss)	11	(3)	4
Interest expense	101	66	57
Other expense	—	—	1
Loss before income taxes and equity in net income of subsidiaries	(90)	(69)	(54)
Income tax benefit	(24)	(21)	(27)
Net loss before equity in net income of subsidiaries	(66)	(48)	(27)
Equity in net income of subsidiaries	118	191	89
Net income	$ 52	$ 143	$ 62

Condensed Statements of Comprehensive Income

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Net income	$ 52	$ 143	$ 62
Other comprehensive income (loss):			
Unrealized investment gain (loss)	3	(5)	—
Less: effect of income taxes	1	(2)	—
Other comprehensive income (loss), net of tax	2	(3)	—
Comprehensive income	$ 54	$ 140	$ 62

See accompanying notes.

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2016	2015	2014
	(In millions)		
Operating activities:			
Net cash provided by operating activities	$ 55	$ 113	$ 74
Investing activities:			
Capital contributions to subsidiaries	(386)	(770)	(292)
Dividends received from subsidiaries	101	142	—
Purchases of investments	(115)	(244)	(129)
Proceeds from sales and maturities of investments	188	118	263
Purchases of property, equipment and capitalized software	(125)	(91)	(94)
Change in amounts due to/from affiliates	(18)	(68)	16
Other, net	6	—	8
Net cash used in investing activities	(349)	(913)	(228)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	—	689	123
Proceeds from common stock offering, net of issuance costs	—	373	—
Proceeds from employee stock plans	18	18	14
Principal payments on convertible senior notes	—	—	(11)
Other, net	2	5	3
Net cash provided by financing activities	20	1,085	129
Net (decrease) increase in cash and cash equivalents	(274)	285	(25)
Cash and cash equivalents at beginning of year	360	75	100
Cash and cash equivalents at end of year	$ 86	$ 360	$ 75

See accompanying notes.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

The Registrant was incorporated in 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for three other state health plans. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2016, 2015, and 2014 for these services amounted to $1,062 million, $914 million, and $692 million, respectively, and are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would

be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Dividends and Capital Contributions

When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries.

For all periods presented, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund business combinations. Such amounts have been recorded as an increase in investment in the respective subsidiaries, net of insignificant returns of capital.

Note D - Related Party Transactions

The Registrant's related party transactions are described in Note 17, "Related Party Transactions."

23. Supplemental Condensed Consolidating Financial Information

As discussed in Note 12, “Debt,” in November 2015 we completed the private offering of $700 million aggregate principal amount of 5.375% Notes, which were subsequently exchanged for registered notes in September 2016.

The 5.375% Notes are fully and unconditionally guaranteed by certain of our wholly owned subsidiaries on a joint and several basis, with exceptions considered customary for such guarantees. The 5.375% Notes and the guarantees are effectively subordinated to all existing and future secured debt of us and our guarantors to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock of our subsidiaries that do not guarantee the 5.375% Notes.

In January 2017, pursuant to the terms of the amended Credit Facility described in Note 12, “Debt,” and the terms of the indenture governing the 5.375% Notes, all guarantors immediately prior to January 3, 2017 other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC and Pathways Health and Community Support LLC were automatically and unconditionally released as guarantors of our amended Credit Facility and the 5.375% Notes.

The following condensed consolidating financial statements present Molina Healthcare, Inc. (as parent guarantor), the subsidiary guarantors, the subsidiary non-guarantors and eliminations.

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Year Ended December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 1,078	$ 556	$ 17,287	$ (1,139)	$ 17,782
Expenses:					
Medical care costs	73	54	14,705	(58)	14,774
Cost of service revenue	—	443	42	—	485
General and administrative expenses	899	48	1,527	(1,081)	1,393
Premium tax expenses	—	—	468	—	468
Health insurer fee expenses	—	—	217	—	217
Depreciation and amortization	95	12	32	—	139
Total operating expenses	1,067	557	16,991	(1,139)	17,476
Operating income (loss)	11	(1)	296	—	306
Interest expense	101	—	—	—	101
(Loss) income before income taxes	(90)	(1)	296	—	205
Income tax (benefit) expense	(24)	(4)	181	—	153
Net (loss) income before equity in earnings of subsidiaries	(66)	3	115	—	52
Equity in net earnings of subsidiaries	118	1	—	(119)	—
Net income	$ 52	$ 4	$ 115	$ (119)	$ 52

	Year Ended December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 931	$ 293	$ 13,931	$ (977)	$ 14,178
Expenses:					
Medical care costs	55	36	11,753	(50)	11,794
Cost of service revenue	—	184	9	—	193
General and administrative expenses	797	41	1,235	(927)	1,146
Premium tax expenses	—	—	397	—	397
Health insurer fee expenses	—	—	157	—	157
Depreciation and amortization	82	4	18	—	104
Total operating expenses	934	265	13,569	(977)	13,791
Operating (loss) income	(3)	28	362	—	387
Total other expenses (income), net	66	—	(1)	—	65
(Loss) income before income taxes	(69)	28	363	—	322
Income tax (benefit) expense	(21)	9	191	—	179
Net (loss) income before equity in earnings of subsidiaries	(48)	19	172	—	143
Equity in net earnings of subsidiaries	191	(1)	—	(190)	—
Net income	$ 143	$ 18	$ 172	$ (190)	$ 143

	Year Ended December 31, 2014				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 706	$ 240	$ 9,454	$ (733)	$ 9,667
Expenses:					
Medical care costs	46	27	8,034	(31)	8,076
Cost of service revenue	—	157	—	—	157
General and administrative expenses	583	29	855	(702)	765
Premium tax expenses	—	—	294	—	294
Health insurer fee expenses	—	—	89	—	89
Depreciation and amortization	73	5	15	—	93
Total operating expenses	702	218	9,287	(733)	9,474
Operating income	4	22	167	—	193
Total other expenses, net	58	—	—	—	58
(Loss) income before income taxes	(54)	22	167	—	135
Income tax (benefit) expense	(27)	8	92	—	73
Net (loss) income before equity in earnings of subsidiaries	(27)	14	75	—	62
Equity in net earnings of subsidiaries	89	—	—	(89)	—
Net income	$ 62	$ 14	$ 75	$ (89)	$ 62

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net income	$ 52	$ 4	$ 115	$ (119)	$ 52
Other comprehensive income, net of tax	2	—	1	(1)	2
Comprehensive income	$ 54	$ 4	$ 116	$ (120)	$ 54

	Year Ended December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net income	$ 143	$ 18	$ 172	$ (190)	$ 143
Other comprehensive loss, net of tax	(3)	—	(3)	3	(3)
Comprehensive income	$ 140	$ 18	$ 169	$ (187)	$ 140

	Year Ended December 31, 2014				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Net income	$ 62	$ 14	$ 75	$ (89)	$ 62
Other comprehensive loss, net of tax	—	—	—	—	—
Comprehensive income	$ 62	$ 14	$ 75	$ (89)	$ 62

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
ASSETS					
Current assets:					
Cash and cash equivalents	$ 86	$ 38	$ 2,695	$ —	$ 2,819
Investments	178	—	1,580	—	1,758
Receivables	2	78	894	—	974
Income tax refundable	17	4	18	—	39
Due from (to) affiliates	104	(19)	(85)	—	—
Prepaid expenses and other current assets	58	40	38	(5)	131
Derivative asset	267	—	—	—	267
Total current assets	712	141	5,140	(5)	5,988
Property, equipment, and capitalized software, net	301	70	83	—	454
Deferred contract costs	—	86	—	—	86
Goodwill and intangible assets, net	58	223	479	—	760
Restricted investments	—	—	110	—	110
Investment in subsidiaries, net	2,609	42	—	(2,651)	—
Deferred income taxes	10	—	—	—	10
Other assets	48	4	5	(16)	41
	$ 3,738	$ 566	$ 5,817	$ (2,672)	$ 7,449
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ 1	$ —	$ 1,928	$ —	$ 1,929
Amounts due government agencies	—	—	1,202	—	1,202
Accounts payable and accrued liabilities	146	56	188	(5)	385
Deferred revenue	—	40	275	—	315
Current portion of long-term debt	472	—	—	—	472
Derivative liability	267	—	—	—	267
Total current liabilities	886	96	3,593	(5)	4,570
Long-term debt	1,173	—	16	(16)	1,173
Deferred income taxes	11	40	(36)	—	15
Other long-term liabilities	19	3	20	—	42
Total liabilities	2,089	139	3,593	(21)	5,800
Total stockholders' equity	1,649	427	2,224	(2,651)	1,649
	$ 3,738	$ 566	$ 5,817	$ (2,672)	$ 7,449

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS

	December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
ASSETS					
Current assets:					
Cash and cash equivalents	$ 360	$ 42	$ 1,927	$ —	$ 2,329
Investments	252	—	1,549	—	1,801
Receivables	—	79	518	—	597
Income tax refundable	7	3	3	—	13
Due from (to) affiliates	86	(4)	(82)	—	—
Prepaid expenses and other current assets	46	11	136	(1)	192
Derivative asset	374	—	—	—	374
Total current assets	1,125	131	4,051	(1)	5,306
Property, equipment, and capitalized software, net	267	52	74	—	393
Deferred contract costs	—	81	—	—	81
Goodwill and intangible assets, net	61	246	334	—	641
Restricted investments	—	—	109	—	109
Investment in subsidiaries, net	2,205	1	—	(2,206)	—
Deferred income taxes	23	(35)	30	—	18
Other assets	36	2	6	(16)	28
	$ 3,717	$ 478	$ 4,604	$ (2,223)	$ 6,576
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ —	$ 3	$ 1,682	$ —	$ 1,685
Amounts due government agencies	—	1	728	—	729
Accounts payable and accrued liabilities	157	35	170	—	362
Deferred revenue	—	34	189	—	223
Current portion of long-term debt	449	—	—	—	449
Derivative liability	374	—	—	—	374
Total current liabilities	980	73	2,769	—	3,822
Long-term debt	1,160	—	16	(16)	1,160
Other long-term liabilities	20	2	16	(1)	37
Total liabilities	2,160	75	2,801	(17)	5,019
Total stockholders' equity	1,557	403	1,803	(2,206)	1,557
	$ 3,717	$ 478	$ 4,604	$ (2,223)	$ 6,576

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Year Ended December 31, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 55	45	573	—	$ 673
Investing activities:					
Purchases of investments	(115)	—	(1,814)	—	(1,929)
Proceeds from sales and maturities of investments	188	—	1,778	—	1,966
Purchases of property, equipment and capitalized software	(125)	(34)	(17)	—	(176)
Decrease in restricted investments	—	—	4	—	4
Net cash paid in business combinations	—	(11)	(37)	—	(48)
Capital contributions to subsidiaries	(386)	20	366	—	—
Dividends received from subsidiaries	101	—	(101)	—	—
Change in amounts due to/from affiliates	(18)	3	15	—	—
Other, net	6	(26)	1	—	(19)
Net cash (used in) provided by investing activities	(349)	(48)	195	—	(202)
Financing activities:					
Proceeds from employee stock plans	18	—	—	—	18
Other, net	2	(1)	—	—	1
Net cash provided by (used in) financing activities	20	(1)	—	—	19
Net (decrease) increase in cash and cash equivalents	(274)	(4)	768	—	490
Cash and cash equivalents at beginning of period	360	42	1,927	—	2,329
Cash and cash equivalents at end of period	$ 86	$ 38	$ 2,695	$ —	$ 2,819

	Year Ended December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 113	58	954	—	$ 1,125
Investing activities:					
Purchases of investments	(244)	—	(1,679)	—	(1,923)
Proceeds from sales and maturities of investments	118	—	1,008	—	1,126
Purchases of property, equipment and capitalized software	(91)	(23)	(18)	—	(132)
Decrease in restricted investments	—	5	(11)	—	(6)
Net cash paid in business combinations	—	(214)	(236)	—	(450)
Capital contributions to subsidiaries	(770)	238	532	—	—
Dividends received from subsidiaries	142	(17)	(125)	—	—
Change in amounts due to/from affiliates	(68)	15	53	—	—
Other, net	—	(35)	—	—	(35)
Net cash used in investing activities	(913)	(31)	(476)	—	(1,420)
Financing activities:					
Proceeds from senior notes offerings, net of issuance costs	689	—	—	—	689
Proceeds from common stock offering, net of issuance costs	373	—	—	—	373
Proceeds from employee stock plans	18	—	—	—	18
Other, net	5	—	—	—	5
Net cash provided by financing activities	1,085	—	—	—	1,085
Net increase in cash and cash equivalents	285	27	478	—	790
Cash and cash equivalents at beginning of period	75	15	1,449	—	1,539
Cash and cash equivalents at end of period	$ 360	$ 42	$ 1,927	$ —	$ 2,329

	Year Ended December 31, 2014				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 74	29	957	—	$ 1,060
Investing activities:					
Purchases of investments	(129)	—	(824)	—	(953)
Proceeds from sales and maturities of investments	263	—	370	—	633
Purchases of property, equipment and capitalized software	(94)	(12)	(9)	—	(115)
Decrease in restricted investments	—	5	(39)	—	(34)
Net cash paid in business combinations	—	—	(44)	—	(44)
Capital contributions to subsidiaries	(292)	14	278	—	—
Dividends received from subsidiaries	—	—	—	—	—
Change in amounts due to/from affiliates	16	(1)	(15)	—	—
Other, net	8	(29)	(2)	—	(23)
Net cash used in investing activities	(228)	(23)	(285)	—	(536)
Financing activities:					
Proceeds from senior notes offerings, net of issuance costs	123	—	—	—	123
Contingent consideration liabilities settled	—	—	(50)	—	(50)
Proceeds from employee stock plans	14	—	—	—	14
Principal payments on convertible senior notes	(10)	—	—	—	(10)
Other, net	2	—	—	—	2
Net cash provided by (used in) financing activities	129	—	(50)	—	79
Net (decrease) increase in cash and cash equivalents	(25)	6	622	—	603
Cash and cash equivalents at beginning of period	100	9	827	—	936
Cash and cash equivalents at end of period	$ 75	$ 15	$ 1,449	$ —	$ 1,539

DIRECTORS, EXECUTIVE OFFICERS, AND CORPORATE GOVERNANCE

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
J. Mario Molina, M.D.	58	President and Chief Executive Officer
John C. Molina, J.D.	52	Chief Financial Officer
Terry P. Bayer	66	Chief Operating Officer
Joseph W. White	58	Chief Accounting Officer
Jeff D. Barlow	54	Chief Legal Officer and Corporate Secretary

Dr. Molina has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board of Directors since 1996. Dr. Molina is the brother of John C. Molina.

Mr. Molina has served as Chief Financial Officer since 1995. He also has served as a member of the Board of Directors since 1994. Mr. Molina is the brother of Dr. J. Mario Molina.

Ms. Bayer has served as Chief Operating Officer since 2005.

Mr. White has served as Chief Accounting Officer since 2007.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010.

The remaining information called for by Item 10 of Form 10-K is incorporated by reference to “Election of Directors,” “Corporate Governance and Board of Directors Matters,” and “Section 16(a) Beneficial Ownership Reporting Compliance” in our definitive proxy statement for our 2017 Annual Meeting of Stockholders.

EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The financial statements included in Financial Statements and Supplementary Data, above, are filed as part of this annual report.

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 1st day of March, 2017.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina

Joseph M. Molina, M.D. (Dr. J. Mario Molina)
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	March 1, 2017
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	March 1, 2017
/s/ Joseph W. White **Joseph W. White**	Chief Accounting Officer (Principal Accounting Officer)	March 1, 2017
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	March 1, 2017
/s/ Daniel Cooperman **Daniel Cooperman**	Director	March 1, 2017
/s/ Charles Z. Fedak **Charles Z. Fedak**	Director	March 1, 2017
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	March 1, 2017
/s/ Steven J. Orlando **Steven J. Orlando**	Director	March 1, 2017
/s/ Ronna E. Romney **Ronna E. Romney**	Director	March 1, 2017
/s/ Richard M. Schapiro **Richard M. Schapiro**	Director	March 1, 2017
/s/ Dale B. Wolf **Dale B. Wolf**	Director	March 1, 2017

INDEX TO EXHIBITS

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K may contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

Number	Description	Method of Filing
2.1	Membership Interest Purchase Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Healthcare, Inc.	Filed as Exhibit 2.1 to registrant's Form 8-K filed September 8, 2015.
2.2	Amendment to Membership Interest Purchase Agreement, dated as of October 30, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Pathways, LLC, as assignee of all rights and obligations of Molina Healthcare, Inc.	Filed as Exhibit 2.2 to registrant's Form 10-K filed February 26, 2016.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Certificate of Amendment to Certificate of Incorporation	Filed as Appendix A to registrant's Definitive Proxy Statement on Form DEF 14A filed March 25, 2013.
3.3	Third Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 10-Q filed July 30, 2014.
4.1	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.2	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.3	Indenture, dated as of September 5, 2014, by and between Molina Healthcare, Inc. and U.S. Bank National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014.
4.4	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014.
4.5	Form of 1.625% Convertible Senior Notes Due 2044 Note Purchase Agreement, dated as of September 11, 2014, by and between Molina Healthcare, Inc. and certain institutional investors	Filed as Exhibit 10.1 to registrant's Form 8-K filed September 12, 2014.
4.6	First Supplemental Indenture, dated as of September 16, 2014, by and between Molina Healthcare, Inc. and the U.S. Bank National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014.
4.7	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014.
4.8	Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.9	Form of 5.375% Senior Notes due 2022	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.

Number	Description	Method of Filing
4.10	Form of Guarantee pursuant to Indenture, dated as of November 10, 2015, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.11	Registration Rights Agreement, dated as of November 10, 2015, by and among Molina Healthcare, Inc., the guarantors party thereto and SunTrust Robinson Humphrey, Inc., as representative of the Initial Purchasers (as defined therein)	Filed as Exhibit 4.4 to registrant's Form 8-K filed November 10, 2015.
4.12	First Supplemental Indenture, dated as of February 16, 2016, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as trustee	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 18, 2016.
*10.1	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
*10.2	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.5 to registrant's Form 10-K filed February 26, 2014.
*10.3	Amendment No. 1 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2014.
*10.4	Amendment No. 2 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.4 to registrant's Form 10-K filed February 26, 2015.
*10.5	2011 Equity Incentive Plan	Filed as Exhibit 10.8 to registrant's Form 10-K filed February 26, 2014.
*10.6	2011 Employee Stock Purchase Plan	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2015.
*10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-Q filed August 9, 2005.
*10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.4 to registrant's Form 10-Q filed August 9, 2005.
*10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.5 to registrant's Form 10-Q filed August 9, 2005.
*10.10	Form of Stock Option Agreement under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
*10.11	Second Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated March 16, 2016	Filed as Exhibit 10.1 to registrant's Form 8-K filed March 16, 2016.
*10.12	Second Amended and Restated Employment Agreement with John C. Molina dated March 16, 2016	Filed as Exhibit 10.2 to registrant's Form 8-K filed March 16, 2016.
*10.13	Employment Agreement with Terry Bayer dated June 14, 2013	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 14, 2013.
*10.14	Employment Agreement with Joseph White dated June 14, 2013	Filed as Exhibit 10.2 to registrant's Form 8-K filed June 14, 2013.
*10.15	Employment Agreement with Jeff Barlow dated June 14, 2013	Filed as Exhibit 10.3 to registrant's Form 8-K filed June 14, 2013.
*10.16	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
*10.17	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
*10.18	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed as Exhibit 10.16 to registrant's Form 10-K filed February 28, 2013.
10.19	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.20	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
10.21	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.

Number	Description	Method of Filing
10.22	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.
10.23	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.24	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.25	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.26	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.27	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.
10.28	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013.
10.29	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013.
10.30	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013.
10.31	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013.
10.32	Lease Agreement, dated as of February 27, 2013, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.32 to registrant's Form 10-K filed February 28, 2013.
10.33	First Amendment to Office Building Lease, effective as of October 31, 2014, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed November 5, 2014.
10.34	Second Amendment to Office Building Lease, effective as of November 2, 2015, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed November 6, 2015.
10.35	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013.
10.36	Credit Agreement, dated as of June 12, 2015, by and among Molina Healthcare, Inc., Molina Information Systems, LLC, Molina Medical Management, Inc., certain lenders named on the signature pages thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2015.
10.37	First Amendment to Credit Agreement, dated as of January 3, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank, including the amended and restated Credit Agreement attached as Exhibit A thereto	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 3, 2017.
10.38	Second Amendment to Credit Agreement, dated as of February 15, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 17, 2017.

Number	Description	Method of Filing
10.39	Guarantor Joinder Agreement, dated February 16, 2016, by and among the guarantors party thereto and SunTrust Bank, as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 18, 2016.
10.40	Purchase Agreement, dated as of February 11, 2013, among Molina Healthcare, Inc. and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Representatives of the Initial Purchasers	Filed as Exhibit 1.1 to registrant's Form 8-K filed February 15, 2013.
10.41	Capitated Medical Group/IPA Provider Services Agreement, effective May 1, 2013, by and between Molina Healthcare of California and Pacific Healthcare IPA	Filed as Exhibit 10.42 to registrant's Form 10-K filed February 26, 2016.
10.42	Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to Molina Healthcare of California Group/IPA Provider Services Agreement(s), effective September 26, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed as Exhibit 10.43 to registrant's Form 10-K filed February 26, 2016.
10.43	Capitated Financial Alignment Demonstration Amendment to Molina Healthcare of California Group/IPA Provider Services Agreement, effective as of July 1, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed as Exhibit 10.44 to registrant's Form 10-K filed February 26, 2016.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
101.INS	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

EXHIBIT 12.1

MOLINA HEALTHCARE, INC.

COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES

	Year Ended December 31,				
	2016	**2015**	**2014**	**2013**	**2012**
	(Dollars in millions)				
Earnings:					
Income before income taxes, continuing operations	$ 205	$ 322	$ 135	$ 81	$ 23
Add fixed charges:					
Interest expense, including amortization of debt discount	101	66	57	52	17
Estimated interest portion of rental expense	12	8	5	4	3
Total fixed charges	113	74	62	56	20
Total earnings available for fixed charges	$ 318	$ 396	$ 197	$ 137	$ 43
Fixed charges from above:	$ 113	$ 74	$ 62	$ 56	$ 20
Ratio of Earnings to Fixed Charges	2.8	5.4	3.2	2.4	2.2
Total rent expense	$ 64	$ 44	$ 32	$ 25	$ 20
Interest factor	18%	18%	16%	16%	14%
Interest component of rental expense	$ 12	$ 8	$ 5	$ 4	$ 3

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Iowa, Inc. *	Iowa
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Mississippi, Inc.*	Mississippi
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of New York, Inc.	New York
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Oklahoma, Inc.*	Oklahoma
Molina Healthcare of Pennsylvania, Inc.*	Pennsylvania
Molina Healthcare of Puerto Rico, Inc.	Puerto Rico/Nevada
Molina Healthcare of South Carolina, LLC	South Carolina
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Health Plan Management, Inc.*	New York
Molina Hospital Management, Inc.	California
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Youth Academy*	California
Molina Medical Management, Inc.	California
Easy Care MSO, LLC~	California
Molina Holdings Corporation*	New York
Molina Clinical Services LLC*	Delaware
Molina Healthcare of Louisiana, Inc.*	Louisiana
Molina Healthcare of Nevada, Inc.*	Nevada
Molina Pathways, LLC	Delaware
Molina Pathways of Ohio, LLC+*	Ohio
Molina Pathways of Texas, Inc.+	Texas
Molina Personal Care of Texas, Inc.+ *	Texas
Molina Personal Care of South Carolina, Inc.+*	South Carolina
Integrated Care Alliance, LLC (Synergy Partners, L.L.C.)+	Michigan
Molina Dental & Vision Services, LLC+*	Delaware

EXHIBIT 21.1

Pathways Health and Community Support LLC+	Delaware
AmericanWork, Inc.-	Delaware
A to Z In-Home Tutoring LLC-	Nevada
Children's Behavioral Health, Inc.-	Pennsylvania
Choices Group, Inc.-	Delaware
College Community Services-	California
Dockside Services, Inc.-	Indiana
Family Preservation Services, Inc.-	Virginia
Family Preservation Services of Florida, Inc.-	Florida
Family Preservation Services of North Carolina, Inc.-	North Carolina
Family Preservation Services of Washington D.C., Inc.-	District of Columbia
Family Preservation Services of West Virginia, Inc.-	West Virginia
Maple Star Nevada, Inc.-	Nevada
Maple Star Oregon, Inc.-	Oregon
Pathways Community Corrections, Inc.-	Delaware
Camelot Care Centers, Inc.>	Illinois
Pathways Community Services LLC-	Delaware
Pathways Community Services LLC-	Pennsylvania
Pathways of Massachusetts LLC-	Delaware
Pathways of Washington, Inc.-	Washington
Pathways of Arizona, Inc.-	Arizona
Pathways of Idaho LLC-	Delaware
Pathways of Delaware, Inc.-	Delaware
Pathways of Maine, Inc.-	Maine
Pathways of Oklahoma, Inc.-	Oklahoma
Pathways Community Support of Texas, Inc.-	Texas
Transitional Family Services, Inc.-	Georgia
Pathways Human Services, LLC.*-	Delaware
The RedCo Group, Inc.-	Pennsylvania
Raystown Developmental Services, Inc./	Pennsylvania

* Non-operational entity

\+ Wholly owned subsidiary of Molina Pathways, LLC

~ Partially owned subsidiary of Molina Medical Management, Inc.

\- Wholly owned subsidiary of Pathways Health and Community Support LLC

/ Wholly owned subsidiary of The RedCo Group, Inc.

> Wholly owned subsidiary of Pathways Community Corrections, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-204558) of Molina Healthcare, Inc.;
(2) Registration Statement (Form S-4 No. 333-213136) of Molina Healthcare, Inc.;
(3) Registration Statement (Form No. 333-174912) pertaining to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan;
(4) Registration Statements (Forms S-8 No. 333-138552, No. 333-153246, and No. 333-170571) pertaining to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and
(5) Registration Statement (Form No. 333-108317) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan and 2002 Employee Stock Purchase Plan;

of our reports dated March 1, 2017, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2016.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 1, 2017

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the annual report on Form 10-K for the period ended December 31, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: March 1, 2017

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed this annual report on Form 10-K for the period ended December 31, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: March 1, 2017

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2016 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 1, 2017

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2016 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 1, 2017

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended September 30, 2016

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2016

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of October 21, 2016, was approximately 56,821,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended September 30, 2016

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	September 30, 2016	December 31, 2015
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,842	$ 2,329
Investments	1,735	1,801
Receivables	1,053	597
Income taxes refundable	—	13
Prepaid expenses and other current assets	169	192
Derivative asset	314	374
Total current assets	6,113	5,306
Property, equipment, and capitalized software, net	450	393
Deferred contract costs	83	81
Intangible assets, net	149	122
Goodwill	619	519
Restricted investments	116	109
Deferred income taxes	—	18
Other assets	40	28
	$ 7,570	$ 6,576
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,871	$ 1,685
Amounts due government agencies	1,232	729
Accounts payable and accrued liabilities	383	362
Deferred revenue	380	223
Income taxes payable	19	—
Current portion of long-term debt	466	449
Derivative liability	314	374
Total current liabilities	4,665	3,822
Senior notes	971	962
Lease financing obligations	198	198
Deferred income taxes	6	—
Other long-term liabilities	39	37
Total liabilities	5,879	5,019
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 57 shares at September 30, 2016 and 56 shares at December 31, 2015	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	831	803
Accumulated other comprehensive gain (loss)	3	(4)
Retained earnings	857	758
Total stockholders' equity	1,691	1,557
	$ 7,570	$ 6,576

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(In millions, except per-share data) (Unaudited)			
Revenue:				
Premium revenue	$ 4,191	$ 3,377	$ 12,215	$ 9,652
Service revenue	133	47	408	146
Premium tax revenue	127	99	345	289
Health insurer fee revenue	85	81	251	203
Investment income	9	5	25	12
Other revenue	1	2	4	5
Total revenue	4,546	3,611	13,248	10,307
Operating expenses:				
Medical care costs	3,748	3,016	10,930	8,581
Cost of service revenue	119	34	362	103
General and administrative expenses	343	287	1,034	830
Premium tax expenses	127	99	345	289
Health insurer fee expenses	55	36	163	117
Depreciation and amortization	36	26	102	76
Total operating expenses	4,428	3,498	12,936	9,996
Operating income	118	113	312	311
Interest expense	26	15	76	45
Income before income tax expense	92	98	236	266
Income tax expense	50	52	137	153
Net income	$ 42	$ 46	$ 99	$ 113
Net income per share:				
Basic	$ 0.77	$ 0.84	$ 1.79	$ 2.21
Diluted	$ 0.76	$ 0.77	$ 1.77	$ 2.07

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(Amounts in millions) (Unaudited)			
Net income	$ 42	$ 46	$ 99	$ 113
Other comprehensive (loss) income:				
Unrealized investment (loss) gain	(3)	2	10	1
Less: effect of income taxes	(2)	—	3	—
Other comprehensive (loss) income, net of tax	(1)	2	7	1
Comprehensive income	$ 41	$ 48	$ 106	$ 114

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2016	2015
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net income	$ 99	$ 113
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	135	93
Deferred income taxes	20	(12)
Share-based compensation	24	16
Amortization of convertible senior notes and lease financing obligations	23	22
Other, net	14	13
Changes in operating assets and liabilities:		
Receivables	(427)	(23)
Prepaid expenses and other assets	(116)	(63)
Medical claims and benefits payable	168	359
Amounts due government agencies	503	453
Accounts payable and accrued liabilities	1	34
Deferred revenue	157	(129)
Income taxes	32	30
Net cash provided by operating activities	633	906
Investing activities:		
Purchases of investments	(1,444)	(1,311)
Proceeds from sales and maturities of investments	1,512	863
Purchases of property, equipment and capitalized software	(143)	(101)
Change in restricted investments	4	(5)
Net cash paid in business combinations	(48)	(77)
Other, net	(12)	(34)
Net cash used in investing activities	(131)	(665)
Financing activities:		
Proceeds from common stock offering, net of issuance costs	—	373
Proceeds from employee stock plans	10	8
Other, net	1	3
Net cash provided by financing activities	11	384
Net increase in cash and cash equivalents	513	625
Cash and cash equivalents at beginning of period	2,329	1,539
Cash and cash equivalents at end of period	$ 2,842	$ 2,164

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Nine Months Ended September 30,	
	2016	2015
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (8)	$ (9)
Details of change in fair value of derivatives, net:		
(Loss) gain on 1.125% Call Option	$ (60)	$ 161
Gain (loss) on 1.125% Conversion Option	60	(161)
Change in fair value of derivatives, net	$ —	$ —
Details of business combinations:		
Fair value of assets acquired	$ (186)	$ (69)
Fair value of liabilities assumed	28	—
Purchase price amounts accrued/received (paid)	8	(8)
Reversal of amounts advanced to sellers in prior year	102	—
Net cash paid in business combinations	$ (48)	$ (77)

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
September 30, 2016

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment, which includes our behavioral health and social services subsidiary, Pathways. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015. All prior periods reported conform to this presentation.

The Health Plans segment consists of health plans in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of September 30, 2016, these health plans served 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Health Insurance Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with the Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

The Other segment includes businesses, such as our Pathways behavioral health and social services provider, which do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Market Updates - Health Plans

Proposed acquisition. On August 2, 2016, we entered into substantially identical agreements with each of Aetna, Inc. and Humana, Inc. to acquire certain of their Medicare Advantage membership and other assets related to such Medicare Advantage business (the Medicare Acquisition) for cash. The Medicare Acquisition is related to Aetna Inc.'s proposed acquisition of Humana Inc. (the Aetna-Humana Merger). We expect the Medicare Acquisition to close in 2017 subject to the following:

- Completion of the Aetna-Humana Merger;
- Resolution, in a manner permitting the Medicare Acquisition, of the pending litigation brought by the United States Department of Justice challenging the Aetna-Humana Merger;
- Approval by the federal Centers for Medicare & Medicaid Services (CMS) of the novation to us of each of the contracts to be divested under the Medicare Acquisition; and
- Customary closing conditions, including approvals of state departments of insurance and other regulators.

Completed acquisitions. For all of the following transactions, see Note 4, "Business Combinations," for further information.

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisitions of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago, and Loyola Physician Partners, LLC.

On March 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Better Health Network, LLC.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc.

New York. On August 1, 2016, we closed on our acquisition to acquire all outstanding equity interests of Today's Options of New York, Inc., which operates the Total Care Medicaid plan.

Washington. On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Columbia United Providers, Inc.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2016.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2015. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2015 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2015 audited consolidated financial statements.

2. Significant Accounting Policies

Revenue Recognition – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $323 million and $214 million at September 30, 2016 and December 31, 2015, respectively, to amounts due government agencies. Approximately $298 million and $208 million of the liability accrued at September 30, 2016 and December 31, 2015, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. We recorded receivables of $1 million and $3 million at September 30, 2016 and December 31, 2015, respectively, relating to such provisions.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Under these provisions, we recorded a liability of $9 million and $10 million at September 30, 2016 and December 31, 2015, respectively, for profit in excess of the amount we are allowed to retain.

Retroactive Premium Adjustments: The state Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies. In the first quarter of 2016, our Florida health plan recorded a retroactive increase to Medicaid premium revenue of approximately $18 million relating to dates of service prior to 2016.

Cost Plus Retroactive Premium Adjustments: In New Mexico, when members are retroactively enrolled into our health plan, we earn revenue only to the extent of the actual medical costs incurred by us for services provided during those retroactive periods, plus a small percentage of that medical cost for administration and profit. This arrangement first became effective July 1, 2014 (retroactive to January 1, 2014). We are paid normal monthly capitation rates for the retroactive eligibility periods, and the difference between those capitation rates and the amounts due to us on a cost plus basis are periodically settled with the state. To date, no such settlement has been made. During the years ended December 31, 2014 and 2015, our New Mexico contract was not specific as to the definition of retroactive membership, and the amount we owe the state (or that the state owes us) for the difference between capitation received and amounts due to us under the cost plus arrangement during those periods varies widely depending upon the definition of retroactive membership. Although we believe that the amount we have recorded as a

liability for this matter is consistent with the state's expectations, we cannot be certain that the state will not seek to recover an amount in excess of our recorded liability.

Medicare

Risk Adjustment: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and CMS practices. Based on our estimates, we have recorded a net payable of $17 million and $4 million for anticipated Medicare risk adjustment premiums and Medicare Part D settlements at September 30, 2016 and December 31, 2015, respectively.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the minimum annual medical loss ratio (Minimum MLR) when the amounts are reasonably estimable as described below, and, for receivables, collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	September 30, 2016			December 31, 2015
	Current Benefit Year	Prior Benefit Years	Total	
		(In millions)		
Risk adjustment	$ (372)	$ 2	$ (370)	$ (214)
Reinsurance	62	4	66	36
Risk corridor	(4)	(1)	(5)	(10)
Minimum MLR	(11)	(4)	(15)	(3)

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. On June 30, 2016, CMS released the final update on risk transfer and reinsurance payments for the 2015 benefit year, and we adjusted our accruals accordingly.
- Reinsurance: This program is designed to provide reimbursement to insurers for high cost members. Our health plans pay an annual contribution on a per-member basis, and are eligible for recoveries if claims for individual members exceed a specified threshold, up to a maximum amount. This three-year program will end on December 31, 2016. We recognize the assessments to fund the transitional reinsurance program as a reduction to premium revenue in our consolidated statements of income. We recognize recoveries under the reinsurance program as a reduction to medical care costs in our consolidated statements of income.
- Risk corridor: This program is intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by CMS. Variances from the target amount exceeding certain thresholds may result in amounts due to or receivables due from CMS. This three-year program will end on December 31, 2016. Due to uncertainties as to the amount of federal funding available to support the risk corridor program, we do not recognize amounts receivable under this program. Our estimate of the unrecorded receivable for the Marketplace risk corridor amounted to approximately $80 million as of September 30, 2016. Of this total amount, $52 million relates to the 2015 benefit year and $28 million relates to the nine months ended September 30, 2016. All liabilities are recognized as incurred. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk corridor program as an adjustment to premium revenue in our consolidated statements of income.

Additionally, the ACA established a Minimum MLR of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. What constitutes medical costs and premium revenue are specifically defined by federal regulations. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

During the second quarter of 2016, we were informed by the Texas Department of Health and Human Services that it will not recoup any quality revenue for calendar years 2014, 2015, and 2016. Therefore, we recognized previously deferred quality revenue amounting to approximately $51 million in the second quarter of 2016. Of the $51 million total adjustment, $44 million related to 2015 and 2014 dates of service, and $7 million related to the first quarter of 2016.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2016 are not known, we have no reason to believe that the adjustments to prior periods noted below are not indicative of the potential future changes in our estimates as of September 30, 2016, other than the Texas quality revenue recognized in the second quarter of 2016 described above.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(In millions)			
Maximum available quality incentive premium - current period	$ 33	$ 28	$ 114	$ 86
Amount of quality incentive premium revenue recognized in current period:				
Earned current period	$ 26	$ 17	$ 80	$ 38
Earned prior periods	—	—	54	11
Total	$ 26	$ 17	$ 134	49
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.6%	0.5%	1.1%	0.5%

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), certain compensation, and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. For example, in the third quarter of 2016 we entered into an agreement with the seller in the Pathways acquisition to change the allocation of the purchase price across certain legal entities, allowing us to recognize a $4 million tax benefit. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Recent Accounting Pronouncements

Statement of Cash Flows. In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments*, which amends Accounting Standards Codification (ASC) 230 to add or clarify guidance on eight classification issues related to the statement of cash flows such as debt prepayment or debt extinguishment costs, and contingent consideration payments made after a business combination. ASU 2016-15 is effective for fiscal periods beginning after December 15, 2017 and must be adopted using a retrospective transition method to each period presented but may be applied prospectively if retrospective application would be impracticable. Early adoption is permitted, including adoption in an interim period. We are evaluating the potential effects of the adoption to our financial statements.

Revenue Recognition. In May 2016, the FASB issued ASU 2016-12, *Revenue from Contracts with Customers (Topic 606).* The amendments, which address transition, collectibility, non-cash consideration and the presentation of sales and other similar taxes, do not change the core principles of ASU 2014-09, but rather address implementation issues and are intended to result in

more consistent application. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

In April 2016, the FASB issued ASU 2016-10, *Identifying Performance Obligations and Licensing*, which amends certain aspects of ASC 606, *Revenue from Contracts with Customers*. ASU 2016-10 amends step two of the new revenue standard's five-step model to include guidance on immaterial promised goods or services, shipping and handling activities and identifying when promises represent performance obligations. ASU 2016-10 also provides guidance related to licensing such as, but not limited to, sales-based and usage-based royalties and renewals of licenses that provide a right to use intellectual property. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

In March 2016, the FASB issued ASU 2016-08, *Revenue from Contracts with Customers - Principal vs. Agent Considerations*, which amends the principal–versus–agent implementation guidance in ASC 606. ASU 2016-08 clarifies that an entity should evaluate whether it is the principal or agent for each specified good or service promised in a contract with a customer as defined in ASC 606. The entity must first identify each specified good or service to be provided to the customer and then assess whether it controls each specified good or service. The ASU also removed two of the five indicators used in evaluating control under the old guidance and reframes the remaining three indicators. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*, which changes how companies measure credit losses on most financial instruments measured at amortized cost, such as loans, receivables and held-to-maturity debt securities. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument's contractual life. ASU 2016-13 is effective for fiscal periods beginning after December 15, 2019 and must be adopted as a cumulative effect adjustment to retained earnings. Early adoption is permitted. We are evaluating the potential effects of the adoption to our financial statements.

Stock Compensation. In March 2016, the FASB issued ASU 2016-09, *Compensation-Stock Compensation*, which simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, statutory tax and classification in the statement of cash flows. ASU 2016-09 is effective for fiscal periods beginning after December 15, 2016 and must be adopted using the modified retrospective approach except for classification in the statement of cash flows, which must be adopted using either the prospective or retrospective approach. Early adoption is permitted. We are evaluating the potential effects of the adoption to our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of basic and diluted net income per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(In millions, except net income per share)			
Numerator:				
Net income	$ 42	$ 46	$ 99	$ 113
Denominator:				
Shares outstanding at the beginning of the period	56	55	55	49
Weighted-average number of shares:				
Issued in common stock offering	—	—	—	2
Denominator for basic net income per share	56	55	55	51
Effect of dilutive securities:				
Share-based compensation	—	—	—	1
Convertible senior notes (1)	—	1	—	1
1.125% Warrants (1)	—	4	1	2
Denominator for diluted net income per share	56	60	56	55
Net income per share (2):				
Basic	$ 0.77	$ 0.84	$ 1.79	$ 2.21
Diluted	$ 0.76	$ 0.77	$ 1.77	$ 2.07

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(1) For more information regarding the convertible senior notes, refer to Note 10, "Debt." For more information regarding the 1.125% Warrants, refer to Note 12, "Stockholders' Equity."
(2) Source data for calculations in thousands.

4. Business Combinations

Health Plans Segment

In 2016, we closed on several business combinations in the Health Plans segment, consistent with our strategy to grow in our existing markets and expand into new markets. For all of these transactions, we applied the acquisition method of accounting, where the total purchase price was allocated, or preliminarily allocated, to tangible and intangible assets acquired, and liabilities assumed based on their respective fair values. For the Health Plans acquisitions described below, except New York, only intangible assets were acquired. All of these acquisitions were funded using available cash and acquisition-related costs were insignificant. The individual transactions were as follows:

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. The final purchase price was approximately $30 million, and the Illinois health plan added approximately 50,000 Medicaid members as a result of this transaction.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. The final purchase price was approximately $12 million, and the Illinois health plan added approximately 18,000 Medicaid members as a result of this transaction.

On March 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Better Health Network, LLC. The final purchase price was approximately $15 million, and the Illinois health plan added approximately 28,000 Medicaid members as a result of this transaction.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. The final purchase price was approximately $31 million, and the Michigan health plan added approximately 68,000 Medicaid and MIChild members as a result of this transaction.

New York. On August 1, 2016, we closed on our acquisition to acquire all outstanding equity interests of Today's Options of New York, Inc., which operates the Total Care Medicaid plan. The initial purchase price was approximately $38 million, and we now serve approximately 37,000 Medicaid members in upstate New York as a result of the transaction. As of September 30, 2016, the purchase price allocation was preliminary, subject to final purchase price adjustments as provided in the stock purchase agreement.

Washington. On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Columbia United Providers, Inc. The final purchase price was approximately $28 million, and the Washington health plan added approximately 57,000 Medicaid members as a result of this transaction.

For these acquisitions, we recorded goodwill to the Health Plans segment amounting to $95 million in the aggregate, which relates to future economic benefits arising from expected synergies to be achieved. Such synergies include use of our existing infrastructure to support the added membership. In general, the amount recorded as goodwill is deductible for income tax purposes. For the New York acquisition, the tax deductibility of goodwill will be determined once the purchase price is finalized.

The following table presents the intangible assets identified in the transactions described above. The weighted-average amortization period, in the aggregate, is 5.7 years. For these acquisitions in the aggregate, we expect to record amortization of approximately $6 million in 2016, $8 million per year in the years 2017 through 2020, and $3 million in 2021.

	Fair Value	Life
	(In millions)	(Years)
Intangible asset type:		
Contract rights - member list	$ 38	5
Provider network	7	10
	$ 45	

Other Segment

Pathways. On November 1, 2015, we acquired the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways). In the third quarter of 2016, we recorded a pre-acquisition contingent liability and corresponding indemnification asset in the amount of $14 million in connection with the Rodriguez Litigation matter defined and described further in Note 14, "Commitments and Contingencies." Also in the third quarter of 2016, certain tax elections were made such that approximately 50% of the goodwill recorded in this transaction is deductible for income tax purposes.

5. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs. Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include derivative financial instruments.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of September 30, 2016 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 11, “Derivatives,” the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values offset, with minimal impact to the

consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the nine months ended September 30, 2016.

Our financial instruments measured at fair value on a recurring basis at September 30, 2016, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,127	$ —	$ 1,127	$ —
Government-sponsored enterprise securities (GSEs)	259	259	—	—
Municipal securities	148	—	148	—
Asset-backed securities	76	—	76	—
U.S. treasury notes	65	65	—	—
Certificates of deposit	60	—	60	—
Subtotal - current investments	1,735	324	1,411	—
1.125% Call Option derivative asset	314	—	—	314
Total assets measured at fair value on a recurring basis	$ 2,049	$ 324	$ 1,411	$ 314
1.125% Conversion Option derivative liability	$ 314	$ —	$ —	$ 314
Total liabilities measured at fair value on a recurring basis	$ 314	$ —	$ —	$ 314

Our financial instruments measured at fair value on a recurring basis at December 31, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,184	$ —	$ 1,184	$ —
GSEs	211	211	—	—
Municipal securities	185	—	185	—
Asset-backed securities	63	—	63	—
U.S. treasury notes	78	78	—	—
Certificates of deposit	80	—	80	—
Subtotal - current investments	1,801	289	1,512	—
1.125% Call Option derivative asset	374	—	—	374
Total assets measured at fair value on a recurring basis	$ 2,175	$ 289	$ 1,512	$ 374
1.125% Conversion Option derivative liability	$ 374	$ —	$ —	$ 374
Total liabilities measured at fair value on a recurring basis	$ 374	$ —	$ —	$ 374

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table.

	September 30, 2016		December 31, 2015	
	Carrying Value	Fair Value	Carrying Value	Fair Value
	(In millions)			
5.375% Notes	$ 690	$ 725	$ 689	$ 700
1.125% Convertible Notes	466	827	448	865
1.625% Convertible Notes	281	358	273	365
	$ 1,437	$ 1,910	$ 1,410	$ 1,930

6. Investments

The following tables summarize our investments as of the dates indicated:

	September 30, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,123	$ 4	$ —	$ 1,127
GSEs	259	—	—	259
Municipal securities	147	1	—	148
Asset-backed securities	76	—	—	76
U.S. treasury notes	65	—	—	65
Certificates of deposit	60	—	—	60
	$ 1,730	$ 5	$ —	$ 1,735

	December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,189	$ —	$ 5	$ 1,184
GSEs	212	—	1	211
Municipal securities	186	—	1	185
Asset-backed securities	63	—	—	63
U.S. treasury notes	78	—	—	78
Certificates of deposit	80	—	—	80
	$ 1,808	$ —	$ 7	$ 1,801

The contractual maturities of our investments as of September 30, 2016 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 887	$ 887
Due after one year through five years	817	821
Due after five years through ten years	26	27
	$ 1,730	$ 1,735

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and nine months ended September 30, 2016 and 2015 were insignificant.

We have determined that unrealized gains and losses at September 30, 2016 and December 31, 2015, are temporary in nature, because the change in market value for these securities resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

There were no available-for-sale investments in a material continuous loss position as of September 30, 2016.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2015:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 825	$ 4	588	$ 119	$ 1	87
GSEs	182	1	77	—	—	—
Municipal securities	128	1	181	—	—	—
	$ 1,135	$ 6	846	$ 119	$ 1	87

7. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial. The information below is presented by segment.

	September 30, 2016	December 31, 2015
	(In millions)	
California	$ 174	$ 104
Florida	79	22
Illinois	81	35
Michigan	71	39
New Mexico	78	51
New York	33	—
Ohio	133	66
Puerto Rico	82	33
South Carolina	12	6
Texas	62	56
Utah	32	18
Washington	94	53
Wisconsin	27	22
Direct delivery and other	3	6
Total Health Plans segment	961	511
Molina Medicaid Solutions segment	39	37
Other segment	53	49
	$ 1,053	$ 597

8. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of

restricted investments:

	September 30, 2016	December 31, 2015
	(In millions)	
Florida	$ 28	$ 34
Illinois	3	—
Michigan	1	1
New Mexico	43	43
New York	9	—
Ohio	12	12
Puerto Rico	10	10
Texas	4	4
Utah	4	4
Wisconsin	1	1
Other	1	—
Total Health Plans segment	$ 116	$ 109

The contractual maturities of our held-to-maturity restricted investments as of September 30, 2016 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 115	$ 115
Due after one year through five years	1	1
	$ 116	$ 116

9. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	September 30, 2016	December 31, 2015
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,333	$ 1,191
Pharmacy payable	114	88
Capitation payable	27	140
Other	397	266
	$ 1,871	$ 1,685

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $237 million and $167 million as of September 30, 2016 and December 31, 2015, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30, 2016	Year Ended December 31, 2015
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 1,685	$ 1,201
Components of medical care costs related to:		
Current period	11,120	11,935
Prior periods	(190)	(141)
Total medical care costs	10,930	11,794
Change in non-risk provider payables	70	48
Payments for medical care costs related to:		
Current period	9,536	10,448
Prior periods	1,278	910
Total paid	10,814	11,358
Medical claims and benefits payable, ending balance	$ 1,871	$ 1,685
Benefit from prior period as a percentage of:		
Balance at beginning of period	11.3%	11.8%
Premium revenue, trailing twelve months	1.2%	1.1%
Medical care costs, trailing twelve months	1.3%	1.2%

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2016 and 2015 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at September 30, 2016 are as follows:

- Our New York health plan acquisition closed on August 1, 2016. This acquisition added approximately 37,000 new members. Because these members are new to Molina, our estimates of the liability we have incurred for services provided to these members are subject to more than the usual amount of uncertainty.
- At our Florida, New Mexico, Puerto Rico, Utah and Washington health plans, we overpaid certain inpatient and outpatient facility claims. We adjusted our claims payment history to reflect the claims payment pattern that would have occurred without these overpayments. For this reason, our liability estimates at these health plans are subject to more than the usual amount of uncertainty.
- At our Washington health plan, the covered benefits in two counties were expanded effective April 2016 to include behavioral health benefits under the state's new fully integrated managed care program, which impacted about 85,000 members. Because these are new benefits, our liability estimate at this health plan is subject to more than the usual amount of uncertainty.
- Fluctuations in the volume of claims received in a paper format (rather than an electronic format) during the third quarter have created more than the usual amount of uncertainty regarding our estimate of the liability at our California health plan.

We recognized favorable prior period claims development in the amount of $190 million for the nine months ended September 30, 2016. This amount represents our estimate, as of September 30, 2016, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2015 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- A new version of diagnostic codes was required for all claims with dates of service on October 1, 2015, and later. As a result, payment was delayed or denied for a significant number of claims due to provider submission of claims with diagnostic codes that were no longer valid. Once providers were able to submit claims with the correct diagnostic codes, our actual costs were ultimately less than expected.

- At our New Mexico health plan, we overestimated the impact of several pending high-dollar claims, and our actual costs were ultimately less than expected.
- At our Washington health plan, we overpaid certain outpatient facility claims in 2015 when the state converted to a new payment methodology. We did not include an estimate in the reserves for this potential recovery as of December 31, 2015.
- At our California health plan, approximately 55,000 new members were added to our Medicaid Expansion product in 2015. For these new members, our actual costs were ultimately less than expected.

10. Debt

As of September 30, 2016, contractual maturities of debt for the years ending December 31 are as follows:

	Total	2016	2017	2018	2019	2020	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ —	$ —	$ —	$ 700
1.125% Convertible Notes	550	—	—	—	—	550	—
1.625% Convertible Notes (1)	302	—	—	—	—	—	302
	$ 1,552	$ —	$ —	$ —	$ —	$ 550	$ 1,002

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on contractually specified dates beginning in 2018, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The principal amounts, unamortized discount (net of premium related to the 1.625% Notes), unamortized issuance costs, and net carrying amounts of debt were as follows:

	Principal Balance	Unamortized Discount	Unamortized Issuance Costs	Net Carrying Amount
		(In millions)		
September 30, 2016:				
5.375% Notes	$ 700	$ —	$ 10	$ 690
1.125% Convertible Notes	550	78	6	466
1.625% Convertible Notes	302	18	3	281
	$ 1,552	$ 96	$ 19	$ 1,437
December 31, 2015:				
5.375% Notes	$ 700	$ —	$ 11	$ 689
1.125% Convertible Notes	550	95	7	448
1.625% Convertible Notes	302	25	4	273
Other	1	—	—	1
	$ 1,553	$ 120	$ 22	$ 1,411

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(In millions)			
Contractual interest coupon rate	$ 2	$ 3	$ 8	$ 9
Amortization of the discount	7	7	22	21
	$ 9	$ 10	$ 30	$ 30

Debt Commitment Letter. On August 2, 2016, in connection with the Medicare Acquisition, we entered into a debt commitment letter with Barclays Bank PLC (Barclays). The primary terms of the debt commitment letter provide that Barclays will lend us up to $400 million which may be used as follows: to finance the Medicare Acquisition, including related transaction costs and regulatory or statutory capital requirements; to finance any ongoing working capital requirements; or for other general corporate purposes.

5.375% Notes due 2022. On November 10, 2015, we completed the private offering of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. In connection with their issuance and sale, we entered into a registration rights agreement to exchange the 5.375% Notes for registered notes having substantially identical terms, including guarantees. Such exchange was completed on September 16, 2016. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15.

Certain of our wholly owned subsidiaries jointly and severally guarantee our obligations under the 5.375% Notes. The 5.375% Notes contain customary non-financial covenants and change of control provisions. At September 30, 2016, we were in compliance with all financial covenants under the 5.375% Notes.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. As of September 30, 2016, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Certain of our wholly owned subsidiaries jointly and severally guarantee our obligations under the Credit Facility. The Credit Facility contains customary non-financial and financial covenants, including a minimum fixed charge coverage ratio, a maximum debt-to-EBITDA ratio and minimum statutory net worth. At September 30, 2016, we were in compliance with all financial covenants under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes (1.125% Notes) due January 15, 2020, unless earlier repurchased or converted.

Interest is payable semiannually in arrears on January 15 and July 15. The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. The 1.125% Notes met the stock price trigger in the quarter ended September 30, 2016, and are convertible to cash through at least December 31, 2016. Because the 1.125% Notes may be converted into cash within 12 months, the $466 million carrying amount is reported in current portion of long-term debt as of September 30, 2016.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of September 30, 2016, the 1.125% Notes have a remaining amortization period of 3.3 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $177 million and $332 million as of September 30, 2016 and December 31, 2015, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $125 million principal amount of 1.625% convertible senior notes (1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Combined with the 1.625% Notes issued in an exchange transaction in 2014, the aggregate principal amount of 1.625% Notes issued was $302 million. Interest is payable semiannually in arrears on February 15 and August 15. The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. As of September 30, 2016, the 1.625% Notes were not convertible.

Because the 1.625% Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and

ending on the first date we may redeem the 1.625% Notes in August 2018. As of September 30, 2016, the 1.625% Notes have a remaining amortization period of 1.9 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value did not exceed their principal amount at September 30, 2016 and exceeded their principal amount at December 31, 2015 by approximately $10 million. At September 30, 2016 and December 31, 2015, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $23 million.

11. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	September 30, 2016	December 31, 2015
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 314	$ 374
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 314	$ 374

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Notes due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 5, "Fair Value Measurements."

As of September 30, 2016, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of September 30, 2016, as described in Note 10, "Debt."

12. Stockholders' Equity

Stockholders' equity increased $134 million during the nine months ended September 30, 2016 compared with stockholders' equity at December 31, 2015. The increase was primarily due to net income of $99 million, $7 million of other comprehensive income and $28 million related to employee stock transactions.

1.125% Warrants. In connection with the Call Spread Overlay transaction described in Note 11, "Derivatives," in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common

stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Program. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Stock Incentive Plans. In connection with our equity incentive plans and employee stock purchase plan, approximately 467,000 shares of common stock were purchased or vested, net of shares used to settle employees' income tax obligations, during the nine months ended September 30, 2016.

Charged to general and administrative expenses, total share-based compensation expense was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(In millions)			
Restricted stock and performance awards	$ 7	$ 6	$ 20	$ 13
Employee stock purchase plan and stock options	1	1	4	3
	$ 8	$ 7	$ 24	$ 16

As of September 30, 2016, there was $38 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.6 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 4.3% for non-executive employees as of September 30, 2016.

Restricted stock. Restricted and performance stock activity for the nine months ended September 30, 2016 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
	(In thousands)	
Unvested balance as of December 31, 2015	1,035	$ 46.68
Granted	517	63.94
Vested	(342)	41.79
Forfeited	(19)	52.01
Unvested balance as of September 30, 2016	1,191	55.50

The total fair value of restricted and performance awards granted during the nine months ended September 30, 2016 and 2015 was $33 million and $28 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, which vested during the nine months ended September 30, 2016 and 2015 was $22 million and $25 million, respectively.

As of September 30, 2016, there were approximately 603,000 unvested restricted shares outstanding which contained one or more performance measures. In the event the vesting conditions are not achieved, the awards will lapse. Based on our assessment as of September 30, 2016, we expect the performance conditions for approximately 425,000 of these outstanding restricted share awards to be met in full.

13. Segment Information

We have three reportable segments. These segments include our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment, which includes our behavioral health and social services subsidiary, Pathways. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015. All prior periods reported conform to this presentation.

Our reportable segments are consistent with how we currently manage our business and view the markets we serve. The Health Plans segment consists of our health plans and our direct delivery business. Our health plans are operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. The Other segment includes businesses, such as

our Pathways behavioral health and social services provider, which do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
Three Months Ended September 30, 2016				
Total revenue (1)	$ 4,412	$ 48	$ 86	$ 4,546
Gross margin	443	6	8	457
Nine Months Ended September 30, 2016				
Total revenue (1)	$ 12,835	$ 146	$ 267	$ 13,248
Gross margin	1,285	17	29	1,331
Three Months Ended September 30, 2015				
Total revenue (1)	$ 3,562	$ 47	$ 2	$ 3,611
Gross margin	361	13	—	374
Nine Months Ended September 30, 2015				
Total revenue (1)	$ 10,155	$ 146	$ 6	$ 10,307
Gross margin	1,071	43	—	1,114
Total Assets				
September 30, 2016	$ 5,891	$ 267	$ 1,412	$ 7,570
December 31, 2015	4,707	213	1,656	6,576

(1) Total revenue consists primarily of premium revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments.

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(In millions)			
Gross margin:				
Health Plans	$ 443	$ 361	$ 1,285	$ 1,071
Molina Medicaid Solutions	6	13	17	43
Other	8	—	29	—
Total gross margin	457	374	1,331	1,114
Add: other operating revenues (1)	222	187	625	509
Less: other operating expenses (2)	(561)	(448)	(1,644)	(1,312)
Operating income	118	113	312	311
Other expenses, net	(26)	(15)	(76)	(45)
Income before income tax expense	$ 92	$ 98	$ 236	$ 266

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

14. Commitments and Contingencies

Legal Proceedings. The health care and Medicaid-related business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe that, pursuant to a settlement with the state, this matter will be dismissed against Molina Medicaid Solutions with no liability.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. On October 22, 2015, the Relator filed a third amended complaint. On July 11, 2016, the District Court dismissed with prejudice the third amended complaint, without leave to amend. On September 23, 2016, the plaintiff filed an appeal with the Ninth Circuit Court of Appeals.

Rodriguez v. Providence Community Corrections. On October 1, 2015, seven individuals, on behalf of themselves and all others similarly situated, filed a complaint in the District Court for the Middle District of Tennessee, Nashville Division, Case No. 3:15-cv-01048 (the Rodriquez Litigation), against Providence Community Corrections, Inc. (now known as Pathways Community Corrections, Inc., or PCC). Rutherford County, Tennessee formerly contracted with PCC for the administration of

misdemeanor probation, which involved the collection of court costs and fees from probationers. The complaint alleges, among other things, that PCC illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay such amounts. The plaintiffs in the Rodriguez Litigation seek alleged compensatory, treble, and punitive damages, plus attorneys' fees, for alleged federal and state constitutional violations, as well as alleged violations of the Racketeer Influenced and Corrupt Organization Act. PCC's agreement with Rutherford County terminated effective December 29, 2015. On November 1, 2015, one month after the Rodriguez Litigation had been commenced, we acquired PCC from The Providence Service Corporation (Providence) pursuant to a membership interest purchase agreement. In September 2016, the parties to the Rodriguez Litigation accepted a mediation proposal for settlement pursuant to which PCC would pay the plaintiffs $14 million. The parties are in the process of finalizing the settlement agreement. We expect to recover the full amount of the settlement under the indemnification provisions of the membership interest purchase agreement with Providence.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

States' Budgets. From time to time, the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. For example, the state of Illinois is currently operating under a stopgap budget that expires in January 2017. It is unclear when or if the state's budget difficulties will be resolved. As of September 30, 2016, our Illinois health plan served approximately 195,000 members and recorded premium revenue of approximately $466 million for the nine months ended September 30, 2016. As of October 24, 2016, the state of Illinois owed us approximately $43 million for May and June 2016 premiums.

In another example, the Commonwealth of Puerto Rico's fiscal plan, issued on October 14, 2016, reported that current revenues are insufficient to support existing current operations and debt service. While the Commonwealth reports that it will prioritize health care spending, it stresses the need to address the cap on federal matching funds it receives for its participation in the Medicaid program. Among the fiscal issues expected to further exacerbate the Commonwealth's current debt crisis is the depletion of ACA funds, estimated to occur in the Commonwealth's fiscal year 2018. As of September 30, 2016, our Puerto Rico health plan served approximately 331,000 members and recorded premium revenue of approximately $535 million for the nine months ended September 30, 2016. As of October 24, 2016, the Commonwealth is current with its premium payments.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us.

Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,406 million at September 30, 2016, and $1,229 million at December 31, 2015. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $388 million and $612 million as of September 30, 2016 and December 31, 2015, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state.

As of September 30, 2016, our health plans had aggregate statutory capital and surplus of approximately $1,510 million compared with the required minimum aggregate statutory capital and surplus of approximately $857 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2016. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

15. Related Party Transactions

Refer to Note 16, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

16. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. JMMPC also provides certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant. For the three months ended September 30, 2016 and 2015, our health plans paid $31 million and $28 million, respectively, to JMMPC for health care services provided by JMMPC to the health plans' members. For the nine months ended September 30, 2016 and 2015, our health plans paid $92 million and $80 million, respectively, to JMMPC for health care services provided by JMMPC to the health plans' members.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of September 30, 2016, JMMPC had total assets of $16 million, and total liabilities of $15 million. As of December 31, 2015, JMMPC had total assets of $17 million, and total liabilities of $17 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

17. Supplemental Condensed Consolidating Financial Information

As discussed in Note 10, "Debt," on November 10, 2015, we completed the private offering of $700 million aggregate principal amount of 5.375% Notes. In connection with their issuance and sale, we entered into a registration rights agreement to exchange the 5.375% Notes for registered notes having substantially identical terms, including guarantees. Such exchange was completed on September 16, 2016.

The 5.375% Notes are fully and unconditionally guaranteed by certain of our wholly owned subsidiaries on a joint and several basis, with exceptions considered customary for such guarantees. The 5.375% Notes and the guarantees are effectively subordinated to all existing and future secured debt of us and our guarantors to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock of our subsidiaries that do not guarantee the 5.375% Notes.

The following condensed consolidating financial statements present Molina Healthcare, Inc. (as parent guarantor), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. These condensed consolidating financial statements have been prepared and presented in accordance with SEC Regulation S-X Rule 3-10, "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered."

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING BALANCE SHEET

	September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 125	$ 37	$ 2,680	$ —	$ 2,842
Investments	263	—	1,472	—	1,735
Receivables	3	84	966	—	1,053
Due from (to) affiliates	98	(5)	(93)	—	—
Prepaid expenses and other current assets	51	37	82	(1)	169
Derivative asset	314	—	—	—	314
Total current assets	854	153	5,107	(1)	6,113
Property, equipment, and capitalized software, net	300	69	81	—	450
Deferred contract costs	—	83	—	—	83
Intangible assets, net	7	21	121	—	149
Goodwill	51	231	337	—	619
Restricted investments	—	—	116	—	116
Investment in subsidiaries	2,526	1	—	(2,527)	—
Other assets	47	4	5	(16)	40
	$ 3,785	$ 562	$ 5,767	$ (2,544)	$ 7,570
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ —	$ —	$ 1,871	$ —	$ 1,871
Amounts due government agencies	—	—	1,232	—	1,232
Accounts payable and accrued liabilities	146	53	185	(1)	383
Deferred revenue	—	42	338	—	380
Income taxes payable	(13)	(5)	37	—	19
Current portion of long-term debt	466	—	—	—	466
Derivative liability	314	—	—	—	314
Total current liabilities	913	90	3,663	(1)	4,665
Long-term debt	1,169	—	16	(16)	1,169
Deferred income taxes	(7)	41	(28)	—	6
Other long-term liabilities	19	2	18	—	39
Total liabilities	2,094	133	3,669	(17)	5,879
Total stockholders' equity	1,691	429	2,098	(2,527)	1,691
	$ 3,785	$ 562	$ 5,767	$ (2,544)	$ 7,570

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING BALANCE SHEET

	December 31, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
ASSETS					
Current assets:					
Cash and cash equivalents	$ 360	$ 42	$ 1,927	$ —	$ 2,329
Investments	252	—	1,549	—	1,801
Receivables	—	79	518	—	597
Income tax refundable	7	3	3	—	13
Intercompany	86	(4)	(82)	—	—
Prepaid expenses and other current assets	46	11	136	(1)	192
Derivative asset	374	—	—	—	374
Total current assets	1,125	131	4,051	(1)	5,306
Property, equipment, and capitalized software, net	267	52	74	—	393
Deferred contract costs	—	81	—	—	81
Goodwill and intangible assets, net	61	246	334	—	641
Restricted investments	—	—	109	—	109
Investment in subsidiaries, net	2,205	1	—	(2,206)	—
Deferred income taxes	23	(35)	30	—	18
Other assets	36	2	6	(16)	28
	$ 3,717	$ 478	$ 4,604	$ (2,223)	$ 6,576
LIABILITIES AND STOCKHOLDERS' EQUITY					
Current liabilities:					
Medical claims and benefits payable	$ —	$ 3	$ 1,682	$ —	$ 1,685
Amounts due government agencies	—	1	728	—	729
Accounts payable and accrued liabilities	157	35	170	—	362
Deferred revenue	—	34	189	—	223
Current portion of long-term debt	449	—	—	—	449
Derivative liability	374	—	—	—	374
Total current liabilities	980	73	2,769	—	3,822
Long-term debt	1,160	—	16	(16)	1,160
Other long-term liabilities	20	2	16	(1)	37
Total liabilities	2,160	75	2,801	(17)	5,019
Total stockholders' equity	1,557	403	1,803	(2,206)	1,557
	$ 3,717	$ 478	$ 4,604	$ (2,223)	$ 6,576

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Three Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 274	$ 135	$ 4,424	$ (287)	$ 4,546
Expenses:					
Medical care costs	19	15	3,727	(13)	3,748
Cost of service revenue	—	109	10	—	119
General and administrative expenses	223	5	389	(274)	343
Premium tax expenses	—	—	127	—	127
Health insurer fee expenses	—	—	55	—	55
Depreciation and amortization	25	4	7	—	36
Total operating expenses	267	133	4,315	(287)	4,428
Operating income	7	2	109	—	118
Interest expense	26	—	—	—	26
(Loss) income before income taxes	(19)	2	109	—	92
Income tax (benefit) expense	4	(3)	49	—	50
Net (loss) income before equity in earnings of subsidiaries	(23)	5	60	—	42
Equity in net earnings of subsidiaries	65	—	—	(65)	—
Net income	$ 42	$ 5	$ 60	$ (65)	$ 42

	Three Months Ended September 30, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 234	$ 60	$ 3,563	$ (246)	$ 3,611
Expenses:					
Medical care costs	14	9	3,005	(12)	3,016
Cost of service revenue	—	34	—	—	34
General and administrative expenses	200	8	313	(234)	287
Premium tax expenses	—	—	99	—	99
Health insurer fee expenses	—	—	36	—	36
Depreciation and amortization	21	1	4	—	26
Total operating expenses	235	52	3,457	(246)	3,498
Operating (loss) income	(1)	8	106	—	113
Interest expense	15	—	—	—	15
(Loss) income before income taxes	(16)	8	106	—	98
Income tax (benefit) expense	3	3	46	—	52
Net (loss) income before equity in earnings of subsidiaries	(19)	5	60	—	46
Equity in net earnings of subsidiaries	65	(1)	—	(64)	—
Net income	$ 46	$ 4	$ 60	$ (64)	$ 46

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF INCOME

	Nine Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 786	$ 412	$ 12,874	$ (824)	$ 13,248
Expenses:					
Medical care costs	50	37	10,884	(41)	10,930
Cost of service revenue	—	330	32	—	362
General and administrative expenses	659	28	1,130	(783)	1,034
Premium tax expenses	—	—	345	—	345
Health insurer fee expenses	—	—	163	—	163
Depreciation and amortization	70	10	22	—	102
Total expenses	779	405	12,576	(824)	12,936
Operating income	7	7	298	—	312
Interest expense	76	—	—	—	76
(Loss) income before income taxes	(69)	7	298	—	236
Income tax (benefit) expense	(24)	(1)	162	—	137
Net (loss) income before equity in earnings of subsidiaries	(45)	8	136	—	99
Equity in net earnings of subsidiaries	144	—	—	(144)	—
Net income	$ 99	$ 8	$ 136	$ (144)	$ 99

	Nine Months Ended September 30, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Revenue:					
Total revenue	$ 677	$ 183	$ 10,159	$ (712)	$ 10,307
Expenses:					
Medical care costs	40	26	8,552	(37)	8,581
Cost of service revenue	—	103	—	—	103
General and administrative expenses	577	23	905	(675)	830
Premium tax expenses	—	—	289	—	289
Health insurer fee expenses	—	—	117	—	117
Depreciation and amortization	62	2	12	—	76
Total expenses	679	154	9,875	(712)	9,996
Operating (loss) income	(2)	29	284	—	311
Interest expense	45	—	—	—	45
(Loss) income before income taxes	(47)	29	284	—	266
Income tax (benefit) expense	(4)	11	146	—	153
Net (loss) income before equity in earnings of subsidiaries	(43)	18	138	—	113
Equity in net earnings of subsidiaries	156	(1)	—	(155)	—
Net income	$ 113	$ 17	$ 138	$ (155)	$ 113

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 42	$ 5	$ 60	$ (65)	$ 42
Other comprehensive loss, net of tax	(1)	—	(1)	1	(1)
Comprehensive income	$ 41	$ 5	$ 59	$ (64)	$ 41

	Three Months Ended September 30, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 46	$ 4	$ 60	$ (64)	$ 46
Other comprehensive income, net of tax	2	—	1	(1)	2
Comprehensive income	$ 48	$ 4	$ 61	$ (65)	$ 48

	Nine Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 99	$ 8	$ 136	$ (144)	$ 99
Other comprehensive income, net of tax	7	—	6	(6)	7
Comprehensive income	$ 106	$ 8	$ 142	$ (150)	$ 106

	Nine Months Ended September 30, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
	(In millions)				
Net income	$ 113	$ 17	$ 138	$ (155)	$ 113
Other comprehensive income, net of tax	1	—	—	—	1
Comprehensive income	$ 114	$ 17	$ 138	$ (155)	$ 114

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30, 2016				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 43	35	555	—	$ 633
Investing activities:					
Purchases of investments	(114)	—	(1,330)	—	(1,444)
Proceeds from sales and maturities of investments	103	—	1,409	—	1,512
Purchases of property, equipment and capitalized software	(102)	(28)	(13)	—	(143)
Decrease in restricted investments	—	—	4	—	4
Net cash paid in business combinations	—	(11)	(37)	—	(48)
Capital contributions to subsidiaries	(221)	18	203	—	—
Dividends received from subsidiaries	50	—	(50)	—	—
Change in amounts due to/from affiliates	(12)	1	11	—	—
Other, net	6	(19)	1	—	(12)
Net cash (used in) provided by investing activities	(290)	(39)	198	—	(131)
Financing activities:					
Proceeds from employee stock plans	10	—	—	—	10
Other, net	2	(1)	—	—	1
Net cash provided by (used in) financing activities	12	(1)	—	—	11
Net (decrease) increase in cash and cash equivalents	(235)	(5)	753	—	513
Cash and cash equivalents at beginning of period	360	42	1,927	—	2,329
Cash and cash equivalents at end of period	$ 125	$ 37	$ 2,680	$ —	$ 2,842

	Nine Months Ended September 30, 2015				
	Parent Guarantor	Other Guarantors	Non-Guarantors	Eliminations	Consolidated
			(In millions)		
Operating activities:					
Net cash provided by operating activities	$ 93	70	743	—	$ 906
Investing activities:					
Purchases of investments	(23)	—	(1,288)	—	(1,311)
Proceeds from sales and maturities of investments	90	—	773	—	863
Purchases of property, equipment and capitalized software	(68)	(19)	(14)	—	(101)
Decrease in restricted investments	—	5	(10)	—	(5)
Net cash paid in business combinations	—	—	(77)	—	(77)
Capital contributions to subsidiaries	(167)	3	164	—	—
Dividends received from subsidiaries	42	(17)	(25)	—	—
Change in amounts due to/from affiliates	(15)	—	15	—	—
Other, net	(1)	(25)	(8)	—	(34)
Net cash used in investing activities	(142)	(53)	(470)	—	(665)
Financing activities:					
Proceeds from common stock offering, net of issuance costs	373	—	—	—	373
Proceeds from employee stock plans	8	—	—	—	8
Other, net	3	—	—	—	3
Net cash provided by financing activities	384	—	—	—	384
Net increase in cash and cash equivalents	335	17	273	—	625
Cash and cash equivalents at beginning of period	75	15	1,449	—	1,539
Cash and cash equivalents at end of period	$ 410	$ 32	$ 1,722	$ —	$ 2,164

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This Quarterly Report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this Quarterly Report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this Quarterly Report. Any forward-looking statement made by us in this Quarterly Report is based only on information currently available to us and speaks only as of the date on which it is made. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- the success of our profit improvement and cost-cutting initiatives;
- uncertainties and evolving market and provider economics associated with the implementation of the Affordable Care Act (the "ACA"), the Medicaid expansion, the insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the Medicare-Medicaid dual eligible demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;
- management of our medical costs, including our ability to reduce over time the high medical costs commonly associated with new patient populations;
- our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates in new plans, geographies, and programs where we have less experience with patient and provider populations, and also including utilization rates associated with seasonal flu patterns or other newly emergent diseases;
- our ability to manage growth, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;
- our ability to consummate and realize benefits from proposed acquisitions, including the pending Aetna-Humana Medicare Advantage divestiture transaction;
- our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;
- our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;
- the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions;
- our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions, including but not limited to cost-plus reimbursement for retroactively eligible members in New Mexico, the Medicaid expansion cost corridors in New Mexico and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation, or are at least partially dependent upon information about the health status of state or federal program participants who are not Molina members;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;
- the interpretation and implementation of state contract performance requirements regarding the achievement of certain quality measures, and our ability to avoid liquidated damages associated therewith;
- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;

- the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, the effect of the newly enacted PROMESA law, and our efforts to better manage the health care costs of our Puerto Rico health plan;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the resolution of the Illinois budget impasse and continued payment of all amounts due to our Illinois health plan;
- the accurate estimation of incurred but not reported or paid medical costs across our health plans;
- subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer, risk corridors, and reinsurance;
- efforts by states to recoup previously paid amounts;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;
- the continuation and renewal of the government contracts of our health plans, Molina Medicaid Solutions, and Pathways, and the terms under which such contracts are renewed;
- complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings;
- the relatively small number of states in which we operate health plans;
- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;
- newly emergent viruses or widespread epidemics, including the Zika virus, public catastrophes or terrorist attacks, and associated public alarm;
- changes in general economic conditions, including unemployment rates;
- the sufficiency of our funds on hand to pay the amounts due upon conversion of our outstanding notes; and
- increasing competition and consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2015 for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2015.

Company Overview

Molina Healthcare, Inc. provides quality managed health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans segment, which comprises the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment, which includes our behavioral health and social services subsidiary, Pathways. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015. All prior periods reported conform to this presentation.

Update on 2016 Financial Performance

Third Quarter 2016 Compared with Second Quarter 2016

Third quarter 2016 financial performance improved significantly when compared with the second quarter of 2016. Earnings per diluted share increased to $0.76 in the third quarter of 2016 from $0.58 in the second quarter. Adjusted earnings per diluted share increased to $0.85 in the third quarter of 2016 from $0.67 in the second quarter.

Higher profitability in the third quarter of 2016, when compared with the second quarter of 2016, was primarily the result of:

- **Improved profitability among products other than the Marketplace, partially offset by lower profitability for the Marketplace product.** Excluding adjustments related to 2015 dates of service, the medical care ratio for all products combined (excluding Marketplace) declined to 89.6% in the third quarter from 90.3% in the second quarter. The medical care ratio for the Marketplace program (also excluding adjustments related to 2015 dates of service) increased to 89.0% in the third quarter from 79.7% in the second quarter. Although third quarter results for the Marketplace business were lower than anticipated, we believe that Marketplace performance for full year 2016 dates of service will be approximately breakeven. We continue to record substantial liabilities for Marketplace risk transfer payments under the risk adjustment program. We estimate that such payments reduced our Marketplace premium revenue by approximately 25% for the nine months ended September 30, 2016. We have recommended that the risk transfer formula be modified so that payments between health plans are allocated based solely upon medical costs, rather than upon premiums. Such a change would have lowered the percentage of premium revenue returned as a result of risk transfer from 25% to 20% for the nine months ended September 30, 2016. We believe that the methodology used to calculate Marketplace risk transfer payments penalizes comparatively efficient and affordable health plans and, as a result, those purchasing affordable Marketplace policies ultimately pay higher premiums.

- **Improved administrative efficiency**. Our general and administrative expense ratio fell to 7.6% in the third quarter of 2016 from 8.1% in the second quarter.

- **Lower effective tax rate.** The benefit of approximately $5 million in discrete items reduced our effective tax rate to 54.0% in the third quarter of 2016, from 59.8% in the second quarter.

Management Expectations for Full Year 2016 Results

As previously disclosed, we expect the following factors, among others, to affect our financial performance in the rest of 2016:

- The ultimate savings to be realized from various cost savings initiatives and the speed at which such savings will be realized.
- Medicaid rate increases (excluding Medicaid Expansion) of approximately 3.0% in California (effective July 1, 2016); approximately 2.5% in Puerto Rico (effective July 1, 2016); approximately 3.0% in Texas (effective September 1, 2016); and approximately 4.0% in Florida (effective September 1, 2016). All rate changes are consistent with our previous expectations.
- Medicaid Expansion rate decreases of approximately 11.0% in California (effective July 1, 2016) and approximately 2.0% in Ohio (effective July 1, 2016). All rate changes are consistent with our previous expectations.
- The implementation of a medical care ratio floor of 86.0% for the South Carolina Medicaid program effective July 1, 2016.
- Declining margins for our Marketplace business during the second half of 2016 due to normal membership attrition; the addition of higher cost members through the special enrollment process; higher costs as members reach the limits of the cost-sharing provisions of their insurance coverage; and increasing utilization as members become more engaged with our care networks.

Market Updates

Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," for a discussion of the current year market updates.

Understanding Our Business

Health Plans Segment

The Health Plans segment consists of health plans in 12 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of September 30, 2016, these health plans served 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Health Insurance Marketplace (Marketplace) members, most of whom receive government premium subsidies.

Health Plans Segment Membership by Health Plan and Program. The following tables set forth our Health Plans membership as of the dates indicated:

	September 30, 2016	December 31, 2015	September 30, 2015
Ending Membership by Health Plan:			
California	683,000	620,000	611,000
Florida	563,000	440,000	349,000
Illinois	195,000	98,000	101,000
Michigan	387,000	328,000	340,000
New Mexico	253,000	231,000	231,000
New York (1)	37,000	—	—
Ohio	339,000	327,000	344,000
Puerto Rico	331,000	348,000	356,000
South Carolina	109,000	99,000	102,000
Texas	352,000	260,000	263,000
Utah	150,000	102,000	102,000
Washington	716,000	582,000	568,000
Wisconsin	131,000	98,000	103,000
	4,246,000	3,533,000	3,470,000
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,529,000	2,312,000	2,249,000
Medicaid Expansion	658,000	557,000	540,000
Marketplace	568,000	205,000	226,000
Aged, Blind or Disabled (ABD)	395,000	366,000	359,000
Medicare-Medicaid Plan (MMP) – Integrated (2)	51,000	51,000	56,000
Medicare Special Needs Plans (Medicare)	45,000	42,000	40,000
	4,246,000	3,533,000	3,470,000

(1) The New York health plan was acquired on August 1, 2016.
(2) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

Health Plans Segment Premiums by Program. The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a per-member per-month (PMPM) basis, for the nine months ended September 30, 2016. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 320.00	$ 180.00
Medicaid Expansion	320.00	480.00	380.00
Marketplace	160.00	360.00	230.00
ABD	390.00	1,530.00	990.00
MMP – Integrated	1,170.00	3,290.00	2,160.00
Medicare	780.00	1,110.00	1,020.00

Health Plans Segment Medical Care Costs by Type. The following table provides the details of consolidated medical care costs by type for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended September 30,					
	2016			2015		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,799	$ 220.29	74.7%	$ 2,224	$ 218.69	73.8%
Pharmacy	567	44.65	15.1	418	41.07	13.9
Capitation	302	23.83	8.1	260	25.57	8.6
Direct delivery	21	1.66	0.5	31	2.97	1.0
Other	59	4.58	1.6	83	8.19	2.7
	$ 3,748	$ 295.01	100.0%	$ 3,016	$ 296.49	100.0%

	Nine Months Ended September 30,					
	2016			2015		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 8,156	$ 215.96	74.6%	$ 6,275	$ 217.63	73.1%
Pharmacy	1,621	42.93	14.8	1,161	40.26	13.5
Capitation	901	23.86	8.3	725	25.13	8.5
Direct delivery	55	1.46	0.5	85	2.94	1.0
Other	197	5.20	1.8	335	11.62	3.9
	$ 10,930	$ 289.41	100.0%	$ 8,581	$ 297.58	100.0%

Molina Medicaid Solutions Segment

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with the Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Other Segment

The Other segment includes businesses, such as our Pathways behavioral health and social services provider, which do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

How We Assess Performance

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. The following table presents gross margin for our segments. Management's discussion and analysis of the changes in the individual components of gross margin, by reportable segment, is presented below under "Results of Operations."

	Three Months Ended September 30,		Change		Nine Months Ended September 30,		Change	
	2016	2015	$	%	2016	2015	$	%
	(Dollars in millions)							
Health Plans:								
Premium revenue	$ 4,191	$ 3,377	$ 814	24 %	$ 12,215	$ 9,652	$ 2,563	27 %
Less: medical care costs	3,748	3,016	732	24	10,930	8,581	2,349	27
Medical margin	$ 443	$ 361	$ 82	23	$ 1,285	$ 1,071	$ 214	20
Medical care ratio	89.4%	89.3%			89.5%	88.9%		
Molina Medicaid Solutions:								
Service revenue	$ 48	$ 47	$ 1	2	$ 146	$ 146	$ —	—
Less: cost of service revenue	42	34	8	24	129	103	26	25
Service margin	$ 6	$ 13	$ (7)	(54)	$ 17	$ 43	$ (26)	(60)
Service cost ratio	86.7%	72.7%			88.3%	70.4%		
Other:								
Service revenue	$ 85	$ —			$ 262	$ —		
Less: cost of service revenue	77	—			233	—		
Service margin	$ 8	$ —			$ 29	$ —		
Service cost ratio	90.3%	—%			89.0%	—%		

Our Use of Non-GAAP Financial Measures

We use two non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures. The year over year changes for the individual components of both of these measures are described below in "Results of Operations."

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization (EBITDA). We believe that EBITDA is particularly helpful in assessing our ability to meet the cash demands of our operating units. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2016	2015	2016	2015
	(In millions)			
Net income	$ 42	$ 46	$ 99	$ 113
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	42	29	118	87
Interest expense	26	15	76	45
Income tax expense	50	52	137	153
EBITDA	$ 160	$ 142	$ 430	$ 398

The second of these non-GAAP measures is adjusted net income (including adjusted net income per diluted share). We believe that adjusted net income per diluted share is very helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net income.

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2016		2015		2016		2015	
	(In millions, except diluted per-share amounts)							
Net income	$ 42	$ 0.76	$ 46	$ 0.77	$ 99	$ 1.77	$ 113	2.07
Adjustment, net of tax:								
Amortization of intangible assets	5	0.09	2	0.04	15	0.26	8	0.15
Adjusted net income (1)	$ 47	$ 0.85	$ 48	$ 0.81	$ 114	$ 2.03	$ 121	$ 2.22

(1) Beginning in the first quarter of 2016, we revised our calculation of adjusted net income. We no longer subtract "Amortization of convertible senior notes and lease financing obligations" from net income to arrive at adjusted net income. We made this change because various capital transactions completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources of capital. We believe that this change enhances the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors. All periods presented conform to this presentation.

Results of Operations

Health Plans Segment

Three Months Ended September 30, 2016 Compared with Three Months Ended September 30, 2015

Strong enrollment growth generated approximately $814 million, or 24%, more premium revenue in the third quarter of 2016 compared with the third quarter of 2015. Enrollment growth was primarily due to increased Marketplace enrollment, and acquisitions that added Medicaid membership. Consolidated premium revenue measured on a PMPM basis was essentially unchanged in the third quarter of 2016 when compared with the third quarter of 2015.

The medical care ratio increased slightly to 89.4% in the third quarter of 2016, from 89.3% in the third quarter of 2015. This increase was driven by lower percentage margins for Medicaid Expansion and Marketplace membership which more than offset higher margins for TANF and ABD combined. Consolidated medical care costs measured on a PMPM basis were nearly constant in the third quarter of 2016 when compared with the third quarter of 2015.

Financial Performance by Program. The following tables present the components of premium revenue and medical care costs by program (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions).

	Three Months Ended September 30, 2016						
	Member Months(1)	Premium Revenue		Medical Care Costs		MCR(2)	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.6	$ 1,373	$ 180.74	$ 1,246	$ 164.04	90.8%	$ 127
Medicaid Expansion	2.0	763	386.98	642	325.68	84.2	121
Marketplace	1.7	399	238.86	352	210.38	88.1	47
ABD	1.1	1,186	1,008.28	1,094	929.93	92.2	92
MMP	0.2	334	2,165.26	280	1,818.75	84.0	54
Medicare	0.1	136	1,019.19	134	1,003.85	98.5	2
	12.7	$ 4,191	$ 329.88	$ 3,748	$ 295.01	89.4%	$ 443

	Three Months Ended September 30, 2015						
	Member Months(1)	Premium Revenue		Medical Care Costs		MCR(2)	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	6.6	$ 1,139	$ 171.16	$ 1,070	$ 160.85	94.0%	$ 69
Medicaid Expansion	1.5	565	366.80	458	297.16	81.0	107
Marketplace	0.6	170	262.74	124	192.21	73.2	46
ABD	1.1	1,070	1,017.68	979	931.11	91.5	91
MMP	0.2	310	1,975.10	271	1,718.13	87.0	39
Medicare	0.1	123	1,002.50	114	930.43	92.8	9
	10.1	$ 3,377	$ 332.05	$ 3,016	$ 296.49	89.3%	$ 361

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

The following discussion highlights the primary drivers of our performance, by program.

Medicaid TANF, CHIP and ABD. Medical care ratios for the TANF, CHIP and ABD programs fluctuated among health plans between the third quarters of 2016 and 2015. The medical care ratio on a consolidated basis for the ABD program was consistent between the third quarters of 2016 and 2015. The medical care ratio on a consolidated basis for the TANF and CHIP programs combined fell in the third quarter of 2016 when compared to the third quarter of 2015. Lower medical care ratios for the Florida, Illinois and New Mexico health plans more than offset higher or flat medical care ratios in other health plans.

Medicaid Expansion. Member months increased 28% in the third quarter of 2016, when compared with the third quarter of 2015, as a result of membership growth in all states, but higher medical care ratios in Michigan, New Mexico, Ohio and Washington led to an increase in the consolidated medical care ratio for the Expansion program, when compared with the third quarter of 2015.

Marketplace. Marketplace member months increased by almost 160% in the third quarter of 2016 when compared with the third quarter of 2015. The medical care ratio of aggregate Marketplace membership increased substantially in the third quarter of 2016 when compared with the third quarter of 2015, primarily as a result of lower revenue due to increased liabilities for the Marketplace risk adjustment program.

MMP and Medicare. Membership, revenue and medical care ratios were consistent on a consolidated basis for the MMP and Medicare programs when comparing the third quarter of 2016 with the third quarter of 2015.

Financial Performance by State Health Plan. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended September 30, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.1	$ 612	$ 298.05	$ 523	$ 254.11	85.3%	$ 89
Florida	1.6	494	297.24	462	277.79	93.5	32
Illinois	0.6	163	275.26	145	244.86	89.0	18
Michigan	1.2	387	334.25	337	290.16	86.8	50
New Mexico	0.8	338	440.12	304	396.35	90.1	34
New York (3)	0.1	32	427.40	30	403.71	94.5	2
Ohio	1.0	501	491.51	424	415.87	84.6	77
Puerto Rico	1.0	184	183.46	167	167.44	91.3	17
South Carolina	0.3	102	312.28	94	285.97	91.6	8
Texas	1.1	597	559.98	525	493.07	88.1	72
Utah	0.4	106	236.31	104	230.53	97.6	2
Washington	2.1	569	265.48	521	243.49	91.7	48
Wisconsin	0.4	103	262.32	90	231.86	88.4	13
Other (4)	—	3	—	22	—	—	(19)
	12.7	$ 4,191	$ 329.88	$ 3,748	$ 295.01	89.4%	$ 443

	Three Months Ended September 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.9	$ 524	$ 288.45	$ 438	$ 241.09	83.6%	$ 86
Florida	0.9	300	299.33	265	264.39	88.3	35
Illinois	0.3	106	347.34	100	327.61	94.3	6
Michigan	0.9	281	330.00	236	276.61	83.8	45
New Mexico	0.7	297	421.76	275	390.26	92.5	22
New York (3)	—	—	—	—	—	—	—
Ohio	1.0	510	498.36	436	425.98	85.5	74
Puerto Rico	1.0	181	170.91	162	152.69	89.3	19
South Carolina	0.3	86	264.37	68	211.76	80.1	18
Texas	0.8	524	661.69	493	622.84	94.1	31
Utah	0.3	85	276.72	77	250.50	90.5	8
Washington	1.7	400	238.03	371	221.14	92.9	29
Wisconsin	0.3	71	232.32	57	184.94	79.6	14
Other (4)	—	12	—	38	—	—	(26)
	10.1	$ 3,377	$ 332.05	$ 3,016	$ 296.49	89.3%	$ 361

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) The New York health plan was acquired effective August 1, 2016.
(4) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

The following discussion highlights the primary drivers of our performance, by health plan.

California. Premium revenue grew to $612 million in the third quarter of 2016, from $524 million in the third quarter of 2015, as a result of higher membership in the TANF, Medicaid Expansion and Marketplace programs. The medical care ratio increased to 85.3% in the third quarter of 2016, from 83.6% in the third quarter of 2015, due to a higher medical care ratio in the TANF and ABD programs, partially offset by a decrease in the medical care ratio for the Medicaid Expansion program.

Florida. Premium revenue grew to $494 million in the third quarter of 2016, from $300 million in the third quarter of 2015, due to increased Marketplace membership and the addition of over 100,000 members from Medicaid contract acquisitions, most of which closed in the fourth quarter of 2015. The medical care ratio increased to 93.5% in the third quarter of 2016, from 88.3% in the third quarter of 2015, primarily as a result of an increase in the medical care ratio for the Marketplace membership, which more than offset a decrease to the medical care ratio for the TANF membership.

Illinois. Premium revenue grew to $163 million in the third quarter of 2016, from $106 million in the third quarter of 2015. The plan added approximately 100,000 members from Medicaid contract acquisitions in the first quarter of 2016. The medical care ratio decreased to 89.0% in the third quarter of 2016, from 94.3% in the third quarter of 2015. The decrease in the medical care ratio was primarily due to higher margins for TANF and Medicaid Expansion members.

Michigan. Premium revenue grew $106 million, or 38%, in the third quarter of 2016 compared with the third quarter of 2015, due to the addition of over 100,000 members from Medicaid contract acquisitions closed in the third quarter of 2015 and the first quarter of 2016. The medical care ratio increased to 86.8% in the third quarter of 2016, from 83.8% in the third quarter of 2015, primarily as a result of lower margins for TANF and Medicaid Expansion membership.

New Mexico. The medical care ratio decreased to 90.1% in the third quarter of 2016, from 92.5% in the third quarter of 2015, primarily as a result of a lower medical care ratio for the health plan's TANF membership, partially offset by an increase to the medical care ratio for the Medicaid Expansion membership.

New York. The medical care ratio was 94.5% in the third quarter of 2016. Our New York health plan was acquired effective August 1, 2016 and is the smallest of our health plans.

Ohio. Premium revenue declined $9 million, or 2%, in the third quarter of 2016 compared with the third quarter of 2015, despite a slight increase in enrollment. Medicaid premium rates decreased effective January 1, 2016, by approximately 2.5% (including a 5% decrease in Medicaid Expansion rates). Despite lower per member per month premiums, the medical care ratio decreased to 84.6% in the third quarter of 2016, from 85.5% in the third quarter of 2015.

Puerto Rico. The medical care ratio increased to 91.3% in the third quarter of 2016, from 89.3% in the third quarter of 2015.

South Carolina. The medical care ratio increased to 91.6% in the third quarter of 2016, from 80.1% in the third quarter of 2015. Premium increases in South Carolina have not been sufficient to cover the cost of expanded benefits.

Texas. Premium revenue grew $73 million, or 14%, in the third quarter of 2016 compared with the third quarter of 2015. The medical care ratio decreased to 88.1% in the third quarter of 2016 compared with 94.1% in the third quarter of 2015, primarily due to a decline in the medical care ratio for ABD membership and growth in Marketplace membership, which has a lower medical care ratio than the health plan's other membership.

Utah. Premium revenue grew $21 million, or 25%, in the third quarter of September 30, 2016 compared with the third quarter of 2015, primarily due to higher Marketplace enrollment. The medical care ratio increased to 97.6% in the third quarter of 2016, from 90.5% in the third quarter of 2015, primarily due to an increase in the medical care ratio of the growing Marketplace program.

Washington. Premium revenue grew $169 million, or 42%, in the third quarter of 2016 compared with the third quarter of 2015, primarily due to membership growth in the Medicaid (both TANF and ABD) and Medicaid Expansion programs. The medical care ratio decreased to 91.7% in the third quarter of 2016, from 92.9% in the third quarter of 2015.

Wisconsin. Premium revenue grew $32 million, or 44%, in the third quarter of 2016 when compared with the third quarter of 2015 as a result of increased Marketplace enrollment. The medical care ratio increased to 88.4% in the third quarter of 2016, from 79.6% in the third quarter of 2015 due to an increase in the medical care ratio of the Marketplace membership.

Nine Months Ended September 30, 2016 Compared with Nine Months Ended September 30, 2015

In the nine months ended September 30, 2016, a 30% increase in membership, partially offset by a 3% decrease in revenue PMPM, resulted in increased premium revenue of approximately 27%, or $2.6 billion, when compared with the nine months ended September 30, 2015. The decline in PMPM premium revenue was primarily the result of lower PMPM premiums for Medicaid Expansion membership and an increase in the percentage of our premium revenue derived from TANF and Marketplace membership.

Medical care costs as a percent of premium revenue increased to 89.5% in the nine months ended September 30, 2016, from 88.9% in the nine months ended September 30, 2015. The increase in our medical care ratio was driven primarily by lower percentage margins for Medicaid Expansion and Marketplace membership. Medical margin (measured in absolute dollars) increased 20% in the nine months ended September 30, 2016 over the nine months ended September 30, 2015.

Financial Performance by Program. The following tables present the components of premium revenue and medical care costs by program (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions).

	Nine Months Ended September 30, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	22.5	$ 3,999	$ 177.60	$ 3,646	$ 161.93	91.2%	$ 353
Medicaid Expansion	5.8	2,184	376.98	1,850	319.38	84.7	334
Marketplace	5.1	1,181	231.69	1,009	197.77	85.4	172
ABD	3.5	3,466	987.20	3,173	903.85	91.6	293
MMP	0.5	989	2,160.14	867	1,894.38	87.7	122
Medicare	0.4	396	1,015.14	385	986.40	97.2	11
	37.8	$ 12,215	$ 323.44	$ 10,930	$ 289.41	89.5%	$ 1,285

	Nine Months Ended September 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	18.6	$ 3,280	$ 175.52	$ 3,030	$ 162.16	92.4%	$ 250
Medicaid Expansion	4.2	1,654	393.71	1,325	315.33	80.1	329
Marketplace	2.0	525	259.97	370	183.33	70.5	155
ABD	3.2	3,063	965.91	2,789	879.27	91.0	274
MMP	0.4	733	1,981.40	684	1,847.03	93.2	49
Medicare	0.4	397	1,026.00	383	991.53	96.6	14
	28.8	$ 9,652	$ 334.74	$ 8,581	$ 297.58	88.9%	$ 1,071

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

The following discussion highlights the primary drivers of our performance, by program.

Medicaid TANF, CHIP and ABD. TANF, CHIP and ABD revenue increased in the nine months ended September 30, 2016 when compared with the nine months ended September 30, 2015, due to health plan acquisitions in late 2015 and early 2016, as well as the inclusion of a full three quarters of Puerto Rico operations year to date in 2016 (Puerto Rico began operations effective April 1, 2015). The slight decline in the medical care ratio for these programs on a consolidated basis when comparing the nine months ended September 30, 2016 with the same period in 2015 is not significant given normal margin fluctuations observed when performance is reviewed at this level of detail.

Medicaid Expansion. Member months increased 38% in the nine months ended September 30, 2016, when compared with the same period in 2015 as a result of membership growth in all states; but higher medical care ratios in Illinois, Michigan, New Mexico and Ohio led to an increase in the consolidated medical care ratio for the Expansion program.

Marketplace. Marketplace member months increased by over 150% in the nine months ended September 30, 2016, when compared with the same period in 2015. The medical care ratio of aggregate Marketplace membership increased substantially in 2016 when compared to 2015, primarily as a result of lower revenue due to increased liabilities for the Marketplace risk adjustment program.

MMP and Medicare. Membership and revenue increased on a consolidated basis for the MMP and Medicare programs when comparing the nine months ended September 30, 2016 with the same period in 2015. The medical care ratio for these programs decreased on a consolidated basis due to higher margins for the MMP program.

Financial Performance by State Health Plan. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Nine Months Ended September 30, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	6.1	$ 1,707	$ 280.21	$ 1,485	$ 243.64	86.9%	$ 222
Florida	5.0	1,447	288.74	1,301	259.60	89.9	146
Illinois	1.8	466	266.11	414	236.39	88.8	52
Michigan	3.6	1,143	322.08	1,018	286.77	89.0	125
New Mexico	2.3	1,016	447.07	905	398.22	89.1	111
New York (3)	0.1	32	427.40	30	403.71	94.5	2
Ohio	3.0	1,472	484.82	1,306	430.14	88.7	166
Puerto Rico	3.0	535	176.44	516	170.46	96.6	19
South Carolina	0.9	273	288.93	232	245.13	84.8	41
Texas	3.3	1,852	570.65	1,599	492.79	86.4	253
Utah	1.3	330	246.78	312	233.14	94.5	18
Washington	6.2	1,634	261.91	1,479	237.15	90.5	155
Wisconsin	1.2	299	252.45	278	235.25	93.2	21
Other (4)	—	9	—	55	—	—	(46)
	37.8	$ 12,215	$ 323.44	$ 10,930	$ 289.41	89.5%	$ 1,285

	Nine Months Ended September 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.3	$ 1,538	$ 292.64	$ 1,349	$ 256.71	87.7%	$ 189
Florida	2.9	868	294.05	763	258.49	87.9	105
Illinois	0.9	312	342.27	288	315.68	92.2	24
Michigan	2.4	738	310.01	621	260.53	84.0	117
New Mexico	2.1	933	448.75	843	405.60	90.4	90
New York (3)	—	—	—	—	—	—	—
Ohio	3.1	1,534	498.76	1,281	416.69	83.5	253
Puerto Rico	2.1	375	175.17	346	161.60	92.3	29
South Carolina	1.0	270	269.11	209	208.45	77.5	61
Texas	2.4	1,418	597.53	1,313	553.35	92.6	105
Utah	0.8	242	284.83	223	262.14	92.0	19
Washington	4.9	1,186	242.75	1,094	223.99	92.3	92
Wisconsin	0.9	206	221.97	162	173.99	78.4	44
Other (4)	—	32	—	89	—	—	(57)
	28.8	$ 9,652	$ 334.74	$ 8,581	$ 297.58	88.9%	$ 1,071

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) The New York health plan was acquired effective August 1, 2016.
(4) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

California. Premium revenue grew to $1,707 million in the nine months ended September 30, 2016, from $1,538 million in the nine months ended September 30, 2015, as a result of higher membership in the TANF, Medicaid Expansion and Marketplace programs. The medical care ratio decreased to 86.9% in the nine months ended September 30, 2016, from 87.7% in the nine months ended September 30, 2015, due to improvements in the medical care ratios for the TANF, Medicaid Expansion and MMP membership. These improvements more than offset a higher medical care ratio for the ABD membership.

Florida. Premium revenue grew to $1,447 million in the nine months ended September 30, 2016, from $868 million in the nine months ended September 30, 2015, primarily due to increased Marketplace membership, and the addition of over 100,000

members from Medicaid contract acquisitions, most of which closed in the fourth quarter of 2015. The medical care ratio increased to 89.9% in the nine months ended September 30, 2016, from 87.9% in the nine months ended September 30, 2015, primarily as a result of an increase in the medical care ratio for the Marketplace membership, which more than offset a decrease in the medical care ratio for the TANF and ABD membership.

Illinois. Premium revenue grew to $466 million in the nine months ended September 30, 2016, from $312 million in the nine months ended September 30, 2015. The health plan added approximately 100,000 members from Medicaid contract acquisitions in the first quarter of 2016. The health plan's medical care ratio decreased to 88.8% for the nine months ended September 30, 2016, from 92.2% for the nine months ended September 30, 2015. The decrease in the medical care ratio was primarily due to higher margins for the health plan's TANF membership.

Michigan. Premium revenue grew $405 million, or 55%, in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015, due to the addition of over 100,000 members from Medicaid contract acquisitions in the third quarter of 2015 and the first quarter of 2016. The medical care ratio increased to 89.0% in the nine months ended September 30, 2016, from 84.0% in the nine months ended September 30, 2015, primarily as a result of lower margins for TANF and Medicaid Expansion membership.

New Mexico. The medical care ratio decreased to 89.1% in the nine months ended September 30, 2016, from 90.4% in the nine months ended September 30, 2015, due to a lower medical care ratio for the TANF membership, partially offset by an increase in the medical care ratio for the Medicaid Expansion membership.

New York. As noted above, the New York health plan was acquired effective August 1, 2016.

Ohio. Premium revenue declined $62 million, or 4%, in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015, due to reduced overall state Medicaid enrollment and a Medicaid premium rate decrease effective January 1, 2016 of approximately 2.5% (which included a 5% decrease in Medicaid Expansion rates). The medical care ratio increased to 88.7% in the nine months ended September 30, 2016, from 83.5% in the nine months ended September 30, 2015, as a result of the rate decrease noted above and less favorable development of prior period medical liability estimates year to date in 2016 compared with 2015.

Puerto Rico. The medical care ratio increased to 96.6% in the nine months ended September 30, 2016, from 92.3% in the nine months ended September 30, 2015, primarily due to increased pharmacy costs, and reductions to revenue previously recorded for 2015 dates of service which decreased pretax income by approximately $11 million in the second quarter of 2016. The plan served its first members effective April 1, 2015.

South Carolina. The medical care ratio increased to 84.8% in the nine months ended September 30, 2016, from 77.5% in the nine months ended September 30, 2015. Premium increases in South Carolina have not been sufficient to cover the cost of expanded benefits.

Texas. Premium revenue grew $434 million, or 31%, in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015. Growth in premium revenue was primarily the result of increased Marketplace enrollment; the revenue associated with additional nursing home services provided to some ABD members effective March 1, 2015; the start-up of the Texas MMP program on that same date; and the recognition (in the second quarter of 2016) of approximately $44 million in out-of-period quality revenue relating to 2015 and 2014 dates of service. The plan's medical care ratio decreased to 86.4% for the nine months ended September 30, 2016, from 92.6% for the nine months ended September 30, 2015. Without the benefit of out-of-period quality revenue, the medical care ratio of the Texas health plan would have been approximately 88% in the nine months ended September 30, 2016.

Utah. Premium revenue grew $88 million, or 36%, in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015, primarily due to higher Marketplace enrollment. The medical care ratio increased to 94.5% in the nine months ended September 30, 2016, from 92.0% in the nine months ended September 30, 2015, primarily due to an increase in the medical care ratio of the growing Marketplace program.

Washington. Premium revenue grew $448 million, or 38%, in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015, primarily due to membership growth in the Marketplace, TANF and Medicaid Expansion programs. The medical care ratio decreased to 90.5% in the nine months ended September 30, 2016, from 92.3% in the nine months ended September 30, 2015, due to improved medical cost efficiency across nearly all programs.

Wisconsin. Premium revenue grew $93 million, or 45%, in the nine months ended September 30, 2016 when compared with the nine months ended September 30, 2015 as a result of increased Marketplace enrollment. The medical care ratio increased to 93.2% for the nine months ended September 30, 2016, from 78.4% for the nine months ended September 30, 2015 due to an increase in the medical care ratio of the Marketplace membership.

Molina Medicaid Solutions Segment

Service margin declined $7 million in the third quarter of 2016 compared with the third quarter of 2015, and $26 million in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015, primarily due to increased service costs associated with legacy state contracts that were re-procured.

Other Segment

Service margin was $8 million and $29 million for the three and nine months ended September 30, 2016, respectively. Because we acquired our Pathways behavioral health and social services provider in the fourth quarter of 2015, there was no service margin in the Other segment for the three and nine months ended September 30, 2015.

Income Statement Components that are Not Unique to Individual Segments

General and Administrative Expenses. General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") decreased to 7.6% in the third quarter of 2016, from 8.0% in the third quarter of 2015. The general and administrative expense ratio decreased to 7.8% for the nine months ended September 30, 2016, compared with 8.1% for the nine months ended September 30, 2015. In both the three and nine months ended September 30, 2016, the increase in total revenue outpaced the increase in general and administrative expenses.

Premium Tax Expenses. The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) decreased to 2.7% in the nine months ended September 30, 2016, compared with 2.9% in the nine months ended September 30, 2015, primarily due to the significant revenue growth at our Florida health plan, which operates in a state with no premium tax, and growth in MMP revenue. The Medicare portion of MMP revenue is not subject to premium tax.

Health Insurer Fee Revenue and Expenses. HIF revenue, as a percentage of premium revenue, decreased to 2.0% in the third quarter of 2016, from 2.4% in the third quarter of 2015. In the third quarter of 2015, we recognized reimbursement of certain HIF revenue related to prior periods. The total amount of out-of-period HIF revenue recognized in the third quarter of 2015 represented approximately $8 million ($0.08 per diluted share) of HIF revenue related to 2014 and approximately $17 million ($0.18 per diluted share) related to the first two quarters of 2015. There was no such out-of-period recognition of HIF revenue in the third quarter of 2016. Year to date 2016 HIF revenue recognized, as a percentage of premium revenue, was consistent with year to date 2015 at 2.1%. In 2015, our Puerto Rico health plan was not subject to the HIF because it was not operational during the previous year (2014).

Depreciation and Amortization. When measured as a percentage of total revenue, the year over year change in depreciation and amortization was insignificant.

Interest Expense. Interest expense increased to $26 million for the third quarter of 2016, from $15 million for the third quarter of 2015. Interest expense increased to $76 million for the nine months ended September 30, 2016, from $45 million for the nine months ended September 30, 2015. The increase was primarily due to our issuance of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, in the fourth quarter of 2015.

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on our convertible senior notes, which amounted to $8 million and $7 million for the third quarters of 2016 and 2015, respectively, and $23 million and $22 million for the nine months ended September 30, 2016 and 2015, respectively.

Income Tax Expense. The provision for income taxes was recorded at an effective rate of 54.0% for the third quarter of 2016, compared with 52.6% for the third quarter of 2015, and 58.0% for the nine months ended September 30, 2016 compared with 57.3% for the nine months ended September 30, 2015. Differences in the effective tax rate between periods are the result of different amounts of non-deductible expenses and discrete tax events.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary sources of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest the cash of our regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

As of September 30, 2016, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Investment income increased to $25 million for the nine months ended September 30, 2016, compared with $12 million for the nine months ended September 30, 2015, primarily due to an increase in invested assets.

Cash in excess of the capital needs of our regulated health plans is generally paid to us in the form of dividends, when and as permitted by applicable regulations, for general corporate use. For the nine months ended September 30, 2016, we received $50 million in dividends from our regulated health plan subsidiaries. For the nine months ended September 30, 2015, we received $25 million in dividends from our regulated health plan subsidiaries, and $17 million from our unregulated subsidiaries.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Nine Months Ended September 30,		
	2016	2015	Change
	(In millions)		
Net cash provided by operating activities	$ 633	$ 906	$ (273)
Net cash used in investing activities	(131)	(665)	534
Net cash provided by financing activities	11	384	(373)
Net increase in cash and cash equivalents	$ 513	$ 625	$ (112)

Operating Activities. Net cash provided by operating activities decreased $273 million in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015.

The year over year changes in the following accounts decreased cash provided by operating activities:

- Receivables and deferred revenue. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. In general, states may delay our premium payment, which we record as a receivable, or they may prepay the following month premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In the current year, the net effect of the timing of premiums received in California and Washington negatively impacted our cash flows from operating activities.
- Medical claims and benefits payable. In the nine months ended September 30, 2016, medical claims and benefits payable increased at a slower pace than the same period in 2015. In particular, our Puerto Rico health plan commenced operations on April 1, 2015, leading to a significant increase in medical claims and benefits payable at September 30, 2015, compared with a much smaller increase in the current year as the membership base has stabilized.

Investing Activities. Net cash used in investing activities was $131 million in the nine months ended September 30, 2016, compared with $665 million in the nine months ended September 30, 2015. Net cash used in investing activities was higher in 2015 than in 2016 largely due to the investment in 2015 of a large portion of the $373 million in proceeds, net of issuance costs, that we received from the June 2015 offering of 5.75 million shares of our common stock.

Financing Activities. Net cash provided by financing activities decreased $373 million in the nine months ended September 30, 2016 compared with the nine months ended September 30, 2015, primarily due to our 2015 common stock offering.

Financial Condition

We believe that our cash resources, internally generated funds and committed acquisition bridge financing (see below under *"Commitment Letter"*) will be sufficient to support our operations, planned acquisitions, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at September 30, 2016, our working capital was $1,448 million, compared with $1,484 million at December 31, 2015. At September 30, 2016, our cash and investments amounted to $4,695 million, compared with $4,241 million at December 31, 2015. Cash, cash equivalents and investments held by the parent company (Molina Healthcare, Inc.) amounted to $388 million and $612 million as of September 30, 2016 and December 31, 2015, respectively.

Regulatory Capital and Dividend Restrictions. For more information on our regulatory capital and dividend restrictions, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 14, "Commitments and Contingencies."

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "Ba3" by Moody's Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and costs.

Future Sources and Uses of Liquidity

Proposed Acquisition. As described in Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," we announced the Medicare Acquisition on August 2, 2016, which is expected to close in 2017. The purchase price is currently estimated to be $117 million, subject to certain closing adjustments.

Commitment Letter. As described in Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 10, "Debt," we entered into a debt commitment letter with Barclays Bank PLC (Barclays). The primary terms of the debt commitment letter provide that Barclays will lend us up to $400 million which may be used as follows: to finance the Medicare Acquisition, including related transaction costs and regulatory or statutory capital requirements; to finance any ongoing working capital requirements; or for other general corporate purposes.

States' Budgets. From time to time, the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. For example, the state of Illinois is currently operating under a stopgap budget that expires in January 2017. It is unclear when or if the state's budget difficulties will be resolved. As of September 30, 2016, our Illinois health plan served approximately 195,000 members and recorded premium revenue of approximately $466 million for the nine months ended September 30, 2016. As of October 24, 2016, the state of Illinois owed us approximately $43 million for May and June 2016 premiums.

In another example, the Commonwealth of Puerto Rico's fiscal plan, issued on October 14, 2016, reported that current revenues are insufficient to support existing current operations and debt service. While the Commonwealth reports that it will prioritize health care spending, it stresses the need to address the cap on federal matching funds it receives for its participation in the Medicaid program. Among the fiscal issues expected to further exacerbate the Commonwealth's current debt crisis is the depletion of ACA funds, estimated to occur in the Commonwealth's fiscal year 2018. As of September 30, 2016, our Puerto Rico health plan served approximately 331,000 members and recorded premium revenue of approximately $535 million for the nine months ended September 30, 2016. As of October 24, 2016, the Commonwealth is current with its premium payments.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. Our ability to borrow under the Credit Facility is subject to compliance with certain financial covenants. At September 30, 2016, we were in compliance with all financial covenants under the Credit Facility. As of September 30, 2016, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Convertible Senior Notes. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes (1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. In September 2014, we issued $302 million aggregate principal amount of 1.625% convertible senior notes due August 15, 2044 (1.625% Notes), unless earlier repurchased, redeemed, or converted. The principal amounts of both the 1.125% Notes and the 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The 1.125% Notes met their $53.00 stock price trigger in the quarter ended September 30, 2016, therefore, the 1.125% Notes were convertible as of September 30, 2016. The 1.625% Notes did not meet their $75.52 stock price trigger in the quarter ended September 30, 2016, therefore, the 1.625% Notes were not convertible as of September 30, 2016.

Securities Repurchase Program. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2015, was disclosed in our 2015 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the nine months ended September 30, 2016. For further discussion and maturities of our long-term debt, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 9, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the nine months ended September 30, 2016, to our disclosure reported in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015.
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. For a discussion of this topic, including amounts recorded to our consolidated financial statements, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded to our consolidated financial statements, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Molina Medicaid Solutions segment revenue and cost recognition*. There have been no significant changes during the nine months ended September 30, 2016, to our disclosure reported in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

For information regarding market risk, see Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2016 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

For information regarding legal proceedings, see Part I, Item 1 of this Form 10-Q, Note 14, "Commitments and Contingencies."

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2015 and under Part II, Item 1A – Risk Factors, in our Quarterly Report on Form 10-Q for the quarter ended March 31, 2016. The risk factors described in our 2015 Annual Report and 2016 first quarter Quarterly Report are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Unregistered Issuances of Equity Securities

None.

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended September 30, 2016 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
July 1 - July 31	667	$ 49.83	—	$ 50,000,000
August 1 - August 31	573	$ 56.16	—	$ 50,000,000
September 1 - September 30	329	$ 53.54	—	$ 50,000,000
Total	1,569	$ 52.92	—	

(a) During the three months ended September 30, 2016, we withheld 1,569 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: October 27, 2016

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: October 27, 2016

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
2.1	Asset Purchase Agreement, dated as of August 6, 2016, between Molina Healthcare, Inc. and Aetna Inc. (Incorporated herein by reference to Exhibit 2.1 to Molina Healthcare, Inc.'s Current Report on Form 8-K filed on August 5, 2016.)
2.2	Asset Purchase Agreement, dated as of August 6, 2016, between Molina Healthcare, Inc. and Humana Inc. (Incorporated herein by reference to Exhibit 2.2 to Molina Healthcare, Inc.'s Current Report on Form 8-K filed on August 5, 2016.)
10.1	Commitment Letter, dated August 2, 2016, between Molina Healthcare, Inc. and Barclays Bank PLC (Incorporated herein by reference to Exhibit 10.1 to Molina Healthcare, Inc.'s Current Report on Form 8-K filed August 5, 2016.)
10.2*	Molina Healthcare, Inc. 2011 Employee Stock Purchase Plan (Filed to reflect immaterial amendments approved by the Board of Directors on July 26, 2016).
10.3*	Amendment No. 3, dated as of August 8, 2016, to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013).
10.4*	Molina Healthcare, Inc. 2011 Equity Incentive Plan (Filed to reflect amendment to Section 16.2 approved by the Compensation Committee on October 25, 2016).
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

* Management contract or compensatory plan or arrangement.

MOLINA HEALTHCARE, INC.

2011 EMPLOYEE STOCK PURCHASE PLAN*

1. Establishment of Plan. Molina Healthcare, Inc., a Delaware corporation (the "Company"), proposes to grant options to purchase shares of the Company's common stock, $0.001 par value per share (the "Common Stock"), to eligible employees of the Company and its Participating Affiliates (as defined below) pursuant to this 2011 Employee Stock Purchase Plan (this "Plan"). For purposes of this Plan, "Parent Corporation" and "Subsidiary Corporation" shall have the same meanings as "parent corporation" and "subsidiary corporation" in Sections 424(e) and 424(f), respectively, of the Internal Revenue Code of 1986, as amended (the "Code"). "Participating Affiliates" are Parent Corporations or Subsidiary Corporations that the Board of Directors of the Company (the "Board") designates from time to time as corporations that shall participate in this Plan. Affiliates may be designated as Participating Affiliates either before or after this Plan is approved by the Company's stockholders as provided in Section 22. The Company intends this Plan to qualify as an "employee stock purchase plan" under Section 423 of the Code (including any amendments to or replacements of such Section), and this Plan shall be so construed. Any term not expressly defined in this Plan but defined for purposes of Section 423 of the Code shall have the same definition herein. A total of three million (3,000,000)[1] shares of the Common Stock are reserved for issuance under this Plan.

2. Purpose. The purpose of this Plan is to provide eligible employees of the Company and Participating Affiliates with a convenient means of acquiring an equity interest in the Company through payroll deductions, to enhance such employees' sense of participation in the affairs of the Company and Participating Affiliates, and to provide an incentive for continued employment.

3. Administration

(a) This Plan shall be administered by the Compensation Committee of the Board (the "Committee"). Subject to the provisions of this Plan and the limitations of Section 423 of the Code or any successor provision in the Code, all questions of interpretation or application of this Plan shall be determined by the Committee in its sole discretion and its decisions shall be final and binding upon all participants. Members of the Committee shall receive no compensation for their services in connection with the administration of this Plan, other than standard fees as established from time to time by the Board for services rendered by Board members serving on Board committees. All expenses incurred in connection with the administration of this Plan shall be paid by the Company.

*As amended on July 26, 2016.

[1] Represents the number of shares adjusted for the 3-for-2 common stock split in the form of a stock dividend that was effective May 20, 2011.

(b) The Committee may, from time to time, consistent with this Plan and the requirements of Section 423 of the Code, establish, change or terminate such rules, guidelines, policies, procedures, limitations, or adjustments as deemed advisable by the Company, in its sole discretion, for the proper administration of this Plan, including, without limitation: (a) a minimum payroll deduction amount required for participation in an Offering Period, (b) a limitation on the frequency or number of changes permitted in the rate of payroll deduction during an Offering Period, (c) a payroll deduction greater or less than the amount designated by a participant in order to adjust for the Company's delay or mistake in processing an Enrollment Form or in otherwise effecting a participant's election under this Plan or as advisable to comply with the requirements of Section 423 of the Code, (d) determination of the date and manner by which the Fair Market Value of the Common Stock is determined for purposes of administration of this Plan, (e) delegate responsibility for Plan operation, management and administration, subject to the Committee's oversight and control, on such terms as the Committee may establish, and (f) delegate to other persons the responsibility for performing appropriate functions as necessary, desirable or appropriate to further the purposes of this Plan.

4. Eligibility. Any individual employed by the Company or the Participating Affiliates on the "Offering Date" of an "Offering Period" (each as defined in Section 5 below) is eligible to participate in such Offering Period except the following:

(a) employees who are customarily employed for less than (20) hours per week; and

(b) employees who, together with any other person whose stock would be attributed to such employee pursuant to Section 424(d) of the Code, own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined voting power or value of all classes of stock of the Company or any of its Participating Affiliates or who, as a result of being granted an option under this Plan with respect to such Offering Period, would own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined power or value of all classes of stock of the Company or any of its Participating Affiliates; and

(c) individuals who provide services to the Company or any of its Participating Affiliates as independent contractors who are reclassified as common law employees for any reason except for federal income and employment tax purposes.

5. Offering Periods. The offering periods of this Plan (each, an "Offering Period") shall be of six (6) months duration commencing on January 1 and July 1 of the Company's fiscal year. The first day of each Offering Period is referred to as the "Offering Date." The last day of each Offering Period is referred to as the "Purchase Date." The Committee shall have the power to change the Offering Dates or Purchase Dates and the duration of Offering Periods without stockholder approval if such change is announced prior to the start of the relevant Offering Period, or prior to such other time period as specified by the Committee; provided, however, that no Offering Period may have a duration exceeding twenty-seven (27) months. If the first or last day of an Offering Period is not a day on which the New York

Stock Exchange is open for trading, the Company shall specify the trading day that will be deemed the first or last day, as the case may be, of the Offering Period.

6. Participation in this Plan. An employee may participate during an Offering Period on the first Offering Date after such employee satisfies the eligibility requirements set forth in Section 4 above and delivers an appropriate enrollment form (the "Enrollment Form") to the Company prior to such Offering Date, or such other time period as specified by the Committee. Notwithstanding the foregoing, the Committee may set a later time for filing the Enrollment Form authorizing payroll deductions for all eligible employees with respect to a given Offering Period. An eligible employee who does not timely deliver an Enrollment Form to the Company after becoming eligible to participate in such Offering Period shall not participate in that Offering Period or any subsequent Offering Period until filing an Enrollment Form with the Company prior to the applicable Offering Date, or such other time period as specified by the Committee. Once an employee becomes a participant in an Offering Period, such employee will automatically participate in the Offering Period commencing immediately following the last day of the prior Offering Period unless the employee withdraws or is deemed to withdraw from this Plan or terminates further participation in the Offering Period as set forth in Section 11 below. A participant who has not otherwise withdrawn from this Plan under Section 11 is not required to file any additional Enrollment Form in order to continue participation in this Plan. However a participant may deliver a new Enrollment Form for a subsequent Offering Period in accordance with applicable rules and procedures if the participant wishes to change any of the elections contained in the participant's then effective Enrollment Form.

7. Grant of Option on Enrollment. Enrollment by an eligible employee in an Offering Period under this Plan will constitute the grant (as of the Offering Date for such Offering Period) by the Company to such employee of an option to purchase on the Purchase Date up to that number of shares of Common Stock of the Company determined by dividing (a) the amount accumulated in such employee's payroll deduction account during such Offering Period by (b) the Per Share Purchase Price as determined pursuant to Section 8 below (but in no event less than the par value of a share of Company's Common Stock), provided, however, that the number of shares of the Company's Common Stock subject to any option granted pursuant to this Plan shall not exceed the maximum number of shares which may be purchased pursuant to Section 10 below with respect to the applicable Purchase Date. The Fair Market Value of a share of the Company's Common Stock shall be determined as provided in Section 8 below.

8. Purchase Price. The purchase price per share ("Per Share Purchase Price") at which a share of Common Stock will be sold in any Offering Period shall be eighty-five percent (85%) of the lesser of:

(a) The Fair Market Value on the Offering Date; or

(b) The Fair Market Value on the Purchase Date.

For purposes of this Plan, the term "Fair Market Value" of the Common Stock on any given date means (i) the last reported closing price for a share of Stock on the New York Stock Exchange or, (ii) in the absence of reported sales on the New York Stock Exchange on a given date, the closing price of the New York Stock Exchange on the last date on which a sale occurred prior to such date; or (iii) if the stock is no longer publicly traded on the New York Stock Exchange, the Committee in good faith shall determine Fair Market Value; provided that, if the date for which the Fair Market Value is determined is the first day when trading prices for the Stock are reported on the New York Stock Exchange, the Fair Market Value shall be the public offering price set forth on the cover page for the final prospectus relating to the Company's Initial Public Offering.

9. Payment of Purchase Price; Changes in Payroll Deductions; Issuance of Shares.

(a) The purchase price of the shares shall be accumulated by regular payroll deductions made during each Offering Period. The deductions are made as a percentage of the participant's Compensation in one percent (1%) increments not less than one percent (1%) (except as a result of an election pursuant to Section 9(c) to stop payroll deductions during an Offering Period), nor greater than fifteen percent (15%) or such lower limit set by the Committee. "Compensation" shall mean all W-2 cash compensation, including base salary, wages, commissions, overtime, shift premiums and bonuses, provided, however, that for purposes of determining a participant's compensation, any election by such participant to reduce his or her regular cash remuneration under Sections 125 or 401(k) of the Code shall be treated as if the participant did not make such election. Notwithstanding the foregoing, Compensation shall not include reimbursements of expenses, allowances, long-term disability, workers' compensation or any amount deemed received without the actual transfer of cash or any amounts directly or indirectly paid pursuant to this Plan or any other stock purchase or stock option plan, or any other compensation not included above. Payroll deductions shall commence on the first payday of the Offering Period and shall continue to the end of the Offering Period unless sooner altered or terminated as provided in this Plan.

(b) A participant may increase or decrease the rate of payroll deductions during an Offering Period by providing to the Company a new Enrollment Form, in which case the new rate shall become effective for the next payroll period commencing after the Company's receipt of the Enrollment Form and shall continue for the remainder of the Offering Period unless changed as described below. Such change in the rate of payroll deductions may be made at any time during an Offering Period, but not more than one (1) increase and one (1) decrease in the rate of payroll deductions may be made during any Offering Period. A participant may increase or decrease the rate of payroll deductions for any subsequent Offering Period by filing with the Company a new Enrollment Form prior to the beginning of such Offering Period, or prior to such other time period as specified by the Committee. Any changes to the rate of payroll deductions during an Offering Period which are received by the Company after the commencement of the enrollment period for a new Offering Period will be made by the Company at its discretion, only to the extent such changes are administratively possible.

(c) A participant may reduce his or her payroll deduction percentage to zero during an Offering Period by providing to the Company a revised Enrollment Form. Such reduction shall be effective beginning with the next payroll period after the Company's receipt of the request and no further payroll deductions will be made for the duration of the Offering Period. Payroll deductions credited to the participant's account prior to the effective date of the request shall be used to purchase shares of Common Stock in accordance with Section (e) below. Notwithstanding Section 9(b), a participant may not resume making payroll deductions during the Offering Period in which he or she reduced his or her payroll deductions to zero. Any reduction to a participant's payroll deduction percentage to zero during an Offering Period which is received by the Company after the commencement of the enrollment period for a new Offering Period will be made by the Company at its discretion, only to the extent such changes are administratively possible.

(d) All payroll deductions made for a participant are credited to his or her account under this Plan and are deposited with the general funds of the Company. No interest accrues on the payroll deductions. All payroll deductions received or held by the Company may be used by the Company for any corporate purpose, and the Company shall not be obligated to segregate such payroll deductions.

(e) On each Purchase Date, so long as this Plan remains in effect and provided that the participant has not submitted a revised Enrollment Form withdrawing from this Plan before such Purchase Date in accordance with Section 11, the Company shall apply the funds then in the participant's account (or, if applicable, the lump sum cash payment received from the participant) to the purchase of whole shares of Common Stock reserved under the option granted to such participant with respect to the Offering Period to the extent that such option is exercisable on the Purchase Date. The Per Share Purchase Price shall be as specified in Section 8. Any cash remaining in such participant's account on a Purchase Date which is less than the amount necessary to purchase a full share of Common Stock of the Company shall be refunded without interest. If this Plan has been oversubscribed, all funds not used to purchase shares on the Purchase Date shall be returned to the participant, without interest. No Common Stock shall be purchased on a Purchase Date on behalf of any employee whose participation in this Plan has terminated prior to such Purchase Date.

(f) As promptly as practicable after the Purchase Date, the Company shall issue shares for the participant's benefit representing the shares purchased upon exercise of his or her option, subject to compliance with Section 24 below.

(g) During a participant's lifetime, his or her option to purchase shares hereunder is exercisable only by him or her. The participant will have no interest or voting right in shares covered by his or her option until such option has been exercised.

1. Limitations on Shares to be Purchased.

(a) No participant shall be entitled to purchase Common Stock under this Plan at a rate which, when aggregated with his or her rights to purchase stock under all other employee stock purchase plans of the Company or any Parent Corporation or Subsidiary

Corporation, exceeds $25,000 in Fair Market Value, determined as of the Offering Date (or such other limit as may be imposed by the Code) for each calendar year in which the employee participates in this Plan. The Company shall automatically suspend the payroll deductions of any participant as necessary to enforce such limit; provided that when the Company automatically resumes such payroll deductions, the Company must apply the rate in effect immediately prior to such suspension.

(b) No participant shall be entitled to purchase more than the Maximum Share Amount (as defined below) on any single Purchase Date. Prior to the commencement of any Offering Period or before such time period as specified by the Committee, the Committee may, in its sole discretion, set a maximum number of shares which may be purchased by any employee at any single Purchase Date (the "Maximum Share Amount"). Until otherwise determined by the Committee, there shall be no Maximum Share Amount. If a new Maximum Share Amount is set, then all participants must be notified of such Maximum Share Amount before commencing the next Offering Period. The Maximum Share Amount shall continue to apply with respect to all succeeding Purchase Dates and Offering Periods unless revised by the Committee as set forth above.

(c) If the number of shares to be purchased on a Purchase Date by all employees participating in this Plan exceeds the number of shares then available for issuance under this Plan, then the Company will make a pro rata allocation of the remaining shares in as uniform a manner as shall be reasonably practicable and as the Committee shall determine to be equitable.

(d) Any payroll deductions accumulated in a participant's account which are not used to purchase stock due to the limitations in this Section 10 shall be returned to the participant as soon as practicable after the end of the applicable Offering Period, without interest, including any amount remaining in such participant's account which is less than the amount necessary to purchase a full share of Common Stock of the Company.

2. Withdrawal.

(a) Each participant may withdraw from an Offering Period under this Plan by signing and delivering to the Company a revised Enrollment Form indicating such participant's intention to withdraw. Such withdrawal may be elected at any time prior to the end of an Offering Period, or such other time period as specified by the Committee.

(b) Upon withdrawal from this Plan, the accumulated payroll deductions shall be returned to the withdrawn participant, without interest, and his or her interest in this Plan shall terminate. If a participant voluntarily elects to withdraw from this Plan, he or she may not resume his or her participation in this Plan during the same Offering Period, but he or she may participate in any Offering Period under this Plan commencing after such withdrawal by filing a new authorization for payroll deductions in the same manner as set forth in Section 6 above for initial participation in this Plan.

3. Termination of Employment. Termination of a participant's employment for any reason, including retirement, death or the failure of a participant to remain an eligible employee of the Company or of a Participating Affiliate, immediately terminates his or her participation in this Plan. In such event, the payroll deductions credited to the participant's account will be returned to him or her or, in the case of his or her death, to his or her legal representative, without interest. For purposes of this Section 12, an employee will not be deemed to have terminated employment or failed to remain in the continuous employ of the Company or of a Participating Affiliate in the case of sick leave, military leave, or any other leave of absence approved by the Board; provided that such leave is for a period of not more than ninety (90) days or reemployment upon the expiration of such leave is guaranteed by contract or statute.

4. Return of Payroll Deductions. If a participant's interest in this Plan is terminated by withdrawal, termination of employment or otherwise, or if this Plan is terminated by the Board, the Company shall deliver to the participant all payroll deductions credited to such participant's account. No interest shall accrue on the payroll deductions of a participant in this Plan.

5. Capital Changes. Subject to any required action by the stockholders of the Company, the number of shares of Common Stock covered by each option under this Plan which has not yet been exercised and the number of shares of Common Stock which have been authorized for issuance under this Plan but have not yet been placed under option (collectively, the "Reserves"), as well as the price per share of Common Stock covered by each option under this Plan which has not yet been exercised, shall be proportionately adjusted for any increase or decrease in the number of issued and outstanding shares of Common Stock resulting from a stock split or the payment of a stock dividend (but only on the Common Stock) or any other increase or decrease in the number of issued and outstanding shares of Common Stock effected without receipt of any consideration by the Company; provided, however, that conversion of any convertible securities of the Company shall not be deemed to have been "effected without receipt of consideration". Notwithstanding the foregoing, any fractional shares resulting from an adjustment pursuant to this Section 14 shall be rounded down to the nearest whole number, and in no event may the Per Share Purchase Price be decreased to an amount less than the par value, if any, of the Common Stock. Such adjustment shall be made by the Committee, whose determination shall be final, binding and conclusive.

In the event of the proposed dissolution or liquidation of the Company, the Offering Period will terminate immediately prior to the consummation of such proposed action, unless otherwise provided by the Committee. The Committee may, in its sole discretion in such instances, declare that this Plan shall terminate as of a date fixed by the Committee and either give each participant the right to purchase shares under this Plan prior to such termination or return all accumulated payroll deductions to each participant, without interest. In the event of (i) a merger or consolidation in which the Company is not the surviving corporation (other than a merger or consolidation with a wholly-owned subsidiary, a reincorporation of the Company in a different jurisdiction, or other transaction in which there is no substantial change in the stockholders of the Company or their relative stock holdings, provided that the options under this Plan are assumed, converted or replaced by the successor

corporation, which assumption will be binding on all participants), (ii) a merger in which the Company is the surviving corporation but after which the stockholders of the Company immediately prior to such merger (other than any stockholder that merges, or which owns or controls another corporation that merges, with the Company in such merger) cease to own their shares or other equity interest in the Company, (iii) the sale of all or substantially all of the assets of the Company or (iv) the acquisition, sale, or transfer of more than 50% of the outstanding shares of the Company by tender offer or similar transaction, (each a "Sale Event") the Company shall apply the funds contributed under this Plan to the purchase of shares of Common Stock pursuant to the provisions of Section 9 immediately prior to the effective date of such Sale Event. Notwithstanding the foregoing, the surviving, continuing, successor or purchasing corporation or parent corporation thereof (the "Acquiring Corporation"), may elect to assume the Company's rights and obligations under this Plan and, in that event, there shall be no purchase before the end of the Offering Period in which the Sale Event occurs.

The Committee may, if it so determines in its sole discretion, also make provision for adjusting the share reserve set forth in Section 1, as well as the price per share of Common Stock covered by each outstanding option, solely in the event that the Company effects one or more reorganizations, recapitalizations, rights offerings or other increases or reductions of shares of its outstanding Common Stock, or in the event of the Company being consolidated with or merged into any other corporation.

6. Withholding. The participant shall make adequate provision for the foreign, federal, state and local tax withholding obligations of the Company or any of its Participating Affiliates, if any, which arise in connection with participation in this Plan. The Company and its Participating Affiliates shall, to the extent permitted by law, have the right to deduct any such taxes from any payment of any kind otherwise due to the participant.

7. Nonassignability. Neither payroll deductions credited to a participant's account nor any rights with regard to the exercise of an option or to receive shares under this Plan may be assigned, transferred, pledged or otherwise disposed of in any way (other than by will, the laws of descent and distribution or as provided in Section 23 below) by the participant. Any such attempt at assignment, transfer, pledge or other disposition shall be void and without effect.

8. Reports. Individual accounts will be maintained for each participant in this Plan. Each participant shall receive as soon as practicable after the end of each Offering Period a report of his or her account setting forth the total payroll deductions accumulated, the number of shares purchased, the per share price thereof and the remaining cash balance, if any, carried forward to the next Offering Period.

9. Notice of Disqualifying Disposition. Each participant shall notify the Company in writing if the participant disposes of any of the shares purchased in any Offering Period pursuant to this Plan if such disposition occurs within two (2) years from the Offering Date or within one (1) year from the Purchase Date on which such shares were purchased (the "Notice Period"). The Company may, at any time during the Notice Period, place a legend or legends on any certificate representing shares acquired pursuant to this Plan requesting the

Company's transfer agent to notify the Company of any transfer of the shares. The obligation of the participant to provide such notice shall continue notwithstanding the placement of any such legend on the certificates.

10. No Rights as Stockholder or to Continued Employment. A participant shall have no rights as a stockholder by virtue of participation in this Plan until the date of the issuance of a certificate for the shares purchased pursuant to the exercise of the participant's purchase right (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date such certificate is issued, except as provided in Section 14. Neither this Plan nor the grant of any option hereunder shall confer any right on any employee to remain in the employ of the Company or any Participating Affiliate, or restrict the right of the Company or any Participating Affiliate to terminate such employee's employment at any time.

11. Equal Rights and Privileges. All eligible employees shall have equal rights and privileges with respect to this Plan so that this Plan qualifies as an "employee stock purchase plan" within the meaning of Section 423 or any successor provision of the Code and the related regulations. Any provision of this Plan which is inconsistent with Section 423 or any successor provision of the Code shall, without further act or amendment by the Company, the Committee or the Board, be reformed to comply with the requirements of Section 423. This Section 20 shall take precedence over all other provisions in this Plan.

12. Notices. All notices or other communications by a participant to the Company under or in connection with this Plan shall be deemed to have been duly given when received in the form specified by the Company at the location, or by the person, designated by the Company for the receipt thereof.

13. Term; Stockholder Approval. This Plan was adopted by the Board of Directors of the Company on March 18, 2011, effective as of July 1, 2011 (the "Effective Date"), and shall apply to any purchase right granted, or stock transferred pursuant to any purchase right granted, on or after the Effective Date. This Plan shall continue until the earlier to occur of (a) termination of this Plan by the Board (which termination may be effected by the Board at any time), (b) issuance of all of the shares of Common Stock reserved for issuance under this Plan, or (c) April 27, 2021.

14. Designation of Beneficiary

(a) A participant may file a written designation of a beneficiary who is to receive any shares and cash, if any, from the participant's account under this Plan in the event of such participant's death subsequent to the end of any Offering Period but prior to delivery to him of such shares and cash. In addition, a participant may file a written designation of a beneficiary who is to receive any cash from the participant's account under this Plan in the event of such participant's death prior to a Purchase Date.

(b) Such designation of beneficiary may be changed by the participant at any time by written notice. In the event of the death of a participant and in the absence of a beneficiary validly designated under this Plan who is living at the time of such participant's death, the Company shall deliver such shares or cash to the executor or administrator of the estate of the participant, or if no such executor or administrator has been appointed (to the knowledge of the Company), the Company, in its discretion, may deliver such shares or cash to the spouse or to any one or more dependents or relatives of the participant, or if no spouse, dependent or relative is known to the Company, then to such other person as the Company may designate.

15. Conditions Upon Issuance of Shares; Limitation on Sale of Shares. Shares shall not be issued with respect to an option unless the exercise of such option and the issuance and delivery of such shares pursuant thereto shall comply with all applicable provisions of law, domestic or foreign, including, without limitation, the Securities Act of 1933, as amended, the Securities Exchange Act of 1934, as amended, the rules and regulations promulgated thereunder, and the requirements of any stock exchange or automated quotation system upon which the shares may then be listed, and shall be further subject to the approval of counsel for the Company with respect to such compliance.

16. Applicable Law. This Plan shall be governed by the substantive laws (excluding the conflict of laws rules) of the State of California.

17. Amendment or Termination of this Plan. The Board may at any time amend, terminate or extend the term of this Plan, except that (i) any such termination cannot affect options previously granted under this Plan unless the Board determines that the termination of this Plan immediately following any Purchase Date is in the best interests of the Company and its stockholders, (ii) any amendment may not adversely affect the previously granted purchase right of any participant unless permitted by this Plan or as may be necessary to qualify this Plan as an employee stock purchase plan pursuant to Section 423 of the Code or to obtain qualification or registration of the Common Stock under applicable federal, state or foreign securities laws, and (iii) any amendment must be approved by the stockholders of the Company in accordance with Section 2 above within twelve (12) months of the adoption of such amendment (or earlier if required by Section 22) if such amendment would:

(a) increase the number of shares that may be issued under this Plan;

(b) change the designation of the employees (or class of employees) eligible for participation in this Plan; or

(c) any other action taken by the Board that, by its terms, is contingent on stockholder approval.

Notwithstanding the foregoing, the Board may make such amendments to this Plan as the Board determines to be advisable, if the continuation of this Plan or any Offering Period would result in financial accounting treatment for this Plan that is different from the financial accounting treatment in effect on the Effective Date.

AMENDMENT NO. 3
TO THE
MOLINA HEALTHCARE, INC.
AMENDED AND RESTATED DEFERRED COMPENSATION PLAN (2013)

WHEREAS, Molina Healthcare, Inc., a Delaware corporation ("Company"), has previously adopted the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013), as amended by Amendments No. 1 and No. 2 to the Amended and Restated Deferred Compensation Plan executed on November 14, 2013 and October 29, 2014 respectively ("Plan") for the benefit of a select group of employees of the Company;

WHEREAS, the Company desires to amend the Plan to (1) permit daily changes in the notional asset value of Participant Accounts, effective as of September 1, 2016 (or as soon as administratively practicable thereafter); (2) replace the $5,000 minimum dollar deferral of combined base salary and bonus pay with a minimum deferral of 3% of base salary and bonus pay effective for Plan Years commencing after the date of adoption of the Plan amendment; and (3) reduce the maximum base salary deferral from 100% to 75% effective for Plan Years commencing after the date of adoption of the Plan amendment;

WHEREAS, Section 7.1 of the Plan permits the Company to amend the Plan; and

WHEREAS, the Board of Directors of the Company has approved this Amendment and authorized and directed the appropriate officers of the Company to execute this Amendment and to take such other actions as they deem necessary or appropriate to implement this Amendment.

NOW, THEREFORE, the Plan is amended as follows effective as set forth herein:

1. Effective for Plan Years commencing on or after January 1, 2017, Section 2.3.b. is deleted in its entirety and replaced in its stead with the following:

    b. A Participant must provide a separate Written Election for each subsequent Plan Year that specifies the percentage of Plan Year Compensation that Participant has determined to defer for each such Plan Year. Such Written Election is only effective for the Plan Year for which the election is made and if no Written Election to defer Plan Year Compensation is executed in relation to a subsequent Plan Year, no Plan Year Compensation will be deferred for such subsequent Plan Year. Any election of the amount of Plan Year Compensation to defer for a given Plan Year shall be irrevocable on and after the first day of the Plan Year for which the election was made.

2. Effective as of September 1, 2016, Section 2.3.c. is deleted in its entirety and replaced in its stead with the following:

    c. A Participant may change the investment vehicle(s) in which the Participant desires to have that portion of the Participant's Account attributable to Plan Year Compensation and investment income invested and the percentage of the Participant's Account allocated to each investment vehicle by completing and

submitting any form or forms required by the Company. Changes in investment vehicle(s) will be made as of the applicable business day (or as soon as practicable thereafter) following the date that the change is requested.

3. Effective for Plan Years commencing on or after January 1, 2017, Section 3.1 is deleted in its entirety and replaced in its stead with the following:

3.1. Participant Contributions. A Participant may elect to defer a portion of (i) up to 75% of Plan Year Compensation constituting base pay and (ii) up to 100% of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay). For a Participant's initial Plan Year of participation, the minimum deferral percentage for base pay and bonus pay must be 3% for each such component. For succeeding years of participation, a Participant may not defer an amount less than the minimum percentage established from year to year by the Plan Committee. A written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of Plan Year Compensation constituting base pay the Participant has chosen to defer. A separate written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay) the employee has chosen to defer. Once a Participant's contributions for a Plan Year reach the Participant's elected percentage, such Participant shall not be allowed to defer additional portions of such Participant's Plan Year Compensation for the remainder of the Plan Year. Any amounts in excess of the Participant's elected percentage inadvertently deferred shall be refunded to the Participant as soon as practicable.

4. Effective as of September 1, 2016, Section 3.5 is deleted in its entirety and replaced in its stead with the following:

3.5. Credited Earnings. The Account of each Participant (which includes such Participant's Participant Deferral Account established under Section 3.1 and such Participant's Company Contribution Account established under Section 3.2) shall be credited as of each applicable business day with the actual earnings on the investments allocated to the Participant's Account.

IN WITNESS WHEREOF, this Amendment is executed this 8th day of August, 2016.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chief Executive Officer

Molina Healthcare, Inc. 2011 Equity Incentive Plan*

1. ESTABLISHMENT, PURPOSE AND TERM OF PLAN.

1.1 **Establishment.** The Molina Healthcare, Inc. 2011 Equity Incentive Plan (the *"**Plan**"*) is hereby established effective as of April 27, 2011, the date of its approval by the stockholders of the Company (the *"**Effective Date**"*).

1.2 **Purpose.** The purpose of the Plan is to advance the interests of the Participating Company Group and its stockholders by providing an incentive to attract, retain and reward persons performing services for the Participating Company Group and by motivating such persons to contribute to the growth and profitability of the Participating Company Group. The Plan seeks to achieve this purpose by providing for Awards in the form of Options, Stock Appreciation Rights, Restricted Stock Purchase Rights, Restricted Stock Bonuses, Restricted Stock Units, Performance Shares, Performance Units, Cash-Based Awards and Other Stock-Based Awards.

1.3 **Term of Plan.** The Plan shall continue in effect until its termination by the Committee; provided, however, that all Awards shall be granted, if at all, within ten (10) years from the Effective Date.

2. DEFINITIONS AND CONSTRUCTION.

2.1 **Definitions.** Whenever used herein, the following terms shall have their respective meanings set forth below:

(a) *"**Affiliate**"* means (i) a parent entity, other than a Parent Corporation, that directly, or indirectly through one or more intermediary entities, controls the Company or (ii) a subsidiary entity, other than a Subsidiary Corporation, that is controlled by the Company directly or indirectly through one or more intermediary entities. For this purpose, the terms "parent," "subsidiary," "control" and "controlled by" shall have the meanings assigned such terms for the purposes of registration of securities on Form S-8 under the Securities Act.

(b) *"**Award**"* means any Option, Stock Appreciation Right, Restricted Stock Purchase Right, Restricted Stock Bonus, Restricted Stock Unit, Performance Share, Performance Unit, Cash-Based Award or Other Stock-Based Award granted under the Plan.

(c) *"**Award Agreement**"* means a written or electronic agreement between the Company and a Participant setting forth the terms, conditions and restrictions applicable to an Award.

(d) *"**Board**"* means the Board of Directors of the Company.

(e) *"**Cash-Based Award**"* means an Award denominated in cash and granted pursuant to Section 11.

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* As amended as of October 25, 2016.

(f) *"**Cause**"* means, unless such term or an equivalent term is otherwise defined by the applicable Award Agreement or other written agreement between a Participant and a Participating Company applicable to an Award, any of the following: (i) the Participant's theft, dishonesty, willful misconduct, breach of fiduciary duty for personal profit, or falsification of any Participating Company documents or records; (ii) the Participant's material failure to abide by a Participating Company's code of conduct or other policies (including, without limitation, policies relating to confidentiality and reasonable workplace conduct); (iii) the Participant's unauthorized use, misappropriation, destruction or diversion of any tangible or intangible asset or corporate opportunity of a Participating Company (including, without limitation, the Participant's improper use or disclosure of a Participating Company's confidential or proprietary information); (iv) any intentional act by the Participant which has a material detrimental effect on a Participating Company's reputation or business; (v) the Participant's repeated failure or inability to perform any reasonable assigned duties after written notice from a Participating Company of, and a reasonable opportunity to cure, such failure or inability; (vi) any material breach by the Participant of any employment, service, non-disclosure, non-competition, non-solicitation or other similar agreement between the Participant and a Participating Company, which breach is not cured pursuant to the terms of such agreement; or (vii) the Participant's conviction (including any plea of guilty or *nolo contendere*) of any criminal act involving fraud, dishonesty, misappropriation or moral turpitude, or which impairs the Participant's ability to perform his or her duties with a Participating Company.

(g) *"**Change in Control**"* means, unless such term or an equivalent term is otherwise defined by the applicable Award Agreement or other written agreement between the Participant and a Participating Company applicable to an Award, the occurrence of any of the following:

(i) any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) becomes the "beneficial owner" (as such term is defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent (50%) of the total Fair Market Value or total combined voting power of the Company's then-outstanding securities entitled to vote generally in the election of Directors; provided, however, that a Change in Control shall not be deemed to have occurred if such degree of beneficial ownership results from any of the following: (A) an acquisition by any person who on the Effective Date is the beneficial owner of more than fifty percent (50%) of such voting power, (B) any acquisition directly from the Company, including, without limitation, pursuant to or in connection with a public offering of securities, (C) any acquisition by the Company, (D) any acquisition by a trustee or other fiduciary under an employee benefit plan of a Participating Company or (E) any acquisition by an entity owned directly or indirectly by the stockholders of the Company in substantially the same proportions as their ownership of the voting securities of the Company; or

(ii) an Ownership Change Event or series of related Ownership Change Events (collectively, a *"**Transaction**"*) in which the stockholders of the Company immediately before the Transaction do not retain immediately after the Transaction direct or indirect beneficial ownership of more than fifty percent (50%) of the total combined voting power of the outstanding securities entitled to vote generally in the election of Directors or, in the case of an Ownership Change Event described in Section 2.1(cc)(iii), the entity to which the assets of the Company were transferred (the *"**Transferee**"*), as the case may be; or

(iii) approval by the stockholders of a plan of complete liquidation or dissolution of the Company;

provided, however, that a Change in Control shall be deemed not to include a transaction described in subsections (i) or (ii) of this Section 2.1(g) in which a majority of the members of the board of directors of the continuing, surviving or successor entity, or parent thereof, immediately after such transaction is comprised of Incumbent Directors.

For purposes of the preceding sentence, indirect beneficial ownership shall include, without limitation, an interest resulting from ownership of the voting securities of one or more corporations or other business entities which own the Company or the Transferee, as the case may be, either directly or through one or more subsidiary corporations or other business entities. The Committee shall determine whether multiple sales or exchanges of the voting securities of the Company or multiple Ownership Change Events are related, and its determination shall be final, binding and conclusive.

(h) *"**Code**"* means the Internal Revenue Code of 1986, as amended, and any applicable regulations or administrative guidelines promulgated thereunder.

(i) *"**Committee**"* means the Compensation Committee and such other committee or subcommittee of the Board, if any, duly appointed to administer the Plan and having such powers in each instance as shall be specified by the Board. If, at any time, there is no committee of the Board then authorized or properly constituted to administer the Plan, the Board shall exercise all of the powers of the Committee granted herein, and, in any event, the Board may in its discretion exercise any or all of such powers.

(j) *"**Company**"* means Molina Healthcare, Inc., a Delaware corporation, or any successor corporation thereto.

(k) *"**Consultant**"* means a person engaged to provide consulting or advisory services (other than as an Employee or a member of the Board) to a Participating Company, provided that the identity of such person, the nature of such services or the entity to which such services are provided would not preclude the Company from offering or selling securities to such person pursuant to the Plan in reliance on registration on Form S-8 under the Securities Act.

(l) "***Covered Employee***" means, at any time the Plan is subject to Section 162(m), any Employee who is or may reasonably be expected to become a "covered employee" as defined in Section 162(m), or any successor statute, and who is designated, either as an individual Employee or a member of a class of Employees, by the Committee no later than the earlier of (i) the date that is ninety (90) days after the beginning of the Performance Period, or (ii) the date on which twenty-five percent (25%) of the Performance Period has elapsed, as a "Covered Employee" under this Plan for such applicable Performance Period.

(m) *"**Director**"* means a member of the Board.

(n) *"**Disability**"* means the permanent and total disability of the Participant, within the meaning of Section 22(e)(3) of the Code.

(o) *"**Dividend Equivalent Right**"* means the right of a Participant, granted at the discretion of the Committee or as otherwise provided by the Plan, to receive a credit for the account of such Participant in an amount equal to the cash dividends paid on one share of Stock for each share of Stock represented by an Award held by such Participant.

(p) *"**Employee**"* means any person treated as an employee (including an Officer or a member of the Board who is also treated as an employee) in the records of a Participating Company and, with respect to any Incentive Stock Option granted to such person, who is an employee for purposes of Section 422 of the Code; provided, however, that neither service as a member of the Board nor payment of a director's fee shall be sufficient to constitute employment for purposes of the Plan. The Company shall determine in good faith and in the exercise of its discretion whether an individual has become or has ceased to be an Employee and the effective date of such individual's employment or termination of employment, as the case may be. For purposes of an individual's rights, if any, under the terms of the Plan as of the time of the Company's determination of whether or not the individual is an Employee, all such determinations by the Company shall be final, binding and conclusive as to such rights, if any, notwithstanding that the Company or any court of law or governmental agency subsequently makes a contrary determination as to such individual's status as an Employee.

(q) *"**Exchange Act**"* means the Securities Exchange Act of 1934, as amended.

(r) *"**Fair Market Value**"* means, as of any date, the value of a share of Stock or other property as determined by the Committee, in its discretion, or by the Company, in its discretion, if such determination is expressly allocated to the Company herein, subject to the following:

(i) Except as otherwise determined by the Committee, if, on such date, the Stock is listed or quoted on a national or regional securities exchange or quotation system, the Fair Market Value of a share of Stock shall be the closing price of a share of Stock as quoted on the national or regional securities exchange or quotation system constituting the primary market for the Stock, as reported in *The Wall Street Journal* or such other source as the Company deems reliable. If the relevant date does not fall on a day on which the Stock has traded on such securities exchange or quotation system, the date on which the Fair Market Value shall be established shall be the last day on which the Stock was so traded or quoted prior to the relevant date, or such other appropriate day as shall be determined by the Committee, in its discretion.

(ii) Notwithstanding the foregoing, the Committee may, in its discretion, determine the Fair Market Value of a share of Stock on the basis of the opening, closing, or average of the high and low sale prices of a share of Stock on such date or the preceding trading day, the actual sale price of a share of Stock received by a Participant, any other reasonable basis using actual transactions in the Stock as reported on a national or regional securities exchange or quotation system, or on any other basis consistent with the requirements of Section 409A. The Committee may vary its method of determination of the Fair Market Value as provided in this Section for different purposes under the Plan to the extent consistent with the requirements of Section 409A.

(iii) If, on such date, the Stock is not listed or quoted on a national or regional securities exchange or quotation system, the Fair Market Value of a share of Stock shall be as determined by the Committee in good faith without regard to any restriction other than a restriction which, by its terms, will never lapse, and in a manner consistent with the requirements of Section 409A.

(s) *"**Full Value Award**"* means any Award settled in Stock, other than (i) an Option, (ii) a Stock Appreciation Right, or (iii) a Restricted Stock Purchase Right or an Other Stock-Based Award under which the Company will receive monetary consideration equal to the Fair Market Value (determined on the effective date of grant) of the shares subject to such Award.

(t) *"**Incentive Stock Option**"* means an Option intended to be (as set forth in the Award Agreement) and which qualifies as an incentive stock option within the meaning of Section 422(b) of the Code.

(u) *"**Incumbent Director**"* means a director who either (i) is a member of the Board as of the Effective Date or (ii) is elected, or nominated for election, to the Board with the affirmative votes of at least a majority of the Incumbent Directors at the time of such election or nomination (but excluding a director who was elected or nominated in connection with an actual or threatened proxy contest relating to the election of directors of the Company).

(v) *"**Insider**"* means an Officer, Director or any other person whose transactions in Stock are subject to Section 16 of the Exchange Act.

(w) *"**Net Exercise**"* means a procedure pursuant to which (i) the Company will reduce the number of shares otherwise issuable to a Participant upon the exercise of an Option by the largest whole number of shares having a Fair Market Value that does not exceed the aggregate exercise price for the shares with respect to which the Option is exercised, and (ii) the Participant shall pay to the Company in cash the remaining balance of such aggregate exercise price not satisfied by such reduction in the number of whole shares to be issued.

(x) *"**Nonemployee Director**"* means a Director who is not an Employee.

(y) *"**Nonstatutory Stock Option**"* means an Option not intended to be (as set forth in the Award Agreement) or which does not qualify as an incentive stock option within the meaning of Section 422(b) of the Code.

(z) *"**Officer**"* means any person designated by the Board as an officer of the Company.

(aa) *"**Option**"* means an Incentive Stock Option or a Nonstatutory Stock Option granted pursuant to the Plan.

(bb) *"**Other Stock-Based Award**"* means an Award denominated in shares of Stock and granted pursuant to Section 11.

(cc) *"**Ownership Change Event**"* means the occurrence of any of the following with respect to the Company: (i) the direct or indirect sale or exchange in a single or series of related transactions by the stockholders of the Company of securities of the Company representing more than fifty percent (50%) of the total combined voting power of the Company's then-outstanding securities entitled to vote generally in the election of Directors; (ii) a merger or consolidation in which the Company is a party; or (iii) the sale, exchange, or transfer of all or substantially all of the assets of the Company (other than a sale, exchange or transfer to one or more subsidiaries of the Company).

(dd) *"**Parent Corporation**"* means any present or future "parent corporation" of the Company, as defined in Section 424(e) of the Code.

(ee) *"**Participant**"* means any eligible person who has been granted one or more Awards.

(ff) *"**Participating Company**"* means the Company or any Parent Corporation, Subsidiary Corporation or Affiliate.

(gg) *"**Participating Company Group**"* means, at any point in time, the Company and all other entities collectively which are then Participating Companies.

(hh) *"**Performance Award**"* means an Award of Performance Shares or Performance Units.

(ii) *"**Performance Award Formula**"* means, for any Performance Award, a formula or table established by the Committee pursuant to Section 10.3 which provides the basis for computing the value of a Performance Award at one or more levels of attainment of applicable Performance Goal(s) measured as of the end of the applicable Performance Period.

(jj) "***Performance-Based Compensation***" means compensation under an Award that satisfies the requirements of Section 162(m) for certain performance-based compensation paid to Covered Employees.

(kk) *"**Performance Goal**"* means a performance goal established by the Committee pursuant to Section 10.3.

(ll) *"**Performance Period**"* means a period established by the Committee pursuant to Section 10.3 at the end of which one or more Performance Goals are to be measured.

(mm) *"**Performance Share**"* means a right granted to a Participant pursuant to Section 10 to receive a payment equal to the value of a Performance Share, as determined by the Committee, based upon attainment of applicable Performance Goal(s).

(nn) *"**Performance Unit**"* means a right granted to a Participant pursuant to Section 10 to receive a payment equal to the value of a Performance Unit, as determined by the Committee, based upon attainment of applicable Performance Goal(s).

(oo) *"**Restricted Stock Award**"* means an Award of a Restricted Stock Bonus or a Restricted Stock Purchase Right.

(pp) *"**Restricted Stock Bonus**"* means Stock granted to a Participant pursuant to Section 8.

(qq) *"**Restricted Stock Purchase Right**"* means a right to purchase Stock granted to a Participant pursuant to Section 8.

(rr) *"**Restricted Stock Unit**"* means a right granted to a Participant pursuant to Section 9 to receive on a future date or event a share of Stock or cash in lieu thereof, as determined by the Committee.

(ss) *"**Rule 16b-3**"* means Rule 16b-3 under the Exchange Act, as amended from time to time, or any successor rule or regulation.

(tt) *"**SAR**"* or *"**Stock Appreciation Right**"* means a right granted to a Participant pursuant to Section 7 to receive payment, for each share of Stock subject to such Award, of an amount equal to the excess, if any, of the Fair Market Value of a share of Stock on the date of exercise of the Award over the exercise price thereof.

(uu) *"**Section 162(m)**"* means Section 162(m) of the Code.

(vv) *"**Section 409A**"* means Section 409A of the Code.

(ww) *"**Section 409A Deferred Compensation**"* means compensation provided pursuant to an Award that constitutes nonqualified deferred compensation within the meaning of Section 409A.

(xx) *"**Securities Act**"* means the Securities Act of 1933, as amended.

(yy) *"**Service**"* means a Participant's employment or service with the Participating Company Group, whether as an Employee, a Director or a Consultant. Unless otherwise provided by the Committee, a Participant's Service shall not be deemed to have terminated merely because of a change in the capacity in which the Participant renders such Service or a change in the Participating Company for which the Participant renders such Service, provided that there is no interruption or termination of the Participant's Service. Furthermore, a Participant's Service shall not be deemed to have been interrupted or terminated if the Participant takes any military leave, sick leave, or other bona fide leave of absence approved by the Company. However, unless otherwise provided by the Committee, if any such leave taken by a Participant exceeds ninety (90) days, then on the ninety-first (91st) day following the commencement of such leave the Participant's Service shall be deemed to have terminated, unless the Participant's right to return to Service is guaranteed by statute or contract. Notwithstanding the foregoing, unless otherwise designated by the Company or required by law, an unpaid leave of absence shall not be treated as Service for purposes of determining vesting under the Participant's Award Agreement. A Participant's Service shall be deemed to have terminated either upon an actual termination of Service or upon the business entity for which the Participant performs Service ceasing to be a Participating Company. Subject

to the foregoing, the Company, in its discretion, shall determine whether the Participant's Service has terminated and the effective date of such termination.

(zz) *"**Stock**"* means the common stock of the Company, as adjusted from time to time in accordance with Section 4.2.

(aaa) *"**Subsidiary Corporation**"* means any present or future "subsidiary corporation" of the Company, as defined in Section 424(f) of the Code.

(bbb) *"**Ten Percent Owner**"* means a Participant who, at the time an Option is granted to the Participant, owns stock possessing more than ten percent (10%) of the total combined voting power of all classes of stock of a Participating Company (other than an Affiliate) within the meaning of Section 422(b)(6) of the Code.

(ccc) *"**Trading Compliance Policy**"* means the written policy of the Company pertaining to the purchase, sale, transfer or other disposition of the Company's equity securities by Directors, Officers, Employees or other service providers who may possess material, nonpublic information regarding the Company or its securities.

(ddd) *"**Vesting Conditions**"* mean those conditions established in accordance with the Plan prior to the satisfaction of which shares subject to an Award remain subject to forfeiture or a repurchase option in favor of the Company exercisable for the Participant's monetary purchase price, if any, for such shares upon the Participant's termination of Service.

2.2 **Construction.** Captions and titles contained herein are for convenience only and shall not affect the meaning or interpretation of any provision of the Plan. Except when otherwise indicated by the context, the singular shall include the plural and the plural shall include the singular. Use of the term "or" is not intended to be exclusive, unless the context clearly requires otherwise.

3. ADMINISTRATION.

3.1 **Administration by the Committee.** The Plan shall be administered by the Committee. All questions of interpretation of the Plan, of any Award Agreement or of any other form of agreement or other document employed by the Company in the administration of the Plan or of any Award shall be determined by the Committee, and such determinations shall be final, binding and conclusive upon all persons having an interest in the Plan or such Award, unless fraudulent or made in bad faith. Any and all actions, decisions and determinations taken or made by the Committee in the exercise of its discretion pursuant to the Plan or Award Agreement or other agreement thereunder (other than determining questions of interpretation pursuant to the preceding sentence) shall be final, binding and conclusive upon all persons having an interest therein. All expenses incurred in the administration of the Plan shall be paid by the Company.

3.2 **Authority of Officers.** Any Officer shall have the authority to act on behalf of the Company with respect to any matter, right, obligation, determination or election which is the responsibility of or which is allocated to the Company herein, provided the Officer has apparent authority with respect to such matter, right, obligation, determination or election. To the extent permitted by applicable law, the Committee may, in its discretion, delegate to a committee comprised

of one or more Officers the authority to grant one or more Awards, without further approval of the Committee, to any Employee, other than a person who, at the time of such grant, is an Insider or a Covered Employee, and to exercise such other powers under the Plan as the Committee may determine; provided, however, that (a) the Committee shall fix the maximum number of shares subject to Awards that may be granted by such Officers, (b) each such Award shall be subject to the terms and conditions of the appropriate standard form of Award Agreement approved by the Board or the Committee and shall conform to the provisions of the Plan, and (c) each such Award shall conform to such other limits and guidelines as may be established from time to time by the Committee.

3.3 **Administration with Respect to Insiders.** With respect to participation by Insiders in the Plan, at any time that any class of equity security of the Company is registered pursuant to Section 12 of the Exchange Act, the Plan shall be administered in compliance with the requirements, if any, of Rule 16b-3.

3.4 **Committee Complying with Section 162(m).** If the Company is a "publicly held corporation" within the meaning of Section 162(m), the Board may establish a Committee of "outside directors" within the meaning of Section 162 (m) to approve the grant of any Award intended to result in the payment of Performance-Based Compensation.

3.5 **Powers of the Committee.** In addition to any other powers set forth in the Plan and subject to the provisions of the Plan, the Committee shall have the full and final power and authority, in its discretion:

(a) to determine the persons to whom, and the time or times at which, Awards shall be granted and the number of shares of Stock, units or monetary value to be subject to each Award;

(b) to determine the type of Award granted;

(c) to determine the Fair Market Value of shares of Stock or other property;

(d) to determine the terms, conditions and restrictions applicable to each Award (which need not be identical) and any shares acquired pursuant thereto, including, without limitation, (i) the exercise or purchase price of shares pursuant to any Award, (ii) the method of payment for shares purchased pursuant to any Award, (iii) the method for satisfaction of any tax withholding obligation arising in connection with any Award, including by the withholding or delivery of shares of Stock, (iv) the timing, terms and conditions of the exercisability or vesting of any Award or any shares acquired pursuant thereto, (v) the Performance Measures, Performance Period, Performance Award Formula and Performance Goals applicable to any Award and the extent to which such Performance Goals have been attained, (vi) the time of the expiration of any Award, (vii) the effect of the Participant's termination of Service on any of the foregoing, and (viii) all other terms, conditions and restrictions applicable to any Award or shares acquired pursuant thereto not inconsistent with the terms of the Plan;

(e) to determine whether an Award will be settled in shares of Stock, cash, other property, or in any combination thereof;

(f) to approve one or more forms of Award Agreement;

(g) to amend, modify, extend, cancel or renew any Award or to waive any restrictions or conditions applicable to any Award or any shares acquired pursuant thereto;

(h) to accelerate, continue, extend or defer the exercisability or vesting of any Award or any shares acquired pursuant thereto, including with respect to the period following a Participant's termination of Service;

(i) to prescribe, amend or rescind rules, guidelines and policies relating to the Plan, or to adopt sub-plans or supplements to, or alternative versions of, the Plan, including, without limitation, as the Committee deems necessary or desirable to comply with the laws or regulations of or to accommodate the tax policy, accounting principles or custom of, foreign jurisdictions whose citizens may be granted Awards; and

(j) to correct any defect, supply any omission or reconcile any inconsistency in the Plan or any Award Agreement and to make all other determinations and take such other actions with respect to the Plan or any Award as the Committee may deem advisable to the extent not inconsistent with the provisions of the Plan or applicable law.

3.6 **Option or SAR Repricing.** Without the affirmative vote of holders of a majority of the shares of Stock cast in person or by proxy at a meeting of the stockholders of the Company at which a quorum representing a majority of all outstanding shares of Stock is present or represented by proxy, the Committee shall not approve a program providing for either (a) the cancellation of outstanding Options or SARs having exercise prices per share greater than the then Fair Market Value of a share of Stock (*"**Underwater Awards**"*) and the grant in substitution therefore of new Options or SARs having a lower exercise price, Full Value Awards or payments in cash, or (b) the amendment of outstanding Underwater Awards to reduce the exercise price thereof. This Section shall not apply to adjustments pursuant to the assumption of or substitution for an Option or SAR in a manner that would comply with Section 424(a) or Section 409A of the Code or to an adjustment pursuant to Section 4.2.

3.7 **Indemnification.** In addition to such other rights of indemnification as they may have as members of the Board or the Committee or as officers or employees of the Participating Company Group, members of the Board or the Committee and any officers or employees of the Participating Company Group to whom authority to act for the Board, the Committee or the Company is delegated shall be indemnified by the Company against all reasonable expenses, including attorneys' fees, actually and necessarily incurred in connection with the defense of any action, suit or proceeding, or in connection with any appeal therein, to which they or any of them may be a party by reason of any action taken or failure to act under or in connection with the Plan, or any right granted hereunder, and against all amounts paid by them in settlement thereof (provided such settlement is approved by independent legal counsel selected by the Company) or paid by them in satisfaction of a judgment in any such action, suit or proceeding, except in relation to matters as to which it shall be adjudged in such action, suit or proceeding that such person is liable for gross negligence, bad faith or intentional misconduct in duties; provided, however, that within sixty (60)

days after the institution of such action, suit or proceeding, such person shall offer to the Company, in writing, the opportunity at its own expense to handle and defend the same.

4. SHARES SUBJECT TO PLAN.

4.1 **Maximum Number of Shares Issuable.** Subject to adjustment as provided in Section 4.2, the maximum aggregate number of shares of Stock that may be issued under the Plan shall be four million five hundred thousand (4,500,000) and shall consist of authorized but unissued shares of Stock, and the shares of Stock underlying any Awards which are reacquired by the Company, forfeited, or cancelled, satisfied without the issuance of Stock, or otherwise terminated (other than by exercise) without the issuance of Stock, or any combination thereof.

4.2 **Adjustments for Changes in Capital Structure.** Subject to any required action by the stockholders of the Company and the requirements of Sections 409A and 424 of the Code to the extent applicable, in the event of any change in the Stock effected without receipt of consideration by the Company, whether through merger, consolidation, reorganization, reincorporation, recapitalization, reclassification, stock dividend, stock split, reverse stock split, split-up, split-off, spin-off, combination of shares, exchange of shares, or similar change in the capital structure of the Company, or in the event of payment of a dividend or distribution to the stockholders of the Company in a form other than Stock (excepting regular, periodic cash dividends) that has a material effect on the Fair Market Value of shares of Stock, appropriate and proportionate adjustments shall be made in the number and kind of shares subject to the Plan and to any outstanding Awards, in the Award limits set forth in Section 5.3 and in the exercise or purchase price per share under any outstanding Award in order to prevent dilution or enlargement of Participants' rights under the Plan. For purposes of the foregoing, conversion of any convertible securities of the Company shall not be treated as "effected without receipt of consideration by the Company." If a majority of the shares which are of the same class as the shares that are subject to outstanding Awards are exchanged for, converted into, or otherwise become (whether or not pursuant to an Ownership Change Event) shares of another corporation (the *"**New Shares**"*), the Committee may unilaterally amend the outstanding Awards to provide that such Awards are for New Shares. In the event of any such amendment, the number of shares subject to, and the exercise or purchase price per share of, the outstanding Awards shall be adjusted in a fair and equitable manner as determined by the Committee, in its discretion. Any fractional share resulting from an adjustment pursuant to this Section shall be rounded down to the nearest whole number, and in no event may the exercise or purchase price under any Award be decreased to an amount less than the par value, if any, of the stock subject to such Award. The Committee in its discretion, may also make such adjustments in the terms of any Award to reflect, or related to, such changes in the capital structure of the Company or distributions as it deems appropriate, including modification of Performance Goals, Performance Award Formulas and Performance Periods. The adjustments determined by the Committee pursuant to this Section shall be final, binding and conclusive.

4.3 **Assumption or Substitution of Awards.** The Committee may, without affecting the number of shares of Stock available pursuant to Section 4.1, authorize the issuance or assumption of benefits under this Plan in connection with any merger, consolidation, acquisition of property or stock, or reorganization upon such terms and conditions as it may deem appropriate, subject to compliance with Section 409A and any other applicable provisions of the Code.

5. **ELIGIBILITY, PARTICIPATION AND AWARD LIMITATIONS.**

5.1 **Persons Eligible for Awards.** Awards may be granted only to Employees, Consultants and Directors.

5.2 **Participation in the Plan.** Awards are granted solely at the discretion of the Committee. Eligible persons may be granted more than one Award. However, eligibility in accordance with this Section shall not entitle any person to be granted an Award, or, having been granted an Award, to be granted an additional Award.

5.3 **Award Limitations.**

(a) ***Incentive Stock Option Limitations.***

(i) **Maximum Number of Shares Issuable Pursuant to Incentive Stock Options.** Subject to adjustment as provided in Section 4.2, the maximum aggregate number of shares of Stock that may be issued under the Plan pursuant to the exercise of Incentive Stock Options shall not exceed four million five hundred thousand (4,500,000). The maximum aggregate number of shares of Stock that may be issued under the Plan pursuant to all Awards other than Incentive Stock Options shall be the number of shares determined in accordance with Section 4.1.

(ii) **Persons Eligible.** An Incentive Stock Option may be granted only to a person who, on the effective date of grant, is an Employee of the Company, a Parent Corporation or a Subsidiary Corporation (each being an *"**ISO-Qualifying Corporation**"*). Any person who is not an Employee of an ISO-Qualifying Corporation on the effective date of the grant of an Option to such person may be granted only a Nonstatutory Stock Option.

(iii) **Fair Market Value Limitation.** To the extent that options designated as Incentive Stock Options (granted under all stock option plans of the Participating Company Group, including the Plan) become exercisable by a Participant for the first time during any calendar year for stock having a Fair Market Value greater than One Hundred Thousand Dollars ($100,000), the portion of such options which exceeds such amount shall be treated as Nonstatutory Stock Options. For purposes of this Section, options designated as Incentive Stock Options shall be taken into account in the order in which they were granted, and the Fair Market Value of stock shall be determined as of the time the option with respect to such stock is granted. If the Code is amended to provide for a limitation different from that set forth in this Section, such different limitation shall be deemed incorporated herein effective as of the date and with respect to such Options as required or permitted by such amendment to the Code. If an Option is treated as an Incentive Stock Option in part and as a Nonstatutory Stock Option in part by reason of the limitation set forth in this Section, the Participant may designate which portion of such Option the Participant is exercising. In the absence of such designation, the Participant shall be deemed to have exercised the Incentive Stock Option portion of the Option first. Upon exercise, shares issued pursuant to each such portion shall be separately identified.

(b) ***Section 162(m) Award Limits.*** Subject to adjustment as provided in Section 4.2, no Employee shall be granted within any fiscal year of the Company one or more Awards

intended to qualify for treatment as Performance-Based Compensation which in the aggregate are for more than seven hundred and fifty thousand (750,000) shares.

6. **STOCK OPTIONS.**

Options shall be evidenced by Award Agreements specifying the number of shares of Stock covered thereby, in such form as the Committee shall from time to time establish. Award Agreements evidencing Options may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

6.1 **Exercise Price.** The exercise price for each Option shall be established in the discretion of the Committee; provided, however, that (a) the exercise price per share shall be not less than the Fair Market Value of a share of Stock on the effective date of grant of the Option and (b) no Incentive Stock Option granted to a Ten Percent Owner shall have an exercise price per share less than one hundred ten percent (110%) of the Fair Market Value of a share of Stock on the effective date of grant of the Option. Notwithstanding the foregoing, an Option (whether an Incentive Stock Option or a Nonstatutory Stock Option) may be granted with an exercise price lower than the minimum exercise price set forth above if such Option is granted pursuant to an assumption or substitution for another option in a manner that would qualify under the provisions of Section 409A or 424(a) of the Code.

6.2 **Exercisability and Term of Options.** Options shall be exercisable at such time or times, or upon such event or events, and subject to such terms, conditions, performance criteria and restrictions as shall be determined by the Committee and set forth in the Award Agreement evidencing such Option; provided, however, that (a) no Option shall be exercisable after the expiration of ten (10) years after the effective date of grant of such Option, (b) no Incentive Stock Option granted to a Ten Percent Owner shall be exercisable after the expiration of five (5) years after the effective date of grant of such Option and (c) no Option granted to an Employee who is a non-exempt employee for purposes of the Fair Labor Standards Act of 1938, as amended, shall be first exercisable until at least six (6) months following the date of grant of such Option (except in the event of such Employee's death, disability or retirement, upon a Change in Control, or as otherwise permitted by the Worker Economic Opportunity Act). Subject to the foregoing, unless otherwise specified by the Committee in the grant of an Option, each Option shall terminate ten (10) years after the effective date of grant of the Option, unless earlier terminated in accordance with its provisions.

6.3 **Payment of Exercise Price.**

(a) ***Forms of Consideration Authorized.*** Except as otherwise provided below, payment of the exercise price for the number of shares of Stock being purchased pursuant to any Option shall be made (i) in cash, by check or in cash equivalent, (ii) by tender to the Company, or attestation to the ownership, of shares of Stock owned by the Participant having a Fair Market Value not less than the exercise price (a *"**Stock Tender Exercise**"*), (iii) by delivery of a properly executed notice of exercise together with irrevocable instructions to a broker providing for the assignment to the Company of the proceeds of a sale or loan with respect to some or all of the shares being acquired upon the exercise of the Option (including, without limitation, through an exercise complying with the provisions of Regulation T as promulgated from time to time by the Board of

Governors of the Federal Reserve System) (a *"**Cashless Exercise**"*), (iv) by delivery of a properly executed notice electing a Net Exercise, (v) by such other consideration as may be approved by the Committee from time to time to the extent permitted by applicable law, or (vi) by any combination thereof. The Committee may at any time or from time to time grant Options which do not permit all of the foregoing forms of consideration to be used in payment of the exercise price or which otherwise restrict one or more forms of consideration.

(b) ***Limitations on Forms of Consideration.***

(i) **Stock Tender Exercise.** Notwithstanding the foregoing, a Stock Tender Exercise shall not be permitted if it would constitute a violation of the provisions of any law, regulation or agreement restricting the redemption of the Company's stock. If required by the Company, an Option may not be exercised by tender to the Company, or attestation to the ownership, of shares of Stock unless such shares either have been owned by the Participant for a period of time required by the Company (and not used for another option exercise by attestation during such period) or were not acquired, directly or indirectly, from the Company.

(ii) **Cashless Exercise.** The Company reserves, at any and all times, the right, in the Company's sole and absolute discretion, to establish, decline to approve or terminate any program or procedures for the exercise of Options by means of a Cashless Exercise, including with respect to one or more Participants specified by the Company notwithstanding that such program or procedures may be available to other Participants.

6.4 **Effect of Termination of Service.**

(a) ***Option Exercisability.*** Subject to earlier termination of the Option as otherwise provided herein and unless otherwise provided by the Committee, an Option shall terminate immediately upon the Participant's termination of Service to the extent that it is then unvested and shall be exercisable after the Participant's termination of Service to the extent it is then vested only during the applicable time period determined in accordance with this Section and thereafter shall terminate.

(i) **Disability.** If the Participant's Service terminates because of the Disability of the Participant, the Option, to the extent unexercised and exercisable for vested shares on the date on which the Participant's Service terminated, may be exercised by the Participant (or the Participant's guardian or legal representative) at any time prior to the expiration of twelve (12) months after the date on which the Participant's Service terminated, but in any event no later than the date of expiration of the Option's term as set forth in the Award Agreement evidencing such Option (the *"**Option Expiration Date**"*).

(ii) **Death.** If the Participant's Service terminates because of the death of the Participant, then (A) the Option, to the extent unexercised and exercisable for vested shares on the date on which the Participant's Service terminated, may be exercised by the Participant's legal representative or other person who acquired the right to exercise the Option by reason of the Participant's death at any time prior to the expiration of twelve (12) months after the date on which the Participant's Service terminated, but in any event no later than the Option Expiration Date, and (B) solely for the purposes of determining the number of vested shares subject to the Option as of

the date on which the Participant's Service terminated, the Participant shall be credited with an additional twelve (12) months of Service. The Participant's Service shall be deemed to have terminated on account of death if the Participant dies within three (3) months after the Participant's termination of Service; provided, however, that the Participant shall not be credited with additional months of Service if the Participant dies after the Participant's Service has otherwise terminated.

(iii) **Termination for Cause.** Notwithstanding any other provision of the Plan to the contrary, if the Participant's Service is terminated for Cause or if, following the Participant's termination of Service and during any period in which the Option otherwise would remain exercisable, the Participant engages in any act that would constitute Cause, the Option shall terminate in its entirety and cease to be exercisable immediately upon such termination of Service or act.

(iv) **Other Termination of Service.** If the Participant's Service terminates for any reason, except Disability, death or Cause, the Option, to the extent unexercised and exercisable for vested shares on the date on which the Participant's Service terminated, may be exercised by the Participant at any time prior to the expiration of three (3) months after the date on which the Participant's Service terminated, but in any event no later than the Option Expiration Date.

(b) ***Extension if Exercise Prevented by Law.*** Notwithstanding the foregoing, other than termination of Service for Cause, if the exercise of an Option within the applicable time periods set forth in Section 6.4(a) is prevented by the provisions of Section 14 below, the Option shall remain exercisable until the later of (i) thirty (30) days after the date such exercise first would no longer be prevented by such provisions or (ii) the end of the applicable time period under Section 6.4 (a), but in any event no later than the Option Expiration Date.

6.5 **Transferability of Options.** During the lifetime of the Participant, an Option shall be exercisable only by the Participant or the Participant's guardian or legal representative. An Option shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. Notwithstanding the foregoing, to the extent permitted by the Committee, in its discretion, and set forth in the Award Agreement evidencing such Option, an Option shall be assignable or transferable subject to the applicable limitations, if any, described in the General Instructions to Form S-8 under the Securities Act or, in the case of an Incentive Stock Option, only as permitted by applicable regulations under Section 421 of the Code in a manner that does not disqualify such Option as an Incentive Stock Option.

7. STOCK APPRECIATION RIGHTS.

Stock Appreciation Rights shall be evidenced by Award Agreements specifying the number of shares of Stock subject to the Award, in such form as the Committee shall from time to time establish. Award Agreements evidencing SARs may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

7.1 **Types of SARs Authorized.** SARs may be granted in tandem with all or any portion of a related Option (a *"**Tandem SAR**"*) or may be granted independently of any Option (a *"**Freestanding SAR**"*). A Tandem SAR may only be granted concurrently with the grant of the related Option.

7.2 **Exercise Price.** The exercise price for each SAR shall be established in the discretion of the Committee; provided, however, that (a) the exercise price per share subject to a Tandem SAR shall be the exercise price per share under the related Option and (b) the exercise price per share subject to a Freestanding SAR shall be not less than the Fair Market Value of a share of Stock on the effective date of grant of the SAR. Notwithstanding the foregoing, a an SAR may be granted with an exercise price lower than the minimum exercise price set forth above if such SAR is granted pursuant to an assumption or substitution for another stock appreciation right in a manner that would qualify under the provisions of Section 409A of the Code.

7.3 **Exercisability and Term of SARs.**

(a) ***Tandem SARs.*** Tandem SARs shall be exercisable only at the time and to the extent, and only to the extent, that the related Option is exercisable, subject to such provisions as the Committee may specify where the Tandem SAR is granted with respect to less than the full number of shares of Stock subject to the related Option. The Committee may, in its discretion, provide in any Award Agreement evidencing a Tandem SAR that such SAR may not be exercised without the advance approval of the Company and, if such approval is not given, then the Option shall nevertheless remain exercisable in accordance with its terms. A Tandem SAR shall terminate and cease to be exercisable no later than the date on which the related Option expires or is terminated or canceled. Upon the exercise of a Tandem SAR with respect to some or all of the shares subject to such SAR, the related Option shall be canceled automatically as to the number of shares with respect to which the Tandem SAR was exercised. Upon the exercise of an Option related to a Tandem SAR as to some or all of the shares subject to such Option, the related Tandem SAR shall be canceled automatically as to the number of shares with respect to which the related Option was exercised.

(b) ***Freestanding SARs.*** Freestanding SARs shall be exercisable at such time or times, or upon such event or events, and subject to such terms, conditions, performance criteria and restrictions as shall be determined by the Committee and set forth in the Award Agreement evidencing such SAR; provided, however, that (i) no Freestanding SAR shall be exercisable after the expiration of ten (10) years after the effective date of grant of such SAR and (b) no Freestanding SAR granted to an Employee who is a non-exempt employee for purposes of the Fair Labor Standards Act of 1938, as amended, shall be first exercisable until at least six (6) months following the date of grant of such SAR (except in the event of such Employee's death, disability or retirement, upon a Change in Control, or as otherwise permitted by the Worker Economic Opportunity Act). Subject to the foregoing, unless otherwise specified by the Committee in the grant of a Freestanding SAR, each Freestanding SAR shall terminate ten (10) years after the effective date of grant of the SAR, unless earlier terminated in accordance with its provisions.

7.4 **Exercise of SARs.** Upon the exercise (or deemed exercise pursuant to Section 7.5) of an SAR, the Participant (or the Participant's legal representative or other person who acquired the right to exercise the SAR by reason of the Participant's death) shall be entitled to receive payment

of an amount for each share with respect to which the SAR is exercised equal to the excess, if any, of the Fair Market Value of a share of Stock on the date of exercise of the SAR over the exercise price. Payment of such amount shall be made (a) in the case of a Tandem SAR, solely in shares of Stock in a lump sum upon the date of exercise of the SAR and (b) in the case of a Freestanding SAR, in cash, shares of Stock, or any combination thereof as determined by the Committee, in a lump sum upon the date of exercise of the SAR. When payment is to be made in shares of Stock, the number of shares to be issued shall be determined on the basis of the Fair Market Value of a share of Stock on the date of exercise of the SAR. For purposes of Section 7, an SAR shall be deemed exercised on the date on which the Company receives notice of exercise from the Participant or as otherwise provided in Section 7.5.

7.5 **Deemed Exercise of SARs.** If, on the date on which an SAR would otherwise terminate or expire, the SAR by its terms remains exercisable immediately prior to such termination or expiration and, if so exercised, would result in a payment to the holder of such SAR, then any portion of such SAR which has not previously been exercised shall automatically be deemed to be exercised as of such date with respect to such portion.

7.6 **Effect of Termination of Service.** Subject to earlier termination of the SAR as otherwise provided herein and unless otherwise provided by the Committee, an SAR shall be exercisable after a Participant's termination of Service only to the extent and during the applicable time period determined in accordance with Section 6.4 (treating the SAR as if it were an Option) and thereafter shall terminate.

7.7 **Transferability of SARs.** During the lifetime of the Participant, an SAR shall be exercisable only by the Participant or the Participant's guardian or legal representative. An SAR shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. Notwithstanding the foregoing, to the extent permitted by the Committee, in its discretion, and set forth in the Award Agreement evidencing such Award, a Tandem SAR related to a Nonstatutory Stock Option or a Freestanding SAR shall be assignable or transferable subject to the applicable limitations, if any, described in the General Instructions to Form S-8 under the Securities Act.

8. RESTRICTED STOCK AWARDS.

Restricted Stock Awards shall be evidenced by Award Agreements specifying whether the Award is a Restricted Stock Bonus or a Restricted Stock Purchase Right and the number of shares of Stock subject to the Award, in such form as the Committee shall from time to time establish. Award Agreements evidencing Restricted Stock Awards may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

8.1 **Types of Restricted Stock Awards Authorized.** Restricted Stock Awards may be granted in the form of either a Restricted Stock Bonus or a Restricted Stock Purchase Right. Restricted Stock Awards may be granted upon such conditions as the Committee shall determine, including, without limitation, upon the attainment of one or more Performance Goals described in Section 10.4. If either the grant of or satisfaction of Vesting Conditions applicable to a Restricted Stock Award is to be contingent upon the attainment of one or more Performance Goals, the

Committee shall follow procedures substantially equivalent to those set forth in Sections 10.3 through 10.5(a).

8.2 **Purchase Price.** The purchase price for shares of Stock issuable under each Restricted Stock Purchase Right shall be established by the Committee in its discretion. No monetary payment (other than applicable tax withholding) shall be required as a condition of receiving shares of Stock pursuant to a Restricted Stock Bonus, the consideration for which shall be services actually rendered to a Participating Company or for its benefit. Notwithstanding the foregoing, if required by applicable state corporate law, the Participant shall furnish consideration in the form of cash or past services rendered to a Participating Company or for its benefit having a value not less than the par value of the shares of Stock subject to a Restricted Stock Award.

8.3 **Purchase Period.** A Restricted Stock Purchase Right shall be exercisable within a period established by the Committee, which shall in no event exceed thirty (30) days from the effective date of the grant of the Restricted Stock Purchase Right.

8.4 **Payment of Purchase Price.** Except as otherwise provided below, payment of the purchase price for the number of shares of Stock being purchased pursuant to any Restricted Stock Purchase Right shall be made (a) in cash, by check or in cash equivalent, (b) by such other consideration as may be approved by the Committee from time to time to the extent permitted by applicable law, or (c) by any combination thereof.

8.5 **Vesting and Restrictions on Transfer.** Shares issued pursuant to any Restricted Stock Award shall be made subject to Vesting Conditions based upon the satisfaction of such Service requirements, conditions, restrictions or performance criteria, including, without limitation, Performance Goals as described in Section 10.4, as shall be established by the Committee and set forth in the Award Agreement evidencing such Award; provided that, with respect to all Restricted Stock Awards other than those made to any Nonemployee Director, (i) the Vesting Conditions for non-performance based Restricted Stock Awards shall provide that the vesting period be at least three years, over which period vesting may be pro-rata in the manner specified in the Award Agreement and (ii) the Vesting Conditions for performance-based Restricted Stock Awards shall provide that the vesting period be at least one year.

During any period in which shares acquired pursuant to a Restricted Stock Award remain subject to Vesting Conditions, such shares may not be sold, exchanged, transferred, pledged, assigned or otherwise disposed of other than pursuant to an Ownership Change Event or as provided in Section 8.8. The Committee, in its discretion, may provide in any Award Agreement evidencing a Restricted Stock Award that, if the satisfaction of Vesting Conditions with respect to any shares subject to such Restricted Stock Award would otherwise occur on a day on which the sale of such shares would violate the provisions of the Trading Compliance Policy, then satisfaction of the Vesting Conditions automatically shall be determined on the next trading day on which the sale of such shares would not violate the Trading Compliance Policy. Upon request by the Company, each Participant shall execute any agreement evidencing such transfer restrictions prior to the receipt of shares of Stock hereunder and shall promptly present to the Company any and all certificates representing shares of Stock acquired hereunder for the placement on such certificates of appropriate legends evidencing any such transfer restrictions.

8.6 **Voting Rights; Dividends and Distributions.** Except as provided in this Section, Section 8.5 and any Award Agreement, during any period in which shares acquired pursuant to a Restricted Stock Award remain subject to Vesting Conditions, the Participant shall have all of the rights of a stockholder of the Company holding shares of Stock, including the right to vote such shares and to receive all dividends and other distributions paid with respect to such shares; provided, however, that if so determined by the Committee and provided by the Award Agreement, such dividends and distributions shall be subject to the same Vesting Conditions as the shares subject to the Restricted Stock Award with respect to which such dividends or distributions were paid, and otherwise shall be paid no later than the end of the calendar year in which such dividends or distributions are paid to stockholders (or, if later, the 15th day of the third month following the date such dividends or distributions are paid to stockholders). In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant is entitled by reason of the Participant's Restricted Stock Award shall be immediately subject to the same Vesting Conditions as the shares subject to the Restricted Stock Award with respect to which such dividends or distributions were paid or adjustments were made.

8.7 **Effect of Termination of Service.** Unless otherwise provided by the Committee in the Award Agreement evidencing a Restricted Stock Award, if a Participant's Service terminates for any reason, whether voluntary or involuntary (including the Participant's death or disability), then (a) the Company shall have the option to repurchase for the purchase price paid by the Participant any shares acquired by the Participant pursuant to a Restricted Stock Purchase Right which remain subject to Vesting Conditions as of the date of the Participant's termination of Service and (b) the Participant shall forfeit to the Company any shares acquired by the Participant pursuant to a Restricted Stock Bonus which remain subject to Vesting Conditions as of the date of the Participant's termination of Service. The Company shall have the right to assign at any time any repurchase right it may have, whether or not such right is then exercisable, to one or more persons as may be selected by the Company.

8.8 **Nontransferability of Restricted Stock Award Rights.** Rights to acquire shares of Stock pursuant to a Restricted Stock Award shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or the laws of descent and distribution. All rights with respect to a Restricted Stock Award granted to a Participant hereunder shall be exercisable during his or her lifetime only by such Participant or the Participant's guardian or legal representative.

9. RESTRICTED STOCK UNIT AWARDS.

Restricted Stock Unit Awards shall be evidenced by Award Agreements specifying the number of Restricted Stock Units subject to the Award, in such form as the Committee shall from time to time establish. Award Agreements evidencing Restricted Stock Units may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

9.1 **Grant of Restricted Stock Unit Awards.** Restricted Stock Unit Awards may be granted upon such conditions as the Committee shall determine, including, without limitation, upon the attainment of one or more Performance Goals described in Section 10.4. If either the grant of a Restricted Stock Unit Award or the Vesting Conditions with respect to such Award is to be contingent upon the attainment of one or more Performance Goals, the Committee shall follow procedures substantially equivalent to those set forth in Sections 10.3 through 10.5(a).

9.2 **Purchase Price.** No monetary payment (other than applicable tax withholding, if any) shall be required as a condition of receiving a Restricted Stock Unit Award, the consideration for which shall be services actually rendered to a Participating Company or for its benefit. Notwithstanding the foregoing, if required by applicable state corporate law, the Participant shall furnish consideration in the form of cash or past services rendered to a Participating Company or for its benefit having a value not less than the par value of the shares of Stock issued upon settlement of the Restricted Stock Unit Award.

9.3 **Vesting.** Restricted Stock Unit Awards may (but need not) be made subject to Vesting Conditions based upon the satisfaction of such Service requirements, conditions, restrictions or performance criteria, including, without limitation, Performance Goals as described in Section 10.4, as shall be established by the Committee and set forth in the Award Agreement evidencing such Award. The Committee, in its discretion, may provide in any Award Agreement evidencing a Restricted Stock Unit Award that, if the satisfaction of Vesting Conditions with respect to any shares subject to the Award would otherwise occur on a day on which the sale of such shares would violate the provisions of the Trading Compliance Policy, then the satisfaction of the Vesting Conditions automatically shall be determined on the first to occur of (a) the next trading day on which the sale of such shares would not violate the Trading Compliance Policy or (b) the later of (i) last day of the calendar year in which the original vesting date occurred or (ii) the last day of the Company's taxable year in which the original vesting date occurred.

9.4 **Voting Rights, Dividend Equivalent Rights and Distributions.** Participants shall have no voting rights with respect to shares of Stock represented by Restricted Stock Units until the date of the issuance of such shares (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). However, the Committee, in its discretion, may provide in the Award Agreement evidencing any Restricted Stock Unit Award that the Participant shall be entitled to Dividend Equivalent Rights with respect to the payment of cash dividends on Stock during the period beginning on the date such Award is granted and ending, with respect to each share subject to the Award, on the earlier of the date the Award is settled or the date on which it is terminated. Such Dividend Equivalent Rights, if any, shall be paid by crediting the Participant with additional whole Restricted Stock Units as of the date of payment of such cash dividends on Stock. The number of additional Restricted Stock Units (rounded to the nearest whole number) to be so credited shall be determined by dividing (a) the amount of cash dividends paid on such date with respect to the number of shares of Stock represented by the Restricted Stock Units previously credited to the Participant by (b) the Fair Market Value per share of Stock on such date. Such additional Restricted Stock Units shall be subject to the same terms and conditions and shall be settled in the same manner and at the same time as the Restricted Stock Units originally subject to the Restricted Stock Unit Award. In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, appropriate adjustments shall be made in the Participant's Restricted

Stock Unit Award so that it represents the right to receive upon settlement any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant would be entitled by reason of the shares of Stock issuable upon settlement of the Award, and all such new, substituted or additional securities or other property shall be immediately subject to the same Vesting Conditions as are applicable to the Award.

9.5 **Effect of Termination of Service.** Unless otherwise provided by the Committee and set forth in the Award Agreement evidencing a Restricted Stock Unit Award, if a Participant's Service terminates for any reason, whether voluntary or involuntary (including the Participant's death or disability), then the Participant shall forfeit to the Company any Restricted Stock Units pursuant to the Award which remain subject to Vesting Conditions as of the date of the Participant's termination of Service.

9.6 **Settlement of Restricted Stock Unit Awards.** The Company shall issue to a Participant on the date on which Restricted Stock Units subject to the Participant's Restricted Stock Unit Award vest or on such other date determined by the Committee, in its discretion, and set forth in the Award Agreement one (1) share of Stock (and/or any other new, substituted or additional securities or other property pursuant to an adjustment described in Section 9.4) for each Restricted Stock Unit then becoming vested or otherwise to be settled on such date, subject to the withholding of applicable taxes, if any. If permitted by the Committee, the Participant may elect, consistent with the requirements of Section 409A, to defer receipt of all or any portion of the shares of Stock or other property otherwise issuable to the Participant pursuant to this Section, and such deferred issuance date(s) and amount(s) elected by the Participant shall be set forth in the Award Agreement. Notwithstanding the foregoing, the Committee, in its discretion, may provide for settlement of any Restricted Stock Unit Award by payment to the Participant in cash of an amount equal to the Fair Market Value on the payment date of the shares of Stock or other property otherwise issuable to the Participant pursuant to this Section.

9.7 **Nontransferability of Restricted Stock Unit Awards.** The right to receive shares pursuant to a Restricted Stock Unit Award shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. All rights with respect to a Restricted Stock Unit Award granted to a Participant hereunder shall be exercisable during his or her lifetime only by such Participant or the Participant's guardian or legal representative.

10. PERFORMANCE AWARDS.

Performance Awards shall be evidenced by Award Agreements in such form as the Committee shall from time to time establish. Award Agreements evidencing Performance Awards may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

10.1 **Types of Performance Awards Authorized.** Performance Awards may be granted in the form of either Performance Shares or Performance Units. Each Award Agreement evidencing a Performance Award shall specify the number of Performance Shares or Performance Units subject

thereto, the Performance Award Formula, the Performance Goal(s) and Performance Period applicable to the Award, and the other terms, conditions and restrictions of the Award.

10.2 **Initial Value of Performance Shares and Performance Units.** Unless otherwise provided by the Committee in granting a Performance Award, each Performance Share shall have an initial monetary value equal to the Fair Market Value of one (1) share of Stock, subject to adjustment as provided in Section 4.2, on the effective date of grant of the Performance Share, and each Performance Unit shall have an initial monetary value established by the Committee at the time of grant. The final value payable to the Participant in settlement of a Performance Award determined on the basis of the applicable Performance Award Formula will depend on the extent to which Performance Goals established by the Committee are attained within the applicable Performance Period established by the Committee.

10.3 **Establishment of Performance Period, Performance Goals and Performance Award Formula.** In granting each Performance Award, the Committee shall establish in writing the applicable Performance Period, Performance Award Formula and one or more Performance Goals which, when measured at the end of the Performance Period, shall determine on the basis of the Performance Award Formula the final value of the Performance Award to be paid to the Participant. Unless otherwise permitted in compliance with the requirements under Section 162(m) with respect to each Performance Award intended to result in the payment of Performance-Based Compensation, the Committee shall establish the Performance Goal(s) and Performance Award Formula applicable to each Performance Award no later than the earlier of (a) the date ninety (90) days after the commencement of the applicable Performance Period or (b) the date on which 25% of the Performance Period has elapsed, and, in any event, at a time when the outcome of the Performance Goals remains substantially uncertain. Once established, the Performance Goals and Performance Award Formula applicable to a Covered Employee shall not be changed during the Performance Period. The Company shall notify each Participant granted a Performance Award of the terms of such Award, including the Performance Period, Performance Goal(s) and Performance Award Formula.

10.4 **Measurement of Performance Goals.** Performance Goals shall be established by the Committee on the basis of targets to be attained (*"**Performance Targets**"*) with respect to one or more measures of business or financial performance (each, a *"**Performance Measure**"*), subject to the following:

(a) ***Performance Measures.*** Performance Measures shall be calculated in accordance with the Company's financial statements, or, if such terms are not used in the Company's financial statements, they shall be calculated in accordance with generally accepted accounting principles, a method used generally in the Company's industry, or in accordance with a methodology established by the Committee prior to the grant of the Performance Award. Performance Measures shall be calculated with respect to the Company and each Subsidiary Corporation consolidated therewith for financial reporting purposes or such division or other business unit as may be selected by the Committee. Unless otherwise determined by the Committee prior to the grant of the Performance Award, the Performance Measures applicable to the Performance Award shall be calculated prior to the accrual of expense for any Performance Award for the same Performance Period and excluding the effect (whether positive or negative) on the Performance Measures of any change in accounting standards or any extraordinary, unusual or nonrecurring item, as determined

by the Committee, occurring after the establishment of the Performance Goals applicable to the Performance Award. Each such adjustment, if any, shall be made solely for the purpose of providing a consistent basis from period to period for the calculation of Performance Measures in order to prevent the dilution or enlargement of the Participant's rights with respect to a Performance Award. Performance Measures may be one or more of the following, as determined by the Committee:

(i) revenue;

(ii) sales;

(iii) expenses;

(iv) operating income;

(v) gross margin;

(vi) operating margin;

(vii) earnings before any one or more of: stock-based compensation expense, interest, taxes, depreciation and amortization;

(viii) pre-tax profit;

(ix) net operating income;

(x) net income;

(xi) economic value added;

(xii) free cash flow;

(xiii) operating cash flow;

(xiv) balance of cash, cash equivalents and marketable securities;

(xv) stock price;

(xvi) earnings per share;

(xvii) return on stockholder equity;

(xviii) return on capital;

(xix) return on assets;

(xx) return on investment;

(xxi) total stockholder return;

(xxii) employee satisfaction;

(xxiii) employee retention;

(xxiv) market share;

(xxv) customer satisfaction;

(xxvi) product development;

(xxvii) research and development expenses;

(xxviii) completion of an identified special project; and

(xxix) completion of a joint venture or other corporate transaction.

(b) ***Performance Targets.*** Performance Targets may include a minimum, maximum, target level and intermediate levels of performance, with the final value of a Performance Award determined under the applicable Performance Award Formula by the level attained during the applicable Performance Period. A Performance Target may be stated as an absolute value, a growth or reduction in a value, or as a value determined relative to an index, budget or other standard selected by the Committee.

10.5 **Settlement of Performance Awards.**

(a) ***Determination of Final Value.*** As soon as practicable following the completion of the Performance Period applicable to a Performance Award, the Committee shall certify in writing the extent to which the applicable Performance Goals have been attained and the resulting final value of the Award earned by the Participant and to be paid upon its settlement in accordance with the applicable Performance Award Formula.

(b) ***Discretionary Adjustment of Award Formula.*** In its discretion, the Committee may, either at the time it grants a Performance Award or at any time thereafter, provide for the positive or negative adjustment of the Performance Award Formula applicable to a Performance Award granted to any Participant who is not a Covered Employee to reflect such Participant's individual performance in his or her position with the Company or such other factors as the Committee may determine. If permitted under a Covered Employee's Award Agreement, the Committee shall have the discretion, on the basis of such criteria as may be established by the Committee, to reduce some or all of the value of the Performance Award that would otherwise be paid to the Covered Employee upon its settlement notwithstanding the attainment of any Performance Goal and the resulting value of the Performance Award determined in accordance with the Performance Award Formula. No such reduction may result in an increase in the amount payable upon settlement of another Participant's Performance Award that is intended to result in Performance-Based Compensation.

(c) ***Effect of Leaves of Absence.*** Unless otherwise required by law or a Participant's Award Agreement, payment of the final value, if any, of a Performance Award held by a Participant who has taken in excess of thirty (30) days in unpaid leaves of absence during a Performance Period shall be prorated on the basis of the number of days of the Participant's Service during the Performance Period during which the Participant was not on an unpaid leave of absence.

(d) ***Notice to Participants.*** As soon as practicable following the Committee's determination and certification in accordance with Sections 10.5(a) and (b), the Company shall notify each Participant of the determination of the Committee.

(e) ***Payment in Settlement of Performance Awards.*** As soon as practicable following the Committee's determination and certification in accordance with Sections 10.5(a) and (b), but in any event within the Short-Term Deferral Period described in Section 15.1 (except as otherwise provided below or consistent with the requirements of Section 409A), payment shall be made to each eligible Participant (or such Participant's legal representative or other person who acquired the right to receive such payment by reason of the Participant's death) of the final value of the Participant's Performance Award. Payment of such amount shall be made in cash, shares of Stock, or a combination thereof as determined by the Committee. Unless otherwise provided in the Award Agreement evidencing a Performance Award, payment shall be made in a lump sum. If permitted by the Committee, the Participant may elect, consistent with the requirements of Section 409A, to defer receipt of all or any portion of the payment to be made to the Participant pursuant to this Section, and such deferred payment date(s) elected by the Participant shall be set forth in the Award Agreement. If any payment is to be made on a deferred basis, the Committee may, but shall not be obligated to, provide for the payment during the deferral period of Dividend Equivalent Rights or interest.

(f) ***Provisions Applicable to Payment in Shares.*** If payment is to be made in shares of Stock, the number of such shares shall be determined by dividing the final value of the Performance Award by the Fair Market Value of a share of Stock determined by the method specified in the Award Agreement. Shares of Stock issued in payment of any Performance Award may be fully vested and freely transferable shares or may be shares of Stock subject to Vesting Conditions as provided in Section 8.5. Any shares subject to Vesting Conditions shall be evidenced by an appropriate Award Agreement and shall be subject to the provisions of Sections 8.5 through 8.8 above.

10.6 **Voting Rights; Dividend Equivalent Rights and Distributions.** Participants shall have no voting rights with respect to shares of Stock represented by Performance Share Awards until the date of the issuance of such shares, if any (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). However, the Committee, in its discretion, may provide in the Award Agreement evidencing any Performance Share Award that the Participant shall be entitled to Dividend Equivalent Rights with respect to the payment of cash dividends on Stock during the period beginning on the date the Award is granted and ending, with respect to each share subject to the Award, on the earlier of the date on which the Performance Shares are settled or the date on which they are forfeited. Such Dividend Equivalent Rights, if any, shall be credited to the Participant in the form of additional whole Performance Shares as of the date of payment of such cash dividends on Stock. The number of additional Performance Shares (rounded to the nearest whole number) to be so credited shall be determined by dividing (a)

the amount of cash dividends paid on the dividend payment date with respect to the number of shares of Stock represented by the Performance Shares previously credited to the Participant by (b) the Fair Market Value per share of Stock on such date. Dividend Equivalent Rights may be paid currently or may be accumulated and paid to the extent that Performance Shares become nonforfeitable, as determined by the Committee. Settlement of Dividend Equivalent Rights may be made in cash, shares of Stock, or a combination thereof as determined by the Committee, and may be paid on the same basis as settlement of the related Performance Share as provided in Section 10.5. Dividend Equivalent Rights shall not be paid with respect to Performance Units. In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, appropriate adjustments shall be made in the Participant's Performance Share Award so that it represents the right to receive upon settlement any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant would be entitled by reason of the shares of Stock issuable upon settlement of the Performance Share Award, and all such new, substituted or additional securities or other property shall be immediately subject to the same Performance Goals as are applicable to the Award.

10.7 **Effect of Termination of Service.** Unless otherwise provided by the Committee and set forth in the Award Agreement evidencing a Performance Award, the effect of a Participant's termination of Service on the Performance Award shall be as follows:

(a) ***Death or Disability.*** If the Participant's Service terminates because of the death or Disability of the Participant before the completion of the Performance Period applicable to the Performance Award, the final value of the Participant's Performance Award shall be determined by the extent to which the applicable Performance Goals have been attained with respect to the entire Performance Period and shall be prorated based on the number of months of the Participant's Service during the Performance Period. Payment shall be made following the end of the Performance Period in any manner permitted by Section 10.5.

(b) ***Other Termination of Service.*** If the Participant's Service terminates for any reason except death or Disability before the completion of the Performance Period applicable to the Performance Award, such Award shall be forfeited in its entirety; provided, however, that in the event of an involuntary termination of the Participant's Service, the Committee, in its discretion, may waive the automatic forfeiture of all or any portion of any such Award and determine the final value of the Performance Award in the manner provided by Section 10.7(a). Payment of any amount pursuant to this Section shall be made following the end of the Performance Period in any manner permitted by Section 10.5.

10.8 **Nontransferability of Performance Awards.** Prior to settlement in accordance with the provisions of the Plan, no Performance Award shall be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. All rights with respect to a Performance Award granted to a Participant hereunder shall be exercisable during his or her lifetime only by such Participant or the Participant's guardian or legal representative.

11. CASH-BASED AWARDS AND OTHER STOCK-BASED AWARDS.

Cash-Based Awards and Other Stock-Based Awards shall be evidenced by Award Agreements in such form as the Committee shall from time to time establish. Award Agreements evidencing Cash-Based Awards and Other Stock-Based Awards may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

11.1 **Grant of Cash-Based Awards**. Subject to the provisions of the Plan, the Committee, at any time and from time to time, may grant Cash-Based Awards to Participants in such amounts and upon such terms and conditions, including the achievement of performance criteria, as the Committee may determine.

11.2 **Grant of Other Stock-Based Awards**. The Committee may grant other types of equity-based or equity-related Awards not otherwise described by the terms of this Plan (including the grant or offer for sale of unrestricted securities, stock-equivalent units, stock appreciation units, securities or debentures convertible into common stock or other forms determined by the Committee) in such amounts and subject to such terms and conditions as the Committee shall determine. Other Stock-Based Awards may be made available as a form of payment in the settlement of other Awards or as payment in lieu of compensation to which a Participant is otherwise entitled. Other Stock-Based Awards may involve the transfer of actual shares of Stock to Participants, or payment in cash or otherwise of amounts based on the value of Stock and may include, without limitation, Awards designed to comply with or take advantage of the applicable local laws of jurisdictions other than the United States.

11.3 **Value of Cash-Based and Other Stock-Based Awards**. Each Cash-Based Award shall specify a monetary payment amount or payment range as determined by the Committee. Each Other Stock-Based Award shall be expressed in terms of shares of Stock or units based on such shares of Stock, as determined by the Committee. The Committee may require the satisfaction of such Service requirements, conditions, restrictions or performance criteria, including, without limitation, Performance Goals as described in Section 10.4, as shall be established by the Committee and set forth in the Award Agreement evidencing such Award. If the Committee exercises its discretion to establish performance criteria, the final value of Cash-Based Awards or Other Stock-Based Awards that will be paid to the Participant will depend on the extent to which the performance criteria are met. The establishment of performance criteria with respect to the grant or vesting of any Cash-Based Award or Other Stock-Based Award intended to result in Performance-Based Compensation shall follow procedures substantially equivalent to those applicable to Performance Awards set forth in Section 10.

11.4 **Payment or Settlement of Cash-Based Awards and Other Stock-Based Awards**. Payment or settlement, if any, with respect to a Cash-Based Award or an Other Stock-Based Award shall be made in accordance with the terms of the Award, in cash, shares of Stock or other securities or any combination thereof as the Committee determines. The determination and certification of the final value with respect to any Cash-Based Award or Other Stock-Based Award intended to result in Performance-Based Compensation shall comply with the requirements applicable to Performance Awards set forth in Section 10. To the extent applicable, payment or settlement with respect to each Cash-Based Award and Other Stock-Based Award shall be made in compliance with the requirements of Section 409A.

11.5 **Voting Rights; Dividend Equivalent Rights and Distributions.** Participants shall have no voting rights with respect to shares of Stock represented by Other Stock-Based Awards until the date of the issuance of such shares of Stock (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company), if any, in settlement of such Award. However, the Committee, in its discretion, may provide in the Award Agreement evidencing any Other Stock-Based Award that the Participant shall be entitled to Dividend Equivalent Rights with respect to the payment of cash dividends on Stock during the period beginning on the date such Award is granted and ending, with respect to each share subject to the Award, on the earlier of the date the Award is settled or the date on which it is terminated. Such Dividend Equivalent Rights, if any, shall be paid in accordance with the provisions set forth in Section 9.4. Dividend Equivalent Rights shall not be granted with respect to Cash-Based Awards. In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, appropriate adjustments shall be made in the Participant's Other Stock-Based Award so that it represents the right to receive upon settlement any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant would be entitled by reason of the shares of Stock issuable upon settlement of such Award, and all such new, substituted or additional securities or other property shall be immediately subject to the same Vesting Conditions and performance criteria, if any, as are applicable to the Award.

11.6 **Effect of Termination of Service**. Each Award Agreement evidencing a Cash-Based Award or Other Stock-Based Award shall set forth the extent to which the Participant shall have the right to retain such Award following termination of the Participant's Service. Such provisions shall be determined in the discretion of the Committee, need not be uniform among all Cash-Based Awards or Other Stock-Based Awards, and may reflect distinctions based on the reasons for termination, subject to the requirements of Section 409A, if applicable.

11.7 **Nontransferability of Cash-Based Awards and Other Stock-Based Awards.** Prior to the payment or settlement of a Cash-Based Award or Other Stock-Based Award, the Award shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. The Committee may impose such additional restrictions on any shares of Stock issued in settlement of Cash-Based Awards and Other Stock-Based Awards as it may deem advisable, including, without limitation, minimum holding period requirements, restrictions under applicable federal securities laws, under the requirements of any stock exchange or market upon which such shares of Stock are then listed and/or traded, or under any state securities laws or foreign law applicable to such shares of Stock.

12. STANDARD FORMS OF AWARD AGREEMENT.

12.1 **Award Agreements.** Each Award shall comply with and be subject to the terms and conditions set forth in the appropriate form of Award Agreement approved by the Committee and as amended from time to time. No Award or purported Award shall be a valid and binding obligation of the Company unless evidenced by a fully executed Award Agreement, which execution may be evidenced by electronic means. Any Award Agreement may consist of an appropriate form of Notice

of Grant and a form of Agreement incorporated therein by reference, or such other form or forms, including electronic media, as the Committee may approve from time to time.

12.2 **Authority to Vary Terms.** The Committee shall have the authority from time to time to vary the terms of any standard form of Award Agreement either in connection with the grant or amendment of an individual Award or in connection with the authorization of a new standard form or forms; provided, however, that the terms and conditions of any such new, revised or amended standard form or forms of Award Agreement are not inconsistent with the terms of the Plan.

13. **CHANGE IN CONTROL.**

13.1 **Effect of Change in Control on Awards.** Subject to the requirements and limitations of Section 409A, if applicable, the Committee may provide for any one or more of the following:

(a) ***Accelerated Vesting.*** In its discretion, the Committee may provide in the grant of any Award or at any other time may take such action as it deems appropriate to provide for acceleration of the exercisability, vesting and/or settlement in connection with a Change in Control of each or any outstanding Award or portion thereof and shares acquired pursuant thereto upon such conditions, including termination of the Participant's Service prior to, upon, or following such Change in Control, and to such extent as the Committee shall determine.

(b) ***Assumption, Continuation or Substitution.*** In the event of a Change in Control, the surviving, continuing, successor, or purchasing corporation or other business entity or parent thereof, as the case may be (the *"**Acquiror**"*), may, without the consent of any Participant, either assume or continue the Company's rights and obligations under each or any Award or portion thereof outstanding immediately prior to the Change in Control or substitute for each or any such outstanding Award or portion thereof a substantially equivalent award with respect to the Acquiror's stock, as applicable. For purposes of this Section, if so determined by the Committee in its discretion, an Award denominated in shares of Stock shall be deemed assumed if, following the Change in Control, the Award confers the right to receive, subject to the terms and conditions of the Plan and the applicable Award Agreement, for each share of Stock subject to the Award immediately prior to the Change in Control, the consideration (whether stock, cash, other securities or property or a combination thereof) to which a holder of a share of Stock on the effective date of the Change in Control was entitled (and if holders were offered a choice of consideration, the type of consideration chosen by the holders of a majority of the outstanding shares of Stock); provided, however, that if such consideration is not solely common stock of the Acquiror, the Committee may, with the consent of the Acquiror, provide for the consideration to be received upon the exercise or settlement of the Award, for each share of Stock subject to the Award, to consist solely of common stock of the Acquiror equal in Fair Market Value to the per share consideration received by holders of Stock pursuant to the Change in Control. Any Award or portion thereof which is neither assumed or continued by the Acquiror in connection with the Change in Control nor exercised or settled as of the time of consummation of the Change in Control shall terminate and cease to be outstanding effective as of the time of consummation of the Change in Control.

(c) ***Cash-Out of Outstanding Stock-Based Awards.*** The Committee may, in its discretion and without the consent of any Participant, determine that, upon the occurrence of a Change in Control, each or any Award denominated in shares of Stock or portion thereof outstanding

immediately prior to the Change in Control and not previously exercised or settled shall be canceled in exchange for a payment with respect to each vested share (and each unvested share, if so determined by the Committee) of Stock subject to such canceled Award in (i) cash, (ii) stock of the Company or of a corporation or other business entity a party to the Change in Control, or (iii) other property which, in any such case, shall be in an amount having a Fair Market Value equal to the Fair Market Value of the consideration to be paid per share of Stock in the Change in Control, reduced (but not below zero) by the exercise or purchase price per share, if any, under such Award. In the event such determination is made by the Committee, an Award having an exercise or purchase price per share equal to or greater than the Fair Market Value of the consideration to be paid per share of Stock in the Change in Control may be canceled without payment of consideration to the holder thereof. Payment pursuant to this Section (reduced by applicable withholding taxes, if any) shall be made to Participants in respect of the vested portions of their canceled Awards as soon as practicable following the date of the Change in Control and in respect of the unvested portions of their canceled Awards in accordance with the vesting schedules applicable to such Awards.

13.2 **Federal Excise Tax Under Section 4999 of the Code.**

(a) ***Excess Parachute Payment.*** In the event that any acceleration of vesting pursuant to an Award and any other payment or benefit received or to be received by a Participant would subject the Participant to any excise tax pursuant to Section 4999 of the Code due to the characterization of such acceleration of vesting, payment or benefit as an "excess parachute payment" under Section 280G of the Code, the Participant may elect to reduce the amount of any acceleration of vesting called for under the Award in order to avoid such characterization.

(b) ***Determination by Independent Accountants.*** To aid the Participant in making any election called for under Section 13.2(a), no later than the date of the occurrence of any event that might reasonably be anticipated to result in an "excess parachute payment" to the Participant as described in Section 13.2(a), the Company shall request a determination in writing by independent public accountants selected by the Company (the *"**Accountants**"*). As soon as practicable thereafter, the Accountants shall determine and report to the Company and the Participant the amount of such acceleration of vesting, payments and benefits which would produce the greatest after-tax benefit to the Participant. For the purposes of such determination, the Accountants may rely on reasonable, good faith interpretations concerning the application of Sections 280G and 4999 of the Code. The Company and the Participant shall furnish to the Accountants such information and documents as the Accountants may reasonably request in order to make their required determination. The Company shall bear all fees and expenses the Accountants charge in connection with their services contemplated by this Section.

14. **COMPLIANCE WITH SECURITIES LAW.**

The grant of Awards and the issuance of shares of Stock pursuant to any Award shall be subject to compliance with all applicable requirements of federal, state and foreign law with respect to such securities and the requirements of any stock exchange or market system upon which the Stock may then be listed. In addition, no Award may be exercised or shares issued pursuant to an Award unless (a) a registration statement under the Securities Act shall at the time of such exercise or issuance be in effect with respect to the shares issuable pursuant to the Award, or (b) in the opinion of legal counsel to the Company, the shares issuable pursuant to the Award may be issued in

accordance with the terms of an applicable exemption from the registration requirements of the Securities Act. The inability of the Company to obtain from any regulatory body having jurisdiction the authority, if any, deemed by the Company's legal counsel to be necessary to the lawful issuance and sale of any shares hereunder shall relieve the Company of any liability in respect of the failure to issue or sell such shares as to which such requisite authority shall not have been obtained. As a condition to issuance of any Stock, the Company may require the Participant to satisfy any qualifications that may be necessary or appropriate, to evidence compliance with any applicable law or regulation and to make any representation or warranty with respect thereto as may be requested by the Company.

15. **COMPLIANCE WITH SECTION 409A.**

15.1 **Awards Subject to Section 409A.** The Company intends that Awards granted pursuant to the Plan shall either be exempt from or comply with Section 409A, and the Plan shall be so construed. The provisions of this Section 15 shall apply to any Award or portion thereof that constitutes or provides for payment of Section 409A Deferred Compensation. Such Awards may include, without limitation:

(a) A Nonstatutory Stock Option or SAR that includes any feature for the deferral of compensation other than the deferral of recognition of income until the later of (i) the exercise or disposition of the Award or (ii) the time the stock acquired pursuant to the exercise of the Award first becomes substantially vested.

(b) Any Restricted Stock Unit Award, Performance Award, Cash-Based Award or Other Stock-Based Award that either (i) provides by its terms for settlement of all or any portion of the Award at a time or upon an event that will or may occur later than the end of the Short-Term Deferral Period (as defined below) or (ii) permits the Participant granted the Award to elect one or more dates or events upon which the Award will be settled after the end of the Short-Term Deferral Period.

Subject to the provisions of Section 409A, the term "***Short-Term Deferral Period***" means the 2½ month period ending on the later of (i) the 15th day of the third month following the end of the Participant's taxable year in which the right to payment under the applicable portion of the Award is no longer subject to a substantial risk of forfeiture or (ii) the 15th day of the third month following the end of the Company's taxable year in which the right to payment under the applicable portion of the Award is no longer subject to a substantial risk of forfeiture. For this purpose, the term "substantial risk of forfeiture" shall have the meaning provided by Section 409A.

15.2 **Deferral and/or Distribution Elections.** Except as otherwise permitted or required by Section 409A, the following rules shall apply to any compensation deferral and/or payment elections (each, an "***Election***") that may be permitted or required by the Committee pursuant to an Award providing Section 409A Deferred Compensation:

(a) Elections must be in writing and specify the amount of the payment in settlement of an Award being deferred, as well as the time and form of payment as permitted by this Plan.

(b) Elections shall be made by the end of the Participant's taxable year prior to the year in which services commence for which an Award may be granted to such Participant.

(c) Elections shall continue in effect until a written revocation or change in Election is received by the Company, except that a written revocation or change in Election must be received by the Company prior to the last day for making the Election determined in accordance with paragraph (b) above or as permitted by Section 15.3.

15.3 **Subsequent Elections.** Except as otherwise permitted or required by Section 409A, any Award providing Section 409A Deferred Compensation which permits a subsequent Election to delay the payment or change the form of payment in settlement of such Award shall comply with the following requirements:

(a) No subsequent Election may take effect until at least twelve (12) months after the date on which the subsequent Election is made.

(b) Each subsequent Election related to a payment in settlement of an Award not described in Section 15.4(a)(ii), 15.4(a)(iii) or 15.4(a)(vi) must result in a delay of the payment for a period of not less than five (5) years from the date on which such payment would otherwise have been made.

(c) No subsequent Election related to a payment pursuant to Section 15.4(a)(iv) shall be made less than twelve (12) months before the date on which such payment would otherwise have been made.

(d) Subsequent Elections shall continue in effect until a written revocation or change in the subsequent Election is received by the Company, except that a written revocation or change in a subsequent Election must be received by the Company prior to the last day for making the subsequent Election determined in accordance the preceding paragraphs of this Section 15.3.

15.4 **Payment of Section 409A Deferred Compensation.**

(a) ***Permissible Payments.*** Except as otherwise permitted or required by Section 409A, an Award providing Section 409A Deferred Compensation must provide for payment in settlement of the Award only upon one or more of the following:

(i) The Participant's "separation from service" (as such term is defined by Section 409A);

(ii) The Participant's becoming "disabled" (as such term is defined by Section 409A);

(iii) The Participant's death;

(iv) A time or fixed schedule that is either (i) specified by the Committee upon the grant of an Award and set forth in the Award Agreement evidencing such Award or (ii)

specified by the Participant in an Election complying with the requirements of Section 15.2 or 15.3, as applicable;

(v) A change in the ownership or effective control or the Company or in the ownership of a substantial portion of the assets of the Company determined in accordance with Section 409A; or

(vi) The occurrence of an "unforeseeable emergency" (as such term is defined by Section 409A).

(b) ***Installment Payments.*** It is the intent of this Plan that any right of a Participant to receive installment payments (within the meaning of Section 409A) shall, for all purposes of Section 409A, be treated as a right to a series of separate payments.

(c) ***Required Delay in Payment to Specified Employee Pursuant to Separation from Service.*** Notwithstanding any provision of the Plan or an Award Agreement to the contrary, except as otherwise permitted by Section 409A, no payment pursuant to Section 15.4(a)(i) in settlement of an Award providing for Section 409A Deferred Compensation may be made to a Participant who is a "specified employee" (as such term is defined by Section 409A) as of the date of the Participant's separation from service before the date (the "***Delayed Payment Date***") that is six (6) months after the date of such Participant's separation from service, or, if earlier, the date of the Participant's death. All such amounts that would, but for this paragraph, become payable prior to the Delayed Payment Date shall be accumulated and paid on the Delayed Payment Date.

(d) ***Payment Upon Disability.*** All distributions payable by reason of a Participant becoming disabled shall be paid in a lump sum or in periodic installments as established by the Participant's Election. If the Participant has made no Election with respect to distributions upon becoming disabled, all such distributions shall be paid in a lump sum upon the determination that the Participant has become disabled.

(e) ***Payment Upon Death.*** If a Participant dies before complete distribution of amounts payable upon settlement of an Award subject to Section 409A, such undistributed amounts shall be distributed to his or her beneficiary under the distribution method for death established by the Participant's Election upon receipt by the Committee of satisfactory notice and confirmation of the Participant's death. If the Participant has made no Election with respect to distributions upon death, all such distributions shall be paid in a lump sum upon receipt by the Committee of satisfactory notice and confirmation of the Participant's death.

(f) ***Payment Upon Change in Control.*** Notwithstanding any provision of the Plan or an Award Agreement to the contrary, to the extent that any amount constituting Section 409A Deferred Compensation would become payable under this Plan by reason of a Change in Control, such amount shall become payable only if the event constituting a Change in Control would also constitute a change in ownership or effective control of the Company or a change in the ownership of a substantial portion of the assets of the Company within the meaning of Section 409A. Any Award which constitutes Section 409A Deferred Compensation and which would vest and otherwise become payable upon a Change in Control as a result of the failure of the Acquiror to assume, continue or substitute for such Award in accordance with Section 13.1(b) shall vest to the extent

provided by such Award but shall be converted automatically at the effective time of such Change in Control into a right to receive, in cash on the date or dates such award would have been settled in accordance with its then existing settlement schedule (or as required by Section 15.4(c)), an amount or amounts equal in the aggregate to the intrinsic value of the Award at the time of the Change in Control.

(g) ***Payment Upon Unforeseeable Emergency.*** The Committee shall have the authority to provide in the Award Agreement evidencing any Award providing for Section 409A Deferred Compensation for payment in settlement of all or a portion of such Award in the event that a Participant establishes, to the satisfaction of the Committee, the occurrence of an unforeseeable emergency. In such event, the amount(s) distributed with respect to such unforeseeable emergency cannot exceed the amounts reasonably necessary to satisfy the emergency need plus amounts necessary to pay taxes reasonably anticipated as a result of such distribution(s), after taking into account the extent to which such emergency need is or may be relieved through reimbursement or compensation by insurance or otherwise, by liquidation of the Participant's assets (to the extent the liquidation of such assets would not itself cause severe financial hardship) or by cessation of deferrals under the Award. All distributions with respect to an unforeseeable emergency shall be made in a lump sum upon the Committee's determination that an unforeseeable emergency has occurred. The Committee's decision with respect to whether an unforeseeable emergency has occurred and the manner in which, if at all, the payment in settlement of an Award shall be altered or modified, shall be final, conclusive, and not subject to approval or appeal.

(h) ***Prohibition of Acceleration of Payments.*** Notwithstanding any provision of the Plan or an Award Agreement to the contrary, this Plan does not permit the acceleration of the time or schedule of any payment under an Award providing Section 409A Deferred Compensation, except as permitted by Section 409A.

(i) ***No Representation Regarding Section 409A Compliance.*** Notwithstanding any other provision of the Plan, the Company makes no representation that Awards shall be exempt from or comply with Section 409A. No Participating Company shall be liable for any tax, penalty or interest imposed on a Participant by Section 409A.

16. **TAX WITHHOLDING.**

16.1 **Tax Withholding in General.** The Company shall have the right to deduct from any and all payments made under the Plan, or to require the Participant, through payroll withholding, cash payment or otherwise, to make adequate provision for, the federal, state, local and foreign taxes (including social insurance), if any, required by law to be withheld by any Participating Company with respect to an Award or the shares acquired pursuant thereto. The Company shall have no obligation to deliver shares of Stock, to release shares of Stock from an escrow established pursuant to an Award Agreement, or to make any payment in cash under the Plan until the Participating Company Group's tax withholding obligations have been satisfied by the Participant.

16.2 **Withholding in or Directed Sale of Shares.** The Company shall have the right, but not the obligation, to deduct from the shares of Stock issuable to a Participant upon the exercise or settlement of an Award, or to accept from the Participant the tender of, a number of whole shares of Stock having a Fair Market Value, as determined by the Company, equal to all or any part of

the tax withholding obligations of any Participating Company as determined under applicable provisions of the Code. Prior to January 1, 2017, the Fair Market Value of any shares of Stock withheld or tendered to satisfy any such tax withholding obligations shall not exceed the amount determined by the applicable minimum statutory withholding rates. Effective January 1, 2017, the Fair Market Value of any shares of Stock withheld or tendered to satisfy any such tax withholding obligations shall not exceed the amount determined by the applicable maximum statutory withholding rates. The Company may require a Participant to direct a broker, upon the vesting, exercise or settlement of an Award, to sell a portion of the shares subject to the Award determined by the Company in its discretion to be sufficient to cover the tax withholding obligations of any Participating Company and to remit an amount equal to such tax withholding obligations to the Company in cash.

17. **AMENDMENT, SUSPENSION OR TERMINATION OF PLAN.**

The Committee may amend, suspend or terminate the Plan at any time. However, without the approval of the Company's stockholders, there shall be (a) no increase in the maximum aggregate number of shares of Stock that may be issued under the Plan (except by operation of the provisions of Section 4.2), (b) no change in the class of persons eligible to receive Incentive Stock Options, and (c) no other amendment of the Plan that would require approval of the Company's stockholders under any applicable law, regulation or rule, including the rules of any stock exchange or quotation system upon which the Stock may then be listed or quoted. No amendment, suspension or termination of the Plan shall affect any then outstanding Award unless expressly provided by the Committee. Except as provided by the next sentence, no amendment, suspension or termination of the Plan may adversely affect any then outstanding Award without the consent of the Participant. Notwithstanding any other provision of the Plan to the contrary, the Committee may, in its sole and absolute discretion and without the consent of any Participant, amend the Plan or any Award Agreement, to take effect retroactively or otherwise, as it deems necessary or advisable for the purpose of conforming the Plan or such Award Agreement to any present or future law, regulation or rule applicable to the Plan, including, but not limited to, Section 409A.

18. **MISCELLANEOUS PROVISIONS.**

18.1 **Repurchase Rights.** Shares issued under the Plan may be subject to one or more repurchase options, or other conditions and restrictions as determined by the Committee in its discretion at the time the Award is granted. The Company shall have the right to assign at any time any repurchase right it may have, whether or not such right is then exercisable, to one or more persons as may be selected by the Company. Upon request by the Company, each Participant shall execute any agreement evidencing such transfer restrictions prior to the receipt of shares of Stock hereunder and shall promptly present to the Company any and all certificates representing shares of Stock acquired hereunder for the placement on such certificates of appropriate legends evidencing any such transfer restrictions.

18.2 **Forfeiture Events.**

(a) The Committee may specify in an Award Agreement that the Participant's rights, payments, and benefits with respect to an Award shall be subject to reduction, cancellation, forfeiture, or recoupment upon the occurrence of specified events, in addition to any otherwise

applicable vesting or performance conditions of an Award. Such events may include, but shall not be limited to, termination of Service for Cause or any act by a Participant, whether before or after termination of Service, that would constitute Cause for termination of Service.

(b) If the Company is required to prepare an accounting restatement due to the material noncompliance of the Company, as a result of misconduct, with any financial reporting requirement under the securities laws, any Participant who knowingly or through gross negligence engaged in the misconduct, or who knowingly or through gross negligence failed to prevent the misconduct, and any Participant who is one of the individuals subject to automatic forfeiture under Section 304 of the Sarbanes-Oxley Act of 2002, shall reimburse the Company for (i) the amount of any payment in settlement of an Award received by such Participant during the twelve-(12-) month period following the first public issuance or filing with the United States Securities and Exchange Commission (whichever first occurred) of the financial document embodying such financial reporting requirement, and (ii) any profits realized by such Participant from the sale of securities of the Company during such twelve-(12-) month period.

18.3 **Provision of Information.** Each Participant shall be given access to information concerning the Company equivalent to that information generally made available to the Company's common stockholders.

18.4 **Rights as Employee, Consultant or Director.** No person, even though eligible pursuant to Section 5, shall have a right to be selected as a Participant, or, having been so selected, to be selected again as a Participant. Nothing in the Plan or any Award granted under the Plan shall confer on any Participant a right to remain an Employee, Consultant or Director or interfere with or limit in any way any right of a Participating Company to terminate the Participant's Service at any time. To the extent that an Employee of a Participating Company other than the Company receives an Award under the Plan, that Award shall in no event be understood or interpreted to mean that the Company is the Employee's employer or that the Employee has an employment relationship with the Company.

18.5 **Rights as a Stockholder.** A Participant shall have no rights as a stockholder with respect to any shares covered by an Award until the date of the issuance of such shares (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date such shares are issued, except as provided in Section 4.2 or another provision of the Plan.

18.6 **Delivery of Title to Shares.** Subject to any governing rules or regulations, the Company shall issue or cause to be issued the shares of Stock acquired pursuant to an Award and shall deliver such shares to or for the benefit of the Participant by means of one or more of the following: (a) by delivering to the Participant evidence of book entry shares of Stock credited to the account of the Participant, (b) by depositing such shares of Stock for the benefit of the Participant with any broker with which the Participant has an account relationship, or (c) by delivering such shares of Stock to the Participant in certificate form.

18.7 **Fractional Shares.** The Company shall not be required to issue fractional shares upon the exercise or settlement of any Award.

18.8 **Retirement and Welfare Plans**. Neither Awards made under this Plan nor shares of Stock or cash paid pursuant to such Awards may be included as "compensation" for purposes of computing the benefits payable to any Participant under any Participating Company's retirement plans (both qualified and non-qualified) or welfare benefit plans unless such other plan expressly provides that such compensation shall be taken into account in computing a Participant's benefit.

18.9 **Beneficiary Designation.** Subject to local laws and procedures, each Participant may file with the Company a written designation of a beneficiary who is to receive any benefit under the Plan to which the Participant is entitled in the event of such Participant's death before he or she receives any or all of such benefit. Each designation will revoke all prior designations by the same Participant, shall be in a form prescribed by the Company, and will be effective only when filed by the Participant in writing with the Company during the Participant's lifetime. If a married Participant designates a beneficiary other than the Participant's spouse, the effectiveness of such designation may be subject to the consent of the Participant's spouse. If a Participant dies without an effective designation of a beneficiary who is living at the time of the Participant's death, the Company will pay any remaining unpaid benefits to the Participant's legal representative.

18.10 **Severability**. If any one or more of the provisions (or any part thereof) of this Plan shall be held invalid, illegal or unenforceable in any respect, such provision shall be modified so as to make it valid, legal and enforceable, and the validity, legality and enforceability of the remaining provisions (or any part thereof) of the Plan shall not in any way be affected or impaired thereby.

18.11 **No Constraint on Corporate Action.** Nothing in this Plan shall be construed to: (a) limit, impair, or otherwise affect the Company's or another Participating Company's right or power to make adjustments, reclassifications, reorganizations, or changes of its capital or business structure, or to merge or consolidate, or dissolve, liquidate, sell, or transfer all or any part of its business or assets; or (b) limit the right or power of the Company or another Participating Company to take any action which such entity deems to be necessary or appropriate.

18.12 **Unfunded Obligation.** Participants shall have the status of general unsecured creditors of the Company. Any amounts payable to Participants pursuant to the Plan shall be considered unfunded and unsecured obligations for all purposes, including, without limitation, Title I of the Employee Retirement Income Security Act of 1974. No Participating Company shall be required to segregate any monies from its general funds, or to create any trusts, or establish any special accounts with respect to such obligations. The Company shall retain at all times beneficial ownership of any investments, including trust investments, which the Company may make to fulfill its payment obligations hereunder. Any investments or the creation or maintenance of any trust or any Participant account shall not create or constitute a trust or fiduciary relationship between the Committee or any Participating Company and a Participant, or otherwise create any vested or beneficial interest in any Participant or the Participant's creditors in any assets of any Participating Company. The Participants shall have no claim against any Participating Company for any changes in the value of any assets which may be invested or reinvested by the Company with respect to the Plan.

18.13 **Choice of Law.** Except to the extent governed by applicable federal law, the validity, interpretation, construction and performance of the Plan and each Award Agreement shall be governed by the laws of the State of California, without regard to its conflict of law rules

IN WITNESS WHEREOF, the undersigned Secretary of the Company certifies that the foregoing sets forth the Molina Healthcare, Inc. 2011 Equity Incentive Plan as duly adopted by the Board.

/s/ Jeff D. Barlow
Corporate Secretary

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the annual report on Form 10-K for the period ended September 30, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 27, 2016

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed this annual report on Form 10-K for the period ended September 30, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 27, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended September 30, 2016 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 27, 2016

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended September 30, 2016 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 27, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended June 30, 2016

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2016

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of July 22, 2016, was approximately 56,801,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended June 30, 2016

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2016	December 31, 2015
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,345	$ 2,329
Investments	1,968	1,801
Receivables	1,012	597
Income taxes refundable	23	13
Prepaid expenses and other current assets	197	192
Derivative asset	—	374
Total current assets	5,545	5,306
Property, equipment, and capitalized software, net	448	393
Deferred contract costs	80	81
Intangible assets, net	146	122
Goodwill	611	519
Restricted investments	107	109
Deferred income taxes	—	18
Derivative asset	226	—
Other assets	39	28
	$ 7,202	$ 6,576
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,766	$ 1,685
Amounts due government agencies	1,238	729
Accounts payable and accrued liabilities	537	362
Deferred revenue	104	223
Current portion of long-term debt	1	449
Derivative liability	—	374
Total current liabilities	3,646	3,822
Senior notes	1,428	962
Lease financing obligations	198	198
Deferred income taxes	25	—
Derivative liability	226	—
Other long-term liabilities	38	37
Total liabilities	5,561	5,019
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 57 shares at June 30, 2016 and 56 shares at December 31, 2015	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	822	803
Accumulated other comprehensive gain (loss)	4	(4)
Retained earnings	815	758
Total stockholders' equity	1,641	1,557
	$ 7,202	$ 6,576

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In millions, except per-share data) (Unaudited)			
Revenue:				
Premium revenue	$ 4,029	$ 3,304	$ 8,024	$ 6,275
Service revenue	135	47	275	99
Premium tax revenue	109	95	218	190
Health insurer fee revenue	76	74	166	122
Investment income	8	4	16	7
Other revenue	2	1	3	3
Total revenue	4,359	3,525	8,702	6,696
Operating expenses:				
Medical care costs	3,594	2,929	7,182	5,565
Cost of service revenue	116	33	243	69
General and administrative expenses	351	287	691	543
Premium tax expenses	109	95	218	190
Health insurer fee expenses	50	40	108	81
Depreciation and amortization	34	25	66	50
Total operating expenses	4,254	3,409	8,508	6,498
Operating income	105	116	194	198
Interest expense	25	15	50	30
Income before income tax expense	80	101	144	168
Income tax expense	47	62	87	101
Net income	$ 33	$ 39	$ 57	$ 67
Net income per share:				
Basic	$ 0.58	$ 0.78	$ 1.02	$ 1.36
Diluted	$ 0.58	$ 0.72	$ 1.01	$ 1.29

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(Amounts in millions) (Unaudited)			
Net income	$ 33	$ 39	$ 57	$ 67
Other comprehensive income (loss):				
Unrealized investment gain (loss)	4	(3)	13	(1)
Less: effect of income taxes	2	(1)	5	—
Other comprehensive income (loss), net of tax	2	(2)	8	(1)
Comprehensive income	$ 35	$ 37	$ 65	$ 66

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2016	2015
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net income	$ 57	$ 67
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	89	62
Deferred income taxes	39	7
Share-based compensation	16	9
Amortization of convertible senior notes and lease financing obligations	15	15
Other, net	11	9
Changes in operating assets and liabilities:		
Receivables	(415)	(35)
Prepaid expenses and other assets	(143)	(97)
Medical claims and benefits payable	82	292
Amounts due government agencies	509	298
Accounts payable and accrued liabilities	147	158
Deferred revenue	(119)	(138)
Income taxes	(10)	1
Net cash provided by operating activities	278	648
Investing activities:		
Purchases of investments	(974)	(993)
Proceeds from sales and maturities of investments	812	541
Purchases of property, equipment and capitalized software	(102)	(66)
Change in restricted investments	5	(14)
Net cash paid in business combinations	(8)	(8)
Other, net	(6)	(17)
Net cash used in investing activities	(273)	(557)
Financing activities:		
Proceeds from common stock offering, net of issuance costs	—	373
Proceeds from employee stock plans	10	8
Other, net	1	3
Net cash provided by financing activities	11	384
Net increase in cash and cash equivalents	16	475
Cash and cash equivalents at beginning of period	2,329	1,539
Cash and cash equivalents at end of period	$ 2,345	$ 2,014

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Six Months Ended June 30,	
	2016	2015
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (7)	$ (9)
Details of change in fair value of derivatives, net:		
Loss on 1.125% Call Option	$ (148)	$ (179)
Gain on 1.125% Conversion Option	148	179
Change in fair value of derivatives, net	$ —	$ —
Details of business combinations:		
Fair value of assets acquired	$ (131)	$ —
Purchase price amounts accrued/received (paid)	21	(8)
Reversal of amounts advanced to sellers in prior year	102	—
Net cash paid in business combinations	$ (8)	$ (8)

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2016

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other. All prior periods reported conform to this presentation.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of June 30, 2016, these health plans served 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Our Other segment includes businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Market Updates - Health Plans

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago and Loyola Physician Partners, LLC. See Note 4, "Business Combinations," for further information.

On March 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Better Health Network, LLC. See Note 4, "Business Combinations," for further information.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. See Note 4, "Business Combinations," for further information.

New York. On April 19, 2016, we entered into an agreement with Universal American Corp. to acquire all outstanding equity interests of Today's Options of New York, Inc., which operates the Total Care Medicaid plan. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close in the second half of 2016.

Washington. On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Columbia United Providers, Inc. See Note 4, "Business Combinations," for further information.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2016.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended

December 31, 2015. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2015 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2015 audited consolidated financial statements.

2. Significant Accounting Policies

Revenue Recognition – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $326 million and $214 million at June 30, 2016 and December 31, 2015, respectively, to amounts due government agencies. Approximately $297 million and $208 million of the liability accrued at June 30, 2016 and December 31, 2015, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. We recorded receivables of $1 million and $3 million at June 30, 2016 and December 31, 2015, respectively, relating to such provisions.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Under these provisions, we recorded a liability of $1 million and $10 million at June 30, 2016 and December 31, 2015, respectively, for profit in excess of the amount we are allowed to retain.

Retroactive Premium Adjustments: The state Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies. In the first quarter of 2016 our Florida health plan recorded a retroactive increase to Medicaid premium revenue of approximately $18 million, relating to dates of service prior to 2016.

Cost Plus Retroactive Premium Adjustments: In New Mexico, when members are retroactively enrolled into our health plan, we earn revenue only to the extent of the actual medical costs incurred by us for services provided during those retroactive periods, plus a small percentage of that medical cost for administration and profit. This arrangement first became effective July 1, 2014 (retroactive to January 1, 2014). We are paid normal monthly capitation rates for the retroactive eligibility periods, and the difference between those capitation rates and the amounts due to us on a cost plus basis are periodically settled with the state. To date, no such settlement has been made. During the years ended December 31, 2014 and 2015, our New Mexico contract was not specific as to the definition of retroactive membership, and the amount we owe the state (or that the state owes us) for the difference between capitation received and amounts due to us under the cost plus arrangement during those periods varies widely depending upon the definition of retroactive membership. Although we believe that the amount we have recorded as a liability for this matter is consistent with the state's expectations, we cannot be certain that the state will not seek to recover an amount in excess of our recorded liability.

Medicare

Risk Adjustment: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and federal Centers for Medicare and Medicaid Services (CMS) practices. Based on our estimates, we have recorded a net receivable of $19 million and a net payable of $4 million for anticipated Medicare risk adjustment premiums at June 30, 2016 and December 31, 2015, respectively.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described below, and, for receivables, collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	June 30, 2016			December 31, 2015
	Current Benefit Year	Prior Benefit Years	Total	
	(In millions)			
Risk adjustment	$ (220)	$ (254)	$ (474)	$ (214)
Reinsurance	57	24	81	36
Risk corridor	(9)	(3)	(12)	(10)
Minimum MLR	(17)	(2)	(19)	(3)

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared to the overall average risk score for the relevant state and market pool. Generally, our health plans will pay into the pool if their composite risk scores are below the average risk score, and will receive funds from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. On June 30, 2016, CMS released the final update on risk adjustment and reinsurance payments for the 2015 benefit year, and we adjusted our accruals accordingly.
- Reinsurance: This program is designed to provide reimbursement to insurers for high cost members. Our health plans pay an annual contribution on a per-member basis, and are eligible for recoveries if claims for individual members exceed a specified threshold, up to a maximum amount. This three-year program will end on December 31, 2016. We recognize the assessments to fund the transitional reinsurance program as a reduction to premium revenue in our consolidated statements of income. We recognize recoveries under the reinsurance program as a reduction to medical care costs in our consolidated statements of income.
- Risk corridor: This program is intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by the CMS. Variances from the target amount exceeding certain thresholds may result in amounts due to or receivables due from CMS. This three-year program will end on December 31, 2016. Due to uncertainties as to the amount of federal funding available to support the risk corridor program, we do not recognize amounts receivable under this program. All liabilities are recognized as incurred. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk corridor program as an adjustment to premium revenue in our consolidated statements of income.

Additionally, the ACA established a minimum annual medical loss ratio (Minimum MLR) of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. What constitutes medical costs and premium revenue are specifically defined by federal regulations. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

During the second quarter, we were informed by the Texas Department of Health and Human Services that it will not recoup any quality revenue for calendar years 2014, 2015, and 2016. Therefore, we recognized previously deferred quality revenue amounting to approximately $51 million in the second quarter of 2016. Of the $51 million adjustment, $44 million related to 2015 and 2014 dates of service, and $7 million related to the first quarter of 2016.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2016 are not known, we have no reason to believe that the

adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2016, other than the Texas quality revenue recognized in the second quarter of 2016 described above.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In millions)			
Maximum available quality incentive premium - current period	$ 41	$ 28	$ 81	$ 58
Amount of quality incentive premium revenue recognized in current period:				
Earned current period	$ 36	$ 11	$ 54	$ 21
Earned prior periods	49	11	54	11
Total	$ 85	$ 22	$ 108	32
Quality incentive premium revenue recognized as a percentage of total premium revenue	2.1%	0.7%	1.3%	0.5%

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), certain compensation, and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Recent Accounting Pronouncements

Revenue Recognition. In May 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2016-12, *Revenue from Contracts with Customers (Topic 606).* The amendments, which address transition, collectibility, non-cash consideration and the presentation of sales and other similar taxes, do not change the core principles of ASU 2014-09, but rather address implementation issues and are intended to result in more consistent application. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

In April 2016, the FASB issued ASU 2016-10, *Identifying Performance Obligations and Licensing*, which amends certain aspects of ASC 606, *Revenue from Contracts with Customers*. ASU 2016-10 amends step two of the new revenue standard's five-step model to include guidance on immaterial promised goods or services, shipping and handling activities and identifying when promises represent performance obligations. ASU 2016-10 also provides guidance related to licensing such as, but not limited to, sales-based and usage-based royalties and renewals of license that provide a right to use intellectual property. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

In March 2016, the FASB issued ASU 2016-08, *Revenue from Contracts with Customers - Principal vs. Agent Considerations*, which amends the principal–versus–agent implementation guidance in ASC 606. ASU 2016-08 clarifies that an entity should evaluate whether it is the principal or agent for each specified good or service promised in a contract with a customer as defined in ASC 606. The entity must first identify each specified good or service to be provided to the customer and then assess whether it controls each specified good or service. The ASU also removed two of the five indicators used in evaluating control under the old guidance and reframes the remaining three indicators. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

Credit Losses. In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments*, which changes how companies measure credit losses on most financial instruments measured at amortized cost, such as loans, receivables and held-to-maturity debt securities. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument's contractual life. ASU 2016-13 is effective for fiscal periods beginning after December 15, 2019 and must

be adopted as a cumulative effect adjustment to retained earnings. Early adoption is permitted. We are evaluating the potential effects of the adoption to our financial statements.

Stock Compensation. In March 2016, the FASB issued ASU 2016-09, *Compensation-Stock Compensation*, which simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, statutory tax and classification in the statement of cash flows. ASU 2016-09 is effective for fiscal periods beginning after December 15, 2016 and must be adopted using the modified retrospective approach except for classification in the statement of cash flows, which must be adopted using either the prospective or retrospective approach. Early adoption is permitted. We are evaluating the potential effects of the adoption to our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of basic and diluted net income per share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In millions, except net income per share)			
Numerator:				
Net income	$ 33	$ 39	$ 57	$ 67
Denominator:				
Shares outstanding at the beginning of the period	55	49	55	49
Weighted-average number of shares:				
Issued in common stock offering	—	1	—	1
Denominator for basic net income per share	55	50	55	50
Effect of dilutive securities:				
Convertible senior notes (1)	—	1	—	—
1.125% Warrants (1)	—	3	1	2
Denominator for diluted net income per share	55	54	56	52
Net income per share (2):				
Basic	$ 0.58	$ 0.78	$ 1.02	$ 1.36
Diluted	$ 0.58	$ 0.72	$ 1.01	$ 1.29

(1) For more information regarding the convertible senior notes, refer to Note 10, "Debt." For more information regarding the 1.125% Warrants, refer to Note 11, "Derivatives."
(2) Source data for calculations in thousands.

4. Business Combinations

In the first quarter of 2016, we closed on several business combinations in the Health Plans segment. For all of these transactions, we applied the acquisition method of accounting, where the total purchase price was allocated, or preliminarily allocated, to tangible and intangible assets acquired, and liabilities assumed based on their respective fair values. For the Health Plans acquisitions, described below, only intangible assets were acquired. All of these acquisitions were funded using available cash and acquisition-related costs were insignificant.

Health Plans

Consistent with our strategy to grow in our existing markets, we closed the following Health Plans acquisitions in the first quarter of 2016:

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. The initial purchase price was approximately $35 million, and the Illinois health plan added approximately 58,000 Medicaid members as a result of this transaction.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. The final purchase price was approximately $12 million, and the Illinois health plan added approximately 18,000 Medicaid members as a result of this transaction.

On March 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Better Health Network, LLC. The initial purchase price was approximately $18 million, and the Illinois health plan added approximately 34,000 Medicaid members as a result of this transaction.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. The final purchase price was approximately $31 million, and the Michigan health plan added approximately 68,000 Medicaid and MIChild members as a result of this transaction.

Washington. On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Columbia United Providers, Inc. The final purchase price was approximately $28 million, and the Washington health plan added approximately 57,000 Medicaid members as a result of this transaction.

For these acquisitions, we recorded goodwill to the Health Plans segment amounting to $90 million in the aggregate, which relates to future economic benefits arising from expected synergies to be achieved. Such synergies include use of our existing infrastructure to support the added membership. The amount recorded as goodwill is deductible for income tax purposes.

The following table presents the intangible assets identified in the transactions described above. The weighted-average amortization period, in the aggregate, is 5.9 years. For these acquisitions in the aggregate, we expect to record amortization of approximately $6 million per year in the years 2016 through 2020 and $1 million in 2021.

	Fair Value	Life
	(In millions)	(Years)
Intangible asset type:		
Contract rights - member list	$ 28	5
Provider network	6	10
	$ 34	

5. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs. Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include derivative financial instruments.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of June 30, 2016 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 11, “Derivatives,” the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the six months ended June 30, 2016.

Our financial instruments measured at fair value on a recurring basis at June 30, 2016, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,345	$ —	$ 1,345	$ —
Government-sponsored enterprise securities (GSEs)	196	196	—	—
Municipal securities	180	—	180	—
U.S. treasury notes	108	108	—	—
Asset-backed securities	71	—	71	—
Certificates of deposit	68	—	68	—
Subtotal - current investments	1,968	304	1,664	—
1.125% Call Option derivative asset	226	—	—	226
Total assets measured at fair value on a recurring basis	$ 2,194	$ 304	$ 1,664	$ 226
1.125% Conversion Option derivative liability	$ 226	$ —	$ —	$ 226
Total liabilities measured at fair value on a recurring basis	$ 226	$ —	$ —	$ 226

Our financial instruments measured at fair value on a recurring basis at December 31, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,184	$ —	$ 1,184	$ —
GSEs	211	211	—	—
Municipal securities	185	—	185	—
U.S. treasury notes	78	78	—	—
Asset-backed securities	63	—	63	—
Certificates of deposit	80	—	80	—
Subtotal - current investments	1,801	289	1,512	—
1.125% Call Option derivative asset	374	—	—	374
Total assets measured at fair value on a recurring basis	$ 2,175	$ 289	$ 1,512	$ 374
1.125% Conversion Option derivative liability	$ 374	$ —	$ —	$ 374
Total liabilities measured at fair value on a recurring basis	$ 374	$ —	$ —	$ 374

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table.

	June 30, 2016		December 31, 2015	
	Carrying Value	Fair Value	Carrying Value	Fair Value
		(In millions)		
5.375% Notes	$ 690	$ 702	$ 689	$ 700
1.125% Convertible Notes	460	742	448	865
1.625% Convertible Notes	278	329	273	365
	$ 1,428	$ 1,773	$ 1,410	$ 1,930

6. Investments

The following tables summarize our investments as of the dates indicated:

	June 30, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,340	$ 5	$ —	$ 1,345
GSEs	196	—	—	196
Municipal securities	178	2	—	180
U.S. treasury notes	108	—	—	108
Asset-backed securities	71	—	—	71
Certificates of deposit	68	—	—	68
	$ 1,961	$ 7	$ —	$ 1,968

	December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,189	$ —	$ 5	$ 1,184
GSEs	212	—	1	211
Municipal securities	186	—	1	185
U.S. treasury notes	78	—	—	78
Asset-backed securities	63	—	—	63
Certificates of deposit	80	—	—	80
	$ 1,808	$ —	$ 7	$ 1,801

The contractual maturities of our investments as of June 30, 2016 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,084	$ 1,084
Due after one year through five years	844	850
Due after five years through ten years	33	34
	$ 1,961	$ 1,968

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and six months ended June 30, 2016 and 2015 were insignificant.

We have determined that unrealized gains and losses at June 30, 2016 and December 31, 2015, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

There were no available-for-sale investments in a material continuous loss position as of June 30, 2016.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2015:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 825	$ 4	588	$ 119	$ 1	87
GSEs	182	1	77	—	—	—
Municipal securities	128	1	181	—	—	—
	$ 1,135	$ 6	846	$ 119	$ 1	87

7. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial. The information below is presented by segment.

	June 30, 2016	December 31, 2015
	(In millions)	
California	$ 180	$ 104
Florida	103	22
Illinois	106	35
Michigan	62	39
New Mexico	64	51
Ohio	112	66
Puerto Rico	50	33
South Carolina	11	6
Texas	60	56
Utah	38	18
Washington	81	53
Wisconsin	46	22
Direct delivery and other	5	6
Total Health Plans segment	918	511
Molina Medicaid Solutions segment	41	37
Other segment	53	49
	$ 1,012	$ 597

8. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of

restricted investments:

	June 30, 2016	December 31, 2015
	(In millions)	
Florida	$ 28	$ 34
Illinois	3	—
Michigan	1	1
New Mexico	43	43
Ohio	12	12
Puerto Rico	10	10
Texas	4	4
Utah	4	4
Wisconsin	1	1
Other	1	—
Total Health Plans segment	$ 107	$ 109

The contractual maturities of our held-to-maturity restricted investments as of June 30, 2016 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 106	$ 106
Due after one year through five years	1	1
	$ 107	$ 107

9. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	June 30, 2016	December 31, 2015
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,292	$ 1,191
Pharmacy payable	103	88
Capitation payable	37	140
Other	334	266
	$ 1,766	$ 1,685

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $191 million and $167 million as of June 30, 2016 and December 31, 2015, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30, 2016	Year Ended December 31, 2015
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 1,685	$ 1,201
Components of medical care costs related to:		
Current period	7,371	11,935
Prior periods	(189)	(141)
Total medical care costs	7,182	11,794
Change in non-risk provider payables	24	48
Payments for medical care costs related to:		
Current period	5,885	10,448
Prior periods	1,240	910
Total paid	7,125	11,358
Medical claims and benefits payable, ending balance	$ 1,766	$ 1,685
Benefit from prior period as a percentage of:		
Balance at beginning of period	11.3%	11.8%
Premium revenue, trailing twelve months	1.3%	1.1%
Medical care costs, trailing twelve months	1.4%	1.2%

The portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). Our IBNP, included in medical claims and benefits payable, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under– or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2016 and 2015 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at June 30, 2016 are as follows:

- In the first half of 2016, our Marketplace enrollment across all health plans increased by approximately 392,000 members. Some of the states with significant increases included:
    - California: 57,000

- Florida: 94,000
- Texas: 110,000
- Utah: 48,000
- Wisconsin: 38,000

Because these new Marketplace members may have different utilization patterns than our legacy members, our estimates of the liability we have incurred for services provided to these members are subject to more than the usual amount of uncertainty.

- Our Illinois health plan added over 100,000 new members under acquisitions of three Medicaid contracts during the first half of 2016. Because these new members may have different utilization patterns than our legacy members, our estimates of the liability we have incurred for services provided to these members are subject to more than the usual amount of uncertainty.
- At our New Mexico, Puerto Rico and Washington health plans, we overpaid certain inpatient and outpatient facility claims. We adjusted our claims payment history to reflect the claims payment pattern that would have occurred without these overpayments. For this reason, our liability estimates at these health plans are subject to more than the usual amount of uncertainty.
- At our Washington health plan, the covered benefits in two counties were expanded to include behavioral health benefits under the state's new fully integrated managed care program, which impacted about 80,000 members. Because these are new benefits, our liability estimate at this health plan is subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $189 million for the six months ended June 30, 2016. This amount represents our estimate as of June 30, 2016, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2015 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- A new version of diagnostic codes was required for all claims with dates of service on October 1, 2015, and later. As a result, payment was delayed or denied for a significant number of claims due to provider submission of claims with diagnostic codes that were no longer valid. Once providers were able to submit claims with the correct diagnostic codes, our actual costs were ultimately less than expected.
- At our New Mexico health plan, we overestimated the impact of several pending high-dollar claims, and our actual costs were ultimately less than expected.
- At our Washington health plan, we overpaid certain outpatient facility claims in 2015 when the state converted to a new payment methodology. We did not include an estimate in the reserves for this potential recovery as of December 31, 2015.
- At our California health plan, approximately 55,000 new members were added to our Medicaid Expansion product in 2015. For these new members, our actual costs were ultimately less than expected.

10. Debt

As of June 30, 2016, contractual maturities of debt for the years ending December 31 are as follows:

	Total	2016	2017	2018	2019	2020	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ —	$ —	$ —	$ 700
1.125% Convertible Notes	550	—	—	—	—	550	—
1.625% Convertible Notes (1)	302	—	—	—	—	—	302
	$ 1,552	$ —	$ —	$ —	$ —	$ 550	$ 1,002

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The principal amounts, unamortized discount (net of premium related to the 1.625% Notes), unamortized issuance costs, and net carrying amounts of debt were as follows:

	Principal Balance	Unamortized Discount	Unamortized Issuance Costs	Net Carrying Amount
		(In millions)		
June 30, 2016:				
5.375% Notes	$ 700	$ —	$ 10	$ 690
1.125% Convertible Notes	550	84	6	460
1.625% Convertible Notes	302	20	4	278
	$ 1,552	$ 104	$ 20	$ 1,428
December 31, 2015:				
5.375% Notes	$ 700	$ —	$ 11	$ 689
1.125% Convertible Notes	550	95	7	448
1.625% Convertible Notes	302	25	4	273
Other	1	—	—	1
	$ 1,553	$ 120	$ 22	$ 1,411

Interest cost recognized relating to our convertible senior notes for the periods presented was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In millions)			
Contractual interest coupon rate	$ 3	$ 3	$ 6	$ 6
Amortization of the discount	8	7	15	14
	$ 11	$ 10	$ 21	$ 20

5.375% Senior Notes due 2022. On November 10, 2015, we completed the private offering of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest is payable semiannually in arrears on May 15 and November 15. The 5.375% Notes are not convertible into our common stock or any other securities.

The 5.375% Notes are guaranteed by certain of our wholly owned subsidiaries. The 5.375% Notes and the guarantees are effectively subordinated to all existing and future secured debt of us and our guarantors to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock of our subsidiaries that do not guarantee the 5.375% Notes.

We may redeem some or all of the 5.375% Notes at any time, and prior to August 15, 2022, at a price equal to 100% of the principal amount redeemed plus accrued and unpaid interest thereon, plus a "make-whole" premium. Thereafter, we may redeem some or all of the 5.375% Notes at a price equal to 100% of the principal amount redeemed plus accrued and unpaid interest thereon. The 5.375% Notes contain customary non-financial covenants and change of control provisions.

In connection with the issuance and sale of the 5.375% Notes, we entered into a registration rights agreement. Under this agreement, we will use commercially reasonable efforts to register substantially identical notes (the Exchange Notes) with the SEC in 2016. We will then offer such freely tradable Exchange Notes in exchange for the 5.375% Notes. We will pay additional interest on the 5.375% Notes if the Exchange Notes offering is not completed timely.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. As of June 30, 2016, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Although the Credit Facility is not secured by any of our assets, certain of our wholly owned subsidiaries have jointly and severally guaranteed our obligations under the Credit Facility.

The Credit Facility contains customary non-financial and financial covenants, including a minimum fixed charge coverage ratio, a maximum debt-to-EBITDA ratio and minimum statutory net worth. At June 30, 2016, we were in compliance with all financial covenants under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes (1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest is payable semiannually in arrears on January 15 and July 15.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date. Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;

- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;

- upon the occurrence of specified corporate events; or

- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes did not meet the stock price trigger in the quarter ended June 30, 2016; therefore the $460 million carrying amount was reclassified to long-term debt as of June 30, 2016.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of June 30, 2016, the 1.125% Notes have a remaining amortization period of 3.5 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $180 million and $332 million as of June 30, 2016 and December 31, 2015, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $125 million principal amount of 1.625% convertible senior notes (1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Combined with the 1.625% Notes issued in an exchange transaction in 2014, the aggregate principal amount of 1.625% Notes issued was $302 million.

Interest is payable semiannually in arrears on February 15 and August 15. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of

the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of June 30, 2016, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem all or part of the 1.625% Notes for cash, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the 1.625% Notes in August 2018. As of June 30, 2016, the 1.625% Notes have a remaining amortization period of 2.1 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value did not exceed their principal amount at June 30, 2016 and exceeded their principal amount at December 31, 2015 by approximately $10 million. At June 30, 2016 and December 31, 2015, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $23 million.

11. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	June 30, 2016	December 31, 2015
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ —	$ 374
	Non-current assets: Derivative asset	$ 226	$ —
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ —	$ 374
	Non-current liabilities: Derivative liability	$ 226	$ —

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Notes due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 5, "Fair Value Measurements."

As of June 30, 2016, the 1.125% Call Option and the 1.125% Conversion Option were classified as a non-current asset and non-current liability, respectively, because the 1.125% Notes may not be converted within 12 months of June 30, 2016, as described in Note 10, "Debt."

12. Stockholders' Equity

Stockholders' equity increased $84 million during the six months ended June 30, 2016 compared with stockholders' equity at December 31, 2015. The increase was primarily due to net income of $57 million, $8 million of other comprehensive income and $19 million related to employee stock transactions.

1.125% Warrants. In connection with the Call Spread Overlay transaction described in Note 11, "Derivatives," in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Program. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Stock Incentive Plans. In connection with our equity incentive plans and employee stock purchase plan, approximately 446,000 shares of common stock vested, net of shares used to settle employees' income tax obligations, during the six months ended June 30, 2016.

Charged to general and administrative expenses, total share-based compensation expense was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In millions)			
Restricted stock and performance awards	$ 8	$ 2	$ 13	$ 7
Employee stock purchase plan and stock options	1	1	3	2
	$ 9	$ 3	$ 16	$ 9

As of June 30, 2016, there was $45 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.8 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 4.3% for non-executive employees as of June 30, 2016.

Restricted stock. Restricted and performance stock activity for the six months ended June 30, 2016 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
	(In thousands)	
Unvested balance as of December 31, 2015	1,035	$ 46.68
Granted	505	64.22
Vested	(329)	41.45
Forfeited	(19)	52.01
Unvested balance as of June 30, 2016	1,192	55.47

The total fair value of restricted and performance awards granted during the six months ended June 30, 2016 and 2015 was $32 million and $27 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, which vested during the six months ended June 30, 2016 and 2015 was $21 million and $24 million, respectively.

As of June 30, 2016, there were approximately 603,000 unvested restricted shares outstanding which contained one or more performance measures. In the event the vesting conditions are not achieved, the awards will lapse. Based on our assessment as of June 30, 2016, we expect the performance conditions for approximately 425,000 of these outstanding restricted share awards to be met in full.

13. Segment Information

We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other.

Our reportable segments are consistent with how we currently manage the business and view the markets we serve. The Health Plans segment consists of our health plans and our direct delivery business. Our health plans are operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides Medicaid management information system (MMIS) design, development, and implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies. Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by GAAP, as well as corporate amounts not allocated to other reportable segments.

Gross margin is the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
Three Months Ended June 30, 2016				
Total revenue (1)	$ 4,223	$ 46	$ 90	$ 4,359
Gross margin	435	5	14	454
Six Months Ended June 30, 2016				
Total revenue (1)	$ 8,424	$ 98	$ 180	$ 8,702
Gross margin	842	11	21	874
Three Months Ended June 30, 2015				
Total revenue (1)	$ 3,477	$ 47	$ 1	$ 3,525
Gross margin	375	14	—	389
Six Months Ended June 30, 2015				
Total revenue (1)	$ 6,593	$ 99	$ 4	$ 6,696
Gross margin	710	30	—	740
Total Assets				
June 30, 2016	$ 5,521	$ 252	$ 1,429	$ 7,202
December 31, 2015	4,707	213	1,656	6,576

(1) Total revenue consists primarily of premium revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments.

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In millions)			
Gross margin:				
Health Plans	$ 435	$ 375	$ 842	$ 710
Molina Medicaid Solutions	5	14	11	30
Other	14	—	21	—
Total gross margin	454	389	874	740
Add: other operating revenues (1)	195	174	403	322
Less: other operating expenses (2)	(544)	(447)	(1,083)	(864)
Operating income	105	116	194	198
Other expenses, net	(25)	(15)	(50)	(30)
Income before income tax expense	$ 80	$ 101	$ 144	$ 168

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(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

14. Commitments and Contingencies

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable and is not reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. On October 22, 2015, the Relator filed a third amended complaint. On July 11, 2016, the District Court dismissed with prejudice the third amended complaint, without leave to amend, thereby concluding this litigation.

Rodriguez v. Providence Community Corrections. On October 1, 2015, seven individuals, on behalf of themselves and all others similarly situated, filed a complaint in the District Court for the Middle District of Tennessee, Nashville Division, Case No. 3:15-cv-01048 (the "Rodriquez Litigation"), against Providence Community Corrections, Inc. (now known as Pathways Community Corrections, Inc., or "PCC"). Rutherford County, Tennessee formerly contracted with PCC for the administration of misdemeanor probation, which involved the collection of court costs and fees from probationers. The complaint alleges, among other things, that PCC illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay such amounts. The plaintiffs in the Rodriguez Litigation seek alleged compensatory, treble, and punitive damages, plus attorneys' fees, for alleged federal and state constitutional violations, as well as alleged violations of the Racketeer Influenced and Corrupt Organization Act. PCC's agreement with Rutherford County terminated effective December 29, 2015. On November 1, 2015, one month after the Rodriguez Litigation had been commenced, we acquired PCC from The Providence Service Corporation ("Providence") pursuant to a membership interest purchase agreement. We have notified Providence that, for its failure to disclose the Rodriguez Litigation, we intend to seek indemnification from Providence under the membership interest purchase agreement for any liability arising from the Rodriguez Litigation.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

States' Budgets. From time to time, the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. It has been our practice in the past to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us.

Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,299 million at June 30, 2016, and $1,229 million at December 31, 2015. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $466 million and $612 million as of June 30, 2016 and December 31, 2015, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state.

As of June 30, 2016, our health plans had aggregate statutory capital and surplus of approximately $1,384 million compared with the required minimum aggregate statutory capital and surplus of approximately $854 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2016. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

15. Related Party Transactions

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina, our Chief Executive Officer, and John C. Molina, our Chief Financial Officer. Under the terms of this provider agreement, the California health plan pays Pacific for medical care Pacific provides to health plan members. For the three and six months ended June 30, 2016 and 2015, the amounts paid to Pacific were insignificant.

Refer to Note 16, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

16. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. JMMPC also provides certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund

JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant. For the three months ended June 30, 2016 and 2015, our health plans paid $31 million and $27 million, respectively, to JMMPC for health care services provided by JMMPC to the health plans' members. For the six months ended June 30, 2016 and 2015, our health plans paid $61 million and $52 million, respectively, to JMMPC for health care services provided by JMMPC to the health plans' members.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of June 30, 2016, JMMPC had total assets of $13 million, and total liabilities of $13 million. As of December 31, 2015, JMMPC had total assets of $17 million, and total liabilities of $17 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This Quarterly Report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this Quarterly Report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- the success of our profit improvement and cost-cutting initiatives;
- uncertainties and evolving market and provider economics associated with the implementation of the Affordable Care Act (the "ACA"), the Medicaid expansion, the insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the Medicare-Medicaid dual eligible demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;
- management of our medical costs, including our ability to reduce over time the high medical costs commonly associated with new patient populations;
- our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates in new plans, geographies, and programs where we have less experience with patient and provider populations, and also including utilization rates associated with seasonal flu patterns or other newly emergent diseases;
- our ability to manage growth, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives designed to control costs;
- our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;
- our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;
- the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;
- the interpretation and implementation of state contract performance requirements regarding the achievement of certain quality measures, and our ability to avoid liquidated damages associated therewith;
- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;
- the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, the effect of the newly enacted PROMESA law, and our efforts to better manage the health care costs of our Puerto Rico health plan;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the resolution of the Illinois budget impasse and continued payment of all amounts due to our Illinois health plan;
- the accurate estimation of incurred but not reported or paid medical costs across our health plans;
- subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts due to or receivable from CMS under the ACA's "three R's" marketplace premium stabilization programs;
- efforts by states to recoup previously paid amounts, including our dispute with the state of New Mexico related to reimbursement for retroactively enrolled members in 2014;

- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;
- the continuation and renewal of the government contracts of our health plans, Molina Medicaid Solutions, and Pathways, and the terms under which such contracts are renewed;
- complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings;
- the relatively small number of states in which we operate health plans;
- the effect on our Los Angeles County subcontract of Centene Corporation's acquisition of Health Net Inc.;
- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;
- newly emergent viruses or widespread epidemics, including the Zika virus, public catastrophes or terrorist attacks, and associated public alarm;
- changes in general economic conditions, including unemployment rates;
- the sufficiency of our funds on hand to pay the amounts due upon conversion of our outstanding notes; and
- increasing competition and consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2015 and Part II, Item 1A of this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2015.

Company Overview

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other. All prior periods reported conform to this presentation.

Update on 2016 Financial Performance

Second Quarter 2016 Compared With First Quarter 2016

Second quarter 2016 financial performance improved significantly when compared with the first quarter of 2016. Earnings per diluted share increased to $0.58 in the second quarter of 2016 from $0.43 in the first quarter. Adjusted earnings per diluted share increased to $0.67 in the second quarter of 2016 from $0.51 in the first quarter.

Higher profitability in the second quarter was primarily the result of improvements at the Ohio and Texas health plans. The medical care ratio of the Ohio health plan decreased to 89.7% in the second quarter of 2016 from 92.0% in the first quarter. The medical care ratio of the Texas health plan decreased to 78.5% in the second quarter of 2016 from 92.8% in the first quarter. Even without the benefit of out-of-period quality revenue adjustments discussed below, the medical care ratio of the Texas health plan would have been approximately 85.3% in the second quarter, still well under the 92.8% medical care ratio reported in the first quarter.

In total, out-of-period adjustments related to 2015 dates of service were not significant to second quarter performance. Out-of-period adjustments were significant, however, on a geographic and program basis. Out-of-period adjustments were the result of changes in accounting estimates made as new information became available to the Company. The table below will help the reader to understand the discussion that follows.

Summary of Significant Out-of-Period Adjustments Affecting 2016 Financial Results

	Three Months Ended June 30, 2016		Six Months Ended June 30, 2016	
	(In millions, except per diluted share amounts)			
	Amount	Per diluted share	Amount	Per diluted share
Marketplace adjustments for 2015 dates of service	$ (37)	$ (0.42)	$ (68)	$ (0.76)
Texas quality revenue adjustment for 2014/2015 dates of service	44	0.50	44	0.49
Texas quality revenue adjustment for 1Q 2016 dates of service	7	0.08	N/A	N/A
Puerto Rico premium revenue adjustment for 2015 dates of service	(11)	(0.12)	(11)	(0.12)
Florida premium revenue adjustment for 2014/2015 dates of service	—	—	18	0.20
Total out-of-period adjustments, net	$ 3	$ 0.04	$ (17)	$ (0.19)

Out-of-period adjustments increased pretax income by approximately $3 million in the second quarter of 2016. Specifically:

- Adjustments related to 2015 dates of service reduced Marketplace pretax income by approximately $37 million in the second quarter. On June 30, 2016, the Centers for Medicare and Medicaid Services released the final update on risk adjustment and reinsurance payments for the 2015 benefit year, and we adjusted our accruals accordingly.
- During the second quarter, we were informed by the Texas Department of Health and Human Services that it will not recoup any quality revenue for calendar years 2014, 2015, and 2016. Therefore, we recognized previously deferred quality revenue amounting to approximately $51 million in the second quarter of 2016. Of the $51 million adjustment, $44 million related to 2015 and 2014 dates of service, and $7 million related to the first quarter of 2016.
- Reductions to revenue previously recorded for 2015 dates of service in Puerto Rico decreased pretax income by approximately $11 million in the second quarter.

Understanding the First Half of 2016

We reported pretax income of $144 million for the first half of 2016. These results were affected by several out-of-period adjustments related to dates of service in 2015 and 2014. In total, these adjustments reduced pretax income in the first half of 2016 by approximately $17 million. Specifically:

- Adjustments related to 2015 dates of service reduced Marketplace pretax income by approximately $68 million in the first half of 2016. We now estimate that the medical care ratio for our Marketplace program for all of 2015 was approximately 80%. Through June 30, 2016, the medical care ratio of our Marketplace program for months of service in the first half of 2016 alone (exclusive of out-of-period adjustments) was approximately 78%.
- As described above, the recognition of Texas quality revenue associated with calendar years 2014 and 2015 increased pretax income in the first half of 2016 by approximately $44 million.
- Also as noted above, reductions to 2015 premium revenue in Puerto Rico reduced pretax income by approximately $11 million in the first half of 2016.
- Retroactive adjustments to premium revenue in Florida for dates of service in 2014 and 2015 increased pretax income by approximately $18 million in the first half of 2016. Prior to reporting first quarter 2016 results, we were informed by the Florida Agency for Health Care Administration that we were due a retroactive increase to Medicaid premium revenue relating to dates of service prior to 2016. We reported this development in our first quarter 2016 results.

Management Expectations Regarding the Second Half of 2016

We expect the following factors, among others, to affect our financial performance in the second half of 2016:

- The ultimate savings to be realized from various cost savings initiatives and the speed at which such savings will be realized.
- Medicaid rate increases (excluding Medicaid Expansion) of approximately 3.0% in California (effective July 1, 2016); approximately 2.5% in Puerto Rico (effective July 1, 2016); and approximately 3.0% in Texas (effective September 1, 2016). All rate changes are consistent with our previous expectations.
- Medicaid Expansion rate decreases of approximately 11.0% in California (effective July 1, 2016) and approximately 2.0% in Ohio (effective July 1, 2016). All rate changes are consistent with our previous expectations.
- The implementation of a medical care ratio floor of 86.0% for the South Carolina Medicaid program effective July 1, 2016.
- Declining margins for our Marketplace business during the second half of 2016 due to normal membership attrition; the addition of higher cost members through the special enrollment process; higher costs as members reach the limits of the cost-sharing provisions of their insurance coverage; and increasing utilization as members become more engaged with our care networks. This is consistent with our previous expectations.

Market Updates

Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," for a discussion of the current year market updates.

Understanding Our Business

Health Plans Segment

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of June 30, 2016, these health plans served 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, most of whom receive government premium subsidies.

Health Plan Segment Membership by Health Plan and Program. The following tables set forth our Health Plans membership as of the dates indicated:

	June 30, 2016	March 31, 2016	December 31, 2015	June 30, 2015
Ending Membership by Health Plan:				
California	680,000	676,000	620,000	593,000
Florida	565,000	576,000	440,000	348,000
Illinois	201,000	206,000	98,000	101,000
Michigan	393,000	399,000	328,000	260,000
New Mexico	251,000	246,000	231,000	225,000
Ohio	341,000	336,000	327,000	332,000
Puerto Rico	336,000	339,000	348,000	361,000
South Carolina	105,000	102,000	99,000	114,000
Texas	367,000	380,000	260,000	266,000
Utah	151,000	151,000	102,000	92,000
Washington	709,000	672,000	582,000	553,000
Wisconsin	134,000	137,000	98,000	107,000
	4,233,000	4,220,000	3,533,000	3,352,000
Ending Membership by Program:				
Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP)	2,500,000	2,485,000	2,312,000	2,180,000
Medicaid Expansion	654,000	632,000	557,000	475,000
Marketplace	597,000	630,000	205,000	261,000
Aged, Blind or Disabled (ABD)	387,000	380,000	366,000	353,000
Medicare-Medicaid Plan (MMP) – Integrated (1)	51,000	50,000	51,000	39,000
Medicare Special Needs Plans (Medicare)	44,000	43,000	42,000	44,000
	4,233,000	4,220,000	3,533,000	3,352,000

(1) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

Health Plan Segment Premiums by Program. The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a per-member per-month (PMPM) basis, for the six months ended June 30, 2016. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 290.00	$ 180.00
Medicaid Expansion	310.00	490.00	370.00
Marketplace	170.00	350.00	230.00
ABD	400.00	1,530.00	980.00
MMP – Integrated	970.00	3,190.00	2,160.00
Medicare	790.00	1,080.00	1,010.00

Health Plan Segment Medical Care Costs by Type. The following table provides the details of consolidated medical care costs by type for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended June 30,					
	2016			2015		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,620	$ 206.01	72.9%	$ 2,103	$ 209.34	71.8%
Pharmacy	529	41.59	14.7	392	39.01	13.3
Capitation	304	23.87	8.5	248	24.72	8.5
Direct delivery	18	1.39	0.5	27	2.78	1.0
Other	123	9.68	3.4	159	15.80	5.4
	$ 3,594	$ 282.54	100.0%	$ 2,929	$ 291.65	100.0%

	Six Months Ended June 30,					
	2016			2015		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 5,357	$ 213.77	74.6%	$ 4,051	$ 217.05	72.8%
Pharmacy	1,054	42.05	14.7	743	39.81	13.4
Capitation	599	23.87	8.3	465	24.90	8.3
Direct delivery	34	1.36	0.5	54	2.93	1.0
Other	138	5.52	1.9	252	13.49	4.5
	$ 7,182	$ 286.57	100.0%	$ 5,565	$ 298.18	100.0%

Molina Medicaid Solutions Segment

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida. Operations in each of those jurisdictions are performed pursuant to separate contracts with each respective Medicaid agency.

Other Segment

Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to the other reportable segments.

How We Assess Performance

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. The following table presents gross margin for our segments. Management's discussion and analysis of the changes in the individual components of gross margin, by reportable segment, is presented below under Results of Operations.

	Three Months Ended June 30,				Six Months Ended June 30,			
	2016	2015	$ Change	% Change	2016	2015	$ Change	% Change
	(In millions)				(In millions)			
Health Plans:								
Premium revenue	$ 4,029	$ 3,304	$ 725	22 %	$ 8,024	$ 6,275	$ 1,749	28 %
Less: medical care costs	3,594	2,929	665	23	7,182	5,565	1,617	29
Medical margin	$ 435	$ 375	$ 60	16 %	$ 842	$ 710	$ 132	19 %
Medical care ratio	89.2%	88.7%			89.5%	88.7%		
Molina Medicaid Solutions:								
Service revenue	$ 46	$ 47	$ (1)	(2)%	$ 98	$ 99	$ (1)	(1)%
Less: cost of service revenue	41	33	8	24	87	69	18	26
Service margin	$ 5	$ 14	$ (9)	(64)%	$ 11	$ 30	$ (19)	(63)%
Service cost ratio	89.5%	69.5%			89.1%	69.3%		
Other:								
Service revenue	$ 89	$ —			$ 177	$ —		
Less: cost of service revenue	75	—			156	—		
Service margin	$ 14	$ —			$ 21	$ —		
Service cost ratio	84.6%	—%			88.3%	—%		

Our Use of Non-GAAP Financial Measures

We use two non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures. The year over year changes for the individual components of both of these measures are described below in Results of Operations.

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization (EBITDA). We believe that EBITDA is particularly helpful in assessing our ability to meet the cash demands of our operating units. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In millions)			
Net income	$ 33	$ 39	$ 57	$ 67
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	39	29	76	58
Interest expense	25	15	50	30
Income tax expense	47	62	87	101
EBITDA	$ 144	$ 145	$ 270	$ 256

The second of these non-GAAP measures is adjusted net income (including adjusted net income per diluted share). We believe that adjusted net income per diluted share is very helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net income.

	Three Months Ended June 30,				Six Months Ended June 30,			
	2016		2015		2016		2015	
	(In millions, except diluted per-share amounts)							
Net income	$ 33	$ 0.58	$ 39	$ 0.72	$ 57	$ 1.01	$ 67	1.29
Adjustment, net of tax:								
Amortization of intangible assets	5	0.09	3	0.05	10	0.17	6	0.10
Adjusted net income (1)	$ 38	$ 0.67	$ 42	$ 0.77	$ 67	$ 1.18	$ 73	$ 1.39

(1) Beginning in the first quarter of 2016, we revised our calculation of adjusted net income. We no longer subtract "Amortization of convertible senior notes and lease financing obligations" from net income to arrive at adjusted net income. We made this change because various capital transactions completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources of capital. We believe that this change enhances the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors. All periods presented conform to this presentation.

Results of Operations

Health Plans Segment

Three Months Ended June 30, 2016 Compared with Three Months Ended June 30, 2015

Strong enrollment growth generated approximately $725 million, or 22% more premium revenue in the second quarter of 2016 compared with the second quarter of 2015. Enrollment growth was primarily due to increased Marketplace enrollment, and acquisitions that added Medicaid membership. Consolidated premium revenue measured on a PMPM basis decreased approximately 4% in the second quarter of 2016 when compared with the second quarter of 2015. The decline in PMPM premium revenue was primarily the result of lower PMPM premiums for Medicaid Expansion membership and an increase in the percentage of our premium revenue derived from TANF and Marketplace membership.

The medical care ratio increased to 89.2% in the second quarter of 2016, from 88.7% in the second quarter of 2015. The increase in our medical care ratio was driven by lower percentage margins for TANF, Medicaid Expansion and Marketplace membership. Consolidated medical care costs measured on a PMPM basis decreased approximately 3% in the second quarter of 2016 when compared with the second quarter of 2015. The PMPM decrease in medical care costs, which was primarily related to increased Marketplace membership, was more than offset by the declines in PMPM revenue as described above.

Financial Performance by Program. The following tables present the components of premium revenue and medical care costs by program (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions).

	Three Months Ended June 30, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.5	$ 1,302	$ 173.57	$ 1,202	$ 160.26	92.3%	$ 100
Medicaid Expansion	1.9	742	378.19	634	323.56	85.6	108
Marketplace	1.8	373	206.88	323	178.79	86.4	50
ABD	1.2	1,168	991.38	1,038	881.80	88.9	130
MMP	0.2	315	2,093.29	270	1,792.78	85.6	45
Medicare	0.2	129	997.44	127	974.30	97.7	2
	12.8	$ 4,029	$ 316.72	$ 3,594	$ 282.54	89.2%	$ 435

	Three Months Ended June 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	6.5	$ 1,169	$ 178.38	$ 1,063	$ 162.24	91.0%	$ 106
Medicaid Expansion	1.4	582	419.67	474	341.67	81.4	108
Marketplace	0.8	161	204.22	90	113.21	55.4	71
ABD	1.1	1,053	984.99	947	885.84	89.9	106
MMP	0.1	198	1,784.30	214	1,934.40	108.4	(16)
Medicare	0.2	141	1,059.90	141	1,062.71	100.3	—
	10.1	$ 3,304	$ 328.96	$ 2,929	$ 291.65	88.7%	$ 375

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

The following discussion highlights the primary drivers of our performance, by program.

Medicaid Expansion. Although member months have increased 41%, premium revenue decreased 10% on a PMPM basis in the second quarter of 2016, when compared with the second quarter of 2015. This decline was due to premium rate decreases in multiple states that went into effect for Medicaid Expansion members between June 30, 2015 and January 1, 2016.

Marketplace. Adjustments related to 2015 dates of service reduced Marketplace pretax income by approximately $37 million in the second quarter. On June 30, 2016, the Centers for Medicare and Medicaid Services released the final update on risk adjustment and reinsurance payments for the 2015 benefit year, and we adjusted our accruals accordingly. We now estimate that the medical care ratio for our Marketplace business for all of 2015 was approximately 80%.

Financial Performance by State Health Plan. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended June 30, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 554	$ 268.95	$ 493	$ 239.63	89.1%	$ 61
Florida	1.8	464	273.90	426	251.69	91.9	38
Illinois	0.6	154	256.17	137	227.71	88.9	17
Michigan	1.2	369	312.18	334	282.86	90.6	35
New Mexico	0.8	342	451.72	305	403.52	89.3	37
Ohio	1.0	483	473.91	433	424.87	89.7	50
Puerto Rico	1.0	170	169.04	175	173.49	102.6	(5)
South Carolina	0.3	87	277.22	71	226.27	81.6	16
Texas	1.1	635	571.14	499	448.23	78.5	136
Utah	0.5	110	240.26	106	233.12	97.0	4
Washington	2.1	559	264.40	500	236.32	89.4	59
Wisconsin	0.4	99	244.88	96	235.88	96.3	3
Other (3)	—	3	—	19	—	—	(16)
	12.8	$ 4,029	$ 316.72	$ 3,594	$ 282.54	89.2%	$ 435

	Three Months Ended June 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.7	$ 503	$ 285.14	$ 459	$ 259.85	91.1%	$ 44
Florida	1.1	257	244.35	217	205.97	84.3	40
Illinois	0.3	102	337.55	98	325.91	96.6	4
Michigan	0.8	237	307.27	200	258.67	84.2	37
New Mexico	0.7	322	466.46	276	400.27	85.8	46
Ohio	1.1	509	510.30	432	433.75	85.0	77
Puerto Rico	1.1	194	179.33	184	170.32	95.0	10
South Carolina	0.4	93	276.36	67	196.92	71.3	26
Texas	0.8	512	635.74	468	581.42	91.5	44
Utah	0.2	80	288.60	72	258.88	89.7	8
Washington	1.6	410	249.39	371	225.46	90.4	39
Wisconsin	0.3	75	233.15	56	175.62	75.3	19
Other (3)	—	10	—	29	—	—	(19)
	10.1	$ 3,304	$ 328.96	$ 2,929	$ 291.65	88.7%	$ 375

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

The following discussion highlights the primary drivers of our performance, by health plan.

California. Premium revenue grew to $554 million in the second quarter of 2016, from $503 million in the second quarter of 2015, as a result of higher membership. The medical care ratio decreased to 89.1% in the second quarter of 2016, from 91.1% in the second quarter of 2015, due to improvement in medical care ratios for the MMP and Medicaid Expansion programs, offset partially by a higher medical care ratio in the TANF and ABD programs.

Florida. Premium revenue grew to $464 million in the second quarter of 2016, from $257 million in the second quarter of 2015, due to increased Marketplace membership and the addition of over 100,000 members from Medicaid contract acquisitions most of which closed in the fourth quarter of 2015. The medical care ratio increased to 91.9% in the second quarter

of 2016, from 84.3% in the second quarter of 2015, primarily as a result of adjustments related to 2015 dates of service for Marketplace membership, which more than offset the Medicaid rate increase of approximately 5% effective September 1, 2015.

Illinois. Premium revenue grew to $154 million in the second quarter of 2016, from $102 million in the second quarter of 2015, and the medical care ratio decreased to 88.9% in the second quarter of 2016, from 96.6% in the second quarter of 2015. The plan added over 100,000 members from Medicaid contract acquisitions in the first quarter of 2016. The decrease in the medical care ratio was primarily due to higher margins for TANF membership.

Michigan. Premium revenue grew $131 million, or 55%, in the second quarter of 2016 compared with the second quarter of 2015, due to the addition of over 100,000 members from Medicaid contract acquisitions closed in the third quarter of 2015 and the first quarter of 2016. The medical care ratio increased to 90.6% in the second quarter of 2016, from 84.2% in the second quarter of 2015, primarily as a result of lower margins for TANF and Medicaid Expansion membership.

New Mexico. The medical care ratio increased to 89.3% in the second quarter of 2016, from 85.8% in the second quarter of 2015, primarily as a result of lower margins for TANF membership.

Ohio. Premium revenue declined $25 million, or 5%, in the second quarter of 2016 compared with the second quarter of 2015, due to reduced reimbursement rates and unfavorable member mix. The medical care ratio increased to 89.7% in the second quarter of 2016, from 85.0% in the second quarter of 2015. The increase in the 2016 medical care ratio was primarily the result of a blended rate decrease of approximately 2.5% effective January 1, 2016.

Puerto Rico. The medical care ratio increased to 102.6% in the second quarter of 2016, from 95.0% in the second quarter of 2015, primarily due to increased pharmacy costs, decreased membership and premium revenue, and reductions to revenue previously recorded for 2015 dates of service which decreased pretax income by approximately $11 million.

South Carolina. The medical care ratio increased to 81.6% in the second quarter of 2016, from 71.3% in the second quarter of 2015.

Texas. Premium revenue grew $123 million, or 24%, in the second quarter of 2016 compared with the second quarter of 2015. Growth in premium revenue was primarily the result of the recognition of approximately $51 million in out-of-period quality revenue and increased Marketplace enrollment. Of the total $51 million adjustment, $44 million related to 2015 and 2014 dates of service, and $7 million related to the first quarter of 2016. The plan's medical care ratio of 78.5% in the second quarter of 2016 was significantly lower than the second quarter of 2015. Even without the benefit of out-of-period quality revenue adjustments, the medical care ratio of the Texas health plan would have been approximately 85.3%, still well under the 91.5% medical care ratio reported in the second quarter of 2015.

Utah. The medical care ratio increased to 97.0% in the second quarter of 2016, from 89.7% in the second quarter of 2015, primarily due to an increase in the medical care ratio of the growing Marketplace program.

Washington. Premium revenue grew $149 million, or 36%, in the second quarter of 2016 compared with the second quarter of 2015, primarily due to membership growth in the Medicaid (both TANF and ABD) and Medicaid Expansion programs. The medical care ratio decreased to 89.4% in the second quarter of 2016, from 90.4% in the second quarter of 2015, due to improved medical cost efficiency across nearly all programs.

Wisconsin. Premium revenue grew $24 million, or 32%, in the second quarter of 2016 when compared with the second quarter of 2015 as a result of increased Marketplace enrollment. The medical care ratio increased to 96.3% in the second quarter of 2016, from 75.3% in the second quarter of 2015 due to adjustments related to 2015 dates of service for Marketplace membership and the comparatively higher medical care ratio of the growing Marketplace membership.

Six Months Ended June 30, 2016 Compared with Six Months Ended June 30, 2015

In the first half of 2016, a 33% increase in membership, was partially offset by a 5% decrease in revenue PMPM, resulted in increased premium revenue of approximately 28%, or $1.8 billion, when compared with the first half of 2015. The decline in PMPM premium revenue was primarily the result of lower PMPM premiums for Medicaid Expansion membership and an increase in the percentage of our premium revenue derived from TANF and Marketplace membership.

Medical care costs as a percent of premium revenue increased to 89.5% in the first half of 2016, from 88.7% in the first half of 2015. The increase in our medical care ratio was driven by lower percentage margins for Medicaid Expansion and Marketplace membership. Medical margin increased 19% in the first half of 2016 over the first half of 2015.

Financial Performance by Program. The following tables present the components of premium revenue and medical care costs by program (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions).

	Six Months Ended June 30, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	14.9	$ 2,626	$ 176.00	$ 2,400	$ 160.85	91.4%	$ 226
Medicaid Expansion	3.8	1,421	371.82	1,208	316.13	85.0	213
Marketplace	3.4	782	228.19	657	191.62	84.0	125
ABD	2.4	2,280	976.58	2,079	890.71	91.2	201
MMP	0.3	655	2,157.55	587	1,932.73	89.6	68
Medicare	0.3	260	1,013.04	251	977.35	96.5	9
	25.1	$ 8,024	$ 320.17	$ 7,182	$ 286.57	89.5%	$ 842

	Six Months Ended June 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	12.0	$ 2,141	$ 177.93	$ 1,960	$ 162.89	91.6%	$ 181
Medicaid Expansion	2.7	1,089	409.29	867	325.84	79.6	222
Marketplace	1.4	355	258.66	246	179.15	69.3	109
ABD	2.1	1,993	940.23	1,810	853.56	90.8	183
MMP	0.2	423	1,986.04	413	1,942.20	97.8	10
Medicare	0.3	274	1,036.95	269	1,020.01	98.4	5
	18.7	$ 6,275	$ 336.21	$ 5,565	$ 298.18	88.7%	$ 710

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

The following discussion highlights the primary drivers of our performance, by program.

Medicaid TANF, CHIP and ABD. TANF, CHIP and ABD revenue increased in the first half of 2016 when compared to the first half of 2015 due to the acquisitions made after July 1, 2015, as well as the inclusion of a full two quarters of Puerto Rico operations in the first half of 2016 (Puerto Rico began operations effective April 1, 2015).

Medicaid Expansion. Increased enrollment of Medicaid Expansion members in the first half of 2016 when compared to the first half of 2015 was offset by lower PMPM premium revenue discussed above and a higher medical care ratio.

Marketplace. Adjustments related to 2015 dates of service reduced Marketplace pretax income by approximately $68 million in the first half of 2016. We now estimate that the medical care ratio for our Marketplace program for all of 2015 was approximately 80%. Through June 30, 2016, the medical care ratio of our Marketplace program for months of service in the first half of 2016 alone (exclusive of out-of-period adjustments) was approximately 78%.

Financial Performance by State Health Plan. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Six Months Ended June 30, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	4.0	$ 1,095	$ 271.14	$ 962	$ 238.30	87.9%	$ 133
Florida	3.4	953	284.53	839	250.58	88.1	114
Illinois	1.2	303	261.43	269	232.06	88.8	34
Michigan	2.4	756	316.18	681	285.13	90.2	75
New Mexico	1.5	678	450.62	601	399.17	88.6	77
Ohio	2.0	971	481.44	882	437.35	90.8	89
Puerto Rico	2.0	351	172.98	349	171.95	99.4	2
South Carolina	0.6	171	276.61	138	223.58	80.8	33
Texas	2.2	1,255	575.87	1,074	492.65	85.5	181
Utah	0.9	224	252.08	208	234.46	93.0	16
Washington	4.1	1,065	260.05	958	233.84	89.9	107
Wisconsin	0.8	196	247.57	188	236.92	95.7	8
Other[3]	—	6	—	33	—	—	(27)
	25.1	$ 8,024	$ 320.17	$ 7,182	$ 286.57	89.5%	$ 842

	Six Months Ended June 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	3.4	$ 1,014	$ 294.85	$ 911	$ 264.97	89.9%	$ 103
Florida	2.0	568	291.33	498	255.45	87.7	70
Illinois	0.6	206	339.72	188	309.66	91.2	18
Michigan	1.5	457	298.87	385	251.57	84.2	72
New Mexico	1.4	636	462.62	568	413.48	89.4	68
Ohio	2.1	1,024	498.96	845	412.05	82.6	179
Puerto Rico	1.1	194	179.33	184	170.32	95.0	10
South Carolina	0.7	184	271.35	141	206.88	76.2	43
Texas	1.6	894	565.45	820	518.60	91.7	74
Utah	0.5	157	289.42	146	268.72	92.8	11
Washington	3.2	786	245.22	723	225.47	91.9	63
Wisconsin	0.6	135	216.85	105	168.58	77.7	30
Other(3)	—	20	—	51	—	—	(31)
	18.7	$ 6,275	$ 336.21	$ 5,565	$ 298.18	88.7%	$ 710

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

California. Premium revenue grew to $1,095 million in the six months ended June 30, 2016, from $1,014 million in the six months ended June 30, 2015, as a result of higher membership. The medical care ratio decreased to 87.9% in the six months ended June 30, 2016, from 89.9% in the six months ended June 30, 2015, due to improvements in the medical care ratios for the MMP and TANF programs as well as the favorable medical care ratio and growth in Marketplace. These improvements more than offset a higher medical care ratio for the ABD program.

Florida. Premium revenue grew to $953 million in the six months ended June 30, 2016, from $568 million in the six months ended June 30, 2015, due to increased Marketplace membership, an $18 million retroactive increase to Medicaid premium revenue for dates of service in 2014 and 2015 in the first quarter of 2016, and the addition of over 100,000 members from Medicaid contract acquisitions, most of which closed in the fourth quarter of 2015. The medical care ratio increased to 88.1% in the six months ended June 30, 2016, from 87.7% in the six months ended June 30, 2015, primarily as a result of adjustments

related to 2015 dates of service for Marketplace membership, partially offset by the Medicaid rate increase of approximately 5% effective September 1, 2015, and the retroactive increase to Medicaid premium revenue noted above.

Illinois. Premium revenue grew to $303 million in the six months ended June 30, 2016, from $206 million in the six months ended June 30, 2015, and the medical care ratio decreased to 88.8% in the six months ended June 30, 2016, from 91.2% in the six months ended June 30, 2015. The plan added over 100,000 members from Medicaid contract acquisitions in the first quarter of 2016. The decrease in the medical care ratio was primarily due to higher margin TANF membership.

Michigan. Premium revenue grew $299 million, or 65%, in the six months ended June 30, 2016 compared with the six months ended June 30, 2015, due to the addition of over 100,000 members from Medicaid contract acquisitions in the third quarter of 2015 and the first quarter of 2016. The medical care ratio increased to 90.2% in the six months ended June 30, 2016, from 84.2% in the six months ended June 30, 2015, primarily as a result of lower margins for TANF and Medicaid Expansion membership.

New Mexico. The medical care ratio decreased to 88.6% in the six months ended June 30, 2016, from 89.4% in the six months ended June 30, 2015, due to a lower medical care ratio for the TANF membership.

Ohio. Premium revenue declined $53 million, or 5%, in the six months ended June 30, 2016 compared with the six months ended June 30, 2015, due to reduced overall state Medicaid enrollment and Medicaid premium rate cuts effective January 1, 2016. The medical care ratio increased to 90.8% in the six months ended June 30, 2016, from 82.6% in the six months ended June 30, 2015, as a result of a blended rate decrease of approximately 2.5% effective January 1, 2016 (which included a 5% decrease in Medicaid Expansion rates) and favorable development of prior period medical liability estimates in the first half of 2015 compared with the first half of 2016.

Puerto Rico. The medical care ratio increased to 99.4% in the six months ended June 30, 2016, from 95.0% in the six months ended June 30, 2015, primarily due to increased pharmacy costs, decreased membership and premium revenue, and reductions to revenue previously recorded for 2015 dates of service which decreased pretax income by approximately $11 million. The plan served its first members effective April 1, 2015.

South Carolina. The medical care ratio increased to 80.8% in the six months ended June 30, 2016, from 76.2% in the six months ended June 30, 2015.

Texas. Premium revenue grew $361 million, or 40%, in the six months ended June 30, 2016 compared with the six months ended June 30, 2015. Growth in premium revenue was primarily the result of the recognition of approximately $44 million in out-of-period quality revenue (discussed above), increased Marketplace enrollment and the revenue associated with additional nursing home services provided to some ABD members effective March 1, 2015 and the start-up of the Texas MMP program on that same date. The plan's medical care ratio decreased to 85.5% in the six months ended June 30, 2016, from 91.7% in the six months ended June 30, 2015. Without the benefit of out-of-period quality revenue, the medical care ratio of the Texas health plan would have been approximately 88.6% in the first half of 2016.

Utah. Premium revenue grew $67 million, or 42%, in the six months ended June 30, 2016 compared with the six months ended June 30, 2015, primarily due to higher Marketplace enrollment. The medical care ratio increased slightly to 93.0% in the six months ended June 30, 2016, from 92.8% in the six months ended June 30, 2015, primarily due to an increase in the medical care ratio of the growing Marketplace program.

Washington. Premium revenue grew $279 million, or 36%, in the six months ended June 30, 2016 compared with the six months ended June 30, 2015, primarily due to membership growth in the Marketplace, TANF and Medicaid Expansion programs. The medical care ratio decreased to 89.9% in the six months ended June 30, 2016, from 91.9% in the six months ended June 30, 2015, due to improved medical cost efficiency across nearly all programs.

Wisconsin. Premium revenue grew $61 million, or 45%, in the six months ended June 30, 2016 when compared with the six months ended June 30, 2015 as a result of increased Marketplace enrollment. The medical care ratio increased to 95.7% in the six months ended June 30, 2016, from 77.7% in the six months ended June 30, 2015 due to adjustments related to 2015 dates of service for Marketplace membership and the comparatively higher medical care ratio of the growing Marketplace membership.

Molina Medicaid Solutions Segment

Service margin declined $9 million in the second quarter of 2016 compared with the second quarter of 2015, and $19 million in the six months ended June 30, 2016 compared with the six months ended June 30, 2015, primarily due to increased service costs associated with legacy state contracts that were recently re-procured.

Other Segment

Service margin was $14 million and $21 million for the three and six months ended June 30, 2016, respectively. Because we acquired our Pathways behavioral health and social services provider in November 1, 2015, there was no service margin for the three and six months ended June 30, 2015.

Income Statement Components that are Not Unique to Individual Segments

General and Administrative Expenses. General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") were 8.1% in the second quarters of both 2016 and 2015. The general and administrative expense ratio decreased to 7.9% for the six months ended June 30, 2016, compared with 8.1% for the six months ended June 30, 2015.

Premium Tax Expenses. The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.6% in the second quarter of 2016, compared with 2.8% in the second quarter of 2015, and 2.6% in the six months ended June 30, 2016, compared with 2.9% in the six months ended June 30, 2015. For both periods, the decrease was primarily due to the current year increase in MMP revenues. The Medicare portion of MMP revenue is not subject to premium tax.

Health Insurer Fee Revenue and Expenses. For our Medicaid program, actuarial standards require that we be reimbursed by state Medicaid agencies for both the expense associated with the HIF and the absence of tax deductibility for that expense. Subsequent to the first quarter of 2015, we secured full reimbursement for our expenses under the HIF (including the absence of tax deductibility). As a result, HIF revenue, as a percentage of premium revenue, increased to 2.1% in the six months ended June 30, 2016, from 1.9% in the six months ended June 30, 2016. HIF expenses were consistent year over year.

Depreciation and Amortization. As a percentage of total revenue, the year over year change in depreciation and amortization was insignificant.

Interest Expense. Interest expense increased to $25 million for the second quarter of 2016, from $15 million for the second quarter of 2015. Interest expense increased to $50 million for the six months ended June 30, 2016, from $30 million for the six months ended June 30, 2015. The increase was primarily due to our issuance of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, in the fourth quarter of 2015.

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $7 million and $8 million for the second quarter of 2016 and 2015, respectively and $15 million for both the six months ended June 30, 2016 and 2015.

Income Tax Expense. The provision for income taxes was recorded at an effective rate of 59.8% for the second quarter of 2016, compared with 61.3% for the second quarter of 2015, and 60.7% for the six months ended June 30, 2016 compared with 60.1% for the six months ended June 30, 2015. Differences in the effective tax rate between periods are the result of different amounts of non-deductible expenses and discrete tax events.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary sources of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

As of June 30, 2016, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Investment income increased to $16 million for the six months ended June 30, 2016, compared with $7 million for the six months ended June 30, 2015, primarily due to an increase in invested assets.

Cash in excess of the capital needs of our regulated health plans is generally paid to us in the form of dividends, when and as permitted by applicable regulations, for general corporate use. For the six months ended June 30, 2016, we received $50

million in dividends from our regulated health plan subsidiaries. For the six months ended June 30, 2015, we received $25 million in dividends from our regulated health plan subsidiaries, and $17 million from our unregulated subsidiaries.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Six Months Ended June 30,		
	2016	2015	Change
	(In millions)		
Net cash provided by operating activities	$ 278	$ 648	$ (370)
Net cash used in investing activities	(273)	(557)	284
Net cash provided by financing activities	11	384	(373)
Net increase in cash and cash equivalents	$ 16	$ 475	$ (459)

Operating Activities. Net cash provided by operating activities decreased $370 million in the six months ended June 30, 2016 compared with the six months ended June 30, 2015.

The year over year changes in the following accounts decreased cash provided by operating activities:

- Receivables. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. In general, states may delay our premium payment, which we record as a receivable, or they may prepay the following month premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In the current year, the timing of premiums received in California, Florida and Illinois negatively impacted our cash flows from operating activities.
- Medical claims and benefits payable. In the six months ended June 30, 2016, medical claims and benefits payable increased at a slower pace than the same period in 2015. In particular, our Puerto Rico health plan commenced operations on April 1, 2015, leading to a significant increase in medical claims and benefits payable at June 30, 2015, compared with a much smaller increase in the current year as the membership base has stabilized.

These changes were partially offset by the increase in amounts due government agencies. In connection with Health Plans segment membership growth in programs that contain medical cost floors, medical cost corridors, or risk adjustment provisions, a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned to the federal or state governments.

Investing Activities. Net cash used in investing activities was $273 million in the six months ended June 30, 2016, compared with $557 million in the six months ended June 30, 2015. In the current year, we received approximately $271 million more in proceeds from sales and maturities of investments than in the prior year.

Financing Activities. Net cash provided by financing activities decreased $373 million in the six months ended June 30, 2016 compared with the six months ended June 30, 2015, primarily due to the prior year proceeds from a common stock offering, with no comparable activity in the current year.

Financial Condition

We believe that our cash resources and internally generated funds will be sufficient to support our operations, planned acquisitions, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at June 30, 2016, our working capital was $1,899 million, compared with $1,484 million at December 31, 2015. At June 30, 2016, our cash and investments amounted to $4,422 million, compared with $4,241 million at December 31, 2015. Cash, cash equivalents and investments held by the parent company (Molina Healthcare, Inc.) amounted to $466 million and $612 million as of June 30, 2016 and December 31, 2015, respectively.

Regulatory Capital and Dividend Restrictions. For more information on our regulatory capital and dividend restrictions, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 14, "Commitments and Contingencies."

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "Ba3" by Moody's Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and costs.

Future Sources and Uses of Liquidity

Announced Acquisition. As described in Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," we announced a Health Plans segment acquisition on April 19, 2016, that we expect to close in the second half of 2016. We expect the purchase price for this acquisition to amount to approximately $41 million, subject to certain closing adjustments.

States' Budgets. From time to time, the states in which our health plans operate may experience financial difficulties, which could lead to delays in premium payments. It has been our practice in the past to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. Our ability to borrow under the Credit Facility is subject to compliance with certain financial covenants. At June 30, 2016, we were in compliance with all financial covenants under the Credit Facility. As of June 30, 2016, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Convertible Senior Notes. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020 (1.125% Notes), unless earlier repurchased or converted. In September 2014, we issued $302 million aggregate principal amount of 1.625% convertible senior notes due August 15, 2044 (1.625% Notes), unless earlier repurchased, redeemed, or converted. The principal amounts of both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The 1.125% Notes did not meet the $53.00 stock price trigger in the quarter ended June 30, 2016, therefore, the 1.125% Notes were not convertible as of June 30, 2016. The 1.625% Notes did not meet the $75.52 stock price trigger in the quarter ended June 30, 2016, therefore, the 1.625% Notes were not convertible as of June 30, 2016.

Securities Repurchase Program. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2015, was disclosed in our 2015 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the six months ended June 30, 2016. For further discussion and maturities of our long-term debt, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 9, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the six months ended June 30, 2016, to our disclosure reported in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015.

- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the six months ended June 30, 2016 in connection with such contractual provisions.
- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Molina Medicaid Solutions segment revenue and cost recognition*. There have been no significant changes during the six months ended June 30, 2016, to our disclosure reported in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

For information regarding market risk, see Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2016 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

For information regarding legal proceedings, see Part I, Item 1 of this Form 10-Q, Note 14, "Commitments and Contingencies."

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2015 and under Part II, Item 1A – Risk Factors, in our Quarterly Report on Form 10-Q for the quarter ended March 31, 2016. The risk factors described in our 2015 Annual Report and 2016 first quarter Quarterly Report are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Unregistered Issuances of Equity Securities

None.

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended June 30, 2016 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
April 1 - April 30	12,534	$ 64.91	—	$ 50,000,000
May 1 - May 31	1,490	$ 51.76	—	$ 50,000,000
June 1 - June 30	399	$ 49.29	—	$ 50,000,000
Total	14,423	$ 63.12	—	

(a) During the three months ended June 30, 2016, we withheld 14,423 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: July 27, 2016

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: July 27, 2016

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the annual report on Form 10-K for the period ended June 30, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 27, 2016

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed this annual report on Form 10-K for the period ended June 30, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 27, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended June 30, 2016 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 27, 2016

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended June 30, 2016 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 27, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended March 31, 2016

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2016

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of April 25, 2016, was approximately 56,584,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended March 31, 2016

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	March 31, 2016	December 31, 2015
	(Amounts in millions, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,156	$ 2,329
Investments	2,070	1,801
Receivables	863	597
Income taxes refundable	38	13
Prepaid expenses and other current assets	260	192
Derivative asset	377	374
Total current assets	5,764	5,306
Property, equipment, and capitalized software, net	419	393
Deferred contract costs	79	81
Intangible assets, net	149	122
Goodwill	619	519
Restricted investments	116	109
Deferred income taxes	—	18
Other assets	37	28
	$ 7,183	$ 6,576
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,940	$ 1,685
Amounts due government agencies	910	729
Accounts payable and accrued liabilities	601	362
Deferred revenue	94	223
Current portion of long-term debt	455	449
Derivative liability	377	374
Total current liabilities	4,377	3,822
Senior notes	965	962
Lease financing obligations	198	198
Deferred income taxes	15	—
Other long-term liabilities	38	37
Total liabilities	5,593	5,019
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 57 shares at March 31, 2016 and 56 shares at December 31, 2015	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	806	803
Accumulated other comprehensive gain (loss)	2	(4)
Retained earnings	782	758
Total stockholders' equity	1,590	1,557
	$ 7,183	$ 6,576

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2016	2015
	(In millions, except per-share data) (Unaudited)	
Revenue:		
Premium revenue	$ 3,995	$ 2,971
Service revenue	140	52
Premium tax revenue	109	95
Health insurer fee revenue	90	48
Investment income	8	3
Other revenue	1	2
Total revenue	4,343	3,171
Operating expenses:		
Medical care costs	3,588	2,636
Cost of service revenue	127	36
General and administrative expenses	340	256
Premium tax expenses	109	95
Health insurer fee expenses	58	41
Depreciation and amortization	32	25
Total operating expenses	4,254	3,089
Operating income	89	82
Interest expense	25	15
Income before income tax expense	64	67
Income tax expense	40	39
Net income	$ 24	$ 28
Net income per share:		
Basic	$ 0.44	$ 0.58
Diluted	$ 0.43	$ 0.56

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2016	2015
	(Amounts in millions) (Unaudited)	
Net income	$ 24	$ 28
Other comprehensive income:		
Unrealized investment gain	9	2
Less: effect of income taxes	3	1
Other comprehensive income, net of tax	6	1
Comprehensive income	$ 30	$ 29

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2016	2015
	(Amounts in millions) (Unaudited)	
Operating activities:		
Net income	$ 24	$ 28
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	44	33
Deferred income taxes	30	1
Share-based compensation	7	6
Amortization of convertible senior notes and lease financing obligations	8	7
Other, net	6	3
Changes in operating assets and liabilities:		
Receivables	(266)	105
Prepaid expenses and other assets	(202)	(137)
Medical claims and benefits payable	255	248
Amounts due government agencies	181	95
Accounts payable and accrued liabilities	205	189
Deferred revenue	(129)	(26)
Income taxes	(24)	2
Net cash provided by operating activities	139	554
Investing activities:		
Purchases of investments	(611)	(438)
Proceeds from sales and maturities of investments	348	255
Purchases of property, equipment and capitalized software	(46)	(25)
Increase in restricted investments	(4)	(5)
Net cash paid in business combinations	(2)	(8)
Other, net	1	(7)
Net cash used in investing activities	(314)	(228)
Financing activities:		
Proceeds from employee stock plans	—	1
Other, net	2	4
Net cash provided by financing activities	2	5
Net (decrease) increase in cash and cash equivalents	(173)	331
Cash and cash equivalents at beginning of period	2,329	1,539
Cash and cash equivalents at end of period	$ 2,156	$ 1,870

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Three Months Ended March 31,	
	2016	2015
	(Amounts in millions) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Common stock used for share-based compensation	$ (7)	$ (9)
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 3	$ 145
Loss on 1.125% Conversion Option	(3)	(145)
Change in fair value of derivatives, net	$ —	$ —
Details of business combinations:		
Fair value of assets acquired	$ (134)	$ —
Purchase price amounts accrued/received (paid)	30	(8)
Reversal of amounts advanced to sellers in prior year	102	—
Net cash paid in business combinations	$ (2)	$ (8)

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
March 31, 2016

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other. All prior periods reported conform to this presentation.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of March 31, 2016, these health plans served 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Our Other segment includes businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Market Updates - Health Plans

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. See Note 4, "Business Combinations," for further information.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. See Note 4, "Business Combinations," for further information.

On March 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Better Health Network, LLC. See Note 4, "Business Combinations," for further information.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. See Note 4, "Business Combinations," for further information.

New York. On April 19, 2016, we entered into an agreement with Universal American Corp. to acquire all outstanding equity interests of Today's Options of New York, Inc., which operates the Total Care Medicaid plan. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close in the second half of 2016.

Washington. On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Columbia United Providers, Inc. See Note 4, "Business Combinations," for further information.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2016.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2015. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2015 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2015 audited consolidated financial statements.

2. Significant Accounting Policies

Revenue Recognition – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $278 million and $214 million at March 31, 2016 and December 31, 2015, respectively, to amounts due government agencies. Approximately $270 million and $208 million of the liability accrued at March 31, 2016 and December 31, 2015, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. We recorded receivables of $1 million and $3 million at March 31, 2016 and December 31, 2015, respectively, relating to such provisions.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Under these provisions we recorded a receivable of $2 million at March 31, 2016, for estimated amounts overpaid for prior periods, and a liability of $10 million at December 31, 2015, for profit in excess of the amount we are allowed to retain.

Retroactive Premium Adjustments: The state Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies. For example, in the first quarter of 2016 we recorded a retroactive increase to Medicaid premium revenue of approximately $18 million, relating to dates of service prior to 2016.

Cost Plus Retroactive Premium Adjustments: In New Mexico, when members are retroactively enrolled into our health plan we earn revenue only to the extent of the actual medical costs incurred by us for services provided during those retroactive periods, plus a small percentage of that medical cost for administration and profit. This cost plus arrangement for members retroactively enrolled in our health plan first became effective July 1, 2014 (retroactive to January 1, 2014). We are paid normal monthly capitation rates for the retroactive eligibility periods, and the difference between those capitation rates and the amounts due us on a cost plus basis are periodically settled with the state. To date, no such settlement has been made with the state. During the years ended December 31, 2014 and 2015, our New Mexico contract was not specific as to the definition of retroactive membership, and the amount we owe the state (or that the state owes us) for the difference between capitation received and amounts due to us under the cost plus arrangement during those periods varies widely depending upon the definition of retroactive membership.

In August 2015, the state provided us with a request for payment under the terms of this contract provision for the period January 1, 2014 through December 31, 2014. That request was based upon definitions of retroactive membership that were at odds with our interpretations of that term. Using the state's definition of retroactive membership, we estimate that the state may ultimately seek repayment of an amount that ranges from $25 million to $30 million higher than the amount we have accrued. We do not believe that any reasonable definition of retroactive membership supports the state's position, and expect to resolve this matter with payment of the amount we have accrued at March 31, 2016. We are currently engaged in discussions with the state regarding the appropriate amount, if any, owed to the state under this contract term.

Medicare

Risk Adjustment: Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (measured as a member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns, risk scores and CMS practices. Based on our estimates, we have recorded a net receivable of $13 million and a net payable of $4 million for anticipated Medicare risk adjustment premiums at March 31, 2016 and December 31, 2015, respectively.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program.

- Permanent risk adjustment program: Under this permanent program, our health plans' composite risk scores are compared to the overall average risk score for the relevant state and market pool. Generally, our health plans will pay into the pool if their composite risk scores are below the average risk score, and will receive funds from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. To better estimate amounts to be accrued, we utilize third party sources that attempt to estimate the overall average risk score for the relevant state and market pools. In the first quarter of 2016, we recorded an additional liability of approximately $20 million related to 2015 based upon new information primarily obtained from third party sources.
- Transitional reinsurance program: This program is designed to provide reimbursement to insurers for high cost members. Our health plans pay an annual contribution on a per-member basis, and are eligible for recoveries if claims for individual members exceed a specified threshold, up to a maximum amount. This three-year program will end on December 31, 2016. We recognize the assessments to fund the transitional reinsurance program as a reduction to premium revenue in our consolidated statements of income. We recognize recoveries under the reinsurance program as a reduction to medical care costs in our consolidated statements of income.
- Temporary risk corridor program: This program is intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by the U.S. Department of Health and Human Services (HHS). Variances from the target amount exceeding certain thresholds may result in amounts due to or receivables due from HHS. This three-year program will end on December 31, 2016. Due to uncertainties as to the amount of federal funding available to support the risk corridor program, we do not recognize amounts receivable under this program. All liabilities are recognized as incurred. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk corridor program as an adjustment to premium revenue in our consolidated statements of income.

Additionally, the ACA established a minimum annual medical loss ratio (Minimum MLR) of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. What constitutes medical costs and premium revenue are specifically defined by federal regulations. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described above, and, for receivables, collection is reasonably assured.

Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

	March 31, 2016	December 31, 2015
	(In millions)	
Risk adjustment	$ (301)	$ (214)
Reinsurance	47	36
Risk corridor	(15)	(10)
Minimum MLR	(11)	(3)

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2016 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2016.

	Three Months Ended March 31,	
	2016	2015
	(In millions)	
Maximum available quality incentive premium - current period	$ 40	$ 30
Amount of quality incentive premium revenue recognized in current period:		
Earned current period	$ 18	$ 10
Earned prior periods	5	—
Total	$ 23	$ 10
Quality incentive premium revenue recognized as a percentage of total premium revenue	0.6%	0.3%

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the Health Insurer Fee (HIF), certain compensation, and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

Recent Accounting Pronouncements

In April 2016, the Financial Accounting Standards Board (FASB) issued ASU 2016-10, *Identifying Performance Obligations and Licensing*, which amends certain aspects of ASC 606, *Revenue from Contracts with Customers*. ASU 2016-10 amends step two of the new revenue standard's five-step model to include guidance on immaterial promised goods or services, shipping and handling activities and identifying when promises represent performance obligations. ASU 2016-10 also provided guidance related to licensing such as, but not limited to, sales-based and usage-based royalties and renewals of license that provide a right to use intellectual property. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

In March 2016, the FASB issued ASU 2016-09, *Compensation-Stock Compensation*, which simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, statutory tax and classification in the statement of cash flows. ASU 2016-09 is effective for fiscal periods beginning after December 15, 2016 and must be adopted using the modified retrospective approach except for classification in the statement of cash flows, which must be adopted using either the prospective or retrospective approach. Early adoption is permitted. We are evaluating the potential effects of the adoption to our financial statements.

In March 2016, the FASB issued ASU 2016-08, *Revenue from Contracts with Customers - Principal vs. Agent Considerations*, which amends the principal–versus–agent implementation guidance in ASC 606. ASU 2016-08 clarifies that an entity should evaluate whether it is the principal or agent for each specified good or service promised in a contract with a customer as defined in ASC 606. The entity must first identify each specified good or service to be provided to the customer and then assess whether it controls each specified good or service. The ASU also removed two of the five indicators used in evaluating control under the old guidance and reframes the remaining three indicators. We intend to adopt this standard on January 1, 2018. We are evaluating the potential effects of the adoption to our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of basic and diluted net income per share:

	Three Months Ended March 31,	
	2016	2015
	(In millions, except net income per share)	
Numerator:		
Net income	$ 24	$ 28
Denominator:		
Denominator for basic net income per share	55	49
Effect of dilutive securities:		
Share-based compensation	1	—
1.125% Warrants (1)	1	1
Denominator for diluted net income per share	57	50
Net income per share: (2)		
Basic	$ 0.44	$ 0.58
Diluted	$ 0.43	$ 0.56

(1) For more information regarding the 1.125% Warrants, refer to Note 11, "Derivatives."
(2) Source data for calculations in thousands.

Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive.

4. Business Combinations

In the first quarter of 2016, we closed on several business combinations in the Health Plans segment. For all of these transactions we applied the acquisition method of accounting, where the total purchase price was allocated, or preliminarily allocated, to tangible and intangible assets acquired, and liabilities assumed based on their respective fair values. For Health Plans acquisitions, in general, only intangible assets are acquired. All of these acquisitions were funded using available cash and acquisition-related costs were insignificant.

Health Plans

Consistent with our strategy to grow in our existing markets, we closed the following Health Plans acquisitions in 2016:

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. The initial purchase price was approximately $35 million, and the Illinois health plan added approximately 58,000 Medicaid members as a result of this transaction.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. The initial purchase price was approximately $15 million, and the Illinois health plan added approximately 21,000 Medicaid members as a result of this transaction.

On March 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Better Health Network, LLC. The initial purchase price was approximately $18 million, and the Illinois health plan added approximately 34,000 Medicaid members as a result of this transaction.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. The initial purchase price was approximately $36

million, and the Michigan health plan added approximately 81,000 Medicaid and MIChild members as a result of this transaction.

Washington. On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Columbia United Providers, Inc. The final purchase price was approximately $28 million, and the Washington health plan added approximately 57,000 Medicaid members as a result of this transaction.

For the acquisitions described above, we recorded goodwill to the Health Plans segment amounting to $98 million in the aggregate, which relates to future economic benefits arising from expected synergies to be achieved. Such synergies include use of our existing infrastructure to support the added membership. The amount recorded as goodwill is deductible for income tax purposes.

The following table presents the intangible assets identified in the transactions described above. The weighted-average amortization period, in the aggregate, is 5.9 years. For these acquisitions in the aggregate, we expect to record amortization of approximately $6 million per year in the years 2016 through 2020 and $1 million in 2021.

	Fair Value	Life
	(In millions)	(Years)
Intangible asset type:		
Contract rights - member list	$ 28	5
Provider network	6	10
	$ 34	

5. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include the following:

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of March 31, 2016 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 11, “Derivatives,” the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The changes in fair value of Level 3 financial instruments for the three months ended March 31, 2016 were insignificant.

Our financial instruments measured at fair value on a recurring basis at March 31, 2016, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,425	$ —	$ 1,425	$ —
Government-sponsored enterprise securities (GSEs)	214	214	—	—
Municipal securities	165	—	165	—
U.S. treasury notes	114	114	—	—
Certificates of deposit	78	—	78	—
Asset-backed securities	74	—	74	—
Subtotal - current investments	2,070	328	1,742	—
1.125% Call Option derivative asset	377	—	—	377
Total assets measured at fair value on a recurring basis	$ 2,447	$ 328	$ 1,742	$ 377
1.125% Conversion Option derivative liability	$ 377	$ —	$ —	$ 377
Total liabilities measured at fair value on a recurring basis	$ 377	$ —	$ —	$ 377

Our financial instruments measured at fair value on a recurring basis at December 31, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,184	$ —	$ 1,184	$ —
GSEs	211	211	—	—
Municipal securities	185	—	185	—
U.S. treasury notes	78	78	—	—
Certificates of deposit	80	—	80	—
Asset-backed securities	63	—	63	—
Subtotal - current investments	1,801	289	1,512	—
1.125% Call Option derivative asset	374	—	—	374
Total assets measured at fair value on a recurring basis	$ 2,175	$ 289	$ 1,512	$ 374
1.125% Conversion Option derivative liability	$ 374	$ —	$ —	$ 374
Total liabilities measured at fair value on a recurring basis	$ 374	$ —	$ —	$ 374

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table.

	March 31, 2016		December 31, 2015	
	Carrying Value	Fair Value	Carrying Value	Fair Value
		(In millions)		
5.375% Notes	$ 689	$ 721	$ 689	$ 700
1.125% Convertible Notes	454	914	448	865
1.625% Convertible Notes	276	379	273	365
	$ 1,419	$ 2,014	$ 1,410	$ 1,930

6. Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,424	$ 3	$ 2	$ 1,425
GSEs	214	—	—	214
Municipal securities	164	1	—	165
U.S. treasury notes	114	—	—	114
Certificates of deposit	78	—	—	78
Asset-backed securities	74	—	—	74
	$ 2,068	$ 4	$ 2	$ 2,070

	December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,189	$ —	$ 5	$ 1,184
GSEs	212	—	1	211
Municipal securities	186	—	1	185
U.S. treasury notes	78	—	—	78
Certificates of deposit	80	—	—	80
Asset-backed securities	63	—	—	63
	$ 1,808	$ —	$ 7	$ 1,801

The contractual maturities of our investments as of March 31, 2016 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 1,109	$ 1,109
Due after one year through five years	938	940
Due after five years through ten years	21	21
	$ 2,068	$ 2,070

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three months ended March 31, 2016 and 2015 were insignificant.

We have determined that unrealized gains and losses at March 31, 2016 and December 31, 2015, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2016:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 453	$ 2	274	$ —	$ —	—

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2015:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 825	$ 4	588	$ 119	$ 1	87
GSEs	182	1	77	—	—	—
Municipal securities	128	1	181	—	—	—
	$ 1,135	$ 6	846	$ 119	$ 1	87

7. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial. The information below is presented by segment.

	March 31, 2016	December 31, 2015
	(In millions)	
California	$ 121	$ 104
Florida	62	22
Illinois	94	35
Michigan	58	39
New Mexico	73	51
Ohio	89	66
Puerto Rico (1)	54	33
South Carolina	10	6
Texas	77	56
Utah	28	18
Washington	69	53
Wisconsin	24	22
Direct delivery and other	9	6
Total Health Plans segment	768	511
Molina Medicaid Solutions segment	37	37
Other segment	58	49
	$ 863	$ 597

(1) See Note 14, Commitments and Contingencies, for further discussion of Puerto Rico health plan receivables.

8. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of

restricted investments:

	March 31, 2016	December 31, 2015
	(In millions)	
Florida	$ 34	$ 34
Illinois	3	—
Michigan	1	1
New Mexico	47	43
Ohio	12	12
Puerto Rico	10	10
Texas	4	4
Utah	4	4
Wisconsin	1	1
Total Health Plans segment	$ 116	$ 109

The contractual maturities of our held-to-maturity restricted investments as of March 31, 2016 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 111	$ 111
Due after one year through five years	5	5
	$ 116	$ 116

9. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	March 31, 2016	December 31, 2015
	(In millions)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,392	$ 1,191
Pharmacy payable	111	88
Capitation payable	138	140
Other	299	266
	$ 1,940	$ 1,685

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $191 million and $167 million as of March 31, 2016 and December 31, 2015, respectively.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31, 2016	Year Ended December 31, 2015
	(Dollars in millions)	
Medical claims and benefits payable, beginning balance	$ 1,685	$ 1,201
Components of medical care costs related to:		
Current period	3,755	11,935
Prior periods	(167)	(141)
Total medical care costs	3,588	11,794
Change in non-risk provider payables	24	48
Payments for medical care costs related to:		
Current period	2,241	10,448
Prior periods	1,116	910
Total paid	3,357	11,358
Medical claims and benefits payable, ending balance	$ 1,940	$ 1,685
Benefit from prior period as a percentage of:		
Balance at beginning of period	10.0%	11.8%
Premium revenue, trailing twelve months	1.2%	1.1%
Medical care costs, trailing twelve months	1.3%	1.2%

The portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). Our IBNP, as included in medical claims and benefits payable, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under– or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2016 and 2015 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at March 31, 2016 are as follows:

- In the first quarter of 2016, our Marketplace enrollment across all health plans increased by approximately 425,000 members. Some of the states with significant increases included:
    - California: 57,000

- Florida: 114,000
- Texas: 122,000
- Utah: 48,000
- Wisconsin: 39,000

Because these new Marketplace members may have different utilization patterns than our legacy members, the reserves are subject to more than the usual amount of uncertainty.

- Our Illinois health plan added over 100,000 new members under acquisitions of three Medicaid contracts during the first quarter of 2016. Because these new members may have different utilization patterns than our legacy members, the reserves are subject to more than the usual amount of uncertainty.
- Our Florida health plan added approximately 100,000 new members under an acquisition in the fourth quarter of 2015. Because these new members may have different utilization patterns than our legacy members, the reserves are subject to more than the usual amount of uncertainty.
- At our New Mexico health plan, we overpaid certain inpatient and outpatient facility claims. We adjusted our claims payment history to reflect the claims payment pattern that would have occurred without these overpayments. For this reason, the reserves are subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $167 million for the three months ended March 31, 2016. This amount represents our estimate as of March 31, 2016, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2015 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- A new version of diagnostic codes was required for all claims with dates of service October 1, 2015, and later. As a result, payment was delayed or denied for a significant number of claims due to provider submission of claims with diagnostic codes that were no longer valid. Once providers were able to submit claims with the correct diagnostic codes, our actual costs were ultimately less than expected.
- At our New Mexico health plan, we overstated the impact of several pending high-dollar claims, and our actual costs were ultimately less than expected.
- At our Washington health plan, we overpaid certain outpatient facility claims in 2015 when the state converted to a new payment methodology. We did not include an estimate in the reserves for this potential recovery as of December 31, 2015.

10. Debt

As of March 31, 2016, contractual maturities of debt for the years ending December 31 are as follows:

	Total	2016	2017	2018	2019	2020	Thereafter
				(In millions)			
5.375% Notes	$ 700	$ —	$ —	$ —	$ —	$ —	$ 700
1.125% Convertible Notes	550	—	—	—	—	550	—
1.625% Convertible Notes (1)	302	—	—	—	—	—	302
Other	1	1	—	—	—	—	—
	$ 1,553	$ 1	$ —	$ —	$ —	$ 550	$ 1,002

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The principal amounts, unamortized discount (net of premium related to 1.625% Notes), unamortized issuance costs, and net carrying amounts of debt were as follows:

	Principal Balance	Unamortized Discount	Unamortized Issuance Costs	Net Carrying Amount
		(In millions)		
March 31, 2016:				
5.375% Notes	$ 700	$ —	$ 11	$ 689
1.125% Convertible Notes	550	89	7	454
1.625% Convertible Notes	302	22	4	276
Other	1	—	—	1
	$ 1,553	$ 111	$ 22	$ 1,420
December 31, 2015:				
5.375% Notes	$ 700	$ —	$ 11	$ 689
1.125% Convertible Notes	550	95	7	448
1.625% Convertible Notes	302	25	4	273
Other	1	—	—	1
	$ 1,553	$ 120	$ 22	$ 1,411

	Three Months Ended March 31,	
	2016	2015
	(In millions)	
Interest cost recognized for the period relating to the:		
Contractual interest coupon rate	$ 12	$ 3
Amortization of the discount	7	7
	$ 19	$ 10

5.375% Senior Notes due 2022. On November 10, 2015, we completed the private offering of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest is payable semiannually in arrears on May 15 and November 15, beginning on May 15, 2016. The 5.375% Notes are not convertible into our common stock or any other securities.

The 5.375% Notes are guaranteed by certain of our wholly owned subsidiaries. The 5.375% Notes and the guarantees are effectively subordinated to all existing and future secured debt of us and our guarantors to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock of our subsidiaries that do not guarantee the 5.375% Notes.

We may redeem some or all of the 5.375% Notes at any time, and prior to August 15, 2022, at a price equal to 100% of the principal amount redeemed plus accrued and unpaid interest thereon, plus a "make-whole" premium. Thereafter, we may redeem some or all of the 5.375% Notes at a price equal to 100% of the principal amount redeemed plus accrued and unpaid interest thereon. The 5.375% Notes contain customary non-financial covenants and change of control provisions.

In connection with the issuance and sale of the 5.375% Notes, we entered into a registration rights agreement. Under this agreement, we will use commercially reasonable efforts to register substantially identical notes (the Exchange Notes) with the SEC in 2016. We will then offer such freely tradable Exchange Notes in exchange for the 5.375% Notes. We will pay additional interest on the 5.375% Notes if the Exchange Notes offering is not completed timely.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. As of March 31, 2016, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Although the Credit Facility is not secured by any of our assets, certain of our wholly owned subsidiaries have jointly and severally guaranteed our obligations under the Credit Facility.

The Credit Facility contains customary non-financial and financial covenants, including a minimum fixed charge coverage ratio, a maximum debt-to-EBITDA ratio and minimum statutory net worth. At March 31, 2016, we were in compliance with all financial covenants under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes (1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest is payable semiannually in arrears on January 15 and July 15.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date. Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;

- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;

- upon the occurrence of specified corporate events; or

- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes met the stock price trigger in the quarter ended March 31, 2016, and are convertible to cash through at least June 30, 2016. Because the 1.125% Notes may be converted into cash within 12 months, the $454 million carrying amount is reported in current portion of long-term debt as of March 31, 2016.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of March 31, 2016, the 1.125% Notes have a remaining amortization period of 3.8 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $239 million and $332 million as of March 31, 2016 and December 31, 2015, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $125 million principal amount of 1.625% convertible senior notes (1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Combined with the 1.625% Notes issued in connection with the 3.75% Exchange described below, the aggregate principal amount issued under the 1.625% Notes was $302 million.

Interest is payable semiannually in arrears on February 15 and August 15. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of March 31, 2016, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the 1.625% Notes in August 2018. As of March 31, 2016, the 1.625% Notes have a remaining amortization period of 2.4 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value exceeded their principal amount by approximately $30 million and $10 million as of March 31, 2016 and December 31, 2015, respectively. At March 31, 2016 and December 31, 2015, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $23 million.

11. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	March 31, 2016	December 31, 2015
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 377	$ 374
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 377	$ 374

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the 1.125% Notes due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 5, "Fair Value Measurements."

As of March 31, 2016, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of March 31, 2016, as described in Note 10, "Debt."

12. Stockholders' Equity

Stockholders' equity increased $33 million during the three months ended March 31, 2016 compared with stockholders' equity at December 31, 2015. The increase was primarily due to net income of $24 million, $6 million of other comprehensive income and $3 million related to employee stock transactions.

1.125% Warrants. In connection with the 1.125% Notes Call Spread Overlay transaction described in Note 11, "Derivatives," in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Program. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Stock Incentive Plans. In connection with our equity incentive plans and employee stock purchase plan, we issued approximately 200,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the three months ended March 31, 2016.

Charged to general and administrative expenses, total share-based compensation expense was as follows:

	Three Months Ended March 31,	
	2016	2015
	(In millions)	
Restricted stock and performance awards	$ 5	$ 5
Employee stock purchase plan and stock options	2	1
	$ 7	$ 6

As of March 31, 2016, there was $53 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 2.1 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 3.8% for non-executive employees as of March 31, 2016.

Restricted stock. Restricted and performance stock activity for the three months ended March 31, 2016 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
	(In thousands)	
Unvested balance as of December 31, 2015	1,035	$ 46.68
Granted	498	64.21
Vested	(291)	39.09
Forfeited	(1)	33.53
Unvested balance as of March 31, 2016	1,241	55.50

The total fair value of restricted and performance awards granted during the three months ended March 31, 2016 and 2015 was $18 million and $11 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, which vested during the three months ended March 31, 2016 and 2015 was $32 million and $23 million, respectively.

As of March 31, 2016, there were approximately 603,000 unvested restricted shares outstanding which contained one or more performance measures. In the event the vesting conditions are not achieved, the awards will lapse. Based on our assessment as of March 31, 2016, we expect the performance conditions for approximately 425,000 of these outstanding restricted share awards to be met in full.

13. Segment Information

We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other.

Our reportable segments are consistent with how we currently manage the business and view the markets we serve. The Health Plans segment consists of our health plans and our direct delivery business. Our health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides MMIS design, development, and implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies. Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

The following table presents gross margin as the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage

of premium revenue. One of the key metrics used to assess the performance of the Health Plans segment is the medical care ratio; therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue. We previously reported our segment results to the operating income level, where we reported the cost of all centralized services within our most significant segment, the Health Plans segment.

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
Three Months Ended March 31, 2016				
Total revenue (1)	$ 4,201	$ 52	$ 90	$ 4,343
Gross margin	407	6	7	420
Three Months Ended March 31, 2015				
Total revenue (1)	3,117	52	2	3,171
Gross margin	335	16	—	351
Total Assets				
March 31, 2016	5,302	250	1,631	7,183
December 31, 2015	4,707	213	1,656	6,576

(1) Total revenue consists primarily of premium revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments.

The following table reconciles gross margin by segment to consolidated income before income tax expense:

	Three Months Ended March 31,	
	2016	2015
	(In millions)	
Gross margin:		
Health Plans	$ 407	$ 335
Molina Medicaid Solutions	6	16
Other	7	—
Other operating revenues (1)	208	148
Less: other operating expenses (2)	539	417
Operating income	89	82
Other expenses, net	25	15
Income before income tax expense	$ 64	$ 67

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

14. Commitments and Contingencies

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem

the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable and not reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. The District Court dismissed this action as to Molina without leave to amend as to some allegations and with leave to amend as to other allegations. On October 22, 2015, the Relator filed a third amended complaint. We believe that we have several meritorious defenses to the claims of the Relator, and any liability for the alleged claims is not currently probable and not reasonably estimable.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

States' Budgets. From time to time the states in which our health plans operate may experience financial difficulties, which could lead to delays premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of March 31, 2016, our Illinois health plan served approximately 206,000 members, and recognized premium revenue of approximately $149 million in the first quarter of 2016. As of April 25, 2016, Illinois is current with its premium payments through February 29, 2016, but has not paid us for March 2016.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs, including health care-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. On May 2, 2016, Puerto Rico defaulted on approximately $422 million in debt repayment obligations to certain bondholders. In addition, it is likely to default on the $2 billion debt repayment obligation due to such bondholders on July 1, 2016.

As of April 29, 2016, the Commonwealth had paid us the first three weekly installments due for the month of April 2016. However, in a letter dated April 29, 2016, the Puerto Rico Health Insurance Administrator notified our Puerto Rico health plan that it would be unable at this time to make the fourth and final 25% installment payment of the capitation amount due for April 2016, or approximately $15 million. We are uncertain when the Puerto Rico health plan will be paid the fourth and final capitation amount for April 2016, as well as when our health plan will be paid the initial weekly capitation installments for May 2016.

As of March 31, 2016, the plan served approximately 339,000 members and recognized premium revenue of approximately $181 million in the first quarter of 2016, or approximately $60 million per month. Total premiums receivable from the Commonwealth as of March 31, 2016, were approximately $30 million, of which approximately $15 million has been collected.

Puerto Rico Member Eligibility and Premium Revenue. It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility.

Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter.

It has been our practice in the past to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us. We are continuing to closely monitor the situation in Puerto Rico, including whether we should exit the Puerto Rico market.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us.

Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,221 million at March 31, 2016, and $1,229 million at December 31, 2015. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $542 million and $612 million as of March 31, 2016 and December 31, 2015, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state.

As of March 31, 2016, our health plans had aggregate statutory capital and surplus of approximately $1,349 million compared with the required minimum aggregate statutory capital and surplus of approximately $854 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2016. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

15. Related Party Transactions

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina and John C. Molina. Under the terms of this provider agreement, the California health plan pays Pacific for medical care Pacific provides to health plan members. For the three months ended March 31, 2016 and 2015, the amounts paid to Pacific were insignificant.

Refer to Note 16, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

16. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. JMMPC also provides certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and

access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant. For the three months ended March 31, 2016 and 2015, our health plans paid $31 million and $25 million, respectively, to JMMPC for health care services provided by JMMPC to the health plans' members.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of March 31, 2016, JMMPC had total assets of $12 million, and total liabilities of $12 million. As of December 31, 2015, JMMPC had total assets of $17 million, and total liabilities of $17 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- uncertainties and evolving market and provider economics associated with the implementation of the Affordable Care Act, the Medicaid Expansion, the insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the Medicare-Medicaid dual eligible demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, our ability to reduce over time the high medical costs commonly associated with new patient populations, and the success of our care management initiatives;
- our ability to predict with a reasonable degree of accuracy utilization rates in newly acquired plans and new geographies where we have less experience with both the patient and the provider populations;
- our ability to manage growth, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, and the overall success of care management initiatives designed to control costs;
- our ability to deal with increased pharmacy costs, including the increasing cost of high-cost specialty drugs, and formulary changes that allow the option of higher priced nongeneric drugs;
- our ability to manage in an environment where the overall trend suggests lower premiums per patient per month (PMPM) than past experience;
- federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, risk adjustment and conflicting interpretations thereof;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;
- the interpretation and implementation of state contract performance requirements regarding the achievement of certain quality measures, and our ability to avoid liquidated damages associated therewith;
- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;
- the success of our new health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, and our efforts to have providers prescribe generics notwithstanding recent changes to Puerto Rico's formulary;
- specialty drugs or generic drugs that are exorbitantly priced but not factored into the calculation of our capitated rates;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the resolution of the Illinois budget impasse and continued payment of all amounts due to our Illinois health plan;
- the accurate estimation of incurred but not reported or paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments or new information;
- efforts by states to recoup previously paid amounts, including but not limited to our dispute with the state of New Mexico related to reimbursement for retroactively enrolled members in 2014;
- the success of our profit improvement and cost-cutting initiatives;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;

- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings;
- the relatively small number of states in which we operate health plans;
- the effect on our Los Angeles County subcontract of Centene's acquisition of Health Net;
- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;
- newly emergent viruses or widespread epidemics, including the Zika virus, and associated public alarm;
- changes in general economic conditions, including unemployment rates;
- the sufficiency of our funds on hand to pay the amounts due upon conversion of our outstanding notes; and
- increasing competition and consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2015 and Part II, Item 1A of this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2015.

Company Overview

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other. All prior periods reported conform to this presentation.

First Quarter 2016 Compared with First Quarter 2015

Net income per diluted share decreased to $0.43 in the first quarter of 2016 compared with $0.56 reported for the first quarter of 2015. The primary reason for the decline in earnings year over year was reduced Medicaid Expansion premium rates that lowered income before taxes by approximately $50 million ($0.55 per diluted share).

Strong enrollment growth generated approximately $1 billion, or 34% more premium revenue in the first quarter of 2016 compared with the first quarter of 2015. Enrollment growth was primarily due to increased Marketplace enrollment, the start-up of the Puerto Rico health plan in April 2015, and acquisitions. Consolidated premium revenue measured on a per-member per-month (PMPM) basis decreased approximately 6% in the first quarter of 2016 when compared with the first quarter of 2015. The decline in PMPM premium revenue was primarily the result of lower PMPM premiums for Medicaid Expansion and the Marketplace.

The medical care ratio increased to 89.8% in the first quarter of 2016, from 88.7% in the first quarter of 2015. Consolidated medical care costs measured on a PMPM basis decreased approximately 5% in the first quarter of 2016 when compared with the first quarter of 2015. The PMPM decrease in medical care costs, which was primarily related to increased Marketplace membership, was more than offset by the declines in PMPM revenues as described above.

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") decreased slightly to 7.8% in the first quarter of 2016, from 8.1% in the first quarter of 2015, primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Market Updates
Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," for a discussion of the current year market updates.

Understanding Our Business

Health Plans Segment

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of March 31, 2016, these health plans served 4.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, most of whom receive government premium subsidies.

Health Plan Segment Membership by Health Plan and Program. The following tables set forth our Health Plans membership as of the dates indicated:

	March 31, 2016	December 31, 2015	March 31, 2015
Ending Membership by Health Plan:			
California	676,000	620,000	574,000
Florida	576,000	440,000	352,000
Illinois	206,000	98,000	102,000
Michigan	399,000	328,000	256,000
New Mexico	246,000	231,000	222,000
Ohio	336,000	327,000	350,000
Puerto Rico (1)	339,000	348,000	—
South Carolina	102,000	99,000	111,000
Texas	380,000	260,000	268,000
Utah	151,000	102,000	90,000
Washington	672,000	582,000	533,000
Wisconsin	137,000	98,000	107,000
	4,220,000	3,533,000	2,965,000
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF) and CHIP (2)	2,485,000	2,312,000	1,825,000
Medicaid Expansion	632,000	557,000	437,000
Aged, Blind or Disabled (ABD)	380,000	366,000	358,000
Marketplace	630,000	205,000	266,000
Medicare-Medicaid Plan (MMP) – Integrated (3)	50,000	51,000	34,000
Medicare Special Needs Plans (Medicare)	43,000	42,000	45,000
	4,220,000	3,533,000	2,965,000

(1) The Puerto Rico health plan began serving members effective April 1, 2015.
(2) CHIP stands for Children's Health Insurance Program.
(3) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

Health Plan Segment Premiums by Program. The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a PMPM basis, for the three months ended March 31, 2016. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF and CHIP	$ 120.00	$ 290.00	$ 180.00
Medicaid Expansion	320.00	490.00	370.00
ABD	410.00	1,530.00	960.00
Marketplace	180.00	370.00	250.00
MMP – Integrated	1,210.00	3,220.00	2,220.00
Medicare	810.00	1,100.00	1,030.00

Health Plan Segment Medical Care Costs by Type. The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Three Months Ended March 31,					
	2016			2015		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,737	$ 221.77	76.3%	$ 1,948	$ 226.04	73.9%
Pharmacy	525	42.53	14.6	351	40.75	13.3
Capitation	295	23.87	8.2	217	25.10	8.2
Direct delivery	16	1.34	0.5	27	3.11	1.0
Other	15	1.23	0.4	93	10.80	3.6
	$ 3,588	$ 290.74	100.0%	$ 2,636	$ 305.80	100.0%

Molina Medicaid Solutions Segment

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida. Operations in each of those jurisdictions are performed pursuant to separate contracts with each respective Medicaid agency.

Other Segment

Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

How We Assess Performance

One of the key metrics used to assess the performance of our most significant segment, the Health Plans segment, is the medical care ratio. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying gross margin, or the amount earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. The following table presents gross margin for the Health Plans and Molina Medicaid Solutions segments; the comparison of results for the Other segment was not meaningful for the periods presented. Management's discussion and analysis of the changes in the individual components of gross margin, by reportable segment, is below under Results of Operations.

	Three Months Ended March 31,			
	2016	2015	$ Change	% Change
	(In millions)			
Health Plans:				
Premium revenue	$ 3,995	$ 2,971	$ 1,024	34 %
Less: medical care costs	3,588	2,636	952	36
Medical margin	$ 407	$ 335	$ 72	21 %
Medical care ratio	89.8%	88.7%		
Molina Medicaid Solutions:				
Service revenue	$ 52	$ 52	$ —	— %
Less: cost of service revenue	46	36	10	28
Service margin	$ 6	$ 16	$ (10)	(63)%
Service cost ratio	88.8%	69.2%		

Our Use of Non-GAAP Financial Measures

We use two non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not as substitutes for or superior to, GAAP measures. The year over year changes for items comprising both of these measures are described below in Results of Operations, in the components of net income.

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization (EBITDA). We believe that EBITDA is particularly helpful in assessing our ability to meet the cash demands of our operating units. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended March 31,	
	2016	2015
	(In millions)	
Net income	$ 24	$ 28
Adjustments:		
Depreciation, and amortization of intangible assets and capitalized software	37	29
Interest expense	25	15
Income tax expense	40	39
EBITDA	$ 126	$ 111

The second of these non-GAAP measures is adjusted net income (including adjusted net income per diluted share). We believe that adjusted net income per diluted share is very helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to adjusted net income.

	Three Months Ended March 31,			
	2016		2015	
	(In millions, except diluted per-share amounts)			
Net income	$ 24	$ 0.43	$ 28	$ 0.56
Adjustment, net of tax:				
Amortization of intangible assets	5	0.08	3	0.06
Adjusted net income (1)	$ 29	$ 0.51	$ 31	$ 0.62

(1) Beginning in the first quarter of 2016, we revised our calculation of adjusted net income. We no longer subtract "Amortization of convertible senior notes and lease financing obligations" from net income to arrive at adjusted net income. We made this change because various capital transactions that we completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources

of capital. We believe that this change enhances the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors. All periods presented conform to this presentation.

Results of Operations

Three Months Ended March 31, 2016 Compared with Three Months Ended March 31, 2015

Health Plans Segment

In the first quarter of 2016, a 41% increase in membership and a 6% decrease in revenue PMPM (which was primarily the result of lower Medicaid Expansion and Marketplace revenue PMPM) resulted in increased premium revenue of approximately 34%, or $1.0 billion, when compared with the first quarter of 2015.

Medical care costs as a percent of premium revenue increased to 89.8% in the first quarter of 2016 from 88.7% in the first quarter of 2015. Medical margin increased 21% in the first quarter of 2016 over the first quarter of 2015.

Financial Performance by Program. The following tables present the components of premium revenue and medical care costs by program (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions).

	Three Months Ended March 31, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	7.4	$ 1,324	$ 178.47	$ 1,198	$ 161.46	90.5%	$ 126
Medicaid Expansion	1.9	679	365.11	574	308.30	84.4	105
ABD	1.2	1,112	961.49	1,041	899.79	93.6	71
Marketplace	1.6	409	251.85	334	205.86	81.7	75
MMP	0.1	340	2,220.68	317	2,070.23	93.2	23
Medicare	0.1	131	1,029.10	124	980.49	95.3	7
	12.3	$ 3,995	$ 323.73	$ 3,588	$ 290.74	89.8%	$ 407

	Three Months Ended March 31, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	5.5	$ 972	$ 177.40	$ 897	$ 163.67	92.3%	$ 75
Medicaid Expansion	1.3	507	397.99	393	308.59	77.5	114
ABD	1.0	940	894.70	863	820.72	91.7	77
Marketplace	0.6	194	332.52	156	268.60	80.8	38
MMP	0.1	225	2,206.17	199	1,950.71	88.4	26
Medicare	0.1	133	1,013.66	128	977.09	96.4	5
	8.6	$ 2,971	$ 344.65	$ 2,636	$ 305.80	88.7%	$ 335

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.

The following discussion highlights the primary drivers of our performance, by program, for the first quarter of 2016.

Medicaid TANF, CHIP and ABD. In the first quarter of 2016, we recorded a retroactive increase to Medicaid premium revenue of approximately $18 million, relating to dates of service prior to 2016.

Medicaid Expansion. Income before taxes for the first quarter of 2016 declined approximately $50 million ($0.55 per diluted share) in the first quarter of 2016, when compared with the first quarter of 2015, as a result of premium rate cuts to our Medicaid Expansion product. Rate decreases of 13% in California, 8% in New Mexico, and 5% in Ohio went into effect for Medicaid Expansion members on January 1, 2016.

Marketplace. In the first quarter of 2016, in response to new information, we increased Marketplace liabilities related to 2015 dates of service by approximately $30 million, approximately $20 million of which relates to our liability for risk adjustment payments that we expect to make to the federal government. Our estimated liability for risk adjustments is based on the relative health of our members (measured as an average risk score for each health plan), as compared to the expected average risk score

for all Marketplace plans measured over each calendar year. At December 31, 2015, we estimated that our Marketplace risk adjustment liability for 2015 was approximately $214 million. This liability was based on our estimate of the difference between our risk scores for 2015 in each state where we operate, compared with the average of all Marketplace plans within each state. During the first quarter of 2016, analysis performed by third party sources indicated that difference between the risk scores of our health plans and those of other Marketplace health plans for the year ended December 31, 2015 has widened even further. Accordingly, in the first quarter of 2016, we increased our risk adjustment liability for dates of service in 2015 by approximately $20 million.

During the first quarter of 2016, we also accrued the cost of certain provider settlements related to Marketplace member utilization in 2015.

We now estimate that the medical care ratio for our Marketplace business for all of 2015 was approximately 77%.

Financial Performance by State Health Plan. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Three Months Ended March 31, 2016						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	2.0	$ 541	$ 273.42	$ 469	$ 236.92	86.7%	$ 72
Florida	1.6	489	295.42	413	249.45	84.4	76
Illinois	0.6	149	267.10	132	236.76	88.6	17
Michigan	1.2	387	320.14	347	287.34	89.8	40
New Mexico	0.7	336	449.52	296	394.77	87.8	40
Ohio	1.0	488	489.14	449	450.11	92.0	39
Puerto Rico (3)	1.0	181	176.85	174	170.43	96.4	7
South Carolina	0.3	84	275.97	67	220.78	80.0	17
Texas	1.1	620	580.81	575	538.91	92.8	45
Utah	0.4	114	264.62	102	235.88	89.1	12
Washington	2.0	506	255.41	458	231.18	90.5	48
Wisconsin	0.4	97	250.36	92	238.01	95.1	5
Other (4)	—	3	—	14	—	—	(11)
	12.3	$ 3,995	$ 323.73	$ 3,588	$ 290.74	89.8%	$ 407

	Three Months Ended March 31, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1.7	$ 511	$ 305.10	$ 452	$ 270.37	88.6%	$ 59
Florida	0.9	311	346.46	281	313.51	90.5	30
Illinois	0.3	104	341.86	90	293.58	85.9	14
Michigan	0.7	220	290.29	185	244.32	84.2	35
New Mexico	0.7	314	458.75	292	426.82	93.0	22
Ohio	1.0	515	488.26	413	391.56	80.2	102
Puerto Rico (3)	—	—	—	—	—	—	—
South Carolina	0.3	91	266.42	74	216.67	81.3	17
Texas	0.8	382	492.38	352	453.30	92.1	30
Utah	0.3	77	290.27	74	278.99	96.1	3
Washington	1.6	376	240.83	352	225.49	93.6	24
Wisconsin	0.3	60	199.61	49	161.13	80.7	11
Other (4)	—	10	—	22	—	—	(12)
	8.6	$ 2,971	$ 344.65	$ 2,636	$ 305.80	88.7%	$ 335

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) "MCR" represents medical costs as a percentage of premium revenue.

(3) The Puerto Rico health plan began serving members effective April 1, 2015.
(4) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

The following discussion highlights the primary drivers of our performance, by health plan, for the first quarter of 2016.

California. Premium revenue grew to $541 million in the first quarter of 2016, from $511 million in the first quarter of 2015, as a result of higher membership. The medical care ratio decreased to 86.7% in the first quarter of 2016, from 88.6% in the first quarter of 2015, because higher medical care ratios for the MMP and Medicaid Expansion programs were more than offset by lower medical care ratios for other programs.

Florida. Premium revenue grew to $489 million in the first quarter of 2016, from $311 million in the first quarter of 2015, due to increased Marketplace membership, and the addition of over 100,000 members from Medicaid contract acquisitions primarily in the fourth quarter of 2015. The medical care ratio decreased to 84.4% in the first quarter of 2016, from 90.5% in the first quarter of 2015, primarily as a result of a Medicaid rate increase of approximately 5% effective September 1, 2015, a retroactive rate increase and various cost containment activities undertaken by the health plan; which were partially offset by retroactive increases to 2015 Marketplace liabilities. Absent out of period adjustments recorded in the first quarter of 2016, the medical care ratio for the Florida health plan would have been approximately 87% in the first quarter of 2016.

Illinois. Premium revenue grew to $149 million in the first quarter of 2016, from $104 million in the first quarter of 2015, and the medical care ratio increased to 88.6% in the first quarter of 2016, from 85.9% in the first quarter of 2015. The plan added over 100,000 members from Medicaid contract acquisitions in the first quarter of 2016. The medical care ratio increased for the TANF, ABD and Medicaid Expansion programs.

Michigan. Premium revenue grew $167 million, or 76%, in the first quarter of 2016 compared with the first quarter of 2015, due to the addition of over 100,000 members from Medicaid contract acquisitions in the third quarter of 2015 and the first quarter of 2016. The medical care ratio increased to 89.8% in the first quarter of 2016, from 84.2% in the first quarter of 2015. The medical care ratio increased in the first quarter of 2016 due to the launch of the comparatively lower margin MMP program subsequent to the first quarter of 2015, a rate decrease of approximately 1% effective January 1, 2016 and a reduction to revenue of approximately $5 million in 2016 for the true up of the medical cost floor related to 2015.

New Mexico. The medical care ratio decreased to 87.8% in the first quarter of 2016, from 93.0% in the first quarter of 2015, due to lower medical care ratios for the TANF and ABD programs, which more than offset an increase in the medical care ratio for the Medicaid Expansion and Medicare programs.

Ohio. Premium revenue declined $27 million, or 5%, in the first quarter of 2016 compared with the first quarter of 2015, due to reduced overall state Medicaid enrollment and reimbursement rates. The medical care ratio increased to 92.0% in the first quarter of 2016, from 80.2% in the first quarter of 2015. The increase in the 2016 medical care ratio was the result of a blended rate decrease of approximately 2.5% effective January 1, 2016 (which included a 5% decrease in Medicaid Expansion rates); substantially higher utilization of medical services in the first quarter of 2016 when compared to the same period in 2015; and a shift from very favorable development of prior period medical liability estimates in the first quarter of 2015 to slightly unfavorable development in the first quarter of 2016.

Puerto Rico. The medical care ratio was 96.4% in the first quarter of 2016. The plan served its first members effective April 1, 2015. See further information regarding our Puerto Rico health plan below under Part II, Item 1A – Risk Factors.

South Carolina. The medical care ratio decreased to 80.0% in the first quarter of 2016, from 81.3% in the first quarter of 2015.

Texas. Premium revenue grew $238 million, or 62%, in the first quarter of 2016 compared with the first quarter of 2015, primarily due to the addition of Marketplace membership, the addition of ABD members receiving nursing facility benefits effective March 1, 2015, and the start-up of the Texas MMP program on that same date. The plan's medical care ratio of 92.8% in the first quarter of 2016 was slightly higher than the first quarter of 2015.

Utah. The medical care ratio decreased to 89.1% in the first quarter of 2016, from 96.1% in the first quarter of 2015, due to improved medical cost efficiency across all programs.

Washington. Premium revenue grew $130 million, or 35%, in the first quarter of 2016 compared with the first quarter of 2015, primarily due to membership growth in the TANF, Medicaid Expansion and Marketplace programs. The medical care ratio decreased to 90.5% in the first quarter of 2016, from 93.6% in the first quarter of 2015, due to improved medical cost efficiency across nearly all programs.

Wisconsin. Premium revenue grew $37 million, or 61%, in the first quarter of 2016 when compared with the first quarter of 2015 as a result of increased Marketplace enrollment. The medical care ratio increased to 95.1% in the first quarter of 2016, from 80.7% in the first quarter of 2015 due to the higher medical care ratio of the Marketplace membership. Absent out of period costs recorded in the first quarter of 2016 that were related to 2015 Marketplace activity, the medical care ratio for the Wisconsin health plan would have been approximately 85% in the first quarter of 2016.

Molina Medicaid Solutions Segment

Service revenue was consistent between the first quarter of 2016 and the first quarter of 2015. Service margin declined $10 million in the first quarter of 2016 compared with the first quarter of 2015, primarily due to increased service costs associated with legacy state contracts that were recently re-procured.

Other Segment

The Other segment service margin for the three months ended March 31, 2016, was insignificant.

Income Statement Categories that are Not Unique to Individual Segments

General and Administrative Expenses. General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") decreased slightly to 7.8% in the first quarter of 2016, from 8.1% in the first quarter of 2015, primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Premium Tax Expenses. The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.6% in the first quarter of 2016 compared with 3.1% in the first quarter of 2015. This decrease was primarily due to the current year increase in MMP revenues. The Medicare portion of MMP revenue is not subject to premium tax.

Health Insurer Fee Revenue and Expenses. For our Medicaid program, actuarial standards require that we be reimbursed by state Medicaid agencies for both the expense associated with the HIF and the absence of tax deductibility for that expense. Subsequent to the first quarter of 2015, we secured full reimbursement for our expenses under the HIF (including the absence of tax deductibility) and as a result HIF revenue, as a percentage of premium revenue, increased to 2.2% in the first quarter of 2016 from 1.6% in the first quarter of 2015. HIF expenses, as a percentage of premium revenue, were 1.5% in the first quarter of 2016, compared with 1.4% in the first quarter of 2015.

Depreciation and Amortization. Depreciation and amortization amounted to 0.8% of total revenue for both periods.

Interest Expense. Interest expense increased to $25 million for the first quarter of 2016, from $15 million for the first quarter of 2015. The increase was primarily due to our issuance of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, in the fourth quarter of 2015.

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $8 million and $7 million for the three months ended March 31, 2016 and 2015, respectively.

Income Tax Expense. The provision for income taxes was recorded at an effective rate of 61.7% for the first quarter of 2016, compared with 58.2% for the first quarter of 2015. The effective tax rate for 2016 is higher than 2015 primarily as a result of higher non-deductible HIF expenses and nondeductible compensation.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary sources of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries is in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board-approved investment policies that conform to applicable state laws and regulations.

As of March 31, 2016, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Investment income increased to $8 million for the three months ended March 31, 2016, compared with $3 million for the three months ended March 31, 2015, primarily due to the increase in invested assets.

Cash in excess of the capital needs of our regulated health plans is generally paid to us in the form of dividends, when and as permitted by applicable regulations, for general corporate use. For the three months ended March 31, 2016, the parent received

no dividends from subsidiaries. For the three months ended March 31, 2015, we received dividends from our regulated health plan subsidiaries amounting to $25 million, and $17 million from our unregulated subsidiaries.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Three Months Ended March 31,		
	2016	2015	Change
	(In millions)		
Net cash provided by operating activities	$ 139	$ 554	$ (415)
Net cash used in investing activities	(314)	(228)	(86)
Net cash provided by financing activities	2	5	(3)
Net (decrease) increase in cash and cash equivalents	$ (173)	$ 331	$ (504)

Operating Activities. Net cash provided by operating activities decreased $415 million in the three months ended March 31, 2016 compared with the three months ended March 31, 2015, primarily due to the following:

- The change in receivables resulted in a use of cash of $266 million in the first quarter of 2016, and was a source of cash of $105 million in the first quarter of 2015. In the current year, receivables increased due to the addition of receivables from our Puerto Rico health plan which began operations on April 1, 2015, and acquisition-related growth. In the prior year, receivables decreased due to significant collections of premiums receivable at our California health plan in the first quarter of 2015.
- The change in deferred revenue resulted in a use of cash of $129 million in the first quarter of 2016, and a use of cash of $26 million in the first quarter of 2015. In the current year, deferred revenue decreased due to the advance receipt of $146 million in premium revenue at our Washington health plan as of December 31, 2015, with no corresponding receipt as of March 31, 2016. In the first quarter of 2015, the Washington health plan received comparable advanced receipts of premiums at the end of both December 2014 and March 2015.

These changes were partially offset by the increase in amounts due government agencies, which provided additional cash of $86 million year over year. In connection with Health Plans segment membership growth in programs that contain medical cost floors or medical cost corridors, a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs.

Investing Activities. Net cash used in investing activities increased $86 million in the three months ended March 31, 2016 compared with the three months ended March 31, 2015, primarily due to higher purchases of investments, net of sales and maturities, in the current year.

Financing Activities. There was no significant year over year change in financing activities.

Financial Condition

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at March 31, 2016, our working capital was $1,387 million, compared with $1,484 million at December 31, 2015. At March 31, 2015, our cash and investments amounted to $4,344 million, compared to $4,241 million at December 31, 2015. Cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. – amounted to $542 million and $612 million as of March 31, 2016 and December 31, 2015, respectively.

Regulatory Capital and Dividend Restrictions. For more information on our regulatory capital and dividend restrictions, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 14, "Commitments and Contingencies."

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "Ba3" by Moody's Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and costs.

Future Sources and Uses of Liquidity

Announced Acquisition. As described in Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," we announced a Health Plans segment acquisition on April 19, 2016, that we expect to close in the second half of 2016. We expect the purchase price for this acquisition to amount to approximately $41 million, subject to certain closing adjustments.

States' Budgets. From time to time the states in which our health plans operate may experience financial difficulties, which could lead to delays premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of March 31, 2016, our Illinois health plan served approximately 206,000 members, and recognized premium revenue of approximately $149 million in the first quarter of 2016. As of April 25, 2016, Illinois is current with its premium payments through February 29, 2016, but has not paid us for March 2016.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs, including health care-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. On May 2, 2016, Puerto Rico defaulted on approximately $422 million in debt repayment obligations to certain bondholders. In addition, it is likely to default on the $2 billion debt repayment obligation due to such bondholders on July 1, 2016.

As of April 29, 2016, the Commonwealth had paid us the first three weekly installments due for the month of April 2016. However, in a letter dated April 29, 2016, the Puerto Rico Health Insurance Administrator notified our Puerto Rico health plan that it would be unable at this time to make the fourth and final 25% installment payment of the capitation amount due for April 2016, or approximately $15 million. We are uncertain when the Puerto Rico health plan will be paid the fourth and final capitation amount for April 2016, as well as when our health plan will be paid the initial weekly capitation installments for May 2016.

As of March 31, 2016, the plan served approximately 339,000 members and recognized premium revenue of approximately $181 million in the first quarter of 2016, or approximately $60 million per month. Total premiums receivable from the Commonwealth as of March 31, 2016, were approximately $30 million, of which approximately $15 million has been collected.

Puerto Rico Member Eligibility and Premium Revenue. It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility. Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter.

It has been our practice in the past to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us. We are continuing to closely monitor the situation in Puerto Rico, including whether we should exit the Puerto Rico market.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. Our ability to borrow under the Credit Facility is subject to compliance with certain covenants. As of March 31, 2016, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Convertible Senior Notes. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020 (1.125% Notes), unless earlier repurchased or converted. In September 2014, we issued $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044 (1.625% Notes), unless earlier repurchased, redeemed, or converted. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The 1.125% Notes met the stock price trigger in the quarter ended March 31, 2016, and are convertible to cash through at least June 30, 2016.

Because the 1.125% Notes may be converted into cash within 12 months, the $454 million net carrying amount is reported in current portion of long-term debt as of March 31, 2016. In addition, holders of our 1.625% Notes may convert their notes into cash during any calendar quarter (and only during such calendar quarter) if the last reported sales price of our common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on May 2, 2016 was $49.79 per share. As of March 31, 2016, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next 12 months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash. As of March 31, 2016, we had sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

Securities Repurchase Program. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2015, was disclosed in our 2015 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the three months ended March 31, 2016. For further discussion and maturities of our long-term debt, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 9, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements. Other than the discussion as noted above, there have been no significant changes during the three months ended March 31, 2016, to our disclosure reported in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015.
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. Refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the first quarter of 2016 in connection with such contractual provisions.
- *Health Plans segment quality incentives*. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Molina Medicaid Solutions segment revenue and cost recognition*. There have been no significant changes during the three months ended March 31, 2016, to our disclosure reported in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

For information regarding market risk, see Part I, Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended March 31, 2016 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

For information regarding legal proceedings, see Part I, Item 1 of this Form 10-Q, Note 14, "Commitments and Contingencies."

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2015. The risk factors described herein, and in our 2015 Annual Report on Form 10-K, are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

The Commonwealth of Puerto Rico has defaulted on its May debt repayment obligation, and has also failed to pay our Puerto Rico health plan the final weekly capitation installment due for the month of April 2016.

On May 2, 2016, Puerto Rico defaulted on approximately $422 million in debt repayment obligations to certain bondholders. Governor Alejandro Garcia Padilla has said that the debt default was necessary in order to preserve the funding of public services, which include Medicaid services. Puerto Rico is scheduled to make another debt repayment to such bondholders in the amount of roughly $2 billion on July 1, 2016. Without Congressional action, it is expected that Puerto Rico will default on the July 1st debt repayment obligation as well.

Pursuant to a letter dated April 16, 2015, the Puerto Rico Health Insurance Administration (PRHIA) had agreed to pay our Puerto Rico health plan on a weekly basis in four allocated installments, with 20% of the monthly capitation amount being paid in each of the first and second weeks of the month, 35% of the capitation amount being paid in the third week, and the final 25% of the monthly capitation amount being paid in the final week of the month. In April 2016, the Puerto Rico Health Insurance Administration paid the first three installments due for the month of April. However, in a letter dated April 29, 2016, the Puerto Rico Health Insurance Administrator notified our Puerto Rico health plan that it would be "unable at this time to make the fourth and final payment" of the capitation amount for April 2016. We are uncertain when the Puerto Rico health plan will be paid the fourth and final capitation amount for April, as well as when our health plan will be paid the initial weekly capitation installments for May 2016. In addition, in connection with an unresolved enrollment dispute, Puerto Rico is continuing to withhold capitation payments to us we believe we are legally owed in the amount of approximately $12 million for periods in 2015.

Moreover, the Director for the Centers for Disease Control has been quoted as saying that, "Before the year is out, there could be hundreds of thousands of Zika infections in Puerto Rico." A high incidence of Zika cases in Puerto Rico could increase our Puerto Rico's health plan's medical expenses in 2016 beyond the amounts actuarially factored into the health plan's capitation rates.

We are continuing to closely monitor the situation in Puerto Rico, including whether we should exit the Puerto Rico market. The termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Unregistered Issuances of Equity Securities

None.

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended March 31, 2016 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
January 1 - January 31	—	$ —	—	$ 50,000,000
February 1 - February 29	511	$ 54.40	—	$ 50,000,000
March 1 - March 31	102,583	$ 63.74	—	$ 50,000,000
Total	103,094	$ 63.69	—	

(a) During the three months ended March 31, 2016, we withheld 103,094 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This repurchase program extends through December 31, 2016.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 2, 2016

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: May 2, 2016

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
10.1	Second Amended and Restated Employment Agreement with Dr. J. Mario Molina, dated March 16, 2016. Filed as Exhibit 10.1 to registrant's Form 8-K filed March 16, 2016.
10.2	Second Amended and Restated Employment Agreement with John C. Molina dated March 16, 2016. Filed as Exhibit 10.2 to registrant's Form 8-K filed March 16, 2016.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the annual report on Form 10-K for the period ended March 31, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 2, 2016

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed this annual report on Form 10-K for the period ended March 31, 2016 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 2, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended March 31, 2016 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 2, 2016

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended March 31, 2016 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 2, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

2015 MHI Form 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2015

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2015, the last business day of our most recently completed second fiscal quarter, was approximately $2,823.5 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2015).

As of February 23, 2016, approximately 56,199,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2016 Annual Meeting of Stockholders to be held on April 27, 2016, are incorporated by reference into Part III of this Form 10-K.

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Molina Healthcare, Inc.
Form 10-K
For the Year Ended December 31, 2015
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This Annual Report on Form 10-K ("Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the headings "Business," and "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly from the results discussed in the forward-looking statements. Factors that might cause such differences include, but are not limited to, those discussed in Part I, Item 1A of this Form 10-K under the heading "Risk Factors." Each of the terms "Company," "Molina Healthcare," "we," "our," and "us," as used herein refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

PART I

Item 1: Business

OVERVIEW

Our Vision and Mission

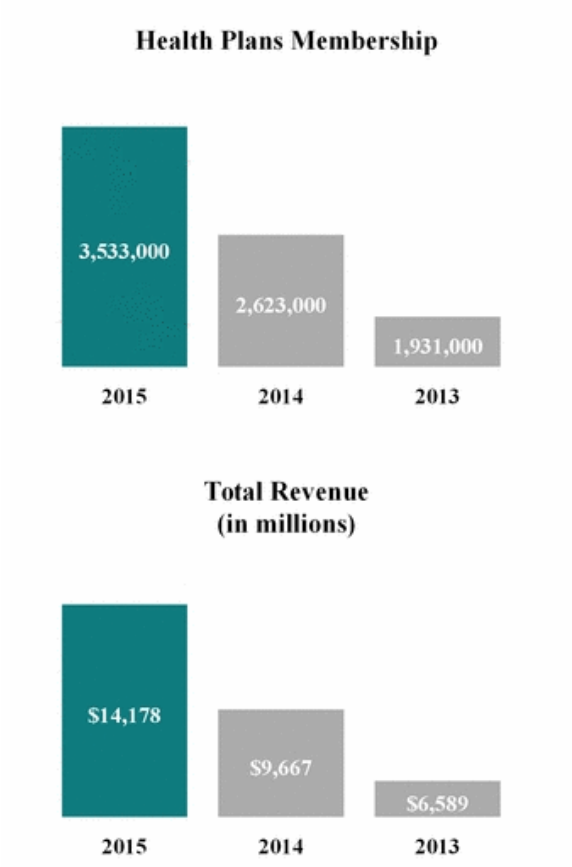
Molina Healthcare, Inc. offers cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program.We envision a future where everyone receives quality health care, and our mission is to provide quality health care to people receiving government assistance. To execute on our vision and mission, we dedicate ourselves to the following core values:

- Caring - We care about those we serve and advocate on their behalf.
- Enthusiasm - We enthusiastically address problems and seek creative solutions.
- Respect - We respect each other and value ethical business practices.
- Focus - We focus on our mission.
- Thrift - We are careful with scarce resources.
- Accountability - We are personally accountable for our actions and collaborate to get results.
- Feedback - We strive to improve the organization and achieve meaningful change through feedback and coaching.

Our Strategy

The primary objectives of our strategy over the past 35 years have been to grow and diversify our revenue; sustain our mission by being profitable; and to always remain focused on providing access to high quality healthcare for our members.

According to the U.S. Department of Health and Human Services (HHS), by late 2015 nearly 18 million people nationally gained health insurance by signing up for Medicaid or the Health Insurance Marketplace (Marketplace), since several of the Affordable Care Act's coverage provisions took effect. The uninsured rate has fallen from a high of 18% to nearly 11%; the lowest uninsured rate in 50 years according to an ongoing study by the Centers for Disease Control and Prevention. We have participated in this trend by enrolling approximately 1.6 million members since January 2014, including more than a half million Medicaid expansion members and 205,000 low-income Marketplace members. In total, as of December 31, 2015, our health plans served over 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals.



Beyond growing the number of members we serve, we believe our most important contribution lies in our commitment to provide access to quality health care for our members. To that end, we have set about expanding and deepening the care capabilities that we provide, focusing on quality outcomes, care integration, and measurable results. For example, the National Committee for Quality Assurance (NCQA) has accredited nine of our 12 Medicaid managed care plans. Our newer Illinois and South Carolina health plans are preparing for NCQA accreditation review in 2016. Our Puerto Rico health plan, which began serving members in 2015, will seek NCQA accreditation as soon as it is eligible to do so. We believe that these objective measures of the quality of the services we provide are increasingly important to state Medicaid agencies.

In addition, as states continue to seek cost-effective strategies to manage the care of individuals with more complex healthcare and behavioral needs, we believe that the movement toward the integration of behavioral health and medical care will continue.

Our growth strategy has four components:

- Growth and retention in our existing markets;
- Expansion into new geographies;
- Transitioning members and benefits from fee for service to managed care; and
- Developing and acquiring new products and capabilities.

Significant accomplishments in support of our strategic growth initiatives during 2015 and early 2016 included:

- *Growth and retention in our existing markets.*
    - We retained and grew existing business with our re-procurement wins in Michigan and Washington. Our new contract in Michigan expanded our service area across all of the Lower Peninsula, spanning an additional 18 counties. The Washington win, along with the acquisition described below, strengthens our position in the southwestern region of that state.
    - Our Florida and Michigan health plans acquired Medicaid contracts which added approximately 192,000 new members in 2015.
    - We have announced and/or closed on Medicaid contract acquisitions in Illinois, Michigan and Washington that we expect to add approximately 257,000 new members in the first quarter of 2016.
    - Our Marketplace enrollment grew from approximately 15,000 members in 2014, to over 200,000 members as of December 31, 2015.
    - Molina Medicaid Solutions entered into a 10-year contract with the state of New Jersey to design and operate that state's new Medicaid management information system (MMIS).
- *Expansion into new geographies.* Our Puerto Rico health plan began serving its first members in April 2015. As of December 31, 2015, our Puerto Rico plan enrollment amounted to approximately 348,000 members.

- *Transitioning members and benefits from fee for service to managed care.* In 2015, we saw strong growth in our Medicare-Medicaid Plan (MMP) and Aged, Blind or Disabled (ABD) programs. While smaller programs in total membership, they translate to strong revenue growth because these members bring much higher premiums when

compared with our other members, including those in the Temporary Assistance for Needy Families, Medicaid expansion and Marketplace programs.

- *Developing and acquiring new products and capabilities*. We acquired Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC, a division of The Providence Service Corporation. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia. We believe this acquisition will complement our Health Plans segment services with behavioral health and other services that focus on social determinants of health, as we increasingly arrange for healthcare services for members with complex needs.

Finally, to support our future growth initiatives, in 2015 we raised approximately $1.1 billion under debt and equity financing transactions, and supplemented our financing resources under a new unsecured $250 million revolving credit facility.

Our Strengths

From a strategic perspective, we believe our organizational structure allows us to participate in an expanding sector of the economy and continue our mission to provide quality health care to people receiving government assistance. Our approach to our business is based on the following strengths:

Flexible Health Services Portfolio. We offer a comprehensive suite of Medicaid services, ranging from quality care, disease management, cost management, and direct delivery of health care services, to state-level Medicaid management information systems (MMIS) administration through our Molina Medicaid Solutions segment. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. We believe that our Molina Medicaid Solutions platform, which is based on commercial off-the-shelf technology, has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Focus on People Receiving Government Assistance. Our experience over more than 35 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Scalable Administrative Infrastructure. Our operations share common systems platforms, which allow for economies of scale and common experience in meeting the needs of state Medicaid programs. We have centralized and standardized various functions and practices to increase administrative efficiency. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Consistent Medicaid National Brand. Since the founding of our company in 1980 to serve the Medicaid population in southern California through a small network of primary care clinics, we have increased our Health Plans membership to 3.5 million members as of December 31, 2015, added Molina Medicaid Solutions, and introduced new capabilities with the acquisition of Pathways.

Seasoned Management Team. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today, we remain a provider-focused company led by his son, Dr. J. Mario Molina, whose tenure with Molina is over 19 years. The rest of our named executive officers have been with Molina for periods ranging from 10 years to 20 years. We believe that this extensive experience allows senior management to take a longer-term view of our operations, while maintaining consistency.

Unique Culture. We believe that we are unique culturally because of our employees' dedication to our core values and our mission. Many of our employees seek to work here—and continue to work here—because of our shared belief that we envision a future where everyone receives quality healthcare.

OUR INDUSTRY

Medicaid

Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all jurisdictions is currently about 59%, and ranges from a federally established FMAP floor of 50% to as high as 74%.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program (TANF), which covers primarily low-income mothers and children. In states that have elected to participate, Medicaid expansion provides eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Another common state-administered Medicaid program is for ABD Medicaid beneficiaries, which covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients, and typically use more services because of their critical health issues. Additionally, the Children's Health Insurance Program (CHIP) is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.

Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. To improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services (CMS). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (PMPM) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

Medicaid Management Information Systems

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we actively participate in this market.

Competition

The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of health care reform, business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, quality of provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., and Aetna Inc. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- Multi-Product Managed Care Organizations - National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- Medicaid HMOs - National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- Prepaid Health Plans - Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- Primary Care Case Management Programs - Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services, ACS (owned by Xerox Corporation), Computer Services Corporation, and CNSI.

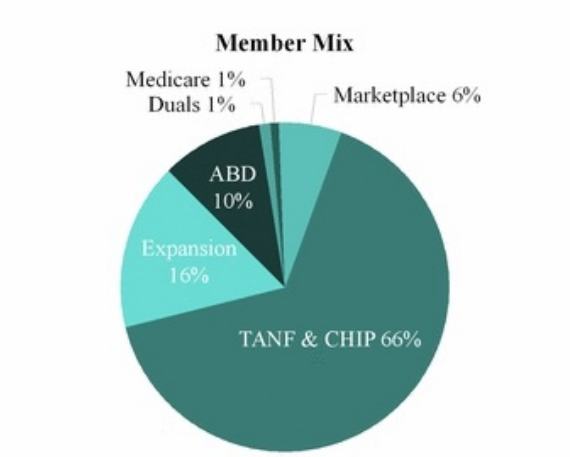
BUSINESS OPERATIONS

Our Structure

We currently manage our operations through three reportable segments: the Health Plans segment, the Molina Medicaid Solutions segment, and Other, which includes our recent Pathways acquisition described above. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition activity and changing laws and regulations. Therefore, these reportable segments may change in the future.

We derive our revenues primarily from health insurance premiums. Refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," and Note 20, "Segment Information," for revenue information by state health plan, and segment revenue, profit and total asset information, respectively.

Health Plans. The Health Plans segment consists of operational health plans in 11 states and the Commonwealth of Puerto Rico, and our direct delivery business. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate health plans. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements that limit the ability of our health plan subsidiaries to pay dividends to us. As of December 31, 2015, the components of our membership by program, are indicated in the following chart.



Molina Medicaid Solutions. The Molina Medicaid Solutions segment provides design, development, implementation (DDI), and business process outsourcing (BPO) solutions to state governments for their Medicaid management information systems. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia; the U.S. Virgin Islands; and a contract to provide pharmacy rebate administration services for the Florida Medicaid program. The Molina Medicaid Solutions segment supports state Medicaid agency administrative needs, reduces the variability in our earnings resulting from fluctuations in medical care costs, improves our operating profit margin percentages, and improves our cash flow by adding a business for which there are no restrictions on dividend payments.

Other. Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly. Additionally, our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

Pricing

Medicaid. Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members' health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Medicare. Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment.

Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

Marketplace. For our Marketplace plans, we develop premium rates during early spring each year for policies effective January 1st of the following year. We develop our premium rates based on our estimates of projected member utilization, medical unit costs, member risk acuity, and administrative costs, with the intent of realizing a target pretax percentage profit margin. Our

actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proved to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use predictive modeling that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs such as the following:

- *Disease Management Programs.* We develop specialized disease management programs that address the particular health care needs of our members. "*motherhood matters!*℠" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. "*breathe with ease!*" is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15. "*Healthy Living with Diabetes*" is a diabetes disease management program. "*Heart Healthy Living*" is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.
- *Educational Programs.* Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate members on the use of primary care physicians, emergency rooms, and nurse call centers.
- *Pharmacy Management Programs.* Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members, to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations (IPAs). Primary care physicians provide office-based primary care services. Primary care

physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups (DRGs) capitation, and case rates.

Direct Delivery. The clinics we operate are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics we operate assist us in developing and implementing community education, disease management, and other programs. Direct clinic management experience also enables us to better understand the needs of our contracted providers.

Reinsurance

Our health plans currently have reinsurance agreements with an unaffiliated insurer to cover certain claims. We enter into these contracts to reduce the risk of catastrophic losses which in turn reduce our capital and surplus requirements. We frequently evaluate reinsurance opportunities and review our reinsurance and risk management strategies on a regular basis.

Management Information Systems

All of our health plan information technology systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- Provider Self Services - Providers have the ability to access information regarding their members and claims. Key functionalities include "Check Member Eligibility," "View Claim," and "View/Submit Authorizations."
- Member Self Services - Members can access information regarding their personal data, and can perform the following key functionalities: "View Benefits," "Request New ID Card," "Print Temporary ID Card," and "Request Change of Address/PCP."
- File Exchange Services - Various trading partners, such as service partners, providers, vendors, management companies, and individual IPAs, are able to exchange data files (such as those that may be required by federal health care privacy regulations, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness Data and Information Set (HEDIS), and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT system).

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered. Payment is subordinated to the health plan’s ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the HHS. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

CONTRACTING AND REGULATORY COMPLIANCE

Government Contracts

Medicaid. In all the states in which we operate health plans, we enter into a contract with the state's Medicaid agency to offer managed care benefits to Medicaid-eligible individuals. Some states award contracts to any applicant demonstrating that it meets the state's requirements, while other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population; for example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. We are regulated by the state agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. For example, we must demonstrate that:

- Our provider network is adequate;
- Our quality and utilization management processes comply with state requirements;
- We have adequate procedures in place for responding to member and provider complaints and grievances;
- We can meet requirements for the timely processing of provider claims;
- We can collect and analyze the information needed to manage our quality improvement activities;
- We have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs;
- We have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion; and
- We have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Our state contracts determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and dis-enrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan.

The contractual relationship with the state is generally for a period of three to four years and is renewable on an annual or biennial basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months' prior written notice.

Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals (RFP), subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, in early 2012 our Missouri health plan was notified that it was not awarded a new contract under that state's RFP, and therefore its contract expired in that year.

Medicare. Under annually renewable contracts with CMS, our state health plans offer Medicare Advantage special needs plans which include a mandatory Part D prescription drug benefit. Molina Medicare Options Plus, our trade name for these plans, serves beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically under-served families and individuals. We employ sales personnel, and engage independent brokers, agents and consultants to enroll new Molina Medicare Options Plus members. None of our health plans operates a Medicare Advantage private fee-for-service plan.

Federal regulations place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. Additionally, there are certain restrictions on agent and broker compensation.

Molina Medicaid Solutions. We continually monitor the status of various states' legacy MMIS capabilities and contracts to determine whether Molina Medicaid Solutions' value proposition and core strengths will address a state's MMIS goals. Once an RFP with a Medicaid agency is won, our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we deliver extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the initial term of our most recently implemented Molina Medicaid Solutions contract in New Jersey is 10 years in total, consisting of 2.5 years allocated for the delivery of DDI services, followed by 7.5 years for the performance of BPO services. In most of these engagements option years are offered which span 2-3 years. The terms of some of our other established Molina Medicaid Solutions contracts—which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements)—are shorter in duration than our more recent contracts.

The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 75% of the costs incurred in operating a certified MMIS. Federal certification increases the share of the claims processing costs the federal government will pay for monthly operations. With an uncertified system, the federal government contributes approximately 50% of claims processing costs, with the state paying the other half. With a certified system, the federal government pays 75% of costs, reducing the state's share.

Other. Substantially all of Pathways' revenue is derived from contracts with state or local government agencies and government intermediaries, the majority of which are negotiated fee-for-service arrangements. A significant number of these contracts allow the payer to terminate the contract immediately for cause, such as for our failure to meet our contract obligations. Additionally, these contracts typically permit the payer to terminate the contract at any time prior to its stated expiration date without cause, at will and without penalty to the payer, either upon the expiration of a short notice period, typically 30 days, or immediately, in the event federal or state appropriations supporting the programs serviced by the contract are reduced or eliminated.

Regulatory Compliance

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

States' Risk-Based Capital Requirements. Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital (RBC) requirements. The RBC requirements are based on guidelines established

by the National Association of Insurance Commissioners (NAIC) and are administered by the states. All of our state health plans are subject to RBC requirements, except California and Florida. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute. For further information regarding RBC requirements, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 19, "Commitments and Contingencies."

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the American Recovery and Reinvestment Act of 2009, or ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. As required by ARRA, the Secretary of HHS has promulgated regulations implementing various provisions of the HITECH Act. The Final Omnibus Rule promulgated by HHS in January 2013, included the Final Breach Notification Rule as well as provisions that apply the HIPAA regulatory scheme to business associates. We anticipate that HHS will promulgate additional rules under the HITECH Act to implement provisions of the statute which were not addressed in the Final Omnibus Rule. The various requirements of the HITECH Act and the Final Omnibus Rule have different compliance dates, and in some cases, the applicable compliance date may depend on the publication of additional rules or guidance by HHS. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with such provisions. With respect to additional requirements that may be issued in the future by HHS, it is our intention to implement any such new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as "*qui tam*" actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Act of 2005 (DRA) encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Federal and State Self-Referral Prohibitions. We may be subject to federal and state statutes banning payments for referrals of patients and referrals by physicians to healthcare providers with whom the physicians have a financial relationship. Section 1877 of the Social Security Act, also known as the "Stark Law," prohibits physicians from making a "referral" for "designated health services" for Medicare (and in many cases Medicaid) patients from entities or facilities in which such physicians directly or indirectly hold a "financial relationship." A financial relationship can take the form of a direct or indirect ownership, investment or compensation arrangement. A referral includes the request by a physician for, or ordering of, or the certifying or re-certifying the need for, any designated health services.

Certain services that we provide may be identified as "designated health services" for purposes of the Stark Law. We cannot provide assurance that future regulatory changes will not result in other services we provide becoming subject to the Stark Law's ownership, investment or compensation prohibitions in the future.

Many states, including some states where we do business, have adopted similar or broader prohibitions against payments that are intended to induce referrals of clients. Moreover, many states where we operate have laws similar to the Stark Law prohibiting physician self-referrals. We contract with a significant number of human services providers and practitioners, including therapists, physicians and psychiatrists, and arrange for these individuals or entities to provide services to our clients. While we believe that these contracts are in compliance with the Stark Law, no assurance can be made that such contracts will not be considered in violation of the Stark Law.

For-profit ownership. Certain of the agencies for which we provide services restrict our ability to contract directly as a for-profit organization. Instead, these agencies contract directly with a not-for-profit organization and in certain cases we negotiate to provide administrative and management services to the not-for-profit providers. The extent to which other agencies impose such requirements may affect our ability to continue to provide the full range of services that we provide or limit the organizations with which we can contract directly to provide services.

Corporate practice of medicine and fee splitting. Some states in which we operate prohibit general business entities, such as us, from "practicing medicine," which definition varies from state to state and can include employing physicians, professional therapists and other mental health professionals, as well as engaging in fee-splitting arrangements with these health care providers. Among other things, we currently contract with professional therapists to provide intensive home based counseling and with nurse practitioners to perform comprehensive health assessments. We believe that we have structured our operations appropriately, however, we could be alleged or found to be in violation of some or all of these laws. If a state determines that some portion of our business violates these laws, it may seek to have us discontinue those portions or subject us to penalties, fines, certain license requirements or other measures. Any determination that we have acted improperly in this regard may result in liability to us. In addition, agreements between the corporation and the professional may be considered void and unenforceable.

Professional licensure and other requirements. Many of our employees are subject to federal and state laws and regulations governing the ethics and practice of their professions. In addition, professionals who are eligible to participate in Medicare and Medicaid as individual providers must not have been excluded from participation in government programs at any time. Our ability to provide services depends upon the ability of our personnel to meet individual licensure and other requirements.

OTHER INFORMATION

Intellectual Property

We have registered and maintain various service marks, trademarks and trade names that we use in our businesses, including marks and names incorporating the "Molina" or "Molina Healthcare" phrase, and from time to time we apply for additional registrations of such marks. We utilize these and other marks and names in connection with the marketing and identification of products and services. We believe such marks and names are valuable and material to our marketing efforts.

Employees

As of December 31, 2015, we had approximately 21,000 employees. Our employee base is multicultural and reflects the diverse membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Available Information

Molina Healthcare, Inc. is a C corporation under Delaware law incorporated in 2002. Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

You can access our website at *www.molinahealthcare.com* to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors

committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Executive Officers of the Registrant

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
J. Mario Molina, M.D.	57	President and Chief Executive Officer
John C. Molina, J.D.	51	Chief Financial Officer
Terry P. Bayer	65	Chief Operating Officer
Joseph W. White	57	Chief Accounting Officer
Jeff D. Barlow	53	Chief Legal Officer and Corporate Secretary

Dr. Molina has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board of Directors since 1996. Dr. Molina is the brother of John C. Molina.

Mr. Molina has served as Chief Financial Officer since 1995. He also has served as a member of the Board of Directors since 1994. Mr. Molina is the brother of Dr. J. Mario Molina.

Ms. Bayer has served as Chief Operating Officer since 2005.

Mr. White has served as Chief Accounting Officer since 2007.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010.

Item 1A: Risk Factors

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This Annual Report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the U.S. Securities Exchange Commission, or SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Segment

Numerous risks associated with the Affordable Care Act and its implementation, and changes to health care regulatory laws, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act (collectively, the Affordable Care Act, or ACA). The ACA enacted comprehensive changes to the U.S. health care system, elements of which have been phased in at various stages over the past several years. The most significant changes effected by the ACA were implemented as of January 1, 2014. There are a multitude of risks associated with the scope of change in the health care system represented by the ACA, including, but not limited to, the following:

- *Risks associated with the duals expansion*. Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for the nearly 50 million elderly and under-65 disabled beneficiaries in 2012. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered coverage beginning in the second quarter of 2015. At December 31, 2015, our membership included approximately 51,000 integrated MMP members.

  There are numerous risks associated with the initial implementation of a new program, with a health plan's expansion into a new service area, and with the provision of medical services to a new population which has not previously been

in managed care. One such risk is the development of actuarially sound rates. Because there is limited historical information on which to develop rates, certain assumptions are required to be made which may subsequently prove to have been inaccurate. Rates of utilization could be significantly higher than had been projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, because of our lack of actuarial experience for that program, region, or population, our reserve levels may be set at an inadequate level. For instance, these problems arose at our Texas health plan in 2012, leading to extremely elevated medical care costs and substantial losses at the health plan. All of these risks are present in the implementation of the duals demonstration programs. In the event these risks materialize at one or more of our health plans, the negative results of the health plan or plans could adversely affect our business, financial condition, cash flows, or results of operations.

- *Risks associated with Medicaid expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have participated in Medicaid expansion. At December 31, 2015, our membership included approximately 557,000 Medicaid expansion members, or 16% of total membership. The new enrollees in our health plans represent a population that is different from the population of Medicaid enrollees we have historically managed. All of the risk factors described above with regard to the duals demonstration programs apply equally to Medicaid expansion.
- *Risks associated with health insurance marketplaces*. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois, Puerto Rico and South Carolina. At December 31, 2015, our membership included approximately 205,000 Marketplace members, with approximately 133,000, or 65%, of those members in Florida. All of the risk factors described above with regard to the duals demonstration programs apply equally to our participation in the insurance marketplaces.
- *Risk associated with implementing regulations*. There are many parts of the ACA that require further guidance in the form of regulations. Due to the breadth and complexity of the ACA, the lack of implementing regulations and interpretive guidance, and the phased nature of the ACA's implementation, the overall impact of the ACA on our business and on the health industry in general over the coming years is difficult to predict and not yet fully known, and implementing regulations could contain provisions that have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Changes to health care regulatory laws under the ACA, including the recently proposed Medicaid managed care rule, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The health care regulatory law landscape is constantly changing. For example, on May 26, 2015, CMS posted a new proposed rule to the Federal Register regarding Medicaid programs and CHIP, Medicaid managed care, CHIP delivered in managed care, Medicaid and CHIP comprehensive quality strategies, and revisions related to third party liability that, if implemented, would, among other things, impose a medical loss ratio of 85% for Medicaid and CHIP programs, establish a Medicaid managed care quality rating system like the five-star system for Medicare Advantage plans, and expand health plans' responsibilities in program integrity efforts. It is difficult to predict what final rules may be adopted and implemented by CMS, and if the final rule would result in any material adverse effect on our business, financial condition, cash flows, or results of operations.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio, continuing operations of 89.1%, for the year ended December 31, 2015 had been one percentage point higher, or 90.1%, our net income from continuing operations for the year ended December 31, 2015 would have been approximately $1.08 per diluted share rather than our actual income from continuing operations of $2.58 per diluted share, a decrease of approximately 58%.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual flu season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of

providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs remain elevated at the same time that state budgets are suffering from significant fiscal strain. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it is a prime target for cost-containment efforts. The states in which we operate our health plans regularly face significant budgetary pressures. These budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

We are unable to determine how any future congressional spending cuts will affect Medicare and Medicaid reimbursement. There likely will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The Commonwealth of Puerto Rico may become unable to pay the premiums of our Puerto Rico health plan.

The government of Puerto Rico currently faces major fiscal and liquidity challenges. The government recently warned that it may lack sufficient resources to fund all necessary governmental programs and services as well as meet debt service obligations for fiscal year 2016. The extreme financial difficulties faced by the Commonwealth may make it impossible for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2015, our Puerto Rico health plan served approximately 348,000 members, and had recognized premium revenue of approximately $192 million in the fourth quarter of 2015, or approximately $64 million per month. It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility. Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid" (IBNP) medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to duals, Medicaid expansion members, or aged, blind or disabled Medicaid members, is impacted by the more limited experience we have had with those populations.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

Large-scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.

Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions. For example, natural disasters, such as a major earthquake in Los Angeles or Cascadia, or a major hurricane in Florida or South Carolina, could have a significant impact on the health of a large number of our covered members. Other conditions that could impact our members include an influenza epidemic, or newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikungunya virus, conditions for which vaccines may not exist, are not effective, or have not been widely administered. In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction. All of these conditions, and others, could have a significant impact on the health of the population of wide-spread areas. We seek to set our IBNP reserves appropriately to account for anticipatable spikes in utilization, such as for the flu season. However, if one of our health plan states were to experience a large-scale natural disaster, a viral epidemic or pandemic, a significant terrorism attack, or some other large-scale event affecting the health of a large number of our members, our covered medical expenses in that state would rise, which could have a material adverse effect on our business, cash flows, financial condition, and results of operations, or, in the event of extreme circumstances, could threaten our viability.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. In the event the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states, and our premium revenues could be materially reduced as a result. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

If we sustain a cyber-attack or suffer privacy or data security breaches that disrupt our operations or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information, vandalize our systems, create system disruptions, or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Our systems are also susceptible to human error. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world, we may be unable to proactively address these techniques or to implement adequate preventive measures. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, acts of malicious insiders, or other similar events that could negatively affect our systems and our and our members' data. The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. While we currently expend significant resources and have implemented solutions, processes and procedures to protect against cyber-attacks and security breaches, we may need to expend significant additional resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

In 2014, Gilead's pricing of the hepatitis C drug, Sovaldi, at $84,000 per standard course of therapy received major attention as a health care policy and public policy matter. Because of the relatively high incidence of hepatitis C throughout the nation, particularly in the Medicaid population, the pricing of specialty drugs for the treatment of hepatitis C represents a major public health and public financing problem. In the case of Sovaldi, because of its advent on the health care market in early 2014, the cost of the drug was generally not factored into our 2014 capitation rates, thus threatening to undermine the actuarial soundness of those rates. New high priced specialty drugs and generic drugs are expected to enter the health care market in 2015. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. We will seek to work with state Medicaid agencies to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals. In the event we are required to bear the high costs of new specialty drugs or generic drugs without an appropriate rate adjustment or other reimbursement mechanism, or if new regulations or mandates affect our pharmaceutical costs, our business, financial condition, cash flows, or results of operations could be adversely affected.

States may not adequately compensate us for the value of drug rebates that were previously earned by us but that are now collectible by the states.

The ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers have renegotiated or discontinued their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours continue to remain at levels that are much lower than prior to ACA implementation. There are provisions in the ACA that require rates paid to Medicaid managed care plans to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from 11 state health plans, and commenced operations with our Puerto Rico health plan in April 2015. If we are unable to continue to operate in any of those jurisdictions, or if our current operations in any portion of the jurisdictions we are in are significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of jurisdictions could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic, an unexpected increase in utilization, general economic conditions, and similar factors in those jurisdictions. Our inability to continue to operate in any of the jurisdictions in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

A large portion of our premium revenues are subject to risks related to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost-plus and performance-based reimbursement programs.

A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost floors and corridors, administrative cost and profit ceilings, cost-plus reimbursement, premium stabilization programs, and profit-sharing arrangements. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are potentially subject to differing interpretations by ourselves and the relevant government agency with whom we contract. In the event the applicable government agency disagrees with our interpretation or implementation of a particular contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to the government agency. Any interpretation of these contract provisions at variance with our interpretation and implementation of the provision, or that is inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. In the event we are unsuccessful in achieving the stated performance

measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

Failure to attain profitability in any new start-up operations, including in our new Puerto Rico health plan, could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state or commonwealth to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state or commonwealth, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state or commonwealth will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or commonwealth, or expanding a health plan in an existing state or commonwealth could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Centene's acquisition of Health Net could affect the Los Angeles county subcontract of our California health plan.

Our California health plan operates in Los Angeles County, California as a subcontractor to Health Net, which holds a direct Medi-Cal contract with the state of California. Health Net has entered into a merger agreement with Centene Corporation, with the merger expected to close in early 2016. We currently do not expect there to be any material change to our Los Angeles county subcontract in connection with Centene's acquisition of Health Net. However, if Centene seeks to modify our subcontract or otherwise refuses to perform under the contract, our business, financial condition, cash flows, or results of operations may be adversely affected.

Reductions in Medicare payments could reduce our earnings potential for our Medicare Advantage plans and our duals demonstration programs.

The Sequestration Transparency Act of 2012 included a 2% reduction of payments from CMS to our Medicare Advantage plans beginning April 1, 2013. Medicare Advantage plans will continue to be affected until Congress lifts the sequestration mandated under the Sequestration Transparency Act of 2012. Such reduction in our Medicare payments may have an adverse effect on our earnings potential for our Medicare Advantage plans and our duals demonstration programs. In addition, reductions to provider reimbursement rates associated with sequestration may adversely impact our relations with the impacted providers.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth

strategy. Many of the other potential purchasers of these assets—particularly operators of large commercial health plans—have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us, or at all, or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years, or that we will not complete acquisitions that turn out to be unfavorable. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

In addition, we may be unable to successfully identify, consummate, and integrate future acquisitions, including integrating the acquired businesses on our information technology platform, or to implement our operations strategy in order to operate acquired businesses profitably. Furthermore, we may incur significant transaction expenses in connection with a potential acquisition which may or may not be consummated. These expenses could impact our selling, general and administrative expense ratio.

For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, improper marketing, and the violation of patient privacy rights. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services (HHS), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. We are currently defending one *qui tam* action where the federal government has declined to intervene: *United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al*. Other qui tam actions may have been filed against us of which we are presently unaware, or other qui tam actions may be filed against us in the future. In the event we are subject to liability under these or other *qui tam* actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

HHS released rules pursuant to the Health Insurance Portability and Accountability Act, or HIPAA, which mandate the use of standard formats in electronic health care transactions. HHS also published rules requiring the use of standardized code sets and unique identifiers for providers. These new standardized code sets, known as ICD-10, require substantial investments from health care organizations, including us. We implemented ICD-10 effective as of October 1, 2015. Use of the ICD-10 code sets require significant administrative changes and may result in errors and otherwise negatively impact our service levels. In addition, we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, results of operations, and cash flows.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped when the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which we do not participate. These actions and the resulting negative publicity could become associated with or imputed to us, regardless of our actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which we do not participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts

over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. We received $125 million in dividends from our regulated health plan subsidiaries during 2015. We did not receive any dividends from our regulated health plan subsidiaries during 2014, because significant growth across all of our health plans necessitated that the plans retain their cash to meet increasing net worth requirements. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2015 and 2014, without approval of the regulatory authorities, were approximately $121 million and $96 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under the senior notes or the revolving credit facility.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our use and disclosure of individually identifiable information, including health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations, including HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of individually identifiable information, including protected health information, or PHI. HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities for compliance with the HIPAA Privacy and Security Standards. Investigations of violations that indicate willful neglect, for which penalties are now mandatory, are statutorily required. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the civil monetary penalty fine paid by the violator.

HIPAA further requires covered entities to notify affected individuals "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach" if their unsecured PHI is subject to an unauthorized access, use, or disclosure. If a breach affects 500 patients or more, it must be reported to HHS and local media without unreasonable delay, and HHS will post the name of the breaching entity on its public website. If a breach affects fewer than 500 individuals, the covered entity must log it and notify HHS at least annually. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal

penalties, divert management's time and energy, and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Risks Related to the Operation of Our Molina Medicaid Solutions Segment

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida. If we are unable to continue to operate in any of those six jurisdiction, or if our current operations in any of those jurisdictions are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business could be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results and damage our reputation.

Computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business or retain existing MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance of contracts, including those with respect to which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties, including software and hardware vendors, to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenues and profitability.

Our business may be adversely affected by the transition from traditional fee-for-service to Medicaid managed care.

In order to save on costs, a number of state Medicaid programs are expected to pursue the transition from a fee-for-service focus of their Medicaid programs to a Medicaid managed care focus. A shift in Medicaid payment models from fee-for-service to managed care will require a concomitant shift in the focus of MMIS. In connection with such a transition, MMIS must also make a transition from a system built around claims adjudication to one that performs analytics and can be used to manage Medicaid population health outcomes. In the event Molina Medicaid Solutions is unable to accomplish this transition, our business, financial condition, cash flows, or results of operations may be adversely affected.

Risks Related to our General Business Operations

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

We expect to continue to grow our membership and to expand into other markets through acquisitions and other opportunities. Continued rapid growth could place a significant strain on our management and on our other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, or results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability, and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, health care regulatory law-based litigation, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary

medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of our clinics or caused by one of our employees. We maintain medical malpractice insurance for our clinics in an amount which we believe to be reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the New York Stock Exchange, SEC, or other regulatory authorities which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles (GAAP) and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments

and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes, such as the health care federal excise tax discussed above. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations could have a material adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. It is critical that we recruit, manage, enable, and retain talent to successfully execute our strategic objections which requires aligned policies, a positive work environment, and a robust succession and talent development process. Further, particularly in light of the changing health care environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. If we are unsuccessful in recruiting, retaining, managing, and enabling such personnel and are unable to meet upcoming challenges and opportunities, our operations could be negatively impacted.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not

fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could adversely impact our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2015, goodwill was $519 million, and intangible assets, net, were $122 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives.

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable.

The determination of the value of goodwill, and intangible assets, net, requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

We are subject to the risks of owning and leasing real property.

We are a tenant under numerous leases in multiple states, including a 25-year lease of an approximately 460,000 square foot office building housing our principal executive offices in Long Beach, California. We also own a 186,000 square-foot office building in Troy, Michigan, a 26,700 square-foot data center in Albuquerque, New Mexico, a 24,000 square-foot community clinic in Pomona, California, and 40 properties in Pennsylvania, which are primarily residential housing facilities. Accordingly, we are subject to all of the risks generally associated with leasing and owning real estate, which include, but are not limited to: the possibility of environmental contamination, the costs associated with fixing any environmental problems and the risk of damages resulting from such contamination; adverse changes in the value of the property due to interest rate changes, changes in the neighborhood in which the property is located, or other factors; ongoing maintenance expenses and costs of improvements; the possible need for structural improvements in order to comply with changes in zoning, seismic, disability act, or other requirements; inability to renew or enter into leases for space not utilized by us on commercially acceptable terms or at all; and possible disputes with neighboring owners or other individuals and entities.

Our substantial indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of any variable rate debt, and prevent us from meeting our our outstanding indebtedness.

We have a significant amount of indebtedness. As of December 31, 2015, our total indebtedness was approximately $1,609 million, including lease financing obligations. As of December 31, 2015, we also had $244 million available for borrowing under our revolving credit facility. Our substantial indebtedness could have significant consequences, including:

- increasing our vulnerability to adverse economic, industry, or competitive developments;
- requiring a substantial portion of our cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund operations, make capital expenditures, and pursue future business opportunities;
- exposing us to the risk of increased interest rates to the extent of any future borrowings, including borrowings under the revolving credit facility, at variable rates of interest;
- making it more difficult for us to satisfy our obligations with respect to our indebtedness, including the revolving credit facility and our outstanding senior notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indenture governing our outstanding senior notes and the agreements governing such other indebtedness;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product and service development, debt service requirements, acquisitions, and general corporate or other purposes; and

- limiting our flexibility in planning for, or reacting to, changes in our business or market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged and who, therefore, may be able to take advantage of opportunities that our substantial indebtedness may prevent us from exploiting.

Despite our high indebtedness level, we and our subsidiaries are able to incur substantial additional amounts of debt, including secured debt, which could further exacerbate the risks associated with our substantial indebtedness.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. Although the indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances, the amount of indebtedness that could be incurred in compliance with these restrictions could be substantial. As of December 31, 2015, we had approximately $244 million available for additional borrowing under our revolving credit facility. In addition, the indentures governing our outstanding senior notes and the credit agreement governing our revolving credit facility do not prevent us from incurring obligations that do not constitute prohibited indebtedness thereunder. If new debt is added to our and our subsidiaries' existing debt levels, the related risks that we now face would increase.

The terms of our debt impose, and will impose, restrictions on us that may affect our ability to successfully operate our business and our ability to make payments on our outstanding senior notes.

The indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain various covenants that could materially and adversely affect our ability to finance our future operations or capital needs and to engage in other business activities that may be in our best interest. These covenants limit our ability to, among other things:

- incur additional indebtedness or issue certain preferred equity;
- pay dividends on, repurchase, or make distributions in respect of our capital stock, prepay, redeem, or repurchase certain debt or make other restricted payments;
- make certain investments;
- create certain liens;
- sell assets, including capital stock of restricted subsidiaries;
- enter into agreements restricting our restricted subsidiaries' ability to pay dividends to us;
- consolidate, merge, sell, or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates; and
- designate our restricted subsidiaries as unrestricted subsidiaries.

All of these covenants may restrict our ability to expand or to pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, such as prevailing economic conditions and changes in regulations, and if such events occur, we cannot be sure that we will be able to comply. A breach of these covenants could result in a default under the indentures for our outstanding senior notes and/or the credit agreement governing the revolving credit facility including, as a result of cross default provisions and, in the case of the revolving credit facility permit the lenders to cease making loans to us. If there were an event of default under the indentures governing our outstanding senior notes and/or the credit agreement governing the revolving credit facility, holders of such defaulted debt could cause all amounts borrowed under these instruments to be due and payable immediately. Our assets or cash flow may not be sufficient to repay borrowings under our outstanding debt instruments in the event of a default thereunder.

In addition, the restrictive covenants in the credit agreement governing the revolving credit facility require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests will depend on our ongoing financial and operating performance, which, in turn, will be subject to economic conditions and to financial, market, and competitive factors, many of which are beyond our control.

If our operating performance declines, we may be required to obtain waivers from the lenders under the revolving credit facility, from the holders of our outstanding senior notes or from the holders of other obligations, to avoid defaults thereunder. If we are not able to obtain such waivers, our creditors could exercise their rights upon default, and we could be forced into bankruptcy or liquidation.

We may not have the funds necessary to pay the amounts due upon conversion or required repurchase of our outstanding notes, and our indebtedness may contain limitations on our ability to pay the amounts due upon conversion or required repurchase.

In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Notes. In September 2014, we issued $301.6 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Notes. As of December 31, 2015, the aggregate outstanding principal amount of our 1.125% Notes and our 1.625% Notes was $550 million and $302 million, respectively. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The 1.125% Notes met the stock price trigger in the quarter ended December 31, 2015, and are convertible to cash through at least March 31, 2016. Because the 1.125% Notes may be converted into cash within 12 months, the $448 million carrying amount is reported in current portion of long-term debt as of December 31, 2015. In addition, holders of our 1.625% Notes may convert their notes into cash during any calendar quarter (and only during such calendar quarter) if the last reported sales price of our common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on February 23, 2016 was $62.28 per share. As of December 31, 2015, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash. As of December 31, 2015, we had sufficient available cash, combined with borrowing capacity available under our revolving credit facility, to fund such conversions.

In addition, in the event of a change in control or the termination in trading of our stock, each holder of our 1.125% Notes and our 1.625% Notes would have the right to require us to purchase some or all of their notes at a purchase price in cash equal to 100% of the principal amount of the notes, plus any accrued and unpaid interest.

In the event of conversions or required repurchases, we may not have enough available cash or be able to obtain financing at the time we are required to comply with our conversion or repurchase obligations. In addition, our ability to comply with these obligations may be limited by law, by regulatory authority, or by agreements governing our future indebtedness. The indentures for the 1.125% Notes and the 1.625% Notes provide that it would be an event of default if we do not make the cash payments due upon conversion or required repurchase of the notes. The occurrence of an event of default under one or both of these indentures may also constitute an event of default under our revolving credit facility and under our other indebtedness we may have outstanding at such time. Any such default could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.

Our borrowings under the revolving credit facility are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness could increase even though the amount borrowed remained the same, and our net income could decrease. The applicable margin with respect to the loan under the revolving credit facility is a percentage per annum equal to a reference rate plus the applicable margin. In order to manage our exposure to interest rate risk, in the future we may enter into derivative financial instruments, typically interest rate swaps and caps, involving the exchange of floating for fixed rate interest payments. If we are unable to enter into interest rate swaps, it may adversely affect our cash flow and may impact our ability to make required principal and interest payments on our indebtedness.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments, including the revolving credit facility, and the indentures governing our outstanding senior notes, may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which would harm our ability to incur additional indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies may increase our future borrowing costs and reduce our access to capital.

Our debt currently has a non-investment grade rating, and there can be no assurance that any rating assigned by the rating agencies to our debt or our corporate rating will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, future circumstances relating to the basis of the rating, such as adverse changes, so warrant. A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies would likely increase our future borrowing costs and reduce our access to capital, which could have a materially adverse impact on our financial condition and results of operations.

Risks Related to Our Common Stock

Delaware law and our charter documents may impede or discourage a takeover, which could cause the market price of our common stock to decline.

We are a Delaware corporation, and the anti-takeover provisions of Delaware law impose various impediments to the ability of a third party to acquire control of us, even if a change in control would be beneficial to our existing stockholders. In addition, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock and certain provisions of Delaware law and our certificate of incorporation and bylaws could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock and the value of our convertible senior notes.

Members of the Molina family own a significant amount of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate owned or were entitled to receive upon certain events approximately 26% of our capital stock as of December 31, 2015. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election of directors, amendments to our charter, and any merger, consolidation, or sale of our company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to

our stockholders. Our certificate of incorporation provides that we have authority to issue 150,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2015, approximately 56,000,000 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Item 1B: Unresolved Staff Comments

None.

Item 2: Properties

As of December 31, 2015, the Health Plans segment leased a total of 84 facilities, the Molina Medicaid Solutions segment leased a total of 12 facilities and the Other segment leased a total of 215 facilities. We own a 186,000 square-foot office building in Troy, Michigan and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. We own a 26,700 square-foot data center in Albuquerque, New Mexico and 40 properties in Pennsylvania, which are primarily residential housing facilities, under our Other segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operations growth prospects to determine if additional space is required, and where it would be best located.

Item 3: Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana v. Molina Medicaid Solutions et al. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. The petitioner seeks actual damages to be proved at trial, plus interest. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The relator seeks treble damages in the amount of $3 billion, plus interest and penalties. The Department of Justice has declined to intervene. The District Court dismissed this action as to Molina without leave to amend as to some allegations and with leave to amend as to other allegations. On October 22, 2015, the Relator filed a third amended complaint. We believe that we have several meritorious defenses to the claims of the Relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Item 4: Mine Safety Disclosures

None.

PART II

Item 5: Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of February 23, 2016, there were approximately 120 holders of record of our common stock. The high and low intra-day sales prices of our common stock for specified periods are set forth below:

	High	Low
2015		
First Quarter	$ 67.58	$ 49.37
Second Quarter	$ 73.98	$ 57.35
Third Quarter	$ 82.37	$ 65.72
Fourth Quarter	$ 70.82	$ 55.49
2014		
First Quarter	$ 39.21	$ 32.41
Second Quarter	$ 46.17	$ 32.86
Third Quarter	$ 48.03	$ 39.23
Fourth Quarter	$ 54.57	$ 40.79

Dividends

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business growth. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Additionally, the indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain various covenants that limit our ability to pay dividends on our common stock.

Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, in "Liquidity and Capital Resources," under the subheading "Regulatory Capital and Dividend Restrictions."

Unregistered Issuances of Equity Securities

None.

Stock Repurchase Programs

Securities Repurchases and Repurchase Programs. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This newly authorized repurchase program extends through December 31, 2016.

Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2015, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (1)	Average Price Paid per Share (1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (2)	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs (2)
October 1 — October 31	94	$ 66.79	—	$ 50,000,000
November 1 — November 30	576	$ 62.00	—	$ 50,000,000
December 1 — December 31	104,222	$ 59.15	—	$ 50,000,000
	104,892	$ 59.17	—	

(1) During the quarter we withheld 104,892 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

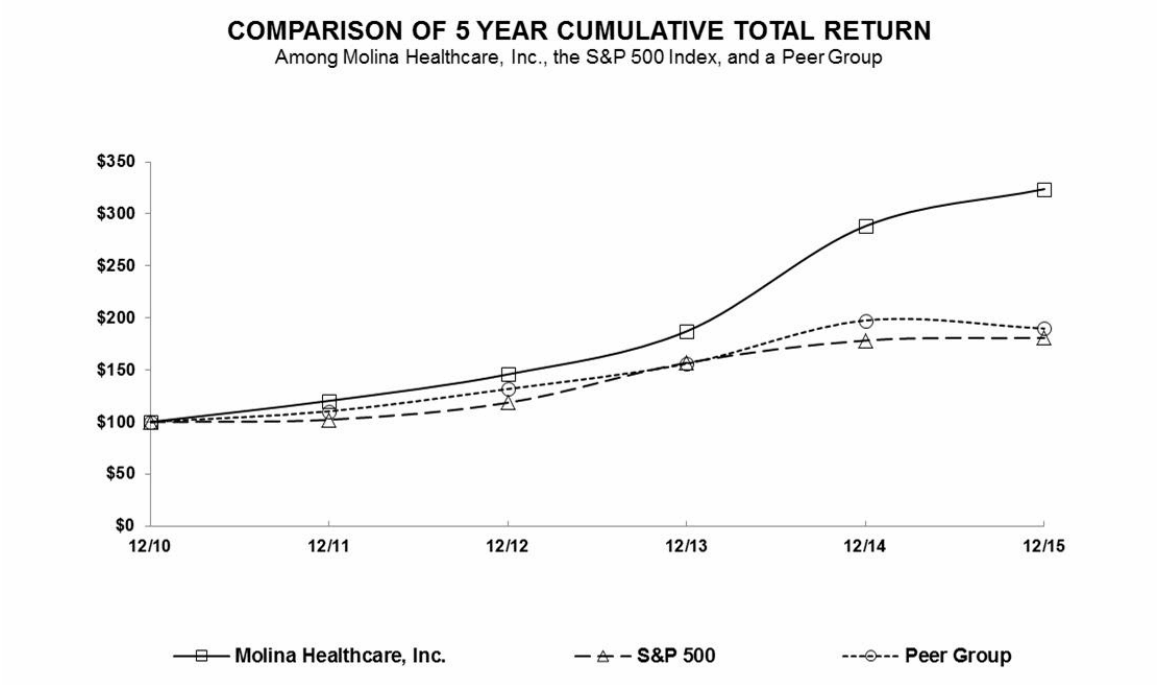
(2) Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. This repurchase program expired December 31, 2015.

STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the SEC (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (S&P 500) and a peer group index for the five-year period from December 31, 2010 to December 31, 2015. The comparison assumes $100 was invested on December 31, 2010, in the Company's common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.

The peer group index consists of Brookdale Senior Living, Inc. (BKD), Catamaran Corporation (CTRX), Centene Corporation (CNC), Community Health Systems, Inc. (CYH), DaVita HealthCare Partners, Inc. (DVA), Health Net, Inc. (HNT), Kindred Healthcare, Inc. (KND), Laboratory Corporation of America Holdings (LH), Life Point Hospitals, Inc. (LPNT), Magellan Health, Inc. (MGLN), Omnicare, Inc. (OCR), Quest Diagnostics, Inc. (DGX), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).



	December 31,					
Name	2010	2011	2012	2013	2014	2015
Molina Healthcare, Inc.	$ 100.00	$ 120.27	$ 145.75	$ 187.16	$ 288.31	$ 323.86
S&P 500	100.00	102.11	118.45	156.82	178.29	180.75
Peer Group	100.00	110.25	131.73	155.98	197.59	189.81

Item 6. Selected Financial Data

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics, Continuing Operations") for the five years ended December 31, 2015 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollar amounts are presented in millions, except per-share data. The data under the caption "Operating Statistics, Continuing Operations" has not been audited.

	Year Ended December 31,				
	2015 (1)	2014	2013	2012	2011
Statements of Income Data:					
Revenue:					
Premium revenue	$ 13,241	$ 9,023	$ 6,179	$ 5,544	$ 4,212
Service revenue (1)	253	210	205	188	160
Premium tax revenue	397	294	172	159	155
Health insurer fee revenue	264	120	—	—	—
Investment income	18	8	7	5	5
Other revenue	5	12	26	18	8
Total revenue	14,178	9,667	6,589	5,914	4,540
Operating expenses:					
Medical care costs	11,794	8,076	5,380	4,991	3,664
Cost of service revenue (1)	193	157	161	141	144
General and administrative expenses	1,146	765	666	519	393
Premium tax expenses	397	294	172	159	155
Health insurer fee expenses	157	89	—	—	—
Depreciation and amortization	104	93	73	63	48
Total operating expenses	13,791	9,474	6,452	5,873	4,404
Operating income	387	193	137	41	136
Other expenses, net:					
Interest expense	66	57	52	17	16
Other (income) expense, net	(1)	1	4	1	—
Total other expenses, net	65	58	56	18	16
Income from continuing operations before income taxes	322	135	81	23	120
Income tax expense	179	73	36	10	43
Income from continuing operations	143	62	45	13	77
Income (loss) from discontinued operations, net of tax expense (benefit) (2)	—	—	8	(3)	(56)
Net income	$ 143	$ 62	$ 53	$ 10	$ 21
Basic net income per share: (3)					
Income from continuing operations	$ 2.75	$ 1.34	$ 0.98	$ 0.28	$ 1.69
(Loss) income from discontinued operations	—	(0.01)	0.18	(0.07)	(1.24)
Basic net income per share	$ 2.75	$ 1.33	$ 1.16	$ 0.21	$ 0.45
Diluted net income per share: (3)					
Income from continuing operations	$ 2.58	$ 1.30	$ 0.96	$ 0.27	$ 1.67
(Loss) income from discontinued operations	—	(0.01)	0.17	(0.06)	(1.22)
Diluted net income per share	$ 2.58	$ 1.29	$ 1.13	$ 0.21	$ 0.45
Weighted average shares outstanding:					
Basic	52	47	46	46	46
Diluted	56	48	47	47	46
Operating Statistics, Continuing Operations: (3)					
Medical care ratio (4)	89.1%	89.5%	87.1%	90.0%	87.0%
General and administrative expense ratio (5)	8.1%	7.9%	10.1%	8.8%	8.7%
Net profit margin(5)	1.0%	0.6%	0.7%	0.2%	1.7%
Members (6)	3,533,000	2,623,000	1,931,000	1,797,000	1,618,000

	December 31,				
	2015	2014	2013	2012	2011
Balance Sheet Data:					
Cash and cash equivalents	$ 2,329	$ 1,539	$ 936	$ 796	$ 494
Total assets [7]	6,576	4,435	2,988	1,901	1,631
Long-term debt, including current maturities [7] [8]	1,609	887	770	261	216
Total liabilities [7]	5,019	3,425	2,095	1,119	876
Stockholders' equity	1,557	1,010	893	782	755

(1) Service revenue and cost of service revenue include revenue and costs generated by our Pathways subsidiary, which was acquired on November 1, 2015.

(2) Income (loss) from discontinued operations is presented net of income tax expense (benefit), which was insignificant in 2015 and 2014, and $(10), and $(1), and $1, in 2013, 2012 and 2011, respectively.

(3) Source data for calculations in thousands.

(4) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, utilization of medical services, our ability to effectively manage costs, contract changes, and changes in accounting estimates related to incurred but not paid claims. See Item 7 in this Form 10-K, "Management's Discussion and Analysis of Financial Condition and Results of Operations," for further discussion.

(5) Computed as a percentage of total revenue.

(6) Number of members at end of period.

(7) We have reclassified certain amounts in prior periods to conform to the 2015 presentation. Specifically, deferred issuance costs relating to our senior notes are now reported as a direct deduction of the applicable debt liabilities. Additionally, aggregate deferred income taxes are now reported as non-current. Both reclassifications are a result of recently adopted accounting pronouncements. See Item 8 in this Form 10-K, "Financial Statements and Supplementary Data," for further discussion.

(8) Includes senior notes, lease financing obligations, and other long-term debt.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with Items 6 and 8 of this Form 10-K, Selected Financial Data, and Financial Statements and Supplementary Data, respectively. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth in Part I, Item 1A of this Form 10-K, Risk Factors.

Overview

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of December 31, 2015, these health plans served over 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

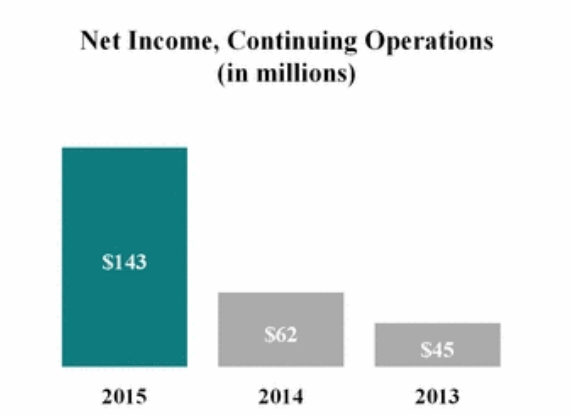
Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

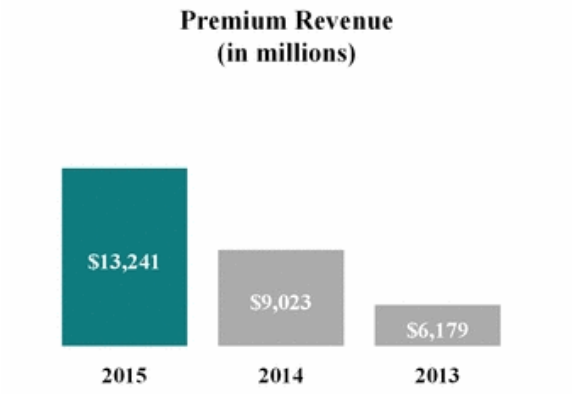
Refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," for a comprehensive description of our Health Plans and Molina Medicaid Solutions revenues and costs, and how we recognize them.We report revenue and costs attributable to Pathways as service revenue and cost of service revenue, respectively.

Beginning in 2013, after our Medicaid contract with the state of Missouri expired, we have reported the results relating to the Missouri health plan as discontinued operations for all periods presented. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise noted.

Fiscal Year 2015 Financial Highlights

- Earnings per diluted share nearly doubled in 2015 when compared with 2014, while net income more than doubled. Substantial increases in revenue, along with improved operating efficiency, were responsible for our improved performance. Our after-tax margin increased to 1.0% in 2015 from 0.6% in 2014.
- Strong enrollment growth across all of our programs, combined with a 5% increase in premium revenue per member, generated over $4 billion, or 47%, more premium revenue in 2015 compared with 2014.
- Medical care costs as a percentage of premium revenue (the "medical care ratio") decreased to 89.1% in 2015, from 89.5% in 2014.
- General and administrative expenses as a percentage of revenue (the "general and administrative expense ratio") increased slightly to 8.1% in 2015, versus 7.9% in 2014, primarily as a result of dramatic growth in our Marketplace membership. Excluding Marketplace broker and exchange fees from both years, the general and administrative expense ratio decreased to 7.5% in 2015 from 7.9% in 2014.
- Debt and equity financing transactions generated net cash of $1,062 million.





Market Updates—Health Plans

Medicare-Medicaid Plans. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered coverage beginning in the second quarter of 2015. At December 31, 2015, our membership included approximately 51,000 integrated MMP members.

Florida. On November 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to operation of the Medicaid business, of Integral Health Plan, Inc.

On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc.

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. We assumed approximately 58,000 Medicaid members in this acquisition.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. We assumed approximately 21,000 Medicaid members in this acquisition.

On November 30, 2015, we announced that our Illinois health plan entered into an agreement to assume the membership and certain Medicaid assets of Better Health Network, LLC (Better Health). As of November 30, 2015, Better Health served approximately 40,000 members in the Medicaid Family Health program in Cook County. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the first half of 2016.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. We assumed approximately 81,000 Medicaid and MIChild members in this acquisition.

In October 2015, the Michigan Department of Health and Human Services announced that Molina Healthcare of Michigan was recommended to serve the state's Medicaid members under Michigan's Comprehensive Health Plan, which commenced on January 1, 2016. The new contract has a five-year term with three one-year extensions, and covers Regions 2 through 6, and 8 through 10 of the state, representing an expansion into 18 additional counties compared with the previous Michigan Medicaid contract.

On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc.

Puerto Rico. Effective April 1, 2015, our Puerto Rico health plan served its first members. As of December 31, 2015, our Puerto Rico plan enrollment amounted to approximately 348,000 members.

Washington. In November 2015, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to negotiate and enter into managed care contracts for the Southwest region of the state's Apple Health Fully Integrated Managed Care Program. The start date is scheduled for April 1, 2016.

On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid membership and certain Medicaid assets of Columbia United Providers, Inc. We assumed approximately 57,000 Medicaid members in this acquisition.

Market Update—Molina Medicaid Solutions

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate that state's new Medicaid management information system (MMIS). The new contract was effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's incumbent MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Market Update—Other

Pathways. On November 1, 2015, we acquired all of the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia.

Financial Performance Summary

The following table summarizes our financial and operating performance from continuing operations for the years ended December 31, 2015, 2014, and 2013. All dollar amounts are presented in millions, except per-share data.

	Year Ended December 31,			Year Ended December 31,		
	2015	2014	% Change	2014	2013	% Change
Revenue:						
Premium revenue	$ 13,241	$ 9,023	46.7 %	$ 9,023	$ 6,179	46.0 %
Service revenue	253	210	20.5	210	205	2.4
Premium tax revenue	397	294	35.0	294	172	70.9
Health insurer fee revenue	264	120	120.0	120	—	—
Investment income	18	8	125.0	8	7	14.3
Other revenue	5	12	(58.3)	12	26	(53.8)
Total revenue	14,178	9,667	46.7	9,667	6,589	46.7
Operating expenses:						
Medical care costs	11,794	8,076	46.0	8,076	5,380	50.1
Cost of service revenue	193	157	22.9	157	161	(2.5)
General and administrative expenses	1,146	765	49.8	765	666	14.9
Premium tax expenses	397	294	35.0	294	172	70.9
Health insurer fee expenses	157	89	76.4	89	—	—
Depreciation and amortization	104	93	11.8	93	73	27.4
Total operating expenses	13,791	9,474	45.6	9,474	6,452	46.8
Operating income	387	193	100.5	193	137	40.9
Other expenses, net:						
Interest expense	66	57	15.8	57	52	9.6
Other (income) expense, net	(1)	1	(200.0)	1	4	(75.0)
Total other expenses, net	65	58	12.1	58	56	3.6
Income from continuing operations before income tax expense	322	135	138.5	135	81	66.7
Income tax expense	179	73	145.2	73	36	102.8
Income from continuing operations	$ 143	$ 62	130.6 %	$ 62	$ 45	37.8 %
Diluted net income per share, continuing operations (1)	$ 2.58	$ 1.30	98.5 %	$ 1.30	$ 0.96	35.4 %
Diluted weighted average shares outstanding	56	48	16.7 %	48	47	2.1 %
Non-GAAP Measures: (2)						
Adjusted net income per share, continuing operations (1)(3)	$ 3.11	$ 1.93	61.1 %	$ 1.93	$ 1.55	24.5 %
EBITDA	$ 508	$ 305	66.6 %	$ 305	$ 225	35.6 %
Operating Statistics: (1)						
Medical care ratio (4)	89.1%	89.5%		89.5%	87.1%	
Service revenue ratio (5)	76.4%	74.6%		74.6%	79.0%	
General and administrative expense ratio (6)	8.1%	7.9%		7.9%	10.1%	
Premium tax ratio (4)	2.9%	3.2%		3.2%	2.7%	
Effective tax rate	55.5%	53.8%		53.8%	44.8%	
Net profit margin (6)	1.0%	0.6%		0.6%	0.7%	

(1) Source data for calculations of per-share amounts and ratios in thousands.
(2) See reconciliation of non-GAAP financial measures to U.S. GAAP below.
(3) Effective January 1, 2016, we will no longer exclude amortization of convertible notes and lease financing obligations from our presentation of adjusted net income and adjusted net income per share. We made this change because various capital transactions that we completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources of capital. We believe that this change will enhance the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors.
(4) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(5) Service revenue ratio represents cost of service revenue as a percentage of service revenue.
(6) Computed as a percentage of total revenue.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	As of December 31,		
	2015	2014	2013
Ending Membership by Health Plan:			
California	620,000	531,000	368,000
Florida	440,000	164,000	89,000
Illinois	98,000	100,000	4,000
Michigan	328,000	242,000	213,000
New Mexico	231,000	212,000	168,000
Ohio	327,000	347,000	255,000
Puerto Rico (1)	348,000	—	—
South Carolina (2)	99,000	118,000	—
Texas	260,000	245,000	252,000
Utah	102,000	83,000	86,000
Washington	582,000	497,000	403,000
Wisconsin	98,000	84,000	93,000
	3,533,000	2,623,000	1,931,000
Ending Membership by Program:			
Temporary Assistance for Needy Families (TANF), CHIP (3)	2,312,000	1,809,000	1,603,000
Medicaid Expansion (4)	557,000	385,000	—
Aged, Blind or Disabled (ABD)	366,000	347,000	289,000
Marketplace (4)	205,000	15,000	—
Medicare-Medicaid Plan (MMP) – Integrated (5)	51,000	18,000	—
Medicare Special Needs Plans (Medicare)	42,000	49,000	39,000
	3,533,000	2,623,000	1,931,000

(1) Our Puerto Rico health plan began serving members effective April 1, 2015.

(2) Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

(3) CHIP stands for Children's Health Insurance Program.

(4) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

(5) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures.

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA. The increases in EBITDA for both 2015 over 2014, and 2014 over 2013, were due primarily to increased net income and income taxes. The increases for both of these items are described below in Results of Operations, in the components of net income.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Net income	$ 143	$ 62	$ 53
Adjustments:			
Depreciation, and amortization of intangible assets and capitalized software	120	114	94
Interest expense	66	57	52
Income tax expense	179	72	26
EBITDA	$ 508	$ 305	$ 225

The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. The following tables reconcile net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations. The increases in adjusted net income and adjusted net income per diluted share for both 2015 over 2014, and 2014 over 2013, were due primarily to increased net income. Such increases are described below in Results of Operations, in the components of net income.

	Year Ended December 31,					
	2015		2014		2013	
	(In millions, except diluted per-share amounts)					
Net income, continuing operations	$ 143	$ 2.58	$ 62	$ 1.30	$ 45	$ 0.96
Adjustments, net of tax:						
Amortization of convertible senior notes and lease financing obligations	19	0.33	17	0.36	14	0.31
Amortization of intangible assets	11	0.20	13	0.27	13	0.28
Adjusted net income per diluted share, continuing operations (1)(2)	$ 173	$ 3.11	$ 92	$ 1.93	$ 72	$ 1.55

(1) Beginning in the first quarter of 2015, we revised the calculation of adjusted net income, continuing operations. We no longer subtract "depreciation, and amortization of capitalized software" and "share-based compensation" from net income, continuing operations to arrive at adjusted net income, continuing operations. We have made this change to better reflect how we evaluate financial performance, make financing and business decisions, and forecast and plans for future periods. All periods presented conform to this presentation.

(2) Effective January 1, 2016, we will no longer exclude amortization of convertible notes and lease financing obligations from our presentation of adjusted net income and adjusted net income per share. We made this change because various capital transactions that we completed in 2015 reduced our relative reliance on convertible notes and lease financing as sources of capital. We believe that this change will enhance the comparability of these non-GAAP measures with the corresponding non-GAAP measures used by our competitors.

Results of Operations, Continuing Operations

As described above, as of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015. The following table presents gross margin as the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the actual dollars earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. One of the key metrics used to assess the performance of the Health Plans segment is the medical care ratio; therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Health Plans:			
Premium revenue	$ 13,241	$ 9,023	$ 6,179
Less: medical care costs	11,794	8,076	5,380
Medical margin	$ 1,447	$ 947	$ 799
Molina Medicaid Solutions:			
Service revenue	$ 195	$ 210	$ 205
Less: cost of service revenue	140	157	161
Service margin	$ 55	$ 53	$ 44
Other:			
Service revenue	$ 58	$ —	$ —
Less: cost of service revenue	53	—	—
Service margin	$ 5	$ —	$ —

Health Plans Segment

Premium Revenue. Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate, and, to a lesser degree, from Medicare contracts entered into with the Centers for Medicare and Medicaid Services (CMS), a federal government agency.

2015 Compared with 2014

In 2015, a 42% increase in membership and a 5% increase in revenue PMPM resulted in increased premium revenue of 47%, or over $4.2 billion, when compared with 2014.

Enrollment growth was primarily due to increased Medicaid expansion, Marketplace and integrated Medicare-Medicaid Plan (MMP) enrollment, and the start-up of the Puerto Rico health plan in April 2015.

2014 Compared with 2013

In 2014, premium revenue increased 46% over 2013, due to a 28% increase in membership, and an 18% increase in revenue PMPM.

Enrollment growth was primarily due to Medicaid expansion program membership added as a result of the Affordable Care Act, and membership added at our South Carolina and Illinois health plans. Higher PMPM premium revenue was primarily the result of the inclusion of long-term services and supports (LTSS) benefits in various Medicaid managed care programs in California, Florida, Illinois, New Mexico, and Ohio.

Premiums by Program. The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program, on a per-member per-month basis for the year ended December 31, 2015. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
TANF, CHIP	$ 120.00	$ 280.00	$ 180.00
Medicaid Expansion	310.00	500.00	410.00
ABD	470.00	1,470.00	970.00
Marketplace	180.00	400.00	250.00
MMP – Integrated	1,170.00	3,220.00	2,030.00
Medicare	900.00	1,110.00	1,040.00

Medical Care Costs. Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Estimates" below, and Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 11, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

2015 Compared with 2014

Our medical margin increased nearly 53% in 2015 over 2014, and our consolidated medical care ratio decreased to 89.1% in 2015 from 89.5% in 2014.

2014 Compared with 2013

Although medical margin increased nearly 20% in 2014 over 2013, our consolidated medical care ratio increased to 89.5% in 2014 from 87.1% in 2013.

The medical care ratio increased substantially in 2014 as a result of three developments:

- Much of our revenue growth has come from participation in Medicaid programs covering LTSS. Percentage profit margins for LTSS benefits are generally lower than percentage profit margins for acute medical benefits.
- Increases to our base premiums in recent years have not kept pace with medical cost trends.
- Lack of coordination in the design of profit caps and medical cost floors in some of our state Medicaid contracts is resulting in counterproductive outcomes. In some instances, givebacks due to profitable performance in one program cannot be offset against losses in other programs.

Medical Care Costs by Category. The following table provides the details of consolidated medical care costs by category for the periods indicated (dollars in millions except PMPM amounts):

	Year Ended December 31,								
	2015			2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 8,572	$ 218.35	72.7%	$ 5,673	$ 202.87	70.2%	$ 3,612	$ 160.43	67.1%
Pharmacy	1,610	41.01	13.7	1,273	45.54	15.8	935	41.54	17.4
Capitation	982	25.02	8.3	748	26.77	9.3	604	26.83	11.2
Direct delivery	128	3.26	1.1	96	3.44	1.2	48	2.14	0.9
Other	502	12.79	4.2	286	10.22	3.5	181	8.05	3.4
	$ 11,794	$ 300.43	100.0%	$ 8,076	$ 288.84	100.0%	$ 5,380	$ 238.99	100.0%

Financial Performance by Program. The following table presents the components of premium revenue and medical care costs by program.

	Year Ended December 31, 2015 (1)						
	Member Months[2]	Premium Revenue		Medical Care Costs		MCR[3]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	25.5	$ 4,483	$ 175.64	$ 4,122	$ 161.50	92.0%	$ 361
Medicaid Expansion	5.9	2,389	408.51	1,931	330.18	80.8	458
ABD	4.3	4,124	966.83	3,784	887.27	91.8	340
Marketplace	2.6	652	251.96	481	185.85	73.8	171
MMP	0.5	1,063	2,034.51	974	1,863.93	91.6	89
Medicare	0.5	530	1,038.15	502	982.50	94.6	28
	39.3	$ 13,241	$ 337.28	$ 11,794	$ 300.43	89.1%	$ 1,447

(1) Year ended December 31, 2014 and 2013 data not presented due to lack of comparability.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Financial Performance by State Health Plan. The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by state health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in millions):

	Year Ended December 31, 2015						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	7.1	$ 2,200	$ 310.89	$ 1,926	$ 272.22	87.6%	$ 274
Florida	4.1	1,199	289.85	1,081	261.49	90.2	118
Illinois	1.2	397	328.93	367	303.72	92.3	30
Michigan	3.4	1,067	317.15	903	268.27	84.6	164
New Mexico	2.8	1,237	446.27	1,106	398.98	89.4	131
Ohio	4.1	2,034	499.34	1,718	421.61	84.4	316
Puerto Rico [1]	3.2	567	178.31	505	158.80	89.1	62
South Carolina [1]	1.3	348	267.25	278	213.30	79.8	70
Texas	3.1	1,961	621.37	1,809	573.32	92.3	152
Utah	1.2	331	286.22	300	259.32	90.6	31
Washington	6.6	1,602	242.36	1,470	222.36	91.7	132
Wisconsin	1.2	261	213.48	215	176.01	82.4	46
Other [2]	—	37	—	116	—	—	(79)
	39.3	$ 13,241	$ 337.28	$ 11,794	$ 300.43	89.1%	$ 1,447

	Year Ended December 31, 2014						
	Member Months	Premium Revenue		Medical Care Costs		MCR	Medical Margin
		Total	PMPM	Total	PMPM		
California	5.6	$ 1,523	$ 270.51	$ 1,269	$ 225.37	83.3%	$ 254
Florida	1.1	439	397.79	419	379.95	95.5	20
Illinois	0.3	153	498.48	141	456.88	91.7	12
Michigan	2.8	781	278.68	661	235.81	84.6	120
New Mexico	2.5	1,076	435.17	996	402.92	92.6	80
Ohio	3.7	1,553	425.47	1,335	365.87	86.0	218
Puerto Rico [1]	—	—	—	—	—	—	—
South Carolina [1]	1.5	381	260.72	323	220.89	84.7	58
Texas	3.0	1,318	442.32	1,197	401.81	90.8	121
Utah	1.0	310	310.64	285	286.43	92.2	25
Washington	5.5	1,305	236.27	1,219	220.75	93.4	86
Wisconsin	1.0	156	150.87	136	130.91	86.8	20
Other [2]	—	28	—	95	—	—	(67)
	28.0	$ 9,023	$ 322.68	$ 8,076	$ 288.84	89.5%	$ 947

	Year Ended December 31, 2013						
	Member Months	Premium Revenue		Medical Care Costs			
		Total	PMPM	Total	PMPM	MCR	Medical Margin
California	4.2	$ 750	$ 177.10	$ 667	$ 157.46	88.9%	$ 83
Florida	1.0	265	272.23	231	237.57	87.3	34
Illinois	—	8	1,201.34	8	1,164.10	96.9	—
Michigan	2.6	676	261.91	571	221.09	84.4	105
New Mexico	1.5	447	299.36	384	257.62	86.1	63
Ohio	3.0	1,099	365.44	925	307.53	84.2	174
Puerto Rico (1)	—	—	—	—	—	—	—
South Carolina (1)	—	—	—	—	—	—	—
Texas	3.2	1,291	406.27	1,115	350.84	86.4	176
Utah	1.0	311	299.05	259	249.51	83.4	52
Washington	4.9	1,168	236.47	1,028	208.10	88.0	140
Wisconsin	1.1	143	135.40	114	107.91	79.7	29
Other (2)	—	21	—	78	—	—	(57)
	22.5	$ 6,179	$ 274.48	$ 5,380	$ 238.99	87.1%	$ 799

(1) Our Puerto Rico health plan began serving members effective April 1, 2015. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Individual Health Plan Analysis

2015 Compared with 2014

California. Premium revenue grew $677 million, or 44%, in 2015 compared with 2014, the result of higher membership. Overall, enrollment on a member-month basis increased 31% in 2015 compared with 2014. Increased premium revenue was also driven by a 15% increase in premium revenue PMPM, which was the result of the higher relative premium revenue PMPM among those programs experiencing enrollment growth (Medicaid expansion and MMP); and the addition of long-term care benefits to some of the California health plan's Medicaid membership. The medical care ratio increased to 87.6% in 2015, from 83.3% in 2014. During 2014, the plan benefited from the recognition of approximately $23 million in premium revenue and medical margin that related to 2013, as a result of certain programmatic changes implemented by the state of California. Absent this benefit, the medical care ratio of the California plan would have been 84.6% in 2014.

Florida. Premium revenue grew to $1,199 million in 2015, from $439 million in 2014, due to increased Marketplace membership. The medical care ratio decreased to 90.2% in 2015, from 95.5% in 2014, due to the lower medical care ratio of the Marketplace membership more than offsetting an increase in the medical care ratio for the Medicaid program.

Illinois. Premium revenue grew to $397 million in 2015, from $153 million in 2014, due to significant membership growth in late 2014. The medical care ratio increased to 92.3% in 2015, from 91.7% in 2014.

Michigan. Premium revenue grew $286 million, or 37%, in 2015 compared with 2014, due to increased Medicaid expansion membership and the startup of the MMP program. The medical care ratio of 84.6% for 2015 was unchanged from 2014.

New Mexico. Premium revenue grew $161 million, or 15%, in 2015 compared with 2014, due to substantial increases in membership in all Medicaid programs. The medical care ratio decreased to 89.4% in 2015, from 92.6% in 2014, due to improved profitability for the ABD and Medicaid expansion programs.

Ohio. Premium revenue grew $481 million, or 31%, in 2015 compared with 2014, due to growth in membership within the Medicaid expansion, and MMP programs. The medical care ratio decreased to 84.4% in 2015, from 86.0% in 2014, due to lower medical care ratios in these newer programs, as well as ABD.

Puerto Rico. The Puerto Rico health plan began serving members on April 1, 2015, and finished the year with a medical care ratio of 89.1%. See further discussion below, under *Financial Condition*, regarding the Commonwealth of Puerto Rico.

South Carolina. The medical care ratio decreased to 79.8% in 2015, from 84.7% in 2014. We believe that medical care ratios below 80% are not sustainable over time, and that the performance of the South Carolina health plan in 2014 is more representative of its likely long-term performance than are its financial results for 2015.

Texas. Premium revenue grew $643 million, or 49%, in 2015 compared with 2014, primarily due to the addition of ABD members receiving nursing facility benefits effective March 1, 2015, and the start-up of the Texas MMP program on that date. The medical care ratio increased to 92.3% in 2015, from 90.8% in 2014, primarily as a result of lower percentage margins on premiums to support nursing home services. As previously disclosed, we are unable to recognize certain quality related revenue in Texas because we do not have historical information, clear definitions, and clarity around minimum standards.

Utah. The medical care ratio of the Utah health plan decreased to 90.6% in 2015, from 92.2% in 2014, primarily due to improved financial performance of the plan's Medicare program.

Washington. Premium revenue grew $297 million, or 23%, in 2015 when compared with 2014, primarily due to growth in Medicaid expansion membership. The medical care ratio decreased to 91.7% in 2015, from 93.4% in 2014, as a lower medical care ratio for the ABD program more than offset a higher medical care ratio in the TANF and Medicaid expansion programs.

Wisconsin. Premium revenue grew $105 million, or 67%, in 2015 compared with 2014 as a result of increased Marketplace enrollment. The medical care ratio decreased to 82.4% in 2015, from 86.8% in 2014, primarily as a result of improvement in the financial performance of the Wisconsin health plan's Medicaid program.

2014 Compared with 2013

California. The medical care ratio for the California health plan decreased significantly to 83.3% in 2014 from 88.9% in 2013. Additionally, medical margin improved $171 million when compared with 2013. This improvement was the result of higher enrollment, primarily due to the addition of approximately 107,000 Medicaid expansion members; and premium increases effective October 1, 2013 (2.5%), and July 1, 2014 (5.5%). During 2014, the plan benefited from the recognition of approximately $23 million in premium revenue and medical margin that related to 2013 as a result of certain programmatic changes implemented by the state of California. In 2013, the plan recognized approximately $32 million of premium revenue related to 2012 and earlier years as a result of retroactive rate increases from the state of California. The plan served its first MMP members in 2014.

Florida. Due to the re-procurement undertaken by the Florida Agency for Health Care Administration starting in 2014, the Florida health plan transitioned many of its members to other health plans in the second quarter of 2014, and then added approximately 105,000 members in the second half of 2014, both from the addition of new service areas and through acquisitions. Although revenue increased approximately 66% at the plan for the year ended December 31, 2014, when compared with 2013, profitability fell in 2014. The higher medical care costs were the result of 1) the assumption of risk for LTSS benefits for certain members effective December 2013 (as noted above percentage profit margins for LTSS benefits are generally less than those for other benefits); and 2) our inability to recognize revenue related to a rate increase effective September 1, 2014, as a result of those rates not being finalized prior to year end.

Illinois. The medical care ratio for the Illinois health plan decreased to 91.7% in 2014, from 96.9% in 2013. The plan experienced significant growth in 2014; enrollment increased approximately 96,000 members overall, with 78,000 members added in the fourth quarter alone. This growth occurred primarily within the traditional TANF program, and to a lesser degree within the Medicaid expansion program. The Illinois health plan served its first MMP members in 2014.

Michigan. The medical care ratio of the Michigan health plan was consistent year over year, at 84.6% in 2014, compared with 84.4% in 2013.

New Mexico. Premium revenue at the New Mexico health plan increased 141% for 2014 compared with 2013, primarily as a result of the addition of Medicaid behavioral health and LTSS benefits effective January 1, 2014, and the addition of approximately 54,000 Medicaid expansion members during the course of 2014. The medical care ratio of the plan increased to 92.6% in 2014, from 86.1% in 2013. The higher medical care ratio was the result of: 1) the assumption of risk for LTSS benefits effective January 1, 2014; and 2) premium rates effective January 1, 2014 that did not keep pace with the increase in medical costs in 2014.

Ohio. The medical care ratio of the Ohio health plan increased to 86.0% in 2014, from 84.2% in 2013, primarily due to the increase in Medicaid expansion enrollment (which is incurring a medical care ratio slightly in excess of the plan's traditional experience), and the initiation of the Ohio MMP.

South Carolina. The South Carolina health plan began serving members on January 1, 2014, and finished the year with a medical care ratio of 84.7%.

Texas. Financial performance at the Texas health plan declined in 2014, when compared with 2013. The medical care ratio of the Texas health plan increased to 90.8% in 2014, from 86.4% in 2013. Our inability to recognize a portion of the plan's quality

revenue reduced income before taxes by approximately $26 million, or $0.33 per diluted share, for the year ended December 31, 2014. Approximately $20 million of this amount is related to measures for which we lack sufficient information to calculate our compliance. Removing quality revenue and profit-sharing adjustments would have resulted in a medical care ratio of approximately 88% in 2014 and 86% in 2013.

Utah. The medical care ratio of the Utah health plan increased to 92.2% in 2014, from 83.4% in 2013, due to deteriorating margins for both Medicaid and Medicare products.

Washington. Financial performance at the Washington health plan declined in 2014, when compared with 2013.The medical care ratio of the plan increased to 93.4% in 2014, compared with 88.0% in 2013, primarily due to the high cost of medical services relative to revenue for members served under the state's program for ABD members. The plan added approximately 102,000 Medicaid expansion members in 2014. The plan received a blended rate increase of approximately 3% effective January 1, 2015. For the plan's ABD membership, the rate increase effective January 1, 2015 was 11%.

Wisconsin. The medical care ratio of the Wisconsin health plan increased to 86.8% in 2014, compared with 79.7% in 2013.

Molina Medicaid Solutions Segment

2015 Compared with 2014

Service revenue declined $15 million in 2015 compared with 2014, primarily due to an extension of the Idaho contract under which we are now amortizing certain deferred revenues over a longer term. Service margin was consistent between 2015 and 2014, with 2015 showing a $2 million increase.

2014 Compared with 2013

Service margin improved $9 million for the year ended December 31, 2014, compared with 2013, primarily the result of increased revenues due to higher Medicaid transaction volumes and lower cost of services overall.

Other Segment

Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments. The Other segment service margin for the year ended December 31, 2015, was insignificant.

Consolidated Expenses

General and Administrative Expenses. General and administrative expenses increased slightly to 8.1% of revenue in 2015, from 7.9% in 2014, primarily the result of dramatic growth in our Marketplace membership. Excluding Marketplace broker and exchange fees from both years, the general and administrative expense ratio decreased to 7.5% in 2015 from 7.9% in 2014.

General and administrative expenses decreased to 7.9% of revenue in 2014, from 10.1% in 2013. The significant decline in the ratio of general and administrative expenses relative to total revenue was primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Premium Tax Expense. The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) decreased to 2.9% in 2015, from 3.2% in 2014. This decrease was primarily due to the current year increase in MMP revenues, which are not subject to premium taxes.

The premium tax ratio increased to 3.2% in 2014, from 2.7% in 2013. In June 2014, the state of Michigan instituted a 6% use tax on medical premiums. That state agreed to fund this tax through rate increases; as a result, we recorded approximately $30 million in additional premium revenue in 2014, as well as corresponding premium tax expense.

Health Insurer Fee (HIF) Revenue and Expenses. For our Medicaid program, actuarial standards require that we be reimbursed by state Medicaid agencies for both the expense associated with the HIF and the absence of tax deductibility for that expense. During 2015, we secured full reimbursement for our expenses under the HIF (including the absence of tax deductibility) and as a result HIF revenue, as a percentage of premium revenue, increased to 2.0% in 2015, from 1.3% in 2014. During 2015, we recognized approximately $20 million of HIF premium revenue meant to reimburse us for the cost of HIF expense recognized in 2014. Health insurer fee expenses, as a percentage of premium revenue, were 1.2% in 2015, compared with 1.0% in 2014.

In addition, both HIF revenue and expenses increased over the prior year proportionally to the increase in the total HIF tax base, which is assessed to all insurers. This base increased to $11.3 billion in 2015, from $8.0 billion in 2014. Refer to "Liquidity and Capital Resources—Financial Condition" below, for further discussion of the HIF.

Depreciation and Amortization. The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,			
	2015		2014	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in millions)			
Depreciation, and amortization of capitalized software, continuing operations	$ 87	0.6%	$ 75	0.8%
Amortization of intangible assets, continuing operations	17	0.1	18	0.2
Depreciation and amortization, continuing operations	104	0.7	93	1.0
Amortization recorded as reduction of service revenue	1	—	3	—
Amortization of capitalized software recorded as cost of service revenue	21	0.1	38	0.4
Depreciation and amortization reported in statement of cash flows	$ 126	0.8%	$ 134	1.4%

	Year Ended December 31,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in millions)			
Depreciation, and amortization of capitalized software, continuing operations	$ 75	0.8%	$ 55	0.8%
Amortization of intangible assets, continuing operations	18	0.2	18	0.3
Depreciation and amortization, continuing operations	93	1.0	73	1.1
Amortization recorded as reduction of service revenue	3	—	3	—
Amortization of capitalized software recorded as cost of service revenue	38	0.4	18	0.3
Depreciation and amortization reported in statement of cash flows	$ 134	1.4%	$ 94	1.4%

Interest Expense. Interest expense increased to $66 million for the year ended December 31, 2015, compared with $57 million for the year ended December 31, 2014. The increase was due primarily to our issuance of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, in the fourth quarter of 2015. For further details regarding this transaction, please refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Debt."

Interest expense increased to $57 million for the year ended December 31, 2014, compared with $52 million for the year ended December 31, 2013. The increase was due primarily to our 3.75% Notes exchange transaction and related issuance of 1.625% Notes in 2014, and lease financing transactions executed in 2013. For further details regarding these transactions, please refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Debt."

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $30 million, $27 million and $23 million for the years ended December 31, 2015, 2014, and 2013, respectively.

We expect interest expense to continue to increase in the future due to interest on the 5.375% Notes which were issued in November 2015.

Income Taxes. The provision for income taxes in continuing operations is recorded at an effective rate of 55.5% for the year ended December 31, 2015, compared with 53.8% for the year ended December 31, 2014. The effective tax rate for 2015 is higher than 2014 primarily as a result of certain discrete tax benefits recorded in 2014 that were not recurring in 2015.

The provision for income taxes in continuing operations was recorded at an effective rate of 53.8% for the year ended December 31, 2014, compared with 44.8% for the year ended December 31, 2013. The increase is primarily due to the nondeductible health insurer fee in 2014 that did not exist in 2013.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. As of December 31, 2015, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted primarily of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased to $18 million for the year ended December 31, 2015, compared with $8 million for the year ended December 31, 2014, primarily due to the increase in invested assets. Our annualized portfolio yields for the year ended December 31, 2015 was 0.5%, and for both years ended December 31, 2014 and 2013, was 0.4%.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our unregulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use. We received $125 million in dividends from our regulated health plan subsidiaries, and $17 million in dividends from our unregulated subsidiaries during 2015. We did not receive any dividends from our regulated health plan subsidiaries during the year ended December 31, 2014, because significant growth across all of our health plans necessitated that the plans retain their cash to meet increasing net worth requirements. See further discussion in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 19, "Commitments and Contingencies," under the subheading "Regulatory Capital and Dividend Restrictions," and Note 22, "Condensed Financial Information of Registrant," under "Note C - Dividends and Capital Contributions."

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Year Ended December 31,				
	2015	2014	2013	2014 to 2015 Change	2013 to 2014 Change
	(In millions)				
Net cash provided by operating activities	$ 1,125	$ 1,060	$ 190	$ 65	$ 870
Net cash used in investing activities	(1,420)	(536)	(543)	(884)	7
Net cash provided by financing activities	1,085	79	493	1,006	(414)
Net increase in cash and cash equivalents	$ 790	$ 603	$ 140	$ 187	$ 463

Operating Activities. Cash provided by operating activities was $1,125 million in 2015 compared with $1,060 million in 2014, an increase of $65 million. This increase was due primarily to increased net income of $81 million, and collection of premiums receivable at our California health plan in the first quarter of 2015. These sources of cash were partially offset by:

- A decrease in amounts due to government agencies of $268 million, primarily due to a fourth quarter 2015 Medicaid expansion-related payment to the state of Washington's Medicaid authority of $247 million. Changes in this account

relate primarily to Health Plans segment programs that contain medical cost floors or medical cost corridors. Under such programs, a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs; and

- The change in medical claims and benefits payable, which resulted in the use of $49 million, primarily because membership and related medical costs grew at a higher rate in 2014 than in 2015, resulting in a lower year-over-year change in 2015.

In 2014, cash provided by operating activities was $1,060 million compared with $190 million for 2013, an increase of $870 million. This increase was primarily due to a $442 million increase in amounts due to government agencies because of a significant increase in amounts accrued for medical cost floor contract provisions, primarily associated with our Medicaid expansion membership. In addition, medical claims and benefits payable increased $356 million due to significant membership growth in 2014.

Investing Activities. Cash used in investing activities increased to $1,420 million in 2015, compared with $536 million in 2014, an increase of $884 million. This increase was due in part to higher purchases of investments, net of sales and maturities, amounting to $477 million, a result of cash generated from 2015 financing activities, described below.

In addition, cash paid for business acquisitions increased $406 million. As described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 1 ,"Basis of Presentation," we closed several business acquisitions in 2015. Additionally, we announced several Health Plans acquisitions in 2015 that did not close until January 1, 2016. Because the closing dates for these acquisitions fell on January 1, 2016, a holiday, approximately $101 million was recorded to prepaid expenses and other assets as of December 31, 2015, for purchase price amounts funded in December 2015. Such amounts are reported in investing activities in the accompanying consolidated statements of cash flows.

In 2014, cash used in investing activities was $536 million, comparable with $543 million in 2013.

Financing Activities. Cash provided by financing activities was $1,085 million in 2015, primarily due to net proceeds from our fiscal 2015 offerings of 5.375% Notes, amounting to $689 million, and common stock, amounting to $373 million. In 2014, cash provided by financing activities was $79 million, which included primarily $123 million net proceeds from our fiscal 2014 offering of 1.625% Notes, partially offset by $50 million paid to settle contingent consideration liabilities associated with our 2013 business acquisitions. In 2013, net proceeds from our 1.125% Notes offering and lease financing transactions provided $623 million, which was partially offset by $53 million used to purchase treasury stock and $88 million to repay debt.

Financial Condition

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at December 31, 2015, our working capital was $1,484 million compared with $1,028 million at December 31, 2014. At December 31, 2015, our cash and investments amounted to $4,241 million, compared with $2,666 million of cash and investments at December 31, 2014.

Regulatory Capital. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us.

Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,229 million at December 31, 2015, and $859 million at December 31, 2014. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $612 million and $203 million as of December 31, 2015, and 2014, respectively.

Debt Ratings. Our 5.375% Notes are rated "BB" by Standard & Poor's, and "Ba3" by Moody's Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

Health Insurer Fee. Effective January 1, 2014, the ACA requires most health plans to pay a fee based on premium revenue (the Health Insurer Fee, or HIF). The HIF is not tax deductible. Actuarial standards require that states reimburse us for the HIF we incur related to Medicaid revenue, in addition to paying us a "tax gross up" to compensate us for incremental income taxes we pay because the HIF is not tax deductible. During 2015, we secured full reimbursement for our expenses under the HIF.

The following table provides the details of our HIF revenue reimbursement by health plan to date in 2015 (in millions):

	HIF Reimbursement Revenue, Gross[1]					
	Year Ended December 31, 2015					
	Recognized					Necessary for Full Reimbursement
	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Total	
2015 HIF:						
California	$ —	$ 17	$ 6	$ 8	$ 31	$ 31
Florida	2	2	2	2	8	8
Illinois	1	1	1	1	4	4
Michigan	—	—	21	7	28	28
New Mexico	7	8	8	7	30	30
Ohio	12	12	12	12	48	48
South Carolina	3	3	3	3	12	12
Texas	6	6	6	5	23	23
Utah	—	—	4	2	6	6
Washington	11	11	6	9	37	37
Wisconsin	1	1	1	2	5	5
Subtotal, Medicaid	43	61	70	58	232	232
Marketplace	—	—	1	1	2	2
Medicare	6	4	4	5	19	19
	49	65	75	64	253	$ 253
2014 HIF:						
California	—	12	—	—	12	
Michigan	—	—	7	—	7	
Utah	—	—	1	—	1	
	$ 49	$ 77	$ 83	$ 64	$ 273	
Recognized in:						
Health insurer fee revenue	$ 48	$ 74	$ 81	$ 61	$ 264	
Premium tax revenue	1	3	2	3	9	
	$ 49	$ 77	$ 83	$ 64	$ 273	

(1) Amounts in the table include our estimate of the full economic impact of the excise tax including premium tax and the income tax effect.

Future Sources and Uses of Liquidity

Shelf Registration Statement. We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. Our ability to borrow under the Credit Facility is subject to compliance with certain covenants. As of December 31, 2015, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Announced Acquisitions. As described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 1, "Basis of Presentation," we announced several Health Plans acquisitions in 2015 that did not close until January 1, 2016. Because the closing dates for these acquisitions fell on January 1, 2016, a holiday, approximately $101 million was recorded to prepaid expenses and other assets as of December 31, 2015, for purchase price amounts funded in December 2015. Such amounts are reported in investing activities in the accompanying consolidated statements of cash flows. The total aggregate purchase price for these acquisitions amounted to approximately $115 million.

Convertible Senior Notes. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Notes. In September 2014, we issued $302 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Notes. As of December 31, 2015, the aggregate outstanding principal amount of our 1.125% Notes and our 1.625% Notes was $550 million and $302 million, respectively. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The 1.125% Notes met the stock price trigger in the quarter ended December 31, 2015, and are convertible to cash through at least March 31, 2016. Because the 1.125% Notes may be converted into cash within 12 months, the $448 million carrying amount is reported in current portion of long-term debt as of December 31, 2015. In addition, holders of our 1.625% Notes may convert their notes into cash during any calendar quarter (and only during such calendar quarter) if the last reported sales price of our common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on February 23, 2016 was $62.28 per share. As of December 31, 2015, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash. As of December 31, 2015, we had sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

States' Budgets. From time to time the states in which our health plans operate may delay premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of December 31, 2015, our Illinois health plan served approximately 98,000 members, and recognized premium revenue of approximately $397 million for the year ended December 31, 2015. As of February 23, 2016, Illinois is current with its premium payments.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs including health care-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. Our Puerto Rico health plan became operational on April 1, 2015. As of December 31, 2015, the plan served approximately 348,000 members and recognized premium revenue of approximately $192 million in the fourth quarter of 2015, or approximately $64 million per month. As of February 23, 2016, the Commonwealth continues to pay us weekly for current membership.

It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility. Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter.

It has been our practice in the past, and will remain so in the future, to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable* (see discussion below).
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- *Health Plans segment quality incentives.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- *Molina Medicaid Solutions segment revenue and cost recognition.* For a comprehensive discussion of this topic, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	December 31,		
	2015	2014	2013
	(In millions)		
Fee-for-service claims incurred but not paid (IBNP)	$ 1,191	$ 871	$ 424
Pharmacy payable	88	71	45
Capitation payable	140	28	20
Other (1)	266	231	181
	$ 1,685	$ 1,201	$ 670

(1) "Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. As of December 31, 2015, 2014 and 2013, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $167 million, $119 million and $151 million, respectively.

The determination of our liability for medical claims and benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for medical claims and benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $1,191 million of our total medical claims and benefits payable of $1,685 million as of December 31, 2015.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse

claims deviation, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2015 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2015, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in millions.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 348
(4)%	232
(2)%	116
2%	(116)
4%	(232)
6%	(348)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2015 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in millions.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (202)
(4)%	(135)
(2)%	(67)
2%	67
4%	135
6%	202

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 56 million diluted shares outstanding for the year ended December 31, 2015. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2015, net income for the year ended December 31, 2015 would increase or decrease by approximately $37 million, or $0.66 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2015, net income for the year ended December 31, 2015 would increase or decrease by approximately $21 million, or $0.38 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $183 million, or $3.29 per diluted share, and $106 million, or $1.91 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $37 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse deviation in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims deviation. The provision for adverse claims deviation is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled, changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims deviation.

We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date.

The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for additional information regarding the specific factors used to determine our changes in estimates of IBNP for all periods presented in the accompanying consolidated financial statements.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year ended December 31,		
	2015	2014	2013
	(Dollars in millions, except per-member amounts)		
Balances at beginning of period	$ 1,201	$ 670	$ 495
Components of medical care costs related to:			
Current period	11,935	8,123	5,434
Prior periods (1)	(141)	(46)	(53)
Total medical care costs	11,794	8,077	5,381
Change in non-risk provider payables	48	(32)	111
Payments for medical care costs related to:			
Current period	10,448	7,064	4,932
Prior periods	910	450	385
Total paid	11,358	7,514	5,317
Balances at end of period	$ 1,685	$ 1,201	$ 670
Benefit from prior periods as a percentage of:			
Balance at beginning of period	11.8%	6.9%	10.7%
Premium revenue	1.1%	0.5%	0.9%
Medical care costs	1.2%	0.6%	1.0%
Claims Data:			
Days in claims payable, fee for service	48	49	43
Number of members at end of period	3,533,000	2,623,000	1,931,000
Number of claims in inventory at end of period	380,800	307,700	145,800
Billed charges of claims in inventory at end of period	$ 816	$ 719	$ 277
Claims in inventory per member at end of period	0.11	0.12	0.08
Billed charges of claims in inventory per member end of period	$ 230.91	$ 273.92	$ 143.19
Number of claims received during the period	40,173,300	27,597,000	21,317,500
Billed charges of claims received during the period	$ 46,211	$ 30,316	$ 21,415

Commitments and Contingencies

We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 19 ,"Commitments and Contingencies."

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2015. Some of the amounts included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table.

Additionally, we have a variety of other contractual agreements related to acquiring services used in our operations. However, we believe these other agreements do not contain material noncancelable commitments.

	Total (1)	2016	2017-2018	2019-2020	2021 and Beyond
			(In millions)		
Medical claims and benefits payable	$ 1,685	$ 1,685	$ —	$ —	$ —
Principal amount of senior notes (2)	1,552	—	—	550	1,002
Amounts due government agencies	729	729	—	—	—
Interest on long-term debt	424	49	97	91	187
Lease financing obligations	403	15	32	33	323
Operating leases	232	49	88	56	39
Purchase commitments	15	11	4	—	—
	$ 5,040	$ 2,538	$ 221	$ 730	$ 1,551

(1) As of December 31, 2015, we have recorded approximately $9 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 14, "Income Taxes."

(2) Represents the principal amounts due on our 5.375% Senior Notes due 2022, 1.125% Cash Convertible Senior Notes due 2020, and our 1.625% Convertible Senior Notes due 2044 (1.625% Notes). The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 12, "Debt."

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Quantitative and Qualitative Disclosures About Market Risk

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 8. Financial Statements and Supplementary Data

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2015. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2015 and 2014, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 26, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2016

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2015	2014
	(Amounts in millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,329	$ 1,539
Investments	1,801	1,019
Receivables	597	596
Income taxes refundable	13	—
Prepaid expenses and other current assets	192	49
Derivative asset	374	—
Total current assets	5,306	3,203
Property, equipment, and capitalized software, net	393	341
Deferred contract costs	81	54
Intangible assets, net	122	89
Goodwill	519	272
Restricted investments	109	102
Derivative asset	—	329
Deferred income taxes	18	15
Other assets	28	30
	$ 6,576	$ 4,435
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,685	$ 1,201
Amounts due government agencies	729	527
Accounts payable and accrued liabilities	362	242
Deferred revenue	223	196
Income taxes payable	—	9
Current maturities of long-term debt	449	—
Derivative liability	374	—
Total current liabilities	3,822	2,175
Senior notes	962	690
Lease financing obligations	198	157
Lease financing obligations - related party	—	40
Derivative liability	—	329
Other long-term liabilities	37	34
Total liabilities	5,019	3,425
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding: 56 shares at December 31, 2015 and 50 shares at December 31, 2014	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	803	396
Accumulated other comprehensive loss	(4)	(1)
Retained earnings	758	615
Total stockholders' equity	1,557	1,010
	$ 6,576	$ 4,435

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2015	2014	2013
	(In millions, except per-share data)		
Revenue:			
Premium revenue	$ 13,241	$ 9,023	$ 6,179
Service revenue	253	210	205
Premium tax revenue	397	294	172
Health insurer fee revenue	264	120	—
Investment income	18	8	7
Other revenue	5	12	26
Total revenue	14,178	9,667	6,589
Operating expenses:			
Medical care costs	11,794	8,076	5,380
Cost of service revenue	193	157	161
General and administrative expenses	1,146	765	666
Premium tax expenses	397	294	172
Health insurer fee expenses	157	89	—
Depreciation and amortization	104	93	73
Total operating expenses	13,791	9,474	6,452
Operating income	387	193	137
Other expenses, net:			
Interest expense	66	57	52
Other (income) expense, net	(1)	1	4
Total other expenses, net	65	58	56
Income from continuing operations before income tax expense	322	135	81
Income tax expense	179	73	36
Income from continuing operations	143	62	45
Income from discontinued operations, net of tax expense (benefit) of $0, $0, and $(10), respectively	—	—	8
Net income	$ 143	$ 62	$ 53
Basic net income per share:			
Income from continuing operations	$ 2.75	$ 1.34	$ 0.98
(Loss) income from discontinued operations	—	(0.01)	0.18
Basic net income per share	$ 2.75	$ 1.33	$ 1.16
Diluted net income per share:			
Income from continuing operations	$ 2.58	$ 1.30	$ 0.96
(Loss) income from discontinued operations	—	(0.01)	0.17
Diluted net income per share	$ 2.58	$ 1.29	$ 1.13
Weighted average shares outstanding:			
Basic	52	47	46
Diluted	56	48	47

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Net income	$ 143	$ 62	$ 53
Other comprehensive income (loss):			
Unrealized investment loss	(5)	—	(1)
Effect of income tax benefit	2	—	—
Other comprehensive loss, net of tax	(3)	—	(1)
Comprehensive income	$ 140	$ 62	$ 52

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
				(In millions)			
Balance at January 1, 2013	47	$ —	$ 285	$ —	$ 500	$ (3)	$ 782
Net income	—	—	—	—	53	—	53
Other comprehensive loss, net	—	—	—	(1)	—	—	(1)
Purchase of treasury stock	(2)	—	—	—	—	(53)	(53)
Retirement of treasury stock	—	—	(56)	—	—	56	—
Issuance of warrants	—	—	79	—	—	—	79
Share-based compensation	1	—	31	—	—	—	31
Tax benefit from share-based compensation	—	—	2	—	—	—	2
Balance at December 31, 2013	46	—	341	(1)	553	—	893
Net income	—	—	—	—	62	—	62
Convertible senior notes transactions, including issuance costs	2	—	22	—	—	—	22
Share-based compensation	2	—	30	—	—	—	30
Tax benefit from share-based compensation	—	—	3	—	—	—	3
Balance at December 31, 2014	50	—	396	(1)	615	—	1,010
Net income	—	—	—	—	143	—	143
Other comprehensive loss, net	—	—	—	(3)	—	—	(3)
Common stock offering, including issuance costs	6	—	373	—	—	—	373
Share-based compensation	—	—	26	—	—	—	26
Tax benefit from share-based compensation	—	—	8	—	—	—	8
Balance at December 31, 2015	56	$ —	$ 803	$ (4)	$ 758	$ —	$ 1,557

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Operating activities:			
Net income	$ 143	$ 62	$ 53
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	126	134	94
Deferred income taxes	(7)	(2)	(32)
Share-based compensation	23	22	29
Amortization of convertible senior notes and lease financing obligations	30	27	23
Other, net	19	7	18
Changes in operating assets and liabilities, net of effects from acquisitions:			
Receivables	56	(298)	(149)
Prepaid expenses and other current assets	(35)	(20)	(23)
Medical claims and benefits payable	482	531	175
Amounts due government agencies	202	470	28
Accounts payable and accrued liabilities	84	11	33
Deferred revenue	24	74	(20)
Income taxes	(22)	42	(39)
Net cash provided by operating activities	1,125	1,060	190
Investing activities:			
Purchases of investments	(1,923)	(953)	(770)
Proceeds from sales and maturities of investments	1,126	633	400
Purchases of equipment	(132)	(115)	(98)
Increase in restricted investments	(6)	(34)	(19)
Net cash paid in business combinations	(450)	(44)	(62)
Other, net	(35)	(23)	6
Net cash used in investing activities	(1,420)	(536)	(543)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	689	123	538
Proceeds from common stock offering, net of issuance costs	373	—	—
Proceeds from sale-leaseback transactions	—	—	159
Purchase of call option	—	—	(149)
Proceeds from issuance of warrants	—	—	75
Contingent consideration liabilities settled	—	(50)	—
Treasury stock purchases	—	—	(53)
Principal payments on term loan	—	—	(48)
Repayment of amount borrowed under credit facility	—	—	(40)
Proceeds from employee stock plans	18	14	9
Principal payments on convertible senior notes	—	(10)	—
Other, net	5	2	2
Net cash provided by financing activities	1,085	79	493
Net increase in cash and cash equivalents	790	603	140
Cash and cash equivalents at beginning of period	1,539	936	796
Cash and cash equivalents at end of period	$ 2,329	$ 1,539	$ 936

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(continued)

	Year Ended December 31,		
	2015	2014	2013
	(Amounts in millions)		
Supplemental cash flow information:			
Cash paid during the period for:			
Income taxes	$ 197	$ 30	$ 95
Interest	$ 38	$ 29	$ 35
Schedule of non-cash investing and financing activities:			
Senior notes exchange transaction	$ —	$ 177	$ —
Retirement of treasury stock	$ —	$ —	$ 56
Increase in non-cash lease financing obligation - related party	$ —	$ 14	$ 27
Common stock used for stock-based compensation	$ (15)	$ (9)	$ (8)
Details of business combinations:			
Fair value of assets acquired	$ (389)	$ (52)	$ (122)
Fair value of liabilities assumed	41	—	—
Fair value of contingent consideration liabilities incurred	—	—	60
Payable to seller	—	8	—
Amounts advanced for acquisitions	(102)	—	—
Net cash paid in business combinations	$ (450)	$ (44)	$ (62)
Details of change in fair value of derivatives, net:			
Gain on 1.125% Notes Call Option	$ 45	$ 143	$ 37
Loss on 1.125% Notes Conversion Option	(45)	(143)	(37)
Loss on 1.125% Warrants	—	—	(4)
Change in fair value of derivatives, net	$ —	$ —	$ (4)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other. See Note 20, "Segment Information," for further details.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of December 31, 2015, these health plans served over 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

Market Update—Other

Pathways. On November 1, 2015, we acquired all of the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia. See Note 4, "Business Combinations," for further information.

Market Updates—Health Plans

Medicare-Medicaid Plans. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered coverage beginning in the second quarter of 2015. At December 31, 2015, our membership included approximately 51,000 integrated MMP members.

Florida. On November 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to operation of the Medicaid business, of Integral Health Plan, Inc. See Note 4, "Business Combinations," for further information.

On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc. See Note 4, "Business Combinations," for further information.

Illinois. On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business of, Accountable Care Chicago, LLC, also known as MyCare Chicago. We assumed approximately 58,000 Medicaid members in this acquisition.

On January 1, 2016, our Illinois health plan closed on its acquisition of the Medicaid membership, and certain assets related to the Medicaid business, of Loyola Physician Partners, LLC. We assumed approximately 21,000 Medicaid members in this acquisition.

On November 30, 2015, we announced that our Illinois health plan entered into an agreement to assume the membership and certain Medicaid assets of Better Health Network, LLC (Better Health). As of November 30, 2015, Better Health served approximately 40,000 members in the Medicaid Family Health program in Cook County. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the first half of 2016.

Michigan. On January 1, 2016, our Michigan health plan closed on its acquisition of the Medicaid and MIChild membership, and certain Medicaid and MIChild assets, of HAP Midwest Health Plan, Inc. We assumed approximately 81,000 Medicaid and MIChild members in this acquisition.

In October 2015, the Michigan Department of Health and Human Services announced that Molina Healthcare of Michigan was recommended to serve the state's Medicaid members under Michigan's Comprehensive Health Plan, which commenced on January 1, 2016. The new contract has a five-year term with three one-year extensions, and covers Regions 2 through 6, and 8 through 10 of the state, representing an expansion into 18 additional counties compared with the previous Michigan Medicaid contract.

On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc. See Note 4, "Business Combinations," for further information.

Puerto Rico. Effective April 1, 2015, our Puerto Rico health plan served its first members. As of December 31, 2015, our Puerto Rico plan enrollment amounted to approximately 348,000 members.

Washington. In November 2015, our Washington health plan was selected by the Washington State Health Care Authority (HCA) to negotiate and enter into managed care contracts for the Southwest region of the state's Apple Health Fully Integrated Managed Care Program. Molina Healthcare of Washington was selected by HCA pursuant to the request for proposal HCA issued in August 2015. The start date for the new contract is scheduled for April 1, 2016.

On January 1, 2016, our Washington health plan closed on its acquisition of the Medicaid membership and certain Medicaid assets of Columbia United Providers, Inc. We assumed approximately 57,000 Medicaid members in this acquisition.

Market Update—Molina Medicaid Solutions

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate that state's new Medicaid management information system (MMIS). The new contract was effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's incumbent MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 18, "Variable Interest Entities (VIEs)," for more information regarding these variable interest entities. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

Presentation and Reclassifications

Beginning in 2013, after our Medicaid contract with the state of Missouri expired, we have reported the results relating to the Missouri health plan as discontinued operations for all periods presented. Additionally, we abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of $10 million, which is also included in discontinued operations in the consolidated statements of income. The Missouri health plan's premium revenues were insignificant for all periods presented.

We have reclassified certain amounts in the 2014 consolidated balance sheet to conform to the 2015 presentation relating to the presentation of deferred taxes and debt issuance costs. Both reclassifications are a result of recently adopted accounting pronouncements. See Note 2, "Significant Accounting Policies," for further information.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of medical claims and benefits payable of our Health Plans segment;
- Health plan contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- Molina Medicaid Solutions segment revenue and cost recognition;
- Settlements under risk or savings sharing programs;
- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method.

Our investment policy requires that all of our investments have final maturities of 10 years or less (excluding variable rate securities where interest rates may be periodically reset), and that the average maturity be three years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our current and non-current investments, see Note 5, "Fair Value Measurements," Note 6, "Investments," and Note 10, "Restricted Investments."

Receivables

Receivables are readily determinable and because our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables."

Property, Equipment, and Capitalized Software

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years. See Note 8, "Property, Equipment, and Capitalized Software."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of service revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Depreciation, and amortization of capitalized software, continuing operations	$ 87	$ 75	$ 55
Amortization of intangible assets, continuing operations	17	18	18
Depreciation and amortization, continuing operations	104	93	73
Amortization recorded as reduction of service revenue	1	3	3
Amortization of capitalized software recorded as cost of service revenue	21	38	18
Depreciation and amortization reported in the statement of cash flows	$ 126	$ 134	$ 94

Long-Lived Assets, including Intangible Assets

Long-lived assets consist primarily of property, equipment, capitalized software and intangible assets. Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at fair value and are then amortized on a straight-line basis over their expected useful lives, generally between two and 15 years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2015, 2014, and 2013.

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount.

To determine whether goodwill is impaired, we measure the fair values of our reporting units and compare them to the carrying values of the respective units, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared with the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows. To determine fair values, we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

No impairment charges relating to goodwill were recorded in the years ended December 31, 2015, 2014, and 2013.

Business Combinations

Accounting for acquisitions requires us to recognize separately from goodwill the assets acquired and the liabilities assumed at their acquisition date fair values. Goodwill as of the acquisition date is measured as the excess of consideration transferred over the net of the acquisition date fair values of the assets acquired and the liabilities assumed. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Upon the conclusion of the measurement period or final determination of the values of assets acquired or liabilities assumed, whichever comes first, any subsequent adjustments are recorded to our consolidated statements of income. Refer to Note 4, "Business Combinations," for further details regarding our 2015 acquisitions.

Restricted Investments

Restricted investments, which consist of certificates of deposit and U.S. treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates fair value. The use of these funds is limited to specific purposes as required by regulation in the various states in which we operate, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2015 and 2014.

Premium Revenue - Health Plans

Premium revenue is generated primarily from our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. Premium revenue is generally received based on per member per month (PMPM) rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. The state Medicaid programs and the federal Medicare program periodically adjust premium. Additionally, many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is

earned under such provisions.

The following table summarizes premium revenue from continuing operations for the periods indicated:

	Year Ended December 31,					
	2015		2014		2013	
	Amount	% of Total	Amount	% of Total	Amount	% of Total
	(Dollars in millions)					
California	$ 2,200	16.6%	$ 1,523	16.9%	$ 750	12.1%
Florida	1,199	9.0	439	4.9	265	4.3
Illinois	397	3.0	153	1.7	8	0.1
Michigan	1,067	8.1	781	8.7	676	11.0
New Mexico	1,237	9.3	1,076	11.9	447	7.2
Ohio	2,034	15.4	1,553	17.2	1,099	17.8
Puerto Rico	567	4.3	—	—	—	—
South Carolina	348	2.6	381	4.2	—	—
Texas	1,961	14.8	1,318	14.6	1,291	20.9
Utah	331	2.5	310	3.4	311	5.0
Washington	1,602	12.1	1,305	14.5	1,168	18.9
Wisconsin	261	2.0	156	1.7	143	2.3
Direct delivery	37	0.3	28	0.3	21	0.4
	$ 13,241	100.0%	$ 9,023	100.0%	$ 6,179	100.0%

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $224 million and $392 million at December 31, 2015 and December 31, 2014, respectively, to amounts due government agencies. Approximately $208 million of the liability accrued at December 31, 2015 relates to our participation in Medicaid expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. We had $3 million recorded at December 31, 2015 relating to such provisions. No such receivables were recorded at December 31, 2014.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to retain, we recorded a liability of $10 million at December 31, 2015. The amount recorded at December 31, 2014 was insignificant.

Retroactive Premium Adjustments: In New Mexico, when members are retroactively enrolled into our health plan we earn revenue only to the extent of the actual medical costs incurred by us for services provided during those retroactive periods, plus a small percentage of that medical cost for administration and profit. This cost plus arrangement for members retroactively enrolled in our health plan first became effective July 1, 2014 (retroactive to January 1, 2014). We are paid normal monthly capitation rates for the retroactive eligibility periods, and the difference between those capitation rates and the amounts due us on a cost plus basis are periodically settled with the state. To date, no such settlement has been made with the state. Our New Mexico contract is not specific as to the definition of retroactive membership, and the amount we owe the state (or that the state owes us) for the difference between capitation received and amounts due us under the cost plus arrangement varies widely depending upon the definition of retroactive membership.

In August 2015 the state provided us with a request for payment under the terms of this contract provision for the period January 1, 2014 through December 31, 2014. That request was based upon definitions of retroactive membership that were at odds with our interpretations of that term. The New Mexico health plan reduced revenue by approximately $24 million in 2015

as a result of aligning more closely our definition of retroactive membership with the state's definition. Using the state's definition of retroactive membership, however, we estimate that the state will ultimately seek repayment of an amount that ranges from $15 million to $20 million higher than what we have accrued. We do not believe that any reasonable definition of retroactive membership supports the state's position, and expect to resolve this matter with payment of the amount we have accrued at December 31, 2015. We are currently engaged in discussions with the state regarding the appropriate amount, if any, owed to the state under this contract term.

Medicare

Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive increase or decrease based upon member medical conditions for up to two years after the original year of service. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses, we have recorded a net payable of $4 million and a net receivable of $8 million for anticipated Medicare risk adjustment premiums at December 31, 2015 and December 31, 2014, respectively.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program.

- Permanent risk adjustment program: Under this permanent program, our health plans' risk scores are compared to the overall average risk score for the relevant state and market pool. Generally, our health plans will pay into the pool if their risk scores are below the average risk score, and will receive funds from the pool if their risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income.
- Transitional reinsurance program: This program is designed to provide reimbursement to insurers for high cost members. Our health plans pay an annual contribution on a per-member basis, and are eligible for recoveries if claims for individual members exceed a specified threshold, up to a maximum amount. This three-year program will end on December 31, 2016. We recognize the assessments to fund the transitional reinsurance program as a reduction to premium revenue in our consolidated statements of income. We recognize recoveries under the reinsurance program as a reduction to medical care costs in our consolidated statements of income.
- Temporary risk corridor program: This program is intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by the U.S. Department of Health and Human Services (HHS). Variances from the target amount exceeding certain thresholds may result in amounts due to or receivables due from HHS. This three-year program will end on December 31, 2016. Due to uncertainties as to the amount of federal funding available to support the risk corridor program, we do not recognize amounts receivable under this program. All liabilities are recognized as incurred. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk corridor program as an adjustment to premium revenue in our consolidated statements of income.

Additionally, the ACA established a minimum annual medical loss ratio (Minimum MLR) of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. What constitutes medical costs and premium revenue are specifically defined by federal regulations. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income.

We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described above, and, for receivables, collection is reasonably assured.

Our receivables (payables) for each of these programs, as of the dates indicated, were as follows (in millions):

	December 31, 2015	December 31, 2014
Risk adjustment	$ (214)	$ (5)
Reinsurance	36	5
Risk corridor	(10)	—
Minimum MLR	(3)	—

Quality Incentives

At several of our health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2015 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2015.

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Maximum available quality incentive premium - current period	$ 118	$ 90	$ 63
Amount of quality incentive premium revenue recognized in current period:			
Earned current period	$ 66	$ 40	$ 46
Earned prior periods	13	4	9
Total	$ 79	$ 44	$ 55
Total premium revenue recognized for state health plans with quality incentive premiums	$ 11,107	$ 7,084	$ 2,980

Medical Care Costs - Health Plans

Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.
- *Pharmacy expenses:* All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Capitation expenses:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.
- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management,

and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2015, 2014, and 2013, medically related administrative costs were $398 million, $263 million, and $153 million, respectively.

The following table provides the details of our consolidated medical care costs from continuing operations for the periods indicated (dollars in millions, except PMPM amounts):

	Year Ended December 31,								
	2015			2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 8,572	$ 218.35	72.7%	$ 5,673	$ 202.87	70.2%	$ 3,612	$ 160.43	67.1%
Pharmacy	1,610	41.01	13.7	1,273	45.54	15.8	935	41.54	17.4
Capitation	982	25.02	8.3	748	26.77	9.3	604	26.83	11.2
Direct delivery	128	3.26	1.1	96	3.44	1.2	48	2.14	0.9
Other	502	12.79	4.2	286	10.22	3.5	181	8.05	3.4
Total	$ 11,794	$ 300.43	100.0%	$ 8,076	$ 288.84	100.0%	$ 5,380	$ 238.99	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. For further information, see Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. Such reinsurance coverage does not relieve us of our primary obligation to our policyholders. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Health Insurer Fee. The federal government under the ACA imposes an annual fee, or excise tax, on health insurers for each calendar year. The HIF is based on a company's share of the industry's net premiums written during the preceding calendar year, and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Because we primarily serve individuals in government-sponsored programs, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment or payment from a state to reimburse us for the HIF; such HIF revenue is recognized ratably throughout the year.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expense in the consolidated statements of income.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2015 or 2014.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element, and are therefore multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. If the deliverable has standalone value, the arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. Therefore, absent any contingencies as discussed in the following paragraph, or contract extensions, we would recognize all revenue associated with those contracts over the initial contract period. When a contract is extended, we generally consider the extension to be a continuation of the single unit of accounting; therefore, the deferred revenue as of the extension date is recognized prospectively over the new remaining term of the contract. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances, we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts, for example. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;

- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state and Puerto Rico taxes, nondeductible expenses under the Affordable Care Act Health Insurer Fee (HIF), nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers. For further discussion and disclosure, see Note 14, "Income Taxes."

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2015 and 2014, our investments with PFM amounted to approximately $605 million and $321 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment-grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited because our payors consist principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans primarily as a direct contractor with the states (or Commonwealth), and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements Not Yet Adopted

Leases. In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) ASU 2016-02, *Leases*. ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The ASU is effective for us beginning in the first quarter of 2019, and requires a modified retrospective transition approach. Early adoption is permitted; we are currently evaluating the potential effects of the adoption to our financial statements.

Financial Instruments. In January 2016, the FASB issued ASU 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*, which will require public business entities to use the exit price notion when measuring the fair value of financial instruments for disclosure purposes. Also, entities will have to assess the realizability of a deferred tax asset related to an available for sale debt security in combination with the entity's other deferred tax assets. Effective for us in the first quarter of 2018, ASU 2016-01 is applied prospectively with a cumulative-effect adjustment to beginning retained earnings as of the beginning of the first reporting period in which the guidance is adopted. Early adoption is permitted in regards to certain provisions of the standard; we are evaluating the potential effects of the adoption to our financial statements.

Revenue Recognition. In July 2015, the FASB affirmed its proposal to defer the effective date of ASU 2014-09, *Revenue from Contracts with Customers,* for all entities by one year. As a result, public business entities will apply the new revenue standard to annual reporting periods beginning after December 15, 2017, and for interim reporting periods within annual reporting periods beginning after December 15, 2017. We intend to adopt this standard on January 1, 2018. We are currently evaluating our plan for adoption and its impact to our revenue recognition policies, procedures and control framework, and the resulting impact to our consolidated financial position, results of operations and cash flows.

Short-Duration Contracts. In May 2015, the FASB issued ASU 2015-09, *Disclosures about Short-Duration Contracts*, which will require additional disclosure on the liability for unpaid claims and claim adjustment expenses. We intend to adopt this standard effective for our annual report for the year ending December 31, 2016, and for interim periods thereafter. It requires additional disclosure only and will not have a significant impact to our consolidated financial statements.

Software Licenses. In April 2015, the FASB issued ASU 2015-05, *Customer's Accounting for Fees Paid in a Cloud Computing Arrangement*, which will require customers to determine whether a cloud computing arrangement includes the license of software by applying the same guidance cloud service providers use to make this determination. The ASU also eliminates the existing requirement for customers to account for software licenses they acquire by analogizing to the guidance on leases. This ASU will be effective for us in the first quarter of 2016, and is applied either prospectively or retrospectively. We are evaluating the potential effects of adoption to our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the SEC did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

Recent Accounting Pronouncements Adopted

Income Taxes. In the fourth quarter of 2015, we early adopted ASU 2015-17, *Balance Sheet Classification of Deferred Taxes*, which requires deferred tax assets and liabilities to be classified as non-current, in a classified statement of financial position. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption had an insignificant impact to our consolidated balance sheets, and had no impact to our consolidated statements of income, stockholders' equity, and cash flows.

Business Combinations. In the fourth quarter of 2015, we early adopted ASU 2015-16, *Simplifying the Accounting for Measurement-Period Adjustments*, which requires acquirers to recognize adjustments to provisional amounts identified during the measurement period (a reasonable time period after the acquisition date) in the reporting period in which such adjustment amounts are determined. For the year ended December 31, 2015, there was no impact to our consolidated financial statements.

Debt Issuance Costs. In the fourth quarter of 2015, we early adopted ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*, which requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of such debt liability, consistent with debt discounts. In a subsequent Staff Announcement, the SEC announced that it would not object to the deferral and presentation of debt issuance costs relating to line-of-credit arrangements as an asset. We have applied the guidance retrospectively to all periods presented. Such retrospective adoption had an insignificant impact to our consolidated balance sheets, and had no impact to our consolidated statements of income, stockholders' equity, and cash flows.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	December 31,		
	2015	2014	2013
	(In millions)		
Shares outstanding at the beginning of the period	49	46	47
Weighted-average number of shares:			
Issued:			
Common stock offering	3	—	—
Convertible senior notes	—	1	—
Repurchased	—	—	(1)
Denominator for basic net income per share	52	47	46
Effect of dilutive securities:			
Share-based compensation	1	—	1
Convertible senior notes (1)	1	1	—
1.125% Warrants (1)	2	—	—
Denominator for diluted net income per share	56	48	47
Potentially dilutive common shares excluded from calculations (2):			
1.125% Warrants	—	13	12

(1) For more information regarding the convertible senior notes, including the 1.625% Notes, 3.75% Notes, and 3.75% Exchange, refer to Note 12, "Debt." For more information regarding the 1.125% Warrants, refer to Note 13, "Derivatives."

(2) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the years ended December 31, 2014 and 2013, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

4. Business Combinations

During 2015, we closed on business combinations in both the Health Plans and Other segments. For all of these transactions we applied the acquisition method of accounting, where the total purchase price was allocated, or preliminarily allocated, to tangible and intangible assets acquired, and liabilities assumed based on their respective fair values. For Health Plans acquisitions, in general, only intangible assets are acquired. All of the 2015 acquisitions were funded using available cash.

Health Plans

Consistent with our strategy to grow in our existing markets, we closed the following Health Plans acquisitions in 2015:

Florida. On November 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to operation of the Medicaid business, of Integral Health Plan, Inc. The final purchase price was $67 million, and the Florida health plan added approximately 101,000 members in the Northwest and Southwest regions of Florida as a result of this transaction. On the closing date, we withheld 10%, or approximately $7 million, of the purchase price to establish an indemnification amount held as security for the seller's indemnification obligations under the purchase agreement. We have recorded the indemnification amount to restricted assets, which will be settled in November 2016. If we do not have any claims against the seller on or before the settlement date, we will pay the full withhold amount to the seller. As of December 31, 2015, we had not made any claims against the withhold amount.

On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc. The final purchase price was $8 million, and the Florida health plan added approximately 23,000 members as a result of this transaction.

Michigan. On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc. The purchase price was $47 million, and the Michigan health plan added approximately 68,000 members as a result of this transaction.

For the Health Plans acquisitions closed in 2015, we recorded goodwill amounting to $90 million in the aggregate, which relates to future economic benefits arising from expected synergies to be achieved. Such synergies include use of our existing infrastructure to support the added membership. The amount recorded as goodwill represents intangible assets that do not qualify for separate recognition as identifiable intangible assets. The entire amount recorded as goodwill is deductible for income tax purposes. Refer to the table below for a summary of the intangible assets identified, and their economic lives.

Announced Acquisitions. As described in Note 1, "Basis of Presentation," we announced several Health Plans acquisitions in 2015 that did not close until January 1, 2016. Because the closing dates for these acquisitions fell on January 1, 2016, a holiday, approximately $101 million was recorded to prepaid expenses and other assets as of December 31, 2015, for purchase price amounts funded in December 2015. Such amounts are reported in investing activities in the accompanying consolidated statements of cash flows. The total aggregate purchase price for these acquisitions amounted to approximately $115 million, which will be allocated among goodwill and intangible assets. The initial accounting for these transactions is incomplete.

Transaction costs associated with the Health Plans acquisitions were insignificant.

Other

Pathways. Consistent with our strategy to acquire and develop new products and capabilities, on November 1, 2015, we acquired all of the outstanding ownership interests in Pathways Health and Community Support LLC (Pathways), formerly known as Providence Human Services, LLC. Pathways is one of the largest national providers of accessible, outcome-based behavioral/mental health and social services with operations in 23 states and the District of Columbia.

The following table summarizes the preliminary values of the assets acquired and liabilities assumed at the date of acquisition.

	November 1, 2015 (In millions)
Assets:	
Cash and cash equivalents	$ 20
Receivables	52
Prepaid expenses and other current assets	4
Property and equipment	14
Intangible assets	19
Goodwill	155
Other assets	1
Liabilities:	
Medical claims and benefits payable	(2)
Accounts payable and accrued liabilities	(23)
Deferred revenue	(2)
Other long-term liabilities	(7)
Total purchase price	$ 231

As of December 31, 2015, the purchase price allocation for the acquisition was preliminary and subject to completion. Adjustments to the current fair value estimates in the above table may occur as the process conducted for various valuations and assessments is finalized, including tax assets and liabilities. Goodwill is calculated as the excess of the consideration transferred over the net assets recognized and represents the estimated future economic benefits arising from other assets acquired that could not be individually identified and separately recognized, including expected medical cost synergies to be achieved, and the workforce acquired. Such synergies include the achievement of better outcomes for our members through more effective care coordination and integration, and our retention of the net profit margin captured by the mental health provider. The workforce acquired is a significant component of goodwill because it represents primarily the patient-facing employees, now employed by us, who provide the behavioral/mental health and social services. Approximately 10% of the goodwill recorded at December 31, 2015, is deductible for income tax purposes. This percentage may increase if certain tax elections are completed in 2016.

The gross contractual amount of receivables, at the acquisition date, was approximately $61 million. At the acquisition date, the best estimate of contractual cash flows not expected to be collected was approximately $9 million.

In connection with this acquisition, we incurred approximately $3 million in transaction costs, which are recorded in general and administrative expenses.

The following table presents the intangible assets identified, by segment. The weighted-average amortization period for the Health Plans identified intangible assets, in the aggregate, is 6.4 years. The weighted-average amortization period for the Other identified intangible assets, in the aggregate, is 4.2 years.

	Fair Value	Life (years)
	(In millions)	
Intangible asset type		
Health Plans:		
Contract rights - member list	$ 23	5
Provider network	9	10
Other:		
Contract licenses	5	2
Contract rights - member list	14	5
	$ 51	

5. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include the following:

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2015 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 13, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated. The changes in Level 3 instruments for the year ended December 31, 2015 were insignificant.

Our financial instruments measured at fair value on a recurring basis at December 31, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 1,184	$ —	$ 1,184	$ —
Government-sponsored enterprise securities (GSEs)	211	211	—	—
Municipal securities	185	—	185	—
Certificates of deposit	80	—	80	—
U.S. treasury notes	78	78	—	—
Asset-backed securities	63	—	63	—
Subtotal - current investments	1,801	289	1,512	—
1.125% Call Option derivative asset	374	—	—	374
Total assets measured at fair value on a recurring basis	$ 2,175	$ 289	$ 1,512	$ 374
1.125% Conversion Option derivative liability	$ 374	$ —	$ —	$ 374
Total liabilities measured at fair value on a recurring basis	$ 374	$ —	$ —	$ 374

Our financial instruments measured at fair value on a recurring basis at December 31, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In millions)		
Corporate debt securities	$ 641	$ —	$ 641	$ —
GSEs	122	122	—	—
Municipal securities	127	—	127	—
Certificates of deposit	69	—	69	—
U.S. treasury notes	60	60	—	—
Subtotal - current investments	1,019	182	837	—
1.125% Call Option derivative asset	329	—	—	329
Total assets measured at fair value on a recurring basis	$ 1,348	$ 182	$ 837	$ 329
1.125% Conversion Option derivative liability	$ 329	$ —	$ —	$ 329
Total liabilities measured at fair value on a recurring basis	$ 329	$ —	$ —	$ 329

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. As described in Note 2, "Significant Accounting Policies," the carrying amount of debt has been reduced by deferred issuance costs for all periods presented.

	December 31, 2015		December 31, 2014	
	Carrying Amount	Total Fair Value	Carrying Amount	Total Fair Value
		(In millions)		
5.375% Notes	$ 689	$ 700	$ —	$ —
1.125% Convertible Notes	448	865	426	767
1.625% Convertible Notes	273	365	264	337
	$ 1,410	$ 1,930	$ 690	$ 1,104

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 1,189	$ —	$ 5	$ 1,184
GSEs	212	—	1	211
Municipal securities	186	—	1	185
Certificates of deposit	80	—	—	80
U.S. treasury notes	78	—	—	78
Asset-backed securities	63	—	—	63
	$ 1,808	$ —	$ 7	$ 1,801

	December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In millions)			
Corporate debt securities	$ 643	$ —	$ 2	$ 641
GSEs	122	—	—	122
Municipal securities	127	—	—	127
Certificates of deposit	69	—	—	69
U.S. treasury notes	60	—	—	60
	$ 1,021	$ —	$ 2	$ 1,019

The contractual maturities of our investments as of December 31, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 830	$ 829
Due after one year through five years	967	962
Due after five years through ten years	11	10
	$ 1,808	$ 1,801

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the years ended December 31, 2015, 2014 and 2013 were insignificant.

We have determined that unrealized gains and losses at December 31, 2015 and 2014 are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2015.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 825	$ 4	588	$ 119	$ 1	87
GSEs	182	1	77	—	—	—
Municipal securities	128	1	181	5	—	12
Certificates of deposit	53	—	218	—	—	—
U.S. treasury notes	53	—	32	—	—	—
Asset-backed securities	55	—	47	—	—	—
	$ 1,296	$ 6	1,143	$ 124	$ 1	99

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2014.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in millions)					
Corporate debt securities	$ 379	$ 1	265	$ 29	$ 1	10
GSEs	75	—	22	3	—	3
Municipal securities	54	—	64	11	—	13
Certificates of deposit	13	—	52	—	—	—
U.S. treasury notes	19	—	13	—	—	—
	$ 540	$ 1	416	$ 43	$ 1	26

7. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial. The information below is presented by segment.

	December 31,	
	2015	2014
	(In millions)	
California	$ 104	$ 311
Florida	22	2
Illinois	35	32
Michigan	39	20
New Mexico	51	50
Ohio	66	45
Puerto Rico	33	—
South Carolina	6	4
Texas	56	29
Utah	18	6
Washington	53	43
Wisconsin	22	8
Direct delivery and other	6	11
Total Health Plans segment	511	561
Molina Medicaid Solutions segment	37	35
Other segment	49	—
	$ 597	$ 596

8. Property, Equipment, and Capitalized Software

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2015	2014
	(In millions)	
Land	$ 16	$ 15
Building and improvements	153	195
Furniture and equipment	250	141
Capitalized software	336	267
	755	618
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(167)	(129)
Less: accumulated amortization for capitalized software	(195)	(148)
	(362)	(277)
Property, equipment, and capitalized software, net	$ 393	$ 341

Depreciation recognized for building and improvements, and furniture and equipment was $49 million, $35 million, and $27 million for the years ended December 31, 2015, 2014 and 2013, respectively. Amortization of capitalized software was $52 million, $59 million, and $46 million for the years ended December 31, 2015, 2014 and 2013, respectively.

Molina Center. We acquired the Molina Center in December 2011. Subsequently, in June 2013 we entered into a sale-leaseback transaction for the Molina Center. Due to our continuing involvement with the leased property, the sale did not qualify for sales recognition and we remain the "accounting owner" of the property. See Note 12, "Debt."

Future minimum rental income on noncancelable leases from third party tenants of the Molina Center is sublease rental income, and is reported in other revenue in our consolidated statements of income. The future minimum rental income is as follows:

	2016	2017	2018	2019	2020	Thereafter	Total
	(In millions)						
Future minimum rentals	$ 4	4	4	2	2	1	$ 17

9. Goodwill and Intangible Assets

The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
	(In millions)		
Intangible assets:			
Contract rights and licenses	$ 224	$ 120	$ 104
Customer relationships	25	23	2
Contract backlog	24	24	—
Provider networks	27	11	16
Balance at December 31, 2015	$ 300	$ 178	$ 122
Intangible assets:			
Contract rights and licenses	$ 182	$ 105	$ 77
Customer relationships	25	23	2
Contract backlog	24	23	1
Provider networks	18	9	9
Balance at December 31, 2014	$ 249	$ 160	$ 89

Based on the balances of our identifiable intangible assets as of December 31, 2015, we estimate that our intangible asset amortization will be $25 million in 2016, $25 million in 2017, $22 million in 2018, $18 million in 2019, and $13 million in 2020. For a presentation of our goodwill and intangible assets by reportable segment, refer to Note 20, "Segment Information."

The following table presents the balances of goodwill as of December 31, 2015 and 2014:

		Acquisitions by Segment		
	December 31, 2014	Health Plans	Other	December 31, 2015
	(In millions)			
Goodwill, gross	$ 330	$ 90	$ 157	$ 577
Accumulated impairment losses	(58)	—	—	(58)
Goodwill, net	$ 272	$ 90	$ 157	$ 519

The changes in the carrying amounts of goodwill and intangible assets, at cost, in 2015 were due to the acquisitions described in Note 4, "Business Combinations."

10. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. In connection with a Molina Medicaid Solutions segment state contract, we maintained restricted investments as collateral for a letter of credit as of December 31, 2014. The following table presents the balances of restricted investments:

	December 31,	
	2015	2014
	(In millions)	
Florida	$ 34	$ 29
Michigan	1	1
New Mexico	43	35
Ohio	12	13
Puerto Rico	10	5
South Carolina	—	6
Texas	4	3
Utah	4	4
Wisconsin	1	—
Other	—	1
Total Health Plans segment	109	97
Molina Medicaid Solutions segment	—	5
	$ 109	$ 102

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2015 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In millions)	
Due in one year or less	$ 100	$ 100
Due one year through five years	9	9
	$ 109	$ 109

11. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	December 31,		
	2015	2014	2013
	(In millions)		
Fee-for-service claims incurred but not paid (IBNP)	$ 1,191	$ 871	$ 424
Pharmacy payable	88	71	45
Capitation payable	140	28	20
Other	266	231	181
	$ 1,685	$ 1,201	$ 670

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $167 million, $119 million and $151 million, as of December 31, 2015, 2014 and 2013, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for "Components of medical care costs

related to: Prior periods" represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,		
	2015	2014	2013
	(Dollars in millions)		
Balances at beginning of period	$ 1,201	$ 670	$ 495
Components of medical care costs related to:			
Current period	11,935	8,123	5,434
Prior periods	(141)	(46)	(53)
Total medical care costs	11,794	8,077	5,381
Change in non-risk provider payables	48	(32)	111
Payments for medical care costs related to:			
Current period	10,448	7,064	4,932
Prior periods	910	450	385
Total paid	11,358	7,514	5,317
Balances at end of period	$ 1,685	$ 1,201	$ 670

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). Our IBNP, as included in medical claims and benefits payable, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under– or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2015, 2014, and 2013 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

2015

We believe that the most significant factors that will determine the accuracy of our IBNP estimates at December 31, 2015 are:

- A new version of diagnosis codes was required for all claims with dates of service October 1, 2015 and later. As a result, payment was delayed for a significant number of claims due to the use of diagnosis codes that were no longer valid. Due to the resulting variability in the ratio of paid to billed amounts, the reserves are subject to more than the usual amount of uncertainty.

- At our Illinois, Puerto Rico and Wisconsin health plans, we overpaid certain provider and outpatient facility claims due to a system configuration error. For this reason, the reserves are subject to more than the usual amount of uncertainty.
- Our Michigan health plan added approximately 68,000 new members under an acquisition in the third quarter of 2015. Because these new members may have different utilization patterns than our legacy members, the reserves are subject to more than the usual amount of uncertainty.
- Our Puerto Rico health plan started operations on April 1, 2015. Because we lack sufficient historical claims data, our reserves as of December 31, 2015 are based on a combination of claims payment experience and the expected claims in the pricing assumptions. For this reason, the reserves are subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $141 million for the year ended December 31, 2015. This amount represents our estimate as of December 31, 2015, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio and California health plans, approximately 61,000 and 100,000 members, respectively, were enrolled in the new Medicaid expansion program during 2014. Also in Ohio, approximately 17,000 members were enrolled in the new MMP program in 2014. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.
- At our New Mexico health plan, the state implemented a retroactive increase to the provider fee schedules in mid-2014. As a result, many claims that were previously settled were reopened, and subject to, additional payment. Because our reserving methodology is most accurate when claims payment patterns are consistent and predictable, the payment of additional amounts on claims that in some cases had been settled more than six months before added a substantial degree of complexity to our liability estimation process. Due to the difficulties in addressing that added complexity, liabilities recorded as of December 31, 2014, were in excess of amounts ultimately paid.
- At our Washington health plan, in 2015 we collected amounts related to certain claims paid in 2013. Such collections were not anticipated in our reserves as of December 31, 2014.

2014

We recognized favorable prior period claims development in the amount of $46 million for the year ended December 31, 2014. This amount represented our estimate as of December 31, 2014, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2013 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio health plan, we entered new regions in the state, and a new product, ABD Kids, in July 2013. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.
- At our Michigan health plan, we overestimated the impact of certain unpaid potentially high-dollar claims. In addition, we overestimated the impact of the flu season on the outpatient claims for November and December 2013, which caused an overestimation in our outpatient reserve liability as of December 31, 2013.

2013

We recognized favorable prior period claims development in the amount of $53 million for the year ended December 31, 2013. This amount represented our estimate as of December 31, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Washington health plan certain high-cost newborns, as well as other high-cost disabled members, were covered by the health plan effective July 1, 2012. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors. Our actual costs were ultimately less than expected.
- At our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.

- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to our ABD members.

12. Debt

As of December 31, 2015, contractual maturities of debt for the years ending December 31 are as follows (in millions):

	Total	2016	2017	2018	2019	2020	Thereafter
5.375% Notes	$ 700	$ —	$ —	$ —	$ —	$ —	$ 700
1.125% Convertible Notes	550	—	—	—	—	550	—
1.625% Convertible Notes (1)	302	—	—	—	—	—	302
Other	1	1	—	—	—	—	—
	$ 1,553	$ 1	$ —	$ —	$ —	$ 550	$ 1,002

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The principal amounts, unamortized discount (net of premium related to 1.625% Notes), unamortized issuance costs, and net carrying amounts of debt were as follows:

	Principal Balance	Unamortized Discount	Unamortized Issuance Costs	Net Carrying Amount
	(In millions)			
December 31, 2015:				
5.375% Notes	$ 700	$ —	$ 11	$ 689
1.125% Convertible Notes	550	95	7	448
1.625% Convertible Notes	302	25	4	273
Other	1	—	—	1
	$ 1,553	$ 120	$ 22	$ 1,411
December 31, 2014:				
1.125% Convertible Notes	$ 550	$ 115	$ 9	$ 426
1.625% Convertible Notes	302	33	5	264
	$ 852	$ 148	$ 14	$ 690

	Years Ended December 31,		
	2015	2014	2013
	(In millions)		
Interest cost recognized for the period relating to:			
Contractual interest coupon rate	$ 17	$ 13	$ 13
Amortization of the discount	29	26	22
	$ 46	$ 39	$ 35

5.375% Senior Notes due 2022. On November 10, 2015, we completed the private offering of $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest is payable semiannually in arrears on May 15 and November 15, beginning on May 15, 2016. The 5.375% Notes are not convertible into our common stock or any other securities.

The 5.375% Notes are guaranteed by certain of our wholly owned subsidiaries. The 5.375% Notes and the guarantees are effectively subordinated to all existing and future secured debt of us and our guarantors to the extent of the assets securing such debt. In addition, the 5.375% Notes and the guarantees are structurally subordinated to all indebtedness and other liabilities and preferred stock of our subsidiaries that do not guarantee the 5.375% Notes.

We may redeem some or all of the 5.375% Notes at any time, and prior to August 15, 2022, at a price equal to 100% of the principal amount redeemed plus accrued and unpaid interest thereon, plus a "make-whole" premium. Thereafter, we may redeem some or all of the 5.375% Notes at a price equal to 100% of the principal amount redeemed plus accrued and unpaid

interest thereon. The 5.375% Notes contain customary non-financial covenants and change of control provisions.

In connection with the issuance and sale of the 5.375% Notes, we entered into a registration rights agreement. Under this agreement, we will use commercially reasonable efforts to register substantially identical notes (the Exchange Notes) with the SEC in 2016. We will then offer such freely tradable Exchange Notes in exchange for the 5.375% Notes. We will pay additional interest on the 5.375% Notes if the Exchange Notes offering is not completed timely.

Credit Facility. In June 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility). The Credit Facility has a term of five years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. As of December 31, 2015, outstanding letters of credit amounting to $6 million reduced the borrowing capacity to $244 million, and no amounts were outstanding under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Although the Credit Facility is not secured by any of our assets, certain of our wholly owned subsidiaries have jointly and severally guaranteed our obligations under the Credit Facility.

The Credit Facility contains customary non-financial and financial covenants, including a minimum fixed charge coverage ratio, a maximum debt-to-EBITDA ratio and minimum statutory net worth. At December 31, 2015, we were in compliance with all financial covenants under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550 million aggregate principal amount of 1.125% cash convertible senior notes (1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest is payable semiannually in arrears on January 15 and July 15.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date. Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;

- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;

- upon the occurrence of specified corporate events; or

- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes met the stock price trigger in the quarter ended December 31, 2015, and are convertible into cash through at least March 31, 2016. Because the 1.125% Notes may be converted to cash within 12 months, the $448 million carrying amount is reported in current portion of long-term debt as of December 31, 2015.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount).

This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of December 31, 2015, the 1.125% Notes have a remaining amortization period of 4.0 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $332 million and $93 million as of December 31, 2015 and December 31, 2014, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $125 million principal amount of 1.625% convertible senior notes (1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Combined with the 1.625% Notes issued in connection with the 3.75% Exchange described below, the aggregate principal amount issued under the 1.625% Notes was $302 million.

Interest is payable semiannually in arrears on February 15 and August 15. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of December 31, 2015, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and

ending on the first date we may redeem the notes in August 2018. As of December 31, 2015, the 1.625% Notes have a remaining amortization period of 2.6 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value exceeded their principal amount by approximately $10 million as of December 31, 2015, and did not exceed their principal amount as of December 31, 2014. At December 31, 2015 and December 31, 2014, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $23 million.

3.75% Exchange. In August 2014, we entered into separate, privately negotiated, exchange agreements (the 3.75% Exchange) with certain holders of our outstanding 3.75% convertible senior notes due 2014 (the 3.75% Notes). In this transaction, we exchanged $177 million aggregate principal amount of the 3.75% Notes for $177 million principal amount of 1.625% convertible senior notes due 2044, approximately 2 million shares of our common stock, and payment of accrued interest on the exchanged 3.75% Notes; additionally, we issued approximately 81,000 shares of common stock for services rendered in connection with the 3.75% Exchange. We did not receive any proceeds from the 3.75% Exchange.

3.75% Notes. As described above, we entered into the 3.75% Exchange transaction in August 2014, under which we exchanged $177 million of the outstanding principal amount of the 3.75% Notes for the 1.625% Notes. The remaining $10 million principal amount was repaid in full in October 2014.

Lease Financing Obligations. In 2013, we entered into a sale-leaseback transaction for the Molina Center located in Long Beach, California, and our Ohio health plan office building located in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sales recognition and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Rent will increase 3% per year through the initial term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest amounted to $13 million for both years ended December 31, 2015 and 2014.

As described and defined in further detail in Note 17, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings. We have concluded that we are the accounting owner of the buildings due to our continuing involvement with the properties. We have recorded $36 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of December 31, 2015, which represents the total cost incurred by the Landlord for the construction of the buildings, net of accumulated depreciation. As of December 31, 2015 and December 31, 2014, the aggregate amount recorded to lease financing obligations, including the current portion, amounted to $40 million and $41 million, respectively. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense was $4 million and $3 million for the year ended December 31, 2015 and 2014, respectively. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was $1 million for both years ended December 31, 2015 and 2014. For information regarding the future minimum lease obligation, refer to Note 19, "Commitments and Contingencies."

13. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

		December 31,	
	Balance Sheet Location	2015	2014
		(In millions)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 374	$ —
	Non-current assets: Derivative asset	$ —	$ 329
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 374	$ —
	Non-current liabilities: Derivative liability	$ —	$ 329

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the notes due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 5, "Fair Value Measurements."

As of December 31, 2015, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of December 31, 2015, as described in Note 12, "Debt."

14. Income Taxes

The provision for income taxes for continuing operations consisted of the following:

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Current:			
Federal	$ 172	$ 72	$ 67
State	8	3	—
Foreign	6	—	—
Total current	186	75	67
Deferred:			
Federal	(10)	—	(25)
State	4	(2)	(6)
Foreign	(1)	—	—
Total deferred	(7)	(2)	(31)
	$ 179	$ 73	$ 36

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate for continuing operations is as follows:

	Year Ended December 31,		
	2015	2014	2013
Statutory federal tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	2.4	0.4	(0.5)
Change in unrecognized tax benefits	0.9	(0.1)	(3.7)
Nondeductible health insurer fee (HIF)	17.0	22.9	—
Nondeductible compensation	0.6	(4.1)	9.6
Nondeductible fair value of 1.125% Warrants	—	—	2.4
Other	(0.4)	(0.3)	2.0
Effective tax rate	55.5 %	53.8 %	44.8 %

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our

effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, foreign, and local tax laws.

During 2014, the Internal Revenue Service (IRS) issued final regulations related to compensation deduction limitations applicable to certain health insurance issuers. Pursuant to these final regulations, we reversed amounts treated as nondeductible in 2013 and recognized a tax benefit during 2014.

During 2015, 2014, and 2013, excess tax benefits from share-based compensation amounted to $8 million, $3 million, and $2 million, respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital.

Deferred tax assets and liabilities are classified as non-current. Significant components of our deferred tax assets and liabilities as of December 31, 2015 and 2014 were as follows:

	December 31,	
	2015	2014
	(In millions)	
Accrued expenses	$ 37	$ 13
Reserve liabilities	14	4
Other accrued medical costs	5	4
Net operating losses	7	3
Unrealized losses	2	1
Unearned premiums	21	22
Lease financing obligation	35	34
Deferred compensation	8	10
Tax credit carryover	8	8
Valuation allowance	(9)	(6)
Total deferred income tax assets, net of valuation allowance	128	93
Prepaid expenses	(9)	(6)
Depreciation and amortization	(83)	(57)
Basis in debt	(18)	(15)
Total deferred income tax liabilities	(110)	(78)
Net deferred income tax asset - long term	$ 18	$ 15

At December 31, 2015, we had state net operating loss carryforwards of $180 million, which begin expiring in 2016.

At December 31, 2015, we had California enterprise zone tax credit carryovers of $11 million, which will begin to expire in 2024, and foreign tax credit carryovers of $1 million, which expire in 2025.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2015, $9 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state tax operating loss and foreign tax credit carryforwards. Therefore, we increased our valuation allowance by $3 million, from $6 million at December 31, 2014, to $9 million as of December 31, 2015.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the United States, Puerto Rico, and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Gross unrecognized tax benefits at beginning of period	$ (3)	$ (8)	$ (11)
Increases in tax positions for current year	(1)	—	—
Increases in tax positions for prior years	(5)	(1)	(2)
Decreases in tax positions for prior years	—	—	5
Settlements	—	6	—
Gross unrecognized tax benefits at end of period	$ (9)	$ (3)	$ (8)

The total amount of unrecognized tax benefits at December 31, 2015, 2014 and 2013 that, if recognized, would affect the effective tax rates is $7 million, $2 million and $6 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $1 million due to the normal expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2015, and 2014 were insignificant.

We are under examination by the IRS for calendar year 2011 and may be subject to examination for calendar years 2012 through 2014. We are under examination, or may be subject to examination, in Puerto Rico and certain state and local jurisdictions, with the major state jurisdictions being California, Utah, and Michigan, for the years 2010 through 2014.

15. Stockholders' Equity

Stockholders' equity increased $547 million during the year ended December 31, 2015. The increase was primarily due to the common stock offering described below, net income of $143 million, and $34 million related to share-based compensation transactions.

Common Stock Offering. In June 2015, we completed an underwritten public offering of 5,750,000 shares of our common stock, including the over-allotment option. Net of issuance costs, proceeds from the offering amounted to $373 million, or $64.90 per share, resulting in an increase to additional paid-in capital. We are using the proceeds to finance working capital needs, acquisitions, capital expenditures, and other general corporate activities.

1.125% Warrants. In connection with the 1.125% Notes Call Spread Overlay transaction described in Note 13, "Derivatives," in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Programs. Effective as of December 16, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock or senior notes. This newly authorized repurchase program extends through December 31, 2016.

In February 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. We did not repurchase any shares under this program, which expired December 31, 2015.

Stock Incentive Plans. At December 31, 2015, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan (2011 Plan); and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

The 2011 Plan provides for the award of restricted shares and units, performance shares and units, stock options and stock bonuses to the company’s officers, employees, directors, consultants, advisers, and other service providers. The 2011 Plan provides for the issuance of up to 4.5 million shares of common stock.

Restricted share awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an

exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

In connection with our stock plans, we issued approximately 830,000 shares of common stock, net of shares used to settle employees' income tax obligations, in the year ended December 31, 2015.

The following table illustrates the components of our share-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2015		2014		2013	
	(In millions)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock and performance awards	$ 19	$ 13	$ 19	$ 12	$ 26	$ 23
Employee stock purchase plan and stock options	4	3	3	2	3	2
	$ 23	$ 16	$ 22	$ 14	$ 29	$ 25

As of December 31, 2015, there was $25 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.6 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 6.5% for non-executive employees as of December 31, 2015. As of December 31, 2015, the unrecognized compensation expense related to unvested stock options was insignificant.

Restricted stock. Restricted and performance stock activity for the year ended December 31, 2015 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2014	1,282,072	$ 33.55
Granted - restricted shares	273,710	64.56
Granted - performance shares	162,827	63.90
Vested - restricted shares	(371,489)	34.58
Vested - performance shares	(264,604)	30.80
Forfeited	(47,759)	37.51
Unvested balance as of December 31, 2015	1,034,757	46.68

The total fair value of restricted and performance share awards granted during the years ended December 31, 2015, 2014, and 2013 was $28 million, $25 million, and $33 million, respectively. The total fair value of restricted share awards, including those with performance or market conditions which vested during the years ended December 31, 2015, 2014, and 2013 was $39 million, $24 million, and $22 million, respectively.

In 2015, our named executive officers were granted approximately 163,000 restricted shares with performance and market conditions. The grant date fair value for the awards with market conditions were determined based on a Monte Carlo Simulation which projected Total Stockholder Return (TSR) over the performance period using correlations and volatilities of our ISS peer groups. The weighted-average grant date fair value per share of the 2015 performance awards based on three-year TSR was $49.43, determined using additional inputs as follows: risk-free interest rate of 0.8%, dividend yield of 0%, and expected life of 2.8 years.

As of December 31, 2015, there were approximately 377,000 unvested restricted shares outstanding which contained one or more performance measures. In the event the vesting conditions are not achieved, the awards will lapse. Based on our assessment as of December 31, 2015, we expect the performance conditions relating to approximately 199,000 of these outstanding restricted share awards to be met in full.

In 2015, we reversed approximately $3 million in share-based compensation expense recognized from grant date through March 31, 2015, related to 178,000 of the awards granted in 2014, due to management's determination in the second quarter of 2015 that the achievement of the underlying performance conditions was not probable.

In December 2015, approximately 229,000 restricted stock awards with performance conditions, granted in 2013, vested due to achievement of the total revenue metric as defined in the terms of the grant.

Employee Stock Purchase Plan. Under our employee stock purchase plan (ESPP), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2015, 2014, and 2013, the inputs to this model were as follows: risk-free interest rates of approximately 0.1%; expected volatilities ranging from approximately 30% to 50%, dividend yields of 0%, and an average expected life of 0.5 years. We issued approximately 301,900, 327,200 and 299,600 shares of our common stock under the ESPP during the years ended December 31, 2015, 2014, and 2013, respectively. The 2011 ESPP provides for the issuance of up to three million shares of common stock.

Stock Options. No stock options were granted in 2015 and 2014, and stock options outstanding as of December 31, 2015 were insignificant. The grant date fair value per share of the stock options awarded to the new members of our board of directors during 2013 was $14.67. We estimated the fair value of each stock option award using the Black-Scholes option pricing model, with the following inputs: risk-free interest rate of 1.4%, expected volatility of 41.3%, dividend yield of 0%, and expected life of 7 years. The total intrinsic value of options exercised during the years ended December 31, 2015, 2014, and 2013 was $6 million, $2 million, and $1 million, respectively.

16. Employee Benefits

We sponsor defined contribution 401(k) plans that cover substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plans totaled $27 million, $21 million and $13 million in the years ended December 31, 2015, 2014, and 2013, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

17. Related Party Transactions

Prior to December 22, 2015, we were the lessee under a lease with 6th & Pine Development, LLC (the Landlord) for two office buildings. The principal members of the Landlord were John C. Molina, our chief financial officer and a director of Molina Healthcare, Inc., and his wife. In addition, in connection with the development of the buildings being leased, John C. Molina pledged certain of his common stock holdings in Molina Healthcare, Inc. Dr. J. Mario Molina, our chief executive officer, president and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary. On December 22, 2015, the Landlord assigned the lease to an unrelated third party. There were no significant changes to the lease other than the assignment to the new owner. As a result of the assignment, as of December 31, 2015, amounts previously reported as lease financing obligations - related party were reported in lease financing obligations on the accompanying consolidated balance sheets. For information regarding the lease financing obligation associated with this lease, refer to Note 12, "Debt."

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. J. Mario Molina and John C. Molina. Under the terms of this provider agreement, the California health plan paid Pacific approximately $1 million in each of 2015 and 2014 for medical care provided to health plan members. Payments in 2013 were insignificant.

Refer to Note 18, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

18. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. Beginning in 2014, JMMPC also provided certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2015, JMMPC had total assets of $17 million, and total liabilities of $17 million. As of December 31, 2014, JMMPC had total assets of $31 million, and total liabilities of $31 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

New Markets Tax Credit

In 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC (Wells Fargo), its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC (Investment Fund), and certain of Wells Fargo's affiliated Community Development Entities (CDEs), in connection with our participation in the federal government's New Markets Tax Credit Program (NMTC). The NMTC was established by Congress to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $6 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $16 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $21 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $6 million. Additionally, financing costs incurred in structuring the arrangement amounting to $1 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE—collecting and remitting interest and fees and NMTC compliance—were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $6 million is included in cash at December 31, 2015 and December 31, 2014 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

19. Commitments and Contingencies

Certain Leasing Transactions. As described in Note 12, "Debt," we entered into certain leasing transactions that have been classified as lease financing obligations. Such leases have initial terms that range from 16.5 years to 25 years. Additionally, the leases provide for renewal options ranging from 10 years to 25 years in aggregate.

Operating Leases. We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2025. Facility lease terms generally range from five to 10 years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under all operating leases and lease financing obligations consist of the following approximate amounts:

	Lease Financing Obligations	Operating Leases	Total
		(In millions)	
2016	$ 15	$ 49	$ 64
2017	16	47	63
2018	16	41	57
2019	16	32	48
2020	17	24	41
Thereafter	323	39	362
	$ 403	$ 232	$ 635

Rental expense related to operating leases amounted to $44 million, $32 million, and $25 million for the years ended December 31, 2015, 2014, and 2013, respectively. The amounts reported in "Lease Financing Obligations" above represent our contractual lease commitments for the properties described in Note 12, "Debt" under the subheading "Lease Financing Obligations." Payments under these leases adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income.

Employment Agreements. In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which were amended and restated in 2009. These employment agreements had initial terms of one to three years and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of equity compensation, and a cash payment for health and welfare benefits.

In 2013 we entered into employment agreements with our Chief Operating Officer, Chief Accounting Officer, and Chief Legal Officer. These agreements continue until terminated by us, or the executive resigns. If the executive's employment is terminated by us without cause or the executive resigns for good reason, the executive will be entitled to receive one year's base salary and termination bonus, as defined, full vesting of time-based equity compensation, and a cash payment for health and welfare benefits.

Payment of the severance benefits described above is contingent upon the executive's signing a release agreement waiving claims against us. If the executives are terminated for cause, no further payments are due under the contracts.

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by Relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. The District Court dismissed this action as to Molina without leave to amend as to some allegations and with leave to amend as to other allegations. On October 22, 2015, the Relator filed a third amended complaint. We believe that we have several meritorious defenses to the claims of the Relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Hospital Management Contract. During the fourth quarter of 2015, we recorded a contract settlement charge of approximately $15 million as a result of our termination of a hospital management agreement.

Professional Liability Insurance. We carry medical professional liability insurance for health care services rendered in the primary care institutions that we manage. In addition, we also carry errors and omissions insurance for all Molina entities.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

States' Budgets. From time to time the states in which our health plans operate may delay premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of December 31, 2015, our Illinois health plan served approximately 98,000 members, and recognized premium revenue of approximately $397 million for the year ended December 31, 2015. As of February 23, 2016, Illinois is current with its premium payments.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs including health care-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. Our Puerto Rico health plan became operational on April 1, 2015. As of December 31, 2015, the plan served approximately 348,000 members and recognized premium revenue of approximately $192 million in the fourth quarter of 2015, or approximately $64 million per month. As of February 23, 2016, the Commonwealth continues to pay us weekly for current membership.

It is the practice of the Commonwealth to pay us for eligible members only after those members have been assigned to us, and our plan has sent electronic confirmation of the receipt of eligibility. Particularly in the early stages of our contract with Puerto Rico, the plan's confirmation of eligibility of certain members was not accepted by the Commonwealth as a result of various technical issues. The plan has continued to pay for medical services for all members in question, but the Commonwealth is withholding payment of approximately $12 million of premium revenue related to those members. We believe we have a valid claim to all of the premiums withheld and we are in discussions with the Commonwealth regarding this matter.

It has been our practice in the past, and will remain so in the future, to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,229 million at December 31, 2015, and $859 million at December 31, 2014. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $612 million and $203 million as of December 31, 2015, and 2014, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states in which our health plans operate, except California and Florida, have adopted these rules. California and Florida have not adopted NAIC risk-based capital requirements for HMOs, and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2015, our health plans had aggregate statutory capital and surplus of approximately $1,350 million compared with the required minimum aggregate statutory capital and surplus of approximately $776 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2015. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

20. Segment Information

We have three reportable segments. These segments include our Health Plans and Molina Medicaid Solutions segments, which comprise the vast majority of our operations, and our Other segment. As of December 31, 2015, we changed our reporting structure as a result of the Pathways acquisition in November 2015, which is reported in Other.

Our reportable segments are consistent with how we currently manage the business and view the markets we serve. The Health Plans segment consists of our health plans and our direct delivery business. Our health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides MMIS design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies. Our Other segment includes other businesses, such as our Pathways behavioral health and social services provider, that do not meet the quantitative thresholds for a

reportable segment as defined by U.S. generally accepted accounting principles (GAAP), as well as corporate amounts not allocated to other reportable segments.

The following table presents gross margin as the appropriate earnings measure for our reportable segments, based on how our chief operating decision maker currently reviews results, assesses performance, and allocates resources.

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." Medical margin represents the actual dollars earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue. One of the key metrics used to assess the performance of the Health Plans segment is the medical care ratio; therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue. We previously reported our segment results to the operating income level, where we reported the cost of all centralized services within our most significant segment, the Health Plans segment.

The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies."

	Health Plans	Molina Medicaid Solutions	Other	Consolidated
		(In millions)		
2015				
Total revenue (1)	$ 13,917	$ 195	$ 66	$ 14,178
Gross margin	1,447	55	5	1,507
Depreciation and amortization (2)	95	25	6	126
Goodwill, and intangible assets, net	393	73	175	641
Total assets	4,707	213	1,656	6,576
2014				
Total revenue (1)	9,449	210	8	9,667
Gross margin	947	53	—	1,000
Depreciation and amortization (2)	83	46	5	134
Goodwill, and intangible assets, net	286	75	—	361
Total assets	3,355	185	895	4,435
2013				
Total revenue (1)	6,376	205	8	6,589
Gross margin	799	44	—	843
Depreciation and amortization (2)	60	28	6	94
Goodwill, and intangible assets, net	249	81	—	330
Total assets	1,921	176	891	2,988

(1) Total revenues consists primarily of premium revenue for the Health Plans segment, and service revenue for the Molina Medicaid Solutions and Other segments.

(2) Depreciation and amortization reported in accompanying consolidated statements of cash flows.

The following table reconciles gross margin by segment to consolidated income from continuing operations before income tax expense:

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Gross margin:			
Health Plans	$ 1,447	$ 947	$ 799
Molina Medicaid Solutions	55	53	44
Other	5	—	—
Other operating revenues (1)	684	434	205
Other operating expenses (2)	1,804	1,241	911
Operating income	387	193	137
Other expenses, net	65	58	56
Income from continuing operations before income tax expense	$ 322	$ 135	$ 81

(1) Other operating revenues include premium tax revenue, health insurer fee revenue, investment income and other revenue.

(2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fee expenses and depreciation and amortization.

21. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2015 and 2014.

	For The Quarter Ended			
	March 31, 2015	June 30, 2015	September 30, 2015	December 31, 2015
	(In millions, except per-share data)			
Premium revenue	$ 2,971	$ 3,304	$ 3,377	$ 3,589
Service revenue	52	47	47	107
Operating income	82	116	113	76
Income from continuing operations	28	39	46	30
Net income	28	39	46	30
Net income per share (1):				
Basic	$ 0.58	$ 0.78	$ 0.84	$ 0.54
Diluted	$ 0.56	$ 0.72	$ 0.77	$ 0.52

	For The Quarter Ended			
	March 31, 2014	June 30, 2014	September 30, 2014	December 31, 2014
	(In millions, except per-share data)			
Premium revenue	$ 1,940	$ 2,167	$ 2,317	$ 2,599
Service revenue	54	50	52	54
Operating income	24	32	40	97
Income from continuing operations	4	8	16	34
Net income	4	8	16	34
Net income per share (1):				
Basic	$ 0.10	$ 0.17	$ 0.34	$ 0.70
Diluted	$ 0.09	$ 0.16	$ 0.33	$ 0.69

(1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the year ended December 31, 2014, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

22. Condensed Financial Information of Registrant

The condensed balance sheets as of December 31, 2015 and 2014, and the related condensed statements of income, comprehensive income and cash flows for each of the three years in the period ended December 31, 2015 for our parent company Molina Healthcare, Inc. (the Registrant), are presented below.

Condensed Balance Sheets

	December 31,	
	2015	2014
	(Amounts in millions, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 360	$ 75
Investments	252	126
Income taxes refundable	7	13
Due from affiliates	86	18
Prepaid expenses and other current assets	46	33
Derivative asset	374	—
Total current assets	1,125	265
Property, equipment, and capitalized software, net	267	265
Goodwill and intangible assets, net	61	65
Investments in subsidiaries	2,205	1,377
Deferred income taxes	23	11
Derivative asset	—	329
Advances to related parties and other assets	36	43
	$ 3,717	$ 2,355
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 157	$ 107
Current portion of long-term debt	449	—
Derivative liability	374	—
Total current liabilities	980	107
Senior notes	962	690
Lease financing obligations	198	157
Lease financing obligations - related party	—	40
Derivative liability	—	329
Other long-term liabilities	20	22
Total liabilities	2,160	1,345
Stockholders' equity:		
Common stock, $0.001 par value; 150 shares authorized; outstanding:		
56 shares at December 31, 2015 and 50 shares at December 31, 2014	—	—
Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	803	396
Accumulated other comprehensive loss	(4)	(1)
Retained earnings	758	615
Total stockholders' equity	1,557	1,010
	$ 3,717	$ 2,355

Condensed Statements of Income

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Revenue:			
Management fees and other operating revenue	$ 928	$ 704	$ 599
Investment income	3	2	3
Total revenue	931	706	602
Expenses:			
Medical care costs	55	46	38
General and administrative expenses	797	583	504
Depreciation and amortization	82	73	51
Total operating expenses	934	702	593
Operating (loss) income	(3)	4	9
Interest expense	66	57	51
Other expense	—	1	4
Loss before income taxes and equity in net income of subsidiaries	(69)	(54)	(46)
Income tax benefit	(21)	(27)	(16)
Net loss before equity in net income of subsidiaries	(48)	(27)	(30)
Equity in net income of subsidiaries	191	89	83
Net income	$ 143	$ 62	$ 53

Condensed Statements of Comprehensive Income

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Net income	$ 143	$ 62	$ 53
Other comprehensive income (loss):			
Unrealized investment loss	(5)	—	(1)
Effect of income tax benefit	2	—	—
Other comprehensive loss, net of tax	(3)	—	(1)
Comprehensive income	$ 140	$ 62	$ 52

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2015	2014	2013
	(In millions)		
Operating activities:			
Net cash provided by operating activities	$ 113	$ 74	$ 63
Investing activities:			
Capital contributions to subsidiaries	(770)	(292)	(166)
Dividends received from subsidiaries	142	—	24
Purchases of investments	(244)	(129)	(363)
Proceeds from sales and maturities of investments	118	263	98
Purchases of equipment	(91)	(94)	(77)
Change in amounts due to/from affiliates	(68)	16	(6)
Other, net	—	8	(6)
Net cash used in investing activities	(913)	(228)	(496)
Financing activities:			
Proceeds from senior notes offerings, net of issuance costs	689	123	538
Proceeds from common stock offering, net of issuance costs	373	—	—
Proceeds from sale-leaseback transactions	—	—	159
Purchase of call option	—	—	(149)
Proceeds from issuance of warrants	—	—	75
Treasury stock repurchases	—	—	(53)
Principal payment on term loan of subsidiary	—	—	(47)
Repayment of amount borrowed under credit facility	—	—	(40)
Proceeds from employee stock plans	18	14	9
Principal payments on convertible senior notes	—	(11)	—
Other, net	5	3	2
Net cash provided by financing activities	1,085	129	494
Net increase (decrease) in cash and cash equivalents	285	(25)	61
Cash and cash equivalents at beginning of year	75	100	39
Cash and cash equivalents at end of year	$ 360	$ 75	$ 100

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

The Registrant was incorporated in 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for three other state health plans. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2015, 2014, and 2013 for these services amounted to $914 million, $692 million, and $592 million, respectively, and are included in operating revenue.

During 2013, the Registrant used a portion of the proceeds from the sale of the Molina Center, described in Note 12, "Debt," to repay the remaining principal balance of the related term loan, on behalf of a subsidiary of the Registrant.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Dividends and Capital Contributions

When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries.

For all periods presented, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries, net of insignificant returns of capital.

Note D - Related Party Transactions

The Registrant's related party transactions are described in Note 17, "Related Party Transactions."

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosures

None.

Item 9A. Controls and Procedures

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2015. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework* (2013 framework).

Our management's evaluation did not include an assessment of the effectiveness of internal control over financial reporting at Pathways Health and Community Support LLC (Pathways), which was acquired on November 1, 2015. The total assets and net assets of Pathways included in our consolidated balance sheets at December 31, 2015, were $276 million and $231 million, respectively. Total revenue and net loss of Pathways included in our consolidated results of operations for the year ended December 31, 2015, were $57 million and $4 million, respectively. Our management has not had sufficient time to make an assessment of this subsidiary's internal control over financial reporting.

Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2015, based on the 2013 framework criteria.

Ernst & Young, LLP, the independent registered public accounting firm who audited the Company's Consolidated Financial Statements included in this Form 10-K, has issued a report on the Company's internal control over financial reporting, which is included herein.

Changes in Internal Control over Financial Reporting. There were no changes in the Company's internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2015, that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Pathways Health and Community Support LLC (Pathways), which is included in the 2015 consolidated financial statements of Molina Healthcare, Inc. and constituted $276 million and $231 million of total and net assets, respectively, as of December 31, 2015, and $57 million and $4 million of revenues and net loss, respectively, for the year then ended. Our audit of internal control over financial reporting of Molina Healthcare, Inc. also did not include an evaluation of the internal control over financial reporting of Pathways.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2015 and our report dated February 26, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2016

PART III

Item 10. Directors, Executive Officers, and Corporate Governance

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our definitive proxy statement for our 2016 Annual Meeting of Stockholders. The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Election of Directors," "Corporate Governance," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 11. Executive Compensation

The information required by Items 402, 407(e)(4), and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2015)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)		Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)	
Equity compensation plans approved by security holders	121,711	(1)	$ 25.40	4,058,668	(2)

(1) Options to purchase shares of our common stock issued under the 2002 Equity Incentive Plan and 2011 Equity Incentive Plan. Further grants under the 2002 Equity Incentive Plan have been suspended.

(2) Includes shares remaining available to issue under the 2011 Equity Incentive Plan, and the 2011 Employee Stock Purchase Plan.

The remaining information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Related Party Transactions," "Corporate Governance," and "Director Independence" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Additionally, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 17, "Related Party Transactions," and Note 18, "Variable Interest Entities (VIEs)," under the subheading "Joseph M. Molina M.D., Professional Corporations."

Item 14. Principal Accountant Fees and Services

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Auditor Fees" in our definitive proxy statement for our 2016 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The financial statements included in Item 8 of this Form 10-K, Financial Statements and Supplementary Data, above are filed as part of this annual report.

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 26th day of February, 2016.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina

Joseph M. Molina, M.D. (Dr. J. Mario Molina)
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	February 26, 2016
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	February 26, 2016
/s/ Joseph W. White **Joseph W. White**	Chief Accounting Officer (Principal Accounting Officer)	February 26, 2016
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	February 26, 2016
/s/ Daniel Cooperman **Daniel Cooperman**	Director	February 26, 2016
/s/ Charles Z. Fedak **Charles Z. Fedak**	Director	February 26, 2016
/s/ Steven G. James **Steven G. James**	Director	February 26, 2016
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	February 26, 2016
/s/ Steven J. Orlando **Steven J. Orlando**	Director	February 26, 2016
/s/ Ronna E. Romney **Ronna E. Romney**	Director	February 26, 2016
/s/ Richard M. Schapiro **Richard M. Schapiro**	Director	February 26, 2016
/s/ Dale B. Wolf **Dale B. Wolf**	Director	February 26, 2016

INDEX TO EXHIBITS

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K may contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

Number	Description	Method of Filing
2.1	Membership Interest Purchase Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Healthcare, Inc.	Filed as Exhibit 2.1 to registrant's Form 8-K filed September 8, 2015.
2.2	Amendment to Membership Interest Purchase Agreement, dated as of October 30, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Pathways, LLC, as assignee of all rights and obligations of Molina Healthcare, Inc.	Filed herewith.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Certificate of Amendment to Certificate of Incorporation	Filed as Exhibit 3.1 to registrant’s Form 8-K filed July 24, 2013.
3.3	Third Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 10-Q filed July 30, 2014.
4.1	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.2	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.3	Indenture, dated as of September 5, 2014, by and between Molina Healthcare, Inc. and U.S. Bank National Association	Filed as Exhibit 4.1 to registrant’s Form 8-K filed September 8, 2014.
4.4	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant’s Form 8-K filed September 8, 2014.
4.5	Form of 1.625% Convertible Senior Notes Due 2044 Note Purchase Agreement, dated as of September 11, 2014, by and between Molina Healthcare, Inc. and certain institutional investors	Filed as Exhibit 10.1 to registrant’s Form 8-K filed September 12, 2014.
4.6	First Supplemental Indenture, dated as of September 16, 2014, by and between Molina Healthcare, Inc. and the U.S. Bank National Association	Filed as Exhibit 4.1 to registrant’s Form 8-K filed September 17, 2014.
4.7	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant’s Form 8-K filed September 17, 2014.
4.8	Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee.	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.9	Form of 5.375% Senior Notes due 2022.	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.10	Form of Guarantee pursuant to Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee.	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.

Number	Description	Method of Filing
4.11	Registration Rights Agreement dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and SunTrust Robinson Humphrey, Inc., as representative of the Initial Purchasers (as defined therein).	Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015.
4.12	First Supplemental Indenture, dated February 18, 2016, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as trustee.	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 18, 2016.
*10.1	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
*10.2	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.5 to registrant's Form 10-K filed February 26, 2014.
*10.3	Amendment No. 1 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2014.
*10.4	Amendment No. 2 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.4 to registrant's Form 10-K filed February 26, 2015.
*10.5	2011 Equity Incentive Plan	Filed as Exhibit 10.8 to registrant's Form 10-K filed February 26, 2014.
*10.6	2011 Employee Stock Purchase Plan	Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2015.
*10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
*10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
*10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
*10.10	Form of Stock Option Agreement under Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
*10.11	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.
*10.12	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
*10.13	Employment Agreement with Terry Bayer dated June 14, 2013	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 14, 2013.
*10.14	Employment Agreement with Joseph White dated June 14, 2013	Filed as Exhibit 10.2 to registrant's Form 8-K filed June 14, 2013.
*10.15	Employment Agreement with Jeff Barlow, dated June 14, 2013	Filed as Exhibit 10.3 to registrant's Form 8-K filed June 14, 2013.
*10.16	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
*10.17	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
*10.18	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed as Exhibit 10.16 to registrant's Form 10-K filed February 28, 2013.
10.19	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.20	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
10.21	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.
10.22	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.

Number	Description	Method of Filing
10.23	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.24	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.25	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.26	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.27	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.
10.28	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013.
10.29	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013.
10.30	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013.
10.31	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013.
10.32	Lease Agreement, dated as of February 27, 2013, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.32 to registrant's Form 10-K filed February 28, 2013.
10.33	First Amendment to Office Building Lease, effective as of October 31, 2014, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed November 5, 2014.
10.34	Second Amendment to Office Building Lease, effective as of November 2, 2015, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed November 6, 2015.
10.35	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013.
10.36	Agreement of Purchase and Sale, dated as of June 12, 2013, by and between Molina Healthcare, Inc. and Molina Center, LLC, and AG Net Lease Acquisition Corp.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed July 25, 2013.
10.37	Lease Agreement, dated as of June 13, 2013, by and between AGNL Clinic, L.P., and Molina Healthcare, Inc.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed July 25, 2013.
10.38	Form of Exchange Agreement, dated August 11, 2014, by and between Molina Healthcare, Inc. and certain beneficial owners of Molina Healthcare, Inc.'s 3.75% Convertible Senior Notes due 2014	Filed as Exhibit 10.1 to registrant's Form 8-K filed August 12, 2014.
10.39	Credit Agreement, dated as of June 12, 2015, by and among Molina Healthcare, Inc., Molina Information Systems, LLC, Molina Medical Management, Inc., certain lenders named on the signature pages thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2015.
10.40	Guarantor Joinder Agreement, dated February 18, 2016, by and among the guarantor parties thereto and SunTrust Bank, as Administrative Agent.	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 18, 2016.

Number	Description	Method of Filing
10.41	Purchase Agreement, dated as of February 11, 2013, among Molina Healthcare, Inc. and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Representatives of the Initial Purchasers	Filed as Exhibit 1.1 to registrant's Form 8-K filed February 15, 2013.
10.42	Capitated Medical Group/IPA Provider Services Agreement, effective May 1, 2013, by and between Molina Healthcare of California and Pacific Healthcare IPA.	Filed herewith.
10.43	Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to Molina Healthcare of California Group/IPA Provider Services Agreement(s), effective September 26, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed herewith.
10.44	Capitated Financial Alignment Demonstration Amendment to Molina Healthcare of California Group/IPA Provider Services Agreement, effective as of July 1, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc.	Filed herewith.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
101.INS	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

Exhibit 2.2
Execution Copy

AMENDMENT TO MEMBERSHIP INTEREST PURCHASE AGREEMENT

This Amendment to Membership Interest Purchase Agreement (this "Amendment") is made and entered into as of October 30, 2015, by and among The Providence Service Corporation, a Delaware corporation ("PSC"), Ross Innovative Employment Solutions Corp., a Delaware Corporation ("Ross", and together with PSC, each a "Seller" and together, the "Sellers"), and Molina Pathways, LLC, a Delaware limited liability company ("Buyer") as assignee of all rights and obligations of Molina Healthcare, Inc., a Delaware corporation ("Molina").

WHEREAS, the Sellers and Molina entered into that certain Membership Interest Purchase Agreement (the "Purchase Agreement"), dated as of September 3, 2015;

WHEREAS, pursuant to that certain Assignment and Assumption Agreement, dated as of October 29, 2015, by and between Molina and Buyer, Molina assigned all of its rights and obligations under the Purchase Agreement to Buyer;

WHEREAS, the Sellers and Buyer have agreed, pursuant to Section 10.5 of the Purchase Agreement, to amend the Purchase Agreement as provided in this Amendment; and

WHEREAS, all capitalized terms used but not otherwise defined herein shall have the meanings ascribed to them in the Purchase Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged and incorporating the recitals set forth above, the parties hereto hereby agree as follows:

1. Certain Intercompany Obligations. Notwithstanding anything to the contrary in the Purchase Agreement, no Intercompanies between or among the Acquired Companies arising in the ordinary course of business consistent with past practice on or after October 15, 2015 through the Closing will be taken into account when determining Indebtedness of the Acquired Companies, the Estimated Purchase Price, Purchase Price or Final Purchase Price.

2. Defined Terms: Any reference to the defined term "Real Property Representations" in the Purchase Agreement is hereby amended and restated to read in its entirety as "Real Estate Representations".

3. No Other Amendments: Except as otherwise expressly amended or modified hereby, all of the terms and conditions of the Purchase Agreement shall continue in full force and effect.

4. Entire Agreement: This letter agreement and the Purchase Agreement together superseded any and all oral or written agreements and understandings heretofore made relating to the subject matter hereof and thereof and contain the entire agreement of the parties hereto relating to the subject matter hereof and thereof.

5. Incorporation of Miscellaneous Provisions: This letter agreement shall be subject to the miscellaneous provisions contained in Article 10 of the Purchase Agreement, which are hereby incorporated by reference herein, *mutatis mutandis*.

6. Counterparts: This letter agreement may be executed in two or more counterparts (including by means of facsimile or .pdf signature pages), each of which shall be deemed to constitute an original, but all of which together shall constitute one and the same document.

[*Remainder of Page Intentionally Blank*]

IN WITNESS WHEREOF, each of the parties hereto has caused this Amendment to be duly executed on its behalf as of the day and year first above written.

THE PROVIDENCE SERVICE CORPORATION

By:/s/James M. Lindstrom
Name: James M. Lindstrom
Title: CEO

ROSS INNOVATIVE EMPLOYMENT SOLUTIONS CORP.

By:/s/David Shackelton
Name: David Shackelton
Title: CFO

MOLINA PATHWAYS, LLC

By:/s/Terry Bayer
Name: Terry Bayer
Title: Manager

[Signature Page to Amendment to Membership Interest Purchase Agreement]

MOLINA HEALTHCARE OF CALIFORNIA

CAPITATED MEDICAL GROUP / IPA

PROVIDER SERVICES AGREEMENT

This Capitated Medical Group / IPA ("Agreement") is entered by and between Molina Healthcare of California, a California corporation ("Health Plan"), and **Pacific Healthcare IPA** ("Provider").

RECITALS

A. Health Plan arranges for the provision of certain Health Care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain Health Care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render certain Health Care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

 Provider or authorized representative's initials: FB

ARTICLE ONE - DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B.

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall serve on Health Plan's panel of providers for the products specified in Attachment C. Provider agrees that its practice information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Practice Information includes, but is not limited to, name, address, telephone number, hours of operation, type of practice, and ability to accept new patients. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care.**

a. Provision of Covered Services. Provider shall provide Covered Services to Members, within the scope of Provider's business and practice, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. Standard of Care. Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. Facilities, Equipment, and Personnel. Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this

 Provider or authorized representative's initials: FB

Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. Prior Authorization. If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care.

e. Contracted Providers. Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. Member Eligibility Verification. Provider shall verify eligibility of Members prior to rendering services.

g. Admissions. Provider shall cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

h. Emergency Room Referral. If Provider refers a Member to an emergency room for Covered Services, Provider shall provide notification to Health Plan within twenty-four (24) hours of the referral.

i. Prescriptions. Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

 Provider or authorized representative's initials: FB

j. Subcontract Arrangements. Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services.

k. Availability of Services. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

l. Treatment Alternatives. Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of Covered Services limitations. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.

2.3 **Promotional Activities.** At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) shall cooperate with and participate in all reasonable Health Plan's marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.4 **Nondiscrimination.**

a. Enrollment. Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. Employment. Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping.**

a. Maintaining Member Medical Records. Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. Confidentiality of Member Health Information. Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. HIPAA. To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **National Provider Identification ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider shall obtain an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider shall make best efforts to report its NPI and any subparts to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider shall use its NPI to identify itself on all claims and encounters (both electronic and paper formats) submitted to Health Plan.

e. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan and/or as required to any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services. If Provider is a medical group or IPA, Provider shall accept delegation of utilization management responsibilities from Health Plan at Health Plan's request. If delegation of utilization management responsibilities is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider by the Utilization Payment Reduction Amount specified in Attachment D.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or reassign Members to another provider. If Provider is a medical group or IPA, Provider shall accept delegation of credentialing responsibilities at Health Plan's request and shall cooperate with Health Plan in establishing and maintaining appropriate credentialing mechanisms within Provider's organization. If delegation of credentialing responsibilities to a group or IPA is revoked, Health Plan shall reduce any otherwise applicable payments owing to group or IPA by the Credentialing Reduction Amount specified in Attachment D.

 Provider or authorized representative's initials: FB

e. Provider Manual. Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. Health Education/Training. Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall ensure that Provider promptly delivers to Provider's constituent providers, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Licensure and Standing.**

a. Licensure. Provider warrants and represents that it is appropriately licensed to render health care services within the scope of Provider's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. Unrestricted Status. Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Staffing Privileges for Providers.** Consistent with community standards, every physician Provider shall have staff privileges with at least one Health Plan contracted Hospital as necessary to provide services to members under this Agreement, and shall authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of his/her hospital privileges.

e. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Every physician Provider shall maintain, at a minimum, professional liability insurance with limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate for the policy year and for each physician comprising Provider. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider shall deliver copies of such insurance policies to Health Plan within five business days of a written request by Health Plan.

2.8 **Claims Payment.**

a. **Submitting Claims.** If applicable**,** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored

program requirements, any claims that are not submitted by Provider to Health Plan within ninety (90) days of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor.

b. Compensation. When applicable, Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. Co-payments and Deductibles. Provider is responsible for collection of co-payments and deductibles, if any.

d. Coordination of Benefits. Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.

e. Offset. In the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days notice in which to exercise Provider's appeal rights under this Agreement. As a material

condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

f. Claims Review and Audit. Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

g. Payments which are the Responsibility of a Capitated Provider. Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with another provider contracted with Health Plan; who receives capitation from Health Plan and is responsible for arranging for Covered Services through subcontract arrangements ("Capitated Provider"), Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

2.9 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to state licensing statutes and regulations set forth in Attachment E and all applicable sub-attachments to Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F and all applicable sub-attachments to Attachment F, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.

c. Provider acknowledges that all Covered Services rendered in conjunction with the Medicare program are subject to the Medicare provisions set forth in Attachment H, the effect of which provisions is limited solely to activities and Covered Services related to the Medicare program.

2.10 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another medical group, IPA, or provider without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.11 **Fraud and Abuse Reporting.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall

establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of Health Care Services under the Medi-Cal program. Upon the request of Health Plan and/or the State, Provider shall consult with the appropriate State agency prior to and during the course of any such investigations.

2.12 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2.13 **Reciprocity Agreements.** Provider shall cooperate with Health Plan's Participating Providers and affiliates of Health Plan and agrees to provide Covered Services to Members enrolled in various government sponsored health programs and other health products, and various government sponsored health programs and other health products of affiliates, and to assure reciprocity of health care services. Without limiting the foregoing, if any Member receives services or treatment constituting Covered Services from Provider and a capitated Participating Provider is financially responsible for such services, such Participating Provider shall be solely responsible for compensating Provider for any Covered Services provided by the Provider in accordance with the applicable Payments which are the Responsibility of a Capitated Provider provisions of this Agreement. Payment by the Participating Provider shall be at; (i) the rates agreed by the Participating Provider and Provider, or (ii) if there is no applicable agreement, at the lesser of Provider's billed charges or an amount equivalent to one hundred percent (100%) of the governing rates provided by applicable State and Federal Law specific to the Member's enrolled benefit plan (i.e. Medicaid, Medicare, etc) in place at the time services are rendered, or (iii) at the election of the Participating Provider, at the rates set forth in this Agreement. Provider agrees that the applicable provisions of the Compensation section of this Agreement shall continue to be binding upon Provider, especially in that Provider shall not balance bill Members for any Covered Services. Provider shall comply with the procedures established by Health Plan or its affiliates and this Agreement for reimbursement of such services or treatment. Provider shall not encourage Members to receive Covered Services from non-Participating Providers. Breach of this section shall constitute breach of a material term of the Agreement and will give rise to cause for termination of this Agreement pursuant to the applicable Termination with Cause provisions of this Agreement. Provider shall abide by all

provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

2.14 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider shall forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Plan's or the Member's request to transfer the records.

2.15 **Notification of Network Change.** Where Provider constitutes specialists, is a medical group, IPA, or any other similar entity/organization, Provider shall provide Health Plan and Member with timely written notification in the event a constituent specialty provider terminates its contract with Provider. Said written notification shall be in compliance with all state and federal laws or government sponsored program requirements.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of the Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of both the; (i) medical, and (ii) medically-related scientific and technical, aspects of Health Plan.

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for one year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable provisions set forth in the attachments.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least one hundred and fifty (150) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation

methodology;

f. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

g. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise terminated as a provider by any state or federal health care program;

h. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

i. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.

4.5 **Notice to Members of Termination.** In the event one of the parties to this Agreement provides notification of termination of this Agreement, Health Plan shall provide affected Members with timely written notification, of such termination, prior to the effective date of specialist termination, as required for compliance with any state and federal laws, government sponsored program requirement, or accreditation requirement. Notification to affected members shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f).

ARTICLE FIVE - GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The contract between the state and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend this Agreement

only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules then in effect by a single arbitrator in Los Angeles County; provided, however, that binding arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters. If possible, the arbitrator shall be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor shall the arbitrator have the authority to award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement:

Attachment A – Provider Identification Sheet
Attachment B – Definitions
Attachment C – Products/Programs
Attachment D – Compensation Schedule
Attachment E – Licensing Provisions
Attachment E-1 – Financial Solvency Provisions
Attachment E-2 – Provider Claims Processing Provisions
Attachment F – Medicaid Program Provisions
Attachment F-1 – Emergency Services Provisions
Attachment G – Acknowledgment of Receipt of Provider Manual
Attachment H – Medicare Program Provisions
Attachment I – Disclosure Form
Attachment J – Certificate of Ownership
Attachment K – Matrix of Financial Responsibility
Attachment L – Business Associate Addendum

5.10 **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:
Molina Healthcare of California
200 Oceangate, Suite 100, Long Beach, California, 90802
Attention: President/CEO

If to Provider:
Pacific Healthcare IPA Associates, Inc.

5000 Airport Plaza Drive, Suite 150,Long Beach, CA 90815
Attention: Kathy Hegstrom

The parties may change the names and addresses noted above through written

notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

***** THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK *****

SIGNATURE AUTHORIZATION

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth by Health Plan below. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

Pacific Healthcare IPA **Molina Healthcare of California**

Provider Signature:	/s/ Faustino Bernadett	Molina Signature:	/s/ Teri Lauenstein
Signatory Name (Printed):	Faustino Bernadett, M.D.	Signatory Name (Printed):	Teri Lauenstein
Signatory Title (Printed):	President	Signatory Title (Printed):	Vice President, Network Management & Operations
Signature Date:	3/12/2013	Signature Date:	3/28/13
		Effective Date:	(To be completed by Health Plan) May 1, 2013

ATTACHMENT A

Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

Y Group/IPA (a list of constituent members with their License No., UPIN and DEA numbers is attached and incorporated herein)

Please enter "N/A" for the following if not applicable or not available:

Provider Name	Pacific Healthcare IPA	Billing Address: 5000 Airport Plaza Drive #150, Long Beach, CA 90815
Telephone No.	(562) 766-2000	
Facsimile No.	(562) 766-2008	
Tax I.D. No. (TIN)	20-4396324	
License No.		
NPI	1265785323	Physical Address (if different than above): 5000 Airport Plaza Drive #150, Long Beach, CA 90815
NPI Taxonomy		
DEA No.		

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

/s/ Faustino Bernadett_____
Provider Signature

Faustino Bernadett MD_____
Signatory Name (Printed)

President _____
Signatory Title (Printed)

3/12/2013_____
Signature Date

ATTACHMENT B

Definitions

1. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

2. **Agreement** means this Provider Services Agreement, all Attachments, and incorporated documents or materials.

3. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.

4. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

5. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.

6. **CMS Agreement** means the Medicare Advantage contract between Health Plan and CMS.

7. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.

8. **Credentialing Payment Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event Provider is dedelegated responsibility for credentialing.

9. **Emergency Services** are Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid / Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.

10. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.

11. **Health Plan** means Molina Healthcare of California.

12. **HEDIS Studies** means Health Employer Data and Information Set.

13. **IPA** means Independent Practice Association.

14. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent

with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

15. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

16. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D Services.

17. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

18. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

19. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a Group/IPA or Hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Group/IPA or Hospital. All of said persons are bound by the terms of this Agreement.

20. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

21. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

22. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

23. **Utilization Management Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event that Provider is de-delegated responsibility for utilization management.

ATTACHMENT C

Products/Programs

Provider hereby elects to participate as a panel provider for each of the following Health Plan products as offered and applicable.

N Medi-Cal Geographic Managed Care

N Medi-Cal Two-Plan Model

Y MA-SNP (Molina Medicare Options Plus)

Y CFAD (Medicare Capitated Financial Alignment Demonstration and successor(s))

N Molina Health Benefit Exchange Product

N Other Products - Provider agrees that Health Plan may from time to time add additional products for which provider agrees to participate as a contracted provider

Health Plan shall maintain any applicable benefit and Covered Services descriptions in its Provider Manual.

ATTACHMENT D

Compensation Schedule

Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the reimbursement terms set forth in this Attachment and any applicable sub-attachments referenced hereto and incorporated herein.

ARTICLE ONE – COMPENSATION TERMS

6.1 **Definitions.** The following terms shall have the meanings attributed below for purposes of this attachment. Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Agreement.

a. Capitation Payments are the monthly payments made to Provider on a prepaid basis for Covered Services provided or arranged by Provider under this Agreement. Capitation Payments to Provider shall be made to the Provider by the fifteenth (15th) day of each month. In the event the fifteenth (15th) day of the month is not a business day, the Capitation Payment shall be due and payable on the next business day following the fifteenth (15th) day of the month.

b. Medicare Program Members are the Members enrolled in the following Medicare program(s) as specified in Attachment C and checked below:

Y MA-SNP (Molina Medicare Options Plus))
Y CFAD (Capitated Financial Alignment Demonstration and successor(s)

c. Medicare Program Revenue is the Part A and B Monthly CMS Payment that Health Plan receives from CMS for Medicare Program Members assigned to Provider.

6.2 **Capitation Payment Terms.**

a. Matrix of Financial Responsibility. For each Health Plan program or set of programs (ie. Medicaid Programs, Medicare Programs, etc) that Provider is reimbursed on a Capitation Payment basis, there is an attached Matrix of Financial Responsibility at Attachment K specifying the financial responsibility for Covered Services between Health Plan and Provider.

b. Capitation Payments for Medicare Program Members assigned to Provider shall be made based upon a per Member per month capitation rate.

For Medicare Program Members, Health Plan shall pay provider at thirty-eight percent (38%) of the Medicare Program Revenue per Medicare Program Member per month. Health Plan may amend this Agreement, in accordance with the applicable Amendment section of this Agreement, to modify these Capitation Payments in order to account for any revenue reduction in the applicable government-sponsored program(s) and benefits, if any.

c. **Collection of Copayments.** Provider shall be responsible for the collection of copayments and deductibles (if any) upon rendering Covered Services to Members. Any copayments or deductibles which are stated as a percentage shall be calculated utilizing the fee-for-service rates set forth in the "Non-Capitated Services Submission of Claims/Claims Payment" provisions in this Attachment, applicable to Member's Health Plan program, for such Covered Services. Provider shall not refuse to provide Covered Services in the event a Member is unable to pay their copayment or deductible except as may be specifically permitted in the Provider Manual or as approved in advance by Health Plan.

d. **Coordination of Benefits for Capitated Providers.** Notwithstanding any other provisions of this Agreement, if Provider is reimbursed on a capitated basis and a coordination of benefits occurs, Provider shall not be eligible for additional compensation from Health Plan beyond the applicable Capitation Payments or Non-Capitated Services Submission of Claims/Claims Payments.

e. **Retroactive Adjustments.** Capitation Payments shall be subject to retroactive adjustments due to retroactive changes in the following; (i) for those programs based on a percent of premium capitation payment method, the amounts related to such premium adjustments for each program as demographic (ie. age, gender, hospice, ESRD, part A/B coverage, institutionalized, working aged, Medicaid, etc) and/or risk adjustments (ie. CMS Hierarchical Condition Category "HCC" adjustments), if any, which Health Plan receives in government funding sources for each Member assigned to Provider, and/or (ii) for all capitation payment methods, whether on a per Member per month or percent of premium basis, the retroactive changes in the number of Members assigned to Provider for each program.

f. **Character of Payments.** Capitation Payments to Provider pursuant to this Agreement are for the primary purpose of compensating Provider for the value of Covered Services provided pursuant to this Agreement. Provider shall assure that claims and compensation for Covered Services provided or arranged pursuant to this Agreement are paid from the Capitation Payments from Health Plan to Provider as may be necessary for Provider to satisfy its financial obligations under this Agreement. Health Plan shall have the right, but not the obligation, to pay claims which Provider fails to pay for Covered Services provided to Members. Provider specifically agrees that Health Plan may recover such owed amounts by way of offset or recoupment in accordance with the Offset provisions of this Agreement.

g. **Legislation Regulating Provider Risk.** Provider recognizes that the compensation terms set forth in this Attachment are established in exchange for Provider's provision of Covered Services that are the financial responsibility of Provider, as outlined in the applicable Matrix of Financial Responsibility. In the event that any state or federal law, policy, directive, or government sponsored program requirement requires Health Plan to assume financial risk for certain Covered Services previously assigned to Provider, Health Plan may, without Provider's consent, amend this Agreement to comply. Health Plan will provide Provider with forty-five (45) business days' notice of the change unless a shorter timeframe is necessary for compliance.

   Health Plan will present Provider with its actuarial valuation of the services that will no longer be the financial risk of Provider. Provider will have the opportunity to either present Health Plan with its expense data or an independent actuarial valuation of the same services. If Provider chooses to retain an independent actuary at its expense, the selection of the actuary must be mutually agreeable to both parties. If the independent actuary's findings indicate that the value of the services is less than Health Plan's valuation and if Health Plan and Provider reach mutual agreement on a lower valuation, then an adjustment corresponding to the mutually agreed upon valuation shall be made to the Health Plan's compensation as of the effective date of Health Plan's implementation of the legislation. The negotiated rate will be documented via an amendment of the Agreement by the parties.

h. **Non-Capitated Services Submission of Claims/Claims Payment.** For Clean Claims for Covered Services rendered to Members which are provided

or arranged by Provider, but are (i) Health Plan's financial responsibility under the applicable Matrix of Financial Responsibility, and (ii) are not covered by Capitation Payments (collectively the "Non-Capitated Services"), Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. Health Plan shall then reimburse Provider for such Non-Capitated Services on a fee-for-service basis in accordance with the applicable Claims Payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable fee-for-service rates set forth below less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

(1) Non-Capitated Services Payment Rate for Medicare Program Members. An amount equivalent to one hundred percent (100%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service program payment rates as of the date(s) of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service program as of the date(s) of service, payment shall be at thirty percent (30%) of Provider's billed charges.

(2) Non-Capitated Services Payment Rate for all other Members not otherwise designated above. An amount equivalent to sixty-five percent percent (65%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service program payment rates as of the date(s) of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service program as of the date(s) of service, payment shall be at thirty percent (30%) of Provider's billed charges.

i. Adequacy of Compensation. Provider shall accept payments as provided herein, along with any applicable co-payments, deductibles, and coordination of benefits collections as payment in full for providing or arranging Covered Services under this Agreement. Provider shall not balance bill Members for

any Covered Services.

ARTICLE TWO – REVOCATION OF DELEGATED RESPONSIBILITIES

7.1 **Revocation of Delegated Responsibilities.** If applicable, Health Plan shall reduce any otherwise applicable payments owing to Provider by the amounts specified below in the event delegation of the responsibilities set forth in the applicable Program Participation sections in this Agreement are revoked.

a. Utilization Management Payment Reduction Amount. If delegation of utilization management responsibilities is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider by sixty-five cents ($0.65) per Member per month.

b. Credentialing Payment Reduction Amount. If delegation of credentialing responsibilities is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider by sixty-five cents ($0.65) per Member per month.

ATTACHMENT E

REQUIRED PROVISIONS

(Health Care Service Plans)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

DMHC Provisions

1. In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan.

Provider shall not collect or attempt to collect from a Member or subscriber any sums owed to Provider by the Health Plan. Provider may not and will not maintain any action at law against a Member or subscriber to collect sums owed to the Provider by Health Plan. (Health and Safety Code section 1379)

2. To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system. (Rule 1300.51, J-5)

3. Provider is responsible for coordinating the provision of Health Care Services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))

4. Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))

5. Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))

6. To the extent Provider has any role in rendering Emergency Services, Provider shall make such Emergency Services available and accessible twenty-four (24) hours a day, seven days a week. (Rule 1300.67.2(c))

7. Provider shall participate in Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or inability to maintain Health Plan's access standards. (Rule 1300.67(f))

 Provider or authorized representative's initials: FB

8. Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 of the Health and Safety Code), and the Regulations promulgated hereunder (subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulation that is required to be in this Agreement shall bind the Health Plan whether or not expressly set forth in this Agreement. (Rule 1300.67.4(a)(9))

9. Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Section 1345 of the Health and Safety Code) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code section 1373.96) (Rule 1300.67.4(a)(10))

10. Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f)

11. Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least two years: this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code section 1381) (Rule 1300.67.8(b))

12. Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the

 Provider or authorized representative's initials: FB

financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c))

13. Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services. Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and offsetting the cost of the same against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))

14. Upon Health Plan's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code section 1385)

15. To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)

16. Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Provider Services Department, Molina Medical Centers, Third Floor, One Golden Shore Drive, Long Beach, CA 90802 (800) 526-8196, ext. 1249. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)

17. Provider shall display in each reception and waiting area a notice informing Members how to contact their health plan, file a complaint with their plan, obtain assistance from the DMHC, and seek an independent medical review. (Rule 1300.67.8(f))

18. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68(b))

19. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code section 3040.

20. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend the Provider Manual only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party.

21. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider is not the primary payer under coordination of benefits, Provider may submit claims to Health Plan or Health Plan's capitated provider within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

22. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider denies a claim because it was filed beyond the claim filing deadline, Health Plan will, upon Provider's submission of a provider dispute pursuant to Title 28, California Code of Regulations, section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to California Health & Safety Code section 1371 or 1371.35, whichever is applicable, and the California Code of Regulations.

ATTACHMENT E-1

DMHC Financial Solvency Provisions

This Attachment is required to comply with the financial standards and reporting requirements Rules 1300.75.4 through 1300.75.4.8. References to the term "Rule" identify regulatory citations in Title 28 of the California Code of Regulations.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

I. DEFINITIONS

1.1 **"Cash-to-Claims Ratio"** is Provider's cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by Provider's unpaid claims liability. Unpaid claims liability is claims payable plus incurred but not reported claims ("IBNR").

1.2 **"Contracted Plans"** means all full-service health care service plans as defined in Section 1345(f) of the California Health & Safety Code with which Provider has contracts involving a Risk Arrangement.

1.3 **"Corrective Action Plan" ("CAP")** means a plan reflected in a document containing requirements for correcting and monitoring Provider's efforts to correct any financial solvency deficiencies in the Grading Criteria, financial deficiencies or other claims payment deficiencies, determined through the DMHC's review or audit process, indicating that Provider may lack the capacity to meets its contractual obligations consistent with the requirements of Rule 1300.70(b)(2)(H)(1).

 Provider or authorized representative's initials: FB

1.4 **"DMHC"** means the California Department of Managed Health Care. Whenever the Solvency Regulations reference the Department, that reference includes the DMHC or its External Party.

1.5 **"External Party"** means the DMHC or its designated agent, which may be contracted or appointed to fulfill the functions stated in these Solvency Regulations.

1.6 **"Grading Criteria"** means the four grading/reviewing criteria specified in Health and Safety Code sections 1375.4(b)(1)(A) (i), (ii), (iii), and (iv) and the Cash-to-Claims Ratio as defined above.

1.7 **"Risk Arrangement"** is defined to include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(a) Risk-Sharing Arrangement means any compensation arrangement between Provider and Health Plan under which Provider shares the risk of financial gain or loss with Health Plan.

(b) Risk-Shifting Arrangement means a contractual arrangement between Provider and Health Plan under which Health Plan pays Provider on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by Provider.

1.8 **"Solvency Regulations"** means Rules 1300.75.4 through 1300.75.4.8 .

II. OBLIGATIONS OF HEALTH PLAN

2.1 Monthly Membership Reports. Notwithstanding any different provisions of the Agreement, Health Plan will provide the following information to Provider on a monthly basis for members assigned to Provider, within ten (10) calendar days following the start of each month:

(a) Membership information containing at least the following elements for each member: i) identification number; ii) name; iii) birth date; iv) gender; v) address (including zip code); vi) benefit plan selected; vii) employer group identification (name and number); viii) identity of other third party coverage (if known); ix) dates of enrollment/disenrollment from Provider; x) Provider number; xi) primary care physician selected; xii) primary care physician effective date; xiii) type of change to coverage; xiv) co-payment amounts; xv) deductible (if applicable); xvi) amount of monthly capitation payment.

(b) The following additional information: i) member additions and terminations for the month (including at least: member name, member identification number); ii) number of additional members under each managed care plan; iii) number of terminated members under each managed care plan.

(c) Health Plan shall submit the information from Section 2.1(a) and 2.1(b) to Provider electronically, unless both Health Plan and Provider agree in writing that hard copy reports will be submitted instead.

(d) If the information from Section 2.1(a) and 2.1(b) above is provided to Provider in more than one report, all reports shall be processed by Health Plan on the same date.

(e) Within forty-five (45) calendar days of the close of each calendar quarter, Health Plan shall disclose to Provider a reconciliation of any variances between the reports for information listed in sections 2.1(a) and 2.1(b) above through electronic transmission, or in hard copy if mutually agreed upon by Provider and Health Plan.

2.2 Intentionally Left Blank.

2.3 Intentionally Left Blank.

2.4 Annual Financial Risk Disclosure. On the Agreement anniversary date each year, Health Plan shall disclose to Provider the financial risk assumed under the Agreement by providing to Provider the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under the Agreement:

(a) A matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Provider, a hospital(s) or Health Plan under the Risk Arrangement.

(b) Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

2.5 Annual Disclosure of Capitation Payments. On the Agreement anniversary date each year, Health Plan shall disclose to Provider the amount of capitation payments to be paid per member per month.

2.6 Capitation Deduction Detail. Health Plan shall provide to Provider sufficient details to allow Provider to verify the accuracy and appropriateness of any deductions from capitation payments made by Health Plan including, but not

limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

III. OBLIGATIONS OF MEDICAL GROUP

3.1 Cash-to-Claims Ratio. Provider shall maintain at least the following Cash-to-Claims Ratio:

(a) 0.60 – January 1, 2006 through June 30, 2006

(b) 0.65 – July 1, 2006 through December 31, 2006

(c) 0.75 – January 1, 2007 and thereafter

3.2 Quarterly Financial Survey. No later than forty-five (45) calendar days following the close of each quarter of its fiscal year beginning on or after July 1, 2005, Provider agrees to submit a quarterly financial survey report in an electronic format to the DMHC as required by Rule 1300.41.8 of Title 28 of the California Code of Regulations as set forth below:

(a) The quarterly financial survey report shall include the following if Provider has at least 10,000 covered lives under all Risk Arrangements as of December 31 of the preceding calendar year:

(i) A Financial survey report, (including a balance sheet, an income statement and a statement of cash flows), or comparable financial statements if Provider is a nonprofit entity, and supporting schedule information (including, but not limited to, aging of receivable information), reflecting the results of operations for the immediately preceding quarter, prepared in accordance with Generally Accepted Accounting Principles ("GAAP"). Financial survey reports must be on a combining basis with an affiliate, if Provider or such Provider affiliate is legally or financially responsible for payment of Provider's claims. Any affiliated entity included in this

financial survey report must be separately identified in a combining schedule format. For the purposes of this section, Provider's use: (1) of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay Provider's claims liability.

(ii) A claims report, which includes the percentage of claims that have been timely reimbursed, contested or denied during the quarter by Provider in accordance with the requirements of sections 1371 and 1371.35 of the California Health & Safety Code, Rule 1300.71, and any other applicable state and federal laws and regulations. If less than ninety-five percent (95%) of all complete claims have been reimbursed, contested or denied on a timely basis, the claims report must also describe the reasons why Provider's claims adjudication process is not meeting the requirements of applicable law, any actions taken to correct the deficiency, and any results of the actions. This claims report is for the purpose of monitoring the financial solvency of Provider and is not intended to change or alter existing state and federal laws and regulations relating to claims payment settlement practices and timeliness.

(iii) A statement as to whether or not Provider has estimated and documented, on a monthly basis, its liability for ("IBNR") claims in accordance with Rule 1300.77.2 ("IBNR Statement") and that these estimates are the basis for the quarterly financial survey report submitted to the DMHC. If the estimated and documented liability is not in compliance with Rule 1300.77.2 in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider's failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and records on an accrual accounting basis shall result in Provider's failure to maintain, at all times, positive tangible net equity ("TNE") and positive working capital as set forth in section 3.2(a)(iv) below.

(iv) A statement as to whether or not Provider has maintained at all times throughout the quarter (1) a positive TNE as defined in Rule 1300.76(e) and (2) a positive level of working capital, calculated according to GAAP ("TNE/Working Capital Statement"). If either the required TNE or the required working capital has not been maintained at all times, a statement must be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider may reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital and Cash-to-Claim Ratio in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B) so long as the sponsoring organization has filed with the DMHC: (1) its audited annual financial statements within one hundred twenty (120) calendar days of the end of the sponsoring organization's fiscal year and (2) a copy of the written guarantee meeting the requirements of Health and Safety Code Rule 1375.4(b)(1)(B). For purposes of the Health and Safety Code Rule 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or TNE in a lesser amount approved by the DMHC, in situations where Provider can demonstrate to the DMHC's satisfaction that a lesser amount of TNE is sufficient. If Provider has a sponsoring organization, Provider shall provide a statement demonstrating the capacity of the sponsoring organization to guarantee Provider's debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code Section 1375.4(b)(1)(B).

(v) For the quarter beginning on or after January 1, 2006, a statement as to whether or not Provider has, at all times during the quarter, maintained a Cash-to-Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

 Provider or authorized representative's initials: FB

(b) The quarterly financial survey report shall include the following if Provider has fewer than 10,000 covered lives under all Risk Arrangements as of December 31 of the preceding calendar year:

(i) The disclosure statements set forth in sections 3.2(a)(ii),(iii), (iv) and (v) above.

(ii) In the event Provider serves fewer than 10,000 covered lives under all Risk Arrangements and it: (i) fails to satisfactorily demonstrate its compliance with the Grading Criteria; (ii) experiences an event that materially alters its ability to remain compliant with the Grading Criteria; (iii) is found, by the DMHC's (or the DMHC's designee's) review or audit activities, to potentially lack sufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of Rule 1300.70(b)(2)(H)(1); or (iv) is found, through the DMHC's HMO Help Center, medical audits and surveys, or any other source, to be delaying referrals, authorizations, or access to basic health care services based on financial considerations, Provider shall, within thirty (30) calendar days of the DMHC's written request, begin submitting all quarterly financial survey reports set forth in sections 3.2(a) above.

3.3 Annual Financial Survey. Provider agrees to submit to the DMHC on a yearly basis, not more than one hundred fifty (150) calendar days after the close of Provider's fiscal year beginning on or after January 1, 2005, annual financial survey reports, in an electronic format determined by the DMHC as required by Rule 1300.41.8, based upon Provider's annual audited financial statement prepared in accordance with generally accepted auditing standards and containing all of the following:

(a) An annual financial survey report, based upon Provider's annual audited financial statements, (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures) or comparable financial statements if Provider is a nonprofit entity, and supporting schedule information, (including, but not limited to, aging of receivable information

and debt maturity information) for the immediately preceding fiscal year, prepared by an independent certified public accountant in accordance with GAAP. For the purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16 of the California Code of Regulations) shall apply.

(b) The financial survey reports of Provider shall be on a combining basis with an affiliate if Provider or such affiliate is legally or financially responsible for the payment of Provider's claims. Any affiliated entity included in the report shall be separately identified. Provider's use of: (1) a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital or (2) an affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay Provider's claims liability. When combined financial statements are required, the independent accountant's report or opinion must address all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, Provider shall also file the report or opinion issued by the other auditor.

(c) Opinion of an independent certified public accountant indicating whether Provider's annual audited statements present fairly, in all material respects, the financial position of Provider and whether the financial statements were prepared in accordance with GAAP. If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.

(d) An IBNR Statement consistent with the requirements outlined in section 3.2(a)(iii) of this Amendment. If the estimated and documented liability is not in compliance with Rule 1300.77.2 in any way, the IBNR Statement shall describe in detail for each deficiency the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider's failure to: (1) estimate and document, on a monthly basis, its liability for IBNR claims or (2) maintain its books and

records on an accrual accounting basis shall result in Provider's failure to maintain, at all times, positive tangible net equity ("TNE") and positive working capital as set forth in section 3.3(e) below.

(e) A TNE/Working Capital Statement consistent with the TNE reporting requirements as outlined in Section 3.2(a)(iv) of this Amendment. If either the required TNE or the required working capital has not been maintained at all times, the TNE/Working Capital Statement shall describe in detail the nature of the deficiency, the reasons for the deficiency, any actions taken to correct the deficiency, and any results of those actions. Provider may reduce its liabilities for purposes of calculating its TNE and working capital in a manner as required by Rule 1300.41.8 and as outlined in section 3.2(a)(iv) of this Amendment.

(f) For fiscal years beginning on or after January 1, 2006, a statement as to whether or not Provider has at all times during the year maintained a Cash-to Claims Ratio as required in section 3.1 above, calculated in a manner consistent with GAAP. If the required Cash-to-Claims Ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(g) A statement as to whether Provider maintains reinsurance and/or professional stop-loss coverage.

(h) A copy of Provider's complete annual audited financial statement, including footnotes and the certificate or opinion of the independent certified public accountant.

3.4 Annual Statement of Organization Survey. Provider shall submit to the DMHC a "Statement of Organization," in an electronic format determined by the DMHC to be filed with Provider's annual financial survey report. Such Statement of

Organization shall include the following information as of December 31 of each calendar year prior to the filing:

(a) Name and address of Provider;

(b) Financial and public contact person, with title, address, telephone, fax and e-mail address;

(c) A list of all health plans with which Provider has Risk Arrangements;

(d) Type of Provider: Independent Practice Association (IPA), Medical Group, Foundation or other entity, or some combination. If Provider is a foundation, identify each and every medical group within the foundation and whether any of those medical groups independently qualifies as a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g).

(e) Corporate status: professional corporation, partnership, not-for-profit corporation, sole proprietor or other form of business;

(f) The name, address and principal officer of each of Provider's affiliates as defined in Rule 1300.45(c)(1) and (2);

(g) Whether Provider is partially or wholly owned by a hospital or hospital system;

(h) A matrix listing all major categories of medical care offered by Provider, including but not limited to anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology, and radiology, and next

 Provider or authorized representative's initials: FB

to each listed category in the matrix a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by Provider to compensate the majority of providers of that category of care;

(i) An approximation of the number of enrollees served by Provider through Risk Arrangements, pursuant to a list of ranges developed by the DMHC;

(j) The name of any Management Services Organization ("MSO") that Provider contracts with for administrative services;

(k) Total number of contracted physicians in employment and/or contractual arrangements with Provider;

(l) Disclosure by California county or counties of Provider's primary service area (excluding out-of-area tertiary facilities and providers);

(m) Provider's address, telephone number and website link, if available, where providers may access written information and instructions for filing of provider disputes with Provider's dispute resolution mechanism consistent with requirements of Rule 1300.71.38;

(n) Any other information which the DMHC deems reasonable and necessary, as permitted by law, to understand the operational structure and finances of Provider.

3.5 Attestation. Provider shall submit a written verification for each report made under Sections 3.2, 3.3, and 3.4 of this Amendment stating that the report is true and correct to the best knowledge and belief of a principal officer of Provider, and signed by a principal officer, as defined by Rule 1300.45(o).

3.6 Notification to DMHC & Health Plan. Provider agrees to notify the DMHC and Health Plan no later than five (5) business days from discovering that Provider has experienced any event that materially alters its financial situation or threatens its solvency.

3.7 DMHC Evaluation of Provider. Provider shall:

(a) Permit the DMHC to make any examination that it deems reasonable and necessary to implement section 1375.4 of the Health and Safety Code, and provide to the DMHC for inspection and copying, upon request, any books or records that the DMHC deems relevant or useful in such examination, as permitted by law.

(b) Comply with the DMHC's review and audit process that is used to determine Provider's compliance with the Grading Criteria.

(c) Permit the DMHC to obtain and evaluate supplemental financial information pertaining to Provider when:

(i) Provider fails to satisfactorily demonstrate its compliance with the Grading Criteria;

(ii) Provider experiences an event that materially alters its ability to remain compliant with the Grading Criteria;

(ii) The External Party's review or audit process indicates that Provider may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of Rules 1300.70(b)(2)(H)(1);

(iv) The DMHC receives information from complaints submitted to the HMO Help Center, Health Plan reporting, medical audits and surveys or any other source that indicates Provider may be delaying referrals or authorizations or failing to meet access standards for basic health care services based on financial considerations.

IV. OBLIGATIONS OF MEDICAL GROUP & HEALTH PLAN

4.1 Corrective Action Plans. Provider and Health Plan shall comply with the DMHC's Corrective Action Plan ("CAP") process as set forth below.

(a) Beginning with the financial survey submission filed for the third quarter of calendar year 2005, in the event Provider has deficiencies in any of the Grading Criteria, it shall simultaneously submit a self-initiated CAP proposal, in an electronic format developed by the DMHC, to the DMHC and Health Plan that meets the following requirements:

(i) Identifies the Grading Criteria that Provider has failed to meet;

(ii) Identifies the amount by which Provider has failed to meet the Grading Criteria;

(ii) Identifies Health Plan and other Contracted Plans, including the identification of the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at Health Plan and each Contracted Plan for monitoring compliance with the CAP;

(iv) Describes the specific actions Provider has taken or will take to correct the identified deficiencies, including any written representations made by Health Plan and/or other Contracted Plans to assist Provider in the implementation of its CAP. The actions shall be appropriate and reasonable in scope and breadth depending upon the nature and degree of the deficiency, and acceptable to the DMHC;

(v) Describes the timeframe for completing the corrective action and specifies a schedule for submitting progress reports to the DMHC, Health Plan and all other Contracted Plans. All corrective actions must be completed within the following timeframes, unless an extension is approved in writing by the DMHC:

(A) Timeframes for correcting working capital deficiencies shall not exceed 12 months;

(B) Timeframes for correcting TNE deficiencies shall not exceed 12 months;

(C) Timeframes for correcting IBNR deficiencies shall not exceed three (3) months;

(D) Timeframes for correcting claims timeliness deficiencies shall not exceed six (6) months;

(E) Timeframes for correcting cash-to-claims ratio deficiencies shall not exceed twelve (12) months.

(vi) Identifies the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at Provider for ensuring compliance with the CAP;

(vii) Describes:

(A) Provider's patient record retention and storage policies;

(B) The procedures and the steps Provider will take to ensure that patient medical records are appropriately stored and maintained;

(C) The procedures and the steps Provider will take to ensure that patient medical records will be readily available and transferable to patients in the event Provider ceases operations or Provider fails to meet its obligations set forth in the CAP. At a minimum, Provider's patient medical records policies and procedures shall be consistent with existing laws relating to the responsibilities for the preservation and maintenance of medical records and the protection of the confidentiality of medical information.

(b) Notwithstanding section 4.1(a) above, Provider shall not be required to submit a CAP if Provider proactively demonstrates to the DMHC's written satisfaction that necessary and prudent capital investments have or may cause a temporary deficiency in Provider's TNE, working capital or Cash-to-Claims Ratios and that Provider has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in its claim payment timeliness.

(c) To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of Health Plan and all other Contracted Plans.

(d) The self-initiated CAP shall be considered a final CAP, subject to the DMHC's approval process as set forth in section 4.1(j) below, unless, within fifteen (15) calendar days of the receipt of Provider's self-initiated CAP proposal, Health Plan or another Contracted Plan provides written notice to the DMHC and Provider stating the reason for its objections and recommendations for revisions,

(e) In the event that Health Plan or another Contracted Plan files a written objection with the DMHC and Provider, Provider shall within twenty (20) calendar days: (1) implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by Health Plan or another Contracted Plan; and (2) submit to Health Plan, all other Contracted Plans and the DMHC a revised CAP proposal that addresses the concerns raised by the objecting Contracted Plan(s), including Health Plan. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of Health Plan and all other Contracted Plans.

(f) Health Plan shall have ten (10) calendar days to submit to Provider and the DMHC its objections and recommended revisions, in an electronic format determined by the DMHC, to the self-initiated revised CAP proposal.

(g) Within fifteen (15) calendar days of receipt of Health Plan's or any other Contracted Plan's objections and recommended revisions to the revised CAP proposal, the DMHC shall schedule a meeting ("CAP Settlement Conference") with Provider, Health Plan and all other Contracted Plans to discuss and reconcile the differences.

(h) Within seven (7) calendar days of the CAP Settlement Conference, Provider shall submit a final self-initiated CAP proposal to Health Plan and the DMHC.

(i) Within ten (10) calendar days of receipt of Provider's final self-initiated CAP proposal, the External Party shall submit its recommendation to the DMHC to approve, disapprove or modify Provider's final self-initiated CAP proposal.

(j) Within ten (10) calendar days of receipt of the External Party's recommendation, the DMHC shall approve, disapprove or modify Provider's final self-initiated CAP proposal, which shall then become the final CAP. If the DMHC does not act upon the recommendations of the External Party within ten (10) calendar days, the External Party's recommendation shall be deemed approved.

(k) A final CAP shall remain in effect until Provider demonstrates compliance with the requirements of the CAP, or the CAP expires in accordance with its own terms.

(l) In addition to the CAP requirements specified in section 4.1(a) above, the DMHC may direct Provider to initiate a CAP whenever it determines that Provider has experienced an event that materially alters its ability to remain compliant with the Grading Criteria or when the DMHC's review process indicates that Provider may lack sufficient financial capacity to meet its contractual obligations consistent with the requirements of Rule 1300.70(b)(2)(11)(1).

(m) Provider shall submit to the DMHC and Health Plan each periodic progress report prepared pursuant to a final CAP, and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of Provider, as defined by Rule 1300.45(o) of Title 28 California Code of Regulations.

(n) Provider shall advise Health Plan and the DMHC in writing within five (5) calendar days if Provider experiences an event that materially alters Provider's ability to remain compliant with the requirements of a final CAP.

(o) Upon request from the DMHC, Provider shall provide additional documentation to the DMHC and Health Plan to demonstrate Provider's progress towards fulfilling the requirements of a CAP.

(p) All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the DMHC shall be received and maintained on a confidential basis by Health Plan and shall not be disclosed, except as allowed or required under this Amendment.

ATTACHMENT E-2

DMHC Provider Claims Processing Provisions

This Attachment is required to comply with the claims payment and processing requirements. In processing claims, Provider shall comply with Title 42 U.S.C. Section 1396u-2(f) and Health and Safety Code Sections 1371 through 1371.8. Unless otherwise stated, references to the term “Rule” identify regulatory citations in Title 28 of the California Code of Regulations.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

(1) Provider shall accept and adjudicate claims for health care services provided to plan enrollees in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and Rules 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

(2) Provider shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and Rules 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

(3) Provider shall submit a Quarterly Claims Payment Performance Report (“Quarterly Claims Report") to Health Plan within thirty (30) days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Provider's compliance status with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and Rules 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

Provider shall include in its Quarterly Claims Report a tabulated record of each provider dispute it received, categorized by date of receipt, and including the identification of the provider, type of dispute, disposition, and working days to resolution, as to each provider dispute received. Each individual dispute contained in a Provider's bundled notice of provider dispute shall be reported separately to the Heath Plan

The Quarterly Claims Report be signed by and include the written verification of a principal officer, as defined by Rule 1300.45(o), of Provider, stating that the report is true and correct to the best knowledge and belief of the principal officer.

(4) Provider shall make available to Health Plan and the DMHC all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.

(5) Any provider that submits a claim dispute to Provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to Health Plan's dispute resolution process for a de novo review and resolution for a period of 60 working days from Provider's Date of Determination, pursuant to the provisions of Rule 1300.71.38(a)(4).

(6) In the event Provider fails to timely and accurately reimburse its claims (including the payment of interest and penalties), Health Plan and Provider shall attempt to establish an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code. Health Plan shall have the authority to assume processing and timely reimbursement of Provider’s claims while the parties are attempting to establish a corrective action plan. In the event Health Plan and Provider fail to agree upon an approved corrective action plan or if Provider fails to comply with the corrective action plan, Health Plan shall have the authority to assume responsibility for the processing and timely reimbursement of Provider’s claims. Health Plan shall recover any such amounts paid by way of offset or recoupment from current or future amounts due Provider.

(7) In the event Provider fails to timely resolve its provider disputes including the issuance of a written decision, Health Plan and Provider shall attempt to establish an approved corrective action plan consistent with section 1375.4(b)(4) of the Health and Safety Code. Health Plan shall have the authority to assume responsibility for the administration of the Provider's dispute resolution mechanism(s) and for the timely resolution of provider disputes while the parties are attempting to establish a corrective action plan. In the event Health Plan and Provider fail to agree upon an approved corrective action plan or if Provider fails to comply with the corrective action plan, Health Plan shall have the authority to assume responsibility for the administration of the Provider's dispute resolution mechanism(s) and for the timely resolution of provider disputes.

ATTACHMENT F [Not Applicable]

DHCS Provisions

The following provisions apply exclusively to Covered Services provided and activities engaged in pursuant to Medicaid Program:

1. All Medicaid covered services are set forth in Attachment C and the Provider Manual as set forth in this Agreement. (Rule 53250(c)(1))

2. This Agreement shall be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Health Plan. (Rule 53250(c)(2))

3. This Agreement shall become effective upon approval by the Department of Health Care Services ("DHCS") in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within 60 days of receipt. (Rule 53250(c)(3))

4. Amendments to this Agreement shall be submitted to the DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the Amendment, whichever is later. (Rule 53250(c)(3))

5. Provider agrees to submit all reports required and requested by Health Plan, in a form acceptable to Health Plan. (Rule 53250(c)(5))

6. Provider shall make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:

   a. By the DHCS, the United States Department of Health and Human Services, the DMHC, and the Department of Justice;

   b. At all reasonable times, at Provider's place of business or at such other mutually agreeable location in California;

   c. In a form maintained in accordance with the general standards applicable to such book or record keeping;

   d. For a term of at least five years from the close of the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created;

   e. Including all encounter data for a period of at least five years. (Rule 53250(e)(1))

7. Provider agrees to notify the DHCS in the event that this Agreement is amended or terminated. Notice to the DHCS shall be considered given when properly addressed and deposited in the United States Postal Service as First Class Registered Mail, postage attached. (Rule 53250(e)(4))

8. Provider shall maintain and make available to the DHCS, upon request, copies of all subcontracts and shall ensure that all subcontracts are in writing and require that subcontractors:

a. Make all applicable books and records available at all reasonable times for inspection, examining or copying by the DHCS, the U.S. Department of Health and Human Services, the DMHC, and the Department of Justice;

b. Retain such books and records for a term of at least five years from the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created. (Rule 53250(e)(3))

9. Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. (Rule 53250(e)(5))

10. Provider agrees to hold harmless both the State of California and Health Plan members in the event that Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. (Rule 53250(e)(6))

11. Provider shall assist Health Plan in the transfer of care in the event Health Plan's Two-Plan Model Contract with the DHCS expires or terminates. Providers shall assist Health Plan in the transfer and care in the event this Agreement expires or terminates for any reason.

12. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers' compensation. Provider shall report to the DHCS within ten (10) days after discovery any circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation award. (Rule 53222(b))

13. Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider, if any, and major creditors holding more than five percent (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (W&I Code section 14452(a))

14. Provider acknowledges that Health Plan bears significant risk by assuming financial responsibility for all in-patient hospitalization expenditures, including expenditures for services connected with the period of hospitalization. (Rule 53251(c) & (e))

15. Non-Discrimination Clause.

a. During the performance of this Agreement, Provider and Provider's subcontractors will not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and denial of family care leave. Provider and Provider's subcontractors will ensure the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. Provider and Provider's subcontractors will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et. seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990(a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and Provider's subcontractors as the case may require will give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

b. Provider shall permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

16. Provider agrees to arrange for the provision of interpreter services for Members at all provider sites.

17. Nothing in this Agreement shall be interpreted in any manner to terminate or diminish Health Plan's independent obligations to the State of California under one or more of its contracts with the Department of Health Care Services.

18. Provider shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, California Code of Regulations, Division 1, Chapter 9, commencing with Section 37000. Provider shall document and appropriately follow up on blood lead screening test results.

Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's Medical Record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent(s) or guardian shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Members Medical Record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement.

19. Provider shall provide Health Plan with the Disclosure Statement set forth in Title 22, California Code of Regulations Section 51000.35 prior to commencing services under this Agreement

20. Upon request by DHCS, Provider shall timely gather, preserve and provide to DSHS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any

litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan's contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms specified in Health Plan's contract with DHCS.

ATTACHMENT F-1 [Not Applicable]

DHCS Provisions

The following provisions apply exclusively to Covered Services provided and activities engaged in pursuant to Medicaid Program, and those Providers that have assumed financial obligations for certain Emergency Services:

Non-Contracting Emergency Service Providers

Provider shall cover Emergency Services in accordance with the requirements of Title 22, CCR, Section 53855 and 53912.5 including the following:

A. Provider shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary services rendered to a Member until the Member's condition has stabilized sufficiently to permit discharge, or referral and transfer in accordance with instructions from Health Plan. Emergency Services shall not be subject to Prior Authorization by Provider or Health Plan. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. Emergency Services shall not be subject to Prior Authorization by Provider.

B. At a minimum, Provider must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

C. For all other non-contracting providers, reimbursement by Provider for properly documented claims for services rendered by a non-contracting provider pursuant to this provision shall be the lower of the following rates applicable at the time the services were rendered by the non-contracting provider:

1) The usual charges made to the general public by the non-contracting provider.

2) The maximum Fee-For-Service rates for similar services under the Medi-Cal program.

3) The rate agreed to by Provider and the non-contracting provider.

D. Provider shall not refuse to cover reimbursement for Emergency Services rendered by a non-contracting provider based on the emergency room provider, hospital, or fiscal agent not notifying the Member's Primary Care Physician or Provider of the Member's screening and treatment within 10 calendar days of presentation for emergency. Provider shall not limit what constitutes an emergency medical condition solely on the basis of lists of diagnoses or symptoms.

E. In accordance with California Code of Regulations, Title 28, Section 1300.71.4, Provider shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a Member within 30 minutes of the request. If Provider fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approve. Provider is financially responsible for post-stabilization service payment as provided by subprovision C above.

F. Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California 95814 for resolution under the provisions of Welfare and Institutions Code Section 14454 and California Code of Regulations, Title 22, Section

53620et. eq., except Section 53698. Provider agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Provider is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof or reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and California Code of Regulations, Title 22, section 53702.

ATTACHMENT G

Acknowledgement of Receipt of Provider Manual

Provider hereby acknowledges receipt of Health Plan's Provider Manual.

Date of receipt: 3/8/2013_____

Initials of authorized
representative of Provider: KH

 Provider or authorized
representative's initials: FB

ATTACHMENT H

MEDICARE PROGRAM REQUIREMENTS---HEALTH CARE SERVICES

This Attachment H sets forth Medicare program requirements that are hereby incorporated into contracts and/or agreements with Providers covering the provision of health care services. The Agreement and this attachment shall be automatically modified to conform to subsequent amendments to Medicare program requirements. In the event of any inconsistency between the terms of this attachment and the Agreement, the terms of this attachment shall control.

1. **Downstream Compliance**. Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare enrollees to agree in writing to all of the terms provided herein.

2. **Right to Audit**. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii)).

3. **Confidentiality**. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

4. **Hold Harmless/Cost Sharing.** Provider agrees it may not under any circumstances, including nonpayment of moneys due the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the

Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. Members who are dually eligible for Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii)).

5. **Delegation**. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment H-1. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).

6. **Prompt Payment**. Health Plan and Provider agree that Health Plan shall pay all clean claims for services that are covered by Medicare within sixty (60) days of the date such claim is delivered by Provider to Health Plan and Health Plan determines such claim is complete/clean. Any claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor. Health Plan reserves the right to deny any claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b)).

7. **Reporting.** Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8)).

8. **Accountability**. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment H-1. (42 CFR 422.504(i)(3)(ii)).

9. **Compliance with Medicare Laws and Regulations**. Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

10. **Benefit Continuation.** Provider agrees to provide for continuation of enrollee health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Molina for Medicare services; and (ii) for Members who are hospitalized on the date Molina's contract with CMS terminates, or, in the event of an insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 422.504(g)(2)(ii) and 422.504(g)(3).

ATTACHMENT H-1

Medicare Program Requirements---Delegated Services

This Attachment H-1 sets forth Medicare program requirements that are hereby incorporated into contracts and/or agreements that delegate to Provider responsibility for any management or administrative services. The Agreement and this attachment shall be automatically modified to conform to subsequent amendments to Medicare program requirements. In the event of any inconsistency between the terms of this attachment and the Agreement, the terms of this attachment shall control.

1. **Downstream Compliance.** Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare enrollees to agree in writing to all of the terms provided herein.

2. **Medicare Compliance**. Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).

3. **Confidentiality**. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

4. **Right to Audit**. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii)).

5. **Responsibilities and Reporting Arrangements.** The Agreement specifies the delegated activities and reporting responsibilities. To the extent applicable, Provider shall support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data . (42 CFR 504(a)(8)).

6. **Revocation of Delegated Activities**. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. (42 CFR 422.504(i)(4)(ii)).

7. **Accountability** Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 422.504(i)(3)(iii)).

8. **Credentialing.** If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (422.504(i)(4) and 422.504(i)(5)).

9. **Monitoring.** Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contractual obligations. Health Plan shall monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 422.504(i)(4)).

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10. **Further Requirements.** Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5)).

ATTACHMENT I

DISCLOSURE FORM

(Welfare and Institutions Code Section 14452 (a))

Name of Subcontractor: **Pacific Healthcare IPA**

The undersigned hereby certifies that the following information regarding **Pacific Healthcare IPA** (the "Organization") is true and correct as of the date set forth below.

---

1. Officers/Directors General Partners:
Faustino Bernadett, Jr. MD, Robert Lugliani, MD

---

2. Co-Owner(s):
See #1

---

3. Stockholders owning more than ten percent (10%) of the stock of the Organization:
See #1

---

4. Major creditors holding more than five percent (5%) of Organization's debt:
N/A

---

5. Form of Organization (Corporation, Partnership, Sole Proprietorship, Individual):
corporation

---

6. If not already disclosed above, is Organization, either directly or indirectly, related to or affiliated with the Contracting Health Plan? Explain:

Date: 3/12/2013 By: Faustino Bernadett

Print Name: Faustino Bernadett, MD

Title: President

ATTACHMENT J

CERTIFICATE OF OWNERSHIP

I, Faustino Bernadett, MD, an authorized representative of Pacific Healthcare, IPA, do certify that, to the best of my knowledge, the individuals or entities listed below have a five percent or more ownership, direct or indirect, or control interest in the aforementioned entity as defined under 42 U.S. C. Section 1320 a 3 (2). This form is to be submitted annually to the organization contracting with the Managed Risk Medical Insurance Board for the Healthy Families Program and/or Access to Infants and Mothers Program.

Name of Individual/Entity	Employer Identification Number	Social Security Number
Faustino Bernadett, MD		
Robert Lugliani, MD		

- No one is listed because there are no individuals or entities with a five (5%) percent or more interest
- No one is listed because the plan is under government ownership.
- No one is listed because the provider of services is a non-profit, public benefit corporation for which there are no outside controlling interests.

Faustino Bernadett_____ 3/12/2013_____
Signature of Authorized Representative and Title Date

ATTACHMENT K

Matrix of Financial Responsibility

The following matrices outlines the division of financial responsibility between Health Plan and Provider ("Matrix of Financial Responsibility"), the intent being to clarify Covered Services categories in order to provide for accurate administration of this Agreement. For services not specifically listed, each matrix serves as a model under which broad service categories suggest the appropriate financial responsibility. The applicable provisions and attachments of this Agreement, including Health Plan's Provider Manual, should be consulted for an accurate and complete description of Covered Services. Member benefit information and eligibility shall be verified by Provider prior to the provision of any services. The following matrices are included in this Agreement, referenced hereto and incorporated herein:

Attachment K-1 (MA-SNP & CFAD)

ATTACHMENT K-1

Matrix of Financial Responsibility

MA-SNP (Molina Medicare Options Plus) Program

CFAD (Capitated Financial Alignment Demonstration and successor(s))

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Abortion			X
Acupuncture	Not covered under Medicare or Medi-Cal		
Allergy Testing (including serum)	X		
Alpha-fetoprotein Test			X
Ambulance, Air or Ground (Emergency Services) In Area Out-of-Area	 X X		
Ambulance, Air or Ground (Non-Emergency, Facility to Facility) In Area Out-of-Area		 X X	
Amniocentesis Facility Component Professional Component	 X X		
Anesthetics, Administration of Inpatient Outpatient	 X X		
Blood and Blood Products		X	
Blood Donations		X	
Blood Donations, Autologous (when Medically Necessary)		X	

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Cancer Drugs and Administration of the Drug		X	
Inpatient Facility Component and Drugs	X X		
Inpatient Professional Component	X		
Physician's office	X		
Outpatient Facility Component		X	
Outpatient Professional Component			
Oral taken by patient			
Caregiver Relief: Assist with Member bathing, feeding, dressing and other needs		X	
Chemical Dependency (Acute Inpatient Overdose Treatment)			
Inpatient Facility Component		X	
Inpatient Professional Component		X	
Chemical Dependency – Detoxification & Rehabilitation (Outpatient Treatment			
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Child Health and Disability Prevention Services (CHDP)			X
California Children Services (CCS)			X
Chiropractic Care	X		
Clinical Trials 3 (when a Medicare covered benefit)		X	
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component			

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CPSP – Comprehensive Perinatal Services Program			X
Dental Services (routine)			X
Dental Services (including treatment of TMJ) (when medically necessary related to accidental injury or trauma to sound natural teeth, and for dental work necessary to construct non-dental structures) Professional Component Anesthesia (only when medically indicated) Facility Component	X X	X	
Diabetic Supplies (includes glucose monitors, test strips, lancets, screening tests)		X	
Dialysis Inpatient Facility Component Outpatient Facility Component Professional Component Out-of-Area Routine	 X X X	X	
Disease Management		X	
Drugs/Medications Inpatient Outpatient Prescriptions (Oral Medications) Injectable Medications Administered by Home Health Provider Depo Provera, Lupron, Growth Hormones (administered in	 X X	 X X X X X	

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Physician's Office)			
Administered in the Physician's		X	
Office (excluding Depo Provera,		X	
Lupron, Growth hormones)		X	
Infusion Therapy (i.e. TPN)		X	
Self Administered			
Self Administered Insulin			
Vaccinations (except in conjunction with CHDP)			
Durable Medical Equipment (DME)			
Inpatient		X	
Outpatient Dispensing	X		
Emergency Room Visits, In-Area			
Facility Component		X	
Professional Component –	X		
Anesthesiology, ER Physicians,			
Pathology, Radiology	X		
Professional Component Other			
Emergency Room Visits, Out-of-Area			
Facility Component		X	
Professional Component –		X	
Anesthesiology, ER Physicians,			
Pathology, Radiology		X	
Professional Component Other			
Emergency Medical Response – In home emergency response unit allowing Member to communicate with a central monitoring station in an emergency.		X	
Endoscopic Studies			
Professional	X		
Outpatient Facility Component	X		

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Family Planning Services			
Inpatient Facility Component			X
Inpatient Professional Component			X
Outpatient Facility			X
Outpatient Professional Component			X
Fetal Monitoring			
Inpatient Facility Component			X
Outpatient Facility and Professional Component			X
Genetic Testing (when medically necessary)	X		
Outpatient Facility Component	X		
Outpatient Professional Component			
Health Education	X		
Hearing Aid			X
Hearing Aid Replacement Batteries		X	
Hearing Screening			
Routine Hearing Exam			X
Diagnostic Hearing Exams	X		
Home Health Care (Including home hospice, MSW, OT, PT, RT, SN, injections, IV infusion supplies and injected substances, etc.)		X	
Hospice Care			
Inpatient Facility 3		X	
Professional Component	X		
Hospitalization – In-Area			
Facility Component		X	
Professional Component	X		
Hospitalization – Out-of-Area			
Facility Component		X	

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Professional Component		X	
Professional Component (where Member is stable for transfer and group/provider refuses to transfer Member)	X		
Implantable Lenses (following cataract surgery)	X		
Infertility Services	Not covered by Medicare or Medi-Cal		
Investigational/Experimental Procedures (when a Medicare covered benefit)			
Inpatient Professional		X	
Outpatient Professional		X	
Inpatient Facility		X	
Outpatient Facility		X	
Immunizations (Flu Vaccine, Hep B, Pneumonia Vaccine)		X	
Professional Component	X		
Laboratory Tests (except when related to ER Pathology)			
Inpatient Facility Component		X	
Outpatient Facility and Professional Component (including Pathology)	X		
Medical/Surgical Supplies (including ostomy supplies)		X	
Inpatient	X		
Outpatient & Office			
Mental Health			
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component		X	

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Nutrition/Diet Counseling	X		
Nutritional Supplements/Enteral Feeding Therapy (when Medically Necessary)	X		
Nurse Advice Line – Twenty-four (24) hour unlimited telephone access to live registered nurse to answer medical questions.		X	
Obstetrical Care Inpatient Facility Component Outpatient Diagnostic Services (including but not limited to fetal monitoring, ultrasound, & observation) Total OB Care (Professional Component)	 X X	X	
Office Visit Supplies (i.e. Splints, bandages, casting, etc.)	X		
Organ Transplant (when a covered benefit i.e. Kidney and Cornea) (also refer to CCS) Inpatient Facility Component Inpatient Professional Component Investigational/Experimental Transplants are not covered.	 X	X	
Organ Transplant Work Up Facility Component Professional Component	 X	X	
Ostomy Supplies Inpatient Outpatient	 X	X	
Outpatient Diagnostic Services	X		

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
(including but not limited to…) Angiograms, Colonoscopy, Echocardiograms, EDG, EEG, EKG, EMG/NCV, Sleep Studies, Treadmill, Drug			
Outpatient Surgery (excluding abortion) Facility Component Professional Component	 X	X	
Pathology Services (except when related to ER visit) Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	X	
Physical Therapy / Occupational Therapy / Respiratory Therapy / Speech Therapy, Rehabilitation Inpatient Outpatient	 X	X	
Personal Patient Navigator		X	
Preventative Care – Colorectal Services, TB Screening, Bone Density, Mammograms, Prostate Screening In office Outpatient Professional Outpatient Facility	 X X X		
Primary and Specialty Care Physician Services – Inpatient, Outpatient, SNF, Office, Patient's Home (see Emergency Room for exceptions)	X		
Podiatry Services			

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
Includes two routine visits per calendar year	X		
Medically necessary foot care	X		
Pre-Admission Diagnostic Testing Facility and Professional Component	X		
Prosthetics/Orthotics Inpatient and Surgically Implanted Outpatient Dispensing		X X	
Radiation Therapy Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	X	
Radiology Services Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	X	
Reconstructive Surgery (Non-cosmetic) Facility Component Professional Component	 X	X	
Routine Physical Examinations (when a Medicare covered benefit)	X		
Skilled Nursing Facility (SNF) Facility Component Professional Component	 X	X	
Sterilization			X
Transportation – Ambulatory, Van, Wheelchair, Gurney			X
Urgent Care Services	X		
Vision Care Eye exams for the diagnosis and	X		

LIST OF BENEFITS/SERVICES 1 These services are either provided by or coordinated through Health Plan. Provider is not financially responsible for these services. 2 These services are not covered under Health Plan's MA-SNP programs as a Medicare benefit but are covered under Health Plan's Medi-Cal programs. There is no Medicare financially responsibility by Provider or Health Plan for these services. 3 The Medicare Program is financially responsible and will pay for these charges.	PROVIDER (MEDICAL GROUP/IPA)	HEALTH PLAN 1	MEDI-CAL PROGRAM 2
treatment for diseases and conditions of the eye.			X
One routine eye exam per calendar year.			X
Eyeglass frames and lenses or contact lenses every two years		X	
Following cataract surgery, one pair of eye glasses or contact lenses			
Well Baby Exams			X

ATTACHMENT L

Business Associate Addendum

With respect to the creation, receipt, maintenance, or transmission of Protected Health Information in the performance of certain delegated functions on behalf of Health Plan ("Molina Healthcare") in accordance with the term and conditions set forth in this Agreement, Provider agrees that it is Health Plan's business associate ("Business Associate") with all the rights and obligations set forth in this Attachment.

RECITALS

WHEREAS, Business Associate may create, receive, maintain, or transmit protected health information on behalf of Molina Healthcare in conjunction with the services described in the Agreement;

WHEREAS, such protected health information may be used or disclosed only in accordance with the Privacy Rule issued by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

WHEREAS, Business Associate must safeguard any electronic protected health information that it creates, receives, maintains, or transmits on behalf of Molina Healthcare as required by the Security Rule issued by the U.S. Department of Health and Human Services under HIPAA and;

WHEREAS, Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") provisions in the American Recovery and Reinvestment Act of 2009 ("ARRA") amended HIPAA and its implementing regulations.

NOW THEREFORE, the parties agree as follows:

1. **DEFINITIONS**

Unless otherwise provided for in this Addendum, terms used in this Attachment shall have the same meanings as set forth in HIPPA, ARRA, the Privacy Rule and the Security Rule.

“ARRA” means Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§17921-17954, and any and all references in this Addendum to sections of ARRA shall be deemed to include all associated existing and future implementing regulations, when and as each is effective.

"Availability" means the property that data or information is accessible and useable upon demand by an authorized person.

“Breach” shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

"Business Associate" means an entity or a person that performs a function on behalf of, or provides a service to, Molina Healthcare that involves the creation, receipt, use or disclosure of PHI.

“Compliance Date” shall mean, in each case, the date by which compliance is required under the referenced provision of ARRA and/or its implementing regulations, as applicable; provided that, in any case for which that date occurs prior to the effective date of this Addendum, the Compliance Date shall mean the effective date of this Addendum.

Confidentiality means the property that data or information is not made available or disclosed to unauthorized persons or processes.

Electronic Protected Health Information (“Electronic PHI”) means Protected Health Information that is transmitted by, or maintained in, electronic media.

Integrity means the property that data or information have not been altered or destroyed in an unauthorized manner.

Protected Health Information (“PHI”) means individually identifiable information, transmitted or maintained in any form or medium, relating to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care

provided to an individual, as more fully defined in 45 CFR § 160.103, and any amendments thereto.

Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Security Rule means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to Molina Healthcare under the Agreement, including those set forth in this Addendum, as amended by written agreement of the parties from time to time.

"Unsecured PHI" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services (HHS) in guidance issued pursuant to ARRA.

2. **GENERAL PROVISIONS**

2.1 Effect. This Addendum supersedes any agreements between the parties involving the disclosure of PHI by Molina Healthcare to Business Associate. To the extent any conflict or inconsistency between this Addendum and the terms and conditions of any agreement exists, the terms of this Addendum shall prevail.

2.2 Amendment. The parties agree to amend this Addendum as necessary to comply with the Privacy Rule, the Security Rule, and such other regulations promulgated by the Secretary of Health and Human Services pursuant to HIPAA.

3. **SCOPE OF USE AND DISCLOSURE**

3.1 Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under this Agreement, if such use or disclosure of PHI would not violate the Privacy Rule. Unless otherwise limited herein, Business Associate may use or disclose PHI:

a. for Business Associate's proper management and administrative services;

b. to carry out the legal responsibilities of Business Associate; and

c. to provide data aggregation services relating to the health care operations of Molina Healthcare if required under the Agreement.

3.2 Business Associate shall not request, use or release more than the minimum amount of PHI necessary to accomplish the purpose of the use or disclosure and comply with 42 U.S.C. § 17935(b) as of its Compliance Date.. Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Molina Healthcare is the sole property of Molina Healthcare.

3.3 Business Associate. or its agents or subcontractors shall not perform any work outside the United States of America that involves access to, or the disclosure of, PHI without the prior written consent of Molina Healthcare.

3.4 As of the Compliance Date, Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.

3.5 As of the Compliance Date, Business Associate shall not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

3.6 As of the Compliance Date, Business Associate shall not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

4. **OBLIGATIONS OF BUSINESS ASSOCIATE.**

4.1 Use or disclose PHI only as permitted or required by this Addendum or as required by law.

4.2 Establish and use appropriate safeguards to prevent unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of Health Plan.

4.4 Promptly report to Molina Healthcare any unauthorized use or disclosure of PHI, or security incident, with no more than three (3) days after Business Associate becomes aware of the unauthorized use of disclosure of PHI or security Incident..

Business Associate shall take all reasonable steps to mitigate any harmful effects of such breach or security incident. Business Associate shall indemnify Molina Healthcare against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of Business Associate's or its agent's or subcontractor's unauthorized use or disclosure of PHI or Breach of Unsecured PHI including but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI.

4.5 Business Associate shall, following discovery of a Breach of Unsecured PHI that is caused by Business Associate or its agents or subcontractors, notify Molina Healthcare of such Breach, without unreasonably delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to Molina Healthcare shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Molina Healthcare is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach;

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 Ensure that all of its subcontractors and agents are bound by the same restrictions and obligations contained herein, whenever PHI is made accessible to such subcontractors or agents.

4.7 Within ten (10) days of receiving a request, make all PHI and related information in its possession available as follows:

a. To the individual or Molina Healthcare to the extent necessary to permit Molina Healthcare to respond to an individual's request for access to their PHI for inspection and copying in accordance with 45 CFR § 164.524, to the extent the PHI is maintained in a Designated Record Set;

b. To the individual or Molina Healthcare to the extent necessary to permit Molina Healthcare to make an accounting of disclosures of PHI about the individual, in accordance with 45 CFR § 164.528. At a minimum, Business Associate shall provide Health Plan with the following information: (i) the date of the disclosure, (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person, (iii) a brief

description of the PHI disclosed, and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

c. In the event that Business Associate in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an individual, then Business Associate shall provide an accounting of disclosures of PHI, within ten (10) days, to Molina Healthcare, or when and as directed by Molina Healthcare, directly to an individual in accordance with the requirements for accounting for disclosures made through an Electronic Health Record in 42 U.S.C. 17935(c), as of its Compliance Date.

4.8 Within fifteen (15) days of receiving a request from Molina Healthcare, incorporate any amendment or correction to the PHI in accordance with the Privacy Rule, to the extent the PHI is maintained in a Designated Record Set.

4.9 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Molina Healthcare available to Molina Healthcare or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the Privacy Rule.

4.10 Upon termination of the Agreement, Business Associate shall, at the option of Molina Healthcare, return or destroy all PHI created or received from, or on behalf of, Molina Healthcare. Business Associate shall not retain any copies of PHI except as required by law. If PHI is destroyed, Business Associate agrees to provide Molina Healthcare with certification of such destruction. If return or destruction of all PHI, and all copies of PHI, is not feasible, Business Associate shall extend the protections of this Attachment to such information for as long as it is maintained. Termination of this Agreement attached hereto shall not affect any of its provisions that, by wording or nature, are intended to remain effective and to continue in operation.

4.11 Standard Transactions. To the extent Business Associate conducts Standard Transaction(s) on behalf of Molina Healthcare, Business Associate shall comply with the HIPAA Regulations, "Administrative Requirements," 45 C.F.R. § 162.100 et seq., by the applicable compliance date(s) and shall not: (a) Change the definition, data condition or use of a data element or segment in a standard; (b) Add any data elements or segments to the maximum defined data set; (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) Change the meaning or intent of the standard's implementation specifications.

5. **INDEMNIFICATION**

Each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation contained herein by such party, its employees, agents, subcontractors or other representatives.

6. **TERMINATION OF AGREEMENT**

Notwithstanding any other provision of this Addendum or the Agreement, Molina Healthcare may terminate this Addendum and the Agreement upon five (5) days written notice to Business Associate if Molina Healthcare determines, in its sole discretion, that Business Associate has violated a material term of this Addendum and such breach is not cured within such five (5) day period.

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Exhibit 10.43

REGULATORY AMENDMENT FOR THE CAPITATED FINANCIAL ALIGNMENT DEMONSTRATION PRODUCT TO MOLINA HEAL TH CARE OF CALIFORNIA GROUP/IPA PROVIDER SERVICES AGREEMENT(S)

This Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to the Group/IPA Provider Services Agreement(s}, or other health care service contract applicable to Provider (the "Amendment") is made and entered into by and between Molina Healthcare of California ("Health Plan") and Pacific Healthcare IPA Associates, Inc. ("Provider").

A. **Whereas,** Health Plan and Provider have previously entered into a Group/IPA Provider Services Agreement, or other corresponding health care services agreement or contract as may have been amended from time to time ("Agreement"); and

B. Whereas, Health Plan desires to amend the Agreement to add regulatory provisions that Provider and Health Plan must remain in compliance with for the Capitated Financial Alignment Demonstration Product as governed by the 3-way agreement between DHCS, CMS and Health Plan and applicable regulations.

NOW, THEREFORE, in consideration of the promises, covenants and warranties stated herein, both parties agree as follows:

1. Section 5.11 **Attachments (**or equivalent section of the Agreement) is amended to add the following to the list of Attachments which are part of the Agreement:

   Attachment M -Capitated Financial Alignment Demonstration Program Requirements
   Attachment M-1- Capitated Financial Alignment Demonstration Program Requirements Delegated Services

2. Attachment M-Capitated Financial Alignment Demonstration Program Requirements, attached hereto, is hereby added to the Agreement.

3. Attachment M-1- Capitated Financial Alignment Demonstration Program Requirements-Delegated Services, attached hereto, is hereby added to the Agreement.

4. Health Plan and Provider acknowledge that Attachment H, Medicare Program Requirements Healthcare Services, and Attachment H-1, Medicare Program Requirements-Delegated Services, are applicable only to Health Plan's Medicare Advantage (Molina Medicare Options) and Medicare Advantage Special Needs Plan (Molina Medicare Options Plus) programs, and nothing in this Amendment or Agreement shall be construed to apply such requirements to the Medicare-Medicaid Program, otherwise known as the Capitated Financial Alignment Demonstration.

5. Health Plan and Provider acknowledge that the Capitated Financial Alignment product is part of the Medicare-Medicaid Program and is not a sub-product under the Medicare or Medicaid Products. In the event that the Capitated Financial Alignment Demonstration was categorized as a sub-productunder the Medicare or Medicaid Program in the Agreement or previous Amendments, they will now be treated as a separate product under the Capitated Financial Alignment Demonstration Program.

6. Compliance with Applicable Law, section 2.9 (or equivalent section of the Agreement), is modified to add the following subsection, which reads:

Provider acknowledges that all Covered Services rendered pursuant to the Medicare-Medicaid Program are subject to the additional provisions set forth in Attachment M.

7. Pursuant to Section 5.6, Amendment, or equivalent section of the Agreement, Health Plan may amend this Agreement to maintain compliance with any state or federal law, policy, directive or government sponsored program by providing forty-five (45) business days' notice, unless a shorter time is necessary for compliance.

8. Effective Date. This Amendment shall become effective immediately upon receipt.

9. Use of Defined Terms. Unless otherwise defined in this Amendment, capitalized terms utilized in this Amendment will have the same meaning(s) ascribed to such terms in the Agreement.

10. No Other Modifications. Except as provided herein, the terms and conditions of the Agreement shall remain the same, in full force and effect.

ATTACHMENT M

Capitated Financial Alignment Demonstration Program Requirements

This attachment sets forth the applicable Capitated Financial Alignment Demonstration Program requirements, which is otherwise known as the Medicare-Medicaid Program, covering the provision of health care services that are required by CMS and the State of California to be included in contracts and/or agreements between; (i) health plans I health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS and the State of California requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare-Medicaid Program Members to agree in writing to all of the terms provided herein.

2. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, computer or other electronic systems, including medical records. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare-Medicaid Program Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later.

3 . Confidentiality. Provider will comply with the confidentiality and Medicare-Medicaid Program Member record accuracy requirements set forth in 42 CFR 422.118.

4. Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Medicare-Medicaid Program Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. In addition, Medicare-Medicaid Program Members will not be held liable for any Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services will be provided at zero-cost share to the Medicare-Medicaid Program Member.5. Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment M-lof this Agreement.

6. Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS and DHCS.

7. Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for Covered Services, which are determined by Health Plan to be payable, within sixty (60) days of the date

such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean.

8. Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.

9. Compliance with Medicare Laws and Regulations. Provider will comply with all federal and state laws, regulations, and CMS instructions.

10. Benefit Continuation. Provider agrees to provide for continuation of Medicare-Medicaid Program Member health care benefits (i) for all Medicare-Medicaid Program Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Medicare-Medicaid Program Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge.

11. Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all Medicare-Medicaid Program Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

12. Provider will render all services in accordance with Health Plan's contractual obligations to CMS and DHCS.

13. Provider will render all services associated with the Medicare-Medicaid Program, which is otherwise known as the Capitated Financial Alignment Demonstration, in compliance with 42 C.F.R. § § 422.504, 423.505, and 438.6(1).

14. Provider must maintain Medicare-Medicaid Program Member records and information in an accurate and timely manner.

15. Provider must comply with the Federal Emergency Medical Treatment and Labor Act (EMT ALA) and all requirements outlined in 42 U.S. Code § 1395dd and Health Plan will not create any policies that conflict with the Provider's obligations under EMTALA.

16. Provider may not close or otherwise limit its acceptance of Medicare-Medicaid Program Members as patients unless the same limitations apply to all commercially insured Medicare-Medicaid Program Members.

17. Health Plan may not refuse to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:

a. Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Health Plan's health benefit plans as they relate to the needs of such provider's patients; or

b. Communicated with one or more of his or her prospective, current, or former patients with respect to the method by which such provider is compensated by the Health Plan for services provided to the patient.

18. Provider is not required to indemnify Health Plan for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Health Plan based on the Health Plan's management decisions, utilization review provisions or other policies, guidelines or actions.

19. Prior written approval must be obtained from DHCS before this Agreement is assigned or delegated.

20. Provider is required to provider interpreter services to Members.

21. Provider must timely gather, preserve and provide to DHCS, any records in the Provider's possession.

22. Provider must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003.

23. Health Plan shall make no payment to Provider for a provider preventable condition as defined by law.

ATTACHMENT M-1

Capitated Financial Alignment Demonstration Program Requirements - Delegated Services

This attachment sets forth the applicable Capitated Financial Alignment Demonstration Program requirements, which is otherwise known as the Medicare-Medicaid Program, covering the delegation to Provider of any management responsibilities or administrative services, if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans I health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS or DHCS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare-Medicaid Program Members to agree in writing to all of the terms provided herein.

2. Medicare Compliance. Provider will comply with all federal and state laws, regulations, and CMS instructions.

3. Confidentiality. Provider will comply with the confidentiality and Medicare-Medicaid Program Member record accuracy requirements set forth in 42 CFR 422.118.

4. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare-Medicaid Program Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later.

5. Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities, if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data.

6. Revocation of Delegated Activities. In the event CMS, DHCS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked.

7. Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS.

8. Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement.

9. Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities.

10. Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement.

Exhibit 10.44

CAPITATED FINANCIAL ALIGNMENT DEMONSTRATION AMENDMENT TO
MOLINA HEALTHCARE OF CALIFORNIA
GROUP/IPA PROVIDER SERVICES AGREEMENT

This Capitated Financial Alignment Demonstration Amendment to the Group/IPA Provider Services Agreement (the "Amendment") is made and entered into by and between Molina Healthcare of California ("Health Plan") **and Pacific Healthcare IPA Associates, Inc.** ("Provider").

A. **Whereas**, Health Plan and Provider have previously entered into Group/IPA Provider Services Agreement, as may have been amended from time to time ("Agreement"); and

B. **Whereas,** Health Plan desires to amend the Agreement in regards to Provider's compensation for the Capitated Financial Alignment Demonstration product.

NOW, THEREFORE, in consideration of the promises, covenants and warranties stated herein, both parties agree as follows:

1. Attachment B, Definitions, is amended to add the following definition:

   Capitated Financial Alignment Demonstration (CFAD) Product, or Medicare and Medicaid Program, means the managed care program established by the Centers for Medicare and Medicaid Services (CMS) through the capitated financial alignment demonstration in which the state, CMS and Health Plan will enter into a three-way contract that will allow the health plan to provide care to beneficiaries eligible for both Medicaid and Medicare.

2. Attachment K-2 - CFAD Matrix of Financial Responsibility is hereby added to the Agreement and attached hereto.

3. Attachment D-1 - Compensation Schedule for CFAD Members, is hereby added to the Agreement and attached hereto.

4. All references in the Agreement which treat the CFAD product as a Medicare product are null and void. The CFAD product is its own separate and distinct product.

5. Any reference to additional payments for incentive programs or the preventive care compensation programs shall not be applicable to the CFAD product. If the CFAD product will be eligible for additional compensation, a separate amendment will be issued at a future date.

6. Attachment H, Medicare Program Provisions, shall also apply to the Capitated Financial Alignment Demonstration Product for all Medicare services provided under the Capitated Financial Alignment Demonstration Product.

7. Use of Defined Terms. Unless otherwise defined in this Amendment, capitalized terms utilized in this Amendment will have the same meaning(s) ascribed to such terms in the Agreement.

8. No Other Modifications. Except as provided herein, the terms and conditions of the Agreement shall remain the same, in full force and effect.

9. Counterparts. This Amendment may be executed in one or more counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers thereunto duly authorized.

Pacific Healthcare IPA Associates, Inc.		**Molina Healthcare of California**	
By:	/s/ F. Bernadett	By:	/s/ Michelle Espinoza
			Michelle Espinoza
Its:	President	Its:	Vice President, Provider Network Management
Date:	6/13/2014	Date:	7/3/14

Effective date (to be entered by Health Plan): 7/1/14

ATTACHMENT K-2

CFAD MATRIX OF FINANCIAL RESPONSIBILITY

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Abortion			
Facility Component			X
Office/Outpatient Setting Component			X
Professional Component			X
Acupuncture	Not a Covered Service		
Allergy Testing (including serum)	X		
Alpha-fetoprotein Test			X
Ambulance, Air or Ground (Emergency Services)			
In Area		X	
Out-of-Area		X	
Amniocentesis			
Facility Component	X		
Professional Component	X		
Anesthetics, Administration of			
Inpatient	X		
Outpatient	X		
Blood and Blood Products		X	
Blood Donations		X	
Blood Donations, Autologous (when Medically Necessary)		X	
Cancer Drugs (including infusion) and Administration of the Drug in the following settings:			
Inpatient Facility Component		X	
Inpatient Professional Component			
Cancer Drugs administered in Physician's Office	X		
Outpatient Facility Component	X		
Outpatient Professional Component	X		
Oral taken By Patient	X	X	
Caregiver Relief: Assist with Member bathing, feeding, dressing and other needs		X	
Chemical Dependency (Acute Inpatient Overdose Treatment)			
Inpatient Facility		X	
Inpatient Professional Component		X	
Chemical Dependency - Detoxification & Rehabilitation (Outpatient Treatment)			
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Chiropractic Care	X		

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Clinical Trials			
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Custodial Care (In a Skilled Nursing Facility)		X	
Dental Services (Routine)		X	
Dental Services (including treatment of TMJ, when Medically Necessary related to accidental injury or trauma to sound natural teeth and for dental work necessary to construct non-dental structures)			
Professional Component			
Anesthesia (only when medically indicated)	X		
Facility Component	X	X	
Diabetic Supplies (includes glucose monitors, test strips, lancets, screening tests)		X	
Dialysis (inclusive of injectables)			
Inpatient Facility Component			
Outpatient Facility Component	X		
Professional Component	X		
Out-of-Area Routine	X	X	
Disease Management		X	
Drugs/Medications			
Inpatient			
Outpatient		X	
Prescriptions (Oral Medications)			
Injectable Medications		X	
Administered by Home Health Provider		X	
Depo Provera, Lupron, Growth Hormones (administered by Physician's Office)		X X	
Administered in the Physician's Office - (excluding Depo Provera, Lupron, Growth Hormones)			
Infusion Therapy (i.e. TPN. For cancer related drugs or infusion, refer to Cancer Drugs and Administration of Cancer Drugs section in Matrix)		X	
Self Administered		X	
Self Administered Insulin		X	
Vaccinations	X	X	
Durable Medical Equipment (DME)			
Inpatient			
Outpatient Dispensing	X	X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Emergency Room Visits, In-Area Facility Component Professional Component (Anesthesiology, ER Physicians, Pathology, Radiology) Professional Component Other than above	 X	 X X	
Emergency Room Visits, Out-of-Area Facility Component Professional Component (Anesthesiology, ER Physicians, Pathology, Radiology) Professional Component Other than above		 X X X	
Emergency Medical Response - In home emergency response unit allowing Member to communicate with a central monitoring station in an Emergency.		X	
Endoscopic Studies Professional Outpatient Facility Component	 X X		
Family Planning Services Inpatient Facility Component Inpatient Professional Component Outpatient Facility Outpatient Professional Component		 X	 X X X
Fetal Monitoring Inpatient Facility Component Outpatient Facility and Professional Component		 X	 X
Genetic Testing (when Medically Necessary Outpatient Facility Component Outpatient Professional Component	 X X		
Health Education	X		
Hearing Aid Hearing Aid Replacement Batteries		X X	
Hearing Screening Routine Hearing Exam Diagnostic Hearing Exams	 X	 X	
Home Health Care (Including home hospice, MSW, OT, PT, RT, SN, injections, IV infusion, supplies and injected substances, etc.)		X	
Hospice Care Inpatient Facility Professional Component		X X	
Hospitalization In-Area Facility Component Professional Component	 X	 X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Hospitalization Out-of-Area			
Facility Component			
Professional Component			
Professional Component (where Member is stable for transfer and group/provider refuses to transfer Member)	X	X X	
Implantable Lenses (following cataract surgery)		X	
Incontinence Supplies			X
Infertility Services	Not a Covered Service		
Investigational/Experimental Procedures (when a Medicare Covered Benefit)			
Inpatient Professional		X	
Outpatient Professional		X	
Inpatient Facility		X	
Outpatient Facility		X	
Immunizations (Flu Vaccine, Hep B, Pneumonia Vaccine)			
Professional Component	X		
Laboratory Tests (except when related to ER Pathology)			
Inpatient Facility Component			
Outpatient Facility and Professional Component (including Pathology)	X	X	
Medical/Surgical Supplies (including ostomy supplies)			
Inpatient			
Outpatient & Office	X	X	
Mental Health			
Inpatient Professional Component		X	
Inpatient Facility Component		X	
Outpatient Professional Component		X	
Outpatient Facility Component		X	
Nutrition/Diet Counseling	X		
Nutritional Supplements/Enteral Feeding Therapy (when Medically Necessary)		X	
Nurse Advice Line - Twenty-Four (24) hour unlimited telephone access to live registered nurse to answer medical questions.		X	
Obstetrical Care			
Inpatient Facility Component			
Outpatient Diagnostic Services (including but not limited to fetal monitoring, ultrasound and observation)	X		
Total OB Care (Professional Component)	X	X	
Office Visit Supplies (i.e. Splints, Bandages, Casting, etc.)	X		
Organ Transplant (when a Covered Benefit*)			
Inpatient Facility Component			
Inpatient Professional Component		X	
**Investigational/Experimental Transplants are not covered.*		X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Organ Transplant Work Up Facility Component Professional Component	 X	 X	
Ostomy Supplies Inpatient Outpatient	 X	 X	
Outpatient Diagnostic Services, including but not limited to: Angiograms, Colonoscopy, Echocardiograms, EDG, EEG, EKG, EMG/NCV, Sleep Studies, Treadmill, Drug	 X		
Outpatient Surgery Facility Component Professional Component	 X	 X	
Pathology Services (except when related to ER visit) Inpatient Facility Component Outpatient Facility Component Professional Component	 X X	 X	
Physical Therapy , Occupational Therapy, Respiratory Therapy, Speech Therapy, Rehabilitation Inpatient Outpatient	 X	 X	
Personal Patient Navigator		X	
Preventive Care - Colorectal Services, TB Screening, Bone Density, Mammograms, Prostate Screening In Office Outpatient Professional Outpatient Facility	 X X X		
Primary and Specialty Care Physician Services* Inpatient Outpatient SNF Office Patient's Home **See Emergency Room for exceptions*	 X X X X	 X	
Podiatry Services (includes two (2) routine visits per calendar year) Medically Necessary podiatry/foot care	X X		
Pre-Admission Diagnostic Testing Professional Component Facility Component	 X X		
Prosthetics/Orthotics Inpatient and Surgically Implanted Outpatient Dispensing		 X X	

LIST OF BENEFITS/SERVICES --- [1] These services are provided by or coordinated through the Provider. The Health Plan is not financially responsible for these services. [2] These services are provided by or coordinated through the Health Plan. The Provider is not financially responsible for these services. [3] Should the Provider choose to provide or coordinate these Covered Services, the Provider or any other rendering provider will be reimbursed by the Health Plan on a Fee-For-Service basis. Claims for these services should be billed directly to the Health Plan.	**Pacific Healthcare IPA Associates, Inc.[1]**	**MOLINA[2]**	**OTHER COVERED SERVICES[3]**
Radiation Therapy			
Inpatient Facility Component			
Outpatient Facility Component	X		
Professional Component	X	X	
Radiology Services			
Inpatient Facility Component			
Outpatient Facility Component	X		
Professional Component	X	X	
Reconstructive Surgery (Non-Cosmetic)			
Facility Component			
Professional Component	X	X	
Routine Physical Examinations	X		
Skilled Nursing Facility			
Facility Component		X	
Professional Component		X	
Sterilization			X
Transportation - Ambulatory, Van, Wheelchair, Gurney		X	
Urgent Care Services	X		
Vision Care			
Eye exams for the diagnosis and treatment for diseases and conditions of the eye.			
One routine eye exam per calendar year.		X	
Eyeglass frames and lenses or contact lenses every two (2) years.		X	
Following cataract surgery, one pair of eye glasses or contact lenses.	X	X	

Long Term Services and Support (LTSS):

Health Plan shall be responsible for providing and/or coordinating Covered Services that are included as a part of the following programs: Long Term Care (LTC), Multipurpose Senior Services Program (MSSP), In-Home Support Services (IHSS) services, and Community-Based Adult Services (CBAS). Claims for these services should be billed directly to the Health Plan.

ATTACHMENT D-1

COMPENSATION SCHEDULE FOR CFAD MEMBERS

Capitation Payments for Capitated Financial Alignment Demonstration Members. Provider shall be compensated for all CFAD Members assigned to Provider based upon a per Member per month capitation rate. For Capitated Financial Alignment Demonstration Members, Health Plan shall pay Provider at a rate equivalent to Thirty Eight percent (38%) of the Medicare Part A and B premium it receives from CMS. Health Plan may amend the Agreement, in accordance with the applicable Amendment section of the Agreement to modify these Capitation Payments in order to account for any revenue reduction in the applicable government sponsored program(s) and benefits, if any.

Non-Capitated Services Submission of Claims/Claims Payment. For Clean Claims for Covered Services rendered to Members which are provided or arranged by Provider, but are (i) Health Plan financial responsibility or listed as Other Covered Services under the applicable Matrix of Financial Responsibility, and/or (ii) are not covered by Capitation Payments (collectively the "Non-Capitated Services"), Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. Health Plan shall reimburse Provider for such Non-Capitated Services on a fee-for service basis in accordance with the applicable Claims Payment provisions of this Agreement, at the lesser of: (i) Provider's billed charges, or (ii) pursuant to the methodology described below.

(1) **Non-Capitated Services Payment Rate for Capitated Financial Alignment Demonstration Members.** Provider will receive an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the date(s) of service, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including but not limited to co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

In the event a Covered Service is covered by Medicaid or is primary to Medicaid, but not Medicare, Health Plan agrees to compensate Provider for such Covered Services rendered to Members, that are submitted on a Clean Claim and determined by Health Plan to be payable, on a fee-for-service basis, at the lesser of; (i) Provider's billed charges, or (ii) at an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of California in effect on the date(s) of service, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

Provider acknowledges that CMS and the State of California have not released final joint-capitation rate to be paid to Health Plan for this product/program. If, after the final capitation rate is released, Health Plan determines that the above compensation for this product/program is unsustainable, Provider agrees to negotiate a new compensation rate for this product/program with Health Plan in good faith. If Health Plan and Provider cannot agree to a new rate before this product/program begins, Health Plan or Provider may immediately terminate this product/program from this Agreement, in compliance with applicable laws.

EXHIBIT 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2015	**2014**	**2013**	**2012**	**2011**
	(Dollars in Millions)				
Earnings:					
Income before income taxes, continuing operations	$ 322	$ 135	$ 81	$ 23	$ 120
Add fixed charges:					
Interest expense, including amortization of debt discount and expense	66	57	52	17	16
Estimated interest portion of rental expense	8	5	4	3	2
Total fixed charges	74	62	56	20	18
Total earnings available for fixed charges	$ 396	$ 197	$ 137	$ 43	$ 138
Fixed charges from above:	$ 74	$ 62	$ 56	$ 20	$ 18
Ratio of Earnings to Fixed Charges	5.4	3.2	2.4	2.2	7.7
Total rent expense	$ 44	$ 32	$ 25	$ 20	$ 23
Interest factor	18%	16%	16%	14%	11%
Interest component of rental expense	$ 8	$ 5	$ 4	$ 3	$ 2

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Iowa, Inc. *	Iowa
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Mississippi, Inc.*	Mississippi
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of New York, Inc.*	New York
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Oklahoma, Inc.*	Oklahoma
Molina Healthcare of Pennsylvania, Inc.*	Pennsylvania
Molina Healthcare of Puerto Rico, Inc.	Puerto Rico/Nevada
Molina Healthcare of South Carolina, LLC	South Carolina
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company^	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Health Plan Management, Inc.*	New York
Molina Hospital Management, Inc.	California
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Youth Academy	California
Molina Medical Management, Inc.	California
Easy Care MSO, LLC~	California
Molina Pathways, LLC	Delaware
Molina Pathways of Ohio, LLC+*	Ohio
Molina Pathways of Texas, Inc.+	Texas
Molina Personal Care of Texas, Inc.+ *	Texas
Molina Personal Care of South Carolina, Inc.+*	South Carolina
Synergy Partners, L.L.C.+	Michigan
Pathways Health and Community Support LLC+	Delaware
AmericanWork, Inc.-	Delaware
A to Z In-Home Tutoring LLC-	Nevada
Children's Behavioral Health, Inc.-	Pennsylvania
Choices Group, Inc.-	Delaware

EXHIBIT 21.1

College Community Services-	California
Dockside Services, Inc.-	Indiana
Family Builders, Inc.- *	Arizona
Family Preservation Services, Inc.-	Virginia
Family Preservation Services of Florida, Inc.-	Florida
Family Preservation Services of North Carolina, Inc.-	North Carolina
Family Preservation Services of Washington D.C., Inc.-	District of Columbia
Family Preservation Services of West Virginia, Inc.-	West Virginia
Maple Star Nevada, Inc.-	Nevada
Maple Star Oregon, Inc.-	Oregon
Pathways Community Corrections, Inc.-	Delaware
Camelot Care Centers, Inc.>	Illinois
Pathways Community Services LLC-	Delaware
Pathways Community Services LLC-	Pennsylvania
Pathways of Massachusetts LLC-	Delaware
Pathways of Washington, Inc.-	Washington
Pathways Health and Community Support of Florida, Inc.-	Florida
Pathways of Arizona, Inc.-	Arizona
Pathways of Idaho LLC-	Delaware
Pathways of Alabama, Inc.-	Alabama
Pathways of Delaware, Inc.-	Delaware
Pathways of Maine, Inc.-	Maine
Pathways of Oklahoma, Inc.-	Oklahoma
Pathways Community Support of Texas, Inc.-	Texas
The RedCo Group, Inc.-	Pennsylvania
Raystown Developmental Services, Inc./	Pennsylvania
Transitional Family Services, Inc.-	Georgia
W.D. Management, LLC-	Missouri

* Non-operational entity

^ Wholly owned subsidiary of Molina Healthcare of Texas, Inc.

\+ Wholly owned subsidiary of Molina Pathways, LLC

~ Partially owned subsidiary of Molina Medical Management, Inc.

\- Wholly owned subsidiary of Pathways Health and Community Support LLC

/ Wholly owned subsidiary of The RedCo Group, Inc.

> Wholly owned subsidiary of Pathways Community Corrections, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statements No. 333-108317, No. 333-138552, No. 333-153246, No. 333-170571, and No. 333-174912 on Form S-8 pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan; 2002 Equity Incentive Plan; 2002 Employee Stock Purchase Plan; 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and Registration Statement No. 333-204558 on Form S-3, of our reports dated February 26, 2016, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2015.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2016

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the annual report on Form 10-K for the period ended December 31, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 26, 2016

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed this annual report on Form 10-K for the period ended December 31, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 26, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2015 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 26, 2016

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2015 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 26, 2016

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended September 30, 2015

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2015

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of October 23, 2015, was approximately 56,082,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended September 30, 2015

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	September 30, 2015	December 31, 2014
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,164,210	$ 1,539,063
Investments	1,461,467	1,019,462
Receivables	619,891	596,456
Deferred income taxes	54,231	39,532
Prepaid expenses and other current assets	120,438	50,884
Derivative asset	490,087	—
Total current assets	4,910,324	3,245,397
Property, equipment, and capitalized software, net	374,862	340,778
Deferred contract costs	73,619	53,675
Intangible assets, net	96,424	89,273
Goodwill	321,220	271,964
Restricted investments	101,970	102,479
Derivative asset	—	329,323
Other assets	36,612	44,326
	$ 5,915,031	$ 4,477,215
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,559,570	$ 1,200,522
Amounts due government agencies	980,317	527,193
Accounts payable and accrued liabilities	274,131	241,654
Deferred revenue	67,227	196,076
Income taxes payable	39,205	8,987
Current portion of long-term debt	450,780	341
Derivative liability	489,940	—
Total current liabilities	3,861,170	2,174,773
Convertible senior notes	275,050	704,097
Lease financing obligations	161,553	160,710
Lease financing obligations – related party	39,868	40,241
Deferred income taxes	27,111	24,271
Derivative liability	—	329,194
Other long-term liabilities	32,270	33,487
Total liabilities	4,397,022	3,466,773
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 56,075 shares at September 30, 2015 and 49,727 shares at December 31, 2014	56	50
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	789,907	396,059
Accumulated other comprehensive loss	(701)	(1,019)
Retained earnings	728,747	615,352
Total stockholders' equity	1,518,009	1,010,442
	$ 5,915,031	$ 4,477,215

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 3,377,030	$ 2,316,759	$ 9,652,054	$ 6,424,238
Service revenue	47,551	52,557	146,652	156,419
Premium tax revenue	99,047	81,240	289,003	203,053
Health insurer fee revenue	81,158	29,427	202,996	67,785
Investment income	4,832	2,041	11,675	5,615
Other revenue	1,745	2,327	4,996	8,523
Total revenue	3,611,363	2,484,351	10,307,376	6,865,633
Operating expenses:				
Medical care costs	3,015,371	2,097,836	8,580,689	5,753,793
Cost of service revenue	34,573	40,067	103,294	117,831
General and administrative expenses	287,691	178,879	830,277	560,205
Premium tax expenses	99,047	81,240	289,003	203,053
Health insurer fee expenses	35,985	22,308	117,415	66,443
Depreciation and amortization	25,843	24,242	75,987	67,835
Total operating expenses	3,498,510	2,444,572	9,996,665	6,769,160
Operating income	112,853	39,779	310,711	96,473
Other expenses, net:				
Interest expense	15,269	14,419	45,091	42,234
Other (income) expense, net	(40)	863	(82)	810
Total other expenses, net	15,229	15,282	45,009	43,044
Income from continuing operations before income tax expense	97,624	24,497	265,702	53,429
Income tax expense	51,329	8,427	152,335	24,784
Income from continuing operations	46,295	16,070	113,367	28,645
Income (loss) from discontinued operations, net of tax	4	52	28	(214)
Net income	$ 46,299	$ 16,122	$ 113,395	$ 28,431
Basic net income (loss) per share:				
Continuing operations	$ 0.84	$ 0.34	$ 2.21	$ 0.62
Discontinued operations	—	—	—	(0.01)
Basic net income per share	$ 0.84	$ 0.34	$ 2.21	$ 0.61
Diluted net income (loss) per share:				
Continuing operations	$ 0.77	$ 0.33	$ 2.07	$ 0.60
Discontinued operations	—	—	—	(0.01)
Diluted net income per share	$ 0.77	$ 0.33	$ 2.07	$ 0.59

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
	(Amounts in thousands) (Unaudited)			
Net income	$ 46,299	$ 16,122	$ 113,395	$ 28,431
Other comprehensive income (loss):				
Unrealized investment gain (loss)	1,792	(1,061)	531	756
Effect of income taxes	663	(404)	213	287
Other comprehensive income (loss), net of tax	1,129	(657)	318	469
Comprehensive income	$ 47,428	$ 15,465	$ 113,713	$ 28,900

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2015	2014
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 113,395	$ 28,431
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	92,583	99,464
Deferred income taxes	(12,072)	(10,705)
Share-based compensation	16,226	16,115
Amortization of convertible senior notes and lease financing obligations	22,101	20,195
Other, net	13,212	3,875
Changes in operating assets and liabilities:		
Receivables	(23,429)	(126,748)
Prepaid expenses and other assets	(63,312)	(51,582)
Medical claims and benefits payable	359,048	454,059
Amounts due government agencies	453,124	340,775
Accounts payable and accrued liabilities	33,541	(26,384)
Deferred revenue	(128,849)	68,640
Income taxes	30,218	25,063
Net cash provided by operating activities	905,786	841,198
Investing activities:		
Purchases of investments	(1,311,231)	(616,324)
Proceeds from sales and maturities of investments	862,572	473,836
Purchases of property, equipment and capitalized software	(100,361)	(71,771)
Increase in restricted investments	(5,216)	(24,301)
Net cash paid in business combinations	(77,316)	(7,500)
Other, net	(33,523)	(15,220)
Net cash used in investing activities	(665,075)	(261,280)
Financing activities:		
Proceeds from common stock offering, net of issuance costs	373,151	—
Proceeds from issuance of convertible senior notes, net of issuance costs	—	123,387
Contingent consideration liabilities settled	—	(50,349)
Proceeds from employee stock plans	8,636	7,628
Other, net	2,649	2,117
Net cash provided by financing activities	384,436	82,783
Net increase in cash and cash equivalents	625,147	662,701
Cash and cash equivalents at beginning of period	1,539,063	935,895
Cash and cash equivalents at end of period	$ 2,164,210	$ 1,598,596

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Nine Months Ended September 30,	
	2015	2014
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
3.75% Notes exchanged for 1.625% Notes	$ —	$ 176,551
Increase in non-cash lease financing obligation – related party	$ —	$ 13,841
Common stock used for share-based compensation	$ (9,012)	$ (8,595)
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 160,764	$ 36,646
Loss on 1.125% Conversion Option	(160,746)	(36,638)
Change in fair value of derivatives, net	$ 18	$ 8
Details of business combinations:		
Fair value of assets acquired	$ (68,982)	$ (7,500)
Fair value of contingent consideration incurred	(410)	—
Payable to seller	(7,924)	—
Net cash paid in business combinations	$ (77,316)	$ (7,500)

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
September 30, 2015

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to persons receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of September 30, 2015, these health plans served 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate, as well as the management of a hospital in southern California under a management services agreement.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Market Updates - Health Plans Segment

Direct Delivery. On September 3, 2015, we entered into an agreement to acquire all the outstanding ownership interests in Providence Human Services, LLC (PHS) and Providence Community Services, LLC, both wholly owned subsidiaries of The Providence Service Corporation, for approximately $200 million. PHS is one of the largest national providers of accessible, outcome-based behavioral and mental health services and operates in 23 states and the District of Columbia. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the fourth quarter of 2015.

Medicare-Medicaid Plans. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered coverage beginning in the second quarter of 2015. At September 30, 2015, our membership included approximately 56,000 integrated MMP members.

Florida. On August 3, 2015, we announced that our Florida health plan entered into an agreement with Integral Health Plan, Inc. (Integral) to assume Integral's Medicaid contract, as well as acquire certain assets related to the operations of its Medicaid business. As of August 3, 2015, Integral served approximately 90,000 Medicaid members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the fourth quarter of 2015.

On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts in Miami-Dade and Monroe counties, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc. The Florida health plan added approximately 23,000 members as a result of this transaction. See Note 4, "Business Combinations," for further information.

As of September 30, 2015, our Florida health plan served 148,000 Marketplace members, more than double its total membership as of December 31, 2014.

Illinois. On October 9, 2015, we announced that our Illinois health plan entered into an agreement with Loyola Physician Partners, LLC (Loyola). Under this agreement, we will receive the right to transition Loyola's Medicaid members in Cook County and assume certain assets related to the operation of its Medicaid business. Loyola serves approximately 20,000 members in the Medicaid Family Health program in Cook County. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the first quarter of 2016.

On July 15, 2015, we announced that our Illinois health plan entered into an agreement with Accountable Care Chicago, LLC, also known as MyCare Chicago. Under this agreement, we will receive the right to assume MyCare Chicago's Medicaid members in Cook County, as well as acquire certain assets related to the operation of its Medicaid business. As of July 15, 2015, MyCare Chicago served approximately 61,000 Medicaid members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the first quarter of 2016.

Michigan. On October 13, 2015, the Michigan Department of Health and Human Services announced that Molina Healthcare of Michigan, Inc. is one of the health plans recommended to serve the state's Medicaid members under Michigan's Comprehensive Health Plan expected to commence effective January 1, 2016. The new contract has a five-year term with three one-year extensions, and covers Regions 2 through 6, and 8 through 10, of the state, representing an expansion into 15 additional counties as compared to the existing Michigan Medicaid contract.

On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc. The Michigan health plan added approximately 88,000 members as a result of this transaction. See Note 4, "Business Combinations," for further information.

Puerto Rico. Effective April 1, 2015, our Puerto Rico health plan served its first members. As of September 30, 2015, our Puerto Rico plan enrollment amounted to approximately 356,000 members.

Market Updates - Molina Medicaid Solutions Segment

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate that state's new Medicaid management information system (MMIS). The new contract is effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions is the state's incumbent MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities (VIEs) in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such VIEs are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2015.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2014. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2014 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2014 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2014 statement of cash flows to conform to the 2015 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. Certain components of premium revenue are subject to accounting estimates as follows:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Medicaid

Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $536.5 million and $392.0 million

at September 30, 2015 and December 31, 2014, respectively, to amounts due government agencies. Approximately $523.2 million of the liability accrued at September 30, 2015 relates to our participation in Medicaid expansion programs.

In general, such amounts are subject to future changes in estimate based upon our actual cost performance and clarification and alteration of the definitions of allowable medical costs and revenue. At our Washington health plan (where we had recorded a liability of approximately $280 million related to the Medicaid expansion medical cost floor for 2014 and 2015 combined at September 30, 2015), premium revenue may be retroactively adjusted across the entire state Medicaid expansion program based upon the medical cost performance of the program as a whole. As such, our liability under Washington's contractual provisions is determined not just by our own medical cost performance, but by that of all health plans participating in the program; and we have limited visibility into the costs of those health plans. In October 2015, we settled our 2014 Medicaid expansion medical cost floor liability with the state of Washington with the payment of $246.6 million. This amount exceeded our estimate of that liability as of June 30, 2015 by approximately $7 million.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. We had $9.2 million recorded at September 30, 2015 relating to such provisions. No such receivables were recorded at December 31, 2014.

Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to retain, we recorded a liability of $9.3 million and $0.5 million at September 30, 2015 and December 31, 2014, respectively.

Retroactive Premium Adjustments: In New Mexico, when members are retroactively enrolled into our health plan we earn revenue only to the extent of the actual medical costs incurred by us for services provided during those retroactive periods, plus a small percentage of that medical cost for administration and profit. This cost plus arrangement for members retroactively enrolled in our health plan first became effective July 1, 2014 (retroactive to January 1, 2014). We are paid normal monthly capitation rates for the retroactive eligibility periods, and the difference between those capitation rates and the amounts due us on a cost plus basis are periodically settled with the state. To date, no such settlement has been made with the state. Our New Mexico contract is not specific as to the definition of retroactive membership, and the amount we owe back to the state for the difference between capitation received and amounts due us under the cost plus arrangement varies widely depending upon the definition of retroactive membership. In August 2015 the state provided us with a request for payment under the terms of this contract provision for the period January 1, 2014 through December 31, 2014. That request was based upon definitions of retroactive membership that were at odds with our interpretations of that term. The New Mexico health plan reduced revenue by approximately $20 million in the third quarter of 2015 to better align our interpretation of certain contractual provisions related to revenue for members added retroactively to the state's interpretation of those provisions. Even after that adjustment, however, we estimate that, based upon our interpretation of the state's proposed definition of retroactive membership, the amount we would owe for the period January 1, 2014 through September, 2015 would exceed our accrual for such liability at September 30, 2015 by between $15 million and $20 million. We are currently engaged in discussions with the state regarding the appropriate amount, if any, owed to the state under this contract term.

Medicare

Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive increase or decrease based upon member medical conditions for up to two years after the original year of service. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses, we have recorded a net receivable of $2.3 million and $7.6 million for anticipated Medicare risk adjustment premiums at September 30, 2015 and December 31, 2014, respectively.

Marketplace

Premium Stabilization Programs: The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs based on our year-to-date experience when the amounts are reasonably estimable, and, for receivables, collection is reasonably assured.

- Permanent risk adjustment program: Under this permanent program, our health plans' risk scores are compared to the overall average risk score for the relevant state and market pool. Generally, our health plans will pay into the pool if their risk scores are below the average risk score, and will receive funds from the pool if their risk scores are above the average risk score.

- Transitional reinsurance program: This program is designed to provide reimbursement to insurers for high cost members. Our health plans pay an annual contribution on a per-member basis, and are eligible for recoveries if claims for individual members exceed a specified threshold, up to a maximum amount. This three-year program will end in 2016.
- Temporary risk corridor program: This program is intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by the U.S. Department of Health and Human Services (HHS). Variances from the target amount exceeding certain thresholds may result in amounts due to or receivable from HHS. This three-year program will end in 2016. Due to uncertainties as to the amount of federal funding available to support the risk corridor program, we do not recognize amounts receivable under this program. All liabilities are recognized as incurred.

Additionally, the ACA established a minimum annual medical loss ratio (Minimum MLR) of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue, where the components of medical costs and premium revenue are specifically defined by federal regulations. Each of the 3R programs is taken into consideration when computing the Minimum MLR. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders.

Our receivables (payables) for each of these programs, as of the dates indicated, were as follows (in millions):

	September 30, 2015	December 31, 2014
Risk adjustment	$ (136.1)	$ (4.8)
Reinsurance	21.9	4.9
Risk corridor	(11.8)	(0.5)
Minimum MLR	(12.5)	—

Quality Incentives

At our California, Illinois, New Mexico, Ohio, South Carolina, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is not earned unless specified performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2015 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30, 2015.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
	(In thousands)			
Maximum available quality incentive premium - current period	$ 28,384	$ 24,477	$ 86,529	$ 68,941
Amount of quality incentive premium revenue recognized in current period:				
Earned current period	$ 17,073	$ 12,921	$ 37,849	$ 30,935
Earned prior periods	(609)	208	10,862	3,412
Total	$ 16,464	$ 13,129	$ 48,711	34,347
Total premium revenue recognized for state health plans with quality incentive premiums	$ 2,517,474	$ 1,818,375	$ 7,396,280	$ 5,005,444

California Health Plan Rate Settlement Agreement

In 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, DHCS may be required to make a payment to us if the California health plan's pre-tax margin falls below certain levels. The maximum amount that DHCS

would pay to us under the terms of the settlement agreement is $40.0 million; no amounts receivable were recorded related to this agreement at September 30, 2015 or December 31, 2014. The agreement expires effective December 31, 2017.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses under the Affordable Care Act Health Insurer Fee (HIF), nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

New Accounting Standards

Business Combinations. In September 2015, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2015-16, *Simplifying the Accounting for Measurement-Period Adjustments*, which will require that an acquirer recognize adjustments to provisional amounts that are identified during the measurement period (a reasonable time period after the acquisition date) in the reporting period in which the adjustment amounts are determined. Effective for us in the first quarter of 2016, ASU 2015-16 is applied prospectively.

Revenue Recognition. On July 9, 2015, the FASB affirmed its proposal to defer the effective date of ASU No. 2014-09, *Revenue from Contracts with Customers,* for all entities by one year. As a result, public business entities will apply the new revenue standard to annual reporting periods beginning after December 15, 2017, and for interim reporting periods within annual reporting periods beginning after December 15, 2017. We continue to evaluate whether to elect the full or modified retrospective adoption method, and the potential effects to our financial statements.

Short-Duration Contracts. In May 2015, the FASB issued ASU 2015-09, *Disclosures about Short-Duration Contracts*, which will require additional disclosure on the liability for unpaid claims and claim adjustment expenses. Effective for us in the first quarter of 2016, ASU 2015-09 is applied retrospectively to all prior periods presented in the financial statements. Early adoption is permitted; we are evaluating the potential effects of the adoption to our financial statements.

Debt Issuance Costs. In April 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*, which will require debt issuance costs related to a recognized debt liability to be presented in the balance sheet as a direct deduction from the carrying amount of such debt liability, consistent with debt discounts. In a subsequent Staff Announcement, the Securities and Exchange Commission (SEC) announced that it would not object to an entity deferring and presenting debt issuance costs relating to a line-of-credit arrangement as an asset. This Staff Announcement was incorporated by the FASB through ASU 2015-15, issued in August 2015. Effective for us in the first quarter of 2016, ASU 2015-03 is applied retrospectively to all prior periods presented in the financial statements. Early adoption is permitted; we are evaluating the potential effects of the adoption to our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the SEC did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
	(In thousands)			
Shares outstanding at the beginning of the period	54,788	46,494	48,578	45,871
Weighted-average number of shares issued:				
Common stock offering	—	—	2,393	—
Issued, 3.75% Notes and 3.75% Exchange (1)	—	460	—	155
Share-based compensation	15	37	295	409
Denominator for basic net income per share	54,803	46,991	51,266	46,435
Effect of dilutive securities:				
Share-based compensation	353	365	417	441
Convertible senior notes (1)	1,126	1,288	602	1,212
1.125% Warrants (1)	3,696	—	2,414	—
Denominator for diluted net income per share	59,978	48,644	54,699	48,088
Potentially dilutive common shares excluded from calculations (2):				
Restricted shares	—	—	3	—
1.125% Warrants	—	13,490	—	13,490

(1) For more information regarding the convertible senior notes, refer to Note 11, "Debt." For more information regarding the 1.125% Warrants, refer to Note 12, "Derivatives."

(2) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the three and nine months ended September 30, 2014, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

4. Business Combinations

Health Plans Segment

Florida. On August 1, 2015, our Florida health plan closed on its acquisition of the Medicaid contracts in Miami-Dade and Monroe counties, and certain assets related to the operation of the Medicaid business, of Preferred Medical Plan, Inc. The final purchase price was $8.2 million, and the Florida health plan added approximately 23,000 members as a result of this transaction.

In December 2014, our Florida health plan acquired certain assets relating to the Medicaid business of First Coast Advantage, LLC (FCA). Under this transaction, we assumed FCA's Medicaid contract and certain provider agreements for Region 4 of the Statewide Medicaid Managed Care Managed Medical Assistance Program in the state of Florida. The Florida health plan added approximately 62,000 members as a result of this transaction. The final purchase price was $44.6 million, of which $36.6 million was paid in December 2014, and $8.0 million was paid in the first quarter of 2015.

Michigan. On September 1, 2015, our Michigan health plan closed on its acquisition of the Medicaid and MIChild contracts, and certain provider agreements, of HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc.The purchase price was $61.1 million, and the Michigan health plan added approximately 88,000 members as a result of this transaction.

5. Share-Based Compensation

As of September 30, 2015, there were approximately 475,000 unvested restricted shares awarded to our named executive officers, with market and performance conditions, outstanding. In the event the vesting conditions are not achieved, the awards will lapse. Based on our assessment as of September 30, 2015, we expect the performance conditions relating to approximately

297,000 of such restricted share awards to be met in full. For the remaining 178,000 unvested restricted share awards, we reversed share-based compensation expense recognized from inception through March 31, 2015, or approximately $2.6 million, in the second quarter of 2015.

Charged to general and administrative expenses, total share-based compensation expense was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
	(In thousands)			
Restricted stock and performance awards	$ 5,707	$ 4,774	$ 12,962	$ 13,596
Employee stock purchase plan and stock options	1,278	885	3,264	2,519
	$ 6,985	$ 5,659	$ 16,226	$ 16,115

As of September 30, 2015, there was $30.1 million of total unrecognized compensation expense related to unvested restricted stock awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.6 years.

Restricted and performance stock activity for the nine months ended September 30, 2015 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2014	1,282,072	$ 33.55
Granted	428,223	64.25
Vested	(397,115)	33.39
Forfeited	(47,759)	37.51
Unvested balance as of September 30, 2015	1,265,421	43.84

The total fair value of restricted and performance awards granted during the nine months ended September 30, 2015 and 2014 was $27.9 million and $24.8 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, which vested during the nine months ended September 30, 2015 and 2014 was $25.2 million and $22.5 million, respectively.

6. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include the following:

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine

fair value as of September 30, 2015 included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Contingent consideration liability. The contingent consideration liability represents the remaining liability associated with the Medicare-Medicaid Plan (MMP) component of our South Carolina health plan acquisition in 2013, and is recorded in accounts payable and accrued liabilities. We applied a cash flow analysis to determine the fair value of this liability. The significant unobservable input is the purchase price estimate for the projected membership.

Auction rate securities. Auction rate securities are designated as available-for-sale and are reported at fair value in other assets. To estimate the fair value of these securities, we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of September 30, 2015.

Our financial instruments measured at fair value on a recurring basis at September 30, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 938,284	$ —	$ 938,284	$ —
Municipal securities	201,921	—	201,921	—
GSEs	133,624	133,624	—	—
U.S. treasury notes	74,943	74,943	—	—
Certificates of deposit	84,593	—	84,593	—
Asset-backed securities	27,282	—	27,282	—
Mortgage-backed securities	820	—	820	—
Subtotal - current investments	1,461,467	208,567	1,252,900	—
Auction rate securities	2,355	—	—	2,355
1.125% Call Option derivative asset	490,087	—	—	490,087
Total assets measured at fair value on a recurring basis	$ 1,953,909	$ 208,567	$ 1,252,900	$ 492,442
1.125% Conversion Option derivative liability	$ 489,940	$ —	$ —	$ 489,940
Contingent consideration liability	500	—	—	500
Total liabilities measured at fair value on a recurring basis	$ 490,440	$ —	$ —	$ 490,440

Our financial instruments measured at fair value on a recurring basis at December 31, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 641,729	$ —	$ 641,729	$ —
Municipal securities	127,045	—	127,045	—
GSEs	122,269	122,269	—	—
U.S. treasury notes	59,543	59,543	—	—
Certificates of deposit	68,876	—	68,876	—
Subtotal - current investments	1,019,462	181,812	837,650	—
Auction rate securities	4,847	—	—	4,847
1.125% Call Option derivative asset	329,323	—	—	329,323
Total assets measured at fair value on a recurring basis	$ 1,353,632	$ 181,812	$ 837,650	$ 334,170
1.125% Conversion Option derivative liability	$ 329,194	$ —	$ —	$ 329,194
Contingent consideration liability	500	—	—	500
Total liabilities measured at fair value on a recurring basis	$ 329,694	$ —	$ —	$ 329,694

The following table presents activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liability
	(In thousands)		
Balance at December 31, 2014	$ 4,847	$ 129	$ (500)
Total gains for the period recognized in:			
Other expenses, net	—	18	—
Other comprehensive income	108	—	—
Settlements	(2,600)	—	—
Balance at September 30, 2015	$ 2,355	$ 147	$ (500)

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our convertible senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	September 30, 2015				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 450,304	$ 960,515	$ —	$ 960,515	$ —
1.625% Notes	275,050	393,099	—	393,099	—
	$ 725,354	$ 1,353,614	$ —	$ 1,353,614	$ —

	December 31, 2014				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 435,330	$ 767,377	$ —	$ 767,377	$ —
1.625% Notes	268,767	337,292	—	337,292	—
	$ 704,097	$ 1,104,669	$ —	$ 1,104,669	$ —

7. Investments

The following tables summarize our investments as of the dates indicated:

	September 30, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 939,611	$ 668	$ 1,995	$ 938,284
Municipal securities	201,876	317	272	201,921
GSEs	133,528	126	30	133,624
U.S. treasury notes	74,724	219	—	74,943
Certificates of deposit	84,615	4	26	84,593
Asset-backed securities	27,265	24	7	27,282
Mortgage-backed securities	817	3	—	820
Subtotal - current investments	1,462,436	1,361	2,330	1,461,467
Auction rate securities	2,500	—	145	2,355
	$ 1,464,936	$ 1,361	$ 2,475	$ 1,463,822

	December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 642,910	$ 201	$ 1,382	$ 641,729
Municipal securities	127,185	129	269	127,045
GSEs	122,317	34	82	122,269
U.S. treasury notes	59,546	30	33	59,543
Certificates of deposit	68,893	1	18	68,876
Subtotal - current investments	1,020,851	395	1,784	1,019,462
Auction rate securities	5,100	—	253	4,847
	$ 1,025,951	$ 395	$ 2,037	$ 1,024,309

The contractual maturities of our investments as of September 30, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 659,930	$ 659,729
Due after one year through five years	771,762	770,930
Due after five years through ten years	30,744	30,808
Due after ten years	2,500	2,355
	$ 1,464,936	$ 1,463,822

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and nine months ended September 30, 2015 and 2014 were immaterial.

We have determined that unrealized gains and losses on our investments at September 30, 2015 and December 31, 2014, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of September 30, 2015:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 408,736	$ 1,611	300	$ 136,776	$ 384	80
Municipal securities	88,681	190	110	12,155	82	15
GSEs	51,393	30	17	—	—	—
Certificates of deposit	35,654	26	148	—	—	—
Asset-backed securities	16,689	7	20	—	—	—
Auction rate securities	—	—	—	2,355	145	3
	$ 601,153	$ 1,864	595	$ 151,286	$ 611	98

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2014:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 379,034	$ 1,151	265	$ 28,668	$ 231	10
Municipal securities	53,626	168	64	11,075	101	13
GSEs	75,025	69	22	2,986	13	3
U.S. treasury notes	19,199	33	13	—	—	—
Certificates of deposit	12,591	18	52	—	—	—
Auction rate securities	—	—	—	4,847	253	6
	$ 539,475	$ 1,439	416	$ 47,576	$ 598	32

8. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial.

	September 30, 2015	December 31, 2014
	(In thousands)	
California	$ 108,972	$ 310,938
Florida	23,096	2,141
Illinois	78,159	31,594
Michigan	49,348	19,880
New Mexico	87,493	49,609
Ohio	102,786	45,187
Puerto Rico	14,430	—
South Carolina	6,626	4,134
Texas	41,531	29,348
Utah	11,595	6,389
Washington	38,999	42,848
Wisconsin	26,530	8,102
Direct delivery and other	5,761	11,295
Total Health Plans segment	595,326	561,465
Molina Medicaid Solutions segment	24,565	34,991
	$ 619,891	$ 596,456

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. In connection with a Molina Medicaid Solutions segment state contract as of December 31, 2014, we maintained restricted investments as collateral for a letter of credit. The

following table presents the balances of restricted investments:

	September 30, 2015	December 31, 2014
	(In thousands)	
California	$ 373	$ 373
Florida	27,029	28,649
Illinois	311	311
Michigan	1,014	1,014
New Mexico	42,645	35,135
Ohio	11,726	12,719
Puerto Rico	10,098	5,097
South Carolina	310	6,040
Texas	3,502	3,500
Utah	3,616	3,601
Washington	151	151
Wisconsin	953	—
Other	242	888
Total Health Plans segment	101,970	97,478
Molina Medicaid Solutions segment	—	5,001
	$ 101,970	$ 102,479

The contractual maturities of our held-to-maturity restricted investments as of September 30, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 91,518	$ 91,519
Due one year through five years	10,452	10,464
	$ 101,970	$ 101,983

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	September 30, 2015	December 31, 2014
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,184,147	$ 870,429
Pharmacy payable	93,953	71,412
Capitation payable	30,061	28,150
Other	251,409	230,531
	$ 1,559,570	$ 1,200,522

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $161.4 million and $119.3 million as of September 30, 2015 and December 31, 2014, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30, 2015	Year Ended December 31, 2014
	(Dollars in thousands)	
Medical claims and benefits payable, beginning balance	$ 1,200,522	$ 669,787
Components of medical care costs related to:		
Current period	8,723,573	8,122,885
Prior periods (1)	(142,948)	(45,979)
Total medical care costs	8,580,625	8,076,906
Change in non-risk provider payables	42,067	(31,973)
Payments for medical care costs related to:		
Current period	7,371,504	7,064,427
Prior periods	892,140	449,771
Total paid	8,263,644	7,514,198
Medical claims and benefits payable, ending balance	$ 1,559,570	$ 1,200,522
Benefit from prior period as a percentage of:		
Balance at beginning of period	11.9%	6.9%
Premium revenue, trailing twelve months	1.2%	0.5%
Medical care costs, trailing twelve months	1.3%	0.6%

(1) The benefit from prior period development of medical claims and benefits payable for the nine months ended September 30, 2015 included approximately $23 million relating to programs that contain medical cost floor or corridor provisions. Accordingly, premium revenue for the nine months ended September 30, 2015 was reduced by the same amount.

The portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). IBNP represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under– or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2015 and 2014 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the

reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant uncertainties surrounding our IBNP estimates at September 30, 2015 are as follows:

- At our Illinois and Wisconsin health plans, we overpaid certain outpatient facility claims due to a system configuration error. For this reason, the reserves are subject to more than the usual amount of uncertainty.
- At our Washington health plan, delays related to the implementation of revised fee schedules resulted in a significant increase to our outpatient claims inventory in the first quarter of 2015, followed by a reduction in inventory during the second quarter of 2015. This significant fluctuation in inventory adds to the uncertainty of our unpaid claims estimates.
- Our Michigan health plan added approximately 88,000 new members through an acquisition in the third quarter of 2015. Because these new members may have different utilization patterns than our legacy members, the reserves are subject to more than the usual amount of uncertainty.
- Our Texas health plan enrolled approximately 15,000 members to its new MMP (Medicare-Medicaid Program) in the second and third quarters of 2015. Because we lack sufficient historical claims data, we are estimating the reserves for these new members by applying an estimated medical care ratio (MCR) based upon the assumptions supporting our premium rates. Because estimating incurred claims in this way is not directly tied to the actual claims experience, the reserves are subject to more than the usual amount of uncertainty.

We recognized favorable prior period claims development in the amount of $142.9 million for the nine months ended September 30, 2015. This amount represents our estimate as of September 30, 2015, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio and California health plans, approximately 61,000 and 100,000 members, respectively, were enrolled in the new Medicaid expansion program during 2014. Also in Ohio, approximately 17,000 members were enrolled in the new MMP program in 2014. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.
- At our New Mexico health plan, the state implemented a retroactive increase to the provider fee schedules in mid-2014. As a result, many claims that were previously settled were reopened, and subject to, additional payment. Because our reserving methodology is most accurate when claims payment patterns are consistent and predictable, the payment of additional amounts on claims that in some cases had been settled more than six months before added a substantial degree of complexity to our liability estimation process. Due to the difficulties in addressing that added complexity, liabilities recorded as of December 31, 2014 were in excess of amounts ultimately paid out.
- At our Washington health plan, in 2015 we collected amounts related to certain claims paid in 2013. Such collections were not anticipated in our reserves as of December 31, 2014.

11. Debt

As of September 30, 2015, contractual maturities of debt for the years ending December 31 are as follows (in thousands):

	Total	2015	2016	2017	2018	2019	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
1.625% Notes (1)	301,551	—	—	—	—	—	301,551
	$ 851,551	$ —	$ —	$ —	$ —	$ —	$ 851,551

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Credit Facility. On June 12, 2015, we entered into an unsecured $250 million revolving credit facility (Credit Facility) which will be used to finance working capital needs, acquisitions, capital expenditures, and other general corporate activities. The Credit Facility has a term of 5 years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit

Facility to up to $350 million. As of September 30, 2015, a $5 million letter of credit outstanding reduced borrowing available to $245 million, and no amounts were outstanding under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Although the Credit Facility is not secured by any of our assets, two of our wholly owned subsidiaries, Molina Medicaid Solutions and Molina Medical Management, Inc. (MMM), have jointly and severally guaranteed our obligations under the Credit Facility.

The Credit Facility contains customary non-financial and financial covenants, including a minimum fixed charge coverage ratio, a maximum debt-to-EBITDA ratio and minimum statutory net worth. We are required to not exceed a maximum debt-to-EBITDA ratio of 4.00 to 1.00. At September 30, 2015, we were in compliance with all financial covenants under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes (the 1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 at a rate of 1.125% per annum.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date.

Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;

- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;

- upon the occurrence of specified corporate events; or

- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes met the stock price trigger in the quarter ended September 30, 2015, and are convertible to cash through at least December 31, 2015. Because the 1.125% Notes may be converted into cash within 12 months, the $450.3 million carrying amount is reported in current portion of long-term debt as of September 30, 2015.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of September 30, 2015, the 1.125% Notes have a remaining amortization period of 4.3 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $458 million and $93 million as of September 30, 2015 and December 31, 2014, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $301.6 million aggregate principal amount of 1.625% convertible senior notes (the 1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Interest on the 1.625% Notes is payable semiannually in arrears on February 15 and August 15, at a rate of 1.625% per annum, beginning on February 15, 2015. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of September 30, 2015, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the notes in August 2018. As of September 30, 2015, the 1.625% Notes have a remaining amortization period of 2.9 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value exceeded their principal amount by approximately $89 million as of September 30, 2015, and did not exceed their principal amount as of December 31, 2014. At September 30, 2015, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $22.9 million.

The principal amounts, unamortized discount (net of premium related to 1.625% Notes), and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
September 30, 2015:			
1.125% Notes	$ 550,000	$ 99,696	$ 450,304
1.625% Notes	301,551	26,501	275,050
	$ 851,551	$ 126,197	$ 725,354
December 31, 2014:			
1.125% Notes	$ 550,000	$ 114,670	$ 435,330
1.625% Notes	301,551	32,784	268,767
	$ 851,551	$ 147,454	$ 704,097

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
		(In thousands)		
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate	$ 2,772	$ 3,132	$ 8,316	$ 9,732
Amortization of the discount	7,185	6,455	21,257	19,183
	$ 9,957	$ 9,587	$ 29,573	$ 28,915

Lease Financing Obligations. In 2013, we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the Molina Center located in Long Beach, California, and our Ohio health plan office building located in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Rent will increase 3% per year through the initial term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense amounted to $9.4 million and $9.3 million for the nine months ended September 30, 2015 and 2014, respectively.

As described and defined in further detail in Note 16, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings. We have concluded that we are the accounting owner of the buildings due to our continuing involvement with the properties. We have recorded $36.5 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheets as of September 30, 2015, which represents the total cost incurred by the Landlord for the construction of the buildings, net of accumulated depreciation. As of September 30, 2015 and December 31, 2014, the aggregate amount recorded to lease financing obligations, including the current portion, amounted to $40.3 million and $40.6 million, respectively. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense was $3.0 million and $2.2 million for the nine months ended September 30, 2015 and 2014, respectively. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was $0.9 million and $0.8 million for the nine months ended September 30, 2015 and 2014, respectively.

12. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	September 30, 2015	December 31, 2014
		(In thousands)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 490,087	$ —
	Non-current assets: Derivative asset	$ —	$ 329,323
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 489,940	$ —
	Non-current liabilities: Derivative liability	$ —	$ 329,194

Our derivative financial instruments do not qualify for hedge treatment; therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments in excess of the principal amount of the notes due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 6, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 6, "Fair Value Measurements."

As of September 30, 2015, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of September 30, 2015, as described in Note 11, "Debt."

13. Stockholders' Equity

Stockholders' equity increased $507.6 million during the nine months ended September 30, 2015 compared with stockholders' equity at December 31, 2014. The increase was due primarily to the common stock offering described below, net income of $113.4 million, and $20.7 million related to employee stock transactions.

Common Stock Offering. In June 2015, we completed an underwritten public offering of 5,750,000 shares of our common stock, including the over-allotment option, conducted pursuant to an effective shelf registration statement filed with the SEC in May 2015. Net of issuance costs, proceeds from the offering amounted to $373.2 million, or $64.90 per share, resulting in an increase to additional paid-in capital. We are using the proceeds to finance working capital needs, acquisitions, capital expenditures, and other general corporate activities.

1.125% Warrants. In connection with the 1.125% Notes Call Spread Overlay transaction described in Note 12, "Derivatives," we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under

the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, "Net Income per Share," for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Programs. Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2015.

Stock Plans. In connection with our equity incentive plans and employee stock purchase plan, we issued approximately 480,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the nine months ended September 30, 2015.

14. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our health plans and our direct delivery business. Our health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development, and implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." For presentation purposes, the cost of centralized services is reported within the Health Plans segment.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
	(In thousands)			
Revenue, continuing operations:				
Health Plans segment:				
Premium revenue	$ 3,377,030	$ 2,316,759	$ 9,652,054	$ 6,424,238
Premium tax revenue	99,047	81,240	289,003	203,053
Health insurer fee revenue	81,158	29,427	202,996	67,785
Investment income	4,832	2,041	11,675	5,615
Other revenue	1,745	2,327	4,996	8,523
Molina Medicaid Solutions segment:				
Service revenue	47,551	52,557	146,652	156,419
	$ 3,611,363	$ 2,484,351	$ 10,307,376	$ 6,865,633
Income from continuing operations before income tax expense:				
Health Plans segment	$ 101,899	$ 29,874	$ 272,924	$ 65,879
Molina Medicaid Solutions segment	10,954	9,905	37,787	30,594
Operating income, continuing operations	112,853	39,779	310,711	96,473
Other expenses, net	15,229	15,282	45,009	43,044
	$ 97,624	$ 24,497	$ 265,702	$ 53,429

	September 30, 2015	December 31, 2014
Total assets:		
Health Plans segment	$ 5,676,304	$ 4,270,870
Molina Medicaid Solutions segment	238,727	206,345
	$ 5,915,031	$ 4,477,215

15. Commitments and Contingencies

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that in late 2008 and early 2009, in connection with the acquisition of Florida NetPass under which Molina Healthcare of Florida, Inc. began conducting business in the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. Both the United States of America and the state of Florida have declined to intervene. The District Court dismissed this case with prejudice. The Relator filed a motion for rehearing, which we opposed and which we believe has little chance of success. Should the motion for rehearing be denied, this case will be over. Should the motion for rehearing be granted, we believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. The District Court dismissed this action as to Molina without leave to amend as to some allegations and with leave to amend as to other allegations. On October 22, 2015, the Relator filed a third amended complaint. We believe that we have several meritorious defenses to the claims of the Relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Hospital Management Contract. Our subsidiary, Molina Hospital Management, Inc. (MHM), manages a portion of a hospital owned by College Health Enterprises (College) in Long Beach, California pursuant to the terms of a Management Services Agreement dated as of August 30, 2013 (the MSA) by and between MHM and CHLB, LLC, an affiliate of College. MHM's management services pursuant to the MSA have generated a financial loss each month since the inception of this arrangement, and could continue to generate losses. On August 27, 2015, MHM delivered to College a notice of immediate termination for

cause of the MSA by reason of alleged material breaches by CHLB, LLC of various duties, obligations, and covenants in the MSA. On September 8, 2015, College notified us that it disputes the validity of our notice of termination in its entirety and, if the parties are unable to resolve their differences, College will commence binding arbitration. It is not possible to accurately predict or determine the eventual outcome of this matter.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,072 million at September 30, 2015, and $859 million at December 31, 2014. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $471.8 million and $202.6 million as of September 30, 2015 and December 31, 2014, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state.

As of September 30, 2015, our health plans had aggregate statutory capital and surplus of approximately $1,166 million compared with the required minimum aggregate statutory capital and surplus of approximately $592 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2015. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Related Party Transactions

We have entered into a lease (the Amended Lease) with 6th & Pine Development, LLC (the Landlord) for two office buildings. The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, John C. Molina pledged shares of common stock in the Company that he holds. Dr. J. Mario Molina, our chief executive officer, president and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

The Amended Lease provides for an annual rent escalator of 3.4% per year, and will expire on December 31, 2029, unless extended or earlier terminated. For information regarding the lease financing obligation, refer to Note 11, "Debt."

Refer to Note 17, "Variable Interest Entities (VIEs)," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

17. Variable Interest Entities (VIEs)

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. Beginning in the fourth quarter of 2014, JMMPC also provided certain specialty referral services to our California health plan

members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of September 30, 2015, JMMPC had total assets of $7.1 million, and total liabilities of $6.8 million. As of December 31, 2014, JMMPC had total assets of $31.1 million, and total liabilities of $30.8 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- uncertainties associated with the implementation of the Affordable Care Act, the Medicaid expansion, the insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the Medicare-Medicaid dual eligible demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and our ability to reduce over time the high medical costs commonly associated with new patient populations;
- federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and conflicting interpretations thereof;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, including 2014 and 2015 at-risk premium rules in the state of Texas;
- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;
- the success of our new health plan in Puerto Rico, including the successful resolution of the Puerto Rico debt crisis and the payment of all amounts due under our Medicaid contract;
- newly FDA-approved specialty drugs such as Sovaldi, Olysio, Harvoni, and other specialty drugs or generic drugs that are exorbitantly priced but not factored into the calculation of our capitated rates;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the resolution of the Illinois budget impasse and continued payment of our Illinois health plan;
- the accurate estimation of incurred but not reported or paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates or retroactive premium rate increases;
- efforts by states to recoup previously paid amounts;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable or unfavorable resolution of litigation, arbitration, or administrative proceedings, including a pending qui tam action in California, and the litigation commenced against us by the state of Louisiana alleging that Molina Medicaid Solutions and its predecessors used an incorrect reimbursement formula for the payment of pharmaceutical claims;
- the relatively small number of states in which we operate health plans;
- our management of a portion of College Health Enterprises' hospital in Long Beach, California;

- the effect on our Los Angeles County subcontract of Centene's acquisition of Health Net;
- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- newly emergent viruses or widespread epidemics, and associated public alarm;
- changes in general economic conditions, including unemployment rates;
- the sufficiency of our funds, on hand, to pay the amounts due upon conversion of our outstanding notes; and
- increasing competition and consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2014 and Part II, Item 1A of this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2014.

Company Overview

Molina Healthcare, Inc. provides quality health care to persons receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of September 30, 2015, these health plans served 3.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate, as well as the management of a hospital in southern California under a management services agreement.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise noted.

Overview of Financial Results, Continuing Operations

Financial results for the third quarter of 2015 improved significantly over the same quarter of 2014 due to higher revenue, greater medical cost efficiency, and full state reimbursement of the Affordable Care Act Health Insurer Fee (HIF).

Income from continuing operations, before tax expense, increased to $98 million in the third quarter of 2015, from $24 million in the third quarter of 2014.

Premium revenue increased approximately 46% in the third quarter of 2015, compared with the third quarter of 2014, due to increased Medicaid expansion, integrated Medicare-Medicaid Plan and Marketplace enrollment, growth in our Illinois health plan, and the start-up of our Puerto Rico health plan earlier this year.

Medical care costs as a percent of premium revenue (the "medical care ratio") decreased to 89.3% in the third quarter of 2015, from 90.6% in the third quarter of 2014.

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") increased to 8.0% in the third quarter of 2015, from 7.2% in the third quarter of 2014, primarily due to broker and exchange fees associated with our Marketplace product.

Health Care Reform

Government-sponsored initiatives, including the Affordable Care Act (ACA), will remain the primary focus of our business. Three recently implemented government-sponsored initiatives that have a significant impact on our current operations are as follows:

- *Medicaid Expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all people under age 65 with incomes that are at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington participate in Medicaid expansion. At September 30, 2015, our membership included approximately 540,000 Medicaid expansion members, or 16% of total membership.
- *Marketplace*. The ACA authorized the creation of Marketplace health insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois, Puerto Rico and South Carolina. At September 30, 2015, our membership included approximately 226,000 Marketplace members, with approximately 148,000, or 65%, of those members in Florida.
- Medicare-Medicaid Plans . To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states. Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMP in Michigan offered

coverage beginning in the second quarter of 2015. At September 30, 2015, our membership included approximately 56,000 integrated MMP members.

Health Insurer Fee Update

Effective January 1, 2014, the ACA requires most health plans to pay a fee based on premium revenue (the Health Insurer Fee, or HIF). The HIF is not tax deductible. Actuarial standards require that states reimburse us for the HIF we incur related to Medicaid revenue, in addition to paying us a "tax gross up" to compensate us for incremental income taxes we pay because the HIF is not tax deductible. From January 1, 2014 through June 30, 2015 we experienced varying degrees of success in securing formal commitments for the reimbursement of Medicaid related HIF and the associated tax gross up from our state partners. Consequently, we were not able to recognize as revenue such HIF reimbursement in full until the third quarter of 2015.

As of the third quarter of 2015, we have cumulatively recognized as revenue full reimbursement for Medicaid HIF and Medicaid HIF related tax effects for the period January 1, 2014 through September 30, 2015 across all of our health plans. During the third quarter of 2015, we recognized as revenue certain amounts of HIF reimbursement due from Michigan and Utah for prior periods. These amounts represented approximately $8 million ($0.08 per diluted share) of HIF revenue related to 2014 and approximately $17 million ($0.18 per diluted share) related to the first two quarters of 2015.

The amount of HIF reimbursement not recognized in the third quarter of 2014 was approximately $6 million ($0.07 per diluted share) and approximately $37 million ($0.49 per diluted share) for the nine months ended September 30, 2014.

For further discussion of the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates - Health Plans Segment and Molina Medicaid Solutions Segment

Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 1, "Basis of Presentation," for a discussion of the current year market updates for the Health Plans and Molina Medicaid Solutions segments.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, from our contracts with state Medicaid agencies, the federal Centers for Medicare and Medicaid Services (CMS), and our individual Marketplace membership.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new RFP open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services), populations such as the aged, blind or disabled, and regions or service areas. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

Premium revenue is fixed in advance of the periods covered, and is not generally subject to significant accounting estimates, except as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies." These premium revenues are recognized in the month that members are entitled to receive health care services. Premiums received in advance are deferred.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a PMPM basis, for the nine months ended September 30, 2015. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
Temporary Assistance for Needy Families (TANF), CHIP (1)	$ 110.00	$ 280.00	$ 180.00
Medicaid Expansion	310.00	490.00	390.00
Aged, Blind or Disabled (ABD)	470.00	1,530.00	970.00
Marketplace	180.00	440.00	260.00
Medicare-Medicaid Plan (MMP) – Integrated (2)	1,100.00	3,220.00	1,980.00
Medicare Special Needs Plans (Medicare)	860.00	1,100.00	1,030.00

(1) CHIP stands for Children's Health Insurance Program.
(2) MMP members for whom we provide both Medicaid and Medicare coverage. We began serving members under this program in the second quarter of 2014.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	September 30, 2015	June 30, 2015	December 31, 2014	September 30, 2014
Ending Membership by Health Plan:				
California	611,000	593,000	531,000	496,000
Florida	349,000	348,000	164,000	98,000
Illinois	101,000	101,000	100,000	21,000
Michigan	340,000	260,000	242,000	238,000
New Mexico	231,000	225,000	212,000	207,000
Ohio	344,000	332,000	347,000	337,000
Puerto Rico (1)	356,000	361,000	—	—
South Carolina	102,000	114,000	118,000	118,000
Texas	263,000	266,000	245,000	249,000
Utah	102,000	92,000	83,000	83,000
Washington	568,000	553,000	497,000	473,000
Wisconsin	103,000	107,000	84,000	84,000
	3,470,000	3,352,000	2,623,000	2,404,000
Ending Membership by Program:				
TANF/CHIP	2,249,000	2,180,000	1,809,000	1,678,000
Medicaid Expansion (2)	540,000	475,000	385,000	315,000
ABD	359,000	353,000	347,000	335,000
Marketplace (2)	226,000	261,000	15,000	16,000
MMP–Integrated	56,000	39,000	18,000	14,000
Medicare	40,000	44,000	49,000	46,000
	3,470,000	3,352,000	2,623,000	2,404,000

(1) The Puerto Rico health plan began serving members effective April 1, 2015.
(2) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of an MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When

providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. Our contracts may contain contingencies that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services (including long-term services and supports, or LTSS), general and administrative expenses, premium tax and health insurer fee expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on the actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Nearly all of our hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis.

- *Pharmacy expenses:* All drug, injectables, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses.

- *Capitation expenses:* Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.

- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.

- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements in Note 10, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the contract term, consistent with the revenue recognition period.

Financial Performance Summary, Continuing Operations

The following table summarizes our financial and operating performance from continuing operations for the three and nine months ended September 30, 2015 and 2014 (in thousands, except per-share data and percentages):

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2015	2014	% Change	2015	2014	% Change
Revenue:						
Premium revenue	$ 3,377,030	$ 2,316,759	45.8 %	$ 9,652,054	$ 6,424,238	50.2 %
Service revenue	47,551	52,557	(9.5)	146,652	156,419	(6.2)
Premium tax revenue	99,047	81,240	21.9	289,003	203,053	42.3
Health insurer fee revenue	81,158	29,427	175.8	202,996	67,785	199.5
Investment income	4,832	2,041	136.7	11,675	5,615	107.9
Other revenue	1,745	2,327	(25.0)	4,996	8,523	(41.4)
Total revenue	3,611,363	2,484,351	45.4	10,307,376	6,865,633	50.1
Operating expenses:						
Medical care costs	3,015,371	2,097,836	43.7	8,580,689	5,753,793	49.1
Cost of service revenue	34,573	40,067	(13.7)	103,294	117,831	(12.3)
General and administrative expenses	287,691	178,879	60.8	830,277	560,205	48.2
Premium tax expenses	99,047	81,240	21.9	289,003	203,053	42.3
Health insurer fee expenses	35,985	22,308	61.3	117,415	66,443	76.7
Depreciation and amortization	25,843	24,242	6.6	75,987	67,835	12.0
Total operating expenses	3,498,510	2,444,572	43.1	9,996,665	6,769,160	47.7
Operating income	112,853	39,779	183.7	310,711	96,473	222.1
Other expenses, net:						
Interest expense	15,269	14,419	5.9	45,091	42,234	6.8
Other (income) expense, net	(40)	863	(104.6)	(82)	810	(110.1)
Total other expenses, net	15,229	15,282	(0.3)	45,009	43,044	4.6
Income from continuing operations before income tax expense	97,624	24,497	298.5	265,702	53,429	397.3
Income tax expense	51,329	8,427	509.1	152,335	24,784	514.7
Income from continuing operations	$ 46,295	$ 16,070	188.1 %	$ 113,367	$ 28,645	295.8 %
Diluted net income per share, continuing operations	$ 0.77	$ 0.33	133.3 %	$ 2.07	$ 0.59	250.8 %
Diluted weighted average shares outstanding	59,978	48,644	23.3 %	54,699	48,088	13.7 %
Non-GAAP Measures:						
Adjusted net income per share, continuing operations	$ 0.89	$ 0.48	85.4 %	$ 2.47	$ 1.06	133.0 %
EBITDA	$ 142,363	$ 68,287	108.5 %	$ 398,118	$ 178,614	122.9 %
Operating Statistics:						
Medical care ratio (1)	89.3%	90.6%		88.9%	89.6%	
Service revenue ratio (2)	72.7%	76.2%		70.4%	75.3%	
General and administrative expense ratio (3)	8.0%	7.2%		8.1%	8.2%	
Premium tax ratio (1)	2.8%	3.4%		2.9%	3.1%	
Effective tax rate	52.6%	34.4%		57.3%	46.4%	
Net profit margin, continuing operations (3)	1.3%	0.6%		1.1%	0.4%	

(1) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) Service revenue ratio represents cost of service revenue as a percentage of service revenue.
(3) Computed as a percentage of total revenue.

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. generally accepted accounting principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2014	2015	2014
	(In thousands)			
Net income	$ 46,299	$ 16,122	$ 113,395	$ 28,431
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	29,463	29,307	87,261	83,513
Interest expense	15,269	14,419	45,091	42,234
Income tax expense	51,332	8,439	152,371	24,436
EBITDA	$ 142,363	$ 68,287	$ 398,118	$ 178,614

The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. The following table reconciles net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations.

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2015		2014		2015		2014	
	(In thousands, except per diluted share amounts)							
Net income, continuing operations	$ 46,295	$ 0.77	$ 16,070	$ 0.33	$ 113,367	$ 2.07	$ 28,645	0.59
Adjustments, net of tax:								
Amortization of convertible senior notes and lease financing obligations	4,672	0.08	4,246	0.09	13,924	0.25	12,723	0.26
Amortization of intangible assets	2,371	0.04	3,189	0.06	7,919	0.15	9,727	0.20
Adjusted net income, continuing operations (1)	$ 53,338	$ 0.89	$ 23,505	$ 0.48	$ 135,210	$ 2.47	$ 51,095	$ 1.06

(1) Beginning in the first quarter of 2015, we have revised the calculation of adjusted net income, continuing operations. We no longer subtract "depreciation, and amortization of capitalized software" and "share-based compensation" from net income, continuing operations to arrive at adjusted net income, continuing operations. We have made this change to better reflect the way in which we evaluate our financial performance, make financing and business decisions, and forecast and plan for future periods. All periods presented conform to this presentation.

Results of Operations, Continuing Operations

Three Months Ended September 30, 2015 Compared with Three Months Ended September 30, 2014

Health Plans Segment

Premium Revenue

Premium revenue increased approximately 46% in the third quarter of 2015, compared with the third quarter of 2014, due to increased Medicaid expansion, integrated Medicare-Medicaid Plan and Marketplace enrollment, growth in our Illinois health plan, and the start-up of our Puerto Rico health plan earlier this year.

Medical Care Costs

In the third quarter of 2015, medical care costs as a percent of premium revenue decreased to 89.3% in the third quarter of 2015 from 90.6% in the third quarter of 2014. Medical margin increased 65% in the third quarter of 2015 over the third quarter of 2014.

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended September 30,					
	2015			2014		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,224,141	$ 218.69	73.8%	$ 1,469,765	$ 206.43	70.1%
Pharmacy	417,721	41.07	13.9	337,150	47.35	16.1
Capitation	260,033	25.57	8.6	190,277	26.73	9.1
Direct delivery	30,226	2.97	1.0	24,863	3.49	1.1
Other	83,250	8.19	2.7	75,781	10.65	3.6
Total	$ 3,015,371	$ 296.49	100.0%	$ 2,097,836	$ 294.65	100.0%

The following table provides detailed fee-for-service medical claims data for the periods presented (dollars in thousands, except per-member amounts):

	Three Months Ended September 30,	
	2015	2014
Days in claims payable, fee for service	49	50
Number of claims in inventory at end of period	408,100	315,900
Billed charges of claims in inventory at end of period	$ 908,200	$ 749,300
Claims in inventory per member at end of period	0.12	0.13
Billed charges of claims in inventory per member at end of period	$ 261.73	$ 311.69
Number of claims received during the period	10,405,100	7,062,100
Billed charges of claims received during the period	$ 12,012,000	$ 7,897,500

Individual Health Plan Analysis

California. Premium revenue grew to $523.8 million in the third quarter of 2015, from $384.1 million in the third quarter of 2014, the result of higher Medicaid expansion membership (up 60,000 members) and TANF and ABD membership (up 44,000 members), as well as the start-up of an MMP plan in the second quarter of 2014 (15,000 members at September 30, 2015). Overall, enrollment on a member-month basis increased 27% in the third quarter of 2015 compared with the third quarter of 2014. The medical care ratio decreased to 83.6% in the third quarter of 2015, from 85.2% in the third quarter of 2014, as a higher medical care ratio for the Medicaid expansion program was more than offset by lower medical care ratios for other programs.

Florida. Premium revenue grew to $300.0 million in the third quarter of 2015, from $106.3 million in the third quarter of 2014, due to increases in Marketplace membership in 2015. In addition, medical margin improved $32.6 million in the third quarter of 2015 compared with the third quarter of 2014. The medical care ratio decreased to 88.3% from 97.8% in the third quarter of 2014, due to the lower medical care ratio of the Marketplace membership more than offsetting an increased medical care ratio for the Medicaid program.

Illinois. Premium revenue grew to $106.1 million in the third quarter of 2015, from $34.5 million in the third quarter of 2014. The plan experienced significant growth in late 2014, primarily within the traditional TANF program, and to a lesser degree within the Medicaid expansion program. Additionally, the plan served its first MMP members in the first half of 2014. The medical care ratio for the plan increased to 94.3% in the third quarter of 2015, from 82.1% in the third quarter of 2014. The plan's higher medical care ratio in 2015 was the result of higher medical care ratios among the health plan's TANF and ABD membership, which was only partially offset by lower medical care ratios for MMP and Medicaid expansion members.

Michigan. Premium revenue grew $72.5 million, or 35%, in the third quarter of 2015 compared with the third quarter of 2014, due to the addition of Medicaid expansion members beginning in the second quarter of 2014, and the Medicaid contract acquisition which closed in the third quarter of 2015. The medical care ratio decreased to 83.8% in the third quarter of 2015, from 85.1% in the third quarter of 2014, primarily due to growth of the Medicaid expansion program which has a lower medical care ratio than the plan's traditional Medicaid business.

New Mexico. Premium revenue grew $13.7 million, or 5%, in the third quarter of 2015 compared with the third quarter of 2014, due to substantial increases in membership in the Medicaid expansion program. The medical care ratio decreased to 92.5% in the third quarter of 2015, from 93.5% in the third quarter of 2014, due to lower medical care ratios for the ABD programs, which more than offset an increase in the medical care ratio for the Medicaid expansion and TANF programs. The New Mexico health plan reduced revenue by approximately $20 million in the third quarter of 2015 to better align our interpretation of certain contractual provisions related to revenue for members added retroactively to the state's interpretation of those provisions. Even after that adjustment, however, we estimate that, based upon our interpretation of the state's proposed definition of retroactive membership, the amount we would owe for the period January 1, 2014 through September, 2015 would exceed our accrual for such liability at September 30, 2015 by between $15 million and $20 million.

Ohio. Premium revenue grew $55.7 million, or 12%, in the third quarter of 2015 compared with the third quarter of 2014, due to growth in membership within the Medicaid expansion, MMP, and ABD programs. The medical care ratio decreased to 85.5% in the third quarter of 2015, from 86.9% in the third quarter of 2014, primarily due to lower medical care ratios for the health plan's Medicaid Expansion, MMP, and ABD membership, which were partially offset by a higher medical care ratio for its TANF membership.

Puerto Rico. The medical care ratio was 89.3% in the third quarter of 2015. The plan served its first members effective April 1, 2015.

South Carolina. The medical care ratio increased to 80.1% in the third quarter of 2015, from 78.0% in the third quarter of 2014.

Texas. Premium revenue grew $185.9 million, or 55%, in the third quarter of 2015 compared with the third quarter of 2014, primarily due to the addition of ABD members receiving nursing facility benefits effective March 1, 2015 and the start-up of the Texas MMP program on that same date. The medical care ratio for the Texas health plan increased to 94.1% in the third quarter of 2015, from 90.9% in the third quarter of 2014, primarily due to the addition of nursing facility benefits for ABD members and the startup of the MMP program. For a discussion of the plan's quality related revenue, refer to *Individual Health Plan Analysis* under "Nine Months Ended September 30, 2015 Compared with Nine Months Ended September 30, 2014," below.

Utah. The medical care ratio decreased to 90.5% in the third quarter of 2015, from 95.6% in the third quarter of 2014, due to improvement in the Medicaid medical care ratio and the addition of Marketplace membership which has a lower medical care ratio than the plan's traditional Medicaid business, which more than offset an increase to the medical care ratio for the health plan's Medicare membership.

Washington. Premium revenue grew $118.9 million, or 42%, in the third quarter of 2015 compared with the third quarter of 2014, primarily due to growth in Medicaid expansion membership. The medical care ratio decreased to 92.9% in the third quarter of 2015, from 97.6% in the third quarter of 2014, due to lower medical care ratios for the Medicaid expansion and ABD programs, which more than offset an increase in the medical care ratio for the TANF program.

Wisconsin. Premium revenue grew $28.5 million, or 66%, in the third quarter of 2015 when compared with the third quarter of 2014 as a result of increased Marketplace enrollment. The medical care ratio decreased to 79.6% in the third quarter of 2015, from 88.8% in the third quarter of 2014. We believe that medical care ratios below 80% are not sustainable over time.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan and program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended September 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,816	$ 523,798	$ 288.45	$ 437,785	$ 241.09	83.6%	$ 86,013
Florida	1,003	299,971	299.33	264,956	264.39	88.3	35,015
Illinois	306	106,089	347.34	100,063	327.61	94.3	6,026
Michigan	853	281,359	330.00	235,837	276.61	83.8	45,522
New Mexico	706	297,744	421.76	275,503	390.26	92.5	22,241
Ohio	1,024	510,135	498.36	436,045	425.98	85.5	74,090
Puerto Rico	1,057	180,783	170.91	161,511	152.69	89.3	19,272
South Carolina	322	85,115	264.37	68,178	211.76	80.1	16,937
Texas	791	523,342	661.69	492,617	622.84	94.1	30,725
Utah	307	84,921	276.72	76,876	250.50	90.5	8,045
Washington	1,679	399,791	238.03	371,439	221.14	92.9	28,352
Wisconsin	307	71,460	232.32	56,886	184.94	79.6	14,574
Other [3]	—	12,522	—	37,675	—	—	(25,153)
	10,171	$ 3,377,030	$ 332.05	$ 3,015,371	$ 296.49	89.3%	$ 361,659

	Three Months Ended September 30, 2014						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,451	$ 384,147	$ 264.79	$ 327,389	$ 225.66	85.2%	$ 56,758
Florida	243	106,275	437.47	103,898	427.69	97.8	2,377
Illinois	38	34,514	906.78	28,333	744.41	82.1	6,181
Michigan	727	208,873	287.15	177,680	244.27	85.1	31,193
New Mexico	652	284,058	435.67	265,697	407.51	93.5	18,361
Ohio	994	454,410	457.17	395,098	397.49	86.9	59,312
South Carolina	355	95,455	268.97	74,489	209.89	78.0	20,966
Texas	748	337,430	451.24	306,577	409.98	90.9	30,853
Utah	250	78,703	315.04	75,270	301.30	95.6	3,433
Washington	1,410	280,883	199.18	274,213	194.45	97.6	6,670
Wisconsin	252	42,933	170.40	38,107	151.25	88.8	4,826
Other [3]	—	9,078	—	31,085	—	—	(22,007)
	7,120	$ 2,316,759	$ 325.40	$ 2,097,836	$ 294.65	90.6%	$ 218,923

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

	Three Months Ended September 30, 2015 (1)							
	Member Months[2]	Premium Revenue		Medical Care Costs		MCR[3]	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	6,652	$ 1,138,673	$ 171.16	$ 1,070,109	$ 160.85	94.0%	$ 68,564
Medicaid Expansion	1,541	564,982	366.80	457,716	297.16	81.0	107,266
ABD	1,052	1,069,999	1,017.68	978,973	931.11	91.5	91,026
Marketplace	646	169,670	262.74	124,121	192.21	73.2	45,549
Medicare	123	123,255	1,002.50	114,394	930.43	92.8	8,861
MMP	157	310,451	1,975.10	270,058	1,718.13	87.0	40,393
	10,171	$ 3,377,030	$ 332.05	$ 3,015,371	$ 296.49	89.3%	$ 361,659

(1) Three months ended September 30, 2014 data not presented due to lack of comparability.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended September 30,	
	2015	2014
	(In thousands)	
Service revenue before amortization	$ 47,551	$ 53,286
Amortization recorded as reduction of service revenue	—	(729)
Service revenue	47,551	52,557
Cost of service revenue	34,573	40,067
General and administrative costs	1,854	1,791
Amortization of customer relationship intangibles	170	794
Operating income	$ 10,954	$ 9,905

Operating income for our Molina Medicaid Solutions segment increased by $1.0 million in the third quarter of 2015, compared with the third quarter of 2014.

Results of Operations, Continuing Operations

Nine Months Ended September 30, 2015 Compared with Nine Months Ended September 30, 2014

Health Plans Segment

Premium Revenue

Premium revenue increased approximately 50% in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014, as a result of enrollment growth across all health plan programs.

Medical Care Costs

In the nine months ended September 30, 2015, medical care costs as a percent of premium revenue decreased to 88.9% from 89.6% during the nine months ended September 30, 2014. Medical margin increased 60% in the nine months ended September 30, 2015 over the nine months ended September 30, 2014.

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Nine Months Ended September 30,					
	2015			2014		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 6,275,222	$ 217.63	73.1%	$ 4,028,863	$ 198.61	70.0%
Pharmacy	1,160,818	40.26	13.5	919,374	45.32	16.0
Capitation	724,715	25.13	8.5	536,533	26.45	9.3
Direct delivery	84,882	2.94	1.0	69,947	3.45	1.2
Other	335,052	11.62	3.9	199,076	9.81	3.5
Total	$ 8,580,689	$ 297.58	100.0%	$ 5,753,793	$ 283.64	100.0%

The following table provides detailed fee-for-service medical claims data for the periods presented (dollars in thousands, except per-member amounts):

	Nine Months Ended September 30,	
	2015	2014
Days in claims payable, fee for service	49	50
Number of claims in inventory at end of period	408,100	315,900
Billed charges of claims in inventory at end of period	$ 908,200	$ 749,300
Claims in inventory per member at end of period	0.12	0.13
Billed charges of claims in inventory per member at end of period	$ 261.73	$ 311.69
Number of claims received during the period	29,084,100	19,703,300
Billed charges of claims received during the period	$ 33,517,100	$ 21,506,500

Individual Health Plan Analysis

California. Premium revenue grew $478.2 million, or 45%, in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014, the result of higher membership, as described above. Overall, enrollment on a member-month basis increased 34% in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014. Increased premium revenue was also driven by a 12% increase in premium revenue PMPM, which was the result of the higher relative premium revenue PMPM among those programs experiencing enrollment growth (Medicaid expansion and MMP); and the addition of long-term care benefits to some of the health plan's Medicaid membership. The medical care ratio increased to 87.7% in the nine months ended September 30, 2015, from 83.9% in the nine months ended September 30, 2014, as a lower medical care ratio for the ABD program was more than offset by higher medical care ratios for other programs.

Florida. Premium revenue grew to $868.3 million in the nine months ended September 30, 2015, from $312.9 million in the nine months ended September 30, 2014, due to increased Marketplace membership. The medical care ratio decreased to 87.9% in the nine months ended September 30, 2015, from 92.8% in the nine months ended September 30, 2014, due to the lower medical care ratio of the Marketplace membership more than offsetting an increase in the medical care ratio for the Medicaid program.

Illinois. Premium revenue grew to $312.0 million in the nine months ended September 30, 2015, from $68.9 million in the nine months ended September 30, 2014, due to significant membership growth in late 2014, as described above. The medical care ratio increased to 92.2% in the nine months ended September 30, 2015, from 91.8% in the nine months ended September 30, 2014.

Michigan. Premium revenue grew $170.7 million, or 30%, in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014, due to increased Medicaid expansion membership and the startup of the MMP program. The medical care ratio of 84.0% for the nine months ended September 30, 2015, was essentially unchanged from the 83.9% reported for the nine months ended September 30, 2014.

New Mexico. Premium revenue grew $156.1 million, or 20%, in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014, due to substantial increases in membership in all Medicaid programs. The medical care ratio of 90.4% in the nine months ended September 30, 2015, was comparable with the medical care ratio in the nine months ended September 30, 2014.

Ohio. Premium revenue grew $472.4 million, or 45%, in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014, due to growth in membership within the Medicaid expansion, MMP, and ABD programs. The medical care ratio decreased to 83.5% in the nine months ended September 30, 2015, from 85.7% in the nine months ended September 30, 2014, due to lower medical care ratios in all Medicaid programs.

Puerto Rico. As previously disclosed, the plan began serving members on April 1, 2015. The plan's medical care ratio was 92.3% for the nine months ended September 30, 2015.

South Carolina. The medical care ratio decreased to 77.5% in the nine months ended September 30, 2015, from 86.6% in the nine months ended September 30, 2014. We believe that medical care ratios below 80% are not sustainable over time.

Texas. Premium revenue grew $439.0 million, or 45%, in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014, primarily due to the addition of ABD members receiving nursing facility benefits effective March 1, 2015, and the start-up of the Texas MMP program on that date. The medical care ratio increased to 92.6% in the nine months ended September 30, 2015, from 91.7% in the nine months ended September 30, 2014.

As previously disclosed, we have deferred recognition of that portion of our quality related revenue in Texas that is based upon measures for which we do not have historical information, clear definitions, and clarity around minimum standards. Such revenue is estimated to be approximately $20 million for all of 2014 and $17 million for the nine months ended September 30, 2015. We have not recognized any of this revenue through September 30, 2015.

Utah. The financial performance of the plan was consistent between the nine months ended September 30, 2015, and the same period in 2014.

Washington. Premium revenue grew $244.6 million, or 26%, in the nine months ended September 30, 2015 when compared with the nine months ended September 30, 2014, primarily due to growth in Medicaid expansion membership. The medical care ratio decreased to 92.3% in the nine months ended September 30, 2015, from 93.2% in the nine months ended September 30, 2014, as a lower medical care ratio for members served under the ABD program more than offset a higher medical care ratio in the TANF and Medicaid expansion programs.

Wisconsin. Premium revenue grew $87.9 million, or 74%, in the nine months ended September 30, 2015 compared with the nine months ended September 30, 2014 as a result of increased Marketplace enrollment. The medical care ratio decreased to 78.4% in the nine months ended September 30, 2015, from 84.5% in the nine months ended September 30, 2014. We believe that medical care ratios below 80% are not sustainable over time.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan and program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Nine Months Ended September 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	5,256	$ 1,538,081	$ 292.64	$ 1,349,265	$ 256.71	87.7%	$ 188,816
Florida	2,953	868,259	294.05	763,251	258.49	87.9	105,008
Illinois	912	312,003	342.27	287,760	315.68	92.2	24,243
Michigan	2,382	738,390	310.01	620,540	260.53	84.0	117,850
New Mexico	2,080	933,208	448.75	843,473	405.60	90.4	89,735
Ohio	3,075	1,533,690	498.76	1,281,305	416.69	83.5	252,385
Puerto Rico	2,139	374,767	175.17	345,751	161.60	92.3	29,016
South Carolina	1,002	269,530	269.11	208,779	208.45	77.5	60,751
Texas	2,372	1,417,535	597.53	1,312,724	553.35	92.6	104,811
Utah	850	242,027	284.83	222,747	262.14	92.0	19,280
Washington	4,885	1,185,899	242.75	1,094,250	223.99	92.3	91,649
Wisconsin	929	206,334	221.97	161,735	173.99	78.4	44,599
Other [3]	—	32,331	—	89,109	—	—	(56,778)
	28,835	$ 9,652,054	$ 334.74	$ 8,580,689	$ 297.58	88.9%	$ 1,071,365

	Nine Months Ended September 30, 2014						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,040	$ 1,059,860	$ 262.34	$ 889,656	$ 220.21	83.9%	$ 170,204
Florida	742	312,864	421.80	290,224	391.28	92.8	22,640
Illinois	69	68,948	998.03	63,299	916.26	91.8	5,649
Michigan	2,077	567,706	273.28	476,392	229.33	83.9	91,314
New Mexico	1,818	777,120	427.55	702,257	386.36	90.4	74,863
Ohio	2,615	1,061,335	405.81	909,142	347.62	85.7	152,193
South Carolina	1,109	287,928	259.69	249,437	224.97	86.6	38,491
Texas	2,239	978,492	437.00	897,434	400.80	91.7	81,058
Utah	745	233,931	314.13	215,564	289.47	92.1	18,367
Washington	4,050	941,303	232.40	877,418	216.63	93.2	63,885
Wisconsin	782	118,386	151.48	100,059	128.03	84.5	18,327
Other [3]	—	16,365	—	82,911	—	—	(66,546)
	20,286	$ 6,424,238	$ 316.69	$ 5,753,793	$ 283.64	89.6%	$ 670,445

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

	Nine Months Ended September 30, 2015 (1)							
	Member Months(2)	Premium Revenue		Medical Care Costs		MCR(3)	Medical Margin
		Total	PMPM	Total	PMPM		
TANF and CHIP	18,687	$ 3,279,989	$ 175.52	$ 3,030,424	$ 162.16	92.4%	$ 249,565
Medicaid Expansion	4,202	1,654,321	393.71	1,324,945	315.33	80.1	329,376
ABD	3,172	3,063,365	965.91	2,788,586	379.27	91.0	274,779
Marketplace	2,017	524,395	259.97	369,803	183.33	70.5	154,592
Medicare	387	396,727	1,026.00	383,399	991.53	96.6	13,328
MMP	370	733,257	1,981.40	683,532	1,847.03	93.2	49,725
	28,835	$ 9,652,054	$ 334.74	$ 8,580,689	$ 297.58	88.9%	$ 1,071,365

(1) Nine months ended September 30, 2014, data not presented due to lack of comparability.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Nine Months Ended September 30,	
	2015	2014
	(In thousands)	
Service revenue before amortization	$ 147,713	$ 158,605
Amortization recorded as reduction of service revenue	(1,061)	(2,186)
Service revenue	146,652	156,419
Cost of service revenue	103,294	117,831
General and administrative costs	5,062	5,432
Amortization of customer relationship intangibles	509	2,562
Operating income	$ 37,787	$ 30,594

Operating income for our Molina Medicaid Solutions segment increased $7.2 million in the nine months ended September 30, 2015, compared with the nine months ended September 30, 2014, primarily as a result of renegotiated and extended state contracts, various operational efficiencies, and decreased intangible amortization.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") increased to 8.0% in the third quarter of 2015, from 7.2% in the third quarter of 2014, primarily due to increased broker and exchange fees associated with the Marketplace program. The general and administrative expense ratio decreased slightly to 8.1% for the nine months ended September 30, 2015, compared with 8.2% for the nine months ended September 30, 2014, primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Premium Tax Expense

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.8% in the third quarter of 2015 compared with 3.4% in the third quarter of 2014, and 2.9% in the nine months ended September 30, 2015 compared with 3.1% in the nine months ended September 30, 2014.

Health Insurer Fee Revenue and Expenses

As noted above, from January 1, 2014 through June 30, 2015, we experienced varying degrees of success in securing formal commitments for the reimbursement of Medicaid related HIF and the associated tax gross up from our state partners. Consequently, we were not able to recognize as revenue such HIF reimbursement in full until the third quarter of 2015.

As of the third quarter of 2015, we have cumulatively recognized as revenue full reimbursement for Medicaid HIF and Medicaid HIF related tax effects for the period January 1, 2014 through September 30, 2015 across all of our health plans.

Health insurer fee revenue, as a percentage of premium revenue, increased to 2.4% in the third quarter of 2015 from 1.3% in the third quarter of 2014, and increased to 2.1% in the nine months ended September 30, 2015, from 1.1% in the nine months ended September 30, 2014. HIF revenue increased in 2015 compared with 2014 due to improved reimbursement of Medicaid-related HIF expenses in 2015.

Health insurer fee expenses, as a percentage of premium revenue, were 1.1% in the third quarter of 2015, compared with 1.0% in the third quarter of 2014, and 1.2% in the nine months ended September 30, 2015, compared with 1.0% in the nine months ended September 30, 2014.

In addition, both HIF revenue and expenses increased over the prior year proportionally to the increase in the total HIF tax base, which is assessed to all insurers. This base increased to $11.3 billion in 2015, from $8.0 billion in 2014. Refer to "Liquidity and Capital Resources—Financial Condition" below, for further discussion of the HIF.

Depreciation and Amortization

The following tables present all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Three Months Ended September 30,			
	2015		2014	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 22,079	0.6%	$ 19,910	0.8%
Amortization of intangible assets, continuing operations	3,764	0.1	4,332	0.2
Depreciation and amortization, continuing operations	25,843	0.7	24,242	1.0
Amortization recorded as reduction of service revenue	—	—	729	—
Amortization of capitalized software recorded as cost of service revenue	4,664	0.1	8,839	0.4
	$ 30,507	0.8%	$ 33,810	1.4%

	Nine Months Ended September 30,			
	2015		2014	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 64,478	0.6%	$ 54,582	0.8%
Amortization of intangible assets, continuing operations	11,509	0.1	13,253	0.2
Depreciation and amortization, continuing operations	75,987	0.7	67,835	1.0
Amortization recorded as reduction of service revenue	1,061	—	2,186	—
Amortization of capitalized software recorded as cost of service revenue	15,535	0.2	29,443	0.4
Depreciation and amortization reported in the statement of cash flows	$ 92,583	0.9%	$ 99,464	1.4%

Interest Expense

Interest expense increased to $15.3 million for the third quarter of 2015, from $14.4 million for the third quarter of 2014. Interest expense increased to $45.1 million for the nine months ended September 30, 2015, from $42.2 million for the nine months ended September 30, 2014. The increase was due primarily to the issuance of the 1.625% Notes in the third quarter of 2014. For further details regarding convertible senior notes transactions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 11, "Debt."

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $7.4 million and $6.7 million for the three months ended September 30, 2015 and 2014, respectively, and $22.1 million and $20.2 million for the nine months ended September 30, 2015 and 2014, respectively.

Income Taxes

The provision for income taxes in continuing operations was recorded at an effective rate of 52.6% for the third quarter of 2015, compared with 34.4% for the third quarter of 2014, and 57.3% for the nine months ended September 30, 2015 compared with 46.4% for the nine months ended September 30, 2014. The effective tax rate for 2015 is higher than 2014 primarily as a result of higher non-deductible HIF expenses in 2015, and our inability to record tax benefits for certain losses incurred at our Puerto Rico health plan, which commenced operations in 2015. The effective tax rate would have been approximately 60% for the third quarter of 2015 absent certain discrete tax benefits.

Liquidity and Capital Resources

Introduction

Our regulated health plan subsidiaries generate significant cash flows from premium revenue. We generally receive premium revenue a short time before we pay for the related health care services; such cash flows generate our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. In addition, the majority of our premium revenues comes from the joint federal and state funding of the Medicaid and CHIP programs. From time to time, states may delay premium payments. Whenever a state delays payments, for whatever the reason, our liquidity is reduced. See further discussion under *Financial Condition*, below.

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our regulated subsidiaries is in the form of cash, cash equivalents, and investments. Cash in excess of the capital needs of our regulated health plans is generally paid to us in the form of dividends, when and as permitted by applicable regulations, for general corporate use. For the nine months ended September 30, 2015, we received dividends from subsidiaries amounting to $42 million. For the nine months ended September 30, 2014, the parent received no dividends from subsidiaries.

We generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies that conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of September 30, 2015, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities.

All of our investments are classified as current assets, except for our restricted investments and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Nine Months Ended September 30,		
	2015	2014	Change
	(In thousands)		
Net cash provided by operating activities	$ 905,786	$ 841,198	$ 64,588
Net cash used in investing activities	(665,075)	(261,280)	(403,795)
Net cash provided by financing activities	384,436	82,783	301,653
Net increase in cash and cash equivalents	$ 625,147	$ 662,701	$ (37,554)

Operating Activities. Net cash provided by operating activities increased $64.6 million in the nine months ended September 30, 2015 compared to the nine months ended September 30, 2014, primarily due to the following sources of cash:

- Net income increased $85.0 million;
- Accounts receivable provided $103.3 million, primarily due to collections of premiums receivable at our California health plan in the first quarter of 2015;
- Amounts due government agencies provided $112.3 million, in connection with Health Plans segment membership growth in programs that contain medical cost floors or medical cost corridors. Under such programs, a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs; and
- Accounts payable and accrued liabilities provided $59.9 million, primarily due to increases in accruals for expenses associated with growth in our workforce.

The sources of cash were partially offset by the following uses of cash:

- Medical claims and benefits payable were a use of $95.0 million, primarily because membership and related medical costs grew at a higher rate for the same period in 2014 than in 2015, resulting in a lower year-over-year change; and
- Deferred revenue was a use of $197.5 million, primarily due to an advance premium payment received by our Washington health plan in September 2014, with no comparable activity in September 2015.

Investing Activities. Cash used in investing activities increased $403.8 million in the nine months ended September 30, 2015 compared to the nine months ended September 30, 2014, primarily due to the investment of the net proceeds from our common stock offering in June 2015, as described below. In addition, net cash paid in business combinations increased $69.8 million, as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 4, "Business Combinations."

Financing Activities. Cash provided by financing activities increased $301.7 million year over year, primarily due to $373.2 million proceeds, net of issuance costs, from the June 2015 offering of 5.75 million shares of our common stock.

Financial Condition

On a consolidated basis, at September 30, 2015, working capital amounted to $1,049.2 million, compared with $1,070.6 million at December 31, 2014. We held cash and investments, including restricted investments, of $3,730.0 million and $2,665.9 million at September 30, 2015 and December 31, 2014, respectively.

Credit Facility Covenants. The $250 million revolving Credit Facility contains customary non-financial and financial covenants, including a minimum interest coverage ratio, a maximum net debt-to-EBITDA ratio, and minimum statutory net worth, as described in greater detail in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt." As of September 30, 2015, a $5 million letter of credit outstanding reduced borrowing available to $245 million, and no amounts were outstanding, under the Credit Facility. At September 30, 2015, we were in compliance with all financial covenants under the Credit Facility.

States' Budgets. As noted above, from time to time the states in which our health plans operate may delay premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of September 30, 2015, our Illinois health plan served approximately 101,000 members, and recognized premium revenue of approximately $312 million for the nine months ended September 30, 2015. As of October 23, 2015, Illinois is current with its premium payments through August 31, 2015, but has not paid us in full for September 2015.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs including healthcare-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. Our Puerto Rico health plan became operational on April 1, 2015. As of September 30, 2015, the plan served approximately 356,000 members and recognized premium revenue of approximately $181 million in the third quarter of 2015, or approximately $60 million per month. As of October 23, 2015, the Commonwealth continues to pay us weekly and is current with its payments.

It has been our practice in the past, and will remain so in the future, to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Health Insurer Fee. Effective January 1, 2014, the ACA requires most health plans to pay a fee based on premium revenue (the Health Insurer Fee, or HIF). The HIF is not tax deductible. From January 1, 2014 through June 30, 2015, we experienced varying degrees of success in securing formal commitments for the reimbursement of Medicaid-related HIF and the associated tax gross up from our state partners. Consequently, we were not able to recognize as revenue such HIF reimbursement in full until the third quarter of 2015. As of the third quarter of 2015, however, we have been able to recognize as revenue full reimbursement for Medicaid HIF and Medicaid HIF related tax effects for the period January 1, 2014 through September 30, 2015 across all of our health plans. We do not believe that the failure to achieve full reimbursement of the HIF going forward represents a significant business risk.

The following table provides the details of our HIF revenue reimbursement by health plan as of September 30, 2015 (in thousands):

	HIF Reimbursement Revenue, Gross[1]					
	Nine Months Ended September 30, 2015					Year Ending Dec. 31, 2015
	Recognized				Necessary for Full Reimbursement	Necessary for Full Reimbursement
	Q1 2015	Q2 2015	Q3 2015	Total		
2015 HIF:						
California	$ —	$ 17,258	$ 5,925	$ 23,183	$ 23,183	$ 30,910
Florida	2,027	2,042	2,056	6,125	6,125	8,167
Illinois	965	973	922	2,860	2,860	3,814
Michigan	—	—	20,735	20,735	20,735	27,646
New Mexico	7,539	7,597	7,647	22,783	22,783	30,377
Ohio	11,936	12,027	12,105	36,068	36,068	48,091
South Carolina	3,053	3,077	3,097	9,227	9,227	12,303
Texas	5,839	5,884	5,922	17,645	17,645	23,527
Utah	—	—	4,467	4,467	4,467	5,956
Washington	10,951	10,963	5,721	27,635	27,635	36,847
Wisconsin	1,126	1,135	1,142	3,403	3,403	4,537
Subtotal, Medicaid	43,436	60,956	69,739	174,131	174,131	232,175
Marketplace	398	400	402	1,200	1,200	1,601
Medicare	5,702	3,652	4,711	14,065	14,065	18,754
	49,536	65,008	74,852	189,396	$ 189,396	$ 252,530
2014 HIF:						
California	—	11,616	—	11,616		
Michigan	—	—	6,797	6,797		
Utah	—	—	1,286	1,286		
	$ 49,536	$ 76,624	$ 82,935	$ 209,095		
Recognized in:						
Health insurer fee revenue	$ 47,948	$ 73,890	81,158	$ 202,996		
Premium tax revenue	1,588	2,734	1,777	6,099		
	$ 49,536	$ 76,624	$ 82,935	$ 209,095		

(1) Amounts in the table include our estimate of the full economic impact of the HIF including the premium tax and income tax effect.

Convertible Senior Notes Classification. As described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 11, "Debt," our 1.125% Notes met the stock price trigger in the quarter ended September 30, 2015, and are convertible to cash through at least December 31, 2015. Because the 1.125% Notes may be converted into cash within 12 months, the $450.3 million carrying amount is reported in current portion of long-term debt as of September 30, 2015, which resulted in decreased working capital as of September 30, 2015. We believe that the amount of the 1.125% Notes that may be converted over the next twelve months, if any, will be insignificant. For more information, refer to Part II, Item 1A of this Form 10-Q, "Risk Factors."

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Future Sources and Uses of Liquidity

In Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 4, "Business Combinations," we describe two Medicaid contract acquisitions in Florida and Michigan that closed in the third quarter of 2015 for total consideration of approximately $69 million. We have also entered into agreements to acquire Medicaid contracts that we expect to add approximately 180,000 additional members within the next six months to our health plans in Florida and Illinois. In addition, we have entered into an agreement to acquire a behavioral and mental health services provider for approximately $200 million, which we expect to close in the fourth quarter of 2015. The aggregate amount we expect to spend for the acquisitions that have been announced but not yet closed as of October 29, 2015, is approximately $309 million.

For information on our Credit Facility, convertible senior notes, and other financing arrangements, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt."

For information on our common stock offering, shelf registration statement, and securities repurchase program, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 13, "Stockholders' Equity."

Regulatory Capital and Dividend Restrictions

For information on our regulatory capital requirements and dividend restrictions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 15, "Commitments and Contingencies."

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2014, was disclosed in our 2014 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the nine months ended September 30, 2015. For further discussion and maturities of our long-term debt, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements.
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the third quarter of 2015 in connection with such contractual provisions.
- *Health Plans segment Marketplace premium stabilization programs*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the third quarter of 2015 in connection with such premium stabilization programs.
- *Health Plans segment quality incentives*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the third quarter of 2015 in connection with such quality incentives.
- *Molina Medicaid Solutions segment revenue and cost recognition*. Refer to Part II, Item 8 of our 2014 Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of Molina Medicaid Solutions' service revenue and cost of service revenue recognition.

There have been no significant changes during the nine months ended September 30, 2015, to the items that we disclosed as our critical accounting estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2014.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2015 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

A description of our legal proceedings is included in and incorporated by reference to Note 15 of the Notes to the Consolidated Financial Statements contained in Part I, Item 1 of this report.

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed below, which supplement and should be read together with the risk factors, discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2014 and Part II, Item 1A - Risk Factors, in our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2015. The risk factors described herein, in our 2014 Annual Report on Form 10-K and our June 30, 2015 Quarterly Report on Form 10-Q, are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

Centene's acquisition of Health Net could affect the Los Angeles county subcontract of our California health plan.

Our California health plan operates in Los Angeles County, California as a subcontractor to Health Net, which holds a direct Medi-Cal contract with the state of California. Health Net has entered into a merger agreement with Centene Corporation, with the merger expected to close in early 2016. We currently do not expect there to be any material change to our Los Angeles county subcontract in connection with Centene's acquisition of Health Net. However, if Centene seeks to modify our subcontract or otherwise refuses to perform under the contract, our business, financial condition, cash flows, or results of operations may be adversely affected.

Our management of a portion of a hospital owned by College Health Enterprises in Long Beach, California has generated, and could continue to generate, losses.

Our subsidiary, Molina Hospital Management, Inc. (MHM), manages a portion of a hospital owned by College Health Enterprises (College) in Long Beach, California pursuant to the terms of a Management Services Agreement dated as of August 30, 2013 (the MSA) by and between MHM and CHLB, LLC, an affiliate of College. MHM's management services pursuant to the MSA have generated a financial loss each month since the inception of this arrangement, and could continue to generate losses.

On August 27, 2015, MHM delivered to College a notice of immediate termination for cause of the MSA by reason of alleged material breaches by CHLB, LLC of various duties, obligations, and covenants in the MSA. On September 8, 2015, College notified us that it disputes the validity of our notice of termination in its entirety and, if the parties are unable to resolve their differences, College will commence binding arbitration. Subsequent to September 8, 2015, the parties engaged in extensive discussions regarding the issues presented, and additional discussions between the parties are anticipated. If the parties are unable to resolve this matter, the dispute will likely proceed to arbitration. The MSA provides that it may not be terminated until there has been a final determination that such termination was proper in accordance with the dispute resolution procedures provided for in the MSA. Until receipt of such final determination, the MSA provides that it shall remain in full force and effect, and thus prior to such final determination both parties are required to continue to perform under the MSA, and MHM would likely continue to generate losses under the MSA.

In addition to its rights with regard to termination for breach, MHM has the right to terminate the MSA without cause. However, termination without cause would trigger an obligation to pay CHLB, LLC all amounts due under the remaining eight-year term of the MSA, discounted to present value, as well as certain contract run-out costs (totaling between $30 million and $40 million).

The Commonwealth of Puerto Rico may become unable to pay the premiums of our Puerto Rico health plan.

The government of Puerto Rico currently faces major fiscal and liquidity challenges. The government recently warned that it may “lack sufficient resources to fund all necessary governmental programs and services as well as meet debt service obligations for fiscal year 2016.” Much of the Puerto Rican government’s revenue stream for the first part of its fiscal year, which began on July 1st, is earmarked to redeem revenue bonds. On June 29, 2015, Puerto Rico’s governor, Alejandro Garcia Padilla, stated during a televised address that “the debt is not payable.” Further, the island’s ability to access credit markets appears highly uncertain, and its ability to meet future debt service payments depends in part on the willingness of investors to roll over existing debt.

The extreme financial difficulties faced by the Commonwealth may make it impossible for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties’ Medicaid contract. As of September 30, 2015, our

Puerto Rico health plan served approximately 356,000 members, and had recognized premium revenue of approximately $181 million in the third quarter of 2015, or approximately $60 million per month. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We may not have the funds necessary to pay the amounts due upon conversion or required repurchase of our outstanding notes, and our indebtedness may contain limitations on our ability to pay the amounts due upon conversion or required repurchase.

In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Notes. In September 2014, we issued $301.6 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Notes. As of September 30, 2015, the aggregate outstanding principal amount of our 1.125% Notes and our 1.625% Notes was $550.0 million and $301.6 million, respectively. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The 1.125% Notes met the stock price trigger in the quarter ended September 30, 2015, and are convertible to cash through at least December 31, 2015. Because the 1.125% Notes may be converted into cash within 12 months, the $450.3 million carrying amount is reported in current portion of long-term debt as of September 30, 2015. In addition, holders of our 1.625% Notes may convert their notes into cash during any calendar quarter (and only during such calendar quarter) if the last reported sales price of our common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to $75.51 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on October 28, 2015 was $67.80 per share. As of September 30, 2015, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash. As of September 30, 2015, we had sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

In addition, in the event of a change in control or the termination in trading of our stock, each holder of our 1.125% Notes and our 1.625% Notes would have the right to require us to purchase some or all of their notes at a purchase price in cash equal to 100% of the principal amount of the notes, plus any accrued and unpaid interest.

In the event of conversions or required repurchases, we may not have enough available cash or be able to obtain financing at the time we are required to comply with our conversion or repurchase obligations. In addition, our ability to comply with these obligations may be limited by law, by regulatory authority, or by agreements governing our future indebtedness. The indentures for the 1.125% Notes and the 1.625% Notes provide that it would be an event of default if we do not make the cash payments due upon conversion or required repurchase of the notes. The occurrence of an event of default under one or both of these indentures may also constitute an event of default under our Credit Facility and under our other indebtedness we may have outstanding at such time. Any such default could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

There are performance risks related to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, cost plus reimbursement and performance based revenue associated with a large portion of our premium revenues.

Approximately 85% of our premium revenue is subject to contract provisions pertaining to medical cost floors and corridors, administrative cost and profit ceilings, cost plus reimbursement, premium stabilization programs and profit-sharing arrangements. Many of these provisions are poorly defined and subject to differing interpretations between the contracting parties. In the event the applicable government agency disagrees with our interpretation or application of the sometimes complicated contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to the government agency. Any interpretation or application of these provisions at variance

with our interpretation, or inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. In the event we are unsuccessful in achieving the stated performance measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended September 30, 2015 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
July 1 - July 31	—	$ —	—	$ 50,000,000
August 1 - August 31	881	$ 75.43	—	$ 50,000,000
September 1 - September 30	329	$ 72.67	—	$ 50,000,000
Total	1,210	$ 74.68	—	

(a) During the three months ended September 30, 2015, we withheld 1,210 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2015.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: October 29, 2015

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: October 29, 2015

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
2.1	Membership Interest Purchase Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Healthcare, Inc. Filed as Exhibit 2.1 to registrant's Form 8-K filed September 8, 2015.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 29, 2015

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 29, 2015

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2015 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 29, 2015

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2015 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 29, 2015

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended June 30, 2015

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2015

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of July 24, 2015, was approximately 56,056,000.

MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended June 30, 2015

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2015	December 31, 2014
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,013,882	$ 1,539,063
Investments	1,466,622	1,019,462
Receivables	631,124	596,456
Deferred income taxes	37,480	39,532
Prepaid expenses and other current assets	148,615	50,884
Derivative asset	508,504	—
Total current assets	4,806,227	3,245,397
Property, equipment, and capitalized software, net	363,244	340,778
Deferred contract costs	65,410	53,675
Intangible assets, net	80,462	89,273
Goodwill	272,046	271,964
Restricted investments	110,956	102,479
Derivative asset	—	329,323
Other assets	37,814	44,326
	$ 5,736,159	$ 4,477,215
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,492,252	$ 1,200,522
Amounts due government agencies	824,934	527,193
Accounts payable and accrued liabilities	399,186	241,654
Deferred revenue	57,723	196,076
Income taxes payable	10,396	8,987
Current portion of long-term debt	445,668	341
Derivative liability	508,355	—
Total current liabilities	3,738,514	2,174,773
Convertible senior notes	272,930	704,097
Lease financing obligations	161,323	160,710
Lease financing obligations – related party	40,016	40,241
Deferred income taxes	29,174	24,271
Derivative liability	—	329,194
Other long-term liabilities	31,095	33,487
Total liabilities	4,273,052	3,466,773
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 56,050 shares at June 30, 2015 and 49,727 shares at December 31, 2014	56	50
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	782,433	396,059
Accumulated other comprehensive loss	(1,830)	(1,019)
Retained earnings	682,448	615,352
Total stockholders' equity	1,463,107	1,010,442
	$ 5,736,159	$ 4,477,215

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 3,304,372	$ 2,167,142	$ 6,275,024	$ 4,107,479
Service revenue	47,243	50,232	99,101	103,862
Premium tax revenue	94,609	70,120	189,956	121,813
Health insurer fee revenue	73,890	19,662	121,838	38,358
Investment income	3,828	1,945	6,843	3,574
Other revenue	948	2,938	3,251	6,196
Total revenue	3,524,890	2,312,039	6,696,013	4,381,282
Operating expenses:				
Medical care costs	2,929,534	1,934,299	5,565,318	3,655,957
Cost of service revenue	32,819	37,107	68,721	77,764
General and administrative expenses	286,496	193,239	542,586	381,326
Premium tax expenses	94,609	70,120	189,956	121,813
Health insurer fee expenses	40,652	21,945	81,430	44,135
Depreciation and amortization	25,152	22,902	50,144	43,593
Total operating expenses	3,409,262	2,279,612	6,498,155	4,324,588
Operating income	115,628	32,427	197,858	56,694
Other expenses, net:				
Interest expense	14,946	13,993	29,822	27,815
Other income, net	(32)	(9)	(42)	(53)
Total other expenses, net	14,914	13,984	29,780	27,762
Income from continuing operations before income tax expense	100,714	18,443	168,078	28,932
Income tax expense	61,783	10,702	101,006	16,357
Income from continuing operations	38,931	7,741	67,072	12,575
Income (loss) from discontinued operations, net of tax	12	70	24	(266)
Net income	$ 38,943	$ 7,811	$ 67,096	$ 12,309
Basic net income per share:				
Continuing operations	$ 0.78	$ 0.17	$ 1.36	$ 0.27
Basic net income per share	$ 0.78	$ 0.17	$ 1.36	$ 0.27
Diluted net income per share:				
Continuing operations	$ 0.72	$ 0.16	$ 1.29	$ 0.26
Diluted net income per share	$ 0.72	$ 0.16	$ 1.29	$ 0.26

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(Amounts in thousands) (Unaudited)			
Net income	$ 38,943	$ 7,811	$ 67,096	$ 12,309
Other comprehensive (loss) income:				
Unrealized investment (loss) gain	(3,377)	391	(1,261)	1,817
Effect of income taxes	(1,250)	(31)	(450)	691
Other comprehensive (loss) income, net of tax	(2,127)	422	(811)	1,126
Comprehensive income	$ 36,816	$ 8,233	$ 66,285	$ 13,435

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2015	2014
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 67,096	$ 12,309
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	62,076	65,654
Deferred income taxes	7,405	1,692
Share-based compensation	9,241	10,456
Amortization of convertible senior notes and lease financing obligations	14,685	13,455
Other, net	8,641	1,723
Changes in operating assets and liabilities:		
Receivables	(34,668)	(174,579)
Prepaid expenses and other assets	(97,027)	(66,887)
Medical claims and benefits payable	291,730	254,395
Amounts due government agencies	297,741	119,872
Accounts payable and accrued liabilities	157,734	57,625
Deferred revenue	(138,353)	(76,271)
Income taxes	1,409	16,016
Net cash provided by operating activities	647,710	235,460
Investing activities:		
Purchases of investments	(992,978)	(368,304)
Proceeds from sales and maturities of investments	541,050	326,648
Purchases of property, equipment and capitalized software	(65,860)	(37,670)
Increase in restricted investments	(14,202)	(15,622)
Net cash paid in business combinations	(8,006)	—
Other, net	(16,853)	(7,388)
Net cash used in investing activities	(556,849)	(102,336)
Financing activities:		
Proceeds from common stock offering, net of issuance costs	373,151	—
Contingent consideration liabilities settled	—	(50,349)
Proceeds from employee stock plans	8,387	7,617
Other, net	2,420	1,064
Net cash provided by (used in) financing activities	383,958	(41,668)
Net increase in cash and cash equivalents	474,819	91,456
Cash and cash equivalents at beginning of period	1,539,063	935,895
Cash and cash equivalents at end of period	$ 2,013,882	$ 1,027,351

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Six Months Ended June 30,	
	2015	2014
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Increase in non-cash lease financing obligation – related party	$ —	$ 12,447
Common stock used for share-based compensation	$ (8,921)	$ (8,453)
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ (179,161)	$ 63,809
Loss on 1.125% Conversion Option	179,181	(63,799)
Change in fair value of derivatives, net	$ 20	$ 10
Details of business combinations:		
Fair value of assets acquired	$ (82)	$ —
Payable to seller	(7,924)	—
Net cash paid in business combinations	$ (8,006)	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2015

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of June 30, 2015, these health plans served 3.4 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate, as well as the management of a hospital in southern California under a management services agreement.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Market Updates - Health Plans Segment

Florida. On July 14, 2015, we announced that our Florida health plan entered into an agreement with Preferred Medical Plan, Inc. Under this agreement, we will assume Preferred's Medicaid contract in Miami-Dade and Monroe counties, as well as acquire certain assets related to the operation of its Medicaid business. Preferred currently serves approximately 25,000 Medicaid members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the third quarter of 2015.

As of June 30, 2015, our Florida health plan served 176,000 Marketplace members, more than double its total membership as of December 31, 2014.

Illinois. On July 15, 2015, we announced that our Illinois health plan entered into an agreement with Accountable Care Chicago, LLC, also known as MyCare Chicago. Under this agreement, we will receive the right to assume MyCare Chicago's Medicaid members in Cook County, as well as acquire certain assets related to the operation of the Medicaid business. MyCare Chicago currently serves approximately 61,000 Medicaid members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the fourth quarter of 2015.

Michigan. On May 15, 2015, we announced that our Michigan health plan entered into an agreement with HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc. (collectively, HealthPlus). Under this agreement, we will assume HealthPlus Partners' Medicaid contract and HealthPlus of Michigan's MIChild contract, as well as certain provider agreements. HealthPlus currently serves approximately 90,000 Medicaid and 6,000 MIChild members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the third quarter of 2015.

Puerto Rico. Effective April 1, 2015, our Puerto Rico health plan served its first members. As of June 30, 2015, our Puerto Rico plan enrollment amounted to approximately 361,000 members.

Market Updates - Molina Medicaid Solutions Segment

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate its new Medicaid management information system (MMIS). The new contract is effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's previous MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are

insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2015.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2014. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2014 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2014 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2014 statement of cash flows to conform to the 2015 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred.

Certain components of premium revenue are subject to accounting estimates as follows:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Health Plan Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $516.8 million and $392.4 million at June 30, 2015 and December 31, 2014, respectively, to amounts due government agencies. Approximately $458.1 million of the liability accrued at June 30, 2015 relates to our participation in Medicaid expansion programs.

In general, such amounts are subject to future changes in estimate based upon our actual cost performance and interpretations of allowable medical costs and revenue. At our Washington health plan (where we had recorded a liability of approximately $271.1 million related to the Medicaid expansion medical cost floor at June 30, 2015), premium revenue may be retroactively adjusted across the entire state Medicaid expansion program based upon the medical cost performance of the program as a whole. As such, our liability under Washington's contractual provisions is determined not just by our own medical cost performance, but by that of all health plans participating in the program; and we have limited visibility into the costs of those health plans.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold; we had no receivables recorded at June 30, 2015 or December 31, 2014 that were related to such provisions.

Health Plan Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to retain, we recorded a liability of $5.4 million and $0.5 million at June 30, 2015 and December 31, 2014, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS will recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS will pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the

periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses, we have recorded a net receivable of $30.8 million and $7.6 million for anticipated Medicare risk adjustment premiums at June 30, 2015 and December 31, 2014, respectively.

Quality Incentives

At our California, Illinois, New Mexico, Ohio, South Carolina, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is not earned unless specified performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2015 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2015.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(In thousands)			
Maximum available quality incentive premium - current period	$ 27,830	$ 24,300	$ 58,145	$ 44,464
Amount of quality incentive premium revenue recognized in current period:				
Earned current period	$ 11,225	$ 12,717	$ 20,776	$ 18,014
Earned prior periods	11,088	3,582	11,471	3,204
Total	$ 22,313	$ 16,299	$ 32,247	21,218
Total premium revenue recognized for state health plans with quality incentive premiums	$ 2,525,571	$ 1,708,808	$ 4,878,806	$ 3,187,069

California Health Plan Rate Settlement Agreement

In 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, DHCS may be required to make a payment to us if the California health plan's pre-tax margin falls below certain levels. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40.0 million; no amounts receivable were recorded related to this agreement at June 30, 2015 or December 31, 2014. The agreement expires effective December 31, 2017.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses under the Affordable Care Act Health Insurer Fee (HIF), nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

New Accounting Standards

Revenue Recognition. On July 9, 2015, the Financial Accounting Standards Board (FASB) affirmed its proposal to defer the effective date of Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers,* for all entities by one year. As a result, public business entities will apply the new revenue standard to annual reporting periods beginning after December 15, 2017, and for interim reporting periods within annual reporting periods beginning after December 15, 2017. We continue to evaluate whether to elect the full or modified retrospective adoption method, and the potential effects to our financial statements.

Short-Duration Contracts. In May 2015, the FASB issued ASU 2015-09, *Disclosures about Short-Duration Contracts*, which will require additional disclosure on the liability for unpaid claims and claim adjustment expenses. Effective for us in the first quarter of 2016, ASU 2015-09 is applied retrospectively to all prior periods presented in the financial statements. Early adoption is permitted; we are evaluating the potential effects of the adoption to our financial statements.

Debt Issuance Costs. In April 2015, the FASB issued ASU 2015-03, *Simplifying the Presentation of Debt Issuance Costs*, which will require debt issuance costs related to a recognized debt liability to be presented in the balance sheet as a direct deduction from the carrying amount of such debt liability, consistent with debt discounts. Effective for us in the first quarter of 2016, ASU 2015-03 is applied retrospectively to all prior periods presented in the financial statements. Early adoption is permitted; we are evaluating the potential effects of the adoption to our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(In thousands)			
Shares outstanding at the beginning of the period	48,852	46,263	48,578	45,871
Weighted-average number of shares issued:				
Common stock offering	1,365	—	687	—
Share-based compensation	25	16	203	279
Denominator for basic net income per share	50,242	46,279	49,468	46,150
Effect of dilutive securities:				
Share-based compensation	319	361	426	527
Convertible senior notes (1)	682	1,363	341	1,147
1.125% Warrants (1)	2,628	—	1,773	—
Denominator for diluted net income per share	53,871	48,003	52,008	47,824
Potentially dilutive common shares excluded from calculations (2):				
Stock options	—	—	—	45
1.125% Warrants	—	13,490	—	13,490

(1) For more information regarding the convertible senior notes, refer to Note 11, "Debt." For more information regarding the 1.125% Warrants, refer to Note 12, "Derivatives."

(2) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the three and six months ended June 30, 2014, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

4. Business Combinations

Health Plans Segment

Florida. In December 2014, our Florida health plan acquired certain assets relating to the Medicaid business of First Coast Advantage, LLC (FCA). As part of the transaction, we assumed FCA's Medicaid contract and certain provider agreements for Region 4 of the Statewide Medicaid Managed Care Managed Medical Assistance Program in the state of Florida. The Florida health plan's membership increased by approximately 62,000 members as a result of this transaction. The final purchase price for this acquisition amounted to $44.6 million, of which $36.6 million was paid in December 2014, and $8.0 million was paid in the first quarter of 2015.

5. Share-Based Compensation

As of June 30, 2015, there are approximately 475,000 unvested restricted shares awarded to our named executive officers, with market and performance conditions, outstanding. In the event the vesting conditions are not achieved, the awards will lapse. Based on our assessment as of June 30, 2015, we expect the performance conditions relating to approximately 297,000 of such restricted share awards to be met in full. For the remaining 178,000 unvested restricted share awards, we reversed share-based compensation expense recognized from inception through March 31, 2015, or approximately $2.6 million, in the second quarter of 2015.

Charged to general and administrative expenses, total share-based compensation expense was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(In thousands)			
Restricted stock and performance awards	$ 2,654	$ 4,214	$ 7,255	$ 8,822
Employee stock purchase plan and stock options	912	646	1,986	1,634
	$ 3,566	$ 4,860	$ 9,241	$ 10,456

As of June 30, 2015, there was $34.3 million of total unrecognized compensation expense related to unvested restricted stock awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.8 years.

Restricted and performance stock activity for the six months ended June 30, 2015 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2014	1,282,072	$ 33.55
Granted	412,994	64.01
Vested	(386,634)	32.77
Forfeited	(46,634)	37.61
Unvested balance as of June 30, 2015	1,261,798	43.61

The total fair value of restricted and performance awards granted during the six months ended June 30, 2015 and 2014 was $26.8 million and $23.5 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, which vested during the six months ended June 30, 2015 and 2014 was $24.4 million and $21.5 million, respectively.

6. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include the following:

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of June 30, 2015 included the price of our common stock, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Contingent consideration liability. The contingent consideration liability represents the remaining liability associated with the Medicare-Medicaid Plan (MMP) component of our South Carolina health plan acquisition in 2013, and is recorded in accounts payable and accrued liabilities. We applied a cash flow analysis to determine the fair value of this liability. The significant unobservable input is the purchase price estimate for the projected membership.

Auction rate securities. Auction rate securities are designated as available-for-sale and are reported at fair value in other assets. To estimate the fair value of these securities, we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of June 30, 2015.

Our financial instruments measured at fair value on a recurring basis at June 30, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
	(In thousands)			
Corporate debt securities	$ 961,796	$ —	$ 961,796	$ —
Municipal securities	177,416	—	177,416	—
GSEs	162,413	162,413	—	—
U.S. treasury notes	65,741	65,741	—	—
Certificates of deposit	72,164	—	72,164	—
Asset-backed securities	26,276	—	26,276	—
Mortgage-backed securities	816	816	—	—
Subtotal - current investments	1,466,622	228,970	1,237,652	—
Auction rate securities	2,365	—	—	2,365
1.125% Call Option derivative asset	508,504	—	—	508,504
Total assets measured at fair value on a recurring basis	$ 1,977,491	$ 228,970	$ 1,237,652	$ 510,869
1.125% Conversion Option derivative liability	$ 508,355	$ —	$ —	$ 508,355
Contingent consideration liability	500	—	—	500
Total liabilities measured at fair value on a recurring basis	$ 508,855	$ —	$ —	$ 508,855

Our financial instruments measured at fair value on a recurring basis at December 31, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 641,729	$ —	$ 641,729	$ —
Municipal securities	127,045	—	127,045	—
GSEs	122,269	122,269	—	—
U.S. treasury notes	59,543	59,543	—	—
Certificates of deposit	68,876	—	68,876	—
Subtotal - current investments	1,019,462	181,812	837,650	—
Auction rate securities	4,847	—	—	4,847
1.125% Call Option derivative asset	329,323	—	—	329,323
Total assets measured at fair value on a recurring basis	$ 1,353,632	$ 181,812	$ 837,650	$ 334,170
1.125% Conversion Option derivative liability	$ 329,194	$ —	$ —	$ 329,194
Contingent consideration liability	500	—	—	500
Total liabilities measured at fair value on a recurring basis	$ 329,694	$ —	$ —	$ 329,694

The following table presents activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liability
		(In thousands)	
Balance at December 31, 2014	$ 4,847	$ 129	$ (500)
Total gains for the period recognized in:			
Other expenses, net	—	20	—
Other comprehensive income	118	—	—
Settlements	(2,600)	—	—
Balance at June 30, 2015	$ 2,365	$ 149	$ (500)

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our convertible senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	June 30, 2015				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
1.125% Notes	$ 445,239	$ 973,770	$ —	$ 973,770	$ —
1.625% Notes	272,930	394,199	—	394,199	—
	$ 718,169	$ 1,367,969	$ —	$ 1,367,969	$ —

	December 31, 2014				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
1.125% Notes	$ 435,330	$ 767,377	$ —	$ 767,377	$ —
1.625% Notes	268,767	337,292	—	337,292	—
	$ 704,097	$ 1,104,669	$ —	$ 1,104,669	$ —

7. Investments

The following tables summarize our investments as of the dates indicated:

	June 30, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 964,150	$ 226	$ 2,580	$ 961,796
Municipal securities	177,898	142	624	177,416
GSEs	162,496	79	162	162,413
U.S. treasury notes	65,571	185	15	65,741
Certificates of deposit	72,165	—	1	72,164
Asset-backed securities	26,294	3	21	26,276
Mortgage-backed securities	818	—	2	816
Subtotal - current investments	1,469,392	635	3,405	1,466,622
Auction rate securities	2,500	—	135	2,365
	$ 1,471,892	$ 635	$ 3,540	$ 1,468,987

	December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 642,910	$ 201	$ 1,382	$ 641,729
Municipal securities	127,185	129	269	127,045
GSEs	122,317	34	82	122,269
U.S. treasury notes	59,546	30	33	59,543
Certificates of deposit	68,893	1	18	68,876
Subtotal - current investments	1,020,851	395	1,784	1,019,462
Auction rate securities	5,100	—	253	4,847
	$ 1,025,951	$ 395	$ 2,037	$ 1,024,309

The contractual maturities of our investments as of June 30, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 695,555	$ 695,104
Due one year through five years	740,989	738,942
Due after five years through ten years	32,848	32,576
Due after ten years	2,500	2,365
	$ 1,471,892	$ 1,468,987

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and six months ended June 30, 2015 and 2014 were insignificant.

We have determined that unrealized gains and losses on our investments at June 30, 2015 and December 31, 2014, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of June 30, 2015:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 584,246	$ 2,253	422	$ 81,997	$ 327	41
Municipal securities	116,735	542	162	5,725	82	12
GSEs	73,182	162	28	—	—	—
U.S. treasury notes	8,274	15	5	—	—	—
Certificates of deposit	734	1	3	—	—	—
Asset-backed securities	17,793	21	19	—	—	—
Mortgage-backed securities	816	2	2	—	—	—
Auction rate securities	—	—	—	2,365	135	3
	$ 801,780	$ 2,996	641	$ 90,087	$ 544	56

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2014:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 379,034	$ 1,151	265	$ 28,668	$ 231	10
Municipal securities	53,626	168	64	11,075	101	13
GSEs	75,025	69	22	2,986	13	3
U.S. treasury notes	19,199	33	13	—	—	—
Certificates of deposit	12,591	18	52	—	—	—
Auction rate securities	—	—	—	4,847	253	6
	$ 539,475	$ 1,439	416	$ 47,576	$ 598	32

8. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial.

	June 30, 2015	December 31, 2014
	(In thousands)	
California	$ 175,864	$ 310,938
Florida	16,529	2,141
Illinois	43,963	31,594
Michigan	25,959	19,880
New Mexico	71,434	49,609
Ohio	84,484	45,187
Puerto Rico	10,607	—
South Carolina	4,579	4,134
Texas	51,654	29,348
Utah	16,201	6,389
Washington	69,823	42,848
Wisconsin	27,888	8,102
Direct delivery and other	6,886	11,295
Total Health Plans segment	605,871	561,465
Molina Medicaid Solutions segment	25,253	34,991
	$ 631,124	$ 596,456

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. In connection with a Molina Medicaid Solutions segment state contract, we maintain restricted investments as collateral for a letter of credit. The following table presents the balances of restricted investments:

	June 30, 2015	December 31, 2014
	(In thousands)	
California	$ 373	$ 373
Florida	27,016	28,649
Illinois	311	311
Michigan	1,014	1,014
New Mexico	46,643	35,135
Ohio	11,725	12,719
Puerto Rico	10,094	5,097
South Carolina	310	6,040
Texas	3,502	3,500
Utah	3,619	3,601
Washington	151	151
Wisconsin	954	—
Other	242	888
Total Health Plans segment	105,954	97,478
Molina Medicaid Solutions segment	5,002	5,001
	$ 110,956	$ 102,479

The contractual maturities of our held-to-maturity restricted investments as of June 30, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 100,792	$ 100,792
Due one year through five years	10,164	10,167
	$ 110,956	$ 110,959

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	June 30, 2015	December 31, 2014
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,138,794	$ 870,429
Pharmacy payable	80,902	71,412
Capitation payable	30,673	28,150
Other	241,883	230,531
	$ 1,492,252	$ 1,200,522

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $134.2 million and $119.3 million as of June 30, 2015 and December 31, 2014, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30, 2015	Year Ended December 31, 2014
	(Dollars in thousands)	
Medical claims and benefits payable, beginning balance	$ 1,200,522	$ 669,787
Components of medical care costs related to:		
Current period	5,703,391	8,122,885
Prior periods (1)	(138,131)	(45,979)
Total medical care costs	5,565,260	8,076,906
Change in non-risk provider payables	14,826	(31,973)
Payments for medical care costs related to:		
Current period	4,448,820	7,064,427
Prior periods	839,536	449,771
Total paid	5,288,356	7,514,198
Medical claims and benefits payable, ending balance	$ 1,492,252	$ 1,200,522
Benefit from prior period as a percentage of:		
Balance at beginning of period	11.5%	6.9%
Premium revenue, trailing twelve months	1.2%	0.5%
Medical care costs, trailing twelve months	1.4%	0.6%

(1) The benefit from prior period development of medical claims and benefits payable for the six months ended June 30, 2015 included approximately $22 million relating to programs that contain medical cost floor or corridor provisions. Accordingly, premium revenue for the six months ended June 30, 2015 was reduced by the same amount.

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). IBNP represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under– or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2015 and 2014 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant factors that will determine the accuracy of our IBNP estimates at June 30, 2015 are as follows:

- At our Florida health plan, Marketplace enrollment increased by 175,000 members in the first half of 2015. Because of these new members the reserves are more subject to change than usual.
- At our Illinois health plan, enrollment has increased by nearly 79,000 members during the fourth quarter of 2014 and the first half of 2015. Because of these new members the reserves are more subject to change than usual.
- At our Ohio health plan, enrollment in the MMP integrated duals program has increased by approximately 9,000 members during the first half of 2015. Because of these new members the reserves are more subject to change than usual.
- At our Washington health plan, certain delays related to the implementation of revised fee schedules resulted in a significant increase to our outpatient claims inventory in the first quarter of 2015, followed by a reduction in inventory during the second quarter of 2015. This significant change in inventory adds to the uncertainty of our unpaid claims estimates.

We recognized favorable prior period claims development in the amount of $138.1 million for the six months ended June 30, 2015. This amount represents our estimate as of June 30, 2015, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio health plan, approximately 17,000 members were enrolled in the new MMP program during 2014. Since we did not have enough historical claims data to use the pattern of paid and incurred claims, we initially estimated the reserves for these new members by applying an estimated medical care ratio (MCR). This resulted in an overstatement in our reserve liability as of December 31, 2014.

- Also at our Ohio health plan, approximately 61,000 members were enrolled in the Medicaid expansion program in 2014. The reserves for such members were partially based on expected costs built into the pricing assumptions because this program was new in 2014. Our costs were ultimately less than those assumed in those pricing assumptions, resulting in an overestimation of our liability as of December 31, 2014.
- At our California health plan, more than 100,000 members were enrolled in the Medicaid expansion program in 2014. The reserves for such members were partially based on expected costs built into the pricing assumptions because this program was new in 2014. Our costs were ultimately less than those assumed in those pricing assumptions, resulting in an overestimation of our liability as of December 31, 2014.
- At our New Mexico health plan, there was a retroactive increase to the provider fee schedules implemented by the state in mid-2014. This resulted in many claims adjustments paid well after the dates of service, causing an increase in the average time between the date of service and the date of payment. This resulted in an overstatement of the reserves as of December 31, 2014.

11. Debt

As of June 30, 2015, maturities of debt for the years ending December 31 are as follows (in thousands):

	Total	2015	2016	2017	2018	2019	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
1.625% Notes (1)	301,551	—	—	—	—	—	301,551
	$ 851,551	$ —	$ —	$ —	$ —	$ —	$ 851,551

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

Credit Facility. On June 12, 2015, we entered into an unsecured $250 million revolving Credit Facility which will be used to finance working capital needs, acquisitions, capital expenditures, and other general corporate activities. The Credit Facility has a term of 5 years and all amounts outstanding will be due and payable on June 12, 2020. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $350 million. As of June 30, 2015, no amounts were outstanding under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee.

Although the Credit Facility is not secured by any of our assets, two of our wholly owned subsidiaries, Molina Medicaid Solutions and Molina Medical Management, Inc., have jointly and severally guaranteed our obligations under the Credit Facility.

The Credit Facility contains customary non-financial and financial covenants, including a minimum fixed charge coverage ratio, a maximum debt-to-EBITDA ratio and minimum statutory net worth. We are required to not exceed a maximum debt-to-EBITDA ratio of 4.00 to 1.00. At June 30, 2015, we were in compliance with all financial covenants under the Credit Facility.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes (the 1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 at a rate of 1.125% per annum.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date.

Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;

- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;

- upon the occurrence of specified corporate events; or

- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes met the stock price trigger in the quarter ended June 30, 2015, and are convertible to cash through at least September 30, 2015. Because the 1.125% Notes may be converted into cash within 12 months, the $445.2 million carrying amount is reported in current portion of long-term debt as of June 30, 2015.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option transaction settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of June 30, 2015, the 1.125% Notes have a remaining amortization period of 4.5 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $361 million and $93 million as of June 30, 2015 and December 31, 2014, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $301.6 million aggregate principal amount of 1.625% convertible senior notes (the 1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Interest on the 1.625% Notes is payable semiannually in arrears on February 15 and August 15, at a rate of 1.625% per annum, beginning on February 15, 2015. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;

- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of June 30, 2015, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the notes in August 2018. As of June 30, 2015, the 1.625% Notes have a remaining amortization period of 3.1 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value exceeded their principal amount by approximately $58 million as of June 30, 2015, and did not exceed their principal amount as of December 31, 2014. At June 30, 2015, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $22.9 million.

The principal amounts, unamortized discount (net of premium related to 1.625% Notes), and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
June 30, 2015:			
1.125% Notes	$ 550,000	$ 104,761	$ 445,239
1.625% Notes	301,551	28,621	272,930
	$ 851,551	$ 133,382	$ 718,169
December 31, 2014:			
1.125% Notes	$ 550,000	$ 114,670	$ 435,330
1.625% Notes	301,551	32,784	268,767
	$ 851,551	$ 147,454	$ 704,097

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
		(In thousands)		
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate	$ 2,772	$ 3,300	$ 5,544	$ 6,600
Amortization of the discount	7,086	6,414	14,072	12,728
	$ 9,858	$ 9,714	$ 19,616	$ 19,328

Lease Financing Obligations. In 2013, we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the Molina Center located in Long Beach, California, and our Ohio health plan office building located in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Rent will increase 3% per year through the initial term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense amounted to $6.3 million and $6.2 million for the six months ended June 30, 2015 and 2014, respectively.

As described and defined in further detail in Note 16, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings. We have concluded that we are the accounting owner of the buildings due to our continuing involvement with the properties. We have recorded $37.1 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of June 30, 2015, which represents the total cost incurred by the Landlord for the construction of the buildings, net of accumulated depreciation. As of June 30, 2015 and December 31, 2014, the aggregate amount recorded to lease financing obligations, including the current portion, amounted to $40.4 million and $40.6 million, respectively. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense was $2.0 million and $1.1 million for the six months ended June 30, 2015 and 2014, respectively. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was $0.6 million and $0.4 million for the six months ended June 30, 2015 and 2014, respectively.

12. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	June 30, 2015	December 31, 2014
		(In thousands)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 508,504	$ —
	Non-current assets: Derivative asset	$ —	$ 329,323
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 508,355	$ —
	Non-current liabilities: Derivative liability	$ —	$ 329,194

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 6, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion

option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 6, "Fair Value Measurements."

As of June 30, 2015, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of June 30, 2015, as described in Note 11, "Debt."

13. Stockholders' Equity

Stockholders' equity increased $452.7 million during the six months ended June 30, 2015 compared with stockholders' equity at December 31, 2014. The increase was due primarily to the common stock offering described below, net income of $67.1 million, and $13.2 million related to employee stock transactions.

Common Stock Offering. In June 2015, we completed an underwritten public offering of 5,750,000 shares of our common stock, including the over-allotment option, conducted pursuant to an effective shelf registration statement filed with the SEC in May 2015. Net of issuance costs, proceeds from the offering amounted to approximately $373.2 million, or $64.90 per share, resulting in an increase to additional paid-in capital. We will use the proceeds to finance working capital needs, acquisitions, capital expenditures, and other general corporate activities.

1.125% Warrants. In connection with the 1.125% Notes Call Spread Overlay transaction described in Note 12, "Derivatives," we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Programs. Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2015.

Shelf Registration Statement. As noted above, we filed an automatic shelf registration statement on Form S-3 in May 2015 covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with our equity incentive plans and employee stock purchase plan, we issued approximately 460,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the six months ended June 30, 2015.

14. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our health plans and our direct delivery business. Our health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development, and implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." For presentation purposes, the cost of centralized services is reported within the Health Plans segment.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(In thousands)			
Revenue, continuing operations:				
Health Plans segment:				
Premium revenue	$ 3,304,372	$ 2,167,142	$ 6,275,024	$ 4,107,479
Premium tax revenue	94,609	70,120	189,956	121,813
Health insurer fee revenue	73,890	19,662	121,838	38,358
Investment income	3,828	1,945	6,843	3,574
Other revenue	948	2,938	3,251	6,196
Molina Medicaid Solutions segment:				
Service revenue	47,243	50,232	99,101	103,862
	$ 3,524,890	$ 2,312,039	$ 6,696,013	$ 4,381,282
Income from continuing operations before income tax expense:				
Health Plans segment	$ 102,585	$ 21,986	$ 171,025	$ 36,005
Molina Medicaid Solutions segment	13,043	10,441	26,833	20,689
Operating income, continuing operations	115,628	32,427	197,858	56,694
Other expenses, net	14,914	13,984	29,780	27,762
	$ 100,714	$ 18,443	$ 168,078	$ 28,932

15. Commitments and Contingencies

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that in late 2008 and early 2009, in connection with the acquisition of Florida NetPass under which Molina Healthcare of Florida, Inc. began conducting business in the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. Both the United States of

America and the state of Florida have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. We believe that we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,005 million at June 30, 2015, and $859 million at December 31, 2014. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $536.4 million and $202.6 million as of June 30, 2015 and December 31, 2014, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state.

As of June 30, 2015, our health plans had aggregate statutory capital and surplus of approximately $1,071 million compared with the required minimum aggregate statutory capital and surplus of approximately $589 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2015. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Related Party Transactions

We have entered into a lease (the Amended Lease) with 6th & Pine Development, LLC (the Landlord) for two office buildings. The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, John C. Molina has pledged shares of common stock in the Company that he holds. Dr. J. Mario Molina, our chief executive officer, president and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

The Amended Lease provides for an annual rent escalator of 3.4% per year, and will expire on December 31, 2029, unless extended or earlier terminated. For information regarding the lease financing obligation, refer to Note 11, "Debt."

Refer to Note 17, "Variable Interest Entities," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

17. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. Beginning in the fourth quarter of 2014, JMMPC also provided certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a variable interest entity (VIE), and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of June 30, 2015, JMMPC had total assets of $14.2 million, and total liabilities of $14.1 million. As of December 31, 2014, JMMPC had total assets of $31.1 million, and total liabilities of $30.8 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- uncertainties associated with the implementation of the Affordable Care Act, including the full grossed up reimbursement by states of the non-deductible ACA health insurer fee, the Medicaid expansion, the insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the Medicare-Medicaid dual eligible demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and our ability to reduce over time the high medical costs commonly associated with new patient populations;
- federal or state medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, including 2014 and 2015 at-risk premium rules in the state of Texas;
- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;
- the success of our new health plan in Puerto Rico, including the successful resolution of the Puerto Rico debt crisis and the payment of all amounts due under our Medicaid contract;
- newly FDA-approved specialty drugs such as Sovaldi, Olysio, Harvoni, and other specialty drugs or generic drugs that are exorbitantly priced but not factored into the calculation of our capitated rates;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria, including the resolution of the Illinois budget impasse and continued payment of our Illinois health plan;
- the accurate estimation of incurred but not paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates or retroactive premium rate increases;
- efforts by states to recoup previously paid amounts;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, including the pending Medicaid RFP in Michigan;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable or unfavorable resolution of litigation, arbitration, or administrative proceedings, including pending qui tam actions in California and Florida, and the litigation commenced against us by the state of Louisiana alleging that Molina Medicaid Solutions and its predecessors used an incorrect reimbursement formula for the payment of pharmaceutical claims;
- the relatively small number of states in which we operate health plans;

- our management of a portion of College Health Enterprises' hospital in Long Beach, California;
- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- public alarm associated with newly emergent viruses or widespread epidemics;
- changes in general economic conditions, including unemployment rates; and
- increasing competition and consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2014 and Part II, Item 1A of this Quarterly Report on Form 10-Q, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2014.

Company Overview

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of June 30, 2015, these health plans served 3.4 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate, as well as the management of a hospital in southern California under a management services agreement.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise noted.

Overview of Financial Results, Continuing Operations

Financial results for the second quarter of 2015 improved significantly over the same quarter of 2014 due to higher revenue, greater medical and administrative cost efficiency, and more complete state reimbursement of the Affordable Care Act Health Insurer Fee (HIF).

Income from continuing operations, before tax expense, increased to $101 million in the second quarter of 2015, from $18 million in the second quarter of 2014, and $67 million in the first quarter of this year.

Premium revenue increased approximately 52% in the second quarter of 2015 compared with the second quarter of 2014 due to increased Medicaid expansion and Marketplace enrollment, growth in our Illinois health plan, and the recent start-up of our Puerto Rico health plan.

Medical care costs as a percent of premium revenue (the "medical care ratio") decreased to 88.7% in the second quarter of 2015, from 89.3% in the second quarter of 2014, and were unchanged from the first quarter of this year.

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") decreased to 8.1% in the second quarter of 2015, from 8.4% in the second quarter of 2014, and were unchanged from the first quarter of this year.

Financing Activities

In June 2015, we issued 5.75 million shares of common stock, raising $373 million, after offering costs. Additionally in June 2015, we entered into a $250 million revolving credit facility. Both of these actions will finance working capital needs, acquisitions, capital expenditures, and other general corporate activities.

Health Care Reform

Government-sponsored initiatives, including the Affordable Care Act (ACA), will remain the primary focus of our business. Three of those government-sponsored initiatives that have a significant impact on our current operations are as follows:

- *Medicaid Expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington participate in Medicaid expansion. At June 30, 2015, our membership included approximately 475,000 Medicaid expansion members, or 14% of total membership.
- *Marketplace*. The ACA authorized the creation of Marketplace health insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois, Puerto Rico and South Carolina. At June 30, 2015, our membership included approximately 261,000 Marketplace members, with approximately 176,000, or 67%, of those members in Florida.

- *Medicare-Medicaid Plans*. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and our MMPs in Michigan offered coverage beginning in the second quarter of 2015. At June 30, 2015, our membership included approximately 39,000 integrated MMP members.

Health Insurer Fee Update

We continue to make progress in securing full reimbursement for the Medicaid portion of our expense under the HIF.

During the second quarter of 2015, we recognized as revenue the entire HIF reimbursement due from California for the period January 1, 2014 through June 30, 2015. We recognized approximately $12 million ($0.14 per diluted share) related to 2014; and approximately $17 million ($0.20 per diluted share) related to the first half of 2015. After allowing for HIF revenue not recognized for Michigan and Utah (approximately $8 million, or $0.10 per diluted share, for each of the first and second quarters), the net impact of HIF reimbursement was $12 million ($0.14 per diluted share) favorable for the second quarter and $5 million ($0.06 per diluted share) unfavorable for the six months ended June 30.

The comparable amount of HIF reimbursement not recognized in the second quarter of 2014 was approximately $15 million ($0.20 per diluted share) for the second quarter and approximately $32 million ($0.42 per diluted share) for the six months ended June 30.

For further discussion of the risks and uncertainties relating to the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates - Health Plans Segment

Florida. On July 14, 2015, we announced that our Florida health plan entered into an agreement with Preferred Medical Plan, Inc. Under this agreement, we will assume Preferred's Medicaid contract in Miami-Dade and Monroe counties, as well as acquire certain assets related to the operation of its Medicaid business. Preferred currently serves approximately 25,000 Medicaid members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the third quarter of 2015.

As of second quarter of 2015, our Florida health plan served 176,000 Marketplace members, more than double its total membership as of December 31, 2014.

Illinois. On July 15, 2015, we announced that our Illinois health plan entered into an agreement with Accountable Care Chicago, LLC, also known as MyCare Chicago. Under this agreement, we will receive the right to assume MyCare Chicago's Medicaid members in Cook County, as well as acquire certain assets related to the operation of the Medicaid business. MyCare Chicago currently serves approximately 61,000 Medicaid members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the fourth quarter of 2015.

Michigan. On May 15, 2015, we announced that our Michigan health plan entered into an agreement with HealthPlus of Michigan and its subsidiary, HealthPlus Partners, Inc. (collectively, HealthPlus). Under this agreement, we will assume HealthPlus Partners' Medicaid contract and HealthPlus of Michigan's MIChild contract, as well as certain provider agreements. HealthPlus currently serves approximately 90,000 Medicaid and 6,000 MIChild members. Subject to regulatory approvals and the satisfaction of other closing conditions, we expect the transaction to close during the third quarter of 2015.

Puerto Rico. Effective April 1, 2015, our Puerto Rico health plan served its first members. As of June 30, 2015, our Puerto Rico plan enrollment amounted to approximately 361,000 members.

Market Updates - Molina Medicaid Solutions Segment

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate its new Medicaid management information system (MMIS). The new contract is effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's previous MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from our health plans' Medicaid contracts and, to a lesser degree, from Medicare contracts entered into with the Centers for Medicare and Medicaid Services (CMS), a federal government agency.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new RFP open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

Premium revenue is fixed in advance of the periods covered and is not generally subject to significant accounting estimates, except as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies." These premium revenues are recognized in the month that members are entitled to receive health care services. Premiums received in advance are deferred.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program, on a PMPM basis for the six months ended June 30, 2015. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
Temporary Assistance for Needy Families (TANF), CHIP (1)	$ 110.00	$ 300.00	$ 180.00
Medicaid Expansion	320.00	500.00	410.00
Aged, Blind or Disabled (ABD)	460.00	1,530.00	940.00
Marketplace	220.00	420.00	260.00
Medicare Special Needs Plans (Medicare)	870.00	1,100.00	1,040.00
Medicare-Medicaid Plan (MMP) – Integrated (2)	1,180.00	3,150.00	1,990.00

(1) CHIP stands for Children's Health Insurance Program.
(2) MMP members for whom we provide both Medicaid and Medicare coverage. We began serving members under this program in the second quarter of 2014.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	June 30, 2015	March 31, 2015	December 31, 2014	June 30, 2014
Ending Membership by Health Plan:				
California	593,000	574,000	531,000	455,000
Florida	348,000	352,000	164,000	58,000
Illinois	101,000	102,000	100,000	6,000
Michigan	260,000	256,000	242,000	244,000
New Mexico	225,000	222,000	212,000	195,000
Ohio	332,000	350,000	347,000	302,000
Puerto Rico (1)	361,000	—	—	—
South Carolina	114,000	111,000	118,000	119,000
Texas	266,000	268,000	245,000	247,000
Utah	92,000	90,000	83,000	83,000
Washington	553,000	533,000	497,000	461,000
Wisconsin	107,000	107,000	84,000	85,000
	3,352,000	2,965,000	2,623,000	2,255,000
Ending Membership by Program:				
TANF/CHIP	2,180,000	1,825,000	1,809,000	1,642,000
Medicaid Expansion (2)	475,000	437,000	385,000	232,000
ABD	353,000	358,000	347,000	314,000
Marketplace (2)	261,000	266,000	15,000	18,000
Medicare	44,000	45,000	49,000	44,000
MMP–Integrated	39,000	34,000	18,000	5,000
	3,352,000	2,965,000	2,623,000	2,255,000

(1) The Puerto Rico health plan began serving members effective April 1, 2015.
(2) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of an MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. Our contracts may contain contingencies that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services (including long-term services and supports, or LTSS), general and administrative expenses, premium tax and health insurer fee expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Nearly all hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis.

- *Pharmacy expenses:* All drug, injectables, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses.

- *Capitation expenses:* Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.

- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.

- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements in Note 10, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the contract term, consistent with the revenue recognition period.

Financial Performance Summary, Continuing Operations

The following table briefly summarizes our financial and operating performance from continuing operations for the three months and six months ended June 30, 2015 and 2014 (in thousands, except per-share data and percentages):

	Three Months Ended June 30,			Six Months Ended June 30,		
	2015	2014	% Change	2015	2014	% Change
Revenue:						
Premium revenue	$ 3,304,372	$ 2,167,142	52.5 %	$ 6,275,024	$ 4,107,479	52.8 %
Service revenue	47,243	50,232	(6.0)	99,101	103,862	(4.6)
Premium tax revenue	94,609	70,120	34.9	189,956	121,813	55.9
Health insurer fee revenue	73,890	19,662	275.8	121,838	38,358	217.6
Investment income	3,828	1,945	96.8	6,843	3,574	91.5
Other revenue	948	2,938	(67.7)	3,251	6,196	(47.5)
Total revenue	3,524,890	2,312,039	52.5	6,696,013	4,381,282	52.8
Operating expenses:						
Medical care costs	2,929,534	1,934,299	51.5	5,565,318	3,655,957	52.2
Cost of service revenue	32,819	37,107	(11.6)	68,721	77,764	(11.6)
General and administrative expenses	286,496	193,239	48.3	542,586	381,326	42.3
Premium tax expenses	94,609	70,120	34.9	189,956	121,813	55.9
Health insurer fee expenses	40,652	21,945	85.2	81,430	44,135	84.5
Depreciation and amortization	25,152	22,902	9.8	50,144	43,593	15.0
Total operating expenses	3,409,262	2,279,612	49.6	6,498,155	4,324,588	50.3
Operating income	115,628	32,427	256.6	197,858	56,694	249.0
Other expenses, net:						
Interest expense	14,946	13,993	6.8	29,822	27,815	7.2
Other income, net	(32)	(9)	255.6	(42)	(53)	(20.8)
Total other expenses, net	14,914	13,984	6.7	29,780	27,762	7.3
Income from continuing operations before income tax expense	100,714	18,443	446.1	168,078	28,932	480.9
Income tax expense	61,783	10,702	477.3	101,006	16,357	517.5
Income from continuing operations	$ 38,931	$ 7,741	402.9 %	$ 67,072	$ 12,575	433.4 %
Diluted net income per share, continuing operations	$ 0.72	$ 0.16	350.0 %	$ 1.29	$ 0.26	396.2 %
Diluted weighted average shares outstanding	53,871	48,003	12.2 %	52,008	47,824	8.7 %
Non-GAAP Measures:						
Adjusted net income per share, continuing operations	$ 0.86	$ 0.32	168.8 %	$ 1.57	$ 0.58	170.7 %
EBITDA	$ 144,376	$ 60,856	137.2 %	$ 255,755	$ 110,327	131.8 %
Operating Statistics:						
Medical care ratio (1)	88.7%	89.3%		88.7%	89.0%	
Service revenue ratio (2)	69.5%	73.9%		69.3%	74.9%	
General and administrative expense ratio (3)	8.1%	8.4%		8.1%	8.7%	
Premium tax ratio (1)	2.8%	3.1%		2.9%	2.9%	
Effective tax rate	61.3%	58.0%		60.1%	56.5%	
Net profit margin, continuing operations (3)	1.1%	0.3%		1.0%	0.3%	

(1) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) Service revenue ratio represents cost of service revenue as a percentage of service revenue.
(3) Computed as a percentage of total revenue.

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. generally accepted accounting principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(In thousands)			
Net income	$ 38,943	$ 7,811	$ 67,096	$ 12,309
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	28,688	28,292	57,798	54,206
Interest expense	14,946	13,993	29,822	27,815
Income tax expense	61,799	10,760	101,039	15,997
EBITDA	$ 144,376	$ 60,856	$ 255,755	$ 110,327

The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. The following table reconciles net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations.

	Three Months Ended June 30,				Six Months Ended June 30,			
	2015		2014		2015		2014	
	(In thousands, except per diluted share amounts)							
Net income, continuing operations	$ 38,931	$ 0.72	$ 7,741	$ 0.16	$ 67,072	$ 1.29	$ 12,575	0.26
Adjustments, net of tax:								
Amortization of convertible senior notes and lease financing obligations	4,659	0.09	4,272	0.09	9,252	0.18	8,477	0.18
Amortization of intangible assets	2,671	0.05	3,209	0.07	5,548	0.10	6,538	0.14
Adjusted net income, continuing operations (1)	$ 46,261	$ 0.86	$ 15,222	$ 0.32	$ 81,872	$ 1.57	$ 27,590	$ 0.58

(1) Beginning in the first quarter of 2015, we have revised the calculation of adjusted net income, continuing operations. We no longer subtract "depreciation, and amortization of capitalized software" and "share-based compensation" from net income, continuing operations to arrive at adjusted net income, continuing operations. We have made this change to better reflect the way in which we evaluate our financial performance, make financing and business decisions, and forecast and plan for future periods. All periods presented below conform to this presentation.

Results of Operations, Continuing Operations

Three Months Ended June 30, 2015 Compared with Three Months Ended June 30, 2014

Health Plans Segment

Premium Revenue

Premium revenue increased approximately 52% in the second quarter of 2015 compared with the second quarter of 2014 due to increased Medicaid expansion and Marketplace enrollment, growth in our Illinois health plan, and the recent start-up of our Puerto Rico health plan.

Medical Care Costs

In the second quarter of 2015, medical care costs as a percent of premium revenue decreased to 88.7% in the second quarter of 2015 from 89.3% in the second quarter of 2014. Medical margin increased 61% in the second quarter of 2015 over the second quarter of 2014.

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended June 30,					
	2015			2014		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,102,776	$ 209.34	71.8%	$ 1,378,037	$ 205.08	71.2%
Pharmacy	391,899	39.01	13.3	295,596	43.99	15.3
Capitation	248,357	24.72	8.5	176,817	26.31	9.1
Direct delivery	27,885	2.78	1.0	23,063	3.43	1.2
Other	158,617	15.80	5.4	60,786	9.06	3.2
Total	$ 2,929,534	$ 291.65	100.0%	$ 1,934,299	$ 287.87	100.0%

The following table provides detailed fee-for-service medical claims data for the periods presented (dollars in thousands, except per-member amounts):

	Three Months Ended June 30,	
	2015	2014
Days in claims payable, fee for service	49	46
Number of claims in inventory at end of period	463,200	180,600
Billed charges of claims in inventory at end of period	$ 904,800	$ 400,000
Claims in inventory per member at end of period	0.14	0.08
Billed charges of claims in inventory per member at end of period	$ 269.93	$ 177.38
Number of claims received during the period	10,043,400	6,655,300
Billed charges of claims received during the period	$ 11,613,100	$ 7,255,000

Individual Health Plan Analysis

California. Premium revenue grew 26.5% in the second quarter of 2015 compared with the second quarter of 2014, the result of higher Medicaid expansion membership (up 69,000 members) and TANF and ABD membership (up 51,000 members); as well as the start-up of an MMP plan in the second quarter of 2014 (15,000 members at June 30, 2015). Overall, enrollment on a member-month basis increased 31% in the second quarter of 2015 compared with the second quarter of 2014. The medical care ratio increased to 91.1% in the second quarter of 2015, from 81.6% in the second quarter of 2014, as a lower medical care ratio for the ABD program was more than offset by higher medical care ratios for other programs.

Florida. The Florida health plan added approximately 175,000 Marketplace members in the first half of 2015. As a result, premium revenue increased significantly, and medical margin improved $31.9 million in the second quarter of 2015 compared with the second quarter of 2014. The medical care ratio decreased to 84.3% from 91.6% in the second quarter of 2014, due to the lower medical care ratio of the Marketplace membership more than offsetting an increased medical care ratio for the Medicaid program.

Illinois. Premium revenue grew to $101.8 million in the second quarter of 2015, from $19.3 million in the second quarter of 2014. The plan experienced significant growth in late 2014, primarily within the traditional TANF program, and to a lesser degree within the Medicaid expansion program. Additionally, the plan served its first MMP members in the first half of 2014. The medical care ratio for the Illinois health plan decreased to 96.6% in the second quarter of 2015, from 106.3% in the second quarter of 2014. The plan's higher medical care ratio in 2014 was primarily the result of a small membership base transitioning to managed care, and increased medically related administrative costs incurred in preparation of anticipated enrollment growth in late 2014.

Michigan. Premium revenue grew $52.2 million, or 28%, in the second quarter of 2015 compared with the second quarter of 2014 due to the addition of Medicaid expansion members beginning in the second quarter of 2014. Medicaid expansion enrollment reached 53,000 members by June 30, 2015. The consolidated medical care ratio decreased to 84.2% in the second quarter of 2015, from 88.2% for the second quarter of 2014, due to growth of the Medicaid expansion program which has a lower medical care ratio than the plan's traditional Medicaid business.

New Mexico. Premium revenue grew $53.8 million, or 20%, in the second quarter of 2015 compared with the second quarter of 2014, due to substantial increases in membership in all Medicaid programs. The medical care ratio decreased to 85.8% in the second quarter of 2015, from 89.6% in the second quarter of 2014, due to lower medical care ratios for the TANF and ABD programs, which more than offset an increase in the medical care ratio for the Medicaid expansion program.

Ohio. Premium revenue grew $179.8 million, or 55%, in the second quarter of 2015 compared with the second quarter of 2014, due to growth in membership within the Medicaid expansion, MMP, and ABD programs. The medical care ratio increased to 85.0% in the second quarter of 2015, from 84.2% in the second quarter of 2014, primarily due to medical costs associated with the plan's higher-acuity MMP members.

Puerto Rico. The medical care ratio was 95.0% in the second quarter of 2015. The plan served its first members effective April 1, 2015.

South Carolina. The medical care ratio decreased to 71.3% in the second quarter of 2015, from 87.8% in the second quarter of 2014. In the first quarter of 2014, the plan enrolled its first members who were transitioned from Medicaid fee-for-service to managed care. We believe that medical care ratios below 80% are not sustainable over time.

Texas. Premium revenue grew $191.4 million, or 60%, in the second quarter of 2015 compared with the second quarter of 2014, primarily due to the addition of ABD members receiving nursing facility benefits effective March 1, 2015 and the start-up of the Texas MMP program on that same date. The medical care ratio for the Texas health plan decreased to 91.5% in the second quarter of 2015, from 92.8% in the second quarter of 2014. For a discussion of the plan's quality related revenue, refer to *Individual Health Plan Analysis* under "Six Months Ended June 30, 2015 Compared with Six Months Ended June 30, 2014," below.

Utah. The medical care ratio decreased to 89.7% in the second quarter of 2015, from 95.5% in the second quarter of 2014, due to improvement in the Medicare medical care ratio and the addition of Marketplace membership which has a lower medical care ratio than the plan's traditional Medicaid business.

Washington. Premium revenue grew $72.8 million, or 22%, in the second quarter of 2015 compared with the second quarter of 2014, primarily due to growth in Medicaid expansion membership. The medical care ratio was consistent at 90.4% in the second quarter of 2015, compared with 90.5% in the second quarter of 2014.

Wisconsin. Premium revenue grew $37.6 million, or 102%, in the second quarter of 2015 when compared with the second quarter of 2014 as a result of increased Marketplace enrollment. The medical care ratio decreased to 75.3% in the second quarter of 2015, from 89.8% in the second quarter of 2014. We believe that medical care ratios below 80% are not sustainable over time.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan and program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended June 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,767	$ 503,739	$ 285.14	$ 459,045	$ 259.85	91.1%	$ 44,694
Florida	1,053	257,317	244.35	216,906	205.97	84.3	40,411
Illinois	301	101,769	337.55	98,260	325.91	96.6	3,509
Michigan	773	237,506	307.27	199,940	258.67	84.2	37,566
New Mexico	690	321,808	466.46	276,144	400.27	85.8	45,664
Ohio	996	508,468	510.30	432,186	433.75	85.0	76,282
Puerto Rico	1,082	193,984	179.33	184,240	170.32	95.0	9,744
South Carolina	337	93,089	276.36	66,332	196.92	71.3	26,757
Texas	806	512,408	635.74	468,629	581.42	91.5	43,779
Utah	277	79,964	288.60	71,727	258.88	89.7	8,237
Washington	1,643	409,758	249.39	370,437	225.46	90.4	39,321
Wisconsin	320	74,532	233.15	56,140	175.62	75.3	18,392
Other [3]	—	10,030	—	29,548	—	—	(19,518)
	10,045	$ 3,304,372	$ 328.96	$ 2,929,534	$ 291.65	88.7%	$ 374,838

	Three Months Ended June 30, 2014						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,335	$ 398,071	$ 298.11	$ 324,923	$ 243.33	81.6%	$ 73,148
Florida	229	101,423	443.05	92,865	405.67	91.6	8,558
Illinois	17	19,263	1,136.20	20,472	1,207.48	106.3	(1,209)
Michigan	702	185,337	264.18	163,392	232.89	88.2	21,945
New Mexico	617	267,994	434.57	240,151	389.42	89.6	27,843
Ohio	849	328,630	386.79	276,716	325.69	84.2	51,914
Puerto Rico	—	—	—	—	—	—	—
South Carolina	360	96,453	268.38	84,686	235.64	87.8	11,767
Texas	742	320,966	432.46	297,899	401.38	92.8	23,067
Utah	249	76,574	307.47	73,094	293.49	95.5	3,480
Washington	1,364	336,959	247.03	305,098	223.67	90.5	31,861
Wisconsin	256	36,925	144.42	33,143	129.63	89.8	3,782
Other [3]	—	(1,453)	—	21,860	—	—	(23,313)
	6,720	$ 2,167,142	$ 322.52	$ 1,934,299	$ 287.87	89.3%	$ 232,843

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

	Three Months Ended June 30, 2015 (1)					
	Member Months[2]	Premium Revenue		Medical Care Costs		
		Total	PMPM	Total	PMPM	MCR[3]	Medical Margin
TANF and CHIP	6,556	$ 1,169,277	$ 178.38	$ 1,063,489	$ 162.24	91.0%	$ 105,788
Medicaid Expansion	1,387	582,443	419.67	474,198	341.67	81.4	108,245
ABD	1,069	1,053,098	984.99	947,093	885.84	89.9	106,005
Marketplace	789	161,214	204.22	89,368	113.21	55.4	71,846
Medicare	133	140,137	1,059.90	140,508	1,062.71	100.3	(371)
MMP	111	198,203	1,784.30	214,878	1,934.40	108.4	(16,675)
	10,045	$ 3,304,372	$ 328.96	$ 2,929,534	$ 291.65	88.7%	$ 374,838

(1) Three months ended June 30, 2014 data not presented due to lack of comparability.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended June 30,	
	2015	2014
	(In thousands)	
Service revenue before amortization	$ 47,626	$ 50,960
Amortization recorded as reduction of service revenue	(383)	(728)
Service revenue	47,243	50,232
Cost of service revenue	32,819	37,107
General and administrative costs	1,212	1,891
Amortization of customer relationship intangibles	169	793
Operating income	$ 13,043	$ 10,441

Operating income for our Molina Medicaid Solutions segment increased $2.6 million in the second quarter of 2015, compared with the second quarter of 2014, primarily the result of a renegotiated state contract, various operational efficiencies, and decreased intangibles amortization.

Results of Operations, Continuing Operations

Six Months Ended June 30, 2015 Compared with Six Months Ended June 30, 2014

Health Plans Segment

Premium Revenue

Premium revenue increased approximately 53% in the six months ended June 30, 2015 compared with the six months ended June 30, 2014, as a result of enrollment growth across all health plan programs.

Medical Care Costs

In the six months ended June 30, 2015, medical care costs as a percent of premium revenue decreased slightly to 88.7% from 89.0% during the six months ended June 30, 2014. Medical margin increased 57% in six months ended June 30, 2015 over the six months ended June 30, 2014.

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Six Months Ended June 30,					
	2015			2014		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 4,051,081	$ 217.05	72.8%	$ 2,559,098	$ 194.38	70.0%
Pharmacy	743,097	39.81	13.4	582,224	44.22	15.9
Capitation	464,682	24.90	8.3	346,256	26.30	9.5
Direct delivery	54,656	2.93	1.0	45,084	3.42	1.2
Other	251,802	13.49	4.5	123,295	9.37	3.4
Total	$ 5,565,318	$ 298.18	100.0%	$ 3,655,957	$ 277.69	100.0%

The following table provides detailed fee-for-service medical claims data for the periods presented (dollars in thousands, except per-member amounts):

	Six Months Ended June 30,	
	2015	2014
Days in claims payable, fee for service	49	46
Number of claims in inventory at end of period	463,200	180,600
Billed charges of claims in inventory at end of period	$ 904,800	$ 400,000
Claims in inventory per member at end of period	0.14	0.08
Billed charges of claims in inventory per member at end of period	$ 269.93	$ 177.38
Number of claims received during the period	18,679,000	12,641,300
Billed charges of claims received during the period	$ 21,505,000	$ 13,609,000

Individual Health Plan Analysis

California. Premium revenue grew 50.1% in the six months ended June 30, 2015 compared with the six months ended June 30, 2014, the result of higher membership, as described above. Overall, enrollment on a member-month basis increased 37% in the six months ended June 30, 2015 compared with the six months ended June 30, 2014. Increased premium revenue was also driven by a 13% increase in premium revenue PMPM, which was the result of the higher relative premium revenue PMPM among those programs experiencing enrollment growth (Medicaid expansion and MMP); and the addition of long-term care benefits to some of the health plan's ABD membership. The medical care ratio increased to 89.9% in the six months ended June 30, 2015, from 83.2% in the six months ended June 30, 2014 due to higher medical care ratios for all programs.

Florida. The health plan's premium revenue increased significantly, and medical margin improved $49.7 million in the six months ended June 30, 2015 compared with the six months ended June 30, 2014, due to the increase in Marketplace membership described above. The medical care ratio decreased to 87.7% from 90.2% in the six months ended June 30, 2014, due to the lower medical care ratio of the Marketplace membership more than offsetting an increase in the medical care ratio for the Medicaid program.

Illinois. Premium revenue grew to $205.9 million in the six months ended June 30, 2015, from $34.4 million in the six months ended June 30, 2014, due to significant membership growth in late 2014, as described above. The medical care ratio for the

Illinois health plan decreased to 91.2% in the six months ended June 30, 2015, from 101.5% in the six months ended June 30, 2014. The plan's higher medical care ratio in 2014 was primarily the result of a small membership base transitioning to managed care, and increased medically related administrative costs incurred in preparation of anticipated enrollment growth in late 2014.

Michigan. Premium revenue grew $98.2 million, or 27%, in the six months ended June 30, 2015 compared with the six months ended June 30, 2014 due to the addition of Medicaid expansion members starting in the second quarter of 2014, as described above. Higher medical care ratios for both the TANF and ABD programs offset a lower medical care ratio for the Medicaid expansion program, resulting in an increased medical care ratio of 84.2% for the six months ended June 30, 2015, compared with 83.2% for the six months ended June 30, 2014.

New Mexico. Premium revenue grew $142.4 million, or 29%, in the six months ended June 30, 2015 compared with the six months ended June 30, 2014, due to substantial increases in membership in all Medicaid programs. The medical care ratio increased to 89.4% in the six months ended June 30, 2015, from 88.5% in the six months ended June 30, 2014, as increases in the medical care ratios of the TANF more than offset lower medical care ratios for the Medicaid expansion and ABD programs.

Ohio. Premium revenue grew $416.6 million, or 69%, in the six months ended June 30, 2015 compared with the six months ended June 30, 2014, due to growth in membership within the Medicaid expansion, MMP, and ABD programs. The medical care ratio of the Ohio health plan decreased to 82.6% in the six months ended June 30, 2015, from 84.7% in the six months ended June 30, 2014, due to lower medical care ratios in all Medicaid programs.

Puerto Rico. The plan began serving members on April 1, 2015; therefore its medical care ratio of 95.0% was the same for the six months ended June 30, 2015, as the second quarter of 2015.

South Carolina. The medical care ratio decreased to 76.2% in the six months ended June 30, 2015, from 90.9% in the six months ended June 30, 2014. In the first quarter of 2014, the plan enrolled its first members who were transitioned from Medicaid fee-for-service to managed care. We believe that medical care ratios below 80% are not sustainable over time.

Texas. Premium revenue grew $253.1 million, or 39%, in the six months ended June 30, 2015 compared with the six months ended June 30, 2014, primarily due to the addition of ABD members receiving nursing facility benefits effective March 1, 2015, and the start-up of the Texas MMP program on that same date. The medical care ratio decreased slightly to 91.7% in the six months ended June 30, 2015, from 92.2% in the six months ended June 30, 2014.

As previously disclosed, we have deferred recognition of that portion of our quality related revenue in Texas that is based upon measures for which we do not have historical information, clear definitions, and clarity around minimum standards. Such revenue is estimated to be approximately $20 million for all of 2014, and $12 million for the first half of 2015. We have not recognized any of this revenue through June 30, 2015.

Utah. The medical care ratio increased to 92.8% in the six months ended June 30, 2015, from 90.4% in the six months ended June 30, 2014, as a higher medical care ratio for members served under the TANF and ABD programs more than offset a lower medical care ratio in the Medicare program.

Washington. Premium revenue grew $125.7 million, or 19%, in the six months ended June 30, 2015 when compared with the six months ended June 30, 2014, primarily due to growth in Medicaid expansion membership. The medical care ratio increased to 91.9% in the six months ended June 30, 2015, from 91.3% in the six months ended June 30, 2014, as a higher medical care ratio for members served under the TANF program more than offset a lower medical care ratio in the ABD program.

Wisconsin. Premium revenue grew $59.4 million, or 79%, in the six months ended June 30, 2015 compared with the six months ended June 30, 2014 as a result of increased Marketplace enrollment. The medical care ratio of the Wisconsin health plan decreased to 77.7% in the six months ended June 30, 2015, from 82.1% in the six months ended June 30, 2014. We believe that medical care ratios below 80% are not sustainable over time.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan and program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Six Months Ended June 30, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	3,440	$ 1,014,283	$ 294.85	$ 911,480	$ 264.97	89.9%	$ 102,803
Florida	1,950	568,288	291.33	498,295	255.45	87.7	69,993
Illinois	606	205,914	339.72	187,697	309.66	91.2	18,217
Michigan	1,529	457,031	298.87	384,703	251.57	84.2	72,328
New Mexico	1,374	635,464	462.62	567,970	413.48	89.4	67,494
Ohio	2,051	1,023,555	498.96	845,260	412.05	82.6	178,295
Puerto Rico	1,082	193,984	179.33	184,240	170.32	95.0	9,744
South Carolina	680	184,415	271.35	140,601	206.88	76.2	43,814
Texas	1,581	894,193	565.45	820,107	518.60	91.7	74,086
Utah	543	157,106	289.42	145,871	268.72	92.8	11,235
Washington	3,206	786,108	245.22	722,811	225.47	91.9	63,297
Wisconsin	622	134,874	216.85	104,849	168.58	77.7	30,025
Other [3]	—	19,809	—	51,434	—	—	(31,625)
	18,664	$ 6,275,024	$ 336.21	$ 5,565,318	$ 298.18	88.7%	$ 709,706

	Six Months Ended June 30, 2014						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	2,589	$ 675,713	$ 260.97	$ 562,267	$ 217.16	83.2%	$ 113,446
Florida	499	206,589	414.17	186,326	373.55	90.2	20,263
Illinois	31	34,434	1,109.99	34,966	1,127.12	101.5	(532)
Michigan	1,350	358,833	265.81	298,712	221.27	83.2	60,121
New Mexico	1,166	493,062	423.00	436,560	374.53	88.5	56,502
Ohio	1,621	606,925	374.33	514,044	317.04	84.7	92,881
Puerto Rico	—	—	—	—	—	—	—
South Carolina	754	192,473	255.31	174,948	232.07	90.9	17,525
Texas	1,491	641,062	429.85	590,857	396.19	92.2	50,205
Utah	495	155,228	313.67	140,294	283.49	90.4	14,934
Washington	2,640	660,420	250.15	603,205	228.48	91.3	57,215
Wisconsin	530	75,453	142.48	61,952	116.99	82.1	13,501
Other [3]	—	7,287	—	51,826	—	—	(44,539)
	13,166	$ 4,107,479	$ 311.98	$ 3,655,957	$ 277.69	89.0%	$ 451,522

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

	Six Months Ended June 30, 2015 (1)					
	Member Months[2]	Premium Revenue		Medical Care Costs		
		Total	PMPM	Total	PMPM	MCR[3]	Medical Margin
TANF and CHIP	12,035	$ 2,141,316	$ 177.93	$ 1,960,315	$ 162.89	91.5%	$ 181,001
Medicaid Expansion	2,661	1,089,339	409.29	867,229	325.84	79.6	222,110
ABD	2,120	1,993,366	940.23	1,809,613	853.56	90.8	183,753
Marketplace	1,371	354,725	258.66	245,682	179.15	69.3	109,043
Medicare	264	273,472	1,036.95	269,005	1,020.01	98.4	4,467
MMP	213	422,806	1,986.04	413,474	1,942.20	97.8	9,332
	18,664	$ 6,275,024	$ 336.21	$ 5,565,318	$ 298.18	88.7%	$ 709,706

(1) Six months ended June 30, 2014 data not presented due to lack of comparability.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Six Months Ended June 30,	
	2015	2014
	(In thousands)	
Service revenue before amortization	$ 100,162	$ 105,319
Amortization recorded as reduction of service revenue	(1,061)	(1,457)
Service revenue	99,101	103,862
Cost of service revenue	68,721	77,764
General and administrative costs	3,208	3,641
Amortization of customer relationship intangibles	339	1,768
Operating income	$ 26,833	$ 20,689

Operating income for our Molina Medicaid Solutions segment increased $6.1 million in the six months ended June 30, 2015, compared with the six months ended June 30, 2014, primarily the result of a renegotiated state contract, various operational efficiencies, and decreased intangible amortization.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") decreased to 8.1% in the second quarter of 2015 compared with 8.4% in the second quarter of 2014. The general and administrative expense ratio decreased to 8.1% for the six months ended June 30, 2015, compared with 8.7% for the six months ended June 30, 2014. For both periods, the decline in this ratio was primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Premium Tax Expense

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.8% in the second quarter of 2015 compared with 3.1% in the second quarter of 2014, and 2.9% in both the six months ended June 30, 2015 and the six months ended June 30, 2014.

Health Insurer Fee Revenue and Expenses

Health insurer fee revenue, as a percentage of premium revenue, increased to 2.2% in the second quarter of 2015 from 0.9% in the second quarter of 2014, and increased to 1.9% in the six months ended June 30, 2015, from 0.9% in the six months ended June 30, 2014.

Health insurer fee expenses, as a percentage of premium revenue, were 1.2% in the second quarter of 2015, compared with 1.0% in the second quarter of 2014, and 1.3% in the six months ended June 30, 2015, compared with 1.1% in the six months ended June 30, 2014.

HIF revenue increased in 2015 compared with 2014 due to improved reimbursement of Medicaid-related HIF expenses in 2015. In addition, both HIF revenue and expenses increased over the prior year proportionally to the increase in the total HIF tax base, which is assessed to all insurers. This base increased to $11.3 billion in 2015, from $8.0 billion in 2014. Refer to "Liquidity and Capital Resources—Financial Condition" below, for further discussion of the HIF.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Three Months Ended June 30,			
	2015		2014	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 21,296	0.6%	$ 18,536	0.8%
Amortization of intangible assets, continuing operations	3,856	0.1	4,366	0.2
Depreciation and amortization, continuing operations	25,152	0.7	22,902	1.0
Amortization recorded as reduction of service revenue	383	—	728	—
Amortization of capitalized software recorded as cost of service revenue	3,967	0.1	9,030	0.4
	$ 29,502	0.8%	$ 32,660	1.4%

	Six Months Ended June 30,			
	2015		2014	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 42,399	0.6%	$ 34,672	0.8%
Amortization of intangible assets, continuing operations	7,745	0.1	8,921	0.2
Depreciation and amortization, continuing operations	50,144	0.7	43,593	1.0
Amortization recorded as reduction of service revenue	1,061	—	1,457	—
Amortization of capitalized software recorded as cost of service revenue	10,871	0.2	20,604	0.5
Depreciation and amortization reported in the statement of cash flows	$ 62,076	0.9%	$ 65,654	1.5%

Interest Expense

Interest expense increased to $14.9 million for the second quarter of 2015, from $14.0 million for the second quarter of 2014. Interest expense increased to $29.8 million for the six months ended June 30, 2015, from $27.8 million for the six months ended June 30, 2014. The increase was due primarily to the issuance of the 1.625% Notes in the third quarter of 2014. For further details regarding convertible senior notes transactions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 11, "Debt."

Interest expense includes non-cash interest expense relating primarily to the amortization of the discount on convertible senior notes, which amounted to $7.4 million and $6.8 million for the three months ended June 30, 2015 and 2014, respectively, and $14.7 million and $13.5 million for the six months ended June 30, 2015 and 2014, respectively.

Income Taxes

The provision for income taxes in continuing operations was recorded at an effective rate of 61.3% for the second quarter of 2015, compared with 58.0% for the second quarter of 2014, and 60.1% for the six months ended June 30, 2015 compared with

56.5% for the six months ended June 30, 2014. The effective tax rate for 2015 is higher than 2014 primarily as a result of higher non-deductible HIF expenses in 2015, and our inability to record tax benefits for losses incurred at our Puerto Rico health plan, which commenced operations in 2015.

Liquidity and Capital Resources

Introduction

Our regulated health plan subsidiaries generate significant cash flows from premium revenue. We generally receive premium revenue a short time before we pay for the related health care services; such cash flows generate our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. In addition, the majority of our premium revenues comes from the joint federal and state funding of the Medicaid and CHIP programs. From time to time, states may delay premium payments. Whenever a state delays payments, for whatever the reason, our liquidity is reduced. See further discussion under *Financial Condition*, below.

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

A majority of the assets held by our regulated subsidiaries is in the form of cash, cash equivalents, and investments. Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use. For the six months ended June 30, 2015, the non-regulated parent company received dividends from subsidiaries amounting to $42 million. For the six months ended June 30, 2014, the parent received no dividends from subsidiaries.

We generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of June 30, 2015, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities.

All of our investments are classified as current assets, except for our restricted investments and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Six Months Ended June 30,		
	2015	2014	Change
	(In thousands)		
Net cash provided by operating activities	$ 647,710	$ 235,460	$ 412,250
Net cash used in investing activities	(556,849)	(102,336)	(454,513)
Net cash provided by (used in) financing activities	383,958	(41,668)	425,626
Net increase in cash and cash equivalents	$ 474,819	$ 91,456	$ 383,363

Operating Activities. Cash provided by operating activities increased $412.3 million year over year, primarily due to the changes in receivables, amounts due government agencies, and accounts payable and accrued liabilities.

The change in accounts receivable provided $139.9 million year over year, primarily due to collections of premiums receivable at our California health plan in the six months ended June 30, 2015. The change in amounts due government agencies provided $177.9 million in the six months ended June 30, 2015, in connection with Health Plans segment membership growth in

programs that contain medical cost floors or medical cost corridors. Under such programs, a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. The change in accounts payable and accrued liabilities provided $100.1 million, primarily due to the accrual of the 2015 HIF in the six months ended June 30, 2015.

Investing Activities. Cash used in investing activities in the six months ended June 30, 2015 increased to $556.8 million, from $102.3 million in the same period of 2014 primarily due to the investment of the net proceeds from our common stock offering, as described below. In addition, purchases of property, equipment and capitalized software increased approximately $28.2 million, primarily due to the start-up of our operations in Puerto Rico on April 1, 2015.

Financing Activities. Cash provided by financing activities in the six months ended June 30, 2015 amounted to $384.0 million, due primarily to $373.2 million proceeds, net of issuance costs, from the June 2015 offering of 5.75 million shares of our common stock. Cash used in financing activities in the six months ended June 30, 2014 related primarily to the settlement of $50.3 million of contingent consideration liabilities for our 2013 South Carolina health plan acquisition, with no comparable activity in the six months ended June 30, 2015.

Financial Condition

On a consolidated basis, at June 30, 2015, working capital amounted to $1,067.7 million, compared with $1,070.6 million at December 31, 2014. We held cash and investments, including restricted investments, of $3,593.8 million and $2,665.9 million at June 30, 2015 and December 31, 2014, respectively.

Credit Facility Covenants. The $250 million revolving Credit Facility contains customary non-financial and financial covenants, including a minimum interest coverage ratio, a maximum net debt-to-EBITDA ratio, and minimum statutory net worth, as described in greater detail in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt." As of June 30, 2015, there were no borrowings outstanding under our Credit Facility and we were in compliance with all covenants.

States' Budgets. As noted above, from time to time the states in which our health plans operate may delay premium payments. For example, the state of Illinois is currently operating without a budget for its fiscal year ending June 30, 2016. As of June 30, 2015, our Illinois health plan served approximately 101,000 members, and recognized premium revenue of approximately $205.9 million for the six months ended June 30, 2015. As of July 30, 2015, Illinois is current with its premium payments through June 30, 2015, but has not paid us for July or August 2015.

In another example, the Commonwealth of Puerto Rico has reported that it may lack sufficient resources to fund all necessary governmental programs including healthcare-related programs, as well as meet its debt obligations for its fiscal year ending June 30, 2016. Our Puerto Rico health plan became operational on April 1, 2015. As of June 30, 2015, the plan served approximately 361,000 members and recognized premium revenue of approximately $194 million in the second quarter of 2015. As of July 30, 2015, the Commonwealth continues to pay us weekly and is current with its payments.

It has been our practice in the past, and will remain so in the future, to continue to serve our members and pay health care providers for services rendered in circumstances where state (or Commonwealth) governments are temporarily unable to pay us, so long as we continue to believe that such state (or Commonwealth) governments will ultimately pay us.

Health Insurer Fee. We expect the 2015 HIF assessment related to our Medicaid business to be approximately $150 million, with an expected tax effect from the reimbursement of the assessment of approximately $92 million. Therefore, the total reimbursement necessary as a result of the Medicaid-related 2015 HIF assessment is approximately $242 million. We have secured agreements from all of our state partners except Michigan and Utah for the reimbursement of the 2015 HIF.

We continue to work with the states of Michigan and Utah to secure agreement for the reimbursement for the full economic impact of the HIF. The failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows and results of operations. Michigan and Utah combined need to pay us approximately $33 million for all of 2015 to make us whole for Medicaid-related 2015 HIF expenses in those two states.

The following table provides the details of our HIF revenue reimbursement by health plan as of June 30, 2015 (in thousands):

	HIF Reimbursement Revenue, Gross[1]				
	Six Months Ended June 30, 2015				Year Ending Dec. 31, 2015
	Recognized			Necessary for Full Reimbursement	Necessary for Full Reimbursement
	Q1 2015	Q2 2015	Total		
2015 HIF:					
California	$ —	$ 17,258	$ 17,258	$ 17,258	$ 34,517
Florida	2,027	2,042	4,069	4,069	8,139
Illinois	965	973	1,938	1,938	3,875
Michigan	—	—	—	13,776	27,551
New Mexico	7,539	7,597	15,136	15,136	30,273
Ohio	11,936	12,027	23,963	23,963	47,925
South Carolina	3,053	3,077	6,130	6,130	12,261
Texas	5,839	5,884	11,723	11,723	23,446
Utah	—	—	—	2,968	5,936
Washington	10,951	10,963	21,914	21,914	43,828
Wisconsin	1,126	1,135	2,261	2,261	4,522
Subtotal, Medicaid	43,436	60,956	104,392	121,136	242,273
Marketplace	398	400	798	798	1,595
Medicare	5,702	3,652	9,354	9,354	18,702
	49,536	65,008	114,544	$ 131,288	$ 262,570
2014 HIF:					
California	—	11,616	11,616		
	$ 49,536	$ 76,624	$ 126,160		
Recognized in:					
Health insurer fee revenue	$ 47,948	$ 73,890	$ 121,838		
Premium tax revenue	1,588	2,734	4,322		
	$ 49,536	$ 76,624	$ 126,160		

(1) Amounts in the table include the Company's estimate of the full economic impact of the HIF including premium tax and the income tax effect.

Convertible Senior Notes Classification. As described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 11, "Debt," our 1.125% Notes met the stock price trigger in the quarter ended June 30, 2015, and are convertible to cash through at least September 30, 2015. Because the 1.125% Notes may be converted into cash within 12 months, the $445.2 million carrying amount is reported in current portion of long-term debt as of June 30, 2015, which resulted in decreased working capital as of June 30, 2015. We believe that the amount of the 1.125% Notes that may be converted over the next twelve months, if any, will be insignificant. For more information, refer to Part II, Item 1A of this Form 10-Q, "Risk Factors."

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Future Sources and Uses of Liquidity

During June and July 2015, we announced that we had entered into agreements to acquire Medicaid contracts that will add a total of approximately 180,000 members by the end of 2015 to our health plans in Florida, Illinois and Michigan. We expect to spend approximately $110 million in total for these three acquisitions.

For information on our Credit Facility, convertible senior notes, and other financing arrangements, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt."

For information on our common stock offering, shelf registration statement, and securities repurchase program, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 13, "Stockholders' Equity."

Regulatory Capital and Dividend Restrictions

For information on our regulatory capital requirements and dividend restrictions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 15, "Commitments and Contingencies."

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2014, was disclosed in our 2014 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the six months ended June 30, 2015. For further discussion and maturities of our long-term debt, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements.
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the second quarter of 2015 in connection with such contractual provisions.
- *Health Plans segment quality incentives*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the second quarter of 2015 in connection with such quality incentives.
- *Health Plans segment Marketplace premium stabilization programs* (see discussion below).
- *Molina Medicaid Solutions segment revenue and cost recognition*. Refer to Part II, Item 8 of our 2014 Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of Molina Medicaid Solutions' service revenue and cost of service revenue recognition.

There have been no significant changes during the six months ended June 30, 2015, to the items that we disclosed as our critical accounting estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2014.

Marketplace Premium Stabilization Programs - Health Plans Segment

The ACA established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio (Minimum MLR) of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue, where the components of medical costs and premium revenue are specifically defined by federal regulations. Each of the 3R programs are taken into consideration when computing the Minimum MLR. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders.

Our receivables (payables) for each of these programs were as follows (in millions):

	June 30, 2015	December 31, 2014
Risk adjustment	$ (78.1)	$ (4.8)
Reinsurance	18.1	4.9
Risk corridor	(20.4)	(0.5)
Minimum MLR	(18.3)	—

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)), are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2015 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

A description of our legal proceedings is included in and incorporated by reference to Note 15 of the Notes to the Consolidated Financial Statements contained in Part I, Item 1 of this report.

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should be carefully consider the risk factors discussed below, which supplement and should be read together with the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2014. The risk factors described herein and in our 2014 Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

The Commonwealth of Puerto Rico may become unable to pay the premiums of our Puerto Rico health plan.

The government of Puerto Rico currently faces major fiscal and liquidity challenges. The government recently warned that it may "lack sufficient resources to fund all necessary governmental programs and services as well as meet debt service obligations for fiscal year 2016." Much of the Puerto Rican government's revenue stream for the first part of its fiscal year, which began on July 1st, is earmarked to redeem revenue bonds. On June 29, 2015, Puerto Rico's governor, Alejandro Garcia Padilla, stated during a televised address that "the debt is not payable." Further, the island's ability to access credit markets appears highly uncertain, and its ability to meet future debt service payments depends in part on the willingness of investors to roll over existing debt.

The extreme financial difficulties faced by the Commonwealth may make it impossible for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of June 30, 2015, our Puerto Rico health plan served approximately 361,000 members, and had recognized premium revenue of approximately $194 million in the second quarter of 2015, or approximately $65 million per month. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a materially adverse effect on our business, financial condition, cash flows, or results of operations.

Changes to health care regulatory laws under the Affordable Care Act including the recently proposed Medicaid managed care rule, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The health care regulatory law landscape is constantly changing. For example, on May 26, 2015, CMS posted a new proposed rule to the Federal Register regarding Medicaid programs and CHIP, Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability that, if implemented, would, among other things, impose a medical loss ratio of 85% for Medicaid and CHIP programs, establish a Medicaid managed care quality rating system like the five-star system for Medicare Advantage plans, and expand health plans' responsibilities in program integrity efforts. It is difficult to predict what final rules may be adopted and implemented by CMS, and if the final rule would result in any material adverse effect on our business, financial condition, cash flows, or results of operations.

If the responsive bids of our health plans (including our Michigan health plan) for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. In the event the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

Our Michigan Medicaid contract is subject to a new RFP that was released on May 8, 2015. If we are successful in our attempt to renew this contract, we expect that the new contract will become effective on January 1, 2016. If our attempt to renew this contract is not successful, the contract will terminate effective December 31, 2015. If we are unable to renew,

successfully re-bid, or compete for any of our government contracts, including our Michigan contract, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including federal and state anti-kickback statutes, prohibited referrals, the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, improper marketing, and the violation of patient privacy rights. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services (HHS), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. We are currently defending two *qui tam* actions where the federal government has declined to intervene: (i) *USA ex rel Anita Silingo v. Mobile Medical Examination Service, Molina Healthcare of California, et al; and (ii) USA and State of Florida ex rel Charles Wilhelm v. Molina Healthcare and Molina Healthcare of Florida.* We believe we have meritorious defenses to both matters, and intend to defend both matters vigorously. Other *qui tam* actions may have been filed against us of which we are presently unaware, or other *qui tam* actions may be filed against us in the future. In the event we are subject to liability under these or other *qui tam* actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our use and disclosure of individually identifiable information, including health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations, including HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of individually identifiable information, including protected health information, or PHI. HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in

violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities for compliance with the HIPAA Privacy and Security Standards. Investigations of violations that indicate willful neglect, for which penalties are now mandatory, are statutorily required. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the civil monetary penalty fine paid by the violator.

HIPAA further requires covered entities to notify affected individuals "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach" if their unsecured PHI is subject to an unauthorized access, use, or disclosure. If a breach affects 500 patients or more, it must be reported to HHS and local media without unreasonable delay, and HHS will post the name of the breaching entity on its public website. If a breach affects fewer than 500 individuals, the covered entity must log it and notify HHS at least annually. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal penalties, divert management's time and energy, and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Other large-scale medical emergencies may have a material adverse effect on our business, cash flows, financial condition, and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons. In addition, natural disasters and the potential for a wide-spread pandemic of influenza or other diseases, coupled with the lack of availability of appropriate preventative medicines, can have a significant impact on the health of the population of wide-spread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas, or a large-scale pandemic or epidemic, our covered medical expenses could rise and we could experience a material adverse effect on our business, cash flows, financial condition, and results of operations, or, in the event of extreme circumstances, our viability could be threatened.

We may not have the funds necessary to pay the amounts due upon conversion or required repurchase of our outstanding notes, and our indebtedness may contain limitations on our ability to pay the amounts due upon conversion or required repurchase.

In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020, unless earlier repurchased or converted. We refer to these notes as our 1.125% Notes. In September 2014, we issued $301.6 million aggregate principal amount of 1.625% convertible senior notes due August 14, 2044, unless earlier repurchased, redeemed, or converted. We refer to these notes as our 1.625% Notes. As of June 30, 2015, the aggregate outstanding principal amount of our 1.125% Notes and our 1.625% Notes was $550.0 million and $301.6 million, respectively. Both our 1.125% Notes and our 1.625% Notes are convertible into cash prior to their respective maturity dates under certain situations, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The 1.125% Notes met the stock price trigger in the quarter ended June 30, 2015, and are convertible to cash through at least September 30, 2015. Because the 1.125% Notes may be converted into cash within 12 months, the $445.2 million carrying amount is reported in current portion of long-term debt as of June 30, 2015. In addition, holders of our 1.625% Notes may convert their notes into cash during any calendar quarter (and only during such calendar quarter) if the last reported sales price of our common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to $75.52 per share. The last reported sale price of our common stock as reported on the New York Stock Exchange on July 29, 2015 was $68.83 per share. As of June 30, 2015, our 1.625% Notes were not convertible. If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

For economic reasons related to the trading market for our 1.125% Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price

of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Notes may elect to convert the notes to cash. As of June 30, 2015, we have sufficient available cash, combined with borrowing capacity available under our Credit Facility, to fund such conversions.

In addition, in the event of a change in control or the termination in trading of our stock, each holder of our 1.125% Notes and our 1.625% Notes would have the right to require us to purchase some or all of their notes at a purchase price in cash equal to 100% of the principal amount of the notes, plus any accrued and unpaid interest.

In the event of conversions or required repurchases, we may not have enough available cash or be able to obtain financing at the time we are required to comply with our conversion or repurchase obligations. In addition, our ability to comply with these obligations may be limited by law, by regulatory authority, or by agreements governing our future indebtedness. The indentures for the 1.125% Notes and the 1.625% Notes provide that it would be an event of default if we do not make the cash payments due upon conversion or required repurchase of the notes. The occurrence of an event of default under one or both of these indentures may also constitute an event of default under our Credit Facility and under our other indebtedness we may have outstanding at such time. Any such default could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended June 30, 2015 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
April 1 - April 30	508	$ 66.31	—	$ 50,000,000
May 1 - May 31	1,453	$ 59.55	—	$ 50,000,000
June 1 - June 30	388	$ 72.27	—	$ 50,000,000
Total	2,349	$ 63.11	—	

(a) During the three months ended June 30, 2015, we withheld 2,349 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2015.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: July 30, 2015

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: July 30, 2015

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
10.1	Credit Agreement, dated as of June 12, 2015, by and among Molina Healthcare, Inc., Molina Information Systems, LLC, Molina Medical Management, Inc., certain lenders named on the signature pages thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank. Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2015.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 30, 2015

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 30, 2015

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2015 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 30, 2015

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2015 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 30, 2015

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended March 31, 2015

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2015

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of May 1, 2015, was approximately 50,132,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended March 31, 2015

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	March 31, 2015	December 31, 2014
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,870,024	$ 1,539,063
Investments	1,203,866	1,019,462
Receivables	491,430	596,456
Deferred income taxes	42,631	39,532
Prepaid expenses and other current assets	193,498	50,884
Derivative asset	474,121	—
Total current assets	4,275,570	3,245,397
Property, equipment, and capitalized software, net	344,727	340,778
Deferred contract costs	57,314	53,675
Intangible assets, net	84,702	89,273
Goodwill	272,046	271,964
Restricted investments	101,366	102,479
Derivative asset	—	329,323
Other assets	34,064	44,326
	$ 5,169,789	$ 4,477,215
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,448,132	$ 1,200,522
Amounts due government agencies	622,158	527,193
Accounts payable and accrued liabilities	427,644	241,654
Deferred revenue	169,811	196,076
Income taxes payable	10,836	8,987
Current portion of long-term debt	440,632	341
Derivative liability	473,983	—
Total current liabilities	3,593,196	2,174,773
Convertible senior notes	270,836	704,097
Lease financing obligations	161,013	160,710
Lease financing obligations – related party	40,135	40,241
Deferred income taxes	29,267	24,271
Derivative liability	—	329,194
Other long-term liabilities	33,349	33,487
Total liabilities	4,127,796	3,466,773
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 49,908 shares at March 31, 2015 and 49,727 shares at December 31, 2014	50	50
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	398,141	396,059
Accumulated other comprehensive income (loss)	297	(1,019)
Retained earnings	643,505	615,352
Total stockholders' equity	1,041,993	1,010,442
	$ 5,169,789	$ 4,477,215

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2015	2014
	(Amounts in thousands, except net income (loss) per share) (Unaudited)	
Revenue:		
Premium revenue	$ 2,970,652	$ 1,940,337
Service revenue	51,858	53,630
Premium tax revenue	95,347	51,693
Health insurer fee revenue	47,948	18,696
Investment income	3,015	1,629
Other revenue	2,303	3,258
Total revenue	3,171,123	2,069,243
Operating expenses:		
Medical care costs	2,635,784	1,721,658
Cost of service revenue	35,902	40,657
General and administrative expenses	256,090	188,087
Premium tax expenses	95,347	51,693
Health insurer fee expenses	40,778	22,190
Depreciation and amortization	24,992	20,691
Total operating expenses	3,088,893	2,044,976
Operating income	82,230	24,267
Other expenses, net:		
Interest expense	14,876	13,822
Other income, net	(10)	(44)
Total other expenses, net	14,866	13,778
Income from continuing operations before income tax expense	67,364	10,489
Income tax expense	39,223	5,655
Income from continuing operations	28,141	4,834
Income (loss) from discontinued operations, net of tax	12	(336)
Net income	$ 28,153	$ 4,498
Basic net income (loss) per share:		
Continuing operations	$ 0.58	$ 0.11
Discontinued operations	—	(0.01)
Basic net income per share	$ 0.58	$ 0.10
Diluted net income (loss) per share:		
Continuing operations	$ 0.56	$ 0.10
Discontinued operations	—	(0.01)
Diluted net income per share	$ 0.56	$ 0.09

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2015	2014
	(Amounts in thousands) (Unaudited)	
Net income	$ 28,153	$ 4,498
Other comprehensive income:		
Unrealized investment gain	2,116	1,426
Effect of income taxes	800	722
Other comprehensive income, net of tax	1,316	704
Comprehensive income	$ 29,469	$ 5,202

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2015	2014
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 28,153	$ 4,498
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	32,574	32,994
Deferred income taxes	1,097	(670)
Share-based compensation	5,675	5,596
Amortization of convertible senior notes and lease financing obligations	7,290	6,674
Other, net	3,564	(1,548)
Changes in operating assets and liabilities:		
Receivables	105,026	(39,297)
Prepaid expenses and other assets	(137,278)	(78,023)
Medical claims and benefits payable	247,610	149,754
Amounts due government agencies	94,965	43,265
Accounts payable and accrued liabilities	189,373	58,952
Deferred revenue	(26,265)	24,060
Income taxes	1,849	4,642
Net cash provided by operating activities	553,633	210,897
Investing activities:		
Purchases of investments	(438,591)	(142,145)
Proceeds from sales and maturities of investments	255,609	147,370
Purchases of property, equipment and capitalized software	(24,974)	(17,788)
Increase in restricted investments	(4,612)	(14,381)
Net cash paid in business combinations	(8,006)	—
Other, net	(7,216)	(547)
Net cash used in investing activities	(227,790)	(27,491)
Financing activities:		
Contingent consideration liabilities settled	—	(38,119)
Proceeds from employee stock plans	1,089	1,330
Other, net	4,029	857
Net cash provided by (used in) financing activities	5,118	(35,932)
Net increase in cash and cash equivalents	330,961	147,474
Cash and cash equivalents at beginning of period	1,539,063	935,895
Cash and cash equivalents at end of period	$ 1,870,024	$ 1,083,369

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Three Months Ended March 31,	
	2015	2014
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Schedule of non-cash investing and financing activities:		
Increase in non-cash lease financing obligation – related party	$ —	$ 7,775
Common stock used for share-based compensation	$ (8,774)	$ (8,217)
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 144,798	$ 10,266
Loss on 1.125% Conversion Option	(144,789)	(10,264)
Change in fair value of derivatives, net	$ 9	$ 2
Details of business combinations:		
Fair value of assets acquired	$ (82)	$ —
Payable to seller	(7,924)	—
Net cash paid in business combinations	$ (8,006)	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
March 31, 2015

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of March 31, 2015, these health plans served nearly 3 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate, as well as of the management of a hospital in southern California under a management services agreement.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Market Updates - Health Plans Segment

Florida. In the first quarter of 2015, our Florida health plan enrolled 185,000 Marketplace members, more than doubling its total membership as of December 31, 2014.

Puerto Rico. On April 1, 2015, our Puerto Rico health plan became operational, enrolling approximately 350,000 members.

Market Updates - Molina Medicaid Solutions Segment

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate its new Medicaid management information system (MMIS). The new contract is effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's previous MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2015.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2014. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2014 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2014 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2014 statement of cash flows to conform to the 2015 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred.

Certain components of premium revenue are subject to accounting estimates as follows:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Health Plan Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $446.5 million and $392.4 million at March 31, 2015, and December 31, 2014, respectively, to amounts due government agencies. Approximately $430 million of the liability accrued at March 31, 2015 relates to our participation in Medicaid expansion programs.

In general, such amounts are subject to future changes in estimate based upon our actual cost performance and interpretations of allowable medical costs and revenue. At our Washington health plan (where we had recorded a liability of approximately $260 million related to the Medicaid expansion medical cost floor at March 31, 2015), premium revenue may be retroactively adjusted across the entire state Medicaid expansion program based upon the medical cost performance of the program as a whole. As such, our liability under Washington's contractual provisions is determined not just by our own medical cost performance, but by that of all health plans participating in the program; and we have limited visibility into the costs of those health plans.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold, but we had no receivables recorded at March 31, 2015 or December 31, 2014 that were related to such provisions. Separately, in certain states we may be levied with non-monetary sanctions if certain minimum amounts are not spent on defined medical care costs, or if administrative costs exceed certain amounts.

Health Plan Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to retain, we recorded a liability of $5.6 million and $0.5 million at March 31, 2015 and December 31, 2014, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS will recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS will pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of $17.3 million and $7.6 million for anticipated Medicare risk adjustment premiums at March 31, 2015, and December 31, 2014, respectively.

Quality Incentives

At our California, Illinois, New Mexico, Ohio, South Carolina, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned if specified performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2015 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2015.

	Three Months Ended March 31,	
	2015	2014
	(In thousands)	
Maximum available quality incentive premium - current period	$ 30,315	$ 20,164
Amount of quality incentive premium revenue recognized in current period:		
Earned current period	$ 9,551	$ 5,297
Earned prior periods	383	(378)
Total	$ 9,934	$ 4,919
Total premium revenue recognized for state health plans with quality incentive premiums	$ 2,353,235	$ 1,200,619

California Health Plan Rate Settlement Agreement

In 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, a settlement account (the Account) applicable to the California health plan's managed care contracts has been established.

Effective January 1, 2014, the Account was established with an initial balance of zero, and will be settled after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our managed care contracts. The Account will be adjusted annually to reflect a calendar year deficit or surplus, which is determined by comparing the California health plan's pre-tax margin and a target margin established in the settlement agreement. Upon expiration of the settlement agreement, if the Account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. If the Account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40.0 million.

We estimate and recognize the retrospective adjustments to premium revenue based on our experience to date under the California health plan's managed care contracts. As of March 31, 2015, the California health plan's pre-tax margin exceeded the target margin, resulting in a surplus position. Consequently, a retrospective premium adjustment was not required at March 31, 2015.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses under the Affordable Care Act's Health Insurer Fee (HIF), nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

New Accounting Standards

In April 2015, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2015-03 - *Simplifying the Presentation of Debt Issuance Costs*, which will require debt issuance costs related to a recognized debt liability to be presented in the balance sheet as a direct deduction from the carrying amount of such debt liability, consistent with debt discounts. This ASU will be effective for us in the first quarter of 2016, and is applied retrospectively to all prior periods presented in the financial statements; early adoption is permitted. We are evaluating the potential effects of the adoption of the ASU on our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended March 31,	
	2015	2014
	(In thousands)	
Shares outstanding at the beginning of the period	48,578	45,871
Weighted-average number of shares:		
Issued, share-based compensation	107	150
Denominator for basic net income per share	48,685	46,021
Effect of dilutive securities:		
Share-based compensation	468	597
Convertible senior notes (1)	—	902
1.125% Warrants (1)	918	—
Denominator for diluted net income per share	50,071	47,520
Potentially dilutive common shares excluded from calculations (2):		
Stock options	—	45
Restricted shares	55	192
1.125% Warrants	—	13,490

(1) For more information regarding the convertible senior notes, refer to Note 11, "Debt." For more information regarding the 1.125% Warrants, refer to Note 12, "Derivatives."

(2) The dilutive effect of all potentially dilutive common shares is calculated using the treasury-stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income per share because to do so would be anti-dilutive. For the three months ended March 31, 2014, the 1.125% Warrants were excluded from diluted shares outstanding because the exercise price exceeded the average market price of our common stock.

4. Business Combinations

Health Plans Segment

Florida. In December 2014, our Florida health plan acquired certain assets relating to the Medicaid business of First Coast Advantage, LLC (FCA). As part of the transaction, we assumed FCA's Medicaid contract and certain provider agreements for Region 4 of the Statewide Medicaid Managed Care Managed Medical Assistance Program in the state of Florida. The Florida health plan's membership increased by approximately 62,000 members as a result of this transaction. The final purchase price for this acquisition amounted to $44.6 million, of which $36.6 million was paid in December 2014, and $8.0 million was paid in the first quarter of 2015.

5. Share-Based Compensation

As of March 31, 2015, there are approximately 312,000 unvested restricted shares awarded to our named executive officers with market and performance conditions outstanding. In the event the vesting conditions are not achieved, the awards will lapse. As of March 31, 2015, we expect the performance conditions to be met in full.

Charged to general and administrative expenses, total share-based compensation expense was as follows:

	Three Months Ended March 31,	
	2015	2014
	(In thousands)	
Restricted stock and performance awards	$ 4,601	$ 4,608
Employee stock purchase plan and stock options	1,074	988
	$ 5,675	$ 5,596

As of March 31, 2015, there was $29.3 million of total unrecognized compensation expense related to unvested restricted stock awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 2.0 years.

Restricted and performance stock activity for the three months ended March 31, 2015 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2014	1,282,072	$ 33.55
Granted	171,835	63.07
Vested	(371,198)	32.03
Forfeited	(26,582)	37.35
Unvested balance as of March 31, 2015	1,056,127	38.79

The total fair value of restricted and performance awards granted during the three months ended March 31, 2015 and 2014 was $10.8 million and $22.9 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, which vested during the three months ended March 31, 2015 and 2014 was $23.4 million and $20.9 million, respectively.

6. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, other assets, trade accounts payable, medical claims and benefits payable, amounts due government agencies, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, certificates of deposit, and asset-backed securities that are classified as current investments in the accompanying consolidated balance sheets. Such investments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of March 31, 2015 included the price of our common stock, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, “Derivatives,” the 1.125%

Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Contingent consideration liability. The contingent consideration liability represents the remaining liability associated with the Medicare-Medicaid Plan (MMP) component of our South Carolina health plan acquisition in 2013, and is recorded in accounts payable and accrued liabilities. We applied a cash flow analysis to determine the fair value of this liability. The significant unobservable input is the purchase price estimate for the projected membership.

Auction rate securities. Auction rate securities are designated as available-for-sale and are reported at fair value in other assets. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of March 31, 2015.

Our financial instruments measured at fair value on a recurring basis at March 31, 2015, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 809,150	$ —	$ 809,150	$ —
Municipal securities	120,157	—	120,157	—
GSEs	142,859	142,859	—	—
U.S. treasury notes	64,327	64,327	—	—
Certificates of deposit	56,018	—	56,018	—
Asset-backed securities	11,355	—	11,355	—
Auction rate securities	2,800	—	—	2,800
1.125% Call Option derivative asset	474,121	—	—	474,121
Total assets measured at fair value on a recurring basis	$ 1,680,787	$ 207,186	$ 996,680	$ 476,921
1.125% Conversion Option derivative liability	$ 473,983	$ —	$ —	$ 473,983
Contingent consideration liability	500	—	—	500
Total liabilities measured at fair value on a recurring basis	$ 474,483	$ —	$ —	$ 474,483

Our financial instruments measured at fair value on a recurring basis at December 31, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 641,729	$ —	$ 641,729	$ —
Municipal securities	127,045	—	127,045	—
GSEs	122,269	122,269	—	—
U.S. treasury notes	59,543	59,543	—	—
Certificates of deposit	68,876	—	68,876	—
Auction rate securities	4,847	—	—	4,847
1.125% Call Option derivative asset	329,323	—	—	329,323
Total assets measured at fair value on a recurring basis	$ 1,353,632	$ 181,812	$ 837,650	$ 334,170
1.125% Conversion Option derivative liability	$ 329,194	$ —	$ —	$ 329,194
Contingent consideration liability	500	—	—	500
Total liabilities measured at fair value on a recurring basis	$ 329,694	$ —	$ —	$ 329,694

The following table presents activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liability
		(In thousands)	
Balance at December 31, 2014	$ 4,847	$ 129	$ (500)
Total gains for the period recognized in:			
Other expenses, net	—	9	—
Other comprehensive income	53	—	—
Settlements	(2,100)	—	—
Balance at March 31, 2015	$ 2,800	$ 138	$ (500)

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our convertible senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	March 31, 2015				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
1.125% Notes	$ 440,248	$ 919,919	$ —	$ 919,919	$ —
1.625% Notes	270,836	381,610	—	381,610	—
	$ 711,084	$ 1,301,529	$ —	$ 1,301,529	$ —

	December 31, 2014				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
1.125% Notes	$ 435,330	$ 767,377	$ —	$ 767,377	$ —
1.625% Notes	268,767	337,292	—	337,292	—
	$ 704,097	$ 1,104,669	$ —	$ 1,104,669	$ —

7. Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 809,009	$ 783	$ 642	$ 809,150
Municipal securities	119,896	291	30	120,157
GSEs	142,851	98	90	142,859
U.S. treasury notes	64,061	266	—	64,327
Certificates of deposit	56,019	1	2	56,018
Asset-backed securities	11,359	1	5	11,355
Subtotal - current investments	1,203,195	1,440	769	1,203,866
Auction rate securities	3,000	—	200	2,800
	$ 1,206,195	$ 1,440	$ 969	$ 1,206,666

	December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 642,910	$ 201	$ 1,382	$ 641,729
Municipal securities	127,185	129	269	127,045
GSEs	122,317	34	82	122,269
U.S. treasury notes	59,546	30	33	59,543
Certificates of deposit	68,893	1	18	68,876
Subtotal - current investments	1,020,851	395	1,784	1,019,462
Auction rate securities	5,100	—	253	4,847
	$ 1,025,951	$ 395	$ 2,037	$ 1,024,309

The contractual maturities of our investments as of March 31, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 594,621	$ 594,574
Due one year through five years	601,243	601,953
Due after five years through ten years	7,331	7,339
Due after ten years	3,000	2,800
	$ 1,206,195	$ 1,206,666

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three months ended March 31, 2015 and 2014 were insignificant.

For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at March 31, 2015 and December 31, 2014, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2015:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 307,035	$ 455	189	$ 75,899	$ 187	33
Municipal securities	23,469	13	31	3,820	17	9
GSEs	67,378	90	16	—	—	—
Certificates of deposit	7,037	2	29	—	—	—
Asset-backed securities	7,456	5	6	—	—	—
Auction rate securities	—	—	—	2,800	200	4
	$ 412,375	$ 565	271	$ 82,519	$ 404	46

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2014:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 379,034	$ 1,151	265	$ 28,668	$ 231	10
Municipal securities	53,626	168	64	11,075	101	13
GSEs	75,025	69	22	2,986	13	3
U.S. treasury notes	19,199	33	13	—	—	—
Certificates of deposit	12,591	18	52	—	—	—
Auction rate securities	—	—	—	4,847	253	6
	$ 539,475	$ 1,439	416	$ 47,576	$ 598	32

Auction Rate Securities. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 16 years to 31 years. Considering the insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction rate securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at March 31, 2015. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $79.1 million of these instruments at par value.

For the three months ended March 31, 2015 and 2014, we recorded unrealized gains of $0.05 million and $0.03 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future impairment is other-than-temporary, we will record a charge to earnings as appropriate.

8. Receivables

Receivables consist primarily of amounts due from state Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is immaterial.

	March 31, 2015	December 31, 2014
	(In thousands)	
California	$ 83,772	$ 310,938
Florida	19,833	2,141
Illinois	85,640	31,594
Michigan	20,748	19,880
New Mexico	61,532	49,609
Ohio	59,167	45,187
South Carolina	13,386	4,134
Texas	40,642	29,348
Utah	10,176	6,389
Washington	45,474	42,848
Wisconsin	11,752	8,102
Direct delivery and other	10,642	11,295
Total Health Plans segment	462,764	561,465
Molina Medicaid Solutions segment	28,666	34,991
	$ 491,430	$ 596,456

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by government authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. In connection with a Molina Medicaid Solutions segment state contract, we maintain restricted investments as collateral for a letter of credit. The following table presents the balances of restricted investments:

	March 31, 2015	December 31, 2014
	(In thousands)	
California	$ 373	$ 373
Florida	28,661	28,649
Illinois	311	311
Michigan	1,014	1,014
New Mexico	39,639	35,135
Ohio	12,719	12,719
Puerto Rico	5,095	5,097
South Carolina	310	6,040
Texas	3,502	3,500
Utah	3,600	3,601
Washington	151	151
Other	990	888
Total Health Plans segment	96,365	97,478
Molina Medicaid Solutions segment	5,001	5,001
	$ 101,366	$ 102,479

The contractual maturities of our held-to-maturity restricted investments as of March 31, 2015 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 96,101	$ 96,103
Due one year through five years	5,265	5,271
	$ 101,366	$ 101,374

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	March 31, 2015	December 31, 2014
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 1,089,903	$ 870,429
Pharmacy payable	84,180	71,412
Capitation payable	47,171	28,150
Other	226,878	230,531
	$ 1,448,132	$ 1,200,522

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Such non-risk provider payables amounted to $105.4 million and $119.3 million as of March 31, 2015 and December 31, 2014, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31, 2015	Year Ended December 31, 2014
	(Dollars in thousands)	
Medical claims and benefits payable, beginning balance	$ 1,200,522	$ 669,787
Components of medical care costs related to:		
Current period	2,771,588	8,122,885
Prior periods (1)	(135,833)	(45,979)
Total medical care costs	2,635,755	8,076,906
Change in non-risk provider payables	(13,914)	(31,973)
Payments for medical care costs related to:		
Current period	1,647,981	7,064,427
Prior periods	726,250	449,771
Total paid	2,374,231	7,514,198
Medical claims and benefits payable, ending balance	$ 1,448,132	$ 1,200,522
Benefit from prior period as a percentage of:		
Balance at beginning of period	11.3%	6.9%
Premium revenue, trailing twelve months	1.4%	0.5%
Medical care costs, trailing twelve months	1.5%	0.6%

(1) The benefit from prior period development of medical claims and benefits payable for the three months ended March 31, 2015 included approximately $25 million relating to programs that contain medical cost floor or corridor provisions. Accordingly, premium revenue for the three months ended March 31, 2015 was reduced by the same amount.

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). Our IBNP, as included in medical claims and benefits payable, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2015 and 2014 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We believe that the most significant factors that will determine the accuracy of our IBNP estimates at March 31, 2015 are as follows:

- At our Florida health plan, Marketplace enrollment increased by 185,000 members in the first quarter of 2015. Because of these new members the reserves are more subject to change than usual.
- At our Illinois health plan, enrollment has increased by nearly 81,000 members during the fourth quarter of 2014 and the first quarter of 2015. Because of these new members the reserves are more subject to change than usual.
- At our Ohio health plan, enrollment in the MMP integrated duals program has increased by approximately 9,000 members during the first quarter of 2015. Because of these new members the reserves are more subject to change than usual.
- At our Washington health plan, certain delays related to the implementation of revised fee schedules resulted in a significant increase to our claims inventory in the first quarter of 2015. This additional inventory adds to the uncertainty of our unpaid claims estimates.

We recognized favorable prior period claims development in the amount of $135.8 million for the three months ended March 31, 2015. This amount represents our estimate as of March 31, 2015, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio health plan, approximately 17,000 members were enrolled in the new MMP program during 2014. Since we did not have enough historical claims data to use the pattern of paid and incurred claims, we initially estimated the reserves for these new members by applying an estimated medical care ratio (MCR). This resulted in an overstatement in our reserve liability as of December 31, 2014.

- Also at our Ohio health plan, reserves for the Medicaid expansion population were partially based on expected costs built into the pricing assumptions because this program was new in 2014. Our costs were ultimately less than those assumed in those pricing assumptions, resulting in an overestimation of our liability as of December 31, 2014.
- At our California health plan, the reserves for the Medicaid expansion membership were also partially based on expected claims in the pricing assumptions. Since experience was ultimately better than assumed in the pricing, this caused an overstatement of reserves as of December 31, 2014.

11. Debt

As of March 31, 2015, maturities of debt for the years ending December 31 are as follows (in thousands):

	Total	2015	2016	2017	2018	2019	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
1.625% Notes (1)	301,551	—	—	—	—	—	301,551
	$ 851,551	$ —	$ —	$ —	$ —	$ —	$ 851,551

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes (the 1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 at a rate of 1.125% per annum.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date.

Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events; or
- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The 1.125% Notes met the stock price trigger in the quarter ended March 31, 2015, and are convertible to cash through at least June 30, 2015. Because the 1.125% Notes may be converted within 12 months, the $440.2 million carrying amount is reported in current portion of long-term debt as of March 31, 2015.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Conversion Option transaction settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance

discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate of approximately 6%. As of March 31, 2015, the 1.125% Notes have a remaining amortization period of 4.8 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $237 million and $93 million as of March 31, 2015, and December 31, 2014, respectively.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $301.6 million aggregate principal amount of 1.625% convertible senior notes (the 1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Interest on the 1.625% Notes is payable semiannually in arrears on February 15 and August 15, at a rate of 1.625% per annum, beginning on February 15, 2015. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of March 31, 2015, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the notes in August 2018. As of March 31, 2015, the 1.625% Notes have a remaining amortization period of 3.4 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would

have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value exceeded their principal amount by approximately $29 million as of March 31, 2015, and did not exceed their principal amount as of December 31, 2014. At March 31, 2015, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $22.9 million.

The principal amounts, unamortized discount (net of premium related to 1.625% Notes), and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
March 31, 2015:			
1.125% Notes	$ 550,000	$ 109,752	$ 440,248
1.625% Notes	301,551	30,715	270,836
	$ 851,551	$ 140,467	$ 711,084
December 31, 2014:			
1.125% Notes	$ 550,000	$ 114,670	$ 435,330
1.625% Notes	301,551	32,784	268,767
	$ 851,551	$ 147,454	$ 704,097

	Three Months Ended March 31,	
	2015	2014
	(In thousands)	
Interest cost recognized for the period relating to the:		
Contractual interest coupon rate	$ 2,772	$ 3,300
Amortization of the discount	6,986	6,314
	$ 9,758	$ 9,614

Lease Financing Obligations. In 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the Molina Center located in Long Beach, California, and our Ohio health plan office building located in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Rent will increase 3% per year through the initial term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense amounted to $3.1 million for the three months ended March 31, 2015 and 2014.

As described and defined in further detail in Note 16, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings. We have concluded that we are the accounting owner of the buildings due to our continuing involvement with the properties. We have recorded $37.7 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of March 31, 2015, which represents the total cost incurred by the Landlord for the construction of the buildings, net of accumulated depreciation. As of March 31, 2015, the aggregate amount recorded to lease financing obligations, including the current portion, amounted to $40.5 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense was $1.0 million and $0.6 million for the three months ended March 31, 2015 and 2014, respectively. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was insignificant for the three months ended March 31, 2015, and 2014.

12. Derivatives

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	March 31, 2015	December 31, 2014
		(In thousands)	
Derivative asset:			
1.125% Call Option	Current assets: Derivative asset	$ 474,121	$ —
	Non-current assets: Derivative asset	$ —	$ 329,323
Derivative liability:			
1.125% Conversion Option	Current liabilities: Derivative liability	$ 473,983	$ —
	Non-current liabilities: Derivative liability	$ —	$ 329,194

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

As of March 31, 2015, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Notes may be converted within 12 months of March 31, 2015, as described in Note 11, "Debt."

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 6, "Fair Value Measurements."

1.125% Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Conversion Option, refer to Note 6, "Fair Value Measurements."

13. Stockholders' Equity

Stockholders' equity increased $31.6 million during the three months ended March 31, 2015 compared with stockholders' equity at December 31, 2014. The increase was due to net income of $28.2 million, $1.3 million related to other comprehensive income and $2.1 million related to employee stock transactions.

1.125% Warrants. In connection with the 1.125% Notes Call Spread Overlay transaction described in Note 12, "Derivatives," we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchase Programs. Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2015.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with our equity incentive plans, we issued approximately 273,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the three months ended March 31, 2015.

14. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our health plans and our direct delivery business. Our health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development, and implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." For presentation purposes, the cost of centralized services is reported within the Health Plans segment.

	Three Months Ended March 31,	
	2015	2014
	(In thousands)	
Revenue, continuing operations:		
Health Plans segment:		
Premium revenue	$ 2,970,652	$ 1,940,337
Premium tax revenue	95,347	51,693
Health insurer fee revenue	47,948	18,696
Investment income	3,015	1,629
Other revenue	2,303	3,258
Molina Medicaid Solutions segment:		
Service revenue	51,858	53,630
	$ 3,171,123	$ 2,069,243
Income from continuing operations before income tax expense:		
Health Plans segment	$ 68,440	$ 14,019
Molina Medicaid Solutions segment	13,790	10,248
Operating income, continuing operations	82,230	24,267
Other expenses, net	14,866	13,778
	$ 67,364	$ 10,489

15. Commitments and Contingencies

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem

the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that in late 2008 and early 2009, in connection with the acquisition of Florida NetPass under which Molina Healthcare of Florida, Inc. began conducting business in the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. Both the United States of America and the state of Florida have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. We believe that we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $928 million at March 31, 2015, and $859 million at December 31, 2014. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $210.6 million and $202.6 million as of March 31, 2015 and December 31, 2014, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state.

As of March 31, 2015, our health plans had aggregate statutory capital and surplus of approximately $987 million compared with the required minimum aggregate statutory capital and surplus of approximately $581 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2015. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Related Party Transactions

We have entered into a lease (the Amended Lease) with 6th & Pine Development, LLC (the Landlord) for two office buildings. The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, John C. Molina has pledged shares of common stock in the Company that he holds. Dr. J. Mario Molina, our chief executive officer, president and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

The Amended Lease provides for an annual rent escalator of 3.4% per year, and will expire on December 31, 2029, unless extended or earlier terminated. For information regarding the lease financing obligation, refer to Note 11, "Debt."

Refer to Note 17, "Variable Interest Entities," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

17. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's primary shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. Beginning in the fourth quarter of 2014, JMMPC also provided certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a variable interest entity (VIE), and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of March 31, 2015, JMMPC had total assets of $10.7 million, and total liabilities of $8.8 million. As of December 31, 2014, JMMPC had total assets of $31.1 million, and total liabilities of $30.8 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll, employee benefits and medical care costs associated with JMMPC's specialty referral activities. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- continuing uncertainties associated with the implementation of the Affordable Care Act, including the full grossed up reimbursement by states of the non-deductible ACA health insurer fee, the Medicaid expansion, the insurance marketplaces, the effect of various implementing regulations, the King v. Burwell case now pending before the Supreme Court, and uncertainties regarding the Medicare-Medicaid dual eligible demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and our ability to reduce over time the high medical costs commonly associated with new patient populations;
- federal or state medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, including 2014 and 2015 at-risk premium rules in the state of Texas;
- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;
- the success of our new health plan in Puerto Rico;
- newly FDA-approved specialty drugs such as Sovaldi, Olysio, Harvoni, and other specialty drugs or generic drugs that are exorbitantly priced but not factored into the calculation of our capitated rates;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- the accurate estimation of incurred but not paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates or retroactive premium rate increases;
  efforts by states to recoup previously paid amounts;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable or unfavorable resolution of litigation, arbitration, or administrative proceedings, including pending qui tam actions in Florida and California, and the litigation commenced against us by the state of Louisiana alleging that Molina Medicaid Solutions and its predecessors used an incorrect reimbursement formula for the payment of pharmaceutical claims;
- the relatively small number of states in which we operate health plans;
- our management of a portion of College Health Enterprises' hospital in Long Beach, California;

- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- public alarm associated with the Ebola virus, measles, or any actual widespread epidemic;
- changes in general economic conditions, including unemployment rates; and
- increasing competition and consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2014, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2014.

Company Overview

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states and the Commonwealth of Puerto Rico, and includes our direct delivery business. As of March 31, 2015, these health plans served nearly 3 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in several states in which we operate, as well as of the management of a hospital in southern California under a management services agreement.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise noted.

Overview of Financial Results, Continuing Operations

Financial results for the first quarter of 2015 improved markedly over the first quarter of 2014 due to higher revenue, greater administrative cost efficiency, and steady medical care costs. Both income from continuing operations before income tax expense and net income per diluted share, continuing operations, increased substantially in the first quarter of 2015 compared with the first quarter of 2014.

Premium revenue increased approximately 53% in the first quarter of 2015 compared with the first quarter of 2014, resulting from:

- An increase of over 38% in enrollment due to growth across all health plan programs.
- An increase of nearly 15% in premium revenue per member per month (PMPM) due to membership growth in programs serving the needs of members with more complex medical conditions for whom we receive higher monthly premiums.

Medical care costs as a percent of premium revenue (the "medical care ratio") were consistent with the first quarter of 2014 at 88.7% and improved over the fourth quarter of 2014 medical care ratio of 89.4%. Medical margin (defined as the excess of premium revenue over medical care costs) increased 53% in 2015 over 2014.

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") decreased significantly to 8.1% in the first quarter of 2015 compared with 9.1% in the first quarter of 2014. The decrease in the general and administrative expense ratio would have been even greater but for expenses associated with the start-up of our Puerto Rico health plan, broker commissions and Marketplace fees. Without these costs, the first quarter 2015 general and administrative expense ratio would have been approximately 7.4%.

Health Care Reform

We believe that government-sponsored initiatives, including the Affordable Care Act (ACA) will continue to provide us with significant opportunities for membership growth in our existing markets and in new programs in the future as follows:

- *Medicaid Expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington participate in Medicaid expansion. At March 31, 2015, our membership included approximately 437,000 Medicaid expansion members, or 15% of total membership.
- *Marketplace*. The ACA authorized the creation of Marketplace health insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois and South Carolina. At March 31, 2015, our membership included approximately 266,000 Marketplace members, with approximately 185,000, or 70%, of those members in Florida.

- *Medicare-Medicaid Plans*. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014; our MMPs in South Carolina and Texas offered coverage beginning in the first quarter of 2015; and we expect to begin offering MMP coverage in Michigan in the second quarter of 2015. At March 31, 2015, our membership included approximately 34,000 integrated MMP members.

Health Insurer Fee Update

Our results continue to be adversely affected by delays in reimbursement of the ACA's Health Insurer Fee (HIF) by some states. Due to progress made in securing agreements for the reimbursement of the HIF with various state Medicaid agencies in 2014, we recognized approximately 73% of the Medicaid-related reimbursement revenue associated with HIF expense in the first quarter of 2015, compared with only 51% in the first quarter of 2014.

Delay in recognition of the HIF expense reimbursement from California, Michigan and Utah reduced income before taxes by approximately $16 million, or $0.20 per diluted share in the first quarter of 2015.

The comparable amount of HIF reimbursement not recognized in the first quarter of 2014 was approximately $16 million, which reduced net income per diluted share, continuing operations, by approximately $0.21 per diluted share.

During the first quarter of 2015, we did not recognize any of the $20 million of outstanding HIF reimbursement related to 2014.

For further discussion of the risks and uncertainties relating to the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates - Health Plans Segment

Florida. In the first quarter of 2015, our Florida health plan enrolled 185,000 Marketplace members, more than doubling its total membership as of December 31, 2014.

Puerto Rico. On April 1, 2015, our Puerto Rico health plan became operational, enrolling approximately 350,000 members.

Market Updates - Molina Medicaid Solutions Segment

New Jersey. On April 9, 2015, the state of New Jersey announced its selection of Molina Medicaid Solutions to design and operate its new Medicaid management information system (MMIS). The new contract is effective May 1, 2015, and has a term of 10 years with three one-year renewal options. Molina Medicaid Solutions was the state's previous MMIS provider, and was awarded the new contract as a result of Molina Medicaid Solutions' submission in response to the state of New Jersey's request for proposals.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from our health plans' Medicaid contracts and, to a lesser degree, from Medicare contracts entered into with the Centers for Medicare and Medicaid Services (CMS), a federal government agency.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new RFP open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

Premium revenue is fixed in advance of the periods covered and is not generally subject to significant accounting estimates, except as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies." These premium revenues are recognized in the month that members are entitled to receive health care services. Premiums received in advance are deferred.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program, on a PMPM basis for the three months ended March 31, 2015. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	PMPM Premiums		
	Low	High	Consolidated
Temporary Assistance for Needy Families (TANF), CHIP (1)	$ 110.00	$ 300.00	$ 180.00
Medicaid Expansion	310.00	500.00	400.00
Aged, Blind or Disabled (ABD)	420.00	1,470.00	900.00
Marketplace	220.00	400.00	330.00
Medicare Special Needs Plans (Medicare)	820.00	1,070.00	1,010.00
Medicare-Medicaid Plan (MMP) – Integrated (2)	1,240.00	3,160.00	2,210.00

(1) CHIP stands for Children's Health Insurance Program.
(2) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	March 31, 2015	December 31, 2014	March 31, 2014
Ending Membership by Health Plan:			
California	574,000	531,000	418,000
Florida	352,000	164,000	91,000
Illinois	102,000	100,000	5,000
Michigan	256,000	242,000	218,000
New Mexico	222,000	212,000	183,000
Ohio	350,000	347,000	260,000
South Carolina	111,000	118,000	126,000
Texas	268,000	245,000	246,000
Utah	90,000	83,000	80,000
Washington	533,000	497,000	434,000
Wisconsin	107,000	84,000	90,000
	2,965,000	2,623,000	2,151,000
Ending Membership by Program:			
TANF/CHIP	1,825,000	1,809,000	1,659,000
Medicaid Expansion (1)	437,000	385,000	133,000
ABD	358,000	347,000	310,000
Marketplace (1)	266,000	15,000	8,000
Medicare	45,000	49,000	41,000
MMP–Integrated	34,000	18,000	—
	2,965,000	2,623,000	2,151,000

(1) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of an MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a

straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services (including long-term services and supports, or LTSS), general and administrative expenses, premium tax and health insurer fee expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Nearly all hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis.

- *Pharmacy expenses:* All drug, injectables, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses.

- *Capitation expenses:* Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.

- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.

- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements in Note 10, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the contract term, consistent with the revenue recognition period.

Financial Performance Summary, Continuing Operations

The following table briefly summarizes our financial and operating performance from continuing operations for the three months ended March 31, 2015 and 2014 (in thousands, except per-share data and percentages):

	Three Months Ended March 31,		% Change 2014 - 2015
	2015	2014	
Revenue:			
Premium revenue	$ 2,970,652	$ 1,940,337	53.1 %
Service revenue	51,858	53,630	(3.3)
Premium tax revenue	95,347	51,693	84.4
Health insurer fee revenue	47,948	18,696	156.5
Investment income	3,015	1,629	85.1
Other revenue	2,303	3,258	(29.3)
Total revenue	3,171,123	2,069,243	53.3
Operating expenses:			
Medical care costs	2,635,784	1,721,658	53.1
Cost of service revenue	35,902	40,657	(11.7)
General and administrative expenses	256,090	188,087	36.2
Premium tax expenses	95,347	51,693	84.4
Health insurer fee expenses	40,778	22,190	83.8
Depreciation and amortization	24,992	20,691	20.8
Total operating expenses	3,088,893	2,044,976	51.0
Operating income	82,230	24,267	238.9
Other expenses, net:			
Interest expense	14,876	13,822	7.6
Other income, net	(10)	(44)	(77.3)
Total other expenses, net	14,866	13,778	7.9
Income from continuing operations before income tax expense	67,364	10,489	542.2
Income tax expense	39,223	5,655	593.6
Income from continuing operations	$ 28,141	$ 4,834	482.1 %
Diluted net income per share, continuing operations	$ 0.56	$ 0.10	460.0 %
Diluted weighted average shares outstanding	50,071	47,520	5.4 %
Non-GAAP Measures:			
Adjusted net income per share, continuing operations	$ 0.71	$ 0.27	163.0 %
EBITDA	$ 111,379	$ 49,471	125.1 %
Operating Statistics, Continuing Operations:			
Medical care ratio (1)	88.7%	88.7%	
Service revenue ratio (2)	69.2%	75.8%	
General and administrative expense ratio (3)	8.1%	9.1%	
Premium tax ratio (1)	3.1%	2.6%	
Effective tax rate	58.2%	53.9%	
Net income, continuing operations (3)	0.9%	0.2%	

(1) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(2) Service revenue ratio represents cost of service revenue as a percentage of service revenue.
(3) Computed as a percentage of total revenue.

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. generally accepted accounting principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended March 31,	
	2015	2014
	(In thousands)	
Net income	$ 28,153	$ 4,498
Adjustments:		
Depreciation, and amortization of intangible assets and capitalized software	29,110	25,914
Interest expense	14,876	13,822
Income tax expense	39,240	5,237
EBITDA	$ 111,379	$ 49,471

The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. Effective for the first quarter of 2015, we have revised the calculation of adjusted net income, continuing operations. We no longer subtract "depreciation, and amortization of capitalized software" and "share-based compensation" from net income, continuing operations to arrive at adjusted net income, continuing operations. We have made this change to better reflect the way in which we evaluate our financial performance, make financing and business decisions, and forecast and plan for future periods. All periods presented below conform to this presentation.

The following tables reconcile net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations.

	Three Months Ended March 31,			
	2015		2014	
	(In thousands, except diluted per-share amounts)			
Net income, continuing operations	$ 28,141	$ 0.56	$ 4,834	$ 0.10
Adjustments, net of tax:				
Amortization of convertible senior notes and lease financing obligations	4,593	0.09	4,205	0.10
Amortization of intangible assets	2,877	0.06	3,329	0.07
Adjusted net income per diluted share, continuing operations	$ 35,611	$ 0.71	$ 12,368	$ 0.27

Results of Operations, Continuing Operations

Three Months Ended March 31, 2015 Compared with Three Months Ended March 31, 2014

Health Plans Segment

Premium Revenue

Premium revenue increased approximately 53% in the first quarter of 2015 compared with the first quarter of 2014, resulting from:

- An increase of over 38% in enrollment due to growth across all health plan programs.
- An increase of nearly 15% in premium revenue PMPM due to membership growth in programs serving the needs of members with more complex medical conditions for whom we receive higher monthly premiums.

Medical Care Costs

In the first quarter of 2015, medical care costs as a percent of premium revenue were consistent with the first quarter of 2014 at 88.7%. Medical margin increased 53% in first quarter of 2015 over the first quarter of 2014.

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended March 31,					
	2015			2014		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 1,948,305	$ 226.04	73.9%	$ 1,181,061	$ 183.21	68.6%
Pharmacy	351,198	40.75	13.3	286,628	44.46	16.7
Capitation	216,325	25.10	8.2	169,439	26.28	9.8
Direct delivery	26,771	3.11	1.0	22,021	3.42	1.3
Other	93,185	10.80	3.6	62,509	9.71	3.6
Total	$ 2,635,784	$ 305.80	100.0%	$ 1,721,658	$ 267.08	100.0%

The following table provides detailed fee-for-service medical claims data for the periods presented (dollars in thousands, except per-member amounts):

	Three Months Ended March 31,	
	2015	2014
Days in claims payable, fee for service	51	46
Number of claims in inventory at end of period	319,300	287,300
Billed charges of claims in inventory at end of period	$ 848,200	$ 517,300
Claims in inventory per member at end of period	0.11	0.13
Billed charges of claims in inventory per member at end of period	$ 286.07	$ 240.49
Number of claims received during the period	8,635,500	5,986,000
Billed charges of claims received during the period	$ 9,891,800	$ 6,354,000

Individual Health Plan Analysis

California. Premium revenue grew approximately 84% in the first quarter of 2015 when compared with the first quarter of 2014, the result of higher Medicaid expansion membership (up 69,000 members) and TANF and ABD membership (up 58,000 members); as well as the start-up of an MMP plan in the second quarter of 2014 (18,000 members at March 31, 2015). Overall, enrollment on a member-month basis increased 46% in the first quarter of 2015 compared with the first quarter of 2014. Increased premium revenue was also driven by a 38% increase in premium revenue PMPM, which was the result of the higher relative premium revenue PMPM among those programs experiencing enrollment growth (Medicaid expansion and MMP); and the addition of long-term care benefits to some of the health plan's ABD membership. Medical margin improved $17.8 million at the California health plan when compared with the first quarter of 2014, primarily due to higher enrollment. The medical care ratio for the California health plan increased to 88.6% in the first quarter of 2015, from 85.5% in the first quarter of 2014 as higher medical care ratios for the TANF and ABD programs more than offset a lower medical care ratio for the Medicaid expansion program.

Florida. The Florida health plan added approximately 185,000 Marketplace members in the first quarter of 2015. As a result, premium revenue nearly tripled, and medical margin improved $17.9 million in the first quarter of 2015 when compared with the first quarter of 2014. The medical care ratio increased to 90.5% from 88.9% in the first quarter of 2014, as higher medical care ratios related to Medicaid programs offset the lower medical care ratio of the Marketplace membership.

Illinois. Premium revenue grew to approximately $104 million in the first quarter of 2015, from $15 million in the first quarter of 2014. The plan experienced significant growth in 2014, primarily within the traditional TANF program, and to a lesser degree within the Medicaid expansion program. Additionally, the plan served its first MMP members in the first half of 2014. The medical care ratio for the Illinois health plan decreased to 85.9% in the first quarter of 2015, from 95.5% in the first quarter of 2014. The plan's higher medical care ratio in early 2014 was primarily the result of a small membership base transitioning to managed care, and increased medically related administrative costs incurred in preparation of anticipated enrollment growth in late 2014.

Michigan. Premium revenue grew approximately $46 million, or 27%, in the first quarter of 2015 when compared with the first quarter of 2014 due to the addition of Medicaid expansion members starting in the second quarter of 2014. Medicaid expansion enrollment reached 51,000 members by March 31, 2015. Higher medical care ratios for both the TANF and ABD programs offset a lower medical care ratio for the Medicaid expansion program; resulting in an increase of the health plan’s consolidated medical care ratio to 84.2% in the first quarter of 2015, from 78.0% for the first quarter of 2014.

New Mexico. Premium revenue grew approximately $89 million, or 39%, in the first quarter of 2015 when compared with the first quarter of 2014, due to substantial increases in membership in all Medicaid programs. The medical care ratio increased to 93.0% in the first quarter of 2015, from 87.3% in the first quarter of 2014, as increases in the medical care ratios of the TANF and ABD programs offset lower medical care ratios for the Medicaid expansion and long-term care ABD programs. The medical care ratio in the first quarter of 2015 of 93.0% was significantly lower than the medical care ratio of 98.4% recorded in the fourth quarter of 2014.

Ohio. Premium revenue grew approximately $237 million, or 85%, in the first quarter of 2015 when compared with the first quarter of 2014, due to growth in membership within the Medicaid expansion, MMP, and ABD programs. The medical care ratio of the Ohio health plan decreased to 80.2% in the first quarter of 2015, from 85.3% in the first quarter of 2014, due to decreased medical care ratios across all programs.

South Carolina. The medical care ratio for the South Carolina health plan decreased to 81.3% in the first quarter of 2015, from 94.0% in the first quarter of 2014. In the first quarter of 2014, the plan enrolled its first members who were transitioned from Medicaid fee-for-service to managed care.

Texas. Premium revenue grew approximately $62 million, or 19%, in the first quarter of 2015 when compared with the first quarter of 2014, primarily due to the addition of ABD members receiving nursing facility benefits effective March 1, 2015. The medical care ratio for the Texas health plan increased slightly to 92.1% in the first quarter of 2015, from 91.5% in the first quarter of 2014.

We did not recognize approximately $7 million before income taxes, or $0.09 per diluted share, of the approximately $9 million of quality revenue available to the Texas health plan in the first quarter of 2015. This compares with approximately $6 million before income taxes, or $0.08 per diluted share, of the approximately $9 million of quality revenue available to the Texas health plan in the first quarter of 2014. Absent quality revenue and profit-sharing adjustments, the medical care ratio at the Texas health plan would have been approximately 89% for the first quarter of 2015 and 88% for the first quarter of 2014.

We recognized no Texas quality revenue related to 2014 in the first quarter of 2015. We previously disclosed that approximately $20 million of Texas quality revenue for 2014 has not been recognized because we lack sufficient information to calculate how much we are owed. We may be able to recognize additional revenue from 2014 Texas quality incentives in the future.

Utah. Financial performance at the Utah health plan declined in the first quarter of 2015, when compared with the first quarter of 2014, due to deteriorating margins for both Medicaid and Medicare products. The medical care ratio of the Utah health plan increased to 96.1% in the first quarter of 2015, from 85.4% in the first quarter of 2014.

Washington. Premium revenue grew approximately $53 million, or 16%, in the first quarter of 2015 when compared with the first quarter of 2014, primarily due to growth in Medicaid expansion membership. The medical care ratio of the Washington health plan increased to 93.6% in the first quarter of 2015, from 92.2% in the first quarter of 2014, as a higher medical care ratio for members served under the TANF program more than offset a lower medical care ratio in the ABD program.

Wisconsin. Premium revenue grew approximately $22 million, or 57%, in the first quarter of 2015 when compared with the first quarter of 2014 as a result of increased Marketplace enrollment. The medical care ratio of the Wisconsin health plan increased to 80.7% in the first quarter of 2015, from 74.8% in the first quarter of 2014. We have previously expressed our belief that medical care ratios below 80% are not sustainable.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan and program for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended March 31, 2015						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,673	$ 510,544	$ 305.10	$ 452,435	$ 270.37	88.6%	$ 58,109
Florida	897	310,971	346.46	281,389	313.51	90.5	29,582
Illinois	305	104,145	341.86	89,437	293.58	85.9	14,708
Michigan	756	219,525	290.29	184,763	244.32	84.2	34,762
New Mexico	684	313,656	458.75	291,826	426.82	93.0	21,830
Ohio	1,055	515,087	488.26	413,074	391.56	80.2	102,013
South Carolina	343	91,326	266.42	74,269	216.67	81.3	17,057
Texas	775	381,785	492.38	351,478	453.30	92.1	30,307
Utah	266	77,142	290.27	74,144	278.99	96.1	2,998
Washington	1,563	376,350	240.83	352,374	225.49	93.6	23,976
Wisconsin	302	60,342	199.61	48,709	161.13	80.7	11,633
Other [3]	—	9,779	—	21,886	—	—	(12,107)
	8,619	$ 2,970,652	$ 344.65	$ 2,635,784	$ 305.80	88.7%	$ 334,868

	Three Months Ended March 31, 2014						
	Member Months[1]	Premium Revenue		Medical Care Costs		MCR[2]	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,254	$ 277,642	$ 221.42	$ 237,344	$ 189.28	85.5%	$ 40,298
Florida	270	105,166	389.67	93,461	346.30	88.9	11,705
Illinois	14	15,171	1,078.41	14,494	1,030.28	95.5	677
Michigan	648	173,496	267.58	135,320	208.70	78.0	38,176
New Mexico	549	225,068	410.00	196,409	357.79	87.3	28,659
Ohio	772	278,295	360.62	237,328	307.53	85.3	40,967
South Carolina	394	96,020	243.41	90,262	228.82	94.0	5,758
Texas	749	320,096	427.27	292,958	391.05	91.5	27,138
Utah	246	78,654	319.96	67,200	273.37	85.4	11,454
Washington	1,276	323,461	253.48	298,107	233.61	92.2	25,354
Wisconsin	274	38,528	140.67	28,809	105.19	74.8	9,719
Other [3]	—	8,740	—	29,966	—	—	(21,226)
	6,446	$ 1,940,337	$ 301.00	$ 1,721,658	$ 267.08	88.7%	$ 218,679

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

	Three Months Ended March 31, 2015[1]					
	Member Months[2]	Premium Revenue		Medical Care Costs		
		Total	PMPM	Total	PMPM	MCR[3]	Medical Margin
TANF and CHIP	5,479	$ 972,039	$ 177.40	$ 896,826	$ 163.67	92.3%	$ 75,213
Medicaid Expansion	1,274	506,896	397.99	393,031	308.59	77.5	113,865
ABD	1,051	940,268	894.70	862,520	820.72	91.7	77,748
Marketplace	582	193,511	332.52	156,314	268.60	80.8	37,197
Medicare	131	133,335	1,013.66	128,497	977.09	96.4	4,838
MMP	102	224,603	2,206.17	198,596	1,950.71	88.4	26,007
	8,619	$ 2,970,652	$ 344.65	$ 2,635,784	$ 305.80	88.7%	$ 334,868

(1) Three months ended March 31, 2014 data not presented due to lack of comparability.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended March 31,	
	2015	2014
	(In thousands)	
Service revenue before amortization	$ 52,536	$ 54,359
Amortization recorded as reduction of service revenue	(678)	(729)
Service revenue	51,858	53,630
Cost of service revenue	35,902	40,657
General and administrative costs	1,996	1,750
Amortization of customer relationship intangibles	170	975
Operating income	$ 13,790	$ 10,248

Operating income for our Molina Medicaid Solutions segment increased $3.5 million in the first quarter of 2015, compared with the first quarter of 2014, primarily the result of a renegotiated state contract, various operational efficiencies, and decreased intangible amortization.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses as a percentage of total revenue decreased significantly to 8.1% in the first quarter of 2015 compared with 9.1% in the first quarter of 2014. The decrease in the general and administrative expense ratio would have been even greater but for expenses associated with our Puerto Rico start-up health plan, and the expansion of our Marketplace enrollment. Absent the costs of the Puerto Rico start-up and Marketplace broker commissions and exchange fees, the first quarter 2015 general and administrative expense ratio would have been approximately 7.4%.

Premium Tax Expense

Premium tax expense was 3.1% in the first quarter of 2015, compared with 2.6% in the first quarter of 2014. In June 2014, the state of Michigan instituted a 6% use tax on medical premiums. That state has agreed to fund this tax through rate increases; as a result, we recorded approximately $12 million in additional revenue in the first quarter of 2015, as well as a corresponding premium tax expense.

Health Insurer Fee Revenue and Expenses

Health insurer fee revenue, as a percentage of premium revenue, was 1.6% in the first quarter of 2015 and 1.0% in the first quarter of 2014. Health insurer fee expenses, as a percentage of premium revenue, were 1.4% in the first quarter of 2015 and 1.1% in the first quarter of 2014. Both HIF revenue and expenses increased over the prior year proportionally to the increase in

the total HIF tax base, which is assessed to all insurers. This base increased to $11.3 billion in 2015, from $8.0 billion in 2014. Refer to "Liquidity and Capital Resources—Financial Condition" below, for further discussion of the HIF.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Three Months Ended March 31,			
	2015		2014	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 21,103	0.7%	$ 16,136	0.8%
Amortization of intangible assets, continuing operations	3,889	0.1	4,555	0.2
Depreciation and amortization, continuing operations	24,992	0.8	20,691	1.0
Amortization recorded as reduction of service revenue	678	—	729	—
Amortization of capitalized software recorded as cost of service revenue	6,904	0.2	11,574	0.6
Depreciation and amortization reported in the statement of cash flows	$ 32,574	1.0%	$ 32,994	1.6%

Interest Expense

Interest expense increased to $14.9 million for the first quarter of 2015, from $13.8 million for the first quarter of 2014. The increase was due primarily to the issuance of the 1.625% Notes in third quarter of 2014. For further details regarding convertible senior notes transactions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 11, "Debt."

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $7.3 million and $6.7 million for the first quarter of 2015, and 2014, respectively.

Income Taxes

The provision for income taxes in continuing operations was recorded at an effective rate of 58.2% for the first quarter of 2015, compared with 53.9% for the first quarter of 2014. The first quarter 2015 rate is higher primarily due to the increase in the nondeductible HIF.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of March 31, 2015, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our

restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income was $3.0 million for the three months ended March 31, 2015, compared with $1.6 million for the three months ended March 31, 2014. Our annualized portfolio yield for the three months ended March 31, 2015 and 2014 was 0.4%.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Three Months Ended March 31,		
	2015	2014	Change
	(In thousands)		
Net cash provided by operating activities	$ 553,633	$ 210,897	$ 342,736
Net cash used in investing activities	(227,790)	(27,491)	(200,299)
Net cash provided by (used in) financing activities	5,118	(35,932)	41,050
Net increase in cash and cash equivalents	$ 330,961	$ 147,474	$ 183,487

Operating Activities. Cash provided by operating activities increased $342.7 million year over year, primarily due to the changes in receivables, accounts payable and accrued liabilities, and medical claims and benefits payable, partially offset by the change in deferred revenue.

The decrease in accounts receivable provided $144.3 million, primarily due to collections of premiums receivable at our California health plan in the first quarter of 2015. The increase in accounts payable and accrued liabilities provided $130.4 million, primarily due to the accrual of the 2015 HIF in the first quarter of 2015. The increase in medical claims and benefits payable provided $97.9 million in connection with our membership growth in the first quarter of 2015, as described above. These items were partially offset by the $50.3 million decline relating to the change in deferred revenue in the first quarter of 2015.

Investing Activities. Cash used in investing activities in the first quarter of 2015 increased to $227.8 million, from $27.5 million in the same period of 2014 primarily due to increased purchases of investments.

Financing Activities. Cash provided by financing activities in the first quarter of 2015 amounted to $5.1 million. Cash used in financing activities in the first quarter of 2014 related primarily to the settlement of $38.1 million of contingent consideration liabilities for our 2013 South Carolina health plan acquisition, with no comparable activity in the first quarter of 2015.

Financial Condition

On a consolidated basis, at March 31, 2015, working capital amounted to $682.4 million, compared with $1,070.6 million at December 31, 2014.

As described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 11, "Debt," our 1.125% Notes met the stock price trigger in the quarter ended March 31, 2015, and are convertible to cash through at least June 30, 2015. Because the 1.125% Notes may be converted within 12 months, the $440.2 million carrying amount is reported in current portion of long-term debt as of March 31, 2015, which resulted in decreased working capital as of March 31, 2015. We believe that the amount of the 1.125% Notes that may be converted over the next twelve months, if any, will be insignificant.

At March 31, 2015, and December 31, 2014, we had cash and investments, including restricted investments, of $3,178.1 million, and $2,665.9 million, respectively. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Health Insurer Fee. We expect the 2015 HIF assessment related to our Medicaid business to be approximately $148 million, with an expected tax effect from the reimbursement of the assessment of approximately $91 million. Therefore, the total reimbursement necessary as a result of the Medicaid-related 2015 HIF assessment is approximately $239 million. We have

secured agreements from all of our state partners except California, Michigan and Utah for the reimbursement of the 2015 HIF. Of this total 2015 HIF assessment, $65 million relates to our California, Michigan and Utah health plans.

Delay in recognition of the HIF expense reimbursement from California, Michigan and Utah reduced income before taxes by approximately $16 million in the first quarter of 2015. We recognized no HIF reimbursement related to 2014 ($20 million in the aggregate) in the first quarter of 2015. However, in April 2015 we received reimbursement of the 2014 HIF, including the related tax effects, from the state of California.

We continue to work with the states of California, Michigan and Utah to secure agreement for the reimbursement for the full economic impact of the HIF. The failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows and results of operations.

The following table provides the details of our HIF revenue reimbursement by health plan as of March 31, 2015 (in thousands):

	HIF Reimbursement Revenue, Gross[1]		
	Three Months Ended March 31, 2015		Year Ended Dec. 31, 2015
	Recognized	Necessary for Full Reimbursement	Necessary for Full Reimbursement
2015 HIF:			
California	$ —	$ 7,724	$ 30,898
Florida	2,027	2,027	8,108
Illinois	965	965	3,861
Michigan	—	6,998	27,993
New Mexico	7,539	7,539	30,157
Ohio	11,936	11,936	47,743
South Carolina	3,053	3,053	12,214
Texas	5,839	5,839	23,357
Utah	—	1,453	5,813
Washington	10,951	10,951	43,802
Wisconsin	1,126	1,126	4,505
Subtotal, Medicaid	43,436	59,611	238,451
Marketplace	398	398	1,586
Medicare	5,702	5,702	22,801
	$ 49,536	$ 65,711	$ 262,838
Recognized in:			
Health insurer fee revenue	$ 47,948		
Premium tax revenue	1,588		
	$ 49,536		

(1) Amounts in the table include the Company's estimate of the full economic impact of the HIF including premium tax and the income tax effect.

Regulatory Capital and Dividend Restrictions

For information on our regulatory capital requirements and dividend restrictions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, Note 15, "Commitments and Contingencies."

Future Sources and Uses of Liquidity

For information on our debt instruments, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt."

For information on our shelf registration statement and our securities repurchase program, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 13, "Stockholders' Equity."

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2014, was disclosed in our 2014 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the three months ended March 31, 2015. For further discussion and maturities of our long-term debt, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements.
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the first quarter of 2015 in connection with such contractual provisions.
- *Health Plans segment quality incentives*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the first quarter of 2015 in connection with such quality incentives.
- *Molina Medicaid Solutions segment revenue and cost recognition*.

There have been no significant changes during the three months ended March 31, 2015, to the items that we disclosed as our critical accounting estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2014.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our chief executive officer and our chief financial officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended March 31, 2015 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

A description of our legal proceedings is included in and incorporated by reference to Note 15 of the Notes to the Consolidated Financial Statements contained in Part I, Item 1 of this report.

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2014. The risk factors described herein and in our 2014 Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

There have been no material changes to the risk factors disclosed in our 2014 Annual Report on Form 10-K.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended March 31, 2015 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
January 1 - January 31	3,541	$ 53.53	—	$ —
February 1 - February 28	1,721	$ 50.91	—	$ 50,000,000
March 1 - March 31	133,392	$ 63.69	—	$ 50,000,000
Total	138,654	$ 63.27	—	

(a) During the three months ended March 31, 2015, we withheld 138,654 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2015.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 7, 2015

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: May 7, 2015

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 7, 2015

/s/ Joseph M. Molina

Joseph M. Molina
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2015 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 7, 2015

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2015 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 7, 2015

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2015 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 7, 2015

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

2014 MHI Form 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2014

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2014, the last business day of our most recently completed second fiscal quarter, was approximately $1,338.4 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2014).

As of February 20, 2015, approximately 49,873,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2015 Annual Meeting of Stockholders to be held on May 6, 2015, are incorporated by reference into Part III of this Form 10-K.

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Molina Healthcare, Inc.
Form 10-K
For the Year Ended December 31, 2014
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This Annual Report on Form 10-K ("Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the headings "Business," and "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly from the results discussed in the forward-looking statements. Factors that might cause such differences include, but are not limited to, those discussed in Part I, Item 1A of this Form 10-K under the heading "Risk Factors." Each of the terms "Company," "Molina Healthcare," "we," "our," and "us," as used herein refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

PART I

Item 1: Business

OVERVIEW

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program.

As of December 31, 2014, our health plans served over 2.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today, we remain a provider-focused company led by his son, Dr. J. Mario Molina.

Significant Accomplishments in 2014

Our mission is to provide quality health care to those receiving government assistance. Our goal is to achieve this mission while improving our financial strength. Our significant operational, financial and strategic accomplishments supporting this goal during 2014 included:

- *Expanding existing markets.* Our Health Plans segment enrollment has grown approximately 36% since December 31, 2013, primarily a result of:
    - Our 2014 growth initiatives associated with the Affordable Care Act (ACA). Since the inception of these programs in January 2014 through the end of fiscal 2014, we have added approximately 385,000 Medicaid expansion members, 18,000 integrated Medicare-Medicaid Plan (MMP) members, and 15,000 Marketplace members;
    - The inception and growth of operations at our newer health plans in South Carolina and Illinois, adding over 200,000 members in the aggregate in fiscal 2014; and
    - Acquisition of two Medicaid contracts in Florida, which added approximately 73,000 new members in fiscal 2014.
- *Entering new strategic markets.* In 2014, we were awarded a managed care contract in the Commonwealth of Puerto Rico that is expected to enroll its first members April 1, 2015. Total enrollment is expected to be approximately 350,000 new members, with anticipated annualized revenue of $750 million.
- *Funding future growth.* Debt financing transactions generated net cash of approximately $123 million; such transactions both extended the maturity date and lowered the rate of our convertible senior notes previously due in 2014.

Our Structure

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. We derive our revenues primarily from health insurance premiums and service revenues. Refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," and Note 21, "Segment Information," for revenue information by state health plan, and segment revenue, profit and total asset information, respectively.

The Health Plans segment consists of operational health plans in 11 states and our direct delivery business. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate health plans. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements that limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation (DDI), and business process outsourcing (BPO) solutions to state governments for their Medicaid management information systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia; the U.S. Virgin Islands; and a contract to provide pharmacy rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in 2010 to expand our product offerings to include support of state Medicaid agency administrative needs, reduce the variability in our earnings resulting from fluctuations in medical care costs, improve our operating profit margin percentages, and improve our cash flow by adding a business for which there are no restrictions on dividend payments.

Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly. Additionally, our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

Health Care Reform

The ACA has made broad-based changes to the U.S. health care system that have significantly affected the U.S. economy and our business. We expect the ACA to continue to significantly impact our business operations and financial results, including our medical care ratios.

Key components of the legislation will continue to be phased in over the next several years, with the most significant changes having occurred at the start of 2014, including the implementation of the Medicaid expansion (in electing states) and Marketplace programs, Medicare and Marketplace minimum medical loss ratios (MLRs), and new industry-wide fees, assessments, and taxes. We have dedicated material resources and have incurred material expenses in implementing and complying with the ACA, and we will continue to do so. As a result of the novelty and extremely broad scale of all of the programmatic changes effected by the ACA, many of the business and market impacts of the ACA will not be known for several years. Further, given the inherent difficulty of foreseeing how individuals will respond to the choices afforded to them by the ACA, we cannot predict the full effect the ACA will have on us.

Our Strategic Growth Initiatives

Our mission is to provide quality health care to those receiving government assistance. This mission drives our strategic growth and growth-related initiatives as follows:

Enter New Programs Within Existing Markets

- *Medicaid Expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. At December 31, 2014, our membership included approximately 385,000 Medicaid expansion members, or 15% of total membership.
- *Health Insurance Marketplace*. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois and South Carolina. At December 31, 2014, we had approximately 15,000 Marketplace members.
- *Medicare-Medicaid Plans*. Policymakers at the federal and state levels are increasingly focused on the design and implementation of programs that improve the coordination of care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner. As a result of these efforts, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014, and we expect to begin offering MMP coverage in South Carolina and Texas in the first quarter of 2015, and in Michigan in the second quarter of 2015.

- *Direct Delivery*. Growth and aging of the U.S. population foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to worsen this shortage. We believe the shortage will be felt most acutely among already under-served populations, such as the financially vulnerable families and individuals we serve. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging our direct delivery capability on a selective basis we can improve access for our plan members in areas that are most under-served by primary care providers. We operate primary care clinics in the states of California, Florida, New Mexico, Utah, Virginia and Washington. In addition, we perform certain medical and administrative management services for a hospital in Long Beach, California, including the assumption of financial benefit and risk for a number of acute care beds at the hospital. We believe that this arrangement improves hospital access for our members in the Long Beach, California area, and enhances our overall direct delivery strategy. We may incur losses while we seek to modify various business operations and patient behaviors under the management services agreement.

Enter New Strategic Markets

We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size, and, where practicable, mandated Medicaid managed care enrollment. As described above, in December 2014 we entered into a Medicaid contract with the Puerto Rico Health Insurance Administration. The operational start date for the program is expected to be April 1, 2015.

Deliver Administrative Value to Medicaid Agencies

As Medicaid expenditures increase, we believe that an increasing number of states' and other Medicaid agencies will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state and other Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs.

Leverage Operational Efficiencies

We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost. For example, our general and administrative expenses as a percentage of revenue (the general and administrative expense ratio) declined to 7.9% for the year ended December 31, 2014, compared with 10.1% for the year ended December 31, 2013.

OUR INDUSTRY

Medicaid

Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states is currently about 57%, and ranges from a federally established FMAP floor of 50% to as high as 74%.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program (TANF), which covers primarily low-income mothers and children. In states that have elected to participate, Medicaid expansion provides eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Another common state-administered Medicaid program is for aged, blind or disabled (ABD) Medicaid beneficiaries, which covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients, and typically use more services because of their critical health issues. Additionally, the Children's Health Insurance Program (CHIP) is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs. As of December 31, 2014, approximately 70% of our members were TANF beneficiaries, 15% were Medicaid expansion beneficiaries, 12% were ABD beneficiaries, 2% were Medicare beneficiaries, and 1% were integrated MMP and Marketplace beneficiaries combined. For the year ended December 31, 2014, approximately 54% of our premium revenue was from TANF and Medicaid expansion membership combined; 36% was from ABD membership, 7% was from Medicare membership, 2% was from MMP integrated membership, and 1% was from Marketplace membership.

Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. To improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services (CMS). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (PMPM) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

Medicaid Management Information Systems

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a

managed care delivery model. MMIS are used by states to support these administrative activities. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we actively participate in this market.

Competition

The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of health care reform, business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, quality of provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., and Aetna Inc. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- Multi-Product Managed Care Organizations - National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- Medicaid HMOs - National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- Prepaid Health Plans - Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- Primary Care Case Management Programs - Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, and CNSI.

BUSINESS OPERATIONS

Our Strengths

From a strategic perspective, we believe our two business segments allow us to participate in an expanding sector of the economy and continue our mission to provide quality health services to financially vulnerable families and individuals covered by government programs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, cost management, and direct delivery of health care services, to state-level MMIS administration through our Molina Medicaid Solutions segment. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others. We also believe that we may have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. We believe that our Molina Medicaid Solutions platform, which is based on commercial off-the-shelf technology, has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our Health Plans segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The initial acquisitions of our New Mexico, South Carolina and Wisconsin health plans have demonstrated our ability to expand into new states. The establishment of our health plans in Florida, Illinois, Ohio, Texas and Utah reflects our ability to replicate our business model on a start-up basis in new states, while significant contract acquisitions in California, Michigan, New Mexico and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform and standardization of medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Recognition for Quality of Care. The National Committee for Quality Assurance (NCQA) has accredited nine of our 11 Medicaid managed care plans. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our company in 1980 to serve the Medicaid population in southern California through a small network of primary care clinics, we have increased our membership to 2.6 million members as of December 31, 2014, expanded our Health Plans segment to 11 states, and added our Molina Medicaid Solutions segment. Our experience over more than 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Pricing

Medicaid. Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members' health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Medicare. Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment.

Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to

federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

Marketplace. For our Marketplace plans, we develop premium rates during early spring of any given year to take effect on January 1st of the following year. We develop our premium rates based on our estimates of projected member utilization, medical unit costs, and administrative costs, with the intent of realizing a target pretax percentage profit margin. In setting premium rates for our Marketplace plans, we also take into account the competitive environment on a region–by–region basis. Our actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proved to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use predictive modeling that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs such as the following:

- *Disease Management Programs.* We develop specialized disease management programs that address the particular health care needs of our members. "*motherhood matters!*℠" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. "*breathe with ease!"* is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15. "*Healthy Living with Diabetes"* is a diabetes disease management program. "*Heart Healthy Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.
- *Educational Programs.* Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate members on the use of primary care physicians, emergency rooms, and nurse call centers.
- *Pharmacy Management Programs.* Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members, to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations (IPAs). Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups (DRGs) capitation, and case rates.

Direct Delivery. The clinics we operate are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics we operate, and the clinics and hospital services we manage, assist us in developing and implementing community education, disease management, and other programs. Direct clinic management experience also enables us to better understand the needs of our contracted providers.

Reinsurance

Our health plans currently have reinsurance agreements with an unaffiliated insurer to cover certain claims. We enter into these contracts to reduce the risk of catastrophic losses which in turn reduce our capital and surplus requirements. We frequently evaluate reinsurance opportunities and review our reinsurance and risk management strategies on a regular basis.

Management Information Systems

All of our health plan information technology systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- Provider Self Services - Providers have the ability to access information regarding their members and claims. Key functionalities include "Check Member Eligibility," "View Claim," and "View/Submit Authorizations."
- Member Self Services - Members can access information regarding their personal data, and can perform the following key functionalities: "View Benefits," "Request New ID Card," "Print Temporary ID Card," and "Request Change of Address/PCP."
- File Exchange Services - Various trading partners, such as service partners, providers, vendors, management companies, and individual IPAs, are able to exchange data files (such as those that may be required by federal health care privacy regulations, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness Data and Information Set (HEDIS), and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT system).

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan's ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS). Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

CONTRACTING AND REGULATORY COMPLIANCE

Government Contracts

Medicaid. In all the states in which we operate health plans, we enter into a contract with the state's Medicaid agency to offer managed care benefits to Medicaid-eligible individuals. Some states award contracts to any applicant demonstrating that it meets the state's requirements, while other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population; for example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. We are regulated by the state agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. For example, we must demonstrate that:

- Our provider network is adequate;
- Our quality and utilization management processes comply with state requirements;
- We have adequate procedures in place for responding to member and provider complaints and grievances;
- We can meet requirements for the timely processing of provider claims;
- We can collect and analyze the information needed to manage our quality improvement activities;
- We have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs;
- We have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion; and
- We have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Our state contracts determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and dis-enrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan.

The contractual relationship with the state is generally for a period of three to four years and is renewable on an annual or biennial basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months' prior written notice.

Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals (RFP), subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, in early 2012 our Missouri health plan was notified that it was not awarded a new contract under that state's RFP, and therefore its contract expired in that year.

Medicare. Under annually renewable contracts with CMS, our state health plans offer Medicare Advantage special needs plans which include a mandatory Part D prescription drug benefit. Molina Medicare Options Plus, our trade name for these plans, serves beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically under-served families and individuals. We employ sales personnel, and engage independent brokers, agents and consultants to enroll new Molina Medicare Options Plus members. None of our health plans operates a Medicare Advantage private fee-for-service plan.

Total enrollment in our Medicare Advantage plans as of December 31, 2014 was approximately 49,000 members. For the year ended December 31, 2014, Medicare premium revenues in the aggregate represented approximately 7% of our total premium revenues.

Federal regulations place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. Additionally, there are certain restrictions on agent and broker compensation.

Molina Medicaid Solutions. We continually monitor the status of various states' legacy MMIS capabilities and contracts to determine whether Molina Medicaid Solutions' value proposition and core strengths will address a state's MMIS goals. Once an RFP with a Medicaid agency is won, our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we deliver extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the initial terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. The terms of our other Molina Medicaid Solutions contracts - which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) - are shorter in duration than our Idaho and Maine contracts.

The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 75% of the costs incurred in operating a certified MMIS. Federal certification increases the share of the claims processing costs the federal government will pay for monthly operations. With an uncertified system, the federal government contributes approximately 50% of claims processing costs, with the state paying the other half. With a certified system, the federal government pays 75% of costs, reducing the state's share.

Regulatory Compliance

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

Health Insurer Fee (HIF). One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. Additionally, when states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231 million.

For further discussion of the risks and uncertainties relating to this excise tax, refer to Part II, Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, under the subheading "Liquidity and Capital Resources—Financial Condition."

States' Risk-Based Capital Requirements. Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital (RBC) requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners (NAIC) and are administered by the states. All of our state health plans are subject to RBC requirements, except California and Florida. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute. For further information regarding RBC requirements, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20, "Commitments and Contingencies."

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the American Recovery and Reinvestment Act of 2009, or ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. As required by ARRA, the Secretary of HHS has promulgated regulations implementing various provisions of the HITECH Act. The Final Omnibus Rule promulgated by HHS in January 2013, included the Final Breach Notification Rule as well as provisions that apply the HIPAA regulatory scheme to business associates. We anticipate that HHS will promulgate additional rules under the HITECH Act to implement provisions of the statute which were not addressed in the Final Omnibus Rule. The various requirements of the HITECH Act and the Final Omnibus Rule have different compliance dates, and in some cases, the applicable compliance date may depend on the publication of additional rules or guidance by HHS. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with such provisions. With respect to additional requirements that may be issued in the future by HHS, it is our intention to implement any such new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as "*qui tam*" actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Act of 2005 (DRA) encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

OTHER INFORMATION

Intellectual Property

We have registered and maintain various service marks, trademarks and trade names that we use in our businesses, including marks and names incorporating the "Molina" or "Molina Healthcare" phrase, and from time to time we apply for additional registrations of such marks. We utilize these and other marks and names in connection with the marketing and identification of products and services. We believe such marks and names are valuable and material to our marketing efforts.

Employees

As of December 31, 2014, we had approximately 10,500 employees. Our employee base is multicultural and reflects the diverse membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Available Information

We are organized as a C corporation under Delaware law. Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

You can access our website at *www.molinahealthcare.com* to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Executive Officers of the Registrant

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
J. Mario Molina, M.D.	56	President and Chief Executive Officer
John C. Molina, J.D.	50	Chief Financial Officer
Terry P. Bayer	64	Chief Operating Officer
Joseph W. White	56	Chief Accounting Officer
Jeff D. Barlow	52	Chief Legal Officer and Corporate Secretary

Dr. Molina has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board of Directors since 1996. Dr. Molina is the brother of John C. Molina.

Mr. Molina has served as Chief Financial Officer since 1995. He also has served as a member of the Board of Directors since 1994. Mr. Molina is the brother of Dr. J. Mario Molina.

Ms. Bayer has served as Chief Operating Officer since 2005.

Mr. White has served as Chief Accounting Officer since 2007.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010. From 2004 to 2010, Mr. Barlow served as Vice President, Assistant Secretary, and Assistant General Counsel of Molina Healthcare.

Item 1A: Risk Factors

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This Annual Report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the U.S. Securities Exchange Commission, or SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Segment

Numerous risks associated with the Affordable Care Act and its implementation could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act (collectively, the Affordable Care Act, or ACA). The ACA enacts comprehensive changes to the United States health care system, elements of which will be phased in at various stages over the next several years. However, the most significant changes effected by the ACA were implemented as of January 1, 2014. There are a multitude of risks associated with the scope of change in the health care system represented by the ACA, including, but not limited to, the following:

- *Risks associated with the health care federal excise tax*. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums. However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. Additionally, when states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. The state of California has not formally committed to reimburse us for either the HIF itself, or the related tax effects. The states of Michigan and Utah have reimbursed us for the HIF, but have not formally committed to reimbursement for the related tax effect. The total amount of HIF revenue for which agreements were not secured (and revenue was not recognized) amounted to approximately $20 million for fiscal 2014. We expect to collect and recognize this revenue related to 2014 in 2015. We further expect to recognize revenue in 2015 sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2015. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231

million. The failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows or results of operations.

- *Risks associated with the duals expansion*. Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for the nearly 50 million elderly and under-65 disabled beneficiaries in 2012. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. Policymakers at the federal and state levels are increasingly focused on the design and implementation of programs that improve the coordination of care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner. As a result of these efforts, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014, and we expect to begin offering MMP coverage in South Carolina and Texas in the first quarter of 2015, and in Michigan in the second quarter of 2015.

  There are numerous risks associated with the initial implementation of a new program, with a health plan's expansion into a new service area, and with the provision of medical services to a new population which has not previously been in managed care. One such risk is the development of actuarially sound rates. Because there is limited historical information on which to develop rates, certain assumptions are required to be made which may subsequently prove to have been inaccurate. Rates of utilization could be significantly higher than had been projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, because of our lack of actuarial experience for that program, region, or population, our reserve levels may be set at an inadequate level. For instance, these problems arose at our Texas health plan in the second quarter of 2012, leading to extremely elevated medical care costs and substantial losses at the health plan. All of these risks are present in the implementation of the duals demonstration programs. In the event these risks materialize at one or more of our health plans, the negative results of the health plan or plans could adversely affect our business, financial condition, cash flows, or results of operations.

- *Risks associated with Medicaid expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. At December 31, 2014, our membership included approximately 385,000 Medicaid expansion members, or 15% of total membership. The new enrollees in our health plans represent a population that is different from the population of Medicaid enrollees we have historically managed. All of the risk factors described above with regard to the duals demonstration programs apply equally to Medicaid expansion.

- *Risks associated with health insurance marketplaces*. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois and South Carolina. At December 31, 2014, we had approximately 15,000 Marketplace members, and that enrollment is expected to grow appreciably in 2015, particularly at our Florida health plan. All of the risk factors described above with regard to the duals demonstration programs apply equally to our participation in the insurance marketplaces.

- *Risks associated with the King v. Burwell case*. There is a case currently pending before the United States Supreme Court to be argued on March 4, 2015, challenging whether the IRS may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through exchanges established by the federal government under Section 1321 of the ACA. In the event the Supreme Court rules against Health and Human Services Secretary Burwell, no federal subsidies would be allowed to be paid to those individuals purchasing health insurance through the federally facilitated exchanges, of which there are currently 36. This would undermine the functioning of those exchanges, and cause major disruption under the entire ACA throughout the nation.

- *Risk associated with implementing regulations*. There are many parts of the ACA that require further guidance in the form of regulations. Due to the breadth and complexity of the ACA, the lack of implementing regulations and interpretive guidance, and the phased nature of the ACA's implementation, the overall impact of the ACA on our business and on the health industry in general over the coming years is difficult to predict and not yet fully known, and implementing regulations could contain provisions that have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio, continuing operations, for the year ended December 31, 2014 of 89.5% had been one percentage point higher, or 90.5%, our net income from continuing operations for the year ended December 31, 2014 would have been approximately $0.12 per diluted share rather than our actual income from continuing operations of $1.30 per diluted share, a decrease of approximately 91%.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual flu season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs remain elevated at the same time that state budgets are suffering from significant fiscal strain. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it is a prime target for cost-containment efforts. The states in which we operate our health plans regularly face significant budgetary pressures. These budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

We are unable to determine how any future Congressional spending cuts will affect Medicare and Medicaid reimbursement. There likely will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid" (IBNP) medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to duals, Medicaid expansion members, or aged, blind or disabled Medicaid members, is impacted by the more limited experience we have had with those populations.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our

results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

An increased incidence of flu in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results can be significantly impacted by a severe flu season in the states in which we operated our health plans. We seek to set our IBNP reserves appropriately to account for seasonal spikes in the incidence of the flu. However, if the actual utilization rates of our members are higher than we had anticipated, our results in the relevant periods could be materially and adversely affected.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. In the event the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of the unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. Further, most of our contracts are terminable without cause.

Our government contracts generally run for periods of three to four years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. Although our health plans have generally been successful in obtaining the renewal and/or extension of their state contracts, there can be no guarantee that any of our state government contracts will be renewed or extended, as shown by the loss of our Missouri contract in 2012 in connection with an unsuccessful RFP bid. During 2015, our Michigan Medicaid contract will be subject to a new RFP. We expect the Michigan RFP to be released on May 1, 2015, and for the new contract to become effective on October 1, 2015. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, including our Michigan contract, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

If we sustain a cyberattack or suffer privacy or data security breaches that disrupt our operations or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information, create system disruptions, or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world, we may be unable to proactively address these techniques or to implement adequate preventive measures. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; misplaced or lost data; human errors; acts of malicious insiders, or other similar events that could negatively affect our systems and our and our members' data. The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

In 2014, Gilead's pricing of the hepatitis C drug, Sovaldi, at $84,000 per standard course of therapy received major attention as a health care policy and public policy matter. Because of the relatively high incidence of hepatitis C throughout the nation, particularly in the Medicaid population, the pricing of specialty drugs for the treatment of hepatitis C represents a major public health and public financing problem. In the case of Sovaldi, because of its advent on the health care market in early 2014, the cost of the drug was generally not factored into our 2014 capitation rates, thus threatening to undermine the actuarial soundness of those rates. New high priced specialty drugs and generic drugs are expected to enter the health care market in 2015. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. We will seek to work with state Medicaid agencies to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals. In the event we are required to bear the high costs of new specialty drugs or generic drugs without an appropriate rate adjustment or other reimbursement mechanism, or if new regulations or mandates affect our pharmaceutical costs, our business, financial condition, cash flows, or results of operations could be adversely affected.

States may not adequately compensate us for the value of drug rebates that were previously earned by us but that are now collectible by the states.

ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers have renegotiated or discontinued their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours continue to remain at levels that are much lower than prior to ACA implementation. There are provisions in the ACA that require rates paid to Medicaid managed care plans to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from 11 state health plans, with our Puerto Rico health plan expected to commence operations in April 2015. If we are unable to continue to operate in any of those 11 states, or if our current operations in any portion of the states we are in are significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic, an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

There are performance risks and other risks associated with certain provisions in the state Medicaid contracts of several of our health plans.

The state contracts of our California, Illinois, New Mexico, Ohio, Texas, Washington, and Wisconsin health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, the health plan will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations. In addition, the state contracts of our California, Florida, Illinois, Michigan, New Mexico, Ohio, Texas, and Washington health plans contain provisions pertaining to medical cost floors and corridors, administrative cost and profit ceilings, and profit-sharing arrangements. Our Medicare and Marketplace business is also subject to medical cost floor requirements enacted by the Federal government. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the sometimes complicated contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at

variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations, including in our new Puerto Rico health plan, could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. All of these risks will pertain to our new start-up Puerto Rico health plan, which is expected to commence operations in April 2015. The expenses associated with starting up a health plan in a new state or commonwealth, or expanding a health plan in an existing state could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Reductions in Medicare payments could reduce our earnings potential for our Medicare Advantage plans and our duals demonstration programs.

The Sequestration Transparency Act of 2012 included a 2% reduction of payments from CMS to our Medicare Advantage plans beginning April 1, 2013. Medicare Advantage plans will continue to be affected until Congress lifts the sequestration mandated under the Sequestration Transparency Act of 2012. The impact of sequestration cuts on our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements paid to those providers with rates indexed to the Medicare fee-for-service reimbursement rates. Such reduction in our Medicare payments may have an adverse effect on our earnings potential for our Medicare Advantage plans and our duals demonstration programs. In addition, reductions to provider reimbursement rates associated with sequestration may adversely impact our relations with the impacted providers.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets—particularly operators of large commercial health plans—have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us, or at all, or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years, or that we will not complete acquisitions that turn out to be unfavorable. Further, to the extent we complete an acquisition, we

may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

In addition, we may be unable to successfully identify, consummate, and integrate future acquisitions, including integrating the acquired businesses on our information technology platform, or to implement our operations strategy in order to operate acquired businesses profitably. Furthermore, we may incur significant transaction expenses in connection with a potential acquisition which may or may not be consummated. These expenses could impact our selling, general and administrative expense ratio.

For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws which may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties, and assessments. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information

we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. We are currently defending two *qui tam* actions where both the federal and state governments declined to intervene: (i) *USA and State of Florida ex rel Charles Wilhelm v. Molina Healthcare and Molina Healthcare of Florida*; and (ii) *USA ex rel Anita Silingo v. Mobile Medical Examination Service, Molina Healthcare of California, et al*. We believe we have meritorious defenses to both matters, and intend to defend both matters vigorously. In the event we are subject to liability under these or other *qui tam* actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

The U.S. Department of Health and Human Services, or HHS, has released rules pursuant to the Health Insurance Portability and Accountability Act, or HIPAA, which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. CMS has now scheduled implementation of ICD-10 by October 1, 2015. Use of the ICD-10 code sets will require significant administrative changes and may result in errors and otherwise negatively impact our service levels. In addition, we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, results of operations, and cash flows.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped when the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims,

we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which we do not participate. These actions and the resulting negative publicity could become associated with or imputed to us, regardless of our actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which we do not participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. For the years ended December 31, 2013 and 2012, we received dividends from our health plan subsidiaries amounting to $24.4 million and $101.8 million, respectively. We did not receive any dividends from our health plan subsidiaries during the year ended December 31, 2014. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2014, 2013 and 2012, without approval of the regulatory authorities, were approximately $96 million, $54 million, and $24 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our convertible senior notes or any credit facility.

Risks Related to the Operation of Our Molina Medicaid Solutions Segment

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently has management contracts in only six states. If we are unable to continue to operate in any of those six states, or if our current operations in any of those six states are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, in 2012, the government contract of Molina Medicaid Solutions in Louisiana was subject to competitive bidding, and we were unsuccessful in being awarded a new contract. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business could be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results and damage our reputation.

Computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our

brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business or retain existing MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance on contracts, including those on which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties, including software and hardware vendors, to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenues and profitability.

Risks Related to our General Business Operations

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

We expect to continue to grow our membership and to expand into other markets through acquisitions and other opportunities. Continued rapid growth could place a significant strain on our management and on our other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, or results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or

different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability, and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of our clinics or caused by one of our employees. We maintain medical malpractice insurance for our clinics in an amount which we believe to be reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC, or other regulatory authorities which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles (GAAP) and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our

judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes, such as the health care federal excise tax discussed above. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations could have a material adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. It is critical that we recruit, manage, enable, and retain talent to successfully execute our strategic objections which requires aligned policies, a positive work environment, and a robust succession and talent development process. Further, particularly in light of the changing healthcare environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. If we are unsuccessful in recruiting, retaining, managing, and enabling such personnel and are unable to meet upcoming challenges and opportunities, our operations could be negatively impacted.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could adversely impact our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2014, the balance of goodwill was $272.0 million, and the balance of intangible assets, net, was $89.3 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives.

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit

below its carrying amount. Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable.

The determination of the value of goodwill, and intangible assets, net, requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

We are subject to the risks of owning and leasing real property.

We are a tenant under numerous leases in multiple states, including a 25-year lease of an approximately 460,000 square foot office building housing our principal executive offices in Long Beach, California. We also own a 186,000 square-foot office building in Troy, Michigan, a 26,700 square-foot data center in Albuquerque, New Mexico, and a 24,000 square-foot community clinic in Pomona, California. Accordingly, we are subject to all of the risks generally associated with leasing and owning real estate, which include, but are not limited to: the possibility of environmental contamination, the costs associated with fixing any environmental problems and the risk of damages resulting from such contamination; adverse changes in the value of the property due to interest rate changes, changes in the neighborhood in which the property is located, or other factors; ongoing maintenance expenses and costs of improvements; the possible need for structural improvements in order to comply with changes in zoning, seismic, disability act, or other requirements; inability to renew or enter into leases for space not utilized by us on commercially acceptable terms or at all; and possible disputes with neighboring owners or other individuals and entities.

Risks Related to Our Common Stock

Delaware law and our charter documents may impede or discourage a takeover, which could cause the market price of our common stock to decline.

We are a Delaware corporation, and the anti-takeover provisions of Delaware law impose various impediments to the ability of a third party to acquire control of us, even if a change in control would be beneficial to our existing stockholders. In addition, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock and certain provisions of Delaware law and our certificate of incorporation and bylaws could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock and the value of our convertible senior notes.

Members of the Molina family own a significant amount of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate owned or were entitled to receive upon certain events approximately 32% of our capital stock as of December 31, 2014. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election of directors, amendments to our charter, and any merger, consolidation, or sale of our company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2014, approximately 49,727,000 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Item 1B: Unresolved Staff Comments

None.

Item 2: Properties

As of December 31, 2014, the Health Plans segment leases a total of 70 facilities and the Molina Medicaid Solutions segment leases a total of 12 facilities. We own a 186,000 square-foot office building in Troy, Michigan, a 26,700 square-foot data center in Albuquerque, New Mexico, and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operations growth prospects to determine if additional space is required, and where it would be best located.

Item 3: Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana v. Molina Medicaid Solutions et al. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. The petitioner seeks actual damages to be proved at trial, plus interest. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm v Molina Healthcare of Florida et al. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that, in late 2008 and early 2009, in connection with the acquisition of Florida NetPass by which Molina Healthcare entered into the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. The relator seeks treble damages in the alleged amount of $62.3 million, plus interest and penalties. Both the United States of America and the state of Florida have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The relator seeks treble damages in the amount of $3 billion, plus interest and penalties. The Department of Justice has declined to intervene. We believe that we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Item 4: Mine Safety Disclosures

None.

PART II

Item 5: Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of February 20, 2015, there were approximately 120 holders of record of our common stock. The high and low intra-day sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2014		
First Quarter	$ 39.21	$ 32.41
Second Quarter	$ 46.17	$ 32.86
Third Quarter	$ 48.03	$ 39.23
Fourth Quarter	$ 54.57	$ 40.79
2013		
First Quarter	$ 33.85	$ 25.70
Second Quarter	$ 38.74	$ 30.26
Third Quarter	$ 40.90	$ 33.31
Fourth Quarter	$ 37.39	$ 31.10

Dividends

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business growth. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Any future determination to pay dividends will be at the discretion of our Board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, in "Liquidity and Capital Resources," under the subheading "Regulatory Capital and Dividend Restrictions."

Unregistered Issuances of Equity Securities

None.

Stock Repurchase Programs

Securities Repurchases and Repurchase Programs. Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This newly authorized repurchase program extends through December 31, 2015.

Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2014, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (1)	Average Price Paid per Share (1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (2)	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs (2)
October 1 — October 31	1,052	$ 41.66	—	$ 47,338,505
November 1 — November 30	1,781	$ 48.64	—	$ 47,338,505
December 1 — December 31	1,523	$ 49.96	—	$ 47,338,505
	4,356	$ 47.42	—	

(1) During the quarter we withheld 4,356 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(2) Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. This repurchase program expired December 31, 2014.

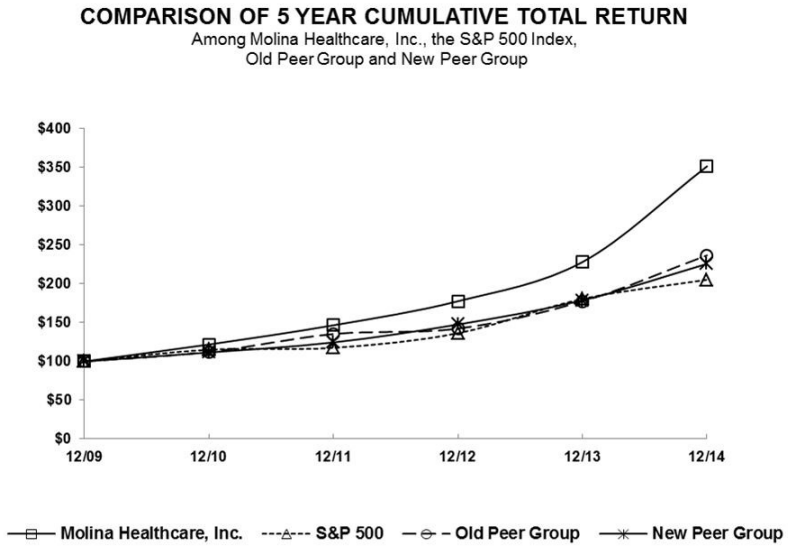
STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the SEC (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (S&P 500) and a peer group index for the five-year period from December 31, 2009 to December 31, 2014. The comparison assumes $100 was invested on December 31, 2009, in the Company's common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.

The old peer group index, used in last year's Annual Report on Form 10-K and also set forth below, consists of Centene Corporation (CNC), Community Health Systems, Inc. (CYH), Coventry Health Care, Inc. (CVH), Health Management Associates, Inc. (HMA), Health Net, Inc. (HNT), Laboratory Corporation of America Holdings (LH), Lifepoint Hospitals, Inc. (LPNT), Magellan Health Services, Inc. (MGLN), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), and WellCare Health Plans, Inc. (WCG).

The new peer group index consists of Brookdale Senior Living, Inc. (BKD), Catamaran Corporation (CTRX), Centene Corporation (CNC), Community Health Systems, Inc. (CYH), DaVita HealthCare Partners, Inc. (DVA), Health Net, Inc. (HNT), Kindred Healthcare, Inc. (KND), Laboratory Corporation of America Holdings (LH), Life Point Hospitals, Inc. (LPNT), Magellan Health, Inc. (MGLN), Omnicare, Inc. (OCR), Quest Diagnostics, Inc. (DGX), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).



	December 31,					
Name	2009	2010	2011	2012	2013	2014
Molina Healthcare, Inc.	$ 100.00	$ 121.78	$ 146.46	$ 177.48	$ 227.92	$ 351.09
S&P 500	100.00	115.06	117.49	136.30	180.44	205.14
Old Peer Group	100.00	112.08	135.26	142.21	177.30	236.56
New Peer Group	100.00	111.51	124.46	147.53	178.64	225.58

Item 6. Selected Financial Data

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics, Continuing Operations") for the five years ended December 31, 2014 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollar amounts are presented in thousands, except per-share data. The data under the caption "Operating Statistics, Continuing Operations" has not been audited.

	Year Ended December 31,				
	2014	2013	2012	2011	2010 (1)
Statements of Income Data:					
Revenue:					
Premium revenue	$ 9,022,511	$ 6,179,170	$ 5,544,121	$ 4,211,493	$ 3,632,142
Service revenue (1)	210,051	204,535	187,710	160,447	89,809
Premium tax revenue	294,388	172,017	158,991	154,589	139,775
Health insurer fee revenue	119,484	—	—	—	—
Investment income	8,093	6,890	5,075	5,446	6,198
Other revenue	12,074	26,322	18,312	8,288	7,140
Total revenue	9,666,601	6,588,934	5,914,209	4,540,263	3,875,064
Operating expenses:					
Medical care costs	8,076,331	5,380,124	4,991,188	3,664,161	3,190,566
Cost of service revenue (1)	156,764	161,494	141,208	143,987	78,647
General and administrative expenses	764,693	665,996	518,615	393,452	326,193
Premium tax expenses	294,388	172,017	158,991	154,589	139,775
Health insurer fee expenses	88,591	—	—	—	—
Depreciation and amortization	92,917	72,743	63,114	48,253	43,246
Total operating expenses	9,473,684	6,452,374	5,873,116	4,404,442	3,778,427
Operating income	192,917	136,560	41,093	135,821	96,637
Other expenses, net:					
Interest expense	56,811	52,071	16,769	15,519	15,509
Other expense, net	802	3,343	945	—	—
Total other expenses, net	57,613	55,414	17,714	15,519	15,509
Income from continuing operations before income taxes	135,304	81,146	23,379	120,302	81,128
Income tax expense	72,726	36,316	10,513	42,914	30,511
Income from continuing operations	62,578	44,830	12,866	77,388	50,617
(Loss) income from discontinued operations, net of tax (benefit) expense (2)	(355)	8,099	(3,076)	(56,570)	4,353
Net income	$ 62,223	$ 52,929	$ 9,790	$ 20,818	$ 54,970
Basic net income per share:					
Income from continuing operations	$ 1.34	$ 0.98	$ 0.28	$ 1.69	$ 1.23
(Loss) income from discontinued operations	(0.01)	0.18	(0.07)	(1.24)	0.11
Basic net income per share	$ 1.33	$ 1.16	$ 0.21	$ 0.45	$ 1.34
Diluted net income per share:					
Income from continuing operations	$ 1.30	$ 0.96	$ 0.27	$ 1.67	$ 1.22
(Loss) income from discontinued operations	(0.01)	0.17	(0.06)	(1.22)	0.10
Diluted net income per share	$ 1.29	$ 1.13	$ 0.21	$ 0.45	$ 1.32
Weighted average shares outstanding:					
Basic	46,935,000	45,717,000	46,380,000	45,756,000	41,174,000
Diluted	48,340,000	46,862,000	46,999,000	46,425,000	41,631,000
Operating Statistics, Continuing Operations:					
Medical care ratio (3)	89.5%	87.1%	90.0%	87.0%	87.8%
General and administrative expense ratio (4)	7.9%	10.1%	8.8%	8.7%	8.4%
Premium tax ratio (5)	3.2%	2.7%	2.8%	3.5%	3.7%
Members (6)	2,623,000	1,931,000	1,797,000	1,618,000	1,532,000

	Year Ended December 31,				
	2014	2013	2012	2011	2010
Balance Sheet Data:					
Cash and cash equivalents	$ 1,539,063	$ 935,895	$ 795,770	$ 493,827	$ 455,886
Total assets	4,477,215	3,002,937	1,934,822	1,652,146	1,509,214
Long-term debt, including current maturities (7)	905,389	784,862	262,939	218,126	164,014
Total liabilities	3,466,773	2,110,000	1,152,508	897,073	790,157
Stockholders' equity	1,010,442	892,937	782,314	755,073	719,057

(1) Service revenue and cost of service revenue represent revenue and costs generated by our Molina Medicaid Solutions segment. Because we acquired this business on May 1, 2010, results for the year ended December 31, 2010 include eight months of results for this segment.

(2) As previously reported, in February 2012 the Division of Purchasing of the Missouri Office of Administration notified our Missouri health plan that it was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, the Missouri health plan's existing contract with the state expired without renewal on June 30, 2012. In connection with this notification, the Missouri health plan recorded a non-cash impairment charge of $64.6 million in the fourth quarter of 2011. Results relating to the Missouri health plan have been reported as discontinued operations for all periods presented. (Loss) income from discontinued operations is presented net of income tax (benefit) expense of $(203), $(9,912), $(1,238), $922, and $4,011, respectively.

(3) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, utilization of medical services, our ability to effectively manage costs, contract changes, and changes in accounting estimates related to incurred but not paid claims. See Item 7 in this Form 10-K, "Management's Discussion and Analysis of Financial Condition and Results of Operations," for further discussion.

(4) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(5) Premium tax ratio represents such expenses as a percentage of premium revenue plus premium tax revenue.

(6) Number of members at end of period.

(7) Includes convertible senior notes, lease financing obligations, and other long-term debt.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with Items 6 and 8 of this Form 10-K, Selected Financial Data, and Financial Statements and Supplementary Data, respectively. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth in Part I, Item 1A of this Form 10-K, Risk Factors.

Overview

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of December 31, 2014, these health plans served over 2.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplace members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we reported the results relating to the Missouri health plan as discontinued operations for all periods presented. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise noted.

Fiscal Year 2014 Financial Highlights

- Net income from continuing operations increased to $62.6 million in 2014, from $44.8 million in 2013 due to increases in enrollment and revenue, and improved administrative cost efficiency; which offset higher medical costs and higher tax rates.
- Strong enrollment growth across all of our programs combined with an 18% increase in premium revenue per member, generated almost $3 billion, or 46%, more premium revenue in 2014 compared with 2013.
- General and administrative expenses as a percentage of revenue declined to 7.9% in 2014, versus 10.1% in 2013.
- Medical care costs as a percentage of premium revenue increased to 89.5% in 2014, from 87.1% in 2013.
- Debt financing transactions generated net cash of $122.6 million; such transactions both extended the maturity date and lowered the rate of our convertible senior notes previously due in 2014.

Health Care Reform

We believe that the government-sponsored initiatives, including the Affordable Care Act (ACA), will continue to provide us with significant opportunities for membership growth in our existing markets and in new programs in the future as follows:

- *Medicaid Expansion*. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. At December 31, 2014 our membership included approximately 385,000 Medicaid expansion members, or 15% of total membership.
- *Marketplace*. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois and South Carolina. At December 31, 2014, we had approximately 15,000 Marketplace members, and that enrollment is expected to grow appreciably in 2015, particularly at our Florida health plan.

- *Medicare-Medicaid Plans*. Policymakers at the federal and state levels are increasingly focused on the design and implementation of programs that improve the coordination of care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner. As a result of these efforts, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014, and we expect to begin offering MMP coverage in South Carolina and Texas in the first quarter of 2015, and in Michigan in the second quarter of 2015.

Health Insurer Fee. The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. A health insurer's liability for the payment of the fee (the health insurer fee, or HIF) is established upon first writing business in 2014 or any subsequent year. In other words, an active health insurer becomes liable for the fee on January 1st of any given year. The amount of the HIF for the insurer is based upon the insurer's share of the industry's net premiums written during the preceding calendar year. The HIF must be paid by the insurer by September 30th of the year in which the insurer becomes liable for the HIF. During the third quarter of 2014 we paid our 2014 HIF assessment, which amounted to $88.6 million. This expense was recognized on a straight-line basis in 2014; and is non-deductible for income tax purposes.

We believe that state Medicaid agencies are required to reimburse us for the HIF imposed on our Medicaid premiums, as well as for the negative financial impact associated with the absence of tax deductibility for the HIF. Although all of our state Medicaid partners have agreed informally to reimbursement of the HIF and the costs of its related tax effects, we have not secured binding commitments to that effect from California, Michigan and Utah. Our 2014 results were adversely affected by our inability to recognize as revenue reimbursement (including reimbursement for tax effects) for the full impact of the HIF from those states. The state of California has not formally committed to reimburse us for either the HIF itself, or the related tax effects. The states of Michigan and Utah have reimbursed us for the HIF, but have not formally committed to reimbursement for the related tax effect. The total amount of HIF revenue for which agreements were not secured (and revenue was not recognized) amounted to approximately $20 million for fiscal 2014. We expect to collect and recognize this revenue related to 2014 in 2015. We further expect to recognize revenue in 2015 sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2015. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231 million.

For further discussion of the risks and uncertainties relating to the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates—Health Plans Segment

Florida. During 2014, our Florida health plan acquired two Medicaid contracts, adding approximately 73,000 members.

Puerto Rico. In 2014, we were awarded a managed care contract in the Commonwealth of Puerto Rico that is expected to enroll its first members April 1, 2015. Total enrollment is expected to be approximately 350,000 new members, with anticipated annualized revenue of $750 million.

South Carolina. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

Market Update—Molina Medicaid Solutions Segment

In 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid management information system (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana canceled its contract award to CNSI. The state had informed us that we will continue to perform under our current contract until a successor is named. On December 18, 2014, Molina Medicaid Solutions received notice from the state of Louisiana that they have extended our contract through December 31, 2015. We recognized approximately $41 million of service revenue under this contract in 2014.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate; and, to a lesser degree, from Medicare contracts entered into with the Centers for Medicare and Medicaid Services (CMS), a federal government agency.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or

without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled (ABD); and regions or service areas.

Premium revenue is fixed in advance of the periods covered and, except as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2 "Significant Accounting Policies," is not generally subject to significant accounting estimates. For the year ended December 31, 2014, we received more than 95% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. Revenue not received on a fixed PMPM basis is recognized as earned.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program, on a per-member per-month basis for the year ended December 31, 2014. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	Ending	PMPM Premiums		
	Membership	Low	High	Consolidated
Temporary Assistance for Needy Families (TANF), CHIP (1)	1,831,000	$ 130.00	$ 280.00	$ 180.00
Medicaid Expansion	385,000	340.00	520.00	420.00
Aged, Blind or Disabled (ABD)	325,000	320.00	1,580.00	900.00
Medicare Special Needs Plans (Medicare)	49,000	970.00	1,480.00	1,180.00
Medicare-Medicaid Plan (MMP) – Integrated (2)	18,000	1,510.00	3,240.00	1,970.00
Marketplace	15,000	190.00	560.00	320.00

(1) CHIP stands for Children's Health Insurance Program.
(2) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	As of December 31,		
	2014	2013	2012
Ending Membership by Health Plan:			
California	531,000	368,000	336,000
Florida	164,000	89,000	73,000
Illinois	100,000	4,000	—
Michigan	242,000	213,000	220,000
New Mexico	212,000	168,000	91,000
Ohio	347,000	255,000	244,000
South Carolina (1)	118,000	—	—
Texas	245,000	252,000	282,000
Utah	83,000	86,000	87,000
Washington	497,000	403,000	418,000
Wisconsin	84,000	93,000	46,000
	2,623,000	1,931,000	1,797,000
Ending Membership by Program:			
TANF/CHIP	1,831,000	1,624,000	1,517,000
Medicaid Expansion (2)	385,000	—	—
ABD	325,000	268,000	244,000
Medicare	49,000	39,000	36,000
MMP - Integrated	18,000	—	—
Marketplace (2)	15,000	—	—
	2,623,000	1,931,000	1,797,000

(1) Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

(2) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed. For further information regarding revenue recognition for the Molina Medicaid Solutions segment, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services (including long-term services and supports, or LTSS), general and administrative expenses, premium tax and health insurer fee expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are

recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.

- *Pharmacy expenses:* All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Capitation expenses:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.
- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2014, 2013, and 2012, medically related administrative costs were $262.6 million, $153.0 million, and $125.2 million, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Estimates" below, and Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the contract term, consistent with the revenue recognition period.

Financial Performance Summary, Continuing Operations

The following table and narrative briefly summarize our financial and operating performance from continuing operations for the years ended December 31, 2014, 2013, and 2012. All ratios, with the exception of the medical care ratio and the premium tax ratio, are computed as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue, and the premium tax ratio is computed as a percentage of premium revenue plus premium tax revenue, because direct relationships exist between premium revenue earned, and the cost of health care and premium taxes.

	Year Ended December 31,		
	2014	2013	2012
	(Dollar amounts in thousands, except per-share data)		
Net income per diluted share	$ 1.30	$ 0.96	$ 0.27
Adjusted net income per diluted share	$ 3.43	$ 3.13	$ 1.72
Premium revenue	$ 9,022,511	$ 6,179,170	$ 5,544,121
Service revenue	$ 210,051	$ 204,535	$ 187,710
Operating income	$ 192,917	$ 136,560	$ 41,093
Net income	$ 62,578	$ 44,830	$ 12,866
Total ending membership	2,623,000	1,931,000	1,797,000
Premium revenue	93.3%	93.8%	93.7%
Service revenue	2.2	3.1	3.2
Premium tax revenue	3.1	2.6	2.7
Health insurer fee revenue	1.2	—	—
Investment income	0.1	0.1	0.1
Other revenue	0.1	0.4	0.3
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	89.5%	87.1%	90.0%
General and administrative expense ratio	7.9%	10.1%	8.8%
Premium tax ratio	3.2%	2.7%	2.8%
Operating income	2.0%	2.1%	0.7%
Net income	0.6%	0.7%	0.2%
Effective tax rate	53.8%	44.8%	45.0%

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. generally accepted accounting principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Net income	$ 62,223	$ 52,929	$ 9,790
Adjustments:			
Depreciation, and amortization of intangible assets and capitalized software	113,715	93,866	78,764
Interest expense	56,811	52,071	16,769
Income tax expense	72,523	26,404	9,275
EBITDA	$ 305,272	$ 225,270	$ 114,598

The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. The following tables reconcile net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations.

	Year Ended December 31,					
	2014		2013		2012	
	(In thousands, except diluted per-share amounts)					
Net income, continuing operations	$ 62,578	$ 1.30	$ 44,830	$ 0.96	$ 12,866	$ 0.27
Adjustments, net of tax:						
Depreciation, and amortization of capitalized software	58,770	1.21	46,018	0.98	35,267	0.75
Amortization of convertible senior notes and lease financing obligations	17,249	0.36	14,377	0.31	3,714	0.08
Share-based compensation	14,288	0.29	24,501	0.52	14,556	0.31
Amortization of intangible assets	12,870	0.27	13,117	0.28	13,592	0.29
Change in fair value of derivatives	(10)	—	3,580	0.08	817	0.02
Adjusted net income per diluted share, continuing operations	$ 165,745	$ 3.43	$ 146,423	$ 3.13	$ 80,812	$ 1.72

Results of Operations, Continuing Operations

Year Ended December 31, 2014 Compared with the Year Ended December 31, 2013

Health Plans Segment

Premium Revenue

A 28% increase in membership and an 18% increase in revenue PMPM in 2014 resulted in an increase in premium revenue of 46%, or over $2.8 billion, when compared with 2013. Medicare premium revenue was approximately $627 million in the year ended December 31, 2014, compared with approximately $526 million in the year ended December 31, 2013.

Enrollment growth was primarily due to Medicaid expansion program membership added as a result of the Affordable Care Act, and membership added at our South Carolina and Illinois health plans. Higher PMPM premium revenue was primarily the result of the inclusion of long-term services and supports (LTSS) benefits in various Medicaid managed care programs in California, Florida, Illinois, New Mexico, and Ohio.

Medical Care Costs

Although medical margin (defined as the excess of premium revenue over medical care costs) increased nearly 20% in 2014 over 2013; our consolidated medical care ratio (defined as medical care costs as a percentage of premium revenue) increased to 89.5% in 2014 from 87.1% in 2013.

The medical care ratio increased substantially in 2014 as a result of three developments:

- Much of our revenue growth has come from participation in Medicaid programs covering LTSS. Percentage profit margins for LTSS benefits are generally lower than percentage profit margins for acute medical benefits.
- Increases to our base premiums in recent years have not kept pace with medical cost trends.
- Lack of coordination in the design of profit caps and medical cost floors in some of our state Medicaid contracts is resulting in counterproductive outcomes. In some instances, givebacks due to profitable performance in one product cannot be offset against losses in other products.

Medical care ratios by program for 2014 were as follows: TANF and CHIP - 89.3%; Medicaid expansion - 79.4%; ABD - 92.3%; Medicare - 95.8%; MMP integrated - 92.1%; and Marketplace - 83.7%.

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 5,672,483	$ 202.87	70.2%	$ 3,611,529	$ 160.43	67.1%
Pharmacy	1,273,329	45.54	15.8	935,204	41.54	17.4
Capitation	748,388	26.77	9.3	603,938	26.83	11.2
Direct delivery	96,196	3.44	1.2	48,288	2.14	0.9
Other	285,935	10.22	3.5	181,165	8.05	3.4
	$ 8,076,331	$ 288.84	100.0%	$ 5,380,124	$ 238.99	100.0%

Individual Health Plan Analysis

California. The medical care ratio for the California health plan decreased significantly to 83.3% in 2014, from 88.9% in 2013. Additionally, medical margin improved $171.0 million when compared with 2013. This improvement was the result of higher enrollment, primarily due to the addition of approximately 107,000 Medicaid expansion members; and premium increases effective October 1, 2013 (2.5%), and July 1, 2014 (5.5%). During 2014, the California health plan benefited from the recognition of approximately $23 million in premium revenue that related to 2013 as a result of certain programmatic changes implemented by the state of California. In 2013, the California health plan recognized approximately $32 million of premium revenue related to 2012 and earlier years as a result of retroactive rate increases from the state of California. The California health plan served its first MMP members in 2014.

Florida. Due to the re-procurement undertaken by the Florida Agency for Health Care Administration as part of its Managed Medical Assistance program starting in 2014, the Florida health plan transitioned many of its members to other health plans in the second quarter of 2014, and then added approximately 105,000 members in the second half of 2014, both from the addition of new service areas and through acquisitions. Although revenue increased approximately 66% at the Florida health plan for the year ended December 31, 2014, when compared with 2013, profitability fell in 2014. Medical margin declined $14.1 million, and the medical care ratio increased to 95.5% from 87.3% in 2013. The higher medical care costs were the result of 1) the assumption of risk for LTSS benefits for certain members effective December 2013 (as noted above percentage profit margins for LTSS benefits are generally less than those for other benefits); and 2) our inability to recognize revenue related to a rate increase effective September 1, 2014, as a result of those rates not being finalized prior to year end.

Illinois. The medical care ratio for the Illinois health plan decreased to 91.7% in 2014, from 96.9% in 2013. The plan experienced significant growth in 2014; enrollment increased approximately 96,000 members overall, with 78,000 members added in the fourth quarter alone. This growth occurred primarily within the traditional TANF program, and to a lesser degree within the Medicaid expansion program. The Illinois health plan served its first MMP members in 2014.

Michigan. The medical care ratio of the Michigan health plan was consistent year over year, at 84.6% in 2014, compared with 84.4% in 2013.

New Mexico. Premium revenue at the New Mexico health plan increased 141% for 2014 compared with 2013, primarily as a result of the addition of Medicaid behavioral health and LTSS benefits effective January 1, 2014, and the addition of approximately 54,000 Medicaid expansion members during the course of 2014. The medical care ratio of the New Mexico health plan increased to 92.6% in 2014, from 86.1% in 2013. The higher medical care ratio was the result of 1) the assumption of risk for LTSS benefits effective January 1, 2014; and 2) premium rates effective January 1, 2014 that did not keep pace with the increase in medical costs in 2014. The New Mexico health plan received a blended rate increase of approximately 3% effective January 1, 2015. For the portion of New Mexico health plan's membership that is eligible for LTSS benefits, the rate increase effective January 1, 2015 was 8%.

Ohio. The medical care ratio of the Ohio health plan increased to 86.0% in 2014, from 84.2% in 2013, primarily due to the increase in Medicaid expansion enrollment (which is incurring a medical care ratio slightly in excess of the plan's traditional experience), and the initiation of the Ohio MMP.

South Carolina. Our South Carolina health plan commenced operations effective January 1, 2014 and finished the year with a medical care ratio of 84.7%.

Texas. Financial performance at the Texas health plan declined in 2014, when compared with 2013. The medical care ratio of the Texas health plan increased to 90.8% in 2014, from 86.4% in 2013. Our inability to recognize a portion of the Texas health

plan's quality revenue reduced income before taxes by approximately $26 million, or $0.33 per diluted share, for the year ended December 31, 2014. Approximately $20 million of this amount is related to measures for which we lack sufficient information to calculate our compliance. Should such information become available in the future, we may be able to recognize all or a portion of such revenue. Removing quality revenue and profit-sharing adjustments would have resulted in a medical care ratio at the Texas health plan of approximately 88% in 2014 and 86% in 2013.

Utah. The medical care ratio of the Utah health plan increased to 92.2% in 2014, from 83.4% in 2013, due to deteriorating margins for both Medicaid and Medicare products.

Washington. Financial performance at the Washington health plan declined in 2014, when compared with 2013. The medical care ratio of the Washington health plan increased to 93.4% in 2014, compared with 88.0% in 2013, primarily due to the high cost of medical services relative to revenue for members served under the state's program for ABD members; and to the $11.2 million net settlement with the Washington Health Care Authority, as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20, "Commitments and Contingencies." The Washington health plan added approximately 102,000 Medicaid expansion members in 2014. The Washington health plan received a blended rate increase of approximately 3% effective January 1, 2015. For the Washington health plan’s ABD membership, the rate increase effective January 1, 2015 was 11%.

Wisconsin. The medical care ratio of the Wisconsin health plan increased to 86.8% in 2014, compared with 79.7% in 2013.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2014						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	5,630	$ 1,523,084	$ 270.51	$ 1,268,937	$ 225.37	83.3%	$ 254,147
Florida	1,104	439,107	397.79	419,422	379.95	95.5	19,685
Illinois	307	153,271	498.48	140,480	456.88	91.7	12,791
Michigan	2,802	780,896	278.68	660,790	235.81	84.6	120,106
New Mexico	2,471	1,075,330	435.17	995,626	402.92	92.6	79,704
Ohio	3,650	1,552,949	425.47	1,335,436	365.87	86.0	217,513
South Carolina	1,463	381,317	260.72	323,061	220.89	84.7	58,256
Texas	2,980	1,318,192	442.32	1,197,465	401.81	90.8	120,727
Utah	996	309,411	310.64	285,303	286.43	92.2	24,108
Washington	5,522	1,304,605	236.27	1,218,886	220.75	93.4	85,719
Wisconsin	1,036	156,229	150.87	135,557	130.91	86.8	20,672
Other[3]	—	28,120	—	95,368	—	—	(67,248)
	27,961	$ 9,022,511	$ 322.68	$ 8,076,331	$ 288.84	89.5%	$ 946,180

	Year Ended December 31, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,233	$ 749,755	$ 177.10	$ 666,592	$ 157.46	88.9%	$ 83,163
Florida	973	264,998	272.23	231,261	237.57	87.3	33,737
Illinois	7	8,121	1,201.34	7,869	1,164.10	96.9	252
Michigan	2,581	676,000	261.91	570,644	221.09	84.4	105,356
New Mexico	1,492	446,758	299.36	384,466	257.62	86.1	62,292
Ohio	3,007	1,098,795	365.44	924,675	307.53	84.2	174,120
South Carolina	—	—	—	—	—	—	—
Texas	3,178	1,291,001	406.27	1,114,852	350.84	86.4	176,149
Utah	1,040	310,895	299.05	259,397	249.51	83.4	51,498
Washington	4,941	1,168,405	236.47	1,028,210	208.10	88.0	140,195
Wisconsin	1,060	143,465	135.40	114,340	107.91	79.7	29,125
Other (3)	—	20,977	—	77,818	—	—	(56,841)
	22,512	$ 6,179,170	$ 274.48	$ 5,380,124	$ 238.99	87.1%	$ 799,046

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31,	
	2014	2013
	(In thousands)	
Service revenue before amortization	$ 212,965	$ 207,449
Amortization recorded as reduction of service revenue	(2,914)	(2,914)
Service revenue	210,051	204,535
Cost of service revenue	156,764	161,494
General and administrative costs	7,105	5,285
Amortization of customer relationship intangibles	3,355	5,127
Operating income	$ 42,827	$ 32,629

Operating income for our Molina Medicaid Solutions segment improved $10.2 million for the year ended December 31, 2014, compared with 2013. This improvement was primarily the result of increased revenues due to higher Medicaid transaction volumes and lower cost of services overall, as existing contract operations gained efficiencies.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses decreased to 7.9% of revenue in 2014, from 10.1% in 2013. The significant decline in the ratio of general and administrative expenses relative to total revenue was primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Premium Tax Expense

Premium tax expense was 3.2% in 2014, compared with 2.7% in 2013. In June 2014, the state of Michigan instituted a 6% use tax on medical premiums. That state has agreed to fund this tax through rate increases; as a result, we recorded approximately $30 million in additional premium revenue in 2014, as well as corresponding premium tax expense.

Health Insurer Fee Revenue and Expenses

Refer to "Liquidity and Capital Resources—Financial Condition" below for a comprehensive discussion of the HIF.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 75,402	0.8%	$ 54,837	0.8%
Amortization of intangible assets, continuing operations	17,515	0.2	17,906	0.3
Depreciation and amortization, continuing operations	92,917	1.0	72,743	1.1
Depreciation and amortization, discontinued operations	—	—	2	—
Amortization recorded as reduction of service revenue	2,914	—	2,914	—
Amortization of capitalized software recorded as cost of service revenue	38,573	0.4	18,207	0.3
Depreciation and amortization reported in statement of cash flows	$ 134,404	1.4%	$ 93,866	1.4%

Interest Expense

Interest expense increased to $56.8 million for the year ended December 31, 2014, compared with $52.1 million for the year ended December 31, 2013. The increase was due primarily to our 3.75% Notes exchange transaction and related issuance of 1.625% Notes in the third quarter of 2014, and lease financing transactions executed in 2013. For further details regarding these transactions, please refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Long-Term Debt."

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $27.4 million and $22.8 million for the years ended December 31, 2014 and 2013, respectively.

Other Expenses, Net

Other expenses, net decreased to $0.8 million for the year ended December 31, 2014, from $3.3 million for the year ended December 31, 2013. Other expenses, net include primarily gains or losses associated with changes in the fair value of our derivative financial instruments. In the second quarter of 2013 we recorded a one-time non-cash charge of $3.9 million related to the change in fair value of warrants issued in connection with the 1.125% Notes, with no comparable activity in 2014.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 53.8% for the year ended December 31, 2014, compared with 44.8% for the year ended December 31, 2013. The increase is primarily due to the nondeductible health insurer fee in 2014 that did not exist in 2013.

Results of Operations, Continuing Operations

Year Ended December 31, 2013 Compared with the Year Ended December 31, 2012

Premium Revenue

Premium revenue in 2013 increased 11% over 2012, due to a 6% increase in member months, and a 5% increase in revenue PMPM. Medicare premium revenue was $526 million for the year ended December 31, 2013, compared with $468 million for the year ended December 31, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 3,611,529	$ 160.43	67.1%	$ 3,423,751	$ 161.67	68.6%
Pharmacy	935,204	41.54	17.4	835,830	39.47	16.7
Capitation	603,938	26.83	11.2	552,136	26.07	11.1
Direct delivery	48,288	2.14	0.9	33,920	1.60	0.7
Other	181,165	8.05	3.4	145,551	6.87	2.9
	$ 5,380,124	$ 238.99	100.0%	$ 4,991,188	$ 235.68	100.0%

Excluding our Illinois health plan, which was not operational until 2013, eight of our nine health plans reported higher medical margins in 2013 than in 2012. The consolidated medical margin increased by approximately 45% year over year. Our consolidated medical care ratio decreased to 87.1% for the year ended December 31, 2013, compared with 90.0% for the year ended December 31, 2012.

Individual Health Plan Analysis

California. Financial performance improved at the California health plan in 2013, when compared with 2012, primarily due to the receipt of premium rate increases for both TANF and ABD membership; and lower inpatient facility costs for the TANF membership. Approximately $32 million of premium revenue received and recognized in 2013 related to 2012 and earlier years. The medical care ratio at the California health plan decreased to 88.9% in 2013 from 91.1% in 2012.

Florida. The medical care ratio of the Florida health plan increased to 87.3% in 2013, from 85.3% in 2012, due to higher fee-for-service costs that more than offset lower pharmacy costs.

Illinois. The medical care ratio for the Illinois health plan was 96.9% in 2013. The Illinois health plan served its first member effective September 2013.

Michigan. Financial performance improved at the Michigan health plan in 2013, when compared with 2012. The medical care ratio of the Michigan health plan decreased to 84.4% in 2013, from 88.3% in 2012, primarily due to lower fee-for-service and pharmacy costs for both the ABD and the TANF membership.

New Mexico. Financial performance improved at the New Mexico health plan in 2013, when compared with 2012. The medical care ratio of the New Mexico health plan decreased to 86.1% in 2013, from 87.0% in 2012, primarily as a result of higher Medicaid premium rates PMPM effective January 1, 2013, and stable medical costs PMPM. The New Mexico health plan added approximately 80,000 new members in 2013, as a result of its acquisition of Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program effective August 1, 2013.

Ohio. Financial performance improved at the Ohio health plan in 2013, when compared with 2012. The medical care ratio of the Ohio health plan decreased to 84.2% in 2013, from 88.6% in 2012, primarily due to lower fee-for-service and pharmacy costs for both the ABD and the TANF membership. Financial performance deteriorated in the second half of 2013 due to both premium decreases, and increases to fee schedules effective July 1, 2013, that combined to reduce medical margin approximately 3% for the second half of 2013. We also experienced an additional 1.5% decrease in premium rates in Ohio effective July 1, 2013, due to a re-basing of revenue risk adjusters.

Texas. Financial performance improved at the Texas health plan in 2013, when compared with 2012. The medical care ratio of the Texas health plan decreased to 86.4% in 2013, from 93.7% in 2012, primarily due to rate increases received on September 1, 2013 and 2012, respectively.

Utah. Financial performance deteriorated at the Utah health plan in 2013, when compared with 2012. Reductions to the medical portion of the Medicaid premium, and the addition of the pharmacy benefit to our Medicaid premium, both effective January 1, 2013, more than offset stable medical costs. The medical care ratio of the Utah health plan increased to 83.4% in 2013, from 82.3% in 2012.

Washington. The medical care ratio of the Washington health plan increased to 88.0% in 2013, compared with 86.8% in 2012, due to the addition of ABD members effective July 1, 2012 and lower TANF premium rates. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio, so that medical margin increased to $140.2 million in 2013, from $129.0 million in 2012.

Wisconsin. Financial performance improved at the Wisconsin health plan in 2013, when compared with 2012. The medical care ratio of the Wisconsin health plan decreased to 79.7% in 2013, compared with 96.2% in 2012, due to both higher revenue PMPM and lower fee-for-service physician, specialty and outpatient costs PMPM. Additionally, the health plan gained approximately 50,000 members in the first half of 2013 due to another health plan's exit from the market.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2013						
	Member Months (2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,233	$ 749,755	$ 177.10	$ 666,592	$ 157.46	88.9%	$ 83,163
Florida	973	264,998	272.23	231,261	237.57	87.3	33,737
Illinois	7	8,121	1,201.34	7,869	1,164.10	96.9	252
Michigan	2,581	676,000	261.91	570,644	221.09	84.4	105,356
New Mexico	1,492	446,758	299.36	384,466	257.62	86.1	62,292
Ohio	3,007	1,098,795	365.44	924,675	307.53	84.2	174,120
Texas	3,178	1,291,001	406.27	1,114,852	350.84	86.4	176,149
Utah	1,040	310,895	299.05	259,397	249.51	83.4	51,498
Washington	4,941	1,168,405	236.47	1,028,210	208.10	88.0	140,195
Wisconsin	1,060	143,465	135.40	114,340	107.91	79.7	29,125
Other(4)	—	20,977	—	77,818	—	—	(56,841)
	22,512	$ 6,179,170	$ 274.48	$ 5,380,124	$ 238.99	87.1%	$ 799,046

	Year Ended December 31, 2012						
	Member Months (2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,177	$ 665,600	$ 159.36	$ 606,494	$ 145.20	91.1%	$ 59,106
Florida	850	228,832	269.36	195,226	229.80	85.3	33,606
Illinois	—	—	—	—	—	—	—
Michigan	2,639	646,551	244.97	570,636	216.20	88.3	75,915
New Mexico	1,069	321,853	301.08	280,108	262.03	87.0	41,745
Ohio	3,065	1,095,137	357.36	970,504	316.69	88.6	124,633
Texas	3,245	1,233,621	380.18	1,155,433	356.08	93.7	78,188
Utah	1,026	298,392	290.78	245,671	239.41	82.3	52,721
Washington	4,600	974,712	211.91	845,733	183.87	86.8	128,979
Wisconsin	508	70,678	139.25	67,968	133.91	96.2	2,710
Other(4)	—	8,745	—	53,415	—	—	(44,670)
	21,179	$ 5,544,121	$ 261.79	$ 4,991,188	$ 235.68	90.0%	$ 552,933

(1) Premium revenue for our former Missouri health plan was $0.2 million and $114.4 million for the years ended December 31, 2013 and 2012, respectively. Medical care costs for the plan were $1.5 million and $105.6 million for the years ended December 31, 2013 and 2012, respectively. These amounts are excluded from the tables above because the results of this health plan are classified as discontinued operations.
(2) A member month is defined as the aggregate of each month's ending membership for the period presented.
(3) "MCR" represents medical costs as a percentage of premium revenue.
(4) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$ 207,449	$ 189,281
Amortization recorded as reduction of service revenue	(2,914)	(1,571)
Service revenue	204,535	187,710
Cost of service revenue	161,494	141,208
General and administrative costs	5,285	17,648
Amortization of customer relationship intangibles	5,127	5,127
Operating income	$ 32,629	$ 23,727

Operating income for our Molina Medicaid Solutions segment increased $8.9 million for the year ended December 31, 2013, compared with 2012. The increase in operating income was primarily the result of additional sales in existing markets, and the favorable resolution of certain contingencies related to the Maine contract.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 10.1% of revenue in 2013, from 8.8% in 2012, primarily due to higher costs incurred as we prepared for significant membership growth anticipated in 2014. Increased administrative expenses related to anticipated membership growth represented approximately 2% of premium revenue, or $135 million during 2013.

Premium Tax Expense

Premium tax expense was consistent year over year.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Year Ended December 31,			
	2013		2012	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 54,837	0.8%	$ 42,938	0.7%
Amortization of intangible assets, continuing operations	17,906	0.3	20,176	0.3
Depreciation and amortization, continuing operations	72,743	1.1	63,114	1.0
Depreciation and amortization, discontinued operations	2	—	590	—
Amortization recorded as reduction of service revenue	2,914	—	1,571	—
Amortization of capitalized software recorded as cost of service revenue	18,207	0.3	13,489	0.2
	$ 93,866	1.4%	$ 78,764	1.2%

Interest Expense

Interest expense was $52.1 million for the year ended December 31, 2013, compared with $16.8 million for the year ended December 31, 2012. Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $22.8 million and $5.9 million for the years ended December 31, 2013 and 2012, respectively. The increase in interest expense for the year ended December 31, 2013, was primarily due to our issuance of $550.0 million aggregate principal amount 1.125% cash convertible senior notes due 2020 (the 1.125% Notes) in the first quarter of 2013. Interest expense in 2013 also included the immediate recognition of approximately $6 million in debt issuance costs associated with this transaction. The remaining fees associated with that issuance, amounting to approximately $12 million, are being amortized over the life of the 1.125% Notes. For the year ended December 31, 2013, interest expense also includes amounts relating to lease financing transactions executed in the second quarter of 2013.

Other Expenses, Net

Other expenses, net increased to $3.3 million for the year ended December 31, 2013, from $0.9 million for the year ended December 31, 2012. Other expenses, net include primarily gains or losses associated with changes in the fair value of our derivative financial instruments. In the second quarter of 2013 we recorded a one-time non-cash charge of $3.9 million related to the change in fair value of warrants issued in connection with the 1.125% Notes. We settled the interest rate swap in the second quarter of 2013, which resulted in a gain of $0.4 million, partially offsetting the $3.9 million charge described above. Other expenses, net was $0.9 million for the year ended December 31, 2012, primarily due to the change in fair value of the interest rate swap.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 44.8% for the year ended December 31, 2013, compared with 45.0% for the year ended December 31, 2012.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2014, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased to $8.1 million for the year ended December 31, 2014, compared with $6.9 million for the year ended December 31, 2013, primarily due to the increase in invested assets. Our annualized portfolio yields for the years ended December 31, 2014 and 2013 were 0.4% and for 2012 was 0.5%.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use. We did not receive any dividends from our health plan subsidiaries during the year ended December 31, 2014, because significant growth across all of our health plans necessitated that the plans retain their capital for operations. See further discussion in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 20, "Commitments and Contingencies," under the subheading

"Regulatory Capital and Dividend Restrictions," and Note 23, "Condensed Financial Information of Registrant," under "Note C - Dividends and Capital Contributions."

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Year Ended December 31,		
	2014	2013	Change
	(In thousands)		
Net cash provided by operating activities	$ 1,060,257	$ 190,083	$ 870,174
Net cash used in investing activities	(535,729)	(543,311)	7,582
Net cash provided by financing activities	78,640	493,353	(414,713)
Net increase in cash and cash equivalents	$ 603,168	$ 140,125	$ 463,043

	Year Ended December 31,		
	2013	2012	Change
	(In thousands)		
Net cash provided by operating activities	$ 190,083	$ 347,784	$ (157,701)
Net cash used in investing activities	(543,311)	(93,584)	(449,727)
Net cash provided by financing activities	493,353	47,743	445,610
Net increase in cash and cash equivalents	$ 140,125	$ 301,943	$ (161,818)

*Operating Activities***.** Cash provided by operating activities was $1,060.3 million in 2014 compared with $190.1 million in 2013, an increase of $870.2 million. This increase was due primarily to the following:

- $441.8 million increase in amounts due to government agencies, due to a significant increase in amounts accrued for medical cost floor contract provisions primarily associated with our Medicaid expansion membership; and
- $355.5 million increase in medical claims and benefits payable due to significant membership growth in 2014.

In 2013, cash provided by operating activities was $190.1 million compared with $347.8 million for 2012, a decrease of $157.7 million. In 2013, deferred revenue was a use of cash from operations amounting to $19.6 million, compared with a source of cash amounting to $90.9 million in 2012. This was primarily due to an advance premium payment received by our Washington health plan in December 2012, with no comparable advance premium receipts in December 2013.

Investing Activities. Cash used in investing activities decreased to $535.7 million in 2014, compared with $543.3 million in 2013. This $7.6 million decline in cash used was primarily due to lower purchases of investments, net of sales and maturities, compared with 2013. As described below, there was greater investment activity in 2013 associated with significant debt financing transactions.

In 2013, cash used in investing activities was $543.3 million compared with $93.6 million in 2012. This $449.7 million increase was primarily due to greater purchases of investments in 2013, as a result of the cash generated in financing activities, described below. In addition to increased purchases of investments, we paid $61.5 million in connection with business combinations in 2013, with no comparable activity in 2012.

Financing Activities. Cash provided by financing activities was $78.6 million in 2014 compared with $493.4 million in 2013, a decrease of $414.7 million. Cash provided by financing activities in 2014 included primarily $122.6 million net proceeds from our fiscal 2014 offering of 1.625% Notes, partially offset by $50.3 million paid in the settlement of contingent consideration liabilities associated with our 2013 business combinations. Cash provided by financing activities in 2014 was significantly outpaced by debt financing activities in 2013, as described below.

In 2013, cash provided by financing activities was $493.4 million compared with $47.7 million in 2012, an increase of $445.6 million. The increase in cash provided by financing activities was primarily due to 2013 activity including $538.0 million in proceeds received from our offering of 1.125% Notes, $158.7 million received from sale-leaseback transactions, and $75.1 million from the sale of warrants, partially offset by $149.3 million paid for the purchased call option relating to 1.125% Notes, $52.7 million paid for repurchases of our common stock, $47.5 million used to repay our term loan, and $40.0 million used to repay our credit facility. Our credit facility was terminated in early 2013 when the balance was repaid.

Financial Condition

On a consolidated basis, at December 31, 2014, our working capital was $1,070.6 million compared with $745.7 million at December 31, 2013. At December 31, 2014, our cash and investments amounted to $2,665.9 million, compared with $1,712.9 million of cash and investments at December 31, 2013.

Health Insurer Fee. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. Additionally, when states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231 million.

Our 2014 HIF assessment amounted to $88.6 million, which was paid in September 2014. As indicated in the table below, it was necessary for the states to pay us an incremental amount of approximately $131 million during 2014 to account for the HIF and the absence of its deductibility.

The state of California has not formally committed to reimburse us for either the HIF itself, or the related tax effects. The states of Michigan and Utah have reimbursed us for the HIF, but have not formally committed to reimbursement for the related tax effect. The total amount of HIF revenue for which agreements were not secured (and revenue was not recognized) amounted to approximately $20 million for fiscal 2014. We expect to collect and recognize this revenue related to 2014 in 2015. We further expect to recognize revenue in 2015 sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2015.

We continue to work with our state partners to obtain reimbursement for the full economic impact of the excise tax. The failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows or results of operations.

The following table provides the details of our HIF revenue reimbursement by health plan to date in 2014 (in thousands):

	HIF Reimbursement Recognized					Required HIF Reimbursement through Dec. 31, 2014
	Three Months Ended				Year Ended Dec. 31, 2014	
	March 31, 2014	June 30, 2014	Sept. 30, 2014	Dec. 31, 2014		
	Gross (1)					
California	$ —	$ —	$ —	$ —	$ —	$ 11,616
Florida	1,416	1,473	1,487	1,459	5,835	5,835
Illinois	40	42	40	40	162	162
Michigan	—	—	8,011	2,663	10,674	17,471
New Mexico	—	—	—	11,322	11,322	11,322
Ohio	7,791	8,117	6,912	7,606	30,426	30,426
Texas	—	—	—	18,518	18,518	18,518
Utah	—	—	3,000	1,049	4,049	5,332
Washington	6,229	6,489	6,217	6,311	25,246	25,246
Wisconsin	1,080	1,126	1,372	1,193	4,771	4,771
Medicaid	16,556	17,247	27,039	50,161	111,003	130,699
Medicare	2,892	3,199	3,068	3,053	12,212	12,212
	$ 19,448	$ 20,446	$ 30,107	$ 53,214	$ 123,215	$ 142,911
Recognized in:						
Health insurer fee revenue	$ 18,696	$ 19,662	$ 29,427	$ 51,699	$ 119,484	
Premium tax revenue	752	784	680	1,515	3,731	
	$ 19,448	$ 20,446	$ 30,107	$ 53,214	$ 123,215	

(1) Amounts in the table include the full economic impact of the excise tax including premium tax and the income tax effect.

Regulatory Capital and Dividend Restrictions

For a comprehensive discussion of our regulatory capital requirements and dividend restrictions, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20 "Commitments and Contingencies."

Future Sources and Uses of Liquidity

For a comprehensive discussion of our debt instruments, including our convertible senior notes transactions in 2014 and 2013, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12 "Long-Term Debt."

For a discussion of our shelf registration statement, and our securities repurchase programs through December 31, 2014, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 15, "Stockholders' Equity."

Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This newly authorized repurchase program extends through December 31, 2015.

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable* (see discussion below).
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- *Health Plans segment quality incentives.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- *Molina Medicaid Solutions segment revenue and cost recognition.* For a comprehensive discussion of this topic, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	December 31,		
	2014	2013	2012
	(In thousands)		
Fee-for-service claims incurred but not paid (IBNP)	$ 870,429	$ 424,173	$ 377,614
Pharmacy payable	71,412	45,037	38,992
Capitation payable	28,150	20,267	49,066
Other (1)	230,531	180,310	28,858
	$ 1,200,522	$ 669,787	$ 494,530

(1) "Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. As of December 31, 2014 and 2013, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $119.3 million and $151.3 million, respectively.

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated

liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $870.4 million of our total medical claims and benefits payable of $1,200.5 million as of December 31, 2014. Excluding amounts that we anticipate paying on behalf of certain capitated providers in Ohio (which we will subsequently withhold from those providers' monthly capitation payments), our IBNP liability at December 31, 2014, was $861.8 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse claims deviation, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2014 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2014, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 223,129
(4)%	148,753
(2)%	74,376
2%	(74,376)
4%	(148,753)
6%	(223,129)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2014 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (135,631)
(4)%	(90,421)
(2)%	(45,210)
2%	45,210
4%	90,421
6%	135,631

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 48.3 million diluted shares outstanding for the year ended December 31, 2014. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2014, net income for the year ended December 31, 2014 would increase or decrease by approximately $23 million, or $0.48 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2014, net income for the year ended December 31, 2014 would increase or decrease by approximately $14 million, or $0.29 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $117 million, or $2.42 per diluted share, and $71 million, or $1.47 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $23 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse deviation in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims deviation. The provision for adverse claims deviation is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims deviation.

We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date.

The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended

PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for additional information regarding the specific factors used to determine our changes in estimates of IBNP for all periods presented in the accompanying consolidated financial statements.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year ended December 31,		
	2014	2013	2012
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of period	$ 669,787	$ 494,530	$ 402,476
Components of medical care costs related to:			
Current period	8,122,885	5,434,443	5,136,055
Prior periods	(45,979)	(52,779)	(39,295)
Total medical care costs	8,076,906	5,381,664	5,096,760
Change in non-risk provider payables	(31,973)	111,267	(7,004)
Payments for medical care costs related to:			
Current period	7,064,427	4,932,195	4,689,395
Prior periods	449,771	385,479	308,307
Total paid	7,514,198	5,317,674	4,997,702
Balances at end of period	$ 1,200,522	$ 669,787	$ 494,530
Benefit from prior periods as a percentage of:			
Balance at beginning of period	6.9%	10.7%	9.8%
Premium revenue	0.5%	0.9%	0.7%
Medical care costs	0.6%	1.0%	0.8%
Claims Data:			
Days in claims payable, fee for service	49	43	40
Number of members at end of period	2,623,000	1,931,000	1,797,000
Number of claims in inventory at end of period	307,700	145,800	122,700
Billed charges of claims in inventory at end of period	$ 718,500	$ 276,500	$ 255,200
Claims in inventory per member at end of period	0.12	0.08	0.07
Billed charges of claims in inventory per member end of period	$ 273.92	$ 143.19	$ 142.01
Number of claims received during the period	27,597,000	21,317,500	20,842,400
Billed charges of claims received during the period	$ 30,315,600	$ 21,414,600	$ 19,429,300

Commitments and Contingencies

We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20 ,"Commitments and Contingencies."

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2014.[1] Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2015	2016-2017	2018-2019	2020 and Beyond
Medical claims and benefits payable	$ 1,200,522	$ 1,200,522	$ —	$ —	$ —
Principal amount of convertible senior notes (2)	851,551	—	—	—	851,551
Amounts due government agencies	527,193	527,193	—	—	—
Lease financing obligations	380,956	11,397	23,830	25,282	320,447
Interest on long-term debt	176,405	11,088	22,176	22,175	120,966
Operating leases	122,035	29,142	44,591	33,073	15,229
Lease financing obligations - related party	102,394	5,346	11,243	12,021	73,784
Purchase commitments	26,029	14,232	11,797	—	—
	$ 3,387,085	$ 1,798,920	$ 113,637	$ 92,551	$ 1,381,977

(1) As of December 31, 2014, we have recorded approximately $2.6 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 14, "Income Taxes."

(2) Represents the principal amounts due on our 1.125% Cash Convertible Senior Notes due 2020, and our 1.625% Convertible Senior Notes due 2044 (1.625% Notes). The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Long-Term Debt."

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Quantitative and Qualitative Disclosures About Market Risk

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 8. Financial Statements and Supplementary Data

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2014 and 2013, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2014. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2014 and 2013, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2014, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 26, 2015 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2015

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2014	2013
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,539,063	$ 935,895
Investments	1,019,462	703,052
Receivables	596,456	298,935
Income tax refundable	—	32,742
Deferred income taxes	39,532	26,556
Prepaid expenses and other current assets	50,884	42,484
Total current assets	3,245,397	2,039,664
Property, equipment, and capitalized software, net	340,778	292,083
Deferred contract costs	53,675	45,675
Intangible assets, net	89,273	98,871
Goodwill	271,964	230,738
Restricted investments	102,479	63,093
Derivative asset	329,323	186,351
Other assets	44,326	46,462
	$ 4,477,215	$ 3,002,937
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,200,522	$ 669,787
Accounts payable and accrued liabilities	241,654	263,043
Amounts due government agencies	527,193	56,922
Deferred revenue	196,076	122,216
Income taxes payable	8,987	—
Current maturities of long-term debt	341	182,008
Total current liabilities	2,174,773	1,293,976
Convertible senior notes	704,097	416,368
Lease financing obligations	160,710	159,394
Lease financing obligations - related party	40,241	27,092
Deferred income taxes	24,271	580
Derivative liability	329,194	186,239
Other long-term liabilities	33,487	26,351
Total liabilities	3,466,773	2,110,000
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 49,727 shares at December 31, 2014 and 45,871 shares at December 31, 2013	50	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	396,059	340,848
Accumulated other comprehensive loss	(1,019)	(1,086)
Retained earnings	615,352	553,129
Total stockholders' equity	1,010,442	892,937
	$ 4,477,215	$ 3,002,937

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2014	2013	2012
	(In thousands, except per-share data)		
Revenue:			
Premium revenue	$ 9,022,511	$ 6,179,170	$ 5,544,121
Service revenue	210,051	204,535	187,710
Premium tax revenue	294,388	172,017	158,991
Health insurer fee revenue	119,484	—	—
Investment income	8,093	6,890	5,075
Other revenue	12,074	26,322	18,312
Total revenue	9,666,601	6,588,934	5,914,209
Operating expenses:			
Medical care costs	8,076,331	5,380,124	4,991,188
Cost of service revenue	156,764	161,494	141,208
General and administrative expenses	764,693	665,996	518,615
Premium tax expenses	294,388	172,017	158,991
Health insurer fee expenses	88,591	—	—
Depreciation and amortization	92,917	72,743	63,114
Total operating expenses	9,473,684	6,452,374	5,873,116
Operating income	192,917	136,560	41,093
Other expenses, net:			
Interest expense	56,811	52,071	16,769
Other expense, net	802	3,343	945
Total other expenses, net	57,613	55,414	17,714
Income from continuing operations before income tax expense	135,304	81,146	23,379
Income tax expense	72,726	36,316	10,513
Income from continuing operations	62,578	44,830	12,866
(Loss) income from discontinued operations, net of tax (benefit) expense of $(203), $(9,912), and $(1,238), respectively	(355)	8,099	(3,076)
Net income	$ 62,223	$ 52,929	$ 9,790
Basic net income per share:			
Income from continuing operations	$ 1.34	$ 0.98	$ 0.28
(Loss) income from discontinued operations	(0.01)	0.18	(0.07)
Basic net income per share	$ 1.33	$ 1.16	$ 0.21
Diluted net income per share:			
Income from continuing operations	$ 1.30	$ 0.96	$ 0.27
(Loss) income from discontinued operations	(0.01)	0.17	(0.06)
Diluted net income per share	$ 1.29	$ 1.13	$ 0.21
Weighted average shares outstanding:			
Basic	46,935	45,717	46,380
Diluted	48,340	46,862	46,999

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Net income	$ 62,223	$ 52,929	$ 9,790
Other comprehensive income (loss):			
Unrealized investment gain (loss)	108	(1,015)	1,529
Effect of income tax expense (benefit)	41	(386)	581
Other comprehensive income (loss), net of tax	67	(629)	948
Comprehensive income	$ 62,290	$ 52,300	$ 10,738

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
				(In thousands)			
Balance at January 1, 2012	45,815	$ 46	$ 266,022	$ (1,405)	$ 490,410	$ —	$ 755,073
Net income	—	—	—	—	9,790	—	9,790
Other comprehensive income, net	—	—	—	948	—	—	948
Purchase of treasury stock	(111)	—	—	—	—	(3,000)	(3,000)
Share-based compensation	1,058	1	16,361	—	—	—	16,362
Tax benefit from share-based compensation	—	—	3,141	—	—	—	3,141
Balance at December 31, 2012	46,762	47	285,524	(457)	500,200	(3,000)	782,314
Net income	—	—	—	—	52,929	—	52,929
Other comprehensive loss, net	—	—	—	(629)	—	—	(629)
Purchase of treasury stock	(1,710)	(2)	—	—	—	(52,660)	(52,662)
Retirement of treasury stock	—	—	(55,660)	—	—	55,660	—
Issuance of warrants	—	—	78,997	—	—	—	78,997
Share-based compensation	819	1	30,385	—	—	—	30,386
Tax benefit from share-based compensation	—	—	1,602	—	—	—	1,602
Balance at December 31, 2013	45,871	46	340,848	(1,086)	553,129	—	892,937
Net income	—	—	—	—	62,223	—	62,223
Other comprehensive income, net	—	—	—	67	—	—	67
Convertible senior notes transactions, including issuance costs	1,787	2	21,961	—	—	—	21,963
Share-based compensation	2,069	2	30,261	—	—	—	30,263
Tax benefit from share-based compensation	—	—	2,989	—	—	—	2,989
Balance at December 31, 2014	49,727	$ 50	$ 396,059	$ (1,019)	$ 615,352	$ —	$ 1,010,442

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Operating activities:			
Net income	$ 62,223	$ 52,929	$ 9,790
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	134,404	93,866	78,764
Deferred income taxes	(2,352)	(31,047)	(9,887)
Share-based compensation	21,727	28,694	20,018
Amortization of convertible senior notes and lease financing obligations	27,379	22,820	5,942
Gain on sale of subsidiary	—	—	(1,747)
Other, net	6,222	17,729	11,224
Changes in operating assets and liabilities:			
Receivables	(297,521)	(149,253)	18,216
Prepaid expenses and other current assets	(19,517)	(23,064)	(8,958)
Medical claims and benefits payable	530,735	175,257	92,054
Accounts payable and accrued liabilities	11,097	32,550	8,078
Amounts due government agencies	470,271	28,446	15,267
Deferred revenue	73,860	(19,582)	90,851
Income taxes	41,729	(39,262)	18,172
Net cash provided by operating activities	1,060,257	190,083	347,784
Investing activities:			
Purchases of investments	(953,355)	(770,083)	(306,437)
Proceeds from sales and maturities of investments	632,800	399,595	298,006
Purchases of equipment	(114,934)	(98,049)	(78,145)
Net cash paid in business combinations	(44,133)	(61,521)	—
Increase in restricted investments	(33,661)	(18,992)	(2,647)
Proceeds from sale of subsidiary, net of cash surrendered	—	—	9,162
Other, net	(22,446)	5,739	(13,523)
Net cash used in investing activities	(535,729)	(543,311)	(93,584)
Financing activities:			
Proceeds from issuance of convertible senior notes, net of financing costs paid	122,625	537,973	—
Proceeds from sale-leaseback transactions	—	158,694	—
Purchase of call option	—	(149,331)	—
Proceeds from issuance of warrants	—	75,074	—
Contingent consideration liabilities settled	(50,349)	—	—
Treasury stock purchases	—	(52,662)	(3,000)
Principal payments on term loan	—	(47,471)	(1,129)
Repayment of amount borrowed under credit facility	—	(40,000)	(20,000)
Proceeds from employee stock plans	14,040	9,402	8,205
Principal payments on convertible senior notes	(10,449)	—	—
Amount borrowed under credit facility	—	—	60,000
Other, net	2,773	1,674	3,667
Net cash provided by financing activities	78,640	493,353	47,743
Net increase in cash and cash equivalents	603,168	140,125	301,943
Cash and cash equivalents at beginning of period	935,895	795,770	493,827
Cash and cash equivalents at end of period	$ 1,539,063	$ 935,895	$ 795,770

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(continued)

	Year Ended December 31,		
	2014	2013	2012
	(Amounts in thousands)		
	(Unaudited)		
Supplemental cash flow information:			
Cash paid (received) during the period for:			
Income taxes	$ 30,413	$ 95,240	$ (4,634)
Interest	$ 29,178	$ 34,881	$ 10,099
Schedule of non-cash investing and financing activities:			
3.75% Notes exchanged for 1.625% Notes	$ 176,551	$ —	$ —
Retirement of treasury stock	$ —	$ 55,660	$ —
Increase in non-cash lease financing obligation - related party	$ 13,841	$ 27,211	$ —
Common stock used for stock-based compensation	$ (8,802)	$ (7,711)	$ (11,862)
Details of business combinations:			
Fair value of assets acquired	$ (52,057)	$ (121,801)	$ —
Fair value of contingent consideration liabilities incurred	—	59,948	—
Payable to seller	7,924	—	—
Escrow deposit	—	332	—
Net cash paid in business combinations	$ (44,133)	$ (61,521)	$ —
Details of change in fair value of derivatives, net:			
Gain on 1.125% Call Option	$ 142,972	$ 37,020	$ —
Loss on 1.125% Notes Conversion Option	(142,955)	(36,908)	—
Loss on 1.125% Warrants	—	(3,923)	—
Gain (loss) on interest rate swap	—	433	(1,307)
Change in fair value of derivatives, net	$ 17	$ (3,378)	$ (1,307)
Details of sale of subsidiary:			
Decrease in carrying value of assets	$ —	$ —	$ 30,942
Decrease in carrying value of liabilities	—	—	(23,527)
Gain on sale	—	—	1,747
Proceeds from sale of subsidiary, net of cash surrendered	$ —	$ —	$ 9,162

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of December 31, 2014, these health plans served over 2.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplace members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Market Updates—Health Plans Segment

Florida. During 2014, our Florida health plan acquired two Medicaid contracts, adding approximately 73,000 members. See Note 4, "Business Combinations," for further information.

Puerto Rico. In 2014, we were awarded a managed care contract in the Commonwealth of Puerto Rico that is expected to enroll its first members April 1, 2015.

South Carolina. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

Market Update—Molina Medicaid Solutions Segment

In 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid management information system (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana canceled its contract award to CNSI. The state had informed us that we will continue to perform under our current contract until a successor is named. On December 18, 2014, Molina Medicaid Solutions received notice from the state of Louisiana that they have extended our contract through December 31, 2015. We recognized approximately $41 million of service revenue under this contract in 2014.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 19, "Variable Interest Entities," for more information regarding these variable interest entities. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

Presentation and Reclassifications

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we reported the results relating to the Missouri health plan as discontinued operations for all periods presented. Additionally, we abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the

recognition of a tax benefit of $9.5 million, which is also included in discontinued operations in the consolidated statements of income. The Missouri health plan's premium revenues were insignificant in 2014 and 2013, and amounted to $114.4 million for the year ended December 31, 2012.

We have reclassified certain amounts in the 2013 consolidated balance sheet, and 2013 and 2012 statements of cash flows to conform to the 2014 presentation, including the presentation of amounts due government agencies as a separate line item in the consolidated balance sheets and statements of cash flows.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- Health plan contractual provisions that may limit revenue recognition based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The determination of medical claims and benefits payable of our Health Plans segment;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis.

Our investment policy requires that all of our investments have final maturities of 10 years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be three years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. Our auction rate securities are classified as non-current assets and reported in other assets. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," Note 6, "Investments," and Note 10, "Restricted Investments."

Receivables

Receivables are readily determinable and because our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables."

Property, Equipment, and Capitalized Software

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years. See Note 8, "Property, Equipment, and Capitalized Software."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of service revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Depreciation, and amortization of capitalized software, continuing operations	$ 75,402	$ 54,837	$ 42,938
Amortization of intangible assets, continuing operations	17,515	17,906	20,176
Depreciation and amortization, continuing operations	92,917	72,743	63,114
Depreciation and amortization, discontinued operations	—	2	590
Amortization recorded as reduction of service revenue	2,914	2,914	1,571
Amortization of capitalized software recorded as cost of service revenue	38,573	18,207	13,489
Depreciation and amortization reported in the statement of cash flows	$ 134,404	$ 93,866	$ 78,764

Long-Lived Assets, including Intangible Assets

Long-lived assets comprise primarily property, equipment, capitalized software and intangible assets. Finite-lived, separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at their fair values and are then amortized on a straight-line basis over their expected useful lives, generally between three and 15 years.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships as follows:

- The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to acquisition. Because each acquired contract constitutes a single revenue stream, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a

straight-line basis for each specific contract over periods generally ranging from one to six years. The contract backlog intangible assets will be fully amortized in 2015.

- The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2014, 2013, and 2012.

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount.

To determine whether goodwill is impaired, we measure the fair values of our reporting units and compare them to the carrying values of the respective units, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows. To determine fair values, we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

No impairment charges relating to goodwill were recorded in the years ended December 31, 2014, 2013, and 2012.

Restricted Investments

Restricted investments, which consist of certificates of deposit and U.S. treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Other Assets

Other assets primarily includes deferred financing costs associated with our convertible senior notes and lease financing obligations, and certain investments held in connection with our employee deferred compensation program. The deferred financing costs are being amortized on a straight-line basis over the terms of the convertible senior notes and lease financing obligations.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2014 and 2013.

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2014, we received more than 95% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. Revenue not received on a fixed PMPM basis is recognized as earned. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue from continuing operations for the periods indicated:

	Year Ended December 31,					
	2014		2013		2012	
	Amount	% of Total	Amount	% of Total	Amount	% of Total
	(Dollars in thousands)					
California	$ 1,523,084	16.9%	$ 749,755	12.1%	$ 665,600	12.0%
Florida	439,107	4.9	264,998	4.3	228,832	4.1
Illinois	153,271	1.7	8,121	0.1	—	—
Michigan	780,896	8.7	676,000	11.0	646,551	11.7
New Mexico	1,075,330	11.9	446,758	7.2	321,853	5.8
Ohio	1,552,949	17.2	1,098,795	17.8	1,095,137	19.7
South Carolina	381,317	4.2	—	—	—	—
Texas	1,318,192	14.6	1,291,001	20.9	1,233,621	22.2
Utah	309,411	3.4	310,895	5.0	298,392	5.4
Washington	1,304,605	14.5	1,168,405	18.9	974,712	17.6
Wisconsin	156,229	1.7	143,465	2.3	70,678	1.3
Direct delivery	28,120	0.3	20,977	0.4	8,745	0.2
	$ 9,022,511	100.0%	$ 6,179,170	100.0%	$ 5,544,121	100.0%

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Health Plan Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $392.4 million and $1.4 million at December 31, 2014, and December 31, 2013, respectively, to amounts due government agencies. Such liability amounts could be subject to future changes in estimate. The increase is primarily driven by contractual provisions relating to the Medicaid expansion program, which began to phase in during January 2014. Beginning in 2014, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined

maximum threshold. Separately, in certain states we may be levied with non-monetary sanctions if certain minimum amounts are not spent on defined medical care costs, or if administrative costs exceed certain amounts.

Health Plan Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to fully retain, we recorded a liability of $0.5 million and $2.5 million at December 31, 2014 and December 31, 2013, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of $7.6 million and $20.8 million for anticipated Medicare risk adjustment premiums at December 31, 2014 and December 31, 2013, respectively.

Quality Incentives

At our California, Illinois, New Mexico, Ohio, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2014 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2014.

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Maximum available quality incentive premium - current period	$ 90,327	$ 63,311	$ 74,564
Amount of quality incentive premium revenue recognized in current period:			
Earned current period	$ 40,396	$ 45,803	$ 62,489
Earned prior periods	3,950	9,056	2,202
Total	$ 44,346	$ 54,859	$ 64,691
Total premium revenue recognized for state health plans with quality incentive premiums	$ 7,083,660	$ 2,980,019	$ 2,721,289

California Health Plan Rate Settlement Agreement

In the fourth quarter of 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, a settlement account (the Account) applicable to the California health plan's managed care contracts has been established.

Effective January 1, 2014, the Account was established with an initial balance of zero, and will be settled after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our managed care contracts. The Account will be adjusted annually to reflect a calendar year deficit or surplus, which is determined by comparing the California health plan's pre-tax margin and a target margin established in the settlement agreement. Upon expiration of the settlement agreement, if the Account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. If the Account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40.0 million.

We estimate and recognize the retrospective adjustments to premium revenue based on our experience to date under the California health plan's managed care contracts. As of December 31, 2014, the California health plan's pre-tax margin exceeded the target margin, resulting in a surplus position. Consequently, a retrospective premium adjustment was not required for the year ended December 31, 2014.

Medical Care Costs

Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.
- *Pharmacy expenses:* All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Capitation expenses:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.
- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2014, 2013, and 2012, medically related administrative costs were $262.6 million, $153.0 million, and $125.2 million, respectively.

The following table provides the details of our consolidated medical care costs from continuing operations for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2014			2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 5,672,483	$ 202.87	70.2%	$ 3,611,529	$ 160.43	67.1%	$ 3,423,751	$ 161.67	68.6%
Pharmacy	1,273,329	45.54	15.8	935,204	41.54	17.4	835,830	39.47	16.7
Capitation	748,388	26.77	9.3	603,938	26.83	11.2	552,136	26.07	11.1
Direct delivery	96,196	3.44	1.2	48,288	2.14	0.9	33,920	1.60	0.7
Other	285,935	10.22	3.5	181,165	8.05	3.4	145,551	6.87	2.9
Total	$ 8,076,331	$ 288.84	100.0%	$ 5,380,124	$ 238.99	100.0%	$ 4,991,188	$ 235.68	100.0%

The Missouri health plan's medical care costs, which are not included in the table above, amounted to $0.6 million, $1.5 million, and $105.6 million for the years ended December 31, 2014, 2013, and 2012, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP claims reserve, as reported in our

balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. For further information, see Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Health Insurer Fee. The federal government under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA) imposes an annual fee, or excise tax, on health insurers for each calendar year. The health insurer fee (HIF) is based on a company's share of the industry's net premiums written during the preceding calendar year, and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Because we primarily serve individuals in government-sponsored programs, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment from a state to reimburse us for the HIF; such HIF revenue is recognized ratably throughout the year.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expense in the consolidated statements of income.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2014, or 2013.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element, and are therefore multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. If the deliverable has standalone value, the arrangement’s consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and

- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. Therefore, absent any contingencies as discussed in the following paragraph, or contract extensions, we would recognize all revenue associated with those contracts over the initial contract period. When a contract is extended, we generally consider the extension to be a continuation of the single unit of accounting; therefore, the deferred revenue as of the extension date is recognized prospectively over the new remaining term of the contract. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances, we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts, for example. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;
- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible HIF expenses, nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the mathematical impact of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers. For further discussion and disclosure, see Note 14, "Income Taxes."

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end

management investment fund. As of December 31, 2014, and 2013, our investments with PFM amounted to approximately $321 million and $374 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of 10 years and an average duration of three years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans in 11 states, primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements

Health Insurer Fee. In the first quarter of 2014, we adopted the guidance of the Financial Accounting Standards Board (FASB) related to accounting for the fees to be paid by health insurers to the federal government under the ACA, specifically the HIF. The HIF is imposed beginning in 2014, is based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year. Effective January 1, 2014, we recorded our estimate of the 2014 liability to accounts payable and accrued liabilities. During the third quarter of 2014 we paid our 2014 HIF assessment, which amounted to $88.6 million.

Revenue Recognition. In May 2014, the FASB issued Accounting Standards Update (ASU) 2014-09 - *Revenue from Contracts with Customers*, which will supersede nearly all existing revenue recognition guidance under U.S. generally accepted accounting principles (GAAP). The core principal of this ASU is that an entity should recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. This ASU also requires additional disclosure about the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in judgments and assets recognized from costs incurred to obtain or fulfill a contract. This ASU will be effective for us in the first quarter of 2017; early adoption is not permitted. The ASU allows for either full retrospective or modified retrospective adoption. We are evaluating the transition method that will be elected and the potential effects of the adoption of this ASU on our financial statements.

Discontinued Operations. In April 2014, the FASB issued ASU 2014-08 - *Reporting Discontinued Operations and Disclosures of Disposal of Components of an Entity*, which raises the threshold for disposals to qualify as discontinued operations by focusing on strategic shifts that have or will have a major effect on an entity’s operations and financial results. This ASU will be effective for us in the first quarter of 2015, and is applied prospectively. Early adoption is permitted but only for disposals (or classifications as held for sale) that have not been reported in financial statements previously issued or available for issue. We are evaluating the potential effects of the adoption of the ASU on our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants (AICPA), and the Securities and Exchange Commission (SEC), did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	December 31,		
	2014	2013	2012
	(In thousands)		
Shares outstanding at the beginning of the period	45,871	46,762	45,815
Weighted-average number of shares:			
Repurchased	—	(1,445)	(2)
Issued, 3.75% Notes and 3.75% Exchange (1)	566	—	—
Issued, share-based compensation	498	400	567
Denominator for basic net income per share	46,935	45,717	46,380
Effect of dilutive securities:			
Share-based compensation	498	643	619
3.75% Notes and 3.75% Exchange (1)	907	502	—
Denominator for diluted net income per share	48,340	46,862	46,999
Potentially dilutive common shares excluded from calculations (2):			
Stock options	—	51	87
1.125% Warrants	13,490	11,975	—
Restricted shares	—	—	304

(1) For more information regarding the 3.75% Exchange and 3.75% Notes, refer to Note 12, "Long-Term Debt."

(2) Potentially dilutive shares issuable pursuant to certain of our employee stock options, 1.125% Warrants (defined in Note 13, "Derivative Financial Instruments"), and 1.625% Notes (defined in Note 12, "Long-Term Debt") were not included in the computation of diluted net income per share because to do so would have been anti-dilutive.

4. Business Combinations

Health Plans Segment

Florida. In December 2014, our Florida health plan acquired certain assets relating to the Medicaid business of First Coast Advantage, LLC (FCA). As part of the transaction, we assumed FCA's Medicaid contract and certain provider agreements for Region 4 of the Statewide Medicaid Managed Care Managed Medical Assistance Program in the state of Florida. The Florida health plan's membership increased by approximately 62,000 members as a result of this transaction. We estimate that the final purchase price for this acquisition, to be settled in the first quarter of 2015, will be approximately $44.6 million.

In August 2014, our Florida health plan acquired certain assets relating to the Medicaid business of Healthy Palm Beaches, Inc. The final purchase price for this acquisition was $7.5 million. The Florida health plan's membership increased by approximately 11,000 members as a result of this transaction.

In connection with these transactions, we recorded goodwill amounting to $41.2 million, which relates to future economic benefits arising from expected synergies to be achieved. Such synergies include use of our existing infrastructure to support the added membership. The amount recorded as goodwill represents intangible assets that do not qualify for separate recognition as identifiable intangible assets. Goodwill is not amortized, but is subject to an annual impairment test. The entire amount recorded as goodwill is deductible for income tax purposes. We also recorded intangible assets in the following major classes: contract rights and licenses amounting to $5.8 million, and provider networks amounting to $5.0 million. Contract rights and licenses are amortized over a period of five years, and provider networks are amortized over a period of 10 years. The weighted-average amortization period, in the aggregate, is 7.3 years.

South Carolina. In July 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including rights to convert certain of CHS' Medicaid members covered by South Carolina's full-risk Medicaid managed care program. The conversion conditions under the agreement were satisfied by January 1, 2014, and on that date such Medicaid members were converted to the managed care program and enrolled with our South Carolina health plan. The total purchase price for the converted Medicaid membership amounted to $57.2 million, of which $49.7 million was

paid in the first half of 2014, and $7.5 million was paid when the agreement was executed in 2013. The total amount paid included indemnification withhold funds transferred to restricted investments amounting to $5.7 million, which were released to CHS in January 2015.

Because the number of Medicaid members we would ultimately convert was unknown as of the acquisition date in 2013, we recorded a contingent consideration liability for such members to be settled when the final purchase price was known in the second quarter of 2014. In addition, we recorded a contingent consideration liability for dual-eligible members we expect to enroll in our Medicare-Medicaid Plan (MMP) implementation in South Carolina in 2015. The contingent consideration liability is remeasured to fair value at each quarter until the contingency is resolved with fair value adjustments, if any, recorded to operations. As of December 31, 2014, the fair value of the remaining contingent consideration liability for the MMP implementation amounted to $0.5 million. The aggregate contingent consideration liability fair value adjustments for the South Carolina transaction resulted in a gain of $5.2 million in the year ended December 31, 2014.

New Mexico. In August 2013, our New Mexico health plan acquired Lovelace Community Health Plan's contract for the state of New Mexico's Medicaid program. In addition to Lovelace's Medicaid members, we also added membership previously covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace. Effective January 1, 2014, these SCI members were either enrolled in New Mexico's Medicaid program, or eligible to enroll in New Mexico's Marketplace. Because the number of SCI members we would ultimately retain was unknown as of the acquisition date in 2013, we recorded a contingent consideration liability for such members to be settled when the final purchase price was known in the second quarter of 2014. The aggregate contingent consideration liability fair value adjustments for the New Mexico transaction resulted in a gain of $1.5 million in the year ended December 31, 2014.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, other assets, trade accounts payable, medical claims and benefits payable, amounts due government agencies, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities (excluding contingent consideration) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Such investments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Notes Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2014 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 13, "Derivative Financial Instruments," the 1.125% Call Option asset and the 1.125% Notes Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Contingent consideration liability. Such liability relates to our South Carolina health plan acquisition described in Note 4, "Business Combinations," and is recorded in accounts payable and accrued liabilities. We applied a cash flow analysis to determine the fair value of this liability. Significant unobservable inputs primarily related to the purchase price estimate for the projected membership.

Auction rate securities. Auction rate securities are designated as available-for-sale and are reported at fair value in other assets. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides

a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of December 31, 2014.

Our financial instruments measured at fair value on a recurring basis at December 31, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 641,729	$ —	$ 641,729	$ —
Municipal securities	127,045	—	127,045	—
GSEs	122,269	122,269	—	—
U.S. treasury notes	59,543	59,543	—	—
Certificates of deposit	68,876	—	68,876	—
Auction rate securities	4,847	—	—	4,847
1.125% Call Option derivative asset	329,323	—	—	329,323
Total assets measured at fair value on a recurring basis	$ 1,353,632	$ 181,812	$ 837,650	$ 334,170
1.125% Notes Conversion Option derivative liability	$ 329,194	$ —	$ —	$ 329,194
Contingent consideration liability	500	—	—	500
Total liabilities measured at fair value on a recurring basis	$ 329,694	$ —	$ —	$ 329,694

Our financial instruments measured at fair value on a recurring basis at December 31, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 449,772	$ —	$ 449,772	$ —
Municipal securities	113,330	—	113,330	—
GSEs	68,817	68,817	—	—
U.S. treasury notes	37,376	37,376	—	—
Certificates of deposit	33,757	—	33,757	—
Auction rate securities	10,898	—	—	10,898
1.125% Call Option derivative asset	186,351	—	—	186,351
Total assets measured at fair value on a recurring basis	$ 900,301	$ 106,193	$ 596,859	$ 197,249
1.125% Notes Conversion Option derivative liability	$ 186,239	$ —	$ —	$ 186,239
Contingent consideration liabilities	57,548	—	—	57,548
Total liabilities measured at fair value on a recurring basis	$ 243,787	$ —	$ —	$ 243,787

The following table presents activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liabilities
	(In thousands)		
Balance at December 31, 2013	$ 10,898	$ 112	$ (57,548)
Total gains for the period recognized in:			
General and administrative expenses	—	—	6,699
Other expense, net	—	17	—
Other comprehensive income	249	—	—
Settlements	(6,300)	—	50,349
Balance at December 31, 2014	$ 4,847	$ 129	$ (500)

Fair Value Measurements - Disclosure Only

The carrying amounts and estimated fair values of our convertible senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	December 31, 2014				
	Carrying Amount	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 435,330	$ 767,377	$ —	$ 767,377	$ —
1.625% Notes	268,767	337,292	—	337,292	—
	$ 704,097	$ 1,104,669	$ —	$ 1,104,669	$ —

	December 31, 2013				
	Carrying Amount	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 416,368	$ 572,627	$ —	$ 572,627	$ —
3.75% Notes	181,872	219,491	—	219,491	—
	$ 598,240	$ 792,118	$ —	$ 792,118	$ —

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 642,910	$ 201	$ 1,382	$ 641,729
Municipal securities	127,185	129	269	127,045
GSEs	122,317	34	82	122,269
U.S. treasury notes	59,546	30	33	59,543
Certificates of deposit	68,893	1	18	68,876
Subtotal - current investments	1,020,851	395	1,784	1,019,462
Auction rate securities	5,100	—	253	4,847
	$ 1,025,951	$ 395	$ 2,037	$ 1,024,309

	December 31, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 450,162	$ 442	$ 832	$ 449,772
Municipal securities	114,126	119	915	113,330
GSEs	68,898	6	87	68,817
U.S. treasury notes	37,360	44	28	37,376
Certificates of deposit	33,756	2	1	33,757
Subtotal - current investments	704,302	613	1,863	703,052
Auction rate securities	11,400	—	502	10,898
	$ 715,702	$ 613	$ 2,365	$ 713,950

The contractual maturities of our investments as of December 31, 2014 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 448,880	$ 448,732
Due one year through five years	571,971	570,730
Due after ten years	5,100	4,847
	$ 1,025,951	$ 1,024,309

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the year ended December 31, 2014, 2013, and 2012 were insignificant.

For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at December 31, 2014, and 2013, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2014.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 379,034	$ 1,151	265	$ 28,668	$ 231	10
Municipal securities	53,626	168	64	11,075	101	13
GSEs	75,025	69	22	2,986	13	3
U.S. treasury notes	19,199	33	13	—	—	—
Certificates of deposit	12,591	18	52	—	—	—
Auction rate securities	—	—	—	4,847	253	6
	$ 539,475	$ 1,439	416	$ 47,576	$ 598	32

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2013.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Positions	Estimated Fair Value	Unrealized Losses	Total Number of Positions
	(Dollars in thousands)					
Corporate debt securities	$ 210,057	$ 802	91	$ 2,540	$ 30	3
Municipal securities	30,715	398	49	31,091	517	39
GSEs	53,308	87	21	—	—	—
U.S. treasury notes	12,037	28	11	—	—	—
Certificates of deposit	414	1	2	—	—	—
Auction rate securities	—	—	—	10,898	502	15
	$ 306,531	$ 1,316	174	$ 44,529	$ 1,049	57

Auction Rate Securities. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 16 years to 32 years. Considering the insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction rate securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at December 31, 2014. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $77.0 million of these instruments at par value.

For the years ended December 31, 2014, 2013 and 2012, we recorded unrealized gains of $0.2 million, $0.7 million and $1.6 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future impairment is other-than-temporary, we will record a charge to earnings as appropriate.

7. Receivables

Receivables consist primarily of amounts due from the various states in which we operate, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are state governments, our allowance for doubtful accounts is immaterial. Accounts receivable increased as of December 31, 2014, primarily due to significant enrollment growth in 2014.

	December 31,	
	2014	2013
	(In thousands)	
California	$ 310,938	$ 148,654
Florida	2,141	2,901
Illinois	31,594	5,773
Michigan	19,880	15,253
New Mexico	49,609	17,056
Ohio	45,187	43,969
South Carolina	4,134	—
Texas	29,348	9,736
Utah	6,389	10,953
Washington	42,848	13,455
Wisconsin	8,102	8,087
Direct delivery and other	11,295	2,463
Total Health Plans segment	561,465	278,300
Molina Medicaid Solutions segment	34,991	20,635
	$ 596,456	$ 298,935

8. Property, Equipment, and Capitalized Software

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2014	2013
	(In thousands)	
Land	$ 15,514	$ 15,764
Building and improvements	195,405	165,670
Furniture and equipment	140,691	131,478
Capitalized software	266,782	187,105
	618,392	500,017
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(129,161)	(103,918)
Less: accumulated amortization for capitalized software	(148,453)	(104,016)
	(277,614)	(207,934)
Property, equipment, and capitalized software, net	$ 340,778	$ 292,083

Depreciation recognized for building and improvements, and furniture and equipment was $34.6 million, $26.6 million, and $20.5 million for the years ended December 31, 2014, 2013 and 2012, respectively. Amortization of capitalized software was $58.7 million, $46.4 million, and $36.2 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Molina Center. We acquired the Molina Center in December 2011. Subsequently, in June 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the Molina Center. Due to our continuing involvement with the leased property, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the property. See Note 12, "Long-Term Debt."

Future minimum rental income on noncancelable leases from third party tenants of the Molina Center is sublease rental income, and is reported in other revenue in our consolidated statements of income. The future minimum rental income is as follows:

	(In thousands)
2015	$ 4,313
2016	4,035
2017	4,256
2018	4,116
2019	1,557
Thereafter	2,164
Total minimum future rentals	$ 20,441

9. Goodwill and Intangible Assets

The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses	$ 182,228	$ 105,613	$ 76,615
Customer relationships	24,550	22,154	2,396
Contract backlog	23,600	22,540	1,060
Provider networks	18,401	9,199	9,202
Balance at December 31, 2014	$ 248,779	$ 159,506	$ 89,273
Intangible assets:			
Contract rights and licenses	$ 176,428	$ 92,789	$ 83,639
Customer relationships	24,550	18,801	5,749
Contract backlog	23,600	19,624	3,976
Provider networks	13,370	7,863	5,507
Balance at December 31, 2013	$ 237,948	$ 139,077	$ 98,871

Based on the balances of our identifiable intangible assets as of December 31, 2014, we estimate that our intangible asset amortization will be $16.3 million in 2015, $14.4 million in 2016, $14.1 million in 2017, $13.8 million in 2018, and $9.2 million in 2019. For a presentation of our goodwill and intangible assets by reportable segment, refer to Note 21, "Segment Information."

The following table presents the balances of goodwill as of December 31, 2014 and 2013:

	December 31, 2013	Acquisitions	December 31, 2014
		(In thousands)	
Goodwill, gross	$ 289,268	$ 41,226	$ 330,494
Accumulated impairment losses	(58,530)	—	(58,530)
Goodwill, net	$ 230,738	$ 41,226	$ 271,964

The change in the carrying amount of goodwill in 2014 was due to the acquisitions described in Note 4, "Business Combinations."

10. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with a Molina Medicaid Solutions segment state contract, we maintain restricted investments as collateral for a letter of credit. The following table presents the balances of restricted investments:

	December 31,	
	2014	2013
	(In thousands)	
California	$ 373	$ 373
Florida	28,649	9,242
Illinois	311	310
Michigan	1,014	1,014
New Mexico	35,135	24,622
Ohio	12,719	9,080
South Carolina	6,040	310
Texas	3,500	3,500
Utah	3,601	3,301
Washington	151	151
Other	5,985	886
Total Health Plans segment	97,478	52,789
Molina Medicaid Solutions segment	5,001	10,304
	$ 102,479	$ 63,093

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2014 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 101,017	$ 101,022
Due one year through five years	1,462	1,462
	$ 102,479	$ 102,484

11. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

	December 31,		
	2014	2013	2012
	(In thousands)		
Fee-for-service claims incurred but not paid (IBNP)	$ 870,429	$ 424,173	$ 377,614
Pharmacy payable	71,412	45,037	38,992
Capitation payable	28,150	20,267	49,066
Other	230,531	180,310	28,858
	$ 1,200,522	$ 669,787	$ 494,530

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Such non-risk provider payables amounted to $119.3 million and $151.3 million as of December 31, 2014 and 2013, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,		
	2014	2013	2012
	(Dollars in thousands)		
Balances at beginning of period	$ 669,787	$ 494,530	$ 402,476
Components of medical care costs related to:			
Current period	8,122,885	5,434,443	5,136,055
Prior periods	(45,979)	(52,779)	(39,295)
Total medical care costs	8,076,906	5,381,664	5,096,760
Change in non-risk provider payables	(31,973)	111,267	(7,004)
Payments for medical care costs related to:			
Current period	7,064,427	4,932,195	4,689,395
Prior periods	449,771	385,479	308,307
Total paid	7,514,198	5,317,674	4,997,702
Balances at end of period	$ 1,200,522	$ 669,787	$ 494,530

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is fee-for-service claims incurred but not paid (IBNP). Our IBNP, as included in medical claims and benefits payable, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims deviation and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under– or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate.

As indicated above, the amounts ultimately paid out on our medical claims and benefits payable liabilities in fiscal years 2014, 2013, and 2012 were less than what we had expected when we had established those liabilities. The differences between our original estimates and the amounts ultimately paid out (or now expected to be ultimately paid out) for the most part related to IBNP. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

2014

We believe that the most significant factors that will determine the accuracy of our IBNP estimates at December 31, 2014 are:

- The addition since January 1, 2014, of 385,000 members under Medicaid expansion in six of our health plans. Because these members are transitioning into managed care, and have different demographics than those of our legacy membership, we have little insight into their utilization of medical services. Additionally, as of December 31, 2014, we have relatively little medical claims payment history related to Medicaid expansion membership in Illinois, Michigan and Ohio because such members were enrolled in these states later in the year. Accordingly, our estimates of the claims liability for this population are subject to a higher degree of uncertainty.
- The addition of approximately 6,000 to 8,000 members per month on a retroactive basis during the last several months of 2014 at our New Mexico health plan. Because we have no claims payment history for these members, our estimates of the claims liability for this population are subject to a higher degree of uncertainty. However, for these members, the state will reimburse the health plan for claims with dates of services during the retroactive period on a cost-plus basis (claims paid plus an administration fee).
- The addition of new membership to our MMP and aged, blind or disabled (ABD) programs at several of our health plans whose benefits include a substantial amount of managed LTSS benefits. Because these are newer members with substantially different benefits than our legacy members, our estimates of the claims liability for this population are subject to a higher degree of uncertainty.

We recognized favorable prior period claims development in the amount of $46.0 million for the year ended December 31, 2014. This amount represents our estimate as of December 31, 2014, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2013 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Ohio health plan, we entered new regions in the state, and a new product, ABD Kids, in July 2013. Since we did not have enough historical claims data to use the pattern of paid and incurred claims, we initially estimated the reserves for these new members by applying an estimated medical care ratio (MCR). This resulted in an overstatement of our reserve liability as of December 31, 2013.
- At our Michigan health plan, we overestimated the impact of certain unpaid potentially high-dollar claims. In addition, we overestimated the impact of the flu season on the outpatient claims for November and December 2013, which caused an overestimation in our outpatient reserve liability as of December 31, 2013.

2013

We recognized favorable prior period claims development in the amount of $52.8 million for the year ended December 31, 2013. This amount represents our estimate as of December 31, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe the overestimation was due primarily to the following factors:

- At our Washington health plan certain high-cost newborns, as well as other high-cost disabled members, were covered by the health plan effective July 1, 2012. At the end of 2012, we had limited claims history with which to estimate the claims liability of these members, and overstated the liability for such members.
- At our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.
- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to our ABD members.

2012

Prior period claims development of our estimate as of December 31, 2011 through December 31, 2012 was favorable by $39.3 million.

12. Long-Term Debt

As of December 31, 2014, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2015	2016	2017	2018	2019	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
1.625% Notes (1)	301,551	—	—	—	—	—	301,551
	$ 851,551	$ —	$ —	$ —	$ —	$ —	$ 851,551

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, or we may redeem any or all of the 1.625% Notes.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550.0 million aggregate principal amount of 1.125% cash convertible senior notes (the 1.125% Notes) due January 15, 2020, unless earlier repurchased or converted. Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 at a rate of 1.125% per annum.

The 1.125% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. The conversion rate is subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. Holders may convert their 1.125% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;

- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;

- upon the occurrence of specified corporate events; or

- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Notes prior to the maturity date.

As of December 31, 2014, the 1.125% Notes were not convertible.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Notes Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Notes Conversion Option transaction settles or expires. The initial fair value liability of the 1.125% Notes Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 6%. As of December 31, 2014, we expect the 1.125% Notes to be outstanding until their maturity date, for a remaining amortization period of 5.0 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $93 million as of December 31, 2014, and did not exceed their principal amount as of December 31, 2013.

3.75% Exchange. In August 2014, we entered into separate, privately negotiated, exchange agreements (the 3.75% Exchange) with certain holders of our outstanding 3.75% convertible senior notes due 2014 (the 3.75% Notes). In this transaction, we

exchanged $176.6 million aggregate principal amount of the 3.75% Notes for $176.6 million principal amount of 1.625% convertible senior notes due 2044 (see further discussion below), approximately 1.7 million shares of our common stock, and payment of accrued interest on the exchanged 3.75% Notes. We did not receive any proceeds related to the 3.75% Exchange.

1.625% Convertible Senior Notes due 2044. In September 2014, we issued $125.0 million principal amount of 1.625% convertible senior notes (the 1.625% Notes) due August 15, 2044, unless earlier repurchased, redeemed or converted. Combined with the 1.625% Notes issued in connection with the 3.75% Exchange described above, the aggregate principal amount issued under the 1.625% Notes was $301.6 million.

Interest on the 1.625% Notes is payable semiannually in arrears on February 15 and August 15, at a rate of 1.625% per annum, beginning on February 15, 2015. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The proceeds from the issuance of the 1.625% Notes amounted to $122.6 million, including a premium of $0.6 million, and net of deferred issuance costs paid for both the 3.75% Exchange and the additional $125.0 million principal amount issued. In connection with aggregate principal amount of the 1.625% Notes, we have recorded total deferred issuance costs of approximately $6 million, which will be amortized over the expected term of the debt, as discussed further below.

The 1.625% Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture). Holders may convert their 1.625% Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

As of December 31, 2014, the 1.625% Notes were not convertible.

We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the notes in August 2018. As of December 31, 2014, we expect the 1.625% Notes to be outstanding until August 2018, for a remaining amortization period of 3.6 years. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value did not exceed their principal amount as of December 31, 2014. At December 31, 2014, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $22.9 million.

3.75% Convertible Senior Notes due 2014. As described above, we entered into the 3.75% Exchange transaction in August 2014, under which we exchanged $176.6 million of the outstanding principal amount of the 3.75% Notes for the 1.625% Notes. The remaining $10.4 million principle amount was repaid in full in October 2014. In addition to the repayment of the outstanding principle balance, in early October 2014 we issued approximately 0.1 million shares to settle the 3.75% Notes' conversion feature.

The principal amounts, unamortized discount (net of premium related to 1.625% Notes), and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
December 31, 2014:			
1.125% Notes	$ 550,000	$ 114,670	$ 435,330
1.625% Notes	301,551	32,784	268,767
	$ 851,551	$ 147,454	$ 704,097
December 31, 2013:			
1.125% Notes	$ 550,000	$ 133,632	$ 416,368
3.75% Notes	187,000	5,128	181,872
	$ 737,000	$ 138,760	$ 598,240

	Years Ended December 31,		
	2014	2013	2012
		(In thousands)	
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate	$ 12,504	$ 12,427	$ 7,012
Amortization of the discount	26,064	22,103	5,942
	$ 38,568	$ 34,530	$ 12,954

Lease Financing Obligations. In 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the Molina Center located in Long Beach, California, and our Ohio health plan office building located in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Rent will increase 3% per year through the initial term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest amounted to $12.5 million and $6.8 million for the year ended December 31, 2014 and 2013, respectively.

As described and defined in further detail in Note 18, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings. We have concluded that we are the accounting owner of the buildings due to our continuing involvement with the properties. We have recorded $38.4 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of December 31, 2014, which represents the total cost incurred by the Landlord for the construction of the buildings, net of accumulated depreciation. As of December 31, 2014, the aggregate amount recorded to lease financing obligations, including the current portion, amounted to $40.6 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense for the years ended December 31, 2014, and 2013, was $3.2 million and $1.3

million, respectively. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, amounting to $1.1 million for the year ended December 31, 2014, and insignificant for the year ended December 31, 2013. For information regarding the future minimum lease obligation, refer to Note 20, "Commitments and Contingencies."

13. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

		December 31,	
	Balance Sheet Location	2014	2013
		(In thousands)	
Derivative asset:			
1.125% Call Option	Non-current assets: Derivative asset	$ 329,323	$ 186,351
Derivative liability:			
1.125% Notes Conversion Option	Non-current liabilities: Derivative liability	$ 329,194	$ 186,239

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expense, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013 as described in Note 12, "Long-Term Debt," we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

1.125% Notes Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Notes Conversion Option, refer to Note 5, "Fair Value Measurements."

Interest Rate Swap. In 2012, we entered into a $42.5 million notional amount interest rate swap, which was intended to reduce our exposure to fluctuations in the contractual variable interest rates under our term loan agreement that was repaid in June 2013. In June 2013, we settled the interest rate swap for $0.9 million.

14. Income Taxes

The provision for income taxes for continuing operations consisted of the following:

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Current:			
Federal	$ 72,040	$ 66,883	$ 23,019
State	3,038	581	1,254
Total current	75,078	67,464	24,273
Deferred:			
Federal	(72)	(25,498)	(9,205)
State	(2,280)	(5,650)	(4,555)
Total deferred	(2,352)	(31,148)	(13,760)
	$ 72,726	$ 36,316	$ 10,513

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate for continuing operations is as follows:

	Year Ended December 31,		
	2014	2013	2012
Statutory federal tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	0.4	(0.5)	(9.2)
Change in unrecognized tax benefits	(0.1)	(3.7)	0.7
Nondeductible health insurer fee (HIF)	22.9	—	—
Nondeductible compensation	(4.1)	9.6	6.2
Nondeductible lobbying	(0.3)	1.6	4.2
Nondeductible fair value of 1.125% Warrants	—	2.4	—
Change in fair value of contingent consideration liabilities	—	(0.3)	4.8
Other	—	0.7	3.3
Effective tax rate	53.8 %	44.8 %	45.0 %

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws.

During 2014, the Internal Revenue Service (IRS) issued final regulations related to compensation deduction limitations applicable to certain health insurance issuers. Pursuant to these final regulations, we reversed amounts treated as nondeductible in 2013 and recognized a tax benefit during 2014.

During 2014, 2013, and 2012, excess tax benefits from share-based compensation amounted to $3.0 million, $1.6 million, and $3.1 million, respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital.

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2014 and 2013 were as follows:

	December 31,	
	2014	2013
	(In thousands)	
Accrued expenses	$ 13,323	$ 19,545
Reserve liabilities	2,487	1,712
State taxes	(134)	(1,323)
Other accrued medical costs	3,800	2,540
Net operating losses	27	27
Unrealized losses	444	380
Unearned premiums	21,749	10,543
Prepaid expenses	(5,920)	(5,354)
Basis in debt	(210)	(2,162)
Deferred compensation	5,252	2,087
Other, net	(244)	(928)
Valuation allowance	(1,042)	(511)
Deferred tax asset, net of valuation allowance — current	39,532	26,556
Reserve liabilities	2,017	1,909
State tax credit carryover	8,157	7,027
Net operating losses	3,138	2,326
Unrealized losses	181	286
Depreciation and amortization	(57,068)	(40,433)
Deferred compensation	4,405	3,404
Lease financing obligation	34,084	27,543
Basis in debt	(14,724)	466
Other, net	(96)	(24)
Valuation allowance	(4,365)	(3,084)
Deferred tax liability, net of valuation allowance — long term	(24,271)	(580)
Net deferred income tax asset	$ 15,261	$ 25,976

At December 31, 2014, we had federal and state net operating loss carryforwards of $0.2 million and $84.0 million, respectively. The federal net operating loss begins expiring in 2018, and state net operating losses begin expiring in 2015. The utilization of the net operating losses is subject to certain limitations under federal law.

At December 31, 2014, we had California enterprise zone tax credit carryovers of $12.5 million which expire in 2024.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2014, $5.4 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state tax operating loss carryforwards. Therefore, we increased our valuation allowance by $1.8 million, from $3.6 million at December 31, 2013, to $5.4 million as of December 31, 2014.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Gross unrecognized tax benefits at beginning of period	$ (8,030)	$ (10,622)	$ (10,712)
Increases in tax positions for prior years	—	—	(441)
Decreases in tax positions for prior years	—	3,615	320
Increases in tax positions for current year	(777)	(2,084)	—
Decreases in tax positions for current year	—	886	—
Settlements	5,960	—	—
Lapse in statute of limitations	253	175	211
Gross unrecognized tax benefits at end of period	$ (2,594)	$ (8,030)	$ (10,622)

The total amount of unrecognized tax benefits at December 31, 2014, 2013 and 2012 that, if recognized, would affect the effective tax rates is $1.6 million, $5.7 million and $7.4 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $0.1 million due to the normal expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2014, and 2013 were insignificant.

We are under examination by the IRS for calendar year 2011 and may be subject to examination for calendar years 2012 through 2014. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Utah, and Michigan, for the years 2010 through 2014.

15. Stockholders' Equity

Stockholders' equity increased $117.5 million during the year ended December 31, 2014. The increase was due to net income of $62.2 million, $22.0 million related to 1.625% Notes and 3.75% Exchange, $33.2 million related to share-based compensation transactions, and $0.1 million related to other comprehensive income.

3.75% Exchange and 3.75% Notes. As described in Note 12, "Long-Term Debt," we issued approximately 1.8 million shares in connection with the 3.75% Exchange, and the 3.75% Notes settlement in 2014; additionally, we issued approximately 81,000 shares of common stock for services rendered in connection with the 3.75% Exchange.

1.125% Warrants. In connection with the 1.125% Notes Call Spread Overlay transaction described in Note 13, "Derivative Financial Instruments," we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

Securities Repurchases. In connection with the issuance and settlement of the 1.125% Notes, we used a portion of the net proceeds from the offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. In February 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Securities Repurchase Programs. Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This newly authorized repurchase program extends through December 31, 2015.

Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Under this program, we purchased approximately 85,000 shares of our common stock for $2.7 million (average cost of $31.28 per share) during November 2013. This repurchase program expired December 31, 2014.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with the stock plans described in Note 17, "Share-Based Compensation," we issued approximately 840,000, and 820,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the years ended December 31, 2014 and 2013, respectively.

16. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $21.2 million, $12.8 million and $10.7 million in the years ended December 31, 2014, 2013, and 2012, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

17. Share-Based Compensation

At December 31, 2014, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan (2011 Plan); and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

The 2011 Plan provides for the award of stock options, restricted shares and units, performance shares and units, and stock bonuses to the company's officers, employees, directors, consultants, advisers, and other service providers. The 2011 Plan allows for the issuance of 4.5 million shares of common stock.

In March 2014, our named executive officers were granted a total of 356,292 restricted shares with service, market, and performance conditions. In the event the vesting conditions are not achieved, the awards shall lapse. As of December 31, 2014, we expect the performance conditions to be met in full.

Restricted share awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our employee stock purchase plan (ESPP), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2014, 2013, 2012, the inputs to this model were as follows: risk-free interest rates ranging from approximately 0.1% to 0.2%; expected volatilities ranging from approximately 30% to 50%, dividend yields of 0%, and an average expected life of 0.5 years. We issued approximately 327,200, 299,600 and 277,400 shares of our common stock under the ESPP during the years ended December 31, 2014, 2013, and 2012, respectively. The 2011 ESPP allows for the issuance of three million shares of common stock.

The following table illustrates the components of our share-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2014		2013		2012	
	(In thousands)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock and performance awards	$ 18,535	$ 11,936	$ 26,116	$ 22,489	$ 18,106	$ 12,943
Employee stock purchase plan and stock options	3,192	2,352	2,578	2,012	1,912	1,613
	$ 21,727	$ 14,288	$ 28,694	$ 24,501	$ 20,018	$ 14,556

As of December 31, 2014, there was $24.5 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.7 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 4.0% as of December 31,

2014. Also as of December 31, 2014, there was $0.3 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.0 year.

Restricted and performance stock activity for the year ended December 31, 2014 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2013	1,299,852	$ 29.03
Granted - restricted stock	420,352	38.06
Granted - performance stock	249,402	34.61
Vested - restricted stock	(423,970)	26.70
Vested - performance stock	(199,948)	30.18
Forfeited	(63,616)	31.31
Unvested balance as of December 31, 2014	1,282,072	33.55

The total fair value of restricted and performance awards granted during the year ended December 31, 2014, 2013, and 2012 was $25.4 million, $33.3 million, and $16.2 million, respectively. The total fair value of restricted awards, including those with performance and market conditions which vested during the year ended December 31, 2014, 2013, and 2012 was $23.7 million, $22.3 million, and $25.4 million, respectively.

The weighted-average grant date fair value per share of the performance awards with vesting conditions based on one-year Total Stockholder Return (TSR) was $27.25. We estimated the fair value on the grant date using a Monte Carlo Simulation to project TSR over the performance period using correlations and volatilities of the ISS peer group. Additional inputs included a risk-free interest rate of 0.1%, dividend yield of 0%, and an expected life of 0.8 years. The weighted-average grant date fair value per share of the performance awards with vesting conditions based on three-year TSR, as described above, was $26.60. Additional inputs included a risk-free interest rate of 0.5%, dividend yield of 0%, and an expected life of 2.8 years.

The total fair value of restricted stock units granted during the year ended December 31, 2012 was $0.3 million with a weighted average grant date fair value of $35.01. These restricted stock units vested during 2013. No restricted stock units were granted in 2014 and 2013 and there were no outstanding restricted stock units as of December 31, 2014.

Stock option activity for the year ended December 31, 2014 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Stock options outstanding as of December 31, 2013	379,221	$ 24.14		
Exercised	(122,523)	24.93		
Stock options outstanding as of December 31, 2014	256,698	23.77	$ 7,640	3.3
Stock options exercisable and expected to vest as of December 31, 2014	256,698	23.77	$ 7,640	3.3
Exercisable as of December 31, 2014	221,698	22.26	$ 6,932	2.5

The weighted-average grant date fair value per share of the stock options awarded to the new members of our board of directors during 2013 was $14.67. The weighted-average grant date fair value per share of the stock option awarded to the director appointed during 2012 was $13.97. We estimate the fair value of each stock option award on the grant date using the Black-Scholes option pricing model. To determine the fair value of these stock options we applied risk-free interest rates of 1.1% to 1.4%, expected volatilities of 41.3% to 43.0%, dividend yields of 0%, and expected lives of 6 years to 7 years. No stock options were granted in 2014.

The total intrinsic value of options exercised during the year ended December 31, 2014, 2013, and 2012 was $2.1 million, $1.2 million, and $2.0 million, respectively. The following is a summary of information about stock options outstanding and exercisable at December 31, 2014:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$19.11	46,148	1.1	$ 19.11	46,148	$ 19.11
$20.88	139,500	2.2	20.88	139,500	20.88
$22.86 – $34.82	71,050	6.9	32.46	36,050	31.66
	256,698			221,698	

18. Related Party Transactions

In February 2013, the Parent (as defined in Note 23, "Condensed Financial Information of Registrant,") entered into a lease with 6th & Pine Development, LLC (the Landlord) for two office buildings, referred to as Building A and Building B, in Long Beach, California. The lease term for Building A commenced in June 2013, and the lease term for Building B commenced in July 2014.

The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, John C. Molina has pledged shares of common stock in the Company that he holds. Dr. J. Mario Molina, our chief executive officer, president and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

Effective October 31, 2014, the Parent entered into the First Amendment to Office Building Lease (the Amended Lease) with the Landlord. The Amended Lease reduced the annual rent escalator under the original lease from 3.75% per year to 3.4% per year. The Amended Lease also extended the initial base term of the original lease by five years such that the Amended Lease will now expire on December 31, 2029, unless extended or earlier terminated. The Amended Lease also converted the original lease from a full service gross lease to a triple-net lease. For information regarding the future minimum lease payments, refer to Note 20, "Commitments and Contingencies." For information regarding the lease financing obligation, refer to Note 12, "Long-Term Debt."

Refer to Note 19, "Variable Interest Entities," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

19. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides primary care medical services through its employed physicians and other medical professionals. Beginning in the fourth quarter of 2014, JMMPC also provided certain specialty referral services to our California health plan members through a contracted provider network. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a variable interest entity (VIE), and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive

benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2014, JMMPC had total assets of $31.1 million, and total liabilities of $30.8 million. As of December 31, 2013, JMMPC had total assets of $6.9 million, and total liabilities of $6.6 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. Additionally, in connection with specialty referral services provided beginning in 2014, our exposure to loss includes medical care costs associated with such services. We believe that such loss exposures will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

New Markets Tax Credit

In 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC (Wells Fargo), its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC (Investment Fund), and certain of Wells Fargo's affiliated Community Development Entities (CDEs), in connection with our participation in the federal government's New Markets Tax Credit Program (NMTC). The NMTC was established by Congress in 2000 to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In the fourth quarter of 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $5.9 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $15.5 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $20.9 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $5.9 million. Additionally, financing costs incurred in structuring the arrangement amounting to $1.2 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE—collecting and remitting interest and fees and NMTC compliance—were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $5.9 million is included in cash at December 31, 2014 and December 31, 2013 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

20. Commitments and Contingencies

Certain Leasing Transactions. As described in Note 12, "Long-Term Debt," we entered into certain leasing transactions that have been classified as lease financing obligations. Such leases have initial terms that range from 16.5 years to 25 years. Additionally, the leases provide for renewal options ranging from 10 years to 25 years in aggregate.

Operating Leases. We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2023. Facility lease terms generally range from five to 10 years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under all operating leases and lease financing obligations consist of the following approximate amounts:

	Lease Financing Obligations	Lease Financing Obligations - Related Party	Operating Leases	Total
		(In thousands)		
2015	$ 11,397	$ 5,346	$ 29,142	$ 45,885
2016	11,739	5,528	22,989	40,256
2017	12,091	5,715	21,602	39,408
2018	12,454	5,910	20,296	38,660
2019	12,828	6,111	12,777	31,716
Thereafter	320,447	73,784	15,229	409,460
	$ 380,956	$ 102,394	$ 122,035	$ 605,385

Rental expense related to operating leases amounted to $32.4 million, $24.5 million, and $20.5 million for the years ended December 31, 2014, 2013, and 2012, respectively. The amounts reported in "Lease Financing Obligations," and "Lease Financing Obligations - Related Party," above represent our contractual lease commitments for the properties described in Note 12, "Long-Term Debt" under the subheading "Lease Financing Obligations." Payments under these leases adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income.

Employment Agreements. In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which were amended and restated in 2009. These employment agreements had initial terms of one to three years and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of stock-based awards, and a cash payment for health and welfare benefits.

In 2013 we entered into employment agreements with our Chief Operating Officer, Chief Accounting Officer, and Chief Legal Officer. These agreements continue until terminated by us, or the executive resigns. If the executive's employment is terminated by us without cause or the executive resigns for good reason, the executive will be entitled to receive one year's base salary and termination bonus, as defined, full vesting of all time-based equity compensation, and a cash payment for health and welfare benefits.

Payment of the executives' severance benefits is contingent upon the executive's signing a release agreement waiving claims against us. If the executives are terminated for cause, no further payments are due under the contracts.

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through

discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Washington Health Plan. In September 2014, our Washington health plan paid $19.2 million to the Washington Health Care Authority (HCA) to settle two outstanding overpayment matters. The matters related to demands for recoupment of claims for psychotropic drugs and claims for health plan members under the Washington Community Options Program Entry System (COPES). Additionally, in September 2014 HCA paid our Washington health plan $8.0 million to settle certain matters brought by the Washington health plan related to auto-assignment provisions in the parties' contract. The net effect of these settlements resulted in a premium revenue reduction of $11.2 million in the third quarter of 2014, and resolved all pending disputes between the parties.

State of Louisiana. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that, in late 2008 and early 2009, in connection with the acquisition of Florida NetPass by which Molina Healthcare entered into the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. Both the United States of America and the state of Florida have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. We believe that we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Professional Liability Insurance. We carry medical professional liability insurance for health care services rendered in the primary care and hospital institutions that we manage. In addition, we also carry errors and omissions insurance for all Molina entities.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $859 million at December 31, 2014, and $608 million at December 31, 2013. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained

earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $202.6 million and $365.2 million as of December 31, 2014, and 2013, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC), rules. Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs, and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2014, our health plans had aggregate statutory capital and surplus of approximately $955 million compared with the required minimum aggregate statutory capital and surplus of approximately $541 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2014, with the exception of our Florida health plan, which was funded in February 2015 to meet the minimum capital requirement. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

21. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." For presentation purposes, the cost of centralized services is reported within the Health Plans segment.

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Revenue, continuing operations:			
Health Plans segment:			
Premium revenue	$ 9,022,511	$ 6,179,170	$ 5,544,121
Premium tax revenue	294,388	172,017	158,991
Health insurer fee revenue	119,484	—	—
Investment income	8,093	6,890	5,075
Other revenue	12,074	26,322	18,312
Molina Medicaid Solutions segment:			
Service revenue	210,051	204,535	187,710
	$ 9,666,601	$ 6,588,934	$ 5,914,209
Depreciation and amortization reported in the consolidated statements of cash flows:			
Health Plans segment	$ 89,438	$ 67,446	$ 58,577
Molina Medicaid Solutions segment	44,966	26,420	20,187
	$ 134,404	$ 93,866	$ 78,764
Income from continuing operations before income tax expense:			
Health Plans segment	$ 150,090	$ 103,931	$ 17,366
Molina Medicaid Solutions segment	42,827	32,629	23,727
Operating income, continuing operations	192,917	136,560	41,093
Other expenses, net	57,613	55,414	17,714
	$ 135,304	$ 81,146	$ 23,379

	As of December 31,		
	2014	2013	2012
	(In thousands)		
Goodwill and intangible assets, net:			
Health Plans segment	$ 286,459	$ 248,562	$ 139,710
Molina Medicaid Solutions segment	74,778	81,047	89,089
	$ 361,237	$ 329,609	$ 228,799
Total assets:			
Health Plans segment	$ 4,270,870	$ 2,809,439	$ 1,702,212
Molina Medicaid Solutions segment	206,345	193,498	232,610
	$ 4,477,215	$ 3,002,937	$ 1,934,822

Goodwill and intangible assets increased in the Health Plans segment due to the acquisitions described in Note 4, "Business Combinations."

22. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2014 and 2013. As described in Note 1, "Basis of Presentation," the results of the Missouri health plan are reported as discontinued operations for all periods presented. For further information relating to our segment reporting, refer to Note 21, "Segment Information."

	For The Quarter Ended			
	March 31, 2014	June 30, 2014	September 30, 2014	December 31, 2014
	(In thousands, except per-share data)			
Premium revenue	$ 1,940,337	$ 2,167,142	$ 2,316,759	$ 2,598,273
Service revenue	53,630	50,232	52,557	53,632
Operating income, Health Plans segment	14,019	21,986	29,874	84,211
Operating income, Molina Medicaid Solutions segment	10,248	10,441	9,905	12,233
Income from continuing operations	$ 4,834	$ 7,741	$ 16,070	$ 33,933
(Loss) income from discontinued operations	(336)	70	52	(141)
Net income	$ 4,498	$ 7,811	$ 16,122	$ 33,792
Net income per share (1):				
Basic	$ 0.10	$ 0.17	$ 0.34	$ 0.70
Diluted	$ 0.09	$ 0.16	$ 0.33	$ 0.69

	For The Quarter Ended			
	March 31, 2013	June 30, 2013 (2)	September 30, 2013	December 31, 2013
	(In thousands, except per-share data)			
Premium revenue	$ 1,497,433	$ 1,501,729	$ 1,584,656	$ 1,595,352
Service revenue	49,756	49,672	51,100	54,007
Operating income (loss), Health Plans segment	61,520	40,151	16,929	(14,669)
Operating income, Molina Medicaid Solutions segment	6,353	6,295	7,997	11,984
Income (loss) from continuing operations	$ 30,522	$ 15,796	$ 7,553	$ (9,041)
(Loss) income from discontinued operations	(607)	8,775	16	(85)
Net income (loss)	$ 29,915	$ 24,571	$ 7,569	$ (9,126)
Net income (loss) per share (1):				
Basic	$ 0.65	$ 0.54	$ 0.17	$ (0.20)
Diluted	$ 0.64	$ 0.53	$ 0.16	$ (0.20)

(1) Potentially dilutive shares issuable pursuant to our 1.125% Warrants and 1.625% Notes were not included in the computation of diluted net income per share, because to do so would have been anti-dilutive. Potentially dilutive shares issuable pursuant to our 3.75% Notes were not included in the computation of diluted net income per share for the quarter ended March 31, 2013, because to do so would have been anti-dilutive.

(2) We abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of $9.5 million, which is reported in (loss) income from discontinued operations.

23. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2014 and 2013, and our condensed statements of income, condensed statements of comprehensive income and condensed statements of cash flows for each of the three years in the period ended December 31, 2014.

Condensed Balance Sheets

	December 31,	
	2014	2013
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 74,696	$ 99,698
Investments	126,439	262,665
Income tax refundable	13,413	8,403
Deferred income taxes	8,546	10,073
Due from affiliates	17,567	35,928
Prepaid expenses and other current assets	36,143	28,387
Total current assets	276,804	445,154
Property, equipment, and capitalized software, net	265,110	225,522
Goodwill and intangible assets, net	64,972	68,902
Investments in subsidiaries	1,376,613	992,998
Deferred income taxes	2,824	17,245
Derivative asset	329,323	186,351
Advances to related parties and other assets	57,263	52,615
	$ 2,372,909	$ 1,988,787
LIABILITIES AND STOCKHOLDERS' EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 106,212	$ 109,388
Long-term debt	865,148	757,770
Lease financing obligations - related party	40,241	27,092
Derivative liability	329,194	186,239
Other long-term liabilities	21,672	15,361
Total liabilities	1,362,467	1,095,850
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding:		
49,727 shares at December 31, 2014 and 45,871 shares at December 31, 2013	50	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	396,059	340,848
Accumulated other comprehensive loss	(1,019)	(1,086)
Retained earnings	615,352	553,129
Total stockholders' equity	1,010,442	892,937
	$ 2,372,909	$ 1,988,787

Condensed Statements of Income

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Revenue:			
Management fees and other operating revenue	$ 703,710	$ 599,049	$ 406,981
Investment income	2,218	2,768	550
Total revenue	705,928	601,817	407,531
Expenses:			
Medical care costs	46,437	37,862	33,102
General and administrative expenses	582,587	503,781	367,606
Depreciation and amortization	72,995	51,562	38,794
Total operating expenses	702,019	593,205	439,502
Operating income (loss)	3,909	8,612	(31,971)
Interest expense	56,728	50,508	14,469
Other expense	844	3,811	—
Loss before income taxes and equity in net income of subsidiaries	(53,663)	(45,707)	(46,440)
Income tax benefit	(26,776)	(15,455)	(15,779)
Net loss before equity in net income of subsidiaries	(26,887)	(30,252)	(30,661)
Equity in net income of subsidiaries	89,110	83,181	40,451
Net income	$ 62,223	$ 52,929	$ 9,790

Condensed Statements of Comprehensive Income

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Net income	$ 62,223	$ 52,929	$ 9,790
Other comprehensive income (loss):			
Unrealized investment gain (loss)	108	(1,015)	1,529
Effect of income tax expense (benefit)	41	(386)	581
Other comprehensive income (loss), net of tax	67	(629)	948
Comprehensive income	$ 62,290	$ 52,300	$ 10,738

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Operating activities:			
Net cash provided by operating activities	$ 73,674	$ 62,602	$ 20,611
Investing activities:			
Capital contributions to subsidiaries	(292,232)	(166,112)	(100,221)
Dividends received from subsidiaries	—	24,429	101,800
Purchases of investments	(128,996)	(362,927)	(1,905)
Proceeds from sales and maturities of investments	263,479	97,713	4,067
Proceeds from sale of subsidiary, net of cash surrendered	—	—	9,162
Purchases of equipment	(93,610)	(76,873)	(61,813)
Change in amounts due to/from affiliates	16,054	(5,888)	5,187
Other, net	7,640	(6,175)	(1,342)
Net cash used in investing activities	(227,665)	(495,833)	(45,065)
Financing activities:			
Proceeds from issuance of convertible senior notes, net of financing costs paid	122,625	537,973	—
Proceeds from sale-leaseback transactions	—	158,694	—
Purchase of call option	—	(149,331)	—
Proceeds from issuance of warrants	—	75,074	—
Treasury stock repurchases	—	(52,662)	(3,000)
Principal payment on term loan of subsidiary	—	(46,963)	—
Repayment of amount borrowed under credit facility	—	(40,000)	(20,000)
Proceeds from employee stock plans	14,040	9,402	8,205
Principal payments on convertible senior notes	(10,449)	—	—
Amount borrowed under credit facility	—	—	60,000
Other, net	2,773	1,674	3,667
Net cash provided by financing activities	128,989	493,861	48,872
Net (decrease) increase in cash and cash equivalents	(25,002)	60,630	24,418
Cash and cash equivalents at beginning of year	99,698	39,068	14,650
Cash and cash equivalents at end of year	$ 74,696	$ 99,698	$ 39,068

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

Molina Healthcare, Inc. (the Registrant, or the Parent), was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc., Molina Healthcare of Michigan, Inc., and Molina Healthcare of Washington, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management,

financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2014, 2013, and 2012 for these services amounted to $691.6 million, $592.1 million, and $406.4 million, respectively, and are included in operating revenue.

During 2013, the Registrant used a portion of the proceeds from the sale of the Molina Center, described in Note 12, "Long-Term Debt," to repay the remaining principal balance of the related term loan, on behalf of a subsidiary of the Registrant.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Dividends and Capital Contributions

During 2013 and 2012, the Registrant received dividends from its subsidiaries. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2014, 2013, and 2012, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries, net of insignificant returns of capital.

Note D - Related Party Transactions

The Registrant's related party transactions are described in Note 18, "Related Party Transactions."

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosures

None.

Item 9A. Controls and Procedures

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2014. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework* (2013 framework).

Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2014, based on those criteria.

Ernst & Young, LLP, the independent registered public accounting firm who audited the Company's Consolidated Financial Statements included in this Form 10-K, has issued a report on the Company's internal control over financial reporting, which is included herein.

Changes in Internal Control over Financial Reporting. There were no changes in the Company's internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2014, that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2014 and 2013, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2014 and our report dated February 26, 2015 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2015

PART III

Item 10. Directors, Executive Officers, and Corporate Governance

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our definitive proxy statement for our 2015 Annual Meeting of Stockholders. The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Election of Directors," "Corporate Governance," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2015 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 11. Executive Compensation

The information required by Items 402, 407(e)(4), and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2015 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2014)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)		Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)	
Equity compensation plans approved by security holders	256,698	(1)	$ 23.77	4,529,223	(2)

(1) Options to purchase shares of our common stock issued under the 2002 Equity Incentive Plan and 2011 Equity Incentive Plan. Further grants under the 2002 Equity Incentive Plan have been suspended.

(2) Includes shares remaining available to issue under the 2011 Equity Incentive Plan, and the 2011 Employee Stock Purchase Plan.

The remaining information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2015 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Related Party Transactions," "Corporate Governance," and "Director Independence" in our definitive proxy statement for our 2015 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Additionally, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 18, "Related Party Transactions," and Note 19, "Variable Interest Entities," under the subheading "Joseph M. Molina M.D., Professional Corporations."

Item 14. Principal Accountant Fees and Services

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Auditor Fees" in our definitive proxy statement for our 2015 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The financial statements included in Item 8 of this Form 10-K, Financial Statements and Supplementary Data, above are filed as part of this annual report.

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 26th day of February, 2015.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina

Joseph M. Molina, M.D. (Dr. J. Mario Molina)
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	February 26, 2015
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	February 26, 2015
/s/ Joseph W. White **Joseph W. White**	Chief Accounting Officer (Principal Accounting Officer)	February 26, 2015
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	February 26, 2015
/s/ Daniel Cooperman **Daniel Cooperman**	Director	February 26, 2015
/s/ Charles Z. Fedak **Charles Z. Fedak**	Director	February 26, 2015
/s/ Steven G. James **Steven G. James**	Director	February 26, 2015
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	February 26, 2015
/s/ Steven J. Orlando **Steven J. Orlando**	Director	February 26, 2015
/s/ Ronna E. Romney **Ronna E. Romney**	Director	February 26, 2015
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	February 26, 2015
/s/ Dale B. Wolf **Dale B. Wolf**	Director	February 26, 2015

INDEX TO EXHIBITS

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K may contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

Number	Description	Method of Filing
1.1	Purchase Agreement, dated as of February 11, 2013, among Molina Healthcare, Inc. and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Representatives of the Initial Purchasers	Filed as Exhibit 1.1 to registrant's Form 8-K filed February 15, 2013.
2.1	Asset Purchase Agreement between Molina Healthcare, Inc. and Unisys Corporation dated as of January 18, 2010	Filed as Exhibit 2.1 to registrant's Form 8-K filed January 19, 2010.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Certificate of Amendment to Certificate of Incorporation	Filed as Exhibit 3.1 to registrant’s Form 8-K filed July 24, 2013.
3.3	Third Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 10-Q filed July 30, 2014.
4.1	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.2	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.3	Indenture, dated as of September 5, 2014, by and between Molina Healthcare, Inc. and U.S. Bank National Association	Filed as Exhibit 4.1 to registrant’s Form 8-K filed September 8, 2014.
4.4	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant’s Form 8-K filed September 8, 2014.
4.5	Form of 1.625% Convertible Senior Notes Due 2044 Note Purchase Agreement, dated as of September 11, 2014, by and between Molina Healthcare, Inc. and certain institutional investors	Filed as Exhibit 10.1 to registrant’s Form 8-K filed September 12, 2014.
4.6	First Supplemental Indenture, dated as of September 16, 2014, by and between Molina Healthcare, Inc. and the U.S. Bank National Association	Filed as Exhibit 4.1 to registrant’s Form 8-K filed September 17, 2014.
4.7	Form of 1.625% Convertible Senior Note due 2044	Included in Exhibit 4.1 to registrant’s Form 8-K filed September 17, 2014.
*10.1	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
*10.2	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.5 to registrant’s Form 10-K filed February 26, 2014.
*10.3	Amendment No. 1 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed as Exhibit 10.6 to registrant’s Form 10-K filed February 26, 2014.
*10.4	Amendment No. 2 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed herewith.
*10.5	2011 Equity Incentive Plan	Filed as Exhibit 10.8 to registrant’s Form 10-K filed February 26, 2014.

Number	Description	Method of Filing
*10.6	2011 Employee Stock Purchase Plan	Filed herewith.
*10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
*10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
*10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
*10.10	Form of Stock Option Agreement under Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
*10.11	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.
*10.12	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
*10.13	Employment Agreement with Terry Bayer dated June 14, 2013	Filed as Exhibit 10.1 to registrant’s Form 8-K filed June 14, 2013.
*10.14	Employment Agreement with Joseph White dated June 14, 2013	Filed as Exhibit 10.2 to registrant’s Form 8-K filed June 14, 2013.
*10.15	Employment Agreement with Jeff Barlow, dated June 14, 2013	Filed as Exhibit 10.3 to registrant’s Form 8-K filed June 14, 2013.
*10.16	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
*10.17	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
*10.18	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed as Exhibit 10.16 to registrant’s Form 10-K filed February 28, 2013.
10.19	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.20	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
10.21	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.
10.22	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.
10.23	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.24	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.25	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.26	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.27	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.

Number	Description	Method of Filing
10.28	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013.
10.29	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013.
10.30	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013.
10.31	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013.
10.32	Lease Agreement, dated as of February 27, 2013, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.32 to registrant's Form 10-K filed February 28, 2013.
10.33	First Amendment to Office Building Lease, effective as of October 31, 2014, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.1 to registrant's Form 8-K filed November 5, 2014.
10.34	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013.
10.35	Agreement of Purchase and Sale, dated as of June 12, 2013, by and between Molina Healthcare, Inc. and Molina Center, LLC, and AG Net Lease Acquisition Corp.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed July 25, 2013.
10.36	Lease Agreement, dated as of June 13, 2013, by and between AGNL Clinic, L.P., and Molina Healthcare, Inc.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed July 25, 2013.
10.37	Form of Exchange Agreement, dated August 11, 2014, by and between Molina Healthcare, Inc. and certain beneficial owners of Molina Healthcare, Inc.'s 3.75% Convertible Senior Notes due 2014	Filed as Exhibit 10.1 to registrant's Form 8-K filed August 12, 2014.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
101.INS	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

EXHIBIT 10.4

AMENDMENT NO. 2
TO THE
MOLINA HEALTHCARE, INC.
AMENDED AND RESTATED DEFERRED COMPENSATION PLAN (2013)

WHEREAS, Molina Healthcare, Inc., a Delaware corporation ("Company"), has previously adopted the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013), as amended by Amendment No. 1 to the Amended and Restated Deferred Compensation Plan executed on November 14, 2013 (the "Plan") for the benefit of a select group of employees of the Company;

WHEREAS, the Company desires to amend the Plan to remove the requirement that a participant's written deferral election remain in effect for subsequent plan years and replace in its stead that a participant must provide a written deferral election for each plan year;

WHEREAS, Section 7.1 of the Plan permits the Company to amend the Plan; and

WHEREAS, the Board of Directors of the Company has approved this Amendment and authorized and directed the appropriate officers of the Company to execute this Amendment and to take such other actions as they deem necessary or appropriate to implement this Amendment.

NOW, THEREFORE, the Plan is amended as follows effective as of October 29, 2014:

1. Section 2.3.b. is deleted in its entirety and replaced in its stead with the following:

b. A Participant must provide a separate Written Election for each subsequent Plan Year that specifies the dollar amount or percentage of Plan Year Compensation that Participant has determined to defer for each such Plan Year. Such Written Election is only effective for the Plan Year for which the election is made and if no Written Election to defer Plan Year Compensation is executed in relation to a subsequent Plan Year, no Plan Year Compensation will be deferred for such subsequent Plan Year. Any election of the amount of Plan Year Compensation to defer for a given Plan Year shall be irrevocable on and after the first day of the Plan Year for which the election was made.

c. A Participant may change the investment vehicle(s) in which he desires to have that portion of his Account attributable to Plan Year Compensation and investment income invested and the percentage of his Account allocated to each investment vehicle by completing and submitting any form or forms required by the Company. Changes in investment vehicle(s) will be made as of the last business day of each month. The Participant must submit the completed form or forms with the requested changes to the Trustee on or before the twenty-fifth (25th) day of the current month (or the last business day immediately preceding the twenty-fifth of the month) for the changes to be made by the last business day of the current month. Changes requested on forms submitted after the twenty-fifth (25th) day of the current month will be made on the last business day of the following month.

d. Notwithstanding the foregoing, the Trustee shall, at the direction of the Plan Committee, have the duty and authority to invest the trust assets and funds in accordance with the terms of the Trust Agreement, and all rights associated with the trust assets shall be exercised by the Trustee as designated by the Plan Committee and shall in no event be exercisable by or be settled upon Participants or their Beneficiaries.

e. Participant may change the date or form of distribution by submitting a new Written Election to the Company, provided that the following conditions are met:

   i. That such election may not take effect until at least twelve (12) months after the date on which the election is made;

   ii. In the case of an election related to a payment other than a payment on account of death, disability or the occurrence of an financial hardship, such payment must be deferred for a period of not less than five (5) years from the date such payment would have otherwise been made, and

   iii. Any election related to a payment at a specified time or pursuant to a fixed schedule may not be made less than twelve (12) months prior to the date of the first scheduled payment.

IN WITNESS WHEREOF, this Amendment is executed this 29th day of October, 2014.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chief Executive Officer

EXHIBIT 10.6

MOLINA HEALTHCARE, INC.

2011 EMPLOYEE STOCK PURCHASE PLAN

1. Establishment of Plan. Molina Healthcare, Inc., a Delaware corporation (the "Company"), proposes to grant options to purchase shares of the Company's common stock, $0.001 par value per share (the "Common Stock"), to eligible employees of the Company and its Participating Affiliates (as defined below) pursuant to this 2011 Employee Stock Purchase Plan (this "Plan"). For purposes of this Plan, "Parent Corporation" and "Subsidiary Corporation" shall have the same meanings as "parent corporation" and "subsidiary corporation" in Sections 424(e) and 424(f), respectively, of the Internal Revenue Code of 1986, as amended (the "Code"). "Participating Affiliates" are Parent Corporations or Subsidiary Corporations that the Board of Directors of the Company (the "Board") designates from time to time as corporations that shall participate in this Plan. Affiliates may be designated as Participating Affiliates either before or after this Plan is approved by the Company's stockholders as provided in Section 22. The Company intends this Plan to qualify as an "employee stock purchase plan" under Section 423 of the Code (including any amendments to or replacements of such Section), and this Plan shall be so construed. Any term not expressly defined in this Plan but defined for purposes of Section 423 of the Code shall have the same definition herein. A total of three million (3,000,000) shares of the Common Stock are reserved for issuance under this Plan.

2. Purpose. The purpose of this Plan is to provide eligible employees of the Company and Participating Affiliates with a convenient means of acquiring an equity interest in the Company through payroll deductions, to enhance such employees' sense of participation in the affairs of the Company and Participating Affiliates, and to provide an incentive for continued employment.

3. Administration

(a) This Plan shall be administered by the Compensation Committee of the Board (the "Committee"). Subject to the provisions of this Plan and the limitations of Section 423 of the Code or any successor provision in the Code, all questions of interpretation or application of this Plan shall be determined by the Committee in its sole discretion and its decisions shall be final and binding upon all participants. Members of the Committee shall receive no compensation for their services in connection with the administration of this Plan, other than standard fees as established from time to time by the Board for services rendered by Board members serving on Board committees. All expenses incurred in connection with the administration of this Plan shall be paid by the Company.

(b) The Committee may, from time to time, consistent with this Plan and the requirements of Section 423 of the Code, establish, change or terminate such rules, guidelines, policies, procedures, limitations, or adjustments as deemed advisable by the Company, in its sole discretion, for the proper administration of this Plan, including, without limitation: (a) a

minimum payroll deduction amount required for participation in an Offering Period, (b) a limitation on the frequency or number of changes permitted in the rate of payroll deduction during an Offering Period, (c) a payroll deduction greater or less than the amount designated by a participant in order to adjust for the Company's delay or mistake in processing an Enrollment Form or in otherwise effecting a participant's election under this Plan or as advisable to comply with the requirements of Section 423 of the Code, (d) determination of the date and manner by which the Fair Market Value of the Common Stock is determined for purposes of administration of this Plan, (e) delegate responsibility for Plan operation, management and administration, subject to the Committee's oversight and control, on such terms as the Committee may establish, and (f) delegate to other persons the responsibility for performing appropriate functions as necessary, desirable or appropriate to further the purposes of this Plan.

4. Eligibility. Any individual employed by the Company or the Participating Affiliates on the "Offering Date" of an "Offering Period" (each as defined in Section 5 below) is eligible to participate in such Offering Period except the following:

(a) employees who are customarily employed for less than (20) hours per week; and

(b) employees who, together with any other person whose stock would be attributed to such employee pursuant to Section 424(d) of the Code, own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined voting power or value of all classes of stock of the Company or any of its Participating Affiliates or who, as a result of being granted an option under this Plan with respect to such Offering Period, would own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined power or value of all classes of stock of the Company or any of its Participating Affiliates; and

(c) individuals who provide services to the Company or any of its Participating Affiliates as independent contractors who are reclassified as common law employees for any reason except for federal income and employment tax purposes.

5. Offering Periods. The offering periods of this Plan (each, an "Offering Period") shall be of six (6) months duration commencing on January 1 and July 1 of the Company's fiscal year. The first day of each Offering Period is referred to as the "Offering Date." The last day of each Offering Period is referred to as the "Purchase Date." The Committee shall have the power to change the Offering Dates or Purchase Dates and the duration of Offering Periods without stockholder approval if such change is announced prior to the start of the relevant Offering Period, or prior to such other time period as specified by the Committee; provided, however, that no Offering Period may have a duration exceeding twenty-seven (27) months. If the first or last day of an Offering Period is not a day on which the New York Stock Exchange is open for trading, the Company shall specify the trading day that will be deemed the first or last day, as the case may be, of the Offering Period.

6. Participation in this Plan. An employee may participate during an Offering Period on the first Offering Date after such employee satisfies the eligibility requirements set forth in Section 4 above and delivers an appropriate enrollment form (the "Enrollment Form") to the Company prior to such Offering Date, or such other time period as specified by the Committee. Notwithstanding the foregoing, the Committee may set a later time for filing the Enrollment Form authorizing payroll deductions for all eligible employees with respect to a given Offering Period. An eligible employee who does not timely deliver an Enrollment Form to the Company after becoming eligible to participate in such Offering Period shall not participate in that Offering Period or any subsequent Offering Period until filing an Enrollment Form with the Company prior to the applicable Offering Date, or such other time period as specified by the Committee. Once an employee becomes a participant in an Offering Period, such employee will automatically participate in the Offering Period commencing immediately following the last day of the prior Offering Period unless the employee withdraws or is deemed to withdraw from this Plan or terminates further participation in the Offering Period as set forth in Section 11 below. A participant who has not otherwise withdrawn from this Plan under Section 11 is not required to file any additional Enrollment Form in order to continue participation in this Plan. However a participant may deliver a new Enrollment Form for a subsequent Offering Period in accordance with applicable rules and procedures if the participant wishes to change any of the elections contained in the participant's then effective Enrollment Form.

7. Grant of Option on Enrollment. Enrollment by an eligible employee in an Offering Period under this Plan will constitute the grant (as of the Offering Date for such Offering Period) by the Company to such employee of an option to purchase on the Purchase Date up to that number of shares of Common Stock of the Company determined by dividing (a) the amount accumulated in such employee's payroll deduction account during such Offering Period by (b) the Per Share Purchase Price as determined pursuant to Section 8 below (but in no event less than the par value of a share of Company's Common Stock), provided, however, that the number of shares of the Company's Common Stock subject to any option granted pursuant to this Plan shall not exceed the maximum number of shares which may be purchased pursuant to Section 10 below with respect to the applicable Purchase Date. The Fair Market Value of a share of the Company's Common Stock shall be determined as provided in Section 8 below.

8. Purchase Price. The purchase price per share ("Per Share Purchase Price") at which a share of Common Stock will be sold in any Offering Period shall be eighty-five percent (85%) of the lesser of:

(a) The Fair Market Value on the Offering Date; or

(b) The Fair Market Value on the Purchase Date.

For purposes of this Plan, the term "Fair Market Value" of the Common Stock on any given date means (i) the last reported closing price for a share of Stock on the New York Stock Exchange or, (ii) in the absence of reported sales on the New York Stock Exchange on a given date, the closing price of the New York Stock Exchange on the last date on which

a sale occurred prior to such date; or (iii) if the stock is no longer publicly traded on the New York Stock Exchange, the Committee in good faith shall determine Fair Market Value; provided that, if the date for which the Fair Market Value is determined is the first day when trading prices for the Stock are reported on the New York Stock Exchange, the Fair Market Value shall be the public offering price set forth on the cover page for the final prospectus relating to the Company's Initial Public Offering.

9. Payment of Purchase Price; Changes in Payroll Deductions; Issuance of Shares.

(a) The purchase price of the shares shall be accumulated by regular payroll deductions made during each Offering Period. The deductions are made as a percentage of the participant's Compensation in one percent (1%) increments not less than one percent (1%) (except as a result of an election pursuant to Section 9(c) to stop payroll deductions during an Offering Period), nor greater than fifteen percent (15%) or such lower limit set by the Committee. "Compensation" shall mean all W-2 cash compensation, including base salary, wages, commissions, overtime, shift premiums and bonuses, provided, however, that for purposes of determining a participant's compensation, any election by such participant to reduce his or her regular cash remuneration under Sections 125 or 401(k) of the Code shall be treated as if the participant did not make such election. Notwithstanding the foregoing, Compensation shall not include reimbursements of expenses, allowances, long-term disability, workers' compensation or any amount deemed received without the actual transfer of cash or any amounts directly or indirectly paid pursuant to this Plan or any other stock purchase or stock option plan, or any other compensation not included above. Payroll deductions shall commence on the first payday of the Offering Period and shall continue to the end of the Offering Period unless sooner altered or terminated as provided in this Plan.

(b) A participant may increase or decrease the rate of payroll deductions during an Offering Period by providing to the Company a new Enrollment Form, in which case the new rate shall become effective for the next payroll period commencing after the Company's receipt of the Enrollment Form and shall continue for the remainder of the Offering Period unless changed as described below. Such change in the rate of payroll deductions may be made at any time during an Offering Period, but not more than one (1) increase and one (1) decrease in the rate of payroll deductions may be made during any Offering Period. A participant may increase or decrease the rate of payroll deductions for any subsequent Offering Period by filing with the Company a new Enrollment Form prior to the beginning of such Offering Period, or prior to such other time period as specified by the Committee. Any changes to the rate of payroll deductions during an Offering Period which are received by the Company after the commencement of the enrollment period for a new Offering Period will be made by the Company at its discretion, only to the extent such changes are administratively possible.

(c) A participant may reduce his or her payroll deduction percentage to zero during an Offering Period by providing to the Company a revised Enrollment Form. Such reduction shall be effective beginning with the next payroll period after the Company's receipt of the request and no further payroll deductions will be made for the duration of the Offering Period. Payroll deductions credited to the participant's account prior to the effective date of

the request shall be used to purchase shares of Common Stock in accordance with Section (e) below. Notwithstanding Section 9(b), a participant may not resume making payroll deductions during the Offering Period in which he or she reduced his or her payroll deductions to zero. Any reduction to a participant's payroll deduction percentage to zero during an Offering Period which is received by the Company after the commencement of the enrollment period for a new Offering Period will be made by the Company at its discretion, only to the extent such changes are administratively possible.

(d) All payroll deductions made for a participant are credited to his or her account under this Plan and are deposited with the general funds of the Company. No interest accrues on the payroll deductions. All payroll deductions received or held by the Company may be used by the Company for any corporate purpose, and the Company shall not be obligated to segregate such payroll deductions.

(e) On each Purchase Date, so long as this Plan remains in effect and provided that the participant has not submitted a revised Enrollment Form withdrawing from this Plan before such Purchase Date in accordance with Section 11, the Company shall apply the funds then in the participant's account (or, if applicable, the lump sum cash payment received from the participant) to the purchase of whole shares of Common Stock reserved under the option granted to such participant with respect to the Offering Period to the extent that such option is exercisable on the Purchase Date. The Per Share Purchase Price shall be as specified in Section 8. Any cash remaining in such participant's account on a Purchase Date which is less than the amount necessary to purchase a full share of Common Stock of the Company shall be carried forward, without interest, into the next Offering Period. If this Plan has been oversubscribed, all funds not used to purchase shares on the Purchase Date shall be returned to the participant, without interest. No Common Stock shall be purchased on a Purchase Date on behalf of any employee whose participation in this Plan has terminated prior to such Purchase Date.

(f) As promptly as practicable after the Purchase Date, the Company shall issue shares for the participant's benefit representing the shares purchased upon exercise of his or her option, subject to compliance with Section 24 below.

(g) During a participant's lifetime, his or her option to purchase shares hereunder is exercisable only by him or her. The participant will have no interest or voting right in shares covered by his or her option until such option has been exercised.

10. Limitations on Shares to be Purchased.

(a) No participant shall be entitled to purchase Common Stock under this Plan at a rate which, when aggregated with his or her rights to purchase stock under all other employee stock purchase plans of the Company or any Parent Corporation or Subsidiary Corporation, exceeds $25,000 in Fair Market Value, determined as of the Offering Date (or such other limit as may be imposed by the Code) for each calendar year in which the employee participates in this Plan. The Company shall automatically suspend the payroll deductions of any participant as necessary to enforce such limit; provided that when the Company

automatically resumes such payroll deductions, the Company must apply the rate in effect immediately prior to such suspension.

(b) No participant shall be entitled to purchase more than the Maximum Share Amount (as defined below) on any single Purchase Date. Prior to the commencement of any Offering Period or before such time period as specified by the Committee, the Committee may, in its sole discretion, set a maximum number of shares which may be purchased by any employee at any single Purchase Date (the "Maximum Share Amount"). Until otherwise determined by the Committee, there shall be no Maximum Share Amount. If a new Maximum Share Amount is set, then all participants must be notified of such Maximum Share Amount before commencing the next Offering Period. The Maximum Share Amount shall continue to apply with respect to all succeeding Purchase Dates and Offering Periods unless revised by the Committee as set forth above.

(c) If the number of shares to be purchased on a Purchase Date by all employees participating in this Plan exceeds the number of shares then available for issuance under this Plan, then the Company will make a pro rata allocation of the remaining shares in as uniform a manner as shall be reasonably practicable and as the Committee shall determine to be equitable.

(d) Any payroll deductions accumulated in a participant's account which are not used to purchase stock due to the limitations in this Section 10 shall be returned to the participant as soon as practicable after the end of the applicable Offering Period, without interest, provided that, any amount remaining in such participant's account which is less than the amount necessary to purchase a full share of Common Stock of the Company shall be carried forward, without interest, into the next Offering Period or Offering Period.

11. Withdrawal.

(a) Each participant may withdraw from an Offering Period under this Plan by signing and delivering to the Company a revised Enrollment Form indicating such participant's intention to withdraw. Such withdrawal may be elected at any time prior to the end of an Offering Period, or such other time period as specified by the Committee.

(b) Upon withdrawal from this Plan, the accumulated payroll deductions shall be returned to the withdrawn participant, without interest, and his or her interest in this Plan shall terminate. If a participant voluntarily elects to withdraw from this Plan, he or she may not resume his or her participation in this Plan during the same Offering Period, but he or she may participate in any Offering Period under this Plan commencing after such withdrawal by filing a new authorization for payroll deductions in the same manner as set forth in Section 6 above for initial participation in this Plan.

12. Termination of Employment. Termination of a participant's employment for any reason, including retirement, death or the failure of a participant to remain an eligible employee of the Company or of a Participating Affiliate, immediately terminates his or her participation in this Plan. In such event, the payroll deductions credited to the participant's account will

be returned to him or her or, in the case of his or her death, to his or her legal representative, without interest. For purposes of this Section 12, an employee will not be deemed to have terminated employment or failed to remain in the continuous employ of the Company or of a Participating Affiliate in the case of sick leave, military leave, or any other leave of absence approved by the Board; provided that such leave is for a period of not more than ninety (90) days or reemployment upon the expiration of such leave is guaranteed by contract or statute.

13. Return of Payroll Deductions. If a participant's interest in this Plan is terminated by withdrawal, termination of employment or otherwise, or if this Plan is terminated by the Board, the Company shall deliver to the participant all payroll deductions credited to such participant's account. No interest shall accrue on the payroll deductions of a participant in this Plan.

14. Capital Changes. Subject to any required action by the stockholders of the Company, the number of shares of Common Stock covered by each option under this Plan which has not yet been exercised and the number of shares of Common Stock which have been authorized for issuance under this Plan but have not yet been placed under option (collectively, the "Reserves"), as well as the price per share of Common Stock covered by each option under this Plan which has not yet been exercised, shall be proportionately adjusted for any increase or decrease in the number of issued and outstanding shares of Common Stock resulting from a stock split or the payment of a stock dividend (but only on the Common Stock) or any other increase or decrease in the number of issued and outstanding shares of Common Stock effected without receipt of any consideration by the Company; provided, however, that conversion of any convertible securities of the Company shall not be deemed to have been "effected without receipt of consideration". Notwithstanding the foregoing, any fractional shares resulting from an adjustment pursuant to this Section 14 shall be rounded down to the nearest whole number, and in no event may the Per Share Purchase Price be decreased to an amount less than the par value, if any, of the Common Stock. Such adjustment shall be made by the Committee, whose determination shall be final, binding and conclusive.

In the event of the proposed dissolution or liquidation of the Company, the Offering Period will terminate immediately prior to the consummation of such proposed action, unless otherwise provided by the Committee. The Committee may, in its sole discretion in such instances, declare that this Plan shall terminate as of a date fixed by the Committee and either give each participant the right to purchase shares under this Plan prior to such termination or return all accumulated payroll deductions to each participant, without interest. In the event of (i) a merger or consolidation in which the Company is not the surviving corporation (other than a merger or consolidation with a wholly-owned subsidiary, a reincorporation of the Company in a different jurisdiction, or other transaction in which there is no substantial change in the stockholders of the Company or their relative stock holdings, provided that the options under this Plan are assumed, converted or replaced by the successor corporation, which assumption will be binding on all participants), (ii) a merger in which the Company is the surviving corporation but after which the stockholders of the Company immediately prior to such merger (other than any stockholder that merges, or which owns or controls another corporation that merges, with the Company in such merger) cease to own

their shares or other equity interest in the Company, (iii) the sale of all or substantially all of the assets of the Company or (iv) the acquisition, sale, or transfer of more than 50% of the outstanding shares of the Company by tender offer or similar transaction, (each a "Sale Event") the Company shall apply the funds contributed under this Plan to the purchase of shares of Common Stock pursuant to the provisions of Section 9 immediately prior to the effective date of such Sale Event. Notwithstanding the foregoing, the surviving, continuing, successor or purchasing corporation or parent corporation thereof (the "Acquiring Corporation"), may elect to assume the Company's rights and obligations under this Plan and, in that event, there shall be no purchase before the end of the Offering Period in which the Sale Event occurs.

The Committee may, if it so determines in its sole discretion, also make provision for adjusting the share reserve set forth in Section 1, as well as the price per share of Common Stock covered by each outstanding option, solely in the event that the Company effects one or more reorganizations, recapitalizations, rights offerings or other increases or reductions of shares of its outstanding Common Stock, or in the event of the Company being consolidated with or merged into any other corporation.

15. Withholding. The participant shall make adequate provision for the foreign, federal, state and local tax withholding obligations of the Company or any of its Participating Affiliates, if any, which arise in connection with participation in this Plan. The Company and its Participating Affiliates shall, to the extent permitted by law, have the right to deduct any such taxes from any payment of any kind otherwise due to the participant.

16. Nonassignability. Neither payroll deductions credited to a participant's account nor any rights with regard to the exercise of an option or to receive shares under this Plan may be assigned, transferred, pledged or otherwise disposed of in any way (other than by will, the laws of descent and distribution or as provided in Section 23 below) by the participant. Any such attempt at assignment, transfer, pledge or other disposition shall be void and without effect.

17. Reports. Individual accounts will be maintained for each participant in this Plan. Each participant shall receive as soon as practicable after the end of each Offering Period a report of his or her account setting forth the total payroll deductions accumulated, the number of shares purchased, the per share price thereof and the remaining cash balance, if any, carried forward to the next Offering Period.

18. Notice of Disqualifying Disposition. Each participant shall notify the Company in writing if the participant disposes of any of the shares purchased in any Offering Period pursuant to this Plan if such disposition occurs within two (2) years from the Offering Date or within one (1) year from the Purchase Date on which such shares were purchased (the "Notice Period"). The Company may, at any time during the Notice Period, place a legend or legends on any certificate representing shares acquired pursuant to this Plan requesting the Company's transfer agent to notify the Company of any transfer of the shares. The obligation of the participant to provide such notice shall continue notwithstanding the placement of any such legend on the certificates.

19. No Rights as Stockholder or to Continued Employment. A participant shall have no rights as a stockholder by virtue of participation in this Plan until the date of the issuance of a certificate for the shares purchased pursuant to the exercise of the participant's purchase right (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date such certificate is issued, except as provided in Section 14. Neither this Plan nor the grant of any option hereunder shall confer any right on any employee to remain in the employ of the Company or any Participating Affiliate, or restrict the right of the Company or any Participating Affiliate to terminate such employee's employment at any time.

20. Equal Rights and Privileges. All eligible employees shall have equal rights and privileges with respect to this Plan so that this Plan qualifies as an "employee stock purchase plan" within the meaning of Section 423 or any successor provision of the Code and the related regulations. Any provision of this Plan which is inconsistent with Section 423 or any successor provision of the Code shall, without further act or amendment by the Company, the Committee or the Board, be reformed to comply with the requirements of Section 423. This Section 20 shall take precedence over all other provisions in this Plan.

21. Notices. All notices or other communications by a participant to the Company under or in connection with this Plan shall be deemed to have been duly given when received in the form specified by the Company at the location, or by the person, designated by the Company for the receipt thereof.

22. Term; Stockholder Approval. This Plan was adopted by the Board of Directors of the Company on March 18, 2011, effective as of July 1, 2011 (the "Effective Date"), and shall apply to any purchase right granted, or stock transferred pursuant to any purchase right granted, on or after the Effective Date. This Plan shall continue until the earlier to occur of (a) termination of this Plan by the Board (which termination may be effected by the Board at any time), (b) issuance of all of the shares of Common Stock reserved for issuance under this Plan, or (c) April 27, 2021.

23. Designation of Beneficiary

(a) A participant may file a written designation of a beneficiary who is to receive any shares and cash, if any, from the participant's account under this Plan in the event of such participant's death subsequent to the end of any Offering Period but prior to delivery to him of such shares and cash. In addition, a participant may file a written designation of a beneficiary who is to receive any cash from the participant's account under this Plan in the event of such participant's death prior to a Purchase Date.

(b) Such designation of beneficiary may be changed by the participant at any time by written notice. In the event of the death of a participant and in the absence of a beneficiary validly designated under this Plan who is living at the time of such participant's death, the Company shall deliver such shares or cash to the executor or administrator of the estate of the participant, or if no such executor or administrator has been appointed (to the

knowledge of the Company), the Company, in its discretion, may deliver such shares or cash to the spouse or to any one or more dependents or relatives of the participant, or if no spouse, dependent or relative is known to the Company, then to such other person as the Company may designate.

24. Conditions Upon Issuance of Shares; Limitation on Sale of Shares. Shares shall not be issued with respect to an option unless the exercise of such option and the issuance and delivery of such shares pursuant thereto shall comply with all applicable provisions of law, domestic or foreign, including, without limitation, the Securities Act of 1933, as amended, the Securities Exchange Act of 1934, as amended, the rules and regulations promulgated thereunder, and the requirements of any stock exchange or automated quotation system upon which the shares may then be listed, and shall be further subject to the approval of counsel for the Company with respect to such compliance.

25. Applicable Law. This Plan shall be governed by the substantive laws (excluding the conflict of laws rules) of the State of California.

26. Amendment or Termination of this Plan. The Board may at any time amend, terminate or extend the term of this Plan, except that (i) any such termination cannot affect options previously granted under this Plan unless the Board determines that the termination of this Plan immediately following any Purchase Date is in the best interests of the Company and its stockholders, (ii) any amendment may not adversely affect the previously granted purchase right of any participant unless permitted by this Plan or as may be necessary to qualify this Plan as an employee stock purchase plan pursuant to Section 423 of the Code or to obtain qualification or registration of the Common Stock under applicable federal, state or foreign securities laws, and (iii) any amendment must be approved by the stockholders of the Company in accordance with Section 2 above within twelve (12) months of the adoption of such amendment (or earlier if required by Section 22) if such amendment would:

(a) increase the number of shares that may be issued under this Plan;

(b) change the designation of the employees (or class of employees) eligible for participation in this Plan; or

(c) any other action taken by the Board that, by its terms, is contingent on stockholder approval.

Notwithstanding the foregoing, the Board may make such amendments to this Plan as the Board determines to be advisable, if the continuation of this Plan or any Offering Period would result in financial accounting treatment for this Plan that is different from the financial accounting treatment in effect on the Effective Date.

EXHIBIT 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2014	**2013**	**2012**	**2011**	**2010**
	(Dollars in Thousands)				
Earnings:					
Income before income taxes, continuing operations	$ 135,304	$ 81,146	$ 23,379	$ 120,302	$ 81,128
Add fixed charges:					
Interest expense, including amortization of debt discount and expense	56,811	52,071	16,769	15,519	15,509
Estimated interest portion of rental expense	5,180	3,922	2,865	2,542	4,522
Total fixed charges	61,991	55,993	19,634	18,061	20,031
Total earnings available for fixed charges	$ 197,295	$ 137,139	$ 43,013	$ 138,363	$ 101,159
Fixed charges from above:	$ 61,991	$ 55,993	$ 19,634	$ 18,061	$ 20,031
Ratio of Earnings to Fixed Charges	3.2	2.4	2.2	7.7	5.1
Total rent expense	$ 32,375	$ 24,510	$ 20,462	$ 23,110	$ 25,124
Interest factor	16%	16%	14%	11%	18%
Interest component of rental expense	$ 5,180	$ 3,922	$ 2,865	$ 2,542	$ 4,522

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Mississippi, Inc.*	Mississippi
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Puerto Rico, Inc.	Puerto Rico
Molina Healthcare of South Carolina, Inc.	South Carolina
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company^	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Hospital Management, Inc.	California
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Medical Management, Inc.	California
Molina Pathways, LLC*	Delaware
Molina Pathways of Texas, Inc.+*	Texas
Molina Personal Care, Inc.+ *	Texas
Molina Personal Care of South Carolina, Inc.+*	South Carolina
Molina Youth Academy	California

* Non-operational entity

^ Wholly owned subsidiary of Molina Healthcare of Texas, Inc.

\+ Wholly owned subsidiary of Molina Pathways, LLC

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statements No. 333-108317, No. 333-138552, No. 333-153246, No. 333-170571, and No. 333-174912 on Form S-8 pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan; 2002 Equity Incentive Plan; 2002 Employee Stock Purchase Plan; 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and Registration Statement No. 333-181804 on Form S-3, of our reports dated February 26, 2015, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2014.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2015

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2014, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Joseph M. Molina

Joseph M. Molina

Chief Executive Officer and President

February 26, 2015

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2014, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ John C. Molina

John C. Molina, J.D.

Chief Financial Officer and Treasurer

February 26, 2015

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2014, as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chief Executive Officer and President

February 26, 2015

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2014, as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

February 26, 2015

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended September 30, 2014

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2014

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of October 24, 2014, was approximately 48,397,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended September 30, 2014

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	September 30, 2014	December 31, 2013
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,598,596	$ 935,895
Investments	842,683	703,052
Receivables	425,683	298,935
Income taxes refundable	7,679	32,742
Deferred income taxes	30,817	26,556
Prepaid expenses and other current assets	82,062	42,484
Total current assets	2,987,520	2,039,664
Property, equipment, and capitalized software, net	328,547	292,083
Deferred contract costs	51,179	45,675
Intangible assets, net	85,035	98,871
Goodwill	236,635	230,738
Restricted investments	93,119	63,093
Derivative asset	222,997	186,351
Other assets	51,108	46,462
	$ 4,056,140	$ 3,002,937
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 1,123,846	$ 669,787
Accounts payable and accrued liabilities	609,444	319,965
Deferred revenue	190,856	122,216
Current maturities of long-term debt	11,927	182,008
Total current liabilities	1,936,073	1,293,976
Convertible senior notes	697,210	416,368
Lease financing obligations	160,412	159,394
Lease financing obligations – related party	39,258	27,092
Deferred income taxes	7,719	580
Derivative liability	222,877	186,239
Other long-term liabilities	28,300	26,351
Total liabilities	3,091,849	2,110,000
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 48,279 shares at September 30, 2014 and 45,871 shares at December 31, 2013	48	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	383,300	340,848
Accumulated other comprehensive loss	(617)	(1,086)
Retained earnings	581,560	553,129
Total stockholders' equity	964,291	892,937
	$ 4,056,140	$ 3,002,937

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 2,316,759	$ 1,584,656	$ 6,424,238	$ 4,583,818
Service revenue	52,557	51,100	156,419	150,528
Premium tax revenue	81,240	43,723	203,053	127,606
Health insurer fee revenue	29,427	—	67,785	—
Investment income	2,041	1,740	5,615	4,884
Other revenue	2,327	5,860	8,523	16,476
Total revenue	2,484,351	1,687,079	6,865,633	4,883,312
Operating expenses:				
Medical care costs	2,097,836	1,383,213	5,753,793	3,965,834
Cost of service revenue	40,067	40,113	117,831	119,188
General and administrative expenses	178,879	176,233	560,205	478,990
Premium tax expenses	81,240	43,723	203,053	127,606
Health insurer fee expenses	22,308	—	66,443	—
Depreciation and amortization	24,242	18,871	67,835	52,449
Total operating expenses	2,444,572	1,662,153	6,769,160	4,744,067
Operating income	39,779	24,926	96,473	139,245
Other expenses, net:				
Interest expense	14,419	13,532	42,234	38,236
Other expense (income), net	863	(24)	810	3,347
Total other expenses, net	15,282	13,508	43,044	41,583
Income from continuing operations before income tax expense	24,497	11,418	53,429	97,662
Income tax expense	8,427	3,865	24,784	43,791
Income from continuing operations	16,070	7,553	28,645	53,871
Income (loss) from discontinued operations, net of tax	52	16	(214)	8,184
Net income	$ 16,122	$ 7,569	$ 28,431	$ 62,055
Basic net income (loss) per share:				
Continuing operations	$ 0.34	$ 0.17	$ 0.62	$ 1.18
Discontinued operations	—	—	(0.01)	0.18
Basic net income per share	$ 0.34	$ 0.17	$ 0.61	$ 1.36
Diluted net income (loss) per share:				
Continuing operations	$ 0.33	$ 0.16	$ 0.60	$ 1.15
Discontinued operations	—	—	(0.01)	0.18
Diluted net income per share	$ 0.33	$ 0.16	$ 0.59	$ 1.33

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(Amounts in thousands) (Unaudited)			
Net income	$ 16,122	$ 7,569	$ 28,431	$ 62,055
Other comprehensive (loss) income:				
Unrealized investment (loss) gain	(1,061)	2,087	756	(1,539)
Effect of income taxes	(404)	793	287	(585)
Other comprehensive (loss) income, net of tax	(657)	1,294	469	(954)
Comprehensive income	$ 15,465	$ 8,863	$ 28,900	$ 61,101

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2014	2013
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 28,431	$ 62,055
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	99,464	68,035
Deferred income taxes	(10,705)	(38,442)
Stock–based compensation	16,115	20,654
Amortization of convertible senior notes and lease financing obligations	20,195	16,128
Other, net	3,875	14,406
Changes in operating assets and liabilities:		
Receivables	(126,748)	(144,285)
Prepaid expenses and other assets	(51,582)	(27,552)
Medical claims and benefits payable	454,059	138,176
Accounts payable and accrued liabilities	314,391	20,991
Deferred revenue	68,640	(17,410)
Income taxes	25,063	(1,012)
Net cash provided by operating activities	841,198	111,744
Investing activities:		
Purchases of investments	(616,324)	(627,953)
Proceeds from sales and maturities of investments	473,836	227,800
Purchases of equipment	(71,771)	(64,426)
Increase in restricted investments	(24,301)	(21,124)
Net cash paid in business combinations	(7,500)	(57,684)
Other, net	(15,220)	1,971
Net cash used in investing activities	(261,280)	(541,416)
Financing activities:		
Proceeds from issuance of convertible senior notes, net of deferred financing costs	123,387	537,973
Proceeds from sale-leaseback transactions	—	158,694
Purchase of call option	—	(149,331)
Proceeds from issuance of warrants	—	75,074
Treasury stock purchases	—	(50,000)
Principal payments on term loan	—	(47,471)
Repayment of amounts borrowed under credit facility	—	(40,000)
Contingent consideration liabilities settled	(50,349)	—
Proceeds from employee stock plans	7,628	5,156
Other, net	2,117	363
Net cash provided by financing activities	82,783	490,458
Net increase in cash and cash equivalents	662,701	60,786
Cash and cash equivalents at beginning of period	935,895	795,770
Cash and cash equivalents at end of period	$ 1,598,596	$ 856,556

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Nine Months Ended September 30,	
	2014	2013
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 7,991	$ 72,156
Interest	$ 24,384	$ 28,035
Schedule of non-cash investing and financing activities:		
3.75% Notes exchanged for 1.625% Notes	$ 176,551	$ —
Retirement of treasury stock	$ —	$ 53,000
Increase in non-cash lease financing obligation – related party	$ 13,841	$ 19,222
Common stock used for stock-based compensation	$ 8,595	$ 6,667
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 36,646	$ 42,332
Loss on 1.125% Notes Conversion Option	(36,638)	(42,225)
Loss on 1.125% Warrants	—	(3,923)
Gain on interest rate swap	—	433
Change in fair value of derivatives, net	$ 8	$ (3,383)
Details of business combinations:		
Fair value of assets acquired	$ 7,500	$ 121,845
Fair value of contingent consideration liabilities incurred	—	(59,947)
Payable to seller	—	(3,882)
Escrow deposit	—	(332)
Net cash paid in business combinations	$ 7,500	$ 57,684

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
September 30, 2014

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of September 30, 2014, these health plans served approximately 2.4 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

On October 15, 2014, the Puerto Rico Health Insurance Administration announced that it has selected Molina Healthcare of Puerto Rico to operate the Commonwealth's Medicaid-funded Government Health Plan program in the East and Southwest regions. We expect to begin serving members in the second quarter of 2015.

In August 2014, we announced that our Florida health plan entered into an agreement with First Coast Advantage, LLC (FCA) to acquire certain assets related to FCA's Medicaid business. As part of the transaction, we will assume FCA's Medicaid contract and certain provider agreements for Region 4 of the Statewide Medicaid Managed Care Managed Medical Assistance Program in the state of Florida. We have received approval for the transaction from the Florida Agency for Health Care Administration, and expect to close in late 2014 or early 2015.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we classified the operations for our Missouri health plan as discontinued operations for all periods presented in our consolidated financial statements.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2014.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2013. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2013 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2013 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2013 consolidated balance sheet and statement of cash flows to conform to the 2014 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

(1) Contractual provisions that may adjust or limit revenue or profit:

Health Plan Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $272.6 million and $1.4 million at September 30, 2014, and December 31, 2013, respectively, to accounts payable and accrued liabilities. The increase is primarily driven by contractual provisions relating to the Medicaid expansion program, which began to phase in during January 2014. Beginning in 2014, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. In the aggregate, we recorded a receivable under the terms of such contract provisions of $3.6 million at September 30, 2014. Separately, in certain states we may be levied with non-monetary sanctions if certain minimum amounts are not spent on defined medical care costs, or if administrative costs exceed certain amounts.

Health Plan Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to fully retain, we recorded a liability of $24.5 million and $2.5 million at September 30, 2014 and December 31, 2013, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of $18.6 million and $20.8 million for anticipated Medicare risk adjustment premiums at September 30, 2014, and December 31, 2013, respectively.

(2) Quality incentives:

At our California, Illinois, New Mexico, Ohio, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1% to 4% of health plan premiums is earned if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and in prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2014 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30, 2014.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(In thousands)			
Maximum available quality incentive premium - current period	$ 24,477	$ 20,939	$ 68,941	$ 62,050
Amount of quality incentive premium revenue recognized in current period:				
Earned current period	$ 12,921	$ 17,538	$ 30,935	$ 52,483
Earned prior periods	208	(50)	3,412	7,759
Total	$ 13,129	$ 17,488	$ 34,347	60,242
Total premium revenue recognized for state health plans with quality incentive premiums	$ 1,818,375	$ 771,615	$ 5,005,444	$ 2,192,249

(3) California health plan rate settlement agreement:

In the fourth quarter of 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, a settlement account (the Account) applicable to the California health plan's managed care contracts has been established.

Effective January 1, 2014, the Account was established with an initial balance of zero, and will be settled after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our managed care contracts. The Account will be adjusted annually to reflect a calendar year deficit or surplus, which is determined by comparing the California health plan's pre-tax margin and a target margin established in the settlement agreement. Upon expiration of the settlement agreement, if the Account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. If the Account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40.0 million.

We estimate and recognize the retrospective adjustments to premium revenue based on our experience to date under the California health plan's managed care contracts. As of September 30, 2014, we recorded a deficit, or receivable, of $3.5 million, net of a valuation discount of $0.2 million, reflecting our estimated retrospective premium adjustment to the Account based on the California health plan's actual pretax margin for the nine months ended September 30, 2014.

In addition to the three categories of accounting estimates discussed above, our California health plan recognized a benefit of approximately $15 million in the second quarter of 2014 for certain premium revenue which related to the year ended December 31, 2013.

Service Revenue and Cost of Service Revenue – Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the contract term, consistent with the revenue recognition period.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible health insurer fee expenses, nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the mathematical impact of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

During the third quarter of 2014, the Internal Revenue Service (IRS) issued final regulations related to compensation deduction limitations applicable to certain health insurance issuers. Pursuant to these final regulations, we recognized a tax benefit during the third quarter of 2014 of approximately $7 million, or $0.15 per diluted share, for periods prior to the third quarter of 2014.

The total amount of unrecognized tax benefits was $1.8 million and $8.0 million as of September 30, 2014 and December 31, 2013, respectively. The unrecognized tax benefits recorded at December 31, 2013 decreased by $6.2 million during the nine months ended September 30, 2014 as a result of the execution of a state settlement agreement and the expiration of statutes of limitation. This decrease had a nominal impact to the tax provision for the nine months ended September 30, 2014. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $1.6 million and $5.7 million as of September 30, 2014 and December 31, 2013, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $0.1 million due to the expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of September 30, 2014 and December 31, 2013 were insignificant.

Income taxes relating to discontinued operations for the three months ended September 30, 2014 and 2013 were insignificant. During the nine months ended September 30, 2014 and 2013, we recognized tax benefits of $0.3 million and $10.0 million, respectively, related to discontinued operations.

New Accounting Standards

Health Insurer Fee. In the first quarter of 2014, we adopted the guidance of the Financial Accounting Standards Board (FASB) related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA). The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. The health insurer fee (HIF) is imposed beginning in 2014, is based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year.

Effective January 1, 2014, we recorded our estimate of the 2014 liability to accounts payable and accrued liabilities. During the third quarter of 2014 we paid our 2014 HIF assessment, which amounted to $88.6 million. This expense is being recognized on a straight-line basis in 2014; and is non-deductible for income tax purposes.

Because we primarily serve individuals in government-sponsored programs, we must secure additional reimbursement from our state partners for this added cost. We recognize HIF revenue when we have obtained a contractual commitment from a state to reimburse us for the health insurer fee. Such HIF revenue is recognized ratably throughout the year.

Revenue Recognition. In May 2014, the FASB issued Accounting Standards Update (ASU) 2014-09 - *Revenue from Contracts with Customers*, which will supersede nearly all existing revenue recognition guidance under U.S. generally accepted accounting principles (GAAP). The core principal of this ASU is that an entity should recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. This ASU also requires additional disclosure about the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in judgments and assets recognized from costs incurred to obtain or fulfill a contract. This ASU will be effective for us in the first quarter of 2017; early adoption is not permitted. The ASU allows for either full retrospective or modified retrospective adoption. We are evaluating the transition method that will be elected and the potential effects of the adoption of this ASU on our financial statements.

Discontinued Operations. In April 2014, the FASB issued ASU 2014-08 - *Reporting Discontinued Operations and Disclosures of Disposal of Components of an Entity*, which raises the threshold for disposals to qualify as discontinued operations by focusing on strategic shifts that have or will have a major effect on an entity's operations and financial results. This ASU will be effective for us in the first quarter of 2015, and is applied prospectively. Early adoption is permitted but only for disposals (or classifications as held for sale) that have not been reported in financial statements previously issued or available for issue. We are evaluating the potential effects of the adoption of the ASU on our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(In thousands)			
Shares outstanding at the beginning of the period	46,494	45,683	45,871	46,762
Weighted-average number of shares:				
Repurchased	—	—	—	(1,375)
Issued, 3.75% Exchange (1)	460	—	155	—
Issued, stock-based compensation and other	37	16	409	321
Denominator for basic net income per share	46,991	45,699	46,435	45,708
Effect of dilutive securities:				
Stock-based compensation	365	453	441	532
3.75% Notes and 3.75% Exchange (1)	1,288	910	1,212	527
Denominator for diluted net income per share	48,644	47,062	48,088	46,767
Potentially dilutive common shares excluded from calculations (2):				
Stock options	—	60	—	49
1.125% Warrants	13,490	13,490	13,490	11,464

(1) For more information regarding the 3.75% Exchange and 3.75% Notes, refer to Note 11, "Long-Term Debt."

(2) Potentially dilutive shares issuable pursuant to certain of our employee stock options, 1.125% Warrants (defined in Note 12, "Derivative Financial Instruments"), and 1.625% Notes (defined in Note 11, "Long-Term Debt") were not included in the computation of diluted net income per share because to do so would have been anti-dilutive.

4. Business Combinations

Health Plans Segment

South Carolina. In July 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members covered by South Carolina's full-risk Medicaid managed care program. The conversion conditions under the agreement were satisfied by January 1, 2014, and on that date such Medicaid members were converted to the managed care program and enrolled with our South Carolina health plan. Because the number of Medicaid members we would ultimately convert was unknown as of the acquisition date in 2013, we recorded a contingent consideration liability for such members to be settled when the final purchase price was known in the second quarter of 2014. The total purchase price for the converted Medicaid membership amounted to $57.2 million, of which $49.7 million was paid in the first half of 2014, and $7.5 million was paid when the agreement was executed in 2013. The total amount paid includes indemnification withhold funds transferred to restricted investments amounting to $5.7 million. Any unused and remaining portion of such indemnification funds will become unrestricted and released to CHS on the one-year anniversary date of the conversion, or January 1, 2015.

As part of this transaction, we have also recorded a contingent consideration liability for dual-eligible members we expect to enroll in our Medicare-Medicaid Plan (MMP) implementation in South Carolina. The contingent consideration liability is remeasured to fair value at each quarter until the contingency is resolved with fair value adjustments, if any, recorded to operations. As of September 30, 2014, the fair value of the remaining contingent consideration liability for the MMP implementation amounted to $1.5 million.

The aggregate contingent consideration liability fair value adjustments for the South Carolina transaction have resulted in a gain of $4.2 million in the nine months ended September 30, 2014.

New Mexico. In August 2013, our New Mexico health plan acquired Lovelace Community Health Plan's contract for the state of New Mexico's Medicaid program. In addition to Lovelace's Medicaid members, we also added membership previously covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace. Effective January 1, 2014, these SCI members were either enrolled in New Mexico's Medicaid program, or eligible to enroll in New Mexico's Marketplace. Because the number of SCI members we would ultimately retain was unknown as of the acquisition date in 2013, we recorded a contingent consideration liability for such members to be settled when the final purchase price was known in the second quarter of 2014. The aggregate contingent consideration liability fair value adjustments for the New Mexico transaction have resulted in a gain of $1.5 million in the nine months ended September 30, 2014.

Florida. In August 2014, our Florida health plan acquired certain assets relating to the Medicaid business of Healthy Palm Beaches, Inc. The final purchase price for this acquisition was $7.5 million. The Florida health plan's membership increased by approximately 11,000 members as a result of this transaction.

5. Stock-Based Compensation

In March 2014, our named executive officers were granted a total of 356,292 restricted shares with service, market, and performance conditions. In the event the vesting conditions are not achieved, the awards will lapse. As of September 30, 2014, we expect the performance conditions to be met in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(In thousands)			
Restricted stock and performance awards	$ 4,774	$ 7,634	$ 13,596	$ 18,593
Employee stock purchase plan and stock options	885	870	2,519	2,061
	$ 5,659	$ 8,504	$ 16,115	$ 20,654

As of September 30, 2014, there was $28.6 million of total unrecognized compensation expense related to unvested restricted stock awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 2.0 years.

Restricted and performance stock activity for the nine months ended September 30, 2014 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2013	1,299,852	$ 29.03
Granted	656,452	36.68
Vested	(597,301)	27.70
Forfeited	(60,742)	31.20
Unvested balance as of September 30, 2014	1,298,261	33.40

The total fair value of restricted and performance awards granted during the nine months ended September 30, 2014 and 2013 was $24.8 million and $33.3 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, which vested during the nine months ended September 30, 2014 and 2013 was $22.5 million and $19.3 million, respectively.

6. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, other assets, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities (excluding contingent consideration) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Such investments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Notes Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of September 30, 2014 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, “Derivative Financial Instruments,” the 1.125% Call Option asset and the 1.125% Notes Conversion Option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Contingent consideration liability. Such liability relates to our South Carolina health plan acquisition described in Note 4, "Business Combinations," and is recorded in accounts payable and accrued liabilities. We applied discounted cash flow analysis to determine the fair value of this liability. Significant unobservable inputs primarily related to the probability weighted present value of the purchase price estimate for the projected membership.

Auction rate securities. Auction rate securities are designated as available-for-sale and are reported at fair value in other assets. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of September 30, 2014.

Our financial instruments measured at fair value on a recurring basis at September 30, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 553,936	$ —	$ 553,936	$ —
Municipal securities	96,873	—	96,873	—
GSEs	99,254	99,254	—	—
U.S. treasury notes	41,031	41,031	—	—
Certificates of deposit	51,589	—	51,589	—
Auction rate securities	6,891	—	—	6,891
1.125% Call Option derivative asset	222,997	—	—	222,997
Total assets measured at fair value on a recurring basis	$ 1,072,571	$ 140,285	$ 702,398	$ 229,888
1.125% Notes Conversion Option derivative liability	$ 222,877	$ —	$ —	$ 222,877
Contingent consideration liability	1,500	—	—	1,500
Total liabilities measured at fair value on a recurring basis	$ 224,377	$ —	$ —	$ 224,377

Our financial instruments measured at fair value on a recurring basis at December 31, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 449,772	$ —	$ 449,772	$ —
Municipal securities	113,330	—	113,330	—
GSEs	68,817	68,817	—	—
U.S. treasury notes	37,376	37,376	—	—
Certificates of deposit	33,757	—	33,757	—
Auction rate securities	10,898	—	—	10,898
1.125% Call Option derivative asset	186,351	—	—	186,351
Total assets measured at fair value on a recurring basis	$ 900,301	$ 106,193	$ 596,859	$ 197,249
1.125 % Notes Conversion Option derivative liability	$ 186,239	$ —	$ —	$ 186,239
Contingent consideration liabilities	57,548	—	—	57,548
Total liabilities measured at fair value on a recurring basis	$ 243,787	$ —	$ —	$ 243,787

The following table presents activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Change in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liabilities
		(In thousands)	
Balance at December 31, 2013	$ 10,898	$ 112	$ (57,548)
Total gains for the period recognized in:			
General and administrative expenses	—	—	5,699
Other expenses, net	—	8	—
Other comprehensive income	193	—	—
Settlements	(4,200)	—	50,349
Balance at September 30, 2014	$ 6,891	$ 120	$ (1,500)

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our convertible senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on

quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	September 30, 2014				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 430,484	$ 649,770	$ —	$ 649,770	$ —
1.625% Notes	266,726	302,908	—	302,908	—
3.75% Notes	10,449	15,290	—	15,290	—
	$ 707,659	$ 967,968	$ —	$ 967,968	$ —

	December 31, 2013				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 416,368	$ 572,627	$ —	$ 572,627	$ —
3.75% Notes	181,872	219,491	—	219,491	—
	$ 598,240	$ 792,118	$ —	$ 792,118	$ —

7. Investments

The following tables summarize our investments as of the dates indicated:

	September 30, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 554,359	$ 448	$ 871	$ 553,936
Municipal securities	96,899	179	205	96,873
GSEs	99,436	16	198	99,254
U.S. treasury notes	41,074	13	56	41,031
Certificates of deposit	51,601	3	15	51,589
Subtotal - current investments	843,369	659	1,345	842,683
Auction rate securities	7,200	—	309	6,891
	$ 850,569	$ 659	$ 1,654	$ 849,574

	December 31, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 450,162	$ 442	$ 832	$ 449,772
Municipal securities	114,126	119	915	113,330
GSEs	68,898	6	87	68,817
U.S. treasury notes	37,360	44	28	37,376
Certificates of deposit	33,756	2	1	33,757
Subtotal - current investments	704,302	613	1,863	703,052
Auction rate securities	11,400	—	502	10,898
	$ 715,702	$ 613	$ 2,365	$ 713,950

The contractual maturities of our investments as of September 30, 2014 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 312,449	$ 312,493
Due one year through five years	530,920	530,190
Due after ten years	7,200	6,891
	$ 850,569	$ 849,574

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the three and nine months ended September 30, 2014 and 2013 were insignificant.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at September 30, 2014 and December 31, 2013, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of September 30, 2014:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 231,598	$ 639	163	$ 43,112	$ 232	13
Municipal securities	39,331	90	34	13,419	115	14
GSEs	71,602	161	21	5,992	37	6
U.S. treasury notes	21,545	51	12	4,245	5	2
Certificates of deposit	11,762	15	49	—	—	—
Auction rate securities	—	—	—	6,891	309	10
	$ 375,838	$ 956	279	$ 73,659	$ 698	45

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2013:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 210,057	$ 802	91	$ 2,540	$ 30	3
Municipal securities	30,715	398	49	31,091	517	39
GSEs	53,308	87	21	—	—	—
U.S. treasury notes	12,037	28	11	—	—	—
Certificates of deposit	414	1	2	—	—	—
Auction rate securities	—	—	—	10,898	502	15
	$ 306,531	$ 1,316	174	$ 44,529	$ 1,049	57

Auction Rate Securities. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 16 years to 32 years. Considering the insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current

intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction rate securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at September 30, 2014. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $74.9 million of these instruments at par value.

For the nine months ended September 30, 2014 and 2013, we recorded pretax unrealized gains of $0.2 million and $0.5 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future impairment is other-than-temporary, we will record a charge to earnings as appropriate.

8. Receivables

Receivables consist primarily of amounts due from the various states in which we operate, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are state governments, our allowance for doubtful accounts is immaterial.

	September 30, 2014	December 31, 2013
	(In thousands)	
California	$ 184,368	$ 148,654
Florida	7,599	2,901
Illinois	3,412	5,773
Michigan	21,327	15,253
New Mexico	28,393	17,056
Ohio	66,839	43,969
South Carolina	4,229	—
Texas	14,608	9,736
Utah	9,274	10,953
Washington	33,214	13,455
Wisconsin	12,492	8,087
Direct delivery and other	8,240	2,463
Total Health Plans segment	393,995	278,300
Molina Medicaid Solutions segment	31,688	20,635
	$ 425,683	$ 298,935

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with the Molina Medicaid Solutions contract with the state of Maine, we maintain restricted investments as collateral for a letter of credit. The following table

presents the balances of restricted investments:

	September 30, 2014	December 31, 2013
	(In thousands)	
California	$ 373	$ 373
Florida	23,291	9,242
Illinois	312	310
Michigan	1,014	1,014
New Mexico	31,132	24,622
Ohio	12,719	9,080
South Carolina	6,038	310
Texas	3,500	3,500
Utah	3,601	3,301
Washington	151	151
Other	5,987	886
Total Health Plans segment	88,118	52,789
Molina Medicaid Solutions segment	5,001	10,304
	$ 93,119	$ 63,093

The contractual maturities of our held-to-maturity restricted investments as of September 30, 2014 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 92,807	$ 92,817
Due one year through five years	312	312
	$ 93,119	$ 93,129

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated:

	September 30, 2014	December 31, 2013
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 796,433	$ 424,173
Pharmacy payable	62,322	45,037
Capitation payable	31,535	20,267
Other	233,556	180,310
	$ 1,123,846	$ 669,787

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Such non-risk provider payables amounted to $136.0 million and $151.3 million as of September 30, 2014 and December 31, 2013, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts presented for “Components of medical care costs related to: Prior period” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30, 2014	Year Ended December 31, 2013
	(Dollars in thousands)	
Balances at beginning of period	$ 669,787	$ 494,530
Components of medical care costs related to:		
Current period	5,795,404	5,434,443
Prior period	(41,033)	(52,779)
Total medical care costs	5,754,371	5,381,664
Change in non-risk provider payables	(15,344)	111,267
Payments for medical care costs related to:		
Current period	4,841,429	4,932,195
Prior period	443,539	385,479
Total paid	5,284,968	5,317,674
Balances at end of period	$ 1,123,846	$ 669,787
Benefit from prior period as a percentage of:		
Balance at beginning of period	6.1%	10.7%
Premium revenue, trailing twelve months	0.5%	0.9%
Medical care costs, trailing twelve months	0.6%	1.0%

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2014 and 2013 were less than what we had expected when we established our reserves. For example, for the year ended December 31, 2013, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2012 by 10.7%. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

While prior period development of our estimate as of December 31, 2013 through September 30, 2014 has been favorable by $41.0 million, that amount is substantially less than the favorable prior period development of $52.8 million that we recognized in all of 2013.

In estimating our claims liability at September 30, 2014, we adjusted our base calculation to take account of the numerous factors that we believe will likely change our final claims liability amount. We believe the most significant among those factors are:

- Since January 1, 2014, we have added 314,500 members under Medicaid expansion in six of our health plans. Because these members are transitioning into managed care, and have different demographics than those of our legacy membership, we have little insight into their utilization of medical services. Additionally, as of September 30, 2014, we have relatively little medical claims payment history related to Medicaid expansion membership in Illinois, Michigan and Ohio because such membership was enrolled in these states later in the year. Accordingly, our estimates of the claims liability for this population are subject to a higher degree of uncertainty.

- Since January 1, 2014, we have added 118,000 new members at our South Carolina health plan. Because we have only nine months of claims payment history, the reserves are subject to greater uncertainty than that of our legacy Medicaid membership.
- At our New Mexico health plan, the state has been adding approximately 10,000 to 15,000 members per month on a retroactive basis since March 2014. Because we have no claims payment history for these members, our estimates of the claims liability for this population are subject to a higher degree of uncertainty. However, for these members, the state will reimburse the health plan for claims with dates of service during the retroactive period on a cost-plus basis, i.e., for claims paid plus an administration fee.
- Beginning in the third quarter of 2014, there was a substantial backlog of inpatient claims at our Washington health plan. This backlog was a result of payments held as the state of Washington considered whether to adjust its payment methodology for inpatient claims. We have adjusted the inpatient reserves to reflect the estimated impact of the claims backlog.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2013, and for the nine months ended September 30, 2014, the absence of adverse development of the liability for medical claims and benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both periods, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

11. Long-Term Debt

As of September 30, 2014, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2014	2015	2016	2017	2018	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
1.625% Notes (1)	301,551	—	—	—	—	—	301,551
3.75% Notes	10,449	10,449	—	—	—	—	—
	$ 862,000	$ 10,449	$ —	$ —	$ —	$ —	$ 851,551

(1) The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 as described below, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes.

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes), which were outstanding as of September 30, 2014 and December 31, 2013. Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15, at a rate of 1.125% per annum. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date. The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities.

The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of the 1.125% Notes. This represents an initial conversion price of approximately $40.77 per share of our common stock. The conversion rate is subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest.

The 1.125% Notes contain an embedded cash conversion option (the 1.125% Notes Conversion Option), which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the 1.125% Notes Conversion Option transaction settles or expires. The initial fair value liability of the 1.125% Notes Conversion Option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5.9%. As of September 30, 2014, we expect the 1.125% Notes to be

outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 5.3 years. The 1.125% Notes' if-converted value exceeded their principal amount by approximately $48 million as of September 30, 2014, and did not exceed their principal amount as of December 31, 2013.

3.75% Exchange. In August 2014, we entered into separate, privately negotiated, exchange agreements (the 3.75% Exchange) with certain holders of our outstanding 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes). In this transaction, we exchanged $176.6 million aggregate principal amount of the 3.75% Notes for $176.6 million aggregate principal amount of 1.625% Convertible Senior Notes due 2044 (the 1.625% Notes, see further discussion below), approximately 1.7 million shares of our common stock (the Exchange Shares), and payment of accrued interest on the exchanged 3.75% Notes. In connection with the 3.75% Exchange, we did not receive any proceeds from the issuance of the 1.625% Notes or the Exchange Shares.

1.625% Convertible Senior Notes due 2044. In addition to the 1.625% Notes issued in connection with the 3.75% Exchange described above, we issued $125.0 million principal amount of 1.625% Notes in September 2014, amounting to $301.6 million aggregate principal amount outstanding under the 1.625% Notes as of September 30, 2014. The proceeds from the issuance of the $125.0 million principal amount of the 1.625% Notes amounted to $123.4 million, including a premium of $0.6 million, and net of deferred issuance costs paid. In connection with the 1.625% Notes, we have recorded total deferred issuance costs of approximately $6 million, which will be amortized over the expected term of the debt (discussed below).

Interest on the 1.625% Notes is payable semiannually in arrears on February 15 and August 15, at a rate of 1.625% per annum, beginning on February 15, 2015. The 1.625% Notes will mature on August 15, 2044 unless repurchased or converted in accordance with their terms prior to such date. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Notes during any semiannual interest period in which certain conditions are satisfied, or under certain events of default. Furthermore, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Notes outstanding is less than $100 million.

The initial conversion rate for the 1.625% Notes is 17.2157 shares of our common stock per $1,000 principal amount of the 1.625% Notes. This represents an initial conversion price of approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture). We may not redeem the 1.625% Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Notes, except for the 1.625% Notes we are required to repurchase in connection with a fundamental change (as defined in the related indenture) or on any specified repurchase date (as defined in the indenture). The redemption price for the 1.625% Notes will equal 100% of the principal amount of the 1.625% Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Notes have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Notes resulted in a debt discount that is amortized back to the 1.625% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the notes in August 2018. This has resulted in our recognition of interest expense on the 1.625% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Notes' if-converted value did not exceed principal amount as of September 30, 2014. At September 30, 2014, the equity component of the 1.625% Notes, including the impact of deferred taxes, was $22.6 million.

3.75% Convertible Senior Notes due 2014. We had $10.4 million and $187.0 million of the 3.75% Notes outstanding as of September 30, 2014 and December 31, 2013, respectively. As described above, we entered into the 3.75% Exchange transaction in August 2014, under which we exchanged $176.6 million of the outstanding principal amount of the 3.75% Notes for the 1.625% Notes. The remaining $10.4 million principal amount outstanding as of September 30, 2014 was repaid in full in early October 2014. In addition to the repayment of the outstanding principal balance, in early October 2014 we issued approximately 0.1 million shares to settle the 3.75% Notes' conversion feature.

Because the 3.75% Notes had cash settlement features, we allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that was amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or 7.5%. The outstanding 3.75% Notes' if-converted value exceeded their principal amount by approximately $4 million and $11 million as of September 30, 2014, and December 31, 2013, respectively.

The principal amounts, unamortized discount (net of premium related to the 1.625% Notes), and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
September 30, 2014:			
1.125% Notes	$ 550,000	$ 119,516	$ 430,484
1.625% Notes	301,551	34,825	266,726
3.75% Notes	10,449	—	10,449
	$ 862,000	$ 154,341	$ 707,659
December 31, 2013:			
1.125% Notes	$ 550,000	$ 133,632	$ 416,368
3.75% Notes	187,000	5,128	181,872
	$ 737,000	$ 138,760	$ 598,240

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
		(In thousands)		
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate	$ 3,132	$ 3,300	$ 9,732	$ 9,127
Amortization of the discount	6,455	6,059	19,183	15,747
Total interest cost recognized	$ 9,587	$ 9,359	$ 28,915	$ 24,874

Lease Financing Obligations. In 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the Molina Center located in Long Beach, California, and our Ohio health plan office building in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense amounted to $9.3 million and $3.7 million for the nine months ended September 30, 2014 and 2013, respectively.

As described and defined in further detail in Note 16, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings then under construction. We have concluded that we are the accounting owner of the properties due to our continuing involvement with the properties. We have recorded $38.9 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of September 30, 2014, which represents the total cost, including imputed interest, incurred by the Landlord for the construction of the buildings, net of accumulated depreciation. As of September 30, 2014, the aggregate amount recorded to lease financing obligations amounted to $40.7 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense was $2.2 million for the nine months ended September 30, 2014. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was $0.8 million for the nine months ended September 30, 2014.

12. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	September 30, 2014	December 31, 2013
		(In thousands)	
Derivative asset:			
1.125% Call Option	Non-current assets: Derivative asset	$ 222,997	$ 186,351
Derivative liability:			
1.125% Notes Conversion Option	Non-current liabilities: Derivative liability	$ 222,877	$ 186,239

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expenses, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013 as described in Note 11, "Long-Term Debt," we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 6, "Fair Value Measurements."

1.125% Notes Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Notes Conversion Option, refer to Note 6, "Fair Value Measurements."

13. Stockholders' Equity

Stockholders' equity increased $71.4 million during the nine months ended September 30, 2014 compared with stockholders' equity at December 31, 2013. The increase was due to net income of $28.4 million, $25.0 million related to 1.625% Notes and 3.75% Exchange, $0.5 million related to other comprehensive income and $17.5 million related to employee stock transactions.

3.75% Exchange and 3.75% Notes. As described in Note 11, "Long-Term Debt," we issued approximately 1.7 million shares in connection with the exchange of our 3.75% Notes for the 1.625% Notes in the third quarter of 2014. Additionally, we issued 0.1 million shares in connection with the conversion of the 3.75% Notes in the fourth quarter of 2014.

1.125% Warrants. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants.

Securities Repurchases and Repurchase Program. Effective September 30, 2013, our board of directors authorized the repurchase of up to $50.0 million in aggregate of our common stock through December 31, 2014. Stock repurchases under this

program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and other market conditions. As of September 30, 2014, the remaining balance available to repurchase our stock under this program was $47.3 million.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with our equity incentive plans, we issued approximately 643,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the nine months ended September 30, 2014.

14. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segment is charged to the Health Plans segment.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(In thousands)			
Revenue from continuing operations:				
Health Plans segment:				
Premium revenue	$ 2,316,759	$ 1,584,656	$ 6,424,238	$ 4,583,818
Premium tax revenue	81,240	43,723	203,053	127,606
Health insurer fee revenue	29,427	—	67,785	—
Investment income	2,041	1,740	5,615	4,884
Other revenue	2,327	5,860	8,523	16,476
Molina Medicaid Solutions segment:				
Service revenue	52,557	51,100	156,419	150,528
Total revenue	$ 2,484,351	$ 1,687,079	$ 6,865,633	$ 4,883,312
Income from continuing operations before income tax:				
Health Plans segment	$ 29,874	$ 16,929	$ 65,879	$ 118,600
Molina Medicaid Solutions segment	9,905	7,997	30,594	20,645
Total operating income from continuing operations	39,779	24,926	96,473	139,245
Other expenses, net	15,282	13,508	43,044	41,583
Income from continuing operations before income tax expense	$ 24,497	$ 11,418	$ 53,429	$ 97,662

15. Commitments and Contingencies

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem

the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Washington Health Plan. In September 2014, our Washington health plan paid $19.2 million to the Washington Health Care Authority (HCA) to settle two outstanding overpayment matters. The matters related to demands for recoupment of claims for psychotropic drugs and claims for health plan members under the Washington Community Options Program Entry System (COPES). Additionally, in September 2014 HCA paid our Washington health plan $8.0 million to settle certain matters brought by the Washington health plan related to auto-assignment provisions in the parties' contract. The net effect of these settlements resulted in a premium revenue reduction of $11.2 million in the third quarter of 2014, and resolved all pending disputes between the parties.

State of Louisiana. On June 26, 2014, the State of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that, in late 2008 and early 2009, in connection with the acquisition of Florida NetPass by which Molina Healthcare entered into the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. Both the United States of America and the State of Florida have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by relator, Anita Silingo. The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc., turned a "blind eye" to these unlawful practices. The Department of Justice has declined to intervene. We believe that we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statues, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $717 million at September 30, 2014, and $608 million at December 31, 2013. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained

earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $374.3 million and $365.2 million as of September 30, 2014 and December 31, 2013, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2014, our health plans had aggregate statutory capital and surplus of approximately $798 million compared with the required minimum aggregate statutory capital and surplus of approximately $413 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2014. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Related Party Transactions

In February 2013, we entered into a lease with 6th & Pine Development, LLC (the Landlord) for office space located in Long Beach, California. The lease consists of two office buildings, referred to as Building A and Building B.

The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, John C. Molina has pledged shares of common stock in the Company that he holds as trustee. Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

The lease term for Building A commenced in June 2013, and the lease term for Building B commenced in July 2014. The initial lease term for both buildings expires on December 31, 2024, subject to two five-year renewal options. Annual rent for Building A is approximately $3 million, and initial annual rent for Building B is approximately $4 million. Rent increases 3.75% per year during the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

Refer to Note 17, "Variable Interest Entity," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

17. Variable Interest Entity

Joseph M. Molina M.D., Professional Corporations. The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides professional medical services to the general public for routine non-life threatening, outpatient health care needs. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, Molina Medical Management, Inc. (MMM), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by MMM are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the MMM services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a variable interest entity (VIE), and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of September 30, 2014, JMMPC had total assets

of $12.1 million, and total liabilities of $11.8 million. As of December 31, 2013, JMMPC had total assets of $6.9 million and total liabilities of $6.6 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- uncertainties associated with the implementation of the Affordable Care Act, including the full grossed up reimbursement by states of the non-deductible health insurer fee, the expansion of Medicaid eligibility in the states that participate to previously uninsured populations unfamiliar with managed care, the implementation of state insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures, including the dual eligibles demonstration programs in California, Illinois, Michigan, Ohio, and South Carolina;
- newly FDA-approved specialty drugs such as Sovaldi, Olysio, Harvoni, and other specialty drugs that are exorbitantly priced but not factored into the calculation of our capitated rates;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and our ability to reduce over time the high medical costs commonly associated with new patient populations;
- the accurate estimation of incurred but not paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates or retroactive premium rate increases;
- efforts by states to recoup previously paid amounts;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, including the success of the proposal of Molina Medicaid Solutions in New Jersey;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed, including the extension of the Louisiana contract of Molina Medicaid Solutions through 2015;
- complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- federal or state medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, including 2014 at-risk premium rules in the state of Texas;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable or unfavorable resolution of litigation, arbitration, or administrative proceedings, including pending qui tam actions in Florida and California, and the litigation commenced against us by the state of Louisiana alleging that Molina Medicaid Solutions and its predecessors used an incorrect reimbursement formula for the payment of pharmaceutical claims;
- the relatively small number of states in which we operate health plans;
- our management of a portion of College Health Enterprises' hospital in Long Beach, California;

- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- public alarm associated with the Ebola virus, or any actual widespread epidemic;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2013, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2013.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of September 30, 2014, these health plans served approximately 2.4 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplace (Marketplace) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we classified the operations for our Missouri health plan as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Health Care Reform

New Markets. We believe that the government-sponsored initiatives, including the Affordable Care Act (defined below) will continue to provide us with significant opportunities for membership growth in our existing markets and, potentially, in new markets in the future as follows:

- *Medicaid Expansion*. In the states that have elected to participate, the Affordable Care Act provides for the expansion of the Medicaid program to provide eligibility to nearly all low-income people under age 65 with incomes at or below 138 percent of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. In the nine months ended September 30, 2014, we added approximately 314,500 Medicaid expansion members, or 13% of total membership.
- *Health Insurance Marketplace*. On October 1, 2013, Marketplace became available for consumers to access and begin the enrollment process for coverage beginning January 1, 2014. The Marketplace allows individuals and small groups to purchase health insurance that is federally subsidized. We participate in the Marketplace in all of the states in which we operate, except Illinois and South Carolina. At September 30, 2014, we had fewer than 20,000 Marketplace members.
- *Medicare-Medicaid Plans*. Policymakers at the federal and state levels are increasingly focused on the design and implementation of programs that improve the coordination of care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner. As a result of these efforts, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in the second quarter of 2014.

Health Insurer Fee. The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. The health insurer fee (HIF) is imposed beginning in 2014, is based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year.

During the third quarter of 2014 we paid our 2014 HIF assessment, which amounted to $88.6 million. This expense is being recognized on a straight-line basis in 2014; and is non-deductible for income tax purposes. For further discussion of the risks and uncertainties relating to the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates - Health Plans Segment

NCQA Rankings. In September 2014, we announced that the National Committee for Quality Assurance (NCQA) has included our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin in NCQA's Medicaid Health Insurance Plan Rankings for 2014-2015.

Florida. Enrollment at the Florida health plan declined between the first and second quarters of 2014 due to a reassignment of membership as part of the implementation of Florida's Managed Medical Assistance (MMA) program. In the third quarter of 2014, such enrollment increased by approximately 40,000 members due primarily to the addition of certain service areas effective August 1, 2014.

In August 2014, we announced that our Florida health plan entered into an agreement with First Coast Advantage, LLC (FCA) to acquire certain assets related to FCA's Medicaid business. As part of the transaction, we will assume FCA's Medicaid contract and certain provider agreements for Region 4 of the Statewide Medicaid Managed Care Managed Medical Assistance Program in the state of Florida. We have received approval for the transaction from the Florida Agency for Health Care Administration, and expect to close in late 2014 or early 2015.

In August 2014, our Florida health plan acquired certain assets relating to the Medicaid business of Healthy Palm Beaches, Inc. The final purchase price for this acquisition was $7.5 million. The Florida health plan's membership increased by approximately 11,000 members as a result of this transaction.

Puerto Rico. On October 15, 2014, the Puerto Rico Health Insurance Administration announced that it has selected Molina Healthcare of Puerto Rico to operate the Commonwealth's Medicaid-funded Government Health Plan program in the East and Southwest regions. We expect to begin serving members in the second quarter of 2015.

South Carolina. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014. For further information on this transaction, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 4, "Business Combinations."

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate; and, to a lesser degree, from Medicare contracts entered into with the Centers for Medicare and Medicaid Services (CMS), a federal government agency.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new RFP open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Premium revenue is fixed in advance of the periods covered and, except as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," is not generally subject to significant accounting estimates. For the nine months ended September 30, 2014, we received the majority of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our Medicaid and Medicare contracts; and agreements with other managed care organizations for which we operate as subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates. For the nine months ended September 30, 2014, we recognized approximately 3% of our premium revenue in the form of "birth income"—a one-time payment for the delivery of a child—from the Medicaid programs in all of our state health plans except Illinois and New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans in the nine months ended September 30, 2014, by program:

	Ending Membership	PMPM Premiums		
		Low	High	Consolidated
Temporary Assistance for Needy Families (TANF)	1,608,900	$ 110.00	$ 250.00	$ 160.00
Medicaid Expansion	314,500	330.00	530.00	420.00
Aged, Blind or Disabled (ABD)	314,400	380.00	1,410.00	820.00
Children's Health Insurance Program (CHIP)	69,000	90.00	130.00	120.00
Medicare Special Needs Plans (Medicare)	46,400	990.00	1,320.00	1,210.00
MMP–Medicaid Only (1) (2)	20,500	1,380.00	1,520.00	1,490.00
MMP–Integrated (1) (3)	14,400	1,320.00	3,510.00	2,030.00
Marketplace	15,900	170.00	610.00	340.00

(1) MMP members are dually eligible for Medicare and Medicaid.

(2) MMP members who receive Medicaid coverage only from Molina Healthcare.

(3) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	September 30, 2014	June 30, 2014	December 31, 2013	September 30, 2013
Ending Membership by Health Plan:				
California	496,000	455,000	368,000	363,000
Florida (1)	98,000	58,000	89,000	84,000
Illinois	21,000	6,000	4,000	—
Michigan	238,000	244,000	213,000	213,000
New Mexico	207,000	195,000	168,000	172,000
Ohio	337,000	302,000	255,000	261,000
South Carolina (2)	118,000	119,000	—	—
Texas	249,000	247,000	252,000	258,000
Utah	83,000	83,000	86,000	87,000
Washington	473,000	461,000	403,000	409,000
Wisconsin	84,000	85,000	93,000	95,000
	2,404,000	2,255,000	1,931,000	1,942,000
Ending Membership by Program:				
TANF	1,608,900	1,564,500	1,503,800	1,519,200
Medicaid Expansion (3)	314,500	232,300	—	—
ABD	314,400	305,300	288,600	283,200
CHIP	69,000	77,000	99,200	101,500
Medicare	46,400	44,000	39,400	38,100
MMP–Medicaid Only	20,500	8,400	—	—
MMP–Integrated	14,400	5,200	—	—
Marketplace (3)	15,900	18,300	—	—
	2,404,000	2,255,000	1,931,000	1,942,000

(1) Enrollment at the Florida health plan declined between the first and second quarters of 2014 due to a reassignment of membership as part of the implementation of Florida's Managed Medical Assistance (MMA) program. In the third quarter of 2014, such enrollment increased by approximately 40,000 members due primarily to the addition of certain service areas effective August 1, 2014.

(2) Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

(3) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services (including long-term services and supports, or LTSS), general and administrative expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Nearly all hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis.

- *Pharmacy expenses:* All drug, injectables, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses.

- *Capitation expenses:* Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.

- *Direct delivery expenses:* All costs associated with our direct delivery of medical care are separately identified.

- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements in Note 10, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the contract term, consistent with the revenue recognition period.

Financial Performance Summary, Continuing Operations

The following table and narrative briefly summarize our financial and operating performance from continuing operations for the three and nine months ended September 30, 2014 and 2013. All ratios, with the exception of the medical care ratio and the premium tax ratio, are computed as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue; and the premium tax ratio is computed as a percentage of premium revenue plus premium tax revenue, because direct relationships exist between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(Dollar amounts in thousands, except per share data)			
Net income per diluted share	$ 0.33	$ 0.16	$ 0.60	$ 1.15
Premium revenue	$ 2,316,759	$ 1,584,656	$ 6,424,238	$ 4,583,818
Service revenue	$ 52,557	$ 51,100	$ 156,419	$ 150,528
Operating income	$ 39,779	$ 24,926	$ 96,473	$ 139,245
Net income	$ 16,070	$ 7,553	$ 28,645	$ 53,871
Total ending membership	2,404,000	1,942,000	2,404,000	1,942,000
Premium revenue	93.3%	93.9%	93.6%	93.9%
Service revenue	2.1	3.0	2.3	3.1
Premium tax revenue	3.2	2.6	2.9	2.6
Health insurer fee revenue	1.2	—	1.0	—
Investment income	0.1	0.2	0.1	0.1
Other revenue	0.1	0.3	0.1	0.3
Total revenue	100.0%	100.0%	100.0%	100.0%
Operating Statistics:				
Medical care ratio	90.6%	87.3%	89.6%	86.5%
Service revenue ratio	76.2%	78.5%	75.3%	79.2%
General and administrative expense ratio	7.2%	10.4%	8.2%	9.8%
Premium tax ratio	3.4%	2.7%	3.1%	2.7%
Operating income	1.6%	1.5%	1.4%	2.9%
Net income	0.6%	0.4%	0.4%	1.1%
Effective tax rate	34.4%	33.9%	46.4%	44.8%
Medical Claims Data:				
Days in claims payable, fee for service	50	41	50	41
Number of claims in inventory at end of period	315,900	137,100	315,900	137,100
Billed charges of claims in inventory at end of period	$ 749,300	$ 257,600	$ 749,300	$ 257,600
Claims in inventory per member at end of period	0.13	0.07	0.13	0.07
Billed charges of claims in inventory per member at end of period	$ 311.69	$ 132.65	$ 311.69	$ 132.65
Number of claims received during the period	7,062,100	5,227,000	19,703,300	15,751,500
Billed charges of claims received during the period	$ 7,897,500	$ 5,371,100	$ 21,506,500	$ 15,848,900

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. generally accepted accounting principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(In thousands)			
Net income	$ 16,122	$ 7,569	$ 28,431	$ 62,055
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	29,307	24,128	83,513	68,035
Interest expense	14,419	13,532	42,234	38,236
Income tax expense	8,439	3,962	24,436	33,745
EBITDA	$ 68,287	$ 49,191	$ 178,614	$ 202,071

The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. The following tables reconcile net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations.

	Three Months Ended September 30,			
	2014		2013	
	(In thousands, except diluted per-share amounts)			
Net income, continuing operations	$ 16,070	$ 0.33	$ 7,553	$ 0.16
Adjustments, net of tax:				
Depreciation, and amortization of capitalized software	15,275	0.31	11,821	0.25
Amortization of convertible senior notes and lease financing obligations	4,246	0.09	4,058	0.08
Stock-based compensation	1,739	0.04	7,010	0.15
Amortization of intangible assets	3,189	0.06	3,378	0.07
Change in fair value of derivatives, net	1	—	(1)	—
Adjusted net income, continuing operations	$ 40,520	$ 0.83	$ 33,819	$ 0.71

	Nine Months Ended September 30,			
	2014		2013	
	(In thousands, except diluted per-share amounts)			
Net income, continuing operations	$ 28,645	$ 0.60	$ 53,871	$ 1.15
Adjustments, net of tax:				
Depreciation, and amortization of capitalized software	42,887	0.89	33,375	0.71
Amortization of convertible senior notes and lease financing obligations	12,723	0.26	10,161	0.21
Stock-based compensation	10,960	0.23	17,026	0.36
Amortization of intangible assets	9,727	0.20	9,485	0.20
Change in fair value of derivatives, net	(5)	—	3,582	0.08
Adjusted net income, continuing operations	$ 104,937	$ 2.18	$ 127,500	$ 2.71

Analysis of Financial Results – Trends and Developments

Strong enrollment growth across all of our products (Medicaid, Medicare special needs plans and dual eligible Medicare-Medicaid Plans) generated almost $2 billion, or 40%, more premium revenue for the nine months ended September 30, 2014, when compared with the same period in 2013.

Despite an increase in medical care costs as a percentage of premium revenue (the medical care ratio), higher per-member per-month (PMPM) premiums produced an increase of 8.5%, or $52.5 million, in medical margin for the nine months ended September 30, 2014, when compared with the same period in 2013.

The medical care ratio increased substantially in 2014 as a result of three developments:

- Much of our revenue growth has come from participation in Medicaid programs covering long-term services and supports (LTSS). Percentage profit margins for LTSS benefits are generally lower than percentage profit margins for acute medical benefits. The addition of members eligible for LTSS benefits at the Florida and New Mexico health

plans, as well as members who have joined our California, Illinois, and Ohio health plans through participation in Medicare-Medicaid Plan implementations, added 1.2% to our consolidated medical care ratio in the third quarter of 2014, and 0.8% for the nine months ended September 30, 2014.

- Increases to our base premiums in recent years have not kept pace with medical cost trends.
- Lack of coordination in the design of profit caps and medical cost floors in some of our contracts is resulting in counterproductive outcomes. In some instances, givebacks due to profitable performance in one product cannot be offset against losses in other products.

  For example, at the Washington health plan, a minimum medical loss ratio requirement for the Medicaid expansion program reduced income from continuing operations before income taxes by approximately $17 million for the third quarter of 2014, and $23 million for the nine months ended September 30, 2014. Simultaneously, the Washington health plan incurred a medical care ratio in excess of 100% for its aged, blind or disabled members. However, the health plan is unable to offset profits from its Medicaid expansion contract against its other contracts. The Washington health plan is therefore left in a position where it must return profits under its Medicaid expansion contract to the state; while it receives no relief from losses incurred under another contract.

  In a similar manner, at the New Mexico health plan, a contract provision limiting profits on retroactively added members reduced income from continuing operations before income taxes by approximately $6 million for the nine months ended September 30, 2014. At the same time, the New Mexico health plan's LTSS program operated at a medical care ratio in excess of 100%.

We reported substantial improvements in administrative cost efficiency in 2014. General and administrative expenses as a percentage of revenue declined to 7.2% for the third quarter of 2014, from 10.4% for the same period in 2013, and to 8.2% for the nine months ended September 30, 2014, from 9.8% for the same period of 2013. Our general and administrative expense ratio has not been below 7.2% since the second quarter of 2009.

Health Insurer Fee Update

We previously reported that our results have been adversely affected by delays in reimbursement (including reimbursement for tax effects) of the HIF from California, Michigan, New Mexico, Texas and Utah.

During the third quarter, Michigan and Utah committed to reimbursement of the HIF, but not to the reimbursement of the related tax effects. However, both states have informally indicated that it is their desire to reimburse us for those tax effects. As a result of these developments, we were able to recognize an additional $11 million in HIF revenue (but not amounts related to tax effects) from Michigan and Utah during the third quarter of 2014.

Nevertheless, HIF not reimbursed by California, New Mexico and Texas, as well as tax effects not yet reimbursed by Michigan and Utah, reduced income from continuing operations before income taxes by approximately $6 million or $0.07 per diluted share, for the third quarter of 2014, and $37 million, or $0.49 per diluted share, for the nine months ended September 30, 2014 (per-share amounts for both periods on a GAAP and adjusted basis). While we remain guardedly optimistic that we will eventually secure reimbursement from all of our state partners, we no longer expect that all reimbursement will be secured prior to the close of 2014. Accordingly, we do not expect to recognize the full amount of revenue associated with reimbursement of the HIF payment during 2014.

The following table summarizes the status of HIF Medicaid revenue recognition for the nine months ended September 30, 2014:

	HIF Medicaid Revenue		
	Recognized	Required Reimbursement through Sept. 30, 2014	Not Recognized
	(In millions)		
Quarter 1	$ 16.6	$ 32.7	$ 16.1
Quarter 2	17.2	32.7	15.5
Quarter 3	27.0	32.7	5.7
Nine months ended September 30, 2014	$ 60.8	$ 98.1	$ 37.3

We have secured agreements allowing the recognition of approximately $20 million of HIF revenue in the fourth quarter of 2014. We have not yet secured agreements from the states of California, New Mexico, Texas, Michigan (tax effect not secured), and Utah (tax effect not secured). The total amount of HIF revenue for which agreements have not been secured is approximately $50 million for the full year of 2014.

Texas Health Plan Quality Revenue Update

Our non-recognition of a portion of the Texas health plan's quality revenue reduced income from continuing operations before income taxes by approximately $4 million, or $0.05 per diluted share, for the third quarter of 2014, and $18 million, or $0.23 per diluted share, for the nine months ended September 30, 2014 (per-share amounts for both periods on a GAAP and adjusted basis). Unless we receive clarification of the standards and full transparency on the calculations by which quality revenue is to be assessed by the state, we are unable to independently assess the Texas health plan's performance against those standards. As such, we are doubtful that we will be able to recognize the full amount of the Texas quality revenue in 2014.

The following table summarizes the status of Texas quality revenue recognition for the nine months ended September 30, 2014:

	Texas Quality Revenue		
	Recognized	Available	Not Recognized
	(In millions)		
Quarter 1	$ 2.6	$ 8.6	$ 6.0
Quarter 2	1.1	8.6	7.5
Quarter 3	4.6	8.8	4.2
Nine months ended September 30, 2014	$ 8.3	$ 26.0	$ 17.7

Washington Health Plan Settlement Update

As previously disclosed, we recorded a net decrease to premium revenue and income from continuing operations before income taxes of $11.2 million, or $0.14 per diluted share, in the third quarter of 2014 as a result of the settlements of three unrelated issues with the Washington Health Care Authority (HCA) that related to periods prior to 2014.

Income Tax Update

During the third quarter of 2014, the Internal Revenue Service (IRS) issued final regulations related to compensation deduction limitations applicable to certain health insurance issuers. Pursuant to these final regulations, we recognized a tax benefit during the third quarter of 2014 of approximately $7 million, or $0.15 per diluted share, for periods prior to the third quarter of 2014.

Full Year 2014 Update

We have previously disclosed issues relating to our inability to fully recognize HIF revenue and Texas quality revenue in 2014. These issues, along with medical care costs that are trending higher than we anticipated compared with our full-year estimate, and the impact of certain contractual provisions that limit our ability to retain profits, will adversely impact 2014 earnings. Accordingly, we now expect that our net income per diluted share, continuing operations, and adjusted net income per diluted share, continuing operations, may fall short of the low end of the ranges for those respective metrics as included in our previously issued 2014 guidance.

Results of Operations, Continuing Operations

Three Months Ended September 30, 2014 Compared with Three Months Ended September 30, 2013

Health Plans Segment

Premium Revenue

Premium revenue for the third quarter of 2014 increased 46% over the third quarter of 2013, due to a 24% increase in member months, and an 18% increase in revenue per member per month (PMPM). Membership increased primarily as a result of members added through Medicaid expansion and the startup of our South Carolina health plan. PMPM revenue increased due to proportionally higher per-member revenue associated with Medicaid expansion members and an increase in the number of chronically ill members we serve through our Medicare-Medicaid Plans and state Medicaid programs for the aged, blind or disabled.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended September 30,					
	2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 1,469,765	$ 206.43	70.1%	$ 928,165	$ 161.39	67.1%
Pharmacy	337,150	47.35	16.1	237,073	41.22	17.1
Capitation	190,277	26.73	9.1	162,554	28.27	11.8
Direct delivery	24,863	3.49	1.1	9,612	1.67	0.7
Other	75,781	10.65	3.6	45,809	7.97	3.3
Total	$ 2,097,836	$ 294.65	100.0%	$ 1,383,213	$ 240.52	100.0%

Our consolidated medical care ratio increased to 90.6% in the third quarter of 2014, from 87.3% in the third quarter of 2013.

Individual Health Plan Analysis

California. Medical margin improved $39.3 million at the California health plan, when compared with the third quarter of 2013. This improvement was the result of higher enrollment—particularly as a result of 90,000 members added due to Medicaid expansion—and premium increases effective October 1, 2013 (2.5%), and July 1, 2014 (5.5%).

Florida. Although revenue increased nearly 60% in the third quarter of 2014 when compared to the third quarter of 2013, medical margin at the Florida health plan fell $5.2 million and the medical care ratio increased to 97.8% from 88.8% in the third quarter of 2013. Effective December 2013, the plan assumed risk for LTSS benefits for certain members. Although premium revenue for members receiving LTSS benefits is substantially higher than that earned for those receiving only medical benefits, the percentage margin for profit and administrative cost included in such premiums is much lower than for stand-alone medical benefits.

Additionally, as a result of the re-procurement undertaken by the Florida Agency for Health Care Administration (AHCA) as part of its Managed Medical Assistance program (MMA) starting in 2014, the Florida health plan transitioned many of its members to other health plans in the second quarter of 2014, and then added approximately 40,000 members in the third quarter of 2014, both from the addition of new service areas and through an acquisition. We customarily experience a short-term increase in the medical care ratio when we enroll new member populations. Therefore, while a portion of the higher medical care ratio we experienced in Florida during the third quarter of 2014 was related to reduced margins we expected as a result of the MMA program, we also believe that a portion of the higher medical care ratio is the result of the transition of new members into our Florida health plan. We believe the plan's medical care ratio will therefore decline during 2015.

Illinois. The medical care ratio for the Illinois health plan was 82.1% in the third quarter of 2014. The Illinois health plan served its first member effective September 2013 and its first Medicaid expansion members in August 2014.

Michigan. Financial performance at the Michigan health plan declined in the third quarter of 2014, when compared with the third quarter of 2013, primarily due to comparatively higher medical care ratios for the Medicaid expansion (new in 2014) and Medicare programs. The medical care ratio of the Michigan health plan increased to 85.1% for the third quarter of 2014, from 82.1% for the third quarter of 2013. The Michigan health plan added its first Medicaid expansion members during the second quarter of 2014, with enrollment of approximately 33,000 members as of September 30, 2014.

New Mexico. Financial performance at the New Mexico health plan declined in the third quarter of 2014, when compared with the third quarter of 2013. The medical care ratio increased to 93.5% in the third quarter of 2014, from 85.6% in the third quarter of 2013, primarily the result of the addition of Medicaid behavioral health and LTSS benefits effective January 1, 2014 (which are reimbursed at a higher medical care ratio than traditional medical benefits), and a return to more typical medical cost levels overall in 2014. The New Mexico health plan added approximately 50,000 Medicaid expansion members in 2014; as well as approximately 60,000 new members in a business combination effective August 1, 2013.

Ohio. The medical care ratio of the Ohio health plan decreased slightly to 86.9% for the third quarter of 2014, from 87.3% for the third quarter of 2013. The Ohio health plan added its first meaningful number of Medicaid expansion members during the second quarter of 2014, with enrollment of approximately 51,000 members as of September 30, 2014.

South Carolina. The medical care ratio for the South Carolina health plan was 78.0% in the third quarter of 2014. The South Carolina health plan served its first members effective January 2014, with enrollment of 118,000 members as of September 30, 2014.

Texas. The medical care ratio of the Texas health plan increased slightly to 90.9% in the third quarter of 2014, from 89.6% in the third quarter of 2013 due to a decrease in quality revenue as described above and an increase in amounts returned to the state under a profit-sharing agreement. Removing quality revenue and profit-sharing adjustments would have resulted in a medical care ratio at the Texas health plan of approximately 88% for the third quarter of 2014 and 90% for the third quarter of 2013.

Utah. Financial performance at the Utah health plan declined in the third quarter of 2014, when compared with the third quarter of 2013, due to deteriorating margins for both Medicaid and Medicare products. The medical care ratio of the Utah health plan increased to 95.6% in the third quarter of 2014, from 78.7% in the third quarter of 2013. We believe that medical care ratios below 80% are not sustainable over time.

Washington. Financial performance at the Washington health plan declined in the third quarter of 2014, when compared with the third quarter of 2013. The medical care ratio of the Washington health plan increased to 97.6% in the third quarter of 2014, from 86.3% in the third quarter of 2013, primarily due to the high cost of medical services relative to revenue for members served under the state's program for aged, blind, or disabled members; and to the $11.2 million net settlement with the HCA, as described above and in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 15, "Commitments and Contingencies." Removing the net HCA settlement would have resulted in a medical care ratio of approximately 94% for the third quarter of 2014. The Washington health plan added approximately 89,000 Medicaid expansion members in 2014.

Wisconsin. Financial performance at the Wisconsin health plan declined in the third quarter of 2014, when compared with the third quarter of 2013. The medical care ratio of the Wisconsin health plan increased to 88.8% in the third quarter of 2014, from 69.8% in the third quarter of 2013. We believe that medical care ratios below 80% are not sustainable over time.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended September 30, 2014						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,451	$ 384,147	$ 264.79	$ 327,389	$ 225.66	85.2%	$ 56,758
Florida	243	106,275	437.47	103,898	427.69	97.8	2,377
Illinois (3)	38	34,514	906.78	28,333	744.41	82.1	6,181
Michigan	727	208,873	287.15	177,680	244.27	85.1	31,193
New Mexico	652	284,058	435.67	265,697	407.51	93.5	18,361
Ohio	994	454,410	457.17	395,098	397.49	86.9	59,312
South Carolina	355	95,455	268.97	74,489	209.89	78.0	20,966
Texas	748	337,430	451.24	306,577	409.98	90.9	30,853
Utah	250	78,703	315.04	75,270	301.30	95.6	3,433
Washington	1,410	280,883	199.18	274,213	194.45	97.6	6,670
Wisconsin	252	42,933	170.40	38,107	151.25	88.8	4,826
Other (4)	—	9,078	—	31,085	—	—	(22,007)
	7,120	$ 2,316,759	$ 325.40	$ 2,097,836	$ 294.65	90.6%	$ 218,923

	Three Months Ended September 30, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,076	$ 184,235	$ 171.16	$ 166,774	$ 154.93	90.5%	$ 17,461
Florida	251	67,688	269.58	60,127	239.46	88.8	7,561
Illinois (3)	—	—	—	—	—	—	—
Michigan	641	174,706	272.65	143,498	223.95	82.1	31,208
New Mexico	435	130,318	299.19	111,599	256.21	85.6	18,719
Ohio	786	280,964	357.66	245,148	312.07	87.3	35,816
South Carolina	—	—	—	—	—	—	—
Texas	780	320,657	411.17	287,446	368.59	89.6	33,211
Utah	261	84,525	323.83	66,555	254.98	78.7	17,970
Washington	1,234	294,808	238.96	254,430	206.23	86.3	40,378
Wisconsin	287	39,676	138.36	27,694	96.58	69.8	11,982
Other (3)(4)	—	7,079	—	19,942	—	—	(12,863)
	5,751	$ 1,584,656	$ 275.55	$ 1,383,213	$ 240.52	87.3%	$ 201,443

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) The MCR represents medical costs as a percentage of premium revenue.
(3) The Illinois health plan's results prior to October 1, 2013, were insignificant and reported in "Other."
(4) "Other" medical care costs include primarily medically related administrative costs at the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended September 30,	
	2014	2013
	(In thousands)	
Service revenue before amortization	$ 53,286	$ 51,829
Amortization recorded as reduction of service revenue	(729)	(729)
Service revenue	52,557	51,100
Cost of service revenue	40,067	40,113
General and administrative costs	1,791	1,708
Amortization of customer relationship intangibles recorded as amortization	794	1,282
Operating income	$ 9,905	$ 7,997

Operating income for our Molina Medicaid Solutions segment increased $1.9 million in the third quarter of 2014, compared with the third quarter of 2013, primarily the result of increased revenues due to higher Medicaid transaction volumes.

Results of Operations, Continuing Operations

Nine Months Ended September 30, 2014 Compared with Nine Months Ended September 30, 2013

Health Plans Segment

Premium Revenue

Premium revenue for the nine months ended September 30, 2014 increased 40% over the nine months ended September 30, 2013, due to a 21% increase in member months, and a 15% increase in revenue PMPM. The increase in member months was due to the addition of Medicaid expansion membership and the addition of Medicaid members at our South Carolina health plan, all effective January 1, 2014. Additionally, our New Mexico health plan added approximately 60,000 new members in a business combination effective August 1, 2013. PMPM revenue increased due to proportionally higher per member revenue associated with Medicaid expansion members and an increase in the number of chronically ill members we serve through our Medicare-Medicaid Plans and state Medicaid programs for the aged, blind, or disabled.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Nine Months Ended September 30,					
	2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 4,028,863	$ 198.61	70.0%	$ 2,674,785	$ 160.14	67.5%
Pharmacy	919,374	45.32	16.0	691,903	41.42	17.4
Capitation	536,533	26.45	9.3	441,287	26.42	11.1
Direct delivery	69,947	3.45	1.2	27,739	1.66	0.7
Other	199,076	9.81	3.5	130,120	7.79	3.3
Total	$ 5,753,793	$ 283.64	100.0%	$ 3,965,834	$ 237.43	100.0%

Our consolidated medical care ratio increased to 89.6% in the nine months ended September 30, 2014, from 86.5% in the nine months ended September 30, 2013.

Individual Health Plan Analysis

California. Medical margin improved $114.6 million at the California health plan, when compared with the nine months ended September 30, 2013. This improvement was the result of the following:

- Higher enrollment, primarily as a result of Medicaid expansion;

- Premium increases effective October 1, 2013 (2.5%), and July 1, 2014 (5.5%); and
- Approximately $15 million benefit from recognition, in the second quarter of 2014, of certain premium revenue which related to the year ended December 31, 2013.

The California health plan served its first MMP members in 2014.

Florida. Although revenue increased over 65% for the nine months ended September 30, 2014 when compared to 2013, medical margin at the Florida health plan fell $3.6 million, and the medical care ratio increased to 92.8% from 86.0% in 2013. As noted above, the addition of members receiving LTSS benefits, and changes related to the state's transition to its MMA program reduced margins in 2014.

Illinois. The medical care ratio for the Illinois health plan was 91.8% in the nine months ended September 30, 2014. The plan served its first MMP members in 2014.

Michigan. The medical care ratio of the Michigan health plan decreased to 83.9% for the nine months ended September 30, 2014, from 84.9% for the nine months ended September 30, 2013.

New Mexico. Premium revenue at the New Mexico health plan increased 160% for the nine months ended September 30, 2014 compared to the same period in 2013. Premium revenue increased primarily as a result of the transfer of behavioral health and LTSS benefits to the health plan effective January 1, 2014, and significantly increased membership, as described above. Although medical margin improved in the nine months ended September 30, 2014, the medical care ratio increased to 90.4% from 84.3% for the nine months ended September 30, 2013. The higher medical care ratio was primarily the result of the addition of benefits as described above.

Ohio. The medical care ratio of the Ohio health plan increased to 85.7% for the nine months ended September 30, 2014, from 83.9% for the nine months ended September 30, 2013, primarily due to the increase in Medicaid expansion enrollment (which is incurring a medical care ratio in excess of the plan's traditional experience), and the initiation of the Ohio MMP.

South Carolina. The medical care ratio for the South Carolina health plan was 86.6% in the nine months ended September 30, 2014.

Texas. Financial performance at the Texas health plan declined in the nine months ended September 30, 2014, when compared with the nine months ended September 30, 2013, as described above. The medical care ratio of the Texas health plan increased to 91.7% in the nine months ended September 30, 2014, from 85.6% in the nine months ended September 30, 2013. Removing quality revenue and profit-sharing adjustments would have resulted in a medical care ratio at the Texas health plan of approximately 88% for the nine months ended September 30, 2014 and 86% for the nine months ended September 30, 2013.

Utah. The medical care ratio of the Utah health plan increased to 92.1% in the nine months ended September 30, 2014, from 81.5% in the nine months ended September 30, 2013, due to deteriorating margins for both Medicaid and Medicare products.

Washington. Financial performance at the Washington health plan declined in the nine months ended September 30, 2014, when compared with the nine months ended September 30, 2013. The medical care ratio of the Washington health plan increased to 93.2% in the nine months ended September 30, 2014, from 87.3% in the nine months ended September 30, 2013, primarily due to the high cost of medical services relative to revenue for members served under the state’s program for aged, blind, or disabled members; and to the net settlement with the HCA. Removing the net HCA settlement would have resulted in a medical care ratio of approximately 92% for the nine months ended September 30, 2014.

Wisconsin. The medical care ratio of the Wisconsin health plan increased to 84.5% in the nine months ended September 30, 2014, from 79.0% in the nine months ended September 30, 2013.

Operating Data

The following tables summarize member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Nine Months Ended September 30, 2014						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,040	$ 1,059,860	$ 262.34	$ 889,656	$ 220.21	83.9%	$ 170,204
Florida	742	312,864	421.80	290,224	391.28	92.8	22,640
Illinois (3)	69	68,948	998.03	63,299	916.26	91.8	5,649
Michigan	2,077	567,706	273.28	476,392	229.33	83.9	91,314
New Mexico	1,818	777,120	427.55	702,257	386.36	90.4	74,863
Ohio	2,615	1,061,335	405.81	909,142	347.62	85.7	152,193
South Carolina	1,109	287,928	259.69	249,437	224.97	86.6	38,491
Texas	2,239	978,492	437.00	897,434	400.80	91.7	81,058
Utah	745	233,931	314.13	215,564	289.47	92.1	18,367
Washington	4,050	941,303	232.40	877,418	216.63	93.2	63,885
Wisconsin	782	118,386	151.48	100,059	128.03	84.5	18,327
Other (4)	—	16,365	—	82,911	—	—	(66,546)
	20,286	$ 6,424,238	$ 316.69	$ 5,753,793	$ 283.64	89.6%	$ 670,445

	Nine Months Ended September 30, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	3,132	$ 552,950	$ 176.54	$ 497,314	$ 158.78	89.9%	$ 55,636
Florida	712	187,689	263.62	161,446	226.76	86.0	26,243
Illinois (3)	—	—	—	—	—	—	—
Michigan	1,941	508,748	262.14	432,105	222.65	84.9	76,643
New Mexico	984	298,767	303.59	252,001	256.07	84.3	46,766
Ohio	2,234	819,879	367.03	688,266	308.11	83.9	131,613
South Carolina	—	—	—	—	—	—	—
Texas	2,417	969,063	400.90	829,854	343.31	85.6	139,209
Utah	781	236,992	303.41	193,261	247.42	81.5	43,731
Washington	3,722	892,627	239.85	779,339	209.41	87.3	113,288
Wisconsin	780	104,540	134.04	82,543	105.84	79.0	21,997
Other (3)(4)	—	12,563	—	49,705	—	—	(37,142)
	16,703	$ 4,583,818	$ 274.43	$ 3,965,834	$ 237.43	86.5%	$ 617,984

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) The MCR represents medical costs as a percentage of premium revenue.
(3) The Illinois health plan's results prior to October 1, 2013, were insignificant and reported in "Other."
(4) "Other" medical care costs include primarily medically related administrative costs at the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Nine Months Ended September 30,	
	2014	2013
	(In thousands)	
Service revenue before amortization	$ 158,605	$ 152,714
Amortization recorded as reduction of service revenue	(2,186)	(2,186)
Service revenue	156,419	150,528
Cost of service revenue	117,831	119,188
General and administrative costs	5,432	6,849
Amortization of customer relationship intangibles recorded as amortization	2,562	3,846
Operating income	$ 30,594	$ 20,645

Operating income for our Molina Medicaid Solutions segment increased $9.9 million in the nine months ended September 30, 2014, compared with the nine months ended September 30, 2013, primarily the result of increased revenues due to higher Medicaid transaction volumes and lower general and administrative costs overall.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses decreased to 7.2% of total revenue for the third quarter of 2014, compared with 10.4% of total revenue for the third quarter of 2013. General and administrative expenses decreased to 8.2% of total revenue for the nine months ended September 30, 2014, compared with 9.8% of total revenue for the nine months ended September 30, 2013. The declines in the ratio of general and administrative expenses relative to total revenue for both periods in 2014 was primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

Premium Tax Expense

Premium tax expense was 3.4% of premium revenue plus premium tax revenue in the third quarter of 2014, compared with 2.7% in the third quarter of 2013 and 3.1% of premium revenue plus premium tax revenue in the nine months ended September 30, 2014, compared with 2.7% in the nine months ended September 30, 2013. In June 2014, the state of Michigan instituted a 6% use tax on medical premiums. The state has agreed to fund this tax through rate increases; as a result, we recorded approximately $11 million and $20 million in additional premium revenue in the three and nine months ended September 30, 2014, respectively, as well as a corresponding premium tax payable.

Health Insurer Fee Revenue and Expenses

Refer to "Liquidity and Capital Resources—Financial Condition" below, for a comprehensive discussion of the HIF.

Depreciation and Amortization

The following tables present all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended September 30,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 19,910	0.8%	$ 14,237	0.8%
Amortization of intangible assets, continuing operations	4,332	0.2	4,634	0.3
Depreciation and amortization, continuing operations	24,242	1.0	18,871	1.1
Amortization recorded as reduction of service revenue	729	—	729	—
Amortization recorded as cost of service revenue	8,839	0.4	4,528	0.3
Depreciation and amortization reported in the consolidated statements of cash flows	$ 33,810	1.4%	$ 24,128	1.4%

	Nine Months Ended September 30,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 54,582	0.8%	$ 39,578	0.8%
Amortization of intangible assets, continuing operations	13,253	0.2	12,871	0.3
Depreciation and amortization, continuing operations	67,835	1.0	52,449	1.1
Depreciation and amortization, discontinued operations	—	—	2	—
Amortization recorded as reduction of service revenue	2,186	—	2,186	—
Amortization recorded as cost of service revenue	29,443	0.4	13,398	0.3
Depreciation and amortization reported in the consolidated statements of cash flows	$ 99,464	1.4%	$ 68,035	1.4%

Interest Expense

Interest expense increased to $14.4 million for the third quarter of 2014, from $13.5 million for the third quarter of 2013. Interest expense increased to $42.2 million for the nine months ended September 30, 2014, from $38.2 million for the nine months ended September 30, 2013 primarily due to lease financing transactions in the second quarter of 2013. Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $6.7 million and $6.4 million for the three months ended September 30, 2014, and 2013, respectively and $20.2 million and $16.1 million for the nine months ended September 30, 2014 and 2013, respectively.

Income Taxes

The provision for income taxes in continuing operations was recorded at an effective rate of 34.4% for the third quarter of 2014, compared with 33.9% for the third quarter of 2013, and 46.4% for the nine months ended September 30, 2014 compared with 44.8% for the nine months ended September 30, 2013.

During the third quarter of 2014, the Internal Revenue Service (IRS) issued final regulations related to compensation deduction limitations applicable to certain health insurance issuers. Pursuant to these final regulations, we recognized a tax benefit during the third quarter of 2014 of approximately $7 million, or $0.15 per diluted share, for periods prior to the third quarter of 2014.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of September 30, 2014, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income was $5.6 million for the nine months ended September 30, 2014, compared with $4.9 million for the nine months ended September 30, 2013. Our annualized portfolio yield for the nine months ended September 30, 2014 and 2013 was 0.4%.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Nine Months Ended September 30,		
	2014	2013	Change
	(In thousands)		
Net cash provided by operating activities	$ 841,198	$ 111,744	$ 729,454
Net cash used in investing activities	(261,280)	(541,416)	280,136
Net cash provided by financing activities	82,783	490,458	(407,675)
Net increase in cash and cash equivalents	$ 662,701	$ 60,786	$ 601,915

Operating Activities. Cash provided by operating activities increased $729.5 million year over year, primarily due to the change in medical claims and benefits payable, which increased $315.9 million in connection with our membership growth in the nine months ended September 30, 2014, as described above in "Results of Operations." Additionally, accrued liabilities increased $293.4 million due to a significant increase in amounts accrued for medical cost floor contract provisions, primarily at our Washington health plan. Finally, deferred revenue increased $86.1 million primarily due to the advanced receipt of premiums at our Washington health plan. Both accrued liabilities and deferred revenue had much less significant comparable activity in 2013.

Investing Activities. Cash used in investing activities in the nine months ended September 30, 2014 decreased to $261.3 million, from $541.4 million in the same period of 2013. The year-over-year decrease was primarily due to significant purchases of investments, net of sales and maturities, amounting to $400.2 million in the nine months ended September 30, 2013. Such

significant purchases of investments were a result of the investment of proceeds from the issuance of our 1.125% Notes in February 2013.

Financing Activities. Cash provided by financing activities in the nine months ended September 30, 2014 related primarily to $123.4 million net proceeds we received from our offering of 1.625% Notes in the third quarter of 2014, partially offset by the settlement of $50.3 million of contingent consideration liabilities relating to our 2013 South Carolina health plan acquisition in the first half of 2014. Financing activities generated net cash of $490.5 million in the nine months ended September 30, 2013, primarily due to the issuance of the 1.125% Notes and related financing transactions in February 2013.

Financial Condition

On a consolidated basis, at September 30, 2014, we had working capital of $1,051.4 million compared with $745.7 million at December 31, 2013. At September 30, 2014, and December 31, 2013, we had cash and investments, including restricted investments, of $2,541.3 million, and $1,712.9 million, respectively. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Health Insurer Fee. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government–funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. Additionally, when states reimburse us for the amount of the HIF, that reimbursement will itself be subject to income tax, the HIF, and applicable state premium taxes. Our 2014 HIF assessment amounted to $88.6 million, which was paid in September 2014. Because this amount is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. As indicated in the table below, states will need to pay us an incremental amount of approximately $131 million during 2014 to account for the HIF and the absence of its tax deductibility.

We have not yet secured agreements from the states of California, New Mexico, Texas, Michigan (tax effect not secured), and Utah (tax effect not secured). The total amount of HIF revenue for which agreements have not been secured is approximately $50 million for the full year of 2014.

We continue to work with our state partners to obtain reimbursement for the full economic impact of the excise tax. If we are unable to obtain either premium increases or direct reimbursements to offset the impact of the tax on a fully grossed up basis, our business, financial condition, cash flows or results of operations could be materially adversely affected.

The following table provides the details of our HIF revenue reimbursement by health plan to date in 2014 (in thousands):

	Three Months Ended			Nine Months Ended Sept. 30, 2014	Required ACA HIF Reimbursement through Dec. 31, 2014
	March 31, 2014	June 30, 2014	Sept. 30, 2014		
			Gross (1)		
California	$ —	$ —	$ —	$ —	$ 11,616
Florida	1,416	1,473	1,487	4,376	5,835
Illinois	40	42	40	122	162
Michigan	—	—	8,011	8,011	17,471
New Mexico	—	—	—	—	11,322
Ohio	7,791	8,117	6,912	22,820	30,426
Texas	—	—	—	—	18,518
Utah	—	—	3,000	3,000	5,332
Washington	6,229	6,489	6,217	18,935	25,246
Wisconsin	1,080	1,126	1,372	3,578	4,771
Medicaid	16,556	17,247	27,039	60,842	130,699
Medicare	2,892	3,199	3,068	9,159	12,212
	$ 19,448	$ 20,446	$ 30,107	$ 70,001	$ 142,911

(1) Amounts in the table include the full economic impact of the excise tax including premium tax and the income tax effect.

Regulatory Capital and Dividend Restrictions

For information on our regulatory capital requirements and dividend restrictions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 15, "Commitments and Contingencies."

Future Sources and Uses of Liquidity

For information on our debt instruments, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Long-Term Debt."

For information on our shelf registration statement and our securities repurchase program, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 13, "Stockholders' Equity."

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2013, was disclosed in our 2013 Annual Report on Form 10-K. We have experienced significant changes in certain categories of contractual obligations since that date. Therefore, in the table below, we present our contractual obligations as of September 30, 2014. Some of the amounts included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2014	2015-2016	2017-2018	2019 and Beyond
Significant changes from December 31, 2013: (1)					
Medical claims and benefits payable (2)	$ 1,123,846	$ 1,123,846	$ —	$ —	$ —
Principal amount of convertible senior notes (3)	862,000	10,449	—	—	851,551
Amounts due under various contractual provisions (4)	297,083	297,083	—	—	—
Interest (coupon) on long-term debt (3)	179,176	2,772	22,175	22,175	132,054
Contingent consideration liability (5)	1,500	1,500	—	—	—
No significant changes from December 31, 2013: (6)					
Lease financing obligations	392,021	11,065	23,136	24,545	333,275
Operating leases	109,038	29,117	39,086	27,266	13,569
Lease financing obligations - related party	84,974	3,330	14,018	15,088	52,538
Purchase commitments	27,522	21,548	5,974	—	—
Total contractual obligations	$ 3,077,160	$ 1,500,710	$ 104,389	$ 89,074	$ 1,382,987

(1) These categories of contractual obligations have changed significantly since December 31, 2013. The amounts presented represent the remaining obligation for 2014 as of September 30, 2014.

(2) Increase due to significantly increased membership in 2014, as described further in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Medical Claims and Benefits Payable," and Item 2, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

(3) Increases due to our third quarter 2014 issuance of 1.625% Convertible Senior Notes due 2044 (1.625% Notes), including an exchange transaction, as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Long-Term Debt." The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018, holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes.

(4) Represents amounts due under various contractual provisions that may adjust or limit revenue or profit, as discussed in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies." The increase is primarily driven by contractual provisions relating to the Medicaid expansion program, which began to phase in effective January 1, 2014.

(5) Decrease due to settlement of contingent consideration liabilities during 2014 as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 4, "Business Combinations."

(6) Amounts presented reflect the amounts reported in our 2013 Annual Report on Form 10-K because there have been no significant changes since that date.

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements.
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the third quarter of 2014 in connection with such contractual provisions.
- *Health Plans segment quality incentives*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the third quarter of 2014 in connection with such quality incentives.
- *Molina Medicaid Solutions segment revenue and cost recognition*.

There have been no significant changes during the nine months ended September 30, 2014, to the items that we disclosed as our critical accounting estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2013.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2014 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

A description of our legal proceedings is included in and incorporated by reference to Note 15 of the Notes to the Consolidated Financial Statements contained in Part I, Item 1 of this report.

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2013. The risk factors described herein and in our 2013 Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

There have been no material changes to the risk factors disclosed in our 2013 Annual Report on Form 10-K.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended September 30, 2014 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
July 1 - July 31	276	$ 46.10	—	$ 47,338,505
August 1 - August 31	2,108	$ 41.19	—	$ 47,338,505
September 1 - September 30	897	$ 47.84	—	$ 47,338,505
Total	3,281	$ 43.42	—	

(a) During the three months ended September 30, 2014, we withheld 3,281 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50.0 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2014.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: October 30, 2014

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: October 30, 2014

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2014 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 30, 2014

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2014 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 30, 2014

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2014 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 30, 2014

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2014 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 30, 2014

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended June 30, 2014

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2014

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of July 25, 2014, was approximately 46,508,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended June 30, 2014

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2014	December 31, 2013
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,027,351	$ 935,895
Investments	740,874	703,052
Receivables	473,514	298,935
Income taxes refundable	16,726	32,742
Deferred income taxes	19,518	26,556
Prepaid expenses and other current assets	93,862	42,484
Total current assets	2,371,845	2,039,664
Property, equipment, and capitalized software, net	317,630	292,083
Deferred contract costs	47,969	45,675
Intangible assets, net	88,493	98,871
Goodwill	230,738	230,738
Restricted investments	84,440	63,093
Auction rate securities	11,025	10,898
Deferred income taxes	4,075	—
Derivative asset	250,160	186,351
Other assets	45,654	35,564
	$ 3,452,029	$ 3,002,937
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 924,182	$ 669,787
Accounts payable and accrued liabilities	475,358	319,965
Deferred revenue	45,945	122,216
Current maturities of long-term debt	185,451	182,008
Total current liabilities	1,630,936	1,293,976
Convertible senior notes	425,709	416,368
Lease financing obligations	160,121	159,394
Lease financing obligations – related party	39,436	27,092
Deferred income taxes	—	580
Derivative liability	250,038	186,239
Other long-term liabilities	28,719	26,351
Total liabilities	2,534,959	2,110,000
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 46,494 shares at June 30, 2014 and 45,871 shares at December 31, 2013	46	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	351,546	340,848
Accumulated other comprehensive income (loss)	40	(1,086)
Retained earnings	565,438	553,129
Total stockholders' equity	917,070	892,937
	$ 3,452,029	$ 3,002,937

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 2,167,142	$ 1,501,729	$ 4,107,479	$ 2,999,162
Service revenue	50,232	49,672	103,862	99,428
Premium tax revenue	70,120	46,883	121,813	83,883
Health insurer fee revenue	19,662	—	38,358	—
Investment income	1,945	1,628	3,574	3,144
Other revenue	2,938	5,922	6,196	10,616
Total revenue	2,312,039	1,605,834	4,381,282	3,196,233
Operating expenses:				
Medical care costs	1,934,299	1,294,706	3,655,957	2,582,621
Cost of service revenue	37,107	39,305	77,764	79,075
General and administrative expenses	193,239	161,479	381,326	302,757
Premium tax expenses	70,120	46,883	121,813	83,883
Health insurer fee expenses	21,945	—	44,135	—
Depreciation and amortization	22,902	17,015	43,593	33,578
Total operating expenses	2,279,612	1,559,388	4,324,588	3,081,914
Operating income	32,427	46,446	56,694	114,319
Other expenses, net:				
Interest expense	13,993	11,667	27,815	24,704
Other (income) expense, net	(9)	3,502	(53)	3,371
Total other expenses, net	13,984	15,169	27,762	28,075
Income from continuing operations before income tax expense	18,443	31,277	28,932	86,244
Income tax expense	10,702	15,481	16,357	39,926
Income from continuing operations	7,741	15,796	12,575	46,318
Income (loss) from discontinued operations, net of tax	70	8,775	(266)	8,168
Net income	$ 7,811	$ 24,571	$ 12,309	$ 54,486
Basic net income per share:				
Continuing operations	$ 0.17	$ 0.35	$ 0.27	$ 1.01
Discontinued operations	—	0.19	—	0.18
Basic net income per share	$ 0.17	$ 0.54	$ 0.27	$ 1.19
Diluted net income per share:				
Continuing operations	$ 0.16	$ 0.34	$ 0.26	$ 1.00
Discontinued operations	—	0.19	—	0.17
Diluted net income per share	$ 0.16	$ 0.53	$ 0.26	$ 1.17

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(Amounts in thousands) (Unaudited)			
Net income	$ 7,811	$ 24,571	$ 12,309	$ 54,486
Other comprehensive income:				
Unrealized investment gain (loss)	391	(4,045)	1,817	(3,626)
Effect of income taxes	(31)	(1,537)	691	(1,378)
Other comprehensive income (loss), net of tax	422	(2,508)	1,126	(2,248)
Comprehensive income	$ 8,233	$ 22,063	$ 13,435	$ 52,238

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2014	2013
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 12,309	$ 54,486
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	65,654	43,907
Deferred income taxes	1,692	(22,155)
Stock–based compensation	10,456	12,150
Amortization of convertible senior notes and lease financing obligations	13,455	9,688
Amortization of premium/discount on investments	5,524	4,298
Amortization of deferred financing costs	1,301	2,366
Change in fair value of derivatives, net	(10)	3,384
Change in fair value of contingent consideration liabilities	(4,199)	—
Gain on disposal of property and equipment, net	(860)	—
Tax deficiency from employee stock compensation	(33)	(38)
Changes in operating assets and liabilities:		
Receivables	(174,579)	(64,094)
Prepaid expenses and other assets	(66,887)	(22,856)
Medical claims and benefits payable	254,395	(29,043)
Accounts payable and accrued liabilities	177,497	(16,968)
Deferred revenue	(76,271)	(95,849)
Income taxes	16,016	8,976
Net cash provided by (used in) operating activities	235,460	(111,748)
Investing activities:		
Purchases of investments	(368,304)	(532,151)
Proceeds from sales and maturities of investments	326,648	149,420
Purchases of equipment	(37,670)	(35,229)
Increase in restricted investments	(15,622)	(12,834)
Proceeds from sale of property and equipment	6,807	—
Change in deferred contract costs	(13,742)	6,994
Change in other noncurrent assets and liabilities	(453)	(8,012)
Net cash used in investing activities	(102,336)	(431,812)
Financing activities:		
Proceeds from issuance of 1.125% Notes, net of deferred financing costs	—	537,973
Proceeds from sale-leaseback transactions	—	158,694
Purchase of 1.125% Notes call option	—	(149,331)
Proceeds from issuance of warrants	—	75,074
Treasury stock purchases	—	(50,000)
Principal payments on term loan	—	(47,471)
Repayment of amounts borrowed under credit facility	—	(40,000)
Contingent consideration liabilities settled	(50,349)	—
Proceeds from employee stock plans	7,617	4,852
Excess tax benefits from employee stock compensation	1,111	1,544
Settlement of interest rate swap	—	(875)
Principal payments on lease financing obligations - related party	(47)	—
Net cash (used in) provided by financing activities	(41,668)	490,460
Net increase (decrease) in cash and cash equivalents	91,456	(53,100)
Cash and cash equivalents at beginning of period	935,895	795,770
Cash and cash equivalents at end of period	$ 1,027,351	$ 742,670

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Six Months Ended June 30,	
	2014	2013
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash (received) paid during the period for:		
Income taxes	$ (2,714)	$ 41,407
Interest	$ 13,210	$ 21,933
Schedule of non-cash investing and financing activities:		
Retirement of treasury stock	$ —	$ 53,000
Common stock used for stock-based compensation	$ 8,453	$ 5,669
Non-cash lease financing obligation – related party	$ 12,447	$ —
Details of change in fair value of derivatives, net:		
Gain on 1.125% Call Option	$ 63,809	$ 57,792
Loss on embedded cash conversion option	(63,799)	(57,686)
Loss on 1.125% Warrants	—	(3,923)
Gain on interest rate swap	—	433
Change in fair value of derivatives, net	$ 10	$ (3,384)

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2014

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of June 30, 2014, these health plans served approximately 2.3 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplaces (Marketplaces) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in California.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we classified the operations for our Missouri health plan as discontinued operations for all periods presented in our consolidated financial statements.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2014.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2013. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2013 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2013 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2013 consolidated statements of income to conform to the 2014 presentation of separately presenting premium tax revenue and premium revenue.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates and fall into two categories:

(1) Contractual provisions that may adjust or limit revenue or profit:

Health Plan Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain Medicaid, Medicare, and Marketplaces premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In some cases, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. In the aggregate, we recorded a liability under the terms of such contract provisions of $80.6 million and $1.4 million at June 30, 2014, and December 31, 2013, respectively. The increase is driven by contractual provisions relating to Medicaid expansion populations, which began to phase in during January 2014. Separately, in certain states we may be levied with non-monetary sanctions if certain minimum amounts are not spent on defined medical care costs, or if administrative costs exceed certain amounts.

Health Plan Profit Sharing and Profit Ceiling: Our contracts with the states of New Mexico, Texas, and Washington contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to fully retain, we recorded a liability of $19.2 million and $2.5 million at June 30, 2014 and December 31, 2013, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of $34.1 million and $20.8 million for anticipated Medicare risk adjustment premiums at June 30, 2014, and December 31, 2013, respectively.

(2) Quality incentives:

At our California, Illinois, New Mexico, Ohio, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1.00% to 5.00% of health plan premiums is earned if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and in prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2014 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2014.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(In thousands)			
Maximum available quality incentive premium - current period	$ 24,300	$ 20,496	$ 44,464	$ 41,111
Amount of quality incentive premium revenue recognized in current period:				
Earned current period	$ 12,717	$ 17,297	$ 18,014	$ 32,193
Earned prior periods	3,582	3,849	3,204	10,561
Total	$ 16,299	$ 21,146	$ 21,218	42,754
Total premium revenue recognized for state health plans with quality incentive premiums	$ 1,708,808	$ 711,251	$ 3,187,069	$ 1,420,634

We recognized a benefit of approximately $25 million from the recognition in the second quarter of 2014 of certain premium revenues of which $15 million related to the year ended December 31, 2013, and $5 million related to the first quarter of 2014.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we generally recognize revenue associated with such contracts on a straight-line basis over the original contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible health insurer fee expenses, nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the mathematical impact of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $2.0 million and $8.0 million as of June 30, 2014 and December 31, 2013, respectively. The unrecognized tax benefits recorded at December 31, 2013 decreased by $6.0 million during the six months ended June 30, 2014 as a result of the execution of a state settlement agreement. This decrease had a nominal impact to the tax provision for the six months ended June 30, 2014. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $1.8 million and $5.7 million as of June 30, 2014 and December 31, 2013, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $0.2 million due to the expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of June 30, 2014 and December 31, 2013, we had accrued $0.08 million for the payment of interest and penalties.

During the three months ended June 30, 2014 and 2013, we recognized tax expense of $0.1 million and tax benefits of $10.0 million, respectively, related to discontinued operations. During the six months ended June 30, 2014 and 2013, we recognized tax benefits related to discontinued operations of $0.4 million and $10.1 million, respectively.

New Accounting Standards

Health Insurer Fee. In the first quarter of 2014, we adopted the guidance of the Financial Accounting Standards Board (FASB) related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA). The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. The health insurer fee (HIF) is imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year.

Effective January 1, 2014, we recorded our estimate of the 2014 liability to accounts payable and accrued liabilities. As of June 30, 2014, we expect the liability to amount to $88.3 million. We are recognizing this expense on a straight-line basis in

2014, and recorded $21.9 million and $44.1 million to health insurer fee expenses in the three months and six months ended June 30, 2014, respectively. As enacted, this federal premium-based assessment is non-deductible for income tax purposes.

Because we primarily serve individuals in government-sponsored programs, we must secure additional reimbursement from our state partners for this added cost. We recognize health insurer fee revenue when we have obtained a contractual commitment from a state to reimburse us for the full economic impact of the health insurer fee, including the effect of premium tax and federal non-deductibility. Such health insurer fee revenue is recognized ratably throughout the year.

Revenue Recognition. In May 2014, the FASB issued Accounting Standards Update (ASU) 2014-09 - *Revenue from Contracts with Customers*, which will supersede nearly all existing revenue recognition guidance under U.S. generally accepted accounting principles (GAAP). The core principal of this ASU is that an entity should recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. This ASU also requires additional disclosure about the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in judgments and assets recognized from costs incurred to obtain or fulfill a contract. This ASU will be effective for us in our first quarter of 2017. Early adoption is not permitted. The ASU allows for either full retrospective or modified retrospective adoption. We are evaluating the transition method that will be elected and the potential effects of the adoption of this ASU on our financial statements.

Discontinued Operations. In April 2014, the FASB issued ASU 2014-08 - *Reporting Discontinued Operations and Disclosures of Disposal of Components of an Entity*, which raises the threshold for disposals to qualify as discontinued operations by focusing on strategic shifts that have or will have a major effect on an entity's operations and financial results. The guidance allows companies to have significant continuing involvement and continuing cash flows with the disposed component. The standard requires additional disclosures for discontinued operations and new disclosures for individually material disposal transactions that do not meet the definition of a discontinued operation. This ASU will be effective for us in our first quarter of 2015. The ASU is applied prospectively. Early adoption is permitted but only for disposals (or classifications as held for sale) that have not been reported in financial statements previously issued or available for issue. We are evaluating the potential effects of the adoption of the ASU on our financial statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(In thousands)			
Shares outstanding at the beginning of the period	46,263	45,415	45,871	46,762
Weighted-average number of shares repurchased	—	—	—	(1,248)
Weighted-average number of shares issued	16	31	279	198
Denominator for basic net income per share	46,279	45,446	46,150	45,712
Dilutive effect of employee restricted stock awards and stock options	361	378	527	488
Dilutive effect of 3.75% Notes	1,363	683	1,147	306
Denominator for diluted net income per share	48,003	46,507	47,824	46,506
Potentially dilutive amounts excluded from calculations:				
Stock options	—	60	45	43
1.125% Warrants (1)	13,490	13,490	13,490	10,434

(1) Potentially dilutive shares issuable pursuant to our 1.125% Warrants (defined in Note 12, "Derivative Financial Instruments") were not included in the computation of diluted net income per share because to do so would have been anti-dilutive.

4. Business Combinations

Health Plans Segment

South Carolina. In July 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members covered by South Carolina's full-risk Medicaid managed care program. The conversion conditions under the agreement were satisfied by January 1, 2014, and on that date such Medicaid members were converted to the managed care program and enrolled with our South Carolina health plan. Because the number of Medicaid members we would ultimately convert was unknown as of the acquisition date in 2013, we recorded a contingent consideration liability for members we expected to enroll until the final purchase price was settled in the second quarter of 2014. The total purchase price for the converted Medicaid membership amounted to $57.2 million, of which $49.7 million was paid in the first half of 2014, and $7.5 million was paid when the agreement was executed in 2013. The total amount paid includes indemnification withhold funds transferred to restricted investments amounting to $5.7 million. If unused, such indemnification funds will become unrestricted on the one-year anniversary date of the conversion, or January 1, 2015.

As part of this transaction, we have also recorded a contingent consideration liability for dual-eligible members we expect to enroll in our Medicare-Medicaid Plan (MMP) implementation in South Carolina. The contingent consideration liability is remeasured to fair value at each quarter until the contingency is resolved with fair value adjustments, if any, recorded to operations. As of June 30, 2014, the fair value of the remaining contingent consideration liability for the MMP implementation amounted to $3.0 million.

The aggregate contingent consideration liability fair value adjustments for the South Carolina transaction have resulted in a gain of $2.7 million in the six months ended June 30, 2014.

New Mexico. In August 2013, our New Mexico health plan acquired the Lovelace Community Health Plan's contract for the state of New Mexico's Medicaid program. In addition to Lovelace's Medicaid members, we also added membership previously covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace. Effective January 1, 2014, these SCI members were either a) enrolled in New Mexico's Medicaid program, or b) eligible to enroll in New Mexico's Marketplace.

Because the number of SCI members we would ultimately retain was unknown as of the acquisition date in 2013, we recorded a contingent consideration liability for such members until the final purchase price was settled in the second quarter of 2014. The aggregate contingent consideration liability fair value adjustments for the New Mexico transaction have resulted in a gain of $1.5 million in the six months ended June 30, 2014.

5. Stock-Based Compensation

In March 2014, our named executive officers were granted a total of 356,292 restricted shares with service, market, and performance conditions. In the event the vesting conditions are not achieved, the awards will lapse. As of June 30, 2014, we expect the performance conditions to be met in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(In thousands)			
Restricted stock and performance awards	$ 4,214	$ 7,111	$ 8,822	$ 10,959
Employee stock purchase plan and stock options	646	618	1,634	1,191
	$ 4,860	$ 7,729	$ 10,456	$ 12,150

As of June 30, 2014, there was $33.3 million of total unrecognized compensation expense related to unvested restricted stock awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 2.2 years. Also as of June 30, 2014, there was $0.4 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.6 years.

Restricted and performance stock activity for the six months ended June 30, 2014 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2013	1,299,852	$ 29.03
Granted	643,852	36.49
Vested	(574,708)	27.35
Forfeited	(37,594)	30.18
Unvested balance as of June 30, 2014	1,331,402	33.33

The total fair value of restricted and performance awards granted during the six months ended June 30, 2014 and 2013 was $23.5 million and $33.1 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, vested during the six months ended June 30, 2014 and 2013 was $21.5 million and $16.2 million, respectively.

Stock option activity for the six months ended June 30, 2014 is summarized below:

	Options	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Outstanding as of December 31, 2013	379,221	$ 24.14		
Exercised	(81,300)	23.37		
Outstanding as of June 30, 2014	297,921	24.35	$ 6,041	3.4
Stock options exercisable and expected to vest as of June 30, 2014	297,921	24.35	$ 6,041	3.4
Exercisable as of June 30, 2014	262,921	23.16	$ 5,644	2.8

6. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, other assets, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities (excluding contingent consideration) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Such investments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the embedded cash conversion option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of June 30, 2014 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, “Derivative Financial

Instruments," the 1.125% Call Option asset and the embedded cash conversion option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Contingent consideration liability. Such liability relates to our South Carolina health plan acquisition described in Note 4, "Business Combinations," and is recorded in accounts payable and accrued liabilities. We applied discounted cash flow analysis to determine the fair value of this liability. Significant unobservable inputs primarily related to the probability weighted present values of the purchase price estimate for the projected membership.

Auction rate securities. Auction rate securities are designated as available-for-sale and are reported at fair value. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of June 30, 2014.

Our financial instruments measured at fair value on a recurring basis at June 30, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
	(In thousands)			
Corporate debt securities	$ 484,437	$ —	$ 484,437	$ —
Municipal securities	96,898	—	96,898	—
GSEs	71,499	71,499	—	—
U.S. treasury notes	37,026	37,026	—	—
Certificates of deposit	51,014	—	51,014	—
Auction rate securities	11,025	—	—	11,025
1.125% Call Option derivative asset	250,160	—	—	250,160
Total assets measured at fair value on a recurring basis	$ 1,002,059	$ 108,525	$ 632,349	$ 261,185
Embedded cash conversion option derivative liability	$ 250,038	$ —	$ —	$ 250,038
Contingent consideration liability	3,000	—	—	3,000
Total liabilities measured at fair value on a recurring basis	$ 253,038	$ —	$ —	$ 253,038

Our financial instruments measured at fair value on a recurring basis at December 31, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
	(In thousands)			
Corporate debt securities	$ 449,772	$ —	$ 449,772	$ —
Municipal securities	113,330	—	113,330	—
GSEs	68,817	68,817	—	—
U.S. treasury notes	37,376	37,376	—	—
Certificates of deposit	33,757	—	33,757	—
Auction rate securities	10,898	—	—	10,898
1.125% Call Option derivative asset	186,351	—	—	186,351
Total assets measured at fair value on a recurring basis	$ 900,301	$ 106,193	$ 596,859	$ 197,249
Embedded cash conversion option derivative liability	$ 186,239	$ —	$ —	$ 186,239
Contingent consideration liabilities	57,548	—	—	57,548
Total liabilities measured at fair value on a recurring basis	$ 243,787	$ —	$ —	$ 243,787

The following table presents activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Change in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liabilities
	(In thousands)		
Balance at December 31, 2013	$ 10,898	$ 112	$ (57,548)
Total gains for the period recognized in:			
General and administrative expenses	—	—	4,199
Other expenses, net	—	10	—
Other comprehensive income	127	—	—
Settlements	—	—	50,349
Balance at June 30, 2014	$ 11,025	$ 122	$ (3,000)

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our convertible senior notes, which are classified as Level 2 financial instruments, are indicated in the following table. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	June 30, 2014				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 425,709	$ 687,819	$ —	$ 687,819	$ —
3.75% Notes	185,258	269,905	—	269,905	—
	$ 610,967	$ 957,724	$ —	$ 957,724	$ —

	December 31, 2013				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 416,368	$ 572,627	$ —	$ 572,627	$ —
3.75% Notes	181,872	219,491	—	219,491	—
	$ 598,240	$ 792,118	$ —	$ 792,118	$ —

7. Investments

The following tables summarize our investments as of the dates indicated:

	June 30, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 484,130	$ 563	$ 256	$ 484,437
Municipal securities	96,763	278	143	96,898
GSEs	71,522	25	48	71,499
U.S. treasury notes	36,992	51	17	37,026
Certificates of deposit	51,027	2	15	51,014
Subtotal - current investments	740,434	919	479	740,874
Auction rate securities	11,400	—	375	11,025
	$ 751,834	$ 919	$ 854	$ 751,899

	December 31, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 450,162	$ 442	$ 832	$ 449,772
Municipal securities	114,126	119	915	113,330
GSEs	68,898	6	87	68,817
U.S. treasury notes	37,360	44	28	37,376
Certificates of deposit	33,756	2	1	33,757
Subtotal - current investments	704,302	613	1,863	703,052
Auction rate securities	11,400	—	502	10,898
	$ 715,702	$ 613	$ 2,365	$ 713,950

The contractual maturities of our investments as of June 30, 2014 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 328,339	$ 328,437
Due one year through five years	412,095	412,437
Due after ten years	11,400	11,025
	$ 751,834	$ 751,899

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Net realized investment gains for the three and six months ended June 30, 2014 and 2013 were insignificant.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at June 30, 2014 and December 31, 2013, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of June 30, 2014:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 139,464	$ 155	74	$ 22,928	$ 101	7
Municipal securities	25,715	49	18	13,877	94	15
GSEs	27,136	24	9	6,009	24	6
U.S. treasury notes	6,971	14	5	4,276	3	2
Certificates of deposit	14,977	15	55	—	—	—
Auction rate securities	—	—	—	11,025	375	15
	$ 214,263	$ 257	161	$ 58,115	$ 597	45

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2013:

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 210,057	$ 802	91	$ 2,540	$ 30	3
Municipal securities	30,715	398	49	31,091	517	39
GSEs	53,308	87	21	—	—	—
U.S. treasury notes	12,037	28	11	—	—	—
Certificates of deposit	414	1	2	—	—	—
Auction rate securities	—	—	—	10,898	502	15
	$ 306,531	$ 1,316	174	$ 44,529	$ 1,049	57

Auction Rate Securities. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not

been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 17 years to 32 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction rate securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at June 30, 2014. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $70.7 million of these instruments at par value.

For the six months ended June 30, 2014 and 2013, we recorded pretax unrealized gains of $0.1 million and $0.4 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future impairment is other-than-temporary, we will record a charge to earnings as appropriate.

8. Receivables

Receivables consist primarily of amounts due from the various states in which we operate, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are state governments, our allowance for doubtful accounts is immaterial.

	June 30, 2014	December 31, 2013
	(In thousands)	
California	$ 221,336	$ 148,654
Florida	4,562	2,901
Illinois	130	5,773
Michigan	31,017	15,253
New Mexico	56,143	17,056
Ohio	50,548	43,969
South Carolina	1,999	—
Texas	13,240	9,736
Utah	13,337	10,953
Washington	38,740	13,455
Wisconsin	12,654	8,087
Direct delivery and other	8,199	2,463
Total Health Plans segment	451,905	278,300
Molina Medicaid Solutions segment	21,609	20,635
	$ 473,514	$ 298,935

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with the Molina Medicaid Solutions contract with the state of Maine, we maintain restricted investments as collateral for a letter of credit. The following table

presents the balances of restricted investments:

	June 30, 2014	December 31, 2013
	(In thousands)	
California	$ 373	$ 373
Florida	23,620	9,242
Illinois	310	310
Michigan	1,014	1,014
New Mexico	26,628	24,622
Ohio	12,718	9,080
South Carolina	6,037	310
Texas	3,500	3,500
Utah	3,601	3,301
Washington	151	151
Other	1,487	886
Total Health Plans segment	79,439	52,789
Molina Medicaid Solutions segment	5,001	10,304
	$ 84,440	$ 63,093

The contractual maturities of our held-to-maturity restricted investments as of June 30, 2014 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 83,840	$ 83,851
Due one year through five years	600	601
	$ 84,440	$ 84,452

10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	June 30, 2014	December 31, 2013
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 697,038	$ 424,173
Pharmacy payable	54,935	45,037
Capitation payable	29,560	20,267
Other	142,649	180,310
	$ 924,182	$ 669,787

"Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $68.3 million and $151.3 million as of June 30, 2014 and December 31, 2013, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts displayed for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30, 2014	Year Ended December 31, 2013
	(Dollars in thousands)	
Balances at beginning of period	$ 669,787	$ 494,530
Components of medical care costs related to:		
Current period	3,693,730	5,434,443
Prior period	(37,131)	(52,779)
Total medical care costs	3,656,599	5,381,664
Change in non-risk provider payables	(83,044)	111,267
Payments for medical care costs related to:		
Current period	2,891,174	4,932,195
Prior period	427,986	385,479
Total paid	3,319,160	5,317,674
Balances at end of period	$ 924,182	$ 669,787
Benefit from prior period as a percentage of:		
Balance at beginning of period	5.5%	10.7%
Premium revenue, trailing twelve months	0.5%	0.9%
Medical care costs, trailing twelve months	0.6%	1.0%

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2014 and 2013 were less than what we had expected when we had established our reserves. For example, for the year ended December 31, 2013, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2012 by 10.7%. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

While prior period development of our estimate as of December 31, 2013 through June 30, 2014 has been favorable by $37.1 million, that amount is substantially less than the favorable prior period development of $52.8 million that we recognized in all of 2013. Furthermore, favorable development through June 30, 2014 was less than the 8% to 10% we typically expect.

In estimating our claims liability at June 30, 2014, we adjusted our base calculation to take account of the numerous factors that we believe will likely change our final claims liability amount. We believe the most significant among those factors are:

- Since January 1, 2014, we have added approximately 232,300 members under Medicaid expansion. Because these members have different demographics than our current members and are transitioning into managed are, we have little insight into their utilization of medical services. Additionally, as of June 30, 2014, we have relatively little medical claims payment history related to these members. Accordingly, our estimates of our liability are subject to a high degree of uncertainty.
- Since January 1, 2014, we have added approximately 119,000 new members at our South Carolina health plan. Because we have only six months of claims payment history, the reserves are more subject to change than usual.

- At our Texas health plan, we have recorded reserves to cover estimated liabilities for potential payment of additional claims where the initial claim payments were disputed by the providers. The actual additional payments may differ from the amount we have reserved.
- At our New Mexico health plan, the state has been adding 10,000 to 15,000 members per month on a retroactive basis since March, 2014. Because we have no claims payment history for these members, our estimates of our liability are subject to a high degree of uncertainty.

The use of a consistent methodology in estimating our liability for medical claims and benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2013, and for the six months ended June 30, 2014, the absence of adverse development of the liability for medical claims and benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both periods, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

11. Long-Term Debt

As of June 30, 2014, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2014	2015	2016	2017	2018	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	187,000	—	—	—	—	—
	$ 737,000	$ 187,000	$ —	$ —	$ —	$ —	$ 550,000

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes), which were outstanding as of June 30, 2014 and December 31, 2013. Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum, and commenced on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date. The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities.

The initial conversion rate for the 1.125% Notes is 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate is subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest.

The 1.125% Notes contain an embedded cash conversion option, which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the embedded cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5.9%. As of June 30, 2014, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 5.5 years. The 1.125% Notes' if-converted value did not exceed their principal amount as of June 30, 2014 and December 31, 2013.

3.75% Convertible Senior Notes due 2014. We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of June 30, 2014 and December 31, 2013. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock.

Because the 3.75% Notes have cash settlement features, we have allocated the proceeds from their issuance between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that is amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected

life of the debt. This has resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. While the 3.75% Notes may be converted beginning July 1, 2014, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 3 months. The 3.75% Notes' if-converted value exceeded their principal amount by approximately $79 million and $11 million as of June 30, 2014, and December 31, 2013, respectively. At June 30, 2014, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million.

The principal amounts, unamortized discount and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
June 30, 2014:			
1.125% Notes	$ 550,000	$ 124,291	$ 425,709
3.75% Notes	187,000	1,742	185,258
	$ 737,000	$ 126,033	$ 610,967
December 31, 2013:			
1.125% Notes	$ 550,000	$ 133,632	$ 416,368
3.75% Notes	187,000	5,128	181,872
	$ 737,000	$ 138,760	$ 598,240

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
		(In thousands)		
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate	$ 3,300	$ 3,300	$ 6,600	$ 5,827
Amortization of the discount	6,414	5,965	12,728	9,688
Total interest cost recognized	$ 9,714	$ 9,265	$ 19,328	$ 15,515

Lease Financing Obligations. In 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of two properties, including the Molina Center located in Long Beach, California, and our Ohio health plan office building in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income.

As described and defined in further detail in Note 16, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings then under construction. We have concluded that we are the accounting owner of the properties due to of our continuing involvement with the properties. We have recorded $38.5 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of June 30, 2014, which represents the total cost, including imputed interest, incurred by the Landlord thus far for the construction of the buildings. As of June 30, 2014, the aggregate amount recorded to lease financing obligations amounted to $39.4 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Such interest expense was $1.1 million for the six months ended June 30, 2014. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was $0.4 million for the six months ended June 30, 2014.

12. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	June 30, 2014	December 31, 2013
		(In thousands)	
Derivative asset:			
1.125% Call Option	Non-current assets: Derivative asset	$ 250,160	$ 186,351
Derivative liability:			
Embedded cash conversion option	Non-current liabilities: Derivative liability	$ 250,038	$ 186,239

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, and reported in other expenses, net. Gains and losses for our derivative financial instruments are presented individually in the consolidated statements of cash flows, supplemental cash flow information.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013 as described in Note 11, "Long-Term Debt," we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 6, "Fair Value Measurements."

Embedded Cash Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the embedded cash conversion option, refer to Note 6, "Fair Value Measurements."

13. Stockholders' Equity

Stockholders' equity increased $24.1 million during the six months ended June 30, 2014 compared with stockholders' equity at December 31, 2013. The increase was due to net income of $12.3 million, $1.1 million related to other comprehensive income and $10.7 million related to employee stock transactions.

1.125% Warrants. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants.

Securities Repurchases and Repurchase Program. Effective September 30, 2013, our board of directors authorized the repurchase of up to $50.0 million in aggregate of our common stock through December 31, 2014. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and other market conditions. As of June 30, 2014, the remaining balance available to repurchase our stock under this program was $47.3 million.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with our equity incentive plans, we issued approximately 623,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the six months ended June 30, 2014.

14. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes as they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segment is charged to the Health Plans segment.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(In thousands)			
Revenue from continuing operations:				
Health Plans segment:				
Premium revenue	$ 2,167,142	$ 1,501,729	$ 4,107,479	$ 2,999,162
Premium tax revenue	70,120	46,883	121,813	83,883
Health insurer fee revenue	19,662	—	38,358	—
Investment income	1,945	1,628	3,574	3,144
Other revenue	2,938	5,922	6,196	10,616
Molina Medicaid Solutions segment:				
Service revenue	50,232	49,672	103,862	99,428
Total revenue	$ 2,312,039	$ 1,605,834	$ 4,381,282	$ 3,196,233
Operating income from continuing operations:				
Health Plans segment	$ 21,986	$ 40,151	$ 36,005	$ 101,671
Molina Medicaid Solutions segment	10,441	6,295	20,689	12,648
Total operating income from continuing operations	32,427	46,446	56,694	114,319
Other expenses, net	13,984	15,169	27,762	28,075
Income from continuing operations before income tax expense	$ 18,443	$ 31,277	$ 28,932	$ 86,244

15. Commitments and Contingencies

California Health Plan Rate Settlement Agreement. In the fourth quarter of 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, a settlement account (the Account) applicable to the California health plan's managed care contracts has been established.

Effective January 1, 2014, the Account was established with an initial balance of zero, and will be settled after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our managed care contracts. The Account will be adjusted annually to reflect a calendar year deficit or surplus, which is determined by comparing the California health plan's pre-tax margin and a target margin established in the settlement agreement. Upon expiration of the settlement agreement, if the Account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. If the Account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40.0 million.

We estimate and recognize the retrospective adjustments to premium revenue based on our experience to date under the California health plan's managed care contracts. As of June 30, 2014, we recorded a deficit, or receivable, of $9.5 million, net of a valuation discount of $0.5 million, reflecting our estimated retrospective premium adjustment to the Account based on the California health plan's actual pretax margin for the six months ended June 30, 2014.

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Washington Health Plan. The Washington Health Care Authority (HCA) has communicated that it believes it has overpaid our Washington health plan with regard to certain claims. The alleged overpayments purportedly involve an undifferentiated incremental component of the capitation rates paid to our Washington health plan from and after July 1, 2012, the start date of the contract at issue. On March 25, 2014, HCA alleged that the total "overpayments" related to HCA's delayed enrollment of so-called Washington Community Options Program Entry System (COPES) members were $14.4 million, and demanded payment in that amount. On April 7, 2014, HCA alleged that the total "overpayments" related to certain psychotropic drug claims that had been included in the Request for Proposal (RFP) rate book were $5.8 million, and demanded payment in that amount. HCA has provided us with minimal data by which we might independently validate HCA's allegations. Furthermore, both alleged errors, if they in fact occurred, were unilateral errors committed and caused by HCA for which our Washington health plan had no contemporaneous knowledge and had assumed and bore no contractual risk. We have responded to HCA's demands for payment, noting, among other things, that the demands are improper as a matter of law because under the Washington statue cited regarding the definition of an "overpayment," there were in fact no "overpayments" since payment was made consistent with the express terms of the parties' contract. We believe that any actual liability for the alleged overpayment claims is not currently probable or reasonably estimable.

State of Louisiana. On June 26, 2014, the State of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that, in late 2008 and early 2009, in connection with the acquisition of Florida NetPass by which Molina Healthcare entered into the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. Both the United States of America and the State of Florida have reviewed the allegations made in the Complaint, and have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statues, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $663 million at June 30, 2014, and $608 million at December 31, 2013. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $299.8 million and $365.2 million as of June 30, 2014 and December 31, 2013, respectively.

The National Association of Insurance Commissioners (NAIC) adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2014, our health plans had aggregate statutory capital and surplus of approximately $728 million compared with the required minimum aggregate statutory capital and surplus of approximately $418 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2014. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Related Party Transactions

In February 2013, we entered into a lease with 6th & Pine Development, LLC (the Landlord) for office space located in Long Beach, California. The lease consists of two office buildings, referred to as Building A and Building B.

The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of common stock in the Company the Landlord holds as trustee. Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

The lease term for Building A commenced in June 2013, and the lease term for Building B commenced in July 2014. The initial lease term for both buildings expires on December 31, 2024, subject to two five-year renewal options. Annual rent for Building A is approximately $3 million, and initial annual rent for Building B is approximately $4 million. Rent increases 3.75% per year during the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

Refer to Note 17, "Variable Interest Entities," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

17. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations. The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides professional medical services to the general public for routine non-life threatening, outpatient health care needs. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, American Family Care, Inc. (AFC), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by AFC are reviewed annually to assure the achievement of this goal.

Separately, our California, Florida, New Mexico, Utah and Washington health plans have entered into primary care services agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because

the AFC services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a variable interest entity (VIE), and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of June 30, 2014, JMMPC had total assets of $10.4 million, and total liabilities of $10.1 million. As of December 31, 2013, JMMPC had total assets of $6.9 million and total liabilities of $6.6 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- uncertainties associated with the implementation of the Affordable Care Act, including the full grossed up reimbursement by states of the non-deductible health insurer fee, the expansion of Medicaid eligibility in the states that participate to previously uninsured populations unfamiliar with managed care, the implementation of state insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures, including the dual eligibles demonstration programs in California, Illinois, Michigan, Ohio, and South Carolina;
- newly FDA-approved drugs such as Sovaldi, Olysio, and other drugs for hepatitis C or other medical conditions that are exorbitantly priced but not factored into the calculation of our capitated rates for 2014;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and our ability to reduce over time the high medical costs commonly associated with new patient populations;
- the accurate estimation of incurred but not paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates or retroactive premium rate increases;
- efforts by states to recoup previously paid amounts, including claims by the Washington Health Care Authority (HCA) that it overpaid our Washington health plan for certain claims related to psychotropic drugs and the Washington Community Options Program Entry System (COPES);
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, including the success of the proposal of Molina Medicaid Solutions in New Jersey;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed, including the extension of the Louisiana contract of Molina Medicaid Solutions through 2015;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- federal or state medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures, including 2014 at-risk premium rules in the state of Texas;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable or unfavorable resolution of litigation, arbitration, or administrative proceedings, including the litigation commenced against us by the state of Louisiana alleging that Molina Medicaid Solutions and its predecessors used an incorrect reimbursement formula for the payment of pharmaceutical claims;
- the relatively small number of states in which we operate health plans;
- our management of a portion of College Health Enterprises' hospital in Long Beach, California;

- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2013, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2013.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of June 30, 2014, these health plans served approximately 2.3 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplaces (Marketplaces) members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in California.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we classified the operations for our Missouri health plan as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Health Care Reform

We believe that the Affordable Care Act (defined below) will continue to provide us with significant opportunities for membership growth in our existing markets and, potentially, in new markets in the future as follows:

Medicaid Expansion. In the states that have elected to participate, the Affordable Care Act provides for the expansion of the Medicaid program to provide eligibility to nearly all low-income people under age 65 with incomes at or below 138 percent of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. In the six months ended June 30, 2014, we added approximately 232,300 Medicaid expansion members, or 10% of total membership.

Health Insurance Marketplaces. On October 1, 2013, Marketplaces became available for consumers to access and begin the enrollment process for coverage beginning January 1, 2014. Marketplaces allow individuals and small groups to purchase health insurance that is federally subsidized. We participate in Marketplaces in all of the states in which we operate, except Illinois and South Carolina. At June 30, 2014, we had fewer than 20,000 Marketplaces members.

Dual Eligibles. Policymakers at the federal and state levels are increasingly developing initiatives, and the Centers for Medicare and Medicaid Services (CMS) has implemented several demonstrations, designed to improve the coordination of care for dual eligibles and reduce spending under Medicare and Medicaid. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for dual eligibles in the state. We refer to such demonstrations as our Medicare-Medicaid Plan (MMP) implementations. Our MMP implementations in California, Illinois, and Ohio offered coverage beginning in the second quarter of 2014.

Health Insurer Fee. In the first quarter of 2014, we adopted the guidance of the Financial Accounting Standards Board (FASB) related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA). The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. The health insurer fee (HIF) is imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year.

As of June 30, 2014, we expect the liability to amount to $88.3 million. We are recognizing this expense on a straight-line basis in 2014, and recorded $21.9 million and $44.1 million to health insurer fee expenses in the three months and six months ended June 30, 2014, respectively. As enacted, this federal premium-based assessment is non-deductible for income tax purposes.

For further discussion of the risks and uncertainties relating to the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates - Health Plans Segment

Florida. Enrollment at the Florida health plan declined between the first and second quarters of 2014 due to a reassignment of membership as part of the implementation of Florida's Managed Medical Assistance program. We believe that enrollment at the Florida health plan will grow later in the year.

On March 12, 2014, our Florida health plan entered into an agreement with Healthy Palm Beaches, Inc. (HPB) to acquire certain assets relating to HPB's Medicaid business for $7.5 million. Our Florida health plan expects to close on this transaction in the third quarter of 2014.

South Carolina. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014. For further information on this transaction, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 4, "Business Combinations."

Composition of Revenue and Membership

Health Plans Segment

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new RFP open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," is not generally subject to significant accounting estimates. For the six months ended June 30, 2014, we received approximately 97% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our Medicaid contracts with state agencies, Medicare and other managed care organizations for which we operate as subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the six months ended June 30, 2014, we recognized approximately 3% of our premium revenue in the form of "birth income"—a one-time payment for the delivery of a child—from the Medicaid programs in all of our state health plans except Illinois and New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans in the six months ended June 30, 2014, by program:

	Ending	PMPM Premiums		
	Membership	Low	High	Consolidated
Temporary Assistance for Needy Families (TANF)	1,564,500	$ 100.00	$ 260.00	$ 160.00
Aged, Blind or Disabled (ABD)	305,300	370.00	1,260.00	770.00
Medicaid Expansion	232,300	370.00	550.00	500.00
Children's Health Insurance Program (CHIP)	77,000	90.00	130.00	120.00
Medicare Special Needs Plans (Medicare)	44,000	530.00	1,280.00	1,190.00
Marketplaces	18,300	170.00	640.00	300.00
MMP–Integrated (1)	5,200	1,230.00	3,240.00	1,910.00
MMP–Medicare Opt Out (1)	8,400	1,370.00	1,420.00	1,390.00

(1) MMPs serve members who are dually eligible for Medicare and Medicaid.

(2) MMP members who have elected to "opt out" of Medicare coverage and receive Medicaid coverage only.

The following tables set forth our Health Plans segment membership as of the dates indicated:

	June 30, 2014	March 31, 2014	December 31, 2013	June 30, 2013
Ending Membership by Health Plan:				
California	455,000	418,000	368,000	355,000
Florida (1)	58,000	91,000	89,000	81,000
Illinois	6,000	5,000	4,000	—
Michigan	244,000	218,000	213,000	215,000
New Mexico	195,000	183,000	168,000	92,000
Ohio	302,000	260,000	255,000	240,000
South Carolina (2)	119,000	126,000	—	—
Texas	247,000	246,000	252,000	266,000
Utah	83,000	80,000	86,000	87,000
Washington	461,000	434,000	403,000	413,000
Wisconsin	85,000	90,000	93,000	98,000
	2,255,000	2,151,000	1,931,000	1,847,000
Ending Membership by Program:				
TANF	1,564,500	1,575,300	1,503,800	1,435,400
ABD	305,300	309,900	288,600	270,300
Medicaid Expansion (3)	232,300	133,000	—	—
CHIP	77,000	83,700	99,200	105,000
Medicare	44,000	41,400	39,400	36,300
Marketplaces (3)	18,300	7,700	—	—
MMP–Integrated	5,200	—	—	—
MMP–Medicare Opt Out	8,400	—	—	—
	2,255,000	2,151,000	1,931,000	1,847,000

(1) Enrollment at our Florida health plan declined between the first and second quarters of 2014 due to a reassignment of membership as part of the implementation of Florida's Managed Medical Assistance program. We believe enrollment at our Florida health plan will grow later in the year.

(2) Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

(3) Medicaid expansion membership phased in, and Health Insurance Marketplaces became available for consumers to access coverage, beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we generally recognize revenue associated with such contracts on a straight-line basis over the original contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, general and administrative expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Nearly all hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis.

- *Pharmacy expenses:* All drug, injectables, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses.

- *Capitation expenses:* Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.

- *Direct delivery expenses:* All costs associated with our operation of primary care clinics are classified as direct delivery expenses.

- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements in Note 10, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Second Quarter Financial Performance Summary, Continuing Operations

The following table and narrative briefly summarize our financial and operating performance from continuing operations for the three and six months ended June 30, 2014 and 2013. All ratios, with the exception of the medical care ratio and the premium tax ratio, are computed as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue, the premium tax ratio is computed as a percentage of premium revenue plus premium tax revenue because direct relationships exist between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(Dollar amounts in thousands, except per share data)			
Net income per diluted share	$ 0.16	$ 0.34	$ 0.26	$ 1.00
Premium revenue	$ 2,167,142	$ 1,501,729	$ 4,107,479	$ 2,999,162
Service revenue	$ 50,232	$ 49,672	$ 103,862	$ 99,428
Operating income	$ 32,427	$ 46,446	$ 56,694	$ 114,319
Net income	$ 7,741	$ 15,796	$ 12,575	$ 46,318
Total ending membership	2,255,000	1,847,000	2,255,000	1,847,000
Premium revenue	93.7%	93.5%	93.7%	93.9%
Service revenue	2.2	3.1	2.4	3.1
Premium tax revenue	3.0	2.9	2.8	2.6
Health insurer fee revenue	0.9	—	0.9	—
Investment income	0.1	0.1	0.1	0.1
Other revenue	0.1	0.4	0.1	0.3
Total revenue	100.0%	100.0%	100.0%	100.0%
Operating Statistics:				
Medical care ratio	89.3%	86.2%	89.0%	86.1%
Service revenue ratio	73.9%	79.1%	74.9%	79.5%
General and administrative expense ratio	8.4%	10.1%	8.7%	9.5%
Premium tax ratio	3.1%	3.0%	2.9%	2.7%
Operating income	1.4%	2.9%	1.3%	3.6%
Net income	0.3%	1.0%	0.3%	1.4%
Effective tax rate	58.0%	49.5%	56.5%	46.3%
Medical Claims Data:				
Days in claims payable, fee for service	46	38	46	38
Number of claims in inventory at end of period	180,600	109,900	180,600	109,900
Billed charges of claims in inventory at end of period	$ 400,000	$ 200,400	$ 400,000	$ 200,400
Claims in inventory per member at end of period	0.08	0.06	0.08	0.06
Billed charges of claims in inventory per member at end of period	$ 177.38	$ 108.50	$ 177.38	$ 108.50
Number of claims received during the period	6,655,300	5,253,500	12,641,300	10,524,500
Billed charges of claims received during the period	$ 7,255,000	$ 5,307,200	$ 13,609,000	$ 10,477,900

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. generally accepted accounting principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(In thousands)			
Net income	$ 7,811	$ 24,571	$ 12,309	$ 54,486
Adjustments:				
Depreciation, and amortization of intangible assets and capitalized software	28,292	22,108	54,206	43,907
Interest expense	13,993	11,667	27,815	24,704
Income tax expense	10,760	5,513	15,997	29,783
EBITDA	$ 60,856	$ 63,859	$ 110,327	$ 152,880

The second of these non-GAAP measures is adjusted net income, continuing operations. The following table reconciles net income from continuing operations, which we believe to be the most comparable GAAP measure, to adjusted net income, continuing operations.

	Three Months Ended June 30,			
	2014		2013	
	(In thousands, except diluted per-share amounts)			
Net income, continuing operations	$ 7,741	$ 0.16	$ 15,796	$ 0.34
Adjustments, net of tax:				
Depreciation, and amortization of capitalized software	14,614	0.30	10,875	0.23
Stock-based compensation	4,322	0.09	5,890	0.13
Amortization of convertible senior notes and lease financing obligations	4,272	0.09	3,758	0.08
Amortization of intangible assets	3,209	0.07	3,053	0.07
Change in fair value of derivatives, net	(5)	—	3,658	0.08
Adjusted net income, continuing operations	$ 34,153	$ 0.71	$ 43,030	$ 0.93

	Six Months Ended June 30,			
	2014		2013	
	(In thousands, except diluted per-share amounts)			
Net income, continuing operations	$ 12,575	$ 0.26	$ 46,318	$ 1.00
Adjustments, net of tax:				
Depreciation, and amortization of capitalized software	27,612	0.58	21,554	0.46
Stock-based compensation	9,221	0.19	9,490	0.20
Amortization of convertible senior notes and lease financing obligations	8,477	0.18	6,103	0.13
Amortization of intangible assets	6,538	0.14	6,107	0.13
Change in fair value of derivatives, net	(6)	—	3,583	0.08
Adjusted net income, continuing operations	$ 64,417	$ 1.35	$ 93,155	$ 2.00

Analysis of Second Quarter 2014 Financial Results - Trends and Developments

We previously reported that our first quarter of 2014 results were adversely affected by delays in securing agreements for the reimbursement (including reimbursement for tax effect) of the HIF, and delays in the recognition of quality related revenue. Those circumstances continued through the end of the second quarter of 2014. Net income reported for the second quarter and six months ended June 30, 2014 would have been higher except for:

- HIF not reimbursed by our state partners reduced earnings approximately $16 million, or $0.14 per diluted share for the second quarter of 2014, and $32 million, or $0.29 per diluted share for the six months ended June 30, 2014 (per-share amounts for both periods on a GAAP and adjusted basis). We remain guardedly optimistic that we will secure reimbursement agreements with all of our state partners prior to the close of 2014.
- Our non-recognition of a portion of the Texas health plan's quality incentive program reduced earnings approximately $7 million, or $0.06 per diluted share for the second quarter of 2014, and $13 million, or $0.12 per diluted share, for the six months ended June 30, 2014 (per-share amounts for both periods on a GAAP and adjusted basis). We remain guardedly optimistic that we will be able to recognize most of our quality revenue in Texas prior to the close of 2014.

Results of Operations, Continuing Operations

Health Plans Segment

Premium Revenue

Premium revenue for the second quarter of 2014 increased 44% over the second quarter of 2013, due to a 21% increase in member months, and a 19% increase in revenue per member per month (PMPM). The increase in member months was due to the addition of Medicaid expansion membership primarily at our health plans in California, New Mexico, Ohio and Washington, and the addition of Medicaid members at our South Carolina health plan, all effective January 1, 2014.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended June 30,					
	2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 1,378,037	$ 205.08	71.2%	$ 879,865	$ 158.96	68.0%
Pharmacy	295,596	43.99	15.3	222,992	40.29	17.2
Capitation	176,817	26.31	9.1	138,409	25.00	10.7
Direct delivery	23,063	3.43	1.2	9,443	1.71	0.7
Other	60,786	9.06	3.2	43,997	7.95	3.4
Total	$ 1,934,299	$ 287.87	100.0%	$ 1,294,706	$ 233.91	100.0%

Our consolidated medical care ratio increased to 89.3% in the second quarter of 2014, from 86.2% in the second quarter of 2013. We recognized approximately $15 million of revenue related to 2013 in the second quarter of 2014. This out of period benefit was offset by unfavorable development of our consolidated medical claims and benefits payable liability at the end of the prior year; when compared with the second quarter of 2013.

Individual Health Plan Analysis

California. Medical margin improved $63.0 million at the California health plan, when compared with the second quarter of 2013. This improvement was the result of the following:

- Higher enrollment and PMPM premiums, particularly as a result of 66,000 members added due to Medicaid expansion;
- Approximately $25 million benefit from recognition in the second quarter of 2014 of certain premium revenues of which $15 million related to the year ended December 31, 2013, and $5 million related to the first quarter of 2014; and
- A $4.5 million benefit from the rate settlement agreement with the DHCS.

Florida. Despite an increase in revenue of over 60%, medical margin fell at the Florida health plan by $1.4 million in the second quarter of 2014 when compared with the second quarter of 2013. Although we earn a comparatively large premium for long-term care members, the medical care ratio associated with these services is very high compared to the benefits traditionally offered by us. Accordingly, the medical care ratio of the Florida health plan increased to 91.6% in the second quarter of 2014 from 84.0% in the second quarter of 2013.

Illinois. The medical care ratio for the Illinois health plan was 106.3% in the second quarter of 2014. The Illinois health plan served its first member effective September 2013. The high medical care ratio at the Illinois health plan is the result of: 1) a small membership base transitioning into managed care; and 2) the need to incur relatively high medically related administrative costs in light of the enrollment increase anticipated at the health plan later in 2014.

Michigan. Financial performance at the Michigan health plan declined in the second quarter of 2014, when compared with the second quarter of 2013, primarily due to to comparatively higher medical care ratios for the Medicaid expansion (new in 2014) and Medicare programs. The medical care ratio of the Michigan health plan increased to 88.2% for the second quarter of 2014, from 84.7% for the second quarter of 2013. The Michigan health plan added its first Medicaid expansion members during the second quarter of 2014. Medicaid expansion enrollment as of June 30, 2014 was approximately 20,000.

New Mexico. Medical margin improved at the New Mexico health plan in the second quarter of 2014, when compared with the second quarter of 2013, primarily due to higher revenues that offset an increase in the medical care ratio to 89.6% in the second quarter of 2014, from 80.8% in the second quarter of 2013. The New Mexico health plan added approximately 42,000 Medicaid expansion members in the first half of 2014; as well as approximately 60,000 new members in a business combination effective August 1, 2013. The higher medical care ratio was primarily the result of the addition of Medicaid behavioral health and long-term care services effective January 1, 2014 (which are reimbursed at a higher medical care ratio than traditional medical benefits); and a return to more typical medical cost levels overall in 2014.

Ohio. The medical care ratio of the Ohio health plan increased to 84.2% for the second quarter of 2014, from 79.8% for the second quarter of 2013. Medical care costs increased to a more typical level in the second quarter of 2014. We do not believe that medical care ratios below 80% are sustainable over time. The Ohio health plan added its first meaningful number of Medicaid expansion members during the second quarter of 2014. Medicaid expansion enrollment as of June 30, 2014 was approximately 30,000.

South Carolina. The medical care ratio for the South Carolina health plan was 87.8% in the second quarter of 2014. The South Carolina health plan served its first members effective January 2014.

Texas. Financial performance worsened at the Texas health plan in the second quarter of 2014, when compared with the second quarter of 2013, due to a decrease in quality revenue as described above and an increase in amounts returned to the state under a profit-sharing agreement. The medical care ratio of the Texas health plan increased to 92.8% in the second quarter of 2014, from 86.5% in the second quarter of 2013. Removing quality revenue and profit-sharing adjustments for both quarters would have resulted in a medical care ratio at the Texas health plan of approximately 91% for the second quarter of 2014 and 92% for the second quarter of 2013.

Utah. Financial performance worsened at the Utah health plan in the second quarter of 2014, when compared with the second quarter of 2013, due to higher inpatient utilization and a general return of medical costs to a more typical level in the second quarter of 2014. The medical care ratio of the Utah health plan increased to 95.5% in the second quarter of 2014, from 79.6% in the second quarter of 2013. We do not believe that medical care ratios below 80% are sustainable over time.

Washington. Financial performance worsened at the Washington health plan in the second quarter of 2014, when compared with the second quarter of 2013, primarily due to lower premiums relative to the risk assumed for our members. The medical care ratio of the Washington health plan increased to 90.5% in the second quarter of 2014, from 88.0% in the second quarter of 2013. The Washington health plan added approximately 73,000 Medicaid expansion members in the first half of 2014.

Wisconsin. Financial performance worsened at the Wisconsin health plan in the second quarter of 2014, when compared with the second quarter of 2013. The medical care ratio of the Wisconsin health plan increased to 89.8% in the second quarter of 2014, from 82.6% in the second quarter of 2013.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended June 30, 2014						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,335	$ 398,071	$ 298.11	$ 324,923	$ 243.33	81.6%	$ 73,148
Florida	229	101,423	443.05	92,865	405.67	91.6	8,558
Illinois (3)	17	19,263	1,136.20	20,472	1,207.48	106.3	(1,209)
Michigan	702	185,337	264.18	163,392	232.89	88.2	21,945
New Mexico	617	267,994	434.57	240,151	389.42	89.6	27,843
Ohio	849	328,630	386.79	276,716	325.69	84.2	51,914
South Carolina	360	96,453	268.38	84,686	235.64	87.8	11,767
Texas	742	320,966	432.46	297,899	401.38	92.8	23,067
Utah	249	76,574	307.47	73,094	293.49	95.5	3,480
Washington	1,364	336,959	247.03	305,098	223.67	90.5	31,861
Wisconsin	256	36,925	144.42	33,143	129.63	89.8	3,782
Other (4)	—	(1,453)	—	21,860	—	—	(23,313)
	6,720	$ 2,167,142	$ 322.52	$ 1,934,299	$ 287.87	89.3%	$ 232,843

	Three Months Ended June 30, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,055	$ 180,927	$ 171.58	$ 170,777	$ 161.96	94.4%	$ 10,150
Florida	238	61,837	260.61	51,915	218.80	84.0	9,922
Illinois (3)	—	—	—	—	—	—	—
Michigan	648	167,485	258.40	141,859	218.86	84.7	25,626
New Mexico	275	84,449	307.20	68,253	248.28	80.8	16,196
Ohio	722	270,107	373.78	215,664	298.44	79.8	54,443
South Carolina	—	—	—	—	—	—	—
Texas	805	318,955	396.05	275,959	342.66	86.5	42,996
Utah	261	77,511	296.69	61,677	236.08	79.6	15,834
Washington	1,238	299,533	241.89	263,512	212.80	88.0	36,021
Wisconsin	293	37,740	128.79	31,185	106.43	82.6	6,555
Other (3)(4)	—	3,185	—	13,905	—	—	(10,720)
	5,535	$ 1,501,729	$ 271.30	$ 1,294,706	$ 233.91	86.2%	$ 207,023

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) The MCR represents medical costs as a percentage of premium revenue.
(3) The Illinois health plan's results prior to October 1, 2013, were insignificant and reported in "Other."
(4) "Other" medical care costs include primarily medically related administrative costs at the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended June 30,	
	2014	2013
	(In thousands)	
Service revenue before amortization	$ 50,960	$ 50,400
Amortization recorded as reduction of service revenue	(728)	(728)
Service revenue	50,232	49,672
Cost of service revenue	37,107	39,305
General and administrative costs	1,891	2,790
Amortization of customer relationship intangibles recorded as amortization	793	1,282
Operating income	$ 10,441	$ 6,295

Operating income for our Molina Medicaid Solutions segment increased $4.1 million in the second quarter of 2014, compared with the second quarter of 2013, primarily due to reduced service costs associated with our West Virginia and Maine contracts, and lower general and administrative costs overall.

Results of Operations, Continuing Operations

Six Months Ended June 30, 2014 Compared with Six Months Ended June 30, 2013

Health Plans Segment

Premium Revenue

Premium revenue for the six months ended June 30, 2014 increased 37% over the six months ended June 30, 2013, due to a 20% increase in member months, and a 14% increase in revenue PMPM. The increase in member months was due to the addition of Medicaid expansion membership primarily at our health plans in California, New Mexico, Ohio and Washington, and the addition of Medicaid members at our South Carolina health plan, all effective January 1, 2014. Additionally, our New Mexico health plan added approximately 60,000 new members in a business combination effective August 1, 2013.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Six Months Ended June 30,					
	2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,559,098	$ 194.38	70.0%	$ 1,746,620	$ 159.48	67.6%
Pharmacy	582,224	44.22	15.9	454,830	41.53	17.6
Capitation	346,256	26.30	9.5	278,733	25.45	10.8
Direct delivery	45,084	3.42	1.2	18,127	1.66	0.7
Other	123,295	9.37	3.4	84,311	7.69	3.3
Total	$ 3,655,957	$ 277.69	100.0%	$ 2,582,621	$ 235.81	100.0%

Our consolidated medical care ratio increased to 89.0% in the six months ended June 30, 2014, from 86.1% in the six months ended June 30, 2013.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Six Months Ended June 30, 2014						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	2,589	$ 675,713	$ 260.97	$ 562,267	$ 217.16	83.2%	$ 113,446
Florida	499	206,589	414.17	186,326	373.55	90.2	20,263
Illinois (3)	31	34,434	1,109.99	34,966	1,127.12	101.5	(532)
Michigan	1,350	358,833	265.81	298,712	221.27	83.2	60,121
New Mexico	1,166	493,062	423.00	436,560	374.53	88.5	56,502
Ohio	1,621	606,925	374.33	514,044	317.04	84.7	92,881
South Carolina	754	192,473	255.31	174,948	232.07	90.9	17,525
Texas	1,491	641,062	429.85	590,857	396.19	92.2	50,205
Utah	495	155,228	313.67	140,294	283.49	90.4	14,934
Washington	2,640	660,420	250.15	603,205	228.48	91.3	57,215
Wisconsin	530	75,453	142.48	61,952	116.99	82.1	13,501
Other (4)	—	7,287	—	51,826	—	—	(44,539)
	13,166	$ 4,107,479	$ 311.98	$ 3,655,957	$ 277.69	89.0%	$ 451,522

	Six Months Ended June 30, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	2,056	$ 368,715	$ 179.36	$ 330,540	$ 160.79	89.6%	$ 38,175
Florida	461	120,001	260.38	101,319	219.84	84.4	18,682
Illinois (3)	—	—	—	—	—	—	—
Michigan	1,300	334,042	256.96	288,607	222.01	86.4	45,435
New Mexico	549	168,449	307.08	140,402	255.95	83.3	28,047
Ohio	1,448	538,915	372.10	443,118	305.96	82.2	95,797
South Carolina	—	—	—	—	—	—	—
Texas	1,637	648,406	396.01	542,408	331.27	83.7	105,998
Utah	520	152,467	293.16	126,706	243.63	83.1	25,761
Washington	2,488	597,819	240.29	524,909	210.98	87.8	72,910
Wisconsin	493	64,864	131.53	54,849	111.22	84.6	10,015
Other (3)(4)	—	5,484	—	29,763	—	—	(24,279)
	10,952	$ 2,999,162	$ 273.85	$ 2,582,621	$ 235.81	86.1%	$ 416,541

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) The MCR represents medical costs as a percentage of premium revenue.
(3) The Illinois health plan's results prior to October 1, 2013, were insignificant and reported in "Other."
(4) "Other" medical care costs include primarily medically related administrative costs at the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Six Months Ended June 30,	
	2014	2013
	(In thousands)	
Service revenue before amortization	$ 105,319	$ 100,885
Amortization recorded as reduction of service revenue	(1,457)	(1,457)
Service revenue	103,862	99,428
Cost of service revenue	77,764	79,075
General and administrative costs	3,641	5,141
Amortization of customer relationship intangibles recorded as amortization	1,768	2,564
Operating income	$ 20,689	$ 12,648

Operating income for our Molina Medicaid Solutions segment increased $8.0 million in the six months ended June 30, 2014, compared with the six months ended June 30, 2013, primarily the result of increased revenues due to Medicaid expansion membership, reduced service costs associated with our West Virginia and Maine contracts, and lower general and administrative costs overall.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses decreased to 8.4% of total revenue for the second quarter of 2014, compared with 10.1% of total revenue for the second quarter of 2013. General and administrative expenses decreased to 8.7% of total revenue for the six months ended June 30, 2014, compared with 9.5% of total revenue for the six months ended June 30, 2013.

Premium Tax Expense

Premium tax expense was 3.1% of premium revenue plus premium tax revenue in the second quarter of 2014, compared with 3.0% in the second quarter of 2013 and 2.9% of premium revenue plus premium tax revenue in the six months ended June 30, 2014, compared with 2.7% in the six months ended June 30, 2013.

Health Insurer Fee Revenue and Expenses

Refer to "Liquidity and Capital Resources—Financial Condition" below, for a comprehensive discussion of the HIF.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended June 30,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 18,536	0.8%	$ 12,896	0.8%
Amortization of intangible assets, continuing operations	4,366	0.2	4,119	0.3
Depreciation and amortization, continuing operations	22,902	1.0	17,015	1.1
Amortization recorded as reduction of service revenue	728	—	728	—
Amortization recorded as cost of service revenue	9,030	0.4	4,365	0.3
Depreciation and amortization reported in the consolidated statements of cash flows	$ 32,660	1.4%	$ 22,108	1.4%

	Six Months Ended June 30,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 34,672	0.8%	$ 25,341	0.8%
Amortization of intangible assets, continuing operations	8,921	0.2	8,237	0.3
Depreciation and amortization, continuing operations	43,593	1.0	33,578	1.1
Depreciation and amortization, discontinued operations	—	—	2	—
Amortization recorded as reduction of service revenue	1,457	—	1,457	—
Amortization recorded as cost of service revenue	20,604	0.5	8,870	0.3
Depreciation and amortization reported in the consolidated statements of cash flows	$ 65,654	1.5%	$ 43,907	1.4%

Interest Expense

Interest expense increased to $14.0 million for the second quarter of 2014, from $11.7 million for the second quarter of 2013, and increased to $27.8 million for the six months ended June 30, 2014, from $24.7 million for the six months ended June 30, 2013 primarily due to lease financing transactions in the second quarter of 2013. Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $6.8 million and $6.0 million for the three months ended June 30, 2014, and 2013, respectively and $13.5 million and $9.7 million for the six months ended June 30, 2014 and 2013, respectively.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 58.0% for the second quarter of 2014, compared with 49.5% for the second quarter of 2013, and 56.5% for the six months ended June 30, 2014 compared with 46.3% for the six months ended June 30, 2013. The disparity between rates in 2014 and 2013 is primarily due to the nondeductible HIF in 2014.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of June 30, 2014, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income was $3.6 million for the six months ended June 30, 2014, compared with $3.1 million for the six months ended June 30, 2013. Our annualized portfolio yield for the six months ended June 30, 2014 and 2013 was 0.4%.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Six Months Ended June 30,		
	2014	2013	Change
	(In thousands)		
Net cash provided by (used in) operating activities	$ 235,460	$ (111,748)	$ 347,208
Net cash used in investing activities	(102,336)	(431,812)	329,476
Net cash (used in) provided by financing activities	(41,668)	490,460	(532,128)
Net increase (decrease) in cash and cash equivalents	$ 91,456	$ (53,100)	$ 144,556

Operating Activities. Cash provided by operating activities increased $347.2 million, primarily due to the year-over-year change in medical claims and benefits payable, which increased $283.4 million in connection with our membership growth in the six months ended June 30, 2014, as described above in "Results of Operations."

Investing Activities. Cash used in investing activities decreased $329.5 million primarily due to significant purchases of investments, net of sales and maturities, amounting to $382.7 million in the second quarter of 2013. Such significant purchases of investments were a result of financing transactions described below in "Financing Activities," with no comparable activity in 2014.

Financing Activities. Cash used in financing activities for the six months ended June 30, 2014 related primarily to the settlement of $50.3 million of contingent consideration liabilities relating to our 2013 South Carolina health plan acquisition. Financing activities generated net cash of $490.5 million in the six months ended June 30, 2013, primarily due to proceeds from the issuance of the 1.125% Notes and related financing transactions, with no comparable activity in the six months ended June 30, 2014.

Financial Condition

On a consolidated basis, at June 30, 2014, we had working capital of $740.9 million compared with $745.7 million at December 31, 2013. At June 30, 2014, and December 31, 2013, we had cash and investments, including restricted investments, of $1,863.7 million, and $1,712.9 million, respectively. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Health Insurer Fee. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government–funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. We continue to work with our state partners to obtain reimbursement for the full economic impact of the excise tax. Currently, we project that the HIF payable by September 30, 2014 will be $88.3 million. Because this amount is not deductible for income tax purposes, our net income will be reduced by the full amount of the assessment.

When states reimburse us for the amount of the HIF, that reimbursement will itself be subject to income tax, the HIF, and applicable state premium taxes. If our estimate of the $88.3 million HIF liability in 2014 is correct, and if our estimate of the amount allocable to Medicaid of approximately $81 million is correct, states will need to pay us an incremental amount of approximately $132 million in revenue during 2014 to account for the HIF and the absence of its tax deductibility. As of June 30, 2014, we had received contract amendments for reimbursement representing approximately 50% of the Medicaid-related HIF. On a percentage basis, we anticipate that states will need to increase our Medicaid premium rates by approximately 1.5% to reimburse us for the HIF we will owe (based upon our estimated pro-rata share of total industry revenue in 2013). In addition, we estimate that states will need to increase our Medicaid premium rates by a further 0.9% to make us

whole for the lack of tax deductibility of the HIF, representing an estimated overall premium rate increase of approximately 2.4%.

As of July 30, 2014, we have contractual commitments from the states of Florida, Illinois, Ohio, Washington and Wisconsin to reimburse us by way of a lump sum payment for the full economic impact of the HIF in their respective states. While all of our remaining states have acknowledged the actuarial requirement that they reimburse us for the HIF, and its related income tax effects, no state other than those indicated above have contractually committed to do so.

Furthermore, states which have acknowledged the requirement to include the impact of the tax in our premium payments may argue that current premium rates will remain actuarially sound even if no adjustment is made to those rates. We continue to work with state officials to address the issue of fully grossed up reimbursement. If we are unable to obtain either premium increases or direct reimbursements to offset the impact of the tax on a fully grossed up basis, our business, financial condition, cash flows or results of operations could be materially adversely affected.

Regulatory Capital and Dividend Restrictions

For information on our regulatory capital requirements and dividend restrictions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 15, "Commitments and Contingencies."

Future Sources and Uses of Liquidity

For information on our debt instruments, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Long-Term Debt."

For information on our shelf registration statement and our securities repurchase program, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 13, "Stockholders' Equity."

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2013, was disclosed in our 2013 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the six months ended June 30, 2014. For further discussion and maturities of our long-term debt, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Long-Term Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements.
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the second quarter of 2014 in connection with such contractual provisions.
- *Health Plans segment quality incentives*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the second quarter of 2014 in connection with such quality incentives.
- *Molina Medicaid Solutions segment revenue and cost recognition*.

There have been no significant changes during the six months ended June 30, 2014, to the items that we disclosed as our critical accounting estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2013.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2014 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

Washington Health Plan. The Washington Health Care Authority (HCA) has communicated that it believes it has overpaid our Washington health plan with regard to certain claims. The alleged overpayments purportedly involve an undifferentiated incremental component of the capitation rates paid to our Washington health plan from and after July 1, 2012, the start date of the contract at issue. On March 25, 2014, HCA alleged that the total "overpayments" related to HCA's delayed enrollment of so-called Washington Community Options Program Entry System (COPES) members were $14.4 million, and demanded payment in that amount. On April 7, 2014, HCA alleged that the total "overpayments" related to certain psychotropic drug claims that had been included in the Request for Proposal (RFP) rate book were $5.8 million, and demanded payment in that amount. HCA has provided us with minimal data by which we might independently validate HCA's allegations. Furthermore, both alleged errors, if they in fact occurred, were unilateral errors committed and caused by HCA for which our Washington health plan had no contemporaneous knowledge and had assumed and bore no contractual risk. We have responded to HCA's demands for payment, noting, among other things, that the demands are improper as a matter of law because under the Washington statue cited regarding the definition of an "overpayment," there were in fact no "overpayments" since payment was made consistent with the express terms of the parties' contract. We believe that any actual liability for the alleged overpayment claims is not currently probable or reasonably estimable.

State of Louisiana. On June 26, 2014, the State of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that, in late 2008 and early 2009, in connection with the acquisition of Florida NetPass by which Molina Healthcare entered into the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. Both the United States of America and the State of Florida have reviewed the allegations made in the Complaint, and have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2013. The risk factors described herein and in our 2013 Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

There have been no material changes to the risk factors disclosed in our 2013 Annual Report on Form 10-K.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended June 30, 2014 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
April 1 - April 30	360	$ 37.50	—	$ 47,338,505
May 1 - May 31	1,490	$ 37.82	—	$ 47,338,505
June 1 - June 30	2,702	$ 43.09	—	$ 47,338,505
Total	4,552	$ 40.92	—	

(a) During the three months ended June 30, 2014, we withheld 4,552 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50.0 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2014.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: July 30, 2014

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: July 30, 2014

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
3.1	Third Amended and Restated Bylaws.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 3.1

THIRD AMENDED AND RESTATED BYLAWS

OF

MOLINA HEALTHCARE, INC.

a Delaware corporation

THIRD AMENDED AND RESTATED BYLAWS
OF
MOLINA HEALTHCARE, INC.

ARTICLE I

OFFICES

Section 1.1. Registered Office. The registered office of the Corporation shall be maintained in the County of New Castle, State of Delaware, and the registered agent in charge thereof is Corporation Service Company.

Section 1.2. Other Offices. The Corporation may also have offices and keep the books and records of the Corporation, except as may otherwise be required by law, at such other places both within and outside the State of Delaware as the Board of Directors of the Corporation (the "Board of Directors") may from time to time determine or the business of the Corporation may require.

ARTICLE II

STOCKHOLDERS' MEETINGS

Section 2.1. Place of Meetings. All meetings of the stockholders, whether annual or special, shall be held at an office of the Corporation or at such other place, within or outside the State of Delaware, as may be fixed from time to time by the Board of Directors.

Section 2.2. Annual Meetings.

(a) The annual meeting of the stockholders shall be held at such date and time as shall be designated from time to time by the Board of Directors and stated in the notice of annual meeting, at which such stockholders shall elect members to the Board of Directors and transact such other business as may properly be brought before such meeting. Nominations of persons for election to the Board of Directors of the Corporation and the proposal of business to be considered by the stockholders may be made at an annual meeting of stockholders (i) pursuant to the Corporation's notice of meeting of stockholders, (ii) by or at the direction of the Board of Directors or (iii) by any stockholder of the Corporation who was a stockholder of record at the time of giving of notice provided for in Section 2.2(b), who is entitled to vote at such meeting and who complied with the notice procedures set forth in Section 2.2(b). In lieu of holding an annual meeting of stockholders at a designated place, the Board of Directors may, in its sole discretion, determine that any annual meeting of stockholders may be held solely by means of remote communication, pursuant to Section 2.12.

(b) At an annual meeting of the stockholders, only such business as shall have been properly brought before such meeting shall be conducted. For nominations or other business to be properly brought before an annual meeting by a stockholder pursuant to Section 2.2(c) of these Amended and Restated Bylaws (these "Bylaws"), (i) such stockholder must have given timely notice thereof in writing to the Secretary of the Corporation, (ii) such other business must be a proper matter for stockholder action under the General Corporation Law of the State of Delaware, (iii) if such stockholder, or the beneficial owner on whose behalf any such nomination or proposal is made, has provided the Corporation with a Solicitation Notice (as such term is hereinafter defined), such stockholder or beneficial owner must, in the case of a nomination or nominations, have delivered a proxy statement and form of proxy to holders of a percentage of the Corporation's voting shares reasonably believed by such stockholder or beneficial owner to be sufficient to elect the nominee or nominees proposed to be nominated by such stockholder, and must, in either case, have included in such materials the Solicitation Notice or, in the case of a proposal, have delivered a proxy statement and form of proxy to holders of at least the percentage of the Corporation's voting shares required under applicable law to carry any such proposal and (iv) if no Solicitation Notice relating thereto has been timely provided pursuant to this Section 2.2(b), the stockholder or beneficial owner proposing such nomination or business must not have solicited a number of proxies sufficient to have required the delivery of such a Solicitation Notice under this Section 2.2. To be timely, a stockholder's notice shall be delivered to the Secretary of the Corporation at the principal executive offices of the Corporation not later than the close of business on the ninetieth (90th) day nor earlier than the close of business on the one hundred twentieth (120th) day prior to the first anniversary of the preceding year's annual meeting of the stockholders; provided, however, that in the event that the date of the annual meeting is scheduled more than thirty (30) days prior to the anniversary of the preceding year's annual meeting, notice by the stockholder, to be timely, must be so delivered not earlier than the close of business on the one hundred twentieth (120th) day prior to such annual meeting and not later than the close of business on the later of the ninetieth (90th) day prior to such annual meeting or the tenth (10th) day following the day on which public announcement of the date of such meeting is first made. In no event shall the public announcement of an adjournment of an annual meeting of the stockholders commence a new time period for the giving of a stockholder's notice as described above (the "Stockholder's Notice"). The Stockholder's Notice shall set forth (A) as to each person that the stockholder proposes to nominate for election or reelection as a director all information relating to such person that is required to be disclosed in solicitations of proxies for the election of directors in an election contest or is otherwise required, in each case pursuant to Regulation 14A under the Securities Exchange Act of 1934, as amended (the "1934 Act") (including such person's written consent to being named in the proxy statement as a nominee and to serving as a director if elected), (B) as to any other business that such stockholder proposes to bring before the meeting, a brief description of the business desired to be brought before such meeting, the text of the proposal or business (including the text of any resolutions proposed for consideration and in the event that such business includes a proposal to amend the Bylaws of the Corporation, the language of the proposed amendment), the reasons for conducting such business at the meeting and any material interest in such business of such stockholder and the beneficial owner, if any, on whose behalf such proposal is made and (C) as to the stockholder giving the notice and the beneficial owner, if any, on whose behalf such stockholder's nomination or proposal is made (i) the name and address of such stockholder, as they appear on the Corporation's books, and of such beneficial owner, (ii) the following information regarding the ownership interests

of the stockholder or such other beneficial owner, which shall be supplemented by such stockholder and such other beneficial owner not later than 10 days after the record date for the meeting to disclose such interests as of the record date: (A) the class and number of shares of the corporation that are owned beneficially and of record by the stockholder and such other beneficial owner; (B) any option, warrant, convertible security, stock appreciation right, or similar right with an exercise or conversion privilege or a settlement payment or mechanism at a price related to any class or series of shares of the Corporation or with a value derived in whole or in part from the value of any class or series of shares of the Corporation, whether or not such instrument or right shall be subject to settlement in the underlying class or series of capital stock of the Corporation or otherwise (a "Derivative Instrument") directly or indirectly owned beneficially by such stockholder and any other direct or indirect opportunity to profit or share in any profit derived from any increase or decrease in the value of shares of the Corporation; (C) any proxy, contract, arrangement, understanding, or relationship with respect to a nomination or proposal between or among such stockholder and/or such beneficial owner, any of their respective affiliates or associates, and any others acting in concert with any of the foregoing, including in the case of a nomination, the nominee or pursuant to which such stockholder or beneficial owner has a right or obligation to vote any shares of any security of the Corporation; (D) any short interest in any security of the Corporation (for purposes of this Section 2.2, a person shall be deemed to have a short interest in a security if such person directly or indirectly, through any contract, arrangement, understanding, relationship or otherwise, has the opportunity to profit or share in any profit derived from any decrease in the value of the subject security); (E) any rights to dividends on the shares of the Corporation owned beneficially by such stockholder that are separated or separable from the underlying shares of the Corporation; (F) any proportionate interest in shares of the Corporation or Derivative Instruments held, directly or indirectly, by a general or limited partnership in which such stockholder is a general partner or, directly or indirectly, beneficially owns an interest in a general partner; and (G) any performance-related fees (other than an asset-based fee) to which such stockholder is entitled based on any increase or decrease in the value of shares of the Corporation or Derivative Instruments, if any, as of the date of such notice, including, without limitation, any such interests held by members of such stockholder's immediate family sharing the same household, (iii) a representation that the stockholder is a holder of record of stock of the Corporation entitled to vote at such meeting and intends to appear in person or by proxy at the meeting to propose such business or nomination, and (iv) whether either such stockholder or beneficial owner intends (or is part of a group that intends) to deliver a proxy statement and form of proxy to holders of, in the case of a nomination or nominations, a sufficient number of holders of the Corporation's voting shares to elect such nominee or nominees or, in the case of the proposal, at least the percentage of the Corporation's voting shares required under applicable law to carry the proposal (an affirmative statement of such intent, a "Solicitation Notice").

(c) Notwithstanding anything in the second sentence of Section 2.2(b) of these Bylaws to the contrary, in the event that the number of directors to be elected to the Board of Directors of the Corporation is increased effective after the time period for which nominations would otherwise be due under Section 2.2(b) and there is no public announcement naming all of the nominees for director or specifying the size of the increased Board of Directors made by the Corporation at least one hundred (100) days prior to the first anniversary of the preceding year's annual meeting, a stockholder's notice required by this Section shall also be considered timely, but

only with respect to nominees for any new positions created by such increase, if it shall be delivered to the Secretary at the principal executive offices of the Corporation not later than the close of business on the tenth (10th) day following the day on which such public announcement is first made by Corporation.

(d) Notwithstanding the foregoing provisions of this Section 2.2, in order to include information with respect to a stockholder proposal in the proxy statement and form of proxy for a stockholders' meeting, stockholders must provide notice as required by the regulations promulgated under the 1934 Act. Nothing in these Bylaws shall be deemed to affect any rights of stockholders to request inclusion of proposals in the Corporation proxy statement pursuant to Rule 14a-8 under the 1934 Act.

(e) For purposes of this Section 2.2, "public announcement" shall mean disclosure in a press release reported by the Dow Jones News Service, Associated Press or comparable national news service or in a document publicly filed by the Corporation with the Securities and Exchange Commission pursuant to Section 13, 14 or 15(d) of the 1934 Act.

Section 2.3. Notice of Annual Meeting. Written notice of the annual meeting stating the place, date and time of the meeting, shall be given not less than ten nor more than sixty days before the date of the meeting to each stockholder entitled to vote at such meeting. If mailed, notice is given when deposited in the United States mail, postage prepaid, directed to the stockholder at his address as it appears on the records of the Corporation. In lieu of holding an annual meeting of stockholders at a designated place, the Board of Directors may, in its sole discretion, determine that any annual meeting of stockholders may be held solely by means of remote communication in accordance with Section 2.12.

Section 2.4. Stockholders' List. At least ten (10) days before every meeting of stockholders, a complete list of the stockholders entitled to vote at said meeting, arranged in alphabetical order and showing the address of each stockholder and the number of shares registered in the name of each stockholder, shall be prepared by the Secretary. Such list shall be open to the examination of any stockholder, for any purpose germane to the meeting, during ordinary business hours, for a period of at least ten days prior to the meeting at the place where the meeting is to be held. The list shall also be produced and kept at the time and place of the meeting during the whole time thereof, and may be inspected by any stockholder who is present. If the meeting is held solely by means of remote communication, then the list shall be open to the examination of any stockholder during the whole time of the meeting on a reasonably accessible electronic network, and the information required to access the list shall be provided with the notice of the meeting.

Section 2.5. Special Meetings.

(a) Pursuant to the Certificate of Incorporation, special meetings of the stockholders of the Corporation for any purpose or purposes may be called at any time by the President or Chief Executive Officer of the Corporation, the Chairperson of the Board of Directors, the Board of Directors or by a committee of the Board of Directors which has been duly designated by the Board of Directors and the powers and authority of which, as provided in a resolution of the

Board of Directors or in the Bylaws of the Corporation, include the power to call such meetings. Such special meetings may not be called by any other person or persons.

(b) If a special meeting is properly called by any person or persons other than the Board of Directors, the request shall be in writing, specifying the general nature of the business proposed to be transacted, and shall be delivered personally or sent by registered mail or by telegraphic or other facsimile transmission to the Secretary of the Corporation. No business may be transacted at such special meeting, otherwise than specified in such notice or as resolved by the Board of Directors. The Board of Directors shall determine the time and place of such special meeting, which shall be held not less than thirty- five (35) nor more than one hundred twenty (120) days after the date of the receipt of the request. Upon determination of the time and place of the meeting, the Secretary shall cause notice to be given to the stockholders entitled to vote, in accordance with the provisions of Section 2.6 of these Bylaws. If the notice is not given within one hundred (100) days after the receipt of the request, the person or persons properly requesting the meeting may set the time and place of the meeting and give the notice. Nothing contained in this paragraph (b) shall be construed as limiting, fixing, or affecting the time when a meeting of stockholders called by action of the Board of Directors may be held.

(c) Nominations of persons for election to the Board of Directors may be made at a special meeting of stockholders at which directors are to be elected pursuant to the Corporation's notice of meeting (i) by or at of the direction of the Board of Directors or (ii) provided that the Board of Directors has determined that directors shall be elected at such meeting, by any stockholder of the Corporation who is a stockholder of record at the time of giving notice provided for in these Bylaws who shall be entitled to vote at the meeting and who complies with the notice procedures set forth in this Section 2.5(c). In the event the Corporation calls a special meeting of stockholders for the purpose of electing one or more directors to the Board of Directors, any such stockholder may nominate a person or persons (as the case may be), for election to such position(s) as specified in the Corporation's notice of meeting, if a Stockholder's Notice (as provided pursuant to Section 2.2(b) of these Bylaws) shall be delivered to the Secretary at the principal executive offices of the Corporation not earlier than the close of business on the one hundred twentieth (120th) day prior to such special meeting and not later than the close of business on the later of the ninetieth (90th) day prior to such meeting or the tenth (10th) day following the day on which public announcement is first made of the date of the special meeting and of the nominees proposed by the Board of Directors to be elected at such meeting. In no event shall the public announcement of an adjournment of a special meeting commence a new time period for the giving of a stockholder's notice as described above.

Section 2.6. Notice of Special Meetings. Written notice of a special meeting, stating the place, date and hour of the meeting and the purpose or purposes for which the meeting is called, shall be given not less than ten nor more than sixty days before the date of the meeting to each stockholder entitled to vote at such meeting. If mailed, notice is given when deposited in the United States mail, postage prepaid, directed to the stockholder at his address as it appears on the records of the Corporation. In lieu of holding a special meeting of stockholders at a designated place, the Board of Directors may, in its sole discretion, determine that any special meeting of stockholders may be held solely by means of remote communication in accordance with Section 2.12.

Section 2.7. Quorum; Adjournment. The holders of a majority of the shares issued and outstanding and entitled to vote thereat, present in person or represented by proxy, shall be requisite and shall constitute a quorum at all meetings of the stockholders for the transaction of business except as otherwise provided by statute, by the Certificate of Incorporation or by these Bylaws. If, however, such quorum shall not be present or represented at any meeting of the stockholders, the chairman of the meeting or, in the absence of such person, any officer entitled to preside at or act as secretary of such meeting, or the stockholders entitled to vote thereat, present in person or represented by proxy, shall have the power to adjourn the meeting from time to time, without notice other than announcement at the meeting, of the place, date and hour of the adjourned meeting, until a quorum shall again be present or represented by proxy. At the adjourned meeting at which a quorum shall be present or represented by proxy, the Corporation may transact any business which might have been transacted at the original meeting. If the adjournment is for more than thirty (30) days, or if after the adjournment, a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each stockholder of record entitled to vote at the meeting. Shares of its own stock belonging to the Corporation or to another corporation, if a majority of the shares entitled to vote in the election of directors of such other corporation is held, directly or indirectly, by the Corporation, shall neither be entitled to vote nor be counted for quorum purposes; provided, however, that the foregoing shall not limit the right of the Corporation to vote stock, including, without limitation, its own stock, held by it in a fiduciary capacity.

Section 2.8. Conduct of Business. (a) Only persons who are nominated in accordance with the procedures set forth in Section 2.2 or Section 2.5 shall be eligible to serve as directors and only such business shall be conducted at a meeting of stockholders as shall have been brought before the meeting in accordance with the procedures set forth in Section 2.2 or 2.5. Except as otherwise provided by law, the Chairman of the meeting shall have the power and duty to determine whether a nomination or any business proposed to be brought before the meeting was made, or proposed, as the case may be, in accordance with the procedures set forth in these Bylaws and, if any proposed nomination or business is not in compliance with these Bylaws, to declare that such defective proposal or nomination shall not be presented for stockholder action at the meeting and shall be disregarded. Notwithstanding the foregoing provisions of this Section 2.8, unless otherwise required by law, if the stockholder (or a qualified representative of the stockholder) does not appear at the annual or special meeting of stockholders of the Corporation to present a nomination or proposed business, such nomination shall be disregarded and such proposed business shall not be transacted, notwithstanding that proxies in respect of such vote may have been received by the Corporation.

(b) At every meeting of the stockholders, the President or, in his or her absence, such other person as may be appointed by the Board of Directors, shall act as chairman of the meeting. The Secretary of the corporation or, in his or her absence, such other person as designated by the chairman of the meeting, shall act as secretary of the meeting. The chairman of the meeting shall call the meeting to order, establish the agenda, and conduct the business of the meeting in accordance therewith or, at the chairman's discretion, it may be conducted otherwise in accordance with the wishes of the stockholders in attendance. The date and time of the opening and closing of the polls for each matter upon which the stockholders will vote at the meeting shall be announced at the meeting. The chairman shall also conduct the meeting in an orderly manner,

rule on the precedence of, and procedure on, motions and other procedural matters, and exercise discretion with respect to such procedural matters with fairness and good faith toward all those entitled to take part. Without limiting the foregoing, the chairman of the meeting may (a) restrict attendance at any time to bona fide stockholders of record and their proxies and other persons as invited by the chairman or Board of Directors, (b) restrict use of audio or video recording devices at the meeting, and (c) impose reasonable limits on the amount of time taken up at the meeting on discussion in general or on remarks by any one stockholder. Should any person in attendance become unruly or obstruct the meeting proceedings, the chairman shall have the power to have such person removed from the meeting. Notwithstanding anything in the Bylaws to the contrary, no business shall be conducted at a meeting except in accordance with the procedures set forth in this Section 2.8.

Section 2.9. Voting. When a quorum is present at any meeting, and subject to the provisions of the General Corporation Law of the State of Delaware, the Certificate of Incorporation or by these Bylaws or any other applicable law or the rules of any stock exchange on which the Corporation's shares are listed in respect of the vote that shall be required for a specified action, the vote of the holders of a majority of the shares having voting power, present in person or represented by proxy and entitled to vote on such matter, shall decide any question brought before such meeting, unless the question is one upon which, by express provision of the General Corporation Law of the State of Delaware or of the Certificate of Incorporation or of these Bylaws or of such other applicable law or the rules of any stock exchange on which the Corporation's shares are listed, a different vote is required in which case such express provision shall govern and control the decision of such question. Each stockholder shall have one vote for each share of stock having voting power registered in his name on the books of the Corporation, except as otherwise provided in the Certificate of Incorporation.

Section 2.10. Proxies.

(a) Each stockholder entitled to vote at a meeting of stockholders or to express consent or dissent to corporate action in writing without a meeting may authorize another person or persons to act for him by proxy, but no such proxy shall be voted or acted upon after three years from its date, unless the proxy provides for a longer period.

(b) A stockholder may issue a valid proxy by (i) executing a written authorization therefor identifying the person or persons authorized to act for such stockholder by proxy or (ii) transmitting or authorizing the transmission of a telegram, cablegram or other means of electronic transmission, provided that the telegram, cablegram or other means of electronic transmission either sets forth or is submitted with information from which it can be determined that the telegram, cablegram or other electronic transmission was authorized by the stockholder. A copy, facsimile transmission or other reliable reproduction of a written or electronically-transmitted proxy authorized by this Section 2.10 may be substituted for or used in lieu of the original writing or electronic transmission. Each proxy shall be delivered to the inspectors of election prior to or at the meeting.

Section 2.11. Inspectors. Either the Board of Directors or, in the absence of designation of inspectors by the Board of Directors, the chairman of any meeting of the stockholders may, in its or such person's discretion, appoint one (1) or more inspectors to act at any meeting of the stockholders. Each inspector, before discharging his or her duties, shall take and sign an oath faithfully to execute the duties of inspector with strict impartiality and according to the best of his or her ability. Such inspectors shall perform such duties as shall be specified by the Board of Directors or the chairman of the meeting. Inspectors need not be Stockholders, employees, officers or directors of the Corporation. No director or nominee for the office of director shall be appointed as any such inspector.

Section 2.12. Meetings by Remote Communication. If authorized by the Board of Directors, and subject to such guidelines and procedures as the Board may adopt, stockholders and proxy holders not physically present at a meeting of stockholders may, by means of remote communication, participate in the meeting and be deemed present in person and vote at the meeting, whether such meeting is to be held at a designated place or solely by means of remote communication, provided that (i) the corporation shall implement reasonable measures to verify that each person deemed present and permitted to vote at the meeting by means of remote communication is a stockholder or proxy holder, (ii) the corporation shall implement reasonable measures to provide such stockholders and proxy holders a reasonable opportunity to participate in the meeting and to vote on matters submitted to the stockholders, including an opportunity to read or hear the proceedings of the meeting substantially concurrently with such proceedings, and (iii) if any stockholder or proxy holder votes or takes other action at the meeting by means of remote communication, a record of such vote or other action shall be maintained by the corporation.

ARTICLE III

DIRECTORS

Section 3.1. General Powers. The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors which may exercise all such powers of the Corporation and do all such acts and things as are not, by the General Corporation Law of the State of Delaware nor by the Certificate of Incorporation nor by these Bylaws, directed or required to be exercised or done by the stockholders.

Section 3.2. Number and Qualifications of Directors.

(a) The number of directors which shall constitute the whole Board of Directors shall be no less than seven and no more than eleven; provided that until changed by resolution of the Board of Directors, the number of directors shall be fixed at eleven. Except as otherwise required by applicable law, the Certificate of Incorporation or Section 3.3 of this Article III, a nominee for director shall be elected by the affirmative vote of a majority of the votes cast with respect to such director, provided that nominees for director shall be elected by the vote of a plurality of the votes cast at any meeting of stockholders for which, as of a date that is ten (10) days

in advance of the date on which the Corporation files its definitive proxy statement with the Securities and Exchange Commission (regardless of whether thereafter revised or supplemented), the number of nominees for director exceeds the number of directors to be elected, as determined by the Secretary of the Corporation. For purposes of this Section 3.2, a majority of the votes cast means that the number of shares voted "for" a director exceeds the number of votes cast "against" that director. The following shall not be votes cast: (a) a share whose ballot is marked as withheld; (b) a share otherwise present at the meeting but for which there is an abstention; and (c) a share otherwise present at the meeting as to which a shareholder gives no authority or direction.

If an incumbent director is not elected due to a failure to receive a majority of the votes cast as described above, and his or her successor is not otherwise elected and qualified, such director shall tender his or her offer to resign to the Secretary of the Corporation promptly following the certification of the election results. Within ninety (90) days after the date of the certification of the election results, (i) the Corporate Governance and Nominating Committee will make a recommendation to the Board of Directors on whether to accept or reject the resignation, or whether other action should be taken and (ii) the Board of Directors will act on such committee's recommendation and publicly disclose its decision and the rationale behind it, provided that any director who tenders his or her offer to resign shall not participate in either the Corporate Governance and Nominating Committee's or Board of Directors' deliberations regarding the offer to resign, and if a quorum of the Corporate Governance and Nominating Committee cannot be met without the presence of the directors who did not receive a majority of the votes cast, then the Board of Directors shall appoint a committee of independent directors to consider the resignation offers and recommend to the Board of Directors whether to accept or reject the resignations, or whether other action should be taken. Directors need not be stockholders.

Section 3.3. Vacancies; Resignation and Removal of Directors.

(a) If the office of any director or directors becomes vacant by reason of death, resignation, retirement, disqualification, removal from office, or otherwise, or a new directorship is created, the Board of Directors shall choose a successor or successors, or a director to fill the newly created directorship, who shall hold office for the unexpired term (in the case of a vacancy) or until the next election of directors (in the case of a new directorship).

(b) Any director of the Corporation may at any time resign by giving written notice to the Board of Directors, the Chairman of the Board, the President or the Secretary of the Corporation. Such resignation shall take effect upon receipt thereof by the Corporation, or such later time specified therein; and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

(c) Any director may be removed at any time only for cause by an affirmative vote of the holders of sixty-six and two-thirds percent (66-2/3%) of the shares then entitled to vote in the election of directors.

Section 3.4. Place of Meetings. The Board of Directors may hold its meetings inside or outside of the State of Delaware, at the office of the Corporation or at such other places as they

may from time to time determine, or as shall be fixed in the respective notices or waivers of notice of such meetings.

Section 3.5. Compensation of Directors. Directors who are not at the time also a salaried officer or employee of the Corporation or any of its subsidiaries may receive such stated salary for their services and/or such fixed sums and expenses of attendance for attendance at each regular or special meeting of the Board of Directors as may be established by resolution of the Board; provided that nothing herein contained shall be construed to preclude any director from serving the Corporation in any other capacity and receiving compensation therefor. Members of special or standing committees may be allowed like compensation for attending committee meetings. Each director, whether or not a salaried officer or employee of the Corporation or any of its subsidiaries, shall be entitled to receive from the Corporation reimbursement for the reasonable expenses incurred by such person in connection with the performance of such person's duties as a director.

Section 3.6. Regular Meetings. Regular meetings of the Board of Directors shall be held at such times and places as the Board shall from time to time by resolution determine, except that the annual meeting of the Board to elect officers of the Corporation for the ensuing year shall be held within ten (10) days after the annual meeting of stockholders. If any day fixed for a regular meeting shall be a legal holiday under the laws of the place where the meeting is to be held, then the meeting which would otherwise be held on that day shall be held at the same hour on the next succeeding business day.

Section 3.7. Special Meetings. Special meetings of the Board of Directors may be held at any time on the call of the President or at the request in writing of a majority of the directors. Notice of any such meeting, unless waived, shall be given to directors personally, by telephone, by first-class United States mail, postage prepaid or by facsimile or electronic transmission to each director at his or her address as the same appears on the records of the Corporation not later than two days prior to the day on which such meeting is to be held if such notice is delivered personally, by telephone or by facsimile or electronic transmission, and not less than four days prior to the day on which the meeting is to be held if such notice is by first-class United States mail, provided, however, that notice of any such special meeting need not be given to any such member who shall, either before or after such special meeting, submit a signed waiver of such notice or who shall attend such meeting without protesting, prior to or at its commencement, the lack of such notice to such member. . If the Secretary shall fail or refuse to give such notice, then the notice may be given by the President or any one of the directors calling the meeting. Any such meeting may be held at such place as the Board may fix from time to time or as may be specified or fixed in such notice or waiver thereof. Any meeting of the Board of Directors shall be a legal meeting without any notice thereof having been given, if all the directors shall waive notice or be present thereat, and no notice of a meeting shall be required to be given to any director who shall attend such meeting without protesting, prior to or at its commencement, the lack of such notice to such member.. Notice of any adjourned meeting of the Board of Directors need not be given to any director in attendance.

Section 3.8. Action Without Meeting; Use of Communications Equipment.

(a) Any action required or permitted to be taken at any meeting of the Board of Directors or any committee thereof may be taken without a meeting if all members of the Board or of such committee, as the case may be, consent to such action in writing or by electronic transmission and such written consent or electronic transmissions are filed with the minutes of proceedings of the Board of Directors.

(b) Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

Section 3.9. Quorum and Manner of Acting.

(a) Except as otherwise provided in these Bylaws, a majority of the total number of directors as at the time specified as provided in the Bylaws shall constitute a quorum at any regular or special meeting of the Board of Directors. Except as otherwise provided by statute, by the Certificate of Incorporation or by these Bylaws, the vote of a majority of the directors present at any meeting at which a quorum is present shall be the act of the Board of Directors. In the absence of a quorum, a majority of the directors present may adjourn the meeting from time to time until a quorum shall be present. .

(b) The Board of Directors may adopt such rules and regulations not inconsistent with the provisions of these Bylaws for the conduct of its meetings and management of the affairs of the Corporation as the Board may deem to be proper. In the absence of the Chairman of the Board, such person designated by the Board shall preside at Board meetings.

ARTICLE IV

EXECUTIVE AND OTHER COMMITTEES

Section 4.1. Executive Committee. The Board of Directors may, by resolution adopted by a majority of the entire Board of Directors, designate annually three (3) or more of the directors to constitute members or alternate members of an Executive Committee, which Executive Committee shall have and may exercise, between the meetings of the Board of Directors, all of the powers and authority of the Board of Directors in the management of the business and affairs of the Corporation, including, without limitation, if such Executive Committee is so empowered and authorized by resolution adopted by a majority of the entire Board of Directors, the power and authority to declare a dividend and to authorize the issuance of stock, and may authorize the seal of the Corporation to be affixed to all papers which may require it, except that such Executive Committee shall not have such power or authority in reference to:

(a) amending the Certificate of Incorporation or these Bylaws;

(b) adopting an agreement of merger or consolidation involving the Corporation;

(c) recommending to the stockholders the sale, lease or exchange of all or substantially all of the property and assets of the Corporation;

(d) recommending to the stockholders a dissolution of the Corporation or a revocation of a dissolution;

(e) taking any action related to the approval or determination of any matter in connection with any business combination;

(f) filling vacancies on the Board of Directors or on any committee of the Board of Directors, including, but not limited to, the Executive Committee; or

(g) amending or repealing any resolution of the Board of Directors which by its terms may be amended or repealed only by the Board of Directors.

The Board of Directors shall have the power at any time to change the membership of the Executive Committee, to fill all vacancies in it and to discharge it, either with or without cause.

Section 4.2. Other Committees. The Board of Directors may, by resolution adopted by a majority of the entire Board of Directors (except to the extent prohibited by law), designate from among the directors one or more other committees, each of which shall have such authority of the Board of Directors as may be specified in the resolution of the Board of Directors designating such committee; provided that no committee shall have the power or authority in reference to the matters described in Section 4.1(a) through 4.1(g) above. A majority of all of the members of such committee may determine its action and fix the time and place of its meetings, unless the Board of Directors shall otherwise provide. The Board of Directors shall have the power at any time to change the membership of, to fill all vacancies in and to discharge any such committee, either with or without cause. The committees shall keep regular minutes of their proceedings and report the same to the Board of Directors when required.

Section 4.3. Procedure; Meeting; Quorum. Regular meetings of the Executive Committee or of any other committee of the Board of Directors, of which no notice shall be necessary, may be held at such times and places as shall be fixed by resolution adopted by a majority of the members thereof. Special meetings of the Executive Committee or any other committee of the Board of Directors shall be called at the request of any member thereof. Notice of each special meeting of the Executive Committee or of any other committee of the Board of Directors shall be delivered personally, by telephone, by first-class United States mail, postage prepaid or by facsimile or electronic transmission to each member thereof not later than one day prior to the day on which such meeting is to be held if such notice is delivered personally, by telephone or by facsimile or electronic transmission and not less than four days prior to the day on which such meeting is to be held if such notice is delivered by first-class United States mail; provided, however, that notice of any such special meeting need not be given to any such member who shall, either before or after

such special meeting, submit a signed waiver of such notice or who shall attend such meeting without protesting, prior to or at its commencement, the lack of such notice to such member. Any special meeting of the Executive Committee or any other committee of the Board of Directors shall be a valid meeting without any notice thereof having been given if all of the members thereof shall waive notice or be present thereat without protesting, prior to or at its commencement, the lack of such notice to such member. Notice of any adjourned meeting of any committee of the Board of Directors need not be given to any director in attendance. Each of the Executive Committee and each other committee of the Board of Directors may adopt such rules and regulations that are not inconsistent with the provisions of law, the Certificate of Incorporation or these Bylaws for the conduct of its meetings as the Executive Committee or each other committee of the Board of Directors, as the case may be, may deem to be proper. A majority of the members of the Executive Committee or of any other committee of the Board of Directors shall constitute a quorum for the transaction of business at any meeting thereof, and the vote of a majority of the members thereof present at any meeting thereof at which such a quorum is present shall be the act of the Executive Committee or such other committee, as the case may be. Each of the Executive Committee and each other committee of the Board of Directors shall keep written minutes of its proceedings and shall report on such proceedings to the Board of Directors.

ARTICLE V

OFFICERS

Section 5.1. Executive Officers. The executive officers of the Corporation shall be a President and Chief Executive Officer, a Chief Financial Officer, a Chief Legal Officer, a Chief Operating Officer, a Treasurer, a Secretary, and such number of executive vice presidents, if any, as the Board of Directors may determine. One person may hold any number of said offices.

Section 5.2. Election, Term of Office and Eligibility. The executive officers of the Corporation shall be elected annually by the Board of Directors, and new or additional officers may be elected at any meeting of the Board. Each officer, except such officers as may be appointed in accordance with the provisions of Section 5.3, shall hold office until the next annual election of officers or until his or her death, resignation or removal. None of the other officers need be members of the Board.

Section 5.3. Subordinate Officers. The Board of Directors may appoint a Controller, such vice presidents, assistant secretaries, assistant treasurers and such other officers, and such agents as the Board may determine, to hold office for such period and with such authority and to perform such duties as the Board may from time to time determine. The Board may, by specific resolution, empower the Chief Executive Officer of the Corporation or the Executive Committee to appoint any such subordinate officers or agents.

Section 5.4. Removal. The President, Chief Executive Officer, Chief Financial Officer, Chief Legal Officer, Chief Operating Officer, Treasurer, Secretary, and any executive vice president may be removed at any time, either with or without cause, but only by the affirmative vote of the majority of the total number of directors as at the time specified by the Bylaws. Any

subordinate officer appointed pursuant to Section 5.3 may be removed at any time, either with or without cause, by the majority vote of the directors present at any meeting of the Board or by any committee or officer empowered to appoint such subordinate officers.

Section 5.5. Chairman of the Board. The Chairman of the Board shall, if present, preside at meetings of the Board of Directors. The Chairman of the Board shall be a member of the Board of Directors.

Section 5.6. The President. The President shall be the chief executive officer of the Corporation. He shall have executive authority to see that all orders and resolutions of the Board of Directors are carried into effect and, subject to the control vested in the Board of Directors by statute, by the Certificate of Incorporation, or by these Bylaws, shall administer and be responsible for the management of the business and affairs of the Corporation. He shall in general perform all duties incident to the office of the president and such other duties as from time to time may be assigned to him by the Board of Directors.

Section 5.7. Other Executive Officers and Executive Vice Presidents. In the event of the absence or disability of the President, the other executive officers of the Corporation, in the order designated, or in the absence of any designation, then in the order of their election, shall perform the duties of the President. The other officers and executive vice presidents of the Corporation shall also perform such other duties as from time to time may be assigned to them by the Board of Directors or by the President of the Corporation.

Section 5.8. The Secretary. The Secretary shall:

(a) Keep the minutes of the meetings of the stockholders and of the Board of Directors;

(b) See that all notices are duly given in accordance with the provisions of these Bylaws or as required by law;

(c) Be custodian of the records and of the seal of the Corporation and see that the seal or a facsimile or equivalent thereof is affixed to or reproduced on all documents, the execution of which on behalf of the Corporation under its seal is duly authorized;

(d) Have charge of the stock record books of the Corporation;

(e) In general, perform all duties incident to the office of Secretary, and such other duties as are provided by these Bylaws and as from time to time are assigned to him by the Board of Directors or by the chief executive officer of the Corporation.

Section 5.9. The Treasurer. The Treasurer shall:

(a) Receive and be responsible for all funds of and securities owned or held by the Corporation and, in connection therewith, among other things: keep or cause to be kept

full and accurate records and accounts for the Corporation; deposit or cause to be deposited to the credit of the Corporation all moneys, funds and securities so received in such bank or other depositary as the Board of Directors or an officer designated by the Board may from time to time establish; and disburse or supervise the disbursement of the funds of the Corporation as may be properly authorized.

(b) Render to the Board of Directors at any meeting thereof, or from time to time whenever the Board of Directors or the chief executive officer of the Corporation may require, financial and other appropriate reports on the condition of the Corporation;

(c) In general, perform all the duties incident to the office of Treasurer and such other duties as from time to time may be assigned to him by the Board of Directors or by the chief executive officer of the Corporation.

Section 5.10. Salaries. The salaries of the officers shall be fixed from time to time by the Board of Directors, and no officer shall be prevented from receiving such salary by reason of the fact that he is also a director of the Corporation.

Section 5.11. Delegation of Duties. In case of the absence of any officer of the Corporation or for any other reason which may seem sufficient to the Board of Directors, the Board of Directors may, for the time being, delegate his powers and duties, or any of them, to any other officer or to any director.

ARTICLE VI

SHARES OF STOCK

Section 6.1. Regulation. Subject to the terms of any contract of the Corporation, the Board of Directors may make such rules and regulations as it may deem expedient concerning the issue, transfer, and registration of certificates for shares of the stock of the Corporation, including the issue of new certificates for lost, stolen or destroyed certificates, and including the appointment of transfer agents and registrars.

Section 6.2. Stock Certificates. The shares of the corporation shall be represented by certificates, provided that the Board of Directors may provide by resolution or resolutions that some or all of any class or series of its stock shall be uncertificated shares; provided, however, that no such resolution shall apply to shares represented by a certificate until such certificate is surrendered to the corporation. Every holder of stock of the corporation represented by certificates, and, upon written request to the corporation's transfer agent or registrar, any holder of uncertificated shares, shall be entitled to have a certificate, in such form as may be prescribed by law and by the Board of Directors, certifying the number and class of shares owned by him in the corporation. Certificates for shares of the stock of the Corporation shall be respectively numbered serially for each class of stock, or series thereof, as they are issued, shall be impressed with the corporate seal or a facsimile thereof, and shall be signed by the President or other executive officer, and by the

Secretary or Treasurer, or an Assistant Secretary or an Assistant Treasurer, provided that such signatures may be facsimiles on any certificate countersigned by a transfer agent other than the Corporation or its employee. Each certificate shall exhibit the name of the Corporation, the class (or series of any class) and number of shares represented thereby, and the name of the holder. Each certificate shall be otherwise in such form as may be prescribed by the Board of Directors.

Section 6.3. Restriction on Transfer of Securities. A restriction on the transfer or registration of transfer of securities of the Corporation may be imposed either by the Certificate of Incorporation or by these Bylaws or by an agreement among any number of security holders or among such holders and the Corporation. No restriction so imposed shall be binding with respect to securities issued prior to the adoption of the restriction unless the holders of the securities are parties to an agreement or voted in favor of the restriction.

A restriction on the transfer of securities of the Corporation is permitted by this Section if it:

(a) Obligates the holder of the restricted securities to offer to the Corporation or to any other holders of securities of the Corporation or to any other person or to any combination of the foregoing a prior opportunity, to be exercised within a reasonable time, to acquire the restricted securities; or

(b) Obligates the Corporation or any holder of securities of the Corporation or any other person or any combination of the foregoing to purchase the securities which are the subject of an agreement respecting the purchase and sale of the restricted securities; or

(c) Requires the Corporation or the holders of any class of securities of the Corporation to consent to any proposed transfer of the restricted securities or to approve the proposed transferee of the restricted securities; or

(d) Prohibits the transfer of the restricted securities to designated persons or classes of persons; and such designation is not manifestly unreasonable; or

(e) Restricts transfer or registration of transfer in any other lawful manner.

Unless noted conspicuously on the security, a restriction, even though permitted by this Section, is ineffective except against a person with actual knowledge of the restriction.

Section 6.4. Transfer of Shares. Except as otherwise established by rules and regulations adopted by the Board of Directors, and subject to applicable law, shares of stock may be transferred on the books of the corporation: (i) in the case of shares represented by a certificate, by the surrender to the corporation or its transfer agent of the certificate representing such shares properly endorsed or accompanied by a written assignment or power of attorney properly executed, and with such proof of authority or authenticity of signature as the corporation or its transfer agent

may reasonably require; and (ii) in the case of uncertificated shares, upon the receipt of proper transfer instructions from the registered owner thereof. Except as may be otherwise required by law, the Certificate of Incorporation or the Bylaws, the corporation shall be entitled to treat the record holder of stock as shown on its books as the owner of such stock for all purposes, including the payment of dividends and the right to vote with respect to such stock, regardless of any transfer, pledge or other disposition of such stock until the shares have been transferred on the books of the corporation in accordance with the requirements of these Bylaws.

Section 6.5. Fixing Date for Determination of Stockholders of Record.

(a) In order that the Corporation may determine the stockholders entitled to notice of or to vote at any meeting of stockholders or any adjournment thereof, the Board of Directors may fix a record date, which record date shall not precede the date upon which the resolution fixing the record date is adopted by the Board of Directors, and which record date shall not be more than sixty (60) nor less than ten (10) days before the date of such meeting. If no record is fixed by the Board of Directors, the record date for determining stockholders entitled to notice of or to vote at a meeting of stockholders shall be at the close of business on the day next preceding the day on which notice is given, or, if notice is waived, at the close of business on the day next preceding the day on which the meeting is held. A determination of stockholders of record entitled to notice of or to vote at a meeting of stockholders shall apply to any adjournment of the meeting; providing, however, that the Board of Directors may fix a new record date for the adjourned meeting.

(b) In order that the Corporation may determine the stockholders entitled to receive payment of any dividend or other distribution or allotment of any rights or the stockholders entitled to exercise any rights in respect of any change, conversion or exchange of stock, or for the purpose of any other lawful action, the Board of Directors may fix a record date, which record date shall not precede the date upon which the resolution fixing the record date is adopted, and which record date shall be not more than sixty days prior to such action. If no record date is fixed, the record date for determining stockholders for any such purpose shall be at the close of business on the day on which the Board of Directors adopts the resolution relating thereto.

Section 6.6. Lost Certificate. Any stockholder claiming that a certificate representing shares of stock has been lost, stolen or destroyed may make an affidavit or affirmation of the fact and, if the Board of Directors so requires, advertise the same in a manner designated by the Board, and give the Corporation a bond of indemnity in form and with security for an amount satisfactory to the Board (or an officer or officers designated by the Board), whereupon a new certificate may be issued of the same tenor and representing the same number, class and/or series of shares as were represented by the certificate alleged to have been lost, stolen or destroyed.

ARTICLE VII

BOOKS AND RECORDS

Section 7.1. Location. The books, accounts and records of the Corporation may be kept at such place or places within or outside the State of Delaware as the Board of Directors may from time to time determine.

Section 7.2. Inspection. The books, accounts, and records of the Corporation shall be open to inspection by any member of the Board of Directors at all times; and open to inspection by the stockholders at such times, and subject to such regulations as the Board of Directors may prescribe, except as otherwise provided by statute.

Section 7.3. Corporate Seal. The corporate seal shall contain two concentric circles between which shall be the name of the Corporation and the word "Delaware" and in the center shall be inscribed the words "Corporate Seal."

ARTICLE VIII

DIVIDENDS AND RESERVES

Section 8.1. Dividends. The Board of Directors of the Corporation, subject to any restrictions contained in the Certificate of Incorporation and other lawful commitments of the Corporation, may declare and pay dividends upon the shares of its capital stock either out of the surplus of the Corporation, as defined in and computed in accordance with the General Corporation Law of the State of Delaware, or in case there shall be no such surplus, out of the net profits of the Corporation for the fiscal year in which the dividend is declared and/or the preceding fiscal year. If the capital of the Corporation, computed in accordance with the General Corporation Law of the State of Delaware, shall have been diminished by depreciation in the value of its property, or by losses, or otherwise, to an amount less than the aggregate amount of the capital represented by the issued and outstanding stock of all classes having a preference upon the distribution of assets, the Board of Directors of the Corporation shall not declare and pay out of such net profits any dividends upon any shares of any classes of its capital stock until the deficiency in the amount of capital represented by the issued and outstanding stock of all classes having a preference upon the distribution of assets shall have been repaired.

Section 8.2. Reserves. The Board of Directors of the Corporation may set apart, out of any of the funds of the Corporation available for dividends, a reserve or reserves for any proper purpose and may abolish any such reserve.

ARTICLE IX

MISCELLANEOUS PROVISIONS

Section 9.1. Fiscal Year. The fiscal year of the Corporation shall end on the 31st day of December of each year.

Section 9.2. Depositories. The Board of Directors or an officer designated by the Board shall appoint banks, trust companies, or other depositories in which shall be deposited from time to time the money or securities of the Corporation.

Section 9.3. Checks, Drafts and Notes. All checks, drafts, or other orders for the payment of money and all notes or other evidences of indebtedness issued in the name of the Corporation shall be signed by such officer or officers or agent or agents as shall from time to time be designated by resolution of the Board of Directors or by an officer appointed by the Board.

Section 9.4. Contracts and Other Instruments. The Board of Directors may authorize any officer or agent to enter into any contract or execute and deliver any instrument in the name and on behalf of the Corporation and such authority may be general or confined to specific instances.

Section 9.5. Notices. In addition to other means of notice permitted herein, whenever under the provisions of the statutes or of the Certificate of Incorporation or of these Bylaws notice is required to be given to any director or stockholder, it shall not be construed to mean personal notice, but such notice may be given in writing, by mail, by depositing the same in a post office or letter box, in a postpaid sealed wrapper, or by delivery to a telegraph company, addressed to such director or stockholder at such address as appears on the records of the Corporation, or, in default of other address, to such director or stockholder at the General Post Office in the City of Dover, Delaware, and such notice shall be deemed to be given at the time when the same shall be thus mailed or delivered to a telegraph company.

Section 9.6. Waivers of Notice. Whenever any notice is required to be given under the provisions of the statutes or of the Certificate of Incorporation or of these Bylaws, a waiver thereof in writing signed by the person or persons entitled to said notice, whether before or after the time stated therein, shall be deemed equivalent to notice. Attendance of a person at a meeting shall constitute a waiver of notice of such meeting, except when the person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the stockholders, directors or members of a committee of directors need be specified in any written waiver of notice.

Section 9.7. Stock in Other Corporations. Any shares of stock in any other Corporation which may from time to time be held by this Corporation may be represented and voted at any meeting of shareholders of such Corporation by the President or other executive officer, or by any other person or persons thereunto authorized by the Board of Directors, or by any proxy designated by written instrument of appointment executed in the name of this Corporation by its

President or an executive officer. Shares of stock belonging to the Corporation need not stand in the name of the Corporation, but may be held for the benefit of the Corporation in the individual name of the Treasurer or of any other nominee designated for the purpose by the Board of Directors. Certificates for shares so held for the benefit of the Corporation shall be endorsed in blank or have proper stock powers attached so that said certificates are at all times in due form for transfer, and shall be held for safekeeping in such manner as shall be determined from time to time by the Board of Directors.

Section 9.8. Indemnification.

(a) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to, or is otherwise involved in, any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was a director or an officer of the Corporation, against all judgments, fines, amounts paid in settlement and other liability and loss suffered, and all expenses (including, without limitation, attorneys' fees) reasonably incurred thereby in connection with such action, suit or proceeding to the fullest extent permitted by the General Corporation Law of the State of Delaware and any other applicable law as from time to time in effect. Such right of indemnification shall include the right to payment of expenses incurred in defending any proceeding in advance of final disposition of such proceeding upon tendering of any undertaking to repay such expenses required by law as a condition to advancement of such expenses, and shall not be deemed to be exclusive of any rights to which any such director or officer may otherwise be entitled. The foregoing provisions of this Section 9.8(a) shall be deemed to be a contract between the Corporation and each director and officer of the Corporation serving in such capacity at any time while this Section 9.8(a) is in effect, and any repeal or modification thereof shall not affect any right or obligation then existing with respect to any state of facts then or theretofore existing or any action, suit or proceeding theretofore or thereafter brought or threatened based in whole or in part upon any such state of facts. Notwithstanding the first sentence of Section 9.8(a), except as otherwise provided in Section 9.8(c), the Corporation shall be required to indemnify a person in connection with a proceeding (or part thereof) commenced by such person only if the commencement of such proceeding (or part thereof) by the person was authorized in the specific case by the Board of Directors.

(b) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to, or is otherwise involved in, any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was an employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another Corporation, partnership, joint venture, trust or other enterprise, against all judgments, fines, amounts paid in settlement and other liability and loss suffered, and all expenses (including, without limitation, attorneys' fees) reasonably incurred thereby in connection with such action, suit or proceeding to the extent permitted by and in the manner set forth in and permitted by the General Corporation Law of the State of Delaware and any other applicable law as from time to time in effect. Such right of indemnification may include the right to payment of expenses incurred in defending any proceeding in advance of final disposition of such proceeding upon tendering of any

undertaking to repay such expenses required by the board of directors as a condition to advancement of such expenses, and shall not be deemed to be exclusive of any other rights to which any such person may otherwise be entitled. Notwithstanding the first sentence of Section 9.8(b), except as otherwise provided in Section 9.8(c), the Corporation shall be required to indemnify a person in connection with a proceeding (or part thereof) commenced by such person only if the commencement of such proceeding (or part thereof) by the person was authorized in the specific case by the Board of Directors.

(c) If a claim under subsection (a) or (b) of this Section is not paid in full by the Corporation within thirty days after a written claim has been received by the Corporation, the claimant may at any time thereafter bring suit against the Corporation to recover the unpaid amount of the claim and, if successful in whole or in part, the claimant shall also be entitled to be paid the expense of prosecuting such claim. It shall be a defense to any action (other than an action brought to enforce a claim for expenses incurred in defending any proceeding in advance of its final disposition where the required undertaking has been tendered to the Corporation) that the claimant has failed to meet a standard of conduct which makes it permissible under Delaware law for the Corporation to indemnify the claimant for the amount claimed, but the burden of proving such defense shall be on the Corporation. Neither the failure of the Corporation (including its Board of Directors, independent legal counsel, or its stockholders) to have made a determination prior to the commencement of such action that indemnification of the claimant is permissible in the circumstances because he has met such standard of conduct, nor an actual determination by the Corporation (including its Board of Directors, independent legal counsel, or its stockholders) that the claimant has not met such standard of conduct, nor the termination of any proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall be a defense to the action or create a presumption that the claimant has failed to meet the required standard of conduct.

(d) The right to indemnification and the payment of expenses incurred in defending a proceeding in advance of its final disposition conferred in this Section shall not be exclusive of any other right which any person may have or hereafter acquire under any statute, provision of the Certificate of Incorporation, bylaw, agreement, vote of stockholders or disinterested directors or otherwise.

(e) The Corporation may maintain insurance, at its expense, to protect itself and any director, officer, employee or agent of the Corporation or another Corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss, whether or not the Corporation would have the power to indemnify such person against such expense, liability or loss under Delaware law.

(f) To the extent that any director, officer, employee or agent of the Corporation is by reason of such position, or a position with another entity at the request of the Corporation, a witness in any proceeding, he shall be indemnified against all costs and expenses actually and reasonably incurred by him or on his behalf in connection therewith.

(g) Any amendment, repeal or modification of any provision of this Section by the stockholders or the directors of the Corporation shall not adversely affect any right or protection of a director or officer of the Corporation with respect to any action or omission occurring prior to the time of such amendment, repeal or modification.

Section 9.9. Amendment of Bylaws.

(a) The stockholders, by the affirmative vote of the holders of a majority of the stock issued and outstanding and having voting power may, at any annual or special meeting if notice of such alteration or amendment of the Bylaws is contained in the notice of such meeting, adopt, amend, or repeal these Bylaws, and alterations or amendments of Bylaws made by the stockholders shall not be altered or amended by the Board of Directors.

(b) The Board of Directors, by the affirmative vote of a majority of the whole Board, may adopt, amend, or repeal these Bylaws at any meeting, except as provided in the above paragraph. Bylaws made by the Board of Directors may be altered or repealed by the stockholders.

ARTICLE X

EXCLUSIVE FORUM

Section 10.1. Exclusive Forum. Unless the Corporation consents in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware shall, to the fullest extent permitted by law, be the sole and exclusive forum for (1) any derivative action or proceeding brought on behalf of the Corporation, (2) any action asserting a claim of breach of a fiduciary duty owed by any director, officer, or other employee of the Corporation to the Corporation or the Corporation's stockholders, (3) any action asserting a claim against the Corporation or any director, officer, or other employee of the Corporation arising pursuant to any provision of the Delaware General Corporation Law, or the Corporation's Certificate of Incorporation or Bylaws (as either may be amended from time to time) or (4) any action asserting a claim against the Corporation, or any director, officer, or other employee of the Corporation governed by the internal affairs doctrine.

* * * * *

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2014 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 30, 2014

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2014 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 30, 2014

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2014 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 30, 2014

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2014 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 30, 2014

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended March 31, 2014

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2014

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 **Long Beach, California**	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock, $0.001 par value, outstanding as of April 25, 2014, was approximately 46,264,000.

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MOLINA HEALTHCARE, INC.
Form 10-Q

For the Quarterly Period Ended March 31, 2014

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PART I. FINANCIAL INFORMATION

Item 1. Financial Statements

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	March 31, 2014	December 31, 2013
	(Amounts in thousands, except per share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,083,369	$ 935,895
Investments	696,200	703,052
Receivables	338,232	298,935
Income taxes refundable	28,100	32,742
Deferred income taxes	22,414	26,556
Prepaid expenses and other current assets	112,916	42,484
Total current assets	2,281,231	2,039,664
Property, equipment, and capitalized software, net	310,364	292,083
Deferred contract costs	44,740	45,675
Intangible assets, net	93,587	98,871
Goodwill	230,738	230,738
Restricted investments	82,036	63,093
Auction rate securities	10,928	10,898
Deferred income taxes	3,510	—
Derivative asset	196,617	186,351
Other assets	39,730	35,564
	$ 3,293,481	$ 3,002,937
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 819,541	$ 669,787
Accounts payable and accrued liabilities	406,414	319,965
Deferred revenue	146,276	122,216
Current maturities of long-term debt	183,713	182,008
Total current liabilities	1,555,944	1,293,976
Convertible senior notes	421,004	416,368
Lease financing obligations	159,754	159,394
Lease financing obligations – related party	34,820	27,092
Deferred income taxes	—	580
Derivative liability	196,503	186,239
Other long-term liabilities	27,736	26,351
Total liabilities	2,395,761	2,110,000
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 46,263 shares at March 31, 2014 and 45,871 shares at December 31, 2013	46	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	340,429	340,848
Accumulated other comprehensive loss	(382)	(1,086)
Retained earnings	557,627	553,129
Total stockholders' equity	897,720	892,937
	$ 3,293,481	$ 3,002,937

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2014	2013
	(Amounts in thousands, except net income (loss) per share) (Unaudited)	
Revenue:		
Premium revenue	$ 1,940,337	$ 1,497,433
Service revenue	53,630	49,756
Premium tax revenue	51,693	37,000
Health insurer fee revenue	18,696	—
Investment income	1,629	1,516
Other revenue	3,258	4,694
Total revenue	2,069,243	1,590,399
Operating expenses:		
Medical care costs	1,721,658	1,287,915
Cost of service revenue	40,657	39,770
General and administrative expenses	188,087	141,278
Premium tax expenses	51,693	37,000
Health insurer fee expenses	22,190	—
Depreciation and amortization	20,691	16,563
Total operating expenses	2,044,976	1,522,526
Operating income	24,267	67,873
Other expenses, net:		
Interest expense	13,822	13,037
Other income, net	(44)	(131)
Total other expenses, net	13,778	12,906
Income from continuing operations before income tax expense	10,489	54,967
Income tax expense	5,655	24,445
Income from continuing operations	4,834	30,522
Loss from discontinued operations, net of tax	(336)	(607)
Net income	$ 4,498	$ 29,915
Basic net income (loss) per share:		
Continuing operations	$ 0.11	$ 0.66
Discontinued operations	(0.01)	(0.01)
Basic net income per share	$ 0.10	$ 0.65
Diluted net income (loss) per share:		
Continuing operations	$ 0.10	$ 0.65
Discontinued operations	(0.01)	(0.01)
Diluted net income per share	$ 0.09	$ 0.64

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2014	2013
	(Amounts in thousands) (Unaudited)	
Net income	$ 4,498	$ 29,915
Other comprehensive income:		
Gross unrealized investment gains	1,426	419
Effect of income tax expense	722	159
Other comprehensive income, net of tax	704	260
Comprehensive income	$ 5,202	$ 30,175

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2014	2013
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 4,498	$ 29,915
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	32,994	21,799
Deferred income taxes	(670)	(16)
Stock–based compensation	5,596	4,421
Amortization of convertible senior notes and lease financing obligations	6,674	3,723
Amortization of premium/discount on investments	3,023	1,502
Amortization of deferred financing costs	651	1,248
Gain on derivatives, net	(2)	(119)
Change in fair value of contingent consideration liabilities	(4,265)	—
Gain on disposal of property and equipment, net	(950)	—
Tax deficiency from employee stock compensation	(5)	(42)
Changes in operating assets and liabilities:		
Receivables	(39,297)	(569)
Prepaid expenses and other assets	(78,023)	(8,956)
Medical claims and benefits payable	149,754	(3,385)
Accounts payable and accrued liabilities	102,217	(31,847)
Deferred revenue	24,060	(5,994)
Income taxes	4,642	8,424
Net cash provided by operating activities	210,897	20,104
Investing activities:		
Purchases of investments	(142,145)	(76,012)
Sales and maturities of investments	147,370	75,647
Purchases of equipment	(17,788)	(11,167)
Increase in restricted investments	(14,381)	(11,016)
Sale of property and equipment	5,715	—
Change in deferred contract costs	(6,145)	1,756
Change in other noncurrent assets and liabilities	(117)	(408)
Net cash used in investing activities	(27,491)	(21,200)
Financing activities:		
Proceeds from issuance of 1.125% Notes, net of deferred financing costs	—	537,973
Purchase of 1.125% Notes call option	—	(149,331)
Proceeds from issuance of warrants	—	75,074
Treasury stock purchases	—	(50,000)
Principal payments on term loan	—	(291)
Repayment of amounts borrowed under credit facility	—	(40,000)
Contingent consideration liabilities settled	(38,119)	—
Proceeds from employee stock plans	1,330	235
Excess tax benefits from employee stock compensation	877	1,177
Principal payments on lease financing obligations	(20)	—
Net cash (used in) provided by financing activities	(35,932)	374,837
Net increase in cash and cash equivalents	147,474	373,741
Cash and cash equivalents at beginning of period	935,895	795,770
Cash and cash equivalents at end of period	$ 1,083,369	$ 1,169,511

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Three Months Ended March 31,	
	2014	2013
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 481	$ 14,712
Interest	$ 6,388	$ 17,065
Schedule of non-cash investing and financing activities:		
Retirement of treasury stock	$ —	$ 53,000
Common stock used for stock-based compensation	$ 8,217	$ 4,644
Non-cash lease financing obligation – related party	$ 7,775	$ —
Details of gain (loss) on derivatives:		
Gain (loss) on 1.125% Call Option	$ 10,266	$ (1,946)
(Loss) gain on embedded cash conversion option	(10,264)	2,022
Gain on interest rate swap	—	43
Gain on derivatives, net	$ 2	$ 119

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
March 31, 2014

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of March 31, 2014, these health plans served approximately 2.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplaces members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in California.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we classified the operations for our Missouri health plan as discontinued operations for all periods presented in our consolidated financial statements.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2014.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2013. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2013 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2013 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2013 consolidated statements of income to conform to the 2014 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates and fall into two categories:

(1) Contractual provisions with revenue or profit limits:

Health Plan Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain Medicaid premiums received by our California, Florida, Illinois, New Mexico, and Washington health plans may be returned to the state if certain minimum amounts are not spent on defined medical care costs. In some cases, the health

plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Additionally, all of our health plans with Medicare and Health Insurance Marketplaces membership are required to spend certain minimum amounts on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $2.0 million and $1.4 million at March 31, 2014, and December 31, 2013, respectively. In Michigan and Ohio, the state may levy non-monetary sanctions on us if certain minimum amounts are not spent on defined medical care costs, or if administrative costs exceed certain amounts.

Health Plan Profit Sharing and Profit Ceiling: Our contracts with the states of New Mexico, Texas, and Washington contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to fully retain, we recorded a liability of $11.1 million and $2.5 million at March 31, 2014 and December 31, 2013, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS (the Centers for Medicare and Medicaid Services), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of $33.4 million and $20.8 million for anticipated Medicare risk adjustment premiums at March 31, 2014 and December 31, 2013, respectively.

(2) Quality incentives:

At our Illinois, New Mexico, Ohio, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1.00% to 5.00% of health plan premiums is earned if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2014 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2014.

	Three Months Ended March 31,	
	2014	2013
	(In thousands)	
Maximum available quality incentive premium - current period	$ 20,164	$ 20,615
Amount of quality incentive premium revenue recognized in current period:		
Earned current period	$ 5,297	$ 14,896
Earned prior periods	(378)	6,712
Total	$ 4,919	21,608
Total premium revenue recognized for state health plans with quality incentive premiums	$ 1,200,619	$ 709,383

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes, nondeductible health insurer fee expenses, nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $2.0 million and $8.0 million as of March 31, 2014 and December 31, 2013, respectively. The unrecognized tax benefits recorded at December 31, 2013 decreased by $6.0 million during the quarter ending March 31, 2014 as a result of executing a settlement agreement with a state. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $1.8 million and $5.7 million as of March 31, 2014 and December 31, 2013, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $0.2 million due to the expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of March 31, 2014 and December 31, 2013, we had accrued $0.07 million and $0.08 million, respectively, for the payment of interest and penalties.

During the three months ended March 31, 2014 and 2013, we recognized tax benefits related to discontinued operations of $0.4 million and $0.2 million, respectively.

New Accounting Standards

Health Insurer Fee. In the first quarter of 2014, we adopted the guidance of the Financial Accounting Standards Board (FASB) related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA). The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. The health insurer fee (HIF) is imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year.

Effective January 1, 2014, we recorded our estimate of the 2014 liability to accounts payable and accrued liabilities, amounting to $88.8 million. We are amortizing this liability on a straight-line basis in 2014, and recorded $22.2 million to health insurer fee expenses in the first quarter of 2014. As enacted, this federal premium-based assessment is non-deductible for income tax purposes.

Income Taxes. In the first quarter of 2014, we adopted the FASB's guidance for the presentation of an unrecognized tax benefit when a net operating loss carryforward, a similar tax loss, or a tax credit carryforward exists. The new guidance states that an unrecognized tax benefit, or a portion of an unrecognized tax benefit, should be presented in the financial statements as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward. The adoption of this new guidance did not impact our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended March 31,	
	2014	2013
	(In thousands)	
Shares outstanding at the beginning of the period	45,871	46,762
Weighted-average number of shares repurchased	—	(867)
Weighted-average number of shares issued	150	86
Denominator for basic net income per share	46,021	45,981
Dilutive effect of employee restricted stock awards and stock options	597	462
Dilutive effect of 3.75% Notes (1)	902	—
Denominator for diluted net income per share	47,520	46,443
Potentially dilutive amounts excluded from calculations (1),(2):		
Restricted stock awards	192	203
Stock options	45	26
1.125% Warrants	13,490	7,345

(1) Potentially dilutive shares issuable pursuant to our 3.75% Notes (defined in Note 11, "Long-Term Debt") were not included in the computation of diluted net income per share for the three months ended March 31, 2013, because to do so would have been anti-dilutive. Potentially dilutive shares issuable pursuant to our 1.125% Warrants (defined in Note 12, "Derivative Financial Instruments") were not included in the computation of diluted net income per share for the three months ended March 31, 2014 and 2013 because to do so would have been anti-dilutive.

(2) Unvested restricted shares are included in the calculation of diluted net income per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. Options to purchase common shares are included in the calculation of diluted net income per share when their exercise prices are below the average fair value of the common shares for each of the periods presented.

4. Business Combinations

Health Plans Segment

South Carolina. In July 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members covered by South Carolina's full-risk Medicaid managed care program. The conversion conditions under the agreement were satisfied by January 1, 2014, and on that date such Medicaid members were converted to the managed care program and enrolled with our South Carolina health plan. In January 2014 we made an interim payment of $38.1 million according to the terms of the agreement, which included indemnification withhold funds transferred to restricted investments amounting to $4.6 million. Such indemnification funds will become unrestricted on the one-year anniversary date of the conversion, or January 1, 2015.

Because the number of Medicaid members we would ultimately convert was unknown as of the acquisition date in 2013, we have recorded a contingent consideration liability for such members we expect to enroll through the final purchase price determination date in the second quarter of 2014. We have also recorded a contingent consideration liability for dual-eligible members we may enroll in our Medicare-Medicaid Plan (MMP) implementation in South Carolina. The contingent consideration liability is remeasured to fair value at each quarter until the contingency is resolved, with fair value adjustments, if any, recorded to operations. As of March 31, 2014, the fair value of the contingent consideration liability amounted to $14.7 million. This amount reflects a reduction from the December 31, 2013 balance for the January 2014 payment noted above, and for the fair value adjustment measured as of March 31, 2014. The fair value adjustment resulted in a decrease to the liability of $2.7 million, with a corresponding gain recorded to operations. On April 17, 2014, we paid $11.6 million, including indemnification withhold funds transferred to restricted investments, in satisfaction of the final purchase price determination relating to the converted Medicaid membership.

New Mexico. In August 2013, our New Mexico health plan acquired the Lovelace Community Health Plan's contract for the state of New Mexico's Medicaid program. In addition to Lovelace's Medicaid members, we also added membership previously

covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace. Effective January 1, 2014, these SCI members were either a) enrolled in New Mexico's Medicaid program, or b) eligible to enroll in New Mexico's Marketplace.

Because the number of SCI members we would ultimately retain was unknown as of the acquisition date in 2013, we have recorded a contingent consideration liability for such members we expect to enroll through the final purchase price determination date in the second quarter of 2014. As of March 31, 2014, the fair value of this contingent consideration liability amounted to $0.5 million. The fair value adjustment resulted in a decrease to the liability of $1.6 million, with a corresponding gain recorded to operations.

5. Stock-Based Compensation

In March 2014, our named executive officers were granted a total of 356,292 restricted shares with service, market, and performance conditions. In the event the vesting conditions are not achieved, the awards will lapse. As of March 31, 2014, we expect the market and performance conditions to be met in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows:

	Three Months Ended March 31,	
	2014	2013
	(In thousands)	
Restricted stock and performance awards	$ 4,608	$ 3,848
Employee stock purchase plan and stock options	988	573
	$ 5,596	$ 4,421

As of March 31, 2014, there was $37.8 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 2.4 years. Also as of March 31, 2014, there was $0.5 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 1.8 years.

Restricted and performance stock activity for the three months ended March 31, 2014 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2013	1,299,852	$ 29.03
Granted	628,936	36.46
Vested	(561,407)	27.46
Forfeited	(6,125)	27.36
Unvested balance as of March 31, 2014	1,361,256	33.12

The total fair value of restricted and performance awards granted during the three months ended March 31, 2014 and 2013 was $22.9 million and $19.3 million, respectively. The total fair value of restricted awards, including those with performance and market conditions, vested during the three months ended March 31, 2014 and 2013 was $20.9 million and $13.1 million, respectively.

Stock option activity for the three months ended March 31, 2014 is summarized below:

	Options	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Outstanding as of December 31, 2013	379,221	$ 24.14		
Exercised	(51,750)	25.69		
Outstanding as of March 31, 2014	327,471	23.90	$ 4,475	3.5
Stock options exercisable and expected to vest as of March 31, 2014	327,471	23.90	$ 4,475	3.5
Exercisable as of March 31, 2014	292,471	22.77	$ 4,325	2.9

6. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, other assets, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities (excluding contingent consideration liabilities) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Such investments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Derivative financial instruments. Derivative financial instruments include the 1.125% Call Option derivative asset and the embedded cash conversion option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of March 31, 2014 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, “Derivative Financial Instruments,” the 1.125% Call Option asset and the embedded cash conversion option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Contingent consideration liabilities. Such liabilities primarily relate to our South Carolina health plan acquisition described in Note 4, "Business Combinations," and are recorded in accounts payable and accrued liabilities. We applied discounted cash flow analysis to determine the fair value of the contingent consideration liabilities. Significant unobservable inputs primarily related to the probability weighted present values of the purchase price estimates for the projected membership.

Auction rate securities. Auction rate securities are designated as available-for-sale and are reported at fair value. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of March 31, 2014.

Our financial instruments measured at fair value on a recurring basis at March 31, 2014, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 451,682	$ —	$ 451,682	$ —
Municipal securities	99,748	—	99,748	—
GSEs	69,326	69,326	—	—
U.S. treasury notes	35,035	35,035	—	—
Certificates of deposit	40,409	—	40,409	—
Auction rate securities	10,928	—	—	10,928
1.125% Call Option derivative asset	196,617	—	—	196,617
Total assets measured at fair value on a recurring basis	$ 903,745	$ 104,361	$ 591,839	$ 207,545
Embedded cash conversion option derivative liability	$ 196,503	$ —	$ —	$ 196,503
Contingent consideration liabilities	15,164	—	—	15,164
Total liabilities measured at fair value on a recurring basis	$ 211,667	$ —	$ —	$ 211,667

Our financial instruments measured at fair value on a recurring basis at December 31, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 449,772	$ —	$ 449,772	$ —
Municipal securities	113,330	—	113,330	—
GSEs	68,817	68,817	—	—
U.S. treasury notes	37,376	37,376	—	—
Certificates of deposit	33,757	—	33,757	—
Auction rate securities	10,898	—	—	10,898
1.125% Call Option derivative asset	186,351	—	—	186,351
Total assets measured at fair value on a recurring basis	$ 900,301	$ 106,193	$ 596,859	$ 197,249
Embedded cash conversion option derivative liability	$ 186,239	$ —	$ —	$ 186,239
Contingent consideration liabilities	57,548	—	—	57,548
Total liabilities measured at fair value on a recurring basis	$ 243,787	$ —	$ —	$ 243,787

The following table presents activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Change in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liabilities
		(In thousands)	
Balance at December 31, 2013	$ 10,898	$ 112	$ (57,548)
Total gains for the period recognized in:			
General and administrative expenses	—	—	4,265
Other expenses, net	—	2	—
Other comprehensive income	30	—	—
Settlements	—	—	38,119
Balance at March 31, 2014	$ 10,928	$ 114	$ (15,164)

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our long-term debt, as well as the applicable fair value hierarchy tiers, are contained in the tables below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these

securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

	March 31, 2014				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 421,004	$ 615,313	$ —	$ 615,313	$ —
3.75% Notes	183,549	229,075	—	229,075	—
	$ 604,553	$ 844,388	$ —	$ 844,388	$ —

	December 31, 2013				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 416,368	$ 572,627	$ —	$ 572,627	$ —
3.75% Notes	181,872	219,491	—	219,491	—
	$ 598,240	$ 792,118	$ —	$ 792,118	$ —

7. Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 451,484	$ 613	$ 415	$ 451,682
Municipal securities	99,775	266	293	99,748
GSEs	69,379	18	71	69,326
U.S. treasury notes	35,004	57	26	35,035
Certificates of deposit	40,412	5	8	40,409
Subtotal - current investments	696,054	959	813	696,200
Auction rate securities	11,400	—	472	10,928
	$ 707,454	$ 959	$ 1,285	$ 707,128

	December 31, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 450,162	$ 442	$ 832	$ 449,772
Municipal securities	114,126	119	915	113,330
GSEs	68,898	6	87	68,817
U.S. treasury notes	37,360	44	28	37,376
Certificates of deposit	33,756	2	1	33,757
Subtotal - current investments	704,302	613	1,863	703,052
Auction rate securities	11,400	—	502	10,898
	$ 715,702	$ 613	$ 2,365	$ 713,950

The contractual maturities of our investments as of March 31, 2014 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 329,504	$ 329,633
Due one year through five years	366,550	366,567
Due after ten years	11,400	10,928
	$ 707,454	$ 707,128

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Net realized investment gains for the three months ended March 31, 2014 and 2013 were insignificant.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at March 31, 2014 and December 31, 2013, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2014.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 137,383	$ 334	64	$ 11,829	$ 81	5
Municipal securities	14,143	110	18	27,085	183	30
GSEs	28,741	63	11	5,541	8	6
U.S. treasury notes	8,821	26	7	—	—	—
Certificates of deposit	10,566	8	43	—	—	—
Auction rate securities	—	—	—	10,928	472	15
	$ 199,654	$ 541	143	$ 55,383	$ 744	56

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2013.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 210,057	$ 802	91	$ 2,540	$ 30	3
Municipal securities	30,715	398	49	31,091	517	39
GSEs	53,308	87	21	—	—	—
U.S. treasury notes	12,037	28	11	—	—	—
Certificates of deposit	414	1	2	—	—	—
Auction rate securities	—	—	—	10,898	502	15
	$ 306,531	$ 1,316	174	$ 44,529	$ 1,049	57

Auction Rate Securities. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not

been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 17 years to 32 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction rate securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at March 31, 2014. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $70.7 million of these instruments at par value.

For the three months ended March 31, 2014 and 2013, we recorded pretax unrealized gains of $0.03 million and $0.3 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future impairment was other-than-temporary, we would record a charge to earnings as appropriate.

8. Receivables

Receivables consist primarily of amounts due from the various states in which we operate, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial.

	March 31, 2014	December 31, 2013
	(In thousands)	
Health Plans segment:		
California	$ 134,872	$ 148,654
Florida	3,123	2,901
Illinois	284	5,773
Michigan	19,446	15,253
New Mexico	29,732	17,056
Ohio	53,493	43,969
South Carolina	12,612	—
Texas	11,398	9,736
Utah	13,700	10,953
Washington	25,145	13,455
Wisconsin	7,857	8,087
Direct delivery and other	9,043	2,463
Total Health Plans segment	320,705	278,300
Molina Medicaid Solutions segment	17,527	20,635
	$ 338,232	$ 298,935

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, we maintain restricted investments as collateral for letters of credit. The following

table presents the balances of restricted investments:

	March 31, 2014	December 31, 2013
	(In thousands)	
California	$ 373	$ 373
Florida	23,317	9,242
Illinois	310	310
Michigan	1,014	1,014
New Mexico	24,625	24,622
Ohio	9,081	9,080
South Carolina	4,872	310
Texas	3,500	3,500
Utah	3,602	3,301
Washington	151	151
Other	885	886
Total Health Plans segment	71,730	52,789
Molina Medicaid Solutions segment	10,306	10,304
	$ 82,036	$ 63,093

The contractual maturities of our held-to-maturity restricted investments as of March 31, 2014 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 76,957	$ 76,963
Due one year through five years	5,079	5,083
	$ 82,036	$ 82,046

10. Medical Claims and Benefits Payable

Medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non-risk provider payables amounted to $122.7 million and $151.3 million as of March 31, 2014, and December 31, 2013, respectively.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,		Year Ended
	2014	2013	December 31, 2013
	(Dollars in thousands)		
Balances at beginning of period	$ 669,787	$ 494,530	$ 494,530
Components of medical care costs related to:			
Current period	1,773,332	1,347,181	5,434,443
Prior periods	(50,904)	(58,427)	(52,779)
Total medical care costs	1,722,428	1,288,754	5,381,664
Change in non-risk provider payables	(28,560)	(7,638)	111,267
Payments for medical care costs related to:			
Current period	1,172,672	948,820	4,932,195
Prior periods	371,442	335,681	385,479
Total paid	1,544,114	1,284,501	5,317,674
Balances at end of period	$ 819,541	$ 491,145	$ 669,787
Benefit from prior period as a percentage of:			
Balance at beginning of period	7.6%	11.8%	10.7%
Premium revenue, trailing twelve months	0.8%	1.0%	0.9%
Medical care costs, trailing twelve months	0.9%	1.1%	1.0%

Assuming that our initial estimate of claims incurred but not paid (IBNP) is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate – we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2014 and 2013 were less than what we had expected when we had established our reserves. For example, for the year ended December 31, 2013, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2012 by 10.7%. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $50.9 million for the three months ended March 31, 2014. This amount represents our estimate as of March 31, 2014, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2013 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2013 was due primarily to the following factors:

- At our Ohio health plan, we entered new regions in the state, and a new product, ABD Kids, in July 2013. Since we did not have enough historical claims data to use the pattern of paid and incurred claims, we initially estimated the reserves for these new members by applying an estimated medical care ratio (MCR). This resulted in an overstatement of our reserve liability as of December 31, 2013.

- At our Michigan health plan, we overestimated the impact of certain unpaid potentially high-dollar claims. In addition, we overestimated the impact of the flu season on the outpatient claims for November and December 2013, which caused an overestimation in our outpatient reserve liability as of December 31, 2013.

We recognized favorable prior period claims development in the amount of $58.4 million for the three months ended March 31, 2013. This amount represents our estimate as of March 31, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that would ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012, was due primarily to the following factors:

- At our Texas health plan, we saw a reduction in STAR+PLUS (the state's program for aged and disabled members) membership during mid to late 2012. This caused a reduction in costs per member that we did not fully recognize in our December 31, 2012 reserve estimates.
- At our Washington health plan, prior to July 2012, certain high-cost newborns that were approved for Supplemental Security Income (SSI) coverage by the state were retroactively dis-enrolled from our Healthy Options (TANF) coverage, and the health plan was reimbursed for the claims paid on behalf of these members. Starting July 1, 2012, these newborns, as well as other high-cost disabled members, are now covered by the health plan under the Health Options Blind and Disabled (HOBD) program. At the end of 2012, we did not have enough claims history to accurately estimate the claims liability of the HOBD members, and as a result the liability for these high-cost members was overstated.
- For our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.

In estimating our claims liability at March 31, 2014, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Effective January 1, 2014, we began covering approximately 133,000 members under Medicaid Expansion. These are new members and a new product, so we do not have historical claims data to use for purposes of establishing the reserves. Therefore, we are applying an estimated MCR to establish the estimated incurred claims and the reserves for these members.
- Effective January 1, 2014, we began covering approximately 126,000 new members at our South Carolina health plan. Because this is a new health plan for us, we do not have historical claims data to use for purposes of establishing the reserves. Therefore, we are applying an estimated MCR to establish the estimated incurred claims and the reserves for these members.
- At our Texas health plan, we continue to see a significant number of older claims that are being paid as a result of disputes with providers over the initial paid amounts. We have included an allowance for additional provider-disputed claims in our reserves as of March 31, 2014, but it is often difficult to predict the frequency and amount of such claims.
- At our New Mexico health plan, the state had fallen behind in adding members to our enrollment. As we were developing our March 31, 2014 reserves, we learned of a large number of members that were enrolled to our health plan retroactively. Since we had no claims history for these members, we applied the projected MCR to estimate the claims and reserves for these members. In addition, effective January 1, 2014, the benefits for New Mexico Medicaid members were expanded to include behavioral health benefits. The additional projected claims, and therefore the additional reserves, for behavioral health benefits were substantial.
- At our New Mexico and Washington health plans, we began using an outside vendor to review high-dollar claims. As part of the process, some claims are denied and more information is requested so that a detailed review of the billed amounts can be conducted. This has caused a disruption in the normal flow of claims payments that we have attempted to reflect in our reserves.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2013, and for the three months ended March 31, 2014, the absence of adverse development of the liability for claims and medical benefits

payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both periods, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

11. Long-Term Debt

As of March 31, 2014, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2014	2015	2016	2017	2018	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	187,000	—	—	—	—	—
	$ 737,000	$ 187,000	$ —	$ —	$ —	$ —	$ 550,000

1.125% Cash Convertible Senior Notes due 2020. In February 2013, we issued $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes), which were outstanding as of March 31, 2014 and December 31, 2013. Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum, and commenced on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date. The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities.

The initial conversion rate for the 1.125% Notes was 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate is subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest.

The 1.125% Notes contain an embedded cash conversion option, which was separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the embedded cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5.9%. As of March 31, 2014, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 5.8 years. The 1.125% Notes' if-converted value did not exceed their principal amount as of March 31, 2014 and December 31, 2013.

3.75% Convertible Senior Notes due 2014. We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of March 31, 2014 and December 31, 2013. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock.

Because the 3.75% Notes have cash settlement features, we have allocated the proceeds from their issuance between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that is amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. As of March 31, 2014, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 6 months. The 3.75% Notes' if-converted value exceeded their principal amount by approximately $37 million, and $11 million as of March 31, 2014, and December 31, 2013, respectively. At March 31, 2014, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million.

The principal amounts, unamortized discount and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
March 31, 2014:			
1.125% Notes	$ 550,000	$ 128,996	$ 421,004
3.75% Notes	187,000	3,451	183,549
	$ 737,000	$ 132,447	$ 604,553
December 31, 2013:			
1.125% Notes	$ 550,000	$ 133,632	$ 416,368
3.75% Notes	187,000	5,128	181,872
	$ 737,000	$ 138,760	$ 598,240

	Three Months Ended March 31,	
	2014	2013
	(In thousands)	
Interest cost recognized for the period relating to the:		
Contractual interest coupon rate	$ 3,300	$ 2,527
Amortization of the discount	6,314	3,723
Total interest cost recognized	$ 9,614	$ 6,250

Lease Financing Obligations. In 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of two properties, including the Molina Center located in Long Beach, California, and the building that houses our Ohio health plan located in Columbus, Ohio. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The lease financing obligation is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income.

As described and defined in further detail in Note 16, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings then under construction, one of which was completed in June 2013. We have concluded that we are the accounting owner of the construction projects because of our continuing involvement in those projects. We have recorded $34.1 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of March 31, 2014, which represents the total cost, including imputed interest, incurred by the Landlord thus far in the construction projects. As of March 31, 2014, the aggregate amount recorded to lease financing obligations for the construction projects amounted to $34.8 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was immaterial for the three months ended March 31, 2014.

12. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	March 31, 2014	December 31, 2013
		(In thousands)	
Derivative asset:			
1.125% Call Option	Non-current assets: Derivative asset	$ 196,617	$ 186,351
Derivative liability:			
Embedded cash conversion option	Non-current liabilities: Derivative liability	$ 196,503	$ 186,239

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, in other income, net. Gains and losses for each of our derivative financial instruments are presented in the consolidated statements of cash flows.

1.125% Notes Call Spread Overlay. Concurrent with the issuance of the 1.125% Notes in 2013 as described in Note 11, "Long-Term Debt," we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). We refer to these transactions collectively as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by proceeds from the sale of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

1.125% Call Option. The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to the cash settlement features until the 1.125% Call Option settles or expires. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 6, "Fair Value Measurements."

Embedded Cash Conversion Option. The embedded cash conversion option within the 1.125% Notes is accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the embedded cash conversion option, refer to Note 6, "Fair Value Measurements."

13. Stockholders' Equity

Stockholders' equity increased $4.8 million during the three months ended March 31, 2014 compared with stockholders' equity at December 31, 2013. The increase was primarily due to net income of $4.5 million.

1.125% Warrants. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants.

Securities Repurchases and Repurchase Program. Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50.0 million in aggregate of our common stock through December 31, 2014. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and other market conditions. As of March 31, 2014, the remaining balance available to repurchase our stock under this program was $47.3 million.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with our equity incentive plans, we issued approximately 391,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the three months ended March 31, 2014.

14. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and also includes our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segment is charged to the Health Plans segment.

	Three Months Ended March 31,	
	2014	2013
	(In thousands)	
Revenue from continuing operations:		
Health Plans segment:		
Premium revenue	$ 1,940,337	$ 1,497,433
Premium tax revenue	51,693	37,000
Health insurer fee revenue	18,696	—
Investment income	1,629	1,516
Other revenue	3,258	4,694
Molina Medicaid Solutions segment:		
Service revenue	53,630	49,756
	$ 2,069,243	$ 1,590,399
Operating income from continuing operations:		
Health Plans segment	$ 14,019	$ 61,520
Molina Medicaid Solutions segment	10,248	6,353
Total operating income from continuing operations	24,267	67,873
Other expenses, net	13,778	12,906
Income from continuing operations before income tax expense	$ 10,489	$ 54,967

15. Commitments and Contingencies

California Health Plan Rate Settlement Agreement. In the fourth quarter of 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, a settlement account (the Account) applicable to the California health plan's managed care contracts has been established.

Effective January 1, 2014, the Account was established with an initial balance of zero, and will be settled after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our managed care contracts. The Account will be adjusted annually to reflect a calendar year deficit or surplus, which is determined by comparing the California health plan's pre-tax margin and a target margin established in the settlement agreement. Upon expiration of the settlement agreement, if the Account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. If the Account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40.0 million.

We estimate and recognize the retrospective adjustments to premium revenue based on our experience to date under the California health plan's managed care contracts. As of March 31, 2014, we recorded a deficit, or receivable, of $5.0 million, net of a valuation discount of $0.3 million, reflecting our estimated retrospective premium adjustment to the Account based on the California health plan's actual pretax margin for the three months ended March 31, 2014.

Legal Proceedings. The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these

estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Washington Health Plan. The Washington Health Care Authority (HCA) has communicated that it believes it has overpaid our Washington health plan with regard to certain claims. The alleged overpayments, which relate to and were incorporated into the capitation rates paid to our Washington health plan, date back to July 1, 2012, the start date of the current contract. On March 25, 2014, HCA alleged that the total "overpayments" related to HCA's delayed enrollment of so-called Washington Community Options Program Entry System (COPES) members were $14.4 million, and demanded payment in that amount. On April 7, 2014, HCA alleged that the total "overpayments" related to certain psychotropic drug claims that had been included in the Request for Proposal (RFP) rate book were $5.8 million, and demanded payment in that amount. HCA has provided us with minimal data by which we might independently validate HCA's allegations. Furthermore, both alleged errors, if they in fact occurred, were unilateral errors committed and caused by HCA for which our Washington health plan had no contemporaneous knowledge and had assumed and bore no contractual risk. We are in the process of responding to HCA's demands for payment, noting that the demands are improper since under Washington law there were in fact no "overpayments" since payment was made consistent with the express terms of the parties' contract. We believe that any actual liability for the alleged overpayment claims is not currently probable or reasonably estimable.

Provider Claims. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions. Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statues, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $592 million at March 31, 2014, and $608 million at December 31, 2013. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $339.8 million and $365.2 million as of March 31, 2014 and December 31, 2013, respectively.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of March 31, 2014, our health plans had aggregate statutory capital and surplus of approximately $641 million compared with the required minimum aggregate statutory capital and surplus of approximately $410 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2014. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Related Party Transactions

In February 2013, we entered into a lease with 6th & Pine Development, LLC (the Landlord) for office space located in Long Beach, California. The lease consists of two office buildings, one of which is under construction.

The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of common stock in the Company the Landlord holds as trustee. Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

The lease term for the completed building commenced in June 2013, and the lease term for the building under construction is expected to commence in September 2014. The initial lease term for both buildings expires on December 31, 2024, subject to two five-year renewal options. Annual rent for the completed building is approximately $3 million, and initial annual rent for the building under construction is expected to be approximately $4 million. Rent increases 3.75% per year during the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

Refer to Note 17, "Variable Interest Entities," for a discussion of the Joseph M. Molina, M.D. Professional Corporations.

17. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations. The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our chief executive officer, president, and chairman of the board of directors. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides professional medical services to the general public for routine non-life threatening, outpatient health care needs. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, American Family Care, Inc. (AFC), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will operate at break even, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by AFC are reviewed annually to assure the achievement of this goal.

Our California, Florida, New Mexico and Washington health plans have entered into primary care capitation agreements with JMMPC. These agreements direct our health plans to perform a monthly reconciliation, to either fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, such that JMMPC will derive no profit or loss. Because the AFC services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are generally insignificant.

We have determined that JMMPC is a variable interest entity (VIE), and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of March 31, 2014, JMMPC had total assets of $8.9 million, and total liabilities of $8.6 million. As of December 31, 2013, JMMPC had total assets of $6.9 million and total liabilities of $6.6 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words “anticipate(s),” “believe(s),” “estimate(s),” “expect(s),” “intend(s),” “may,” “plan(s),” “project(s),” “will,” “would,” “could,” “should” and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those known risks and uncertainties include, but are not limited to, the following:

- uncertainties associated with the implementation of the Affordable Care Act, including the full grossed up reimbursement by states of the non-deductible health insurer fee, the expansion of Medicaid eligibility in the states that participate to previously uninsured populations unfamiliar with managed care, the implementation of state insurance marketplaces, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures, including the dual eligibles demonstration programs in California, Illinois, Michigan, Ohio, and South Carolina;
- newly FDA-approved drugs such as sovaldi, olysio, and other drugs for hepatitis C or other medical conditions that are exorbitantly priced but not factored into the calculation of our capitated rates for 2014;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and our ability to reduce over time the high medical costs commonly associated with new patient populations;
- the accurate estimation of incurred but not paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates or retroactive premium rate increases;
- efforts by states to recoup previously paid amounts, including claims by the Washington Health Care Authority (HCA) that it overpaid our Washington health plan for certain claims related to psychotropic drugs and the Washington Community Options Program Entry System (COPES);
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to increase our revenues consistent with our expectations;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- government audits and reviews, and any fine, enrollment freeze, or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable or unfavorable resolution of litigation, arbitration, or administrative proceedings;
- the relatively small number of states in which we operate health plans;
- our management of a portion of College Health Enterprises’ hospital in Long Beach, California;

- the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2013, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report, and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2013.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of March 31, 2014, these health plans served approximately 2.2 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplaces members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in California.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we classified the operations for our Missouri health plan as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Health Care Reform

We believe that the Affordable Care Act (defined below) will continue to provide us with significant opportunities for membership growth in our existing markets and, potentially, in new markets in the future as follows:

Medicaid Expansion. As of January 1, 2014, in the states that have elected to participate, the Affordable Care Act provides for the expansion of the Medicaid program to provide eligibility to nearly all low-income people under age 65 with incomes at or below 138 percent of the federal poverty line. Among the 11 states where we currently operate our health plans, the states of California, Illinois, Michigan, New Mexico, Ohio, and Washington participate in Medicaid expansion. In the first quarter of 2014, we added approximately 133,000 Medicaid expansion members, or 6% of total membership.

Health Insurance Marketplaces. On October 1, 2013, Health Insurance Marketplaces (Marketplaces) became available for consumers to access and begin the enrollment process for coverage beginning January 1, 2014. Marketplaces allow individuals and small groups to purchase health insurance that is federally subsidized. We participate in Marketplaces in all of the states in which we operate, except Illinois and South Carolina. In the first quarter of 2014, we added approximately 7,700 Marketplaces members, or 0.4% of total membership.

Dual Eligibles. Policymakers at the federal and state levels are increasingly developing initiatives, and the Centers for Medicare and Medicaid Services (CMS) has implemented several demonstrations, designed to improve the coordination of care for dual eligibles and reduce spending under Medicare and Medicaid. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for dual eligibles in the state. We refer to such demonstrations as our Medicare-Medicaid Plan (MMP) implementations. Our Illinois health plan began serving MMP members in March 2014. Our health plans in California, Ohio, Michigan and South Carolina intend to commence their MMP implementations during 2014 and early 2015.

Health Insurer Fee. In the first quarter of 2014, we adopted the guidance of the Financial Accounting Standards Board (FASB) related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA). The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. The health insurer fee (HIF) is imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year.

Effective January 1, 2014, we recorded our estimate of the 2014 liability to accounts payable and accrued liabilities, amounting to $88.8 million. We are amortizing this liability on a straight-line basis in 2014, and recorded $22.2 million to health insurer fee expenses in the first quarter of 2014. As enacted, this federal premium-based assessment is non-deductible for income tax purposes.

For further discussion of the risks and uncertainties relating to the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates - Health Plans Segment

Florida. On March 12, 2014, our Florida health plan entered into an agreement with Healthy Palm Beaches, Inc. (HPB) to acquire certain assets relating to HPB's Medicaid business for $8.0 million, subject to adjustment. Our Florida health plan expects to close on this transaction in the second quarter of 2014.

South Carolina. Our South Carolina health plan began serving 126,000 members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014. For further information refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 4, "Business Combinations."

Composition of Revenue and Membership

Health Plans Segment

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," is not generally subject to significant accounting estimates. For the three months ended March 31, 2014, we received approximately 97% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our Medicaid contracts with state agencies, Medicare and other managed care organizations for which we operate as subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the three months ended March 31, 2014, we recognized approximately 3% of our premium revenue in the form of "birth income"—a one-time payment for the delivery of a child—from the Medicaid programs in all of our state health plans except Illinois and New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans in the three months ended March 31, 2014, by program.

	Ending	PMPM Premiums		
	Membership	Low	High	Consolidated
Temporary Assistance for Needy Families (TANF)	1,575,300	$ 110.00	$ 320.00	$ 170.00
Aged, Blind or Disabled (ABD)	309,900	380.00	1,240.00	750.00
Medicaid Expansion	133,000	530.00	630.00	570.00
Children's Health Insurance Program (CHIP)	83,700	90.00	130.00	120.00
Medicare Special Needs Plans (Medicare)	41,400	530.00	1,340.00	1,240.00
Health Insurance Marketplaces (Marketplaces)	7,700	320.00	670.00	410.00

The following tables set forth our Health Plans segment membership as of the dates indicated:

	March 31, 2014	December 31, 2013	March 31, 2013
Health Plans Segment Ending Membership by Health Plan:			
California	418,000	368,000	332,000
Florida	91,000	89,000	75,000
Illinois	5,000	4,000	—
Michigan	218,000	213,000	217,000
New Mexico	183,000	168,000	91,000
Ohio	260,000	255,000	242,000
South Carolina (1)	126,000	—	—
Texas	246,000	252,000	274,000
Utah	80,000	86,000	87,000
Washington	434,000	403,000	416,000
Wisconsin	90,000	93,000	86,000
	2,151,000	1,931,000	1,820,000
Health Plans Segment Ending Membership by Program:			
TANF	1,575,300	1,503,800	1,402,000
ABD	309,900	288,600	269,300
Medicaid Expansion (2)	133,000	—	—
CHIP	83,700	99,200	114,400
Medicare	41,400	39,400	34,300
Marketplaces (3)	7,700	—	—
	2,151,000	1,931,000	1,820,000

(1) Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

(2) Medicaid Expansion membership phased in effective January 1, 2014.

(3) Marketplaces became available for consumers to access coverage beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service expenses:* Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. Nearly all hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis.

- *Capitation expenses:* Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.

- *Pharmacy expenses:* All drug, injectables, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses.

- *Direct delivery expenses:* All costs associated with our operation of primary care clinics are classified as direct delivery expenses.

- *Other medical expenses:* All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements in Note 10, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

First Quarter Financial Performance Summary, Continuing Operations

The following table and narrative briefly summarize our financial and operating performance from continuing operations for the three months ended March 31, 2014 and 2013. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue, the premium tax ratio is computed as a percentage of premium revenue plus premium tax revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended March 31,	
	2014	2013
	(Dollar amounts in thousands, except per share data)	
Net income per diluted share	$ 0.10	$ 0.65
Premium revenue	$ 1,940,337	$ 1,497,433
Service revenue	$ 53,630	$ 49,756
Operating income	$ 24,267	$ 67,873
Net income	$ 4,834	$ 30,522
Total ending membership	2,151,000	1,820,000
Premium revenue	93.8%	94.2%
Service revenue	2.6	3.1
Premium tax revenue	2.5	2.3
Health insurer fee revenue	0.9	—
Investment income	0.1	0.1
Other revenue	0.1	0.3
Total revenue	100.0%	100.0%
Medical care ratio	88.7%	86.0%
General and administrative expense ratio	9.1%	8.9%
Premium tax ratio	2.6%	2.4%
Operating income	1.2%	4.3%
Net income	0.2%	1.9%
Effective tax rate	53.9%	44.5%

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. Generally Accepted Accounting Principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended March 31,	
	2014	2013
	(In thousands)	
Net income	$ 4,498	$ 29,915
Adjustments:		
Depreciation, and amortization of intangible assets and capitalized software	25,914	21,799
Interest expense	13,822	13,037
Income tax expense	5,237	24,270
EBITDA	$ 49,471	$ 89,021

The second of these non-GAAP measures is adjusted net income, continuing operations. The following table reconciles net income from continuing operations, which we believe to be the most comparable GAAP measure, to adjusted net income, continuing operations.

	Three Months Ended March 31,			
	2014		2013	
	(In thousands, except diluted per-share amounts)			
Net income, continuing operations	$ 4,834	$ 0.10	$ 30,522	$ 0.65
Adjustments, net of tax:				
Depreciation, and amortization of capitalized software	12,998	0.27	10,679	0.23
Stock-based compensation	4,899	0.10	3,600	0.08
Amortization of convertible senior notes and lease financing obligations	4,205	0.10	2,345	0.05
Amortization of intangible assets	3,329	0.07	3,054	0.07
Change in fair value of derivatives	(1)	—	(75)	—
Adjusted net income, continuing operations	$ 30,264	$ 0.64	$ 50,125	$ 1.08

Analysis of First Quarter 2014 Financial Results - Trends and Developments

At our Investor Day on February 13, 2014, we stated that our first quarter results could be adversely affected by three factors: (A) general and administrative expenses incurred before related revenue is realized; (B) delays in securing agreements for the reimbursement (including reimbursement for tax impacts) of the HIF; and (C) delays in the recognition of quality or at risk performance related revenue.

Results reported for the first quarter of 2014 would have been higher except for:

(A) General and administrative expenses for which no related revenue was recognized reduced first quarter earnings by approximately $20 million, or $0.19 per diluted share (GAAP and adjusted basis). Our full year guidance for 2014 anticipates an administrative expense ratio of 7.5% for the fourth quarter of 2014.

(B) The absence of full reimbursement for the HIF reduced first quarter earnings by approximately $16 million, or $0.15 per diluted share (GAAP and adjusted basis). We had not secured agreements with the states of California, Michigan, New Mexico, Texas, Utah and South Carolina at the close of the first quarter 2014 for the reimbursement (including income tax effect) of the HIF. We remain guardedly optimistic that we will secure such agreements with all of our state partners prior to the close of 2014.

(C) The failure to recognize a portion of the Texas health plan's quality incentive revenue reduced first quarter earnings by approximately $6 million, or $0.06 per diluted share (GAAP and adjusted basis). Changes to the metrics associated with the achievement of that quality incentive revenue make it difficult to recognize revenue as of March 31, 2014. We remain guardedly optimistic that we will be able to recognize most of our quality revenue in Texas prior to the close of 2014.

Results of Operations, Continuing Operations

First Quarter of 2014 Compared with the Fourth Quarter of 2013

Diluted net income per share, continuing operations, increased to $0.10 in the first quarter 2014 from a diluted net loss per share, continuing operations of $0.20 in the fourth quarter of 2013. Adjusted net income per diluted share, continuing operations, similarly increased to $0.64 in the first quarter 2014, from $0.44 in the fourth quarter of 2013. First quarter 2014 financial results improved when compared with fourth quarter 2013 due to:

- An increase in total revenue of 21%; primarily due to our expansion into South Carolina, expanded member benefits in New Mexico and Florida, and substantial membership increases in California; and
- A decrease in the general and administrative expense ratio to 9.1%, from 11.0% in the fourth quarter of 2013; partially offset by
- The impact of that portion of the HIF not reimbursed by our state partners which reduced pretax income in the first quarter 2014 by approximately $16 million.

First Quarter of 2014 Compared with the First Quarter of 2013

Diluted net income per share, continuing operations decreased to $0.10 in the first quarter 2014, from $0.65 in the first quarter 2013. Adjusted net income per diluted share, continuing operations, similarly decreased to $0.64 in the first quarter 2014, from $1.08 in the first quarter 2013. Financial results for the first quarter of 2014 are difficult to compare with the first quarter of 2013 for the following reasons:

- The recognition in the first quarter 2013 of $24 million in revenue related to 2012 and 2011;

- The $16 million of HIF not reimbursed by our state partners in the first quarter 2014;
- The ‘gross up' of HIF revenue that was recognized in the quarter to compensate us for the lack of tax deductibility of the HIF;
- The $6 million of quality revenue not recognized in the first quarter 2014;
- An out of period benefit recorded at the Texas health plan in the first quarter of 2013 that improved that health plan’s financial performance by approximately $13 million over what it would have otherwise reported;
- The impact of lower margins associated with the startup of operations in South Carolina and the provision of new benefits to members in Florida and New Mexico; and
- The impact of a much higher effective tax rate in the first quarter 2014 due to the non-deductibility of the HIF.

Health Plans Segment

Premium Revenue

Premium revenue for the first quarter of 2014 increased 30% over the first quarter of 2013, due to a 19% increase in member months, and a 9% increase in revenue per member per month (PMPM). The 19% increase in member months was primarily due to the addition of Medicaid expansion membership at our health plans in California, New Mexico, Ohio and Washington, and the addition of Medicaid members at our South Carolina health plan, all effective January 1, 2014.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended March 31,					
	2014			2013		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 1,181,061	$ 183.21	68.6%	$ 866,755	$ 160.02	67.3%
Pharmacy	286,628	44.46	16.7	231,838	42.80	18.0
Capitation	169,439	26.28	9.8	140,324	25.91	10.9
Direct delivery	22,021	3.42	1.3	8,684	1.60	0.7
Other	62,509	9.71	3.6	40,314	7.44	3.1
Total	$ 1,721,658	$ 267.08	100.0%	$ 1,287,915	$ 237.77	100.0%

Our consolidated medical care ratio increased to 88.7% in the first quarter of 2014, from 86.0% in the first quarter of 2013.

Individual Health Plan Analysis

California. Medical margin improved at the California health plan $12.3 million, or approximately 40%, in the first quarter of 2014, when compared with the first quarter of 2013. Higher enrollment and higher PMPM premium—particularly as a result of the 47,000 members added due to Medicaid expansion—and a $5.0 million benefit from the rate settlement agreement with the California Department of Health Care Services (DHCS), were mainly responsible for the improved financial performance. The increase in medical margin at the California health plan was even more notable given the recognition of approximately $18 million in revenue in the first quarter of 2013 (without related medical expense offset) that related to 2012 and 2011.

Florida. Medical margin improved at the Florida health plan by $2.9 million because the higher dollar margins associated with the enrollment of long-term care members beginning in December 2013. Premiums for long-term care members are typically set at a higher medical care ratio than for our traditional membership, but the much larger premiums associated with long-term members often generate higher dollar margins despite lower percentage margins.

Illinois. The medical care ratio for the Illinois health plan was 95.5% in the first quarter of 2014. The Illinois health plan served its first member effective September 2013.

Michigan. Financial performance improved at the Michigan health plan in the first quarter of 2014, when compared with the first quarter of 2013, primarily due to an improved bed day management program and lower seasonal flu experience thus far in 2014. The medical care ratio of the Michigan health plan decreased to 78.0% in the first quarter of 2014, from 88.1% in the first quarter of 2013.

New Mexico. Medical margin improved at the New Mexico health plan in the first quarter of 2014, when compared with the first quarter of 2013, primarily due to increased revenues associated with the addition of approximately 91,000 Medicaid

members and the inclusion of additional member benefits into premium rates. The increased membership in 2014 includes the addition of approximately 30,000 Medicaid expansion members in the first quarter of 2014, and approximately 60,000 new members in 2013 relating to a business combination effective August 1, 2013. The medical care ratio of the New Mexico health plan increased to 87.3% in the first quarter of 2014, from 85.9% in the first quarter of 2013. The higher medical care ratio was primarily the result of the addition of Medicaid expansion members and the addition of Medicaid behavioral health and long-term care services effective January 1, 2014.

Ohio. Financial performance worsened slightly at the Ohio health plan in the first quarter of 2014, when compared with the first quarter of 2013, due to growth in ABD membership, which typically carries a higher medical care ratio. The medical care ratio of the Ohio health plan increased to 85.3% for the first quarter of 2014, from 84.6% for the first quarter of 2013.

South Carolina. The medical care ratio for the South Carolina health plan was 94.0% in the first quarter of 2014. The South Carolina health plan served its first members effective January 2014. Our experience has been that members transitioning from Medicaid fee-for-service into managed care (as is the case with our South Carolina membership) experience higher medical care costs during the initial months of their enrollment.

Texas. Financial performance worsened at the Texas health plan in the first quarter of 2014, when compared with the first quarter of 2013, due to a decrease in quality based revenue, increased profit rebates payable to the state of Texas, and the absence in 2014 of the substantial ($13.5 million) favorable prior period claims development that improved reported financial performance in the first quarter of 2013. The medical care ratio of the Texas health plan increased to 91.5% in the first quarter of 2014, from 80.9% in the first quarter of 2013.

Utah. Financial performance improved at the Utah health plan in the first quarter of 2014, when compared with the first quarter of 2013, due to improved performance in both the Medicaid and the Medicare lines of business. The medical care ratio of the Utah health plan decreased to 85.4% in the first quarter of 2014, from 86.8% in the first quarter of 2013.

Washington. Financial performance worsened at the Washington health plan in the first quarter of 2014, when compared with the first quarter of 2013, primarily due to a 7% decrease in premium rates effective January 2014. The medical care ratio of the Washington health plan increased to 92.2% in the first quarter of 2014, from 87.6% in the first quarter of 2013. The Washington health plan added approximately 49,000 Medicaid expansion members in the first quarter of 2014.

Wisconsin. Financial performance improved at the Wisconsin health plan in the first quarter of 2014, when compared with the first quarter of 2013. The medical care ratio of the Wisconsin health plan decreased to 74.8% in the first quarter of 2014, from 87.2% in the first quarter of 2013.

Health Insurer Fee Revenue and Expenses

Refer to "Liquidity and Capital Resources—Financial Condition" below, for a comprehensive discussion of the HIF.

Premium Tax Expense

Premium tax expense was 2.6% of premium revenue plus premium tax revenue in the three months ended March 31, 2014, compared with 2.4% in the three months ended March 31, 2013.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended March 31, 2014						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,254	$ 277,642	$ 221.42	$ 237,344	$ 189.28	85.5%	$ 40,298
Florida	270	105,166	389.67	93,461	346.30	88.9	11,705
Illinois (3)	14	15,171	1,078.41	14,494	1,030.28	95.5	677
Michigan	648	173,496	267.58	135,320	208.70	78.0	38,176
New Mexico	549	225,068	410.00	196,409	357.79	87.3	28,659
Ohio	772	278,295	360.62	237,328	307.53	85.3	40,967
South Carolina	394	96,020	243.41	90,262	228.82	94.0	5,758
Texas	749	320,096	427.27	292,958	391.05	91.5	27,138
Utah	246	78,654	319.96	67,200	273.37	85.4	11,454
Washington	1,276	323,461	253.48	298,107	233.61	92.2	25,354
Wisconsin	274	38,528	140.67	28,809	105.19	74.8	9,719
Other (4)	—	8,740	—	29,966	—	—	(21,226)
	6,446	$ 1,940,337	$ 301.00	$ 1,721,658	$ 267.08	88.7%	$ 218,679

	Three Months Ended March 31, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,001	$ 187,788	$ 187.55	$ 159,763	$ 159.56	85.1%	$ 28,025
Florida	223	58,164	260.13	49,404	220.95	84.9	8,760
Michigan	652	166,557	255.52	146,748	225.13	88.1	19,809
New Mexico	274	84,000	306.97	72,149	263.66	85.9	11,851
Ohio	726	268,808	370.44	227,454	313.45	84.6	41,354
Texas	832	329,451	395.96	266,449	320.24	80.9	63,002
Utah	259	74,956	289.59	65,029	251.24	86.8	9,927
Washington	1,250	298,286	238.70	261,397	209.18	87.6	36,889
Wisconsin	200	27,124	135.53	23,664	118.24	87.2	3,460
Other (3)(4)	—	2,299	—	15,858	—	—	(13,559)
	5,417	$ 1,497,433	$ 276.45	$ 1,287,915	$ 237.77	86.0%	$ 209,518

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) The MCR represents medical costs as a percentage of premium revenue.
(3) The Illinois health plan's results prior to October 1, 2013, were insignificant and reported in "Other."
(4) "Other" medical care costs include primarily medically related administrative costs at the parent company, and direct delivery costs.

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	March 31, 2014	December 31, 2013
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 592,403	$ 424,173
Pharmacy payable	51,743	45,037
Capitation payable	23,583	20,267
Other	151,812	180,310
	$ 819,541	$ 669,787

The following table provides detailed medical claims data for the periods presented:

	Three Months Ended March 31,		Year Ended December 31,
	2014	2013	2013
	(Dollars in thousands, except per-member amounts)		
Days in claims payable, fee for service	46	38	43
Number of claims in inventory at end of period	287,300	135,400	145,800
Billed charges of claims in inventory at end of period	$ 517,300	$ 236,700	$ 276,500
Claims in inventory per member at end of period	0.13	0.07	0.08
Billed charges of claims in inventory per member at end of period	$ 240.49	$ 130.05	$ 143.19
Number of claims received during the period	5,986,000	5,271,000	21,317,500
Billed charges of claims received during the period	$ 6,354,000	$ 5,170,700	$ 21,414,600

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended March 31,	
	2014	2013
	(In thousands)	
Service revenue before amortization	$ 54,359	$ 50,485
Amortization recorded as reduction of service revenue	(729)	(729)
Service revenue	53,630	49,756
Cost of service revenue	40,657	39,770
General and administrative costs	1,750	2,351
Amortization of customer relationship intangibles recorded as amortization	975	1,282
Operating income	$ 10,248	$ 6,353

Operating income for our Molina Medicaid Solutions segment increased $3.9 million for the three months ended March 31, 2014, compared with the same prior year period. The increase in operating income was primarily the result of increased revenues due to Medicaid Expansion membership.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 9.1% of total revenue for the three months ended March 31, 2014, compared with 8.9% of total revenue for the three months ended March 31, 2013, and declined from 11.0% in the fourth quarter of 2013. The year-over-year increase was primarily due to higher costs incurred as a result of continuing costs in connection with significant membership growth in 2014. General and administrative expense incurred during the three months ended March 31, 2014, for which no related revenue was recognized, amounted to approximately $20 million.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended March 31,			
	2014		2013	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 16,136	0.8%	$ 12,445	0.8%
Amortization of intangible assets, continuing operations	4,555	0.2	4,118	0.3
Depreciation and amortization, continuing operations	20,691	1.0	16,563	1.1
Depreciation and amortization, discontinued operations	—	—	2	—
Amortization recorded as reduction of service revenue	729	—	729	0.1
Amortization recorded as cost of service revenue	11,574	0.6	4,505	0.2
Depreciation and amortization reported in the consolidated statements of cash flows	$ 32,994	1.6%	$ 21,799	1.4%

Interest Expense

Interest expense increased to $13.8 million for the three months ended March 31, 2014, from $13.0 million for the three months ended March 31, 2013, primarily due to lease financing transactions in the second quarter of 2013. Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $6.7 million and $3.7 million for the three months ended March 31, 2014, and 2013, respectively.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 53.9% for the three months ended March 31, 2014, compared with 44.5% for the three months ended March 31, 2013. The disparity between rates in the first quarters of 2014 and 2013 is primarily due to the nondeductible HIF in 2014.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of March 31, 2014, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income was $1.6 million for the three months ended March 31, 2014, compared with $1.5 million for the three months ended March 31, 2013. Our annualized portfolio yield for the three months ended March 31, 2014 and 2013 was 0.4%.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Three Months Ended March 31,		
	2014	2013	Change
	(In thousands)		
Net cash provided by operating activities	$ 210,897	$ 20,104	$ 190,793
Net cash used in investing activities	(27,491)	(21,200)	(6,291)
Net cash (used in) provided by financing activities	(35,932)	374,837	(410,769)
Net increase in cash and cash equivalents	$ 147,474	$ 373,741	$ (226,267)

Operating Activities. Cash provided by operating activities increased $190.8 million, primarily due to the change in medical claims and benefits payable, which increased $153.1 million in connection with our membership growth in the first quarter of 2014 as described above.

Investing Activities. Cash used in investing activities increased $6.3 million, primarily due to increased Health Plans segment statutory deposit requirements resulting from membership growth in the first quarter of 2014, which is reflected in the increase in restricted investments.

Financing Activities. Cash used in financing activities for the first quarter of 2014 related primarily to the settlement of $38.1 million of contingent consideration liabilities for our 2013 South Carolina health plan acquisition. Financing activities generated net cash of $374.8 million in the first quarter of 2013, primarily due to the 1.125% Notes and related financing transactions, with no comparable activity in the first quarter of 2014.

Financial Condition

On a consolidated basis, at March 31, 2014, we had working capital of $725.3 million compared with $745.7 million at December 31, 2013. At March 31, 2014, and December 31, 2013, we had cash and investments, including restricted investments, of $1,872.5 million, and $1,712.9 million, respectively. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Health Insurer Fee. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government–funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. We continue to work with our state partners to obtain reimbursement for the full economic impact of the excise tax. Currently, we project that the HIF payable by September 30, 2014 will be $88.8 million. Because this amount is not deductible for income tax purposes, our net income will be reduced by the full amount of the assessment.

When states reimburse us for the amount of the HIF, that reimbursement will itself be subject to income tax, the HIF, and applicable state premium taxes. If our estimate of the $88.8 million HIF liability in 2014 is correct, and if our estimate of the amount allocable to Medicaid of approximately $81 million is correct, states will need to pay us an incremental amount of approximately $134 million in revenue during 2014 to account for the HIF and the absence of its tax deductibility. On a percentage basis, we anticipate that states will need to increase our Medicaid premium rates by approximately 1.4% to reimburse us for the HIF we will owe (based upon our estimated pro-rata share of total industry revenue in 2013). In addition,

we estimate that states will need to increase our Medicaid premium rates by a further 0.9% to make us whole for the lack of tax deductibility of the HIF, representing an estimated overall premium rate increase of approximately 2.3%.

As of May 1, 2014, we have contractual commitments from the states of Florida, Illinois, Ohio, Washington and Wisconsin to reimburse us by way of a lump sum payment for the full economic impact of the HIF in their respective states. While all of our remaining states have acknowledged the actuarial requirement that they reimburse us for the HIF, and its related income tax effects, no state other than those indicated above have contractually committed to do so.

Furthermore, states which have acknowledged the requirement to include the impact of the tax in our premium payments may argue that current premium rates will remain actuarially sound even if no adjustment is made to those rates. We continue to work with state officials to address the issue of fully grossed up reimbursement. If we are unable to obtain either premium increases or direct reimbursements to offset the impact of the tax on a fully grossed up basis, our business, financial condition, cash flows or results of operations could be materially adversely affected.

Regulatory Capital and Dividend Restrictions

For information on our regulatory capital requirements and dividend restrictions, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 15, "Commitments and Contingencies."

Future Sources and Uses of Liquidity

For information on our debt instruments, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Long-Term Debt."

For information on our shelf registration statement and our securities repurchase program, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 13, "Stockholders' Equity."

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2013, was disclosed in our 2013 Annual Report on Form 10-K. There were no material changes to this previously filed information outside the ordinary course of business during the three months ended March 31, 2014. For further discussion and maturities of our long-term debt, refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 11, "Long-Term Debt."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures; actual results could differ from these estimates. Our critical accounting estimates relate to:

- *Health Plans segment medical claims and benefits payable*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 10, "Medical Claims and Benefits Payable," for a table which presents the components of the change in medical claims and benefits payable, and for additional information regarding the factors used to determine our changes in estimates for all periods presented in the accompanying consolidated financial statements.
- *Health Plans segment contractual provisions with revenue or profit limits*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the first quarter of 2014 in connection with such contractual provisions.
- *Health Plans segment quality incentives*. Refer to Item 1 of this Form 10-Q, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," for a discussion of amounts recorded in the first quarter of 2014 in connection with such quality incentives.
- *Molina Medicaid Solutions segment revenue and cost recognition*.

There have been no significant changes during the three months ended March 31, 2014, to the items that we disclosed as our critical accounting estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2013.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently.

Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended March 31, 2014 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II. OTHER INFORMATION

Item 1. Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse

determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. Risk Factors

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A – Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2013. The risk factors described herein and in our 2013 Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

There have been no material changes to the risk factors disclosed in our 2013 Annual Report on Form 10-K.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

Issuer Purchases of Equity Securities

Share repurchase activity during the three months ended March 31, 2014 was as follows:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
January 1 – January 31	3,762	$ 34.75	—	$ 47,338,505
February 1 – February 28	42,890	$ 36.12	—	$ 47,338,505
March 1 – March 31	174,800	$ 37.68	—	$ 47,338,505
Total	221,452	$ 37.33	—	

(a) During the three months ended March 31, 2014, we withheld 221,452 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50.0 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This repurchase program extends through December 31, 2014.

Item 3. Defaults Upon Senior Securities

None.

Item 5. Other Information

None.

Item 6. Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 1, 2014

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: May 1, 2014

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

INDEX TO EXHIBITS

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2014 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 1, 2014

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2014 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 1, 2014

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2014 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 1, 2014

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2014 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 1, 2014

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

2013 MHI Form 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2013

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 28, 2013, the last business day of our most recently completed second fiscal quarter, was approximately $1,060.9 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 28, 2013).

As of February 20, 2014, approximately 45,977,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Stockholders to be held on April 30, 2014 of this Form 10-K.

Molina Healthcare, Inc.
Form 10-K

For the Year Ended December 31, 2013

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This Annual Report on Form 10-K ("Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, that involve risks and uncertainties. Many of the forward-looking statements are located under the headings "Business," and "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly from the results discussed in the forward-looking statements. Factors that might cause such differences include, but are not limited to, those discussed in Part I, Item 1A of this Form 10-K under the heading "Risk Factors," which are incorporated herein by reference. Each of the terms "Company," "Molina Healthcare," "we," "our," and "us," as used herein refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

PART I

Item 1: Business

OVERVIEW

Molina Healthcare provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program.

As of December 31, 2013, our health plans served approximately 1.9 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today, we remain a provider-focused company led by his son, Dr. J. Mario Molina.

Significant Accomplishments in 2013

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs. Our goal is to achieve this mission while improving our financial strength. Our significant operational, financial and strategic accomplishments supporting this goal during 2013 included:

- Expanding existing markets by acquiring a Medicaid contract in New Mexico, adding approximately 80,000 new members to our Health Plans segment.
- Entering new strategic markets by acquiring the rights to convert certain Medicaid enrollees covered by South Carolina’s new full-risk Medicaid managed care program effective January 1, 2014. On that date, we added approximately 137,000 members to our Health Plans segment.
- Funding future growth by entering into new debt (and related hedge transactions), and lease financing transactions which in aggregate generated net cash of approximately $482 million, after debt repayment and stock repurchases.
- Building our infrastructure to support our 2014 growth initiatives associated with the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA).

Our Structure

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. We derive our revenues primarily from health insurance premiums and service revenues. Refer to Part II, Item 7 of this Form 10-K, Management’s Discussion and Analysis of Financial Condition and Results of Operations, and Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements in Notes 2, "Significant Accounting Policies," and Note 21, "Segment Information," regarding revenue, profit and total asset information for each of our business segments, and revenue information by state health plan.

The Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in California. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements that limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation (DDI), and business process outsourcing (BPO) solutions to state governments for their Medicaid management information systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, the U.S. Virgin Islands, and a contract to provide pharmacy rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in 2010 to expand our product offerings to include support of state Medicaid agency administrative needs, reduce the variability in our earnings resulting from fluctuations in medical care costs, improve our operating profit margin percentages, and improve our cash flow by adding a business for which there are no restrictions on dividend payments.

Health Care Reform

The Affordable Care Act has changed, and will continue to make broad-based changes to, the U.S. health care system that could significantly affect the U.S. economy, and we expect will continue to significantly impact our business operations and financial results, including our medical care ratios. The ACA presents us with new business opportunities, but also with new financial and regulatory challenges.

Key components of the legislation will continue to be phased in over the next several years, with the most significant changes having occurred at the start of this year, including the implementation of the Medicaid expansion (in electing states), the Health Insurance Marketplaces, Medicare minimum medical loss ratios (MLRs), and new industry-wide fees, assessments, and taxes. We have dedicated material resources and have incurred material expenses in implementing and complying with the ACA, and we will continue to do so. As a result of the novelty and extremely broad scale of all of the programmatic changes effected by the ACA, many of the business and market impacts of the ACA will not be known for several years. Further, given the inherent difficulty of foreseeing how individuals will respond to the choices afforded to them by the ACA, we cannot predict the full effect the ACA will have on us.

Our Strategic Growth Initiatives

Our mission to provide quality health services to financially vulnerable families and individuals covered by government programs is the core philosophy that drives our strategic growth and growth-related initiatives to:

Expand Within Existing Markets

- New Mexico Health Plan - In August 2013, our New Mexico health plan closed on its acquisition of the Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program. As a result of this transaction, Lovelace's Medicaid members became our Medicaid members and now receive their Medicaid managed services and benefits from our New Mexico health plan. We expect the final purchase price for the acquisition, to be determined by the second quarter of 2014, to amount to approximately $ 53 million. As of December 31, 2013, our membership increased by approximately 80,000 members as a result of this transaction.

- Dual Eligibles - Nine million low-income elderly and disabled people in the United States are covered under both the Medicare and Medicaid programs. These beneficiaries, often called "dual eligibles" or simply "duals," are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for millions of elderly and under-65 disabled beneficiaries. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs.

  Policymakers at the federal and state levels are increasingly developing initiatives, and the Centers for Medicare and Medicaid Services (CMS) has implemented several demonstrations, designed to improve the coordination of care for dual eligibles and reduce spending under Medicare and Medicaid. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for dual eligibles in the state. We refer to such demonstrations as our Medicare-Medicaid Plan (MMP) implementations. Our health plans in California, Illinois, Ohio, Michigan and South Carolina intend to commence their MMP implementations during 2014.

- Medicaid Expansion - As of January 1, 2014, in the states that elect to participate, the ACA provides for the expansion of the Medicaid program to provide eligibility to nearly all low-income people under age 65 with incomes at or below 138 percent of the federal poverty line. As a result, millions of low-income adults without children who previously could not qualify for coverage, as well as many low-income parents and, in some instances, children covered through Children's Health Insurance Program (CHIP), are now eligible for Medicaid. Among the 11 states where we currently operate our health plans, the states of California, Illinois, Michigan, New Mexico, Ohio, and Washington have indicated that they intend to participate in the Medicaid expansion; and the states of Florida, South Carolina, Texas, Utah, and Wisconsin have indicated that they do not intend to participate in the expansion. In those states that

participate in the expansion, our Medicaid membership is likely to grow appreciably. We believe there are significant opportunities to increase our revenues through Medicaid expansion.

- Health Insurance Marketplaces - On October 1, 2013, Health Insurance Marketplaces became available for consumers to access and begin the enrollment process for coverage beginning January 1, 2014. Health Insurance Marketplaces allow individuals and small groups to purchase health insurance that is federally subsidized. We intend to participate in Health Insurance Marketplaces in all of the states in which we operate, except Illinois and South Carolina. We participate in the Health Insurance Marketplace primarily to continue to serve members whose income may fluctuate above the eligibility threshold for Medicaid, which is 138% of the federal poverty line. By retaining that member in the Health Insurance Marketplace, if the member's income subsequently declines, we will continuously serve that member in all instances.

- Direct Delivery - Growth and aging of the U.S. population foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to worsen this shortage. We believe the shortage will be felt most acutely among already under-served populations, such as the financially vulnerable families and individuals we serve. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging our direct delivery capability on a selective basis we can improve access for our plan members in areas that are most under-served by primary care providers. For instance, in the fourth quarter of 2013, we entered into a 10-year agreement with College Health Enterprises (CHE) to perform certain medical and administrative management services for CHE's hospital in Long Beach, California. Under the agreement, we will assume financial benefit and risk for a number of acute care beds at the hospital. We believe that this arrangement will improve hospital access for our members in the Long Beach, California area, and will also enhance our overall direct delivery strategy. As with any new start-up activity, we may incur losses while we modify various business operations during the initial months of the management services agreement.

Enter New Strategic Markets

We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size, and, where practicable, mandated Medicaid managed care enrollment. For instance, in July 2013 we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire the rights to convert certain of CHS' Medicaid members to be covered by South Carolina's full-risk Medicaid managed care program. On January 1, 2014, approximately 137,000 members who were covered under this program became members of our South Carolina health plan under this acquisition. We expect the final purchase price for the acquisition, to be determined by the second quarter of 2014, to amount to approximately $ 63 million.

Deliver Administrative Value to Medicaid Agencies

As Medicaid expenditures increase, we believe that an increasing number of states' and other Medicaid agencies will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state and other Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs. For example, Molina Medicaid Solutions of West Virginia secured a partnership with the U.S. Virgin Islands (USVI) in 2012, under which USVI's Medicaid claims are processed using West Virginia's certified MMIS. On August 1, 2013 the system went live, marking the first MMIS for a U.S. territory, and the first to be shared between two government agencies on a single business processing platform.

Leverage Operational Efficiencies

We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost. For example, in preparation for the growth initiatives described above, we augmented our infrastructure. Such preparations have included increased hiring during 2013 to support expansion of product development and pricing, network customization, and marketing; technology enhancements relating to premium billing and collections; and upgraded care management tools and telecommunications.

OUR INDUSTRY

Medicaid

Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs - one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states is currently about 57%, and ranges from a federally established FMAP floor of 50% to as high as 74%.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program (TANF), which covers primarily low-income mothers and children. Another common state-administered Medicaid program is for aged, blind or disabled (ABD) Medicaid beneficiaries, which covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients, and typically use more services because of their critical health issues. Additionally, CHIP is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs. As of December 31, 2013, approximately 76% of our members were TANF beneficiaries, 15% were ABD beneficiaries, 7% were CHIP beneficiaries, and 2% were Medicare beneficiaries.

Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. To improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by CMS. Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (PMPM) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

Medicaid Management Information Systems

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 75% of the costs incurred in operating an MMIS. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we actively participate in this market.

Competition

The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of Health care reform, business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- Multi-Product Managed Care Organizations - National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- Medicaid HMOs - National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- Prepaid Health Plans - Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- Primary Care Case Management Programs - Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan’s provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, and CNSI.

BUSINESS OPERATIONS

Our Strengths

From a strategic perspective, we believe our two business segments allow us to participate in an expanding sector of the economy and continue our mission to provide quality health services to financially vulnerable families and individuals covered by government programs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, cost management, and direct delivery of health care services, to state-level MMIS administration through our Molina Medicaid Solutions segment. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others. We also believe that we may have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. We believe that our Molina Medicaid Solutions platform, which is based on commercial off-the-shelf technology, has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our Health Plans segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The initial acquisitions of our New Mexico, South Carolina and Wisconsin health plans have demonstrated our ability to expand into new states. The establishment of our health plans in Florida, Illinois, Ohio, Texas and Utah reflects our ability to replicate our business model on a start-up basis in new states, while significant contract acquisitions in California, Michigan, New Mexico and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform and standardization of medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Recognition for Quality of Care. The National Committee for Quality Assurance, or NCQA, has accredited eight of our 11 Medicaid managed care plans. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our company in 1980 to serve the Medicaid population in Southern California through a small network of primary care clinics, we have increased our membership to 1.9 million members as of December 31, 2013, expanded our Health Plans segment to 11 states, and added our Molina Medicaid Solutions segment. Our experience over more than 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Pricing

Medicaid. Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members' health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state.

Medicare. Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and is adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment. Our Medicare Advantage contracts also provide a risk-sharing arrangement with CMS to limit our exposure to unfavorable expenses or benefit from favorable expenses.

Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proved to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use predictive modeling that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *"motherhood matters!*℠" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *"breathe with ease!*" is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15. *"Healthy Living with Diabetes*" is a diabetes disease management program. *"Heart Healthy Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate members on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members, to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations (IPAs). Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups (DRGs) capitation, and case rates.

Direct Delivery. The clinics we operate are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics we operate, and the clinics and hospital services we manage, assist us in developing and implementing community education, disease management, and other programs. Direct clinic management experience also enables us to better understand the needs of our contracted providers.

Reinsurance

Our health plans currently have reinsurance agreements with an unaffiliated insurer to cover certain claims. We enter into these contracts to reduce the risk of catastrophic losses which in turn reduce our capital and surplus requirements. We frequently evaluate reinsurance opportunities and review our reinsurance and risk management strategies on a regular basis.

Management Information Systems

All of our health plan information technology systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- Provider Self Services - Providers have the ability to access information regarding their members and claims. Key functionalities include "Check Member Eligibility," "View Claim," and "View/Submit Authorizations."

- Member Self Services - Members can access information regarding their personal data, and can perform the following key functionalities: "View Benefits," "Request New ID Card," "Print Temporary ID Card," and "Request Change of Address/PCP."

- File Exchange Services - Various trading partners, such as service partners, providers, vendors, management companies, and individual IPAs, are able to exchange data files (such as those that may be required by federal health care privacy regulations, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness Data and Information Set (HEDIS), and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT system).

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan’s ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS). Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

CONTRACTING AND REGULATORY COMPLIANCE

Government Contracts

Medicaid. In all the states in which we operate health plans, we enter into a contract with the state's Medicaid agency to offer managed care benefits to Medicaid-eligible individuals. Some states award contracts to any applicant demonstrating that it meets the state's requirements, while other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population; for example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. We are regulated by the state agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. For example, we must demonstrate that:

- Our provider network is adequate;
- Our quality and utilization management processes comply with state requirements;
- We have adequate procedures in place for responding to member and provider complaints and grievances;
- We can meet requirements for the timely processing of provider claims:
- We can collect and analyze the information needed to manage our quality improvement activities;
- We have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs;
- We have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion; and
- We have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Our state contracts determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and dis-enrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan.

The contractual relationship with the state is generally for a period of three to four years and is renewable on an annual or biennial basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months' prior written notice.

Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals (RFP), subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, in early 2012 our Missouri health plan was notified that it was not awarded a new contract under that state's RFP, and therefore its contract expired on June 30, 2012.

Medicare. Under annually renewable contracts with CMS, our state health plans offer Medicare Advantage special needs plans which include a mandatory Part D prescription drug benefit. Molina Medicare Options Plus, our trade name for these plans, serves beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically under-served families and individuals. We employ sales personnel, and engage independent brokers, agents and consults to enroll new Molina Medicare Options Plus members. None of our health plans operates a Medicare Advantage private fee-for-service plan.

Total enrollment in our Medicare Advantage plans as of December 31, 2013 was approximately 39,000 members. For the year ended December 31, 2013, Medicare premium revenues in the aggregate represented approximately 9% of our total premium revenues.

Federal regulations place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. Additionally, there are certain restrictions on agent and broker compensation.

Molina Medicaid Solutions. We continually monitor the status of various states' legacy MMIS capabilities and contracts to determine whether Molina Medicaid Solutions' value proposition and core strengths will address a state's MMIS goals. Once an RFP with a Medicaid agency is won, our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we deliver extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the initial terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. The terms of our other Molina Medicaid Solutions contracts - which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) - are shorter in duration than our Idaho and Maine contracts.

The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 75% of the costs incurred in operating a certified MMIS. Federal certification increases the share of the claims processing costs the federal government will pay for monthly operations. With an uncertified system, the federal government contributes approximately 50% of claims processing costs, with the state paying the other half. With a certified system, the federal government pays 75% of costs, reducing the state's share.

Regulatory Compliance

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

Health Care Federal Excise Tax. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. In Medicaid, capitation rates paid to managed care plans are required to be developed using principles of actuarial soundness. Actuarial soundness requires that the full costs of doing business, including the costs of both federal and state taxes, be considered and factored into the applicable payment to the health plan. Thus, for Medicaid managed care plans like Molina Healthcare, the excise tax should be included in the plans' capitated rates. However, because of the novelty of this new tax, states have been slow to factor the tax into the premiums paid to us. Moreover, because the tax will be based on a health plan's market share as applied to a total excise tax base of $8 billion in 2014 (and rising substantially thereafter), there is uncertainty regarding the precise amount of the tax that will be assessed on us.

For further discussion of the risks and uncertainties relating to this excise tax, refer to Part II, Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, under the subheading "Liquidity and Capital Resources -- Financial Condition."

States' Risk-Based Capital Requirements. Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital (RBC) requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners (NAIC) and are administered by the states. All of our state health plans are subject to RBC requirements, except California and Florida. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute. For further information regarding RBC requirements, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20, "Commitments and Contingencies."

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the American Recovery and Reinvestment Act of 2009, or ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. HHS, as required by the HITECH Act, has issued interim final rules that set forth the breach notification obligations applicable to covered entities and their business associates, or the HHS Breach Notification Rule. The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as *"qui tam"* actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Act of 2005 (DRA), encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

OTHER INFORMATION

Intellectual Property

We have registered and maintain various service marks, trademarks and trade names that we use in our businesses, including marks and names incorporating the "Molina" or "Molina Healthcare" phrase, and from time to time we apply for additional registrations of such marks. We utilize these and other marks and names in connection with the marketing and identification of products and services. We believe such marks and names are valuable and material to our marketing efforts.

Employees

As of December 31, 2013, we had approximately 8,200 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Available Information

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

You can access our website at *www.molinahealthcare.com* to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors committee charters, and Code of Business Conduct and Ethics from our website. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Executive Officers of the Registrant

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
J. Mario Molina	5 5	President and Chief Executive Officer
John C. Molina, J.D.	49	Chief Financial Officer
Terry P. Bayer	63	Chief Operating Officer
Joseph W. White	5 5	Chief Accounting Officer
Jeff D. Barlow	5 1	Chief Legal Officer and Corporate Secretary

Dr. Molina has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board of Directors since 1996. Dr. Molina is the brother of John C. Molina.

Mr. Molina has served as Chief Financial Officer since 1995. He also has served as a member of the Board of Directors since 1994. Mr. Molina is the brother of Dr. J. Mario Molina.

Ms. Bayer has served as Chief Operating Officer since 2005.

Mr. White has served as Chief Accounting Officer since 2007.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010. From 2004 to 2010, Mr. Barlow served as Vice President, Assistant Secretary, and Assistant General Counsel of Molina Healthcare.

Item 1A: Risk Factors

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This Annual Report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the U.S. Securities Exchange Commission, or SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Segment

Numerous risks associated with the Affordable Care Act and its implementation could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act (collectively, the Affordable Care Act, or ACA). The ACA enacts comprehensive changes to the United States health care system, elements of which will be phased in at various stages over the next several years. However, the most significant changes effected by the ACA were implemented as of January 1, 2014. There are a multitude of risks associated with the scope of change in the health care system represented by the ACA, including, but not limited to, the following:

- *Risks associated with the health care federal excise tax* . One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums. However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. In Medicaid, capitation rates paid to managed care plans are required to be developed using principles of actuarial soundness. Actuarial soundness requires that the full costs of doing business, including the costs of both federal and state taxes, be considered and factored into the applicable payment to the health plan. Thus, for Medicaid managed care plans like Molina Healthcare, the excise tax should be included in the plans' capitated rates. However, because of the novelty of this new tax, states have been slow to factor the tax into the premiums paid to us. Moreover, because the tax will be based on a health plan's market share as applied to a total excise tax base of $8 billion in 2014 (and rising substantially thereafter), there is uncertainty regarding the precise amount of the tax that will be assessed on us. While we and others in the health plan industry are working with Congress to delay and/or repeal the tax on Medicaid plans, we are also working with our state partners to obtain reimbursement for the full economic impact of the excise tax. However, state budget constraints, inaccurate actuarial calculations, political opposition to the ACA, inadequate federal oversight of actuarial soundness, and market competition, could result in a failure to receive

reimbursement for the full economic impact of the tax. Currently, we project that the excise tax assessed on us in August 2014 will be approximately $85 million. Because this amount is not deductible for income tax purposes, our net income will be reduced by the full amount of the assessment. For example, based on our total net income for fiscal years 2013 and 2012 of approximately $53 million and $10 million, respectively, the excise tax could exceed the entire amount of our earnings. Our efforts at obtaining relief from the tax are complicated by the fact that any amounts paid to us by the states in reimbursement of the excise tax must include a gross up for the absence of tax deductibility of the excise tax and applicable state premium taxes; and the amount paid for the gross up will itself be subject to the excise tax, its related non-deductibility and applicable state premium taxes. In other words, when states reimburse us for the amount of the excise tax, that reimbursement will itself be subject to income tax, the excise tax, and applicable state premium taxes. If our estimate of an $85 million excise tax liability in 2014 is correct, and if our estimate of the amount allocable to Medicaid of $79 million is correct, states will need to pay us an incremental amount of approximately $128 million in revenue during 2014 to account for the excise tax and the absence of its tax deductibility. On a percentage basis, we anticipate that states will need to increase our Medicaid premium rates by approximately 1.4% to reimburse us for the excise tax we will owe (based upon our estimated pro rata share of total industry revenue in 2013). In addition, we estimate that states will need to increase our Medicaid premium rates by a further 0.9% to make us whole for the lack of tax deductibility of the excise tax, representing an estimated overall premium rate increase of approximately 2.3%. As of February 26, 2014, we have contractual commitments from the states of Washington and Wisconsin to reimburse us by way of a lump sum payment for the full economic impact of the excise tax in their respective states. While all of our remaining states have acknowledged the actuarial requirement that they reimburse us for the federal excise tax, and its related income tax effects, no state other than Washington and Wisconsin has contractually committed to do so. Furthermore, states which have acknowledged the requirement to include the impact of the tax in our premium payments may argue that current premium rates will remain actuarially sound even if no adjustment is made to those rates. The tax is required to be paid in full by September 30, 2014. We are continuing to work with our states to address the issue of fully grossed up reimbursement. If we are unable to obtain either premium increases or direct reimbursements to offset the impact of the tax on a fully grossed up basis, our business, financial condition, cash flows or results of operations could be materially adversely affected.

- *Risks associated with the duals expansion*. Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries, often called “dual eligibles,” are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for the nearly 50 million elderly and under-65 disabled beneficiaries in 2012. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare’s premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. Policymakers at the federal and state level are increasingly developing initiatives for dual eligibles, both to improve the coordination of their care, and to reduce spending. The Centers for Medicare and Medicaid Services (CMS) has implemented several demonstration projects designed to improve the coordination of care for dual eligibles and to reduce Medicare and Medicaid spending. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for dual eligibles in the relevant state. Our health plans in California, Illinois, Ohio, Michigan, South Carolina and Texas intend to take part in the duals demonstrations in those states. Our California health plan intends to serve duals in Riverside, San Bernardino, and San Diego counties beginning in April 2014, and in Los Angeles County no sooner than July 2014. Our Illinois health plan will begin serving duals in March 2014. Our Ohio health plan will serve duals in three regions in Ohio, beginning with the Southwest region in June 2014, and the Central and Central West regions in July 2014. Our Michigan health plan will serve duals in Wayne and Macomb counties beginning in October 2014. Our South Carolina health plan will serve duals starting in July 2014. Finally, our Texas health plan is expected to begin serving duals in January 2015.

  There are numerous risks associated with the initial implementation of a new program, with a health plan’s expansion into a new service area, and with the provision of medical services to a new population which has not previously been in managed care. One such risk is the development of actuarially sound rates. Because there is limited historical information on which to develop rates, certain assumptions are required to be made which may subsequently prove to have been inaccurate. Rates of utilization could be significantly higher than had been projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, because of our lack of actuarial experience for that program, region, or population, our reserve levels may be set at an inadequate level. For instance, these problems arose at our Texas health plan in the second quarter of 2012, leading to extremely elevated medical care costs and substantial losses at the health plan. All of these risks are presented in the implementation of the duals demonstration programs. In the event these risks materialize at one or more of our health plans, the negative results of the health plan or plans could adversely affect our business, financial condition, cash flows, or results of operations.

- *Risks associated with the Medicaid expansion* . Among other things, as of January 1, 2014, in the states that elect to participate, the ACA provides for the expansion of the Medicaid program to provide eligibility to nearly all low-income people under age 65 with incomes at or below 138 percent of the federal poverty line. As a result, millions of low-income adults without children who previously could not qualify for coverage, as well as many low-income parents and, in some instances, children covered through CHIP, are now eligible for Medicaid. As of December 31, 2013, among the states where we currently operate our health plans, the states of California, Illinois, Michigan, New Mexico, Ohio, and Washington have indicated that they intend to participate in the Medicaid expansion; and the states of Florida, South Carolina, Texas, Utah, and Wisconsin have indicated that they do not intend to participate in the expansion. In those states that participate in the expansion, our Medicaid membership is likely to grow appreciably. The new enrollees in our health plans will represent a population that is different from the population of Medicaid enrollees we have historically managed. In addition, such enrollees may be unfamiliar with managed care, and may have substantial pent-up demand for medical services that could result in greater than anticipated rates of utilization. All of the risk factors described above with regard to the duals demonstration programs apply equally to Medicaid expansion.

- *Risks associated with health insurance marketplaces* . Under the ACA, online health insurance marketplaces are organized on a state-by-state basis, although in many instances a state insurance marketplace is operated by the federal government. In the insurance marketplace, individuals and groups can purchase health insurance that is federally subsidized up to 400% of the applicable federal poverty level. We will be participating as a qualified health plan, or QHP, in the insurance marketplaces in nine of the 11 states in which we currently operate our health plans (with Illinois and South Carolina being the sole exceptions). Our principal focus in participating in the marketplace is to capture the “churn” in membership that may result from a Medicaid member’s income rising above the 138% level of the federal poverty line. By retaining that member in our marketplace plan or QHP, if the member’s income subsequently declines, we will continuously serve that same member in all instances and not “lose” the member to another health plan. All of the risk factors described above with regard to the duals demonstration programs apply equally to our participation in the insurance marketplaces.

- *Risk associated with implementing regulations* . There are many parts of the ACA that require further guidance in the form of regulations. Due to the breadth and complexity of the ACA, the lack of implementing regulations and interpretive guidance, and the phased nature of the ACA’s implementation, the overall impact of the ACA on our business and on the health industry in general over the coming years is difficult to predict and not yet fully known, and implementing regulations could contain provisions that have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The exorbitant cost of the recently FDA-approved drug, Sovaldi, could have a material adverse effect on the level of our medical costs and our results of operations.

On December 6, 2013, the Food and Drug Administration, or FDA, approved for the treatment of hepatitis C the Gilead drug, Sovaldi (generic name, sofosbuvir). Because Sovaldi was approved for use after 2014 rates had already been calculated, the cost of claims for the treatment of hepatitis C using Sovaldi were not factored into the calculation of actuarially sound rates. Since Gilead has priced a standard twelve-week course of treatment with Sovaldi at approximately $84,000, the omission of that cost in our 2014 rates is a significant issue.

This issue is made worse by the relatively high incidence of hepatitis C, particularly in the Medicaid population. According to the CDC, hepatitis C is the most common chronic blood borne infection in the United States, with an estimated 3.2 million persons chronically infected. However, the actual incidence of hepatitis C may be significantly higher because of inadequate screening for the disease. In June 2013, the U.S. Public Health Services Task Force (USPSTF) released a new recommendation for hepatitis C screening. As a result, a number of individuals who were not previously aware that they had hepatitis C will likely learn of their infection, and seek treatment. Moreover, many of the newly insured under the Affordable Care Act Medicaid expansion have not received any health care treatment in the past because they lacked health insurance or were unable to pay for treatment. Finally, anecdotal data suggests that a number of medical providers have delayed initiating any alternative treatment regimen for their hepatitis C patients because they knew Sovaldi would soon become available. Thus, for all of these reasons, there is likely a significant pent-up demand for hepatitis C treatment using Sovaldi, and the number of Medicaid beneficiaries seeking such treatment could be substantial.

Molina is actively seeking guidance from state Medicaid agencies clarifying that it will not be expected to pay for the costs associated with Sovaldi coverage, or, in the event it is required to do so, that Molina will receive appropriate and actuarially sound reimbursement. In the event Molina is required to bear such costs without an appropriate rate adjustment or other reimbursement mechanism, our business, financial condition, cash flows, or results of operations could be adversely affected.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio, continuing operations, for the year ended December 31, 2013 of 87.1% had been one percentage point higher, or 88.1%, our net income from continuing operations for the year ended December 31, 2013 would have been approximately $0.12 per diluted share rather than our actual income from continuing operations of $0.96 per diluted share, a decrease of approximately 87%.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual flu season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs remain elevated at the same time that state budgets are suffering from significant fiscal strain. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it is a prime target for cost-containment efforts. All of the states in which we currently operate our health plans are currently facing significant budgetary pressures. These budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction proposals would fundamentally change the structure and financing of the Medicaid program. Recently, various proposals have been advanced to reduce annual federal deficits and to slow the increase in the national debt. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

In addition, potential reductions in Medicare and Medicaid spending have been included in discussions in Congress regarding deficit reduction measures. The Budget Control Act of 2011 provides that Medicare payments may be reduced by no more than 2%. We are unable to determine how any future Congressional spending cuts will affect Medicare and Medicaid reimbursement. There likely will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such “incurred but not paid” (IBNP) medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to duals, Medicaid expansion members, or aged, blind or disabled Medicaid members, is impacted by the more limited experience we have had with those populations. With regard to the new previously uninsured Medicaid members we began to enroll commencing January 1, 2014 due to the Medicaid expansion under the ACA, certain new members may be disproportionately costly due to high utilization in their first several months of Medicaid membership as a result of their previously having been uninsured and therefore not seeking, or deferring, medical treatment.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

An increased incidence of flu in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results during 2009 were significantly impacted by the widespread incidence of the H1N1 flu in the states in which we operated our health plans. We seek to set our IBNP reserves appropriately to account for seasonal spikes in the incidence of the flu. However, if the actual utilization rates of our members are higher than we had anticipated, our results in the relevant periods could be materially and adversely affected.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. In the event the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of the unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. Further, most of our contracts are terminable without cause.

Our government contracts generally run for periods of one to four years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. Although our health plans have generally been successful in obtaining the renewal and/or extension of their state contracts, there can be no guarantee that any of our state government contracts will be renewed or extended, as shown by the loss of our Missouri contract in 2012 in connection with an unsuccessful RFP bid. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

States may not adequately compensate us for the value of drug rebates that were previously earned by us but that are now collectible by the states.

ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers have renegotiated or discontinued their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours continue to remain at levels that are much lower than prior to ACA implementation. There are provisions in the ACA that require rates paid to Medicaid managed care plans to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from 11 state health plans. If we are unable to continue to operate in any of those 11 states, or if our current operations in any portion of the states we are in are significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic, an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

There are performance risks and other risks associated with certain provisions in the state Medicaid contracts of several of our health plans.

The state contracts of our New Mexico, Ohio, Texas, and Wisconsin health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, the health plan will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations. In addition, the state contracts of our California, Florida, New Mexico, Texas, and Washington health plans, and our contract with CMS, contain provisions pertaining to medical cost floors, administrative cost and profit ceilings, and profit-sharing arrangements. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the sometimes complicated contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. For instance, during 2010, due to a prolonged budget impasse, some of the monthly premium payments made by the state of California to our California health plan were several months late. Any significant delay in the monthly payment of premiums to

any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we are required to return any alleged overpayments to the Washington Health Care Authority, our results of operations may be adversely affected.

The Washington Health Care Authority (HCA) has communicated to our Washington health plan that it believes it has erroneously overpaid the plan with regard to certain claims, including claims for psychotropic drugs, and claims for health plan members under the Washington Community Options Program Entry System (COPES). HCA claims the alleged overpayments date back to the July 1, 2012 start date of the current contract. Because of the unilateral errors underlying the overpayments, HCA has indicated an intent to seek recoupment of the allegedly overpaid amounts. In the event that, as a result of this unilateral and unsubstantiated error by HCA, our Washington health plan is required to disgorge to HCA rate amounts that had been previously paid to it, our results of operations in the quarter such disgorgement occurred would be adversely affected.

Reductions in Medicare payments could reduce our earnings potential for our Medicare Advantage plans and our duals demonstration programs.

The Sequestration Transparency Act of 2012 included a 2% reduction of payments from CMS to our Medicare Advantage plans beginning April 1, 2013. Medicare Advantage plans will continue to be affected until Congress lifts the sequestration mandated under the Sequestration Transparency Act of 2012. The impact of sequestration cuts on our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements paid to those providers with rates indexed to the Medicare fee-for-service reimbursement rates. Such reduction in our Medicare payments may have an adverse effect on our earnings potential for our Medicare Advantage plans and our duals demonstration programs. In addition, reductions to provider reimbursement rates associated with sequestration may adversely impact our relations with the impacted providers.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets-particularly operators of large commercial health plans-have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us, or at all, or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years, or that we will not complete acquisitions that turn out to be unfavorable. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

In addition, we may be unable to successfully identify, consummate and integrate future acquisitions, including integrating the acquired businesses on our information technology platform, or to implement our operations strategy in order to operate acquired businesses profitably. Furthermore, we may incur significant transaction expenses in connection with a potential acquisition which may or may not be consummated. These expenses could impact our selling, general and administrative expense ratio.

For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws which may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as “fraud and abuse” laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties, and assessments. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. Many states, including states where we currently operate, have enacted parallel legislation. In the event we are subject to liability under a *qui tam* action, our business, financial condition, cash flows, or results of operations could be adversely affected.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

The U.S. Department of Health and Human Services, or HHS, has released rules pursuant to the Health Insurance Portability and Accountability Act, or HIPAA, which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. Originally, the federal government required that health care organizations, including health insurers, upgrade to updated and expanded standardized code sets used for documenting health conditions by October 2013. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. However, CMS has now postponed implementation of ICD-10 to October 1, 2014. Use of the ICD-10 code sets will require significant administrative changes and may result in errors and otherwise negatively impact our service levels. In addition, we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, results of operations, and cash flows.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped when the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which we do not participate. These actions and the resulting negative publicity could become associated with or imputed to us, regardless of our actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which we do not participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. For the years ended December 31, 2013, 2012 and 2011, we received dividends from our health plan subsidiaries amounting to $ 24.4 million, $101.8 million and $86.3 million, respectively. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2013, 2012 and 2011, without approval of the regulatory authorities, were approximately $54 million, $24 million, and $18 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our convertible senior notes, including the notes offered hereby, or any credit facility.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A security breach or unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process, and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The Health Information Technology for Economic and Clinical Health Act, or HITECH, provisions of the American Recovery and Reinvestment Act of 2009, further expand the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, increasing penalties for violations, and requiring public disclosure of improper disclosures of the health information of more than 500 individuals.

Under HITECH, civil penalties for HIPAA violations by covered entities and business associates are increased up to an amount of $1.5 million per calendar year for HIPAA violations. In addition, imposition of these penalties is now more likely because HITECH strengthens enforcement. For example, HHS conducts periodic audits to confirm compliance. Investigations of violations that indicate willful neglect, for which penalties are now mandatory, are statutorily required. In addition, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. In addition, HITECH requires us to notify affected individuals, HHS, and in some cases the media when unsecured protected health information is subject to a security breach.

HITECH also contains a number of provisions that provide incentives for providers and states to initiate certain programs related to health care and health care technology, such as electronic health records. While some HITECH provisions may not apply to us directly, states wishing to apply for grants under HITECH, or otherwise participating in such programs, may impose new health care technology requirements on us through our contracts with state Medicaid agencies. We are unable to predict what such requirements may entail or what their effect on our business may be.

On January 25, 2013, HHS, as required by HITECH, issued the Final Omnibus Rules that provide final modifications for the implementation of HITECH. The various requirements of HITECH have different compliance dates, some of which have passed and some of which will occur in the future. We will continue to assess our compliance obligations as regulations under HITECH are promulgated and more guidance becomes available from HHS and other federal agencies. The new HITECH privacy and security requirements, however, may require substantial operational and systems changes, employee education and resources and there is no guarantee that we will be able to implement them adequately or prior to their effective date. Given HIPAA's complexity and the new regulations, which may be subject to changing and perhaps conflicting interpretation, our ongoing ability to comply with all of the HIPAA requirements is uncertain, which may expose us to the criminal and increased civil penalties provided under HITECH and may require us to incur significant costs in order to seek to comply with its requirements.

While we currently expend significant resources and have implemented solutions, processes and procedures to protect against cyber-attacks and security breaches, we may need to expend additional significant resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world, we may be unable to proactively address these techniques or to implement adequate preventive measures.

Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third-party service providers, may be vulnerable to security breaches, acts of vandalism, acts of malicious insiders, computer viruses, misplaced or lost data, programming and/or human errors, or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could subject us to civil and criminal penalties, divert management's time and energy and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Risks Related to the Operation of Our Molina Medicaid Solutions Segment

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently has management contracts in only six states. If we are unable to continue to operate in any of those six states, or if our current operations in any of those six states are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, in 2012, the government contract of Molina Medicaid Solutions in Louisiana was subject to competitive bidding, and we were unsuccessful in being awarded a new contract. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these

contracts less profitable or unprofitable, which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business could be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results and damage our reputation.

Computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business or retain existing MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance on contracts, including those on which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties, including software and hardware vendors, to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenues and profitability.

Risks Related to our General Business Operations

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

We expect to continue to grow our membership and to expand into other markets through acquisitions and other opportunities. Continued rapid growth could place a significant strain on our management and on our other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, or results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to

protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability, and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of our clinics or caused by one of our employees. We maintain medical malpractice insurance for our clinics in an amount which we believe to be reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC, or other regulatory authorities which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles (GAAP) and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes, such as the health care federal excise tax discussed above. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations could have a material adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. It is critical that we recruit, manage, enable, and retain talent to successfully execute our strategic objections which requires aligned policies, a positive work environment, and a robust succession and talent development process. Further, particularly in light of the changing healthcare environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. If we are unsuccessful in recruiting, retaining, managing, and enabling such personnel and are unable to meet upcoming challenges and opportunities, our operations could be negatively impacted.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could adversely impact our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2013, the balance of goodwill was $230.7 million. As of December 31, 2013, the balance of intangible assets, net, was $98.9 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives.

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable.

The determination of the value of goodwill, and intangible assets, net, requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

We are subject to the risks of the owning and leasing of real property.

We are a tenant under numerous leases in multiple states, including a 25-year lease of an approximately 460,000 square foot office building housing our principal executive offices in Long Beach, California. We also own a 150,000 square-foot office building in Troy, Michigan, a 26,000 square-foot data center in Albuquerque, New Mexico, and a community clinic in Pomona, California. Accordingly, we are subject to all of the risks generally associated with leasing and owning real estate, which include, but are not limited to: the possibility of environmental contamination, the costs associated with fixing any environmental problems and the risk of damages resulting from such contamination; adverse changes in the value of the property due to interest rate changes, changes in the neighborhood in which the property is located, or other factors; ongoing maintenance expenses and costs of improvements; the possible need for structural improvements in order to comply with changes in zoning, seismic, disability act, or other requirements; inability to renew or enter into leases for space not utilized by us on commercially acceptable terms or at all; and possible disputes with neighboring owners or other individuals and entities.

Risks Related to Our Common Stock

Delaware law and our charter documents may impede or discourage a takeover, which could cause the market price of our common stock to decline.

We are a Delaware corporation, and the anti-takeover provisions of Delaware law impose various impediments to the ability of a third party to acquire control of us, even if a change in control would be beneficial to our existing stockholders. In addition, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock and certain provisions of Delaware law and our certificate of incorporation and bylaws could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock and the value of your notes.

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $10.75 to a high of $40.90. A number of factors could continue to influence the market price of our common stock, including:

- the implementation of the ACA and duals demonstration programs,
- state and federal budget pressures,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- changes in government payment levels,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies in the health care industry,
- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change,
- general economic conditions, including unemployment rates, inflation, and interest rates, and

- the other factors set forth under "Risk factors" in this Annual Report on Form 10-K.

Our common stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our common stock does not continue to develop, securities analysts may not maintain or initiate research coverage of us and our common stock, and this could depress the market for our common stock.

Members of the Molina family own a significant amount of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate owned or were entitled to receive upon certain events approximately 36% of our capital stock as of December 31, 2013. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election of directors, amendments to our charter, and any merger, consolidation, or sale of our company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2013, approximately 45,871,000 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Item 1B: Unresolved Staff Comments

None.

Item 2: Properties

The Health Plans segment leases a total of 66 facilities and the Molina Medicaid Solutions segment leases a total of 13 facilities. We own a 150,000 square-foot office building in Troy, Michigan, a 26,000 square-foot data center in Albuquerque, New Mexico, and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operations growth prospects to determine if additional space is required, and where it would be best located.

Item 3: Legal Proceedings

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20, "Commitments and Contingencies," for a discussion of legal proceedings.

Item 4: Mine Safety Disclosures

None.

PART II

Item 5: Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of February 20, 2014, there were approximately 125 holders of record of our common stock. The high and low intra-day sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2013		
First Quarter	$ 33.85	$ 25.70
Second Quarter	$ 38.74	$ 30.26
Third Quarter	$ 40.90	$ 33.31
Fourth Quarter	$ 37.39	$ 31.10
2012		
First Quarter	$ 36.83	$ 22.25
Second Quarter	$ 35.37	$ 17.63
Third Quarter	$ 27.73	$ 21.62
Fourth Quarter	$ 29.82	$ 21.74

Dividends

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business growth. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Any future determination to pay dividends will be at the discretion of our Board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, in "Liquidity and Capital Resources," under the subheading "Regulatory Capital and Dividend Restrictions."

Unregistered Issuances of Equity Securities

None.

Stock Repurchase Programs

Securities Repurchases and Repurchase Programs. Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. As indicated in the table below, we repurchased 85,086 shares of our common stock for an average price of $31.28 under this program in November 2013. This newly authorized repurchase program extends through December 31, 2014, and replaces in its entirety the $75 million repurchase program adopted by the board of directors on February 13, 2013.

Common Stock Repurchase in Connection with Offering of 1.125% Cash Convertible Senior Notes Due 2020. We used a portion of the net proceeds in this offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2013, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (1)	Average Price Paid per Share (1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs
October 1 — October 31	1,690	$ 36.27	—	$ 50,000,000
November 1 — November 30	1,857	$ 31.61	85,086	$ 47,338,505
December 1 — December 31	25,078	$ 34.68	—	$ 47,338,505
Total	28,625	$ 34.58	85,086	

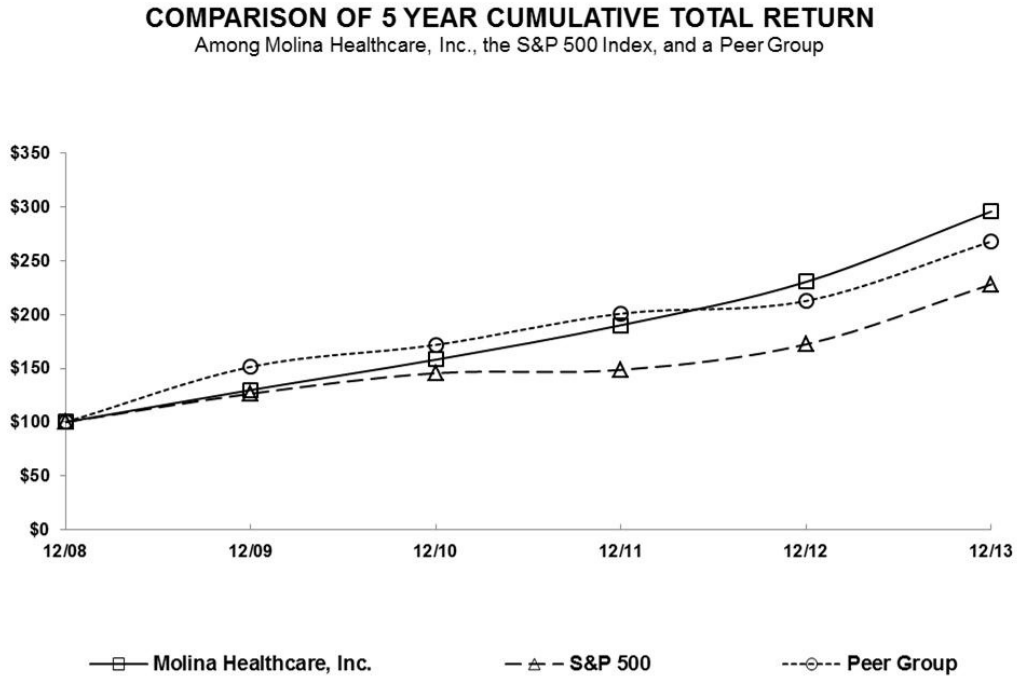
(1) During the quarter we withheld 28,625 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the SEC (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (S&P 500) and a peer group index for the five-year period from December 31, 2008 to December 31, 2013. The comparison assumes $100 was invested on December 31, 2008, in the Company's common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.

The peer group index consists of Centene Corporation (CNC), Community Health Systems, Inc. (CYH), Coventry Health Care, Inc. (CVH), Health Management Associates, Inc. (HMA), Health Net, Inc. (HNT), Laboratory Corporation of America Holdings (LH), Lifepoint Hospitals, Inc. (LPNT), Magellan Health Services, Inc. (MGLN), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), and WellCare Health Plans, Inc. (WCG).



	December 31,					
Name	2008	2009	2010	2011	2012	2013
Molina Healthcare, Inc.	$ 100.00	$ 129.87	$ 158.15	$ 190.20	$ 230.49	$ 296.00
S&P 500	100.00	126.46	145.51	148.59	172.37	228.19
Peer Group	100.00	151.46	171.84	200.93	212.70	268.11

Item 6. Selected Financial Data

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics, Continuing Operations") for the five years ended December 31, 2013 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollar amounts are presented in thousands, except per-share data. The data under the caption "Operating Statistics, Continuing Operations" has not been audited.

	Year Ended December 31,				
	2013	2012	2011	2010 (2)	2009
Statements of Income Data (1):					
Revenue:					
Premium revenue	$ 6,179,170	$ 5,544,121	$ 4,211,493	$ 3,632,142	$ 3,297,733
Premium tax revenue	172,017	158,991	154,589	139,775	128,581
Service revenue (2)	204,535	187,710	160,447	89,809	—
Investment income	6,890	5,075	5,446	6,198	8,936
Rental income and other revenue	26,322	18,312	8,288	7,140	3,671
Total revenue	6,588,934	5,914,209	4,540,263	3,875,064	3,438,921
Operating expenses:					
Medical care costs	5,380,124	4,991,188	3,664,161	3,190,566	2,984,651
Cost of service revenue (2)	161,494	141,208	143,987	78,647	—
General and administrative expenses	665,996	518,615	393,452	326,193	252,643
Premium tax expenses	172,017	158,991	154,589	139,775	128,581
Depreciation and amortization	72,743	63,114	48,253	43,246	35,649
Total operating expenses	6,452,374	5,873,116	4,404,442	3,778,427	3,401,524
Gain on purchase of convertible senior notes	—	—	—	—	1,532
Operating income	136,560	41,093	135,821	96,637	38,929
Other expenses, net:					
Interest expense	52,071	16,769	15,519	15,509	13,777
Other expense, net	3,343	945	—	—	—
Total other expenses, net	55,414	17,714	15,519	15,509	13,777
Income from continuing operations before income taxes	81,146	23,379	120,302	81,128	25,152
Income tax expense	36,316	10,513	42,914	30,511	1,970
Income from continuing operations	44,830	12,866	77,388	50,617	23,182
Income (loss) from discontinued operations, net of tax (benefit) expense (3)	8,099	(3,076)	(56,570)	4,353	7,686
Net income	$ 52,929	$ 9,790	$ 20,818	$ 54,970	$ 30,868
Basic income per share:					
Income from continuing operations	$ 0.98	$ 0.28	$ 1.69	$ 1.23	$ 0.60
Income (loss) from discontinued operations	0.18	(0.07)	(1.24)	0.11	0.20
Basic net income per share	$ 1.16	$ 0.21	$ 0.45	$ 1.34	$ 0.80
Diluted income per share					
Income from continuing operations	$ 0.96	$ 0.27	$ 1.67	$ 1.22	$ 0.59
Income (loss) from discontinued operations	0.17	(0.06)	(1.22)	0.10	0.20
Diluted net income per share	$ 1.13	$ 0.21	$ 0.45	$ 1.32	$ 0.79
Weighted average number of common shares outstanding	45,717,000	46,380,000	45,756,000	41,174,000	38,765,000
Weighted average number of common shares and potential dilutive common shares outstanding	46,862,000	46,999,000	46,425,000	41,631,000	38,976,000
Operating Statistics, Continuing Operations:					
Medical care ratio (4)	87.1%	90.0%	87.0%	87.8%	90.5%
General and administrative expense ratio (5)	10.1%	8.8%	8.7%	8.4%	7.3%
Premium tax ratio (6)	2.7%	2.8%	3.5%	3.7%	3.8%
Members (7)	1,931,000	1,797,000	1,618,000	1,532,000	1,377,000

	Year Ended December 31,				
	2013	2012	2011	2010	2009
Balance Sheet Data:					
Cash and cash equivalents	$ 935,895	$ 795,770	$ 493,827	$ 455,886	$ 469,501
Total assets	3,002,937	1,934,822	1,652,146	1,509,214	1,244,035
Long-term debt, including current maturities (8)	784,862	262,939	218,126	164,014	158,900
Total liabilities	2,110,000	1,152,508	897,073	790,157	701,297
Stockholders' equity	892,937	782,314	755,073	719,057	542,738

(1) As previously reported, on February 17, 2012 the Division of Purchasing of the Missouri Office of Administration notified our Missouri health plan that it was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, the Missouri health plan's existing contract with the state expired without renewal on June 30, 2012. In connection with this notification, the Missouri heath plan recorded a non-cash impairment charge of $64.6 million in the fourth quarter of 2011. Effective in 2013, upon the termination of the transition obligations associated with that contract and abandonment of our equity interest in the Missouri health plan, we have recast the results relating to the Missouri health plan as discontinued operations for all periods presented.

(2) Service revenue and cost of service revenue represent revenue and costs generated by our Molina Medicaid Solutions segment. Because we acquired this business on May 1, 2010, results for the year ended December 31, 2010 include eight months of results for this segment.

(3) Income (loss) from discontinued operations is presented net of income tax (benefit) expense of $(9,912), $(1,238), $922, $4,011, and $5,319, respectively.

(4) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, utilization of medical services, our ability to effectively manage costs, contract changes, and changes in accounting estimates related to incurred but not paid claims. See Item 7 in this Form 10-K, "Management's Discussion and Analysis of Financial Condition and Results of Operations," for further discussion.

(5) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(6) Premium tax ratio represents such expenses as a percentage of premium revenue plus premium tax revenue.

(7) Number of members at end of period.

(8) Includes convertible senior notes, lease financing obligations, and other long-term debt.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with Items 6 and 8 of this Form 10-K, Selected Financial Data, and Financial Statements and Supplementary Data, respectively. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth in Part I, Item 1A of this Form 10-K, Risk Factors.

Discontinued Operations. We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal on June 30, 2012. Effective June 30, 2013, the transition obligations associated with that contract terminated. Therefore, we have reclassified the results relating to the Missouri health plan to discontinued operations for all periods presented. These results are presented in a single line item, net of taxes, in the consolidated statements of income. Additionally, we abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of $9.5 million, which is also included in discontinued operations in the consolidated statements of income. The Missouri health plan's premium revenues amounted to $0.2 million, $114.4 million and $229.6 million for the years ended December 31, 2013, 2012 and 2011, respectively.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of December 31, 2013, these health plans served approximately 1.9 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in California.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Fiscal Year 2013 Financial Highlights

- Net income from continuing operations increased to $44.8 million in 2013, from $12.9 million in 2012 as a result of higher medical margin (measured as the excess of premium revenue over medical care costs). Higher medical margin was partially offset by increased administrative expenses related to our preparations for significant membership growth expected in 2014.
- Premium revenue in 2013 increased 11% over 2012, due to a 6% increase in enrollment (on a member-month basis), and a 5% increase in revenue per member per month (PMPM).
- Excluding our Illinois health plan, which was not operational until 2013, eight of our nine health plans reported higher medical margins in 2013 than in 2012. The consolidated medical margin increased by approximately 45% year over year. Our consolidated medical care ratio (measured as medical care costs as a percentage of premium revenue) decreased to 87.1% in 2013, from 90.0% in 2012.
- General and administrative expenses increased to 10.1% of revenue in 2013, from 8.8% in 2012. Increased administrative expenses related to anticipated membership growth represented approximately 2% of premium revenue, or $135 million during 2013.
- We entered into new debt (and related hedge transactions), and lease financing transactions which in aggregate generated net cash of approximately $482 million, after debt repayment and stock repurchases.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA) has changed, and will continue to make broad-based changes to, the U.S. health care system which could significantly affect the U.S. economy, and we expect will continue to significantly impact our business operations and financial results, including our medical care ratios. We believe that the ACA presents us with new business opportunities as described below, but also with new financial and regulatory challenges as described further below in "Liquidity and Capital Resources," under the subheading "Financial Condition."

Dual Eligibles. Policymakers at the federal and state levels are increasingly developing initiatives, and the Centers for Medicare and Medicaid Services (CMS) has implemented several demonstrations designed, to improve the coordination of care for dual eligibles and reduce spending under Medicare and Medicaid. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for dual eligibles in the state. We refer to such demonstrations as our Medicare-Medicaid Plan (MMP) implementations. Our health plans in California, Illinois, Michigan, Ohio and South Carolina intend to commence their MMP implementations during 2014.

Medicaid Expansion. The ACA also provides for expanded Medicaid coverage which became effective in January 2014, but remains subject to implementation at the state level. As of December 31, 2013, among the 11 states where we currently operate our health plans, the states of California, Illinois, Michigan, New Mexico, Ohio, and Washington have indicated that they intend to participate in the Medicaid expansion; and the states of Florida, South Carolina, Texas, Utah, and Wisconsin have indicated that they do not intend to participate in the expansion. We believe there are significant opportunities to increase our revenues through Medicaid expansion.

Health Insurance Marketplaces. Health Insurance Marketplaces became available for consumers to access coverage beginning January 1, 2014. In some instances, Health Insurance Marketplaces allow individuals and small groups to purchase health insurance that is federally subsidized. We intend to participate in Health Insurance Marketplaces in all of the states in which we operate, except Illinois and South Carolina. We participate in the Health Insurance Marketplace primarily to serve our members who have lost Medicaid eligibility.

Market Updates

For a discussion of the market updates for the Health Plans and Molina Medicaid Solutions segments, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 1, "Basis of Presentation" under the subheadings "Market Updates - Health Plans Segment," and "Market Updates - Molina Medicaid Solutions Segment."

Composition of Revenue and Membership

Health Plans Segment

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits such as pharmacy services, behavioral health services, or long-term care services; populations such as the aged, blind or disabled (ABD); and regions or service areas.

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2 "Significant Accounting Policies," is not generally subject to significant accounting estimates. For the year ended December 31, 2013, we received approximately 97% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the year ended December 31, 2013, we recognized approximately 3% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program (CHIP) members are generally among our lowest, with rates as low as approximately $90 PMPM in Washington. Premium revenues for Medicaid members are generally higher. Among the TANF, Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $270 in Ohio. Among our ABD membership, PMPM premiums range from approximately $400 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, long-term care, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums in the aggregate, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2013	2012	2011
Total Membership by Health Plan (1)(2):			
California	368,000	336,000	355,000
Florida	89,000	73,000	69,000
Illinois	4,000	—	—
Michigan	213,000	220,000	222,000
New Mexico	168,000	91,000	88,000
Ohio	255,000	244,000	248,000
Texas	252,000	282,000	155,000
Utah	86,000	87,000	84,000
Washington	403,000	418,000	355,000
Wisconsin	93,000	46,000	42,000
	1,931,000	1,797,000	1,618,000
Membership for our Medicare Advantage Plans (2):			
California	8,800	7,700	6,900
Florida	600	900	800
Michigan	10,400	9,700	8,200
New Mexico	900	900	800
Ohio	500	300	200
Texas	2,800	1,500	700
Utah	8,300	8,200	8,400
Washington	7,100	6,500	5,000
	39,400	35,700	31,000
Membership for our Aged, Blind or Disabled Population (2):			
California	46,700	44,700	31,500
Florida	14,700	10,300	10,400
Illinois	4,000	—	—
Michigan	45,300	41,900	37,500
New Mexico	11,300	5,700	5,600
Ohio	32,000	28,200	29,100
Texas	90,200	95,900	63,700
Utah	9,700	9,000	8,500
Washington	33,000	30,000	4,800
Wisconsin	1,700	1,700	1,700
	288,600	267,400	192,800

(1) The state of South Carolina's new full-risk Medicaid managed care program became effective January 1, 2014. On that date, our South Carolina health plan added approximately 137,000 members.

(2) Membership reported for our Medicare Advantage Plans, and for our Aged, Blind or Disabled Population is included in Total Membership by Health Plan.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. For further information regarding revenue recognition for the Molina Medicaid Solutions segment, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

- *Fee-for-service:* Nearly all hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit manager. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Direct delivery:* Costs associated with our operation and/or management of primary care clinics and hospital services in California, Florida, New Mexico, Virginia, and Washington.

- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2013, 2012, and 2011, medically related administrative costs were $153.0 million, $125.2 million, and $99.3 million, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Estimates" below, and Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

2013 Financial Performance Summary, Continuing Operations

The following table briefly summarizes our financial and operating performance from continuing operations for the years ended December 31, 2013, 2012, and 2011. All ratios, with the exception of the medical care ratio and the premium tax ratio, are computed as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue, and the premium tax ratio is computed as a percentage of premium revenue plus premium tax revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Year Ended December 31,		
	2013	2012	2011
	(Dollar amounts in thousands, except per-share data)		
Net income per diluted share	$ 0.96	$ 0.27	$ 1.67
Adjusted net income per diluted share	$ 3.13	$ 1.72	$ 2.93
Premium revenue	$ 6,179,170	$ 5,544,121	$ 4,211,493
Service revenue	$ 204,535	$ 187,710	$ 160,447
Operating income	$ 136,560	$ 41,093	$ 135,821
Net income	$ 44,830	$ 12,866	$ 77,388
Total ending membership	1,931,000	1,797,000	1,618,000
Premium revenue	93.8%	93.7%	92.8%
Premium tax revenue	2.6%	2.7%	3.4%
Service revenue	3.1%	3.2%	3.5%
Investment income	0.1%	0.1%	0.1%
Rental income and other revenue	0.4%	0.3%	0.2%
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	87.1%	90.0%	87.0%
General and administrative expense ratio	10.1%	8.8%	8.7%
Premium tax ratio	2.7%	2.8%	3.5%
Operating income	2.1%	0.7%	3.0%
Net income	0.7%	0.2%	1.7%
Effective tax rate	44.8%	45.0%	35.7%

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, our financing and business decisions, and in forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in evaluating our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for Generally Accepted Accounting Principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization (EBITDA). The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Net income	$ 52,929	$ 9,790	$ 20,818
Adjustments:			
Depreciation and amortization reported in the consolidated statements of cash flows	93,866	78,764	74,383
Interest expense	52,071	16,769	15,519
Income tax expense	26,404	9,275	43,836
EBITDA	$ 225,270	$ 114,598	$ 154,556

The second of these non-GAAP measures is adjusted net income per diluted share, continuing operations. The following table reconciles net income per diluted share, which we believe to be the most comparable GAAP measure, to adjusted net income per diluted share.

	Year Ended December 31,		
	2013	2012	2011
Net income per diluted share, continuing operations	$ 0.96	$ 0.27	$ 1.67
Adjustments, net of tax:			
Depreciation, and amortization of capitalized software	0.98	0.75	0.64
Stock-based compensation	0.52	0.31	0.23
Amortization of convertible senior notes and lease financing obligations	0.31	0.08	0.07
Amortization of intangible assets	0.28	0.29	0.32
Change in fair value of derivatives	0.08	0.02	—
Adjusted net income per diluted share, continuing operations	$ 3.13	$ 1.72	$ 2.93

Results of Operations, Continuing Operations

Year Ended December 31, 2013 Compared with the Year Ended December 31, 2012

Health Plans Segment

Premium Revenue

Premium revenue in 2013 increased 11% over 2012, due to a 6% increase in member months, and a 5% increase in revenue PMPM. Medicare premium revenue was approximately $526 million in the year ended December 31, 2013, compared with approximately $468 million in the year ended December 31, 2012. The shift in member mix to populations generating higher premium revenue PMPM and expanded benefits observed in 2012, was less pronounced in 2013.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 3,611,529	$ 160.43	67.1%	$ 3,423,751	$ 161.67	68.6%
Pharmacy	935,204	41.54	17.4	835,830	39.47	16.7
Capitation	603,938	26.83	11.2	552,136	26.07	11.1
Direct delivery	48,288	2.14	0.9	33,920	1.60	0.7
Other	181,165	8.05	3.4	145,551	6.87	2.9
	$ 5,380,124	$ 238.99	100.0%	$ 4,991,188	$ 235.68	100.0%

Excluding our Illinois health plan, which was not operational until 2013, eight of our nine health plans reported higher medical margins in 2013 than in 2012. The consolidated medical margin increased by approximately 45% year over year. Our consolidated medical care ratio (measured as medical care costs as a percentage of premium revenue) decreased to 87.1% in 2013, from 90.0% in 2012.

Individual Health Plan Analysis

Financial performance improved at the California health plan in 2013, when compared with 2012, primarily due to the receipt of premium rate increases for both TANF and ABD membership; and lower inpatient facility costs for the TANF membership. Approximately $32 million of premium revenue received and recognized in 2013 related to 2012 and earlier years. The medical care ratio at the California health plan decreased to 88.9% in 2013 from 91.1% in 2012.

The medical care ratio of the Florida health plan increased to 87.3% in 2013, from 85.3% in 2012 due to higher fee-for-service costs that more than offset lower pharmacy costs.

The medical care ratio for the Illinois health plan was 96.9% in 2013. The Illinois health plan served its first member effective September 2013.

Financial performance improved at the Michigan health plan in 2013, when compared with 2012. The medical care ratio of the Michigan health plan decreased to 84.4% in 2013, from 88.3% in 2012, primarily due to lower fee-for-service and pharmacy costs for both the ABD and the TANF membership.

Financial performance improved at the New Mexico health plan in 2013, when compared with 2012. The medical care ratio of the New Mexico health plan decreased to 86.1% in 2013, from 87.0% in 2012, primarily as a result of higher Medicaid premium rates PMPM effective January 1, 2013, and stable medical costs PMPM. The New Mexico health plan added approximately 80,000 new members in 2013, as a result of its acquisition of Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program effective August 1, 2013.

Financial performance improved at the Ohio health plan in 2013, when compared with 2012. The medical care ratio of the Ohio health plan decreased to 84.2% in 2013, from 88.6% in 2012, primarily due to lower fee-for-service and pharmacy costs for both the ABD and the TANF membership. Financial performance deteriorated in the second half of 2013 due to both premium decreases, and increases to fee schedules effective July 1, 2013, that combined to reduce medical margin approximately 3% for

the second half of 2013. We also experienced an additional 1.5% decrease in premium rates in Ohio effective July 1, 2013, due to a re-basing of revenue risk adjusters.

Financial performance improved at the Texas health plan in 2013, when compared with 2012. The medical care ratio of the Texas health plan decreased to 86.4% in 2013, from 93.7% in 2012, primarily due to rate increases received on September 1, 2013 and 2012, respectively.

Financial performance deteriorated at the Utah health plan in 2013, when compared with 2012. Reductions to the medical portion of the Medicaid premium, and the addition of the pharmacy benefit to our Medicaid premium, both effective January 1, 2013, more than offset stable medical costs. The medical care ratio of the Utah health plan increased to 83.4% in 2013, from 82.3% in 2012.

The medical care ratio of the Washington health plan increased to 88.0% in 2013, compared with 86.8% in 2012, due to the addition of ABD members effective July 1, 2012 and lower TANF premium rates. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio, so that medical margin increased to $140.2 million in 2013, from $129.0 million in 2012.

Financial performance improved at the Wisconsin health plan in 2013, when compared with 2012. The medical care ratio of the Wisconsin health plan decreased to 79.7% in 2013, compared with 96.2% in 2012, due to both higher revenue PMPM and lower fee-for-service physician, specialty and outpatient costs PMPM. Additionally, the health plan gained approximately 50,000 members in the first half of 2013 due to another health plan's recent exit from the market.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2013						
	Member Months(2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,233	$ 749,755	$ 177.10	$ 666,592	$ 157.46	88.9%	$ 83,163
Florida	973	264,998	272.23	231,261	237.57	87.3	33,737
Illinois [4]	7	8,121	1,201.34	7,869	1,164.10	96.9	252
Michigan	2,581	676,000	261.91	570,644	221.09	84.4	105,356
New Mexico	1,492	446,758	299.36	384,466	257.62	86.1	62,292
Ohio	3,007	1,098,795	365.44	924,675	307.53	84.2	174,120
Texas	3,178	1,291,001	406.27	1,114,852	350.84	86.4	176,149
Utah	1,040	310,895	299.05	259,397	249.51	83.4	51,498
Washington	4,941	1,168,405	236.47	1,028,210	208.10	88.0	140,195
Wisconsin	1,060	143,465	135.40	114,340	107.91	79.7	29,125
Other [4] [5]	—	20,977	—	77,818	—	—	(56,841)
	22,512	$ 6,179,170	$ 274.48	$ 5,380,124	$ 238.99	87.1%	$ 799,046

	Year Ended December 31, 2012						
	Member Months(2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,177	$ 665,600	$ 159.36	$ 606,494	$ 145.20	91.1%	$ 59,106
Florida	850	228,832	269.36	195,226	229.80	85.3	33,606
Michigan	2,639	646,551	244.97	570,636	216.20	88.3	75,915
New Mexico	1,069	321,853	301.08	280,108	262.03	87.0	41,745
Ohio	3,065	1,095,137	357.36	970,504	316.69	88.6	124,633
Texas	3,245	1,233,621	380.18	1,155,433	356.08	93.7	78,188
Utah	1,026	298,392	290.78	245,671	239.41	82.3	52,721
Washington	4,600	974,712	211.91	845,733	183.87	86.8	128,979
Wisconsin	508	70,678	139.25	67,968	133.91	96.2	2,710
Other (4) (5)	—	8,745	—	53,415	—	—	(44,670)
	21,179	$ 5,544,121	$ 261.79	$ 4,991,188	$ 235.68	90.0%	$ 552,933

(1) Premium revenue for the Missouri health plan was $0.2 million and $114.4 million for the years ended December 31, 2013 and 2012, respectively. Medical care costs for the Missouri health plan were $1.5 million and $105.6 million for the years ended December 31, 2013 and 2012, respectively. These amounts are excluded from the tables above.

(2) A member month is defined as the aggregate of each month's ending membership for the period presented.

(3) "MCR" represents medical costs as a percentage of premium revenue.

(4) The results of the Illinois health plan, until it became operational in 2013, were insignificant and reported in "Other."

(5) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$ 207,449	$ 189,281
Amortization recorded as reduction of service revenue	(2,914)	(1,571)
Service revenue	204,535	187,710
Cost of service revenue	161,494	141,208
General and administrative costs	5,285	17,648
Amortization of customer relationship intangibles	5,127	5,127
Operating income	$ 32,629	$ 23,727

Operating income for our Molina Medicaid Solutions segment improved $8.9 million for the year ended December 31, 2013, compared with 2012. The increase in operating income was primarily the result of additional sales in existing markets, and the favorable resolution of certain contingencies related to the Maine contract.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 10.1% of revenue in 2013, from 8.8% in 2012, primarily due to higher costs incurred as we prepared for significant membership growth anticipated in 2014. Increased administrative expenses related to anticipated membership growth represented approximately 2% of premium revenue, or $135 million during 2013.

Premium Tax Expense

Premium tax expense was consistent year over year.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of service revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,			
	2013		2012	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 54,837	0.8%	$ 42,938	0.7%
Amortization of intangible assets, continuing operations	17,906	0.3	20,176	0.3
Depreciation and amortization, continuing operations	72,743	1.1	63,114	1.0
Depreciation and amortization, discontinued operations	2	—	590	—
Amortization recorded as reduction of service revenue	2,914	—	1,571	—
Amortization of capitalized software recorded as cost of service revenue	18,207	0.3	13,489	0.2
	$ 93,866	1.4%	$ 78,764	1.2%

Interest Expense

Interest expense was $52.1 million for the year ended December 31, 2013, compared with $16.8 million for the year ended December 31, 2012. Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $22.8 million and $5.9 million for the years ended December 31, 2013 and 2012, respectively. The increase in interest expense for the year ended December 31, 2013, was primarily due to our issuance of $550.0 million aggregate principal amount 1.125% cash convertible senior notes due 2020 (the 1.125% Notes) in the first quarter of 2013. Interest expense in 2013 also included the immediate recognition of approximately $6 million in debt issuance costs associated with this transaction. The remaining fees associated with that issuance, amounting to approximately $12 million, are being amortized over the life of the 1.125% Notes.

For the year ended December 31, 2013, interest expense also includes amounts relating to lease financing transactions executed in the second quarter of 2013. As described in further detail Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12 "Long-Term Debt," lease payments under these transactions adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income.

Other Expenses, Net

Other expenses, net increased to $3.3 million for the year ended December 31, 2013, from $0.9 million for the year ended December 31, 2012. Other expenses, net include primarily gains or losses associated with changes in the fair value of our derivative financial instruments. In the second quarter of 2013 we recorded a one-time non-cash charge of $3.9 million related to the change in fair value of warrants issued in connection with the 1.125% Notes. We settled the interest rate swap in the second quarter of 2013, which resulted in a gain of $0.4 million, partially offsetting the $3.9 million charge described above. Other expenses (income) was $0.9 million for the year ended December 31, 2012, primarily due to the change in fair value of the interest rate swap.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 44.8% for the year ended December 31, 2013, compared with 45.0% for the year ended December 31, 2012.

Results of Operations, Continuing Operations

Year Ended December 31, 2012 Compared with the Year Ended December 31, 2011

Premium Revenue

We earned premium revenues of $5.5 billion, up 32% in the year ended December 31, 2012, compared with the year ended December 31, 2011, primarily due to a shift in member mix to populations generating higher premium revenue PMPM, benefit expansions, and an increase in membership. Medicare premium revenue was $468 million for the year ended December 31, 2012, compared with $388 million for the year ended December 31, 2011.

Growth in our ABD membership led to higher premium revenue PMPM in 2012. ABD membership, as a percent of total membership, increased approximately 25% year over year. Premium revenue PMPM also increased in the year ended December 31, 2012, as a result of the inclusion of revenue from pharmacy benefit for our Ohio health plan effective October 1, 2011, and as a result of the inclusion of revenue from inpatient facility and pharmacy benefits across all of our Texas health plan membership effective March 1, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 3,423,751	$ 161.67	68.6%	$ 2,587,380	$ 136.72	70.6%
Pharmacy	835,830	39.47	16.7	418,019	22.09	11.4
Capitation	552,136	26.07	11.1	505,892	26.73	13.8
Direct delivery	33,920	1.60	0.7	29,683	1.57	0.8
Other	145,551	6.87	2.9	123,187	6.51	3.4
	$ 4,991,188	$ 235.68	100.0%	$ 3,664,161	$ 193.62	100.0%

The medical care ratio increased to 90.0% for the year ended December 31, 2012, compared with 87.0% for the year ended December 31, 2011.

Individual Health Plan Analysis

The medical care ratio of the California health plan increased to 91.1% for the year ended December 31, 2012, from 86.9% for the year ended December 31, 2011. As noted above, margins on newly transitioned ABD members were considerably less than those experienced by the Company overall.

The medical care ratio of the Florida health plan decreased to 85.3% for the year ended December 31, 2012, from 91.9% for the year ended December 31, 2011, due to a premium rate increase effective September 1, 2011, the re-contracting of portions of the health plan's specialty care network, lower inpatient utilization and lower pharmacy costs.

The medical care ratio of the Michigan health plan increased to 88.3% for the year ended December 31, 2012, from 86.3% for the year ended December 31, 2011. The deterioration in the Michigan plan's medical care ratio was the result of higher pharmacy and fee for service costs. We received a blended rate increase in Michigan of approximately 2%, effective October 1, 2012.

The medical care ratio of the New Mexico health plan increased to 87.0% for the year ended December 31, 2012, from 84.4% for the year ended December 31, 2011, primarily as a result of lower premiums and higher inpatient facility costs. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011.

The medical care ratio of the Ohio health plan increased to 88.6% for the year ended December 31, 2012, from 84.1% for the year ended December 31, 2011. The increase in the Ohio health plan's medical care ratio was partially the result of a 2% rate reduction effective January 1, 2012, together with the assumption of the lower margin pharmacy benefit effective October 1, 2011.

The medical care ratio of the Texas health plan decreased to 93.7% for the year ended December 31, 2012, from 95.1% for the year ended December 31, 2011. Membership and premium revenue increased significantly at the Texas health plan in 2012 as a result of the transition of large numbers of ABD, TANF and CHIP members from fee-for-service reimbursement into managed care effective March 1, 2012. Also on that date inpatient facility and pharmacy benefits that had previously been reimbursed through fee for service for managed care members were transitioned into managed care contracts; further increasing premium revenue and related medical costs.

The medical care ratio of the Utah health plan increased to 82.3% for the year ended December 31, 2012, from 78.1% for the year ended December 31, 2011. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2012.

The medical care ratio of the Washington health plan increased to 86.8% for the year ended December 31, 2012 from 85.4% for the year ended December 31, 2011. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio so that income from operations was consistent between 2012 and 2011.

The medical care ratio of the Wisconsin health plan increased to 96.2% for the year ended December 31, 2012 from 92.5% for the year ended December 31, 2011, primarily due to increases in inpatient costs. The plan has implemented provider contracting initiatives and new utilization management techniques as a part of its efforts to improve profitability.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2012						
	Member Months(2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,177	$ 665,600	$ 159.36	$ 606,494	$ 145.20	91.1%	$ 59,106
Florida	850	228,832	269.36	195,226	229.80	85.3	33,606
Michigan	2,639	646,551	244.97	570,636	216.20	88.3	75,915
New Mexico	1,069	321,853	301.08	280,108	262.03	87.0	41,745
Ohio	3,065	1,095,137	357.36	970,504	316.69	88.6	124,633
Texas	3,245	1,233,621	380.18	1,155,433	356.08	93.7	78,188
Utah	1,026	298,392	290.78	245,671	239.41	82.3	52,721
Washington	4,600	974,712	211.91	845,733	183.87	86.8	128,979
Wisconsin	508	70,678	139.25	67,968	133.91	96.2	2,710
Other(4)	—	8,745	—	53,415	—	—	(44,670)
	21,179	$ 5,544,121	$ 261.79	$ 4,991,188	$ 235.68	90.0%	$ 552,933

	Year Ended December 31, 2011						
	Member Months(2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,190	$ 567,677	$ 135.48	$ 493,419	$ 117.75	86.9%	$ 74,258
Florida	788	203,904	258.65	187,358	237.66	91.9	16,546
Michigan	2,660	623,394	234.35	537,779	202.16	86.3	85,615
New Mexico	1,074	328,706	306.08	277,338	258.25	84.4	51,368
Ohio	2,966	912,219	307.55	766,949	258.57	84.1	145,270
Texas	1,616	402,178	248.99	382,390	236.74	95.1	19,788
Utah	972	287,290	295.51	224,513	230.94	78.1	62,777
Washington	4,171	808,458	193.85	690,513	165.57	85.4	117,945
Wisconsin	488	69,552	142.47	64,346	131.81	92.5	5,206
Other(4)	—	8,115	—	39,556	—	—	(31,441)
	18,925	$ 4,211,493	$ 222.54	$ 3,664,161	$ 193.62	87.0%	$ 547,332

(1) Premium revenue for the Missouri health plan was $114.4 million and $229.6 million for the years ended December 31, 2012 and 2011, respectively. Medical care costs for the Missouri health plan were $105.6 million and $195.8 million for the years ended December 31, 2012 and 2011, respectively. These amounts are excluded from the tables above.

(2) A member month is defined as the aggregate of each month's ending membership for the period presented.

(3) "MCR" represents medical costs as a percentage of premium revenue.

(4) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31,	
	2012	2011
	(In thousands)	
Service revenue before amortization	$ 189,281	$ 167,269
Amortization recorded as reduction of service revenue	(1,571)	(6,822)
Service revenue	187,710	160,447
Cost of service revenue	141,208	143,987
General and administrative costs	17,648	9,270
Amortization of customer relationship intangibles	5,127	5,127
Operating income	$ 23,727	$ 2,063

Operating income for our Molina Medicaid Solutions segment increased $21.7 million for the year ended December 31, 2012, compared with the same prior year period. This improvement was primarily the result of stabilization of our newest contracts in Idaho and Maine.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 8.8% of total revenue for the year ended December 31, 2012, compared with 8.7% for the year ended December 31, 2011.

Premium Tax Expense

The premium tax ratio decreased to 2.8% for the year ended December 31, 2012, compared with 3.5% for December 31, 2011. The decrease in 2012 was primarily due to the reduction of premium taxes at the Michigan and California health plans effective

in 2012, and the growth in revenue at our Texas health plan, which is subject to a lower premium tax rate (measured as a percentage of premium revenue plus premium tax revenue) than our consolidated average.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Year Ended December 31,			
	2012		2011	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 42,938	0.7%	$ 30,803	0.7%
Amortization of intangible assets, continuing operations	20,176	0.3	17,450	0.4
Depreciation and amortization, continuing operations	63,114	1.0	48,253	1.1
Depreciation and amortization, discontinued operations	590	—	2,437	—
Amortization recorded as reduction of service revenue	1,571	—	6,822	0.1
Amortization of capitalized software recorded as cost of service revenue	13,489	0.2	16,871	0.4
	$ 78,764	1.2%	$ 74,383	1.6%

Interest Expense

Interest expense was $16.8 million for the year ended December 31, 2012, compared with $15.5 million for the year ended December 31, 2011. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $5.9 million and $5.5 million for the years ended December 31, 2012 and 2011, respectively.

Other Expenses, Net

Other expenses, net includes primarily gains or losses associated with changes in the fair value of our derivative financial instruments. Other expenses, net was $0.9 million for the year ended December 31, 2012, primarily due to the change in fair value of the interest rate swap.

Income Taxes

Income tax expense was recorded at an effective rate of 45.0% for the year ended December 31, 2012, compared with 35.7% for the year ended December 31, 2011. The effective rate for the year ended December 31, 2012 is higher than our statutory rate primarily due to nondeductible expenses primarily relating to compensation and changes in the fair value of contingent consideration.

Acquisitions

For details relating to business combinations, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 4, "Business Combinations."

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner

consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2013, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased to $6.9 million for the year ended December 31, 2013, compared with $5.1 million for the year ended December 31, 2012, primarily due to the increase in invested assets. Our annualized portfolio yields for the years ended December 31, 2013, 2012, and 2011 were 0.4%, 0.5%, and 0.6%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use. See further discussion in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 20, "Commitments and Contingencies," under the subheading "Regulatory Capital and Dividend Restrictions."

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Year Ended December 31,		
	2013	2012	Change
	(In thousands)		
Net cash provided by operating activities	$ 190,083	$ 347,784	$ (157,701)
Net cash used in investing activities	(543,311)	(93,584)	(449,727)
Net cash provided by financing activities	493,353	47,743	445,610
Net increase in cash and cash equivalents	$ 140,125	$ 301,943	$ (161,818)

	Year Ended December 31,		
	2012	2011	Change
	(In thousands)		
Net cash provided by operating activities	$ 347,784	$ 225,395	$ 122,389
Net cash used in investing activities	(93,584)	(236,927)	143,343
Net cash provided by financing activities	47,743	49,473	(1,730)
Net increase in cash and cash equivalents	$ 301,943	$ 37,941	$ 264,002

Operating Activities. Cash provided by operating activities was $190.1 million in 2013 compared with $347.8 million in 2012, a decrease of $157.7 million. In 2013, deferred revenue was a use of cash from operations amounting to $19.6 million, compared with a source of cash amounting to $90.9 million in 2012. This was primarily due to an advance premium payment received by our Washington health plan in December 2012, with no comparable advance premium receipts in December 2013. In addition to the change in deferred revenue, cash provided by operating activities decreased due to the increase in receivables, primarily as a result of increased premium revenues in 2013. The aggregate increase in receivables was partially offset by increases in amounts payable to certain providers on behalf of various state agencies under which we assume no financial risk.

In 2012, cash provided by operating activities was $347.8 million compared with $225.4 million for 2011, an increase of $122.4 million. In 2012, deferred revenue was a source of cash from operations amounting to $90.9 million, compared with a use of cash amounting to $8.2 million in 2011. This was primarily due to an advance premium payment received by our Washington health plan in December 2012, with no comparable advance premium receipts in December 2011.

Investing Activities. Cash used in investing activities increased significantly to $543.3 million in 2013, compared with $93.6 million in 2012. This $449.7 million increase was primarily due to greater purchases of investments in 2013, a result of the cash generated in financing activities, described below. In addition to increased purchases of investments, we paid $61.5 million in connection with business combinations in 2013, with no comparable activity in 2012.

In 2012, cash used in investing activities was $93.6 million compared with $236.9 million in 2011, a decrease of $143.3 million. This decrease was primarily due to the change in cash paid in business combinations resulting from our fourth quarter 2011 acquisition of the Molina Center amounting to $81.0 million, with no comparable activity in 2012.

Financing Activities. Cash provided by financing activities was $493.4 million in 2013 compared with $47.7 million in 2012, an increase of $445.6 million. The increase in cash provided by financing activities was primarily due to 2013 activity including $538.0 million in proceeds we received from our offering of 1.125% Notes, $158.7 million received from sale-leaseback transactions, and $75.1 million from the sale of warrants, partially offset by $149.3 million paid for the purchased call option relating to 1.125% Notes, $52.7 million paid for repurchases of our common stock, $47.5 million used to repay our term loan, and $40.0 million used to repay our credit facility. Our credit facility was terminated in early 2013 when the balance was repaid.

In 2012, cash provided by financing activities was $47.7 million compared with $49.5 million in 2011, a decrease of nearly $1.8 million. Cash provided from net borrowings under our credit facility in 2012 amounting to $40.0 million was consistent with cash provided from the $48.6 million term loan in 2011 used to finance the acquisition of the Molina Center.

Financial Condition

On a consolidated basis, at December 31, 2013, we had working capital of $745.7 million compared with $521.1 million at December 31, 2012. At December 31, 2013, we had cash and investments of $1,712.9 million, compared with $1,196.1 million of cash and investments at December 31, 2012.

We expect our $187.0 million aggregate principal amount 3.75% convertible senior notes due 2014 (the 3.75% Notes) to be outstanding until their October 1, 2014 maturity date; we intend to repay the $187.0 million principal amount due on that date from available cash at the parent company. Additionally, we anticipate that we will pay the remaining balance due for our recent New Mexico and South Carolina acquisitions in the second quarter of 2014 from available cash at the parent company. We expect this amount to be approximately $20 million, which represents our $57.5 million contingent consideration liability as of December 31, 2013, less approximately $38 million paid to one of the sellers in January 2014.

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Health Care Federal Excise Tax. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a “fee” in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. In Medicaid, capitation rates paid to managed care plans are required to be developed using principles of actuarial soundness. Actuarial soundness requires that the full costs of doing business, including the costs of both federal and state taxes, be considered and factored into the applicable payment to the health plan. Thus, for Medicaid managed care plans like Molina Healthcare, the excise tax should be included in the plans’ capitated rates. However, because of the novelty of this new tax, states have been slow to factor the tax into the premiums paid to us. Moreover, because the tax will be based on a health plan’s market share as applied to a total excise tax base of $8 billion in 2014 (and rising substantially thereafter), there is uncertainty regarding the precise amount of the tax that will be assessed on us.

While we and others in the health plan industry are working with Congress to delay and/or repeal the tax on Medicaid plans, we are also working with our state partners to obtain reimbursement for the full economic impact of the excise tax. However, state budget constraints, inaccurate actuarial calculations, political opposition to the ACA, inadequate federal oversight of actuarial soundness, and market competition, could result in a failure to receive reimbursement for the full economic impact of the tax.

Currently, we project that the excise tax assessed on us in August 2014 will be approximately $85 million. Because this amount is not deductible for income tax purposes, our net income will be reduced by the full amount of the assessment. For example, based on our total net income for fiscal years 2013 and 2012 of approximately $53 million and $10 million, respectively, the excise tax could exceed the entire amount of our earnings.

Our efforts at obtaining relief from the tax are complicated by the fact that any amounts paid to us by the states in reimbursement of the excise tax must include a gross up for the absence of tax deductibility of the excise tax and applicable state premium taxes; and the amount paid for the gross up will itself be subject to the excise tax, its related non-deductibility and applicable state premium taxes. In other words, when states reimburse us for the amount of the excise tax, that reimbursement will itself be subject to income tax, the excise tax, and applicable state premium taxes. If our estimate of an $85 million excise tax liability in 2014 is correct, and if our estimate of the amount allocable to Medicaid of $79 million is correct,

states will need to pay us an incremental amount of approximately $128 million in revenue during 2014 to account for the excise tax and the absence of its tax deductibility. On a percentage basis, we anticipate that states will need to increase our Medicaid premium rates by approximately 1.4% to reimburse us for the excise tax we will owe (based upon our estimated pro rata share of total industry revenue in 2013). In addition, we estimate that states will need to increase our Medicaid premium rates by a further 0.9% to make us whole for the lack of tax deductibility of the excise tax, representing an estimated overall premium rate increase of approximately 2.3%.

As of February 26, 2014, we have contractual commitments from the states of Washington and Wisconsin to reimburse us by way of a lump sum payment for the full economic impact of the excise tax in their respective states. While all of our remaining states have acknowledged the actuarial requirement that they reimburse us for the federal excise tax, and its related income tax effects, no state other than Washington and Wisconsin has contractually committed to do so. Furthermore, states which have acknowledged the requirement to include the impact of the tax in our premium payments may argue that current premium rates will remain actuarially sound even if no adjustment is made to those rates. The tax is required to be paid in full by September 30, 2014. We are continuing to work with our states to address the issue of fully grossed up reimbursement. If we are unable to obtain either premium increases or direct reimbursements to offset the impact of the tax on a fully grossed up basis, our business, financial condition, cash flows or results of operations could be materially adversely affected.

Regulatory Capital and Dividend Restrictions

For a comprehensive discussion of our regulatory capital requirements and dividend restrictions, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20 "Commitments and Contingencies."

Future Sources and Uses of Liquidity

For a comprehensive discussion of our debt instruments, including our convertible senior notes transaction in the first quarter of 2013, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12 "Long-Term Debt."

For a discussion of our shelf registration statement and our securities repurchase programs, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 15, "Stockholders' Equity."

Critical Accounting Estimates

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting estimates relate to:

- The determination of medical claims and benefits payable for our Health Plans segment (see discussion below).
- Health Plans segment contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. For a comprehensive discussion of this topic, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- Health Plans segment quality incentives that allow us to recognize incremental revenue if certain quality standards are met. For a comprehensive discussion of this topic, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- The recognition of revenue and costs associated with our Molina Medicaid Solutions segment. For a comprehensive discussion of this topic, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	December 31,		
	2013	2012	2011
	(In thousands)		
Fee-for-service claims incurred but not paid (IBNP)	$ 424,173	$ 377,614	$ 301,020
Pharmacy payable	45,037	38,992	26,178
Capitation payable	20,267	49,066	53,532
Other (1)	180,310	28,858	21,746
	$ 669,787	$ 494,530	$ 402,476

(1) "Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. As of December 31, 2013, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $151.3 million.

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $424.2 million of our total medical claims and benefits payable of $669.8 million as of December 31, 2013. Excluding amounts that we anticipate paying on behalf of certain capitated providers in Ohio (which we will subsequently withhold from those provider's monthly capitation payments), our IBNP liability at December 31, 2013, was $413.8 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2013 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2013, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 155,752
(4)%	103,834
(2)%	51,917
2%	(51,917)
4%	(103,834)
6%	(155,752)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2013 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (80,787)
(4)%	(53,858)
(2)%	(26,929)
2%	26,929
4%	53,858
6%	80,787

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 46.9 million diluted shares outstanding for the year ended December 31, 2013. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2013, net income for the year ended December 31, 2013 would increase or decrease by approximately $16.4 million, or $0.35 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2013, net income for the year ended December 31, 2013 would increase or decrease by approximately $8.5 million, or $0.18 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $81.8 million, or $1.74 per diluted share, and $42.4 million, or $0.91 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $16.4 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states

in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development.

We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date.

The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for additional information regarding the factors used to determine our changes in estimates of IBNP for all periods presented in the accompanying consolidated financial statements.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts displayed for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year ended December 31,		
	2013	2012	2011
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of period	$ 494,530	$ 402,476	$ 354,356
Components of medical care costs related to:			
Current period	5,434,443	5,136,055	3,911,803
Prior period	(52,779)	(39,295)	(51,809)
Total medical care costs	5,381,664	5,096,760	3,859,994
Change in non-risk provider payables	111,267	(7,004)	20,630
Payments for medical care costs related to:			
Current period	4,932,195	4,689,395	3,564,030
Prior period	385,479	308,307	268,474
Total paid	5,317,674	4,997,702	3,832,504
Balances at end of period	$ 669,787	$ 494,530	$ 402,476
Benefit from prior periods as a percentage of:			
Balance at beginning of period	10.7%	9.8%	14.6%
Premium revenue	0.9%	0.7%	1.2%
Medical care costs	1.0%	0.8%	1.3%
Claims Data:			
Days in claims payable, fee for service	43	40	40
Number of members at end of period	1,931,000	1,797,000	1,697,000
Number of claims in inventory at end of period	145,800	122,700	111,100
Billed charges of claims in inventory at end of period	$ 276,500	$ 255,200	$ 207,600
Claims in inventory per member at end of period	0.08	0.07	0.07
Billed charges of claims in inventory per member end of period	$ 143.19	$ 142.01	$ 122.33
Number of claims received during the period	21,317,500	20,842,400	17,207,500
Billed charges of claims received during the period	$ 21,414,600	$ 19,429,300	$ 14,306,500

Commitments and Contingencies

We are not an obligor to or guarantor of any indebtedness of any other party, except for our obligation to pay benefits under policies in-force relating to an insurance subsidiary we sold in the first quarter of 2012 in the event such benefits are not paid by the reinsurer or current owner. This transaction is more fully described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20, "Commitments and Contingencies."

We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20 ,"Commitments and Contingencies."

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2013. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2014	2015-2016	2017-2018	2019 and Beyond
Principal amount of convertible senior notes (1)	$ 737,000	$ 187,000	$ —	$ —	$ 550,000
Medical claims and benefits payable	669,787	669,787	—	—	—
Lease financing obligations	392,021	11,065	23,136	24,545	333,275
Operating leases	109,038	29,117	39,086	27,266	13,569
Lease financing obligations - related party	84,974	3,330	14,018	15,088	52,538
Contingent consideration liability (2)	57,548	57,548	—	—	—
Interest on long-term debt	42,642	11,447	12,375	12,375	6,445
Purchase commitments	27,522	21,548	5,974	—	—
Total contractual obligations	$ 2,120,532	$ 990,842	$ 94,589	$ 79,274	$ 955,827

(1) Represents the principal amounts due on our 1.125% Cash Convertible Senior Notes due 2020 and our 3.75% Convertible Senior Notes due 2014.

(2) Represents the estimate of contingent consideration due to the sellers in connection with two business combinations completed in 2013, of which $38.1 million was paid in January 2014. The remaining balance is payable in 2014. For further information, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 4, "Business Combinations."

As of December 31, 2013, we have recorded approximately $8.0 million of unrecognized tax benefits. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 14, "Income Taxes."

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Quantitative and Qualitative Disclosures About Market Risk

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 8. Financial Statements and Supplementary Data

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2013 and 2012, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2013. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2013 and 2012, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2013, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2013, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (1992 framework) and our report dated February 26, 2014 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2014

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2013	2012
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 935,895	$ 795,770
Investments	703,052	342,845
Receivables	298,935	149,682
Income tax refundable	32,742	—
Deferred income taxes	26,556	32,443
Prepaid expenses and other current assets	42,484	28,386
Total current assets	2,039,664	1,349,126
Property, equipment, and capitalized software, net	292,083	221,443
Deferred contract costs	45,675	58,313
Intangible assets, net	98,871	77,711
Goodwill	230,738	151,088
Restricted investments	63,093	44,101
Auction rate securities	10,898	13,419
Derivative asset	186,351	—
Other assets	35,564	19,621
	$ 3,002,937	$ 1,934,822
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 669,787	$ 494,530
Accounts payable and accrued liabilities	319,965	184,034
Deferred revenue	122,216	141,798
Income taxes payable	—	6,520
Current maturities of long-term debt	182,008	1,155
Total current liabilities	1,293,976	828,037
Convertible senior notes	416,368	175,468
Lease financing obligations	159,394	—
Lease financing obligations - related party	27,092	—
Other long-term debt	—	86,316
Deferred income taxes	580	37,900
Derivative liability	186,239	1,307
Other long-term liabilities	26,351	23,480
Total liabilities	2,110,000	1,152,508
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 45,871 shares at December 31, 2013 and 46,762 shares at December 31, 2012	46	47
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	340,848	285,524
Accumulated other comprehensive loss	(1,086)	(457)
Treasury stock, at cost; outstanding: 111 shares at December 31, 2012	—	(3,000)
Retained earnings	553,129	500,200
Total stockholders' equity	892,937	782,314
	$ 3,002,937	$ 1,934,822

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2013	2012	2011
	(In thousands, except per-share data)		
Revenue:			
Premium revenue	$ 6,179,170	$ 5,544,121	$ 4,211,493
Premium tax revenue	172,017	158,991	154,589
Service revenue	204,535	187,710	160,447
Investment income	6,890	5,075	5,446
Rental income and other revenue	26,322	18,312	8,288
Total revenue	6,588,934	5,914,209	4,540,263
Operating expenses:			
Medical care costs	5,380,124	4,991,188	3,664,161
Cost of service revenue	161,494	141,208	143,987
General and administrative expenses	665,996	518,615	393,452
Premium tax expenses	172,017	158,991	154,589
Depreciation and amortization	72,743	63,114	48,253
Total operating expenses	6,452,374	5,873,116	4,404,442
Operating income	136,560	41,093	135,821
Other expenses, net:			
Interest expense	52,071	16,769	15,519
Other expense, net	3,343	945	—
Total other expenses, net	55,414	17,714	15,519
Income from continuing operations before income tax expense	81,146	23,379	120,302
Income tax expense	36,316	10,513	42,914
Income from continuing operations	44,830	12,866	77,388
Income (loss) from discontinued operations, net of tax (benefit) expense of $(9,912), $(1,238), and $922, respectively	8,099	(3,076)	(56,570)
Net income	$ 52,929	$ 9,790	$ 20,818
Basic income per share:			
Income from continuing operations	$ 0.98	$ 0.28	$ 1.69
Income (loss) from discontinued operations	0.18	(0.07)	(1.24)
Basic net income per share	$ 1.16	$ 0.21	$ 0.45
Diluted income per share:			
Income from continuing operations	$ 0.96	$ 0.27	$ 1.67
Income (loss) from discontinued operations	0.17	(0.06)	(1.22)
Diluted net income per share	$ 1.13	$ 0.21	$ 0.45
Weighted average shares outstanding:			
Basic	45,717	46,380	45,756
Diluted	46,862	46,999	46,425

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Net income	$ 52,929	$ 9,790	$ 20,818
Other comprehensive (loss) income, before tax:			
Gross unrealized investment (loss) gain	(1,015)	1,529	1,167
Effect of income tax (benefit) expense	(386)	581	380
Other comprehensive (loss) income, net of tax	(629)	948	787
Comprehensive income	$ 52,300	$ 10,738	$ 21,605

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
				(In thousands)			
Balance at January 1, 2011	45,463	$ 45	$ 251,612	$ (2,192)	$ 469,592	$ —	$ 719,057
Net income	—	—	—	—	20,818	—	20,818
Other comprehensive income, net of tax	—	—	—	787	—	—	787
Purchase of treasury stock	—	—	—	—	—	(7,000)	(7,000)
Retirement of treasury stock	(400)	—	(7,000)	—	—	7,000	—
Employee stock grants and employee stock plan purchases	752	1	20,473	—	—	—	20,474
Tax benefit from employee stock compensation	—	—	937	—	—	—	937
Balance at December 31, 2011	45,815	46	266,022	(1,405)	490,410	—	755,073
Net income	—	—	—	—	9,790	—	9,790
Other comprehensive income, net of tax	—	—	—	948	—	—	948
Purchase of treasury stock	(111)	—	—	—	—	(3,000)	(3,000)
Employee stock grants and employee stock plan purchases	1,058	1	16,361	—	—	—	16,362
Tax benefit from employee stock compensation	—	—	3,141	—	—	—	3,141
Balance at December 31, 2012	46,762	47	285,524	(457)	500,200	(3,000)	782,314
Net income	—	—	—	—	52,929	—	52,929
Other comprehensive loss, net of tax	—	—	—	(629)	—	—	(629)
Purchase of treasury stock	(1,710)	(2)	—	—	—	(52,660)	(52,662)
Retirement of treasury stock	—	—	(55,660)	—	—	55,660	—
Issuance of warrants	—	—	78,997	—	—	—	78,997
Employee stock grants and employee stock plan purchases	819	1	30,385	—	—	—	30,386
Tax benefit from employee stock compensation	—	—	1,602	—	—	—	1,602
Balance at December 31, 2013	45,871	$ 46	$ 340,848	$ (1,086)	$ 553,129	$ —	$ 892,937

See accompanying notes.

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MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Operating activities:			
Net income	$ 52,929	$ 9,790	$ 20,818
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	93,866	78,764	74,383
Deferred income taxes	(31,047)	(9,887)	13,836
Stock-based compensation	28,694	20,018	17,052
Amortization of convertible senior notes and lease financing obligations	22,820	5,942	5,512
Amortization of premium/discount on investments	11,787	6,746	7,242
Amortization of deferred financing costs	3,692	1,089	2,818
Change in fair value of derivatives	3,378	1,307	—
Change in fair value of contingent consideration liabilities	(2,400)	—	—
Loss on disposal of property and equipment	1,345	2,608	—
Tax deficiency from employee stock compensation	(73)	(526)	(714)
Gain on sale of subsidiary	—	(1,747)	—
Impairment of goodwill and intangible assets	—	—	64,575
Gain on acquisition	—	—	(1,676)
Changes in operating assets and liabilities:			
Medical claims and benefits payable	175,257	92,054	48,120
Receivables	(149,253)	18,216	352
Accounts payable and accrued liabilities	60,996	23,345	2,778
Income taxes	(39,262)	18,172	(24,855)
Prepaid expenses and other current assets	(23,064)	(8,958)	3,308
Deferred revenue	(19,582)	90,851	(8,154)
Net cash provided by operating activities	190,083	347,784	225,395
Investing activities:			
Purchases of investments	(770,083)	(306,437)	(345,968)
Sales and maturities of investments	399,595	298,006	302,667
Purchases of equipment	(98,049)	(78,145)	(60,581)
Net cash paid in business combinations	(61,521)	—	(84,253)
Increase in restricted investments	(18,992)	(2,647)	(4,064)
Change in deferred contract costs	12,638	(11,610)	(42,830)
Proceeds from sale of subsidiary, net of cash surrendered	—	9,162	—
Change in other noncurrent assets and liabilities	(6,899)	(1,913)	(1,898)
Net cash used in investing activities	(543,311)	(93,584)	(236,927)
Financing activities:			
Proceeds from issuance of 1.125% Notes, net of deferred issuance costs	537,973	—	—
Proceeds from sale-leaseback transactions	158,694	—	—
Purchase of 1.125% Notes call option	(149,331)	—	—
Proceeds from issuance of warrants	75,074	—	—
Treasury stock purchases	(52,662)	(3,000)	(7,000)
Principal payments on term loan	(47,471)	(1,129)	—
Repayment of amount borrowed under credit facility	(40,000)	(20,000)	—
Proceeds from employee stock plans	9,402	8,205	7,347
Excess tax benefits from employee stock compensation	1,674	3,667	1,651
Amount borrowed under credit facility	—	60,000	—
Amount borrowed under term loan	—	—	48,600
Credit facility fees paid	—	—	(1,125)
Net cash provided by financing activities	493,353	47,743	49,473
Net increase in cash and cash equivalents	140,125	301,943	37,941
Cash and cash equivalents at beginning of period	795,770	493,827	455,886
Cash and cash equivalents at end of period	$ 935,895	$ 795,770	$ 493,827

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(continued)

	Year Ended December 31,		
	2013	**2012**	**2011**
	(Amounts in thousands)		
	(Unaudited)		
Supplemental cash flow information:			
Cash paid (received) during the period for:			
Income taxes	$ 95,240	$ (4,634)	$ 54,663
Interest	$ 34,881	$ 10,099	$ 11,399
Schedule of non-cash investing and financing activities:			
Retirement of treasury stock	$ 55,662	$ —	$ 7,000
Common stock used for stock-based compensation	$ (7,711)	$ (11,862)	$ (3,926)
Non-cash lease financing obligations - related party	$ 27,211	$ —	$ —
Details of business combinations:			
Fair value of assets acquired	$ (121,801)	$ —	$ (81,256)
Fair value of contingent consideration liabilities incurred	59,948	—	—
Payable to seller	—	—	(1,952)
Decrease in fair value of liabilities assumed	—	—	(1,045)
Escrow deposit	332	—	—
Net cash paid in business combinations	$ (61,521)	$ —	$ (84,253)
Details of change in fair value of derivatives:			
Gain on 1.125% Call Option	$ 37,020	$ —	$ —
Loss on embedded cash conversion option	(36,908)	—	—
Loss on 1.125% Warrants	(3,923)	—	—
Gain (loss) on interest rate swap	433	(1,307)	—
Change in fair value of derivatives	$ (3,378)	$ (1,307)	$ —
Details of sale of subsidiary:			
Decrease in carrying value of assets	$ —	$ 30,942	$ —
Decrease in carrying value of liabilities	—	(23,527)	—
Gain on sale	—	1,747	—
Proceeds from sale of subsidiary, net of cash surrendered	$ —	$ 9,162	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of December 31, 2013, these health plans served approximately 1.9 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the operation of primary care clinics in California.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Market Updates - Health Plans Segment

California. In the fourth quarter of 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services. The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in California's Medicaid program. See Note 20, "Commitments and Contingencies," for further information.

Florida. In the fourth quarter of 2013, our Florida health plan and the Florida Agency for Health Care Administration (AHCA), agreed to a settlement under which we have been awarded contracts to serve three regions under the Florida Statewide Medicaid Managed Care Managed Medical Assistance Invitation to Negotiate. The contracts are expected to commence in the second half of 2014. During 2014 we will also cease to serve members in three separate regions. As a result of these changes, we expect to experience a moderate increase in membership at our Florida health plan in 2014.

Also in the fourth quarter of 2013, we began to serve approximately 3,000 members under the Florida's Statewide Medicaid Managed Care Long-Term Care Program. This program includes long-term care benefits, including institutional and home and community-based services.

New Mexico. On August 1, 2013 our New Mexico health plan closed on its acquisition of the Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program, under which Lovelace's Medicaid members became Molina Healthcare Medicaid members. See Note 4, "Business Combinations," for further information.

In the first quarter of 2013, we announced that our New Mexico health plan was selected by the New Mexico Human Services Department (HSD) to participate in the new Centennial Care program, which replaced and consolidated the state's legacy Medicaid programs effective January 1, 2014. In addition to continuing to provide physical and acute health care services, under the new program our New Mexico health plan expanded its services to provide behavioral health and long-term care services. The selection of our New Mexico health plan was made by HSD pursuant to its RFP issued in August 2012.

South Carolina. In the third quarter of 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members covered by South Carolina's full-risk Medicaid managed care program. See Note 4, "Business Combinations," for further information.

Market Updates - Molina Medicaid Solutions Segment

Maine. In the fourth quarter of 2013, Molina Medicaid Solutions of Maine entered into an agreement which, among other things, extended our MMIS contract with the state of Maine through August 2020.

U.S. Virgin Islands and West Virginia. In 2012, Molina Medicaid Solutions of West Virginia secured a partnership with the United States Virgin Islands (USVI). The partnership involves processing the USVI's Medicaid claims using West Virginia's certified Medicaid management information system. On August 1, 2013 the system went live, marking the first Medicaid management information system (MMIS) for a U.S. Territory, and the first to be shared between two government agencies on a single business processing platform.

Louisiana. In 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement MMIS to a different vendor, CNSI. However, in March 2013, the state of Louisiana cancelled its contract award to CNSI. CNSI is currently challenging the contract cancellation. The state has informed us that we will continue to perform under our current contract until a successor is named. At such time as a new RFP may be issued, we intend to respond to the state's RFP. For the year ended December 31, 2013, our revenue under the Louisiana MMIS contract was $40.5 million, or 19.8% of total service revenue. So long as our Louisiana MMIS contract continues, we expect to recognize $40 million of service revenue annually under this contract.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 19, "Variable Interest Entities," for more information regarding these variable interest entities. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

Presentation and Reclassifications

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal on June 30, 2012. Effective June 30, 2013, the transition obligations associated with that contract terminated. Therefore, we have reclassified the results relating to the Missouri health plan to discontinued operations for all periods presented. These results are presented in a single line item, net of taxes, in the consolidated statements of income. Additionally, we abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of $9.5 million, which is also included in discontinued operations in the consolidated statements of income. The Missouri health plan's premium revenues amounted to $0.2 million, $114.4 million and $229.6 million for the years ended December 31, 2013, 2012 and 2011, respectively.

We have reclassified certain amounts in the 2012 consolidated balance sheet, and 2012 and 2011 statements of income and cash flows to conform to the 2013 presentation, including the presentation of premium tax revenue as a separate line item in the consolidated statements of income.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The determination of medical claims and benefits payable of our Health Plans segment;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and

- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis.

Our investment policy requires that all of our investments have final maturities of five years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be two years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. Our auction rate securities are classified as non-current assets. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," Note 6, "Investments," and Note 10, "Restricted Investments."

Receivables

Receivables are readily determinable, our creditors are primarily state governments, and our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables."

Property, Equipment, and Capitalized Software

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years. See Note 8, "Property, Equipment, and Capitalized Software."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of service revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Depreciation, and amortization of capitalized software, continuing operations	$ 54,837	$ 42,938	$ 30,803
Amortization of intangible assets, continuing operations	17,906	20,176	17,450
Depreciation and amortization, continuing operations	72,743	63,114	48,253
Depreciation and amortization, discontinued operations	2	590	2,437
Amortization recorded as reduction of service revenue	2,914	1,571	6,822
Amortization of capitalized software recorded as cost of service revenue	18,207	13,489	16,871
Total	$ 93,866	$ 78,764	$ 74,383

Long-Lived Assets, including Intangible Assets

Long-lived assets comprise primarily property, equipment, capitalized software and intangible assets. Finite-lived, separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at their fair values and are then amortized on a straight-line basis over their expected useful lives, generally between one and 15 years.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships as follows:

- The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to acquisition. Because each acquired contract constitutes a single revenue stream, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a straight-line basis for each specific contract over periods generally ranging from one to six years. The contract backlog intangible assets will be fully amortized in 2015.

- The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed as in the case of our Missouri health plan, described below.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

On February 17, 2012, we received notification that our Missouri Health plan's contract with the state of Missouri would expire without renewal on June 30, 2012. As a result, we recorded a total non-cash impairment charge of $64.6 million in the fourth quarter of 2011, of which $6.1 million related to finite-lived intangible assets, and $58.5 million related to goodwill, discussed below. The impairment charge comprised substantially all intangible assets relating to contract rights and licenses, and provider networks recorded at the time of our acquisition of the Missouri health plan in 2007. The non-cash impairment charge is included in the discontinued operations line item, net of tax, in the statement of income. No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2013, and 2012.

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount.

To determine whether goodwill is impaired, we measure the fair values of our reporting units and compare them to the carrying values of the respective units, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows. To determine fair values, we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

In connection with our Missouri health plan as described above, we recorded a non-cash impairment charge of $58.5 million in the fourth quarter of 2011, which is included in the discontinued operations line item, net of taxes, in the statement of income. The impairment charge comprised all of the goodwill recorded at the time of our acquisition of the Missouri health plan in 2007, and was not tax deductible. No impairment charges relating to goodwill were recorded in the years ended December 31, 2013, and 2012.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, “Restricted Investments.”

Other Assets

Other assets primarily includes deferred financing costs associated with our convertible senior notes and lease financing obligations, and certain investments held in connection with our employee deferred compensation program. The deferred financing costs are being amortized on a straight-line basis over the terms of the convertible senior notes and lease financing obligations.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states’ laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2013 and 2012.

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2013, we received approximately 97% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue from continuing operations for the periods indicated:

	Year Ended December 31,					
	2013		2012		2011	
	Amount	% of Total	Amount	% of Total	Amount	% of Total
	(Dollars in thousands)					
California	$ 749,755	12.1%	$ 665,600	12.0%	$ 567,677	13.5%
Florida	264,998	4.3	228,832	4.1	203,904	4.8
Illinois	8,121	0.1	—	—	—	—
Michigan	676,000	11.0	646,551	11.7	623,394	14.8
New Mexico	446,758	7.2	321,853	5.8	328,706	7.8
Ohio	1,098,795	17.8	1,095,137	19.7	912,219	21.7
Texas	1,291,001	20.9	1,233,621	22.2	402,178	9.5
Utah	310,895	5.0	298,392	5.4	287,290	6.8
Washington	1,168,405	18.9	974,712	17.6	808,458	19.2
Wisconsin	143,465	2.3	70,678	1.3	69,552	1.7
Direct delivery	20,977	0.4	8,745	0.2	8,115	0.2
	$ 6,179,170	100%	$ 5,544,121	100%	$ 4,211,493	100%

For the year ended December 31, 2013, we recognized approximately 3% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

(1) Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract.

These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn would lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income.

Health Plan Medical Cost Floors (Minimums), and Administrative Cost and Profit Ceilings (Maximums): A portion of certain premiums received by our California, Florida, Illinois, New Mexico, and Washington health plans may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profits exceed certain amounts. In Ohio, the state may levy sanctions on us if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $1.4 million and $0.3 million at December 31, 2013, and December 31, 2012, respectively.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain

specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of $2.5 million and $3.2 million pursuant to our profit-sharing agreement with the state of Texas at December 31, 2013 and December 31, 2012, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of $20.8 million and $0.3 million for anticipated Medicare risk adjustment premiums at December 31, 2013 and December 31, 2012, respectively.

(2) Quality incentives that allow us to recognize incremental revenue if certain quality standards are met.

At our New Mexico, Ohio, Texas and Wisconsin health plans, incremental revenue ranging from 0.75% to 5.00% of health plan premiums is earned if certain performance measures are met. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2013 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2013.

	Year Ended December 31, 2013				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 3,113	$ 2,618	$ 154	$ 2,772	$ 446,758
Ohio	12,093	3,465	606	4,071	1,098,795
Texas	43,688	37,053	5,995	43,048	1,291,001
Wisconsin	4,417	2,667	2,301	4,968	143,465
	$ 63,311	$ 45,803	$ 9,056	$ 54,859	$ 2,980,019

	Year Ended December 31, 2012				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 2,244	$ 1,889	$ 643	$ 2,532	$ 321,853
Ohio	12,033	8,079	966	9,045	1,095,137
Texas	58,516	52,521	—	52,521	1,233,621
Wisconsin	1,771	—	593	593	70,678
	$ 74,564	$ 62,489	$ 2,202	$ 64,691	$ 2,721,289

	Year Ended December 31, 2011				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 2,271	$ 1,558	$ 378	$ 1,936	$ 328,706
Ohio	10,212	8,363	3,501	11,864	912,219
Texas	—	—	—	—	402,178
Wisconsin	1,705	542	—	542	69,552
	$ 14,188	$ 10,463	$ 3,879	$ 14,342	$ 1,712,655

Medical Care Costs

Expenses related to medical care services are captured in the following categories:

- *Fee-for-service:* Nearly all hospital services and the majority of our primary care and physician specialist services are paid on a fee-for-service basis. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit manager. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Direct delivery:* Costs associated with our operation and/or management of primary care clinics and hospital services in California, Florida, New Mexico, Virginia, and Washington.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2013, 2012, and 2011, medically related administrative costs were $153.0 million, $125.2 million, and $99.3 million, respectively.

The following table provides the details of our consolidated medical care costs from continuing operations for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2013			2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 3,611,529	$ 160.43	67.1%	$ 3,423,751	$ 161.67	68.6%	$ 2,587,380	$ 136.72	70.6%
Pharmacy	935,204	41.54	17.4	835,830	39.47	16.7	418,019	22.09	11.4
Capitation	603,938	26.83	11.2	552,136	26.07	11.1	505,892	26.73	13.8
Direct delivery	48,288	2.14	0.9	33,920	1.60	0.7	29,683	1.57	0.8
Other	181,165	8.05	3.4	145,551	6.87	2.9	123,187	6.51	3.4
Total	$ 5,380,124	$ 238.99	100.0%	$ 4,991,188	$ 235.68	100.0%	$ 3,664,161	$ 193.62	100.0%

The Missouri health plan's medical care costs, which are not included in the table above, amounted to $1.5 million, $105.6 million, and $195.8 million for the years ended December 31, 2013, 2012, and 2011, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. For further information, see Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expense in the consolidated statements of income. Prior to 2013, premium tax revenue was included in premium revenue. The presentation change affected only premium revenue amounts previously reported, by reducing premium revenue for the amount now included in premium tax revenue. There is no effect on income from continuing operations, net income, or per-share amounts. This change was made to more clearly present the portion of premium revenue paid to us as a result of a related premium tax, and therefore not available to the general operations of our health plans. All prior periods presented have been adjusted to conform to this presentation.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2013, or 2012.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI), of a MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we deliver extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. Following the completion of DDI, we generally receive a flat monthly payment for BPO services.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element, and are therefore multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. If the deliverable has standalone value, the arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of

fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. Therefore, absent any contingencies as discussed in the following paragraph, or contract extensions, we would recognize all revenue associated with those contracts over the initial contract period. When a contract is extended, we generally consider the extension to be a continuation of the single unit of accounting; therefore, the deferred revenue as of the extension date is recognized prospectively over the new remaining term of the contract. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances, we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts, for example. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;
- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes and nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers. For further discussion and disclosure, see Note 14, "Income Taxes."

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2013, and 2012, our investments with PFM amounted to approximately $374 million and $428 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans in 11 states, primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements

Health Care Federal Excise Tax. In July 2011, the Financial Accounting Standards Board (FASB) issued guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (ACA). The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. The excise tax will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year.

The new guidance specifies that the liability for the excise tax should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the excise tax is payable, with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the excise tax over the calendar year that it is payable. The new guidance is effective for annual reporting periods beginning after December 31, 2013, when the excise tax initially becomes effective. As enacted, this health care federal excise tax is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this excise tax will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this excise tax as currently written is expected to have a material impact on our financial position, results of operations, and cash flows in future periods. We estimate that our portion of the excise tax in 2014 will be approximately $85 million.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants (AICPA), and the Securities and Exchange Commission (SEC), did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	December 31,		
	2013	2012	2011
	(In thousands)		
Shares outstanding at the beginning of the period	46,762	45,815	45,463
Weighted-average number of shares repurchased	(1,445)	(2)	(160)
Weighted-average number of shares issued	400	567	453
Denominator for basic net income per share	45,717	46,380	45,756
Dilutive effect of employee stock options and stock grants (1)	643	619	669
Dilutive effect of convertible senior notes (2)	502	—	—
Denominator for diluted net income per share	46,862	46,999	46,425

(1) Unvested restricted shares are included in the calculation of diluted net income per share when their grant date fair values are below the average fair value of our common shares for each of the periods presented. Options to purchase common shares are included in the calculation of diluted net income per share when their exercise prices are below the average fair value of our common shares for each of the periods presented. For the years ended December 31, 2013, 2012, and 2011 there were approximately 51,000, 87,000 and 137,000 anti-dilutive weighted options, respectively. For the years ended December 31, 2013 and 2011 anti-dilutive restricted shares were insignificant. For the year ended December 31, 2012 there were approximately 304,000 anti-dilutive restricted shares.

(2) Potentially dilutive shares issuable pursuant to our 1.125% Warrants (defined in Note 12, "Long-Term Debt") were not included in the computation of diluted net income per share for the year ended December 31, 2013, because to do so would have been anti-dilutive. Potentially dilutive shares issuable pursuant to our 3.75% Notes (defined in Note 12, "Long-Term Debt") were not included in the computation of diluted net income per share for the years ended December 31, 2012, and 2011 because to do so would have been anti-dilutive.

4. Business Combinations

Health Plans Segment

South Carolina. On July 26, 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members covered by South Carolina's full-risk Medicaid managed care program, consistent with our stated strategy to enter new markets. The conversion of such members was contingent on our successful receipt of an HMO license from the South Carolina Department of Insurance, the award to Molina Healthcare of a full-risk Medicaid managed care contract by the South Carolina Department of Health and Human Services, and the state's conversion to a full-risk Medicaid managed care program. Each of these three conditions was satisfied by January 2014, and on January 1, 2014 approximately 137,000 members were converted to the managed care program and enrolled with our South Carolina health plan. We expect the final purchase price for the acquisition to amount to approximately $63 million, of which $7.5 million was paid in the third quarter of 2013, and $38.1 million was paid in January 2014.

Because the number of members we will ultimately convert to the Medicaid managed care program was unknown as of the acquisition date, we recorded an initial contingent consideration liability on the acquisition date amounting to $57.5 million. As of December 31, 2013, we expected the remaining purchase price payable to range from approximately $46 million to $59 million, although the theoretical maximum amount of the payment would be based on the total number of Medicaid members in the state of South Carolina. As of December 31, 2013, we recorded the fair value of the liability amounting to $55.4 million, which represents the remaining purchase price associated with the CHS membership we currently expect to enroll through the purchase price determination date. The final determination date for substantially the entire purchase price will occur in the second quarter of 2014. We will continue to remeasure the contingent consideration liability to fair value at each quarter until the contingency is resolved with adjustments, if any, recorded to operations. The fair value adjustment we recorded from the

date of acquisition to December 31, 2013, was a decrease to the liability of $2.1 million, resulting in a gain recorded to operations.

In connection with this transaction, we recorded goodwill, which relates to future economic benefits arising from expected synergies achieved in the transaction. Such synergies include use of our existing infrastructure to support our health plan operations in South Carolina. We also recorded intangible assets, for which accumulated amortization was immaterial as of December 31, 2013. We expect to record amortization of $1.9 million per year in the years 2014 through 2018. The goodwill and intangible assets amounts are indicated in the table below.

New Mexico. Consistent with our stated strategy to expand within existing markets, on August 1, 2013 our New Mexico health plan closed on its acquisition of the Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program, under which Lovelace's Medicaid members became Molina Healthcare Medicaid members. As part of this acquisition, we also added membership covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace in 2013. Effective January 1, 2014, members in the SCI program were a) enrolled in the Centennial Care program as Medicaid members, or b) eligible to enroll in New Mexico's health insurance marketplace. We expect the final purchase price for the acquisition to amount to approximately $53 million, of which $51.0 million was paid in 2013. As of December 31, 2013, the New Mexico health plan's membership increased by approximately 80,000 members as a result of this transaction.

Because the number of SCI members we will ultimately retain was unknown as of the acquisition date, we recorded an initial contingent consideration liability on the acquisition date amounting to $6.0 million, which was immediately reduced to $2.5 million when we made the acquisition date initial payment. As of December 31, 2013, the fair value of the liability was $2.2 million, which represents the remaining purchase price associated with the SCI program membership we currently expect to enroll, as of the final determination date of the purchase price in the second quarter of 2014. We will continue to remeasure the contingent consideration liability to fair value at each quarter until the contingency is resolved with adjustments, if any, recorded to operations. We believe the contingent consideration liability may decrease further as we learn more about how many SCI members we will retain, but is unlikely to increase. The fair value adjustment we recorded from the date of acquisition to December 31, 2013, was a decrease to the liability of $0.3 million, resulting in a gain recorded to operations.

In connection with this transaction, we recorded goodwill, which relates to future economic benefits arising from expected synergies achieved in the transaction. Such synergies include use of our existing infrastructure to support the added membership. We also recorded intangible assets, for which accumulated amortization was immaterial as of December 31, 2013. We expect to record amortization of $1.8 million per year in the years 2014 through 2018. The goodwill and intangible assets amounts are indicated in the table below.

Florida. In the second quarter of 2013, our Florida health plan acquired assets relating to the Statewide Medicaid Managed Care Long-Term Care Program from Neighborly Care Network, Inc. The final purchase price for this acquisition was $3.3 million. Accumulated amortization as of December 31, 2013, and future amortization for this acquisition are immaterial.

The following table presents assets acquired and the weighted average useful life for the major asset categories for the business combinations in 2013:

	Fair Value of Assets Acquired - Health Plans Segment				
	Weighted average useful life	**South Carolina**	**New Mexico**	**Florida**	**Total**
	(Years)	*(In thousands)*			
Membership conversion rights	12.0	$ 21,800	$ —	$ —	$ 21,800
Contract rights	10.6	—	18,300	—	18,300
Other finite-lived intangibles	7.7	1,060	—	990	2,050
Goodwill	Indefinite	42,140	35,178	2,332	79,650
		$ 65,000	$ 53,478	$ 3,322	$ 121,800

Acquisition costs relating to these transactions were immaterial individually and in the aggregate. The amounts recorded as goodwill represent intangible assets that do not qualify for separate recognition as identifiable intangible assets. The entire amounts recorded as goodwill are deductible for income tax purposes. Goodwill is not amortized, but is subject to an annual impairment test.

Molina Center. In late 2011, we acquired a 460,000 square foot office building located in Long Beach, California. The building (referred to as the Molina Center), consists of two conjoined fourteen-story office towers on approximately five acres of land. For the last several years we have leased approximately 155,000 square feet of the Molina Center for use as our corporate headquarters and also for use by our California health plan subsidiary. The final purchase price was approximately $81 million, which amount was paid with a combination of cash on hand and bank financing under a term loan agreement. We acquired this business primarily to facilitate space needs for the projected future growth of the Company. In the second quarter of 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the Molina Center. Due to our continuing involvement with the leased property, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the property. See Note 12, "Long-Term Debt."

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, other current assets, a derivative asset, trade accounts payable, medical claims and benefits payable, long-term debt, a derivative liability, contingent consideration, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs. Our Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs. Our Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Such investments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs. Our Level 3 financial instruments recorded at fair value consist of derivative financial instruments relating to our 1.125% Notes, including the 1.125% Call Option asset, and the embedded cash conversion option liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2013 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, “Long-Term Debt,” and Note 13, “Derivative Financial Instruments,” the 1.125% Call Option asset and the embedded cash conversion option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of income. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Level 3 financial instruments also include contingent consideration liabilities, primarily relating to the acquisition in South Carolina as described in Note 4, "Business Combinations," and recorded to accounts payable and accrued liabilities in our consolidated balance sheets. We applied discounted cash flow analysis to determine the fair value of the contingent consideration liabilities. Significant unobservable inputs primarily related to the probability weighted present values of the purchase price estimates for the projected membership. As of December 31, 2013, we have estimated that such South Carolina acquisition membership could range from approximately 120,000 to 140,000 members, as updated to reflect the successful conversion of membership to our health plan effective January 1, 2014.

Finally, Level 3 financial instruments include non-current auction rate securities that are designated as available-for-sale, and are reported at fair value. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of December 31, 2013.

Our financial instruments measured at fair value on a recurring basis at December 31, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 449,772	$ —	$ 449,772	$ —
GSEs	68,817	68,817	—	—
Municipal securities	113,330	—	113,330	—
U.S. treasury notes	37,376	37,376	—	—
Certificates of deposit	33,757	—	33,757	—
Auction rate securities	10,898	—	—	10,898
1.125% Call Option derivative asset	186,351	—	—	186,351
Total assets measured at fair value on a recurring basis	$ 900,301	$ 106,193	$ 596,859	$ 197,249
Embedded cash conversion option derivative liability	$ 186,239	$ —	$ —	$ 186,239
Contingent consideration liabilities	57,548	—	—	57,548
Total liabilities measured at fair value on a recurring basis	$ 243,787	$ —	$ —	$ 243,787

Our financial instruments measured at fair value on a recurring basis at December 31, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 191,008	$ —	$ 191,008	$ —
GSEs	29,525	29,525	—	—
Municipal securities	75,848	—	75,848	—
U.S. treasury notes	35,740	35,740	—	—
Certificates of deposit	10,724	—	10,724	—
Auction rate securities	13,419	—	—	13,419
Total assets measured at fair value on a recurring basis	$ 356,264	$ 65,265	$ 277,580	$ 13,419
Interest rate swap derivative liability	$ 1,307	$ —	$ 1,307	$ —

The following tables present activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments		
	Auction Rate Securities	Derivatives, Net	Contingent Consideration Liabilities
Balance at December 31, 2011	$ 16,134	$ —	$ —
Net unrealized gains included in other comprehensive income	1,635	—	—
Auction rate securities settlements	(4,350)	—	—
Balance at December 31, 2012	13,419	—	—
Net unrealized gains included in other comprehensive income	729	—	—
Net unrealized losses included in other expenses	—	(3,810)	—
Derivative issuance	—	(75,074)	—
Auction rate securities settlements	(3,250)	—	—
Derivative re-designation	—	78,996	—
Acquisitions	—	—	(57,548)
Balance at December 31, 2013	$ 10,898	$ 112	$ (57,548)
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at December 31, 2013	$ 541	$ —	$ —
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at December 31, 2012	$ 1,059	$ —	$ —

Fair Value Measurements - Disclosure Only

The carrying amounts and estimated fair values of our long-term debt, as well as the applicable fair value hierarchy tier, are contained in the tables below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The credit facility was repaid and terminated in February 2013, and the term loan was repaid in June 2013.

	December 31, 2013				
	Carrying Amount	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
1.125% Notes	$ 416,368	$ 572,627	$ —	$ 572,627	$ —
3.75% Notes	181,872	219,491	—	219,491	—
	$ 598,240	$ 792,118	$ —	$ 792,118	$ —

	December 31, 2012				
	Carrying Amount	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
3.75% Notes	$ 175,468	$ 208,460	$ —	$ 208,460	$ —
Term loan	47,471	47,471	—	—	47,471
Credit facility	40,000	40,000	—	—	40,000
	$ 262,939	$ 295,931	$ —	$ 208,460	$ 87,471

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 450,162	$ 442	$ 832	$ 449,772
GSEs	68,898	6	87	68,817
Municipal securities	114,126	119	915	113,330
U.S. treasury notes	37,360	44	28	37,376
Certificates of deposit	33,756	2	1	33,757
Subtotal - current investments	704,302	613	1,863	703,052
Auction rate securities	11,400	—	502	10,898
	$ 715,702	$ 613	$ 2,365	$ 713,950

	December 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 190,545	$ 528	$ 65	$ 191,008
GSEs	29,481	45	1	29,525
Municipal securities	75,909	185	246	75,848
U.S. treasury notes	35,700	42	2	35,740
Certificates of deposit	10,715	9	—	10,724
Subtotal - current investments	342,350	809	314	342,845
Auction rate securities	14,650	—	1,231	13,419
	$ 357,000	$ 809	$ 1,545	$ 356,264

The contractual maturities of our investments as of December 31, 2013 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 350,488	$ 350,605
Due one year through five years	353,814	352,447
Due after ten years	11,400	10,898
	$ 715,702	$ 713,950

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Net realized investment gains for the year ended December 31, 2013, 2012, and 2011 were $0.3 million, $0.3 million, and $0.4 million, respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at December 31, 2013, and 2012, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to

experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2013.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 210,057	$ 802	91	$ 2,540	$ 30	3
GSEs	53,308	87	21	—	—	—
Municipal securities	30,715	398	49	31,091	517	39
U.S. treasury notes	12,037	28	11	—	—	—
Certificates of deposit	414	1	2	—	—	—
Auction rate securities	—	—	—	10,898	502	15
	$ 306,531	$ 1,316	174	$ 44,529	$ 1,049	57

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2012.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 44,457	$ 65	23	$ —	$ —	—
GSEs	5,004	1	1	—	—	—
Municipal securities	35,223	246	43	—	—	—
U.S. treasury notes	4,511	2	5	—	—	—
Auction rate securities	—	—	—	13,419	1,231	21
	$ 89,195	$ 314	72	$ 13,419	$ 1,231	21

Auction Rate Securities. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 17 years to 32 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction rate securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at December 31, 2013. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $70.7 million of these instruments at par value.

For the year ended December 31, 2013 and 2012, we recorded pretax unrealized gains of $0.7 million and $1.6 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future impairment was other-than-temporary, we would record a charge to earnings as appropriate.

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Accounts receivable increased as of December 31, 2013, primarily due to certain intermediary arrangements with state agencies entered into in the third quarter of 2013. For further information on these arrangements, refer to Note 11, "Medical Claims and Benefits Payable."

	December 31,	
	2013	2012
	(In thousands)	
Health Plans segment:		
California	$ 148,654	$ 28,553
Florida	2,901	953
Illinois	5,773	—
Michigan	15,253	12,873
New Mexico	17,056	9,059
Ohio	43,969	40,980
Texas	9,736	7,459
Utah	10,953	3,359
Washington	13,455	17,587
Wisconsin	8,087	4,098
Direct delivery and other	2,463	2,177
Total Health Plans segment	278,300	127,098
Molina Medicaid Solutions segment	20,635	22,584
	$ 298,935	$ 149,682

8. Property, Equipment, and Capitalized Software

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2013	2012
	(In thousands)	
Land	$ 15,764	$ 15,764
Building and improvements	165,670	124,163
Furniture and equipment	131,478	97,865
Capitalized software	187,105	154,708
	500,017	392,500
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(103,918)	(84,156)
Less: accumulated amortization for capitalized software	(104,016)	(86,901)
	(207,934)	(171,057)
Property, equipment, and capitalized software, net	$ 292,083	$ 221,443

Depreciation recognized for building and improvements, and furniture and equipment was $26.6 million, $20.5 million, and $17.5 million for the years ended December 31, 2013, 2012 and 2011, respectively. Amortization of capitalized software was $46.4 million, $36.2 million, and $30.2 million for the years ended December 31, 2013, 2012 and 2011, respectively.

Molina Center. As described in Note 4, "Business Combinations," we acquired the Molina Center in December 2011. Subsequently, in June 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of the

Molina Center. Due to our continuing involvement with the leased property, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the property. See Note 12, "Long-Term Debt."

Future minimum rental income on noncancelable leases from third party tenants of the Molina Center is now considered to be sublease rental income, and continues to be reported in rental income in our consolidated statements of income. The future minimum rental income is as follows:

	(In thousands)
2014	$ 4,192
2015	4,110
2016	3,542
2017	3,742
2018	3,581
Thereafter	2,832
Total minimum future rentals	$ 21,999

9. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 10 years, for customer relationships is approximately five years, for backlog is approximately three years, and for provider networks is approximately 10 years. Based on the balances of our identifiable intangible assets as of December 31, 2013, we estimate that our intangible asset amortization will be $20.4 million in 2014, $14.7 million in 2015, $12.7 million in 2016, $12.4 million in 2017, and $12.1 million in 2018. The following table provides the details of identified intangible assets, by major class, for the periods indicated. For a description of our goodwill and intangible assets by reportable segment, refer to Note 21, “Segment Information.”

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses	$ 176,428	$ 92,789	$ 83,639
Customer relationships	24,550	18,801	5,749
Contract backlog	23,600	19,624	3,976
Provider networks	13,370	7,863	5,507
Balance at December 31, 2013	$ 237,948	$ 139,077	$ 98,871
Intangible assets:			
Contract rights and licenses	$ 135,932	$ 81,376	$ 54,556
Customer relationships	24,550	12,513	12,037
Contract backlog	23,600	17,870	5,730
Provider networks	11,990	6,602	5,388
Balance at December 31, 2012	$ 196,072	$ 118,361	$ 77,711

The following table presents the balances of goodwill as of December 31, 2013 and 2012:

	December 31, 2012	Acquisitions	December 31, 2013
		(In thousands)	
Goodwill, gross	$ 209,618	$ 79,650	$ 289,268
Accumulated impairment losses	(58,530)	—	(58,530)
Goodwill, net	$ 151,088	$ 79,650	$ 230,738

The change in the carrying amount in 2013 was due to the acquisitions described in Note 4, "Business Combinations."

10. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, we maintain restricted investments as collateral for letters of credit. The following table presents the balances of restricted investments:

	December 31,	
	2013	2012
	(In thousands)	
California	$ 373	$ 373
Florida	9,242	5,738
Illinois	310	310
Michigan	1,014	1,014
New Mexico	24,622	15,915
Ohio	9,080	9,082
Texas	3,500	3,503
Utah	3,301	3,126
Washington	151	151
Other	1,196	4,889
Total Health Plans segment	52,789	44,101
Molina Medicaid Solutions segment	10,304	—
	$ 63,093	$ 44,101

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2013 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 58,542	$ 58,543
Due one year through five years	4,551	4,555
	$ 63,093	$ 63,098

11. Medical Claims and Benefits Payable

As of December 31, 2013, medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. As of December 31, 2013, we recorded non-risk provider payables relating to such intermediary arrangements of $151.3 million.

The following table presents the components of the change in our medical claims and benefits payable from continuing and discontinued operations combined for the periods indicated. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,		
	2013	2012	2011
	(Dollars in thousands)		
Balances at beginning of period	$ 494,530	$ 402,476	$ 354,356
Components of medical care costs related to:			
Current period	5,434,443	5,136,055	3,911,803
Prior periods	(52,779)	(39,295)	(51,809)
Total medical care costs	5,381,664	5,096,760	3,859,994
Change in non-risk provider payables	111,267	(7,004)	20,630
Payments for medical care costs related to:			
Current period	4,932,195	4,689,395	3,564,030
Prior periods	385,479	308,307	268,474
Total paid	5,317,674	4,997,702	3,832,504
Balances at end of period	$ 669,787	$ 494,530	$ 402,476
Benefit from prior period as a percentage of:			
Balance at beginning of period	10.7%	9.8%	14.6%
Premium revenue	0.9%	0.7%	1.2%
Medical care costs	1.0%	0.8%	1.3%

Assuming that our initial estimate of claims incurred but not paid (IBNP) is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2013, 2012, and 2011 were less than what we had expected when we had established our reserves. For example, during the years ended December 31, 2013, 2012 and 2011, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2012, 2011 and 2010, by 10.7%, 9.8% and 14.6%, respectively. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $52.8 million for the year ended December 31, 2013. This amount represents our estimate as of December 31, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012 was due primarily to the following factors:

- At our Washington health plan certain high-cost newborns, as well as other high-cost disabled members, were covered by the health plan effective July 1, 2012. At the end of 2012, we had limited claims history with which to estimate the claims liability of these members, and overstated the liability for such members.
- At our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.
- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to our aged, blind or disabled (ABD) members.

We recognized favorable prior period claims development in the amount of $39.3 million for the year ended December 31, 2012. This amount represents our estimate as of December 31, 2012, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that would ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2011 was due primarily to the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.

- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.

- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.

- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

We recognized favorable prior period claims development in the amount of $51.8 million for the year ended December 31, 2011. This amount represents our estimate as of December 31, 2011, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 was more than the amount that would ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2010 was due primarily to the following factors:

- At our Ohio health plan, we overestimated the impact of a buildup in claims inventory.

- At our California health plan, we overestimated the impact of the settlement of disputed provider claims.

- At our New Mexico health plan, we underestimated the impact of a reduction in the outpatient facility fee schedule.

In estimating our claims liability at December 31, 2013, we adjusted our base calculation to take account of the numerous factors that we believe will likely change our final claims liability amount. We believe that the most significant among those factors are:

- At our Texas health plan, we have noted an unusually large number of claims dated older than 12 months. This has caused distortion in the claims lag pattern that we use to estimate incurred claims.

- At our Michigan health plan, there were a large number of claim recoveries recorded in June 2013 due to overpayments that resulted from a system configuration issue. These recoveries impacted the completion factors used to estimate incurred claims. While we attempted to remove this distortion from the claims data to develop a more accurate reserve estimate, this type of correction in claims data added a degree of uncertainty for the Michigan reserves as of December 31, 2013.

- The state of Florida changed their inpatient Medicaid payment methodology effective July 1, 2013. The majority of our Florida health plan's provider contracts were also changed accordingly. These changes were intended to be cost neutral, but may have an impact on our specific mix of claims and providers. Also, a new Florida long-term care product became effective on December 1, 2013. This product covers some members who are institutionalized and others who could become institutionalized and would incur very high costs. This added a degree of uncertainty to the reserve estimate as of December 31, 2013.

- Our Ohio health plan added approximately 25,000 Temporary Assistance for Needy Families (TANF) program members from new regions effective July 1, 2013. Also effective July 1, 2013, the health plan began covering blind and disabled children under a new product. These two new groups of members added a degree of uncertainty to the reserve estimate as of December 31, 2013.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held as part of the liability at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2013, 2012 and 2011, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In these years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because replenishment of reserves in the respective periods generally offset the benefit from the prior period.

12. Long-Term Debt

As of December 31, 2013, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2014	2015	2016	2017	2018	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	187,000	—	—	—	—	—
	$ 737,000	$ 187,000	$ —	$ —	$ —	$ —	$ 550,000

1.125% Cash Convertible Senior Notes due 2020

In February 2013, we issued $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes). This transaction included the initial issuance of $450.0 million on February 11, 2013, plus the exercise of the full amount of the $100.0 million over-allotment option on February 13, 2013. The aggregate net proceeds of the 1.125% Notes were $463.7 million, after payment of the net cost of the Call Spread Overlay described below and in Note 13, "Derivative Financial Instruments," and deferred issuance costs. Additionally, we used $50.0 million of the net proceeds to purchase shares of our common stock (see Note 15, "Stockholders' Equity"), and $40.0 million to repay the principal owed under our Credit Facility.

Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum, and commenced on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. Holders may convert their 1.125% Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.125% Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its 1.125% Notes in connection with such a corporate event in certain circumstances. We may not redeem the 1.125% Notes prior to the maturity date, and no sinking fund is provided for the 1.125% Notes.

If we undergo a fundamental change (as defined in the indenture to the 1.125% Notes), holders may require us to repurchase for cash all or part of their 1.125% Notes at a repurchase price equal to 100% of the principal amount of the 1.125% Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The 1.125% Notes are senior unsecured obligations, and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

The 1.125% Notes contain an embedded cash conversion option. We have determined that the embedded cash conversion option is a derivative financial instrument, required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the embedded cash

conversion option transaction settles or expires. The initial fair value of the embedded cash conversion option liability was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). For further discussion of the derivative financial instruments relating to the 1.125% Notes, refer to Note 13, "Derivative Financial Instruments."

As noted above, the reduced carrying value on the 1.125% Notes resulted in a debt discount that is amortized to the 1.125% Notes' principal amount through the recognition of interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 1.125% Notes is approximately 5.9%, which was imputed based on the amortization of the debt discount over the remaining term of the 1.125% Notes. As of December 31, 2013, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 6.0 years. The 1.125% Notes' if-converted value did not exceed their principal amount as of December 31, 2013.

In connection with the issuance of the 1.125% Notes, we paid approximately $16.9 million in transaction costs. Such costs have been allocated to the 1.125% Notes, the 1.125% Call Option (defined below) and the 1.125% Warrants (defined below) according to their relative fair values. The amount allocated to the 1.125% Notes, or $12.0 million, was capitalized and will be amortized over the term of the 1.125% Notes. The aggregate amount allocated to the 1.125% Call Option and 1.125% Warrants, or $4.9 million, was recorded to interest expense in the first quarter of 2013.

1.125% Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Notes, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). These transactions are collectively referred to as the Call Spread Overlay. Under the Call Spread Overlay, the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call Spread Overlay. The 1.125% Call Option is a derivative financial instrument. Until April 22, 2013, the 1.125% Warrants were classified as derivative financial instruments; refer to Note 13, "Derivative Financial Instruments" for further discussion.

Aside from the initial payment of a premium to the Counterparties of $149.3 million, for the 1.125% Call Option, we will not be required to make any cash payments to the Counterparties under the 1.125% Call Option, and will be entitled to receive from the Counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

3.75% Convertible Senior Notes due 2014

We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of December 31, 2013. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their 3.75% Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;

- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the 3.75% Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their 3.75% Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of 3.75% Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of the 3.75% Notes have been allocated between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that is amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. As of December 31, 2013, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 9 months; we intend to repay the $187.0 million principal amount due on that date from available cash at the parent company. As of December 31, 2013, the 3.75% Notes' if-converted value exceeded their principal amount by approximately $11.1 million. The 3.75% Notes' if-converted value did not exceed their principal amount as of December 31, 2012. At December 31, 2013, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million.

The principal amounts, unamortized discount and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
December 31, 2013:			
1.125% Notes	$ 550,000	$ 133,632	$ 416,368
3.75% Notes	187,000	5,128	181,872
	$ 737,000	$ 138,760	$ 598,240
December 31, 2012:			
3.75% Notes	$ 187,000	$ 11,532	$ 175,468

	Years Ended December 31,		
	2013	2012	2011
		(In thousands)	
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate	$ 12,427	$ 7,012	$ 7,012
Amortization of the discount	22,103	5,942	5,512
Total interest cost recognized	$ 34,530	$ 12,954	$ 12,524

Lease Financing Obligations

In June 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of two properties, including the Molina Center located in Long Beach, California, and the building that houses our Ohio health plan located in Columbus, Ohio. We sold the two properties for $158.7 million in the aggregate. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. The carrying values of these properties, including the related intangible assets, amounted to $76.8 million in the aggregate as of December 31, 2013. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The sales price was recorded as a lease financing obligation, which is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. As of December 31, 2013, the aggregate lease financing obligation for these properties amounted to $159.4 million. Rent will increase 3% per year through the initial term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Associated transaction costs, amounting to $3.5 million, have been deferred and will be amortized over the initial lease term. For information regarding the future minimum rental income, refer to Note 8, "Property, Equipment, and Capitalized Software." For information regarding the future minimum lease obligation, refer to Note 20, “Commitments and Contingencies.”

As described and defined in further detail in Note 18, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings then under construction, one of which was completed in June 2013. We have concluded that we are the accounting owner of the construction projects because of our continuing involvement in those projects. Therefore, we have recorded $26.6 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of December 31, 2013, which represents the total cost, including imputed interest, incurred by the Landlord for the completed office building, and thus far for the construction project still in process. As of December 31, 2013, the aggregate amount recorded to lease financing obligations for the construction projects amounted to $27.2 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income. Interest expense for the year ended December 31, 2013 was $1.3 million. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was immaterial for the year ended December 31, 2013. For information regarding the future minimum lease obligation, refer to Note 20, “Commitments and Contingencies.”

Term Loan

In December 2011, we entered into a term loan agreement with various lenders and East West Bank to borrow $48.6 million to finance a portion of the purchase price for the Molina Center, located in Long Beach, California. In June 2013, we repaid the principal balance outstanding under the term loan on that date with proceeds we received in the sale-leaseback transaction described above.

Credit Facility

In February 2013, we used $40.0 million of the net proceeds from the offering of the 1.125% Notes to repay all of the outstanding indebtedness under our $170 million revolving Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the issuance of the 1.125% Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution. Such direct issue letters of credit are collateralized by restricted investments.

13. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	December 31, 2013	December 31, 2012
		(In thousands)	
Derivative asset:			
1.125% Call Option	Non-current assets: Derivative asset	$ 186,351	$ —
Derivative liability:			
Embedded cash conversion option	Non-current liabilities: Derivative liability	$ 186,239	$ —
Interest rate swap	Non-current liabilities: Derivative liability	—	1,307
		$ 186,239	$ 1,307

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, in other expense. The following table summarizes the gains (losses) recorded in the periods presented. There were no gains or losses for the year ended December 31, 2011.

	Year Ended December 31, 2013	Year Ended December 31, 2012
Derivative gains (losses):		
1.125% Call Option	$ 37,020	$ —
Embedded cash conversion option	(36,908)	—
1.125% Warrants	(3,923)	—
Interest rate swap	433	(1,307)
	$ (3,378)	$ (1,307)

1.125% Notes Call Spread Overlay

As described in Note 12, "Long-Term Debt," we entered into a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to the cash settlement features until the 1.125% Call Option settles or expires. The 1.125% Call Option is measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, “Fair Value Measurements.”

Until April 22, 2013, the 1.125% Warrants were recorded as a derivative liability that required mark-to-market accounting treatment due to certain terms in the 1.125% Warrants that prevented such instruments being considered to be indexed in our common stock. Effective April 22, 2013, we entered into amended and restated warrant confirmations with the Counterparties to clarify these terms, such that 1.125% Warrants are no longer considered to be derivative instruments, and were re-designated as additional paid-in capital. In 2013, we recorded a loss for the change in fair value of the 1.125% Warrants from February 15, 2013 to April 22, 2013.

Embedded Cash Conversion Option

The embedded cash conversion option within the 1.125% Notes is required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. For further discussion of the inputs used to determine the fair value of the embedded cash conversion option, refer to Note 5, “Fair Value Measurements.”

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, (Swap Agreement), with an effective date of March 1, 2013. The Swap Agreement was intended to reduce our exposure to fluctuations in the contractual variable interest rates under our term loan agreement that was repaid in June 2013. The Swap Agreement was measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. In June 2013, we settled the interest rate swap for $0.9 million.

14. Income Taxes

The provision for income taxes for continuing operations consisted of the following:

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Current:			
Federal	$ 66,883	$ 23,019	$ 24,435
State	581	1,254	1,587
Total current	67,464	24,273	26,022
Deferred:			
Federal	(25,498)	(9,205)	16,905
State	(5,650)	(4,555)	(13)
Total deferred	(31,148)	(13,760)	16,892
Total provision for income taxes	$ 36,316	$ 10,513	$ 42,914

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate for continuing operations is as follows:

	Year Ended December 31,		
	2013	2012	2011
Statutory federal tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	(0.5)	(9.2)	0.9
Change in unrecognized tax benefits	(3.7)	0.7	(0.3)
Nondeductible compensation	9.6	6.2	—
Nondeductible lobbying	1.6	4.2	0.6
Purchase accounting adjustment	—	—	(0.8)
Nondeductible fair value of 1.125% Warrants	2.4	—	—
Change in fair value of contingent consideration liabilities	(0.3)	4.8	—
Other	0.7	3.3	0.3
Effective tax rate	44.8 %	45.0 %	35.7 %

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws.

During 2013, 2012, and 2011 excess tax benefits from shared-based compensation were $1.6 million, $3.1 million, and $0.9 million respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital.

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2013 and 2012 were as follows:

	December 31,	
	2013	2012
	(In thousands)	
Accrued expenses	$ 19,545	$ 15,381
Reserve liabilities	1,712	2,936
State taxes	(1,323)	(606)
Other accrued medical costs	2,540	2,518
Net operating losses	27	27
Unrealized losses (gains)	380	(283)
Unearned premiums	10,543	15,675
Prepaid expenses	(5,354)	(4,390)
Basis in debt	(2,162)	—
Deferred compensation	2,087	1,611
Other, net	(928)	176
Valuation allowance	(511)	(602)
Deferred tax asset, net of valuation allowance — current	26,556	32,443
Reserve liabilities	1,909	2,013
State tax credit carryover	7,027	4,149
Net operating losses	2,326	3,341
Unrealized losses	286	563
Depreciation and amortization	(40,433)	(44,198)
Deferred compensation	3,404	3,323
Lease financing obligation	27,543	—
Debt basis	466	(5,410)
Other, net	(24)	702
Valuation allowance	(3,084)	(2,383)
Deferred tax liability, net of valuation allowance — long term	(580)	(37,900)
Net deferred income tax asset (liability)	$ 25,976	$ (5,457)

At December 31, 2013, we had federal and state net operating loss carryforwards of $0.2 million and $57.2 million, respectively. The federal net operating loss begins expiring in 2018, and state net operating losses begin expiring in 2015. The utilization of the net operating losses is subject to certain limitations under federal law.

At December 31, 2013, we had California enterprise zone tax credit carryovers of $10.8 million which expire in 2024.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2013, $3.6 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state tax operating loss carryforwards. We increased our valuation allowance $0.6 million from $3.0 million at December 31, 2012 to $3.6 million as of December 31, 2013.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll-forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Gross unrecognized tax benefits at beginning of period	$ (10,622)	$ (10,712)	$ (10,962)
Increases in tax positions for prior years	—	(441)	(137)
Decreases in tax positions for prior years	3,615	320	—
Increases in tax positions for current year	(2,084)	—	—
Decreases in tax positions for current year	886	—	—
Lapse in statute of limitations	175	211	387
Gross unrecognized tax benefits at end of period	$ (8,030)	$ (10,622)	$ (10,712)

The total amount of unrecognized tax benefits at December 31, 2013, 2012 and 2011 that, if recognized, would affect the effective tax rates is $5.7 million, $7.4 million and $7.4 million, respectively. Approximately $5.9 million of the unrecognized tax benefits recorded at December 31, 2013 relates to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $6.2 million due the resolution to the state refund claim as well as the normal expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2013, December 31, 2012, and December 31, 2011, we had accrued $79,000, $56,000, and $65,000, respectively, for the payment of interest and penalties.

We are under examination, or may be subject to examination, by the Internal Revenue Service (IRS) for calendar years 2010 through 2013. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Utah, and Michigan, for the years 2004 through 2013.

15. Stockholders' Equity

Stockholders' equity increased $110.6 million during the year ended December 31, 2013. The increase was primarily due to the $79.0 million re-designation of the 1.125% Warrants as additional paid-in capital, net income of $52.9 million, and $32.0 million related to employee stock transactions, partially offset by $52.7 million in repurchases of our common stock, as described in further detail below.

Common Shares Authorized. On May 1, 2013, our stockholders approved an amendment to our certificate of incorporation to increase the number of authorized shares of our common stock from 80,000,000 to 150,000,000.

1.125% Warrants. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants will generally begin to expire in the 160 trading day measurement following April 15, 2020.

We will not receive any additional proceeds if the 1.125% Warrants are exercised. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants. As described in Note 13, "Derivative Financial Instruments," we re-designated the 1.125% Warrants as additional paid-in capital during the second quarter of 2013, resulting in an increase to stockholders' equity.

Securities Repurchases and Repurchase Program. In connection with the issuance and settlement of the 1.125% Notes, we used a portion of the net proceeds from the offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. In February 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares

repurchased depends on a variety of factors including price, corporate and regulatory requirements and other market conditions. Under this program, we purchased 85,086 shares of our common stock for $2.7 million (average cost of $31.28 per share) during November 2013. This newly authorized repurchase program extends through December 31, 2014, and replaces in its entirety, the $75 million repurchase program adopted by the board of directors in February 2013.

In December 2012, we purchased 110,988 shares of our common stock from certain Molina family trusts for an aggregate purchase price of $3.0 million. This purchase transaction was approved by our board of directors. The shares were purchased at a price of $27.03, representing the closing price per share of our common stock on December 26, 2012. See Note 18, "Related Party Transactions."

In October 2011, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our 3.75% Notes (see Note 12, "Long-Term Debt"). The repurchase program expired in October 2012. No securities were purchased under this program in 2012.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with the stock plans described in Note 17, "Share-Based Compensation," we issued approximately 820,000, and 1,057,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the years ended December 31, 2013 and 2012, respectively. For the years ended December 31, 2013 and 2012, stock plan activity resulted in increases to additional paid-in capital of $32.0 million and $19.5 million, respectively.

16. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $12.8 million, $10.7 million and $8.5 million in the years ended December 31, 2013, 2012, and 2011, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

17. Share-Based Compensation

At December 31, 2013, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan (2011 Plan); and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

The 2011 Plan provides for the award of stock options, restricted shares and units, performance shares and units, and stock bonuses to the company's officers, employees, directors, consultants, advisors, and other service providers. The 2011 Plan allows for the issuance of 4.5 million shares of common stock.

In March 2013, our named executive officers were granted restricted stock awards with performance conditions as follows: our chief executive officer was awarded 186,858 shares, our chief financial officer was awarded 93,429 shares, our chief operating officer was awarded 62,286 shares, our chief accounting officer was awarded 28,029 shares, and our general counsel was awarded 21,800 shares. These awards were apportioned into four equal increments, and will vest in accordance with the following four measures: (i) 1/4th will vest in equal 1/3rd increments over three years on March 1, 2014, March 1, 2015, and March 1, 2016; (ii) 1/4th will vest upon our achievement of three-year Total Stockholder Return (TSR) as determined by Institutional Shareholder Services Inc. (ISS) calculations for the three-year period ending December 31, 2013 equal to or greater than the 50th percentile within our ISS peer group; (iii) 1/4th shall vest upon our achievement of total revenue in any of the 2013, 2014, or 2015 fiscal years equal to or greater than $12 billion, and (iv) 1/4th shall vest upon our achievement of the three-year earnings before interest, taxes, depreciation and amortization (EBITDA) margin percentage for the three-year period ending December 31, 2013 equal to or greater than 2.5%. In the event the vesting conditions are not achieved, the awards shall lapse. As of December 31, 2013 the TSR- and EBITDA-related performance measures were achieved.

Restricted share awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our employee stock purchase plan (ESPP), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2013, 2012, 2011, the inputs to this model were as follows: risk-free interest rates ranging from approximately 0.1% to 0.2%; expected volatilities ranging from approximately 30% to 50%, dividend yields of 0%, and an average expected life of 0.8 years. We issued approximately 299,600, 277,400 and 201,700 shares of our common stock under the ESPP during the years ended December 31, 2013, 2012, and 2011, respectively. In 2011, stockholders approved our 2011 ESPP, which superseded the 2002 Employee Stock Purchase Plan. The 2011 ESPP allows for the issuance of three million shares of common stock.

The following table illustrates the components of our share-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2013		2012		2011	
	(In thousands)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock and performance awards	$ 26,116	$ 22,489	$ 18,106	$ 12,943	$ 15,914	$ 9,946
Employee stock purchase plan and stock options	2,578	2,012	1,912	1,613	1,138	712
	$ 28,694	$ 24,501	$ 20,018	$ 14,556	$ 17,052	$ 10,658

As of December 31, 2013, there was $20.1 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.8 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 6.1% as of December 31, 2013. Also as of December 31, 2013, there was $0.6 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.0 years.

Restricted and performance stock activity for the year ended December 31, 2013 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2012	986,577	$ 23.74
Granted - restricted stock	587,706	32.15
Granted - performance stock	456,174	30.80
Vested - restricted stock	(669,075)	25.45
Forfeited	(61,530)	26.20
Unvested balance as of December 31, 2013	1,299,852	29.03

The total fair value of restricted and performance awards granted during the year ended December 31, 2013, 2012, and 2011 was $33.3 million, $16.2 million, and $18.4 million, respectively. The total fair value of restricted awards, including those with performance conditions, vested during the year ended December 31, 2013, 2012, and 2011 was $22.3 million, $25.4 million, and $12.2 million, respectively.

The weighted-average grant date fair value per share of the performance awards with vesting conditions based on TSR, as described above, was $28.24. We estimated the fair value on the grant date using a Monte Carlo Simulation to project TSR over the performance period using correlations and volatilities of the ISS peer group. Additional inputs included a risk-free interest rate of 0.14%, dividend yield of 0%, and an expected life of 0.83 years.

The total fair value of restricted stock units granted during the year ended December 31, 2012 was $0.3 million with a weighted average grant date fair value of $35.01. These restricted stock units vested during 2013. No restricted stock units were granted in 2013 and 2011 and there were no outstanding restricted stock units as of December 31, 2013.

Stock option activity for the year ended December 31, 2013 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Stock options outstanding as of December 31, 2012	414,061	$ 22.39		
Granted	45,000	33.02		
Exercised	(79,540)	20.09		
Forfeited	(300)	17.63		
Stock options outstanding as of December 31, 2013	379,221	24.14	$ 4,024	3.4
Stock options exercisable and expected to vest as of December 31, 2013	379,221	24.14	$ 4,024	3.4
Exercisable as of December 31, 2013	324,221	22.58	$ 3,947	2.5

The weighted-average grant date fair value per share of stock options awarded to the new members of our board of directors during 2013 was $14.67. The weighted-average grant date fair value per share of the stock option awarded to the director appointed during 2012 was $13.97. We estimate the fair value of each stock option award on the grant date using the Black-Scholes option pricing model. To determine the fair value of these stock options we applied risk-free interest rates of 1.1% to 1.4%, expected volatilities of 41.3% to 43.0%, dividend yields of 0%, and expected lives of 6 years to 7 years. No stock options were granted in 2011. The following is a summary of information about stock options outstanding and exercisable at December 31, 2013:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$16.89 – $19.11	78,671	2.0	$ 19.05	78,671	$ 19.05
$20.88	147,000	3.2	20.88	147,000	20.88
$22.86 – $34.82	153,550	4.4	29.87	98,550	27.93
	379,221			324,221	

18. Related Party Transactions

Leased Office Buildings

In February 2013, the Parent (as defined in Note 23, "Condensed Financial Information of Registrant,") entered into a lease (the "Lease") with 6th & Pine Development, LLC (the "Landlord") for office space located in Long Beach, California. The Lease consists of two office buildings, one of which is under construction. The first building which comprises approximately 90,000 square feet of office and storage space (Building A) was completed in June 2013; immediately following its completion, we occupied Building A and commenced lease payments. The second building (Building B) is expected to comprise approximately 120,000 square feet of office space.

The term of the Lease with respect to Building A commenced in June 2013, and the term of the Lease with respect to Building B is expected to commence in November 2014. The initial term of the Lease with respect to both buildings expires on December 31, 2024, subject to two options to extend the term for a period of five years each. Initial annual rent for Building A is approximately $2.6 million and initial annual rent for Building B is expected to be approximately $4.0 million. Rent will increase 3.75% per year through the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent. For information regarding the lease financing obligation, refer to Note 12, "Long-Term Debt."

The principal members of the Landlord are John C. Molina, our Chief Financial Officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of common stock in the Parent he holds as trustee. Dr. J. Mario Molina, our Chief Executive Officer and Chairman of the Board of Directors, holds a partial interest in such shares as trust beneficiary.

Stock Repurchase

In December 2012, the Parent purchased 110,988 shares of our common stock from certain Molina family trusts for an aggregate purchase price of $3.0 million. This purchase transaction was approved by our board of directors. The shares were purchased at a price of $27.03, representing the closing price per share of our common stock on December 26, 2012. The shares were purchased from the Janet M. Watt Separate Property Trust dated 10/22/2007, (Separate Property Trust), and the Watt Family Trust dated 10/11/1996 (Family Trust). Janet M. Watt is the sister, and her husband Lawrence B. Watt is the brother-in-law, of Dr. J. Mario Molina and John Molina. Ms. Watt is the sole trustee of the Separate Property Trust, and a co-trustee with Lawrence B. Watt of the Family Trust.

19. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our Chairman of the Board, President and Chief Executive Officer. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides professional medical services to the general public for routine non-life threatening, outpatient health care needs. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, American Family Care, Inc. (AFC), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will not operate at a loss, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by AFC are reviewed annually to assure the achievement of this goal.

Our California, Florida, New Mexico and Washington health plans have entered into primary care capitation agreements with JMMPC. These agreements also direct our health plans to fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, based on a monthly reconciliation. Because the AFC services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are insignificant.

We have determined that JMMPC is a variable interest entity (VIE), and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2013, JMMPC had total assets of $6.9 million, and total liabilities of $6.6 million. As of December 31, 2012, JMMPC had total assets of $1.4 million, and total liabilities of $1.1 million.

Our maximum exposure to loss as a result of our involvement with JMMPC is generally limited to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future. We provided an initial cash infusion of $0.3 million to JMMPC in the first quarter of 2012 to fund its start-up operations. During 2013 our health plans did not receive any amounts from JMMPC under the terms of the affiliation agreement. During 2012 our health plans received $0.2 million from JMMPC under the terms of the affiliation agreement.

New Markets Tax Credit

During the fourth quarter of 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC (Wells Fargo), its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC (Investment Fund), and certain of Wells Fargo's affiliated Community Development Entities (CDEs), in connection with our participation in the federal government's New Markets Tax Credit Program (NMTC). The NMTC was established by Congress in 2000 to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In the fourth quarter of 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $5.9 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $ 15.5 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $20.9 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $5.9 million. Additionally, financing costs incurred in structuring the arrangement amounting to $1.2 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE-collecting and remitting interest and fees and NMTC compliance-were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $5.9 million is included in cash at December 31, 2013 and December 31, 2012 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

20. Commitments and Contingencies

Certain Leasing Transactions

As described in Note 12, "Long-Term Debt," we entered into certain leasing transactions that have been classified as lease financing obligations. For the transaction entered into in June 2013, the initial lease term is 25 years, with five five-year renewal options. For the transaction relating to the construction project completed in June 2013, the initial lease term is 11.5 years, with two five-year renewal options.

Operating Leases

We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2023. Facility lease terms generally range from five to ten years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under all operating leases and lease financing obligations consist of the following approximate amounts:

	Lease Financing Obligations	Lease Financing Obligations - Related Party	Operating Leases	Total
		(In thousands)		
2014	$ 11,065	$ 3,330	$ 29,117	$ 43,512
2015	11,397	6,880	23,196	41,473
2016	11,739	7,138	15,890	34,767
2017	12,091	7,405	14,434	33,930
2018	12,454	7,683	12,832	32,969
Thereafter	333,275	52,538	13,569	399,382
Total minimum lease payments	$ 392,021	$ 84,974	$ 109,038	$ 586,033

Rental expense related to operating leases amounted to $24.5 million, $20.5 million, and $23.1 million for the years ended December 31, 2013, 2012, and 2011, respectively. The amounts reported in "Lease Financing Obligations," and "Lease Financing Obligations - Related Party," above represent our contractual lease commitments for the properties described in Note 12, "Long-Term Debt" under the subheading "Lease Financing Obligations." Payments under these leases adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of income.

Employment Agreements

In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which were amended and restated in 2009. These employment agreements had initial terms of one to three years and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of stock-based awards, and a cash payment for health and welfare benefits.

In 2013 we entered into employment agreements with our Chief Operating Officer, Chief Accounting Officer, and Chief Legal Officer. These agreements continue until terminated by us, or the executive resigns. If the executive's employment is terminated by us without cause or the executive resigns for good reason, the executive will be entitled to receive one year's base salary and termination bonus, as defined, full vesting of all time-based equity compensation, and a cash payment for health and welfare benefits.

Payment of the executives' severance benefits is contingent upon the executive's signing a release agreement waiving claims against us. If the executives are terminated for cause, no further payments are due under the contracts.

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently

uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial condition, cash flows, or results of operations.

Washington Health Plan

The Washington Health Care Authority (HCA) has communicated that it believes it has erroneously overpaid our Washington health plan with regard to certain claims. The alleged overpayments, which were incorporated into the capitation rates paid to our Washington health plan, date back to the July 1, 2012 start date of the current contract. However, HCA has provided us with minimal data by which we might independently validate such allegations. Furthermore, the alleged errors, if they in fact occurred, were unilateral errors by HCA for which our Washington health plan had assumed and bore no contractual risk. We believe that any actual liability for the alleged overpayment claims is not currently probable or reasonably estimable.

California Health Plan Rate Settlement Agreement

In the fourth quarter of 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program).

Under the terms of the settlement agreement, DHCS has agreed to extend each of the California health plan's existing Medi-Cal managed care contracts for an additional five years, including its contracts in San Diego, San Bernardino, Riverside, and Sacramento counties. In addition, effective January 1, 2014, the settlement established a settlement account applicable to the California health plan's Medi-Cal, Seniors and Persons with Disabilities (SPD), and the dual eligibles pilot programs. The settlement account was established with an initial balance of zero, and will be adjusted annually to reflect a calendar year deficit or surplus. A deficit or surplus will result to the extent the health plan's pre-tax margin is below or above 3.25%, subject to further adjustment as specified in the settlement agreement. Such settlement amount shall be based on 75% of the health plan's revenue in 2014; and 50% of the health plan's revenue in each subsequent year of the settlement agreement. Cash settlement will occur after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our Medi-Cal managed care contracts. Upon expiration of the settlement agreement, if the settlement account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. The alternative minimum amount is calculated as follows: (i) $40 million, minus (ii) any partial settlement payments previously made to our California health plan by DHCS, minus (iii) 50% of the pre-tax income on our Medi-Cal, SPD, and dual eligibles pilot program business in excess of a 2.0% pre-tax margin for each calendar from 2014 through 2017. If the settlement account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40 million.

The settlement agreement did not impact our consolidated financial condition, cash flows, or results of operations for the year ending December 31, 2013.

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered through our primary care clinics. We also carry claims-made managed care errors and omissions professional liability insurance for our health plan operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also attempt to enforce capital requirements upon us that require the retention of net worth in

excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $608 million at December 31, 2013, and $550 million at December 31, 2012. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $365.2 million and $46.9 million as of December 31, 2013, and 2012, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC), rules. All of our state health plans have adopted these rules, which may vary from state to state, except California and Florida. California and Florida have not adopted NAIC risk-based capital requirements for HMOs, and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2013, our health plans had aggregate statutory capital and surplus of approximately $662 million compared with the legally required minimum aggregate statutory capital and surplus of approximately $389 million. As described in Note 2, "Significant Accounting Policies," under the subheading "Recent Accounting Pronouncements," we anticipate that the health care federal excise tax on health insurers will result in the recording of a liability of approximately $85 million spread across our all of our health plans. The liability for that excise tax, when recorded effective January 1, 2014, will reduce our aggregate statutory capital and surplus by the same amount. All of our health plans were in compliance with the minimum capital requirements at December 31, 2013. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Receivable/Liability for Ceded Life and Annuity Contracts

Prior to February 2012, we reported a 100% ceded reinsurance arrangement for life insurance policies written and held by our then wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. In February 2012, we sold Molina Healthcare Insurance Company and recorded a gain of $1.7 million to general and administrative expenses in 2012 upon closing of the transaction.

Molina Healthcare Insurance Company is now named Catamaran Insurance of Ohio (Catamaran). In the event that both the reinsurer and Catamaran are unable to pay benefits on policies that were in-force as of the sale date, we remain ultimately liable for payment of such benefits. Because we no longer own Catamaran, we no longer have access to its financial records; therefore, the maximum amount of potential future payments is not determinable. We believe the possibility of our having to pay such benefits is remote, and no provision for the payment of such benefits is included in our consolidated financial statements.

21. Segment Information

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and also includes our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides MMIS design, development and implementation; business process outsourcing solutions; hosting services; and information technology support services to Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, “Significant Accounting Policies.” The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Revenue from continuing operations:			
Health Plans segment:			
Premium revenue	$ 6,179,170	$ 5,544,121	$ 4,211,493
Premium tax revenue	172,017	158,991	154,589
Investment income	6,890	5,075	5,446
Rental income and other revenue	26,322	18,312	8,288
Molina Medicaid Solutions segment:			
Service revenue	204,535	187,710	160,447
	$ 6,588,934	$ 5,914,209	$ 4,540,263
Depreciation and amortization reported in the consolidated statements of cash flows:			
Health Plans segment	$ 67,446	$ 58,577	$ 45,734
Molina Medicaid Solutions segment	26,420	20,187	28,649
	$ 93,866	$ 78,764	$ 74,383
Operating income from continuing operations:			
Health Plans segment	$ 103,931	$ 17,366	$ 133,758
Molina Medicaid Solutions segment	32,629	23,727	2,063
Total operating income from continuing operations	136,560	41,093	135,821
Interest expense	52,071	16,769	15,519
Other expenses	3,343	945	—
Income from continuing operations before income taxes	$ 81,146	$ 23,379	$ 120,302

	As of December 31,		
	2013	2012	2011
	(In thousands)		
Goodwill and intangible assets, net:			
Health Plans segment	$ 248,562	$ 139,710	$ 159,963
Molina Medicaid Solutions segment	81,047	89,089	95,787
	$ 329,609	$ 228,799	$ 255,750
Total assets:			
Health Plans segment	$ 2,809,439	$ 1,702,212	$ 1,429,283
Molina Medicaid Solutions segment	193,498	232,610	222,863
	$ 3,002,937	$ 1,934,822	$ 1,652,146

Goodwill and intangible assets increased in the Health Plans segment due to the acquisitions described in Note 4, "Business Combinations."

22. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2013 and 2012. We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal on June 30, 2012. Effective June 30, 2013 the transition obligations associated with that contract terminated. Therefore, we have reclassified the results relating to the Missouri health plan to discontinued operations for all periods presented.

	For The Quarter Ended			
	March 31, 2013(1)	June 30, 2013(3)	September 30, 2013	December 31, 2013
	(In thousands, except per-share data)			
Premium revenue (2)	$ 1,497,433	$ 1,501,729	$ 1,584,656	$ 1,595,352
Service revenue	49,756	49,672	51,100	54,007
Operating income (loss), Health Plans segment	61,520	40,151	16,929	(14,669)
Operating income, Molina Medicaid Solutions segment	6,353	6,295	7,997	11,984
Income (loss) from continuing operations	$ 30,522	$ 15,796	$ 7,553	$ (9,041)
(Loss) income from discontinued operations	(607)	8,775	16	(85)
Net income (loss)	$ 29,915	$ 24,571	$ 7,569	$ (9,126)
Net income (loss) per share (4):				
Basic	$ 0.65	$ 0.54	$ 0.17	$ (0.20)
Diluted	$ 0.64	$ 0.53	$ 0.16	$ (0.20)

	For The Quarter Ended			
	March 31, 2012(1)	June 30, 2012	September 30, 2012	December 31, 2012
	(In thousands, except per-share data)			
Premium revenue (2)	$ 1,225,363	$ 1,392,774	$ 1,448,600	$ 1,477,384
Service revenue	42,205	41,724	48,422	55,359
Operating income (loss), Health Plans segment	27,903	(56,072)	(5,788)	51,323
Operating income, Molina Medicaid Solutions segment	8,409	6,642	8,156	520
Income (loss) from continuing operations	$ 19,894	$ (33,057)	$ (165)	$ 26,194
(Loss) income from discontinued operations	(1,805)	(4,249)	3,529	(551)
Net income (loss)	$ 18,089	$ (37,306)	$ 3,364	$ 25,643
Net income (loss) per share (4):				
Basic	$ 0.39	$ (0.80)	$ 0.07	$ 0.55
Diluted	$ 0.39	$ (0.80)	$ 0.07	$ 0.54

(1) In connection with the reclassification of Missouri health plan results to discontinued operations, amounts differ from amounts previously reported in our Quarterly Reports on Form 10-Q as follows: premium revenue for the quarters ended March 31, 2013 and 2012 decreased $0.2 million and $56.6 million, respectively; operating income, Health Plans segment, for the quarters ended March 31, 2013 and 2012 decreased $0.8 million and $2.9 million, respectively.

(2) Prior to the third quarter of 2013, premium tax revenue was included in premium revenue. The presentation change reduced premium revenue for the amount now reported as premium tax revenue. In connection with this presentation change, amounts differ from the amounts previously reported in our Quarterly Reports on Form 10-Q as follows: premium revenue reported for the quarter ended March 31, 2013 and 2012 decreased $37.0 million and $43.4 million, respectively; premium revenue reported for the quarter ended June 30, 2013 and 2012 decreased $46.9 million and $39.6 million, respectively.

(3) We abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of $9.5 million, which is included in (loss) income from discontinued operations.

(4) Potentially dilutive shares issuable pursuant to our 1.125% Warrants were not included in the computation of diluted net income per share for all quarters in 2013, because to do so would have been anti-dilutive. Potentially dilutive shares issuable pursuant to our 3.75% Notes were not included in the computation of diluted net income per share for the quarters ended March 31, 2013, June 30, 2013, and all quarters in 2012, because to do so would have been anti-dilutive.

23. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2013 and 2012, and our condensed statements of income, condensed statements of comprehensive income and condensed statements of cash flows for each of the three years in the period ended December 31, 2013.

Condensed Balance Sheets

	December 31,	
	2013	2012
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 99,698	$ 39,068
Investments	262,665	2,015
Income tax refundable	8,403	8,868
Deferred income taxes	10,073	9,706
Due from affiliates	35,928	55,382
Prepaid and other current assets	28,387	19,164
Total current assets	445,154	134,203
Property and equipment, net	225,522	108,808
Goodwill and intangible assets, net	68,902	52,302
Investments in subsidiaries	992,998	768,765
Deferred income taxes	17,245	—
Derivative asset	186,351	—
Advances to related parties and other assets	52,615	38,215
	$ 1,988,787	$ 1,102,293
LIABILITIES AND STOCKHOLDERS' EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 109,388	$ 73,883
Long-term debt	784,862	215,468
Deferred income taxes	—	17,122
Derivative liability	186,239	—
Other long-term liabilities	15,361	13,506
Total liabilities	1,095,850	319,979
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding:		
45,871 shares at December 31, 2013 and 46,762 shares at December 31, 2012	46	47
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	340,848	285,524
Accumulated other comprehensive loss	(1,086)	(457)
Treasury stock, at cost; outstanding: 111 shares at December 31, 2012	—	(3,000)
Retained earnings	553,129	500,200
Total stockholders' equity	892,937	782,314
	$ 1,988,787	$ 1,102,293

Condensed Statements of Income

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Revenue:			
Management fees and other operating revenue	$ 599,049	$ 406,981	$ 308,287
Investment income	2,768	550	81
Total revenue	601,817	407,531	308,368
Expenses:			
Medical care costs	37,862	33,102	31,672
General and administrative expenses	503,781	367,606	272,302
Depreciation and amortization	51,562	38,794	31,355
Total expenses	593,205	439,502	335,329
Operating income (loss)	8,612	(31,971)	(26,961)
Interest expense	50,508	14,469	14,958
Other expense	3,811	—	—
Loss before income taxes and equity in net income of subsidiaries	(45,707)	(46,440)	(41,919)
Income tax benefit	(15,455)	(15,779)	(14,826)
Net loss before equity in net income of subsidiaries	(30,252)	(30,661)	(27,093)
Equity in net income of subsidiaries	83,181	40,451	47,911
Net income	$ 52,929	$ 9,790	$ 20,818

Condensed Statements of Comprehensive Income

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Net income	$ 52,929	$ 9,790	$ 20,818
Other comprehensive income:			
Gross unrealized investment (loss) gain	(1,015)	1,529	1,167
Effect of income tax (benefit) expense	(386)	581	380
Other comprehensive (loss) income, net of tax	(629)	948	787
Comprehensive income	$ 52,300	$ 10,738	$ 21,605

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Operating activities:			
Net cash provided by operating activities	$ 62,602	$ 20,611	$ 28,606
Investing activities:			
Capital contributions to subsidiaries	(166,112)	(100,221)	(58,412)
Dividends received from subsidiaries	24,429	101,800	86,284
Purchases of investments	(362,927)	(1,905)	(2,020)
Sales and maturities of investments	97,713	4,067	3,760
Proceeds from sale of subsidiary, net of cash surrendered	—	9,162	—
Purchases of equipment	(76,873)	(61,813)	(30,930)
Changes in amounts due to/from affiliates	(5,888)	5,187	(50,090)
Change in other assets and liabilities	(6,175)	(1,342)	(20,441)
Net cash used in investing activities	(495,833)	(45,065)	(71,849)
Financing activities:			
Proceeds from issuance of 1.125% Notes, net of deferred issuance costs	537,973	—	—
Proceeds from sale-leaseback transactions	158,694	—	—
Purchase of 1.125% Notes call option	(149,331)	—	—
Proceeds from issuance of warrants	75,074	—	—
Treasury stock repurchases	(52,662)	(3,000)	(7,000)
Principal payment on term loan of subsidiary	(46,963)	—	—
Payment of credit facility fees	—	—	(1,125)
Repayment of amount borrowed under credit facility	(40,000)	(20,000)	—
Proceeds from exercise of stock options and employee stock plan purchases	9,402	8,205	7,347
Excess tax benefits from employee stock compensation	1,674	3,667	1,651
Amount borrowed under credit facility	—	60,000	—
Net cash provided by financing activities	493,861	48,872	873
Net increase (decrease) in cash and cash equivalents	60,630	24,418	(42,370)
Cash and cash equivalents at beginning of year	39,068	14,650	57,020
Cash and cash equivalents at end of year	$ 99,698	$ 39,068	$ 14,650

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

Molina Healthcare, Inc. (the Registrant, or the Parent), was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc. Molina Healthcare of Michigan, Inc. and Molina Healthcare of Washington, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and

other restrictive financial requirements of the states in which they operate. Charges in 2013, 2012, and 2011 for these services amounted to $592.1 million, $406.4 million, and $307.9 million, respectively, which are included in operating revenue.

During 2013, the Registrant used a portion of the proceeds from the sale of the Molina Center, described in Note 12, "Long-Term Debt," to repay the remaining principal balance of the related term loan, on behalf of a subsidiary of the Registrant.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Dividends, Capital Contributions and Surplus Note

During 2013, 2012, and 2011, the Registrant received dividends from its subsidiaries. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries. In addition, in 2011 a subsidiary of the Registrant repaid a surplus note in favor of the Registrant amounting to $9.7 million, including accrued interest. Such amount was a reduction of due from affiliates and prepaid and other current assets.

During 2013, 2012, and 2011, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries, net of insignificant returns of capital.

Note D - Related Party Transactions

The Registrant's related party transactions are described in Note 18, "Related Party Transactions."

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosures

None.

Item 9A. Controls and Procedures

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2013. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework* (1992 framework).

Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2013, based on those criteria.

Ernst & Young, LLP, the independent registered public accounting firm who audited the Company's Consolidated Financial Statements included in this Form 10-K, has issued a report on the Company's internal control over financial reporting, which is included herein.

Changes in Internal Control over Financial Reporting. There were no changes in the Company's internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2013, that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2013, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (1992 framework) (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2013 and 2012, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2013 and our report dated February 26, 2014 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2014

PART III

Item 10. Directors, Executive Officers, and Corporate Governance

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our definitive proxy statement for our 2014 Annual Meeting of Stockholders. The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Election of Directors," "Corporate Governance," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2014 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 11. Executive Compensation

The information required by Items 402, 407(e)(4), and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2014 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2013)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)		Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)	
Equity compensation plans approved by security holders	379,221	(1)	$ 24.14	5,308,237	(2)

(1) Options to purchase shares of our common stock issued under the 2002 Equity Incentive Plan. Further grants under the 2002 Equity Incentive Plan have been suspended.

(2) Includes shares remaining available to issue under the 2011 Equity Incentive Plan, and the 2011 Employee Stock Purchase Plan.

The remaining information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2014 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Related Party Transactions" and "Corporate Governance" in our definitive proxy statement for our 2014 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

Additionally, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 18, "Related Party Transactions," and Note 19, "Variable Interest Entities," under the subheading "Joseph M. Molina M.D., Professional Corporations."

Item 14. Principal Accountant Fees and Services

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2014 Annual Meeting of Stockholders, and such required information is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The financial statements included in Item 8 of this Form 10-K, Financial Statements and Supplementary Data, above are filed as part of this annual report.

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 26th day of February, 2014.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina

Joseph M. Molina, M.D. (Dr. J. Mario Molina)
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	February 26, 2014
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	February 26, 2014
/s/ Joseph W. White **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	February 26, 2014
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	February 26, 2014
/s/ Daniel Cooperman **Daniel Cooperman**	Director	February 26, 2014
/s/ Charles Z. Fedak **Charles Z. Fedak, CPA, MBA**	Director	February 26, 2014
/s/ Steven James **Steven James, CPA**	Director	February 26, 2014
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	February 26, 2014
/s/ Steven Orlando **Steven Orlando, CPA (inactive)**	Director	February 26, 2014
/s/ Ronna Romney **Ronna Romney**	Director	February 26, 2014
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	February 26, 2014
/s/ Dale Wolf **Dale Wolf**	Director	February 26, 2014

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INDEX TO EXHIBITS

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

Number	Description	Method of Filing
1.1	Purchase Agreement, dated as of February 11, 2013, among Molina Healthcare, Inc. and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Representatives of the Initial Purchasers	Filed as Exhibit 1.1 to registrant's Form 8-K filed February 15, 2013.
2.1	Asset Purchase Agreement between Molina Healthcare, Inc. and Unisys Corporation dated as of January 18, 2010	Filed as Exhibit 2.1 to registrant's Form 8-K filed January 19, 2010.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Certificate of Amendment to Certificate of Incorporation	Filed as Exhibit 3.1 to registrant's Form 8-K filed July 24, 2013.
3.3	Second Amended and Restated Bylaws of Molina Healthcare, Inc.	Filed as Exhibit 3.1 to registrant's Form 8-K filed July 24, 2013.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2007.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2007.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2007.
4.4	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.5	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.4	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.5	Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed herewith.
10.6	Amendment No.1 to the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013)	Filed herewith.
10.7	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.8	2011 Equity Incentive Plan	Filed herewith.
10.9	2011 Employee Stock Purchase Plan	Filed herewith.

Number	Description	Method of Filing
10.10	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.11	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.12	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.13	Form of Stock Option Agreement under Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.14	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.
10.15	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
10.16	Employment Agreement with Terry Bayer dated June 14, 2013	Filed as Exhibit 10.1 to registrant’s Form 8-K filed June 14, 2013.
10.17	Employment Agreement with Joseph White dated June 14, 2013	Filed as Exhibit 10.2 to registrant’s Form 8-K filed June 14, 2013.
10.18	Employment Agreement with Jeff Barlow, dated June 14, 2013	Filed as Exhibit 10.3 to registrant’s Form 8-K filed June 14, 2013.
10.19	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
10.20	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
10.21	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed as Exhibit 10.16 to registrant’s Form 10-K filed February 28, 2013.
10.22	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.23	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
10.24	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.
10.25	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.
10.26	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.27	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.28	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.29	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.30	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.
10.31	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013.

Number	Description	Method of Filing
10.32	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013.
10.33	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013.
10.34	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013.
10.35	Lease Agreement, dated as of February 27, 2013, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed as Exhibit 10.32 to registrant’s Form 10-K filed February 28, 2013.
10.36	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013.
10.37	Agreement of Purchase and Sale, dated as of June 12, 2013, by and between Molina Healthcare, Inc. and Molina Center, LLC, and AG Net Lease Acquisition Corp.	Filed as Exhibit 10.1 to registrant's Form 10-Q filed July 25, 2013.
10.38	Lease Agreement, dated as of June 13, 2013, by and between AGNL Clinic, L.P., and Molina Healthcare, Inc.	Filed as Exhibit 10.2 to registrant's Form 10-Q filed July 25, 2013.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
101.INS	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

EXHIBIT 10.5

MOLINA HEALTHCARE, INC.

AMENDED AND RESTATED

DEFERRED COMPENSATION PLAN

(2013)

This Deferred Compensation Plan (the "Plan") is amended and restated effective October 1, 2013 (the "Restatement"), by MOLINA HEALTHCARE, INC., a Delaware corporation (the "Company") with reference to the following:

A. The Company originally established a Deferred Compensation Plan for key employees, effective September 1, 1999 (the "Original Plan"). The Original Plan was amended on March 29, 2001.

B. As a result of the adoption of section 409A of the Internal Revenue Code of 1986 (the "Code"), the Original Plan was frozen effective at midnight on December 31, 2004.

C. This Plan was implemented effective January 1, 2005 to replace the Original Plan with a new plan that complies with the requirements of Code section 409A and the related Treasury Regulations (and other guidance from the Internal Revenue Service) thereunder (collectively, the "409A Requirements").

D. This Plan was established to provide key employees of the Company and its subsidiaries a tax deferred, capital accumulation program. The Plan is intended to provide benefits to a select group of management or highly compensated personnel in order to attract and retain the highest quality executives. The Company does not intend for this to be a qualified plan within the meaning of sections 401(a) and 501(a) of the Code.

E. This Plan is hereby amended and restated to ensure compliance with the 409A Requirements.

F. This Plan is intended to be an unfunded plan for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Company contributions and voluntary compensation deferrals shall be held in a "Rabbi Trust," as that term is defined in Revenue Procedure 92-64, 1992-2 C.B. 422.

NOW, THEREFORE, the Company hereby adopts this Plan on the following terms and conditions:

1. Definitions. Whenever used in this Plan, the following words and phrases shall have the meaning set forth below, unless a different meaning is expressly provided or plainly required by the context in which the words or phrases are used:

1.1. Beneficiary means a person designated by a Participant to receive Plan benefits in the event of the Participant's death.

1.2. Board means the Board of Directors of the Company and its successors.

1.3. Change in Control means, a Change in Ownership, a Change in the Effective Control, a Change in Assets or a termination of the Plan and distribution of compensation deferred hereunder within twelve (12) months after any of the foregoing events. For purposes of this Section, "Company" shall include (i) the company for which a Participant is performing services at the time of the Change in Control, (ii) the company liable for the payment of the deferred compensation (or all companies liable if more than one company is liable), or a company that is a majority shareholder of a company identified in (i) or (ii), or any company in a chain of companies in which each company is a majority shareholder of another company in the chain, ending in a company identified in (i) or (ii). The events described in this section will not be considered to occur, with respect to an employee of a participating entity, if a participating entity is sold and the employee of the participating entity continues employment with the Employer subsequent to the sale. The events described in this section have the following meanings:

a. Change in Ownership means the acquisition of stock by any one person or persons acting in concert (a "group") of the Company, that when added to the stock of the person or group constitutes more than 50% of the total fair market value or total voting power of the stock of the Company. The acquisition of additional stock by any person or group who are already considered to own more than 50% of the stock of the Company shall not constitute a change in ownership of the Company. An increase in the percentage of stock owned by any person or group, as result of a transaction in which the Company acquires its stock in exchange for property will be treated as an acquisition of stock for purposes of this section.

b. Change in the Effective Control means the occurrence of any of the following events, despite the fact that the Company has not undergone a Change in Ownership as described above:

i. The acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of ownership of stock of the Company possessing 35% or more of the total voting power of the stock, except if such acquisition is the result of a change in "record ownership" and not a change in "beneficial ownership;"

ii. The replacement of a majority of the Company's board of directors during any 12-month period by directors whose appointment or election is not endorsed by a majority of the members of the

Company's board of directors prior to the date of the appointment or election; or

iii. A transaction between the Company and another company resulting in a Change in Control. Provided that this section shall not apply to the acquisition of additional control of the Company by any person or group, if that person or group is considered to effectively control the Company prior to the acquisition.

iv. Provided that this section shall not apply to the acquisition of additional control of the Company by any person or group, if that person or group is considered to effectively control the Company prior to the acquisition.

c. Change in Assets means the acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of assets from the Company, that have a total gross fair market value equal to, or more than, 40% of the total gross fair market value of all the assets of the Company immediately prior to such acquisition or acquisitions. A transfer of assets by the Company will not be treated as a Change in Assets if the assets are transferred to any of the following (determined immediately after the transfer):

i. A shareholder of the Company (as determined, immediately before the asset transfer) in exchange for or with respect to its stock;

ii. An entity, 50% or more of the total value or voting power of which is owned directly or indirectly by the Company;

iii. A person or group that owns, directly or indirectly, 50% or more of the total value or voting power of all the outstanding stock of the Company; or

iv. An entity, at least 50% of the total value or voting power of which is owned, directly or indirectly, by a person described in (iii).

For purposes of this subsection (c), the gross fair market value of assets is the value of the assets of the Company or the value of the assets being disposed of with regard to any liabilities associated with such assets. If assets are transferred to an entity that is controlled by the shareholders of the transferring company immediately after the transfer, there is no Change in Control.

1.4. Company means MOLINA HEALTHCARE, INC., a Delaware corporation.

1.5. Company Stock means shares of stock issued by the Company.

1.6. Disability means with respect to a Participant (i) the inability to engage in any substantial gainful activity by reason of any medically determinable physical or

mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months, or (ii) the receipt of income replacement benefits for a period of not less than three (3) months under an accident and health plan covering employees of the Company, by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months.

1.7. The original Effective Date of this Plan means January 1, 2005. The Effective Date of this Restatement shall mean October 1, 2013.

1.8. Key Employee means an employee of the Company or a Subsidiary, who is (A) a member of a select group of management or highly compensated employees within the meaning of §2520.104-23 of the Department of Labor ERISA Regulations, (B) projected to receive Plan Year Compensation (base pay plus bonus), including amounts deferred to any 401(k) Plan, Deferred Compensation Plan, or Cafeteria Plan maintained by the Company, of $125,000 or more and (C) designated by the Plan Committee as a Key Employee.

1.9. Participant means (A) a Key Employee who timely files a Written Election pursuant to Section 2.3, below, and (B) a former Employee who, at the time of his termination from employment, retirement, death, or occurrence of Disability, retains, or whose beneficiary retains, benefits earned under the Plan in accordance with its terms. A Participant is considered an Active Participant in the Plan until the earlier of the following: (A) the Participant separates from service under the terms of this Plan; or (B) the Participant is no longer a Key Employee.

1.10. Plan means the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013) evidenced by this document and the Trust Agreement previously established in connection herewith.

1.11. Plan Committee means the individuals appointed by the Board from time to time to administer the Plan as provided herein.

1.12. Plan Year means the calendar year.

1.13. Plan Year Compensation means the total taxable income (other than Share Awards) paid to an Active Participant by the Company or a Subsidiary during any Plan Year, or portion thereof in which he is a Participant in this Plan, as reflected on a Key Employee's form W-2.

1.14. Separation from Service. A separation from service with the Company, provided such separation constitutes a separation from service under Treasury Regulation Section 1.409A-1(h).

1.15. Share Awards means shares of Company Stock which are awarded to a Participant as an employee by the Company.

1.16. Specified Employee means a "key employee" of the Company, as defined in section 416(i) of the Code without regard to paragraph five (5) thereof.

1.17. Subsidiary means any entity in which the Company owns not less than 80% of the outstanding voting interests.

1.18. Trust Agreement means the grantor trust established in connection with this Plan between the Company as grantor and the Trustee.

1.19. Trustee means Union Bank of California and any successor institutional trustee named to succeed such Trustee under the terms of the Trust Agreement established in connection with this Plan.

1.20. Unforeseeable Financial Emergency means: (i) an illness or accident of the Participant or beneficiary, the Participant's or beneficiary's spouse, or the Participant's or beneficiary's dependent; (ii) the loss of the Participant's or beneficiary's property due to casualty; or (iii) other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant or beneficiary. Determination of whether a Participant has incurred an Unforeseeable Financial Emergency shall be made by the Plan Committee, in accordance with the requirements of Section 409A of the Code and any guidance issued thereunder.

2. Participation.

2.1. Eligibility. An employee of the Company or a Subsidiary is eligible to participate in this Plan upon meeting the criteria for Key Employee specified in Section 1.7. Any Key Employee who was a Participant in the Original Plan and who continued in the employ of the Company on the Effective Date will continue to be a Participant in this Plan, subject to the right of the Company's Chief Executive to no longer designate such employee as a Key Employee thereafter.

2.2. Entry Date. An employee of the Company or a Subsidiary who met the eligibility requirement specified in Section 2.1 as of the Effective Date of this Plan Restatement is a Participant in the Plan as of the Effective Date. Newly eligible employees of the Company who have met the enrollment requirements under Section 2.3 of the Plan shall commence participation in the Plan within thirty (30) days of their date of hire. An employee of the Company or a Subsidiary who meets the eligibility requirements specified in Section 2.1 but fails to meet the requirements in accordance with Section 2.3 within the period required, shall become a Participant in this Plan on the first day of the next Plan year following submission of a Written Election form as specified in Section 2.3.

2.3. Written Election by Participant. As a condition to participation in the Plan, each newly eligible Employee shall complete, sign and return to the Plan Committee a Written Election within thirty (30) days after the date the Participant becomes eligible to participate in the Plan. Annual enrollment shall be in December each year for the following Plan Year. Each Participant shall submit a Written Election prior to the first day of the Plan Year in which he or she will be a Participant.

a. Such Written Election shall be made on the form presented to the Participant by the Plan Committee and shall set forth:

v. his election to participate in this Plan under the terms hereof;

vi. the amount of Plan Year Compensation the Participant has determined to defer under the Plan for the Plan Year, pursuant to Section 3.1 below;

vii. the investment vehicles into which the Participant desires to have his Account attributable to deferral of Plan Year Compensation invested, as provided in Section 3.5 below, and the percentage of such Account allocated to each elected investment vehicle;

viii. the date on which his benefit is to be distributed which is the earliest of: (a) the date specified for an In-Service Withdrawal; (b) an Unforeseeable Financial Emergency; (c) the later of (i) when he separates from service with the Company for any reason or (ii) a date subsequent to his termination of employment specified by the Participant;

ix. the form in which his benefit is to be distributed upon separation from service or retirement.

b. A Participant's most recently submitted Written Election shall remain in effect for subsequent Plan Years until the Participant changes it in accordance with the following:

v. A Participant may change the amount of Plan Year Compensation he/she will defer under the Plan for future Plan Years by submitting a new Written Election to the Company. Such new election must be submitted to the Company on or before the seventh (7th) day immediately preceding the Plan Year for which the new election is to be effective. Any election of the amount of Plan Year Compensation to defer for a given Plan Year shall be irrevocable on and after the first day of the Plan Year for which the election was made.

vi. A Participant may change the investment vehicle(s) in which he desires to have that portion of his Account attributable to Plan Year

Compensation and investment income invested and the percentage of his Account allocated to each investment vehicle by completing and submitting any form or forms required by the Company. Changes in investment vehicle(s) will be made as of the last business day of each month. The Participant must submit the completed form or forms with the requested changes to the Trustee on or before the twenty-fifth (25th) day of the current month (or the last business day immediately preceding the twenty-fifth of the month) for the changes to be made by the last business day of the current month. Changes requested on forms submitted after the twenty-fifth (25th) day of the current month will be made on the last business day of the following month.

vii. Notwithstanding the foregoing, the Trustee shall, at the direction of the Plan Committee, have the duty and authority to invest the trust assets and funds in accordance with the terms of the Trust Agreement, and all rights associated with the trust assets shall be exercised by the Trustee as designated by the Plan Committee and shall in no event be exercisable by or be settled upon Participants or their Beneficiaries.

viii. A Participant may change the date or form of distribution by submitting a new Written Election to the Company, provided that the following conditions are met:

(1) That such election may not take effect until at least twelve (12) months after the date on which the election is made;

(2) In the case of an election related to a payment other than a payment on account of death, disability or the occurrence of an financial hardship, such payment must be deferred for a period of not less than five (5) years from the date such payment would have otherwise been made, and

(3) Any election related to a payment at a specified time or pursuant to a fixed schedule may not be made less than twelve (12) months prior to the date of the first scheduled payment.

2.4. Duration of Participation. Any Key Employee who has become a Participant at any time shall remain a Participant, even though he is no longer an Active Participant, until his entire benefit under the terms of the Plan has been paid to him (or to his Beneficiary in the event of his death), at which time he ceases to be a Participant.

2.5. Maintenance of Records. The annual Designation of Participants by the Plan Committee shall be maintained in the corporate minute book. The Written Elections by Participants shall be maintained in the corporate records with all other files pertaining to this Plan by the Plan Committee.

3. Contributions and Allocation.

3.1. Participant Contributions. A Participant may elect to defer a portion, up to 100%, of his Plan Year Compensation. For a Participant's initial Plan Year of participation, the minimum deferral for base pay and bonus pay, combined, must be at least $5,000. For succeeding years of participation, a Participant may not defer an amount less than the minimum established from year to year by the Plan Committee. A written election must be submitted, pursuant to the terms of Section 2.3, specifying the dollar amount or percentage of Plan Year Compensation the Participant has chosen to defer. A separate written election must be submitted, pursuant to the terms of Section 2.3, specifying the dollar amount or percentage of bonus pay the employee has chosen to defer. Once a Participant's contributions for a Plan Year reach his elected dollar amount or percentage, such Participant shall not be allowed to defer additional portions of his Plan Year Compensation for the remainder of the Plan Year. Any amounts in excess of his elected dollar amount or percentage inadvertently deferred shall be refunded to the Participant as soon as practicable.

3.2. Company Contributions. The Company may, subject to the sole discretion of its Board of Directors, make contributions for the Participants, reserving the right to discriminate among the Participants in the amount or percentage of contributions made in any Plan Year.

3.3. Allocation of Participant Contributions. All amounts which a Participant elects to defer under the terms of this Plan shall be allocated to his Account as of the last business day of each month. Each such Participant Deferral Account shall be credited with earnings as provided in Section 3.5 below.

3.4. Allocation of Company Contributions. Any amounts contributed by the Company on behalf of a Participant under Section 3.2 above shall be allocated to the Company Contribution Account of each Participant. Each such Company Contribution Account shall be credited with earnings as provided in Section 3.5 below.

3.5. Credited Earnings. The Account of each Participant (which includes his Participant Deferral Account established under Section 3.1 and his Company Contribution Account established under Section 3.2) shall be credited as of the last business day of each month with the actual monthly earnings on the investments allocated to his Account.

3.6. Funding. The assets of the Plan shall be held under the Trust Agreement (a "grantor trust") designated in Article I above. As such, the Plan is intended to be an unfunded plan for purposes of the requirements of ERISA and the Code.

Notwithstanding the provisions under the terms of the Plan that amounts contributed to this Plan, plus earnings thereon, shall be allocated to separate Accounts of Participants, all such amounts credited to such individual Accounts shall remain the general assets of the Employer, and as such shall remain subject to the claims of the general creditors of the Company. This Plan and the related

Trust Agreement do not create, nor does any Employee, Participant or Beneficiary have, any right with respect to any specific assets of the Company or the Plan.

4. Vesting of Accounts. The Participant Deferral Accounts and the Company Contribution Account of each Participant shall be 100% vested in such Participant at all times.

5. Types of Benefits.

5.1. Separation from Service Benefit. A Participant's Separation for Service Benefit is the unpaid balance of his Accounts which equals the total of all contributions made by the Participant and the Company allocated to his Account and all earnings credited to his Account in accordance with the terms of the Plan and the Trust Agreement, less any distributions already paid.

5.2. Disability Benefit. If a Participant becomes Disabled as defined in Section 1.5 above, the Company will pay his Retirement Benefit, calculated under Section 5.1, in the applicable form elected by the Participant in his Written Election.

A Participant who believes he has suffered a Disability within the meaning of Section 1.5 shall make application to the Plan Committee, on a form prescribed by the Plan Committee, for a determination of whether he is Disabled under the terms of Section 1.5. The Participant shall make such written application to the Plan Committee on or after the date which is at least five (5) consecutive months following the date he first suffered the impairment under consideration. Any determination by the Plan Committee that a Disability exists under the provisions of Section 1.5 shall be effective only after the date the Disability has existed for six (6) consecutive months. All determinations made by the Plan Committee shall be final, and no Participant shall be considered Disabled for any purpose whatsoever under the provisions of this Plan if determined not to be Disabled by the Plan Committee under the procedures set forth in this Section.

The Plan Committee shall notify each Participant who has made application under this Section 5.2, in writing, of its determination within three (3) months of the date the Plan Committee receives the Participant's application hereunder. The Participant shall cooperate in providing any information to the Plan Committee which it requires in making its determination, including, but not limited to, access to the Participant's medical records, direct contact with his physician, and physical examination by a physician selected by the Company. Any Participant who does not fully cooperate shall be deemed not Disabled by the Plan Committee and so notified.

5.3. Death Benefit.

(1) If a Participant dies after a distribution has commenced or if the Company has not purchased a life insurance contract in connection with the Participant's Retirement Benefit, the Company will continue the payments of such distribution otherwise due to the Participant to his designated Beneficiary, in the applicable form elected by the Participant in his Written Election.

(2) If a Participant dies while still employed by the Company and the Company has purchased a life insurance contract in connection with such Participant's Retirement Benefit, the Company will pay the Participant's designated Beneficiary the greater of his Retirement Benefit as determined under Section 5.1 above or his Projected Retirement Benefit (as defined below), in the applicable form elected by the Participant in his Written Election. "Projected Retirement Benefit" means the amount determined by projecting the average of the Participant's contributions for all years of participation hereunder, at an earnings rate periodically set by the Plan Committee, to retirement at age 60.

5.4. In-Service Withdrawal. A Participant may designate a date in the future for receipt of an In-Service Withdrawal with respect to the Participant's contribution for a given Plan Year. Such withdrawal may be paid while the Participant remains employed with the Company, but shall be paid without Credited Earnings attributable to such Participant Contribution (which Credited Earnings shall be distributed upon termination of employment or retirement) in four (4) equal yearly installments commencing no earlier three (3) years after such Participant's commencement of participation in the Plan; provided, however, that a Participant may elect to defer commencement of an In-Service Withdrawal subject to the following requirements:

i. the Participant must deliver to the Company of a written election not later than twelve (12) months prior to the date the payment is scheduled to be paid;

ii. the payments that are subject to the election must be delayed at least five (5) years from the date the payments would have otherwise been made; and

iii. the election will not take effect until at least twelve (12) months after the election is made.

5.5. Unforeseeable Financial Emergency Benefit. A Participant may request a portion of his Retirement Benefit as an Unforeseeable Financial Emergency Benefit at any time by providing the Plan Committee, to its satisfaction, with a written request, proof of an Unforeseeable Financial Emergency, and proof that all other financial resources have been explored and utilized to: (i) receive a partial or full payout from the Plan and/or (ii) suspend any deferrals required to be made by a Participant. The amount of a Unforeseeable Financial Emergency Benefit shall be limited to the lesser of the amount needed for the financial hardship or such Participant's Retirement Benefit. If a Participant receives a distribution as a result of an Unforeseeable Financial Emergency, such Participant may not participate in the Plan during the Plan Year following the year of the hardship distribution.

6. Distributions.

6.1. Form of Benefits. The Company shall pay benefits in the form associated with Type of Benefit elected by the Participant, and, to the extent a Type of Benefit may be distributed in various forms, the Company shall pay benefits in the form elected by the Participant. The forms of benefits associated with the Types of Benefits are the following:

a. Separation from Service Benefit, Disability Benefit, and Death Benefit shall be paid in (i) one lump sum; (ii) 5 yearly installments; (iii) 10 yearly installments; or (iv) 15 yearly installments;

b. In-Service Withdrawal shall be paid as provided in Section 5.5 above; and

c. Unforeseeable Financial Emergency Benefit shall be paid in one lump sum.

6.2. Commencement of Payments. The Company will pay, or begin to pay, the Types of Benefits under this Plan to the Participant in accordance with the following:

b. Separation from Service Benefit, Disability Benefit, and Death Benefit payments shall commence no later than 65 days following the date on which the Participant retires, terminates service, becomes disabled, or dies;

c. In-Service Withdrawal payments shall commence on the date designated by the Participant on his Written Election pursuant to Section 2.3, provided that such payments are from Participant Contributions that have been in such Participant's Deferral Account for at least two years;

d. Unforeseeable Financial Emergency Benefit payments shall commence no later than sixty-five (65) days after a request for a Unforeseeable Financial Emergency Benefit is approved by the Plan Committee.

6.3. Domestic Relations Order. In the event the Plan Committee receives a Domestic Relations Order from a potential Alternate Payee, the Plan Committee shall notify the Participant whose benefit is the subject of such order and provide him/her with information concerning the Plan's procedures for administering Qualified Domestic Relations Orders ("QDROs"). Unless and until the order is set aside, the following provisions shall apply:

b. The Plan Committee shall within a reasonable time determine whether the order is a QDRO and shall notify the Participant whose benefit is the subject of the order, of its determination. The Plan Committee may designate a representative to carry out its duties under this provision.

c. Nothing in this Section shall be deemed to allow payment under a QDRO to an Alternate Payee of any benefit which would violate Section 409A of the Code and the regulations thereunder.

d. QDRO definitions. For purposes of Section 6.3 the following definitions and rules shall apply:

i. Alternate Payee means any spouse, former spouse, child or other dependent of a Participant who is recognized by a QDRO as having a right to receive all, or a portion of, the benefits payable under this Plan with respect to the Participant.

ii. Domestic Relations Order means any judgment, decree, or order (including approval of a property settlement agreement) which:

(4) relates to the provision of child support, alimony payments, or marital property rights to a spouse, child, or other dependent of a Participant; and

(5) is made pursuant to a state domestic relations law (including a community property law).

iii. Qualified Domestic Relations Order means any Domestic Relations Order meeting the requirements for a Qualified Domestic Relations Order under Code section 414(p), which satisfies any additional criteria under policies established by the Plan Committee.

Notwithstanding sections 6.2 and 7.3, distributions to a Specified Employee shall not commence earlier than six (6) months after the date such Specified Employee experiences a separation from service (or, if earlier, the date of death of the employee).

7. Amendment, Termination of Plan, Change in Control.

7.1. Amendment. The Company reserves the right to amend the Plan at any time by resolution of the Plan Committee. The Plan Committee will determine the effective date of any such amendment. The amendment may not deprive any Participant or Beneficiary of any portion of a benefit under the terms of this Plan at the time of the amendment.

7.2. Termination of Plan. The Company reserves the right to terminate the Plan under the following circumstances:

e. The Plan Committee may resolve to terminate the Plan provided that:

i. all arrangements of the same type (account balance plans, nonaccount balance plans, separation pay plans or other arrangements) are terminated with respect to all participants;

ii. no payments other than those otherwise payable under the terms of the plan absent a termination of the plan are made within twelve (12) months of the termination of the arrangement;

iii. all payments are made within twenty-four (24) moths of the termination of the arrangement; and

iv. the Company does not adopt a new arrangement that would be aggregated with any terminated arrangement under the plan aggregation rules at any time for a period of five years following the date of termination of the arrangement.

f. The Plan Committee may terminate the Plan and make payments to the participants at any time during the twelve (12) months following a change in control of the corporation;

g. A corporate dissolution taxed under section 331, or with the approval of a bankruptcy court pursuant to 11 U.S.C. §503(b)(1)(A), provided that the amounts deferred under the plan are included in the participants' gross incomes by the latest of:

i. the calendar year in which the plan termination occurs,

ii. the calendar year in which the amount is no longer subject to a substantial risk of forfeiture, or

iii. the first calendar year in which the payment is administratively practicable.

7.3. Change in Control. In the event of a Change in Control, the Company shall, as soon as possible, but in no event later than ten days after the Change in Control, notify the Trustee, and the Trustee or its agent shall immediately calculate the Retirement Benefit of each Participant and distribute such amounts to the Participant or Beneficiary in a lump sum within thirty (30) days of the notification. If the Company fails to notify the Trustee as specified in this section, the Trustee may act upon notification of the "Change of Control" obtained in an alternate manner. The Trustee shall incur no liability to any person for any action taken pursuant to such notification and in conformity with the terms of the Plan.

8. Benefits Not Funded. Participants and Beneficiaries have the status of unsecured creditors of the Company, and the Plan constitutes a mere promise by the Company to make benefit payments in the future. A Participant's or Beneficiary's interest in the Plan is an unsecured claim against the general assets of the Company, and neither the Participant nor a Beneficiary has any right against the account until the Plan has distributed the benefit. All amounts credited to an account are the general assets of the Company and may be disposed of or used by the Company in such manner as it determines.

Notwithstanding the first paragraph of this Section 8, the Company will make deposits to a trust pursuant to a Trust Agreement, a copy of which is attached, as provided above. Such Trust Agreement created by the Company is intended to be a grantor trust, and any assets held by such

trust to assist the Company in meeting its obligations under the Plan will conform to the terms of the model trust, as described in Revenue Procedure 92-64, 1992-2 C.B. 422, promulgated by the Internal Revenue Service. The Company will make a transfer of cash to the trust annually in the amount necessary to pay the deferred compensation required.

It is the intention of the parties that this Plan and the accompanying Trust Agreement shall constitute an unfunded arrangement maintained for the purpose of providing deferred compensation for a select group of management or highly compensated employees for purposes of Title I of ERISA.

9. Administration.

9.1. Plan Committee. The Plan shall be administered by the Plan Committee. The Plan Committee shall have full authority and power to administer and construe the Plan, subject to applicable requirements of law. Without limiting the generality of the foregoing, the Plan Committee shall have the powers indicated in the foregoing Sections of the Plan and the following additional powers and duties:

a. To make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan;

b. To interpret the Plan and to decide all questions concerning the Plan;

c. To determine the amount and the recipient of any payments to be made under the Plan;

d. To designate and value any investments deemed held in the Accounts; and

e. To make all other determinations and to take all other steps necessary or advisable for the administration of the Plan.

All decisions made by the Plan Committee pursuant to the provisions of the Plan shall be made in its sole discretion and shall be final, conclusive, and binding upon all parties.

9.2. Delegation of Duties. The Plan Committee may delegate such of its duties and may engage such experts and other persons as it deems appropriate in connection with administering the Plan. The Plan Committee shall be fully protected in any action taken, in good faith, in reliance upon any opinions or reports furnished them by any such experts or other persons.

9.3. Indemnification of Committee. The Company agrees to indemnify and to defend to the fullest extent permitted by law any person serving as a member of the Plan Committee, and each employee of the Company or any of its affiliates appointed by the Plan Committee to carry out duties under this Plan, against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

9.4. Liability. To the extent permitted by law, neither the Plan Committee nor any other person shall incur any liability for any acts or for any failure to act except for liability arising out of such person's own willful misconduct or willful breach of the Plan.

9.5. Claims Review Procedure.

a. A claim for benefits may be filed, in writing, with the Plan Committee. A written disposition of a claim shall be furnished to the claimant within a reasonable time after the claim for benefits is filed. In the event a claim for benefits is denied, the Plan Committee shall provide the claimant with the reasons for denial.

b. A claimant whose claim for benefits was denied may file for a review of such denial, with the Plan Committee, no later than 60 days after he has received written notification of the denial.

c. The Plan Committee shall give a request for review a full and fair review. If the claim for benefits is denied upon completion of a full and fair review, notice of such denial shall be provided to the claimant within 60 days after the Plan Committee's receipt of such written claim for review. This 60-day period may be extended in the event of special circumstances. Such special circumstances shall be communicated to the claimant in writing within the 60-day period. If there is an extension, a decision shall be made as soon as possible, but not later than 120 days after receipt by the Plan Committee of such claim for review.

d. If benefits are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of a state, the claims procedure relating to these benefits may provide for review. If so, that company, service, or organization will be the entity to which claims are addressed.

10. General Provisions

10.1. Designation of Beneficiary. Each Participant shall designate, in writing, prior to the date he first becomes a Participant in the Plan, one or more beneficiaries to receive his benefit under the provisions of Section 5.4. The Participant shall file the written designation with the Plan Committee. The Participant may revoke a previous beneficiary designation by filing a new written beneficiary designation with the Plan Committee.

In any event, if a Participant or Beneficiary who has designated another Beneficiary is divorced, all beneficiary designations executed prior to the effective date of the dissolution of marriage (or other decree or order entered under applicable state law) are automatically revoked under the terms of this Section 10.1. In such event, the Participant or Beneficiary may designate one or more Beneficiaries in accordance with the terms of this Section 9.1. If none is made following

the effective date of the dissolution of the marriage, the individual's benefit shall pass under the laws of intestate succession and the terms of the next following paragraph.

If a Participant fails to file a valid designation of beneficiary with the Plan Committee under the provisions of this Section 10.1, or if a designated Beneficiary fails to survive to receive any or all payments due hereunder, then the death benefit payable under this Plan shall be payable to the Participant's (or the Beneficiary's) spouse; if no spouse survives, then to the Participant's (or Beneficiary's) children, with equal shares among living children and with the living descendants of a deceased child receiving equal portions of the deceased child's share; in the absence of spouse or descendants, to the Participant's (or Beneficiary's) parents; and in the absence of spouse, descendants or parents, to the Participant's (or Beneficiary's) brothers and sisters, with the living descendants of a deceased brother and those of a deceased sister receiving equal portions of the deceased brother's or sister's share; in the absence of any of the persons name herein, to the Participant's (or Beneficiary's) estate.

For purposes of this Section 10.1, the term "descendant" means all persons who are descended from the person referred to either by birth to or legal adoption by such person, and "child" or "children" includes adopted children.

10.2. Benefits Not Assignable. The rights of each Participant are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment, or garnishment by creditors of the Participant or any Beneficiary. Neither the Participant nor Beneficiary may assign, transfer or pledge the benefits under this Plan. Any attempt to assign, transfer or pledge a Participant's benefits under this Plan is void.

10.3. Benefit. This Plan constitutes an agreement between the Company and each of the Participants which is binding upon and inures to the Company, its successors and assigns and upon the Participant and his heirs and legal representatives.

10.4. Headings. The headings of the Articles and Sections of this Plan are included for purposes of convenience only, and shall not affect the construction or interpretation of any of it provisions.

10.5. Notices. All notices, requests, demands, and other communications under this Plan shall be in writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the third day after mailing if mailed to the party to whom notice is to be given, by first class mail, registered or certified (return receipt requested), postage prepaid, and properly addressed to the last known address to each party as set forth on the first page thereof. Any party may change its address for purposes of this Section by giving the other parties written notice of the new address in the manner set forth above.

10.6. No Loans. The Plan does not permit any loans to be made to any Participant or Beneficiary.

10.7. Gender Usage. The use of the masculine gender includes the feminine gender for all purposes of this Plan.

10.8. Expenses. Costs of administration of the Plan shall be paid by the Company.

IN WITNESS WHEREOF, the Company has executed this Amended and Restated Deferred Compensation Plan (2013) on October 3, 2013, effective as of the Effective Date.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.

Chief Executive Officer

EXHIBIT 10.6

AMENDMENT NO. 1
to the
MOLINA HEALTHCARE, INC.
AMENDED AND RESTATED
DEFERRED COMPENSATION PLAN (2013)

WHEREAS, Molina Healthcare, Inc. (the "Company") adopted the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2013) (the "Plan"), effective October 1, 2013; and

WHEREAS, Treasury Regulation Section 1.409A-3(j)(4)(v) permits a plan to accelerate distribution of small account balances under the Plan in accordance with the requirements set forth therein; and

WHEREAS, the Company desires to amend the Plan to include a provision providing for distribution of small account balances upon a participant's separation from service; and

WHEREAS, the Company desires to amend the Plan to revise the eligibility provisions thereof; and

WHEREAS, Section 7.1 of the Plan provides that the Company has the right to amend the Plan;

NOW, THEREFORE, pursuant to resolutions adopted by the Company, the Plan is amended as follows:

1. Effective January 1, 2014, Section 1.8 of the Plan is amended and restated in its entirety to read as follows:

"1.8. Key Employee means an employee of the Company or a Subsidiary, who is (A) a member of a select group of management or highly compensated employees within the meaning of §2520.104-23 of the Department of Labor ERISA Regulations, (B) projected to receive Plan Year Compensation (including base pay and bonus), plus amounts deferred to any 401(k) plan, deferred compensation plan, or cafeteria plan maintained by the Company, of $200,000 or more and (C) designated by the Plan Committee as a Key Employee."

2. Effective January 1, 2014, Section 1.9 of the Plan is amended and restated in its entirety to read as follows:

"1.9. Participant means (A) a Key Employee who timely files a Written Election pursuant to Section 2.3, below, and (B) a former Employee who, at the time of his termination from employment, retirement, death, or occurrence of Disability, retains, or whose beneficiary retains, benefits earned under the Plan in accordance with its terms. A Participant is considered an Active Participant in the Plan (even if the Participant no longer satisfies the requirements of Section 1.8

(B), but subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee) until the Participant separates from service under the terms of this Plan."

3. Effective January 1, 2014, Section 2.1 of the Plan is amended and restated in its entirety to read as follows:

"2.1. Eligibility. An employee of the Company or a Subsidiary is eligible to participate in this Plan upon meeting the criteria for Key Employee specified in Section 1.8. Any Key Employee who was a Participant in the Original Plan and who continued in the employ of the Company on the Effective Date will continue to be a Participant in this Plan, subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee thereafter."

4. Effective as of the date of execution of this Amendment, the Plan is amended to add a new section, Section 6.4., to provide for the distribution of small account balances from the Plan:

"6.4. Limited Cashout. Notwithstanding any Written Election made by the Participant, if, upon a Participant's Separation from Service, such Participant's accrued benefit under the Plan (and any other deferred compensation plan required to be aggregated with this Plan) does not exceed the then-current limit under Section 402(g)(1)(B) of the Code, the Company shall immediately distribute such Participant's accrued benefit under the Plan in a single lump sum payment to the Participant (or the Beneficiary, if the Participant is deceased), provided that such distribution results in a termination and complete liquidation of such Participant's interest under the Plan (and any other deferred compensation plan required to be aggregated with this Plan)."

Executed on November 14, 2013.

HEALTHCARE, INC.

/s/Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chief Executive Officer

Molina Healthcare, Inc. 2011 Equity Incentive Plan

1. ESTABLISHMENT, PURPOSE AND TERM OF PLAN.

1.1 **Establishment.** The Molina Healthcare, Inc. 2011 Equity Incentive Plan (the *"**Plan**"*) is hereby established effective as of April 27, 2011, the date of its approval by the stockholders of the Company (the *"**Effective Date**"*).

1.2 **Purpose.** The purpose of the Plan is to advance the interests of the Participating Company Group and its stockholders by providing an incentive to attract, retain and reward persons performing services for the Participating Company Group and by motivating such persons to contribute to the growth and profitability of the Participating Company Group. The Plan seeks to achieve this purpose by providing for Awards in the form of Options, Stock Appreciation Rights, Restricted Stock Purchase Rights, Restricted Stock Bonuses, Restricted Stock Units, Performance Shares, Performance Units, Cash-Based Awards and Other Stock-Based Awards.

1.3 **Term of Plan.** The Plan shall continue in effect until its termination by the Committee; provided, however, that all Awards shall be granted, if at all, within ten (10) years from the Effective Date.

2. DEFINITIONS AND CONSTRUCTION.

2.1 **Definitions.** Whenever used herein, the following terms shall have their respective meanings set forth below:

(a) *"**Affiliate**"* means (i) a parent entity, other than a Parent Corporation, that directly, or indirectly through one or more intermediary entities, controls the Company or (ii) a subsidiary entity, other than a Subsidiary Corporation, that is controlled by the Company directly or indirectly through one or more intermediary entities. For this purpose, the terms "parent," "subsidiary," "control" and "controlled by" shall have the meanings assigned such terms for the purposes of registration of securities on Form S-8 under the Securities Act.

(b) *"**Award**"* means any Option, Stock Appreciation Right, Restricted Stock Purchase Right, Restricted Stock Bonus, Restricted Stock Unit, Performance Share, Performance Unit, Cash-Based Award or Other Stock-Based Award granted under the Plan.

(c) *"**Award Agreement**"* means a written or electronic agreement between the Company and a Participant setting forth the terms, conditions and restrictions applicable to an Award.

(d) *"**Board**"* means the Board of Directors of the Company.

(e) *"**Cash-Based Award**"* means an Award denominated in cash and granted pursuant to Section 11.

(f) *"**Cause**"* means, unless such term or an equivalent term is otherwise defined by the applicable Award Agreement or other written agreement between a Participant and a Participating Company applicable to an Award, any of the following: (i) the Participant's theft, dishonesty, willful misconduct, breach of fiduciary duty for personal profit, or falsification of any Participating Company documents or records; (ii) the Participant's material failure to abide by a Participating Company's code of conduct or other policies (including, without limitation, policies relating to confidentiality and reasonable workplace conduct); (iii) the Participant's unauthorized use, misappropriation, destruction or diversion of any tangible or intangible asset or corporate opportunity of a Participating Company (including, without limitation, the Participant's improper use or disclosure of a Participating Company's confidential or proprietary information); (iv) any intentional act by the Participant which has a material detrimental effect on a Participating Company's reputation or business; (v) the Participant's repeated failure or inability to perform any reasonable assigned duties after written notice from a Participating Company of, and a reasonable opportunity to cure, such failure or inability; (vi) any material breach by the Participant of any employment, service, non-disclosure, non-competition, non-solicitation or other similar agreement between the Participant and a Participating Company, which breach is not cured pursuant to the terms of such agreement; or (vii) the Participant's conviction (including any plea of guilty or *nolo contendere*) of any criminal act involving fraud, dishonesty, misappropriation or moral turpitude, or which impairs the Participant's ability to perform his or her duties with a Participating Company.

(g) *"**Change in Control**"* means, unless such term or an equivalent term is otherwise defined by the applicable Award Agreement or other written agreement between the Participant and a Participating Company applicable to an Award, the occurrence of any of the following:

(i) any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) becomes the "beneficial owner" (as such term is defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent (50%) of the total Fair Market Value or total combined voting power of the Company's then-outstanding securities entitled to vote generally in the election of Directors; provided, however, that a Change in Control shall not be deemed to have occurred if such degree of beneficial ownership results from any of the following: (A) an acquisition by any person who on the Effective Date is the beneficial owner of more than fifty percent (50%) of such voting power, (B) any acquisition directly from the Company, including, without limitation, pursuant to or in connection with a public offering of securities, (C) any acquisition by the Company, (D) any acquisition by a trustee or other fiduciary under an employee benefit plan of a Participating Company or (E) any acquisition by an entity owned directly or indirectly by the stockholders of the Company in substantially the same proportions as their ownership of the voting securities of the Company; or

(ii) an Ownership Change Event or series of related Ownership Change Events (collectively, a *"**Transaction**"*) in which the stockholders of the Company immediately before the Transaction do not retain immediately after the Transaction direct or indirect beneficial ownership of more than fifty percent (50%) of the total combined voting power of the outstanding securities entitled to vote generally in the election of Directors or, in the case of an Ownership

Change Event described in Section 2.1(cc)(iii), the entity to which the assets of the Company were transferred (the *"**Transferee**"*), as the case may be; or

(iii) approval by the stockholders of a plan of complete liquidation or dissolution of the Company;

provided, however, that a Change in Control shall be deemed not to include a transaction described in subsections (i) or (ii) of this Section 2.1(g) in which a majority of the members of the board of directors of the continuing, surviving or successor entity, or parent thereof, immediately after such transaction is comprised of Incumbent Directors.

For purposes of the preceding sentence, indirect beneficial ownership shall include, without limitation, an interest resulting from ownership of the voting securities of one or more corporations or other business entities which own the Company or the Transferee, as the case may be, either directly or through one or more subsidiary corporations or other business entities. The Committee shall determine whether multiple sales or exchanges of the voting securities of the Company or multiple Ownership Change Events are related, and its determination shall be final, binding and conclusive.

(h) *"**Code**"* means the Internal Revenue Code of 1986, as amended, and any applicable regulations or administrative guidelines promulgated thereunder.

(i) *"**Committee**"* means the Compensation Committee and such other committee or subcommittee of the Board, if any, duly appointed to administer the Plan and having such powers in each instance as shall be specified by the Board. If, at any time, there is no committee of the Board then authorized or properly constituted to administer the Plan, the Board shall exercise all of the powers of the Committee granted herein, and, in any event, the Board may in its discretion exercise any or all of such powers.

(j) *"**Company**"* means Molina Healthcare, Inc., a Delaware corporation, or any successor corporation thereto.

(k) *"**Consultant**"* means a person engaged to provide consulting or advisory services (other than as an Employee or a member of the Board) to a Participating Company, provided that the identity of such person, the nature of such services or the entity to which such services are provided would not preclude the Company from offering or selling securities to such person pursuant to the Plan in reliance on registration on Form S-8 under the Securities Act.

(l) "***Covered Employee***" means, at any time the Plan is subject to Section 162(m), any Employee who is or may reasonably be expected to become a "covered employee" as defined in Section 162(m), or any successor statute, and who is designated, either as an individual Employee or a member of a class of Employees, by the Committee no later than the earlier of (i) the date that is ninety (90) days after the beginning of the Performance Period, or (ii) the date on which twenty-five percent (25%) of the Performance Period has elapsed, as a "Covered Employee" under this Plan for such applicable Performance Period.

(m) *"**Director**"* means a member of the Board.

(n) *"**Disability**"* means the permanent and total disability of the Participant, within the meaning of Section 22(e)(3) of the Code.

(o) *"**Dividend Equivalent Right**"* means the right of a Participant, granted at the discretion of the Committee or as otherwise provided by the Plan, to receive a credit for the account of such Participant in an amount equal to the cash dividends paid on one share of Stock for each share of Stock represented by an Award held by such Participant.

(p) *"**Employee**"* means any person treated as an employee (including an Officer or a member of the Board who is also treated as an employee) in the records of a Participating Company and, with respect to any Incentive Stock Option granted to such person, who is an employee for purposes of Section 422 of the Code; provided, however, that neither service as a member of the Board nor payment of a director's fee shall be sufficient to constitute employment for purposes of the Plan. The Company shall determine in good faith and in the exercise of its discretion whether an individual has become or has ceased to be an Employee and the effective date of such individual's employment or termination of employment, as the case may be. For purposes of an individual's rights, if any, under the terms of the Plan as of the time of the Company's determination of whether or not the individual is an Employee, all such determinations by the Company shall be final, binding and conclusive as to such rights, if any, notwithstanding that the Company or any court of law or governmental agency subsequently makes a contrary determination as to such individual's status as an Employee.

(q) *"**Exchange Act**"* means the Securities Exchange Act of 1934, as amended.

(r) *"**Fair Market Value**"* means, as of any date, the value of a share of Stock or other property as determined by the Committee, in its discretion, or by the Company, in its discretion, if such determination is expressly allocated to the Company herein, subject to the following:

(i) Except as otherwise determined by the Committee, if, on such date, the Stock is listed or quoted on a national or regional securities exchange or quotation system, the Fair Market Value of a share of Stock shall be the closing price of a share of Stock as quoted on the national or regional securities exchange or quotation system constituting the primary market for the Stock, as reported in *The Wall Street Journal* or such other source as the Company deems reliable. If the relevant date does not fall on a day on which the Stock has traded on such securities exchange or quotation system, the date on which the Fair Market Value shall be established shall be the last day on which the Stock was so traded or quoted prior to the relevant date, or such other appropriate day as shall be determined by the Committee, in its discretion.

(ii) Notwithstanding the foregoing, the Committee may, in its discretion, determine the Fair Market Value of a share of Stock on the basis of the opening, closing, or average of the high and low sale prices of a share of Stock on such date or the preceding trading day, the actual sale price of a share of Stock received by a Participant, any other reasonable basis using actual transactions in the Stock as reported on a national or regional securities exchange or quotation system, or on any other basis consistent with the requirements of Section 409A. The Committee

may vary its method of determination of the Fair Market Value as provided in this Section for different purposes under the Plan to the extent consistent with the requirements of Section 409A.

(iii) If, on such date, the Stock is not listed or quoted on a national or regional securities exchange or quotation system, the Fair Market Value of a share of Stock shall be as determined by the Committee in good faith without regard to any restriction other than a restriction which, by its terms, will never lapse, and in a manner consistent with the requirements of Section 409A.

(s) *"**Full Value Award**"* means any Award settled in Stock, other than (i) an Option, (ii) a Stock Appreciation Right, or (iii) a Restricted Stock Purchase Right or an Other Stock-Based Award under which the Company will receive monetary consideration equal to the Fair Market Value (determined on the effective date of grant) of the shares subject to such Award.

(t) *"**Incentive Stock Option**"* means an Option intended to be (as set forth in the Award Agreement) and which qualifies as an incentive stock option within the meaning of Section 422(b) of the Code.

(u) *"**Incumbent Director**"* means a director who either (i) is a member of the Board as of the Effective Date or (ii) is elected, or nominated for election, to the Board with the affirmative votes of at least a majority of the Incumbent Directors at the time of such election or nomination (but excluding a director who was elected or nominated in connection with an actual or threatened proxy contest relating to the election of directors of the Company).

(v) *"**Insider**"* means an Officer, Director or any other person whose transactions in Stock are subject to Section 16 of the Exchange Act.

(w) *"**Net Exercise**"* means a procedure pursuant to which (i) the Company will reduce the number of shares otherwise issuable to a Participant upon the exercise of an Option by the largest whole number of shares having a Fair Market Value that does not exceed the aggregate exercise price for the shares with respect to which the Option is exercised, and (ii) the Participant shall pay to the Company in cash the remaining balance of such aggregate exercise price not satisfied by such reduction in the number of whole shares to be issued.

(x) *"**Nonemployee Director**"* means a Director who is not an Employee.

(y) *"**Nonstatutory Stock Option**"* means an Option not intended to be (as set forth in the Award Agreement) or which does not qualify as an incentive stock option within the meaning of Section 422(b) of the Code.

(z) *"**Officer**"* means any person designated by the Board as an officer of the Company.

(aa) *"**Option**"* means an Incentive Stock Option or a Nonstatutory Stock Option granted pursuant to the Plan.

(bb) *"**Other Stock-Based Award**"* means an Award denominated in shares of Stock and granted pursuant to Section 11.

(cc) *"**Ownership Change Event**"* means the occurrence of any of the following with respect to the Company: (i) the direct or indirect sale or exchange in a single or series of related transactions by the stockholders of the Company of securities of the Company representing more than fifty percent (50%) of the total combined voting power of the Company's then-outstanding securities entitled to vote generally in the election of Directors; (ii) a merger or consolidation in which the Company is a party; or (iii) the sale, exchange, or transfer of all or substantially all of the assets of the Company (other than a sale, exchange or transfer to one or more subsidiaries of the Company).

(dd) *"**Parent Corporation**"* means any present or future "parent corporation" of the Company, as defined in Section 424(e) of the Code.

(ee) *"**Participant**"* means any eligible person who has been granted one or more Awards.

(ff) *"**Participating Company**"* means the Company or any Parent Corporation, Subsidiary Corporation or Affiliate.

(gg) *"**Participating Company Group**"* means, at any point in time, the Company and all other entities collectively which are then Participating Companies.

(hh) *"**Performance Award**"* means an Award of Performance Shares or Performance Units.

(ii) *"**Performance Award Formula**"* means, for any Performance Award, a formula or table established by the Committee pursuant to Section 10.3 which provides the basis for computing the value of a Performance Award at one or more levels of attainment of applicable Performance Goal(s) measured as of the end of the applicable Performance Period.

(jj) "***Performance-Based Compensation***" means compensation under an Award that satisfies the requirements of Section 162(m) for certain performance-based compensation paid to Covered Employees.

(kk) *"**Performance Goal**"* means a performance goal established by the Committee pursuant to Section 10.3.

(ll) *"**Performance Period**"* means a period established by the Committee pursuant to Section 10.3 at the end of which one or more Performance Goals are to be measured.

(mm) *"**Performance Share**"* means a right granted to a Participant pursuant to Section 10 to receive a payment equal to the value of a Performance Share, as determined by the Committee, based upon attainment of applicable Performance Goal(s).

(nn) *"**Performance Unit**"* means a right granted to a Participant pursuant to Section 10 to receive a payment equal to the value of a Performance Unit, as determined by the Committee, based upon attainment of applicable Performance Goal(s).

(oo) *"**Restricted Stock Award**"* means an Award of a Restricted Stock Bonus or a Restricted Stock Purchase Right.

(pp) *"**Restricted Stock Bonus**"* means Stock granted to a Participant pursuant to Section 8.

(qq) *"**Restricted Stock Purchase Right**"* means a right to purchase Stock granted to a Participant pursuant to Section 8.

(rr) *"**Restricted Stock Unit**"* means a right granted to a Participant pursuant to Section 9 to receive on a future date or event a share of Stock or cash in lieu thereof, as determined by the Committee.

(ss) *"**Rule 16b-3**"* means Rule 16b-3 under the Exchange Act, as amended from time to time, or any successor rule or regulation.

(tt) *"**SAR**"* or *"**Stock Appreciation Right**"* means a right granted to a Participant pursuant to Section 7 to receive payment, for each share of Stock subject to such Award, of an amount equal to the excess, if any, of the Fair Market Value of a share of Stock on the date of exercise of the Award over the exercise price thereof.

(uu) *"**Section 162(m)**"* means Section 162(m) of the Code.

(vv) *"**Section 409A**"* means Section 409A of the Code.

(ww) *"**Section 409A Deferred Compensation**"* means compensation provided pursuant to an Award that constitutes nonqualified deferred compensation within the meaning of Section 409A.

(xx) *"**Securities Act**"* means the Securities Act of 1933, as amended.

(yy) *"**Service**"* means a Participant's employment or service with the Participating Company Group, whether as an Employee, a Director or a Consultant. Unless otherwise provided by the Committee, a Participant's Service shall not be deemed to have terminated merely because of a change in the capacity in which the Participant renders such Service or a change in the Participating Company for which the Participant renders such Service, provided that there is no interruption or termination of the Participant's Service. Furthermore, a Participant's Service shall not be deemed to have been interrupted or terminated if the Participant takes any military leave, sick leave, or other bona fide leave of absence approved by the Company. However, unless otherwise provided by the Committee, if any such leave taken by a Participant exceeds ninety (90) days, then on the ninety-first (91st) day following the commencement of such leave the Participant's Service shall be deemed to have terminated, unless the Participant's right to return to Service is guaranteed by statute or contract. Notwithstanding the foregoing, unless otherwise designated by

the Company or required by law, an unpaid leave of absence shall not be treated as Service for purposes of determining vesting under the Participant's Award Agreement. A Participant's Service shall be deemed to have terminated either upon an actual termination of Service or upon the business entity for which the Participant performs Service ceasing to be a Participating Company. Subject to the foregoing, the Company, in its discretion, shall determine whether the Participant's Service has terminated and the effective date of such termination.

(zz) *"**Stock**"* means the common stock of the Company, as adjusted from time to time in accordance with Section 4.2.

(aaa) *"**Subsidiary Corporation**"* means any present or future "subsidiary corporation" of the Company, as defined in Section 424(f) of the Code.

(bbb) *"**Ten Percent Owner**"* means a Participant who, at the time an Option is granted to the Participant, owns stock possessing more than ten percent (10%) of the total combined voting power of all classes of stock of a Participating Company (other than an Affiliate) within the meaning of Section 422(b)(6) of the Code.

(ccc) *"**Trading Compliance Policy**"* means the written policy of the Company pertaining to the purchase, sale, transfer or other disposition of the Company's equity securities by Directors, Officers, Employees or other service providers who may possess material, nonpublic information regarding the Company or its securities.

(ddd) *"**Vesting Conditions**"* mean those conditions established in accordance with the Plan prior to the satisfaction of which shares subject to an Award remain subject to forfeiture or a repurchase option in favor of the Company exercisable for the Participant's monetary purchase price, if any, for such shares upon the Participant's termination of Service.

2.2 **Construction.** Captions and titles contained herein are for convenience only and shall not affect the meaning or interpretation of any provision of the Plan. Except when otherwise indicated by the context, the singular shall include the plural and the plural shall include the singular. Use of the term "or" is not intended to be exclusive, unless the context clearly requires otherwise.

3. ADMINISTRATION.

3.1 **Administration by the Committee.** The Plan shall be administered by the Committee. All questions of interpretation of the Plan, of any Award Agreement or of any other form of agreement or other document employed by the Company in the administration of the Plan or of any Award shall be determined by the Committee, and such determinations shall be final, binding and conclusive upon all persons having an interest in the Plan or such Award, unless fraudulent or made in bad faith. Any and all actions, decisions and determinations taken or made by the Committee in the exercise of its discretion pursuant to the Plan or Award Agreement or other agreement thereunder (other than determining questions of interpretation pursuant to the preceding sentence) shall be final, binding and conclusive upon all persons having an interest therein. All expenses incurred in the administration of the Plan shall be paid by the Company.

3.2 **Authority of Officers.** Any Officer shall have the authority to act on behalf of the Company with respect to any matter, right, obligation, determination or election which is the responsibility of or which is allocated to the Company herein, provided the Officer has apparent authority with respect to such matter, right, obligation, determination or election. To the extent permitted by applicable law, the Committee may, in its discretion, delegate to a committee comprised of one or more Officers the authority to grant one or more Awards, without further approval of the Committee, to any Employee, other than a person who, at the time of such grant, is an Insider or a Covered Employee, and to exercise such other powers under the Plan as the Committee may determine; provided, however, that (a) the Committee shall fix the maximum number of shares subject to Awards that may be granted by such Officers, (b) each such Award shall be subject to the terms and conditions of the appropriate standard form of Award Agreement approved by the Board or the Committee and shall conform to the provisions of the Plan, and (c) each such Award shall conform to such other limits and guidelines as may be established from time to time by the Committee.

3.3 **Administration with Respect to Insiders.** With respect to participation by Insiders in the Plan, at any time that any class of equity security of the Company is registered pursuant to Section 12 of the Exchange Act, the Plan shall be administered in compliance with the requirements, if any, of Rule 16b-3.

3.4 **Committee Complying with Section 162(m).** If the Company is a "publicly held corporation" within the meaning of Section 162(m), the Board may establish a Committee of "outside directors" within the meaning of Section 162 (m) to approve the grant of any Award intended to result in the payment of Performance-Based Compensation.

3.5 **Powers of the Committee.** In addition to any other powers set forth in the Plan and subject to the provisions of the Plan, the Committee shall have the full and final power and authority, in its discretion:

(a) to determine the persons to whom, and the time or times at which, Awards shall be granted and the number of shares of Stock, units or monetary value to be subject to each Award;

(b) to determine the type of Award granted;

(c) to determine the Fair Market Value of shares of Stock or other property;

(d) to determine the terms, conditions and restrictions applicable to each Award (which need not be identical) and any shares acquired pursuant thereto, including, without limitation, (i) the exercise or purchase price of shares pursuant to any Award, (ii) the method of payment for shares purchased pursuant to any Award, (iii) the method for satisfaction of any tax withholding obligation arising in connection with any Award, including by the withholding or delivery of shares of Stock, (iv) the timing, terms and conditions of the exercisability or vesting of any Award or any shares acquired pursuant thereto, (v) the Performance Measures, Performance Period, Performance Award Formula and Performance Goals applicable to any Award and the extent to which such Performance Goals have been attained, (vi) the time of the expiration of any Award, (vii) the effect of the Participant's termination of Service on any of the foregoing, and (viii) all other terms,

conditions and restrictions applicable to any Award or shares acquired pursuant thereto not inconsistent with the terms of the Plan;

(e) to determine whether an Award will be settled in shares of Stock, cash, other property, or in any combination thereof;

(f) to approve one or more forms of Award Agreement;

(g) to amend, modify, extend, cancel or renew any Award or to waive any restrictions or conditions applicable to any Award or any shares acquired pursuant thereto;

(h) to accelerate, continue, extend or defer the exercisability or vesting of any Award or any shares acquired pursuant thereto, including with respect to the period following a Participant's termination of Service;

(i) to prescribe, amend or rescind rules, guidelines and policies relating to the Plan, or to adopt sub-plans or supplements to, or alternative versions of, the Plan, including, without limitation, as the Committee deems necessary or desirable to comply with the laws or regulations of or to accommodate the tax policy, accounting principles or custom of, foreign jurisdictions whose citizens may be granted Awards; and

(j) to correct any defect, supply any omission or reconcile any inconsistency in the Plan or any Award Agreement and to make all other determinations and take such other actions with respect to the Plan or any Award as the Committee may deem advisable to the extent not inconsistent with the provisions of the Plan or applicable law.

3.6 **Option or SAR Repricing.** Without the affirmative vote of holders of a majority of the shares of Stock cast in person or by proxy at a meeting of the stockholders of the Company at which a quorum representing a majority of all outstanding shares of Stock is present or represented by proxy, the Committee shall not approve a program providing for either (a) the cancellation of outstanding Options or SARs having exercise prices per share greater than the then Fair Market Value of a share of Stock (*"**Underwater Awards**"*) and the grant in substitution therefore of new Options or SARs having a lower exercise price, Full Value Awards or payments in cash, or (b) the amendment of outstanding Underwater Awards to reduce the exercise price thereof. This Section shall not apply to adjustments pursuant to the assumption of or substitution for an Option or SAR in a manner that would comply with Section 424(a) or Section 409A of the Code or to an adjustment pursuant to Section 4.2.

3.7 **Indemnification.** In addition to such other rights of indemnification as they may have as members of the Board or the Committee or as officers or employees of the Participating Company Group, members of the Board or the Committee and any officers or employees of the Participating Company Group to whom authority to act for the Board, the Committee or the Company is delegated shall be indemnified by the Company against all reasonable expenses, including attorneys' fees, actually and necessarily incurred in connection with the defense of any action, suit or proceeding, or in connection with any appeal therein, to which they or any of them may be a party by reason of any action taken or failure to act under or in connection with the Plan, or any right granted hereunder, and against all amounts paid by them in settlement thereof (provided such

settlement is approved by independent legal counsel selected by the Company) or paid by them in satisfaction of a judgment in any such action, suit or proceeding, except in relation to matters as to which it shall be adjudged in such action, suit or proceeding that such person is liable for gross negligence, bad faith or intentional misconduct in duties; provided, however, that within sixty (60) days after the institution of such action, suit or proceeding, such person shall offer to the Company, in writing, the opportunity at its own expense to handle and defend the same.

4. SHARES SUBJECT TO PLAN.

4.1 **Maximum Number of Shares Issuable.** Subject to adjustment as provided in Section 4.2, the maximum aggregate number of shares of Stock that may be issued under the Plan shall be four million five hundred thousand (4,500,000) and shall consist of authorized but unissued shares of Stock, and the shares of Stock underlying any Awards which are reacquired by the Company, forfeited, or cancelled, satisfied without the issuance of Stock, or otherwise terminated (other than by exercise) without the issuance of Stock, or any combination thereof.

4.2 **Adjustments for Changes in Capital Structure.** Subject to any required action by the stockholders of the Company and the requirements of Sections 409A and 424 of the Code to the extent applicable, in the event of any change in the Stock effected without receipt of consideration by the Company, whether through merger, consolidation, reorganization, reincorporation, recapitalization, reclassification, stock dividend, stock split, reverse stock split, split-up, split-off, spin-off, combination of shares, exchange of shares, or similar change in the capital structure of the Company, or in the event of payment of a dividend or distribution to the stockholders of the Company in a form other than Stock (excepting regular, periodic cash dividends) that has a material effect on the Fair Market Value of shares of Stock, appropriate and proportionate adjustments shall be made in the number and kind of shares subject to the Plan and to any outstanding Awards, in the Award limits set forth in Section 5.3 and in the exercise or purchase price per share under any outstanding Award in order to prevent dilution or enlargement of Participants' rights under the Plan. For purposes of the foregoing, conversion of any convertible securities of the Company shall not be treated as "effected without receipt of consideration by the Company." If a majority of the shares which are of the same class as the shares that are subject to outstanding Awards are exchanged for, converted into, or otherwise become (whether or not pursuant to an Ownership Change Event) shares of another corporation (the *"**New Shares**"*), the Committee may unilaterally amend the outstanding Awards to provide that such Awards are for New Shares. In the event of any such amendment, the number of shares subject to, and the exercise or purchase price per share of, the outstanding Awards shall be adjusted in a fair and equitable manner as determined by the Committee, in its discretion. Any fractional share resulting from an adjustment pursuant to this Section shall be rounded down to the nearest whole number, and in no event may the exercise or purchase price under any Award be decreased to an amount less than the par value, if any, of the stock subject to such Award. The Committee in its discretion, may also make such adjustments in the terms of any Award to reflect, or related to, such changes in the capital structure of the Company or distributions as it deems appropriate, including modification of Performance Goals, Performance Award Formulas and Performance Periods. The adjustments determined by the Committee pursuant to this Section shall be final, binding and conclusive.

4.3 **Assumption or Substitution of Awards.** The Committee may, without affecting the number of shares of Stock available pursuant to Section 4.1, authorize the issuance or assumption

of benefits under this Plan in connection with any merger, consolidation, acquisition of property or stock, or reorganization upon such terms and conditions as it may deem appropriate, subject to compliance with Section 409A and any other applicable provisions of the Code.

5. ELIGIBILITY, PARTICIPATION AND AWARD LIMITATIONS

5.1 **Persons Eligible for Awards.** Awards may be granted only to Employees, Consultants and Directors.

5.2 **Participation in the Plan.** Awards are granted solely at the discretion of the Committee. Eligible persons may be granted more than one Award. However, eligibility in accordance with this Section shall not entitle any person to be granted an Award, or, having been granted an Award, to be granted an additional Award.

5.3 **Award Limitations.**

(a) ***Incentive Stock Option Limitations.***

(i) **Maximum Number of Shares Issuable Pursuant to Incentive Stock Options.** Subject to adjustment as provided in Section 4.2, the maximum aggregate number of shares of Stock that may be issued under the Plan pursuant to the exercise of Incentive Stock Options shall not exceed four million five hundred thousand (4,500,000). The maximum aggregate number of shares of Stock that may be issued under the Plan pursuant to all Awards other than Incentive Stock Options shall be the number of shares determined in accordance with Section 4.1.

(ii) **Persons Eligible.** An Incentive Stock Option may be granted only to a person who, on the effective date of grant, is an Employee of the Company, a Parent Corporation or a Subsidiary Corporation (each being an *"**ISO-Qualifying Corporation**"*). Any person who is not an Employee of an ISO-Qualifying Corporation on the effective date of the grant of an Option to such person may be granted only a Nonstatutory Stock Option.

(iii) **Fair Market Value Limitation.** To the extent that options designated as Incentive Stock Options (granted under all stock option plans of the Participating Company Group, including the Plan) become exercisable by a Participant for the first time during any calendar year for stock having a Fair Market Value greater than One Hundred Thousand Dollars ($100,000), the portion of such options which exceeds such amount shall be treated as Nonstatutory Stock Options. For purposes of this Section, options designated as Incentive Stock Options shall be taken into account in the order in which they were granted, and the Fair Market Value of stock shall be determined as of the time the option with respect to such stock is granted. If the Code is amended to provide for a limitation different from that set forth in this Section, such different limitation shall be deemed incorporated herein effective as of the date and with respect to such Options as required or permitted by such amendment to the Code. If an Option is treated as an Incentive Stock Option in part and as a Nonstatutory Stock Option in part by reason of the limitation set forth in this Section, the Participant may designate which portion of such Option the Participant is exercising. In the absence of such designation, the Participant shall be deemed to have exercised the Incentive Stock Option portion of the Option first. Upon exercise, shares issued pursuant to each such portion shall be separately identified.

(b) ***Section 162(m) Award Limits.*** Subject to adjustment as provided in Section 4.2, no Employee shall be granted within any fiscal year of the Company one or more Awards intended to qualify for treatment as Performance-Based Compensation which in the aggregate are for more than seven hundred and fifty thousand (750,000) shares.

6. STOCK OPTIONS.

Options shall be evidenced by Award Agreements specifying the number of shares of Stock covered thereby, in such form as the Committee shall from time to time establish. Award Agreements evidencing Options may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

6.1 **Exercise Price.** The exercise price for each Option shall be established in the discretion of the Committee; provided, however, that (a) the exercise price per share shall be not less than the Fair Market Value of a share of Stock on the effective date of grant of the Option and (b) no Incentive Stock Option granted to a Ten Percent Owner shall have an exercise price per share less than one hundred ten percent (110%) of the Fair Market Value of a share of Stock on the effective date of grant of the Option. Notwithstanding the foregoing, an Option (whether an Incentive Stock Option or a Nonstatutory Stock Option) may be granted with an exercise price lower than the minimum exercise price set forth above if such Option is granted pursuant to an assumption or substitution for another option in a manner that would qualify under the provisions of Section 409A or 424(a) of the Code.

6.2 **Exercisability and Term of Options.** Options shall be exercisable at such time or times, or upon such event or events, and subject to such terms, conditions, performance criteria and restrictions as shall be determined by the Committee and set forth in the Award Agreement evidencing such Option; provided, however, that (a) no Option shall be exercisable after the expiration of ten (10) years after the effective date of grant of such Option, (b) no Incentive Stock Option granted to a Ten Percent Owner shall be exercisable after the expiration of five (5) years after the effective date of grant of such Option and (c) no Option granted to an Employee who is a non-exempt employee for purposes of the Fair Labor Standards Act of 1938, as amended, shall be first exercisable until at least six (6) months following the date of grant of such Option (except in the event of such Employee's death, disability or retirement, upon a Change in Control, or as otherwise permitted by the Worker Economic Opportunity Act). Subject to the foregoing, unless otherwise specified by the Committee in the grant of an Option, each Option shall terminate ten (10) years after the effective date of grant of the Option, unless earlier terminated in accordance with its provisions.

6.3 **Payment of Exercise Price.**

(a) ***Forms of Consideration Authorized.*** Except as otherwise provided below, payment of the exercise price for the number of shares of Stock being purchased pursuant to any Option shall be made (i) in cash, by check or in cash equivalent, (ii) by tender to the Company, or attestation to the ownership, of shares of Stock owned by the Participant having a Fair Market Value not less than the exercise price (a *"**Stock Tender Exercise**"*), (iii) by delivery of a properly executed notice of exercise together with irrevocable instructions to a broker providing for the assignment

to the Company of the proceeds of a sale or loan with respect to some or all of the shares being acquired upon the exercise of the Option (including, without limitation, through an exercise complying with the provisions of Regulation T as promulgated from time to time by the Board of Governors of the Federal Reserve System) (a *"**Cashless Exercise**"*), (iv) by delivery of a properly executed notice electing a Net Exercise, (v) by such other consideration as may be approved by the Committee from time to time to the extent permitted by applicable law, or (vi) by any combination thereof. The Committee may at any time or from time to time grant Options which do not permit all of the foregoing forms of consideration to be used in payment of the exercise price or which otherwise restrict one or more forms of consideration.

(b) ***Limitations on Forms of Consideration.***

(i) **Stock Tender Exercise.** Notwithstanding the foregoing, a Stock Tender Exercise shall not be permitted if it would constitute a violation of the provisions of any law, regulation or agreement restricting the redemption of the Company's stock. If required by the Company, an Option may not be exercised by tender to the Company, or attestation to the ownership, of shares of Stock unless such shares either have been owned by the Participant for a period of time required by the Company (and not used for another option exercise by attestation during such period) or were not acquired, directly or indirectly, from the Company.

(ii) **Cashless Exercise.** The Company reserves, at any and all times, the right, in the Company's sole and absolute discretion, to establish, decline to approve or terminate any program or procedures for the exercise of Options by means of a Cashless Exercise, including with respect to one or more Participants specified by the Company notwithstanding that such program or procedures may be available to other Participants.

6.4 **Effect of Termination of Service.**

(a) ***Option Exercisability.*** Subject to earlier termination of the Option as otherwise provided herein and unless otherwise provided by the Committee, an Option shall terminate immediately upon the Participant's termination of Service to the extent that it is then unvested and shall be exercisable after the Participant's termination of Service to the extent it is then vested only during the applicable time period determined in accordance with this Section and thereafter shall terminate.

(i) **Disability.** If the Participant's Service terminates because of the Disability of the Participant, the Option, to the extent unexercised and exercisable for vested shares on the date on which the Participant's Service terminated, may be exercised by the Participant (or the Participant's guardian or legal representative) at any time prior to the expiration of twelve (12) months after the date on which the Participant's Service terminated, but in any event no later than the date of expiration of the Option's term as set forth in the Award Agreement evidencing such Option (the *"**Option Expiration Date**"*).

(ii) **Death.** If the Participant's Service terminates because of the death of the Participant, then (A) the Option, to the extent unexercised and exercisable for vested shares on the date on which the Participant's Service terminated, may be exercised by the Participant's legal representative or other person who acquired the right to exercise the Option by reason of the

Participant's death at any time prior to the expiration of twelve (12) months after the date on which the Participant's Service terminated, but in any event no later than the Option Expiration Date, and (B) solely for the purposes of determining the number of vested shares subject to the Option as of the date on which the Participant's Service terminated, the Participant shall be credited with an additional twelve (12) months of Service. The Participant's Service shall be deemed to have terminated on account of death if the Participant dies within three (3) months after the Participant's termination of Service; provided, however, that the Participant shall not be credited with additional months of Service if the Participant dies after the Participant's Service has otherwise terminated.

(iii) **Termination for Cause.** Notwithstanding any other provision of the Plan to the contrary, if the Participant's Service is terminated for Cause or if, following the Participant's termination of Service and during any period in which the Option otherwise would remain exercisable, the Participant engages in any act that would constitute Cause, the Option shall terminate in its entirety and cease to be exercisable immediately upon such termination of Service or act.

(iv) **Other Termination of Service.** If the Participant's Service terminates for any reason, except Disability, death or Cause, the Option, to the extent unexercised and exercisable for vested shares on the date on which the Participant's Service terminated, may be exercised by the Participant at any time prior to the expiration of three (3) months after the date on which the Participant's Service terminated, but in any event no later than the Option Expiration Date.

(b) ***Extension if Exercise Prevented by Law.*** Notwithstanding the foregoing, other than termination of Service for Cause, if the exercise of an Option within the applicable time periods set forth in Section 6.4(a) is prevented by the provisions of Section 14 below, the Option shall remain exercisable until the later of (i) thirty (30) days after the date such exercise first would no longer be prevented by such provisions or (ii) the end of the applicable time period under Section 6.4 (a), but in any event no later than the Option Expiration Date.

6.5 **Transferability of Options.** During the lifetime of the Participant, an Option shall be exercisable only by the Participant or the Participant's guardian or legal representative. An Option shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. Notwithstanding the foregoing, to the extent permitted by the Committee, in its discretion, and set forth in the Award Agreement evidencing such Option, an Option shall be assignable or transferable subject to the applicable limitations, if any, described in the General Instructions to Form S-8 under the Securities Act or, in the case of an Incentive Stock Option, only as permitted by applicable regulations under Section 421 of the Code in a manner that does not disqualify such Option as an Incentive Stock Option.

7. STOCK APPRECIATION RIGHTS.

Stock Appreciation Rights shall be evidenced by Award Agreements specifying the number of shares of Stock subject to the Award, in such form as the Committee shall from time to time

establish. Award Agreements evidencing SARs may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

7.1 **Types of SARs Authorized.** SARs may be granted in tandem with all or any portion of a related Option (a *"**Tandem SAR**"*) or may be granted independently of any Option (a *"**Freestanding SAR**"*). A Tandem SAR may only be granted concurrently with the grant of the related Option.

7.2 **Exercise Price.** The exercise price for each SAR shall be established in the discretion of the Committee; provided, however, that (a) the exercise price per share subject to a Tandem SAR shall be the exercise price per share under the related Option and (b) the exercise price per share subject to a Freestanding SAR shall be not less than the Fair Market Value of a share of Stock on the effective date of grant of the SAR. Notwithstanding the foregoing, a an SAR may be granted with an exercise price lower than the minimum exercise price set forth above if such SAR is granted pursuant to an assumption or substitution for another stock appreciation right in a manner that would qualify under the provisions of Section 409A of the Code.

7.3 **Exercisability and Term of SARs.**

(a) ***Tandem SARs.*** Tandem SARs shall be exercisable only at the time and to the extent, and only to the extent, that the related Option is exercisable, subject to such provisions as the Committee may specify where the Tandem SAR is granted with respect to less than the full number of shares of Stock subject to the related Option. The Committee may, in its discretion, provide in any Award Agreement evidencing a Tandem SAR that such SAR may not be exercised without the advance approval of the Company and, if such approval is not given, then the Option shall nevertheless remain exercisable in accordance with its terms. A Tandem SAR shall terminate and cease to be exercisable no later than the date on which the related Option expires or is terminated or canceled. Upon the exercise of a Tandem SAR with respect to some or all of the shares subject to such SAR, the related Option shall be canceled automatically as to the number of shares with respect to which the Tandem SAR was exercised. Upon the exercise of an Option related to a Tandem SAR as to some or all of the shares subject to such Option, the related Tandem SAR shall be canceled automatically as to the number of shares with respect to which the related Option was exercised.

(b) ***Freestanding SARs.*** Freestanding SARs shall be exercisable at such time or times, or upon such event or events, and subject to such terms, conditions, performance criteria and restrictions as shall be determined by the Committee and set forth in the Award Agreement evidencing such SAR; provided, however, that (i) no Freestanding SAR shall be exercisable after the expiration of ten (10) years after the effective date of grant of such SAR and (b) no Freestanding SAR granted to an Employee who is a non-exempt employee for purposes of the Fair Labor Standards Act of 1938, as amended, shall be first exercisable until at least six (6) months following the date of grant of such SAR (except in the event of such Employee's death, disability or retirement, upon a Change in Control, or as otherwise permitted by the Worker Economic Opportunity Act). Subject to the foregoing, unless otherwise specified by the Committee in the grant of a Freestanding SAR, each Freestanding SAR shall terminate ten (10) years after the effective date of grant of the SAR, unless earlier terminated in accordance with its provisions.

7.4 **Exercise of SARs.** Upon the exercise (or deemed exercise pursuant to Section 7.5) of an SAR, the Participant (or the Participant's legal representative or other person who acquired the right to exercise the SAR by reason of the Participant's death) shall be entitled to receive payment of an amount for each share with respect to which the SAR is exercised equal to the excess, if any, of the Fair Market Value of a share of Stock on the date of exercise of the SAR over the exercise price. Payment of such amount shall be made (a) in the case of a Tandem SAR, solely in shares of Stock in a lump sum upon the date of exercise of the SAR and (b) in the case of a Freestanding SAR, in cash, shares of Stock, or any combination thereof as determined by the Committee, in a lump sum upon the date of exercise of the SAR. When payment is to be made in shares of Stock, the number of shares to be issued shall be determined on the basis of the Fair Market Value of a share of Stock on the date of exercise of the SAR. For purposes of Section 7, an SAR shall be deemed exercised on the date on which the Company receives notice of exercise from the Participant or as otherwise provided in Section 7.5.

7.5 **Deemed Exercise of SARs.** If, on the date on which an SAR would otherwise terminate or expire, the SAR by its terms remains exercisable immediately prior to such termination or expiration and, if so exercised, would result in a payment to the holder of such SAR, then any portion of such SAR which has not previously been exercised shall automatically be deemed to be exercised as of such date with respect to such portion.

7.6 **Effect of Termination of Service.** Subject to earlier termination of the SAR as otherwise provided herein and unless otherwise provided by the Committee, an SAR shall be exercisable after a Participant's termination of Service only to the extent and during the applicable time period determined in accordance with Section 6.4 (treating the SAR as if it were an Option) and thereafter shall terminate.

7.7 **Transferability of SARs.** During the lifetime of the Participant, an SAR shall be exercisable only by the Participant or the Participant's guardian or legal representative. An SAR shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. Notwithstanding the foregoing, to the extent permitted by the Committee, in its discretion, and set forth in the Award Agreement evidencing such Award, a Tandem SAR related to a Nonstatutory Stock Option or a Freestanding SAR shall be assignable or transferable subject to the applicable limitations, if any, described in the General Instructions to Form S-8 under the Securities Act.

8. RESTRICTED STOCK AWARDS.

Restricted Stock Awards shall be evidenced by Award Agreements specifying whether the Award is a Restricted Stock Bonus or a Restricted Stock Purchase Right and the number of shares of Stock subject to the Award, in such form as the Committee shall from time to time establish. Award Agreements evidencing Restricted Stock Awards may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

8.1 **Types of Restricted Stock Awards Authorized.** Restricted Stock Awards may be granted in the form of either a Restricted Stock Bonus or a Restricted Stock Purchase Right. Restricted Stock Awards may be granted upon such conditions as the Committee shall determine,

including, without limitation, upon the attainment of one or more Performance Goals described in Section 10.4. If either the grant of or satisfaction of Vesting Conditions applicable to a Restricted Stock Award is to be contingent upon the attainment of one or more Performance Goals, the Committee shall follow procedures substantially equivalent to those set forth in Sections 10.3 through 10.5(a).

8.2 **Purchase Price.** The purchase price for shares of Stock issuable under each Restricted Stock Purchase Right shall be established by the Committee in its discretion. No monetary payment (other than applicable tax withholding) shall be required as a condition of receiving shares of Stock pursuant to a Restricted Stock Bonus, the consideration for which shall be services actually rendered to a Participating Company or for its benefit. Notwithstanding the foregoing, if required by applicable state corporate law, the Participant shall furnish consideration in the form of cash or past services rendered to a Participating Company or for its benefit having a value not less than the par value of the shares of Stock subject to a Restricted Stock Award.

8.3 **Purchase Period.** A Restricted Stock Purchase Right shall be exercisable within a period established by the Committee, which shall in no event exceed thirty (30) days from the effective date of the grant of the Restricted Stock Purchase Right.

8.4 **Payment of Purchase Price.** Except as otherwise provided below, payment of the purchase price for the number of shares of Stock being purchased pursuant to any Restricted Stock Purchase Right shall be made (a) in cash, by check or in cash equivalent, (b) by such other consideration as may be approved by the Committee from time to time to the extent permitted by applicable law, or (c) by any combination thereof.

8.5 **Vesting and Restrictions on Transfer.** Shares issued pursuant to any Restricted Stock Award shall be made subject to Vesting Conditions based upon the satisfaction of such Service requirements, conditions, restrictions or performance criteria, including, without limitation, Performance Goals as described in Section 10.4, as shall be established by the Committee and set forth in the Award Agreement evidencing such Award; provided that, with respect to all Restricted Stock Awards other than those made to any Nonemployee Director, (i) the Vesting Conditions for non-performance based Restricted Stock Awards shall provide that the vesting period be at least three years, over which period vesting may be pro-rata in the manner specified in the Award Agreement and (ii) the Vesting Conditions for performance-based Restricted Stock Awards shall provide that the vesting period be at least one year.

During any period in which shares acquired pursuant to a Restricted Stock Award remain subject to Vesting Conditions, such shares may not be sold, exchanged, transferred, pledged, assigned or otherwise disposed of other than pursuant to an Ownership Change Event or as provided in Section 8.8. The Committee, in its discretion, may provide in any Award Agreement evidencing a Restricted Stock Award that, if the satisfaction of Vesting Conditions with respect to any shares subject to such Restricted Stock Award would otherwise occur on a day on which the sale of such shares would violate the provisions of the Trading Compliance Policy, then satisfaction of the Vesting Conditions automatically shall be determined on the next trading day on which the sale of such shares would not violate the Trading Compliance Policy. Upon request by the Company, each Participant shall execute any agreement evidencing such transfer restrictions prior to the receipt of shares of Stock hereunder and shall promptly present to the Company any and all certificates

representing shares of Stock acquired hereunder for the placement on such certificates of appropriate legends evidencing any such transfer restrictions.

8.6 **Voting Rights; Dividends and Distributions.** Except as provided in this Section, Section 8.5 and any Award Agreement, during any period in which shares acquired pursuant to a Restricted Stock Award remain subject to Vesting Conditions, the Participant shall have all of the rights of a stockholder of the Company holding shares of Stock, including the right to vote such shares and to receive all dividends and other distributions paid with respect to such shares; provided, however, that if so determined by the Committee and provided by the Award Agreement, such dividends and distributions shall be subject to the same Vesting Conditions as the shares subject to the Restricted Stock Award with respect to which such dividends or distributions were paid, and otherwise shall be paid no later than the end of the calendar year in which such dividends or distributions are paid to stockholders (or, if later, the 15th day of the third month following the date such dividends or distributions are paid to stockholders). In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant is entitled by reason of the Participant's Restricted Stock Award shall be immediately subject to the same Vesting Conditions as the shares subject to the Restricted Stock Award with respect to which such dividends or distributions were paid or adjustments were made.

8.7 **Effect of Termination of Service.** Unless otherwise provided by the Committee in the Award Agreement evidencing a Restricted Stock Award, if a Participant's Service terminates for any reason, whether voluntary or involuntary (including the Participant's death or disability), then (a) the Company shall have the option to repurchase for the purchase price paid by the Participant any shares acquired by the Participant pursuant to a Restricted Stock Purchase Right which remain subject to Vesting Conditions as of the date of the Participant's termination of Service and (b) the Participant shall forfeit to the Company any shares acquired by the Participant pursuant to a Restricted Stock Bonus which remain subject to Vesting Conditions as of the date of the Participant's termination of Service. The Company shall have the right to assign at any time any repurchase right it may have, whether or not such right is then exercisable, to one or more persons as may be selected by the Company.

8.8 **Nontransferability of Restricted Stock Award Rights.** Rights to acquire shares of Stock pursuant to a Restricted Stock Award shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or the laws of descent and distribution. All rights with respect to a Restricted Stock Award granted to a Participant hereunder shall be exercisable during his or her lifetime only by such Participant or the Participant's guardian or legal representative.

9. **RESTRICTED STOCK UNIT AWARDS.**

Restricted Stock Unit Awards shall be evidenced by Award Agreements specifying the number of Restricted Stock Units subject to the Award, in such form as the Committee shall from time to time establish. Award Agreements evidencing Restricted Stock Units may incorporate all

or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

9.1 **Grant of Restricted Stock Unit Awards.** Restricted Stock Unit Awards may be granted upon such conditions as the Committee shall determine, including, without limitation, upon the attainment of one or more Performance Goals described in Section 10.4. If either the grant of a Restricted Stock Unit Award or the Vesting Conditions with respect to such Award is to be contingent upon the attainment of one or more Performance Goals, the Committee shall follow procedures substantially equivalent to those set forth in Sections 10.3 through 10.5(a).

9.2 **Purchase Price.** No monetary payment (other than applicable tax withholding, if any) shall be required as a condition of receiving a Restricted Stock Unit Award, the consideration for which shall be services actually rendered to a Participating Company or for its benefit. Notwithstanding the foregoing, if required by applicable state corporate law, the Participant shall furnish consideration in the form of cash or past services rendered to a Participating Company or for its benefit having a value not less than the par value of the shares of Stock issued upon settlement of the Restricted Stock Unit Award.

9.3 **Vesting.** Restricted Stock Unit Awards may (but need not) be made subject to Vesting Conditions based upon the satisfaction of such Service requirements, conditions, restrictions or performance criteria, including, without limitation, Performance Goals as described in Section 10.4, as shall be established by the Committee and set forth in the Award Agreement evidencing such Award. The Committee, in its discretion, may provide in any Award Agreement evidencing a Restricted Stock Unit Award that, if the satisfaction of Vesting Conditions with respect to any shares subject to the Award would otherwise occur on a day on which the sale of such shares would violate the provisions of the Trading Compliance Policy, then the satisfaction of the Vesting Conditions automatically shall be determined on the first to occur of (a) the next trading day on which the sale of such shares would not violate the Trading Compliance Policy or (b) the later of (i) last day of the calendar year in which the original vesting date occurred or (ii) the last day of the Company's taxable year in which the original vesting date occurred.

9.4 **Voting Rights, Dividend Equivalent Rights and Distributions.** Participants shall have no voting rights with respect to shares of Stock represented by Restricted Stock Units until the date of the issuance of such shares (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). However, the Committee, in its discretion, may provide in the Award Agreement evidencing any Restricted Stock Unit Award that the Participant shall be entitled to Dividend Equivalent Rights with respect to the payment of cash dividends on Stock during the period beginning on the date such Award is granted and ending, with respect to each share subject to the Award, on the earlier of the date the Award is settled or the date on which it is terminated. Such Dividend Equivalent Rights, if any, shall be paid by crediting the Participant with additional whole Restricted Stock Units as of the date of payment of such cash dividends on Stock. The number of additional Restricted Stock Units (rounded to the nearest whole number) to be so credited shall be determined by dividing (a) the amount of cash dividends paid on such date with respect to the number of shares of Stock represented by the Restricted Stock Units previously credited to the Participant by (b) the Fair Market Value per share of Stock on such date. Such additional Restricted Stock Units shall be subject to the same terms and conditions and shall be settled in the same manner and at the same time as the Restricted Stock Units originally subject

to the Restricted Stock Unit Award. In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, appropriate adjustments shall be made in the Participant's Restricted Stock Unit Award so that it represents the right to receive upon settlement any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant would be entitled by reason of the shares of Stock issuable upon settlement of the Award, and all such new, substituted or additional securities or other property shall be immediately subject to the same Vesting Conditions as are applicable to the Award.

9.5 **Effect of Termination of Service.** Unless otherwise provided by the Committee and set forth in the Award Agreement evidencing a Restricted Stock Unit Award, if a Participant's Service terminates for any reason, whether voluntary or involuntary (including the Participant's death or disability), then the Participant shall forfeit to the Company any Restricted Stock Units pursuant to the Award which remain subject to Vesting Conditions as of the date of the Participant's termination of Service.

9.6 **Settlement of Restricted Stock Unit Awards.** The Company shall issue to a Participant on the date on which Restricted Stock Units subject to the Participant's Restricted Stock Unit Award vest or on such other date determined by the Committee, in its discretion, and set forth in the Award Agreement one (1) share of Stock (and/or any other new, substituted or additional securities or other property pursuant to an adjustment described in Section 9.4) for each Restricted Stock Unit then becoming vested or otherwise to be settled on such date, subject to the withholding of applicable taxes, if any. If permitted by the Committee, the Participant may elect, consistent with the requirements of Section 409A, to defer receipt of all or any portion of the shares of Stock or other property otherwise issuable to the Participant pursuant to this Section, and such deferred issuance date(s) and amount(s) elected by the Participant shall be set forth in the Award Agreement. Notwithstanding the foregoing, the Committee, in its discretion, may provide for settlement of any Restricted Stock Unit Award by payment to the Participant in cash of an amount equal to the Fair Market Value on the payment date of the shares of Stock or other property otherwise issuable to the Participant pursuant to this Section.

9.7 **Nontransferability of Restricted Stock Unit Awards.** The right to receive shares pursuant to a Restricted Stock Unit Award shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. All rights with respect to a Restricted Stock Unit Award granted to a Participant hereunder shall be exercisable during his or her lifetime only by such Participant or the Participant's guardian or legal representative.

10. **PERFORMANCE AWARDS.**

Performance Awards shall be evidenced by Award Agreements in such form as the Committee shall from time to time establish. Award Agreements evidencing Performance Awards may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

10.1 **Types of Performance Awards Authorized.** Performance Awards may be granted in the form of either Performance Shares or Performance Units. Each Award Agreement evidencing a Performance Award shall specify the number of Performance Shares or Performance Units subject thereto, the Performance Award Formula, the Performance Goal(s) and Performance Period applicable to the Award, and the other terms, conditions and restrictions of the Award.

10.2 **Initial Value of Performance Shares and Performance Units.** Unless otherwise provided by the Committee in granting a Performance Award, each Performance Share shall have an initial monetary value equal to the Fair Market Value of one (1) share of Stock, subject to adjustment as provided in Section 4.2, on the effective date of grant of the Performance Share, and each Performance Unit shall have an initial monetary value established by the Committee at the time of grant. The final value payable to the Participant in settlement of a Performance Award determined on the basis of the applicable Performance Award Formula will depend on the extent to which Performance Goals established by the Committee are attained within the applicable Performance Period established by the Committee.

10.3 **Establishment of Performance Period, Performance Goals and Performance Award Formula.** In granting each Performance Award, the Committee shall establish in writing the applicable Performance Period, Performance Award Formula and one or more Performance Goals which, when measured at the end of the Performance Period, shall determine on the basis of the Performance Award Formula the final value of the Performance Award to be paid to the Participant. Unless otherwise permitted in compliance with the requirements under Section 162(m) with respect to each Performance Award intended to result in the payment of Performance-Based Compensation, the Committee shall establish the Performance Goal(s) and Performance Award Formula applicable to each Performance Award no later than the earlier of (a) the date ninety (90) days after the commencement of the applicable Performance Period or (b) the date on which 25% of the Performance Period has elapsed, and, in any event, at a time when the outcome of the Performance Goals remains substantially uncertain. Once established, the Performance Goals and Performance Award Formula applicable to a Covered Employee shall not be changed during the Performance Period. The Company shall notify each Participant granted a Performance Award of the terms of such Award, including the Performance Period, Performance Goal(s) and Performance Award Formula.

10.4 **Measurement of Performance Goals.** Performance Goals shall be established by the Committee on the basis of targets to be attained (*"**Performance Targets**"*) with respect to one or more measures of business or financial performance (each, a *"**Performance Measure**"*), subject to the following:

(a) ***Performance Measures.*** Performance Measures shall be calculated in accordance with the Company's financial statements, or, if such terms are not used in the Company's financial statements, they shall be calculated in accordance with generally accepted accounting principles, a method used generally in the Company's industry, or in accordance with a methodology established by the Committee prior to the grant of the Performance Award. Performance Measures shall be calculated with respect to the Company and each Subsidiary Corporation consolidated therewith for financial reporting purposes or such division or other business unit as may be selected by the Committee. Unless otherwise determined by the Committee prior to the grant of the Performance Award, the Performance Measures applicable to the Performance Award shall be

calculated prior to the accrual of expense for any Performance Award for the same Performance Period and excluding the effect (whether positive or negative) on the Performance Measures of any change in accounting standards or any extraordinary, unusual or nonrecurring item, as determined by the Committee, occurring after the establishment of the Performance Goals applicable to the Performance Award. Each such adjustment, if any, shall be made solely for the purpose of providing a consistent basis from period to period for the calculation of Performance Measures in order to prevent the dilution or enlargement of the Participant's rights with respect to a Performance Award. Performance Measures may be one or more of the following, as determined by the Committee:

(i) revenue;

(ii) sales;

(iii) expenses;

(iv) operating income;

(v) gross margin;

(vi) operating margin;

(vii) earnings before any one or more of: stock-based compensation expense, interest, taxes, depreciation and amortization;

(viii) pre-tax profit;

(ix) net operating income;

(x) net income;

(xi) economic value added;

(xii) free cash flow;

(xiii) operating cash flow;

(xiv) balance of cash, cash equivalents and marketable securities;

(xv) stock price;

(xvi) earnings per share;

(xvii) return on stockholder equity;

(xviii) return on capital;

(xix) return on assets;

(xx) return on investment;

(xxi) total stockholder return;

(xxii) employee satisfaction;

(xxiii) employee retention;

(xxiv) market share;

(xxv) customer satisfaction;

(xxvi) product development;

(xxvii) research and development expenses;

(xxviii) completion of an identified special project; and

(xxix) completion of a joint venture or other corporate transaction.

(b) ***Performance Targets.*** Performance Targets may include a minimum, maximum, target level and intermediate levels of performance, with the final value of a Performance Award determined under the applicable Performance Award Formula by the level attained during the applicable Performance Period. A Performance Target may be stated as an absolute value, a growth or reduction in a value, or as a value determined relative to an index, budget or other standard selected by the Committee.

10.5 **Settlement of Performance Awards.**

(a) ***Determination of Final Value.*** As soon as practicable following the completion of the Performance Period applicable to a Performance Award, the Committee shall certify in writing the extent to which the applicable Performance Goals have been attained and the resulting final value of the Award earned by the Participant and to be paid upon its settlement in accordance with the applicable Performance Award Formula.

(b) ***Discretionary Adjustment of Award Formula.*** In its discretion, the Committee may, either at the time it grants a Performance Award or at any time thereafter, provide for the positive or negative adjustment of the Performance Award Formula applicable to a Performance Award granted to any Participant who is not a Covered Employee to reflect such Participant's individual performance in his or her position with the Company or such other factors as the Committee may determine. If permitted under a Covered Employee's Award Agreement, the Committee shall have the discretion, on the basis of such criteria as may be established by the Committee, to reduce some or all of the value of the Performance Award that would otherwise be paid to the Covered Employee upon its settlement notwithstanding the attainment of any Performance Goal and the resulting value of the Performance Award determined in accordance with the Performance Award Formula. No such reduction may result in an increase in the amount payable

upon settlement of another Participant's Performance Award that is intended to result in Performance-Based Compensation.

(c) ***Effect of Leaves of Absence.*** Unless otherwise required by law or a Participant's Award Agreement, payment of the final value, if any, of a Performance Award held by a Participant who has taken in excess of thirty (30) days in unpaid leaves of absence during a Performance Period shall be prorated on the basis of the number of days of the Participant's Service during the Performance Period during which the Participant was not on an unpaid leave of absence.

(d) ***Notice to Participants.*** As soon as practicable following the Committee's determination and certification in accordance with Sections 10.5(a) and (b), the Company shall notify each Participant of the determination of the Committee.

(e) ***Payment in Settlement of Performance Awards.*** As soon as practicable following the Committee's determination and certification in accordance with Sections 10.5(a) and (b), but in any event within the Short-Term Deferral Period described in Section 15.1 (except as otherwise provided below or consistent with the requirements of Section 409A), payment shall be made to each eligible Participant (or such Participant's legal representative or other person who acquired the right to receive such payment by reason of the Participant's death) of the final value of the Participant's Performance Award. Payment of such amount shall be made in cash, shares of Stock, or a combination thereof as determined by the Committee. Unless otherwise provided in the Award Agreement evidencing a Performance Award, payment shall be made in a lump sum. If permitted by the Committee, the Participant may elect, consistent with the requirements of Section 409A, to defer receipt of all or any portion of the payment to be made to the Participant pursuant to this Section, and such deferred payment date(s) elected by the Participant shall be set forth in the Award Agreement. If any payment is to be made on a deferred basis, the Committee may, but shall not be obligated to, provide for the payment during the deferral period of Dividend Equivalent Rights or interest.

(f) ***Provisions Applicable to Payment in Shares.*** If payment is to be made in shares of Stock, the number of such shares shall be determined by dividing the final value of the Performance Award by the Fair Market Value of a share of Stock determined by the method specified in the Award Agreement. Shares of Stock issued in payment of any Performance Award may be fully vested and freely transferable shares or may be shares of Stock subject to Vesting Conditions as provided in Section 8.5. Any shares subject to Vesting Conditions shall be evidenced by an appropriate Award Agreement and shall be subject to the provisions of Sections 8.5 through 8.8 above.

10.6 **Voting Rights; Dividend Equivalent Rights and Distributions.** Participants shall have no voting rights with respect to shares of Stock represented by Performance Share Awards until the date of the issuance of such shares, if any (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). However, the Committee, in its discretion, may provide in the Award Agreement evidencing any Performance Share Award that the Participant shall be entitled to Dividend Equivalent Rights with respect to the payment of cash dividends on Stock during the period beginning on the date the Award is granted and ending, with respect to each share subject to the Award, on the earlier of the date on which the Performance Shares are settled or the date on which they are forfeited. Such Dividend Equivalent

Rights, if any, shall be credited to the Participant in the form of additional whole Performance Shares as of the date of payment of such cash dividends on Stock. The number of additional Performance Shares (rounded to the nearest whole number) to be so credited shall be determined by dividing (a) the amount of cash dividends paid on the dividend payment date with respect to the number of shares of Stock represented by the Performance Shares previously credited to the Participant by (b) the Fair Market Value per share of Stock on such date. Dividend Equivalent Rights may be paid currently or may be accumulated and paid to the extent that Performance Shares become nonforfeitable, as determined by the Committee. Settlement of Dividend Equivalent Rights may be made in cash, shares of Stock, or a combination thereof as determined by the Committee, and may be paid on the same basis as settlement of the related Performance Share as provided in Section 10.5. Dividend Equivalent Rights shall not be paid with respect to Performance Units. In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, appropriate adjustments shall be made in the Participant's Performance Share Award so that it represents the right to receive upon settlement any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant would be entitled by reason of the shares of Stock issuable upon settlement of the Performance Share Award, and all such new, substituted or additional securities or other property shall be immediately subject to the same Performance Goals as are applicable to the Award.

10.7 **Effect of Termination of Service.** Unless otherwise provided by the Committee and set forth in the Award Agreement evidencing a Performance Award, the effect of a Participant's termination of Service on the Performance Award shall be as follows:

(a) ***Death or Disability.*** If the Participant's Service terminates because of the death or Disability of the Participant before the completion of the Performance Period applicable to the Performance Award, the final value of the Participant's Performance Award shall be determined by the extent to which the applicable Performance Goals have been attained with respect to the entire Performance Period and shall be prorated based on the number of months of the Participant's Service during the Performance Period. Payment shall be made following the end of the Performance Period in any manner permitted by Section 10.5.

(b) ***Other Termination of Service.*** If the Participant's Service terminates for any reason except death or Disability before the completion of the Performance Period applicable to the Performance Award, such Award shall be forfeited in its entirety; provided, however, that in the event of an involuntary termination of the Participant's Service, the Committee, in its discretion, may waive the automatic forfeiture of all or any portion of any such Award and determine the final value of the Performance Award in the manner provided by Section 10.7(a). Payment of any amount pursuant to this Section shall be made following the end of the Performance Period in any manner permitted by Section 10.5.

10.8 **Nontransferability of Performance Awards.** Prior to settlement in accordance with the provisions of the Plan, no Performance Award shall be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. All rights with respect to a Performance Award granted to a Participant hereunder

shall be exercisable during his or her lifetime only by such Participant or the Participant's guardian or legal representative.

11. CASH-BASED AWARDS AND OTHER STOCK-BASED AWARDS

Cash-Based Awards and Other Stock-Based Awards shall be evidenced by Award Agreements in such form as the Committee shall from time to time establish. Award Agreements evidencing Cash-Based Awards and Other Stock-Based Awards may incorporate all or any of the terms of the Plan by reference and shall comply with and be subject to the following terms and conditions:

11.1 **Grant of Cash-Based Awards**. Subject to the provisions of the Plan, the Committee, at any time and from time to time, may grant Cash-Based Awards to Participants in such amounts and upon such terms and conditions, including the achievement of performance criteria, as the Committee may determine.

11.2 **Grant of Other Stock-Based Awards**. The Committee may grant other types of equity-based or equity-related Awards not otherwise described by the terms of this Plan (including the grant or offer for sale of unrestricted securities, stock-equivalent units, stock appreciation units, securities or debentures convertible into common stock or other forms determined by the Committee) in such amounts and subject to such terms and conditions as the Committee shall determine. Other Stock-Based Awards may be made available as a form of payment in the settlement of other Awards or as payment in lieu of compensation to which a Participant is otherwise entitled. Other Stock-Based Awards may involve the transfer of actual shares of Stock to Participants, or payment in cash or otherwise of amounts based on the value of Stock and may include, without limitation, Awards designed to comply with or take advantage of the applicable local laws of jurisdictions other than the United States.

11.3 **Value of Cash-Based and Other Stock-Based Awards**. Each Cash-Based Award shall specify a monetary payment amount or payment range as determined by the Committee. Each Other Stock-Based Award shall be expressed in terms of shares of Stock or units based on such shares of Stock, as determined by the Committee. The Committee may require the satisfaction of such Service requirements, conditions, restrictions or performance criteria, including, without limitation, Performance Goals as described in Section 10.4, as shall be established by the Committee and set forth in the Award Agreement evidencing such Award. If the Committee exercises its discretion to establish performance criteria, the final value of Cash-Based Awards or Other Stock-Based Awards that will be paid to the Participant will depend on the extent to which the performance criteria are met. The establishment of performance criteria with respect to the grant or vesting of any Cash-Based Award or Other Stock-Based Award intended to result in Performance-Based Compensation shall follow procedures substantially equivalent to those applicable to Performance Awards set forth in Section 10.

11.4 **Payment or Settlement of Cash-Based Awards and Other Stock-Based Awards**. Payment or settlement, if any, with respect to a Cash-Based Award or an Other Stock-Based Award shall be made in accordance with the terms of the Award, in cash, shares of Stock or other securities or any combination thereof as the Committee determines. The determination and certification of the final value with respect to any Cash-Based Award or Other Stock-Based Award intended to

result in Performance-Based Compensation shall comply with the requirements applicable to Performance Awards set forth in Section 10. To the extent applicable, payment or settlement with respect to each Cash-Based Award and Other Stock-Based Award shall be made in compliance with the requirements of Section 409A.

11.5 **Voting Rights; Dividend Equivalent Rights and Distributions.** Participants shall have no voting rights with respect to shares of Stock represented by Other Stock-Based Awards until the date of the issuance of such shares of Stock (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company), if any, in settlement of such Award. However, the Committee, in its discretion, may provide in the Award Agreement evidencing any Other Stock-Based Award that the Participant shall be entitled to Dividend Equivalent Rights with respect to the payment of cash dividends on Stock during the period beginning on the date such Award is granted and ending, with respect to each share subject to the Award, on the earlier of the date the Award is settled or the date on which it is terminated. Such Dividend Equivalent Rights, if any, shall be paid in accordance with the provisions set forth in Section 9.4. Dividend Equivalent Rights shall not be granted with respect to Cash-Based Awards. In the event of a dividend or distribution paid in shares of Stock or other property or any other adjustment made upon a change in the capital structure of the Company as described in Section 4.2, appropriate adjustments shall be made in the Participant's Other Stock-Based Award so that it represents the right to receive upon settlement any and all new, substituted or additional securities or other property (other than regular, periodic cash dividends) to which the Participant would be entitled by reason of the shares of Stock issuable upon settlement of such Award, and all such new, substituted or additional securities or other property shall be immediately subject to the same Vesting Conditions and performance criteria, if any, as are applicable to the Award.

11.6 **Effect of Termination of Service**. Each Award Agreement evidencing a Cash-Based Award or Other Stock-Based Award shall set forth the extent to which the Participant shall have the right to retain such Award following termination of the Participant's Service. Such provisions shall be determined in the discretion of the Committee, need not be uniform among all Cash-Based Awards or Other Stock-Based Awards, and may reflect distinctions based on the reasons for termination, subject to the requirements of Section 409A, if applicable.

11.7 **Nontransferability of Cash-Based Awards and Other Stock-Based Awards.** Prior to the payment or settlement of a Cash-Based Award or Other Stock-Based Award, the Award shall not be subject in any manner to anticipation, alienation, sale, exchange, transfer, assignment, pledge, encumbrance, or garnishment by creditors of the Participant or the Participant's beneficiary, except transfer by will or by the laws of descent and distribution. The Committee may impose such additional restrictions on any shares of Stock issued in settlement of Cash-Based Awards and Other Stock-Based Awards as it may deem advisable, including, without limitation, minimum holding period requirements, restrictions under applicable federal securities laws, under the requirements of any stock exchange or market upon which such shares of Stock are then listed and/or traded, or under any state securities laws or foreign law applicable to such shares of Stock.

12. STANDARD FORMS OF AWARD AGREEMENT.

12.1 **Award Agreements.** Each Award shall comply with and be subject to the terms and conditions set forth in the appropriate form of Award Agreement approved by the Committee and

as amended from time to time. No Award or purported Award shall be a valid and binding obligation of the Company unless evidenced by a fully executed Award Agreement, which execution may be evidenced by electronic means. Any Award Agreement may consist of an appropriate form of Notice of Grant and a form of Agreement incorporated therein by reference, or such other form or forms, including electronic media, as the Committee may approve from time to time.

12.2 **Authority to Vary Terms** The Committee shall have the authority from time to time to vary the terms of any standard form of Award Agreement either in connection with the grant or amendment of an individual Award or in connection with the authorization of a new standard form or forms; provided, however, that the terms and conditions of any such new, revised or amended standard form or forms of Award Agreement are not inconsistent with the terms of the Plan.

13. CHANGE IN CONTROL.

13.1 **Effect of Change in Control on Awards.** Subject to the requirements and limitations of Section 409A, if applicable, the Committee may provide for any one or more of the following:

(a) ***Accelerated Vesting.*** In its discretion, the Committee may provide in the grant of any Award or at any other time may take such action as it deems appropriate to provide for acceleration of the exercisability, vesting and/or settlement in connection with a Change in Control of each or any outstanding Award or portion thereof and shares acquired pursuant thereto upon such conditions, including termination of the Participant's Service prior to, upon, or following such Change in Control, and to such extent as the Committee shall determine.

(b) ***Assumption, Continuation or Substitution.*** In the event of a Change in Control, the surviving, continuing, successor, or purchasing corporation or other business entity or parent thereof, as the case may be (the *"**Acquiror**"*), may, without the consent of any Participant, either assume or continue the Company's rights and obligations under each or any Award or portion thereof outstanding immediately prior to the Change in Control or substitute for each or any such outstanding Award or portion thereof a substantially equivalent award with respect to the Acquiror's stock, as applicable. For purposes of this Section, if so determined by the Committee in its discretion, an Award denominated in shares of Stock shall be deemed assumed if, following the Change in Control, the Award confers the right to receive, subject to the terms and conditions of the Plan and the applicable Award Agreement, for each share of Stock subject to the Award immediately prior to the Change in Control, the consideration (whether stock, cash, other securities or property or a combination thereof) to which a holder of a share of Stock on the effective date of the Change in Control was entitled (and if holders were offered a choice of consideration, the type of consideration chosen by the holders of a majority of the outstanding shares of Stock); provided, however, that if such consideration is not solely common stock of the Acquiror, the Committee may, with the consent of the Acquiror, provide for the consideration to be received upon the exercise or settlement of the Award, for each share of Stock subject to the Award, to consist solely of common stock of the Acquiror equal in Fair Market Value to the per share consideration received by holders of Stock pursuant to the Change in Control. Any Award or portion thereof which is neither assumed or continued by the Acquiror in connection with the Change in Control nor exercised or settled as of the time of consummation of the Change in Control shall terminate and cease to be outstanding effective as of the time of consummation of the Change in Control.

(c) ***Cash-Out of Outstanding Stock-Based Awards.*** The Committee may, in its discretion and without the consent of any Participant, determine that, upon the occurrence of a Change in Control, each or any Award denominated in shares of Stock or portion thereof outstanding immediately prior to the Change in Control and not previously exercised or settled shall be canceled in exchange for a payment with respect to each vested share (and each unvested share, if so determined by the Committee) of Stock subject to such canceled Award in (i) cash, (ii) stock of the Company or of a corporation or other business entity a party to the Change in Control, or (iii) other property which, in any such case, shall be in an amount having a Fair Market Value equal to the Fair Market Value of the consideration to be paid per share of Stock in the Change in Control, reduced (but not below zero) by the exercise or purchase price per share, if any, under such Award. In the event such determination is made by the Committee, an Award having an exercise or purchase price per share equal to or greater than the Fair Market Value of the consideration to be paid per share of Stock in the Change in Control may be canceled without payment of consideration to the holder thereof. Payment pursuant to this Section (reduced by applicable withholding taxes, if any) shall be made to Participants in respect of the vested portions of their canceled Awards as soon as practicable following the date of the Change in Control and in respect of the unvested portions of their canceled Awards in accordance with the vesting schedules applicable to such Awards.

13.2 **Federal Excise Tax Under Section 4999 of the Code.**

(a) ***Excess Parachute Payment.*** In the event that any acceleration of vesting pursuant to an Award and any other payment or benefit received or to be received by a Participant would subject the Participant to any excise tax pursuant to Section 4999 of the Code due to the characterization of such acceleration of vesting, payment or benefit as an "excess parachute payment" under Section 280G of the Code, the Participant may elect to reduce the amount of any acceleration of vesting called for under the Award in order to avoid such characterization.

(b) ***Determination by Independent Accountants.*** To aid the Participant in making any election called for under Section 13.2(a), no later than the date of the occurrence of any event that might reasonably be anticipated to result in an "excess parachute payment" to the Participant as described in Section 13.2(a), the Company shall request a determination in writing by independent public accountants selected by the Company (the *"**Accountants**"*). As soon as practicable thereafter, the Accountants shall determine and report to the Company and the Participant the amount of such acceleration of vesting, payments and benefits which would produce the greatest after-tax benefit to the Participant. For the purposes of such determination, the Accountants may rely on reasonable, good faith interpretations concerning the application of Sections 280G and 4999 of the Code. The Company and the Participant shall furnish to the Accountants such information and documents as the Accountants may reasonably request in order to make their required determination. The Company shall bear all fees and expenses the Accountants charge in connection with their services contemplated by this Section.

14. **COMPLIANCE WITH SECURITIES LAW.**

The grant of Awards and the issuance of shares of Stock pursuant to any Award shall be subject to compliance with all applicable requirements of federal, state and foreign law with respect to such securities and the requirements of any stock exchange or market system upon which the Stock may then be listed. In addition, no Award may be exercised or shares issued pursuant to an

Award unless (a) a registration statement under the Securities Act shall at the time of such exercise or issuance be in effect with respect to the shares issuable pursuant to the Award, or (b) in the opinion of legal counsel to the Company, the shares issuable pursuant to the Award may be issued in accordance with the terms of an applicable exemption from the registration requirements of the Securities Act. The inability of the Company to obtain from any regulatory body having jurisdiction the authority, if any, deemed by the Company's legal counsel to be necessary to the lawful issuance and sale of any shares hereunder shall relieve the Company of any liability in respect of the failure to issue or sell such shares as to which such requisite authority shall not have been obtained. As a condition to issuance of any Stock, the Company may require the Participant to satisfy any qualifications that may be necessary or appropriate, to evidence compliance with any applicable law or regulation and to make any representation or warranty with respect thereto as may be requested by the Company.

15. **COMPLIANCE WITH SECTION 409A.**

15.1 **Awards Subject to Section 409A.** The Company intends that Awards granted pursuant to the Plan shall either be exempt from or comply with Section 409A, and the Plan shall be so construed. The provisions of this Section 15 shall apply to any Award or portion thereof that constitutes or provides for payment of Section 409A Deferred Compensation. Such Awards may include, without limitation:

(a) A Nonstatutory Stock Option or SAR that includes any feature for the deferral of compensation other than the deferral of recognition of income until the later of (i) the exercise or disposition of the Award or (ii) the time the stock acquired pursuant to the exercise of the Award first becomes substantially vested.

(b) Any Restricted Stock Unit Award, Performance Award, Cash-Based Award or Other Stock-Based Award that either (i) provides by its terms for settlement of all or any portion of the Award at a time or upon an event that will or may occur later than the end of the Short-Term Deferral Period (as defined below) or (ii) permits the Participant granted the Award to elect one or more dates or events upon which the Award will be settled after the end of the Short-Term Deferral Period.

Subject to the provisions of Section 409A, the term "***Short-Term Deferral Period***" means the 2½ month period ending on the later of (i) the 15th day of the third month following the end of the Participant's taxable year in which the right to payment under the applicable portion of the Award is no longer subject to a substantial risk of forfeiture or (ii) the 15th day of the third month following the end of the Company's taxable year in which the right to payment under the applicable portion of the Award is no longer subject to a substantial risk of forfeiture. For this purpose, the term "substantial risk of forfeiture" shall have the meaning provided by Section 409A.

15.2 **Deferral and/or Distribution Elections.** Except as otherwise permitted or required by Section 409A, the following rules shall apply to any compensation deferral and/or payment elections (each, an "***Election***") that may be permitted or required by the Committee pursuant to an Award providing Section 409A Deferred Compensation:

(a) Elections must be in writing and specify the amount of the payment in settlement of an Award being deferred, as well as the time and form of payment as permitted by this Plan.

(b) Elections shall be made by the end of the Participant's taxable year prior to the year in which services commence for which an Award may be granted to such Participant.

(c) Elections shall continue in effect until a written revocation or change in Election is received by the Company, except that a written revocation or change in Election must be received by the Company prior to the last day for making the Election determined in accordance with paragraph (b) above or as permitted by Section 15.3.

15.3 **Subsequent Elections.** Except as otherwise permitted or required by Section 409A, any Award providing Section 409A Deferred Compensation which permits a subsequent Election to delay the payment or change the form of payment in settlement of such Award shall comply with the following requirements:

(a) No subsequent Election may take effect until at least twelve (12) months after the date on which the subsequent Election is made.

(b) Each subsequent Election related to a payment in settlement of an Award not described in Section 15.4(a)(ii), 15.4(a)(iii) or 15.4(a)(vi) must result in a delay of the payment for a period of not less than five (5) years from the date on which such payment would otherwise have been made.

(c) No subsequent Election related to a payment pursuant to Section 15.4(a)(iv) shall be made less than twelve (12) months before the date on which such payment would otherwise have been made.

(d) Subsequent Elections shall continue in effect until a written revocation or change in the subsequent Election is received by the Company, except that a written revocation or change in a subsequent Election must be received by the Company prior to the last day for making the subsequent Election determined in accordance the preceding paragraphs of this Section 15.3.

15.4 **Payment of Section 409A Deferred Compensation.**

(a) ***Permissible Payments.*** Except as otherwise permitted or required by Section 409A, an Award providing Section 409A Deferred Compensation must provide for payment in settlement of the Award only upon one or more of the following:

(i) The Participant's "separation from service" (as such term is defined by Section 409A);

(ii) The Participant's becoming "disabled" (as such term is defined by Section 409A);

(iii) The Participant's death;

(iv) A time or fixed schedule that is either (i) specified by the Committee upon the grant of an Award and set forth in the Award Agreement evidencing such Award or (ii) specified by the Participant in an Election complying with the requirements of Section 15.2 or 15.3, as applicable;

(v) A change in the ownership or effective control or the Company or in the ownership of a substantial portion of the assets of the Company determined in accordance with Section 409A; or

(vi) The occurrence of an "unforeseeable emergency" (as such term is defined by Section 409A).

(b) ***Installment Payments.*** It is the intent of this Plan that any right of a Participant to receive installment payments (within the meaning of Section 409A) shall, for all purposes of Section 409A, be treated as a right to a series of separate payments.

(c) ***Required Delay in Payment to Specified Employee Pursuant to Separation from Service.*** Notwithstanding any provision of the Plan or an Award Agreement to the contrary, except as otherwise permitted by Section 409A, no payment pursuant to Section 15.4(a)(i) in settlement of an Award providing for Section 409A Deferred Compensation may be made to a Participant who is a "specified employee" (as such term is defined by Section 409A) as of the date of the Participant's separation from service before the date (the "***Delayed Payment Date***") that is six (6) months after the date of such Participant's separation from service, or, if earlier, the date of the Participant's death. All such amounts that would, but for this paragraph, become payable prior to the Delayed Payment Date shall be accumulated and paid on the Delayed Payment Date.

(d) ***Payment Upon Disability.*** All distributions payable by reason of a Participant becoming disabled shall be paid in a lump sum or in periodic installments as established by the Participant's Election. If the Participant has made no Election with respect to distributions upon becoming disabled, all such distributions shall be paid in a lump sum upon the determination that the Participant has become disabled.

(e) ***Payment Upon Death.*** If a Participant dies before complete distribution of amounts payable upon settlement of an Award subject to Section 409A, such undistributed amounts shall be distributed to his or her beneficiary under the distribution method for death established by the Participant's Election upon receipt by the Committee of satisfactory notice and confirmation of the Participant's death. If the Participant has made no Election with respect to distributions upon death, all such distributions shall be paid in a lump sum upon receipt by the Committee of satisfactory notice and confirmation of the Participant's death.

(f) ***Payment Upon Change in Control.*** Notwithstanding any provision of the Plan or an Award Agreement to the contrary, to the extent that any amount constituting Section 409A Deferred Compensation would become payable under this Plan by reason of a Change in Control, such amount shall become payable only if the event constituting a Change in Control would also constitute a change in ownership or effective control of the Company or a change in the ownership of a substantial portion of the assets of the Company within the meaning of Section 409A. Any

Award which constitutes Section 409A Deferred Compensation and which would vest and otherwise become payable upon a Change in Control as a result of the failure of the Acquiror to assume, continue or substitute for such Award in accordance with Section 13.1(b) shall vest to the extent provided by such Award but shall be converted automatically at the effective time of such Change in Control into a right to receive, in cash on the date or dates such award would have been settled in accordance with its then existing settlement schedule (or as required by Section 15.4(c)), an amount or amounts equal in the aggregate to the intrinsic value of the Award at the time of the Change in Control.

(g) ***Payment Upon Unforeseeable Emergency.*** The Committee shall have the authority to provide in the Award Agreement evidencing any Award providing for Section 409A Deferred Compensation for payment in settlement of all or a portion of such Award in the event that a Participant establishes, to the satisfaction of the Committee, the occurrence of an unforeseeable emergency. In such event, the amount(s) distributed with respect to such unforeseeable emergency cannot exceed the amounts reasonably necessary to satisfy the emergency need plus amounts necessary to pay taxes reasonably anticipated as a result of such distribution(s), after taking into account the extent to which such emergency need is or may be relieved through reimbursement or compensation by insurance or otherwise, by liquidation of the Participant's assets (to the extent the liquidation of such assets would not itself cause severe financial hardship) or by cessation of deferrals under the Award. All distributions with respect to an unforeseeable emergency shall be made in a lump sum upon the Committee's determination that an unforeseeable emergency has occurred. The Committee's decision with respect to whether an unforeseeable emergency has occurred and the manner in which, if at all, the payment in settlement of an Award shall be altered or modified, shall be final, conclusive, and not subject to approval or appeal.

(h) ***Prohibition of Acceleration of Payments.*** Notwithstanding any provision of the Plan or an Award Agreement to the contrary, this Plan does not permit the acceleration of the time or schedule of any payment under an Award providing Section 409A Deferred Compensation, except as permitted by Section 409A.

(i) ***No Representation Regarding Section 409A Compliance.*** Notwithstanding any other provision of the Plan, the Company makes no representation that Awards shall be exempt from or comply with Section 409A. No Participating Company shall be liable for any tax, penalty or interest imposed on a Participant by Section 409A.

16. **TAX WITHHOLDING.**

16.1 **Tax Withholding in General.** The Company shall have the right to deduct from any and all payments made under the Plan, or to require the Participant, through payroll withholding, cash payment or otherwise, to make adequate provision for, the federal, state, local and foreign taxes (including social insurance), if any, required by law to be withheld by any Participating Company with respect to an Award or the shares acquired pursuant thereto. The Company shall have no obligation to deliver shares of Stock, to release shares of Stock from an escrow established pursuant to an Award Agreement, or to make any payment in cash under the Plan until the Participating Company Group's tax withholding obligations have been satisfied by the Participant.

16.2 **Withholding in or Directed Sale of Shares.** The Company shall have the right, but not the obligation, to deduct from the shares of Stock issuable to a Participant upon the exercise or settlement of an Award, or to accept from the Participant the tender of, a number of whole shares of Stock having a Fair Market Value, as determined by the Company, equal to all or any part of the tax withholding obligations of any Participating Company. The Fair Market Value of any shares of Stock withheld or tendered to satisfy any such tax withholding obligations shall not exceed the amount determined by the applicable minimum statutory withholding rates. The Company may require a Participant to direct a broker, upon the vesting, exercise or settlement of an Award, to sell a portion of the shares subject to the Award determined by the Company in its discretion to be sufficient to cover the tax withholding obligations of any Participating Company and to remit an amount equal to such tax withholding obligations to the Company in cash.

17. AMENDMENT, SUSPENSION OR TERMINATION OF PLAN.

The Committee may amend, suspend or terminate the Plan at any time. However, without the approval of the Company's stockholders, there shall be (a) no increase in the maximum aggregate number of shares of Stock that may be issued under the Plan (except by operation of the provisions of Section 4.2), (b) no change in the class of persons eligible to receive Incentive Stock Options, and (c) no other amendment of the Plan that would require approval of the Company's stockholders under any applicable law, regulation or rule, including the rules of any stock exchange or quotation system upon which the Stock may then be listed or quoted. No amendment, suspension or termination of the Plan shall affect any then outstanding Award unless expressly provided by the Committee. Except as provided by the next sentence, no amendment, suspension or termination of the Plan may adversely affect any then outstanding Award without the consent of the Participant. Notwithstanding any other provision of the Plan to the contrary, the Committee may, in its sole and absolute discretion and without the consent of any Participant, amend the Plan or any Award Agreement, to take effect retroactively or otherwise, as it deems necessary or advisable for the purpose of conforming the Plan or such Award Agreement to any present or future law, regulation or rule applicable to the Plan, including, but not limited to, Section 409A.

18. MISCELLANEOUS PROVISIONS.

18.1 **Repurchase Rights.** Shares issued under the Plan may be subject to one or more repurchase options, or other conditions and restrictions as determined by the Committee in its discretion at the time the Award is granted. The Company shall have the right to assign at any time any repurchase right it may have, whether or not such right is then exercisable, to one or more persons as may be selected by the Company. Upon request by the Company, each Participant shall execute any agreement evidencing such transfer restrictions prior to the receipt of shares of Stock hereunder and shall promptly present to the Company any and all certificates representing shares of Stock acquired hereunder for the placement on such certificates of appropriate legends evidencing any such transfer restrictions.

18.2 **Forfeiture Events.**

(a) The Committee may specify in an Award Agreement that the Participant's rights, payments, and benefits with respect to an Award shall be subject to reduction, cancellation, forfeiture, or recoupment upon the occurrence of specified events, in addition to any otherwise

applicable vesting or performance conditions of an Award. Such events may include, but shall not be limited to, termination of Service for Cause or any act by a Participant, whether before or after termination of Service, that would constitute Cause for termination of Service.

(b) If the Company is required to prepare an accounting restatement due to the material noncompliance of the Company, as a result of misconduct, with any financial reporting requirement under the securities laws, any Participant who knowingly or through gross negligence engaged in the misconduct, or who knowingly or through gross negligence failed to prevent the misconduct, and any Participant who is one of the individuals subject to automatic forfeiture under Section 304 of the Sarbanes-Oxley Act of 2002, shall reimburse the Company for (i) the amount of any payment in settlement of an Award received by such Participant during the twelve-(12-) month period following the first public issuance or filing with the United States Securities and Exchange Commission (whichever first occurred) of the financial document embodying such financial reporting requirement, and (ii) any profits realized by such Participant from the sale of securities of the Company during such twelve-(12-) month period.

18.3 **Provision of Information.** Each Participant shall be given access to information concerning the Company equivalent to that information generally made available to the Company's common stockholders.

18.4 **Rights as Employee, Consultant or Director.** No person, even though eligible pursuant to Section 5, shall have a right to be selected as a Participant, or, having been so selected, to be selected again as a Participant. Nothing in the Plan or any Award granted under the Plan shall confer on any Participant a right to remain an Employee, Consultant or Director or interfere with or limit in any way any right of a Participating Company to terminate the Participant's Service at any time. To the extent that an Employee of a Participating Company other than the Company receives an Award under the Plan, that Award shall in no event be understood or interpreted to mean that the Company is the Employee's employer or that the Employee has an employment relationship with the Company.

18.5 **Rights as a Stockholder.** A Participant shall have no rights as a stockholder with respect to any shares covered by an Award until the date of the issuance of such shares (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date such shares are issued, except as provided in Section 4.2 or another provision of the Plan.

18.6 **Delivery of Title to Shares.** Subject to any governing rules or regulations, the Company shall issue or cause to be issued the shares of Stock acquired pursuant to an Award and shall deliver such shares to or for the benefit of the Participant by means of one or more of the following: (a) by delivering to the Participant evidence of book entry shares of Stock credited to the account of the Participant, (b) by depositing such shares of Stock for the benefit of the Participant with any broker with which the Participant has an account relationship, or (c) by delivering such shares of Stock to the Participant in certificate form.

18.7 **Fractional Shares.** The Company shall not be required to issue fractional shares upon the exercise or settlement of any Award.

18.8 **Retirement and Welfare Plans**. Neither Awards made under this Plan nor shares of Stock or cash paid pursuant to such Awards may be included as "compensation" for purposes of computing the benefits payable to any Participant under any Participating Company's retirement plans (both qualified and non-qualified) or welfare benefit plans unless such other plan expressly provides that such compensation shall be taken into account in computing a Participant's benefit.

18.9 **Beneficiary Designation.** Subject to local laws and procedures, each Participant may file with the Company a written designation of a beneficiary who is to receive any benefit under the Plan to which the Participant is entitled in the event of such Participant's death before he or she receives any or all of such benefit. Each designation will revoke all prior designations by the same Participant, shall be in a form prescribed by the Company, and will be effective only when filed by the Participant in writing with the Company during the Participant's lifetime. If a married Participant designates a beneficiary other than the Participant's spouse, the effectiveness of such designation may be subject to the consent of the Participant's spouse. If a Participant dies without an effective designation of a beneficiary who is living at the time of the Participant's death, the Company will pay any remaining unpaid benefits to the Participant's legal representative.

18.10 **Severability**. If any one or more of the provisions (or any part thereof) of this Plan shall be held invalid, illegal or unenforceable in any respect, such provision shall be modified so as to make it valid, legal and enforceable, and the validity, legality and enforceability of the remaining provisions (or any part thereof) of the Plan shall not in any way be affected or impaired thereby.

18.11 **No Constraint on Corporate Action.** Nothing in this Plan shall be construed to: (a) limit, impair, or otherwise affect the Company's or another Participating Company's right or power to make adjustments, reclassifications, reorganizations, or changes of its capital or business structure, or to merge or consolidate, or dissolve, liquidate, sell, or transfer all or any part of its business or assets; or (b) limit the right or power of the Company or another Participating Company to take any action which such entity deems to be necessary or appropriate.

18.12 **Unfunded Obligation.** Participants shall have the status of general unsecured creditors of the Company. Any amounts payable to Participants pursuant to the Plan shall be considered unfunded and unsecured obligations for all purposes, including, without limitation, Title I of the Employee Retirement Income Security Act of 1974. No Participating Company shall be required to segregate any monies from its general funds, or to create any trusts, or establish any special accounts with respect to such obligations. The Company shall retain at all times beneficial ownership of any investments, including trust investments, which the Company may make to fulfill its payment obligations hereunder. Any investments or the creation or maintenance of any trust or any Participant account shall not create or constitute a trust or fiduciary relationship between the Committee or any Participating Company and a Participant, or otherwise create any vested or beneficial interest in any Participant or the Participant's creditors in any assets of any Participating Company. The Participants shall have no claim against any Participating Company for any changes in the value of any assets which may be invested or reinvested by the Company with respect to the Plan.

18.13 **Choice of Law.** Except to the extent governed by applicable federal law, the validity, interpretation, construction and performance of the Plan and each Award Agreement shall be governed by the laws of the State of California, without regard to its conflict of law rules

IN WITNESS WHEREOF, the undersigned Secretary of the Company certifies that the foregoing sets forth the Molina Healthcare, Inc. 2011 Equity Incentive Plan as duly adopted by the Board.

/s/ Jeff D. Barlow
Corporate Secretary

EXHIBIT 10.9

MOLINA HEALTHCARE, INC.

2011 EMPLOYEE STOCK PURCHASE PLAN

1. Establishment of Plan. Molina Healthcare, Inc., a Delaware corporation (the "Company"), proposes to grant options to purchase shares of the Company's common stock, $0.001 par value per share (the "Common Stock"), to eligible employees of the Company and its Participating Affiliates (as defined below) pursuant to this 2011 Employee Stock Purchase Plan (this "Plan"). For purposes of this Plan, "Parent Corporation" and "Subsidiary Corporation" shall have the same meanings as "parent corporation" and "subsidiary corporation" in Sections 424(e) and 424(f), respectively, of the Internal Revenue Code of 1986, as amended (the "Code"). "Participating Affiliates" are Parent Corporations or Subsidiary Corporations that the Board of Directors of the Company (the "Board") designates from time to time as corporations that shall participate in this Plan. Affiliates may be designated as Participating Affiliates either before or after this Plan is approved by the Company's stockholders as provided in Section 22. The Company intends this Plan to qualify as an "employee stock purchase plan" under Section 423 of the Code (including any amendments to or replacements of such Section), and this Plan shall be so construed. Any term not expressly defined in this Plan but defined for purposes of Section 423 of the Code shall have the same definition herein. A total of three million five hundred thousand (3,500,000) shares of the Common Stock are reserved for issuance under this Plan.

2. Purpose. The purpose of this Plan is to provide eligible employees of the Company and Participating Affiliates with a convenient means of acquiring an equity interest in the Company through payroll deductions, to enhance such employees' sense of participation in the affairs of the Company and Participating Affiliates, and to provide an incentive for continued employment.

3. Administration

(a) This Plan shall be administered by the Compensation Committee of the Board (the "Committee"). Subject to the provisions of this Plan and the limitations of Section 423 of the Code or any successor provision in the Code, all questions of interpretation or application of this Plan shall be determined by the Committee in its sole discretion and its decisions shall be final and binding upon all participants. Members of the Committee shall receive no compensation for their services in connection with the administration of this Plan, other than standard fees as established from time to time by the Board for services rendered by Board members serving on Board committees. All expenses incurred in connection with the administration of this Plan shall be paid by the Company.

(b) The Committee may, from time to time, consistent with this Plan and the requirements of Section 423 of the Code, establish, change or terminate such rules, guidelines,

policies, procedures, limitations, or adjustments as deemed advisable by the Company, in its sole discretion, for the proper administration of this Plan, including, without limitation: (a) a minimum payroll deduction amount required for participation in an Offering Period, (b) a limitation on the frequency or number of changes permitted in the rate of payroll deduction during an Offering Period, (c) a payroll deduction greater or less than the amount designated by a participant in order to adjust for the Company's delay or mistake in processing an Enrollment Form or in otherwise effecting a participant's election under this Plan or as advisable to comply with the requirements of Section 423 of the Code, (d) determination of the date and manner by which the Fair Market Value of the Common Stock is determined for purposes of administration of this Plan, (e) delegate responsibility for Plan operation, management and administration, subject to the Committee's oversight and control, on such terms as the Committee may establish, and (f) delegate to other persons the responsibility for performing appropriate functions as necessary, desirable or appropriate to further the purposes of this Plan.

4. Eligibility. Any individual employed by the Company or the Participating Affiliates on the "Offering Date" of an "Offering Period" (each as defined in Section 5 below) is eligible to participate in such Offering Period except the following:

(a) employees who are customarily employed for less than (20) hours per week; and

(b) employees who, together with any other person whose stock would be attributed to such employee pursuant to Section 424(d) of the Code, own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined voting power or value of all classes of stock of the Company or any of its Participating Affiliates or who, as a result of being granted an option under this Plan with respect to such Offering Period, would own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined power or value of all classes of stock of the Company or any of its Participating Affiliates; and

(c) individuals who provide services to the Company or any of its Participating Affiliates as independent contractors who are reclassified as common law employees for any reason except for federal income and employment tax purposes.

5. Offering Periods. The offering periods of this Plan (each, an "Offering Period") shall be of six (6) months duration commencing on January 1 and July 1 of the Company's fiscal year. The first day of each Offering Period is referred to as the "Offering Date." The last day of each Offering Period is referred to as the "Purchase Date." The Committee shall have the power to change the Offering Dates or Purchase Dates and the duration of Offering Periods without stockholder approval if such change is announced prior to the start of the relevant Offering Period, or prior to such other time period as specified by the Committee; provided, however, that no Offering Period may have a duration exceeding twenty-seven (27) months. If the first or last day of an Offering Period is not a day on which the New York Stock Exchange is open for trading, the Company shall specify the trading day that will be deemed the first or last day, as the case may be, of the Offering Period.

6. Participation in this Plan. An employee may participate during an Offering Period on the first Offering Date after such employee satisfies the eligibility requirements set forth in Section 4 above and delivers an appropriate enrollment form (the "Enrollment Form") to the Company prior to such Offering Date, or such other time period as specified by the Committee. Notwithstanding the foregoing, the Committee may set a later time for filing the Enrollment Form authorizing payroll deductions for all eligible employees with respect to a given Offering Period. An eligible employee who does not timely deliver an Enrollment Form to the Company after becoming eligible to participate in such Offering Period shall not participate in that Offering Period or any subsequent Offering Period until filing an Enrollment Form with the Company prior to the applicable Offering Date, or such other time period as specified by the Committee. Once an employee becomes a participant in an Offering Period, such employee will automatically participate in the Offering Period commencing immediately following the last day of the prior Offering Period unless the employee withdraws or is deemed to withdraw from this Plan or terminates further participation in the Offering Period as set forth in Section 11 below. A participant who has not otherwise withdrawn from this Plan under Section 11 is not required to file any additional Enrollment Form in order to continue participation in this Plan. However a participant may deliver a new Enrollment Form for a subsequent Offering Period in accordance with applicable rules and procedures if the participant wishes to change any of the elections contained in the participant's then effective Enrollment Form.

7. Grant of Option on Enrollment. Enrollment by an eligible employee in an Offering Period under this Plan will constitute the grant (as of the Offering Date for such Offering Period) by the Company to such employee of an option to purchase on the Purchase Date up to that number of shares of Common Stock of the Company determined by dividing (a) the amount accumulated in such employee's payroll deduction account during such Offering Period by (b) the Per Share Purchase Price as determined pursuant to Section 8 below (but in no event less than the par value of a share of Company's Common Stock), provided, however, that the number of shares of the Company's Common Stock subject to any option granted pursuant to this Plan shall not exceed the maximum number of shares which may be purchased pursuant to Section 10 below with respect to the applicable Purchase Date. The Fair Market Value of a share of the Company's Common Stock shall be determined as provided in Section 8 below.

8. Purchase Price. The purchase price per share ("Per Share Purchase Price") at which a share of Common Stock will be sold in any Offering Period shall be eighty-five percent (85%) of the lesser of:

(a) The Fair Market Value on the Offering Date; or

(b) The Fair Market Value on the Purchase Date.

For purposes of this Plan, the term "Fair Market Value" of the Common Stock on any given date means (i) the last reported closing price for a share of Stock on the New York Stock Exchange or, (ii) in the absence of reported sales on the New York Stock Exchange on a given date, the closing price of the New York Stock Exchange on the last date on which

a sale occurred prior to such date; or (iii) if the stock is no longer publicly traded on the New York Stock Exchange, the Committee in good faith shall determine Fair Market Value; provided that, if the date for which the Fair Market Value is determined is the first day when trading prices for the Stock are reported on the New York Stock Exchange, the Fair Market Value shall be the public offering price set forth on the cover page for the final prospectus relating to the Company's Initial Public Offering.

9. Payment of Purchase Price; Changes in Payroll Deductions; Issuance of Shares .

(a) The purchase price of the shares shall be accumulated by regular payroll deductions made during each Offering Period. The deductions are made as a percentage of the participant's Compensation in one percent (1%) increments not less than one percent (1%) (except as a result of an election pursuant to Section 9(c) to stop payroll deductions during an Offering Period), nor greater than fifteen percent (15%) or such lower limit set by the Committee. "Compensation" shall mean all W-2 cash compensation, including base salary, wages, commissions, overtime, shift premiums and bonuses, provided, however, that for purposes of determining a participant's compensation, any election by such participant to reduce his or her regular cash remuneration under Sections 125 or 401(k) of the Code shall be treated as if the participant did not make such election. Notwithstanding the foregoing, Compensation shall not include reimbursements of expenses, allowances, long-term disability, workers' compensation or any amount deemed received without the actual transfer of cash or any amounts directly or indirectly paid pursuant to this Plan or any other stock purchase or stock option plan, or any other compensation not included above. Payroll deductions shall commence on the first payday of the Offering Period and shall continue to the end of the Offering Period unless sooner altered or terminated as provided in this Plan.

(b) A participant may increase or decrease the rate of payroll deductions during an Offering Period by providing to the Company a new Enrollment Form, in which case the new rate shall become effective for the next payroll period commencing after the Company's receipt of the Enrollment Form and shall continue for the remainder of the Offering Period unless changed as described below. Such change in the rate of payroll deductions may be made at any time during an Offering Period, but not more than one (1) increase and one (1) decrease in the rate of payroll deductions may be made during any Offering Period. A participant may increase or decrease the rate of payroll deductions for any subsequent Offering Period by filing with the Company a new Enrollment Form prior to the beginning of such Offering Period, or prior to such other time period as specified by the Committee. Any changes to the rate of payroll deductions during an Offering Period which are received by the Company after the commencement of the enrollment period for a new Offering Period will be made by the Company at its discretion, only to the extent such changes are administratively possible.

(c) A participant may reduce his or her payroll deduction percentage to zero during an Offering Period by providing to the Company a revised Enrollment Form. Such reduction shall be effective beginning with the next payroll period after the Company's receipt of the request and no further payroll deductions will be made for the duration of the Offering Period. Payroll deductions credited to the participant's account prior to the effective date of

the request shall be used to purchase shares of Common Stock in accordance with Section (e) below. Notwithstanding Section 9(b), a participant may not resume making payroll deductions during the Offering Period in which he or she reduced his or her payroll deductions to zero. Any reduction to a participant's payroll deduction percentage to zero during an Offering Period which is received by the Company after the commencement of the enrollment period for a new Offering Period will be made by the Company at its discretion, only to the extent such changes are administratively possible.

(d) All payroll deductions made for a participant are credited to his or her account under this Plan and are deposited with the general funds of the Company. No interest accrues on the payroll deductions. All payroll deductions received or held by the Company may be used by the Company for any corporate purpose, and the Company shall not be obligated to segregate such payroll deductions.

(e) On each Purchase Date, so long as this Plan remains in effect and provided that the participant has not submitted a revised Enrollment Form withdrawing from this Plan before such Purchase Date in accordance with Section 11, the Company shall apply the funds then in the participant's account (or, if applicable, the lump sum cash payment received from the participant) to the purchase of whole shares of Common Stock reserved under the option granted to such participant with respect to the Offering Period to the extent that such option is exercisable on the Purchase Date. The Per Share Purchase Price shall be as specified in Section 8. Any cash remaining in such participant's account on a Purchase Date which is less than the amount necessary to purchase a full share of Common Stock of the Company shall be carried forward, without interest, into the next Offering Period. If this Plan has been oversubscribed, all funds not used to purchase shares on the Purchase Date shall be returned to the participant, without interest. No Common Stock shall be purchased on a Purchase Date on behalf of any employee whose participation in this Plan has terminated prior to such Purchase Date.

(f) As promptly as practicable after the Purchase Date, the Company shall issue shares for the participant's benefit representing the shares purchased upon exercise of his or her option, subject to compliance with Section 24 below.

(g) During a participant's lifetime, his or her option to purchase shares hereunder is exercisable only by him or her. The participant will have no interest or voting right in shares covered by his or her option until such option has been exercised.

1. Limitations on Shares to be Purchased.

(a) No participant shall be entitled to purchase Common Stock under this Plan at a rate which, when aggregated with his or her rights to purchase stock under all other employee stock purchase plans of the Company or any Parent Corporation or Subsidiary Corporation, exceeds $25,000 in Fair Market Value, determined as of the Offering Date (or such other limit as may be imposed by the Code) for each calendar year in which the employee participates in this Plan. The Company shall automatically suspend the payroll deductions of any participant as necessary to enforce such limit; provided that when the Company

automatically resumes such payroll deductions, the Company must apply the rate in effect immediately prior to such suspension.

(b) No participant shall be entitled to purchase more than the Maximum Share Amount (as defined below) on any single Purchase Date. Prior to the commencement of any Offering Period or before such time period as specified by the Committee, the Committee may, in its sole discretion, set a maximum number of shares which may be purchased by any employee at any single Purchase Date (the "Maximum Share Amount"). Until otherwise determined by the Committee, there shall be no Maximum Share Amount. If a new Maximum Share Amount is set, then all participants must be notified of such Maximum Share Amount before commencing the next Offering Period. The Maximum Share Amount shall continue to apply with respect to all succeeding Purchase Dates and Offering Periods unless revised by the Committee as set forth above.

(c) If the number of shares to be purchased on a Purchase Date by all employees participating in this Plan exceeds the number of shares then available for issuance under this Plan, then the Company will make a pro rata allocation of the remaining shares in as uniform a manner as shall be reasonably practicable and as the Committee shall determine to be equitable.

(d) Any payroll deductions accumulated in a participant's account which are not used to purchase stock due to the limitations in this Section 10 shall be returned to the participant as soon as practicable after the end of the applicable Offering Period, without interest, provided that, any amount remaining in such participant's account which is less than the amount necessary to purchase a full share of Common Stock of the Company shall be carried forward, without interest, into the next Offering Period or Offering Period.

2. Withdrawal.

(a) Each participant may withdraw from an Offering Period under this Plan by signing and delivering to the Company a revised Enrollment Form indicating such participant's intention to withdraw. Such withdrawal may be elected at any time prior to the end of an Offering Period, or such other time period as specified by the Committee.

(b) Upon withdrawal from this Plan, the accumulated payroll deductions shall be returned to the withdrawn participant, without interest, and his or her interest in this Plan shall terminate. If a participant voluntarily elects to withdraw from this Plan, he or she may not resume his or her participation in this Plan during the same Offering Period, but he or she may participate in any Offering Period under this Plan commencing after such withdrawal by filing a new authorization for payroll deductions in the same manner as set forth in Section 6 above for initial participation in this Plan.

3. Termination of Employment. Termination of a participant's employment for any reason, including retirement, death or the failure of a participant to remain an eligible employee of the Company or of a Participating Affiliate, immediately terminates his or her participation in this Plan. In such event, the payroll deductions credited to the participant's account will

be returned to him or her or, in the case of his or her death, to his or her legal representative, without interest. For purposes of this Section 12, an employee will not be deemed to have terminated employment or failed to remain in the continuous employ of the Company or of a Participating Affiliate in the case of sick leave, military leave, or any other leave of absence approved by the Board; provided that such leave is for a period of not more than ninety (90) days or reemployment upon the expiration of such leave is guaranteed by contract or statute.

4. Return of Payroll Deductions. If a participant's interest in this Plan is terminated by withdrawal, termination of employment or otherwise, or if this Plan is terminated by the Board, the Company shall deliver to the participant all payroll deductions credited to such participant's account. No interest shall accrue on the payroll deductions of a participant in this Plan.

5. Capital Changes. Subject to any required action by the stockholders of the Company, the number of shares of Common Stock covered by each option under this Plan which has not yet been exercised and the number of shares of Common Stock which have been authorized for issuance under this Plan but have not yet been placed under option (collectively, the " Reserves"), as well as the price per share of Common Stock covered by each option under this Plan which has not yet been exercised, shall be proportionately adjusted for any increase or decrease in the number of issued and outstanding shares of Common Stock resulting from a stock split or the payment of a stock dividend (but only on the Common Stock) or any other increase or decrease in the number of issued and outstanding shares of Common Stock effected without receipt of any consideration by the Company; provided, however, that conversion of any convertible securities of the Company shall not be deemed to have been "effected without receipt of consideration". Notwithstanding the foregoing, any fractional shares resulting from an adjustment pursuant to this Section 14 shall be rounded down to the nearest whole number, and in no event may the Per Share Purchase Price be decreased to an amount less than the par value, if any, of the Common Stock. Such adjustment shall be made by the Committee, whose determination shall be final, binding and conclusive.

In the event of the proposed dissolution or liquidation of the Company, the Offering Period will terminate immediately prior to the consummation of such proposed action, unless otherwise provided by the Committee. The Committee may, in its sole discretion in such instances, declare that this Plan shall terminate as of a date fixed by the Committee and either give each participant the right to purchase shares under this Plan prior to such termination or return all accumulated payroll deductions to each participant, without interest. In the event of (i) a merger or consolidation in which the Company is not the surviving corporation (other than a merger or consolidation with a wholly-owned subsidiary, a reincorporation of the Company in a different jurisdiction, or other transaction in which there is no substantial change in the stockholders of the Company or their relative stock holdings, provided that the options under this Plan are assumed, converted or replaced by the successor corporation, which assumption will be binding on all participants), (ii) a merger in which the Company is the surviving corporation but after which the stockholders of the Company immediately prior to such merger (other than any stockholder that merges, or which owns or controls another corporation that merges, with the Company in such merger) cease to own

their shares or other equity interest in the Company, (iii) the sale of all or substantially all of the assets of the Company or (iv) the acquisition, sale, or transfer of more than 50% of the outstanding shares of the Company by tender offer or similar transaction, (each a "Sale Event") the Company shall apply the funds contributed under this Plan to the purchase of shares of Common Stock pursuant to the provisions of Section 9 immediately prior to the effective date of such Sale Event. Notwithstanding the foregoing, the surviving, continuing, successor or purchasing corporation or parent corporation thereof (the " Acquiring Corporation"), may elect to assume the Company's rights and obligations under this Plan and, in that event, there shall be no purchase before the end of the Offering Period in which the Sale Event occurs.

The Committee may, if it so determines in its sole discretion, also make provision for adjusting the share reserve set forth in Section 1, as well as the price per share of Common Stock covered by each outstanding option, solely in the event that the Company effects one or more reorganizations, recapitalizations, rights offerings or other increases or reductions of shares of its outstanding Common Stock, or in the event of the Company being consolidated with or merged into any other corporation.

6. Withholding. The participant shall make adequate provision for the foreign, federal, state and local tax withholding obligations of the Company or any of its Participating Affiliates, if any, which arise in connection with participation in this Plan. The Company and its Participating Affiliates shall, to the extent permitted by law, have the right to deduct any such taxes from any payment of any kind otherwise due to the participant.

7. Nonassignability. Neither payroll deductions credited to a participant's account nor any rights with regard to the exercise of an option or to receive shares under this Plan may be assigned, transferred, pledged or otherwise disposed of in any way (other than by will, the laws of descent and distribution or as provided in Section 23 below) by the participant. Any such attempt at assignment, transfer, pledge or other disposition shall be void and without effect.

8. Reports. Individual accounts will be maintained for each participant in this Plan. Each participant shall receive as soon as practicable after the end of each Offering Period a report of his or her account setting forth the total payroll deductions accumulated, the number of shares purchased, the per share price thereof and the remaining cash balance, if any, carried forward to the next Offering Period.

9. Notice of Disqualifying Disposition. Each participant shall notify the Company in writing if the participant disposes of any of the shares purchased in any Offering Period pursuant to this Plan if such disposition occurs within two (2) years from the Offering Date or within one (1) year from the Purchase Date on which such shares were purchased (the " Notice Period"). The Company may, at any time during the Notice Period, place a legend or legends on any certificate representing shares acquired pursuant to this Plan requesting the Company's transfer agent to notify the Company of any transfer of the shares. The obligation of the participant to provide such notice shall continue notwithstanding the placement of any such legend on the certificates.

10. No Rights as Stockholder or to Continued Employment. A participant shall have no rights as a stockholder by virtue of participation in this Plan until the date of the issuance of a certificate for the shares purchased pursuant to the exercise of the participant's purchase right (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date such certificate is issued, except as provided in Section 14. Neither this Plan nor the grant of any option hereunder shall confer any right on any employee to remain in the employ of the Company or any Participating Affiliate, or restrict the right of the Company or any Participating Affiliate to terminate such employee's employment at any time.

11. Equal Rights and Privileges. All eligible employees shall have equal rights and privileges with respect to this Plan so that this Plan qualifies as an "employee stock purchase plan" within the meaning of Section 423 or any successor provision of the Code and the related regulations. Any provision of this Plan which is inconsistent with Section 423 or any successor provision of the Code shall, without further act or amendment by the Company, the Committee or the Board, be reformed to comply with the requirements of Section 423. This Section 20 shall take precedence over all other provisions in this Plan.

12. Notices. All notices or other communications by a participant to the Company under or in connection with this Plan shall be deemed to have been duly given when received in the form specified by the Company at the location, or by the person, designated by the Company for the receipt thereof.

13. Term; Stockholder Approval. This Plan was adopted by the Board of Directors of the Company on March 18, 2011, effective as of July 1, 2011 (the "Effective Date"), and shall apply to any purchase right granted, or stock transferred pursuant to any purchase right granted, on or after the Effective Date. This Plan shall continue until the earlier to occur of (a) termination of this Plan by the Board (which termination may be effected by the Board at any time), (b) issuance of all of the shares of Common Stock reserved for issuance under this Plan, or (c) April 27, 2021.

14. Designation of Beneficiary

(a) A participant may file a written designation of a beneficiary who is to receive any shares and cash, if any, from the participant's account under this Plan in the event of such participant's death subsequent to the end of any Offering Period but prior to delivery to him of such shares and cash. In addition, a participant may file a written designation of a beneficiary who is to receive any cash from the participant's account under this Plan in the event of such participant's death prior to a Purchase Date.

(b) Such designation of beneficiary may be changed by the participant at any time by written notice. In the event of the death of a participant and in the absence of a beneficiary validly designated under this Plan who is living at the time of such participant's death, the Company shall deliver such shares or cash to the executor or administrator of the estate of the participant, or if no such executor or administrator has been appointed (to the

knowledge of the Company), the Company, in its discretion, may deliver such shares or cash to the spouse or to any one or more dependents or relatives of the participant, or if no spouse, dependent or relative is known to the Company, then to such other person as the Company may designate.

15. Conditions Upon Issuance of Shares; Limitation on Sale of Shares . Shares shall not be issued with respect to an option unless the exercise of such option and the issuance and delivery of such shares pursuant thereto shall comply with all applicable provisions of law, domestic or foreign, including, without limitation, the Securities Act of 1933, as amended, the Securities Exchange Act of 1934, as amended, the rules and regulations promulgated thereunder, and the requirements of any stock exchange or automated quotation system upon which the shares may then be listed, and shall be further subject to the approval of counsel for the Company with respect to such compliance.

16. Applicable Law. This Plan shall be governed by the substantive laws (excluding the conflict of laws rules) of the State of California.

17. Amendment or Termination of this Plan. The Board may at any time amend, terminate or extend the term of this Plan, except that (i) any such termination cannot affect options previously granted under this Plan unless the Board determines that the termination of this Plan immediately following any Purchase Date is in the best interests of the Company and its stockholders, (ii) any amendment may not adversely affect the previously granted purchase right of any participant unless permitted by this Plan or as may be necessary to qualify this Plan as an employee stock purchase plan pursuant to Section 423 of the Code or to obtain qualification or registration of the Common Stock under applicable federal, state or foreign securities laws, and (iii) any amendment must be approved by the stockholders of the Company in accordance with Section 2 above within twelve (12) months of the adoption of such amendment (or earlier if required by Section 22) if such amendment would:

(a) increase the number of shares that may be issued under this Plan;

(b) change the designation of the employees (or class of employees) eligible for participation in this Plan; or

(c) any other action taken by the Board that, by its terms, is contingent on stockholder approval.

Notwithstanding the foregoing, the Board may make such amendments to this Plan as the Board determines to be advisable, if the continuation of this Plan or any Offering Period would result in financial accounting treatment for this Plan that is different from the financial accounting treatment in effect on the Effective Date.

EXHIBIT 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2013	2012	2011	2010	2009
	(Dollars in Thousands)				
Earnings:					
Income before income taxes, continuing operations	$ 81,146	$ 23,379	$ 120,302	$ 81,128	$ 25,152
Add fixed charges:					
Interest expense, including amortization of debt discount and expense	52,071	16,769	15,519	15,509	13,777
Estimated interest portion of rental expense	3,922	2,865	2,542	4,522	5,181
Total fixed charges	55,993	19,634	18,061	20,031	18,958
Total earnings available for fixed charges	$ 137,139	$ 43,013	$ 138,363	$ 101,159	$ 44,110
Fixed charges from above:	$ 55,993	$ 19,634	$ 18,061	$ 20,031	$ 18,958
Ratio of Earnings to Fixed Charges	2.4	2.2	7.7	5.1	2.3
Total rent expense	$ 24,510	$ 20,462	$ 23,110	$ 25,124	$ 20,723
Interest factor	16%	14%	11%	18%	25%
Interest component of rental expense	$ 3,922	$ 2,865	$ 2,542	$ 4,522	$ 5,181

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
American Family Care, Inc.	California
American Family Care Hospital Management, Inc.	California
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of Arizona, Inc.*	Arizona
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.*	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Maryland, Inc.*	Maryland
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Mississippi, Inc.*	Mississippi
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of North Carolina, Inc.*	North Carolina
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of South Carolina, Inc.	South Carolina
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company^	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Pathways, LLC*	Delaware

* Non-operational entity

^ Wholly owned subsidiary of Molina Healthcare of Texas, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statements No. 333-108317, No. 333-138552, No. 333-153246, No. 333-170571, and No. 333-174912 on Form S-8 pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan; 2002 Equity Incentive Plan; 2002 Employee Stock Purchase Plan; 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and Registration Statement No. 333-181804 on Form S-3, of our reports dated February 26, 2014, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year end ed December 31, 2013.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2014

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2013, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Joseph M. Molina

Joseph M. Molina
Chief Executive Officer and President

February 26, 2014

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2013, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

February 26, 2014

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2013, as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chief Executive Officer and President

February 26, 2014

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2013, as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

February 26, 2014

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

MHI Form 10-Q for the Period Ended September 30, 2013

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2013
Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

Molina Healthcare, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock outstanding as of October 28, 2013, was approximately 45,760,400.

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MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	September 30, 2013	December 31, 2012
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 856,556	$ 795,770
Investments	735,151	342,845
Receivables	293,967	149,682
Deferred income taxes	30,480	32,443
Prepaid expenses and other current assets	50,061	28,386
Total current assets	1,966,215	1,349,126
Property, equipment, and capitalized software, net	267,277	221,443
Deferred contract costs	48,768	58,313
Intangible assets, net	104,635	77,711
Goodwill and indefinite-lived intangible assets	230,783	151,088
Derivative asset	191,663	—
Restricted investments	65,225	44,101
Auction rate securities	11,674	13,419
Deferred income taxes	3,090	—
Other assets	35,736	19,621
	$ 2,925,066	$ 1,934,822
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 632,706	$ 494,530
Accounts payable and accrued liabilities	282,727	184,034
Deferred revenue	124,388	141,798
Income taxes payable	5,508	6,520
Current maturities of long-term debt	109	1,155
Total current liabilities	1,045,438	828,037
Convertible senior notes	591,884	175,468
Lease financing obligations	178,188	—
Other long-term debt	—	86,316
Derivative liabilities	191,556	1,307
Deferred income taxes	—	37,900
Other long-term liabilities	25,152	23,480
Total liabilities	2,032,218	1,152,508
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 45,757 shares at September 30, 2013 and 46,762 shares at December 31, 2012	46	47
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	331,958	285,524
Accumulated other comprehensive loss	(1,411)	(457)
Treasury stock, at cost; 111 shares at December 31, 2012	—	(3,000)
Retained earnings	562,255	500,200
Total stockholders' equity	892,848	782,314
	$ 2,925,066	$ 1,934,822

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(Amounts in thousands, except net income (loss) per share) (Unaudited)			
Revenue:				
Premium revenue	$ 1,584,656	$ 1,448,600	$ 4,583,818	$ 4,066,737
Premium tax receipts	43,723	37,894	127,606	120,953
Service revenue	51,100	48,422	150,528	132,351
Investment income	1,740	1,155	4,884	3,893
Rental and other income	5,860	4,079	16,476	12,315
Total revenue	1,687,079	1,540,150	4,883,312	4,336,249
Expenses:				
Medical care costs	1,383,213	1,319,991	3,965,834	3,715,455
Cost of service revenue	40,113	37,004	119,188	98,111
General and administrative expenses	176,233	127,035	478,990	365,564
Premium tax expenses	43,723	37,894	127,606	120,953
Depreciation and amortization	18,871	15,858	52,449	46,916
Total expenses	1,662,153	1,537,782	4,744,067	4,346,999
Operating income (loss)	24,926	2,368	139,245	(10,750)
Other expenses:				
Interest expense	13,532	4,315	38,236	12,421
Other (income) expense	(24)	184	3,347	1,270
Total other expenses	13,508	4,499	41,583	13,691
Income (loss) from continuing operations before income tax expense	11,418	(2,131)	97,662	(24,441)
Income tax expense (benefit)	3,865	(1,966)	43,791	(11,113)
Income (loss) from continuing operations	7,553	(165)	53,871	(13,328)
Income (loss) from discontinued operations, net of tax expense (benefit) of $97, $1,474, $(10,046), and $(4,115), respectively	16	3,529	8,184	(2,525)
Net income (loss)	$ 7,569	$ 3,364	$ 62,055	$ (15,853)
Basic income (loss) per share:				
Income (loss) from continuing operations	$ 0.17	$ (0.01)	$ 1.18	$ (0.29)
Income (loss) from discontinued operations	—	0.08	0.18	(0.05)
Basic net income (loss) per share	$ 0.17	$ 0.07	$ 1.36	$ (0.34)
Diluted income (loss) per share:				
Income (loss) from continuing operations	$ 0.16	$ (0.01)	$ 1.15	$ (0.29)
Income (loss) from discontinued operations	—	0.08	0.18	(0.05)
Diluted net income (loss) per share	$ 0.16	$ 0.07	$ 1.33	$ (0.34)
Weighted average shares outstanding:				
Basic	45,699	46,546	45,708	46,301
Diluted	47,062	46,880	46,767	46,301

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(Amounts in thousands) (Unaudited)			
Net income (loss)	$ 7,569	$ 3,364	$ 62,055	$ (15,853)
Other comprehensive income (loss):				
Gross unrealized investment gain (loss)	2,087	733	(1,539)	1,734
Effect of income taxes	793	278	(585)	659
Other comprehensive income (loss), net of tax	1,294	455	(954)	1,075
Comprehensive income (loss)	$ 8,863	$ 3,819	$ 61,101	$ (14,778)

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2013	2012
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income (loss)	$ 62,055	$ (15,853)
Adjustments to reconcile net income (loss) to net cash change in operating activities:		
Depreciation and amortization	68,035	58,289
Deferred income taxes	(38,442)	523
Stock-based compensation	20,654	15,448
Gain on sale of subsidiary	—	(1,747)
Amortization of convertible senior notes and lease financing obligations	16,128	4,414
Change in fair value of derivatives	3,383	1,270
Amortization of premium/discount on investments	8,053	5,166
Amortization of deferred financing costs	3,042	825
Tax deficiency from employee stock compensation	(72)	(159)
Changes in operating assets and liabilities:		
Receivables	(144,285)	10,989
Prepaid expenses and other current assets	(27,552)	(10,574)
Medical claims and benefits payable	138,176	133,987
Accounts payable and accrued liabilities	20,991	(9,030)
Deferred revenue	(17,410)	92,354
Income taxes	(1,012)	(21,878)
Net cash provided by operating activities	111,744	264,024
Investing activities:		
Purchases of equipment	(64,426)	(52,548)
Purchases of investments	(627,953)	(234,465)
Sales and maturities of investments	227,800	213,665
Proceeds from sale of subsidiary, net of cash surrendered	—	9,162
Net cash paid in business combinations	(57,684)	—
Change in deferred contract costs	9,545	(18,799)
Increase in restricted investments	(21,124)	(3,034)
Change in other non-current assets and liabilities	(7,574)	(4,775)
Net cash used in investing activities	(541,416)	(90,794)
Financing activities:		
Proceeds from issuance of 1.125% Notes, net of deferred financing costs	537,973	—
Proceeds from sale-leaseback transactions	158,694	—
Purchase of 1.125% Notes call option	(149,331)	—
Proceeds from issuance of warrants	75,074	—
Treasury stock purchases	(50,000)	—
Repayment of amounts borrowed under credit facility	(40,000)	(20,000)
Amount borrowed under credit facility	—	60,000
Principal payments on term loan	(47,471)	(846)
Settlement of interest rate swap	(875)	—
Proceeds from employee stock plans	5,156	5,571
Excess tax benefits from employee stock compensation	1,238	3,698
Net cash provided by financing activities	490,458	48,423
Net increase in cash and cash equivalents	60,786	221,653
Cash and cash equivalents at beginning of period	795,770	493,827
Cash and cash equivalents at end of period	$ 856,556	$ 715,480

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Nine Months Ended September 30,	
	2013	2012
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 72,156	$ 1,074
Interest	$ 28,035	$ 5,663
Schedule of non-cash investing and financing activities:		
Retirement of treasury stock	$ 53,000	$ —
Common stock used for stock-based compensation	$ 6,667	$ 9,852
Non-cash financing obligation for construction projects	$ 19,222	$ —
Details of business combinations:		
Fair value of assets acquired	$ 121,845	$ —
Fair value of contingent consideration liabilities incurred	(59,947)	—
Payable to seller	(3,882)	—
Escrow deposit	(332)	$ —
Net cash paid in business combinations	$ 57,684	$ —
Details of change in fair value of derivatives:		
Gain on 1.125% Call Option	$ 42,332	$ —
Loss on embedded cash conversion option	(42,225)	—
Loss on 1.125% Warrants	(3,923)	—
Gain (loss) on interest rate swap	433	(1,270)
Change in fair value of derivatives	$ (3,383)	$ (1,270)
Details of sale of subsidiary:		
Decrease in carrying value of assets	$ —	$ 30,942
Decrease in carrying value of liabilities	—	(23,527)
Gain on sale	—	1,747
Proceeds from sale of subsidiary, net of cash surrendered	$ —	$ 9,162

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
September 30, 2013

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Illinois, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of September 30, 2013, these health plans served approximately 1.9 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico, and Washington.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

Market Updates - Health Plans Segment

California Health Plan Tentative Rate Settlement Agreement. In the third quarter of 2013, our California health plan reached a tentative settlement agreement with the California Department of Health Care Services (DHCS), conditioned on final government approvals. The tentative settlement agreement settles rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in California's Medicaid program, or Medi-Cal.

Under the terms of the tentative settlement agreement, DHCS has agreed to extend each of the California health plan's existing Medi-Cal managed care contracts for an additional five years, including its contracts in San Diego, San Bernardino, Riverside, and Sacramento counties. In addition, effective January 1, 2014, the settlement establishes a settlement account applicable to the California health plan's Medi-Cal, Seniors and Persons with Disabilities, and the dual eligibles pilot programs. The settlement account will be established with an initial balance of zero, and will be adjusted annually to reflect a calendar year deficit or surplus. A deficit or surplus will result to the extent the plan's pre-tax margin is below or above a specified percentage, subject to further adjustment as specified in the settlement agreement. Cash settlement will occur after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our Medi-Cal managed care contracts. Upon expiration of the settlement agreement, if the settlement account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. If the settlement account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is limited. See Note 18, "Subsequent Events," for further information.

We do not expect the tentative settlement agreement to impact our consolidated financial condition, cash flows, or results of operations for the year ending December 31, 2013.

Florida. On October 23, 2013, our Florida health plan and the Florida Agency for Health Care Administration (AHCA), agreed to a settlement under which our health plan will be awarded three contracts under the Florida Statewide Medicaid Managed Care Managed Medical Assistance Invitation to Negotiate. The three contracts are expected to commence in the second or third quarter of 2014.

On February 14, 2013, we announced that AHCA awarded our Florida health plan contracts in three regions under the Statewide Medicaid Managed Care Long-Term Care Program. As a result of the awards, we will now enter into a comprehensive pre-contracting assessment, with the program currently scheduled to commence on December 1, 2013. Under the program, we will provide long-term care benefits, including institutional and home and community-based services.

New Mexico. On August 1, 2013, our New Mexico health plan closed on its acquisition of the Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program, under which Lovelace's Medicaid members became Molina Healthcare Medicaid members and now receive their Medicaid managed services and benefits from our New Mexico health plan. Additionally, in the coming months we expect to add membership currently covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace. See Note 4, "Business Combinations," for further information.

On February 11, 2013, we announced that our New Mexico health plan was selected by the New Mexico Human Services Department (HSD) to participate in the new Centennial Care program. In addition to continuing to provide physical and acute health care services, under the new program our New Mexico health plan will expand its services to provide behavioral health and long-term care services. The selection of our New Mexico health plan was made by HSD pursuant to its RFP issued in August 2012. The operational start date for the program is currently scheduled for January 2014.

South Carolina. On July 26, 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members who will be covered by South Carolina's full-risk Medicaid managed care program. See Note 4, "Business Combinations," for further information.

Market Updates - Molina Medicaid Solutions Segment

U.S. Virgin Islands and West Virginia. In 2012, Molina Medicaid Solutions of West Virginia secured a historic partnership with the United States Virgin Islands (USVI). The partnership involves processing the USVI's Medicaid claims using West Virginia's certified Medicaid management information system. On August 1, 2013 the system went live, marking the first MMIS for a U.S. Territory, and the first to be shared between two government agencies on a single business processing platform.

Louisiana. In 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement MMIS to a different vendor, CNSI. However, in March 2013, the state of Louisiana cancelled its contract award to CNSI. CNSI is currently challenging the contract cancellation. The state has informed us that we will continue to perform under our current contract until a successor is named. At such time as a new RFP may be issued, we intend to respond to the state's RFP. For the nine months ended September 30, 2013, our revenue under the Louisiana MMIS contract was approximately $31.1 million, or 20.7% of total service revenue. So long as our Louisiana MMIS contract continues, we expect to recognize approximately $40.0 million of service revenue annually under this contract.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2013.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2012. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2012 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2012 audited consolidated financial statements.

Presentation and Reclassifications

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal on June 30, 2012. Effective June 30, 2013 the transition obligations associated with that contract terminated. Therefore, we have reclassified the results relating to the Missouri health plan to discontinued operations for all periods presented. These results are presented in a single line item, net of taxes, in the unaudited consolidated statements of operations. Additionally, we abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of

approximately $9.5 million, which is also included in discontinued operations in the unaudited consolidated statements of operations. The Missouri health plan's revenues amounted to $0.2 million and $113.8 million for the nine months ended September 30, 2013 and 2012, respectively.

We have reclassified certain amounts in the 2012 consolidated balance sheet, and statements of operations and cash flows to conform to the 2013 presentation, including the presentation of premium tax receipts as a separate line item in the consolidated statements of operations.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

(1) Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract: These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates), our revenue earned for those periods will also change. In all of these instances, our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn would lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of approximately $0.8 million and $0.3 million at September 30, 2013 and December 31, 2012, respectively.

Florida Health Plan Medical Cost Floor (Minimum): A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs (in all counties except Broward). A similar minimum expenditure is required for total health care costs in Broward county only. At both September 30, 2013 and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit, as defined in the contract, exceed certain amounts. At both September 30, 2013 and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

Ohio Health Plan Medical Cost Floors (Minimums): Sanctions may be levied by the state if certain minimum amounts are not spent on defined medical care costs. These sanctions include the requirements to file a corrective action plan as well as an enrollment freeze.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $2.2 million and $3.2 million pursuant to our profit-sharing agreement with the state of Texas at September 30, 2013 and December 31, 2012, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At

September 30, 2013, we recorded a liability under the terms of these contract provisions of approximately $0.3 million. At December 31, 2012, we had not recorded any liability under the terms of this contract provision.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $18.4 million and $0.3 million as of September 30, 2013 and December 31, 2012, respectively for anticipated Medicare risk adjustment premiums.

(2) Quality incentives that allow us to recognize incremental revenue if certain quality standards are met: These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, incremental revenue of up to 3.25% of total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2013 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30,

2013.

	Three Months Ended September 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 906	$ 818	$ 2	$ 820	$ 130,318
Ohio	3,080	976	(52)	924	280,964
Texas	15,744	15,744	—	15,744	320,657
Wisconsin	1,209	—	—	—	39,676
	$ 20,939	$ 17,538	$ (50)	$ 17,488	$ 771,615

	Three Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 560	$ 532	$ —	$ 532	$ 80,846
Ohio	2,824	1,412	—	1,412	282,489
Texas	17,685	10,453	—	10,453	344,522
Wisconsin	419	—	246	246	16,279
	$ 21,488	$ 12,397	$ 246	$ 12,643	$ 724,136

	Nine Months Ended September 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 2,079	$ 1,685	$ 159	$ 1,844	$ 298,767
Ohio	9,049	3,115	501	3,616	819,879
Texas	47,683	47,683	5,995	53,678	969,063
Wisconsin	3,239	—	1,104	1,104	104,540
	$ 62,050	$ 52,483	$ 7,759	$ 60,242	$ 2,192,249

	Nine Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 1,676	$ 1,350	$ 658	$ 2,008	$ 240,568
Ohio	8,222	6,810	966	7,776	827,219
Texas	41,687	30,487	—	30,487	892,377
Wisconsin	1,284	—	492	492	52,209
	$ 52,869	$ 38,647	$ 2,116	$ 40,763	$ 2,012,373

Taxes Based on Premiums

Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, included in premium tax

receipts (within revenue), and premium tax expense (within expenses), in the consolidated statements of operations. Prior to the third quarter of 2013, premium tax receipts were included in premium revenue. The presentation change affected only premium revenue amounts previously reported, by reducing premium revenue for the amount now included in premium tax receipts. There is no effect on income from continuing operations, net income, or per-share amounts. This change was made to more clearly present the portion of premium revenue not available in the general operations of our health plans. All prior periods presented have been adjusted to conform to this presentation.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. While providing BPO services (which include claims payment and eligibility processing), we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and

- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In

those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software-related costs and other costs. With respect to software-related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;
- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes and non-deductible compensation under a provision of the Affordable Care Act that limits deductions claimed by health insurers on compensation earned after December 31, 2009 that is paid after December 31, 2012. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $12.5 million and $10.6 million as of September 30, 2013 and December 31, 2012, respectively. Approximately $10.5 million and $8.4 million of the unrecognized tax benefits recorded at September 30, 2013 and December 31, 2012, respectively, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $8.6 million and $7.4 million as of September 30, 2013 and December 31, 2012, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $10.7 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of September 30, 2013 and December 31, 2012, we had accrued $67,000 and $56,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

Income Taxes. In July 2013, the Financial Accounting Standards Board (FASB) issued guidance for the presentation of an unrecognized tax benefit when a net operating loss carryforward, a similar tax loss, or a tax credit carryforward exists. The

new guidance states that an unrecognized tax benefit, or a portion of an unrecognized tax benefit, should be presented in the financial statements as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward. To the extent one of these items is not available at the reporting date; the unrecognized tax benefit should be presented in the financial statements as a liability and should not be combined with deferred tax assets. The new guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2013, with early adoption permitted. The new guidance should be applied prospectively to all unrecognized tax benefits that exist at the effective date, with retrospective application permitted. We do not expect the adoption of this new guidance to have a material impact on our consolidated financial position, results of operations or cash flows.

Reclassifications Out of Accumulated Other Comprehensive Income. In February 2013, the FASB issued guidance for the reporting of amounts reclassified out of accumulated other comprehensive income. The new guidance requires entities to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under U.S. generally accepted accounting principles (GAAP) to be reclassified in its entirety to net income. The new guidance does not change the current requirements for reporting net income or other comprehensive income in financial statements and is effective prospectively for reporting periods beginning after December 15, 2012. The adoption of this new guidance in 2013 did not impact our consolidated financial position, results of operations or cash flows.

Balance Sheet Offsetting. In December 2011, the FASB issued guidance for new disclosure requirements related to the nature of an entity's rights of set-off and related arrangements associated with its financial instruments and derivative instruments. The new guidance is effective for annual reporting periods, and interim periods within those years, beginning on or after January 1, 2013. The adoption of this new guidance in 2013 did not impact our consolidated financial position, results of operations or cash flows.

Federal Premium-Based Assessment. In July 2011, the FASB issued guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (ACA). The ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year.

The new guidance specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The new guidance is effective for annual reporting periods beginning after December 31, 2013, when the fee initially becomes effective. As enacted, this federal premium-based assessment is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this premium-based assessment will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this assessment as currently written is expected to have a material impact on our financial position, results of operations, and cash flows in future periods. We estimate that the fee in 2014 will be approximately $100.0 million.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants (AICPA), and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(In thousands)			
Shares outstanding at the beginning of the period	45,683	46,527	46,762	45,815
Weighted-average number of shares repurchased	—	—	(1,375)	—
Weighted-average number of shares issued	16	19	321	486
Denominator for basic net income (loss) per share	45,699	46,546	45,708	46,301
Dilutive effect of employee stock options and stock grants (1)	453	334	532	—
Dilutive effect of convertible senior notes	910	—	527	—
Denominator for diluted net income (loss) per share (2)	47,062	46,880	46,767	46,301

(1) Unvested restricted shares are included in the calculation of diluted net income per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. Options to purchase common shares are included in the calculation of diluted net income per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three and nine months ended September 30, 2013 there were no anti-dilutive weighted restricted shares. For the three and nine months ended September 30, 2013 there were approximately 60,000 and 48,600 anti-dilutive weighted options, respectively. For the three months ended September 30, 2012, there were approximately 370,000 anti-dilutive weighted restricted shares and 125,000 anti-dilutive weighted options. Potentially dilutive unvested restricted shares and stock options were not included in the computation of diluted loss per share for the nine months ended September 30, 2012, because to do so would have been anti-dilutive.

(2) Potentially dilutive shares issuable pursuant to our 1.125% Warrants (defined in Note 11, "Long-Term Debt") were not included in the computation of diluted income per share for the three and nine month period ended September 30, 2013, because to do so would have been anti-dilutive. Potentially dilutive shares issuable pursuant to our 3.75% Notes (defined in Note 11, "Long-Term Debt") were not included in the computation of diluted loss per share for the three and nine month period ended September 30, 2012, because to do so would have been anti-dilutive.

4. Business Combinations

Health Plans Segment

South Carolina. On July 26, 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members who will be covered by South Carolina's full-risk Medicaid managed care program, consistent with our stated strategy to enter new markets. The conversion of such members is contingent on our successful receipt of an HMO license from the South Carolina Department of Insurance, the award to Molina Healthcare of a full-risk Medicaid managed care contract by the South Carolina Department of Health and Human Services, and the state's conversion to a full-risk Medicaid managed care program. Each of these three conditions is expected to be satisfied by January 2014. In connection with the agreement, we paid CHS $7.5 million on the closing date. We currently expect to convert approximately 130,000 members under the agreement, for a total estimated discounted purchase price of $65.0 million. The final purchase price will be settled when the member conversion has been completed.

Because the number of members we will ultimately convert was unknown as of the July 26, 2013 acquisition date, $57.5 million of the purchase price represents contingent consideration for the number of members we expect to enroll in our health plan as a result of the conversion. The contingent consideration liability will be remeasured to fair value at each quarter until the contingency is resolved, with adjustments, if any, recorded to operations. The undiscounted amount we could be required to pay under this contingent consideration arrangement ranges from $7.5 million (which we paid on the closing date) to approximately $70 million. We expect most of the contingent consideration liability to be settled in the second quarter of 2014.

We recorded $42.1 million in goodwill, which relates to future economic benefits arising from expected synergies achieved in the transaction. Such synergies include use of our existing infrastructure to support our health plan operations in South Carolina. We also recorded $22.9 million in intangible assets, as indicated in the table below. Accumulated amortization was immaterial as of September 30, 2013. We expect to record amortization of approximately $1.9 million per year in the years 2014 through 2018.

New Mexico. Consistent with our stated strategy to expand within existing markets, on August 1, 2013, our New Mexico health plan closed on its acquisition of the Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program, under which Lovelace's Medicaid members became Molina Healthcare Medicaid members and now receive their Medicaid managed services and benefits from our New Mexico health plan. As part of this acquisition, we also expect to add membership currently covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace in the near future. Effective January 1, 2014, members in this program will ultimately be a) enrolled in the Centennial Care program as Medicaid members, or b) eligible to enroll in New Mexico's health insurance marketplace. All members transferred from Lovelace will be able to continue with Molina Healthcare as the state transitions to the Centennial Care program. We expect the final purchase price for the acquisition to amount to approximately $53.5 million, of which $47.2 million was paid on the closing date. As of September 30, 2013, the New Mexico health plan's membership increased by approximately 80,000 members as a result of this transaction.

Because the number of SCI members we will ultimately retain was unknown as of the August 1, 2013 acquisition date, $2.4 million of contingent consideration was recorded for this SCI membership as of September 30, 2013. We believe the contingent consideration amount may decrease as we learn more about how many SCI members we will retain, but is unlikely to increase. The contingent consideration liability will be remeasured to fair value at each quarter until the contingency is resolved, with adjustments, if any, recorded to operations. We expect that the contingency will be settled in the second quarter of 2014.

We recorded $35.2 million in goodwill, which relates to future economic benefits arising from expected synergies achieved in the transaction. Such synergies include use of our existing infrastructure to support the added membership. We also recorded $18.3 million in intangible assets, as indicated in the table below. Accumulated amortization was immaterial as of September 30, 2013. We expect to record amortization of approximately $1.8 million per year in the years 2014 through 2018.

Florida. On June 30, 2013, our Florida health plan acquired assets relating to the Statewide Medicaid Managed Care Long-Term Care Program from Neighborly Care Network, Inc. The final purchase price for this acquisition was $3.3 million. Accumulated amortization as September 30, 2013, and future amortization for this acquisition are immaterial.

The following table presents assets acquired and the weighted average useful life for the major asset categories for the business combinations in 2013:

	Fair Value of Assets Acquired - Health Plans Segment				
	Weighted average useful life	**South Carolina**	**New Mexico**	**Florida**	**Total**
	(Years)	*(In thousands)*			
Membership conversion rights	12.0	$ 21,800	$ —	$ —	$ 21,800
Contract rights	10.6	—	18,300	—	18,300
Other finite-lived intangibles	7.7	1,060	—	990	2,050
Goodwill	—	42,140	35,223	2,332	79,695
		$ 65,000	$ 53,523	$ 3,322	$ 121,845

Acquisition costs relating to these transactions were immaterial individually and in the aggregate. The amounts recorded as goodwill represent intangible assets that do not qualify for separate recognition as identifiable intangible assets. The entire amounts recorded as goodwill are deductible for income tax purposes. Goodwill is not amortized, but is subject to an annual impairment test.

5. Stock-Based Compensation

At September 30, 2013, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan; and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

In March 2013, our named executive officers were granted restricted stock awards with performance conditions as follows: our chief executive officer was awarded 186,858 shares, our chief financial officer was awarded 93,429 shares, our chief operating officer was awarded 62,286 shares, our chief accounting officer was awarded 28,029 shares, and our general counsel was awarded 21,800 shares. These awards were apportioned into four equal increments, and will vest in accordance with the following four measures: (i) 1/4th will vest in equal 1/3rd increments over three years on March 1, 2014, March 1,

2015, and March 1, 2016; (ii) 1/4th will vest upon our achievement of three-year Total Stockholder Return (TSR) as determined by Institutional Shareholder Services Inc. (ISS) calculations for the three-year period ending December 31, 2013 equal to or greater than the 50th percentile within our ISS peer group; (iii) 1/4th shall vest upon our achievement of total revenue in any of the 2013, 2014, or 2015 fiscal years equal to or greater than $12 billion; and (iv) 1/4th shall vest upon our achievement of the three-year earnings before interest, taxes, depreciation and amortization (EBITDA) margin percentage for the three-year period ending December 31, 2013 equal to or greater than 2.5%. In the event the vesting conditions are not achieved, the awards shall lapse. As of September 30, 2013, such performance goals have not yet been met, but we do expect the awards to vest in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three and nine month periods ended September 30, 2013 and 2012:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(In thousands)			
Restricted stock and performance awards	$ 7,634	$ 5,093	$ 18,593	$ 13,943
Employee stock purchase plan and stock options	870	543	2,061	1,505
	$ 8,504	$ 5,636	$ 20,654	$ 15,448

As of September 30, 2013, there was $28.0 million of total unrecognized compensation expense related to unvested restricted share awards, including those with performance conditions, which we expect to recognize over a remaining weighted-average period of 1.7 years. Also as of September 30, 2013, there was $0.6 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.3 years.

Restricted and performance stock activity for the nine months ended September 30, 2013 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2012	986,577	$ 23.74
Granted - restricted stock	587,706	32.15
Granted - performance stock	456,174	30.80
Vested	(581,329)	24.72
Forfeited	(31,500)	25.55
Unvested balance as of September 30, 2013	1,417,628	29.06

The total fair value of restricted and performance awards granted during the nine months ended September 30, 2013 and 2012 was $33.3 million and $23.0 million, respectively. The total fair value of restricted awards, including those with performance conditions, vested during the nine months ended September 30, 2013 and 2012 was $19.3 million and $24.3 million, respectively.

The weighted-average grant date fair value per share of the performance awards with vesting conditions based on TSR, as described above, was $28.24. We estimated the fair value on the grant date using a Monte Carlo Simulation to project TSR over the performance period using correlations and volatilities of the ISS peer group. Additional inputs included a risk-free interest rate of 0.14%, dividend yield of 0%, and an expected life of 0.83 years.

Stock option activity for the nine months ended September 30, 2013 is summarized below:

	Options	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Outstanding as of December 31, 2012	414,061	$ 22.39		
Granted	45,000	33.02		
Exercised	(70,000)	20.11		
Forfeited	(300)	17.63		
Outstanding as of September 30, 2013	388,761	24.04	$ 4,495	3.6
Stock options exercisable and expected to vest as of September 30, 2013	388,761	24.04	$ 4,495	3.6
Exercisable as of September 30, 2013	333,761	22.50	$ 4,371	2.7

The weighted-average grant date fair value per share of stock options awarded to the new members of our board of directors during the nine months ended September 30, 2013 was $14.67. The weighted-average grant date fair value per share of the stock option awarded to the director appointed during 2012 was $13.97. We estimate the fair value of each stock option award on the grant date using the Black-Scholes option pricing model. To determine the fair values of these stock options we applied risk-free interest rates of 1.1% to 1.4%, expected volatilities of 41.3% to 43.0%, dividend yields of 0%, and expected lives of 6 years to 7 years.

6. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, a derivative asset, trade accounts payable, medical claims and benefits payable, long-term debt, a derivative liability, contingent consideration, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

Level 1 — Observable Inputs

Our Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

Level 2 — Directly or Indirectly Observable Inputs

Our Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Such investments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Level 3 — Unobservable Inputs

Our Level 3 financial instruments recorded at fair value include non-current auction rate securities that are designated as available-for-sale, and are reported at fair value of $11.7 million (par value of $12.4 million) as of September 30, 2013. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants including global financial institutions, hedge funds, private equity funds, mutual funds, corporations and other institutional investors. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from two other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of September 30, 2013.

Level 3 financial instruments also include derivative financial instruments comprising the 1.125% Call Option asset, and the embedded cash conversion option liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of September 30, 2013 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 11, “Long-Term Debt,” and Note 12, “Derivative Financial Instruments,” the 1.125% Call Option asset and the embedded cash conversion option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Additionally, Level 3 financial instruments include contingent consideration liabilities of $59.9 million, primarily relating to the acquisition in South Carolina as described in Note 4, "Business Combinations," and recorded to accounts payable and accrued liabilities in our consolidated balance sheets. We applied discounted cash flow analysis to determine the fair value of the contingent consideration liabilities. Significant unobservable inputs primarily related to the probability weighted present values of the purchase price estimates for the membership that could convert in the South Carolina acquisition. Such membership could range from zero to approximately 170,000 members, with a weighted average of approximately 130,000 members.

Our financial instruments measured at fair value on a recurring basis at September 30, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
	(In thousands)			
Corporate debt securities	$ 467,060	$ —	$ 467,060	$ —
GSEs	74,951	74,951	—	—
Municipal securities	107,844	—	107,844	—
U.S. treasury notes	42,207	42,207	—	—
Certificates of deposit	43,089	—	43,089	—
Auction rate securities	11,674	—	—	11,674
1.125% Call Option derivative asset	191,663	—	—	191,663
Total assets measured at fair value on a recurring basis	$ 938,488	$ 117,158	$ 617,993	$ 203,337
Embedded cash conversion option derivative liability	$ 191,556	$ —	$ —	$ 191,556
Contingent consideration liabilities	59,947	—	—	59,947
Total liabilities measured at fair value on a recurring basis	$ 251,503	$ —	$ —	$ 251,503

Our financial instruments measured at fair value on a recurring basis at December 31, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
	(In thousands)			
Corporate debt securities	$ 191,008	$ —	$ 191,008	$ —
GSEs	29,525	29,525	—	—
Municipal securities	75,848	—	75,848	—
U.S. treasury notes	35,740	35,740	—	—
Certificates of deposit	10,724	—	10,724	—
Auction rate securities	13,419	—	—	13,419
Total assets measured at fair value on a recurring basis	$ 356,264	$ 65,265	$ 277,580	$ 13,419
Interest rate swap derivative liability	$ 1,307	$ —	$ 1,307	$ —

The following tables present activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments for the Nine Months Ended September 30, 2013			
	Total	Auction Rate Securities	Derivatives, Net	Contingent Consideration
	(In thousands)			
Balance at December 31, 2012	$ 13,419	$ 13,419	$ —	$ —
Net unrealized gains included in other comprehensive income	505	505	—	—
Net unrealized losses included in other expense	(3,382)	—	(3,382)	—
Issuances	(75,074)	—	(75,074)	—
Auction rate securities settlements and derivative re-designation	76,747	(2,250)	78,997	—
Acquisitions	(59,947)	—	—	(59,947)
Balance at September 30, 2013	$ (47,732)	$ 11,674	$ 541	$ (59,947)
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at September 30, 2013	$ 397	$ 397	$ —	$ —

	Changes in Level 3 Instruments for the Year Ended December 31, 2012			
	Total	Auction Rate Securities	Derivatives, Net	Contingent Consideration
	(In thousands)			
Balance at December 31, 2011	$ 16,134	$ 16,134	$ —	$ —
Net unrealized gains included in other comprehensive income	1,635	1,635	—	—
Settlements	(4,350)	(4,350)	—	—
Balance at December 31, 2012	$ 13,419	$ 13,419	$ —	$ —
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at December 31, 2012	$ 1,059	$ 1,059	$ —	$ —

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our long-term debt, as well as the applicable fair value hierarchy tiers, are contained in the tables below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. As described in greater detail Note 11, "Long-Term Debt," we recorded lease financing obligations in connection with sale-leaseback transactions executed in the first half of 2013. The lease financing obligations are classified as Level 3 financial instruments because certain inputs used to determine their fair value are unobservable, such as our incremental borrowing rate. Fair value for these obligations was determined using discounted cash flow analysis with an estimated incremental borrowing rate for debt with similar terms. The credit facility was repaid and terminated effective February 15, 2013, and the term loan was repaid in June 2013.

	September 30, 2013				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
1.125% Notes	$ 411,659	$ 596,899	$ —	$ 596,899	$ —
3.75% Notes	180,225	229,556	—	229,556	—
Lease financing obligations	178,188	178,500	—	—	178,500
	$ 770,072	$ 1,004,955	$ —	$ 826,455	$ 178,500

	December 31, 2012				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
3.75% Notes	$ 175,468	$ 208,460	$ —	$ 208,460	$ —
Term loan	47,471	47,471	—	—	47,471
Credit facility	40,000	40,000	—	—	40,000
	$ 262,939	$ 295,931	$ —	$ 208,460	$ 87,471

7. Investments

The following tables summarize our investments as of the dates indicated:

	September 30, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 467,785	$ 306	$ 1,031	$ 467,060
GSEs	75,022	18	89	74,951
Municipal securities	108,647	109	912	107,844
U.S. treasury notes	42,159	67	19	42,207
Certificates of deposit	43,087	3	1	43,089
Subtotal - current investments	736,700	503	2,052	735,151
Auction rate securities	12,400	—	726	11,674
	$ 749,100	$ 503	$ 2,778	$ 746,825

	December 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 190,545	$ 528	$ 65	$ 191,008
GSEs	29,481	45	1	29,525
Municipal securities	75,909	185	246	75,848
U.S. treasury notes	35,700	42	2	35,740
Certificates of deposit	10,715	9	—	10,724
Subtotal - current investments	342,350	809	314	342,845
Auction rate securities	14,650	—	1,231	13,419
	$ 357,000	$ 809	$ 1,545	$ 356,264

The contractual maturities of our investments as of September 30, 2013 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 406,330	$ 406,342
Due one year through five years	330,370	328,809
Due after ten years	12,400	11,674
	$ 749,100	$ 746,825

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Net realized investment gains for the three months ended September 30, 2013 and 2012 were $27,000 and $12,000, respectively. Net realized investment gains for the nine months ended September 30, 2013 and 2012 were $169,000 and $250,000, respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at September 30, 2013 and December 31, 2012, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of September 30, 2013.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 254,351	$ 991	99	$ 5,580	$ 40	5
Municipal securities	60,428	736	68	12,424	176	29
GSEs	24,271	89	15	—	—	—
U.S. treasury notes	12,487	19	11	—	—	—
Certificates of deposit	415	1	2	—	—	—
Auction rate securities	—	—	—	11,674	726	17
	$ 351,952	$ 1,836	195	$ 29,678	$ 942	51

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2012.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 44,457	$ 65	23	$ —	$ —	—
Municipal securities	35,223	246	43	—	—	—
GSEs	5,004	1	1	—	—	—
U.S. treasury notes	4,511	2	5	—	—	—
Auction rate securities	—	—	—	13,419	1,231	21
	$ 89,195	$ 314	72	$ 13,419	$ 1,231	21

Auction Rate Securities

Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 17 years to 33 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction rate securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at September 30, 2013. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $69.7 million of these instruments at par value.

For the nine months ended September 30, 2013 and 2012, we recorded pretax unrealized gains of $0.5 million and $1.4 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

8. Receivables

Receivables consist primarily of amounts due from the various states in which we operate. Accounts receivable increased as of September 30, 2013, primarily due to certain intermediary arrangements with state agencies entered into in the third quarter of 2013. For further information on these arrangements, refer to Note 10, "Medical Claims and Benefits Payable."

	September 30, 2013	December 31, 2012
	(In thousands)	
Health Plans segment:		
California	$ 130,718	$ 28,553
Florida	2,239	953
Michigan	16,311	12,873
New Mexico	14,091	9,059
Ohio	79,200	40,980
Texas	5,280	7,459
Utah	10,375	3,359
Washington	12,668	17,587
Wisconsin	5,033	4,098
Other	633	2,177
Total Health Plans segment	276,548	127,098
Molina Medicaid Solutions segment	17,419	22,584
	$ 293,967	$ 149,682

9. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with the Molina Medicaid Solutions segment contracts with the states of Maine and Idaho, we maintain restricted investments as collateral for letters of credit. The following table presents the balances of restricted investments:

	September 30, 2013	December 31, 2012
	(In thousands)	
California	$ 373	$ 373
Florida	8,840	5,738
Michigan	1,014	1,014
New Mexico	24,620	15,915
Ohio	9,081	9,082
Texas	3,500	3,503
Utah	3,308	3,126
Washington	151	151
Other	4,037	5,199
Total Health Plans segment	54,924	44,101
Molina Medicaid Solutions segment	10,301	—
	$ 65,225	$ 44,101

The contractual maturities of our held-to-maturity restricted investments as of September 30, 2013 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 59,633	$ 59,636
Due one year through five years	5,592	5,596
	$ 65,225	$ 65,232

10. Medical Claims and Benefits Payable

As of September 30, 2013, medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. As of September 30, 2013, we recorded provider payables of approximately $64.1 million, and $69.7 million accounts receivable for new intermediary arrangements that began in the third quarter of 2013.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The following table shows the components of the change in medical claims and benefits payable from continuing and discontinued operations for the periods indicated:

	Nine Months Ended September 30, 2013	Three Months Ended September 30, 2013	Year Ended December 31, 2012
		(Dollars in thousands)	
Balances at beginning of period	$ 494,530	$ 465,487	$ 402,476
Components of medical care costs related to:			
Current period	4,021,461	1,415,670	5,136,055
Prior periods	(54,040)	(32,575)	(39,295)
Total medical care costs	3,967,421	1,383,095	5,096,760
Payments for medical care costs related to:			
Current period	3,410,689	851,025	4,649,363
Prior periods	418,556	364,851	355,343
Total paid	3,829,245	1,215,876	5,004,706
Balances at end of period	$ 632,706	$ 632,706	$ 494,530
Benefit from prior period as a percentage of:			
Balance at beginning of period	10.9%	7.0%	9.8%
Premium revenue, trailing twelve months	0.9%	0.5%	0.7%
Medical care costs, trailing twelve months	1.0%	0.6%	0.8%

Assuming that our initial estimate of claims incurred but not paid (IBNP) is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2013 and 2012 were less than what we had expected when we had established our reserves. For example, for the year ended December 31, 2012, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2011 by 9.8%. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $54.0 million for the nine months ended September 30, 2013. This amount represents our estimate, as of September 30, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012 was due primarily to the following factors:

- At our Washington health plan prior to July 2012, certain high-cost newborns that were approved for supplemental security income (SSI) coverage by the state were retroactively dis-enrolled from our Healthy Options (TANF) coverage, and the health plan was reimbursed for the claims paid on behalf of these members. Starting July 1, 2012, these newborns, as well as other high-cost disabled members, are now covered by the health plan under the Healthy Options Blind and Disabled (HOBD) program. At the end of 2012, we had limited claims history with which to estimate the claims liability of the HOBD members, and as a result the liability for these high-cost members was overstated.
- At our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.
- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to our aged, blind or disabled (ABD) members.

We recognized favorable prior period claims development in the amount of $32.6 million for the three months ended September 30, 2013. This amount represents our estimate as of September 30, 2013, of the extent to which our initial estimate of medical claims and benefits payable at June 30, 2013 was more than the amount that will ultimately be paid out in satisfaction of that liability. This amount of favorable development was considerably less than we typically experience, and was significant enough to have a materially unfavorable impact upon our third quarter financial performance. We believe the overestimation of our claims liability at June 30, 2013 was due primarily to the following factors:

- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to critically ill members.
- At our Michigan health plan, we underestimated the impact of future claims overpayment recoveries when establishing reserves at June 30, 2013.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Texas health plan as a result of the costs associated with an unusually large number of older claims. This anomaly was caused primarily by the payment of claims that were delayed as a result of hospital provider disputes that have been resolved. The underestimation of the liability at our Texas health plan was responsible for the relatively small amount of prior period development noted above.

We recognized favorable prior period claims development in the amount of $37.7 million and $39.3 million for the nine months ended September 30, 2012, and the year ended December 31, 2012, respectively. This was primarily caused by the overestimation of our liability claims and medical benefits at December 31, 2011, as a result of the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS, in the Dallas region.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

In estimating our claims liability at September 30, 2013, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- At our Texas health plan, we have noted an unusually large number of older claims dated older than 12 months. This has caused some distortion in the claims lag pattern that we use to estimate the incurred claims.
- At our Michigan health plan, there were a large number of claim recoveries recorded in June 2013 due to overpayments that resulted from a system configuration issue. These recoveries impacted the completion factors used to estimate incurred claims. While we attempted to remove this distortion from the claims data to develop a more accurate reserve estimate, this type of correction in claims data adds a degree of uncertainty for the Michigan reserves as of September 30, 2013.
- Our New Mexico health plan acquired approximately 80,000 new members in August 2013 from another health plan. This acquisition roughly doubled the size of the membership in a single month. For the September 30, 2013 reserve calculation, we have assumed that these new members will incur costs at about the same rate as the New Mexico members that were previously enrolled. With only two months of paid claims for these new members, it is too soon to know whether that assumption is correct or not.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012, and for the nine months ended September 30, 2013, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material

impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

11. Long-Term Debt

As of September 30, 2013, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2013	2014	2015	2016	2017	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	—	187,000	—	—	—	—
	$ 737,000	$ —	$ 187,000	$ —	$ —	$ —	$ 550,000

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we settled the issuance of $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes). This transaction included the initial issuance of $450.0 million on February 11, 2013, plus the exercise of the full amount of the $100.0 million over-allotment option on February 13, 2013. The aggregate net proceeds of the 1.125% Notes were $458.9 million, after payment of the net cost of the Call Spread Overlay described below and in Note 12, “Derivative Financial Instruments,” and transaction costs. Additionally, we used $50.0 million of the net proceeds to purchase shares of our common stock (see Note 13, “Stockholders' Equity”), and $40.0 million to repay the principal owed under our Credit Facility.

Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum, and commenced on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. Holders may convert their 1.125% Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.125% Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its 1.125% Notes in connection with such a corporate event in certain circumstances. We may not redeem the 1.125% Notes prior to the maturity date, and no sinking fund is provided for the 1.125% Notes.

If we undergo a fundamental change (as defined in the indenture to the 1.125% Notes), holders may require us to repurchase for cash all or part of their 1.125% Notes at a repurchase price equal to 100% of the principal amount of the 1.125% Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The 1.125% Notes are senior unsecured obligations, and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

The 1.125% Notes contain an embedded cash conversion option. We have determined that the embedded cash conversion option is a derivative financial instrument, required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the embedded cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). For further discussion of the derivative financial instruments relating to the 1.125% Notes, refer to Note 12, "Derivative Financial Instruments."

As noted above, the reduced carrying value on the 1.125% Notes resulted in a debt discount that is amortized to the 1.125% Notes' principal amount through the recognition of interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 1.125% Notes is 5.9%, which is imputed based on the amortization of the fair value of the embedded cash conversion option over the remaining term of the 1.125% Notes. As of September 30, 2013, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 6.3 years. The 1.125% Notes' if-converted value did not exceed their principal amount as of September 30, 2013.

Also in connection with the settlement of the 1.125% Notes, we paid approximately $16.9 million in transaction costs. Such costs have been allocated to the 1.125% Notes, the 1.125% Call Option (defined below) and the 1.125% Warrants (defined below) according to their relative fair values. The amount allocated to the 1.125% Notes, or $12.0 million, was capitalized and will be amortized over the term of the 1.125% Notes. The aggregate amount allocated to the 1.125% Call Option and 1.125% Warrants, or $4.9 million, was recorded to interest expense in the quarter ended March 31, 2013.

1.125% Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Notes, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). These transactions represent a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call Spread Overlay. The 1.125% Call Option is a derivative financial instrument. Until April 22, 2013, the 1.125% Warrants were classified as derivative financial instruments; refer to Note 12, "Derivative Financial Instruments" for further discussion.

Aside from the initial payment of a premium to the Counterparties of $149.3 million for the 1.125% Call Option, we will not be required to make any cash payments to the Counterparties under the 1.125% Call Option, and will be entitled to receive from the Counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

3.75% Convertible Senior Notes due 2014

We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of September 30, 2013 and December 31, 2012. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Because the 3.75% Notes have cash settlement features, we have allocated the proceeds from their issuance between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that is amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms had been issued. The effective interest rate of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. As of September 30, 2013, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 12 months. As of September 30, 2013, the 3.75% Notes' if-converted value exceeded their principal amount by approximately $30 million. The 3.75% Notes' if-converted value did not exceed their principal amount as of December 31, 2012. At September 30, 2013, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million.

The principal amounts, unamortized discount and net carrying amounts of the convertible senior notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
September 30, 2013:			
1.125% Notes	$ 550,000	$ 138,341	$ 411,659
3.75% Notes	187,000	6,775	180,225
	$ 737,000	$ 145,116	$ 591,884
December 31, 2012:			
3.75% Notes	$ 187,000	$ 11,532	$ 175,468

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
		(In thousands)		
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate	$ 3,300	$ 1,753	$ 9,127	$ 5,259
Amortization of the discount	6,059	1,499	15,747	4,414
Total interest cost recognized	$ 9,359	$ 3,252	$ 24,874	$ 9,673

Lease Financing Obligations

On June 12, 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of two properties, including the Molina Center located in Long Beach, California, and the building that houses our Ohio health plan located in Columbus, Ohio. We sold the two properties for $158.6 million in the aggregate. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. The carrying values of these properties, including the related intangible assets, amounted to $78.3 million in the aggregate as of September 30, 2013. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The sales price of $158.6 million was recorded as a lease financing obligation, which is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. Transaction costs associated with this transaction, amounting to $3.5 million, have been deferred and will be amortized over the initial lease term. Future minimum rental income on noncancelable leases from third party tenants of these properties, as reported in our December 31, 2012 Form 10-K, is now considered to be sublease rental income, and continues to be reported in rental income in our consolidated statements of operations. The future minimum rental income previously reported as of December 31, 2012 is consistent with our expected sublease rental income as of September 30, 2013. For information regarding the future minimum lease obligation, refer to Note 15, “Commitments and Contingencies.”

As described and defined in further detail in Note 16, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings then under construction. We have concluded that we are the accounting owner of the construction projects because of our continuing involvement in those projects. Therefore, we have recorded $18.9 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of September 30, 2013, which represents the total cost, including imputed interest, incurred by the Landlord thus far in the

construction projects. As of September 30, 2013, the aggregate amount recorded to lease financing obligations for the construction projects amounted to $19.2 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was immaterial for the nine months ended September 30, 2013. For information regarding the future minimum lease obligation, refer to Note 15, "Commitments and Contingencies."

Term Loan

In December 2011, our wholly owned subsidiary, Molina Center LLC, entered into a term loan agreement with various lenders and East West Bank to borrow $48.6 million to finance a portion of the purchase price for the Molina Center, located in Long Beach, California. On June 13, 2013, we repaid the principal balance outstanding under the term loan on that date with proceeds we received in the sale-leaseback transaction described above.

Credit Facility

On February 15, 2013, we used $40.0 million of the net proceeds from the offering of the 1.125% Notes to repay all of the outstanding indebtedness under our $170 million revolving Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the 1.125% Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution. Such direct issue letters of credit are collateralized by restricted investments.

12. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	September 30, 2013
		(In thousands)
Derivative asset:		
1.125% Call Option	Non-current assets: Derivative asset	$ 191,663
Derivative liability:		
Embedded cash conversion option	Non-current liabilities: Derivative liability	$ 191,556

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, in other expense. The following table summarizes the gains (losses) recorded in the periods presented:

	Three Months Ended September 30,		Nine months ended September 30,	
	2013	2012	2013	2012
	(In thousands)			
Derivative gains (losses):				
1.125% Call Option	$ (15,460)	$ —	$ 42,332	$ —
Embedded cash conversion option	15,461	—	(42,225)	—
1.125% Warrants	—	—	(3,923)	—
Interest rate swap	—	(184)	433	(1,270)
	$ 1	$ (184)	$ (3,383)	$ (1,270)

1.125% Notes Call Spread Overlay

As described in Note 11, "Long-Term Debt," we entered into a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the debentures was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to the cash settlement features until the 1.125% Call Option settles or expires. The 1.125% Call Option is measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 6, “Fair Value Measurements.”

Until April 22, 2013, the 1.125% Warrants were recorded as a derivative liability that required mark-to-market accounting treatment due to certain terms in the 1.125% Warrants that prevented such instruments being considered to be indexed in our common stock. Effective April 22, 2013, we entered into amended and restated warrant confirmations with the Counterparties to clarify these terms, such that 1.125% Warrants are no longer considered to be derivative instruments, and have been recorded to additional paid-in capital. In the second quarter of 2013, we recorded a loss of $3.9 million for the change in fair value of the 1.125% Warrants from February 15, 2013 to April 22, 2013.

Embedded Cash Conversion Option

The embedded cash conversion option within the 1.125% Notes is required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). The embedded cash conversion option is measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the embedded cash conversion option, refer to Note 6, “Fair Value Measurements.”

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, with an effective date of March 1, 2013. On June 14, 2013, we settled the interest rate swap for $0.9 million.

13. Stockholders’ Equity

Stockholders' equity increased $110.5 million during the nine months ended September 30, 2013. The increase was primarily due to the $79.0 million reclassification of the 1.125% Warrants to additional paid-in capital, net income of $62.1 million, and $19.1 million related to employee stock transactions, partially offset by $50.0 million in repurchases of our common stock, as described in further detail below.

Common Shares Authorized. On May 1, 2013, our stockholders approved an amendment to our certificate of incorporation to increase the number of authorized shares of our common stock from 80,000,000 to 150,000,000.

1.125% Warrants. As described in Note 12, "Derivative Financial Instruments," we reclassified the 1.125% Warrants to additional paid-in capital during the second quarter of 2013, resulting in a $79.0 million increase to stockholders' equity. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants.

Securities Repurchases and Repurchase Program. In connection with the issuance and settlement of the 1.125% Notes, we used a portion of the net proceeds from the offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and other market conditions. This newly authorized repurchase program extends through December 31, 2014, and replaces in its entirety, the $75 million repurchase program adopted by the board of directors on February 13, 2013.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with the plans described in Note 5, "Stock-Based Compensation," we issued approximately 620,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the nine months ended September 30, 2013.

14. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and also includes our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(In thousands)			
Revenue from continuing operations:				
Health Plans:				
Premium revenue	$ 1,584,656	$ 1,448,600	$ 4,583,818	$ 4,066,737
Premium tax receipts	43,723	37,894	127,606	120,953
Investment income	1,740	1,155	4,884	3,893
Rental and other income	5,860	4,079	16,476	12,315
Molina Medicaid Solutions:				
Service revenue	51,100	48,422	150,528	132,351
	$ 1,687,079	$ 1,540,150	$ 4,883,312	$ 4,336,249
Depreciation and amortization reported in the consolidated statements of cash flows:				
Health Plans	$ 17,545	$ 14,753	$ 48,467	$ 43,600
Molina Medicaid Solutions	6,583	5,526	19,568	14,689
	$ 24,128	$ 20,279	$ 68,035	$ 58,289
Operating income (loss) from continuing operations:				
Health Plans	$ 16,929	$ (5,788)	$ 118,600	$ (33,957)
Molina Medicaid Solutions	7,997	8,156	20,645	23,207
Total operating income (loss) from continuing operations	24,926	2,368	139,245	(10,750)
Interest expense	13,532	4,315	38,236	12,421
Other (income) expense	(24)	184	3,347	1,270
Income (loss) from continuing operations before income taxes	$ 11,418	$ (2,131)	$ 97,662	$ (24,441)

	September 30, 2013	December 31, 2012
	(In thousands)	
Goodwill and intangible assets, net:		
Health Plans	$ 252,360	$ 139,710
Molina Medicaid Solutions	83,058	89,089
	$ 335,418	$ 228,799
Total assets:		
Health Plans	$ 2,748,724	$ 1,702,212
Molina Medicaid Solutions	176,342	232,610
	$ 2,925,066	$ 1,934,822

Goodwill and intangible assets increased in the Health Plans segment due to acquisitions that occurred in the third quarter of 2013. See Note 4, "Business Combinations," for further information.

15. Commitments and Contingencies

Sale-Leaseback Transactions

As described in Note 11, "Long-Term Debt," we entered into sale-leaseback transactions that have been classified as lease financing obligations. For the transaction entered into in June 2013, the initial lease term is 25 years, with five five-year renewal options. For the transaction relating to the construction project completed in June 2013, the initial lease term is 11.5 years, with two five-year renewal options. We expect future minimum lease payments under these leases, for the three months ended December 31, 2013, to be $3.3 million. Future minimum lease payments due under these leases beginning January 1, 2014 are as follows:

	(In thousands)
2014	$ 14,395
2015	18,277
2016	18,877
2017	19,496
2018	20,137
Thereafter	385,813
Total minimum lease payments	$ 476,995

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $601.1 million at September 30, 2013, and $549.7 million at December 31, 2012. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $472.1 million and $46.9 million as of September 30, 2013 and December 31, 2012, respectively.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Illinois, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2013, our health plans had aggregate statutory capital and surplus of approximately $637.0 million compared with the required minimum aggregate statutory capital and surplus of approximately $362.2 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2013. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

16. Related Party Transactions

Leased Office Buildings

On February 27, 2013, we entered into a lease (the Lease) with 6th & Pine Development, LLC (the Landlord) for office space located in Long Beach, California. The Lease consists of two office buildings, one of which is under construction. The building which comprises approximately 90,000 square feet of office and storage space (Building A) was completed in June 2013; immediately following its completion, we occupied Building A and commenced lease payments. The second building (Building B) is expected to comprise approximately 120,000 square feet of office space.

The term of the Lease with respect to Building A commenced on June 6, 2013, and the term of the Lease with respect to Building B is expected to commence on November 1, 2014. The initial term of the Lease with respect to both buildings expires on December 31, 2024, subject to two options to extend the term for a period of five years each. Initial annual rent for Building A is approximately $2.6 million, and initial annual rent for Building B is expected to be approximately $4.0 million. Rent will increase 3.75% per year through the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of common stock in the Company he holds as trustee. Dr. J. Mario Molina, our chief executive officer and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

Medical Services

We have an equity investment in a medical service provider that provides certain vision services to our members; we account for this investment under the equity method of accounting. For the three months ended September 30, 2013 and 2012, we paid $8.2 million and $7.0 million, respectively, for medical service fees to this provider. For the nine months ended September 30, 2013 and 2012, we paid $24.6 million and $20.6 million, respectively, for medical service fees to this provider.

17. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our Chairman of the Board, President and Chief Executive Officer. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides outpatient professional medical services to the general public for routine non-life threatening, outpatient health care needs. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, American Family Care, Inc. (AFC), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will not operate at a loss, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by AFC are reviewed annually to assure the achievement of this goal.

Our California, Florida, New Mexico and Washington health plans have entered into primary care capitation agreements with JMMPC. These agreements also direct our health plans to fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, based on a monthly reconciliation. Because the AFC services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are insignificant.

We have determined that JMMPC is a variable interest entity, or VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of September 30, 2013, JMMPC had total assets of $5.6 million, comprising primarily cash and equivalents, and total liabilities of $5.3 million, comprising primarily accrued payroll and employee benefits.

Our maximum exposure to loss as a result of our involvement with JMMPC is limited to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future. We provided an initial cash infusion of $0.3 million to JMMPC in the first quarter of 2012 to fund its start-up operations.

New Markets Tax Credit

During the fourth quarter of 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC, or Wells Fargo, its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC, or Investment Fund, and certain of Wells Fargo's affiliated Community Development Entities, or CDEs, in connection with our participation in the federal government's New Markets Tax Credit Program, or NMTC. The NMTC was established by Congress in 2000 to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In the fourth quarter of 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $5.9 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $15.5 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $20.9 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $5.9 million.

Additionally, financing costs incurred in structuring the arrangement amounting to $1.2 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE-collecting and remitting interest and fees and NMTC compliance-were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $5.9 million is included in cash at December 31, 2012 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

18. Subsequent Events

California Health Plan Rate Settlement Agreement

On October 30, 2013, we finalized the California health plan tentative rate settlement agreement, as described in Note 1, "Basis of Presentation." In connection with this agreement, a deficit or surplus will result to the extent the plan’s pre-tax margin is below or above 3.25%, subject to further adjustment as specified in the settlement agreement. Such settlement amount shall be based on 75% of the plan’s revenue in 2014; and 50% of the plan’s revenue in each subsequent year of the settlement agreement. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40 million. Additionally, DHCS agreed to enter into a Medi-Cal managed care contract with the California health plan for the Imperial County with an original term of five years and extension through October 31, 2023. The foregoing description of the settlement agreement is qualified in its entirety by reference to the Settlement Agreement which is filed as Exhibit 10.1 to this report and is incorporated herein by reference.

Hospital Management Service Agreement

On October 9, 2013, we entered into a 10-year agreement with College Health Enterprises (CHE) to perform certain medical and administrative management services for CHE's hospital in Long Beach, California. Under the agreement, we will assume financial benefit and risk for a number of acute care beds at the hospital. We believe that this arrangement will improve hospital access for our members in the Long Beach, California area, and will also enhance our overall direct delivery strategy. As with any new start up activity, we may incur losses while we modify various business operations during the initial months of the management services agreement.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated. Those risks and uncertainties include, but are not limited to, the following:

- those identified and discussed in our periodic reports and filings with the SEC;
- uncertainties associated with the implementation of the Affordable Care Act, including the impact of, and state rate development associated with, the health insurance industry excise tax, the expansion of Medicaid eligibility in participating states to previously uninsured populations unfamiliar with managed care, the implementation of insurance exchanges or marketplaces and related technical problems, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures, including the duals demonstration programs in California, Illinois, and Ohio;
- the success of our medical cost containment initiatives in Texas;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations and our accruals for incurred but not reported medical costs;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to increase our revenues consistent with our expectations;
- accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and the development of actuarially sound rates with respect to such new enrollees, including duals;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- government audits and reviews, and any enrollment freeze or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings;
- our management of a portion of CHE's hospital in Long Beach, California;
- the relatively small number of states in which we operate health plans;
- the availability of adequate financing to fund and capitalize our expansion and growth activities and to meet our liquidity needs, including the interest expense and other costs associated with such financing;

- a state's failure to renew its federal Medicaid waiver;
- inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2012, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management’s Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2012.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Illinois, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of September 30, 2013, these health plans served approximately 1.9 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico, and Washington.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

Third Quarter 2013 Financial Highlights

- Net income for continuing operations for the third quarter of 2013 increased when compared with the third quarter of 2012 as a result of higher medical margins. Those medical margins were partially offset by increased administrative expense related to the Company's preparations for significant membership growth expected in 2014.

- Premium revenue for the third quarter of 2013 increased 9% over the third quarter of 2012, due to a 5% increase in enrollment, and a 4% increase in revenue per member per month (PMPM). The 5% enrollment increase was primarily due to the acquisition of a contract covering approximately 80,000 members in New Mexico effective August 1, 2013.

- Our consolidated medical care ratio decreased to 87.3% in the third quarter of 2013, from 91.1% in the third quarter of 2012. The decline in the consolidated medical care ratio was the result of improved operating results at most of our health plans. Medical care ratios decreased in eight of our nine health plans, while medical margin (measured as the excess of premium revenue over medical care costs) increased in the same eight of nine health plans.

- General and administrative expenses increased to 10.4% of revenue in the third quarter of 2013, from 8.2% in the third quarter of 2012, primarily due to higher costs incurred as a result of our preparations for significant membership growth in 2014 in connection with the Affordable Care Act. Increased administrative expense related to anticipated membership growth in 2014 represented approximately 1.8% of premium revenue, or $30 million, during the third quarter of 2013.

Health Care Reform

We believe that the Affordable Care Act will provide us with significant opportunities for membership growth in our existing markets and, potentially, in new markets in the future as follows:

Health Insurance Marketplaces. On September 13, 2013, we announced that nine of our state health plan subsidiaries have been selected by the relevant state and federal regulatory agencies overseeing the non-group health insurance marketplaces for individuals to offer certified Qualified Health Plans. We are participating in the federally facilitated marketplaces in Florida, Ohio, Texas, Utah and Wisconsin, and in the state-federal partnership marketplaces in New Mexico and Michigan. In California and Washington, Molina Healthcare has been selected to participate in each of those two states' state-run marketplaces.

Dual Eligibles. The Centers for Medicare and Medicaid Services (CMS) has implemented several demonstrations designed to improve the coordination of care for dual eligible beneficiaries who are enrolled in both Medicare and Medicaid. We refer to such demonstrations as our Medicare-Medicaid Plan (MMP) implementations, which are scheduled to commence as follows:

- California - San Diego, Riverside and San Bernardino counties commence April 1, 2014
- Illinois - 15 counties in the Central Region commence February 1, 2014
- Ohio - 13 counties in Southwest, Central and West Central Regions commence March 1, 2014

Medicaid Expansion. The Affordable Care Act also provides for expanded Medicaid coverage effective in January 2014, which remains subject to implementation at the state level. We believe that we will likely add expansion membership in 2014. In preparation for such expansion membership growth, and for our participation in the health insurance marketplaces and MMP described above, we have augmented our infrastructure. Such preparations have included increased hiring in the nine months ended September 30, 2013, to support expansion of product development and pricing, network customization, and marketing; technology enhancements relating to premium billing and collections; and upgraded care management tools and telecommunications.

Market Updates - Health Plans Segment

California Health Plan Rate Settlement Agreement. On October 30, 2013, our California health plan finalized and entered into a settlement agreement with the California Department of Health Care Services (DHCS). The settlement agreement settles rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in California's Medicaid program, or Medi-Cal.

Under the terms of the settlement agreement, DHCS has agreed to extend each of the California health plan's existing Medi-Cal managed care contracts for an additional five years, including its contracts in San Diego, San Bernardino, Riverside, and Sacramento counties. In addition, effective January 1, 2014, the settlement establishes a settlement account applicable to the California health plan's Medi-Cal, Seniors and Persons with Disabilities (SPD), and the dual eligibles pilot programs. The settlement account will be established with an initial balance of zero, and will be adjusted annually to reflect a calendar year deficit or surplus. A deficit or surplus will result to the extent the plan's pre-tax margin is below or above 3.25%, subject to further adjustment as specified in the settlement agreement. Such settlement amount shall be based on 75% of the plan's revenue in 2014; and 50% of the plan's revenue in each subsequent year of the settlement agreement. Cash settlement will occur after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without replacement, any of our Medi-Cal managed care contracts. Upon expiration of the settlement agreement, if the settlement account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. The alternative minimum amount is calculated as follows: (i) $40 million, minus (ii) any partial settlement payments previously made to our California health plan by DHCS, minus (iii) 50% of the pre-tax income on our Medi-Cal, SPD, and dual eligibles pilot program business in excess of a 2.0% pre-tax margin for each calendar from 2014 through 2017. If the settlement account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40 million. DHCS agreed to enter into a Medi-Cal managed care contract with the California health plan for the Imperial County with an original term of five years and extension through October 31, 2023. The foregoing description of the settlement agreement is qualified in its entirety by reference to the Settlement Agreement which is filed as Exhibit 10.1 to this report and is incorporated herein by reference.

We do not expect the settlement agreement to impact our consolidated financial condition, cash flows, or results of operations for the year ending December 31, 2013.

Hospital Management Services Agreement. On October 9, 2013, we entered into a 10-year agreement with College Health Enterprises (CHE) to perform certain medical and administrative management services for CHE's hospital in Long Beach, California. Under the agreement, we will assume financial benefit and risk for a number of acute care beds at the hospital. We believe that this arrangement will improve hospital access for our members in the Long Beach, California area, and will also enhance our overall direct delivery strategy. As with any new start up activity, we may incur losses while we modify various business operations during the initial months of the management services agreement.

Florida. On October 23, 2013, our Florida health plan and the Florida Agency for Health Care Administration (AHCA), agreed to a settlement under which our health plan will be awarded three contracts under the Florida Statewide Medicaid Managed Care Managed Medical Assistance Invitation to Negotiate. The three contracts are expected to commence in the second or third quarter of 2014.

On February 14, 2013, we announced that AHCA awarded our Florida health plan contracts in three regions under the Statewide Medicaid Managed Care Long-Term Care program. As a result of the awards, we will now enter into a comprehensive pre-contracting assessment, with the program currently scheduled to commence on December 1, 2013. Under the program, we will provide long-term care benefits, including institutional and home and community-based services.

New Mexico. Consistent with our stated strategy to expand within existing markets, on August 1, 2013, our New Mexico health plan closed on its acquisition of the Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program, under which Lovelace's Medicaid members became Molina Healthcare Medicaid members and now receive their

Medicaid managed services and benefits from our New Mexico health plan. As part of this acquisition, we also expect to add membership currently covered under New Mexico's State Coverage Insurance (SCI) program with Lovelace in the near future. Effective January 1, 2014, members in this program will ultimately be a) enrolled in the Centennial Care program as Medicaid members, or b) eligible to enroll in New Mexico's health insurance marketplace. All members transferred from Lovelace will be able to continue with Molina Healthcare as the state transitions to the Centennial Care program. We expect the final purchase price for the acquisition to amount to approximately $53.5 million, of which $47.2 million was paid on the closing date. As of September 30, 2013, the New Mexico health plan's membership increased by approximately 80,000 members as a result of this transaction.

On February 11, 2013, we announced that our New Mexico health plan was selected by the New Mexico Human Services Department, or HSD, to participate in the new Centennial Care program. In addition to continuing to provide physical and acute health care services, under the new program our New Mexico health plan will expand its services to provide behavioral health and long-term care services. The selection of our New Mexico health plan was made by HSD pursuant to its request for proposals issued in August 2012. The operational start date for the program is currently scheduled for January 2014.

South Carolina. On July 26, 2013, we entered into an agreement with Community Health Solutions of America, Inc. (CHS) to acquire certain assets, including the rights to convert certain of CHS' Medicaid members who will be covered by South Carolina's full-risk Medicaid managed care program, consistent with our stated strategy to enter new markets. The conversion of such members will be contingent on our successful receipt of an HMO license from South Carolina Department of Insurance, the award to Molina Healthcare of a full-risk Medicaid managed care contract by the South Carolina Department of Health and Human Services, and the state's conversion to a full-risk Medicaid managed care program. Each of these three conditions is expected to be satisfied by January 2014. In connection with the agreement, we paid CHS $7.5 million on the closing date. We currently expect to convert approximately 130,000 members under the agreement, for a total estimated discounted purchase price of $65.0 million. The final purchase price will be settled when the member conversion has been completed.

Washington. The Washington Health Care Authority (HCA) has communicated to our Washington health plan that it believes it has erroneously overpaid the plan with regard to certain claims, including claims for psychotropic drugs, and claims for health plan members under the Washington Community Options Program Entry System (COPES). The alleged overpayments date back to the July 1, 2012 start date of the current contract. Because of the unilateral errors underlying the overpayments, HCA has indicated an intent to seek recoupment of the allegedly overpaid amounts. Our Washington health plan is seeking additional information from HCA regarding the factual and legal bases for any potential retroactive rate recoupment. In the event our Washington health plan is required to disgorge to HCA, in the fourth quarter of 2013, rate amounts that had been previously paid to it, our results of operations in the fourth quarter of 2013 may be adversely affected.

Market Updates - Molina Medicaid Solutions Segment

U.S. Virgin Islands and West Virginia. In 2012, Molina Medicaid Solutions of West Virginia secured a historic partnership with the United States Virgin Islands (USVI). The partnership involves processing the USVI's Medicaid claims using West Virginia's certified Medicaid management information system (MMIS). On August 1, 2013 the system went live, marking the first MMIS for a U.S. Territory, and the first to be shared between two government agencies on a single business processing platform.

Louisiana. In 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement MMIS to a different vendor, CNSI. However, in March 2013, the state of Louisiana cancelled its contract award to CNSI. CNSI is currently challenging the contract cancellation. The state has informed us that we will continue to perform under our current contract until a successor is named. At such time as a new RFP may be issued, we intend to respond to the state's RFP. For the nine months ended September 30, 2013, our revenue under the Louisiana MMIS contract was approximately $31.1 million, or 20.7% of total service revenue. So long as our Louisiana MMIS contract continues, we expect to recognize approximately $40 million of service revenue annually under this contract.

Discontinued Operations

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal on June 30, 2012. Effective June 30, 2013 the transition obligations associated with that contract terminated. Therefore, we have reclassified the results relating to the Missouri health plan to discontinued operations for all periods presented. These results are presented in a single line item, net of taxes, in the unaudited consolidated statements of operations. Additionally, we abandoned all of our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of approximately $9.5 million, which is also included in discontinued operations in the unaudited consolidated

statements of operations. The Missouri health plan's revenues amounted to $0.2 million and $113.8 million for the nine months ended September 30, 2013 and 2012, respectively.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals, or RFP, open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas.

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in “Critical Accounting Policies” below, is not generally subject to significant accounting estimates. For the nine months ended September 30, 2013, we received approximately 96% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the nine months ended September 30, 2013, we recognized approximately 4% of our premium revenue in the form of “birth income” — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children’s Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $80 PMPM in Michigan. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $270 in Ohio. Among our ABD membership, PMPM premiums range from approximately $400 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums in the aggregate, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	September 30, 2013	June 30, 2013	December 31, 2012	September 30, 2012
Total Ending Membership by Health Plan:				
California	363,000	355,000	336,000	346,000
Florida	84,000	81,000	73,000	71,000
Michigan	213,000	215,000	220,000	219,000
New Mexico	172,000	92,000	91,000	90,000
Ohio	261,000	240,000	244,000	272,000
Texas	258,000	266,000	282,000	291,000
Utah	87,000	87,000	87,000	85,000
Washington	409,000	413,000	418,000	411,000
Wisconsin	95,000	98,000	46,000	41,000
Total	1,942,000	1,847,000	1,797,000	1,826,000
Total Ending Membership for our Medicare Advantage Plans:				
California	8,600	8,100	7,700	7,300
Florida	600	600	900	900
Michigan	10,000	9,500	9,700	9,300
New Mexico	900	900	900	900
Ohio	400	400	300	200
Texas	2,500	2,300	1,500	1,100
Utah	8,200	7,800	8,200	8,300
Washington	6,900	6,600	6,500	6,100
Total	38,100	36,200	35,700	34,100
Total Ending Membership for our Aged, Blind or Disabled Population:				
California	46,300	45,400	44,700	44,100
Florida	12,200	11,200	10,300	10,300
Michigan	45,400	45,000	41,900	40,700
New Mexico	11,400	6,000	5,700	5,600
Ohio	33,000	28,000	28,200	29,000
Texas	90,800	92,000	95,900	101,300
Utah	9,500	9,400	9,000	8,900
Washington	33,000	31,700	30,000	23,400
Wisconsin	1,700	1,600	1,700	1,600
Total	283,300	270,300	267,400	264,900

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses

related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectable, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $107.0 million, and $94.6 million, for the nine months ended September 30, 2013 and 2012, respectively, as well as certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Third Quarter Financial Performance Summary, Continuing Operations

The following table and narrative briefly summarize our financial and operating performance for continuing operations for the three and nine months ended September 30, 2013 and 2012. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue, the premium tax ratio is computed as a percentage of premium revenue plus premium tax receipts because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(Dollar amounts in thousands, except per share data)			
Net income (loss) per diluted share	$ 0.16	$ (0.01)	$ 1.15	$ (0.29)
Premium revenue	$ 1,584,656	$ 1,448,600	$ 4,583,818	$ 4,066,737
Service revenue	$ 51,100	$ 48,422	$ 150,528	$ 132,351
Operating income (loss)	$ 24,926	$ 2,368	$ 139,245	$ (10,750)
Net income (loss)	$ 7,553	$ (165)	$ 53,871	$ (13,328)
Total ending membership	1,942,000	1,826,000	1,942,000	1,826,000
Premium revenue	93.9%	94.1 %	93.9%	93.8 %
Premium tax receipts	2.6%	2.4 %	2.6%	2.8 %
Service revenue	3.0%	3.1 %	3.1%	3.0 %
Investment income	0.2%	0.1 %	0.1%	0.1 %
Rental and other income	0.3%	0.3 %	0.3%	0.3 %
Total revenue	100.0%	100.0 %	100.0%	100.0 %
Medical care ratio	87.3%	91.1 %	86.5%	91.4 %
General and administrative expense ratio	10.4%	8.2 %	9.8%	8.4 %
Premium tax ratio	2.7%	2.5 %	2.7%	2.9 %
Operating income (loss)	1.5%	0.2 %	2.9%	(0.2)%
Net income (loss)	0.4%	— %	1.1%	(0.3)%
Effective tax rate	33.9%	(92.3)%	44.8%	(45.5)%

Non-GAAP Financial Measures

We use the following non-GAAP[1] financial measures as supplemental metrics in evaluating our financial performance, our financing and business decisions, and in forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in evaluating our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures.

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income (loss), which we believe to be the most comparable GAAP measure, to EBITDA.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(In thousands)			
Net income (loss)	$ 7,569	$ 3,364	$ 62,055	$ (15,853)
Adjustments:				
Depreciation and amortization reported in the consolidated statements of cash flows	24,128	20,279	68,035	58,289
Interest expense	13,532	4,315	38,236	12,421
Income tax expense (benefit)	3,962	(492)	33,745	(15,228)
EBITDA	$ 49,191	$ 27,466	$ 202,071	$ 39,629

The second of these non-GAAP measures is adjusted net income per diluted share, continuing operations. The following table reconciles net income (loss) per diluted share, which we believe to be the most comparable GAAP measure, to adjusted net income per diluted share, continuing operations.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(In thousands)			
Net income (loss) per diluted share, continuing operations	$ 0.16	$ (0.01)	$ 1.15	$ (0.29)
Adjustments, net of tax:				
Depreciation and amortization of capitalized software	0.25	0.20	0.71	0.56
Stock-based compensation	0.15	0.09	0.36	0.24
Amortization of intangible assets	0.07	0.07	0.20	0.22
Amortization of convertible senior notes and lease financing obligations	0.08	0.02	0.21	0.06
Change in fair value of derivatives	—	—	0.08	0.02
Adjusted net income per diluted share, continuing operations	$ 0.71	$ 0.37	$ 2.71	$ 0.81

[1]GAAP stands for Generally Accepted Accounting Principles.

Results of Operations, Continuing Operations

Three Months Ended September 30, 2013 Compared with the Three Months Ended September 30, 2012

Health Plans Segment

Premium Revenue

Premium revenue for the third quarter of 2013 increased 9% over the third quarter of 2012, due to a 5% increase in enrollment, and a 4% increase in revenue per member per month (PMPM). The 5% enrollment increase was primarily due to the acquisition of a contract covering approximately 80,000 members in New Mexico effective August 1, 2013.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended September 30,					
	2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 928,165	$ 161.39	67.1%	$ 913,137	$ 166.88	69.2%
Pharmacy	237,073	41.22	17.1	219,823	40.17	16.7
Capitation	162,554	28.27	11.8	142,724	26.08	10.8
Other	55,421	9.64	4.0	44,307	8.10	3.3
Total	$ 1,383,213	$ 240.52	100.0%	$ 1,319,991	$ 241.23	100.0%

Our consolidated medical care ratio decreased to 87.3% in the third quarter of 2013, from 91.1% in the third quarter of 2012. The decline in the consolidated medical care ratio was the result of improved operating results at all but one of our health plans. Medical care ratios decreased in eight of our nine health plans, while medical margin (measured as the excess of premium revenue over medical care costs) increased in the same eight of nine health plans. Medical margin improvements were most pronounced at the California, Michigan and New Mexico health plans.

Individual Health Plan Analysis

The medical care ratio at the California health plan decreased to 90.5% in the third quarter of 2013 from 96.1% in the third quarter of 2012. The lower medical care ratio was primarily the result of premium rate increases received in the first quarter of 2013.

The medical care ratio of the Florida health plan increased to 88.8% in the third quarter of 2013, from 84.0% in the third quarter of 2012 due to inpatient unit cost increases.

The medical care ratio of the Michigan health plan decreased to 82.1% in the third quarter of 2013, from 89.9% in the third quarter of 2012, primarily due to a reduction in inpatient costs.

The medical care ratio of the New Mexico health plan decreased to 85.6% in the third quarter of 2013, from 91.2% in the third quarter of 2012, primarily as a result of higher Medicaid premium rates PMPM effective January 1, 2013, and lower fee-for-service claims costs. The New Mexico health plan gained approximately 80,000 new members in the third quarter of 2013, as a result of its acquisition of Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program effective August 1, 2013.

The medical care ratio of the Ohio health plan decreased to 87.3% for the third quarter of 2013, from 89.7% for the third quarter of 2012, due to lower pharmacy and inpatient fee-for-service expense; partially offset by a combination of premium decreases and increases to fee schedules effective July 1, 2013 that combined to reduce medical margin for the third quarter by approximately 2% of premium revenue. We also experienced an additional 1.5% decrease in premium rates in Ohio effective July 1, 2013, due to a re-basing of risk adjusters.

The medical care ratio of the Texas health plan was 89.6% in the third quarter of 2013 compared with 91.9% in the third quarter of 2012 (which included the reversal of a premium deficiency reserve (PDR) of $10 million established in the second quarter of 2012). We received a blended rate increase in Texas of approximately 6%, or $6 million per month, effective September 1, 2013. In the third quarter of 2012, we received a blended rate increase of 4%, or $4.5 million per month, effective September 1, 2012; and implemented various medical cost containment initiatives in the second half of 2012.

The medical care ratio of the Utah health plan decreased to 78.7% in the third quarter of 2013, from 85.2% in the third quarter of 2012 due to both higher revenue PMPM and lower fee-for-service medical expenses PMPM.

The medical care ratio of the Washington health plan decreased to 86.3% in the third quarter of 2013, from 88.0% in the third quarter of 2012 due to higher premium revenue PMPM which was only partially offset by increased fee-for-service medical expenses PMPM.

The medical care ratio of the Wisconsin health plan decreased to 69.8% in the third quarter of 2013, from 93.5% in the third quarter of 2012 due to both higher revenue PMPM and lower fee-for-service physician expenses PMPM. Additionally, the health plan gained approximately 50,000 members in the first half of 2013 due to another health plan's recent exit from the market.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended September 30, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,076	$ 184,235	$ 171.16	$ 166,774	$ 154.93	90.5%	$ 17,461
Florida	251	67,688	269.58	60,127	239.46	88.8	7,561
Michigan	641	174,706	272.65	143,498	223.95	82.1	31,208
New Mexico	435	130,318	299.19	111,599	256.21	85.6	18,719
Ohio	786	280,964	357.66	245,148	312.07	87.3	35,816
Texas	780	320,657	411.17	287,446	368.59	89.6	33,211
Utah	261	84,525	323.83	66,555	254.98	78.7	17,970
Washington	1,234	294,808	238.96	254,430	206.23	86.3	40,378
Wisconsin	287	39,676	138.36	27,694	96.58	69.8	11,982
Other (3)	—	7,079	—	19,942	—	—	(12,863)
	5,751	$ 1,584,656	$ 275.55	$ 1,383,213	$ 240.52	87.3%	$ 201,443

	Three Months Ended September 30, 2012						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	1,041	$ 162,389	$ 156.00	$ 156,106	$ 149.96	96.1%	$ 6,283
Florida	214	57,433	268.58	48,250	225.64	84.0	9,183
Michigan	656	159,591	243.32	143,513	218.80	89.9	16,078
New Mexico	269	80,846	300.79	73,721	274.28	91.2	7,125
Ohio	805	282,489	350.63	253,447	314.58	89.7	29,042
Texas	890	344,522	387.03	316,716	355.80	91.9	27,806
Utah	256	73,484	287.21	62,630	244.79	85.2	10,854
Washington	1,217	269,191	221.28	236,928	194.76	88.0	32,263
Wisconsin	124	16,279	131.21	15,217	122.65	93.5	1,062
Other (3)	—	2,376	—	13,463	—	—	(11,087)
	5,472	$ 1,448,600	$ 264.74	$ 1,319,991	$ 241.23	91.1%	$ 128,609

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs at the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended September 30,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$ 51,829	$ 48,958
Amortization recorded as reduction of service revenue	(729)	(536)
Service revenue	51,100	48,422
Cost of service revenue	40,113	37,004
General and administrative costs	1,708	1,980
Amortization of customer relationship intangibles recorded as amortization	1,282	1,282
Operating income	$ 7,997	$ 8,156

Operating income for our Molina Medicaid Solutions segment decreased $0.2 million for the three months ended September 30, 2013, compared with the same prior year period. The decrease in operating income was primarily the result of a change in the mix of transactions processed from fee-for-service claims to managed care encounters (processing fees are lower for encounters than for fee-for-service claims) and changes to state contract revenues implemented during 2012.

Results of Operations, Continuing Operations

Nine Months Ended September 30, 2013 Compared with the Nine Months Ended September 30, 2012

Health Plans Segment

Premium Revenue

Premium revenue for the nine months ended September 30, 2013 increased 13% over the nine months ended September 30, 2012, due to both higher enrollment and higher premium revenue PMPM. Medicare premium revenue was $396.7 million for the nine months ended September 30, 2013 compared with $346.6 million for the nine months ended September 30, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Nine Months Ended September 30,					
	2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,674,785	$ 160.14	67.5%	$ 2,566,161	$ 162.76	69.1%
Pharmacy	691,903	41.42	17.4	606,004	38.44	16.3
Capitation	441,287	26.42	11.1	412,692	26.17	11.1
Other	157,859	9.45	4.0	130,598	8.28	3.5
Total	$ 3,965,834	$ 237.43	100.0%	$ 3,715,455	$ 235.65	100.0%

Our medical care ratio decreased to 86.5% in the nine months ended September 30, 2013, from 91.4% in the nine months ended September 30, 2012, primarily due to improved financial performance at our Texas health plan. The decline in the consolidated medical care ratio was the result of improved operating results at most of our health plans. Medical care ratios decreased in seven of our nine health plans, while medical margin (measured as the excess of premium revenue over medical care costs) increased in all nine health plans. Medical margin improvements were most pronounced at the Texas health plan.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Nine Months Ended September 30, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	3,132	$ 552,950	$ 176.54	$ 497,314	$ 158.78	89.9%	$ 55,636
Florida	712	187,689	263.62	161,446	226.76	86.0	26,243
Michigan	1,941	508,748	262.14	432,105	222.65	84.9	76,643
New Mexico	984	298,767	303.59	252,001	256.07	84.3	46,766
Ohio	2,234	819,879	367.03	688,266	308.11	83.9	131,613
Texas	2,417	969,063	400.90	829,854	343.31	85.6	139,209
Utah	781	236,992	303.41	193,261	247.42	81.5	43,731
Washington	3,722	892,627	239.85	779,339	209.41	87.3	113,288
Wisconsin	780	104,540	134.04	82,543	105.84	79.0	21,997
Other (3)	—	12,563	—	49,705	—	—	(37,142)
	16,703	$ 4,583,818	$ 274.43	$ 3,965,834	$ 237.43	86.5%	$ 617,984

	Nine Months Ended September 30, 2012						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	3,156	$ 486,714	$ 154.21	$ 446,694	$ 141.53	91.8%	$ 40,020
Florida	632	170,940	270.50	146,261	231.44	85.6	24,679
Michigan	1,983	480,098	242.13	419,406	211.52	87.4	60,692
New Mexico	801	240,568	300.51	208,668	260.66	86.7	31,900
Ohio	2,313	827,219	357.61	735,432	317.93	88.9	91,787
Texas	2,389	892,377	373.54	890,042	372.57	99.7	2,335
Utah	767	225,533	293.93	183,930	239.71	81.6	41,603
Washington	3,352	684,466	204.22	592,398	176.75	86.5	92,068
Wisconsin	374	52,209	139.46	54,861	146.54	105.1	(2,652)
Other (3)	—	6,613	—	37,763	—	—	(31,150)
	15,767	$ 4,066,737	$ 257.93	$ 3,715,455	$ 235.65	91.4%	$ 351,282

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) "MCR" represents medical costs as a percentage of premium revenue.
(3) "Other" medical care costs include primarily medically related administrative costs at the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Nine Months Ended September 30,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$ 152,714	$ 133,193
Amortization recorded as reduction of service revenue	(2,186)	(842)
Service revenue	150,528	132,351
Cost of service revenue	119,188	98,111
General and administrative costs	6,849	7,187
Amortization of customer relationship intangibles recorded as amortization	3,846	3,846
Operating income	$ 20,645	$ 23,207

Operating income for our Molina Medicaid Solutions segment decreased $2.6 million for the nine months ended September 30, 2013, compared with the same prior year period. The decrease in operating income was primarily the result of a change in the mix of transactions processed from fee-for-service claims to managed care encounters (processing fees are lower for encounters than for fee-for-service claims) and changes to state contract revenues implemented during 2012.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 10.4% of total revenue for the three months ended September 30, 2013, compared with 8.2% of total revenue for the three months ended September 30, 2012. General and administrative expenses increased to 9.8% of total revenue for the nine months ended September 30, 2013, compared with 8.4% of total revenue for the nine months ended September 30, 2012. The increased ratio of general and administrative expenses to total revenue for both the three months and nine months ended September 30, 2013, was primarily due to higher costs incurred as a result of our preparations for significant membership growth in 2014.

Premium Tax Expense

Premium tax expense was 2.7% of premium revenue in the three months ended September 30, 2013, compared with 2.5% in the three months ended September 30, 2012, and 2.7% of premium revenue in the nine months ended September 30, 2013, compared with 2.9% in the nine months ended September 30, 2012.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is recorded in “Depreciation and amortization” in the consolidated statements of operations. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of operations as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading “Depreciation and amortization;”
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of “Service revenue;” and
- Amortization of capitalized software is recorded within the heading “Cost of service revenue.”

The following table presents all depreciation and amortization recorded in our consolidated statements of operations, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended September 30,			
	2013		2012	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 14,237	0.8%	$ 11,352	0.7%
Amortization of intangible assets, continuing operations	4,634	0.3	4,506	0.3
Depreciation and amortization, continuing operations	18,871	1.1	15,858	1.0
Depreciation and amortization, discontinued operations	—	—	176	—
Amortization recorded as reduction of service revenue	729	—	536	0.1
Amortization of capitalized software recorded as cost of service revenue	4,528	0.3	3,709	0.2
Depreciation and amortization reported in the consolidated statements of cash flows	$ 24,128	1.4%	$ 20,279	1.3%

	Nine Months Ended September 30,			
	2013		2012	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software, continuing operations	$ 39,578	0.8%	$ 31,321	0.7%
Amortization of intangible assets, continuing operations	12,871	0.3	15,595	0.4
Depreciation and amortization, continuing operations	52,449	1.1	46,916	1.1
Depreciation and amortization, discontinued operations	2	—	530	—
Amortization recorded as reduction of service revenue	2,186	—	842	—
Amortization of capitalized software recorded as cost of service revenue	13,398	0.3	10,001	0.2
Depreciation and amortization reported in the consolidated statements of cash flows	$ 68,035	1.4%	$ 58,289	1.3%

Interest Expense

Interest expense increased to $13.5 million for the three months ended September 30, 2013, from $4.3 million for the three months ended September 30, 2012, and increased to $38.2 million for the nine months ended September 30, 2013, from $12.4 million for the nine months ended September 30, 2012 primarily due to the issuance of the 1.125% Notes in February 2013. Interest expense includes amortization of the discount on our convertible senior notes, which amounted to $6.1 million and $1.5 million for the three months ended September 30, 2013, and 2012, respectively, and $15.7 million and $4.4 million for the nine months ended September 30, 2013, and 2012, respectively. Interest expense in the nine months ended September 30, 2013, also includes the immediate recognition of approximately $6 million of interest expense relating to debt issuance costs. The remainder of the fees associated with that issuance, amounting to approximately $12 million, are being expensed over the life of the 1.125% Notes.

As described in further detail below, in "Future Sources and Uses of Liquidity – *Lease Financing Obligations*," lease payments under the sale-leaseback transactions adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations.

Other Expense

Other expense increased to $3.3 million for the nine months ended September 30, 2013, from $1.3 million for the nine months ended September 30, 2012, and was insignificant for the three months ended September 30, 2013 and 2012. Other expense includes primarily gains or losses associated with changes in the fair value of our derivative financial instruments. For the nine months ended September 30, 2012, we recorded a $1.3 million charge for the fair value of an interest rate swap derivative liability. In the second quarter of 2013 we recorded a one-time non-cash charge of $3.9 million related to warrants issued in conjunction with our convertible senior notes offering in February 2013. We settled the interest rate swap in the

second quarter of 2013, which resulted in a gain of approximately $0.4 million, partially offsetting the $3.9 million charge described above.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 33.9% for the three months ended September 30, 2013, compared with 92.3% for the three months ended September 30, 2012. The provision for income taxes in continuing operations is recorded at an effective rate of 44.8% for the nine months ended September 30, 2013, compared with 45.5% for the nine months ended September 30, 2012. The disparity between rates in the third quarters of 2013 and 2012 is primarily due to significant differences in pretax income during the applicable periods and the greater proportional impact of non-deductible expenses on lower income before taxes in 2012.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of September 30, 2013, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income was $4.9 million for the nine months ended September 30, 2013, compared with $3.9 million for the nine months ended September 30, 2012. Our annualized portfolio yield for the nine months ended September 30, 2013 was 0.4% compared with 0.5% for the nine months ended September 30, 2012.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Nine Months Ended September 30,		
	2013	2012	Change
	(In thousands)		
Net cash provided by operating activities	$ 111,744	$ 264,024	$ (152,280)
Net cash used in investing activities	(541,416)	(90,794)	(450,622)
Net cash provided by financing activities	490,458	48,423	442,035
Net increase in cash and cash equivalents	$ 60,786	$ 221,653	$ (160,867)

Operating Activities. The decrease in cash provided by operating activities was primarily due to the changes in receivables and deferred revenue, partially offset by increased net income. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may pay the following month's premium payment in advance, which we record as deferred revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In such situations, however, the acceleration or delay in payment is usually only a few days in duration, meaning that the change in cash flows in any given period is usually reversed in the next. The change in receivables and deferred revenue resulted in a use of operating cash amounting to $161.7 million in the aggregate in the nine months ended September 30, 2013, compared with a source of operating cash of $103.3 million in the aggregate in the same period in 2012. Net income increased $77.9 million year over year.

Investing Activities. The increase in cash used in investing activities was primarily due to $393.5 million increased purchases of investments in 2013, a result of increased cash generated in financing activities, described below. Additionally, we paid $57.7 million in connection with business acquisitions in the third quarter of 2013.

Financing Activities. The increase in cash provided by financing activities was primarily due to 2013 activity including $538.0 million in proceeds we received from our offering of 1.125% Notes, $158.7 million received from sale-leaseback transactions, and $75.1 million from the sale of warrants, partially offset by $149.3 million paid for the purchased call option relating to Notes, $50.0 million paid for repurchases of our common stock, $47.5 million used to repay our term loan, and $40.0 million used to repay our Credit Facility.

Financial Condition

On a consolidated basis, at September 30, 2013, we had working capital of $920.8 million compared with $521.1 million at December 31, 2012. At September 30, 2013, and December 31, 2012, we had cash and investments, including restricted investments, of $1,668.6 million, and $1,196.1 million, respectively. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

In July 2011, the Financial Accounting Standards Board (FASB) issued guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (ACA). The ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year.

The new guidance specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The new guidance is effective for annual reporting periods beginning after December 31, 2013, when the fee initially becomes effective. As enacted, this federal premium-based assessment is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this premium-based assessment will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this assessment as currently written is expected to have a material impact on our financial position, results of operations, and cash flows in future periods. We estimate that the fee in 2014 will be approximately $100.0 million.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $601.1 million at September 30, 2013, and $549.7 million at December 31, 2012. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $472.1 million and $46.9 million as of September 30, 2013, and December 31, 2012, respectively. We anticipate that we will pay the remaining balances due for our recent New Mexico and South Carolina acquisitions (approximately $64 million in total) from available cash at the parent company.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Illinois, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2013, our health plans had aggregate statutory capital and surplus of approximately $637.0 million compared with the required minimum aggregate statutory capital and surplus of approximately $362.2 million. As noted above, we anticipate that the ACA annual fee on health insurers will result in the recording of a liability of approximately $100 million spread across our all of our health plans. The liability for that fee, when recorded effective January, 2014, will reduce our aggregate statutory capital and surplus by the same amount. All of our health plans were in compliance with the minimum capital requirements at September 30, 2013. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Future Sources and Uses of Liquidity

As of September 30, 2013, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2013	2014	2015	2016	2017	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	—	187,000	—	—	—	—
	$ 737,000	$ —	$ 187,000	$ —	$ —	$ —	$ 550,000

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we settled the issuance of $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes). This transaction included the initial issuance of $450.0 million on February 11, 2013, plus the exercise of the full amount of the $100.0 million over-allotment option on February 13, 2013. The aggregate net proceeds of the 1.125% Notes were $458.9 million, after payment of the net cost of the Call Spread Overlay described below and transaction costs. Additionally, we used $50.0 million of the net proceeds to purchase shares of our common stock, and $40.0 million to repay the principal owed under our Credit Facility.

Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum, and commenced on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. Holders may convert their 1.125% Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.125% Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its 1.125% Notes in connection with such a corporate event in certain circumstances. We may not redeem the 1.125% Notes prior to the maturity date, and no sinking fund is provided for the 1.125% Notes.

If we undergo a fundamental change (as defined in the indenture to the 1.125% Notes), holders may require us to repurchase for cash all or part of their 1.125% Notes at a repurchase price equal to 100% of the principal amount of the 1.125% Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The 1.125% Notes are senior unsecured obligations, and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

The 1.125% Notes contain an embedded cash conversion option. We have determined that the embedded cash conversion option is a derivative financial instrument, required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the embedded cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount).

As noted above, the reduced carrying value on the 1.125% Notes resulted in a debt discount that is amortized to the 1.125% Notes' principal amount through the recognition of interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 1.125% Notes is 5.9%, which is imputed based on the amortization of the fair value of the embedded cash conversion option over the remaining term of the 1.125% Notes. As of September 30, 2013, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 6.3 years.

Also in connection with the settlement of the 1.125% Notes, we paid approximately $16.9 million in transaction costs. Such costs have been allocated to the 1.125% Notes, the 1.125% Call Option (defined below) and the 1.125% Warrants (defined below) according to their relative fair values. The amount allocated to the 1.125% Notes, or $12.0 million, was capitalized and will be amortized over the term of the 1.125% Notes. The aggregate amount allocated to the 1.125% Call Option and 1.125% Warrants, or $4.9 million, was recorded to interest expense in the quarter ended March 31, 2013.

1.125% Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Notes, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). These transactions represent a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call Spread Overlay. The 1.125% Call Option is a derivative financial instrument.

Until April 22, 2013, the 1.125% Warrants were recorded as a derivative liability that required mark-to-market accounting treatment due to certain terms in the 1.125% Warrants that prevented such instruments being considered to be indexed in our common stock. Effective April 22, 2013, we entered into amended and restated warrant confirmations with the Counterparties to clarify these terms, such that 1.125% Warrants are no longer considered to be derivative instruments, and have been recorded to additional paid-in capital.

Aside from the initial payment of a premium to the Counterparties of $149.3 million for the 1.125% Call Option, we will not be required to make any cash payments to the Counterparties under the 1.125% Call Option, and will be entitled to receive from the Counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional

proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

3.75% Convertible Senior Notes due 2014

We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of September 30, 2013 and December 31, 2012. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Lease Financing Obligations

On June 12, 2013, we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of two properties, including the Molina Center located in Long Beach, California, and the building that houses our Ohio health plan located in Columbus, Ohio. We sold the two properties for $158.6 million in the aggregate. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. The carrying values of these properties, including the related intangible assets, amounted to $78.3 million in the aggregate as of September 30, 2013. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The sales price of $158.6 million was recorded as a lease financing obligation, which is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. Transaction costs associated with this transaction, amounting to $3.5 million, have been deferred and will be amortized over the initial lease term.

We entered into a lease for office space in February 2013 consisting of two office buildings then under construction. We have concluded that we are the accounting owner of the construction projects because of our continuing involvement in those projects. Therefore, we have recorded $18.9 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of September 30, 2013, which represents the total cost, including imputed interest, incurred by the landlord thus far in the construction projects. As of September 30, 2013, the aggregate amounts recorded to property, equipment and capitalized software, net, for both Building A and B are recorded as a lease financing obligation of $19.2 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. In addition to the capitalization of the costs incurred by the landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was immaterial for the nine months ended September 30, 2013.

Term Loan

In December 2011, our wholly owned subsidiary, Molina Center LLC, entered into a term loan agreement with various lenders and East West Bank to borrow $48.6 million to finance a portion of the purchase price for the Molina Center, located in Long Beach, California. On June 13, 2013, we repaid the principal balance outstanding under the term loan on that date, with proceeds we received in the sale-leaseback transaction described above.

Credit Facility

On February 15, 2013, we used $40.0 million of the net proceeds from the offering of the 1.125% Notes to repay all of the outstanding indebtedness under our $170 million revolving Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the 1.125% Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution. Such direct issue letters of credit are collateralized by restricted investments.

Shelf Registration Statement

In the second quarter of 2012, we filed an automatic shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the registration, issuance, and sale of an indeterminate amount of our securities, including

common stock, preferred stock, senior or subordinated debt securities, or warrants. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Securities Repurchase Program

Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchase under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and other market conditions. This newly authorized repurchase program extends through December 31, 2014, and replaces in its entirety, the $75 million repurchase program adopted by the board of directors on February 13, 2013.

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2012, was disclosed in our 2012 Annual Report on Form 10-K. Other than the transactions relating to our February 2013 offering of the 1.125% Notes, the sale-leaseback transactions and our third quarter acquisitions discussed above, there were no material changes to this previously filed information outside the ordinary course of business during the nine months ended September 30, 2013. For further discussion and maturities of our long-term debt, see Note 11 of the accompanying Notes to the Consolidated Financial Statements.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

(1) Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract: These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates), our revenue earned for those periods will also change. In all of these instances, our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn would lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of approximately $0.8 million and $0.3 million at September 30, 2013, and December 31, 2012, respectively.

Florida Health Plan Medical Cost Floor (Minimum): A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs (in all counties except

Broward). A similar minimum expenditure is required for total health care costs in Broward county only. At both September 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit, as defined in the contract, exceed certain amounts. At both September 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

Ohio Health Plan Medical Cost Floors (Minimums): Sanctions may be levied by the state if certain minimum amounts are not spent on defined medical care costs. These sanctions include the requirements to file a corrective action plan as well as an enrollment freeze.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $2.2 million and $3.2 million pursuant to our profit-sharing agreement with the state of Texas at September 30, 2013, and December 31, 2012, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At September 30, 2013, we recorded a liability under the terms of these contract provisions of approximately $0.3 million. At December 31, 2012, we had not recorded any liability under the terms of this contract provision.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $18.4 million and $0.3 million as of September 30, 2013 and December 31, 2012, respectively for anticipated Medicare risk adjustment premiums.

(2) Quality incentives that allow us to recognize incremental revenue if certain quality standards are met: These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, incremental revenue of up to 3.25% of total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2013 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30, 2013.

	Three Months Ended September 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 906	$ 818	$ 2	$ 820	$ 130,318
Ohio	3,080	976	(52)	924	280,964
Texas	15,744	15,744	—	15,744	320,657
Wisconsin	1,209	—	—	—	39,676
	$ 20,939	$ 17,538	$ (50)	$ 17,488	$ 771,615

	Three Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 560	$ 532	$ —	$ 532	$ 80,846
Ohio	2,824	1,412	—	1,412	282,489
Texas	17,685	10,453	—	10,453	344,522
Wisconsin	419	—	246	246	16,279
	$ 21,488	$ 12,397	$ 246	$ 12,643	$ 724,136

	Nine Months Ended September 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 2,079	$ 1,685	$ 159	$ 1,844	$ 298,767
Ohio	9,049	3,115	501	3,616	819,879
Texas	47,683	47,683	5,995	53,678	969,063
Wisconsin	3,239	—	1,104	1,104	104,540
	$ 62,050	$ 52,483	$ 7,759	$ 60,242	$ 2,192,249

	Nine Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Premium Revenue Recognized
	(In thousands)				
New Mexico	$ 1,676	$ 1,350	$ 658	$ 2,008	$ 240,568
Ohio	8,222	6,810	966	7,776	827,219
Texas	41,687	30,487	—	30,487	892,377
Wisconsin	1,284	—	492	492	52,209
	$ 52,869	$ 38,647	$ 2,116	$ 40,763	$ 2,012,373

Taxes Based on Premiums

Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, included in premium tax receipts (within revenue), and premium tax expense (within expenses), in the consolidated statements of operations. Prior to the third quarter of 2013, premium tax receipts were included in premium revenue. The presentation change affected only premium revenue amounts previously reported, by reducing premium revenue for the amount now included in premium tax receipts. There is no effect on income from continuing operations, net income, or per-share amounts. This change was made to more clearly present the portion of premium revenue not available in the general operations of our health plans. All prior periods presented have been adjusted to conform to this presentation.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid Management Information System (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. While providing BPO services (which include claims payment and eligibility processing), we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software-related costs and other costs. With respect to software-related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;
- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	September 30, 2013	December 31, 2012	September 30, 2012
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 393,318	$ 377,614	$ 414,725
Capitation payable	77,051	49,066	55,314
Pharmacy	45,451	38,992	42,681
Other [1]	116,886	28,858	23,743
	$ 632,706	$ 494,530	$ 536,463

(1) "Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. As of September 30, 2013, we recorded provider payables of approximately $64.1 million for new intermediary arrangements that began in the third quarter of 2013.

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various

medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $393.3 million of our total medical claims and benefits payable of $632.7 million at September 30, 2013. Excluding amounts that we anticipate paying on behalf of capitated providers in Ohio (which we will subsequently withhold from those providers' monthly capitation payments), our IBNP liability at September 30, 2013, was $384.6 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of September 30, 2013 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding September 30, 2013, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 145,282
(4)%	96,854
(2)%	48,427
2%	(48,427)
4%	(96,854)
6%	(145,282)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of September 30, 2013 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (134,294)
(4)%	(89,529)
(2)%	(44,765)
2%	44,765
4%	89,529
6%	134,294

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 46.8 million diluted shares outstanding for the nine months ended September 30, 2013. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at September 30, 2013, net income for the nine months ended September 30, 2013 would increase or decrease by approximately $15.3 million, or $0.33 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at September 30, 2013, net income for the nine months ended September 30, 2013 would increase or decrease by approximately $14.1 million, or $0.30 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $76.3 million, or $1.63 per diluted share, and $70.5 million, or $1.51 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $15.3 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom

able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more factors are out of the ordinary.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2013 and 2012 were less than what we had expected when we had established our reserves. For example, for the year ended December 31, 2012, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2011 by 9.8%. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $54.0 million for the nine months ended September 30, 2013. This amount represents our estimate as of September 30, 2013 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012 was due primarily to the following factors:

- At our Washington health plan prior to July 2012, certain high-cost newborns that were approved for supplemental security income (SSI) coverage by the state were retroactively dis-enrolled from our Healthy Options (TANF) coverage, and the health plan was reimbursed for the claims paid on behalf of these members. Starting July 1, 2012, these newborns, as well as other high-cost disabled members, are now covered by the health plan under the Healthy Options Blind and Disabled (HOBD) program. At the end of 2012, we had limited claims history with which to estimate the claims liability of the HOBD members, and as a result the liability for these high-cost members was overstated.
- At our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.
- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to our aged, blind or disabled (ABD) members.

We recognized favorable prior period claims development in the amount of $32.6 million for the three months ended September 30, 2013. This amount represents our estimate as of September 30, 2013 of the extent to which our initial estimate of medical claims and benefits payable at June 30, 2013 was more than the amount that will ultimately be paid out in satisfaction of that liability. This amount of favorable development was considerably less than we typically experience, and was significant enough to have a materially unfavorable impact upon our third quarter financial performance. We believe the overestimation of our claims liability at June 30, 2013 was due primarily to the following factors:

- At our Ohio health plan, we overestimated the impact of several potential high-dollar claims relating to critically ill members.
- At our Michigan health plan, we underestimated the impact of future claims overpayment recoveries when establishing reserves at June 30, 2013.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Texas health plan as a result of the costs associated with an unusually large number of older claims. This anomaly was caused primarily by the payment of claims that were delayed as a result of hospital provider disputes that have been resolved. The underestimation of the liability at our Texas health plan was responsible for the relatively small amount of prior period development noted above.

We recognized favorable prior period claims development in the amount of $37.7 million and $39.3 million for the nine months ended September 30, 2012, and the year ended December 31, 2012, respectively. This was primarily caused by the overestimation of our liability claims and medical benefits at December 31, 2011, as a result of the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS, in the Dallas region.

- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

In estimating our claims liability at September 30, 2013, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- At our Texas health plan, we have noted an unusually large number of older claims dated older than 12 months. This has caused some distortion in the claims lag pattern that we use to estimate the incurred claims.
- At our Michigan health plan, there were a large number of claim recoveries recorded in June 2013 due to overpayments that resulted from a system configuration issue. These recoveries impacted the completion factors used to estimate incurred claims. While we attempted to remove this distortion from the claims data to develop a more accurate reserve estimate, this type of correction in claims data adds a degree of uncertainty for the Michigan reserves as of September 30, 2013.
- Our New Mexico health plan acquired approximately 80,000 new members in August 2013 from another health plan. This acquisition roughly doubled the size of the membership in a single month. For the September 30, 2013 reserve calculation, we have assumed that these new members will incur costs at about the same rate as the New Mexico members that were previously enrolled. With only two months of paid claims for these new members, it is too soon to know whether that assumption is correct or not.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012 and for the nine months ended September 30, 2013, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts displayed for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The following table shows the components of the change in medical claims and benefits payable from continuing and discontinued operations for the periods indicated:

	Nine Months Ended September 30,		Three Months Ended September 30,		Year Ended December 31, 2012
	2013	2012	2013	2012	
	(Dollars in thousands, except per-member amounts)				
Balances at beginning of period	$ 494,530	$ 402,476	$ 465,487	$ 525,538	$ 402,476
Components of medical care costs related to:					
Current period	4,021,461	3,860,825	1,415,670	1,361,539	5,136,055
Prior periods	(54,040)	(37,689)	(32,575)	(46,968)	(39,295)
Total medical care costs	3,967,421	3,823,136	1,383,095	1,314,571	5,096,760
Payments for medical care costs related to:					
Current period	3,410,689	3,332,896	851,025	875,236	4,649,363
Prior periods	418,556	356,253	364,851	428,410	355,343
Total paid	3,829,245	3,689,149	1,215,876	1,303,646	5,004,706
Balances at end of period	$ 632,706	$ 536,463	$ 632,706	$ 536,463	$ 494,530
Benefit from prior period as a percentage of:					
Balance at beginning of period	10.9%	9.0%	7.0%	8.9%	9.8%
Premium revenue, trailing twelve months	0.9%	0.7%	0.5%	0.8%	0.7%
Medical care costs, trailing twelve months	1.0%	0.8%	0.6%	1.0%	0.8%
Claims Data:					
Days in claims payable, fee for service	41	45	41	45	40
Number of members at end of period	1,942,000	1,826,000	1,942,000	1,826,000	1,797,000
Number of claims in inventory at end of period	137,100	163,600	137,100	163,600	122,700
Billed charges of claims in inventory at end of period	$ 257,600	$ 304,600	$ 257,600	$ 304,600	$ 255,200
Claims in inventory per member at end of period	0.07	0.09	0.07	0.09	0.07
Billed charges of claims in inventory per member at end of period	$ 132.65	$ 166.81	$ 132.65	$ 166.81	$ 142.01
Number of claims received during the period	15,751,500	15,455,000	5,227,000	5,079,200	20,842,400
Billed charges of claims received during the period	$ 15,848,900	$ 14,339,700	$ 5,371,100	$ 4,951,000	$ 19,429,300

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. *Quantitative and Qualitative Disclosures About Market Risk*

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end

management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2013 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, the following risk factor was identified by the Company during the third quarter of 2013, and is a supplement to, and should be read together with, the risk factors discussed in Part I, Item 1A - Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2012, and in Part II, Item 1A - Risk Factors, in our Quarterly Report on Form 10-Q for the quarter ended June 30, 2013. The risk factors described herein, in our 2012 Annual Report on Form 10-K, and in our third quarter report on Form 10-Q are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

If we are required to return any alleged overpayments to the Washington Healthcare Authority, our results of operations may be adversely affected.

The Washington Health Care Authority (HCA) has communicated to our Washington health plan that it believes it has erroneously overpaid the plan with regard to certain claims, including claims for psychotropic drugs, and claims for health plan members under the Washington Community Options Program Entry System (COPES). The alleged overpayments date back to the July 1, 2012 start date of the current contract. Because of the unilateral errors underlying the overpayments, HCA has indicated an intent to seek recoupment of the allegedly overpaid amounts. Our Washington health plan is seeking additional

information from HCA regarding the factual and legal bases for any potential retroactive rate recoupment. In the event our Washington health plan is required to disgorge to HCA, in the fourth quarter of 2013, rate amounts that had been previously paid to it, our results of operations in the fourth quarter of 2013 may be adversely affected.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

Issuer Purchases of Equity Securities

Common Stock Repurchase in Connection with Offering of 1.125% Cash Convertible Senior Notes Due 2020. We used a portion of the net proceeds in this offering to repurchase $50.0 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Securities Repurchase Program. Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and other market conditions. This newly authorized repurchase program extends through December 31, 2014, and replaces in its entirety, the $75 million repurchase program adopted by the board of directors on February 13, 2013.

Purchases of common stock made by or on our behalf during the quarter ended September 30, 2013, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs
July 1 - July 31	815	$ 37.89	—	$ 50,000,000
August 1 - August 31	1,969	$ 37.45	—	$ 50,000,000
September 1 - September 30	25,171	$ 34.94	—	$ 50,000,000
Total	27,955	$ 35.76	—	

(a) During the three months ended September 30, 2013, we withheld 27,955 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

Item 6. Exhibits

Exhibit No.	Title
10.1	Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: October 30, 2013

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: October 30, 2013

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

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31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Taxonomy Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.

SETTLEMENT AGREEMENT

This Settlement Agreement ("Agreement" or "Settlement Agreement") is made by and between the Department of Health Care Services ("DHCS," or the "Department") and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc. (collectively known as "Molina"). DHCS and Molina shall be referred to collectively herein as the "Parties."

WHEREAS, the Parties have entered into contracts pursuant to which Molina provides services for DHCS under the State of California's Medi-Cal program, in exchange for reimbursement by DHCS at rates that are established pursuant to the terms of said contracts and under state and federal law; and

WHEREAS, Molina filed Notices of Dispute with respect to certain rate years in connection with the rates established and paid to it by DHCS, and the parties remain in litigation with respect to these matters; and

WHEREAS, the Parties desire to resolve the pending Notices of Dispute and litigation related thereto; and

WHEREAS, DHCS agreed to contract with Molina for the Imperial County Health Plan contract and has agreed to expedite to the extent possible any DHCS or Department of Managed Health Care regulatory filings with the intent to begin enrollment by November 1, 2013; and

WHEREAS, the Parties desire to agree upon other mechanisms for enhancing the efficiency of the Medi-Cal program while ensuring compliance with DHCS and federal requirements regarding such programs;

NOW THEREFORE, in consideration of the foregoing facts and premises, and the mutual covenants and agreements contained herein, the Parties hereby agree as follows:

Section 1. MEDI-CAL CONTRACTS

(a) DHCS agrees to extend the terms of all existing Medi-Cal managed care contracts between it and Molina, defined below, for an additional five years, such that said contracts shall expire on the following schedule:

- Contract number 07-65851 (primary) and Contract number 07-65852 (secondary): Extension through December 31, 2019, for Sacramento County
- Contract number 06-55498 (primary) and Contract number 06-55503 (secondary): Extension through March 31, 2020, for Riverside and San Bernardino Counties

- Contract number 09-86161 (primary) and Contract number 09-86162 (secondary): Extension through June 30, 2020, for San Diego County

- Contract number 13-90285 (primary) and Contract number 13-90286 (secondary): Original Contract Period of five years and Extension through October 31, 2023, for Imperial County.

(b) The Department shall not be prohibited from terminating said contracts pursuant to the provisions of Exhibit E, Attachment 2, Section 14.A of Molina's Two-Plan Contracts and Exhibit E, Attachment 2, Section 13.A. of Molina's Geographic Managed Care Contracts. For purposes of this Agreement, any termination of the aforementioned contracts pursuant to a final, appeal-exhausted court order that the contract extensions set forth in this Section 1 are not enforceable, shall not result in an obligation for the Department to pay Molina a Partial Settlement payment as set forth in Attachment A if: (i) Molina enters into a new contract with the Department subsequent to the court order for the same lines of business and geographic areas and containing substantially similar terms other than the end date of the contract, and (ii) the Department expressly determines, in writing, that such a new, replacement, or future contract shall be subject to the terms or provisions of this Settlement Agreement.

(c) If the Department enters into a new, replacement, or future contract with Molina, other than the contracts set forth in Section 1.a of this Settlement Agreement (including any Medi-Cal expansions in geographic areas covered by any of those contracts), such a new, replacement, or future contract shall not be subject to the terms of Section 3 and/or 4 of this Settlement Agreement unless the Department expressly agrees, in writing, that such a new, replacement, or future contract shall be subject to the terms of Section 3 and/or 4 of this Settlement Agreement.

Section 2. SETTLEMENT ACCOUNT AGREEMENT

The Parties agree to enter into and be bound by the terms of the Settlement Account Agreement set forth in Attachment "A," which is incorporated by reference as if its terms were fully set forth herein. Any amounts payable by the Department pursuant to the terms of the Settlement Account Agreement shall be due to Molina ninety (90) days following Molina's transmittal to the Department of its final calculation of the amount payable (the "Payment Due Date"). If the Department does not pay Molina by the Payment Due Date, such non-payment shall constitute a severable breach of this Agreement such that (a) interest shall begin to accrue on the 90th calendar day following the Payment Due Date at six percent (6%) per annum and (b) notwithstanding this severable breach of the Payment Due Date, all provisions of this Agreement shall remain in full force and effect in accordance with their terms. This settlement payment is intended to pertain to and resolve the rate years and disputes covered by this Agreement as set forth in Section 5, herein.

Section 3. ADMINISTRATIVE CONTRACT MODIFICATIONS

(a) Administrative Tolerance Ranges: DHCS agrees to work with Molina in good faith to identify and implement specific operational efficiencies and, to the extent necessary, revise any contract between Molina and DHCS to reflect such operational efficiencies. The operational efficiencies may include, but not be limited to (i) the consolidation of multiple audits regularly conducted by, or on behalf of, DHCS in connection with the administration of the Medi-Cal program; (ii) methods to streamline new member mailings to achieve a reduction in mailing and material costs; and (iii) establishment of "administrative tolerance ranges" (e.g., 95 – 98%) as constituting administratively acceptable performance standards. DHCS and Molina will discuss in good faith the metrics for which 100 percent performance standards currently exist, detailed in Attachment B, to determine which, if not all, shall be subject to a determined "administrative tolerance range".

(b) Administrative Audits: DHCS agrees to define the types, purpose, and frequency of regular audits in connection with the administration of the Medi-Cal program that DHCS performs, has control over, or that are conducted on its behalf through an Inter-Agency Agreement, with the intent of limiting and consolidating duplicative and potentially burdensome plan audits and to ensure greater efficiencies for the audits that are conducted. These audits include audits performed by DHCS as well as some performed by the Department of Managed Health Care. For purposes of effectuating its obligations under this Section 3(b), DHCS agrees to create a matrix (the "Audit Matrix") in which it will identify specific, required regular Medi-Cal program audits that it performs, has control over, or that are conducted on its behalf through an Inter-Agency Agreement (such as MCR, Administration, Quality, and Financial), and will set forth a specific scheduled timetable for such regular audits. Additionally, DHCS will exercise due diligence and make good-faith reasonable efforts to coordinate the scheduling of audits with audits conducted by entities outside of DHCS' control. DHCS and Molina recognize that the audit requirements related to the duals integration project have not yet been established and are subject to federal approval and federal oversight. DHCS agrees to include the regular audits required for the duals integration project into the Audit Matrix described in this section, and to comply with the other obligations under this Section 3(b) relating to audits to the extent allowable under the duals program.

Nothing in this Agreement shall preclude DHCS from conducting a special audit of Molina in the event that significantly adverse clinical, financial, or quality indicators warrant intervention, and Molina has failed to correct the adverse situation in a timely manner.

(c) Encounter Data Submission: DHCS and Molina agree on the importance of timely and accurate reporting of encounter data, while at the same time recognize the complexities of acquiring such data. As such, DHCS and Molina will work together in good faith to develop and agree upon an "administrative tolerance range"

for submitted encounter data (less than the 100 percent currently required), to develop a mutually agreeable level of encounter submission measurement, and to adjust any penalty provisions accordingly. The encounter "administrative tolerance range" will be structured similarly to that for the performance standards described in Section 3(b) above.

(d) The Parties agree that, to the extent the Department enters into an administrative contract modification with another contracting plan, whether by contract, settlement agreement, or otherwise, Molina shall, at its option, be entitled to adopt such modifications in lieu of or in addition to the terms set forth in this Section 3.

Section 4. LIMITATION ON RETROACTIVE RATE REDUCTIONS

DHCS hereby represents that the process it follows for developing capitated rates for Managed Care Organizations participating in Medi-Cal's Two-Plan and Geographic Managed Care models is attached hereto as Attachment "C". The Department acknowledges and agrees that Molina was not involved in the creation of Attachment C and Molina does not acknowledge its accuracy or compliance with DHCS' legal and contractual obligations. DHCS agrees that any rate reductions related to (a) imposition of copayment policies, (b) elimination of covered benefits and/or services, and/or (c) future DHCS initiated provider rate reductions, shall occur prospectively only, and following CMS approval. For any rate calculation, whether retroactive or prospective, Molina reserves the right to challenge such rates or rate changes, except as otherwise set forth in Section 5 of this Settlement Agreement. The Parties further agree that nothing in this Agreement affects the obligations of the Department to calculate and pay actuarially sound rates to Molina and, other than as set forth herein, nothing in the Agreement expands or reduces DHCS' authority to implement retroactive or prospective rate reductions. The Parties further agree that, notwithstanding this Section 4, the Department shall implement retroactive rate adjustments as required by federal law, regulation, or policy and subject to the right of Molina to challenge the implementation of such rates or rate changes. The Parties further agree that, to the extent the Department agrees to any limitation on retroactive rate adjustments with another contracting plan, whether by contract, settlement agreement, or otherwise, Molina shall, at its option, be entitled to the same limitations in lieu of, or in addition to, the terms set forth in this Section 4. The parties also agree that the Duals Demonstration Project (also known as the Cal MediConnect Project) is excluded from this Section 4 of the Agreement.

Section 5. DISMISSAL OF CLAIMS

In consideration of the terms agreed to herein by the Department, Molina hereby agrees that, within thirty days following execution by the Department of this Agreement, Molina shall request and secure dismissal of the following pending actions:

- 2006-07: DHCS Office of Admin. Hearings and Appeals Case No. MC8-0707-125-DC; and
- 2007-08: DHCS Office of Admin. Hearings and Appeals Case No. MC9-1008-480-CS; and

- 2008-09: DHCS Office of Admin. Hearings and Appeals Case No. MC10-0709-063-FL; and

- 2010-11: DHCS Office of Admin. Hearings and Appeals Case Nos. MC11-0111-583-VH and MC11-0411-774-RW.

Notwithstanding the foregoing, (1) Molina's dismissal of the 2007-08 rate dispute, DHCS Office of Administrative Hearings and Appeals, Case No. MC9-1008-480-CS and 2008-09 rate dispute, DHCS Office of Administrative Hearings and Appeals, Case No. MC10-0709-063-FL, does not affect Molina's right to participate in any rate increases that the Department may issue to contracting plans should the Department not prevail in the provider litigation pertinent to the provider rate reductions; (2) Molina does not release and hereby expressly preserves any claims it has relating to rates established for the Seniors and Persons with Disabilities ("SPD") populations for rate years June 2011- December 2013 and including DHCS Office of Administrative Hearings and Appeals, Case Nos. MC13-0613-866-MO, MC14-0713-109-MO, and any other appeals that have not yet been assigned a case number; and (3) Molina does not release and hereby expressly preserves any claims it has relating to rates established for the Healthy Families populations for Phase 1 rate years January 1, 2013-March 31, 2013, Phase 2 rate years April 1, 2013-July 31, 2013, Phase 3 rate years August 1, 2013-June 30, 2014, including DHCS Office of Administrative Hearings and Appeals, Case No. MC13-0313-587-MO and any other appeals that have not yet been assigned a case number.

In consideration of the terms agreed to herein by the Molina, the Department agrees to, and within thirty days after execution of this Agreement by both Parties, shall dismiss its appeal in the 2003-04 rate dispute, Third District Court of Appeal Case No. C068724. The Parties agree to request that the Superior Court replace the judgment in Sacramento County Superior Court Case No. 34-2008-80000132 with a stipulated judgment agreed to by the parties, attached hereto as Attachment D. In exchange for the aforementioned dismissal and the other consideration set forth herein, Molina agrees that it shall not seek to enforce, or take any action to enforce the stipulated judgment in Attachment D in Sacramento County Superior Court Case No. 34-2008-80000132, provided that the Department complies with its obligations in this Agreement. Molina further agrees that, upon receipt of any payments made by the Department pursuant to the Settlement Account Agreement, as required by this Settlement Agreement during its term, Molina will promptly file with the court a Partial Satisfaction of Judgment and/or a Full Satisfaction of Judgment, as appropriate.

Section 6. LEGAL FEES AND COSTS

Each of the Parties waives any right to costs relating to any pending Notices of Dispute and related litigation dismissed pursuant to Section 5 above, and agrees that it shall bear its own attorney fees related thereto.

Section 7. AUTHORITY TO ENTER INTO AGREEMENT; ENFORCEABILITY

DHCS and Molina hereby warrant and represent to each other that they have full power and authority to enter into this Agreement, and comply with the obligations set forth herein, including but not limited to the Settlement Account Agreement and the extensions of the contracts as set forth in Section 1 (the "Medi-Cal Contracts") and no other action on the part of either party is necessary to enter into this Agreement, the Settlement Account Agreement, or the Contract Extensions as set forth in Section 1.a. This Agreement, the Settlement Account Agreement, and the Contract Extensions as set forth in 1.a, each constitute a binding obligation on each party, enforceable in accordance with the terms of each, and with the terms of this Settlement Agreement.

Section 8. NO ADMISSION

Nothing herein shall be construed as an admission by any party hereto of any liability of any kind to the other party. DHCS and Molina acknowledge that this Agreement is simply intended to resolve pending disputes, as set forth herein, without admitting any liability.

Section 9. ENTIRE AGREEMENT

This Agreement (including the Settlement Account Agreement incorporated by reference) contains the entire understanding of the Parties, and the Parties agree that there are no representations, covenants or undertakings other than those set forth herein. DHCS and Molina each acknowledge that no other party or any agent or attorney of any other party has made any promise, representation, or warranty whatsoever, express or implied, not contained herein, concerning the subject matter hereof, to induce them to execute this Agreement, and they acknowledge that they have not executed this Agreement in reliance on any such promise, representation, or warranty not specifically contained herein.

Section 10. SUCCESSORS AND ASSIGNS

This Agreement and the covenants and conditions herein contained shall apply to, be binding upon, and inure to the benefit of the respective heirs, administrators, executors, legal representatives, assigns, successors, and agents of the Parties hereto.

Section 11. SEVERABILITY

Other than as set forth in this Section 11, the provisions of this Agreement are severable, and should any provision hereof be held unenforceable for any reason, the balance of the provisions hereof shall remain in full force and effect. The Parties shall be obligated to seek to preserve the enforceability of the provisions of this Agreement, including without limitation initiating legal action if necessary. However, in the event that the Department's obligations under Section 1 or Section 2 of this Agreement are found by a court of competent jurisdiction to be unenforceable and/or invalid, in whole or in part, following exhaustion of any appeals, then the Department shall be obligated to pay to Molina a settlement payment as set forth in Attachment A. The termination of any of the contracts set forth in Section 1.a of this Agreement or any of the contract extensions identified in Section 1.a of this Agreement, for any reason, including but not limited to, a final, appeal-exhausted court order, shall result in an obligation for the Department to pay Molina a Partial

Settlement payment as set forth in Attachment A unless, upon the termination of any of the aforementioned contracts: (i) Molina enters into a new contract with the Department, subsequent to the court order or termination, for the same lines of business and containing substantially similar terms other than the end date of the contract, and (ii) the Department expressly determines, in writing, that such a new, replacement, or future contract shall be subject to the terms or provisions of this Settlement Agreement.

Such payment shall be made to Molina within ninety (90) days following the effective date of any judgment triggering this payment obligation. In the event that DHCS does not make the payment by the date it is due, such non-payment shall constitute a severable breach of this Agreement such that (a) interest shall begin to accrue on the 90th calendar day following the date such payment is due at a rate of six percent (6%) per annum and (b) notwithstanding this severable breach, all provisions of this Agreement shall remain in full force and effect in accordance with their terms.

Section 12. CONSTRUCTION

This Agreement shall in all respects be interpreted, enforced and governed by and under the laws of the State of California. This Agreement has been, and shall be deemed to have been, jointly prepared by the Parties hereto, and any uncertainty or ambiguity found to exist herein shall be interpreted under the rules of interpretation of contracts as if each of the Parties participated equally in its preparation.

Section 13. COUNTERPARTS

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Photographic and/or facsimile copies of such signed counterparts may be used in lieu of originals for any purposes.

Section 14. ENFORCEMENT

The Parties agree that any action relating to disputes, claims or controversies between them regarding the validity, enforcement, interpretation or breach of this Agreement shall be commenced in, and the Parties hereby stipulate to the jurisdiction only of, the Superior Court for the County of Sacramento.

Section 15. END OF ENTIRE SETTLEMENT AGREEMENT TERM AND TERMINATION OF COURT JURISDICTION

In addition to the right of the Department to terminate the contracts described in Section 1.a of this Settlement Agreement, under the terms set forth in Section 1, the parties agree that this entire Settlement Agreement, and all of its obligations (except for DHCS's obligation to pay Molina if payment has not yet occurred), shall fully terminate upon the earlier of the following:

(a) The arrival of December 31, 2018;

(b) The termination of all of the contracts between DHCS and Molina; whether initiated by DHCS, and/or Molina, mutually or otherwise; and/or by way of a final, appeal-exhausted court order; and/or any other circumstance.

The parties further agree that, other than as stated below, upon the occurrence of any event set forth in sub-paragraphs a. or b. in this section, above, no court will retain any jurisdiction over this Settlement Agreement, and the parties will not seek to either extend or enforce any court's jurisdiction over this Settlement Agreement beyond the time at which any of the events in sub-paragraphs a. or b. of this section have occurred. Moreover, once any of the events in subparagraphs a. and b. of this section have occurred, any new contracts between the Department and Molina, executed after any of the events in subparagraphs a. and b. of this section have occurred, shall not in any way be governed by the terms of this Settlement Agreement unless expressly agreed to in writing by the Department and Molina. Notwithstanding the foregoing, following a termination of this Settlement Agreement pursuant to this Section 15, the jurisdiction of Superior Court for the County of Sacramento as set forth in Section 14 shall remain in full force and effect for any actions, disputes, claims or controversies regarding the validity, enforcement, interpretation or breach of this Settlement Agreement to the extent they relate to any period of time in which this Settlement Agreement was in effect.

Section 16. AMENDMENT

This Agreement may be modified or amended only by a written instrument executed by all of the Parties hereto.

Section 17. PAYMENTS

The Department is obligated to make payments pursuant to this Agreement (including the Settlement Account Agreement incorporated by reference) subject to the appropriation of funds for that purpose by the State of California pursuant to normal recurring budget appropriation processes.

Section 18. PREVENTING AND RESOLVING RATE DISPUTES

The Parties agree that the current administrative and litigation processes for resolving disputes relating to rate setting is costly, burdensome, and time consuming. In order to minimize disputes and avoid litigation regarding the rate setting process to the extent possible, the Parties agree that it is in their mutual best interest to discuss options to avoid and resolve these issues. Accordingly, the Parties agree that they shall cooperate in good faith to resolve the issues described in this section.

IN WITNESS WHEREOF, the parties hereto have executed this agreement on the below stated date(s).

California Department of Health Care Services

By: /s/ Toby Douglas Date: October 30, 2013

Its: Director, California Department of Health Care Services

Molina Healthcare of California

By: /s/ Richard Chambers Date: October 30, 2013

Its: President

Molina Healthcare of California Partner Plan, Inc.

By: /s/ Richard Chambers Date: October 30, 2013

Its: President

ATTACHMENT A
SETTLEMENT ACCOUNT AGREEMENT

This Settlement Account Agreement is made a part of and incorporated into the Settlement Agreement (the "Settlement Agreement") to which it is attached. The purpose of this Settlement Account Agreement is to describe the precise manner in which the Settlement Account will operate during the term of the Settlement Agreement, and to set forth other terms and conditions of the Settlement Account. Unless otherwise defined in this Settlement Account Agreement, capitalized terms shall have the meanings set forth in the Settlement Agreement.

Explanation of Settlement Account Methodology

1. The methodology for the Settlement Account shall be based on Molina's following lines of business: direct Medi-Cal contracts (including those covering Seniors and Persons with Disabilities), Healthy Families, Dual Eligibles (both Medi-Cal and Medicare portions), and any Medi-Cal expansion populations.

2. The "Settlement Account Balance" will be established on January 1, 2014, with an initial balance of zero dollars due to Molina. This balance will be adjusted annually to reflect the calendar year settlement account "surplus" earned or "deficit" incurred by the Department. A surplus results when the Settlement Percentage is positive as described in Paragraph 6, below. A deficit results when the Settlement Percentage is negative as described in Paragraph 7, below.

3. For purposes of this Settlement Account Agreement, Profit is defined as: Premiums Earned (excluding premiums to pay for the Gross Premiums Insurance Tax, Health Insurer Fee, and any other similar assessment, hereinafter collectively referred to as the "Assessment Exclusions"), less the sum of: (i) annual medical costs incurred, and (ii) general and administrative expenses. All calculated amounts shall relate to the lines of business described above in Paragraph 1. Annual medical costs incurred includes claims for services provided and paid during the specific calendar year as well as claims for services provided during the applicable calendar year and paid by June 30 of the following calendar year (the "Run-Out Period"). In the event of the early termination of a contract, the Run-Out Period shall be the six-month period following the effective date of the termination of that contract. The calculation of Profit shall not include any other income or expenses, including but not limited to investment income or expenses. Premiums Earned shall include only those premiums paid to Molina for the months of service within the Settlement Account Agreement Term (as defined in Paragraph 9 below) and shall not include any premiums paid for months of service outside the Settlement Account Agreement Term. Because the Health Insurer Fee is non-deductible for federal and State tax purposes, it is assumed that premiums will be grossed-up by the amount of the fee to

cover tax costs. If the premium is not grossed-up to cover tax costs, the Actual Profitability Margin, as defined in Paragraph 4, below, will be adjusted accordingly.

4. The Target Profitability Margin to be utilized for purposes of calculating the surplus or deficit for a calendar year shall be three and a quarter percent (3.25%). The Actual Profitability Margin is calculated for a calendar year by taking the Profit as defined in Paragraph 3 above, divided by the total Premiums Earned.

5. The Settlement Percentage for a calendar year during the Settlement Account Agreement Term (as defined in Paragraph 9 below) shall be calculated by subtracting the Target Profitability Margin from the Actual Profitability Margin each as defined in Paragraph 4. For example, if the Actual Profitability Margin for a calendar year calculated in accordance with Paragraph 4 is 4.25 percent, then the Settlement Percentage is a positive 1 percent (4.25 percent – 3.25 percent), creating a surplus. And for example, if the Actual Profitability Margin for a calendar year calculated in accordance with Paragraph 4 is 2.25 percent, then the Settlement Percentage is a negative 1.0 percent (2.25 percent – 3.25 percent), creating a deficit.

6. If the Settlement Percentage is positive, then the Department earns a settlement surplus for that calendar year in an amount equal to fifty percent (50%) of the Settlement Percentage multiplied by the Premiums Earned for the same calendar year. For calendar year 2014 only, the amount of the Department's Settlement Percentage is seventy-five (75%) percent rather than fifty percent (50%).

7. If the Settlement Percentage is negative for any calendar year, then the Department incurs a deficit for that calendar year in an amount equal to fifty percent (50%) of the Settlement Percentage multiplied by the Premiums Earned for the same calendar year. For calendar year 2014 only, the amount of the Department's Settlement Percentage is seventy-five (75%) percent rather than fifty percent (50%).

8. The Settlement Account Balance calculation shall be performed by Molina and submitted to the Department within thirty (30) days after the end of the applicable Run-Out Period. The Department shall have sixty (60) days (the "Certification Period") to certify this calculation submitted by Molina. Once this calculation has been agreed to by the parties, that dollar amount shall be added (if positive) or subtracted (if negative) to/from the Settlement Account Balance. If there is any change in the Premiums Earned by Molina for a calendar year, the Settlement Percentage, settlement account balance, and Alternative Minimum Amount calculations shall be revised based on the final Premiums Earned attributable to that calendar year. Additionally, if Molina and the Department determine that they are unable to agree to the Settlement Account Balance calculation submitted by Molina by the end of the Certification Period, then the parties shall promptly refer the matter to an independent certified public accounting firm of nationally recognized standing as mutually agreed upon by Molina and the Department (the "Disputes Auditor") for determination of the Settlement Account Balance calculation, which determination shall be final and binding on each of Molina and the Department. Each of Molina and the Department agree that they will require the Disputes Auditor to render its determination of the Settlement Account Balance calculation within thirty (30) days after the matter is referred to

the Disputes Auditor. The fees and costs incurred for the Disputes Auditor shall be split evenly between Molina and the Department.

Terms and Conditions

9. The term of this Settlement Account Agreement is four calendar years, commencing on January 1, 2014 (" Settlement Account Agreement Term").

10. At the conclusion of the Settlement Account Agreement Term and the applicable Run-Out Period, the Settlement Account Balance shall be reconciled and settled within one hundred eighty (180) calendar days. In the event the Settlement Account Balance is in a deficit position, the Department shall remit to Molina the greater of: (i) the amount of the Settlement Account Balance, or (ii) the Alternative Minimum Amount payable under Paragraph 13. In no event shall the amount payable by the Department to Molina exceed Forty Million Dollars ($40,000,000). In the event the Settlement Account Balance is in a surplus position, then neither party shall be obligated to pay the other any monies except for the Alternative Minimum Amount payable to Molina under Paragraph 13 below and any previously paid Partial Settlement Payment.

11. If the Department terminates any of Molina's contracts for the lines of business described in Paragraph 1 prior to expiration of the Settlement Account Agreement Term or if any of the contract extensions identified in Section 1.a of the Settlement Agreement are otherwise determined to be invalid as described in Section 11 of the Settlement Agreement, then a Partial Settlement of the Settlement Account Balance shall occur as described in Paragraph 12 below. In the event Molina elects to terminate a contract for the lines of business described in Paragraph 1, Molina shall not be entitled to receive a Partial Settlement Payment with regard to such terminated contract.

12. In the event a contract identified in Section 1.a of the Settlement Agreement is terminated by the Department or otherwise determined to be invalid as described in Paragraph 11 above, the Department will make a Partial Settlement Payment to Molina. The Partial Settlement Payment will be calculated as described in this Paragraph 12. Molina shall calculate the percentage of Premiums Earned the terminated contract(s) provided for all lines of business as specified in Paragraph 1 of this Attachment A. This calculation shall be based on the last full calendar year the terminated contract was in effect. Molina shall also calculate the then-applicable Alternative Minimum Amount payable (as described in Paragraph 13 below) based on all calendar years of the Settlement Account Agreement completed prior to contract termination. The Department shall, within ninety (90) days of receiving the required calculations from Molina, make a Partial Settlement Payment to Molina equal to the percentage of Premium Earned provided by the terminated contract(s) multiplied by the Alternative Minimum Amount payable as calculated in Paragraph 13 below.

13. At the conclusion of the Settlement Account Agreement Term, the Settlement Account Balance will be reconciled and settled within one hundred eighty (180) calendar days. The amount

payable by the Department to Molina shall not be less than an Alternative Minimum Amount. The Alternative Minimum Amount shall be calculated as follows. The Alternative Minimum Amount shall be equal to Forty Million Dollars ($40,000,000), less the Alternative Minimum Credits earned up to the date of the calculation. "Alternative Minimum Credits" shall include the sum of: (i) any Partial Settlement Payments previously made pursuant to Paragraph 12, plus (ii) for each calendar year where Molina's Actual Profitability Margin was above two percent (2%), the percentage difference between Molina's Actual Profitability Margin for that calendar year and two percent (2%), multiplied by 50 percent (50%), and multiplied by the Premiums Earned, for the applicable calendar year. In no event shall the Settlement Account Percentage be negative for the purposes of this Paragraph.

14. Cash settlement of the Settlement Agreement will take place within one hundred eighty (180) days after the conclusion of the Settlement Account Agreement Term.

15. A Settlement Account Balance calculation made in accordance with Paragraph 8 shall be recalculated in the event of a change in Premiums Earned which change the value of a cash settlement after the cash settlement has occurred. The difference between the original cash settlement and the recalculated cash settlement shall result in a payment from the Department to Molina, or from Molina to the Department, and shall be due no later than ninety (90) days after payment of revised Premiums Earned is made. Interest shall be assessed on any payment required by this Paragraph at the same rate as is assessed on any revised Premiums Earned that triggered payment pursuant to this Paragraph. Interest shall accrue from the date the original cash settlement is paid.

16. Section 17 of the Settlement Agreement applies to all payments made by the Department under this Settlement Account Agreement.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2013 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 30, 2013

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2013 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 30, 2013

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2013 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 30, 2013

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2013 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 30, 2013

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended June 30, 2013

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2013
Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

Molina Healthcare, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock outstanding as of July 19, 2013, was approximately 45,684,600.

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MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2013	December 31, 2012
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 742,670	$ 795,770
Investments	718,544	342,845
Receivables	213,776	149,682
Deferred income taxes	21,995	32,443
Prepaid expenses and other current assets	47,817	28,386
Total current assets	1,744,802	1,349,126
Property, equipment, and capitalized software, net	249,298	221,443
Deferred contract costs	51,319	58,313
Intangible assets, net	68,987	77,711
Goodwill and indefinite-lived intangible assets	153,152	151,088
Derivative asset	207,123	—
Restricted investments	56,935	44,101
Auction rate securities	12,527	13,419
Other assets	35,773	19,621
	$ 2,579,916	$ 1,934,822
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 465,487	$ 494,530
Accounts payable and accrued liabilities	180,227	184,034
Deferred revenue	45,949	141,798
Income taxes payable	15,496	6,520
Current maturities of long-term debt	—	1,155
Total current liabilities	707,159	828,037
Convertible senior notes	585,825	175,468
Lease financing obligations	175,666	—
Other long-term debt	—	86,316
Derivative liabilities	207,017	1,307
Deferred income taxes	3,919	37,900
Other long-term liabilities	23,943	23,480
Total liabilities	1,703,529	1,152,508
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 45,683 shares at June 30, 2013 and 46,762 shares at December 31, 2012	46	47
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	324,360	285,524
Accumulated other comprehensive loss	(2,705)	(457)
Treasury stock, at cost; 111 shares at December 31, 2012	—	(3,000)
Retained earnings	554,686	500,200
Total stockholders' equity	876,387	782,314
	$ 2,579,916	$ 1,934,822

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
	(Amounts in thousands, except net income (loss) per share) (Unaudited)			
Revenue:				
Premium revenue	$ 1,548,612	$ 1,432,403	$ 3,083,045	$ 2,701,196
Service revenue	49,672	41,724	99,428	83,929
Investment income	1,628	1,059	3,144	2,738
Rental and other income	5,922	3,977	10,616	8,236
Total revenue	1,605,834	1,479,163	3,196,233	2,796,099
Expenses:				
Medical care costs	1,294,706	1,317,597	2,582,621	2,395,464
Cost of service revenue	39,305	30,613	79,075	61,107
General and administrative expenses	161,479	125,819	302,757	241,048
Premium tax expenses	46,883	38,354	83,883	80,540
Depreciation and amortization	17,015	16,210	33,578	31,058
Total expenses	1,559,388	1,528,593	3,081,914	2,809,217
Operating income (loss)	46,446	(49,430)	114,319	(13,118)
Other expenses:				
Interest expense	11,667	3,808	24,704	8,106
Other expense	3,502	1,086	3,371	1,086
Total other expenses	15,169	4,894	28,075	9,192
Income (loss) from continuing operations before income tax expense	31,277	(54,324)	86,244	(22,310)
Income tax expense (benefit)	15,481	(21,267)	39,926	(9,147)
Income (loss) from continuing operations	15,796	(33,057)	46,318	(13,163)
Income (loss) from discontinued operations, net of tax benefit of $9,968, $4,502, $10,143, and $5,589, respectively	8,775	(4,249)	8,168	(6,054)
Net income (loss)	$ 24,571	$ (37,306)	$ 54,486	$ (19,217)
Basic income (loss) per share				
Income (loss) from continuing operations	$ 0.35	$ (0.71)	$ 1.01	$ (0.29)
Income (loss) from discontinued operations	0.19	(0.09)	0.18	(0.13)
Basic net income (loss) per share	$ 0.54	$ (0.80)	$ 1.19	$ (0.42)
Diluted income (loss) per share				
Income (loss) from continuing operations	$ 0.34	$ (0.71)	$ 1.00	$ (0.29)
Income (loss) from discontinued operations	0.19	(0.09)	0.17	(0.13)
Diluted net income (loss) per share	$ 0.53	$ (0.80)	$ 1.17	$ (0.42)
Weighted average shares outstanding:				
Basic	45,446	46,355	45,712	46,176
Diluted	46,507	46,355	46,506	46,176

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
	(Amounts in thousands) (Unaudited)			
Net income (loss)	$ 24,571	$ (37,306)	$ 54,486	$ (19,217)
Other comprehensive (loss) income:				
Gross unrealized investment (loss) gain	(4,045)	523	(3,626)	1,001
Effect of income taxes	(1,537)	199	(1,378)	381
Other comprehensive (loss) income, net of tax	(2,508)	324	(2,248)	620
Comprehensive income (loss)	$ 22,063	$ (36,982)	$ 52,238	$ (18,597)

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2013	2012
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income (loss)	$ 54,486	$ (19,217)
Adjustments to reconcile net income (loss) to net cash (used in) provided by operating activities:		
Depreciation and amortization	43,907	38,010
Deferred income taxes	(22,155)	(1,264)
Stock-based compensation	12,150	9,812
Gain on sale of subsidiary	—	(1,747)
Amortization of convertible senior notes	9,688	2,915
Change in fair value of derivatives	3,384	1,086
Amortization of premium/discount on investments	4,298	3,615
Amortization of deferred financing costs	2,366	515
Tax deficiency from employee stock compensation	(38)	(50)
Changes in operating assets and liabilities:		
Receivables	(64,094)	6,891
Prepaid expenses and other current assets	(22,856)	(10,352)
Medical claims and benefits payable	(29,043)	123,062
Accounts payable and accrued liabilities	(16,968)	(22,982)
Deferred revenue	(95,849)	125,426
Income taxes	8,976	(19,737)
Net cash (used in) provided by operating activities	(111,748)	235,983
Investing activities:		
Purchases of equipment	(35,229)	(33,301)
Purchases of investments	(532,151)	(144,348)
Sales and maturities of investments	149,420	136,772
Proceeds from sale of subsidiary, net of cash surrendered	—	9,162
Change in deferred contract costs	6,994	(23,055)
Increase in restricted investments	(12,834)	(2,154)
Change in other non-current assets and liabilities	(8,012)	(4,383)
Net cash used in investing activities	(431,812)	(61,307)
Financing activities:		
Proceeds from issuance of 1.125% Notes, net of deferred issuance costs	537,973	—
Proceeds from sale-leaseback transactions	158,694	—
Purchase of 1.125% Notes call option	(149,331)	—
Proceeds from issuance of warrants	75,074	—
Treasury stock purchases	(50,000)	—
Repayment of amounts borrowed under credit facility	(40,000)	(10,000)
Amount borrowed under credit facility	—	60,000
Principal payments on term loan	(47,471)	(573)
Settlement of interest rate swap	(875)	—
Proceeds from employee stock plans	4,852	5,485
Excess tax benefits from employee stock compensation	1,544	3,677
Net cash provided by financing activities	490,460	58,589
Net (decrease) increase in cash and cash equivalents	(53,100)	233,265
Cash and cash equivalents at beginning of period	795,770	493,827
Cash and cash equivalents at end of period	$ 742,670	$ 727,092

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Six Months Ended June 30,	
	2013	2012
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 41,407	$ 1,074
Interest	$ 21,933	$ 4,719
Schedule of non-cash investing and financing activities:		
Retirement of treasury stock	$ 53,000	$ —
Common stock used for stock-based compensation	$ 5,669	$ 9,390
Details of change in fair value of derivatives:		
Gain on 1.125% Call Option	$ 57,792	$ —
Loss on embedded cash conversion option	(57,686)	—
Loss on 1.125% Warrants	(3,923)	—
Gain (loss) on interest rate swap	433	(1,086)
Change in fair value of derivatives	$ (3,384)	$ (1,086)
Details of sale of subsidiary:		
Decrease in carrying value of assets	$ —	$ 30,942
Decrease in carrying value of liabilities	—	(23,527)
Gain on sale	—	1,747
Proceeds from sale of subsidiary, net of cash surrendered	$ —	$ 9,162

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2013

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of June 30, 2013, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico, and Washington.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in retaining their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan, Alliance for Community Health, L.L.C., was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, the Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. On April 5, 2013, the Missouri health plan assigned its affiliate, Molina Healthcare of Illinois, Inc., substantially all of its assets and liabilities. Additionally, the Missouri health plan surrendered its certificate of authority as a health maintenance organization. The Missouri health plan's revenues amounted to $0.2 million and $113.8 million for the six months ended June 30, 2013 and 2012, respectively.

Until the second quarter of 2013, we reported the results of the Missouri health plan in continuing operations because of our continuing significant involvement in the payment of medical claims incurred on or prior to June 30, 2012, for that entity. On May 13, 2013, we abandoned our equity interests in the Missouri health plan to an unrelated entity, and assigned the Missouri health plan's surviving rights, duties and obligations (which we believe to be insignificant) to Molina Healthcare of Illinois, Inc. Effective June 30, 2013, the transition obligations associated with the Missouri health plan's contract with the state terminated. As a result of these activities, we commenced reporting the Missouri health plan as a discontinued operation as of June 30, 2013. In connection with the abandonment of our equity interests in the Missouri health plan to an unrelated entity, we recognized a $9.5 million tax benefit for the tax deduction associated with the basis of such equity interests, which is included in discontinued operations in our consolidated statement of operations. Additionally, we recognized a pretax loss of $0.5 million for the write off of the Missouri health plan's remaining assets in the second quarter of 2013.

Our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services effective March 1, 2012.

On July 3, 2013, we announced that our New Mexico health plan has entered into a definitive agreement to assume Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program. Lovelace Community Health Plan currently participates in the New Mexico Medicaid Salud! State Coverage Insurance Program and arranges for healthcare services for approximately 84,000 New Mexicans. Our New Mexico health plan serves over 92,000 Medicaid members across the state. Subject to satisfaction of customary closing conditions, we anticipate completing the transaction on August 1, 2013; the total payment to Lovelace Community Health Plan will be based on the membership transferred as of that date.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid Management Information System (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana cancelled its contract award to CNSI. CNSI is currently challenging the contract cancellation. The state has informed us that we will continue to perform under our current contract until a successor is named. At such time as a new RFP may be issued, we intend to respond to the state's RFP. For the six months ended June 30, 2013, our revenue under the Louisiana MMIS contract was approximately $20.2 million, or 20.3% of total service revenue. So long as our Louisiana MMIS contract continues, we expect to recognize approximately $40 million of service revenue annually under this contract.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2013.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2012. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2012 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2012 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2012 consolidated balance sheet, and statements of operations and cash flows to conform to the 2013 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

(1) Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract: These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change

from the amounts previously reported (due to changes in estimates), our revenue earned for those periods will also change. In all of these instances, our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn would lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of approximately $0.7 million and $0.3 million at June 30, 2013, and December 31, 2012, respectively.

Florida Health Plan Medical Cost Floor (Minimum): A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs (in all counties except Broward). A similar minimum expenditure is required for total health care costs in Broward county only. At both June 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit, as defined in the contract, exceed certain amounts. At both June 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

Ohio Health Plan Medical Cost Floors (Minimums): Sanctions may be levied by the state if certain minimum amounts are not spent on defined medical care costs. These sanctions include the requirements to file a corrective action plan as well as an enrollment freeze.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $3.9 million and $3.2 million pursuant to our profit-sharing agreement with the state of Texas at June 30, 2013, and December 31, 2012, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At June 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of this contract provision.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services, or CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $7.1 million and $0.3 million as of June 30, 2013 and December 31, 2012, respectively for anticipated Medicare risk adjustment premiums.

(2) Quality incentives that allow us to recognize incremental revenue if certain quality standards are met: These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, incremental revenue of up to 3.25% of total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2013 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2013.

	Three Months Ended June 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 588	$ 535	$ 49	$ 584	$ 86,527
Ohio	2,964	1,087	553	1,640	292,706
Texas	15,675	15,675	2,752	18,427	324,600
Wisconsin	1,269	—	495	495	37,740
	$ 20,496	$ 17,297	$ 3,849	$ 21,146	$ 741,573

	Three Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 561	$ 482	$ 630	$ 1,112	$ 82,706
Ohio	2,720	2,720	—	2,720	297,069
Texas	18,252	14,284	—	14,284	359,486
Wisconsin	449	—	246	246	18,788
	$ 21,982	$ 17,486	$ 876	$ 18,362	$ 758,049

	Six Months Ended June 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
			(In thousands)		
New Mexico	$ 1,173	$ 867	$ 157	$ 1,024	$ 172,325
Ohio	5,969	2,139	553	2,692	584,224
Texas	31,939	29,187	8,747	37,934	659,896
Wisconsin	2,030	—	1,104	1,104	64,864
	$ 41,111	$ 32,193	$ 10,561	$ 42,754	$ 1,481,309

	Six Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
			(In thousands)		
New Mexico	$ 1,116	$ 818	$ 658	$ 1,476	$ 163,932
Ohio	5,398	5,398	966	6,364	590,594
Texas	24,002	20,034	—	20,034	557,722
Wisconsin	865	—	246	246	35,930
	$ 31,381	$ 26,250	$ 1,870	$ 28,120	$ 1,348,178

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid Management Information System (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. While providing BPO services (which include claims payment and eligibility processing), we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable

evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software-related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services ;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance ;
- Costs incurred in maintaining and processing member and provider eligibility ; and
- Costs incurred in communicating with members and providers .

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets .

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes and non-deductible compensation under a provision of the Affordable Care Act that limits deductions claimed by health insurers on compensation earned after December 31, 2009 that is paid after December 31, 2012. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences

between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $10.6 million as of June 30, 2013 and December 31, 2012. Approximately $8.4 million of the unrecognized tax benefits recorded at June 30, 2013 and December 31, 2012, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.4 million as of June 30, 2013 and December 31, 2012. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.6 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of June 30, 2013, and December 31, 2012, we had accrued $75,000 and $56,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

Reclassifications Out of Accumulated Other Comprehensive Income . In February 2013, the Financial Accounting Standards Board (FASB) issued guidance for the reporting of amounts reclassified out of accumulated other comprehensive income. The new guidance requires entities to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under U.S. generally accepted accounting principles (GAAP) to be reclassified in its entirety to net income. The new guidance does not change the current requirements for reporting net income or other comprehensive income in financial statements and is effective prospectively for reporting periods beginning after December 15, 2012. The adoption of this new guidance in 2013 did not impact our financial position, results of operations or cash flows.

Balance Sheet Offsetting. In December 2011, the FASB issued guidance for new disclosure requirements related to the nature of an entity's rights of set-off and related arrangements associated with its financial instruments and derivative instruments. The new guidance is effective for annual reporting periods, and interim periods within those years, beginning on or after January 1, 2013. The adoption of this new guidance in 2013 did not impact our financial position, results of operations or cash flows.

Federal Premium-Based Assessment. In July 2011, the FASB issued guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (ACA). The ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year.

The new guidance specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The new guidance is effective for annual reporting periods beginning after December 31, 2013, when the fee initially becomes effective. As enacted, this federal premium-based assessment is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this premium-based assessment will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this assessment as currently written will have a material impact on our financial position, results of operations, or cash flows in future periods. We are currently evaluating the impact of the fee to our financial position, results of operations and cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants (AICPA), and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
	(In thousands)			
Shares outstanding at the beginning of the period	45,415	46,347	46,762	45,815
Weighted-average number of shares repurchased	—	—	(1,248)	—
Weighted-average number of shares issued	31	8	198	361
Denominator for basic net income per share	45,446	46,355	45,712	46,176
Dilutive effect of employee stock options and stock grants (1)	378	—	488	—
Dilutive effect of convertible senior notes	683	—	306	—
Denominator for diluted net income per share (2)	46,507	46,355	46,506	46,176

(1) Unvested restricted shares are included in the calculation of diluted income per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. Options to purchase common shares are included in the calculation of diluted income per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three and six months ended June 30, 2013 there were no anti-dilutive weighted restricted shares. For the three and six months ended June 30, 2013 there were approximately 60,000 and 42,800 anti-dilutive weighted options, respectively. Potentially dilutive unvested restricted shares and stock options were not included in the computation of diluted loss per share for the three and six months ended June 30, 2012, because to do so would have been anti-dilutive.

(2) Potentially dilutive shares issuable pursuant to our 1.125% Warrants (defined in Note 10, "Long-Term Debt") were not included in the computation of diluted income per share for the three and six month period ended June 30, 2013, because to do so would have been anti-dilutive. Potentially dilutive shares issuable pursuant to our 3.75% Notes (defined in Note 10, "Long-Term Debt") were not included in the computation of diluted loss per share for the three and six month period ended June 30, 2012, because to do so would have been anti-dilutive.

4. Stock-Based Compensation

At June 30, 2013, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan; and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

In March 2013, our named executive officers were granted restricted stock awards with performance conditions as follows: our chief executive officer was awarded 186,858 shares, our chief financial officer was awarded 93,429 shares, our chief operating officer was awarded 62,286 shares, our chief accounting officer was awarded 28,029 shares, and our general counsel was awarded 21,800 shares. These awards were apportioned into four equal increments, and will vest in accordance with the following four measures: (i) 1/4th will vest in equal 1/3rd increments over three years on March 1, 2014, March 1, 2015, and March 1, 2016; (ii) 1/4th will vest upon our achievement of three-year Total Stockholder Return as determined by Institutional Shareholder Services Inc. (ISS) calculations for the three-year period ending December 31, 2013 equal to or greater than the 50th percentile within our ISS peer group; (iii) 1/4th shall vest upon our achievement of total revenue in any of the 2013, 2014, or 2015 fiscal years equal to or greater than $12 billion; and (iv) 1/4th shall vest upon our achievement of the three-year earnings before interest, taxes, depreciation and amortization (EBITDA) margin percentage for the three-year period ending December 31, 2013 equal to or greater than 2.5%. In the event the vesting conditions are not achieved, the awards shall lapse. As of June 30, 2013, such performance goals have not yet been met, but we do expect the awards to vest in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three month and six month periods ended June 30, 2013 and 2012:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
	(In thousands)			
Restricted stock and performance awards	$ 7,111	$ 4,452	$ 10,959	$ 8,850
Employee stock purchase plan and stock options	618	694	1,191	962
	$ 7,729	$ 5,146	$ 12,150	$ 9,812

As of June 30, 2013, there was $35.2 million of total unrecognized compensation expense related to unvested restricted share awards, which we expect to recognize over a remaining weighted-average period of 1.9 years. Also as of June 30, 2013,

there was $0.7 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.5 years.

Restricted stock activity for the six months ended June 30, 2013 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2012	986,577	$ 23.74
Granted	1,038,880	31.53
Vested	(495,221)	23.64
Forfeited	(21,751)	26.63
Unvested balance as of June 30, 2013	1,508,485	29.10

The total fair value of restricted stock and stock unit awards, including those with performance conditions, granted during the six months ended June 30, 2013 and 2012 was $33.1 million and $22.4 million, respectively. The total fair value of restricted stock and stock unit awards vested during the six months ended June 30, 2013 and 2012 was $16.2 million and $23.6 million, respectively.

Stock option activity for the six months ended June 30, 2013 is summarized below:

	Options	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Outstanding as of December 31, 2012	414,061	$ 22.39		
Granted	45,000	33.02		
Exercised	(54,500)	17.93		
Forfeited	(300)	17.63		
Outstanding as of June 30, 2013	404,261	24.18	$ 5,255	3.8
Stock options exercisable and expected to vest as of June 30, 2013	404,261	24.18	$ 5,255	3.8
Exercisable as of June 30, 2013	349,261	22.74	$ 5,045	2.9

The weighted-average grant date fair value per share of stock options awarded to the new members of our board of directors during the six months ended June 30, 2013 was $14.67. The weighted-average grant date fair value per share of the stock option awarded to the director appointed during 2012 was $13.97. To determine the fair values of these stock options we applied risk-free interest rates of 1.1% to 1.4%, expected volatilities of 41.3% to 43.0%, dividend yields of 0%, and expected lives of 6 years to 7 years.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, a derivative asset, trade accounts payable, medical claims and benefits payable, long-term debt, a derivative liability, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Our investments classified as Level 2 are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.
- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* Our Level 3 financial instruments recorded at fair value include non-current auction rate securities that are designated as available-for-sale, and are reported at fair value of $12.5 million (par value of $13.4 million) as of June 30, 2013. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants including global financial institutions, hedge funds, private equity funds, mutual funds, corporations and other institutional investors. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from two other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of June 30, 2013.

  Additionally, Level 3 financial instruments include derivative financial instruments comprising the 1.125% Call Option asset, and the embedded cash conversion option liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of June 30, 2013 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 10, “Long-Term Debt,” and Note 11, “Derivative Financial Instruments,” the 1.125% Call Option asset and the embedded cash conversion option liability were designed such that changes in their fair values would offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

Our financial instruments measured at fair value on a recurring basis at June 30, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
	(In thousands)			
Corporate debt securities	$ 463,723	$ —	$ 463,723	$ —
GSEs	84,101	84,101	—	—
Municipal securities	105,936	—	105,936	—
U.S. treasury notes	26,495	26,495	—	—
Certificates of deposit	38,289	—	38,289	—
Auction rate securities	12,527	—	—	12,527
1.125% Call Option derivative asset	207,123	—	—	207,123
Total assets measured at fair value on a recurring basis	$ 938,194	$ 110,596	$ 607,948	$ 219,650
Embedded cash conversion option derivative liability	$ 207,017	$ —	$ —	$ 207,017

Our financial instruments measured at fair value on a recurring basis at December 31, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 191,008	$ —	$ 191,008	$ —
GSEs	29,525	29,525	—	—
Municipal securities	75,848	—	75,848	—
U.S. treasury notes	35,740	35,740	—	—
Certificates of deposit	10,724	—	10,724	—
Auction rate securities	13,419	—	—	13,419
Total assets measured at fair value on a recurring basis	$ 356,264	$ 65,265	$ 277,580	$ 13,419
Interest rate swap derivative liability	$ 1,307	$ —	$ 1,307	$ —

The following tables present activity relating to our assets (liabilities) measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments for the Six Months Ended June 30, 2013		
	Total	Auction Rate Securities	Derivatives, Net
		(In thousands)	
Balance at December 31, 2012	$ 13,419	$ 13,419	$ —
Net unrealized gains included in other comprehensive income	358	358	—
Net unrealized gains (losses) included in other expense	(3,817)	—	(3,817)
Issuances	(75,074)	—	(75,074)
Settlements and derivative redesignation	77,747	(1,250)	78,997
Balance at June 30, 2013	$ 12,633	$ 12,527	$ 106
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at June 30, 2013	$ 290	$ 290	$ —

	Changes in Level 3 Instruments for the Year Ended December 31, 2012		
	Total	Auction Rate Securities	Derivatives, Net
		(In thousands)	
Balance at December 31, 2011	$ 16,134	$ 16,134	$ —
Net unrealized gains included in other comprehensive income	1,635	1,635	—
Settlements	(4,350)	(4,350)	—
Balance at December 31, 2012	$ 13,419	$ 13,419	$ —
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at December 31, 2012	$ 1,059	$ 1,059	$ —

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our long-term debt, as well as the applicable fair value hierarchy tiers, are contained in the tables below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. As described in greater detail Note 10, "Long-Term Debt," we recorded lease financing obligations in connection with sale-leaseback transactions executed in the first half of 2013. The lease financing obligations are classified as Level 3 financial instruments because certain inputs used to determine their fair value are unobservable. At June 30, 2013, the carrying amount of the lease financing obligations approximate their fair value because of the short period of time between the origination of the obligations in 2013, and June 30, 2013. The credit facility was repaid and terminated effective February 15, 2013, and the term loan was repaid on June 13, 2013.

	June 30, 2013				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
1.125% Notes	$ 407,215	$ 608,416	$ —	$ 608,416	$ —
3.75% Notes	178,610	242,466	—	242,466	—
Lease financing obligations	175,666	175,666	—	—	175,666
	$ 761,491	$ 1,026,548	$ —	$ 850,882	$ 175,666

	December 31, 2012				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
3.75% Notes	$ 175,468	$ 208,460	$ —	$ 208,460	$ —
Term loan	47,471	47,471	—	—	47,471
Credit facility	40,000	40,000	—	—	40,000
	$ 262,939	$ 295,931	$ —	$ 208,460	$ 87,471

6. Investments

The following tables summarize our investments as of the dates indicated:

	June 30, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 465,943	$ 215	$ 2,436	$ 463,722
GSEs	84,310	9	218	84,101
Municipal securities	106,933	103	1,100	105,936
U.S. treasury notes	26,557	11	72	26,496
Certificates of deposit	38,291	3	5	38,289
Subtotal - current investments	722,034	341	3,831	718,544
Auction rate securities	13,400	—	873	12,527
	$ 735,434	$ 341	$ 4,704	$ 731,071

	December 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 190,545	$ 528	$ 65	$ 191,008
GSEs	29,481	45	1	29,525
Municipal securities	75,909	185	246	75,848
U.S. treasury notes	35,700	42	2	35,740
Certificates of deposit	10,715	9	—	10,724
Subtotal - current investments	342,350	809	314	342,845
Auction rate securities	14,650	—	1,231	13,419
	$ 357,000	$ 809	$ 1,545	$ 356,264

The contractual maturities of our investments as of June 30, 2013 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 348,784	$ 348,700
Due one year through five years	373,250	369,844
Due after ten years	13,400	12,527
	$ 735,434	$ 731,071

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Net realized investment gains for the three months ended June 30, 2013, and 2012 were $48,000 and $174,000, respectively. Net realized investment gains for the six months ended June 30, 2013, and 2012 were $142,000 and $238,000, respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at June 30, 2013, and December 31, 2012, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of June 30, 2013.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 349,918	$ 2,436	158	$ —	$ —	—
Municipal securities	82,592	1,100	100	—	—	—
GSEs	70,453	218	27	—	—	—
U.S. treasury notes	20,720	72	17	—	—	—
Certificates of deposit	4,743	5	19	—	—	—
Auction rate securities	—	—	—	12,527	873	18
	$ 528,426	$ 3,831	321	$ 12,527	$ 873	18

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2012.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 44,457	$ 65	23	$ —	$ —	—
Municipal securities	35,223	246	43	—	—	—
GSEs	5,004	1	1	—	—	—
U.S. treasury notes	4,511	2	5	—	—	—
Auction rate securities	—	—	—	13,419	1,231	21
	$ 89,195	$ 314	72	$ 13,419	$ 1,231	21

Auction Rate Securities

Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since

early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 18 years to 34 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at June 30, 2013. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $68.7 million of these instruments at par value.

For the six months ended June 30, 2013, and 2012, we recorded pretax unrealized gains of $0.4 million and $1.0 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

7. Receivables

Receivables consist primarily of amounts due from the various states in which we operate. Accounts receivable were as follows:

	June 30, 2013	December 31, 2012
	(In thousands)	
Health Plans segment:		
California	$ 94,479	$ 28,553
Florida	1,277	953
Michigan	11,087	12,873
New Mexico	11,720	9,059
Ohio	37,103	40,980
Texas	4,647	7,459
Utah	4,507	3,359
Washington	15,292	17,587
Wisconsin	16,332	4,098
Other	852	2,177
Total Health Plans segment	197,296	127,098
Molina Medicaid Solutions segment	16,480	22,584
	$ 213,776	$ 149,682

8. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with the Molina Medicaid Solutions segment contracts with the states of Maine and Idaho, we maintain restricted investments as collateral for letters of credit. The

following table presents the balances of restricted investments:

	June 30, 2013	December 31, 2012
	(In thousands)	
California	$ 373	$ 373
Florida	8,492	5,738
Michigan	1,014	1,014
New Mexico	15,917	15,915
Ohio	9,081	9,082
Texas	3,500	3,503
Utah	3,314	3,126
Washington	151	151
Other	4,792	5,199
Total Health Plans segment	46,634	44,101
Molina Medicaid Solutions segment	10,301	—
	$ 56,935	$ 44,101

The contractual maturities of our held-to-maturity restricted investments as of June 30, 2013 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 52,694	$ 52,697
Due one year through five years	4,241	4,238
	$ 56,935	$ 56,935

9. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts displayed for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The following table shows the components of the change in medical claims and benefits payable from continuing and discontinued operations as of the periods indicated:

	Six Months Ended June 30, 2013	Three Months Ended June 30, 2013	Year Ended Dec. 31, 2012
		(Dollars in thousands)	
Balances at beginning of period	$ 494,530	$ 491,145	$ 402,476
Components of medical care costs related to:			
Current period	2,647,083	1,345,592	5,136,055
Prior periods	(62,757)	(50,020)	(39,295)
Total medical care costs	2,584,326	1,295,572	5,096,760
Payments for medical care costs related to:			
Current period	2,206,474	940,186	4,649,363
Prior periods	406,895	381,044	355,343
Total paid	2,613,369	1,321,230	5,004,706
Balances at end of period	$ 465,487	$ 465,487	$ 494,530
Benefit from prior period as a percentage of:			
Balance at beginning of period	12.7%	10.2%	9.8%
Premium revenue, trailing twelve months	1.0%	0.8%	0.7%
Medical care costs, trailing twelve months	1.2%	1.0%	0.8%

Assuming that our initial estimate of claims incurred but not paid (IBNP) is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2013 and 2012 were less than what we had expected when we had established our reserves. For example, for the year ended December 31, 2012, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2011 by 9.8%. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $62.8 million for the six months ended June 30, 2013. This amount represents our estimate, as of June 30, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012 was due primarily to the following factors:

- At our Texas health plan, STAR+PLUS (the state's program for ABD members) membership declined during mid– to late– 2012. This caused a reduction in costs per member that we did not fully recognize in our December 31, 2012 reserve estimates.
- At our Washington health plan, prior to July 2012, certain high-cost newborns that were approved for supplemental security income (SSI) coverage by the state were retroactively dis-enrolled from our Healthy Options (TANF) coverage, and the health plan was reimbursed for the claims paid on behalf of these members. Starting July 1, 2012, these newborns, as well as other high-cost disabled members, are now covered by the health plan under the Healthy Options Blind and Disabled (HOBD) program. At the end of 2012, we had limited claims history with which to estimate the claims liability of the HOBD members, and as a result the liability for these high-cost members was overstated.
- For our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.

We recognized favorable prior period claims development in the amount of $50.0 million for the three months ended June 30, 2013. This amount represents our estimate as of June 30, 2013, of the extent to which our initial estimate of medical claims and benefits payable at March 31, 2013 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at March 31, 2013 was due primarily to the following factors:

- At our Washington health plan, we had limited claims history with which to estimate the incurred claims for members enrolled in the HOBD program. Because claims on this group of members were being paid at a rate faster than expected, the reserves for unpaid claims were overstated.
- At our Ohio and New Mexico health plans, we overestimated the impact of several potential high-dollar claims on critically ill members.

We recognized favorable prior period claims development in the amount of $36.4 million and $39.3 million for the six months ended June 30, 2012, and the year ended December 31, 2012, respectively. This was primarily caused by the overestimation of our liability claims and medical benefits at December 31, 2011, as a result of the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS, in the Dallas region.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

In estimating our claims liability at June 30, 2013, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- In our Texas health plan, we have noted an unusually large number of claims with incurred dates older than 10 months. This has caused some distortion in the claims lag pattern that we use to estimate the incurred claims.
- Our Wisconsin health plan is experiencing significant membership increases, and approximately doubled in size during the first four months of 2013. This new membership is transitioning to our health plan from a terminated health plan. We enrolled approximately 50,000 new members in February, March and April 2013. We have computed a separate reserve analysis for these members and have noted that paid claims thus far are less than what we would expect for newly transitioned members. It has been our experience that when members move to new health plans, there is a delay in the submission of claims for payment. Therefore, we have increased the reserves for this membership, in anticipation of higher claims costs eventually being reported for these members.
- In our Michigan health plan, there were a large number of claim recoveries recorded in June 2013 due to overpayments that resulted from a system configuration issue. These recoveries impacted the completion factors used to estimate incurred claims. While we have attempted to remove this distortion from the claims data to develop a more accurate reserve estimate, this type of correction in claims data adds a degree of uncertainty for the Michigan reserves as of June 30, 2013.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012, and for the six months ended June 30, 2013, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

10. Long-Term Debt

As of June 30, 2013, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2013	2014	2015	2016	2017	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	—	187,000	—	—	—	—
	$ 737,000	$ —	$ 187,000	$ —	$ —	$ —	$ 550,000

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we settled the issuance of $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes). This transaction included the initial issuance of $450.0 million on February 11, 2013, plus the exercise of the full amount of the $100.0 million over-allotment option on February 13, 2013. The aggregate net proceeds of the 1.125% Notes were $458.9 million, after payment of the net cost of the Call Spread Overlay described below and in Note 11, "Derivative Financial Instruments," and transaction costs. Additionally, we used $50.0 million of the net proceeds to purchase shares of our common stock (see Note 12, "Stockholders' Equity"), and $40.0 million to repay the principal owed under our Credit Facility.

Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum commencing on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. Holders may convert their 1.125% Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.125% Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its 1.125% Notes in connection with such a corporate event in certain circumstances. We may not redeem the 1.125% Notes prior to the maturity date, and no sinking fund is provided for the 1.125% Notes.

If we undergo a fundamental change (as defined in the indenture to the 1.125% Notes), holders may require us to repurchase for cash all or part of their 1.125% Notes at a repurchase price equal to 100% of the principal amount of the 1.125% Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The 1.125% Notes are senior unsecured obligations, and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

The 1.125% Notes contain an embedded cash conversion option. We have determined that the embedded cash conversion option is a derivative financial instrument, required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the embedded cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance

discount). For further discussion of the derivative financial instruments relating to the 1.125% Notes, refer to Note 11, "Derivative Financial Instruments."

As noted above, the reduced carrying value on the 1.125% Notes resulted in a debt discount that is amortized to the 1.125% Notes' principal amount through the recognition of interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 1.125% Notes is 5.9%, which is imputed based on the amortization of the fair value of the embedded cash conversion option over the remaining term of the 1.125% Notes. As of June 30, 2013, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 6.5 years. The 1.125% Notes' if-converted value did not exceed their principal amount as of June 30, 2013.

Also in connection with the settlement of the 1.125% Notes, we paid approximately $16.9 million in transaction costs. Such costs have been allocated to the 1.125% Notes, the 1.125% Call Option (defined below) and the 1.125% Warrants (defined below) according to their relative fair values. The amount allocated to the 1.125% Notes, or $12.0 million, was capitalized and will be amortized over the term of the 1.125% Notes. The aggregate amount allocated to the 1.125% Call Option and 1.125% Warrants, or $4.9 million, was recorded to interest expense in the quarter ended March 31, 2013.

1.125% Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Notes, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). These transactions represent a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call Spread Overlay. The 1.125% Call Option is a derivative financial instrument. Until April 22, 2013, the 1.125% Warrants were classified as derivative financial instruments; refer to Note 11, "Derivative Financial Instruments" for further discussion.

Aside from the initial payment of a premium to the Counterparties of $149.3 million for the 1.125% Call Option, we will not be required to make any cash payments to the Counterparties under the 1.125% Call Option, and will be entitled to receive from the Counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

3.75% Convertible Senior Notes due 2014

We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of June 30, 2013 and December 31, 2012, respectively. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Because the 3.75% Notes have cash settlement features, we have allocated the proceeds from their issuance between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that is amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms had been issued. The effective interest rate

of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. As of June 30, 2013, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 15 months. As of June 30, 2013, the 3.75% Notes' if-converted value exceeded their principal amount by approximately $46 million. The 3.75% Notes' if-converted value did not exceed their principal amount as of December 31, 2012. At June 30, 2013, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million.

The principal amounts, unamortized discount and net carrying amounts of the 1.125% Notes and 3.75% Notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
June 30, 2013:			
1.125% Notes	$ 550,000	$ 142,785	$ 407,215
3.75% Notes	187,000	8,390	178,610
	$ 737,000	$ 151,175	$ 585,825
December 31, 2012:			
3.75% Notes	$ 187,000	$ 11,532	$ 175,468

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
		(In thousands)		
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate	$ 3,300	$ 1,753	$ 5,827	$ 3,506
Amortization of the discount	5,965	1,472	9,688	2,915
Total interest cost recognized	$ 9,265	$ 3,225	$ 15,515	$ 6,421

Lease Financing Obligations

On June 12, 2013 we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of two properties, including the Molina Center located in Long Beach, California, and the building that houses our Ohio health plan located in Columbus, Ohio. We sold the two properties for $158.6 million in the aggregate. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. The carrying values of these properties, including the related intangible assets, amounted to $78.8 million in the aggregate as of June 30, 2013. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The sales price of $158.6 million was recorded as a lease financing obligation, which is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. Transaction costs associated with this transaction, amounting to $3.5 million, have been deferred and will be amortized over the initial lease term. Future minimum rental income on noncancelable leases from third party tenants of these properties, as reported in our December 31, 2012 Form 10-K, is now considered to be sublease rental income, and continues to be reported in rental income in our consolidated statements of operations. The future minimum rental income previously reported as of December 31, 2012 is consistent with our expected sublease rental income as of June 30, 2013. For information regarding the future minimum lease obligation, refer to Note 14, “Commitments and Contingencies.”

As described and defined in further detail in Note 15, "Related Party Transactions," we entered into a lease for office space in February 2013 consisting of two office buildings then under construction. We have concluded that we are the accounting owner of the construction projects because of our continuing involvement in those projects. Therefore, we have recorded $17.0 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of June 30, 2013, which represents the total cost, including imputed interest, incurred by the Landlord thus far in the construction projects. As of June 30, 2013, the aggregate amounts recorded to property, equipment and capitalized software, net, for both Building A and B are also recorded as a corresponding lease financing obligation of $17.0 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. In addition to the capitalization of the costs incurred by the Landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land

and our incremental borrowing rate, and was immaterial for the six months ended June 30, 2013. For information regarding the future minimum lease obligation, refer to Note 14, “Commitments and Contingencies.”

Term Loan

In December 2011, our wholly owned subsidiary, Molina Center LLC, entered into a term loan agreement with various lenders and East West Bank to borrow $48.6 million to finance a portion of the purchase price for the Molina Center, located in Long Beach, California. On June 13, 2013, we repaid the principal balance outstanding under the term loan on that date with proceeds we received in the sale-leaseback transaction described above.

Credit Facility

On February 15, 2013, we used approximately $40.0 million of the net proceeds from the offering of the 1.125% Notes to repay all of the outstanding indebtedness under our $170 million revolving Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the 1.125% Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution. Such direct issue letters of credit are collateralized by restricted investments.

11. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	June 30, 2013
		(In thousands)
Derivative asset:		
1.125% Call Option	Non-current assets: Derivative asset	$ 207,123
Derivative liability:		
Embedded cash conversion option	Non-current liabilities: Derivative liability	$ 207,017

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of operations, in other expense. The following table summarizes the gains (losses) recorded in the periods presented:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
	(In thousands)			
Derivative gains (losses):				
1.125% Call Option	$ 59,738	$ —	$ 57,792	$ —
Embedded cash conversion option	(59,708)	—	(57,686)	—
1.125% Warrants	(3,923)	—	(3,923)	—
Interest rate swap	390	(1,086)	433	(1,086)
	$ (3,503)	$ (1,086)	$ (3,384)	$ (1,086)

1.125% Notes Call Spread Overlay

As described in Note 10, "Long-Term Debt," we entered into a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the debentures was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes.

The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to the cash settlement features until the 1.125% Call Option settles or expires. The 1.125% Call Option is measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, "Fair Value Measurements."

Until April 22, 2013, the 1.125% Warrants were recorded as a derivative liability that required mark-to-market accounting treatment due to certain terms in the 1.125% Warrants that prevented such instruments being considered to be indexed in our common stock. Effective April 22, 2013, we entered into amended and restated warrant confirmations with the Counterparties to clarify these terms, such that 1.125% Warrants are no longer considered to be derivative instruments, and have been recorded to additional paid-in capital. For the six months ended June 30, 2013, we recorded a loss of $3.9 million for the change in fair value of the 1.125% Warrants from February 15, 2013 to April 22, 2013.

Embedded Cash Conversion Option

The embedded cash conversion option within the 1.125% Notes is required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the cash conversion option settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). The embedded cash conversion option is measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the embedded cash conversion option, refer to Note 5, "Fair Value Measurements."

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, with an effective date of March 1, 2013. On June 14, 2013, we settled the interest rate swap for $0.9 million.

12. Stockholders' Equity

Stockholders' equity increased $94.1 million during the six months ended June 30, 2013. The increase was primarily due to the $79.0 million reclassification of the 1.125% Warrants to additional paid-in capital, net income of $54.5 million, and $11.3 million related to employee stock transactions, partially offset by $50.0 million in repurchases of our common stock, as described in further detail below.

Common Shares Authorized. On May 1, 2013, our stockholders approved an amendment to our certificate of incorporation to increase the number of authorized shares of our common stock from 80,000,000 to 150,000,000.

1.125% Warrants. As described in Note 11, "Derivative Financial Instruments," we reclassified the 1.125% Warrants to additional paid-in capital during the second quarter of 2013, resulting in a $79.0 million increase to stockholders' equity. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants.

Securities Repurchases and Repurchase Program. In connection with the issuance and settlement of the 1.125% Notes, we used a portion of the net proceeds from the offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or the 3.75% Notes, in addition to the $50 million repurchase discussed above. The repurchase program extends through December 31, 2014.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the SEC covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with the plans described in Note 4, "Stock-Based Compensation," we issued approximately 546,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the six months ended June 30, 2013.

13. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and also includes our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
	(In thousands)			
Revenue from continuing operations:				
Health Plans:				
Premium revenue	$ 1,548,612	$ 1,432,403	$ 3,083,045	$ 2,701,196
Investment income	1,628	1,059	3,144	2,738
Rental and other income	5,922	3,977	10,616	8,236
Molina Medicaid Solutions:				
Service revenue	49,672	41,724	99,428	83,929
	$ 1,605,834	$ 1,479,163	$ 3,196,233	$ 2,796,099
Depreciation and amortization reported in the consolidated statements of cash flows:				
Health Plans	$ 15,685	$ 15,104	$ 30,922	$ 28,847
Molina Medicaid Solutions	6,423	4,567	12,985	9,163
	$ 22,108	$ 19,671	$ 43,907	$ 38,010
Operating income (loss) from continuing operations:				
Health Plans	$ 40,151	$ (56,072)	$ 101,671	$ (28,169)
Molina Medicaid Solutions	6,295	6,642	12,648	15,051
Total operating income (loss) from continuing operations	46,446	(49,430)	114,319	(13,118)
Interest expense	(11,667)	(3,808)	(24,704)	(8,106)
Other expense	(3,502)	(1,086)	(3,371)	(1,086)
Income (loss) from continuing operations before income taxes	$ 31,277	$ (54,324)	$ 86,244	$ (22,310)

	June 30, 2013	December 31, 2012
	(In thousands)	
Goodwill and intangible assets, net:		
Health Plans	$ 137,071	$ 139,710
Molina Medicaid Solutions	85,068	89,089
	$ 222,139	$ 228,799
Total assets:		
Health Plans	$ 2,376,308	$ 1,702,212
Molina Medicaid Solutions	203,608	232,610
	$ 2,579,916	$ 1,934,822

14. Commitments and Contingencies

Sale-Leaseback Transactions

As described in Note 10, "Long-Term Debt," we entered into sale-leaseback transactions that have been classified as lease financing obligations. For the sale-leaseback transaction entered into in June 2013, the initial lease term is 25 years, with five five-year renewal options. For the sale-leaseback transaction relating to the construction project completed in June 2013, the initial lease term is 11.5 years, with two five-year renewal options. We expect minimum lease payments under these leases, for the six months ended December 31, 2013, to be $6.6 million. Future minimum lease payments due under these leases beginning January 1, 2014 are as follows:

	(In thousands)
2014	$ 14,395
2015	18,277
2016	18,877
2017	19,496
2018	20,137
Thereafter	385,813
Total minimum lease payments	$ 476,995

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance,

interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $607.5 million at June 30, 2013, and $549.7 million at December 31, 2012. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $527.8 million and $46.9 million as of June 30, 2013, and December 31, 2012, respectively.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2013, our health plans had aggregate statutory capital and surplus of approximately $627.7 million compared with the required minimum aggregate statutory capital and surplus of approximately $363.2 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2013. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

As described in Note 2, "Significant Accounting Policies," the ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year. If the fee assessment is enacted as written, our minimum capitalization requirements will increase significantly on January 1, 2014; we are currently evaluating the impact of the fee assessment to our financial position, results of operations and cash flows.

15. Related Party Transactions

Leased Office Buildings

On February 27, 2013, we entered into a lease (the Lease) with 6th & Pine Development, LLC (the Landlord) for office space located in Long Beach, California. The Lease consists of two office buildings, one of which is under construction. The building which comprises approximately 90,000 square feet of office and storage space (Building A) was completed in June 2013; immediately following its completion, we occupied Building A and commenced lease payments. The second building (Building B) is expected to comprise approximately 120,000 square feet of office space.

The term of the Lease with respect to Building A commenced on June 6, 2013, and the term of the Lease with respect to Building B is expected to commence on November 1, 2014. The initial term of the Lease with respect to both buildings expires on December 31, 2024, subject to two options to extend the term for a period of five years each. Initial annual rent for Building A is approximately $2.6 million, and initial annual rent for Building B is expected to be approximately $4.0 million. Rent will increase 3.75% per year through the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of common stock in the Company he holds as trustee. Dr. J. Mario Molina, our chief executive officer and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

Medical Services

We have an equity investment in a medical service provider that provides certain vision services to our members; we account for this investment under the equity method of accounting. For the three months ended June 30, 2013 and 2012, we paid $8.7 million and $7.0 million, respectively, for medical service fees to this provider. For the six months ended June 30, 2013 and 2012, we paid $16.4 million, and $13.6 million, respectively, for medical service fees to this provider.

16. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our Chairman of the Board, President and Chief Executive Officer. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides outpatient professional medical services to the general public for routine non-life threatening, outpatient health care needs. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, American Family Care, Inc. (AFC), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will not operate at a loss, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by AFC are reviewed annually to assure the achievement of this goal.

Our California, Florida, New Mexico and Washington health plans have entered into primary care capitation agreements with JMMPC. These agreements also direct our health plans to fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, based on a monthly reconciliation. Because the AFC services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are insignificant.

We have determined that JMMPC is a variable interest entity, or VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of June 30, 2013, JMMPC had total assets of $1.4 million, comprising primarily cash and equivalents, and total liabilities of $1.1 million, comprising primarily accrued payroll and employee benefits.

Our maximum exposure to loss as a result of our involvement with JMMPC is equal to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future. We provided an initial cash infusion of $0.3 million to JMMPC in the first quarter of 2012 to fund its start-up operations.

New Markets Tax Credit

During the fourth quarter of 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC, or Wells Fargo, its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC, or Investment Fund, and certain of Wells Fargo's affiliated Community Development Entities, or CDEs, in connection with our participation in the federal government's New Markets Tax Credit Program, or NMTC. The NMTC was established by Congress in 2000 to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In the fourth quarter of 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $5.9 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $15.5 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $20.9 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $5.9 million.

Additionally, financing costs incurred in structuring the arrangement amounting to $1.2 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE-collecting and remitting interest and fees and NMTC compliance-were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $5.9 million is included in cash at December 31, 2012 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

Item 2. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words “anticipate(s),” “believe(s),” “estimate(s),” “expect(s),” “intend(s),” “may,” “plan(s),” “project(s),” “will,” “would,” “could,” “should” and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- uncertainties associated with the implementation of the Affordable Care Act, including the impact of the health insurance industry excise tax, the expansion of Medicaid eligibility in participating states to previously uninsured populations unfamiliar with managed care, the implementation of state insurance exchanges currently expected to become operational by October 1, 2013, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures, including the duals demonstration programs in California, Ohio, Michigan, and Texas;
- the success of our medical cost containment initiatives in Texas, and other risks associated with the expansion of our Texas health plan's service areas in 2012;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations and our accruals for incurred but not reported medical costs;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to increase our revenues consistent with our expectations;
- accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and the development of actuarially sound rates with respect to such new enrollees, including duals;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- government audits and reviews, and any enrollment freeze or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, including our pending litigation against the state of California related to rates paid to our California plan in earlier years that were not actuarially sound;
- restrictions and covenants in any future credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of adequate financing to fund and capitalize our expansion and growth activities and to meet our liquidity needs, including the interest expense and other costs associated with such financing;

- a state's failure to renew its federal Medicaid waiver;
- inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2012, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management’s Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2012.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of June 30, 2013, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico, and Washington.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in retaining their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan, Alliance for Community Health, L.L.C., was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, the Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. On April 5, 2013, the Missouri health plan assigned its affiliate, Molina Healthcare of Illinois, Inc., substantially all of its assets and liabilities. Additionally, the Missouri health plan surrendered its certificate of authority as a health maintenance organization. The Missouri health plan's revenues amounted to $0.2 million and $113.8 million for the six months ended June 30, 2013 and 2012, respectively.

Until the second quarter of 2013, we reported the results of the Missouri health plan in continuing operations because of our continuing significant involvement in the payment of medical claims incurred on or prior to June 30, 2012, for that entity. On May 13, 2013, we abandoned our equity interests in the Missouri health plan to an unrelated entity, and assigned the Missouri health plan's surviving rights, duties and obligations (which we believe to be insignificant) to Molina Healthcare of Illinois, Inc. Effective June 30, 2013, the transition obligations associated with the Missouri health plan's contract with the state terminated. As a result of these activities, we commenced reporting the Missouri health plan as a discontinued operation as of June 30, 2013. In connection with the abandonment of our equity interests in the Missouri health plan to an unrelated entity, we recognized a $9.5 million tax benefit for the tax deduction associated with the basis of such equity interests, which is included in discontinued operations in our consolidated statement of operations. Additionally, we recognized a pretax loss of $0.5 million for the write off of the Missouri health plan's remaining assets in the second quarter of 2013.

Our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services effective March 1, 2012.

On July 3, 2013, we announced that our New Mexico health plan has entered into a definitive agreement to assume Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program. Lovelace Community Health Plan currently participates in the New Mexico Medicaid Salud! State Coverage Insurance Program and arranges for healthcare services for approximately 84,000 New Mexicans. Our New Mexico health plan serves over 92,000 Medicaid members across the state. Subject to satisfaction of customary closing conditions, we anticipate completing the transaction on August 1, 2013; the total payment to Lovelace Community Health Plan will be based on the membership transferred as of that date.

On February 14, 2013, we announced that the Florida Agency for Health Care Administration awarded our Florida health plan contracts in three regions under the Statewide Medicaid Managed Care Long-Term Care program. As a result of the awards, we will now enter into a comprehensive pre-contracting assessment, with the program currently scheduled to commence on December 1, 2013. Under the program, we will provide long-term care benefits, including institutional and home and community-based services.

On February 11, 2013, we announced that our New Mexico health plan was selected by the New Mexico Human Services Department, or HSD, to participate in the new Centennial Care program. In addition to continuing to provide physical and acute health care services, under the new program our New Mexico health plan will expand its services to provide behavioral health and long-term care services. The selection of our New Mexico health plan was made by HSD pursuant to its request for proposals issued in August 2012. The operational start date for the program is currently scheduled for January 2014.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid Management Information System (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana cancelled its contract award to CNSI. CNSI is currently challenging the contract cancellation. The state has informed us that we will continue to perform under our current contract until a successor is named. At such time as a new RFP may be issued, we intend to respond to the state's RFP. For the six months ended June 30, 2013, our revenue under the Louisiana MMIS contract was approximately $20.2 million, or 20.3% of total service revenue. So long as our Louisiana MMIS contract continues, we expect to recognize approximately $40 million of service revenue annually under this contract.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in “Critical Accounting Policies” below, is not generally subject to significant accounting estimates. For the six months ended June 30, 2013, we received approximately 96% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the six months ended June 30, 2013, we recognized approximately 4% of our premium revenue in the form of “birth income” — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children’s Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $80 PMPM in Michigan. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $260 in Ohio. Among our ABD membership, PMPM premiums range from approximately $400 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums in the aggregate, at approximately $1,100 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	June 30, 2013	March 31, 2013	December 31, 2012	June 30, 2012
Total Ending Membership by Health Plan:				
California	355,000	332,000	336,000	350,000
Florida	81,000	75,000	73,000	70,000
Michigan	215,000	217,000	220,000	220,000
New Mexico	92,000	91,000	91,000	89,000
Ohio	240,000	242,000	244,000	260,000
Texas	266,000	274,000	282,000	301,000
Utah	87,000	87,000	87,000	86,000
Washington	413,000	416,000	418,000	356,000
Wisconsin	98,000	86,000	46,000	42,000
Total	1,847,000	1,820,000	1,797,000	1,774,000
Total Ending Membership for our Medicare Advantage Plans:				
California	8,100	7,700	7,700	7,000
Florida	600	600	900	900
Michigan	9,500	9,200	9,700	8,900
New Mexico	900	900	900	900
Ohio	400	300	300	200
Texas	2,300	1,900	1,500	800
Utah	7,800	7,600	8,200	8,300
Washington	6,600	6,100	6,500	5,700
Total	36,200	34,300	35,700	32,700
Total Ending Membership for our Aged, Blind or Disabled Population:				
California	45,400	44,600	44,700	41,100
Florida	11,200	10,400	10,300	10,400
Michigan	45,000	44,000	41,900	40,000
New Mexico	6,000	5,800	5,700	5,600
Ohio	28,000	28,200	28,200	29,600
Texas	92,000	94,200	95,900	111,000
Utah	9,400	9,200	9,000	8,800
Washington	31,700	31,300	30,000	4,400
Wisconsin	1,600	1,600	1,700	1,700
Total	270,300	269,300	267,400	252,600

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $68.4 million, and $62.6 million, for the six months ended June 30, 2013 and 2012, respectively, as well as certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Second Quarter Financial Performance Summary, Continuing Operations

The following table and narrative briefly summarize our financial and operating performance for continuing operations for the three and six months ended June 30, 2013 and 2012. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue, net of premium tax and the premium tax ratio is computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2013	2012	2013	2012
	(Dollar amounts in thousands, except per share data)			
Net income (loss) per diluted share	$ 0.34	$ (0.71)	$ 1.00	$ (0.29)
Premium revenue	$ 1,548,612	$ 1,432,403	$ 3,083,045	$ 2,701,196
Service revenue	$ 49,672	$ 41,724	$ 99,428	$ 83,929
Operating income (loss)	$ 46,446	$ (49,430)	$ 114,319	$ (13,118)
Net income (loss)	$ 15,796	$ (33,057)	$ 46,318	$ (13,163)
Total ending membership	1,847,000	1,774,000	1,847,000	1,774,000
Premium revenue	96.4%	96.8 %	96.5%	96.6 %
Service revenue	3.1%	2.8 %	3.1%	3.0 %
Investment income	0.1%	0.1 %	0.1%	0.1 %
Rental and other income	0.4%	0.3 %	0.3%	0.3 %
Total revenue	100.0%	100.0 %	100.0%	100.0 %
Medical care ratio	86.2%	94.5 %	86.1%	91.4 %
General and administrative expense ratio	10.1%	8.5 %	9.5%	8.6 %
Premium tax ratio	3.0%	2.7 %	2.7%	3.0 %
Operating income (loss)	2.9%	(3.3)%	3.6%	(0.5)%
Net income (loss)	1.0%	(2.2)%	1.4%	(0.5)%
Effective tax rate	49.5%	(39.1)%	46.3%	(41.0)%

Reconciliation of Non-GAAP to GAAP Financial Measures

We have included presentations of earnings before interest, taxes, depreciation and amortization (EBITDA) below. EBITDA is a non-GAAP financial measure and is reconciled to net income, which we believe to be the most comparable GAAP measure (GAAP stands for U.S. generally accepted accounting principles).

EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense and income tax expense. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities; nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

	Three months ended June 30,		Six months ended June 30,	
	2013	2012	2013	2012
	(In thousands)			
Net income (loss)	$ 24,571	$ (37,306)	$ 54,486	$ (19,217)
Add back:				
Depreciation and amortization reported in the consolidated statements of cash flows	22,108	19,671	43,907	38,010
Interest expense	11,667	3,808	24,704	8,106
Income tax expense (benefit)	5,513	(25,769)	29,783	(14,736)
EBITDA	$ 63,859	$ (39,596)	$ 152,880	$ 12,163

Second Quarter 2013 Overview

For the second quarter of 2013, net income rose to $24.6 million, or $0.53 per diluted share, compared with a net loss of $37.3 million, or $0.80 per diluted share, for the second quarter of 2012. Net income per diluted share from continuing operations was $0.34 for the second quarter of 2013, versus a net loss of $0.71 per diluted share from continuing operations for the second quarter of 2012.

Premium revenue for the second quarter of 2013 increased 8% over the second quarter of 2012, primarily due to membership growth in Washington and Wisconsin and rate increases in Texas and Washington in the second half of 2012.

Our consolidated medical care ratio decreased to 86.2% in the second quarter of 2013, from 94.5% in the second quarter of 2012. The decline in the consolidated medical care ratio was the result of dramatically improved operating results in Texas combined with improved performance at most of our other health plans. Medical care ratios decreased in seven of our nine health plans; while medical margin (measured as the excess of premium revenue net of premium tax, over medical costs) increased in eight out of nine health plans.

General and administrative expenses increased to 10.1% of revenue in the second quarter of 2013, from 8.5% in the second quarter of 2012, primarily due to higher costs incurred as a result of our preparations for significant membership growth in 2014, and a litigation charge of $3.5 million related to the final settlement of a provider dispute.

Second quarter 2013 results include a one-time non-cash charge of $3.9 million related to warrants issued in conjunction with our convertible senior notes offering in February 2013. As originally issued, certain terms in the warrant agreements required that they be recorded as a derivative liability requiring mark-to-market accounting treatment. The warrants were reclassified to equity during the second quarter and there will be no further mark-to-market adjustments.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal on June 30, 2012. Effective June 30, 2013 the transition obligations associated with that contract terminated. Therefore, we have reclassified the results relating to the Missouri health plan to discontinued operations for all periods presented. These results are presented in a single line item, net of taxes, in the unaudited consolidated statements of operations. Additionally, we abandoned all of our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the recognition of a tax benefit of approximately $9.5 million, which is also included in discontinued operations in the unaudited consolidated statements of operations.

Results of Operations, Continuing Operations

Three Months Ended June 30, 2013 Compared with the Three Months Ended June 30, 2012

Health Plans Segment

Premium Revenue

Premium revenue for the second quarter of 2013 increased 8% over the second quarter of 2012, primarily due to membership growth in Washington and Wisconsin, and rate increases in Texas and Washington in the second half of 2012. Medicare premium revenue was $131.5 million for the second quarter of 2013 compared with $120.8 million for the second quarter of 2012.

Growth in our ABD membership in Washington and California led to higher premium revenue PMPM in 2013. ABD membership, as a percent of total membership, has increased approximately 3% year over year. Premium revenue PMPM also increased in the second quarter of 2013 as a result of the inclusion of revenue for pharmacy benefits for the Utah health plan effective January 1, 2013.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended June 30,					
	2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 879,865	$ 158.96	68.0%	$ 925,039	$ 174.04	70.2%
Pharmacy	222,992	40.29	17.2	212,944	40.06	16.2
Capitation	138,409	25.00	10.7	136,376	25.66	10.3
Other	53,440	9.66	4.1	43,238	8.14	3.3
Total	$ 1,294,706	$ 233.91	100.0%	$ 1,317,597	$ 247.90	100.0%

Medical care costs decreased in the second quarter of 2013 primarily due to significantly lower medical care costs at our Texas health plan. Our consolidated medical care ratio decreased to 86.2% in the second quarter of 2013, from 94.5% in the second quarter of 2012. Higher margins at the Texas health plan, along with stable inpatient utilization and lower pharmacy unit costs across the Company, were the primary causes of the lower medical care ratio in the second quarter of 2013.

Individual Health Plan Analysis

The medical care ratio at the California health plan increased to 94.4% in the second quarter of 2013 from 90.5% in the second quarter of 2012. The higher medical care ratio was primarily the result of higher Medicare inpatient fee-for-service costs.

The medical care ratio of the Florida health plan decreased to 84.0% in the second quarter of 2013, from 84.5% in the second quarter of 2012 due to inpatient utilization reductions and lower pharmacy costs.

The medical care ratio of the Michigan health plan decreased to 84.7% in the second quarter of 2013, from 87.1% in the second quarter of 2012, primarily due to a reduction in inpatient costs.

The medical care ratio of the New Mexico health plan decreased to 80.8% in the second quarter of 2013, from 84.3% in the second quarter of 2012, primarily as a result of higher Medicaid premium rates PMPM effective January 1, 2013, and lower fee-for-service claims costs.

The medical care ratio of the Ohio health plan decreased to 79.8% for the second quarter of 2013, from 89.5% for the second quarter of 2012, due to reductions in inpatient, pharmacy and professional costs as well as a 4% premium rate increase effective January 1, 2013.

The medical care ratio of the Texas health plan was 86.5% in the second quarter of 2013 compared with 111.5% in the second quarter of 2012 (which included a premium deficiency reserve (PDR) of $10 million). We received a blended rate increase in Texas of approximately 4%, or $4.5 million per month, effective September 1, 2012; and implemented various medical cost containment initiatives in the second half of 2012.

The medical care ratio of the Utah health plan decreased to 79.6% in the second quarter of 2013, from 82.5% in the second quarter of 2012 primarily due to a lower fee-for-service claim costs.

The medical care ratio of the Washington health plan increased to 88.0% in the second quarter of 2013, from 85.5% in the second quarter of 2012 primarily due to the addition of ABD members effective July 1, 2012. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio, so that the excess of premium revenue over medical care costs increased to $36.0 million for the second quarter of 2013, compared with $29.6 million for the second quarter of 2012.

The medical care ratio of the Wisconsin health plan decreased to 82.6% in the second quarter of 2013, from 121.1% in the second quarter of 2012. A $3.0 million PDR was recorded in the second quarter of 2012. Absent the PDR, the medical care ratio would have been 105.2% in the second quarter of 2012. The health plan has successfully implemented several cost saving initiatives including improvements in provider contracts, in-sourcing the management of behavioral health services and enhanced utilization management activities. The health plan received a 3% premium rate increase effective January 1, 2013. Additionally, the health plan gained approximately 50,000 members in February, March and April due to another health plan's recent exit from the market. We are closely monitoring the utilization patterns and loss reserves for these new members.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended June 30, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM			
California	1,055	$ 191,059	$ 181.19	$ 170,777	$ 161.96	$ 10,132	94.4%	$ 10,150
Florida	238	61,838	260.61	51,915	218.80	1	84.0	9,922
Michigan	648	168,446	259.88	141,859	218.86	961	84.7	25,626
New Mexico	275	86,527	314.76	68,253	248.28	2,078	80.8	16,196
Ohio	722	292,706	405.05	215,664	298.44	22,599	79.8	54,443
Texas	805	324,600	403.06	275,959	342.66	5,645	86.5	42,996
Utah	261	77,511	296.69	61,677	236.08	—	79.6	15,834
Washington	1,238	305,000	246.30	263,512	212.80	5,467	88.0	36,021
Wisconsin	293	37,740	128.79	31,185	106.43	—	82.6	6,555
Other (3)	—	3,185	—	13,905	—	—	—	(10,720)
	5,535	$ 1,548,612	$ 279.77	$ 1,294,706	$ 233.91	$ 46,883	86.2%	$ 207,023

	Three Months Ended June 30, 2012						
	Member Months (1)	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM			
California	1,056	$ 167,644	$ 158.77	$ 149,239	$ 141.34	$ 2,683	90.5%	$ 15,722
Florida	210	57,303	273.00	48,442	230.79	(21)	84.5	8,882
Michigan	662	162,758	245.89	141,682	214.04	31	87.1	21,045
New Mexico	266	82,706	310.94	67,836	255.03	2,257	84.3	12,613
Ohio	762	297,069	389.85	245,284	321.89	23,011	89.5	28,774
Texas	907	359,486	396.63	393,237	433.87	6,670	111.5	(40,421)
Utah	259	76,911	297.00	63,419	244.90	—	82.5	13,492
Washington	1,068	207,376	194.14	174,045	162.93	3,701	85.5	29,630
Wisconsin	125	18,788	150.12	22,758	181.84	—	121.1	(3,970)
Other (3)	—	2,362	—	11,655	—	22	—	(9,315)
	5,315	$ 1,432,403	$ 269.53	$ 1,317,597	$ 247.90	$ 38,354	94.5%	$ 76,452

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) The MCR represents medical costs as a percentage of premium revenues, where premium revenue is reduced by premium tax expense.
(3) "Other" medical care costs also include medically related administrative costs at the parent company.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended June 30,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$ 50,400	$ 41,877
Amortization recorded as reduction of service revenue	(728)	(153)
Service revenue	49,672	41,724
Cost of service revenue	39,305	30,613
General and administrative costs	2,790	3,187
Amortization of customer relationship intangibles recorded as amortization	1,282	1,282
Operating income	$ 6,295	$ 6,642

Operating income for our Molina Medicaid Solutions segment decreased $0.3 million for the three months ended June 30, 2013, compared with the same prior year period. The decrease in operating income was primarily the result of a change in the mix of transactions processed from fee-for-service claims to managed care encounters (processing fees are lower for encounters than for fee-for-service claims) and changes to state contract revenues implemented during 2012.

Results of Operations, Continuing Operations

Six Months Ended June 30, 2013 Compared with the Six Months Ended June 30, 2012

Health Plans Segment

Premium Revenue

Premium revenue for the six months ended June 30, 2013 increased 14% over the six months ended June 30, 2012, due to both higher enrollment and higher premium revenue PMPM. Medicare premium revenue was $249.9 million for the six months ended June 30, 2013 compared with $230.5 million for the six months ended June 30, 2012.

Growth in our ABD membership in Washington and California led to higher premium revenue PMPM in 2013. ABD membership, as a percent of total membership, has increased approximately 3% year over year. Premium revenue PMPM also increased in the six months ended June 30, 2013 as a result of the inclusion of revenue for pharmacy benefits for the Utah health plan effective January 1, 2013, and as a result of the inclusion of revenue for inpatient facility and pharmacy benefits across all of the Texas health plan's membership effective March 1, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Six Months Ended June 30,					
	2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 1,746,620	$ 159.48	67.6%	$ 1,653,024	$ 160.57	69.0%
Pharmacy	454,830	41.53	17.6	386,181	37.51	16.1
Capitation	278,733	25.45	10.8	269,968	26.22	11.3
Other	102,438	9.35	4.0	86,291	8.38	3.6
Total	$ 2,582,621	$ 235.81	100.0%	$ 2,395,464	$ 232.68	100.0%

Our medical care ratio decreased in the six months ended June 30, 2013, when compared with the six months ended June 30, 2012, primarily due to improved financial performance at our Texas health plan.

Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Six Months Ended June 30, 2013							
	Member Months (1)	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM			
California	2,056	$ 378,939	$ 184.33	$ 330,540	$ 160.79	$ 10,224	89.6%	$ 38,175
Florida	461	120,005	260.39	101,319	219.84	4	84.4	18,682
Michigan	1,300	336,122	258.56	288,607	222.01	2,080	86.4	45,435
New Mexico	549	172,325	314.15	140,402	255.95	3,876	83.3	28,047
Ohio	1,448	584,224	403.39	443,118	305.96	45,309	82.2	95,797
Texas	1,637	659,896	403.02	542,408	331.27	11,490	83.7	105,998
Utah	520	152,467	293.16	126,706	243.63	—	83.1	25,761
Washington	2,488	608,719	244.67	524,909	210.98	10,900	87.8	72,910
Wisconsin	493	64,864	131.53	54,849	111.22	—	84.6	10,015
Other (3)	—	5,484	—	29,763	—	—	—	(24,279)
	10,952	$ 3,083,045	$ 281.51	$ 2,582,621	$ 235.81	$ 83,883	86.1%	$ 416,541

	Six Months Ended June 30, 2012							
	Member Months (1)	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM			
California	2,115	$ 329,329	$ 155.70	$ 290,588	$ 137.39	$ 4,992	89.6%	$ 33,749
Florida	418	113,493	271.44	98,011	234.41	(14)	86.3	15,496
Michigan	1,327	330,664	249.20	275,893	207.92	8,071	85.5	46,700
New Mexico	532	163,932	308.29	134,947	253.78	4,210	84.5	24,775
Ohio	1,508	590,594	391.77	481,985	319.72	45,864	88.5	62,745
Texas	1,499	557,722	372.11	573,326	382.53	9,867	104.6	(25,471)
Utah	511	152,049	297.29	121,300	237.17	—	79.8	30,749
Washington	2,135	422,986	198.11	355,470	166.49	7,517	85.6	59,999
Wisconsin	250	35,930	143.54	39,644	158.31	—	110.3	(3,714)
Other (3)	—	4,497	—	24,300	—	33	—	(19,836)
	10,295	$ 2,701,196	$ 262.38	$ 2,395,464	$ 232.68	$ 80,540	91.4%	$ 225,192

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) The MCR represents medical costs as a percentage of premium revenues, where premium revenue is reduced by premium tax expense.
(3) "Other" medical care costs also include medically related administrative costs at the parent company.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Six Months Ended June 30,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$ 100,885	$ 84,235
Amortization recorded as reduction of service revenue	(1,457)	(306)
Service revenue	99,428	83,929
Cost of service revenue	79,075	61,107
General and administrative costs	5,141	5,207
Amortization of customer relationship intangibles recorded as amortization	2,564	2,564
Operating income	$ 12,648	$ 15,051

Operating income for our Molina Medicaid Solutions segment decreased $2.4 million for the six months ended June 30, 2013, compared with the same prior year period. The decrease in operating income was primarily the result of a change in the mix of transactions processed from fee-for-service claims to managed care encounters (processing fees are lower for encounters than for fee-for-service claims) and changes to state contract revenues implemented during 2012.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 10.1% of total revenue for the three months ended June 30, 2013, compared with 8.5% of total revenue for the three months ended June 30, 2012. General and administrative expenses increased to 9.5% of total revenue for the six months ended June 30, 2013, compared with 8.6% of total revenue for the six months ended June 30, 2012. The increased ratio of general and administrative expenses to total revenue for both the three months and six months ended June 30, 2013, was primarily due to higher costs incurred as a result of our preparations for significant membership growth in 2014.

Premium Tax Expense

Premium tax expense was 3.0% of premium revenue in the three months ended June 30, 2013, compared with 2.7% in the three months ended June 30, 2012, and 2.7% of premium revenue in the six months ended June 30, 2013, compared with 3.0% in the six months ended June 30, 2012. The year-to-date decrease in 2013 was primarily due to the reduction of premium taxes at the Michigan and California health plans effective in 2012.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is recorded in "Depreciation and amortization" in the consolidated statements of operations. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of operations as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of service revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of operations, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended June 30,			
	2013		2012	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation and amortization of capitalized software, continuing operations	$ 12,896	0.8%	$ 10,674	0.7%
Amortization of intangible assets, continuing operations	4,119	0.3	5,536	0.4
Depreciation and amortization, continuing operations	17,015	1.1	16,210	1.1
Depreciation and amortization, discontinued operations	—	—	177	—
Amortization recorded as reduction of service revenue	728	—	153	—
Amortization of capitalized software recorded as cost of service revenue	4,365	0.3	3,131	0.2
	$ 22,108	1.4%	$ 19,671	1.3%

	Six Months Ended June 30,			
	2013		2012	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation and amortization of capitalized software, continuing operations	$ 25,341	0.8%	$ 19,969	0.7%
Amortization of intangible assets, continuing operations	8,237	0.3	11,089	0.4
Depreciation and amortization, continuing operations	33,578	1.1	31,058	1.1
Depreciation and amortization, discontinued operations	2	—	354	—
Amortization recorded as reduction of service revenue	1,457	—	306	—
Amortization of capitalized software recorded as cost of service revenue	8,870	0.3	6,292	0.2
	$ 43,907	1.4%	$ 38,010	1.3%

Interest Expense

Interest expense increased to $11.7 million for the three months ended June 30, 2013, from $3.8 million for the three months ended June 30, 2012, and increased to $24.7 million for the six months ended June 30, 2013, from $8.1 million for the six months ended June 30, 2012 primarily due to the issuance of the 1.125% Notes in February 2013. Interest expense includes amortization of the discount on our convertible senior notes, which amounted to $6.0 million and $1.5 million for the three months ended June 30, 2013, and 2012, respectively, and $9.7 million and $2.9 million for the six months ended June 30, 2013, and 2012, respectively. Interest expense in the first half of 2013 also includes the immediate recognition of approximately $6 million of interest expense relating to debt issuance costs. The remainder of the fees associated with that issuance, amounting to approximately $12 million, are being expensed over the life of the 1.125% Notes.

As described in further detail below, in "Future Sources and Uses of Liquidity – *Lease Financing Obligations*," lease payments under the sale-leaseback transactions adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations.

Other Expense

Other expense increased to $3.5 million for the three months ended June 30, 2013, from $1.1 million for the three months ended June 30, 2012, with a comparable increase for the six months ended June 30, 2013, over the same period in 2012. Other expense includes primarily gains or losses associated with changes in the fair value of our derivative financial instruments. In the second quarter of 2013 we recorded a one-time non-cash charge of $3.9 million related to warrants issued in conjunction with our convertible senior notes offering in February 2013, as described above in "Second Quarter 2013 Overview." For the three months and six months ended June 30, 2012, we recorded a $1.1 million charge for the fair value of

an interest rate swap derivative liability. We settled the interest rate swap in the second quarter of 2013, which resulted in a gain of approximately $0.4 million, which partially offset the $3.9 million charge described above.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 49.5% for the three months ended June 30, 2013 compared with 39.1% for the three months ended June 30, 2012, and 46.3% for the six months ended June 30, 2013 compared with 41.0% for the six months ended June 30, 2012. The increase is primarily due to an increase in non-deductible compensation, and the non-deductibility of the $3.9 million charge related to the warrants, as described above.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of June 30, 2013, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income was $3.1 million for the six months ended June 30, 2013, compared with $2.7 million for the six months ended June 30, 2012. Our annualized portfolio yield for the six months ended June 30, 2013 was 0.4% compared with 0.5% for the six months ended June 30, 2012.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Liquidity

Cash used in operating activities for the six months ended June 30, 2013 was $111.7 million compared with $236.0 million provided by operating activities for the six months ended June 30, 2012, a change of $347.7 million. The decrease in cash from operating activities was primarily due to the changes in deferred revenue and medical claims and benefits payable, partially offset by the change in accounts receivable. Deferred revenue and medical claims and benefits payable were a use of operating cash amounting to $124.9 million in the aggregate in the six months ended June 30, 2013, compared with a source of operating cash of $248.5 million in the aggregate in the same period in 2012. Accounts receivable was a use of operating cash amounting to $64.1 million in the six months ended June 30, 2013, compared with a source of operating cash of $6.9 million in the same period in 2012.

Cash used in investing activities for the six months ended June 30, 2013 was $431.8 million compared with $61.3 million for the six months ended June 30, 2012, an increase of $370.5 million. This increase was primarily due to increased purchases of investments in 2013, a result of increased cash generated in financing activities, described below.

Cash provided by financing activities for the six months ended June 30, 2013 was $490.5 million compared with $58.6 million for the six months ended June 30, 2012, an increase of $431.9 million. The significant increase was primarily due to $538.0 million in proceeds we received from our offering of 1.125% Notes, $158.7 million received from sale-leaseback transactions, and $75.1 million from the sale of warrants, partially offset by $149.3 million paid for the purchased call option relating to the 1.125% Notes, $50.0 million paid for repurchases of our common stock, $47.5 million used to repay our term loan, and $40.0 million used to repay our Credit Facility.

Financial Condition

On a consolidated basis, at June 30, 2013, we had working capital of $1,037.6 million compared with $521.1 million at December 31, 2012. At June 30, 2013, and December 31, 2012, we had cash and investments, including restricted investments, of $1,530.7 million, and $1,196.1 million, respectively. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $607.5 million at June 30, 2013, and $549.7 million at December 31, 2012. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $527.8 million and $46.9 million as of June 30, 2013, and December 31, 2012, respectively.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2013, our health plans had aggregate statutory capital and surplus of approximately $627.7 million compared with the required minimum aggregate statutory capital and surplus of approximately $363.2 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2013. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

As described in Note 2 to the accompanying Notes to the Consolidated Financial Statements, the ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year. If the fee assessment is enacted as written, our minimum capitalization requirements will increase significantly on January 1, 2014; we are currently evaluating the impact of the fee assessment to our financial position, results of operations and cash flows.

Future Sources and Uses of Liquidity

As of June 30, 2013, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2013	2014	2015	2016	2017	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	—	187,000	—	—	—	—
	$ 737,000	$ —	$ 187,000	$ —	$ —	$ —	$ 550,000

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we settled the issuance of $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes). This transaction included the initial issuance of $450.0 million on February 11, 2013, plus the exercise of the full amount of the $100.0 million over-allotment option on February 13, 2013. The aggregate net

proceeds of the 1.125% Notes were $458.9 million, after payment of the net cost of the Call Spread Overlay described below and transaction costs. Additionally, we used $50.0 million of the net proceeds to purchase shares of our common stock, and $40.0 million to repay the principal owed under our Credit Facility.

Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum commencing on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. Holders may convert their 1.125% Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.125% Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its 1.125% Notes in connection with such a corporate event in certain circumstances. We may not redeem the 1.125% Notes prior to the maturity date, and no sinking fund is provided for the 1.125% Notes.

If we undergo a fundamental change (as defined in the indenture to the 1.125% Notes), holders may require us to repurchase for cash all or part of their 1.125% Notes at a repurchase price equal to 100% of the principal amount of the 1.125% Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The 1.125% Notes are senior unsecured obligations, and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

The 1.125% Notes contain an embedded cash conversion option. We have determined that the embedded cash conversion option is a derivative financial instrument, required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the embedded cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount).

As noted above, the reduced carrying value on the 1.125% Notes resulted in a debt discount that is amortized to the 1.125% Notes' principal amount through the recognition of interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued. The effective interest rate of the 1.125% Notes is 5.9%, which is imputed based on the amortization of the fair value of the embedded cash conversion option over the remaining term of the 1.125% Notes. As of June 30, 2013, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 6.5 years.

Also in connection with the settlement of the 1.125% Notes, we paid approximately $16.9 million in transaction costs. Such costs have been allocated to the 1.125% Notes, the 1.125% Call Option (defined below) and the 1.125% Warrants (defined below) according to their relative fair values. The amount allocated to the 1.125% Notes, or $12.0 million, was

capitalized and will be amortized over the term of the 1.125% Notes. The aggregate amount allocated to the 1.125% Call Option and 1.125% Warrants, or $4.9 million, was recorded to interest expense in the quarter ended March 31, 2013.

1.125% Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Notes, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes (the Counterparties). These transactions represent a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the Counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call Spread Overlay. The 1.125% Call Option is a derivative financial instrument.

Aside from the initial payment of a premium to the Counterparties of $149.3 million for the 1.125% Call Option, we will not be required to make any cash payments to the Counterparties under the 1.125% Call Option, and will be entitled to receive from the Counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

3.75% Convertible Senior Notes due 2014

We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of June 30, 2013 and December 31, 2012, respectively. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Lease Financing Obligations

On June 12, 2013, we entered into a sale-leaseback transaction for the sale and contemporaneous leaseback of two properties, including the Molina Center located in Long Beach, California, and the building that houses our Ohio health plan located in Columbus, Ohio. We sold the two properties for $158.6 million in the aggregate. Due to our continuing involvement with these leased properties, the sale did not qualify for sale-leaseback accounting treatment and we remain the "accounting owner" of the properties. The carrying values of these properties, including the related intangible assets, amounted to $78.8 million in the aggregate as of June 30, 2013. These assets continue to be included in our consolidated balance sheets, and also continue to be depreciated and amortized over their remaining useful lives. The sales price of $158.6 million was recorded as a lease financing obligation, which is amortized over the 25-year lease term such that there will be no gain or loss recorded if the lease is not extended at the end of its term. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. Transaction costs associated with this transaction, amounting to $3.5 million, have been deferred and will be amortized over the initial lease term.

We entered into a lease for office space in February 2013 consisting of two office buildings then under construction. We have concluded that we are the accounting owner of the construction projects because of our continuing involvement in those projects. Therefore, we have recorded $17.0 million to property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of June 30, 2013, which represents the total cost, including imputed interest, incurred by the landlord thus far in the construction projects. As of June 30, 2013, the aggregate amounts recorded to property, equipment and capitalized software, net, for both Building A and B are also recorded as a corresponding lease financing obligation of $17.0 million. Payments under the lease adjust the lease financing obligation, and the imputed interest is recorded to interest expense in our consolidated statements of operations. In addition to the capitalization of the costs incurred by the landlord, we impute and record rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was immaterial for the six months ended June 30, 2013.

Term Loan

In December 2011, our wholly owned subsidiary, Molina Center LLC, entered into a term loan agreement with various lenders and East West Bank to borrow $48.6 million to finance a portion of the purchase price for the Molina Center, located in Long Beach, California. On June 13, 2013, we repaid the principal balance outstanding under the term loan on that date, with proceeds we received in the sale-leaseback transaction described above.

Credit Facility

On February 15, 2013, we used approximately $40.0 million of the net proceeds from the offering of the 1.125% Notes to repay all of the outstanding indebtedness under our $170 million revolving Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the 1.125% Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution. Such direct issue letters of credit are collateralized by restricted investments.

Shelf Registration Statement

In the second quarter of 2012, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the registration, issuance, and sale of an indeterminate amount of our securities, including common stock, preferred stock, senior or subordinated debt securities, or warrants. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Securities Repurchase Program

Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in the aggregate of either our common stock or our 3.75% Notes, in addition to the $50 million of our common stock that we repurchased on February 12, 2013. The repurchase program extends through December 31, 2014.

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2012, was disclosed in our 2012 Annual Report on Form 10-K. Other than the transactions relating to our February 2013 offering of the 1.125% Notes, and the sale-leaseback transactions discussed above, there were no material changes to this previously filed information outside the ordinary course of business during the three months ended June 30, 2013. For further discussion and maturities of our long-term debt, see Note 10 of Notes to the Consolidated Financial Statements.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

(1) Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract: These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates), our revenue earned for those periods will also change. In all of these instances, our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn would lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of approximately $0.7 million and $0.3 million at June 30, 2013, and December 31, 2012, respectively.

Florida Health Plan Medical Cost Floor (Minimum): A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs (in all counties except Broward). A similar minimum expenditure is required for total health care costs in Broward county only. At both June 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit, as defined in the contract, exceed certain amounts. At both June 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

Ohio Health Plan Medical Cost Floors (Minimums): Sanctions may be levied by the state if certain minimum amounts are not spent on defined medical care costs. These sanctions include the requirements to file a corrective action plan as well as an enrollment freeze.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $3.9 million and $3.2 million pursuant to our profit-sharing agreement with the state of Texas at June 30, 2013, and December 31, 2012, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At June 30, 2013, and December 31, 2012, we had not recorded any liability under the terms of this contract provision.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $7.1 million and $0.3 million as of June 30, 2013 and December 31, 2012, respectively for anticipated Medicare risk adjustment premiums.

(2) Quality incentives that allow us to recognize incremental revenue if certain quality standards are met: These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, incremental revenue of up to 3.25% of total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2013 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2013.

	Three Months Ended June 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 588	$ 535	$ 49	$ 584	$ 86,527
Ohio	2,964	1,087	553	1,640	292,706
Texas	15,675	15,675	2,752	18,427	324,600
Wisconsin	1,269	—	495	495	37,740
	$ 20,496	$ 17,297	$ 3,849	$ 21,146	$ 741,573

	Three Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 561	$ 482	$ 630	$ 1,112	$ 82,706
Ohio	2,720	2,720	—	2,720	297,069
Texas	18,252	14,284	—	14,284	359,486
Wisconsin	449	—	246	246	18,788
	$ 21,982	$ 17,486	$ 876	$ 18,362	$ 758,049

	Six Months Ended June 30, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,173	$ 867	$ 157	$ 1,024	$ 172,325
Ohio	5,969	2,139	553	2,692	584,224
Texas	31,939	29,187	8,747	37,934	659,896
Wisconsin	2,030	—	1,104	1,104	64,864
	$ 41,111	$ 32,193	$ 10,561	$ 42,754	$ 1,481,309

	Six Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,116	$ 818	$ 658	$ 1,476	$ 163,932
Ohio	5,398	5,398	966	6,364	590,594
Texas	24,002	20,034	—	20,034	557,722
Wisconsin	865	—	246	246	35,930
	$ 31,381	$ 26,250	$ 1,870	$ 28,120	$ 1,348,178

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid Management Information System (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. While providing BPO services (which include claims payment and eligibility processing), we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software-related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets .

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	June 30, 2013	December 31, 2012	June 30, 2012
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 360,153	$ 377,614	$ 378,782
Capitation payable	47,474	49,066	79,739
Pharmacy	37,241	38,992	34,848
Other	20,619	28,858	32,169
	$ 465,487	$ 494,530	$ 525,538

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $360.2 million of our total medical claims and benefits payable of $465.5 million as of June 30, 2013. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at June 30, 2013, was $354.0 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of June 30, 2013 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding June 30, 2013, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 154,224
(4)%	102,816
(2)%	51,408
2%	(51,408)
4%	(102,816)
6%	(154,224)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of June 30, 2013 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical

claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (77,698)
(4)%	(51,799)
(2)%	(25,899)
2%	25,899
4%	51,799
6%	77,698

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 46.5 million diluted shares outstanding for the six months ended June 30, 2013. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at June 30, 2013, net income for the six months ended June 30, 2013 would increase or decrease by approximately $16.2 million, or $0.35 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at June 30, 2013, net income for the six months ended June 30, 2013 would increase or decrease by approximately $8.2 million, or $0.18 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $81.0 million, or $1.74 per diluted share, and $40.8 million, or $0.88 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $16.2 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to

Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that our initial estimate of claims incurred but not paid (IBNP) is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more factors are out of the ordinary.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2013 and 2012 were less than what we had expected when we had established our reserves. For example, for the year ended December 31, 2012, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2011 by 9.8%. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $62.8 million for the six months ended June 30, 2013. This amount represents our estimate as of June 30, 2013 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012 was due primarily to the following factors:

- At our Texas health plan, STAR+PLUS (the state's program for ABD members) membership declined during mid– to late– 2012. This caused a reduction in costs per member that we did not fully recognize in our December 31, 2012 reserve estimates.
- At our Washington health plan, prior to July 2012, certain high-cost newborns that were approved for supplemental security income (SSI) coverage by the state were retroactively dis-enrolled from our Healthy Options (TANF) coverage, and the health plan was reimbursed for the claims paid on behalf of these members. Starting July 1, 2012, these newborns, as well as other high-cost disabled members, are now covered by the health plan under the Healthy Options Blind and Disabled (HOBD) program. At the end of 2012, we had limited claims history with which to estimate the claims liability of the HOBD members, and as a result the liability for these high-cost members was overstated.
- For our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.

We recognized favorable prior period claims development in the amount of $50.0 million for the three months ended June 30, 2013. This amount represents our estimate as of June 30, 2013 of the extent to which our initial estimate of medical claims and benefits payable at March 31, 2013 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at March 31, 2013 was due primarily to the following factors:

- At our Washington health plan, we had limited claims history with which to estimate the incurred claims for members enrolled in the HOBD program. Because claims on this group of members were being paid at a rate faster than expected, the reserves for unpaid claims were overstated.
- At our Ohio and New Mexico health plans, we overestimated the impact of several potential high-dollar claims on critically ill members.

We recognized favorable prior period claims development in the amount of $36.4 million and $39.3 million for the six months ended June 30, 2012, and the year ended December 31, 2012, respectively. This was primarily caused by the overestimation of our liability claims and medical benefits at December 31, 2011, as a result of the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS, in the Dallas region.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

In estimating our claims liability at June 30, 2013, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- In our Texas health plan, we have noted an unusually large number of claims with incurred dates older than 10 months. This has caused some distortion in the claims lag pattern that we use to estimate the incurred claims.
- Our Wisconsin health plan is experiencing significant membership increases, and approximately doubled in size during the first four months of 2013. This new membership is transitioning to our health plan from a terminated health plan. We enrolled approximately 50,000 new members in February, March and April 2013. We have computed a separate reserve analysis for these members and have noted that paid claims thus far are less than what we would expect for newly transitioned members. It has been our experience that when members move to new health plans, there is a delay in the submission of claims for payment. Therefore, we have increased the reserves for this membership, in anticipation of higher claims costs eventually being reported for these members.
- In our Michigan health plan, there were a large number of claim recoveries recorded in June 2013 due to overpayments that resulted from a system configuration issue. These recoveries impacted the completion factors used to estimate incurred claims. While we have attempted to remove this distortion from the claims data to develop a more accurate reserve estimate, this type of correction in claims data adds a degree of uncertainty for the Michigan reserves as of June 30, 2013.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012 and for the six months ended June 30, 2013, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts displayed for “Components of medical care costs related to: Prior periods” represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The following table shows the components of the change in medical claims and benefits payable from continuing and discontinued operations as of the periods indicated:

	Six Months Ended June 30,		Three Months Ended June 30,		Year Ended
	2013	2012	2013	2012	December 31, 2012
	(Dollars in thousands, except per-member amounts)				
Balances at beginning of period	$ 494,530	$ 402,476	$ 491,145	$ 455,833	$ 402,476
Components of medical care costs related to:					
Current period	2,647,083	2,544,922	1,345,592	1,377,084	5,136,055
Prior periods	(62,757)	(36,357)	(50,020)	493	(39,295)
Total medical care costs	2,584,326	2,508,565	1,295,572	1,377,577	5,096,760
Payments for medical care costs related to:					
Current period	2,206,474	2,033,611	940,186	891,573	4,649,363
Prior periods	406,895	351,892	381,044	416,299	355,343
Total paid	2,613,369	2,385,503	1,321,230	1,307,872	5,004,706
Balances at end of period	$ 465,487	$ 525,538	$ 465,487	$ 525,538	$ 494,530
Benefit from prior period as a percentage of:					
Balance at beginning of period	12.7%	9.0%	10.2%	(0.1)%	9.8%
Premium revenue, trailing twelve months	1.0%	0.7%	0.8%	— %	0.7%
Medical care costs, trailing twelve months	1.2%	0.8%	1.0%	— %	0.8%
Claims Data:					
Days in claims payable, fee for service	38	44	38	44	40
Number of members at end of period	1,847,000	1,853,000	1,847,000	1,853,000	1,797,000
Number of claims in inventory at end of period	109,900	209,200	109,900	209,200	122,700
Billed charges of claims in inventory at end of period	$ 200,400	$ 324,500	$ 200,400	$ 324,500	$ 255,200
Claims in inventory per member at end of period	0.06	0.11	0.06	0.11	0.07
Billed charges of claims in inventory per member at end of period	$ 108.50	$ 175.12	$ 108.50	$ 175.12	$ 142.01
Number of claims received during the period	10,524,500	10,375,700	5,253,500	5,520,100	20,842,400
Billed charges of claims received during the period	$ 10,477,900	$ 9,388,700	$ 5,307,200	$ 5,051,800	$ 19,429,300

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. *Quantitative and Qualitative Disclosures About Market Risk*

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC, a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum

maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2013 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, the following risk factors were identified by the Company during the second quarter of 2013, and is a supplement to, and should be read together with, the risk factors discussed in Part I, Item 1A - Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2012. The risk factors described herein and in our 2012 Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

Reductions in Medicare payments could reduce our earnings potential for our Medicare Advantage plans.

The American Taxpayer Relief Act (ATRA) of 2012, known as the "fiscal cliff" deal, delayed the sequestration mandated under the Sequestration Transparency Act of 2012 until March 1, 2013. Although Medicaid is exempt from cuts under ATRA, ATRA triggered automatic across-the-board budget cuts (known as "sequestration"), which included a 2% reduction of payments from the Centers for Medicare and Medicaid Services to our Medicare Advantage plans beginning April 1, 2013. Medicare Advantage plans will continue to be affected until Congress lifts the sequestration mandated under the Sequestration Transparency Act of 2012. The impact of sequestration cuts on our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements paid to those providers with rates indexed to the Medicare fee-for-service reimbursement rates. Such reduction in our Medicare payments may have an adverse effect on our earnings potential for our Medicare Advantage plans and our duals demonstration programs. In addition, reductions to provider reimbursement rates associated with sequestration may adversely impact our relations with the impacted providers.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

Issuer Purchases of Equity Securities

Common Stock Repurchase in Connection with Offering of 1.125% Cash Convertible Senior Notes Due 2020. We used a portion of the net proceeds in this offering to repurchase $50.0 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Securities Repurchase Program. Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or the 3.75% Notes, in addition to the $50.0 million common stock repurchase discussed above. The repurchase program extends through December 31, 2014.

Purchases of common stock made by or on our behalf during the quarter ended June 30, 2013, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs
April 1 - April 30	590	$ 30.76	—	$ 75,000,000
May 1 - May 31	541	$ 33.15	—	$ 75,000,000
June 1 - June 30	26,550	$ 37.26	—	$ 75,000,000
Total	27,681	$ 37.04	—	

(a) During the three months ended June 30, 2013, we withheld 27,681 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

Item 6. Exhibits

Exhibit No.	Title
3.1	Certificate of Amendment to Certificate of Incorporation.
3.2	Second Amendment and Restated Bylaws - Filed as Exhibit 3.1 to registrant's Form 8-K filed July 24, 2013.
10.1	Agreement of Purchase and Sale, dated as of June 12, 2013, by and between Molina Healthcare, Inc. and Molina Center, LLC, and AG Net Lease Acquisition Corp.
10.2	Lease Agreement, dated as of June 13, 2013, by and between AGNL Clinic, L.P., and Molina Healthcare, Inc.
10.3	Employment Agreement with Terry Bayer dated June 14, 2013 - Filed as Exhibit 10.1 to registrant's Form 8-K filed June 14, 2013.
10.4	Employment Agreement with Joseph White dated June 14, 2013 - Filed as Exhibit 10.2 to registrant's Form 8-K filed June 14, 2013.
10.5	Employment Agreement with Jeff Barlow dated June 14, 2013 - Filed as Exhibit 10.3 to registrant's Form 8-K filed June 14, 2013.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS (1)	XBRL Taxonomy Instance Document.
101.SCH (1)	XBRL Taxonomy Extension Schema Document.
101.CAL (1)	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF (1)	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB (1)	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE (1)	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) Pursuant to Rule 406T of Regulation S-T, XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: July 25, 2013

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: July 25, 2013

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT INDEX

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CERTIFICATE OF AMENDMENT
TO THE
CERTIFICATE OF INCORPORATION
OF
MOLINA HEALTHCARE, INC.

Molina Healthcare, Inc., a corporation organized and existing under the General Corporation Law of the State of Delaware (the " Corporation"), DOES HEREBY CERTIFY as follows:

1. The Corporation hereby amends and restates Article IV, Section A of its Certificate of Incorporation (the " Certificate of Incorporation") to read in its entirety as follows:

"A. The total number of shares of all classes of capital stock which the Corporation shall have the authority to issue is 170,000,000, consisting of (a) 150,000,000 shares of Common Stock, par value $0.001 per share ("Common Stock"), and (b) 20,000,000 shares of Preferred Stock, par value $0.001 per share ("Preferred Stock")."

2. The foregoing amendment of the Certificate of Incorporation has been duly approved by the Board of Directors of the Corporation in accordance with Sections 141 and 242 of the General Corporation Law of the State of Delaware.

3. The foregoing amendment of the Certificate of Incorporation has been duly approved by the stockholders of the Corporation in accordance with Sections 228 and 242 of the General Corporation Law of the State of Delaware.

4. The foregoing amendment of the Certificate of Incorporation was duly adopted in accordance with Section 242 of the General Corporation Law of the State of Delaware.

*****

IN WITNESS WHEREOF, this Certificate of Amendment has been executed on behalf of the Corporation by its Chief Executive Officer on this 2nd day of May, 2013.

Molina Healthcare, Inc.

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.

Chief Executive Officer

Execution Copy

AGREEMENT OF PURCHASE AND SALE

by and between

MOLINA HEALTHCARE, INC.,

a Delaware corporation,

and

MOLINA CENTER, LLC,

a Delaware limited liability company,

together as SELLER

and

AG NET LEASE ACQUISITION CORP.,

a Delaware corporation,

as BUYER

Properties: 200 & 300 Oceangate, Long Beach, CA

3000 Corporate Exchange, Columbus, OH

Dated as of: June 12, 2013

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Exhibit N – Notice of Subordination
Exhibit O-1 – Long Beach Title Pro Forma
Exhibit O-2 -- Columbus Title Pro Forma

AGREEMENT OF PURCHASE AND SALE

THIS AGREEMENT OF PURCHASE AND SALE (" Agreement") dated as of June 12, 2013 (the "Effective Date"), is by and among MOLINA HEALTHCARE, INC., a Delaware corporation ("Molina Healthcare"), Molina Center, LLC, a Delaware limited liability company ("Molina Center", together with Molina Healthcare individually or collectively, as the case may be, " Seller"), and AG NET LEASE ACQUISITION CORP., a Delaware corporation ("Buyer").

WITNESSETH:

WHEREAS, Seller is the owner of those certain Properties defined herein; and

WHEREAS, Seller desires to sell to Buyer, and Buyer desires to purchase from Seller, the Properties on the terms and conditions set forth in this Agreement;

NOW, THEREFORE, in consideration of the mutual promises hereinafter set forth and of other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows.

ARTICLE 1
CERTAIN DEFINITIONS

"Act of Bankruptcy" means with respect to any Person (a) the appointment of, or the taking of possession by, a receiver, custodian, trustee or liquidator of such Person or a substantial part of its property, (b) the admission by such Person of its inability to pay its debts as they become due, (c) the making of a general assignment for the benefit of such Person's creditors, (d) the commencement by or against such Person of a voluntary or involuntary proceeding under the Bankruptcy Code or any federal or state insolvency laws or laws for the composition of indebtedness or for the reorganization of debtors, (e) the adjudication of such Person as a bankrupt or insolvent or (f) the taking of any action for the purpose of effecting any of the foregoing.

"Advisor" is defined in Section 8.1.

"Agreement" is defined in the introductory paragraph of this Agreement.

"Apportioned Items" is defined in Section 11.4.

"Appurtenances" means, collectively, the Columbus Appurtenances and the Long Beach Appurtenances.

"Bankruptcy Law" means the United States Bankruptcy Code, 11 U.S.C.A. §§ 101 et seq. or any federal or state insolvency laws or laws for the reorganization of debtors.

"Bill of Sale" is defined in Section 4.1(b).

"Broker" is defined in Section 8.1.

"Business Day" means any day other than a Saturday, Sunday or a day on which commercial banks in New York, New York, are required to be closed.

"Buyer" is defined in the introductory paragraph of this Agreement.

"Buyer Indemnified Parties" is defined in Section 5.6.

"Buyer Objection Notice" is defined in Section 5.4.

"Buyer Transaction Documents" is defined in Section 6.1(b).

"Buyer's Closing Deliveries" is defined in Section 11.3(b).

"Buyer's Default" means the failure of Buyer to (a) perform any of its obligations under this Agreement or (b) otherwise consummate the Transaction notwithstanding that all of the conditions to its obligation to close have been satisfied.

"Buyer's Transaction Costs" is defined in Section 8.2(a).

"Casualty" means any loss of or damage to or destruction of all or any portion of the Property.

"Certificates of Occupancy" is defined in Section 5.1(m).

"Closing" means the consummation of the purchase and sale contemplated hereunder.

"Closing Date" is defined in Section 11.2.

"Code" means United States Internal Revenue Code of 1986, as amended.

"Columbus Appurtenances" is defined in Section 2.1(a)(iii).

"Columbus Fixtures" is defined in Exhibit B-1

"Columbus Improvements" is defined in Section 2.1(a)(ii).

"Columbus Intangible Property" means the Plans, Permits and Warranties related to the Columbus Real Property, the Columbus Improvements, the Columbus Appurtenances, and/or the items listed in clauses (a) and (b) of the definition of Columbus Property Other Assets (but not any Columbus Property Excluded Items).

"Columbus Property" is defined in Section 2.1(a).

"Columbus Property Excluded Items" is defined in Exhibit B-1.

"Columbus Property Equipment" is defined in Exhibit B-1.

"Columbus Property Other Assets" is defined in Exhibit B-1.

"Columbus Real Property" is defined in Section 2.1(a)(i).

"Condemnation" means (a) any taking or damaging of all or any portion of either of the Properties (i) in or by condemnation or other eminent domain proceedings pursuant to any Legal Requirement, or (ii) by reason of any agreement with any condemnor in settlement of or under threat of any such condemnation or other eminent domain proceeding, or (b) any temporary requisition or confiscation of the use or occupancy of all or any portion of either of the Properties by any Governmental Authority, whether pursuant to an agreement with such governmental authority in settlement of or under threat of any such requisition or confiscation.

"Contracts" means utility contracts, service contracts and other agreements entered into by Seller and used in the ownership, use or operation of either of the Properties.

"Custodian" means any receiver, trustee, assignee, liquidator or similar official under any Bankruptcy Law.

"Deed" is defined in Section 4.1(a).

"Deposit" is defined in Section 2.2(b)(i).

"Due Diligence Period" is defined in Section 3.1.

"Effective Date" is defined in the introductory paragraph of this Agreement.

"Environmental Law" means any applicable federal, state or local law, statute, ordinance, rule, regulation, license, permit, authorization, approval, consent, court order, judgment, decree, injunction, code, requirement or agreement with any Governmental Authority (a) relating to pollution (or the cleanup thereof), or the protection of air, water vapor, surface water, groundwater, drinking water supply, land (including land surface or subsurface), plant, aquatic and animal life from injury caused by a Hazardous Substance or (b) concerning exposure to, or the use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, handling, labeling, production, disposal or remediation of any Hazardous Substance or Hazardous Condition. The term Environmental Law includes, without limitation, the Comprehensive Environmental Response Compensation and Liability Act (CERCLA), the Clean Air Act, the Clean Water Act, the Solid Waste Disposal Act, the Toxic Substance Control Act, the Federal Insecticide, Fungicide and Rodenticide Act, the Occupational Safety and Health Act, the National Environmental Policy Act and the Hazardous Materials Transportation Act, each as amended and hereafter in effect and any similar state or local law.

"Environmental Reports" is defined in Section 5.1(n).

"Equipment" means, collectively, the Columbus Property Equipment and the Long Beach Property Equipment.

"Exchange Act" is defined in Section 12.11.

"Existing Insurance Policies" is defined in Section 5.1(v).

"Existing Mortgage" is defined in Section 5.1(r).

"Financial Statements" is defined in Section 5.1(w).

"Fixtures" means, collectively, the Columbus Fixtures and the Long Beach Fixtures.

"GAAP" means U.S. generally accepted accounting principles consistently applied.

"Governmental Authority" means any federal, state or local government, authority, agency or regulatory body.

"Hazardous Condition" means any condition that would support any claim or liability under any Environmental Law, including the presence of USTs at the Columbus Real Property or the Long Beach Real Property in violation of Environmental Law

"Hazardous Substance" means (a) any substance, material, product, derivative, compound, mineral, chemical, gas or mixture thereof, that is toxic, harmful or hazardous to the environment or public health or safety or (b) any substance supporting a claim under any Environmental Law, whether or not defined as hazardous as such under any Environmental Law. Hazardous Substances include, without limitation, medical waste, industrial waste, petroleum or petroleum-derived substances or waste, radon, radioactive materials, asbestos, asbestos-containing materials, urea-formaldehyde foam insulation, lead, toxic mold or other toxic microbial contamination, and polychlorinated biphenyls.

"Immaterial Casualty" means any Casualty that is not a Material Casualty.

"Immaterial Condemnation" means any Condemnation that is not a Material Condemnation.

"Improvements" means, collectively, the Columbus Improvements and the Long Beach Improvements.

"Indemnified Party" is defined in Section 8.1.

"Intangible Property" means, collectively, the Long Beach Intangible Property and the Columbus Intangible Property.

"Knowledge of Seller" is defined in Section 5.3.

"Leases" is defined in Section 5.1(h).

"Legal Requirements" means the requirements of all present and future laws, including all permit and licensing requirements and all covenants, restrictions and conditions, including all easement agreements, now or hereafter of record which may be applicable to the Properties,

including without limitation the Americans With Disabilities Act, 42 U.S.C.A. §§ 1201 et seq., and all zoning, subdivision, building and Environmental Laws.

"Letter of Intent" means that certain Letter of Intent dated January 18, 2013 between Buyer and Seller.

"Long Beach Appurtenances" is defined in Section 2.1(b)(iii).

"Long Beach Fixtures" is defined in Exhibit B-2.

"Long Beach Improvements" is defined in Section 2.1(b)(ii).

"Loan Beach Intangible Property" means the Plans, Permits and Warranties related to the Long Beach Real Property, the Long Beach Improvements, the Long Beach Appurtenances, and/or the items listed in clauses (a) and (b) of the definition of Long Beach Property Other Assets (but not any Long Beach Property Excluded Items).

"Long Beach Property" is defined in Section 2.1(b).

"Long Beach Property Excluded Items" is defined in Exhibit B-2.

"Long Beach Property Equipment" is defined in Exhibit B-2.

"Long Beach Property Other Assets" is defined in Exhibit B-2.

"Long Beach Real Property" is defined in Section 2.1(b)(i).

"Material Casualty" means a Casualty (a) in which a material portion of either of the Properties is destroyed or damaged prior to the Closing and the cost to repair or restore any loss or damage caused thereby is estimated to be greater than ten percent (10%) of the Purchase Price; or (b) that will result in a material loss of access to either of the Properties, in either case, as determined by Buyer in its reasonable discretion.

"Material Condemnation" means a Condemnation (a) that will result in a loss of material access to either of the Properties; or (b) that involves more than ten percent (10%) of the rentable area of either of the Properties.

"Memorandum of Lease Agreement (Columbus)" means a memorandum of lease in the form of Exhibit K.

"Memorandum of Lease Agreement (Long Beach)" means a memorandum of lease in the form of Exhibit J.

"Molina Center" is defined in the introductory paragraph of this Agreement.

"Molina Healthcare" is defined in the introductory paragraph of this Agreement.

"Notice Sublease" means the following Subleases: State Lands Commission; Department of Industrial Relations; Pacific Maritime Association; California Coastal Commission; Department of General Services; Crowell, Weedon & Co.; J. Perez & Associates, Inc.; Bruce A. Dybens, AP; High Rise Goodies Restaurant; Lisa Brandon, CFLS; MVP Energy, LLC; Rose, Klein & Marias; Perona, Langer, Beck; Dr. Michael Trainotti; Lynn E. Moyer; Esq.; Michael W. Binning; Arthritis National Research; APB Car Wash & Detail.

"Outside Date" is defined in Section 11.2.

"Parking Easement" means a permanent parking easement for the benefit of Seller with respect to any Parking Facilities not owned by Seller or any of its affiliates.

"Parking Facilities" means any and all on-site, satellite or off-site parking facilities utilized by Tenant or its employees, agents, invitees or contractors in connection with the use and operation of any Real Property.

"Permits" is defined in Section 5.1(j).

"Permitted Encumbrances" means, collectively, (a) Permitted Exceptions and (b) all Legal Requirements now or hereafter in effect relating to the Properties.

"Permitted Exceptions" is defined in Section 4.2.

"Person" means an individual, partnership, limited liability company, joint venture, corporation, trust, unincorporated association, any other entity or any government or any department or agency thereof, whether acting in an individual, fiduciary or other capacity.

"Plans" is defined in Section 5.1(k).

"Property" and "Properties" are defined in Section 2.1.

"Proprietary Information" means any written, oral, documentary or other information (including reports, tests, and studies) relating to the Transaction which is received by one party from the other party (or from third parties through the other party's authorization) and is not publicly available, including, without limitation, (a) information relating to the ownership, condition, operation and/or financial performance of either of the Properties, (b) the fact that discussions or negotiations are taking place between the parties with respect the Transaction, and (c) information relating to the terms and conditions on which each of Buyer and Seller is willing to enter into the Transaction and the terms on which Buyer is able to obtain financing with respect to the Transaction. Information shall not be deemed Proprietary Information if such information: (i) is already known to the receiving party without obligation of confidentiality, from a source other than the other party; (ii) is or hereafter becomes publicly known by the receiving party through no wrongful act, fault or negligence of the receiving party; or (iii) is independently developed by the receiving party.

"Purchase Price" is defined in Section 2.2(a).

"Real Property" means, collectively, the Columbus Real Property and the Long Beach Real Property.

"Reimbursable Transaction Costs" is defined in Section 8.2(f).

"Representation Objection Notice" is defined in Section 5.5.

"Securities Act" is defined in Section 12.11.

"Seller" is defined in the introductory paragraph of this Agreement.

"Seller Change Notice" is defined in Section 5.4.

"Seller Indemnified Parties" is defined in Section 6.3.

"Seller Transaction Documents" is defined in Section 5.1(b).

"Seller's Closing Deliveries" is defined in Section 11.3(a).

"Seller's Default" means the failure of Seller to (i) perform any of its obligations under this Agreement or (ii) otherwise consummate the Transaction notwithstanding that all of the conditions to its obligation to close have been satisfied.

"SLB Lease Agreement" means that certain Lease Agreement in the form of Exhibit I.

"SNDA Sublease" means a Sublease listed on Schedule 1(b).

"Specially Designated National or Blocked Person" means a Person (i) designated by the Office of Foreign Assets Control at the U.S. Department of the Treasury, or other U.S. governmental entity, and appearing on the List of Specially Designated Nationals and Blocked Persons (http://www.ustreas.gov/offices/enforcement/ofac/sdn/ index.shtml), which List may be updated from time to time; or (ii) with whom Buyer or its affiliates are prohibited from engaging in transactions by any trade embargo, economic sanction or other prohibition of United States law, regulation, or Executive Order of the President of the United States.

"Sublease(s)" means, individually or collectively, one of more of the Leases listed in Exhibit L

"Sublease SNDA" means a Subordination, Non-Disturbance and Attornment Agreement in the form of Exhibit M.

"Tenant" means the Molina Healthcare.

"Termination Notice" is defined in Section 10.3(c).

"Third Party Consents" is defined in Section 5.1(g).

"Third Party Reports" is defined in Section 3.1.

"Title Commitments" is defined in Section 3.1.

"Title Company" means Fidelity National Title Insurance Company.

"Title Policies" is defined in Section 4.2.

"Transaction" means the transactions contemplated in this Agreement.

"USTs" is defined in Section 5.1(n).

"Warranties" is defined in Section 5.1(l).

ARTICLE 2

PURCHASE AND SALE OF PROPERTY

Section 2.1 Sale. Seller hereby agrees to sell and convey to Buyer, and Buyer hereby agrees to purchase and acquire from Seller, subject to the terms and conditions set forth herein, the following (individually and collectively, as the context may require, the "Property" or "Properties"):

(a) The "Columbus Property," which means:

(i) the real property located in Columbus, Ohio particularly described in Exhibit A-1 (the "Columbus Real Property");

(ii) the buildings and all other structures and improvements situated on, or affixed or appurtenant to the Columbus Real Property, including any Parking Facilities owned by Seller, in each case except to the extent owned by tenants or licensees at the Columbus Real Property (collectively, the "Columbus Improvements");

(iii) all tenements, hereditaments, easements, rights-of-way, rights, privileges appurtenant to the Columbus Real Property, including (A) easements over other lands granted by any easement agreement benefiting the Columbus Real Property, including any Parking Easement, and (B) Seller's right, title and interest in and to any streets, ways, alleys, vaults, gores or strips of land adjoining the Columbus Real Property (collectively, the "Columbus Appurtenances"); and

(iv) all Columbus Property Other Assets.

(b) The "Long Beach Property," which means:

(i) the real property located in Long Beach, CA particularly described in Exhibit A-2 (the "Long Beach Real Property");

(ii) the buildings and all other structures and improvements situated on, or affixed or appurtenant to the Long Beach Real Property, including any Parking Facilities owned by Seller, in each case except to the extent owned by tenants or licensees at the Long Beach Real Property (collectively, the "Long Beach Improvements");

(iii) all tenements, hereditaments, easements, rights-of-way, rights, privileges appurtenant to the Long Beach Real Property, including (A) easements over other lands granted by any easement agreement benefiting the Long Beach Real Property, including any Parking Easement, and (B) Seller's right, title and interest in and to any streets, ways, alleys, vaults, gores or strips of land adjoining the Long Beach Real Property (collectively, the "Long Beach Appurtenances"); and

(iv) all Long Beach Property Other Assets.

Section 2.2 Purchase Price.

(a) The purchase price of the Properties is One Hundred Fifty Eight Million Six Hundred Twenty Five Thousand Five Hundred Sixty Six and No/100 Dollars ($158,625,566.00) (the " Purchase Price"), which amount is the sum of One Hundred Thirty Four Million Six Hundred Twenty Five Thousand Five Hundred Sixty-Six and No/100 Dollars ($134,625,566.00) for the purchase of the Long Beach Property and Twenty-Four Million and No/100 Dollars ($24,000,000.00) for the purchase of the Columbus Property.

(b) The Purchase Price shall be paid as follows:

(i) Within two (2) Business Days after the Effective Date, Buyer shall deposit in escrow with the Title Company cash in the amount of Three Million Five Hundred Thousand and No/100 Dollars ($3,500,000.00) (the " Deposit"), provided, however, that if the Closing Date occurs within two (2) Business Days of the Effective Date, the Deposit will be delivered prior to the Closing. The Deposit shall be held in an interest-bearing account and all interest or other income earned from the Deposit shall accrue to the benefit of Buyer. At the Closing, the Deposit shall be paid to Seller and credited against the Purchase Price. Except as otherwise provided in this Agreement, the Deposit shall not be refundable to Buyer.

(ii) IF THE SALE OF THE PROPERTIES IS NOT CONSUMMATED DUE TO THE FAILURE OF ANY CONDITION PRECEDENT AND NO BUYER'S DEFAULT HAS OCCURRED, THEN THE TITLE COMPANY SHALL RETURN THE DEPOSIT TO BUYER. IF THE SALE OF THE PROPERTIES IS NOT CONSUMMATED DUE TO A SELLER'S DEFAULT, THEN, AS BUYER'S SOLE AND EXCLUSIVE REMEDY, BUYER MAY EITHER: (1) TERMINATE THIS AGREEMENT AND RECEIVE A REFUND OF THE DEPOSIT, IN WHICH EVENT NEITHER PARTY SHALL HAVE ANY FURTHER RIGHTS OR OBLIGATIONS HEREUNDER, AND SELLER SHALL REIMBURSE BUYER FOR ALL OF BUYER'S REIMBURSABLE TRANSACTION COSTS OR (2) ENFORCE SPECIFIC PERFORMANCE OF THIS AGREEMENT.

(iii) THE PARTIES HAVE AGREED THAT, IF THE SALE OF THE PROPERTIES IS NOT CONSUMMATED DUE TO A BUYER'S DEFAULT, SELLER'S ACTUAL DAMAGES WOULD BE EXTREMELY DIFFICULT, IF NOT IMPOSSIBLE, TO DETERMINE. AFTER NEGOTIATION, THE PARTIES HAVE AGREED THAT, CONSIDERING ALL THE CIRCUMSTANCES EXISTING ON THE DATE OF THIS AGREEMENT, THE AMOUNT OF THE DEPOSIT IS A FAIR AND REASONABLE ESTIMATE OF THE DAMAGES THAT SELLER WOULD INCUR IN THE EVENT OF A BUYER'S DEFAULT.IN THE EVENT OF A BUYER'S DEFAULT, SELLER MAY TERMINATE THIS AGREEMENT, AND THE DEPOSIT SHALL BE FORFEITED TO AND DELIVERED TO SELLER AS LIQUIDATED DAMAGES AND AS THE SOLE AND EXCLUSIVE REMEDY AVAILABLE TO SELLER FOR SUCH BUYER'S DEFAULT. THE PARTIES HERETO HEREBY ACKNOWLEDGE THAT IT IS IMPOSSIBLE TO MORE PRECISELY ESTIMATE THE SPECIFIC DAMAGE THAT MIGHT BE SUFFERED BY SELLER, AND THE PARTIES HERETO EXPRESSLY ACKNOWLEDGE AND INTEND THAT THIS PROVISION SHALL BE A PROVISION FOR THE RETENTION OF EARNEST

MONEY PURSUANT TO THE APPLICABLE PROVISIONS OF THE LAWS OF THE STATE OF NEW YORK AND ANY OTHER LOCAL LAW AND NOT AS A PENALTYBY PLACING ITS INITIALS BELOW, EACH PARTY SPECIFICALLY CONFIRMS THE ACCURACY OF THE STATEMENTS MADE ABOVE AND THE FACT THAT EACH PARTY WAS REPRESENTED BY COUNSEL WHO EXPLAINED, AT THE TIME THIS AGREEMENT WAS MADE, THE CONSEQUENCES OF THIS LIQUIDATED DAMAGES PROVISION.

(iv) SECTIONS 2.2(b)(ii), 2.2(b)(iii), AND 2.2(b)(iv) SHALL SURVIVE TERMINATION OF THIS AGREEMENT. NOTHING CONTAINED IN SECTION 2.2(b)(ii) OR SECTION 2.2(b)(iii) IS INTENDED TO LIMIT (A) BUYER'S LIABILITY TO SELLER FOR DAMAGES OR INJUNCTIVE RELIEF FOR BREACH OF BUYER'S INDEMNITY OBLIGATIONS UNDER THIS AGREEMENT (INCLUDING WITHOUT LIMITATION UNDER SECTION 6.3), OR FOR ATTORNEY FEES AND COSTS AS DESCRIBED IN SECTION 12.17, OR (B) THE PARTIES' RIGHTS PURSUANT TO ANY OTHER PROVISION OF THIS AGREEMENT THAT EXPRESSLY SURVIVES THE TERMINATION OF THIS AGREEMENT.

(v) WITHOUT LIMITING ANYTHING CONTAINED IN SECTION 12.10, THE PAYMENT OF LIQUIDATED DAMAGES UNDER THIS AGREEMENT IS NOT INTENDED AS A FORFEITURE OR PENALTY WITHIN THE MEANING OF CALIFORNIA CIVIL CODE §3275 OR §3369 BUT IS INTENDED TO CONSTITUTE LIQUIDATED DAMAGES TO SELLER WITHIN THE MEANING OF CALIFORNIA CIVIL CODE §§1671, 1676, AND 1677.

INITIALS: SELLER _____ BUYER _____

(vi) The balance of the Purchase Price shall be paid to Seller in immediately available funds via wire transfer at the Closing.

ARTICLE 3

BUYER'S DUE DILIGENCE

Section 3.1 Due Diligence. Prior to the Effective Date, Buyer completed its due diligence investigation of the Properties and its credit analysis and underwriting of Seller and Tenant (such period being referred to herein as the " Due Diligence Period"). During the Due Diligence Period, Buyer conducted a physical inspection of the Properties and obtained the following, each in form and substance satisfactory to Buyer, with respect to each of the Properties (collectively, the " Third Party Reports"): (i) an engineering/property condition report, including a roof report; (ii) an environmental assessment report(s); (iii) a title report and commitment for title insurance from the Title Company, copies of which are attached hereto as Exhibit O (the "Title Commitments"), together with copies of all underlying documents; (iv) a current "as built" ALTA survey; (v) an MAI appraisal; (vi) a seismic report, if such Property is located in Seismic Design Category D, E or F as designated in the International Building Code; (vii) a property zoning report; and (viii) an Americans with Disabilities Act survey.

ARTICLE 4

TITLE

Section 4.1 Transfer of Title. At the Closing, Seller shall convey to Buyer:

(a) the Real Property, Improvements, Fixtures and Appurtenances by good and sufficient Deeds in the form of Exhibit D-1 and Exhibit D-2, respectively (each, individually, a "Deed"); and

(b) the Equipment and Intangible Property by good and sufficient Bills of Sale in the form of Exhibit E-1 and Exhibit E-2, respectively (each, individually, a "Bill of Sale").

Section 4.2 Evidence of Title. Buyer acknowledges that Title Company has issued the Title Commitments to Buyer, committing the Title Company to issue a standard Owner's American Land Title Association Policy of Title Insurance regarding each Real Property (collectively, the "Title Policies"), in the amount of the Purchase Price allocated to such Real Property, showing title to the applicable Real Property, Improvements, and Appurtenances vested in Buyer and subject only to certain exceptions listed therein. As used herein, the "Permitted Exceptions" means, collectively, the following:

(a) interests of tenants and licensees in possession;

(b) non-delinquent liens for local real estate taxes and assessments;

(c) the exceptions set forth in the Title Commitment regarding such Real Property, Improvements and Appurtenances; and

(d) any other instrument delivered at the Closing pursuant to the terms hereof and recorded against title to any of the Real Property pursuant to the terms of such instrument or this Agreement.

Notwithstanding the foregoing, but without limiting anything contained in Section 10.1, Buyer acknowledges and agrees that in no event shall issuance or delivery of the Title Policies be a covenant of Seller hereunder.

ARTICLE 5

SELLER'S REPRESENTATIONS AND WARRANTIES

Section 5.1 Representations and Warranties of Seller. Seller represents and warrants to Buyer that as of the Effective Date and as of the Closing Date:

(e) Molina Healthcare is a Delaware corporation, duly organized, validly existing and in good standing under the laws of the State of Delaware, and is duly qualified to do business and is in good standing in the State of Ohio. Molina Center is a Delaware corporation,

duly organized, validly existing and in good standing under the laws of the State of Delaware, and is duly qualified to do business and is in good standing in the State of California. Seller's principal place of business is 300 Oceangate, Suite 950, Long Beach, CA 90802.

(f) Seller has full power, authority and legal right to: (i) sell the Properties to Buyer; (ii) execute and deliver this Agreement, the Deeds, the Bills of Sale and such other instruments, documents and agreements as may be necessary or appropriate to effect the Transaction (collectively, the "Seller Transaction Documents"); and (iii) perform and observe the terms and conditions of each of the documents described above.

(g) This Agreement and, at the Closing, all other Seller Transaction Documents (i) are each duly authorized, executed and delivered by Seller, (ii) are each a legal, valid and binding obligation of Seller enforceable against Seller in accordance with its terms except as enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by general equitable principles, (iii) do not violate any of Seller's charter documents and (iv) do not conflict with or result in the breach of any judgment, decree, writ, injunction, order or award of any arbitrator, court or Governmental Authority binding upon Seller, or result in the breach of any term or provision of, or constitute a default, or result in the acceleration of any obligation under any loan agreement, indenture, financing agreement, or any other agreement or instrument of any kind to which Seller is a party or to which Seller or either of the Properties is subject.

(h) Seller is not a foreign corporation, foreign partnership, foreign trust and/or foreign estate (as those terms are defined in the Code and in the accompanying regulations). Molina Healthcare's U.S. employer identification number is 13-4204626. Molina Center's U.S. employer identification number is 27-4034065.

(i) Neither Seller nor any of Seller's officers or directors is a Specially Designated National or Blocked Person.

(j) Seller has not commenced a voluntary case under Bankruptcy Law nor has there been commenced against Seller an involuntary case under Bankruptcy Law, nor has Seller consented to the appointment of a Custodian of it or for all or any substantial part of its property, nor has a court of competent jurisdiction entered an order or decree under any applicable Bankruptcy Law that is for relief against Seller or appoints a Custodian for Seller or for all or any substantial part of Seller's property.

(k) Except for the approvals and consents listed in Schedule 5.1(g) (the "Third Party Consents"), no authorizations, consents or approvals of or filings with any Governmental Authority or any other Person is required in order for Seller to execute and deliver this Agreement and to perform its obligations hereunder. Seller has obtained, or will have obtained prior to the Closing, all Third Party Consents.

(l) The list of leases (including amendments, extensions and supplements, as applicable) in Schedule 5.1(h) (collectively, the "Leases") is a complete list of all of the leases

encumbering the Properties (other than, at Closing, the SLB Lease Agreement). Seller has provided Buyer with a true and complete copy of each Lease. Each Lease is in full force and effect and is a legal, valid, binding and enforceable obligation of each of the parties thereto except as enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by general equitable principles. Except as described in Schedule 5.1(h), no Lease has been amended, modified or supplemented and no provision of any Lease has been waived. To the Knowledge of Seller, except as described in Schedule 5.1(h), no event has occurred which with the giving of notice or the passage of time, or both, would constitute a material default under any of the Leases. Seller has received no written notice of default from any Person alleging any default under any Lease on the part of the Seller. Except as described in Schedule 5.1(h), or otherwise disclosed to Buyer in writing, to the Knowledge of Seller, (i) no tenant of either of the Properties nor any other Person has any purchase option regarding either of the Properties, (ii) no tenant under any Lease has any right to terminate such Lease as a result of the Transaction, and (iii) no tenant under any Lease has any right of first refusal, right of first offer or similar right to purchase any of the Properties or any portion thereof as a result of the Transaction. Except as described in Schedule 5.1(h), or otherwise disclosed to Buyer in writing, there are no brokerage, leasing or other commissions payable by Seller with respect to the Leases. Except as described in Schedule 5.1(h), or otherwise disclosed to Buyer in writing, no party other than Seller, the tenants under the Leases, and licensees under license agreements previously disclosed to Buyer, is entitled to possession or use of the Property or any portion thereof.

(m) The list of Contracts (including amendments, extensions and supplements, as applicable) in Schedule 5.1(i) is a complete list of all of the Contracts affecting each of the Properties to which Seller is a party. Seller has provided Buyer with a true and complete copy of each Contract and each Contract is in full force and effect and is a legal, valid, binding and enforceable obligation of each of the parties thereto except as enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by general equitable principles. Except as described in Schedule 5.1(i), none of the Contracts has been amended, modified or supplemented and no provision of any of the Contracts has been waived.

(n) The list of permits, licenses and approvals (including amendments, extensions and supplements, as applicable) in Schedule 5.1(j) is a complete list of all permits, licenses, and approvals mandated or necessary to own and operate the Properties (collectively, the "Permits"). Seller has provided Buyer with a true and complete copy of each Permit. Except as set forth in Schedule 5.1(j), to the Knowledge of Seller, each Permit (i) has been properly issued and is fully paid for; (ii) is in full force and effect and no suspension, cancellation or amendment of any of such Permit is pending or threatened; and (iii) is transferable and will not be revoked, invalidated, violated or otherwise adversely affected by the Transaction.

(o) The list of plans and drawings in Schedule 5.1(k) is a complete list of all building plans and drawings with respect to the Improvements in the possession of Seller (the "Plans"). Seller has provided to Buyer correct and complete copies of the Plans.

(p) The list of warranties and guaranties in Schedule 5.1(l) is a complete list of all warranties and guaranties with respect to the Improvements in the possession of Seller (the "Warranties"). Seller has provided to Buyer correct and complete copies of the Warranties.

(q) The certificates of occupancy listed on Schedule 5.1(m) are true and complete copies of all of the certificates of occupancy required for the occupancy and operation of the Improvements by Seller (the "Certificates of Occupancy"). To the Knowledge of Seller, the Certificates of Occupancy have been properly issued. All fees payable in connection therewith have been paid in full. No applications are pending to amend any such Certificates of Occupancy.

(r) To the Knowledge of Seller, Seller is and has been in compliance with all applicable Environmental Laws, and Seller has not received any written notice, report or information regarding (i) any past violations of any applicable Environmental Laws that have not been corrected or (ii) any required corrective, investigatory or remedial obligations, arising under any applicable Environmental Law that have not been completed, in each case to the satisfaction of the applicable Governmental Authority. Seller has delivered to Buyer complete, unedited and unredacted copies of all environmental reports in Seller's possession relating to the Property (collectively, the "Environmental Reports"). Except as set forth on Schedule 5.1(n), there are no underground storage tanks ("USTs") located on or under either of the Properties. To the Knowledge of Seller, the UST under the Long Beach Real Property only contains, and has only contained, water and certain water treatment chemicals in compliance with Environmental Laws given the intended uses of such water.

(s) Pursuant to California Health and Safety Code section 25359.7, Seller hereby gives notice to Buyer, and Buyer hereby acknowledges receipt of such notice from Seller, that Seller does not know of or have reasonable cause to believe that a release of Hazardous Substances has come to be located on or beneath either of the Properties. Buyer also hereby acknowledges receipt of the disclosure reports listed on Schedule 5.1(o) and, without limitation, all Seller's representations and warranties contained in this Section 5.1 are deemed qualified by the contents thereof.

(t) Seller has received no written notice that either of the Properties is not in compliance with all applicable Legal Requirements (except where such non-compliance has been corrected).

(u) There are no actions, suits, proceedings or governmental investigations pending or, to the Knowledge of Seller, threatened against Seller or either of the Properties: (i) that could reasonably be expected to result in any adverse change in Seller's business or financial condition; (ii) that could reasonably be expected to adversely affect the current use or operation of either of the Properties or (iii) that could reasonably be expected to adversely affect Seller's ability to perform its obligations under this Agreement.

(v) Except for the indebtedness set forth in Schedule 5.1(r) (the "Existing Mortgage"), which will be repaid as of the Closing, none of the Properties is pledged to secure any indebtedness of Seller or any other Person.

(w) Seller has not granted any unrecorded deeds, mortgages, land contracts, options to purchase, agreements or other instruments adversely affecting title to either of the Properties, and none of Seller or any agent, officer, employee or principal thereof has created any unrecorded lien, encumbrance, transfer of interest, or constructive trust in either of the Properties (provided that in no event shall any of the foregoing in this Section 5.1(s) be deemed to include any of the Leases or other matters disclosed on Schedule 5.1(h), or any other matter disclosed to Buyer in writing).

(x) All real property taxes and assessments due with respect to each of the Properties have been paid in full and there are no tax appeals, tax certiorari proceedings, tax reduction proceedings, tax protests or special assessment proceedings pending with respect to either of the Properties.

(y) There are no Condemnation, zoning or other land-use proceedings, either pending or, to the Knowledge of Seller, threatened, which could reasonably be expected to materially and adversely affect: (i) vehicular access to either of the Properties; (ii) access by either of the Properties to sewer or utility hook-ups; (iii) the current use and operation of either of the Properties or (iv) the value of either of the Properties.

(z) Schedule 5.1(v) contains a list of the existing insurance policies maintained by Seller with respect to the Properties (the "Existing Insurance Policies"). Seller has not received any written notice or demand from any of the insurers of all or any portion of either of the Properties (or insurers of any activities conducted thereon) to correct or change any physical condition on such Property or any practice of Seller (except where such correction or change has been made). Each of the Existing Insurance Policies is in full force and effect, and Seller is in compliance with the requirements of each of the Existing Insurance Policies.

(aa) Schedule 5.1(w) sets forth the financial statements of Molina Healthcare previously provided to Buyer (the "Financial Statements"). The Financial Statements are true and correct in all material respects, have been prepared in accordance with GAAP throughout the periods indicated therein and fairly present the financial condition of Molina Healthcare for the periods indicated therein, subject to customary year-end adjustments with respect to the unaudited financial statements. From December 31, 2012, to the Effective Date, there has been no material adverse change in the assets, liabilities, condition (financial or otherwise) or business of Molina Healthcare from that set forth or reflected in the above-mentioned financial statements other than changes in the ordinary course of business.

(bb) Seller has not made written application to any Governmental Authority for any expansion or further development of either of the Properties and Seller has not received written notice that any expansion or further development of either of the Properties is subject to any restrictions or conditions except as may be in documents recorded against title to either Real Property or set forth in the applicable zoning law requirements or other Legal Requirements.

(cc) Seller has not received written notice (i) from any Governmental Authority of any pending or threatened judicial or administrative action specifically applicable to either

Property or (ii) of any action pending or threatened by land owners adjacent to either of the Properties or other Persons, that in either case of (i) or (ii) would result in a change in the condition of either of the Properties or any part thereof or in any way prevent or limit the construction and/or operation of the Improvements or any part thereof.

(dd) No labor has been performed or materials fabricated or furnished with respect to either of the Properties that could result in a materialman's or mechanic's lien filed against such Property, except as shall have been fully paid or released and except in the ordinary course of tenant improvement work at either of the Properties.

Section 5.2 Survival; Limitation of Liability; Disclosures. All representations and warranties of Seller contained in this Agreement shall survive only for a period of twelve (12) months after the date of Closing. Any disclosure made on any Schedule hereto with respect to any provision of Section 5.1 will be deemed disclosed on all other Schedules relating to all other provisions of Section 5.1 to the extent that it is reasonably apparent from such disclosure that such disclosure also qualifies or applies to such other provisions.

Section 5.3 Knowledge of Seller. Buyer expressly understands and agrees that the phrase to the "Knowledge of Seller" as used in Section 5.1 means a matter that any of the following officers of Seller: John C. Molina, CFO, and Joseph W. White, CAO (a) is actually aware of, (b) received written notice of, or (c) would be expected to discover or otherwise become aware of in the course of conducting reasonable investigation.

Section 5.4 Seller Change Notice. Seller may give written notice to Buyer if, due to any change in circumstance occurring after the date of this Agreement or Seller obtaining any knowledge not possessed on the Effective Date, any representation or warranty of Seller becomes untrue or incorrect prior to Closing (a " Seller Change Notice"). In the event Seller delivers a Seller Change Notice to Buyer, Buyer may, within five (5) Business Days after Buyer's receipt of the Seller Change Notice, either (a) waive any such matter or circumstance which is the subject of such Seller Change Notice or (b) deliver written notice to Seller of Buyer's objection to such matter (a " Buyer Objection Notice"). If Buyer fails to deliver to Seller either such written waiver or a Buyer Objection Notice within said five (5) Business Days, Buyer shall be deemed to have waived any such matter or circumstance in its entirety. If Buyer delivers to Seller a Buyer Objection Notice, Seller shall have the right, but not the obligation, to cure or remedy such matter or circumstance to Buyer's satisfaction, in Buyer's reasonable discretion, within five (5) Business Days after Seller's receipt of the Buyer Objection Notice. If Seller fails to cure or remedy such matter within said five (5) Business Days, Buyer may, within two (2) Business Days after the expiration of said five (5) Business Day cure period, either waive in writing any such matter or circumstance which is the subject of such Seller Change Notice or deliver written notice to Seller of Buyer's election to terminate this Agreement. If Buyer fails to deliver either such written waiver or such written notice of termination to Seller within said two (2) Business Days, Buyer shall be deemed to have waived its right terminate this Agreement pursuant to this Section 5.4. In the event Buyer delivers written notice of election to terminate this Agreement, all obligations of Buyer and Seller hereunder (except the provisions of this Agreement that expressly survive termination of this Agreement) shall terminate and be

of no further force or effect. If necessary, the Closing Date shall be automatically extended for the period of time needed to implement the provisions of this Section and allow for an orderly closing thereafter if this Agreement is not terminated. If Buyer does not exercise such right to terminate this Agreement and the Closing occurs, then at the Closing the Buyer shall be deemed to have accepted the modified representation and warranty of Seller as set forth in the Seller Change Notice. Notwithstanding the foregoing, the parties agree that any lease or other agreement or encumbrance entered into by Seller and approved by Buyer as described in Section 9.1 shall not be deemed a breach of any representation or warranty of Seller under this Agreement, require any Seller Change Notice, or give rise to any right by Buyer to object to same in a Buyer Objection Notice.

Section 5.5 Buyer's Knowledge of Inaccurate Representations and Warranties. In the event that, prior to the Closing, Buyer obtains knowledge that any representation or warranty of Seller set forth in Section 5.1 is inaccurate, then Buyer may notify Seller in writing of such inaccuracy (a "Representation Objection Notice"). If Buyer delivers a Representation Objection Notice, Seller shall have the right, but not the obligation, to cure or remedy such matter or circumstance to Buyer's satisfaction, in Buyer's sole and absolute discretion, within ten (10) Business Days after Seller's receipt of the Representation Objection Notice. If Seller fails to cure or remedy such matter within said ten (10) Business Days, Buyer may, within two (2) Business Days after the expiration of said ten (10) Business Day cure period, either waive any such matter or circumstance which is the subject of such Representation Objection Notice or deliver written notice to Seller of Buyer's election to terminate this Agreement. If Buyer fails to deliver either such written waiver or such written notice of termination to Seller within said two (2) Business Days, Buyer shall be deemed to have waived any objection to such representation or warranty inaccuracy in its entirety. In the event Buyer delivers written notice of election to terminate this Agreement, then (a) all obligations of Buyer hereunder (except the provisions in this Agreement that expressly survive termination of this Agreement) shall terminate and be of no further force or effect and (b) if such inaccuracy resulted from a change in circumstance occurring after the date of this Agreement through no act or omission by Seller, including without limitation Seller obtaining any knowledge not possessed on the date of this Agreement, then Seller shall not be deemed in default of this Agreement and all obligations of Seller hereunder (except the provisions in this Agreement that expressly survive termination of this Agreement) shall terminate and be of no further force or effect. If necessary, the Closing Date shall be automatically extended for the period of time needed to implement the provisions of this Section and allow for an orderly closing thereafter if this Agreement is not terminated. If, in either such event, Buyer does not exercise such right to terminate this Agreement and the Closing occurs, then at the Closing Buyer shall be deemed to have waived all rights and remedies on account of any representation or warranty of Seller to the extent, but only the extent, that Buyer had knowledge prior to the Closing that such representation or warranty was not true. Notwithstanding the foregoing, the parties agree that any lease or other agreement or encumbrance entered into by Seller and approved by Buyer as described in Section 9.1 shall not be deemed a breach of any representation or warranty of Seller under this Agreement, or give rise to any right of Buyer to deliver a Representation Objection Notice.

Section 5.6 Indemnification. Subject to Section 5.4 and 5.5 of this Agreement, from and after the Closing, Seller shall jointly and severally indemnify, defend and hold harmless (a) Buyer, (b) any director, member, manager, officer, shareholder, general partner, limited partner, employee or agent of Buyer (or any legal representative, heir, estate, successor or assign of any thereof), (c) any predecessor or successor partnership, corporation, limited liability company (or other entity) of Buyer, or any of its general partners, members or shareholders and (d) any other affiliates of Buyer (collectively, the " Buyer Indemnified Parties"), from and against any and all liabilities, losses, damages, costs, expenses (including without limitation reasonable attorneys' fees and expenses), causes of action, suits, claims, demands or judgments of any nature in each case caused by or arising from, the fact that any representation or warranty made by Seller herein was materially untrue when made, or any breach by Seller of any representation or warranty set forth herein. This Section 5.6 shall survive the Closing, but shall be of no further force or effect from and after the expiration of the twelve (12) month period following the date of the Closing with respect to any representation or warranty by Seller regarding which Buyer has not previously asserted to Seller, in writing, a breach by Seller (and, in such event, such representation or warranty shall thereafter survive only with respect to such asserted breach).

Section 5.7 "As Is" Purchase; Release. EXCEPT AS OTHERWISE PROVIDED IN THIS AGREEMENT, AND WITHOUT LIMITING ANYTHING CONTAINED IN THE SLB LEASE AGREEMENT, (a) BUYER HAS AGREED TO ACCEPT THE PROPERTY ON THE CLOSING DATE ON AN "AS IS" BASIS. SELLER AND BUYER AGREE THAT THE PROPERTY WILL BE SOLD "AS IS, WHERE IS, WITH ALL FAULTS" WITH NO RIGHT OF SET-OFF OR REDUCTION IN THE PURCHASE PRICE, AND, EXCEPT AS SET FORTH IN SECTION 5.1 OF THIS AGREEMENT, SUCH SALE WILL BE WITHOUT REPRESENTATION OR WARRANTY OF ANY KIND, EXPRESS OR IMPLIED (INCLUDING, WITHOUT LIMITATION, WARRANTY OF INCOME POTENTIAL, OPERATING EXPENSES, USES, MERCHANTABILITY, OR FITNESS FOR A PARTICULAR PURPOSE), AND SELLER DISCLAIMS AND RENOUNCES ANY SUCH REPRESENTATION OR WARRANTY.Except as provided in this Article 5, effective from and after the Closing, Buyer hereby waives, releases, acquits, and forever discharges Seller, and Seller's agents, directors, officers, and employees to the maximum extent permitted by law, of and from any and all claims, actions, causes of action, demands, rights, liabilities, damages, losses, costs, expenses, or compensation whatsoever, direct or indirect, known or unknown, foreseen or unforeseen, that it now has or that may arise in the future because of or in any way growing out of or connected with this Agreement and the Properties (including without limitation the condition of the Property), except matters arising from Seller's fraud or intentional misrepresentation With respect to the claims released in this Section 5.7, Buyer expressly waives any rights or benefits available to it under the provisions of Section 1542 of the California Civil Code, which provides as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known

by him or her must have materially affected his or her settlement with the debtor."

Buyer acknowledges that its attorney at law has explained to it the meaning and effect of this statute. Buyer understands fully the statutory language of California Civil Code Section 1542, and, with this understanding, Buyer nevertheless elects to, and does, assume all risk for claims released under this Agreement whether arising before or after this Agreement and whether now known or unknown, and Buyer specifically waives any rights it may have under California Civil Code Section 1542 and any successive sections or statutes of a similar nature. Buyer fully understands that if the facts with respect to which this Agreement is executed are later found to be other than or different from the facts now believed by it to be true, it expressly accepts and

assumes the risk of that possible difference in facts and agrees that this Agreement shall be and remain effective notwithstanding that difference in facts.

The provisions of this Section 5.7 shall survive the Closing and termination of this Agreement.

_____ _____

Buyer's Initials Seller's Initials

ARTICLE 6

BUYER'S REPRESENTATIONS AND WARRANTIES

Section 6.1 Representations and Warranties of Buyer. Buyer represents and warrants to Seller that as of the Effective Date and as of the Closing Date:

(a) Buyer is a Delaware corporation, duly organized, validly existing and in good standing under the laws of the State of Delaware, and is duly qualified to do business and is in good standing in the State of Ohio and in the State of California. Buyer's principal place of business is 245 Park Avenue, 26th Floor, New York, NY 10167-0094.

(b) Buyer has full power, authority and legal right to: (i) buy the Properties from Seller; (ii) execute and deliver this Agreement, the Bills of Sale and such other instruments, documents and agreements as may be necessary or appropriate to effect the Transaction (collectively, the "Buyer Transaction Documents"); and (iii) perform and observe the terms and conditions of each of the documents described above.

(c) This Agreement and, at the Closing, all other Buyer Transaction Documents (i) are each duly authorized, executed and delivered by Buyer, (ii) are each a legal, valid and binding obligation of Buyer enforceable against Buyer in accordance with its terms except as enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by general equitable principles, (iii) do not violate any of Buyer's charter documents and (iv) do not conflict with or result in the breach of any judgment, decree, writ, injunction, order or award of any arbitrator, court or Governmental Authority binding upon Buyer, or result in the breach of any term or provision of, or constitute a default, or result in the acceleration of any obligation under any loan agreement, indenture, financing agreement, or any other agreement or instrument of any kind to which Buyer is a party.

(d) Neither Buyer nor any of Buyer's officers or directors is a Specially Designated National or Blocked Person.

(e) Buyer has not commenced a voluntary case under Bankruptcy Law nor has there been commenced against Buyer an involuntary case under Bankruptcy Law, nor has Buyer consented to the appointment of a Custodian of it or for all or any substantial part of its property, nor has a court of competent jurisdiction entered an order or decree under any applicable Bankruptcy

Law that is for relief against Buyer or appoints a Custodian for Buyer or for all or any substantial part of Buyer's property.

(f) No authorizations, consents or approvals of or filings with any Governmental Authority or any other Person is required in order for Buyer to execute and deliver this Agreement and to perform its obligations hereunder.

(g) There are no actions, suits, proceedings or governmental investigations pending or, to Buyer's knowledge, threatened against or affecting Buyer: (i) that could reasonably be expected to result in any adverse change in Buyer's business or financial condition; or (ii) that could reasonably be expected to adversely affect Buyer's ability to perform its obligations under this Agreement.

Section 6.2 Survival; Limitation of Liability. All representations and warranties of Buyer contained in this Agreement shall survive only for a period of twelve (12) months after the date of Closing.

Section 6.3 Indemnification. From and after the Closing, Buyer shall indemnify, defend and hold harmless (a) Seller, (b) any director, member, manager, officer, shareholder, general partner, limited partner, employee or agent of Seller (or any legal representative, heir, estate, successor or assign of any thereof), (c) any predecessor or successor partnership, corporation, limited liability company (or other entity) of Seller, or any of its general partners, members or shareholders and (d) any other affiliates of Seller (collectively, the "Seller Indemnified Parties"), from and against any and all liabilities, losses, damages, costs, expenses (including without limitation reasonable attorneys' fees and expenses), causes of action, suits, claims, demands or judgments of any nature in each case caused by or arising from, the fact that any representation or warranty made by Buyer herein was materially untrue when made, or any breach by Buyer of any representation or warranty set forth herein. This Section 6.3 shall survive the Closing but shall be of no further force or effect from and after the expiration of the twelve (12) month period following the date of the Closing with respect to any representation or warranty by Buyer regarding which Seller has not previously asserted to Buyer, in writing, a breach by Buyer (and, in such event, such representation or warranty shall thereafter survive only with respect to such asserted breach)

ARTICLE 7

RISK OF LOSS AND INSURANCE PROCEEDS

Section 7.1 Casualty. Seller shall give Buyer timely notice of any Casualty affecting any portion of either of the Properties prior to Closing. In the event of a Material Casualty prior to Closing, Buyer may, by written notice to Seller delivered not later than ten (10) Business Days after receipt of Seller's notice of such Casualty, either (a) terminate this Agreement or (b) confirm Buyer's intention to consummate the Transaction in accordance with the terms of this Agreement. If Buyer elects to terminate this Agreement or fails to deliver such written notice within such ten (10) Business Day period, then this Agreement shall terminate

at the end of such ten (10) Business Day period in accordance with Section 10.3(c). In the event, prior to Closing, of an Immaterial Casualty or a Material Casualty with respect to which Buyer elects to proceed to consummate the Transaction, then Closing shall occur as scheduled and provisions of the SLB Lease Agreement relating to casualty shall apply. The provisions of this Section 7.1 shall survive the Closing.

Section 7.2 Condemnation.

Seller shall give Buyer notice of any proceeding involving a Condemnation affecting any portion of either of the Properties prior to Closing. In the event of a proceeding involving a Material Condemnation prior to Closing, Buyer may, by written notice to Seller, delivered not later than ten (10) Business Days after receipt of Seller's notice of such Material Condemnation, either (a) terminate this Agreement or (b) confirm Buyer's intention to consummate the Transaction in accordance with the terms of this Agreement. If Buyer elects to terminate this Agreement or fails to deliver to such written notice within such ten (10) Business Day period, then this Agreement shall terminate at the end of such ten (10) Business Day period in accordance with Section 10.3(c). In the event, prior to Closing, of a proceeding involving an Immaterial Condemnation or a Material Condemnation with respect to which Buyer elects to proceed to consummate the Transaction, then Closing shall occur as scheduled and provisions of the SLB Lease Agreement relating to condemnation shall apply. The provisions of this Section 7.2 shall survive the Closing.

Section 7.3 New York General Obligations Law. This Article is an express agreement to the contrary of Section 5-1311 of the New York General Obligations Law.

ARTICLE 8

BROKERS AND EXPENSES

Section 8.1 Brokers. Each of the parties hereto represents and warrants to the other party that except for Western Reserve Partners LLC, whose address is 200 Public Square, Suite 3750, Cleveland, Ohio 44114 (the " Advisor"), whose advisory fee shall be paid by Seller upon the Closing pursuant to a separate agreement, and McKinney Advisory Group whose address is 12250 El Camino Real, Suite 220, San Diego, California 92130 (the " Broker"), whose commission shall be paid by Seller upon the Closing pursuant to a separate agreement, no commercial real estate broker or finder, or advisor, was instrumental in arranging or bringing about the Transaction and that there are no claims or rights for commercial real estate brokerage commissions, finder's fees or advisory fees in connection with the Transaction. If any Person brings a claim for a commercial real estate brokerage commission, finder's fees or advisory fees based upon any contact, dealings or communication with Buyer or Seller, then the party through whom such Person makes his claim shall defend the other party (the " Indemnified Party") from such claim, and shall indemnify the Indemnified Party and hold the Indemnified Party harmless from any and all costs, damages, claims, liabilities or expenses (including, without limitation, reasonable attorneys' fees and disbursements) incurred by the Indemnified Party in defending against the claim. The provisions of this Section 8.1 shall survive the Closing or, if the purchase and sale is not consummated, any termination of this Agreement.

Section 8.2 Expenses.

(a) Unless Buyer terminates this Agreement due to a Seller's Default, Buyer will be responsible for all of Buyer's fees and expenses related to the Transaction, which shall include but not be limited to the cost of the Third Party Reports and any additional third party reports required by Buyer's mortgage lender, Buyer's accounting fees and expenses and Buyer's legal fees and expenses (including Lender's legal fees and expenses) (collectively, "Buyer's Transaction Costs").

(b) Seller will jointly and severally in all cases be responsible for Sellers' legal and accounting fees and expenses.

(c) Buyer will be responsible for the payment of all transfer taxes, recording fees (with respect to both the Deeds and the Buyer's deed of trust, mortgage, and related documents) and Buyer's title insurance premiums.

(d) Buyer and Seller will each be responsible for one-half of all escrow fees.

(e) All other transaction costs and expenses shall be allocated at the Closing in accordance with respective local custom.

(f) In the event that Buyer terminates this Agreement due to a Seller's Default, Seller shall jointly and severally be responsible for paying directly or reimbursing all Buyer's out-of-pocket Transaction Costs that are reasonable and customary, incurred to third parties, and evidenced by written invoices or similar documentation (the " Reimbursable Transaction Costs").

(g) The provisions of this Section 8.2 shall survive the Closing, or, if the sale is not consummated, the termination of this Agreement.

ARTICLE 9

COVENANTS OF SELLER

Section 9.1 Buyer's Approval of Agreements Affecting the Properties. Between the Effective Date and the Closing Date, Seller shall not enter into or suffer to exist any new lease, license, contract, easement, covenant, condition, restriction, lien, security interest or other agreement or encumbrance affecting either of the Properties (other than the Permitted Encumbrances and any actions of third parties under any existing agreements encumbering or affecting any of the Properties where Seller does not have a consent or approval right regarding such actions), or amend, modify, terminate, or waive any provision of, any of the foregoing, without first obtaining Buyer's approval, which approval may be withheld in Buyer's reasonable discretion. Seller shall submit an actual copy of such new lease, license, contract, easement, covenant, condition, restriction, lien, security interest or other agreement, encumbrance, amendment, modification, termination or waiver at the time that Seller seeks Buyer's approval. If Buyer fails to give Seller notice of its approval or disapproval of any such proposed action

within five (5) Business Days after Seller notifies Buyer of Seller's desire to take such action, then Buyer shall be deemed to have withheld its approval. Notwithstanding the foregoing, Seller hereby grants its written approval to all of the matters described on Schedule 9.1.

Section 9.2 Material Adverse Changes. Seller shall promptly notify Buyer of any material adverse change with respect to the condition of either of the Properties, or the financial or operating condition of Seller or of any event or circumstance that makes any representation or warranty of Seller under this Agreement untrue in any material respect. Buyer shall promptly notify Seller of any event or circumstance that makes any representation or warranty of Buyer under this Agreement untrue in any material respect.

ARTICLE 10

CONDITIONS TO CLOSING

Section 10.1 Conditions to Buyer's Obligation to Close. The obligation of Buyer to acquire the Properties on the Closing Date shall be subject to the satisfaction or written waiver by Buyer of the following conditions precedent on and as of the Closing Date:

(a) Representations and Warranties of Seller. The representations and warranties of Seller set forth in Section 5.1 (subject to Section 5.4 and Section 5.5) shall be true, complete and correct in all material respects on and as of the Effective Date and on and as of the Closing Date.

(b) Seller's Performance. Seller shall have performed all covenants and obligations required by this Agreement to be performed or delivered by it on or before the Closing Date.

(c) Seller's Closing Deliveries. Seller shall have delivered to the Title Company all of Seller's Closing Deliveries.

(d) Title Policies. The Title Company shall be unconditionally obligated and prepared, subject only to payment of the applicable premium and other related charges and the recording, as applicable, of all conveyance documents and the release of the Existing Mortgage, to issue each of the Title Policies to Buyer, subject only to the Permitted Exceptions.

(e) No Bankruptcy. No Act of Bankruptcy on the part of Seller shall have occurred and remain outstanding as of the Closing Date.

(f) Repayment of Indebtedness. Seller shall have caused to be delivered to the Title Company a payoff demand letter from the holder of the Existing Mortgage and the liens with respect thereto shall be released at Closing.

(g) Consents. All Third Party Consents shall have been obtained pursuant to documentation reasonably satisfactory to Buyer and the Title Company.

(h) Material Adverse Change. There shall have been no material adverse change in the physical condition of either of the Properties or the financial or operating condition of Seller or Tenant from the Effective Date.

(i) Outside Date. The Closing shall occur on or before the Outside Date.

(j) Sublease SNDAs. Each subtenant under an SNDA Sublease shall have delivered an original Sublease SNDA, duly executed by such subtenant and notarized.

Section 10.2 Conditions to Seller's Obligation to Close. The obligation of Seller to convey and transfer to Buyer each of the Properties on the Closing Date is subject to the satisfaction or written waiver by Seller of the following conditions precedent on and as of the Closing Date:

(a) Representations and Warranties of Buyer. The representations and warranties of Buyer set forth in Section 6.1 shall be true, complete and correct in all material respects on and as of the Effective Date and on and as of the Closing Date.

(b) Buyer's Performance. Buyer shall have performed all covenants and obligations required by this Agreement to be performed or delivered by it on or before the Closing Date, including, without limitation, delivery of the Purchase Price.

(c) Buyer's Closing Deliveries. Buyer shall have delivered to the Title Company all of Buyer's Closing Deliveries.

(d) No Bankruptcy. No Act of Bankruptcy on the part of Buyer shall have occurred and remain outstanding as of the Closing Date.

(e) Outside Date. The Closing shall occur on or before the Outside Date.

Section 10.3 Failure to Satisfy Conditions.

(a) Buyer's Obligations to Close. Without limiting Section 2.2(b), if any of the conditions to Buyer's obligation to close set forth in Section 10.1 is not satisfied on and as of the Closing Date, Buyer shall have the right to either: (i) terminate this Agreement or (ii) consummate the purchase of the Properties with no change in the Purchase Price.

(b) Seller's Obligations to Close. Without limiting Section 2.2(b), if any of the conditions to Seller's obligation to close set forth in Section 10.2 is not satisfied on and as of the Closing Date, Seller shall have the right to: (i) terminate this Agreement or (ii) consummate the sale of the Properties with no change in the Purchase Price.

(c) Termination. In the event that either party wishes to terminate this Agreement pursuant to this Section 10.3, such party shall deliver to the other party and to the Title Company on the Closing Date written notice of such party's intention to terminate this Agreement (a "Termination Notice"). Upon the delivery of a Termination Notice pursuant to this Section 10.3

(c), subject to the provisions of Sections 2.2(b) and provisions hereof that expressly survive termination, this Agreement shall terminate automatically, the Deposit shall be returned to Buyer, and neither party shall have any further rights or obligations hereunder.

ARTICLE 11

CLOSING AND ESCROW

Section 11.1 Escrow Instructions. Upon execution of this Agreement, the parties hereto shall deposit an executed counterpart of this Agreement with the Title Company, and this instrument shall serve as the instructions to the Title Company as the escrow holder for consummation of the Transaction contemplated hereby. Seller and Buyer agree to execute such reasonable additional and supplementary escrow instructions as may be appropriate to enable the Title Company to comply with the terms of this Agreement; provided, however, that in the event of any conflict between the provisions of this Agreement and any supplementary escrow instructions, the terms of this Agreement shall control.

Section 11.2 Closing. The Closing hereunder shall be held and delivery of all items to be made at the Closing under the terms of this Agreement shall be made at the Title Company (at the address for Title Company set forth in Section 12.1), on such date and at such time as Buyer and Seller may mutually agree upon in writing (the " Closing Date"); provided that Buyer and Seller shall use reasonable efforts to set the Closing Date no later than June 12, 2013, but in no event shall the Closing occur later than June 28, 2013 (the "Outside Date"). The Closing shall occur and the transfer of Buyer's funds shall be initiated at or before 12:00 p.m. noon New York time on the Closing Date.

Section 11.3 Deposit of Documents.

(a) At or before the Closing, Seller shall deposit into escrow the following items (collectively, the " Seller's Closing Deliveries"):

(i) one (1) original Deed for each of the Properties, duly executed by Seller and notarized;

(ii) two (2) original counterparts of the Bill of Sale for each of the Properties, duly executed by Seller;

(iii) two (2) original counterparts of the SLB Lease Agreement, duly executed by Seller and notarized;

(iv) an affidavit in the form attached hereto as Exhibit F, duly executed by Seller, and a California FTB form 593-C Real Estate Withholding Certificate, completed and duly executed by Seller;

(v) an owner's affidavit in the form attached hereto as Exhibit G, duly executed by Seller;

(vi) a tenant waiver letter in the form attached hereto as Exhibit H, duly executed by Tenant;

(vii) one (1) original counterpart of the Memorandum Lease Agreement (Columbus) and one (1) original counterpart of the Memorandum Lease Agreement (Long Beach) each duly executed by Tenant and notarized; and

(viii) one (1) original counterpart of a Sublease SNDA with respect to each SNDA Sublease, duly executed by Seller and notarized.

(ix) one (1) duly Notice of Subordination, substantially in the form of Exhibit N, with respect to each Notice Sublease, duly executed by Seller.

(b) At or before the Closing, Buyer shall deposit into escrow the following items (collectively, the " Buyer's Closing Deliveries"):

(i) funds necessary to pay the Purchase Price (net of the Deposit and any other offsets agreed to by Buyer and Seller);

(ii) two (2) original counterparts of the Bill of Sale for each of the Properties, duly executed by Buyer;

(iii) two (2) duly original counterparts of the SLB Lease Agreement, duly executed by Buyer and notarized;

(iv) one (1) original counterpart of the Memorandum Lease Agreement (Columbus) and one (1) original counterpart of the Memorandum Lease Agreement (Long Beach), each duly executed by Buyer and notarized; and

(v) one (1) original counterpart of a Sublease SNDA with respect to each SNDA Sublease, duly executed by Buyer and notarized.

(vi) one (1) Notice of Subordination, substantially in the form of Exhibit N, with respect to each Notice Sublease, duly executed by Buyer.

(c) At or before the Closing, Buyer and Seller shall each deposit such other instruments as are reasonably required by the Title Company or otherwise required to close the escrow and consummate the purchase and sale of the Properties in accordance with the terms hereof. Notwithstanding the foregoing, Buyer acknowledges that the failure of any subtenant to execute and deliver a Sublease SNDA shall not be deemed nor constitute a Seller Default. Buyer and Seller hereby designate Title Company as the "Reporting Person" for the Transaction pursuant to Section 6045(e) of the Code and the regulations promulgated thereunder.

Section 11.4 Pro-rations. The parties acknowledge that, pursuant to the SLB Lease Agreement, from and after the Closing, Tenant will be responsible for the payment of all real property taxes, assessments, insurance premiums, utility charges and all other similar items

customarily apportioned in sales of real property in the jurisdiction in which each of the Properties is located (the " Apportioned Items"). In consideration of the foregoing, no provision shall be made at Closing with respect to the apportionment of any Apportioned Item. The provisions of this Section 11.4 shall survive the Closing.

Section 11.5 Indemnification.

(a) From and after the Closing, Seller jointly and severally agrees to indemnify, defend and hold the Buyer Indemnified Parties harmless from any liability, claim, loss, expense or damage suffered or asserted by any Person against such Buyer Indemnified Parties that arises from any act or omission of Seller or its agents, employees or contractors (i) occurring before or as of the Closing in connection with Sellers' ownership or operation of the Properties, or (ii) in connection with the sale of the Properties to Buyer.

(b) From and after the Closing, Buyer agrees to indemnify, defend and hold the Seller Indemnified Parties harmless from any liability, claim, loss, expense or damage suffered or asserted by any Person against Seller Indemnified Parties that arises from any act or omission of Buyer or its agents, employees or contractors (i) occurring after the Closing in connection with the Buyer's ownership or operation of the Properties or (ii) in connection with the sale of the Properties to Buyer.

(c) From and after the Closing, Seller jointly and severally agrees to indemnify, defend and hold the Buyer Indemnified Parties harmless from any liability, claim, loss, expense or damage asserted by any Person, arising out of or with respect to the Subleases or the actions or omissions of the sublandlords or subtenants thereunder, or of any director, member, manager, officer, shareholder, general partner, limited partner, employee, agent or invitee of any of the foregoing, whether arising prior to, on or after the Closing, except for any liability, claim, loss, expense or damage caused by the gross negligence or willful misconduct of any Buyer Indemnified Party, any breach of the SLB Lease Agreement by any Buyer Indemnified Party, or breach of any agreement between any Buyer Indemnified Party and any subtenant.

(d) The indemnifications set forth in this Section 11.5 shall survive the Closing.

ARTICLE 12

MISCELLANEOUS

Section 12.1 Notices. Any notices required or permitted to be given hereunder shall be given in writing and shall be delivered (a) in person, (b) by certified mail, postage prepaid, return receipt requested, (c) by a commercial overnight courier that guarantees next day delivery and provides a receipt or (d) by facsimile or telecopy, and such notices shall be addressed as follows:

To Buyer:	AG Net Lease Acquisition Corp. c/o Angelo, Gordon & Co., L.P. 245 Park Avenue, 26th Floor New York, NY 10167-0094 Phone No.: (212) 883-4157 Fax No.: (212) 883-4141 Attn: Gordon J. Whiting
With a copy to:	AG Net Lease Acquisition Corp. c/o Angelo, Gordon & Co., L.P. 245 Park Avenue, 26th Floor New York, NY 10167-0094 Phone No.: (212) 692-2296 Fax No.: (212) 867-6448 Attn: Joseph R. Wekselblatt
With a copy to:	Sheppard Mullin Richter & Hampton LLP 1300 I Street, NW 11th Floor East Washington, D.C. 20005 Phone No.: (202) 469-4943 Fax No.: (202) 312-9411 Attn: Michele E. Williams, Esquire
To Seller:	Director of Facilities Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802-4317 Phone No.: (562) 435-3666 Fax No.: (562) 901-1086
	Sidley Austin LLP 555 West 5th Street 40th Floor Los Angeles, CA 90013 Phone No: (213) 896-6018 Fax No.: (213) 896-6600 Attn.: Marc I. Hayutin, Esq.
	and to:
With a copy to:	Sidley Austin LLP 555 West 5th Street 40th Floor Los Angeles, CA 90013 Phone No: (213) 896-6048 Fax No.: (213) 896-6600 Attn.: Edward C. Prokop, Esq.

To Title Company: Fidelity National Title Insurance Company
485 Lexington Avenue, 18th Floor,
New York, NY 10017
Phone No: 212-471-3816
Fax No.: (212) 481-1325
Attn: Andrea Kremen, Esq.

or to such other address as either party may from time to time specify in writing to the other party. Any notice shall be deemed delivered when actually delivered, or at such time as delivery is refused by the party to which notice has been sent.

Section 12.2 Entire Agreement. This Agreement, together with the SLB Lease Agreement, and the Schedules and Exhibits attached hereto and thereto, contain all representations, warranties and covenants made by Buyer and Seller and constitute the entire understanding between the parties hereto with respect to the subject matter hereof. Any prior correspondence, memoranda or agreements with respect to the Transaction, including, without limitation, the Letter of Intent, are replaced in total by this Agreement together with the Schedules and Exhibits hereto. The language in all parts of this Agreement will be construed as a whole in accordance with its fair meaning and without regard to California Civil Code §1654 or similar statutes.

Section 12.3 Entry and Indemnity. In connection with any entry by Buyer, or its agents, employees or contractors onto either of the Properties, Buyer shall give Seller reasonable advance notice of such entry and shall conduct such entry and any inspections in connection therewith so as to minimize, to the greatest extent possible, interference with Seller's business and the business of Seller's tenants, and otherwise in a manner reasonably acceptable to Seller. Without limiting the foregoing, prior to any entry to perform any on-site testing, Buyer shall give Seller two (2) Business Days' notice thereof, which notice shall include the identity of the company or persons who will perform such testing and the proposed scope of the testing. In the event that Buyer proposes to perform any destructive or invasive testing, Seller may approve or disapprove, in Seller's sole and absolute discretion, the proposed destructive or invasive testing within three (3) Business Days after receipt of such notice. Seller shall be deemed to have disapproved any such destructive or invasive testing if Seller does not respond within such three (3) Business Day period. If Buyer or its agents, employees or contractors take any sample from either of the Properties in connection with any such approved testing, at Seller's request, Buyer shall provide to Seller a portion of such sample being tested to allow Seller, if it so chooses, to perform its own testing. Seller or its representative may be present to observe any testing or other inspection performed on either of the Properties. Buyer shall maintain or cause to be maintained, and shall ensure that its contractors maintain, public liability and property damage insurance in amounts and in form and substance adequate, in Seller's reasonable judgment, to insure against the insurable liabilities of Buyer and its agents, employees or contractors, arising out of any entry on or inspections of either of the Properties pursuant to the provisions hereof. Buyer shall indemnify and hold Seller harmless from and against any

actual costs, damages (exclusive of consequential and punitive damages), liabilities, losses, expenses, liens or claims (including, without limitation, reasonable attorneys' fees) arising out of or relating to any entry on either of the Properties by Buyer, its agents, employees or contractors in the course of performing the inspections, testings or inquiries provided for in this Agreement. The foregoing indemnity shall survive the Closing, or, if the sale is not consummated, beyond the termination of this Agreement.

Section 12.4 Time. Time is of the essence in the performance of each of the parties' respective obligations contained herein.

Section 12.5 Further Assurances. The parties hereto hereby agree to take such additional actions and to execute and deliver such additional documents as shall be necessary to consummate the Transaction. The provisions of this Section shall survive the Closing.

Section 12.6 Jury Trial Waiver. The parties hereby agree to waive any right to trial by jury with respect to any action or proceeding brought by either party or any other Person relating to (a) this Agreement and/or any understandings or prior dealings between the parties hereto or (b) either of the Properties or any part thereof. The parties hereby acknowledge and agree that this Agreement constitutes a written consent to waiver of trial by jury pursuant to any applicable state statutes. The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.7 No Merger. The obligations contained herein shall not merge with the transfer of title to either of the Properties. The provisions of this Section shall survive the Closing.

Section 12.8 Assignment. Seller shall have no right to assign any of its interest in this Agreement. Buyer's rights and obligations hereunder shall not be assignable without the prior written consent of Seller, in its sole discretion. Notwithstanding the foregoing, Buyer shall have the right to assign its rights and obligations hereunder to any of its Affiliates without the prior written consent of Seller. Subject to the foregoing, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns. As used in this Section 12.8, "Affiliates" shall mean an entity controlled by, under common control with, or controlling, Buyer. The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.9 Counterparts and Facsimile. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument. The parties contemplate that they may be executing counterparts of this Agreement transmitted by facsimile or electronic transmission and agree and intend that a signature by facsimile or electronic transmission shall bind the party so signing with the same effect as though the signature were an original signature.

Section 12.10 Governing Law; Consent to Jurisdiction.

(a) Each of Seller and Buyer hereby agree that the State of New York has a substantial relationship to the parties and to the Transaction and in all respects (including, without limiting the generality of the foregoing, matters of construction, validity and performance) this Agreement and the obligations arising hereunder shall be governed by, and construed in accordance with, the laws of the State of New York applicable to contracts made and performed therein (without regard to its conflict of laws principles) pursuant to Section 5-1401 of the New York General Obligations Law, and all applicable law of the United States of America. To the fullest extent permitted by law, each of Seller and Buyer hereby unconditionally and irrevocably waives any claim to assert that the law of any other jurisdiction governs this Agreement.

(b) Any legal suit, action or proceeding against either party arising out of or relating to this Agreement shall be instituted in any federal or state court sitting in the Borough of Manhattan, State of New York, pursuant to Section 5-1402 of the New York General Obligations Law, and each of Seller and Buyer waives any objection which it may now or hereafter have to the laying of venue of any such suit, action or proceeding in the Borough of Manhattan, State of New York, and each party hereby expressly and irrevocably submits to the jurisdiction of any such court in any suit, action or proceeding.

(c) The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.11 Confidentiality.

Prior to the Closing, subject to the terms of this Section, Buyer and Seller shall each maintain as confidential any and all Proprietary Information obtained in connection with the Transaction and, accordingly, each party agrees not to disclose all or any portion of such Proprietary Information to any third party for any reason. Each item of Proprietary Information shall be used by the recipient thereof solely for the purpose of evaluating and determining such recipient's interest in consummating the Transaction. Each party agrees that it will not make copies of, or permit any other Person to make copies of, the Proprietary Information for any reason. Each party agrees that it will not retain any item of Proprietary Information after the use thereof is no longer required, and that it will either destroy or return to the other party all written materials constituting Proprietary Information, except to the extent that such destruction is prohibited by law, rule or regulation. Notwithstanding the foregoing, neither party will be required to destroy or return any Proprietary Information that may be stored electronically in such party's information technology system, whether in the form of an e-mail, saved file or otherwise. Notwithstanding anything to the contrary contained herein, each party shall be permitted to disclose any or all of the Proprietary Information: (i) to those principals, employees, representatives, lenders, consultants, counsel, accountants and other professional advisors of such party who have a legitimate need to review or know such Proprietary Information and who have, prior to disclosure, agreed in writing to be bound by the terms of confidentiality set forth herein, (ii) any government or self-regulatory agency whose supervision or oversight such party or any of its affiliates may be subject to the extent required by applicable law, any Governmental Authority or a court of competent jurisdiction, in each case to the extent reasonably necessary to comply with any legal or regulatory requirements to which such party or its affiliates may be subject (or in connection with any enforcement action regarding this

Agreement or the Transaction), and (iii) without limiting the generality of the immediately foregoing subsection, in any filings made by Seller or its affiliates with the Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended (the "Securities Act"), the Securities Exchange Act of 1934, as amended (the " Exchange Act"), and/or as may be made available to any investors or prospective investors in Seller or any of its affiliates in conformance with the Securities Act, Exchange Act, and/or the rules, regulations, and orders issued with respect thereto. Except for publicly available filings referenced in clause (iii) of the immediately preceding sentence, upon disclosing Proprietary Information to any Person to the extent permitted hereunder, Buyer or Seller, as applicable, shall advise such Person of the confidential nature thereof, and shall take all reasonable precautions to prevent the unauthorized disclosure of such information by such Person. In addition, except any press release or public announcement regarding the Transaction required to be issued by Seller pursuant to the Securities Act, the Exchange Act, and/or the rules, regulations, and orders issued with respect thereto, at or prior to the Closing, neither party shall issue any press release or other public announcement regarding the Transaction without first obtaining the other party's written approval with respect to the release or announcement and the content thereof. After the Closing, Buyer and Seller shall be permitted to make such disclosures regarding the Properties and the Transaction (which may include the use of each of Seller's and Buyer's name and company logo) as are similar or consistent with Buyer's and Seller's respective general public disclosure policy, including disclosures made by each of Seller and Buyer and its affiliates to their investors, lenders and analysts. This provision shall survive any termination of this Agreement, and shall be subject to the letter agreement attached as Schedule 12.11 (with the parties acknowledging that this Agreement is a "related agreement" as referenced in such letter agreement)

Section 12.12 Maintenance. Between the Effective Date and the Closing, Seller shall manage and maintain each of the Properties in the ordinary course and in the same manner and condition as before the making of this Agreement, as if Seller were retaining such Property. Seller shall make such repairs and replacements to and of each of the Properties as shall be necessary for Seller to comply this Section 12.12. Through the Closing Date, Seller shall maintain or cause to be maintained, at Seller's sole cost and expense, the Existing Insurance Policies.

Section 12.13 Interpretation of Agreement. The article, section and other headings of this Agreement are for convenience of reference only and shall not be construed to affect the meaning of any provision contained herein. Where the context so requires, the use of the singular shall include the plural and vice versa and the use of the masculine shall include the feminine and the neuter. The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.14 General Rules of Construction. The parties acknowledge that this Agreement has been freely negotiated by both parties, that each party has had the opportunity to review and revise this Agreement, that each party has had the opportunity to consult with counsel with regard to this Agreement, and that the normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party will not be employed in the

interpretation of this Agreement or any amendments or exhibits to this Agreement. The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.15 Limited Liability. Any claim based on or in respect of any liability of Seller under this Agreement shall be enforced only against Seller and its assets, properties and funds, and not against the assets, properties or funds of any of its trustees, officers, directors or shareholders, the general partners, officers, directors or shareholders thereof, or any employees or agents of Seller. Any claim based on or in respect of any liability of Buyer under this Agreement shall be enforced only against Buyer and its assets, properties and funds, and not against the assets, properties or funds of any of its trustees, officers, directors or shareholders, the general partners, officers, directors or shareholders thereof, or any employees or agents of Buyer. The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.16 Amendments. This Agreement may be amended or modified only by a written instrument signed by both Buyer and Seller. The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.17 Attorneys' Fees. In the event that a party hereto prevails against the other party in any action to enforce the obligations of such other party under this Agreement, the prevailing party shall be reimbursed by the other for all reasonable out-of-pocket costs and expenses incurred thereby with respect to such action (including reasonable attorneys' fees). The provisions of this Section shall survive any termination of this Agreement and the Closing.

Section 12.18 Third Party Beneficiaries. Seller and Buyer agree that there are no third party beneficiaries of this Agreement. Without limiting the foregoing, neither Broker nor Advisor is a third party beneficiary of this Agreement. The provisions of this Section shall survive any termination of this Agreement and the Closing.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the respective dates written below.

SELLER: MOLINA HEALTHCARE, INC.,
a Delaware corporation
By: _____
Name: _____
Date: Its: _____

MOLINA CENTER, LLC,
a Delaware limited liability company
By: _____
Name: _____
Its: _____

BUYER: AG NET LEASE ACQUISITION CORP.,
a Delaware corporation

By: _____
Name: Gordon J. Whiting
Date: Its: President

ACCEPTANCE BY TITLE COMPANY:

Fidelity National Title Insurance Company hereby acknowledges that it has received a fully executed counterpart of the foregoing Agreement of Purchase and Sale ("Agreement") and agrees to be bound by and perform the terms thereof as such terms apply to Title Company.

FIDELITY NATIONAL TITLE INSURANCE COMPANY

Dated:_____ By: _____
Name: _____
Title: _____

SCHEDULE 1(b)

SNDA Subleases

1. Long Beach Publishing Company, Inc. (aka Press Telegram)

SCHEDULE 4.2

Permitted Exceptions

The items listed on Schedule B in that certain Proforma Owner's Policy of Title Insurance issued by Fidelity National Title Insurance Company ("Title Company") under Order No. 4257983 (Reference No. 508130029), with respect to the Columbus Leased Premises, and the items listed on Schedule B in that certain Proforma Owner's Policy of Title Insurance issued by Title Company under Order No. 23021588-977-MAT, with respect to the Long Beach Leased Premises.

SCHEDULE 5.1(g)

Third Party Consents

Novation Agreement by and between Seller and the United States of America

California Regional Water Quality Control Board NPDES Permit Transfer from Molina Center LLC to AGNL Clinic, L.P., as New Owner, and Molina Healthcare, Inc., as New Operator

SCHEDULE 5.1(h)

Existing Leases, Access Agreements and License Agreements, Purchase Options, Termination Options, Etc.

EXISTING LEASE AGREEMENTS, ACCESS AGREEMENTS, LICENSE AGREEMENTS, PURCHASE OPTIONS, TERMINATION OPTIONS, ETC. ASSOCIATED WITH 200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA, WITH MOLINA AS LANDLORD:

- 3-Dee International
- Arthritis National Research Foundation
- Lisa Brandon, CFLS
- California Coastal Commission
- Crowell, Weedon & Co.
- Department of Industrial Relations
- High Rise Goodies Restaurant Group, Inc.
- J. Perez Associates, Inc.
- Long Beach Publishing Company, Inc. (aka Press Telegram)
- Lynn E. Moyer
- D. Michael Trainotti
- Michael W. Binning
- Molina Healthcare, Inc.
- MVP Energy, LLC
- Pacific Maritime Association
- Pacific Merchant Shipping
- Bruce A. Dybens, AP
- California State Lands Commission
- US Department of Veterans Affairs
- Perona, Langer, Beck Serbin & Mendoza
- Rose, Klein & Marias, LLP
- United Parcel Services, Inc.
- APB Car Wash & Detailing Specialist - License
- Steel Coil
- Mikko Myong Pivonka, an individual
- TCG Los Angeles, Inc. (aka AT&T) – ACCESS AND LICENSE
- XO Communications Services, LLC – LICENSE
- Molina Healthcare of California (undocumented license agreement)

EXISTING LEASE AGREEMENTS, ACCESS AGREEMENTS, LICENSE AGREEMENTS, PURCHASE OPTIONS, TERMINATION OPTIONS, ETC. ASSOCIATED WITH 3000 CORPORATE EXCHANGE DRIVE, COLUMBUS, OHIO, WITH MOLINA AS LANDLORD:

- Bresco Solutions, LLC - LICENSE
- iQor, Inc.
- Prime Engineering & Architecture, Inc.
- U.S. Congressman Patrick Tiberi

- XO Communications Services, Inc. – ACCESS AGREEMENT

LEASE	RIGHT POTENTIALLY TRIGGERED BY SALE/LEASEBACK TRANSACTION	NOTES/COMMENTS
VA Lease: U.S. Government Lease for Real Property between 200 Oceangate, LLC and United States of America, Department of Veterans Affairs dated April 1, 2010; Supplemental Agreement No. One, dated July 30, 2010; Supplemental Agreement No. Two, dated September 3, 2010	Prohibition of sale/leaseback transaction; required consent of tenant	48 CFR 570.115 requires compliance with FAR 42.12 in the event of a transfer of ownership of the leased premises. FAR 42.12 requires application to the Government for consent to the assignment of the Lease, and further requires a novation and/or change-of-name agreement.
Molina Healthcare, Inc., Lease: Office Lease between Pacific Towers Associates and Molina Healthcare, Inc., dated for reference purposes as of July 10, 2002; Pacific Towers Associates Lease Addendum dated July 10, 2002; First Amendment to Office Lease dated November 5, 2002; Second Amendment to Office Lease dated December 5, 2002; Third Amendment to Office Lease dated April 5, 2006; Fourth Amendment to Office Lease dated June 1, 2006; Fifth Amendment to Office Lease dated July 1, 2006; Sixth Amendment to Office Lease dated May 21, 2007; Seventh Amendment to Office Lease dated February 20, 2012; Eighth Amendment to Office Lease dated June 18, 2012; Ninth Amendment to Office Lease dated November 2012.	Right of First Offer to purchase	Right of Molina Healthcare, Inc. to purchase the property. Section 8, Third Amendment.

Molina Healthcare, Inc. Profits Interest Agreement: Agreement Regarding Capital Event Profits Interest of Molina Healthcare, Inc. between 200 Oceangate, LLC and Molina Healthcare, Inc. dated as of April 5, 2006; First Amendment to Agreement Regarding Capital Event Profits Interest in Molina Healthcare, Inc., dated August 10, 2006; Memorandum of Tenant Investment and Commissions – Molina Healthcare, Inc. between 200 Oceangate, LLC and Molina Healthcare, Inc., dated March 11, 2009.	Profit Sharing Right	Right of Molina Healthcare, Inc. to share in profits of sale of property.

SCHEDULE 5.1(i)

Contracts

Molina Center

Type of Service	Vendor Name	Address	Contract Date	Termination
Copier	Ricoh Business Solutions	5 Dedrick Place, West Caldwell, NJ 07006	5/31/2012	5/30/2015
Elevator	Otis Elevator	711 E. Ball Rd., Anaheim, CA 92805	10/1/2010	9/30/2015
Elevator Advertising	Captivate	6060 Center Dr., Los Angeles, CA 90045	11/30/2000	11/29/2015
Engineering	Able Engineering	3300 W. MacArthur Blvd, Santa Ana, CA 92704	11/1/2007	10/31/2008 then M-M
Int. Landscaping	Associated Group	1610 E. McFadden Ave., Santa Ana, CA 92705	10/1/1998	M-M
Internet	Cogent Communications	1015 31st St. NW, Washington DC 20007	7/21/2008	7/20/12 then renews yearly
Internet	Direct America	148 13th St., Seal Beach, CA 90740	11/30/2006	M-M
IT Support	All Covered	808 S. Figueroa St., Los Angeles, CA 90017	5/1/2012	4/30/13 then renews yearly
Janitorial	United Bldg Svcs (Able)	3300 W. MacArthur Blvd, Santa Ana, CA 92704	10/1/2003	9/30/12 then renews yearly
Landscaping	TruGreen	1323 W. 130th St., Gardena, CA 90247	4/1/2013	3/30/2014
Life Safety	HCI	1354 Parkside Place, Ontario, CA 91761	4/1/2013	3/31/14 the M-M
Life Safety-online	RJ Westmore	1875 Century Park East, Century City, CA 90067	10/10/2010	M-M
Parking	Ampco System Parking	1150 S. Olive Street, 19th Floor, Los Angeles, CA 90015	9/15/1998	4/31/2013
Pest Control	American City Pest Control	614 W. 184th St., Gardena, CA 90248	6/1/1999	M-M
Security	Universal Protection Svcs	340 Golden Shore, Long Beach, CA 90802	11/1/2003	M-M
Telephone	Telepacific Communications	9166 Anaheim Pl., Rancho Cucamonga, CA 91730	5/27/2004	5/26/12 then renews 2-year
Trash-compactor	Master Environmental	17890 Castleton St., City of Industry, CA 91748	3/5/1993	3/4/13 then renews 2-year
Trash/Recycling	Serv-wel Disposal	901 S. Maple Ave., Montebello, CA 90640	6/1/2011	5/30/12 then M-M
Window Cleaning	United Bldg Svcs (Able)	3300 W. MacArthur Blvd, Santa Ana, CA 92704	8/22/2011	8/21/12 M-M
Window Cleaning – RIG	Sky Rider Equipment	1180 N. Blue Gum St., Anaheim, CA 92806	11/1/2009	10/31/10 then M-M
Property Management	McKinney Brokerage Group	12250 El Camino Real Suite 220, San Diego, CA 92130	12/7/2011	12/7/13 then renews 1-year

Molina Healthcare of California (undocumented license agreement)

3000 Corporate Exchange

Type of Service	Vendor Name	Address	Contract Date	Termination
Electric Broker	Champion Energy Services	425 Metro Place North, Ste 550, Dublin, OH 43017	5/25/2011	
Elevator	ThyssenKrupp	PO Box 933004, Atlanta, GA 31193-3004	1/1/2011	1/1/2014
Engineering	CBRE	3000 Corporate Exchange Dr., Columbus, OH 43231	2/1/2013	1/31/2014
HVAC/Backflows	Speer Mechanical	600 Oakland Park Ave., Columbus, OH 43214	11/1/2007	10/31/2008 then renews yearly
HVAC Loan	PNC Equipment Finance	995 Dalton Ave., Cincinnati, OH 45203	2/9/2009	3/1/2014
Int. Landscaping	Plantastic	PO Box 89, Lewis Center, OH 43035	3/1/2011	2/28/2012 then M-M
Janitorial	CSI International	720 Lakeview Plaza Blvd #K, Worthington, OH 43085	4/1/2011	3/31/2012 then M-M
Landscaping	Bildsten Landscaping Services	1080 Camden Ave, Columbus, OH 43201	11/1/2011	4/30/2012 then M-M
Life Safety	Gentry Fire Protection	3540 Parkway Lane, Hilliard, OH 43026	11/10/2010	11/31/10
Lot Sweep	Contract Sweepers	561 Short St., Columbus, OH 43215	11/1/2010	10/31/2011 then M-M
Pest Control	Orkin	258 Campus View Blvd., Columbus, OH 43235	7/20/2009	7/31/10 then M-M
Trash	Republic Waste	933 Frank Rd., Columbus, OH 43223	2/1/2013	1/31/2016
Window Cleaning	Reflective, Inc	8203 Blacks Rd., Pataskala, OH 43062	5/8/2012	4/30/2013 then M-M
Asset Management	McKinney Brokerage Group	12250 El Camino Real Suite 220, San Diego, CA 92130	12/19/2012	12/7/13 then renews 1-year

SCHEDULE 5.1(j)

Permits

MOLINA CENTER / PERMITS

ELEVATORS

CAB #	STATE #	OTIS #	EXP DATE
1	73354	D01637	10/17/12
2	73338	D01641	10/17/12
3	73344	D01642	10/17/12
4	73350	D01643	10/17/12
5	73368	D01644	10/17/12
6	73353	D01645	10/20/12
7	73341	D01646	10/18/12
8	73342	D01647	10/18/12
9	73367	D01648	10/19/12
10	73343	D01649	10/19/12
11	88577	D01652	10/19/12
12	88578	D01654	10/19/12
13	89981	D01655	10/19/12
PASS R-1	073370 (Not in use 5/04)	D01650	01/03/04
PASS R-2*	073355 (Not in use 5/04)	D01651	01/03/04

FIRE		**EXP DATE**
ACCOUNT FP00010461	**(300 T)**	1/15/14
ACCOUNT FP10001354	**(200 T)**	1/15/14

AQMD	**EXP DATE**
PRMT # D15227 ICE (50-500 HP) EM FIRE FGHT-DIESEL	10/31/12
**PRMT # R-D17641 ICE (>500 HP) EM ELEC GEN DIESEL	10/31/12
Facility ID #	
Rule 222 for 1 to 2 Mil BTU/Hr for 4 Boilers	Paid 11/12
(Equipment Registration Fee) – New Ownership	One time fee
Facility ID #154656	

BUSINESS LICENSE - Molina Center, LLC	**EXP DATE**
TOWER 1+2; ACCOUNT BU86043502	06/27/13

BUSINESS LICENSE – McKinney Advisory Group — **EXP DATE**
ACCOUNT BU21210040 — 02/01/14

HAZARDOUS MATERIALS - CUPA — **EXP DATE**
ACCOUNT HC00001692 — HAZ MAT/HAZ WASTE — 11/29/13

AIR PRESSURE TANKS — **EXP DATE**
TANK # 30669-89 — NB# 6596 **(300 T)** — 11/30/2015
TANK # 30668-89 — NB# 5831 **(200 T)** — 11/30/2015

TOXIC SUBSTANCES CONTROL (Disposal of Used Oil)
EPA IDENTIFICATION NUMBER CAL000375391 Molina Center LLC — Effective 6/19/2012

RADIO STATION AUTHORIZATION — **EXP DATE**
FCC Registration Number (FRN): 0021936554 — 01/10/2023

REGIONAL WATER QUALITY CONTROL BOARD (Permit to Discharge Groundwater)
NPDES No. CAG994004, Order No. R4-2008-0032
and Monitoring Report and Reporting Program No. CI-9761

SIGNAGE APPROVAL — **ONE TIME**
City of Long Beach — 07/26/2000

COLUMBUS / PERMITS

ELEVATORS

CAB #	CERT #	STATE ID #	EXP DATE
1	EL41888	41888	08/31/13
2	EL41887	41887	08/31/13
3	EL41886	41886	08/31/13
4	EL41885	41885	08/31/13

CONSTRUCTION PERMITS
6th Floor Construction

TYPE	PERMIT #	ISSUE DATE
Removal Start Permit	RMST1307108	03/11/2013
Electrical Permit	ELEC1313990	05/06/2013
Fire Suppression Permit	FSUP1310933	05/02/2013
Building Permit	INTR1310038	05/02/2013
Environmental Air Permit	ENAR1313706	05/02/2013

SCHEDULE 5.1(k)

Plans

Long Beach Luckman Partnership Inc. (Architects) dated 8/31/1981
1.

Columbus MaddoxNBD (Architects) dated 9/1/1998
1.

SCHEDULE 5.1(l)

Warranties

None.

SCHEDULE 5.1(m)

Certificates of Occupancy

Long Beach – For Building and Molina Leased Space

Date	Permit Name	Space	Permit #	Agency
11/15/1983	Certificate of Occupancy	Building 200 & 300	9715	City of Long Beach
3/13/2013	Certificate of Occupancy	200 Suite 1050	BRMD142770	City of Long Beach
10/29/2012	Certificate of Occupancy	300 Suite 1500	BRMD138959	City of Long Beach
10/29/2012	Certificate of Occupancy	300 Suite 1100	BRMD138957	City of Long Beach
08/09/2012	Certificate of Occupancy	300 Suite 930	BRMD137245	City of Long Beach
04/11/2012	Certificate of Occupancy	300 Suite 450	BRMD133849	City of Long Beach
02/17/2012	Certificate of Occupancy	200 Suite 820	BRMD131772	City of Long Beach
11/22/2002	Certificate of Occupancy	200 2nd/6th/7th Bathrooms	360443	City of Long Beach
8/6/2003	Certificate of Occupancy	3rd and 4th Floors	371614	City of Long Beach
03/04/2003	Certificate of Occupancy	2nd/6th/7th Floors	360444	City of Long Beach
11/10/2005	Certificate of Occupancy	200 Suites 530/535/550/570	442789	City of Long Beach
10/13/2006	Certificate of Occupancy	5th Floor Molina Nurse Advice	426899	City of Long Beach
01/26/2007	Certificate of Occupancy	200 Suite A1400	472345	City of Long Beach
05/03/2007	Certificate of Occupancy	200 Suite A1100	485455	City of Long Beach
08/13/2007	Certificate of Occupancy	200 Suite A0100	490117	City of Long Beach
02/05/2009	Certificate of Occupancy	200 Suite A0100	532666	City of Long Beach

Columbus – For Building

Date	Permit Name	Space	Permit #	Agency
11/10/99	Final Occupancy Permit	Building	9904318	City of Columbus

SCHEDULE 5.1(n)

Underground Storage Tanks

Underground Tank - that certain abandoned 550 gallon underground diesel tank located under the Diesel Pad on the southwest corner of the property called out on the Survey undertaken by Bock & Clark dated 2/27/13

Water Tank - that certain 35,000 gallon capacity underground tank storing firefighting water to the easterly side of the Diesel Pad on the southwest corner of the property called out on the Survey undertaken by Bock & Clark dated 2/27/13

SCHEDULE 5.1(o)

Disclosure Reports

1. Long Beach Leased Premises

    a. Phase 1 Site Assessment undertaken by ESIS Inc. Dated January 4, 2011
    b. Phase 1 Update undertaken by ESIS Inc. dated October 19, 2011
    c. NPDES Permit No. CAG994004
    d. California Commercial Disclosure Reports (2) dated May 6, 2013, Order Number 130506-00397, covering parcel numbers 7278-003-036 and 7278-003-035

2. Columbus Leased Premises

    Phase 1 Environmental Assessment Dated October 12, 2012

SCHEDULE 5.1(r)

Existing Mortgage

That certain Deed of Trust dated December 1, 2011 in favor of East West Bank and recorded as document number 11-1658315 in the books and records of Los Angeles County, California.

SCHEDULE 5.1(v)

Existing Insurance Policies

	Carrier	Coverage	Policy #
1	Lexington Insurance Co.	Property	13113039
2	Philadelphia Indemnity Insurance Co.	Commercial General Liability	PHPK987040
3	Philadelphia Indemnity Insurance Co.	Automobile	PHPK987040
4	Liberty Insurance Underwriters Inc.	Umbrella Liability	1000037294-02
5	Lexington Insurance Co.	Flood (included in property policy)	13113039
6	Everest Indemnity	Earthquake	840001317-131

SCHEDULE 5.1(w)

Financial Statements

(attached)

Molina Healthcare, Inc. (Parent)
Income Statement
For the Year Ended December 31, 2012

Revenue	
42150 Miscellaneous Income	17,322
42190 Corporate Charge-Revenue	406,446,825
Other operating revenue	406,464,147
Premium and other medical revenue	406,464,147
Premium taxes	(4,584)
Premium and other medical revenue (net of premium tax)	406,459,564
45110 Rental Income	174,052
42140 TPA Income	343,200
Rental and other revenue	517,252
44110 Interest Income	560,617
44111 Interest Income (Exempt)	15,733
44520 Equity Earning Uncon Aff	(26,844)
Investment revenue	549,506
Total revenue (net of premium tax)	407,526,321
Premium Taxes	4,584
Total revenue	407,530,905
Medical Expenses	
52110 QA-Compensation	20,290,356
52120 QA-Other	3,784,653
Subtotal Quality Assurance	24,075,009
Medical Costs - Other	24,075,009
54110 Pharmacy	0
Medical Costs - Pharmacy	0
55180 Optometry Capitation	8,527,683
Medical Costs - Capitated	8,527,683
56120 Specialty QNXT Payments	(426)
Subtotal Specialty - Fee for Service	(426)
Subtotal Specialty/Outpatient - Fee for Service	(426)
56570 Healthcare Savings Fees	(280)
Subtotal Other - Fee for Service	(280)
56610 Vision IBNR	500,000
Other Vision FFS	–
Subtotal Vision - Fee for Service	500,000
Medical Costs - Fee for Service	499,294
Total Medical Costs	33,101,987
Medical Margin (Net of Prem Tax)	373,357,577
MCR (Net of Prem Tax)	8.1%
Direct Medical Costs (exel QA)	9,026,978
Direct Medical Margin (exel QA)	397,432,586
Direct MCR (Net of Prem Tax)	2.2%
Administrative Expenses	
61151 Wages-Salaries	139,702,930

Molina Healthcare, Inc. (Parent)
Income Statement
For the Year Ended December 31, 2012

61152 Wages-Severance	796,956
61153 Wages-Restr Stock Comp	18,105,653
61154 Wages-Bonus	21,679,715
61155 Wages-Overtime	2,489,513
61156 Wages-Paid Time Off (PTO)	11,208,722
61157 Wages-Commissions	1,598,863
61158 Wages-Stock Options	61,585
61159 Wages-Phantom Stock	1,262,594
Subtotal Wages	196,906,531
61160 Insurance-Emp Health	(24,438,545)
61161 Insurance-Emp Contrib	(13,492,869)
61162 Ins-EMP Claims Paid	47,679,226
61163 Ins-Emp Health-IBNR	178,141
Subtotal Employee Health Insurance	9,925,953
61170 Insurance-Workman's Comp	2,370,408
61171 Insurance-Officer's Life	175,345
61172 Insurance-Life/Accident	1,837,913
61173 Payroll Taxes	12,340,036
61175 401K Pension Plan	4,808,253
61177 Stock-ESPP	1,850,575
61178 Other Payroll	2,866,470
61179 Deferred Compensation Exp	322,573
61180 Temporary Help	3,308,791
Subtotal Administrative Payroll	236,712,848
61201 Marketing Costs	590,919
61204 Advertising	3,898,490
61206 Business Development	30,523
61208 Sales Promotion	7,083
61209 Surveys	180,479
61210 Provider Meetings	35,756
61220 Patient Education	48,054
61230 Member Outreach Inceptive	28,418
Subtotal Marketing & Advertising	4,819,721
61251 Regulatory Fees	229,646
Subtotal Regulatory Fees	229,646
61301 Accounting Services	3,897,403
61310 Legal Services	6,350,459
61311 Legal Settlement	(482,904)
61320 Payroll Processing Svcs	149,983
61322 Actuarial Services	751,275
61323 Accreditation Services	42,666
61327 Board Fees	1,336,916

Molina Healthcare, Inc. (Parent)
Income Statement
For the Year Ended December 31, 2012

61330 Outside Services-Consult	24,388,059
61331 Outside Services-Other	29,595,262
61332 Outside Services-Translat	303,303
61333 Outside Services-Lobbyist	1,925,608
61340 Broker Commissions	3,506,374
61342 Shareholder Rptng Costs	176,748
Subtotal Outside Services	71,941,150
61360 Bank Service Charges	463,385
61363 Fines and Penalties	6,773
61364 Non-Deductible Fees	13,800
61370 Contributions-Political	471,000
61371 Contributions-Charitable	3,862,392
61380 Periodical Subscriptions	88,226
61390 Membership Dues	610,729
Subtotal Dues and Other Fees	5,516,304
61410 Travel Expenses	4,619,217
61420 Lodging Expenses	1,960,262
61430 Meals & Entertainment	784,461
Subtotal Travel Lodging & Meals	7,363,939
61452 Software Maintenance	8,017,690
61453 IT Operations & Maint Exp	2,208,168
61454 Hardware Expenses	559,819
61455 Repair & Maint-Comp Equip	2,879,698
61456 Software License/Subscrip	15,911,148
61457 Expensed Computer Equip	676,080
Subtotal Computer Expenses	30,252,603
61510 Committee Meetings	2,955
61511 Employee/Leadership Mtgs	64,258
61520 Continuing Ed/User Train	377,810
61521 Conferences/Seminars	401,055
61530 Employment-Recruitment	1,748,382
61540 Employee Functions	841,624
61541 Employee Relations	353,109
61542 Moving Expenses	328,916
Subtotal Employee Expenses	4,118,104
61551 Common Area Maintenance	202,532
61552 Rent	8,840,706
61560 Telephone	9,977,294
61562 Electric	678,921
61563 Gas	10,827
61564 Water	6,446
61565 Rubbish Removal	8,358

Molina Healthcare, Inc. (Parent)
Income Statement
For the Year Ended December 31, 2012

61570 Janitorial	195,792
61571 Gardening	60,153
61572 Laundry	3,159
61573 Security	94,981
61584 Taxes/Property-Unsecured	442,440
61581 Taxes/Property-Secured	299,569
61522 Licenses	1,537,932
61590 Insurance-General	2,269,806
61591 Insurance-Building	2,326
61592 Insurance-Auto	6,501
Subtotal Occupancy & Utilities	24,637,744
61601 Automotive Lease	1,400
61602 Automotive Maintenance	54,204
61610 Equipment Leasing/Rental	4,122,294
61620 Repair &Maintenance-Bldg	243,568
61621 Repair & Maint-Off Equip	38,699
Subtotal Repair & Maintenance	4,460,166
61651 Copier Expense	44,362
61652 Printing Supplies	3,621,704
61660 Office Supplies	772,565
61670 Postage	1,225,051
61671 Fulfillment	905,228
61680 Freight	144,640
Subtotal Printing Postage & Supplies	6,713,551
61920 Miscellaneous Income	(1,715,083)
61921 Miscellaneous Expense	3,192,850
61940 Discounts Earned A/P	(62,565)
61980 Gain/Loss on Sale-Tang Asset	(155,158)
Subtotal Other Administrative	1,260,014
Total Controllable Admin Expenses	398,025,794
62110 Less: Quality Assur P/R	(20,290,356)
62111 Less: Quality Assur Other	(3,784,653)
62150 Less: Project Labor	(6,398,786)
Subtotal Less: Direct Reclass	(30,473,795)
Total Core Administrative Expenses	367,551,998
63110 Premium Taxes	4,584
63140 Gross Receipts & Use Tax	49,249
Subtotal State Taxes & Assessments	53,833
Total Administrative Expenses	367,605,831
Oper Inc before Deprec/Amort	6,823,087
71150 Depreciation-Other	37,368,823
Subtotal Depreciation	37,368,823

Molina Healthcare, Inc. (Parent)
Income Statement
For the Year Ended December 31, 2012

71220 Amortization of Intang	1,424,836
Subtotal Amortization	1,424,836
Subtotal Depreciation & Amortization	38,793,660
Income from Operations	(31,970,573)
Non-Operating Expenses	
81110 Interest Expense	7,598,088
81120 Loan Fees	929,573
81130 Non-Cash Interest Expense	5,941,344
Subtotal Interest Expense	14,469,005
Subtotal Non-Operating Expenses	14,469,005
Income before Corporate Charges	(46,439,579)
81410 Equity Earning Subs	40,450,831
Subtotal Equity Earnings	40,450,831
Income before Taxes	(5,988,748)
Income Taxes	(15,778,710)
Net Income	9,789,962
EBITDA	6,823,087

Schedule 5.1(w)

Molina Healthcare, Inc. (Parent)
Balance Sheet
For the Year Ended December 31, 2012

Assets

Cash	
11011 Cash-Petty Cash	500
11100 Cash-Operating	1,914,398
11210 Cash-Checking-Payroll	(336,467)
11310 Cash-Concentration	18,341,838
11400 Cash-Mny Mkt	19,818,210
11500 Cash-Provider	(672,816)
11600 Cash-Investments	5,632,325
Cash and Equivalents	44,697,987
Accounts Receivable	
12110.1022 A/R-Other Med	433,180
Total Accounts Receivable	433,180
Prepaid Expenses	
13210.6006 Ppd-HW Support Net	786,514
13210.6007 Ppd Insurance Net	778,422
13210.6009 Ppd Interest Net	904,574
13210.6011 Ppd Rent Net	31,200
13210.6012 Ppd Software Term Net	7,004,366
13210.6013 Ppd-SW Support Net	2,267,721
13210.6014 Ppd Taxes-Property Net	260,454
13210.6015 Ppd Taxes-Real EState Net	45,914
13210.6099 Ppd Net	1,456,628
13210.6108 Ppd Ins-W/O (no amort) Net	691,203
Total Prepaid Expenses	14,226,995
Deferred Tax Assets - ST	13,818,437
Other Current Assets	
13400 Deposits-Workman's Comp Net	3,997,570
13410 Deposits-Short Term Net	223,206
13610 Interest Recvbl-Bank Net	2,801
13620 Interest Recvbl-Notes Net	117,554
13660 Due From Employees Net	(1,185)
13710 Accts Recvbl-Other Net	163,040
Total Other Current Assets	4,502,986
Total Current Assets	77,679,584
Property and Equipment	
15110 Land	4,670,119
15120 Buildings	10,751,676
15130 Furniture & Fixtures	5,188,021

Molina Healthcare, Inc. (Parent)
Balance Sheet
For the Year Ended December 31, 2012

15140 Machinery Equipment	57,560
15150 Automobiles	206,478
15160 Computer Equipment	69,099,539
15170 Office Equiment	3,953
15180 Leasehold Improvements	17,520,888
15190 Software	135,931,679
In Progress (CIP)	137,820,355
In Progress (CIP) (Contra)	(130,221,336)
Subtotal In Progress (CIP)	7,599,019
Total Property and Equipment (Cost)	251,028,931
15220 Buildings-Accum	(1,281,966)
15230 Furn & Fixt-Accum	(3,777,765)
15240 Machinery & Equip-Accum	(49,440)
15250 Autos-Accumiation	(134,638)
15260 Computer Equip-Accum	(44,386,817)
15270 Office Equipment-Accum	(3,390)
15280 L/H Improve-Accum	(8,549,920)
15290 Software-Accumiation	(84,037,214)
Total Property and Equipment (Accum)	(142,221,149)
Total Property and Equipment (Net)	108,807,782
Investments	
16120 Notes Rcvbl-LT	15,520,850
Investment in Subsidiary	768,765,171
Investment in Affiliate (Unconsolidated)	3,898,232
Investment - Deferred Compensation	9,319,132
Restricted Cash	2,221,462
Total Investments	799,724,848
Deferred Tax Assets - LT	14,642,488
Intangible Property	
18711 Goodwill	51,122,377
Goodwill (Net)	51,122,377
18721 Indentifiable Intangibles	18,024,637
18725 Indentifiable-Accum	(16,845,080)
18731 Other Intangibles	2,261,800
18735 Other Intangibles-Accum	(2,261,800)
Other Intangibles (Net)	1,179,557
Total Intangibles (Net)	52,301,934
Other Assets	
19310 Prepaid Costs-LT	3,640,427
Total Other Assets	3,640,427

Molina Healthcare, Inc. (Parent)
Balance Sheet
For the Year Ended December 31, 2012

Total Assets	**1,056,797,064**

Liabilities and Stockholder 's Equity

Medical Liabilities	
21135 INBR-Vision	500,000
Total Medical Liabilities	500,000
Accrued Liabilities	
22110 Accounts Payable-Trade	195,893
22140 Received Not Vouch Liab	380,539
22150 Accounts Pyble-Other	19,117,614
22160 Accounts Pyble-Concur	229,058
22210 Accrd Accounting Fees	1,331,502
22230 Accrd Legal Fees	1,700,502
22231 Accrd Lobbyist Expense	54,100
27280 Accrd Workers Compensatio	4,356,690
22290 Accrd Int on Debt	1,756,254
22500 Property Tax Pyble	362,780
22510 Sales & Use Tax Pyble	2,879
22610 Accrd Payroll-Wages	7,836,091
22620 Accrd Payroll-Bonus	20,408,010
22627 Accrd Payroll-Phantom Stock	220,196
22710 Accrd Payroll-PTO	8,759,906
22720 Payroll Liab-401K	(612,720)
22750 Payroll Liab-Garnishment	(98)
22820 Deferred Rent-Current	290,719
22910 Reserve Liab-Emp Hlth Ins	6,319,416
23300 Escheat Liab	380
23510 Income Taxes Pyble-Fed	(29,776,377)
23511 Income Taxes Paid-Fed	22,853,665
23520 Income Taxes Pyble-State	(1,908,289)
23521 Income Taxes Paid-State	(36,740)
Total Accrued Liabilities	63,841,970
Short Term Debt	
24170 Capital Lease Pyble-ST	673,525
23911 Inter-Company Payable	(55,381,566)
Total Short Term Debt	(54,708,042)
Deferred Tax Liabilities - ST	4,111,681
Total Current Liabilities	**13,745,609**
Long Term Debt	
25110 Capital Lease Pyble-LT	57,043
27120 Note Pyble-LT	227,000,000

Molina Healthcare, Inc. (Parent)
Balance Sheet
For the Year Ended December 31, 2012

27800 Debt Discount	(11,532,152)
Total Long Term Debt	215,524,891
Deferred Tax Liabilities - LT	31,763,749
Deferred Tax Liabilities - FIN 48	194,741
Other Liabilities	
29110 Deferred Compensation-LT	9,072,265
29150 Accrd Fees-LT	833,876
29160 Deferred Rent-LT	3,347,774
Total Other Liabilities	13,253,915
Total Long Term Liabilities	**260,737,296**
Total Liabilities	**274,482,905**
Stockholder's Equity	
31110 Issued Common Stock	46,762
31120 Treasury Stock	(3,000,006)
Stock	(2,953,244)
31210 Paid-in-Capital	288,662,881
31220 APIC – Tax Benefit Pool	7,729,657
31230 Eqty Adj-Stk Issue Cost	(10,868,537)
Paid in Capital	285,524,001
31310 Unrlzd-Mkt Securities	745,200
31330 Unrlzd-Tax Effect	(283,177)
31350 Unrlzd-Mkt Sec-LT	(1,481,918)
31370 Unrlzd-Tax Effect-LT	563,129
Unrealized Gain(Loss) - Marketable Securities	(456,766)
39998 Retained Earnings	490,410,205
Net Income	9,789,962
Retained Earnings	500,200,167
Total Stockholder's Equity	**782,314,158**
Total Liabilities and Stockholder's Equity	**1,056,797,064**

SCHEDULE 9.1
Approved Agreements

None.

SCHEDULE 12.11

Letter Agreement Regarding Confidentiality

June __, 2013

By: Email
AG Net Lease Acquisition Corp.
AGNL Clinic, L.P.
c/o Angelo Gordon & Co., L.P.
245 Park Avenue, 26th Floor
New York, New York 10167-0094
Attn: Gordon J. Whiting &
Joseph R. Wekselblatt
Email: gwhiting@angelogordon.com;
jwekselblatt@angelogordon.com

Re: Disclosure of information in connection with that certain term sheet dated January 18, 2013 (the " Term Sheet"), executed by AG Net Lease Acquisition Corp., a Delaware corporation ("Buyer") and Molina Healthcare, Inc., a Delaware corporation ("Seller" and "Lessee"). All defined terms used herein and not otherwise defined shall have the meanings ascribed thereto in the Term Sheet.

Ladies & Gentlemen:

Notwithstanding anything contained in the Term Sheet or any related agreement to the contrary, in order to accomplish the sale-leaseback transaction contemplated by the Term Sheet (the "Sale-Leaseback"), Seller, Molina Center, LLC, a Delaware limited liability company, and Interested Persons acting on their behalf (collectively, "Molina") are hereby authorized to disclose details of the Sale-Leaseback to third parties, including, without limitation, the California Regional Water Quality Control Board, the Department of Veterans Affairs and Press Telegram (f/k/a Long Beach Publishing), as Molina deems necessary or advisable and solely in furtherance of closing the Sale-Leaseback, provided that such third parties agree in writing to keep such disclosed details confidential.

[SIGNATURES ON THE FOLLOWING PAGES]

Very truly yours,

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: __
Name: __
Its: __

MOLINA CENTER, LLC,
a Delaware limited liability company

By: __
Name: __
Its: __

Schedule 12.11

ACKNOWLEDGED AND AGREED TO:

AG NET LEASE ACQUISITION CORP.,
a Delaware corporation

By: __
Name: Gordon J. Whiting
Its: President

AGNL CLINIC, L.P.,
a Delaware limited partnership

By: AGNL Clinic GP, L.L.C.,
a Delaware limited liability company,
its general partner

By: AGNL Manager II, Inc.,
a Delaware corporation,
its Manager

By:
Gordon J. Whiting, President

cc: Sheppard, Mullin, Richter & Hampton LLP
1300 I Street, N.W.
Washington, D.C. 20005-3314
Phone No.: (202) 469-4943
Fax No.: (202) 312-9411
Attn: Michele E. Williams, Esquire

EXHIBIT A-1

Columbus Real Property

PARCEL 1:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 13.727 acre tract, and all of the 0.875 acre tract conveyed to 17 Land Realty Corp. by deeds of record in O.R. 14066 B11 and O.R. 25716 J11, respectively, records of the Recorder's Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning at a railroad spike set at the intersection of the Southerly right-of-way line of Interstate 270 (FRA-270-18.32N) and centerline of Cooper Road (60 feet in width). Said railroad spike being the Northeasterly corner of said 0.875 acre tract;

Thence South 26 deg. 55' 00" East, a distance of 241.79 feet, along said centerline of Cooper Road and Easterly line of said 0.875 acre tract, to a railroad spike set at the Southeasterly corner of said 0.875 acre tract;

Thence North 78 deg. 47' 04" West, a distance of 38.14 feet, along the Southerly line of said 0.875 acre tract, to an iron pin set in the Westerly right-of-way line of said Cooper Road;

Thence South 26 deg. 55' 00" East, a distance of 295.14 feet, along said Westerly right-of-way line of Cooper Road and along the Easterly line of said 13.727 acre tract, to an iron pin set at the point of curvature in the Northerly right-of-way line of Corporate Exchange Drive (60 feet in width) of record in Plat Book 60, Page 22 and 23;

Thence the following four (4) courses and distances along said Northerly right-of-way line of Corporate Exchange Drive and Southerly line of said 13.727 acre tract;

1. Thence along arc of said curve to the right having a radius of 35.00 feet, a central angle of 90 deg. 00' 00", and a chord bearing South 18 deg. 05' 00" West, a chord distance of 49.50 feet to the point of tangency;

2. Thence South 63 deg. 05' 00" West, a distance of 35.00 feet, to an iron pin found at the point of curvature;

3. Thence along arc of said curve to the right having a radius of 270.00 feet, a central angle of 28 deg. 56' 27", and a chord bearing South 77 deg. 33' 14" West, a chord distance of 134.94 feet, to an iron pin set at the point of tangency;

4. Thence North 87 deg. 58' 33" West, a distance of 788.06 feet, to an railroad spike set;

Thence North 02 deg. 01' 27" East, a distance of 318.00 feet across said 13.727 acre tract to a railroad spike set in a Southerly line of the 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence South 87 deg. 58' 33" East, a distance of 15.00 feet along said Southerly line of the 5.103 acre tract to a railroad spike set at a Southeasterly corner of said 5.103 acre tract;

Thence the following three (3) courses and distances along the Easterly lines to said 5.103 acre tract;

1. Thence North 02 deg. 01’ 27” East, a distance of 185.00 feet, to a P.K. nail found;

2. Thence South 87 deg. 58’ 33” East, a distance of 57.50 feet, to a railroad spike set;

3. Thence North 02 deg. 01’ 27” East, a distance of 167.21 feet, to an iron pin set in aforesaid Southerly right-of-way line of Interstate 270 at a Northeasterly corner of said 5.103 acre tract;

Thence South 78 deg. 46’ 49” East, a distance of 677.06 feet, along said Southerly right-of-way line of Interstate 270 and partly along the Northerly line of said 13.727 acre tract and partly along the Northerly line aforesaid 0.875 acre tract, to the point of beginning.

Containing 11.814 acres, more or less, of which 0.167 acres lies within the Cooper Road right-of-way.

The bearings in the above description are based on the bearing of South 87 deg. 58’ 33” East, for the centerline of Corporate Exchange Drive, as shown on the dedication Plat for Corporate Exchange Drive, of record in Deed Book 60, Page 22 and 23, records of the Recorder’s Office, Franklin County, Ohio.

PARCEL 2:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 4.500 and 13.727 acre tracts conveyed to 17 Land Realty Corp. by deed of record in O.R. 14066 B11, Records of the Recorder’s Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning for reference at a PK nail found at the centerline intersection of Presidential Gateway (60 feet in width) as established by the Plat of record in Plat Book 83, Page 80 and Corporate Exchange Drive (60 feet in width) as established by the Plat of record in Plat Book 60, Page 22;

Thence North 87 deg. 58’ 33” West, a distance of 329.18 feet along the centerline of Corporate Exchange Drive to a point;

Thence North 02 deg. 01’ 27” East, a distance of 30.00 feet, to a railroad spike set on the Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 acre tract and being the point of true beginning;

Thence the following three (3) courses and distances along the said Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 and 4.500 acre tracts;

1. Thence North 87 deg. 58’ 33” West, a distance of 94.38 feet to an iron pin set at a point of curvature;

2. Thence along the arc of said curve to the right, having a radius of 420.00 feet, a central angle of 27 deg. 22’ 54”, a chord bearing North 74 deg. 17’ 06” West, and a chord distance of 198.81 feet to an iron pin found at the point of tangency;

3. Thence North 60 deg. 35’ 39” West, a distance of 28.10 feet to an iron pin set at a Southeasterly corner of a 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence the following two (2) courses and distance along the Easterly and Southerly lines of said 5.103 acre tracts;

1. Thence North 02 deg. 01’ 27” East, a distance of 258.02 feet to a railroad spike set;

2. Thence South 87 deg. 58’ 33” East, a distance of 312.50 feet to a railroad spike set;

Thence South 02 deg. 01’ 27” West, a distance of 318.00 feet across said 13.727 acre tract to the point of true beginning, containing 2.183 acres, more or less, subject to all easements, restrictions and rights-of-way of record.

Exhibit A-1

EXHIBIT A-2

Long Beach Real Property

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 7278-003-036

EXHIBIT B-1

Columbus Property Other Assets

The term "Columbus Property Other Assets" means (a) all "fixtures", as defined by Section 9- 102(a)(41) of the Uniform Commercial Code as adopted by the State of New York, owned by Seller and that are now or hereafter affixed or attached to or installed in the Columbus Real Property or the Columbus Improvements (the "Columbus Fixtures"), (b) all of the following, if and to the extent affixed to the Columbus Real Property or the Columbus Improvements and owned by Seller (even if not constituting Fixtures) (collectively, the "Columbus Property Equipment"): built-in fittings and built-in major appliances, including all electrical, anti-pollution, heating, lighting (including hanging fluorescent lighting), incinerating, power, air cooling, air conditioning, humidification, sprinkling, plumbing, lifting, fire prevention, fire extinguishing and ventilating systems, devices and machinery and all engines, pipes, pumps, tanks (including exchange tanks and fuel storage tanks), motors, conduits, ducts, steam circulation coils, blowers, steam lines, compressors, oil burners, boilers, doors, windows, loading platforms, lavatory facilities, stairwells, fencing (including cyclone fencing), passenger and freight elevators, overhead cranes and garage units, and (c) all Columbus Intangible Property; provided, however, notwithstanding the foregoing, Columbus Property Other Assets expressly excludes each and all of the following items (collectively, the "Columbus Property Excluded Items"):

1. all personal property located at the Columbus Real Property or the Columbus Improvements including, without limitation, all computers and other information technology devices, but excluding all items described in clause (b) of the definition of Columbus Property Other Assets; and

2. those other items (regardless of whether such items constitute Fixtures) described on Exhibit B-1-A hereof.

EXHIBIT B-1-A

Other Columbus Property Excluded Items

Qty	Mfg	Description	Model#	Location
1	Aircycle	Bulb eater	55VRSU	Shop
1	Westward	Toolbox		Shop
1	CLC	Toolbag		Shop
2	Maha	Battery Chargers		Shop
1	Dayton	Leaf Blower		Fire pump room
1	Briggs	Generator 5500 watts		Fire pump room
1	Ariens	Snow blower		Fire pump room
1	Snow Ex	Salt speader		Switch Gear cage
1	Rubbermaid	Light bulb cart		Storage
1	Ridgid	Drain snake		Shop
1	Dewalt	Air compressor		Shop
1	Dewalt	18V Drill		Shop
1	Dewalt	18V Impact Drill		Shop
1	Dewalt	18V Circular saw		Shop
1	Dewalt	18V Reciprocating saw		Shop
1	Dewalt	Bench grinder		Shop
1	Dewalt	Masonry bit set		Shop
1	Dewalt	Drill bit set		Shop
1	Westward	Bench grinder		Shop
1	Stanley	25ft Tape measure		Shop
1	Irwin	Paddle bit set		Shop
1	Fluke	Multimeter		Shop
1	Fluke	Infared thermometer		Shop
1	Ideal	Amp clamp		Shop
1	Streamlight	Flashlight		Shop
1	Klien	10 in 1 screw driver		Shop
4	Vise Grip	Pliers		Shop
3	Westward	Adjustable wrenches		Shop
1	Westward	Wrench set		Shop
1	Westward	Socket set		Shop
1	Stanley	Utility knife		Shop
1	Stanley	Tripod light		Shop
3	Westward	Pliers		Shop
1	Elkind	Allen wrench set		Shop
1	Megapro	15 in 1 screw driver		Shop
1	Brother	Printer	MCF845CW	Shop
1	Dell	Computer		Shop
1	Rigid	Hand snake		Shop

1	Zicron	Stud Finder	Shop
1		Scafold 4ft	Shop
1		5 gallon gas can	Fire pump room
1		2 gallon gas can	Fire pump room
1	Ridgid	Power washer 3300psi	Fire pump room
1	Shop Vac	Sweeper	Switch Gear cage

Exhibit B-1-A

EXHIBIT B-2

Long Beach Property Other Assets

The term "Long Beach Property Other Assets" means (a) all "fixtures", as defined by Section 9-102(a)(41) of the Uniform Commercial Code as adopted by the State of New York, owned by Seller and that are now or hereafter affixed or attached to or installed in the Long Beach Real Property or the Long Beach Improvements (the "Long Beach Fixtures"), (b) all of the following, if an to the extent affixed to the Long Beach Real Property or the Long Beach Improvements and owned by Seller (even if not constituting Fixtures) (collectively, the "Long Beach Property Equipment"): built-in fittings and built-in major appliances, including all electrical, anti-pollution, heating, lighting (including hanging fluorescent lighting), incinerating, power, air cooling, air conditioning, humidification, sprinkling, plumbing, lifting, fire prevention, fire extinguishing and ventilating systems, devices and machinery and all engines, pipes, pumps, tanks (including exchange tanks and fuel storage tanks), motors, conduits, ducts, steam circulation coils, blowers, steam lines, compressors, oil burners, boilers, doors, windows, loading platforms, lavatory facilities, stairwells, fencing (including cyclone fencing), passenger and freight elevators, overhead cranes and garage units, and (c) all Long Beach Intangible Property; provided, however, notwithstanding the foregoing, Long Beach Property Other Assets expressly excludes each and all of the following items (collectively, the "Long Beach Property Excluded Items"):

1. all personal property located at the Long Beach Real Property or the Long Beach Improvements including, without limitation, all computers and other information technology devices, but excluding all items described in clause (b) of the definition of Long Beach Property Other Assets; and
2. those other items (regardless of whether such items constitute Fixtures) described on Exhibit B-2-A hereof.

EXHIBIT B-2-A

Other Long Beach Property Excluded Items

(attached)

TOOL INVENTORY

Qty	***Mfg***	***Description***	***Model # (If Applicable)***	***Location (If Applicable)***
1	Ridged	24” bolt cutter		
1	Fluke	Multimeter	73 III	
1	Yellow Jacket	Super Evac LCD Vacuum Gauge	69070	
1	Lisle	Ring Compressor wrinkle band	21700	
1	Zim	Piston Ring Expander		
1	DeWALT	Cordless Drill 12v	1PZ14	
1	Makita	Cordless Drill 9.c Volts (ANGLE)	DA391DW	
1		One Way Screw Remover tool	PH-17061	
1	Ritchie	Manifold Charging Set	41212	
1	Ritchie	Valve Stem wrench ¼” 3/16” 5/16” 3/8”	60613	
1	Ritchie	Big mini tubing cutter 1 ⅛” max.	60142	
1	Fluke	Clamp Meter Amps/volts/ohms	322	
1	RIGID	Tubing Cutter	154	
1	ShopVac	Dry/Wet Vacuum		
2	Vaughn	Ball Pein Hammers 12 oz.		
1	Armstrong	½” Drive Adapter ¾” Male	12-952	
1	Armstrong	½” Drive Adapter ⅜” Male	12-951	
1	Allen	½” Drive Quick Release Ratchet	12800	
1	Proto	½” Drive Flex Head Handle Breaker bar 18 5/8”	5468	
1		U-Shaped Claw and Offset chisel Bar 24”	No I.D. Markings	
2	Supco	HVAC/R Current Probe With Microamps	CPH 100	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Harris	TS30 Test Set Portable handset	7530	
1 set	C. S. Osborne	Hole Punch Set (6)		
4		Misc. Hole Punch Tools		
1		Combination TEE		
1	Proto	Snap Ring Pliers	391	
	Proto	Ignition Set Wrenches	3200C	
1 set	Milwaukee	Flat Boring Bit Kit	49-22-0071	
1	Stanley	Side Cutters	84-133	
22		Misc. Files		
1	Lenox	File Brush		
1	Zim	Piston Ring Expander	204	
1		Piston Ring Compression Tool		
1	Imperial Eastman	Tubing Bender	368-FH	
1		Heavy Duty Puller		
1	UT	3/8” Air Ratchet & Sockets		
1	Vise Grip	9” Locking Welding Clamp		

Exhibit B-2-A

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Proto	Small Puller		
1 set	Allen	15 pc. Metric Long Arm Hex Key Set		
2		Star Wrenches Lug Nut Removal Tool		
2	Flex-Hone	Cylinder Wall Deglazer hones		
1	Proto	¾" Drive Ratchet		
1	Proto	¾" Drive Breaker Bar		
1	Turbo Cat III	Floor Dryer	4390-00	
1		Oxy-Ace Welding Set Lg.		
1		Oxy-Ace Welding Set Sm.		
1		Hex L-Key Set 12 pc.		
1		Metric Hex L-Key Set 9 pc.		
18	Proto	Assorted Open End Wrenches		
1 set	Proto	Ratchet Box End Wrench		
7	Proto	⅜" Swivel Head Socket		
1	Unibit	Step Drill ⅛" to ½"		
1	Proto	Torque Wrench ½ Drive		
1	Utica	⅜" Inch Pound Torque Wrench		
1	Proto	½" Speed Handle		
1	Proto	⅜" Speed Handle		
1 set	Proto	⅜ and ½" Drive Hex		
12	Proto	Metric Open-Box Wrenches		
1 set	Taiwan	Torx Head Drivers		
30		Assorted Allen Wrenches		
11		Assorted Screw Drivers		
9		Nut Drivers		
1	Imperial	Tubing Cutter		
1	Proto	Snap Ring Pliers		
4		Vise Grips Pliers		
7		Assorted Masonry Drill Bits		
1	Proto	Small Gear Puller	4205-B	
1 set	Jawco	Hex Dies		
1 set	Buck Bros.	Wood Chisels (6)		
1	Irwin	Expansive Wood Bit		
1	Greenlee	Knockout Punch Set		
1	Marson	Rivit Gun	HP-2	
1	Desmond	Stone Dresser		
1		Slag Remover Chipping Hammer		
1	Raytek	Noncontact Thermometer	ST2	
1	Amprobe	Test Master		
1	Pasar	Current Tracer		
1	Sensit RFC	Refrigerant Gas Leak Detector	RFC-1	
1	Check-it	Digital Psychrometer Set	622	
1	Environmental Tectonics	Psychometric Chart		
1	General Electric	Foot Candle Meter		
1	Electro-Therm	Digital Thermometer	SH66	
1	Robertshaw	Receiver Controller and Transmitter Calibration Kit	900-012	
1	Starrett	Dial Indicator	25-144	

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Dewalt	Cordless Drill 12v	DW972	
1	Makita	Cordless Drill 12v	6311D	
1	Makita	Cordless Drill 9.6v	6095D	
1	Makita	Cordless Drill 9.6v	6093D	
1	Makita	Cordless Drill 7.2v	DA3000D	
1	Proto	Roll Away Tool Box		
1	Ilco Unican	Key Duplicater Machine	17	
1	RIDGID	Vise		
1	Vaco	T-Handle Hex Keys (set)	90153	
1	K-D	T-Handle Hex Keys (set)		
1 set	Proto	Ratchet, Extensions, Sockets $\frac{3}{8}$"		
1 set	Proto	Ratchet, Extensions, Sockets $\frac{1}{2}$"		
1 set	Proto	Ratchet, Extensions, Sockets $\frac{3}{4}$"		
1 set		Pipe Thread Taps (6)		
14	Proto	Assorted Punches and Chisels		
7	Proto	Socket End-Open End Wrench		
1		50w 12v Drop Light		
1	Magnehelic	2" of Water Capacity		
1	Magnehelic	1" of Water Capacity		
1	Weller	Soldering Gun	TC-202	
2	Powr-Grip	Vacuum-Attaching Hand Tool	LJ6VH	
1 set	Armstrong	QuickRelease Ratchet Set		
2	Sellstrom	Gas Welding Goggles		
1	RIDGID	Lever Bender	408	
1	Magnehelic	3" of Water Capacity		
3	Bacharach	Tempscribe		
1	Dickson	Tempscribe		
1	Schlage	Boring Jig	40-012	
1	Amprobe	AMP, Volt, OHM Meter	ACD-11	
1	Simpson	Volt, OHM Meter	260	
1	Solomat	IAQ Monitoring System		
1	Starrett	Dial Caliper	120A-6	
1	Simpson	Therm-O-Meter	389	
1	Leviton	Splice Pro Tool	49550	
1	Yellow Jacket	Schrader Valve Removal Tool		
1	TIF	Automatic Halogen Leak Detector	6000	
1		Digital Light Meter	DLM2	
1	TIF	Capacitor Tester	660	
1	UE1	Digital Multimeter	DM383	
1	Amprobe	Fastemp		
2	Lenox	Hole Saw Kits		P1 Shop
1	Dayton	8 Piece Silver and Deming Drill Set	1 AO5O	
1	Milwaukee	Heavy Duty Electric Impact Wrench		
1	Kett	Power Shear	K-100	
1		Nut Driver Power Drill		
1	Lenox	Hacksaw	4012	
1	Christie	Portable Car-Start	CS-2	

Exhibit B-2-A

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Wilmar	2¼ ton Floor Jack	W-1634	
1	Kodiak	Shovel	72830	
1	Dayton	Ratchet Puller	2Z449-B	
1	Ramset	Powder Actuated Tool	4170	
1	Hilti	Powder Actuated Tool	DW451	
1	Dewalt	7” Angle Grinder	DW474	
1	Milwaukee	7 ¼” Circular Saw	6365	
1	Milwaukee	Rotary Hammer		
1	Milwaukee	⅜” Drill		
1	Black & Decker	⅜” Drill		
1	Black & Decker	Rotary Hammer		
1	Master	Heat Gun	HG-751B	
1	WEN	Electric Pencil Engraver	21	
1	Vibro-Graver	Electric Engraver	74	
1	Black & Decker	Butane Gas Soldering Gun		
1	Master	Butane Gas Soldering Gun	UT-100si	
1	Arrow Fastener	Staple Gun	T-50m	
1	Dwyer	Visi-Float Flowmeter	VFB-55-BV	
1	Allpax	Gasket Cutter		
2	Proto	Crescent Wrench 16”		One in Each Mech. Rm.
1	Proto	Crescent Wrench 12”		One in Each Mech. Rm.
1	Mayes	Level 24”		One in Each Mech. Rm.
2	Pony	‘C’ Clamps	245	One in Each Mech. Rm.
2	Pony	‘C’ Clamps	246	One in Each Mech. Rm.
1	Uniweld	Manifold Gauge Set	FL33312	One in Each Mech. Rm.
1		Manifold Gauge Set	4 Port	One in Each Mech. Rm.
1		12v Drop Light		
1	Empire	Level 48”		
3		‘T’ Squares 24”		
1		‘T’ Squares 48”	Wood	
1	Johnson	48” Straight Edge	TS48M	
1	Ridgid	36” Bolt Cutters		
1	Millers Falls	Sledge Hammer		
1		5’ Pry Bar		
1	DeWALT	Heavy Duty 4½” Small Angle Grinder	DW818	
1	Makita	Finishing Sander	B04530	
1	Skil	Soldering Gun	2410	
1	Milwaukee	Jig Saw		
1	Dremel	Dremel Variable Speed Grinder		
2 sets	Ace	Tap & Die Set	614	
1	Desco	Tap & Die Set #4 thru 1”	44348	
1	Milwaukee	⅜” Hammer Drill		

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Milwaukee	Sawzall		
1	Weller	Soldering Gun	8200N	
1	Milwaukee	Heavy Duty ½" Drill		
1	Craftsman	Drill Press 17" 16sp ¾ h.p.		P1 Shop
1	Speedaire	Air Compressor		P1 Shop
1	Graymills	Parts Cleaner/Washer	DM 136	P1 Shop
1	Milwaukee	Bench Grinder 7"		P1 Shop
2	RIDGID	Aluminum Pipe Wrench	836 36"	P1 Shop
1	RIDGID	Aluminum Pipe Wrench	824 24"	P1 Shop
1	RIDGID	Pipe Cutter ⅛"-2"	No. 202	P1 Shop
1	Chicago Specialty	Pipe Cutter 1"-3 ⅛"	No. 3720	P1 Shop
1 set	RIDGID	Thread Cut Set ⅛"-2" Pipe		P1 Shop
1	RIDGID	115v Power Threader	700	P1 Shop
1	RIDGID	Spiral Reamer	No. 2-S	P1 Shop
2	Jorgensen	"C" Clamp 6"	176	P1 Shop
2	Jorgensen	"C" Clamp 4"	174	P1 Shop
1	Proto	"C" Clamp 2"	402	P1 Shop
1	Armstrong	"C" Clamp 8"	78-408	P1 Shop
1	RIDGID	Flare	No. 459 45°	P1 Shop
1	Proto	Flaring Tool	No. 351 45°	P1 Shop
1	RIDGID	Basin Wrench	No. 1017	P1 Shop
1	RIDGID	Hex Wrench	No. 11	P1 Shop
1	RIDGID	Offset Hex Wrench	No. E-110	P1 Shop
1 set	Proto	Open End Box Wrench	⅜" to 1¼"	P1 Shop
2	Proto	Brass Hammer		P1 Shop
1		Plastic Mallet		P1 Shop
2	Proto	Rubber Mallets		P1 Shop
1		Ball Peen Hammer 32 oz.		P1 Shop
1	Stanley	Claw Hammer		P1 Shop
1	Vauguan	Ball Peen Hammer 16 oz.		P1 Shop
3	Wiss	Tin Snips		P1 Shop
1	RIDGID	Spud Wrench	No. 342	P1 Shop
2	Sloan Valve	Universal Wrench		P1 Shop
4	Rachex	Ratchet Action Wrench	10-17mm Box Wrench	P1 Shop
1	Lincoln	Wire Feed Welder SP175 T	Link 2302-1	
1	Pro Star	Welding Helmet Auto Darkening	FIB HPD1-F10	
1	J/B	Deep Vacuum Pump 10FM ½ hp	DV-285N	
1	Makita	Portable Cut-off (Chop Saw)	2414NB	
1	BernzOmatic	High Temperature Torch	TS 4000T	
1	LSI	Cordless Spotlight	RC-1100N	
1	Channel Lock	21" Channel Lock Pliers		
1	Skil	7¼" Circular Saw	5400	
1	Honda	Portable Generator	EM 5000SX	
1	Schumacher	Battery Charger	SE4022	
1	Pinnacle	Refrigerant Recovery Unit		
1	Fluke	Volt-OHM Tester	T+Pro	
1	AEMC	Megohm Tester	1026	

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
3	DeWALT	14.4v Cordless Drill		
1	Armstrong	10 pc. Claw Foot (Open End)		
1	Empire	4’ Level Aluminum		
1	Armstrong	⅜” Socket Set MM 13pcs.		
1	Armstrong	⅜” Socket Set MM (Long) 12 pcs.		
1	Proto	¼” Socket Set		
1	Proto	⅜” Socket Set		
4	Wood’s	Powr-Grip 8”	N4950	
1	Milwaukee	Portable Band Saw		
1	Milwaukee	Roto Hammer	5318-21	
1	CPS	Thermo-Psychrometer	TM360	
1	RIDGID	Hand Held Drain Cleaning Machine	K45	
1	Milwaukee	18v Sawzall & Charger		
2	Dayton	Pump Out Wet Vac	6AKY1	
1	Fluke	Clamp On Meter Amp Probe	324	
1	Milwaukee	120v Sawzall		
1	Ridgid	Pipe Breaker	276	
1	Dayton	8” Bench Grinder ¾hp	2LKR9	
1	Weller	120v Solding Gun	SP23L	
1	Master	Gas Solding Gun Ultratorch	UT-40Si	
1	Milwaukee	Electric ½” Drill 5320010330067		
1	Genie	1 Person Lift		
1	Genie	Material Lift		
1	Eureka	Hepa Vacuum Cleaner		
1		Fence Post Installer		
1		Cherry Picker		
1	Husky	5 Piece Reversible Ratching Wrenches	SKU630699	
1	Greenlee	Circuit Seeker	CS8000	
1	Arrow Crane Hoist	Iron 1 ton Capacity Hoist	B-9620	
1	SPANCO Inc	Aluminum 1 ton Capacity Hoist	1ALU1212B	
1	Coffing	1 ton Chainfall		
1	CM	Electric 1 ton Hoist	WL 480v	
1	Tom Cat	Walk Behind Floor Scrubber		

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
1999	Desk Top Multiplex - Security	Pelco Multiplexer MX4016 CS	Console	Plaza Level	6644 9F	Sentry Control Systems
2009	Security Camera System Monitor	Samsung SMT-1922 19 **1-yr Wty: 4/1/09 to 4/1/2010**	Console	Lobby Level	Serial # Y3OC3VUQ900002	CDW Computer Centers, Inc.
2009	Security Camera System Monitor	Planar PL1520M 15 SPK Part Number 997-3266-00 **1-yr Wty: 3/27/09 to 3/27/2011**	Console	Lobby Level	Serial # P96886JA25192	CDW Computer Centers, Inc.
2009	Security IdentiPass System CPU	Dell Optiplex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/2012**	Console	Lobby Level	Service Tag # H8MDGJ1	Dell.com
2013	Desk Top Keyboard - Security Console	Pelco KBD300A Keyboard Vari-speed Pan, Tilt & Zoom Joystick; Model #KBD300A. Installed 1/8/2013	Console	Lobby Level	SN ACW-VP J8	Vision Communications
2013	Security DVR	Pelco Hybrid Video Recorder 16 channel (DVR); Model DX4816-2000; Installed 1/8/2013	Console	Lobby Level	SN ACV-2002	Vision Communications
2000	Desk Top Printer - Engineer	HP DeskJet 842C	Engineer	P-1 Level	CN01M1P0W8	KDC
2005	Desk Top Monitor - Engineer	1704FPTt-HVAC Monitor	Engineer	P-1 Level	CNOY42997161856AANJH	Dell Computer Corporation
2010	Desk Top Printer - Chief Engr's Office	HP LaserJet P2035n Purchased: May 13, 2010 **1-yr Wty: 5/13/2010 to 5/12/2011**	Engineer	P-1 Level	Serial # CNB9D27365; Mfg#: H-P-CE462A#ABA	CDW Computer Centers, Inc.
2010	Desk Top Computer - Chief Engr	Dell Opti Plex 380 MiniTower Base **3-yr Wty: 5/6/2010 to 5/5/2013**	Engineer	P-1 Level	Service Tag $ 21QTRL1; Express Code: 4459089637; Mfg Date: 5/5/2010	Dell.com
2010	Desk Top Monitor - Chief Engr	Dell 22 inch Flat Panel Display; E2210H; 3-yr Wty: 5/3/2010 to 5/2/2013	Engineer	P-1 Level	DP/N OH265R; S/N: CN-OH265R-64180-047-1USL	Dell.com
2010	Desk Top Computer - Engineer - Chief Engineer's Andover HVAC System	Dell OptiPlex380 – Intel Core 2 Duo 2.93 Ghz, 4 GB, 160 GB 7200 RPM SATA HD, 16X DVD-ROM; Service Tag: BCG1PN1; Express Service Code: 24697153549	Engineer	P-1 Level	Windows 7 Pro/OA; Product key: TMXCJ-2VBY4-WV43H-R4TH4-HRDTVX16-96076; 00186-77-094-237; OKXGVD	CGB Enterprises
2012	Printer - Engineers' Lunch Room	HP DeskJet 5650	Engineer	P-2 Level	SN MY7CL1R1JP	Dell
2012	Desk Top Monitor - Engineers' Lunch Rm	Model # E1911C; 22 inch Monitor	Engineer	P-2 Level	SN CN-ONO1VP-64180-219-1C9B	Dell
2012	Desk Top Computer - Engineers' Lunch Rm	Model # Core i5; Windows 7; Product Key# 328HW-M472H-GDMW7-4JK32-2H8M9	Engineer	P-2 Level	Service Tag # 1KMMJS1; Express Service Code: 3424109473	Dell
2013	Desk Top Computer - New HVAC System	Dell OptiPlex 990; Intel Core i5; Windows 7; Product Key: 7Q2F2-7WTHG-W8TWR-YH4XP-TKC2W	Engineer	P-1 Level	Service Tag # CVVPYV1; Express Service Code: 28049119165	Emcor

Exhibit B-2-A

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2013	Desk Top Monitor - New HVAC System	LG 32 inch Monitor LS-34; 32LS3410	Engineer	P-1 Level	SN 209MXLS7Q352	Emcor
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Craig Aydelott	SN 12816A0500; Radio ID# 2001	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Esteban Diaz	SN 12816A0496; Radio ID# 2002	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Alfonso Oregel	SN 12816A0497; Radio ID# 2003	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Richard Marshall	SN 12816A0499; Radio ID# 2004	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Jeremiah Lees	SN 12918A0200; Radio ID# 2020	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Claudia Motte-Alvarez, J1	SN 12816A0495; Radio ID# 2007	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Nancy Hernandez, J2	SN 12816A0494; Radio ID# 2008	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Alex Passarelli, J3	SN 12816A0493; Radio ID# 2009	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Hector Nunez	SN 12918A0199; Radio ID# 2019	Vision Communications
2013	Lobby Level Directory Monitor	Panasonic 42 inch	Lobby	Lobby Level	SN MB21580709; 200 Twr	Jet Communications
2013	Lobby Level Directory Monitor	Panasonic 42 inch	Lobby	Lobby Level	SN MD22360382; 300 Twr	Jet Communications
2003	Desk Top Printer - Guest Room	HP Photosmart 7550 (Color)	OOB	Guest Desk	CN2BS4214N	World Trade Office Supplies
2005	Desk Top Monitor - Guest Room	1704FPTt	OOB	Guest Desk	CNOY42997161856AANM5	Dell Computer Corporation
2005	Desk Top Monitor - Server Room	E153FP	OOB	Server Room	CNOC53696418053UOL5H	Dell Computer Corporation
2005	Desk Top Computer - Guest Room	DHS Mfg Date: 07 20 05	OOB	Guest Desk	6XWKY71	Dell Computer Corporation
2007	Desk Top Printer - Guest Room	HP Photosmart D7260 (Color)	OOB	Guest Desk	MY789U2 NH	HP.com
2009	Desk Top Monitor - Asst. Bldg Mgr	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Mary's Desk	CN-0F532H-74445-93Q-AM6S	Dell.com
2009	Desk Top Monitor - Asst. Bldg Mgr	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Mary's Desk	CN-0F532H-74445-93Q-ANDS	Dell.com
2009	Desk Top Monitor - Property Asst	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Pearl's Desk	CN-0F532H-74445-93Q-AN9S	Dell.com
2009	Security IdentiPass System CPU	DellOptiPlex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/2012**	OOB	Access Card Desk-OOB	Service Tag # BJFDGJ1	Dell.com
2009	Desk Top Scanner - Print Area	HP ScanJet 7650n; Model: (1P): L1943A; Option: (30P): B1H **1-yr Wty: 5/18/09 to5/17/2010**	OOB	Print Area	CN87KT1129	CDW Computer Centers, Inc.

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2009	Conference Room TV Monitor	Sharp LC-42SB45UT: **1-yr Wty: 9/4/09 to 9/8/10**	OOB	Confce Rm	905817411	Kelty Co.
2009	Lobby Level CPU for Directory	Dell Optiplex 740 **3-yr Wty: 9/30/09 to 9/30/2012.**	OOB	Lobby Level	200 Tower: Service Tag # FZ67ZK1; Express Code: 34778501569	Dell.com
2009	Lobby Level CPU for Directory	Dell Optiplex 740 **3-yr Wty: 9/30/09 to 9/30/2012**	OOB	Lobby Level	300 Tower: Service Tag # DZ67ZK1; Express Code: 30424936897	Dell.com
2010	Desk Top Printer - GM's Office	HP LaserJet P3015dn Purchased: May 13, 2010 **1-yr Wty: 5/13/2010 to 5/12/2011**	OOB	Ivette's Desk	Serial # VNBCB406WP; Mfg#: H-P-CE528A#ABA	CDW Computer Centers, Inc.
2010	Desk Top Computer - Property Asst	Dell Opti Plex 380 Minitower Base **3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010.**	OOB	Pearl's Desk	B574KM1	Dell.com
2010	Desk Top Computer - Asst. Bldg Mgr	Dell Opti Plex 380 Minitower Base 3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010.	OOB	Mary's Desk	B582KM1	Dell.com
2010	Desk Top Computer - Server Room	PowerEdge Dell T310 System	OOB	Server Room	Service Tag: 2VL9JS1; Express Service Code: 6263733601	Carapace, Inc.
2012	LapTop Computer - G Mgr	Dell Laptop 13 inch.	OOB	Ivette's Desk	Service Tag (S/N): CKMYFS1; Express Service Code: 27369269857	Dell purchased by Lori McKinney
2012	HP OfficeJet Pro 8600	Model#: SNPRC-1101-01; Product #: CM749A **1-yr Wty: 1/19/2012 to 1/19/2013**	OOB	Print Area	Serial # CN1C31T1C6	Lori McKinney
2012	Desk Top Monitor - GMgr	Dell 22 inch Flat Panel Display	OOB	Ivette's Desk	S/N# CN-0174R7-72872-24B-A2VU	Dell from Lori McKinney
2012	Desk Top Monitor - GMgr	Dell 22 inch Flat Panel Display	OOB	Ivette's Desk	S/N# CN-0174R7-72872-24B-A69U	Dell from Lori McKinney
2012	Copy Machine - Server Room	Ricoh Aficio MPC2551	OOB	Server Room	Equipment ID: V9825200222	Leased from Ricoh Business Solutions
2013	OOB WIFI Unit	Ruckus ZoneFlex 7300 Series (7363)	OOB	Telco Rm	SN 543D37054B00	Allcovered
2013	Security Radio Repeater	Hytera Professional Digital Radio Repeater; Model RD982; Installed 1/8/2013	OOB	A5 LRR ElecRm	SN12529A0096; 3 antennas located in A11, A5 and P2 by Stair #1.	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	OOB	Pearl Tan	SN 12816A0492; Radio ID# 2010	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	OOB	Mary Ramsey	SN 12723D0125; Radio ID# 2011	Vision Communications

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2013	Portable Radio	Hytera PD702 U(2)	OOB	Ivette Walker	SN 12723D0127; Radio ID# 2015	Vision Communications
2013	Portable Radio	Motorola SL7550	Owner's Rep	Salvador Gutierrez	SN 682TNB2423; Radio ID# 2016	Vision Communications
2008	Desk Top Monitor - Parking	Parking Access Monitor	Parking	P-1 Parking	S/N #CN-ORY979-74261-848-6D5U	Dell
2009	Desk Top Monitor - Parking	Dell 19" Widescreen LCD SE 198 WFP **1-yr Wty: 1/1/09 to 1/1/2010**	Parking	P-1 Parking	CN-OC558H-72872-89Q-OMAM	Best Buy
2009	Security IdentiPass System CPU	Dell Optiplex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/12.**	Parking	P-1 Parking	Service Tag # F8MDGJ1	Dell.com
2010	Desk Top Computer - Parking Mgr	Dell Opti Plex 380 Minitower Base **3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010**	Parking	P-1 Parking	B583KM1	Dell.com
2011	Desk Top Printer - Parking Mgr	HP LaserJet 2420d	Parking	P-1 Parking	S/N: CNDJF05457	
2012	Brother AIO Printer - Parking Mgr	Brother Model # MFC-7460 DN; **1-yr Wty: 4/5/2012 to 4/5/2013**	Parking	P-1 Parking	Serial #: U62701K1N199757	World Trade Office Supplies
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P1	SN 12723D0126; Radio ID# 2012	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P2	SN 12723D0120; Radio ID# 2013	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P3	SN 12816A0257; Radio ID# 2014	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P4	SN 12817A0326; Radio ID# 2018	Vision Communications
2007	Desk Top Printer - Security	HP LaserJet 1018; Placed in service on May 19, 2012 by Chip at Allcovered	Security	Kevin's Desk-OOB	CNB1004493	HP.com
2009	Desk Top Monitor - Access Card	Dell Prof 1909, Wide Flat Panel DP/N OW160G: **3-yr Ltd Wty: 9/9/2009 to 9/9/2012**	Security	Access Card Desk-OOB	CN-OW160G-72872-97Q-387S	Dell.com
2010	Desk Top Computer - Dir of Security	Dell Opti Plex 380 MiniTower Base **3-yr Wty: 5/6/2010 to 5/5/2013.**	Security	Kevin's Desk-OOB	Service Tag # 21QYRL1; Express Code: 4459322917; Mfg Date: 5/5/2010	Dell.com
2010	Desk Top Monitor - Dir of Security	Dell 22 inch Flat Panel Display; E2210H; **3-yr Wty: 5/3/2010 to 5/2/2013.**	Security	Kevin's Desk-OOB	DP/N OH265R; S/N: CN-OH265R-64180-047-1TGL	Dell.com
2010	Security Camera at Load Dock on P-1 Level (Camera #2)	Pelco ES3012 20X PTZ Camera at Load Dock; Ship Date: April 6, 2010. **1-yr Wty: 4/6/2010 to 4/5/2011**	Security	P-1 Level	Serial Number: ABA-AP99	Universal Protection Systems

Exhibit B-2-A

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2010	Security Camera at West Monument. Camera #3 at the Plaza Level	Pelco ES3012 - 2 CLZ20PN; Ship Date: May 21, 2010. **1-yr Wty: 5/21/2010 to May 20, 2011.**	Security	Plaza Level	Serial Number: ABC-CYQ8	Vision Communications
2011	Camera 4 on top of East Monument Sign	Pelco Esprit ES3012 Series - Camera (Integrated Positioning System); Installed 3/24/2011.	Security	Plaza Level	SN ABVHVW2; Pelco Esprit ES3012-2CLZ20PN	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Security	Console	SN 12816A0498; Radio ID# 2005	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Security	Patrol	SN 12816A0491; Radio ID# 2006	Vision Communications
2013	Portable Radio	Motorola SL7550	Security	Kevin Stapleton	SN 682TND2817; Radio ID# 2017	Vision Communications

Exhibit B-2-A

EXHIBIT C

Intentionally Omitted.

EXHIBIT D-1

Form of California Deed

RECORDING REQUESTED BY

Fidelity National Title Insurance Company
Escrow No.
Title No:

WHEN RECORDED MAIL DOCUMENT AND
TAX STATEMENTS TO:
Sheppard Mullin Richter & Hampton, LLP
1300 I Street, NW
11th Floor East
Washington, DC 20005
Attn: Michele E. Williams, Esq.

APN: 7278-003-035 and 7278-003-036 THIS SPACE ABOVE FOR RECORDER'S USE

GRANT DEED

FOR VALUABLE CONSIDERATION, the receipt and sufficiency of which are hereby acknowledged, Molina Center, LLC, a Delaware limited liability company (Grantor), hereby grants to AGNL Clinic, L.P., a Delaware limited partnership (Grantee), the real property in the City of Long Beach, County of Los Angeles, State of California, more particularly described in Exhibit A attached hereto and incorporated herein by this reference (the "Property").

This conveyance is made subject to (i) all covenants, conditions, restrictions, rights of way, easements, reservations, and other matters of record; (ii) all laws, rules and regulations governing the use and development of the Property; (iii) all matters that could be ascertained by an inspection or survey of the Property; and (iv) all non-delinquent real property taxes and general and special assessments. Grantor disclaims any and all express or implied warranties regarding the Property other than the warranty stated in subsection 1 of section 1113 of the California Civil Code.

Dated: June ____, 2013

[Signature page follows]

IN WITNESS WHEREOF, the Grantor has executed this Grant Deed as of the date and year first written above.

GRANTOR:
Molina Center, LLC,
a Delaware limited liability company
By: ____
Name: ____
Its: ____

ACIKNOWLEDGMENT

STATE OF CALIFORNIA)
) ss:
COUNTY OF _____)

On _____, 2013, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Exhibit D-1

EXHIBIT "A" TO GRANT DEED

LEGAL DESCRIPTION

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 7278-003-036

EXHIBIT D-2

Form of Ohio Deed

RECORDING REQUESTED BY
AND WHEN RECORDED MAIL TO:

Sheppard Mullin Richter & Hampton, LLP
1300 I Street, NW
11th Floor East
Washington, DC 20005
Attn: Michele E. Williams, Esq.

GENERAL WARRANTY DEED

Molina Healthcare, Inc., a Delaware corporation (at times the "Grantor"), for Ten Dollars ($10.00) and other valuable consideration paid, grants with general warranty covenants (as defined in Section 5302.06 of the Ohio Revised Code) to AGNL Clinic, L.P., a Delaware limited partnership (at times the "Grantee"), the tax mailing address for which is c/o Angelo, Gordon & Co., L.P., 245 Park Avenue, 26th Floor, New York, NY 10167-0094, the following real property:

Legal Description

PARCEL 1:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being part of the 13.727 acre tract, and all of the 0.875 acre tract conveyed to 17 Land Realty Corp. by deeds of record in O.R. 14066B11 and O.R. 25716J11, respectively, records of the Recorder's Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning at a railroad spike set at the intersection of the Southerly right-of-way line of Interstate 270 (FRA-270-18.32N) and centerline of Cooper Road (60 feet in width). Said railroad spike being the Northeasterly corner of said 0.875 acre tract;

Thence South 26 deg. 55' 00" East, a distance of 241.79 feet, along said centerline of Cooper Road and Easterly line of said 0.875 acre tract, to a railroad spike set at the Southeasterly corner of said 0.875 acre tract;

Thence North 78 deg. 47' 04" West, a distance of 38.14 feet, along the Southerly line of said 0.875 acre tract, to an iron pin set in the Westerly right-of-way line of said Cooper Road;

Thence South 26 deg. 55’ 00” East, a distance of 295.14 feet, along said Westerly right-of-way line of Cooper Road and along the Easterly line of said 13.727 acre tract, to an iron pin set at the point of curvature in the Northerly right-of-way line of Corporate Exchange Drive (60 feet in width) of record in Plat Book 60, Page 22 and 23;

Thence the following four (4) courses and distances along said Northerly right-of-way line of Corporate Exchange Drive and Southerly line of said 13.727 acre tract;

1. Thence along arc of said curve to the right having a radius of 35.00 feet, a central angle of 90 deg. 00’ 00”, and a chord bearing South 18 deg. 05’ 00” West, a chord distance of 49.50 feet to the point of tangency;

2. Thence South 63 deg. 05’ 00” West, a distance of 35.00 feet, to an iron pin found at the point of curvature;

3. Thence along arc of said curve to the right having a radius of 270.00 feet, a central angle of 28 deg. 56’ 27”, and a chord bearing South 77 deg. 33’ 14” West, a chord distance of 134.94 feet, to an iron pin set at the point of tangency;

4. Thence North 87 deg. 58’ 33” West, a distance of 788.06 feet, to an railroad spike set;

Thence North 02 deg. 01’ 27” East, a distance of 318.00 feet across said 13.727 acre tract to a railroad spike set in a Southerly line of the 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence South 87 deg. 58’ 33” East, a distance of 15.00 feet along said Southerly line of the 5.103 acre tract to a railroad spike set at a Southeasterly corner of said 5.103 acre tract;

Thence the following three (3) courses and distances along the Easterly lines to said 5.103 acre tract;

1. Thence North 02 deg. 01’ 27” East, a distance of 185.00 feet, to a P.K. nail found;

2. Thence South 87 deg. 58’ 33” East, a distance of 57.50 feet, to a railroad spike set;

3. Thence North 02 deg. 01’ 27” East, a distance of 167.21 feet, to an iron pin set in aforesaid Southerly right-of-way line of Interstate 270 at a Northeasterly corner of said 5.103 acre tract;

Thence South 78 deg. 46’ 49” East, a distance of 677.06 feet, along said Southerly right-of-way line of Interstate 270 and partly along the Northerly line of said 13.727 acre tract and partly along the Northerly Line aforesaid 0.875 acre tract, to the point of beginning.

Containing 11.814 acres, more or less, of which 0.167 acres lies within the Cooper Road right-of-way.

Exhibit D-2

The bearings in the above description are based on the bearing of South 87 deg. 58’ 33” East, for the centerline of Corporate Exchange Drive, as shown on the dedication Plat for Corporate Exchange Drive, of record in Deed Book 60, Page 22 and 23, records of the Recorder’s Office, Franklin County, Ohio.

PARCEL 2:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 4.500 and 13.727 acre tracts conveyed to 17 Land Realty Corp. by deed of record in O.R. 14066 B11, Records of the Recorder’s Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning for reference at a PK nail found at the centerline intersection of Presidential Gateway (60 feet in width) as established by the Plat of record in Plat Book 83, Page 80 and Corporate Exchange Drive (60 feet in width) as established by the Plat of record in Plat Book 60, Page 22;

Thence North 87 deg. 58’ 33” West, a distance of 329.18 feet along the centerline of Corporate Exchange Drive to a point;

Thence North 02 deg. 01’ 27” East, a distance of 30.00 feet, to a railroad spike set on the Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 acre tract and being the point of true beginning;

Thence the following three (3) courses and distances along the said Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 and 4.500 acre tracts;

1. Thence North 87 deg. 58’ 33” West, a distance of 94.38 feet to an iron pin set at a point of curvature;

2. Thence along the arc of said curve to the right, having a radius of 420.00 feet, a central angle of 27 deg. 22’ 54”, a chord bearing North 74 deg. 17’ 06” West, and a chord distance of 198.81 feet to an iron pin found at the point of tangency;

3. Thence North 60 deg. 35’ 39” West, a distance of 28.10 feet to an iron pin set at a Southeasterly corner of a 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence the following two (2) courses and distance along the Easterly and Southerly lines of said 5.103 acre tracts;

1. Thence North 02 deg. 01’ 27” East, a distance of 258.02 feet to a railroad spike set;

2. Thence South 87 deg. 58’ 33” East, a distance of 312.50 feet to a railroad spike set;

Thence South 02 deg. 01’ 27” West, a distance of 318.00 feet across said 13.727 acre tract to the point of true beginning, containing 2.183 acres; more or less, subject to all easements, restrictions and rights-of-way of record.

Subject to (1) zoning ordinances, (2) real estate taxes and assessments, not yet due and payable, (3) easements, restrictions, covenants, reservations and conditions of record which do not adversely affect the use or value thereof.

Parcel Nos.: 600-122680 and 600-215203

Property Address: 3000 Corporate Exchange Drive, Columbus, Ohio.

Prior instrument reference AFN 201212200196229, Franklin County Records.

[Signature Page Follows]

Exhibit D-2

In witness whereof, Molina Healthcare, Inc., through its duly authorized representative, has set its hand this _____ day of _____, 2013.

Molina Healthcare, Inc.,
a Delaware corporation

By: _____
Print Name: __
Title: ____

STATE OF CALIFORNIA)
) SS:
COUNTY OF _____)

Before me, the undersigned, a notary public in and for said county and state on this day personally appeared _____, the _____ of Molina Healthcare, Inc., a Delaware corporation, who acknowledged that he/she did sign the foregoing instrument in such capacity and that the same is his/her free act and deed and the free act and deed of said corporation.

In witness whereof, I have hereunto subscribed my name and affixed my official seal at _____, _____ this _____ day of _____, 2013.

Notary Public

EXHIBIT E-1

BILL OF SALE AND ASSIGNMENT

MOLINA HEALTHCARE, INC.,

a Delaware corporation,

to

AGNL CLINIC, L.P.,

a Delaware limited partnership

KNOW ALL MEN BY THESE PRESENTS, that Molina Healthcare, Inc., a Delaware corporation (" Seller"), for and in consideration of Ten Dollars ($10.00) and other good and valuable consideration, to it in hand paid by AGNL Clinic, L.P., a Delaware limited partnership ("Purchaser"), at or before the sealing and delivery of these presents, the receipt and sufficiency of which is hereby acknowledged, has granted, bargained, sold, transferred and delivered, and by these presents does grant, assign, bargain, sell, transfer and deliver unto Purchaser the following (the "Personal Property"):

all machinery and equipment listed and described on Exhibit B attached hereto and made a part hereof owned by Seller and located on property (the "Property") situate in the City of Columbus, Franklin County, Ohio as described on Exhibit A attached hereto and made a part hereof;

all certificates of occupancy of Seller, and all licenses, permits, and approvals, if any, which are mandated or necessary to own and operate the Property.

any warranties or guaranties in the possession of Seller and given by any contractor, manufacturer or materialmen in connection with the construction, maintenance, repair or renovation of the Property;

all plans and drawings with respect to the Property in the possession of Seller.

TO HAVE AND TO HOLD the Personal Property unto Purchaser, its successors and assigns, to and for its own proper use and benefit forever.

This Bill of Sale shall be governed by the laws of the State of Ohio.

This Bill of Sale and the provisions contained herein shall be binding upon and inure to the benefit of Seller and Purchaser and their respective successors, legal representatives and assigns.

This Bill of Sale may be executed in counterparts, each of which shall be deemed an original, but all of which, together, shall constitute one and the same instrument.

[*No further text on this page. Signature page follows.*]

Exhibit E-1

IN WITNESS WHEREOF, Seller and Purchaser have caused this Bill of Sale to be executed on its behalf, this _____ day of June, 2013.

SELLER:
MOLINA HEALTHCARE, INC.,
a Delaware corporation
By: _____
Name: ____
Title: ____

PURCHASER:
AGNL CLINIC, L.P.,
a Delaware limited partnership
By: AGNL Clinic GP, L.L.C.,
a Delaware limited liability company,
its general partner
By: AGNL Manager II, Inc.,
a Delaware corporation, its manager
By: __
Name: Gordon J. Whiting
Title: President

Exhibit A

LEGAL DESCRIPTION

- PARCEL 1:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 13.727 acre tract, and all of the 0.875 acre tract conveyed to 17 Land Realty Corp. by deeds of record in O.R. 14066 B11 and O.R. 25716 J11, respectively, records of the Recorder's Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning at a railroad spike set at the intersection of the Southerly right-of-way line of Interstate 270 (FRA-270-18.32N) and centerline of Cooper Road (60 feet in width). Said railroad spike being the Northeasterly corner of said 0.875 acre tract;

Thence South 26 deg. 55' 00" East, a distance of 241.79 feet, along said centerline of Cooper Road and Easterly line of said 0.875 acre tract, to a railroad spike set at the Southeasterly corner of said 0.875 acre tract;

Thence North 78 deg. 47' 04" West, a distance of 38.14 feet, along the Southerly line of said 0.875 acre tract, to an iron pin set in the Westerly right-of-way line of said Cooper Road;

Thence South 26 deg. 55' 00" East, a distance of 295.14 feet, along said Westerly right-of-way line of Cooper Road and along the Easterly line of said 13.727 acre tract, to an iron pin set at the point of curvature in the Northerly right-of-way line of Corporate Exchange Drive (60 feet in width) of record in Plat Book 60, Page 22 and 23;

Thence the following four (4) courses and distances along said Northerly right-of-way line of Corporate Exchange Drive and Southerly line of said 13.727 acre tract;

1. Thence along arc of said curve to the right having a radius of 35.00 feet, a central angle of 90 deg. 00' 00", and a chord bearing South 18 deg. 05' 00" West, a chord distance of 49.50 feet to the point of tangency;

2. Thence South 63 deg. 05' 00" West, a distance of 35.00 feet, to an iron pin found at the point of curvature;

3. Thence along arc of said curve to the right having a radius of 270.00 feet, a central angle of 28 deg. 56' 27", and a chord bearing South 77 deg. 33' 14" West, a chord distance of 134.94 feet, to an iron pin set at the point of tangency;

4. Thence North 87 deg. 58' 33" West, a distance of 788.06 feet, to an railroad spike set;

Thence North 02 deg. 01' 27" East, a distance of 318.00 feet across said 13.727 acre tract to a railroad spike set in a Southerly line of the 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence South 87 deg. 58' 33" East, a distance of 15.00 feet along said Southerly line of the 5.103 acre tract to a railroad spike set at a Southeasterly corner of said 5.103 acre tract;

Thence the following three (3) courses and distances along the Easterly lines to said 5.103 acre tract;

1. Thence North 02 deg. 01’ 27” East, a distance of 185.00 feet, to a P.K. nail found;

2. Thence South 87 deg. 58’ 33” East, a distance of 57.50 feet, to a railroad spike set;

3. Thence North 02 deg. 01’ 27” East, a distance of 167.21 feet, to an iron pin set in aforesaid Southerly right-of-way line of Interstate 270 at a Northeasterly corner of said 5.103 acre tract;

Thence South 78 deg. 46’ 49” East, a distance of 677.06 feet, along said Southerly right-of-way line of Interstate 270 and partly along the Northerly line of said 13.727 acre tract and partly along the Northerly line aforesaid 0.875 acre tract, to the point of beginning.

Containing 11.814 acres, more or less, of which 0.167 acres lies within the Cooper Road right-of-way.

The bearings in the above description are based on the bearing of South 87 deg. 58’ 33” East, for the centerline of Corporate Exchange Drive, as shown on the dedication Plat for Corporate Exchange Drive, of record in Deed Book 60, Page 22 and 23, records of the Recorder’s Office, Franklin County, Ohio.

PARCEL 2:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 4.500 and 13.727 acre tracts conveyed to 17 Land Realty Corp. by deed of record in O.R. 14066 B11, Records of the Recorder’s Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning for reference at a PK nail found at the centerline intersection of Presidential Gateway (60 feet in width) as established by the Plat of record in Plat Book 83, Page 80 and Corporate Exchange Drive (60 feet in width) as established by the Plat of record in Plat Book 60, Page 22;

Thence North 87 deg. 58’ 33” West, a distance of 329.18 feet along the centerline of Corporate Exchange Drive to a point;

Thence North 02 deg. 01’ 27” East, a distance of 30.00 feet, to a railroad spike set on the Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 acre tract and being the point of true beginning;

Thence the following three (3) courses and distances along the said Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 and 4.500 acre tracts;

1. Thence North 87 deg. 58’ 33” West, a distance of 94.38 feet to an iron pin set at a point of curvature;

2. Thence along the arc of said curve to the right, having a radius of 420.00 feet, a central angle of 27 deg. 22’ 54”, a chord bearing North 74 deg. 17’ 06” West, and a chord distance of 198.81 feet to an iron pin found at the point of tangency;

3. Thence North 60 deg. 35’ 39” West, a distance of 28.10 feet to an iron pin set at a Southeasterly corner of a 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence the following two (2) courses and distance along the Easterly and Southerly lines of said 5.103 acre tracts;

1. Thence North 02 deg. 01’ 27” East, a distance of 258.02 feet to a railroad spike set;

2. Thence South 87 deg. 58’ 33” East, a distance of 312.50 feet to a railroad spike set;

Thence South 02 deg. 01’ 27” West, a distance of 318.00 feet across said 13.727 acre tract to the point of true beginning, containing 2.183 acres, more or less, subject to all easements, restrictions and rights-of-way of record.

Exhibit E-1

Exhibit B

Machinery and Equipment

The term "Columbus Property Other Assets" means (a) all "fixtures", as defined by Section 9- 102(a)(41) of the Uniform Commercial Code as adopted by the State of New York, owned by Seller and that are now or hereafter affixed or attached to or installed in the Columbus Real Property or the Columbus Improvements (the "Columbus Fixtures"), (b) all of the following, if and to the extent affixed to the Columbus Real Property or the Columbus Improvements and owned by Seller (even if not constituting Fixtures) (collectively, the "Columbus Property Equipment"): built-in fittings and built-in major appliances, including all electrical, anti-pollution, heating, lighting (including hanging fluorescent lighting), incinerating, power, air cooling, air conditioning, humidification, sprinkling, plumbing, lifting, fire prevention, fire extinguishing and ventilating systems, devices and machinery and all engines, pipes, pumps, tanks (including exchange tanks and fuel storage tanks), motors, conduits, ducts, steam circulation coils, blowers, steam lines, compressors, oil burners, boilers, doors, windows, loading platforms, lavatory facilities, stairwells, fencing (including cyclone fencing), passenger and freight elevators, overhead cranes and garage units, and (c) all Columbus Intangible Property; provided, however, notwithstanding the foregoing, Columbus Property Other Assets expressly excludes each and all of the following items (collectively, the "Columbus Property Excluded Items"):

1. all personal property located at the Columbus Real Property or the Columbus Improvements including, without limitation, all computers and other information technology devices, but excluding all items described in clause (b) of the definition of Columbus Property Other Assets; and
2. those other items (regardless of whether such items constitute Fixtures) described on Exhibit B-1 hereof.

Exhibit B-1

Qty	Mfg	Description	Model#	Location
1	Aircycle	Bulb eater	55VRSU	Shop
1	Westward	Toolbox		Shop
1	CLC	Toolbag		Shop
2	Maha	Battery Charger		Shop
1	Dayton	Leaf Blower		Fire pump room
1	Briggs	Generator 5500 watts		Fire pump room
1	Ariens	Snow blower		Fire pump room
1	Snow Ex	Salt speader		Switch Gear cage
1	Rubbermaid	Light bulb cart		Storage
1	Ridgid	Drain snake		Shop
1	Dewalt	Air compressor		Shop
1	Dewalt	18V Drill		Shop
1	Dewalt	18V Impact Drill		Shop
1	Dewalt	18V Circular saw		Shop
1	Dewalt	18V Reciprocating saw		Shop
1	Dewalt	Bench grinder		Shop
1	Dewalt	Masonry bit set		Shop
1	Dewalt	Drill bit set		Shop
1	Westward	Bench grinder		Shop
1	Stanley	25ft Tape measure		Shop
1	Irwin	Paddle bit set		Shop
1	Fluke	Multimeter		Shop
1	Fluke	Infared thermometer		Shop
1	Ideal	Amp clamp		Shop
1	Streamlight	Flashlight		Shop
1	Klien	10 in 1 screw driver		Shop
4	Vise Grip	Pliers		Shop
3	Westward	Adjustable wrenches		Shop
1	Westward	Wrench set		Shop
1	Westward	Socket set		Shop
1	Stanley	Utility knife		Shop
1	Stanley	Tripod light		Shop
3	Westward	Pliers		Shop
1	Elkind	Allen wrench set		Shop
1	Megapro	15 in 1 screw driver		Shop
1	Brother	Printer	MCF845CW	Shop
1	Dell	Computer		Shop
1	Rigid	Hand snake		Shop
1	Zicron	Stud Finder		Shop

1		Scafold 4ft	Shop
1		5 gallon gas can	Fire pump room
1		2 gallon gas can	Fire pump room
1	Ridgid	Power washer 3300psi	Fire pump room
1	Shop Vac	Sweeper	Switch Gear cage

EXHIBIT E-2

Form of Long Beach Property Bill of Sale

BILL OF SALE AND ASSIGNMENT

MOLINA CENTER, LLC,

a Delaware limited liability company,

to

AGNL CLINIC, L.P.,

a Delaware limited partnership

KNOW ALL MEN BY THESE PRESENTS, that Molina Center, LLC, a Delaware limited liability company (" Seller"), for and in consideration of Ten Dollars ($10.00) and other good and valuable consideration, to it in hand paid by AGNL Clinic, L.P., a Delaware limited partnership ("Purchaser"), at or before the sealing and delivery of these presents, the receipt and sufficiency of which is hereby acknowledged, has granted, bargained, sold, transferred and delivered, and by these presents does grant, assign, bargain, sell, transfer and deliver unto Purchaser the following (the "Personal Property"):

all machinery and equipment listed and described on Exhibit B attached hereto and made a part hereof owned by Seller and located on property (the "Property") situate in the City of Columbus, Franklin County, Ohio as described on Exhibit A attached hereto and made a part hereof;

all certificates of occupancy of Seller, and all licenses, permits, and approvals, if any, which are mandated or necessary to own and operate the Property.

any warranties or guaranties in the possession of Seller and given by any contractor, manufacturer or materialmen in connection with the construction, maintenance, repair or renovation of the Property;

all plans and drawings with respect to the Property in the possession of Seller.

TO HAVE AND TO HOLD the Personal Property unto Purchaser, its successors and assigns, to and for its own proper use and benefit forever.

This Bill of Sale shall be governed by the laws of the State of California.

This Bill of Sale and the provisions contained herein shall be binding upon and inure to the benefit of Seller and Purchaser and their respective successors, legal representatives and assigns.

This Bill of Sale may be executed in counterparts, each of which shall be deemed an original, but all of which, together, shall constitute one and the same instrument.

[*No further text on this page. Signature page follows*.]

IN WITNESS WHEREOF, Seller and Purchaser have caused this Bill of Sale to be executed on its behalf, this _____ day of June, 2013.

SELLER:
MOLINA CENTER, LLC,
a Delaware limited liability company
By: _____
Name: ____
Title: ____

PURCHASER:
AGNL CLINIC, L.P.,
a Delaware limited partnership
By: AGNL Clinic GP, L.L.C.,
a Delaware limited liability company,
its general partner
By: AGNL Manager II, Inc.,
a Delaware corporation, its manager
By: __
Name: Gordon J. Whiting
Title: President

Exhibit A

LEGAL DESCRIPTION

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 72787-003-036

Exhibit B

Machinery and Equipment

The term "Long Beach Property Other Assets" means (a) all "fixtures", as defined by Section 9-102(a)(41) of the Uniform Commercial Code as adopted by the State of New York, owned by Seller and that are now or hereafter affixed or attached to or installed in the Long Beach Real Property or the Long Beach Improvements (the "Long Beach Fixtures"), (b) all of the following, if an to the extent affixed to the Long Beach Real Property or the Long Beach Improvements and owned by Seller (even if not constituting Fixtures) (collectively, the "Long Beach Property Equipment"): built-in fittings and built-in major appliances, including all electrical, anti-pollution, heating, lighting (including hanging fluorescent lighting), incinerating, power, air cooling, air conditioning, humidification, sprinkling, plumbing, lifting, fire prevention, fire extinguishing and ventilating systems, devices and machinery and all engines, pipes, pumps, tanks (including exchange tanks and fuel storage tanks), motors, conduits, ducts, steam circulation coils, blowers, steam lines, compressors, oil burners, boilers, doors, windows, loading platforms, lavatory facilities, stairwells, fencing (including cyclone fencing), passenger and freight elevators, overhead cranes and garage units, and (c) all Long Beach Intangible Property; provided, however, notwithstanding the foregoing, Long Beach Property Other Assets expressly excludes each and all of the following items (collectively, the "Long Beach Property Excluded Items"):

1. all personal property located at the Long Beach Real Property or the Long Beach Improvements including, without limitation, all computers and other information technology devices, but excluding all items described in clause (b) of the definition of Long Beach Property Other Assets; and
2. those other items (regardless of whether such items constitute Fixtures) described on Exhibit B-1 hereof.

Exhibit B-1

Other Long Beach Property Excluded Items

(attached)

TOOL INVENTORY

Qty	***Mfg***	***Description***	***Model # (If Applicable)***	***Location (If Applicable)***
1	Ridged	24” bolt cutter		
1	Fluke	Multimeter	73 III	
1	Yellow Jacket	Super Evac LCD Vacuum Gauge	69070	
1	Lisle	Ring Compressor wrinkle band	21700	
1	Zim	Piston Ring Expander		
1	DeWALT	Cordless Drill 12v	1PZ14	
1	Makita	Cordless Drill 9.c Volts (ANGLE)	DA391DW	
1		One Way Screw Remover tool	PH-17061	
1	Ritchie	Manifold Charging Set	41212	
1	Ritchie	Valve Stem wrench ¼” 3/16” 5/16” 3/8”	60613	
1	Ritchie	Big mini tubing cutter 1 ⅛” max.	60142	
1	Fluke	Clamp Meter Amps/volts/ohms	322	
1	RIGID	Tubing Cutter	154	
1	ShopVac	Dry/Wet Vacuum		
2	Vaughn	Ball Pein Hammers 12 oz.		
1	Armstrong	½” Drive Adapter ¾” Male	12-952	
1	Armstrong	½” Drive Adapter ⅜” Male	12-951	
1	Allen	½” Drive Quick Release Ratchet	12800	
1	Proto	½” Drive Flex Head Handle Breaker bar 18 5/8”	5468	
1		U-Shaped Claw and Offset chisel Bar 24”	No I.D. Markings	
2	Supco	HVAC/R Current Probe With Microamps	CPH 100	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Motorola	UHF Portable Handheld Radio	HT 750	
1	Harris	TS30 Test Set Portable handset	7530	
1 set	C. S. Osborne	Hole Punch Set (6)		
4		Misc. Hole Punch Tools		
1		Combination TEE		
1	Proto	Snap Ring Pliers	391	
	Proto	Ignition Set Wrenches	3200C	
1 set	Milwaukee	Flat Boring Bit Kit	49-22-0071	
1	Stanley	Side Cutters	84-133	
22		Misc. Files		
1	Lenox	File Brush		
1	Zim	Piston Ring Expander	204	
1		Piston Ring Compression Tool		
1	Imperial Eastman	Tubing Bender	368-FH	
1		Heavy Duty Puller		
1	UT	⅜” Air Ratchet & Sockets		
1	Vise Grip	9” Locking Welding Clamp		

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Proto	Small Puller		
1 set	Allen	15 pc. Metric Long Arm Hex Key Set		
2		Star Wrenches Lug Nut Removal Tool		
2	Flex-Hone	Cylinder Wall Deglazer hones		
1	Proto	¾" Drive Ratchet		
1	Proto	¾" Drive Breaker Bar		
1	Turbo Cat III	Floor Dryer	4390-00	
1		Oxy-Ace Welding Set Lg.		
1		Oxy-Ace Welding Set Sm.		
1		Hex L-Key Set 12 pc.		
1		Metric Hex L-Key Set 9 pc.		
18	Proto	Assorted Open End Wrenches		
1 set	Proto	Ratchet Box End Wrench		
7	Proto	⅜" Swivel Head Socket		
1	Unibit	Step Drill ⅛" to ½"		
1	Proto	Torque Wrench ½ Drive		
1	Utica	⅜" Inch Pound Torque Wrench		
1	Proto	½" Speed Handle		
1	Proto	⅜" Speed Handle		
1 set	Proto	⅜ and ½" Drive Hex		
12	Proto	Metric Open-Box Wrenches		
1 set	Taiwan	Torx Head Drivers		
30		Assorted Allen Wrenches		
11		Assorted Screw Drivers		
9		Nut Drivers		
1	Imperial	Tubing Cutter		
1	Proto	Snap Ring Pliers		
4		Vise Grips Pliers		
7		Assorted Masonry Drill Bits		
1	Proto	Small Gear Puller	4205-B	
1 set	Jawco	Hex Dies		
1 set	Buck Bros.	Wood Chisels (6)		
1	Irwin	Expansive Wood Bit		
1	Greenlee	Knockout Punch Set		
1	Marson	Rivit Gun	HP-2	
1	Desmond	Stone Dresser		
1		Slag Remover Chipping Hammer		
1	Raytek	Noncontact Thermometer	ST2	
1	Amprobe	Test Master		
1	Pasar	Current Tracer		
1	Sensit RFC	Refrigerant Gas Leak Detector	RFC-1	
1	Check-it	Digital Psychrometer Set	622	
1	Environmental Tectonics	Psychometric Chart		
1	General Electric	Foot Candle Meter		
1	Electro-Therm	Digital Thermometer	SH66	
1	Robertshaw	Receiver Controller and Transmitter Calibration Kit	900-012	
1	Starrett	Dial Indicator	25-144	

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Dewalt	Cordless Drill 12v	DW972	
1	Makita	Cordless Drill 12v	6311D	
1	Makita	Cordless Drill 9.6v	6095D	
1	Makita	Cordless Drill 9.6v	6093D	
1	Makita	Cordless Drill 7.2v	DA3000D	
1	Proto	Roll Away Tool Box		
1	Ilco Unican	Key Duplicater Machine	17	
1	RIDGID	Vise		
1	Vaco	T-Handle Hex Keys (set)	90153	
1	K-D	T-Handle Hex Keys (set)		
1 set	Proto	Ratchet, Extensions, Sockets $^{3}/_{8}$"		
1 set	Proto	Ratchet, Extensions, Sockets $^{1}/_{2}$"		
1 set	Proto	Ratchet, Extensions, Sockets $^{3}/_{4}$"		
1 set		Pipe Thread Taps (6)		
14	Proto	Assorted Punches and Chisels		
7	Proto	Socket End-Open End Wrench		
1		50w 12v Drop Light		
1	Magnehelic	2" of Water Capacity		
1	Magnehelic	1" of Water Capacity		
1	Weller	Soldering Gun	TC-202	
2	Powr-Grip	Vacuum-Attaching Hand Tool	LJ6VH	
1 set	Armstrong	QuickRelease Ratchet Set		
2	Sellstrom	Gas Welding Goggles		
1	RIDGID	Lever Bender	408	
1	Magnehelic	3" of Water Capacity		
3	Bacharach	Tempscribe		
1	Dickson	Tempscribe		
1	Schlage	Boring Jig	40-012	
1	Amprobe	AMP, Volt, OHM Meter	ACD-11	
1	Simpson	Volt, OHM Meter	260	
1	Solomat	IAQ Monitoring System		
1	Starrett	Dial Caliper	120A-6	
1	Simpson	Therm-O-Meter	389	
1	Leviton	Splice Pro Tool	49550	
1	Yellow Jacket	Schrader Valve Removal Tool		
1	TIF	Automatic Halogen Leak Detector	6000	
1		Digital Light Meter	DLM2	
1	TIF	Capacitor Tester	660	
1	UE1	Digital Multimeter	DM383	
1	Amprobe	Fastemp		
2	Lenox	Hole Saw Kits		P1 Shop
1	Dayton	8 Piece Silver and Deming Drill Set	1 AO5O	
1	Milwaukee	Heavy Duty Electric Impact Wrench		
1	Kett	Power Shear	K-100	
1		Nut Driver Power Drill		
1	Lenox	Hacksaw	4012	
1	Christie	Portable Car-Start	CS-2	

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Wilmar	2¼ ton Floor Jack	W-1634	
1	Kodiak	Shovel	72830	
1	Dayton	Ratchet Puller	2Z449-B	
1	Ramset	Powder Actuated Tool	4170	
1	Hilti	Powder Actuated Tool	DW451	
1	Dewalt	7" Angle Grinder	DW474	
1	Milwaukee	7 ¼" Circular Saw	6365	
1	Milwaukee	Rotary Hammer		
1	Milwaukee	⅜" Drill		
1	Black & Decker	⅜" Drill		
1	Black & Decker	Rotary Hammer		
1	Master	Heat Gun	HG-751B	
1	WEN	Electric Pencil Engraver	21	
1	Vibro-Graver	Electric Engraver	74	
1	Black & Decker	Butane Gas Soldering Gun		
1	Master	Butane Gas Soldering Gun	UT-100si	
1	Arrow Fastener	Staple Gun	T-50m	
1	Dwyer	Visi-Float Flowmeter	VFB-55-BV	
1	Allpax	Gasket Cutter		
2	Proto	Crescent Wrench 16"		One in Each Mech. Rm.
1	Proto	Crescent Wrench 12"		One in Each Mech. Rm.
1	Mayes	Level 24"		One in Each Mech. Rm.
2	Pony	'C' Clamps	245	One in Each Mech. Rm.
2	Pony	'C' Clamps	246	One in Each Mech. Rm.
1	Uniweld	Manifold Gauge Set	FL33312	One in Each Mech. Rm.
1		Manifold Gauge Set	4 Port	One in Each Mech. Rm.
1		12v Drop Light		
1	Empire	Level 48"		
3		'T' Squares 24"		
1		'T' Squares 48"	Wood	
1	Johnson	48" Straight Edge	TS48M	
1	Ridgid	36" Bolt Cutters		
1	Millers Falls	Sledge Hammer		
1		5' Pry Bar		
1	DeWALT	Heavy Duty 4½" Small Angle Grinder	DW818	
1	Makita	Finishing Sander	B04530	
1	Skil	Soldering Gun	2410	
1	Milwaukee	Jig Saw		
1	Dremel	Dremel Variable Speed Grinder		
2 sets	Ace	Tap & Die Set	614	
1	Desco	Tap & Die Set #4 thru 1"	44348	
1	Milwaukee	⅜" Hammer Drill		

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
1	Milwaukee	Sawzall		
1	Weller	Soldering Gun	8200N	
1	Milwaukee	Heavy Duty ½" Drill		
1	Craftsman	Drill Press 17" 16sp ¾ h.p.		P1 Shop
1	Speedaire	Air Compressor		P1 Shop
1	Graymills	Parts Cleaner/Washer	DM 136	P1 Shop
1	Milwaukee	Bench Grinder 7"		P1 Shop
2	RIDGID	Aluminum Pipe Wrench	836 36"	P1 Shop
1	RIDGID	Aluminum Pipe Wrench	824 24"	P1 Shop
1	RIDGID	Pipe Cutter ⅛"-2"	No. 202	P1 Shop
1	Chicago Specialty	Pipe Cutter 1"-3 ⅛"	No. 3720	P1 Shop
1 set	RIDGID	Thread Cut Set ⅛"-2" Pipe		P1 Shop
1	RIDGID	115v Power Threader	700	P1 Shop
1	RIDGID	Spiral Reamer	No. 2-S	P1 Shop
2	Jorgensen	"C" Clamp 6"	176	P1 Shop
2	Jorgensen	"C" Clamp 4"	174	P1 Shop
1	Proto	"C" Clamp 2"	402	P1 Shop
1	Armstrong	"C" Clamp 8"	78-408	P1 Shop
1	RIDGID	Flare	No. 459 45°	P1 Shop
1	Proto	Flaring Tool	No. 351 45°	P1 Shop
1	RIDGID	Basin Wrench	No. 1017	P1 Shop
1	RIDGID	Hex Wrench	No. 11	P1 Shop
1	RIDGID	Offset Hex Wrench	No. E-110	P1 Shop
1 set	Proto	Open End Box Wrench	⅜" to 1¼"	P1 Shop
2	Proto	Brass Hammer		P1 Shop
1		Plastic Mallet		P1 Shop
2	Proto	Rubber Mallets		P1 Shop
1		Ball Peen Hammer 32 oz.		P1 Shop
1	Stanley	Claw Hammer		P1 Shop
1	Vauguan	Ball Peen Hammer 16 oz.		P1 Shop
3	Wiss	Tin Snips		P1 Shop
1	RIDGID	Spud Wrench	No. 342	P1 Shop
2	Sloan Valve	Universal Wrench		P1 Shop
4	Rachex	Ratchet Action Wrench	10-17mm Box Wrench	P1 Shop
1	Lincoln	Wire Feed Welder SP175 T	Link 2302-1	
1	Pro Star	Welding Helmet Auto Darkening	FIB HPD1-F10	
1	J/B	Deep Vacuum Pump 10FM ½ hp	DV-285N	
1	Makita	Portable Cut-off (Chop Saw)	2414NB	
1	BernzOmatic	High Temperature Torch	TS 4000T	
1	LSI	Cordless Spotlight	RC-1100N	
1	Channel Lock	21" Channel Lock Pliers		
1	Skil	7¼" Circular Saw	5400	
1	Honda	Portable Generator	EM 5000SX	
1	Schumacher	Battery Charger	SE4022	
1	Pinnacle	Refrigerant Recovery Unit		
1	Fluke	Volt-OHM Tester	T+Pro	
1	AEMC	Megohm Tester	1026	

Qty	*Mfg*	*Description*	*Model # (If Applicable)*	*Location (If Applicable)*
3	DeWALT	14.4v Cordless Drill		
1	Armstrong	10 pc. Claw Foot (Open End)		
1	Empire	4’ Level Aluminum		
1	Armstrong	⅜” Socket Set MM 13pcs.		
1	Armstrong	⅜” Socket Set MM (Long) 12 pcs.		
1	Proto	¼” Socket Set		
1	Proto	⅜” Socket Set		
4	Wood’s	Powr-Grip 8”	N4950	
1	Milwaukee	Portable Band Saw		
1	Milwaukee	Roto Hammer	5318-21	
1	CPS	Thermo-Psychrometer	TM360	
1	RIDGID	Hand Held Drain Cleaning Machine	K45	
1	Milwaukee	18v Sawzall & Charger		
2	Dayton	Pump Out Wet Vac	6AKY1	
1	Fluke	Clamp On Meter Amp Probe	324	
1	Milwaukee	120v Sawzall		
1	Ridgid	Pipe Breaker	276	
1	Dayton	8” Bench Grinder ¾hp	2LKR9	
1	Weller	120v Solding Gun	SP23L	
1	Master	Gas Solding Gun Ultratorch	UT-40Si	
1	Milwaukee	Electric ½” Drill 5320010330067		
1	Genie	1 Person Lift		
1	Genie	Material Lift		
1	Eureka	Hepa Vacuum Cleaner		
1		Fence Post Installer		
1		Cherry Picker		
1	Husky	5 Piece Reversible Ratching Wrenches	SKU630699	
1	Greenlee	Circuit Seeker	CS8000	
1	Arrow Crane Hoist	Iron 1 ton Capacity Hoist	B-9620	
1	SPANCO Inc	Aluminum 1 ton Capacity Hoist	1ALU1212B	
1	Coffing	1 ton Chainfall		
1	CM	Electric 1 ton Hoist	WL 480v	
1	Tom Cat	Walk Behind Floor Scrubber		

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
1999	Desk Top Multiplex - Security	Pelco Multiplexer MX4016 CS	Console	Plaza Level	6644 9F	Sentry Control Systems
2009	Security Camera System Monitor	Samsung SMT-1922 19 **1-yr Wty: 4/1/09 to 4/1/2010**	Console	Lobby Level	Serial # Y3OC3VUQ900002	CDW Computer Centers, Inc.
2009	Security Camera System Monitor	Planar PL1520M 15 SPK Part Number 997-3266-00 **1-yr Wty: 3/27/09 to 3/27/2011**	Console	Lobby Level	Serial # P96886JA25192	CDW Computer Centers, Inc.
2009	Security IdentiPass System CPU	Dell Optiplex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/2012**	Console	Lobby Level	Service Tag # H8MDGJ1	Dell.com
2013	Desk Top Keyboard - Security Console	Pelco KBD300A Keyboard Vari-speed Pan, Tilt & Zoom Joystick; Model #KBD300A. Installed 1/8/2013	Console	Lobby Level	SN ACW-VP J8	Vision Communications
2013	Security DVR	Pelco Hybrid Video Recorder 16 channel (DVR); Model DX4816-2000; Installed 1/8/2013	Console	Lobby Level	SN ACV-2002	Vision Communications
2000	Desk Top Printer - Engineer	HP DeskJet 842C	Engineer	P-1 Level	CN01M1P0W8	KDC
2005	Desk Top Monitor - Engineer	1704FPTt-HVAC Monitor	Engineer	P-1 Level	CNOY42997161856AANJH	Dell Computer Corporation
2010	Desk Top Printer - Chief Engr's Office	HP LaserJet P2035n Purchased: May 13, 2010 **1-yr Wty: 5/13/2010 to 5/12/2011**	Engineer	P-1 Level	Serial # CNB9D27365; Mfg#: H-P-CE462A#ABA	CDW Computer Centers, Inc.
2010	Desk Top Computer - Chief Engr	Dell Opti Plex 380 MiniTower Base **3-yr Wty: 5/6/2010 to 5/5/2013**	Engineer	P-1 Level	Service Tag $ 21QTRL1; Express Code: 4459089637; Mfg Date: 5/5/2010	Dell.com
2010	Desk Top Monitor - Chief Engr	Dell 22 inch Flat Panel Display; E2210H; 3-yr Wty: 5/3/2010 to 5/2/2013	Engineer	P-1 Level	DP/N OH265R; S/N: CN-OH265R-64180-047-1USL	Dell.com

Exhibit E-2

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2010	Desk Top Computer - Engineer - Chief Engineer's Andover HVAC System	Dell OptiPlex380 – Intel Core 2 Duo 2.93 Ghz, 4 GB, 160 GB 7200 RPM SATA HD, 16X DVD-ROM; Service Tag: BCG1PN1; Express Service Code: 24697153549	Engineer	P-1 Level	Windows 7 Pro/OA; Product key: TMXCJ-2VBY4-WV43H-R4TH4-HRDTVX16-96076; 00186-77-094-237; OKXGVD	CGB Enterprises
2012	Printer - Engineers' Lunch Room	HP DeskJet 5650	Engineer	P-2 Level	SN MY7CL1R1JP	Dell
2012	Desk Top Monitor - Engineers' Lunch Rm	Model # E1911C; 22 inch Monitor	Engineer	P-2 Level	SN CN-ONO1VP-64180-219-1C9B	Dell
2012	Desk Top Computer - Engineers' Lunch Rm	Model # Core i5; Windows 7; Product Key# 328HW-M472H-GDMW7-4JK32-2H8M9	Engineer	P-2 Level	Service Tag # 1KMMJS1; Express Service Code: 3424109473	Dell
2013	Desk Top Computer - New HVAC System	Dell OptiPlex 990; Intel Core i5; Windows 7; Product Key: 7Q2F2-7WTHG-W8TWR-YH4XP-TKC2W	Engineer	P-1 Level	Service Tag # CVVPYV1; Express Service Code: 28049119165	Emcor
2013	Desk Top Monitor - New HVAC System	LG 32 inch Monitor LS-34; 32LS3410	Engineer	P-1 Level	SN 209MXLS7Q352	Emcor
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Craig Aydelott	SN 12816A0500; Radio ID# 2001	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Esteban Diaz	SN 12816A0496; Radio ID# 2002	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Alfonso Oregel	SN 12816A0497; Radio ID# 2003	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Richard Marshall	SN 12816A0499; Radio ID# 2004	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Jeremiah Lees	SN 12918A0200; Radio ID# 2020	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Claudia Motte-Alvarez, J1	SN 12816A0495; Radio ID# 2007	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Nancy Hernandez, J2	SN 12816A0494; Radio ID# 2008	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Alex Passarelli, J3	SN 12816A0493; Radio ID# 2009	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Hector Nunez	SN 12918A0199; Radio ID# 2019	Vision Communications

Exhibit E-2

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2013	Lobby Level Directory Monitor	Panasonic 42 inch	Lobby	Lobby Level	SN MB21580709; 200 Twr	Jet Communications
2013	Lobby Level Directory Monitor	Panasonic 42 inch	Lobby	Lobby Level	SN MD22360382; 300 Twr	Jet Communications
2003	Desk Top Printer - Guest Room	HP Photosmart 7550 (Color)	OOB	Guest Desk	CN2BS4214N	World Trade Office Supplies
2005	Desk Top Monitor - Guest Room	1704FPTt	OOB	Guest Desk	CNOY42997161856AANM5	Dell Computer Corporation
2005	Desk Top Monitor - Server Room	E153FP	OOB	Server Room	CNOC53696418053UOL5H	Dell Computer Corporation
2005	Desk Top Computer - Guest Room	DHS Mfg Date: 07 20 05	OOB	Guest Desk	6XWKY71	Dell Computer Corporation
2007	Desk Top Printer - Guest Room	HP Photosmart D7260 (Color)	OOB	Guest Desk	MY789U2 NH	HP.com
2009	Desk Top Monitor - Asst. Bldg Mgr	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Mary's Desk	CN-0F532H-74445-93Q-AM6S	Dell.com
2009	Desk Top Monitor - Asst. Bldg Mgr	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Mary's Desk	CN-0F532H-74445-93Q-ANDS	Dell.com
2009	Desk Top Monitor - Property Asst	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Pearl's Desk	CN-0F532H-74445-93Q-AN9S	Dell.com
2009	Security IdentiPass System CPU	DellOptiPlex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/2012**	OOB	Access Card Desk-OOB	Service Tag # BJFDGJ1	Dell.com
2009	Desk Top Scanner - Print Area	HP ScanJet 7650n; Model: (1P): L1943A; Option: (30P): B1H **1-yr Wty: 5/18/09 to5/17/2010**	OOB	Print Area	CN87KT1129	CDW Computer Centers, Inc.
2009	Conference Room TV Monitor	Sharp LC-42SB45UT: **1-yr Wty: 9/4/09 to 9/8/10**	OOB	Confce Rm	905817411	Kelty Co.

Exhibit E-2

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2009	Lobby Level CPU for Directory	Dell Optiplex 740 **3-yr Wty: 9/30/09 to 9/30/2012.**	OOB	Lobby Level	200 Tower: Service Tag # FZ67ZK1; Express Code: 34778501569	Dell.com
2009	Lobby Level CPU for Directory	Dell Optiplex 740 **3-yr Wty: 9/30/09 to 9/30/2012**	OOB	Lobby Level	300 Tower: Service Tag # DZ67ZK1; Express Code: 30424936897	Dell.com
2010	Desk Top Printer - GM's Office	HP LaserJet P3015dn Purchased: May 13, 2010 **1-yr Wty: 5/13/2010 to 5/12/2011**	OOB	Ivette's Desk	Serial # VNBCB406WP; Mfg#: H-P-CE528A#ABA	CDW Computer Centers, Inc.
2010	Desk Top Computer - Property Asst	Dell Opti Plex 380 Minitower Base **3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010.**	OOB	Pearl's Desk	B574KM1	Dell.com
2010	Desk Top Computer - Asst. Bldg Mgr	Dell Opti Plex 380 Minitower Base 3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010.	OOB	Mary's Desk	B582KM1	Dell.com
2010	Desk Top Computer - Server Room	PowerEdge Dell T310 System	OOB	Server Room	Service Tag: 2VL9JS1; Express Service Code: 6263733601	Carapace, Inc.
2012	LapTop Computer - G Mgr	Dell Laptop 13 inch.	OOB	Ivette's Desk	Service Tag (S/N): CKMYFS1; Express Service Code: 27369269857	Dell purchased by Lori McKinney
2012	HP OfficeJet Pro 8600	Model#: SNPRC-1101-01; Product #: CM749A **1-yr Wty: 1/19/2012 to 1/19/2013**	OOB	Print Area	Serial # CN1C31T1C6	Lori McKinney
2012	Desk Top Monitor - GMgr	Dell 22 inch Flat Panel Display	OOB	Ivette's Desk	S/N# CN-0174R7-72872-24B-A2VU	Dell from Lori McKinney
2012	Desk Top Monitor - GMgr	Dell 22 inch Flat Panel Display	OOB	Ivette's Desk	S/N# CN-0174R7-72872-24B-A69U	Dell from Lori McKinney
2012	Copy Machine - Server Room	Ricoh Aficio MPC2551	OOB	Server Room	Equipment ID: V9825200222	Leased from Ricoh Business Solutions

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2013	OOB WIFI Unit	Ruckus ZoneFlex 7300 Series (7363)	OOB	Telco Rm	SN 543D37054B00	Allcovered
2013	Security Radio Repeater	Hytera Professional Digital Radio Repeater; Model RD982; Installed 1/8/2013	OOB	A5 LRR ElecRm	SN12529A0096; 3 antennas located in A11, A5 and P2 by Stair #1.	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	OOB	Pearl Tan	SN 12816A0492; Radio ID# 2010	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	OOB	Mary Ramsey	SN 12723D0125; Radio ID# 2011	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	OOB	Ivette Walker	SN 12723D0127; Radio ID# 2015	Vision Communications
2013	Portable Radio	Motorola SL7550	Owner's Rep	Salvador Gutierrez	SN 682TNB2423; Radio ID# 2016	Vision Communications
2008	Desk Top Monitor - Parking	Parking Access Monitor	Parking	P-1 Parking	S/N #CN-ORY979-74261-848-6D5U	Dell
2009	Desk Top Monitor - Parking	Dell 19" Widescreen LCD SE 198 WFP **1-yr Wty: 1/1/09 to 1/1/2010**	Parking	P-1 Parking	CN-OC558H-72872-89Q-OMAM	Best Buy
2009	Security IdentiPass System CPU	Dell Optiplex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/12.**	Parking	P-1 Parking	Service Tag # F8MDGJ1	Dell.com
2010	Desk Top Computer - Parking Mgr	Dell Opti Plex 380 Minitower Base **3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010**	Parking	P-1 Parking	B583KM1	Dell.com
2011	Desk Top Printer - Parking Mgr	HP LaserJet 2420d	Parking	P-1 Parking	S/N: CNDJF05457	
2012	Brother AIO Printer - Parking Mgr	Brother Model # MFC-7460 DN; **1-yr Wty: 4/5/2012 to 4/5/2013**	Parking	P-1 Parking	Serial #: U62701K1N199757	World Trade Office Supplies
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P1	SN 12723D0126; Radio ID# 2012	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P2	SN 12723D0120; Radio ID# 2013	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P3	SN 12816A0257; Radio ID# 2014	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P4	SN 12817A0326; Radio ID# 2018	Vision Communications

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2007	Desk Top Printer - Security	HP LaserJet 1018; Placed in service on May 19, 2012 by Chip at Allcovered	Security	Kevin's Desk-OOB	CNB1004493	HP.com
2009	Desk Top Monitor - Access Card	Dell Prof 1909, Wide Flat Panel DP/N OW160G: **3-yr Ltd Wty: 9/9/2009 to 9/9/2012**	Security	Access Card Desk-OOB	CN-OW160G-72872-97Q-387S	Dell.com
2010	Desk Top Computer - Dir of Security	Dell Opti Plex 380 MiniTower Base **3-yr Wty: 5/6/2010 to 5/5/2013.**	Security	Kevin's Desk-OOB	Service Tag # 21QYRL1; Express Code: 4459322917; Mfg Date: 5/5/2010	Dell.com
2010	Desk Top Monitor - Dir of Security	Dell 22 inch Flat Panel Display; E2210H; **3-yr Wty: 5/3/2010 to 5/2/2013.**	Security	Kevin's Desk-OOB	DP/N OH265R; S/N: CN-OH265R-64180-047-1TGL	Dell.com
2010	Security Camera at Load Dock on P-1 Level (Camera #2)	Pelco ES3012 20X PTZ Camera at Load Dock; Ship Date: April 6, 2010. **1-yr Wty: 4/6/2010 to 4/5/2011**	Security	P-1 Level	Serial Number: ABA-AP99	Universal Protection Systems
2010	Security Camera at West Monument. Camera #3 at the Plaza Level	Pelco ES3012 - 2 CLZ20PN; Ship Date: May 21, 2010. **1-yr Wty: 5/21/2010 to May 20, 2011.**	Security	Plaza Level	Serial Number: ABC-CYQ8	Vision Communications
2011	Camera 4 on top of East Monument Sign	Pelco Esprit ES3012 Series - Camera (Integrated Positioning System); Installed 3/24/2011.	Security	Plaza Level	SN ABVHVW2; Pelco Esprit ES3012-2CLZ20PN	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Security	Console	SN 12816A0498; Radio ID# 2005	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Security	Patrol	SN 12816A0491; Radio ID# 2006	Vision Communications
2013	Portable Radio	Motorola SL7550	Security	Kevin Stapleton	SN 682TND2817; Radio ID# 2017	Vision Communications

Exhibit E-2

EXHIBIT F

Form of FIRPTA Affidavit

FIRPTA CERTIFICATE

CERTIFICATE OF NON-FOREIGN STATUS

Section 1445 of the Internal Revenue Code provides that a transferee of a U.S. real property interest must withhold tax if the transferor is a foreign person. For U.S. tax purposes (including Section 1445 of the Internal Revenue Code), the owner of a disregarded entity (which has legal title to a U.S. real property interest under local law) will be the seller of the property and not the disregarded entity. To inform AGNL CLINIC, L.P., a Delaware limited partnership ("Buyer"), that withholding of tax is not required upon the disposition of a U.S. real property interest by _____, a _____ (" Seller"), the undersigned hereby certifies the following on behalf of Seller:

1. Seller is not a foreign corporation, foreign partnership, foreign trust, or foreign estate (as those terms are defined in the Internal Revenue Code and Income Tax Regulations).

2. Seller is not a disregarded entity as defined in Section 1.1445-2(b)(2)(iii) of the Income Tax Regulations.

3. Seller's U.S. employer identification number is _____.

4. Seller's office address is:

Seller understands that this certification may be disclosed to the Internal Revenue Service by Buyer and that any false statement contained herein could be punished by fine, imprisonment, or both.

Under penalties of perjury, the undersigned declares that he/she has examined this certification and to the best of his knowledge and belief it is true, correct and complete, and he/she further declares that he/she has the authority to sign this document on behalf of Seller.

Executed as of the ___ day of ____, 20__.

SELLER

,

a _____
By: ____
Name: ____
Title: ____

STATE OF _____)
) SS.
COUNTY _____)

I, the undersigned, a Notary Public in and for the County and State aforesaid, DO HEREBY CERTIFY, that the above named _____, personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that he/she signed and delivered the foregoing instrument bearing date on the ____ day of June, 2013, as his/her own free and voluntary act and as the free and voluntary act of the _____ of _____. for the uses and purposes therein set forth.

Given under my hand and Notary Seal, this __ day of June, 2013.

Notary Public

My Commission expires: _____

Exhibit F

EXHIBIT G-1

Form of Long Beach Owner's Affidavit

OWNER'S DECLARATION
(200-300 Oceangate, Long Beach, CA)

The undersigned hereby declares as follows:

Article I. Declarant is the _____ of Molina Center, LLC ("Owner"), which is the owner or lessee, as the case may be, of certain premises located at 200-300 Oceangate, Long Beach, California, further described as follows: See Commitment No. 997-23021588-A-TC1 for full legal description (the "Land").

Article II. To the knowledge of Declarant, during the period of six months immediately preceding the date of this declaration no work has been done, no surveys or architectural or engineering plans have been prepared, and no materials have been furnished in connection with the erection, equipment, repair, protection or removal of any building or other structure on the Land or in connection with the improvement of the Land in any manner whatsoever other than work done by tenants and licensees with regard to their leased or licensed space.

Article III. To the knowledge of Declarant, Owner has not previously conveyed the Land; is not a debtor in bankruptcy (and if a partnership, the general partner thereof is not a debtor in bankruptcy); and has not received notice of any pending court action affecting the title to the Land.

Article IV. To the knowledge of Declarant, except as shown in the above-referenced Commitment, there are no unpaid or unsatisfied mortgages, deeds of trust, Uniform Commercial Code financing statements, claims of lien, special assessments, or taxes that constitute a lien against the Land or that affect the Land but have not been recorded in the public records.

Article V. The Land is currently in use as an office building; Owner occupy/occupies the Land; and the following are all of the leases or other occupancy rights affecting the land: See Exhibit A.

Article VI. To the knowledge of Declarant, there are no other persons or entities that are currently asserting an ownership interest in the Land, nor are there unrecorded easements, claims of easement, or boundary disputes that currently affect the Land.

Article VII. To the knowledge of Declarant, there are no outstanding options to purchase or rights of first refusal affecting the Land other than the right of first offer in favor of Molina Healthcare, Inc., which right is being waived in connection with this transaction.

This declaration is made with the intention that Fidelity National Title Insurance Company (the "Company") and its policy issuing agents will rely upon it in issuing their title insurance policies and endorsements. Owner, by the undersigned Declarant, agrees to indemnify the Company against loss or damage (including reasonable attorneys' fees, expenses, and costs) incurred by the Company as a result of any untrue statement made herein.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on June __, 2013 at _____.

OWNER:

MOLINA CENTER, LLC,
a Delaware limited liability company
By: DECLARANT:

Print Name: __
Title: __

Exhibit G-1

EXHIBIT A

List of Leases, Access Agreements and Licenses

LEASE AGREEMENTS, ACESS AGREEMENTS AND LICENSE AGREEMENTS ASSOCIATED WITH 200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA, WITH MOLINA AS LANDLORD:

- 3-Dee International
- Arthritis National Research Foundation
- Lisa Brandon, CFLS
- California Coastal Commission
- Crowell, Weedon & Co.
- Department of Industrial Relations
- High Rise Goodies Restaurant Group, Inc.
- J. Perez Associates, Inc.
- Long Beach Publishing Company, Inc. (aka Press Telegram)
- Lynn E. Moyer
- D. Michael Trainotti
- Michael W. Binning
- Molina Healthcare, Inc.
- MVP Energy, LLC
- Pacific Maritime Association
- Pacific Merchant Shipping
- Bruce A. Dybens, AP
- California State Lands Commission
- US Department of Veterans Affairs
- Perona, Langer, Beck Serbin & Mendoza
- Rose, Klein & Marias, LLP
- United Parcel Services, Inc.
- APB Car Wash & Detailing Specialist - License
- Steel Coil
- Mikko Myong Pvonka, an individual
- TCG Los Angeles, Inc. (aka AT&T) – ACCESS AND LICENSE
- XO Communications Services, LLC – LICENSE
- Molina Healthcare of California (undocumented license agreement)

EXHIBIT G-2

Form of Columbus Owner's Affidavit

AFFIDAVIT AS TO TITLE

TO REAL ESTATE

STATE OF _____)
) SS.
COUNTY OF _____)

_____ ("Affiant"), being first duly sworn, deposes, states and agrees as follows:

Article I. Affiant is the _____ of Molina Healthcare, Inc. (the "Corporation") and is authorized to execute this Affidavit for and on behalf of said corporation.

Article II. The corporation is in good standing in the State of Delaware.

Article III To the knowledge of Affiant, the corporation has marketable title in fee simple to that referenced Property more fully described in Commitment for Title Insurance No. 4257983 dated February 15, 2013, and its possession thereof has been peaceable and undisturbed and the title to said Property has never been disputed or questioned to Affiant's knowledge, nor does Affiant know of any facts by reason of which the title to, or possession of, said Property might be disputed or questioned (the "Property").

Article IV That the corporation is not insolvent or bankrupt and there has been (i) no assignment made for the benefit of its creditors; (ii) no appointment of a receiver for its assets or properties; (iii) no bankruptcy, reorganization or liquidation proceeding instituted by or against it; and (iv) no dissolution proceedings therefor.

Article V That the corporation is not a "foreign person" as defined in the Foreign Investment Property Tax Act, Internal Revenue Code Section 1445; that the address for tax purposes is: _____, and the Federal Taxpayer Identification Number is _____.

Article VI That Affiant is at least eighteen (18) years of age and is not under any legal disability.

Article VII That, to the knowledge of Affiant, there are no unrecorded deeds, mortgages, leases, easements, contracts of sale and/or equities and/or agreements of any kind not fully disclosed of record or unrecorded given by or known to Affiant affecting the title to or use of the Property and that there are no leases, licensees or parties in possession or entitled to possession other than the Corporation and the parties listed on Exhibit A attached hereto.

Article VIII That, to the best of Affiant's knowledge, there are no violations of any covenants, conditions or restrictions of record affecting the Property and that there are no disputes with any adjoining property owners as to either the location of Property lines or the encroachments of any improvements.

Article IXThat, to the knowledge of Affiant, all utility charges (e.g. gas, electric, water bills) against the property have been or will be paid by Affiant.

Article XThat, to the knowledge of Affiant, no construction, labor, repairs, alterations or improvements made, ordered or contracted to be made on or to the Property, nor material ordered therefor, within the last ninety (90) days which has not been paid for in full; nor are there any fixtures attached to the Property which have not been paid for in full, for which the right to file a mechanic's or materialmen's lien might exist, nor has any unsatisfied claim for lien or claim for payment been made for labor or material furnished to the Property, except: as may exist in connection with work performed by tenants or licensees in their applicable space.

Article XIThat, to the knowledge of Affiant, there are no outstanding assessments against the Property nor has any notice been received as to pending assessments, except: _____.

Article XIIThat the foregoing statements are made for the benefit of and to induce Fidelity National Title Insurance Company to issue its owner's/loan policies of title insurance.

In the event that any of the representations made herein prove to be incorrect, for any reason, and a claim is made by third party with respect to these matters, the Corporation agrees to indemnify and hold harmless said Title Insurance Company from all claims and damages, including litigation costs and reasonable attorney fees arising as the result of such claim. All representations herein are made to the best of the knowledge of the parties signing hereto.

Further Affiant Sayeth Naught.

MOLINA HEALTHCARE, INC.,
a Delaware corporation
By: AFFIANT

Print Name: __
Title: __

The foregoing was sworn to and subscribed in my presence on _____.

Notary Public
My term expires: __

Exhibit G-2

EXHIBIT "A"

LEASE AGREEMENTS, ACCESS AGREEMENTS AND LICENSE AGREEMENTS ASSOCIATED WITH 3000 CORPORATE EXCHANGE DRIVE, COLUMBUS, OHIO, WITH MOLINA AS LANDLORD:

- Bresco Solutions, LLC - LICENSE
- iQor, Inc.
- Prime Engineering & Architecture, Inc.
- U.S. Congressman Patrick Tiberi
- XO Communications Services, Inc. – ACCESS AGREEMENT

EXHIBIT H

Form of Tenant Waiver Letter

[TENANT NAME]
[Tenant address]

_____, 20___

AGNL _____, L.L.C.
c/o Angelo, Gordon & Co., L.P.
245 Park Avenue
26th Floor
New York, NY 10167-0094
Attn: Gordon J. Whiting

Re: Lease Agreement, dated as of _____ __, 20___, between AGNL _____, L.L.C., a Delaware limited liability company ("Landlord"), and _____., a _____ ("Tenant") (the "Lease")

Ladies and Gentlemen:

Reference is made to that certain $_____ loan (the "Loan") made by _____ ("Lender") to _____ ("Landlord"), which Loan is secured by, inter alia, a certain [Mortgage] of even date herewith (the "Mortgage") encumbering certain property located at _____ (the "Property"), which Property is leased to _____ ("Tenant") pursuant to the above-referenced Lease.

In consideration of **[the execution and delivery of the Lease by Landlord] [the sum of ten dollars ($10.00)] [latter to be used in lease assumption or loan closed later situations]** and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Tenant hereby covenants and agrees with Landlord that, in the event Tenant or any Affiliate (as hereinafter defined) of Tenant purchases the interest of Lender in the Loan, Tenant or such Affiliate will not exercise any of the remedies provided to Lender under the Mortgage or any of the other documents evidencing or securing the Loan if and so long as an Event of Default (as defined in the Lease) exists and is continuing under the Lease.

[If Tenant is a corporation] [For the purposes hereof, the term "Affiliate" shall mean, with respect to a corporation, (i) any officer or director thereof and any person, trust, corporation, partnership, venture or other entity who or which is, directly or indirectly, the beneficial owner of more than 50% of any class of shares or other equity security of such corporation, or (ii) any person, trust, corporation, partnership, venture or other entity which, directly or indirectly controls or is controlled by or under common control with such corporation, or (iii) any general partner, general partner of a general partner, partnership with a common general partner, or co-venturer of or with any person or entity described in (i) or (ii) above, or (iv) if any general partner or co-venturer is a corporation, any person, trust, corporation, partnership, venture or other entity which is an Affiliate as defined above of such corporation, or (v) if any of the foregoing is a natural person, his or her parents, spouse, children, siblings and their children, and spouse's parents, children, siblings and their children.

"Controls", "controlled by" and "under common control with" each refers to the effective power, directly or indirectly, to direct or cause the direction of the management and policies of the person, trust, corporation, partnership, venture or other entity in question, whether by contract or otherwise.]

[If Tenant is not a corporation] Affiliate" of any Person means any Person which (a) controls, (b) is under the control of, or (c) is under common control with such Person (the term "control" as used herein shall be deemed to mean ownership of more than 50% of the outstanding voting stock of a corporation or other majority equity and control interest if such Person is not a corporation and the power to direct or cause the direction of the management or policies of such Person).

Very truly yours,
[TENANT NAME],
a _____
By: _____
Name: ____
Title: ____

Exhibit H

EXHIBIT I

Form of SLB Lease Agreement

EXHIBIT J

Form of Memorandum of Lease Agreement (Long Beach)

RECORDING REQUESTED BY
AND WHEN RECORDED MAIL TO:

Sheppard Mullin Richter & Hampton,
LLP
1300 I Street, NW
11th Floor East
Washington, DC 20005
Attn: Michele E. Williams, Esq.

THE AREA ABOVE IS RESERVED FOR RECORDER'S USE

APN: 7278-003-035
APN: 7278-003-036

Exempt from Documentary Transfer Tax
(Term of the Lease is Less than 35 Years)

MEMORANDUM OF LEASE

THIS MEMORANDUM OF LEASE is made as of the ____ day of June, 2013, by and between AGNL CLINIC, L.P., a Delaware limited partnership ("Landlord"), having an address at c/o Angelo, Gordon & Co., L.P., 245 Park Avenue, 26th Floor New York, New York 10167-0094, and MOLINA HEALTHCARE, INC., a Delaware corporation ("Tenant"), with an address at 300 Oceangate Blvd., Suite 950, Long Beach, California 90802.

Lease. Landlord has demised and let to Tenant pursuant to the terms and conditions of a Lease Agreement dated as of June ____, 2013 (the "Lease"), the terms and conditions of said Lease are incorporated herein as though set forth in full, certain real property located in the City of Long Beach, County of Los Angeles, State of California described in Exhibit "A" attached hereto (the "Leased Premises").

Initial Term. Under the terms of the Lease, Tenant may have and hold the Leased Premises, together with the tenements, hereditaments, appurtenances and easements thereunto belonging, at the rental and upon the terms and conditions therein stated, for an initial term (the "Initial Term") of three hundred (300) full calendar months commencing as of June ____, 2013.

Renewal Term. Under the terms of the Lease, provided that if, on or prior to the last day of the Initial Term (the "Expiration Date") the Lease shall not have been terminated pursuant to any provision thereof, then on the Expiration Date and on the fifth, tenth, fifteenth, twentieth and twenty-fifth anniversaries of the Expiration Date (each such date, a "Renewal Date"), the term shall be extended for an additional period of five (5) years (each of the extension periods, a "Renewal Term"), provided that Tenant shall have notified Landlord in writing at least eighteen (18) months prior to the Expiration Date that Tenant has elected to so extend the Lease. Any such extension of the term shall be subject to all of the provisions of the Lease (except that Tenant shall not have the right to any additional Renewal Term).

No Responsibility for Liens. NOTICE IS HEREBY GIVEN THAT LANDLORD SHALL NOT BE LIABLE FOR ANY LABOR, SERVICES, EQUIPMENT OR MATERIALS FURNISHED OR TO BE FURNISHED TO TENANT, OR TO ANYONE HOLDING OR OCCUPYING ANY OF THE LEASED PREMISES THROUGH OR UNDER TENANT, AND THAT NO MECHANICS' OR OTHER LIENS FOR ANY SUCH LABOR, SERVICES OR MATERIALS SHALL ATTACH TO OR AFFECT THE INTEREST OF LANDLORD IN AND TO ANY OF THE LEASED PREMISES. LANDLORD MAY AT ANY TIME POST ANY NOTICES ON ANY OF THE LEASED PREMISES REGARDING SUCH NON-LIABILITY OF LANDLORD.

Purpose and Intention. This Memorandum of Lease is executed for the purpose of recordation in the Official Records of the County of Los Angeles, State of California in order to give notice of all of the terms, provisions and conditions of the Lease and is not intended, and shall not be construed, to define, limit or modify the full text of the Lease. The leasehold estate created and conveyed hereby with respect to the Leased Premises is intended to be one and the same estate as was created with respect to the Leased Premises by the Lease and is further intended to be governed in all respects solely by the Lease and all of the provisions thereof. This Memorandum contains only selected provisions of the Lease.

Counterparts. This Memorandum of Lease may be executed in a number of counterparts and by different parties hereto in separate counterparts each of which, when so executed, shall be deemed to be an original and all of which taken together shall constitute but one and the same agreement.

[*Signature pages to follow*]

IN WITNESS WHEREOF, the parties have executed this Memorandum of Lease as of the date and year first written above.

"Landlord"
AGNL CLINIC, L.P.,
a Delaware limited partnership
By: AGNL Clinic GP, L.L.C., a Delaware limited liability company, its General Partner
By: AGNL Manager II, Inc., a Delaware corporation, its Manager
By: __

Name: Gordon J. Whiting

Title: President

[Signature Page 1 to CA Memorandum of Lease]

"Tenant"
MOLINA HEALTHCARE, INC.,
a Delaware corporation
By: __
Name: __
Title: __

[Signature Page 2 to CA Memorandum of Lease]

Exhibit J

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

STATE OF NEW YORK)
)
COUNTY OF NEW YORK)

On _____, before me, _____, a Notary Public, personally appeared Gordon J. Whiting who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of New that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

[Acknowledgement to CA Memorandum of Lease]
Exhibit J

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

STATE OF CALIFORNIA)
)
COUNTY OF _____)

On _____, before me, _____, a Notary Public, personally appeared _____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PURJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

[Acknowledgement to CA Memorandum of Lease]
Exhibit J

Exhibit A

LEGAL DESCRIPTION

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 7278-003-036

Exhibit J

EXHIBIT K

Form of Memorandum of Lease Agreement (Columbus)

RECORDING REQUESTED BY AND WHEN RECORDED MAIL TO: Sheppard Mullin Richter & Hampton, LLP 1300 I Street, NW 11th Floor East Washington, DC 20005 Attn: Michele E. Williams, Esq.	THE AREA ABOVE IS RESERVED FOR RECORDER'S USE

APN: 7278-003-035
APN: 7278-003-036

MEMORANDUM OF LEASE

1. THIS MEMORANDUM OF LEASE is made pursuant to § 5301.251 of the Ohio Revised Code as of the ____ day of June, 2013, by and between AGNL CLINIC, L.P., a Delaware limited partnership ("Landlord"), having an address at c/o Angelo, Gordon & Co., L.P., 245 Park Avenue, 26th Floor New York, New York 10167-0094, and MOLINA HEALTHCARE, INC., a Delaware corporation ("Tenant"), with an address at 300 Oceangate Blvd., Suite 950, Long Beach, California 90802.

2. Lease. Landlord has demised and let to Tenant pursuant to the terms and conditions of a Lease Agreement dated as of June ___, 2013 (the "Lease"), the terms and conditions of said Lease are incorporated herein as though set forth in full, certain real property located in the City of Columbus, Franklin County, Ohio described in Exhibit "A" attached hereto (the "Leased Premises").

3. Title. Landlord claims title to the Leased Premises through a deed filed as instrument _____ of Franklin County Records.

4. Initial Term. Under the terms of the Lease, Tenant may have and hold the Leased Premises, together with the tenements, hereditaments, appurtenances and easements thereunto belonging, at the rental and upon the terms and conditions therein stated, for an initial term (the "Initial Term") of three hundred (300) full calendar months commencing as of June ____, 2013.

5. Renewal Term. Under the terms of the Lease, provided that if, on or prior to the last day of the Initial Term (the "Expiration Date") the Lease shall not have been terminated pursuant to any provision thereof, then on the Expiration Date and on the fifth, tenth, fifteenth, twentieth and twenty-fifth anniversaries of the Expiration Date (each such date, a "Renewal Date"), the term shall be extended for an additional period of five (5) years (each of the extension periods, a "Renewal Term"), provided that Tenant shall have notified Landlord in writing at least eighteen (18) months prior to the Expiration Date that Tenant has elected to so extend the Lease. Any such extension of the term shall be subject to all of the provisions of the Lease (except that Tenant shall not have the right to any additional Renewal Term).

6. No Responsibility for Liens. NOTICE IS HEREBY GIVEN THAT LANDLORD SHALL NOT BE LIABLE FOR ANY LABOR, SERVICES, EQUIPMENT OR MATERIALS FURNISHED OR TO BE FURNISHED TO TENANT, OR TO ANYONE HOLDING OR OCCUPYING ANY OF THE LEASED PREMISES THROUGH OR UNDER TENANT, AND THAT NO MECHANICS' OR OTHER LIENS FOR ANY SUCH LABOR, SERVICES OR MATERIALS SHALL ATTACH TO OR AFFECT THE INTEREST OF LANDLORD IN AND TO ANY OF THE LEASED PREMISES. LANDLORD MAY AT ANY TIME POST ANY NOTICES ON ANY OF THE LEASED PREMISES REGARDING SUCH NON-LIABILITY OF LANDLORD.

7. Purpose and Intention. This Memorandum of Lease is executed for the purpose of recordation in the Official Records of the County of Franklin, State of Ohio in order to give notice of all of the terms, provisions and conditions of the Lease and is not intended, and shall not be construed, to define, limit or modify the full text of the Lease. The leasehold estate created and conveyed hereby with respect to the Leased Premises is intended to be one and the same estate as was created with respect to the Leased Premises by the Lease and is further intended to be governed in all respects solely by the Lease and all of the provisions thereof. This Memorandum contained only selected provisions of the Lease.

8. Counterparts. This Memorandum of Lease may be executed in a number of counterparts and by different parties hereto in separate counterparts each of which, when so executed, shall be deemed to be an original and all of which taken together shall constitute but one and the same agreement.

[*Signature pages to follow*]

IN WITNESS WHEREOF, the parties have executed this Memorandum of Lease as of the date and year first written above.

"Landlord"
AGNL CLINIC, L.P.,
a Delaware limited partnership
By: AGNL Clinic GP, L.L.C., a Delaware limited liability company, its General Partner
By: AGNL Manager II, Inc., a Delaware corporation, its Manager
By: __

Name: Gordon J. Whiting

Title: President

[*Signature Page 1 to OH Memorandum of Lease*]
Exhibit K

"Tenant"
MOLINA HEALTHCARE, INC.,
a Delaware corporation
By: __
Name: __
Title: __

[*Signature Page 2 to OH Memorandum of Lease*]

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

STATE OF NEW YORK)
)
COUNTY OF NEW YORK)

On _____, before me, _____, a Notary Public, personally appeared Gordon J. Whiting who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of New that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

[Acknowledgement to OH Memorandum of Lease]
Exhibit K

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

STATE OF CALIFORNIA)
)
COUNTY OF _____)

On _____, before me, _____, a Notary Public, personally appeared _____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

[Acknowledgement to OH Memorandum of Lease]
Exhibit K

Exhibit A

LEGAL DESCRIPTION

- PARCEL 1:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 13.727 acre tract, and all of the 0.875 acre tract conveyed to 17 Land Realty Corp. by deeds of record in O.R. 14066 B11 and O.R. 25716 J11, respectively, records of the Recorder's Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning at a railroad spike set at the intersection of the Southerly right-of-way line of Interstate 270 (FRA-270-18.32N) and centerline of Cooper Road (60 feet in width). Said railroad spike being the Northeasterly corner of said 0.875 acre tract;

Thence South 26 deg. 55' 00" East, a distance of 241.79 feet, along said centerline of Cooper Road and Easterly line of said 0.875 acre tract, to a railroad spike set at the Southeasterly corner of said 0.875 acre tract;

Thence North 78 deg. 47' 04" West, a distance of 38.14 feet, along the Southerly line of said 0.875 acre tract, to an iron pin set in the Westerly right-of-way line of said Cooper Road;

Thence South 26 deg. 55' 00" East, a distance of 295.14 feet, along said Westerly right-of-way line of Cooper Road and along the Easterly line of said 13.727 acre tract, to an iron pin set at the point of curvature in the Northerly right-of-way line of Corporate Exchange Drive (60 feet in width) of record in Plat Book 60, Page 22 and 23;

Thence the following four (4) courses and distances along said Northerly right-of-way line of Corporate Exchange Drive and Southerly line of said 13.727 acre tract;

1. Thence along arc of said curve to the right having a radius of 35.00 feet, a central angle of 90 deg. 00' 00", and a chord bearing South 18 deg. 05' 00" West, a chord distance of 49.50 feet to the point of tangency;

2. Thence South 63 deg. 05' 00" West, a distance of 35.00 feet, to an iron pin found at the point of curvature;

3. Thence along arc of said curve to the right having a radius of 270.00 feet, a central angle of 28 deg. 56' 27", and a chord bearing South 77 deg. 33' 14" West, a chord distance of 134.94 feet, to an iron pin set at the point of tangency;

4. Thence North 87 deg. 58' 33" West, a distance of 788.06 feet, to an railroad spike set;

Thence North 02 deg. 01' 27" East, a distance of 318.00 feet across said 13.727 acre tract to a railroad spike set in a Southerly line of the 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence South 87 deg. 58' 33" East, a distance of 15.00 feet along said Southerly line of the 5.103 acre tract to a railroad spike set at a Southeasterly corner of said 5.103 acre tract;

Exhibit K

Thence the following three (3) courses and distances along the Easterly lines to said 5.103 acre tract;

1. Thence North 02 deg. 01’ 27” East, a distance of 185.00 feet, to a P.K. nail found;

2. Thence South 87 deg. 58’ 33” East, a distance of 57.50 feet, to a railroad spike set;

3. Thence North 02 deg. 01’ 27” East, a distance of 167.21 feet, to an iron pin set in aforesaid Southerly right-of-way line of Interstate 270 at a Northeasterly corner of said 5.103 acre tract;

Thence South 78 deg. 46’ 49” East, a distance of 677.06 feet, along said Southerly right-of-way line of Interstate 270 and partly along the Northerly line of said 13.727 acre tract and partly along the Northerly line aforesaid 0.875 acre tract, to the point of beginning.

Containing 11.814 acres, more or less, of which 0.167 acres lies within the Cooper Road right-of-way.

The bearings in the above description are based on the bearing of South 87 deg. 58’ 33” East, for the centerline of Corporate Exchange Drive, as shown on the dedication Plat for Corporate Exchange Drive, of record in Deed Book 60, Page 22 and 23, records of the Recorder’s Office, Franklin County, Ohio.

PARCEL 2:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 4.500 and 13.727 acre tracts conveyed to 17 Land Realty Corp. by deed of record in O.R. 14066 B11, Records of the Recorder’s Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning for reference at a PK nail found at the centerline intersection of Presidential Gateway (60 feet in width) as established by the Plat of record in Plat Book 83, Page 80 and Corporate Exchange Drive (60 feet in width) as established by the Plat of record in Plat Book 60, Page 22;

Thence North 87 deg. 58’ 33” West, a distance of 329.18 feet along the centerline of Corporate Exchange Drive to a point;

Thence North 02 deg. 01’ 27” East, a distance of 30.00 feet, to a railroad spike set on the Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 acre tract and being the point of true beginning;

Thence the following three (3) courses and distances along the said Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 and 4.500 acre tracts;

1. Thence North 87 deg. 58’ 33” West, a distance of 94.38 feet to an iron pin set at a point of curvature;

2. Thence along the arc of said curve to the right, having a radius of 420.00 feet, a central angle of 27 deg. 22’ 54”, a chord bearing North 74 deg. 17’ 06” West, and a chord distance of 198.81 feet to an iron pin found at the point of tangency;

3. Thence North 60 deg. 35’ 39” West, a distance of 28.10 feet to an iron pin set at a Southeasterly corner of a 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence the following two (2) courses and distance along the Easterly and Southerly lines of said 5.103 acre tracts;

1. Thence North 02 deg. 01’ 27” East, a distance of 258.02 feet to a railroad spike set;

2. Thence South 87 deg. 58’ 33” East, a distance of 312.50 feet to a railroad spike set;

Thence South 02 deg. 01’ 27” West, a distance of 318.00 feet across said 13.727 acre tract to the point of true beginning, containing 2.183 acres, more or less, subject to all easements, restrictions and rights-of-way of record.

Exhibit K

EXHIBIT L

Existing Leases, Access Agreements and License Agreements

EXISTING, LEASE AGREEMENTS, ACCESS AGREEMENTS AND LICENSE AGREEMENTS ASSOCIATED WITH 200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA, WITH MOLINA AS LANDLORD:

- 3-Dee International
- Arthritis National Research Foundation
- Lisa Brandon, CFLS
- California Coastal Commission
- Crowell, Weedon & Co.
- Department of Industrial Relations
- High Rise Goodies Restaurant Group, Inc.
- J. Perez Associates, Inc.
- Long Beach Publishing Company, Inc. (aka Press Telegram)
- Lynn E. Moyer
- D. Michael Trainotti
- Michael W. Binning
- Molina Healthcare, Inc.
- MVP Energy, LLC
- Pacific Maritime Association
- Pacific Merchant Shipping
- Bruce A. Dybens, AP
- California State Lands Commission
- US Department of Veterans Affairs
- Perona, Langer, Beck Serbin & Mendoza
- Rose, Klein & Marias, LLP
- United Parcel Services, Inc.
- APB Car Wash & Detailing Specialist - License
- Steel Coil
- Mikko Myong Pivonka, an individual
- TCG Los Angeles, Inc. (aka AT&T) – ACCESS AND LICENSE
- XO Communications Services, LLC – LICENSE
- Molina Healthcare of California (undocumented license agreement)

LEASE AGREEMENTS AND LICENSE AGREEMENTS ASSOCIATED WITH 3000 CORPORATE EXCHANGE DRIVE, COLUMBUS, OHIO, WITH MOLINA AS LANDLORD:

- Bresco Solutions, LLC - LICENSE
- iQor, Inc.
- Prime Engineering & Architecture, Inc.
- U.S. Congressman Patrick Tiberi
- XO Communications Services, Inc. – ACCESS AGREEMENT

EXHIBIT M

Form of Subordination, Nondisturbance and Attornment Agreement

RECORDING REQUESTED BY
AND WHEN RECORDED MAIL TO:

Sheppard Mullin Richter & Hampton LLP
1300 I Street NW
Washington, DC 20005
Attention: Michele E. Williams

THIS SPACE ABOVE FOR RECORDER'S USE

SUBORDINATION AGREEMENT, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, AND CONSENT TO SUBLEASE

NOTICE: SUBJECT TO THE NON-DISTURBANCE PROVISIONS CONTAINED HEREIN, THIS SUBORDINATION AGREEMENT RESULTS IN YOUR LEASE BECOMING SUBORDINATE TO, SUBJECT TO AND OF LOWER PRIORITY THAN THE GROUND LEASE (DEFINED BELOW)

THIS SUBORDINATION AGREEMENT, ATTORNMENT AND NON-DISTURBANCE AGREEMENT AND CONSENT TO SUBLEASE (this "Agreement") is made as of _____ ____, 2013 (the "Effective Date"), by and among AGNL Clinic, L.P., a Delaware limited partnership ("AGNL"), Molina Healthcare, Inc., a Delaware corporation ("Molina"), Royal Bank of Scotland PLC and RBS Financial Products, Inc. (collectively, "Lender") and Long Beach Publishing Company, Inc., a Delaware corporation (a/k/a Long Beach Press Telegram) ("Sub-Tenant").

RECITALS:

A. Molina Center LLC, a Delaware limited liability company ("Center"), as landlord, and Sub-Tenant, as tenant (or their respective predecessors in interest), entered into a Standard Form Office Lease made and entered into as of October 21, 2005 (as amended by the First Amendment to Lease dated July 20, 2006 and the Second Amendment to Lease dated March 20, 2008,the "Lease"). Pursuant to the Lease, Sub-Tenant leases from Center that certain portion of the Property (defined below) as more particularly described on Exhibit B attached hereto and incorporated herein by this reference (the "Premises"). A copy of the Lease is attached hereto as Exhibit C and incorporated herein by this reference.

B. On the Effective Date, Center sold and conveyed to AGNL the fee simple interest in that certain real property with an address of 200 and 300 Oceangate Blvd., Long Beach,

California 90802, and described on Exhibit A attached hereto and incorporated herein by this reference (which property, together with all improvements now or hereafter located on the property, is defined as the " Property") and Center assigned the Lease to Molina.

C. On the Effective Date, AGNL, as landlord, and Molina, as tenant, entered into a Lease Agreement dated as of the Effective Date (together with any amendments, modifications, replacements or extensions, the " Ground Lease") pursuant to which AGNL leased to Molina all of the Property and improvements located thereon as more fully described in the Ground Lease and Lender made a loan (the "Loan") to AGNL secured by, among other things, that certain Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing (the "Security Instrument") encumbering AGNL's interest in the Property.

D. As a condition to completing the sale and purchase of the Property and entering into the Ground Lease, AGNL and Lender have required that Molina and Sub-Tenant acknowledge and agree that (notwithstanding the fact that the Lease was entered into prior to the Ground Lease) unconditionally and at all times the Ground Lease shall be prior and superior in title to the Lease and that Molina and Sub-Tenant specifically and unconditionally subordinate their respective interests in the Lease to the priority in title of the Ground Lease, subject to certain "non-disturbance" protections for Sub-Tenant described herein.

E. Subject to certain "non-disturbance" protections for Sub-Tenant described herein, the effect of the foregoing subordination shall be that the Ground Lease shall be deemed a master lease or superior lease and that the Lease shall be deemed a sublease under the Ground Lease.

F. The parties have agreed to the foregoing and to all of the other agreements and understandings set forth in this Agreement.

NOW, THEREFORE, for valuable consideration and to induce AGNL to enter into the transactions described in the recitals, AGNL, Molina, Lender and Sub-Tenant hereby agree as follows:

Subordination; Consent to Sublease. AGNL, Molina, Lender and Sub-Tenant hereby agree that:

Recitals. The foregoing recitals are incorporated herein by reference as if fully set forth in this Agreement.

Prior Title. Subject to Section 4 of this Agreement, the Ground Lease, and any modifications, renewals or extensions thereof, is and shall unconditionally be and at all times remain prior and superior in title to the Lease. Molina shall be the direct landlord under the Lease and shall continue to be liable and obligated to Sub-Tenant for all of landlord's liabilities and obligations thereunder.

Additional Agreements. It is covenanted and agreed that so long as the Ground Lease is in effect:

No Advance Rents. Sub-Tenant will make no payments or prepayments of rent more than one (1) month in advance of the time when the same become due under the Lease except as may be expressly required of Sub-Tenant under the Lease.

Assignment of Rents. Upon receipt by Sub-Tenant of written notice from AGNL that AGNL has elected to terminate the Ground Lease or that an Event of Default (as defined in the Ground Lease) has occurred, Sub-Tenant will pay directly to AGNL all rents due and payable under the Lease. Sub-Tenant shall comply with such direction to pay and shall not be required to determine whether the Ground Lease has been terminated or whether Molina is in default under the Ground Lease, Molina and AGNL hereby agreeing with Sub-Tenant that Sub-Tenant shall be given credit under the Lease for any such payments as though such payments had been made to Molina.

Assignment and Subletting. Sub-Tenant shall not exercise any of its rights to assign, sublet, license, lease, sublease or otherwise transfer any right of use or occupancy for the Premises which requires the prior consent of Molina under the Lease without obtaining the prior written consent of AGNL in accordance with Section 2.6 hereof (the foregoing requirement for AGNL's consent shall exist independent of and regardless of whether Molina has granted its consent to such assignment, subletting, license, lease, sublease or other transfer).

Alterations and Repairs. Tenant shall not make any alteration (as defined in the Lease) at the Premises which requires the prior consent of Molina under the Lease without obtaining the prior written consent of AGNL in accordance with Section 2.6 hereof.

AGNL Agreement. So long as Molina (or any successor landlord) does not have the right to terminate the Lease by reason of default (after any applicable notice and cure periods) on the part of Sub-Tenant, then, in such event, (a) unless any applicable law requires same, Sub-Tenant shall not be joined as a party defendant in any action or proceeding which may be instituted or taken by AGNL for the purpose of terminating the Ground Lease by reason of any default thereunder, (b) Sub-Tenant shall not be evicted from the Premises nor shall any of Sub-Tenant's rights under the Lease be impaired or otherwise affected in any way by reason of any default under the Ground Lease, and (c) Sub-Tenant's estate under the Lease shall not be terminated or disturbed by reason of any default on the part of Molina under the Ground Lease.

Consents. AGNL covenants and agrees that any consents by AGNL provided for hereunder generally shall be given, deemed given or withheld under the same standard as would be the case for Molina under the Lease, provided that Tenant also delivers to AGNL any notices related to such matters at the same time as delivered to Molina in accordance with the terms of the Lease. Tenant agrees that, if Tenant contends that AGNL improperly withheld its consent to any action or occurrence which requires AGNL's consent hereunder, then Tenant may seek an action for declaratory judgment against AGNL seeking to reverse such decision, or otherwise avail itself of any other remedies against AGNL to the extent available against the landlord under the Lease. The foregoing shall not limit or otherwise affect any and all remedies or claims that Tenant may have against Molina under or pursuant to the Lease.

Attornment. Sub-Tenant agrees for the benefit of AGNL and any transferee, successor or assign of AGNL or lender of AGNL, including, without limitation, Lender, which succeeds to the rights of AGNL, as landlord, pursuant to a foreclosure, deed-in-lieu of foreclosure or other exercise of remedies (hereafter referred to, collectively, as "Prime Landlord") following a termination of the Ground Lease, but subject in each case to Section 4 of this Agreement, as follows:

Payment of Rent. Sub-Tenant shall pay to Prime Landlord all rental payments required to be made by Sub-Tenant pursuant to the terms of the Lease for the duration of the term of the Lease.

Continuation of Performance. Sub-Tenant shall be bound to Prime Landlord in accordance with all of the provisions of the Lease for the balance of the term thereof, and Sub-Tenant hereby attorns to Prime Landlord as its landlord following a termination of the Ground Lease, such attornment to be effective and self-operative without the execution of any further instrument immediately upon Prime Landlord's termination of the Ground Lease and delivery of written notice thereof to Sub-Tenant.

No Offset. Prime Landlord shall not be liable for, nor subject to, any offsets, credits or defenses which Sub-Tenant may have by reason of any act or omission of Molina under the Lease (except to the extent specifically provided in the Lease as of the Effective Date and solely for such offsets, credits or defenses accruing or continuing after Prime Landlord becomes the landlord under the Lease), nor for the return of any sums which Sub-Tenant may have paid to Molina under the Lease as and for security deposits, advance rentals or otherwise, except to the extent that such sums are actually delivered by Molina to Prime Landlord (and provided that the foregoing provisions shall not exempt or discharge Prime Landlord, if Prime Landlord succeeds to the interest of Molina under the Lease, from the performance of the obligations of the "Landlord" under the Lease accruing during and applicable to Prime Landlord's period of ownership).

Subsequent Transfer. If Prime Landlord, by succeeding to the interest of Molina under the Lease, should become obligated to perform the covenants of Molina thereunder, then, upon any further transfer of Prime Landlord's interest by Prime Landlord and assumption thereof in writing by the transferee, all of such obligations (except those assumed by Prime Landlord during and applicable to Prime Landlord's period of ownership) shall terminate as to Prime Landlord.

Non-Disturbance. In the event of a termination of the Ground Lease, or other action to enforce AGNL's remedies under the Ground Lease or any other termination or surrender thereof, including, without limitation, pursuant to Section 365(h) of the U.S. Bankruptcy Code or Lender's exercise of remedies under the Security Instrument, so long as there shall then exist no right of the landlord to exercise remedies pursuant to the Lease by reason of default (beyond any applicable notice and cure period) by Sub-Tenant such that there is a right to terminate the Lease, each of AGNL and Lender agrees for itself and each of its successors and assigns that the leasehold interest of Sub-Tenant under the Lease shall not be disturbed, extinguished or terminated by reason of such termination or exercise of remedies by AGNL or Lender, but rather the Lease shall continue in full force and effect and AGNL or Lender (and any party that shall become a transferee of the Property by reason thereof), as applicable, shall recognize and accept Sub-Tenant as tenant under the Lease subject to and upon the terms and provisions of the Lease except as modified by this Agreement.

If a default (beyond any applicable notice and cure period) exists under the Lease such that there is a right to terminate the Lease at the time of the termination of the Ground Lease or the exercise of any of AGNL's remedies thereunder, then both AGNL and Lender may elect to continue the Lease as provided for in this Agreement or terminate the Lease upon written notice from AGNL and/or Lender to Sub-Tenant.

Miscellaneous.

Heirs, Successors, Assigns and Transferees. The covenants herein shall be binding upon, and inure to the benefit of, the heirs, successors and assigns of the parties hereto including, without limitation, Lender or any other lender of AGNL that becomes landlord under the Ground Lease or the Lease.

Notices. All notices or other communications required or permitted to be given pursuant to the provisions hereof shall be deemed served upon personal delivery or, if delivered by overnight courier such as FedEx or UPS, upon the date of delivery, or, if mailed, upon the first to occur of actual receipt or the expiration of three (3) days after deposit in United States Postal Service, certified mail, postage prepaid and addressed to the address of AGNL, Molina, Lender or Sub-Tenant appearing below:

"AGNL"	AGNL Clinic, L.P. c/o Angelo, Gordon & Co., L.P. 245 Park Avenue, 26th Floor New York, NY 10167-0094 Phone No.: (212) 883-4157 Fax No.: (212) 883-4141 Attn: Gordon J. Whiting
With a copy to:	AGNL Manager II, Inc. c/o Angelo, Gordon & Co., L.P. 245 Park Avenue, 26th Floor New York, NY 10167-0094 Phone No.: (212) 692-2296 Fax No.: (212) 867-6448 Attn: Joseph R. Wekselblatt
With a copy to:	Sheppard, Mullin, Richter & Hampton LLP 1300 I Street, N.W., Suite 1100 Washington, D.C. 20005 Phone No.: (202) 469-4943 Fax No.: (202) 312-9411 Attn: Michele E. Williams, Esquire
"Molina"	Director of Facilities Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802-4317

	Phone No.: (562) 435-3666 Fax No.: (562) 901-1086
with a copy to:	Sidley Austin LLP 555 West 5th Street 40th Floor Los Angeles, CA 90013 Phone No: (213) 896-6018 Fax No.: (213) 896-6600 Attn.: Marc I. Hayutin, Esquire
and to:	Sidley Austin LLP 555 West 5th Street 40th Floor Los Angeles, CA 90013 Phone No: (213) 896-6048 Fax No.: (213) 896-6600 Attn.: Edward C. Prokop, Esquire
"Lender"	The Royal Bank of Scotland PLC c/o RBS Financial Products Inc. 600 Washington Boulevard Stamford, Connecticut 06901 Attn: Real Estate Advisory Fax No.: (203) 873-4670
and to:	The Royal Bank of Scotland PLC c/o RBS Financial Products Inc. 600 Washington Boulevard Stamford, Connecticut 06901 Attn: Legal Department Fax No.: (203) 873-4670
with a copy to:	Kaye Scholer LLP 425 Park Avenue New York, New York 10022 Attn: Stephen Gliatta, Esq. Telecopier: (212) 836-8689
"Sub-Tenant"	Long Beach Publishing Company, Inc. 300 Oceangate, Suite 400 Long Beach, California 90802 Attn: _____ Phone No.: ( ) _____ Fax No.: ( ) _____
with a copy to:	_____ _____ _____

and to: George A. Furst
Law Offices of George A. Furst
16161 Ventura Boulevard, Suite C710
Encino, California 91436
Phone No.: (818) 789-5668
Fax No.: (818) 789-5668 (prior notification before sending fax required)

provided, however, that any party shall have the right to change its address for notice hereunder by the giving of written notice thereof to the other parties in the manner set forth in this Agreement.

Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original and all of which together shall constitute and be construed as one and the same instrument.

Remedies Cumulative. All rights of AGNL herein to collect rents on behalf of Molina under the Lease are cumulative and shall be in addition to any and all other rights and remedies provided by law and by other agreements between AGNL and Molina or others.

Paragraph Headings. Paragraph headings in this Agreement are for convenience only and are not to be construed as part of this Agreement or in any way limiting or applying the provisions hereof.

Representations. Each of AGNL, Molina, Lender and Sub-Tenant represents to the other respective parties that it has the power and authority to enter into this Agreement.

Intentionally Omitted.

Governing Law. It is the intention of the parties hereto that this Agreement (and the terms and provisions hereof) shall be construed and enforced in accordance with the laws of the State of California, without regard to any conflict of law principles.

Recordation. At AGNL's option, this Agreement may be recorded in the land records where the Property is located. Any recordation of this Agreement or any memorandum thereof, whether at the request of AGNL, Lender or otherwise, shall not be at Sub-Tenant's expense.

Fee Lender Subordination. AGNL, Molina, Lender and Sub-Tenant agree that the Lease shall be subordinate to the Loan and the Security Instrument and any mortgage or other security instrument hereafter placed upon the Property (which includes the Premises) by AGNL, and to any and all advances made or to be made thereunder, to the interest thereon, and all renewals, replacements and extensions thereof; provided, however, that the foregoing shall not limit Lender's agreements contained herein, including, without limitation, as described in Section 4 hereof.

INCORPORATION. Exhibit A, Exhibit B and Exhibit C are attached hereto and incorporated herein by this reference.

(SIGNATURES FOLLOW)

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above-written.

NOTICE: IT IS RECOMMENDED THAT, PRIOR TO THE EXECUTION OF THIS AGREEMENT, THE PARTIES CONSULT WITH THEIR ATTORNEYS WITH RESPECT HERETO.

"MOLINA"

MOLINA HEALTHCARE, INC.,
a Delaware corporation
By: ____
Name: ____

Date: __ Its: __

"AGNL"

AGNL CLINIC, L.P.,
a Delaware limited partnership
By: AGNL CLINIC GP, L.L.C.,
its general partner
By: AGNL Manager II, Inc.,
its manager
Date: By: ____

Gordon J. Whiting, President

Signature Page to
Sublease SNDA
Exhibit M

"LENDER"

ROYAL BANK OF SCOTLAND PLC

Date:

By: RBS Securities, Inc., its agent

By: __
Name:__
Its:____

RBS FINANCIAL PRODUCTS, INC.,
a Delaware corporation

Date:

By: RBS Securities, Inc., its agent

By: __
Name:__
Its:____

Signature Page to
Sublease SNDA
Exhibit M

"SUB-TENANT"

LONG BEACH PUBLISHING COMPANY, INC.,
a Delaware corporation

Date: By:_____

Name:_____

Its:_____

Signature Page to
Sublease SNDA
Exhibit M

ACKNOWLEDGEMENT
(For Molina)

STATE OF CALIFORNIA)
)ss.
COUNTY OF _____)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Acknowledgement to
Sublease SNDA
Exhibit M

ACKNOWLEDGEMENT
(For AGNL)

STATE OF_____
COUNTY OF ____

On June ___, 2013 before me, _____, a Notary Public, in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her/their authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

Notary Public in and for said State

Acknowledgement to
Sublease SNDA
Exhibit M

ACKNOWLEDGEMENT
(For Lender)

STATE OF_____
COUNTY OF ____

On June ___, 2013 before me, _____, a Notary Public, in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her/their authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

Notary Public in and for said State

ACKNOWLEDGEMENT
(For Lender)

STATE OF_____
COUNTY OF ____

On June ___, 2013 before me, _____, a Notary Public, in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her/their authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

Notary Public in and for said State

Acknowledgement to
Sublease SNDA
Exhibit M

ACKNOWLEDGEMENT
(For Sub-Tenant)

STATE OF CALIFORNIA)
)ss:
COUNTY OF _____)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)]

Acknowledgement to
Sublease SNDA
Exhibit M

EXHIBIT A

PROPERTY

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 7278-003-036

EXHIBIT B

PREMISES

The premises leased from Molina to Sub-Tenant under the Lease, consisting of approximately 26,213 rentable square feet, on portions of the first, fourth and fourteenth floors of the office building located at 300 Oceangate Blvd., Long Beach, California

EXHIBIT C

LEASE

Exhibit M

EXHIBIT N

Form of Notice of Subordination

NOTICE OF SUBORDINATION

THIS NOTICE OF SUBORDINATION (this "Notice") is dated June __, 2013 (the "Effective Date"), by AGNL Clinic, L.P., a Delaware limited partnership ("AGNL") and Molina Healthcare, Inc., a Delaware corporation (" Molina")

1. Molina Center LLC, a Delaware limited liability company ("Center"), as landlord, and _____ ("Sub-Tenant") as tenant (or their respective predecessors in interest), entered into a Lease made and entered into as of _____, 20__ (the "Lease"). Pursuant to the Lease, Sub-Tenant leases from Center that certain portion of the Property (defined below) as more particularly described on Exhibit B attached hereto and incorporated herein by this reference (the " _____ Premises").

2. On the Effective Date, Center, sold and conveyed to AGNL the fee simple interest in that certain real property with an address of 200 and 300 Oceangate Blvd., Suite 950, Long Beach, California 90802, and described on Exhibit A attached hereto and incorporated herein by this reference (which property, together with all improvements now or hereafter located on the property, is defined as the "Property").

3. On the Effective Date, AGNL, as landlord, and Molina, as tenant, entered into a Lease Agreement dated as of the Effective Date (together with any amendments, modifications, replacements or extensions, the " Ground Lease") pursuant to which AGNL leased to Molina all of the Property and improvements located thereon as more fully described in the Ground Lease, Center assigned the Lease to Molina, and Lender made a loan (the "Loan") to AGNL secured by, among other things, that certain Deed of Trust, Assignment of Leases and Rents, Security Agreement and Fixture Filing (the "Security Instrument") encumbering AGNL's interest in the Property.

4. Pursuant to Section 12 or Section 33, as applicable, of the Lease, Sub-Tenant agreed that, at the option of Landlord (as defined in the Lease), all future ground leases would be superior to the Lease. Center, as Landlord under the Lease, hereby exercises such option with regard to the Ground Lease. The effect of the foregoing subordination shall be that the Ground Lease shall be deemed a master lease or superior lease and that the Lease shall be deemed a sublease under the Ground Lease.

[Signature Page Follows]

Sincerely,

AGNL Clinic, L.P.,
a Delaware limited partnership

By: AGNL Clinic GP, L.L.C.,
a Delaware limited liability company,
its general partner

By: AGNL Manager II, Inc.,
a Delaware corporation, its manager

By: _____
Name: Gordon J. Whiting
Title: President

Exhibit N

Exhibit A

LEGAL DESCRIPTION

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 7278-003-036

Exhibit B

[ ] PREMISES

[Address and Suite #]

Exhibit N

EXHIBIT O-1

Long Beach Title Pro Forma

(attached)

Fidelity National Title Insurance Company

POLICY NO.: Pro Forma-23021588

PRO FORMA
OWNER'S POLICY OF TITLE INSURANCE

Issued by

Fidelity National Title Insurance Company

Any notice of claim and any other notice or statement in writing required to be given the Company under this Policy must be given to the Company at the address shown in Section 18 of the Conditions.

COVERED RISKS

SUBJECT TO THE EXCLUSIONS FROM COVERAGE, THE EXCEPTIONS FROM COVERAGE CONTAINED IN SCHEDULE B, AND THE CONDITIONS, FIDELITY NATIONAL TITLE INSURANCE COMPANY, a California corporation (the "Company") insures, as of Date of Policy and, to the extent stated in Covered Risks 9 and 10, after Date of Policy, against loss or damage, not exceeding the Amount of Insurance, sustained or incurred by the Insured by reason of:

1. Title being vested other than as stated in Schedule A.

2. Any defect in or lien or encumbrance on the Title. This Covered Risk includes but is not limited to insurance against loss from

   (a) A defect in the Title caused by

      (i) forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;

      (ii) failure of any person or Entity to have authorized a transfer or conveyance;

      (iii) a document affecting Title not properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered;

      (iv) failure to perform those acts necessary to create a document by electronic means authorized by law;

      (v) a document executed under a falsified, expired, or otherwise invalid power of attorney;

(vi) a document not properly filed, recorded, or indexed in the Public Records including failure to perform those acts by electronic means authorized by law; or

(vii) a defective judicial or administrative proceeding.

(b) The lien of real estate taxes or assessments imposed on the Title by a governmental authority due or payable, but unpaid.

(c) Any encroachment, encumbrance, violation, variation, or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land survey of the Land. The term "encroachment" includes encroachments of existing improvements located on the Land onto adjoining land, and encroachments onto the Land of existing improvements located on adjoining land.

3. Unmarketable Title.

4. No right of access to and from the Land.

5. The violation or enforcement of any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to

(a) the occupancy, use, or enjoyment of the Land;

(b) the character, dimensions, or location of any improvement erected on the Land;

(c) the subdivision of land; or

(d) environmental protection

if a notice, describing any part of the Land, is recorded in the Public Records setting forth the violation or intention to enforce, but only to the extent of the violation or enforcement referred to in that notice.

6. An enforcement action based on the exercise of a governmental police power not covered by Covered Risk 5 if a notice of the enforcement action, describing any part of the Land, is recorded in the Public Records, but only to the extent of the enforcement referred to in that notice.

7. The exercise of the rights of eminent domain if a notice of the exercise, describing any part of the Land, is recorded in the Public Records.

8. Any taking by a governmental body that has occurred and is binding on the rights of a purchaser for value without Knowledge.

9. Title being vested other than as stated Schedule A or being defective

   (a) as a result of the avoidance in whole or in part, or from a court order providing an alternative remedy, of a transfer of all or any part of the title to or any interest in the Land occurring prior to the transaction vesting Title as shown in Schedule A because that prior transfer constituted a fraudulent or preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws; or

   (b) because the instrument of transfer vesting Title as shown in Schedule A constitutes a preferential transfer under federal bankruptcy, state insolvency, or similar creditors' rights laws by reason of the failure of its recording in the Public Records

      (i) to be timely, or

      (ii) to impart notice of its existence to a purchaser for value or to a judgment or lien creditor.

10. Any defect in or lien or encumbrance on the Title or other matter included in Covered Risks 1 through 9 that has been created or attached or has been filed or recorded in the Public Records subsequent to Date of Policy and prior to the recording of the deed or other instrument of transfer in the Public Records that vests Title as shown in Schedule A.

The Company will also pay the costs, attorneys' fees, and expenses incurred in defense of any matter insured against by this Policy, but only to the extent provided in the Conditions.

IN WITNESS WHEREOF, FIDELITY NATIONAL TITLE INSURANCE COMPANY has caused this policy to be signed and sealed by its duly authorized officers.

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Policy. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

27306 (6/06)
Alta Owner's Policy

EXCLUSIONS FROM COVERAGE

The following matters are expressly excluded from the coverage of this policy, and the Company will not pay loss or damage, costs, attorneys' fees, or expenses that arise by reason of:

1. (a) Any law, ordinance, permit, or governmental regulation (including those relating to building and zoning) restricting, regulating, prohibiting, or relating to
   (i) the occupancy, use, or enjoyment of the Land;
   (ii) the character, dimensions or location of any improvement erected on the Land;
   (iii) the subdivision of land; or
   (iv) environmental protection;
   or the effect of any violation of these laws, ordinances, or governmental regulations. This Exclusion 1(a) does not modify or limit the coverage provided under Covered Risk 5.
   (b) Any governmental police power. This Exclusion 1(b) does not modify or limit the coverage provided under Covered Risk 6.
2. Rights of eminent domain. This Exclusion does not modify or limit the coverage provided under Covered Risk 7 or 8.
3. Defects, liens, encumbrances, adverse claims, or other matters:
   (a) created, suffered, assumed, or agreed to by the Insured Claimant;
   (b) not Known to the Company, not recorded in the Public Records at Date of Policy, but Known to the Insured Claimant and not disclosed in writing to the Company by the Insured Claimant prior to the date the Insured Claimant became an Insured under this policy;
   (c) resulting in no loss or damage to the Insured Claimant;
   (d) attaching or created subsequent to Date of Policy (however, this does not modify or limit the coverage provided under Covered Risk 9 and 10); or
   (e) resulting in loss or damage that would not have been sustained if the Insured Claimant had paid value for the Title.
4. Any claim, by reason of the operation of federal bankruptcy, state insolvency, or similar creditors' rights laws, that the transaction vesting the Title as shown in Schedule A, is
   (a) a fraudulent conveyance or fraudulent transfer; or
   (b) a preferential transfer for any reason not stated in Covered Risk 9 of this policy.
5. Any lien on the Title for real estate taxes or assessments imposed by governmental authority and created or attaching between Date of Policy and the date of recording of the deed or other instrument of transfer in the Public Records that vests Title as shown in Schedule A.

CONDITIONS

1. DEFINITION OF TERMS

The following terms when used in this policy mean:

(a) "Amount of Insurance": The amount stated in Schedule A, as may be increased or decreased by endorsement to this policy, increased by Section 8(b), or decreased by Sections 10 and 11 of these Conditions.

(b) "Date of Policy": The date designated as "Date of Policy" in Schedule A.

(c) "Entity": A corporation, partnership, trust, limited liability company, or other similar legal entity.

(d) "Insured": The Insured named in Schedule A.

(i) The term "Insured" also includes

(A) successors to the Title of the Insured by operation of law as distinguished from purchase, including heirs, devisees, survivors, personal representatives, or next of kin;

(B) successors to an Insured by dissolution, merger, consolidation, distribution, or reorganization;

(C) successors to an Insured by its conversion to another kind of Entity;

(D) a grantee of an Insured under a deed delivered without payment of actual valuable consideration conveying the Title

(1) if the stock, shares, memberships, or other equity interests of the grantee are wholly-owned by the named Insured,

(2) if the grantee wholly owns the named Insured,

(3) if the grantee is wholly-owned by an affiliated Entity of the named Insured, provided the affiliated Entity and the named Insured are both wholly-owned by the same person or Entity, or

(4) if the grantee is a trustee or beneficiary of a trust created by a written instrument established by the Insured named in Schedule A for estate planning purposes.

(ii) With regard to (A), (B), (C), and (D) reserving, however, all rights and defenses as to any successor that the Company would have had against any predecessor Insured.

(e) "Insured Claimant": An Insured claiming loss or damage.

(f) "Knowledge" or "Known": Actual knowledge, not constructive knowledge or notice that may be imputed to an Insured by reason of the Public Records or any other records that impart constructive notice of matters affecting the Title.

(g) "Land": The land described in Schedule A, and affixed improvements that by law constitute real property. The term "Land" does not include any property beyond the lines of the area described in Schedule A, nor any right, title, interest, estate, or easement in abutting streets, roads, avenues, alleys, lanes, ways, or waterways, but this does not modify or limit the extent that a right of access to and from the Land is insured by this policy.

(h) "Mortgage": Mortgage, deed of trust, trust deed, or other security instrument, including one evidenced by electronic means authorized by law.

(i) "Public Records": Records established under state statutes at Date of Policy for the purpose of imparting constructive notice of matters relating to real property to purchasers for value and without Knowledge. With respect to Covered Risk 5(d), "Public Records" shall also include environmental protection liens filed in the records of the clerk of the United States District Court for the district where the Land is located.

(j) "Title": The estate or interest described in Schedule A.

(k) "Unmarketable Title": Title affected by an alleged or apparent matter that would permit a prospective purchaser or lessee of the Title or lender on the Title to be released from the obligation to purchase, lease, or lend if there is a contractual condition requiring the delivery of marketable title.

2. CONTINUATION OF INSURANCE

The coverage of this policy shall continue in force as of Date of Policy in favor of an Insured, but only so long as the Insured retains an estate or interest in the Land, or holds an obligation secured by a purchase money Mortgage given by a purchaser from the Insured, or only so long as the Insured shall have liability by reason of warranties in any transfer or conveyance of the Title. This policy shall not continue in force in favor of any purchaser from the Insured of either (i) an estate or interest in the Land, or (ii) an obligation secured by a purchase money Mortgage given to the Insured.

3. NOTICE OF CLAIM TO BE GIVEN BY INSURED CLAIMANT

The Insured shall notify the Company promptly in writing (i) in case of any litigation as set forth in Section 5(a) of these Conditions, (ii) in case Knowledge shall come to an Insured hereunder of any claim of title or interest that is adverse to the Title, as insured, and that might cause loss or damage for which the Company may be liable by virtue of this policy, or (iii) if the Title, as insured, is rejected as Unmarketable Title. If the Company is prejudiced by the failure of the Insured Claimant to provide prompt notice, the Company's liability to the Insured Claimant under the policy shall be reduced to the extent of the prejudice.

4. PROOF OF LOSS

In the event the Company is unable to determine the amount of loss or damage, the Company may, at its option, require as a condition of payment that the Insured Claimant furnish a signed proof of loss. The proof of loss must describe the defect, lien, encumbrance, or other matter insured against by this policy that constitutes the basis of loss or damage and shall state, to the extent possible, the basis of calculating the amount of the loss or damage.

5. DEFENSE AND PROSECUTION OF ACTIONS

(a) Upon written request by the Insured, and subject to the options contained in Section 7 of these Conditions, the Company, at its own cost and without unreasonable delay, shall provide for the defense of an Insured in litigation in which any third party asserts a claim covered by this policy adverse to the Insured. This obligation is limited to only those stated causes of action alleging matters insured against by this policy. The Company shall have the right to select counsel of its choice (subject to the right of the Insured to object for reasonable cause) to represent the Insured as to those stated causes of action. It shall not be liable for and will not pay the fees of any other counsel. The Company will not pay any fees, costs, or expenses incurred by the Insured in the defense of those causes of action that allege matters not insured against by this policy.

(b) The Company shall have the right, in addition to the options contained in Section 7 of these Conditions, at its own cost, to institute and prosecute any action or proceeding or to do any other act that in its opinion may be necessary or desirable to establish the Title, as insured, or to prevent or reduce loss or damage to the Insured. The Company may take any appropriate action under the terms of this policy, whether or not it shall be liable to the Insured. The exercise of these rights shall not be an admission of liability or waiver of any provision of this policy. If the Company exercises its rights under this subsection, it must do so diligently.

(c) Whenever the Company brings an action or asserts a defense as required or permitted by this policy, the Company may pursue the litigation to a final determination by a court of competent jurisdiction, and it expressly reserves the right, in its sole discretion, to appeal from any adverse judgment or order.

6. DUTY OF INSURED CLAIMANT TO COOPERATE

(a) In all cases where this policy permits or requires the Company to prosecute or provide for the defense of any action or proceeding and any appeals, the Insured shall secure to the Company the right to so prosecute or provide defense in the action or proceeding, including the right to use, at its option, the name of the Insured for this purpose. Whenever requested by the Company, the Insured, at the Company's expense, shall give the Company all reasonable aid (i) in securing evidence, obtaining witnesses, prosecuting or defending the action or proceeding, or effecting settlement, and (ii) in any other lawful act that in the opinion of the Company may be necessary or desirable to establish the Title or any other matter as insured. If the Company is prejudiced by the failure of the Insured to furnish the required cooperation, the Company's obligations to the Insured under the policy shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation, with regard to the matter or matters requiring such cooperation.

(b) The Company may reasonably require the Insured Claimant to submit to examination under oath by any authorized representative of the Company and to produce for examination, inspection, and copying, at such reasonable times and places as may be designated by the authorized representative of the Company, all records, in whatever medium maintained, including books, ledgers, checks, memoranda,

correspondence, reports, e-mails, disks, tapes, and videos whether bearing a date before or after Date of Policy, that reasonably pertain to the loss or damage. Further, if requested by any authorized representative of the Company, the Insured Claimant shall grant its permission, in writing, for any authorized representative of the Company to examine, inspect, and copy all of these records in the custody or control of a third party that reasonably pertain to the loss or damage. All information designated as confidential by the Insured Claimant provided to the Company pursuant to this Section shall not be disclosed to others unless, in the reasonable judgment of the Company, it is necessary in the administration of the claim. Failure of the Insured Claimant to submit for examination under oath, produce any reasonably requested information, or grant permission to secure reasonably necessary information from third parties as required in this subsection, unless prohibited by law or governmental regulation, shall terminate any liability of the Company under this policy as to that claim.

7. OPTIONS TO PAY OR OTHERWISE SETTLE CLAIMS; TERMINATION OF LIABILITY

In case of a claim under this policy, the Company shall have the following additional options:

(a) To Pay or Tender Payment of the Amount of Insurance.

To pay or tender payment of the Amount of Insurance under this policy together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment or tender of payment and that the Company is obligated to pay.

Upon the exercise by the Company of this option, all liability and obligations of the Company to the Insured under this policy, other than to make the payment required in this subsection, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

(b) To Pay or Otherwise Settle With Parties Other Than the Insured or With the Insured Claimant.

(i) To pay or otherwise settle with other parties for or in the name of an Insured Claimant any claim insured against under this policy. In addition, the Company will pay any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay; or

(ii) To pay or otherwise settle with the Insured Claimant the loss or damage provided for under this policy, together with any costs, attorneys' fees, and expenses incurred by the Insured Claimant that were authorized by the Company up to the time of payment and that the Company is obligated to pay.

Upon the exercise by the Company of either of the options provided for in subsections (b)(i) or (ii), the Company's obligations to the Insured under this policy for the claimed loss or damage, other than the payments required to be made, shall terminate, including any liability or obligation to defend, prosecute, or continue any litigation.

8. DETERMINATION AND EXTENT OF LIABILITY

This policy is a contract of indemnity against actual monetary loss or damage sustained or incurred by the Insured Claimant who has suffered loss or damage by reason of matters insured against by this policy.

(a) The extent of liability of the Company for loss or damage under this policy shall not exceed the lesser of

(i) the Amount of Insurance; or

(ii) the difference between the value of the Title as insured and the value of the Title subject to the risk insured against by this policy.

(b) If the Company pursues its rights under Section 5 of these Conditions and is unsuccessful in establishing the Title, as insured,

(i) the Amount of Insurance shall be increased by 10%, and

(ii) the Insured Claimant shall have the right to have the loss or damage determined either as of the date the claim was made by the Insured Claimant or as of the date it is settled and paid.

(c) In addition to the extent of liability under (a) and (b), the Company will also pay those costs, attorneys' fees, and expenses incurred in accordance with Sections 5 and 7 of these Conditions.

9. LIMITATION OF LIABILITY

(a) If the Company establishes the Title, or removes the alleged defect, lien or encumbrance, or cures the lack of a right of access to or from the Land, or cures the claim of Unmarketable Title, all as insured, in a reasonably diligent manner by any method, including litigation and the completion of any appeals, it shall have fully performed its obligations with respect to that matter and shall not be liable for any loss or damage caused to the Insured.

(b) In the event of any litigation, including litigation by the Company or with the Company's consent, the Company shall have no liability for loss or damage until there has been a final determination by a court of competent jurisdiction, and disposition of all appeals, adverse to the Title, as insured.

(c) The Company shall not be liable for loss or damage to the Insured for liability voluntarily assumed by the Insured in settling any claim or suit without the prior written consent of the Company.

10. REDUCTION OF INSURANCE; REDUCTION OR TERMINATION OF LIABILITY

All payments under this policy, except payments made for costs, attorneys' fees, and expenses, shall reduce the Amount of Insurance by the amount of the payment.

11. LIABILITY NONCUMULATIVE

The Amount of Insurance shall be reduced by any amount the Company pays under any policy insuring a Mortgage to which exception is taken in Schedule B or to which the Insured has agreed, assumed, or taken subject, or which is executed by an Insured after Date of Policy and which is a charge or lien on the Title, and the amount so paid shall be deemed a payment to the Insured under this policy.

12. PAYMENT OF LOSS

When liability and the extent of loss or damage have been definitely fixed in accordance with these Conditions, the payment shall be made within 30 days.

13. RIGHTS OF RECOVERY UPON PAYMENT OR SETTLEMENT

(a) Whenever the Company shall have settled and paid a claim under this policy, it shall be subrogated and entitled to the rights of the Insured Claimant in the Title and all other rights and remedies in respect to the claim that the Insured Claimant has against any person or property, to the extent of the amount of any loss, costs, attorneys' fees, and expenses paid by the Company. If requested by the Company, the Insured Claimant shall execute documents to evidence the transfer to the Company of these rights

and remedies. The Insured Claimant shall permit the Company to sue, compromise, or settle in the name of the Insured Claimant and to use the name of the Insured Claimant in any transaction or litigation involving these rights and remedies.

If a payment on account of a claim does not fully cover the loss of the Insured Claimant, the Company shall defer the exercise of its right to recover until after the Insured Claimant shall have recovered its loss.

(b) The Company's right of subrogation includes the rights of the Insured to indemnities, guaranties, other policies of insurance, or bonds, notwithstanding any terms or conditions contained in those instruments that address subrogation rights.

14. ARBITRATION

Either the Company or the Insured may demand that the claim or controversy shall be submitted to arbitration pursuant to the Title Insurance Arbitration Rules of the American Land Title Association ("Rules"). Except as provided in the Rules, there shall be no joinder or consolidation with claims or controversies of other persons. Arbitrable matters may include, but are not limited to, any controversy or claim between the Company and the Insured arising out of or relating to this policy, any service in connection with its issuance or the breach of a policy provision, or to any other controversy or claim arising out of the transaction giving rise to this policy. All arbitrable matters when the Amount of Insurance is $2,000,000 or less shall be arbitrated at the option of either the Company or the Insured. All arbitrable matters when the Amount of Insurance is in excess of $2,000,000 shall be arbitrated only when agreed to by both the Company and the Insured. Arbitration pursuant to this policy and under the Rules shall be binding upon the parties. Judgment upon the award rendered by the Arbitrator(s) may be entered in any court of competent jurisdiction.

15. LIABILITY LIMITED TO THIS POLICY; POLICY ENTIRE CONTRACT

(a) This policy together with all endorsements, if any, attached to it by the Company is the entire policy and contract between the Insured and the Company. In interpreting any provision of this policy, this policy shall be construed as a whole.

(b) Any claim of loss or damage that arises out of the status of the Title or by any action asserting such claim shall be restricted to this policy.

(c) Any amendment of or endorsement to this policy must be in writing and authenticated by an authorized person, or expressly incorporated by Schedule A of this policy.

(d) Each endorsement to this policy issued at any time is made a part of this policy and is subject to all of its terms and provisions. Except as the endorsement expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsement, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance.

16. SEVERABILITY

In the event any provision of this policy, in whole or in part, is held invalid or unenforceable under applicable law, the

policy shall be deemed not to include that provision or such part held to be invalid, but all other provisions shall remain in full force and effect.

17. CHOICE OF LAW; FORUM

(a) Choice of Law: The Insured acknowledges the Company has underwritten the risks covered by this policy and determined the premium charged therefor in reliance upon the law affecting interests in real property and applicable to the interpretation, rights, remedies, or enforcement of policies of title insurance of the jurisdiction where the Land is located.

Therefore, the court or an arbitrator shall apply the law of the jurisdiction where the Land is located to determine the validity of claims against the Title that are adverse to the Insured and to interpret and enforce the terms

of this policy. In neither case shall the court or arbitrator apply its conflicts of law principles to determine the applicable law.

(b) Choice of Forum: Any litigation or other proceeding brought by the Insured against the Company must be filed only in a state or federal court within the United States of America or its territories having appropriate jurisdiction.

18. NOTICES, WHERE SENT

Any notice of claim and any other notice or statement in writing required to be given to the Company under this policy must be given to the Company at Fidelity National Title Insurance Company, Attn: Claims Department, Post Office Box 45023, Jacksonville, Florida 32232-5023.

Fidelity National Title Insurance Company

SCHEDULE A

This is a Pro Forma Policy. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

Name and Address of Title Insurance Company: **Fidelity National Title Company**
1300 Dove Street, Suite 310
Newport Beach, CA 92660

Policy No.: **Pro Forma-23021588** Order No.: **23021588-997-MAT**

Address Reference: **200-300 Oceangate, Long Beach, CA**

Amount of Insurance: $134,625,566.00 Premium: **PRO FORMA**

Date of Policy: **PRO FORMA**

1. Name of Insured:

   AGNL Clinic, L.P., a Delaware limited partnership

2. The estate or interest in the Land that is insured by this policy is:

   A FEE

3. Title is vested in:

   AGNL Clinic, L.P., a Delaware limited partnership

4. The Land referred to in this policy is described as follows:

   See Exhibit A attached hereto and made a part hereof.

THIS POLICY VALID ONLY IF SCHEDULE B IS ATTACHED

EXHIBIT A

LEGAL DESCRIPTION

THE LAND REFERRED TO HEREIN BELOW IS SITUATED IN THE COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AND IS DESCRIBED AS FOLLOWS:

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY AND ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 & 7278-003-036

THE ABOVE DESCRIBED LAND IS ALSO DESCRIBED ON THE ALTA SURVEY PREPARED BY FJS LAND CONSULTING FOR BOCK & CLARK'S NATIONAL SURVEYOR'S NETWORK, DATED FEBRUARY 27, 2013 AND LAST REVISED _____, 2013, AND DESIGNATED AS JOB NO. 201300337-002, AS FOLLOWS:

PARCEL 2, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

BEGINNING AT THE NORTHWEST CORNER OF SAID PARCEL 2, BEING A 2 ½" IRON PIPE TAGGED LS 2680; THENCE:

1ST – NORTH 89° 55'49" EAST 584.88 FEET TO A 2 ½" IRON PIPE TAGGED LS 2680; THENCE,
2ND – SOUTH 00° 04'11" EAST 320.00 FEET TO A 2 ½" IRON PIPE TAGGED LS 2680; THENCE,
3RD – SOUTH 89° 55'49" WEST 109.01 FEET TO THE BEGINNING OF A TANGENT CURVE, CONCAVE SOUTHERLY HAVING A RADIUS OF 477.83 FEET; THENCE ALONG SAID CURVE,
4TH – WESTERLY 61.71 FEET THROUGH A CENTRAL ANGLE OF 7° 24'00"; THENCE,
5TH – SOUTH 82° 24'48" WEST 58.94 FEET TO THE BEGINNING OF A TANGENT CURVE, CONCAVE NORTHERLY HAVING A RADIUS OF 652.00 FEET; THENCE ALONG SAID CURVE,
6TH – WESTERLY 84.21 FEET THROUGH A CENTRAL ANGLE OF 7° 24'00", THENCE,
7TH – SOUTH 89° 55'49" WEST 162.45 FEET TO A 2 ½" IRON PIPE TAGGED LS 2680; THENCE,
8TH NORTH 00° 04"11" WEST 161.00 FEET; THENCE,
9TH SOUTH 89° 55'48" WEST 109.46 FEET; THENCE,
10TH NORTH 00° 04'11" WEST 176.00 FEET TO THE TRUE POINT OF BEGINNING.

PARCEL 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

BEGINNING AT THE NORTHWEST CORNER OF SAID PARCEL 3, BEING A 2 1/2" IRON PIPE TAGGED LS 2680; THENCE

1ST – SOUTH 0° 04'11" EAST 76.02 FEET; THENCE,

2ND – SOUTH 88° 26’36” EAST 475.58 FEET; THENCE,
3RD – NORTH 0° 04’11” WEST 80.68 FEET TO A 2 1/2” IRON PIPE TAGGED LS 2680; THENCE

4TH – SOUTH 89° 55’49” WEST 109.01 FEET TO THE BEGINNING OF A TANGENT CURVE, CONCAVE SOUTHERLY HAVING A RADIUS OF 477.83 FEET; THENCE ALONG SAID CURVE,
5TH – WESTERLY 61.71 FEET THROUGH A CENTRAL ANGLE OF 7° 24’00”, THENCE;
NORTHERLY HAVING A RADIUS OF 652.00 FEET; THENCE ALONG SAID CURVE,
6TH – SOUTH 82° 24’48” WEST 58.94 FEET TO THE BEGINNING OF A TANGENT CURVE, CONCAVE NORTHERLY HAVING A RADIUS OF 652.00 FEET; THENCE ALONG SAID CURVE,
7TH – WESTERLY 84.21 FEET THROUGH A CENTRAL ANGLE OF 7° 24’00”, THENCE,
8TH – SOUTH 89° 55’49” WEST 162.45 FEET TO THE TRUE POINT OF BEGINNING.

NOTE: PARCEL 3 ONLY INCLUDES THE AIRSPACE LOCATED 15.5 FEET ABOVE THE FINISHED SURFACE OF SAID LAND

PER THE SURVEYOR THE ABOVE METES AND BOUNDS LEGAL DESCRIPTIONS COVER THE SAME PROPERTY AS THE PROPERTY COVERED BY THE RECORD LEGAL DESCRIPTION. HOWEVER, ARE NOT THE VESTING LEGAL DESCRIPTION. THESE ARE MERELY PROVIDED AS A COURTESY.

THE ABOVE METES AND BOUNDS LEGAL DESCRIPTION IN NOT THE RECORD LEGAL DESCRIPTION AND IS MERELY PROVIDED AS A COURTESY ONLY.NO COVERAGE IS GIVEN AS TO THE ACCURACY THEREOF.

SCHEDULE B

EXCEPTIONS FROM COVERAGE

This policy does not insure against loss or damage, and the Company will not pay costs, attorneys' fees, or expenses that arise by reason of:

1. Property taxes, which are a lien not yet due and payable, including any assessments collected with taxes to be levied for the fiscal year 2013-2014.
2. Intentionally Deleted.
3. Intentionally Deleted
4. The lien of supplemental taxes, if any, assessed pursuant to the provisions of Chapter 3.5 (Commencing with Section 75) of the Revenue and Taxation Code of the State of California. None yet due and payable.
5. Water rights, claims or title to water, whether or not disclosed by the public records.
6. Intentionally deleted
7. The Land described herein is included within a project area of the Redevelopment Agency shown below, and that proceedings for the redevelopment of said project have been instituted under the Redevelopment Law (such redevelopment to proceed only after the adoption of the Redevelopment Plan) as disclosed by a document.

   Redevelopment Agency: Redevelopment Agency of the City of Long Beach, California
   Recording Date: October 21, 1969
   Recording No: 3208 of Official Records
8. Easement(s) for the purpose(s) shown below and rights incidental thereto, as granted in a document:

   Granted by: Redevelopment Agency of the City of Long Beach
   Granted to: The City of Long Beach
   Purpose: Slope and incidental purposes
   Recording Date: April 22, 1976
   Recording No: as Instrument No. 470, Book D7050, Page 668, of Official Records
   Affects: A portion of Parcel 2

9. Matters contained in that certain document

   Entitled: Grants, Covenants and Restrictions
   Executed by: Redevelopment Agency of The City of Long Beach, California, a public body, corporate and politic and Oceangate Financial Center, Ltd., a California limited partnership
   Recording Date: February 18, 1976
   Recording No: as Instrument No. 488, Book M5256, Page 630, of Official Records

10. Covenants, conditions and restrictions but omitting any covenants or restrictions, if any, including but not limited to those based upon race, color, religion, sex, sexual orientation, familial status, marital status, disability, handicap, national origin, ancestry, source of income, gender, gender identity, gender expression, medical condition or genetic information, as set forth in applicable state or federal laws, except to the extent that said covenant or restriction is permitted by applicable law, as set forth in the document

    Entitled: "Resolution No. RA. 13-76"
    Executed by: Redevelopment Agency of The City of Long Beach, California
    Recording Date: May 27, 1976
    Recording No: as Instrument No. 4810, Book D7097, Page 356, of Official Records

    Said covenants, conditions and restrictions provide that a violation thereof shall not defeat the lien of any mortgage or deed of trust made in good faith and for value.

11. Covenants, conditions, restrictions and easements but omitting any covenants or restrictions, if any, including but not limited to those based upon race, color, religion, sex, sexual orientation, familial status, marital status, disability, handicap, national origin, ancestry, source of income, gender, gender identity, gender expression, medical condition or genetic information, as set forth in applicable state or federal laws, except to the extent that said covenant or restriction is permitted by applicable law, as set forth in the document

    Entitled: "Grant Deed"
    Grantor: Redevelopment Agency of The City of Long Beach, California
    Recording Date: November 25, 1980
    Recording No: 80-1188844 of Official Records

    Said covenants, conditions and restrictions provide that a violation thereof shall not defeat the lien of any mortgage or deed of trust made in good faith and for value.

    In connection therewith, a "Certificate of Completion for Construction of Improvements" recorded July 12, 1983, as Instrument No. 83-780907, of Official Records.

12. Matters contained in that certain document

    Entitled: Disposition and Development Agreement
    Executed By and Between: Redevelopment Agency of The City of Long Beach, California and Dillingham Investments, Incorporated and Gilbert F. Platt, Incorporated, a California corporation
    Recording Date: November 25, 1980
    Recording No: 80-1188843, of Official Records

    Reference is hereby made to said document for full particulars.

    In connection therewith, a "Certificate of Completion for Construction of Improvements" recorded July 12, 1983, as Instrument No. 83-780907, of Official Records.

13. Easement(s) for the purpose(s) shown below and rights incidental thereto, as granted in a document:

Grantor:	Norland Properties
Granted to:	The Mutual Life Insurance Company of New York

Purpose:	Subsurface encroachment of a parking structure, the maintenance thereof, and incidental purposes
Recording Date:	December 02, 1982
Recording No:	82-1201843, of Official Records
Affects:	The easterly 4 feet of Parcel 2

14. Easement(s) for the purpose(s) shown below and rights incidental thereto, as granted in a document:

Grantor:	Norland Properties
Granted to:	Southern California Edison Company, a corporation
Purpose:	electrical supply and communication systems, and incidental purposes
Recording Date:	September 29, 1982
Recording No:	82-986386 of Official Records
Affects:	A portion of Parcel 2

15. Recitals as shown on that certain Parcel Map 5196, Book 71, Page 14, of Parcel Maps.

    Which among other things recites:

    a. Abutter's rights of ingress and egress to or from Shoreline Drive, except the public right to travel on same, have been dedicated or relinquished on the map of Tract Map No. 27757 on file in Book 820, Page 91, of Tract Maps.

    b. The following matters as shown in the "NOTES" on Parcel Map No. 5196 filed in Book 71 of Parcel Maps, at Page 14, Los Angeles County Records, as said Parcel Map is referred to in the herein legal description:

        1. "Parcels 3 and 4 represent portions of the undedicated portions of Lots 4 and 10, Tract 27757, M.B. 820, Pgs. 91-94 lying above an imaginary surface which at all points thereon is 15.5 feet vertically above the unfinished surface of said Lots 4 and 10 improved for public street purposes."
        2. "The ownership, sale, lease or financing of all or part of Parcels 2 and 3 separately is prohibited per conditions in Resolution No. 13-76 as recorded in Book D7097, Pgs. 356."
        3. "Pedestrian & vehicular ingress and egress rights into Seaside Way across the southwesterly & southerly line of Parcel 1 and the southerly line of Parcel 2 are retained."

    Reference is hereby made to said document for full particulars.

16. Intentionally Deleted.

17. Intentionally Deleted.

18. Intentionally deleted

19. Intentionally Deleted.

20. Any rights, interests, or claims which may exist or arise by reason of the following matters disclosed by survey,

    Job No.: 201300337-002
    Dated: 2/27/2013 last revised 3/1/2013
    Prepared by: FJS Land Consulting

    A) Intentionally Deleted
    B) An encroachment of an air conditioning unit over an easement for slope purposes. Said easement is described in item 8 above.
    C) Intentionally Deleted
    D) An encroachment of a loading dock over an easement for slope purposes. Said easement is described in item 8 above.
    E) An encroachment of a surface deck and a subterranean parking garage over an easement for utility purposes. Said easement is described in item 14 above.

F) Intentionally Deleted
G) Intentionally Deleted
H) Intentionally Deleted
I) Intentionally Deleted
J) Intentionally Deleted
K) Intentionally Deleted
L) Intentionally Deleted

21. Intentionally Deleted.

22. Open-End Mortgage, Assignment of Leases and Rents and Security Agreement given to secure the original amount shown below, and any other amount payable under the terms thereof.

Amount:	$103,770,000.00
Dated:	__/__/2013
Trustor/Grantor	**AGNL Clinic, L.P., a Delaware limited partnership**
Trustee:	Fidelity National Title Company
Beneficiary:	RBS Financial Products Inc., a Delaware corporation and The Royal Bank of Scotland plc
Recording Date:	__/__/2013
Recording No:	2013 _____

23. An assignment of all moneys due, or to become due as rental or otherwise from said Land, to secure payment of an indebtedness, shown below and upon the terms and conditions therein

Amount:	$TBD
Assigned to:	RBS Financial Products Inc., a Delaware corporation and The Royal Bank of Scotland plc
Assigned By:	**AGNL Clinic, L.P., a Delaware limited partnership**
Recording Date:	__/__/2013
Recording No:	2013 _____

24. A financing statement as follows:

Debtor:	**AGNL Clinic, L.P., a Delaware limited partnership**
Secured Party:	RBS Financial Products Inc., a Delaware corporation and The Royal Bank of Scotland plc
Recording Date:	__/__/2013
Recording No:	2013 _____

25. Any rights of the parties in possession of a portion of, or all of, said Land, which rights are not disclosed by the public records.

END OF SCHEDULE B

This is a pro forma policy furnished to or on behalf of the party to be insured. It neither reflects the present status of title, nor is it intended to be a commitment to insured. The inclusion of endorsements as a part of the pro forma policy in no way evidences the willingness of the company to provide any affirmative coverage shown therein. There are requirements which must be met before a final policy can be issued in the same form as the pro forma policy. A commitment to insure setting forth these requirements should be obtained from the Company.

Additional Matters may be added or other amendments may be made to this pro forma policy by reason of any defects, liens or encumbrances that appear for the first time in the Public Records or come to the attention of the Company and are created or attached between the issuance of this pro forma policy and the issuance of a policy of title insurance. The Company shall have no liability because of such addition or amendment.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued By
Fidelity National Title Insurance Company

1. The insurance provided by this endorsement is subject to the exclusions in Section 4 of this endorsement; and the Exclusions from Coverage, the Exceptions from Coverage contained in Schedule B, and the Conditions in the policy.

2. For the purposes of this endorsement only,

   a. "Covenant" means a covenant, condition, limitation or restriction in a document or instrument in effect at Date of Policy.

   b. "Improvement" means a building, structure located on the surface of the Land, road, walkway, driveway, or curb, affixed to the Land at Date of Policy and that by law constitutes real property, but excluding any crops, landscaping, lawn, shrubbery, or trees.

3. The Company insures against loss or damage sustained by the Insured by reason of:

   a. A violation on the Land at Date of Policy of an enforceable Covenant, unless an exception in Schedule B of the policy identifies the violation;

   b. Enforced removal of an Improvement as a result of a violation, at Date of Policy, of a building setback line shown on a plat of subdivision recorded or filed in the Public Records, unless an exception in Schedule B of the policy identifies the violation; or

   c. A notice of a violation, recorded in the Public Records at Date of Policy, of an enforceable Covenant relating to environmental protection describing any part of the Land and referring to that Covenant, but only to the extent of the violation of the Covenant referred to in that notice, unless an exception in Schedule B of the policy identifies the notice of the violation.

4. This endorsement does not insure against loss or damage (and the Company will not pay costs, attorneys' fees, or expenses) resulting from:

   a. any Covenant contained in an instrument creating a lease;

   b. any Covenant relating to obligations of any type to perform maintenance, repair, or remediation on the Land; or

   c. except as provided in Section 3.c., any Covenant relating to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured by reason of the failure of the Land as described in Schedule A to be the same as that identified on the survey made by FJS Land Consulting for Bock & Clark's National Surveyor's Network, dated February 27, 2013, last revised _____, 2013 and designated as Job No. 201300337-002.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured if, at Date of Policy (i) the Land does not abut and have both actual vehicular and pedestrian access to and from W Ocean Boulevard and Seaside Way (the "Street"), (ii) the Street is not physically open and publicly maintained, or (iii) the Insured has no right to use existing curb cuts or entries along that portion of the Street abutting the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements to it.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured by reason of the failure of a **Commercial improvement**, known as 200-300 Oceangate, Long Beach, CA, to be located on the Land at Date of Policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured by reason of the lack of a right of access to the following utilities or services: (CHECK ALL THAT APPLY)

X Water service X Natural gas service X Telephone service

X Electrical power service X Sanitary sewer X Storm water drainage

☐ ☐ ☐

either over, under or upon rights-of-way or easements for the benefit of the Land because of:

(1) a gap or gore between the boundaries of the Land and the rights-of-way or easements;

(2) a gap between the boundaries of the rights-of-way or easements; or

(3) a termination by a grantor, or its successor, of the rights-of-way or easements.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured by reason of the failure of the Land to constitute a lawfully created parcel according to the subdivision statutes and local subdivision ordinances applicable to the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured by reason of:

1. those portions of the Land identified below not being assessed for real estate taxes under the listed tax identification numbers or those tax identification numbers including any additional land:

   Parcel: Tax Identification Numbers:
   Parcel 2 of Schedule A 7278-003-035

   Parcel 3 of Schedule A 7278-003-036

2. the easements, if any, described in Schedule A being cut off or disturbed by the nonpayment of real estate taxes, Assessments or other charges imposed on the servient estate by a governmental authority.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements to it.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

1. The Company insures against loss or damage sustained by the Insured in the event that, at Date of Policy,

   a. according to applicable zoning ordinances and amendments, the Land is not classified Zone PD-6

   b. the following use or uses are not allowed under that classification:

      Office Building

   c. There shall be no liability under this paragraph 1.b. if the use or uses are not allowed as the result of any lack of compliance with any conditions, restrictions, or requirements contained in the zoning ordinances and amendments, including but not limited to the failure to secure necessary consents or authorizations as a prerequisite to the use or uses. This paragraph 1.c. does not modify or limit the coverage provided in Covered Risk 5.

2. The Company further insures against loss or damage sustained by the Insured by reason of a final decree of a court of competent jurisdiction either prohibiting the use of the Land, with any existing structure, as specified in paragraph 1.b.; or requiring the removal or alteration of the structure, because, at Date of Policy, the zoning ordinances and amendments have been violated with respect to any of the following matters:

   a. Area, width, or depth of the Land as a building site for the structure

   b. Floor space area of the structure

   c. Setback of the structure from the property lines of the Land

   d. Height of the structure, or

   e. Number of parking spaces.

3. There shall be no liability under this endorsement based on:

   a. the invalidity of the zoning ordinances and amendments until after a final decree of a court of competent jurisdiction adjudicating the invalidity, the effect of which is to prohibit the use or uses;

   b. the refusal of any person to purchase, lease or lend money on the Title covered by this policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured by reason of an environmental protection lien that, at Date of Policy, is recorded in the Public Records or filed in the records of the clerk of the United States district court for the district in which the Land is located, unless the environmental protection lien is set forth as an exception in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The Company insures against loss or damage sustained by the Insured by reason of:

1. the failure Parcels 2 and 3 described in Schedule A to be contiguous; or

2. the presence of any gaps, strips, or gores separating any of the contiguous boundary lines described above.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued by
Fidelity National Title Insurance Company

The policy is hereby amended by deleting Paragraph 13 of the Conditions, relating to Arbitration.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

PRO FORMA ENDORSEMENT
Attached to Policy No. Pro Forma-23021588
Issued By
Fidelity National Title Insurance Company

The Company hereby insures the insured against loss which said insured shall sustain, including costs of defense, in the event that any claim is made seeking the removal of any portion of the existing improvements on the land described in Schedule A (including lawns, shrubbery, or trees) by reason of the encroachments shown in Paragraph B, D and E of Exception 20, Schedule B, Part I hereon.

The total liability of the Company under said policy and any endorsements therein shall not exceed, in the aggregate, the face amount of said policy and costs which the Company is obligated under the conditions and stipulations thereof to pay.

This endorsement is made a part of said policy and is subject to the schedules, conditions and stipulations therein, except as modified by the provisions hereof.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Dated: **PRO FORMA**

Fidelity National Title Insurance Company

Countersigned by:

Pro Forma Specimen

Authorized Signature

This is a Pro Forma Endorsement. It does not reflect the present state of the Title and is not a commitment to (i) insure the Title or (ii) issue any of the attached endorsements. Any such commitment must be an express written undertaking on appropriate forms of the Company.

EXHIBIT O-2

Columbus Title Pro Forma

(attached)

Name and Address of Title Insurance Company

Fidelity National Title Insurance Company

PO Box 45023

Jacksonville, FL 32232-5023

Policy No.: PROFORMA

Amount of Insurance: $24,000,000.00

Date of Policy: PROFORMA

1. Name of Insured:

   AGNL Clinic, L.P., a Delaware limited partnership

2. The estate or interest in the Land that is insured by this policy is:

   Fee Simple

3. Title is vested in:

   AGNL Clinic, L.P., a Delaware limited partnership

4. The Land referred to in this policy is described as follows:

   See attached Exhibit “A”

THIS IS A PRO FORMA POLICY FURNISHED TO OR ON BEHALF OF THE PARTY TO BE INSURED. IT DOES NOT REFLECT THE PRESENT STATUS OF TITLE AND IS NOT A COMMITMENT TO INSURE THE ESTATE OR INTEREST AS SHOWN HEREIN, NOR DOES IT EVIDENCE THE WILLINGNESS OF THE COMPANY TO PROVIDE AN AFFIRMATIVE COVERAGE SHOWN HEREIN. ANY SUCH COMMITMENT MUST BE AN EXPRESS WRITTEN UNDERTAKING ON APPROPRIATE FORMS OF THE COMPANY.

Countersigned:

Authorized Officer or Agent

Exhibit A

Policy Number:

PARCEL 1:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 13.727 acre tract, and all of the 0.875 acre tract conveyed to 17 Land Realty Corp. by deeds of record in O.R. 14066 B11 and O.R. 25716 J11, respectively, records of the Recorder's Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning at a railroad spike set at the intersection of the Southerly right-of-way line of Interstate 270 (FRA -270-18.32N) and centerline of Cooper Road (60 feet in width). Said railroad spike being the Northeasterly corner of said 0.875 acre tract;

Thence South 26 deg. 55' 00" East, a distance of 241.79 feet, along said centerline of Cooper Road and Easterly line of said 0.875 acre tract, to a railroad spike set at the Southeasterly corner of said 0.875 acre tract;

Thence North 78 deg. 47' 04" West, a distance of 38.14 feet, along the Southerly line of said 0.875 acre tract, to an iron pin set in the Westerly right-of-way line of said Cooper Road;

Thence South 26 deg. 55' 00" East, a distance of 295.14 feet, along said Westerly right-of-way line of Cooper Road and along the Easterly line of said 13.727 acre tract, to an iron pin set at the point of curvature in the Northerly right-of-way line of Corporate Exchange Drive (60 feet in width) of record in Plat Book 60, Page 22 and 23;

Thence the following four (4) courses and distances along said Northerly right-of-way line of Corporate Exchange Drive and Southerly line of said 13.727 acre tract;

1. Thence along arc of said curve to the right having a radius of 35.00 feet, a central angle of 90 deg. 00' 00", and a chord bearing South 18 deg. 05' 00" West, a chord distance of 49.50 feet to the point of tangency;

2. Thence South 63 deg. 05' 00" West, a distance of 35.00 feet, to an iron pin found at the point of curvature;

3. Thence along arc of said curve to the right having a radius of 270.00 feet, a central angle of 28 deg. 56' 27", and a chord bearing South 77 deg. 33' 14" West, a chord distance of 134.94 feet, to an iron pin set at the point of tangency;

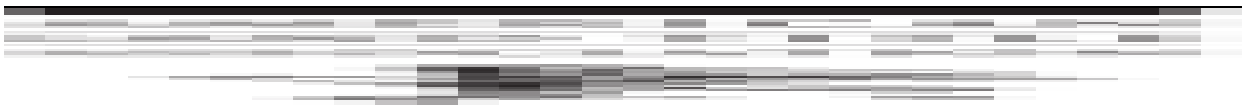
4. Thence North 87 deg. 58' 33" West, a distance of 788.06 feet, to an railroad spike set;

Exhibit A continued

Policy Number:

Thence North 02 deg. 01' 27" East, a distance of 318.00 feet across said 13.727 acre tract to a railroad spike set in a Southerly line of the 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence South 87 deg. 58' 33" East, a distance of 15.00 feet along said Southerly line of the 5.103 acre tract to a railroad spike set at a Southeasterly corner of said 5.103 acre tract;



Thence the following three (3) courses and distances along the Easterly lines to said 5.103 acre tract;

1. Thence North 02 deg. 01' 27" East, a distance of 185.00 feet, to a P.K. nail found;

2. Thence South 87 deg. 58' 33" East, a distance of 57.50 feet, to a railroad spike set;

3. Thence North 02 deg. 01' 27" East, a distance of 167.21 feet, to an iron pin set in aforesaid Southerly right-of-way line of Interstate 270 at a Northeasterly corner of said 5.103 acre tract;

Thence South 78 deg, 46' 49" East, a distance of 677.06 feet, along said Southerly right-of-way line of Interstate 270 and partly along the Northerly line of said 13.727 acre tract and partly along the Northerly line aforesaid 0.875 acre tract, to the point of beginning.

Containing 11.814 acres, more or less, of which 0.167 acres lies within the Cooper Road right-of-way.

The bearings in the above description are based on the bearing of South 87 deg. 58' 33" East, for the centerline of Corporate Exchange Drive, as shown on the dedication Plat for Corporate Exchange Drive, of record in Deed Book 60, Page 22 and 23, records of the Recorder's Office, Franklin County, Ohio.

PARCEL 2:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 4.500 and 13.727 acre tracts conveyed to 17 Land Realty Corp. by deed of record in O.R. 14066 B11, Records of the Recorder's Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning for reference at a PK nail found at the centerline intersection of Presidential Gateway (60 feet in width) as established by the Plat of record in Plat Book 83, Page 80 and Corporate Exchange Drive (60 feet in width) as established by the Plat of record in Plat Book 60, Page 22;

Thence North 87 deg. 58' 33" West, a distance of 329.18 feet along the centerline of Corporate Exchange Drive to a point;

Exhibit A continued

Policy Number:

Thence North 02 deg. 01' 27" East, a distance of 30.00 feet, to a railroad spike set on the Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 acre tract and being the point of true beginning;

Thence the following three (3) courses and distances along the said Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 and 4.500 acre tracts;

1. Thence North 87 deg. 58' 33" West, a distance of 94.38 feet to an iron pin set at a point of curvature;

2. Thence along the arc of said curve to the right, having a radius of 420.00 feet, a central angle of 27 deg. 22' 54", a chord bearing North 74 deg. 17' 06" West, and a chord distance of 198.81 feet to an iron pin found at the point of tangency;

3. Thence North 60 deg. 35’ 39” West, a distance of 28.10 feet to an iron pin set at a Southeasterly corner of a 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence the following two (2) courses and distance along the Easterly and Southerly lines of said 5.103 acre tracts;

1. Thence North 02 deg. 01’ 27” East, a distance of 258.02 feet to a railroad spike set;

2. Thence South 87 deg. 58’ 33” East, a distance of 31250 feet to a railroad spike set;

Thence South 02 deg. 01’ 27” West, a distance of 318.00 feet across said 13.727 acre tract to the point of true beginning, containing 2.183 acres, more or less, subject to all easements, restrictions and rights-of-way of record.

Schedule B
EXCEPTIONS FROM COVERAGE

Policy Number:

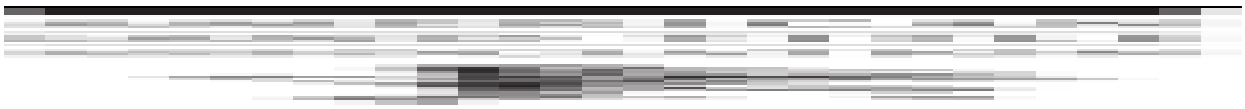
This policy does not insure against loss or damage, and the Company will not pay costs, attorneys' fees, or expenses that arise by reason of:

1. ~~Defects, liens, encumbrances adverse claims or other matters, if any, created, first appearing in the public records or attaching subsequent to the effective date hereof but prior to the date the proposed insured acquires for value of record the estate or interest or mortgage thereon.~~ Intentionally deleted.
2. ~~Assessments, if any, not yet certified to the County Auditor.~~ Intentionally deleted.
3. ~~Rights or claims of parties other than Insured in actual possession of any or all of the property.~~ Intentionally deleted.
4. ~~Any encroachment, encumbrances, violation, variation or adverse circumstance affecting the Title that would be disclosed by an accurate and complete land Insurvey of the Land. The term "encroachment" includes encroachments of existing improvements located on the Land onto adjoining land, and encroachments onto the Land of existing improvements located on adjoining land.~~ Intentionally deleted.
5. ~~Unfiled mechanic's or materialman's liens.~~ Intentionally deleted.
6. ~~No liability is assumes for tax increases occasioned by retroactive revaluation change in land usage, or loss of any homestead exemption status for insured premises.~~ Intentionally deleted.
7. ~~Any inaccuracy in the specific quantity of acreage contained on any survey if any or contained with the legal description of premises insured herein.~~ Intentionally deleted.
8. ~~Any covenant, condition or restriction referred to herein indicating a preference, limitation or discrimination based on race, color, religion, sex, handicap, familial status or national origin is omitted as provided in 42 U.S.C. Section 3604, unless and only to the extent that the restriction (a) is not in violation of state or federal law, (b) is exempt under 42 U.S.C. Section 3607, or (c) related to handicap, but does not discriminate against handicapped people.~~ Intentionally deleted.
9. ~~Covenants, conditions and restrictions and other instruments recorded in the public records and purporting to impose a transfer fee or conveyance fee payable upon the conveyance of a interest in real property or payable for the right to make or accept such a transfer, and any and all fees, liens or charges, whether recorded or unrecorded, if any, currently due payable or that will become due or payable, and any other rights deriving therefrom, that are assessed pursuant thereto.~~ Intentionally deleted.
10. ~~Oil and gas leases, pipeline agreements or any other instruments related to the production or sale of oil and gas which may arise subsequent to the date of the Policy.~~ Intentionally deleted.

Schedule B continued

Policy Number:

11. Any lease, grant, exception or reservation of minerals or mineral rights together with any rights appurtenant thereto.



12. Reservations, restrictions, covenants, limitations, easements and/or other conditions as shown on plat filed for record June 30, 1983, in Plat Book 60, Page 22, of the Franklin County Records as shown on survey prepared by David 1 Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043,

13. Easement for Pole Line to The Columbus Railway Power and Light Company, filed for record November 4, 1932, in Deed Book 982, Page 352, of the Franklin County Records.

14. Easement to Columbus and Southern Ohio Electric Company, filed for record October 22, 1965, in Deed Book 2687, Page 577, of the Franklin County Records as shown on survey prepared by David J. Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043,

~~15. Right of Way to Columbia Gas of Ohio, Inc., filed for record May 13, 1966, in Deed Book 2732, Page 586 of the Franklin County Records.~~ Intentionally deleted.

16. Easement to the City of Columbus, filed for record August 1, 1972, in Deed Book 3258, Page 232, of the Franklin County Records as shown on survey prepared by David J. Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043,

17. Protective Covenants for Corporate Exchange, filed for record April 14, 1983 in Official Record 2681E15, of the Franklin County Records as shown on survey prepared by David J. Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043.

    First Supplement to Protective Covenants for Corporate Exchange, filed for record April 3, 1984 in Official Record 4063I14, of the Franklin County Records,

    Second Supplement to Protective Covenants for Corporate Exchange, filed for record June 7, 1988 in Official Record 11707E20, of the Franklin County Records.

    Third Supplement to Protective Covenants for Corporate Exchange, filed for record June 28, 1988 in Official Record 11831G13, of the Franklin County Records,

18. Easement to Columbus and Southern Ohio Electric Company, filed for record August 11, 1983, in Official Record 3169B07, of the Franklin County Records as shown on survey prepared by David J. Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043.

Schedule B continued

Policy Number:

19. Easement to Columbus and Southern Ohio Electric Company, filed for record January 18, 1985, in Official Record 5276E08, of the Franklin County Records as shown on survey prepared by David J.,

    Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043.

20. Easement to The Ohio Bell Telephone Company, filed for record November 27, 1992, in Official Record 21144J02, of the Franklin County Records as shown on survey prepared by David J. Kuethe, Registered

Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043.

21. Easement Agreement by and between Land Realty Corp. and Corporate Exchange Buildings IV and V Limited Partnership, filed for record November 5, 1993 in Official Record 24554B10, of the Franklin County Records as shown on survey prepared by David J. Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043.

22. Easement & Right-of-Way to Columbus Southern Power Company, filed for record March 29, 1999, in Instrument No. 199903290076085, of the Franklin County Records as shown on survey prepared by David J. Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2013, last revised April 22, 2013, having Job No. 1201300043.

23. Easement for parking, ingress and egress to Corporate Exchange Buildings IV & V Limited Partnership, filed for record July 27, 1999, in Instrument No. 199907270190224, of the Franklin County Records,

24. Non-exclusive Ingress and Egress and Parking Easement to Cass Information Systems, Inc. as established in Deed of Easement recorded December 5, 2007, in Instrument No. 200712050209493, of the Franklin County Records.

25. Open-End Mortgage, Assignment of Leases and Rents and Security Agreement from AGNL Clinic, L.P., a Delaware limited partnership to RBS Financial Products Inc., a Delaware corporation and The Royal Bank of Scotland plc, a Delaware corporation, dated _____, in the principal sum of $100,500,000.00, filed for record ___ of Franklin County Records as Instrument No._____.

26. Assignment of Leases and Rents by and between AGNL Clinic, L.P., a Delaware limited partnership to RBS Financial Products Inc. and RBS Financial Products Inc., a Delaware corporation and The Royal Bank of Scotland plc, a Delaware corporation, dated _____, filed for record ___ of Franklin County Records as Instrument No. _____.

27. UCC Financing Statement from AGNL Clinic, L.P., a Delaware limited partnership, Debtor to RBS Financial Products Inc. and RBS Financial Products Inc., a Delaware corporation and The Royal Bank of Scotland plc, a Delaware corporation, Secured Party, filed for record ___ of Franklin County Records as Instrument No. _____.

Schedule B continued

Policy Number:

28. Rights of Molina Healthcare, Inc., a Delaware corporation, as tenant in possession only, as evidenced by that certain Memorandum of Lease by and between AGNL Clinic, L.P., a Delaware limited partnership,

    as landlord and Molina Healthcare, Inc., as tenant, filed for record _____, 2013 in Official Record _____, of the Franklin County, Ohio records.

29. Subordination, Non-Disturbance and Attornment Agreement by and between AGNL Clinic, L.P., as landlord and Molina Healthcare, Inc., as tenant, and RBS Financial Products Inc., a Delaware corporation and The Royal Bank of Scotland plc, a Delaware corporation (Lender) filed for record _____, 2013 in Official Record _____, of the Franklin County, Ohio records.

~~26. Liens in favor of the State of Ohio filed, but not yet indexed in the dockets of the Franklin County Common Pleas Clerk.~~ Intentionally deleted.

30. Taxes for the second half of 2012 and subsequent years are a lien, but are not yet due and payable.

The County Treasurer's General Tax Records for the tax year 2012 are as follows

PPN 600-122680-00
Taxes for the first half are paid.
Taxes for the second half are a line, not yet due and payable.
Per half amount $192,733.72.

PPN 600-215203-00
Taxes for the first half are paid.
Taxes for the second half are a lien, not yet due and payable.
Per half amount $5,940.81.

ENDORSEMENT
Attached to and forming a part of
Owners Policy No. 508130029
Issued by
FIDELITY NATIONAL TITLE INSURANCE COMPANY

ARBITRATION ENDORSEMENT

Paragraph 14 (Arbitration) of the Conditions and Stipulations of this policy is hereby amended to provide that all arbitrable matters, regardless of the Amount of Insurance provided herein, shall be arbitrated only when agreed to by both the Company and the Insured.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

FIDELITY NATIONAL TITLE INSURANCE COMPANY

Authorized Signature

THIS IS A PROFORMA ENDORSEMENT FURNISHED TO OR ON BEHALF OF THE PARTY TO BE INSURED. IT DOES NOT REFLECT THE PRESENT STATUS OF TITLE AND IS NOT A FINAL ENDORSEMENT TO INSURE THE ESTATE OR INTEREST AS SHOWN HEREIN NOR DOES IT EVIDENCE THE WILLINGNESS OF THE COMPANY TO PROVIDE AN AFFIRMATIVE COVERAGE SHOWN HEREIN. ANY SUCH COMMITMENT MUST BE AN EXPRESS WRITTEN UNDERTAKING ON APPROPRIATE FORMS OF THE COMPANY

ENDORSEMENT
Attached to Policy No. Proforma
Issued by
Fidelity National Title Insurance Company

ALTA Endorsement Form 3.1-06 Zoning-Completed Structure

1. The Company insures against loss or damage sustained by the Insured in the event that, at Date of Policy,

   a. according to applicable zoning ordinances and amendments, the Land is not classified Zone C2-Office Commercial in the H-110 Height District 110 with Parcel Two (parking lot) being located in the CPD, Planned Commercial Zoning District;

   b. the following use or uses are not allowed under that classification: General Office Building and parking lot;

   c. There shall be no liability under this paragraph 1.b. if the use or uses are not allowed as the result of any lack of compliance with any conditions, restrictions, or requirements contained in the zoning ordinances and amendments, including but not limited to the failure to secure necessary consents or authorizations as a prerequisite to the use or uses, This paragraph 1.c. does not modify or limit the coverage provided in Covered Risk 5.

2. The Company further insures against loss or damage sustained by the Insured by reason of a final decree of a court of competent jurisdiction either

   prohibiting the use of the Land, with any existing structure, as specified in paragraph 1.b.; or

   requiring the removal or alteration of the structure, because, at Date of Policy, the zoning ordinances and amendments have been violated with respect to any of the following matters:

   a. Area, width, or depth of the Land as a building site for the structure

   b. Floor space area of the structure

   c. Setback of the structure from the property lines of the Land

   d. Height of the structure, or

   e. Number of parking spaces.

3. There shall be no liability under this endorsement based on:

   a. the invalidity of the zoning ordinances and amendments until after a final decree of a court of competent jurisdiction adjudicating the invalidity, the effect of which is to prohibit the use or uses;

   b. the refusal of any person to purchase, lease or lend money on the Title covered by this policy.

End. — ALTA 3.1-06 Zoning – Completed Structure (10/22/09)

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Fidelity National Title Insurance Company

By: _____
Authorized Signature

THIS IS A PROFORMA ENDORSEMENT FURNISHED TO OR ON BEHALF OF THE PARTY TO BE INSURED IT DOES NOT REFLECT THE PRESENT STATUS OF TITLE AND IS NOT A FINAL ENDORSEMENT TO INSURE THE ESTATE OR INTEREST AS SHOWN HEREIN NOR DOES IT EVIDENCE THE WILLINGNESS OF THE COMPANY TO PROVIDE AN AFFIRMATIVE COVERAGE SHOWN HEREIN ANY SUCH COMMITMENT MUST BE AN EXPRESS WRITTEN UNDERTAKING ON APPROPRIATE FORMS OF THE COMPANY

End – ALTA Form
Form

ENDORSEMENT
Attached to Policy No. Proforma
Issued by
Fidelity National Title Insurance Company

Commercial Environmental Protection Lien ALTA 8.2

The Company insures against loss or damage sustained by the Insured by reason of an environmental protection lien that, at Date of Policy, is recorded in the Public Records or filed in the records of the clerk of the United States district court for the district in which the Land is located, unless the environmental protection lien is set forth as an exception in Schedule B.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Fidelity National Title Insurance Company

By:

Authorized Signature

THIS IS A PROFORMA ENDORSEMENT FURNISHED TO OR ON BEHALF OF THE PARTY TO BE INSURED IT DOES NOT REFLECT THE PRESENT STATUS OF TITLE AND IS NOT A FINAL ENDORSEMENT TO INSURE THE ESTATE OR INTEREST AS SHOWN HEREIN NOR DOES IT EVIDENCE THE WILLINGNESS OF THE COMPANY TO PROVIDE AN AFFIRMATIVE COVERAGE SHOWN HEREIN. ANY SUCH COMMITMENT MUST BE AN EXPRESS WRITTEN UNDERTAKING ON APPROPRIATE FORMS OF THE COMPANY

ENDORSEMENT
Attached to Policy No. PROFORMA
Issued By
Fidelity National Title Insurance Company

ALTA 9.2-06 Covenants, Conditions and Restrictions - Improved Land - Owner's Policy

1. The insurance provided by this endorsement is subject to the exclusions in Section 4 of this endorsement; and the Exclusions from Coverage, the Exceptions from Coverage contained in Schedule B, and the Conditions in the policy.

2. For the purposes of this endorsement only,

   a. "Covenant" means a covenant, condition, limitation or restriction in a document or instrument in effect at Date of Policy.

   b. "Improvement" means a building, structure located on the surface of the Land, road, walkway, driveway, or curb, affixed to the Land at Date of Policy and that by law constitutes real property, but excluding any crops, landscaping, lawn, shrubbery, or trees

3. The Company insures against loss or damage sustained by the Insured by reason of:

   a. A violation on the Land at Date of Policy of an enforceable Covenant, unless an exception in Schedule B of the policy identifies the violation;

   b. Enforced removal of an Improvement as a result of a violation, at Date of Policy, of a building setback line shown on a plat of subdivision recorded or filed in the Public Records, unless an exception in Schedule B of the policy identifies the violation; or

   c. A notice of a violation, recorded in the Public Records at Date of Policy, of an enforceable Covenant relating to environmental protection describing any part of the Land and referring to that Covenant, but only to the extent of the violation of the Covenant referred to in that notice, unless an exception in Schedule B of the policy identifies the notice of the violation.

4. This endorsement does not insure against loss or damage (and the Company will not pay costs, attorneys' fees, or expenses) resulting from:

   a. any Covenant contained in an instrument creating a lease;

   b. any Covenant relating to obligations of any type to perform maintenance, repair, or remediation on the Land; or

   c. except as provided in Section 3.c., any Covenant relating to environmental protection of any kind or nature, including hazardous or toxic matters, conditions, or substances.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or

a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements

Fidelity National Title Insurance Company

Authorized Signatory

THIS IS A PROFORMA ENDORSEMENT FURNISHED TO OR ON BEHALF OF THE PARTY TO BE INSURED. IT DOES NOT REFLECT THE PRESENT STATUS OF TITLE AND IS NOT A FINAL ENDORSEMENT TO INSURE THE ESTATE OR INTEREST AS SHOWN HEREIN NOR DOES IT EVIDENCE THE WILLINGNESS OF THE COMPANY TO PROVIDE AN AFFIRMATIVE COVERAGE SHOWN HEREIN. ANY SUCH COMMITMENT MUST BE AN EXPRESS WRITTEN UNDERTAKING ON APPROPRIATE FORMS OF THE COMPANY.

ENDORSEMENT
Attached to Policy No. Proforma
Issued by
Fidelity National Title Insurance Company

ALTA Endorsement Form 17-06 Access and Entry

The Company insures against loss or damage sustained by the Insured if, at Date of Policy (i) the Land does not abut and have both actual vehicular and pedestrian access to and from Corporate Exchange Drive and Cooper Road (the "Street"), (ii) the Street is not physically open and publicly maintained, or (iii) the Insured has no right to use existing curb cuts or entries along that portion of the Street abutting the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Fidelity National Title Insurance Company

By

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ENDORSEMENT
Attached to
Owner's Policy No. Proforma
Issued by
Fidelity National Title Insurance Company

ALTA Form 17.2-06 Utility Access

The Company insures against loss or damage sustained by the Insured by reason of the lack of a right of access to the following utilities or services:

__X__Water service __X__Natural gas service __X__Telephone service
__X__Electrical power service __X__Sanitary sewer __X__Storm water drainage

either over, under or upon rights-of-way or easements for the benefit of the Land because of:

(1) a gap or gore between the boundaries of the Land and the rights-of-way or easements;

(2) a gap between the boundaries of the rights-of-way or easements; or

(3) a termination by a grantor, or its successor, of the rights-of-way or easements.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

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ENDORSEMENT
Attached to Policy No. Proforma
Issued By
Fidelity National Title Insurance Company

ALTA Endorsement Form 18.1-06 Multiple Tax Parcel

The Company insures against loss or damage sustained by the Insured by reason of:

1. those portions of the Land identified below not being assessed for real estate taxes under the listed tax identification numbers or those tax identification numbers including any additional land:

   600-122680-00 600-215203-00

2. the easements, if any, described in Schedule A being cut off or disturbed by the nonpayment of real estate taxes assessed against the servient estate

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Fidelity National Title Insurance Company

By

Authorized Signature

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ENDORSEMENT
Attached to Policy No. Proforma
Issued by
Fidelity National Title Insurance Company

ALTA Endorsement Form 19-06 Contiguity — Multiple Parcels

The Company insures against loss or damage sustained by the Insured by reason of:

1. the failure of the boundary line of Fee Parcel 1 of the land to be contiguous to the boundary line of Fee Parcel 2: or

2. the presence of any gaps, strips, or gores separating any of the contiguous boundary lines described above.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Fidelity National Title Insurance Company

By

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ENDORSEMENT
Attached to Policy No. Proforma
Issued by
Fidelity National Title Insurance Company

ALTA Endorsement Form 22-06 (Location)

The Company insures against loss or damage sustained by the Insured by reason of the failure of a 7 story brick and glass building, known as 3000 Corporate Exchange Drive, Columbus, OH, to be located on the Land at Date of Policy.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the tetras and provisions of the policy and of any prior endorsements.

Fidelity National Title Insurance Company

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ENDORSEMENT
Attached to and forming a part of
Policy No. Proforma
Issued by
FIDELITY NATIONAL TITLE INSURANCE COMPANY

ALTA Form 25-06 Same as Survey

The Company hereby insures against loss or damage, which the Insured shall sustain by reason of the failure of the land to be the same as that delineated on the plat of survey made by David J. Kuethe, Registered Surveyor No. 7911 of Bock & Clark's National Surveyors Network, dated February 27, 2012, last revised April 11, 2013, having Job No. 1201300043.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

FIDELITY NATIONAL TITLE INSURANCE COMPANY

Authorized Signature

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ALTA Endorsement Form 25-06
(Same as Survey) (10/16/08)

ENDORSEMENT
Attached to Policy No. PROFORMA
Issued by
Fidelity National Title Insurance Company

ALTA Form 26-06 Subdivision

The Company insures against loss or damage sustained by the Insured by reason of the failure of the Land to constitute a lawfully created parcel according to the subdivision statutes and local subdivision ordinances applicable to the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

Fidelity National Title Insurance Company

By

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ENDORSEMENT
Attached to Policy No. PROFORMA
Issued by
Fidelity National Title Insurance Company

ALTA Form 28-06 Easement-Damage or Enforced Removal

The Company insures against loss or damage sustained by the Insured if the exercise of the granted or reserved rights to use or maintain the easement(s) referred to in Exception(s) 12, 13, 14, 16, 17, 18, 19, 20, 21, 22 and 23 of Schedule B results in:

(1) damage to an existing building located on the Land, or

(2) enforced removal or alteration of an existing building located on the Land.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements.

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ENDORSEMENT
Attached to Policy No. PROFORMA
Issued By
Fidelity National Title Insurance Company

ALTA 35-06 Minerals and Other Subsurface Substances - Buildings

1. The insurance provided by this endorsement is subject to the exclusion in Section 4 of this endorsement; and the Exclusions from Coverage, the Exceptions from Coverage contained in Schedule B, and the Conditions in the policy

2. For purposes of this endorsement only, "Improvement" means a building on the Land at Date of Policy.

3. The Company insures against loss or damage sustained by the insured by reason of the enforced removal or alteration of any Improvement resulting from the future exercise of any right existing at Date of Policy to use the surface of the Land for the extraction or development of minerals or any other subsurface substances excepted from the description of the Land or excepted in Schedule B

4. This endorsement does not insure against loss or damage (and the Company will not pay costs, attorneys' fees, or expenses) resulting from:

   a. contamination, explosion, fire, vibration, fracturing, earthquake or subsidence; [or]

   b. negligence by a person or an Entity exercising a right to extract or develop minerals or other subsurface substances[; or

   c. the exercise of the rights described in NONE.

This endorsement is issued as part of the policy. Except as it expressly states, it does not (i) modify any of the terms and provisions of the policy, (ii) modify any prior endorsements, (iii) extend the Date of Policy, or (iv) increase the Amount of Insurance. To the extent a provision of the policy or a previous endorsement is inconsistent with an express provision of this endorsement, this endorsement controls. Otherwise, this endorsement is subject to all of the terms and provisions of the policy and of any prior endorsements

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EXECUTION COPY

LEASE AGREEMENT

by and between

AGNL CLINIC, L.P.,

a Delaware limited partnership,

as LANDLORD

and

MOLINA HEALTHCARE, INC.,

a Delaware corporation,

as TENANT

Premises: 200 & 300 Oceangate Blvd., Long Beach, CA
3000 Corporate Exchange, Columbus, OH

Dated as of: June 13, 2013

TABLE OF CONTENTS

SCHEDULES

EXHIBITS

This LEASE AGREEMENT (as amended, supplemented or modified, this " Lease"), made as of this 13th day of June, 2013 (the "Effective Date"), between AGNL CLINIC, L.P., a Delaware limited partnership (together with its successors and assigns "Landlord"), with an address at c/o Angelo, Gordon & Co., L.P., 245 Park Avenue, 26th Floor New York, New York 10167-0094, and MOLINA HEALTHCARE, INC., a Delaware corporation (together with its successors and permitted assigns, " Tenant", collectively with Landlord the "Parties" and each individually a "Party") with an address at 300 Oceangate Blvd., Suite 950, Long Beach, CA 90802.

In consideration of the rents and provisions herein stipulated to be paid and performed, Landlord and Tenant hereby covenant and agree as follows:

1. Demise of Premises. Landlord hereby demises and lets to Tenant, and Tenant hereby takes and leases from Landlord, for the term and upon the provisions hereinafter specified, the following described property (collectively and individually, as the context may require, the "Leased Premises"):

(a) The "Columbus Leased Premises," which means:

(i) the real property located in Columbus, Ohio particularly described in Exhibit A-1 (the "Columbus Real Property");

(ii) the buildings and all other structures and improvements situated on, or affixed or appurtenant to the Columbus Real Property, including any Parking Facilities owned by Landlord in each case except to the extent owned by subtenants or licensees at the Columbus Real Property (collectively, the "Columbus Improvements");

(iii) all tenements, hereditaments, easements, rights-of-way, rights, privileges appurtenant to the Columbus Real Property, including (A) easements over other lands granted by any easement agreement benefiting the Columbus Real Property, including any Parking Easement, and (B) Landlord's right, title and interest in and to any streets, ways, alleys, vaults, gores or strips of land adjoining the Columbus Real Property (collectively, the "Columbus Appurtenances"); and

(iv) all Columbus Property Other Assets.

(b) The "Long Beach Leased Premises," which means:

(i) the real property located in Long Beach, CA particularly described in Exhibit A-2 (the " Long Beach Real Property");

(ii) the buildings and all other structures and improvements situated on, or affixed or appurtenant to the Long Beach Real Property, including any Parking Facilities owned by Landlord in each case except to the extent owned by subtenants or licensees at the Long Beach Real Property (collectively, the "Long Beach Improvements");

(iii) all tenements, hereditaments, easements, rights-of-way, rights, privileges appurtenant to the Long Beach Real Property, including (A) easements over other lands granted by any easement agreement benefiting the Long Beach Real Property, including any Parking Easement,

and (B) Landlord's right, title and interest in and to any streets, ways, alleys, vaults, gores or strips of land adjoining the Long Beach Real Property (collectively, the "Long Beach Appurtenances"); and

(iv) all Long Beach Property Other Assets.

2. Certain Definitions.

"AAA" is defined in Exhibit D-1.

"Acquisition Cost" means, with respect to any Leased Premises, the Acquisition Cost specified in Exhibit E for such Leased Premises.

"Action" is defined in Paragraph 35(b)(i).

"Additional Rent" is defined in Paragraph 7(a).

"Affiliate" means in relation to any Person, any other Person directly or indirectly controlling, controlled by, or under common control with, the first Person (and, for purposes of this definition, "controlling", "controlled by" and "under common control with" means the possession directly or indirectly of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise).

"Alterations" means all alterations, changes, additions, improvements, reconstructions, restorations, renewals, repairs, replacements or removals of, and all substitutions or replacements for, any of the Improvements, Fixtures or Equipment, both interior and exterior, structural and non-structural, capital and non-capital, and ordinary and extraordinary.

"Appurtenances" means the Columbus Appurtenances and the Long Beach Appurtenances.

"Asset Transfer" is defined in Paragraph 21(c).

"Assignment" means any assignment of rents and leases by Landlord that encumbers any of the Leased Premises, as the same may be amended, supplemented or modified from time to time.

"Bankruptcy Code" means the United States Bankruptcy Reform Act of 1998, as amended, or any similar law or statute of the United States or any state thereof.

"Basic Rent" is defined in Paragraph 6(a).

"Basic Rent Adjustment Date" is defined in Exhibit D.

"Basic Rent Payment Date" is defined in Exhibit D.

"Business Day" means any day other than a Saturday, Sunday or a day on which commercial banks in New York, New York are required or authorized to be closed.

"Casualty" means any loss of or damage to or destruction of all or any portion of any of the Leased Premises by fire or other casualty event.

"Code" is defined in Paragraph 32.

"Columbus Appraisers" is defined in Exhibit D-1.

"Columbus Appurtenances" is defined in Paragraph 1(a)(iii).

"Columbus FMBR" is defined in Exhibit D-1.

"Columbus Improvements" is defined in Paragraph 1(a)(ii).

"Columbus Leased Premises" is defined in Paragraph 1(a).

"Columbus Property Equipment" is defined in Exhibit B-1.

"Columbus Property Excluded Items" is defined in Exhibit B-1.

"Columbus Property Other Assets" is defined in Exhibit B-1.

"Columbus Real Property" is defined in Paragraph 1(a)(i).

"Commencement Date" is defined in Paragraph 5(a).

"Condemnation" means (a) any taking of all or a portion of any of the Leased Premises (i) in or by condemnation or other eminent domain proceedings pursuant to any Law, (ii) by reason of any agreement with any condemning authority in settlement of or under threat of any such condemnation or other eminent domain proceeding, or (iii) Requisition. A Condemnation shall be considered to have taken place as of the later of the date actual physical possession is taken by the condemning authority, or the date on which the right to compensation and damages accrues under the applicable Law.

"Condemnation Notice" means notice or knowledge of the institution of or any threatened institution of any proceeding for Condemnation.

"Control" is defined in Paragraph 21(d).

"Control Person" is defined in Paragraph 21(d).

"Costs" of a Person directly related to a specified transaction or occurrence means all reasonable third-party out-of-pocket costs and expenses incurred by such Person or associated with such transaction, including without limitation, reasonable attorneys' fees and expenses, reasonable consultants' fees and expenses, reasonable travel costs, court costs, reasonable real estate brokerage fees, title insurance premiums and expenses, recording taxes and fees, and transfer taxes, but excluding (in the case of Costs of Landlord) (i) all costs, expenses, and fees associated with the day-to-day management of the Leased Premises and the Lease, and (ii) all costs, expenses and fees associated with any Note or Loan including, without limitation, any Prepayment Premium (provided,

however, that the foregoing shall not limit any express obligation in this Lease of Tenant to pay a Prepayment Premium).

"CPI" means the Consumer Price Index for All Urban Consumers (CPI-U) for the U.S. City Average for All Items (1982-84=100), published by the Bureau of Labor Statistics of the U.S. Department of Labor. If the CPI is not published for any month during the Term, Landlord, in its reasonable discretion, shall substitute a comparable index published by the Bureau of Labor Statistics of the U.S. Department of Labor. If such an index is not published by the Bureau of Labor Statistics, Landlord, in its reasonable discretion, shall select a comparable index published by a nationally recognized responsible financial periodical.

"Credit Entity" means any Person that has a publicly traded debt rating of "Baa" or better from Moody's or a rating of "BBB" or better from S&P (or, if such Person does not then have publicly traded rated debt, a determination by either of such Rating Agencies that such Person's unsecured senior debt would be so rated by such Rating Agency and will not be on "Negative Credit Watch"), and in the event both such Rating Agencies cease to furnish such ratings, then a comparable rating by any rating agency acceptable to Landlord.

"Default Rate" is defined in Paragraph 7(a)(iii).

"Diesel Tank" is defined in Paragraph 10(l).

"Easement Agreement" means any condition, covenant, restriction, easement, declaration, right of way, license or other agreement listed as a Permitted Encumbrance or as may hereafter affect any of the Leased Premises.

"EBITDA" means, for any Person, Net Income *plus*, to the extent deducted from revenues in determining Net Income, (i) Interest Expense, (ii) expense for income taxes paid or accrued, (iii) depreciation, (iv) amortization, (v) non-cash expenses, charges, or losses and (vi) extraordinary or non-recurring charges or losses realized other than in the ordinary course of business *minus*, to the extent included in Net Income, (1) income tax credits and refunds (to the extent not netted from tax expense), (2) any cash payments made during such period in respect of items described in clause (v) above subsequent to the fiscal quarter in which the relevant non-cash expenses or losses were incurred, (3) extraordinary or non-recurring income or gains realized other than in the ordinary course of business and (4) non-cash income or gains, all calculated for such Person in accordance with GAAP on a consolidated basis.

"EBITDAR" means, for any Person, for the most recent twelve (12) month period where applicable financial information is reasonably available, EBITDA plus, to the extent deducted from revenues in determining Net Income, Rental Expense, calculated in accordance with GAAP on a consolidated basis for such period.

"Effective Date" is defined in the introductory Paragraph.

"Environmental Adverse Condition" means the presence or likely presence of any Hazardous Substances on a property under conditions that indicate an existing release, a past release, or material threat of a release of any Hazardous Substances into structures at any of the Leased Premises or

into or on the ground, ground water, or surface water of the Real Property, or the presence or likely presence of any environmental condition that could adversely affect in a material manner business operations at any of the Leased Premises.

"Environmental Law" means (a) whenever enacted or promulgated, any applicable federal, state, or local law, statute, ordinance, rule, regulation, license, permit, authorization, approval, consent, court order, judgment, decree, injunction, code, requirement or agreement with any governmental entity, (i) relating to pollution (or the cleanup thereof), or the protection of air, water vapor, surface water, groundwater, drinking water supply, land (including land surface or subsurface), plant, aquatic and animal life from injury caused by a Hazardous Substance or (ii) concerning exposure to, or the use, containment, storage, recycling, reclamation, reuse, treatment, generation, discharge, transportation, processing, handling, labeling, production, disposal or remediation of any Hazardous Substance, Hazardous Condition or Hazardous Activity, as now or hereafter in effect, and (b) any common law or equitable doctrine (including, without limitation, injunctive relief and tort doctrines such as negligence, nuisance, trespass and strict liability) that may impose liability or obligations for injuries or damages due to or threatened as a result of the presence of, exposure to, or inadvertent ingestion of, any Hazardous Substance. The term Environmental Law includes, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act ("CERCLA"), the Clean Air Act, the Clean Water Act, the Solid Waste Disposal Act, the Toxic Substance Control Act, the Federal Insecticide, Fungicide and Rodenticide Act, the Occupational Safety and Health Act, the National Environmental Policy Act and the Hazardous Materials Transportation Act, each as amended and hereafter in effect and any similar state or local Law.

"Environmental Violation" means (a) any direct or indirect discharge, disposal, spillage, emission, escape, pumping, pouring, injection, leaching, release, seepage, filtration presence or transporting of any Hazardous Substance at, upon, under, onto or within any of the Leased Premises, or from any of the Leased Premises to the environment, in violation of any Environmental Law or in excess of any reportable quantity established under any Environmental Law or which could result in any liability to any federal, state or local government or any other Person for the costs of any removal or remedial action or natural resources damage or for bodily injury or property damage, (b) any deposit, storage, dumping, placement or use of any Hazardous Substance at, upon, under or within any of the Leased Premises or which extends to any adjoining property in violation of any Environmental Law or in excess of any reportable quantity established under any Environmental Law or which could result in any liability to any federal, state or local government or to any other Person for the costs of any removal or remedial action or natural resources damage or for bodily injury or property damage, (c) the abandonment or discarding at the Leased Premises of any drums, barrels, containers or other receptacles containing any Hazardous Substances in violation of any Environmental Laws, (d) any activity, occurrence or condition which could reasonably be expected to result in any liability, cost or expense under any Environmental Law to Landlord, Tenant or Lender or any other owner or occupier of any of the Leased Premises, or which could reasonably be expected to result in a creation of a lien on any of the Leased Premises under any Environmental Law or (e) any material violation of or noncompliance with any Environmental Law at the Leased Premises.

"Equipment" means, collectively, the Columbus Property Equipment and the Long Beach Property Equipment.

"Escrow Charges" is defined in Paragraph 9(g).

"Escrow Payment" is defined in Paragraph 9(g).

"Event of Default" is defined in Paragraph 22(a).

"Exchange Act" is defined in Paragraph 36(n).

"Excluded Claims" is defined in Paragraph 17(a).

"Exempt Person" means (i) any of the following: any Affiliate of Tenant; any Credit Entity; and any Qualified Transferee, (ii) any of the following, and any successor to any of the following: The Molina Foundation; Joseph M. Molina, M.D., Professional Association - Florida, a Florida professional medical corporation; Joseph M. Molina, M.D., Professional Corporation – Southern California; and Joseph M. Molina, M.D., Professional Corporation – Northern California, and (iii) any Subsidiary of any Credit Entity or any Qualified Transferee that enters into a Sublease, provided that such Credit Entity or Qualified Transferee provides a Guaranty with regard to such Sublease.

"Exempt Sublease" means any Existing Sublease, and any extension or non-material modification thereof.

"Existing Insurance Policies" is defined in Paragraph 16(a).

"Existing Sublease" means any of the existing Subleases listed in Exhibit K attached hereto.

"Expiration Date" is defined in Paragraph 5(a).

"Fair Market Basic Rent" is defined in Exhibit D-1.

"First Full Basic Rent Payment Date" is defined in Exhibit D.

"Fitch" means Fitch Ratings Ltd.

"Force Majeure" is defined in Paragraph 36(p).

"GAAP" is defined in Paragraph 28(a).

"Governmental Authority" means any federal, state or local government, authority, agency or regulatory body.

"Governmental Entity" means the United States of America, and any organization, political subdivision or territory thereof, including without limitation any state, county, locality or municipality therein, and any court, commission, administrative agency, department, regulatory body, instrumentality, authority or other entity (in each case whether federal, state, county, local or municipal) exercising executive, legislative, judicial, regulatory or administrative functions.

"Guarantor" means any person who enters into a Guaranty.

"Guaranty" means any guaranty entered into between Landlord and any assignee of Tenant under this Lease, together with any Replacement Guaranty, if any, in each case, as amended, restated, modified and supplemented from time to time.

"Hazardous Activity" means any activity, process, procedure or undertaking which directly or indirectly: (a) procures, generates or creates any Hazardous Substance; (b) causes or results in (or threatens to cause or result in) the release, seepage, spill, leak, flow, discharge presence or emission of any Hazardous Substance into the environment (including the air, soil, ground water, watercourses or water systems); (c) involves the containment or storage of any Hazardous Substance; or (d) would cause any of the Leased Premises or any portion thereof to become a hazardous waste treatment, recycling, reclamation, processing, storage or disposal facility within the meaning of any Environmental Law.

"Hazardous Condition" means any condition which would support any material claim or liability under any Environmental Law, including the presence of underground storage tanks.

"Hazardous Substance" means (a) any substance, material, product, petroleum, petroleum product, derivative, compound or mixture, mineral (including asbestos), chemical, gas, solid, medical waste, or other pollutant, in each case whether naturally occurring, man-made or the by-product of any process, that is toxic, harmful or hazardous or acutely hazardous to the environment or public health or safety or (b) any substance supporting a claim under any Environmental Law, whether or not defined as hazardous as such under any Environmental Law. Hazardous Substances include, without limitation, any toxic or hazardous waste, pollutant, contaminant, industrial waste, petroleum or petroleum-derived substances or waste, radon, radioactive materials, asbestos, asbestos containing materials, urea formaldehyde foam insulation, lead, mold and other microbial contamination, and polychlorinated biphenyls.

"Immediate Repairs" is defined in Paragraph 12(a).

"Impositions" is defined in Paragraph 9(a).

"Improvements" means the Columbus Improvements and the Long Beach Improvements.

"Indemnitee" means (a) Landlord, (b) Lender, (c) any director, member, officer, general partner, limited partner, shareholder, employee or agent of Landlord or Lender (or any legal representative, heir, estate, successor or assign of any thereof), (d) any predecessor or successor partnership, corporation, limited liability company (or any other entity) of Landlord or Lender, or any of its general partners, members or shareholders, or (e) any affiliate of Landlord or Lender.

"Information" is defined in Paragraph 36(n).

"Initial Term" is defined in Paragraph 5(a).

"Insurance Requirements" means the requirements of all insurance policies required to be maintained in accordance with this Lease.

"Interest Expense" means, for any Person, with reference to any period, the interest expense (including without limitation interest expense under capital lease obligations that is treated as interest in accordance with GAAP) of such Person calculated on a consolidated basis for such period with respect to all outstanding indebtedness of such Person allocable to such period in accordance with GAAP.

"Landlord" is defined in the introductory Paragraph.

"Late Charge" is defined in Paragraph 7(a)(ii).

"Law" means any constitution, statute, rule of law, code, ordinance, order, judgment, decree, injunction, rule, regulation, policy, requirement or administrative or judicial determination, even if unforeseen or extraordinary, of every duly constituted governmental authority, court or agency, now or hereafter enacted or in effect.

"Lease" is defined in the introductory Paragraph.

"Lease Adjusted Funded Debt" means, for any Person (on a consolidated basis) at the time of any determination, without duplication, all obligations, contingent or otherwise, of such Person that, in accordance with GAAP, should be classified upon the balance sheet of such Person as indebtedness, but in any event including the following: (a) all obligations for borrowed money; (b) all obligations arising from installment purchases of property or representing the deferred purchase price of property or services in respect of which such Person is liable, contingently or otherwise, as obligor or otherwise (other than trade payables and other current liabilities incurred in the ordinary course of business); (c) all obligations evidenced by notes, bonds, debentures, acceptances or instruments, or arising out of letters of credit (other than trade letters of credit) or bankers' acceptances issued for such Person's account; (d) all obligations, whether or not assumed, secured by any lien or payable out of the proceeds or production from any property or assets now or hereafter owned or acquired by such Person (but only up to the value of such property or assets); (e) the capitalized portion of lease obligations under any capital lease; (f) all obligations for which such Person is obligated pursuant to any derivative agreements or arrangements; (g) all obligations of such Person upon which interest charges are customarily paid or accrued; (h) all obligations of the types listed in clauses (a) through (g) of this paragraph, for which such Person is obligated pursuant to a Guaranty; and (i) the Basic Rent payable under this Lease for the immediately following twelve (12) month period capitalized at a rate of a multiple of eight (8).

"Leased Premises" is as defined in Paragraph 1.

"Leasehold Mortgage" is defined in Paragraph 34.

"Leasehold Mortgagee" is defined in Paragraph 34.

"Legal Requirements" means the requirements of all present and future Laws applicable during the Term, including all applicable permit and licensing requirements and all covenants, restrictions and conditions, including all Easement Agreements, now or hereafter of record which may be applicable to Tenant or to any of the Leased Premises, or to the use, manner of use, occupancy, possession, operation, maintenance, alteration, repair or restoration of any of the Leased Premises.

"Lender" means any Person which may, on or after the date hereof, make a Loan to Landlord or be the holder of a Note, together with its successors, transferees and assigns.

"Letter of Credit" means an irrevocable, transferable standby letter of credit that provides for automatic renewal sixty (60) days prior to the expiration thereof, in form and substance satisfactory to Landlord, issued by a bank or financial institution acceptable to Landlord (a) that is chartered under the laws of the United States, any state thereof or the District of Columbia, and which is insured by the Federal Deposit Insurance Corporation, (b) whose long-term debt ratings on bank level senior debt obligations are rated at least the second highest category by at least two of Fitch, Moody's (and S&P or any other Rating Agency (which shall mean AA from Fitch, Aa from Moody's and AA from S&P) and (c) that has a short-term deposit rating at the bank level in the highest category from at least two Rating Agencies (which shall mean F1 from Fitch, P-1 from Moody's and A-1 from S&P).

"Loan" means any loan made by one or more Lenders to Landlord, which loan is secured by a Mortgage and an Assignment and evidenced by a Note.

"Long Beach Appraisers" is defined in Exhibit D-1.

"Long Beach Appurtenances" is defined in Paragraph 1(b)(iii).

"Long Beach Equipment" is defined in Exhibit B-2.

"Long Beach FMBR" is defined in Exhibit D-1.

"Long Beach Improvements" is defined in Paragraph 1(b)(ii).

"Long Beach Leased Premises" is defined in Paragraph 1(b).

"Long Beach Property Excluded Items" is defined in Exhibit B-2.

"Long Beach Property Other Assets" is defined in Exhibit B-2.

"Long Beach Real Property" is defined in Paragraph 1(b)(i).

"Losses" is defined in Paragraph 15(a).

"MAI" means Member, Appraisal Institute.

"Moody's" means Moody's Investors Service, Inc.

"Moody's Credit Rating" means the credit rating assigned by Moody's Investors Service to the highest rated publicly issued debt securities of the assignee.

"Mortgage" means any mortgage or deed of trust entered into by Landlord that encumbers any of the Leased Premises, as the same may be amended, supplemented or modified from time to time.

"Net Award" means, with respect to any of the Leased Premises, (a) the entire award payable by reason of a Condemnation, less any sums paid pursuant to a separate claim by Tenant as described in Paragraph 17(b); or (b) the entire proceeds of any insurance policy by reason of a Casualty, in each case, less any expenses incurred by Landlord in collecting such award or proceeds.

"Net Income" means, for any Person, with reference to any period, the net income (or loss) of such Person calculated in accordance with GAAP on a consolidated basis (without duplication) for such period.

"Note" means any promissory note evidencing Landlord's obligation to repay a Loan, as the same may be amended, supplemented or modified.

"Parking Easement" means, with respect to either of the Leased Premises, a permanent parking easement for the benefit of such Leased Premises.

"Parking Facilities" means, with respect to either of the Leased Premises, any and all on-site, satellite or off-site parking facilities to be utilized by Tenant or its employees, agents, invitees or contractors in connection with the use and operation of such Leased Premises.

"Partial Casualty" means any Casualty which does not constitute a Termination Event.

"Partial Condemnation" means any Condemnation which does not constitute a Termination Event.

"Party" and "Parties" are defined in the first paragraph of this Lease.

"Permits" is defined in Paragraph 3(d).

"Permitted Asset Transfer" is defined in Paragraph 21(c).

"Permitted Change of Control" is defined in Paragraph 21(d).

"Permitted Encumbrances" means those covenants, restrictions, reservations, liens, conditions and easements and other encumbrances, other than any Mortgage or Assignment, listed on Exhibit C.

"Permitted Use" is defined in Paragraph 4(a).

"Permitted Violations" is defined in Paragraph 14.

"Person" means an individual, corporation, partnership, joint venture, association, joint-stock company, trust, estate, limited liability company, non-incorporated organization or association, or any other entity, any government authority or any agency or political subdivision thereof.

"Portfolio Rent Adjustment Factor" is defined in Exhibit D-1.

"Preapproved Assignment" is defined in Paragraph 21(b).

"Preapproved Sublease" is defined in Paragraph 21(e).

"Prepayment Premium" means any payment required to be made by Landlord to a Lender under a Note or other document evidencing or securing a Loan (other than payments of principal and/or interest) solely by reason of any prepayment or defeasance by Landlord of any principal due under such Loan, and which may, without limitation, take the form of (a) a "make whole" or yield maintenance clause requiring a prepayment premium or (b) a defeasance payment (such defeasance payment to be an amount equal to the positive difference between (i) the total amount required to defease a Loan and (ii) the outstanding principal balance of the Loan as of the date of such defeasance plus Costs of Landlord and Lender).

"Present Value" of any amount means such amount discounted by a rate per annum which is the lower of (a) the Prime Rate at the time such present value is determined or (b) six percent (6%) per annum .

"Prime Rate" means the interest rate per annum as published, from time to time, in The Wall Street Journal as the "Prime Rate" in its column entitled "Money Rate". The Prime Rate may not be the lowest rate of interest charged by any "large U.S. money center commercial banks" and Landlord makes no representations or warranties to that effect. In the event The Wall Street Journal ceases publication or ceases to publish the "Prime Rate" as described above, the Prime Rate shall be the average per annum discount rate (the "Discount Rate") on ninety-one (91) day bills ("Treasury Bills") issued from time to time by the United States Treasury at its most recent auction, plus three hundred (300) basis points. If no such 91-day Treasury Bills are then being issued, the Discount Rate shall be the discount rate on Treasury Bills then being issued for the period of time closest to ninety-one (91) days.

"Property Action" is defined in Paragraph 10(b).

"Property Condition Report" is defined in Paragraph 12(c).

"Purchase and Sale Agreement" means the Purchase and Sale Agreement dated as of June 12, 2013 between Tenant and Molina Center, LLC, as Seller, and Landlord, as Buyer.

"Qualified Institutional Purchaser" means a bank, savings and loan association, insurance company, investment company, employee benefit plan, or investment advisor registered under the Investment Advisors Act, that has at least Five Billion Dollars ($5,000,000,000) in discretionary assets under management, or a private equity, venture capital or similar buyout fund with at least Five Billion Dollars ($5,000,000,000) of equity capital under management.

"Qualified Transferee" means (a) a Qualified Institutional Purchaser or Strategic Buyer; provided that, on a pro forma basis, after giving effect to the applicable transaction, Tenant together with such Qualified Institutional Purchaser or Strategic Buyer, on a consolidated basis, have (i) a tangible net worth of not less than Two Billion Five Hundred Million Dollars ($2,500,000,000), (ii) a ratio of Lease Adjusted Funded Debt to EBITDAR of not more than 2.5 to 1.0, and (iii) EBITDAR of not less than Four Hundred Fifty Million Dollars ($450,000,000.00); (b) in the case of a Control Person that acquires Control of Tenant by purchasing equity interests in Tenant through the "over-

the-counter market" or through any recognized exchange, a Control Person who delivers to Landlord, upon Landlord's request, after notice from Tenant of such Change of Control, a Letter of Credit equal to twelve (12) months of Basic Rent; or (c) any other Person who delivers to Landlord (or, the case of a sublease, to Tenant) a Letter of Credit equal to eighteen (18) months of Basic Rent.

"Rating Agencies" means, collectively, Fitch, Moody's, and S&P, and any successor of any of them.

"Real Property" means the Columbus Real Property and the Long Beach Real Property.

"Record" is defined in Paragraph 11(b).

"Remaining Obligations" is defined in Paragraph 18(e).

"Remaining Sum" is defined in Paragraph 19(c).

"Renewal Date" is defined in Paragraph 5(a).

"Renewal Term" is defined in Paragraph 5(a).

"Rent" means, collectively, Basic Rent and Additional Rent.

"Rental Expense" means, for any Person, with reference to any period, the aggregate fixed amounts payable by such Person under any operating leases, calculated on a consolidated basis for such period in accordance with GAAP.

"Replacement Guarantor" means the Guarantor under any Replacement Guaranty.

"Replacement Guaranty" is defined in Paragraph 21(c).

"Requesting Party" is defined in Paragraph 25.

"Required Sublease Provisions" is defined in Paragraph 21(e).

"Requisition" means a temporary requisition or confiscation of the use or occupancy of all or a portion of any of the Leased Premises by any governmental authority, civil or military, whether pursuant to an agreement with such governmental authority in settlement of or under threat of any such requisition or confiscation.

"Responding Party" is defined in Paragraph 25.

"Restoration Fund" is defined in Paragraph 19(a).

"Review Criteria" means all of the following with respect to any proposed subtenant or assignee of Tenant's interest in the Lease: (i) creditworthiness, (ii) ownership structure, (iii) management experience, and (iv) operating history, if applicable.

"S&P" means Standard & Poor's Rating Service.

"S&P Credit Rating" means the credit rating assigned by Standard & Poor's Rating Group to the highest rated publicly issued debt securities of the assignee.

"Secured Lender" is defined in Paragraph 31(b).

"Secured Property" is defined in Paragraph 31(b).

"Securities Act" is defined in Paragraph 36(n).

"Security Deposit" is defined in Paragraph 33(a).

"Seller" means Molina Healthcare, Inc., a Delaware corporation, and Molina Center, LLC, a Delaware limited liability company, individually or collectively, as the case may be.

"Senior Credit Facility" means, with respect to any Person, any credit facility with an outstanding and drawn principal balance not less than $500,000,000, where such Person is the borrower, and where such facility is secured by all or substantially all of the assets of such Person.

"Set-Off" is defined in Paragraph 8(a).

"Site Assessment" is defined in Paragraph 10(d).

"Site Reviewers" is defined in Paragraph 10(d).

"SNDA" is defined in Paragraph 31(a).

"Specially Designated National or Blocked Person" is defined in Paragraph 36(m).

"Sponsor" is defined in Paragraph 6(c).

"State" means the State of California or the State of Ohio, as the case may be.

"Strategic Buyer" means a domestic exchange-traded public company doing business in the healthcare industry and/or the insurance industry.

"Sublease" means any sublease of any of the Leased Premises and any modifications, amendments, extensions, supplements, restatements or replacements thereof.

"Sublease SNDA" is defined in Paragraph 21(f).

"Subleasing Threshold" is defined in Paragraph 21(e).

"Subsidiary(ies)" means, as to any Person, any corporation, partnership, limited liability company, association, or other business entity of which such Person directly or indirectly owns more than 50% of the capital stock or other equity interests.

"Tenant" is defined in the introductory Paragraph.

"Term" is defined in Paragraph 5(a).

"Termination Amount" means, with respect to any of the Leased Premises, the sum of (i) the Net Award (if received by Tenant), (ii) any Costs incurred by Landlord in collecting such Net Award (to the extent such Costs have not already been reimbursed), and (iii) any insurance deductible payable in connection such Net Award related to a Casualty.

"Termination Date" is defined in Paragraph 18(d).

"Termination Event" means a Casualty or Condemnation regarding which a Termination Notice may be delivered pursuant to Paragraph 18.

"Termination Notice" is defined in Paragraph 18(a).

"Third Party Purchaser" is defined in Paragraph 21(k).

"UCC" means the Uniform Commercial Code as adopted by the State of New York.

"Warranties" is defined in Paragraph 3(d).

"Water Tank" is defined in Paragraph 10(l).

"Work" is defined in Paragraph 13(b).

3. Title and Condition .

(a) Each of the Leased Premises is demised and let subject to (i) any Mortgage and Assignment in effect from time to time (pursuant to and subject to Paragraph 31), (ii) the rights of any Persons in possession of such Leased Premises as of the date hereof, (iii) the state of title of such Leased Premises as of the date hereof, including any Permitted Encumbrances, (iv) any circumstances or conditions which an accurate survey or physical inspection of such Leased Premises might show, (v) all Legal Requirements, including any existing violation thereof, and (vi) the condition of such Leased Premises as of the date hereof (without representation or warranty by Landlord regarding such condition).

(b) Tenant acknowledges that each of the Leased Premises is in good condition and repair as of the date of executing this Lease and that Tenant has owned the Columbus Leased Premises since December 20, 2012 and the Long Beach Leased Premises since December 8, 2011. SUBJECT TO THE TERMS OF THIS LEASE, LANDLORD LEASES AND WILL LEASE AND TENANT TAKES AND WILL TAKE EACH OF THE LEASED PREMISES IN ITS AS IS CONDITION, WHERE IS AND WITH ALL FAULTS. TENANT ACKNOWLEDGES THAT LANDLORD (WHETHER ACTING AS LANDLORD HEREUNDER OR IN ANY OTHER CAPACITY) HAS NOT MADE AND WILL NOT MAKE, NOR SHALL LANDLORD BE DEEMED TO HAVE MADE, ANY WARRANTY OR REPRESENTATION, EXPRESS OR IMPLIED, WITH RESPECT TO ANY OF THE LEASED PREMISES, INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OR REPRESENTATION AS TO (i) THE FITNESS, DESIGN OR CONDITION OF SUCH LEASED PREMISES FOR ANY PARTICULAR USE OR PURPOSE,

(ii) THE QUALITY OF THE MATERIAL OR WORKMANSHIP THEREIN, (iii) THE EXISTENCE OF ANY DEFECT, INCLUDING ANY LATENT OR PATENT DEFECT, (iv) LANDLORD'S TITLE THERETO, (v) VALUE, (vi) COMPLIANCE WITH SPECIFICATIONS, (vii) LOCATION, (viii) USE, (ix) CONDITION, (x) MERCHANTABILITY, (xi) QUALITY, (xii) DESCRIPTION, (xiii) DURABILITY (xiv) OPERATION, (xv) THE EXISTENCE OR PRESENCE OF ANY HAZARDOUS SUBSTANCE, OR (xvi) COMPLIANCE OF THE LEASED PREMISES WITH ANY LEGAL REQUIREMENT; AND, WITHOUT LIMITING THE EXPRESS TERMS OF THIS LEASE, ALL RISKS RELATED TO ANY OF THE FOREGOING ARE TO BE BORNE BY TENANT. TENANT ACKNOWLEDGES THAT THE LEASED PREMISES ARE OF ITS SELECTION AND TO ITS SPECIFICATIONS AND THAT THE LEASED PREMISES HAVE BEEN INSPECTED BY TENANT AND ARE SATISFACTORY TO IT.WITHOUT LIMITING THE EXPRESS TERMS OF THIS LEASE, IN THE EVENT OF ANY DEFECT OR DEFICIENCY IN ANY OF THE LEASED PREMISES OF ANY NATURE, LANDLORD SHALL NOT HAVE ANY RESPONSIBILITY OR LIABILITY WITH RESPECT THERETO AND LANDLORD SHALL NOT BE RESPONSIBLE FOR ANY SPECIAL, PUNITIVE, INCIDENTAL OR CONSEQUENTIAL DAMAGES (INCLUDING STRICT LIABILITY IN TORT). THE PROVISIONS OF THIS PARAGRAPH 3(b) HAVE BEEN NEGOTIATED, AND ARE INTENDED TO BE A COMPLETE EXCLUSION AND NEGATION OF ANY WARRANTIES BY LANDLORD, EXPRESS, IMPLIED OR CREATED BY APPLICABLE LAW, WITH RESPECT TO THE CONDITION OF THE LEASED PREMISES.

With respect to the claims released in this Paragraph 3(b), Tenant expressly waives any rights or benefits available to it under the provisions of Section 1542 of the California Civil Code, which provides as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."

Tenant acknowledges that its attorney at law has explained to it the meaning and effect of this statute. Tenant understands fully the statutory language of California Civil Code Section 1542, and, with this understanding, Tenant nevertheless elects to, and does, assume all risk for claims released by it under this Agreement whether arising before or after this Agreement and whether now known or unknown, and Tenant specifically waives any rights it may have under California Civil Code Section 1542 and any successive sections or statutes of a similar nature. Tenant fully understands that if the facts with respect to which this Agreement is executed are

later found to be other than or different from the facts now believed by it to be true, it expressly accepts and assumes the risk of that possible difference in facts and agrees that this Agreement shall be and remain effective notwithstanding that difference in facts.

The provisions of this Paragraph 3(b) shall survive the termination of this Agreement.

_____ _____

Tenant's Initials Landlord's Initials

(c) Tenant acknowledges that Tenant has examined the title to each of the Leased Premises prior to the execution and delivery of this Lease and has found the same to be satisfactory for all of the purposes permitted under this Lease. Tenant represents and warrants to Landlord that, with respect to each of the Leased Premises, except as disclosed in any document recorded against title to either of the Leased Premises, or otherwise disclosed in writing to Landlord, as of the Effective Date (i) Tenant and any subtenants at the Leased Premises have only the leasehold right of possession and use of such Leased Premises, as provided herein, and (ii) neither Tenant nor any agent, officer, employee, principal or affiliate of Tenant has granted or knowingly suffered to exist any unrecorded deeds, mortgages, land contracts, leases, subleases, licenses, options to purchase, agreements or other instruments adversely affecting title to such Leased Premises or any lien, encumbrance, transfer of interest, constructive trust, or other equity in such Leased Premises, and (iii) Tenant has received no notice of any Casualty, Condemnation or pending or threatened special assessments affecting such Leased Premises. The foregoing representations and warranties and the representations and warranties contained in the Purchase and Sale Agreement (subject to the terms thereof) shall survive the date on which this Lease is fully executed.

(d) Landlord hereby assigns to Tenant, without recourse or warranty whatsoever, in conjunction with Landlord, the non-exclusive right to enforce all assignable warranties, guaranties, indemnities, contract rights, causes of action and similar rights (collectively "Warranties") that Landlord may have against any manufacturer, seller, architect, engineer, contractor, builder or other counterparty in respect of any of the Leased Premises, including without limitation in connection with any building plans, specifications or drawings with respect to the Improvements. Such assignment shall remain in effect and be irrevocable until the expiration or earlier termination of this Lease (unless Tenant or its affiliate or designee acquires such Leased Premises, in which instance such assignment shall become permanent and irrevocable with respect to such Leased Premises), whereupon such assignment shall cease and all of the Warranties shall automatically revert to Landlord. In confirmation of such reversion Tenant shall execute and deliver promptly any certificate or other document reasonably required or requested by Landlord. Landlord shall also retain the right to enforce any Warranties upon the occurrence and during the continuance of an Event of Default. Tenant shall use commercially reasonable efforts to enforce the Warranties in accordance with their respective terms, Landlord shall cooperate with Tenant to the extent necessary to permit Tenant to enforce such Warranties prior to the expiration or earlier termination of this Lease. Tenant shall cooperate with Landlord to the extent necessary to permit Landlord to enforce such Warranties after the expiration or earlier termination of this Lease (to the extent not transferred to Tenant). Landlord shall also reasonably cooperate with Tenant in connection with any permits, licenses, and approvals held by Landlord, if any, that are mandated or necessary to operate the

Properties (collectively, the "Permits"), including exercising rights thereunder and pursuing modifications thereof that Tenant determines would be beneficial to its operations at any of the Leased Premises, and pursuing any additional Permit that Tenant determines would be beneficial to its operations at any of the Leased Premises. The foregoing provisions shall survive the expiration or earlier termination of this Lease.

(e) LANDLORD AND TENANT AGREE THAT IT IS THEIR MUTUAL INTENT TO CREATE, AND THAT THIS LEASE CONSTITUTES, A MASTER LEASE WITH RESPECT TO EACH AND EVERY PARCEL OF REAL PROPERTY AND THE IMPROVEMENTS INCLUDED IN ANY AND ALL OF THE LEASED PREMISES (WHEREVER LOCATED), THAT THIS LEASE IS NOT INTENDED AND SHALL NOT BE CONSTRUED TO BE SEPARATE LEASES AND THAT ALL THE TERMS AND CONDITIONS HEREOF SHALL GOVERN THE RIGHTS AND OBLIGATIONS OF LANDLORD AND TENANT WITH RESPECT THERETO.

(f) TENANT, ON BEHALF OF ITSELF AND ANY TRUSTEE OR LEGAL REPRESENTATIVE (UNDER THE FEDERAL BANKRUPTCY CODE OR ANY SIMILAR STATE INSOLVENCY PROCEEDING) EXPRESSLY ACKNOWLEDGES AND AGREES THAT, NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH 18 HEREOF OR ANY OTHER PROVISION IN THIS LEASE TO THE CONTRARY, IT IS THE EXPRESS INTENT OF LANDLORD AND TENANT TO CREATE, AND THAT THIS LEASE CONSTITUTES, A SINGLE LEASE WITH RESPECT TO EACH AND EVERY PARCEL OF LAND, THE IMPROVEMENTS AND OTHER PROPERTY INCLUDED IN EACH OF THE RELATED PREMISES (WHEREVER LOCATED) AND SHALL NOT BE (OR BE DEEMED TO BE) DIVISIBLE OR SEVERABLE INTO SEPARATE LEASES FOR ANY PURPOSE WHATSOEVER, AND TENANT, ON BEHALF OF ITSELF AND ANY SUCH TRUSTEE OR LEGAL REPRESENTATIVE, HEREBY WAIVES ANY RIGHT TO CLAIM OR ASSERT A CONTRARY POSITION IN ANY ACTION OR PROCEEDING; IT BEING FURTHER UNDERSTOOD AND AGREED BY TENANT THAT THE ALLOCATIONS OF ACQUISITION COST AND PERCENTAGE ALLOCATION OF BASIC RENT AS RESPECTIVELY SET FORTH ON EXHIBIT E AND EXHIBIT F HEREOF ARE INCLUDED TO PROVIDE A FORMULA FOR RENT ADJUSTMENT AND LEASE TERMINATION UNDER CERTAIN CIRCUMSTANCES AND AS AN ACCOMMODATION TO TENANT. ANY EVENT OF DEFAULT HEREUNDER IN CONNECTION WITH ANY PORTION OF THE LEASED PREMISES SHALL BE DEEMED TO BE AN EVENT OF DEFAULT WITH RESPECT TO THE ENTIRE LEASED PREMISES. THE FOREGOING AGREEMENTS AND WAIVERS BY TENANT IN THIS PARAGRAPH 3(f) ARE MADE AS A MATERIAL INDUCEMENT TO LANDLORD TO ENTER INTO THE TRANSACTION CONTEMPLATED BY THIS LEASE AND THAT, BUT FOR THE FOREGOING AGREEMENTS AND WAIVERS BY TENANT, LANDLORD WOULD NOT CONSUMMATE THIS LEASE TRANSACTION.

4. Use of Leased Premises; Quiet Enjoyment.

(a) Tenant may occupy and use each of the Leased Premises for general office use (including parking) (the "Permitted Use") and for no other purpose without the prior written consent of Landlord. Tenant shall be responsible for obtaining and maintaining all permits, licenses, certificates of occupancy, or any other items required by any Legal Requirement with respect to

Tenant's use and occupancy of each of the Leased Premises. Without limiting Tenant's express rights under this Lease (including without limitation with respect to Alterations), Tenant shall not use or occupy or permit any of the Leased Premises to be used or occupied, nor do or permit anything to be done in or on any of the Leased Premises, in a manner that (i) violates any Legal Requirement or Permitted Encumbrance, (ii) makes void or voidable or causes any insurer to cancel any insurance required by this Lease, or could be reasonably expected to make it difficult or impossible to obtain any such insurance at commercially reasonable rates, (iii) makes void or voidable, cancels or causes to be cancelled or releases any of the Warranties (except in the ordinary course of business, including obtaining, where applicable, replacement or similar Warranties for those canceled), (iv) causes structural injury to any of the Improvements, (v) diminishes the market value or impairs the usefulness of such Leased Premises, or (vi) constitutes a public or private nuisance or waste. Without limiting any of Tenant's express rights to terminate the Lease set forth herein, if during the Term Tenant's use or occupancy of any of the Leased Premises is no longer permitted by Law or any Legal Requirement, Tenant shall not have the right to terminate this Lease by reason of same.

(b) Subject to the provisions hereof, so long as no Event of Default has occurred and is continuing, Tenant shall quietly hold, occupy and enjoy each of the Leased Premises throughout the Term, without any hindrance, ejection or molestation by Landlord with respect to matters that arise after the date hereof; provided that Landlord or its agents may enter upon and examine any of the Leased Premises at such reasonable times as Landlord may select and upon reasonable notice to Tenant (except in the case of any emergency, in which event no notice shall be required) for the purpose of inspecting such Leased Premises, verifying compliance or non-compliance by Tenant with its obligations hereunder and the existence or non-existence of an Event of Default or event which with the passage of time and/or notice would constitute an Event of Default, showing such Leased Premises to prospective Lenders and purchasers, making any repairs and taking such other action with respect to such Leased Premises as is permitted by any provision hereof. Landlord shall use commercially reasonable efforts to minimize interference with Tenant's operations and business in connection with any entry upon the Leased Premises by Landlord. Tenant shall permit inspection of any of the Leased Premises by any federal, state, county or municipal officer or representative to determine if such Leased Premises or any portion thereof comply with any Legal Requirement.

5. Term.

(a) Subject to the provisions hereof, Tenant shall have and hold the Leased Premises for an initial term (the " Initial Term", and as extended or renewed in accordance with the provisions hereof, including any exercised Renewal Term, the " Term") commencing on the Effective Date (the "Commencement Date") and ending on the last day of the three hundredth (300 th) full calendar month next following the Effective Date (the "Expiration Date"); provided that if, on or prior to the Expiration Date or any other Renewal Date (as hereinafter defined) this Lease shall not have been terminated pursuant to any provision hereof, and no Events of Default are continuing under this Lease, then on the Expiration Date and on the fifth (5 th), tenth (10th), fifteenth (15th), twentieth (20th) and twenty-fifth (25th) anniversaries of the Expiration Date (each such date, a " Renewal Date"), the Term shall be extended for an additional period of five (5) years (each of the extension periods, a " Renewal Term"); provided that Tenant shall have notified Landlord in writing at least eighteen (18) months prior to such Renewal Date that Tenant has elected to so extend this Lease as of such Renewal Date. At Landlord's request at any time after the giving of a notice of renewal,

Tenant shall execute a notice in recordable form confirming such Renewal Date. Any such extension of the Term shall be subject to all of the provisions of this Lease (except that Tenant shall not have the right to any additional Renewal Terms except as otherwise provided herein).

(b) If Tenant does not exercise any of its options pursuant to Paragraph 5(a) to extend the Term for an additional Renewal Term, or if an Event of Default occurs and is continuing, then Landlord shall have the right during the remainder of the Term then in effect and, in any event, Landlord shall have the right during the last eighteen (18) months of the Term, to (i) advertise the availability of any of the Leased Premises for sale or reletting and to erect upon such Leased Premises signs indicating such availability and (ii) show such Leased Premises to prospective purchasers or tenants or their agents at such reasonable times as Landlord may select and upon five (5) Business Days' prior written notice to Tenant. Landlord shall use commercially reasonable efforts to minimize interference with Tenant's operations and business in connection with any entry upon the Leased Premises by Landlord.

6. Basic Rent.

(a) On each Basic Payment Date, Tenant shall pay to Landlord for the Leased Premises basic rent the amounts described in Exhibit D ("Basic Rent"). Each payment of Basic Rent shall be made to Landlord (or one or more other Persons as Landlord may designate) on each Basic Rent Payment Date, without set-off, abatement (except as otherwise provided in this Lease), or deduction, pursuant to subparagraph (b) below.

(b) Each payment of Basic Rent shall be made to Landlord (or one or more other Persons as Landlord may designate) via wire transfer of immediately available funds on each Basic Rent Payment Date pursuant to wire transfer instructions delivered to Tenant from Landlord. Upon Landlord's request following an Event of Default, Tenant shall deliver to Landlord a complete ACH Authorization Agreement – Pre-Arranged Payments substantially in the form of Exhibit H, together with a voided check for account verification, establishing arrangements whereby payments of Rent are transferred by automated clearing house debit initiated by Landlord from an account established by Tenant (and such account not being subject to any control agreement or other lien or encumbrance) at a bank reasonably acceptable to Landlord that is chartered under the laws of the United States, any state thereof or the District of Columbia, and which is insured by the Federal Deposit Insurance Corporation, to such account as Landlord may designate. Following any such Landlord's request to establish an automated clearing house account, Tenant shall continue to pay all Rent by automated clearing house debit until otherwise directed in writing by Landlord.

(c) If, at any time, Tenant and/or Guarantor, if any, is owned directly or indirectly by one or more private equity funds or other financial sponsors which receive a management fee or other comparable distribution (" Sponsor"), Tenant and/or such Guarantor, as the case may be, shall cause each such Sponsor to enter into a Subordination Agreement substantially in the form of Exhibit I, subordinating Sponsor's right to collect its management fee to Landlord's right to collect Basic Rent under this Lease.

(d) The collection or application of any rent or other amounts directly from any subtenant at the Leased Premises by Landlord shall be subject to Paragraph 21(h) and shall not (i) be deemed

a waiver of any term, covenant or condition of this Lease, or (ii) relieve Tenant from its obligation to fully observe and perform the terms, covenants and conditions of this Lease.

7. Additional Rent.

(a) Tenant shall pay and discharge, as additional rent (collectively, "Additional Rent") the following costs and expenses:

(i) except as otherwise specifically provided herein (including without limitation Paragraph 36(q)), all Costs of Landlord not caused by Landlord's gross negligence, willful misconduct or breach of its obligations under this Lease, and which are incurred in connection with (A) the use, non-use, occupancy, possession, operation, condition, design, construction, maintenance, alteration, repair or restoration of any of the Leased Premises, (B) the Landlord's performance of any of Tenant's obligations under this Lease (if and to the extent permitted under the terms of this Lease), (C) any Condemnation proceedings, (D) the adjustment, settlement or compromise of any insurance claims involving or arising from any of the Leased Premises, (E) the prosecution, defense or settlement of any litigation (1) involving or arising from any of the Leased Premises or this Lease or the sale of any of the Leased Premises by Landlord following an Event of Default or (2) brought by any third-party directly against Landlord related to this Lease, any of the Leased Premises or Tenant's use or occupancy thereof, (F) the exercise or enforcement by Landlord of any of its rights under this Lease, (G) any amendment or supplement to or modification or termination of this Lease requested by Tenant or necessitated by any action of Tenant, including without limitation, any default by Tenant in the performance of any of its obligations under this Lease, (H) any act undertaken by Landlord (or its counsel) at the request of Tenant, any act of Landlord performed on behalf of Tenant (pursuant to any express right of Landlord to act on Tenant's behalf under the terms of this Lease), or the reasonable and customary review and monitoring of compliance by Tenant with the terms of this Lease and applicable Law, and (I) all other items expressly required to be paid by Tenant under this Lease;

(ii) subject to Paragraph 2(b) of Exhibit D, if all or any portion of any installment of Basic Rent is due and not paid by the applicable Basic Rent Payment Date, an amount (the "Late Charge") equal to five percent (5%) of the amount of such unpaid installment of Basic Rent or portion thereof to reimburse Landlord for its Costs and inconvenience incurred as a result of Tenant's delinquency; and

(iii) subject to Paragraph 2(b) of Exhibit D, interest, from the date of delinquency, at the rate (the "Default Rate") of five percent (5%) over the Prime Rate per annum on the following sums until paid in full: (A) all overdue installments of Basic Rent from the respective due dates thereof, (B) all overdue amounts of Additional Rent relating to obligations which Landlord shall have paid on behalf of Tenant, from the date reimbursement is due from Tenant (including any applicable notice, cure, and grace periods) under the express terms of this Lease, and (C) all other overdue amounts of Additional Rent, from the date when such amount becomes due (including any applicable notice and grace periods).

(b) Tenant shall pay and discharge any Additional Rent not later than five (5) Business Days after Landlord's demand for payment thereof, in the case of items billed to Landlord, and

within five (5) Business Days after the due date, in the case of items billed directly to Tenant. After the occurrence of an Event of Default, upon request from Landlord, all payments of Rent shall be paid by automated clearing house debit initiated by Landlord pursuant to Paragraph 6(b).

(c) In no event shall amounts payable under Paragraphs 7(a)(i), (ii), and (iii) or elsewhere in this Lease exceed the maximum amount permitted by applicable Law.

(d) Landlord acknowledges that in no event shall "Additional Rent" include, nor shall Landlord have any rights under this Lease, to any charges or other amounts paid by subtenants or others for parking at the Leased Premises.

8. Net Lease: Non-Terminability.

(a) This is an absolute net lease and all Rent shall be paid without notice or demand, except as otherwise expressly set forth herein, and without set-off, counterclaim, recoupment, abatement (except as otherwise set forth herein), suspension, deferment, diminution, deduction, reduction or defense (collectively, a "Set-Off").

(b) Except as otherwise expressly set forth herein (including without limitation Paragraph 36(p)), this Lease and the rights of Landlord and the obligations of Tenant hereunder shall not be affected by any event or for any reason or cause whatsoever foreseen or unforeseen.

(c) The obligations of Tenant hereunder shall be separate and independent covenants and agreements, all Rent shall continue to be payable in all events (or, in lieu thereof, Tenant shall pay amounts equal thereto), and the obligations of Tenant hereunder shall continue unaffected unless the requirement to pay or perform the same shall have been terminated pursuant to an express provision of this Lease. The obligation to pay Rent shall not be affected by any collection of rents by any governmental body pursuant to a tax lien or otherwise. All Rent payable by Tenant hereunder shall constitute "rent" for all purposes (including Section 502(b)(6) of the Federal Bankruptcy Code).

(d) Except as otherwise expressly provided herein, Tenant shall have no right and hereby waives all rights which it may have under any Law to (i) quit, terminate or surrender this Lease or any of the Leased Premises, or (ii) exercise any right of Set-Off of any Rent.

9. Payment of Impositions.

(a) Tenant shall pay and discharge when due the following to the extent they are imposed on, or with respect to, the Leased Premises: all taxes (including real and personal property taxes, franchise taxes (to the extent imposed in lieu of real property taxes), sales taxes, use taxes, commercial activity taxes (to the extent imposed in lieu of rent taxes), gross receipts (to the extent imposed in lieu of rent taxes) and rent taxes); all charges for any Easement Agreement; all assessments and levies; all taxes, fines, penalties and other Costs in connection with noncompliance of any of the Leased Premises with any applicable Law; all permit, inspection and license fees; all rents and charges for water, sewer, utility and communication services relating to any of the Leased Premises; all ground rents and all other public charges, imposed upon or assessed against (i) Tenant, (ii) Tenant's interest in any of the Leased Premises, (iii) any of the Leased Premises, or (iv) Landlord

as a result of or arising in respect of the acquisition, ownership, occupancy, leasing, use, possession or sale of any of the Leased Premises, any activity conducted on any of the Leased Premises, or the Rent (collectively, the "Impositions"); provided, however that nothing herein shall obligate Tenant to pay (A) income, excess profits, gross receipts tax, franchise or other taxes of Landlord (or Lender) which are determined on the basis of Landlord's (or Lender's) net income or net worth (unless such taxes are in lieu of or a substitute for any other tax, assessment or other charge upon or with respect to any of the Leased Premises which, if it were in effect, would be payable by Tenant under the provisions hereof or by the terms of such tax, assessment or other charge, e.g., any real property tax that is recharacterized as a franchise tax) or that is imposed upon Landlord (or Lender) under Code Section 59A, (B) any estate, inheritance, succession, gift or similar tax imposed on Landlord, (C) any tax imposed on Landlord in connection with the sale, transfer or other disposition of either of the Leased Premises or any interest therein, including, but not limited to, any transfer, capital gains, sales, gross receipts, value added, income, stamp, real property gains or withholding taxes, and (D) any interest or penalties or other charges related to the foregoing. For the avoidance of doubt, nothing in this Paragraph 9(a) shall make Tenant responsible for Landlord's Ohio Commercial Activity Tax liability.

(b) Upon expiration of the Term (or any earlier termination of this Lease), all unpaid taxes and assessments shall be apportioned. If the tax bill for the tax year in which the expiration of the Term (or any earlier termination of this Lease) occurs has not been issued, the apportionment of taxes shall be computed based upon the most recent tax bill available. Landlord and Tenant shall pro-rate any tax refund received by Landlord or Tenant for the tax year in which the expiration of the Term (or any earlier termination of this Lease) occurs.

(c) If any Imposition may be paid in installments without penalty, Tenant shall have the option to pay such Imposition in installments and shall only be liable for the payment of such installments as they become due and payable and that occur during the Term of this Lease. If any Imposition may be paid in installments with interest, Tenant shall have the option to pay such Imposition in installments, provided that if such installments extend beyond the Term, Landlord shall have the option to repay all remaining installments coming due following the Term without interest.

(d) Tenant shall prepare and file all tax reports required by governmental authorities which relate to the Impositions. Landlord shall promptly deliver to Tenant any bill, invoice, settlement or notice that Landlord receives with respect to the Impositions. In addition, Landlord agrees to cooperate with Tenant as and when necessary to enable Tenant to receive tax bills, settlements and notices with respect to the Impositions directly from the respective taxing authorities. Tenant shall deliver to Landlord (i) copies of all settlements and notices pertaining to the Impositions which may be issued by any governmental authority within ten (10) days after Tenant's receipt thereof, (ii) receipts for payment of all taxes required to be paid by Tenant hereunder within thirty (30) days after the due date thereof, and (iii) receipts for payment of all other Impositions within ten (10) days after Landlord's request therefor.

(e) Notwithstanding anything to the contrary herein, Tenant shall not be required to pay or cause to be paid any tax, assessment, charge or levy that is not yet past due, or is being contested in good faith by appropriate actions or proceedings, so long as by reason of such nonpayment and

contest no material item or portion of the Leased Premises is in jeopardy of being seized, levied upon or forfeited. Tenant shall be entitled to any refund of any Impositions (including, without limitation, penalties or interest thereon) received by Tenant or Landlord, whether or not such refund was a result of actions or proceedings instituted by Tenant.

(f) Impositions shall include, without limitation, any increase in any of the foregoing taxes, payments or costs based upon construction of improvements on the Leased Premises or "change in ownership" (as defined in the California and Revenue Taxation Code) of the Leased Premises.

(g) During the continuance of an Event of Default, Tenant shall pay to Landlord or Lender such amounts (each an " Escrow Payment") as required by Landlord or Lender so that there shall be in an escrow account an amount sufficient to pay as they become due the Escrow Charges that will accrue over such period of time as Landlord or Lender shall reasonably require. As used herein, "Escrow Charges" means real estate taxes and assessments on or with respect to any of the Leased Premises or payments in lieu thereof and premiums on any insurance required by this Lease, payments due under any Easement Agreement and any reserves for capital improvements, deferred maintenance, repair and/or tenant improvements and leasing commissions. Landlord shall reasonably determine the amount of the Escrow Charges (it being agreed that if required by a Lender, such amount shall equal any corresponding escrow installments required to be paid by Landlord) and the amount of each Escrow Payment. Notwithstanding the immediately preceding sentence (including without limitation any Lender requirements), the Escrow Payments shall not be commingled with other funds of Landlord or other Persons (and shall not exceed twelve (12) months of Escrow Charges at any given time), shall not exceed with respect to any Escrow Charge in any month one twelfth ($1/12^{th}$) of the annual amount of the applicable Escrow Charge, and in no event may Landlord require any Escrow Payment regarding any Escrow Charge if Landlord is holding the aggregate annual amount of such Escrow Charge. No interest thereon shall be due or payable to Tenant. Landlord or Lender, as applicable, shall apply the Escrow Payments to the payment of the Escrow Charges in such order or priority as Landlord or Lender shall determine or as required by Law. Subject to the foregoing, if at any time the Escrow Payments theretofore paid to Landlord or Lender, as applicable, shall be insufficient for the payment of the Escrow Charges, Tenant, within ten (10) days after Landlord's written demand therefor, shall pay the amount of the deficiency to Landlord or Lender, as applicable.

(h) Tenant agrees to notify Landlord immediately of any changes to the amounts, schedules, or instructions for payment of any Impositions and premiums on any insurance held under this Lease of which Tenant has obtained knowledge and authorizes Landlord or Lender to obtain duplicate copies of the bills for Impositions or Escrow Charges directly from the appropriate authority or entity.

(i) To the extent required by NPDES Permit No. CAG994004, Tenant agrees to (i) conduct monthly sampling of the water in the sump pump at the Long Beach Real Property, and (ii) provide the applicable quarterly reporting thereof to the LA Regional Water Quality Control Board.

10. Compliance with Laws and Easement Agreements; Environmental Matters.

(a) Tenant shall, at its expense, comply with and conform to, and cause each of the Leased Premises and any other Person occupying any part of any of the Leased Premises to materially comply with and conform to all Insurance Requirements and all Legal Requirements (including all applicable Environmental Laws); provided, however, that Tenant shall only be required to cause any other Person to comply with Insurance Requirements if and to the extent such Insurance Requirements are reasonably applicable to such Person and its activities or operations at any Leased Premises. Tenant shall not at any time (i) cause, permit, or suffer to occur, any Environmental Violation or any environmental lien whether due to the acts of Tenant or any other party, (ii) permit any subtenant, assignee or other Person occupying any of the Leased Premises under or through Tenant to cause, permit or suffer to occur any Environmental Violation and, at the request of Landlord, Tenant shall promptly remediate or undertake any other appropriate response action to correct any existing Environmental Violation, however immaterial, or (iii) without the prior written consent of Landlord, permit any drilling or exploration for or extraction, removal, or production of any oil, gas or minerals from the surface or the subsurface of the Real Property, regardless of the depth thereof or the method of mining or extraction thereof. Any and all reports prepared for or by Landlord with respect to any of the Leased Premises shall be for the sole benefit of Landlord and no other Person shall have the right to rely on any such reports.

(b) Tenant, at its sole cost and expense, will at all times promptly and faithfully abide by, discharge and perform all of the covenants, conditions and agreements contained in any Easement Agreement on the part of Landlord, Tenant or any subtenant to be kept and performed thereunder; provided, however, that Landlord shall reasonably cooperate with Tenant to enable and assist Tenant in connection therewith. Neither Party will alter, modify, amend or terminate any Easement Agreement, give any consent or approval thereunder, or enter into any new Easement Agreement without, in each case, the prior written consent of the other Party. Tenant agrees to reasonably cooperate with Landlord, at Tenant' sole cost and expense, in connection with (i) the granting of easements, licenses, rights-of-way and other rights and privileges in the nature of Easement Agreements reasonably necessary or desirable for ownership and operation of any of the Leased Premises as herein provided; (ii) the execution of petitions to have any of the Leased Premises annexed to any municipal corporation or utility district; and (iii) the execution of amendments to any covenants and restrictions affecting any of the Leased Premises; provided, however, that in no event shall Landlord undertake any of the actions described in clauses (i), (ii) and (iii) or any other grant, release, dedication, transfer, easement, amendment or government action, or other action or agreement relating to either of the Leased Premises (any of the foregoing, a " Property Action") without the prior written consent of Tenant, which consent Tenant shall not unreasonably withhold, condition or delay; provided, however, that Tenant may condition such consent in part on receiving from Landlord a certificate stating that such Property Action will not materially interfere with Tenant's use and enjoyment of the Leased Premises.

(c) Subject to the provisions of this Paragraph 10(c), so long as no Event of Default has occurred and is continuing, Landlord hereby agrees to reasonably cooperate with the following actions by Tenant, in the name and stead of Landlord and cause Lender to cooperate with, but at Tenant's sole cost and expense: (i) the granting of easements, licenses, rights-of-way and other rights and privileges in the nature of Easement Agreements reasonably necessary or desirable for

the construction, operation, restoration, use, repair, renovation or maintenance of any of the Leased Premises as herein provided; (ii) the execution of petitions to have any of the Leased Premises annexed to any municipal corporation or utility district; (iii) the execution of amendments to any covenants and restrictions affecting any of the Leased Premises; (iv) Tenant's obtaining all necessary government or third-party actions, consents or agreements necessary for the performance and completion of any Alteration; provided, however that in each case Tenant shall have delivered to Landlord a certificate stating that: (A) the Property Action does not impair the value, utility or remaining useful life of such Leased Premises or have an adverse effect on the value of Landlord's interest in such Leased Premises (other than to a de minimis extent, or, with respect to an Alteration, a temporary extent), (B) such Property Action is reasonably necessary in connection with the use, maintenance, alteration, renovation, construction, operation, restoration, repair or improvement of such Leased Premises, (C) Tenant shall remain obligated under this Lease and under any instrument executed by Tenant consenting to the assignment of Landlord's interest in this Lease as security for indebtedness, in each such case in accordance with their terms, and (D) Tenant shall pay any Costs of Landlord under such Property Action. Without limiting the effectiveness of the foregoing, Landlord shall, within thirty (30) days of receipt of the written request of Tenant, and at Tenant's sole cost and expense (including reasonable fees and disbursements of counsel to Landlord and Lender to review such Property Action), review and either approve or disapprove in writing the proposed Property Action, and, if approved, execute and deliver any instruments and take any other action reasonably necessary or appropriate to confirm any such Property Action, to any person permitted under this Paragraph 10 or to implement any such Property Action.

(d) Upon prior written notice from Landlord, Tenant shall permit such persons as Landlord may designate ("Site Reviewers") to visit any of the Leased Premises during normal business hours and in a manner which does not unreasonably interfere with Tenant's operations and perform environmental site investigations and assessments (" Site Assessments") on such Leased Premises in any of the following circumstances: (i) in connection with any sale, financing or refinancing of such Leased Premises; (ii) within the six (6) month period prior to the expiration of the Term; (iii) if required by Lender or the terms of any credit facility to which Landlord is bound; (iv) if an Event of Default exists; (v) if required under any applicable Law; or (vi) at any other time that, in the opinion of Landlord or Lender, a reasonable basis exists to believe that an Environmental Violation or any condition that could reasonably be expected to result in any Environmental Violation exists; provided, however, that Landlord and Lender may only conduct, in the aggregate, one (1) Site Assessment per calendar year, unless Landlord or its Lender has a reasonable basis to believe that a previously undisclosed material Environmental Violation exists. Such Site Assessments may include both above and below the ground testing for Environmental Violations and such other tests as may be necessary, in the opinion of the Site Reviewers, to conduct the Site Assessments including additional Site Assessments that may be required as a result of any limited Phase II environmental report prepared prior to the date hereof or as may be required by Lender or any provider of insurance for such Leased Premises. Tenant shall supply to the Site Reviewers such historical and operational information regarding such Leased Premises as may be reasonably requested by the Site Reviewers to facilitate the Site Assessments, and shall make available for meetings with the Site Reviewers appropriate personnel having knowledge of such matters. The cost of performing and reporting any Site Assessments pursuant to subsections (i) and (iii) of this Paragraph 10(d) shall be paid by Landlord; all other costs relating to Site Assessments shall be paid by Tenant.

(e) If an Environmental Violation occurs or is found to exist and, in Landlord's reasonable judgment, the cost of remediation of, or other response action with respect to, the same is likely to exceed Five Hundred Thousand Dollars ($500,000) , Tenant shall provide to Landlord, within ten (10) days after Landlord's written request therefor, adequate financial assurances, as determined in Landlord's reasonable discretion, that Tenant will effect such remediation in accordance with applicable Environmental Laws, and fulfill Tenant's indemnification obligations that could reasonably be expected to arise as a result of such Environmental Violation. Such financial assurances shall be in an amount equal to or greater than Landlord's reasonable estimate, based upon a Site Assessment performed pursuant to Paragraph 10(d), of the anticipated cost of such remedial action. Tenant shall comply with all reasonable requests of Landlord with respect to an Environmental Violation, including without limitation (i) a request to effectuate a remediation of any Environmental Violation, (ii) a request for Tenant to comply with any Environmental Laws or to comply with any directive from a governmental authority, or (iii) a reasonable request to take any action necessary to protect human health and safety.

(f) Notwithstanding any other provision of this Lease, if an Environmental Violation occurs or is found to exist and the Term would otherwise terminate or expire, then, at the option of Landlord, the Term shall be automatically extended beyond the date of termination or expiration and this Lease shall remain in full force and effect on a month-to-month basis beyond such date until the earlier to occur of (i) the completion of all remedial action in accordance with applicable Environmental Laws or (ii) the date specified in a written notice from Landlord to Tenant terminating this Lease.

(g) If Tenant fails to comply with any requirement of any Environmental Law, Landlord shall have the right (but no obligation) to take any and all actions as Landlord shall deem necessary or advisable in order to comply with such Environmental Law.

(h) Except as provided in Schedule 10(h), Tenant represents and warrants that (i) it is not aware of any Environmental Violation or suspected Environmental Violation at any of the Leased Premises as of the Effective Date and (ii) Tenant has disclosed to Landlord all known or suspected Environmental Violations and the presence of Hazardous Conditions or Hazardous Substances existing on any of the Leased Premises prior to the Effective Date. If Tenant fails to comply with any requirement of any Environmental Law in connection with any Environmental Violation which occurs or is found to exist, Landlord shall have the right (but no obligation) to take any and all actions as Landlord shall deem necessary or advisable in order to cure such Environmental Violation.

(i) Tenant shall notify Landlord on the earlier of (i) three (3) Business Days after obtaining knowledge thereof or (ii) the date on which notice is required to be delivered to any governmental authority under applicable Environmental Law, or contemporaneous with notice being provided to any governmental authority, with respect to (X) any Environmental Violation (or alleged Environmental Violation), (Y) spill or release of any Hazardous Substances that could reasonably be expected to result in a claim or liability under Environmental Law, or (Z) noncompliance with any of the covenants contained in this Paragraph 10, and shall promptly forward to Landlord copies of all orders, reports, notices, permits, applications or other communications relating to any such violation or noncompliance.

(j) Intentionally Omitted.

(k) Tenant shall, from time to time, upon Landlord's reasonable request, provide Landlord with evidence (a duly authorized and executed officer's certificate from Tenant shall be sufficient evidence) satisfactory to Landlord that the Real Property complies with all Legal Requirements or is exempt from compliance with such Legal Requirements.

(l) Except for the water tank more particularly described in Schedule 10(l) (the " Water Tank"), and the above-ground tank containing diesel fuel described in Schedule 10(l) (the " Diesel Tank"), there are no above or underground tanks at either of the Leased Premises as of the date hereof. Tenant represents and warrants that the Water Tank has not been used by Tenant or its Affiliates for any purpose other than to hold water from a domestic water line as a water reservoir for the fire sprinkler system at the Long Beach Leased Premises. Unless otherwise directed by Landlord, and except for the Water Tank and the Diesel Tank, Tenant shall, at its sole cost and expense, close any tanks (above or underground) or remnants thereof at each of the Leased Premises prior to the termination or expiration of the Term. Tenant shall: (i) remove any such tanks, their contents, and associated equipment and piping at each of the Leased Premises in accordance with Environmental Law; (ii) close any such tanks in accordance with Environmental Law; (iii) perform any Site Assessments reasonably necessary to determine whether the prior use of or removal or closure procedures with respect to any such tanks resulted in an Environmental Adverse Condition; (iv) remediate all Environmental Adverse Conditions associated with any such tanks in accordance with this subparagraph; and (v) notify as required all appropriate Governmental Authorities of the closure and removal of any such tanks that are regulated in accordance with Environmental Law. In the event that Landlord notifies Tenant that any or all of the tanks that otherwise are required to be removed pursuant to this Paragraph 10(l) may remain on any of the Leased Premises at the termination or expiration of the Term, Tenant shall take all appropriate actions to ensure that such tanks are in good working order, are emptied of all contents, are in compliance with all Environmental Laws, and do not constitute an Environmental Adverse Condition at the termination or expiration of the Term. Prior to the termination or expiration of the Term, Tenant shall provide Landlord with (x) proof of closure or removal of any such tanks that are required to be closed or removed pursuant to this Paragraph 10(l), (y) copies of all Site Assessments performed in conjunction with the closure or removal of any such tanks, and (z) all documentation of the regulatory status of all tanks at any of the Leased Premises (including without limitation any such documentation regarding the Water Tank and the Diesel Tank, and any other tanks whether or not Landlord has allowed Tenant to leave in place any other tanks at such Leased Premises).

11. Liens; Recording.

(a) Except as contemplated in Paragraph 10, Tenant shall not, directly or indirectly, create or permit to be created or to remain and shall promptly discharge or remove any lien, levy or encumbrance on any of the Leased Premises or on any Rent or any other sums payable by Tenant under this Lease, other than any Mortgage or Assignment, the Permitted Encumbrances and any mortgage, lien, encumbrance or other charge created by or resulting solely from any act or omission of Landlord. NOTICE IS HEREBY GIVEN THAT LANDLORD SHALL NOT BE LIABLE FOR ANY LABOR, SERVICES, EQUIPMENT OR MATERIALS FURNISHED OR TO BE FURNISHED TO TENANT OR TO ANYONE HOLDING OR OCCUPYING ANY OF THE

LEASED PREMISES THROUGH OR UNDER TENANT, AND THAT NO MECHANICS' OR OTHER LIENS FOR ANY SUCH LABOR, SERVICES OR MATERIALS SHALL ATTACH TO OR AFFECT THE INTEREST OF LANDLORD IN AND TO ANY OF THE LEASED PREMISES. LANDLORD MAY AT ANY TIME POST ANY NOTICES ON ANY OF THE LEASED PREMISES REGARDING SUCH NON-LIABILITY OF LANDLORD. Landlord may record, at its election, notices of non-responsibility pursuant to California Civil Code Section 8444 in connection with any work performed by Tenant at the Leased Premises.

(b) At the request of either Party, the other Party shall execute, deliver and record, file or register (collectively, "Record") all such instruments as may be reasonably required or permitted by any present or future Law in order to evidence the respective interests of Landlord and Tenant in the Leased Premises, and shall cause a memorandum of this Lease and a memorandum memorializing any amendment or supplement hereto or thereto, to be Recorded in such manner and in such places as may be required or permitted by any present or future Law in order to protect the validity and priority of this Lease.

12. Maintenance and Repair.

(a) Tenant shall complete the repairs listed on Schedule 12(a) (the "Immediate Repairs") no later than twelve (12) months after the Effective Date. Upon completion of the Immediate Repairs, Tenant shall deliver to Landlord (i) lien waivers reasonably satisfactory to Landlord and (ii) a certificate of Tenant, signed by an officer of Tenant, stating that the Immediate Repairs have been fully completed and comply with the applicable requirements of this Lease and with all Legal Requirements. Landlord hereby agrees that no Letter of Credit or other security shall be required to be delivered by Tenant to Landlord in connection with the Immediate Repairs.

(b) Subject to the completion of the Immediate Repairs, any Alterations permitted hereunder, restorations following any Casualty or Condemnation, and all other rights of Tenant under this Lease, and subject to reasonable wear and tear, Tenant shall at all times maintain each of the Leased Premises in as good repair, appearance and condition as they are on the Effective Date and fit to be used for the Permitted Use in accordance with the practices generally recognized as then acceptable by other office tenants, and (ii) the Equipment, in as good mechanical condition as it was on the later of the date hereof or the date of its installation, except for ordinary wear and tear, and subject to maintenance, repair and replacement of same. Tenant shall take every other action necessary or appropriate for the preservation and safety of each of the Leased Premises and the life safety of any occupants of each of the Leased Premises or their invitees. Tenant shall promptly make all Alterations of every kind and nature, whether foreseen or unforeseen, which may be required to comply with the foregoing requirements of this Paragraph 12(b) or to comply with any Legal Requirement. Landlord shall not be required to make any Alteration, whether foreseen or unforeseen, or to maintain any of the Leased Premises in any way, and Tenant hereby expressly waives any right which may be provided for in any Law now or hereafter in effect to make Alterations at the expense of Landlord or to require Landlord to make Alterations. Any Alteration made by Tenant pursuant to this Paragraph 12 shall be made in conformity with the provisions of Paragraph 13. Tenant hereby agrees and covenants not to commit or permit any of the Leased Premises to suffer waste, and shall take all precautions necessary to prevent waste from occurring at any of the Leased Premises.

(c) Tenant shall provide Landlord with an engineering or property condition report (at Tenant's sole cost and expense and in form and substance satisfactory to Landlord, in Landlord's reasonable discretion) not more than twenty-four (24) months nor less than eighteen (18) months prior to the end of the Initial Term or any Renewal Term (a "Property Condition Report"). If (i) such Property Condition Report lists replacements of the roof or HVAC systems as required or advisable on any of the Leased Premises during the remainder of the Initial Term or any Renewal Term, or (ii) an Alteration or repair to any of the Leased Premises is required by any Legal Requirement during the last eighteen (18) months of the Initial Term or any Renewal Term, then, provided that such Alteration or repair is the result of normal wear and tear and not due to neglect or waste by Tenant, then the cost of such Alteration or repair, as the case may be, will be apportioned between Landlord and Tenant with Tenant's share equal to the cost of such Alteration or repair, as the case may be, multiplied by a fraction, the numerator of which shall be the remainder of the Term from the time such Alteration or repair is made pursuant to subparagraphs (i) or (ii) above, and the denominator of which shall be the anticipated useful life of such Alteration or repair, as the case may be. If such Alteration or repair is required due to neglect or waste by Tenant or the breach of any of Tenant's other obligations under this Lease, Tenant shall bear the full cost of such Alteration or repair, including any reasonable Costs incurred by Landlord to ensure that the Alteration and repair are completed, and such Alteration or repair shall be made in accordance with Paragraphs 12 and 13 of this Lease.

(d) Except as disclosed by a survey or other writing provided to Landlord prior to the Effective Date, if any Improvement, now or hereafter constructed, shall (i) materially encroach upon any setback or any property, street or right-of-way adjoining such Leased Premises, (ii) materially violate any zoning restrictions, including without limitation height or set-back restrictions, or the provisions of any restrictive covenant affecting such Leased Premises, (iii) hinder or obstruct any Easement Agreement to which such Leased Premises is subject or (iv) impair the rights of others in, to or under any of the foregoing, Tenant shall, promptly after receiving written notice or otherwise acquiring actual knowledge thereof, either (A) obtain from all necessary parties waivers or settlements of all claims, liabilities and damages resulting from each such encroachment, violation, hindrance, obstruction or impairment, whether the same shall affect Landlord, Tenant or both, or (B) take such action as shall be necessary to remove all such encroachments, hindrances or obstructions and to end all such violations or impairments, including, if necessary, making Alterations.

(e) Tenant waives and releases any right it may have to make repairs at Landlord's expense or to quit the Leased Premises under Sections 1941, 1942(a) and 1932(1) of the California Civil Code or any other statute now or hereafter in effect which would otherwise afford Tenant the right to make repairs at Landlord's expense or to terminate this Lease because of Landlord's failure to keep the Leased Premises in good order, condition and repair.

13. Alterations and Improvements.

(a) Tenant shall not make (i) any non-structural Alterations to any of the Long Beach Leased Premises that cost more than One Million Dollars ($1,000,000.00) or to any of the Columbus Leased Premises that cost more than Five Hundred Thousand Dollars ($500,000.00), each in the aggregate, in any calendar year or (ii) any structural Alterations to any Leased Premises, without

having first obtained the prior written consent of Landlord (such consent not to be unreasonably withheld, conditioned or delayed); provided, however that the Alterations (x) in progress as of the Effective Date, (y) planned to be completed before the end of the year 2014, or (z) that are tenant improvements under Existing Subleases and described in Schedule 13(a) of this Lease, are not subject to, and do not and shall not count against, the foregoing monetary caps and are hereby approved by Landlord in all respects. Tenant shall not construct upon the Real Property any additional buildings or other structural improvements without having first obtained the prior written consent of Landlord. Landlord shall have the right to require Tenant to remove at the end of the Term any Alterations so long as Landlord gives Tenant written notice of election to require removal within ten (10) days of giving Tenant approval for such Alteration; provided, however, that Landlord shall not have the right to require Tenant to remove any of the following: Alterations required by Law, Alterations generally consistent with office use, and tenant improvements by subtenants under approved Subleases.

(b) If Tenant makes any Alterations pursuant to this Paragraph 13 or as required by Paragraph 12 or Paragraph 17 (such Alterations and actions being hereinafter collectively referred to as " Work") to any of the Leased Premises, then (i) the market value of such Leased Premises shall not be lessened or its usefulness impaired, by the completion of such Work (ii) all such Work shall be performed by Tenant in a good and workmanlike manner, (iii) all such Work shall be expeditiously completed in compliance with all Legal Requirements, (iv) all such Work shall comply with the requirements of all insurance policies required to be maintained by Tenant hereunder, (v) if any such Work involves the replacement of Equipment or parts thereto, all replacement Equipment or parts shall have a value and useful life equal to the greater of (A) the value and useful life on the Effective Date of the Equipment being replaced or (B) the value and useful life of the Equipment being replaced immediately prior to the occurrence of the event which required its replacement (assuming such replaced Equipment was then in the condition required by this Lease), (vi) Tenant shall promptly discharge or remove all liens filed against such Leased Premises arising out of such Work, (vii) Tenant shall procure and pay for all permits and licenses required in connection with any such Work, (viii) the product and results of all such Work shall be the property of Landlord and shall be subject to this Lease, and Tenant shall execute and deliver to Landlord any document reasonably requested by Landlord evidencing the assignment to Landlord of all estate, right, title and interest (other than the leasehold estate created hereby) of Tenant or any other Person thereto or therein, and (ix) if such Alterations will cost in excess of One Million Dollars ($1,000,000.00), Tenant shall comply, to the extent requested by Landlord or required by this Lease, with the provisions of Paragraph 19(a)(i)-(vii) (provided that (x) any "Restoration Fund" shall be funded within ten (10) Business Days after Landlord's approval of such Alterations, in such as amount as Landlord shall reasonably determine, (y) Tenant shall not be required to hire a casualty consultant, and (z) neither Landlord nor Lender shall commingle amounts in any "Restoration Fund" created pursuant to this Paragraph 13(b) with Landlord's or Lender's other funds, and Tenant agrees that such amounts in any such "Restoration Fund" shall not bear interest), whether or not such Work involves restoration of any of the Leased Premises.

14. Permitted Contests.

Notwithstanding any other provision of this Lease, Tenant shall not be required to (a) pay any Imposition , (b) comply with any Legal Requirement, (c) discharge or remove any lien referred

to in Paragraph 11 or Paragraph 13 or (d) take any action with respect to any encroachment, violation, hindrance, obstruction or impairment referred to in Paragraph 12(d) (such non-compliance with the terms hereof being hereinafter referred to collectively as "Permitted Violations") and may dispute or contest the same, so long as at the time of such non-compliance no Event of Default exists and so long as Tenant shall contest, in good faith, the existence, amount or validity thereof, the amount of the damages caused thereby, or the extent of its or Landlord's liability therefor by appropriate proceedings which shall operate during the pendency thereof to prevent or stay (i) the collection of, or other realization upon, the Permitted Violation so contested, (ii) the sale, forfeiture or loss of any of the Leased Premises or any Rent to satisfy or to pay any damages caused by any Permitted Violation, (iii) any interference with the use or occupancy of any of the Leased Premises, (iv) any interference with the payment of any Rent, (v) the cancellation or increase in the rate of any insurance policy or a statement by the carrier that coverage will be denied or (vi) the enforcement or execution of any injunction, order or Legal Requirement with respect to the Permitted Violation. Tenant shall provide Landlord security (by way of example only, in the form of a cash escrow or Letter of Credit) which is satisfactory, in Landlord's reasonable judgment, to assure that such Permitted Violation is corrected, including all Costs, interest and penalties that may be incurred or become due in connection therewith. While any proceedings which comply with the requirements of this Paragraph 14 are pending and the required security is held by Landlord, Landlord shall not have the right to correct any Permitted Violation thereby being contested unless Landlord is required by Law to correct such Permitted Violation and Tenant's contest does not prevent or stay such requirement as to Landlord. Each such contest shall be promptly and diligently prosecuted by Tenant to a final conclusion, except that Tenant, so long as the conditions of this Paragraph 14 are at all times complied with, has the right to attempt to settle or compromise such contest through negotiations. Tenant shall pay any and all losses, judgments, decrees and Costs in connection with any such contest and shall, promptly after the final determination of such contest, fully pay and discharge the amounts which shall be levied, assessed, charged or imposed or be determined to be payable therein or in connection therewith, together with all penalties, fines, interest and Costs thereof or in connection therewith, and perform all acts the performance of which shall be ordered or decreed as a result thereof. No such contest shall subject Landlord to the risk of any civil or criminal liability. Without limiting the foregoing, Tenant shall also have the right to take any action or undertake any proceeding against any applicable collecting authority to (y) seek an abatement or refund of any Impositions or a reduction in the valuation of the Leased Premises, and/or (z) contest the applicability of any Impositions. In any instance where any permitted action or proceeding is being undertaken by Tenant as set forth in this Paragraph 14, Landlord shall cooperate reasonably with Tenant, at no cost or expense to Landlord, and execute any and all documents reasonably required in connection therewith. Tenant shall be entitled to any refund of any amounts received by Tenant or Landlord pursuant to any permitted action or proceeding described in this Paragraph 14.

15. Indemnification.

(a) Tenant shall pay, protect, indemnify, defend, save and hold harmless Landlord, Lender and all other Indemnitees from and against any and all liabilities, losses, damages (including punitive damages), penalties, Costs (including reasonable attorneys' fees and expenses), causes of action, suits, claims, demands or judgments of any nature whatsoever, without regard to the form of action and whether based on strict liability, gross negligence, negligence, or any other theory of

recovery at law or in equity (collectively, "Losses"), in each case proximately caused by events occurring during the Term, and arising from (i) the ownership, leasing, use, non-use, occupancy, operation, management, condition, design, construction, maintenance, repair or restoration of any of the Leased Premises; (ii) any Casualty in any manner arising from any of the Leased Premises, whether or not Indemnitee has or should have knowledge or notice of any defect or condition causing or contributing to said Casualty; (iii) any violation by Tenant of (A) any provision of this Lease (including any representation or warranty), (B) any contract or agreement to which Tenant is a party, (C) any Legal Requirement or (D) any Permitted Encumbrance or any other encumbrance consented to by Tenant; (iv) any default by Landlord of any Loan, to the extent caused by an Event of Default by Tenant under this Lease, or (v) any alleged, threatened or actual Environmental Violation, including (A) liability for response costs and for costs of removal and remedial action incurred by the United States Government, any state or local governmental unit or any other Person, or damages from injury to or destruction or loss of natural resources, including the reasonable costs of assessing such injury, destruction or loss, incurred pursuant to Sections 107 or 113 of CERCLA, or any successor section or act or provision of any similar state or local Law, (B) liability for costs and expenses of abatement, correction or clean-up, fines, damages, response costs or penalties which arise from the provisions of any of the other Environmental Laws and (C) liability for personal injury or property damage arising under any statutory or common-law tort theory, including damages assessed for the maintenance of a public or private nuisance or for carrying on of a dangerous activity; provided that such acts or omissions took place during the term of the Lease; and provided, further, that, notwithstanding the foregoing, Tenant shall have no liability or obligation to any Indemnitee under this Paragraph 15 to the extent of any Loss arising out of any Indemnitee's gross negligence or willful misconduct.

(b) Landlord shall pay, protect, indemnify, defend, save and hold harmless Tenant from and against any and all Losses arising from any default by Landlord under this Lease, the actions of any Site Reviewers at any of the Leased Premises, any Site Assessments, or the gross negligence or willful misconduct of Landlord or any of Landlord's directors, members, officers, general partners, limited partners, shareholders, employees or agents, or any predecessor, successor or affiliate of any of the foregoing.

(c) In case any action or proceeding is brought against any party indemnified under this Paragraph 15, (i) such indemnified party shall notify the indemnitor to resist or defend such action or proceeding, and such indemnified party will cooperate and assist in the defense of such action or proceeding if reasonably requested to do so by the indemnitor and (ii) in the case that Tenant is the indemnitor, Tenant may, except during the continuance of an Event of Default caused by the failure of Tenant to pay to Landlord any amounts due under this Lease (after any applicable notice and cure periods), select and, retain its own counsel and defend such action (it being understood that Landlord may employ counsel of its choice to monitor the defense of any such action, the cost of which shall be paid by Tenant). During the continuance of an Event of Default caused by the failure of Tenant to pay to Landlord any amounts due under this Lease (after any applicable notice and cure periods), Landlord shall have the right to select counsel, and the fees and expenses of such counsel shall be paid by Tenant.

(d) Tenant hereby indemnifies and holds harmless Landlord from and against any claims (including reasonable attorneys' fees) for brokerage fees or commissions arising out of any existing

Subleases at the Leased Premises. Tenant also hereby indemnifies and holds harmless Landlord against any such action brought by any subtenant at the Leased Premises and any claims or damages suffered by Landlord during the Term as a result of any such action brought by any subtenant, unless such claims or damages are the result of Landlord's gross negligence, willful misconduct, breach of this Lease, or breach of any agreement between Landlord and any subtenant.

(e) The obligations of Landlord and Tenant under this Paragraph 15 shall survive any termination, expiration or rejection in bankruptcy of this Lease.

16. Insurance.

(a) Each policy of insurance listed on Schedule 16(a) attached hereto (the "Existing Insurance Policies") is in full force and effect and all premiums due with respect thereto have been paid. There are no claims outstanding or pending under any Existing Insurance Policies.

(b) Tenant shall obtain, pay for and maintain the following insurance on or in connection with each of the Leased Premises:

(i) Insurance against all risk of physical loss or damage to the Improvements and Equipment as provided under "Special Causes of Loss" form coverage, including the perils of hail, windstorm, flood coverage, earthquake and acts of terrorism, in amounts not less than the actual replacement cost of the Improvements and Equipment without deduction for depreciation on agreed amount basis (except at least $5,000,000 limit for earthquake and flood); provided that, if Tenant's insurance company is unable or unwilling to include any or all of such excluded perils, Tenant shall have the option of purchasing coverage against such perils from another insurer on a "Difference in Conditions" form or through a stand-alone policy. Such policies shall contain if Special Causes of Loss form Law and Ordinance – Full Building Value, $10,000,000 Increased Cost of Construction and Demolition and if standalone earthquake policy $1,000,000 Building Law, Increased Cost of Construction and Demolition. Such policies and endorsements shall contain deductibles not more than $100,000 per occurrence except that earthquake coverage may have a deductible not to exceed 5% percent of actual replacement cost of the Improvements and flood coverage may have a deductible not to exceed $100,000. All such deductibles are Tenant's responsibility. Such policies shall name Landlord as a Named Insured, and Lender as mortgagee/loss payee, with respect to such Leased Premises.

(ii) Comprehensive Boiler and Machinery/Equipment Breakdown Insurance on any of the Equipment in such Leased Premises, in an amount not less than the full replacement cost of such Equipment (subject to an aggregate sublimit of $100,000,000) per accident for damage such Equipment (and which may be carried as part of the coverage required under clause (i) above or pursuant to a separate policy or endorsement). If such coverage is provided pursuant to a separate Boiler and Machinery policy or endorsement, Tenant will obtain a Joint Loss Agreement. Either such Boiler and Machinery policy endorsements or the Special Causes of Loss policy required in clause (i) above shall include at least $5,000,000 per incidence for Off-Premises Service Interruption and Expediting Expenses, Ammonia Contamination, and Hazardous Materials Clean-Up Expense and may contain a deductible not to exceed $100,000 (which is Tenant's responsibility). Such policies shall name Landlord and Lender as loss payees, with respect to such Leased Premises.

(iii) Business Income/Extra Expense Insurance at limits sufficient to cover 100% of the period of indemnity not less than eighteen (18) months from time of loss and an extended period of indemnity of not less than one hundred eighty (180) days. Such policies shall name Landlord and Lender as loss payees with respect to any payments under such policies for Rent under the Lease, and shall name Tenant as the loss payee for all other payments thereunder.

(iv) Commercial General Liability Insurance against claims for personal injury, bodily injury, death, accident or property damage occurring on, in or as a result of the use of such Leased Premises, in an amount not less than $1,000,000 per Occurrence/$2,000,000 Annual Aggregate and $2,000,000 Products/Completed Operations Annual Aggregate on a per location basis and on an occurrence basis. Coverage shall also include elevators/escalators (if any), independent contractors, contractual liability and Products/Completed Operations Liability coverage and liability caused by acts of terrorism. Such policies shall name Landlord and Lender as additional insureds with respect to such Leased Premises.

(v) Business Automobile Liability Insurance (including Owned – if any; Non-Owned and Hired Automobile Liability) in an amount of $1,000,000 Combined Single Limit.

(vi) Workers' Compensation insurance in the amount required by applicable Law (or, in lieu of any Workers' Compensation insurance, a program of self-insurance complying with the rules, regulations and requirements of the appropriate governmental agency).

(vii) Employers' Liability insurance covering all persons employed by Tenant in connection with any work done on or about such Leased Premises in the amount of $1,000,000 per accident, $1,000,000 per illness, per employee, and $1,000,000 per illness, in the aggregate (or, in lieu of any Workers' Compensation insurance (which shall contain Employers' Liability insurance), a program of self-insurance complying with the rules, regulations and requirements of the appropriate governmental agency). Landlord reserves the right to have evidence shown that any self-insurance program has been accepted by the appropriate governmental agency.

(viii) Excess/Umbrella Liability in an amount of not less than $25,000,000 on a per location basis that includes Follow Form coverage for Commercial General Liability, Business Automobile Liability and Employers' Liability coverages (provided, however, that if and to the extent Tenant determines, in its reasonable business judgment, that changes to such coverage are advisable given Tenant's current business and operations, Landlord agrees not to unreasonably withhold, condition or delay its consent to such changes).

(ix) During any period in which any Alterations at any Leased Premises are being undertaken by Tenant, and such Alterations are not insured pursuant to the policies and endorsements required in Paragraph 16(b)(i) above, builder's risk insurance or property insurance (either of which may contain commercially reasonable sublimits) covering the total completed value, including all hard costs with respect to any Improvements being constructed, altered or repaired (on a completed value, non-reporting basis), replacement cost of work performed and equipment, supplies and materials furnished in connection with such construction, alteration or repair of Improvements or Equipment, together with such other endorsements as Landlord may reasonably require, and general liability, worker's compensation and automobile liability insurance with respect to the

Improvements being constructed, altered or repaired, all in form and substance reasonably acceptable to Lender, Landlord and Tenant. Such policies shall name Landlord and Lender as Named Insured, Mortgagee, Additional Insured and/or Loss Payees with respect to such Leased Premises, as applicable.

(x) If Tenant handles, stores or utilizes Hazardous Substances (other than pesticides, cleaning supplies, toner for photocopying machines, and other commercially reasonable amounts of substances directly related to the cleaning, operation and/or maintenance of the Leased Premises or Tenant's office equipment (including, without limitation, diesel fuel contained in the Diesel Tank)) in its business operations, pollution legal liability insurance (with limits to be reasonably determined by Landlord and Tenant on a case by case basis). Such pollution legal liability insurance shall name Landlord and Lender as additional insureds with respect to such Leased Premises.

(xi) Such other insurance of the type and amount that is at the time requested customarily carried by prudent owners or tenants with respect to properties similar in character, location, use and occupancy to the respective Leased Premises (or other terms with respect to any insurance required pursuant to this Paragraph 16, including without limitation amounts of coverage, deductibles, form of mortgagee clause) on or in connection with such Leased Premises, all as may be reasonably agreed upon by Landlord, Lender and Tenant.

(c) The insurance required by Paragraph 16(b) shall be written by companies having a Best's rating of A-X or above and are authorized to write insurance policies by the State Insurance Department (or its equivalent) for the states in which each of the Leased Premises is located. The insurance policies (i) shall be for such terms as Landlord may reasonably approve and (ii) shall be in amounts sufficient at all times to satisfy any coinsurance requirements thereof. If said insurance or any part thereof shall expire, be withdrawn, become void, voidable, unreliable or unsafe for any reason, including a breach of any condition thereof by Tenant or the failure or impairment of the capital of any insurer, or if for any other reason whatsoever said insurance shall become reasonably unsatisfactory to Landlord, Tenant shall promptly obtain new or additional insurance reasonably satisfactory to Landlord.

(d) Each insurance policy referred to in clauses (i), (ii), (iii) and (ix) of Paragraph 16(b) shall contain standard non-contributory mortgagee clauses in favor of and acceptable to Lender. Each policy required by any provision of Paragraph 16(b) shall provide that it may not be cancelled, or allowed to lapse until ten (10) days following nonpayment of any premium therefor. Tenant shall use commercially reasonable efforts to cause each insurer issuing a policy required by any provision of Paragraph 16(b) to agree not to cancel such policy without at least ten (10) days' prior notice to Landlord and Lender.

(e) Tenant shall pay as they become due all premiums for the insurance required by Paragraph 16(b), shall renew or replace each policy and deliver to Landlord evidence of the payment of the full premium therefor or installment then due at least ten (10) days prior to the expiration date of such policy, and shall promptly deliver to Landlord all original certificates of insurance evidencing such coverages or, if requested by Landlord or required by Lender, original or certified policies. All certificates of insurance (including liability coverage) provided to Landlord and Lender

shall be on ACORD Form 28 (2003/10) for Property Coverages or ACORD Form 25 Liability Coverages (or its equivalent in the Landlord's sole discretion).

(f) Anything in this Paragraph 16 to the contrary notwithstanding, any insurance that Tenant is required to obtain pursuant to Paragraph 16(b) may be carried under a "blanket" policy or policies covering other properties of Tenant or under an "umbrella" policy or policies covering other liabilities of Tenant, as applicable; provided that, such blanket or umbrella policy or policies otherwise comply with the provisions of this Paragraph 16, and upon request, Tenant shall provide to Landlord a Statement of Values which may be reviewed annually and shall be amended to the extent determined necessary by Landlord based on revised Replacement Cost Valuations. The original or a certified copy of each such blanket or umbrella policy shall promptly be delivered to Landlord.

(g) Tenant shall not carry separate insurance concurrent in form or contributing in the event of a Casualty with that required in this Paragraph 16 unless (i) Landlord and Lender are included therein as Named Insureds, Additional Insureds, Mortgagee and with Loss Payable as provided herein, and (ii) such separate insurance complies with the other provisions of this Paragraph 16. Tenant shall immediately notify Landlord of such separate insurance and shall deliver to Landlord the original policies or certified copies thereof.

(h) Each policy (other than workers' compensation coverage or any other coverage prohibited by law) shall contain a full waiver of subrogation against the Landlord.

(i) The proceeds of any insurance required under Paragraph 16(b) shall be payable as follows: proceeds payable under clauses (iv), (v), (vi), (vii) and (viii) of Paragraph 16(b) and proceeds attributable to the general liability coverage of construction/alterations insurance under clause (ix) of Paragraph 16(b) shall be payable to the Person entitled to receive such proceeds; and proceeds of insurance required under clauses (i) and (ii) of Paragraph 16(b) and proceeds attributable to construction/alterations insurance (other than its general liability coverage provisions) under clause (ix) of Paragraph 16(b) shall be payable to Landlord or Lender and applied as set forth in Paragraph 17 or, if applicable, Paragraph 18. Proceeds of insurance required under clause (iii) of Paragraph 16(b) for the payment of Rent under the Lease (and proceeds from any other business interruption or similar coverage required hereunder for the payment of Rent under the Lease) shall be payable to Landlord and Lender, and all other proceeds of insurance required under clause (iii) of Paragraph 16(b) (and proceeds from any other business interruption or similar coverage required hereunder other than for the payment of Rent under the Lease) shall be payable to Tenant. Notwithstanding the foregoing in this clause (i), the Parties agree that any proceeds of insurance initially paid by any insurer jointly to Landlord and Tenant shall not be a breach of this Lease; provided, however, that upon any such joint payment, Tenant agrees to take all reasonable steps to deliver any such proceeds (or the full right to such proceeds, if payment is made in the form of a settlement check) to Landlord if and to the extent Landlord is entitled to same under the terms of this Lease. Tenant shall apply the Net Award to restoration of such Leased Premises in accordance with the applicable provisions of this Lease unless a Termination Event shall have occurred and Tenant has given a Termination Notice.

17. Casualty and Condemnation.

(a) Tenant shall give Landlord prompt notice of the occurrence of any Casualty at any of the Leased Premises. Landlord, in its discretion and upon notice to Tenant (except that no notice to Tenant shall be required if an Event of Default has occurred and is continuing), may adjust, collect and compromise all claims under any of the insurance policies required by Paragraph 16(b) (except claims (i) payable from comprehensive general public liability insurance, or (ii) in an amount less than One Million Dollars ($1,000,000) ("Excluded Claims") and to execute and deliver on behalf of Tenant all necessary proofs of loss, receipts, vouchers and releases required by the insurers. Provided that no Event of Default has occurred and is continuing, Tenant shall be entitled to participate with Landlord in any adjustment, collection and compromise of the insurance claim payable in connection with a Casualty. Tenant agrees to sign, upon the request of Landlord, all such proofs of loss, receipts, vouchers and releases. Landlord reserves the right to join Tenant in any claim. If Landlord so requests, Tenant shall adjust, collect and compromise any and all such claims, and Landlord shall have the right to join with Tenant therein. Any adjustment, settlement or compromise of any such claim shall be subject to the prior written approval of Landlord, and Landlord shall have the right to prosecute or contest, or to require Tenant to prosecute or contest, any such claim, adjustment, settlement or compromise. Each insurer is hereby authorized and directed to make payment under said policies, including return of unearned premiums, directly to Landlord instead of to Landlord and Tenant jointly, and Tenant hereby appoints Landlord as Tenant's attorney-in-fact to endorse any draft therefor. The rights of Landlord under this Paragraph 17(a) shall be extended to Lender if and to the extent that any Mortgage so provides. Notwithstanding anything to the contrary contained herein, Tenant shall have the exclusive right to adjust, collect and compromise all Excluded Claims and each insurer is hereby authorized and directed to make payments with respect to Excluded Claims solely to Tenant.

(b) Each Party shall provide the other with immediate written notice of its receipt of a Condemnation Notice relating to any of the Leased Premises. Landlord is authorized to collect, settle and compromise, in its discretion (and, if no Event of Default exists, upon notice to Tenant), the amount of any condemnation award. Provided that no Event of Default has occurred and is continuing, Tenant shall be entitled to participate with Landlord in any Condemnation proceeding or negotiations under threat thereof and to contest the Condemnation or the amount of the condemnation award therefor. No agreement with any condemning authority in settlement or under threat of any Condemnation shall be made by Tenant without the written consent of Landlord. Subject to the provisions of this Paragraph 17(b), Tenant hereby irrevocably assigns to Landlord any award or payment to which Tenant is or may be entitled by reason of any Condemnation, whether the same shall be paid or payable for Tenant's leasehold interest hereunder or otherwise; but nothing in this Lease shall impair Tenant's right to any award or payment on account of Tenant's trade fixtures, equipment or other tangible property that is not part of the Equipment, moving expenses, loss of goodwill, or loss of business, if available, to the extent that and so long as (i) Tenant shall have the right to make, and does make, a separate claim therefor against the condemning authority and (ii) such claim does not in any way reduce either the amount of the award otherwise payable to Landlord for the Condemnation of Landlord's interest in such Leased Premises or the amount of the award (if any) otherwise payable for the Condemnation of Tenant's leasehold interest hereunder. The rights of Landlord under this Paragraph 17(b) shall also be extended to Lender if and to the extent that any Mortgage so provides.

(c) If any Partial Casualty (whether or not insured against) shall occur (other than a Requisition) to any of the Leased Premises, this Lease shall continue, notwithstanding such event, and there shall be no abatement or reduction of any Rent. Promptly after such Partial Casualty or Partial Condemnation, Tenant, as required in Paragraphs 12(b) and 13(b), shall commence and diligently continue to restore such Leased Premises as nearly as possible to its value, condition and character immediately prior to such event (assuming such Leased Premises to have been in the condition required by this Lease). Landlord and Lender shall make any Net Award available to Tenant for restoration in accordance with and subject to the provisions of Paragraph 19(a). If a Requisition shall occur, Tenant shall comply with the terms and conditions of Paragraph 17(d). If any Casualty or Condemnation that is not a Partial Casualty or Partial Condemnation or Requisition shall occur, Tenant shall comply with the terms and conditions of Paragraph 18. Upon the expiration of the Term, any portion of the Net Award that shall not have been paid as expressly set forth herein shall be retained by Landlord.

(d) If any Partial Condemnation or Requisition shall occur to any of the Leased Premises, this Lease shall continue, notwithstanding such event, and the Rent due and payable hereunder shall be reduced by a fraction, the numerator of which is the Net Award paid to Landlord or Lender with respect thereto, and the denominator of which is the Acquisition Cost for the applicable Leased Premises set forth on Exhibit E. In the event of a Requisition of any of the Leased Premises, any Net Award payable by reason of such Requisition shall be (i) retained by Landlord, or (ii) paid to Lender to the extent that any Mortgage so provides.

18. Termination Events.

(a) If all or substantially all of any of the Leased Premises shall be taken by a Condemnation, Tenant shall, within thirty (30) days after Tenant receives a Condemnation Notice, give to Landlord written notice of Tenant's election to terminate this Lease with respect to the applicable Leased Premises (a "Termination Notice").

(b) If any portion of either of the Leased Premises shall be subject to a Condemnation that has or will render such Leased Premises inaccessible, unavailable for use, or unsuitable for restoration for continued use and occupancy in Tenant's business, as determined by a certified structural engineer or other suitable third party retained by Tenant and reasonably acceptable to Landlord, or would prevent current use under applicable zoning or use regulations, Tenant shall have the option of (i) restoring such Leased Premises, to the extent practicable, using the Net Award payable in connection with such Condemnation in accordance with the conditions and requirements set forth in this Lease or (ii) delivering to Landlord a Termination Notice with respect to the applicable Leased Premises prior to the earlier of (x) thirty (30) days after Tenant receives the report of such certified structural engineer or other suitable third party, a copy of which report shall be delivered to Landlord with the Termination Notice, and (y) sixty (60) days after Tenant receives the applicable Condemnation Notice. If Tenant elects not to deliver a Termination Notice, then Tenant shall restore such Leased Premises, to the extent practicable, in accordance with Paragraphs 17 and 19.

(c) If a Casualty occurs with respect to any of the Leased Premises which shall be determined by a certified structural engineer retained by Tenant and acceptable to Landlord to be a loss so substantial that restoration or rebuilding for any Permitted Use under Paragraph 4(a) would

either take more than two hundred seventy (270) days or be economically infeasible, Tenant shall have option of (i) restoring, rebuilding or repairing such Leased Premises, using the Net Award payable in connection with such Casualty in accordance with the conditions and requirements of this Lease, or (ii) delivering to Landlord a Termination Notice with respect to the applicable Leased Premises prior to the earlier of (X) thirty (30) days after Tenant receives the report of such certified structural engineer, a copy of which report shall be delivered to Landlord with the Termination Notice, and (Y) sixty (60) days after the date of such Casualty.

(d) A Termination Notice shall contain (i) notice of Tenant's intention to terminate this Lease with respect to the applicable Leased Premises on the Basic Rent Payment Date immediately following the date on which Landlord receives the Net Award (the "Termination Date"), and (ii) a binding and irrevocable commitment of Tenant to pay the Termination Amount on the Termination Date.

(e) If Tenant delivers a Termination Notice to Landlord, this Lease shall terminate on the Termination Date with respect to the applicable Leased Premises. On the Termination Date, (i) Tenant shall pay to Landlord the Termination Amount and all Rent due on or prior to the Termination Date with respect to the applicable Leased Premises (collectively, "Remaining Obligations"), (ii) all other obligations of Tenant under this Lease with respect to the applicable Leased Premises shall terminate except any obligations hereunder that expressly survive termination of the Lease, (iii) Tenant shall immediately vacate and shall have no further right, title or interest in or to such Leased Premises, and (iv) the Net Award shall be retained by Landlord. Notwithstanding anything to the contrary hereinabove contained, if on the Termination Date, Tenant has not satisfied all Remaining Obligations with respect to the applicable Leased Premises, then Landlord may, at its option, extend the Termination Date to a date which is no later than the first Basic Rent Payment Date after the date on which Tenant has satisfied all such Remaining Obligations.

(f) If this Lease terminates with respect to one of the Leased Premises, this Lease shall continue with respect to the other Leased Premises, and Basic Rent shall be reduced proportionately, consistent with the allocations of Basic Rent between the Leased Premises set forth on Exhibit D.

19. Restoration.

(a) If any Net Award with respect to any of the Leased Premises is in excess of One Million Dollars ($1,000,000) (which amount shall be adjusted annually in proportion to increases in the CPI), Landlord (or Lender if required by any Mortgage) shall hold the Net Award in a fund (the "Restoration Fund") and disburse amounts from the Restoration Fund only in accordance with the following conditions:

(i) Tenant shall commence the restoration as soon as reasonably practical and diligently pursue completion of such restoration to completion;

(ii) prior to commencement of restoration, (A) the architects, contracts, contractors, plans and specifications and a detailed budget for the restoration shall have been approved by Landlord, such detailed budget shall reflect that the Restoration Fund is sufficient to cover the costs of restoration, including any additional insurance required as a result of restoration,

and payments of Rent due under this Lease during the period of such restoration (if Landlord reasonably determines that the Restoration Fund is insufficient to cover such costs, Tenant must deposit such required excess amount as directed by Landlord as provided in, and subject to, Paragraph 19(b) below), (B) Landlord and Lender shall be provided by Tenant with mechanics' lien insurance, "owner contractor's protective liability insurance" (if available), builder's risk completed value insurance and acceptable performance and payment bonds which insure satisfactory completion of and payment for the restoration, are in an amount and form and have a surety acceptable to Landlord, and name Landlord and Lender as additional dual obligees, and (C) appropriate notices of commencement of work shall have been filed if required in the appropriate jurisdiction;

(iii) at the time of any disbursement, (A) no Event of Default shall exist, (B) all materials installed and work and labor performed (except to the extent being paid out of the requested disbursement) in connection with the restoration shall have been paid in full, and (C) no mechanics' or materialmen's liens or stop orders or notices of pendency shall have been filed or threatened against such Leased Premises and remain undischarged or, alternatively, the obligations related to the Work shall be fully bonded to the satisfaction of Landlord;

(iv) disbursements shall be made no more frequently than once a month and be in an amount not exceeding the cost of the Work completed since the last disbursement, upon receipt of (A) satisfactory evidence, including architects' certificates, of the stage of completion, the estimated total cost of completion and performance of the Work to date in a good and workmanlike manner in accordance with the contracts, plans and specifications, (B) waivers of liens (any of which may be conditional waivers if and to the extent the Person delivering the waiver has not yet been paid for the applicable work), (C) sworn statements as to completed Work and the cost thereof for which payment is requested from the contractor engaged to complete the Work, (D) a satisfactory bringdown of title insurance, and (E) other evidence of cost and payment so that Landlord and Lender can verify that the amounts disbursed from time to time are represented by Work that is completed, in place and free and clear of mechanics' and materialmen's lien claims;

(v) each request for disbursement shall be accompanied by a certificate of Tenant, signed by a senior executive officer of Tenant, describing the Work for which payment is requested, stating the cost incurred in connection therewith, stating that Tenant has not previously received payment for such Work and, upon completion of the Work, also stating that the Work has been fully completed and complies with the applicable requirements of this Lease and with all Legal Requirements;

(vi) Landlord may retain ten percent (10%) of the Restoration Fund until the Work is fully completed; and

(vii) such other reasonable conditions as Landlord or Lender may impose; including without limitation, if the costs of restoration exceeds One Million Dollars ($1,000,000) for the Long Beach Real Property or Eight Hundred Thousand Dollars ($800,000) for the Columbus Real Property (which amounts shall be adjusted annually in proportion to increases in the CPI) and Landlord so requests, or, if required by Lender, a requirement that Tenant hire a casualty consultant.

(b) Landlord agrees that neither Landlord nor Lender shall commingle any amounts in any Restoration Fund with Landlord's or Lender's other funds, and Tenant acknowledges that such amounts in any Restoration Fund shall not bear interest. Prior to commencement of restoration and at any time during restoration, if the estimated cost of completing the restoration Work free and clear of all liens, as reasonably determined by Landlord or Lender, exceeds the amount of the Net Award available for such restoration, the amount of such excess shall, upon demand by Landlord, be paid by Tenant to Landlord to be added to the Restoration Fund. Any sum so added by Tenant which remains in the Restoration Fund upon completion of restoration shall be refunded to Tenant. For purposes of determining the source of funds with respect to the disposition of funds remaining after the completion of restoration, the Net Award shall be deemed to be disbursed prior to any amount added by Tenant. For the avoidance of doubt, the Parties acknowledge that any obligation of Tenant to perform any Restoration Work hereunder is conditioned on Tenant being entitled to receive, and receiving (or receiving the benefit of), the applicable Net Award to fund the costs of such Restoration Work (subject to the conditions set forth in this Paragraph 19).

(c) If any sum remains in the Restoration Fund after completion of the restoration and any refund to Tenant pursuant to Paragraph 19(b), such sum (the "Remaining Sum") shall be refunded (i) to Tenant, if the applicable Restoration Work was related to a Casualty, and (ii) to Landlord, if the applicable Restoration Work was related to a Condemnation.

(d) Tenant waives and releases all statutory rights and remedies in favor of Tenant in the event of damage or destruction, including without limitation those available under California Civil Code Sections 1932 and 1933(4). Tenant hereby waives any rights and the benefits of Section 1265.130 of the California Code of Civil Procedure or any other statute granting Tenant specific rights in the event of a Condemnation which are inconsistent with the provisions of Paragraphs 17, 18 and 19.

20. Intentionally Omitted.

21. Assignment and Subletting; Prohibition Against Leasehold Financing.

(a) Except as provided in this Paragraph 21, Tenant shall not assign or sublet Tenant's interest in this Lease and any purported assignment or sublease in violation of this Paragraph 21 shall be null and void. Tenant hereby waives and releases its rights under Section 1995.310 of the California Civil Code or under any similar law, statute or ordinance now or hereafter in effect.

(b) Tenant may assign all, but not less than all, of Tenant's interest in this Lease (voluntarily or involuntarily, whether by operation of law or otherwise, including through merger or consolidation) in connection with a Permitted Asset Transfer or a Permitted Change of Control (each, a "Preapproved Assignment"), without the prior written consent of Landlord. Any other assignment of Tenant's interest in this Lease shall be subject to Landlord's prior written consent, which consent shall not be unreasonably withheld, conditioned or delayed. Tenant agrees that it shall deliver to Landlord in connection with any request for assignment information regarding the Review Criteria of the proposed assignee.

(c) For purposes of this Paragraph 21, the term "Permitted Asset Transfer" shall mean the sale, conveyance, transfer or other disposition by Tenant, to any Person, of all or substantially all of Tenant's assets whether in a single transaction or series of transactions (an "Asset Transfer"), in which the following conditions are met: (i) the Asset Transfer is to (A) a wholly-owned Subsidiary of Tenant, (B) a Credit Entity (or an entity whose obligations under the Lease are guaranteed by a Credit Entity pursuant to a guaranty in form and substance reasonably acceptable to Landlord), or (C) a Qualified Transferee (or an entity whose obligations under the Lease are guaranteed by a Qualified Transferee pursuant to a guaranty in form and substance reasonably acceptable to Landlord); and (ii) this Lease is assigned to such Person as a part of such Asset Transfer. In the event of a Permitted Asset Transfer, Tenant shall be relieved of its obligations under this Lease upon the complete assignment and assumption of the Tenant's obligations under this Lease to such Person and any existing Guarantor shall be released from its obligations under its Guaranty upon the delivery to Landlord of a replacement Guaranty in form and substance reasonably acceptable to Landlord (a " Replacement Guaranty"). Any Replacement Guarantor will comply with the financial reporting provisions of Paragraph 28.

(d) For purposes of this Paragraph 21, the term "Permitted Change of Control" shall mean the acquisition, directly or indirectly, by any Person or "group" (within the meaning of Section 13(d) or Section 14(d) of the Securities Exchange Act of 1934, as amended) pursuant to a single transaction or series of related transactions of (i) more than 50% of the voting stock, partnership interests, membership interests or other equitable and/or beneficial interests of Tenant or (ii) the power (whether or not exercised) to elect a majority of the directors of Tenant or voting control of any partnership or limited liability company or other entity acting as its general partner or managing member (including through a merger or consolidation of Tenant with or into any other Person) (in either case described in clause (i) and (ii), "Control"), in which the purchaser of such Control (the " Control Person") is (A) a wholly-owned Subsidiary of Tenant, (B) after taking into account the transaction that resulted in the acquisition of such Control, a Credit Entity, or (C) a Qualified Transferee. None of the following shall be deemed to be a prohibited or restricted assignment for purposes of this Paragraph 21: (x) the sale of stock by persons or parties through the "over-the-counter market" or through any recognized stock exchange, other than by those deemed to be a "control-person" within the meaning of the Securities Exchange Act of 1934A, or (y) any sale or other transfer of less than 50% of the voting stock, partnership interests, membership interests or other equitable and/or beneficial interests of Tenant where the acquiring Person or group does not otherwise satisfy the criteria for "Control" described in clause (ii) of the definition thereof. In the event of a Permitted Change of Control in which the purchaser by such Control is a Credit Entity, upon execution of by such Control Person of a Replacement Guaranty, the existing Guarantor will be released from any existing Guaranty, and such Control Person shall become the Replacement Guarantor hereunder and comply with the financial reporting provisions of Paragraph 28.

(e) Tenant may, upon thirty (30) days prior written notice to Landlord, and without any requirement for consent or approval by Landlord, enter into one or more Subleases with the following: (i) any Person (including without limitation any Governmental Entity) so long as the aggregate amount of rentable square footage at either of the Leased Premises subject to Subleases to Persons other than Exempt Persons does not exceed 40% of the total rentable square footage at such Leased Premises (the " Subleasing Threshold"), and (ii) without limiting anything contained

in clause (i) of this sentence, any Exempt Person (any such Sublease referenced in clause (i) or clause (ii) of this sentence, a "Preapproved Sublease"). For the avoidance of doubt, the Parties hereby agree that (1) the total rentable square footage at the Long Beach Leased Premises is 461,263 rentable square feet and the total rentable square footage at the Columbus Leased Premises is 160,000 rentable square feet, (2) in no event shall any Sublease with any Exempt Person be deemed to require consent or approval of Landlord by reason of the Subleasing Threshold (or otherwise, except as provided below with respect to the terms of such Sublease); (3) any Existing Subleases (other than any Existing Subleases that are with Exempt Persons) will be included in any determination of whether the Subleasing Threshold is (or would be) exceeded (if and to the extent such Existing Subleases are Subleases at the time of determination), and (4) in no event shall the fact that the Subleasing Threshold may be exceeded on the Effective Date with respect to Existing Leases at either Leased Premises be deemed a breach by Tenant hereunder or require any additional consent or approval by Landlord.. Other than Preapproved Subleases, at no time during the Term shall Tenant enter into a Sublease with respect to all or any portion of any of the Leased Premises without the prior written consent of Landlord, which consent shall not be unreasonably withheld, conditioned or delayed, with Landlord agreeing that, without limitation, Landlord shall grant consent to any proposed Sublease with any Person, so long as such Sublease contains the Required Sublease Provisions (if required pursuant to this Paragraph 21), where the Review Criteria for such Person are reasonably determined to meet or exceed the general requirements for such characteristics of tenants or subtenants imposed by landlords of "Class A" office buildings in the market area for the particular Leased Premises that would be subject to such Sublease. Tenant agrees that each Sublease shall provide as follows (collectively, the "Required Sublease Provisions"): (w) the term of the Sublease does not extend beyond the then-current Term minus one day including any extension options of the sublease, (x) the Sublease is subject and subordinate to this Lease and any Mortgage, and the Sublease terminates upon any termination of this Lease, unless Landlord delivers a Sublease SNDA executed by Landlord and Lender (as described in Paragraph 21(f) below) or otherwise agrees not to disturb subtenant upon a termination of the Lease and elects in writing to cause the subtenant to attorn to and recognize Landlord as the lessor under such Sublease, whereupon following any termination of the Lease such Sublease shall continue as a direct lease between the subtenant and Landlord upon all the terms and conditions of such Sublease, (y) the Sublease contains (i) financial reporting requirements materially similar to those described in Paragraph 28 (except for those Subleases demising less than five percent (5%) of the rentable square footage of either Leased Premises, where financial reporting requirements shall be commercially reasonable for the applicable subtenant), (ii) subtenant obligations that are substantially the same (or more favorable to the Tenant as sublandlord) as Tenant's obligations under Paragraph 4(a) (excluding any provisions therein relating to Alterations), and Paragraph 10(a) (excluding (A) any provisions therein relating to Insurance Requirements, and (B) Paragraph 10(a)(iii)), (iii) provisions requiring subtenant to maintain the sublease premises in as good repair, appearance and condition as they are on the effective date of the applicable Sublease, not to commit or permit waste, and to take all precautions reasonably necessary to prevent waste from occurring at the sublease premises, and (iv) other commercially reasonable terms, and (z) the Sublease requires the subtenant to deliver a certification in form substantially similar to that attached to this Lease as Exhibit G; provided, however, that, in no event shall (A) any Required Sublease Provisions be required to be included in any Exempt Sublease, or (B) any Required Sublease Provisions (except as provided in clause (w) of the Required Sublease Provisions) be required in any Sublease with any Governmental Entity; provided, however,

that (1) any Sublease with any Governmental Entity shall provide that such Sublease is subordinate to any Mortgage and the Lease, if such Government Entity's form of lease/sublease so expressly provides, or any applicable regulations so expressly permit, but, without limitation, such Sublease may provide for automatic nondisturbance protection for the subtenant; and (2) if such Sublease is with a state or municipal agency, or any other Governmental Entity that does not have any publicly rated debt, such Sublease shall comply with clause (y)(i) of the Required Sublease Provisions. Without limiting the foregoing, Landlord agrees that it shall not unreasonably withhold, condition or delay its consent to any form of Sublease proposed by Tenant.

(f) If Tenant assigns all of its rights and interest under this Lease, the assignee under such assignment shall expressly assume all the obligations of Tenant hereunder, actual or contingent, arising after the date of such assignment, by a written instrument delivered to Landlord at the time of such assignment. Landlord shall deliver a subordination, non-disturbance and attornment agreement in connection with any Sublease for more than 7,500 rentable square feet, substantially in the form attached hereto as Exhibit L, or, if requested by Tenant, another form reasonably satisfactory to Landlord and Tenant, in each case executed by Landlord and any Lender or other holder of any Mortgage encumbering the applicable Leased Premises (a " Sublease SNDA"), not less than five (5) Business Days after request therefor from Tenant. Except as expressly provided herein, no assignment or Sublease shall affect or reduce any of the obligations of Tenant hereunder or the obligations of any Guarantor under the Guaranty, and all such obligations of Tenant and such Guarantor shall continue in full force and effect as obligations of a principal and not as obligations of a guarantor, as if no assignment or sublease had been made.

(g) Tenant shall, within ten (10) days after the execution and delivery of any assignment or Sublease, deliver a duplicate original copy thereof to Landlord which, in the event of an assignment, shall be in recordable form. With respect to any Preapproved Assignment or any Preapproved Sublease, at least five (5) days prior to the effective date of such assignment or sublease, respectively, Tenant shall provide to Landlord information reasonably required by Landlord to establish that the proposed assignee or subtenant meets the requirements set forth herein regarding a Preapproved Assignment, or Preapproved Sublease, as the case may be.

(h) As security for the performance of its obligations under this Lease, Tenant hereby grants, conveys and assigns to Landlord all right, title and interest of Tenant in and to all Subleases now in existence or hereafter entered into with respect to all or any portion of any of the Leased Premises, any and all extensions, modifications and renewals thereof and all rents, issues and profits therefrom. Landlord hereby grants to Tenant a license to collect and enjoy all rents and other sums of money payable under any Sublease of any of the Leased Premises; provided, however, that during the continuance of an Event of Default Landlord shall have the right at any time upon notice to Tenant and any subtenants to revoke said license and to collect such rents and sums of money and retain the same. Any amounts collected shall be applied to Rent payments next due and owing. Except with respect to Subleases that do not require Landlord's consent hereunder, Tenant shall not consent to, cause, or allow, any modification or amendment of any of the terms, conditions or covenants of any of the Subleases or the termination thereof (other than pursuant to termination rights of subtenants contained therein, or the expiration of any Sublease by its terms), without the prior written consent of Landlord, nor shall Tenant accept any rents more than thirty (30) days in

advance of the due date thereof, nor do anything that constitutes a breach or default under the terms of any Sublease.

(i) Without limiting Landlord's other obligations in this Paragraph 21, following any delivery by Tenant to Landlord of any request for consent to any proposed Sublease or form of Sublease, or any assignment of any of Tenant's interest in this Lease, Landlord agrees that any failure by Landlord to deliver a notice to Tenant, within thirty (30) days after delivery of such request from Tenant to Landlord, either granting Landlord's consent to same, or withholding Landlord's consent to same and stating in reasonable detail the reasons therefor, shall be deemed a consent by Landlord of such proposed Sublease, form of Sublease, or assignment (as the case may be) for all purposes hereunder; provided, however, that such time period shall be extended as reasonably necessary for Landlord to obtain the response from its Lender to such request (if Lender's consent is required with respect thereto under the terms of any applicable loan document) so long as Landlord (i) delivers to such Lender, within five (5) Business Days after Tenant's request, a written request for such Lender's consent, and (ii) uses commercially reasonable efforts to obtain Lender's consent within such thirty (30) day period, and diligently pursues such consent thereafter.

(j) Except as provided in Paragraph 34, Tenant shall not have the power to mortgage, pledge or otherwise encumber its interest under this Lease or any sublease of any of the Leased Premises, and any such mortgage, pledge or encumbrance made in violation of this Paragraph 21(j) and Paragraph 34 shall be void and of no force or effect.

(k) Landlord may sell or transfer any of the Leased Premises at any time without Tenant's consent to any third party (each a "Third Party Purchaser"); provided, however, that as part of, and prior to the closing of, such sale or transfer the Third Party Purchaser expressly agrees in writing to assume all of the right, duties and obligations of Landlord under this Lease. Landlord and Third Party Purchaser shall reasonably cooperate with Tenant in connection with any such sale or transfer, including, without limitation, coordinating with Tenant for the return of any then outstanding Letters of Credit so that same may be reissued in favor of the Third Party Purchaser. In the event of any such sale or transfer, Tenant shall attorn to such Third Party Purchaser as Landlord so long as both Third Party Purchaser and Landlord provide Tenant with (i) prior written notice of such transfer, (ii) the address or wiring instructions for where Rent is to be delivered by Tenant and (iii) a revised notice address for Third Party Purchaser (as the successor Landlord) in accordance with Paragraph 24. At the request and cost of Landlord, Tenant will execute such documents confirming the agreement referred to above and such other agreements as Landlord may reasonably request; provided, however, that all such agreements do not increase the liabilities and obligations of Tenant hereunder. In no event shall any of the foregoing limit any rights of Tenant under Paragraph 31.

(a) Notwithstanding anything to the contrary contained in this Paragraph 21, Tenant shall not have the right to assign this Lease (voluntarily or involuntarily, whether by operation of law or otherwise, including through merger or consolidation) or sublet all or any part of any of the Leased Premises to any Person at any time that an Event of Default exists or would exist after giving effect to such assignment or sublet.

(b) Any Letter of Credit delivered to Landlord by a Qualified Transferee shall be held by Landlord as a Security Deposit in accordance with Paragraph 33. If, during any period in which

such a Letter of Credit is held by Landlord, the Basic Rent increases hereunder, Tenant shall, within thirty (30) days after such increase (but subject to Paragraph 2(b) of Exhibit D), increase the amount of such Letter of Credit in proportion to such increase in Basic Rent.

(c) Nothing in this Paragraph 21 or otherwise in this Lease shall prohibit or restrict (i) sub-subleases to Tenant or its Affiliates, or assignments by subtenants under Existing Subleases, if and to the extent permitted under the express terms thereof, or (ii) Tenant from entering into commercially reasonable license agreements and access agreements (and modifications thereof) directly related to operations or occupant services at any Leased Premises, including without limitation car wash and detailing, parking operations, telecommunications equipment, and antenna facilities.

22. Events of Default.

(a) The occurrence of any one or more of the following (after expiration of any applicable cure period) shall, at the sole option of Landlord, constitute an "Event of Default" under this Lease:

(i) a failure by Tenant to pay (x) when due any Basic Rent, regardless of the reason, if any, for such failure (provided that (A) the foregoing shall be subject to Paragraph 2(b) of Exhibit D attached hereto, and (B) Tenant shall be entitled to one (1) five (5) day grace period in any twelve (12) month period for failure to pay Basic Rent (in addition to any additional time provided by Paragraph 2(b) of Exhibit D attached hereto)), and (y) within ten (10) Business Days after the date when due any Additional Rent;

(ii) a failure by Tenant duly to perform and observe, or a violation or breach of, any other provision of this Lease not otherwise specifically mentioned in this Paragraph 22(a), which default continues beyond the date that is thirty (30) days from the date on which Tenant receives notice of such default or, if such default cannot be cured within such thirty (30) day period and delay in the exercise of a remedy would not (in Landlord's reasonable judgment) cause a material adverse harm to Landlord or any of the Leased Premises, the cure period shall be extended for the period required to cure the default (but such cure period, including any extension, shall not in the aggregate exceed two hundred seventy (270) days); provided that Tenant shall commence to cure the default within said thirty (30) day period and shall actively and diligently and in good faith proceed with and continue the curing of the default until it shall be fully cured;

(iii) any representation or warranty made by Tenant herein or in any certificate, demand or request made pursuant hereto, including the Purchase and Sale Agreement, proves to have been fraudulent, when made in any material respect.

(iv) Tenant shall fail to maintain insurance coverage specified in Paragraphs 16(b), 16(c), and 16(d), or timely pay insurance premiums in accordance with Paragraph 16(e);

(v) Tenant shall enter into a transaction or series of transactions in violation of Paragraph 21, where such transaction or series of transactions are not rescinded within ten (10) days following such violation;

(vi) Subject to Tenant's right to enter into Subleases pursuant to Paragraph 21 (provided that Tenant is in compliance with the provisions thereof), (A) Tenant shall fail to occupy and use substantially all of any of the Leased Premises for a use permitted in accordance with Paragraph 4, or (B) Tenant shall have ceased operations at and/or abandoned any of the Leased Premises, except in each of (A) and (B) for temporary failures, cessations and/or abandonments due to business realignment (not to exceed one hundred twenty (120) days), or Casualty, Condemnation, or Alterations (without limiting the requirements set forth in this Lease regarding Casualty, Condemnation and Alterations).

(vii) Tenant shall fail to deliver the estoppel certificate described in Paragraph 25 within the time period specified therein;

(viii) if all of the following occur: (a) Tenant or any Guarantor defaults, after any applicable notice or cure periods, under any provision of its Senior Credit Facility (if any), and (b) the lender under such Senior Credit Facility accelerates the maturity of all indebtedness evidenced thereby as a result of such default pursuant to the terms of such Senior Credit Facility;

(ix) a final, non-appealable judgment for the payment of money in excess of Two Hundred Fifty Thousand Dollars ($250,000) shall be rendered against Tenant or any Guarantor and the same shall remain undischarged for a period of sixty (60) consecutive days following receipt of written notice regarding such final, non-appealable judgment by either (a) a licensed attorney at law who is employed in the in-house legal department of such Tenant or Guarantor, or (b) the chief executive officer, chief financial officer, or chief operations officer of such Tenant or Guarantor;

(x) Tenant or any Guarantor shall (A) voluntarily be adjudicated as bankrupt or insolvent, (B) seek or consent to the appointment of a receiver or trustee for itself or for any of the Leased Premises, (C) file a petition seeking relief under the bankruptcy or other similar laws of the United States, any state or any jurisdiction, (D) make a general assignment for the benefit of creditors, or (E) be unable to pay its debts as they mature; provided, however, that none of the foregoing events with respect to any Guarantor shall be an Event of Default if Tenant delivers to Landlord within thirty (30) days thereafter a Replacement Guaranty;

(xi) a court shall enter an order, judgment or decree appointing, without the consent of Tenant or any Guarantor, a receiver or trustee for it or for any of the Leased Premises or approving a petition filed against Tenant or any Guarantor which seeks relief under the bankruptcy or other similar laws of the United States, any state or any jurisdiction, and such order, judgment or decree shall remain undischarged or unstayed ninety (90) days after it is entered; provided, however, that none of the foregoing events with respect to any Guarantor shall be an Event of Default if Tenant delivers to Landlord within thirty (30) days thereafter a Replacement Guaranty;

(xii) Tenant or any Guarantor shall be liquidated or dissolved or shall intentionally begin proceedings towards its liquidation or dissolution; provided, however, that none of the foregoing events with respect to any Guarantor shall be an Event of Default if Tenant delivers to Landlord within thirty (30) days thereafter a Replacement Guaranty

(xiii) the estate or interest of Tenant in any of the Leased Premises shall be levied upon or attached in any proceeding and such estate or interest is about to be sold or transferred and such process shall not be vacated or discharged within ninety (90) days after it is made;

(xiv) any Guarantor shall (A) fail to perform its obligations under the Guaranty, subject to any applicable notice, cure and grace periods set forth herein or in any Guaranty or (B) take any action that causes the Guaranty to terminate or be unenforceable for any reason (other than (1) as expressly permitted pursuant to Paragraph 21, and (2) as described in clauses (x), (xi) or (xii) of this Paragraph 22); or

(xv) the failure of any Qualified Transferee to maintain and replenish, if required under the terms of this Lease, any Letter of Credit delivered by such Qualified Transferee; provided, however, that the foregoing shall be subject to Paragraph 2(b) of Exhibit D and shall not be an Event of Default if Qualified Transferee posts cash collateral in favor of Landlord so that the amount of such cash collateral plus the amount of any Letter of Credit equals the amount otherwise required under the Letter of Credit.

23. Remedies and Damages Upon Default.

(a) If an Event of Default shall have occurred and is continuing, Landlord shall have the right, at its sole option, then or at any time thereafter, to exercise its remedies and to collect damages from Tenant in accordance with this Paragraph 23, without demand upon or notice to Tenant except as otherwise provided in this Paragraph 23 or under any applicable Legal Requirements.

(b) If an Event of Default shall have occurred and is continuing, Landlord may give Tenant notice of Landlord's intention to terminate this Lease on a date specified in such notice. Upon such date, this Lease, the estate hereby granted and all rights of Tenant hereunder shall expire and terminate. Upon such termination, Tenant shall immediately surrender and deliver possession of all of the Leased Premises to Landlord. If Tenant does not so surrender and deliver possession of all of the Leased Premises, Landlord may re-enter and repossess all or any of the Leased Premises not surrendered. Notwithstanding such termination of this Lease, Tenant's liability under this Lease shall continue unaffected.

(c) If an Event of Default shall have occurred and is continuing, Landlord may terminate Tenant's right of possession (but not this Lease) and may repossess all or any of the Leased Premises without terminating this Lease. After repossession of such Leased Premises pursuant hereto, Landlord shall have the right to re-let such Leased Premises to such tenant or tenants, for such term or terms, for such rent, on such conditions and for such uses as Landlord in its sole discretion may determine, and collect and receive any rents payable by reason of such re-letting. Landlord may make such repairs or alterations in connection with such re-letting as it may deem advisable in its sole discretion. If Tenant shall, during the continuance of an Event of Default, voluntarily give up possession of such Leased Premises to Landlord, deliver to Landlord or its agents the keys to such Leased Premises, or both, such actions shall not in any respect diminish Landlord's rights hereunder and the acceptance thereof by Landlord or its agents shall not be deemed to constitute a termination of this Lease. Landlord reserves the right following any reentry and/or re-letting to exercise its

right to terminate this Lease by giving Tenant written notice thereof, in which event this Lease will terminate as specified in said notice; provided, however, that no notice from Landlord hereunder or under a forcible entry and detainer statute or similar law shall constitute an election by Landlord to terminate this Lease unless such notice specifically so states.

(d) If Landlord terminates this Lease pursuant to Paragraph 23(b), Landlord may accelerate Rent due hereunder by electing to require Tenant to pay to Landlord, upon written demand by Landlord, as liquidated and agreed final damages for Tenant's default and in lieu of all current damages beyond the date of such demand (it being agreed that it would be impracticable or extremely difficult to fix the actual damages), an amount equal to the Present Value of the excess, if any, of (A) the sum of all Basic Rent, Additional Rent and other sums which would be payable under this Lease by Tenant from the date of such demand to the date on which the Term is scheduled to expire hereunder in the absence of any earlier termination, re-entry or repossession over (B) the then aggregate fair market rent for the Leased Premises for the same period. Tenant shall also pay to Landlord all accrued Rent then due and unpaid, all other amounts payable by Tenant under this Lease which are then due and unpaid, all amounts which arise or become due by reason of Tenant's default hereunder, including any costs of Landlord in connection with the repossession of such Leased Premises, the removal of all personal property therefrom, and any attempted re-letting or sale thereof, including all brokerage commissions, legal expenses, reasonable attorneys' fees, employees' expenses, reasonable costs of repairs and alterations and reasonable expenses and reasonable preparation for re-letting or sale together with interest thereon at the Default Rate.

(e) If Landlord terminates this Lease pursuant to Paragraph 23(b) and elects not to pursue the remedy available to Landlord under in Paragraph 23(d), or terminates Tenant's right to possession of all or any of the Leased Premises pursuant to Paragraph 23(c), Tenant shall, until the end of what would have been the Term in the absence of any termination of this Lease, and whether or not any of such Leased Premises shall have been re-let, be liable to Landlord for, and shall pay to Landlord, as liquidated and agreed current damages all Basic Rent, Additional Rent and other sums which would be payable under this Lease by Tenant in the absence of such termination as the same would have been due, less the net proceeds, if any, of any re-letting

pursuant to Paragraph 23(c), after deducting from such proceeds all accrued Rent then due and unpaid, all other amounts payable by Tenant which are then due and unpaid, all obligations of Tenant which arise or become due by reason of such Event of Default, including any costs of Landlord incurred in connection with such repossessing and re-letting, including the cost of removal of all personal property from such Leased Premises, all brokerage commissions, reasonable attorneys' fees, expenses and preparation for re-letting together with interest thereon at the Default Rate if not paid within five (5) Business Days after demand therefor.

Tenant's Initials: _____ Landlord's Initials: _____

(f) Landlord may recover from Tenant all costs and expenses, including attorneys' fees, court costs, expert witness fees, costs of tests and analyses, travel and accommodation expenses, deposition and trial transcripts, copies and other similar costs and fees, paid or incurred by Landlord as a result of an Event of Default, regardless of whether or not legal proceedings are actually commenced.

(g) During the continuance of any Event of Default, Landlord may, and with or without notice, except as required herein, set off any money of Tenant or Guarantor, if any, held by Landlord under this Lease or the Guaranty, if any, against any sum owing by Tenant or Guarantor, if any, hereunder.

(h) During the continuance of an Event of Default, Landlord shall have the remedy described in California Civil Code Section 1951.4 (Landlord may continue the Lease in effect after Tenant breach and abandonment and recover rent as it becomes due, if Tenant has the right to sublet or assign, subject only to reasonable limitations). Accordingly, if Landlord does not elect to terminate this Lease on account of any Event of Default, Landlord may, from time to time, without terminating this Lease, enforce all of its rights and remedies under this Lease, including the right to recover all rent as it becomes due.

(i) Notwithstanding anything to the contrary herein contained, in lieu of or in addition to any of the foregoing remedies and damages, Landlord may exercise any remedies and collect any damages available to it at law or in equity during the continuance of an Event of Default. During the continuance of an Event of Default, if Landlord is unable to obtain full satisfaction pursuant to the exercise of any remedy, it may pursue any other remedy which it has hereunder or at law or in equity, including, without limitation, specific performance.

(j) Landlord shall not be required to mitigate any of its damages hereunder unless required to by any applicable Legal Requirement. If any applicable Legal Requirement shall validly limit the amount of any damages provided for herein to an amount which is less than the amount agreed to herein, Landlord shall be entitled to the maximum amount available under such Legal Requirement.

(k) No termination of this Lease, repossession or re-letting of any of the Leased Premises, exercise of any remedy or collection of any damages pursuant to this Paragraph 23 shall relieve Tenant of any obligations of Tenant which survive such expiration or termination by their own terms.

(l) WITH RESPECT TO ANY REMEDY OR PROCEEDING OF LANDLORD OR TENANT HEREUNDER, LANDLORD AND TENANT EACH HEREBY WAIVES THE SERVICE OF NOTICE WHICH MAY BE REQUIRED BY AN APPLICABLE LAW AND WAIVES ANY RIGHT TO A TRIAL BY JURY TO THE FULLEST EXTENT NOW OR HEREAFTER PERMITTED BY APPLICABLE LAW.

(m) During the continuance of any Event of Default, Landlord shall have the right (but no obligation) to perform any act required of Tenant hereunder and charge to Tenant all costs and expenses incurred in connection therewith, together with interest at the Default Rate, which amount shall be deemed Additional Rent and shall be immediately due and payable to Landlord. If performance of such act requires that Landlord enter any of the Leased Premises, Landlord may enter such Leased Premises for such purpose.

(n) During the continuance of any Event of Default, Tenant hereby waives and surrenders, for itself and all those claiming under it, including creditors of all kinds: (i) any right and privilege which it or any of them may have under any present or future Legal Requirement to redeem any of the Leased Premises or to have a continuance of this Lease after termination of this Lease or of Tenant's right of occupancy or possession pursuant to any court order or any provision hereof; and (ii) the benefits of any present or future Legal Requirement which exempts property from liability for debt or for distress for rent.

(o) During the continuance of any Event of Default, Tenant shall be and remain liable for all sums aforesaid, and Landlord may recover such damages from Tenant and institute and maintain successive actions or legal proceedings against Tenant for the recovery of such damages. Nothing herein contained shall be deemed to require Landlord to wait to begin such action or other legal proceedings until the date when the Term would have expired by its own terms had there been no such Event of Default.

(p) Except as otherwise provided herein, all remedies are cumulative and concurrent and no remedy is exclusive of any other remedy. Each remedy may be exercised at any time an Event of Default has occurred and is continuing and may be exercised from time to time. No remedy shall be exhausted by any exercise thereof.

(q) Except as otherwise expressly set forth in this Lease, in the event Tenant remains in possession of any of the Leased Premises after the expiration of this Lease, and without the written consent of Landlord, Tenant, at the option of Landlord, shall be deemed to be occupying such Leased Premises as a tenant from month to month, subject to all the conditions, provisions and obligations of this Lease, at one hundred fifty percent (150%) of the Basic Rent. Except as otherwise expressly set forth in this Lease, Tenant shall also pay and perform, during the period of any such holdover, all other costs and obligations imposed upon Tenant by this Lease, including, without limitation, payment of all real estate taxes, maintenance of all required insurance coverages and all other maintenance and repair obligations hereunder. In the event that Landlord does not consent to Tenant's holding over after the expiration of this Lease, Tenant shall defend, indemnify, protect and hold harmless Landlord and its directors, officers, employees, agents and lenders from and against any and all losses, costs and expenses resulting from Tenant's failure to surrender possession of such Leased Premises upon the expiration of the Term, including, without limitation, any claims

made by any succeeding tenant due to its inability to take possession of such Leased Premises in a timely manner.

(r) No failure by either Landlord or Tenant to insist upon the strict performance by the other of any covenant, agreement, term or condition of this Lease, or to exercise any right or remedy consequent upon a breach thereof, and no acceptance of full or partial payment of Rent or other monetary obligation during the continuance of any such breach shall constitute a waiver of any such breach or of such covenant, agreement, term or condition. No consent or waiver, express or implied, by either Landlord or Tenant to or of any breach by the other of any covenant, condition or duty under this Lease shall be construed as a consent or waiver to or of any other breach of the same or any other covenant, condition or duty, unless in writing signed by the Party waiving same.

(s) Notwithstanding anything to the contrary contained in this Lease, in no event shall Landlord or Tenant have the right to seek or receive special, punitive or other similar measures of damages against the other nor shall Landlord or Tenant be entitled to receive any consequential, indirect or speculative damages, and each Party hereby irrevocably waives, for itself and its successors and assigns, its right to seek or receive any such measure of damages or remedy.

24. Notices.

All notices, demands, requests, consents, approvals, offers, statements and other instruments or communications required or permitted to be given pursuant to the provisions of this Lease shall be in writing and shall be deemed to have been given and received for all purposes when delivered in person or by Federal Express or other reliable 24-hour delivery service or five (5) Business Days after being deposited in the United States mail, by registered or certified mail, return receipt requested, postage prepaid, addressed to the other Party at the address set forth below or when delivery is refused, and such notices shall be addressed as follows:

To Landlord:
AGNL Clinic, L.P.
c/o Angelo, Gordon & Co., L.P.
245 Park Avenue, 26th Floor
New York, NY 10167-0094
Phone No.: (212) 883-4157
Fax No.: (212) 883-4141
Attn: Gordon J. Whiting

With a copy to:
AGNL Manager II, Inc.
c/o Angelo, Gordon & Co., L.P.
245 Park Avenue, 26th Floor
New York, NY 10167-0094
Phone No.: (212) 692-2296
Fax No.: (212) 867-6448
Attn: Joseph R. Wekselblatt

With a copy to: Sheppard, Mullin, Richter & Hampton LLP
1300 I Street, N.W.
Washington, D.C. 20005-3314
Phone No.: (202) 469-4943
Fax No.: (202) 312-9411
Attn: Michele E. Williams, Esquire

To Tenant: Director of Facilities
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802-4317
Phone No.: (562) 435-3666
Fax No.: (562) 901-1086

With a copy to: Sidley Austin LLP
555 West 5th Street, Suite 4000
Los Angeles, CA 90013
Phone No.: (213) 896-6048
Fax No.: (213) 896-6600
Attn: Edward Prokop, Esq.

For the purposes of this Paragraph, any Party may substitute another address stated above (or substituted by a previous notice) for its address by giving ten (10) days' notice of the new address to the other Party, in the manner provided above. Any notices to be provided by Landlord under this Paragraph 24 shall be in lieu of, and not in addition to, any notice required under Section 1161 *et seq.* of the California Code of Civil Procedure.

25. Estoppel Certificate.

At any time upon not less than ten (10) Business Days' prior written request by either Landlord or Tenant (the " Requesting Party") to the other Party (the "Responding Party"), the Responding Party shall deliver to the Requesting Party a statement in writing, executed by an authorized officer of the Responding Party, certifying (a) that, except as otherwise specified, this Lease is unmodified and in full force and effect, (b) the dates to which Rent has been paid, (c) that, to the knowledge of the signer of such certificate and except as otherwise specified, no default by either Landlord or Tenant exists hereunder, (d) such other matters as the Requesting Party may reasonably request, and (e) if Tenant is the Responding Party that, except as otherwise specified, there are no proceedings pending or, to the knowledge of the signer, threatened, against Tenant before or by a court or administrative agency which, if adversely decided, would materially and adversely affect the financial condition and operations of Tenant. Any such statements by the Responding Party may be relied upon by the Requesting Party, any Person whom the Requesting Party notifies the Responding Party in its request for the certificate is an intended recipient or beneficiary of the certificate, any Lender or their assignees and by any prospective purchaser or mortgagee of any of the Leased Premises. Any certificate required under this Paragraph 25 and delivered by Tenant shall state that, in the opinion of each person signing the same, he or she has

made such examination or investigation as is necessary to enable him or her to express an informed opinion as to the subject matter of such certificate.

26. Surrender.

On the date of the expiration or earlier termination of this Lease, Tenant shall peaceably leave and surrender the Leased Premises to Landlord in the same condition in which the Leased Premises were at the commencement of this Lease, except as repaired, rebuilt, restored, altered, replaced or added to as permitted or required by any provision of this Lease, and ordinary wear and tear excepted. Upon such surrender, Tenant shall (a) remove from the Leased Premises all property which is owned by Tenant or third parties (not including any property owned by Landlord or any Alterations) and (b) repair any damage caused by such removal. Property not so removed shall become the property of Landlord, and Landlord may thereafter cause such property to be removed from any of the Leased Premises. The costs of removing and disposing of such property and repairing any damage to any of the Leased Premises caused by such removal shall be paid by Tenant to Landlord upon demand. Landlord shall not in any manner or to any extent be obligated to reimburse Tenant for any such property which becomes the property of Landlord pursuant to this Paragraph 26. The obligations, duties and rights of the parties set forth in this Paragraph 26 shall survive the expiration or termination of this Lease.

27. No Merger of Title.

There shall be no merger of the leasehold estate created by this Lease with the fee estate in any of the Leased Premises by reason of the fact that the same Person may acquire or hold or own, directly or indirectly, (a) the leasehold estate created hereby or any part thereof or interest therein and (b) the fee estate in any of the Leased Premises or any part thereof or interest therein, unless and until all Persons having any interest in the interests described in (a) and (b) above which are sought to be merged shall join in a written instrument effecting such merger and shall duly record the same.

28. Books and Records.

(a) Tenant shall keep adequate records and books of account with respect to the finances and business of Tenant generally and with respect to each of the Leased Premises, in accordance with generally accepted accounting principles consistently applied (" GAAP") (with the exception that quarterly statements do not need to include footnotes), and shall permit Landlord and Lender by their respective agents, accountants and attorneys, upon reasonable notice to Tenant, to visit and inspect any of the Leased Premises and examine (and make copies of) the records and books of account and to discuss the finances and business with the officers of Tenant and Sponsor, if any, at such reasonable times as may be requested by Landlord. Upon the request of Lender or Landlord (either telephonically or in writing), Tenant shall provide the requesting party with copies of any information to which such party would be entitled in the course of a personal visit.

(b) Subject to subparagraph (c) below, Tenant shall deliver to Landlord within ninety (90) days of the close of each fiscal year, annual audited consolidated financial statements of Tenant or, if Tenant is a wholly-owned Subsidiary of a Guarantor, if any, annual audited consolidated

financial statements of such Guarantor, prepared by nationally recognized independent certified public accountants. Tenant shall also furnish to Landlord within forty-five (45) days after the end of each of the three remaining quarters unaudited financial statements and all other quarterly reports of Tenant or Guarantor, as applicable, certified by such reporting party's chief financial officer. All financial statements delivered to Landlord pursuant to this Paragraph 28(b) shall be prepared in accordance with GAAP. All annual financial statements shall be accompanied (i) by an opinion of said accounting firm stating that (A) there are no qualifications as to the scope of the audit and (B) the audit was performed in accordance with GAAP and (ii) by the affidavit of the president, chief financial officer or vice president of finance of the reporting party dated within five (5) days of the delivery of such statement, stating that (A) the affiant knows of no Event of Default, or event which, upon notice or the passage of time or both, would become an Event of Default which has occurred and is continuing hereunder or, if any such event has occurred and is continuing, specifying the nature and period of existence thereof and what action Tenant or any Guarantor, as the case may be, has taken or proposes to take with respect thereto, (B) except as otherwise specified in such affidavit, that Tenant has fulfilled all of its obligations under this Lease which are required to be fulfilled on or prior to the date of such affidavit and (C) unless Tenant is a public recording company, Tenant shall promptly deliver to Landlord copies of (i) any additional reporting information provided to Tenant's lenders and (ii) such credit agreements and other loan documents entered into by Tenant as Landlord may reasonably request.

(c) If Tenant or any Guarantor is a public reporting company, the annual and quarterly financial reporting delivery requirements set forth in Paragraph 28(b) shall be waived by Landlord so long as Tenant, or Guarantor, as the case may be, timely files with the Securities and Exchange Commission, for the applicable reporting periods, its Form 10-K, Form 10-Q and other required filings pursuant to the provisions of the Securities Exchange Act of 1934, as amended and any other applicable Law.

29. Non-Recourse as to Landlord.

Anything contained herein to the contrary notwithstanding, any claim based on or in respect of any liability of Landlord under this Lease shall be limited to actual damages and shall be enforced only against the Leased Premises and not against any other assets, properties or funds of (a) Landlord, (b) any director, member, officer, general partner, limited partner, employee or agent of Landlord (or any legal representative, heir, estate, successor or assign of any thereof), (c) any predecessor or successor partnership, corporation, limited liability company (or other entity) of Landlord, or any of its general partners, members or shareholders, or (d) any other affiliate of Landlord.

30. Financing.

(a) Tenant agrees to pay, within three (3) Business Days after written demand therefor, any Cost imposed upon Landlord by Lender pursuant to the Note, the Mortgage or the Assignment which is caused by an Event of Default by Tenant under this Lease and which is not otherwise reimbursed by Tenant to Landlord pursuant to any other provision of this Lease.

(b) If Landlord desires to obtain or refinance any Loan, Tenant shall agree, upon request of Landlord, to supply any such Lender with such notices and information as Tenant is required to

give to Landlord hereunder, and to execute a commercially reasonable modification to this Lease so long as such modification does not materially and adversely affect any right, benefit or privilege of Tenant under this Lease or materially increase Tenant's obligations under this Lease. Tenant shall also provide, upon the written request of such Lender, an SNDA, so long as such SNDA does not materially and adversely affect any right, benefit or privilege of Tenant under this Lease or materially increase Tenant's obligations under this Lease.

31. Subordination, Non-Disturbance and Attornment.

(a) This Lease shall be subject and subordinate to the lien of any Mortgage now or hereafter in force against either of the Leased Premises, and Tenant covenants and agrees in the event any proceedings are brought for the foreclosure of any Mortgage to which this Lease is subordinate, to attorn, to the purchaser upon any such foreclosure sale, if so requested to do so by such purchaser, and to recognize such purchaser as the case may be, as the lessor under this Lease; provided, however, that the foregoing subordination to the lien of any future Mortgage in force against the Leased Premises, and attornment to the purchaser upon any such foreclosure sale, shall each be conditioned upon Landlord providing Tenant with a subordination, non disturbance and attornment agreement in favor of Tenant in the form attached hereto as Exhibit J, or other commercially reasonable form (either, an "SNDA") requested by Landlord that provides, without limitation, that this Lease and the rights of Tenant hereunder shall survive any foreclosure proceeding brought under such Mortgage. Without limiting the foregoing, as of the Effective Date, each of Landlord, Lender, and Tenant shall execute and deliver to each other an SNDA in the form attached hereto as Exhibit J.

(b) In addition to Tenant's rights under Paragraph 34, if requested by a lender ("Secured Lender") holding or obtaining a security interest in any personal property of Tenant ("Secured Property") that is located at the Leased Premises, Landlord shall enter into such reasonable and customary documentation as the Secured Lender shall reasonably request, including a subordination of any statutory lien that Landlord may have in such Secured Property and permitting such Secured Lender reasonable access to the Leased Premises for the purpose of enforcing such Secured Lender's lien with respect to such Secured Property.

32. Tax Treatment; Reporting.

Landlord and Tenant each acknowledges that each shall treat this transaction as a true lease for state law purposes and shall report this transaction as a lease for federal income tax purposes. For federal income tax purposes each Party shall report this Lease as a true lease with Landlord as the owner of all of the Leased Premises and Tenant as the lessee of such Leased Premises including: (i) treating Landlord as the owner of any of the Improvements and Equipment eligible to claim depreciation deductions under Section 167 or 168 of the Internal Revenue Code of 1986 (the "Code") with respect to such Improvements and Equipment, (ii) Tenant reporting its Rent payments as rent expense under Sections 162 and Section 467 of the Code, as applicable, and (iii) Landlord reporting the Rent payments as rental income. Notwithstanding the foregoing, nothing contained herein shall (a) require Landlord or Tenant to take any action that would be inconsistent with the requirements of GAAP or violate any state or federal law, or (b) be deemed to constitute a guaranty, warranty or representation by either Landlord or Tenant as to the actual treatment of this transaction for state

or federal tax purposes of for purposes of accounting or financial reporting, including but not limited to the determination as to whether this Lease shall qualify for sale-leaseback accounting treatment or whether this Lease shall be properly classified as an operating lease or finance lease in accordance with GAAP.

33. Security Deposit.

(a) On the Commencement Date, Tenant shall not be required to deliver to Landlord any Letter of Credit or security deposit. If in the future, a Letter of Credit is delivered to Landlord pursuant to the provisions of Paragraph 14 or Paragraph 21, such Letter of Credit shall be held by Landlord as a security deposit (the "Security Deposit") and the terms of this Paragraph 33 shall apply. Thereafter, the Security Deposit shall remain in full force and effect during the Term as security for the payment by Tenant of the Rent and all other charges or payments to be paid hereunder and the performance of the covenants and obligations contained herein. In the event Landlord holds any cash Security Deposit hereunder, Landlord shall hold it in trust in a separate, interest-bearing account, and any interest earned thereon shall be added to the Security Deposit.

(b) Upon any adjustment of Basic Rent pursuant to Exhibit D, Tenant shall not later than thirty (30) days after Landlord delivers written notice of such adjustment, adjust the amount of the Letter of Credit, if any, to maintain the Security Deposit in an amount equal to the amount of eighteen (18) months of Basic Rent (or twelve (12) months of Basic Rent, if the original amount of the Letter of Credit required hereunder was twelve (12) months of Basic Rent). The Letter of Credit shall be renewed at least sixty (60) days prior to any expiration thereof. If Tenant fails to renew the Letter of Credit by such date, Landlord shall have the right at any time after the thirtieth (30^{th}) day before such expiration date, and after providing Tenant with five (5) days' prior written notice, to draw on the Letter of Credit and to deposit the proceeds of the Letter of Credit as a cash Security Deposit.

(c) If at any time (except any time during which Landlord is already holding a Cash Security Deposit) the Security Deposit does not meet the requirements of the definition of Letter of Credit, as set forth herein, or if the financial condition of the issuer of such Letter of Credit changes in any other materially adverse way, as determined by Landlord in its reasonable discretion, then Tenant within thirty (30) days after written notice from Landlord shall deliver to Landlord a Replacement Letter of Credit. Tenant's failure to deliver any such Replacement Letter of Credit shall entitle Landlord to immediately draw under the Letter of Credit and hold the proceeds thereof as a cash Security Deposit.

(d) In the event that the issuer of any Letter of Credit is insolvent or is placed into receivership or conservatorship by the Federal Deposit Insurance Corporation, or any successor or similar entity, of if a trustee, receiver or liquidator is appointed for the issuer, then, effective as of the date of such occurrence, such Letter of Credit shall be deemed not to meet the requirements of the definition of Letter of Credit, as set forth herein, and Tenant shall within thirty (30) days after written notice from Landlord deliver to Landlord a Replacement Letter of Credit. Tenant's failure to deliver any such Replacement Security Deposit shall entitle Landlord to immediately draw under the Letter of Credit and hold the proceeds thereof as a cash Security Deposit.

(e) If at any time an Event of Default shall have occurred and be continuing, Landlord shall be entitled, at its sole and absolute discretion, to draw on the Letter of Credit or to withdraw the cash Security Deposit, as the case may be, and apply the proceeds in payment of any Rent that is then due and payable (but in no event shall Landlord apply any Security Deposit funds to prepay any Rent). Tenant further acknowledges and agrees that (1) Landlord's application of the proceeds of the Letter of Credit or cash Security Deposit towards the payment of Rent that is then due and payable constitutes a fair and reasonable use of such proceeds and (2) the application of such proceeds by Landlord towards the payment of Rent that is then due and payable shall not constitute a cure by Tenant of the applicable default (except any default in the payment of such Rent); provided, however, that an Event of Default shall not exist if Tenant restores the Security Deposit to its full amount within five (5) Business Days and in accordance with the requirements of this Paragraph 33, so that the original amount of the Security Deposit shall be again on deposit with Landlord.

(f) So long as no Event of Default then exists, the Letter of Credit or the cash Security Deposit, as the case may be, shall be returned to Tenant within thirty (30) days after the expiration of the Term.

(g) Tenant waives all provisions of Laws, now or hereinafter in force, that restrict the amount or types of claim that a landlord may make upon a security deposit or imposes upon a landlord (or its successors) any obligation with respect to the handling or return of security deposits, including, without limitation, California Civil Code Section 1950.7 (including waiving the return of the security deposit until such time as the amount of such landlord's damages, including those under California Civil Code Section 1951.2, has been determined).

34. Permitted Leasehold Mortgages.

Notwithstanding Paragraph 21 above, but subject to the terms of this Paragraph 34, Landlord agrees that Tenant shall have the right to encumber, pledge or hypothecate Tenant's interest in the leasehold estate created by this Lease (a "Leasehold Mortgage", and the holder of any such Leasehold Mortgage, a "Leasehold Mortgagee"). All proceeds from any Leasehold Mortgage shall remain the property of Tenant. Landlord shall not be obligated to subordinate any or all of Landlord's right, title or interest in and to the Leased Premises and this Lease to the lien of any Leasehold Mortgage. A Leasehold Mortgage shall encumber only Tenant's leasehold interest in the Leased Premises, and shall not encumber Landlord's right, title or interest in the Leased Premises. Landlord shall have no liability whatsoever for the payment of any obligation secured by any Leasehold Mortgage or related obligations. No Leasehold Mortgage shall be for a term longer than the Term of this Lease. Either prior to or concurrently with the recordation of any Leasehold Mortgage, Tenant shall cause a fully conformed copy thereof and of the financing agreement secured thereby to be delivered to Landlord and its Lender, together with a written notice containing the name and post office address of Leasehold Mortgagee. Upon written request from Tenant, Landlord agrees to deliver an estoppel certificate in favor of Leasehold Mortgagee regarding this Lease, in form and substance reasonably acceptable to Leasehold Mortgagee. If Landlord delivers to Tenant a notice of a default or an Event of Default under this Lease, Landlord shall concurrently notify any Leasehold Mortgagee that has delivered to Landlord a prior written request for such notice, and Landlord shall recognize and accept the performance of any obligation of Tenant hereunder by Leasehold Mortgagee; provided, however that nothing contained herein shall obligate Leasehold Mortgagee to take any such actions.

Landlord also hereby agrees, upon request by Tenant or any Leasehold Mortgagee, to enter into a commercially reasonable agreement with such Leasehold Mortgagee that may provide, without limitation (a) Landlord's waiver of any Landlord's lien or other claim against any property of Tenant, (b) that Landlord shall not terminate or amend the Lease without the prior written consent of the Leasehold Mortgagee, (c) that Leasehold Mortgagee shall have the right, but not the obligation, to pay and perform all obligations of Tenant under this Lease, and all obligations of any Guarantor under any Guaranty, (d) that upon any termination of the Lease, Leasehold Mortgagee shall have the right to a new lease with Landlord, for the remainder of the Term of the Lease, and otherwise with the same covenants, conditions and agreements as are contained in the Lease, and (e) that Leasehold Mortgagee shall have rights to enter upon the Leased Premises to remove Tenant's personal property following any default under the Leasehold Mortgage, provided, however that Leasehold Mortgager shall maintain adequate insurance and satisfy Tenant's obligation to pay Basic Rent during such period of possession, not to exceed ninety (90) days, which ninety (90)-day period will be tolled in the event of an applicable bankruptcy proceeding. This Paragraph shall survive termination of this Lease.

35. Tenant Bankruptcy.

(a) As a material inducement to Landlord executing this Lease, Tenant acknowledges and agrees that Landlord is relying upon (i) the financial condition and specific operating experience of Tenant and Tenant's obligation to use each of the Leased Premises specifically for the Permitted Use, (ii) Tenant's timely performance of all of its obligations under this Lease notwithstanding the entry of an order for relief under the Bankruptcy Code for Tenant and (iii) all defaults under this Lease being cured promptly and this Lease being assumed within sixty (60) days of any order for relief entered under the Bankruptcy Code for Tenant, or this Lease being rejected within such sixty (60) day period and the entire Leased Premises surrendered to Landlord.

(b) Accordingly, in consideration of the mutual covenants contained in this Lease and for other good and valuable consideration, Tenant hereby agrees that:

(i) All obligations that accrue or become due under this Lease (including the obligation to pay Rent), from and after the date that a petition is filed under the Bankruptcy Code, a proceeding under any similar law or statute relating to bankruptcy, insolvency, reorganization, winding up or adjustment of debts is initiated (collectively, an "Action") shall be timely performed exactly as provided in this Lease and any failure to so perform shall be harmful and prejudicial to Landlord;

(ii) Any and all obligations under this Lease that accrue or become due from and after the date that an Action is commenced and that are not paid as required by this Lease shall, in the amount of such rents, constitute administrative expense claims allowable under the Bankruptcy Code with priority of payment at least equal to that of any other actual and necessary expenses incurred after the commencement of the Action;

(iii) Any extension of the time period beyond one-hundred twenty (120) day period, subject to an additional ninety (90) day period for good cause shown, within which Tenant may assume or reject this Lease without an obligation to cause all obligations accruing or coming

due under this Lease from and after the date that an Action is commenced to be performed as and when required under this Lease shall be harmful and prejudicial to Landlord;

(iv) Any time period designated as the period within which Tenant must cure all defaults and compensate Landlord for all pecuniary losses which extends beyond the date of assumption of this Lease shall be harmful and prejudicial to Landlord;

(v) Any assignment of this Lease must result in all terms and conditions of this Lease being assumed by the assignee without alteration or amendment, and any assignment which results in an amendment or alteration of the terms and conditions of this Lease without the express written consent of Landlord shall be harmful and prejudicial to Landlord;

(vi) Any proposed assignment of this Lease to an assignee: (a) that will not use any of the Leased Premises specifically for the Permitted Use, (b) that does not possess financial condition, operating performance and experience characteristics equal to or better than the financial condition, operating performance and experience of the Tenant as of the Commencement Date, or (c) that does not provide guarantors of the Tenant's obligations hereunder with financial condition equal to or better than the financial condition of the original guarantors of this Lease as of the Commencement Date, shall be harmful and prejudicial to Landlord;

(vii) The rejection (or deemed rejection) of this Lease for any reason whatsoever shall constitute cause for immediate relief from the automatic stay provisions of the Code, and Tenant stipulates that such automatic stay shall be lifted immediately and possession of the entire Leased Premises will be delivered to Landlord within a commercially reasonable time (as the court shall determine) without the necessity of any further action by Landlord;

(viii) No provision of this Lease shall be deemed a waiver of Landlord's rights or remedies under the Bankruptcy Code or applicable Law to oppose any assumption and/or assignment of this Lease, to require timely performance of Tenant's obligations under this Lease, or to regain possession of any or all of the Leased Premises as a result of the failure of Tenant to comply with the terms and conditions of this Lease or the Bankruptcy Code;

(ix) Notwithstanding anything in this Lease to the contrary, all amounts payable by Tenant to or on behalf of Landlord under this Lease, whether or not expressly denominated as such, shall constitute "rent" for the purposes of the Bankruptcy Code; and

(x) For purposes of this Paragraph 35 addressing the rights and obligations of Landlord and Tenant in the event that an Action is commenced, the term "Tenant" shall include Tenant's successor in bankruptcy, whether a trustee, Tenant as debtor in possession or other responsible person.

36. Miscellaneous.

(a) The Paragraph headings in this Lease are used only for convenience in finding the subject matters and are not part of this Lease or to be used in determining the intent of the Parties or otherwise interpreting this Lease.

(b) As used in this Lease, the singular shall include the plural and any gender shall include all genders as the context requires and the following words and phrases shall have the following meanings: (i) "including" means "including without limitation" (except where "including" is already followed by "without limitation" or words of similar effect); (ii) "provisions" means "provisions, terms, agreements, covenants and/or conditions"; (iii) "lien" means "lien, charge, encumbrance, title retention agreement, pledge, security interest, mortgage and/or deed of trust"; (iv) "obligation" means "obligation, duty, agreement, liability, covenant and/or condition"; (v) "the Leased Premises" means "the Leased Premises or any part thereof or interest therein"; (vi) " the Real Property" means "the Columbus Real Property and the Long Beach Real Property or any part thereof or interest therein"; (vii) " the Improvements" means "the Improvements or any part thereof or interest therein"; (viii) " the Equipment" means "the Equipment or any part thereof or interest therein"; and (ix) "the adjoining property" means "the adjoining property or any part thereof or interest therein".

(c) Any act which Landlord is permitted to perform under this Lease may be performed at any time and from time to time by Landlord or any person or entity designated by Landlord. Each appointment of Landlord as attorney-in-fact for Tenant hereunder is irrevocable and coupled with an interest, but shall only apply during the continuance of an Event of Default.

(d) Except as otherwise expressly provided in this Lease, Landlord shall not unreasonably withhold, condition, or delay its consent or approval whenever such consent or approval is required under this Lease.

(e) Time is of the essence with respect to the performance by Tenant of its obligations under this Lease.

(f) Landlord shall in no event be construed for any purpose to be a partner, joint venturer or associate of Tenant or of any subtenant, operator, concessionaire or licensee of Tenant with respect to any of the Leased Premises or otherwise in the conduct of their respective businesses.

(g) This Lease and any documents which may be executed by Tenant on or about the Effective Date hereof at Landlord's request, including, without limitation, the Purchase and Sale Agreement, constitute the entire agreement between the parties and supersede all prior understandings and agreements, whether written or oral, between the parties hereto relating to any of the Leased Premises and the transactions provided for herein. Landlord and Tenant are business entities having substantial experience with the subject matter of this Lease and have each fully participated in the negotiation and drafting of this Lease. Accordingly, this Lease shall be construed without regard to the rule that ambiguities in a document are to be construed against the drafter.

(h) This Lease may be modified, amended, discharged or waived only by an agreement in writing signed by the Party against whom enforcement of any such modification, amendment, discharge or waiver is sought.

(i) The covenants of this Lease shall run with the land and bind Tenant, its successors and assigns and all present and subsequent encumbrances and subtenants of any of the Leased

Premises, and shall inure to the benefit of Landlord, its successors and assigns. If there is more than one Tenant, the obligations of each shall be joint and several.

(j) If any one or more of the provisions contained in this Lease shall for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Lease, but this Lease shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

(k) All exhibits and schedules attached hereto are incorporated herein as if fully set forth.

(l) Each of Landlord and Tenant hereby agree that the State of New York has a substantial relationship to the parties and to the underlying transaction embodied hereby, and in all respects (including, without limiting the generality of the foregoing, matters of construction, validity and performance) this Lease and the obligations arising hereunder shall be governed by, and construed in accordance with, the laws of the State of New York applicable to contracts made and performed therein and all applicable Law of the United States of America; except that, at all times, the provisions for the creation of the leasehold estate, enforcement of Landlord's rights and remedies with respect to right of re-entry and repossession, surrender, delivery, ejectment, dispossession, eviction or other in-rem proceeding or action regarding any of the Leased Premises pursuant to Paragraph 23 hereof shall be governed by and construed according to the Laws of the State where such Leased Premises is located, it being understood that, to the fullest extent permitted by law of such State, the law of the State of New York shall govern the validity and the enforceability of this Lease, and the obligations arising hereunder. To the fullest extent permitted by law, Tenant hereby unconditionally and irrevocably waives any claim to assert that the law of any other jurisdiction governs this Lease. Except for any legal suit, action or proceeding that pursuant to applicable Law must be brought in the County and State where a Leased Premises is located, any legal suit, action or proceeding against Tenant arising out of or relating to this Lease may be instituted in any federal or state court sitting in the County of New York, State of New York, and Tenant waives any objection which it may now or hereafter have to the laying of venue of any such suit, action or proceeding in such County and State, and Tenant hereby expressly and irrevocably submits to the jurisdiction of any such court in any suit, action or proceeding. Notwithstanding the foregoing, nothing herein shall prevent or prohibit Landlord or Tenant from instituting any suit, action or proceeding in any other proper venue or jurisdiction in which any of the Leased Premises is located or where service of process can be effectuated.

(m) To Tenant's knowledge, neither Tenant nor any of its officers or directors is a Specially Designated National or Blocked Person. As used herein, the term "Specially Designated National or Blocked Person" shall mean a Person (i) designated by the Office of Foreign Assets Control at the U.S. Department of the Treasury, or other U.S. governmental entity, and appearing on the List of Specially Designated Nationals and Blocked Persons (http://www.ustreas.gov/offices/enforcement/ofac/sdn/ index.shtml), which List may be updated from time to time; or (ii) with whom Landlord or its affiliates are prohibited from engaging in transactions by any trade embargo, economic sanction or other prohibition of United States law, regulation, or Executive Order of the President of the United States. Tenant agrees to confirm the statement in the preceding sentence in writing on an annual basis if requested by Landlord to do so.

(n) Subject to the terms of this Paragraph 36(n), Tenant and Landlord shall each maintain as confidential (a) any and all information, data and documents obtained about Landlord or Tenant ("Information") prior to and following the execution of this Lease (including without limitation, any financial or operating information of, or related to, the Landlord or the Tenant), and (b) the terms and conditions of this Lease (as originally circulated or as negotiated) and all other documents related to the execution of this Lease. Each Party agrees that it will not retain any item of Information after the use thereof is no longer required, and that it will either destroy or return to the other Party all written materials constituting Information, except to the extent that such destruction is prohibited by law, rule or regulation. Notwithstanding the foregoing, neither Party will be required to destroy or return any Information that may be stored electronically in such Party's information technology system, whether in the form of an e-mail, saved file or otherwise. Notwithstanding anything to the contrary contained herein, each Party shall be permitted to disclose any or all of the Information: (i) to those principals, employees, representatives, lenders, consultants, counsel, accountants and other professional advisors of such Party who have a legitimate need to review or know such Information and who have, prior to disclosure, agreed to be bound by the terms of confidentiality set forth herein, (ii) any government or self-regulatory agency whose supervision or oversight such Party or any of its affiliates may be subject to the extent required by applicable Law, any governmental authority or a court of competent jurisdiction, in each case to the extent reasonably necessary to comply with any legal or regulatory requirements to which such Party or its affiliates may be subject, and (iii) without limiting the generality of the immediately foregoing subsection, in any filings made by Tenant or its affiliates with the Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended (the " Securities Act"), the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and/or as may be made available to any investors or prospective investors in Tenant or any of its affiliates in conformance with the Securities Act, Exchange Act, and/or the rules, regulations, and orders issued with respect thereto. Except for publicly available filings referenced in clause (iii) of the immediately preceding sentence, upon disclosing Information to any Person to the extent permitted hereunder, Landlord or Tenant, as applicable, shall advise such Person of the confidential nature thereof, and shall take all reasonable precautions to prevent the unauthorized disclosure of such information by such Person. In addition, Landlord and Tenant shall each be permitted to make such disclosures regarding the Lease and the Leased Premises (which may include the use of Tenant's or Landlord's name and corporate logo) as are similar or consistent with Landlord's and Tenant's respective general public disclosure policy, including disclosures made by Landlord and its affiliates to their investors, lenders and analysts. Landlord agrees that any Lender shall abide by the restrictions applicable to Landlord in this Paragraph 36(n). This provision shall survive the termination of this Lease. Landlord and Tenant shall be required to execute, deliver, record and furnish such documents as may be necessary to correct any errors of a typographical nature that may be contained in this Lease, or in any memorandum thereof, whether such memorandum be recorded or unrecorded.

(o) This Lease may be executed in any number of counterparts, each of which shall be an original, but all of which shall together constitute one and the same document.

(p) If either Party shall be prevented or delayed from punctually performing any obligation or satisfying any condition under this Lease by any condition beyond the control of such Party, exclusive of financial inability of a Party (but including without limitation any of the following

beyond the control of (and not caused) by such Party (collectively, "Force Majeure"): strike, lockout, labor dispute, civil unrest, inability to obtain labor, materials or reasonable substitutes thereof, acts of God, present or future governmental restrictions, regulations or control, insurrection, and sabotage), then the time to perform such obligation or satisfy such condition shall be extended by the delay caused by such event, but only for a reasonable period of time not to exceed, in any event, three hundred sixty-five (365) days.

(q) Notwithstanding Paragraph 7 or any other provision of this Lease, in the event an arbitration, suit or action is brought by any Party under this Lease to enforce any of its terms, or in any appeal therefrom, it is agreed that the prevailing Party shall be entitled to reimbursement of reasonable attorneys' fees, as determined by the arbitrator, trial court and/or appellate court.

(r) In the event of any reduction of Rent pursuant to the terms hereof (including without limitation pursuant to Paragraph 17 or Paragraph 18), the related terms hereof (including without limitation in Exhibit D and Exhibit F) shall be deemed modified as appropriate reflect such reduction. Without limiting the foregoing, upon any such reduction of Rent, the Parties agree that upon the request of either Party, both Parties will enter into a written amendment to this Lease further evidencing such reduction of Rent and related appropriate modifications.

(s) *[Signature Pages To Follow]*

IN WITNESS WHEREOF, Landlord and Tenant have caused this Lease to be duly executed under seal as of the day and year first above written.

LANDLORD:

AGNL CLINIC, L.P.,
a Delaware limited partnership

By: AGNL Clinic GP, L.L.C.,
Delaware limited liability company,
its general partner

By: AGNL Manager II, Inc.,
a Delaware corporation, its Manager

By: _____

Gordon J. Whiting
President

STATE OF NEW YORK)

) SS.

COUNTY OF NEW YORK)

I, _____, a Notary Public in and for said County in the State aforesaid, do hereby certify that President, the President of AGNL Manager II, Inc., as Manager of AGNL CLINIC, L.P., a Delaware limited partnership, and AGNL Clinic GP, L.L.C., a Delaware limited liability company, personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that she signed and delivered such instrument as her own free and voluntary act and as the free and voluntary act of said limited liability company, for the uses and purposes set forth therein.

GIVEN under my hand and notarial seal this __ day of _____, 2013.

_____

Notary Public

My Commission expires:_____ _____
Printed Name

My County of Residence:_____

TENANT:

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: _____
Name:_____
Title:_____

STATE OF CALIFORNIA)
) ss:
COUNTY OF _____)

On _____, 2013, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

SCHEDULE 10(h)

ENVIRONMENTAL VIOLATIONS

Environmental Violations or suspected Environmental Violations, if any, disclosed to Landlord in any of the following:

1. Long Beach Leased Premises
    a. Phase 1 Site Assessment undertaken by ESIS Inc. Dated January 4, 2011
    b. Phase 1 Update undertaken by ESIS Inc. dated October 19, 2011
    c. NPDES Permit No. CAG994004

2. Columbus Leased Premises
    a. Phase 1 Environmental Assessment Dated October 12, 2012

SCHEDULE 12(a)

IMMEDIATE REPAIRS

- **Long Beach Property**

Description	Immediate Repairs
Epoxy injection of parking garage concrete deck	$ 5,500
Renewal of sealants	$ 4,850
Plaza elastomeric deck coating	$ 156,344
Comprehensive façade inspection & report	$ 18,000
Repair/repaint cracked stucco surfaces on inside of perimeter roof level parapet walls	$ 13,000
Built up roof replacement section 01a	$ 62,230
Replace elastomeric surface/restripe & PM 01b	$ 5,900
Built up roof replacement section 02	$ 128,366
Built up roof replacement section 03a	$ 62,230
Replace elastomeric surface/restripe & PM 03b	$ 5,900
Built up roof replacement section 04	$ 128,366
Replace elastomeric surface/restripe & PM 05	$ 2,700
Perform IR survey	$ 4,800
Annual inspection & testing FLS system	$ 5,400
Inspect & certify elevators	$ 13,650
Install new slab edge fire-safing (200 locations)	$ 115,000
Perform repairs recommended in façade inspection report	$ 60,375
	$ 792,611

- **Columbus Property**

Description	Immediate Repairs
Regrade along west side of building	$ 2,500
Full depth asphalt repairs and overlay	$ 168,458
Repair curbs	$ 36,000
Repair asphalt paths	$ 1,000
Replace missing landscape material	$ 22,500
Repair and level concrete benches	$ 1,000
Clean fabric pavilion	$ 500
Repair retaining wall	$ 15,000
Remove wiring to former plyon signs	$ 500
Sealant and control joint renewal	$ 20,400
Roof	$ 7,330
ADA add handicap parking spaces	$ 600
ADA add van-access parking spaces	$ 250
ADA sign for van-access parking	$ 150
ADA access path of travel route	$ 350
	$ 276,538

SCHEDULE 13(a)

PENDING ALTERATIONS AND IMPROVEMENTS

Long Beach Property Pending Alterations

Project	Cost	
New central plant	$	3,787,496
Plaza waterproofing	$	371,486
Carbon monoxide monit system	$	34,912
Bldg stairwell lighting retrofit	$	34,989
Bldg window tint both towers	$	250,000
Parking struct lighting retrofit	$	264,229
VAV DDC conversion both towers	$	841,824
Fire alarm control panel & devices	$	340,000
Fire safing survey & installation	$	134,220
Atrium cooling system retrofit	$	114,272
Bldg lighting retrofit	$	676,234
Phase 2 plaza waterproofing	$	3,000,000
Roof replacement both towers	$	394,192
	$	10,243,854

Long Beach Property Tenant Improvements

- **200 Tower**

Suite No.	Sq. Ft.	New Tenant	Occupancy Date	TI's PSF	TI Cost
800	3,784	Molina	6/1/2013	$ 35.00	$ 132,440
1550	8,150	Molina*	10/1/2013	$ 350.00	$ 2,852,500
	11,934				$ 2,984,940
* This cost is based on Event Hall with specialized kitchen for Molina corp g					

- **300 Tower**

Suite No.	Sq. Ft.	New Tenant	Occupancy Date	TI's PSF	TI Cost**	
150	6,456	Molina**	7/1/2013	$ 150.00	$ 968,400	
500	16,575	Molina*	8/1/2013	$ 35.00	$ 580,125	
600	16,575	Molina*	7/1/2013	$ 35.00	$ 580,125	
910	6,516	Molina*	12/1/2013	$ 35.00	$ 228,060	
1400	16,580	Molina	7/1/2013	$ 35.00	$ 580,300	
	62,702				$ 2,937,010	
*These costs are estimated based upon average build-out costs for Molina @$35 psf.						
** This cost is based on fitness center for Molina employees @$150 psf						

Columbus Property Pending Alterations

Project	Cost
Security console desk	$ 20,000
Asphalt repair & slurry seal	$ 168,458
Repair curbs	$ 36,000
Landscape material	$ 22,500
Repair retaining wall	$ 15,000
Sealant & control joint renewal	$ 20,400
Generator	$ 300,000
	$ 582,358

Columbus Property Tenant Improvements

Suite No.	Sq. Ft.	New Tenant	Occupancy Date	TI's PSF	Total TI Cost
100	11326	Molina*	11/1/2013	$ 35.00	$ 396,410
130	3726	Molina **	11/1/2013	$ 200.00	$ 745,200
	1500	Molina***	11/1/2013	$ 150.00	$ 225,000
160	4362	Molina*	11/1/2013	$ 35.00	$ 152,670
200	27775	Molina*	11/1/2013	$ 35.00	$ 972,125
320	21932	Molina*	11/1/2013	$ 35.00	$ 767,620
400	16050	Molina*	8/1/2013	$ 35.00	$ 561,750
401	4123	Molina*	8/1/2013	$ 35.00	$ 144,305
402	2335	Molina*	8/1/2013	$ 35.00	$ 81,725
403	5456	Molina*	8/1/2013	$ 35.00	$ 190,960
500	27204	Molina*	11/1/2013	$ 35.00	$ 952,140
610	13947	Molina*	7/1/2013	$ 35.00	$ 488,145
	139736				$ 5,678,050

* These dates are estimates only and may change if iQor fails to vacate in a timely _____ experienced with space plan finalization or permitting.

**This cost is based on fitness center for Molina employees @$200 psf

*** This cost is based on café for the building as an amenity @$150 psf

SCHEDULE 16(a)

EXISTING INSURANCE POLICIES

	Carrier	Coverage	Policy #
1.	Lexington Insurance Co.	Property	13113039
2.	Philadelphia Indemnity Insurance Co.	Commercial General Liability	PHPK987040
3.	Philadelphia Indemnity Insurance Co.	Automobile	PHPK987040
4.	Liberty Insurance Underwriters Inc.	Umbrella Liability	1000037294-02
5.	TBD	Flood	TBD
6.	TBD	Earthquake	TBD

EXHIBIT A-1

COLUMBUS REAL PROPERTY

PARCEL 1:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 13.727 acre tract, and all of the 0.875 acre tract conveyed to 17 Land Realty Corp. by deeds of record in O.R. 14066 B11 and O.R. 25716 J11, respectively, records of the Recorder's Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning at a railroad spike set at the intersection of the Southerly right-of-way line of Interstate 270 (FRA-270-18.32N) and centerline of Cooper Road (60 feet in width). Said railroad spike being the Northeasterly corner of said 0.875 acre tract;

Thence South 26 deg. 55' 00" East, a distance of 241.79 feet, along said centerline of Cooper Road and Easterly line of said 0.875 acre tract, to a railroad spike set at the Southeasterly corner of said 0.875 acre tract;

Thence North 78 deg. 47' 04" West, a distance of 38.14 feet, along the Southerly line of said 0.875 acre tract, to an iron pin set in the Westerly right-of-way line of said Cooper Road;

Thence South 26 deg. 55' 00" East, a distance of 295.14 feet, along said Westerly right-of-way line of Cooper Road and along the Easterly line of said 13.727 acre tract, to an iron pin set at the point of curvature in the Northerly right-of-way line of Corporate Exchange Drive (60 feet in width) of record in Plat Book 60, Page 22 and 23;

Thence the following four (4) courses and distances along said Northerly right-of-way line of Corporate Exchange Drive and Southerly line of said 13.727 acre tract;

1. Thence along arc of said curve to the right having a radius of 35.00 feet, a central angle of 90 deg. 00' 00", and a chord bearing South 18 deg. 05' 00" West, a chord distance of 49.50 feet to the point of tangency;

2. Thence South 63 deg. 05' 00" West, a distance of 35.00 feet, to an iron pin found at the point of curvature;

3. Thence along arc of said curve to the right having a radius of 270.00 feet, a central angle of 28 deg. 56' 27", and a chord bearing South 77 deg. 33' 14" West, a chord distance of 134.94 feet, to an iron pin set at the point of tangency;

4. Thence North 87 deg. 58' 33" West, a distance of 788.06 feet, to an railroad spike set;

Thence North 02 deg. 01' 27" East, a distance of 318.00 feet across said 13.727 acre tract to a railroad spike set in a Southerly line of the 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence South 87 deg. 58’ 33” East, a distance of 15.00 feet along said Southerly line of the 5.103 acre tract to a railroad spike set at a Southeasterly corner of said 5.103 acre tract;

Thence the following three (3) courses and distances along the Easterly lines to said 5.103 acre tract;

1. Thence North 02 deg. 01’ 27” East, a distance of 185.00 feet, to a P.K. nail found;

2. Thence South 87 deg. 58’ 33” East, a distance of 57.50 feet, to a railroad spike set;

3. Thence North 02 deg. 01’ 27” East, a distance of 167.21 feet, to an iron pin set in aforesaid Southerly right-of-way line of Interstate 270 at a Northeasterly corner of said 5.103 acre tract;

Thence South 78 deg. 46’ 49” East, a distance of 677.06 feet, along said Southerly right-of-way line of Interstate 270 and partly along the Northerly line of said 13.727 acre tract and partly along the Northerly line aforesaid 0.875 acre tract, to the point of beginning.

Containing 11.814 acres, more or less, of which 0.167 acres lies within the Cooper Road right -of-way.

The bearings in the above description are based on the bearing of South 87 deg. 58’ 33” East, for the centerline of Corporate Exchange Drive, as shown on the dedication Plat for Corporate Exchange Drive, of record in Deed Book 60, Page 22 and 23, records of the Recorder’s Office, Franklin County, Ohio.

PARCEL 2:

Situated in the City of Columbus, County of Franklin and State of Ohio, lying in Quarter Township 2, Township 2, Range 17, United States Military Lands:

And known as being a part of the 4.500 and 13.727 acre tracts conveyed to 17 Land Realty Corp. by deed of record in O.R. 14066 B11, Records of the Recorder’s Office, Franklin County, Ohio, and being more particularly described as follows:

Beginning for reference at a PK nail found at the centerline intersection of Presidential Gateway (60 feet in width) as established by the Plat of record in Plat Book 83, Page 80 and Corporate Exchange Drive (60 feet in width) as established by the Plat of record in Plat Book 60, Page 22;

Thence North 87 deg. 58’ 33” West, a distance of 329.18 feet along the centerline of Corporate Exchange Drive to a point;

Thence North 02 deg. 01’ 27” East, a distance of 30.00 feet, to a railroad spike set on the Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 acre tract and being the point of true beginning;

Thence the following three (3) courses and distances along the said Northerly right-of-way line of Corporate Exchange Drive and the Southerly line of said 13.727 and 4.500 acre tracts;

1. Thence North 87 deg. 58’ 33” West, a distance of 94.38 feet to an iron pin set at a point of curvature;

2. Thence along the arc of said curve to the right, having a radius of 420.00 feet, a central angle of 27 deg. 22’ 54”, a chord bearing North 74 deg. 17’ 06” West, and a chord distance of 198.81 feet to an iron pin found at the point of tangency;

3. Thence North 60 deg. 35’ 39” West, a distance of 28.10 feet to an iron pin set at a Southeasterly corner of a 5.103 acre tract conveyed to Corporate Exchange Buildings IV and V Limited Partnership by deed of record in O.R. 24554 B04;

Thence the following two (2) courses and distance along the Easterly and Southerly lines of said 5.103 acre tracts;

1. Thence North 02 deg. 01’ 27” East, a distance of 258.02 feet to a railroad spike set;

2. Thence South 87 deg. 58’ 33” East, a distance of 312.50 feet to a railroad spike set;

Thence South 02 deg. 01’ 27” West, a distance of 318.00 feet across said 13.727 acre tract to the point of true beginning, containing 2.183 acres, more or less, subject to all easements, restrictions and rights-of-way of record.

EXHIBIT A-2

LONG BEACH REAL PROPERTY

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 7278-003-036

EXHIBIT B-1

Columbus Other Assets

The term "Columbus Property Other Assets" means (a) all "fixtures", as defined by Section 9-102(a)(41) of the Uniform Commercial Code as adopted by the State of New York, owned by Landlord and that are now or hereafter affixed or attached to or installed in the Columbus Real Property or the Columbus Improvements (the "Columbus Fixtures"), (b) all of the following, if and to the extent affixed to the Columbus Real Property or the Columbus Improvements and owned by Landlord (even if not constituting Fixtures) (collectively, the "Columbus Property Equipment"): built-in fittings and built-in major appliances, including all electrical, anti-pollution, heating, lighting (including hanging fluorescent lighting), incinerating, power, air cooling, air conditioning, humidification, sprinkling, plumbing, lifting, fire prevention, fire extinguishing and ventilating systems, devices and machinery and all engines, pipes, pumps, tanks (including exchange tanks and fuel storage tanks), motors, conduits, ducts, steam circulation coils, blowers, steam lines, compressors, oil burners, boilers, doors, windows, loading platforms, lavatory facilities, stairwells, fencing (including cyclone fencing), passenger and freight elevators, overhead cranes and garage units, and (c) all Columbus Intangible Property; provided, however, notwithstanding the foregoing, Columbus Property Other Assets expressly excludes each and all of the following items (collectively, the "Columbus Property Excluded Items"):

1. all personal property located at the Columbus Real Property or the Columbus Improvements including, without limitation, all computers and other information technology devices, but excluding all items described in clause (b) of the definition of Columbus Property Other Assets; and

2. those other items (regardless of whether such items constitute Fixtures) described on Exhibit B-1-A hereof.

EXHIBIT B-1-A

Columbus Other Assets Excluded Items

Qty	Mfg	Description	Model#	Location
1	Aircycle	Bulb eater	55VRSU	Shop
1	Westward	Toolbox		Shop
1	CLC	Toolbag		Shop
2	Maha	Battery Chargers		Shop
1	Dayton	Leaf Blower		Fire pump room
1	Briggs	Generator 5500 watts		Fire pump room
1	Ariens	Snow blower		Fire pump room
1	Snow Ex	Salt Spreader		Switch Gear Cage
1	Rubbermaid	Light bulb cart		Shop
1	Ridgid	Drain snake		Shop
1	Dewalt	Air compressor		Shop
1	Dewalt	18v Drill		Shop
1	Dewalt	18v Impact drill		Shop
1	Dewalt	18v Circular saw		Shop
1	Dewalt	18v Reciprocating saw		Shop
1	Dewalt	Bench grinder		Shop
1	Dewalt	Masonary bit set		Shop
1	Dewalt	Drill bit set		Shop
1	Westward	Bench grinder		Shop
1	Stanley	25ft Tape measure		Shop
1	Irwin	Paddle bit set		Shop
1	Fluke	Multimeter		Shop
1	Fluke	Infrared thermometer		Shop
1	Ideal	Amp clamp		Shop
1	Streamlight	Flashlight		Shop
1	Klein	10 in 1 screw driver		Shop
4	Vise Grip	Pliers		Shop
3	Westward	Adjustable wrenches		Shop
1	Westward	Wrench set		Shop
1	Westward	Socket Set		Shop
1	Stanley	Utility knife		Shop
1	Stanley	Tripod light		Shop
3	Westward	Pliers		Shop
1	Elkind	Allen wrench set		Shop
1	Megapro	15 in 1 screw driver		Shop
1	Brother	Printer	MCF845CW	Shop
1	Dell	Computer		Shop
1	Rigid	Hand snake		Shop

1 Zicron	Stud Finder	Shop
1	Scafold 4ft	Shop
1	5 gallon gas can	Fire pump room
1	2 gallon gas can	Fire pump room
1 Ridgid	Power washer 3300psi	Fire pump room
1 Shop Vac	Sweeper	Switch Gear cage

EXHIBIT B-2

Long Beach Other Assets

The term "Long Beach Property Other Assets" means (a) all "fixtures", as defined by Section 9-102(a)(41) of the Uniform Commercial Code as adopted by the State of New York, owned by Landlord and that are now or hereafter affixed or attached to or installed in the Long Beach Real Property or the Long Beach Improvements (the " Long Beach Fixtures"), (b) all of the following, if and to the extent affixed to the Long Beach Real Property or the Long Beach Improvements and owned by Landlord (even if not constituting Fixtures) (collectively, the "Long Beach Property Equipment"): built-in fittings and built-in major appliances, including all electrical, anti-pollution, heating, lighting (including hanging fluorescent lighting), incinerating, power, air cooling, air conditioning, humidification, sprinkling, plumbing, lifting, fire prevention, fire extinguishing and ventilating systems, devices and machinery and all engines, pipes, pumps, tanks (including exchange tanks and fuel storage tanks), motors, conduits, ducts, steam circulation coils, blowers, steam lines, compressors, oil burners, boilers, doors, windows, loading platforms, lavatory facilities, stairwells, fencing (including cyclone fencing), passenger and freight elevators, overhead cranes and garage units, and (c) all Long Beach Intangible Property; provided, however, notwithstanding the foregoing, Long Beach Property Other Assets expressly excludes each and all of the following items (collectively, the "Long Beach Property Excluded Items"):

1. all personal property located at the Long Beach Real Property or the Long Beach Improvements including, without limitation, all computers and other information technology devices, but excluding all items described in clause (b) of the definition of Long Beach Property Other Assets; and

2. those other items (regardless of whether such items constitute Fixtures) described on Exhibit B-2-A hereof.

EXHIBIT B-2-A

Long Beach Other Assets Excluded Items

See attached.

ABM Engineering Services

TOOL INVENTORY

Qty	***Mfg***	***Description***	***Model #*** (If Applicable)	***Location*** (If Applicable)
1	Ridged	24” bolt cutter		
1	Fluke	Multimeter	73 III	
1	Yellow Jacket	Super EVAC LCD Vacuum Gauge	69070	
1	Lisle	Ring Compressor Wrinkle band	21700	
1	Zim	Piston Ring Expander		
1	DeWalt	Cordless Drill 12v	1PZ14	
1	Makita	Cordless Drill 9.c Volts (Angle)	DA391DW	
1		One Way Screw Remover tool	PH-17061	
1	Ritchie	Manifold Charging Set	41212	
1	Ritchie	Valve Stem Wrench ¼” 3/16” 5/16” ⅜”	60613	
1	Ritchie	Big Mini tubing cutter 1⅛” max.	60142	
1	Fluke	Clamp meter Amps/volts/Ohms	322	
1	Rigio	Tubing Cutter	154	
1	Shopvac	Dry/wet vacuum		
2	Vaughn	Ball Peen Hammers 12 oz.		
1	Armstrong	½” Drive Adapter ¾” male	12-952	
1	Armstrong	½” Drive Adapter ⅜” male	12-951	
1	Allen	½” Drive Quick Release Ratchet	12800	
1	Proto	½” Drive Flex Head Handle Breaker bar 18⅝”	5468	
1		U-Shaped Claw and Offset Chisel Bar 24”	No I.D. Markings	
2	Supco	HVAC/R Current Probe with Micro Amps	CPH 100	
1	Motorola	UHF Portable Hand held Radio	HT 750	
1	Motorola	UHF Portable Hand held Radio	HT 750	
1	Motorola	UHF Portable Hand held Radio	HT 750	
1	Motorola	UHF Portable Hand held Radio	HT 750	
1	Harris	TS30 Test set portable handset	TS30	
1 set	C.S. Osborne	Hole punch set (6)		
4		Misc. Hole punch tools		
1		Combination TEE		
1	Proto	Snap Ring Pliers	391	

Rev Date: 6/4/2013

Qty	***Mfg***	***Description***	***Model #*** (If Applicable)	***Location*** (If Applicable)
	Proto	Ignition set wrenches	3200c	
1 set	Milwaukee	Flat boring bit kit	49-22-0071	
1	Stanley	Side Cutters	84-133	
22		Misc. Files		
1	Lenox	File brush		
1	Zim	Piston Ring Expander	204	
1		Piston Ring compression tool		
1	Imperial Eastman	Tubing Bender	368-FH	
1		Heavy Duty Puller		
1	UT	⅜" Air Ratchet & Sockets		
1	Vise Grip	9" Locking Welding Clamp		
1	Proto	Small Puller		
1 set	Allen	15 pc. Metric Long Arm Hex Key Set		
2		Star Wrenches Lug Nut Removal tool		
2	Flex-hone	Cylinder Wall deglazer hones		
1	Proto	¾" Drive Ratchet		
1	Proto	¾" Drive Breaker Bar		
1	Turbo Cat III	Floor Dryer	4390-00	
1		Oxy-Ace Welding set Lg.		
1		Oxy-AC Welding set Sm.		
1		Hex L-Key set 12 pc.		
1		Metric Hex L-Key set 9 pc.		
18	Proto	Assorted open end wrenches		
1 set	Proto	Ratchet box end wrench		
7	Proto	⅜" Swivel head socket		
1	Unibit	Step drill ⅛" to ½"		
1	Proto	Torque wrench ½" drive		
1	Utica	⅜" inch pound torque wrench		
1	Proto	½" Speed handle		
1	Proto	⅜" Speed handle		
1 set	Proto	⅜" and ½" drive Hex		
12	Proto	Metric open-box wrenches		
1 set	Taiwan	Torx head Drivers		
30		Assorted Allen Wrenches		
11		Assorted Screw Drivers		
9		Nut Drivers		
1	Imperial	Tubing cutter		
1	Proto	Snap Ring Pliers		

Qty	***Mfg***	***Description***	***Model #*** (If Applicable)	***Location*** (If Applicable)
4		Vise Grips Pliers		
7		Assorted Masonry Drill bits		
1	Proto	Small Gear Puller	4205-B	
1 set	Jawco	Hex Dies		
1 set	Buck bros.	Wood chisels (6)		
1	Irwin	Expansive Wood Bit		
1	Greenlee	Knockout Punch set		
1	Marson	Rivit Gun	HP-2	
1	Desmond	Stone dresser		
1		Slag Remover chipping hammer		
1	Raytek	Noncontact thermometer	ST2	
1	Amprobe	Test master		
1	PASAR	Current tracer		
1	Sensit RFC	Refrigerant Gas Leak Detector	RFC-1	
1	Check-it	Digital Psychrometer set	622	
1	General Electric	Foot Candle meter		
1	Electro-Therm	Digital Thermometer	SH66	
1	Robertshaw	Receiver controller and transmitter calibration kit	900-012	
1	Starrett	Dial indicator	25-144	
1	DeWalt	Cordless Drill 12v	DW972	
1	Makita	Cordless Drill 12v	6311D	
1	Makita	Cordless Drill 9.6v	6095D	
1	Makita	Cordless Drill 9.6v	6093D	
1	Makita	Cordless Drill 7.2v	DA3000D	
1	Proto	Roll Away Tool Box		
1	ilco Unican	Key Duplicator Machine	17	
1	Ridgid	Vise		
1	Vaco	T-Handle Hex Keys (set)	90153	
1	K-D	T-Handle Hex Keys (set)		
1 set	Proto	Ratchet, Extensions, sockets ⅜”		
1 set	Proto	Ratchet, Extensions, sockets ½”		
1 set	Proto	Ratchet, Extensions, sockets ¾”		
1 set		Pipe thread taps (6)		
14	Proto	Assorted End-Open End Wrench		
1				
1		50w 12v Drop Light		
1	Magnehelic	2” of water capacity		
1	Magnehelic	1” of water capacity		
1	Weller	Soldering gun	TC-202	
2	Powr-Grip	Vacuum-Attaching handtool	LJ6VH	

Qty	***Mfg***	***Description***	***Model #*** (If Applicable)	***Location*** (If Applicable)
1 set	Armstrong	Quick Release Ratchet set		
2	Sellstrom	Gas welding goggles		
1	Ridgid	Lever Bender	408	
1	Magnehlic	3” of water capacity		
3	Bacharach	Tempscribe		
1	Dickson	Tempscribe		
1				
1	Schlage	Boring Jig	40-012	
1	Amprobe	AMP, Volt, OHM Meter	ACD-11	
1	Simpson	Volt, OHM Meter	260	
1	Solomat	IAQ monitoring system		
1	Starrett	Dial Caliper	120A-6	
1	Simpson	Therm O Meter	389	
1	Leviton	Splice Pro Tool	49550	
1	Yellow Jacket	Schrader Valve Removal Tool		
1	TIF	Automatic Halogen Leak Detector	6000	
1		Digital Light Meter	DLM2	
1	TIF	Capacitor tester	660	
1	UE1	Digital multimeter	DM383	
1	Amprobe	Fastemp		
2	Lenox	Hole Saw Kits		PI Shop
1	Dayton	8 Piece Silver and Deming Drill Set	1A050	
1	Milwaukee	Heavy Duty Electric Impact Wrench		
1	Kett	Power Shear	K-100	
1		Nut Driver Power Drill		
1	Lenox	Hacksaw	4012	
1	Christie	Portable Car-Start	CS-2	
1	Wilmar	2¼ Ton Floor Jack	W-1634	
1	Kodiak	Shovel	72830	
1	Dayton	Ratchet puller	2Z449-B	
1	Ramset	Powder Actuated tool	4170	
1	Hilti	Power Actuated tool	DX451	
1	DeWalt	7” Angle Grinder	DW474	
1	Milwaukee	7¼” Circular Saw	6365	
1	Milwaukee	Rotary Hammer		
1	Milwaukee	⅜” Drill		
1	Black & Decker	⅜” Drill		
1	Black & Decker	Rotary Hammer		
1	Master	Heat Gun	HG-751B	
1	Wen	Electric Pencil Engraver	21	

Qty	***Mfg***	***Description***	***Model #*** (If Applicable)	***Location*** (If Applicable)
1	Vibro-Graver	Electric Engraver	74	
1	Black & Decker	Butane gas soldering gun		
1	Master	Butane gas soldering gun	UT-100si	
1	Arrow Fastener	Staple gun	T-50m	
1	Dwyer	Visi-Float Flowmeter	VFB-55-BV	
1	Allpax	Gasket cutter		
2	Proto	Crescent wrench 16”		One in each mech. Rm.
1	Proto	Crescent wrench 12”		One in each mech. Rm.
1	Mayes	Level 24”		One in each mech. Rm.
2	Pony	‘C’ clamps	245	One in each mech. Rm.
2	Pony	‘C’ clamps	246	One in each mech. Rm.
1	Uniweld	Manifold Gauge Set	FL 33312	One in each mech. Rm.
1		Manifold Gauge Set	4 port	One in each mech. Rm.
1		12v Drop Light		
1	Empire	Level 48”		
3		‘T’ Squares 24”		
1		‘T’ Squares 48”	Wood	
1	Johnson	48” Straight edge	TS48M	
1	Ridgid	36” Bolt cutters		
1	Millers Falls	Sledge hammer		
1		5’ Pry Bar		
1	DeWalt	Heavy Duty 4½” Small Angle Grinder	DW818	
1	Makita	Finishing Sander	BO4530	
1	SKIL	Soldering gun	2410	
1	Milwaukee	Jig saw		
1	Dremel	Dremel variable speed grinder		
2 sets	ACE	Tap & Die Set	614	
1	Desco	Tap & Die Set #4 thru 1”	44348	
1	Milwaukee	⅜” Hammer Drill		
1	Milwaukee	Sawzall		
1	Weller	Soldering Gun	8200N	
1	Milwaukee	Heavy Duty ½” Drill		
1	Craftsman	Drill Press 17” 16sp ¾hp		PI Shop
1	Speedaire	Air compressor		PI Shop

Qty	***Mfg***	***Description***	***Model #*** (If Applicable)	***Location*** (If Applicable)
1	Graymills	Parts Cleaner/Washer	DM136	PI Shop
1	Milwaukee	Bench Grinder 7”		PI Shop
2	Ridgid	Aluminum Pipe Wrench	836 36”	PI Shop
1	Ridgid	Aluminum Pipe Wrench	824 24”	PI Shop
1	Ridgid	Pipe Cutter ⅛”-2”	No. 202	PI Shop
1	Chicago Specialty	Pipe Cutter 1”-3⅛”	No. 3720	PI Shop
1 set	Ridgid	Thread Cut set ⅛”-2” pipe		PI Shop
1	Ridgid	115v Power Threader	700	PI Shop
1	Ridgid	Spiral Reamer	No. 2-S	PI Shop
2	Jorgensen	“C” Clamps 6”	176	PI Shop
2	Jorgensen	“C” Clamps 4”	174	PI Shop
1	Proto	“C” Clamp 2”	402	PI Shop
1	Armstrong	“C” Clamp 8”	78-408	PI Shop
1	Ridgid	Flare	No. 459 45°	PI Shop
1	Proto	Flaring Tool	No. 351 45°	PI Shop
1	Ridgid	Basin wrench	No. 1017	PI Shop
1	Ridgid	Hex wrench	No. 11	PI Shop
1	Ridgid	Offset hex wrench	No. E-110	PI Shop
1 set	Proto	Open end box wrench	⅜” to 1¼”	PI Shop
2	Proto	Brass Hammer		PI Shop
1		Plastic mallet		PI Shop
2	Proto	Rubber mallets		PI Shop
1		Ball Peen Hammer 32 oz.		PI Shop
1	Stanley	Claw Hammer		PI Shop
1	Vaughan	Ball Peen hammer 16 oz.		PI Shop
3	Wiss	Tin snips		PI Shop
1	Ridgid	Spud wrench	No.342	PI Shop
2	Sloan Valve	Universal wrench		PI Shop
4	Rachex	Ratchet Action Wrench	10-17mm box wrench	PI Shop
1	Lincoln	Wire Feed Welder SP175 T	Link 2302-1	
1	Pro Star	Welding Helmet Auto Darkening	FIB HPD1-F10	
1	J/B	Deep Vacuum Pump 10cfm ½hp	DV-285N	
1	Makita	Portable Cut-off (chop saw)	2414NB	
1	BernzOmatic	High Temperature Torch	TS4000T	
1	LSI	Cordless Spotlight	RC-1100N	
1	Channellock	21” Channel Lock Pliers		
1	SKIL	7¼ Circular Saw	5400	
1	Honda	Portable Generator	EM5000SX	
1	Schumacher	Battery Charger	SE4022	

Qty	***Mfg***	***Description***	***Model #*** (If Applicable)	***Location*** (If Applicable)
1	Pinnacle	Refrigerant Recovery Unit		
1	Fluke	Volt-OHM Tester	T+PRO	
1	AEMC	Megohm Tester	1026	
3	DeWalt	14.4v Cordless Drill		
1	Armstrong	10 pc. Claw Foot (open end)		
1	Empire	4' Level Aluminum		
1	Armstrong	⅜" Socket Set MM 13 pcs.		
1	Armstrong	⅜" Socket Set MM (Long) 12 pcs.		
1	Proto	¼" Socket set		
1	Proto	⅜" Socket set		
4	Wood's	Powr-Grip 8"	N4950	
1	Milwaukee	Portable Band Saw		
1	Milwaukee	Roto Hammer	5318-21	
1	CPS	Thermo-Psychrometer	TM360	
1	Ridgid	Handheld Drain Cleaning Machine	K45	
1	Milwaukee	18v Sawzall + Charger		
2	Dayton	Pumpout wet vac	6AKY1	
1	Fluke	Clamp on Meter AMP Probe	324	
1	Milwaukee	120v Sawzall		
1	Ridgid	Pipe Breaker	276	
1	Dayton	8" Bench Grinder ¾ hp	2LKR9	
1	Weller	120v Solding Gun	SP23L	
1	Master	Gas Solding Gun Ultratorch	UT-40si	
1	Milwaukee	Electric ½" Drill 5320010330067		
1	Genie	1 Person Lift		
1	Genie	Material Lift		
1	Eureka	Hepa Vacuum Cleaner		
1		Fence Post Installer		
1		Cherry Picker		
1	Husky	5 Piece Reversible Ratching Wrench's	SKU630699	
1	Greenlee	Circuit Seeker	CS 8000	
1	Arrow Crane Hoist	Iron 1 Ton capacity Hoist	B-9620	
1	SPANCO Inc.	Aluminum 1 ton Capacity Hoist	1ALU1212B	
1	Coffing	1 Ton Chainfall		
1	CM	Electric 1 Ton Hoist	WL 480v	
1	Tomcat	Walk Behind Floor Scrubber		

MOLINA CENTER, LLC - OFFICE EQUIPMENT BY DEPARTMENT

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
1999	Desk Top Multiplex - Security	Pelco Multiplexer MX4016 CS	Console	Plaza Level	6644 9F	Sentry Control Systems
2009	Security Camera System Monitor	Samsung SMT-1922 19 **1-yr Wty: 4/1/09 to 4/1/2010**	Console	Lobby Level	Serial # Y3OC3VUQ900002	CDW Computer Centers, Inc.
2009	Security Camera System Monitor	Planar PL1520M 15 SPK Part Number 997-3266-00 **1-yr Wty: 3/27/09 to 3/27/2011**	Console	Lobby Level	Serial # P96886JA25192	CDW Computer Centers, Inc.
2009	Security IdentiPass system CPU	Dell Optiplex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/2012**	Console	Lobby Level	Service Tag # H8MDGJ1	Dell.com
2013	Desk Top Keyboard - Security Console	Pelco KBD300A Keyboard Vari-speed Pan, Tilt & Zoom Joystick; Model #KBD300A. Installed 1/8/2013	Console	Lobby Level	SN ACW-VP J8	Vision Communications
2013	Security DVR	Pelco Hybrid Video Recorder 16 channel (DVR); Model DX4816-2000; installed 1/8/2013	Console	Lobby Level	SN ACV-2002	Vision Communications
2000	Desk Top Printer - Engineer	HP DeskJet 842C	Engineer	P-1 Level	CN01M1P0W8	KDC
2005	Desk Top Monitor - Engineer	1704FPTt-HVAC Monitor	Engineer	P-1 Level	CNOY42997161856AANJH	Dell Computer Corporation
2010	Desk Top Printer - Chief Engr's Office	HP LaserJet P2035n Purchased: May 13, 2010 **1-yr Wty: 5/13/2010 to 5/12/2011**	Engineer	P-1 Level	Serial # CNB9D27365; Mfg#: H-P-CE462A#ABA	CDW Computer Centers, Inc.
2010	Desk Top Computer - Chief Engr	Dell Opti Plex 380 MiniTower Base **3-yr Wty: 5/6/2010 to 5/5/2013**	Engineer	P-1 Level	Service Tag $ 21QTRL1; Express Code: 4459089637; Mfg Date: 5/5/2010	Dell.com
2010	Desk Top Monitor - Chief Engr	Dell 22 inch Flat Panel Display; E2210H**: 3-yr Wty: 5/2/2010 to 5/2/2013**	Engineer	P-1 Level	DP/N OH265R; CN-OH265R-64180-047-1USL	Dell.com
2010	Desk Top Computer - Engineer - Chief Engineer's Andover HVAC System	Dell OptiPlex380 – Intel Core 2 Duo 2.93 Ghz, 4 GB, 160 GB 7200 RPM SATA HD, 16X DVD-ROM; Service Tag: BCG1PN1; Express Service Code: 24697153549	Engineer	P-1 Level	Windows 7 Pro/OA; Product key: TMXCJ-2VBY4-WV43H-R4TH4-HRDTVX16-96076; 00186-77-094-237; OKXGVD	CGB Enterprises

Rev Date: 6/4/2013

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2012	Printer - Engineers' Lunch Room	HP DeskJet 5650	Engineer	P-2 Level	SN MY7CL1R1JP	Dell
2012	Desk Top Monitor - Engineers' Lunch Rm	Model # E1911C; 22 inch Monitor	Engineer	P-2 Level	SN CN-ONO1VP-64180-219-1C9B	Dell
2012	Desk Top Computer - Engineers' Lunch Rm	Model # Core i5; Windows 7; Product Key# 328HW-M472H-GDMW7-4JK 32-2H8M9	Engineer	P-2 Level	Service Tag # 1KMMJS1; Express Service Code: 342109473	Dell
2013	Desk Top Computer - New HVAC System	Dell OptiPlex 990; Intel Core i5; Windows 7; Product Key: 7Q2F2-7WTHG-W8TWR-YH4XP-TKC2W	Engineer	P-1 Level	Service Tag # CVVPYV1; Express Service Code: 28049119165	Emcor
2013	Desk Top Monitor-New HVAC System	LG 32 inch Monitor LS-34; 32LS3410	Engineer	P-1 Level	SN 209MXLS7Q352	Emcor
2013	Potable Radio	Hytera PD702 U(2)	Engineer	Craig Aydelott	SN 12816A0500; Radio ID# 2001	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Esteban Diaz	SN 12816A0496; Radio ID# 2002	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Alfonso Oregel	SN 12816A0497; Radio ID# 2003	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Richard Marshall	SN 12816A0499; Radio ID# 2004	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Engineer	Jeremiah Lees	SN 12918A0200; Radio ID#2020	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Claudia Motte-Alvarez, J1	SN 12816A0495; Radio ID# 2007	Vision Communications

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Nancy Hernandez, J2	SN 12816A0494; Radio ID# 2008	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Alex Passarelli, J3	SN 12816A0493; Radio ID# 2009	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Janitorial	Hector Nunez	SN 12918A0199; Radio ID# 2019	Vision Communications
2013	Lobby Level Directory Monitor	Panasonic 42 inch	Lobby	Lobby Level	SN MB21580709; 200 Twr	Jet Communications
2013	Lobby Level Directory Monitor	Panasonic 42 inch	Lobby	Lobby Level	SN MD22360382; 300 Twr	Jet Communications
2013	Desk Top Printer - Guest Room	HP Photosmart 7550 (Color)	OOB	Guest Desk	CN2BS4214N	World Trade Office Supplies
2013	Desk Top Monitor - Guest Room	1704FPTt	OOB	Guest Desk	CNOY42997161856AANM5	Dell Computer Corporation
2005	Desk Top Monitor - Server Room	E153FP	OOB	Server Room	CNOC53696418053UOL5H	Dell Computer Corporation
2005	Desk Top Computer - Guest Room	DHS Mfg Date: 07 20 05	OOB	Guest Desk	6XWKY71	Dell Computer Corporation
2005	Desk Top Printer - Guest Room	HP Photosmart D7260 (Color)	OOB	Guest Desk	MY789U2NH	HP.com
2009	Desk Top Monitor - Asst. Bldg Mgr	Dell 22” LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Mary’s Desk	CN-0F532H-74445-93Q-AM6S	Dell.com

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2009	Desk Top Monitor - Asst. Bldg Mgr	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Mary's Desk	CN-0F532H-74445-93Q-ANDS	Dell.com
2009	Desk Top Monitor - Property Asst	Dell 22" LCD DP/N 0F532H 2208 WFP **3-yr Wty: 5/7/09 to 5/7/2012**	OOB	Pearl's Desk	CN-0F532H-74445-93Q-AN9S	Dell.com
2009	Security IdentiPass System CPU	Dell OptiPlex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/2012**	OOB	Access Card Desk-OOB	Service Tag # BJFDGJ1	Dell.com
2009	Desk Top Scanner - Print Area	HP ScanJet 7650n; Model: (1P): L1943A; Option (30P); B1H **1-yr Wty: 5/18/09 to 5/17/2010**	OOB	Print Area	CN87KT1129	CDW Computer Centers, Inc.
2009	Conference Room TV Monitor	Sharp LC-42SB45UT: **1-yr Wty: 9/4/09 to 9/8/10**	OOB	Confce Rm	905817411	Kelty Co.
2009	Lobby Level CPU for Directory	Dell Optiplex 740 **3-yr Wty: 9/30/09 to 9/30/2012.**	OOB	Lobby Level	200 Tower: Service Tag # FZ67ZK1; Express Code: 34778501569	Dell.com
2009	Lobby Level CPU for Directory	Dell Optiplex 740 **3-yr Wty: 9/30/09 to 9/30/2012**	OOB	Lobby Level	300 Tower: Service Tag # DZ67ZK1; Express Code: 30424936897	Dell.com
2010	Desk Top Printer – GM's Office	HP LaserJet P3015dn Purchased: May 13, 2010 **1-yr Wty: 5/13/2010 to 5/12/2011**	OOB	Ivette's Desk	Serial # VNBCB406WP; Mfg#: H-P-CE528A#ABA	CDW Computer Centers, Inc.
2010	Desk Top Computer – Property Asst	Dell Opti Plex 380 Minitower Base **3-yr Wty: 6/7/2010 to 6/6/2013. Placed in Service 6/25/2010.**	OOB	Pearl's Desk	B574KM1	Dell.com

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2010	Desk Top Computer – Asst. Bldg Mgr	Dell Opti Plex 380 Minitower Base **3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010.**	OOB	Mary's Desk	B582KM1	Dell.com
2012	Desk Top Computer – Server Room	PowerEdge Dell T310 System	OOB	Server Room	Service Tag: 2VL9JS1; Express Service Code: 6263733601	Carapace Inc.
2012	LapTop Computer – G Mgr	**Dell Laptop 13 inch.**	OOB	Ivette's Desk	Service Tag (S/N): CKMYFS1; Express Service Code: 27369269857	Dell purchased by Lori McKinney
2012	HP OfficeJet Pro 8600	Model#: SNPRC-1101-01; Product #: CM749A **1-yr Wty: 1/19/2012 to 1/19/2013**	OOB	Print Area	Serial # CN1C31T1C6	Lori McKinney
2012	Desk Top Monitor – GMgr	Dell 22 inch Flat Panel Display	OOB	Ivette's Desk	S/N# CN-0174R7-72872-24B-A2VU	Dell from Lori McKinney
2012	Desk Top Monitor – GMgr	Dell 22 inch Flat Panel Display	OOB	Ivette's Desk	S/N# CN-0174R7-72872-24B-A69U	Dell from Lori McKinney
2012	Copy Machine – Server Room	Ricoh Aficio MPC2551	OOB	Server Room	Equipment ID: V9825200222	Leased from Ricoh Business Solutions
2013	OOB WIFI Unit	Ruckus ZoneFlex 7300 Series (7363)	OOB	Telco Rm	SN 543D37054B00	Allcovered
2013	Security Radio Repeater	Hytera Professional Digital Radio Repeater; Model RD982; Installed 1/8/2013	OOB	A5 LRR ElecRm	SN12529A0096; 3 antennas located in A11, A5 and P2 by Stair #1.	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	OOB	Pearl Tan	SN 12816A0492; Radio ID# 2010	Vision Communications

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2013	Portable Radio	Hytera PD702 U(2)	OOB	Mary Ramsey	SN 12723D0125; Radio ID# 2011	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	OOB	Ivette Walker	SN 12723D0127; Radio ID# 2015	Vision Communications
2013	Portable Radio	Motorola SL7550	Owner's Rep	Salvador Gutierrez	SN 682TNB2423; Radio ID# 2016	Vision Communications
2008	Desk Top Monitor – Parking	Parking Access Monitor	Parking	P-1 Parking	S/N #CN-ORY979-74261-848-6D5U	Dell
2009	Desk Top Monitor – Parking	Dell 19" Widescreen LCD SE 198 WFP **1-yr Wty: 1/1/09 to 1/1/2010**	Parking	P-1 Parking	CN-OC558H-72872-89Q-OMAM	Best Buy
2009	Security IdentiPass System CPU	Dell Optiplex 740 MiniTower Athlon 1640B **3-yr Wty: 3/3/09 to 3/3/2012.**	Parking	P-1 Parking	Service Tag # F8MDGJ1	Dell.com
2010	Desk Top Computer – Parking Mgr	Dell Opti Plex 380 Minitower Base **3-yr Wty: 6/7/2010 to 6/6/2013. Placed in service 6/25/2010**	Parking	P-1 Parking	B583KM1	Dell.com
2011	Desk Top Printer – Parking Mgr	HP Laser Jet 2420d	Parking	P-1 Parking	S/N: CNDJF05457	
2012	Brother AIO Printer – Parking Mgr	Brother Model # MFC-7460 DN; **1-yr Wty: 4/5/2012 to 4/5/2013**	Parking	P-1 Parking	Serial #: U62701K1N199757	World Trade Office Supplies
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P1	SN 12723D0126; Radio ID# 2012	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P2	SN 12723D0120; Radio ID# 2013	Vision Communications

Year	Type of Equipment	Model/Make	Dept	Location	Serial Number	Vendor
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P3	SN 12816A0257; Radio ID# 2014	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Parking	Rosana Brickey; P4	SN 12817A0326; Radio ID# 2018	Vision Communications
2007	Desk Top Printer – Security	HP LaserJet 1018; Placed in service on May 19, 2012 by Chip at Allcovered	Security	Kevin's Desk-OOB	CNB1004493	HP.com
2009	Desk Top Monitor – Access Card	Dell Prof 1909, Wide Flat Panel DP/N OW160G: **3-yr Ltd Wty: 9/9/2009 to 9/9/2012**	Security	Access Card Desk-OOB	CN-OW160G-72872-97Q-387S	Dell.com
2010	Desk Top Computer – Dir of Security	Dell Opti Plex 380 MiniTower Base **3-yr Wty: 5/6/2010 to 5/5/2013.**	Security	Kevin's Desk-OOB	Service Tag # 21QYRL1; Express Code: 4459322917; Mfg Date: 5/5/2010	Dell.com
2010	Desk Top Monitor – Dir of Security	Dell 22 inch Flat Panel Display; E2210H; **3-yr Wty: 5/3/2010 to 5/2/2013.**	Security	Kevin's Desk-OOB	DP/N OH265R; S/N: CN-OH265R-64180-047-1TGL	Dell.com
2010	Security Camera at Load Dock on P-1 Level (Camera #2)	Pelco ES3012 20X PTZ Camera at Load Dock; Ship Date: April 6, 2010. **1-yr Wty: 4/6/2010 to 4/5/2011**	Security	P-1 Level	Serial Number: ABA-AP99	Universal Protection Systems
2010	Security Camera at West Monument. Camera #3 at the Plaza Level	Pelco ES3012 – 2 CLZ20PN; Ship Date: May 21, 2010. **1-yr Wty: 5/21/2010 to May 20, 2011.**	Security	Plaza Level	Serial Number: ABC-CYQ8	Vision Communications
2011	Camera 4 on top of East Monument Sign	Pelco Esprit ES3012 Series – Camera (Integrated Positioning System); Installed 3/24/2011.	Security	Plaza Level	SN ABVHVW2; Pelco Esprit ES3012-2CLZ20PN	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Security	Console	SN 12816A0498; Radio ID# 2005	Vision Communications
2013	Portable Radio	Hytera PD702 U(2)	Security	Patrol	SN 12816A0491; Radio ID# 2006	Vision Communications
2013	Portable Radio	Motorola SL7550	Security	Kevin Stapleton	SN 682TND2817; Radio ID# 2017	Vision Communications

EXHIBIT C

PERMITTED ENCUMBRANCES

The items listed on Schedule B in that certain Proforma Owner's Policy of Title Insurance issued by Fidelity National Title Insurance Company ("Title Company") under Order No. 4257983 (Reference No. 508130029), with respect to the Columbus Leased Premises, and the items listed on Schedule B in that certain Proforma Owner's Policy of Title Insurance issued by Title Company under Order No. 23021588-977-MAT, with respect to the Long Beach Leased Premises.

EXHIBIT D

BASIC RENT PAYMENTS

1. Basic Rent.

Subject to the adjustments provided for in Paragraph 2 below, Basic Rent payable in respect of the Term shall be $9,221,851 per annum for the Long Beach Property and $1,680,000 per annum for the Columbus Property, payable monthly in advance on the first (1st) Business Day of each calendar month during the Term (each a "Basic Rent Payment Date"), in equal installments of $768,487.58 each month with respect to the Long Beach Property and $140,000 each month with respect to the Columbus Property. Pro rata Basic Rent for the period from the date hereof through the last day of June, 2013 shall be paid on the Effective Date, and pro rata Basic Rent for the period from the final Basic Rent Payment Date of the Term through the last day of the Term shall be paid as the final installment of Basic Rent for the Term.

2. Adjustments to Basic Rent. (a) Basic Rent shall not be adjusted until the first (1st) anniversary of the Basic Rent Payment Date on which the first full monthly installment of Basic Rent shall be due and payable (the " First Full Basic Rent Payment Date"). As of the first (1st) anniversary of the First Full Basic Rent Payment Date and thereafter on each anniversary of the First Full Basic Rent Payment Date (the "Basic Rent Adjustment Date"), Basic Rent shall be increased by three percent (3%) per annum; provided that Basic Rent for the first (1st) year of each Renewal Term shall be the greater of (i) one hundred three percent (103%) of the Basic Rent for the immediately preceding Lease Year, and (ii) Fair Market Basic Rent (as determined pursuant to Exhibit D-1).

(b) Notice of the new annual Basic Rent shall be delivered to Tenant on or before the tenth (10th) day preceding each Basic Rent Adjustment Date, but any failure to do so by Landlord shall not be or be deemed to be a waiver by Landlord of Landlord's rights to collect such sums. Tenant shall pay to Landlord, within ten (10) days after a notice of the new annual Basic Rent is delivered to Tenant, all amounts due from Tenant, but unpaid, because the stated amount as set forth above was not delivered to Tenant at least ten (10) days preceding the Basic Rent Adjustment Date in question (and, for the avoidance of doubt, any failure by Tenant to pay the amount of any increase in Basic Rent, or increase the amount of any Letter of Credit in connection with any increase in Basic Rent, shall not be a default or Event of Default under the Lease, or result in any Late Charge or interest, unless and until (i) with respect to the payment of Basic Rent, Tenant has failed to pay such amount within ten (10) days after notice of the new annual Basic Rent is delivered to Tenant by Landlord, and (ii) with respect to any increase of the amount of any Letter of Credit, Tenant has failed to increase the Letter of Credit within thirty (30) days after notice of the new annual Basic Rent is delivered to Tenant by Landlord).

EXHIBIT D-1

DETERMINATION OF FAIR MARKET BASIC RENT

For purposes of this Lease, Fair Market Basic Rent shall be determined in accordance with the following procedure:

Within ten (10) days after Landlord receives Tenant's notice that it has elected to extend this Lease pursuant to Paragraph 5(a), Landlord shall deliver to Tenant Landlord's calculation of the Fair Market Basic Rent for the first year of the applicable Renewal Term. As used herein, "Fair Market Basic Rent" means the sum of (A) amount of Basic Rent that Landlord could reasonably be expected to obtain upon a re-letting of the Long Beach Leased Premises on then current market terms (the " Long Beach FMBR"), plus (B) the amount of Basic Rent that Landlord could reasonably be expected to obtain upon a re-letting of the Columbus Leased Premises on then current market terms (the "Columbus FMBR"), as any of (A) and (B) are appropriately adjusted to reflect the fact that the Leased Premises constitute a portfolio that will be leased as a whole to a single tenant (any such adjustment, a " Portfolio Rent Adjustment Factor").

If Tenant disagrees with Landlord's calculation of Fair Market Basic Rent, Tenant shall notify Landlord of such disagreement within five (5) Business Days after Tenant's receipt of Landlord's calculation, and Landlord and Tenant shall within five (5) Business Days after the date of Tenant's notice each appoint one appraiser for each Leased Premises and notify the other in writing of the name, address and qualifications of such appraisers. The appraiser appointed by Landlord with respect to the Long Beach Leased Premises and the appraiser appointed by Tenant with respect to the Long Beach Leased Premises are referred to herein collectively as the " Long Beach Appraisers". The appraiser appointed by Landlord with respect to the Columbus Leased Premises and the appraiser appointed by Tenant with respect to the Columbus Leased Premises are referred to herein collectively as the " Columbus Appraisers".

The Long Beach Appraisers shall endeavor to agree upon the Long Beach FMBR based on a written appraisal made by each of them within thirty (30) days after the later of the two appraisers' appointments. The Columbus Appraisers shall endeavor to agree upon Columbus FMBR based on a written appraisal made by each of them within thirty (30) days after the later of the two appraisers' appointments. In determining the Long Beach FMBR or Columbus FMBR, as applicable, the appointed appraisers shall determine the amount that a willing tenant would pay, and a willing landlord of a comparable building located in a radius of ten (10) miles of the applicable Leased Premises would accept, at arm's length, to rent a building of comparable size and quality as the applicable Improvements, taking into account: (i) the age, quality, condition (as required by this Lease) of the Improvements; (ii) that the applicable Leased Premises will be leased as a whole or substantially as a whole to a single user; (iii) a lease term equal to the applicable Renewal Term; (iv) a lease with terms substantially similar to this Lease; and (v) such other items that professional real estate appraisers customarily consider; provided, however, that such appraisers shall not take into account any Portfolio Rent Adjustment Factor. If the Long Beach Appraisers agree upon the Long Beach FMBR, then such determination shall be binding and conclusive upon Landlord and Tenant. If the Columbus Appraisers agree upon the Columbus FMBR, then such determination shall be binding and conclusive upon Landlord and Tenant.

If the Long Beach Appraisers are unable to agree upon the Long Beach FMBR within forty‑five (45) days after the later of the applicable two appraisers' appointments, then such appraisers shall advise Landlord and Tenant of their respective determinations and shall select a third appraiser within fifteen (15) days thereafter to make the determination of the Long Beach FMBR. If the Columbus Appraisers are unable to agree upon the Columbus FMBR within forty‑five (45) days after the later of the applicable two appraisers' appointments, then such appraisers shall advise Landlord and Tenant of their respective determinations and shall select a third appraiser within fifteen (15) days thereafter to make the determination of the Columbus FMBR. The selection of any third appraiser pursuant to this paragraph shall be binding and conclusive upon Landlord and Tenant. If a third appraiser is not selected within either such fifteen (15) day period, then either Landlord or Tenant may petition the American Arbitration Association or any successor thereto ("AAA") (with a copy to the other Party) to so determine such third appraiser and the Parties shall cooperate reasonably with each other and the AAA (including by responding promptly to any requests for information made by the AAA) in connection with such determination. The decision of the AAA shall be final and conclusive as to the identity of any third appraiser. The determination of the Long Beach FMBR or Columbus FMBR, as applicable, made by the applicable third appraiser appointed or determined pursuant hereto shall be made within thirty (30) days after such appointment. The Long Beach FMBR or Columbus FMBR, as applicable, shall be the average of the determination made by the applicable third appraiser and the determination made by the appraiser appointed by Landlord or Tenant whose determination is nearer to that of such third appraiser. Such average shall be binding and conclusive upon Landlord and Tenant.

Once the Long Beach FMBR and Columbus FMBR have been determined pursuant to the foregoing, the Parties will submit all relevant calculations to an appraiser at Jones Lang LaSalle, CB Richard Ellis, Cushman & Wakefield, Eastdil Secured, or another national real estate brokerage firm or accounting firm reasonably acceptable to both Landlord and Tenant for determination of any Portfolio Rent Adjustment Factor within thirty (30) days following such submission.

Each appraiser appointed or selected pursuant to the provisions of this Exhibit D-1 (1) shall be an independent qualified MAI appraiser with at least ten (10) years of experience in the county where the applicable the Leased Premises is located, (2) shall have no right, power or authority to alter or modify the provisions of this Lease, (3) shall utilize the definition of Fair Market Basic Rent hereinabove set forth, and (4) shall be registered in the State where the applicable Leased Premises is located. The fees and costs of the foregoing appraisal process shall be shared equally by Landlord and Tenant (including without limitation any fees associated with the engagement of the AAA).

Exhibit D shall be deemed amended to reflect the Basic Rent for each Leased Premises as determined pursuant to this Exhibit D-1. Notwithstanding the foregoing, at either Party's request, both Parties shall enter into an amendment of this Lease reflecting the Basic Rent for each Leased Premises as determined pursuant to this Exhibit D-1.

EXHIBIT E

ACQUISITION COSTS

$134,625,566 for the Long Beach Leased Premises

$24,000,000 for the Columbus Leased Premises

EXHIBIT F

PERCENTAGE ALLOCATION OF BASIC RENT PER LEASED PREMISES

Long Beach Leased Premises – 84.59 %

Columbus Leased Premises – 15.41 %

EXHIBIT G

CERTIFICATION RELATED TO THE USA PATRIOT ACT

On behalf of [Insert name of subtenant/assignee] **("[Subtenant/Assignee]")**, I hereby certify to the following:

1. [**Subtenant/Assignee**] maintains a place of business that is located at a fixed address (other than an electronic address or post office box) known as [_____].

2. [**Subtenant/Assignee**] is subject to the laws of the United States and has no knowledge that it is not in full compliance with laws relating to bribery, corruption, fraud, money laundering and the Foreign Corrupt Practices Act.

3. The names and addresses of [**Subtenant/Assignee**]'s Owners, officers and directors are accurately reflected on Annex A to this certification. "Owner" means any individual who owns, controls, or has the power to vote more than 50% of any class of [**Subtenant/Assignee**]'s stock, or otherwise controls or has the power to control [**Subtenant/Assignee**].

4. None of said Owners, officers or directors is a Specially Designated National or Blocked Person. As used herein, the term "Specially Designated National or Blocked Person" shall mean a Person (i) designated by the Office of Foreign Assets Control at the U.S. Department of the Treasury, or other U.S. governmental entity, and appearing on the List of Specially Designated Nationals and Blocked Persons (http://www.ustreas.gov/offices/enforcement/ofac/sdn/ index.shtml), which List may be updated from time to time; or (ii) with whom Landlord or its affiliates are prohibited from engaging in transactions by any trade embargo, economic sanction or other prohibition of United States law, regulation, or Executive Order of the President of the United States. [**Subtenant/Assignee**] agrees to confirm this representation and warranty in writing on an annual basis if requested by Landlord to do so.

5. [**Subtenant/Assignee**] does not transact business on behalf of, or for the direct or indirect benefit of, any individual or entity that is a Specially Designated National or Blocked Person. [**Subtenant/Assignee**] agrees to confirm this representation and warranty in writing on an annual basis if requested by Landlord to do so.

I, [_____], certify that I have read and understand this Certification and that the statements made in this certification and the attached Annexes are true and correct.

[Signature Page Immediately Follows]

This Certification is made on behalf of [**Subtenant/Assignee**].

(Signature)

(Title)

Executed on this _____ day of _____, 20__.

ANNEX A – OWNERS, OFFICERS AND DIRECTORS

NAME	TITLE/POSITION

EXHIBIT H

FORM OF ACH AUTHORIZATION AGREEMENT

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Company Name _____ Company ID Number _____

I (we) hereby authorize _____, hereinafter called COMPANY, to initiate debit entries to my (our) ☐ Checking Account/ ☐ Savings Account (select one) indicated below at the depository financial institution named below, hereafter call DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number _____ Account Number _____

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s) _____ ID Number _____
(Please Print)

Date _____ Signature _____

EXHIBIT I

SUBORDINATION AGREEMENT

THIS SUBORDINATION AGREEMENT ("Subordination Agreement") dated as of _____, 20___, is made by _____, a _____ (" Tenant") and _____, a _____ ("Manager") in favor of AGNL _____, L.L.C., a Delaware limited liability company, (" Landlord").

WITNESSETH:

WHEREAS, pursuant to a Lease Agreement dated as of the date hereof (the " Lease") between Landlord and Tenant, Landlord has agreed to lease to Tenant, and Tenant has agreed to lease from Landlord, certain real property and improvements more particularly described therein (the "Property");

WHEREAS, pursuant to a Management Agreement dated _____, 20___ (the " Management Agreement") between Manager and Tenant, Manager is responsible for the management of the business affairs of Tenant, in return for which Tenant is obligated to pay to Manager [_____] fees (the " Management Fees"); and

WHEREAS, it is a condition precedent to Landlord's obligation to lease the Property to Tenant under the Lease, that Manager shall have executed and delivered this Subordination Agreement to Landlord;

NOW, THEREFORE, in consideration of the premises and for the purpose of inducing Landlord to enter into the Lease and perform its obligations thereunder, Tenant and Manager hereby covenant and agree as follows:

AGREEMENTS

1. **Incorporation of Recitals**. The recitals are incorporated herein by reference.

2. **Capitalized Terms**. Capitalized terms not defined herein shall have the meaning ascribed to them in the Lease.

3. **Subordination of Management Fees**. The Management Fees are subordinated in right of payment, to the extent and in the manner provided in this Subordination Agreement, to the prior payment in full of all Rent and other Monetary Obligations under the Lease.

4. **Payments to Landlord**.

(a) In the event of any insolvency or bankruptcy proceedings, or any receivership, reorganization or other similar proceedings in connection therewith, relative to Tenant or its property, and in the event of any proceedings for liquidation, dissolution or other winding up of Tenant, whether or not involving insolvency or bankruptcy (any such proceedings hereinafter referred to as "Bankruptcy or Insolvency Proceedings"), Landlord shall be entitled to receive

payment in full of all Rent and other Monetary Obligations under the Lease before Manager shall be entitled to receive any payment or distribution on account of the Management Fees. Pursuant to the foregoing, Landlord shall be entitled to receive any payment or distribution on account of the Management Fees which may be payable or deliverable in any such Bankruptcy or Insolvency Proceedings.

(b) Upon the occurrence of an Event of Default under Paragraph **[22(a)(i) of the Lease]** (a "Payment Default"), no payment or distribution on account of the Management Fees shall be made until such Payment Default shall have been cured or waived or shall otherwise have ceased to exist.

5. **Default, Termination and Modification of Management Agreement**. Manager will notify Landlord promptly of any default by Tenant under the Management Agreement or termination by Tenant of the Management Agreement. Upon any termination of the Management Agreement, Manager may, if allowed in the Management Agreement, seek recourse against Tenant, subject to the subordination provisions contained herein. Manager and Tenant shall not modify or assign the Management Agreement or enter into a new management agreement without the prior written consent of Landlord which shall not be unreasonably withheld, conditioned or delayed, provided that such modification, assignment or new agreement is subject to all provisions hereof relating to the Management Agreement.

6. **Estoppel**. Manager shall, within twenty (20) days after the written request of Landlord, execute an estoppel letter confirming, to the extent such matters are true at such time, that (a) the Management Agreement is in full force and effect and has not been modified, amended or assigned, (b) neither Manager nor, to Manager's knowledge, Tenant is in default under any of the terms, covenants or provisions of the Management Agreement, (c) neither Manager nor Tenant has commenced any action or given or received any written notice for the purpose of terminating the Management Agreement, and (d) all Management Fees have been paid in full.

7. **Further Assurances**. Manager and Tenant agree to execute such further agreements of subordination as may be determined by Landlord to be reasonably necessary to establish the priority of Tenant's obligations under the Lease over its obligations under the Management Agreement, which agreements shall be in substantially the same form as this Agreement and contain such matters of estoppel with respect to Manager's obligation to perform under the Management Agreement as may be true as of the date of such execution and as may be reasonably required by Landlord.

8. **Indemnification**. Manager and Tenant hereby jointly and severally agree to indemnify, defend and hold harmless Landlord; any director, member, officer, general partner, limited partner, employee or agent of Landlord (or any legal representative, heir, estate, successor or assign of any thereof); any predecessor or successor partnership, corporation, limited liability company (or other entity) of Landlord, or any of its general partners, members or shareholders; or any affiliate of Landlord from and against all liabilities, losses, damages, costs, expenses (including, without limitation, reasonable attorneys' fees and expenses), causes of action, suits, claims, demands or judgments of any nature imposed upon or incurred by or asserted against Landlord by reason of, or in any way related to, this Subordination Agreement.

9. **Term**. This Subordination Agreement shall be effective continuously from the date hereof until payment in full of all Rent and other Monetary Obligations under the Lease.

10. **Legal Fees**. Each of Manager and Tenant agrees that it shall be jointly and severally liable for all fees and expenses incurred by Landlord in connection with the enforcement of this Agreement, including, without limitation reasonable attorneys' fees and expenses.

11. **Assignment of Rights and Responsibilities**. This Subordination Agreement shall inure to the benefit of and may be enforced by Landlord and its successors and assigns under the Lease, and shall be binding upon and enforceable against Tenant and Manager and each of their respective successors and assigns.

12. **Choice of Law**. This Subordination Agreement will be governed by and construed pursuant to the laws of the State of New York (the "State"). Each of Tenant and Manager specifically consents that any action brought under this Subordination Agreement may be brought in the State in any court of competent jurisdiction and venue therein and consents to the service of process issued from said court. Each of Tenant and Manager hereby waives trial by jury in and in respect of any and every action, proceeding, claim (whether or not denominated, a claim, counterclaim, cross-claim, off-set or the like) brought or asserted by Landlord with respect to any matter arising out of, under or connected with this Subordination Agreement.

13. **Amendments**. This Subordination Agreement may be modified, amended, discharged or waived only by an agreement in writing signed by each of the parties hereto.

14. **Severability**. If any one or more of the provisions contained in this Subordination Agreement shall for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Subordination Agreement, but this Subordination Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

(*Signature page follows.*)

IN WITNESS WHEREOF, the parties hereto have caused this Subordination Agreement to be executed under seal as of the day and year first written above.

MANAGER:

,
a __
By: __
Name:__
Title: __

TENANT:

,
a __
By: __
Name:__
Title: __

EXHIBIT J

FORM OF SNDA

SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT

THIS SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT ("***Agreement***") is entered into as of _____ ___, 201_ (the "***Effective Date***") by and between _____ (together with any other holder of the Loan (defined below) and their respective successors and assigns, the "***Mortgagee***"), **MOLINA HEALTHCARE, INC.**, a Delaware corporation (hereinafter, the "***Tenant***") and **AGNL CLINIC, L.P.**, a Delaware limited partnership (the "***Landlord***"), with reference to the following facts:

A. Landlord owns fee simple title in the real property described in Exhibit "A" attached hereto (the " ***Property***").

B. Mortgagee has made or intends to make a loan to Landlord (the " ***Loan***").

C. To secure the Loan, Landlord has or will encumber the Property by entering into a mortgage or deed of trust in favor of Mortgagee (as amended, increased, renewed, extended, spread, consolidated, severed, restated, or otherwise changed from time to time, the "***Mortgage***") to be recorded in land records.

D. Pursuant to the Lease dated [April _____], 2013, (the " ***Lease***") between Landlord and Tenant, Landlord leased to Tenant a portion of the Property, as said portion is more particularly described in the Lease (the " ***Leased Premises***").

E. Tenant and Mortgagee desire to agree upon the relative priorities of their interests in the Property and their rights and obligations if certain events occur.

NOW, THEREFORE, for good and sufficient consideration, Tenant and Mortgagee agree:

1. *Definitions*. The following terms shall have the following meanings for purposes of this Agreement.

2. *Foreclosure Event*. A "***Foreclosure Event***" means: (i) foreclosure under the Mortgage; (ii) any other exercise by Mortgagee of rights and remedies (whether under the Mortgage or under applicable law, including bankruptcy law) as holder of the Loan and/or the Mortgage, as a result of which Mortgagee becomes owner of the Property; or (iii) delivery by Landlord to Mortgagee (or its designee or nominee) of a deed or other conveyance of Landlord's interest in the Property in lieu of any of the foregoing.

3. *Former Landlord*. A "***Former Landlord***" means Landlord and any other party that was landlord under the Lease at any time before the occurrence of any attornment under this Agreement.

4. *Offset Right*. An "***Offset Right***" means any right or alleged right of Tenant to any offset, defense (other than one arising from actual payment and performance, which payment and performance would bind a Successor Landlord pursuant to this Agreement), claim, counterclaim, reduction, deduction, or abatement against Tenant's payment of Rent or performance of Tenant's other obligations under the Lease, arising (whether under the Lease or under applicable law) from Landlord's breach or default under the Lease.

5. *Rent*. The "***Rent***" means any fixed rent, base rent or additional rent under the Lease.

6. *Successor Landlord*. A "***Successor Landlord***" means any party that becomes owner of the Property as the result of a Foreclosure Event.

7. *Termination Right*. A "***Termination Right***" means any right of Tenant to cancel or terminate the Lease or to claim a partial or total eviction arising (whether under the Lease or under applicable law) from Landlord's breach or default under the Lease.

8. *Other Capitalized Terms*. If any capitalized term is used in this Agreement and no separate definition is contained in this Agreement, then such term shall have the same respective definition as set forth in the Lease.

9. *Subordination*. The Lease, as the same may hereafter be modified, amended or extended, shall be, and shall at all times remain, subject and subordinate to the Mortgage (but not to the terms thereof), the lien imposed by the Mortgage, and all advances made under the Mortgage. Notwithstanding the foregoing, Mortgagee may elect, in its sole and absolute discretion, to subordinate the lien of the Mortgage to the Lease.

10. *Nondisturbance, Recognition and Attornment*.

11. *No Exercise of Mortgage Remedies Against Tenant*. So long as the Tenant is not in default under the Lease beyond any applicable grace or cure periods (an "***Event of Default***"), Mortgagee (i) shall not terminate or disturb Tenant's possession of the Leased Premises under the Lease, except in accordance with the terms of the Lease and (ii) shall not name or join Tenant as a defendant in any exercise of Mortgagee's rights and remedies arising upon a default under the Mortgage unless applicable law requires Tenant to be made a party thereto as a condition to proceeding against Landlord or prosecuting such rights and remedies. In the latter case, Mortgagee may join Tenant as a defendant in such action only for such purpose and not to terminate the Lease or otherwise adversely affect Tenant's rights under the Lease or this Agreement in such action.

12. *Recognition and Attornment*. Upon Successor Landlord taking title to the Property (i) Successor Landlord shall be bound to Tenant under all the terms and conditions of the Lease (except as provided in this Agreement); (ii) Tenant shall recognize and attorn to Successor Landlord as Tenant's direct landlord under the Lease as affected by this Agreement; and (iii) the Lease shall continue in full force and effect as a direct lease, in accordance with its terms (except as provided in this Agreement), between Successor

Landlord and Tenant. Tenant hereby acknowledges that pursuant to the Mortgage and assignment of rents, leases and profits, Landlord has granted to the Mortgagee an absolute, present assignment of the Lease and Rents which provides that Tenant continue making payments of Rents and other amounts owed by Tenant under the Lease to the Landlord and to recognize the rights of Landlord under the Lease until notified otherwise in writing by the Mortgagee. After receipt of such notice from Mortgagee, the Tenant shall thereafter make all such payments directly to the Mortgagee or as the Mortgagee may otherwise direct, without any further inquiry on the part of the Tenant. Landlord specifically agrees that Tenant may conclusively rely upon any written notice Tenant receives from Mortgagee notwithstanding any claim by Landlord contesting the validity of any term or condition of such notice, including, but not limited to, any default claimed by Mortgagee, and that Landlord shall not make any claim of any kind whatsoever against Tenant or Tenant's leasehold interest with respect to any amounts paid to Mortgagee by Tenant or any acts performed by Tenant pursuant to such written notice.

13. *Further Documentation*. The provisions of this Article 3 shall be effective and self-operative without any need for Successor Landlord or Tenant to execute any further documents. Tenant and Successor Landlord shall, however, confirm the provisions of this Article 3 in writing upon request by either of them within ten (10) days of such request.

14. *Protection of Successor Landlord*. Notwithstanding anything to the contrary in the Lease or the Mortgage, Successor Landlord shall not be liable for or bound by any of the following matters:

15. *Claims Against Former Landlord*. Any Offset Right that Tenant may have against any Former Landlord, unless (i) such Offset Right arises after the date Mortgagee encumbers the Property with the Mortgage and (ii) Tenant shall have given written notice to Mortgagee of such Offset Right prior to commencement of a Foreclosure Event. The foregoing shall not limit either (x) Tenant's right to exercise against Successor Landlord any Offset Right otherwise available to Tenant because of events occurring after the date of attornment or (y) Successor Landlord's obligation to correct any conditions that existed as of the date of attornment and violate Successor Landlord's obligations as landlord under the Lease.

16. *Prepayments*. Any payment of Rent that Tenant may have made to Former Landlord more than thirty (30) days before the date such Rent was first due and payable under the Lease with respect to any period after the date of attornment other than, and only to the extent that, the Lease expressly required such a prepayment or such payment was delivered to Mortgagee or Successor Landlord.

17. *Security Deposit*. Any obligation with respect to any security deposited with Former Landlord, unless such security was actually delivered to Mortgagee or Successor Landlord.

18. *Modification, Amendment or Waiver*. Any modification or amendment of the Lease, or any waiver of the terms of the Lease, made without Mortgagee's written consent,

excepting, however, commercially reasonable amendments or modifications of the Lease which are the result of good faith, arm's length negotiations between Landlord and Tenant.

19. *Surrender, Etc*. Any consensual or negotiated surrender, cancellation, or termination of the Lease, in whole or in part, agreed upon between Landlord and Tenant, unless effected unilaterally by Tenant pursuant to the express terms of the Lease.

20. *Casualty and Condemnation*. Mortgagee agrees that, notwithstanding any provision of the Mortgage or any instrument secured by the Mortgage, any insurance proceeds and any condemnation awards which may be received by any party hereto and which relate to the Property shall be used or disbursed in accordance with the terms of the Lease.

21. *Mortgagee's Right to Cure*. Notwithstanding anything to the contrary in the Lease or this Agreement, before exercising any Offset Right or Termination Right:

22. *Notice to Mortgagee*. Tenant shall provide Mortgagee with notice of the breach or default by Landlord giving rise to same (the "***Default Notice***") and, thereafter, the opportunity to cure such breach or default as provided for below.

23. *Mortgagee's Cure Period*. After Mortgagee receives a Default Notice, Mortgagee shall have a period of thirty (30) days under the Lease in which to cure the breach or default by Landlord. Mortgagee shall have no obligation to cure (and, without limiting anything contained in Section 4.a. above, shall have no liability or obligation for not curing) any breach or default by Landlord, except to the extent that Mortgagee agrees or undertakes otherwise in writing. In addition, as to any breach or default by Landlord the cure of which requires possession and control of the Property, if Mortgagee undertakes such cure or causes such cure to be commenced by a receiver within the period permitted by this paragraph, and so long as Mortgagee continues to or causes a receiver to diligently and in good faith cure such breach or default, Mortgagee's cure period shall continue for such additional time as Mortgagee may reasonably require.

24. *Miscellaneous*.

25. *Notices*. Any notice or request given or demand made under this Agreement by one party to the other shall be in writing, and may be given or be served by hand delivered personal service, or by depositing the same with a reliable overnight courier service or by deposit in the United States mail, postpaid, registered or certified mail, and addressed to the party to be notified, with return receipt requested or by telefax transmission, with the original machine - generated transmit confirmation report as evidence of transmission. Notice deposited in the mail in the manner hereinabove described shall be effective from and after the expiration of three (3) days after it is so deposited; however, delivery by overnight courier service shall be deemed effective on the next succeeding business day after it is so deposited and notice by personal service or telefax transmission shall be deemed effective when delivered to its addressee or within two (2) hours after its transmission unless given after 3:00 p.m. on a business day, in which case it shall be deemed effective at 9:00 a.m. on the

next business day. For purposes of notice, the addresses and telefax number of the parties shall, until changed as herein provided, be as follows:

26. If to the Mortgagee, at:

and

27. If to the Tenant, at:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Attn: _____

Telecopy No.: (___) _____

28. *Successors and Assigns*. This Agreement shall bind and benefit the parties, their successors and assigns, any Successor Landlord, and its successors and assigns. If Mortgagee assigns the Mortgage, then upon delivery to Tenant of written notice thereof accompanied by the assignee's written assumption of all obligations under this Agreement, all liability of the assignor shall terminate.

29. *Entire Agreement*. This Agreement constitutes the entire agreement between Mortgagee and Tenant regarding the subordination of the Lease to the Mortgage and the rights and obligations of Tenant and Mortgagee as to the subject matter of this Agreement.

30. *Interaction with Lease and with Mortgage*. If this Agreement conflicts with the Lease, then this Agreement shall govern as between the parties and any Successor Landlord, including upon any attornment pursuant to this Agreement. This Agreement supersedes, and constitutes full compliance with, any provisions in the Lease that provide for subordination of the Lease to, or for delivery of nondisturbance agreements by the holder of, the Mortgage.

31. *Mortgagee's Rights and Obligations*. Except as expressly provided for in this Agreement, Mortgagee shall have no obligations to Tenant with respect to the Lease. If an attornment occurs pursuant to this Agreement, then all rights and obligations of Mortgagee under this Agreement shall terminate, without thereby affecting in any way the rights and obligations of Successor Landlord provided for in this Agreement or under the Lease.

32. *Interpretation; Governing Law*. The interpretation, validity and enforcement of this Agreement shall be governed by and construed under the internal laws of the State in which the Leased Premises are located, excluding such State's principles of conflict of laws.

33. *Amendments*. This Agreement may be amended, discharged or terminated, or any of its provisions waived, only by a written instrument executed by the party to be charged.

34. *Due Authorization*. Tenant represents to Mortgagee that it has full authority to enter into this Agreement, which has been duly authorized by all necessary actions. Mortgagee represents to Tenant that it has full authority to enter into this Agreement, which has been duly authorized by all necessary actions.

35. *Execution*. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

[THIS SPACE INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the Mortgagee, Tenant and Landlord have caused this Agreement to be executed as of the date first above written.

MORTGAGEE:

[Signature Pages Continue on Following Page]

TENANT:
MOLINA HEALTHCARE, INC.
a Delaware corporation
By:__
Name:
Title:

LANDLORD:
AGNL Clinic, L.P.,
a Delaware limited partnership

By: AGNL Clinic GP, L.L.C.,
Its general partner

By: AGNL Manager II,
Its manager

By:
Name: Gordon J. Whiting
Title: President

MORTGAGEE'S ACKNOWLEDGEMENT

STATE OF _____)
) ss.
COUNTY OF _____)

On the ____ day of _____ in the year _____ before me, the undersigned, a Notary Public in and for said state, personally, appeared _____, proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Signature of Notary Public

TENANT'S ACKNOWLEDGMENT

STATE OF _____)
) ss.
COUNTY OF _____)

On the ____ day of _____ in the year _____ before me, the undersigned, a Notary Public in and for said state, personally, appeared _____, proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Signature of Notary Public

LANDLORD'S ACKNOWLEDGMENT

STATE OF _____)
) ss.
COUNTY OF _____)

On the ____ day of _____ in the year _____ before me, the undersigned, a Notary Public in and for said state, personally, appeared _____, proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Signature of Notary Public

LIST OF EXHIBITS

If any exhibit is not attached hereto at the time of execution of this Agreement, it may thereafter be attached by written agreement of the parties, evidenced by initialing said exhibit.

Exhibit “A” - Legal Description of the Land

EXHIBIT K

List of Leases, Access Agreements and License Agreements

LEASE AGREEMENTS, ACCESS AGREEMENTS AND LICENSE AGREEMENTS ASSOCIATED WITH 200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA, WITH MOLINA AS LANDLORD:

- 3-Dee International
- Arthritis National Research Foundation
- Lisa Brandon, CFLS
- California Coastal Commission
- Crowell, Weedon & Co.
- Department of Industrial Relations
- High Rise Goodies Restaurant Group, Inc.
- J. Perez Associates, Inc.
- Long Beach Publishing Company, Inc. (aka Press Telegram)
- Lynn E. Moyer
- D. Michael Trainotti
- Michael W. Binning
- Molina Healthcare, Inc.
- MVP Energy, LLC
- Pacific Maritime Association
- Pacific Merchant Shipping
- Bruce A. Dybens, AP
- California State Lands Commission
- US Department of Veterans Affairs
- Perona, Langer, Beck Serbin & Mendoza
- Rose, Klein & Marias, LLP
- United Parcel Services, Inc.
- APB Car Wash & Detailing Specialist – License
- Steel Coil
- Mikko Myong Pivonka, an individual
- TCG Los Angeles, Inc. (aka AT&T) – ACCESS AND LICENSE
- XO Communications Services, LLC – LICENSE
- Molina Healthcare of California (undocumented license agreement)

LEASE AGREEMENTS, ACCESS AGREEMENTS AND LICENSE AGREEMENTS ASSOCIATED WITH 3000 CORPORATE EXCHANGE DRIVE, COLUMBUS, OHIO, WITH MOLINA AS LANDLORD:

- Bresco Solutions, LLC – LICENSE
- iQor, Inc.
- Prime Engineering & Architecture, Inc.
- U.S. Congressman Patrick Tiberi
- XO Communications Services, Inc. – ACCESS AGREEMENT

Exhibit L

Form of Sublease SNDA

RECORDING REQUESTED BY
AND WHEN RECORDED MAIL TO:

Sheppard Mullin Richter & Hampton LLP
1300 I Street NW, Washington, DC 20005
Attention: Michele E. Williams

THIS SPACE ABOVE FOR RECORDER'S USE

SUBORDINATION AGREEMENT; ATTORNMENT AND NON-DISTURBANCE AGREEMENT, AND CONSENT TO SUBLEASE DATED AS OF _____ __, 2013, EXECUTED BY AGNL CLINIC, L.P., A DELAWARE LIMITED PARTNERSHIP, AS "AGNL", MOLINA HEALTHCARE, INC., A DELAWARE CORPORATION, AS "MOLINA", _____, COLLECTIVELY, AS "LENDER" AND _____, A _____, AS "SUB-TENANT".

NOTICE: SUBJECT TO THE NON-DISTURBANCE PROVISIONS CONTAINED HEREIN, THIS SUBORDINATION AGREEMENT RESULTS IN YOUR LEASE BECOMING SUBORDINATE TO, SUBJECT TO AND OF LOWER PRIORITY THAN THE GROUND LEASE (DEFINED BELOW)

THIS SUBORDINATION AGREEMENT, ATTORNMENT AND NON-DISTURBANCE AGREEMENT AND CONSENT TO SUBLEASE (this "Agreement") is made _____ __, 2013 (the "Effective Date"), by and among AGNL Clinic, L.P., a Delaware limited partnership ("AGNL"), Molina Healthcare, Inc., a Delaware corporation ("Molina"), _____ (collectively, "Lender") and _____, a _____ ("Sub-Tenant").

RECITALS:

1. Molina Center LLC, a Delaware limited liability company ("Center"), as landlord, and Sub-Tenant, as tenant (or their respective predecessors in interest), entered into a Lease made and entered into as of _____ (the "Lease"). Pursuant to the Lease, Sub-Tenant leases from Center that certain portion of the Property (defined below) as more particularly described on Exhibit B attached hereto and incorporated herein by this reference (the " Premises"). A copy of the Lease is attached hereto as Exhibit C and incorporated herein by this reference.

2. On the Effective Date, Center, sold and conveyed to AGNL the fee simple interest in that certain real property with an address of 200 and 300 Oceangate Blvd., Long Beach, California 90802, and described on Exhibit A attached hereto and incorporated herein by this reference (which

property, together with all improvements now or hereafter located on the property, is defined as the " Property") and Center assigned the Lease to Molina.

3. On the Effective Date, AGNL, as landlord, and Molina, as tenant, entered into a Lease Agreement dated as of the Effective Date (together with any amendments, modifications, replacements or extensions, the " Ground Lease") pursuant to which AGNL leased to Molina all of the Property and improvements located thereon as more fully described in the Ground Lease and Lender made a loan (the "Loan") to AGNL secured by, among other things, that certain _____ (the "Security Instrument") encumbering AGNL's interest in the Property.

4. As a condition to completing the sale and purchase of the Property and entering into the Ground Lease, AGNL and Lender have required that Molina and Sub-Tenant acknowledge and agree that (notwithstanding the fact that the Lease was entered into prior to the Ground Lease) unconditionally and at all times the Ground Lease shall be prior and superior in title to the Lease and that Molina and Sub-Tenant specifically and unconditionally subordinate their respective interests in the Lease to the priority in title of the Ground Lease, subject to certain "non-disturbance" protections for Sub-Tenant described herein.

5. Subject to certain "non-disturbance" protections for Sub-Tenant described herein, the effect of the foregoing subordination shall be that the Ground Lease shall be deemed a master lease or superior lease and that the Lease shall be deemed a sublease under the Ground Lease.

6. The parties have agreed to the foregoing and to all of the other agreements and understandings set forth in this Agreement.

NOW, THEREFORE, for valuable consideration and to induce AGNL to enter into the transaction described in the recitals, AGNL, Molina, Lender and Sub-Tenant hereby agree as follows:

1. Subordination; Consent to Sublease. AGNL, Molina, Lender and Sub-Tenant hereby agree that:

1.1 Recitals. The foregoing recitals are incorporated herein by reference as if fully set forth in this Agreement.

1.2 Prior Title. Subject to Section 4 of this Agreement, the Ground Lease, and any modifications, renewals or extensions thereof, is and shall unconditionally be and at all times remain prior and superior in title to the Lease. Molina shall be the direct landlord under the Lease and shall continue to be liable and obligated to Sub-Tenant for all of landlord's liabilities and obligations thereunder.

2. Additional Agreements. It is covenanted and agreed that so long as the Ground Lease is in effect:

2.1 No Advance Rents. Sub-Tenant will make no payments or prepayments of rent more than one (1) month in advance of the time when the same become due under the Lease except as may be expressly required of Sub-Tenant under the Lease.

2.2 Assignment of Rents. Upon receipt by Sub-Tenant of written notice from AGNL that AGNL has elected to terminate the Ground Lease or that an Event of Default (as defined in the Ground Lease) has occurred, Sub-Tenant will pay directly to AGNL all rents due and payable under the Lease. Sub-Tenant shall comply with such direction to pay and shall not be required to determine whether the Ground Lease has been terminated or whether Molina is in default under the Ground Lease; Molina and AGNL hereby agreeing with Sub-Tenant that Sub-Tenant shall be given credit under the Lease for any such payments as though such payments had been made to Molina.

2.3 Assignment and Subletting. Sub-Tenant shall not exercise any of its rights to assign, sublet, license, lease, sublease or otherwise transfer any right of use or occupancy for the Premises which requires the prior consent of Molina under the Lease without obtaining the prior written consent of AGNL in accordance with Section 2.6 hereof (the foregoing requirement for AGNL's consent shall exist independent of and regardless of whether Molina has granted its consent to such assignment, subletting, license, lease, sublease or other transfer).

2.4 Alterations and Repairs. Tenant shall not make any alteration (as defined in the Lease) at the Premises which requires the prior consent of Molina under the Lease without obtaining the prior written consent of AGNL in accordance with Section 2.6 hereof.

2.5 AGNL Agreement. So long as Molina (or any successor landlord) does not have the right to terminate the Lease by reason of default (after any applicable notice and cure periods) on the part of Sub-Tenant, then, in such event, (a) unless any applicable law requires same, Sub-Tenant shall not be joined as a party defendant in any action or proceeding which may be instituted or taken by AGNL for the purpose of terminating the Ground Lease by reason of any default thereunder, (b) Sub-Tenant shall not be evicted from the Premises nor shall any of Sub-Tenant's rights under the Lease be affected in any way by reason of any default under the Ground

Lease, and (c) Sub-Tenant's estate under the Lease shall not be terminated or disturbed by reason of any default on the part of Molina under the Ground Lease.

2.6 Consents. AGNL covenants and agrees that any consents by AGNL provided for hereunder generally shall be given, deemed given or withheld under the same standard as would be the case for Molina under the Lease provided that Tenant also delivers to AGNL any notices related to such matters at the same time as delivered to Molina in accordance with the terms of the Lease. Tenant agrees that, if Tenant contends that AGNL improperly withheld its consent to any action or occurrence which requires AGNL's consent hereunder, then Tenant may seek an action for declaratory judgment against AGNL seeking to reverse such decision, or otherwise avail itself of any other remedies against AGNL to the extent available against the landlord under the Lease. The foregoing shall not limit any and all remedies or claims that Tenant may have against Molina under or pursuant to the Lease.

3. Attornment. Sub-Tenant agrees for the benefit of AGNL and any transferee, successor or assign of AGNL or lender of AGNL, including, without limitation, Lender, which succeeds to the rights of AGNL, as landlord, pursuant to a foreclosure, deed-in-lieu of foreclosure or other exercise of remedies (hereafter referred to, collectively, as "Prime Landlord") following a termination of the Ground Lease, but subject in each case to Section 4 of this Agreement, as follows:

3.1 *Payment of Rent. Sub-Tenant shall pay to Prime Landlord all rental payments required to be made by Sub-Tenant pursuant to the terms of the Lease for the duration of the term of the Lease.*

3.2 *Continuation of Performance. Sub-Tenant shall be bound to Prime Landlord in accordance with all of the provisions of the Lease for the balance of the term thereof, and Sub-Tenant hereby attorns to Prime Landlord as its landlord following a termination of the Ground Lease, such attornment to be effective and self-operative without the execution of any further instrument immediately upon Prime Landlord's termination of the Ground Lease and delivery of written notice thereof to Sub-Tenant.*

3.3 *No Offset. Prime Landlord shall not be liable for, nor subject to, any offsets, credits or defenses which Sub-Tenant may have by reason of any act or omission of Molina under the Lease (except to the extent specifically provided in the Lease as of the Effective Date and solely for such offsets, credits or defenses accruing or continuing after Prime Landlord becomes the landlord under the Lease), nor for the return of any sums which Sub -Tenant may have paid to Molina under the Lease as and for security deposits, advance rentals or otherwise, except to the extent that such sums are actually delivered by Molina to Prime Landlord (and provided that the foregoing provisions shall not exempt Prime Landlord, if Prime Landlord succeeds to the interest of Molina under the Lease, from the performance of the obligations of the "Landlord" under the Lease accruing during and applicable to Prime Landlord's period of ownership).*

3.4 *Subsequent Transfer. If Prime Landlord, by succeeding to the interest of Molina under the Lease, should become obligated to perform the covenants of Molina thereunder, then, upon any further transfer of Prime Landlord's interest by Prime Landlord and assumption*

thereof by the transferee, all of such obligations (except those assumed by Prime Landlord during and applicable to Prime Landlord's period of ownership) shall terminate as to Prime Landlord.

4. Non-Disturbance. In the event of a termination of the Ground Lease, or other action to enforce AGNL's remedies under the Ground Lease or any other termination or surrender thereof, including, without limitation, pursuant to Section 365(h) of the U.S. Bankruptcy Code or Lender's exercise of remedies under the Security Instrument, so long as there shall then exist no right of the landlord to exercise remedies pursuant to the Lease by reason of default (beyond any applicable notice and cure period) by Sub-Tenant such that there is a right to terminate the Lease, AGNL and Lender each agree for itself and each of its successors and assigns that the leasehold interest of Sub-Tenant under the Lease shall not be extinguished or terminated by reason of such termination or exercise of remedies by AGNL or Lender, but rather the Lease shall continue in full force and effect and AGNL or Lender (and any party that shall become a transferee of the Property by reason thereof), as applicable, shall recognize and accept Sub-Tenant as tenant under the Lease subject to and upon the terms and provisions of the Lease except as modified by this Agreement; If a default (beyond any applicable notice and cure period) exists under the Lease such that there is a right to terminate the Lease at the time of the termination of the Ground Lease or the exercise of any of AGNL's remedies thereunder, then both AGNL and Lender may elect to continue the Lease as provided for in this Agreement or terminate the Lease upon written notice from AGNL and/or Lender to Sub-Tenant.

5. Miscellaneous.

5.1 Heirs, Successors, Assigns and Transferees. The covenants herein shall be binding upon, and inure to the benefit of, the heirs, successors and assigns of the parties hereto including, without limitation, Lender or any other lender of AGNL that becomes landlord under the Ground Lease or the Lease.

5.2 Notices. All notices or other communications required or permitted to be given pursuant to the provisions hereof shall be deemed served upon delivery or, if mailed, upon the first to occur of receipt or the expiration of three (3) days after deposit in United States Postal Service, certified mail, postage prepaid and addressed to the address of AGNL, Molina or Sub‑Tenant appearing below:

"AGNL" AGNL Clinic, L.P.
c/o Angelo, Gordon & Co., L.P.
245 Park Avenue, 26th Floor
New York, NY 10167-0094
Phone No.: (212) 883-4157
Fax No.: (212) 883-4141
Attn: Gordon J. Whiting

With a copy to: AGNL Manager II, Inc.
c/o Angelo, Gordon & Co., L.P.
245 Park Avenue, 26th Floor
New York, NY 10167-0094

Phone No.: (212) 692-2296
Fax No.: (212) 867-6448
Attn: Joseph R. Wekselblatt

With a copy to: Sheppard, Mullin, Richter & Hampton LLP
1300 I Street, N.W., Suite 1100
Washington, D.C. 20005
Phone No.: (202) 469-4943
Fax No.: (202) 312-9411
Attn: Michele E. Williams, Esquire

"Molina" Director of Facilities
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802-4317
Phone No.: (562) 435-3666
Fax No.: (562) 901-1086

with a copy to: Sidley Austin LLP
555 West 5th Street
40th Floor
Los Angeles, CA 90013
Phone No.: (213) 896-6018
Fax No.: (213) 896-6600
Attn.: Marc I. Hayutin, Esquire

and to: Sidley Austin LLP
555 West 5th Street
40th Floor
Los Angeles, CA 90013
Phone No.: (213) 896-6048
Fax No.: (213) 896-6600
Attn.: Edward C. Prokop, Esquire

"Lender" [insert lender's contact information]

"Sub-Tenant" [insert tenant's contact information]

provided, however, that any party shall have the right to change its address for notice hereunder by the giving of written notice thereof to the other parties in the manner set forth in this Agreement.

5.3 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original and all of which together shall constitute and be construed as one and the same instrument.

5.4 Remedies Cumulative. All rights of AGNL herein to collect rents on behalf of Molina under the Lease are cumulative and shall be in addition to any and all other rights and remedies provided by law and by other agreements between AGNL and Molina or others.

5.5 Paragraph Headings. Paragraph headings in this Agreement are for convenience only and are not to be construed as part of this Agreement or in any way limiting or applying the provisions hereof.

5.6 Representations. Each of AGNL, Molina, Lender and Sub-Tenant represents to the other respective parties that it has the power and authority to enter into this Agreement.

5.7 Intentionally Omitted.

5.8 Governing Law. It is the intention of the parties hereto that this Agreement (and the terms and provisions hereof) shall be construed and enforced in accordance with the laws of the State of California, without regard to any conflict of law principles.

5.9 Recordation. At AGNL's option, this Agreement may be recorded in the land records where the Property is located. Any recordation of this Agreement or any memorandum thereof, whether at the request of AGNL, Lender or otherwise, shall not be at SubTenant's expense.

5.10 Fee Lender Subordination. AGNL, Molina, Lender and Sub-Tenant agree that the Lease shall be subordinate to the Loan and the Security Instrument and any mortgage or other security instrument hereafter placed upon the Property (which includes the Premises) by AGNL, and to any and all advances made or to be made thereunder, to the interest thereon, and all renewals, replacements and extensions thereof; provided, however, that the foregoing shall not limit Lender's agreements contained herein, including, without limitation, as described in Section 5.4 hereof.

INCORPORATION. Exhibit A, Exhibit B and Exhibit C are attached hereto and incorporated herein by this reference.

(SIGNATURES FOLLOW)

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above-written.

NOTICE: IT IS RECOMMENDED THAT, PRIOR TO THE EXECUTION OF THIS AGREEMENT, THE PARTIES CONSULT WITH THEIR ATTORNEYS WITH RESPECT HERETO.

"MOLINA"

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: _____
Name: _____
Its: _____

Date: _____

"AGNL"

AGNL CLINIC, L.P.,
a Delaware limited partnership

By: AGNL CLINIC GP, L.L.C.,
its general partner

By: AGNL Manager II, Inc.,
its manager

Date: _____ By: _____
Gordon J. Whiting, President

"LENDER"

Date: _____

By: _____
Name: _____
Its: _____

Date: _____

By: _____
Name: _____
Its: _____

"SUB-TENANT"

[_____]

Date: _____

By: _____
Name: _____
Its: _____

ACKNOWLEDGEMENT

(For Molina)

STATE OF CALIFORNIA)

) ss:

COUNTY OF _____)

On _____, before me, _____, a Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature (Seal)

ACKNOWLEDGEMENT
(For AGNL)

STATE OF _____
COUNTY OF _____

On [May] __, 2013 before me, _____, a Notary Public in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

_____
Notary Public in and for said State

ACKNOWLEDGEMENT
(For Lender)

STATE OF _____
COUNTY OF _____

On [May] __, 2013 before me, _____, a Notary Public in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

_____
Notary Public in and for said State

ACKNOWLEDGEMENT
(For Lender)

STATE OF _____
COUNTY OF _____

On [May] __, 2013 before me, _____, a Notary Public in and for said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

_____
Notary Public in and for said State

ACKNOWLEDGEMENT

(For Sub-Tenant)

[STATE OF CALIFORNIA)

) ss:

COUNTY OF_____)

On _____, before me, _____, a Notary Public personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument, the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

Witness my hand and official seal.

Signature _____ (Seal)]

EXHIBIT A

PROPERTY

LEGAL DESCRIPTION

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 AND 7278-003-036

EXHIBIT B

PREMISES

The premises leased from Molina to Sub-Tenant under the Lease, consisting of approximately _____ rentable square feet, on portions of the ground and second floors of the office building located at 200 and 300 Oceangate Blvd., Long Beach, California.

EXHIBIT C

LEASE

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2013 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 25, 2013

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2013 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 25, 2013

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2013 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 25, 2013

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2013 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 25, 2013

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended March 31, 2013

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2013
Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number: 001-31719

Molina Healthcare, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock outstanding as of April 19, 2013, was approximately 45,416,300.

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MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	March 31, 2013	December 31, 2012
	(Amounts in thousands, except per-share data)	
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,169,511	$ 795,770
Investments	341,946	342,845
Receivables	150,251	149,682
Deferred income taxes	25,753	32,443
Prepaid expenses and other current assets	39,577	28,386
Total current assets	1,727,038	1,349,126
Property, equipment, and capitalized software, net	237,735	221,443
Deferred contract costs	53,813	58,313
Intangible assets, net	72,864	77,711
Goodwill and indefinite-lived intangible assets	151,088	151,088
Auction rate securities	13,600	13,419
Restricted investments	55,117	44,101
Derivative asset	147,385	—
Other assets	29,449	19,621
	$ 2,488,089	$ 1,934,822
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 491,145	$ 494,530
Accounts payable and accrued liabilities	159,986	184,034
Deferred revenue	135,804	141,798
Income taxes payable	14,944	6,520
Current maturities of long-term debt	1,167	1,155
Total current liabilities	803,046	828,037
Long-term debt	642,005	261,784
Deferred income taxes	31,353	37,900
Derivative liabilities	223,647	1,307
Other long-term liabilities	23,839	23,480
Total liabilities	1,723,890	1,152,508
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 45,415 shares at March 31, 2013 and 46,762 shares at December 31, 2012	45	47
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	234,236	285,524
Accumulated other comprehensive loss	(197)	(457)
Treasury stock, at cost; 111 shares at December 31, 2012	—	(3,000)
Retained earnings	530,115	500,200
Total stockholders' equity	764,199	782,314
	$ 2,488,089	$ 1,934,822

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2013	2012
	(Amounts in thousands, except net income per share) (Unaudited)	
Revenue:		
Premium revenue	$ 1,534,608	$ 1,325,406
Service revenue	49,756	42,205
Investment income	1,529	1,717
Rental and other income	4,694	4,259
Total revenue	1,590,587	1,373,587
Expenses:		
Medical care costs	1,288,754	1,130,988
Cost of service revenue	39,770	30,494
General and administrative expenses	141,407	121,474
Premium tax expenses	37,000	42,186
Depreciation and amortization	16,565	15,025
Total expenses	1,523,496	1,340,167
Operating income	67,091	33,420
Other expenses (income):		
Interest expense	13,037	4,298
Other income	(131)	—
Total other expenses	12,906	4,298
Income before income taxes	54,185	29,122
Income tax expense	24,270	11,033
Net income	$ 29,915	$ 18,089
Net income per share:		
Basic	$ 0.65	$ 0.39
Diluted	$ 0.64	$ 0.39
Weighted average shares outstanding:		
Basic	45,981	45,998
Diluted	46,443	46,887

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2013	2012
	(Amounts in thousands) (Unaudited)	
Net income	$ 29,915	$ 18,089
Other comprehensive income, net of tax:		
Unrealized gain on investments	260	296
Other comprehensive income	260	296
Comprehensive income	$ 30,175	$ 18,385

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2013	2012
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 29,915	$ 18,089
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	21,799	18,339
Deferred income taxes	(16)	8,263
Stock-based compensation	4,421	4,666
Gain on sale of subsidiary	—	(1,747)
Non-cash interest on convertible senior notes	3,723	1,443
Change in fair value of derivatives	(119)	—
Amortization of premium/discount on investments	1,502	1,850
Amortization of deferred financing costs	1,248	258
Tax deficiency from employee stock compensation	(42)	(31)
Changes in operating assets and liabilities:		
Receivables	(569)	(54,356)
Prepaid expenses and other current assets	(8,956)	(5,640)
Medical claims and benefits payable	(3,385)	53,357
Accounts payable and accrued liabilities	(31,847)	(34,796)
Deferred revenue	(5,994)	44,543
Income taxes	8,424	(3,663)
Net cash provided by operating activities	20,104	50,575
Investing activities:		
Purchases of equipment	(11,167)	(13,505)
Purchases of investments	(76,012)	(88,199)
Sales and maturities of investments	75,647	65,767
Proceeds from sale of subsidiary, net of cash surrendered	—	9,162
Increase in deferred contract costs	1,756	(12,993)
Increase in restricted investments	(11,016)	(493)
Change in other non-current assets and liabilities	(408)	(2,457)
Net cash used in investing activities	(21,200)	(42,718)
Financing activities:		
Proceeds from issuance of 1.125% Notes, net of deferred issuance costs	537,973	—
Purchase of call option relating to 1.125% Notes	(149,331)	—
Proceeds from issuance of warrants	75,074	—
Treasury stock purchases	(50,000)	—
Repayment of amounts borrowed under credit facility	(40,000)	—
Amount borrowed under credit facility	—	10,000
Principal payments on term loan	(291)	(301)
Proceeds from employee stock plans	235	2,748
Excess tax benefits from employee stock compensation	1,177	3,592
Net cash provided by financing activities	374,837	16,039
Net increase in cash and cash equivalents	373,741	23,896
Cash and cash equivalents at beginning of period	795,770	493,827
Cash and cash equivalents at end of period	$ 1,169,511	$ 517,723

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS - (continued)

	Three Months Ended March 31,	
	2013	2012
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 14,712	$ 1,057
Interest	$ 17,065	$ 799
Schedule of non-cash investing and financing activities:		
Retirement of treasury stock	$ 53,000	$ —
Common stock used for stock-based compensation	$ 4,644	$ 8,768
Details of sale of subsidiary:		
Decrease in carrying value of assets	$ —	$ 30,942
Decrease in carrying value of liabilities	—	(23,527)
Gain on sale	—	1,747
Proceeds from sale of subsidiary, net of cash surrendered	$ —	$ 9,162

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
March 31, 2013

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of March 31, 2013, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico, and Washington.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in retaining their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services effective March 1, 2012.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid Management Information System (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana cancelled its contract award to CNSI. CNSI is currently challenging the contract cancellation. The state has informed us that we will continue to perform under our current contract until a successor is named. Subject to the pending challenge, it is currently uncertain whether a new RFP will be issued, and if so, when it will be issued. At such time as a new RFP may be issued, we intend to respond to the state's RFP. For the three months ended March 31, 2013, our revenue under the Louisiana MMIS contract was approximately $10.1 million, or 20.3% of total service revenue. So long as our Louisiana MMIS contract continues, we expect to recognize approximately $40 million of service revenue annually under this contract.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions

have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2013.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2012. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2012 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2012 audited consolidated financial statements.

Reclassifications

We have reclassified certain amounts in the 2012 consolidated balance sheet, and statements of income and cash flows to conform to the 2013 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

(1) Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract: These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates), our revenue earned for those periods will also change. In all of these instances, our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn would lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of approximately $0.3 million at both March 31, 2013, and December 31, 2012.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both March 31, 2013, and December 31, 2012, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. At both March 31, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $3.1 million and $3.2 million pursuant to our profit-sharing agreement with the state of Texas at March 31, 2013, and December 31, 2012, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of approximately $1.0 million at March 31, 2013. At December 31, 2012, we had not recorded any liability under the terms of this contract provision since medical expenses were not less than the contractual floor.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net payable of approximately $0.2 million as of March 31, 2013 and a net receivable of approximately $0.3 million as of December 31, 2012 for anticipated Medicare risk adjustment premiums.

(2) Quality incentives that allow us to recognize incremental revenue if certain quality standards are met: These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, incremental revenue of up to 3.25% of total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2013 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2013.

	Three Months Ended March 31, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 585	$ 332	$ 108	$ 440	$ 85,798
Ohio	3,005	1,052	—	1,052	291,518
Texas	16,264	13,512	5,995	19,507	335,296
Wisconsin	761	—	609	609	27,124
	$ 20,615	$ 14,896	$ 6,712	$ 21,608	$ 739,736

	Three Months Ended March 31, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 555	$ 336	$ 28	$ 364	$ 81,226
Ohio	2,678	2,678	966	3,644	293,525
Texas	5,750	5,750	—	5,750	198,236
Wisconsin	416	—	—	—	17,142
	$ 9,399	$ 8,764	$ 994	$ 9,758	$ 590,129

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid Management Information System (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. While providing BPO services (which include claims payment and eligibility processing), we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable

evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;
- Vendor costs incurred in performing transaction services;
- Costs incurred in performing required monitoring of and reporting on contract performance;
- Costs incurred in maintaining and processing member and provider eligibility; and
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of non-deductible compensation and state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct

business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $10.6 million as of March 31, 2013 and December 31, 2012. Approximately $8.4 million of the unrecognized tax benefits recorded at March 31, 2013 and December 31, 2012, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.2 million as of March 31, 2013 and December 31, 2012. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.6 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of March 31, 2013, and December 31, 2012, we had accrued $60,000 and $56,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

Reclassifications Out of Accumulated Other Comprehensive Income. In February 2013, the Financial Accounting Standards Board (FASB) issued guidance for the reporting of amounts reclassified out of accumulated other comprehensive income. The new guidance requires entities to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under U.S. generally accepted accounting principles (GAAP) to be reclassified in its entirety to net income. The new guidance does not change the current requirements for reporting net income or other comprehensive income in financial statements and is effective prospectively for reporting periods beginning after December 15, 2012. The adoption of this new guidance in 2013 did not impact our financial position, results of operations or cash flows.

Balance Sheet Offsetting. In December 2011, the FASB issued guidance for new disclosure requirements related to the nature of an entity's rights of set-off and related arrangements associated with its financial instruments and derivative instruments. The new guidance is effective for annual reporting periods, and interim periods within those years, beginning on or after January 1, 2013. The adoption of this new guidance in 2013 did not impact our financial position, results of operations or cash flows.

Federal Premium-Based Assessment. In July 2011, the FASB issued guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (ACA). The ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year.

The new guidance specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The new guidance is effective for annual reporting periods beginning after December 31, 2013, when the fee initially becomes effective. As enacted, this federal premium-based assessment is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this premium-based assessment will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this assessment as currently written will have a material impact on our financial position, results of operations, or cash flows in future periods. We are currently evaluating the impact of the fee to our financial position, results of operations and cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants (AICPA), and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income per share:

	Three Months Ended March 31,	
	2013	2012
	(In thousands)	
Shares outstanding at the beginning of the period	46,762	45,815
Weighted-average number of shares repurchased	(867)	—
Weighted-average number of shares issued	86	183
Denominator for basic income per share	45,981	45,998
Dilutive effect of employee stock options and stock grants (1)	462	857
Dilutive effect of convertible senior notes	—	32
Denominator for diluted income per share (2)	46,443	46,887

(1) Unvested restricted shares are included in the calculation of diluted income per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. Options to purchase common shares are included in the calculation of diluted income per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended March 31, 2013 and 2012, there were approximately 202,500 and 199,700 anti-dilutive weighted restricted shares, respectively. For the three months ended March 31, 2013 and 2012 there were approximately 25,500 and 7,900 anti-dilutive weighted options, respectively.

(2) Potentially dilutive shares issuable pursuant to our 3.75% Notes and 1.125% Warrants (both defined in Note 10, "Long-Term Debt") were not included in the computation of diluted income per share for the three month period ended March 31, 2013, because to do so would have been anti-dilutive.

4. Stock-Based Compensation

At March 31, 2013, we had employee equity incentives outstanding under two plans: (1) the 2011 Equity Incentive Plan; and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded).

In March 2013, our named executive officers were granted restricted stock awards with performance conditions as follows: our chief executive officer was awarded 186,858 shares, our chief financial officer was awarded 93,429 shares, our chief operating officer was awarded 62,286 shares, our chief accounting officer was awarded 28,029 shares, and our general counsel was awarded 21,800 shares. These awards were apportioned into four equal increments, and will vest in accordance with the following four measures: (i) 1/4th will vest in equal 1/3rd increments over three years on March 1, 2014, March 1, 2015, and March 1, 2016; (ii) 1/4th will vest upon our achievement of three-year Total Stockholder Return as determined by Institutional Shareholder Services Inc. (ISS) calculations for the three-year period ending December 31, 2013 equal to or greater than the 50th percentile within our ISS peer group; (iii) 1/4th shall vest upon our achievement of total revenue in any of the 2013, 2014, or 2015 fiscal years equal to or greater than $12 billion; and (iv) 1/4th shall vest upon our achievement of the three-year earnings before interest, taxes, depreciation and amortization (EBITDA) margin percentage for the three-year period ending December 31, 2013 equal to or greater than 2.5%. In the event the vesting conditions are not achieved, the awards shall lapse. As of March 31, 2013, such performance goals have not yet been met, but we do expect the awards to vest in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three months ended March 31, 2013 and 2012:

	Three Months Ended March 31,	
	2013	2012
	(In thousands)	
Restricted stock and performance awards	$ 3,848	$ 4,398
Stock options (primarily relating to our employee stock purchase plan)	573	268
	$ 4,421	$ 4,666

As of March 31, 2013, there was $29.2 million of total unrecognized compensation expense related to unvested restricted share awards, which we expect to recognize over a remaining weighted-average period of 1.9 years. Also as of March 31, 2013, there was $0.8 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.8 years.

Restricted stock activity for the three months ended March 31, 2013 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2012	986,577	$ 23.74
Granted	601,175	31.40
Vested	(409,484)	22.16
Forfeited	(7,750)	22.93
Unvested balance as of March 31, 2013	1,170,518	28.23

The total fair value of restricted stock and stock unit awards, including those with performance conditions, granted during the three months ended March 31, 2013 and 2012 was $19.3 million and $19.8 million, respectively. The total fair value of restricted stock and stock unit awards vested during the three months ended March 31, 2013 and 2012 was $13.1 million and $22.8 million, respectively.

Stock option activity for the three months ended March 31, 2013 is summarized below:

	Options	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Outstanding as of December 31, 2012	414,061	$ 22.39		
Granted	45,000	33.02		
Exercised	(13,001)	17.97		
Forfeited	(300)	17.63		
Outstanding as of March 31, 2013	445,760	23.60	$ 3,398	3.8
Stock options exercisable and expected to vest as of March 31, 2013	445,760	23.60	$ 3,398	3.8
Exercisable as of March 31, 2013	390,760	22.23	$ 3,398	3.0

The weighted-average grant date fair value per share of stock options awarded to the new members of our board of directors during the three months ended March 31, 2013 was $14.67. The weighted-average grant date fair value per share of the stock option awarded to the director appointed during 2012 was $13.97. To determine the fair values of these stock options we applied risk-free interest rates of 1.1% to 1.4%, expected volatilities of 41.3% to 43.0%, dividend yields of 0%, and expected lives of 6 years to 7 years.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, a derivative asset, trade accounts payable, medical claims and benefits payable, long-term debt, derivative liabilities, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.
- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets. Our investments classified as Level 2 are traded frequently though not necessarily

daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

Additionally, Level 2 financial instruments include an interest rate swap derivative liability. Fair value for the interest rate swap derivative is based on forward LIBOR rates that are and will be observable at commonly quoted intervals for the full term of the interest rate swap agreement.

- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* Our Level 3 financial instruments recorded at fair value include non-current auction rate securities that are designated as available-for-sale, and are reported at fair value of $13.6 million (par value of $14.5 million) as of March 31, 2013. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants including global financial institutions, hedge funds, private equity funds, mutual funds, corporations and other institutional investors. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from two other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of March 31, 2013.

  Additionally, Level 3 financial instruments include derivative financial instruments comprising the 1.125% Call Option asset, the embedded conversion option liability, and the 1.125% Warrants liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of March 31, 2013 included our common stock price, time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. See Note 10, “Long-Term Debt,” and Note 11, “Derivative Financial Instruments,” for further information, including defined terms, regarding our derivative financial instruments.

Our financial instruments measured at fair value on a recurring basis at March 31, 2013, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 198,567	$ —	$ 198,567	$ —
GSEs	27,399	27,399	—	—
Municipal securities	75,411	—	75,411	—
U.S. treasury notes	31,938	31,938	—	—
Auction rate securities	13,600	—	—	13,600
Certificates of deposit	8,631	—	8,631	—
1.125% Call Option derivative	147,385	—	—	147,385
Total assets measured at fair value on a recurring basis	$ 502,931	$ 59,337	$ 282,609	$ 160,985
Embedded conversion option derivative	$ 147,309	$ —	$ —	$ 147,309
1.125% Warrants derivative	75,074	—	—	75,074
Interest rate swap derivative	1,264	—	1,264	—
Total liabilities measured at fair value on a recurring basis	$ 223,647	$ —	$ 1,264	$ 222,383

Our financial instruments measured at fair value on a recurring basis at December 31, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
	(In thousands)			
Corporate debt securities	$ 191,008	$ —	$ 191,008	$ —
GSEs	29,525	29,525	—	—
Municipal securities	75,848	—	75,848	—
U.S. treasury notes	35,740	35,740	—	—
Auction rate securities	13,419	—	—	13,419
Certificates of deposit	10,724	—	10,724	—
Total assets measured at fair value on a recurring basis	$ 356,264	$ 65,265	$ 277,580	$ 13,419
Interest rate swap derivative	$ 1,307	$ —	$ 1,307	$ —

The following tables present activity relating to our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	Changes in Level 3 Instruments for the Three Months Ended March 31, 2013		
	Total	Auction Rate Securities	Derivatives, Net
	(In thousands)		
Balance at December 31, 2012	$ 13,419	$ 13,419	$ —
Net unrealized gains included in other comprehensive income	331	331	—
Net unrealized gains included in earnings	76	—	76
Purchases and issuances of assets (liabilities)	(75,074)	—	(75,074)
Settlements	(150)	(150)	—
Balance at March 31, 2013	$ (61,398)	$ 13,600	$ (74,998)
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at March 31, 2013	$ 318	$ 318	$ —

	Changes in Level 3 Instruments for the Year Ended December 31, 2012		
	Total	Auction Rate Securities	Derivatives, Net
	(In thousands)		
Balance at December 31, 2011	$ 16,134	$ 16,134	$ —
Net unrealized gains included in other comprehensive income	1,635	1,635	—
Settlements	(4,350)	(4,350)	—
Balance at December 31, 2012	$ 13,419	$ 13,419	$ —
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at December 31, 2012	$ 1,059	$ 1,059	$ —

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our long-term debt, as well as the applicable fair value hierarchy tiers, are contained in the tables below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Our term loan is classified as a Level 3 financial instrument, because certain inputs used to determine the fair value of this financial instrument are unobservable. The carrying value of the term loan at March 31, 2013, approximates its fair value because there has been no significant change to our credit risk relating to this instrument from the term loan's origination date in December 2011, through March 31, 2013. As described in Note 14, "Commitments and Contingencies," we recorded a financing obligation in connection with a lease entered into in February

2013. The financing obligation at March 31, 2013, approximates its fair value because of the short period of time between the origination of the obligation in February 2013 and March 31, 2013. The Credit Facility was repaid and terminated effective February 15, 2013.

	March 31, 2013				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
1.125% Notes	$ 402,836	$ 551,271	$ —	$ 551,271	$ —
3.75% Notes	177,024	223,115	—	223,115	—
Term loan	47,179	47,179	—	—	47,179
Financing obligation	16,133	16,133	—	—	16,133
	$ 643,172	$ 837,698	$ —	$ 774,386	$ 63,312

	December 31, 2012				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
3.75% Notes	$ 175,468	$ 208,460	$ —	$ 208,460	$ —
Term loan	47,471	47,471	—	—	47,471
Credit facility	40,000	40,000	—	—	40,000
	$ 262,939	$ 295,931	$ —	$ 208,460	$ 87,471

6. Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 198,265	$ 441	$ 139	$ 198,567
Government-sponsored enterprise securities (GSEs)	27,372	27	—	27,399
Municipal securities	75,216	348	153	75,411
U.S. treasury notes	31,894	44	—	31,938
Certificates of deposit	8,617	14	—	8,631
Subtotal - current investments	341,364	874	292	341,946
Auction rate securities	14,500	—	900	13,600
	$ 355,864	$ 874	$ 1,192	$ 355,546

	December 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 190,545	$ 528	$ 65	$ 191,008
GSEs	29,481	45	1	29,525
Municipal securities	75,909	185	246	75,848
U.S. treasury notes	35,700	42	2	35,740
Certificates of deposit	10,715	9	—	10,724
Subtotal - current investments	342,350	809	314	342,845
Auction rate securities	14,650	—	1,231	13,419
	$ 357,000	$ 809	$ 1,545	$ 356,264

The contractual maturities of our investments as of March 31, 2013 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 173,871	$ 174,145
Due one year through five years	167,493	167,801
Due after ten years	14,500	13,600
	$ 355,864	$ 355,546

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Net realized investment gains for the three months ended March 31, 2013, and 2012 were $94,000 and $64,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at March 31, 2013, and December 31, 2012, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2013.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 52,264	$ 139	28	$ —	$ —	—
Municipal securities	21,440	153	37	—	—	—
Auction rate securities	—	—	—	13,600	900	19
	$ 73,704	$ 292	65	$ 13,600	$ 900	19

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2012.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 44,457	$ 65	23	$ —	$ —	—
Municipal securities	35,223	246	43	—	—	—
GSEs	5,004	1	1	—	—	—
U.S. treasury notes	4,511	2	5	—	—	—
Auction rate securities	—	—	—	13,419	1,231	21
	$ 89,195	$ 314	72	$ 13,419	$ 1,231	21

Auction Rate Securities

Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 18 years to 34 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at March 31, 2013. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $67.6 million of these instruments at par value.

For the three months ended March 31, 2013, and 2012, we recorded pretax unrealized gains of $0.3 million and $0.1 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

7. Receivables

Receivables consist primarily of amounts due from the various states in which we operate. Accounts receivable were as follows:

	March 31, 2013	December 31, 2012
	(In thousands)	
Health Plans segment:		
California	$ 45,962	$ 28,553
Florida	1,468	953
Michigan	9,519	12,873
New Mexico	12,153	9,059
Ohio	33,041	40,980
Texas	8,100	7,459
Utah	4,790	3,359
Washington	13,160	17,587
Wisconsin	4,404	4,098
Others	1,145	2,177
Total Health Plans segment	133,742	127,098
Molina Medicaid Solutions segment	16,509	22,584
	$ 150,251	$ 149,682

8. Restricted Investments

Pursuant to the regulations governing our Health Plans segment subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. Additionally, in connection with the Molina Medicaid Solutions segment contracts with the states of Maine and Idaho, we maintain restricted investments as collateral for letters of credit. The following table presents the balances of restricted investments:

	March 31, 2013	December 31, 2012
	(In thousands)	
California	$ 373	$ 373
Florida	6,840	5,738
Michigan	1,014	1,014
New Mexico	15,917	15,915
Ohio	9,081	9,082
Texas	3,500	3,503
Utah	3,321	3,126
Washington	151	151
Other	4,619	5,199
Total Health Plans segment	44,816	44,101
Molina Medicaid Solutions segment	10,301	—
	$ 55,117	$ 44,101

The contractual maturities of our held-to-maturity restricted investments as of March 31, 2013 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 51,617	$ 51,622
Due one year through five years	3,500	3,501
	$ 55,117	$ 55,123

9. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,	
	2013	2012
	(Dollars in thousands)	
Balances at beginning of period	$ 494,530	$ 402,476
Components of medical care costs related to:		
Current period	1,347,181	1,167,580
Prior periods	(58,427)	(36,592)
Total medical care costs	1,288,754	1,130,988
Payments for medical care costs related to:		
Current period	916,426	750,994
Prior periods	375,713	326,637
Total paid	1,292,139	1,077,631
Balances at end of period	$ 491,145	$ 455,833
Benefit from prior period as a percentage of:		
Balance at beginning of period	11.8%	9.1%
Premium revenue	3.8%	2.8%
Total medical care costs	4.5%	3.2%

Assuming that our initial estimate of claims incurred but not paid (IBNP) is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range. For example, for the three months ended March 31, 2012, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2011 by 9.1%. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2013 and 2012 were less than what we had expected when we had established our reserves. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $58.4 million for the three months ended March 31, 2013. This amount represents our estimate, as of March 31, 2013, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012 was due primarily to the following factors:

- At our Texas health plan, we saw a reduction in STAR+PLUS (the state's program for aged and disabled members) membership during mid to late 2012. This caused a reduction in costs per member that we did not fully recognize in our December 31, 2012 reserve estimates.
- At our Washington health plan, prior to July 2012, certain high-cost newborns that were approved for SSI coverage by the state were retroactively dis-enrolled from our Healthy Options (TANF) coverage, and the health plan was reimbursed for the claims paid on behalf of these members. Starting July 1, 2012, these newborns, as well as other high-cost disabled members, are now covered by the health plan under the Health Options Blind and Disabled (HOBD) program. At the end of 2012, we did not have enough claims history to accurately estimate the claims liability of the HOBD members, and as a result the liability for these high-cost members was overstated.
- For our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.

We recognized favorable prior period claims development in the amount of $36.6 million for the three months ended March 31, 2012. This amount represents our estimate as of March 31, 2012, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2011 was due primarily to the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

In estimating our claims liability at March 31, 2013, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- In our Texas health plan, although the reduction in STAR+PLUS membership has leveled off in 2013, we have seen a reduction in per member per month (PMPM) cost for outpatient services and an increase in PMPM costs for inpatient services over the past six to nine months. We have estimated the impact of these shifts in cost in our March 31, 2013 liability.
- Our Wisconsin health plan is experiencing significant membership increases, and is expected to approximately double in size during the first four months of 2013. This new membership is transitioning to our health plan from a terminated health plan. We enrolled approximately 40,000 new members in February and March 2013. We have computed a separate reserve analysis for these members and have noted that paid claims are less than what we would expect for newly transitioned members. Therefore, we have increased the reserves for this membership, in anticipation of higher claims costs later than usual for these members.
- Our Washington health plan began covering disabled members, including newborns, that were previously covered by the state under a separate state program. Coverage for this segment began in July of 2012, with gradual growth in membership. As of March 2013 the health plan covered approximately 28,000 members under this program. Because of the high costs for these members and the relative newness of the product category, there is still some uncertainty about the cost and reserve liability for these members as of March 31, 2013.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012 and for the three months ended March 31, 2013, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

10. Long-Term Debt

As of March 31, 2013, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2013	2014	2015	2016	2017	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	—	187,000	—	—	—	—
Term loan	47,179	863	1,206	1,259	1,309	1,372	41,170
	$ 784,179	$ 863	$ 188,206	$ 1,259	$ 1,309	$ 1,372	$ 591,170

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we settled the issuance of $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes). This transaction included the initial issuance of $450.0 million on February 11, 2013, plus the exercise of the full amount of the $100.0 million over-allotment option on February 13, 2013. The aggregate net proceeds of the 1.125% Notes were $458.9 million, after payment of the net cost of the Call Spread Overlay described below and in Note 11, “Derivative Financial Instruments,” and transaction costs. Additionally, we used $50.0 million of the net proceeds to purchase shares of our common stock (see Note 12, “Stockholders' Equity”), and $40.0 million to repay the principal owed under our Credit Facility.

Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum commencing on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. Holders may convert their 1.125% Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.125% Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the Indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion

rate for a holder who elects to convert its 1.125% Notes in connection with such a corporate event in certain circumstances. We may not redeem the 1.125% Notes prior to the maturity date, and no sinking fund is provided for the 1.125% Notes.

If we undergo a fundamental change (as defined in the indenture to the 1.125% Notes), holders may require us to repurchase for cash all or part of their 1.125% Notes at a repurchase price equal to 100% of the principal amount of the 1.125% Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The 1.125% Notes are senior unsecured obligations, and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

The 1.125% Notes contain an embedded cash conversion option. We have determined that the embedded cash conversion option is a derivative financial instrument, required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). For further discussion of the derivative financial instruments relating to the 1.125% Notes, refer to Note 11, “Derivative Financial Instruments.”

As noted above, the reduced carrying value on the 1.125% Notes resulted in a debt discount that is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms had been issued. The effective interest rate of the 1.125% Notes is 5.9%, which is imputed based on the amortization of the fair value of the embedded cash conversion option over the remaining term of the 1.125% Notes. As of March 31, 2013, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 6.8 years. The 1.125% Notes' if-converted value did not exceed their principal amount as of March 31, 2013.

Also in connection with the settlement of the 1.125% Notes, we paid approximately $16.9 million in transaction costs. Such costs have been allocated to the 1.125% Notes, the 1.125% Call Option (defined below) and the 1.125% Warrants (defined below) according to their relative fair values. The amount allocated to the 1.125% Notes, or $12.0 million, was capitalized and will be amortized over the term of the 1.125% Notes. The aggregate amount allocated to the 1.125% Call Option and 1.125% Warrants, or $4.9 million, was recorded to interest expense in the quarter ended March 31, 2013.

1.125% Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Notes, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes. These transactions represent a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call Spread Overlay. The 1.125% Call Option and the 1.125% Warrants are derivative financial instruments; refer to Note 11, “Derivative Financial Instruments” for further discussion.

Aside from the initial payment of a premium to the counterparties of $149.3 million for the 1.125% Call Option, we will not be required to make any cash payments to the counterparties under the 1.125% Call Option, and will be entitled to receive from the counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common

stock underlying the 1.125% Warrants transactions and the additional 1.125% Warrants transactions, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants transactions, we issued 13,490,236 warrants with strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

3.75% Convertible Senior Notes due 2014

We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of March 31, 2013 and December 31, 2012, respectively. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Because the 3.75% Notes have cash settlement features, accounting guidance required us to allocate the proceeds from their issuance between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that is amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms had been issued. The effective interest rate of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. As of March 31, 2013, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 18 months. The 3.75% Notes' if-converted value did not exceed their principal amount as of March 31, 2013. At March 31, 2013, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million.

The principal amounts, unamortized discount and net carrying amounts of the 1.125% Notes and 3.75% Notes were as follows:

	Principal Balance	Unamortized Discount	Net Carrying Amount
		(In thousands)	
March 31, 2013:			
1.125% Notes	$ 550,000	$ 147,164	$ 402,836
3.75% Notes	187,000	9,976	177,024
	$ 737,000	$ 157,140	$ 579,860
December 31, 2012:			
3.75% Notes	$ 187,000	$ 11,532	$ 175,468

	Three Months Ended March 31,	
	2013	2012
	(in thousands)	
Interest cost recognized for the period relating to the:		
Contractual interest coupon rate	$ 2,527	$ 1,753
Amortization of the discount on the liability component	3,723	1,443
Total interest cost recognized	$ 6,250	$ 3,196

Term Loan

In December 2011, our wholly owned subsidiary, Molina Center LLC, entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the Administrative Agent) to borrow $48.6 million to finance a portion of the purchase price for the Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below). The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month,

two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. Interest Period means the period commencing on the first day of each calendar month and ending on the last day of each calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Credit Facility

On February 15, 2013, we used approximately $40.0 million of the net proceeds from the offering of the 1.125% Notes to repay all of the outstanding indebtedness under our $170 million revolving Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the 1.125% Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution.

11. Derivative Financial Instruments

The following table summarizes the fair values and the presentation of our derivative financial instruments (defined and discussed individually below) in the consolidated balance sheets:

	Balance Sheet Location	March 31, 2013
		(In thousands)
Derivative asset:		
1.125% Call Option	Non-current assets: Derivative asset	$ 147,385
Derivative liabilities:		
Embedded cash conversion option	Non-current liabilities: Derivative liabilities	$ 147,309
1.125% Warrants	Non-current liabilities: Derivative liabilities	75,074
Interest rate swap	Non-current liabilities: Derivative liabilities	1,264
		$ 223,647

Our derivative financial instruments do not qualify for hedge treatment, therefore the change in fair value of these instruments is recognized immediately in our consolidated statements of income, in “Other income (expense).” The following table summarizes the gain (loss) recorded in the period presented (as of March 31, 2012, we did not hold any derivative financial instruments):

	Three Months Ended March 31, 2013
	(In thousands)
Derivative gains (losses):	
1.125% Call Option	$ (1,946)
Embedded cash conversion option	2,022
Interest rate swap	43
	$ 119

1.125% Notes Call Spread Overlay

We entered into the 1.125% Call Option and the 1.125% Warrants transactions with certain of the initial purchasers of the 1.125% Notes (the Option Counterparties). These transactions represent a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the debentures was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the counterparties (and 1.125% Warrants strike prices in excess of the

conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call Spread Overlay.

Aside from the initial payment of a premium to the counterparties of $149.3 million for the 1.125% Call Option, we will not be required to make any cash payments to the counterparties under the 1.125% Call Option, and will be entitled to receive from the counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants transactions and the additional 1.125% Warrants transactions, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants transactions, we issued 13,490,236 warrants with strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

The 1.125% Call Option, which is indexed to our common stock, is a derivative asset that requires mark-to-market accounting treatment due to the cash settlement features until such transactions settle or expire. The 1.125% Call Option is measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the 1.125% Call Option, refer to Note 5, “Fair Value Measurements.”

The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the 1.125% Warrants. The 1.125% Warrants are recorded as a derivative liability requiring mark-to-market accounting treatment due to certain terms in the warrant agreements that prevent such instruments being considered to be indexed in our common stock. The 1.125% Warrants are measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the 1.125% Warrants, refer to Note 5, “Fair Value Measurements.”

1.125% Notes Embedded Cash Conversion Option

The embedded cash conversion option within the 1.125% Notes is required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). The embedded cash conversion option is measured and reported at fair value on a recurring basis, within Level 3 of the fair value hierarchy. For further discussion of the inputs used to determine the fair value of the embedded cash conversion option, refer to Note 5, “Fair Value Measurements.”

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement (Swap), with an effective date of March 1, 2013. The Swap is intended to reduce our exposure to fluctuations in the contractual variable interest rates under our Term Loan Agreement, and expires on the maturity date of the Term Loan Agreement, which is November 30, 2018. Since its inception, the Swap has not been designated as a hedge. Under the Swap, we will receive a variable rate of the one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. The Swap is measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. We believe that we are not exposed to more than a nominal amount of credit risk relating to the Swap because the counterparty is an established and well-capitalized financial institution.

12. Stockholders’ Equity

Securities Repurchases and Repurchase Program. In connection with the issuance and settlement of the 1.125% Notes, we used a portion of the net proceeds from the offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date. As of March 31, 2013, additional paid-in capital decreased primarily due to this repurchase.

Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or the 3.75% Notes, in addition to the $50.0 million repurchase discussed above. The repurchase program extends through December 31, 2014.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Plans. In connection with the plans described in Note 4, "Stock-Based Compensation," we issued approximately 279,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the three months ended March 31, 2013.

13. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans and also includes our direct delivery business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to state Medicaid agencies.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

	Three Months Ended March 31,	
	2013	2012
	(In thousands)	
Revenue:		
Health Plans:		
Premium revenue	$ 1,534,608	$ 1,325,406
Investment income	1,529	1,717
Rental and other income	4,694	4,259
Molina Medicaid Solutions:		
Service revenue	49,756	42,205
	$ 1,590,587	$ 1,373,587
Depreciation and amortization:		
Health Plans	$ 15,238	$ 13,743
Molina Medicaid Solutions	6,561	4,596
	$ 21,799	$ 18,339
Operating Income:		
Health Plans	$ 60,738	$ 25,011
Molina Medicaid Solutions	6,353	8,409
Total operating income	67,091	33,420
Interest expense	(13,037)	(4,298)
Other income	131	—
Income before income taxes	$ 54,185	$ 29,122

	March 31, 2013	December 31, 2012
	(In thousands)	
Goodwill and intangible assets, net:		
Health Plans	$ 136,874	$ 139,710
Molina Medicaid Solutions	87,078	89,089
	$ 223,952	$ 228,799
Total assets:		
Health Plans	$ 2,280,460	$ 1,702,212
Molina Medicaid Solutions	207,629	232,610
	$ 2,488,089	$ 1,934,822

14. Commitments and Contingencies

Leases

We lease administrative and clinic facilities, and certain equipment, under non-cancelable operating leases expiring on various dates through 2024. Facility lease terms generally range from five to ten years with one-to-two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

As described and defined in further detail in Note 15, "Related Party Transactions," we entered into a Lease for office space in February 2013 consisting of two office buildings under construction. Because of our involvement in the properties, we are treated as the in-substance owner of the properties. As such, we have recorded $16.1 million to construction in progress, included in property, equipment and capitalized software, net, in the accompanying consolidated balance sheet as of March 31, 2013. This amount represents costs, including construction costs, incurred to date by the Landlord on the properties. We have recorded a corresponding financing obligation of $16.1 million to long-term debt, and will capitalize construction costs as incurred, including imputed interest, until the properties are available for occupancy. In addition to the capitalization of the costs incurred by the Landlord, we have imputed and recorded rent expense relating to the ground leases for the property sites. Such rent expense is computed based on the fair value of the land and our incremental borrowing rate, and was immaterial for the three months ended March 31, 2013.

As of March 31, 2013, our expectation is that Building A will be available for occupancy in June 2013, and Building B will be available for occupancy in November 2014. At the time of occupancy for each property, we will evaluate the accounting guidance applicable to sale-leasebacks of real estate to determine our continuing involvement in the properties, and whether we can remove the assets from our balance sheet.

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $572.9 million at March 31, 2013, and $549.7 million at December 31, 2012. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $450.5 million and $46.9 million as of March 31, 2013, and December 31, 2012, respectively.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of March 31, 2013, our health plans had aggregate statutory capital and surplus of approximately $585.5 million compared with the required minimum aggregate statutory capital and surplus of approximately $341.7 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2013. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

As described in Note 2, "Significant Accounting Policies," the ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year. If the fee assessment is enacted as written, our minimum capitalization requirements will increase significantly on January 1, 2014; we are currently evaluating the impact of the fee assessment to our financial position, results of operations and cash flows.

15. Related Party Transactions

Lease

On February 27, 2013, we entered into a lease (the Lease) with 6th & Pine Development, LLC (the Landlord) for office space located in Long Beach, California. The Lease consists of two office buildings under construction, including a building which comprises approximately 70,000 square feet of office space (Building A); and a building which is expected to comprise approximately 120,000 square feet of office space (Building B).

The term of the Lease with respect to Building A is expected to commence on June 1, 2013, and the term of the Lease with respect to Building B is expected to commence on November 1, 2014. The initial term of the Lease with respect to both buildings expires on December 31, 2024, subject to two options to extend the term for a period of five years each. Initial annual rent for Building A is expected to be approximately $2.5 million, and initial annual rent for Building B is expected to be approximately $4.0 million. Rent will increase 3.75% per year through the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

The principal members of the Landlord are John C. Molina, our chief financial officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of

common stock in the Company he holds as trustee. Dr. J. Mario Molina, our chief executive officer and chairman of the board of directors, holds a partial interest in such shares as trust beneficiary.

Medical Services

We have an equity investment in a medical service provider that provides certain vision services to our members; we account for this investment under the equity method of accounting. For the three months ended March 31, 2013 and 2012, we paid $7.7 million, and $6.6 million, respectively, for medical service fees to this provider.

16. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) were created in 2012 to further advance our direct delivery business. JMMPC's sole shareholder is Dr. J. Mario Molina, our Chairman of the Board, President and Chief Executive Officer. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. JMMPC provides outpatient professional medical services to the general public for routine non-life threatening, outpatient health care needs. Substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities.

Our wholly owned subsidiary, American Family Care, Inc. (AFC), has entered into services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC. The services agreements were designed such that JMMPC will not operate at a loss, ensuring the availability of quality care and access for our health plan members. The services agreements provide that the administrative fees charged to JMMPC by AFC are reviewed annually to assure the achievement of this goal.

Our California, Florida, New Mexico and Washington health plans have entered into primary care capitation agreements with JMMPC. These agreements also direct our health plans to fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, based on a monthly reconciliation. Because the AFC services agreements described above mitigate the likelihood of significant operating deficits or surpluses, such monthly reconciliation amounts are insignificant. There were no amounts recorded under this reconciliation arrangement for the three months ended March 31, 2013 and March 31, 2012.

We have determined that JMMPC is a variable interest entity, or VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to GAAP. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of March 31, 2013, JMMPC had total assets of $1.3 million, comprising primarily cash and equivalents, and total liabilities of $1.1 million, comprising primarily accrued payroll and employee benefits.

Our maximum exposure to loss as a result of our involvement with JMMPC is equal to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future. We provided an initial cash infusion of $0.3 million to JMMPC in the first quarter of 2012 to fund its start-up operations.

New Markets Tax Credit

During the fourth quarter of 2011 our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC, or Wells Fargo, its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC, or Investment Fund, and certain of Wells Fargo's affiliated Community Development Entities, or CDEs, in connection with our participation in the federal government's New Markets Tax Credit Program, or NMTC. The NMTC was established by Congress in 2000 to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In the fourth quarter of 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $5.9 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $15.5 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $20.9 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $5.9 million. Additionally, financing costs incurred in structuring the arrangement amounting to $1.2 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE-collecting and remitting interest and fees and NMTC compliance-were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $5.9 million is included in cash at December 31, 2012 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- uncertainties associated with the implementation of the Affordable Care Act, including the impact of the health insurance industry excise tax, the expansion of Medicaid eligibility in participating states to previously uninsured populations unfamiliar with managed care, the implementation of state insurance exchanges currently expected to become operational by October 1, 2013, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures, including the duals demonstration programs in California, Illinois, Ohio, Michigan, Texas, and Washington;
- the success of our medical cost containment initiatives in Texas, and other risks associated with the expansion of our Texas health plan's service areas in 2012;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations and our accruals for incurred but not reported medical costs;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to increase our revenues consistent with our expectations;
- accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and the development of actuarially sound rates with respect to such new enrollees, including duals;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- government audits and reviews, and any enrollment freeze or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, including our pending litigation against the state of California related to rates paid to our California plan in earlier years that were not actuarially sound;
- restrictions and covenants in any future credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of adequate financing to fund and capitalize our expansion and growth activities and to meet our liquidity needs, including the interest expense and other costs associated with such financing;

- a state's failure to renew its federal Medicaid waiver;
- inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2012, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management’s Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2012.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of March 31, 2013, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico, and Washington.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in retaining their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services effective March 1, 2012.

On February 14, 2013, we announced that the Florida Agency for Health Care Administration awarded our Florida health plan contracts in three regions under the Statewide Medicaid Managed Care Long-Term Care program. As a result of the awards, we will now enter into a comprehensive pre-contracting assessment, with the program currently scheduled to commence on December 1, 2013. Under the program, we will provide long-term care benefits, including institutional and home and community-based services.

On February 11, 2013, we announced that our New Mexico health plan was selected by the New Mexico Human Services Department, or HSD, to participate in the new Centennial Care program. In addition to continuing to provide physical and acute health care services, under the new program our New Mexico health plan will expand its services to provide behavioral health and long-term care services. The selection of our New Mexico health plan was made by HSD pursuant to its request for proposals issued in August 2012. The operational start date for the program is currently scheduled for January 2014.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid Management Information System (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana cancelled its contract award to CNSI. CNSI is currently challenging the contract cancellation. The state has informed us that we will continue to perform under our current contract until a successor is named. Subject to the pending challenge, it is currently uncertain whether a new RFP will be issued, and if so, when it will be issued. At such time as a new RFP may be issued, we intend to respond to the state's RFP. For the three months ended March 31, 2013, our revenue under the Louisiana MMIS contract was approximately $10.1 million, or 20.3% of total service revenue. So long as our Louisiana MMIS contract continues, we expect to recognize approximately $40 million of service revenue annually under this contract.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the three months ended March 31, 2013, we received approximately 96% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the three months ended March 31, 2013, we recognized approximately 4% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $70 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $260 in Ohio. Among our ABD membership, PMPM premiums range from approximately $400 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums in the aggregate, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	March 31, 2013	December 31, 2012	March 31, 2012
Total Ending Membership by Health Plan:			
California	332,000	336,000	351,000
Florida	75,000	73,000	69,000
Michigan	217,000	220,000	222,000
Missouri (1)	—	—	81,000
New Mexico	91,000	91,000	89,000
Ohio	242,000	244,000	249,000
Texas	274,000	282,000	280,000
Utah	87,000	87,000	86,000
Washington	416,000	418,000	356,000
Wisconsin	86,000	46,000	42,000
Total	1,820,000	1,797,000	1,825,000
Total Ending Membership for our Medicare Advantage Plans:			
California	7,700	7,700	6,900
Florida	600	900	800
Michigan	9,200	9,700	8,500
New Mexico	900	900	900
Ohio	300	300	200
Texas	1,900	1,500	800
Utah	7,600	8,200	8,100
Washington	6,100	6,500	5,200
Total	34,300	35,700	31,400
Total Ending Membership for our Aged, Blind or Disabled Population:			
California	44,600	44,700	37,300
Florida	10,400	10,300	10,500
Michigan	44,000	41,900	38,800
New Mexico	5,800	5,700	5,600
Ohio	28,200	28,200	29,700
Texas	94,200	95,900	109,000
Utah	9,200	9,000	8,700
Washington	31,300	30,000	4,700
Wisconsin	1,600	1,700	1,700
Total	269,300	267,400	246,000

(1) Our contract with the state of Missouri expired without renewal on June 30, 2012.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $33.9 million, and $32.1 million, for the three months ended March 31, 2013 and 2012, respectively, as well as certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

First Quarter Financial Performance Summary

The following table and narrative briefly summarize our financial and operating performance for the three months ended March 31, 2013 and 2012. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended March 31,	
	2013	2012
	(Dollar amounts in thousands, except per share data)	
Net income per diluted share	$ 0.64	$ 0.39
Premium revenue	$ 1,534,608	$ 1,325,406
Service revenue	$ 49,756	$ 42,205
Operating income	$ 67,091	$ 33,420
Net income	$ 29,915	$ 18,089
Total ending membership	1,820,000	1,825,000
Premium revenue	96.5%	96.5%
Service revenue	3.1%	3.1%
Investment income	0.1%	0.1%
Rental and other income	0.3%	0.3%
Total revenue	100.0%	100.0%
Medical care ratio	86.1%	88.1%
General and administrative expense ratio	8.9%	8.8%
Premium tax ratio	2.4%	3.2%
Operating income	4.2%	2.4%
Net income	1.9%	1.3%
Effective tax rate	44.8%	37.9%

Earnings before Interest, Taxes, Depreciation and Amortization (EBITDA)

We calculate a non-GAAP measure, EBITDA, which management uses as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry. The reconciliation of this non-GAAP to GAAP financial measure is as follows (GAAP stands for U.S. generally accepted accounting principles):

	Three Months Ended March 31,	
	2013	2012
	(In thousands)	
Net income	$ 29,915	$ 18,089
Add back:		
Depreciation and amortization reported in the consolidated statements of cash flows	21,799	18,339
Interest expense	13,037	4,298
Income tax expense	24,270	11,033
EBITDA (1)	$ 89,021	$ 51,759

(1) EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities; nor should EBITDA be considered in isolation from these GAAP measures of operating performance.

First Quarter 2013 Overview

For the first quarter of 2013, net income was $29.9 million, or $0.64 per diluted share, compared with net income of $18.1 million, or $0.39 per diluted share, for the first quarter of 2012.

Our financial performance in the first quarter of 2013 improved substantially over the first quarter of 2012. Among the key developments affecting first quarter 2013 performance were the following:

- The recognition of approximately $21 million of premium rate changes at the California health plan. Approximately $19 million of the premium revenue related to 2012 and 2011. Net of related expenses, the rate increases resulted in an increase of approximately $19 million to pretax income; $18 million (approximately $0.24 per diluted share) of which related to 2012 and 2011. The adjustment to premium rates resulted from the receipt of new rate sheets from the state of California that restored the rates that had existed prior to the cuts that had been taken effective July 1, 2011, and a modest increase to rates for our ABD membership retroactive to July 1, 2011. The new premium rates are expected to increase premium revenue at the California health plan going forward by approximately $400,000 per month;
- The recognition of approximately $6 million (approximately $0.08 per diluted share) of performance revenue at the Texas health plan related to 2012. The Texas health plan recently received notice from the Texas Department of Health and Human Services that a specific measure is being removed from the calculation of performance revenue for all contracted health plans for 2012. As of December 31, 2012, the Texas health plan had not recognized approximately $6 million of revenue related to this performance measure;
- Flat inpatient utilization compared to the first quarter of 2012;
- Improved performance at the Florida, Texas, Ohio and Wisconsin health plans; and
- The immediate recognition in interest expense of approximately $6 million (approximately $0.08 per diluted share) of debt issuance fees related to our issuance of $550 million of 1.125% cash convertible senior notes (the 1.125% Notes) in February 2013. The remainder of the fees associated with that issuance will be expensed over the seven-year life of the 1.125% Notes.

Results of Operations

Three Months Ended March 31, 2013 Compared with the Three Months Ended March 31, 2012

Health Plans Segment

Premium Revenue

Premium revenue for the first quarter of 2013 increased 16% (or 17%, net of premium taxes) over the first quarter of 2012, primarily due to a shift in member mix to populations generating higher premium revenue per member per month (PMPM). Medicare premium revenue was $118.4 million for the first quarter of 2013 compared with $109.8 million for the first quarter of 2012.

Growth in our ABD membership in Washington and California led to higher premium revenue PMPM in 2013. ABD membership, as a percent of total membership, has increased approximately 10% year over year. Premium revenue PMPM also increased in the first quarter of 2013 as a result of the inclusion of revenue for pharmacy benefits for the Utah health plan effective January 1, 2013, and as a result of the inclusion of revenue for inpatient facility and pharmacy benefits across all of the Texas health plan's membership effective March 1, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended March 31,					
	2013			2012		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 867,648	$ 160.18	67.3%	$ 777,267	$ 148.81	68.7%
Pharmacy	231,838	42.80	18.0%	173,237	33.17	15.3%
Capitation	140,324	25.91	10.9%	136,038	26.04	12.0%
Other	48,944	9.04	3.8%	44,446	8.51	4.0%
Total	$ 1,288,754	$ 237.93	100.0%	$ 1,130,988	$ 216.53	100.0%

Medical care costs increased in the first quarter of 2013 primarily due to the same shifts in member mix and the benefit expansions that led to increased premium revenue, particularly in California, Texas and Washington. Our consolidated medical care ratio, however, decreased to 86.1% in the first quarter of 2013, from 88.1% in the first quarter of 2012. Retroactive rate increases for the California health plan and increased margins at the Texas health plan were the primary drivers of the lower medical care ratio in the first quarter of 2013. Stable inpatient utilization and lower pharmacy unit costs also contributed to the lower medical care ratio in the first quarter of 2013.

Individual Health Plan Analysis

The medical care ratio at the California health plan decreased to 85.1% in the first quarter of 2013 from 88.7% in the first quarter of 2012. The lower medical care ratio was primarily the result of the recognition of retroactive premium rate changes that contributed approximately $19 million to pretax income for the first quarter of 2013, of which approximately $18 million (after related expenses) related to 2012 and 2011.

The medical care ratio of the Florida health plan decreased to 84.9% in the first quarter of 2013, from 88.2% in the first quarter of 2012 due to improved hospital provider contracts, inpatient utilization reductions and lower pharmacy costs.

The medical care ratio of the Michigan health plan increased to 88.1% in the first quarter of 2013, from 84.0% in the first quarter of 2012, primarily as a result of higher pharmacy and fee-for-service costs.

The medical care ratio of the New Mexico health plan increased to 85.9% in the first quarter of 2013, from 84.7% in the first quarter of 2012, primarily as a result of higher pharmacy and fee-for-service costs.

The medical care ratio of the Ohio health plan decreased to 84.6% for the first quarter of 2013, from 87.4% for the first quarter of 2012, primarily as a result of a 4% premium rate increase effective January 1, 2013.

The medical care ratio of the Texas health plan was 80.9% in the first quarter of 2013 compared with 92.3% in the first quarter of 2012. We previously reported on the financial challenges faced by the Texas health plan. Although first quarter results show considerable improvement over the results reported for the first quarter of 2012, management cautions investors regarding the following points:

- The first quarters of 2013 and 2012 are not meaningfully comparable. The state of Texas expanded Medicaid managed care into new regions effective March 1, 2012. Additionally, the state extended inpatient facility and pharmacy benefits into Medicaid managed care on that date. The result of these actions was to dramatically increase the Texas health plan's revenue and medical costs between the first quarter of 2012 and 2013.

- The Texas health plan received a 4% rate increase (adding about $4 million to monthly revenue) effective September 1, 2012.

- Certain out-of-period adjustments artificially lowered the medical care ratio for the Texas health plan in the first quarter of 2013. Absent the previously described $6 million out-of-period benefit related to 2012 performance revenue, and a $13.5 million benefit from favorable development of the claims liability established for the health plan at December 31, 2012, the Texas health plan's medical care ratio for the first quarter of 2013 would have been approximately 86.6% rather than the reported medical care ratio of 80.9%.

- While management continues to work to improve the financial performance of the Texas health plan, management also believes that increased payments to certain providers are necessary. Specifically, the health plan intends to increase provider reimbursement for personal attendant services and day activity and health services effective July 1, 2013. We anticipate that this increase in provider payments alone will add approximately $10 million to medical expense in the second half of 2013.

The medical care ratio of the Utah health plan increased to 86.8% in the first quarter of 2013, from 77.0% in the first quarter of 2012 primarily due to a Medicaid premium rate reduction of approximately 16% (exclusive of the pharmacy benefit added) effective January 1, 2013.

The medical care ratio of the Washington health plan increased to 87.6% in the first quarter of 2013, compared with 85.7% in the first quarter of 2012 primarily due to the addition of ABD members effective July 1, 2012. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio, so that the excess of premium revenue over medical care costs increased to $42.3 million for the first quarter of 2013, compared with $34.2 million for the first quarter of 2012.

The medical care ratio of the Wisconsin health plan decreased to 87.2% in the first quarter of 2013, compared with 98.5% in the first quarter of 2012. The Wisconsin health plan has implemented provider contracting initiatives and new utilization management techniques as a part of its efforts to improve profitability, including in-sourcing the management of behavioral health services. The health plan received a 3% premium rate increase effective January 1, 2013. Additionally, the health plan gained 40,000 members in February and March due to another health plan's recent exit from the market. We are closely monitoring the utilization patterns and loss reserves for these new members.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended March 31, 2013						
		Premium Revenue		Medical Care Costs			
	Member Months (1)	Total	PMPM	Total	PMPM	Premium Tax Expense	MCR (2)
California	1,001	$ 187,880	$ 187.64	$ 159,763	$ 159.56	$ 92	85.1%
Florida	223	58,167	260.15	49,404	220.95	3	84.9
Michigan	652	167,676	257.24	146,748	225.13	1,119	88.1
New Mexico	274	85,798	313.54	72,149	263.66	1,798	85.9
Ohio	726	291,518	401.73	227,454	313.45	22,710	84.6
Texas	832	335,296	402.99	266,449	320.24	5,845	80.9
Utah	259	74,956	289.59	65,029	251.24	—	86.8
Washington	1,250	303,719	243.05	261,397	209.18	5,433	87.6
Wisconsin	200	27,124	135.53	23,664	118.24	—	87.2
Other (3) (4)	—	2,474	—	16,697	—	—	—
	5,417	$ 1,534,608	$ 283.32	$ 1,288,754	$ 237.93	$ 37,000	86.1%

	Three Months Ended March 31, 2012						
		Premium Revenue		Medical Care Costs			
	Member Months (1)	Total	PMPM	Total	PMPM	Premium Tax Expense	MCR (2)
California	1,059	$ 161,685	$ 152.65	$ 141,349	$ 133.45	$ 2,309	88.7%
Florida	208	56,190	269.87	49,569	238.07	7	88.2
Michigan	665	167,906	252.49	134,211	201.82	8,040	84.0
Missouri (4)	243	56,613	233.32	53,120	218.93	—	93.8
New Mexico	266	81,226	305.63	67,111	252.52	1,953	84.7
Ohio	746	293,525	393.73	236,701	317.51	22,853	87.4
Texas	592	198,236	334.61	180,089	303.97	3,197	92.3
Utah	252	75,138	297.59	57,881	229.24	—	77.0
Washington	1,067	215,610	202.08	181,425	170.04	3,816	85.7
Wisconsin	125	17,142	136.97	16,886	134.92	—	98.5
Other (3)	—	2,135	—	12,646	—	11	—
	5,223	$ 1,325,406	$ 253.75	$ 1,130,988	$ 216.53	$ 42,186	88.1%

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) The MCR represents medical costs as a percentage of premium revenues, where premium revenue is reduced by premium tax expense.
(3) "Other" medical care costs also include medically related administrative costs at the parent company.
(4) Our contract with the state of Missouri expired without renewal on June 30, 2012. The Missouri health plan's claims run-out activity subsequent to June 30, 2012, is reported in "Other."

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended March 31,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$ 50,485	$ 42,358
Amortization recorded as reduction of service revenue	(729)	(153)
Service revenue	49,756	42,205
Cost of service revenue	39,770	30,494
General and administrative costs	2,351	2,020
Amortization of customer relationship intangibles recorded as amortization	1,282	1,282
Operating income	$ 6,353	$ 8,409

Operating income for our Molina Medicaid Solutions segment decreased $2.1 million for the three months ended March 31, 2013, compared with the same prior year period. The decrease in operating income was primarily the result of a change in the mix of transactions processed from fee-for-service claims to managed care encounters (processing fees are lower for encounters than for fee-for-service claims) and changes to state contracts implemented during 2012.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 8.9% of total revenue for the three months ended March 31, 2013, compared with 8.8% of total revenue for the three months ended March 31, 2012. The increased ratio of general and administrative expenses to total revenue for the three months ended March 31, 2013, was primarily due to continuing investments in administrative infrastructure in anticipation of opportunities among the dual-eligible population.

Premium Tax Expense

Premium tax expense decreased to 2.4% of premium revenue for the three months ended March 31, 2013, from 3.2% in the three months ended March 31, 2012. The decrease in 2013 was primarily due to the reduction of premium taxes at the Michigan and California health plans effective in 2012.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in “Depreciation and Amortization” in the consolidated statements of income. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading “Depreciation and Amortization;”
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of “Service Revenue;” and
- Amortization of capitalized software is recorded within the heading “Cost of Service Revenue.”

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended March 31,			
	2013		2012	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 12,447	0.8%	$ 9,472	0.7%
Amortization of intangible assets	4,118	0.3	5,553	0.4
Depreciation and amortization reported as such in the consolidated statements of income	16,565	1.1	15,025	1.1
Amortization recorded as reduction of service revenue	729	—	153	—
Amortization of capitalized software recorded as cost of service revenue	4,505	0.3	3,161	0.2
Total	$ 21,799	1.4%	$ 18,339	1.3%

Other Expenses (Income)

Interest expense increased to $13.0 million for the three months ended March 31, 2013, from $4.3 million for the three months ended March 31, 2012, primarily due to the issuance of the 1.125% Notes in February 2013. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $3.7 million and $1.4 million for the three months ended March 31, 2013, and 2012, respectively. Interest expense in 2013 also included the immediate recognition of approximately $6 million of interest expense relating to debt issuance costs. The remainder of the fees associated with that issuance, amounting to approximately $12 million, will be expensed over the seven-year life of the 1.125% Notes.

Income Taxes

The provision for income taxes is recorded at an effective rate of 44.8% for the three months ended March 31, 2013 compared with 37.9% for the three months ended March 31, 2012. The higher rate in 2013 is primarily due to the impact of non-deductible compensation under a provision of the Affordable Care Act that limits deductions claimed by health insurers on compensation earned after December 31, 2009 that is paid after December 31, 2012.

Other Transactions

As described above, our Missouri health plan, Alliance for Community Health, L.L.C. (ACH), was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state (the MC+ Contract) expired without renewal on June 30, 2012, subject to certain transition obligations which terminate on June 30, 2013. On April 5, 2013, ACH entered into an assignment and assumption agreement with an affiliated company, Molina Healthcare of Illinois, Inc., another one of our wholly owned subsidiaries (Molina Illinois), pursuant to which ACH assigned to Molina Illinois substantially all of its assets and liabilities, including its surviving rights, duties and obligations, including all of the post-expiration duties and services under the MC+ Contract. Such assignment was approved by the Missouri Department of Insurance, Financial Institutions and Professional Registration, and the Illinois Department of Insurance. The state of Missouri's Medicaid agency also consented to the assignment. Subsequent to the effectiveness of the assignment and assumption agreement, ACH surrendered its Missouri certificate of authority as a health maintenance organization. We intend to abandon our equity interests in ACH to an unrelated entity. Pursuant to such transaction, ACH will retain certain assets and investments to which we will no longer have access after the abandonment transaction is effected, and which amounts we intend to write off.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of March 31, 2013, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income was $1.5 million for the three months ended March 31, 2013, compared with $1.7 million for the three months ended March 31, 2012. Our annualized portfolio yield for the three months ended March 31, 2013 was 0.4% compared with 0.6% for the three months ended March 31, 2012.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Liquidity

Cash provided by operating activities for the three months ended March 31, 2013 was $20.1 million compared with $50.6 million for the three months ended March 31, 2012, a decrease of $30.5 million. The decrease in cash provided by operating activities was primarily due to the changes in deferred revenue and medical claims and benefits payable, partially offset by the change in accounts receivable. Deferred revenue and medical claims and benefits payable were a use of operating cash amounting to $9.4 million in the aggregate in the three months ended March 31, 2013, compared with a source of operating cash of $97.9 million in the aggregate in the same period in 2012. Accounts receivable was a use of operating cash amounting to $0.6 million in the three months ended March 31, 2013, compared with $54.4 million in the same period in 2012.

Cash used in investing activities for the three months ended March 31, 2013 was $21.2 million compared with $42.7 million for the three months ended March 31, 2012, a decrease of $21.5 million. This decrease was primarily due to reduced purchases of investments in 2013.

Cash provided by financing activities for the three months ended March 31, 2013 was $374.8 million compared with $16.0 million for the three months ended March 31, 2012, an increase of $358.8 million. The significant increase was primarily due to $538.0 million in proceeds we received from our offering of 1.125% Notes and $75.1 million from the sale of warrants, partially offset by $149.3 million paid for the purchased call option relating to the 1.125% Notes, $50.0 million paid for repurchases of our common stock, and $40.0 million used to repay our Credit Facility.

Financial Condition

On a consolidated basis, at March 31, 2013, we had working capital of $924.0 million compared with $521.1 million at December 31, 2012. At March 31, 2013, and December 31, 2012, we had cash and investments, including restricted investments, of $1,580.2 million, and $1,196.1 million, respectively. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each

state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $572.9 million at March 31, 2013, and $549.7 million at December 31, 2012. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $450.5 million and $46.9 million as of March 31, 2013, and December 31, 2012, respectively.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of March 31, 2013, our health plans had aggregate statutory capital and surplus of approximately $585.5 million compared with the required minimum aggregate statutory capital and surplus of approximately $341.7 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2013. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

As described in Note 2 to the accompanying Notes to the Consolidated Financial Statements, the ACA imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The fee will be imposed beginning in 2014 based on a company's share of the industry's net premiums written during the preceding calendar year. If the fee assessment is enacted as written, our minimum capitalization requirements will increase significantly on January 1, 2014; we are currently evaluating the impact of the fee assessment to our financial position, results of operations and cash flows.

Future Sources and Uses of Liquidity

As of March 31, 2013, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2013	2014	2015	2016	2017	Thereafter
1.125% Notes	$ 550,000	$ —	$ —	$ —	$ —	$ —	$ 550,000
3.75% Notes	187,000	—	187,000	—	—	—	—
Term loan	47,179	863	1,206	1,259	1,309	1,372	41,170
	$ 784,179	$ 863	$ 188,206	$ 1,259	$ 1,309	$ 1,372	$ 591,170

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we settled the issuance of $550.0 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020 (the 1.125% Notes). This transaction included the initial issuance of $450.0 million on February 11, 2013, plus the exercise of the full amount of the $100.0 million over-allotment option on February 13, 2013. The aggregate net proceeds of the 1.125% Notes were $458.9 million, after payment of the net cost of the Call Spread Overlay described below. Additionally, we used $50.0 million of the net proceeds to purchase shares of our common stock, and $40.0 million to repay principal and accrued interest owed under our Credit Facility.

Interest on the 1.125% Notes is payable semiannually in arrears on January 15 and July 15 of each year, at a rate of 1.125% per annum commencing on July 15, 2013. The 1.125% Notes will mature on January 15, 2020 unless repurchased or converted in accordance with their terms prior to such date.

The 1.125% Notes are convertible only into cash, and not into shares of our common stock or any other securities. Holders may convert their 1.125% Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive

trading day period in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.125% Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of 1.125% Notes, equal to the settlement amount, determined in the manner set forth in the Indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of 1.125% Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its 1.125% Notes in connection with such a corporate event in certain circumstances. We may not redeem the 1.125% Notes prior to the maturity date, and no sinking fund is provided for the 1.125% Notes.

If we undergo a fundamental change (as defined in the indenture to the 1.125% Notes), holders may require us to repurchase for cash all or part of their 1.125% Notes at a repurchase price equal to 100% of the principal amount of the 1.125% Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The 1.125% Notes are senior unsecured obligations, and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

The 1.125% Notes contain an embedded cash conversion option. We have determined that the embedded cash conversion option is a derivative financial instrument, required to be separated from the 1.125% Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of income until the cash conversion option transaction settles or expires. The initial fair value liability of the embedded cash conversion option was $149.3 million, which simultaneously reduced the carrying value of the 1.125% Notes (effectively an original issuance discount). As of March 31, 2013, the fair value of embedded cash conversion option derivative liability was $147.3 million.

As noted above, the reduced carrying value on the 1.125% Notes resulted in a debt discount that is amortized to the 1.125% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms had been issued. The effective interest rate of the 1.125% Notes is 5.9% which is imputed based on the amortization of the fair value of the embedded cash conversion option over the remaining term of the 1.125% Notes. As of March 31, 2013, we expect the 1.125% Notes to be outstanding until their January 15, 2020 maturity date, for a remaining amortization period of 6.8 years.

Also in connection with the settlement of the 1.125% Notes, we paid approximately $16.9 million in transaction costs. Such costs have been allocated to the 1.125% Notes, the 1.125% Call Option (defined below), and the 1.125% Warrants (defined below) according to their relative fair values. The amount allocated to the 1.125% Notes, or $12.0 million, was capitalized and will be amortized over the term of the 1.125% Notes. The aggregate amount allocated to the 1.125% Call Option and 1.125% Warrants, or $4.9 million, was recorded to interest expense in the quarter ended March 31, 2013.

1.125% Notes Call Spread Overlay

Concurrent with the issuance of the 1.125% Notes, we entered into privately negotiated hedge transactions (collectively, the 1.125% Call Option) and warrant transactions (collectively, the 1.125% Warrants), with certain of the initial purchasers of the 1.125% Notes. These transactions represent a Call Spread Overlay, whereby the cost of the 1.125% Call Option we purchased to cover the cash outlay upon conversion of the 1.125% Notes was reduced by the sales price of the 1.125% Warrants. Assuming full performance by the counterparties (and 1.125% Warrants strike prices in excess of the conversion price of the 1.125% Notes), these transactions are intended to offset cash payments due upon any conversion of the 1.125% Notes. We used $149.3 million of the proceeds from the settlement of the 1.125% Notes to pay for the 1.125% Call Option, and simultaneously received $75.1 million for the sale of the 1.125% Warrants, for a net cash outlay of $74.2 million for the Call

Spread Overlay. The 1.125% Call Option and 1.125% Warrants are derivative financial instruments; refer to Note 11 of the accompanying Notes to Consolidated Financial Statements for further discussion.

Aside from the initial payment of a premium to the counterparties of $149.3 million for the 1.125% Call Option, we will not be required to make any cash payments to the counterparties under the 1.125% Call Option, and will be entitled to receive from the counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the 1.125% Call Options during the relevant valuation period. The strike price under the 1.125% Call Option is initially equal to the conversion price of the 1.125% Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period under the 1.125% Warrants, we will be obligated to issue to the counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants transactions and the additional 1.125% Warrants transactions, subject to a share delivery cap. We will not receive any additional proceeds if the 1.125% Warrants are exercised. Pursuant to the 1.125% Warrants transactions, we issued 13,490,236 warrants with strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. On April 22, 2013, in order to clarify certain accounting matters with respect to the 1.125% Warrants, we entered into amended and restated warrant confirmations with JPMorgan Chase Bank and Bank of America, copies of which are filed as Exhibits 10.1 through 10.4 to this Quarterly Report.

3.75% Convertible Senior Notes due 2014

We had $187.0 million of 3.75% Convertible Senior Notes due 2014 (the 3.75% Notes) outstanding as of March 31, 2013 and December 31, 2012, respectively. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Because the 3.75% Notes have cash settlement features, accounting guidance required us to allocate the proceeds from their issuance between a liability component and an equity component. The reduced carrying value on the 3.75% Notes resulted in a debt discount that is amortized back to the 3.75% Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 3.75% Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms had been issued. The effective interest rate of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. As of March 31, 2013, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 18 months. The 3.75% Notes' if-converted value did not exceed their principal amount as of March 31, 2013. At March 31, 2013, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million.

Term Loan

In December 2011, our wholly owned subsidiary, Molina Center LLC, entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the Administrative Agent) to borrow $48.6 million to finance a portion of the purchase price for the Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below). The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. Interest Period means the period commencing on the first day of each calendar month and ending on the last day of each calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Credit Facility

On February 15, 2013, we used approximately $40.0 million of the net proceeds from the offering of the 1.125% Notes to repay all of the outstanding indebtedness under our $170 million revolving Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the 1.125% Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution.

Shelf Registration Statement

In the second quarter of 2012, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the registration, issuance, and sale of an indeterminate amount of our securities, including common stock, preferred stock, senior or subordinated debt securities, or warrants. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Securities Repurchase Program

Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in the aggregate of either our common stock or our 3.75% Notes, in addition to the $50.0 million of our common stock that we repurchased on February 12, 2013. The repurchase program extends through December 31, 2014.

Contractual Obligations

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2012, was disclosed in our 2012 Form 10-K. Other than the transactions relating to our February 2013 offering of the 1.125% Notes, there were no material changes to this previously filed information outside the ordinary course of business during the three months ended March 31, 2013. For further discussion and maturities of our long-term debt, see Note 10 of Notes to the Consolidated Financial Statements.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

(1) ***Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract:*** These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates), our revenue earned for those periods will

also change. In all of these instances, our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn would lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of $0.3 million at both March 31, 2013, and December 31, 2012.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both March 31, 2013, and December 31, 2012, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. At both March 31, 2013, and December 31, 2012, we had not recorded any liability under the terms of these contract provisions.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $3.1 million and $3.2 million pursuant to our profit-sharing agreement with the state of Texas at March 31, 2013, and December 31, 2012, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of approximately $1.0 million at March 31, 2013. At December 31, 2012, we had not recorded any liability under the terms of this contract provision since medical expenses were not less than the contractual floor.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net payable of approximately $0.2 million as of March 31, 2013 and a net receivable of approximately $0.3 million as of December 31, 2012 for anticipated Medicare risk adjustment premiums.

(2) Quality incentives that allow us to recognize incremental revenue if certain quality standards are met: These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, incremental revenue of up to 3.25% of total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2013 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2013.

	Three Months Ended March 31, 2013				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 585	$ 332	$ 108	$ 440	$ 85,798
Ohio	3,005	1,052	—	1,052	291,518
Texas	16,264	13,512	5,995	19,507	335,296
Wisconsin	761	—	609	609	27,124
	$ 20,615	$ 14,896	$ 6,712	$ 21,608	$ 739,736

	Three Months Ended March 31, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 555	$ 336	$ 28	$ 364	$ 81,226
Ohio	2,678	2,678	966	3,644	293,525
Texas	5,750	5,750	—	5,750	198,236
Wisconsin	416	—	—	—	17,142
	$ 9,399	$ 8,764	$ 994	$ 9,758	$ 590,129

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid Management Information System (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. While providing BPO services (which include claims payment and eligibility processing), we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs

to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	March 31, 2013	December 31, 2012	March 31, 2012
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 378,926	$ 377,614	$ 347,307
Capitation payable	45,048	49,066	37,289
Pharmacy	39,495	38,992	38,443
Other	27,676	28,858	32,794
	$ 491,145	$ 494,530	$ 455,833

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $378.9 million of our total medical claims and benefits payable of $491.1 million as of March 31, 2013. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at March 31, 2013, was $372.0 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of March 31, 2013 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding March 31, 2013, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 156,550
(4)%	104,366
(2)%	52,183
2%	(52,183)
4%	(104,366)
6%	(156,550)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of March 31, 2013 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ (76,431)
(4)%	(50,954)
(2)%	(25,477)
2%	25,477
4%	50,954
6%	76,431

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 46.4 million diluted shares outstanding for the three months ended March 31, 2013. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at March 31, 2013, net income for the three months ended March 31, 2013 would increase or decrease by approximately $16.3 million, or $0.35 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at March 31, 2013, net income for the three months ended March 31, 2013 would increase or decrease by approximately $8.0 million, or $0.17 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $81.5 million, or $1.76 per diluted share, and $39.8 million, or $0.86 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $16.3 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee

schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that our initial estimate of claims incurred but not paid (IBNP) is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range. For example, for the three months ended March 31, 2012, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2011 by 9.1%. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more factors are out of the ordinary.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2013 and 2012 were less than what we had expected when we had established our reserves. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

We recognized favorable prior period claims development in the amount of $58.4 million for the three months ended March 31, 2013. This amount represents our estimate as of March 31, 2013 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2012 was due primarily to the following factors:

- At our Texas health plan, we saw a reduction in STAR+PLUS (the state's program for aged and disabled members) membership during mid to late 2012. This caused a reduction in costs per member that we did not fully recognize in our December 31, 2012 reserve estimates.
- At our Washington health plan, prior to July 2012, certain high-cost newborns that were approved for SSI coverage by the state were retroactively dis-enrolled from our Healthy Options (TANF) coverage, and the health plan was reimbursed for the claims paid on behalf of these members. Starting July 1, 2012, these newborns, as well as other high-cost disabled members, are now covered by the health plan under the Health Options Blind and Disabled (HOBD) program. At the end of 2012, we did not have enough claims history to accurately estimate the claims liability of the HOBD members, and as a result the liability for these high-cost members was overstated.

- For our New Mexico health plan, we overestimated the impact of certain high-dollar outstanding claim payments as of December 31, 2012.

We recognized favorable prior period claims development in the amount of $36.6 million for the three months ended March 31, 2012. This amount represents our estimate as of December 31, 2012 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe the overestimation of our claims liability at December 31, 2011 was due primarily to the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

In estimating our claims liability at March 31, 2013, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- In our Texas health plan, although the reduction in STAR+PLUS membership has leveled off in 2013, we have seen a reduction in per member per month (PMPM) cost for outpatient services and an increase in PMPM costs for inpatient services over the past six to nine months. We have estimated the impact of these shifts in cost in our March 31, 2013 liability.
- Our Wisconsin health plan is experiencing significant membership increases, and is expected to approximately double in size during the first four months of 2013. This new membership is transitioning to our health plan from a terminated health plan. We enrolled approximately 40,000 new members in February and March 2013. We have computed a separate reserve analysis for these members and have noted that paid claims are less than what we would expect for newly transitioned members. Therefore, we have increased the reserves for this membership, in anticipation of higher claims costs later than usual for these members.
- Our Washington health plan began covering disabled members, including newborns, that were previously covered by the state under a separate state program. Coverage for this segment began in July of 2012, with gradual growth in membership. As of March 2013 the health plan covered approximately 28,000 members under this program. Because of the high costs for these members and the relative newness of the product category, there is still some uncertainty about the cost and reserve liability for these members as of March 31, 2013.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012 and for the three months ended March 31, 2013, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the replenishment of reserves in the respective periods generally offset the benefit from the prior period.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,		Year Ended December 31, 2012
	2013	2012	
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of period	$ 494,530	$ 402,476	$ 402,476
Components of medical care costs related to:			
Current period	1,347,181	1,167,580	5,136,055
Prior periods	(58,427)	(36,592)	(39,295)
Total medical care costs	1,288,754	1,130,988	5,096,760
Payments for medical care costs related to:			
Current period	916,426	750,994	4,649,363
Prior periods	375,713	326,637	355,343
Total paid	1,292,139	1,077,631	5,004,706
Balances at end of period	$ 491,145	$ 455,833	$ 494,530
Benefit from prior period as a percentage of:			
Balance at beginning of period	11.8%	9.1%	9.8%
Premium revenue	3.8%	2.8%	0.7%
Total medical care costs	4.5%	3.2%	0.8%
Claims Data:			
Days in claims payable, fee for service	38	44	40
Number of members at end of period	1,820,000	1,825,000	1,797,000
Number of claims in inventory at end of period	135,400	260,800	122,700
Billed charges of claims in inventory at end of period	$ 236,700	$ 403,800	$ 255,200
Claims in inventory per member at end of period	0.07	0.14	0.07
Billed charges of claims in inventory per member at end of period	$ 130.05	$ 221.26	$ 142.01
Number of claims received during the period	5,271,000	4,855,600	20,842,400
Billed charges of claims received during the period	$ 5,170,700	$ 4,337,000	$ 19,429,300

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

We are also exposed to interest rate risk relating to contractual variable interest rates under our Term Loan Agreement which matures on November 30, 2018. We manage this floating rate debt using an interest rate swap agreement that we expect will reduce our exposure to the impact of changing interest rates to our consolidated results of operations and future outflows for interest. The interest rate swap is not designated as a hedging instrument.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended March 31, 2013 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2012. The risk factors described herein and in our 2012 Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

There have been no material changes to the risk factors disclosed in our 2012 Form 10-K.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

Issuer Purchases of Equity Securities

Common Stock Repurchase in Connection with Offering of 1.125% Cash Convertible Senior Notes Due 2020. We used a portion of the net proceeds in this offering to repurchase $50.0 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Securities Repurchase Program. Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or the 3.75% Notes, in addition to the $50.0 million common stock repurchase discussed above. The repurchase program extends through December 31, 2014.

Purchases of common stock made by or on our behalf during the quarter ended March 31, 2013, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs
January 1—January 31	3,445	$ 27.06	—	$ 75,000,000
February 1—February 28	1,626,960	$ 30.77	—	$ 75,000,000
March 1—March 31	140,641	$ 31.95	—	$ 75,000,000
Total	1,771,046	$ 30.85	—	

(a) During the three months ended March 31, 2013, we withheld 146,087 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

Item 6. Exhibits

Exhibit No.	Title
10.1	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.
10.2	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.
10.3	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.
10.4	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS (1)	XBRL Taxonomy Instance Document.
101.SCH (1)	XBRL Taxonomy Extension Schema Document.
101.CAL (1)	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF (1)	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB (1)	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE (1)	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) Pursuant to Rule 406T of Regulation S-T, XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 2, 2013

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: May 2, 2013

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

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EXHIBIT INDEX

Exhibit No.	Title
10.1	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.
10.2	Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.
10.3	Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.
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31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
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J.P.Morgan

JPMorgan Chase Bank, National Association
London Branch
25 Bank Street
Canary Wharf
London E14 5JP
England

April 22, 2013

To: **Molina Healthcare, Inc.**
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

Re: Base Warrants

The purpose of this letter agreement (this "**Confirmation**") is to amend and restate, in its entirety, the Base Warrants Confirmation dated February 11, 2013 between the parties hereto and to confirm the terms and conditions of the Warrants issued by **Molina Healthcare, Inc.** ("**Company**") to **JPMorgan Chase Bank, National Association, London Branch** ("**Dealer**") as of the Trade Date specified below (the "**Transaction**"). The parties hereto agree and acknowledge that the amendments reflected in this amended and restated Confirmation are non-substantive, clarifying changes made for the avoidance of doubt. This letter agreement constitutes a "Confirmation" as referred to in the ISDA Master Agreement specified below. This Confirmation shall replace any previous agreements and serve as the final documentation for the Transaction.

The definitions and provisions contained in the 2002 ISDA Equity Derivatives Definitions (the "**Equity Definitions**"), as published by the International Swaps and Derivatives Association, Inc. ("**ISDA**"), are incorporated into this Confirmation. In the event of any inconsistency between the Equity Definitions and this Confirmation, this Confirmation shall govern.

Each party is hereby advised, and each such party acknowledges, that the other party has engaged in, or refrained from engaging in, substantial financial transactions and has taken other material actions in reliance upon the parties' entry into the Transaction to which this Confirmation relates on the terms and conditions set forth below.

1. This Confirmation evidences a complete and binding agreement between Dealer and Company as to the terms of the Transaction to which this Confirmation relates. This Confirmation shall supplement, form a part of, and be subject to an agreement in the form of the 2002 ISDA Master Agreement (the "**Agreement**") as if Dealer and Company had executed an agreement in such form (but without any Schedule except for the election of the laws of the State of New York as the governing law (without reference to choice of law doctrine)) on the Trade Date. In the event of any inconsistency between provisions of the Agreement and this Confirmation, this Confirmation will prevail for the purpose of the Transaction to which this Confirmation relates. The parties hereby agree that no transaction other than the Transaction to which this Confirmation relates shall be governed by the Agreement.

2. The Transaction is a Warrant Transaction, which shall be considered a Share Option Transaction for purposes of the Equity Definitions. The terms of the particular Transaction to which this Confirmation relates are as follows:

General Terms.

Trade Date: February 11, 2013

Effective Date:	The third Exchange Business Day immediately prior to the Premium Payment Date
Warrants:	Equity call warrants, each giving the holder the right to purchase a number of Shares equal to the Warrant Entitlement at a price per Share equal to the Strike Price, subject to the terms set forth under the caption "Settlement Terms" below. For the purposes of the Equity Definitions, each reference to a Warrant herein shall be deemed to be a reference to a Call Option.
Warrant Style:	European
Seller:	Company
Buyer:	Dealer
Shares:	The common stock of Company, par value USD 0.001 per Share (Exchange symbol "MOH")
Number of Warrants:	5,849,857. For the avoidance of doubt, the Number of Warrants shall be reduced by any Warrants exercised or deemed exercised hereunder. In no event will the Number of Warrants be less than zero.
Warrant Entitlement:	One Share per Warrant
Maximum Number of Shares:	For any day, 4,955,958 Shares, *minus* the aggregate number of Shares delivered prior to such day pursuant to (i) this Confirmation and (ii) any other substantially similar confirmation for Warrants sold by Company to Dealer with a trade date within 16 days of the Trade Date and with expiration dates the same as the Expiration Dates. Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, in no event shall the Maximum Number of Shares be subject to adjustment, except for any adjustment pursuant to the terms of this Confirmation and the Equity Definitions in connection with a Potential Adjustment Event (as defined in Section 11.2(e) of the Equity Definitions and without any amendment thereto pursuant to the terms of this Confirmation). Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, the Maximum Number of Shares shall not be adjusted on account of any event that (x) constitutes a Potential Adjustment Event solely on account of Section 11.2(e)(vii) of the Equity Definitions and (y) is not an event within Company's control.
Strike Price:	USD 53.8475
Premium:	USD 32,555,012
Premium Payment Date:	February 15, 2013

Exchange:	The New York Stock Exchange
Related Exchange(s):	All Exchanges

Procedures for Exercise.

Expiration Time:	The Valuation Time
Expiration Dates:	Each Scheduled Trading Day during the period from, and including, the First Expiration Date to, but excluding, the 160th Scheduled Trading Day following the First Expiration Date shall be an "Expiration Date" for a number of Warrants equal to the Daily Number of Warrants on such date; *provided* that, notwithstanding anything to the contrary in the Equity Definitions, if any such date is a Disrupted Day, the Calculation Agent shall make adjustments, if applicable, to the Daily Number of Warrants or shall reduce such Daily Number of Warrants to zero for which such day shall be an Expiration Date and shall designate a Scheduled Trading Day or a number of Scheduled Trading Days as the Expiration Date(s) for the remaining Daily Number of Warrants or a portion thereof for the originally scheduled Expiration Date; and *provided further* that if such Expiration Date has not occurred pursuant to this clause as of the eighth Scheduled Trading Day following the last scheduled Expiration Date under the Transaction, the Calculation Agent shall have the right to declare such Scheduled Trading Day to be the final Expiration Date and the Calculation Agent shall determine its good faith estimate of the fair market value for the Shares as of the Valuation Time on that eighth Scheduled Trading Day or on any subsequent Scheduled Trading Day, as the Calculation Agent shall determine using commercially reasonable means.
First Expiration Date:	April 15, 2020 (or if such day is not a Scheduled Trading Day, the next following Scheduled Trading Day), subject to Market Disruption Event below.
Daily Number of Warrants:	For any Expiration Date, the Number of Warrants that have not expired or been exercised as of such day, *divided* by the remaining number of Expiration Dates (including such day), rounded down to the nearest whole number, subject to adjustment pursuant to the provisos to "Expiration Dates".
Automatic Exercise:	Applicable; and means that for each Expiration Date, a number of Warrants equal to the Daily Number of Warrants for such Expiration Date will be deemed to be automatically exercised at the Expiration Time on such Expiration Date.
Market Disruption Event:	Section 6.3(a) of the Equity Definitions is hereby amended by replacing clause (ii) in its entirety with "(ii) an Exchange Disruption, or" and inserting immediately following clause (iii) the phrase "; in each case that the Calculation Agent determines is material."

Section 6.3(d) of the Equity Definitions is hereby amended by deleting the remainder of the provision following the words "Scheduled Closing Time" in the fourth line thereof.

Valuation Terms.

Valuation Time:	Scheduled Closing Time; *provided* that if the principal trading session is extended, the Calculation Agent shall determine the Valuation Time in good faith using its commercially reasonable discretion.
Valuation Date:	Each Exercise Date.

Settlement Terms.

Settlement Method:	Net Share Settlement.
Net Share Settlement:	On the relevant Settlement Date, Company shall deliver to Dealer a number of Shares equal to the Share Delivery Quantity for such Settlement Date to the account specified herein free of payment through the Clearance System, and Dealer shall be treated as the holder of record of such Shares at the time of delivery of such Shares or, if earlier, at 5:00 p.m. (New York City time) on such Settlement Date, and Company shall pay to Dealer cash in lieu of any fractional Share based on the Settlement Price on the relevant Valuation Date.
Share Delivery Quantity:	For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date for such Settlement Date; *provided* that in no event shall the Share Delivery Quantity for any Settlement Date exceed the Maximum Number of Shares for such Settlement Date.
Net Share Settlement Amount:	For any Settlement Date, an amount equal to the product of (i) the number of Warrants exercised or deemed exercised on the relevant Exercise Date, (ii) the Strike Price Differential for the relevant Valuation Date and (iii) the Warrant Entitlement.
Settlement Price:	For any Valuation Date, the per Share volume-weighted average price as displayed under the heading "Bloomberg VWAP" on Bloomberg page MOH <equity> AQR (or any successor thereto) in respect of the period from the scheduled opening time of the Exchange to the Scheduled Closing Time on such Valuation Date (or if such volume-weighted average price is unavailable, the market value of one Share on such Valuation Date, as determined by the Calculation Agent). Notwithstanding the foregoing, if (i) any Expiration Date is a Disrupted Day and (ii) the Calculation Agent determines that such Expiration Date shall be an Expiration Date for fewer than the Daily Number of Warrants, as described above, then the Settlement Price

	for the relevant Valuation Date shall be the volume-weighted average price per Share on such Valuation Date on the Exchange, as determined by the Calculation Agent based on such sources as it deems appropriate using a volume-weighted methodology, for the portion of such Valuation Date for which the Calculation Agent determines there is no Market Disruption Event.
Settlement Dates:	As determined pursuant to Section 9.4 of the Equity Definitions, subject to Section 9(k)(i) hereof.
Other Applicable Provisions:	The provisions of Sections 9.1(c), 9.8, 9.9, 9.11 and 9.12 of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Net Share Settled." "Net Share Settled" in relation to any Warrant means that Net Share Settlement is applicable to that Warrant.
Representation and Agreement:	Notwithstanding Section 9.11 of the Equity Definitions, the parties acknowledge that any Shares delivered to Dealer may be, upon delivery, subject to restrictions and limitations arising from Company's status as issuer of the Shares under applicable securities laws.

3. <u>Additional Terms applicable to the Transaction</u>.

Adjustments applicable to the Transaction:

Method of Adjustment:	Calculation Agent Adjustment. For the avoidance of doubt, in making any adjustments under the Equity Definitions, the Calculation Agent may make adjustments, if any, to any one or more of the Strike Price, the Number of Warrants, the Daily Number of Warrants and the Warrant Entitlement. Notwithstanding the foregoing, any cash dividends or distributions on the Shares, whether or not extraordinary, shall be governed by Section 9(f) of this Confirmation in lieu of Article 10 or Section 11.2(c) of the Equity Definitions.

Extraordinary Events applicable to the Transaction:

New Shares:	Section 12.1(i) of the Equity Definitions is hereby amended (a) by deleting the text in clause (i) thereof in its entirety (including the word "and" following clause (i)) and replacing it with the phrase "publicly quoted, traded or listed (or whose related depositary receipts are publicly quoted, traded or listed) on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors)" and (b) by inserting immediately prior to the period the phrase "and (iii) of an entity or person that is a corporation organized under the laws of the United States, any State thereof or the District of Columbia that also becomes Company under the Transaction following such Merger Event or Tender Offer".

Consequence of Merger Events:	
Merger Event:	Applicable; *provided* that if an event occurs that constitutes both a Merger Event under Section 12.1(b) of the Equity Definitions and an Additional Termination Event under Section 9(h)(ii)(B) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the provisions of Section 12.2 of the Equity Definitions or Section 9(h)(ii)(B) will apply.
Share-for-Share:	Modified Calculation Agent Adjustment
Share-for-Other:	Cancellation and Payment (Calculation Agent Determination)
Share-for-Combined:	Cancellation and Payment (Calculation Agent Determination); *provided* that Dealer may elect, in its commercially reasonable judgment, Component Adjustment (Calculation Agent Determination) for all or any portion of the Transaction.
Consequence of Tender Offers:	
Tender Offer:	Applicable; *provided* that if an event occurs that constitutes both a Tender Offer under Section 12.1(d) of the Equity Definitions and Additional Termination Event under Section 9(h)(ii)(A) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the provisions of Section 12.3 of the Equity Definitions or Section 9(h)(ii)(A) will apply.
Share-for-Share:	Modified Calculation Agent Adjustment
Share-for-Other:	Modified Calculation Agent Adjustment
Share-for-Combined:	Modified Calculation Agent Adjustment
Announcement Event:	If an Announcement Date occurs in respect of a Merger Event (for the avoidance of doubt, determined without regard to the language in the definition of "Merger Event" following the definition of "Reverse Merger" therein) or Tender Offer (such occurrence, an "**Announcement Event**"), then on the earliest of the Expiration Date, Early Termination Date or other date of cancellation (the "**Announcement Event Adjustment Date**") in respect of each Warrant, the Calculation Agent will determine the economic effect on such Warrant of the Announcement Event (regardless of whether the Announcement Event actually results in a Merger Event or Tender Offer, and taking into account such factors as the Calculation Agent may determine, including, without limitation, changes in volatility, expected dividends, stock loan rate or liquidity relevant to the Shares or the Transaction whether prior to or after the Announcement Event or for any period of time, including, without limitation, the period from the

	Announcement Event to the relevant Announcement Event Adjustment Date). If the Calculation Agent determines that such economic effect on any Warrant is material, then on the Announcement Event Adjustment Date for such Warrant, the Calculation Agent may make such adjustment to the exercise, settlement, payment or any other terms of such Warrant as the Calculation Agent determines appropriate to account for such economic effect, which adjustment shall be effective immediately prior to the exercise, termination or cancellation of such Warrant, as the case may be.
Announcement Date:	The definition of "Announcement Date" in Section 12.1 of the Equity Definitions is hereby amended by (i) replacing the words "a firm" with the word "any" in the second and fourth lines thereof, (ii) replacing the word "leads to the" with the words ", if completed, would lead to a" in the third and the fifth lines thereof, (iii) replacing the words "voting shares" with the word "Shares" in the fifth line thereof, and (iv) inserting the words "by any entity" after the word "announcement" in the second and the fourth lines thereof.
Nationalization, Insolvency or Delisting:	Cancellation and Payment (Calculation Agent Determination); *provided* that, in addition to the provisions of Section 12.6(a)(iii) of the Equity Definitions, it will also constitute a Delisting if the Exchange is located in the United States and the Shares are not immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors); if the Shares are immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors), such exchange or quotation system shall thereafter be deemed to be the Exchange.
Additional Disruption Events:	
Change in Law:	Applicable; *provided* that Section 12.9(a)(ii) of the Equity Definitions is hereby amended by (i) replacing the word "Shares" with the phrase "Hedge Positions" in clause (X) thereof and (ii) inserting the parenthetical "(including, for the avoidance of doubt and without limitation, adoption, effectiveness or promulgation of new regulations authorized or mandated by existing statute)" at the end of clause (A) thereof.
Failure to Deliver:	Not Applicable
Insolvency Filing:	Applicable
Hedging Disruption:	Applicable; *provided* that:
	(i) Section 12.9(a)(v) of the Equity Definitions is hereby amended by (a) inserting the following words

at the end of clause (A) thereof: "in the manner contemplated by the Hedging Party on the Trade Date" and (b) inserting the following two phrases at the end of such Section:

"For the avoidance of doubt, the term "equity price risk" shall be deemed to include, but shall not be limited to, stock price and volatility risk. And, for the further avoidance of doubt, any such transactions or assets referred to in phrases (A) or (B) above must be available on commercially reasonable pricing terms."; and

(ii) Section 12.9(b)(iii) of the Equity Definitions is hereby amended by inserting in the third line thereof, after the words "to terminate the Transaction", the words "or a portion of the Transaction affected by such Hedging Disruption".

Increased Cost of Hedging:	Applicable
Loss of Stock Borrow:	Applicable
Maximum Stock Loan Rate:	100 basis points
Increased Cost of Stock Borrow:	Applicable
Initial Stock Loan Rate:	25 basis points
Hedging Party:	For all applicable Additional Disruption Events, Dealer.
Determining Party:	For all applicable Extraordinary Events, Dealer.
Non-Reliance:	Applicable
Agreements and Acknowledgments Regarding Hedging Activities:	Applicable
Additional Acknowledgments:	Applicable

4. **Calculation Agent.** Dealer

5. **Account Details.**

(a)Account for payments to Company: To Be Advised.

Account for delivery of Shares from Company: To Be Advised.

(b)Account for payments to Dealer:

Bank: JPMorgan Chase Bank, N.A.
ABA#: 021000021
Acct No.: 099997979
Beneficiary: JPMorgan Chase Bank, N.A. New York
Ref: Derivatives

Account for delivery of Shares to Dealer:

DTC 0060

6. Offices.

(a)The Office of Company for the Transaction is: Inapplicable, Company is not a Multibranch Party.

(b)The Office of Dealer for the Transaction is: London

JPMorgan Chase Bank, National Association
London Branch
25 Bank Street
Canary Wharf
London E14 5JP
England

7. Notices.

(a)Address for notices or communications to Company:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

(b)Address for notices or communications to Dealer:

JPMorgan Chase Bank, National Association
EDG Marketing Support
Email: EDG_OTC_HEDGING_MS@jpmorgan.com
Facsimile No: 1-866-886-4506

With a copy to:

Attention: Jason Wood
Title: Managing Director; Head of Equity Linked Capital Markets—Americas
Telephone No: 212-622-8783
Facsimile No: 415-226-0616

8. Representations and Warranties of Company.

Each of the representations and warranties of Company set forth in Section 3 of the Purchase Agreement (the "**Purchase Agreement**"), dated as of February 11, 2013, among Company and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as representatives of the Initial Purchasers party thereto (the "**Initial Purchasers**"), other than the representations set forth in Section 3(o), Section 3(r) and Section 3(s) of the Purchase Agreement, in each case, as such representations relate to the Transaction, are true and correct and are hereby deemed to be repeated to Dealer as if set forth herein. Company hereby further represents and warrants to Dealer on the Trade Date, the date hereof, on and as of the Premium Payment Date and, in the case of the representations in Section 8(d), at all times until termination of the Transaction, that:

(a)Company has all necessary corporate power and authority to execute, deliver and perform its obligations in respect of the Transaction; such execution, delivery and performance have been duly authorized by all necessary corporate action on Company's part; and this Confirmation has been duly and validly executed and delivered by Company and constitutes its valid and binding obligation, enforceable against Company in accordance with its terms, subject to applicable bankruptcy,

insolvency, fraudulent conveyance, reorganization, moratorium and similar laws affecting creditors' rights and remedies generally, and subject, as to enforceability, to general principles of equity, including principles of commercial reasonableness, good faith and fair dealing (regardless of whether enforcement is sought in a proceeding at law or in equity) and except that rights to indemnification and contribution hereunder may be limited by federal or state securities laws or public policy relating thereto.

(b) Neither the execution and delivery of this Confirmation nor the incurrence or performance of obligations of Company hereunder will conflict with or result in a breach of the certificate of incorporation or by-laws (or any equivalent documents) of Company, or any applicable law or regulation, or any order, writ, injunction or decree of any court or governmental authority or agency, or any agreement or instrument to which Company or any of its subsidiaries is a party or by which Company or any of its subsidiaries is bound or to which Company or any of its subsidiaries is subject, or constitute a default under, or result in the creation of any lien under, any such agreement or instrument.

(c) No consent, approval, authorization, or order of, or filing with, any governmental agency or body or any court is required in connection with the execution, delivery or performance by Company of this Confirmation, except such as have been obtained or made and such as may be required under the Securities Act of 1933, as amended (the "**Securities Act**") or state securities laws.

(d) A number of Shares equal to the Maximum Number of Shares (the "**Warrant Shares**") have been reserved for issuance by all required corporate action of Company. The Warrant Shares have been duly authorized and, when delivered against payment therefor (which may include Net Share Settlement in lieu of cash) and otherwise as contemplated by the terms of the Warrants following the exercise of the Warrants in accordance with the terms and conditions of the Warrants, will be validly issued, fully-paid and non-assessable, and the issuance of the Warrant Shares will not be subject to any preemptive or similar rights.

(e) Company is not and, after consummation of the transactions contemplated hereby, will not be required to register as an "investment company" as such term is defined in the Investment Company Act of 1940, as amended.

(f) Company is an "eligible contract participant" (as such term is defined in Section 1a(18) of the Commodity Exchange Act, as amended, other than a person that is an eligible contract participant under Section 1a(18)(C) of the Commodity Exchange Act).

(g) Company and each of its affiliates is not, on the date hereof, in possession of any material non-public information with respect to Company.

(h) No state or local (including any non-U.S. jurisdiction's) law, rule, regulation or regulatory order applicable to the Shares would give rise to any reporting, consent, registration or other requirement (including without limitation a requirement to obtain prior approval from any person or entity) as a result of Dealer or its affiliates owning or holding (however defined) Shares.

(i) Company (A) is capable of evaluating investment risks independently, both in general and with regard to all transactions and investment strategies involving a security or securities; (B) will exercise independent judgment in evaluating the recommendations of any broker-dealer or its associated persons, unless it has otherwise notified the broker-dealer in writing; and (C) has total assets of at least $50 million.

9. Other Provisions.

(a) *Opinions*. Company shall deliver to Dealer an opinion of counsel, dated as of the Trade Date, with respect to the matters set forth in Sections 8(a) through (d) of this Confirmation. Delivery of such

opinion to Dealer shall be a condition precedent for the purpose of Section 2(a)(iii) of the Agreement with respect to each obligation of Dealer under Section 2(a)(i) of the Agreement.

(b) *Repurchase Notices*. Company shall, on any day on which Company effects any repurchase of Shares, promptly give Dealer a written notice of such repurchase (a "**Repurchase Notice**") on such day if following such repurchase, the number of outstanding Shares on such day, subject to any adjustments provided herein, is (i) less than 45,295,973 (in the case of the first such notice) or (ii) thereafter more than 1,390,754 less than the number of Shares included in the immediately preceding Repurchase Notice. Company agrees to indemnify and hold harmless Dealer and its affiliates and their respective officers, directors, employees, affiliates, advisors, agents and controlling persons (each, an "**Indemnified Person**") from and against any and all losses (including losses relating to Dealer's hedging activities as a consequence of becoming, or of the risk of becoming, a Section 16 "insider", including without limitation, any forbearance from hedging activities or cessation of hedging activities and any losses in connection therewith with respect to the Transaction), claims, damages, judgments, liabilities and expenses (including reasonable attorney's fees), joint or several, which an Indemnified Person actually may become subject to, as a result of Company's failure to provide Dealer with a Repurchase Notice on the day and in the manner specified in this paragraph, and to reimburse, within 30 days, upon written request, each of such Indemnified Persons for any reasonable legal or other expenses incurred in connection with investigating, preparing for, providing testimony or other evidence in connection with or defending any of the foregoing. If any suit, action, proceeding (including any governmental or regulatory investigation), claim or demand shall be brought or asserted against the Indemnified Person, such Indemnified Person shall promptly notify Company in writing, and Company, upon request of the Indemnified Person, shall retain counsel reasonably satisfactory to the Indemnified Person to represent the Indemnified Person and any others Company may designate in such proceeding and shall pay the fees and expenses of such counsel related to such proceeding. Company shall not be liable for any settlement of any proceeding effected without its written consent, but if settled with such consent or if there be a final judgment for the plaintiff, Company agrees to indemnify any Indemnified Person from and against any loss or liability by reason of such settlement or judgment. Company shall not, without the prior written consent of the Indemnified Person, effect any settlement of any pending or threatened proceeding in respect of which any Indemnified Person is or could have been a party and indemnity could have been sought hereunder by such Indemnified Person, unless such settlement includes an unconditional release of such Indemnified Person from all liability on claims that are the subject matter of such proceeding on terms reasonably satisfactory to such Indemnified Person. If the indemnification provided for in this paragraph is unavailable to an Indemnified Person or insufficient in respect of any losses, claims, damages or liabilities referred to therein, then Company under such paragraph, in lieu of indemnifying such Indemnified Person thereunder, shall contribute to the amount paid or payable by such Indemnified Person as a result of such losses, claims, damages or liabilities. The remedies provided for in this paragraph are not exclusive and shall not limit any rights or remedies which may otherwise be available to any Indemnified Person at law or in equity. The indemnity and contribution agreements contained in this paragraph shall remain operative and in full force and effect regardless of the termination of the Transaction.

(c) *Regulation M*. Company is not on the Trade Date engaged in a distribution, as such term is used in Regulation M under the Securities Exchange Act of 1934, as amended (the "**Exchange Act**"), of any securities of Company, other than a distribution meeting the requirements of the exception set forth in Rules 101(b)(10) and 102(b)(7) of Regulation M. Company shall not, until the second Scheduled Trading Day immediately following the Effective Date, engage in any such distribution.

(d) *No Manipulation*. Company is not entering into the Transaction to create actual or apparent trading activity in the Shares (or any security convertible into or exchangeable for the Shares) or to raise or depress or otherwise manipulate the price of the Shares (or any security convertible into or exchangeable for the Shares) or otherwise in violation of the Exchange Act.

(e)*Transfer or Assignment*. Company may not transfer any of its rights or obligations under the Transaction without the prior written consent of Dealer. Dealer may, without Company's consent, transfer or assign all or any part of its rights or obligations under the Transaction to any third party. If at any time at which (A) the Section 16 Percentage exceeds 7.5%, (B) the Warrant Equity Percentage exceeds 16.3%, or (C) the Share Amount exceeds the Applicable Share Limit (if any applies) (any such condition described in clauses (A), (B) or (C), an "**Excess Ownership Position**"), Dealer is unable after using its commercially reasonable efforts to effect a transfer or assignment of Warrants to a third party on pricing terms reasonably acceptable to Dealer and within a time period reasonably acceptable to Dealer such that no Excess Ownership Position exists, then Dealer may designate any Exchange Business Day as an Early Termination Date with respect to a portion of the Transaction (the "**Terminated Portion**"), such that following such partial termination no Excess Ownership Position exists. In the event that Dealer so designates an Early Termination Date with respect to a Terminated Portion, a payment shall be made pursuant to Section 6 of the Agreement as if (1) an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants underlying the Terminated Portion, (2) Company were the sole Affected Party with respect to such partial termination and (3) the Terminated Portion were the sole Affected Transaction (and, for the avoidance of doubt, the provisions of Section 9(j) shall apply to any amount that is payable by Company to Dealer pursuant to this sentence as if Company was not the Affected Party). The "**Section 16 Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the number of Shares that Dealer and each person subject to aggregation of Shares with Dealer under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder directly or indirectly beneficially own (as defined under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder) and (B) the denominator of which is the number of Shares outstanding. The "**Warrant Equity Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the sum of (1) the product of the Number of Warrants and the Warrant Entitlement and (2) the aggregate number of Shares underlying any other warrants purchased by Dealer from Company, and (B) the denominator of which is the number of Shares outstanding. The "**Share Amount**" as of any day is the number of Shares that Dealer and any person whose ownership position would be aggregated with that of Dealer (Dealer or any such person, a "**Dealer Person**") under any law, rule, regulation, regulatory order or organizational documents or contracts of Company that are, in each case, applicable to ownership of Shares ("**Applicable Restrictions**"), owns, beneficially owns, constructively owns, controls, holds the power to vote or otherwise meets a relevant definition of ownership under any Applicable Restriction, as determined by Dealer in its reasonable discretion. The "**Applicable Share Limit**" means a number of Shares equal to (A) the minimum number of Shares that could give rise to reporting or registration obligations or other requirements (including obtaining prior approval from any person or entity) of a Dealer Person, or could result in an adverse effect on a Dealer Person, under any Applicable Restriction, as determined by Dealer in its reasonable discretion, *minus* (B) 1% of the number of Shares outstanding. Notwithstanding any other provision in this Confirmation to the contrary requiring or allowing Dealer to purchase, sell, receive or deliver any Shares or other securities, or to make or receive any payment in cash, to or from Company, Dealer may designate any of its affiliates to purchase, sell, receive or deliver such Shares or other securities, or make or receive such payment in cash, and otherwise to perform Dealer's obligations in respect of the Transaction and any such designee may assume such obligations. Dealer shall be discharged of its obligations to Company to the extent of any such performance.

(f)*Dividends*. If at any time during the period from and including the Effective Date, to and including the last Expiration Date, an ex-dividend date for a cash dividend occurs with respect to the Shares (an "**Ex-Dividend Date**"), then the Calculation Agent will adjust any of the Strike Price, Number of Warrants, Daily Number of Warrants and/or any other variable relevant to the exercise, settlement or payment of the Transaction to preserve the fair value of the Warrants after taking into account such dividend.

(g)*Role of Agent*. Each party agrees and acknowledges that (i) J.P. Morgan Securities LLC, an affiliate of Dealer ("**JPMS**"), has acted solely as agent and not as principal with respect to the Transaction and (ii) JPMS has no obligation or liability, by way of guaranty, endorsement or otherwise, in any manner in respect of the Transaction (including, if applicable, in respect of the settlement thereof). Each party agrees it will look solely to the other party (or any guarantor in respect thereof) for performance of such other party's obligations under the Transaction.

(h)*Additional Provisions*.

(i) Amendments to the Equity Definitions:

(A) Section 11.2(a) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the words "an"; and adding the phrase "or Warrants" at the end of the sentence.

(B) Section 11.2(c) of the Equity Definitions is hereby amended by (w) replacing the words "a diluting or concentrative" with "an" in the fifth line thereof, (x) adding the phrase "or Warrants" after the words "the relevant Shares" in the same sentence, (y) deleting the words "diluting or concentrative" in the sixth to last line thereof and (z) deleting the phrase "(provided that no adjustments will be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)" and replacing it with the phrase "(and, for the avoidance of doubt, adjustments may be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)."

(C) Section 11.2(e)(vii) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the word "a material"; and adding the phrase "or Warrants" at the end of the sentence.

(D) Section 12.6(a)(ii) of the Equity Definitions is hereby amended by (1) deleting from the fourth line thereof the word "or" after the word "official" and inserting a comma therefor, and (2) deleting the semi-colon at the end of subsection (B) thereof and inserting the following words therefor "or (C) at Dealer's option, the occurrence of any of the events specified in Section 5(a)(vii) (1) through (9) of the ISDA Master Agreement with respect to that Issuer."

(E) Section 12.9(b)(iv) of the Equity Definitions is hereby amended by:

(x) deleting (1) subsection (A) in its entirety, (2) the phrase "or (B)" following subsection (A) and (3) the phrase "in each case" in subsection (B); and

(y) replacing the phrase "neither the Non-Hedging Party nor the Lending Party lends Shares" with the phrase "such Lending Party does not lend Shares" in the penultimate sentence.

(F) Section 12.9(b)(v) of the Equity Definitions is hereby amended by:

(x) adding the word "or" immediately before subsection "(B)" and deleting the comma at the end of subsection (A); and

(y) (1) deleting subsection (C) in its entirety, (2) deleting the word "or" immediately preceding subsection (C), (3) deleting the penultimate sentence in its entirety and replacing it with the sentence "The Hedging

Party will determine the Cancellation Amount payable by one party to the other." and (4) deleting clause (X) in the final sentence.

(ii) Notwithstanding anything to the contrary in this Confirmation, upon the occurrence of one of the following events, with respect to the Transaction, (1) Dealer shall have the right to designate such event an Additional Termination Event and designate an Early Termination Date pursuant to Section 6(b) of the Agreement, (2) Company shall be deemed the sole Affected Party with respect to such Additional Termination Event and (3) the Transaction, or, at the election of Dealer in its sole discretion, any portion of the Transaction, shall be deemed the sole Affected Transaction; *provided* that if Dealer so designates an Early Termination Date with respect to a portion of the Transaction, (a) a payment shall be made pursuant to Section 6 of the Agreement as if an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants included in the terminated portion of the Transaction, and (b) for the avoidance of doubt, the Transaction shall remain in full force and effect except that the Number of Warrants shall be reduced by the number of Warrants included in such terminated portion:

(A) A "person" or "group" within the meaning of Section 13(d) of the Exchange Act, other than Company, its subsidiaries or its and their employee benefit plans, files a Schedule TO or any schedule, form or report under the Exchange Act disclosing that such person or group has become the direct or indirect "beneficial owner," as defined in Rule 13d-3 under the Exchange Act, of the common equity of Company representing more than 50% of the voting power of such common equity.

(B) Consummation of (I) any recapitalization, reclassification or change of the Shares (other than changes resulting from a subdivision or combination) as a result of which the Shares would be converted into, or exchanged for, stock, other securities, other property or assets or (II) any share exchange, consolidation or merger of Company pursuant to which the Shares will be converted into cash, securities or other property or (III) any sale, lease or other transfer in one transaction or a series of transactions of all or substantially all of the consolidated assets of Company and its subsidiaries, taken as a whole, to any person other than one of Company's subsidiaries. Notwithstanding the foregoing, any transaction or transactions set forth in this clause (B) shall not constitute an Additional Termination Event if (x) at least 90% of the consideration received or to be received by holders of the Shares, excluding cash payments for fractional Shares, in connection with such transaction or transactions consists of shares of common stock that are listed or quoted on any of The New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or any of their respective successors) or will be so listed or quoted when issued or exchanged in connection with such transaction or transactions, and (y) as a result of such transaction or transactions, the Shares will consist of such consideration, excluding cash payments for fractional Shares.

(C) Company's shareholders approve any plan or proposal for the liquidation or dissolution of Company.

(D) Default by Company or any of its subsidiaries with respect to any mortgage, agreement or other instrument under which there may be outstanding, or by which there may be secured or evidenced, any indebtedness for money borrowed in excess of $15 million in the aggregate of Company and/or any such subsidiary, whether such indebtedness now exists or shall hereafter be created (i) resulting in such indebtedness becoming or being declared due and payable or (ii) constituting a failure to pay the principal or interest of any such debt when due and payable at

its stated maturity, upon required repurchase, upon declaration of acceleration or otherwise.

(E) A final judgment for the payment of $15 million or more (excluding any amounts covered by insurance) rendered against Company or any of its subsidiaries, which judgment is not discharged or stayed within 60 days after (I) the date on which the right to appeal thereof has expired if no such appeal has commenced, or (II) the date on which all rights to appeal have been extinguished.

(F) Dealer, despite using commercially reasonable efforts, is unable or reasonably determines that it is impractical or illegal, to hedge its exposure with respect to the Transaction in the public market without registration under the Securities Act or as a result of any legal, regulatory or self-regulatory requirements or related policies and procedures (whether or not such requirements, policies or procedures are imposed by law or have been voluntarily adopted by Dealer).

(G) On any day during the period from and including the Trade Date, to and including the final Expiration Date, (I) the Notional Unwind Shares (as defined below) as of such day exceeds a number of Shares equal to 60% of the Maximum Number of Shares, or (II) Company makes a public announcement of any transaction or event that, in the reasonable opinion of Dealer would, upon consummation of such transaction or upon the occurrence of such event, as applicable, and after giving effect to any applicable adjustments hereunder, cause the Notional Unwind Shares immediately following the consummation of such transaction or the occurrence of such event to exceed a number of Shares equal to 60% of the Maximum Number of Shares. The "**Notional Unwind Shares**" as of any day is a number of Shares equal to (1) the amount that would be payable pursuant to Section 6 of the Agreement (determined as of such day as if an Early Termination Date had been designated in respect of the Transaction and as if Company were the sole Affected Party and the Transaction were the sole Affected Transaction), *divided by* (2) the Settlement Price (determined as if such day were a Valuation Date).

(H) If Company has not obtained Shareholder Approval prior to February 11, 2014 (the "**Approval Deadline**"). For the avoidance of doubt, if Company has not obtained Shareholder Approval prior to the Approval Deadline, Dealer shall have right to designate an Early Termination Date in connection with the Additional Termination Event set forth in this clause (H) on any day from, and including, the Approval Deadline to, and including, the earlier of (x) the date on which Company obtains Shareholder Approval and (y) the final Expiration Date.

(i) *No Collateral or Setoff*. Notwithstanding any provision of the Agreement or any other agreement between the parties to the contrary, the obligations of Company hereunder are not secured by any collateral. Obligations under the Transaction shall not be set off by Company against any other obligations of the parties, whether arising under the Agreement, this Confirmation, under any other agreement between the parties hereto, by operation of law or otherwise. Any provision in the Agreement with respect to the satisfaction of Company's payment obligations to the extent of Dealer's payment obligations to Company in the same currency and in the same Transaction (including, without limitation Section 2(c) thereof) shall not apply to Company and, for the avoidance of doubt, Company shall fully satisfy such payment obligations notwithstanding any payment obligation to Company by Dealer in the same currency and in the same Transaction. In calculating any amounts under Section 6(e) of the Agreement, notwithstanding anything to the contrary in the Agreement, (1) separate amounts shall be calculated as set forth in such Section 6(e) with respect to (a) the Transaction and (b) all other Transactions, and (2) such separate amounts shall be payable pursuant to Section 6(d)(ii) of the Agreement. For the avoidance of doubt and notwithstanding anything to the contrary

provided in this Section 9(i), in the event of bankruptcy or liquidation of either Company or Dealer, neither party shall have the right to set off any obligation that it may have to the other party under the Transaction against any obligation such other party may have to it, whether arising under the Agreement, this Confirmation or any other agreement between the parties hereto, by operation of law or otherwise.

(j) *Alternative Calculations and Payment on Early Termination and on Certain Extraordinary Events*.

(i) If, in respect of the Transaction, an amount is payable by Company to Dealer, (A) pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or (B) pursuant to Section 6(d)(ii) of the Agreement (any such amount, a "**Payment Obligation**"), Company shall satisfy the Payment Obligation by the Share Termination Alternative (as defined below), unless (a) Company gives irrevocable telephonic notice to Dealer, confirmed in writing within one Scheduled Trading Day, no later than 12:00 p.m. (New York City time) on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable, of its election that the Share Termination Alternative shall not apply, (b) Company remakes the representation set forth in Section 8(g) as of the date of such election and (c) Dealer agrees, in its sole discretion, to such election, in which case the provisions of Section 12.7 or Section 12.9 of the Equity Definitions, or the provisions of Section 6(d)(ii) of the Agreement, as the case may be, shall apply.

Share Termination Alternative:	If applicable, Company shall deliver to Dealer the Share Termination Delivery Property on the date (the "**Share Termination Payment Date**") on which the Payment Obligation would otherwise be due pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or Section 6(d)(ii) of the Agreement, as applicable, subject to Section 9(k)(i) below, in satisfaction, subject to Section 9(k)(ii) below, of the relevant Payment Obligation, in the manner reasonably requested by Dealer free of payment.
Share Termination Delivery Property:	A number of Share Termination Delivery Units, as calculated by the Calculation Agent, equal to the relevant Payment Obligation *divided by* the Share Termination Unit Price. The Calculation Agent shall adjust the amount of Share Termination Delivery Property by replacing any fractional portion of a security therein with an amount of cash equal to the value of such fractional security based on the values used to calculate the Share Termination Unit Price (without giving effect to any discount pursuant to Section 9(k)(i)).
Share Termination Unit Price:	The value of property contained in one Share Termination Delivery Unit on the date such Share Termination Delivery Units are to be delivered as Share Termination Delivery Property, as determined by the Calculation Agent in its good faith discretion by commercially reasonable means. In the case of a Private Placement of Share Termination Delivery Units that are Restricted Shares (as defined below), as set forth in

Section 9(k)(i) below, the Share Termination Unit Price shall be determined by the discounted price applicable to such Share Termination Delivery Units. In the case of a Registration Settlement of Share Termination Delivery Units that are Restricted Shares (as defined below) as set forth in Section 9(k)(ii) below, notwithstanding the foregoing, the Share Termination Unit Price shall be the Settlement Price on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable. The Calculation Agent shall notify Company of the Share Termination Unit Price at the time of notification of such Payment Obligation to Company or, if applicable, at the time the discounted price applicable to the relevant Share Termination Units is determined pursuant to Section 9(k)(i).

Share Termination Delivery Unit: One Share or, if the Shares have changed into cash or any other property or the right to receive cash or any other property as the result of a Nationalization, Insolvency or Merger Event (any such cash or other property, the "**Exchange Property**"), a unit consisting of the type and amount of Exchange Property received by a holder of one Share (without consideration of any requirement to pay cash or other consideration in lieu of fractional amounts of any securities) in such Nationalization, Insolvency or Merger Event. If such Nationalization, Insolvency or Merger Event involves a choice of Exchange Property to be received by holders, such holder shall be deemed to have elected to receive the maximum possible amount of cash.

Failure to Deliver: Inapplicable

Other applicable provisions: If Share Termination Alternative is applicable, the provisions of Sections 9.8, 9.9, 9.11 and 9.12 (as modified above) of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Share Termination Settled" and all references to "Shares" shall be read as references to "Share Termination Delivery Units". "Share Termination Settled" in relation to the Transaction means that the Share Termination Alternative is applicable to the Transaction.

(ii) Notwithstanding anything to the contrary in this Confirmation, any Payment Obligation under this Confirmation shall, for all purposes, be calculated as if the Maximum Number of Shares were equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) but any deliveries under Section 9(j)(i) shall be limited to the Maximum Number of Shares as defined in Section 2 hereof. In the event Company shall not have delivered to Dealer the full number of Shares

or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has not obtained shareholder approval pursuant to Section 9(q) for the Maximum Number of Shares to equal two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) (such deficit, the "**Approval Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Approval Deficit Shares have been delivered pursuant to this Section 9(j)(ii), when, and to the extent that the Company obtains shareholder approval; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(j)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares as so increased pursuant to Section 9(q).

(k) *Registration/Private Placement Procedures*. If, in the reasonable opinion of Dealer, following any delivery of Shares or Share Termination Delivery Property to Dealer hereunder, such Shares or Share Termination Delivery Property would be in the hands of Dealer subject to any applicable restrictions with respect to any registration or qualification requirement or prospectus delivery requirement for such Shares or Share Termination Delivery Property pursuant to any applicable federal or state securities law (including, without limitation, any such requirement arising under Section 5 of the Securities Act as a result of such Shares or Share Termination Delivery Property being "restricted securities", as such term is defined in Rule 144 under the Securities Act, or as a result of the sale of such Shares or Share Termination Delivery Property being subject to paragraph (c) of Rule 145 under the Securities Act) (such Shares or Share Termination Delivery Property, "**Restricted Shares**"), then delivery of such Restricted Shares shall be effected pursuant to either clause (i) or (ii) below at the election of Company, unless Dealer waives the need for registration/private placement procedures set forth in (i) and (ii) below. Notwithstanding the foregoing, solely in respect of any Daily Number of Warrants exercised or deemed exercised on any Expiration Date, Company shall elect, prior to the first Settlement Date for the first applicable Expiration Date, a Private Placement Settlement or Registration Settlement for all deliveries of Restricted Shares for all such Expiration Dates which election shall be applicable to all remaining Settlement Dates for such Warrants and the procedures in clause (i) or clause (ii) below shall apply for all such delivered Restricted Shares on an aggregate basis commencing after the final Settlement Date for such Warrants. The Calculation Agent shall make reasonable adjustments to settlement terms and provisions under this Confirmation to reflect a single Private Placement or Registration Settlement for such aggregate Restricted Shares delivered hereunder.

(i) If Company elects to settle the Transaction pursuant to this clause (i) (a "**Private Placement Settlement**"), then delivery of Restricted Shares by Company shall be effected in customary private placement procedures with respect to such Restricted Shares reasonably acceptable to Dealer; *provided* that Company may not elect a Private Placement Settlement if, on the date of its election, it has taken, or caused to be taken, any action that would make unavailable either the exemption pursuant to Section 4(2) of the Securities Act for the sale by Company to Dealer (or any affiliate designated by Dealer) of the Restricted Shares or the exemption pursuant to Section 4(1) or Section 4(3) of the Securities Act for resales of the Restricted Shares by Dealer (or any such affiliate of Dealer). The Private Placement Settlement of such Restricted Shares shall include customary representations, covenants, blue sky and other governmental filings and/or registrations, indemnities to Dealer, due diligence rights (for Dealer or any designated buyer of the Restricted Shares by Dealer), opinions and certificates, and such other documentation as is customary for private placement agreements of similar size, all reasonably acceptable to Dealer. In the case of a Private Placement Settlement, Dealer shall determine the appropriate discount to the Share Termination Unit Price (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or any Settlement Price (in the case of settlement of Shares pursuant to Section

2 above) applicable to such Restricted Shares in a commercially reasonable manner and appropriately adjust the number of such Restricted Shares to be delivered to Dealer hereunder, which discount shall only take into account the illiquidity resulting from the fact that the Restricted Shares will not be registered for resale and any commercially reasonable fees and expenses of Dealer (and any affiliate thereof) in connection with such resale. Notwithstanding anything to the contrary in the Agreement or this Confirmation, the date of delivery of such Restricted Shares shall be the Exchange Business Day following notice by Dealer to Company, of such applicable discount and the number of Restricted Shares to be delivered pursuant to this clause (i). For the avoidance of doubt, delivery of Restricted Shares shall be due as set forth in the previous sentence and not be due on the Share Termination Payment Date (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or on the Settlement Date for such Restricted Shares (in the case of settlement in Shares pursuant to Section 2 above).

(ii) If Company elects to settle the Transaction pursuant to this clause (ii) (a "**Registration Settlement**"), then Company shall promptly (but in any event no later than the beginning of the Resale Period) file and use its reasonable best efforts to make effective under the Securities Act a registration statement or supplement or amend an outstanding registration statement in form and substance reasonably satisfactory to Dealer, to cover the resale of such Restricted Shares in accordance with customary resale registration procedures, including covenants, conditions, representations, underwriting discounts (if applicable), commissions (if applicable), indemnities due diligence rights, opinions and certificates, and such other documentation as is customary for equity resale underwriting agreements of similar size, all reasonably acceptable to Dealer. If Dealer, in its sole reasonable discretion, is not satisfied with such procedures and documentation Private Placement Settlement shall apply. If Dealer is satisfied with such procedures and documentation, it shall sell the Restricted Shares pursuant to such registration statement during a period (the "**Resale Period**") commencing on the Exchange Business Day following delivery of such Restricted Shares (which, for the avoidance of doubt, shall be (x) the Share Termination Payment Date in case of settlement in Share Termination Delivery Units pursuant to Section 9(j) above or (y) the Settlement Date in respect of the final Expiration Date for all Daily Number of Warrants) and ending on the earliest of (i) the Exchange Business Day on which Dealer completes the sale of all Restricted Shares in a commercially reasonable manner or, in the case of settlement of Share Termination Delivery Units, a sufficient number of Restricted Shares so that the realized net proceeds of such sales equals or exceeds the Payment Obligation (as defined above), (ii) the date upon which all Restricted Shares have been sold or transferred pursuant to Rule 144 (or similar provisions then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act and (iii) the date upon which all Restricted Shares may be sold or transferred by a non-affiliate pursuant to Rule 144 (or any similar provision then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act. If the Payment Obligation exceeds the realized net proceeds from such resale, Company shall transfer to Dealer by the open of the regular trading session on the Exchange on the Exchange Trading Day immediately following such resale the amount of such excess (the "**Additional Amount**") in cash or in a number of Shares ("**Make-whole Shares**") in an amount that, based on the Settlement Price on such day (as if such day was the "Valuation Date" for purposes of computing such Settlement Price), has a dollar value equal to the Additional Amount. The Resale Period shall continue to enable the sale of the Make-whole Shares. If Company elects to pay the Additional Amount in Shares, the requirements and provisions for Registration Settlement shall apply. This provision shall be applied successively until the Additional Amount is equal to zero. In no event shall Company deliver a number of Restricted Shares greater than the Maximum Number of Shares.

(iii) Without limiting the generality of the foregoing, Company agrees that (A) any Restricted Shares delivered to Dealer may be transferred by and among Dealer and its affiliates and Company shall effect such transfer without any further action by Dealer and (B) after the period of 6 months from the Trade Date (or 1 year from the Trade Date if, at such time, informational requirements of Rule 144(c) under the Securities Act are not satisfied with respect to Company) has elapsed in respect of any Restricted Shares delivered to Dealer, Company shall promptly remove, or cause the transfer agent for such Restricted Shares to remove, any legends referring to any such restrictions or requirements from such Restricted Shares upon request by Dealer (or such affiliate of Dealer) to Company or such transfer agent, without any requirement for the delivery of any certificate, consent, agreement, opinion of counsel, notice or any other document, any transfer tax stamps or payment of any other amount or any other action by Dealer (or such affiliate of Dealer). Notwithstanding anything to the contrary herein, to the extent the provisions of Rule 144 of the Securities Act or any successor rule are amended, or the applicable interpretation thereof by the Securities and Exchange Commission or any court change after the Trade Date, the agreements of Company herein shall be deemed modified to the extent necessary, in the opinion of outside counsel of Company, to comply with Rule 144 of the Securities Act, as in effect at the time of delivery of the relevant Shares or Share Termination Delivery Property.

(iv) If the Private Placement Settlement or the Registration Settlement shall not be effected as set forth in clauses (i) or (ii), as applicable, then failure to effect such Private Placement Settlement or such Registration Settlement shall constitute an Event of Default with respect to which Company shall be the Defaulting Party.

(l) *Limit on Beneficial Ownership*. Notwithstanding any other provisions hereof, Dealer may not exercise any Warrant hereunder or be entitled to take delivery of any Shares deliverable hereunder, and Automatic Exercise shall not apply with respect to any Warrant hereunder, to the extent (but only to the extent) that, after such receipt of any Shares upon the exercise of such Warrant or otherwise hereunder, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. Any purported delivery hereunder shall be void and have no effect to the extent (but only to the extent) that, after such delivery, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. If any delivery owed to Dealer hereunder is not made, in whole or in part, as a result of this provision, Company's obligation to make such delivery shall not be extinguished and Company shall make such delivery as promptly as practicable after, but in no event later than one Business Day after, Dealer gives notice to Company that, after such delivery, (i) the Section 16 Percentage would not exceed 7.5%, and (ii) the Share Amount would not exceed the Applicable Share Limit.

(m) *Share Deliveries*. Notwithstanding anything to the contrary herein, Company agrees that any delivery of Shares or Share Termination Delivery Property shall be effected by book-entry transfer through the facilities of DTC, or any successor depositary, if at the time of delivery, such class of Shares or class of Share Termination Delivery Property is in book-entry form at DTC or such successor depositary.

(n) *Waiver of Jury Trial.* Each party waives, to the fullest extent permitted by applicable law, any right it may have to a trial by jury in respect of any suit, action or proceeding relating to the Transaction. Each party (i) certifies that no representative, agent or attorney of the other party has represented, expressly or otherwise, that such other party would not, in the event of such a suit, action or proceeding, seek to enforce the foregoing waiver and (ii) acknowledges that it and the other party have been induced to enter into the Transaction, as applicable, by, among other things, the mutual waivers and certifications provided herein.

(o) *Tax Disclosure.* Effective from the date of commencement of discussions concerning the Transaction, Company and each of its employees, representatives, or other agents may disclose to any and all

persons, without limitation of any kind, the tax treatment and tax structure of the Transaction and all materials of any kind (including opinions or other tax analyses) that are provided to Company relating to such tax treatment and tax structure.

(p) *Maximum Share Delivery*.

(i) Notwithstanding any other provision of this Confirmation, the Agreement or the Equity Definitions, in no event will Company at any time be required to deliver a number of Shares greater than the Maximum Number of Shares to Dealer in connection with the Transaction.

(ii) In the event Company shall not have delivered to Dealer the full number of Shares or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has insufficient authorized but unissued Shares (such deficit, the "**Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Deficit Shares have been delivered pursuant to this Section 9(p)(ii), when, and to the extent that, (A) Shares are repurchased, acquired or otherwise received by Company or any of its subsidiaries after the Trade Date (whether or not in exchange for cash, fair value or any other consideration), (B) authorized and unissued Shares previously reserved for issuance in respect of other transactions become no longer so reserved or (C) Company additionally authorizes any unissued Shares that are not reserved for other transactions; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(p)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares. Company shall immediately notify Dealer of the occurrence of any of the foregoing events (including the number of Shares subject to clause (A), (B) or (C) and the corresponding number of Shares or Restricted Shares, as the case may be, to be delivered) and promptly deliver such Shares or Restricted Shares, as the case may be, thereafter.

(q) *Shareholder Approval*. Company shall use its reasonable best efforts to seek approval from its shareholders ("**Shareholder Approval**"), in accordance with the requirements of Rule 312.03(c) of The New York Stock Exchange Listed Company Manual or any successor rule, for the issuance pursuant to the Transaction of a number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2). If Company succeeds in obtaining such approval, then upon such approval and without any further action by either party, (i) the provisions set forth opposite the caption "Maximum Number of Shares" in Section 2 shall be deemed to be replaced in their entirety with the phrase "A number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement," (ii) the Additional Termination Event set forth in Section 9(h)(ii)(G) shall no longer be applicable, (iii) the provisions set forth in Section 9(j)(ii) shall be deleted in their entirety and (iv) the provisions opposite the caption "Share Delivery Quantity" in Section 2 shall be replaced in their entirety with the sentence "For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date for such Settlement Date."

(r) *Right to Extend.* Dealer may postpone or add, in whole or in part, any Expiration Date or any other date of valuation or delivery with respect to some or all of the relevant Warrants (in which event the Calculation Agent shall make appropriate adjustments to the Daily Number of Warrants with respect to one or more Expiration Dates) if Dealer determines, in its commercially reasonable judgment, that such extension is reasonably necessary or appropriate to preserve Dealer's hedging or hedge unwind activity hereunder in light of existing liquidity conditions or to enable Dealer to effect purchases of Shares in connection with its hedging, hedge unwind or settlement activity hereunder in a manner that would, if Dealer were Issuer or an affiliated purchaser of Issuer, be in compliance with applicable

legal, regulatory or self-regulatory requirements, or with related policies and procedures applicable to Dealer.

(s) *Status of Claims in Bankruptcy.* Dealer acknowledges and agrees that this Confirmation is not intended to convey to Dealer rights against Company with respect to the Transaction that are senior to the claims of common stockholders of Company in any United States bankruptcy proceedings of Company; *provided* that nothing herein shall limit or shall be deemed to limit Dealer's right to pursue remedies in the event of a breach by Company of its obligations and agreements with respect to the Transaction; *provided*, *further*, that nothing herein shall limit or shall be deemed to limit Dealer's rights in respect of any transactions other than the Transaction.

(t) *Securities Contract; Swap Agreement.* The parties hereto intend for (i) the Transaction to be a "securities contract" and a "swap agreement" as defined in the Bankruptcy Code (Title 11 of the United States Code) (the "**Bankruptcy Code**"), and the parties hereto to be entitled to the protections afforded by, among other Sections, Sections 362(b)(6), 362(b)(17), 546(e), 546(g), 555 and 560 of the Bankruptcy Code, (ii) a party's right to liquidate the Transaction and to exercise any other remedies upon the occurrence of any Event of Default under the Agreement with respect to the other party to constitute a "contractual right" as described in the Bankruptcy Code, and (iii) each payment and delivery of cash, securities or other property hereunder to constitute a "margin payment" or "settlement payment" and a "transfer" as defined in the Bankruptcy Code.

(u) *Wall Street Transparency and Accountability Act* . In connection with Section 739 of the Wall Street Transparency and Accountability Act of 2010 ("**WSTAA**"), the parties hereby agree that neither the enactment of WSTAA or any regulation under the WSTAA, nor any requirement under WSTAA or an amendment made by WSTAA, shall limit or otherwise impair either party's otherwise applicable rights to terminate, renegotiate, modify, amend or supplement this Confirmation or the Agreement, as applicable, arising from a termination event, force majeure, illegality, increased costs, regulatory change or similar event under this Confirmation, the Equity Definitions incorporated herein, or the Agreement (including, but not limited to, rights arising from Change in Law, Hedging Disruption, Increased Cost of Hedging, an Excess Ownership Position, or Illegality (as defined in the Agreement)).

(v) *Agreements and Acknowledgements Regarding Hedging*. Company understands, acknowledges and agrees that: (A) at any time on and prior to the last Expiration Date, Dealer and its affiliates may buy or sell Shares or other securities or buy or sell options or futures contracts or enter into swaps or other derivative securities in order to adjust its hedge position with respect to the Transaction; (B) Dealer and its affiliates also may be active in the market for Shares other than in connection with hedging activities in relation to the Transaction; (C) Dealer shall make its own determination as to whether, when or in what manner any hedging or market activities in securities of Issuer shall be conducted and shall do so in a manner that it deems appropriate to hedge its price and market risk with respect to the Settlement Prices; and (D) any market activities of Dealer and its affiliates with respect to Shares may affect the market price and volatility of Shares, as well as the Settlement Prices, each in a manner that may be adverse to Company.

(w) *Early Unwind.* In the event the sale of the "Underwritten Securities" (as defined in the Purchase Agreement) is not consummated with the Initial Purchasers for any reason, or Company fails to deliver to Dealer opinions of counsel as required pursuant to Section 9(a), in each case by 5:00 p.m. (New York City time) on the Premium Payment Date, or such later date as agreed upon by the parties (the Premium Payment Date or such later date the "**Early Unwind Date**"), the Transaction shall automatically terminate (the "**Early Unwind**"), on the Early Unwind Date and (i) the Transaction and all of the respective rights and obligations of Dealer and Company under the Transaction shall be cancelled and terminated and (ii) each party shall be released and discharged by the other party from and agrees not to make any claim against the other party with respect to any obligations or liabilities of the other party arising out of and to be performed in connection with the Transaction either prior to or after the Early Unwind Date; *provided* that Company shall purchase from Dealer

on the Early Unwind Date all Shares purchased by Dealer or one or more of its affiliates in connection with the Transaction at the then prevailing market price. Each of Dealer and Company represents and acknowledges to the other that, subject to the proviso included in this Section 9(w), upon an Early Unwind, all obligations with respect to the Transaction shall be deemed fully and finally discharged.

(x) *Payment by Dealer*. In the event that (i) an Early Termination Date occurs or is designated with respect to the Transaction as a result of a Termination Event or an Event of Default (other than an Event of Default arising under Section 5(a)(ii) or 5(a)(iv) of the Agreement) and, as a result, Dealer owes to Company an amount calculated under Section 6(e) of the Agreement, or (ii) Dealer owes to Company, pursuant to Section 12.7 or Section 12.9 of the Equity Definitions, an amount calculated under Section 12.8 of the Equity Definitions, such amount shall be deemed to be zero.

(y) If Company has not obtained Shareholder Approval prior to the Approval Deadline, on the Approval Deadline (x) the First Expiration Date shall be extended by one calendar year, (y) the Warrants shall, as of April 15, 2020 (the " **Original First Expiration Date**"), cease to be to be "European Options" (as such term is defined in the Equity Definitions) and shall become, as of the Original First Expiration Date, "American Options" (as such term is defined in the Equity Definitions) exercisable as of the Original First Expiration Date and (z) the Calculation Agent shall make commercially reasonable conforming amendments to the exercise and settlement terms of the Transaction to reflect the change of the Warrants from European Options to American Options, for the avoidance of doubt, retaining (i) contingencies to exercise that are not an observable market, other than the market for the Company's stock or an observable index, other than an index calculated or measured solely by reference to the Company's own operations, (ii) the commercially reasonable nature of adjustments permitted to the Transaction (such as to consider changes in volatility, expected dividends, stock loan rate or liquidity relevant to the Shares and the ability to maintain a commercially reasonable hedge position in the underlying shares) and (iii) the Company's unilateral right to settle in shares pursuant to 9(k), including pursuant to a Share Termination Alternative as provided under Section 9(j). On each anniversary of the Approval Deadline occurring prior to the final Expiration Date, if Company has not, as of such date, obtained Shareholder Approval, the First Expiration Date shall be further extended by one additional calendar year.

(z) *Adjustments*. For the avoidance of doubt, whenever the Calculation Agent or Determining Party is called upon to make an adjustment pursuant to the terms of this Confirmation or the Equity Definitions to take into account the effect of an event, the Calculation Agent or Determining Party shall make such adjustment by reference to the effect of such event on the Hedging Party, assuming that the Hedging Party maintains a commercially reasonable hedge position.

(aa) *Delivery or Receipt of Cash*. For the avoidance of doubt, other than receipt of the Premium by Company, nothing in this Confirmation shall be interpreted as requiring Company to cash settle the Transaction, except in circumstances where cash settlement is within Company's control (including, without limitation, where Company elects to deliver or receive cash, or where Company has made Private Placement settlement unavailable due to the occurrence of events within its control) or in those circumstances in which holders of Shares would also receive cash.

(bb) *No Reliance*. The Company hereby confirms that it has relied on the advice of its own counsel and other advisors (to the extent it deems appropriate) with respect to any legal, tax, accounting, or regulatory consequences of this Confirmation, that it has not relied on Dealer or its affiliates in any respect in connection therewith, and that it will not hold Dealer or its affiliates accountable for any such consequences.

Please confirm that the foregoing correctly sets forth the terms of our agreement by executing this Confirmation and returning it to EDG Confirmation Group, J.P. Morgan Securities LLC, 277 Park Avenue, 11th Floor, New York, NY 10172-3401, or by fax to **(212) 622 8519**.

Very truly yours,

J.P. Morgan Securities LLC, as agent for JPMorgan Chase Bank, National Association

By: /s/ Yun Xie
Authorized Signatory

Name: Yun Xie

Accepted and confirmed
as of the date hereof:

Molina Healthcare, Inc.

By: /s/ John Molina

Authorized Signatory
Name: John Molina

Bank of America, N.A.
c/o Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park
New York, NY 10036
Attention: John Servidio
Telephone: 646-855-6770
Facsimile: 704-208-2869

April 22, 2013

To: **Molina Healthcare, Inc.**
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

Re: Base Warrants

The purpose of this letter agreement (this "**Confirmation**") is to amend and restate, in its entirety, the Base Warrants Confirmation dated February 11, 2013 between the parties hereto and to confirm the terms and conditions of the Warrants issued by **Molina Healthcare, Inc.** ("**Company**") to **Bank of America, N.A.** ("**Dealer**") as of the Trade Date specified below (the "**Transaction**"). The parties hereto agree and acknowledge that the amendments reflected in this amended and restated Confirmation are non-substantive, clarifying changes made for the avoidance of doubt. This letter agreement constitutes a "Confirmation" as referred to in the ISDA Master Agreement specified below. This Confirmation shall replace any previous agreements and serve as the final documentation for the Transaction.

The definitions and provisions contained in the 2002 ISDA Equity Derivatives Definitions (the "**Equity Definitions**"), as published by the International Swaps and Derivatives Association, Inc. ("**ISDA**"), are incorporated into this Confirmation. In the event of any inconsistency between the Equity Definitions and this Confirmation, this Confirmation shall govern.

Each party is hereby advised, and each such party acknowledges, that the other party has engaged in, or refrained from engaging in, substantial financial transactions and has taken other material actions in reliance upon the parties' entry into the Transaction to which this Confirmation relates on the terms and conditions set forth below.

1. This Confirmation evidences a complete and binding agreement between Dealer and Company as to the terms of the Transaction to which this Confirmation relates. This Confirmation shall supplement, form a part of, and be subject to an agreement in the form of the 2002 ISDA Master Agreement (the "**Agreement**") as if Dealer and Company had executed an agreement in such form (but without any Schedule except for the election of the laws of the State of New York as the governing law (without reference to choice of law doctrine)) on the Trade Date. In the event of any inconsistency between provisions of the Agreement and this Confirmation, this Confirmation will prevail for the purpose of the Transaction to which this Confirmation relates. The parties hereby agree that no transaction other than the Transaction to which this Confirmation relates shall be governed by the Agreement.

2. The Transaction is a Warrant Transaction, which shall be considered a Share Option Transaction for purposes of the Equity Definitions. The terms of the particular Transaction to which this Confirmation relates are as follows:

General Terms.

Trade Date:	February 11, 2013
Effective Date:	The third Exchange Business Day immediately prior to the Premium Payment Date

Warrants:	Equity call warrants, each giving the holder the right to purchase a number of Shares equal to the Warrant Entitlement at a price per Share equal to the Strike Price, subject to the terms set forth under the caption "Settlement Terms" below. For the purposes of the Equity Definitions, each reference to a Warrant herein shall be deemed to be a reference to a Call Option.
Warrant Style:	European
Seller:	Company
Buyer:	Dealer
Shares:	The common stock of Company, par value USD 0.001 per Share (Exchange symbol "MOH")
Number of Warrants:	5,187,609. For the avoidance of doubt, the Number of Warrants shall be reduced by any Warrants exercised or deemed exercised hereunder. In no event will the Number of Warrants be less than zero.
Warrant Entitlement:	One Share per Warrant
Maximum Number of Shares:	For any day, 4,394,906 Shares, *minus* the aggregate number of Shares delivered prior to such day pursuant to (i) this Confirmation and (ii) any other substantially similar confirmation for Warrants sold by Company to Dealer with a trade date within 16 days of the Trade Date and with expiration dates the same as the Expiration Dates. Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, in no event shall the Maximum Number of Shares be subject to adjustment, except for any adjustment pursuant to the terms of this Confirmation and the Equity Definitions in connection with a Potential Adjustment Event (as defined in Section 11.2(e) of the Equity Definitions and without any amendment thereto pursuant to the terms of this Confirmation). Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, the Maximum Number of Shares shall not be adjusted on account of any event that (x) constitutes a Potential Adjustment Event solely on account of Section 11.2(e)(vii) of the Equity Definitions and (y) is not an event within Company's control.
Strike Price:	USD 53.8475
Premium:	USD 28,869,539
Premium Payment Date:	February 15, 2013
Exchange:	The New York Stock Exchange
Related Exchange(s):	All Exchanges

Procedures for Exercise.

Expiration Time:	The Valuation Time
Expiration Dates:	Each Scheduled Trading Day during the period from, and including, the First Expiration Date to, but excluding, the 160th Scheduled Trading Day following the First Expiration Date shall be an "Expiration Date" for a number of Warrants equal to the Daily Number of Warrants on such date; *provided* that, notwithstanding anything to the contrary in the Equity Definitions, if any such date is a Disrupted Day, the Calculation Agent shall make adjustments, if applicable, to the Daily Number of Warrants or shall reduce such Daily Number of Warrants to zero for which such day shall be an Expiration Date and shall designate a Scheduled Trading Day or a number of Scheduled Trading Days as the Expiration Date(s) for the remaining Daily Number of Warrants or a portion thereof for the originally scheduled Expiration Date; and *provided further* that if such Expiration Date has not occurred pursuant to this clause as of the eighth Scheduled Trading Day following the last scheduled Expiration Date under the Transaction, the Calculation Agent shall have the right to declare such Scheduled Trading Day to be the final Expiration Date and the Calculation Agent shall determine its good faith estimate of the fair market value for the Shares as of the Valuation Time on that eighth Scheduled Trading Day or on any subsequent Scheduled Trading Day, as the Calculation Agent shall determine using commercially reasonable means.
First Expiration Date:	April 15, 2020 (or if such day is not a Scheduled Trading Day, the next following Scheduled Trading Day), subject to Market Disruption Event below.
Daily Number of Warrants:	For any Expiration Date, the Number of Warrants that have not expired or been exercised as of such day, *divided* by the remaining number of Expiration Dates (including such day), rounded down to the nearest whole number, subject to adjustment pursuant to the provisos to "Expiration Dates".
Automatic Exercise:	Applicable; and means that for each Expiration Date, a number of Warrants equal to the Daily Number of Warrants for such Expiration Date will be deemed to be automatically exercised at the Expiration Time on such Expiration Date.
Market Disruption Event:	Section 6.3(a) of the Equity Definitions is hereby amended by replacing clause (ii) in its entirety with "(ii) an Exchange Disruption, or" and inserting immediately following clause (iii) the phrase "; in each case that the Calculation Agent determines is material." Section 6.3(d) of the Equity Definitions is hereby amended by deleting the remainder of the provision following the words "Scheduled Closing Time" in the fourth line thereof.

Valuation Terms.

Valuation Time:	Scheduled Closing Time; *provided* that if the principal trading session is extended, the Calculation Agent shall

	determine the Valuation Time in good faith using its commercially reasonable discretion.
Valuation Date:	Each Exercise Date.

Settlement Terms.

Settlement Method:	Net Share Settlement.
Net Share Settlement:	On the relevant Settlement Date, Company shall deliver to Dealer a number of Shares equal to the Share Delivery Quantity for such Settlement Date to the account specified herein free of payment through the Clearance System, and Dealer shall be treated as the holder of record of such Shares at the time of delivery of such Shares or, if earlier, at 5:00 p.m. (New York City time) on such Settlement Date, and Company shall pay to Dealer cash in lieu of any fractional Share based on the Settlement Price on the relevant Valuation Date.
Share Delivery Quantity:	For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date for such Settlement Date; *provided* that in no event shall the Share Delivery Quantity for any Settlement Date exceed the Maximum Number of Shares for such Settlement Date.
Net Share Settlement Amount:	For any Settlement Date, an amount equal to the product of (i) the number of Warrants exercised or deemed exercised on the relevant Exercise Date, (ii) the Strike Price Differential for the relevant Valuation Date and (iii) the Warrant Entitlement.
Settlement Price:	For any Valuation Date, the per Share volume-weighted average price as displayed under the heading "Bloomberg VWAP" on Bloomberg page MOH <equity> AQR (or any successor thereto) in respect of the period from the scheduled opening time of the Exchange to the Scheduled Closing Time on such Valuation Date (or if such volume-weighted average price is unavailable, the market value of one Share on such Valuation Date, as determined by the Calculation Agent). Notwithstanding the foregoing, if (i) any Expiration Date is a Disrupted Day and (ii) the Calculation Agent determines that such Expiration Date shall be an Expiration Date for fewer than the Daily Number of Warrants, as described above, then the Settlement Price for the relevant Valuation Date shall be the volume-weighted average price per Share on such Valuation Date on the Exchange, as determined by the Calculation Agent based on such sources as it deems appropriate using a volume-weighted methodology, for the portion of such Valuation Date for which the Calculation Agent determines there is no Market Disruption Event.
Settlement Dates:	As determined pursuant to Section 9.4 of the Equity Definitions, subject to Section 9(k)(i) hereof.

Other Applicable Provisions:	The provisions of Sections 9.1(c), 9.8, 9.9, 9.11 and 9.12 of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Net Share Settled." "Net Share Settled" in relation to any Warrant means that Net Share Settlement is applicable to that Warrant.
Representation and Agreement:	Notwithstanding Section 9.11 of the Equity Definitions, the parties acknowledge that any Shares delivered to Dealer may be, upon delivery, subject to restrictions and limitations arising from Company's status as issuer of the Shares under applicable securities laws.

3. Additional Terms applicable to the Transaction.

Adjustments applicable to the Transaction:

Method of Adjustment:	Calculation Agent Adjustment. For the avoidance of doubt, in making any adjustments under the Equity Definitions, the Calculation Agent may make adjustments, if any, to any one or more of the Strike Price, the Number of Warrants, the Daily Number of Warrants and the Warrant Entitlement. Notwithstanding the foregoing, any cash dividends or distributions on the Shares, whether or not extraordinary, shall be governed by Section 9(f) of this Confirmation in lieu of Article 10 or Section 11.2(c) of the Equity Definitions.

Extraordinary Events applicable to the Transaction:

New Shares:	Section 12.1(i) of the Equity Definitions is hereby amended (a) by deleting the text in clause (i) thereof in its entirety (including the word "and" following clause (i)) and replacing it with the phrase "publicly quoted, traded or listed (or whose related depositary receipts are publicly quoted, traded or listed) on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors)" and (b) by inserting immediately prior to the period the phrase "and (iii) of an entity or person that is a corporation organized under the laws of the United States, any State thereof or the District of Columbia that also becomes Company under the Transaction following such Merger Event or Tender Offer".

Consequence of Merger Events:

Merger Event:	Applicable; *provided* that if an event occurs that constitutes both a Merger Event under Section 12.1(b) of the Equity Definitions and an Additional Termination Event under Section 9(h)(ii)(B) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the provisions of Section 12.2 of the Equity Definitions or Section 9(h)(ii)(B) will apply.
Share-for-Share:	Modified Calculation Agent Adjustment
Share-for-Other:	Cancellation and Payment (Calculation Agent Determination)

Share-for-Combined:	Cancellation and Payment (Calculation Agent Determination); *provided* that Dealer may elect, in its commercially reasonable judgment, Component Adjustment (Calculation Agent Determination) for all or any portion of the Transaction.
Consequence of Tender Offers:	
Tender Offer:	Applicable; *provided* that if an event occurs that constitutes both a Tender Offer under Section 12.1(d) of the Equity Definitions and Additional Termination Event under Section 9(h)(ii)(A) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the provisions of Section 12.3 of the Equity Definitions or Section 9(h)(ii)(A) will apply.
Share-for-Share:	Modified Calculation Agent Adjustment
Share-for-Other:	Modified Calculation Agent Adjustment
Share-for-Combined:	Modified Calculation Agent Adjustment
Announcement Event:	If an Announcement Date occurs in respect of a Merger Event (for the avoidance of doubt, determined without regard to the language in the definition of "Merger Event" following the definition of "Reverse Merger" therein) or Tender Offer (such occurrence, an "**Announcement Event**"), then on the earliest of the Expiration Date, Early Termination Date or other date of cancellation (the "**Announcement Event Adjustment Date**") in respect of each Warrant, the Calculation Agent will determine the economic effect on such Warrant of the Announcement Event (regardless of whether the Announcement Event actually results in a Merger Event or Tender Offer, and taking into account such factors as the Calculation Agent may determine, including, without limitation, changes in volatility, expected dividends, stock loan rate or liquidity relevant to the Shares or the Transaction whether prior to or after the Announcement Event or for any period of time, including, without limitation, the period from the Announcement Event to the relevant Announcement Event Adjustment Date). If the Calculation Agent determines that such economic effect on any Warrant is material, then on the Announcement Event Adjustment Date for such Warrant, the Calculation Agent may make such adjustment to the exercise, settlement, payment or any other terms of such Warrant as the Calculation Agent determines appropriate to account for such economic effect, which adjustment shall be effective immediately prior to the exercise, termination or cancellation of such Warrant, as the case may be.
Announcement Date:	The definition of "Announcement Date" in Section 12.1 of the Equity Definitions is hereby amended by (i) replacing the words "a firm" with the word "any" in the second and fourth lines thereof, (ii) replacing the word "leads to the" with the words ", if completed, would lead to a" in the third

and the fifth lines thereof, (iii) replacing the words "voting shares" with the word "Shares" in the fifth line thereof, and (iv) inserting the words "by any entity" after the word "announcement" in the second and the fourth lines thereof.

Nationalization, Insolvency or Delisting: Cancellation and Payment (Calculation Agent Determination); *provided* that, in addition to the provisions of Section 12.6(a)(iii) of the Equity Definitions, it will also constitute a Delisting if the Exchange is located in the United States and the Shares are not immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors); if the Shares are immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors), such exchange or quotation system shall thereafter be deemed to be the Exchange.

Additional Disruption Events:

Change in Law: Applicable; *provided* that Section 12.9(a)(ii) of the Equity Definitions is hereby amended by (i) replacing the word "Shares" with the phrase "Hedge Positions" in clause (X) thereof and (ii) inserting the parenthetical "(including, for the avoidance of doubt and without limitation, adoption, effectiveness or promulgation of new regulations authorized or mandated by existing statute)" at the end of clause (A) thereof.

Failure to Deliver: Not Applicable

Insolvency Filing: Applicable

Hedging Disruption: Applicable; *provided* that:

(i) Section 12.9(a)(v) of the Equity Definitions is hereby amended by (a) inserting the following words at the end of clause (A) thereof: "in the manner contemplated by the Hedging Party on the Trade Date" and (b) inserting the following two phrases at the end of such Section:

"For the avoidance of doubt, the term "equity price risk" shall be deemed to include, but shall not be limited to, stock price and volatility risk. And, for the further avoidance of doubt, any such transactions or assets referred to in phrases (A) or (B) above must be available on commercially reasonable pricing terms."; and

(ii) Section 12.9(b)(iii) of the Equity Definitions is hereby amended by inserting in the third line thereof, after the words "to terminate the Transaction", the words "or a portion of the Transaction affected by such Hedging Disruption".

Increased Cost of Hedging: Applicable

Loss of Stock Borrow:	Applicable
Maximum Stock Loan Rate:	100 basis points
Increased Cost of Stock Borrow:	Applicable
Initial Stock Loan Rate:	25 basis points
Hedging Party:	For all applicable Additional Disruption Events, Dealer.
Determining Party:	For all applicable Extraordinary Events, Dealer.
Non-Reliance:	Applicable
Agreements and Acknowledgments Regarding Hedging Activities:	Applicable
Additional Acknowledgments:	Applicable

4. **Calculation Agent.** Dealer

5. **Account Details.**

(a)Account for payments to Company: To Be Advised.

Account for delivery of Shares from Company: To Be Advised.

(b)Account for payments to Dealer:

Bank of America, N.A.
New York, NY
SWIFT: BOFAUS3N
Bank Routing: 026-009-593
Account Name: Bank of America
Account No. : 0012334-61892

6. **Offices.**

(a)The Office of Company for the Transaction is: Inapplicable, Company is not a Multibranch Party.

(b)The Office of Dealer for the Transaction is: New York

Bank of America, N.A.
c/o Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park
New York, NY 10036
Attention: John Servidio
Telephone: 646-855-7127
Facsimile: 704-208-2869

7. **Notices.**

(a)Address for notices or communications to Company:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

(b)Address for notices or communications to Dealer:

To: Bank of America, N.A.
c/o Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park
New York, NY 10036

Attention: John Servidio
Telephone: 646-855-7127
Facsimile: 704-208-2869

8. Representations and Warranties of Company.

Each of the representations and warranties of Company set forth in Section 3 of the Purchase Agreement (the "**Purchase Agreement**"), dated as of February 11, 2013, among Company and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as representatives of the Initial Purchasers party thereto (the "**Initial Purchasers**"), other than the representations set forth in Section 3(o), Section 3(r) and Section 3(s) of the Purchase Agreement, in each case, as such representations relate to the Transaction, are true and correct and are hereby deemed to be repeated to Dealer as if set forth herein. Company hereby further represents and warrants to Dealer on the Trade Date, the date hereof, on and as of the Premium Payment Date and, in the case of the representations in Section 8(d), at all times until termination of the Transaction, that:

(a)Company has all necessary corporate power and authority to execute, deliver and perform its obligations in respect of the Transaction; such execution, delivery and performance have been duly authorized by all necessary corporate action on Company's part; and this Confirmation has been duly and validly executed and delivered by Company and constitutes its valid and binding obligation, enforceable against Company in accordance with its terms, subject to applicable bankruptcy, insolvency, fraudulent conveyance, reorganization, moratorium and similar laws affecting creditors' rights and remedies generally, and subject, as to enforceability, to general principles of equity, including principles of commercial reasonableness, good faith and fair dealing (regardless of whether enforcement is sought in a proceeding at law or in equity) and except that rights to indemnification and contribution hereunder may be limited by federal or state securities laws or public policy relating thereto.

(b)Neither the execution and delivery of this Confirmation nor the incurrence or performance of obligations of Company hereunder will conflict with or result in a breach of the certificate of incorporation or by-laws (or any equivalent documents) of Company, or any applicable law or regulation, or any order, writ, injunction or decree of any court or governmental authority or agency, or any agreement or instrument to which Company or any of its subsidiaries is a party or by which Company or any of its subsidiaries is bound or to which Company or any of its subsidiaries is subject, or constitute a default under, or result in the creation of any lien under, any such agreement or instrument.

(c)No consent, approval, authorization, or order of, or filing with, any governmental agency or body or any court is required in connection with the execution, delivery or performance by Company of this Confirmation, except such as have been obtained or made and such as may be required under the Securities Act of 1933, as amended (the "**Securities Act**") or state securities laws.

(d)A number of Shares equal to the Maximum Number of Shares (the "**Warrant Shares**") have been reserved for issuance by all required corporate action of Company. The Warrant Shares have been duly authorized and, when delivered against payment therefor (which may include Net Share Settlement in lieu of cash) and otherwise as contemplated by the terms of the Warrants following the exercise of the Warrants in accordance with the terms and conditions of the Warrants, will be validly issued, fully-paid and non-assessable, and the issuance of the Warrant Shares will not be subject to any preemptive or similar rights.

(e)Company is not and, after consummation of the transactions contemplated hereby, will not be required to register as an "investment company" as such term is defined in the Investment Company Act of 1940, as amended.

(f)Company is an "eligible contract participant" (as such term is defined in Section 1a(18) of the Commodity Exchange Act, as amended, other than a person that is an eligible contract participant under Section 1a(18)(C) of the Commodity Exchange Act).

(g)Company and each of its affiliates is not, on the date hereof, in possession of any material non-public information with respect to Company.

(h)No state or local (including any non-U.S. jurisdiction's) law, rule, regulation or regulatory order applicable to the Shares would give rise to any reporting, consent, registration or other requirement (including without limitation a requirement to obtain prior approval from any person or entity) as a result of Dealer or its affiliates owning or holding (however defined) Shares.

(i)Company (A) is capable of evaluating investment risks independently, both in general and with regard to all transactions and investment strategies involving a security or securities; (B) will exercise independent judgment in evaluating the recommendations of any broker-dealer or its associated persons, unless it has otherwise notified the broker-dealer in writing; and (C) has total assets of at least $50 million.

9. Other Provisions.

(a)*Opinions*. Company shall deliver to Dealer an opinion of counsel, dated as of the Trade Date, with respect to the matters set forth in Sections 8(a) through (d) of this Confirmation. Delivery of such opinion to Dealer shall be a condition precedent for the purpose of Section 2(a)(iii) of the Agreement with respect to each obligation of Dealer under Section 2(a)(i) of the Agreement.

(b)*Repurchase Notices*. Company shall, on any day on which Company effects any repurchase of Shares, promptly give Dealer a written notice of such repurchase (a "**Repurchase Notice**") on such day if following such repurchase, the number of outstanding Shares on such day, subject to any adjustments provided herein, is (i) less than 45,295,973 (in the case of the first such notice) or (ii) thereafter more than 1,390,754 less than the number of Shares included in the immediately preceding Repurchase Notice. Company agrees to indemnify and hold harmless Dealer and its affiliates and their respective officers, directors, employees, affiliates, advisors, agents and controlling persons (each, an "**Indemnified Person**") from and against any and all losses (including losses relating to Dealer's hedging activities as a consequence of becoming, or of the risk of becoming, a Section 16 "insider", including without limitation, any forbearance from hedging activities or cessation of hedging activities and any losses in connection therewith with respect to the Transaction), claims, damages, judgments, liabilities and expenses (including reasonable attorney's fees), joint or several, which an Indemnified Person actually may become subject to, as a result of Company's failure to provide Dealer with a Repurchase Notice on the day and in the manner specified in this paragraph, and to reimburse, within 30 days, upon written request, each of such Indemnified Persons for any reasonable legal or other expenses incurred in connection with investigating, preparing for, providing testimony or other evidence in connection with or defending any of the foregoing. If any suit, action, proceeding (including any governmental or regulatory investigation), claim or demand shall be brought or asserted against the Indemnified Person, such Indemnified Person shall promptly notify Company in writing, and Company, upon request of the Indemnified Person, shall retain counsel reasonably satisfactory to the Indemnified Person to represent the Indemnified Person and any others Company may designate in such proceeding and shall pay the fees and expenses of such counsel related to such proceeding. Company shall not be liable for any settlement of any proceeding effected without its written consent, but if settled with such consent or if there be a final judgment for the plaintiff, Company agrees to indemnify any Indemnified Person from and against any loss or liability by reason of such settlement or judgment. Company shall not, without the prior written consent of the Indemnified Person, effect any settlement of any pending or threatened proceeding in respect of which any Indemnified Person is or could have been a party and indemnity could have been sought hereunder by such Indemnified Person, unless such settlement includes an unconditional release of such Indemnified Person from all liability on claims that are the subject matter of such proceeding on terms reasonably satisfactory to such Indemnified Person. If the indemnification provided for in this paragraph is unavailable to an Indemnified Person or insufficient in respect of any losses, claims, damages or liabilities referred

to therein, then Company under such paragraph, in lieu of indemnifying such Indemnified Person thereunder, shall contribute to the amount paid or payable by such Indemnified Person as a result of such losses, claims, damages or liabilities. The remedies provided for in this paragraph are not exclusive and shall not limit any rights or remedies which may otherwise be available to any Indemnified Person at law or in equity. The indemnity and contribution agreements contained in this paragraph shall remain operative and in full force and effect regardless of the termination of the Transaction.

(c) *Regulation M*. Company is not on the Trade Date engaged in a distribution, as such term is used in Regulation M under the Securities Exchange Act of 1934, as amended (the "**Exchange Act**"), of any securities of Company, other than a distribution meeting the requirements of the exception set forth in Rules 101(b)(10) and 102(b)(7) of Regulation M. Company shall not, until the second Scheduled Trading Day immediately following the Effective Date, engage in any such distribution.

(d) *No Manipulation*. Company is not entering into the Transaction to create actual or apparent trading activity in the Shares (or any security convertible into or exchangeable for the Shares) or to raise or depress or otherwise manipulate the price of the Shares (or any security convertible into or exchangeable for the Shares) or otherwise in violation of the Exchange Act.

(e) *Transfer or Assignment*. Company may not transfer any of its rights or obligations under the Transaction without the prior written consent of Dealer. Dealer may, without Company's consent, transfer or assign all or any part of its rights or obligations under the Transaction to any third party. If at any time at which (A) the Section 16 Percentage exceeds 7.5%, (B) the Warrant Equity Percentage exceeds 16.3%, or (C) the Share Amount exceeds the Applicable Share Limit (if any applies) (any such condition described in clauses (A), (B) or (C), an "**Excess Ownership Position**"), Dealer is unable after using its commercially reasonable efforts to effect a transfer or assignment of Warrants to a third party on pricing terms reasonably acceptable to Dealer and within a time period reasonably acceptable to Dealer such that no Excess Ownership Position exists, then Dealer may designate any Exchange Business Day as an Early Termination Date with respect to a portion of the Transaction (the "**Terminated Portion**"), such that following such partial termination no Excess Ownership Position exists. In the event that Dealer so designates an Early Termination Date with respect to a Terminated Portion, a payment shall be made pursuant to Section 6 of the Agreement as if (1) an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants underlying the Terminated Portion, (2) Company were the sole Affected Party with respect to such partial termination and (3) the Terminated Portion were the sole Affected Transaction (and, for the avoidance of doubt, the provisions of Section 9(j) shall apply to any amount that is payable by Company to Dealer pursuant to this sentence as if Company was not the Affected Party). The "**Section 16 Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the number of Shares that Dealer and each person subject to aggregation of Shares with Dealer under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder directly or indirectly beneficially own (as defined under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder) and (B) the denominator of which is the number of Shares outstanding. The "**Warrant Equity Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the sum of (1) the product of the Number of Warrants and the Warrant Entitlement and (2) the aggregate number of Shares underlying any other warrants purchased by Dealer from Company, and (B) the denominator of which is the number of Shares outstanding. The "**Share Amount**" as of any day is the number of Shares that Dealer and any person whose ownership position would be aggregated with that of Dealer (Dealer or any such person, a "**Dealer Person**") under any law, rule, regulation, regulatory order or organizational documents or contracts of Company that are, in each case, applicable to ownership of Shares ("**Applicable Restrictions**"), owns, beneficially owns, constructively owns, controls, holds the power to vote or otherwise meets a relevant definition of ownership under any Applicable Restriction, as determined by Dealer in its reasonable discretion. The "**Applicable Share Limit**" means a number of Shares equal to (A) the minimum number of Shares that could give rise to reporting or registration obligations or other requirements (including obtaining prior approval from any person or entity) of a Dealer Person, or could result in an adverse effect on a Dealer Person, under any Applicable Restriction, as determined by Dealer in its reasonable

discretion, *minus* (B) 1% of the number of Shares outstanding. Notwithstanding any other provision in this Confirmation to the contrary requiring or allowing Dealer to purchase, sell, receive or deliver any Shares or other securities, or to make or receive any payment in cash, to or from Company, Dealer may designate any of its affiliates to purchase, sell, receive or deliver such Shares or other securities, or make or receive such payment in cash, and otherwise to perform Dealer's obligations in respect of the Transaction and any such designee may assume such obligations. Dealer shall be discharged of its obligations to Company to the extent of any such performance.

(f) *Dividends*. If at any time during the period from and including the Effective Date, to and including the last Expiration Date, an ex-dividend date for a cash dividend occurs with respect to the Shares (an "**Ex-Dividend Date**"), then the Calculation Agent will adjust any of the Strike Price, Number of Warrants, Daily Number of Warrants and/or any other variable relevant to the exercise, settlement or payment of the Transaction to preserve the fair value of the Warrants after taking into account such dividend.

(g) *Designation by Dealer*. Notwithstanding any other provision in this Confirmation to the contrary requiring or allowing Dealer to purchase, sell, receive or deliver any Shares or other securities to or from Company, Dealer may designate any of its affiliates to purchase, sell, receive or deliver such shares or other securities and otherwise to perform Dealer obligations in respect of the Transaction and any such designee may assume such obligations. Dealer shall be discharged of its obligations to Company to the extent of any such performance.

(h) *Additional Provisions*.

(i) Amendments to the Equity Definitions:

(A) Section 11.2(a) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the words "an"; and adding the phrase "or Warrants" at the end of the sentence.

(B) Section 11.2(c) of the Equity Definitions is hereby amended by (w) replacing the words "a diluting or concentrative" with "an" in the fifth line thereof, (x) adding the phrase "or Warrants" after the words "the relevant Shares" in the same sentence, (y) deleting the words "diluting or concentrative" in the sixth to last line thereof and (z) deleting the phrase "(provided that no adjustments will be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)" and replacing it with the phrase "(and, for the avoidance of doubt, adjustments may be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)."

(C) Section 11.2(e)(vii) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the word "a material"; and adding the phrase "or Warrants" at the end of the sentence.

(D) Section 12.6(a)(ii) of the Equity Definitions is hereby amended by (1) deleting from the fourth line thereof the word "or" after the word "official" and inserting a comma therefor, and (2) deleting the semi-colon at the end of subsection (B) thereof and inserting the following words therefor "or (C) at Dealer's option, the occurrence of any of the events specified in Section 5(a)(vii) (1) through (9) of the ISDA Master Agreement with respect to that Issuer."

(E) Section 12.9(b)(iv) of the Equity Definitions is hereby amended by:

(x) deleting (1) subsection (A) in its entirety, (2) the phrase "or (B)" following subsection (A) and (3) the phrase "in each case" in subsection (B); and

(y) replacing the phrase "neither the Non-Hedging Party nor the Lending Party lends Shares" with the phrase "such Lending Party does not lend Shares" in the penultimate sentence.

(F) Section 12.9(b)(v) of the Equity Definitions is hereby amended by:

(x) adding the word "or" immediately before subsection "(B)" and deleting the comma at the end of subsection (A); and

(y) (1) deleting subsection (C) in its entirety, (2) deleting the word "or" immediately preceding subsection (C), (3) deleting the penultimate sentence in its entirety and replacing it with the sentence "The Hedging Party will determine the Cancellation Amount payable by one party to the other." and (4) deleting clause (X) in the final sentence.

(ii) Notwithstanding anything to the contrary in this Confirmation, upon the occurrence of one of the following events, with respect to the Transaction, (1) Dealer shall have the right to designate such event an Additional Termination Event and designate an Early Termination Date pursuant to Section 6(b) of the Agreement, (2) Company shall be deemed the sole Affected Party with respect to such Additional Termination Event and (3) the Transaction, or, at the election of Dealer in its sole discretion, any portion of the Transaction, shall be deemed the sole Affected Transaction; *provided* that if Dealer so designates an Early Termination Date with respect to a portion of the Transaction, (a) a payment shall be made pursuant to Section 6 of the Agreement as if an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants included in the terminated portion of the Transaction, and (b) for the avoidance of doubt, the Transaction shall remain in full force and effect except that the Number of Warrants shall be reduced by the number of Warrants included in such terminated portion:

(A) A "person" or "group" within the meaning of Section 13(d) of the Exchange Act, other than Company, its subsidiaries or its and their employee benefit plans, files a Schedule TO or any schedule, form or report under the Exchange Act disclosing that such person or group has become the direct or indirect "beneficial owner," as defined in Rule 13d-3 under the Exchange Act, of the common equity of Company representing more than 50% of the voting power of such common equity.

(B) Consummation of (I) any recapitalization, reclassification or change of the Shares (other than changes resulting from a subdivision or combination) as a result of which the Shares would be converted into, or exchanged for, stock, other securities, other property or assets or (II) any share exchange, consolidation or merger of Company pursuant to which the Shares will be converted into cash, securities or other property or (III) any sale, lease or other transfer in one transaction or a series of transactions of all or substantially all of the consolidated assets of Company and its subsidiaries, taken as a whole, to any person other than one of Company's subsidiaries. Notwithstanding the foregoing, any transaction or transactions set forth in this clause (B) shall not constitute an Additional Termination Event if (x) at least 90% of the consideration received or to be received by holders of the Shares, excluding cash payments for fractional Shares, in connection with such transaction or transactions consists of shares of common stock that are listed or quoted on any of The New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or any of their respective successors) or will be so listed or quoted when issued or exchanged in connection with such transaction or transactions, and (y) as a result of such transaction or transactions, the Shares will consist of such consideration, excluding cash payments for fractional Shares.

(C) Company's shareholders approve any plan or proposal for the liquidation or dissolution of Company.

(D) Default by Company or any of its subsidiaries with respect to any mortgage, agreement or other instrument under which there may be outstanding, or by which there may be secured or evidenced, any indebtedness for money borrowed in excess of $15 million in the aggregate of Company and/or any such subsidiary, whether such indebtedness now exists or shall hereafter be created (i) resulting in such indebtedness becoming or being declared due and payable or (ii) constituting a failure to pay the principal or interest of any such debt when due and payable at its stated maturity, upon required repurchase, upon declaration of acceleration or otherwise.

(E) A final judgment for the payment of $15 million or more (excluding any amounts covered by insurance) rendered against Company or any of its subsidiaries, which judgment is not discharged or stayed within 60 days after (I) the date on which the right to appeal thereof has expired if no such appeal has commenced, or (II) the date on which all rights to appeal have been extinguished.

(F) Dealer, despite using commercially reasonable efforts, is unable or reasonably determines that it is impractical or illegal, to hedge its exposure with respect to the Transaction in the public market without registration under the Securities Act or as a result of any legal, regulatory or self-regulatory requirements or related policies and procedures (whether or not such requirements, policies or procedures are imposed by law or have been voluntarily adopted by Dealer).

(G) On any day during the period from and including the Trade Date, to and including the final Expiration Date, (I) the Notional Unwind Shares (as defined below) as of such day exceeds a number of Shares equal to 60% of the Maximum Number of Shares, or (II) Company makes a public announcement of any transaction or event that, in the reasonable opinion of Dealer would, upon consummation of such transaction or upon the occurrence of such event, as applicable, and after giving effect to any applicable adjustments hereunder, cause the Notional Unwind Shares immediately following the consummation of such transaction or the occurrence of such event to exceed a number of Shares equal to 60% of the Maximum Number of Shares. The "**Notional Unwind Shares**" as of any day is a number of Shares equal to (1) the amount that would be payable pursuant to Section 6 of the Agreement (determined as of such day as if an Early Termination Date had been designated in respect of the Transaction and as if Company were the sole Affected Party and the Transaction were the sole Affected Transaction), *divided by* (2) the Settlement Price (determined as if such day were a Valuation Date).

(H) If Company has not obtained Shareholder Approval prior to February 11, 2014 (the "**Approval Deadline**"). For the avoidance of doubt, if Company has not obtained Shareholder Approval prior to the Approval Deadline, Dealer shall have right to designate an Early Termination Date in connection with the Additional Termination Event set forth in this clause (H) on any day from, and including, the Approval Deadline to, and including, the earlier of (x) the date on which Company obtains Shareholder Approval and (y) the final Expiration Date.

(i) *No Collateral or Setoff*. Notwithstanding any provision of the Agreement or any other agreement between the parties to the contrary, the obligations of Company hereunder are not secured by any collateral. Obligations under the Transaction shall not be set off by Company against any other obligations of the parties, whether arising under the Agreement, this Confirmation, under any other agreement between the parties hereto, by operation of law or otherwise. Any provision in the Agreement with respect to the satisfaction of Company's payment obligations to the extent of Dealer's payment obligations to Company in the same currency and in the same Transaction (including, without

limitation Section 2(c) thereof) shall not apply to Company and, for the avoidance of doubt, Company shall fully satisfy such payment obligations notwithstanding any payment obligation to Company by Dealer in the same currency and in the same Transaction. In calculating any amounts under Section 6(e) of the Agreement, notwithstanding anything to the contrary in the Agreement, (1) separate amounts shall be calculated as set forth in such Section 6(e) with respect to (a) the Transaction and (b) all other Transactions, and (2) such separate amounts shall be payable pursuant to Section 6(d)(ii) of the Agreement. For the avoidance of doubt and notwithstanding anything to the contrary provided in this Section 9(i), in the event of bankruptcy or liquidation of either Company or Dealer, neither party shall have the right to set off any obligation that it may have to the other party under the Transaction against any obligation such other party may have to it, whether arising under the Agreement, this Confirmation or any other agreement between the parties hereto, by operation of law or otherwise.

(j) *Alternative Calculations and Payment on Early Termination and on Certain Extraordinary Events*.

(i) If, in respect of the Transaction, an amount is payable by Company to Dealer, (A) pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or (B) pursuant to Section 6(d)(ii) of the Agreement (any such amount, a "**Payment Obligation**"), Company shall satisfy the Payment Obligation by the Share Termination Alternative (as defined below), unless (a) Company gives irrevocable telephonic notice to Dealer, confirmed in writing within one Scheduled Trading Day, no later than 12:00 p.m. (New York City time) on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable, of its election that the Share Termination Alternative shall not apply, (b) Company remakes the representation set forth in Section 8(g) as of the date of such election and (c) Dealer agrees, in its sole discretion, to such election, in which case the provisions of Section 12.7 or Section 12.9 of the Equity Definitions, or the provisions of Section 6(d)(ii) of the Agreement, as the case may be, shall apply.

Share Termination Alternative:	If applicable, Company shall deliver to Dealer the Share Termination Delivery Property on the date (the "**Share Termination Payment Date**") on which the Payment Obligation would otherwise be due pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or Section 6(d)(ii) of the Agreement, as applicable, subject to Section 9(k)(i) below, in satisfaction, subject to Section 9(k)(ii) below, of the relevant Payment Obligation, in the manner reasonably requested by Dealer free of payment.
Share Termination Delivery Property:	A number of Share Termination Delivery Units, as calculated by the Calculation Agent, equal to the relevant Payment Obligation *divided by* the Share Termination Unit Price. The Calculation Agent shall adjust the amount of Share Termination Delivery Property by replacing any fractional portion of a security therein with an amount of cash equal to the value of such fractional security based on the values used to calculate the Share Termination Unit Price (without giving effect to any discount pursuant to Section 9(k)(i)).
Share Termination Unit Price:	The value of property contained in one Share Termination Delivery Unit on the date such Share Termination Delivery Units are to be delivered as Share Termination Delivery Property, as determined by the

Calculation Agent in its good faith discretion by commercially reasonable means. In the case of a Private Placement of Share Termination Delivery Units that are Restricted Shares (as defined below), as set forth in Section 9(k)(i) below, the Share Termination Unit Price shall be determined by the discounted price applicable to such Share Termination Delivery Units. In the case of a Registration Settlement of Share Termination Delivery Units that are Restricted Shares (as defined below) as set forth in Section 9(k)(ii) below, notwithstanding the foregoing, the Share Termination Unit Price shall be the Settlement Price on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable. The Calculation Agent shall notify Company of the Share Termination Unit Price at the time of notification of such Payment Obligation to Company or, if applicable, at the time the discounted price applicable to the relevant Share Termination Units is determined pursuant to Section 9(k)(i).

Share Termination Delivery Unit: One Share or, if the Shares have changed into cash or any other property or the right to receive cash or any other property as the result of a Nationalization, Insolvency or Merger Event (any such cash or other property, the "**Exchange Property**"), a unit consisting of the type and amount of Exchange Property received by a holder of one Share (without consideration of any requirement to pay cash or other consideration in lieu of fractional amounts of any securities) in such Nationalization, Insolvency or Merger Event. If such Nationalization, Insolvency or Merger Event involves a choice of Exchange Property to be received by holders, such holder shall be deemed to have elected to receive the maximum possible amount of cash.

Failure to Deliver: Inapplicable

Other applicable provisions: If Share Termination Alternative is applicable, the provisions of Sections 9.8, 9.9, 9.11 and 9.12 (as modified above) of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Share Termination Settled" and all references to "Shares" shall be read as references to "Share Termination Delivery Units". "Share Termination Settled" in relation to the Transaction means that the Share Termination Alternative is applicable to the Transaction.

(ii) Notwithstanding anything to the contrary in this Confirmation, any Payment Obligation under this Confirmation shall, for all purposes, be calculated as if the Maximum Number of Shares were equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) but any deliveries under Section 9(j)(i) shall be limited to the Maximum Number of Shares as defined in Section 2

hereof. In the event Company shall not have delivered to Dealer the full number of Shares or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has not obtained shareholder approval pursuant to Section 9(q) for the Maximum Number of Shares to equal two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) (such deficit, the "**Approval Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Approval Deficit Shares have been delivered pursuant to this Section 9(j)(ii), when, and to the extent that the Company obtains shareholder approval; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(j)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares as so increased pursuant to Section 9(q).

(k) *Registration/Private Placement Procedures*. If, in the reasonable opinion of Dealer, following any delivery of Shares or Share Termination Delivery Property to Dealer hereunder, such Shares or Share Termination Delivery Property would be in the hands of Dealer subject to any applicable restrictions with respect to any registration or qualification requirement or prospectus delivery requirement for such Shares or Share Termination Delivery Property pursuant to any applicable federal or state securities law (including, without limitation, any such requirement arising under Section 5 of the Securities Act as a result of such Shares or Share Termination Delivery Property being "restricted securities", as such term is defined in Rule 144 under the Securities Act, or as a result of the sale of such Shares or Share Termination Delivery Property being subject to paragraph (c) of Rule 145 under the Securities Act) (such Shares or Share Termination Delivery Property, "**Restricted Shares**"), then delivery of such Restricted Shares shall be effected pursuant to either clause (i) or (ii) below at the election of Company, unless Dealer waives the need for registration/private placement procedures set forth in (i) and (ii) below. Notwithstanding the foregoing, solely in respect of any Daily Number of Warrants exercised or deemed exercised on any Expiration Date, Company shall elect, prior to the first Settlement Date for the first applicable Expiration Date, a Private Placement Settlement or Registration Settlement for all deliveries of Restricted Shares for all such Expiration Dates which election shall be applicable to all remaining Settlement Dates for such Warrants and the procedures in clause (i) or clause (ii) below shall apply for all such delivered Restricted Shares on an aggregate basis commencing after the final Settlement Date for such Warrants. The Calculation Agent shall make reasonable adjustments to settlement terms and provisions under this Confirmation to reflect a single Private Placement or Registration Settlement for such aggregate Restricted Shares delivered hereunder.

(i) If Company elects to settle the Transaction pursuant to this clause (i) (a "**Private Placement Settlement**"), then delivery of Restricted Shares by Company shall be effected in customary private placement procedures with respect to such Restricted Shares reasonably acceptable to Dealer; *provided* that Company may not elect a Private Placement Settlement if, on the date of its election, it has taken, or caused to be taken, any action that would make unavailable either the exemption pursuant to Section 4(2) of the Securities Act for the sale by Company to Dealer (or any affiliate designated by Dealer) of the Restricted Shares or the exemption pursuant to Section 4(1) or Section 4(3) of the Securities Act for resales of the Restricted Shares by Dealer (or any such affiliate of Dealer). The Private Placement Settlement of such Restricted Shares shall include customary representations, covenants, blue sky and other governmental filings and/or registrations, indemnities to Dealer, due diligence rights (for Dealer or any designated buyer of the Restricted Shares by Dealer), opinions and certificates, and such other documentation as is customary for private placement agreements of similar size, all reasonably acceptable to Dealer. In the case of a Private Placement Settlement, Dealer shall determine the appropriate discount to the Share Termination Unit Price (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or any Settlement Price (in the case of settlement of Shares pursuant to Section 2 above) applicable to such Restricted Shares in a commercially reasonable manner and appropriately adjust the number of such Restricted Shares to be delivered to Dealer

hereunder, which discount shall only take into account the illiquidity resulting from the fact that the Restricted Shares will not be registered for resale and any commercially reasonable fees and expenses of Dealer (and any affiliate thereof) in connection with such resale. Notwithstanding anything to the contrary in the Agreement or this Confirmation, the date of delivery of such Restricted Shares shall be the Exchange Business Day following notice by Dealer to Company, of such applicable discount and the number of Restricted Shares to be delivered pursuant to this clause (i). For the avoidance of doubt, delivery of Restricted Shares shall be due as set forth in the previous sentence and not be due on the Share Termination Payment Date (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or on the Settlement Date for such Restricted Shares (in the case of settlement in Shares pursuant to Section 2 above).

(ii) If Company elects to settle the Transaction pursuant to this clause (ii) (a "**Registration Settlement**"), then Company shall promptly (but in any event no later than the beginning of the Resale Period) file and use its reasonable best efforts to make effective under the Securities Act a registration statement or supplement or amend an outstanding registration statement in form and substance reasonably satisfactory to Dealer, to cover the resale of such Restricted Shares in accordance with customary resale registration procedures, including covenants, conditions, representations, underwriting discounts (if applicable), commissions (if applicable), indemnities due diligence rights, opinions and certificates, and such other documentation as is customary for equity resale underwriting agreements of similar size, all reasonably acceptable to Dealer. If Dealer, in its sole reasonable discretion, is not satisfied with such procedures and documentation Private Placement Settlement shall apply. If Dealer is satisfied with such procedures and documentation, it shall sell the Restricted Shares pursuant to such registration statement during a period (the "**Resale Period**") commencing on the Exchange Business Day following delivery of such Restricted Shares (which, for the avoidance of doubt, shall be (x) the Share Termination Payment Date in case of settlement in Share Termination Delivery Units pursuant to Section 9(j) above or (y) the Settlement Date in respect of the final Expiration Date for all Daily Number of Warrants) and ending on the earliest of (i) the Exchange Business Day on which Dealer completes the sale of all Restricted Shares in a commercially reasonable manner or, in the case of settlement of Share Termination Delivery Units, a sufficient number of Restricted Shares so that the realized net proceeds of such sales equals or exceeds the Payment Obligation (as defined above), (ii) the date upon which all Restricted Shares have been sold or transferred pursuant to Rule 144 (or similar provisions then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act and (iii) the date upon which all Restricted Shares may be sold or transferred by a non-affiliate pursuant to Rule 144 (or any similar provision then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act. If the Payment Obligation exceeds the realized net proceeds from such resale, Company shall transfer to Dealer by the open of the regular trading session on the Exchange on the Exchange Trading Day immediately following such resale the amount of such excess (the "**Additional Amount**") in cash or in a number of Shares ("**Make-whole Shares**") in an amount that, based on the Settlement Price on such day (as if such day was the "Valuation Date" for purposes of computing such Settlement Price), has a dollar value equal to the Additional Amount. The Resale Period shall continue to enable the sale of the Make-whole Shares. If Company elects to pay the Additional Amount in Shares, the requirements and provisions for Registration Settlement shall apply. This provision shall be applied successively until the Additional Amount is equal to zero. In no event shall Company deliver a number of Restricted Shares greater than the Maximum Number of Shares.

(iii) Without limiting the generality of the foregoing, Company agrees that (A) any Restricted Shares delivered to Dealer may be transferred by and among Dealer and its affiliates and Company shall effect such transfer without any further action by Dealer and (B) after the period of 6 months from the Trade Date (or 1 year from the Trade Date if, at such time, informational requirements of Rule 144(c) under the Securities Act are not satisfied with respect to Company) has elapsed in respect of any Restricted Shares delivered to Dealer,

Company shall promptly remove, or cause the transfer agent for such Restricted Shares to remove, any legends referring to any such restrictions or requirements from such Restricted Shares upon request by Dealer (or such affiliate of Dealer) to Company or such transfer agent, without any requirement for the delivery of any certificate, consent, agreement, opinion of counsel, notice or any other document, any transfer tax stamps or payment of any other amount or any other action by Dealer (or such affiliate of Dealer). Notwithstanding anything to the contrary herein, to the extent the provisions of Rule 144 of the Securities Act or any successor rule are amended, or the applicable interpretation thereof by the Securities and Exchange Commission or any court change after the Trade Date, the agreements of Company herein shall be deemed modified to the extent necessary, in the opinion of outside counsel of Company, to comply with Rule 144 of the Securities Act, as in effect at the time of delivery of the relevant Shares or Share Termination Delivery Property.

(iv) If the Private Placement Settlement or the Registration Settlement shall not be effected as set forth in clauses (i) or (ii), as applicable, then failure to effect such Private Placement Settlement or such Registration Settlement shall constitute an Event of Default with respect to which Company shall be the Defaulting Party.

(l) *Limit on Beneficial Ownership*. Notwithstanding any other provisions hereof, Dealer may not exercise any Warrant hereunder or be entitled to take delivery of any Shares deliverable hereunder, and Automatic Exercise shall not apply with respect to any Warrant hereunder, to the extent (but only to the extent) that, after such receipt of any Shares upon the exercise of such Warrant or otherwise hereunder, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. Any purported delivery hereunder shall be void and have no effect to the extent (but only to the extent) that, after such delivery, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. If any delivery owed to Dealer hereunder is not made, in whole or in part, as a result of this provision, Company's obligation to make such delivery shall not be extinguished and Company shall make such delivery as promptly as practicable after, but in no event later than one Business Day after, Dealer gives notice to Company that, after such delivery, (i) the Section 16 Percentage would not exceed 7.5%, and (ii) the Share Amount would not exceed the Applicable Share Limit.

(m) *Share Deliveries*. Notwithstanding anything to the contrary herein, Company agrees that any delivery of Shares or Share Termination Delivery Property shall be effected by book-entry transfer through the facilities of DTC, or any successor depositary, if at the time of delivery, such class of Shares or class of Share Termination Delivery Property is in book-entry form at DTC or such successor depositary.

(n) *Waiver of Jury Trial.* Each party waives, to the fullest extent permitted by applicable law, any right it may have to a trial by jury in respect of any suit, action or proceeding relating to the Transaction. Each party (i) certifies that no representative, agent or attorney of the other party has represented, expressly or otherwise, that such other party would not, in the event of such a suit, action or proceeding, seek to enforce the foregoing waiver and (ii) acknowledges that it and the other party have been induced to enter into the Transaction, as applicable, by, among other things, the mutual waivers and certifications provided herein.

(o) *Tax Disclosure.* Effective from the date of commencement of discussions concerning the Transaction, Company and each of its employees, representatives, or other agents may disclose to any and all persons, without limitation of any kind, the tax treatment and tax structure of the Transaction and all materials of any kind (including opinions or other tax analyses) that are provided to Company relating to such tax treatment and tax structure.

(p) *Maximum Share Delivery*.

(i) Notwithstanding any other provision of this Confirmation, the Agreement or the Equity Definitions, in no event will Company at any time be required to deliver a number of Shares greater than the Maximum Number of Shares to Dealer in connection with the Transaction.

(ii) In the event Company shall not have delivered to Dealer the full number of Shares or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has insufficient authorized but unissued Shares (such deficit, the "**Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Deficit Shares have been delivered pursuant to this Section 9(p)(ii), when, and to the extent that, (A) Shares are repurchased, acquired or otherwise received by Company or any of its subsidiaries after the Trade Date (whether or not in exchange for cash, fair value or any other consideration), (B) authorized and unissued Shares previously reserved for issuance in respect of other transactions become no longer so reserved or (C) Company additionally authorizes any unissued Shares that are not reserved for other transactions; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(p)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares. Company shall immediately notify Dealer of the occurrence of any of the foregoing events (including the number of Shares subject to clause (A), (B) or (C) and the corresponding number of Shares or Restricted Shares, as the case may be, to be delivered) and promptly deliver such Shares or Restricted Shares, as the case may be, thereafter.

(q) *Shareholder Approval*. Company shall use its reasonable best efforts to seek approval from its shareholders ("**Shareholder Approval**"), in accordance with the requirements of Rule 312.03(c) of The New York Stock Exchange Listed Company Manual or any successor rule, for the issuance pursuant to the Transaction of a number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2). If Company succeeds in obtaining such approval, then upon such approval and without any further action by either party, (i) the provisions set forth opposite the caption "Maximum Number of Shares" in Section 2 shall be deemed to be replaced in their entirety with the phrase "A number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement," (ii) the Additional Termination Event set forth in Section 9(h)(ii)(G) shall no longer be applicable, (iii) the provisions set forth in Section 9(j)(ii) shall be deleted in their entirety and (iv) the provisions opposite the caption "Share Delivery Quantity" in Section 2 shall be replaced in their entirety with the sentence "For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date for such Settlement Date."

(r) *Right to Extend.* Dealer may postpone or add, in whole or in part, any Expiration Date or any other date of valuation or delivery with respect to some or all of the relevant Warrants (in which event the Calculation Agent shall make appropriate adjustments to the Daily Number of Warrants with respect to one or more Expiration Dates) if Dealer determines, in its commercially reasonable judgment, that such extension is reasonably necessary or appropriate to preserve Dealer's hedging or hedge unwind activity hereunder in light of existing liquidity conditions or to enable Dealer to effect purchases of Shares in connection with its hedging, hedge unwind or settlement activity hereunder in a manner that would, if Dealer were Issuer or an affiliated purchaser of Issuer, be in compliance with applicable legal, regulatory or self-regulatory requirements, or with related policies and procedures applicable to Dealer.

(s) *Status of Claims in Bankruptcy.* Dealer acknowledges and agrees that this Confirmation is not intended to convey to Dealer rights against Company with respect to the Transaction that are senior to the claims of common stockholders of Company in any United States bankruptcy proceedings of Company; *provided* that nothing herein shall limit or shall be deemed to limit Dealer's right to pursue remedies in the event of a breach by Company of its obligations and agreements with respect to the Transaction; *provided*, *further*, that nothing herein shall limit or shall be deemed to limit Dealer's rights in respect of any transactions other than the Transaction.

(t) *Securities Contract; Swap Agreement.* The parties hereto intend for (i) the Transaction to be a "securities contract" and a "swap agreement" as defined in the Bankruptcy Code (Title 11 of the

United States Code) (the "**Bankruptcy Code**"), and the parties hereto to be entitled to the protections afforded by, among other Sections, Sections 362(b)(6), 362(b)(17), 546(e), 546(g), 555 and 560 of the Bankruptcy Code, (ii) a party's right to liquidate the Transaction and to exercise any other remedies upon the occurrence of any Event of Default under the Agreement with respect to the other party to constitute a "contractual right" as described in the Bankruptcy Code, and (iii) each payment and delivery of cash, securities or other property hereunder to constitute a "margin payment" or "settlement payment" and a "transfer" as defined in the Bankruptcy Code.

(u)*Wall Street Transparency and Accountability Act*. In connection with Section 739 of the Wall Street Transparency and Accountability Act of 2010 ("**WSTAA**"), the parties hereby agree that neither the enactment of WSTAA or any regulation under the WSTAA, nor any requirement under WSTAA or an amendment made by WSTAA, shall limit or otherwise impair either party's otherwise applicable rights to terminate, renegotiate, modify, amend or supplement this Confirmation or the Agreement, as applicable, arising from a termination event, force majeure, illegality, increased costs, regulatory change or similar event under this Confirmation, the Equity Definitions incorporated herein, or the Agreement (including, but not limited to, rights arising from Change in Law, Hedging Disruption, Increased Cost of Hedging, an Excess Ownership Position, or Illegality (as defined in the Agreement)).

(v)*Agreements and Acknowledgements Regarding Hedging*. Company understands, acknowledges and agrees that: (A) at any time on and prior to the last Expiration Date, Dealer and its affiliates may buy or sell Shares or other securities or buy or sell options or futures contracts or enter into swaps or other derivative securities in order to adjust its hedge position with respect to the Transaction; (B) Dealer and its affiliates also may be active in the market for Shares other than in connection with hedging activities in relation to the Transaction; (C) Dealer shall make its own determination as to whether, when or in what manner any hedging or market activities in securities of Issuer shall be conducted and shall do so in a manner that it deems appropriate to hedge its price and market risk with respect to the Settlement Prices; and (D) any market activities of Dealer and its affiliates with respect to Shares may affect the market price and volatility of Shares, as well as the Settlement Prices, each in a manner that may be adverse to Company.

(w)*Early Unwind*. In the event the sale of the "Underwritten Securities" (as defined in the Purchase Agreement) is not consummated with the Initial Purchasers for any reason, or Company fails to deliver to Dealer opinions of counsel as required pursuant to Section 9(a), in each case by 5:00 p.m. (New York City time) on the Premium Payment Date, or such later date as agreed upon by the parties (the Premium Payment Date or such later date the "**Early Unwind Date**"), the Transaction shall automatically terminate (the "**Early Unwind**"), on the Early Unwind Date and (i) the Transaction and all of the respective rights and obligations of Dealer and Company under the Transaction shall be cancelled and terminated and (ii) each party shall be released and discharged by the other party from and agrees not to make any claim against the other party with respect to any obligations or liabilities of the other party arising out of and to be performed in connection with the Transaction either prior to or after the Early Unwind Date; *provided* that Company shall purchase from Dealer on the Early Unwind Date all Shares purchased by Dealer or one or more of its affiliates in connection with the Transaction at the then prevailing market price. Each of Dealer and Company represents and acknowledges to the other that, subject to the proviso included in this Section 9(w), upon an Early Unwind, all obligations with respect to the Transaction shall be deemed fully and finally discharged.

(x)*Payment by Dealer*. In the event that (i) an Early Termination Date occurs or is designated with respect to the Transaction as a result of a Termination Event or an Event of Default (other than an Event of Default arising under Section 5(a)(ii) or 5(a)(iv) of the Agreement) and, as a result, Dealer owes to Company an amount calculated under Section 6(e) of the Agreement, or (ii) Dealer owes to Company, pursuant to Section 12.7 or Section 12.9 of the Equity Definitions, an amount calculated under Section 12.8 of the Equity Definitions, such amount shall be deemed to be zero.

(y)If Company has not obtained Shareholder Approval prior to the Approval Deadline, on the Approval Deadline (x) the First Expiration Date shall be extended by one calendar year, (y) the Warrants shall, as of April 15, 2020 (the " **Original First Expiration Date**"), cease to be to be "European Options" (as

such term is defined in the Equity Definitions) and shall become, as of the Original First Expiration Date, "American Options" (as such term is defined in the Equity Definitions) exercisable as of the Original First Expiration Date and (z) the Calculation Agent shall make commercially reasonable conforming amendments to the exercise and settlement terms of the Transaction to reflect the change of the Warrants from European Options to American Options, for the avoidance of doubt, retaining (i) contingencies to exercise that are not an observable market, other than the market for the Company's stock or an observable index, other than an index calculated or measured solely by reference to the Company's own operations, (ii) the commercially reasonable nature of adjustments permitted to the Transaction (such as to consider changes in volatility, expected dividends, stock loan rate or liquidity relevant to the Shares and the ability to maintain a commercially reasonable hedge position in the underlying shares) and (iii) the Company's unilateral right to settle in shares pursuant to 9(k), including pursuant to a Share Termination Alternative as provided under Section 9(j). On each anniversary of the Approval Deadline occurring prior to the final Expiration Date, if Company has not, as of such date, obtained Shareholder Approval, the First Expiration Date shall be further extended by one additional calendar year.

(z) *Adjustments*. For the avoidance of doubt, whenever the Calculation Agent or Determining Party is called upon to make an adjustment pursuant to the terms of this Confirmation or the Equity Definitions to take into account the effect of an event, the Calculation Agent or Determining Party shall make such adjustment by reference to the effect of such event on the Hedging Party, assuming that the Hedging Party maintains a commercially reasonable hedge position.

(aa) *Delivery or Receipt of Cash*. For the avoidance of doubt, other than receipt of the Premium by Company, nothing in this Confirmation shall be interpreted as requiring Company to cash settle the Transaction, except in circumstances where cash settlement is within Company's control (including, without limitation, where Company elects to deliver or receive cash, or where Company has made Private Placement settlement unavailable due to the occurrence of events within its control) or in those circumstances in which holders of Shares would also receive cash.

(bb) *No Reliance*. The Company hereby confirms that it has relied on the advice of its own counsel and other advisors (to the extent it deems appropriate) with respect to any legal, tax, accounting, or regulatory consequences of this Confirmation, that it has not relied on Dealer or its affiliates in any respect in connection therewith, and that it will not hold Dealer or its affiliates accountable for any such consequences.

Company hereby agrees (a) to check this Confirmation carefully and immediately upon receipt so that errors or discrepancies can be promptly identified and rectified and (b) to confirm that the foregoing (in the exact form provided by Dealer) correctly sets forth the terms of the agreement between Dealer and Company with respect to the Transaction, by manually signing this Confirmation or this page hereof as evidence of agreement to such terms and providing the other information requested herein and immediately returning an executed copy to John Servidio, Facsimile No. 704-208-2869.

Very truly yours,

Bank of America, N.A.

By: /s/ Christopher A. Hutmaker
Name: Christopher A. Hutmaker
Title: Managing Director

Accepted and confirmed
as of the date hereof:

Molina Healthcare, Inc.

By: /s/ John Molina
Authorized Signatory
Name: John Molina

J.P.Morgan

JPMorgan Chase Bank, National Association
London Branch
25 Bank Street
Canary Wharf
London E14 5JP
England

April 22, 2013

To: **Molina Healthcare, Inc.**
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

Re: Additional Warrants

The purpose of this letter agreement (this "**Confirmation**") is to amend and restate, in its entirety, the Additional Warrants Confirmation dated February 13, 2013 between the parties hereto and to confirm the terms and conditions of the Warrants issued by **Molina Healthcare, Inc.** ("**Company**") to **JPMorgan Chase Bank, National Association, London Branch** ("**Dealer**") as of the Trade Date specified below (the "**Transaction**"). The parties hereto agree and acknowledge that the amendments reflected in this amended and restated Confirmation are non-substantive, clarifying changes made for the avoidance of doubt. This letter agreement constitutes a "Confirmation" as referred to in the ISDA Master Agreement specified below. This Confirmation shall replace any previous agreements and serve as the final documentation for the Transaction.

The definitions and provisions contained in the 2002 ISDA Equity Derivatives Definitions (the "**Equity Definitions**"), as published by the International Swaps and Derivatives Association, Inc. ("**ISDA**"), are incorporated into this Confirmation. In the event of any inconsistency between the Equity Definitions and this Confirmation, this Confirmation shall govern.

Each party is hereby advised, and each such party acknowledges, that the other party has engaged in, or refrained from engaging in, substantial financial transactions and has taken other material actions in reliance upon the parties' entry into the Transaction to which this Confirmation relates on the terms and conditions set forth below.

1. This Confirmation evidences a complete and binding agreement between Dealer and Company as to the terms of the Transaction to which this Confirmation relates. This Confirmation shall supplement, form a part of, and be subject to an agreement in the form of the 2002 ISDA Master Agreement (the "**Agreement**") as if Dealer and Company had executed an agreement in such form (but without any Schedule except for the election of the laws of the State of New York as the governing law (without reference to choice of law doctrine)) on the Trade Date. In the event of any inconsistency between provisions of the Agreement and this Confirmation, this Confirmation will prevail for the purpose of the Transaction to which this Confirmation relates. The parties hereby agree that no transaction other than the Transaction to which this Confirmation relates shall be governed by the Agreement.

2. The Transaction is a Warrant Transaction, which shall be considered a Share Option Transaction for purposes of the Equity Definitions. The terms of the particular Transaction to which this Confirmation relates are as follows:

General Terms.

Trade Date: February 13, 2013

Effective Date:	The third Exchange Business Day immediately prior to the Premium Payment Date
Warrants:	Equity call warrants, each giving the holder the right to purchase a number of Shares equal to the Warrant Entitlement at a price per Share equal to the Strike Price, subject to the terms set forth under the caption "Settlement Terms" below. For the purposes of the Equity Definitions, each reference to a Warrant herein shall be deemed to be a reference to a Call Option.
Warrant Style:	European
Seller:	Company
Buyer:	Dealer
Shares:	The common stock of Company, par value USD 0.001 per Share (Exchange symbol "MOH")
Number of Warrants:	1,299,968. For the avoidance of doubt, the Number of Warrants shall be reduced by any Warrants exercised or deemed exercised hereunder. In no event will the Number of Warrants be less than zero.
Warrant Entitlement:	One Share per Warrant
Maximum Number of Shares:	For any day, 4,955,958 Shares, *minus* the aggregate number of Shares delivered prior to such day pursuant to (i) this Confirmation and (ii) any other substantially similar confirmation for Warrants sold by Company to Dealer with a trade date within 16 days of the Trade Date and with expiration dates the same as the Expiration Dates. Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, in no event shall the Maximum Number of Shares be subject to adjustment, except for any adjustment pursuant to the terms of this Confirmation and the Equity Definitions in connection with a Potential Adjustment Event (as defined in Section 11.2(e) of the Equity Definitions and without any amendment thereto pursuant to the terms of this Confirmation). Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, the Maximum Number of Shares shall not be adjusted on account of any event that (x) constitutes a Potential Adjustment Event solely on account of Section 11.2(e)(vii) of the Equity Definitions and (y) is not an event within Company's control.
Strike Price:	USD 53.8475
Premium:	USD 7,234,447
Premium Payment Date:	February 15, 2013

Exchange:	The New York Stock Exchange
Related Exchange(s):	All Exchanges

Procedures for Exercise.

Expiration Time:	The Valuation Time
Expiration Dates:	Each Scheduled Trading Day during the period from, and including, the First Expiration Date to, but excluding, the 160th Scheduled Trading Day following the First Expiration Date shall be an "Expiration Date" for a number of Warrants equal to the Daily Number of Warrants on such date; *provided* that, notwithstanding anything to the contrary in the Equity Definitions, if any such date is a Disrupted Day, the Calculation Agent shall make adjustments, if applicable, to the Daily Number of Warrants or shall reduce such Daily Number of Warrants to zero for which such day shall be an Expiration Date and shall designate a Scheduled Trading Day or a number of Scheduled Trading Days as the Expiration Date(s) for the remaining Daily Number of Warrants or a portion thereof for the originally scheduled Expiration Date; and *provided further* that if such Expiration Date has not occurred pursuant to this clause as of the eighth Scheduled Trading Day following the last scheduled Expiration Date under the Transaction, the Calculation Agent shall have the right to declare such Scheduled Trading Day to be the final Expiration Date and the Calculation Agent shall determine its good faith estimate of the fair market value for the Shares as of the Valuation Time on that eighth Scheduled Trading Day or on any subsequent Scheduled Trading Day, as the Calculation Agent shall determine using commercially reasonable means.
First Expiration Date:	April 15, 2020 (or if such day is not a Scheduled Trading Day, the next following Scheduled Trading Day), subject to Market Disruption Event below.
Daily Number of Warrants:	For any Expiration Date, the Number of Warrants that have not expired or been exercised as of such day, *divided* by the remaining number of Expiration Dates (including such day), rounded down to the nearest whole number, subject to adjustment pursuant to the provisos to "Expiration Dates".
Automatic Exercise:	Applicable; and means that for each Expiration Date, a number of Warrants equal to the Daily Number of Warrants for such Expiration Date will be deemed to be automatically exercised at the Expiration Time on such Expiration Date.
Market Disruption Event:	Section 6.3(a) of the Equity Definitions is hereby amended by replacing clause (ii) in its entirety with "(ii) an Exchange Disruption, or" and inserting immediately following clause (iii) the phrase "; in each case that the Calculation Agent determines is material."

Section 6.3(d) of the Equity Definitions is hereby amended by deleting the remainder of the provision following the words "Scheduled Closing Time" in the fourth line thereof.

Valuation Terms.

Valuation Time:	Scheduled Closing Time; *provided* that if the principal trading session is extended, the Calculation Agent shall determine the Valuation Time in good faith using its commercially reasonable discretion.
Valuation Date:	Each Exercise Date.

Settlement Terms.

Settlement Method:	Net Share Settlement.
Net Share Settlement:	On the relevant Settlement Date, Company shall deliver to Dealer a number of Shares equal to the Share Delivery Quantity for such Settlement Date to the account specified herein free of payment through the Clearance System, and Dealer shall be treated as the holder of record of such Shares at the time of delivery of such Shares or, if earlier, at 5:00 p.m. (New York City time) on such Settlement Date, and Company shall pay to Dealer cash in lieu of any fractional Share based on the Settlement Price on the relevant Valuation Date.
Share Delivery Quantity:	For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date for such Settlement Date; *provided* that in no event shall the Share Delivery Quantity for any Settlement Date exceed the Maximum Number of Shares for such Settlement Date, *minus* the Share Delivery Quantity (as defined in the letter agreement dated February 11, 2013 between Dealer and Company regarding Base Warrants (the "**Base Warrant Confirmation**")), if any, for such Settlement Date.
Net Share Settlement Amount:	For any Settlement Date, an amount equal to the product of (i) the number of Warrants exercised or deemed exercised on the relevant Exercise Date, (ii) the Strike Price Differential for the relevant Valuation Date and (iii) the Warrant Entitlement.
Settlement Price:	For any Valuation Date, the per Share volume-weighted average price as displayed under the heading "Bloomberg VWAP" on Bloomberg page MOH <equity> AQR (or any successor thereto) in respect of the period from the scheduled opening time of the Exchange to the Scheduled Closing Time on such Valuation Date (or if such volume-weighted average price is unavailable, the market value of one Share on such Valuation Date, as determined by the Calculation Agent). Notwithstanding the foregoing, if (i)

	any Expiration Date is a Disrupted Day and (ii) the Calculation Agent determines that such Expiration Date shall be an Expiration Date for fewer than the Daily Number of Warrants, as described above, then the Settlement Price for the relevant Valuation Date shall be the volume-weighted average price per Share on such Valuation Date on the Exchange, as determined by the Calculation Agent based on such sources as it deems appropriate using a volume-weighted methodology, for the portion of such Valuation Date for which the Calculation Agent determines there is no Market Disruption Event.
Settlement Dates:	As determined pursuant to Section 9.4 of the Equity Definitions, subject to Section 9(k)(i) hereof.
Other Applicable Provisions:	The provisions of Sections 9.1(c), 9.8, 9.9, 9.11 and 9.12 of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Net Share Settled." "Net Share Settled" in relation to any Warrant means that Net Share Settlement is applicable to that Warrant.
Representation and Agreement:	Notwithstanding Section 9.11 of the Equity Definitions, the parties acknowledge that any Shares delivered to Dealer may be, upon delivery, subject to restrictions and limitations arising from Company's status as issuer of the Shares under applicable securities laws.

3. <u>Additional Terms applicable to the Transaction</u>.

Adjustments applicable to the Transaction:

Method of Adjustment:	Calculation Agent Adjustment. For the avoidance of doubt, in making any adjustments under the Equity Definitions, the Calculation Agent may make adjustments, if any, to any one or more of the Strike Price, the Number of Warrants, the Daily Number of Warrants and the Warrant Entitlement. Notwithstanding the foregoing, any cash dividends or distributions on the Shares, whether or not extraordinary, shall be governed by Section 9(f) of this Confirmation in lieu of Article 10 or Section 11.2(c) of the Equity Definitions.

Extraordinary Events applicable to the Transaction:

New Shares:	Section 12.1(i) of the Equity Definitions is hereby amended (a) by deleting the text in clause (i) thereof in its entirety (including the word "and" following clause (i)) and replacing it with the phrase "publicly quoted, traded or listed (or whose related depositary receipts are publicly quoted, traded or listed) on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors)" and (b) by inserting immediately prior to the period the phrase "and (iii) of an entity or person that is a corporation organized

under the laws of the United States, any State thereof or the District of Columbia that also becomes Company under the Transaction following such Merger Event or Tender Offer".

Consequence of Merger Events:

Merger Event: Applicable; *provided* that if an event occurs that constitutes both a Merger Event under Section 12.1(b) of the Equity Definitions and an Additional Termination Event under Section 9(h)(ii)(B) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the provisions of Section 12.2 of the Equity Definitions or Section 9(h)(ii)(B) will apply.

Share-for-Share: Modified Calculation Agent Adjustment

Share-for-Other: Cancellation and Payment (Calculation Agent Determination)

Share-for-Combined: Cancellation and Payment (Calculation Agent Determination); *provided* that Dealer may elect, in its commercially reasonable judgment, Component Adjustment (Calculation Agent Determination) for all or any portion of the Transaction.

Consequence of Tender Offers:

Tender Offer: Applicable; *provided* that if an event occurs that constitutes both a Tender Offer under Section 12.1(d) of the Equity Definitions and Additional Termination Event under Section 9(h)(ii)(A) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the provisions of Section 12.3 of the Equity Definitions or Section 9(h)(ii)(A) will apply.

Share-for-Share: Modified Calculation Agent Adjustment

Share-for-Other: Modified Calculation Agent Adjustment

Share-for-Combined: Modified Calculation Agent Adjustment

Announcement Event: If an Announcement Date occurs in respect of a Merger Event (for the avoidance of doubt, determined without regard to the language in the definition of "Merger Event" following the definition of "Reverse Merger" therein) or Tender Offer (such occurrence, an "**Announcement Event**"), then on the earliest of the Expiration Date, Early Termination Date or other date of cancellation (the "**Announcement Event Adjustment Date**") in respect of each Warrant, the Calculation Agent will determine the economic effect on such Warrant of the Announcement Event (regardless of whether the Announcement Event actually results in a Merger Event or Tender Offer, and taking into account such factors as the Calculation Agent may determine, including, without limitation, changes in

	volatility, expected dividends, stock loan rate or liquidity relevant to the Shares or the Transaction whether prior to or after the Announcement Event or for any period of time, including, without limitation, the period from the Announcement Event to the relevant Announcement Event Adjustment Date). If the Calculation Agent determines that such economic effect on any Warrant is material, then on the Announcement Event Adjustment Date for such Warrant, the Calculation Agent may make such adjustment to the exercise, settlement, payment or any other terms of such Warrant as the Calculation Agent determines appropriate to account for such economic effect, which adjustment shall be effective immediately prior to the exercise, termination or cancellation of such Warrant, as the case may be.
Announcement Date:	The definition of "Announcement Date" in Section 12.1 of the Equity Definitions is hereby amended by (i) replacing the words "a firm" with the word "any" in the second and fourth lines thereof, (ii) replacing the word "leads to the" with the words ", if completed, would lead to a" in the third and the fifth lines thereof, (iii) replacing the words "voting shares" with the word "Shares" in the fifth line thereof, and (iv) inserting the words "by any entity" after the word "announcement" in the second and the fourth lines thereof.
Nationalization, Insolvency or Delisting:	Cancellation and Payment (Calculation Agent Determination); *provided* that, in addition to the provisions of Section 12.6(a)(iii) of the Equity Definitions, it will also constitute a Delisting if the Exchange is located in the United States and the Shares are not immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors); if the Shares are immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors), such exchange or quotation system shall thereafter be deemed to be the Exchange.
Additional Disruption Events:	
Change in Law:	Applicable; *provided* that Section 12.9(a)(ii) of the Equity Definitions is hereby amended by (i) replacing the word "Shares" with the phrase "Hedge Positions" in clause (X) thereof and (ii) inserting the parenthetical "(including, for the avoidance of doubt and without limitation, adoption, effectiveness or promulgation of new regulations authorized or mandated by existing statute)" at the end of clause (A) thereof.
Failure to Deliver:	Not Applicable
Insolvency Filing:	Applicable

Hedging Disruption:	Applicable; *provided* that:

(i) Section 12.9(a)(v) of the Equity Definitions is hereby amended by (a) inserting the following words at the end of clause (A) thereof: "in the manner contemplated by the Hedging Party on the Trade Date" and (b) inserting the following two phrases at the end of such Section:

"For the avoidance of doubt, the term "equity price risk" shall be deemed to include, but shall not be limited to, stock price and volatility risk. And, for the further avoidance of doubt, any such transactions or assets referred to in phrases (A) or (B) above must be available on commercially reasonable pricing terms."; and

(ii) Section 12.9(b)(iii) of the Equity Definitions is hereby amended by inserting in the third line thereof, after the words "to terminate the Transaction", the words "or a portion of the Transaction affected by such Hedging Disruption".

Increased Cost of Hedging:	Applicable
Loss of Stock Borrow:	Applicable
Maximum Stock Loan Rate:	100 basis points
Increased Cost of Stock Borrow:	Applicable
Initial Stock Loan Rate:	25 basis points
Hedging Party:	For all applicable Additional Disruption Events, Dealer.
Determining Party:	For all applicable Extraordinary Events, Dealer.
Non-Reliance:	Applicable
Agreements and Acknowledgments Regarding Hedging Activities:	Applicable
Additional Acknowledgments:	Applicable

4. **Calculation Agent.** Dealer

5. **Account Details.**

(a)Account for payments to Company: To Be Advised.

Account for delivery of Shares from Company: To Be Advised.

(b)Account for payments to Dealer:

Bank: JPMorgan Chase Bank, N.A.
ABA#: 021000021
Acct No.: 099997979

Beneficiary: JPMorgan Chase Bank, N.A. New York
Ref: Derivatives

Account for delivery of Shares to Dealer:

DTC 0060

6. Offices.

(a)The Office of Company for the Transaction is: Inapplicable, Company is not a Multibranch Party.

(b)The Office of Dealer for the Transaction is: London

JPMorgan Chase Bank, National Association
London Branch
25 Bank Street
Canary Wharf
London E14 5JP
England

7. Notices.

(a)Address for notices or communications to Company:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

(b)Address for notices or communications to Dealer:

JPMorgan Chase Bank, National Association
EDG Marketing Support
Email: EDG_OTC_HEDGING_MS@jpmorgan.com
Facsimile No: 1-866-886-4506

With a copy to:

Attention: Jason Wood
Title: Managing Director; Head of Equity Linked Capital Markets—Americas
Telephone No: 212-622-8783
Facsimile No: 415-226-0616

8. Representations and Warranties of Company.

Each of the representations and warranties of Company set forth in Section 3 of the Purchase Agreement (the "**Purchase Agreement**"), dated as of February 11, 2013, among Company and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as representatives of the Initial Purchasers party thereto (the "**Initial Purchasers**"), other than the representations set forth in Section 3(o), Section 3(r) and Section 3(s) of the Purchase Agreement, in each case, as such representations relate to the Transaction, are true and correct and are hereby deemed to be repeated to Dealer as if set forth herein. Company hereby further represents and warrants to Dealer on the Trade Date, the date hereof, on and as of the Premium Payment Date and, in the case of the representations in Section 8(d), at all times until termination of the Transaction, that:

(a) Company has all necessary corporate power and authority to execute, deliver and perform its obligations in respect of the Transaction; such execution, delivery and performance have been duly authorized by all necessary corporate action on Company's part; and this Confirmation has been duly and validly executed and delivered by Company and constitutes its valid and binding obligation, enforceable against Company in accordance with its terms, subject to applicable bankruptcy, insolvency, fraudulent conveyance, reorganization, moratorium and similar laws affecting creditors' rights and remedies generally, and subject, as to enforceability, to general principles of equity, including principles of commercial reasonableness, good faith and fair dealing (regardless of whether enforcement is sought in a proceeding at law or in equity) and except that rights to indemnification and contribution hereunder may be limited by federal or state securities laws or public policy relating thereto.

(b) Neither the execution and delivery of this Confirmation nor the incurrence or performance of obligations of Company hereunder will conflict with or result in a breach of the certificate of incorporation or by-laws (or any equivalent documents) of Company, or any applicable law or regulation, or any order, writ, injunction or decree of any court or governmental authority or agency, or any agreement or instrument to which Company or any of its subsidiaries is a party or by which Company or any of its subsidiaries is bound or to which Company or any of its subsidiaries is subject, or constitute a default under, or result in the creation of any lien under, any such agreement or instrument.

(c) No consent, approval, authorization, or order of, or filing with, any governmental agency or body or any court is required in connection with the execution, delivery or performance by Company of this Confirmation, except such as have been obtained or made and such as may be required under the Securities Act of 1933, as amended (the "**Securities Act**") or state securities laws.

(d) A number of Shares equal to the Maximum Number of Shares (the "**Warrant Shares**") have been reserved for issuance by all required corporate action of Company. The Warrant Shares have been duly authorized and, when delivered against payment therefor (which may include Net Share Settlement in lieu of cash) and otherwise as contemplated by the terms of the Warrants following the exercise of the Warrants in accordance with the terms and conditions of the Warrants, will be validly issued, fully-paid and non-assessable, and the issuance of the Warrant Shares will not be subject to any preemptive or similar rights.

(e) Company is not and, after consummation of the transactions contemplated hereby, will not be required to register as an "investment company" as such term is defined in the Investment Company Act of 1940, as amended.

(f) Company is an "eligible contract participant" (as such term is defined in Section 1a(18) of the Commodity Exchange Act, as amended, other than a person that is an eligible contract participant under Section 1a(18)(C) of the Commodity Exchange Act).

(g) Company and each of its affiliates is not, on the date hereof, in possession of any material non-public information with respect to Company.

(h) No state or local (including any non-U.S. jurisdiction's) law, rule, regulation or regulatory order applicable to the Shares would give rise to any reporting, consent, registration or other requirement (including without limitation a requirement to obtain prior approval from any person or entity) as a result of Dealer or its affiliates owning or holding (however defined) Shares.

(i) Company (A) is capable of evaluating investment risks independently, both in general and with regard to all transactions and investment strategies involving a security or securities; (B) will exercise independent judgment in evaluating the recommendations of any broker-dealer or its associated persons, unless it has otherwise notified the broker-dealer in writing; and (C) has total assets of at least $50 million.

9. Other Provisions.

(a) *Opinions*. Company shall deliver to Dealer an opinion of counsel, dated as of the Trade Date, with respect to the matters set forth in Sections 8(a) through (d) of this Confirmation. Delivery of such opinion to Dealer shall be a condition precedent for the purpose of Section 2(a)(iii) of the Agreement with respect to each obligation of Dealer under Section 2(a)(i) of the Agreement.

(b) *Repurchase Notices*. Company shall, on any day on which Company effects any repurchase of Shares, promptly give Dealer a written notice of such repurchase (a "**Repurchase Notice**") on such day if following such repurchase, the number of outstanding Shares on such day, subject to any adjustments provided herein, is (i) less than 45,295,973 (in the case of the first such notice) or (ii) thereafter more than 1,390,754 less than the number of Shares included in the immediately preceding Repurchase Notice. Company agrees to indemnify and hold harmless Dealer and its affiliates and their respective officers, directors, employees, affiliates, advisors, agents and controlling persons (each, an "**Indemnified Person**") from and against any and all losses (including losses relating to Dealer's hedging activities as a consequence of becoming, or of the risk of becoming, a Section 16 "insider", including without limitation, any forbearance from hedging activities or cessation of hedging activities and any losses in connection therewith with respect to the Transaction), claims, damages, judgments, liabilities and expenses (including reasonable attorney's fees), joint or several, which an Indemnified Person actually may become subject to, as a result of Company's failure to provide Dealer with a Repurchase Notice on the day and in the manner specified in this paragraph, and to reimburse, within 30 days, upon written request, each of such Indemnified Persons for any reasonable legal or other expenses incurred in connection with investigating, preparing for, providing testimony or other evidence in connection with or defending any of the foregoing. If any suit, action, proceeding (including any governmental or regulatory investigation), claim or demand shall be brought or asserted against the Indemnified Person, such Indemnified Person shall promptly notify Company in writing, and Company, upon request of the Indemnified Person, shall retain counsel reasonably satisfactory to the Indemnified Person to represent the Indemnified Person and any others Company may designate in such proceeding and shall pay the fees and expenses of such counsel related to such proceeding. Company shall not be liable for any settlement of any proceeding effected without its written consent, but if settled with such consent or if there be a final judgment for the plaintiff, Company agrees to indemnify any Indemnified Person from and against any loss or liability by reason of such settlement or judgment. Company shall not, without the prior written consent of the Indemnified Person, effect any settlement of any pending or threatened proceeding in respect of which any Indemnified Person is or could have been a party and indemnity could have been sought hereunder by such Indemnified Person, unless such settlement includes an unconditional release of such Indemnified Person from all liability on claims that are the subject matter of such proceeding on terms reasonably satisfactory to such Indemnified Person. If the indemnification provided for in this paragraph is unavailable to an Indemnified Person or insufficient in respect of any losses, claims, damages or liabilities referred to therein, then Company under such paragraph, in lieu of indemnifying such Indemnified Person thereunder, shall contribute to the amount paid or payable by such Indemnified Person as a result of such losses, claims, damages or liabilities. The remedies provided for in this paragraph are not exclusive and shall not limit any rights or remedies which may otherwise be available to any Indemnified Person at law or in equity. The indemnity and contribution agreements contained in this paragraph shall remain operative and in full force and effect regardless of the termination of the Transaction.

(c) *Regulation M*. Company is not on the Trade Date engaged in a distribution, as such term is used in Regulation M under the Securities Exchange Act of 1934, as amended (the "**Exchange Act**"), of any securities of Company, other than a distribution meeting the requirements of the exception set forth in Rules 101(b)(10) and 102(b)(7) of Regulation M. Company shall not, until the second Scheduled Trading Day immediately following the Effective Date, engage in any such distribution.

(d)*No Manipulation*. Company is not entering into the Transaction to create actual or apparent trading activity in the Shares (or any security convertible into or exchangeable for the Shares) or to raise or depress or otherwise manipulate the price of the Shares (or any security convertible into or exchangeable for the Shares) or otherwise in violation of the Exchange Act.

(e)*Transfer or Assignment*. Company may not transfer any of its rights or obligations under the Transaction without the prior written consent of Dealer. Dealer may, without Company's consent, transfer or assign all or any part of its rights or obligations under the Transaction to any third party. If at any time at which (A) the Section 16 Percentage exceeds 7.5%, (B) the Warrant Equity Percentage exceeds 16.3%, or (C) the Share Amount exceeds the Applicable Share Limit (if any applies) (any such condition described in clauses (A), (B) or (C), an "**Excess Ownership Position**"), Dealer is unable after using its commercially reasonable efforts to effect a transfer or assignment of Warrants to a third party on pricing terms reasonably acceptable to Dealer and within a time period reasonably acceptable to Dealer such that no Excess Ownership Position exists, then Dealer may designate any Exchange Business Day as an Early Termination Date with respect to a portion of the Transaction (the "**Terminated Portion**"), such that following such partial termination no Excess Ownership Position exists. In the event that Dealer so designates an Early Termination Date with respect to a Terminated Portion, a payment shall be made pursuant to Section 6 of the Agreement as if (1) an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants underlying the Terminated Portion, (2) Company were the sole Affected Party with respect to such partial termination and (3) the Terminated Portion were the sole Affected Transaction (and, for the avoidance of doubt, the provisions of Section 9(j) shall apply to any amount that is payable by Company to Dealer pursuant to this sentence as if Company was not the Affected Party). The "**Section 16 Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the number of Shares that Dealer and each person subject to aggregation of Shares with Dealer under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder directly or indirectly beneficially own (as defined under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder) and (B) the denominator of which is the number of Shares outstanding. The "**Warrant Equity Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the sum of (1) the product of the Number of Warrants and the Warrant Entitlement and (2) the aggregate number of Shares underlying any other warrants purchased by Dealer from Company, and (B) the denominator of which is the number of Shares outstanding. The "**Share Amount**" as of any day is the number of Shares that Dealer and any person whose ownership position would be aggregated with that of Dealer (Dealer or any such person, a "**Dealer Person**") under any law, rule, regulation, regulatory order or organizational documents or contracts of Company that are, in each case, applicable to ownership of Shares ("**Applicable Restrictions**"), owns, beneficially owns, constructively owns, controls, holds the power to vote or otherwise meets a relevant definition of ownership under any Applicable Restriction, as determined by Dealer in its reasonable discretion. The "**Applicable Share Limit**" means a number of Shares equal to (A) the minimum number of Shares that could give rise to reporting or registration obligations or other requirements (including obtaining prior approval from any person or entity) of a Dealer Person, or could result in an adverse effect on a Dealer Person, under any Applicable Restriction, as determined by Dealer in its reasonable discretion, *minus* (B) 1% of the number of Shares outstanding. Notwithstanding any other provision in this Confirmation to the contrary requiring or allowing Dealer to purchase, sell, receive or deliver any Shares or other securities, or to make or receive any payment in cash, to or from Company, Dealer may designate any of its affiliates to purchase, sell, receive or deliver such Shares or other securities, or make or receive such payment in cash, and otherwise to perform Dealer's obligations in respect of the Transaction and any such designee may assume such obligations. Dealer shall be discharged of its obligations to Company to the extent of any such performance.

(f)*Dividends*. If at any time during the period from and including the Effective Date, to and including the last Expiration Date, an ex-dividend date for a cash dividend occurs with respect to the Shares (an "**Ex-Dividend Date**"), then the Calculation Agent will adjust any of the Strike Price, Number of

Warrants, Daily Number of Warrants and/or any other variable relevant to the exercise, settlement or payment of the Transaction to preserve the fair value of the Warrants after taking into account such dividend.

(g) *Role of Agent*. Each party agrees and acknowledges that (i) J.P. Morgan Securities LLC, an affiliate of Dealer ("**JPMS**"), has acted solely as agent and not as principal with respect to the Transaction and (ii) JPMS has no obligation or liability, by way of guaranty, endorsement or otherwise, in any manner in respect of the Transaction (including, if applicable, in respect of the settlement thereof). Each party agrees it will look solely to the other party (or any guarantor in respect thereof) for performance of such other party's obligations under the Transaction.

(h) *Additional Provisions*.

(i) Amendments to the Equity Definitions:

(A) Section 11.2(a) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the words "an"; and adding the phrase "or Warrants" at the end of the sentence.

(B) Section 11.2(c) of the Equity Definitions is hereby amended by (w) replacing the words "a diluting or concentrative" with "an" in the fifth line thereof, (x) adding the phrase "or Warrants" after the words "the relevant Shares" in the same sentence, (y) deleting the words "diluting or concentrative" in the sixth to last line thereof and (z) deleting the phrase "(provided that no adjustments will be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)" and replacing it with the phrase "(and, for the avoidance of doubt, adjustments may be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)."

(C) Section 11.2(e)(vii) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the word "a material"; and adding the phrase "or Warrants" at the end of the sentence.

(D) Section 12.6(a)(ii) of the Equity Definitions is hereby amended by (1) deleting from the fourth line thereof the word "or" after the word "official" and inserting a comma therefor, and (2) deleting the semi-colon at the end of subsection (B) thereof and inserting the following words therefor "or (C) at Dealer's option, the occurrence of any of the events specified in Section 5(a)(vii) (1) through (9) of the ISDA Master Agreement with respect to that Issuer."

(E) Section 12.9(b)(iv) of the Equity Definitions is hereby amended by:

(x) deleting (1) subsection (A) in its entirety, (2) the phrase "or (B)" following subsection (A) and (3) the phrase "in each case" in subsection (B); and

(y) replacing the phrase "neither the Non-Hedging Party nor the Lending Party lends Shares" with the phrase "such Lending Party does not lend Shares" in the penultimate sentence.

(F) Section 12.9(b)(v) of the Equity Definitions is hereby amended by:

(x) adding the word "or" immediately before subsection "(B)" and deleting the comma at the end of subsection (A); and

(y) (1) deleting subsection (C) in its entirety, (2) deleting the word "or" immediately preceding subsection (C), (3) deleting the penultimate sentence in its entirety and replacing it with the sentence "The Hedging Party will determine the Cancellation Amount payable by one party to the other." and (4) deleting clause (X) in the final sentence.

(ii) Notwithstanding anything to the contrary in this Confirmation, upon the occurrence of one of the following events, with respect to the Transaction, (1) Dealer shall have the right to designate such event an Additional Termination Event and designate an Early Termination Date pursuant to Section 6(b) of the Agreement, (2) Company shall be deemed the sole Affected Party with respect to such Additional Termination Event and (3) the Transaction, or, at the election of Dealer in its sole discretion, any portion of the Transaction, shall be deemed the sole Affected Transaction; *provided* that if Dealer so designates an Early Termination Date with respect to a portion of the Transaction, (a) a payment shall be made pursuant to Section 6 of the Agreement as if an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants included in the terminated portion of the Transaction, and (b) for the avoidance of doubt, the Transaction shall remain in full force and effect except that the Number of Warrants shall be reduced by the number of Warrants included in such terminated portion:

(A) A "person" or "group" within the meaning of Section 13(d) of the Exchange Act, other than Company, its subsidiaries or its and their employee benefit plans, files a Schedule TO or any schedule, form or report under the Exchange Act disclosing that such person or group has become the direct or indirect "beneficial owner," as defined in Rule 13d-3 under the Exchange Act, of the common equity of Company representing more than 50% of the voting power of such common equity.

(B) Consummation of (I) any recapitalization, reclassification or change of the Shares (other than changes resulting from a subdivision or combination) as a result of which the Shares would be converted into, or exchanged for, stock, other securities, other property or assets or (II) any share exchange, consolidation or merger of Company pursuant to which the Shares will be converted into cash, securities or other property or (III) any sale, lease or other transfer in one transaction or a series of transactions of all or substantially all of the consolidated assets of Company and its subsidiaries, taken as a whole, to any person other than one of Company's subsidiaries. Notwithstanding the foregoing, any transaction or transactions set forth in this clause (B) shall not constitute an Additional Termination Event if (x) at least 90% of the consideration received or to be received by holders of the Shares, excluding cash payments for fractional Shares, in connection with such transaction or transactions consists of shares of common stock that are listed or quoted on any of The New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or any of their respective successors) or will be so listed or quoted when issued or exchanged in connection with such transaction or transactions, and (y) as a result of such transaction or transactions, the Shares will consist of such consideration, excluding cash payments for fractional Shares.

(C) Company's shareholders approve any plan or proposal for the liquidation or dissolution of Company.

(D) Default by Company or any of its subsidiaries with respect to any mortgage, agreement or other instrument under which there may be outstanding, or by which there may be secured or evidenced, any indebtedness for money borrowed in excess of $15 million in the aggregate of Company and/or any such subsidiary, whether

such indebtedness now exists or shall hereafter be created (i) resulting in such indebtedness becoming or being declared due and payable or (ii) constituting a failure to pay the principal or interest of any such debt when due and payable at its stated maturity, upon required repurchase, upon declaration of acceleration or otherwise.

(E) A final judgment for the payment of $15 million or more (excluding any amounts covered by insurance) rendered against Company or any of its subsidiaries, which judgment is not discharged or stayed within 60 days after (I) the date on which the right to appeal thereof has expired if no such appeal has commenced, or (II) the date on which all rights to appeal have been extinguished.

(F) Dealer, despite using commercially reasonable efforts, is unable or reasonably determines that it is impractical or illegal, to hedge its exposure with respect to the Transaction in the public market without registration under the Securities Act or as a result of any legal, regulatory or self-regulatory requirements or related policies and procedures (whether or not such requirements, policies or procedures are imposed by law or have been voluntarily adopted by Dealer).

(G) On any day during the period from and including the Trade Date, to and including the final Expiration Date, (I) the Notional Unwind Shares (as defined below) as of such day exceeds a number of Shares equal to 60% of the Maximum Number of Shares, or (II) Company makes a public announcement of any transaction or event that, in the reasonable opinion of Dealer would, upon consummation of such transaction or upon the occurrence of such event, as applicable, and after giving effect to any applicable adjustments hereunder, cause the Notional Unwind Shares immediately following the consummation of such transaction or the occurrence of such event to exceed a number of Shares equal to 60% of the Maximum Number of Shares. The "**Notional Unwind Shares**" as of any day is a number of Shares equal to (1) the amount that would be payable pursuant to Section 6 of the Agreement (determined as of such day as if an Early Termination Date had been designated in respect of the Transaction and as if Company were the sole Affected Party and the Transaction were the sole Affected Transaction), *divided by* (2) the Settlement Price (determined as if such day were a Valuation Date). For the purposes of this clause (G), the Share Delivery Quantity shall be deemed to include the "Share Delivery Quantity" (as defined in the Base Warrant Confirmation) and the terms set forth above for determining the Share Delivery Quantity shall apply *mutatis mutandis* for the purposes of determining the "Share Delivery Quantity" under the Base Warrant Confirmation.

(H) If Company has not obtained Shareholder Approval prior to February 11, 2014 (the "**Approval Deadline**"). For the avoidance of doubt, if Company has not obtained Shareholder Approval prior to the Approval Deadline, Dealer shall have right to designate an Early Termination Date in connection with the Additional Termination Event set forth in this clause (H) on any day from, and including, the Approval Deadline to, and including, the earlier of (x) the date on which Company obtains Shareholder Approval and (y) the final Expiration Date.

(i) *No Collateral or Setoff*. Notwithstanding any provision of the Agreement or any other agreement between the parties to the contrary, the obligations of Company hereunder are not secured by any collateral. Obligations under the Transaction shall not be set off by Company against any other obligations of the parties, whether arising under the Agreement, this Confirmation, under any other agreement between the parties hereto, by operation of law or otherwise. Any provision in the Agreement with respect to the satisfaction of Company's payment obligations to the extent of Dealer's

payment obligations to Company in the same currency and in the same Transaction (including, without limitation Section 2(c) thereof) shall not apply to Company and, for the avoidance of doubt, Company shall fully satisfy such payment obligations notwithstanding any payment obligation to Company by Dealer in the same currency and in the same Transaction. In calculating any amounts under Section 6(e) of the Agreement, notwithstanding anything to the contrary in the Agreement, (1) separate amounts shall be calculated as set forth in such Section 6(e) with respect to (a) the Transaction and (b) all other Transactions, and (2) such separate amounts shall be payable pursuant to Section 6(d)(ii) of the Agreement. For the avoidance of doubt and notwithstanding anything to the contrary provided in this Section 9(i), in the event of bankruptcy or liquidation of either Company or Dealer, neither party shall have the right to set off any obligation that it may have to the other party under the Transaction against any obligation such other party may have to it, whether arising under the Agreement, this Confirmation or any other agreement between the parties hereto, by operation of law or otherwise.

(j) *Alternative Calculations and Payment on Early Termination and on Certain Extraordinary Events*.

(i) If, in respect of the Transaction, an amount is payable by Company to Dealer, (A) pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or (B) pursuant to Section 6(d)(ii) of the Agreement (any such amount, a "**Payment Obligation**"), Company shall satisfy the Payment Obligation by the Share Termination Alternative (as defined below), unless (a) Company gives irrevocable telephonic notice to Dealer, confirmed in writing within one Scheduled Trading Day, no later than 12:00 p.m. (New York City time) on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable, of its election that the Share Termination Alternative shall not apply, (b) Company remakes the representation set forth in Section 8(g) as of the date of such election and (c) Dealer agrees, in its sole discretion, to such election, in which case the provisions of Section 12.7 or Section 12.9 of the Equity Definitions, or the provisions of Section 6(d)(ii) of the Agreement, as the case may be, shall apply.

Share Termination Alternative:	If applicable, Company shall deliver to Dealer the Share Termination Delivery Property on the date (the "**Share Termination Payment Date**") on which the Payment Obligation would otherwise be due pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or Section 6(d)(ii) of the Agreement, as applicable, subject to Section 9(k)(i) below, in satisfaction, subject to Section 9(k)(ii) below, of the relevant Payment Obligation, in the manner reasonably requested by Dealer free of payment.
Share Termination Delivery Property:	A number of Share Termination Delivery Units, as calculated by the Calculation Agent, equal to the relevant Payment Obligation *divided by* the Share Termination Unit Price. The Calculation Agent shall adjust the amount of Share Termination Delivery Property by replacing any fractional portion of a security therein with an amount of cash equal to the value of such fractional security based on the values used to calculate the Share Termination Unit Price (without giving effect to any discount pursuant to Section 9(k)(i)).

Share Termination Unit Price:	The value of property contained in one Share Termination Delivery Unit on the date such Share Termination Delivery Units are to be delivered as Share Termination Delivery Property, as determined by the Calculation Agent in its good faith discretion by commercially reasonable means. In the case of a Private Placement of Share Termination Delivery Units that are Restricted Shares (as defined below), as set forth in Section 9(k)(i) below, the Share Termination Unit Price shall be determined by the discounted price applicable to such Share Termination Delivery Units. In the case of a Registration Settlement of Share Termination Delivery Units that are Restricted Shares (as defined below) as set forth in Section 9(k)(ii) below, notwithstanding the foregoing, the Share Termination Unit Price shall be the Settlement Price on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable. The Calculation Agent shall notify Company of the Share Termination Unit Price at the time of notification of such Payment Obligation to Company or, if applicable, at the time the discounted price applicable to the relevant Share Termination Units is determined pursuant to Section 9(k)(i).
Share Termination Delivery Unit:	One Share or, if the Shares have changed into cash or any other property or the right to receive cash or any other property as the result of a Nationalization, Insolvency or Merger Event (any such cash or other property, the "**Exchange Property**"), a unit consisting of the type and amount of Exchange Property received by a holder of one Share (without consideration of any requirement to pay cash or other consideration in lieu of fractional amounts of any securities) in such Nationalization, Insolvency or Merger Event. If such Nationalization, Insolvency or Merger Event involves a choice of Exchange Property to be received by holders, such holder shall be deemed to have elected to receive the maximum possible amount of cash.
Failure to Deliver:	Inapplicable
Other applicable provisions:	If Share Termination Alternative is applicable, the provisions of Sections 9.8, 9.9, 9.11 and 9.12 (as modified above) of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Share Termination Settled" and all references to "Shares" shall be read as references to "Share Termination Delivery Units". "Share Termination Settled" in relation to the Transaction means that the Share Termination Alternative is applicable to the Transaction.

(ii) Notwithstanding anything to the contrary in this Confirmation, any Payment Obligation under this Confirmation shall, for all purposes, be calculated as if the Maximum Number of Shares were equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) but any deliveries under Section 9(j)(i) shall be limited to the Maximum Number of Shares as defined in Section 2 hereof. In the event Company shall not have delivered to Dealer the full number of Shares or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has not obtained shareholder approval pursuant to Section 9(q) for the Maximum Number of Shares to equal two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) (such deficit, the "**Approval Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Approval Deficit Shares have been delivered pursuant to this Section 9(j)(ii), when, and to the extent that the Company obtains shareholder approval; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(j)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares as so increased pursuant to Section 9(q).

(k) *Registration/Private Placement Procedures*. If, in the reasonable opinion of Dealer, following any delivery of Shares or Share Termination Delivery Property to Dealer hereunder, such Shares or Share Termination Delivery Property would be in the hands of Dealer subject to any applicable restrictions with respect to any registration or qualification requirement or prospectus delivery requirement for such Shares or Share Termination Delivery Property pursuant to any applicable federal or state securities law (including, without limitation, any such requirement arising under Section 5 of the Securities Act as a result of such Shares or Share Termination Delivery Property being "restricted securities", as such term is defined in Rule 144 under the Securities Act, or as a result of the sale of such Shares or Share Termination Delivery Property being subject to paragraph (c) of Rule 145 under the Securities Act) (such Shares or Share Termination Delivery Property, "**Restricted Shares**"), then delivery of such Restricted Shares shall be effected pursuant to either clause (i) or (ii) below at the election of Company, unless Dealer waives the need for registration/private placement procedures set forth in (i) and (ii) below. Notwithstanding the foregoing, solely in respect of any Daily Number of Warrants exercised or deemed exercised on any Expiration Date, Company shall elect, prior to the first Settlement Date for the first applicable Expiration Date, a Private Placement Settlement or Registration Settlement for all deliveries of Restricted Shares for all such Expiration Dates which election shall be applicable to all remaining Settlement Dates for such Warrants and the procedures in clause (i) or clause (ii) below shall apply for all such delivered Restricted Shares on an aggregate basis commencing after the final Settlement Date for such Warrants. The Calculation Agent shall make reasonable adjustments to settlement terms and provisions under this Confirmation to reflect a single Private Placement or Registration Settlement for such aggregate Restricted Shares delivered hereunder.

(i) If Company elects to settle the Transaction pursuant to this clause (i) (a "**Private Placement Settlement**"), then delivery of Restricted Shares by Company shall be effected in customary private placement procedures with respect to such Restricted Shares reasonably acceptable to Dealer; *provided* that Company may not elect a Private Placement Settlement if, on the date of its election, it has taken, or caused to be taken, any action that would make unavailable either the exemption pursuant to Section 4(2) of the Securities Act for the sale by Company to Dealer (or any affiliate designated by Dealer) of the Restricted Shares or the exemption pursuant to Section 4(1) or Section 4(3) of the Securities Act for resales of the Restricted Shares by Dealer (or any such affiliate of Dealer). The Private Placement Settlement of such Restricted Shares shall include customary representations, covenants, blue sky and

other governmental filings and/or registrations, indemnities to Dealer, due diligence rights (for Dealer or any designated buyer of the Restricted Shares by Dealer), opinions and certificates, and such other documentation as is customary for private placement agreements of similar size, all reasonably acceptable to Dealer. In the case of a Private Placement Settlement, Dealer shall determine the appropriate discount to the Share Termination Unit Price (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or any Settlement Price (in the case of settlement of Shares pursuant to Section 2 above) applicable to such Restricted Shares in a commercially reasonable manner and appropriately adjust the number of such Restricted Shares to be delivered to Dealer hereunder, which discount shall only take into account the illiquidity resulting from the fact that the Restricted Shares will not be registered for resale and any commercially reasonable fees and expenses of Dealer (and any affiliate thereof) in connection with such resale. Notwithstanding anything to the contrary in the Agreement or this Confirmation, the date of delivery of such Restricted Shares shall be the Exchange Business Day following notice by Dealer to Company, of such applicable discount and the number of Restricted Shares to be delivered pursuant to this clause (i). For the avoidance of doubt, delivery of Restricted Shares shall be due as set forth in the previous sentence and not be due on the Share Termination Payment Date (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or on the Settlement Date for such Restricted Shares (in the case of settlement in Shares pursuant to Section 2 above).

(ii) If Company elects to settle the Transaction pursuant to this clause (ii) (a "**Registration Settlement**"), then Company shall promptly (but in any event no later than the beginning of the Resale Period) file and use its reasonable best efforts to make effective under the Securities Act a registration statement or supplement or amend an outstanding registration statement in form and substance reasonably satisfactory to Dealer, to cover the resale of such Restricted Shares in accordance with customary resale registration procedures, including covenants, conditions, representations, underwriting discounts (if applicable), commissions (if applicable), indemnities due diligence rights, opinions and certificates, and such other documentation as is customary for equity resale underwriting agreements of similar size, all reasonably acceptable to Dealer. If Dealer, in its sole reasonable discretion, is not satisfied with such procedures and documentation Private Placement Settlement shall apply. If Dealer is satisfied with such procedures and documentation, it shall sell the Restricted Shares pursuant to such registration statement during a period (the "**Resale Period**") commencing on the Exchange Business Day following delivery of such Restricted Shares (which, for the avoidance of doubt, shall be (x) the Share Termination Payment Date in case of settlement in Share Termination Delivery Units pursuant to Section 9(j) above or (y) the Settlement Date in respect of the final Expiration Date for all Daily Number of Warrants) and ending on the earliest of (i) the Exchange Business Day on which Dealer completes the sale of all Restricted Shares in a commercially reasonable manner or, in the case of settlement of Share Termination Delivery Units, a sufficient number of Restricted Shares so that the realized net proceeds of such sales equals or exceeds the Payment Obligation (as defined above), (ii) the date upon which all Restricted Shares have been sold or transferred pursuant to Rule 144 (or similar provisions then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act and (iii) the date upon which all Restricted Shares may be sold or transferred by a non-affiliate pursuant to Rule 144 (or any similar provision then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act. If the Payment Obligation exceeds the realized net proceeds from such resale, Company shall transfer to Dealer by the open of the regular trading session on the Exchange on the Exchange Trading Day immediately following such resale the amount of such excess (the "**Additional Amount**") in cash or in a number of Shares ("**Make-whole Shares**") in an amount that, based on the Settlement Price on such day (as if such day was the "Valuation Date" for purposes of computing such Settlement Price), has a dollar value equal to the Additional Amount. The Resale Period shall continue to enable the sale of the

Make-whole Shares. If Company elects to pay the Additional Amount in Shares, the requirements and provisions for Registration Settlement shall apply. This provision shall be applied successively until the Additional Amount is equal to zero. In no event shall Company deliver a number of Restricted Shares greater than the Maximum Number of Shares.

(iii) Without limiting the generality of the foregoing, Company agrees that (A) any Restricted Shares delivered to Dealer may be transferred by and among Dealer and its affiliates and Company shall effect such transfer without any further action by Dealer and (B) after the period of 6 months from the Trade Date (or 1 year from the Trade Date if, at such time, informational requirements of Rule 144(c) under the Securities Act are not satisfied with respect to Company) has elapsed in respect of any Restricted Shares delivered to Dealer, Company shall promptly remove, or cause the transfer agent for such Restricted Shares to remove, any legends referring to any such restrictions or requirements from such Restricted Shares upon request by Dealer (or such affiliate of Dealer) to Company or such transfer agent, without any requirement for the delivery of any certificate, consent, agreement, opinion of counsel, notice or any other document, any transfer tax stamps or payment of any other amount or any other action by Dealer (or such affiliate of Dealer). Notwithstanding anything to the contrary herein, to the extent the provisions of Rule 144 of the Securities Act or any successor rule are amended, or the applicable interpretation thereof by the Securities and Exchange Commission or any court change after the Trade Date, the agreements of Company herein shall be deemed modified to the extent necessary, in the opinion of outside counsel of Company, to comply with Rule 144 of the Securities Act, as in effect at the time of delivery of the relevant Shares or Share Termination Delivery Property.

(iv) If the Private Placement Settlement or the Registration Settlement shall not be effected as set forth in clauses (i) or (ii), as applicable, then failure to effect such Private Placement Settlement or such Registration Settlement shall constitute an Event of Default with respect to which Company shall be the Defaulting Party.

(l) *Limit on Beneficial Ownership*. Notwithstanding any other provisions hereof, Dealer may not exercise any Warrant hereunder or be entitled to take delivery of any Shares deliverable hereunder, and Automatic Exercise shall not apply with respect to any Warrant hereunder, to the extent (but only to the extent) that, after such receipt of any Shares upon the exercise of such Warrant or otherwise hereunder and after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. Any purported delivery hereunder shall be void and have no effect to the extent (but only to the extent) that, after such delivery and after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. If any delivery owed to Dealer hereunder is not made, in whole or in part, as a result of this provision, Company's obligation to make such delivery shall not be extinguished and Company shall make such delivery as promptly as practicable after, but in no event later than one Business Day after, Dealer gives notice to Company that, after such delivery, (i) the Section 16 Percentage would not exceed 7.5%, and (ii) the Share Amount would not exceed the Applicable Share Limit.

(m) *Share Deliveries*. Notwithstanding anything to the contrary herein, Company agrees that any delivery of Shares or Share Termination Delivery Property shall be effected by book-entry transfer through the facilities of DTC, or any successor depositary, if at the time of delivery, such class of Shares or class of Share Termination Delivery Property is in book-entry form at DTC or such successor depositary.

(n) *Waiver of Jury Trial.* Each party waives, to the fullest extent permitted by applicable law, any right it may have to a trial by jury in respect of any suit, action or proceeding relating to the Transaction.

Each party (i) certifies that no representative, agent or attorney of the other party has represented, expressly or otherwise, that such other party would not, in the event of such a suit, action or proceeding, seek to enforce the foregoing waiver and (ii) acknowledges that it and the other party have been induced to enter into the Transaction, as applicable, by, among other things, the mutual waivers and certifications provided herein.

(o) *Tax Disclosure.* Effective from the date of commencement of discussions concerning the Transaction, Company and each of its employees, representatives, or other agents may disclose to any and all persons, without limitation of any kind, the tax treatment and tax structure of the Transaction and all materials of any kind (including opinions or other tax analyses) that are provided to Company relating to such tax treatment and tax structure.

(p) *Maximum Share Delivery*.

(i) Notwithstanding any other provision of this Confirmation, the Agreement or the Equity Definitions, in no event will Company at any time be required to deliver a number of Shares greater than the Maximum Number of Shares to Dealer in connection with the Transaction after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation.

(ii) In the event Company shall not have delivered to Dealer the full number of Shares or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has insufficient authorized but unissued Shares (such deficit, the "**Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Deficit Shares have been delivered pursuant to this Section 9(p)(ii), when, and to the extent that, (A) Shares are repurchased, acquired or otherwise received by Company or any of its subsidiaries after the Trade Date (whether or not in exchange for cash, fair value or any other consideration), (B) authorized and unissued Shares previously reserved for issuance in respect of other transactions become no longer so reserved or (C) Company additionally authorizes any unissued Shares that are not reserved for other transactions; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(p)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares. Company shall immediately notify Dealer of the occurrence of any of the foregoing events (including the number of Shares subject to clause (A), (B) or (C) and the corresponding number of Shares or Restricted Shares, as the case may be, to be delivered) and promptly deliver such Shares or Restricted Shares, as the case may be, thereafter.

(q) *Shareholder Approval*. Company shall use its reasonable best efforts to seek approval from its shareholders ("**Shareholder Approval**"), in accordance with the requirements of Rule 312.03(c) of The New York Stock Exchange Listed Company Manual or any successor rule, for the issuance pursuant to the Transaction of a number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2). If Company succeeds in obtaining such approval, then upon such approval and without any further action by either party, (i) the provisions set forth opposite the caption "Maximum Number of Shares" in Section 2 shall be deemed to be replaced in their entirety with the phrase "A number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement," (ii) the Additional Termination Event set forth in Section 9(h)(ii)(G) shall no longer be applicable, (iii) the provisions set forth in Section 9(j)(ii) shall be deleted in their entirety, (iv) the provisions opposite the caption "Share Delivery Quantity" in Section 2 shall be replaced in their entirety with the sentence "For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date

for such Settlement Date" and (v) the phrase "after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation" in Section 9(p)(i) shall be deleted in its entirety.

(r) *Right to Extend.* Dealer may postpone or add, in whole or in part, any Expiration Date or any other date of valuation or delivery with respect to some or all of the relevant Warrants (in which event the Calculation Agent shall make appropriate adjustments to the Daily Number of Warrants with respect to one or more Expiration Dates) if Dealer determines, in its commercially reasonable judgment, that such extension is reasonably necessary or appropriate to preserve Dealer's hedging or hedge unwind activity hereunder in light of existing liquidity conditions or to enable Dealer to effect purchases of Shares in connection with its hedging, hedge unwind or settlement activity hereunder in a manner that would, if Dealer were Issuer or an affiliated purchaser of Issuer, be in compliance with applicable legal, regulatory or self-regulatory requirements, or with related policies and procedures applicable to Dealer.

(s) *Status of Claims in Bankruptcy.* Dealer acknowledges and agrees that this Confirmation is not intended to convey to Dealer rights against Company with respect to the Transaction that are senior to the claims of common stockholders of Company in any United States bankruptcy proceedings of Company; *provided* that nothing herein shall limit or shall be deemed to limit Dealer's right to pursue remedies in the event of a breach by Company of its obligations and agreements with respect to the Transaction; *provided*, *further*, that nothing herein shall limit or shall be deemed to limit Dealer's rights in respect of any transactions other than the Transaction.

(t) *Securities Contract; Swap Agreement.* The parties hereto intend for (i) the Transaction to be a "securities contract" and a "swap agreement" as defined in the Bankruptcy Code (Title 11 of the United States Code) (the "**Bankruptcy Code**"), and the parties hereto to be entitled to the protections afforded by, among other Sections, Sections 362(b)(6), 362(b)(17), 546(e), 546(g), 555 and 560 of the Bankruptcy Code, (ii) a party's right to liquidate the Transaction and to exercise any other remedies upon the occurrence of any Event of Default under the Agreement with respect to the other party to constitute a "contractual right" as described in the Bankruptcy Code, and (iii) each payment and delivery of cash, securities or other property hereunder to constitute a "margin payment" or "settlement payment" and a "transfer" as defined in the Bankruptcy Code.

(u) *Wall Street Transparency and Accountability Act* . In connection with Section 739 of the Wall Street Transparency and Accountability Act of 2010 ("**WSTAA**"), the parties hereby agree that neither the enactment of WSTAA or any regulation under the WSTAA, nor any requirement under WSTAA or an amendment made by WSTAA, shall limit or otherwise impair either party's otherwise applicable rights to terminate, renegotiate, modify, amend or supplement this Confirmation or the Agreement, as applicable, arising from a termination event, force majeure, illegality, increased costs, regulatory change or similar event under this Confirmation, the Equity Definitions incorporated herein, or the Agreement (including, but not limited to, rights arising from Change in Law, Hedging Disruption, Increased Cost of Hedging, an Excess Ownership Position, or Illegality (as defined in the Agreement)).

(v) *Agreements and Acknowledgements Regarding Hedging*. Company understands, acknowledges and agrees that: (A) at any time on and prior to the last Expiration Date, Dealer and its affiliates may buy or sell Shares or other securities or buy or sell options or futures contracts or enter into swaps or other derivative securities in order to adjust its hedge position with respect to the Transaction; (B) Dealer and its affiliates also may be active in the market for Shares other than in connection with hedging activities in relation to the Transaction; (C) Dealer shall make its own determination as to whether, when or in what manner any hedging or market activities in securities of Issuer shall be conducted and shall do so in a manner that it deems appropriate to hedge its price and market risk with respect to the Settlement Prices; and (D) any market activities of Dealer and its affiliates with respect to Shares may affect the market price and volatility of Shares, as well as the Settlement Prices, each in a manner that may be adverse to Company.

(w)*Early Unwind*. In the event the sale of the "Option Securities" (as defined in the Purchase Agreement) is not consummated with the Initial Purchasers for any reason, or Company fails to deliver to Dealer opinions of counsel as required pursuant to Section 9(a), in each case by 5:00 p.m. (New York City time) on the Premium Payment Date, or such later date as agreed upon by the parties (the Premium Payment Date or such later date the "**Early Unwind Date**"), the Transaction shall automatically terminate (the "**Early Unwind**"), on the Early Unwind Date and (i) the Transaction and all of the respective rights and obligations of Dealer and Company under the Transaction shall be cancelled and terminated and (ii) each party shall be released and discharged by the other party from and agrees not to make any claim against the other party with respect to any obligations or liabilities of the other party arising out of and to be performed in connection with the Transaction either prior to or after the Early Unwind Date; *provided* that Company shall purchase from Dealer on the Early Unwind Date all Shares purchased by Dealer or one or more of its affiliates in connection with the Transaction at the then prevailing market price. Each of Dealer and Company represents and acknowledges to the other that, subject to the proviso included in this Section 9(w), upon an Early Unwind, all obligations with respect to the Transaction shall be deemed fully and finally discharged.

(x)*Payment by Dealer*. In the event that (i) an Early Termination Date occurs or is designated with respect to the Transaction as a result of a Termination Event or an Event of Default (other than an Event of Default arising under Section 5(a)(ii) or 5(a)(iv) of the Agreement) and, as a result, Dealer owes to Company an amount calculated under Section 6(e) of the Agreement, or (ii) Dealer owes to Company, pursuant to Section 12.7 or Section 12.9 of the Equity Definitions, an amount calculated under Section 12.8 of the Equity Definitions, such amount shall be deemed to be zero.

(y)If Company has not obtained Shareholder Approval prior to the Approval Deadline, on the Approval Deadline (x) the First Expiration Date shall be extended by one calendar year, (y) the Warrants shall, as of April 15, 2020 (the " **Original First Expiration Date**"), cease to be to be "European Options" (as such term is defined in the Equity Definitions) and shall become, as of the Original First Expiration Date, "American Options" (as such term is defined in the Equity Definitions) exercisable as of the Original First Expiration Date and (z) the Calculation Agent shall make commercially reasonable conforming amendments to the exercise and settlement terms of the Transaction to reflect the change of the Warrants from European Options to American Options, for the avoidance of doubt, retaining (i) contingencies to exercise that are not an observable market, other than the market for the Company's stock or an observable index, other than an index calculated or measured solely by reference to the Company's own operations, (ii) the commercially reasonable nature of adjustments permitted to the Transaction (such as to consider changes in volatility, expected dividends, stock loan rate or liquidity relevant to the Shares and the ability to maintain a commercially reasonable hedge position in the underlying shares) and (iii) the Company's unilateral right to settle in shares pursuant to 9(k), including pursuant to a Share Termination Alternative as provided under Section 9(j). On each anniversary of the Approval Deadline occurring prior to the final Expiration Date, if Company has not, as of such date, obtained Shareholder Approval, the First Expiration Date shall be further extended by one additional calendar year.

(z)*Adjustments*. For the avoidance of doubt, whenever the Calculation Agent or Determining Party is called upon to make an adjustment pursuant to the terms of this Confirmation or the Equity Definitions to take into account the effect of an event, the Calculation Agent or Determining Party shall make such adjustment by reference to the effect of such event on the Hedging Party, assuming that the Hedging Party maintains a commercially reasonable hedge position.

(aa)*Delivery or Receipt of Cash*. For the avoidance of doubt, other than receipt of the Premium by Company, nothing in this Confirmation shall be interpreted as requiring Company to cash settle the Transaction, except in circumstances where cash settlement is within Company's control (including, without limitation, where Company elects to deliver or receive cash, or where Company has made Private Placement settlement unavailable due to the occurrence of events within its control) or in those circumstances in which holders of Shares would also receive cash.

(bb) *No Reliance*. The Company hereby confirms that it has relied on the advice of its own counsel and other advisors (to the extent it deems appropriate) with respect to any legal, tax, accounting, or regulatory consequences of this Confirmation, that it has not relied on Dealer or its affiliates in any respect in connection therewith, and that it will not hold Dealer or its affiliates accountable for any such consequences.

J.P.Morgan

Please confirm that the foregoing correctly sets forth the terms of our agreement by executing this Confirmation and returning it to EDG Confirmation Group, J.P. Morgan Securities LLC, 277 Park Avenue, 11th Floor, New York, NY 10172-3401, or by fax to **(212) 622 8519**.

Very truly yours,

J.P. Morgan Securities LLC, as agent for JPMorgan Chase Bank, National Association

By: /s/ Yun Xie
Authorized Signatory
Name: Yun Xie

Accepted and confirmed
as of the date hereof:

Molina Healthcare, Inc.

By: /s/ John Molina
Authorized Signatory
Name: John Molina

Bank of America, N.A.
c/o Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park
New York, NY 10036
Attention: John Servidio
Telephone: 646-855-6770
Facsimile: 704-208-2869

April 22, 2013

To: **Molina Healthcare, Inc.**
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

Re: Additional Warrants

The purpose of this letter agreement (this "**Confirmation**") is to amend and restate, in its entirety, the Additional Warrants Confirmation dated February 13, 2013 between the parties hereto and to confirm the terms and conditions of the Warrants issued by **Molina Healthcare, Inc.** ("**Company**") to **Bank of America, N.A.** ("**Dealer**") as of the Trade Date specified below (the "**Transaction**"). The parties hereto agree and acknowledge that the amendments reflected in this amended and restated Confirmation are non-substantive, clarifying changes made for the avoidance of doubt. This letter agreement constitutes a "Confirmation" as referred to in the ISDA Master Agreement specified below. This Confirmation shall replace any previous agreements and serve as the final documentation for the Transaction.

The definitions and provisions contained in the 2002 ISDA Equity Derivatives Definitions (the "**Equity Definitions**"), as published by the International Swaps and Derivatives Association, Inc. ("**ISDA**"), are incorporated into this Confirmation. In the event of any inconsistency between the Equity Definitions and this Confirmation, this Confirmation shall govern.

Each party is hereby advised, and each such party acknowledges, that the other party has engaged in, or refrained from engaging in, substantial financial transactions and has taken other material actions in reliance upon the parties' entry into the Transaction to which this Confirmation relates on the terms and conditions set forth below.

1. This Confirmation evidences a complete and binding agreement between Dealer and Company as to the terms of the Transaction to which this Confirmation relates. This Confirmation shall supplement, form a part of, and be subject to an agreement in the form of the 2002 ISDA Master Agreement (the "**Agreement**") as if Dealer and Company had executed an agreement in such form (but without any Schedule except for the election of the laws of the State of New York as the governing law (without reference to choice of law doctrine)) on the Trade Date. In the event of any inconsistency between provisions of the Agreement and this Confirmation, this Confirmation will prevail for the purpose of the Transaction to which this Confirmation relates. The parties hereby agree that no transaction other than the Transaction to which this Confirmation relates shall be governed by the Agreement.

2. The Transaction is a Warrant Transaction, which shall be considered a Share Option Transaction for purposes of the Equity Definitions. The terms of the particular Transaction to which this Confirmation relates are as follows:

General Terms.

Trade Date: February 13, 2013

Effective Date:	The third Exchange Business Day immediately prior to the Premium Payment Date
Warrants:	Equity call warrants, each giving the holder the right to purchase a number of Shares equal to the Warrant Entitlement at a price per Share equal to the Strike Price, subject to the terms set forth under the caption "Settlement Terms" below. For the purposes of the Equity Definitions, each reference to a Warrant herein shall be deemed to be a reference to a Call Option.
Warrant Style:	European
Seller:	Company
Buyer:	Dealer
Shares:	The common stock of Company, par value USD 0.001 per Share (Exchange symbol "MOH")
Number of Warrants:	1,152,802. For the avoidance of doubt, the Number of Warrants shall be reduced by any Warrants exercised or deemed exercised hereunder. In no event will the Number of Warrants be less than zero.
Warrant Entitlement:	One Share per Warrant
Maximum Number of Shares:	For any day, 4,394,906 Shares, *minus* the aggregate number of Shares delivered prior to such day pursuant to (i) this Confirmation and (ii) any other substantially similar confirmation for Warrants sold by Company to Dealer with a trade date within 16 days of the Trade Date and with expiration dates the same as the Expiration Dates. Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, in no event shall the Maximum Number of Shares be subject to adjustment, except for any adjustment pursuant to the terms of this Confirmation and the Equity Definitions in connection with a Potential Adjustment Event (as defined in Section 11.2(e) of the Equity Definitions and without any amendment thereto pursuant to the terms of this Confirmation). Notwithstanding anything to the contrary in the Agreement, this Confirmation or the Equity Definitions, the Maximum Number of Shares shall not be adjusted on account of any event that (x) constitutes a Potential Adjustment Event solely on account of Section 11.2(e)(vii) of the Equity Definitions and (y) is not an event within Company's control.
Strike Price:	USD 53.8475
Premium:	USD 6,415,454
Premium Payment Date:	February 15, 2013
Exchange:	The New York Stock Exchange

Related Exchange(s):	All Exchanges

Procedures for Exercise.

Expiration Time:	The Valuation Time
Expiration Dates:	Each Scheduled Trading Day during the period from, and including, the First Expiration Date to, but excluding, the 160th Scheduled Trading Day following the First Expiration Date shall be an "Expiration Date" for a number of Warrants equal to the Daily Number of Warrants on such date; *provided* that, notwithstanding anything to the contrary in the Equity Definitions, if any such date is a Disrupted Day, the Calculation Agent shall make adjustments, if applicable, to the Daily Number of Warrants or shall reduce such Daily Number of Warrants to zero for which such day shall be an Expiration Date and shall designate a Scheduled Trading Day or a number of Scheduled Trading Days as the Expiration Date(s) for the remaining Daily Number of Warrants or a portion thereof for the originally scheduled Expiration Date; and *provided further* that if such Expiration Date has not occurred pursuant to this clause as of the eighth Scheduled Trading Day following the last scheduled Expiration Date under the Transaction, the Calculation Agent shall have the right to declare such Scheduled Trading Day to be the final Expiration Date and the Calculation Agent shall determine its good faith estimate of the fair market value for the Shares as of the Valuation Time on that eighth Scheduled Trading Day or on any subsequent Scheduled Trading Day, as the Calculation Agent shall determine using commercially reasonable means.
First Expiration Date:	April 15, 2020 (or if such day is not a Scheduled Trading Day, the next following Scheduled Trading Day), subject to Market Disruption Event below.
Daily Number of Warrants:	For any Expiration Date, the Number of Warrants that have not expired or been exercised as of such day, *divided* by the remaining number of Expiration Dates (including such day), rounded down to the nearest whole number, subject to adjustment pursuant to the provisos to "Expiration Dates".
Automatic Exercise:	Applicable; and means that for each Expiration Date, a number of Warrants equal to the Daily Number of Warrants for such Expiration Date will be deemed to be automatically exercised at the Expiration Time on such Expiration Date.
Market Disruption Event:	Section 6.3(a) of the Equity Definitions is hereby amended by replacing clause (ii) in its entirety with "(ii) an Exchange Disruption, or" and inserting immediately following clause (iii) the phrase "; in each case that the Calculation Agent determines is material." Section 6.3(d) of the Equity Definitions is hereby amended by deleting the remainder of the provision following the words "Scheduled Closing Time" in the fourth line thereof.

Valuation Terms.

Valuation Time:	Scheduled Closing Time; *provided* that if the principal trading session is extended, the Calculation Agent shall determine the Valuation Time in good faith using its commercially reasonable discretion.
Valuation Date:	Each Exercise Date.

Settlement Terms.

Settlement Method:	Net Share Settlement.
Net Share Settlement:	On the relevant Settlement Date, Company shall deliver to Dealer a number of Shares equal to the Share Delivery Quantity for such Settlement Date to the account specified herein free of payment through the Clearance System, and Dealer shall be treated as the holder of record of such Shares at the time of delivery of such Shares or, if earlier, at 5:00 p.m. (New York City time) on such Settlement Date, and Company shall pay to Dealer cash in lieu of any fractional Share based on the Settlement Price on the relevant Valuation Date.
Share Delivery Quantity:	For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date for such Settlement Date; *provided* that in no event shall the Share Delivery Quantity for any Settlement Date exceed the Maximum Number of Shares for such Settlement Date, *minus* the Share Delivery Quantity (as defined in the letter agreement dated February 11, 2013 between Dealer and Company regarding Base Warrants (the "**Base Warrant Confirmation**")), if any, for such Settlement Date.
Net Share Settlement Amount:	For any Settlement Date, an amount equal to the product of (i) the number of Warrants exercised or deemed exercised on the relevant Exercise Date, (ii) the Strike Price Differential for the relevant Valuation Date and (iii) the Warrant Entitlement.
Settlement Price:	For any Valuation Date, the per Share volume-weighted average price as displayed under the heading "Bloomberg VWAP" on Bloomberg page MOH <equity> AQR (or any successor thereto) in respect of the period from the scheduled opening time of the Exchange to the Scheduled Closing Time on such Valuation Date (or if such volume-weighted average price is unavailable, the market value of one Share on such Valuation Date, as determined by the Calculation Agent). Notwithstanding the foregoing, if (i) any Expiration Date is a Disrupted Day and (ii) the Calculation Agent determines that such Expiration Date shall be an Expiration Date for fewer than the Daily Number of Warrants, as described above, then the Settlement Price for the relevant Valuation Date shall be the volume-weighted average price per Share on such Valuation Date on the Exchange, as determined by the Calculation Agent based on such sources as it deems appropriate using a volume-

	weighted methodology, for the portion of such Valuation Date for which the Calculation Agent determines there is no Market Disruption Event.
Settlement Dates:	As determined pursuant to Section 9.4 of the Equity Definitions, subject to Section 9(k)(i) hereof.
Other Applicable Provisions:	The provisions of Sections 9.1(c), 9.8, 9.9, 9.11 and 9.12 of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Net Share Settled." "Net Share Settled" in relation to any Warrant means that Net Share Settlement is applicable to that Warrant.
Representation and Agreement:	Notwithstanding Section 9.11 of the Equity Definitions, the parties acknowledge that any Shares delivered to Dealer may be, upon delivery, subject to restrictions and limitations arising from Company's status as issuer of the Shares under applicable securities laws.

3. <u>Additional Terms applicable to the Transaction</u>.

Adjustments applicable to the Transaction:

Method of Adjustment:	Calculation Agent Adjustment. For the avoidance of doubt, in making any adjustments under the Equity Definitions, the Calculation Agent may make adjustments, if any, to any one or more of the Strike Price, the Number of Warrants, the Daily Number of Warrants and the Warrant Entitlement. Notwithstanding the foregoing, any cash dividends or distributions on the Shares, whether or not extraordinary, shall be governed by Section 9(f) of this Confirmation in lieu of Article 10 or Section 11.2(c) of the Equity Definitions.

Extraordinary Events applicable to the Transaction:

New Shares:	Section 12.1(i) of the Equity Definitions is hereby amended (a) by deleting the text in clause (i) thereof in its entirety (including the word "and" following clause (i)) and replacing it with the phrase "publicly quoted, traded or listed (or whose related depositary receipts are publicly quoted, traded or listed) on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors)" and (b) by inserting immediately prior to the period the phrase "and (iii) of an entity or person that is a corporation organized under the laws of the United States, any State thereof or the District of Columbia that also becomes Company under the Transaction following such Merger Event or Tender Offer".

Consequence of Merger Events:

Merger Event:	Applicable; *provided* that if an event occurs that constitutes both a Merger Event under Section 12.1(b) of the Equity Definitions and an Additional Termination Event under Section 9(h)(ii)(B) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the

	provisions of Section 12.2 of the Equity Definitions or Section 9(h)(ii)(B) will apply.
Share-for-Share:	Modified Calculation Agent Adjustment
Share-for-Other:	Cancellation and Payment (Calculation Agent Determination)
Share-for-Combined:	Cancellation and Payment (Calculation Agent Determination); *provided* that Dealer may elect, in its commercially reasonable judgment, Component Adjustment (Calculation Agent Determination) for all or any portion of the Transaction.
Consequence of Tender Offers:	
Tender Offer:	Applicable; *provided* that if an event occurs that constitutes both a Tender Offer under Section 12.1(d) of the Equity Definitions and Additional Termination Event under Section 9(h)(ii)(A) of this Confirmation, Dealer may elect, in its commercially reasonable judgment, whether the provisions of Section 12.3 of the Equity Definitions or Section 9(h)(ii)(A) will apply.
Share-for-Share:	Modified Calculation Agent Adjustment
Share-for-Other:	Modified Calculation Agent Adjustment
Share-for-Combined:	Modified Calculation Agent Adjustment
Announcement Event:	If an Announcement Date occurs in respect of a Merger Event (for the avoidance of doubt, determined without regard to the language in the definition of "Merger Event" following the definition of "Reverse Merger" therein) or Tender Offer (such occurrence, an "**Announcement Event**"), then on the earliest of the Expiration Date, Early Termination Date or other date of cancellation (the "**Announcement Event Adjustment Date**") in respect of each Warrant, the Calculation Agent will determine the economic effect on such Warrant of the Announcement Event (regardless of whether the Announcement Event actually results in a Merger Event or Tender Offer, and taking into account such factors as the Calculation Agent may determine, including, without limitation, changes in volatility, expected dividends, stock loan rate or liquidity relevant to the Shares or the Transaction whether prior to or after the Announcement Event or for any period of time, including, without limitation, the period from the Announcement Event to the relevant Announcement Event Adjustment Date). If the Calculation Agent determines that such economic effect on any Warrant is material, then on the Announcement Event Adjustment Date for such Warrant, the Calculation Agent may make such adjustment to the exercise, settlement, payment or any other terms of such Warrant as the Calculation Agent determines appropriate to account for such economic effect, which adjustment shall be effective immediately prior to the

exercise, termination or cancellation of such Warrant, as the case may be.

Announcement Date:	The definition of "Announcement Date" in Section 12.1 of the Equity Definitions is hereby amended by (i) replacing the words "a firm" with the word "any" in the second and fourth lines thereof, (ii) replacing the word "leads to the" with the words ", if completed, would lead to a" in the third and the fifth lines thereof, (iii) replacing the words "voting shares" with the word "Shares" in the fifth line thereof, and (iv) inserting the words "by any entity" after the word "announcement" in the second and the fourth lines thereof.
Nationalization, Insolvency or Delisting:	Cancellation and Payment (Calculation Agent Determination); *provided* that, in addition to the provisions of Section 12.6(a)(iii) of the Equity Definitions, it will also constitute a Delisting if the Exchange is located in the United States and the Shares are not immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors); if the Shares are immediately re-listed, re-traded or re-quoted on any of the New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or their respective successors), such exchange or quotation system shall thereafter be deemed to be the Exchange.
Additional Disruption Events:	
Change in Law:	Applicable; *provided* that Section 12.9(a)(ii) of the Equity Definitions is hereby amended by (i) replacing the word "Shares" with the phrase "Hedge Positions" in clause (X) thereof and (ii) inserting the parenthetical "(including, for the avoidance of doubt and without limitation, adoption, effectiveness or promulgation of new regulations authorized or mandated by existing statute)" at the end of clause (A) thereof.
Failure to Deliver:	Not Applicable
Insolvency Filing:	Applicable
Hedging Disruption:	Applicable; *provided* that:

(i) Section 12.9(a)(v) of the Equity Definitions is hereby amended by (a) inserting the following words at the end of clause (A) thereof: "in the manner contemplated by the Hedging Party on the Trade Date" and (b) inserting the following two phrases at the end of such Section:

"For the avoidance of doubt, the term "equity price risk" shall be deemed to include, but shall not be limited to, stock price and volatility risk. And, for the further avoidance of doubt, any such transactions or assets referred to in phrases (A) or (B) above must be available on commercially reasonable pricing terms."; and

(ii) Section 12.9(b)(iii) of the Equity Definitions is hereby amended by inserting in the third line thereof, after the words "to terminate the Transaction", the words "or a portion of the Transaction affected by such Hedging Disruption".

Increased Cost of Hedging:	Applicable
Loss of Stock Borrow:	Applicable
Maximum Stock Loan Rate:	100 basis points
Increased Cost of Stock Borrow:	Applicable
Initial Stock Loan Rate:	25 basis points
Hedging Party:	For all applicable Additional Disruption Events, Dealer.
Determining Party:	For all applicable Extraordinary Events, Dealer.
Non-Reliance:	Applicable
Agreements and Acknowledgments Regarding Hedging Activities:	Applicable
Additional Acknowledgments:	Applicable

4. **Calculation Agent.** Dealer

5. **Account Details.**

(a)Account for payments to Company: To Be Advised.

Account for delivery of Shares from Company: To Be Advised.

(b)Account for payments to Dealer:

Bank of America, N.A.
New York, NY
SWIFT: BOFAUS3N
Bank Routing: 026-009-593
Account Name: Bank of America
Account No. : 0012334-61892

6. **Offices.**

(a)The Office of Company for the Transaction is: Inapplicable, Company is not a Multibranch Party.

(b)The Office of Dealer for the Transaction is: New York

Bank of America, N.A.
c/o Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park
New York, NY 10036
Attention: John Servidio
Telephone: 646-855-7127
Facsimile: 704-208-2869

7. **Notices.**

(a)Address for notices or communications to Company:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, California 90802
Attention: General Counsel
Telephone No.: (562) 435-3666
Facsimile No.: (916) 646-4572

(b)Address for notices or communications to Dealer:

To: Bank of America, N.A.
c/o Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park
New York, NY 10036
Attention: John Servidio
Telephone: 646-855-7127
Facsimile: 704-208-2869

8. Representations and Warranties of Company.

Each of the representations and warranties of Company set forth in Section 3 of the Purchase Agreement (the "**Purchase Agreement**"), dated as of February 11, 2013, among Company and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as representatives of the Initial Purchasers party thereto (the "**Initial Purchasers**"), other than the representations set forth in Section 3(o), Section 3(r) and Section 3(s) of the Purchase Agreement, in each case, as such representations relate to the Transaction, are true and correct and are hereby deemed to be repeated to Dealer as if set forth herein. Company hereby further represents and warrants to Dealer on the Trade Date, the date hereof, on and as of the Premium Payment Date and, in the case of the representations in Section 8(d), at all times until termination of the Transaction, that:

(a)Company has all necessary corporate power and authority to execute, deliver and perform its obligations in respect of the Transaction; such execution, delivery and performance have been duly authorized by all necessary corporate action on Company's part; and this Confirmation has been duly and validly executed and delivered by Company and constitutes its valid and binding obligation, enforceable against Company in accordance with its terms, subject to applicable bankruptcy, insolvency, fraudulent conveyance, reorganization, moratorium and similar laws affecting creditors' rights and remedies generally, and subject, as to enforceability, to general principles of equity, including principles of commercial reasonableness, good faith and fair dealing (regardless of whether enforcement is sought in a proceeding at law or in equity) and except that rights to indemnification and contribution hereunder may be limited by federal or state securities laws or public policy relating thereto.

(b)Neither the execution and delivery of this Confirmation nor the incurrence or performance of obligations of Company hereunder will conflict with or result in a breach of the certificate of incorporation or by-laws (or any equivalent documents) of Company, or any applicable law or regulation, or any order, writ, injunction or decree of any court or governmental authority or agency, or any agreement or instrument to which Company or any of its subsidiaries is a party or by which Company or any of its subsidiaries is bound or to which Company or any of its subsidiaries is subject, or constitute a default under, or result in the creation of any lien under, any such agreement or instrument.

(c)No consent, approval, authorization, or order of, or filing with, any governmental agency or body or any court is required in connection with the execution, delivery or performance by Company of this Confirmation, except such as have been obtained or made and such as may be required under the Securities Act of 1933, as amended (the "**Securities Act**") or state securities laws.

(d)A number of Shares equal to the Maximum Number of Shares (the "**Warrant Shares**") have been reserved for issuance by all required corporate action of Company. The Warrant Shares have been

duly authorized and, when delivered against payment therefor (which may include Net Share Settlement in lieu of cash) and otherwise as contemplated by the terms of the Warrants following the exercise of the Warrants in accordance with the terms and conditions of the Warrants, will be validly issued, fully-paid and non-assessable, and the issuance of the Warrant Shares will not be subject to any preemptive or similar rights.

(e) Company is not and, after consummation of the transactions contemplated hereby, will not be required to register as an "investment company" as such term is defined in the Investment Company Act of 1940, as amended.

(f) Company is an "eligible contract participant" (as such term is defined in Section 1a(18) of the Commodity Exchange Act, as amended, other than a person that is an eligible contract participant under Section 1a(18)(C) of the Commodity Exchange Act).

(g) Company and each of its affiliates is not, on the date hereof, in possession of any material non-public information with respect to Company.

(h) No state or local (including any non-U.S. jurisdiction's) law, rule, regulation or regulatory order applicable to the Shares would give rise to any reporting, consent, registration or other requirement (including without limitation a requirement to obtain prior approval from any person or entity) as a result of Dealer or its affiliates owning or holding (however defined) Shares.

(i) Company (A) is capable of evaluating investment risks independently, both in general and with regard to all transactions and investment strategies involving a security or securities; (B) will exercise independent judgment in evaluating the recommendations of any broker-dealer or its associated persons, unless it has otherwise notified the broker-dealer in writing; and (C) has total assets of at least $50 million.

9. Other Provisions.

(a) *Opinions*. Company shall deliver to Dealer an opinion of counsel, dated as of the Trade Date, with respect to the matters set forth in Sections 8(a) through (d) of this Confirmation. Delivery of such opinion to Dealer shall be a condition precedent for the purpose of Section 2(a)(iii) of the Agreement with respect to each obligation of Dealer under Section 2(a)(i) of the Agreement.

(b) *Repurchase Notices*. Company shall, on any day on which Company effects any repurchase of Shares, promptly give Dealer a written notice of such repurchase (a "**Repurchase Notice**") on such day if following such repurchase, the number of outstanding Shares on such day, subject to any adjustments provided herein, is (i) less than 45,295,973 (in the case of the first such notice) or (ii) thereafter more than 1,390,754 less than the number of Shares included in the immediately preceding Repurchase Notice. Company agrees to indemnify and hold harmless Dealer and its affiliates and their respective officers, directors, employees, affiliates, advisors, agents and controlling persons (each, an "**Indemnified Person**") from and against any and all losses (including losses relating to Dealer's hedging activities as a consequence of becoming, or of the risk of becoming, a Section 16 "insider", including without limitation, any forbearance from hedging activities or cessation of hedging activities and any losses in connection therewith with respect to the Transaction), claims, damages, judgments, liabilities and expenses (including reasonable attorney's fees), joint or several, which an Indemnified Person actually may become subject to, as a result of Company's failure to provide Dealer with a Repurchase Notice on the day and in the manner specified in this paragraph, and to reimburse, within 30 days, upon written request, each of such Indemnified Persons for any reasonable legal or other expenses incurred in connection with investigating, preparing for, providing testimony or other evidence in connection with or defending any of the foregoing. If any suit, action, proceeding (including any governmental or regulatory investigation), claim or demand shall be brought or asserted against the Indemnified Person, such Indemnified Person shall promptly notify Company in writing, and Company, upon request of the Indemnified Person, shall retain counsel reasonably satisfactory to the Indemnified Person to represent the Indemnified Person and any others Company may designate in such proceeding and shall pay the fees and expenses of such counsel related to such proceeding. Company shall not be liable for any settlement of any proceeding effected without its written consent,

but if settled with such consent or if there be a final judgment for the plaintiff, Company agrees to indemnify any Indemnified Person from and against any loss or liability by reason of such settlement or judgment. Company shall not, without the prior written consent of the Indemnified Person, effect any settlement of any pending or threatened proceeding in respect of which any Indemnified Person is or could have been a party and indemnity could have been sought hereunder by such Indemnified Person, unless such settlement includes an unconditional release of such Indemnified Person from all liability on claims that are the subject matter of such proceeding on terms reasonably satisfactory to such Indemnified Person. If the indemnification provided for in this paragraph is unavailable to an Indemnified Person or insufficient in respect of any losses, claims, damages or liabilities referred to therein, then Company under such paragraph, in lieu of indemnifying such Indemnified Person thereunder, shall contribute to the amount paid or payable by such Indemnified Person as a result of such losses, claims, damages or liabilities. The remedies provided for in this paragraph are not exclusive and shall not limit any rights or remedies which may otherwise be available to any Indemnified Person at law or in equity. The indemnity and contribution agreements contained in this paragraph shall remain operative and in full force and effect regardless of the termination of the Transaction.

(c) *Regulation M*. Company is not on the Trade Date engaged in a distribution, as such term is used in Regulation M under the Securities Exchange Act of 1934, as amended (the "**Exchange Act**"), of any securities of Company, other than a distribution meeting the requirements of the exception set forth in Rules 101(b)(10) and 102(b)(7) of Regulation M. Company shall not, until the second Scheduled Trading Day immediately following the Effective Date, engage in any such distribution.

(d) *No Manipulation*. Company is not entering into the Transaction to create actual or apparent trading activity in the Shares (or any security convertible into or exchangeable for the Shares) or to raise or depress or otherwise manipulate the price of the Shares (or any security convertible into or exchangeable for the Shares) or otherwise in violation of the Exchange Act.

(e) *Transfer or Assignment*. Company may not transfer any of its rights or obligations under the Transaction without the prior written consent of Dealer. Dealer may, without Company's consent, transfer or assign all or any part of its rights or obligations under the Transaction to any third party. If at any time at which (A) the Section 16 Percentage exceeds 7.5%, (B) the Warrant Equity Percentage exceeds 16.3%, or (C) the Share Amount exceeds the Applicable Share Limit (if any applies) (any such condition described in clauses (A), (B) or (C), an "**Excess Ownership Position**"), Dealer is unable after using its commercially reasonable efforts to effect a transfer or assignment of Warrants to a third party on pricing terms reasonably acceptable to Dealer and within a time period reasonably acceptable to Dealer such that no Excess Ownership Position exists, then Dealer may designate any Exchange Business Day as an Early Termination Date with respect to a portion of the Transaction (the "**Terminated Portion**"), such that following such partial termination no Excess Ownership Position exists. In the event that Dealer so designates an Early Termination Date with respect to a Terminated Portion, a payment shall be made pursuant to Section 6 of the Agreement as if (1) an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants underlying the Terminated Portion, (2) Company were the sole Affected Party with respect to such partial termination and (3) the Terminated Portion were the sole Affected Transaction (and, for the avoidance of doubt, the provisions of Section 9(j) shall apply to any amount that is payable by Company to Dealer pursuant to this sentence as if Company was not the Affected Party). The "**Section 16 Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the number of Shares that Dealer and each person subject to aggregation of Shares with Dealer under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder directly or indirectly beneficially own (as defined under Section 13 or Section 16 of the Exchange Act and rules promulgated thereunder) and (B) the denominator of which is the number of Shares outstanding. The "**Warrant Equity Percentage**" as of any day is the fraction, expressed as a percentage, (A) the numerator of which is the sum of (1) the product of the Number of Warrants and the Warrant Entitlement and (2) the aggregate number of Shares underlying any other warrants purchased by Dealer from Company, and (B) the denominator of which is the number of Shares outstanding. The "**Share Amount**" as of any day is the number of Shares that Dealer and any person whose ownership position would be aggregated

with that of Dealer (Dealer or any such person, a "**Dealer Person**") under any law, rule, regulation, regulatory order or organizational documents or contracts of Company that are, in each case, applicable to ownership of Shares ("**Applicable Restrictions**"), owns, beneficially owns, constructively owns, controls, holds the power to vote or otherwise meets a relevant definition of ownership under any Applicable Restriction, as determined by Dealer in its reasonable discretion. The "**Applicable Share Limit**" means a number of Shares equal to (A) the minimum number of Shares that could give rise to reporting or registration obligations or other requirements (including obtaining prior approval from any person or entity) of a Dealer Person, or could result in an adverse effect on a Dealer Person, under any Applicable Restriction, as determined by Dealer in its reasonable discretion, *minus* (B) 1% of the number of Shares outstanding. Notwithstanding any other provision in this Confirmation to the contrary requiring or allowing Dealer to purchase, sell, receive or deliver any Shares or other securities, or to make or receive any payment in cash, to or from Company, Dealer may designate any of its affiliates to purchase, sell, receive or deliver such Shares or other securities, or make or receive such payment in cash, and otherwise to perform Dealer's obligations in respect of the Transaction and any such designee may assume such obligations. Dealer shall be discharged of its obligations to Company to the extent of any such performance.

(f) *Dividends*. If at any time during the period from and including the Effective Date, to and including the last Expiration Date, an ex-dividend date for a cash dividend occurs with respect to the Shares (an "**Ex-Dividend Date**"), then the Calculation Agent will adjust any of the Strike Price, Number of Warrants, Daily Number of Warrants and/or any other variable relevant to the exercise, settlement or payment of the Transaction to preserve the fair value of the Warrants after taking into account such dividend.

(g) *Designation by Dealer*. Notwithstanding any other provision in this Confirmation to the contrary requiring or allowing Dealer to purchase, sell, receive or deliver any Shares or other securities to or from Company, Dealer may designate any of its affiliates to purchase, sell, receive or deliver such shares or other securities and otherwise to perform Dealer obligations in respect of the Transaction and any such designee may assume such obligations. Dealer shall be discharged of its obligations to Company to the extent of any such performance.

(h) *Additional Provisions*.

(i) Amendments to the Equity Definitions:

(A) Section 11.2(a) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the words "an"; and adding the phrase "or Warrants" at the end of the sentence.

(B) Section 11.2(c) of the Equity Definitions is hereby amended by (w) replacing the words "a diluting or concentrative" with "an" in the fifth line thereof, (x) adding the phrase "or Warrants" after the words "the relevant Shares" in the same sentence, (y) deleting the words "diluting or concentrative" in the sixth to last line thereof and (z) deleting the phrase "(provided that no adjustments will be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)" and replacing it with the phrase "(and, for the avoidance of doubt, adjustments may be made to account solely for changes in volatility, expected dividends, stock loan rate or liquidity relative to the relevant Shares)."

(C) Section 11.2(e)(vii) of the Equity Definitions is hereby amended by deleting the words "a diluting or concentrative" and replacing them with the word "a material"; and adding the phrase "or Warrants" at the end of the sentence.

(D) Section 12.6(a)(ii) of the Equity Definitions is hereby amended by (1) deleting from the fourth line thereof the word "or" after the word "official" and inserting a comma therefor, and (2) deleting the semi-colon at the end of subsection (B) thereof and inserting the following words therefor "or (C) at Dealer's option, the occurrence

of any of the events specified in Section 5(a)(vii) (1) through (9) of the ISDA Master Agreement with respect to that Issuer."

(E) Section 12.9(b)(iv) of the Equity Definitions is hereby amended by:

(x) deleting (1) subsection (A) in its entirety, (2) the phrase "or (B)" following subsection (A) and (3) the phrase "in each case" in subsection (B); and

(y) replacing the phrase "neither the Non-Hedging Party nor the Lending Party lends Shares" with the phrase "such Lending Party does not lend Shares" in the penultimate sentence.

(F) Section 12.9(b)(v) of the Equity Definitions is hereby amended by:

(x) adding the word "or" immediately before subsection "(B)" and deleting the comma at the end of subsection (A); and

(y) (1) deleting subsection (C) in its entirety, (2) deleting the word "or" immediately preceding subsection (C), (3) deleting the penultimate sentence in its entirety and replacing it with the sentence "The Hedging Party will determine the Cancellation Amount payable by one party to the other." and (4) deleting clause (X) in the final sentence.

(ii) Notwithstanding anything to the contrary in this Confirmation, upon the occurrence of one of the following events, with respect to the Transaction, (1) Dealer shall have the right to designate such event an Additional Termination Event and designate an Early Termination Date pursuant to Section 6(b) of the Agreement, (2) Company shall be deemed the sole Affected Party with respect to such Additional Termination Event and (3) the Transaction, or, at the election of Dealer in its sole discretion, any portion of the Transaction, shall be deemed the sole Affected Transaction; *provided* that if Dealer so designates an Early Termination Date with respect to a portion of the Transaction, (a) a payment shall be made pursuant to Section 6 of the Agreement as if an Early Termination Date had been designated in respect of a Transaction having terms identical to the Transaction and a Number of Warrants equal to the number of Warrants included in the terminated portion of the Transaction, and (b) for the avoidance of doubt, the Transaction shall remain in full force and effect except that the Number of Warrants shall be reduced by the number of Warrants included in such terminated portion:

(A) A "person" or "group" within the meaning of Section 13(d) of the Exchange Act, other than Company, its subsidiaries or its and their employee benefit plans, files a Schedule TO or any schedule, form or report under the Exchange Act disclosing that such person or group has become the direct or indirect "beneficial owner," as defined in Rule 13d-3 under the Exchange Act, of the common equity of Company representing more than 50% of the voting power of such common equity.

(B) Consummation of (I) any recapitalization, reclassification or change of the Shares (other than changes resulting from a subdivision or combination) as a result of which the Shares would be converted into, or exchanged for, stock, other securities, other property or assets or (II) any share exchange, consolidation or merger of Company pursuant to which the Shares will be converted into cash, securities or other property or (III) any sale, lease or other transfer in one transaction or a series of transactions of all or substantially all of the consolidated assets of Company and its subsidiaries, taken as a whole, to any person other than one of Company's subsidiaries. Notwithstanding the foregoing, any transaction or transactions set forth in this clause (B) shall not constitute an Additional Termination Event if (x) at least 90% of the consideration received or to be received by holders of the Shares, excluding cash payments for fractional Shares, in connection with such transaction or transactions consists of shares of common stock that are listed or quoted on any

of The New York Stock Exchange, The NASDAQ Global Select Market or The NASDAQ Global Market (or any of their respective successors) or will be so listed or quoted when issued or exchanged in connection with such transaction or transactions, and (y) as a result of such transaction or transactions, the Shares will consist of such consideration, excluding cash payments for fractional Shares.

(C) Company's shareholders approve any plan or proposal for the liquidation or dissolution of Company.

(D) Default by Company or any of its subsidiaries with respect to any mortgage, agreement or other instrument under which there may be outstanding, or by which there may be secured or evidenced, any indebtedness for money borrowed in excess of $15 million in the aggregate of Company and/or any such subsidiary, whether such indebtedness now exists or shall hereafter be created (i) resulting in such indebtedness becoming or being declared due and payable or (ii) constituting a failure to pay the principal or interest of any such debt when due and payable at its stated maturity, upon required repurchase, upon declaration of acceleration or otherwise.

(E) A final judgment for the payment of $15 million or more (excluding any amounts covered by insurance) rendered against Company or any of its subsidiaries, which judgment is not discharged or stayed within 60 days after (I) the date on which the right to appeal thereof has expired if no such appeal has commenced, or (II) the date on which all rights to appeal have been extinguished.

(F) Dealer, despite using commercially reasonable efforts, is unable or reasonably determines that it is impractical or illegal, to hedge its exposure with respect to the Transaction in the public market without registration under the Securities Act or as a result of any legal, regulatory or self-regulatory requirements or related policies and procedures (whether or not such requirements, policies or procedures are imposed by law or have been voluntarily adopted by Dealer).

(G) On any day during the period from and including the Trade Date, to and including the final Expiration Date, (I) the Notional Unwind Shares (as defined below) as of such day exceeds a number of Shares equal to 60% of the Maximum Number of Shares, or (II) Company makes a public announcement of any transaction or event that, in the reasonable opinion of Dealer would, upon consummation of such transaction or upon the occurrence of such event, as applicable, and after giving effect to any applicable adjustments hereunder, cause the Notional Unwind Shares immediately following the consummation of such transaction or the occurrence of such event to exceed a number of Shares equal to 60% of the Maximum Number of Shares. The "**Notional Unwind Shares**" as of any day is a number of Shares equal to (1) the amount that would be payable pursuant to Section 6 of the Agreement (determined as of such day as if an Early Termination Date had been designated in respect of the Transaction and as if Company were the sole Affected Party and the Transaction were the sole Affected Transaction), *divided by* (2) the Settlement Price (determined as if such day were a Valuation Date). For the purposes of this clause (G), the Share Delivery Quantity shall be deemed to include the "Share Delivery Quantity" (as defined in the Base Warrant Confirmation) and the terms set forth above for determining the Share Delivery Quantity shall apply mutatis mutandis for the purposes of determining the "Share Delivery Quantity" under the Base Warrant Confirmation.

(H) If Company has not obtained Shareholder Approval prior to February 11, 2014 (the "**Approval Deadline**"). For the avoidance of doubt, if Company has not obtained Shareholder Approval prior to the Approval Deadline, Dealer shall have right to designate an Early Termination Date in connection with the Additional Termination

Event set forth in this clause (H) on any day from, and including, the Approval Deadline to, and including, the earlier of (x) the date on which Company obtains Shareholder Approval and (y) the final Expiration Date.

(i) *No Collateral or Setoff*. Notwithstanding any provision of the Agreement or any other agreement between the parties to the contrary, the obligations of Company hereunder are not secured by any collateral. Obligations under the Transaction shall not be set off by Company against any other obligations of the parties, whether arising under the Agreement, this Confirmation, under any other agreement between the parties hereto, by operation of law or otherwise. Any provision in the Agreement with respect to the satisfaction of Company's payment obligations to the extent of Dealer's payment obligations to Company in the same currency and in the same Transaction (including, without limitation Section 2(c) thereof) shall not apply to Company and, for the avoidance of doubt, Company shall fully satisfy such payment obligations notwithstanding any payment obligation to Company by Dealer in the same currency and in the same Transaction. In calculating any amounts under Section 6(e) of the Agreement, notwithstanding anything to the contrary in the Agreement, (1) separate amounts shall be calculated as set forth in such Section 6(e) with respect to (a) the Transaction and (b) all other Transactions, and (2) such separate amounts shall be payable pursuant to Section 6(d)(ii) of the Agreement. For the avoidance of doubt and notwithstanding anything to the contrary provided in this Section 9(i), in the event of bankruptcy or liquidation of either Company or Dealer, neither party shall have the right to set off any obligation that it may have to the other party under the Transaction against any obligation such other party may have to it, whether arising under the Agreement, this Confirmation or any other agreement between the parties hereto, by operation of law or otherwise.

(j) *Alternative Calculations and Payment on Early Termination and on Certain Extraordinary Events*.

(i) If, in respect of the Transaction, an amount is payable by Company to Dealer, (A) pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or (B) pursuant to Section 6(d)(ii) of the Agreement (any such amount, a "**Payment Obligation**"), Company shall satisfy the Payment Obligation by the Share Termination Alternative (as defined below), unless (a) Company gives irrevocable telephonic notice to Dealer, confirmed in writing within one Scheduled Trading Day, no later than 12:00 p.m. (New York City time) on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable, of its election that the Share Termination Alternative shall not apply, (b) Company remakes the representation set forth in Section 8(g) as of the date of such election and (c) Dealer agrees, in its sole discretion, to such election, in which case the provisions of Section 12.7 or Section 12.9 of the Equity Definitions, or the provisions of Section 6(d)(ii) of the Agreement, as the case may be, shall apply.

Share Termination Alternative:	If applicable, Company shall deliver to Dealer the Share Termination Delivery Property on the date (the "**Share Termination Payment Date**") on which the Payment Obligation would otherwise be due pursuant to Section 12.7 or Section 12.9 of the Equity Definitions or Section 6(d)(ii) of the Agreement, as applicable, subject to Section 9(k)(i) below, in satisfaction, subject to Section 9(k)(ii) below, of the relevant Payment Obligation, in the manner reasonably requested by Dealer free of payment.
Share Termination Delivery Property:	A number of Share Termination Delivery Units, as calculated by the Calculation Agent, equal to the relevant Payment Obligation *divided by* the Share Termination Unit Price. The Calculation Agent shall adjust the amount of Share Termination Delivery

	Property by replacing any fractional portion of a security therein with an amount of cash equal to the value of such fractional security based on the values used to calculate the Share Termination Unit Price (without giving effect to any discount pursuant to Section 9(k)(i)).
Share Termination Unit Price:	The value of property contained in one Share Termination Delivery Unit on the date such Share Termination Delivery Units are to be delivered as Share Termination Delivery Property, as determined by the Calculation Agent in its good faith discretion by commercially reasonable means. In the case of a Private Placement of Share Termination Delivery Units that are Restricted Shares (as defined below), as set forth in Section 9(k)(i) below, the Share Termination Unit Price shall be determined by the discounted price applicable to such Share Termination Delivery Units. In the case of a Registration Settlement of Share Termination Delivery Units that are Restricted Shares (as defined below) as set forth in Section 9(k)(ii) below, notwithstanding the foregoing, the Share Termination Unit Price shall be the Settlement Price on the Merger Date, Tender Offer Date, Announcement Date (in the case of a Nationalization, Insolvency or Delisting), Early Termination Date or date of cancellation, as applicable. The Calculation Agent shall notify Company of the Share Termination Unit Price at the time of notification of such Payment Obligation to Company or, if applicable, at the time the discounted price applicable to the relevant Share Termination Units is determined pursuant to Section 9(k)(i).
Share Termination Delivery Unit:	One Share or, if the Shares have changed into cash or any other property or the right to receive cash or any other property as the result of a Nationalization, Insolvency or Merger Event (any such cash or other property, the "**Exchange Property**"), a unit consisting of the type and amount of Exchange Property received by a holder of one Share (without consideration of any requirement to pay cash or other consideration in lieu of fractional amounts of any securities) in such Nationalization, Insolvency or Merger Event. If such Nationalization, Insolvency or Merger Event involves a choice of Exchange Property to be received by holders, such holder shall be deemed to have elected to receive the maximum possible amount of cash.
Failure to Deliver:	Inapplicable
Other applicable provisions:	If Share Termination Alternative is applicable, the provisions of Sections 9.8, 9.9, 9.11 and 9.12 (as modified above) of the Equity Definitions will be applicable, except that all references in such provisions to "Physically-settled" shall be read as references to "Share Termination Settled" and all references to "Shares" shall be read as references to "Share

Termination Delivery Units". "Share Termination Settled" in relation to the Transaction means that the Share Termination Alternative is applicable to the Transaction.

(ii) Notwithstanding anything to the contrary in this Confirmation, any Payment Obligation under this Confirmation shall, for all purposes, be calculated as if the Maximum Number of Shares were equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) but any deliveries under Section 9(j)(i) shall be limited to the Maximum Number of Shares as defined in Section 2 hereof. In the event Company shall not have delivered to Dealer the full number of Shares or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has not obtained shareholder approval pursuant to Section 9(q) for the Maximum Number of Shares to equal two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2) (such deficit, the "**Approval Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Approval Deficit Shares have been delivered pursuant to this Section 9(j)(ii), when, and to the extent that the Company obtains shareholder approval; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(j)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares as so increased pursuant to Section 9(q).

(k) *Registration/Private Placement Procedures*. If, in the reasonable opinion of Dealer, following any delivery of Shares or Share Termination Delivery Property to Dealer hereunder, such Shares or Share Termination Delivery Property would be in the hands of Dealer subject to any applicable restrictions with respect to any registration or qualification requirement or prospectus delivery requirement for such Shares or Share Termination Delivery Property pursuant to any applicable federal or state securities law (including, without limitation, any such requirement arising under Section 5 of the Securities Act as a result of such Shares or Share Termination Delivery Property being "restricted securities", as such term is defined in Rule 144 under the Securities Act, or as a result of the sale of such Shares or Share Termination Delivery Property being subject to paragraph (c) of Rule 145 under the Securities Act) (such Shares or Share Termination Delivery Property, "**Restricted Shares**"), then delivery of such Restricted Shares shall be effected pursuant to either clause (i) or (ii) below at the election of Company, unless Dealer waives the need for registration/private placement procedures set forth in (i) and (ii) below. Notwithstanding the foregoing, solely in respect of any Daily Number of Warrants exercised or deemed exercised on any Expiration Date, Company shall elect, prior to the first Settlement Date for the first applicable Expiration Date, a Private Placement Settlement or Registration Settlement for all deliveries of Restricted Shares for all such Expiration Dates which election shall be applicable to all remaining Settlement Dates for such Warrants and the procedures in clause (i) or clause (ii) below shall apply for all such delivered Restricted Shares on an aggregate basis commencing after the final Settlement Date for such Warrants. The Calculation Agent shall make reasonable adjustments to settlement terms and provisions under this Confirmation to reflect a single Private Placement or Registration Settlement for such aggregate Restricted Shares delivered hereunder.

(i) If Company elects to settle the Transaction pursuant to this clause (i) (a "**Private Placement Settlement**"), then delivery of Restricted Shares by Company shall be effected in customary private placement procedures with respect to such Restricted Shares reasonably acceptable to Dealer; *provided* that Company may not elect a Private Placement Settlement if, on the date of its election, it has taken, or caused to be taken, any action that would make unavailable either the exemption pursuant to Section 4(2) of the Securities Act for the sale by Company to Dealer (or any affiliate designated by Dealer) of the Restricted Shares or the exemption pursuant to Section 4(1) or Section 4(3) of the Securities Act for resales of the Restricted

Shares by Dealer (or any such affiliate of Dealer). The Private Placement Settlement of such Restricted Shares shall include customary representations, covenants, blue sky and other governmental filings and/or registrations, indemnities to Dealer, due diligence rights (for Dealer or any designated buyer of the Restricted Shares by Dealer), opinions and certificates, and such other documentation as is customary for private placement agreements of similar size, all reasonably acceptable to Dealer. In the case of a Private Placement Settlement, Dealer shall determine the appropriate discount to the Share Termination Unit Price (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or any Settlement Price (in the case of settlement of Shares pursuant to Section 2 above) applicable to such Restricted Shares in a commercially reasonable manner and appropriately adjust the number of such Restricted Shares to be delivered to Dealer hereunder, which discount shall only take into account the illiquidity resulting from the fact that the Restricted Shares will not be registered for resale and any commercially reasonable fees and expenses of Dealer (and any affiliate thereof) in connection with such resale. Notwithstanding anything to the contrary in the Agreement or this Confirmation, the date of delivery of such Restricted Shares shall be the Exchange Business Day following notice by Dealer to Company, of such applicable discount and the number of Restricted Shares to be delivered pursuant to this clause (i). For the avoidance of doubt, delivery of Restricted Shares shall be due as set forth in the previous sentence and not be due on the Share Termination Payment Date (in the case of settlement of Share Termination Delivery Units pursuant to Section 9(j) above) or on the Settlement Date for such Restricted Shares (in the case of settlement in Shares pursuant to Section 2 above).

(ii) If Company elects to settle the Transaction pursuant to this clause (ii) (a "**Registration Settlement**"), then Company shall promptly (but in any event no later than the beginning of the Resale Period) file and use its reasonable best efforts to make effective under the Securities Act a registration statement or supplement or amend an outstanding registration statement in form and substance reasonably satisfactory to Dealer, to cover the resale of such Restricted Shares in accordance with customary resale registration procedures, including covenants, conditions, representations, underwriting discounts (if applicable), commissions (if applicable), indemnities due diligence rights, opinions and certificates, and such other documentation as is customary for equity resale underwriting agreements of similar size, all reasonably acceptable to Dealer. If Dealer, in its sole reasonable discretion, is not satisfied with such procedures and documentation Private Placement Settlement shall apply. If Dealer is satisfied with such procedures and documentation, it shall sell the Restricted Shares pursuant to such registration statement during a period (the "**Resale Period**") commencing on the Exchange Business Day following delivery of such Restricted Shares (which, for the avoidance of doubt, shall be (x) the Share Termination Payment Date in case of settlement in Share Termination Delivery Units pursuant to Section 9(j) above or (y) the Settlement Date in respect of the final Expiration Date for all Daily Number of Warrants) and ending on the earliest of (i) the Exchange Business Day on which Dealer completes the sale of all Restricted Shares in a commercially reasonable manner or, in the case of settlement of Share Termination Delivery Units, a sufficient number of Restricted Shares so that the realized net proceeds of such sales equals or exceeds the Payment Obligation (as defined above), (ii) the date upon which all Restricted Shares have been sold or transferred pursuant to Rule 144 (or similar provisions then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act and (iii) the date upon which all Restricted Shares may be sold or transferred by a non-affiliate pursuant to Rule 144 (or any similar provision then in force) or Rule 145(d)(2) (or any similar provision then in force) under the Securities Act. If the Payment Obligation exceeds the realized net proceeds from such resale, Company shall transfer to Dealer by the open of the regular trading session on the Exchange on the Exchange Trading Day immediately following such resale the amount of such excess (the "**Additional Amount**") in cash or in a number of Shares ("**Make-whole Shares**") in an amount that, based on the Settlement Price on such day (as if such day was the "Valuation Date" for purposes of computing such Settlement Price), has a dollar value equal to the Additional Amount. The Resale Period shall continue to enable the sale of the

Make-whole Shares. If Company elects to pay the Additional Amount in Shares, the requirements and provisions for Registration Settlement shall apply. This provision shall be applied successively until the Additional Amount is equal to zero. In no event shall Company deliver a number of Restricted Shares greater than the Maximum Number of Shares.

(iii) Without limiting the generality of the foregoing, Company agrees that (A) any Restricted Shares delivered to Dealer may be transferred by and among Dealer and its affiliates and Company shall effect such transfer without any further action by Dealer and (B) after the period of 6 months from the Trade Date (or 1 year from the Trade Date if, at such time, informational requirements of Rule 144(c) under the Securities Act are not satisfied with respect to Company) has elapsed in respect of any Restricted Shares delivered to Dealer, Company shall promptly remove, or cause the transfer agent for such Restricted Shares to remove, any legends referring to any such restrictions or requirements from such Restricted Shares upon request by Dealer (or such affiliate of Dealer) to Company or such transfer agent, without any requirement for the delivery of any certificate, consent, agreement, opinion of counsel, notice or any other document, any transfer tax stamps or payment of any other amount or any other action by Dealer (or such affiliate of Dealer). Notwithstanding anything to the contrary herein, to the extent the provisions of Rule 144 of the Securities Act or any successor rule are amended, or the applicable interpretation thereof by the Securities and Exchange Commission or any court change after the Trade Date, the agreements of Company herein shall be deemed modified to the extent necessary, in the opinion of outside counsel of Company, to comply with Rule 144 of the Securities Act, as in effect at the time of delivery of the relevant Shares or Share Termination Delivery Property.

(iv) If the Private Placement Settlement or the Registration Settlement shall not be effected as set forth in clauses (i) or (ii), as applicable, then failure to effect such Private Placement Settlement or such Registration Settlement shall constitute an Event of Default with respect to which Company shall be the Defaulting Party.

(l) *Limit on Beneficial Ownership*. Notwithstanding any other provisions hereof, Dealer may not exercise any Warrant hereunder or be entitled to take delivery of any Shares deliverable hereunder, and Automatic Exercise shall not apply with respect to any Warrant hereunder, to the extent (but only to the extent) that, after such receipt of any Shares upon the exercise of such Warrant or otherwise hereunder and after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. Any purported delivery hereunder shall be void and have no effect to the extent (but only to the extent) that, after such delivery and after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation, (i) the Section 16 Percentage would exceed 7.5%, or (ii) the Share Amount would exceed the Applicable Share Limit. If any delivery owed to Dealer hereunder is not made, in whole or in part, as a result of this provision, Company's obligation to make such delivery shall not be extinguished and Company shall make such delivery as promptly as practicable after, but in no event later than one Business Day after, Dealer gives notice to Company that, after such delivery, (i) the Section 16 Percentage would not exceed 7.5%, and (ii) the Share Amount would not exceed the Applicable Share Limit.

(m) *Share Deliveries*. Notwithstanding anything to the contrary herein, Company agrees that any delivery of Shares or Share Termination Delivery Property shall be effected by book-entry transfer through the facilities of DTC, or any successor depositary, if at the time of delivery, such class of Shares or class of Share Termination Delivery Property is in book-entry form at DTC or such successor depositary.

(n) *Waiver of Jury Trial.* Each party waives, to the fullest extent permitted by applicable law, any right it may have to a trial by jury in respect of any suit, action or proceeding relating to the Transaction. Each party (i) certifies that no representative, agent or attorney of the other party has represented, expressly or otherwise, that such other party would not, in the event of such a suit, action or proceeding, seek to enforce the foregoing waiver and (ii) acknowledges that it and the other party have been

induced to enter into the Transaction, as applicable, by, among other things, the mutual waivers and certifications provided herein.

(o)*Tax Disclosure.* Effective from the date of commencement of discussions concerning the Transaction, Company and each of its employees, representatives, or other agents may disclose to any and all persons, without limitation of any kind, the tax treatment and tax structure of the Transaction and all materials of any kind (including opinions or other tax analyses) that are provided to Company relating to such tax treatment and tax structure.

(p)*Maximum Share Delivery*.

(i) Notwithstanding any other provision of this Confirmation, the Agreement or the Equity Definitions, in no event will Company at any time be required to deliver a number of Shares greater than the Maximum Number of Shares to Dealer in connection with the Transaction after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation.

(ii) In the event Company shall not have delivered to Dealer the full number of Shares or Restricted Shares otherwise deliverable by Company to Dealer pursuant to the terms of the Transaction because Company has insufficient authorized but unissued Shares (such deficit, the "**Deficit Shares**"), Company shall be continually obligated to deliver, from time to time, Shares or Restricted Shares, as the case may be, to Dealer until the full number of Deficit Shares have been delivered pursuant to this Section 9(p)(ii), when, and to the extent that, (A) Shares are repurchased, acquired or otherwise received by Company or any of its subsidiaries after the Trade Date (whether or not in exchange for cash, fair value or any other consideration), (B) authorized and unissued Shares previously reserved for issuance in respect of other transactions become no longer so reserved or (C) Company additionally authorizes any unissued Shares that are not reserved for other transactions; *provided* that in no event shall Company deliver any Shares or Restricted Shares to Dealer pursuant to this Section 9(p)(ii) to the extent that such delivery would cause the aggregate number of Shares and Restricted Shares delivered to Dealer to exceed the Maximum Number of Shares. Company shall immediately notify Dealer of the occurrence of any of the foregoing events (including the number of Shares subject to clause (A), (B) or (C) and the corresponding number of Shares or Restricted Shares, as the case may be, to be delivered) and promptly deliver such Shares or Restricted Shares, as the case may be, thereafter.

(q)*Shareholder Approval*. Company shall use its reasonable best efforts to seek approval from its shareholders ("**Shareholder Approval**"), in accordance with the requirements of Rule 312.03(c) of The New York Stock Exchange Listed Company Manual or any successor rule, for the issuance pursuant to the Transaction of a number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement (without regard to the limitations on adjustment set forth in the second paragraph opposite the caption "Maximum Number of Shares" in Section 2). If Company succeeds in obtaining such approval, then upon such approval and without any further action by either party, (i) the provisions set forth opposite the caption "Maximum Number of Shares" in Section 2 shall be deemed to be replaced in their entirety with the phrase "A number of Shares equal to two times the product of the Number of Warrants and the Warrant Entitlement," (ii) the Additional Termination Event set forth in Section 9(h)(ii)(G) shall no longer be applicable, (iii) the provisions set forth in Section 9(j)(ii) shall be deleted in their entirety, (iv) the provisions opposite the caption "Share Delivery Quantity" in Section 2 shall be replaced in their entirety with the sentence "For any Settlement Date, a number of Shares, as calculated by the Calculation Agent, equal to the Net Share Settlement Amount for such Settlement Date *divided by* the Settlement Price on the Valuation Date for such Settlement Date" and (v) the phrase "after taking into account any Shares deliverable to Dealer under the Base Warrant Confirmation" in Section 9(p)(i) shall be deleted in its entirety.

(r)*Right to Extend.* Dealer may postpone or add, in whole or in part, any Expiration Date or any other date of valuation or delivery with respect to some or all of the relevant Warrants (in which event the Calculation Agent shall make appropriate adjustments to the Daily Number of Warrants with respect

to one or more Expiration Dates) if Dealer determines, in its commercially reasonable judgment, that such extension is reasonably necessary or appropriate to preserve Dealer's hedging or hedge unwind activity hereunder in light of existing liquidity conditions or to enable Dealer to effect purchases of Shares in connection with its hedging, hedge unwind or settlement activity hereunder in a manner that would, if Dealer were Issuer or an affiliated purchaser of Issuer, be in compliance with applicable legal, regulatory or self-regulatory requirements, or with related policies and procedures applicable to Dealer.

(s) *Status of Claims in Bankruptcy.* Dealer acknowledges and agrees that this Confirmation is not intended to convey to Dealer rights against Company with respect to the Transaction that are senior to the claims of common stockholders of Company in any United States bankruptcy proceedings of Company; *provided* that nothing herein shall limit or shall be deemed to limit Dealer's right to pursue remedies in the event of a breach by Company of its obligations and agreements with respect to the Transaction; *provided*, *further*, that nothing herein shall limit or shall be deemed to limit Dealer's rights in respect of any transactions other than the Transaction.

(t) *Securities Contract; Swap Agreement.* The parties hereto intend for (i) the Transaction to be a "securities contract" and a "swap agreement" as defined in the Bankruptcy Code (Title 11 of the United States Code) (the "**Bankruptcy Code**"), and the parties hereto to be entitled to the protections afforded by, among other Sections, Sections 362(b)(6), 362(b)(17), 546(e), 546(g), 555 and 560 of the Bankruptcy Code, (ii) a party's right to liquidate the Transaction and to exercise any other remedies upon the occurrence of any Event of Default under the Agreement with respect to the other party to constitute a "contractual right" as described in the Bankruptcy Code, and (iii) each payment and delivery of cash, securities or other property hereunder to constitute a "margin payment" or "settlement payment" and a "transfer" as defined in the Bankruptcy Code.

(u) *Wall Street Transparency and Accountability Act*. In connection with Section 739 of the Wall Street Transparency and Accountability Act of 2010 ("**WSTAA**"), the parties hereby agree that neither the enactment of WSTAA or any regulation under the WSTAA, nor any requirement under WSTAA or an amendment made by WSTAA, shall limit or otherwise impair either party's otherwise applicable rights to terminate, renegotiate, modify, amend or supplement this Confirmation or the Agreement, as applicable, arising from a termination event, force majeure, illegality, increased costs, regulatory change or similar event under this Confirmation, the Equity Definitions incorporated herein, or the Agreement (including, but not limited to, rights arising from Change in Law, Hedging Disruption, Increased Cost of Hedging, an Excess Ownership Position, or Illegality (as defined in the Agreement)).

(v) *Agreements and Acknowledgements Regarding Hedging*. Company understands, acknowledges and agrees that: (A) at any time on and prior to the last Expiration Date, Dealer and its affiliates may buy or sell Shares or other securities or buy or sell options or futures contracts or enter into swaps or other derivative securities in order to adjust its hedge position with respect to the Transaction; (B) Dealer and its affiliates also may be active in the market for Shares other than in connection with hedging activities in relation to the Transaction; (C) Dealer shall make its own determination as to whether, when or in what manner any hedging or market activities in securities of Issuer shall be conducted and shall do so in a manner that it deems appropriate to hedge its price and market risk with respect to the Settlement Prices; and (D) any market activities of Dealer and its affiliates with respect to Shares may affect the market price and volatility of Shares, as well as the Settlement Prices, each in a manner that may be adverse to Company.

(w) *Early Unwind*. In the event the sale of the "Option Securities" (as defined in the Purchase Agreement) is not consummated with the Initial Purchasers for any reason, or Company fails to deliver to Dealer opinions of counsel as required pursuant to Section 9(a), in each case by 5:00 p.m. (New York City time) on the Premium Payment Date, or such later date as agreed upon by the parties (the Premium Payment Date or such later date the "**Early Unwind Date**"), the Transaction shall automatically terminate (the "**Early Unwind**"), on the Early Unwind Date and (i) the Transaction and all of the respective rights and obligations of Dealer and Company under the Transaction shall be cancelled and terminated and (ii) each party shall be released and discharged by the other party from and agrees not to make any claim against the other party with respect to any obligations or liabilities of the other

party arising out of and to be performed in connection with the Transaction either prior to or after the Early Unwind Date; *provided* that Company shall purchase from Dealer on the Early Unwind Date all Shares purchased by Dealer or one or more of its affiliates in connection with the Transaction at the then prevailing market price. Each of Dealer and Company represents and acknowledges to the other that, subject to the proviso included in this Section 9(w), upon an Early Unwind, all obligations with respect to the Transaction shall be deemed fully and finally discharged.

(x) *Payment by Dealer*. In the event that (i) an Early Termination Date occurs or is designated with respect to the Transaction as a result of a Termination Event or an Event of Default (other than an Event of Default arising under Section 5(a)(ii) or 5(a)(iv) of the Agreement) and, as a result, Dealer owes to Company an amount calculated under Section 6(e) of the Agreement, or (ii) Dealer owes to Company, pursuant to Section 12.7 or Section 12.9 of the Equity Definitions, an amount calculated under Section 12.8 of the Equity Definitions, such amount shall be deemed to be zero.

(y) If Company has not obtained Shareholder Approval prior to the Approval Deadline, on the Approval Deadline (x) the First Expiration Date shall be extended by one calendar year, (y) the Warrants shall, as of April 15, 2020 (the " **Original First Expiration Date**"), cease to be to be "European Options" (as such term is defined in the Equity Definitions) and shall become, as of the Original First Expiration Date, "American Options" (as such term is defined in the Equity Definitions) exercisable as of the Original First Expiration Date and (z) the Calculation Agent shall make commercially reasonable conforming amendments to the exercise and settlement terms of the Transaction to reflect the change of the Warrants from European Options to American Options, for the avoidance of doubt, retaining (i) contingencies to exercise that are not an observable market, other than the market for the Company's stock or an observable index, other than an index calculated or measured solely by reference to the Company's own operations, (ii) the commercially reasonable nature of adjustments permitted to the Transaction (such as to consider changes in volatility, expected dividends, stock loan rate or liquidity relevant to the Shares and the ability to maintain a commercially reasonable hedge position in the underlying shares) and (iii) the Company's unilateral right to settle in shares pursuant to 9(k), including pursuant to a Share Termination Alternative as provided under Section 9(j). On each anniversary of the Approval Deadline occurring prior to the final Expiration Date, if Company has not, as of such date, obtained Shareholder Approval, the First Expiration Date shall be further extended by one additional calendar year.

(z) *Adjustments*. For the avoidance of doubt, whenever the Calculation Agent or Determining Party is called upon to make an adjustment pursuant to the terms of this Confirmation or the Equity Definitions to take into account the effect of an event, the Calculation Agent or Determining Party shall make such adjustment by reference to the effect of such event on the Hedging Party, assuming that the Hedging Party maintains a commercially reasonable hedge position.

(aa) *Delivery or Receipt of Cash*. For the avoidance of doubt, other than receipt of the Premium by Company, nothing in this Confirmation shall be interpreted as requiring Company to cash settle the Transaction, except in circumstances where cash settlement is within Company's control (including, without limitation, where Company elects to deliver or receive cash, or where Company has made Private Placement settlement unavailable due to the occurrence of events within its control) or in those circumstances in which holders of Shares would also receive cash.

(bb) *No Reliance*. The Company hereby confirms that it has relied on the advice of its own counsel and other advisors (to the extent it deems appropriate) with respect to any legal, tax, accounting, or regulatory consequences of this Confirmation, that it has not relied on Dealer or its affiliates in any respect in connection therewith, and that it will not hold Dealer or its affiliates accountable for any such consequences.

Company hereby agrees (a) to check this Confirmation carefully and immediately upon receipt so that errors or discrepancies can be promptly identified and rectified and (b) to confirm that the foregoing (in the exact form provided by Dealer) correctly sets forth the terms of the agreement between Dealer and Company with respect to the Transaction, by manually signing this Confirmation or this page hereof as evidence of agreement to such terms and providing the other information requested herein and immediately returning an executed copy to John Servidio, Facsimile No. 704-208-2869.

Very truly yours,

Bank of America, N.A.

By: /s/ Christopher A. Hutmaker
Name: Christopher A. Hutmaker
Title: Managing Director

Accepted and confirmed
as of the date hereof:

Molina Healthcare, Inc.

By: /s/ John Molina
Authorized Signatory
Name: John Molina

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2013 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 2, 2013

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2013 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 2, 2013

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2013 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 2, 2013

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2013 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 2, 2013

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

2012 MHI Form 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2012

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	**Name of Each Exchange on Which Registered**
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2012, the last business day of our most recently completed second fiscal quarter, was approximately $664.3 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2012).

As of February 22, 2013, approximately 45,154,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2013 Annual Meeting of Stockholders to be held on May 1, 2013, are incorporated by reference into Part III of this Form 10-K.

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MOLINA HEALTHCARE, INC.

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Form 10-K

PART I

Item 1: *Business*

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today, we remain a provider-focused company led by his son, Joseph M. Molina, M.D. (Dr. J. Mario Molina). We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment consists of health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of December 31, 2012, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of 24 primary care clinics in California, Florida, New Mexico, and Washington, and we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our Health Plans segment derives its revenue principally in the form of premiums received under Medicaid contracts with the states in which our health plans operate. While the health plans receive fixed per-member per-month, or PMPM, premium payments from the states, the health plans are at risk for the medical costs associated with their members' health care. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements which limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in May 2010 to expand our product offerings to include support of state Medicaid agency administrative needs, reduce the variability in our earnings resulting from fluctuations in medical care costs, improve our operating profit margin percentages, and improve our cash flow by adding a business for which there are no restrictions on dividend payments.

From a strategic perspective, we believe our two business segments allow us to participate in an expanding sector of the economy and continue our mission of serving low-income families and individuals eligible for government-sponsored health care programs. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We also believe that we may have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is *www.molinahealthcare.com.*

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to “Molina Healthcare,” the “Company,” “we,” “our,” and “us” herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge under the “investors” tab of our website, *www.molinahealthcare.com*, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and the charters of our Audit Committee, Compensation Committee, Corporate Governance and Nominating Committee, and Compliance Committee are also available on our website. Such information is also available in print upon the request of any stockholder to our Investor Relations department at the address of our executive offices set forth above. In accordance with New York Stock Exchange, or NYSE, rules, on May 21, 2012, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Our Industry

The Medicaid and CHIP Programs. The Medicaid program is a federal entitlement program administered by the states. Medicaid provides health care and long-term care services and support to low-income Americans. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or

FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states is currently about 57 percent, and ranges from a federally established FMAP floor of 50% to as high as 74%.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF. Another common state-administered Medicaid program is for aged, blind or disabled, or ABD, Medicaid members. In addition, the Children's Health Insurance Program, or CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.

Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 75% of the costs incurred in operating an MMIS. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we now actively participate in this market.

In certain instances, states have elected to provide medical benefits to individuals and families who are not served by Medicaid. In New Mexico and Washington, our health plan segment participates in programs that are administered in a manner similar to Medicaid and CHIP, but without federal matching funds.

Medicare Advantage Plans. During 2012, all of our health plans, except our Wisconsin health plan, operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operates a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans as of December 31, 2012 was approximately 36,000 members. For the year ended December 31, 2012, premium revenues from Medicare across all health plans represented approximately 8% of our total premium revenues.

As of December 31, 2012, approximately 75% of our members were TANF, 15% were ABD, 8% were CHIP, and 2% were Medicare.

Our Strengths

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. Additionally, we support state Medicaid agencies by providing them with comprehensive solutions to their MMIS development and operating needs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, cost management, and direct delivery of health care services at our clinics through our Health Plans segment, to state-level MMIS administration through our Molina Medicaid Solutions segment. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. Our Molina Medicaid Solutions platform is based upon commercial off-the-shelf technology. As a result, we believe that our Molina Medicaid Solutions platform has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our health plan segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The acquisition of our New Mexico and Wisconsin health plans demonstrated our ability to expand into new states. The establishment of our health plans in Utah, Ohio, Texas, and Florida reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Recognition for Quality of Care. The National Committee for Quality Assurance, or NCQA, has accredited eight of our nine Medicaid managed care plans. Our Wisconsin plan acquired in September 2010 currently plans to seek NCQA accreditation in early 2014. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our Company in 1980 to serve the Medicaid population in Southern California through a small network of primary care clinics, we have increased our membership to 1.8 million members as of December 31, 2012, expanded our Health Plans segment to nine states, and added our Molina Medicaid Solutions segment. Our experience over the last 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Our Strategy

Our objective is to provide a comprehensive suite of Medicaid-related services to meet the health care needs of low-income families and individuals and the state Medicaid agencies that serve them. To achieve our objective, we intend to:

Continue to expand within existing markets, including as a result of the Affordable Care Act Medicaid expansion, the duals pilot projects, and the insurance marketplaces. We plan to continue our growth in existing markets. The Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act, commonly referred to together as the Affordable Care Act, or the ACA, provides us with several opportunities for growth, including the expansion of Medicaid eligibility in the states that elect to participate, the implementation of pilot projects for those who are dually eligible for Medicaid and Medicare, and the implementation of insurance marketplaces.

- *Medicaid expansion*. As of February 27, 2013, among the states where we operate our health plans, the states of California, Florida, Michigan, New Mexico, Ohio, and Washington have indicated that they intend to participate in the Medicaid expansion; the states of Texas and Wisconsin have indicated that they do not intend to participate in the expansion; and the state of Utah is undecided. We believe there are significant opportunities to increase our revenues through the Medicaid expansion.
- *Duals*. Nine million low-income elderly and disabled people in the United States are covered under both the Medicare and Medicaid programs. These beneficiaries, often called “dual eligibles” or simply “duals,” are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Policymakers at the federal and state level are developing initiatives for dual eligibles both to improve the coordination of their care, and to reduce spending for both Medicare and Medicaid. The Centers for Medicare and Medicaid Services, or CMS, has implemented several demonstrations designed to improve the coordination of care for dual eligibles and reduce spending under Medicare and Medicaid. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for dual eligibles in the state. Our health plans in California, Illinois, Michigan, Ohio, Texas, and Washington intend to take part in the duals demonstrations in those states. Beginning in September 2013, our California plan intends to serve duals in Riverside, San Bernardino and San Diego counties, and may participate with Health Net, Inc. for the duals contract in Los Angeles County. Our new Illinois plan will serve duals

in Central Illinois beginning in 2014. Our Michigan plan will respond to a request for proposals to serve duals also beginning in late 2013. Our Ohio plan will serve duals in three regions in southwestern Ohio (Dayton, Columbus and Cincinnati) beginning in late 2013. The state of Texas announced that it intends to cover duals through its existing Medicaid contracts beginning in 2014. Our Washington plan will respond to a request for proposals to serve duals also beginning in 2014.

- *Insurance marketplaces*. Under the ACA, insurance marketplaces will be online marketplaces organized on a state-by-state basis (although in many instances the insurance marketplace in a state will be operated by the federal government, and there could also be regional marketplaces where states combine their marketplace products). In the insurance marketplace, individuals and groups can purchase health insurance that in many instances will be federally subsidized (up to 400% of the federal poverty level by individual or family). We currently intend to participate in the insurance marketplaces in the states in which we operate our health plans. Our principal focus in participating in the marketplace is to capture the transition in membership that may result from a Medicaid member's income rising above the 138% level of the federal poverty line. By retaining that member in the marketplace, if the member's income subsequently declines, we will continuously serve that same member in all instances and not "lose" the member to another health plan. We endorse the so-called "bridge plan" as the best way to serve low-income persons who may qualify for coverage through the insurance marketplaces, and will be working with legislators and regulators during 2013 to advocate for the merits of the bridge plan.

Continue to enter new strategic markets. We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size, and, where practicable, mandated Medicaid managed care enrollment.

Continue to provide quality cost-effective care. We plan to use our strong provider networks and the knowledge gained through the operation of our clinics to further develop and utilize effective medical management and other coordinated programs that address the distinct needs of our members and improve the quality and cost-effectiveness of their care.

Leverage operational efficiencies. We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost.

Deliver administrative value to state Medicaid agencies. As Medicaid expenditures increase, we believe that an increasing number of states will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs.

Open additional primary care clinics. The clinic model offers an integrated approach that helps us improve both the quality and cost-effectiveness of the care our members receive. Our Health Plans segment direct delivery business currently consists of primary care clinics in California, Florida, New Mexico, and Washington, and three county-owned clinics in Fairfax County, Virginia that we manage on behalf of the county. The growth and aging of the population of the United States foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to worsen this shortage. We believe the shortage will be felt most acutely among already under-served populations, such as the low income families and individuals we serve. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging our direct delivery capability on a selective basis we can improve access for our plan members in areas that are most under-served by primary care providers.

Medicaid Contracts

With the exception of our Wisconsin health plan, which does not serve Medicare members, all of our health plans serve TANF, CHIP, ABD, and Medicare members. For its Medicare members, each health plan enters into a one-year annually renewable contract with CMS. For its other members, each health plan enters into a contract with the state's Medicaid agency. The contractual relationship with the state is generally for a period of three to four years and renewable on an annual or biannual basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, our Missouri

health plan was notified that it was not awarded a new contract under that state's RFP, and therefore its contract expired on June 30, 2012.

Our contracts with the state determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and disenrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

We are usually paid a negotiated PMPM amount, with the PMPM amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also paid an additional amount for each newborn delivery from the Medicaid programs in all of our state health plans, except with respect to our New Mexico health plan.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations, or IPAs. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our Health Plans segment operates 24 company-owned primary care clinics located in California, Florida, New Mexico and Washington. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a subsidiary in Virginia that manages three health care clinics for Fairfax County.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-

party software and data warehousing tools to convert data into actionable information. We use predictive modeling that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. "*motherhood matters!*℠" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *"breathe with ease!*" is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15. *"Healthy Living with Diabetes"* is a diabetes disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include "Check Member Eligibility," "View Claim," and "View/Submit Authorizations."
- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: "View Benefits," "Request New ID Card," "Print Temporary ID Card," and "Request Change of Address/PCP."
- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (such as those that may be required by the Health Insurance Portability and Accountability Act of 1996, or HIPAA, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness

Data and Information Set, or HEDIS, and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Eight of our health plans are accredited by the NCQA. Our Wisconsin plan acquired in September 2010 currently plans to seek NCQA accreditation in early 2014.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 4.8 system).

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan's ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- *Medicaid HMOs* — National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- *Prepaid Health Plans* — Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- *Primary Care Case Management Programs* — Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, or CSC, and CNSI.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules can occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have

become increasingly active in recent years in their review and scrutiny of health insurers and managed care organization, including those operating in the Medicaid and Medicare programs.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC, and are administered by the states. Our Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin health plans are subject to RBC requirements. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established in 1965 under the U.S. Social Security Act to provide medical assistance to the poor. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states award contracts to any applicant demonstrating that it meets the state's requirements. Other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by CMS. Medicare beneficiaries have the option to enroll in a Medicare Advantage plan. Under Medicare Advantage, managed care plans contract with CMS to provide benefits that are comparable to original Medicare in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, made numerous changes to the Medicare program, including expanding the Medicare program to include a prescription drug benefit. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan. Plans are not required to offer the same benefits, but are required to provide coverage that is at least actuarially equivalent to the standard drug coverage delineated in the MMA.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, or MIPPA, became law and, in September 2008, CMS promulgated implementing regulations. MIPPA impacts a broad range of Medicare activities and impacts all types of Medicare managed care plans. MIPPA and subsequent CMS guidance place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. MIPPA also establishes certain restrictions on agent and broker compensation.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

The ACA created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers. On September 23, 2010, CMS issued proposed regulations designed to implement these requirements. It is not clear at this time the degree to which managed care providers would have to comply with these new requirements, many of which resemble procedures that we already have in place.

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), a part of the American Recovery and Reinvestment Act of 2009, or ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. The U.S. Department of Health and Human Services, as required by the HITECH Act, has issued interim final rules that set forth the breach notification obligations applicable to covered entities and their business associates, or the HHS Breach Notification Rule. The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as *"qui tam"* actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid

by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Action of 2005, or DRA, encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2012, we had approximately 5,800 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Executive Officers of the Registrant

J. Mario Molina, M.D., 54, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 48, has served in the role of Chief Financial Officer since 1995, and has been employed by the Company for over 30 years in a variety of positions. He also has served as a director since 1994. Mr. Molina is a member of the Los Angeles branch of the Federal Reserve Bank of San Francisco's board of directors. Mr. Molina holds a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of Dr. J. Mario Molina.

Terry P. Bayer, 62, has served as our Chief Operating Officer since 2005. She had formerly served as our Executive Vice President, Health Plan Operations. Ms. Bayer has over 30 years of health care management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University.

Joseph W. White, 54, has served as our Chief Accounting Officer since 2007. In his role as Chief Accounting Officer, Mr. White is responsible for oversight of the Company's accounting, reporting, forecasting, budgeting, actuarial, procurement, treasury and facilities functions. Mr. White has over 30 years of financial management experience in the health care industry. Prior to joining the Company in 2003, Mr. White worked for Maxicare Health Plans, Inc. from 1987 through 2002. Mr. White holds a Master's degree in Business Administration and a Bachelor's degree in Commerce from the University of Virginia. Mr. White is a Certified Public Accountant.

Jeff D. Barlow, 50, has served as our Senior Vice President, General Counsel, and Secretary since 2010. As General Counsel, Mr. Barlow is responsible for setting the overall legal strategy of the Company, and for providing legal counsel to senior management, to the board of directors, and to the consolidated organization. Before joining the Company, Mr. Barlow worked for the national law firm of DLA Piper in its corporate securities group. Mr. Barlow holds a Juris Doctorate from the University of Pittsburgh School of Law, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Philosophy from the University of Utah.

Intellectual Property

We have registered and maintain various service marks, trademarks and trade names that we use in our businesses, including marks and names incorporating the "Molina" or "Molina Healthcare" phrase, and from time to time we apply for additional

registrations of such marks. We utilize these and other marks and names in connection with the marketing and identification of products and services. We believe such marks and names are valuable and material to our marketing efforts.

Item 1A: ***Risk Factors***

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This Annual Report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the U.S. Securities Exchange Commission, or SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Business

Numerous risks associated with the Affordable Care Act and its implementation could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act, commonly referred to together as the Affordable Care Act, or the ACA. The ACA enacts comprehensive changes to the United States health care system, elements of which will be phased in at various stages over the next several years. However, the most significant changes effected by the ACA are currently scheduled to be implemented as of January 1, 2014. There are a multitude of risks associated with the scope of change in the health care system represented by the ACA, including, but not limited to, the following:

- ***Risks associated with the health care excise tax.*** One notable provision of the ACA is an excise tax that applies to most health plans, including both commercial health plans and Medicaid and/or Medicare managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through slightly higher commercial insurance premiums. However, Medicaid is jointly paid for by the federal government and by state governments, so the cost of this excise tax, as it may be applied to Medicaid plans, will be passed on in the form of higher Medicaid costs and rates. In Medicaid and Medicare, capitated rates paid to managed care plans are required to be developed using generally accepted principles of actuarial soundness. Actuarial soundness requires that the full costs of doing business, including the costs of both federal and state taxes, be considered and factored into the applicable rate. Thus, for Medicaid and/or Medicare managed care plans like Molina Healthcare, Inc., the excise tax will be included in their capitated rates. Because of the novelty of this new tax, actuaries have never factored the tax into the development of capitated rates, an exercise which must be undertaken during 2013 and well in advance of the 2014 calendar year when the tax is scheduled to go into effect. Moreover, because the tax will be based on a health plan's market share as applied to a total excise tax base of $8 billion in 2014 (and rising thereafter), there is substantial uncertainty regarding the actual size of the tax assessment on Molina. Currently, we project that the excise tax assessment on Molina will be approximately $100 million. Since this amount is not deductible for income tax purposes under current law, and since our total net income for fiscal year 2011 was $20.8 million, and our net income for fiscal year 2012 was $9.8 million,

our estimated tax rate for 2014 could be driven to 100%, and the excise tax could effectively equal the entire amount of our projected earnings. We and others in the health care industry are working with Congress to carve out the application of the excise tax on Medicaid plans. As an alternative to the repeal of the tax as it applies to Medicaid managed care plans, we and others in the health care industry will also be working with state actuaries to take account of the tax in the calculation of our 2014 rates. However, state budget constraints, inaccurate actuarial calculations, inadequate federal oversight of actuarial soundness, and market competition could result in a failure to reflect in our rates the full amount of the excise tax. If the excise tax is imposed as enacted on Medicaid managed care plans, or we are unable to obtain premium increases to fully offset the impact of the tax or otherwise adjust our business model, our business, financial condition, cash flows, and results of operations could be materially adversely affected .

- ***Risks associated with the duals expansion.*** Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries, often called “dual eligibles,” are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for the nearly 50 million elderly and under-65 disabled beneficiaries in 2012. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and supports, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. Policymakers at the federal and state level are increasingly developing initiatives for dual eligibles, both to improve the coordination of their care, and to reduce spending. The Centers for Medicare and Medicaid Services, or CMS, has implemented several demonstration projects designed to improve the coordination of care for dual eligibles and to reduce Medicare and Medicaid spending. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for dual eligibles in the relevant state. Our health plans in California, Illinois, Michigan, Ohio, Texas, and Washington intend to take part in the duals demonstrations in those states. Beginning in September 2013, our California plan intends to serve duals in Riverside, San Bernardino, and San Diego counties, and may participate with Health Net, Inc. for the duals contract in Los Angeles County. Our new Illinois plan will serve duals in Central Illinois beginning in 2014. Our Michigan plan will respond to a request for proposals to serve duals beginning in late 2013. Our Ohio plan will serve duals in three regions in southwestern Ohio (Dayton, Columbus and Cincinnati) beginning in late 2013. The state of Texas announced that it intends to cover duals through its existing Medicaid contracts beginning in 2014. Our Washington plan will respond to a request for proposals to serve duals also beginning in 2014.

  There are numerous risks associated with the initial implementation of a new program, with a health plan's expansion into a new service area, or with the provision of medical services to a new population which has not previously been in managed care. One such risk is the development of actuarially sound rates. Because there is limited historical information on which to develop rates, certain assumptions are required to be made which may subsequently prove to have been inaccurate. Rates of utilization could be significantly higher than had been projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be seriously flawed. Moreover, because of our lack of actuarial experience for that program, region, or population, our reserve levels may be set at an inadequate level. For instance, these problems arose at our Texas health plan in the second quarter of 2012, leading to extremely elevated medical care costs and substantial losses at the health plan. All of these risks are presented in the implementation of the duals demonstration programs. In the event these risks materialize at one or more of our health plans, the negative results of that health plan or plans could adversely affect our business, financial condition, cash flows, and results of operations.

- ***Risks associated with the Medicaid expansion.*** Among other things, by January 1, 2014, in the states that elect to participate, the ACA provides that the Medicaid program will be greatly expanded to provide eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. As a result, millions of low-income adults without children who currently cannot qualify for coverage, as well as many low-income parents and, in some instances, children now covered through CHIP, will be made eligible for Medicaid. As of February 27, 2013, among the states where we operate our health plans, the states of California, Florida, Michigan, New Mexico, Ohio, and Washington have indicated that they intend to participate in the Medicaid expansion; the states of Texas and Wisconsin have indicated that they do not intend to participate in the expansion; and the state of Utah is undecided. In those states that participate in the expansion, our Medicaid membership is likely to grow appreciably. The new enrollees in our health plans will represent a population that is different from the population of Medicaid enrollees we have historically managed. In addition, such enrollees may be unfamiliar with managed care, and may have substantial pent-up demand for medical services that could result in greater than anticipated rates of utilization. All of the risk factors described above with regard to the duals demonstration programs apply equally to the Medicaid expansion.

- ***Risks associated with the insurance marketplaces .*** Under the ACA, insurance marketplaces will be online marketplaces organized on a state-by-state basis (although in many instances the insurance marketplace in a state will be operated by the federal government, and there could also be regional marketplaces where states combine their marketplace products).

In the insurance marketplace, individuals and groups can purchase health insurance that in many instances will be federally subsidized (up to 400% of the federal poverty level by individual or family). We currently intend to participate in the insurance marketplaces in the states in which we operate our health plans. Our principal focus in participating in the marketplace is to capture the transition in membership that may result from a Medicaid member's income rising above the 138% level of the federal poverty line. By retaining that member in the marketplace, if the member's income subsequently declines, we will continuously serve that same member in all instances and not "lose" the member to another health plan. We endorse the so-called "bridge plan" as the best way to serve low-income persons who may qualify for coverage through the insurance marketplaces, and will be working with legislators and regulators during 2013 to advocate for the merits of the bridge plan. All of the risk factors described above with regard to the duals demonstration programs apply equally to our participation in the insurance marketplaces.

- ***Risk associated with implementing regulations.*** There are many parts of the ACA that will require further guidance in the form of regulations. Due to the breadth and complexity of the ACA, the lack of implementing regulations and interpretive guidance, and the phased-in nature of the ACA's implementation, the overall impact of the ACA on our business and on the health industry in general over the coming years is difficult to predict and not yet fully known.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio for the year ended December 31, 2012 of 89.9% had been one percentage point higher, or 90.9%, our results for the year ended December 31, 2012 would have been a net loss of approximately $(0.55) per diluted share rather than our actual net income of $0.21 per diluted share, a decrease of over 300%.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual influenza, or flu, season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, and results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs remain elevated at the same time that state budgets are suffering from significant fiscal strain. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it is a prime target for cost-containment efforts. All of the states in which we currently operate our health plans are currently facing significant budgetary pressures. These budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction proposals would fundamentally change the structure and financing of the Medicaid program. Recently, various proposals have been advanced to reduce annual federal deficits and to slow the increase in the national debt. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

In addition, potential reductions in Medicare and Medicaid spending have been included in the discussions in Congress regarding deficit reduction measures. The Budget Control Act of 2011 provides that Medicare payments may be reduced by no more than 2% and certain other programs, including Medicaid, would be exempt from the automatic spending cuts associated with sequestration. At this time, we are unable to determine how any Congressional spending cuts will affect Medicare and Medicaid reimbursement in the future. We also cannot predict the initiatives that may be adopted in the future or their full impact. There likely will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could potentially have a material adverse effect on our business, financial condition, cash flows, and results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid," or IBNP, medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to duals, Medicaid expansion members, or aged, blind or disabled Medicaid members, is impacted by the more limited experience we have had with those populations. With regard to the new previously uninsured Medicaid members we expect to enroll in 2014 due to the Medicaid expansion, certain new members may be disproportionately costly due to high utilization in their first several months of Medicaid membership as a result of their previously having been uninsured and therefore not seeking or deferring medical treatment.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

An increased incidence of flu in 2013 in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results during 2009 were significantly impacted by the widespread incidence of the H1N1 flu in the states in which we operate our health plans. During December 2012 and January 2013, the CDC reported that the incidence of the flu nationwide had been very high and is expected to continue through the 2013 flu season. We have taken steps to appropriately set our IBNP reserves to account for the high incidence of the flu. However, if the utilization rates of our members are higher than we anticipated our results in the first quarter of 2013 could be materially and adversely affected.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, the state contract of our Florida health plan will be subject to competitive bidding in 2013 for a new contract commencing January 1, 2014. In the event the responsive bid of our Florida health plan or those of our other health plans are not successful, we will lose our Medicaid contract in the applicable state, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of the unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. Further, most of our contracts are terminable without cause.

Our government contracts generally run for periods of one year to three years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. Although our health plans have generally been successful in obtaining the renewal and/or extension of their state contracts, there can be no guarantee that any of our state government contracts will be renewed or extended, as shown by the loss of our Missouri contract in 2012. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, and results of operations could be adversely affected.

In the event the expected reduction in the rates paid to our California health plan is not finally implemented, is not made effective retroactively to July 1, 2011, or is otherwise modified, our results of operations may be affected.

California Assembly Bill 97, or AB 97, is legislation that was signed by Governor Jerry Brown on March 24, 2011. Among other things, AB 97 proposes to effect a 10% reduction in Medi-Cal provider rates. It is currently uncertain whether the rate cut will be implemented, and if it is implemented, whether it will be effective retroactively to July 1, 2011. If the proposed rate cut is not finally implemented, if it is not made effective retroactively to July 1, 2011, or if it is otherwise modified from its current form, the results of our California health plan could be negatively affected depending on the action taken. In addition, recoveries from providers related to any final implemented rate cut could also affect the results of our California health plan.

States may not adequately compensate us for the value of drug rebates that were previously earned by the Company but that are now collectible by the states.

The ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers have renegotiated or discontinued their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours continue to remain at levels that are much lower than prior to the ACA implementation. There are provisions in the ACA that require rates paid to Medicaid managed care to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, and results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from nine state health plans. If we are unable to continue to operate in any of those nine states, or if our current operations in any portion of the states we are in are significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic, an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, and results of operations.

There are performance risks and other risks associated with certain provisions in the state Medicaid contracts of several of our health plans.

The state contracts of our New Mexico, Ohio, Texas, and Wisconsin health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, the health plan will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could adversely affect our business, financial condition, cash flows, and results of operations. In addition, the state contracts of our California, Florida, New Mexico, Texas, and Washington health plans, and our contract with CMS, contain provisions pertaining to medical cost floors, administrative cost and profit ceilings, and profit-sharing arrangements. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the sometimes complicated contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could adversely affect our business, financial condition, cash flows, and results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have an adverse impact on our business, financial condition, cash flows, and results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, and results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could adversely affect our business, financial condition, cash flows, and results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. For instance, due to a prolonged budget impasse during 2010, some of the monthly premium payments made by the state of California to our California health plan were several months late. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse affect on our business, financial condition, cash flows, and results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets-particularly operators of large commercial health plans-have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not paid, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

In addition, we may be unable to successfully identify, consummate and integrate future acquisitions, including integrating the acquired businesses on our information technology platform, or to implement our operations strategy in order to operate

acquired businesses profitably. Furthermore, we may incur significant transaction expenses in connection with a potential acquisition which may or may not be consummated. These expenses could impact our selling, general and administrative expense ratio.

For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws which may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our financial position, results of operations, and cash flows.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties, and assessments. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. Many states, including states where we currently operate, have enacted parallel legislation. In the event we are subject to liability under a *qui tam* action, our business and operating results could be adversely affected.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

The U.S. Department of Health and Human Services, or HHS, has released rules pursuant to HIPAA which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. Originally, the federal government required that health care organizations, including health insurers, upgrade to updated and expanded standardized code sets used for documenting health conditions by October 2013. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. However, CMS has now postponed implementation of ICD-10 to October 2014. While use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our cash flows, financial position, or results of operations. However, these changes may result in errors and otherwise negatively impact our service levels, and we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial position, cash flows, and results of operations.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have an adverse effect on our business, cash flows, and results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped when the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, and results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which we do not participate. These actions and the resulting negative publicity could become associated with or imputed to us, regardless of our actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which we do participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, and results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other inter-company transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove “extraordinary” dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare ordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the ordinary dividend. For the years ended December 31, 2012, 2011 and 2010, we received dividends from our health plan subsidiaries amounting to $80.0 million, $76.6 million and $81.3 million, respectively. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2012, 2011 and 2010, without approval of the regulatory authorities, were approximately $8.1 million, $17.5 million, and $18.8 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy or service our outstanding indebtedness.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our business, financial condition, cash flows, and results of operations.

A security breach or unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process, and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The Health Information Technology for Economic and Clinical Health Act, or HITECH, provisions of the HITECH American Reinvestment and Recovery Act of 2009 further expand the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, increasing penalties for violations, and requiring public disclosure of improper disclosures of the health information of more than 500 individuals.

Under HITECH, civil penalties for HIPAA violations by covered entities and business associates are increased up to an amount of $1.5 million per calendar year for HIPAA violations. In addition, imposition of these penalties is now more likely because HITECH strengthens enforcement. For example, commencing February 2010, HHS was required to conduct periodic audits to confirm compliance. Investigations of violations that indicate willful neglect, for which penalties are now mandatory, are statutorily required. In addition, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Initially monies collected will be transferred to a division of HHS for further enforcement, and within three years, a methodology will be adopted for distributing a percentage of those monies to affected individuals to fund enforcement and provide incentive for individuals to report violations. In addition, HITECH requires us to notify affected individuals, HHS, and in some cases the media when unsecured protected health information is subject to a security breach.

HITECH also contains a number of provisions that provide incentives for providers and states to initiate certain programs related to health care and health care technology, such as electronic health records. While some HITECH provisions may not apply

to us directly, states wishing to apply for grants under HITECH, or otherwise participating in such programs, may impose new health care technology requirements on us through our contracts with state Medicaid agencies. We are unable to predict what such requirements may entail or what their effect on our business may be.

We will continue to assess our compliance obligations as regulations under HITECH are promulgated and more guidance becomes available from HHS and other federal agencies. The new privacy and security requirements, however, may require substantial operational and systems changes, employee education and resources and there is no guarantee that we be able to implement them adequately or prior to their effective date. Given HIPAA's complexity and the anticipated new regulations, which may be subject to changing and perhaps conflicting interpretation, our ongoing ability to comply with all of the HIPAA requirements is uncertain, which may expose us to the criminal and increased civil penalties provided under HITECH and may require us to incur significant costs in order to seek to comply with its requirements.

While we currently expend significant resources and have implemented solutions, processes and procedures to protect against cyber-attacks and security breaches and have no evidence to suggest that such attacks have resulted in a breach of our systems, we may need to expend additional significant resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world, we may be unable to proactively address these techniques or to implement adequate preventive measures.

Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third-party service providers, may be vulnerable to security breaches, acts of vandalism, acts of malicious insiders, computer viruses, misplaced or lost data, programming and/or human errors, or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could subject us to civil and criminal penalties, divert management's time and energy and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Risks Related to the Operation of Our Molina Medicaid Solutions Business

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently has management contracts in only six states. If we are unable to continue to operate in any of those six states, or if our current operations in any of those six states are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, in 2012, the government contract of Molina Medicaid Solutions in Louisiana was subject to competitive bidding, and we were unsuccessful in being awarded a new contract. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or unanticipated delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our overall business, financial condition, cash flows, and results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business may be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have an adverse effect on our business, financial condition, cash flows, and results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results and damage our reputation.

Experienced computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including “bugs” and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance on contracts, including those on which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties including software and hardware vendors to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenue and profitability.

Risks Related to our General Business Operations

Ineffective management of our growth may negatively affect our business, financial condition, and results of operations.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. Continued rapid growth could place a significant strain on our management and on other Company resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems, could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability, and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be

significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of their clinics or caused by one of their employees. We maintain medical malpractice insurance for our clinics in an amount which we believe to be reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot provide assurance that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, cash flows, and results of operations, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve and could result in the loss of members to other health plans.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal controls over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the New York Stock Exchange, SEC, or other regulatory authorities, which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have an adverse effect on our business, financial condition, cash flows, and results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes, such as the ACA excise tax discussed above. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations could have an adverse effect on our provision for income taxes, estimated income tax liabilities, and results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. It is critical that we recruit, manage, enable, and retain talent to successfully execute our strategic objections which requires aligned policies, a positive work environment, and a robust succession and talent development process. Further, particularly in light of the changing health care environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. If we are unsuccessful in recruiting, retaining, managing, and enabling such personnel and are unable to meet upcoming challenges and opportunities, our operations could be negatively impacted.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by

changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition, and results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could adversely impact our business, financial condition, and results of operations.

An impairment charge with respect to our recorded goodwill and indefinite-lived intangible assets, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2012, the balance of goodwill and indefinite-lived intangible assets was $151.1 million. Goodwill and indefinite-lived intangible assets are not amortized, but are subject to annual impairment testing. Testing is performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the underlying reporting units below their carrying amounts. The underlying reporting units generally comprise our health plan subsidiaries and our Molina Medicaid Solutions segment. As of December 31, 2012, the balance of intangible assets, net, was $77.7 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives. Our intangible assets are subject to impairment tests when events or circumstances indicate that such an asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators, including legal factors, market conditions, and operational performance. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors.

For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. The non-renewal of such a contract would be an indicator of impairment.

If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and indefinite-lived intangible assets, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material adverse impact on our financial results.

We are subject to the risks of owning real property.

We own an approximately 460,000 square foot office building housing our principal executive offices, which we purchased in a transaction that closed on December 7, 2011. We also own a nearby 32,000 square-foot office building in Long Beach, California, a 160,000 square-foot office building in Columbus, Ohio, a 26,000 square-foot data center in Albuquerque, New Mexico, and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California. Accordingly, we are subject to all of the risks generally associated with owning real estate, which include, but are not limited to: the possibility of environmental contamination, the costs associated with fixing any environmental problems and the risk of damages resulting from such contamination; risks related to natural disasters, such as earthquakes, flooding or severe weather; adverse changes in the value of the property due to interest rate changes, changes in the neighborhood in which the property is located, or other factors; ongoing maintenance expenses and costs of improvements; the possible need for structural improvements in order to comply with changes in zoning, seismic, disability act, or other requirements; inability to renew or enter into leases for space not utilized by the Company on commercially acceptable terms or at all; and possible disputes with neighboring owners or other individuals and entities.

Because we have guaranteed one of our subsidiary's obligations under a loan agreement, if this subsidiary fails to meet its obligations under the loan agreement, we may be required to satisfy such obligations, and such an undertaking could have an adverse affect on our financial condition.

On December 7, 2011, Molina Center LLC, or Molina Center, a wholly owned subsidiary of the Company, entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent, to borrow the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the office building housing our corporate headquarters. While all amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the office building in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement, the Company has additionally guaranteed Molina Center's obligations of payment and performance under the Term Loan Agreement, certain promissory notes executed in connection therewith, and other loan documents. The maximum amount of the promissory notes for which the Company is liable under the Guaranty will in no event exceed $20 million, but there

is no cap on the Company's total liability under the Guaranty. Furthermore, Molina Center and the Company also entered into an Environmental Indemnity in favor of the Administrative Agent and the other lenders pursuant to which the Company, jointly and severally with Molina Center, has agreed to indemnify and hold harmless the Administrative Agent and each of the other lenders under the Term Loan Agreement from and against any loss, damage, cost, expense, claim, or liability directly or indirectly arising out of or attributable to the use, generation, storage, release, discharge or disposal, or presence of certain hazardous materials on or about the office building. Neither the Company's nor Molina Center's liability under the Environmental Indemnity is limited by a maximum dollar amount. If Molina Center is unable to comply with the various customary financial covenants of the Term Loan Agreement, if it defaults under the Term Loan Agreement or if there are major environmental liabilities attributed to hazardous materials, such events could have an adverse effect on our business, financial condition, cash flows, and results of operations.

Risks Related to Our Common Stock

Delaware law and our charter documents may impede or discourage a takeover, which could cause the market price of our common stock to decline.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent,
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting, and
- the ability of our board of directors, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $10.75 to a high of $36.83. A number of factors could continue to influence the market price of our common stock, including:

- the implementation of the ACA and duals demonstration programs,
- state and federal budget pressures,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, by us or by security analysts or investors,
- revisions in securities analysts' estimates,
- announcements by us or our competitors of significant acquisitions or dispositions, strategic partnerships, joint ventures, or capital commitments,
- announcements relating to our business or the business of our competitors,
- changes in government payment levels,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies in the health care industry,

- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change,
- general economic conditions, including unemployment rates, inflation, and interest rates, and
- the other factors set forth under "Risk factors" in this Annual Report on Form 10-K.

Our common stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our common stock does not continue to develop, securities analysts may not maintain or initiate research coverage of us and our common stock, and this could depress the market for our common stock.

Members of the Molina family own a significant amount of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate own or are entitled to receive upon certain events approximately 37% of our capital stock as of December 31, 2012. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election of directors, amendments to our charter, and any merger, consolidation, or sale of the Company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 80,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2012, approximately 46,762,000 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

Item 1B: ***Unresolved Staff Comments***

None.

Item 2: ***Properties***

We lease a total of 75 facilities. We own a 460,000 square foot office building housing our corporate headquarters in Long Beach, California, and we also own a nearby 32,000 square-foot office building in Long Beach, California, a 160,000 square-foot office building in Columbus, Ohio, a 26,000 square-foot data center in Albuquerque, New Mexico, and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California. We anticipate leasing additional space in the Long Beach, California area during 2013. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operations growth prospects to determine if additional space is required, and where it would be best located.

Item 3: ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. Based upon the evaluation of information currently available, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 4: ***Mine Safety Disclosures***

None.

PART II

Item 5: ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of December 31, 2012, there were 130 holders of record of our common stock. The high and low intra-day sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2012		
First Quarter	$ 36.83	$ 22.25
Second Quarter	$ 35.37	$ 17.63
Third Quarter	$ 27.73	$ 21.62
Fourth Quarter	$ 29.82	$ 21.74
2011		
First Quarter	$ 26.86	$ 17.77
Second Quarter	$ 29.03	$ 24.72
Third Quarter	$ 28.21	$ 14.82
Fourth Quarter	$ 26.31	$ 13.93

Dividends

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business growth. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Any future determination to pay dividends will be at the discretion of our Board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 — Management's Discussion and Analysis of Financial Condition and Results of Operations — Liquidity and Capital Resources —Regulatory Capital and Dividends Restrictions.

Unregistered Issuances of Equity Securities

None.

Stock Repurchase Programs

Common Stock Repurchase in Connection with Offering of 1.125% Cash Convertible Senior Notes Due 2020. We used a portion of the net proceeds in this offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Securities Repurchases and Repurchase Programs. Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior note due 2014. The repurchase program extends through December 31, 2014.

Effective as of October 26, 2011, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program expired October 25, 2012. No securities were purchased under this program in 2012.

Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2012, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)(b)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares That May Yet Be Purchased Under the Plans or Programs
October 1 — October 31	2,150	$ 25.03	—	$ —
November 1 — November 30	1,892	$ 25.31	—	$ —
December 1 — December 31	194,974	$ 27.97	—	$ —
Total	199,016	$ 27.91	—	

(a) During the three months ended December 31, 2012, we repurchased shares of our common stock from certain Molina family trusts. Janet M. Watt is the sister, and her husband Lawrence B. Watt is the brother-in-law, of Dr. J. Mario Molina, the Company's Chief Executive Officer, and John Molina, the Company's Chief Financial Officer. Ms. Watt is the sole trustee of the Janet M. Watt Separate Property Trust dated 10/22/2007 (the "Separate Property Trust") and a co-trustee with Lawrence B. Watt, of the Watt Family Trust dated 10/11/1996 (the "Family Trust" and together with the Separate Property Trust, the "Trusts"). On December 26, 2012, pursuant to a Stock Purchase Agreement between the Company and the Trusts, the Company purchased an aggregate of 110,988 shares of its common stock from the Trusts for an aggregate purchase price of $3,000,005.64, as follows: (i) 43,767 shares from the Family Trust for an aggregate purchase price of $ 1,183,022.01 and (ii) 67,221 shares from the Separate Property Trust for an aggregate purchase price of $1,816,983.63. The shares were purchased at a price per share of $27.03, representing the closing price per share of the Company's common stock on December 26, 2012, as reported by the New York Stock Exchange. The transaction was approved by the Company's board of directors. Other than these repurchases from the Trusts, we did not repurchase any shares of our common stock outside of our publicly announced repurchase program except shares of common stock withheld to settle our employees' income tax obligations described below.

(b) During the quarter we withheld 88,028 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2012)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	414,061 (1)	$ 22.39	6,537,592 (2)

(1) Options to purchase shares of our common stock issued under the 2002 Equity Incentive Plan. Further grants under the 2002 Equity Incentive Plan have been suspended.

(2) Includes only shares remaining available to issue under the 2011 Equity Incentive Plan, and the 2011 Employee Stock Purchase Plan. Further grants under the 2002 Equity Incentive Plan and the 2002 Employee Stock Purchase Plan have been suspended.

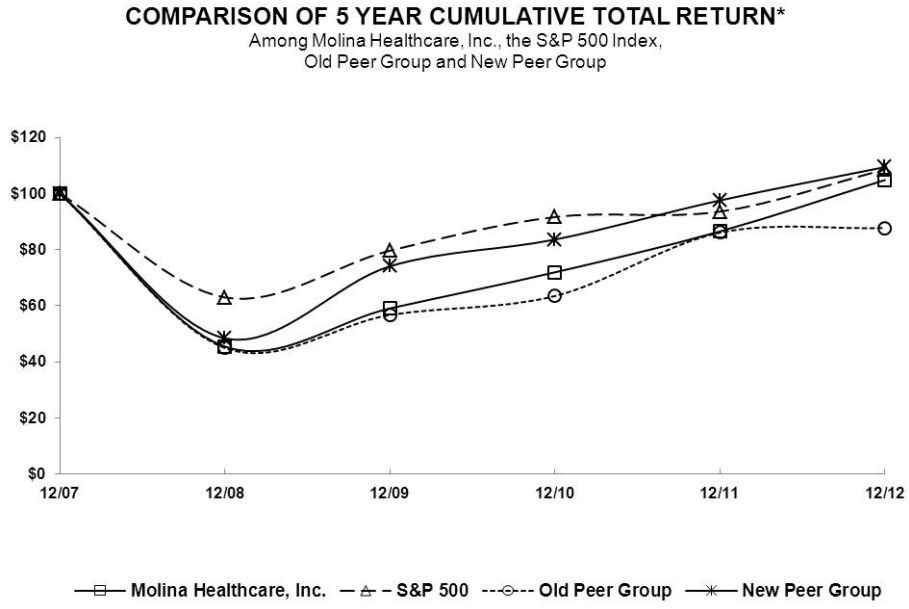
STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the SEC (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500"), our old peer group index (as described below), and a new peer group index (as described below) for the five-year period from December 31, 2007 to December 31, 2012. We have revised our peer group to match the peer group that is used by our Compensation Committee in benchmarking our executive officers' compensation. The comparison assumes $100 was invested on December 31, 2007, in the Company's common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.

The old peer group index, used in last year's Annual Report on Form 10-K and also set forth below, consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

The new peer group index consists of Centene Corporation (CNC), Community Health Systems, Inc. (CYH), Coventry Health Care, Inc. (CVH), Health Management Associates, Inc. (HMA), Health Net, Inc. (HNT), Laboratory Corporation of America Holdings (LH), Lifepoint Hospitals, Inc. (LPNT), Magellan Health Services, Inc. (MGLN), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), and WellCare Health Plans, Inc. (WCG).



Name	12/07	12/08	12/09	12/10	12/11	12/12
Molina Healthcare, Inc.	$ 100.00	$ 45.50	$ 59.10	$ 71.96	$ 86.55	$ 104.88
S&P 500	100.00	63.00	79.67	91.67	93.61	108.59
Old Peer Group	100.00	44.97	56.76	63.52	86.09	87.78
New Peer Group	100.00	48.44	74.11	83.64	97.61	109.47

Item 6. ***Selected Financial Data***

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics") for the five years ended December 31, 2012 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data. The data under the caption "Operating Statistics" has not been audited.

	Year Ended December 31,				
	2012	2011	2010	2009	2008
Statements of Income Data:					
Revenue:					
Premium revenue	$ 5,826,491	$ 4,603,407	$ 3,989,909	$ 3,660,207	$ 3,091,240
Service revenue (1)	187,710	160,447	89,809	—	—
Investment income	5,188	5,539	6,259	9,149	21,126
Rental income	9,374	547	—	—	—
Total revenue	6,028,763	4,769,940	4,085,977	3,669,356	3,112,366
Expenses:					
Medical care costs	5,096,760	3,859,994	3,370,857	3,176,236	2,621,312
Cost of service revenue (1)	141,208	143,987	78,647	—	—
General and administrative expenses	532,627	415,932	345,993	276,027	249,646
Premium tax expenses	158,991	154,589	139,775	128,581	100,165
Depreciation and amortization	63,704	50,690	45,704	38,110	33,688
Total operating costs and expenses	5,993,290	4,625,192	3,980,976	3,618,954	3,004,811
Impairment of goodwill and intangible assets (2)	—	(64,575)	—	—	—
Gain on purchase of convertible senior notes	—	—	—	1,532	—
Operating income	35,473	80,173	105,001	51,934	107,555
Other expenses (income):					
Interest expense	16,769	15,519	15,509	13,777	13,231
Other income	(361)	—	—	—	—
Total other expenses	16,408	15,519	15,509	13,777	13,231
Income before income taxes	19,065	64,654	89,492	38,157	94,324
Provision for income taxes	9,275	43,836	34,522	7,289	34,726
Net income	$ 9,790	$ 20,818	$ 54,970	$ 30,868	$ 59,598
Net income per share:					
Basic	$ 0.21	$ 0.45	$ 1.34	$ 0.80	$ 1.44
Diluted	$ 0.21	$ 0.45	$ 1.32	$ 0.79	$ 1.43
Weighted average number of common shares outstanding	46,380,000	45,756,000	41,174,000	38,765,000	41,514,000
Weighted average number of common shares and potential dilutive common shares outstanding	46,999,000	46,425,000	41,631,000	38,976,000	41,658,000
Operating Statistics:					
Medical care ratio (3)	89.9%	86.8%	87.6%	89.9%	87.6%
General and administrative expense ratio (4)	8.8%	8.7%	8.5%	7.5%	8.0%
Premium tax ratio (5)	2.8%	3.5%	3.6%	3.6%	3.3%
Members (6)	1,797,000	1,697,000	1,613,000	1,455,000	1,256,000

	Year Ended December 31,				
	2012	2011	2010	2009	2008
Balance Sheet Data:					
Cash and cash equivalents	$ 795,770	$ 493,827	$ 455,886	$ 469,501	$ 387,162
Total assets	1,934,822	1,652,146	1,509,214	1,244,035	1,148,068
Long-term debt (including current maturities)	262,939	218,126	164,014	158,900	164,873
Total liabilities	1,152,508	897,073	790,157	701,297	616,306
Stockholders' equity	782,314	755,073	719,057	542,738	531,762

(1) Service revenue and cost of service revenue represent revenue and costs generated by our Molina Medicaid Solutions segment. Because we acquired this business on May 1, 2010, results for the year ended December 31, 2010 include eight months of results for this segment.

(2) On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's existing contract with the state expired without renewal on June 30, 2012. In connection with this notification, we recorded a non-cash impairment charge of $64.6 million in the fourth quarter of 2011.

(3) Medical care ratio represents medical care costs as a percentage of premium revenue, net of premium tax. We now compute the medical care ratio by dividing total medical care costs by premium revenue, net of premium taxes. Previously, we did not adjust premium revenue to remove the impact of premium taxes. We have made this change for all periods presented. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, utilization of medical services, our ability to effectively manage costs, contract changes, and changes in accounting estimates related to incurred but not paid claims. See Item 7 — Management's Discussion and Analysis of Financial Condition and Results of Operations for further discussion.

(4) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(5) Premium tax ratio represents such expenses as a percentage of premium revenue, net of premium tax.

(6) Number of members at end of period.

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of December 31, 2012, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care clinics in California, Florida, New Mexico and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. As of December 31, 2012, we continued to process claims that were incurred by the Missouri health plan's members through the June 30, 2012 termination date. For the six months ended June 30, 2012, our Missouri health plan contributed premium revenue of $113.8 million, or 4.1% of total premium revenue, and comprised 79,000 members, or 4.3% of total Health Plans segment membership as of June 30, 2012.

With regard to our Ohio health plan, as a result of a lawsuit challenging the selection of several plans including our health plan for the new Medicaid managed care program in Ohio, the Ohio Office of Medical Assistance announced on October 5, 2012, that the operation of the program is being delayed from the previously scheduled January 1, 2013 start date and will now commence on July 1, 2013. Following the trial court's dismissal of the lawsuit, the court of appeals has permitted the state of Ohio to move forward with implementation of the new program and finalizing the provider agreements with our Ohio plan and the other selected managed care plans.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services.

During fiscal year 2012, we responded to several RFPs and invitations to negotiate with respect to new business, including proposals to serve dual eligible populations and applications to participate in the Centers for Medicare and Medicaid Services, or CMS', Capitated Financial Alignment Demonstration project. On August 27, 2012, our Ohio health plan was chosen to participate in the Southwest, West Central, and Central markets under the Ohio Integrated Care Delivery System, or ICDS. The Ohio ICDS is intended to improve care coordination for individuals enrolled in both Medicaid and Medicare. The selection of our Ohio health plan was made by the Ohio Department of Jobs and Family Services, or ODJFS, pursuant to the request for applications for qualified health plans to serve in the ICDS issued in April 2012. The commencement of the ICDS is subject to the readiness review of the selected health plans, and the execution of three-way provider agreements between the health plans, ODJFS, and CMS. Enrollment of dual eligible members in the ICDS is expected to begin during the second half of 2013.

On November 15, 2012, we announced that our new Illinois health plan had been chosen to serve members in Central Illinois under the state's Medicare-Medicaid Alignment Initiative (MMAI). The operational start date for the program is currently scheduled for October 2013 with an effective date of January 2014. In addition to the MMAI, we will also serve other seniors and persons with disabilities in the Medicaid Program as the state expands the Integrated Care Program that was implemented in suburban Cook County and the five collar counties in May of 2011.

On February 14, 2013, we announced that the Florida Agency for Health Care Administration awarded our Florida health plan contracts in three regions under the Statewide Medicaid Managed Care Long-Term Care program. As a result of the awards, we will now enter into a comprehensive pre-contracting assessment, with the program currently scheduled to commence on December 1, 2013. Under the program, we will provide long-term care benefits, including institutional and home and community-based services.

On February 11, 2013, we announced that our New Mexico health plan was selected by the New Mexico Human Services Department, or HSD, to participate in the new Centennial Care program. In addition to continuing to provide physical and acute health care services, under the new program our New Mexico health plan will expand its services to provide behavioral health and long-term care services. The selection of our New Mexico health plan was made by HSD pursuant to its request for proposals issued in August 2012. The operational start date for the program is currently scheduled for January 2014.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

On October 12, 2012, the Governor of the U.S. Virgin Islands announced a partnership in which we will provide MMIS to the U.S. Virgin Islands through our West Virginia fiscal agent operation. The contract outlining the sharing of our platform went through several rounds of review at the federal level and has been approved by CMS. The partnership will benefit both the Virgin Islands and taxpayers by circumventing the costs associated with establishing an independent system while gaining leverage from operating under a common platform. This partnership can serve as a model for the country by demonstrating that state and territorial governments can reduce local and federal costs by sharing such technologies for their Medicaid populations.

On July 13, 2012, our Molina Medicaid Solutions segment received full federal certification of its Medicaid Management Information System, or MMIS, in the state of Idaho from CMS. As a result of the CMS certification, the state of Idaho is entitled to receive federal reimbursement of 75% of its MMIS operations costs retroactive to June 1, 2010, the date that the system first began processing claims. Our MMIS in Maine received full federal certification from CMS on December 19, 2011.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement MMIS to another company. For the year ended December 31, 2012, our revenue under the Louisiana MMIS contract was $54.9 million, or 29.2% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize approximately $40 million in revenue annually under our Louisiana MMIS contract.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in “Critical Accounting Policies” below, is not generally subject to significant accounting estimates. For the year ended December 31, 2012, we received approximately 96% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the year ended December 31, 2012, we recognized approximately 4% of our premium revenue in the form of “birth income” — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children’s Health Insurance Program, or CHIP, members are generally among our lowest, with rates as

low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF, Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $110 in California to $260 in Ohio. Among our ABD membership, PMPM premiums range from approximately $330 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums in the aggregate, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2012	2011	2010
Total Ending Membership by Health Plan:			
California	336,000	355,000	344,000
Florida	73,000	69,000	61,000
Michigan	220,000	222,000	227,000
Missouri [1]	—	79,000	81,000
New Mexico	91,000	88,000	91,000
Ohio	244,000	248,000	245,000
Texas	282,000	155,000	94,000
Utah	87,000	84,000	79,000
Washington	418,000	355,000	355,000
Wisconsin	46,000	42,000	36,000
Total	1,797,000	1,697,000	1,613,000
Total Ending Membership by State for our Medicare Advantage Plans:			
California	7,700	6,900	4,900
Florida	900	800	500
Michigan	9,700	8,200	6,300
New Mexico	900	800	600
Ohio	300	200	—
Texas	1,500	700	700
Utah	8,200	8,400	8,900
Washington	6,500	5,000	2,600
Total	35,700	31,000	24,500
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	44,700	31,500	13,900
Florida	10,300	10,400	10,000
Michigan	41,900	37,500	31,700
New Mexico	5,700	5,600	5,700
Ohio	28,200	29,100	28,200
Texas	95,900	63,700	19,000
Utah	9,000	8,500	8,000
Washington	30,000	4,800	4,000
Wisconsin	1,700	1,700	1,700
Total	267,400	192,800	122,200

(1) Our contract with the state of Missouri expired without renewal on June 30, 2012

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of an MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, general and administrative expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. Most hospitals are paid on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. As discussed below, we also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit manager. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2012, 2011, and 2010, medically related administrative costs were approximately $127.5 million, $102.3 million, and $85.5 million, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

2012 Financial Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the years ended December 31, 2012, 2011, and 2010. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue, net of premium tax, because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

We have changed our method of calculating the medical care ratio effective December 31, 2012. We now calculate the medical care ratio by dividing total medical care costs by premium revenue, net of premium taxes. Previously, we did not adjust premium revenue to remove the impact of premium taxes when calculating the medical care ratio. We made this change for all periods presented to allow better comparability of the medical care ratio between periods for health plans operating in states where premium taxes are either increased or decreased. Two states where we operate health plans (Michigan and California) either reduced or eliminated their premium tax during 2012.

	Year Ended December 31,		
	2012	2011	2010
	(Dollar amounts in thousands, except per-share data)		
Earnings per diluted share	$ 0.21	$ 0.45	$ 1.32
Premium revenue	$ 5,826,491	$ 4,603,407	$ 3,989,909
Service revenue	$ 187,710	$ 160,447	$ 89,809
Operating income	$ 35,473	$ 80,173	$ 105,001
Net income	$ 9,790	$ 20,818	$ 54,970
Total ending membership	1,797,000	1,697,000	1,613,000
Premium revenue	96.6%	96.5%	97.6%
Service revenue	3.1%	3.4%	2.2%
Investment income	0.1%	0.1%	0.2%
Rental income	0.2%	—%	—%
Total revenue	100.0%	100.0%	100.0%
Medical care ratio (1)	89.9%	86.8%	87.6%
General and administrative expense ratio	8.8%	8.7%	8.5%
Premium tax ratio (1)	2.8%	3.5%	3.6%
Operating income	0.6%	1.7%	2.6%
Net income	0.2%	0.4%	1.3%
Effective tax rate	48.6%	67.8%	38.6%

(1) Medical care ratio represents medical care costs as a percentage of premium revenue, net of premium taxes; premium tax ratio represents premium taxes as a percentage of premium revenue, net of premium taxes.

Earnings before Interest, Taxes, Depreciation and Amortization, or EBITDA

We calculate a non-GAAP measure, EBITDA, which management uses as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry. The reconciliation of this non-GAAP to GAAP financial measure is as follows (GAAP stands for U.S. generally accepted accounting principles):

	Year Ended December 31,		
	2012	2011	2010
	(In thousands)		
Net income	$ 9,790	$ 20,818	$ 54,970
Add back:			
Depreciation and amortization reported in the consolidated statements of cash flows	78,764	74,383	60,765
Interest expense	16,769	15,519	15,509
Provision for income taxes	9,275	43,836	34,522
EBITDA[1]	$ 114,598	$ 154,556	$ 165,766

(1) EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities; nor should EBITDA be considered in isolation from these GAAP measures of operating performance.

Year Ended December 31, 2012 Compared with the Year Ended December 31, 2011

Fiscal Year 2012 Overview and Highlights

Earnings decreased in 2012 compared with 2011 because lower margins in the Health Plans segment more than offset higher premium revenue. Net income for the year ended December 31, 2012, was $9.8 million, or $0.21 per diluted share, compared with net income of $20.8 million, or $0.45 per diluted share, for the year ended December 31, 2011. Results for the quarter and year ended December 31, 2011, were affected by an impairment charge of $64.6 million related to our Missouri health plan.

Lower net income in 2012 was in large part tied to growth in our ABD membership in California and Texas, where margins were considerably lower than our margins in the aggregate. During 2012, both California and Texas transitioned large numbers of ABD members from fee-for-service reimbursement to managed care contracts. It has been our experience that members transitioning from fee-for-service reimbursement to managed care often bring with them pent up demand for medical services; and that the realization of both improved medical outcomes and costs savings from the application of managed care practices takes time as both members and providers acquaint themselves to new ways of accessing and providing care.

The initial reduction to margins associated with the transition of members from fee-for-service reimbursement to managed care was exacerbated by premium rates that assumed unrealistic costs savings from managed care practices. Premium rate increases received later in 2012 at least partially addressed this issue.

Those rate increases, together with the improved health outcomes and the gradual reduction in medical costs resulting from the application of managed care practices, produced improved financial results in the fourth quarter of 2012. Nevertheless, the aggregate impact of the ABD membership transitioned in 2012 was to substantially reduce margins. We believe, however, that in time the higher premium revenue associated with ABD members will allow us to earn acceptable returns on a total dollar basis even if percentage margins remain lower than those earned by serving TANF members, for whom PMPM revenue is much lower.

Health Plans Segment

Premium Revenue

Premium revenue grew 27% in the year ended December 31, 2012, compared with the year ended December 31, 2011, primarily due to a shift in member mix to populations generating higher premium revenue PMPM, benefit expansions, and an increase in membership. Medicare premium revenue was $468 million in the year ended December 31, 2012, compared with $388 million in the year ended December 31, 2011.

Growth in our ABD membership led to higher premium revenue PMPM in 2012. ABD membership, as a percent of total membership, has increased approximately 31% year over year. Premium revenue PMPM also increased in the year ended December 31, 2012, as a result of the inclusion of revenue from the pharmacy benefit for our Ohio health plan effective October 1, 2011, and as a result of the inclusion of revenue for the inpatient facility and pharmacy benefits across all of our Texas health plan membership effective March 1, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 3,521,960	$ 162.60	69.1%	$ 2,764,309	$ 139.02	71.6%
Capitation	557,087	25.72	10.9	518,835	26.09	13.4
Pharmacy	835,830	38.59	16.4	418,007	21.02	10.8
Other	181,883	8.39	3.6	158,843	8.00	4.2
Total	$ 5,096,760	$ 235.30	100.0%	$ 3,859,994	$ 194.13	100.0%

Medical care costs increased in 2012 primarily due to the same shifts in member mix and the benefit expansions that led to increased premium revenue, particularly in California and Texas. Medical care costs as a percentage of premium revenue, net of premium taxes (the medical care ratio) also increased in 2012 when compared with 2011 because increases in premium rates have not kept pace with increases in medical costs.

Individual Health Plan Analysis

Membership and premium revenue increased significantly at the Texas health plan in 2012 as a result of the transition of large numbers of ABD, TANF and CHIP members from fee-for-service reimbursement into managed care effective March 1, 2012. Also on that date inpatient facility and pharmacy benefits that had previously been reimbursed through fee for service for managed care members were transitioned into managed care contracts; further increasing premium revenue and related medical costs. As noted above, margins on newly transitioned ABD members were considerably less than those experienced by the Company overall. The medical care ratio for the Texas health plan's ABD membership in total was approximately 97.8% for all of 2012. Nevertheless, the medical care ratio for the Texas health plan overall decreased to 93.7% for all of 2012 compared with 95.1% for 2011.

The medical care ratio at the California health plan increased significantly in 2012, to 91.1% in 2012 from 86.9% in 2011. As noted above, margins on newly transitioned ABD members were considerably less than those experienced by the Company overall.

The medical care ratio of the Florida health plan decreased to 85.3% in 2012, from 91.9% in 2011 due to a premium rate increase effective September 1, 2011, the re-contracting of portions of the health plan's specialty care network, lower inpatient utilization and lower pharmacy costs.

The medical care ratio of the Michigan health plan increased to 88.3% in 2012, from 86.3% in 2011. The primary reason for the increase in the medical care ratio in 2012 was a reduction to premium rates linked to a decrease in premium taxes effective April 1, 2012. The result was a higher medical care ratio in 2012 because premium revenue decreased. There was no impact on profitability because premium tax expense was reduced by the same amount as premium revenue. The remainder of the deterioration in the Michigan plan's medical care ratio was the result of higher pharmacy and fee for service costs. We received a blended rate increase in Michigan of approximately 2%, effective October 1, 2012.

The medical care ratio of the New Mexico health plan increased to 84.7% in 2012, from 82.4% in 2011, primarily as a result of lower premiums and higher inpatient facility costs. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011.

The medical care ratio of the Ohio health plan increased to 88.6% in 2012, from 84.1% in 2011. The increase in the Ohio health plan's medical care ratio was partially the result of a 2% rate reduction effective January 1, 2012, together with the assumption of the lower margin pharmacy benefit effective October 1, 2011.

The medical care ratio of the Utah health plan increased to 82.3% in 2012 from 78.1% in 2011. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2012.

The addition of ABD members to the Washington health plan effective July 1, 2012 increased its medical care ratio to 86.8% in the 2012, compared with 85.4% in 2011. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio so that income from operations was consistent between 2012 and 2011.

The medical care ratio of the Wisconsin health plan increased to 96.2% in 2012, compared with 92.5% in 2011 primarily due to increases in inpatient costs. The plan has implemented provider contracting initiatives and new utilization management techniques as a part of its efforts to improve profitability.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2012						
	Member Months[1]	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR Excluding Premium Tax Expense[4]
		Total	PMPM	Total	PMPM		
California	4,177	$ 671,489	$ 160.77	$ 606,494	$ 145.20	$ 5,697	91.1%
Florida	850	228,828	269.36	195,226	229.80	(4)	85.3
Michigan	2,639	658,741	249.59	570,636	216.20	12,190	88.3
Missouri[2]	483	113,818	236.87	113,101	234.15	—	99.4
New Mexico	1,069	338,770	316.90	280,108	262.03	8,208	84.7
Ohio	3,065	1,187,422	387.48	970,504	316.69	92,285	88.6
Texas	3,245	1,255,722	386.99	1,155,433	356.08	22,101	93.7
Utah	1,026	298,392	290.78	245,671	239.41	—	82.3
Washington	4,600	992,748	215.83	845,733	183.87	18,036	86.8
Wisconsin	508	70,673	139.24	67,968	133.91	(5)	96.2
Other[3]	—	9,888	—	45,886	—	483	—
	21,662	$ 5,826,491	$ 268.99	$ 5,096,760	$ 235.30	$ 158,991	89.9%

	Year Ended December 31, 2011						
	Member Months[1]	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR Excluding Premium Tax Expense[4]
		Total	PMPM	Total	PMPM		
California	4,190	$ 575,176	$ 137.27	$ 493,419	$ 117.75	$ 7,499	86.9%
Florida	788	203,945	258.70	187,358	237.66	41	91.9
Michigan	2,660	662,127	248.91	537,779	202.16	38,733	86.3
Missouri[2]	959	229,584	239.38	195,832	204.19	—	85.3
New Mexico	1,074	345,732	321.94	277,338	258.25	9,285	82.4
Ohio	2,966	988,896	333.40	766,949	258.57	76,677	84.1
Texas	1,616	409,295	253.40	382,390	236.74	7,117	95.1
Utah	972	287,290	295.51	224,513	230.94	—	78.1
Washington	4,171	823,323	197.42	690,513	165.57	14,865	85.4
Wisconsin	488	69,596	142.56	64,346	131.81	44	92.5
Other[3]	—	8,443	—	39,557	—	328	—
	19,884	$ 4,603,407	$ 231.51	$ 3,859,994	$ 194.13	$ 154,589	86.8%

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) Our contract with the state of Missouri expired without renewal on June 30, 2012. The Missouri health plan's claims run-out activity subsequent to June 30, 2012, is reported in "Other."

(3) "Other" medical care costs also include medically related administrative costs of the parent company.

(4) The "MCR Excluding Premium Tax Expense" represents medical costs as a percentage of premium revenues, where premium revenue is reduced by premium tax expense.

Days in Medical Claims and Benefits Payable

The days in medical claims and benefits payable were as follows:

	December 31,		
	2012	2011	2010
Days in claims payable: fee-for-service only	40 days	40 days	42 days
Number of claims in inventory at end of period	122,700	111,100	143,600
Billed charges of claims in inventory at end of period (in thousands)	$ 255,200	$ 207,600	$ 218,900

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31,	
	2012	2011
	(In thousands)	
Service revenue before amortization	$ 189,281	$ 167,269
Amortization recorded as reduction of service revenue	(1,571)	(6,822)
Service revenue	187,710	160,447
Cost of service revenue	141,208	143,987
General and administrative costs	17,648	9,270
Amortization of customer relationship intangibles recorded as amortization	5,127	5,127
Operating income	$ 23,727	$ 2,063

Operating income for our Molina Medicaid Solutions segment improved $21.7 million for the year ended December 31, 2012, compared with 2011. This improvement was primarily the result of stabilization of our newest contracts in Idaho and Maine.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 8.8% of total revenue for the year ended December 31, 2012, compared with 8.7% of total revenue for the year ended December 31, 2011.

Premium Tax Expense

Premium tax expense decreased to 2.8% of premium revenue net of premium tax for the year ended December 31, 2012, compared with 3.5% of total premium revenue for the year ended December 31, 2011. The decrease in 2012 was primarily due to the reduction of premium taxes at the Michigan and California health plans effective in 2012, and the growth in revenue at our Texas health plan, which is subject to a lower premium tax rate (measured as a percentage of premium revenue) than our consolidated average.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Depreciation is recorded within the heading "Cost of service revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,			
	2012		2011	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 43,201	0.7%	$ 30,864	0.7%
Amortization of intangible assets	20,503	0.3	19,826	0.4
Depreciation and amortization reported as such in the consolidated statements of income	63,704	1.0	50,690	1.1
Amortization recorded as reduction of service revenue	1,571	—	6,822	0.1
Amortization of capitalized software recorded as cost of service revenue	13,489	0.2	16,871	0.4
Total	$ 78,764	1.2%	$ 74,383	1.6%

Impairment of Goodwill and Intangible Assets

We did not record an impairment charge in 2012. On February 17, 2012, our Missouri health plan was notified that it was not awarded a new contract under the state's RFP, and therefore its contract expired on June 30, 2012. As a result, we recorded a non-cash impairment charge of approximately $64.6 million, or $1.34 per diluted share, in the fourth quarter of 2011. Of the total charge, $58.5 million was not tax deductible, resulting in a disproportionate impact to net income and to the effective tax rate.

Interest Expense

Interest expense was $16.8 million for the year ended December 31, 2012, compared with $15.5 million for the year ended December 31, 2011. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $5.9 million and $5.5 million for the years ended December 31, 2012 and 2011, respectively.

Income Taxes

Income tax expense is recorded at an effective rate of 48.6% for the year ended December 31, 2012, compared with 67.8% for the year ended December 31, 2011. The effective rate for the year ended December 31, 2012 is higher than our statutory rate primarily due to nondeductible expenses primarily relating to compensation and changes in the fair value of contingent consideration. The effective rate for the year ended December 31, 2011 reflects the nondeductible nature of the majority of the Missouri impairment charge and certain discrete tax benefits.

Year Ended December 31, 2011 Compared with the Year Ended December 31, 2010

Fiscal Year 2011 Overview and Highlights

For the year, our net income was $20.8 million, or $0.45 per diluted share, a decrease of 66% over 2010. We recorded a non-cash impairment charge of approximately $64.6 million, or $1.34 per diluted share, in connection with the expiration of our Missouri health plan's contract with the state of Missouri effective June 30, 2012. Absent this impairment charge, improved performance of the Health Plans segment drove our improved performance overall for the year ended December 31, 2011.

We earned premium revenues of $4.6 billion, up 15.4% over the previous year. Meanwhile, we achieved a medical care ratio of 86.8%, compared with a medical care ratio of 87.6% for fiscal year 2010.

Health Plans Segment

Premium Revenue

Premium revenue increased 15.4% in the year ended December 31, 2011, compared with the year ended December 31, 2010, due to a membership increase of approximately 8.4% (on a member-month basis), and PMPM revenue increase of approximately 6.4%. Premium revenues were impacted by the following in 2011:

- In the fourth quarter of 2011, our New Mexico health plan entered into a contract amendment that more closely aligns the calculation of revenue with the methodology adopted under the Affordable Care Act. The contract amendment changed the calculation of the amount of revenue that may be recognized relative to medical costs, and resulted in the recognition of approximately $5.6 million of premium revenue which all related to periods prior to 2011.

- Also in the fourth quarter of 2011, the addition of pharmacy benefits at our Ohio health plan effective October 1, 2011, increased premium revenue.

Absent the adjustment to New Mexico premium revenue and the addition of the pharmacy benefit in Ohio, premium revenue PMPM increased approximately 4.4%, from $218 in 2010 to $227 in 2011. Increased enrollment among the ABD and Medicare populations contributed to the higher premium revenue PMPM. Medicare premium revenue was $388 million for the year ended December 31, 2011, compared with $265 million for the year ended December 31, 2010.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,764,309	$ 139.02	71.6%	$ 2,360,858	$ 128.73	70.0%
Capitation	518,835	26.09	13.4	555,487	30.29	16.5
Pharmacy	418,007	21.02	10.8	325,935	17.77	9.7
Other	158,843	8.00	4.2	128,577	7.01	3.8
Total	$ 3,859,994	$ 194.13	100.0%	$ 3,370,857	$ 183.80	100.0%

The medical care ratio decreased to 86.8% for the year ended December 31, 2011, compared with 87.6% for the year ended December 31, 2010.

The medical care ratio of the California health plan increased to 86.9% for the year ended December 31, 2011, from 84.6% for the year ended December 31, 2010. The California health plan received premium reductions of approximately 3% and 1% effective July 1, 2011, and October 1, 2011, respectively. In the second half of 2011, the California health plan added approximately 14,500 new ABD members with average premium revenue of approximately $385 PMPM.

The medical care ratio of the Florida health plan decreased to 91.9% for the year ended December 31, 2011, from 95.4% for the year ended December 31, 2010, primarily due to initiatives that have reduced pharmacy and behavioral health costs, and a premium rate increase of approximately 7.5% effective September 1, 2011.

The medical care ratio of the Michigan health plan decreased to 86.3% for the year ended December 31, 2011, from 89.3% for the year ended December 31, 2010, primarily due to improved Medicare performance and lower inpatient facility costs. The Michigan health plan received a premium rate increase of approximately 1% effective October 1, 2011.

The medical care ratio of the Missouri health plan decreased to 85.3% for the year ended December 31, 2011, from 85.5% for the year ended December 31, 2010. The health plan received a premium rate increase of approximately 5% effective July 1, 2011.

The medical care ratio of the New Mexico health plan decreased to 82.4% for the year ended December 31, 2011, from 82.7% for the year ended December 31, 2010. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011. As discussed above, the New Mexico health plan entered into a contract amendment that changed the calculation of the amount of revenue that may be recognized relative to medical costs in the fourth quarter of 2011. Consequently, premium revenue recognized in the year ended December 31, 2011, includes $5.6 million related to periods prior to 2011.

The medical care ratio of the Ohio health plan decreased to 84.1% for the year ended December 31, 2011, from 85.9% for the year ended December 31, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011, and relatively flat fee-for-service costs. The pharmacy benefit was restored to all managed care plans in Ohio effective October 1, 2011.

The medical care ratio of the Texas health plan increased to 95.1% for the year ended December 31, 2011, from 87.7% for the year ended December 31, 2010. Effective February 1, 2011, we added approximately 30,000 ABD members in the Dallas-Fort Worth area and effective September 1, 2011, we added approximately 8,000 ABD members and 3,000 TANF members in the Jefferson Service area. Medical costs in the Dallas-Fort Worth area were well in excess of premium revenue. Excluding the ABD population in the Dallas-Fort Worth region, the medical care ratio of the Texas health plan was 87.2% for the year ended December 31, 2011.

The medical care ratio of the Utah health plan decreased to 78.1% for the year ended December 31, 2011, from 91.3% for the year ended December 31, 2010, primarily due to reduced fee-for-service inpatient and physician costs and an increase in

Medicaid premiums PMPM. Effective July 1, 2010, the Utah health plan received a premium rate increase of approximately 7%. Lower fee-for-service costs were the result of both lower unit costs and lower utilization. During the second quarter of 2011 we settled certain claims with the state regarding the savings share provision of our contract in effect from 2003 through June of 2009. We settled for the contract years 2006 through 2009 and recognized $6.9 million in premium revenue without any corresponding charge to expense. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2011.

The medical care ratio of the Washington health plan remained flat at 85.4% for the year ended December 31, 2011 compared with the year ended December 31, 2010. Higher fee-for-service and pharmacy costs were offset by lower capitation costs.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 92.5% for the year ended December 31, 2011. The state of Wisconsin reduced capitation rates by 11% on January 1, 2011.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2011						
	Member Months[1]	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR Excluding Premium Tax Expense[4]
		Total	PMPM	Total	PMPM		
California	4,190	$ 575,176	$ 137.27	$ 493,419	$ 117.75	$ 7,499	86.9%
Florida	788	203,945	258.70	187,358	237.66	41	91.9
Michigan	2,660	662,127	248.91	537,779	202.16	38,733	86.3
Missouri[2]	959	229,584	239.38	195,832	204.19	—	85.3
New Mexico	1,074	345,732	321.94	277,338	258.25	9,285	82.4
Ohio	2,966	988,896	333.40	766,949	258.57	76,677	84.1
Texas	1,616	409,295	253.40	382,390	236.74	7,117	95.1
Utah	972	287,290	295.51	224,513	230.94	—	78.1
Washington	4,171	823,323	197.42	690,513	165.57	14,865	85.4
Wisconsin	488	69,596	142.56	64,346	131.81	44	92.5
Other[3]	—	8,443	—	39,557	—	328	—
	19,884	$ 4,603,407	$ 231.51	$ 3,859,994	$ 194.13	$ 154,589	86.8%

	Year Ended December 31, 2010						
	Member Months[1]	Premium Revenue		Medical Care Costs		Premium Tax Expense	MCR Excluding Premium Tax Expenses[4]
		Total	PMPM	Total	PMPM		
California	4,197	$ 506,871	$ 120.77	$ 423,021	$ 100.79	$ 6,912	84.6%
Florida	664	170,683	256.87	162,839	245.07	1	95.4
Michigan	2,708	630,134	232.66	527,596	194.80	39,187	89.3
Missouri[2]	946	210,852	222.98	180,291	190.66	—	85.5
New Mexico	1,104	366,784	332.02	295,633	267.61	9,300	82.7
Ohio	2,817	860,324	305.42	680,802	241.69	67,358	85.9
Texas	708	188,716	266.72	162,714	229.97	3,251	87.7
Utah	921	258,076	280.27	235,576	255.84	—	91.3
Washington	4,141	758,849	183.27	636,617	153.75	13,513	85.4
Wisconsin	134	30,033	224.75	27,574	206.35	—	91.8
Other[3]	—	8,587	—	38,194	—	253	—
	18,340	$ 3,989,909	$ 217.56	$ 3,370,857	$ 183.80	$ 139,775	87.6%

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) Our contract with the state of Missouri expired without renewal on June 30, 2012.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

(4) The "MCR Excluding Premium Tax Expense" represents medical costs as a percentage of premium revenues, where premium revenue is reduced by premium tax expense.

Molina Medicaid Solutions Segment

We acquired Molina Medicaid Solutions on May 1, 2010; therefore, the year ended December 31, 2010, includes only eight months of operating results for this segment. Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31, 2011	Eight Months Ended December 31, 2010
	(In thousands)	
Service revenue before amortization	$ 167,269	$ 98,125
Amortization recorded as reduction of service revenue	(6,822)	(8,316)
Service revenue	160,447	89,809
Cost of service revenue	143,987	78,647
General and administrative costs	9,270	5,135
Amortization of customer relationship intangibles recorded as amortization	5,127	3,418
Operating income	$ 2,063	$ 2,609

For the year ended December 31, 2011, cost of service revenue included $11.5 million of direct costs associated with the Idaho contract that would otherwise have been recorded as deferred contract costs. In assessing the recoverability of the deferred contract costs associated with the Idaho contract during 2011, we determined that these costs should be expensed as a period cost. In December 2011, our MMIS in Maine received full certification from CMS.

Consolidated Expenses and Other

General and Administrative Expenses

General and administrative expenses were $415.9 million, or 8.7% of total revenue, for the year ended December 31, 2011, compared with $346.0 million, or 8.5% of total revenue, for the year ended December 31, 2010.

Premium Tax Expense

Premium tax expense decreased to 3.5% of premium revenue net of premium tax for the year ended December 31, 2011, compared with 3.6% for December 31, 2010.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Year Ended December 31,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 30,864	0.7%	$ 27,230	0.7%
Amortization of intangible assets	19,826	0.4	18,474	0.4
Depreciation and amortization reported as such in the consolidated statements of income	50,690	1.1	45,704	1.1
Amortization recorded as reduction of service revenue	6,822	0.1	8,316	0.2
Amortization of capitalized software recorded as cost of service revenue	16,871	0.4	6,745	0.2
Total	$ 74,383	1.6%	$ 60,765	1.5%

Impairment of Goodwill and Intangible Assets

On February 17, 2012, our Missouri health plan was notified that it was not awarded a new contract under the state's RFP, and therefore its contract expired on June 30, 2012. As a result, we recorded a non-cash impairment charge of approximately $64.6 million, or $1.34 per diluted share, in the fourth quarter of 2011. Of the total charge, $58.5 million is not tax deductible, resulting in a disproportionate impact to net income and the effective tax rate. We did not record an impairment charge in 2010.

Interest Expense

Interest expense was $15.5 million for each of the years ended December 31, 2011 and 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $5.5 million and $5.1 million for the years ended December 31, 2011 and 2010, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 67.8% for the year ended December 31, 2011, compared with 38.6% for the year ended December 31, 2010. The effective rate for the year ended December 31, 2011 reflects the non-deductible nature of the majority of the Missouri impairment charge, discrete tax benefits of $1.7 million recognized for statute closures, prior year tax return to provision reconciliations, and certain non-recurring income that is not subject to income tax. Excluding the impact from the Missouri impairment charge and discrete tax benefits, the effective tax rate for the year ended December 31, 2011 was 37.9%.

Acquisitions

Molina Center. On December 7, 2011, our wholly owned subsidiary Molina Center LLC closed on its acquisition of the 460,000 square foot office building located in Long Beach, California. The building, or Molina Center, consists of two conjoined fourteen-story office towers on approximately five acres of land. For the last several years we have leased approximately 155,000 square feet of the Molina Center for use as our corporate headquarters and also for use by our California health plan subsidiary. The final purchase price was $81 million, which amount was paid with a combination of cash on hand and bank financing under a term loan agreement. We acquired this business primarily to facilitate space needs for the projected future growth of the Company.

Molina Medicaid Solutions. On May 1, 2010, we acquired a health information management business which we operate under the name, *Molina Medicaid Solutions*SM.

Other Transactions

As described above, our Missouri health plan, Alliance for Community Health, LLC, or ACH, was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state (the "MC+ Contract") expired without renewal on June 30, 2012, subject to certain transition obligations which terminate 365 days after June 30, 2012. ACH intends to enter into an assignment and assumption agreement with another one of our wholly owned subsidiaries, Molina Healthcare of Illinois, Inc., or Molina Illinois, pursuant to which ACH intends to assign to Molina Illinois substantially all of its assets and liabilities, including its surviving rights, duties and obligations, including all of the post-expiration duties and services under the MC+ Contract. Such assignment is subject to prior approval by the Missouri Department of Insurance, Financial Institutions and Professional Registration, the Illinois Department of Insurance, and the written consent of Mo HealthNet. Subsequent to the effectiveness of the assignment and assumption agreement between ACH and Molina Illinois and ACH's surrender of its Missouri certificate of authority, we intend to abandon our equity interests in ACH to an unrelated

entity. Subject to appropriate regulatory approvals discussed above, ACH will retain certain assets and investments, to which we will no longer have access after the abandonment transaction is effected and which amounts we intend to write off.

Liquidity and Capital Resources

Introduction

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2012, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $5.2 million for the year ended December 31, 2012, compared with $5.5 million for the year ended December 31, 2011. Our annualized portfolio yields for the years ended December 31, 2012, 2011, and 2010 were 0.5%, 0.6%, and 0.7%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use. See further discussion below, under *Regulatory Capital and Dividend Restrictions.*

Liquidity

Cash provided by operating activities was $347.8 million in 2012 compared with $225.4 million in 2011, an increase of $122.4 million. In 2012, deferred revenue was a source of cash from operations amounting to $90.9 million, compared with a use of cash amounting to $8.2 million in 2011. This increase was primarily due to an increase in deferred revenue relating to an advance premium payment received by our Washington health plan in December 2012. In 2011, cash provided by operating activities was $225.4 million compared with $161.4 million for 2010, an increase of $64.0 million. This increase was primarily due to higher operating income before giving effect to the $64.6 million non-cash impairment of goodwill and intangible assets relating to our Missouri health plan's state contract termination recorded in the fourth quarter of 2011.

Cash used in investing activities was $93.6 million in 2012 compared with $236.9 million in 2011, a decrease of $143.3 million. This decrease was primarily due to the change in cash paid in business combinations resulting from our fourth quarter 2011 acquisition of the Molina Center amounting to $81.0 million, with no comparable activity in 2012. In 2011, cash provided by financing activities was $236.9 million compared with $288.8 million in 2010, a decrease of $51.9 million. This decrease was primarily due to $46.5 million less cash paid for business combinations in 2011. We acquired Molina Medicaid Solutions in the second quarter of 2010 for $131.1 million, compared with $81.0 million spent to acquire the Molina Center in 2011.

Cash provided by financing activities was $47.7 million in 2012 compared with $49.5 million in 2011, a decrease of $1.8 million. Cash provided from borrowings under our credit facility in 2012 amounting to $40.0 million was consistent with cash provided from the $48.6 million term loan in 2011 used to finance the acquisition of the Molina Center. In 2011, cash provided

by financing activities was $49.5 million compared with $113.8 million in 2010, a decrease of $64.3 million. This decrease was due to $111.1 million of net proceeds from our common stock offering in the third quarter of 2010, compared with the $48.6 million term loan to acquire the Molina Center in 2011.

Financial Condition

On a consolidated basis, at December 31, 2012, we had working capital of $521.1 million compared with $446.2 million at December 31, 2011. At December 31, 2012 we had cash and investments of $1,196.1 million, compared with $893.0 million of cash and investments at December 31, 2011. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after inter-company eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $549.7 million at December 31, 2012, and $492.4 million at December 31, 2011. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders are generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $46.9 million and $23.6 million as of December 31, 2012, and 2011, respectively. This increase was primarily due to increased dividends received from our subsidiaries during 2012.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2012, our health plans had aggregate statutory capital and surplus of approximately $557.9 million compared with the required minimum aggregate statutory capital and surplus of approximately $345.7 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2012. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Future Sources and Uses of Liquidity

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we issued $550 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020, or the Notes. The Notes bear interest at a rate of 1.125% per year, payable semiannually in arrears on January 15 and July 15 of each year, beginning on July 15, 2013. The Notes will mature on January 15, 2020.

The Notes are not convertible into our common stock or any other securities under any circumstances. Holders may convert their Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of Notes, equal to the settlement amount, determined in the manner set forth in the Indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment

in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its Notes in connection with such a corporate event in certain circumstances. We may not redeem the Notes prior to the maturity date, and no sinking fund is provided for the Notes.

If we undergo a fundamental change (as defined in the indenture to the Notes), holders may require us to repurchase for cash all or part of their Notes at a repurchase price equal to 100% of the principal amount of the Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The Notes will be senior unsecured obligations of the Company and will rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

Cash Convertible Note Hedge and Warrant Transactions

In connection with the pricing of the Notes, on February 11, 2013, we entered into cash convertible note hedge transactions and warrant transactions relating to a notional number of shares of our common stock underlying the Notes to be issued by us (without regard to the initial purchasers' $100 million over-allotment option) with two counterparties, JPMorgan Chase Bank, National Association, London Branch and Bank of America, N.A. (the "Option Counterparties"). The cash convertible note hedge transactions are intended to offset cash payments due upon any conversion of the Notes. However, the warrant transactions could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the warrants. The strike price of the warrants will initially be $53.8475 per share, which is 75% above the last reported sale price of our common stock on February 11, 2013.

In connection with the exercise in full by the initial purchasers of their over-allotment option in respect of the Notes, on February 13, 2013, we and the Option Counterparties amended the cash convertible note hedge transactions entered into on February 11, 2013 to upsize such transactions by a notional number of shares of our common stock corresponding to the number of shares underlying the Notes purchased pursuant to the exercise of such over-allotment option. On February 13, 2013, we also entered into additional warrant transactions with the Option Counterparties relating to a number of shares of our common stock corresponding to the number of shares underlying the Notes purchased pursuant to the exercise of such over-allotment option. Each of the amendments to the cash convertible note hedge transactions and the additional warrant transactions were on substantially similar terms to the corresponding transactions entered into on February 11, 2013. Pursuant to these warrant transactions, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

We used approximately $74.3 million of the net proceeds from the offering to pay the cost of the cash convertible note hedge transactions (after such cost was partially offset by the proceeds to us from the sale of warrants in the warrant transactions and the additional warrant transactions).

Aside from the initial payment of a premium to the Option Counterparties of approximately $149.3 million, we will not be required to make any cash payments to the Option Counterparties under the cash convertible note hedge transactions and will be entitled to receive from the Option Counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the cash convertible note hedge transactions during the relevant valuation period. The strike price under the cash convertible note hedge transactions is initially equal to the conversion price of the Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the warrants on any trading day during the 160 trading day measurement period under the warrant transactions and the additional warrant transactions, we will be obligated to issue to the Option Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the warrant transactions and the additional warrant transactions, subject to a share delivery cap. The Company will not receive any additional proceeds if warrants are exercised.

Repurchase in Connection with Offering of 1.125% Cash Convertible Senior Notes Due 2020

We used a portion of the net proceeds in this offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Credit Facility

On February 15, 2013, we used approximately $40.0 million of the net proceeds from the offering of the Notes to repay all of the outstanding indebtedness under our $170 million revolving credit facility, or the Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the Notes. Two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution. The Credit Facility had a term of five years under which all amounts outstanding would have been due and payable on September 9, 2016.

Borrowings under the Credit Facility accrued interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we were required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The applicable margins ranged between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility were secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan). The Credit Facility included usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also required us to maintain as of the end of any fiscal quarter (calculated for each four consecutive fiscal quarter period) a ratio of total consolidated debt to total consolidated EBITDA, as defined in the Credit Facility, of not more than 2.75 to 1.00, and a fixed charge coverage ratio of not less than 1.75 to 1.00. At December 31, 2012, we were in compliance with all financial covenants under the Credit Facility.

3.75% Convertible Senior Notes due 2014

As of December 31, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014, or the 3.75% Notes, remain outstanding. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement, dated as of December 1, 2011, with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. "Interest Period" means the period commencing on the first day of each calendar month and ending on the last day of each calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, or Swap Agreement, with an effective date of March 1, 2013. While not designated as a hedge during the year ended December 31, 2012, the Swap Agreement is intended to reduce our exposure to fluctuations in the contractual variable interest rates under our Term Loan Agreement, and expires on the maturity date of the Term Loan Agreement, which is November 30, 2018. Under the Swap Agreement, we will receive a variable rate of the one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. The Swap Agreement is measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. Gains and losses relating to changes in fair value are reported in earnings in the current period. For the year ended December 31, 2012, we have recorded losses of $1.3 million to general and administrative expense. As of December 31, 2012 the fair value of the Swap Agreement is a liability of $1.3 million, recorded to other noncurrent liabilities. We do not use derivatives for trading or speculative purposes. We believe that we are not exposed to more than a nominal amount of credit risk relating to the Swap Agreement because the counterparty is an established and well-capitalized financial institution.

Shelf Registration Statement

In May 2012, we filed an automatic shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Securities Repurchase Program

Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior note due 2014. The repurchase program extends through December 31, 2014.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and;
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

- *California Health Plan Medical Cost Floors (Minimums):* A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We

recorded a liability under the terms of these contract provisions of $0.3 million and $1.0 million at December 31, 2012, and December 31, 2011, respectively.

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both December 31, 2012 and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.
- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. At both December 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of these contract provisions.
- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we accrued an aggregate liability of approximately $3.2 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at December 31, 2012 and December 31, 2011, respectively.
- *Washington Health Plan Medical Cost Floors (Minimums):* A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At both December 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision because medical expenses are not less than the contractual floor.
- *Medicare Revenue Risk Adjustment:* Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $0.3 million and $5.0 million for anticipated Medicare risk adjustment premiums at December 31, 2012, and December 31, 2011, respectively.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

- *New Mexico Health Plan Quality Incentive Premiums:* Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.
- *Ohio Health Plan Quality Incentive Premiums:* Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.
- *Texas Health Plan Quality Incentive Premiums:* Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.
- *Wisconsin Health Plan Quality Incentive Premiums:* Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of premium revenue is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2012.

	Year Ended December 31, 2012				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,244	$ 1,889	$ 643	$ 2,532	$ 338,770
Ohio	12,033	8,079	966	9,045	1,187,422
Texas	58,516	52,521	—	52,521	1,255,722
Wisconsin	1,771	—	593	593	70,673
	$ 74,564	$ 62,489	$ 2,202	$ 64,691	$ 2,852,587

	Year Ended December 31, 2011				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,271	$ 1,558	$ 378	$ 1,936	$ 345,732
Ohio	10,212	8,363	3,501	11,864	988,896
Texas	—	—	—	—	409,295
Wisconsin	1,705	542	—	542	69,596
	$ 14,188	$ 10,463	$ 3,879	$ 14,342	$ 1,813,519

	Year Ended December 31, 2010				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,581	$ 1,311	$ 579	$ 1,890	$ 366,784
Ohio	9,881	3,114	(1,248)	1,866	860,324
Texas	1,771	1,771	—	1,771	188,716
	$ 14,233	$ 6,196	$ (669)	$ 5,527	$ 1,415,824

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid

Solutions contracts - which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) - are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, Revenue Recognition — Multiple –Element Arrangements, and SEC Staff Accounting Bulletin Topic 13, Revenue Recognition.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011 or 2012. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and

- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions)

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs.
- Employee costs incurred in performing transaction services.
- Vendor costs incurred in performing transaction services.
- Costs incurred in performing required monitoring of and reporting on contract performance.
- Costs incurred in maintaining and processing member and provider eligibility.
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	December 31,		
	2012	2011	2010
	(In thousands)		
Fee-for-service claims incurred but not paid (IBNP)	$ 377,614	$ 301,020	$ 275,259
Capitation payable	49,066	53,532	49,598
Pharmacy	38,992	26,178	14,649
Other	28,858	21,746	14,850
	$ 494,530	$ 402,476	$ 354,356

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $377.6 million of our total medical claims and benefits payable of $494.5 million as of December 31, 2012. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at December 31, 2012, was $371.4 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the

administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2012 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2012, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 152,598
(4)%	101,732
(2)%	50,866
2%	(50,866)
4%	(101,732)
6%	(152,598)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2012 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ (75,312)
(4)%	(50,208)
(2)%	(25,104)
2%	25,104
4%	50,208
6%	75,312

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and $47.0 million diluted shares outstanding for the year ended December 31, 2012. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2012, net income for the year ended December 31, 2012 would increase or decrease by approximately $15.9 million, or $0.34 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2012, net income for the year ended December 31, 2012 would increase or decrease by approximately $7.8 million, or $0.17 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $79.5 million, or $1.69 per diluted share, and $39.2 million, or $0.83 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of

net income by approximately $15.9 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore never perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range. For example, for the years ended December 31, 2011 and 2010, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2010 and 2009, by 14.6% and 15.7%, respectively. Furthermore, because the initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more of those factors are out of the ordinary.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2012, 2011, and 2010 were less than what we had expected when we established our reserves. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimate.

We recognized a benefit from prior period claims development in the amount of $39.3 million for the year ended December 31, 2012. This amount represents our estimate as of December 31, 2012, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe that the overestimation of our claims liability at December 31, 2011 was due primarily to the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.

- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.
- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

We recognized a benefit from prior period claims development in the amount of $51.8 million for the year ended December 31, 2011. This amount represents our estimate as of December 31, 2011, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe that the overestimation of our claims liability at December 31, 2010 was due primarily to the following factors:

- At our Ohio health plan, we overestimated the impact of a buildup in claims inventory.
- At our California health plan, we overestimated the impact of the settlement of disputed provider claims.
- At our New Mexico health plan, we underestimated the impact of a reduction in the outpatient facility fee schedule.

We recognized a benefit from prior period claims development in the amount of $49.4 million for the year ended December 31, 2010. This amount represents our estimate as of December 31, 2010, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2009 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe that the overestimation of our claims liability at December 31, 2009 was due primarily to the following factors:

- At our New Mexico health plan, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- At our California health plan, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at December 31, 2012, we adjusted our base calculation to take account of the numerous factors that we believe will likely change our final claims liability amount. We believe that the most significant among those factors are:

- Our Texas health plan membership nearly doubled effective March 1, 2012. In addition, effective March 1, 2012, we assumed inpatient medical liability for ABD members for which we were not previously responsible. Reserves for new coverage and new regions are now based on the newly developing claims lag patterns. While the lag patterns are now beginning to stabilize for the new membership and coverage, the true reserve liability continues to be more uncertain than usual.
- Data published by the Centers for Disease Control, or CDC, indicated a significant increase in the percentage of office visits for influenza-like illnesses, or ILI, during December 2012. This indicated that the annual flu season was starting earlier than it had in most recent years. This was most noticeable in the southeast region of the country, but impacted other areas as well. Our leading indicators, including inpatient authorizations and overall pharmacy utilization, did not show as great an increase as we had expected based on the severity of the CDC's flu-related indices. However, we did see a significant increase in the use of prescription flu medication, especially in our Texas health plan. Therefore, we increased our reserves to account for expected additional utilization due to the early onset of the flu season.
- Our California health plan has enrolled approximately 20,000 new ABD members since September 30, 2011, as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members converted from a fee-for-service environment. Due to the relatively recent transition of these members to managed care, their utilization of medical services is less predictable than it is for many of our other members.
- Prior to July 2012, it was the state of Washington's practice to disenroll certain sick newborns from the Healthy Options Medicaid managed care program and cover them under the Supplemental Security Income program, or SSI, instead. When this occurred, the health plan would reimburse the premiums received for that member back to the state and the state in turn reimbursed the health plan for the cost of care, usually retroactively to the date of birth. Effective July 1, 2012, the health plans now retain these members and cover them under a new ABD program entitled Healthy Options Blind and Disabled, or HOBD. The premium we receive from the state for the HOBD members is very high to cover

the substantial cost of care. By December, we had enrolled approximately 26,000 members under HOBD. Because the program is relatively new, there is still some uncertainty as to the level of claims to be expected from these high-cost members.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012, 2011 and 2010, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In these years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "Components of medical care costs related to: Prior year" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period was more than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year ended December 31,		
	2012	2011	2010
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of period	$ 402,476	$ 354,356	$ 315,316
Balance of acquired subsidiary	—	—	3,228
Components of medical care costs related to:			
Current year	5,136,055	3,911,803	3,420,235
Prior year	(39,295)	(51,809)	(49,378)
Total medical care costs	5,096,760	3,859,994	3,370,857
Payments for medical care costs related to:			
Current year	4,649,363	3,516,994	3,085,388
Prior year	355,343	294,880	249,657
Total paid	5,004,706	3,811,874	3,335,045
Balances at end of year	$ 494,530	$ 402,476	$ 354,356
Benefit from prior years as a percentage of:			
Balance at beginning of year	9.8%	14.6%	15.7%
Premium revenue	0.7%	1.1%	1.2%
Total medical care costs	0.8%	1.3%	1.5%
Claims Data			
Days in claims payable, fee for service	40	40	42
Number of members at end of period	1,797,000	1,697,000	1,613,000
Number of claims in inventory at end of period	122,700	111,100	143,600
Billed charges of claims in inventory at end of period	$ 255,200	$ 207,600	$ 218,900
Claims in inventory per member at end of period	0.07	0.07	0.09
Billed charges of claims in inventory per member end of period	$ 142.01	$ 122.33	$ 135.71
Number of claims received during the period	20,842,400	17,207,500	14,554,800
Billed charges of claims received during the period	$ 19,429,300	$ 14,306,500	$ 11,686,100

Commitments and Contingencies

We are not an obligor to or guarantor of any indebtedness of any other party, except for our obligation to pay benefits under policies in-force relating to an insurance subsidiary we sold in the first quarter of 2012, in the event such benefits are not paid by the reinsurer or current owner. This transaction is more fully described in Note 19 to the accompanying audited consolidated financial statements for the year ended December 31, 2012.

We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 19 to the accompanying audited consolidated financial statements for the year ended December 31, 2012.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2012. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2013	2014-2015	2016-2017	2018 and Beyond
Medical claims and benefits payable	$ 494,530	$ 494,530	$ —	$ —	$ —
Principal amount of long-term debt(1)	274,471	1,155	189,465	42,681	41,170
Operating leases	86,276	26,866	36,228	15,411	7,771
Interest on long-term debt	23,465	9,035	9,150	3,675	1,605
Purchase commitments	37,537	19,367	17,645	525	—
Total contractual obligations	$ 916,279	$ 550,953	$ 252,488	$ 62,292	$ 50,546

(1) Represents the principal amount due on our 3.75% Convertible Senior Notes due 2014, our term loan due 2018, and the Credit Facility due 2016.

As of December 31, 2012, we have recorded approximately $10.6 million of unrecognized tax benefits. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 13 to the accompanying audited consolidated financial statements for the year ended December 31, 2012 for further information.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

We are also exposed to interest rate risk relating to contractual variable interest rates under our Term Loan Agreement which matures on November 30, 2018. The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period commencing January 1, 2012. We manage this floating rate debt using an Interest Rate Swap Agreement that is intended to reduce our exposure to the impact of changing interest rates to our consolidated results of operations and future outflows for interest expense. Under the Swap Agreement, we will receive a variable rate of one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. At December 31, 2012, a hypothetical 1% increase in the Eurodollar rate would result in a $1.6 million favorable change in the fair value of our Interest Rate Swap Agreement. This favorable change would reduce our exposure to a hypothetical 1% increase in the Eurodollar rate on the outstanding borrowings of our Term Loan, that would result in additional interest expense of only $0.5 million. See Note 12 of the accompanying audited consolidated financial statements for the year ended December 31, 2012 for more information on the Term Loan Agreement and Interest Rate Swap Agreement.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 8. ***Financial Statements and Supplementary Data***

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2012 and 2011, and the related consolidated statements of income and comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2012. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2012 and 2011, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2012, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2012, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 28, 2013 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 28, 2013

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2012	2011
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 795,770	$ 493,827
Investments	342,845	336,916
Receivables	149,682	167,898
Income tax refundable	—	11,679
Deferred income taxes	32,443	18,327
Prepaid expenses and other current assets	28,386	19,435
Total current assets	1,349,126	1,048,082
Property, equipment, and capitalized software, net	221,443	190,934
Deferred contract costs	58,313	54,582
Intangible assets, net	77,711	101,796
Goodwill and indefinite-lived intangible assets	151,088	153,954
Auction rate securities	13,419	16,134
Restricted investments	44,101	46,164
Receivable for ceded life and annuity contracts	—	23,401
Other assets	19,621	17,099
	$ 1,934,822	$ 1,652,146
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 494,530	$ 402,476
Accounts payable and accrued liabilities	184,034	147,214
Deferred revenue	141,798	50,947
Income taxes payable	6,520	—
Current maturities of long-term debt	1,155	1,197
Total current liabilities	828,037	601,834
Long-term debt	261,784	216,929
Deferred income taxes	37,900	33,127
Liability for ceded life and annuity contracts	—	23,401
Other long-term liabilities	24,787	21,782
Total liabilities	1,152,508	897,073
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 46,762 shares at December 31, 2012 and 45,815 shares at December 31, 2011	47	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	285,524	266,022
Accumulated other comprehensive loss	(457)	(1,405)
Treasury stock, at cost; 111 shares at December 31, 2012	(3,000)	—
Retained earnings	500,200	490,410
Total stockholders' equity	782,314	755,073
	$ 1,934,822	$ 1,652,146

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2012	2011	2010
	(In thousands, except per-share data)		
Revenue:			
Premium revenue	$ 5,826,491	$ 4,603,407	$ 3,989,909
Service revenue	187,710	160,447	89,809
Investment income	5,188	5,539	6,259
Rental income	9,374	547	—
Total revenue	6,028,763	4,769,940	4,085,977
Expenses:			
Medical care costs	5,096,760	3,859,994	3,370,857
Cost of service revenue	141,208	143,987	78,647
General and administrative expenses	532,627	415,932	345,993
Premium tax expenses	158,991	154,589	139,775
Depreciation and amortization	63,704	50,690	45,704
Total expenses	5,993,290	4,625,192	3,980,976
Impairment of goodwill and intangible assets	—	(64,575)	—
Operating income	35,473	80,173	105,001
Other expenses (income):			
Interest expense	16,769	15,519	15,509
Other income	(361)	—	—
Total other expenses (income)	16,408	15,519	15,509
Income before income taxes	19,065	64,654	89,492
Provision for income taxes	9,275	43,836	34,522
Net income	$ 9,790	$ 20,818	$ 54,970
Net income per share:			
Basic	$ 0.21	$ 0.45	$ 1.34
Diluted	0.21	0.45	1.32
Weighted average shares outstanding:			
Basic	46,380	45,756	41,174
Diluted	46,999	46,425	41,631

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2012	2011	2010
	(In thousands)		
Net income	$ 9,790	$ 20,818	$ 54,970
Other comprehensive income (loss), before tax:			
Unrealized gain (loss) on investments	1,529	1,167	(613)
Total other comprehensive income (loss), before tax	1,529	1,167	(613)
Income tax expense (benefit) related to items of other comprehensive income	581	380	(233)
Total other comprehensive income (loss), net of tax	948	787	(380)
Comprehensive income	$ 10,738	$ 21,605	$ 54,590

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MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2012	2011	2010
		(In thousands)	
Operating activities:			
Net income	$ 9,790	$ 20,818	$ 54,970
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	78,764	74,383	60,765
Deferred income taxes	(9,887)	13,836	(4,092)
Stock-based compensation	20,018	17,052	9,531
Non-cash interest on convertible senior notes	5,942	5,512	5,114
Impairment of goodwill and intangible assets	—	64,575	—
Change in fair value of interest rate swap	1,307	—	—
Amortization of premium/discount on investments	6,746	7,242	2,029
Amortization of deferred financing costs	1,089	2,818	1,780
Gain on sale of subsidiary	(1,747)	—	—
Loss on disposal of property and equipment	2,608	—	—
Gain on acquisition	—	(1,676)	—
Unrealized gain on trading securities	—	—	(4,170)
Loss on rights agreement	—	—	3,807
Tax deficiency from employee stock compensation	(526)	(714)	(968)
Changes in operating assets and liabilities:			
Receivables	18,216	352	(7,539)
Prepaid expenses and other current assets	(8,958)	3,308	(12,034)
Medical claims and benefits payable	92,054	48,120	34,363
Accounts payable and accrued liabilities	23,345	2,778	40,482
Deferred revenue	90,851	(8,154)	(41,899)
Income taxes	18,172	(24,855)	19,258
Net cash provided by operating activities	347,784	225,395	161,397
Investing activities:			
Purchases of equipment	(78,145)	(60,581)	(48,538)
Purchases of investments	(306,437)	(345,968)	(302,842)
Sales and maturities of investments	298,006	302,667	223,077
Net cash paid in business combinations	—	(84,253)	(130,743)
Proceeds from sale of subsidiary, net of cash surrendered	9,162	—	—
Increase in deferred contract costs	(11,610)	(42,830)	(29,319)
Increase in restricted investments	(2,647)	(4,064)	(5,566)
Change in other noncurrent assets and liabilities	(1,913)	(1,898)	5,108
Net cash used in investing activities	(93,584)	(236,927)	(288,823)
Financing activities:			
Amount borrowed under term loan	—	48,600	—
Amount borrowed under credit facility	60,000	—	105,000
Proceeds from common stock offering, net of issuance costs	—	—	111,131
Repayment of amount borrowed under credit facility	(20,000)	—	(105,000)
Treasury stock purchases	(3,000)	(7,000)	—
Credit facility fees paid	—	(1,125)	(1,671)
Principal payments on term loan	(1,129)	—	—
Proceeds from employee stock plans	8,205	7,347	4,056
Excess tax benefits from employee stock compensation	3,667	1,651	295
Net cash provided by financing activities	47,743	49,473	113,811
Net increase (decrease) in cash and cash equivalents	301,943	37,941	(13,615)
Cash and cash equivalents at beginning of period	493,827	455,886	469,501
Cash and cash equivalents at end of period	$ 795,770	$ 493,827	$ 455,886

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Year Ended December 31,		
	2012	**2011**	**2010**
	(In thousands)		
Supplemental cash flow information:			
Cash (received) paid during the period for:			
Income taxes	$ (4,634)	$ 54,663	$ 18,299
Interest	$ 10,099	$ 11,399	$ 10,951
Schedule of non-cash investing and financing activities:			
Retirement of treasury stock	$ —	$ 7,000	$ —
Retirement of common stock used for stock-based compensation	$ (11,862)	$ (3,926)	$ (2,316)
Details of sale of subsidiary			
Decrease in carrying value of assets	30,942	—	—
Decrease in carrying value of liabilities	(23,527)	—	—
Gain on sale	1,747	—	—
Proceeds from sale of subsidiary, net of cash surrendered	9,162	—	—
Details of business combinations:			
Increase in fair value of assets acquired	$ —	$ (81,256)	$ (159,916)
(Decrease) increase in fair value of liabilities assumed	—	(1,045)	24,450
(Decrease) increase in payable to seller	—	(1,952)	4,723
Net cash paid in business combinations	$ —	$ (84,253)	$ (130,743)

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
	(In thousands)						
Balance at January 1, 2010	38,410	$ 38	$ 129,890	$ (1,812)	$ 414,622	$ —	$ 542,738
Net income	—	—	—	—	54,970	—	54,970
Other comprehensive loss, net of tax	—	—	—	(380)	—	—	(380)
Common stock issued, net of issuance costs	6,525	7	111,124	—	—	—	111,131
Employee stock grants and employee stock purchase plans	528	—	11,271	—	—	—	11,271
Tax deficiency from employee stock compensation	—	—	(673)	—	—	—	(673)
Balance at December 31, 2010	45,463	45	251,612	(2,192)	469,592	—	719,057
Net income	—	—	—	—	20,818	—	20,818
Other comprehensive income, net of tax	—	—	—	787	—	—	787
Purchase of treasury stock	—	—	—	—	—	(7,000)	(7,000)
Retirement of treasury stock	(400)	—	(7,000)	—	—	7,000	—
Employee stock grants and employee stock plan purchases	752	1	20,473	—	—	—	20,474
Tax benefit from employee stock compensation	—	—	937	—	—	—	937
Balance at December 31, 2011	45,815	46	266,022	(1,405)	490,410	—	755,073
Net income	—	—	—	—	9,790	—	9,790
Other comprehensive income, net of tax	—	—	—	948	—	—	948
Purchase of treasury stock	(111)	—	—	—	—	(3,000)	(3,000)
Employee stock grants and employee stock plan purchases	1,058	1	16,361	—	—	—	16,362
Tax benefit from employee stock compensation	—	—	3,141	—	—	—	3,141
Balance at December 31, 2012	46,762	$ 47	$ 285,524	$ (457)	$ 500,200	$ (3,000)	$ 782,314

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of December 31, 2012, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care clinics in California, Florida, New Mexico and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan’s prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. As of December 31, 2012, we continued to process claims that were incurred by the Missouri health plan's members through the June 30, 2012 termination date. For the six months ended June 30, 2012, our Missouri health plan contributed premium revenue of $113.8 million, or 4.1% of total premium revenue, and comprised 79,000 members, or 4.3% of total Health Plans segment membership as of June 30, 2012.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On July 13, 2012, our Molina Medicaid Solutions segment received full federal certification of its Medicaid Management Information System, or MMIS, in the state of Idaho from CMS. As a result of the CMS certification, the state of Idaho is entitled to receive federal reimbursement of 75% of its MMIS operations costs retroactive to June 1, 2010, the date that the system first began processing claims. Our MMIS in Maine received full federal certification from CMS on December 19, 2011.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement MMIS to another company. For the year ended December 31, 2012, our revenue under the Louisiana MMIS contract was $54.9 million, or 29.2% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize approximately $40 million in revenue annually under our Louisiana MMIS contract.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its wholly owned subsidiaries, and two variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 18,

"Variable Interest Entities," for more information regarding these variable interest entities. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The determination of medical claims and benefits payable of our Health Plans segment;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis.

Our investment policy requires that all of our investments have final maturities of five years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be two years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. Our auction rate securities are classified as non-current assets. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," Note 6, "Investments" and Note 10, "Restricted Investments."

Receivables

Receivables are readily determinable, our creditors are primarily state governments, and our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables."

Property, Equipment, and Capitalized Software

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years. See Note 8, “Property, Equipment, and Capitalized Software.”

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in “Depreciation and Amortization” in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading “Depreciation and amortization;”
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of “Service revenue;” and
- Depreciation is recorded within the heading “Cost of service revenue.”

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,		
	2012	2011	2010
	(Dollar amounts in thousands)		
Depreciation, and amortization of capitalized software	$ 43,201	$ 30,864	$ 27,230
Amortization of intangible assets	20,503	19,826	18,474
Depreciation and amortization reported as such in the consolidated statements of income	63,704	50,690	45,704
Amortization recorded as reduction of service revenue	1,571	6,822	8,316
Amortization of capitalized software recorded as cost of service revenue	13,489	16,871	6,745
Total	$ 78,764	$ 74,383	$ 60,765

Long-Lived Assets, including Intangible Assets

Long-lived assets comprise primarily property, equipment, capitalized software and intangible assets. Finite-lived, separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at their fair values and are then amortized on a straight-line basis over their expected useful lives, generally between one and 15 years.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships as follows:

- The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to the acquisition. Because each

acquired contract constitutes a single revenue stream, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a straight-line basis for each specific contract over periods generally ranging from one to six years. The contract backlog intangible assets will be fully amortized in 2015.

- The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed as in the case of our Missouri health plan, described below.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

On February 17, 2012, we received notification that our Missouri Health plan's contract with the state of Missouri would expire without renewal on June 30, 2012. As a result, we recorded a total non-cash impairment charge of $64.6 million in 2011, of which $6.1 million related to finite-lived intangible assets, and $58.5 million related to goodwill, discussed below. The impairment charge comprised substantially all intangible assets relating to contract rights and licenses, and provider networks recorded at the time of our acquisition of the Missouri health plan in 2007. No impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2012, and 2010.

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we measure the fair values of our reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows. To determine fair values, we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

In connection with our Missouri health plan as described above, we recorded a non-cash impairment charge of $58.5 million in the fourth quarter of 2011. The impairment charge comprised all of the goodwill recorded at the time of our acquisition of the Missouri health plan in 2007, and was not tax deductible. No impairment charges relating to goodwill were recorded in the years ended December 31, 2012, and 2010.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Other Assets

Significant items included in other assets include deferred financing costs associated with our convertible senior notes and with our credit facility, certain investments held in connection with our employee deferred compensation program, and an

investment in a vision services provider (see Note 17, “Related Party Transactions”). The deferred financing costs are being amortized on a straight-line basis over the seven-year term of the convertible senior notes and the five-year term of the credit facility. See Note 12, "Long-Term Debt," regarding the termination of the Credit Facility.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states’ laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2012, or December 31, 2011.

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2012 we received approximately 96% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue by health plan for the periods indicated:

	Year Ended December 31,		
	2012	2011	2010
	(In thousands)		
California	$ 671,489	$ 575,176	$ 506,871
Florida	228,828	203,945	170,683
Michigan	658,741	662,127	630,134
Missouri(1)	113,818	229,584	210,852
New Mexico	338,770	345,732	366,784
Ohio	1,187,422	988,896	860,324
Texas	1,255,722	409,295	188,716
Utah	298,392	287,290	258,076
Washington	992,748	823,323	758,849
Wisconsin	70,673	69,596	30,033
Other	9,888	8,443	8,587
	$ 5,826,491	$ 4,603,407	$ 3,989,909

(1) Our contract with the state of Missouri expired without renewal on June 30, 2012.

For the year ended December 31, 2012, we received approximately 4% of our premium revenue in the form of “birth income” — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

- *California Health Plan Medical Cost Floors (Minimums):* A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of $0.3 million and $1.0 million at December 31, 2012, and December 31, 2011, respectively.

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both December 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. At both December 31, 2012, and December 31, 2011 we had not recorded any liability under the terms of these contract provisions.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we accrued an aggregate liability of approximately $3.2 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at December 31, 2012 and December 31, 2011, respectively.

- *Washington Health Plan Medical Cost Floors (Minimums):* A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At both December 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision because medical expenses are not less than the contractual floor.

- *Medicare Revenue Risk Adjustment:* Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to 2 years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $0.3 million and $5.0 million for anticipated Medicare risk adjustment premiums at December 31, 2012 and December 31, 2011, respectively.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress

in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

- *New Mexico Health Plan Quality Incentive Premiums:* Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.
- *Ohio Health Plan Quality Incentive Premiums:* Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.
- *Texas Health Plan Quality Incentive Premiums:* Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.
- *Wisconsin Health Plan Quality Incentive Premiums:* Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of premium revenue is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2012.

	Year Ended December 31, 2012				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,244	$ 1,889	$ 643	$ 2,532	$ 338,770
Ohio	12,033	8,079	966	9,045	1,187,422
Texas	58,516	52,521	—	52,521	1,255,722
Wisconsin	1,771	—	593	593	70,673
	$ 74,564	$ 62,489	$ 2,202	$ 64,691	$ 2,852,587

	Year Ended December 31, 2011				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,271	$ 1,558	$ 378	$ 1,936	$ 345,732
Ohio	10,212	8,363	3,501	11,864	988,896
Texas	—	—	—	—	409,295
Wisconsin	1,705	542	—	542	69,596
	$ 14,188	$ 10,463	$ 3,879	$ 14,342	$ 1,813,519

	Year Ended December 31, 2010				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,581	$ 1,311	$ 579	$ 1,890	$ 366,784
Ohio	9,881	3,114	(1,248)	1,866	860,324
Texas	1,771	1,771	—	1,771	188,716
	$ 14,233	$ 6,196	$ (669)	$ 5,527	$ 1,415,824

Medical Care Costs

Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. Most hospitals are paid on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups, or DRGs, percent of billed charges, and case rates. As discussed below, we also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed per-member per-month, or PMPM, payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit manager. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2012, 2011, and 2010, medically related administrative costs were approximately $127.5 million, $102.3 million, and $85.5 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2012			2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 3,521,960	$ 162.60	69.1%	$ 2,764,309	$ 139.02	71.6%	$ 2,360,858	$ 128.73	70.0%
Capitation	557,087	25.72	10.9	518,835	26.09	13.4	555,487	30.29	16.5
Pharmacy	835,830	38.59	16.4	418,007	21.02	10.8	325,935	17.77	9.7
Other	181,883	8.39	3.6	158,843	8.00	4.2	128,577	7.01	3.8
Total	$ 5,096,760	$ 235.30	100.0%	$ 3,859,994	$ 194.13	100.0%	$ 3,370,857	$ 183.80	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related

administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates. See Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Our California (through June 30, 2012), Florida, Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in premium tax expense.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2012, or 2011.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts - which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) - are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, Revenue Recognition — Multiple –Element Arrangements, and SEC Staff Accounting Bulletin Topic 13, Revenue Recognition.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to

each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011 or 2012. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs.
- Employee costs incurred in performing transaction services.
- Vendor costs incurred in performing transaction services.
- Costs incurred in performing required monitoring of and reporting on contract performance.
- Costs incurred in maintaining and processing member and provider eligibility.
- Costs incurred in communicating with members and providers.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any

remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes and nondeductible compensation and other general and administrative expenses. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers. For further discussion and disclosure, see Note 13, “Income Taxes.”

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2012, and 2011, our investments with PFM totaled $428 million and $209 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2012, we operated health plans in nine states, primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements

Technical Corrections and Improvements. In October 2012, the Financial Accounting Standards Board, or FASB, issued guidance related to amendments that cover a wide range of Topics in the Accounting Standards Codification. These amendments include technical corrections and improvements to the Accounting Standards Codification and conforming amendments related to fair value measurements. The amendments that do not have transition guidance became effective upon issuance. The amendments that are subject to transition guidance become effective for fiscal periods beginning after December 15, 2012. The adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows.

Balance Sheet Offsetting. In January 2013, the FASB issued guidance for new disclosure requirements related to the nature of an entity's rights of setoff and related arrangements associated with certain financial instruments and derivative instruments. The new guidance is effective for annual reporting periods, and interim periods within those years, beginning on or after January 1, 2013. While we do not expect the adoption of this guidance in 2013 to impact our financial position, results of operations or cash flows, it may change our disclosure policies relative to certain arrangements with rights of setoff.

Goodwill. In September 2011, the FASB issued guidance related to evaluating goodwill for impairment. The new guidance provides entities with the option to perform a qualitative assessment of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount before applying the quantitative two-step goodwill impairment test. If an entity

concludes that it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, it would not be required to perform the quantitative two-step goodwill impairment test. Entities also have the option to bypass the assessment of qualitative factors for any reporting unit in any period and proceed directly to performing the first step of the quantitative two-step goodwill impairment test, as was required prior to the issuance of this new guidance. An entity may begin or resume performing the qualitative assessment in any subsequent period. The new guidance became effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2011, with early adoption permitted. The adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows.

Federal Premium-Based Assessment. In July 2011, the FASB issued guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (the "Affordable Care Act"). The Affordable Care Act imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014 that is allocated to health insurers based on the ratio of the amount of an entity's net premium revenues written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. The new guidance specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The new guidance is effective for annual reporting periods beginning after December 31, 2013, when the fee initially becomes effective. As enacted, this federal premium-based assessment is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this premium-based assessment will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this assessment as currently written will have a material impact on our financial position, results of operations, or cash flows in future periods.

Comprehensive Income. In June 2011, the FASB issued guidance, as amended in December 2011, related to the presentation of other comprehensive income. The new guidance provides entities with an option to either replace the statement of income with a statement of comprehensive income which would display both the components of net income and comprehensive income in a combined statement, or to present a separate statement of comprehensive income immediately following the statement of income. The new guidance does not affect the components of other comprehensive income or the calculation of earnings per share. To be applied retrospectively with early adoption permitted, the new guidance became effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2011. We have elected to present a separate statement of comprehensive income immediately following the statement of income. The adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows.

Fair Value. In May 2011, the FASB issued guidance related to fair value measurement and disclosure. The new guidance is a result of joint efforts by the FASB and the International Accounting Standards Board to develop a single converged fair value framework. The new guidance expands existing disclosure requirements for fair value measurements and makes other amendments; mostly to eliminate wording differences between U.S. generally accepted accounting principles, or GAAP, and international financial reporting standards. To be applied prospectively, the new guidance became effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2011. Although the adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows, it did change our disclosure policies relative to fair value measurements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	December 31,		
	2012	2011	2010
	(In thousands)		
Shares outstanding at the beginning of the period	45,815	45,463	38,410
Weighted-average number of shares issued under equity offering	—	—	2,506
Weighted-average number of shares purchased	(2)	(160)	—
Weighted-average number of shares issued under employee stock plans	567	453	258
Denominator for basic earnings per share	46,380	45,756	41,174
Dilutive effect of employee stock options and stock grants(1)	619	669	457
Denominator for diluted earnings per share(2)	46,999	46,425	41,631

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2012, 2011, and 2010 there were approximately 87,000, 137,000 and 478,000 anti-dilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the year ended December 31, 2012, there were approximately 304,000 anti-dilutive restricted shares. For the years ended December 31, 2011 and 2010, anti-dilutive restricted shares were insignificant.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the years ended December 31, 2012, 2011, and 2010.

4. Business Combinations

Molina Center

On December 7, 2011, our wholly owned subsidiary Molina Center LLC acquired a 460,000 square foot office building located in Long Beach, California. The building, or Molina Center, consists of two conjoined fourteen-story office towers on approximately five acres of land. For the last several years we have leased approximately 155,000 square feet of the Molina Center for use as our corporate headquarters and also for use by our California health plan subsidiary. The final purchase price was $81 million, which amount was paid with a combination of cash on hand and bank financing under a term loan agreement. We acquired this business primarily to facilitate space needs for the projected future growth of the Company.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.
- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets, and an interest rate swap derivative recorded as a noncurrent liability. Our investments classified as Level 2 are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Fair value for the interest rate swap derivative is based on forward LIBOR rates that are and will be observable at commonly

quoted intervals for the full term of the interest rate swap agreement. See Note 12, "Long-Term Debt," for further information regarding the interest rate swap agreement.

- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* Our Level 3 financial instruments recorded at fair value consist of non-current auction rate securities that are designated as available-for-sale, and are reported at fair value of $13.4 million (par value of $14.7 million) as of December 31, 2012. To estimate the fair value of these securities we use valuation data from our primary pricing source, a third party who provides a marketplace for illiquid assets with over 10,000 participants including global financial institutions, hedge funds, private equity funds, mutual funds, corporations and other institutional investors. This valuation data is based on a range of prices that represent indicative bids from potential buyers. To validate the reasonableness of the data, we compare these valuations to data from two other third-party pricing sources, which also provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of December 31, 2012.

Our financial instruments measured at fair value on a recurring basis at December 31, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 191,008	$ —	$ 191,008	$ —
GSEs	29,525	29,525	—	—
Municipal securities	75,848	—	75,848	—
U.S. treasury notes	35,740	35,740	—	—
Auction rate securities	13,419	—	—	13,419
Certificates of deposit	10,724	—	10,724	—
Total assets at fair value	$ 356,264	$ 65,265	$ 277,580	$ 13,419
Interest rate swap liability	$ 1,307	$ —	$ 1,307	$ —

Our financial instruments measured at fair value on a recurring basis at December 31, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 231,634	$ —	$ 231,634	$ —
GSEs	33,949	33,949	—	—
Municipal securities	47,313	—	47,313	—
U.S. treasury notes	21,748	21,748	—	—
Auction rate securities	16,134	—	—	16,134
Certificates of deposit	2,272	—	2,272	—
Total assets at fair value	$ 353,050	$ 55,697	$ 281,219	$ 16,134
Interest rate swap liability	$ —	$ —	$ —	$ —

The following table presents activity for the year ended December 31, 2012, relating to our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2011	$ 16,134
Total gains (unrealized only):	
Included in other comprehensive income	1,635
Settlements	(4,350)
Balance at December 31, 2012	$ 13,419
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at December 31, 2012	$ 1,059

Fair Value Measurements - Disclosure Only

The carrying amounts and estimated fair values of our long-term debt as well as the applicable fair value hierarchy tier, at December 31, 2012, are contained in the table below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Borrowings under our credit facility and our term loan are classified as Level 3 financial instruments, because certain inputs used to determine the fair value of these agreements are unobservable. The carrying value of the credit facility at December 31, 2012 is equal to fair value because we repaid the $40 million outstanding under the Credit Facility in February 2013. The carrying value of the term loan at December 31, 2012, approximates its fair value because there has been no significant change to our credit risk relating to this instrument from the term loan's origination date in December 2011, to December 31, 2012.

	December 31, 2012				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
Convertible senior notes	$ 175,468	$ 208,460	$ —	$ 208,460	$ —
Credit facility	40,000	40,000	—	—	40,000
Term loan	47,471	47,471	—	—	47,471
	$ 262,939	$ 295,931	$ —	$ 208,460	$ 87,471

	December 31, 2011				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
Convertible senior notes	$ 169,526	$ 192,049	$ —	$ 192,049	$ —
Credit facility	—	—	—	—	—
Term loan	48,600	48,600	—	—	48,600
	$ 218,126	$ 240,649	$ —	$ 192,049	$ 48,600

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 190,545	$ 528	$ 65	$ 191,008
GSEs	29,481	45	1	29,525
Municipal securities	75,909	185	246	75,848
U.S. treasury notes	35,700	42	2	35,740
Auction rate securities	14,650	—	1,231	13,419
Certificates of deposit	10,715	9	—	10,724
	$ 357,000	$ 809	$ 1,545	$ 356,264

	December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 231,407	$ 442	$ 215	$ 231,634
GSEs	33,912	46	9	33,949
Municipal securities	47,099	232	18	47,313
U.S. treasury notes	21,627	121	—	21,748
Auction rate securities	19,000	—	2,866	16,134
Certificates of deposit	2,272	—	—	2,272
	$ 355,317	$ 841	$ 3,108	$ 353,050

The contractual maturities of our investments as of December 31, 2012 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 195,986	$ 196,201
Due one year through five years	146,364	146,644
Due after ten years	14,650	13,419
	$ 357,000	$ 356,264

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $298.0 million, $302.7 million, and $182.3 million for the year ended December 31, 2012, 2011, and 2010, respectively. Net realized investment gains for the year ended December 31, 2012, 2011, and 2010 were $293,000, $367,000, and $110,000, respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities as described below, we have determined that unrealized gains and losses at December 31, 2012, and 2011, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Auction Rate Securities

Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S.

government, and the range of maturities for such securities is from 18 years to 34 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at December 31, 2012. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $67.4 million of these instruments at par value. For the years ended December 31, 2012, and 2011, we recorded pretax unrealized gains of $1.6 million and $1.2 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuations in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2012.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(In thousands, except number of securities)					
Corporate debt securities	$ 44,457	$ 65	23	$ —	$ —	—
GSEs	5,004	1	1	—	—	—
Municipal securities	35,223	246	43	—	—	—
U.S. treasury notes	4,511	2	5	—	—	—
Auction rate securities	—	—	—	13,419	1,231	21
Total temporarily impaired securities	$ 89,195	$ 314	72	$ 13,419	$ 1,231	21

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2011.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(In thousands, except number of securities)					
Corporate debt securities	$ 72,766	$ 215	47	$ —	$ —	—
GSEs	11,493	9	9	—	—	—
Municipal securities	12,033	18	8	—	—	—
Auction rate securities	—	—	—	16,134	2,866	27
Total temporarily impaired securities	$ 96,292	$ 242	64	$ 16,134	$ 2,866	27

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Accounts receivable were as follows:

	December 31,	
	2012	2011
	(In thousands)	
Health Plans segment:		
California	$ 28,553	$ 22,175
Michigan	12,873	8,864
Missouri	1,053	27,092
New Mexico	9,059	9,350
Ohio	40,980	27,458
Texas	7,459	1,608
Utah	3,359	2,825
Washington	17,587	15,006
Wisconsin	4,098	4,909
Others	2,077	2,489
Total Health Plans segment	127,098	121,776
Molina Medicaid Solutions segment	22,584	46,122
	$ 149,682	$ 167,898

8. Property, Equipment, and Capitalized Software

A summary of property, equipment, and capitalized software is as follows:

	December 31,	
	2012	2011
	(In thousands)	
Land	$ 15,764	$ 14,094
Building and improvements	124,163	109,789
Furniture and equipment	97,865	79,112
Capitalized software	154,708	116,389
	392,500	319,384
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(84,156)	(65,518)
Less: accumulated amortization for capitalized software	(86,901)	(62,932)
	(171,057)	(128,450)
Property, equipment, and capitalized software, net	$ 221,443	$ 190,934

Depreciation recognized for building and improvements, and furniture and equipment was $20.5 million, $17.5 million, and $13.9 million for the years ended December 31, 2012, 2011 and 2010, respectively. Amortization of capitalized software was $36.2 million, $30.2 million, and $20.1 million for the years ended December 31, 2012, 2011 and 2010, respectively.

Molina Center

As described in Note 4, "Business Combinations," we acquired the Molina Center in December 2011. At December 31, 2012, the carrying amount of the Molina Center building and leasehold improvements was $44.4 million and the accumulated depreciation was $1.8 million. Future minimum rentals on noncancelable leases are as follows:

	(In thousands)
2013	$ 9,784
2014	9,954
2015	9,878
2016	8,054
2017	7,419
Thereafter	10,295
Total minimum future rentals	$ 55,384

9. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 11 years, for customer relationships is approximately five years, for backlog is approximately two years, and for provider networks is approximately 10 years. Based on the balances of our identifiable intangible assets as of December 31, 2012, we estimate that our intangible asset amortization will be $17.9 million in 2013, $17.0 million in 2014, $12.1 million in 2015, $9.4 million in 2016, and $9.3 million in 2017. The following table provides the details of identified intangible assets, by major class, for the periods indicated. As described in Note 2, "Significant Accounting Policies," no impairment charges relating to long-lived assets, including intangible assets, were recorded in the year ended December 31, 2012. For a description of our goodwill and intangible assets by reportable segment, refer to Note 20, "Segment Reporting."

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses	$ 135,932	$ 81,376	$ 54,556
Customer relationships	24,550	12,513	12,037
Contract backlog	23,600	17,870	5,730
Provider networks	11,990	6,602	5,388
Balance at December 31, 2012	$ 196,072	$ 118,361	$ 77,711
Intangible assets:			
Contract rights and licenses	$ 140,242	$ 69,515	$ 70,727
Customer relationships	24,550	8,546	16,004
Contract backlog	23,600	15,139	8,461
Provider networks	11,990	5,386	6,604
Balance at December 31, 2011	$ 200,382	$ 98,586	$ 101,796

The following table presents the balances of goodwill and indefinite-lived intangible assets as of December 31, 2012 and 2011:

	December 31, 2011	Reductions	December 31, 2012
		(In thousands)	
Goodwill and indefinite-lived intangible assets, gross	$ 212,484	$ (2,866)	$ 209,618
Accumulated impairment losses	(58,530)	—	(58,530)
Goodwill and indefinite-lived intangible assets, net	$ 153,954	$ (2,866)	$ 151,088

The change in the carrying amount in 2012 was due to the sale of the Molina Healthcare Insurance Company.

10. Restricted Investments

Pursuant to the regulations governing our Health Plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of restricted investments:

	December 31,	
	2012	2011
	(In thousands)	
California	$ 373	$ 372
Florida	5,738	5,198
Insurance Company	—	4,711
Michigan	1,014	1,000
Missouri	500	504
New Mexico	15,915	15,905
Ohio	9,082	9,078
Texas	3,503	3,518
Utah	3,126	2,895
Washington	151	151
Other	4,699	2,832
	$ 44,101	$ 46,164

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2012 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 39,733	$ 39,738
Due one year through five years	4,368	4,368
	$ 44,101	$ 44,106

11. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2012, 2011, and 2010. The amounts displayed for "Components of medical care costs related to: Prior period" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,		
	2012	2011	2010
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of period	$ 402,476	$ 354,356	$ 315,316
Balance of acquired subsidiary	—	—	3,228
Components of medical care costs related to:			
Current period	5,136,055	3,911,803	3,420,235
Prior period	(39,295)	(51,809)	(49,378)
Total medical care costs	5,096,760	3,859,994	3,370,857
Payments for medical care costs related to:			
Current period	4,649,363	3,516,994	3,085,388
Prior period	355,343	294,880	249,657
Total paid	5,004,706	3,811,874	3,335,045
Balances at end of period	$ 494,530	$ 402,476	$ 354,356
Benefit from prior period as a percentage of:			
Balance at beginning of period	9.8%	14.6%	15.7%
Premium revenue	0.7%	1.1%	1.2%
Total medical care costs	0.8%	1.3%	1.5%

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid out would generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is merely an estimate (and therefore never perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range. For example, for the years ended December 31, 2011 and 2010, the amounts ultimately paid out were less than the amount of the reserves we had established as of December 31, 2010 and 2009, by 14.6% and 15.7%, respectively. Furthermore, because the initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate - we only know when the circumstances for any one or more of those factors are out of the ordinary.

As indicated above, the amounts ultimately paid out on our liabilities in fiscal years 2012, 2011, and 2010 were less than what we had expected when we established our reserves. While many related factors working in conjunction with one another determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimate.

We recognized a benefit from prior period claims development in the amount of $39.3 million for the year ended December 31, 2012. This amount represents our estimate as of December 31, 2012, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe that the overestimation of our claims liability at December 31, 2011 was due primarily to the following factors:

- At our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- At our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.

- The overestimation of our liability for medical claims and benefits payable was partially offset by an underestimation of that liability at our Missouri health plan, as a result of the costs associated with an unusually large number of premature infants during the fourth quarter of 2011.

We recognized a benefit from prior period claims development in the amount of $51.8 million for the year ended December 31, 2011. This amount represents our estimate as of December 31, 2011, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe that the overestimation of our claims liability at December 31, 2010 was due primarily to the following factors:

- At our Ohio health plan, we overestimated the impact of a buildup in claims inventory.
- At our California health plan, we overestimated the impact of the settlement of disputed provider claims.
- At our New Mexico health plan, we underestimated the impact of a reduction in the outpatient facility fee schedule.

We recognized a benefit from prior period claims development in the amount of $49.4 million for the year ended December 31, 2010. This amount represents our estimate as of December 31, 2010, of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2009 was more than the amount that will ultimately be paid out in satisfaction of that liability. We believe that the overestimation of our claims liability at December 31, 2009 was due primarily to the following factors:

- At our New Mexico health plan, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- At our California health plan, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at December 31, 2012, we adjusted our base calculation to take account of the numerous factors that we believe will likely change our final claims liability amount. We believe that the most significant among those factors are:

- Our Texas health plan membership nearly doubled effective March 1, 2012. In addition, effective March 1, 2012, we assumed inpatient medical liability for ABD members for which we were not previously responsible. Reserves for new coverage and new regions are now based on the newly developing claims lag patterns. While the lag patterns are now beginning to stabilize for the new membership and coverage, the true reserve liability continues to be more uncertain than usual.
- Data published by the Centers for Disease Control, or CDC, indicated a significant increase in the percentage of office visits for influenza-like illnesses, or ILI, during December 2012. This indicated that the annual flu season was starting earlier than it had in most recent years. This was most noticeable in the southeast region of the country, but impacted other areas as well. Our leading indicators, including inpatient authorizations and overall pharmacy utilization, did not show as great an increase as we had expected based on the severity of the CDC's flu-related indices. However, we did see a significant increase in the use of prescription flu medication, especially in our Texas health plan. Therefore, we increased our reserves to account for expected additional utilization due to the early onset of the flu season.
- Our California health plan has enrolled approximately 20,000 new ABD members since September 30, 2011, as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members converted from a fee-for-service environment. Due to the relatively recent transition of these members to managed care, their utilization of medical services is less predictable than it is for many of our other members.
- Prior to July 2012, it was the state of Washington's practice to disenroll certain sick newborns from the Healthy Options Medicaid managed care program and cover them under the Supplemental Security Income program, or SSI, instead. When this occurred, the health plan would reimburse the premiums received for that member back to the state and the state in turn reimbursed the health plan for the cost of care, usually retroactively to the date of birth. Effective July 1, 2012, the health plans now retain these members and cover them under a new ABD program entitled Healthy Options Blind and Disabled, or HOBD. The premium we receive from the state for the HOBD members is very high to cover the substantial cost of care. By December, we had enrolled approximately 26,000 members under HOBD. Because the program is relatively new, there is still some uncertainty as to the level of claims to be expected from these high-cost members.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a

material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2012, 2011 and 2010, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In these years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

12. Long-Term Debt

1.125% Cash Convertible Senior Notes due 2020

On February 15, 2013, we issued $550 million aggregate principal amount of 1.125% Cash Convertible Senior Notes due 2020, or the Notes. The Notes bear interest at a rate of 1.125% per year, payable semiannually in arrears on January 15 and July 15 of each year, beginning on July 15, 2013. The Notes will mature on January 15, 2020.

The Notes are not convertible into our common stock or any other securities under any circumstances. Holders may convert their Notes solely into cash at their option at any time prior to the close of business on the business day immediately preceding July 15, 2019 only under the following circumstances: (1) during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day; (2) during the five business day period immediately after any five consecutive trading day period in which the trading price per $1,000 principal amount of Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day; or (3) upon the occurrence of specified corporate events. On or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their Notes solely into cash at any time, regardless of the foregoing circumstances. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of Notes, equal to the settlement amount, determined in the manner set forth in the Indenture.

The initial conversion rate will be 24.5277 shares of our common stock per $1,000 principal amount of Notes (equivalent to an initial conversion price of approximately $40.77 per share of common stock). The conversion rate will be subject to adjustment in some events but will not be adjusted for any accrued and unpaid interest. In addition, following certain corporate events that occur prior to the maturity date, we will pay a cash make-whole premium by increasing the conversion rate for a holder who elects to convert its Notes in connection with such a corporate event in certain circumstances. We may not redeem the Notes prior to the maturity date, and no sinking fund is provided for the Notes.

If we undergo a fundamental change (as defined in the indenture to the Notes), holders may require us to repurchase for cash all or part of their Notes at a repurchase price equal to 100% of the principal amount of the Notes to be repurchased, plus accrued and unpaid interest to, but excluding, the fundamental change repurchase date. The indenture provides for customary events of default, including cross acceleration to certain other indebtedness of ours, and our significant subsidiaries.

The Notes will be senior unsecured obligations of the Company and will rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the Notes; equal in right of payment to any of our unsecured indebtedness that is not so subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities (including trade payables) of our subsidiaries.

Cash Convertible Note Hedge and Warrant Transactions

In connection with the pricing of the Notes, on February 11, 2013, we entered into cash convertible note hedge transactions and warrant transactions relating to a notional number of shares of our common stock underlying the Notes to be issued by us (without regard to the initial purchasers' $100 million over-allotment option) with two counterparties, JPMorgan Chase Bank, National Association, London Branch and Bank of America, N.A. (the "Option Counterparties"). The cash convertible note hedge transactions are intended to offset cash payments due upon any conversion of the Notes. However, the warrant transactions could separately have a dilutive effect to the extent that the market value per share of our common stock (as measured under the terms of the warrant transactions) exceeds the applicable strike price of the warrants. The strike price of the warrants will initially be $53.8475 per share, which is 75% above the last reported sale price of our common stock on February 11, 2013.

In connection with the exercise in full by the initial purchasers of their over-allotment option in respect of the Notes, on February 13, 2013, we and the Option Counterparties amended the cash convertible note hedge transactions entered into on February 11, 2013 to upsize such transactions by a notional number of shares of our common stock corresponding to the number of shares underlying the Notes purchased pursuant to the exercise of such over-allotment option. On February 13, 2013, we also entered into additional warrant transactions with the Option Counterparties relating to a number of shares of our common stock corresponding to the number of shares underlying the Notes purchased pursuant to the exercise of such over-allotment option. Each of the amendments to the cash convertible note hedge transactions and the additional warrant transactions were on substantially similar terms to the corresponding transactions entered into on February 11, 2013. Pursuant to these warrant transactions, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances.

We used approximately $74.3 million of the net proceeds from the offering to pay the cost of the cash convertible note hedge transactions (after such cost was partially offset by the proceeds to us from the sale of warrants in the warrant transactions and the additional warrant transactions).

Aside from the initial payment of a premium to the Option Counterparties of approximately $149.3 million, we will not be required to make any cash payments to the Option Counterparties under the cash convertible note hedge transactions and will be entitled to receive from the Option Counterparties an amount of cash, generally equal to the amount by which the market price per share of common stock exceeds the strike price of the cash convertible note hedge transactions during the relevant valuation period. The strike price under the cash convertible note hedge transactions is initially equal to the conversion price of the Notes. Additionally, if the market value per share of our common stock exceeds the strike price of the warrants on any trading day during the 160 trading day measurement period under the warrant transactions and the additional warrant transactions, we will be obligated to issue to the Option Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the warrant transactions and the additional warrant transactions, subject to a share delivery cap. The Company will not receive any additional proceeds if warrants are exercised.

As of December 31, 2012, maturities of long-term debt for the years ending December 31 are as follows (in thousands):

	Total	2013	2014	2015	2016	2017	Thereafter
Credit Facility	$ 40,000	$ —	$ —	$ —	$ 40,000	$ —	$ —
Convertible senior notes	187,000	—	187,000	—	—	—	—
Term loan	47,471	1,155	1,206	1,259	1,309	1,372	41,170
	$ 274,471	$ 1,155	$ 188,206	$ 1,259	$ 41,309	$ 1,372	$ 41,170

Credit Facility

On February 15, 2013, we used approximately $40.0 million of the net proceeds from the offering of the Notes to repay all of the outstanding indebtedness under our $170 million revolving credit facility, or the Credit Facility, with various lenders and U.S. Bank National Association, as Line of Credit Issuer, Swing Line Lender, and Administrative Agent. As of December 31, 2012, there was $40.0 million outstanding under the Credit Facility.

We terminated the Credit Facility in connection with the closing of the offering and sale of the Notes. two letters of credit in the aggregate principal amount of $10.3 million that reduced the amount available for borrowing under the Credit Facility as of December 31, 2012, were transferred to direct issue letters of credit with another financial institution. The Credit Facility had a term of five years under which all amounts outstanding would have been due and payable on September 9, 2016.

Borrowings under the Credit Facility accrued interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we were required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The applicable margins ranged between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility were secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan). The Credit Facility included usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also required us to maintain as of the end of any fiscal quarter (calculated for each four consecutive fiscal quarter period) a ratio of total consolidated debt to total consolidated EBITDA, as defined in the Credit Facility, of not more than 2.75 to 1.00, and a fixed charge coverage ratio of not less than 1.75 to 1.00.. At December 31, 2012, we were in compliance with all financial covenants under the Credit Facility.

3.75% Convertible Senior Notes due 2014

As of December 31, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014, or the 3.75% Notes, remain outstanding. The 3.75% Notes rank equally in right of payment with our existing and future senior indebtedness. The 3.75% Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the 3.75% Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their 3.75% Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the 3.75% Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their 3.75% Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of 3.75% Notes, as follows:

- An amount in cash (the “principal return”) equal to the sum of, for each of the 20 Volume-Weighted Average Price ("VWAP") trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of the 3.75% Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the 3.75% Notes is 7.5%, principally based on the seven-year U.S. Treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the 3.75% Notes are expected to be outstanding, as additional non-cash interest expense. As of December 31, 2012, we expect the 3.75% Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 21 months. The 3.75% Notes’ if-converted value did not exceed their principal amount as of December 31, 2012. At December 31, 2012, the equity component of the 3.75% Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	December 31,	
	2012	2011
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(11,532)	(17,474)
Net carrying amount	$ 175,468	$ 169,526

	Years Ended December 31,		
	2012	2011	2010
	(In thousands)		
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate of 3.75%	$ 7,012	$ 7,012	$ 7,012
Amortization of the discount on the liability component	5,942	5,512	5,114
Total interest cost recognized	$ 12,954	$ 12,524	$ 12,126

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement, dated as of December 1, 2011, with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. "Interest Period" means the period commencing on the first day of each calendar month and ending on the last day of each calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, or Swap Agreement, with an effective date of March 1, 2013. While not designated as a hedge during the year ended December 31, 2012, the Swap Agreement is intended to reduce our exposure to fluctuations in the contractual variable interest rates under our Term Loan Agreement, and expires on the maturity date of the Term Loan Agreement, which is November 30, 2018. Under the Swap Agreement, we will receive a variable rate of the one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. The Swap Agreement is measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. Gains and losses relating to changes in fair value are reported in earnings in the current period. For the year ended December 31, 2012, we have recorded losses of $1.3 million to general and administrative expense. As of December 31, 2012 the fair value of the Swap Agreement is a liability of $1.3 million, recorded to other noncurrent liabilities. We do not use derivatives for trading or speculative purposes. We believe that we are not exposed to more than a nominal amount of credit risk relating to the Swap Agreement because the counterparty is an established and well-capitalized financial institution.

13. Income Taxes

The provision for income taxes consisted of the following:

	Years Ended December 31,		
	2012	2011	2010
	(In thousands)		
Current:			
Federal	$ 17,853	$ 28,336	$ 36,395
State	1,308	1,639	2,144
Total current	19,161	29,975	38,539
Deferred:			
Federal	(6,300)	14,028	(4,717)
State	(3,586)	(167)	700
Total deferred	(9,886)	13,861	(4,017)
Total provision for income taxes	$ 9,275	$ 43,836	$ 34,522

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate is as follows:

	Years Ended December 31,		
	2012	2011	2010
Statutory federal tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	(7.8)	1.5	2.1
Benefit for unrecognized tax benefits	(1.2)	(0.6)	(0.1)
Nondeductible compensation	7.6	—	1.0
Nondeductible goodwill	—	31.7	—
Nondeductible lobbying	5.2	1.1	0.7
Purchase accounting adjustment	—	(1.5)	—
Change in fair value of contingent consideration	5.9	—	—
Other	3.9	0.6	(0.1)
Effective tax rate	48.6 %	67.8 %	38.6 %

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California enterprise zone credits.

During 2012 and 2011, excess tax benefits from shared-based compensation were $3.1 million and $937,000, respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital. During 2010, tax-related deficiencies on share-based compensation were $673,000. This amount was recorded as an adjustment to income taxes payable with a corresponding decrease to additional paid-in capital.

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2012 and 2011 were as follows:

	December 31,	
	2012	2011
	(In thousands)	
Accrued expenses	$ 15,381	$ 14,541
Reserve liabilities	2,936	1,292
State taxes	(606)	(396)
Other accrued medical costs	2,518	2,051
Net operating losses	27	27
Unrealized gains	(283)	(316)
Unearned premiums	15,675	4,139
Prepaid expenses	(4,390)	(3,032)
Deferred compensation	1,611	—
Other, net	(426)	21
Deferred tax asset, net of valuation allowance — current	32,443	18,327
Accrued expenses	—	223
Reserve liabilities	2,013	3,015
State tax credit carryover	4,149	2,609
Net operating losses	3,341	2,694
Unrealized losses	563	1,176
Depreciation and amortization	(44,198)	(39,939)
Deferred compensation	3,323	7,904
Debt basis	(5,410)	(7,604)
Other, net	702	(278)
Valuation allowance	(2,383)	(2,927)
Deferred tax liability, net of valuation allowance — long term	(37,900)	(33,127)
Net deferred income tax liability	$ (5,457)	$ (14,800)

At December 31, 2012, we had federal and state net operating loss carryforwards of $319,000 and $73.0 million, respectively. The federal net operating loss begins expiring in 2018, and state net operating losses begin expiring in 2013. The utilization of the net operating losses is subject to certain limitations under federal law.

At December 31, 2012, we had California enterprise zone tax credit carryovers of $6.3 million which do not expire.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2012, $3.0 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state tax operating loss carryforwards. We increased our valuation allowance $100,000 from $2.9 million at December 31, 2011 to $3.0 million as of December 31, 2012.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll-forward of our unrecognized tax benefits is as follows:

	Years Ended December 31,		
	2012	2011	2010
	(In thousands)		
Gross unrecognized tax benefits at beginning of period	$ (10,712)	$ (10,962)	$ (4,128)
Increases in tax positions for prior years	(441)	(137)	(6,891)
Decreases in tax positions for prior years	320	—	—
Settlements	—	—	—
Lapse in statute of limitations	211	387	57
Gross unrecognized tax benefits at end of period	$ (10,622)	$ (10,712)	$ (10,962)

As of December 31, 2012, we had $10.6 million of unrecognized tax benefits of which $7.4 million, if fully recognized, would affect our effective tax rate. Approximately $8.4 million of the unrecognized tax benefits recorded at December 31, 2012 relates to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.6 million due the resolution to the state refund claim as well as the normal expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2012, December 31, 2011, and December 31, 2010, we had accrued $56,000, $65,000, and $82,000, respectively, for the payment of interest and penalties.

We may be subject to examination by the Internal Revenue Service, or IRS, for calendar years 2009 through 2012. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Missouri, and Michigan, for the years 2004 through 2012.

14. Stockholders' Equity

Repurchase in Connection with Offering of 1.125% Cash Convertible Senior Notes Due 2020. Subsequent to December 31, 2012, we used a portion of the net proceeds from the offering to repurchase $50 million of our common stock in negotiated transactions with institutional investors in the offering, concurrently with the pricing of the offering. On February 12, 2013, we repurchased a total of 1,624,959 shares at $30.77 per share, which was our closing stock price on that date.

Securities Repurchases and Repurchase Programs. Effective as of February 13, 2013, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior note due 2014. The repurchase program extends through December 31, 2014.

On December 26, 2012, we purchased 110,988 shares of our common stock from certain Molina family trusts for an aggregate purchase price of $3.0 million. This purchase transaction was approved by our board of directors. The shares were purchased at a price of $27.03, representing the closing price per share of our common stock on December 26, 2012. See Note 17, "Related Party Transactions."

Effective as of October 26, 2011, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see Note 12, "Long-Term Debt"). The repurchase program expired October 25, 2012. No securities were purchased under this program in 2012.

In July 2011, our board of directors approved a stock repurchase program of up to $7.0 million, to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Under this program, we purchased approximately 400,000 shares of our common stock for $7.0 million (average cost of approximately $17.47 per share) during August 2011. These purchases did not materially impact diluted earnings per share for the year ended December 31, 2011. Subsequently, we retired the $7.0 million of treasury shares purchased, which reduced additional paid-in capital as of December 31, 2011.

Shelf Registration Statement. In May 2012, we filed an automatic shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of an indeterminate number of our securities, including common stock, warrants, or debt securities. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Stock Split. On April 27, 2011, we announced that our board of directors authorized a 3-for-2 stock split of our common stock to be effected in the form of a stock dividend of one share of our stock for every two shares outstanding. The dividend was distributed on May 20, 2011.

Stock Plans. In connection with the plans described in Note 16, "Share-Based Compensation," we issued approximately 1,057,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the year ended December 31, 2012. Stock plan activity resulted in a $19.5 million increase to additional paid-in capital for the same period.

15. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $10.7 million, $8.5 million and $5.9 million in the years ended December 31, 2012, 2011, and 2010, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

16. Share-Based Compensation

In 2011, we adopted the 2011 Equity Incentive Plan (the "2011 Plan") , which provides for the award of stock options, restricted shares and units, performance shares and units, and stock bonuses to the company's officers, employees, directors, consultants, advisors, and other service providers. The 2011 Plan allows for the issuance of 4.5 million shares of common stock.

At December 31, 2012, we had equity incentives outstanding under two plans: (1) the 2011 Plan; and (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded). In March 2012, our chief executive officer, chief financial officer, and chief operating officer were awarded 94,050 performance units, 53,236 performance units, and 30,167 performance units, respectively, that would vest and be settled in shares of the Company's common stock equal in number to the units awarded upon the achievement of certain performance and service conditions as follows: (i) the Company's total operating revenue for 2012 is equal to or greater than $5.5 billion, and (ii) the respective officer continues to be employed by the Company if and when the operating revenue target is met. Such awards vested when the performance and service conditions were met in December 2012. Also in March 2012, our chief executive officer, chief financial officer, chief operating officer, and chief accounting officer were awarded 8,000 performance units, 8,000 performance units, 8,000 performance units, and 3,000 performance units respectively, that would vest and be settled in shares of the Company's common stock equal in number to the units granted upon the certification of our Idaho MMIS by CMS. Such awards vested when the Idaho MMIS was certified in July 2012.

Restricted share awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our employee stock purchase plan (the "ESPP"), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We issued 277,400 and 201,700 shares of our common stock under the ESPP during the years ended December 31, 2012 and 2011, respectively. In 2011, stockholders approved our 2011 ESPP, which superseded the 2002 Employee Stock Purchase Plan. The 2011 ESPP allows for the issuance of three million shares of common stock.

The following table illustrates the components of our share-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2012		2011		2010	
	(In thousands)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted share and performance unit awards	$ 18,106	$ 12,943	$ 15,914	$ 9,946	$ 8,007	$ 5,044
Stock options (including expense relating to our ESPP)	1,912	1,613	1,138	712	1,524	960
	$ 20,018	$ 14,556	$ 17,052	$ 10,658	$ 9,531	$ 6,004

As of December 31, 2012, there was $15.1 million of total unrecognized compensation expense related to unvested restricted share awards, which we expect to recognize over a remaining weighted-average period of 2.1 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 7.5% as of December 31, 2012. Also as of December 31, 2012, there was $0.1 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.1 years.

Restricted share activity for the year ended December 31, 2012 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2011	1,435,882	$ 18.97
Granted	511,557	31.71
Vested	(786,135)	20.49
Forfeited	(174,727)	22.53
Unvested balance as of December 31, 2012	986,577	23.74

The total fair value of restricted shares and performance shares granted during the year ended December 31, 2012, 2011, and 2010 was $16.2 million, $18.4 million, and $12.7 million, respectively. The total fair value of restricted shares vested during the year ended December 31, 2012, 2011, and 2010 was $25.4 million, $12.2 million, and $6.4 million, respectively.

Performance and restricted unit activity for the year ended December 31, 2012 is summarized below:

	Shares	Weighted Average Grant Date Fair Value	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Outstanding as of December 31, 2011	—	$ —		
Granted	213,022	33.59		
Vested	(210,880)	33.58	$ 6,066	
Outstanding as of December 31, 2012	2,142	35.01	$ 58	0.2
Performance and restricted units expected to vest as of December 31, 2012	2,142	35.01	$ 58	0.2

The total fair value of performance and restricted units granted during the year ended December 31, 2012 was $7.2 million No performance or restricted units were granted or vested in 2011 and 2010.

Stock option activity for the year ended December 31, 2012 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Stock options outstanding as of December 31, 2011	553,049	$ 20.91		
Granted	15,000	34.82		
Exercised	(153,238)	18.27		
Forfeited	(750)	22.37		
Stock options outstanding as of December 31, 2012	414,061	22.39	$ 2,204	3.3
Stock options exercisable and expected to vest as of December 31, 2012	414,061	22.39	$ 2,204	3.3
Exercisable as of December 31, 2012	399,061	21.93	$ 2,204	3.1

The weighted-average grant date fair value per share of the sole stock option awarded during 2012 was $13.97. To determine this fair value we applied a risk-free interest rate of 1.1%, expected volatility of 43.0%, an expected option life of 6 years, and expected dividend yield of 0%. No stock options were granted in 2011 or 2010. The following is a summary of information about stock options outstanding and exercisable at December 31, 2012:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$16.89 – $19.11	137,161	2.5	$ 18.46	137,161	$ 18.46
$20.88	148,500	4.1	20.88	148,500	20.88
$22.86 – $34.82	128,400	3.3	28.35	113,400	27.49
	414,061			399,061	

17. Related Party Transactions

On February 27, 2013, we entered into a lease (the "Lease") with 6 th & Pine Development, LLC (the "Landlord") for office space located in Long Beach, California. The lease consists of two office buildings as follows:

- an existing building, which comprises approximately 70,000 square feet of office space, and
- a new building, which is expected to comprise approximately 120,000 square feet of office space.

The term of the Lease with respect to the existing building is expected to commence on June 1, 2013, and the term of the Lease with respect to the new building is expected to commence on November 1, 2014. The initial term of the Lease with respect to both buildings expires on December 31, 2024, subject to two options to extend the term for a period of five years each. Initial annual rent for the existing building is expected to be approximately $2.5 million and initial annual rent for the new building is expected to be approximately $4.0 million. Rent will increase 3.75% per year through the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

The principal members of the Landlord are John C. Molina, the Chief Financial Officer and a director of the Company, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of common stock in the Company he holds as trustee. Dr. J. Mario Molina, the Company's Chief Executive Officer and Chairman of the Board of Directors, holds a partial interest in such shares as trust beneficiary.

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. For both years ended December 31, 2012, and 2011 our carrying amount for this investment amounted to $3.9 million. For the years ended December 31, 2012, 2011, and 2010, we paid $28.4 million, $24.3 million, and $22.0 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach, or Pacific Hospital. Pacific Hospital is owned by Abrazos Healthcare, Inc. Until October 12, 2010, the majority of the shares of Abrazos Healthcare, Inc. were held as community property by Dr. Martha Bernadett and her husband. Dr. Martha Bernadett is the sister of Joseph M. Molina, M.D. (Dr. J. Mario Molina), our Chief Executive Officer, and John Molina, our Chief Financial Officer. On October 12, 2010, Dr. Bernadett and her husband sold their shares in Abrazos Healthcare, Inc., terminating our related party relationship with Pacific Hospital. Under the terms of this fee-for-service agreement we paid Pacific Hospital $0.8 million for the period from January 1, 2010 to October 12, 2010.

On December 26, 2012, we purchased 110,988 shares of our common stock from certain Molina family trusts for an aggregate purchase price of $3.0 million. This purchase transaction was approved by our board of directors. The shares were purchased at a price of $27.03, representing the closing price per share of our common stock on December 26, 2012. The shares were purchased from the Janet M. Watt Separate Property Trust dated 10/22/2007, or the Separate Property Trust, and the Watt Family Trust dated 10/11/1996, or the Family Trust. Janet M. Watt is the sister, and her husband Lawrence B. Watt is the brother-in-law, of Dr. J. Mario Molina and John Molina. Ms. Watt is the sole trustee of the Separate Property Trust, and a co-trustee with Lawrence B. Watt of the Family Trust.

18. Variable Interest Entities

Joseph M. Molina M.D., Professional Corporations

Our wholly owned subsidiary, American Family Care, Inc., or AFC, operates our primary care clinics. In 2012, AFC entered into services agreements with the Joseph M. Molina, M.D. Professional Corporations, or JMMPC. JMMPC was created to further advance our direct delivery line of business. Its sole shareholder is Dr. J. Mario Molina, our Chairman of the Board, President and Chief Executive Officer. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. Under the services agreements, AFC provides the clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC, and JMMPC provides outpatient professional medical services to the general public for routine non-life threatening, outpatient health care needs. While JMMPC may provide services to the general public, substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities. In addition to the services agreements with AFC, JMMPC has entered into affiliation agreements with us. Under these agreements, we have agreed to fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, based on a monthly reconciliation such that JMMPC will operate at break even and derive no profit.

We have determined that JMMPC is a variable interest entity, or VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to U.S. generally accepted accounting principles. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the services and affiliation agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2012, JMMPC had total assets of $1.4 million, comprising primarily cash and equivalents, and total liabilities of $1.1 million, comprising primarily accrued payroll and employee benefits.

Our maximum exposure to loss as a result of our involvement with this entity is equal to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated operating results and cash flows for the foreseeable future. For the year ended December 31, 2012, we provided an initial cash infusion of $0.3 million to JMMPC in the first quarter of 2012 to fund its start-up operations. During 2012 our health plans received $0.2 million from JMMPC under the terms of the affiliation agreement.

New Markets Tax Credit

During the fourth quarter of 2011 our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC, or Wells Fargo, its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC, or Investment Fund, and certain of Wells Fargo's affiliated Community Development Entities, or CDEs, in connection with our participation in the federal government's New Markets Tax Credit Program, or NMTC. The NMTC was established by Congress in 2000 to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions, called CDEs, which provide financing to qualified active businesses operating in low-income communities. The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In the fourth quarter of 2011, as a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $5.9 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $ 15.5 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $20.9 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo's contribution to the Investment Fund, or approximately $5.9 million. Additionally, financing costs incurred in structuring the arrangement amounting to $1.2 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE-collecting and remitting interest and fees and NMTC compliance-were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;

- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $5.9 million is included in cash at December 31, 2012 and the offsetting Wells Fargo's interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

19. Commitments and Contingencies

Leases

We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2021. Facility lease terms generally range from five to ten years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term. Future minimum lease payments by year and in the aggregate under all operating leases consist of the following approximate amounts:

	(In thousands)
2013	$ 26,866
2014	21,420
2015	14,808
2016	8,472
2017	6,939
Thereafter	7,771
Total minimum lease payments	$ 86,276

Rental expense related to these leases amounted to $20.5 million, $23.1 million, and $25.1 million for the years ended December 31, 2012, 2011, and 2010, respectively.

Employment Agreements

In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which have been amended and restated as of December 31, 2009. These employment agreements had initial terms of one to three years and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year’s base salary and termination bonus, as defined, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for 18 months. If the executives are terminated for cause, no further payments are due under the contracts.

If termination occurs within two years following a change of control, the executives will receive two times their base salary and termination bonus, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for three years.

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered through our clinics in California, Florida, New Mexico, Virginia, and Washington. We also carry claims-made managed care errors and omissions professional liability insurance for our health plan operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Such state laws and regulations also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after inter-company eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $549.7 million at December 31, 2012, and $492.4 million December 31, 2011. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders are generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $46.9 million and $23.6 million as of December 31, 2012, and 2011, respectively.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2012, our health plans had aggregate statutory capital and surplus of approximately $557.9 million compared with the required minimum aggregate statutory capital and surplus of approximately $345.7 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2012. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Receivable/Liability for Ceded Life and Annuity Contracts

Prior to February 17, 2012, we reported a 100% ceded reinsurance arrangement for life insurance policies written and held by our then wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable

from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. Effective February 17, 2012, we sold Molina Healthcare Insurance Company. The transaction resulted in the elimination of both the noncurrent receivable and liability for ceded life and annuity contracts, each amounting to $23.4 million as of December 31, 2011. Additionally, we recorded a gain of approximately $1.7 million to general and administrative expenses in the first quarter of 2012 upon closing of the transaction.

Molina Healthcare Insurance Company is now named Catamaran Insurance of Ohio, or Catamaran. In the event that both the reinsurer and Catamaran are unable to pay benefit on policies that were in-force as of the sale date, we remain ultimately liable for payment of such benefits. Because we no longer own Catamaran, we no longer have access to its financial records; therefore, the maximum amount of potential future payments is not determinable. We believe the possibility of our having to pay such benefits is remote, and no provision for the payment of such benefits is included in our consolidated financial statements.

20. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans which serve Medicaid populations in nine states, subsequent to the termination of our Medicaid contract in Missouri effective June 30, 2012, and also includes our smaller direct delivery line of business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to Medicaid agencies in an additional five states. The Molina Medicaid Solutions segment was added to our internal financial reporting structure when we acquired this business in the second quarter of 2010.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, “Significant Accounting Policies.” The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

Molina Medicaid Solutions was acquired on May 1, 2010; therefore, the year ended December 31, 2010 includes only eight months of operating results for this segment. Operating segment information is as follows:

	Year Ended December 31,		
	2012	2011	2010
	(In thousands)		
Segment Information:			
Revenue:			
Health Plans:			
Premium revenue	$ 5,826,491	$ 4,603,407	$ 3,989,909
Investment income	5,188	5,539	6,259
Rental income	9,374	547	—
Molina Medicaid Solutions:			
Service revenue	187,710	160,447	89,809
	$ 6,028,763	$ 4,769,940	$ 4,085,977
Depreciation and amortization:			
Health Plans	$ 58,577	$ 45,734	$ 42,282
Molina Medicaid Solutions	20,187	28,649	18,483
	$ 78,764	$ 74,383	$ 60,765
Operating Income:			
Health Plans	$ 11,746	$ 78,110	$ 102,392
Molina Medicaid Solutions	23,727	2,063	2,609
Total operating income	35,473	80,173	105,001
Interest expense	(16,769)	(15,519)	(15,509)
Other income	361	—	—
Income before income taxes	$ 19,065	$ 64,654	$ 89,492

	As of December 31,	
	2012	2011
	(In thousands)	
Goodwill and intangible assets, net:		
Health Plans	$ 139,710	$ 159,963
Molina Medicaid Solutions	89,089	95,787
	$ 228,799	$ 255,750
Total assets:		
Health Plans	$ 1,702,212	$ 1,429,283
Molina Medicaid Solutions	232,610	222,863
	$ 1,934,822	$ 1,652,146

21. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2012 and 2011.

	For The Quarter Ended,			
	March 31, 2012	June 30, 2012	September 30, 2012	December 31, 2012
	(In thousands, except per-share data)			
Premium revenue	$ 1,327,449	$ 1,492,272	$ 1,488,718	$ 1,518,052
Service revenue	42,205	41,724	48,422	55,359
Operating income (loss)	33,420	(59,267)	7,187	54,133
Income (loss) before income taxes	29,122	(63,075)	2,872	50,146
Net income (loss)	18,089	(37,306)	3,364	25,643
Net income (loss) per share (2):				
Basic	$ 0.39	$ (0.80)	$ 0.07	$ 0.55
Diluted	$ 0.39	$ (0.80)	$ 0.07	$ 0.54

	For The Quarter Ended,			
	March 31, 2011	June 30, 2011	September 30, 2011	December 31, 2011(1)
	(In thousands, except per-share data)			
Premium revenue	$ 1,081,438	$ 1,128,770	$ 1,138,230	$ 1,254,969
Service revenue	36,674	36,888	37,728	49,157
Operating income (loss)	31,300	31,410	33,566	(16,103)
Income (loss) before income taxes	27,697	27,727	29,186	(19,956)
Net income (loss)	17,388	17,440	18,950	(32,960)
Net income (loss) per share (2):				
Basic	$ 0.38	$ 0.38	$ 0.41	$ (0.72)
Diluted	$ 0.38	$ 0.38	$ 0.41	$ (0.72)

(1) On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's existing contract with the state expired without renewal on June 30, 2012. In connection with this notification, we recorded a total non-cash impairment charge of $64.6 million in the fourth quarter of 2011, of which $6.1 million related to finite-lived intangible assets, and $58.5 million related to goodwill. The impairment charge comprised substantially all intangible assets relating to contract rights and licenses, and provider networks recorded at the time of our acquisition of the Missouri health plan in 2007. For the quarter ended December 31, 2011, the impairment charge reduced diluted earnings per share by $1.34.

(2) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2012, and 2011.

22. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2012 and 2011, and our condensed statements of income and condensed statements of cash flows for each of the three years in the period ended December 31, 2012.

Condensed Balance Sheets

	December 31,	
	2012	2011
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 39,068	$ 14,650
Investments	2,015	2,010
Income tax refundable	8,868	14,126
Deferred income taxes	9,706	9,133
Due from affiliates	55,382	60,569
Prepaid and other current assets	19,164	10,467
Total current assets	134,203	110,955
Property and equipment, net	108,808	82,437
Goodwill	52,302	53,769
Auction rate securities	3,615	4,694
Investments in subsidiaries	768,765	740,345
Advances to related parties and other assets	34,600	32,473
	$ 1,102,293	$ 1,024,673
LIABILITIES AND STOCKHOLDERS' EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 73,883	$ 71,392
Long-term debt	215,468	169,526
Deferred income taxes	17,122	16,909
Other long-term liabilities	13,506	11,773
Total liabilities	319,979	269,600
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding:		
46,762 shares at December 31, 2012 and 45,815 shares at December 31, 2011	47	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	285,524	266,022
Accumulated other comprehensive loss	(457)	(1,405)
Treasury stock, at cost; 111 shares at December 31, 2012	(3,000)	—
Retained earnings	500,200	490,410
Total stockholders' equity	782,314	755,073
	$ 1,102,293	$ 1,024,673

Condensed Statements of Income

	Year Ended December 31,		
	2012	2011	2010
	(In thousands)		
Revenue:			
Management fees and other operating revenue	$ 406,981	$ 308,287	$ 238,883
Investment income	550	81	1,153
Total revenue	407,531	308,368	240,036
Expenses:			
Medical care costs	33,102	31,672	30,582
General and administrative expenses	367,606	272,302	218,834
Depreciation and amortization	38,794	31,355	27,166
Total expenses	439,502	335,329	276,582
Operating loss	(31,971)	(26,961)	(36,546)
Interest expense	14,469	14,958	15,500
Loss before income taxes and equity in net income of subsidiaries	(46,440)	(41,919)	(52,046)
Income tax benefit	(15,779)	(14,826)	(16,936)
Net loss before equity in net income of subsidiaries	(30,661)	(27,093)	(35,110)
Equity in net income of subsidiaries	40,451	47,911	90,080
Net income	$ 9,790	$ 20,818	$ 54,970

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2012	2011	2010
	(In thousands)		
Operating activities:			
Cash provided by operating activities	$ 20,611	$ 28,606	$ 19,380
Investing activities:			
Net dividends from and capital contributions to subsidiaries	1,579	27,872	70,800
Purchases of investments	(1,905)	(2,020)	(2,019)
Sales and maturities of investments	4,067	3,760	14,083
Cash paid in business combinations	—	—	(139,762)
Proceeds from sale of subsidiary, net of cash surrendered	9,162	—	—
Purchases of equipment	(61,813)	(30,930)	(40,419)
Changes in amounts due to and due from affiliates	5,187	(50,090)	(5,723)
Change in other assets and liabilities	(1,342)	(20,441)	829
Net cash used in investing activities	(45,065)	(71,849)	(102,211)
Financing activities:			
Proceeds from common stock offering, net of issuance costs	—	—	111,131
Amount borrowed under credit facility	60,000	—	105,000
Repayment of amount borrowed under credit facility	(20,000)	—	(105,000)
Treasury stock repurchases	(3,000)	(7,000)	—
Payment of credit facility fees	—	(1,125)	(1,671)
Excess tax benefits from employee stock compensation	3,667	1,651	295
Proceeds from exercise of stock options and employee stock plan purchases	8,205	7,347	4,056
Net cash provided by financing activities	48,872	873	113,811
Net increase (decrease) in cash and cash equivalents	24,418	(42,370)	30,980
Cash and cash equivalents at beginning of year	14,650	57,020	26,040
Cash and cash equivalents at end of year	$ 39,068	$ 14,650	$ 57,020

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation

Molina Healthcare, Inc., or the Registrant, was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc. Molina Healthcare of Michigan, Inc. and Molina Healthcare of Washington, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B - Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2012, 2011, and 2010 for these services totaled $406.4 million, $307.9 million, and $238.5 million, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate

tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C - Capital Contribution, Dividends and Surplus Note

During 2012, 2011, and 2010, the Registrant received dividends from its subsidiaries amounting to $101.8 million, $76.6 million, and $81.3 million, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries. In addition, in 2011 a subsidiary of the Registrant repaid a surplus note in favor of the Registrant amounting to $9.7 million, including accrued interest. Such amount was a reduction of due from affiliates and prepaid and other current assets.

During 2012, 2011, and 2010, the Registrant made capital contributions to certain subsidiaries amounting to $100.2 million, $58.4 million, and $10.5 million, respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D - Related Party Transactions

On February 27, 2013, the Registrant entered into a lease (the "Lease") with 6 th & Pine Development, LLC (the "Landlord") for office space located in Long Beach, California. The lease consists of two office buildings as follows:

- an existing building, which comprises approximately 70,000 square feet of office space, and
- a new building, which is expected to comprise approximately 120,000 square feet of office space.

The term of the Lease with respect to the existing building is expected to commence on June 1, 2013, and the term of the Lease with respect to the new building is expected to commence on November 1, 2014. The initial term of the Lease with respect to both buildings expires on December 31, 2024, subject to two options to extend the term for a period of five years each. Initial annual rent for the existing building is expected to be approximately $2.5 million and initial annual rent for the new building is expected to be approximately $4.0 million. Rent will increase 3.75% per year through the initial term. Rent during the extension terms will be the greater of then-current rent or fair market rent.

The principal members of the Landlord are John C. Molina, the Chief Financial Officer and a director of the Registrant, and his wife. In addition, in connection with the development of the buildings being leased, the Landlord has pledged shares of common stock in the Registrant he holds as trustee. Dr. J. Mario Molina, the Registrant's Chief Executive Officer and Chairman of the Board of Directors, holds a partial interest in such shares as trust beneficiary.

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because the Registrant has an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. For both years ended December 31, 2012 and 2011, the Registrant's carrying amount for this investment amounted to $3.9 million. For the years ended December 31, 2012, 2011, and 2010, the Registrant paid $28.4 million, $24.3 million, and $22.0 million, respectively, for medical service fees to this provider.

The Registrant is party to a fee-for-service agreement with Pacific Hospital of Long Beach, or Pacific Hospital. Pacific Hospital is owned by Abrazos Healthcare, Inc. Until October 12, 2010, the majority of the shares of Abrazos Healthcare, Inc. were held as community property by Dr. Martha Bernadett and her husband. Dr. Martha Bernadett is the sister of Joseph M. Molina, M.D. (Dr. J. Mario Molina), our Chief Executive Officer, and John Molina, our Chief Financial Officer. On October 12, 2010, Dr. Bernadett and her husband sold their shares in Abrazos Healthcare, Inc., terminating our related party relationship with Pacific Hospital. Under the terms of this fee-for-service agreement we paid Pacific Hospital $0.8 million for the period from January 1, 2010 to October 12, 2010.

On December 26, 2012, the Registrant purchased 110,988 shares of its common stock from certain Molina family trusts for an aggregate purchase price of $3.0 million. This purchase transaction was approved by the Registrant's board of directors. The shares were purchased at a price of $27.03, representing the closing price per share of the Registrant's common stock on December 26, 2012. The shares were purchased from the Janet M. Watt Separate Property Trust dated 10/22/2007, or the Separate Property Trust, and the Watt Family Trust dated 10/11/1996, or the Family Trust. Janet M. Watt is the sister, and her husband Lawrence B. Watt is the brother-in-law, of Dr. J. Mario Molina and John Molina. Ms. Watt is the sole trustee of the Separate Property Trust, and a co-trustee with Lawrence B. Watt of the Family Trust.

23. Subsequent Event

New Mexico Health Plan

On February 11, 2013, we announced that our New Mexico health plan was selected by the New Mexico Human Services Department (HSD) to participate in the new Centennial Care program. In addition to continuing to provide physical and acute health care services, under the new program Molina Healthcare of New Mexico will expand its services to provide behavioral

health and long-term care services. The selection of Molina Healthcare of New Mexico was made by HSD pursuant to its request for proposals issued in August 2012. The operational start date for the program is currently scheduled for January 2014.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting that occurred during the quarter ended December 31, 2012, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2012. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework.*

Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2012, based on those criteria.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on page 117 of this Annual Report on Form 10-K, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2012.

Item 9B. ***Other Information***

6th and Pine Lease

On February 27, 2013, Molina Healthcare, Inc. (the "Company") entered into a build-to-suit office building lease (the "Lease") with 6 th & Pine Development, LLC (the "Landlord") for approximately 190,000 rentable square feet of office space and 15,000 square feet of storage space located at 604 Pine Avenue, Long Beach, California (the "Project"). The Landlord is expected to construct the Project on a "turnkey" basis, which will consist of two office buildings, on-site parking, common areas and certain amenities, and the right to use up to 500 off-site parking spaces to be secured by the Landlord. The two office buildings will be comprised of:

- an existing building located on the site and commonly known as the Independent Press Telegram building (the "Existing Building"), which the Landlord is required to substantially refurbish as part of Phase I of the Project. Upon completion of the refurbishment, the Existing Building is expected to contain approximately 70,000 square feet of office space and 15,000 square feet of storage space, and

- a new building (the "New Building"), which the Landlord is required to construct as part of Phase II of the Project following the demolition of a building currently located on the site commonly known as the Meeker-Baker building. Upon completion of the construction, the New Building is expected to contain approximately 120,000 square feet of office space.

The term of the Lease with respect to the Existing Building is expected to commence on June 1, 2013, and the term of the Lease with respect to the New Building is expected to commence on November 1, 2014. The initial term of the Lease with respect to both buildings expires on December 31, 2024, subject to two options to extend the term for a period of five years each.

Commencing on the commencement date of the lease for the Existing Building, the monthly base rent due under the Lease is (i) for the office space, initially $2.70 per rentable square foot, increasing by 3.75% per year through the initial term, and (ii) for the storage space, $1.40 per rentable square foot, increasing by 3.75% per year through the initial term. Base rent during the extension terms will be the greater of then-current base rent or fair market rent. The Lease is a full service, base year, gross lease. Accordingly, the rent payable by the Company includes the cost of all utilities, taxes, insurance and maintenance with respect to the Project for the base year, 2015. The Company will be responsible for any increases in the cost of utilities, taxes, insurance and/or maintenance in excess of the cost therefor during the base year, 2015 (subject to certain customary limitations). The Company will also pay $600 per year for each on-site parking space (213) and for each off-site parking space that the Company elects to use (up to 500). The per year, per space parking rate will increase by 3% each year for each on-site parking space and by CPI, with a cap of 3%, for each off-site space.

During the first five years of the term of the Lease, the Company has a right of first offer to purchase the Project (including any transferable off-site parking rights held by the Landlord), and from and after year five of the Lease, the Company has an option to purchase the Project (including any transferable off-site parking rights held by the Landlord) for a purchase price equal to the fair market value for the Project.

The principal members of the Landlord are John C. Molina, the Chief Financial Officer and a director of the Company, and his wife. In addition, in connection with the Project the Landlord has pledged shares of common stock in the Company he holds as trustee. Dr. J. Mario Molina, the Company's Chief Executive Officer and Chairman of the Board of Directors, holds a partial interest in such shares as trust beneficiary.

In November 2011, the Company's Board of Directors organized a special committee of five independent directors (the "Special Committee") consisting of Steve Orlando, Ronna Romney, John Szabo, Charles Fedak, and Dr. Frank Murray, and delegated to the Special Committee full power and authority to consider and enter into any real property transaction to meet the Company's space needs. Following its formation, the Special Committee undertook a review of, among other things, the Company's projected space needs and available space options. In connection with its work, the Special Committee retained Latham & Watkins LLP, as its independent legal counsel, and Duff & Phelps LLC, as its independent real estate advisor. Following the completion of its work, the Committee determined that it was appropriate to enter into the Lease with the Landlord under its terms and conditions, and accordingly approved the Company's entry into the Lease.

The foregoing description of the Lease is not complete and is qualified in its entirety by reference to the full text of such agreement, a copy of which is filed as Exhibit 10.32 herewith and which is incorporated herein by reference.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2012, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2012, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2012 and 2011, and the related consolidated statements of income and comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2012 and our report dated February 28, 2013 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 28, 2013

PART III

Item 10. ***Directors, Executive Officers, and Corporate Governance***

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our definitive proxy statement for our 2013 Annual Meeting of Stockholders. The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Election of Directors," "Corporate Governance," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Item 11. ***Executive Compensation***

The information required by Items 402, 407(e)(4), and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference. The remaining information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Joseph M. Molina, M.D., Professional Corporations

Our wholly owned subsidiary, American Family Care, Inc., or AFC, operates our primary care clinics. In 2012, AFC entered into services agreements with the Joseph M. Molina, M.D. Professional Corporations, or JMMPC. JMMPC was created to further advance our direct delivery line of business. Its sole shareholder is Joseph M. Molina, M.D. (Dr. J. Mario Molina), our Chairman of the Board, President and Chief Executive Officer. Dr. Molina is paid no salary and receives no dividends in connection with his work for, or ownership of, JMMPC. Under the services agreements, AFC provides the clinic facilities, clinic administrative support staff, patient scheduling services and medical supplies to JMMPC, and JMMPC provides outpatient professional medical services to the general public for routine non-life threatening, outpatient health care needs. While JMMPC may provide services to the general public, substantially all of the individuals served by JMMPC are members of our health plans. JMMPC does not have agreements to provide professional medical services with any other entities. In addition to the services agreements with AFC, JMMPC has entered into affiliation agreements with us. Under these agreements, we have agreed to fund JMMPC's operating deficits, or receive JMMPC's operating surpluses, based on a monthly reconciliation such that JMMPC will operate at break even and derive no profit.

We have determined that JMMPC is a variable interest entity, or VIE, and that we are its primary beneficiary. We have reached this conclusion under the power and benefits criterion model according to U.S. generally accepted accounting principles. Specifically, we have the power to direct the activities that most significantly affect JMMPC's economic performance, and the obligation to absorb losses or right to receive benefits that are potentially significant to the VIE, under the services and affiliation agreements described above. Because we are its primary beneficiary, we have consolidated JMMPC. JMMPC's assets may be used to settle only JMMPC's obligations, and JMMPC's creditors have no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2012, JMMPC had total assets of $1.4 million, comprising primarily cash and equivalents, and total liabilities of $1.1 million, comprising primarily accrued payroll and employee benefits.

Our maximum exposure to loss as a result of our involvement with this entity is equal to the amounts needed to fund JMMPC's ongoing payroll and employee benefits. We believe that such loss exposure will be immaterial to our consolidated

operating results and cash flows for the foreseeable future. For the year ended December 31, 2012, we provided an initial cash infusion of $0.3 million to JMMPC in the first quarter of 2012 to fund its start-up operations. During 2012 our health plans received $0.2 million from JMMPC under the terms of the affiliation agreement.

Stock Repurchase

Janet M. Watt is the sister, and her husband Lawrence B. Watt is the brother-in-law, of Dr. J. Mario Molina, the Company's Chief Executive Officer, and John Molina, the Company's Chief Financial Officer. Ms. Watt is the sole trustee of the Janet M. Watt Separate Property Trust dated 10/22/2007 (the "Separate Property Trust") and a co-trustee with Lawrence B. Watt, of the Watt Family Trust dated 10/11/1996 (the "Family Trust" and together with the Separate Property Trust, the "Trusts"). On December 26, 2012, pursuant to a Stock Purchase Agreement between the Company and the Trusts, the Company purchased an aggregate of 110,988 shares of its common stock from the Trusts for an aggregate purchase price of $3,000,005.64, as follows: (i) 43,767 shares from the Family Trust for an aggregate purchase price of $ 1,183,022.01 and (ii) 67,221 shares from the Separate Property Trust for an aggregate purchase price of $1,816,983.63. The shares were purchased at a price per share of $27.03, representing the closing price per share of the Company's common stock on December 26, 2012, as reported by the New York Stock Exchange. The transaction was approved by the Company's Board of Directors.

6th and Pine Lease

Please see the information disclosed under Part II, Item 9B. Other Information, in this Annual Report, which disclosure is incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2013 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The Company's consolidated financial statements, the notes thereto and the report of the Independent Registered Public Accounting Firm are on pages 64 through 108 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets - At December 31, 2012 and 2011

Consolidated Statements of Income - Years ended December 31, 2012, 2011, and 2010

Consolidated Statements of Stockholders' Equity - Years ended December 31, 2012, 2011, and 2010

Consolidated Statements of Cash Flows - Years ended December 31, 2012, 2011, and 2010

Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

Number	Description	Method of Filing
1.1	Purchase Agreement, dated as of February 11, 2013, among Molina Healthcare, Inc. and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Representatives of the Initial Purchasers.	Filed as Exhibit 1.1 to registrant's Form 8-K filed February 15, 2013.
2.1	Asset Purchase Agreement between Molina Healthcare, Inc. and Unisys Corporation dated as of January 18, 2010	Filed as Exhibit 2.1 to registrant's Form 8-K filed January 19, 2010.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.2 to registrant's Form 8-K filed February 17, 2009.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2007.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2007.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2007.
4.4	Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association.	Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
4.5	Form of 1.125% Cash Convertible Senior Note due 2020	Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.4	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.5	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.6	2011 Equity Incentive Plan	Filed as Exhibit 10.2 to registrant's Form 8-K filed May 2, 2011.
10.7	2011 Employee Stock Purchase Plan	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 2, 2011.
10.8	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.

Number	Description	Method of Filing
10.10	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.11	Form of Stock Option Agreement under Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.12	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.
10.13	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
10.14	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
10.15	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
10.16	Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012	Filed herewith.
10.17	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.18	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.	Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013.
10.19	Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013.
10.20	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.	Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013.
10.21	Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013.
10.22	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.	Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013.
10.23	Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013.
10.24	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch.	Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013.
10.25	Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A.	Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013.
10.26	Term Loan Agreement, dated as of December 1, 2011, among Molina Center LLC, various lenders and East West Bank, as Administrative Agent	Filed as Exhibit 10.18 to registrant's From 10-K filed February 29, 2012.
10.27	Guaranty, dated as of December 1, 2011, by Molina Healthcare, Inc. in favor of East West Bank, as Administrative Agent	Filed as Exhibit 10.9 to registrant's Form 10-K filed February 29, 2012.
10.28	Environmental Indemnity, dated as of December 1, 2011, by Molina Center LLC and Molina Healthcare, Inc. for the benefit of certain lenders and East West Bank, as Administrative Agent	Filed as Exhibit 10.20 to registrant's Form 10-K filed February 29, 2012.
10.29	Purchase Agreement, dated as of October 11, 2011, between Molina Center LLC and 200 Oceangate, LLC	Filed as Exhibit 10.21 to registrant's Form 10-K filed February 29, 2012.

Number	Description	Method of Filing
10.30	First Amendment to Purchase Agreement, dated as of November 10, 2011, between Molina Center LLC and 200 Oceangate, LLC	Filed as Exhibit 10.22 to registrant's Form 10-K filed February 29, 2012.
10.31	Second Amendment to Purchase Agreement, dated as of November 30, 2011, between Molina Center LLC and 200 Oceangate, LLC	Filed as Exhibit 10.23 to registrant's Form 10-K filed February 29, 2012.
10.32	Lease Agreement, dated as of February 27, 2013, by and between 6th & Pine Development, LLC and Molina Healthcare, Inc.	Filed herewith.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	Filed herewith.
101.INS(1)	XBRL Taxonomy Instance Document	Filed herewith.
101.SCH(1)	XBRL Taxonomy Extension Schema Document	Filed herewith.
101.CAL(1)	XBRL Taxonomy Extension Calculation Linkbase Document	Filed herewith.
101.DEF(1)	XBRL Taxonomy Extension Definition Linkbase Document	Filed herewith.
101.LAB(1)	XBRL Taxonomy Extension Label Linkbase Document	Filed herewith.
101.PRE(1)	XBRL Taxonomy Extension Presentation Linkbase Document	Filed herewith.

(1) Pursuant to Rule 406T of Regulation S-T, XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 28th day of February, 2013.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina

Joseph M. Molina, M.D. (Dr. J. Mario Molina)
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	February 28, 2013
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	February 28, 2013
/s/ Joseph W. White **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	February 28, 2013
/s/ Garrey E. Carruthers **Garrey E. Carruthers, Ph.D.**	Director	February 28, 2013
/s/ Charles Z. Fedak **Charles Z. Fedak, CPA, MBA**	Director	February 28, 2013
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	February 28, 2013
/s/ Steven Orlando **Steven Orlando, CPA (inactive)**	Director	February 28, 2013
/s/ Ronna Romney **Ronna Romney**	Director	February 28, 2013
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	February 28, 2013

EXHIBIT 10.16

CHANGE IN CONTROL AGREEMENT

THIS CHANGE IN CONTROL AGREEMENT (the "Agreement") is entered into as of September 18, 2012, (the "Effective Date"), by and between Jeff Barlow (the "Executive") and Molina Healthcare, Inc., a Delaware corporation (the "Company").

RECITALS

1. Definitions. The following definitions shall apply for all purposes under this Agreement:

(a) Annual Base Salary. "Annual Base Salary" shall mean the Executive's annualized fiscal year base salary (as paid in accordance with the Company's regular payroll practices) as in effect on the date of Executive's Separation from Service (or if Executive's salary was greater, on the date of the Announcement (as such term is defined below)).

(b) Change in Control. "Change in Control" means the occurrence of any of the following events after the Effective Date:

(i) The acquisition (other than by an Excluded Person), directly or indirectly, in one or more transactions, by any person or by any group of persons, within the meaning of Section 13(d) or 14(d) of the Exchange Act, of beneficial ownership (within the meaning of Rule 13d-3 of the Exchange Act) of more than fifty percent (50%) of either the outstanding shares of common stock or the combined voting power of the Company's outstanding voting securities entitled to vote generally, whether or not the acquisition was previously approved by the existing directors, other than an acquisition that complies with clause (x) and (y) of paragraph (ii);

(ii) Consummation of a reorganization, merger, or consolidation of the Company or the sale or other disposition of all or substantially all of the Company's assets unless, immediately following such event, (x) all or substantially all of the stockholders of the Company immediately prior to such event own, directly or indirectly, more than fifty percent (50%) of the then outstanding voting securities of the resulting corporation (including without limitation, a corporation which as a result of such event owns the Company or all or substantially all of the Company's assets either directly or indirectly through one or more subsidiaries) and (y) the securities of the surviving or resulting corporation received or retained by the stockholders of the Company are publicly traded;

(iii) Approval by the stockholders of the complete liquidation or dissolution of the Company; or

(iv) A change in the composition of a majority of the directors on the Company's Board of Directors within 12 months if not approved by a majority of the pre-existing directors.

A transaction shall not constitute a Change in Control if its sole purpose is to change the state of the Company's incorporation or to create a holding company that will be owned in substantially the same proportions by the persons who held the Company's securities immediately before such transaction.

(c) Excluded Person. "Excluded Person" means:

(i) Any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act;

(ii) The Company;

(iii) An employee benefit plan (or related trust) sponsored or maintained by the Company or its successor;

(iv) Any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than 15% of the Common Stock on the Effective Date (or any affiliate, successor, heir, descendant, or related party of or to such person).

(d) Good Reason. "Good Reason" shall mean that, on or after the effective date of a Change in Control, the Executive (without Executive's written consent):

(i) Has incurred a material reduction in his authority or responsibility with the Company in comparison to the Executive's authority or responsibility prior to the public announcement of the Change in Control (the "Announcement");

(ii) Has incurred one or more reductions in his "total compensation" with the Company which is defined as follows:

(A) A material reduction in Annual Base Salary, or

(B) A material reduction in the target annual bonus percentage of Annual Base Salary; or

(iii) A material change in the geographic location of the Executive's principal office with the Company.

(iv) The Executive gives to the Company written notice of the event in clause (i), (ii), or (iii) giving rise to Good Reason within ninety (90) days of the initial existence of such event and the Company has not cured the event giving rise to Good Reason within thirty (30) days of receipt of written notification by Executive and the Executive resigns from employment with the Company within sixty (60) days following the end of the cure period.

(e) Cause. "Cause" includes any of the following committed by Executive (or omitted to be done by Executive) that occur on or after the Effective Date:

(i) Theft, unlawful acts involving moral turpitude, or fraud with respect to any aspect of the Company's business;

(ii) Neglect of or failure to perform employment duties;

(iii) Insubordination;

(iv) Abuse of alcohol or other drugs or substances;

(v) A conviction of or plea of "guilty" or "no contest" to a felony under the laws of the United States or any state thereof (or admission or confession with respect thereto);

(vi) Any violation or breach of any Company policy that has been established to comply with either the Sarbanes-Oxley Act of 2002 (or any regulations or rules or decisions that implement/interpret such Act) or any laws, rules, or requirements of the Securities and Exchange Commission or the New York Stock Exchange;

(vii) Conduct on the part of Executive that constitutes a breach of any fiduciary duty or duty of loyalty owed to the Company or its affiliates by Executive; or

(viii) Breach of this Agreement; provided, however, that any such breach or violation of Sections 1(e)(ii), (iii), (iv), or (viii) hereof shall not constitute Cause unless it is (A) not reasonably curable or (B) if reasonably curable, is not cured by the Executive within thirty (30) days notice from the Company.

(f) Total Disability. "Total Disability" shall be deemed to occur on the ninetieth (90th) consecutive or non-consecutive calendar day within any twelve (12) month period that Executive is unable to perform his duties because of any physical or mental illness or disability.

(g) Target Bonus. "Target Bonus" shall mean the Executive's fiscal year target bonus opportunity.

2. Severance Payment and Equity Compensation .

(a) The Executive shall be entitled to receive a severance payment from the Company as provided herein (the "Severance Payment") if the Executive has a Separation of Service within the first twelve (12) month period after the occurrence of a Change in Control, by reason of either:

(i) The Executive's voluntary resignation of his employment with the Company for Good Reason pursuant to Section 1(d); or

(ii) The Company's discharge of the Executive from employment with the Company for any reason other than Cause, death, or Total Disability.

For all purposes under this Agreement, the amount of the Severance Payment shall be equal to two times (2X) the Annual Base Salary, plus a pro rata portion of the Executive's Target Bonus for the year in which Executive's employment is terminated based on the number of entire months of such year that have elapsed through the date of Executive's termination of employment as a fraction of twelve (12), plus a cash payment of $50,000 for all Company group health benefits. The Severance Payment shall be distributable upon Executive's Separation from Service as follows:

(iii) the portion thereof that does not exceed the Exemption Limit shall satisfy the involuntary separation pay exemption under Treasury Regulation Section 1.409A-1(b)(9)(iii), shall be exempt from Section 409A of the Internal Revenue Code of 1986, as amended (the "Code") and shall be paid in a lump sum payment within the ten (10) day period commencing on the 60th day after the date of Executive's Separation from Service, and

(iv) the remaining portion (if any) shall be subject to and shall comply with Section 409A of the Code and shall be paid in a lump sum payment within the ten (10) day period commencing on the 60th day after the date of the Executive's Separation from Service; provided, however, that, if Executive is a Specified Employee on the date of the Executive's Separation from S

ervice, such payment shall be paid within the ten (10) day period following the earlier of (x) the expiration of the six (6) month period commencing on the date of the Executive's Separation from Service and (y) the date of Executive's death.

Except as may be provided under Sections 2(b) and 2(c), the Severance Payment shall be in lieu of any other post-termination employment payments.

(b) Incentive, Deferred Compensation, and Retirement Programs. If the Executive is entitled to a Severance Payment under Section 2(a) and notwithstanding anything to the contrary in any equity incentive, stock option, stock appreciation right (SAR), or deferred compensation plan or retirement plan or agreements, then (i) the Executive shall become immediately fully vested in all of his outstanding restricted stock, stock options, SARs, warrants, phantom stock, deferred compensation, retirement, or similar plans or agreements of the Company, and (ii) the Executive (or his personal representative if applicable) shall be permitted to exercise any of his vested stock options/SARs until the earlier of: (i) one (1) year after Executive's termination of employment, and (ii) the term of such unexercised stock options, warrants, or SARs.

(c) Mitigation. Except as may be expressly provided elsewhere in this Agreement, the Executive shall not be required to mitigate the amount of any payment or benefit contemplated by this Section 2 (whether by seeking new employment or in any other manner). No such payment shall be reduced by earnings that the Executive may receive from any other source.

(d) Conditions. All payments and benefits provided under this Section 2 are conditioned on Executive's continuing compliance with this Agreement and the Company's policies. All payments and benefits are also conditioned on, and in consideration for, Executive's execution (and effectiveness) of a release of claims and covenant not to sue substantially in the form provided in Exhibit A to be delivered by Executive no later than sixty (60) days following the Executive's Separation of Service, any revocation period required by law has run, and Executive has not revoked the release of claims and covenant not to sue.

3. Limitation on Payments.

(a) Anything in this Agreement to the contrary notwithstanding, in the event it shall be determined that any payment or distribution made, or benefit provided, by the Company to or for the benefit of the Executive under this Agreement or any other agreement between the Company and the Executive or plan of the Company would constitute a "parachute payment" as defined in Section 280G of the Code, then the benefits payable pursuant to this Agreement shall be reduced so that the aggregate present value of all payments in the nature of compensation to (or for the benefit of) the Executive which are contingent on a change of control (as defined in Section 280G(b)(2)(A) of the Code) is One Dollar ($1.00) less than the amount which the Executive could receive without being considered to have received any parachute payment (the amount of this reduction in the benefits payable is referred to herein as the "Excess Amount"). The determination of the amount of any reduction required by this Section 3(a) shall be made by a nationally recognized tax counsel selected by the Company, and such determination shall be conclusive and binding on the parties hereto.

(b) Notwithstanding the provisions of Section 3(a), if it is established, pursuant to a final determination of a court or an Internal Revenue Service proceeding which has been finally

and conclusively resolved, that an Excess Amount was received by the Executive from the Company, then such Excess Amount shall be deemed for all purposes to be a loan to the Executive made on the date the Executive received the Excess Amount and the Executive shall repay the Excess Amount to the Company on demand (but no less than ten (10) days after written demand is received by the Executive) together with interest on the Excess Amount at the "applicable Federal rate" (as defined in Section 1274(d) of the Code) from the date of the Executive's receipt of such Excess Amount until the date of such repayment.

4. Successors.

(a) Company's Successors. Any successor (whether direct or indirect and whether by purchase, lease, merger, consolidation, liquidation, or otherwise) to all or substantially all of the Company's business and/or assets, shall be obligated to perform this Agreement in the same manner and to the same extent as the Company would be required to perform it in the absence of a succession.

(b) Executive's Successors. This Agreement and all rights of the Executive hereunder shall inure to the benefit of, and be enforceable by, the Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees, and legatees.

5. Miscellaneous Provisions.

(a) Notice. Notices and all other communications contemplated by this Agreement shall be in writing and shall be deemed to have been duly given when personally delivered or when mailed by U.S. registered or certified mail, return receipt requested and postage prepaid. In the case of the Executive, mailed notices shall be addressed to him or her at the home address which he most recently communicated to the Company in writing. In the case of the Company, mailed notices shall be addressed to its corporate headquarters, and all notices shall be directed to the attention of its Secretary.

(b) Waiver. No provision of this Agreement shall be modified, waived or discharged unless the modification, waiver or discharge is agreed to in writing and signed by the Executive and by an authorized officer of the Company (other than the Executive). No waiver by either party of any breach of, or of compliance with, any condition or provision of this Agreement by the other party shall be considered a waiver of any other condition or provision or of the same condition or provision at another time.

(c) Whole Agreement. This Agreement contains all the legally binding understandings and agreements between Executive and the Company pertaining to the subject matter of this Agreement and supersedes all such agreements, whether oral or in writing, previously entered into between the parties.

(d) Withholding Taxes. All payments made under this Agreement shall be subject to reduction to reflect taxes required to be withheld by law.

(e) Choice of Law. The validity, interpretation, construction, and performance of this Agreement shall be governed by the laws of the State of California without regard to the conflicts of laws principles thereof.

(f) Severability. The invalidity or unenforceability of any provision or provisions of this Agreement shall not affect the validity or enforceability of any other provision hereof, which shall remain in full force and effect.

(g) No Assignment. The rights of Executive to payments or benefits under this Agreement shall not be made subject to option or assignment, either by voluntary or involuntary assignment or by operation of law, including (without limitation) bankruptcy, garnishment, attachment or other creditor's process, and any action in violation of this Subsection (h) shall be void.

(h) Nondisparagement; Confidentiality. On the Effective Date and thereafter, Executive agrees that he will not disparage the Company or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. Executive further agrees that he will not direct anyone to make any disparaging oral or written remarks to any third parties. During Executive's employment and following Executive's termination of employment for any reason, Executive agrees to not use or disclose the confidential information or trade secrets of the Company.

(i) Nonsolicitation. During the Executive's employment with Company and for twelve months after Executive's termination of employment and payment of the Severance Payment hereunder, the Executive shall not, directly or indirectly, either as an individual or as an employee, agent, consultant, advisor, independent contractor, general partner, officer, director, stockholder, investor, lender, or in any other capacity whatsoever, of any person, firm, corporation, or partnership, (i) induce or attempt to induce, or hire, any person who at the time of such inducement or hire is an employee of the Company (or who was, within six months prior to such inducement or hire, an employee) to perform work or service for any other person or entity other than the Company or (ii) through the use of confidential information or trade secrets, solicit customers, suppliers, or clients of the Company to reduce or discontinue their business with the Company or to engage in business with any competing entity.

(j) Unfunded and Unsecured. The obligations of the Company under this Agreement shall be unfunded and unsecured. With respect to any payments to which the Executive has a fixed and vested interest but that have not yet been made by the Company, nothing contained herein shall give the Executive any rights that are greater than those of a general unsecured creditor of the Company.

(k) Exhibit B. Exhibit B hereto regarding Code Section 409A is incorporated herein by this reference.

IN WITNESS WHEREOF, each of the parties has executed this Agreement, in the case of the Company by its duly authorized officer, as of the day and year first above written.

EXECUTIVE:

—

Jeff Barlow

MOLINA HEALTHCARE, INC.:

By: Joseph M. Molina, M.D.
Its: President and Chief Executive Officer

EXHIBIT A

Form of Release of Claims and Covenant Not To Sue

In consideration of the payments and other benefits that Molina Healthcare, Inc., a Delaware corporation (the "Company"), is providing to Jeff Barlow ("Executive") under the Change in Control Agreement entered into by and between Executive and the Company, dated September 18, 2012, the Executive, on his own behalf and on behalf of Employee's representatives, agents, heirs and assigns, waives, releases, discharges and promises never to assert any and all claims, demands, actions, costs, rights, liabilities, damages or obligations of every kind and nature, whether known or unknown, suspected or unsuspected that Executive ever had, now have or might have as of the date of Executive's termination of employment with the Company against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, attorneys, insurers, successors, or assigns (including all such persons or entities that have a current and/or former relationship with the Company) for any claims arising from or related to Executive's employment with the Company, its parent or any of its affiliates and subsidiaries and the termination of that employment.

These released claims also specifically include, but are not limited to, any claims arising under any federal, state and local statutory or common law, such as (as amended and as applicable) Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, the Americans With Disabilities Act, the Employee Retirement Income Security Act, the Family Medical Leave Act, the Equal Pay Act, the Fair Labor Standards Act, the Industrial Welfare Commission's Orders, the California Fair Employment and Housing Act, the California Constitution, the California Government Code, the California Labor Code and any other federal, state or local constitution, law, regulation or ordinance governing the terms and conditions of employment or the termination of employment, and the law of contract and tort and any claim for attorneys' fees.

Furthermore, the Executive acknowledges that this waiver and release is knowing and voluntary and that the consideration given for this waiver and release is in addition to anything of value to which Executive was already entitled. Executive acknowledges that there may exist facts or claims in addition to or different from those which are now known or believed by Executive to exist. Nonetheless, this Agreement extends to all claims of every nature and kind whatsoever, whether known or unknown, suspected or unsuspected, past or present. Executive also expressly waives the provisions of California Civil Code section 1542, which provides: "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him/her must have materially affected his settlement with the debtor." With respect to the claims released in the preceding sentences, the Executive will not initiate or maintain any legal action or proceeding of any kind against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, successors, or assigns (including all such persons or entities that have a current or former relationship with the Company), for the purpose of obtaining any personal relief, nor assist or participate in any such proceedings, including any proceedings brought by any third parties (except as otherwise required or permitted by law). The Executive further acknowledges that he has been advised by this writing that:

- he should consult with an attorney prior to executing this release;
- he has at least twenty-one (21) days within which to consider this release;
- he has up to seven (7) days following the execution of this release by the parties to revoke the release; and
- this release shall not be effective until such seven (7) day revocation period has expired.

Executive agrees that the release set forth above shall be and remain in effect in all respects as a complete general release as to the matters released.

EXECUTIVE

_____

Jeff Barlow

Date:

Exhibit B

SECTION 409A PROVISIONS

1. EXEMPTION FROM AND COMPLIANCE WITH SECTION 409A OF THE CODE

a. ADMINISTRATION OF AGREEMENT. Certain payments and benefits payable under the Agreement are intended to be exempt from, or comply with, the requirements of Section 409A of the Code. The Agreement shall be interpreted in accordance with the applicable exemptions from Section 409A of the Code and the Treasury Regulations thereunder. To the extent the payments and benefits under the Agreement are subject to Section 409A of the Code, the Agreement shall be interpreted, construed and administered in a manner that satisfies the requirements of Sections 409A(a)(2), (3) and (4) of the Code and the Treasury Regulations and interpretive guidance issued thereunder. If the Company and Executive determine that any compensation, benefits or other payments that are payable under the Agreement and intended to comply with Sections 409A(a)(2), (3) and (4) of the Code do not comply with Section 409A of the Code, the Treasury Regulations and interpretive guidance issued thereunder, the Company and Executive agree to amend the Agreement, or take such other actions as the Company and Executive deem reasonably necessary or appropriate, to comply with the requirements of Section 409A of the Code, the Treasury Regulations and interpretive guidance issued thereunder. In the case of any compensation, benefits or other payments that are payable under the Agreement and intended to comply with Sections 409A (a)(2), (3) and (4) of the Code, if any provision of the Agreement would cause such compensation, benefits or other payments to fail to so comply, such provision shall not be effective and shall be null and void with respect to such compensation, benefits or other payments, and such provision shall otherwise remain in full force and effect.

b. DELAYED DISTRIBUTION UNDER SECTION 409A OF THE CODE. If Executive is a Specified Employee on the date of Executive's Separation from Service, any payments or benefits under the Agreement that are subject to Section 409A of the Code shall be delayed in order to comply with Section 409A(a)(2)(B)(i) of the Code, and such payments or benefits shall be paid or distributed to Executive within the ten (10) day period following the earlier of (x) the expiration of the six (6) month period commencing on the date of Executive's Separation from Service, or (y) the date of Executive's death.

2. DEFINITIONS

For purposes of this Agreement, the following capitalized terms have the meanings set forth below:

a. The "Exemption Limit" shall mean the exemption limit set forth in Treasury Regulation Section 1.409A-1(b)(9)(iii)(A) and shall equal two times the lesser of:

(i) the amount of Executive's annualized compensation based upon the Executive's annual rate of pay for the calendar year immediately preceding the calendar year in which Executive's Separation from Service occurs (adjusted for any increase during the calendar year in which such Separation from Service occurs that would be expected to continue indefinitely had Executive remained employed with the Company), or

(ii) the maximum amount that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the calendar year in which Executive's Separation from Service occurs (the Section 401(a)(17) annual compensation limit for 2012 is $250,000).

b. "Separation from Service", with respect to Executive (or another Service Provider), means Executive's (or such Service Provider's) "separation from service," as defined in Treasury Regulation Section 1.409A-1(h), with respect to the Service Recipient.

c. "Service Provider" means Executive or any other "service provider," as defined in Treasury Regulation Section 1.409A-1(f).

d. "Service Recipient," with respect to Executive, means Molina Healthcare, Inc. or the subsidiary of Molina Healthcare, Inc. employing the Executive, whichever is applicable, and all persons considered part of the "service recipient," as defined in Treasury Regulation Section 1.409A-1(g), as determined from time to time. As provided in Treasury Regulation Section 1.409A-1(g), the "Service Recipient" shall mean the person for whom the services are performed and with respect to whom the legally binding right to compensation arises, and all persons with whom such person would be considered a single employer under Section 414(b) or 414(c) of the Code.

e. "Specified Employee" means a Service Provider who, as of the date of the Service Provider's Separation from Service is a "Key Employee" of the Service Recipient any stock of which is publicly traded on an established securities market or otherwise. For purposes of this definition, a Service Provider is a "Key Employee" if the Service Provider meets the requirements of Section 416(i)(1)(A)(i), (ii) or (iii) of the Code (applied in accordance with the Treasury Regulations thereunder and disregarding Section 416(i)(5) of the Code) at any time during the testing year. If a Service Provider is a "Key Employee" (as defined above) as of a Specified Employee Identification Date, the Service Provider shall be treated as "Key Employee" for the entire twelve (12) month period beginning on the Specified Employee Effective Date. The "Specified Employees" shall be determined in accordance with Section 409A(a)(2)(B)(i) of the Code and Treasury Regulation Section 1.409A-1(i).

f. "Specified Employee Effective Date" means the first day of the fourth month following the Specified Employee Identification Date. The Specified Employee Effective Date may be changed by Molina Healthcare, Inc., in its discretion, in accordance with Treasury Regulation Section 1.409A-1(i)(4).

g. "Specified Employee Identification Date", for purposes of Treasury Regulation Section 1.409A-1(i)(3), shall mean December 31. The "Specified Employee Identification Date" shall apply to all "nonqualified deferred compensation plans" (as defined in Treasury Regulation Section 1.409A-1(a)) of the Service Recipient and all affected Service Providers. The "Specified Employee Identification Date" may be changed by Molina Healthcare, Inc., in its discretion, in accordance with Treasury Regulation Section 1.409A-1(i)(3).

OFFICE BUILDING LEASE

Full Service Gross –Single Tenant Building(s)

LANDLORD: 6th& PINE DEVELOPMENT, LLC,
a California limited liability company

TENANT: MOLINA HEALTHCARE, INC.,
a Delaware corporation

DATE: February 28, 2013

FUNDAMENTAL LEASE PROVISIONS

The following fundamental lease provisions are incorporated into the Lease attached hereto and said provisions shall have the following meanings throughout the Lease.

(a) Landlord: 6th & Pine Development, LLC,
a California limited liability company.

(b) Tenant: Molina Healthcare, Inc.,
a Delaware corporation.

(c) Site and Project: That certain real property having the primary address of 604 Pine Avenue, Long Beach, California, as more particularly described on Exhibit "A-1" attached hereto (the "**Site**"). A site plan of the Buildings, the On-Site Parking and related common areas and amenities (collectively, the "**Project**") is attached hereto as Exhibit "A-2."

(d) Existing Building: The office building located on the Site as of the date hereof and commonly known as the Press-Telegram Building, to be refurbished by Landlord pursuant to the terms of the Work Letter Agreement attached hereto as Exhibit "B" (the "**Work Letter**").

(e) New Building: The office building to be constructed by Landlord on the Site and in the general location of the office building commonly known as the Meeker-Baker Building, pursuant to the terms of the Work Letter; the Existing Building (as refurbished) and the New Building shall sometimes be collectively referred to as the "Buildings" and each, as a "Building."

(f) Premises: The entire Rentable Area of each Building. In addition to the Premises in each Building, Tenant has the exclusive right to use the On-Site Parking Spaces as provided in clause (u) below and Article 30.

(g) Rentable Area of Existing Building: Subject to Section 1.2, approximately 89,702 rentable square feet (" **RSF**"), consisting of (i) approximately 70,110 RSF of office space , and (ii) approximately 19,592 RSF of subterranean storage space (the "**Storage Space**").

(h) Rentable Area of New Building: Subject to Section 1.2 of the Lease, approximately 120,000 RSF of office space.

(i) Rentable Area of Premises: The total Rentable Area of the Existing Building and the New Building.

(j) Scheduled Commencement Date(s): (i) Existing Building: June 1, 2013.

(ii) New Building: November 1, 2014.

(k) Term: (i) Existing Building: Approximately eleven (11) years, six (6) months from the Commencement Date of the Existing Building and ending on the Expiration Date, unless extended pursuant to Exhibit "J" attached hereto or earlier terminated as provided in the Lease.

(ii) New Building: Approximately ten (10) years, one (1) month from the Commencement Date of the New Building and ending on the Expiration Date, unless extended pursuant to Exhibit "J" attached hereto or earlier terminated as provided in the Lease.

(l) Commencement Date(s): See Section 2.3.

(m) Expiration Date: December 31, 2024, unless extended pursuant to Exhibit "J" attached hereto or earlier terminated as provided in the Lease.

(n) Monthly Base Rent: (i) Existing Building. (A) For the period from the Commencement Date of the Existing Building through the date immediately preceding the first (1st) anniversary of the Commencement Date of the Existing Building, $2.70 per RSF for the Existing Building (excluding the Storage Space), and as increased by three point seven five percent (3.75%) per year on the first (1st) and each subsequent anniversary of the Commencement Date of the Existing Building (each such anniversary of the Commencement Date of the Existing Building being referred to herein as an "**Adjustment Date**") thereafter through the end of the stated Term (subject to Exhibit "J" for the Extension Periods), and (B) for the period from the Commencement Date through the date immediately preceding the first Adjustment Date, $1.40 per RSF of the Storage Space, and as increased by three point seven five percent (3.75%) per year on the first (1st) and each subsequent Adjustment Date

thereafter through the end of the stated Term (subject to Exhibit "J" for the Extension Periods).

(ii) New Building. From and after the Commencement Date of the New Building through the end of the stated Term (subject to Exhibit "J" for the Extension Periods), the same per RSF rate as is in effect from time to time with respect to the Existing Building (other than the Storage Space), including any cumulative annual escalations therein.

(o) Security Deposit: None.

(p) Construction of Improvements: Landlord shall construct the Project, including the Tenant Improvements in the Existing Building and the New Building in accordance with the Work Letter.

(q) Use: General business, executive, professional, corporate, and administrative office use only, and any other use only. Notwithstanding the foregoing, Landlord agrees that Tenant may use the Premises, in connection with its general business activities, for meeting, training and conference purposes, for the preparation, service and providing of food and beverages for the Tenant Parties (as defined below), for health club and childcare facilities for the Tenant Parties and others (as long as such use is primarily to provide a service or amenity to Tenant's employees, staff and invitees), on-site sale of logo and amenity type merchandise to employees, display, testing and demonstration events, in each case subject to the restrictions set forth in Article 5 and Applicable Laws.

(r) Tenant's Address for Notices: Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Attention: General Counsel

With a copies to:

Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Attention: Mr. Salvador Gutierrez, AVP, Facilities

and

Molina Healthcare, Inc..
200 Oceangate, Suite 100
Long Beach, CA 90802
Attention: Chairperson of Corporate Governance and Nominating Committee of Board of Directors

(s) Landlord's Address for Notices: 6th& Pine Development, LLC
741 Atlantic Avenue
Long Beach, CA 90813
Attention: 604 Pine Landlord

With a copy to:
6th& Pine Development, LLC
741 Atlantic Avenue
Long Beach, CA 90813
Attention: Property Manager

(t) Landlord's Broker: Cushman & Wakefield of California, Inc.

(u) Parking: As further described in Article 30, a total of up to seven hundred and thirteen (713) parking spaces, to be comprised of (a) (i) for the period commencing on the Commencement Date for the Existing Building and ending on the date immediately preceding the Commencement Date for the New Building, sixty (60) On-Site Parking Spaces (as defined in Section 30.2 below), and (ii) for the period commencing on the Commencement Date for the New Building and continuing through the Expiration Date, two hundred thirteen (213) On-Site Parking Spaces, and (b) for the period commencing on the Commencement Date for the Existing Building and continuing through the Expiration Date, up to five hundred (500) Off-Site Parking Spaces (as defined in Section 30.3 below), in each case as more particularly described in, and to be made available to Tenant in accordance with the terms

of, Article 30 hereof. In the event of a discrepancy between this Section “u” and Article 30, the terms of Article 30 shall prevail.

(v) Renewal Rights: See Exhibit “J” attached hereto.

(w) Right of First Offer to Purchase: See Exhibit “I-1” attached hereto.

(x) Option to Purchase: See Exhibit “I-2” attached hereto.

(y) Base Year: Calendar Year 2015

(z) Tenant’s Share: 100%

LEASE AGREEMENT

This LEASE AGREEMENT (this "**Lease**"), dated as of February 27, 2013 (the "**Effective Date**"), is made and entered into by and between 6th& PINE DEVELOPMENT, LLC, a California limited liability company ("**Landlord**"), and MOLINA HEALTHCARE, INC., a Delaware corporation ("**Tenant**"), who agree generally as follows:

GENERAL CONDITIONS

Landlord and Tenant agree that the following are general conditions which govern all of the rights and obligations of Landlord and Tenant and supersede, to the extent appropriate, any contrary provision in this Lease.

A. Consent/Duty to Act Reasonably. Unless the applicable provision of this Lease expressly references "sole" or "absolute" with respect to a consent right or other exercise of discretion (in which case such standard shall apply), (i) any time the consent of Landlord or Tenant is required, such consent shall not be unreasonably withheld, conditioned or delayed, and (ii) whenever this Lease grants Landlord or Tenant the right to take action, exercise discretion, or make allocations or other determinations, Landlord and Tenant shall act reasonably and in good faith and take no action which might result in the frustration of the reasonable expectations of a sophisticated tenant or landlord concerning the benefits to be enjoyed under this Lease.

B. Quality of Construction; Phasing of Construction; and Landlord Warranties.

(a) Quality of Construction. Landlord hereby represents and warrants to Tenant and covenants that the Project, including the Tenant Improvements to be constructed in the Existing Building and New Building, will be constructed in accordance with the terms and conditions of the Work Letter and industry custom and practice for a "first-class" office project (taking into account that the Project involves (i) with respect to Phase I (as defined in the Work Letter) a material restoration and renovation of a historic building and (ii) with respect to Phase II (as defined in the Work Letter), material reconstruction of an existing building, whereby the historic façade will be retained and incorporated into the New Building), in each case free of all asbestos containing materials (" **ACM**") or other Hazardous Materials (as defined in Section 38.12 below) and in full compliance with all Applicable Laws (as defined below), including, but not limited to, the Americans with Disabilities Act of 1990, 42 U.S.C. 12101 et seq. (" **ADA**") and all Environmental Laws (as defined in Section 38.12 below) existing at the later of the time of construction or the execution of this Lease, which are applicable to such work in order to make the Project suitable for business offices. Landlord will be fully responsible for making all alterations and repairs to the Premises and the Project at its cost, and not as an Operating Expense, resulting from or necessitated by the failure by Landlord and/or Landlord's contractor to comply with such Applicable Laws existing at the later of the time of construction or the execution of this Lease, or from Landlord's and/or Landlord's contractor's utilization of any Hazardous Materials in violation of any Environmental Laws existing at the later of the time of construction or the execution of this Lease or which could pose a health risk to occupants of the Project. Landlord's obligation to perform such work in accordance with Applicable Laws existing at the later of the time of construction or the execution of this Lease shall be deemed to continue with respect to such Applicable Laws and any obligation

created by such Applicable Laws if the obligation was generally known as of the later of the time of construction or the execution of this Lease (and Landlord's obligation shall exist and continue even though the time for performance under such Applicable Laws was contingent on (A) the passage of time, (B) the expenditure of money, (C) the performance of other work which would trigger such compliance, or (D) the expiration or termination of a variance or a grandfathered/grandmothered right). Accordingly, with respect to any costs that the Tenant incurs in connection with Alterations or in the performance of its maintenance and repair obligations under this Lease, which Tenant would not have incurred if the work performed by Landlord with respect to the Project was constructed in full compliance with the Applicable Laws in existence the later of the time of construction or the execution of this Lease, then Landlord shall be solely responsible for, and not as an Operating Expense, or shall otherwise reimburse Tenant for such costs or increases costs, as applicable, and Tenant shall not be responsible for all or any portion thereof. As used in this Lease, the term "**Applicable Laws**" shall mean all governmental regulations, ordinances, statutes or other laws of all governmental authorities with jurisdiction.

(b) Phasing of Construction. Pursuant to the Work Letter, the Project is divided into two Phases. Phase I consists of Landlord's Construction Work (as defined in the Work Letter) relating to the Existing Building and such other portions of the Project, including sixty (60) On-Site Parking Spaces and related common areas as necessary for Tenant's use and occupancy of the Existing Building, and Phase II consists of the balance of the Project, including the New Building and the remaining one hundred fifty-three (153) On-Site Parking Spaces and related common areas, all as more particularly described and provided for in the Work Letter

(c) Landlord Warranties.

(i) In addition to Landlord's other obligations set forth in this Lease, including, without limitation, the terms and conditions of subjection (a) above, General Condition N and Article 9 of this Lease, notwithstanding anything to the contrary set forth in this Lease or the Work Letter, for a period of one (1) year after the Substantial Completion of each of Phase of the Project (including the Tenant Improvements therein), Landlord shall, at Landlord's sole cost and expense, and not as an Operating Expense, promptly repair or replace, or cause to be repaired or replaced, any portion of such Phase (including the Tenant Improvements therein) which shall be materially defective or shall fail to comply with the Approved Base Building Plans (as defined in the Work Letter) and the Approved TI Plans (as defined in the Work Letter) for such Phase. Such repair or replacement shall be commenced as soon as reasonably possible after Landlord's receipt of written notice from Tenant of the need for such work, but only if such notice is given within such one (1) year period, and shall be diligently pursued to completion. For the purposes of this subsection:

(A) Landlord may satisfy its obligation pursuant to this subsection by causing Landlord's general contractor or any subcontractor, equipment manufacturer or material supplier who has provided a warranty, guaranty or quality instruction (collectively, the "**Construction Warranties**") to perform such repair or replacement.

(B) The provisions of this subsection shall not apply to any damage to any Phase of the Project (including the Tenant Improvements therein) caused by

Tenant or any of Tenant's employees, agents, contractors, licensees, directors, officers, partners, trustees, visitors or invitees (excluding, however, for purposes of the foregoing, any principal of the Landlord) (each, a " **Tenant Party**," and collectively, the "**Tenant Parties**") or any vandal or any casualty (fire, wind, rain, lightning, etc.). Landlord's obligations under this subsection shall be limited to defects in the original construction of and failures of such Phase of the Project to comply with Approved Base Building Plans (as defined in the Work Letter) and the Approved TI Plans (as defined in the Work Letter) for such Phase.

(C) During any period of repair or replacement by Landlord pursuant to this subsection, Base Rent and Additional Rent shall be abated to the extent, if at all, that Tenant's operations in the applicable portion of Premises are substantially interfered with, including totally if applicable, in accordance with General Condition F below. Subject to the next sentence, such abatement shall be Tenant's sole remedy in the event of a repair or replacement by Landlord. Notwithstanding the provisions of the immediately preceding sentence, to the extent that Landlord is able to recover the same from any contractor, insurer or other warranting party, Tenant shall be entitled to any damages incurred by Tenant during any such period of repair or replacement.

(ii) Upon the expiration of the one (1) year period specified in this subsection with respect to each Phase of the Project, Landlord shall assign and deliver to Tenant and cause its general contractor to assign and deliver to Tenant all Construction Warranties with respect to such Phase relating to any portion of the Premises that Tenant is responsible during the Term of this Lease to maintain and repair pursuant to Article 7. Such assignment(s) shall be on a form reasonably acceptable to Tenant. Landlord shall ensure that Tenant is listed as third party beneficiary in all construction contract(s) and subcontract(s) with respect to all such Construction Warranties and that that all such Construction Warranties are fully assignable to Tenant without the consent or approval of such general contractor, subcontractor, equipment manufacturer or material supplier.

C. Covenants and Agreements. The failure of Landlord or Tenant to insist in any instance on the strict keeping, observance or performance of any covenant or agreement contained in this Lease, or the exercise of any election contained in this Lease, shall not be construed as a waiver or relinquishment for the future of such covenant or agreement, but the same shall continue and remain in full force and effect.

D. Non-Disturbance, Attornment and Subordination Agreement. Landlord agrees that, on or before the date that is thirty (30) days following the Effective Date, it will provide, without cost to or charge of, Tenant with a non-disturbance, subordination and attornment agreement ("non-disturbance agreement") in favor of Tenant from East West Bank ("**Existing Mortgagee**") in substantially the form attached hereto as Exhibit "H" (the " **Approved SNDA**"), in consideration of Tenant's execution and delivery of, and as a condition precedent to the effectiveness of, this Lease. Said non-disturbance agreement may be recorded at Tenant's election and expense. In the event that Landlord is unable to deliver an Approved SNDA from Existing Mortgagee on or before such date, Tenant may elect to terminate this Lease by delivering written notice thereof to Landlord,

and this Lease will terminate and become null and void. Upon any such termination, neither Landlord nor Tenant shall have any further rights or obligations under this Lease, except for those indemnity provisions and other provisions, which pursuant to General Condition Q below, survive such termination.

Landlord further agrees to provide Tenant with a non-disturbance agreement in favor of Tenant from any other ground lessors, mortgage holders, lien holders or mezzanine debt lien holders (each, a "**Superior Mortgagee**") of Landlord who later come(s) into existence at any time prior to the expiration of the Term, as it may be extended, in a form acceptable to Tenant, in consideration of, and as a condition precedent to, Tenant's agreement to be bound by Section 18.1 below. Said non-disturbance agreement shall be deemed acceptable to Tenant if it is in recordable form and is substantially consistent with the terms of the Approved SNDA, or otherwise shall be acceptable to Tenant in its sole discretion, and may be recorded at Tenant's election and expense.

E. Notice. All references in this Lease to "notice" shall mean written notice given in compliance with Article 32 of this Lease.

F. Abatement of Rent When Tenant Is Prevented From Using Premises. In the event that Tenant is prevented from using, and does not use, the Premises or any portion thereof, for five (5) consecutive business days or ten (10) business days in any twelve (12) month period (the "**Eligibility Period**") as a result of (i) any damage or destruction to the Premises, the On-Site Parking Spaces, the Off-Site Parking Spaces and/or the Project, (ii) any repair, maintenance or alteration performed by Landlord after the applicable Commencement Date, which substantially interferes with Tenant's use of the Premises, the On-Site Parking Spaces, the Off-Site Parking Spaces and/or the Project, (iii) any failure by Landlord to provide Tenant with access to the Premises, the On-Site Parking Spaces, the Off-Site Parking Spaces and/or the Project, (iv) because of breach of any of Landlord's warranties set forth in General Condition B, or (v) the exercise by Tenant of its rights to complete construction of the Project as set forth in General Condition I, then Tenant's Rent shall be abated or reduced, as the case may be, after expiration of the Eligibility Period for such time that Tenant continues to be so prevented from using, and does not use, the Premises or a portion thereof, in the proportion that the RSF of the portion of the Premises that Tenant is prevented from using, and does not use, bears to the total RSF of the Premises. However, in the event that Tenant is prevented from conducting, and does not conduct, its business in any portion of the Premises for a period of time in excess of the Eligibility Period, and the remaining portion of the Premises is not sufficient to allow Tenant to effectively conduct its business therein, and if Tenant does not conduct its business from such remaining portion, then for such time after expiration of the Eligibility Period during which Tenant is so prevented from effectively conducting its business therein, the Rent for the entire Premises shall be abated; provided, however, if Tenant reoccupies and conducts its business from any portion of the Premises during such period, the Rent allocable to such reoccupied portion, based on the proportion that the RSF of such reoccupied portion of the Premises bears to the total RSF of the Premises, shall be payable by Tenant from the date such business operations commence. If Tenant's right to abatement occurs during a free rent period (for these purposes, free rent shall be deemed to include half rent, etc.) which arises after the Commencement Date, Tenant's free rent period shall be extended for the number of days that the abatement period overlapped the free rent period ("**Overlap Period**"). Landlord shall have the right to extend the Expiration Date for a period

of time equal to the Overlap Period if Landlord sends a notice to Tenant of such election within ten (10) days following the end of the extended free rent period. If Tenant's right to abatement occurs because of an eminent domain taking and/or because of damage or destruction to the Premises and/or Tenant's property, Tenant's abatement period shall continue until Tenant has been given sufficient time, and sufficient access to the Premises to rebuild such portion it is required to rebuild, to install its property, furniture, fixtures, and equipment to the extent the same shall have been removed and/or damaged as a result of such damage or destruction and/or eminent domain taking and to move in over a weekend. To the extent Tenant has prepaid rent (as it does each month since Rent is due on the first day of each month) and Tenant is subsequently entitled to an abatement, such prepaid, and subsequently abated, Rent should be refunded to, and paid by Landlord to, Tenant within thirty (30) days after the end of the appropriate month.

G. Arbitration. With the exception of the arbitration provisions which shall specifically apply to the determination of (i) the Fair Market Rental Rate, as set forth in Exhibit "J" attached hereto [Options to Extend], and (ii) the Fair Market Value, as set forth in Exhibit "I-2" [Option to Purchase], the provisions of this General Condition G contain the sole and exclusive method, means and procedure to resolve any and all disputes or disagreements, including whether any particular matter constitutes, or with the passage of time would constitute, an event of default ("**Event of Default**"). The parties hereby irrevocably waive any and all rights to the contrary and shall at all times conduct themselves in strict, full, complete and timely accordance with the provisions of this General Condition G. Any and all attempts to circumvent the provisions of this General Condition G shall be absolutely null and void and of no force or effect whatsoever. As to any matter submitted to arbitration to determine whether it would, with the passage of time, constitute an Event of Default, such passage of time shall not commence to run until any such affirmative determination, so long as it is simultaneously determined that the challenge of such matter as a potential Event of Default was made in good faith, except with respect to the payment of money. With respect to the payment of money, such passage of time shall not commence to run only if the party which is obligated to make the payment does in fact make the payment to the other party. Such payment can be made "under protest," which shall occur when such payment is accompanied by a good-faith notice stating why the party has elected to make a payment under protest. Such protest will be deemed waived unless the subject matter identified in the protest is submitted to arbitration as set forth in the following:

(a) Except as otherwise provided above, all disputes and disagreements shall be determined by final and binding arbitration without appeal or review, pursuant to the laws of the State of California including the limitations period applicable, before a single arbitrator (the "**Arbitrator**") at a location determined by the Arbitrator in Los Angeles County, California and administered by JAMS (or its successor) ("**JAMS**"). If JAMS shall not then exist, or refuses to accept submission of such dispute, such arbitration shall be conducted before such other organization as to which the parties to the dispute may agree. If the parties to the dispute are unable to so agree within fifteen (15) days after the dispute arises, the organization shall be selected by the presiding judge of the Los Angeles County Superior Court or his or her designee upon application by any party to the dispute. Judgment upon any award rendered by the Arbitrator may be entered by any state or federal court having jurisdiction thereof. Any Arbitrator appointed or selected pursuant to

this General Condition G shall be a retired judge of the Superior Court or Court of Appeal of the State of California or a retired Federal District Court judge.

(b) Any arbitration pursuant to this General Condition G shall be initiated by the parties, or either of them, within ten (10) days after either party sends written notice (the " **Arbitration Notice**") of a demand to arbitrate to the other party and to JAMS. The Arbitration Notice shall contain a description of the subject matter of the arbitration, the dispute with respect thereto, the amount involved, if any, and the remedy or determination sought. Any arbitration pursuant to this General Condition G shall be conducted in accordance with the Comprehensive Arbitration Rules and Procedures of JAMS then in effect (the " **Rules**"), regardless of the amount in dispute, except that, whether or not such Rules so provide:

(i) The Arbitrator shall schedule a pre-hearing conference to resolve procedural matters, arrange for the exchange of information, obtain stipulations and attempt to narrow the issues to be arbitrated. The Arbitrator shall have the discretion to order a pre-hearing exchange of information by the parties, including, without limitation, production of requested documents, exchanges of summaries of testimony of proposed witnesses and examination by deposition of parties and third-party witnesses.

(ii) There shall be no mediation or settlement conferences unless all parties agree thereto in writing.

(iii) Discovery shall be limited to that permitted by the Rules, and the Arbitrator shall have discretion to determine the scope thereof.

(iv) All motions shall be in letter form and hearings thereon shall be by conference telephone calls unless the Arbitrator orders otherwise.

(v) Hearings of motions shall require only twenty (20) days prior written notice.

(vi) All notices in connection with any arbitration may be served in any manner permitted by Article 32 of this Lease.

(vii) Fees and costs paid or payable to JAMS shall be included in "reasonable expenses" for purposes of Section 12.4(b). The arbitrator shall specifically have the power to award to the "prevailing party" such party's reasonable expenses incurred in such proceeding, except as otherwise provided in subsection (c) below. Reasonable expenses shall include any reasonable attorneys' fees. The prevailing party shall be the party whose proposal for the resolution of the dispute is the closer to that adopted by the Arbitrator.

(viii) The selection of the Arbitrator (who must be a retired judge) shall be in accordance with the then existing Rules. In the event that the parties are unable to agree upon an arbitrator within the period of time allowed for them to select an arbitrator, JAMS will provide a list of three available retired judges and each party may strike one. The remaining judge (or if

there are two, the one selected by the administrator of the Los Angeles County office of JAMS) will serve as the arbitrator.

(ix) In rendering a decision, the Arbitrator shall determine the rights and obligations of the parties according to the terms of this Lease and the substantive and procedural laws of the State of California. The Arbitrator's decision shall be based on the evidence introduced at the hearing, including any logical and reasonable inferences therefrom. The decision must be based upon, and accompanied by, a written statement of decision explaining the factual and legal basis for the decision as to each of the principal controverted issues.

(x) The Arbitrator may make any determination, and/or grant any relief that is just and equitable, other than an award of exemplary or punitive damages. The Arbitrator's decision shall be conclusive and binding, and it may thereafter be confirmed as a judgment by the Superior Court of the State of California, subject only to challenge on the grounds set forth in California Code of Civil Procedure Section 1286.2, subsections (a), (b), (c), (e) and (f). The validity and enforceability of the Arbitrator's decision is to be determined exclusively by the Courts of the State of California pursuant to the provisions of this Lease.

(c) As soon as practicable after selection of the Arbitrator, JAMS, working with the Arbitrator, shall determine a reasonable estimate of anticipated fees and costs of the arbitration and shall deliver a statement to each party setting forth that party's pro rata share of such fees and costs. Each party shall deposit its pro rata share of such fees and costs with JAMS within ten (10) days after receipt of such statement. If any party fails to make a required deposit hereunder, the other party may make such deposit on behalf of the defaulting party and the amount of such deposit, plus interest thereon at the Interest Rate from date of deposit to date of repayment, shall be awarded against the defaulting party by the Arbitrator in making any final arbitration award without regard to whether the defaulting party is the prevailing party in the arbitration pursuant to this General Condition G.

H. Access to Building and Parking. Tenant shall be granted access to the Buildings, the Premises, the On-Site Parking Spaces and the Project twenty-four (24) hours per day, seven (7) days per week, every day of the year. Tenant shall be granted access to the Off-Site Parking Spaces pursuant to the terms of Article 30 hereof.

I. Right to Repair and Complete Construction. Notwithstanding any provision set forth in this Lease to the contrary, (i) if Tenant provides written notice (or oral notice in the event of an emergency such as damage or destruction to or of any portion of the Buildings and/or anything that could cause material disruption to Tenant's business) to Landlord of an event or circumstance which requires the action of Landlord with respect to repair and/or maintenance, and Landlord fails to commence such action within a reasonable period of time, given the circumstances, or (ii) if Tenant has the right to provide a Termination Notice (as defined in Section 2.6 of this Lease) to Landlord as a result of Landlord's failure to complete construction of the Project as required by General Condition B and the Work Letter, in each case after the receipt of such notice, but in any event not later than seven (7) days after receipt of such notice, then Tenant may, but shall not be required to, proceed to take the required action or to complete construction of the Project upon delivery of an additional three (3) business days' notice to Landlord in the case of a repair and upon delivery of

an additional sixty (60) days' notice to Landlord in the case of an intention to complete construction of the Project, specifying that Tenant is taking such required action or intends to complete construction of the Project (provided, however, that in the case of any failure by Landlord to repair and/or maintain the Premises or the Buildings, neither of the notices shall be required in the event of an emergency which threatens life or where there is imminent danger to property or a possibility that a failure to take immediate action could cause a material disruption in Tenant's normal and customary business activities), and if such action was required under the terms of this Lease to be taken by Landlord or was taken by Tenant as a result of occurrence of a Termination Condition (as defined in Section 2.6 of the Lease), and was not taken by Landlord within such ten (10) day period (unless such notice was not required as provided above), then Tenant shall be entitled to prompt reimbursement by Landlord of Tenant's reasonable costs and expenses in taking such action plus interest thereon at the Interest Rate as defined in General Condition O below plus rent abatement to the extent Tenant would have otherwise been entitled to rent abatement under General Condition F. Landlord agrees that Tenant will have access to the Project (including the Building Systems (as defined in General Condition N below) and the Building Structure (as defined in General Condition N below)) to the extent necessary to perform the work contemplated by this provision. Further, Landlord agrees that it shall cooperate with Tenant in connection with Tenant's effort to complete construction of the Project, including providing Tenant's instructions or directions to any applicable contractors and/or assignment to Tenant of Landlord's rights in and to any applicable construction, engineering or design contracts in furtherance thereof. In the event Tenant takes such action, and such work will affect the Building Structure and/or the Building Systems, Tenant shall use only those contractors used or reasonably approved by Landlord for work on such Building Structure or Building Systems, unless such contractors are unwilling or unable to perform (and are able to immediately perform), or timely and competitively perform, such work, in which event Tenant may utilize the services of any other qualified contractor which normally and regularly performs similar work in Comparable Buildings (as defined in Exhibit "J").

J. Right to Terminate Upon Discovery of Hazardous Material/Conditions.

(a) Notwithstanding anything in this Lease, and except as expressly set forth below, in the event that Tenant is notified or becomes aware of the fact that as a result of:

(i) any discovery of Hazardous Materials in, on or around the Project not placed in, on or around the Project by Tenant or any Tenant Party, that may, considering the nature and amount of the substances involved, interfere with Tenant's use of all or a portion of the Premises or which may present a health risk to any occupants of the Premises); or

(ii) the discovery of any other Hazardous Material with respect to the Premises or the Project not caused by Tenant or any Tenant Party, which would make it dangerous or unsafe for Tenant or any Tenant Party to conduct their normal and customary business operations from the Premises or Project (each of the items set forth in provision (a)(i) or (ii) being referred to herein as a "**Trigger Event**"),

Tenant cannot, within six (6) months ("**Non-Use Period**") of the discovery by Tenant of the Trigger Event, be given reasonable use of, and access to, a safe and healthful Premises, then Tenant may

thereafter elect at any time to exercise an on-going right to terminate this Lease upon ten (10) days' written notice sent to Landlord at any time following the expiration of the Non-Use Period.

(b) In the event of any Trigger Event occurring during the last year of the Term or, if an applicable renewal option has been exercised, during the last year of any renewal Term, should the Non-Use Period continue for thirty (30) days, Tenant may elect to exercise an on-going right to terminate this Lease upon ten (10) days' written notice sent to Landlord at any time following the expiration of the Non-Use Period.

K. Interest on Past Due Obligations. Except with respect to the late payment of Rent (which shall be governed by the provisions of Section 3.2), whenever one party is obligated pursuant to this Lease to make a payment to the other party, if such payment is not paid when due, then the party who does not make such payment when due shall pay interest at the Interest Rate (as such term is defined in General Condition O) to the party on the unpaid amount from the date such amount was due until the date such amount is paid.

L. When Payment Is Due. Whenever in this Lease a payment is required to be made by one party to the other, but a specific date for payment is not set forth or a specific number of days within which payment is to be made is not set forth, or the words "immediately", "promptly" and/or "on demand", or the equivalent, are used to specify when such payment is due, then such payment shall be due thirty (30) days after the party which is entitled to such payment sends written notice to the other party demanding payment.

M. Landlord Bankruptcy Proceeding. In the event that the obligations of Landlord under this Lease are not performed during the pendency of a bankruptcy or insolvency proceeding involving the Landlord as the debtor, or following the rejection of this Lease in accordance with Section 365 of the United States Bankruptcy Code, then notwithstanding any provision of this Lease to the contrary, and in addition to any and all other remedies permitted by this Lease and/or by Applicable Laws Tenant shall have the right to set off against Rents next due and owing under this Lease (a) any and all damages caused by such non-performance of Landlord's obligations under this Lease by Landlord, debtor-in-possession, or the bankruptcy trustee, and (b) any and all damages caused by the non-performance of Landlord's obligations under this Lease following any rejection of this Lease in accordance with Section 365 of the United States Bankruptcy Code.

N. Building Structure and Building Systems. As used in this Lease, the term "**Building Structure**" shall mean the structural portions of the Building, including the foundation, floor/ceiling slabs, roof, curtain wall, exterior glass and mullions, columns, beams, shafts (including elevator shafts), stairs, parking areas (including the On-Site Parking Spaces), stairwells, escalators, elevator cabs, plazas, pavement, sidewalks, curbs, entrances, landscaping, art work, sculptures, washrooms, mechanical, electrical and telephone closets, and all public areas and other exterior portions of the Building and Project, and the term "**Building Systems**" shall mean the mechanical, electrical, life safety, fire detection, fire alarm, plumbing, sprinkler systems (connected to the core) and HVAC systems (including primary and secondary loops connected to the core) (" **Building Systems**). As further provided in Article 9, and subject to the right of Landlord to receive Additional Rent as provided for in Article 4, Landlord shall at all times during the Term maintain the Building Structure and Building Systems in first class condition and repair and shall operate the Project as a first class

office building. Notwithstanding anything in this Lease to the contrary, Tenant shall not be required to make any repair to, modification of, or addition to the Building Structure and/or the Building Systems and/or the Site except and to the extent required because of Tenant's use of all or a portion of the Premises for other than normal and customary business office operations.

O. Interest Rate. The "**Interest Rate**" is defined as the lesser of (i) the rate publicly announced from time to time, by the largest (as measured by deposits) state chartered bank operating in California, as its Prime Rate or its Reference Rate or other similar benchmark, plus two percent (2%), or (ii) the maximum rate permitted by law.

P. Other Temporary Uses. Notwithstanding anything to the contrary in this Lease, Landlord agrees that from time to time, Tenant may use the Premises and Project, at no cost, for filming and taping of entertainment productions, staff and customer parties and other temporary uses provided that Tenant agrees to indemnify Landlord for any damages pursuant to Section 12.2(a).

Q. Survival of Provisions Upon Termination of Lease. This Lease shall survive the expiration of the Term to the extent necessary that any term, covenant or condition of this Lease which requires the performance of obligations or forbearance of an act by either party hereto after the termination of this Lease. Such survival shall be to the extent reasonably necessary to fulfill the intent thereof, or if specified, to the extent of such specification, as same is reasonably necessary to perform the obligations and/or forbearance of an act set forth in such term, covenant or condition. Notwithstanding the foregoing, in the event a specific term, covenant or condition is expressly provided for in such a clear fashion as to indicate that such performance of an obligation or forbearance of an act is no longer required, then the specific shall govern over the General Provisions of this Lease.

R. Financing Contingency. Notwithstanding anything set forth in this Lease to the contrary, the effectiveness of this Lease is contingent upon Tenant's receipt of evidence reasonably acceptable to Tenant that Landlord has obtained a binding commitment, subject to customary qualifications for a transaction of this nature, either from Existing Mortgagee or another commercial lender reasonably acceptable to Tenant in an amount sufficient to complete the construction of the entire Project on or before the date that is no later than sixty (60) days after the Effective Date (the "**Financing Period**"). Landlord shall in good faith apply for and diligently pursue the closing of such financing, including, without limitation, the submittal of all information reasonably requested by Existing Mortgagee or another potential lender(s) reasonably acceptable to Tenant. In the event that Landlord is unable (despite such good faith efforts) to obtain such financing commitment on or before the end of the Financing Period, Tenant may elect to terminate this Lease by delivering thirty (30) days written notice thereof to Landlord during which notice period Landlord shall have the right to obtain the financing commitment in satisfaction of its obligations under this General Condition R, and this Lease will terminate and become null and void. Upon any such termination, neither Landlord nor Tenant shall have any further rights or obligations under this Lease, except for those indemnity provisions and other provisions, which pursuant to General Condition Q above, survive such termination.

S. Impound for Insurance Premiums and Tax Expenses. Landlord and Tenant acknowledge that Landlord is and may be required in the future to impound funds, on a monthly basis, sufficient to pay the annual Insurance Premiums and Tax Expenses (the "**Required Impound Payments**") due with respect to the Project (the "**Impound Obligations**") with Existing Mortgagee, or with another Superior Mortgagee. Landlord agrees that in the event that it must satisfy any Impound Obligations, it shall promptly pay the Required Impound Payments to either Existing Mortgagee or any other Superior Mortgagee, as the case may be, which shall be held by such lender and which shall be disbursed to pay the Insurance Premiums and Tax Expenses prior to delinquency. In the event that Landlord is not required by Existing Mortgagee or any other Superior Mortgagee during the Term of this Lease to satisfy the Impound Obligations with respect to the Required Impound Payments, Landlord agrees that it shall promptly notify Tenant in writing of such fact and open a segregated bank account with a national bank reasonably acceptable to Tenant (and in no event later than five (5) business days after the expiration or termination of the prior existing Impound Obligations) to receive from Landlord the Required Impound Payments. Such Required Impound Payments deposited in to such account shall only be used by Landlord to pay the Insurance Premiums and Tax Expenses prior to delinquency.

SPECIFIC TERMS AND CONDITIONS

Landlord and Tenant specifically agree as follows:

ARTICLE 1 - PREMISES

1.1 Lease of Premises. Landlord leases to Tenant, and Tenant leases from Landlord, the Premises described in provision (f) of the Fundamental Lease Provisions. Notwithstanding the foregoing, Landlord reserves the right to use up to 1,000 RSF located on the 5 th floor of the Existing Building, as shown on the Final Phase I Base Building and Site Plans (as defined in the Work Letter) as the management office for Project (the "**Management Office**"). Landlord's use of the Management Office shall not reduce the RSF of the Existing Building for purposes of determining the Rent due from Tenant hereunder, but otherwise shall be excluded from the "Premises" for all other purposes of this Lease.

1.2 Final Measurement of the Premises. Landlord and Tenant hereby acknowledge and agree that, with respect to each Building, the stated amount of RSF described in clauses (g) and (h) of the Fundamental Lease Provisions is not a representation or warranty of the exact number of RSF therein, but rather is only a reasonable approximation and that, in connection with the Substantial Completion of each Building, Landlord shall cause a third-party architect reasonably acceptable to Tenant to measure the applicable Building in accordance with the standards set forth in ANSI Z65.1 2010 for measuring floor area in office buildings, utilizing the Gross Building Area method for single occupant buildings on pages 10-11, as promulgated by the Building Owners and Managers Association (the "**BOMA Standard**"). In the event that the applicable Commencement Date occurs prior to the Substantial Completion of the applicable Building pursuant to Section 2.3(b) below, Base Rent shall be determined based on the RSF set forth in clause (g) or (h) of the Fundamental Lease Provisions, as applicable, and if the final measurement later produces a RSF number in excess of or lower than the RSF number set forth in clause (g) or (h) of the Fundamental Lease Provisions, as applicable, any payments due to Landlord from Tenant based upon the amount

of RSF contained in the applicable Building shall be proportionally, retroactively and prospectively reduced or increased, as appropriate, to reflect the actual RSF number, as properly measured under the BOMA Standard. If a dispute occurs regarding the final accuracy of such measurements, such dispute will be resolved pursuant to binding arbitration pursuant to General Condition G.

1.3 Right of First Offer to Purchase. Tenant's rights and obligations with respect to the Right of First Offer to Purchase are set forth in Exhibit "I-1" attached and incorporated into this Lease by this reference.

1.4 Option to Purchase. Tenant's rights and obligations with respect to its Option to Purchase are set forth in Exhibit "I-2" attached and incorporated into this Lease by this reference.

ARTICLE 2 - TERM

1.5 Effective Date. This Lease will become binding and effective on the Effective Date.

1.6 Term of Lease. The term of this Lease ("**Term**") shall be for the term set forth in provision (k) of the Fundamental Lease Provisions beginning on the Commencement Date, as such term is defined below, and, unless sooner terminated as hereinafter provided, ending on the Expiration Date specified in provision (m) of the Fundamental Lease Provisions or, when appropriate, at the end of the applicable Extension Period to the extent the rights to extend are exercised pursuant to Exhibit "J".

1.7 Delivery of Premises; Commencement Date(s).

(a) The Premises will be delivered and occupied by Tenant in two Phases. Phase I will include delivery of the Existing Building which will be delivered to Tenant when Landlord's Construction Work with respect to Phase I (including the Tenant Improvements therein) is Substantially Complete and the Existing Building is ready for occupancy. Phase II will include delivery of the New Building which be delivered to Tenant when Landlord's Construction Work with respect to Phase II (including the Tenant Improvements therein) is Substantially Complete and the New Building is ready for occupancy.

(b) The "**Commencement Date**" and Tenant's obligation to pay the Rent, as such term is defined below, shall commence with respect to each Building on the earlier of (i) the date Tenant commences business operations from such Building, and (ii) five (5) business days following the date which is after the earlier of the following (the " **Move-In Period**"):

(i) With respect to the Existing Building, the earlier of (A) the date Landlord delivers to Tenant a factually correct written notice stating that Landlord's Construction Work with respect to Phase I is Substantially Complete and confirming the amount of RSF in the Existing Building, as determined in accordance with the BOMA Standard pursuant to Section 1.2 above, and (B) the date Landlord delivers to Tenant a factually correct written notice stating the date that Landlord's Construction Work with respect to Phase I would have been Substantially Complete were it not for any Tenant Delays (as defined in the Work Letter); and

(ii) With respect to the New Building, the earlier of (A) the date Landlord delivers to Tenant a factually correct written notice stating that Landlord's Construction Work with respect to Phase II is Substantially Complete, and confirming the amount of RSF in the New Building, as determined in accordance with the BOMA Standard pursuant to Section 1.2 above, and (B) the date Landlord delivers to Tenant a factually correct written notice stating the date that Landlord's Construction Work with respect to Phase II would have been Substantially Complete were it not for any Tenant Delays.

Tenant understands that it is in Landlord's best economic interests to have Landlord's Construction Work with respect to each Phase Substantially Completed as soon as reasonably possible in order to have the Commencement Date for the applicable Building occur as early as possible, and Tenant understands that to the extent that Landlord's Construction Work with respect to such Phase is not Substantially Completed because of Tenant Delays, the Commencement Date for the applicable Building will nevertheless occur on the date Landlord's Construction Work for such Phase would have completed had Tenant Delays not occurred.

1.8 Early Entry Into Premises. Landlord shall permit Tenant to enter the Premises of each Building no later than thirty (30) days prior to the anticipated Commencement Date for the purpose of installing furniture, special flooring or carpeting, trade fixtures, telephones, computers, photocopy equipment and other business equipment (" **Early Entry Work**"). Tenant's Early Entry Work shall not cause the Landlord to incur any additional costs (i.e. accelerated schedule(s), out of sequence work, expedited material deliveries etc.) to accommodate Tenant's Early Entry Work. Such early entry shall not advance the Commencement Date, nor trigger the commencement of any Move-In Period, provided Tenant does not commence regular business operations from the Premises. In connection with such early entry, Landlord shall not be responsible for any loss caused by Tenant or those entering the Premises on behalf of Tenant to perform such Early Entry Work, including theft, damage or destruction to any work or material installed or stored by Tenant or any contractor or individual involved in the construction of the Tenant Improvements, or for any injury to Tenant or any Tenant Party or to any other person and provided further that Landlord shall have the right to post the appropriate notices of non-responsibility and to require Tenant to provide Landlord with evidence that Tenant has fulfilled its obligation to provide insurance pursuant to Article 12 hereof.

1.9 Notice of Commencement Date. Landlord or Tenant may send the other party notice of the occurrence of the Commencement Date with respect to each Building in the form of the attached Exhibit "C", which notice the receiving party shall acknowledge by executing a copy of the notice and returning it to the sending party. If the receiving party disputes the accuracy of the information contained in the notice, and the parties are unable to mutually agree as to the Commencement Date, either party may submit the dispute to arbitration pursuant to General Condition G.

1.10 Option to Terminate Because of Non-Commencement or Completion. Notwithstanding anything to the contrary set forth in this Lease, Tenant shall have the right, at Tenant's sole option, to elect to terminate this Lease by delivery to Landlord of a notice (the "**Termination Notice**") if (each, a "**Termination Condition**"):

(a) [Intentionally Deleted];

(b) Once Landlord commences physical construction of Landlord's Construction Work with respect to Phase I, Landlord fails to diligently prosecute the same to completion, subject to any Tenant Delays and/or Force Majeure Delays;

(c) Landlord has not delivered the Existing Building to Tenant with all of Landlord's Construction Work for Phase I Substantially Completed by July 1, 2013 (the "**Existing Building Outside Delivery Date**"), which Existing Building Outside Delivery Date will be extended one (1) day for each day Landlord is delayed in constructing Landlord's Construction Work for Phase I because of any Tenant Delays and/or Force Majeure Delays (as defined in the Work Letter), provided that in no event shall the Existing Building Outside Delivery Date be extended as a result of any Force Majeure Delays beyond December 31, 2013;

(d) Landlord fails to commence physical construction (not merely drawings or design work) of Landlord's Construction Work with respect to Phase II on or before October 1, 2013;

(e) Once Landlord commences physical construction of Landlord's Construction Work with respect to Phase II, Landlord fails to diligently prosecute the same to completion, subject to any Tenant Delays and/or Force Majeure Delays; or

(f) Landlord has not delivered the New Building to Tenant with all of Landlord's Construction Work for Phase II Substantially Completed by December 1, 2014 (the "**New Building Outside Delivery Date**"), which New Building Outside Delivery Date will be extended one (1) day for each day Landlord is delayed in constructing Landlord's Construction Work for Phase II because of any Tenant Delays and/or Force Majeure Delays, provided that in no event shall the New Building Outside Delivery Date be extended as a result of any Force Majeure Delays beyond June 30, 2015.

If Tenant is entitled to and delivers to Landlord a Termination Notice, this Lease shall be deemed terminated effective sixty (60) days after Tenant's delivery of such Termination Notice, unless within such sixty (60) day period (i) in the case of clauses (c), (d) or (f) above, Landlord shall have satisfied the applicable Termination Condition which was not satisfied by the applicable date provided for in such clause, or (ii) in the case of clauses (b) or (e), Landlord shall have recommenced to and thereafter continue to diligently prosecute Landlord's Construction Work to completion. Tenant's right to terminate pursuant to this Section 2.6 shall be Tenant's sole remedy in the event a Termination Condition is not satisfied.

1.11 Options to Extend Term. Tenant's rights and obligations with respect to extending the Term are set forth in Exhibit "J" attached hereto.

ARTICLE 3 - RENT

1.12 Payment of Rent. Without prior notice or demand, without set off or deduction whatsoever (except for Tenant's Rent abatement rights as provided in General Condition B, F and/

or I or as otherwise expressly provided in this Lease), Tenant agrees to pay Landlord, as rent (" **Base Rent**") for the Premises, Monthly Base Rent in the amount specified in or determined pursuant to provision (n) of the Fundamental Lease Provisions. Such Monthly Base Rent shall be paid monthly in advance beginning on the applicable Commencement Date on or before the first day of each calendar month thereafter during the entire Term. On the applicable Commencement Date, Tenant shall pay to Landlord the prorated Monthly Base Rent attributable to the month in which the applicable Commencement Date occurs if the applicable Commencement Date occurs on a date other than the first day of a calendar month.

1.13 Late Charge. Landlord and Tenant acknowledge that the late payment by Tenant of Rent or the late payment by Landlord of amounts owed to Tenant under this Lease will cause the party who was entitled to receive such payment (" **Payee**") to incur damages, including administrative costs, loss of use of the overdue funds and other costs, the exact amount of which would be impractical and extremely difficult to fix. Landlord and Tenant agree that if the Payee does not receive a payment within five (5) days following the delivery by Payee of notice to the other party (" **Payor**") that such payment is overdue, Payor shall pay to Payee a late charge equal to five percent (5%) of the delinquent amount, or the sum of One Hundred Dollars ($100.00), whichever is greater, as liquidated damages for the damages which Payee is likely to incur for the thirty (30) day period following the due date of such payment. Further, all portions of a payment not paid within thirty (30) days following its due date and all late charges associated therewith shall bear interest at the Interest Rate (as such term is defined in General Condition O) beginning on the thirty-first (31st) day following the due date of such payment and continuing until such payment, late charges and interest are paid in full to Payee. Acceptance of the late charge by Payee shall not cure or waive a default, nor prevent Payee from exercising, before or after such acceptance, any of the rights and remedies for a default provided by this Lease or at law. Payment of the late charge is not an alternative means of performance of Payor's obligation at the times specified in this Lease. Payor will be liable for the late charge regardless of whether Payor's failure to pay when due constitutes a default under this Lease.

ARTICLE 4 - ADDITIONAL RENT

1.14 General Terms. Commencing with the first (1st) day after the Base Year, in addition to paying the Base Rent specified in Article 3 of this Lease, Tenant shall pay Tenant's Share (as defined below) of the annual Direct Expenses (as defined below) which are in excess of the amount of Direct Expenses over the Allowance (as defined below). "**Allowance**" shall be the total dollar amount of Direct Expenses actually incurred by Landlord during the Base Year for the Buildings. Landlord and Tenant agree that, notwithstanding anything contained in this Lease to the contrary, commencing with the first Expense Year (as defined below) following the Base Year, and for each Expense Year thereafter, the aggregate Controllable Operating Costs, as that term is defined below, shall not increase more than five percent (5%) in any Expense Year over the maximum amount of the aggregate Controllable Operating Costs chargeable for the immediately preceding Expense Year, with no limit on the aggregate Controllable Operating Costs during the Base Year (except as provided in the definition of Operating Costs below) (the " **Annual Cap**"). "**Controllable Operating Costs**" shall mean all Operating Costs except utility costs, costs of services provided under a union contract and costs associated with repairs due to casualty, vandalism or other source outside of Landlord's

reasonable control and in no event shall Controllable Operating Costs include Tax Expenses or Insurance Premiums. Such payments by Tenant, together with any and all other amounts payable by Tenant to Landlord pursuant to the terms of this Lease including the parking charges (as set forth in Article 30), are hereinafter collectively referred to as the " **Additional Rent**," and the Base Rent and the Additional Rent are herein collectively referred to as " **Rent**". Without limitation on other obligations of Tenant which survive the expiration of the Lease Term, the obligations of Tenant to pay the Additional Rent, related to the period of time during which the Lease is in effect, provided for in this Article 4 shall survive the expiration of the Lease Term.

1.15 Procedure for Payment of Tenant's Share of Direct Expenses. Commencing with the first (1st) day after the Base Year, Tenant shall pay Tenant's Share of any excess Direct Expenses over the Allowance, and subject at all times to the Annual Cap, as follows:

(a) Landlord may, from time to time by providing at least thirty (30) days advance written notice to Tenant, reasonably estimate in advance the amounts Tenant shall owe on a monthly basis for Direct Expenses over the Allowance for any full or partial Expense Year of the Term. Such estimate shall be subject at all times to the Annual Cap. In such event, Tenant shall pay such estimated amounts, on a monthly basis, on or before the first (1st) day of each calendar month, together with Tenant's payment of Monthly Base Rent.

(b) Within one hundred twenty (120) days after the end of each Expense Year after the Base Year, or as soon thereafter as practicable, Landlord shall provide a statement itemized on a line item by line item basis (the " **Statement**") to Tenant showing: (i) the amount of actual Direct Expenses for such Expense Year and for the preceding Expense Year (including the amount of Controllable Operating Costs for each such Expense Year), (ii) any amount paid on an estimated basis by Tenant toward excess Direct Expenses over the Allowance during such Expense Year and (iii) any revised estimate of Tenant's obligations for excess Direct Expenses over the Allowance, and subject to the Annual Cap, for the current Expense Year.

(c) If the Statement shows that Tenant's estimated payments were less than Tenant's actual obligations for excess Direct Expenses over the Allowance and subject to the Annual Cap for such Expense Year, Tenant shall pay the difference. If the Statement shows an increase in Tenant's estimated payments for the current Expense Year, Tenant shall pay the difference between the new and former estimates, for the period from January 1 of the current Expense Year through the month in which the Statement is sent. Tenant shall make such payments within thirty (30) days after Tenant receives the Statement.

(d) If the Statement shows that Tenant's estimated payments exceeded Tenant's actual obligations for excess Direct Expenses over the Allowance, and subject to the Annual Cap, Tenant shall receive a credit of such difference against payments of Rent next due. If the Term shall have expired and no further Rent shall be due, Tenant shall receive a refund of such difference within thirty (30) days after Landlord sends the Statement. In no event shall any decrease in Direct Expenses for any Expense Year below Direct Expenses for the Base Year entitle Tenant any decrease in Base Rent or any credit against any other sums payable by Tenant under this Lease.

(e) So long as Tenant's obligations hereunder are not materially adversely affected, Landlord reserves the right to change, from time to time, but not more frequently than once in any twelve (12) month period, the manner or timing of the foregoing payments. No delay by Landlord in providing the Statement (or separate statements) shall be deemed a default by Landlord but any delay by Landlord (or any successor to Landlord in the event the Building is conveyed to a new owner during the Term) in billing Tenant for Tenant's Share of any excess Direct Expenses over the Allowance, and subject to the Annual Cap, of more than three (3) years, or two (2) years if this Lease has terminated, from the date Landlord incurred such Direct Expenses shall be deemed a waiver of Landlord's right to require payment of Tenant's obligations on account of any such Direct Expenses.

(f) If Tenant's obligation to pay Tenant's Share of excess Direct Expenses over the Allowance commences other than on January 1, or ends other than on December 31, Tenant's obligation to pay estimated and actual amounts toward excess Direct Expenses over the Allowance, and subject to the Annual Cap, for such first or final calendar years shall be prorated to reflect the portion of such years included within the period for which Tenant is obligated to pay Tenant's Share of such Direct Expenses. Such proration shall be made by multiplying the total estimated or actual (as the case may be) excess Direct Expenses over the Allowance, subject to the Annual Cap, for such calendar years by a fraction, the numerator which shall be the number of days within the period for which Tenant is obligated to pay such amounts during such calendar year, and the denominator of which shall be the total number of days in such year.

1.16 Definitions of Key Terms Relating to Additional Rent. As used in this Article 4, the following terms shall have the meanings hereinafter set forth:

1.16.1 Base Year. "**Base Year**" shall mean the period set forth in Section (y) of the Fundamental Lease Provisions of the Summary.

1.16.2 Direct Expenses. "**Direct Expenses**" shall mean Operating Expenses and Tax Expenses (as defined below).

1.16.3 Expense Year. "**Expense Year**" shall mean each calendar year following the Base Year in which any portion of the Lease Term falls, through and including the calendar year in which the Lease Term expires.

1.16.4 Operating Expenses.

1.16.4.1 Inclusions to Operating Expenses. "**Operating Expenses**" shall mean all reasonable expenses, costs and amounts of every kind and nature which Landlord pays during any Expense Year because of or in connection with the ownership, management, maintenance, repair, replacement, restoration or operation of the Project, or any portion thereof, subject to the terms and provisions of Section 4.3.4.2. Without limiting the generality of the foregoing, Operating Expenses shall specifically include any and all of the following:

(i) the actual cost of supplying all utilities, the cost of operating, repairing, maintaining, and renovating the utility, telephone, mechanical, sanitary, storm

drainage, and elevator systems, and the actual and reasonable cost of maintenance and service contracts in connection therewith;

(ii) the actual cost of licenses, certificates, permits and inspections and the actual and reasonable cost of contesting any governmental enactments which may affect Operating Expenses, and the actual costs incurred in connection with a governmentally mandated transportation system management program or similar program;

(iii) all insurance premiums and other charges (including the amount of any deductible payable by Landlord with respect to damage or destruction to all or any portion of the Buildings, but in no event more than the amount of deductibles typically carried by landlords of Comparable Buildings) incurred by Landlord with respect to insuring the Project, including, without limitation, the following to the extent carried by Landlord: (a) fire and extended coverage insurance, windstorm, hail, and explosion; (b) riot attending a strike, civil commotion, aircraft, vehicle and smoke insurance; (c) public liability, bodily injury and property damage insurance; (d) elevator insurance; (e) workers' compensation insurance for employees of the property manager working on-site; (f) boiler and machinery insurance, sprinkler leakage, water damage, property, burglary, fidelity and pilferage insurance on equipment and materials; (g) loss of rent, rent abatement, rent continuation, business interruption insurance, and similar types of insurance (but only to the extent of increases in the cost of such coverage over the cost that would have been incurred for the same coverage in the Base Year); (h) earthquake, flood, tornado, and hurricane insurance to the extent available on a commercially reasonable basis; and (i) such other insurance as is customarily carried by operators of Comparable Buildings or as may be otherwise required by Existing Mortgagee or a future Superior Mortgagee (the "**Insurance Premiums**");

(iv) the reasonable cost of non-capital (as determined pursuant to generally accepted accounting principles) landscaping repair, restoration, and maintenance, and all supplies, tools, equipment and materials used in the operation, repair and maintenance of the Project, or any portion thereof;

(v) the reasonable and actual cost of non-capital (as determined pursuant to generally accepted accounting principles) parking area repair, restoration, and maintenance;

(vi) the reasonable fees and other actual costs, including reasonable management fees of a third party, unrelated property manager (subject to Section 4.3.4.2(a)(xiii), to the extent the same are normally and customarily charged by landlords of Comparable Buildings, consulting fees, legal fees and accounting fees, of all contractors and consultants in connection with the management, operation, maintenance and repair of the Project;

(vii) to the extent Landlord manages the Project, an amount equal to three percent (3%) of the Base Rent payable under this Lease to cover all of Landlord's overhead costs and expenses (including wages, salaries and other compensation and benefits,

including taxes levied thereon, payable to any on-site property manager and other staff), other than an on-site engineer as provided in Section 4.3.4.1(ix) below;

(viii) the reasonable and actual payments under any equipment rental agreements incurred connection with the management, operation, maintenance and repair of the Project;

(ix) subject to Section 4.3.4.2(a)(vi) below, wages, salaries and other compensation and benefits, including taxes levied thereon, of an on-site engineer engaged in the operation and maintenance of the Project in amounts not to exceed then-current market wages, salaries and benefits, provided that any such on-site engineer shall only be employed on a full-time basis if determined to be reasonably necessary by Landlord to operate and maintain the Project in accordance with the terms of this Lease;

(x) the reasonable and actual costs of operation, repair and maintenance of all Building Systems and equipment and components thereof of the Project;

(xi) the reasonable and actual cost of janitorial and other services provided by Landlord pursuant to Section 10.1, and maintenance and replacement of curbs and walkways, and repair to roofs and reroofing;

(xii) amortization (including interest at a market interest rate on the unamortized cost) over the useful life, determined in accordance with generally accepted accounting principles, of the cost of acquiring or the reasonable rental expense of personal property used in the maintenance, operation and repair of the Project, or any portion thereof;

(xiii) the reasonable and actual cost of capital improvements or other costs incurred in connection with the Project (A) which are undertaken to affect economies in the operation or maintenance of the Project, or any portion thereof (but only to the extent of the annual cost savings reasonably anticipated by Landlord), (B) that are required to comply with present or anticipated reasonable conservation programs required by any applicable governmental authority, (C) which are replacements of nonstructural items located in the common areas required to keep the common areas in good order or condition, or (D) subject to General Condition B, that are required under any Applicable Laws enacted after the date of this Lease; provided, however, that any capital expenditure shall be amortized (including interest at a market interest rate on the amortized cost) over its useful life reasonably determined in accordance with generally accepted accounting principles; and

(xiv) the actual costs, fees, charges or assessments imposed by, or resulting from any mandate imposed on Landlord by, any federal, state or local government for fire and police protection, trash removal, community services, or other services which do not constitute Tax Expenses.

Notwithstanding the foregoing, only as provided hereinafter in items [i], [ii], and [iii], in the event Landlord incurs costs or expenses associated with or relating to separate items or categories or subcategories of Operating Expenses which were not part of Operating Expenses during the

entire Base Year, Operating Expenses for the Base Year shall be deemed increased by the amounts Landlord would have incurred during the Base Year with respect to such costs and expenses had such separate items or categories or subcategories of Operating Expenses been included in Operating Expenses during the entire Base Year. The foregoing shall only apply as follows: [i] in the event and to the extent any portion of the Project is covered by a warranty or service agreement which provides warranty-type protection at any time during the Base Year and is not covered by such warranty or such warranty-type protection under such service agreement in a subsequent Expense Year to the same extent, Operating Expenses for the Base Year shall be deemed increased by the amount Landlord would have incurred during the Base Year with respect to the items or matters covered by the subject warranty or warranty-type protection, had such warranty or such service agreement not been in effect during the Base Year; [ii] any Insurance Premium resulting from any new forms of insurance, shall be deemed to be included in Operating Expenses for the Base Year, except to the extent otherwise governmentally mandated; and [iii] any new category of Operating Expenses for new services provided to the Project and/or the Building after the Base Year, unless such new services are required to comply with Applicable Law enacted after the Lease Commencement Date.

1.16.4.2 Exclusions to Operating Expenses.

(a) Notwithstanding the provisions of Section 4.3.4.1 above, for purposes of this Lease, Operating Expenses shall not, however, include:

(i) costs, including advertising costs, marketing costs, legal fees, professional fees (including architects, engineers and space planners), advertising and promotional expenses, and brokerage fees incurred in connection with the original construction or development, or original or any future leasing of the Project, and costs, including permit, license and inspection costs, incurred with respect to the installation of tenant improvements;

(ii) except as expressly set forth in Sections 4.3.4.1(xii), (xiii), and (xiv) above, depreciation, interest and principal payments on mortgages and other debt costs, if any, penalties and interest, costs of capital (as determined pursuant to generally accepted accounting principles) repairs and alterations, and costs of capital improvements and equipment;

(iii) costs for which Landlord is separately reimbursed by insurance by its carrier or any Tenant's carrier or by anyone else, and electric power costs to the extent Tenant directly contracts with the local public service company for such services;

(iv) any bad debt loss, rent loss, or reserves for bad debts, rent loss; reserves for future improvements, repairs or additions;

(v) costs associated with the operation of the business of the partnership or entity which constitutes Landlord, as the same are distinguished from the costs of operation of the Project (which shall specifically include, but not be limited to, accounting costs associated with the operation of the Project). Costs associated with the

operation of the business of the partnership or entity which constitutes Landlord include costs of partnership accounting and legal matters, costs of defending any lawsuits with any mortgagee (except as the actions of the Tenant may be in issue), costs of selling, syndicating, financing, mortgaging or hypothecating any of Landlord's interest in the Project, and costs incurred in connection with any disputes between Landlord and its employees, between Landlord and Project management, or between Landlord and other tenants or occupants, and Landlord's general corporate overhead and general and administrative expenses;

(vi) except as expressly provided in Section 4.3.4.1(ix), the wages and benefits of any employee of Landlord or the wages and benefits of any employee of the third party, unrelated property manager who does not devote substantially all of his or her employed time to the Project unless such wages and benefits are prorated to reflect time spent on operating and managing the Project vis-a-vis time spent on matters unrelated to operating and managing the Project; provided, that in no event shall Operating Expenses for purposes of this Lease include wages and/or benefits attributable to personnel of any third party, unrelated property manager above the level of Project manager;

(vii) amounts paid as ground rental for the Project by Landlord;

(viii) overhead and profit increments paid to the Landlord or to subsidiaries or affiliates of Landlord for services in the Project to the extent the same exceeds the costs of such services rendered by qualified, first-class unaffiliated third parties negotiated on an arm's length basis;

(ix) any compensation paid to clerks, attendants or other persons in commercial concessions operated by Landlord;

(x) rentals and other related expenses incurred in leasing air conditioning systems, elevators or other equipment which if purchased the cost of which would be excluded from Operating Expenses as a capital cost, except equipment not affixed to the Project which is used in providing janitorial or similar services and, further excepting from this exclusion such equipment rented or leased to remedy or ameliorate an emergency condition in the Project;

(xi) all items and services for which Tenant reimburses Landlord;

(xii) costs, other than those incurred in the ordinary maintenance and repair, for sculpture, paintings, fountains or other objects of art displayed in the Building;

(xiii) fees payable by Landlord for management of the Project to a third party, unrelated property manager in excess of three percent (3%) of the Base Rent payable under this Lease;

(xiv) any costs expressly excluded from Operating Expenses elsewhere in this Lease, including, without limitation, costs related to security paid by Tenant;

(xv) rent for any office space occupied by Project management (including the on-site Management Office);

(xvi) costs incurred in connection with upgrading the Building Structure, Building Systems or other components of the Project to comply with any Applicable Laws relating to life, fire and safety which were in existence as of applicable Commencement Date, including penalties or damages incurred due to such non-compliance;

(xvii) tax penalties or interest due on any unpaid taxes or assessments incurred as a result of Landlord's failure to make payments and/or to file any tax or informational returns when due;

(xviii) costs arising from the negligence or willful misconduct of Landlord or the Landlord Parties, or providers of materials or services selected, hired or engaged by Landlord or its agents, including, without limitation, the selection of Building materials;

(xix) costs (A) incurred to comply with laws relating to the removal of Hazardous Material (as defined below) except for immaterial amounts expended in connection with routine maintenance and repairs of the Premises; which was in existence in the Building or on the Project prior to the applicable Commencement Date, and was of such a nature that a federal, State or municipal governmental authority, if it then had knowledge of the presence of such Hazardous Material, in the state, and under the conditions that it then existed in the Building or on the Project, would have then required the removal of such Hazardous Material or other remedial or containment action with respect thereto; and (B) costs incurred to remove, remedy, contain, or treat Hazardous Material, which Hazardous Material is brought into the Building or onto the Project after the date hereof by Landlord or any other tenant of the Project and is of such a nature, at that time, that a federal, State or municipal governmental authority, if it had then had knowledge of the presence of such Hazardous Material, in the state, and under the conditions, that it then exists in the Building or on the Project, would have then required the removal of such Hazardous Material or other remedial or containment action with respect thereto except for immaterial amounts completed in connection with routine maintenance and repairs;

(xx) costs arising from Landlord's charitable or political contributions;

(xxi) costs arising from defects in the Building Structure or Building Systems or improvements installed by Landlord or repair of such defects;

(xxii) costs (including in connection therewith all attorneys' fees and costs of settlement judgments and payments in lieu thereof) arising from claims, disputes or potential disputes in connection with potential or actual claims litigation or arbitrations pertaining to Landlord and/or the Building and/or the Site;

(xxiii) any gifts provided to any entity whatsoever, including, but not limited to, Tenant, other tenants, employees, vendors, contractors, prospective tenants and agents;

(xxiv) the cost of any magazine, newspaper, trade or other subscriptions;

(xxv) any amount paid to Landlord or to subsidiaries or affiliates of Landlord for services in the Project to the extent the same exceeds the cost of such services rendered by qualified, first-class unaffiliated third parties on a competitive basis;

(xxvi) costs arising from Landlord's failure to comply with any Applicable Laws;

(xxvii) the cost of any training or incentive programs, other than for tenant life safety information services;

(xxviii) the cost of any "tenant relations" parties, events or promotion not consented to by an authorized representative of Tenant in writing;

(xxix) costs relating to categories of expenses for the Project parking areas which were not included in Operating Expenses during the Base Year, except to the extent the Base Year is retroactively adjusted to include such categories;

(xxx) any other expenses which, in accordance with generally accepted accounting principles or other comprehensive basis of accounting, consistently applied, would not normally be treated as Operating Expenses by landlords of Comparable Buildings; or

(xxxi) any entertainment expenses and travel expenses of Landlord, its employees, agents, partners and affiliates.

(b) It is understood that Operating Expenses shall be reduced by all cash discounts, trade discounts, quantity discounts, rebates or other amounts received by Landlord or Landlord's managing agent in the purchase of any goods, utilities, or services in connection with the operation of the Building. If capital items and equipment which are customarily purchased by landlords of Comparable Buildings are leased by Landlord, rather than purchased, the decision by Landlord to lease the item in question shall not serve to increase Tenant's Share of Operating Expenses beyond that which would have applied had the item in question been purchased.

1.16.5 Taxes.

1.16.5.1 Payment of Tax Expenses. Landlord shall pay, prior to delinquency, all Tax Expenses (as defined below) for each tax period wholly included prior to or during the period between the Commencement Date and the expiration or earlier termination of the Term. All such payments shall be made directly to the authority charged with the collection thereof prior to the last date on which the same may be paid without interest or penalty, and Landlord shall use commercially reasonable efforts to cause the Premises to be separately assessed and shall deliver

copies of the bills for Tax Expenses to Tenant upon receipt. Landlord shall provide to Tenant a copy of a receipted tax bill or other documentary evidence reasonably satisfactory to Tenant, showing the amount of the Tax Expenses due and the payment of same prior to the delinquency date. The obligation of Landlord pursuant to this Section 4.3.5.1 shall extend to any increase in Tax Expenses resulting from a sale, transfer or other transaction with respect to the Premises which causes a reassessment resulting in an increase in Tax Expenses.

1.16.5.2 Right to Contest. Landlord shall have the right, at Landlord's sole risk and cost, except as expressly provided in Section 4.3.5.4, to contest the amount and/or validity of the applicable Tax Expenses by appropriate legal proceedings. The foregoing shall not, however, be deemed or construed to relieve, modify, or extend Landlord's covenant to pay any such Tax Expenses at the time and in the manner provided in this Section, unless such proceedings shall operate to prevent the sale of the Project or any part thereof or any other property of Landlord or the placing of any lien thereon or on any other property of Landlord to satisfy such taxes prior to the final determination of such proceedings. Upon the termination of such proceedings, Landlord shall promptly pay all Tax Expenses, if any, then payable as the result of such proceedings and the interest and penalties in connection therewith, and the charges accruing in such proceedings. Subject to Section 4.3.5.4, to the extent Tenant receives any refund for any Tax Expenses paid by Landlord hereunder, Tenant shall promptly pay and deliver such refund to Landlord

1.16.5.3 Tax Expenses. "**Tax Expenses**" shall mean all federal, state, county, or local governmental or municipal taxes, fees, charges or other impositions of every kind and nature, whether general, special, ordinary or extraordinary (including, without limitation, real estate taxes, general and special assessments, transit taxes, leasehold taxes or taxes based upon the receipt of rent, including gross receipts or sales taxes applicable to the receipt of rent, unless required to be paid by Tenant, personal property taxes imposed upon the fixtures, machinery, equipment, apparatus, systems and equipment, appurtenances, furniture and other personal property used in connection with the Project, or any portion thereof), which shall be paid or accrued during any Expense Year (without regard to any different fiscal year used by such governmental or municipal authority) because of or in connection with the ownership, leasing and operation of the Project, or any portion thereof including the parking areas. Tax Expenses shall include, without limitation:

(i) any tax on the rent, right to rent or other income from the Project, or any portion thereof, or as against the business of leasing the Project, or any portion thereof;

(ii) any assessment, tax, fee, levy or charge in addition to, or in substitution, partially or totally, of any assessment, tax, fee, levy or charge previously included within the definition of real property tax, it being acknowledged by Tenant and Landlord that Proposition 13 was adopted by the voters of the State of California in the June 1978 election ("**Proposition 13**") and that assessments, taxes, fees, levies and charges may be imposed by governmental agencies for such services as fire protection, street, sidewalk and road maintenance, refuse removal and for other governmental services formerly provided without charge to property owners or occupants, and, in further recognition of the decrease in the level and quality of governmental services and amenities as a result of Proposition 13, Tax Expenses shall also include any governmental or private assessments

or the Project's contribution towards a governmental or private cost-sharing agreement for the purpose of augmenting or improving the quality of services and amenities normally provided by governmental agencies;

(iii) any assessment, tax, fee, levy, or charge allocable to or measured by the area of the Premises or the Rent payable hereunder, including, without limitation, any business or gross income tax or excise tax with respect to the receipt of such rent, or upon or with respect to the possession, leasing, operating, management, maintenance, alteration, repair, use or occupancy by Tenant of the Premises, or any portion thereof;

(iv) any assessment, tax, fee, levy or charge, upon this transaction or any document to which Tenant is a party, creating or transferring an interest or an estate in the Premises; and

(v) all of the real estate taxes and assessments imposed upon or with respect to the Building and Project. To the extent such taxes are not currently known, Landlord shall reasonably estimate the taxes and the Base Year Tax Expenses shall be adjusted accordingly upon receipt of the actual tax adjustment based upon such reassessment.

1.16.5.4 Other Costs and Refunds. Any actual and reasonable costs and expenses (including, without limitation, reasonable attorneys' and consultants' fees) incurred in attempting to protest, reduce or minimize Tax Expenses shall be included in Tax Expenses in the Expense Year such expenses are incurred, but only to the extent of the savings resulting therefrom. Tax refunds shall be credited against Tax Expenses and refunded to Tenant regardless of when received, based on the Expense Year to which the refund is applicable; provided, however, in no event shall the amount to be refunded Tenant for any such Expense Year exceed the total amount paid by Tenant as Additional Rent under this Article 4 for such Expense Year. If Tax Expenses for any period during the Lease Term or any extension thereof are increased after payment thereof for any reason, including, without limitation, error or reassessment by applicable governmental or municipal authorities, Tenant shall pay Landlord upon demand Tenant's Share of any such increased Tax Expenses to the extent the same results in excess Direct Expenses for such Expense Year over the Allowance. Notwithstanding anything to the contrary contained in this Section 4.3.5, there shall be excluded from Tax Expenses (i) all excess profits taxes, franchise taxes, gift taxes, capital stock taxes, inheritance and succession taxes, estate taxes, federal and state income taxes, and other taxes to the extent applicable to Landlord's general or net income (as opposed to rents, receipts or income attributable to operations at the Project), (ii) any items included as Operating Expenses, and (iii) any items paid by Tenant under Section 4.4 of this Lease.

1.16.6 Tenant's Share. "**Tenant's Share**" shall mean the percentage set forth in item (z) of the Fundamental Lease Provisions.

1.17 Taxes and Other Charges for Which Tenant Is Directly Responsible.

1.17.1 Personal Property Taxes. Tenant shall be liable for and shall pay ten (10) days before delinquency, taxes levied against Tenant's equipment, furniture, fixtures and any other personal property located in or about the Premises. Tenant shall cause such taxes to be billed

separately from the property of Landlord. If any such taxes on Tenant's equipment, furniture, fixtures and any other personal property are levied against Landlord or Landlord's property or if the assessed value of Landlord's property is increased by the inclusion therein of a value placed upon such equipment, furniture, fixtures or any other personal property and if Landlord pays the taxes based upon such increased assessment, which Landlord shall have the right to do regardless of the validity thereof but only under proper protest if requested by Tenant, Tenant shall upon demand repay to Landlord the taxes so levied against Landlord or the proportion of such taxes resulting from such increase in the assessment, as the case may be.

1.17.2 Taxes on Improvements in Premises. If the tenant improvements in the Premises, whether installed and/or paid for by Landlord or Tenant and whether or not affixed to the real property so as to become a part thereof, are assessed for real property tax purposes at a valuation higher than the cost of the Original Improvements installed by Landlord, then the Tax Expenses levied against Landlord or the property by reason of such excess assessed valuation shall be deemed to be taxes levied against personal property of Tenant and shall be governed by the provisions of Section 4.4.1, above.

1.17.3 Other Taxes. Notwithstanding any contrary provision herein, Tenant shall pay prior to delinquency any (i) rent tax or sales tax, service tax, transfer tax or value added tax, or any other applicable tax on the rent or services herein or otherwise respecting this Lease, (ii) taxes assessed upon or with respect to the possession, leasing, operation, management, maintenance, alteration, repair, use or occupancy by Tenant of the Premises or any portion of the Project, including the Project parking, or (iii) taxes assessed upon this transaction or any document to which Tenant is a party creating or transferring an interest or an estate in the Premises.

1.18 Landlord's Books and Records. Within six (6) months after receipt of a Statement by Tenant, if Tenant disputes the amount of Additional Rent set forth in the Statement, an independent certified public accountant (which accountant is a member of a nationally recognized accounting firm and has previous experience in reviewing financial operating records of landlords of office buildings and is retained by Tenant on a non-contingency fee basis) (the "**Tenant Auditor**"), designated and paid for by Tenant, may, after reasonable notice to Landlord and at reasonable times, inspect Landlord's records with respect to the Statement at Landlord's offices, provided that Tenant is not then in default under this Lease and Tenant has paid all amounts required to be paid under the applicable Estimated Statement and Statement, as the case may be. In connection with such inspection, Tenant and Tenant's agents must agree in advance to follow Landlord's reasonable rules and procedures regarding inspections of Landlord's records, and shall execute a commercially reasonable confidentiality agreement regarding such inspection. Tenant's failure to dispute the amount of Additional Rent set forth in any Statement within six (6) months following Tenant's receipt of such Statement shall be deemed to be Tenant's approval of such Statement and Tenant, thereafter, waives the right or ability to dispute the amounts set forth in such Statement. If after such inspection, Tenant still disputes such Additional Rent, a determination as to the proper amount shall be made, at Tenant's expense, by an independent certified public accountant (the "**Accountant**") selected by Landlord and subject to Tenant's reasonable approval; provided that if such certification by the Accountant proves that Direct Expenses were overstated by more than three percent (3%), then the cost of the Accountant and the Tenant Auditor, and the cost of such

determination certification, shall be paid by Landlord. Any reimbursement amounts determined to be owing by Landlord to Tenant or by Tenant to Landlord shall be (i) in the case of amounts owing from Tenant to Landlord, paid within thirty (30) days following such determination, and (ii) in the case of amounts owing from Landlord to Tenant, credited against the next payment of Rent due Landlord under the terms of this Lease, or if the Lease Term has expired, paid to Tenant within thirty (30) days following such determination. In no event shall this Section 4.5 be deemed to allow any review of any of Landlord's records by any subtenant of Tenant. Tenant agrees that this Section 4.5 shall be the sole method to be used by Tenant to dispute the amount of any Direct Expenses payable or not payable by Tenant pursuant to the terms of this Lease, and Tenant hereby waives any other rights at law or in equity relating thereto.

ARTICLE 5 - USE

1.19 Permitted Use. The Premises shall be used only for the use specified in provision (q) of the Fundamental Lease Provisions and for no other purpose.

1.20 Restriction on Use. Tenant shall not do or permit to be done in or about the Buildings nor bring, keep or permit to be brought or kept therein, anything which is prohibited by any standard form fire insurance policy or which will in any way increase the existing rate of such insurance (unless Tenant is willing to otherwise pay any such increased cost in connection therewith). Subject to Landlord's obligations set forth in General Condition B above, Tenant shall comply with all Applicable Laws affecting the Premises, and with the requirements of any Board of Fire Underwriters or other similar body now or hereafter instituted, and shall also comply with any order, directive or certificate of occupancy issued pursuant to any Applicable Laws, which affect the condition, use or occupancy of the Premises, including, but not limited to, any requirements of changes to the Building Structure and/or Building Systems related to or affected by Tenant's acts, occupancy or use of the Premises.

ARTICLE 6 - ALTERATIONS AND ADDITIONS

1.21 Tenant's Rights to Make Alterations. Following the date on which Tenant first occupies any portion of the Premises, Tenant, at its sole cost and expense, upon ten (10) days' notice to Landlord, shall have the right to make alterations, additions or improvements (individually and collectively, "**Alterations**") to any occupied portion of the Premises upon receipt of Landlord's consent, which consent will not be unreasonably withheld, conditioned or delayed unless the making or installation of the Alterations (a) adversely affects the Building Structure, (b) adversely affects the Building Systems, (c) affect the exterior appearance of the Building, or (d) do not comply with Applicable Laws (individually and collectively a "**Design Problem**"). Landlord may, in reasonable discretion, as a condition to the installation thereof and if such request is made concurrently with the approval of the plans and specifications therefore, require Tenant to remove and restore any such Alterations at Tenant's sole cost and expense, it being agreed and understood, however, that in no event will Tenant have any obligation to remove any such Alterations unless, in Landlord's reasonable judgment, such Alterations are not customary and typical for general business offices. Notwithstanding anything to the contrary set forth herein, Tenant shall not be required to obtain Landlord's prior consent with respect to any cosmetic work performed within the Premises by Tenant, such as the installation of wall coverings, floor coverings, painting and similar work. All

such Alterations shall be made in conformity with the requirements of Section 6.2 below. Once the Alterations have been completed, such Alterations shall thereafter be included in the designation of Tenant Improvements and shall be treated as Tenant Improvements.

1.22 Installation of Alterations. Any Alterations installed by Tenant during the Term shall be done in strict compliance with all of the following:

(a) If Landlord's approval is required, then no such work shall proceed without Landlord's prior approval of (i) Tenant's contractor(s), which consent shall not be unreasonably withheld, conditioned or delayed; and (ii) detailed plans and specifications for such work to the extent required, which approval shall not be unreasonably withheld, conditioned or delayed unless a Design Problem exists (but which approval may be conditioned upon Landlord's right to require Tenant to remove and restore the Alterations upon the termination of this Lease, subject to the provisions of Section 6.1 above).

(b) All such work shall be done in accordance with industry custom and practice for a "first-class" office project and in conformity with a valid building permit and/or all other permits or licenses when and where required, copies of which shall be furnished to Landlord before the work is commenced, and any work not acceptable to any governmental authority or agency having or exercising jurisdiction over such work, or not done in accordance with industry custom and practice for a "first-class" office project, shall be promptly replaced and corrected at Tenant's expense. Landlord's approval or consent to any such work shall not impose any liability upon Landlord. No work shall proceed until and unless Landlord has received at least ten (10) days' notice that such work is to commence including a commercially reasonable description of the work to be performed including drawings and specifications when necessary;

(c) Tenant shall, within thirty (30) days following Landlord's demand therefor, reimburse Landlord for any actual, reasonable and documented out-of-pocket costs incurred by Landlord by reason of Landlord's review of Tenant's plans and specifications, any faulty work done by Tenant or Tenant's contractors, or by reason of inadequate cleanup. In addition, Tenant shall, if requested by Landlord, pay to Landlord a supervision fee equal to three percent (3%) of the hard construction costs of any Alterations for which Landlord's approval is required; provided, however, that no such supervision fee shall be payable to Landlord pursuant to this subsection (c) so long as 6th and Pine Development, LLC or a Related Landlord is the Landlord under this Lease. As used herein, a "**Related Landlord**" shall mean any person that is a member or equity owner (whether directly or indirectly) of 6 th and Pine Development, LLC as of the date hereof, or any family member of such person, or any entity in which such person or such person's family member is or hereinafter becomes an equity owner (whether directly or indirectly).

1.23 Tenant Improvements - Treatment at End of Lease. All Alterations and any Tenant Improvements made by or for Tenant, which is permanent in character and permanently attached to the Building Structure, made either by Landlord or Tenant, shall unless Tenant is required pursuant to the terms of this Lease and has removed the same and repaired any damage resulting from such removal, shall become Landlord's property on the last day of the Term, and shall be surrendered to Landlord in good condition, reasonable wear and tear and damage by casualty excepted, upon expiration of the Term or termination of this Lease without compensation to Tenant; provided

however, that at the election of Landlord, exercisable by written notice to Tenant (which election must be made at the time Tenant requests Landlord's consent to any Alterations for which Landlord's prior consent is required), Tenant shall, at Tenant's sole expense, prior to the expiration of the Term, remove from the Premises such Alterations to the extent such Alterations are not customary and typical for general business offices, repair all damage to the Premises caused by such removal and restore such improvements to substantially their prior condition; provided, however, that Tenant shall have no obligation to remove any initial Tenant Improvements installed in the Premises. All of Tenant's personal property, including moveable furniture, trade fixtures, and equipment not attached to the Buildings or the Premises, may be removed by Tenant prior to the expiration of the Term. Provided, however, that Tenant shall repair all damage caused by such removal prior to the expiration of the Term, and provided further, that any of Tenant's personal property not so removed shall, at the option of Landlord, upon five (5) business days' notice to Tenant (unless Tenant effectuates the removal within such five (5) business day period) automatically become the property of Landlord upon the expiration or termination of this Lease. Thereafter, Landlord may retain or dispose of in any manner the personal property not so removed, without any liability whatsoever to Tenant.

ARTICLE 7 - TENANT'S REPAIRS

Subject to Landlord's obligations set forth in General Condition B above, from and after the Commencement Date for the Existing Building and the New Building, as the case may be, Tenant shall, at Tenant's own expense, keep the Premises, other than the Building Structure and the Building Systems, in good order, repair and condition at all times during the Lease Term. In addition, Tenant shall, at Tenant's own expense, provided, however, that Tenant shall be entitled to receive reimbursement for such expense to the extent that the cost of any such repair is or is required to be covered by insurance obtained by Landlord as part of Operating Expenses and Article 12, but under the supervision and subject to the prior approval of Landlord, and within any reasonable period of time specified by Landlord, promptly and adequately repair all damage to the Premises and replace or repair all damaged, broken, or worn fixtures and appurtenances, but excluding those items that are the responsibility of Landlord as outlined in Article 9 of this Lease, and excepting damage caused by ordinary wear and tear; provided, however, that, at Landlord's option, if Tenant fails to make such repairs, Landlord may, but need not, make such repairs and replacements, and Tenant shall pay Landlord the cost thereof, including a reasonable and customary percentage of the cost thereof (to be uniformly established for the Buildings and/or the Project) sufficient to reimburse Landlord for all reasonable and actual overhead, general conditions, fees and other costs or expenses arising from Landlord's involvement with such repairs and replacements forthwith upon being billed for same. Landlord may, but shall not be required to, enter the Premises at all reasonable times to make such repairs, alterations, improvements or additions to the Premises or to the Project or to any equipment located in the Project as Landlord shall desire or deem necessary or as Landlord may be required to do by governmental or quasi-governmental authority or court order or decree. Tenant hereby waives any and all rights under and benefits of Sections 1941 and 1942 of the California Civil Code or under any similar law, statute, or ordinance now or hereafter in effect.

ARTICLE 8 - NO LIENS BY TENANT

Tenant shall at all times keep the Premises and the Buildings free from any liens arising out of any work performed or allegedly performed, materials furnished or allegedly furnished or obligations incurred by or for Tenant except any work performed by Landlord pursuant to this Lease or the Work Letter other than any work performed by Landlord that was Tenant's obligation to perform pursuant to the terms of this Lease. Tenant agrees to indemnify and hold Landlord harmless from and against any and all claims for mechanics', materialmen's or other liens in connection with any Alterations, repairs, or any work performed, materials furnished or obligations incurred by Tenant. Landlord reserves the right to enter the Premises for the purpose of posting such notices of non-responsibility as may be permitted by law, or desired by Landlord.

ARTICLE 9 - LANDLORD'S REPAIRS

Landlord shall be responsible for any and all necessary maintenance, repairs and replacements required to be made to the Building Structure and /or the Building Systems, subject to Landlord's right to receive Additional Rent pursuant to Article 4 of this Lease. As also provided General Condition N, Landlord shall, subject to Tenant's repair obligations set forth in Article 7 of this Lease, maintain and operate the Project in a first class manner, keep the Building Structure and the Building Systems in first class condition and repair, in compliance with Applicable Laws, maintain a safe and healthful environment in the Buildings, and operate, maintain, and provide services to the Building in a first class manner comparable to the manner in which sophisticated experienced landlords of other Comparable Buildings, the cost of which shall be included in Operating Expenses, to the extent permitted pursuant to Article 4.

ARTICLE 10 - BUILDING SERVICES

1.24 Standard Tenant Services. Landlord shall provide the following services on all days (unless otherwise stated below) during the Lease Term.

1.24.1 Subject to limitations imposed by all Applicable Laws, Landlord shall provide heating, ventilation and air conditioning ("**HVAC**") when necessary for normal comfort for normal office use in the Premises from 7:00 A.M. to 6:00 P.M. Monday through Friday, and on Saturdays from 9:00 A.M. to 1:00 P.M. (collectively, the "**Building Hours**"), except for the date of observation of New Year's Day, Independence Day, Labor Day, Memorial Day, Thanksgiving Day, Christmas Day and, at Landlord's discretion, other locally or nationally recognized holidays (collectively, the "**Holidays**").

1.24.2 Landlord shall provide adequate electrical wiring and facilities for connection to Tenant's lighting fixtures and incidental use equipment, provided that (i) the connected electrical load of the incidental use equipment does not exceed an average of six (6) watts per usable square foot of the Premises and (ii) the connected electrical load of Tenant's lighting fixtures does not exceed an average of two (2) watts per usable square foot of the Premises, which electrical usage shall be subject to Applicable Laws, including California Code of Regulations, Title 24. Tenant shall bear the cost of replacement of lamps, starters and ballasts for lighting fixtures within the Premises that are not consistent with the Original Improvements, as the same may be updated with lighting fixtures of similar performance in the event that the Original Improvements become obsolete..

1.24.3 Landlord shall provide city water from the regular Building outlets for drinking, lavatory and toilet purposes in the Premises.

1.24.4 Landlord shall provide janitorial services to the Premises and window washing services in a manner consistent with Comparable Buildings.

1.24.5 Landlord shall provide nonexclusive, non-attended automatic passenger elevator service during the Building Hours and shall have one elevator available in each Building at all other times, including on the Holidays.

Tenant shall cooperate fully with Landlord at all times and abide by all regulations and requirements that Landlord may reasonably prescribe for the proper functioning and protection of the HVAC, electrical, mechanical and plumbing systems.

1.25 Overstandard Tenant Use.

1.25.1 Non-Electrical Usage (including After-Hours HVAC). Tenant shall not, without Landlord's prior written consent, use heat-generating machines, machines other than normal fractional horsepower office machines, or equipment or lighting other than Building standard lights in the Premises, which may affect the temperature otherwise maintained by the air conditioning system or increase the water normally furnished for the Premises by Landlord pursuant to the terms of Section 10.1 of this Lease. If Tenant uses water, heat or air conditioning in excess of that required to be supplied by Landlord pursuant to Section 10.1 of this Lease, Tenant shall pay to Landlord, upon billing, the actual cost of such excess consumption, the cost of the installation, operation, and maintenance of equipment which is installed in order to supply such excess consumption, and the cost of the increased wear and tear on existing equipment caused by such excess consumption; and Landlord may install devices to separately meter any increased use and in such event Tenant shall pay the cost of such increased use directly to Landlord, on demand as additional Rent, at the rates charged by the public utility company furnishing the same, including the cost of such additional metering devices. If Tenant desires to use HVAC during non-Building Hours, Tenant shall give Landlord such prior notice, if any, as Landlord shall from time to time reasonably establish as appropriate, of Tenant's desired use in order to supply HVAC, and Landlord shall supply HVAC to the Premises. The cost of after-hours HVAC for the Premises shall be based upon Landlord's actual cost of providing such HVAC services. The cost of HVAC supplied by Landlord during non-Building Hours shall be paid by Tenant as Additional Rent.

1.25.2 Electrical Usage. If in any month Tenant uses electricity (not including any electricity consumed in connection with the operation of the Building's main HVAC system) in excess of the Electricity Usage Standard (as defined below), Landlord may require the Tenant, at its cost, to install, operate and maintain a submeter and/or equipment which is required to be installed to supply such excess capacity and/or consumption to Tenant. Tenant shall pay to Landlord, upon billing, Landlord's cost of electricity consumption in excess of the Electricity Usage Standard, on demand as additional Rent. For purposes hereof, the "**Electricity Usage Standard**" shall be an average of six (6) watts per rentable square foot of the Premises of actual consumption, on a monthly Building Hours basis (such Electricity Usage Standard does not include electrical usage for HVAC serving the Premises). Tenant's use of electricity shall not exceed the capacity of the feeders to the

Project or the risers or wiring installation (which capacity is eight (8) watts per rentable square foot) and Tenant shall promptly discontinue any such excess use promptly following receipt of notice of the same from Landlord.

1.26 Interruption of Use. Notwithstanding anything to the contrary contained herein, except as provided in General Condition B, F and/or I or as otherwise expressly provided in this Lease, Tenant agrees that Landlord shall not be liable for damages, by abatement of Rent or otherwise, for failure to furnish or delay in furnishing any service (including telephone and telecommunication services), or for any diminution in the quality or quantity thereof, when such failure or delay or diminution is occasioned, in whole or in part, by breakage, repairs, replacements, or improvements, by any strike, lockout or other labor trouble, by inability to secure electricity, gas, water, or other fuel at the Building or Project after reasonable effort to do so, by any riot or other dangerous condition, emergency, accident or casualty whatsoever, by act or default of Tenant or any Tenant Party, or by any other cause beyond Landlord's reasonable control; and such failures or delays or diminution shall never be deemed to constitute an eviction or disturbance of Tenant's use and possession of the Premises or relieve Tenant from paying Rent or performing any of its obligations under this Lease.

ARTICLE 11 - ASSIGNMENT AND SUBLETTING

1.27 Right to Assign, Sublease and Encumber. Except at otherwise expressly provided in this Article 11, Tenant may not voluntarily assign or encumber its interest in this Lease or in the Premises, or sublease all or any part of the Premises, or allow any other person or entity (other than the Tenant Parties)) to occupy or use all or any part of the Premises, without first obtaining Landlord's consent (which consent shall not be unreasonably withheld, conditioned or delayed). Landlord shall have no right to recapture all or any portion of the Premises in the event of an assignment, encumbrance or sublease. No consent to an assignment, encumbrance, or sublease shall constitute a further waiver of the provisions of this Article 11. Notwithstanding anything to the contrary contained in this Lease, Tenant shall not be deemed to have waived any of its rights under California Civil Code Section 1995.310.

1.28 Procedure for Assignment and Sublease. Tenant shall advise Landlord by notice of (a) Tenant's intent to assign, encumber, or sublease this Lease, (b) the name of, and information with respect to the business operations of, the proposed assignee or sublessee, (c) the proposed effective date of such assignment, sublease or other transfer, (d) a description of the portion of the Premises to be assigned, sublet or otherwise transferred, (e) the material terms of the proposed assignment, sublease or other transfer, including the relevant documentation with respect thereto and, in the case of a sublease, the consideration therefor, and (f) financial statements for the proposed assignee or sublessee, including, if available, audited financial statements (the " **Transfer Notice**"). Landlord shall approve or disapprove of the proposed assignment, sublease or other transfer within thirty (30) days (the " **Review Period**") after Landlord's receipt of the Transfer Notice. Landlord shall be deemed to have consented to such proposed assignment or sublease if Landlord fails to approve or disapprove of the proposed assignment, sublease or other transfer prior to the expiration of the Review Period. Landlord may reasonably withhold its consent to an assignment or sublease in the event (i) the proposed assignee or sublessee is a governmental entity, (ii) the proposed assignee

or sublessee will have an occupancy density with respect to the space to be assigned or sublet that is greater than Tenant's highest occupancy density during its period of occupany, (iii) the proposed use is other than the Permitted Use, (iv) such assignment, sublease or other transfer would increase the cost of Landlord's obligations under this Lease, or (v) in the case of an assignment or other transfer (but not a sublease), the financial strength of the proposed assignee or transferee is not reasonably acceptable to Landlord; provided, however, that such financial strength of such proposed assignee or transferee shall be deemed acceptable to Landlord if such assignee's or transferee's net worth or shareholder's equity is equal for or greater than $250 million as determined in accordance with generally acceptable accounting principles and demonstrated by financial statements of such assignee or transferee reasonably acceptable to Landlord (herein, a "**Significant Assignee**").

1.29 Conditions Regarding Consent to Subleases. In the event that Landlord shall consent or be deemed to have consented to an assignment or sublease under the provisions of this Article 11, Tenant shall remain directly, primarily and fully responsible and liable for all payments owed by Tenant under this Lease and for compliance with all obligations under the terms, provisions and covenants of this Lease; provided, however, that if such assignment is to a Significant Assignee, then Tenant shall be released from all of its obligations first arising our accruing under this Lease from and after the effective date of such assignment, and upon request, Landlord shall execute and deliver to Tenant a release instrument in form and substance reasonably acceptable to Tenant confirming the same. With respect to any sublease other than pursuant to Section 11.4 below (and excluding specifically an assignment), Tenant shall pay Landlord, as additional Base Rent, fifty percent (50%) of any Profits (as defined below) actually received by Tenant pursuant to such approved sublease. Whenever Landlord is entitled to share in any excess income resulting from an assignment or sublease of the Premises, the following shall constitute the definition of "**Profits**": the gross revenue received from the sublessee during the sublease term, with respect to the space covered by the sublease or the assignment ("**Subleased Space**") less: (a) the gross revenue paid to Landlord by Tenant during the period of the sublease term with respect to the Transferred Space; (b) any improvement allowance or other economic concession (planning allowance, moving expenses, etc.), paid by Tenant to the sublessee; (c) brokers' commissions; (d) attorneys' fees; (e) lease takeover payments; (f) costs of advertising the space for sublease; and (g) any other costs actually paid in subletting the Transferred Space or in negotiating or effectuating the assignment or sublease; provided, however, under no circumstance shall Landlord be paid any Profits until Tenant has recovered all the items set forth in subparts (a) through (g) for such Transferred Space, it being understood that if in any year the gross revenues, less the deductions set forth in subparts (a) through (g) above (the "**Net Revenues**"), are less than any and all costs actually paid in subletting the affected space (collectively "**Transaction Costs**"), the amount of the excess Transaction Costs shall be carried over to the next year and then deducted from Net Revenues with the procedure repeated until a Profit is achieved. It is acknowledged and agreed that, in connection with any sublease, Tenant shall be solely responsible for any bifurcation and/or demising costs associated with creating a multi tenant lobby, multi tenant corridor, or separate suite on any particular floor within the Buildings, but such costs shall costs shall be deemed Transaction Costs for purposes of the foregoing.

1.30 Affiliated Companies/Restructuring of Business Organization. Occupancy of all or part of the Premises by any parent, subsidiary, or affiliated companies of Tenant or of Tenant's

parent or of Tenant's subsidiary shall not be deemed an assignment or subletting provided that such parent, subsidiary or affiliated companies were not formed as a subterfuge to avoid the obligation of this Article 11. Furthermore, without limiting the generality of the foregoing, Tenant may assign this Lease at any time, or sublease all or part of the Premises, without receipt of Landlord's consent (and without triggering Landlord's right to share in Profits pursuant to Section 11.3 above), to any entity which acquires all or part of Tenant, or which is acquired in whole or in part by Tenant, or which is controlled directly or indirectly by Tenant, or which entity controls, directly or indirectly, Tenant (herein, an "**Affiliate**"), or which owns or is owned by the Affiliate, so long as such transaction was not entered into as a subterfuge to avoid the obligations and restrictions of this Lease.

1.31 Landlord's Right to Assign. Subject to the provisions of Exhibit "I-1" [Right of First Offer to Purchase], Landlord shall have the right to sell, encumber, convey, transfer, and/or assign any of its rights and obligations under this Lease.

1.32 Occupancy By Others. Tenant may allow any person or entity which is a client or customer of Tenant or which is providing service to Tenant or one of Tenant's clients to occupy certain portions of the Premises without such occupancy being deemed an assignment or subleasing as long as no new demising walls are constructed to accomplish such occupancy as long as such relationship was not created as a subterfuge to avoid the obligations set forth in this Article 11 and so long as such occupancy is for not more than five percent (5%) of the Premises.

ARTICLE 12 - LIMITATION ON LANDLORD'S LIABILITY; INDEMNIFICATION; INSURANCE

1.33 Limitation on Landlord's Liability and Release. Except as otherwise expressly provided in this Lease to the contrary, Landlord shall not be liable to Tenant for, and Tenant hereby releases and waives all claims and rights of recovery against Landlord and the other Landlord Parties (as defined below) from, any and all Claims (as defined below) sustained by Tenant, the Tenant Parties, any damage to Tenant's property, or any loss to Tenant's business, loss of Tenant's profits or other financial loss of Tenant resulting from or attributable to the condition of, the management of, the repair or maintenance of, the protection of, the supply of services or utilities to, the damage in or destruction of the Premises, the Buildings or the Project; provided, however, that the foregoing release and wavier shall not extend to, and Tenant is not hereby waiving or releasing Landlord from or against, any Claims arising out of or in connection with injuries to persons or property resulting from any Claims as to which Landlord is expressly obligated to defend, indemnify and hold Tenant and the Tenant Parties harmless as provided below in Section 12.2(b) below or elsewhere in this Lease.

1.34 Indemnification.

(a) Tenant shall at its expense defend, indemnify, and hold Landlord and Landlord's agents, contractors, licensees, employees, directors, officers, partners, trustees and invitees (each, a "Landlord Party," and collectively " **Landlord Parties**") harmless from and against any and all loss, cost, liability, damage or expense, including, but not limited to, penalties, fines, attorneys' fees or costs (collectively "**Claims**"), arising out of or in connection with (i) injuries to persons or property in, on or about the Project (but excluding the Management Office) or injuries

to persons or property caused by the use of the Off-Site Parking Spaces by Tenant or any Tenant Party or from activities conducted by Tenant or any Tenant Party and with Tenant's knowledge and consent, express or implied, in the parking lots and/or structures where such Off-Site Parking Spaces are located or (ii) the presence in, on or about the Project of Hazardous Materials to the extent such Hazardous Materials were placed in, on or about Project by Tenant or any Tenant Party. Notwithstanding any provisions of Articles 12 and 13 to the contrary, Tenant shall not be required to indemnify and hold Landlord harmless from any Claims resulting from injuries to any person or property resulting from (i) the negligent acts or omissions or willful misconduct of any Landlord Party in connection with Landlord's activities in, on or about the Project or the Off-Site Parking Spaces, and Landlord hereby so indemnifies and holds Tenant and the Tenant Parties harmless from any such Claims or (ii) any other Claims as to which Landlord is expressly obligated to defend, indemnify and hold Tenant and the Tenant Parties harmless as provided below in Section 12.2(b) below or elsewhere in this Lease. This indemnity shall survive the expiration or termination of this Lease.

(b) Landlord shall at its expense defend, indemnify, and hold Tenant and the Tenant Parties harmless from Claims arising from (i) any noncompliance of Project, or any portion thereof, with any Applicable Laws as of the applicable Commencement Date, (ii) the presence in, on or about the Project of Hazardous Materials, except to the extent such Hazardous Materials were placed in, on or about Project by Tenant or any Tenant Party, (iii) the negligent acts or omissions or willful misconduct of Landlord or any Landlord Party in connection with Landlord's activities in, on or about the Project or the Off-Site Parking Spaces, or (iv) Landlord's breach of this Lease. This indemnity shall survive the expiration or termination of this Lease.

(c) Tenant's agreement to indemnify and hold Landlord harmless pursuant to Section 12.2(a) and the exclusion from Tenant's indemnity and Landlord's agreement to indemnify and hold Tenant harmless pursuant to Section 12.2(b) are not intended to and shall not relieve any insurance carrier of its obligations under policies required to be carried by Landlord or Tenant, respectively, pursuant to this Lease to the extent that such policies cover the results of such acts, omissions or willful misconduct. If Landlord or Tenant has been or at any time hereafter is granted the right to self insure or if either party breaches this Lease by its failure to carry required insurance, such failure shall automatically be deemed to be a covenant and agreement by Landlord or Tenant, respectively, to self-insure to the full extent of such required coverage, with full waiver of subrogation. All of the provisions set forth herein are subject to the provisions of Section 12.5.

1.35 Insurance.

1.35.1 Tenant's Compliance With Landlord's Fire and Casualty Insurance. Tenant shall, at Tenant's expense, comply with all insurance company requirements pertaining to the use of the Premises, provided that Tenant has received not less than ten (10) business days' notice thereof. If Tenant's conduct or use of the Premises causes any increase in the premium for such insurance policies which are paid by Landlord as an Operating Expense, then Tenant shall reimburse Landlord for any such increase.

1.35.2 Tenant's Insurance. Tenant shall maintain the following coverages in the following amounts.

(a) Commercial General Liability Insurance covering the insured against claims of bodily injury, personal injury and property damage (including loss of use thereof) arising out of Tenant's operations, and contractual liabilities (covering the performance by Tenant of its indemnity agreements) including a Broad Form endorsement covering the insuring provisions of this Lease, for limits of liability not less than:

Bodily Injury and Property Damage Liability	$3,000,000 each occurrence $3,000,000 annual aggregate
Personal Injury Liability	$3,000,000 each occurrence $3,000,000 annual aggregate 0% Insured's participation

(b) Physical Damage Insurance covering (i) all office furniture, business and trade fixtures, office equipment, free-standing cabinet work, movable partitions, merchandise and all other items of Tenant's property on the Premises installed by, for, or at the expense of Tenant, (ii) the tenant improvements which exist in the Premises as of the applicable Commencement Date (excluding the Building Structure and Building Systems) (the "**Original Tenant Improvements**"), and (iii) all other Alterations to the Premises made by Tenant. Such insurance shall be written on an "all risks" of physical loss or damage basis, for the full replacement cost value (subject to reasonable deductible amounts) new without deduction for depreciation of the covered items and in amounts that meet any co-insurance clauses of the policies of insurance and shall include coverage for damage or other loss caused by fire or other peril including, but not limited to, vandalism and malicious mischief, theft, water damage of any type, including sprinkler leakage, bursting or stoppage of pipes, and explosion, and providing business interruption coverage for a period of one year.

(c) Worker's Compensation and Employer's Liability or other similar insurance required by all applicable state and local statutes and regulations.

1.35.3 Additional Insurance Obligations of Tenant. Tenant shall carry and maintain during the entire Lease Term, at Tenant's sole cost and expense, increased amounts of the insurance required to be carried by Tenant pursuant to Section 12.3 above and such other reasonable types of insurance coverage and in such reasonable amounts covering the Premises and Tenant's operations therein, in each case as may be reasonably requested by Landlord, but in no event in excess of the amounts and types of insurance then being required of tenants in Comparable Buildings occupying comparable space and engaged in a similar use as Tenant.

1.35.4 Blanket Insurance/Self Insurance of Tenant. Notwithstanding the foregoing, all of the insurance requirements set forth in this Section 12.3 on the part of Tenant to be observed shall be deemed satisfied if the Premises are covered by a blanket insurance policy providing the coverage set forth herein insuring all or most of Tenant's facilities in California or if Tenant sends a letter to Landlord, signed by an authorized officer of Tenant, stating that Tenant has elected to act as a self insurer whereupon Tenant shall have the same obligations and rights, and Landlord shall have the same rights and obligations, as if Tenant was an insurance company furnishing the policies and coverages required under this Lease.

1.35.5 Evidence of Coverage by Tenant. A duplicate original policy, or a certificate of the policy shall be deposited with Landlord at the Commencement Date, and on renewal of the policy a certificate of insurance listing the insurance coverages required hereunder and naming Landlord and any other parties designated by Landlord with an insurable interest as insured, additional insured and/or loss payee, as applicable, shall be deposited with Landlord not less than ten (10) days before expiration of the term of the policy.

1.35.6 Landlord's Insurance.

(a) During all times that Landlord is performing any construction or other work under this Lease or Work Letter, Landlord shall, at its sole cost and expense, and not as an Operating Expense, (i) obtain and, maintain builder's risk insurance covering both the hard and soft costs associated with the construction/performance of construction or other work, in a face amount of not less than the full insurable value of all improvement work (including the Buildings) and materials supplied in connection therewith, with appropriate provisions made to include coverage of materials stored off the Site in an amount not less than the full insurable value of such materials stored off the Site from time to time, naming Landlord as the insured and Tenant as an additional insured to the extent of Tenant's interest therein, (ii) cause the architects, contractors and subcontractors to carry errors and omissions insurance in an amount at least equal to One Million Dollars ($1,000,000) which can be applied to the construction/performance of the applicable work, covering the entire period of design and construction/performance of the applicable work, including the completion of punch list items (which coverage shall be maintained for at least three (3) years after the completion of the applicable work) and (iii) cause its contractors and subcontractors to carry commercially reasonable amounts of auto insurance.

(b) Commencing on the Commencement Date for the Existing Building with respect to the Existing Building, and commencing on the Commencement Date for the New Building with respect to the New Building, and in each case continuing through the expiration or earlier termination of this Lease, Landlord shall obtain and maintain fire and hazard "all risk" insurance covering one hundred percent (100%) of the full replacement cost valuation of the applicable Building and Project (including the Building Structure and Building Systems), subject to commercially reasonable deductibles, in the event of fire, lightning, windstorm, vandalism, malicious mischief and all other risks normally covered by "all risk" policies carried by landlords of Comparable Buildings naming Landlord as the insured and Landlord or any lessors and mortgagees as loss payee. The proceeds from any such policy shall be used by Landlord for the repair and/or replacement of the Project unless this Lease is terminated, in which case Landlord may retain such proceeds, except as otherwise provided in Section 13.6 below. Landlord shall promptly deliver to Tenant evidence of such insurance upon request by Tenant from time to time.

1.35.7 Insurance Criteria. All the insurance required to be maintained by Tenant and Landlord under this Lease shall:

(a) Be issued by insurance companies authorized to do business in the state of California, with a rating of at least A-VII as rated in the most recent edition of Best's Insurance Reports;

(b) Be issued as a primary policy;

(c) Contain an endorsement requiring ten (10) days' written notice from the insurance company to both parties and to Landlord's lender (whose names shall have been furnished to Tenant) before cancellation or any material change in the coverage, scope, or amount of any policy; and

(d) With respect to property loss or damage, a waiver of subrogation must be obtained, as required by Section 12.5.

1.36 Abatement of Rent/Limitations on Liability and Damages.

(d) Abatement of Rent. Except as provided in General Condition B, F and/or I or as otherwise expressly provided in this Lease, Tenant shall not otherwise be entitled to Rent abatement and shall not otherwise have, and hereby releases Landlord from, any Claims resulting from Tenant's inability to utilize all or any part of the Premises.

(e) Limitation of Liability and Damages/Attorney Fees. Landlord agrees that in the event of a default by Tenant under this Lease, Landlord will not have a right to collect from Tenant a greater amount of damages on account of Rent than Landlord would have been able to collect in the event that Tenant did not default under this Lease. Landlord further agrees that it will use commercially reasonable efforts to mitigate its damages in connection with any default by Tenant. Nothing herein shall be construed to prevent Tenant or Landlord, if it is the prevailing party in connection with any litigation, dispute, or controversy between Landlord and Tenant, from collecting, and each agrees that under such circumstances the other shall have a right to collect and shall be awarded, (a) its reasonable attorneys' fees, costs, and expenses incurred in connection with any such litigation, dispute, or controversy and (b) interest, at the Interest Rate, on any amounts not paid when due. Landlord's liability to Tenant is limited to its equity interest in the Buildings as more specifically provided in Section 15.2 of this Lease.

1.37 Allocation of Insured Risks/Subrogation. Landlord and Tenant release each other from any claims and demands of whatever nature for damage, loss or injury to the Premises and/or the Buildings, or to the other's property in, on or about the Premises and the Buildings, that are caused by or result from risks or perils insured against under any property insurance policies required by this Lease to be carried by Landlord and/or Tenant. Landlord and Tenant shall cause each insurance policy obtained by them or either of them to provide that the insurance company waives all right of recovery by way of subrogation against either Landlord or Tenant in connection with any damage covered by any such policy or policies. Neither Landlord nor Tenant shall be liable to the other for any damage caused by fire or any of the risks insured against under any insurance policy required by this Lease. If an insurance policy cannot be obtained with a waiver of subrogation, or is obtainable only by the payment of an additional premium charge above that charged by insurance companies issuing policies without waiver of subrogation, the party undertaking to obtain the insurance shall notify the other party of this fact. The other party shall have a period of ten (10) days after receiving the notice either to place the insurance with a company that is reasonably satisfactory to the other party and that will carry the insurance with a waiver of subrogation at no additional cost, or to agree to pay the additional premium if such a policy is obtainable at additional

cost. If the insurance cannot be obtained or the party in whose favor a waiver of subrogation is desired refuses to pay the additional premium charged, the other party is relieved of the obligation to obtain a waiver of subrogation with respect to the particular insurance involved.

ARTICLE 13 - DAMAGE OR DESTRUCTION

1.38 Loss Covered By Insurance. In the event of any damage to the Building, Premises, or Project, Tenant shall assign to Landlord (or to any party designated by Landlord) all insurance proceeds payable to Tenant under Tenant's insurance required under this Lease with respect to the Original Tenant Improvements and any Alternations made by Tenant (it being understood and agreed that any insurance proceeds payable to Tenant in such event for any loss or damage suffered by Tenant with respect to Tenant's equipment, furniture, fixtures and any other personal property located in or about the Premises shall not be assigned to Landlord). If, at any time prior to the expiration or termination of this Lease, the Premises or either Building is wholly or partially damaged or destroyed by a casualty, the loss to Landlord from which is or should be (except for any applicable deductible for which Tenant shall be solely responsible) fully covered by insurance maintained by Tenant for Landlord's benefit (or required to be maintained by Tenant pursuant to Article 12)), which casualty renders the Premises totally or partially inaccessible or unusable by Tenant in the ordinary conduct of Tenant's business, then:

(a) Repairs Which Can Be Completed Within Nine (9) Months. Within twenty (20) days of notice to Landlord of such damage or destruction, Landlord shall provide Tenant with notice of its determination of whether the damage or destruction can be repaired within nine (9) months of such damage or destruction without the payment of overtime or other premiums. If all repairs to such Premises or Building can, in Landlord's reasonable judgment, be completed within nine (9) months following the date of such damage or destruction without the payment of overtime or other premiums, Landlord shall, at Landlord's expense, repair the same and this Lease shall remain in full force and effect and a reduction of the Rent shall be allowed Tenant as provided in General Condition F; provided, however, that if any such repair is not commenced by Landlord within ninety (90) days after the occurrence of such damage or destruction or is not or cannot practicably be substantially completed by Landlord within nine (9) months after the occurrence of such damage or destruction, then in either such event Tenant may, at its option, upon written notice to Landlord delivered within thirty (30) days of determining that Landlord has not commenced repair within the ninety (90) day period or that the damage or destruction is not or cannot practicably be substantially completed by Landlord within the nine (9) month period, elect to terminate this Lease as of the date of the occurrence of such damage or destruction.

(b) Repairs Which Cannot Be Completed Within Nine (9) Months. If all such repairs to the Building and Premises cannot, in Landlord's reasonable judgment, be completed within nine (9) months following the date of notice to Landlord of such damage or destruction without the payment of overtime or other premiums, Landlord shall notify Tenant of such determination within twenty (20) days of notice to Landlord of such damage or destruction and either Landlord or Tenant may, at its option, upon written notice to the other party given within sixty (60) days after the occurrence of such damage or destruction, elect to terminate this Lease as of the date of the occurrence of such damage or destruction. In the event that neither Landlord nor

Tenant elect to terminate this Lease in accordance with the foregoing provisions, then Landlord shall, at Landlord's expense, repair such damage or destruction, and in such event, this Lease shall continue in full force and effect but the Rent shall be reduced as provided in General Condition F; provided, however, that if any such repair is not commenced by Landlord within ninety (90) days after the occurrence of such damage or destruction or is not or cannot practicably be substantially completed by Landlord within nine (9) months after the occurrence of such damage or destruction, then in either such event Tenant may, at its option, upon written notice to Landlord delivered within thirty (30) days of determining that Landlord has not commenced repair within the ninety (90) day period or that the damage or destruction is not or cannot practicably be substantially completed by Landlord within the nine (9) month period, elect to terminate this Lease as of the date of the occurrence of such damage or destruction.

1.39 Loss Not Covered By Insurance. If, at any time prior to the expiration or termination of this Lease, the Premises or either Building is totally or partially damaged or destroyed from a casualty, the loss to Landlord from which is not fully covered by insurance maintained by Landlord or maintained by Tenant for Landlord's benefit (or required to be maintained by Tenant pursuant to Article 12), which damage renders the Premises inaccessible or unusable to Tenant in the ordinary course of its business, Landlord may, at its option, upon written notice to Tenant within sixty (60) days after notice to Landlord of the occurrence of such damage or destruction, elect to repair or restore such damage or destruction, or Landlord may elect to terminate this Lease so long as (a) the uninsured portion of the damage or destruction is equal to or greater than the replacement cost of the Building, and (b) Landlord makes a decisions not to commence such repairs within two (2) years of the occurrence of such damage and destruction. If Landlord elects to repair or restore such damage or destruction, this Lease shall continue in full force and effect but a reduction of the Rent shall be allowed Tenant as provided in General Condition F. If Landlord does not elect by notice to Tenant to repair such damage this Lease shall terminate. Notwithstanding the foregoing, if all repairs to the Premises or the Building cannot, in Landlord's reasonable judgment, be completed within six (6) months following the date of such damage or destruction without the payment of overtime or other expenses, then either Landlord or Tenant may at its option, upon written notice to the other party given within sixty (60) days after the occurrence of such damage or destruction, elect to terminate this lease as of the date of the occurrence of such damage or destruction.

1.40 Destruction During Final Year. Notwithstanding anything to the contrary contained in Sections 13.1 and 13.2, if the Premises or either Building is wholly or partially damaged or destroyed within the final twelve (12) months of the Term, or, if an applicable renewal option has been exercised, during the last year of any renewal Term, so that Tenant shall be prevented from using the Premises for thirty (30) consecutive days due to such damage or destruction, then either Landlord or Tenant may, at its option, by notice to the other party within sixty (60) days after the occurrence of such damage or destruction, elect to terminate this Lease.

1.41 Destruction of Tenant's Personal Property or Property of Tenant Parties. In the event of any damage to or destruction of the Premises or either Building, under no circumstances shall Landlord be required to repair any injury, or damage to, or make any repairs to or replacements of, Tenant's personal property. Landlord shall have no responsibility for any contents placed or kept in or on the Premises or the Building by Tenant or any Tenant Party.

1.42 Exclusive Remedy. This Article 13 and General Condition F shall be Tenant's sole and exclusive remedy in the event of damage or destruction to the Premises or either Building, and Tenant, as a material inducement to Landlord entering into this Lease, irrevocably waives and releases Tenant's rights under California Civil Code Sections 1932(2) and 1933(4). No damages, compensation or claim shall be payable by Landlord for any inconvenience, any interruption or cessation of Tenant's business, or any annoyance, arising from any damage to or destruction of all or any portion of the Premises or either Building.

1.43 Option to Purchase. In the event that Landlord elects to terminate this Lease pursuant to the provisions of this Article 13, Tenant shall have the right to exercise the Purchase Option set forth on Exhibit "I-2" within thirty (30) days following such termination by Landlord, and upon Tenant's purchase of all or any portion of the Project, Tenant shall be entitled to all insurance proceeds related thereto. This provision (and the terms of the Purchase Option) shall survive the termination of this Lease pursuant to this Article 13.

ARTICLE 14 - EMINENT DOMAIN

1.44 Permanent Taking - When Lease Can Be Terminated. If the whole of the Premises, or so much of the Premises as to render the balance unusable by Tenant, shall be taken under the power of eminent domain, this Lease shall automatically terminate as of the date of final judgment in such condemnation, or as of the date possession is taken by the condemning authority, whichever is earlier. A sale by Landlord under threat of condemnation shall constitute a "taking" for the purpose of this Article 14. Except as provided below, no award for any partial or entire taking shall be apportioned and Tenant assigns to Landlord any award which may be made in such taking or condemnation, together with all rights of Tenant to such award, excluding any award or compensation for the value of all or any part of the leasehold estate ("**Bonus Value**"); provided that nothing contained in this Article 14 shall be deemed to give Landlord any interest in or to require Tenant to assign to Landlord any award, and Tenant shall be able to retain any award, made to Tenant for (a) the taking of Tenant's personal property, (b) interruption of or damage to Tenant's business, (c) the Bonus Value, or (d) Tenant's unamortized cost of the Tenant Improvements (or applicable portion thereof) to the extent paid for by Tenant. "Bonus Value" of the leasehold estate shall be equal to the difference between the rental rate payable under this Lease and the rate established by the condemning authority as an award for compensation purposes, together with any amount Tenant is able to obtain from the condemning authority attributable to Tenant's relocation expenses.

1.45 Permanent Taking - When Lease Cannot Be Terminated. In the event of a partial taking which does not result in a termination of this Lease under Section 14.1, Rent shall be reduced as set forth in General Condition F, and Landlord shall restore the Premises or the applicable Building(s) to the extent of available condemnation proceeds.

1.46 Temporary Taking. No temporary taking of the Premises or any part of the Premises and/or of Tenant's rights to the Premises or under this Lease shall terminate this Lease or give Tenant any right to any abatement of any payments owed to Landlord pursuant to this Lease; any award made to Tenant by reason of such temporary taking shall belong entirely to Tenant. If a taking of the Premises is for less than one (1) year, such taking shall be deemed a Temporary Taking.

1.47 Exclusive Remedy. This Article 14 and General Condition F shall be Tenant's sole and exclusive remedy in the event of a taking or condemnation. Tenant hereby waives the benefit of California Code of Civil Procedure Section 1265.130.

1.48 Release Upon Termination. Upon termination of this Lease pursuant to this Article 14, Tenant and Landlord hereby agree to release each other from any and all obligations and liabilities with respect to this Lease except such obligations and liabilities which arise or accrue prior to such termination.

ARTICLE 15 - DEFAULTS

1.49 Default by Tenant. Each of the following shall be an "**Event of Default**" by Tenant and a material breach of this Lease:

(a) Tenant shall fail to make any payment owed by Tenant under this Lease, as and when due, and where such failure is not cured within five (5) business days following receipt of written notice by Tenant from Landlord. Any such notice shall be in lieu of, and not in addition to, any notice required under Section 1161 of the California Code of Civil Procedure;

(b) Tenant shall fail to observe, keep or perform any of the material terms, covenants, agreements or conditions under this Lease that Tenant is obligated to observe or perform, other than that described in subparagraph (a) above, for a period of thirty (30) days after notice to Tenant of said failure; provided however, that if the nature of Tenant's default is such that more than thirty (30) days are reasonably required for its cure, then Tenant shall not be deemed to be in default under this Lease if Tenant shall commence the cure of such default so specified within said thirty (30) day period and diligently prosecutes the same to completion. Such thirty (30) day notice shall be in lieu of, and not in addition to, any notice required under Section 1161 of the California Code of Civil Procedure. Tenant shall have, and under no circumstances shall Tenant be deemed to have waived, the rights set forth in Sections 1174 and 1179 of the California Civil Code of Procedure.

1.50 Default by Landlord. Each of the following shall be a default by Landlord and a material breach of this Lease:

(a) Landlord shall fail to make any payment owed by Landlord under this Lease, as and when due, and where such failure is not cured within five (5) business days following receipt of written notice by Landlord from Tenant; and

(b) Landlord shall be in default in the performance of any obligation required to be performed by Landlord under this Lease, other than that described in subparagraph (a) above, if Landlord has failed to perform such obligation within thirty (30) days after the receipt of notice from Tenant specifying in detail Landlord's failure to perform; provided, however, that if the nature of Landlord's obligation is such that more than thirty (30) days are required for its performance, Landlord shall not be deemed in default if it shall commence such performance within thirty (30) days and thereafter diligently pursues the same to completion. Tenant shall have no rights as a result of any default by Landlord until Tenant gives thirty (30) days' notice to any person who has

a recorded interest pertaining to the Buildings, specifying the nature of the default. Such person shall then have the right to cure such default, and Landlord shall not be deemed in default if such person cures such default within thirty (30) days after receipt of notice of the default, or within such longer period of time as may reasonably be necessary to cure the default. Notwithstanding anything to the contrary in this Lease, Landlord's liability to Tenant for damages resulting from Landlord's breach of any provision or provisions of this Lease shall not exceed the value of Landlord's equity interest in the Buildings and its right to insurance proceeds.

ARTICLE 16 - LANDLORD'S REMEDIES AND RIGHTS

1.51 Termination of Lease. In the event of any default by Tenant, Landlord shall have the right, in addition to all other rights available to Landlord under this Lease now or later permitted by law or equity, to terminate this Lease by providing Tenant with a notice of termination. Upon termination, Landlord may recover as damages the Rent that Landlord would have received had Tenant not defaulted, plus attorneys' fees, court costs, additional brokerage costs, additional design and construction costs, and any other costs reasonably incurred by Landlord to mitigate damages. Landlord agrees to use reasonable efforts to mitigate damages. Landlord's damages include (to the extent not duplicative of the foregoing) the worth, at the time of any award, of the amount by which the unpaid Rent for the balance of the Term after the time of the award exceeds the amount of the rental loss that the Tenant proves could be reasonably avoided. The worth at the time of award shall be determined by discounting to present value such amount at one percent (1%) more than the discount rate of the Federal Reserve Bank in San Francisco in effect at the time of the award. Other damages to which Landlord is entitled shall earn interest at the Interest Rate; provided, however, in no event shall Tenant be responsible to Landlord for consequential damages.

1.52 Continuation of Lease. In accordance with California Civil Code Section 1951.4 (or any successor statute), Tenant acknowledges that in the event Tenant has breached this Lease and abandoned the Premises, this Lease shall continue in effect for so long as Landlord does not terminate Tenant's right to possession (subject to Tenant's right to sublease and/or assign), and Landlord may enforce all its rights and remedies under this Lease, including the right to recover Rent as it becomes due under this Lease. Acts of maintenance or preservation or efforts to relet the Premises or the appointment of a receiver upon initiative of Landlord to protect Landlord's interest under this Lease shall not constitute a termination of Tenant's right to possession. In addition to its other rights under this Lease, Landlord has the remedy described in California Civil Code Section 1951.4 (Landlord may continue this Lease in effect after Tenant's breach and abandonment and recover Rent (as defined in Section 4.1) as it becomes due, if Tenant has the right to sublet or assign, subject only to reasonable limitations).

1.53 Right of Entry. In the event of any default by Tenant, Landlord shall also have the right, with or without terminating this Lease, to enter the Premises and remove all persons and personal property from the Premises, such property being removed and stored in a public warehouse or elsewhere at Tenant's sole cost and expense. No removal by Landlord of any persons or property in the Premises shall constitute an election to terminate this Lease. Such an election to terminate may only be made by Landlord in writing, or decreed by a court of competent jurisdiction. Landlord's right of entry shall include the right to remodel the Premises and re-let the Premises. All costs

incurred in such entry and re-letting shall be paid by Tenant. Rents collected by Landlord from any other tenant which occupies the Premises shall be offset against the amounts owed to Landlord by Tenant. Tenant shall be responsible for any amounts not recovered by Landlord from any other tenant. Any payments made by Tenant shall be credited to the amounts owed by Tenant in the sole order and discretion of Landlord, irrespective of any designation or request by Tenant. No entry by Landlord shall prevent Landlord from later terminating this Lease by written notice.

1.54 Right to Perform. If an Event of Default occurs, Landlord may perform such covenant or condition at its option, after notice to Tenant. All costs incurred by Landlord in so performing shall immediately be reimbursed to Landlord by Tenant, together with interest at the Interest Rate computed from the date incurred by Landlord. Any performance by Landlord of Tenant's obligations shall not waive or cure such default.

1.55 Remedies Not Exclusive. The rights and remedies of Landlord and Tenant set forth herein are not exclusive, and Landlord and Tenant may exercise any other right or remedy available to it under this Lease, at law or in equity except as otherwise expressly set forth herein. Except as expressly provided in this Lease, including Articles 13 and 14 and General Conditions B, F and I, Tenant hereby waives and relinquishes any right which Tenant may have to terminate this Lease or withhold any payment owed by Tenant under this Lease, on account of any damage, condemnation, destruction or state of disrepair of the Premises (including, without limiting the generality of the foregoing, those rights under California Civil Code Sections 1941, 1941.1 and 1942).

1.56 Waiver of Redemption by Tenant. Tenant hereby waives, for itself and all persons claiming by and under Tenant, all rights and privileges which it might have under any present or future law to redeem the Premises or to continue this Lease after being dispossessed or ejected from the Premises. The rights and remedies of Landlord set forth in this Lease are not exclusive, and Landlord may exercise any other right or remedy available to it under this Lease, at law or in equity.

ARTICLE 17 - ATTORNEYS' FEES

If either Landlord or Tenant commences or engages in, or threatens to commence or engage in, any action or litigation or arbitration against the other party arising out of or in connection with this Lease, the Project, including but not limited to, any action for recovery of any payment owed by either party under this Lease, or to recover possession of the Premises, or for damages for breach of this Lease, the prevailing party shall be entitled to have and recover from the losing party reasonable attorneys' fees and other costs incurred in connection with the action and in preparation for said action. This provision shall survive the termination of this Lease.

ARTICLE 18 - SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE

1.57 Obligations of Tenant. Subject to General Condition D, this Lease and the rights granted to Tenant by this Lease shall be subject and subordinate to (a) all present and future ground or underlying leases affecting all or any part of the Buildings and all amendments, renewals, modifications, supplements and extensions of the leases, and (b) all present and future deeds of trust or mortgages affecting or encumbering all or any part of the Buildings and/or any ground or underlying leasehold estate; provided however, that if Landlord elects at any time to have Tenant's

interest in this Lease be or become superior, senior or prior to any such instrument, then upon receipt by Tenant of written notice of such election, Tenant shall immediately execute all necessary and reasonable subordination instruments or other documents confirming the subordination of such mortgage, deed of trust, ground or underlying lease to this Lease.

1.58 Landlord's Right to Assign. Landlord's interest in this Lease may be assigned to any mortgagee or trust deed beneficiary as additional security. Nothing in this Lease shall empower Tenant to do any act without Landlord's prior consent, which consent may be withheld in Landlord's sole discretion, which can, shall or may encumber the title of the owner of all or any part of the Buildings.

1.59 Attornment by Tenant. Subject to General Condition D, in the event of the cancellation or termination of any or all ground or underlying leases affecting all or any part of the Buildings in accordance with its terms or by the surrender thereof, whether voluntary, involuntary or by operation of law, or by summary proceedings, or in the event of any foreclosure of any or all mortgages or deeds of trust encumbering the Buildings by trustee's sale, voluntary agreement, deed in lieu of foreclosure, or by the commencement of any judicial action seeking foreclosure, Tenant, at the request of the then landlord under this Lease, shall attorn to and recognize (a) the ground or underlying lessor, under the ground or underlying lease being terminated or canceled, and (b) the beneficiary or purchaser at the foreclosure sale, as Tenant's landlord under this Lease, and Tenant agrees to execute and deliver at any time upon request of such ground or underlying lessor, beneficiary, purchaser, or their successors, any instrument to further evidence such attornment. Tenant hereby waives its right, if any, to elect to terminate this Lease or to surrender possession of the Premises in the event of any such ground or underlying lease cancellation or termination or mortgage or deed of trust foreclosure.

1.60 Non-Disturbance. Notwithstanding any of the provisions of this Article 18 to the contrary, Tenant shall be allowed to occupy the Premises, subject to the conditions of this Lease, and this Lease shall remain in effect, until an Event of Default occurs, the end of the Term or until Tenant's rights are modified because of an Eminent Domain proceeding pursuant to Article 14, or because of the occurrence of damage and destruction pursuant to Article 13.

ARTICLE 19 - [INTENTIONALLY DELETED]

ARTICLE 20 - HOLDING OVER

1.61 Surrender of Possession. Tenant shall surrender possession of the Premises immediately upon the expiration of the Term or earlier termination of this Lease. If Tenant shall continue to occupy or possess the Premises after such expiration or termination without the consent of Landlord, then unless Landlord and Tenant have otherwise agreed in writing, Tenant shall be a tenant from month-to-month. All the terms, provisions and conditions of this Lease shall apply to this month-to-month tenancy except those terms, provisions and conditions pertaining to the Term, and except that the monthly Base Rent shall be immediately adjusted upward upon the expiration or termination of this Lease to equal (a) for the first two (2) months of holdover, one hundred twenty-five percent (125%) of the monthly Base Rent for the Premises in effect under this Lease during the month which includes the day immediately prior to the date of the expiration or termination of

this Lease, and (b) thereafter, one hundred fifty percent (150%) of such monthly Base Rent. This month-to-month tenancy may be terminated by Landlord or Tenant upon thirty (30) days' prior notice to the non-terminating party. In the event that Tenant fails to surrender the Premises upon such termination or expiration, then Tenant shall indemnify and hold Landlord harmless against all loss or liability resulting from or arising out of Tenant's failure to surrender the Premises, including, but not limited to, any amounts required to be paid to any tenant or prospective tenant who was to have occupied the Premises after said termination or expiration and any related attorneys' fees and brokerage commissions.

ARTICLE 21 - INSPECTIONS AND ACCESS

1.62 Entry by Landlord. Landlord and the Landlord Parties shall have access to the Project and the right to enter the Premises, at all reasonable times for the purpose of (i) inspecting the Premises, (ii) making any alterations, additions, improvements or repairs to the Project which Landlord is required or permitted to perform under this Lease, or (iii) to submit the Premises to prospective purchasers, prospective tenants, encumbrance holders. Landlord shall give not less than twenty-four (24) hours' notice to Tenant of Landlord's intent to enter the Premises, except, however, in an emergency situation, in which case no prior notice shall be required. If Tenant shall not be personally present to open and permit an entry into the Premises at any time when such entry by Landlord is necessary or permitted under this Lease, Landlord may enter by means of a master key without liability to Tenant except for any failure to exercise due care for Tenant's personal property, and without affecting this Lease. Absent an emergency, Landlord shall conduct and schedule all entries and its activities within the Premises to the extent practicable in a manner which will minimize any interruption or interference with Tenant's business operations within the Premises; provided, however, the foregoing shall not obligate Landlord to incur overtime or after normal business hours labor costs in the making of repairs.

1.63 Secured Areas. Notwithstanding anything to the contrary set forth above, Tenant may designate certain areas of the Premises as "**Secured Areas**" should Tenant require such areas for the purpose of securing certain valuable property or confidential information. Landlord may not enter such Secured Areas except in the case of emergency or in the event of a Landlord inspection, in which case Landlord shall provide Tenant with two (2) days' prior written notice of the specific date and time of such Landlord inspection.

ARTICLE 22 - NAME OF BUILDING

The Buildings shall be called any reasonable name from time to time designated by Tenant or its assignee.

ARTICLE 23 - SURRENDER OF LEASE

The voluntary or other surrender of this Lease by Tenant, or a mutual cancellation of this Lease, shall not work a merger, and shall, at the option of Landlord terminate all or any existing subleases or subtenancies, or may, at the option of Landlord, operate as an assignment to it of Tenant's interest in any or all such subleases or subtenancies.

ARTICLE 24 - WAIVER

The waiver by Landlord or Tenant of any term, covenant, agreement or condition contained in this Lease shall not be deemed to be a waiver of any subsequent breach of the same or of any other term, covenant, agreement, condition or provision of this Lease, nor shall any custom or practice which may develop between the parties in the administration of this Lease be construed to waive or lessen the right of Landlord or Tenant to insist upon the performance by the other in strict accordance with all of the terms, covenants, agreements, conditions, and provisions of this Lease. The subsequent acceptance by Landlord of any payment owed by Tenant to Landlord under this Lease, or the payment of Rent by Tenant, shall not be deemed to be a waiver of any preceding breach by Tenant of any term, covenant, agreement, condition or provision of this Lease, other than the failure of Tenant to make the specific payment so accepted by Landlord, regardless of Landlord's or Tenant's knowledge of such preceding breach at the time of the making or acceptance of such payment.

ARTICLE 25 - SALE BY LANDLORD

Subject to the provisions of Exhibit "I-1" [Right of First Offer to Purchase] attached hereto, in the event Landlord shall sell, assign, convey or transfer all or a part of its interest in the Buildings or any part of the Buildings, Tenant agrees to attorn to such transferee, assignee or new owner, and upon consummation of such sale, conveyance or transfer, Landlord shall automatically be freed and relieved from all liability and obligations accruing or to be performed from and after the date of such sale, transfer, or conveyance. In the event of such sale, assignment, transfer or conveyance, Landlord shall transfer to such transferee, assignee or new owner of the Buildings the balance of the Deposit, if any, remaining after lawful deductions and in accordance with California Civil Code Section 1950.7, after notice to Tenant, and Landlord shall thereupon be relieved of all liability with respect to the Deposit.

ARTICLE 26 - NO LIGHT AND AIR EASEMENT

Any diminution or shutting off of light or air by any structure which may be erected on lands adjacent to or in the vicinity of the Buildings shall not affect this Lease, abate any payment owed by Tenant under this Lease or otherwise impose any liability on Landlord.

ARTICLE 27 - FORCE MAJEURE

Except as otherwise expressly provided in this Lease, any prevention, delay or stoppage caused by fire, earthquake, explosion, flood, hurricane, the elements, or any other similar cause beyond the reasonable control of the party from whom performance is required, or any of their contractors; acts of God or the public enemy; actions, restrictions, limitations or interference of governmental authorities or agents; war, invasion, insurrection, rebellion; riots; strikes or lockouts, or inability to obtain necessary materials, goods, equipment, services, utilities or labor shall excuse the performance of such party for a period equal to the duration of such prevention, delay or stoppage; provided, however, in no event shall financial incapability excuse the performance of either party.

ARTICLE 28 - ESTOPPEL CERTIFICATES

Each party shall, at any time and from time to time upon request of the other party, within ten (10) business days following notice of such request from the requesting party, execute, acknowledge and deliver to the requesting party a certificate (the " **Estoppel Certificate**") in writing in the form of the attached Exhibit "F" or in such other commercially reasonable form as Landlord or Tenant or any of their respective lenders, prospective purchasers, lienholders, assignees or subtenants may deem appropriate; provided, however, if the Estoppel Certificate requests information different than that being requested in the form of the attached Exhibit "F". For purposes of this Article 28, an Estoppel Certificate shall not be deemed to be commercially reasonable if it amends or modifies any of the provisions of this Lease and any provision added by an Estoppel Certificate and not clearly "labeled" an Amendment shall be null and void. If the certifying party fails to deliver the Estoppel Certificate within such ten (10) business day period, as the case may be, the requesting party shall so notify the certifying party and, if the certifying party does not deliver the Estoppel Certificate within three (3) business days thereafter, the certifying party's failure to do so shall automatically be deemed to establish conclusively that this Lease is in full force and effect and has not been modified except as may be represented by the requesting party, but shall not be deemed to have cured any default under this Lease by the party failing to provide the Estoppel Certificate.

ARTICLE 29 - RIGHT TO PERFORMANCE

All covenants and agreements to be performed by Landlord or Tenant under this Lease shall be performed by such party at such party's sole cost and expense, except where a specific provision of this Lease provides to the contrary.

ARTICLE 30 - PARKING

1.64 Tenant Parking. Landlord agrees to provide or otherwise make available to Tenant, at all times during the Term, the parking spaces described in this Article 30 for use by Tenant and the Tenant Parties, on the terms and conditions set forth in this Article 30.

1.65 On-Site Parking Spaces. Pursuant to the Work Letter, Landlord shall construct and deliver to Tenant parking spaces located on the Site (the "**On-Site Parking Spaces**") as follows: (i) as part of Landlord's Construction Work with respect to Phase I, sixty (60) On-Site Parking spaces, comprised of (i) twenty-two (22) single parking spaces and (ii) thirty-eight (38) tandem parking spaces (collectively, the "**Phase I On-Site Parking Spaces**"), and (b) as part of Landlord's Construction Work with respect to Phase II, an additional one hundred fifty-three (153) On-Site Parking Spaces, comprised of (i) sixty-seven (67) single parking spaces, and (ii) eighty-six (86) tandem parking spaces (collectively, the "**Phase II On-Site Parking Spaces**"), for total of two hundred thirteen (213) On-Site Parking Spaces, comprised of eighty-nine (89) single parking spaces and one hundred twenty-four (124) tandem parking spaces. Tenant and the Tenant Parties shall have the exclusive use of the applicable On-Site Parking Spaces at all times during the Term, at a charge of $600.00 per On-Site Parking Space per year, which charge shall increase by 3% on a cumulative and compounding basis on each anniversary of the Commencement Date for the Existing Building. Notwithstanding anything contained in this Lease to the contrary, Landlord shall be responsible, at its sole cost and expense, and not as an Operating Expense, for providing any parking attendant(s) that may be required in connection with Tenant's use of the On-Site Parking Spaces.

The costs of maintenance and repair of the On-Site Parking Spaces shall be included as an Operating Expense to the extent provided in Article 4 above, and the On-Site Parking Spaces shall be deemed part of the Project.

1.66 Off-Site Parking Spaces.

(a) Commencing on the Commencement Date for the Existing Building and continuing through the Expiration Date, Landlord shall make available to Tenant, in accordance with the provisions of this Section 30.3, up to five hundred (500) off-site parking spaces (the "**Off-Site Parking Spaces**") for use by Tenant and the Tenant Parties on weekdays from the hours of 7:00 a.m. through 6:00 p.m. (the "**Off-Site Parking Hours**"). Prior to the Commencement Date for the Existing Building, Tenant shall notify Landlord in writing of the number of Off-Site Parking Spaces that Tenant will require on such Commencement Date, and concurrently with Landlord's delivery of the Existing Building, Landlord shall deliver or make available to Tenant such number of parking passes (up to the total amount of Off-Site Parking Spaces) as Tenant shall request. Thereafter, Tenant shall deliver written notice to Landlord from time to time of its need to increase or decrease the number of Off-Site Parking Spaces used by Tenant, as applicable, upon not less than thirty (30) days' notice to Landlord (provided that in no event shall Tenant be entitled to use more than the amount of the Off-Site Parking Spaces that Landlord has agreed to make available to Tenant and the Tenant Parties as provided in this Section 30.3(a)).

(b) Landlord shall be solely responsible to obtain from one or more third parties the right to use and make available for use by Tenant all Off-Site Parking Spaces which Landlord is obligated to provide to Tenant under this Lease. Landlord further covenants and agrees that all such Off-Site Parking Spaces required to be made available by Landlord for use by Tenant pursuant to this Section 30.3 shall, at all times during the Term, be located in parking lots and/or structures that are located no more than two (2) miles from the Project (the "**Permitted Distance**").

(c) Commencing on the applicable Commencement Date, and on January 1 of each year thereafter, Tenant shall pay to Landlord an annual fee for each Off-Site Parking Space provided to Tenant pursuant to this Section 30.3 equal to (i) if any such Off-Site Parking Space is provided by Landlord to Tenant under the terms of the Off-Site Parking Agreement (as defined below), the amount payable by Landlord for such Off-Site Parking Space under the terms of the Off-Site Parking Agreement, but subject to a cap of three percent (3%) on annual increases each January 1 during the Term, regardless of any actual increase in the cost thereof payable by Landlord under the Off-Site Parking Agreement for any such Off-Site Parking Space (with respect to each Off-Site Parking Space, the "**City-Provided Tenant Parking Fee**"), and (ii) if any such Off-Site Parking Space is provided by Landlord to Tenant under any other arrangement, whether on property owned by Landlord, any Affiliate of Landlord or any other third party, the lesser of (A) the actual amount payable by or incurred by Landlord to provide such Off-Site Parking Space or (B) the City-Provided Tenant Parking Fee for each such Off-Site Parking Space. The amount payable by Tenant to Landlord for each Off-Site Parking Space provided to Tenant pursuant to this Section 30.3 and determined in accordance with the foregoing provisions of this Section 30.3(c) shall be referred to herein as the "Off-Site Parking Fee." The Off-Site Parking Fee shall be prorated for any Off-Site

Parking Space that is used by Tenant for any period less than a full calendar year, and to the extent applicable Tenant shall be entitled to a rebate of any annual Off-Site Parking Fees paid in advance.

(d) From and after the Commencement Date for the Existing Building, Landlord shall be responsible for providing and operating (or causing the operation of), at Landlord's sole cost and expense, and not as an Operating Expense, such number of parking shuttles in connection with Tenant's use of the Off-Site Parking Spaces as reasonably determined by Tenant to be necessary for the efficient operation of Tenant's business at the Premises (the "**Parking Shuttles**"). Landlord and Tenant shall cooperate in good faith throughout the Term to determine the schedule for such parking shuttles from time to time during the Term; provided, that at all times during the Term, the Parking Shuttles shall run at least one hour before and one hour after the Off-Site Parking Hours.

(e) Tenant acknowledges that: (i) Landlord has entered into that certain Parking License Agreement dated as of May 25, 2012 (the "**Off-Site Parking Agreement**") with the City of Long Beach (the "**City**"), a copy of which is attached hereto as Exhibit "K", and (ii) to the extent possible, Landlord intends to fulfill obligations under this Section 30.3 with parking spaces available to Landlord under the Off-Site Parking Agreement. Notwithstanding the foregoing, Landlord acknowledges and agrees that (i) the rights granted to Landlord under the Off-Site Parking Agreement may not be sufficient to enable Landlord to fulfill its obligations to Tenant with respect to the Off-Site Parking Spaces pursuant to this Section 30.3, (ii) such rights of Tenant under this Section 30.3 are independent of Landlord's rights under the Off-Site Parking Agreement, and Landlord's inability to fulfill its obligations under this Section 30.3 with parking spaces available to Landlord under the Off-Site Parking Agreement shall in no way limit such obligations set forth herein, and (iii) without limiting any obligations of Landlord under this Section 30.3 or any of Tenant's other rights and remedies under this Lease, if Landlord fails to make the Off-Site Parking Spaces available to Tenant in accordance with the terms of this Section 30.3 above (notwithstanding the terms of the Off-Site Parking Agreement), Tenant shall have the right to independently obtain off-site parking and shall be entitled to prompt reimbursement by Landlord of Tenant's reasonable costs and expenses in connection with obtaining such parking spaces (up to the total number of Off-Site Parking Spaces required to be provided by Landlord hereunder) in excess of the City-Provided Tenant Parking Fee for each such off-site parking space. Additionally, in the event that Landlord fails to perform any of its duties or obligations under the Off-Site Parking Agreement (including, without limitation, the payment of the license fee thereunder), and Tenant has cured such default (which Tenant shall have the right, but not the obligation to do), then Tenant shall be entitled to prompt reimbursement by Landlord of Tenant's reasonable costs and expenses in connection with curing such default.

(f) During the Term, Landlord shall use its best efforts to obtain the City's agreement to modify the Off-Site Parking Agreement so that Landlord at all times is able to fulfill its obligations to Tenant with respect to the Off-Site Parking Spaces pursuant to the terms thereof, including the City's agreement that (1) all parking under the Off-Site Parking Agreement shall be located within the Permitted Distance (including with respect to any relocation rights of the City), (2) Landlord's rights under the Off-Site Parking Agreement shall be transferrable to future owners of the Project, and (3) an ability to extend the term of the Off-Site Parking Agreement for the Extension Periods (as defined in Exhibit "J" attached hereto) no later than six (6) months prior to

the commencement of the applicable Extension Period, at commercially reasonable parking rates; provided, that Landlord's failure to obtain such agreements from the City shall not constitute a default or breach of this Lease so long as Landlord used its best efforts to do so.

(g) Landlord will use commercially reasonable efforts to obtain from the City, within thirty (30) days following the Effective Date, an Estoppel and Agreement Regarding Off-Site Parking Agreement substantially in the form attached hereto as Exhibit "L" (or such other form as may be reasonably acceptable to the City, Landlord, Tenant and the Existing Mortgagee or any other Superior Mortgagee); provided, that Landlord's failure to obtain such agreement from the City shall not constitute a default or breach of this Lease so long as Landlord used commercially reasonable efforts to do so.

ARTICLE 31 - SECURITY SERVICES

Tenant shall be permitted to install its own security system in the Premises and Buildings, including in the stairwells in the core of the Buildings. Tenant shall also have the right install and maintain such additional security equipment, personnel, procedures and systems during the Term, provided that such will not adversely affect the Building Structure and/or Building Systems.

Tenant acknowledges that: (a) Landlord has no obligation to provide any security personnel or measures for the Project, Premises or any portion of the Premises, with the exception of smoke detection, fire alarm and fire safety systems, which Landlord shall initially provide and thereafter maintain as part of the Building Systems; (b) Landlord has made no representation regarding the safety or security of the Premises or any portion thereof; (c) Tenant will be solely responsible for providing any security it deems necessary to protect itself, the Premises, any personal property located on the Premises, and the Tenant Parties in, on, or about the Premises; (d) Landlord is not a guarantor of the security or safety of Tenant, any Tenant Party or their property; and (e) that such security and safety matters are the responsibility of Tenant and the local law enforcement authorities. If Landlord elects, at Landlord's sole and exclusive discretion and at its sole cost and expense, to provide any security personnel or measures (other than what Landlord is obligated to provide and maintain as provided in clause (a) above) to the Premises at any time: (i) Landlord will not be obligated to continue providing such security personnel or measures for any time period and may discontinue the same without notice and liability to Tenant; (ii) Landlord will not be obligated to provide such security personnel or measures with any particular standard of care; and (iii) Tenant acknowledges that any security or safety measures employed by Landlord are for the protection of Landlord's own interests. Tenant assumes all responsibility for the security and safety of Tenant, the Tenant Parties and any personal property owned by the foregoing.

ARTICLE 32 - NOTICES

All notices, requests, consents, approvals, payments in connection with this Lease, or communications that either party desires or is required or permitted to give or make to the other party under this Lease shall only be deemed to have been given, made and delivered, when made or given in writing and personally served, or deposited in the United States mail, certified or registered mail, postage prepaid, or sent by reputable overnight courier (e.g. Federal Express) and addressed to the parties as follows: If to Tenant, at the address(es) as specified for Tenant in

provision (r) of the Fundamental Lease Provisions, or to such other place as Tenant may from time to time designate in a notice to Landlord given in the manner set forth in this Article 32; if to Landlord, at the address(es) specified for Landlord in provision (s) of the Fundamental Lease Provisions or to such other places as Landlord may from time to time designate in a notice to Tenant given in the manner set forth in this Article 32.

ARTICLE 33 - SIGNAGE AND BUILDING IDENTITY

Tenant at Tenant's sole cost and expense, shall have the exclusive right to install signage, including Tenant's corporate name and logo, on and in the Buildings, including (a) exterior signage, (b) on or adjacent to the entrance doors to Tenant's Premises, and (c) any directory board located in the main entrance to each of the Buildings.

Landlord shall, using commercially reasonable efforts at no cost to Landlord, cooperate with Tenant in obtaining the proper governmental approvals and permits for the requested signage. Tenant shall be responsible maintaining Tenant's signage during the Term and for the removal of its signs, and the cost of repairing any resulting damage to the Buildings and/or Premises, upon the termination or assignment of this Lease.

ARTICLE 34 - INTENTIONALLY DELETED

ARTICLE 35 - ROOF RIGHTS

During the Term (as it may be extended), Tenant shall have the right to install and maintain, on the roof of the Buildings, satellite dishes, television antennas, related receiving equipment, related cable connections and any and all other related equipment (collectively, "**Satellite Dish**") required in connection with Tenant's communications and data transmission network. Tenant shall have the right to use "risers" in the Buildings (and to install additional risers if necessary) as long as there is no adverse effect on the Building Structure or Building Systems. In addition to the foregoing, Tenant shall, at its option exercisable by a thirty (30) days' notice to Landlord, have the right to use space on the roof of the Buildings for installation of any additional HVAC equipment required by Tenant and any and all related equipment to accommodate any such additional HVAC requirements (collectively, "**Supplemental HVAC Unit(s)**"), provided that such will not adversely affect the Building Structure and/or Building Systems. The exact location of any such Satellite Dish or Supplemental HVAC Unit(s) shall be mutually acceptable to Landlord and Tenant and Tenant shall have secured the approval of all governmental authorities and all permits required by governmental authorities having jurisdiction over such approvals and permits for the Satellite Dish and the Supplemental HVAC Unit(s), and shall provide copies of such approvals and permits to Landlord, prior to commencing any work with respect to such Satellite Dish and the Supplemental HVAC Unit(s). Tenant shall pay for any and all costs and expenses in connection with the installation, maintenance, use and removal of the Satellite Dish and the Supplemental HVAC Unit(s), but in no event shall Tenant be obligated to pay Landlord any rental for that portion of the roof of the Buildings on which the Satellite Dish and the HVAC Unit shall be located. Furthermore, Tenant shall, at its sole and absolute discretion when it deems it as necessary or appropriate to do so, repair and maintain the Satellite Dish and Supplemental HVAC Unit(s). Upon the expiration of the Term, Tenant shall,

if requested by Landlord, remove the Satellite Dish and Supplemental HVAC Unit(s)and repair any damage to the roof resulting therefrom.

ARTICLE 36 - SECURITY DEPOSIT

Tenant in recognition of its financial standing and reputation, shall not be obligated to provide a security deposit.

ARTICLE 37 - TENANT'S FINANCIAL STATEMENTS

In the event that Landlord intends to finance the Building(s), Landlord shall deliver written notice of such intention to Tenant, which notice shall include a list of potential lenders (the " **Potential Lenders**") with respect to such financing, and Tenant shall, within ten (10) business days following Tenant's receipt of such notice, deliver to Landlord consolidated annual financial statements (audited) for the most recent two (2) years. Unless publically disclosed by Tenant, all such financial statements delivered by Tenant to Landlord and/or its Potential Lenders shall be kept strictly confidential.

ARTICLE 38 - MISCELLANEOUS

1.67 Authorization to Sign Lease. If Tenant or Landlord is a corporation, each individual executing this Lease on behalf of such party represents and warrants that he/she is duly authorized to execute and deliver this Lease on behalf of such party. If such party is a partnership or trust, each individual executing this Lease on behalf of such party represents and warrants that he/she is duly authorized to execute and deliver this Lease on behalf of such party in accordance with the terms of such entity's partnership agreement or trust agreement, respectively.

1.68 Entire Agreement. It is understood and acknowledged that there are no oral agreements between the parties hereto affecting this Lease and this Lease supersedes and cancels any and all previous negotiations, arrangements, brochures, agreements and understandings, if any, between the parties hereto or displayed by Landlord to Tenant with respect to the subject matter thereof, and none thereof shall be used to interpret or construe this Lease. This Lease, and the exhibits and schedules attached hereto, contain all of the terms, covenants, conditions, warranties and agreements of the parties relating in any manner to the rental, use and occupancy of the Premises and shall be considered to be the only agreements between the parties hereto and their representatives and agents. None of the terms, covenants, conditions or provisions of this Lease can be modified, deleted or added to except in writing signed by the parties hereto. All negotiations and oral agreements acceptable to both parties have been merged into and are included herein. There are no other representations or warranties between the parties, and all reliance with respect to representations is based totally upon the representations and agreements contained in this Lease.

1.69 Separability and Survivability. The illegality, invalidity or unenforceability of any term, condition, or provision of this Lease shall in no way impair or invalidate any other term, provision or condition of this Lease, and all such other terms, provisions and conditions shall remain in full force and effect. In the event that Landlord or Tenant lawfully terminate this Lease, the provisions of this Lease shall otherwise remain in effect to the extent necessary to allow Landlord

and Tenant to enforce rights and obligations accruing prior to the termination of this Lease and attributable to the period of time prior to the termination of this Lease.

1.70 Gender and Headings; Governing Law. The words "**Landlord**" and "**Tenant**" as used herein shall include the plural as well as the singular and, when appropriate, shall refer to action taken by or on behalf of Landlord or Tenant by their respective employees, agents, or authorized representatives. Words in masculine gender include the feminine and neuter. If there be more than one Tenant, the obligations hereunder imposed upon Tenant shall be joint and several. The section and article headings of this Lease are not a part of this Lease and shall have no effect upon the construction or interpretation of any part hereof. Subject to the provisions of Articles 11 and 25, and except as otherwise provided to the contrary in this Lease, the terms, conditions and agreements of this Lease shall apply to and bind the heirs, successors, legal representatives and permitted assigns of the parties hereto. This Lease shall be governed by and construed pursuant to the laws of the State of California.

1.71 Exhibits. Exhibits "A-1," "A-2," "B," "C," "D," "E," "F," "G," "H," "I-1," "I-2," "J," "K" and "L" attached to this Lease, are hereby incorporated by this reference and made a part of this Lease.

1.72 Transportation System Management Program. Tenant hereby covenants and agrees, at its sole cost and expense, to participate in and cooperate with the requirements of any and all transportation system management programs adopted for the Buildings and/or the area in which the Buildings are located by any governmental entity having jurisdiction.

1.73 Quiet Enjoyment. Landlord covenants and agrees that Tenant shall peaceably and quietly hold, occupy and enjoy the Premises during the Term without hindrance or molestation from Landlord subject to the terms and provisions of this Lease.

1.74 Recordation. Landlord and Tenant agree that in no event and under no circumstances shall this Lease be recorded by Tenant; provided, however, that concurrently with the Effective Date, Landlord and Tenant shall execute and acknowledge and promptly thereafter cause to be recorded in Office of the County Recorder, Los Angeles County, California, the Memorandum of Lease (With Certain Purchase Rights) in the form attached hereto as Exhibit "E" (the " **Memo of Lease**"). Tenant shall pay all costs and expenses of recording the Memo of Lease (including any documentary transfer taxes payable in connection therewith). Unless Tenant shall purchase the Project pursuant to Right of First Offer to Purchase set forth on Exhibit "I-1" or the Purchase Option set forth on Exhibit "I-2", upon the expiration or earlier termination of the Term, Tenant shall fully cooperate with Landlord in removing and shall execute such documents and instruments as are necessary to fully remove from title to the Project any encumbrance thereto created by the Memo of Lease, and shall indemnify, defend and hold harmless Landlord from and against any Claims suffered by Landlord as a result of Tenant's failure or refusal to cooperate in the removal thereof. The Memo of Lease is intended to make as a matter of record with respect to the Project the existence of this Lease and Tenant's purchase rights contained herein.

1.75 Cumulative Remedies. No remedy or election provided, allowed or given by any provision of this Lease shall be deemed exclusive unless so indicated, but shall, whenever possible, be cumulative with all other remedies in law or equity.

1.76 Brokers. Other than the broker(s) set forth in provision (t) of the Fundamental Lease Provisions (" **Broker**") each party represents and warrants that it has not dealt with any other real estate broker or agent in connection with this Lease. Each party shall indemnify the other and hold it harmless from any cost, expense, or liability (including costs of suit and reasonable attorneys' fees) for any compensation, commission or fees claimed by any other real estate broker or agent, other than Broker, in connection with this Lease or its negotiation by reason of any act or statement of the indemnifying party. Landlord agrees that it will pay the Broker a brokerage commission pursuant to the terms of a separate agreement between Landlord and the Broker and to the extent such commission is not paid when due, Tenant shall have the right, but not the obligation, to pay such commission to the Broker, and deduct the amount of same from the Rents next due and owing under this Lease, together with interest at the Interest Rate (computed from the date such commission was due until the date of the offset).

1.77 Hazardous Materials.

1.77.1 Generally. Tenant and Landlord shall each comply with all Environmental Laws (as defined below) relating to industrial hygiene and environmental conditions on, under or about the Buildings and Project including, but not limited to, soil and ground water conditions in accordance with the terms of this Lease. Without limiting the generality of the foregoing, Tenant and Landlord shall not transport, use, store, maintain, generate, manufacture, handle, dispose, release or discharge any Hazardous Material (as defined in Section 38.12 below) upon or about the Buildings, nor permit their respective Tenant Parties or Landlord Parties to engage in such activities upon or about the Buildings. However, the foregoing provisions shall not prohibit the transportation to and from, and the use, storage, maintenance and handling within, the Premises of substances customarily used in connection with normal office use provided: (a) such substances shall be used and maintained only in such quantities as are reasonably necessary for the permitted use of the Premises set forth in provision (q) of the Fundamental Lease Provisions, strictly in accordance with Applicable Laws and the manufacturers' instructions therefor, (b) such substances shall not be disposed of, released or discharged on the Buildings, and shall be transported to and from the Premises in compliance with all Environmental Laws, (c) if any Environmental Laws requires that any such substances be disposed of separately from ordinary trash, Tenant shall make arrangements at Tenant's expense for such disposal directly with a qualified and licensed disposal company at a lawful disposal site, and shall ensure that disposal occurs frequently enough to prevent unnecessary storage of such substances in the Premises, and (d) any remaining such substances shall be completely, properly and lawfully removed from the Buildings upon expiration or earlier termination of this Lease.

1.77.2 Notice of Release and Investigation. If, during the Lease Term (including any extensions), either Landlord or Tenant becomes aware of (i) any actual or threatened release of any Hazardous Material on, under, or about the Premises, Building or Project, or (ii) any inquiry, investigation, proceeding, or claim by any government agency or other person regarding the presence

of Hazardous Material on, under, or about the Premises, Building or Project, such party shall give written notice to the other of the release or investigation within five (5) days after learning of it and shall simultaneously furnish to the other party copies of any claims, notices of violation, reports, or other writings received by the party providing notice that concern such release or investigation.

1.77.3 Remediation Obligations; Tenant's Rights to Abatement on Cleanup by Landlord .

(a) If the presence of any Hazardous Material brought onto the Premises, Building or Project by either Landlord or Tenant or by their respective Landlord Parties or Tenant Parties results in contamination of the Premises, Building or Project, that party shall promptly take all necessary actions, at the party's sole expense (and with respect to Landlord, not as an Operating Expense), to return the Premises, Building or Project to the condition that existed before the introduction of such Hazardous Material. If Tenant is the responsible party, Tenant shall first obtain Landlord's approval of the proposed remedial action which it is obligated to undertake pursuant to the immediately preceding sentence, which shall not be unreasonably withheld, conditioned or delayed. This provision does not limit any indemnification obligations of the parties set forth in Article 12 or Tenant's rights under General Condition J.

(b) Without limiting Tenant's rights and remedies under General Condition J, if Landlord undertakes any cleanup, detoxification, or similar action, whether or not required by any government or quasi-government agency, as a result of the presence, release, or disposal in or about the Building or Project of any Hazardous Material, and that action requires that Tenant be denied access to the Premises or Tenant is otherwise unable to conduct its business on the Premises for a period of greater than twenty-four (24) hours, Base Rent and Additional Rent shall be abated for the period that Tenant is unable to conduct its business at the Premises. Subject to Section 12.2(a), the costs of any Hazardous Material testing, cleanup or remediation undertaken by Landlord during the Lease Term shall be borne by Landlord, shall not be included as an Operating Expense and shall not be the obligation of Tenant.

1.78 Definitions of "Hazardous Material" and "Environmental Laws". As used herein, the term "**Hazardous Material**" shall mean any hazardous or toxic substance, material, or waste that is or becomes regulated by the United States, the State of California, or any local government authority having jurisdiction over the Building or Project. Hazardous Material includes:

(a) Any "hazardous substance," as that term is defined in the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA) (42 United States Code Sections 9601-9675);

(b) "Hazardous waste," as that term is defined in the Resource Conservation and Recovery Act of 1976 (RCRA) (42 United States Code Sections 6901-6992k);

(c) Any pollutant, contaminant, or hazardous, dangerous, or toxic chemical, material, or substance, within the meaning of any other applicable federal, state, or local law,

regulation, ordinance, or requirement (including consent decrees and administrative orders imposing liability or standards of conduct concerning any hazardous, dangerous, or toxic waste, substance, or material, now or hereafter in effect);

(d) Petroleum products;

(e) Radioactive material, including any source, special nuclear, or byproduct material as defined in 42 United States Code Sections 2011-2297g-4;

(f) Asbestos in any form or condition; and

(g) Polychlorinated biphenyls (PCBS) and substances or compounds containing PCBS.

As used in this Lease, "**Environmental Laws**" means all Applicable Laws in effect during the Lease Term that relate to public health and safety and protection of the environment, including those Applicable Laws identified above in this Section 38.12.

[signatures on following page]

IN WITNESS WHEREOF, the parties have executed this Lease as of the date first set forth above, acknowledged that each party has carefully read each and every provision of this Lease, that each party has freely entered into this Lease of its own free will and volition, and that the terms, conditions and provisions of this Lease are commercially reasonable as of the day and year first above written.

"LANDLORD"

6th & PINE DEVELOPMENT, LLC,
a California limited liability company

By: __
Name: __
Its: __

"TENANT"

MOLINA HEALTHCARE, INC.
a Delaware corporation

By: __
Name: __
Its: __

EXHIBIT “A-1”

LEGAL DESCRIPTION OF SITE

THE LAND REFERRED TO HEREIN BELOW IS SITUATED IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA. AND IS DESCRIBED AS FOLLOWS:

PARCEL 1:

THE WEST 37112 FEET OF LOTS 1 AND 3, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 19 PAGE 91 ET SEQ., OF MISCELLANEOUS RECORDS OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE WEST LYING BETWEEN THE PROLONGATION OF THE NORTHERLY LINE OF LOT 1 AND THE SOUTHERLY LINE OF LOT 3 BY 8 FEET, AS VACATEI IN RESOLUTION NO. C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

EXCEPT THEREFROM ALL OIL GAS, MINERALS AND HYDROCARBON SUBSTANCES LYING BELOW A DEPTH OF 200 FEET FROM THE SURFACE OF SAID LAND, BUT WITHOUT THE RIGHT OF ENTRY UPON ANY PORTION OF THE SURFACE OF SAID LAND FOR THE PURPOSE OF EXPLORING FOR, BORING, EXTRACTING. DRILLING. MINING. PROSPECTING FOR, REMOVING OR MARKETING SAID SUBSTANCES, AS RESERVED TO THE GRANTOR THEREIN IN DEED EXECUTED BY TITLE INSURANCE AND TRUST COMPANY. TRUSTEE UNDER AGREEMENT AND DECLARATION OF TRUST EXECUTED HEREOF CREATING THOSE CERTAIN TRUSTS KNOWN AS ALBERT C. SELLERY TRUST AND THE ELEANOR D. SELLERY TRUST, RECORDED JULY 15, 1969 AS INSTRUMENT NO. 420, OF OFFICIAL RECORDS.

APN: 7273-025-013

PARCEL 2:

LOTS 5 AND 7, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGE 91 ET SEQ., OF MISCELLANEOUS RECORDS OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE WEST LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY LINE OF LOT 5 AND THE SOUTHERLY LINE OF LOT 7, BY8 FEET, AS VACATEDIN RESOLUTION NO., C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

APN: 7273-025-015

PARCEL 3:

THE SOUTH 5 FEET OF LOT 6 AND ALL OF LOT 8, IN BLOCK 41 OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO

96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THE PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE EAST LYING BETWEEN THE PROLONGATION OF THE NORTHERLY LINE OF THE SOUTHERLY 5 FEET OF LOT 6 AND THE PROLONGATION OF THE SOUTHERLY LINE OF LOT 7, BY 8 FEET, AS VACATED IN RESOLUTION NO. C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

APN: 7273-025-016

PARCEL 4:

LOTS 10, 12 AND 14, IN BLOCK 41 OF THE TOWNSITE OF LONG BEACH, OF THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGE 91 OF MISCELLANEOUS RECORDS OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE EAST LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY LINE OF LOT 10 ANDTHE SOUTHERLY LINE OF LOT 14, BY 8 FEET, AS VACATED IN RESOLUTION NO. C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1.988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

EXCEPT THEREFROM ALL OIL GAS, MINERALS AND OTHER HYDROCARBON SUBSTANCES BELOW A DEPTH OF 200 FEET FROM THE SURFACE THEREOF, WITHOUT RIGHT OF SURFACE ENTRY, AS RESERVED BY EDWARD R. LOVELL TRUSTEE IN DEED RECORDED DECEMBER 1, 1971 AS INSTRUMENT NO. 155, OF OFFICIAL RECORDS.

APN: 7273-025-019 (PORTION)

PARCEL 5:

LOTS 17 TO 21 INCLUSIVE IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING SAID LAND ON THE NORTH LYING BETWEEN THE PROLONGATIONS OF THE WESTERLY LINE OF LOT 17 AND THE EASTERLY LINE OF LOT 21 BY 5 FEET, AS VACATEI IN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED APRIL 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947, OF OFFICIAL RECORDS.

APN: 7273-025-020 (PORTION)

PARCEL 6:

LOTS 9, 11 AND 13, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID AND ON THE WEST LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY LINE OF LOT 9 AND THE SOUTHERLY LINE OF LOT 13 BY 8 FEET, AS VACATED IN RESOLUTION NO. C-24596, OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

APN: 7273-025-017, 018 (PORTION)

PARCEL 7:

LOTS 24 TO 28 INCLUSIVE IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH. AS PER MAP RECORDED IN BOOK 19 PAGES 91 ET SEQ. OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING SAID LAND ON THE NORTH LYING BETWEEN THE PROLONGATIONS OF THE WESTERLY LINE OF LOT 24 AND THE EASTERLY LINE OF LOT 28 BY 5 FEET, AS VACATEI IN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED April 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947, OF OFFICIAL RECORDS.

EXCEPT ALL OIL GAS AND OTHER HYDROCARBONS, IN AND UNDER THAT PORTION OF SAID LAND LOCATED MORE THAN 100 FEET BELOW THE SURFACE THEREOF BUT WITH NO RIGHT OF USE OF THE SURFACE OF SAID LANDS OR ANY PORTION THEREOF WITHIN 100 FEET OF THE SURFACE, AS RESERVED BY COVENANT PRESBYTERIAN CHURCH OF LONG BEACH, CALIFORNIA, IN DEED RECORDED MAY 19,1965 AS INSTRUMENT NO. 999, OF OFFICIAL RECORDS.

APN: 7273-025-021 (PORTION)

PARCEL 8:

LOTS 15, 16, 22 AND 23, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGE 91 ET SEQ. OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING LOTS 15 AND 16 ON THE SOUTH LYING BETWEEN THE PROLONGATIONS OF THE EASTERLY AND WESTERLY LINES OF SAID LOTS 15 AND 16, BY 5 FEET, AS VACATED IN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED APRIL 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947 AND ALSO TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING LOT 15 ON THE WEST AND ADJOINING LOT 16 ON THE EAST, LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY AND SOUTHERLY LINES OF SAID LOTS 15 AND 16, BY 8 FEET, RESPECTIVELY, AS VACATED IN RESOLUTION NO. C-24596, OF THE CITY OF LONG BEACH RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

ALSO TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING LOTS 22 AND 23 OF THE NORTH, LYING BETWEEN THE PROLONGATIONS OF THE EASTERLY AND WESTERLY LINES OF SAID LOTS 22 AND 23, BY 5 FEET, AS VACATEDIN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED APRIL 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947 AND ALSO TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING LOT 22 ON THE EAST AND ADJOINING LOT 23 ON THE WEST, LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY AND SOUTHERLYLINES OF SAID LOTS 22 AND 23, BY 8 FEET, RESPECTIVELY,AS VACATEDIN RESOLUTION NO. C-24596, OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

EXCEPT THEREFROM ALL OIL GAS, AND OTHER HYDROCARBONS, IN AND UNDER THAT PORTION OF SAID LAND LOCATED MORE THAN 100 FEET BELOW THE SURFACE THEREOF, BUT WITH NO RIGHT OF USE OF THE SURFACE OF SAID LANDS OR ANY PORTION THEREOF WITHIN 100 FEET OF THE SURFACE, RESERVED IN DEED RECORDED MAY 19, 1965 AS INSTRUMENT NO. 999, OF OFFICIAL RECORDS.

APN: 7273-025-018 (PORTION), 7273-025-019 (PORTION), 7273-025-020 (PORTION), 7273-025-021 (PORTION)

PARCEL 9:

THE EAST 112.5 FEET OF LOTS 1 AND 3, BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY. .

EXCEPT THEREFROM ALL OIL, GAS AND OTHER MINERAL RIGHTS IN AND UNDER SAID PROPERTY TOGETHER WITH THE EXCLUSIVE RIGHT TO USE SUCH PORTION OF SAID PROPERTY LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR THE EXTRACTION OF OIL GAS AND MINERALS FROM SAID PROPERTY OR PROPERTY IN THE VICINITY THEREOF; HOWEVER, WITH NO RIGHTS OF SURFACE ENTRY WHATSOEVER. AS RESERVED TO THE GRANTOR THEREIN IN DEED EXECUTED BY SOCONY MOBIL OIL COMPANY, INC., A NEW YORK CORPORATION, SUCCESSOR BY MERGER TO GENERAL PETROLEUM CORPORATION, FORMERLY KNOWN AS GENERAL PETROLEUM CORPORATION OF CALIFORNIA, RECORDED MARCH 2, 1966.

APN: 7273-025-001

PARCEL 10:

LOTS 2 AND 4 AND THE NORTH 20 FEET OF THE LOT 6 IN BLOCK 41 OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 19, PAGE(S) 91 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF TRIBUNE COURT VACATEDBY THE CITY OF LONG BEACH, RESOLUTION NO. 24596, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, LYING NORTHERLY OF THE EASTERLY PROLONGATION OF THE SOUTHERLY LINE FEET THE SOUTHERLY 20 FEET OF LOT 6, LYING SOUTHERLY OF THE SOUTHERLY LINE OF 7TH STREET, 80 FEET WIDE, LYING EASTERLY OF THE EASTERLY LINE OF LOTS 2, 4 AND 6 LYING WESTERLY OF THE EASTERLY LINE OF THE WEST 8 FEET OF SAID TRIBUNE COURT.

A NON-EXCLUSIVE EASEMENT FOR INGRESS AND EGRESS OVER THE SOUTH 5 FEET OF LOT 6, AND ALL OF LOT 5, AND LOTS 7 THROUGH 28, INCLUSIVE, IN BLOCK 41 OF LONG BEACH, CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 OF PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS OF THE COUNTY RECORDER OF SAID COUNTY, AS GRANTED BY DOCUMENT RECORDED NOVEMBER 7, 1988, AS INSTRUMENT NO. 88-1791681, OFFICIAL RECORDS.

EXCEPT THEREFROM ALL MINERALS, GAS, OIL, PETROLEUM, NAPHTHA AND OTHER HYDROCARBON SUBSTANCES LOCATED IN AND UNDER SAID LAND BELOW A DEPTH OF 200 FEET FROM THE SURFACE THEREOF, WITHOUT RIGHT OF SURFACE ENTRY. AS RESERVED IN DEED RECORDED APRIL 16, 1993 AS INSTRUMENT NO. 93-716425 OFFICIAL RECORDS.

APN: 7273-025-014 (PORTION)

EXHIBIT “A-2”

SITE PLAN OF SITE

[See attached.]

EXHIBIT “B”

WORK LETTER AGREEMENT

[See attached.]

EXHIBIT "C"

NOTICE OF LEASE TERM DATES

Date: ___

To:

Re: Lease dated _____, 2012 between 6th & Pine Development, LLC, a California limited liability company, Landlord, Molina Healthcare, Inc., a Delaware corporation, Tenant, concerning 604 Pine Avenue, Long Beach, California.

Ladies/Gentlemen:

In accordance with the subject Lease, we wish to advise and/or confirm as follows:

1. That the Tenant has possession of the [Existing Building][New Building] and acknowledges that under the provisions of the subject Lease, the Commencement Date with respect to the [Existing Building][New Building] occurred on _____.

2. That in accordance with the subject Lease, rental commenced to accrue with respect to the [Existing Building][New Building] on the Commencement Date set forth in Section 1, based on _____ RSF (as determined pursuant to Section 1.2 of the Lease).

3. If the Commencement Date set forth in Section 1 is other than the first day of the month, the first billing will contain a pro rata adjustment. Each billing thereafter shall be for the full amount of the monthly installment as provided for in said Lease.

4. Rent is due and payable in advance on the first day of each and every month during the term of said Lease. Your rent checks should be made payable to _____ at _____.

6TH & PINE DEVELOPMENT, LLC,
a California limited liability company

By: _____
Name: _____

Its: _____

AGREED AND ACCEPTED:

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: _____

Name: _____

Its: _____

EXHIBIT “D”

RESERVED

EXHIBIT "E"

MEMO OF LEASE

RECORDING REQUESTED BY
AND WHEN RECORDED MAIL TO:

David C. Meckler
LATHAM & WATKINS LLP
650 Town Center Drive
Costa Mesa, California 92626-1925

SPACE ABOVE THIS LINE FOR RECORDER'S USE ONLY

MEMORANDUM OF LEASE AND, RIGHT OF FIRST OFFER TO PURCHASE

THIS MEMORANDUM OF LEASE AND RIGHT OF FIRST OFFER TO PURCHASE (this "Memorandum") is effective as of [_____], 2013, by and between 6th & PINE DEVELOPMENT, LLC, a California limited liability company ("Landlord"), and MOLINA HEALTHCARE, INC., a Delaware corporation ("Tenant").

1. Lease. Landlord and Tenant have entered into that certain unrecorded Office Building Lease – Full Service Gross – Single Tenant Building(s) dated [_____], 2013 (as amended to date and as the same may hereafter be amended, modified or supplemented from time to time in accordance with the terms thereof, collectively, the "Lease"), pursuant to which Landlord has leased and does hereby lease to Tenant, and Tenant has leased and does hereby lease from Landlord, the premises more particularly described in the Lease and consisting of certain real property more particularly described on Exhibit "A" attached hereto (the "Premises"). Capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the Lease.

2. Term of Lease. The fixed term of the Lease is scheduled to commence on [June 1, 2013] **[To be confirmed]**, and expires on December 31, 2024, unless earlier terminated pursuant to the provisions of the Lease. Tenant has the option, subject to the terms of the Lease, to extend the term of the Lease by two (2) sequential renewal terms of five (5) years each.

3. Rights to Purchase the Premises. Tenant has a right of first offer to purchase the Premises (together with all appurtenant rights with respect thereto) for the first five (5) years of the term, and an option to purchase the Premises (together with all appurtenant rights with respect thereto) thereafter, in each case upon and subject to the terms and conditions set forth in the Lease (collectively, the "Purchase Rights").

4. Miscellaneous. The purpose of this Memorandum is solely to give notice of the existence of the Lease, all the terms of which are incorporated herein by this reference, and the Purchase Rights contained therein. This Memorandum shall not modify or amend any of the provisions of the Lease, including the terms and conditions of any Purchase Rights contained therein.

To the extent that any provision of this Memorandum conflicts with any provision of the Lease, the provisions of the Lease shall control. This Memorandum may be executed in counterparts, each of which shall be an original, but all of which, together, shall constitute one and the same instrument. This Memorandum shall automatically terminate upon the expiration or earlier termination of the Lease.

[Signature Page Follows on Next Page]

IN WITNESS WHEREOF, the parties hereto have executed this Memorandum as of the date and year first above written.

"LESSOR"

6th& PINE DEVELOPMENT, LLC,
a California limited liability company

By: _
Name:_
Title:_

"LESSEE"

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: _
Name:_
Title:_____

State of California)
County of Los Angeles)

On _____ before me, _____ (here insert name and title of the officer), personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

State of California)
County of Los Angeles)

On _____ before me, _____ (here insert name and title of the officer), personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

EXHIBIT “A” TO EXHIBIT “E”
LEGAL DESCRIPTION

(To Be Attached)

EXHIBIT "F"

ESTOPPEL CERTIFICATE

TO: _____

FROM: _____

RE: _____

[Tenant] [Landlord] hereby certifies based on the actual knowledge of [Tenant] [Landlord] without any duty to inquire, the information set forth below with respect to the Lease as of the date of this certificate.

1. The Lease is unmodified and in full force and effect [or "The Lease, as modified by the above-referenced amendment(s), is in full force and effect" except as noted herein].

2. Tenant is current in its obligation to pay rent and additional rent (in respect of tax and operating expense escalations) under the Lease, the most recent payments being made on the following dates, in the following amounts:

	Date	Amount
Rent:	_____, 20__	$_____
Additional Rent:	_____, 20__	$_____

3. To the actual knowledge of [Tenant] [Landlord] without any duty to inquire, [except as set forth below,] neither Landlord nor Tenant is not in default under the Lease.

Date: _____, 20__

_____,

a _____

By: _____

Title: _____

EXHIBIT ”G”

RESERVED

EXHIBIT “H”

FORM OF APPROVED SNDA

[See attached.]

EXHIBIT "I-1"

RIGHT OF FIRST OFFER TO PURCHASE

1. ROFO. Provided no Event of Default by Tenant has occurred and is continuing hereunder, if at any time during the period from the Effective Date through the day prior to the fifth (5th) anniversary of the Effective Date (the "**5th Anniversary of the Effective Date**"), Landlord desires to sell the Project (which for all purposes under this Exhibit "I-1" shall include all of Landlord's right, title and interest in and to the Off-Site Parking Spaces under the Off-Site Parking Agreement to the extent that such rights are transferable, it being acknowledged that if consent is required to transfer the same, each party shall cooperate in good faith to seek such consent), or any portion thereof, Landlord shall in writing notify Tenant (a "**Sale Notice**") of Landlord's intent to sell the Project or portion thereof identified in the Sale Notice. The Sale Notice shall be given prior to any offer or counteroffer (or acceptance of an offer or counteroffer) by Landlord to sell the Project (or any portion thereof) to a third party.

2. Tenant's Notice of Intent to Purchase. Upon receipt of a Sale Notice by Tenant, Tenant shall have fifteen (15) days to notify Landlord in writing of Tenant's intent to purchase the Project or the portion thereof specified in Landlord's Sale Notice. If Tenant timely notifies Landlord of its intent to purchase the Project or portion thereof specified in Landlord's Sale Notice, the parties shall proceed pursuant to Paragraph 3 below. If Tenant does not so timely notify Landlord, or notifies Landlord that it does not intend to purchase the Project or portion thereof specified in Landlord's Sale Notice (the "**Sale Portion**"), Landlord may proceed pursuant to Paragraph 4 below.

3. Exclusive Negotiations. If Tenant timely and properly notifies Tenant of its intent to purchase the Project or Sale Portion, Tenant and Landlord shall, fifteen (15) days after Tenant's notice, enter into exclusive negotiations to attempt to reach a mutually satisfactory agreement as to price and terms of the sale. Such negotiation process shall include at least one good faith written offer by Tenant (the "**Tenant Offer**") of the price at which Tenant proposes to purchase the Project or Sale Portion. If agreement as to price is reached during such fifteen (15) day exclusive negotiation period, the parties shall have an additional fifteen (15) day period to negotiate in good faith for and to enter into and deliver a mutually acceptable and commercially reasonable purchase and sale agreement and open a purchase and sale escrow.

4. Third Party Sale by Landlord. If (a) Tenant fails to timely give the notice provided for in Paragraph 2 above (or notifies Landlord that Tenant does not intend to purchase the Project or Sale Portion), or (b) Tenant and Landlord fail to reach an agreement as to price within the forty-five (45) day exclusive negotiation period pursuant to Paragraph 3 above or (c) Tenant and Landlord reach an agreement as to price during the exclusive negotiation period but fail to execute and deliver a purchase agreement within the thirty (30) day period pursuant to Paragraph 3 (after negotiating in good faith therefor), then, in any such event, Landlord shall be free to sell the Project or Sale Portion to any third party buyer, but only at a price greater than the purchase price contained in the last Tenant Offer by Tenant pursuant to Paragraph 3 above (the "**Tenant Price**").

5. Second Sale Notice. Notwithstanding the provisions of Paragraph 4 above, if Tenant shall have provided to Landlord at least one Tenant Offer during the exclusive negotiation period and either (a) Landlord has not executed a definitive purchase agreement with a third party buyer to sell the Project or Sale Portion within 180 days after the expiration of the forty-five (45) day period in Paragraph 3 above (with no agreement as to price) or 180 days after the expiration of the thirty (30) day period in Paragraph 3 above (with no execution of a purchase and sale agreement, after negotiating in good faith therefor), as applicable, or (ii) Landlord proposes to sell the Project or Sale Portion at a price equal to or less than the Tenant Price, then, in either such event, Landlord shall provide to Tenant a Sale Notice pursuant to Paragraph 2 above and Tenant shall have the same right specified in Paragraph 2 to notify Landlord of its intent to purchase, except that, in the event clause (ii) of this Paragraph 5 is applicable, (1) Tenant shall have ten (10) days from receipt of Landlord's second Sale Notice to give the notice therein described, and (2) for purposes of Paragraph 3 above, the agreed upon price shall be the Tenant Price and the parties shall have thirty (30) days after Tenant notifies Landlord of its intent to purchase to negotiate in good faith for and enter into and deliver a mutually acceptable and commercially reasonable purchase and sale agreement and open a purchase and sale escrow. If Tenant shall not have provided to Landlord at least one Tenant Offer during the exclusive negotiation period, then the provisions of this Paragraph 5 shall not apply, there shall be no second Sale Notice and Landlord shall be free to sell the Project or Sale Portion to any third party at any price and upon any terms agreed upon by Landlord and such third party.

6. Closing under ROFO. If (a) Tenant timely and properly notifies Landlord of its intent to purchase pursuant to Paragraph 2 above, Tenant and Landlord reach agreement upon a sale price and execute and deliver a purchase and sale agreement pursuant to Paragraph 3 above or (b) clause (ii) of Paragraph 5 above applies and Tenant timely notifies Landlord of Tenant's intent to purchase in response to Landlord's second Sale Notice, which purchase shall be at the Tenant Price, and Landlord and Tenant execute a purchase and sale agreement pursuant to subclause (2) of clause (ii) of Paragraph 5 above, then Tenant and Landlord shall proceed to close the sale of the Project or Sale Portion. Such sale shall be for cash at close of a purchase and sale escrow at the price agreed upon pursuant to Section 3 above or the Tenant Price, as applicable. In addition, in connection with such sale:

(a) A purchase and sale escrow (the "**Escrow**") shall be opened with a mutually acceptable title/escrow company in Los Angeles or Orange County, California (the "**Escrow Agent**") within five (5) business days after the execution and delivery of a purchase and sale agreement;

(b) Tenant shall have an agreed thirty (30) day period to conduct a due diligence review of the Project, which shall be limited solely to a review of title, environmental, entitlement and structural matters. Provided Tenant does not terminate the Escrow within the due diligence period, Escrow shall close within ten (10) days following the expiration of the due diligence period;

(c) The purchase price to be paid shall be paid by delivery of immediately available funds at close of the Escrow;

(d) The Project shall be sold to Tenant "AS IS" and with no representations and warranties by Landlord, except as set forth in the purchase and sale agreement. Landlord shall, however, assign to Tenant all design and construction warranties and rights obtained by Landlord and all other ongoing rights of Landlord under the design, development and construction documents with respect to the Project;

(e) Landlord will pay the premium for a standard owner's CLTA or ALTA title policy with respect to the Project in the amount of the purchase price therefor and the cost of any endorsements required to cure title defects. Tenant shall be responsible for all additional premiums and costs for an ALTA extended coverage policy of title insurance (i.e., the premium difference between a CLTA or ALTA standard policy and an ALTA extended coverage policy), plus the cost of any endorsements required by Tenant (other than those required to cure title defects). Landlord shall convey title to the Project to Tenant free and clear of any and all mortgages, deeds of trust or other monetary liens created or suffered by, through or under Landlord, other than any such deeds of trust or other monetary liens that Tenant has agreed in its sole discretion to assume or take title subject to and for which an appropriate reduction in the purchase price has been made at the closing of the Escrow; and

(f) Rent shall be prorated at close of Escrow. Landlord shall pay the documentary transfer tax with respect to the grant deed, the recording fee for the deed and one-half of escrow agent's fees and costs. Tenant shall pay the recording fees for the mutual cancellation of any recorded memorandum of this Lease, all recording fees for any mortgage or deed of trust placed on the Project by Tenant and one-half of escrow agent's fees and costs. All other costs and fees in connection with the Escrow shall be paid in accordance with customary escrow practice in Los Angeles County, California.

7. ROFO Not Personal. The rights granted to Tenant in this Exhibit "I-1" are not personal to Tenant and shall be for the benefit of, and the rights granted herein may be exercised by, any assignee of Tenant's interest in this Lease permitted under the terms hereof; provided, however, that the rights granted to Tenant in this Exhibit "I-1" are not assignable separate and apart from Tenant's interest in this Lease.

8. Terms. All terms used in this Exhibit "I-1" unless otherwise defined in this Exhibit shall have the same meaning as the terms defined elsewhere in this Lease.

EXHIBIT "I-2"

PURCHASE OPTION

1. Option. Provided no Event of Default by Tenant has occurred and is continuing hereunder at the time of the exercise of the option set forth herein, Tenant may elect to purchase the entire Project (which for all purposes under this Exhibit "I-2" shall include all of Landlord's right, title and interest in and to the Off-Site Parking Spaces under the Off-Site Parking Agreement to the extent that such rights are transferable, it being acknowledged that if consent is required to transfer the same, each party shall cooperate in good faith to seek such consent) at any time from and after 5 th Anniversary of the Effective Date (as defined in Exhibit "I-1") and continuing for the balance of the Term (the "**Purchase Option**"), by delivering to Landlord before the end of the Term a written notice (the "**Purchase Option Notice**") of such election. The Purchase Option shall be exercisable only as to the entire Project, and shall not be exercisable as to less than the entire Project.

2. Option Not Personal. The Purchase Option set forth in this Exhibit "I-2" is not personal to Tenant and may be exercised by any assignee of Tenant's interest in this Lease permitted under the terms hereof; provided, however, that, the Purchase Option is not assignable separate and apart from Tenant's interest this Lease.

3. Purchase Price. The purchase price shall be one hundred percent (100%) of the Fair Market Value (as hereinafter defined) (the "**Option Price**").

4. Fair Market Value. For the purposes of this Exhibit "I-2" the term "**Fair Market Value**" shall mean the gross sales price that the Project would bring in a competitive and open market as of the date the Purchase Option Notice was delivered to Landlord under all conditions requisite to a fair sale with a buyer and seller each acting prudently and knowledgeably. The determination of "Fair Market Value" shall assume that: (a) the Project is sold for its highest and best use as of the date the Purchase Option Notice was delivered to Landlord; (b) the sales price is not affected by undue stimulus; (c) buyer and seller are equally motivated; (d) both buyer and seller are well informed or well advised and are acting in what it considers to be in its own best interest; (e) a reasonable time is allowed for the exposure on the open market; (f) payment of the purchase price of Project is made in cash by Buyer on the closing date; and (g) taking into account specifically the parking rights for the benefit of the Project.

Landlord shall determine the Fair Market Value by using its good faith judgment. Landlord shall provide written notice of such amount within thirty (30) days after Tenant delivers the Purchase Option Notice. Tenant shall have thirty (30) days ("**Tenant's FMV Review Period**") after receipt of Landlord's notice of Fair Market Value within which to accept such Fair Market Value in writing. In the event Tenant fails to accept the Fair Market Value proposed by Landlord, Landlord and Tenant shall attempt to agree upon such Fair Market Value, using good faith efforts. If Landlord and Tenant fail to reach agreement within fifteen (15) days following Tenant's FMV Review Period ("**Outside FMV Agreement Date**"), then each party shall place in a separate sealed envelope their final proposal as to Fair Market Value and such determination shall be submitted to arbitration in accordance with subsections (a) through (e) below. Failure of Tenant to so elect in writing within

Tenant's FMV Review Period shall conclusively be deemed its disapproval of the Fair Market Value determined by Landlord.

In the event that Landlord fails to timely generate the initial written notice of Landlord's opinion of the Fair Market Value which triggers the negotiation period of this Paragraph 4, then Tenant may commence such negotiations by providing the initial notice, in which event Landlord shall have fifteen (15) days ("**Landlord's FMV Review Period**") after receipt of Tenant's notice of the Fair Market Value within which to accept such Fair Market Value. In the event Landlord fails to accept in writing such Fair Market Value proposed by Tenant, then such proposal shall be deemed rejected, and Landlord and Tenant shall attempt in good faith to agree upon such Fair Market Value, using good faith efforts. If Landlord and Tenant fail to reach agreement within fifteen (15) days following Landlord's FMV Review Period (which shall be, in such event, the "Outside FMV Agreement Date" in lieu of the above definition of such date), then each party shall place in a separate sealed envelope their final proposal as to Fair Market Value and such determination shall be submitted to arbitration in accordance with subsections (a) through (e) below.

(a) Landlord and Tenant shall meet with each other within five (5) business days of the Outside FMV Agreement Date and exchange the sealed envelopes and then open such envelopes in each other's presence. If Landlord and Tenant do not mutually agree upon the Fair Market Value within three (3) business days of the exchange and opening of envelopes, then, within ten (10) business days of the exchange and opening of envelopes Landlord and Tenant shall agree upon and jointly appoint a single arbitrator who shall (i) by profession be a commercial real estate appraiser, (ii) be a Member of the Appraisal Institute (or any successor organization thereto) and (iii) have been active over the five (5) year period ending on the date of such appointment in the appraisal of Comparable Buildings (as defined in Exhibit "J"). Neither Landlord nor Tenant shall consult with such arbitrator directly or indirectly as to his or her opinion as to Fair Market Value prior to the appointment. The determination of the arbitrator shall be limited solely to the issue of whether Landlord's or Tenant's submitted Fair Market Value for the Project is the closer to the actual Fair Market Value as determined by the arbitrator, taking into account the definition of Fair Market Value as set forth in and the other requirements of this Paragraph. Such arbitrator may hold such hearings and require such briefs as the arbitrator, in his or her sole discretion, determines is necessary. In addition, Landlord or Tenant may submit to the arbitrator with a copy to the other party within five (5) business days after the appointment of the arbitrator any market data and additional information that such party deems relevant to the determination of Fair Market Value (" **FMV Data**") and the other party may submit a reply in writing within five (5) business days after receipt of such FMV Data.

(b) The arbitrator shall, within thirty (30) days of his or her appointment, reach a decision as to whether the parties shall use Landlord's or Tenant's submitted Fair Market Value, and shall notify Landlord and Tenant of such determination.

(c) The decision of the arbitrator shall be binding upon Landlord and Tenant, except as provided in Paragraph 5 below.

(d) If Landlord and Tenant fail to agree upon and appoint an arbitrator, then the appointment of the arbitrator shall be made by the Presiding Judge of the Superior Court of Los Angeles, California, or, if he or she refuses to act, by any judge having jurisdiction over the parties.

(e) The cost of arbitration shall be paid by Landlord and Tenant equally.

5. Rescission by Tenant following Fair Market Value Determination. In the event that Tenant objects to the Fair Market Value as determined by the arbitration provision specified in Paragraph 4 above, Tenant may elect to rescind its Purchase Option Notice at any time within ten (10) business days following the establishment of the Fair Market Value as determined by such arbitration. In the event Tenant elects to rescind such notice, (i) Tenant shall reimburse Landlord for its reasonable attorneys' fees and reasonable costs associated with such arbitration and shall have no obligation to purchase the Project and (ii) the Purchase Option provided for in this Exhibit "I-2" shall lapse and terminate and thereafter not be exercisable by Tenant or any assignee of Tenant's interest under this Lease.

6. Closing under Purchase Option. Unless Tenant exercises its rescission right pursuant to Paragraph 5 above, promptly after the Fair Market Value is determined pursuant to this Exhibit "I-2" (whether by agreement of the parties or by arbitration), negotiate in good faith for and enter into and deliver a mutually acceptable and commercially reasonable purchase and sale agreement and open a purchase and sale escrow for the purchase and sale of the Project. Such sale shall be for cash at close of a purchase and sale escrow at the Option Price. In addition, in connection with such sale:

(a) An Escrow (as defined in Exhibit "I-2" shall be opened with a mutually acceptable title/escrow company in Los Angeles or Orange County, California (the "**Escrow Agent**") within ten (10) business days after the execution and delivery of a purchase and sale agreement;

(b) Tenant shall have an agreed thirty (30) day period to conduct a due diligence review of the Project, which shall be limited solely to a review of title, environmental, entitlement, structural and parking matters. Provided Tenant does not terminate the Escrow within the due diligence period, Escrow shall close within ten (10) days following the expiration of the due diligence period;

(c) The Option Price to be paid shall be paid by delivery of immediately available funds at close of the Escrow;

(d) The Project shall be sold to Tenant "AS IS" and with no representations and warranties by Landlord, except as set forth in the purchase and sale agreement. Landlord shall, however, assign to Tenant all design and construction warranties and rights obtained by Landlord and all other ongoing rights of Landlord under the design, development and construction documents with respect to the Project;

(e) Landlord will pay the premium for a standard owner's CLTA or ALTA title policy with respect to the Project in the amount of the purchase price therefor and the cost

of any endorsements required to cure title defects. Tenant shall be responsible for all additional premiums and costs for an ALTA extended coverage policy of title insurance (i.e., the premium difference between a CLTA or ALTA standard policy and an ALTA extended coverage policy), plus the cost of any endorsements required by Tenant (other than those required to cure title defects). Landlord shall convey title to the Project to Tenant free and clear of any and all mortgages, deeds of trust or other monetary liens created or suffered by, through or under Landlord, other than any such deeds of trust or other monetary liens that Tenant has agreed in its sole discretion to assume or take title subject to and for which an appropriate reduction in the Option Price has been made at the closing of the Escrow; and

(f) Rent shall be prorated at close of Escrow. Landlord shall pay the documentary transfer tax with respect to the grant deed, the recording fee for the deed and one-half of escrow agent's fees and costs. Tenant shall pay the recording fees for the mutual cancellation of any recorded memorandum of this Lease, all recording fees for any mortgage or deed of trust placed on the Project by Tenant and one-half of escrow agent's fees and costs. All other costs and fees in connection with the Escrow shall be paid in accordance with customary escrow practice in Los Angeles County, California

7. Terms. All terms used in this Exhibit "I-2" unless otherwise defined in this Exhibit shall have the same meaning as the terms defined elsewhere in this Lease.

EXHIBIT "J"

OPTIONS TO EXTEND

1. Options. Provided no Event of Default by Tenant has occurred and is continuing at the time of the exercise of the options set forth herein, Tenant may elect to extend the Term ("**Extension Options**") for all of the Premises for two (2) additional periods of five (5) years each (collectively, the "**Extension Periods**"; individually, the "**First Extension Period**" and the "**Second Extension Period**"), by delivering to Landlord not later than twelve (12) months nor earlier than eighteen (18) months before the end of the initial Term or the First Extension Period, as applicable, a written notice (the "**Option Notice**") of such election. The First Extension Period shall commence on the day immediately following the last day of the Term and the Second Extension Period shall commence on the day immediately following the last day of the First Extension Period, and shall be subject to all the terms and conditions of this Lease except that the Base Rent for the applicable Extension Period shall be determined in accordance with Paragraph 3 below.

2. Options Not Personal. The Extension Options set forth herein are not personal to Tenant and may be exercised by any assignee of Tenant's interest in this Lease permitted under the terms hereof; provided, however, that, Extension Options are not assignable separate and apart from Tenant's interest this Lease.

3. Base During Extension Periods. The Base Rent for each Extension Period shall be one hundred percent (100%) of the Fair Market Rental Rate (as hereinafter defined) as of the commencement of the applicable Extension Period and the Base Year shall be the first (1st) calendar year of such Extension Period.

4. Fair Market Rental Rate. For the purposes of this Exhibit "J" the term "**Fair Market Rental Rate**" shall mean the annual effective rent per rental square foot, plus annual percentage increases therein, that landlords of Comparable Buildings (as defined below) have accepted in current transactions (i.e., if available, those transactions where the essential economic terms and conditions were agreed upon six to twelve (6 to 12) months prior to Tenant's exercise of the applicable Extension Period or such other then most recent transactions as are available for comparison) between non-affiliated parties from new, non-expansion (unless the expansion is pursuant to a comparable definition of Fair Market Rental Rate), non‑renewal (unless the renewal is pursuant to a comparable definition of Fair Market Rental Rate), and non‑equity tenants of comparable credit-worthiness, for Comparable Buildings with comparable space (size), for a comparable use and for a comparable period of time ("**Comparable Transactions**"). "**Comparable Buildings**" shall be buildings of comparable size (including floor height), quality, vintage and construction in Downtown Long Beach. In any determination of Comparable Transactions, appropriate consideration shall be given to the annual rental rates per rentable square foot, the standard of measurement by which the rentable square footage is measured, the ratio of rentable square feet to usable square feet, the type of escalation clause (e.g., whether increases in additional rent are determined on a net or gross basis, and if gross, whether such increases are determined according to a base year or a base dollar amount expense stop), the extent of Tenant's liability under this Lease, parking rights (and costs therefor) and obligations, signage rights, abatement provisions reflecting free rent and/or no rent during the period of construction or subsequent to the commencement date as to the space in question, length

of the lease term, size and location of premises being leased, building standard work letter and/or tenant improvement allowances, if any, the condition of the base building and the Landlord's responsibility with respect thereto, the value, if any, of the existing tenant improvements (with such value being judged with respect to the utility of such existing tenant improvements to the general business office user and not this particular Tenant) and other generally applicable conditions of tenancy for such Comparable Transactions. The intent is that Tenant will obtain the same rent and other economic benefits that Landlord would otherwise give in Comparable Transactions and that Landlord will make, and receive the same economic payments and concessions that Landlord would otherwise make, and receive in Comparable Transactions.

Landlord shall determine the Fair Market Rental Rate by using its good faith judgment. Landlord shall provide written notice of such amount within thirty (30) days after Tenant delivers an Option Notice Tenant shall have thirty (30) days ("**Tenant's Review Period**") after receipt of Landlord's notice of the new rental within which to accept such rental in writing. In the event Tenant fails to accept the new rental proposed by Landlord, Landlord and Tenant shall attempt to agree upon such Fair Market Rental Rate, using their good faith efforts. If Landlord and Tenant fail to reach agreement within fifteen (15) days following Tenant's Review Period ("**Outside Agreement Date**"), then each party shall place in a separate sealed envelope their final proposal as to Fair Market Rental Rate and such determination shall be submitted to arbitration in accordance with subsections (a) through (e) below. Failure of Tenant to so elect in writing within Tenant's Review Period shall conclusively be deemed its disapproval of the Fair Market Rental Rate determined by Landlord.

In the event that Landlord fails to timely generate the initial written notice of Landlord's opinion of the Fair Market Rental Rate which triggers the negotiation period of this Paragraph 4, then Tenant may commence such negotiations by providing the initial notice, in which event Landlord shall have fifteen (15) days ("**Landlord's Review Period**") after receipt of Tenant's notice of the new rental within which to accept such rental. In the event Landlord fails to accept in writing such rental proposed by Tenant, then such proposal shall be deemed rejected, and Landlord and Tenant shall attempt in good faith to agree upon such Fair Market Rental Rate, using their good faith efforts. If Landlord and Tenant fail to reach agreement within fifteen (15) days following Landlord's Review Period (which shall be, in such event, the "**Outside Agreement Date**" in lieu of the above definition of such date), then each party shall place in a separate sealed envelope their final proposal as to Fair Market Rental Rate and such determination shall be submitted to arbitration in accordance with subsections (a) through (e) below.

(a) Landlord and Tenant shall meet with each other within five (5) business days of the Outside Agreement Date and exchange the sealed envelopes and then open such envelopes in each other's presence. If Landlord and Tenant do not mutually agree upon the Fair Market Rental Rate within one (1) business day of the exchange and opening of envelopes, then, within ten (10) business days of the exchange and opening of envelopes Landlord and Tenant shall agree upon and jointly appoint a single arbitrator who shall by profession be a real estate broker who shall have been active over the five (5) year period ending on the date of such appointment in the leasing of Comparable Buildings. Neither Landlord nor Tenant shall consult with such arbitrator directly or indirectly as to his or her opinion as to Fair Market Rental Rate prior to the appointment. The

determination of the arbitrator shall be limited solely to the issue of whether Landlord's or Tenant's submitted Fair Market Rental Rate for the Premises is the closer to the actual Fair Market Rental Rate for the Premises as determined by the arbitrator, taking into account the definition of Fair Market Rental Rate set forth in and the other requirements of this Paragraph 4. Such arbitrator may hold such hearings and require such briefs as the arbitrator, in his or her sole discretion, determines is necessary. In addition, Landlord or Tenant may submit to the arbitrator with a copy to the other party within five (5) business days after the appointment of the arbitrator any market data and additional information that such party deems relevant to the determination of Fair Market Rental Rate (" **FMRR Data**") and the other party may submit a reply in writing within five (5) business days after receipt of such FMRR Data.

(b) The arbitrator shall, within thirty (30) days of his or her appointment, reach a decision as to whether the parties shall use Landlord's or Tenant's submitted Fair Market Rental Rate, and shall notify Landlord and Tenant of such determination.

(c) The decision of the arbitrator shall be binding upon Landlord and Tenant, except as provided in Paragraph 5 below.

(d) If Landlord and Tenant fail to agree upon and appoint an arbitrator, then the appointment of the arbitrator shall be made by the Presiding Judge of the Superior Court, or, if he or she refuses to act, by any judge having jurisdiction over the parties.

(e) The cost of arbitration shall be paid by Landlord and Tenant equally.

5. Rescission by Tenant for Insufficient Parking. In the event that Landlord has not reached a mutual agreement with the City to extend the term of the Off-Site Parking Agreement for the applicable extension period no later than six (6) months prior to the commencement of such extension period (in each case, the " **Parking Extension Deadline**"), Tenant may elect to rescind its Option Notice at any time within thirty (30) days following the applicable Parking Extension Deadline. In the event Tenant elects to rescind such notice, this Lease shall expire on the then-current expiration date (unless earlier terminated pursuant to the terms of this Lease), and Landlord and Tenant shall have no further obligations hereunder, except for those obligations that expressly survive the expiration or earlier termination of this Lease.

6. Documentation. Unless Tenant exercises its rescission right pursuant to Paragraph 5 above, promptly after the Base Rent for the applicable Extension Period is determined pursuant to this Exhibit "J", Landlord and Tenant shall execute an amendment to the Lease stating the new Base Rent in effect for such Extension Term.

7. Terms. All terms used in this Exhibit "J" unless otherwise defined in this Exhibit shall have the same meaning as the terms defined elsewhere in this Lease.

EXHIBIT ”K”

OFF-SITE PARKING AGREEMENT

[See attached.]

EXHIBIT ”L”

ESTOPPEL AND AGREEMENT REGARDING OFF-SITE PARKING AGREEMENT

[See attached.]

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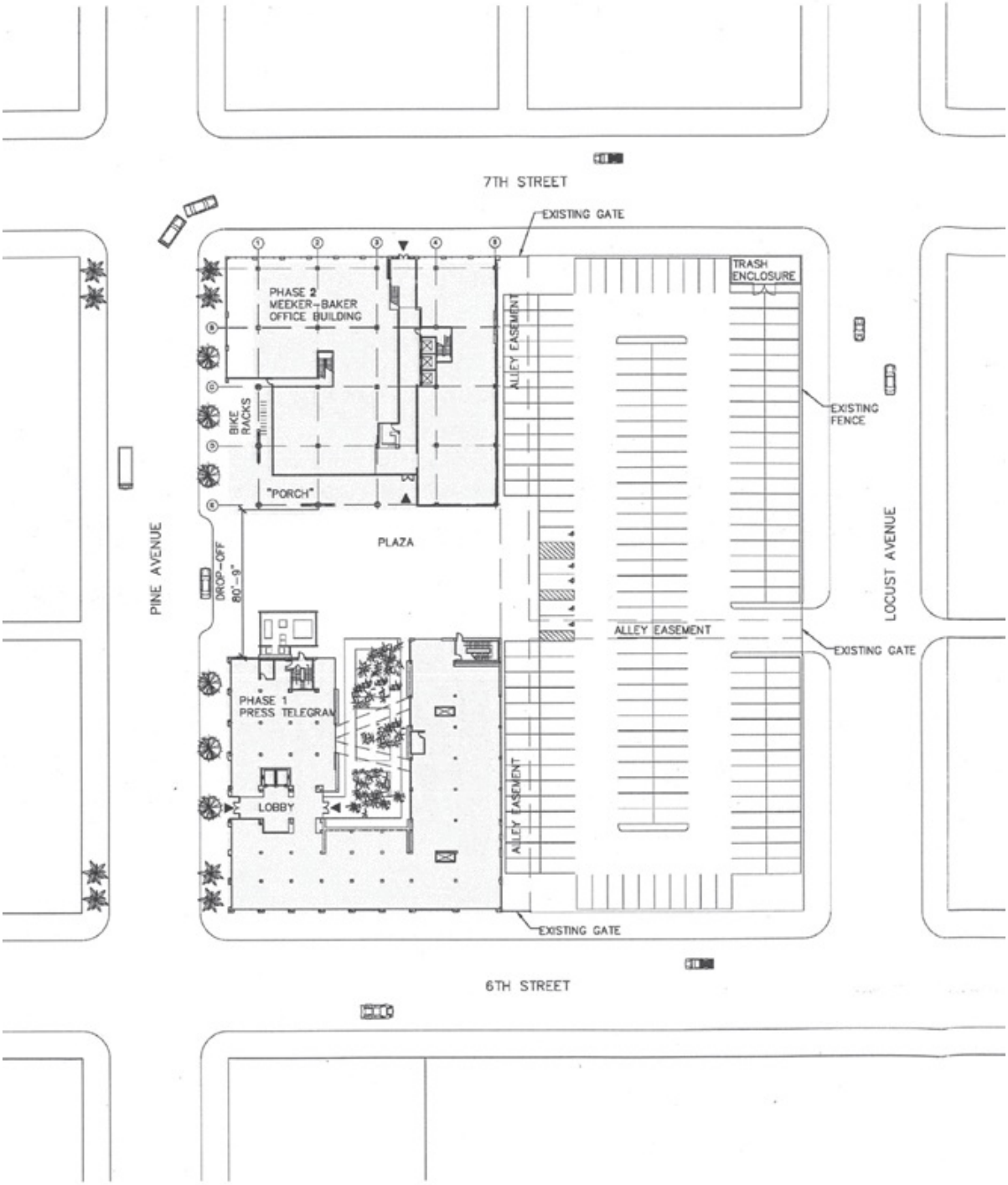
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EXHIBIT "B"

WORK LETTER AGREEMENT

This Work Letter Agreement (the "Work Letter") is made and entered into as of

February 28, 2013, by and between 6th & Pine Development, LLC, a California limited liability company (" Landlord"), and Molina Healthcare, Inc., a Delaware corporation (" Tenant"), and is attached to and made a part of that certain Lease dated as of the date hereof (the "Lease"), by and between Landlord and Tenant for the Project located at 604 Pine Avenue, Long Beach, California. All capitalized terms used but not otherwise defined herein shall have the meanings given them in the Lease.

1. General Requirements.

1.1. Authorized Representatives.

1.1.1. Tenant designates Sal Gutierrez ("Tenant's Authorized Representative") as the person authorized to initial all plans, drawings, changes orders and approvals pursuant to this Work Letter. Landlord shall not be obligated to respond to or act upon any such item until such item has been initialed by Tenant's Authorized Representative. Tenant may change Tenant's Authorized Representative upon five (5) days' prior written notice to Landlord.

1.1.2. Landlord designates Michelle Molina ("Landlord's Authorized Representative") as the person authorized to initial all plans, drawings, changes orders and approvals pursuant to this Work Letter. Tenant shall not be obligated to respond to or act upon any such item until such item has been initialed by Landlord's Authorized Representative. Landlord may change Landlord's Authorized Representative upon five (5) days' prior written notice to Tenant.

1.2. Landlord's Construction Work. Landlord and Tenant acknowledge and agree that the Project will be constructed and delivered by Landlord in two phases (referred to herein as " Phase I" and "Phase II", respectively), each on a "turnkey" basis, subject to the terms and conditions of this Work Letter. Phase I will include the Phase I Base Building and Site Work and the Phase I Tenant Improvements (each as defined below, and collectively, the "Phase I Work"), and Phase II will include the Phase II Base Building and Site Work and the Phase II Tenant Improvements (each as defined below, and collectively, the "Phase II Work"). The Phase I Base Building and Site Work and the Phase II Base Building and Site Work are collectively referred to herein as " Landlord's Base Building and Site Work", the Phase I Tenant Improvements and the Phase II Tenant Improvements are collectively referred to herein as the "Tenant Improvements", and the Phase I Work and the Phase II Work are collectively referred to as "Landlord's Construction Work". Landlord's anticipated schedules for the design, governmental approvals (i.e., building department, historical commissions, planning, etc.), development, construction and performance of Landlord's Construction Work are attached hereto as **Schedule 1** to this Work Letter (the "Landlord's Construction Work Schedule"). The Landlord's Construction Work Schedule shall be subject to adjustment as mutually agreed upon in writing by the parties, or as provided in this Work Letter.

Additionally, Tenant acknowledges that Landlord's Construction Schedule with respect to the Phase II Work is conceptual and preliminary in nature, and remains subject to further revision by Landlord until such time as Landlord has received all approvals that are required from applicable governmental agencies in connection with the Phase II Work. Notwithstanding the foregoing, nothing in this Section 1.2 shall limit Tenant's rights and remedies pursuant to Section 2.6 of the Lease.

1.3. Architects and Consultants. The architect, engineering consultants, design team, general contractor and subcontractors responsible for the design, construction and performance of Landlord's Construction Work shall be selected by Landlord and approved by Tenant, which approval Tenant shall not unreasonably withhold, condition or delay. Tenant hereby approves of Nadel Architects and GMA Architects as the architects for Landlord's Base Building and Site Work (collectively, the "Base Building Architect"), GMA Architects as the architect for the Tenant Improvements (the "TI Architect"), ARCO National Construction Company as Landlord's general contractor for Landlord's Base Building and Site Work (the "Base Building Contractor"), and ARCO National Construction Company as Landlord's general contractor for the Tenant Improvements (the "TI Contractor", and together with the Base Building Architect, the TI Architect and the Base Building Contractor, the "Approved Consultants"). Tenant acknowledges that Landlord will use the Approved Consultants for the Phase I Work, but that Landlord may elect to replace one or more of such Approved Consultants with respect to the Phase II Work, subject to Tenant's right to reasonably approve such replacement pursuant to this Section 1.3.

1.4. Logical Evolutions. For purposes of this Work Letter, the term "Logical Evolution" or "Logical Evolutions" shall mean refinement and amplification of the applicable plans which is consistent with and a direct outgrowth of the scope of such plans and which flow naturally and foreseeably from said plans and are in accordance with custom and practice in the related fields of the architectural and engineering design professions and the construction industry in Southern California, in each case with respect to the construction of a "First-class" office project (taking into account that the Project involves (i) with respect to Phase I, a material restoration and renovation of a historic building and (ii) with respect to Phase II, material reconstruction of an existing building, whereby the historic façade will be retained and incorporated into the New Building), Applicable Laws, and plan check and permit conditions.

2. Landlord's Base Building and Site Work.

2.1. Phase I Base Building and Site Work. Landlord shall, at Landlord's sole cost and expense (but subject to Section 2.5 below), cause Base Building Contractor (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed), to commence and thereafter diligently prosecute to completion the refurbishment and/or construction of the shell and core of the Existing Building and such other portions of the Project, including the Phase I On-Site Parking Spaces and related common areas, as are necessary for Tenant's use and occupancy of the Existing Building (collectively, the "Phase I Base Building and Site Work"), in accordance with the final plans described in the Drawing Log attached hereto as **Schedule 2** (the "Final Phase I Base Building and Site Plans"), Landlord's Construction Work Schedule with respect thereto, and subject only to those changes approved in accordance with Section 2.5 below. The Phase I Base Building and Site Work shall be performed

in accordance with industry custom and practice for a "first-class" office project (taking into account that the Phase I Base Building and Site Work involves a material restoration and renovation of a historic building), and in compliance with all Applicable Laws. The commencement and completion of the Phase I Base Building and Site Work shall be subject to delays resulting from acts of God; acts of terrorism; adverse weather conditions; war; invasion; insurrection; acts of a public enemy; terrorism; riot; mob violence; civil commotion; sabotage; labor disputes; general shortage of labor, materials, facilities, equipment or supplies on the open market; delay in transportation; delays caused by new, or changes to existing, laws, rules, regulations or orders of any governmental authority; moratorium or other governmental action; inability to obtain permits or approvals, including, without limitation, city and public utility approvals beyond the time periods that generally prevail for obtaining such permits and approvals; the acts or inaction of any contractor and/or subcontractors, if any; or any other cause beyond the reasonable control of Landlord, financial ability and failure to order long lead time items sufficiently in advance excepted, whether similar or dissimilar to the foregoing (collectively, " Force Majeure").

2.2. Phase II Base Building and Site Work. Landlord shall, at Landlord's sole cost and expense (but subject to Section 2.5 below), cause Base Building Contractor (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed), to commence and thereafter diligently prosecute to completion the refurbishment and/or construction of the shell and core of the New Building and the remaining balance of the Project, including the Phase II On-Site Parking Spaces and related common areas (collectively, the " Phase II Base Building and Site Work"), in accordance with the Final Phase II Base Building and Site Plans (as defined below) , Landlord's Construction Work Schedule with respect thereto, and subject only to changes approved in accordance with Section 2.5 below. The Phase II Base Building and Site Work shall be performed in accordance with industry custom and standard for a "first-class" office project (taking into account that the Phase II Base Building and Site Work involves the material reconstruction of an existing building, whereby the historic façade will be retained and incorporated into the New Building), and in compliance with all Applicable Laws. The commencement and completion of the Phase II Base Building and Site Work shall be subject to delays resulting from acts of Force Majeure.

2.3. Phase II Design Plans. Landlord shall cause the Base Building Architect (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed), with Tenant's cooperation, to prepare and submit to Tenant for approval, design plans for the Phase II Base Building and Site Work (the " Phase II Design Plans"). The Phase II Design Plans shall contain sufficient information and detail to accurately describe the proposed design of the Phase II Base Building and Site Work to Tenant and such other information as Tenant may reasonably request. Tenant shall be solely responsible for ensuring that the Phase II Design Plans satisfy Tenant's business requirements. Tenant shall notify Landlord in writing within ten (10) business days after receipt of the Phase II Design Plans whether Tenant approves or reasonably disapproves of the Phase II Design Plans and the manner, if any, in which the Phase II Design Plans are reasonable objectionable. If Tenant reasonably objects to the Phase II Design Plans, then Landlord shall cause the Base Building Architect (with Tenant's cooperation) to revise the Phase II Design Plans to address Tenant's reasonable objections thereto. Landlord shall then resubmit the revised Phase II Design Plans to Tenant for approval within seven

(7) business days after Landlord received Tenant's comments to the Phase II TI Space Plans. Tenant's approval of or reasonable objection to revised Phase II Design Plans and Landlord's correction of the same shall be in accordance with this Section 2.3, until Tenant has approved the Phase II Design Plans in writing. The iteration of the Phase II Design Plans that is approved by Tenant without objection shall be referred to herein as the "Approved Phase II Design Plans."

2.4. Final Phase II Base Building and Site Plans. Landlord shall cause the Base Building Architect (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed) to prepare working drawings for the Phase II Base Building and Site Work (the "Phase II Working Drawings") that are consistent with and are Logical Evolutions of (i) the Approved Phase II Design Plans and (ii) to the extent applicable, the Final Phase I Base Building and Site Plans. As soon as Phase II Working Drawings have been prepared, Landlord shall deliver the same to Tenant for Tenant's approval, which approval may be reasonably withheld only if: (i) the Phase II Working Drawings are not consistent with or Logical Evolutions of the Approved Phase II Design Plans and, to the extent applicable, the Final Phase I Base Building and Site Plans, (ii) Tenant requests changes to the Phase II Working Drawings in accordance with Section 2.5(a)(i) (other than Base Building Permitted Changes), or (iii) Tenant objects to any Landlord-requested Base Building Change (other than Base Building Permitted Changes) to the Phase II Working Drawings. Such Phase II Working Drawings shall be approved or disapproved by Tenant within ten (10) business days after delivery to Tenant. If Tenant fails to respond within such ten (10)-business day period, then Landlord shall provide Tenant with a second written notice stating that "Tenant's failure to respond within three (3) days after Landlord's second notice shall be deemed Tenant's approval to such Phase II Working Drawings," and if Tenant does not respond within such three (3) day period, then Tenant shall be deemed to have approved the Phase II Working Drawings. If the Phase II Working Drawings are disapproved by Tenant, Tenant shall notify Landlord in writing of its objections to such Phase II Working Drawings and, if applicable, shall submit any requested Base Building Changes through a Base Building Tenant Change Order Request (as defined below), then the parties shall confer and negotiate in good faith to reach agreement on the Phase II Working Drawings. Promptly after the Phase II Working Drawings are approved by Landlord and Tenant (thereafter, the "Final Phase II Base Building and Site Plans"), two (2) copies of such Final Phase II Base Building and Site Plans shall be initialed and dated by Landlord and Tenant as soon as approved by Landlord and Tenant and Landlord shall promptly submit such Final Phase II Base Building and Site Plans to all appropriate governmental agencies for approval.

2.5. Changes to Landlord's Base Building and Site Work. Any changes to the Final Phase I Base Building and Site Plans, the Phase II Working Drawings or the Final Phase II Base Building and Site Plans (each, a "Base Building Change") requested by Landlord or Tenant shall be requested and instituted in accordance with the provisions of this Section 2.5 and, except for Base Building Permitted Changes, shall be subject to the written approval of the other party in accordance with this Work Letter.

(a) Base Building Changes Requested by Tenant.

(i) Base Building Tenant Change Order Request. Tenant may request Base Building Changes to the Final Phase I Base Building and Site Plans, the Phase II Working Drawings or the Final Phase II Base Building and Site Plans by notifying Landlord thereof in writing (a "Base Building Tenant Change Order Request"), which Base Building Tenant Change Order Request shall detail the nature and extent of any requested Base Building Changes, including, without limitation, (a) the Base Building Change, and (b) any modification of the Final Phase I Base Building and Site Plans, the Phase II Working Drawings or the Final Phase II Base Building and Site Plans, as applicable. If the nature of a Base Building Change requires revisions to the Final Phase I Base Building and Site Plans, the Phase II Working Drawings or the Final Phase II Base Building and Site Plans, as applicable, or would cause a delay in the Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in Landlord's Construction Work Schedule), then Tenant shall be solely responsible for the cost and expense of such revisions. In the event Landlord approves or is deemed to have approved of any such Base Building Change resulting from a Base Building Tenant Change Order Request in accordance with Section 2.5(a)(ii) below, Landlord shall: (1) notify Tenant if it reasonably believes such Base Building Change could cause a delay in the Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in Landlord's Construction Work Schedule); and (2) provide Landlord's reasonable estimate of any additional costs and expenses associated with such Base Building Change. Tenant shall deposit with Landlord the additional cost and expense payable by Landlord, as reasonably estimated by Landlord, to complete the Base Building Tenant Change Order Request (the "Base Building Deposit") within thirty (30) days following Tenant's receipt of Landlord's written estimate. In the event that such Base Building Deposit is not sufficient to cover the actual cost of such approved Base Building Change, Tenant shall reimburse Landlord the difference between the actual cost of such Base Building Change and the Base Building Deposit within thirty (30) days following Tenant's receipt of an invoice therefor, which invoice shall include reasonable back-up documentation with respect to the amount of such difference. In the event that such Base Building Deposit exceeds the actual cost of such approved Base Building Change, Landlord shall return such excess amount to Tenant within thirty (30) days following the completion of such approved Base Building Change. Base Building Tenant Change Order Requests shall be signed by Tenant's Authorized Representative.

(ii) Landlord's Approval of Base Building Changes. Landlord shall have five (5) business days after receipt of a Base Building Tenant Change Order Request to notify Tenant in writing of Landlord's approval or rejection of the Tenant-requested Base Building Change, which approval shall not be unreasonably withheld or conditioned so long as such Base Building Change requested by Tenant could not reasonably be expected, as reasonably determined by Landlord, to cause a Design Problem or a delay in Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule). If Landlord fails to respond within such five (5)-business day period, then Tenant shall provide Landlord with a second written notice stating that "Landlord's failure to respond within three (3) days after Tenant's second notice shall be deemed Landlord's approval to such Base Building Tenant Change Order Request," and if Landlord does not respond within such three (3) day period, then Landlord shall be deemed to have approved such Base Building Tenant Change

Order Request, and Tenant shall be permitted to cause Landlord to alter the Phase I Base Building and Site Work or the Phase II Base Building and Site Work, as contemplated by such Base Building Tenant Change Order Request.

(b) Changes Requested by Landlord.

(i) Base Building Landlord Change Order Request. Landlord may request Base Building Changes to the Final Phase I Base Building and Site Plans, the Phase II Working Drawings or the Final Phase II Base Building and Site Plans by notifying Tenant thereof in writing (a "Base Building Landlord Change Order Request"), which Base Building Landlord Change Order Request shall detail the nature and extent of any requested Base Building Changes, including, without limitation, (a) the Base Building Change, and (b) any modification of the Final Phase I Base Building and Site Plans, the Phase II Working Drawings or the Final Phase II Base Building and Site Plans, as applicable, and any delay in the Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule), necessitated by the Base Building Change. In the event Tenant approves or is deemed to have approved of any such Base Building Change resulting from a Base Building Landlord Change Order Request in accordance with Section 2.5(b)(ii) below, Landlord shall be solely responsible for any and all any additional costs and expenses associated with such Base Building Change. Base Building Landlord Change Order Requests shall be signed by Landlord's Authorized Representative.

(ii) Tenant's Approval of Base Building Change. Tenant shall have five (5) business days after receipt of a Base Building Landlord Change Order Request to notify Landlord in writing of Tenant's approval or rejection of the Landlord-requested Base Building Change, which approval shall not be unreasonably withheld or conditioned so long as such Base Building Change requested by Landlord could not reasonably be expected, as reasonably determined by Tenant, to interfere with Tenant's ability to operate its business in the Premises or cause a delay in Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule). If Tenant fails to respond within such five (5)-business day period, then Landlord shall provide Tenant with a second written notice stating that "Tenant's failure to respond within three (3) days after Landlord's second notice shall be deemed Tenant's approval to such Base Building Landlord Change Order Request," and if Tenant does not respond within such three (3) day period, then Tenant shall be deemed to have approved such Base Building Landlord Change Order Request, and Landlord shall be permitted to alter the Phase I Base Building and Site Work or the Phase II Base Building and Site Work, as contemplated by such Base Building Landlord Change Order Request.

(c) Base Building Permitted Changes. Notwithstanding anything to the contrary contained in this Work Letter, neither Landlord nor Tenant shall disapprove a Base Building Permitted Change requested by the other. For purposes of this Work Letter, a "Base Building Permitted Change" shall mean: (i) minor field changes; (ii) changes required by governmental authority; (iii) with respect to the Phase II Working Drawings only, any change required to make such drawings consistent with or Logical Evolutions of the approved Phase II Design Plans; (iv) with respect to the Final Phase I Base Building and Site Plans and the Final Phase II Base Building

and Site Plans, any changes that would constitute Logical Evolutions thereof; and (v) any other changes that: (1) do not materially and adversely affect the Building Structure and Building Systems to be constructed as part of the Phase I Base Building and Site Work or the Phase II Base Building and Site Work, as applicable, (2) do not materially change the size, cost, configuration, or overall appearance of the Project or Landlord's ability to construct the Phase I Base Building and Site Work or the Phase II Base Building and Site Work, as applicable, (3) do not materially change the size, cost, configuration, or overall appearance of Phase I Tenant Improvements or the Phase II Tenant Improvements, as applicable, or Tenant's ability to operate its business in the Project, and (4) will not cause a delay in Substantial Completion of the Phase I Work or the Phase II Work, as applicable (and in each case as set forth in the Landlord's Construction Work Schedule). Additionally, notwithstanding to anything the contrary contained in this Work Letter, Landlord shall not be required to provide Tenant with notice or obtain Tenant's approval of any Base Building Change that satisfies the requirements set forth in (1) through (4) of subsection (v) of this paragraph.

(d) The Final Phase I Base Building and Site Plans, as modified by any Base Building Changes thereto that are approved in accordance with this Section 2.5 above, including any Base Building Permitted Changes thereto (collectively, the "Approved Phase I Base Building and Site Plans"), and the Final Phase II Base Building and Site Plans, as modified by any Base Building Changes thereto that are approved in accordance with this Section 2.5 above, including any Base Building Permitted Changes thereto (collectively, the "Approved Phase II Base Building and Site Plans"), are collectively referred to herein as the "Approved Base Building and Site Plans" and shall become part of the Lease as though set forth in full.

3. Tenant Improvements.

3.1. Phase I Tenant Improvements. Landlord shall, at Landlord's sole cost and expense (subject to Section 3.6 below), cause TI Contractor (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed) to commence and thereafter diligently prosecute to completion the construction of the tenant improvements to the Existing Building (the "Phase I Tenant Improvements") in accordance with the Final Phase I TI Plans (defined below), Landlord's Construction Work Schedule with respect thereto, and subject only to those changes approved in accordance with Section 3.6 below. The Phase I Tenant Improvements shall be performed in accordance with industry custom and practice for a "first-class" office project (taking into account that the Phase I Work involves a material restoration and renovation of a historic building), and in compliance with all Applicable Laws. The commencement and completion of the Phase I Tenant Improvements shall be subject to delays resulting from acts of Force Majeure.

3.2. Final Phase I TI Plans. Landlord shall cause the TI Architect (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed) to prepare working drawings for the Phase I Tenant Improvements (the "Phase I TI Working Drawings") that: (a) are consistent with and are Logical Evolutions of those certain space plans dated April 9, 2012 (and last revised on December 10, 2012) and prepared by the TI Architect, which are attached hereto as **Schedule 3** and are hereby approved by Tenant (the "Approved Phase I TI Space Plans"), (b) incorporate TI Permitted Changes, and

(c) incorporate any other Landlord-requested (and Tenant approved) TI Changes. As soon as Phase I TI Working Drawings are completed, Landlord shall deliver the same to Tenant for Tenant's approval, which approval may be reasonably withheld only if: (i) the Phase I TI Working Drawings are not consistent with or Logical Evolutions of the Approved Phase I TI Space Plans, (ii) Tenant intends to request changes to the Phase I TI Working Drawings in accordance with Section 3.6(a)(i) (other than TI Permitted Changes), or (iii) Tenant objects to any Landlord-requested TI Change (other than TI Permitted Changes) to the Phase I TI Working Drawings. Such Phase I TI Working Drawings shall be approved or disapproved by Tenant within ten (10) business days after delivery to Tenant. If Tenant fails to notify Landlord of disapproval within such ten (10)-business day period, then Tenant shall be deemed to have approved such Phase I TI Working Drawings. If the Phase I TI Working Drawings are disapproved by Tenant, Tenant shall notify Landlord in writing of its objections to such Phase I TI Working Drawings and, if applicable, shall submit any requested TI Changes through a TI Tenant Change Order Request (as defined below), then the parties shall confer and negotiate in good faith to reach agreement on the Phase I TI Working Drawings (thereafter, the "Final Phase I TI Plans"). Promptly after the Final Phase I TI Plans are approved by Landlord and Tenant, two (2) copies of such Final Phase I TI Plans shall be initialed and dated by Landlord and Tenant as soon as approved by Landlord and Tenant and Landlord shall promptly submit such Final Phase I TI Plans to all appropriate governmental agencies for approval.

3.3. Phase II Tenant Improvements. Landlord shall, at Landlord's sole cost and expense (subject to Section 3.6 below), cause TI Contractor (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed) to commence and thereafter diligently prosecute to completion the construction of the tenant improvements to the New Building (the "Phase II Tenant Improvements") in accordance with the Final Phase II TI Plans (as defined below), Landlord's Construction Work Schedule with respect thereto, and subject only to those changes approved in accordance with Section 3.6 below. The Phase II Tenant Improvements shall be performed in accordance with industry custom and practice for a "first-class" office project (taking into account that the Phase I Work involves a material restoration and renovation of a historic building), and in compliance with all Applicable Laws. The commencement and completion of the Tenant Improvements shall be subject to delays resulting from acts of Force Majeure.

3.4. Phase II TI Space Plans. Landlord shall cause the TI Architect (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed), with Tenant's cooperation, to prepare and submit to Tenant for approval, space plans for the Phase II Tenant Improvements that are substantially consistent with the general standard and scope of the Final Phase I TI Plans (the "Phase II TI Space Plans"). The Phase II TI Space Plans shall contain sufficient information and detail to accurately describe the proposed design to Tenant and such other information as Tenant may reasonably request. Tenant shall be solely responsible for ensuring that the Phase II TI Space Plans satisfy Tenant's business requirements. Tenant shall notify Landlord in writing within ten (10) business days after receipt of the Phase II TI Space Plans whether Tenant approves or reasonably disapproves of the Phase II TI Space Plans and the manner, if any, in which the Phase II TI Space Plans are reasonable objectionable. If Tenant reasonably objects to the Phase II TI Space Plans, then Landlord shall cause the TI Architect (with Tenant's cooperation) to revise the Phase II TI Space Plans to address

Tenant's reasonable objections thereto. Landlord shall then resubmit the revised Phase II TI Space Plans to Tenant for approval within seven (7) business days after Landlord received Tenant's comments to the Phase II TI Space Plans. Tenant's approval of or reasonable objection to revised Phase II TI Space Plans and Landlord's correction of the same shall be in accordance with this Section 3.4, until Tenant has approved the Phase II TI Space Plans in writing. Tenant shall not unreasonably withhold its approval of any iteration of the Phase II TI Space Plans so long as such iteration is substantially consistent with the standard and scope of the Final Phase I TI Plans . The iteration of the Phase II TI Space Plans that is approved by Tenant without objection shall be referred to herein as the " Approved Phase II TI Space Plans."

3.5. Final Phase II TI Plans. Landlord shall cause the TI Architect (or such replacement thereof as Landlord may make from time to time with Tenant's approval, which approval shall not be unreasonably withheld or delayed) to prepare working drawings for the Phase II Tenant Improvements (the "Phase II TI Working Drawings") that: (a) are consistent with and are Logical Evolutions of the Approved Phase II TI Space Plans, (b) incorporate TI Permitted Changes, and (c) incorporate any other Landlord-requested (and Tenant approved) TI Changes. As soon as Phase II TI Working Drawings are completed, Landlord shall deliver the same to Tenant for Tenant's approval, which approval may be reasonably withheld only if: (i) the Phase II TI Working Drawings are not consistent with or Logical Evolutions of the Approved Phase II TI Space Plans, (ii) Tenant intends to request changes to the Phase II TI Working Drawings in accordance with Section 3.6(a)(i) (other than TI Permitted Changes), or (iii) Tenant objects to any Landlord-requested TI Change (other than TI Permitted Changes) to the Phase II TI Working Drawings. Such Phase II TI Working Drawings shall be approved or disapproved by Tenant within ten (10) business days after delivery to Tenant. If Tenant fails to notify Landlord of disapproval within such ten (10)-business day period, then Tenant shall be deemed to have approved such Phase II TI Working Drawings. If the Phase II TI Working Drawings are disapproved by Tenant, Tenant shall notify Landlord in writing of its objections to such Phase II TI Working Drawings and, if applicable, shall submit any requested TI Changes through a TI Tenant Change Order Request (as defined below), then the parties shall confer and negotiate in good faith to reach agreement on the Phase II TI Working Drawings (thereafter, the " Final Phase II TI Plans"). Promptly after the Final Phase II TI Plans are approved by Landlord and Tenant, two (2) copies of such Final Phase II TI Plans shall be initialed and dated by Landlord and Tenant as soon as approved by Landlord and Tenant and Landlord shall promptly submit such Final Phase II TI Plans to all appropriate governmental agencies for approval.

3.6. Changes to Tenant Improvements. Any changes to the Final Phase I TI Plans, the Phase II TI Working Drawings or the Final Phase II TI Plans (each, a "TI Change") requested by Landlord or Tenant shall be requested and instituted in accordance with the provisions of this Section 3.6 and, except for TI Permitted Changes, shall be subject to the written approval of the other party in accordance with this Work Letter.

(a) TI Changes Requested by Tenant.

(i) TI Tenant Change Order Request. Tenant may request TI Changes to the Final Phase I TI Plans, the Phase II TI Working Drawings or the Final Phase II TI Plans by notifying Landlord thereof in writing (a " TI Tenant Change Order Request"), which TI

Tenant Change Order Request shall detail the nature and extent of any requested TI Changes, including, without limitation, (a) the TI Change, and (b) any modification of the Final Phase I TI Plans, the Phase II TI Working Drawings or the Final Phase II TI Plans, as applicable. If the nature of a TI Change requires revisions to the Final Phase I TI Plans, the Phase II TI Working Drawings or the Final Phase II TI Plans, as applicable, or would cause a delay in Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule), then Tenant shall be solely responsible for the cost and expense of such revisions (except to the extent that such TI Change is required as the result of a Landlord-requested Base Building Change that has been approved by Tenant pursuant to Section 2.5(b)(ii) above, in which case such cost and expense shall be part of Landlord's Turnkey Costs (as defined below)). In the event Landlord approves or is deemed to have approved of any such TI Change resulting from a TI Tenant Change Order Request in accordance with Section 3.6(a)(ii) below, Landlord shall: (1) notify Tenant if it reasonably believes such TI Change could cause a delay in Substantial Completion of the Phase I Work or the Phase II Work (in each case as set forth in the Landlord's Construction Work Schedule); and (2) provide Landlord's reasonable estimate of any additional costs and expenses associated with such TI Change. Tenant shall deposit with Landlord the additional cost and expense payable by Landlord, as reasonably estimated by Landlord, to complete the TI Tenant Change Order Request (the "TI Deposit") within thirty (30) days following Tenant receipt of Landlord's written estimate. In the event such TI Deposit is not sufficient to cover the actual cost of such approved TI Change, Tenant shall reimburse Landlord the difference between the actual cost of such TI Change and the TI Deposit within thirty (30) days following Tenant's receipt of an invoice therefor, which invoice shall include reasonable back-up documentation with respect to the amount of such difference. In the event such TI Deposit exceeds the actual cost of such approved Base Building Change, Landlord shall return such excess amount to Tenant within thirty (30) days following the completion of such approved TI Change. TI Tenant Change Order Requests shall be signed by Tenant's Authorized Representative.

(ii) Landlord's Approval of TI Changes. Landlord shall have five (5) business days after receipt of a TI Tenant Change Order Request to notify Tenant in writing of Landlord's approval or rejection of the Tenant-requested TI Change, which approval shall not be unreasonably withheld or conditioned so long as such TI Change requested by Tenant could not reasonably be expected, as reasonably determined by Landlord, to cause a Design Problem or cause a delay in Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule). If Landlord fails to respond within such five (5)-business day period, then Landlord shall be deemed to have approved such TI Tenant Change Order Request, and Tenant shall be permitted to cause Landlord to alter the Phase I Tenant Improvements or the Phase II Tenant Improvements, as contemplated by such TI Tenant Change Order Request.

(b) TI Changes Requested by Landlord.

(i) TI Landlord Change Order Request. Landlord may request TI Changes to the Final Phase I TI Plans, the Phase II TI Working Drawings or the Final Phase II TI Plans by notifying Tenant thereof in writing (a "TI Landlord Change Order Request"), which TI Landlord Change Order Request shall detail the nature and extent of any requested TI Changes,

including, without limitation, (a) the TI Change, and (b) any modification of the Final Phase I TI Plans, the Phase II TI Working Drawings or the Final Phase II TI Plans, as applicable, and any delay in the Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule), necessitated by the TI Change. In the event Tenant approves or is deemed to have approved of any such TI Change resulting from a TI Landlord Change Order Request in accordance with Section 3.6(b)(ii) below, Landlord shall be solely responsible for any and all any additional costs and expenses associated with such TI Change as part of the Turnkey Costs. TI Landlord Change Order Requests shall be signed by Tenant's Authorized Representative.

(ii) Tenant's Approval of TI Change. Tenant shall have five (5) business days after receipt of a TI Landlord Change Order Request to notify Landlord in writing of Tenant's approval or rejection of the Landlord-requested TI Change, which approval shall not be unreasonably withheld or conditioned so long as such TI Change requested by Landlord could not reasonably be expected, as reasonably determined by Tenant, to interfere with Tenant's ability to operate its business in the Premises or cause a delay in Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule). If Tenant fails to respond within such five (5)-business day period, then Tenant shall be deemed to have approved such TI Landlord Change Order Request, and Landlord shall be permitted to alter the Phase I Tenant Improvements or the Phase II Tenant Improvements, as contemplated by such TI Landlord Change Order Request.

(c) TI Permitted Changes. Notwithstanding anything to the contrary contained in this Work Letter, neither Landlord nor Tenant shall disapprove a TI Permitted Change requested by the other. For purposes of this Work Letter, a "TI Permitted Change" shall mean: (i) minor field changes; (ii) changes required by governmental authority; (iii) with respect to the Phase II TI Working Drawings only, any change required to make such plans consistent with or Logical Evolutions of the Approved Phase II TI Space Plans; (iv) with respect to the Final Phase I TI Plans and the Final Phase II TI Plans, any changes that would constitute Logical Evolutions thereof; and (v) any other changes that: (1) do not materially and adversely affect the Building Structure and Building Systems to be constructed as part of the Phase I Tenant Improvements or Phase II Tenant Improvements, as applicable, (2) do not materially change the size, cost, configuration, or overall appearance of the Phase I Tenant Improvements or the Phase II Tenant Improvements, as applicable, or Tenant's ability to operate its business in the Project, and (3) will not cause a delay in Substantial Completion of the Phase I Work or the Phase II Work, as applicable (in each case as set forth in the Landlord's Construction Work Schedule). Additionally, notwithstanding anything the contrary contained in this Work Letter, Landlord shall not be required to provide Tenant with notice or obtain Tenant's approval of any TI Change that satisfies the requirements set forth in (1) through (3) of subsection (v) of this paragraph.

(d) The Final Phase I TI Plans, as modified by any TI Changes thereto that are approved in accordance with this Section 3.6 above, including any TI Permitted Changes thereto (collectively, the "Approved Phase I TI Plans"), and the Final Phase II TI Plans, as modified by any TI Changes thereto that are approved in accordance with this Section 3.6 above, including any TI

Permitted Changes thereto (collectively, the "Approved Phase II TI Plans"), are collectively referred to herein as the "Approved TI Plans" and shall become part of the Lease as though set forth in full.

3.7. Turnkey Costs. Subject to Section 3.6 above, Landlord shall be responsible for the costs and expenses of constructing the Tenant Improvements (as further described herein, the "Turnkey Costs"). The "Turnkey Costs" shall include the costs of (i) construction, (ii) space planning, architect, engineering and other related services, (iii) costs and expenses for labor, materials, building system equipment and fixtures, (iv) building permits and other taxes, fees, charges and levies by governmental and quasi-governmental agencies for permits or for inspections of the Tenant Improvements, and (v) any costs and expenses of Landlord pursuant to Section 3.6 above. Notwithstanding the foregoing, in no event shall Turnkey Costs include the costs of (w) any security, low voltage cable, telephone cable/switch handsets, relocation, technology, audio visual equipment or signage; (x) any furniture, personal property or other non-building system equipment, (y) resulting from any default by Tenant of its obligations under the Lease, or (z) costs that are recoverable or reasonably recoverable by Tenant from a third party (e.g., insurers, warrantors or tortfeasors).

3.8. Completion of Phase I Work. The Phase I Work shall be deemed "Substantially Complete" or there shall be "Substantial Completion" thereof if (i) Landlord has completed, in compliance with all Applicable Laws, (a) all of the Phase I Base Building and Site Work identified on and substantially in accordance with the Approved Phase I Base Building and Site Plans, and (b) all of the Phase I Tenant Improvements identified on and substantially in accordance with the Approved Phase I TI Plans, subject only to such incomplete or defective work as will not materially or adversely impact Tenant's continuous and uninterrupted use of Phase I (including the Existing Building and the Phase I On-Site Parking Spaces) for its permitted use pursuant to the Lease following the Substantial Completion of the Phase I Work (collectively, the "Phase I Punchlist Items"), and minor deviations that do not alter the type, scope and quality of the Phase I Tenant Improvements depicted on the Approved Phase I TI Plans, (ii) Tenant is provided with continuous and uninterrupted use of the Existing Building and the Phase I On-Site Parking Spaces for its permitted use pursuant to the Lease, except to the extent reasonably necessary for TI Contractor to complete any Phase I Punchlist Items, and (iii) Landlord has obtained a certificate of occupancy or temporary certificate of occupancy (or its equivalent) allowing Tenant to legally occupy the Existing Building. Landlord shall cause the TI Contractor to complete with reasonable promptness the Phase I Punchlist Items and repair with reasonable promptness all defects in the construction of the Phase I Work as to which Tenant notifies Landlord in writing (which notice Tenant shall give within ten (10) business days following the Commencement Date for the Existing Building). Notwithstanding the foregoing, Landlord shall cause all Phase I Punchlist Items that reasonably can be completed within forty-five (45) days after Substantial Completion of the Phase I Work to be completed within such forty-five (45)-day period (subject to availability of materials). Except for such Phase I Punchlist Items and except for latent defects and non-compliance of Phase I Work with Applicable Laws, Tenant shall, subject to the terms hereof, be deemed to have accepted the Phase I Work in the condition delivered to it "As Is," provided, however, that the Phase I Work shall be subject to the Landlord warranties set forth in General Condition B of the Lease.

3.9. Completion of Phase II Work. The Phase II Work shall be deemed "Substantially Complete" or there shall be "Substantial Completion" thereof if (i) Landlord has completed, in compliance with all Applicable Laws, (a) all of the Phase II Base Building and Site Work identified on and substantially in accordance with the Approved Phase II Base Building and Site Plans, and (b) all of the Phase II Tenant Improvements identified on and substantially in accordance with the Approved Phase II TI Plans, subject only to such incomplete or defective work as will not materially or adversely impact Tenant's continuous and uninterrupted use of Phase II (including the New Building and the Phase II On-Site Parking Spaces) for its permitted use pursuant to the Lease following the Substantial Completion of the Phase II Work (collectively, the "Phase II Punchlist Items"), and minor deviations that do not alter the type, scope and quality of the Phase II Tenant Improvements depicted on the Approved Phase II TI Plans, (ii) Tenant is provided with continuous and uninterrupted use of the New Building and the Phase II On-Site Parking Spaces for its permitted use pursuant to the Lease, except to the extent reasonably necessary for TI Contractor to complete any Phase II Punchlist Items, and (iii) Landlord has obtained a certificate of occupancy or temporary certificate of occupancy (or its equivalent) allowing Tenant to legally occupy the New Building. Landlord shall cause the TI Contractor to complete with reasonable promptness the Phase II Punchlist Items and repair with reasonable promptness all defects in the construction of the Phase II Work as to which Tenant notifies Landlord in writing (which notice Tenant shall give within ten (10) business days following the Commencement Date for the New Building). Notwithstanding the foregoing, Landlord shall cause all Phase II Punchlist Items that reasonably can be completed within forty-five (45) days after Substantial Completion of the Phase II Work to be completed within such forty-five (45)-day period (subject to availability of materials) . Except for such Phase II Punchlist Items and except for latent defects and non-compliance of Phase II Work with Applicable Laws, Tenant shall, subject to the terms hereof, be deemed to have accepted the Phase II Work in the condition delivered to it "As Is," provided, however, that the Phase II Work shall be subject to the Landlord warranties set forth in General Condition B of the Lease.

4. Tenant Delay. Landlord shall endeavor (but shall not be obligated) to tender possession of each Phase of the Project on or before the applicable Scheduled Commencement Date. If the Phase I Work or the Phase II Work, as applicable, as required pursuant to the terms of this Work Letter, is not Substantially Complete on or before the applicable Scheduled Commencement Date for any reason whatsoever, then, except as provided in the Lease, the Lease shall not be void or voidable, Landlord shall not be liable to Tenant for any loss or damage resulting therefrom and the applicable Commencement Date shall not occur until Substantial Completion of the Phase I Work or the Phase II Work, as applicable, occurs; provided, however, if the satisfaction of the requirements for Substantial Completion of the Phase I Work or the Phase II Work, as applicable, have been actually delayed by any Tenant Delay (as defined below), then, subject to the terms hereof, Substantial Completion of the Phase I Work or the Phase II Work, as applicable, shall be deemed to occur when (as reasonably determined and substantiated by Landlord) Substantial Completion of the Phase I Work or the Phase II Work, as applicable, would have occurred if such Tenant Delay had not occurred. "Tenant Delay" shall mean: (1) delays or failure of Tenant to deliver items in accordance with this Work Letter; (2) Tenant's failure to timely fulfill its obligations as set forth in this Work Letter within the time periods set forth therein; (3) delays caused by Base Building Tenant Change Order Requests or TI Tenant Change Order Requests; (4) unavailability of materials, components or finishes for the Tenant Improvements that have an unusually long lead-time for delivery (unless

Landlord, the TI Contractor or any subcontractors or suppliers fail to timely order such items); (5) a willful or negligent act or omission of Tenant or Tenant's consultants, vendors, contractors, subcontractors, or agents that interferes with the progress of the work; or (6) any other event or circumstance expressly described as a Tenant Delay in this Work Letter. Landlord shall not assess any day towards a Tenant Delay for delays caused by Landlord, any architect, engineering consultant, design team, general contractor, subcontractor or vendor selected by Landlord or any third parties or due to Force Majeure. Notwithstanding anything above to the contrary, (i) no delay shall be considered a Tenant Delay unless Landlord provides Tenant written notice of such Tenant Delay within ten (10) days of the date that Landlord becomes aware of the occurrence of a Tenant Delay, and Tenant fails to cure such delay within three (3) days; provided that no such notice and cure period shall be required if such delay is with respect to interference with the Landlord's construction activities and Landlord has previously notified Tenant of similar Tenant Delays, and (ii) no delay shall be considered a Tenant Delay in the event Substantial Completion of the Phase I Work or the Phase II Work, as applicable, occurs on or before the applicable Scheduled Commencement Date. Landlord and its contractors shall take commercially reasonable actions, remedial or otherwise, to complete the Phase I Work and the Phase II Work by the applicable Scheduled Commencement Dates notwithstanding any Tenant Delay. All additional cost and expense payable by Landlord, if any, to complete the Phase I Work or the Phase II Work due to Tenant Delay ("Tenant Delay Costs"), shall be paid by Tenant within thirty (30) days following Tenant's receipt of an invoice therefor, which invoice shall include reasonable back-up documentation with respect to such Tenant Delay Costs.

5. Requests for Consent. Except as otherwise provided in this Work Letter, each of Landlord and Tenant shall respond to all requests for consents, approvals or directions made by the other pursuant to this Work Letter within five (5) business days following such party's receipt of such request from the other. If a party fails to respond within such five (5)-business day period, then the non-responding party shall be deemed to have approved such item.

6. Completion of Landlord's Construction Work. Without limiting any other provision of this Work Letter, Landlord shall complete Landlord's Construction Work described in this Work Letter in all respects in accordance with the provisions of the Lease and this Work Letter. Landlord's Construction Work shall be deemed completed at such time as Landlord shall furnish to Tenant evidence that (a) all Landlord's Construction Work has been completed (which shall be evidenced by the Base Building Architect's and the TI Architect's respective certificates of completion certifying that all work performed in, on or about the Project is in accordance with the Approved Base Building and Site Plans and the Approved TI Plans) and paid for in full (or for which final lien waivers have otherwise been obtained), and (b) all certifications and approvals with respect to Landlord's Construction Work that may be required from any governmental authority and any board of fire underwriters or similar body for the use and occupancy of the Premises have been obtained.

7. Miscellaneous.

7.1. Headings, Etc. Where applicable in this Work Letter, the singular includes the plural and the masculine or neuter includes the masculine, feminine and neuter. The Section headings of

this Work Letter are not a part of this Work Letter and shall have no effect upon the construction or interpretation of any part hereof.

7.2. Time of the Essence. Time is of the essence with respect to the performance of every provision of this Work Letter in which time of performance is a factor.

7.3. Covenants. Each provision of this Work Letter performable by Landlord or Tenant shall be deemed both a covenant and a condition.

7.4. Consent. Whenever consent or approval of either party is required, that party shall not unreasonably withhold, condition or delay such consent or approval, except as may be expressly set forth to the contrary. Whenever the written consent or approval of either party is required, such consent or approval may be provided in the form of electronic mail from Landlord's Authorized Representative or Tenant's Authorized Representative, as applicable.

7.5. Entire Agreement. The terms of this Work Letter are intended by the parties as a final expression of their agreement with respect to the terms as are included herein, and may not be contradicted by evidence of any prior or contemporaneous agreement, other than the Lease. To the extent there is any conflict between the terms of this Work Letter and the terms of the Lease, with respect to the design, construction or performance of Landlord's Construction Work, the terms and provisions of this Work Letter shall control.

7.6. Invalid Provisions. Any provision of this Work Letter that shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision hereof, and all other provisions of this Work Letter shall remain in full force and effect and shall be interpreted as if the invalid, void or illegal provision did not exist.

7.7. Construction. The language in all parts of this Work Letter shall be in all cases construed as a whole according to its fair meaning and not strictly for or against either Landlord or Tenant.

7.8. Assigns. Each of the covenants, conditions and agreements herein contained shall inure to the benefit of and shall apply to and be binding upon the parties hereto and their respective heirs; legatees; devisees; executors; administrators; and permitted successors, assigns, sublessees. Nothing in this Section 7.8 shall in any way alter the provisions of the Lease restricting assignment or subletting.

7.9. Authority. That individual or those individuals signing this Work Letter guarantee, warrant and represent that said individual or individuals have the power, authority and legal capacity to sign this Work Letter on behalf of and to bind all entities, corporations, partnerships, limited liability companies, joint venturers or other organizations and entities on whose behalf said individual or individuals have signed.

7.10. Counterparts. This Work Letter may be executed in one or more counterparts, each of which, when taken together, shall constitute one and the same document.

7.11. Notice of Completion. Within thirty (30) days after completion of construction of Landlord's Construction Work, Landlord shall cause a Notice of Completion to be recorded in the office of the Recorder of the County in which the Project is located and shall furnish a copy thereof to Tenant upon such recordation.

7.12. No Fee to Landlord. Except as otherwise provided in the Lease, Landlord shall receive no fee for supervision, profit, over overhead in connection with the Landlord's Construction Work. In no event shall this Section 7.12 limit the fees that are payable to the architect, engineering consultants, design team, general contractor, subcontractors and any third-party construction manager .

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IN WITNESS WHEREOF, Landlord and Tenant have executed this Work Letter to be effective on the date first above written.

LANDLORD:

6th & PINE, LLC,
a California limited liability company

By: __
Name: __
Title: __

TENANT:

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: __
Name: __
Title: __

SCHEDULE 1

Landlord's Construction Work Schedule

[see attached]

SCHEDULE 2

Drawing Log for Final Phase I Base Building and Site Plans

[see attached]

SCHEDULE 3

Approved Phase I TI Space Plans

[see attached]

MILLWORKS

PRESS TELEGRAM REDEVELOPMENT

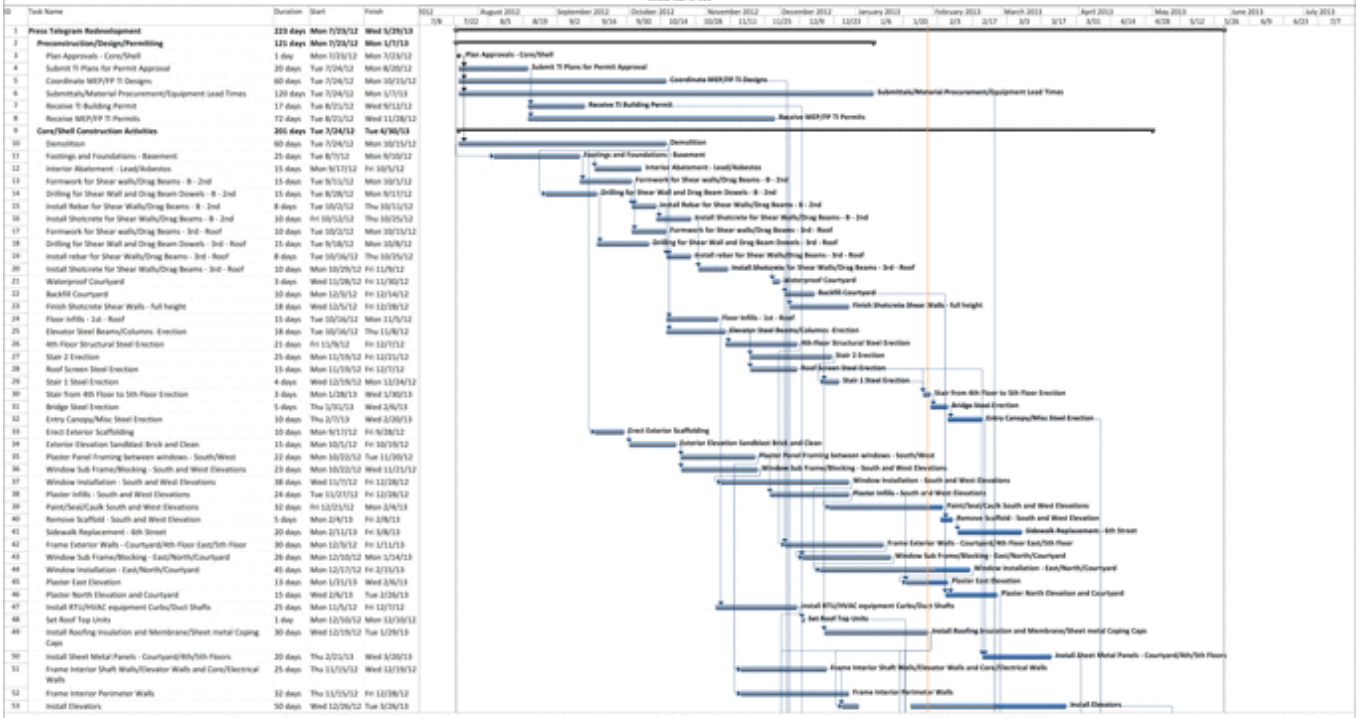
LONG BEACH, CA

CONSTRUCTION SCHEDULE

JANUARY 30, 2013 PROGRESS UPDATE

ARCO No. N-410

ARCO National Construction Company, Inc.



ID	Task Name	Duration	Start	Finish
1	**Press Telegram Redevelopment**	**223 days**	**Mon 7/23/12**	**Wed 5/29/13**
2	**Preconstruction/Design/Permitting**	**121 days**	**Mon 7/23/12**	**Mon 1/7/13**
3	Plan Approvals - Core/Shell	1 day	Mon 7/23/12	Mon 7/23/12
4	Submit TI Plans for Permit Approval	20 days	Tue 7/24/12	Mon 8/20/12
5	Coordinate MEP/FP TI Designs	60 days	Tue 7/24/12	Mon 10/15/12
6	Submittals/Material Procurement/Equipment Lead Times	120 days	Tue 7/24/12	Mon 1/7/13
7	Receive TI Building Permit	17 days	Tue 8/21/12	Wed 9/12/12
8	Receive MEP/FP TI Permits	72 days	Tue 8/21/12	Wed 11/28/12
9	**Core/Shell Construction Activities**	**201 days**	**Tue 7/24/12**	**Tue 4/30/13**
10	Demolition	60 days	Tue 7/24/12	Mon 10/15/12
11	Footings and Foundations - Basement	25 days	Tue 8/7/12	Mon 9/10/12
12	Interior Abatement - Lead/Asbestos	15 days	Mon 9/17/12	Fri 10/5/12
13	Formwork for Shear walls/Drag Beams - B - 2nd	15 days	Tue 9/11/12	Mon 10/1/12
14	Drilling for Shear Wall and Drag Beam Dowels - B - 2nd	15 days	Tue 8/28/12	Mon 9/17/12
15	Install Rebar for Shear Walls/Drag Beams - B - 2nd	8 days	Tue 10/2/12	Thu 10/11/12
16	Install Shotcrete for Shear Walls/Drag Beams - B - 2nd	10 days	Fri 10/12/12	Thu 10/25/12
17	Formwork for Shear walls/Drag Beams - 3rd - Roof	10 days	Tue 10/2/12	Mon 10/15/12
18	Drilling for Shear Wall and Drag Beam Dowels - 3rd - Roof	15 days	Tue 9/18/12	Mon 10/8/12
19	Install rebar for Shear Walls/Drag Beams - 3rd - Roof	8 days	Tue 10/16/12	Thu 10/25/12
20	Install Shotcrete for Shear Walls/Drag Beams - 3rd - Roof	10 days	Mon 10/29/12	Fri 11/9/12
21	Waterproof Courtyard	3 days	Wed 11/28/12	Fri 11/30/12
22	Backfill Courtyard	10 days	Mon 12/3/12	Fri 12/14/12
23	Finish Shotcrete Shear Walls - full height	18 days	Wed 12/5/12	Fri 12/28/12
24	Floor Infills - 1st - Roof	15 days	Tue 10/16/12	Mon 11/5/12
25	Elevator Steel Beams/Columns -Erection	18 days	Tue 10/16/12	Thu 11/8/12
26	4th Floor Structural Steel Erection	21 days	Fri 11/9/12	Fri 12/7/12
27	Stair 2 Erection	25 days	Mon 11/19/12	Fri 12/21/12
28	Roof Screen Steel Erection	15 days	Mon 11/19/12	Fri 12/7/12
29	Stair 1 Steel Erection	4 days	Wed 12/19/12	Mon 12/24/12
30	Stair from 4th Floor to 5th Floor Erection	3 days	Mon 1/28/13	Wed 1/30/13
31	Bridge Steel Erection	5 days	Thu 1/31/13	Wed 2/6/13
32	Entry Canopy/Misc Steel Erection	10 days	Thu 2/7/13	Wed 2/20/13
33	Erect Exterior Scaffolding	10 days	Mon 9/17/12	Fri 9/28/12
34	Exterior Elevation Sandblast Brick and Clean	15 days	Mon 10/1/12	Fri 10/19/12
35	Plaster Panel Framing between windows - South/West	22 days	Mon 10/22/12	Tue 11/20/12
36	Window Sub Frame/Blocking - South and West Elevations	23 days	Mon 10/22/12	Wed 11/21/12
37	Window Installation - South and West Elevations	38 days	Wed 11/7/12	Fri 12/28/12
38	Plaster Infills - South and West Elevations	24 days	Tue 11/27/12	Fri 12/28/12
39	Paint/Seal/Caulk South and West Elevations	32 days	Fri 12/21/12	Mon 2/4/13
40	Remove Scaffold - South and West Elevation	5 days	Mon 2/4/13	Fri 2/8/13
41	Sidewalk Replacement - 6th Street	20 days	Mon 2/11/13	Fri 3/8/13
42	Frame Exterior Walls - Courtyard/4th Floor East/5th Floor	30 days	Mon 12/3/12	Fri 1/11/13
43	Window Sub Frame/Blocking - East/North/Courtyard	26 days	Mon 12/10/12	Mon 1/14/13
44	Window Installation - East/North/Courtyard	45 days	Mon 12/17/12	Fri 2/15/13
45	Plaster East Elevation	13 days	Mon 1/21/13	Wed 2/6/13
46	Plaster North Elevation and Courtyard	15 days	Wed 2/6/13	Tue 2/26/13
47	Install RTU/HVAC equipment Curbs/Duct Shafts	25 days	Mon 11/5/12	Fri 12/7/12
48	Set Roof Top Units	1 day	Mon 12/10/12	Mon 12/10/12
49	Install Roofing Insulation and Membrane/Sheet metal Coping Caps	30 days	Wed 12/19/12	Tue 1/29/13
50	Install Sheet Metal Panels - Courtyard/4th/5th Floors	20 days	Thu 2/21/13	Wed 3/20/13
51	Frame Interior Shaft Walls/Elevator Walls and Core/Electrical Walls	25 days	Thu 11/15/12	Wed 12/19/12
52	Frame Interior Perimeter Walls	32 days	Thu 11/15/12	Fri 12/28/12
53	Install Elevators	50 days	Wed 12/26/12	Tue 3/26/13

Project: Press Telegram Redevelopment
Date: Wed 1/30/13

Task | Milestone | Summary | External Tasks | Critical | Progress

MILLWORKS

PRESS TELEGRAM REDEVELOPMENT

LONG BEACH, CA

CONSTRUCTION SCHEDULE

JANUARY 30, 2013 PROGRESS UPDATE

ARCO No. N-410

ARCO National Construction Company, Inc.

ID	Task Name	Duration	Start	Finish
54	Install Courtyard Drainage/Underground Rough-in work	15 days	Tue 2/26/13	Mon 3/18/13
55	Install Irrigation System in courtyard	15 days	Tue 3/12/13	Mon 4/1/13
56	Install waterfeature at Courtyard	15 days	Tue 3/26/13	Mon 4/15/13
57	Install Hardscape at Courtyard and around building	15 days	Tue 4/2/13	Mon 4/22/13
58	Install Landscaping	15 days	Wed 4/10/13	Tue 4/30/13
59	**Interior Fit-Out - 5th Floor**	**72 days**	**Tue 12/4/12**	**Wed 3/13/13**
60	Overhead MEP/FP Rough In - 5th Floor	8 days	Tue 12/4/12	Thu 12/13/12
61	Frame Interior Walls - 5th Floor	4 days	Mon 12/10/12	Thu 12/13/12
62	Wall Rough In - 5th Floor	5 days	Fri 12/14/12	Thu 12/20/12
63	Install Door Frames - 5th Floor	2 days	Fri 12/14/12	Mon 12/17/12
64	Hang/Tape/Finish Drywall - 5th Floor	8 days	Mon 1/21/13	Wed 1/30/13
65	Paint Walls - Prime/1st coat - 5th Floor	5 days	Wed 1/30/13	Tue 2/5/13
66	Install Ceiling Grid - 5th Floor	4 days	Wed 2/6/13	Mon 2/11/13
67	Ceiling Grid MEP/FP Rough In - 5th Floor	4 days	Tue 2/12/13	Fri 2/15/13
68	Install Ceiling Pads - 5th Floor	2 days	Mon 2/18/13	Tue 2/19/13
69	Paint Final Coat - 5th Floor	3 days	Wed 2/20/13	Fri 2/22/13
70	MEP/FP Trim Out/Start Up - 5th Floor	4 days	Mon 2/25/13	Thu 2/28/13
71	Install Doors/Hardware/Specialties - 5th Floor	4 days	Mon 2/25/13	Thu 2/28/13
72	Install Flooring and Base - 5th Floor	6 days	Fri 3/1/13	Fri 3/8/13
73	Final Cleaning - 5th Floor	3 days	Mon 3/11/13	Wed 3/13/13
74	**Interior Fit-Out - 4th Floor**	**84 days**	**Wed 12/5/12**	**Mon 4/1/13**
75	Overhead MEP/FP Rough In - 4th Floor	15 days	Wed 12/5/12	Tue 12/25/12
76	Frame Interior Walls - 4th Floor	10 days	Wed 12/19/12	Tue 1/1/13
77	Wall Rough In - 4th Floor	16 days	Mon 1/7/13	Mon 1/28/13
78	Install Door Frames - 4th Floor	4 days	Wed 1/23/13	Mon 1/28/13
79	Hang/Tape/Finish Drywall - 4th Floor	14 days	Wed 1/23/13	Mon 2/11/13
80	Paint Walls - Prime/1st coat - 4th Floor	9 days	Wed 2/6/13	Mon 2/18/13
81	Install Ceiling Grid - 4th Floor	6 days	Thu 2/7/13	Thu 2/14/13
82	Install Millwork/Cabinets - 4th Floor	7 days	Tue 2/26/13	Wed 3/6/13
83	Ceiling Grid MEP/FP Rough In - 4th Floor	10 days	Tue 2/12/13	Mon 2/25/13
84	Install Ceiling Pads - 4th Floor	4 days	Fri 2/22/13	Wed 2/27/13
85	Paint Final Coat - 4th Floor	7 days	Tue 2/26/13	Wed 3/6/13
86	MEP/FP Trim Out/Start Up - 4th Floor	8 days	Tue 3/5/13	Thu 3/14/13
87	Install Doors/Hardware/Specialties - 4th Floor	10 days	Thu 3/7/13	Wed 3/20/13
88	Install Flooring and Base - 4th Floor	10 days	Thu 3/14/13	Wed 3/27/13
89	Final Cleaning - 4th Floor	5 days	Tue 3/26/13	Mon 4/1/13
90	**Interior Fit-Out - 3rd Floor**	**87 days**	**Thu 11/22/12**	**Fri 4/19/13**
91	Overhead MEP/FP Rough In - 3rd Floor	15 days	Thu 12/20/12	Wed 1/9/13
92	Frame Interior Walls - 3rd Floor	10 days	Mon 1/21/13	Fri 2/1/13
93	Wall Rough In - 3rd Floor	15 days	Mon 1/21/13	Fri 2/8/13
94	Install Door Frames - 3rd Floor	3 days	Thu 1/31/13	Mon 2/4/13
95	Hang/Tape/Finish Drywall - 3rd Floor	15 days	Thu 2/7/13	Wed 2/27/13
96	Paint Walls - Prime/1st coat - 3rd Floor	9 days	Fri 2/22/13	Wed 3/6/13
97	Install Ceiling Grid - 3rd Floor	10 days	Mon 2/25/13	Fri 3/8/13
98	Install Millwork/Cabinets - 3rd Floor	7 days	Thu 3/14/13	Fri 3/22/13
99	Ceiling Grid MEP/FP Rough In - 3rd Floor	10 days	Wed 3/6/13	Tue 3/19/13
100	Install Ceiling Pads - 3rd Floor	4 days	Mon 3/18/13	Thu 3/21/13
101	Paint Final Coat - 3rd Floor	7 days	Wed 3/20/13	Thu 3/28/13
102	MEP/FP Trim Out/Start Up - 3rd Floor	8 days	Mon 3/25/13	Wed 4/3/13
103	Install Doors/Hardware/Specialties - 3rd Floor	10 days	Wed 3/27/13	Tue 4/9/13
104	Install Flooring and Base - 3rd Floor	10 days	Wed 4/3/13	Tue 4/16/13
105	Final Cleaning - 3rd Floor	5 days	Mon 4/15/13	Fri 4/19/13
106	**Interior Fit-Out - 2nd Floor**	**84 days**	**Fri 1/4/13**	**Wed 5/1/13**
107	Overhead MEP/FP Rough In - 2nd Floor	22 days	Fri 1/4/13	Mon 2/4/13
108	Frame Interior Walls - 2nd Floor	17 days	Wed 1/30/13	Thu 2/21/13

Project: Press Telegram Redevelopment
Date: Wed 1/30/13

Task | Milestone | Summary | External Tasks | Critical | Progress

MILLWORKS

PRESS TELEGRAM REDEVELOPMENT

LONG BEACH, CA

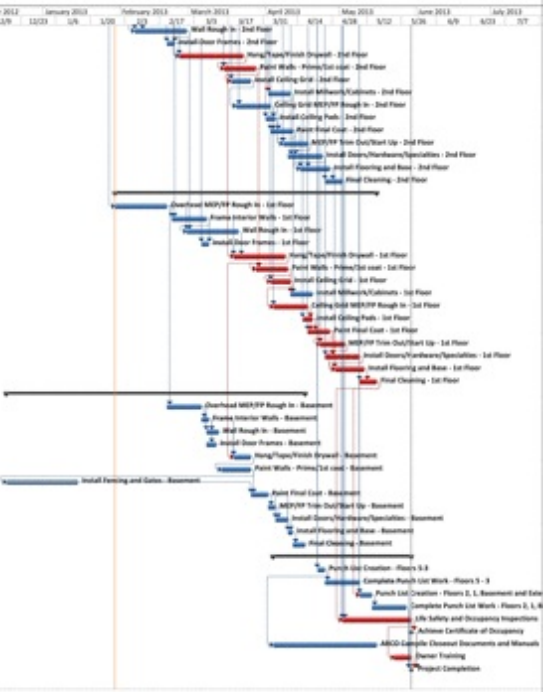
CONSTRUCTION SCHEDULE

JANUARY 30, 2013 PROGRESS UPDATE

ARCO No. N-410

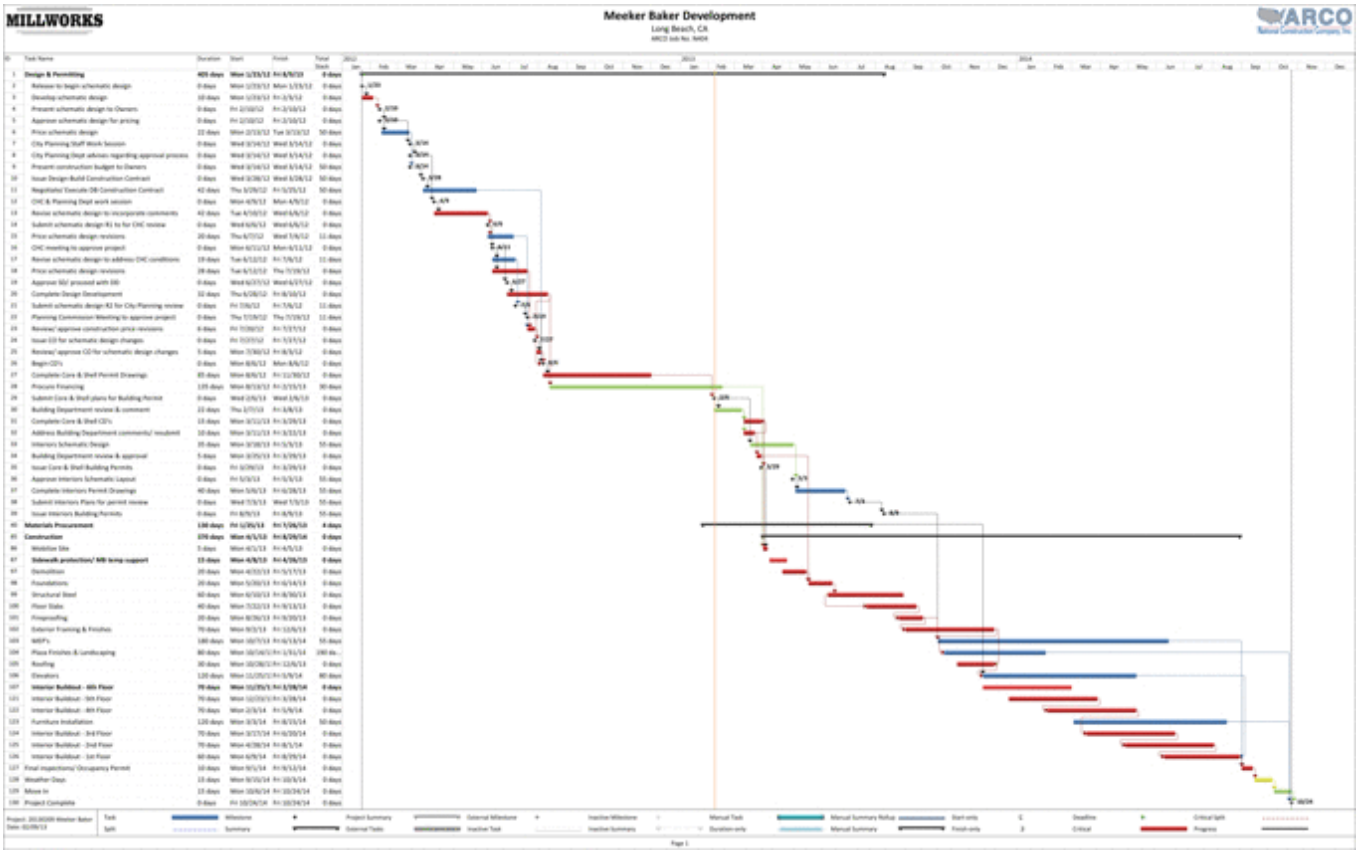
ARCO National Construction Company, Inc.

ID	Task Name	Duration	Start	Finish
109	Wall Rough In - 2nd Floor	15 days	Thu 2/7/13	Wed 2/27/13
110	Install Door Frames - 2nd Floor	3 days	Wed 2/20/13	Fri 2/22/13
111	Hang/Tape/Finish Drywall - 2nd Floor	20 days	Mon 2/25/13	Fri 3/22/13
112	Paint Walls - Prime/1st coat - 2nd Floor	9 days	Fri 3/15/13	Wed 3/27/13
113	Install Ceiling Grid - 2nd Floor	6 days	Mon 3/18/13	Mon 3/25/13
114	Install Millwork/Cabinets - 2nd Floor	7 days	Tue 4/2/13	Wed 4/10/13
115	Ceiling Grid MEP/FP Rough In - 2nd Floor	10 days	Wed 3/20/13	Tue 4/2/13
116	Install Ceiling Pads - 2nd Floor	4 days	Mon 4/1/13	Thu 4/4/13
117	Paint Final Coat - 2nd Floor	7 days	Wed 4/3/13	Thu 4/11/13
118	MEP/FP Trim Out/Start Up - 2nd Floor	8 days	Mon 4/8/13	Wed 4/17/13
119	Install Doors/Hardware/Specialties - 2nd Floor	10 days	Wed 4/10/13	Tue 4/23/13
120	Install Flooring and Base - 2nd Floor	10 days	Mon 4/15/13	Fri 4/26/13
121	Final Cleaning - 2nd Floor	5 days	Thu 4/25/13	Wed 5/1/13
122	**Interior Fit-Out - 1st Floor**	**76 days**	**Wed 1/30/13**	**Wed 5/15/13**
123	Overhead MEP/FP Rough In - 1st Floor	15 days	Wed 1/30/13	Tue 2/19/13
124	Frame Interior Walls - 1st Floor	10 days	Fri 2/22/13	Thu 3/7/13
125	Wall Rough In - 1st Floor	15 days	Thu 2/28/13	Wed 3/20/13
126	Install Door Frames - 1st Floor	3 days	Wed 3/6/13	Fri 3/8/13
127	Hang/Tape/Finish Drywall - 1st Floor	15 days	Tue 3/19/13	Mon 4/8/13
128	Paint Walls - Prime/1st coat - 1st Floor	9 days	Thu 3/28/13	Tue 4/9/13
129	Install Ceiling Grid - 1st Floor	6 days	Wed 4/3/13	Wed 4/10/13
130	Install Millwork/Cabinets - 1st Floor	7 days	Thu 4/11/13	Fri 4/19/13
131	Ceiling Grid MEP/FP Rough In - 1st Floor	10 days	Thu 4/4/13	Wed 4/17/13
132	Install Ceiling Pads - 1st Floor	4 days	Tue 4/16/13	Fri 4/19/13
133	Paint Final Coat - 1st Floor	7 days	Thu 4/18/13	Fri 4/26/13
134	MEP/FP Trim Out/Start Up - 1st Floor	8 days	Tue 4/23/13	Thu 5/2/13
135	Install Doors/Hardware/Specialties - 1st Floor	10 days	Thu 4/25/13	Wed 5/8/13
136	Install Flooring and Base - 1st Floor	10 days	Mon 4/29/13	Fri 5/10/13
137	Final Cleaning - 1st Floor	5 days	Thu 5/9/13	Wed 5/15/13
138	**Interior Fit-Out - Basement**	**87 days**	**Mon 12/17/12**	**Tue 4/16/13**
139	Overhead MEP/FP Rough In - Basement	10 days	Wed 2/20/13	Tue 3/5/13
140	Frame Interior Walls - Basement	3 days	Wed 3/6/13	Fri 3/8/13
141	Wall Rough In - Basement	3 days	Fri 3/8/13	Tue 3/12/13
142	Install Door Frames - Basement	2 days	Fri 3/8/13	Mon 3/11/13
143	Hang/Tape/Finish Drywall - Basement	5 days	Tue 3/19/13	Mon 3/25/13
144	Paint Walls - Prime/1st coat - Basement	8 days	Thu 3/14/13	Mon 3/25/13
145	Install Fencing and Gates - Basement	21 days	Mon 12/17/12	Mon 1/14/13
146	Paint Final Coat - Basement	5 days	Tue 3/26/13	Mon 4/1/13
147	MEP/FP Trim Out/Start Up - Basement	3 days	Tue 4/2/13	Thu 4/4/13
148	Install Doors/Hardware/Specialties - Basement	3 days	Fri 4/5/13	Tue 4/9/13
149	Install Flooring and Base - Basement	2 days	Wed 4/10/13	Thu 4/11/13
150	Final Cleaning - Basement	3 days	Fri 4/12/13	Tue 4/16/13
151	**Testing and Inspections**	**40 days**	**Thu 4/4/13**	**Wed 5/29/13**
152	Punch List Creation - Floors 5-3	3 days	Mon 4/22/13	Wed 4/24/13
153	Complete Punch List Work - Floors 5 - 3	10 days	Thu 4/25/13	Wed 5/8/13
154	Punch List Creation - Floors 2, 1, Basement and Exterior	3 days	Thu 5/9/13	Mon 5/13/13
155	Complete Punch List Work - Floors 2, 1, Basement and Exterior	10 days	Tue 5/14/13	Mon 5/27/13
156	Life Safety and Occupancy Inspections	20 days	Thu 5/2/13	Wed 5/29/13
157	Achieve Certificate of Occupancy	0 days	Wed 5/29/13	Wed 5/29/13
158	ARCO Compile Closeout Documents and Manuals	30 days	Thu 4/4/13	Wed 5/15/13
159	Owner Training	5 days	Thu 5/23/13	Wed 5/29/13
160	Project Completion	0 days	Wed 5/29/13	Wed 5/29/13
161				



Project: Press Telegram Redevelopment
Date: Wed 1/30/13

Task · Milestone · Summary · External Tasks · Critical · Progress


MILLWORKS
Meeker Baker Development
Long Beach, CA
ARCO
Task Name
Duration
Start
Finish
Design & Permitting
Materials Procurement
Construction
Milestone
Summary
Project Summary
Manual Task
Manual Summary
Deadline
Critical
Progress

ARCO
NATIONAL CONSTRUCTION

ARCO NATIONAL CONSTRUCTION COMPANY, INC.
900 North Rock Hill Road, Saint Louis, Missouri 63119 | OFFICE: 314.963.0715 | FAX: 314.963.7114 | www.arconational.com

EXHIBIT F - DRAWING LOG

Millworks – Press Telegram
89,702 SF Office Retrofit
ARCO Job N-410
CA License # 807644
Updated 2/6/13

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer
	Civils				
C0.01	Title Sheet	2/17/12	--	--	Kpff Consulting Engineers
C1.00	Site Plan	2/17/12	--	--	Kpff Consulting Engineers
C1.10	Erosion Control Plan	2/17/12	--	--	Kpff Consulting Engineers
C1.30	Grading & Drainage Plan	2/17/12	--	--	Kpff Consulting Engineers
C5.00	Civil Details	2/17/12	--	--	Kpff Consulting Engineers
	Landscaping				
L-1.0	Paving Details & Legend	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-1.1	Concrete Paver Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-1.2	Water Feature Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-1.3	Bench Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-2.0	Irrigation Notes	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-2.1	Landscape Irrigation Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-2.2	Landscape Irrigation Specifications & Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-2.3	Portable Planting Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-3.0	Planting Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
L-3.1	Tree Planting Details	8/21/12	4	12/10/12	Landscape Architecture Laboratory
	Architectural				
A1.0	Site Plan	8/21/12	6	2/6/13	GMA Architects, Inc.
A1.1	Architectural Site Details	8/21/12	6	2/6/13	GMA Architects, Inc.
A1.2	Architectural Site Details	8/21/12	5	1/22/13	GMA Architects, Inc.
A2.0	Basement Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
A2.1	First Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
A2.2	Second Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
A2.3	Third Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
A2.4	Fourth Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer
A2.4A	Fourth Floor Mezzanine Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
A2.5	Fifth Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
A2.6	Overall Roof Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
A5.1	Exterior Elevations	8/21/12	6	2/6/13	GMA Architects, Inc.
A5.2	Exterior Elevations	8/21/12	6	2/6/13	GMA Architects, Inc.
A5.3	Exterior Elevations	8/21/12	3	12/10/12	GMA Architects, Inc.
A5.4	Window Types	8/21/12	3	12/10/12	GMA Architects, Inc.
A5.5	Window Types	8/21/12	3	12/10/12	GMA Architects, Inc.
A5.6	Window Types	8/21/12	3	12/10/12	GMA Architects, Inc.
A5.7	Window Types	8/21/12	3	12/10/12	GMA Architects, Inc.
A6.1	Exterior Wall Sections	8/21/12	3	12/10/12	GMA Architects, Inc.
A7.1	Section Details	8/21/12	3	12/10/12	GMA Architects, Inc.
A7.2	Section Details	8/21/12	3	12/10/12	GMA Architects, Inc.
A7.3	Section Details	8/21/12	3	12/10/12	GMA Architects, Inc.
A7.4	Section Details	8/21/12	3	12/10/12	GMA Architects, Inc.

ARCO
NATIONAL CONSTRUCTION

Exhibit

F – Drawing Log 2 ARCO Job No. N-4

		Issue	Rev	Rev	

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer
A7.5	Roof Enlarged Details	8/21/12	3	12/10/12	GMA Architects, Inc.
A7.6	Architectural Details	8/21/12	3	12/10/12	GMA Architects, Inc.
A7.7	Architectural Details	8/21/12	3	12/10/12	GMA Architects, Inc.
A7.8	Canopy Details	8/21/12	6	2/6/13	GMA Architects, Inc.
A7.9	Metal Panel Detail	8/21/12	3	12/10/12	GMA Architects, Inc.
A8.1	Enlarged Stair Plans	8/21/12	3	12/10/12	GMA Architects, Inc.
A8.2	Stair Sections	8/21/12	3	12/10/12	GMA Architects, Inc.
A8.3	Stair Sections	8/21/12	3	12/10/12	GMA Architects, Inc.
A8.4	Elevator Sections	8/21/12	3	12/10/12	GMA Architects, Inc.
A8.5	Enlarged Elevation Plans	8/21/12	3	12/10/12	GMA Architects, Inc.
A9.1	UL References	8/21/12	3	12/10/12	GMA Architects, Inc.
A9.2	UL References	8/21/12	3	12/10/12	GMA Architects, Inc.
	Tenant Improvement Architectural				
TT1.0	Title Sheet	8/21/12	3	12/10/12	GMA Architects, Inc.
TT2.1	City General Notes	8/21/12	3	12/10/12	GMA Architects, Inc.
TT2.2	Accessibility Notes	8/21/12	3	12/10/12	GMA Architects, Inc.
TT3.1	Long Beach CalGreen Checklist	8/21/12	3	12/10/12	GMA Architects, Inc.
TT3.2	Long Beach CalGreen Checklist	8/21/12	3	12/10/12	GMA Architects, Inc.
TLS1.0	Basement Life Safety Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TLS1.1	1st Floor Life Safety Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TLS1.2	2nd Floor Life Safety Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TLS1.3	3rd Floor Life Safety Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TLS1.4	4th Floor Life Safety Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TLS1.5	5th Floor Life Safety Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA2.0	Basement Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.

ARCO
NATIONAL CONSTRUCTION

Exhibit

F – Drawing Log 3 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

TA2.1	1st Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA2.2	2nd Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA2.3	3rd Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA2.4	4th Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA2.4B	1st Floor Ramp Details	8/21/12	3	12/10/12	GMA Architects, Inc.
TA2.5	5th Floor Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA3.1	1st Floor Reflected Ceiling Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA3.2	2nd Floor Reflected Ceiling Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA3.3	3rd Floor Reflected Ceiling Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA3.4	4th Floor Reflected Ceiling Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA3.4A	4th Floor Ceiling Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA3.5	5th Floor Reflected Ceiling Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA4.1	Details	8/21/12	3	12/10/12	GMA Architects, Inc.
TA4.2	Partition Types	8/21/12	3	12/10/12	GMA Architects, Inc.
TA4.3	Partition Types	8/21/12	3	12/10/12	GMA Architects, Inc.
TA4.3A	Partition Types – Shell	8/21/12	3	12/10/12	GMA Architects, Inc.
TA4.4	Doors and Details – Shell	8/21/12	3	12/10/12	GMA Architects, Inc.
TA4.5	Interior Door Schedule	8/21/12	3	12/10/12	GMA Architects, Inc.
TA4.6	Doors – Interior	8/21/12	3	12/10/12	GMA Architects, Inc.
TA5.1	Door Schedule	8/21/12	3	12/10/12	GMA Architects, Inc.
TA5.2	Door Details	8/21/12	3	12/10/12	GMA Architects, Inc.
TA 6.1	Restrooms	8/21/12	3	12/10/12	GMA Architects, Inc.
TA6.2	Restrooms	8/21/12	3	12/10/12	GMA Architects, Inc.
TA6.3	Restrooms	8/21/12	3	12/10/12	GMA Architects, Inc.
TA7.1	Millwork	8/21/12	3	12/10/12	GMA Architects, Inc.

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F – Drawing Log 4 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

TA7.2	Millwork	8/21/12	3	12/10/12	GMA Architects, Inc.
TA7.3	Millwork	8/21/12	3	12/10/12	GMA Architects, Inc.
TA7.4	Lobby Elevation	8/21/12	3	12/10/12	GMA Architects, Inc.
TA8.0	Finish Schedule	8/21/12	3	12/10/12	GMA Architects, Inc.
TA8.1	1st Floor Finish Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA8.2	2nd Floor Finish Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA8.3	3rd Floor Finish Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA8.4	4th Floor Finish Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
TA8.5	5th Floor Finish Plan	8/21/12	3	12/10/12	GMA Architects, Inc.
SK-1	TA2.1 Revision	10/17/12	--	--	GMA Architects, Inc.
SK-2	TA3.1 Revision	10/17/12	--	--	GMA Architects, Inc.
SK-3	A7.9 Revision	10/17/12	--	--	GMA Architects, Inc.
SK-4	TA4.5 Revision	10/19/12	--	--	GMA Architects, Inc.
SK-5	TA2.2 Revision	10/25/12	--	--	GMA Architects, Inc.
SK-6	TA2.3 Revision	10/25/12	--	--	GMA Architects, Inc.
SK-7	TA2.4 Revision	10/25/12	--	--	GMA Architects, Inc.
SK-8	TA3.2 Revision	10/25/12	--	--	GMA Architects, Inc.
SK-9	TA3.3 Revision	10/25/12	--	--	GMA Architects, Inc.
SK-10	TA2.4 Revision	10/25/12	--	--	GMA Architects, Inc.
SK-11	A2.4 Revision	11/12/12	--	--	GMA Architects, Inc.
SK-12	A5.2 Revision	11/12/12	--	--	GMA Architects, Inc.
SK-13	A2.4 Revision	11/12/12	--	--	GMA Architects, Inc.
	Structural				
S0.01	General Notes	8/21/12	5	12/10/12	Englekirk Structural Engineers
S0.02	General Notes	8/21/12	5	12/10/12	Englekirk Structural Engineers
S0.03	General Notes	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.01	Typical Concrete Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.02	Typical Concrete Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.03	Typical Concrete Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.11	Typical Shearwall Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.12	Typical Shearwall Details	8/21/12	5	12/10/12	Englekirk Structural Engineers

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F – Drawing Log 5 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

S1.13	Typical Shearwall Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.21	Typical Steel Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.22	Typical Steel Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.23	Typical Steel Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.31	Typical Metal Stud Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.32	Typical Metal Stud Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.33	Typical Metal Stud Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S1.41	Typical Stair Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S2.00	Basement/Foundation Plan	8/21/12	5	12/10/12	Englekirk Structural Engineers
S2.01	First Floor Framing Plan	8/21/12	6	12/21/12	Englekirk Structural Engineers
S2.02	Second Floor Framing Plan	8/21/12	5	12/10/12	Englekirk Structural Engineers
S2.03	Third Floor Framing Plan	8/21/12	5	12/10/12	Englekirk Structural Engineers
S2.04	Fourth Floor Framing Plan	8/21/12	5	12/10/12	Englekirk Structural Engineers
S2.05	Fifth Floor/Roof Framing Plan	8/21/12	5	12/10/12	Englekirk Structural Engineers
S2.06	Roof Framing Plan	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.01	Sections and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.02	Section and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.03	Sections and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.11	Sections and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.12	Sections and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.13	Sections and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.14	Sections and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S3.15	Sections and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S4.01	Bridge Elevation and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S4.02	Bridge Elevation and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers

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F – Drawing Log 6 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

S4.03	Bridge Elevation and Details	8/21/12	5	12/10/12	Englekirk Structural Engineers
S5.01	Electrical / Trash Enclosure Elevations	8/21/12	8	1/31/13	Englekirk Structural Engineers
SK4	Sketch	10/30/12	--	--	Englekirk Structural Engineers
SSK 18	Sign Anchorage	12/18/12	--	--	Englekirk Structural Engineers
	Mechanical				
M-0.1	Cover Sheet	8/21/12	4	12/10/12	Icon Mechanical
M-1.0	Mechanical Basement Plan	8/21/12	5	1/11/13	Icon Mechanical
M-1.1	Mechanical First Floor Plan	8/21/12	5	1/11/13	Icon Mechanical
M-1.2	Mechanical Second Floor Plan	8/21/12	5	1/11/13	Icon Mechanical
M-1.3	Mechanical Third Floor Plan	8/21/12	5	1/11/13	Icon Mechanical
M-1.4	Mechanical Fourth Floor Plan	8/21/12	5	1/11/13	Icon Mechanical
M-1.5	Mechanical Fifth Floor & Roof Plan	8/21/12	5	1/11/13	Icon Mechanical
M-2.1	Mechanical First Floor Piping Plan	8/21/12	5	1/11/13	Icon Mechanical
M-2.2	Mechanical Second Floor Piping Plan	8/21/12	5	1/11/13	Icon Mechanical
M-2.3	Mechanical Third Floor Piping Plan	8/21/12	5	1/11/13	Icon Mechanical
M-2.4	Mechanical Fourth Floor Piping Plan	8/21/12	5	1/11/13	Icon Mechanical
M-2.5	Mechanical Fifth Floor & Roof Piping Plan	8/21/12	5	1/11/13	Icon Mechanical
M-4.1	Mechanical Details	8/21/12	4	12/10/12	Icon Mechanical
M-4.2	Mechanical Details	8/21/12	4	12/10/12	Icon Mechanical
M-6.1	Mechanical Schedules	8/21/12	4	12/10/12	Icon Mechanical
M-6.2	Mechanical Schedules	8/21/12	4	12/10/12	Icon Mechanical
	Electrical				
TE0.0	Title Sheet	8/21/12	6	1/16/13	InPwr, Inc.
TE0.1	Symbols, Notes, and Abbreviations	8/21/12	6	1/16/13	InPwr, Inc.
TE0.2	Title 24	8/21/12	6	1/16/13	InPwr, Inc.
TE0.3	Title 24	8/21/12	6	1/16/13	InPwr, Inc.
TE0.4	Title 24	8/21/12	6	1/16/13	InPwr, Inc.
TE0.5	Title 24	8/21/12	6	1/16/13	InPwr, Inc.
TE1.0	Site Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE2.0	Basement Floor Distribution Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE2.1	First Floor Distribution Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE2.2	Second Floor Distribution Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE2.3	Third Floor Distribution Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE2.4	Fourth Floor Distribution Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE2.5	Fifth Floor Distribution Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE3.0	Basement Floor Lighting Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE3.1	First Floor Lighting Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE3.2	Second Floor Lighting Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE3.3	Third Floor Lighting Plan	8/21/12	6	1/16/13	InPwr, Inc.

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F – Drawing Log 7 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

TE3.4	Fourth Floor Lighting Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE3.5	Fifth Floor Lighting Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE3.6	Basement Floor Lighting Plan – Less than 50V	8/21/12	6	1/16/13	InPwr, Inc.
TE3.7	First Floor Lighting Plan – Less than 50V	8/21/12	6	1/16/13	InPwr, Inc.
TE3.8	Second Floor Lighting Plan – Less than 50V	8/21/12	6	1/16/13	InPwr, Inc.
TE3.9	Third Floor Lighting Plan – Less than 50V	8/21/12	6	1/16/13	InPwr, Inc.
TE3.10	Fourth Floor Lighting Plan – Less than 50V	8/21/12	6	1/16/13	InPwr, Inc.
TE3.11	Fifth Floor Lighting Plan – Less than 50V	8/21/12	6	1/16/13	InPwr, Inc.
TE4.0	Basement Floor Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE4.1	First Floor Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE4.2	Second Floor Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE4.3	Third Floor Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE4.4	Fourth Floor Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE4.5	Fifth Floor Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE5.0	Basement Floor HVAC Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE5.1	First Floor HVAC Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE5.2	Second Floor HVAC Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE5.3	Third Floor HVAC Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE5.4	Fourth Floor HVAC Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE5.5	Fifth Floor HVAC Power Plan	8/21/12	6	1/16/13	InPwr, Inc.
TE6.0	Enlarged Plans	8/21/12	6	1/16/13	InPwr, Inc.
TE6.1	Enlarged Plans	8/21/12	6	1/16/13	InPwr, Inc.
TE6.2	Elevation Plans	8/21/12	6	1/16/13	InPwr, Inc.
TE6.3	Enlarged Plans	8/21/12	6	1/16/13	InPwr, Inc.
TE7.0	Details	8/21/12	6	1/16/13	InPwr, Inc.
TE7.1	Details	8/21/12	6	1/16/13	InPwr, Inc.
TE7.2	Details	8/21/12	6	1/16/13	InPwr, Inc.
TE8.0	One Line Diagram	8/21/12	6	1/16/13	InPwr, Inc.
TE9.0	Schedules	8/21/12	6	1/16/13	InPwr, Inc.
TE9.1	Panel Schedules	8/21/12	6	1/16/13	InPwr, Inc.
TE9.2	Panel Schedules	8/21/12	6	1/16/13	InPwr, Inc.
TE9.3	Schedules	8/21/12	6	1/16/13	InPwr, Inc.
	Plumbing				
P0.1	Plumbing Legend, Schedules &Gen. Notes	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P2.0	Plumbing Basement Base Plan	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P2.1	Plumbing First Floor Plan	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P2.2	Plumbing Second Floor Plan	7/26/12	5	12/10/12	Andersen Commercial Plumbing

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Exhibit

F – Drawing Log 8 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

P2.3	Plumbing Third Floor Plan	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P2.4	Plumbing Fourth Floor Plan	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P2.5	Plumbing 5th Floor/4th Roof Plans	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P3.1	Plumbing Fifth Floor Roof Plan	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P4.1	Riser Diagrams	7/26/12	5	12/10/12	Andersen Commercial Plumbing
P4.2	Riser Diagrams	7/26/12	5	12/10/12	Andersen Commercial Plumbing
	Tenant Improvement Plumbing				
TP0.1	Plumbing Legend, Schedules &Gen. Notes	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP2.0	Plumbing Basement Floor Plan	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP2.1	Plumbing First Floor Plan	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP2.2	Plumbing Second Floor Plan	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP2.3	Plumbing Third Floor Plan	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP2.4	Plumbing Fourth Floor Plan	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP3.1	Plumbing Fifth Floor Roof Plan	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP4.1	Plumbing Partial Floor Plans	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP4.2	Plumbing Partial Floor Plans	5/21/12	5	12/10/12	Andersen Commercial Plumbing
TP5.1	Plumbing Riser Diagrams	5/21/12	5	12/10/12	Andersen Commercial Plumbing
	Fire Protection				
FP-1	Notes & Details	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-2	Site Plan / UG Details	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-3	Stand Pipe Details	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-4	Sections & Details	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-5	EQB Calcs & Details	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-6	Basement Piping Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-7	1st Floor Piping Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-8	2nd Floor Piping Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection

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Exhibit

F – Drawing Log 9 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

FP-9	3rd Floor Piping Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-10	4th Floor Piping Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-11	5th Floor Piping Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-12	Hydraulic Placards	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-13	1st Floor Reflective Ceiling Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-14	2nd Floor Reflective Ceiling Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-15	3rd Floor Reflective Ceiling Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-16	4th Floor Reflective Ceiling Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
FP-17	5th Floor Reflective Ceiling Plan	4/25/12	4	12/10/12	Mr. Sprinkler Fire Protection
	Fire Alarm				
FA 3 of 10	Cover Sheet	12/20/12	--	--	Siemens
FA 2 of 10	Standby Battery & Voltage Drop Calculations	12/20/12	--	--	Siemens
FA 3 of 10	Basement Floor Plan with Fire Alarm Equipment	12/20/12	--	--	Siemens
FA 4 of 10	First Floor Plan with Fire Alarm Equipment	12/20/12	--	--	Siemens
FA 5 of 10	Second Floor Plan with Fire Alarm Equipment	12/20/12	--	--	Siemens
FA 6 of 10	Third Floor Plan with Fire Alarm Equipment	12/20/12	--	--	Siemens
FA 7 of 10	Fourth Floor Plan with Fire Alarm Equipment	12/20/12	--	--	Siemens
FA 8 of 10	Fifth Floor Plan with Fire Alarm Equipment	12/20/12	--	--	Siemens
FA 9 of 10	Fire Alarm System Riser Diagram	12/20/12	--	--	Siemens
FA 9 of 10	Point to Point Wiring Diagram	12/20/12	--	--	Siemens
	Control Drawings				
Cover	Cover Page	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-1	Network Diagram Floors 5, 4 & 3	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-2	Network Diagram Floors 2, 1 & Basement	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-3	VAV Box Wiring Diagram & I/O Points	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-4	FTU W/ Hot Water Reheat Wiring Diagram & I/O Points	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-5	VAV Box Wiring Diagram w/VEF & I/O Points	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-6	Not Used	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-7	Central Plant Schematic Drawing	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-8	Central Plant Wiring Diagram	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.

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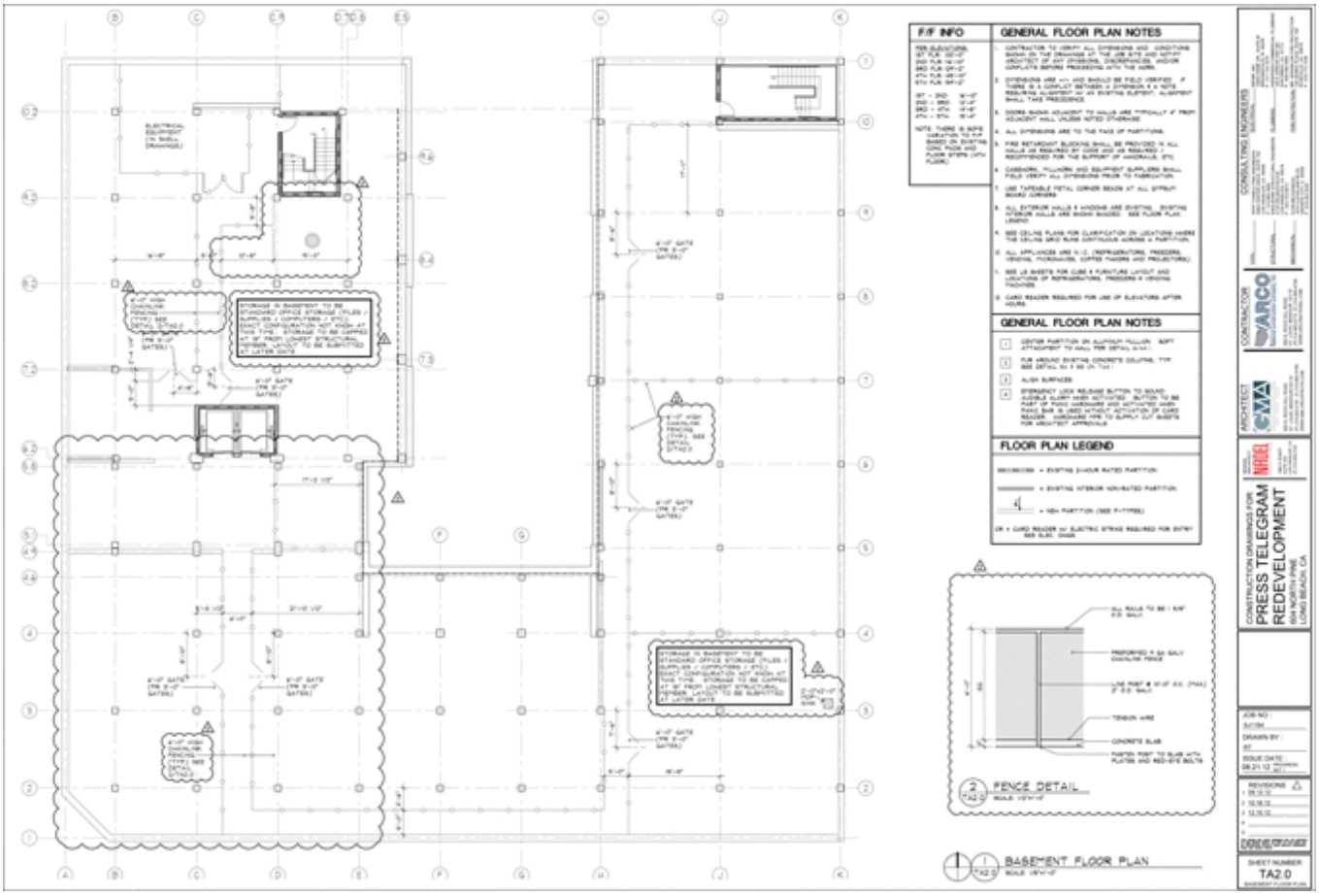
Exhibit

F – Drawing Log 10 ARCO Job No. N-4

Dwg No.	Description	Issue Date	Rev. No.	Rev. Date	Architect/Engineer

TCC-9	Central Plant I/O Points List	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-10	Central Plant I/O Points List Notes	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-11	Central Plant Control Panel TCP-1	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-12	AHU-1/CU-1 Schematic Drawing	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-13	AHU-1/CU-1 Wiring Diagram	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-14	AHU-1/CU-1 BAC 5802 I/O Points List & Notes	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-15	TCP-2 Control Panel	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-16	Valve Schedule	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.
TCC-17	FTU & VAV Unit Schedule	9/19/12	1.4	1/11/13	Taycon-TMI, Inc.



F/F INFO
PER ELEVATIONS: 1ST FLR: 00'-0" 2ND FLR: 14'-10" 3RD FLR: 29'-1" 4TH FLR: 43'-3" 5TH FLR: 58'-5" 1ST - 2ND: 14'-10" 2ND - 3RD: 13'-4" 3RD - 4TH: 14'-2" 4TH - 5TH: 15'-4" NOTE: THERE IS SOME VARIATION TO F/F BASED ON EXISTING CONC FLOOR AND FLOOR STEPS (4TH FLOOR)

GENERAL FLOOR PLAN NOTES

1. CONTRACTOR TO VERIFY ALL DIMENSIONS AND CONDITIONS SHOWN ON THE DRAWINGS AT THE JOB SITE AND NOTIFY ARCHITECT OF ANY OMISSIONS, DISCREPANCIES, AND/OR CONFLICTS BEFORE PROCEEDING WITH THE WORK.
2. DIMENSIONS ARE +/- AND SHOULD BE FIELD VERIFIED. IF THERE IS A CONFLICT BETWEEN A DIMENSION & A NOTE, REFERENCE ALIGNMENT OF AN EXISTING ELEMENT, ALIGNMENT SHALL TAKE PRECEDENCE.
3. DOORS SHOWN ADJACENT TO WALLS ARE TYPICALLY AT FRONT ADJACENT WALL UNLESS NOTED OTHERWISE.
4. ALL DIMENSIONS ARE TO THE FACE OF PARTITIONS.
5. FIRE RETARDANT BLOCKING SHALL BE PROVIDED IN ALL WALLS AS REQUIRED BY CODE AND AS REQUIRED / RECOMMENDED FOR THE SUPPORT OF HANDRAILS, ETC.
6. CASEWORK, MILLWORK AND EQUIPMENT SUPPLIERS SHALL FIELD VERIFY ALL DIMENSIONS PRIOR TO FABRICATION.
7. USE TAPERABLE METAL CORNER BEADS AT ALL GYPSUM BOARD CORNERS.
8. ALL EXTERIOR WALLS & WINDOWS ARE EXISTING. EXISTING INTERIOR WALLS ARE SHOWN SHADED. SEE FLOOR PLAN LEGEND.
9. SEE CEILING PLANS FOR CLARIFICATION ON LOCATIONS WHERE THE CEILING GRID RUNS CONTINUOUS ACROSS A PARTITION.
10. ALL APPLIANCES ARE N.I.C. (REFRIGERATORS, FREEZERS, VENDING, MICROWAVES, COFFEE MAKERS AND PROJECTORS).
11. SEE UX SHEETS FOR CUBE & FURNITURE LAYOUT AND LOCATIONS OF REFRIGERATORS, FREEZERS & VENDING MACHINES.
12. CARD READER REQUIRED FOR USE OF ELEVATORS AFTER HOURS.

GENERAL FLOOR PLAN NOTES

1. CENTER PARTITION ON ALIGNOUT PILLOW. SOFT ATTACHMENT TO WALL PER DETAIL 6/A4.1.
2. FUR AROUND EXISTING CONCRETE COLUMN. TYP. SEE DETAIL 6/-1 & 8/-1 TYP.
3. ALIGN SURFACES
4. EMERGENCY LOCK RELEASE BUTTON TO SOUND AUDIBLE ALARM WHEN ACTIVATED. BUTTON TO BE PART OF PANIC HARDWARE AND ACTIVATED WHEN PANIC BAR IS USED WITHOUT ACTIVATION OF CARD READER. HARDWARE PER TO SUPPLY CUT SHEETS FOR ARCHITECT APPROVAL

FLOOR PLAN LEGEND

EXISTING 2-HOUR RATED PARTITION

EXISTING INTERIOR NON-RATED PARTITION

NEW PARTITION (SEE P-TYPES)

OR = CARD READER W/ ELECTRIC STRIKE REQUIRED FOR ENTRY SEE ELEC. SHEET

2 / TA2.0 FENCE DETAIL
SCALE: 1/2"=1'-0"

1 / TA2.0 BASEMENT FLOOR PLAN
SCALE: 1/8"=1'-0"

CONSULTING ENGINEERS

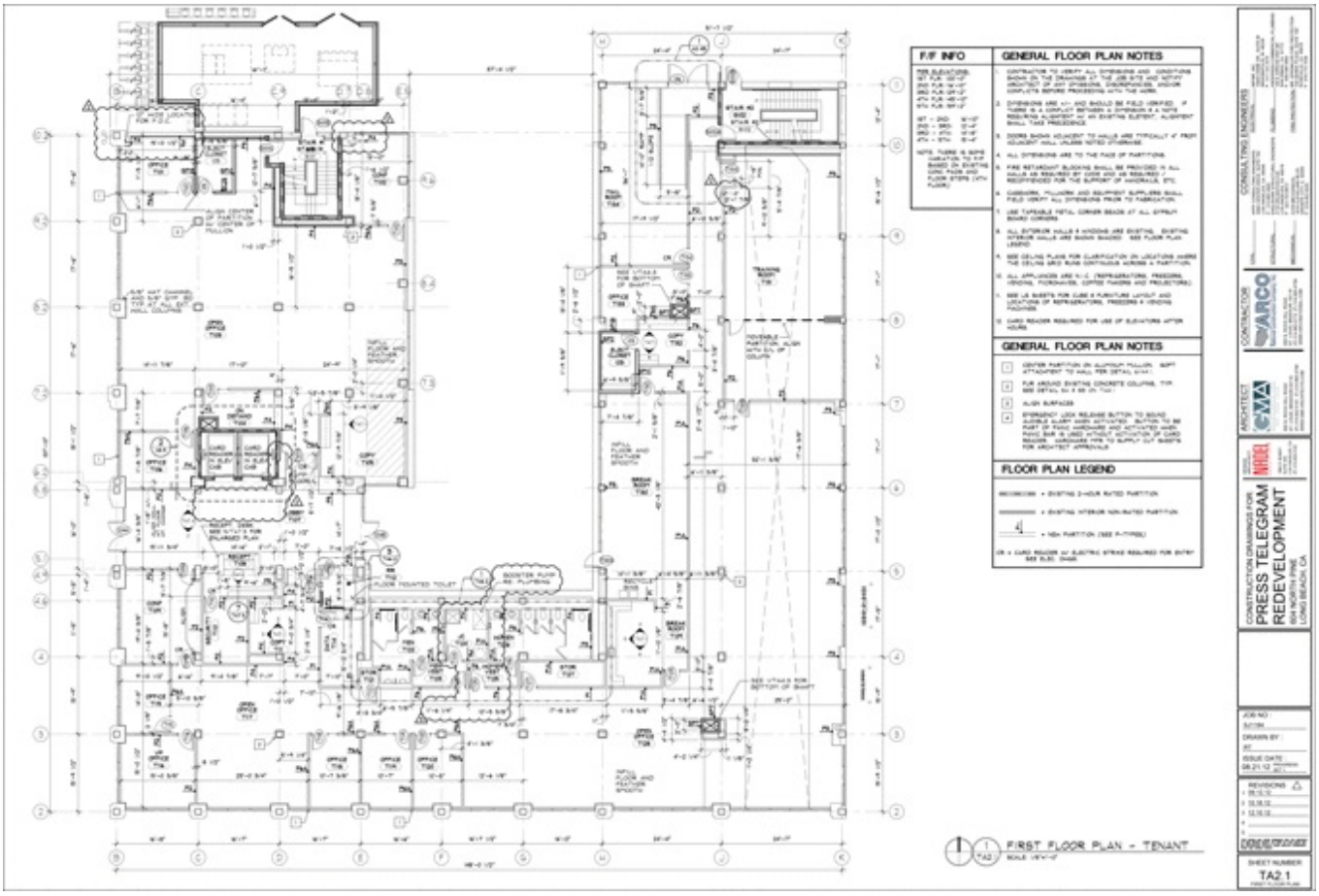
CONTRACTOR: ARCO

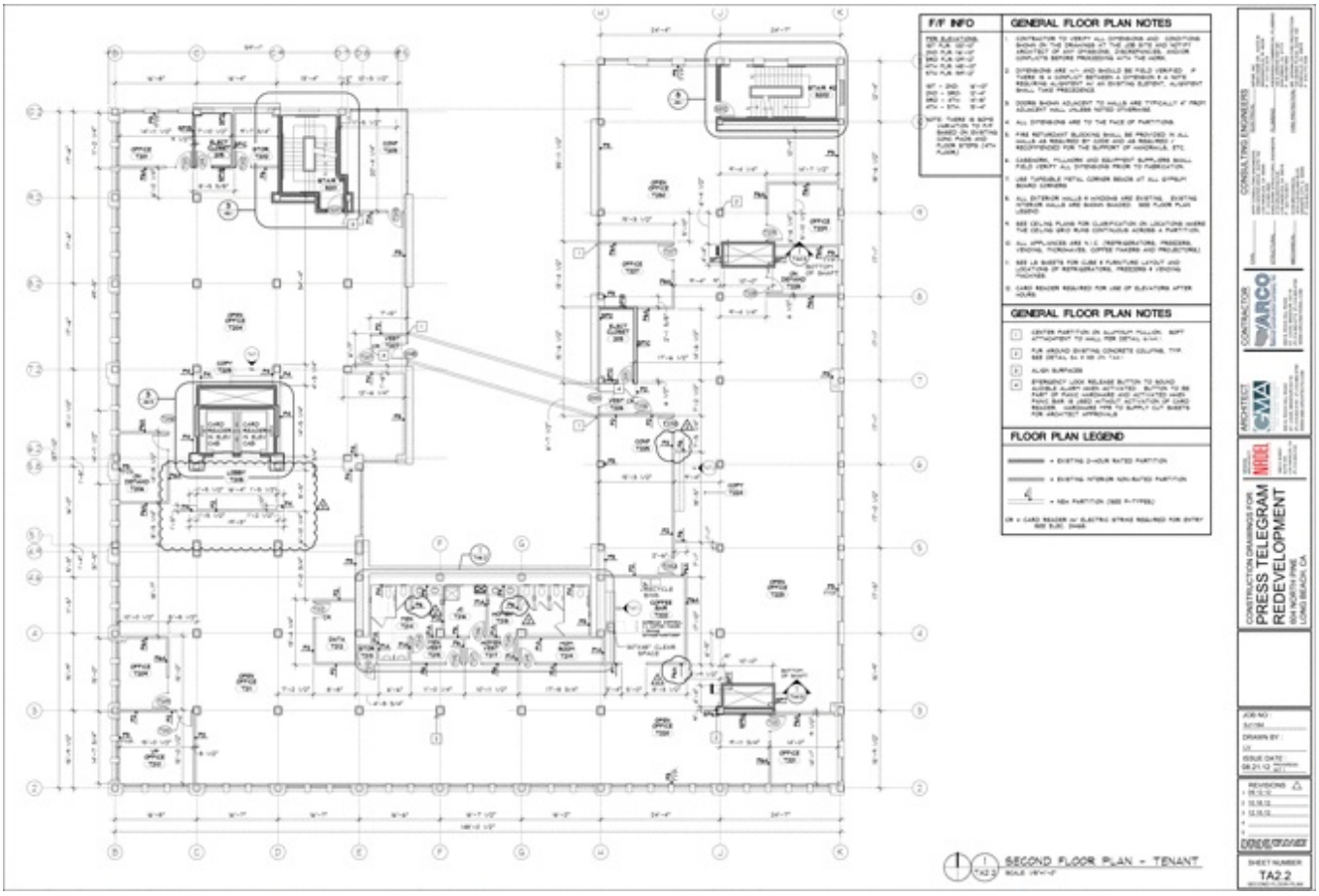
ARCHITECT: GMA

CONSTRUCTION DRAWINGS FOR
PRESS TELEGRAM
REDEVELOPMENT
604 NORTH PINE
LONG BEACH, CA

JOB NO :
DRAWN BY :
ISSUE DATE:
REVISIONS

SHEET NUMBER
TA2.0
BASEMENT FLOOR PLAN


F/F INFO
GENERAL FLOOR PLAN NOTES
GENERAL FLOOR PLAN NOTES
FLOOR PLAN LEGEND
FIRST FLOOR PLAN - TENANT
CONSULTING ENGINEERS
CONTRACTOR
ARCHITECT
CONSTRUCTION DRAWINGS FOR
PRESS TELEGRAM
REDEVELOPMENT
604 NORTH PINE
LONG BEACH, CA
JOB NO :
DRAWN BY :
ISSUE DATE
08.21.12
REVISIONS
SHEET NUMBER
TA2.1


F/F INFO
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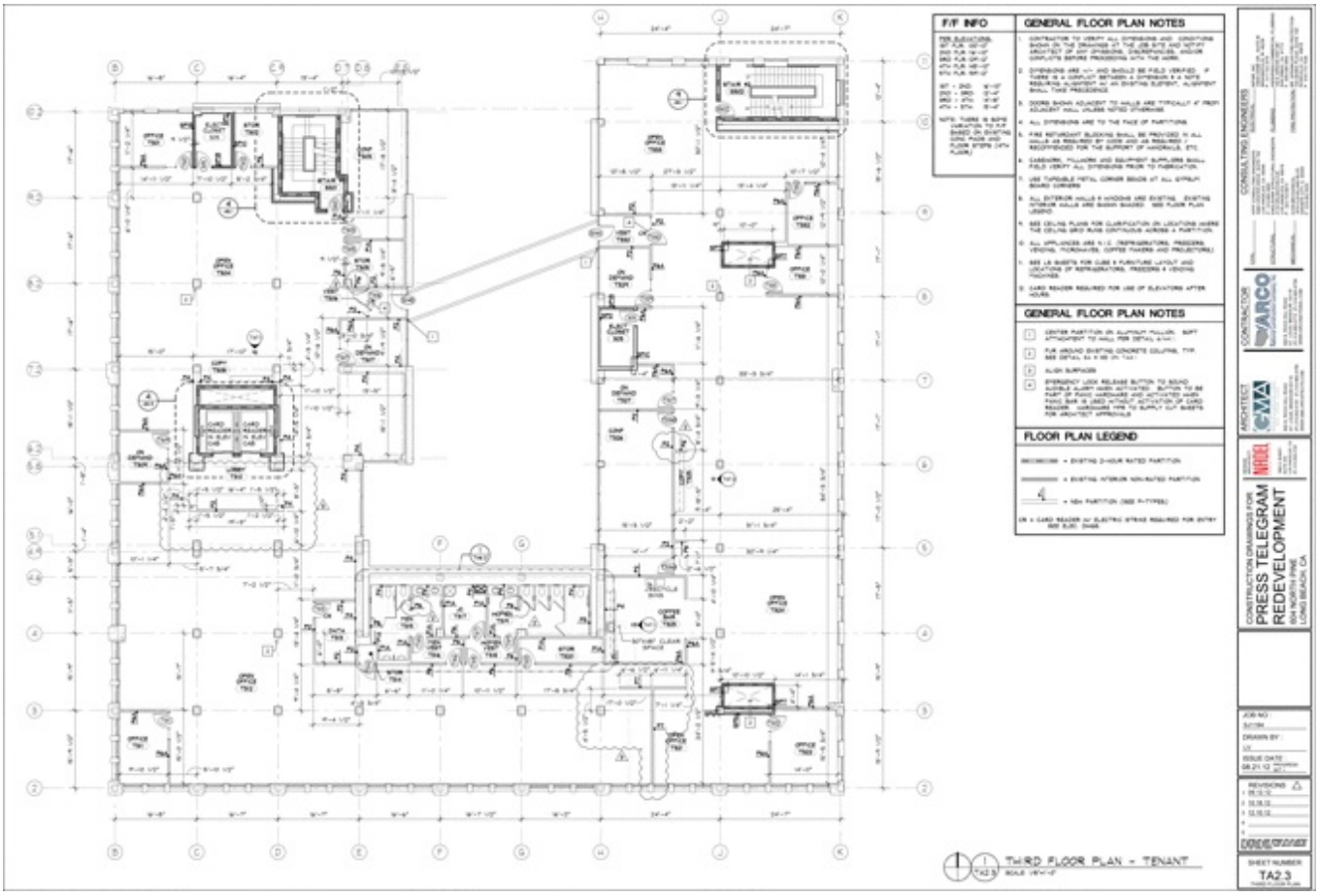
GENERAL FLOOR PLAN NOTES
FLOOR PLAN LEGEND
SECOND FLOOR PLAN - TENANT
CONSULTING ENGINEERS
CONTRACTOR
ARCHITECT
CONSTRUCTION DRAWINGS FOR
PRESS TELEGRAM
REDEVELOPMENT
604 NORTH PINE
LONG BEACH, CA
JOB NO :
DRAWN BY :
ISSUE DATE :
08.21.12
REVISIONS
SHEET NUMBER
TA2.2


F/F INFO
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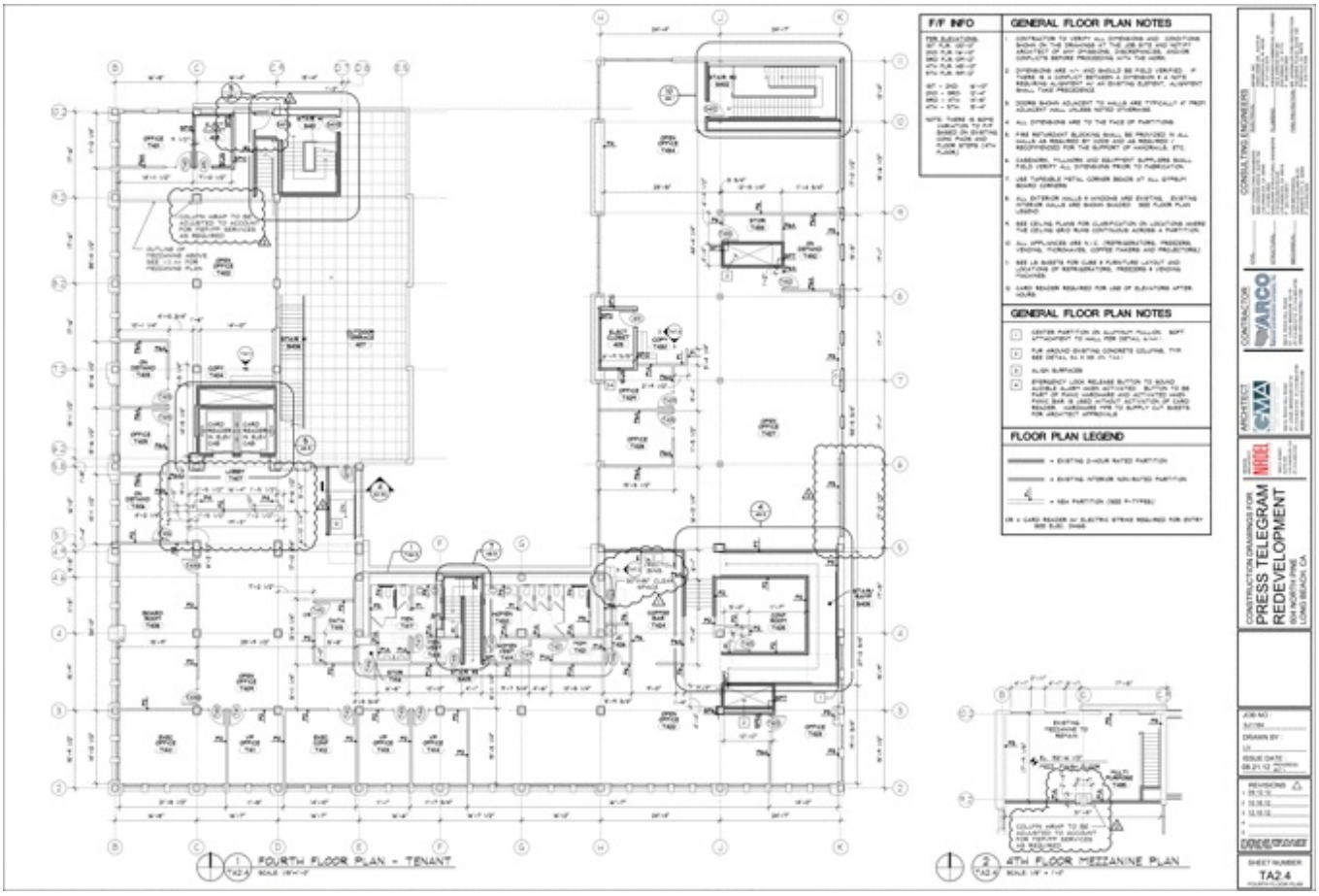
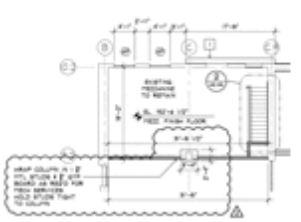
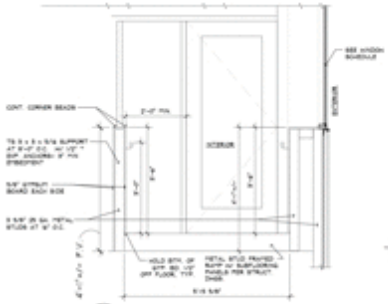
GENERAL FLOOR PLAN NOTES
FLOOR PLAN LEGEND
THIRD FLOOR PLAN - TENANT
CONSULTING ENGINEERS
CONTRACTOR
ARCHITECT
CONSTRUCTION DRAWINGS FOR
PRESS TELEGRAM
REDEVELOPMENT
604 NORTH PINE
LONG BEACH, CA
JOB NO :
DRAWN BY :
ISSUE DATE
08.21.12
REVISIONS
SHEET NUMBER
TA2.3

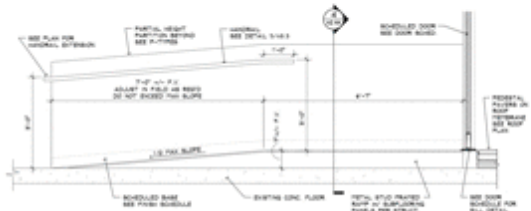

F/F INFO
GENERAL FLOOR PLAN NOTES
GENERAL FLOOR PLAN NOTES
FLOOR PLAN LEGEND
FOURTH FLOOR PLAN - TENANT
4TH FLOOR MEZZANINE PLAN
CONSULTING ENGINEERS
CONTRACTOR
ARCHITECT
CONSTRUCTION DRAWINGS FOR
PRESS TELEGRAM
REDEVELOPMENT
604 NORTH PINE
LONG BEACH, CA
SHEET NUMBER
TA2.4



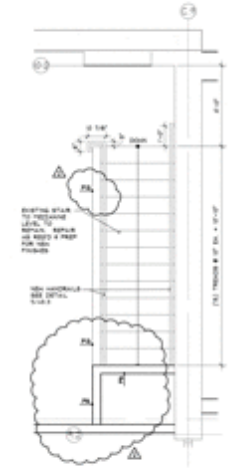
1 A2.4A 4TH FLOOR MEZZANINE PLAN
SCALE: 1/8" = 1'-0"



4 A2.4A RAMP LANDING CROSS-SECTION
SCALE: 3/4" = 1'-0"



5 A2.4A RAMP LANDING LONGITUDINAL-SECTION
SCALE: 3/4" = 1'-0"

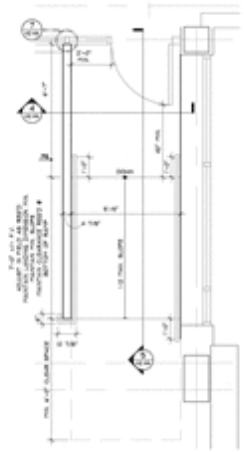


1 A2.4A 2 A2.4A 4TH FLOOR MEZZANINE STAIR
SCALE: 1/2" = 1'-0"

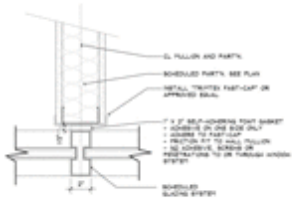
GENERAL STAIR NOTES

1. SEE DETAIL 1/A2.1 FOR CONTRASTING TREAD REQUIREMENTS FOR INTERIOR AND EXTERIOR STAIRS
2. GRIND ALL WELDS SMOOTH
3. ALL HANDRAIL ENDS MUST RETURN TO A WALL, GUARD OR RAILING SURFACE

3 A2.4A STAIR SECTION MOVED TO INTERIOR PACKAGE
SCALE: 1/2" = 1'-0"



6 A2.4A 4TH FLOOR RAMP
SCALE: 1/2" = 1'-0"



7 A2.4A PARTITION @ MULLION
SCALE: 3" = 1'-0"

CONSULTING ENGINEERS

CONTRACTOR ARCO

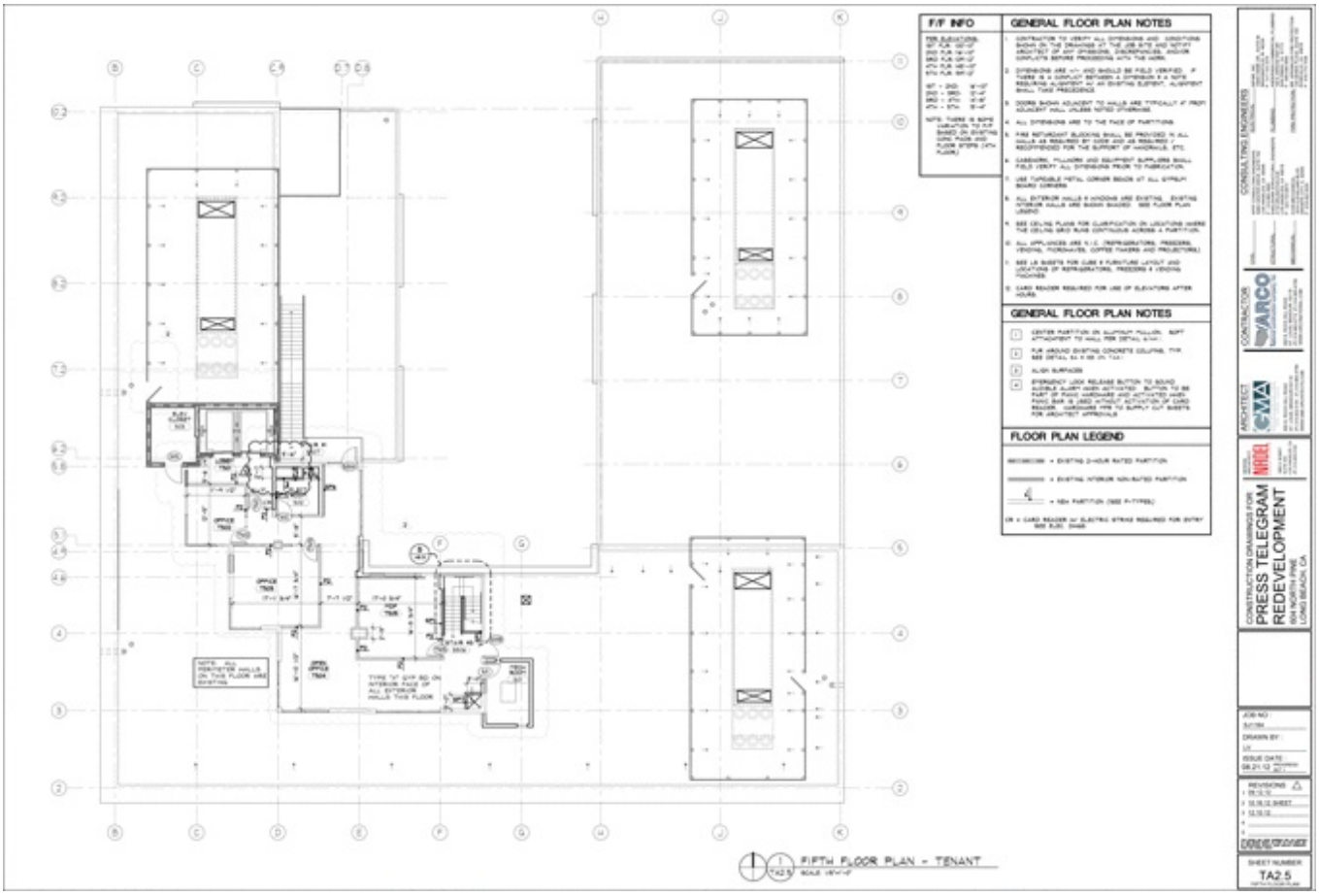
ARCHITECT GMA

CONSTRUCTION DRAWINGS FOR
PRESS TELEGRAM
REDEVELOPMENT
604 NORTH PINE
LONG BEACH, CA

JOB NO : 5J1184
DRAWN BY : LT
ISSUE DATE : 08.21.12

REVISIONS
1 09.13.12
2 10.16.12
3 12.18.12
4
5

SHEET NUMBER
A2.4A


F/F INFO
GENERAL FLOOR PLAN NOTES
GENERAL FLOOR PLAN NOTES
FLOOR PLAN LEGEND
FIFTH FLOOR PLAN - TENANT
CONSULTING ENGINEERS
CONTRACTOR
ARCHITECT
CONSTRUCTION DRAWINGS FOR
PRESS TELEGRAM
REDEVELOPMENT
604 NORTH PINE
LONG BEACH, CA
JOB NO :
DRAWN BY :
ISSUE DATE
08.21.12
REVISIONS
SHEET NUMBER
TA2.5

RECORDING REQUESTED BY &)
WHEN RECORDED RETURN TO:)
)
East West Bank)
9300 Flair Drive, 6th Floor)
El Monte, CA 91731)
Attn: Loan Servicing)
)

(Space Above This Line For Recorder's Use)

SUBORDINATION AGREEMENT AND
AGREEMENT OF NON-DISTURBANCE AND ATTORNMENT

(EWB Form – Rev. 2-2007)

This Subordination Agreement and Agreement of Non-Disturbance and Attornment ("Agreement") is made and entered into as of this ___ day of _____, 2013, among (i) East West Bank ("Lender"), (ii) Molina Healthcare, Inc. ("Tenant") and (iii) 6th & Pine Development, LLC ("Owner"), with reference to the following:

RECITALS

A. Lender has made a loan in the amount of approximately $1,530,000 and is proposing to make additional loans (collectively, the "Loans") to Owner, which are secured or are to be secured by, among other things, (i) certain deeds of trust recorded or to be recorded against all or a portion of the real property legally described in Exhibit A attached hereto and the improvements thereon (collectively, the "Real Property"), consisting of (a) an existing Deed of Trust in the amount of $1,530,000 in connection with Owner's development of Phase II (as such term is defined in the Lease described below) (which, upon the recordation of the Construction Deed of Trust for Phase II described in (c) below, is expected to be paid in full and reconveyed), (b) a Construction Deed of Trust, which is expected to be recorded in the amount of approximately $15,795,000 in connection with Owner's development of Phase I (as such term is defined in the Lease described below), and (c) a Construction Deed of Trust, which is expected to be recorded in the amount of approximately $25,350,000 in connection with Owner's development of Phase II (each, a "Deed of Trust" and collectively, the "Deeds of Trust"), and (ii) a collateral assignment (the "Collateral Assignment") of Owner's rights under that certain Parking License Agreement dated as of May 25, 2012 (together with all amendments thereto, the "Parking Agreement"), between the City of Long Beach, as "Licensor," and Owner, as "Licensee". The Real Property, together with Owner's rights under the Parking Agreement, shall be referred to herein, collectively, as the "Property".

B. Tenant has leased the Real Property and been granted certain off-site parking rights which Owner intends to satisfy, to the extent possible, with parking spaces provided to it under the Parking Agreement (collectively, the "Premises), pursuant to that certain Office Building Lease – Full Service Gross – Single Tenant Building(s) dated as of February 28, 2013 (together with all amendments thereto being referred to as the "Lease"), by and between Owner and Tenant.

C. Lender and Tenant desire to enter into this Agreement under which Tenant subordinates the Lease and its interest in the Property and agrees to attorn to Lender and under which Lender agrees to not disturb Tenant's possession of or right to use the Premises all to the extent set forth herein, and so long as Tenant is not in default under the Lease.

NOW THEREFORE, with reference to the foregoing recitals and for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties to this Agreement agree as follows:

1. Subordination. Subject to the terms and conditions of this Agreement, the Lease, and the rights of Tenant in, to and under the Lease and the Premises, are hereby subjected and subordinated to the lien of each Deed of Trust, it being understood and agreed that the foregoing subordination shall apply to any and all increases, renewals, modifications, extensions, substitutions, replacements and/or consolidations of each Deed of Trust, provided that any and all such increases, renewals, modifications, extensions, substitutions, replacements and/or consolidations shall nevertheless be subject to the terms of this Agreement.

2. Tenant Not to Be Disturbed; Rights Preserved. So long as Tenant is not in default in the payment of rent or of any of the terms, covenants or conditions of the Lease on Tenant's part to be performed (beyond any period given Tenant in the Lease to cure such default) and Tenant attorns to Lender as provided herein, (a) neither Tenant's possession or use or right to possession or use of the Premises, nor any other right or privilege granted or inuring to the benefit of Tenant under the Lease, shall be diminished, disturbed or interfered with by Lender, and (b) Lender will not join Tenant as a party defendant in any action or proceeding foreclosing any one or more of the Deeds of Trust unless such joinder is necessary to foreclose such Deed(s) of Trust and then only for such purpose and not for the purpose of terminating the Lease. Lender acknowledges that Tenant has a right of first offer to purchase the Premises, as set forth in Exhibit "I-1" of the Lease, and an option to purchase the Premises, as set forth in Exhibit "I-2" of the Lease (collectively, the "Tenant Purchase Rights"). Lender acknowledges and agrees that the Tenant Purchase Rights will expressly survive (and may be exercised by Tenant pursuant to the respective terms thereof following) any transfer of the Premises to any third-party purchaser that occurs as the result of a foreclosure or other proceeding brought to enforce any one or more of the Deeds of Trust, or any such transfer of the Premises by deed in lieu of foreclosure; provided, however, that Tenant's Purchase Rights shall not be exercisable (i) in any transfer that occurs as the result of a foreclosure, deed in lieu of foreclosure or other such proceeding or (ii) during such time as Lender is the owner of the Premises (provided that Tenant's Purchase Rights shall be exercisable pursuant to their respective terms against any other Successor Landlord, as defined in Section 3 below).

3. Tenant to Attorn To Lender. Subject to Section 2 above, if Lender shall become the owner of the Premises or the Premises shall be sold by reason of foreclosure or other proceedings brought to enforce any one or more of the Deeds of Trust or the Premises shall be transferred by deed in lieu of foreclosure, the Lease shall continue in full force and effect as a direct Lease between the then owner of the Premises (a "Successor Landlord"), who shall succeed to the rights and duties of the landlord under the Lease. Subject to Section 2 above, Tenant shall attorn to such Successor Landlord as its landlord under the Lease, said attornment to be effective and self-operative without the execution of any further instruments. Tenant hereby waives the provisions of any statute or rule of law, now or hereafter in effect, which may give or purport to give Tenant any right or election to terminate or otherwise adversely affect the Lease and the obligations of Tenant thereunder as a result of any such foreclosure or deed-in-lieu of foreclosure.

4. Notice of Default; Rent Payments to Lender. In the event that Lender notifies Tenant of a default under any one or more of the Deeds of Trust and requests Tenant to pay its rent and all other sums due under the Lease to Lender, Tenant shall pay such sums directly to Lender, or as Lender may otherwise request, without any further consent of Owner. Owner hereby irrevocably authorizes and directs Tenant to make such payments to Lender despite the receipt of any contrary instructions from Owner or any other party, except a court of competent jurisdiction. Payment of rent and any other sums due under the Lease by Tenant in accordance with the provisions of this Section shall constitute performance by Tenant under the Lease as to all amounts paid.

5. Limitations.

(a) The following terms shall have the following meanings for purposes of this Section 5:

(i) Construction-Related Obligation. A "Construction-Related Obligation" means any obligation of Owner under the Lease to make, pay for, or reimburse Tenant for any alterations, demolition, or other improvements at the Premises, including the construction of any on-site parking spaces. "Construction-Related Obligations" shall not include: (a) reconstruction or repair following fire, casualty or condemnation; or (b) ordinary maintenance and repairs.

(ii) Former Landlord. A “Former Landlord” means Owner and any other party that was landlord under the Lease at any time before the occurrence of any attornment under this Agreement.

(iii) Offset Right. An "Offset Right" means any right or alleged right of Tenant to any offset, defense (other than one arising from actual payment and performance, which payment and performance would bind a Successor Landlord pursuant to this Agreement), claim, counterclaim, reduction, deduction, or abatement against Tenant's payment of Rent or performance of Tenant's other obligations under the Lease, arising (whether under the Lease or other applicable law) from Owner's breach or default under the Lease, other than in connection with Construction-Related Obligations.

(iv) Rent. The "Rent" means any fixed rent, base rent or additional rent under the Lease.

(b) A Successor Landlord shall not be liable for or bound by (i) any Offsite Right that Tenant may have against any Former Landlord relating to any event or occurrence before the date of attornment, including any claim for damages of any kind whatsoever as the result of any breach by Former Landlord that occurred before the date of attornment (provided, that subject to subsection (iii) of this paragraph below, the foregoing shall not limit either (A) Tenant’s right to exercise any Offset Right against Successor Landlord otherwise available to Tenant because of events occurring after the date of attornment, or (B) Successor Landlord’s obligation to correct any conditions that existed as of the date of attornment and violate Successor Landlord’s obligations as landlord under the Lease), (ii) any security deposit or payment of rent (for more than one month in advance of the date due under the Lease) made by Tenant to any Former Landlord, except to the extent actually received by Successor Landlord, (iii) any Construction-Related Obligations (provided, that the foregoing shall not limit (y) any Successor Landlord’s maintenance and repair obligations under the Lease, including, without limitation, under General Condition N or Article 9 thereof, or (z) Tenant’s rights with respect to warranty claims under General Condition B of the Lease with respect to any Successor Landlord other than Lender, against whom such rights of Tenant shall not be enforceable), or (iv) any obligation to expend funds which are capital in nature, except for items of ordinary maintenance and repair for the Premises. Notwithstanding the foregoing, or any provision to the contrary set forth in this Agreement, subject to Section 6 below, nothing in this Agreement is intended to limit Tenant’s right to terminate the Lease in the event that Owner or any Successor Landlord fails to satisfy the obligations of the landlord under the Lease, including, without limitation, the failure to satisfy the conditions set forth in General Condition R or Section 2.6 of the Lease.

(c) Notwithstanding any term of the Lease, upon foreclosure of any one or more of the Deeds of Trust, or acceptance of a deed in lieu thereof or other similar transfer, any environmental/hazardous materials indemnity and/or reimbursement provisions under the Lease shall not be applicable to, or enforceable against any Successor Landlord with respect to any period prior to such Successor Landlord’s ownership and thereafter only to the extent caused by such Successor Landlord. If Lender becomes the owner of all or a portion of the Property or the Property (or a portion thereof) is sold to a third party by reason of foreclosure or other proceedings brought to enforce any one or more of the Deeds of Trust or the Property (or a portion thereof) is conveyed by deed-in-lieu of foreclosure, Tenant agrees that, notwithstanding anything to the contrary contained in the Lease, after such foreclosure sale or conveyance by deed-in-lieu of foreclosure, neither Lender nor any such third party shall have any personal liability to Tenant under the Lease and Tenant shall look solely to the owner’s interest in the Property (or portion thereof) for satisfaction of any of its remedies for collection of a judgment or other judicial process requiring payment of money. Further, in the event Lender transfers its interest in the Lease to a third party, Lender shall be automatically

freed and released, from and after the date of such transfer or conveyance, of all liability for the performance of any covenants and agreements which accrue after the date of such transfer of Lender's interest.

6. Modification; Notice and Cure Rights**.** The Lease shall not be amended, modified or supplemented, nor will the Lease be terminated (except as set forth in the Lease after a default or other trigger event and after the notice and cure rights set forth below) or any party having liability under the Lease be released by the other, without the prior written consent of Lender. Tenant shall not terminate or seek to terminate the Lease until Tenant has given written notice, by personal service, overnight courier or registered or certified mail, return receipt requested, of said act or omission to Lender, which notice shall be addressed to East West Bank, 9300 Flair Drive, 6th Floor, El Monte, CA 91731; and until a period of time equal to the greater of: (a) the time allowed landlord under the Lease or (b) thirty days following such notice has elapsed, during which period Lender has the right, but not the obligation, to remedy such act, omission or other matter. If possession by Lender of the Property is necessary to effect such remedy and would be commercially reasonable, then the period of time for remedying such act or omission shall include a reasonable period of time for Lender to gain possession of the Premises, whether by foreclosure or otherwise (but in no event to exceed ninety (90) days).

7. Tenant Representations and Warranties. Tenant hereby represents and warrants that (a) the Lease is solely and exclusively for the Premises described in the Lease and located on the Property identified in Exhibit "A" attached to this Agreement and the off-site parking areas described in the Lease, (b) the Lease is not a "master lease" for any other premises and/or property leased by Tenant from Owner, (c) any default under the Lease, and the exercise of Owner's rights and remedies in connection with such default, shall only impact and/or effect Tenant's obligations with respect to the Premises and/or the Property, and (d) any default by Tenant under any other lease with Owner or any other landlord, and the exercise of any such landlord's rights and remedies in connection with such default, shall not affect Tenant's obligations under the Lease.

8. Miscellaneous. This Agreement and each and every covenant, agreement and other provision hereof shall be binding upon and shall inure to the benefit of the parties hereto and their representatives, successors and assigns. This Agreement may not be modified orally or in any manner other than by an agreement in writing signed by the parties hereto or their respective successors in interest. The term "Lender" as used throughout this Agreement includes any successor or assign of Lender and any holder(s) of any interest in the indebtedness secured by the Deeds of Trust. This Agreement and the rights and duties of the parties hereunder shall be governed for all purposes by the law of the State of California and the law of the United States applicable to transactions within such state. This Agreement may be executed in multiple counterparts, and by the different parties hereto in separate counterparts, each of which when so executed and delivered shall be deemed to be one and the same instrument with the same signature as if all parties to this Agreement had signed the same signature page.

8. Attorneys' Fees. If any lawsuit, judicial reference or arbitration is commenced which arises out of or relates to this Agreement, the prevailing party shall be entitled to recover from each other party such sums as the court, referee or arbitrator may adjudge to be reasonable attorneys' fees, in addition to costs and expenses otherwise allowed by law.

[signatures follow]

IN WITNESS WHEREOF, the parties hereto have each caused this Agreement to be executed as of the date first above written.

Owner:

6th & PINE DEVELOPMENT, LLC

BY: _____
Name: _____
Title: _____

Tenant:

MOLINA HEALTHCARE, INC.

BY: _____
Name: _____
Title: _____

Lender:

EAST WEST BANK

BY: _____
Name: _____
Title: _____

EXHIBIT A
LEGAL DESCRIPTION

THE LAND REFERRED TO HEREIN BELOW IS SITUATED IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA. AND IS DESCRIBED AS FOLLOWS:

PARCEL 1:

THE WEST 37112 FEET OF LOTS 1 AND 3, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 19 PAGE 91 ET SEQ., OF MISCELLANEOUS RECORDS OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE WEST LYING BETWEEN THE PROLONGATION OF THE NORTHERLY LINE OF LOT 1 AND THE SOUTHERLY LINE OF LOT 3 BY 8 FEET, AS VACATED IN RESOLUTION NO. C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

EXCEPT THEREFROM ALL OIL GAS, MINERALS AND HYDROCARBON SUBSTANCES LYING BELOW A DEPTH OF 200 FEET FROM THE SURFACE OF SAID LAND, BUT WITHOUT THE RIGHT OF ENTRY UPON ANY PORTION OF THE SURFACE OF SAID LAND FOR THE PURPOSE OF EXPLORING FOR, BORING, EXTRACTING. DRILLING. MINING. PROSPECTING FOR, REMOVING OR MARKETING SAID SUBSTANCES, AS RESERVED TO THE GRANTOR THEREIN IN DEED EXECUTED BY TITLE INSURANCE AND TRUST COMPANY. TRUSTEE UNDER AGREEMENT AND DECLARATION OF TRUST EXECUTED HEREOF CREATING THOSE CERTAIN TRUSTS KNOWN AS ALBERT C. SELLERY TRUST AND THE ELEANOR D. SELLERY TRUST, RECORDED JULY 15, 1969 AS INSTRUMENT NO. 420, OF OFFICIAL RECORDS.

APN: 7273-025-013

PARCEL 2:

LOTS 5 AND 7, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGE 91 ET SEQ., OF MISCELLANEOUS RECORDS OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE WEST LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY LINE OF LOT 5 AND THE SOUTHERLY LINE OF LOT 7, BY 8 FEET, AS VACATEDIN RESOLUTION NO., C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

APN: 7273-025-015

PARCEL 3:

THE SOUTH 5 FEET OF LOT 6 AND ALL OF LOT 8, IN BLOCK 41 OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THE PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE EAST LYING BETWEEN THE PROLONGATION OF THE NORTHERLY LINE OF THE SOUTHERLY 5 FEET OF LOT 6 AND THE PROLONGATION OF THE SOUTHERLY LINE OF LOT 7, BY 8 FEET, AS VACATED IN

RESOLUTION NO. C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

APN: 7273-025-016

PARCEL 4:

LOTS 10, 12 AND 14, IN BLOCK 41 OF THE TOWNSITE OF LONG BEACH, OF THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGE 91 OF MISCELLANEOUS RECORDS OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID LAND ON THE EAST LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY LINE OF LOT 10 AND THE SOUTHERLY LINE OF LOT 14, BY 8 FEET, AS VACATED IN RESOLUTION NO. C-24596 OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1.988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

EXCEPT THEREFROM ALL OIL GAS, MINERALS AND OTHER HYDROCARBON SUBSTANCES BELOW A DEPTH OF 200 FEET FROM THE SURFACE THEREOF, WITHOUT RIGHT OF SURFACE ENTRY, AS RESERVED BY EDWARD R. LOVELL, TRUSTEE IN DEED RECORDED DECEMBER 1, 1971 AS INSTRUMENT NO. 155, OF OFFICIAL RECORDS.

APN: 7273-025-019 (PORTION)

PARCEL 5:

LOTS 17 TO 21 INCLUSIVE IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING SAID LAND ON THE NORTH LYING BETWEEN THE PROLONGATIONS OF THE WESTERLY LINE OF LOT 17 AND THE EASTERLY LINE OF LOT 21 BY 5 FEET, AS VACATED IN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED APRIL 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947, OF OFFICIAL RECORDS.

APN: 7273-025-020 (PORTION)

PARCEL 6:

LOTS 9, 11 AND 13, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING SAID AND ON THE WEST LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY LINE OF LOT 9 AND THE SOUTHERLY LINE OF LOT 13 BY 8 FEET, AS VACATED IN RESOLUTION NO. C-24596, OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

APN: 7273-025-017, 018 (PORTION)

PARCEL 7:

LOTS 24 TO 28 INCLUSIVE IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH. AS PER MAP RECORDED IN BOOK 19 PAGES 91 ET SEQ. OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING SAID LAND ON THE NORTH LYING BETWEEN THE PROLONGATIONS OF THE WESTERLY LINE OF LOT 24 AND THE EASTERLY LINE OF LOT 28 BY 5 FEET, AS VACATED IN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED April 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947, OF OFFICIAL RECORDS.

EXCEPT ALL OIL GAS AND OTHER HYDROCARBONS, IN AND UNDER THAT PORTION OF SAID LAND LOCATED MORE THAN 100 FEET BELOW THE SURFACE THEREOF BUT WITH NO RIGHT OF USE OF THE SURFACE OF SAID LANDS OR ANY PORTION THEREOF WITHIN 100 FEET OF THE SURFACE, AS RESERVED BY COVENANT PRESBYTERIAN CHURCH OF LONG BEACH, CALIFORNIA, IN DEED RECORDED MAY 19,1965 AS INSTRUMENT NO. 999, OF OFFICIAL RECORDS.

APN: 7273-025-021 (PORTION)

PARCEL 8:

LOTS 15, 16, 22 AND 23, IN BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 PAGE 91 ET SEQ. OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING LOTS 15 AND 16 ON THE SOUTH LYING BETWEEN THE PROLONGATIONS OF THE EASTERLY AND WESTERLY LINES OF SAID LOTS 15 AND 16, BY 5 FEET, AS VACATED IN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED APRIL 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947 AND ALSO TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING LOT 15 ON THE WEST AND ADJOINING LOT 16 ON THE EAST, LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY AND SOUTHERLY LINES OF SAID LOTS 15 AND 16, BY 8 FEET, RESPECTIVELY, AS VACATED IN RESOLUTION NO. C-24596, OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

ALSO TOGETHER WITH THAT PORTION OF THE ALLEY 10 FEET WIDE ADJOINING LOTS 22 AND 23 OF THE NORTH, LYING BETWEEN THE PROLONGATIONS OF THE EASTERLY AND WESTERLY LINES OF SAID LOTS 22 AND 23, BY 5 FEET, AS VACATED IN RESOLUTION NO. C-21081, OF THE CITY OF LONG BEACH, RECORDED APRIL 10, 1972 AS INSTRUMENT NO. 2966 AND RECORDED MAY 9, 1972 AS INSTRUMENT NO. 3947 AND ALSO TOGETHER WITH THAT PORTION OF THE ALLEY 16 FEET WIDE ADJOINING LOT 22 ON THE EAST AND ADJOINING LOT 23 ON THE WEST, LYING BETWEEN THE PROLONGATIONS OF THE NORTHERLY AND SOUTHERLY LINES OF SAID LOTS 22 AND 23, BY 8 FEET, RESPECTIVELY,AS VACATED IN RESOLUTION NO. C-24596, OF THE CITY OF LONG BEACH, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, OF OFFICIAL RECORDS.

EXCEPT THEREFROM ALL OIL GAS, AND OTHER HYDROCARBONS, IN AND UNDER THAT PORTION OF SAID LAND LOCATED MORE THAN 100 FEET BELOW THE SURFACE THEREOF, BUT WITH NO RIGHT OF USE OF THE SURFACE OF SAID LANDS OR ANY PORTION THEREOF WITHIN 100 FEET OF THE SURFACE, RESERVED IN DEED RECORDED MAY 19, 1965 AS INSTRUMENT NO. 999, OF OFFICIAL RECORDS.

APN: 7273-025-018 (PORTION), 7273-025-019 (PORTION), 7273-025-020 (PORTION), 7273-025-021 (PORTION)

PARCEL 9:

THE EAST 112.5 FEET OF LOTS 1 AND 3, BLOCK 41, OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 19 PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY. .

EXCEPT THEREFROM ALL OIL, GAS AND OTHER MINERAL RIGHTS IN AND UNDER SAID PROPERTY TOGETHER WITH THE EXCLUSIVE RIGHT TO USE SUCH PORTION OF SAID PROPERTY LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR THE EXTRACTION OF OIL GAS AND MINERALS FROM SAID PROPERTY OR PROPERTY IN THE VICINITY THEREOF; HOWEVER, WITH NO RIGHTS OF SURFACE ENTRY WHATSOEVER. AS RESERVED TO THE GRANTOR THEREIN IN DEED EXECUTED BY SOCONY MOBIL OIL COMPANY, INC., A NEW YORK CORPORATION, SUCCESSOR BY MERGER TO GENERAL PETROLEUM CORPORATION, FORMERLY KNOWN AS GENERAL PETROLEUM CORPORATION OF CALIFORNIA, RECORDED MARCH 2, 1966.

APN: 7273-025-001

PARCEL 10:

LOTS 2 AND 4 AND THE NORTH 20 FEET OF THE LOT 6 IN BLOCK 41 OF THE TOWNSITE OF LONG BEACH, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGELES, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 19, PAGE(S) 91 OF MISCELLANEOUS RECORDS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

TOGETHER WITH THAT PORTION OF TRIBUNE COURT VACATED BY THE CITY OF LONG BEACH, RESOLUTION NO. 24596, RECORDED NOVEMBER 14, 1988 AS INSTRUMENT NO. 88-1824834, LYING NORTHERLY OF THE EASTERLY PROLONGATION OF THE SOUTHERLY LINE FEET THE SOUTHERLY 20 FEET OF LOT 6, LYING SOUTHERLY OF THE SOUTHERLY LINE OF 7TH STREET, 80 FEET WIDE, LYING EASTERLY OF THE EASTERLY LINE OF LOTS 2, 4 AND 6 LYING WESTERLY OF THE EASTERLY LINE OF THE WEST 8 FEET OF SAID TRIBUNE COURT.

A NON-EXCLUSIVE EASEMENT FOR INGRESS AND EGRESS OVER THE SOUTH 5 FEET OF LOT 6, AND ALL OF LOT 5, AND LOTS 7 THROUGH 28, INCLUSIVE, IN BLOCK 41 OF LONG BEACH, CITY OF LONG BEACH, AS PER MAP RECORDED IN BOOK 19 OF PAGES 91 TO 96 INCLUSIVE OF MISCELLANEOUS RECORDS OF THE COUNTY RECORDER OF SAID COUNTY, AS GRANTED BY DOCUMENT RECORDED NOVEMBER 7, 1988, AS INSTRUMENT NO. 88-1791681, OFFICIAL RECORDS.

EXCEPT THEREFROM ALL MINERALS, GAS, OIL, PETROLEUM, NAPHTHA AND OTHER HYDROCARBON SUBSTANCES LOCATED IN AND UNDER SAID LAND BELOW A DEPTH OF 200 FEET FROM THE SURFACE THEREOF, WITHOUT RIGHT OF SURFACE ENTRY. AS RESERVED IN DEED RECORDED APRIL 16, 1993 AS INSTRUMENT NO. 93-716425 OFFICIAL RECORDS.

APN: 7273-025-014 (PORTION)

CERTIFICATE OF ACKNOWLEDGEMENT

State of _____

County of _____

On _____ before me, _____ , a notary public, personally appeared _____

_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.
I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand and official seal.

_____ (Seal)
Signature
Notary Public

CERTIFICATE OF ACKNOWLEDGEMENT

State of _____

County of _____

On _____ before me, _____ , a notary public, personally appeared _____
_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.
I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand and official seal.

_____ (Seal)
Signature
Notary Public

CERTIFICATE OF ACKNOWLEDGEMENT

State of _____

County of _____

On _____ before me, _____ , a notary public, personally appeared _____
_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.
I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand and official seal.

_____ (Seal)
Signature
Notary Public

PARKING LICENSE AGREEMENT

THIS PARKING LICENSE AGREEMENT ("Agreement") is entered into this 25th day of May, 2012, by the CITY OF LONG BEACH, a California municipal corporation ("Licensor"), pursuant to a minute order adopted by its City Council on May 1, 2012, and 6TH & PINE DEVELOPMENT, LLC, a California limited liability company ("Licensee").

For and in consideration of the faithful performance of the terms and conditions hereinafter set forth, the parties agree as follows:

1. PARKING SPACES AND PREMISES. City hereby grants Licensee the use of not more than five hundred (500) parking spaces on all weekdays during the Term from the hours of 7:00am through 6:00pm ("Parking Spaces") for purposes of providing parking to its tenant at the development at the corner of 6th Street and Pine Avenue, Long Beach, California, and commonly known as the "Press-Telegram Building" (the "Development"). The Parking Spaces may be located on more than one City-owned parking lot or structure, located anywhere within the City limits, as designated by City (collectively, the "Premises"). City, upon sixty (60) days advance written notice to Licensee and at its sole and absolute discretion, may relocate all or a portion of the Parking Spaces to alternate Premises located anywhere within the City limits. City shall issue to Licensee annual parking permits authorizing use of the Parking Spaces ("Permits") in accordance with its standard procedures. City shall issue only as many Permits as Licensee requests

in writing, which such total requested number of Permits may increase or decrease from month-to-month and costs associated with such Permits shall be pro-rated accordingly. This Agreement is meant to meet the parking demands of Licensee's tenant at the Development only, and in no way shall the parking rights granted to Licensee under this Agreement be interpreted to satisfy or displace any code-required parking in connection with new construction at the Development as required by the Long Beach Municipal Code or other applicable regulations.

2. TERM. The term of this Agreement shall commence on January 1, 2013 (the "Commencement Date"), and shall terminate at midnight on December 31, 2024, unless sooner terminated as provided herein (the "Term"). City and Licensee may mutually agree to renew this Agreement for two (2) additional five (5)-year terms. All provisions of this Agreement applicable to the original term shall apply with equal force to the extended term.

3. PARKING PERMIT FEES. Subject to the provisions of Section 4, Licensee shall pay an annual fee equal to Six Hundred Dollars ($600) per Permit issued by City ("Parking Fee").

4. ADJUSTMENT TO PARKING FEES. The Parking Fee to be paid to City by Licensee for each Permit shall be adjusted annually effective on the adjustment date of January 1st, by the 12 Months Percent Change in the Consumer Price Index for All Urban Consumers, All Items, Base Period 1982-84=100, for the Los Angeles-Riverside-Orange County, CA Area, published by the United States Department of Labor, Bureau of Labor Statistics. The December Index immediately prior to the adjustment date shall be the "Current Index," and the December Index

for the year previous shall be the "Beginning Index". If the Current Index is greater than the Beginning Index, the then-current rent or adjusted Parking Fee shall increase by the same percentage rounded to the nearest tenth as did the Current Index increase over the Beginning Index, so that the Parking Fee shall increase each year by the same percentage as did the Consumer Price Index. In no event shall any Parking Fee adjustment result in a Parking Fee less than that paid during the preceding period.

5. USE OF PREMISES. The Premises shall be used during Licensee's periods of exclusive occupancy for parking by employees of Licensee's tenant at the Development and for no other purpose. Licensee shall not occupy, use, or grant permission to anyone to occupy or use the Premises for any unlawful purpose. Licensee shall conduct its business and activities and control its agents, employees, invitees, licensees, volunteers, and visitors in such a manner that will not create any nuisance, unreasonable annoyance or waste. On weekends and weekday overnights between the hours of 6:00pm through 7:00am the Premises shall be available to the public. Nothing contained in this Section 5 shall require Licensee to supervise, control, or be responsible for activities upon or use of the Premises by the public. Prior to issuing a parking citation to any vehicle displaying a valid Permit issued pursuant to this Agreement, City shall grant such vehicle a 30-minute grace period.

6. CONDITION OF PREMISES. City shall deliver the Premises to Licensee paved, striped, and free of debris on the Commencement Date. Any replacement Premises designated by City pursuant to Section 1 shall also be

delivered to Licensee, paved, striped and free of debris. Except as otherwise described above, City delivers the Premises to Licensee “AS IS” and with all faults.

7. MAINTENANCE OF PREMISES. City shall provide for the ordinary care and maintenance of the Premises; provided, however, that Licensee shall be responsible for all costs associated with damage caused by Licensee’s use of the Premises beyond reasonable wear and tear.

8. INDEMNIFICATION. Licensee shall defend, indemnify, and hold harmless City, its officers and employees (“City Indemnified Parties”) from and against all causes of actions, damage, proceedings, claims, demands, loss, liens, costs and expenses alleging injury to or death of persons, or damage to property, or any other claim of damage brought, made, filed against, imposed on or sustained by the City Indemnified Parties, or any of them, and arising from or attributable to or caused, directly or indirectly (collectively or individually, a “claim"):

(i) by the use of the Premises or any equipment or materials located thereon, or from activities conducted thereon by Licensee, its employees, invitees, agents, or by any person or persons acting on behalf of Licensee and with Licensee's knowledge and consent, express or implied during periods of Licensee’s exclusive use; or

City shall defend, indemnify, and hold harmless Licensee, its officers and employees (“Licensee Indemnified Parties”) from and against all causes of actions, damage, proceedings, claims, demands, loss, liens, costs and expenses alleging injury to or death of persons, or damage to

property, or any other claim of damage brought, made, filed against, imposed on or sustained by the Licensee Indemnified Parties, or any of them, and arising from or attributable to or caused, directly or indirectly (collectively or individually, a "claim") by the use of the Premises by the public, or the employees, agents or invitees of City or by any person or persons acting on behalf of City.

9. INSURANCE. Upon execution of this Agreement and in partial performance of Licensee's obligations hereunder, Licensee shall procure and maintain, at its cost, during the Term and any extensions or renewals thereof, from an insurer admitted in California or having a minimum rating of or equivalent to A:VIII in Best's Insurance Guide:

(i) Comprehensive General Liability insurance with a combined single limit of at least $1,000,000 for each occurrence or Two Million Dollars ($2,000,000) general aggregate. City, its officials, employees and agents shall be covered as additional insureds with respect to liability arising from activities performed by or on behalf of Licensee. Said insurance shall be primary insurance with respect to City and shall contain a cross-liability endorsement. (ii) "All Risk" property insurance in an amount sufficient to cover the full replacement value of Licensee's personal property, improvements and equipment on the Premises.

(iii) Upon the execution of this Agreement, Licensee shall deliver to City certificates of insurance with original endorsements evidencing the coverage required by this Agreement. The certificates and endorsements shall be

signed by a person authorized by the insurer to bind coverage on its behalf. City reserves the right to require complete certified copies of all policies at any time.

(iv) Said insurance shall contain an endorsement requiring thirty (30) days' prior written notice from insurers to City before cancellation or change of coverage.

(v) Said insurances may provide for such deductibles or self-insured retention as may be acceptable to the City Manager or his designee. In the event such insurance does provide for deductibles or self-insured retention, Licensee agrees that it will fully protect City, its officials, and employees in the same manner as these interests would have been protected had the policy or policies not contained a deductible or retention provisions. With respect to damage to property, City and Licensee hereby waive all rights of subrogation, one against the other, but only to the extent that collectible commercial insurance is available for said damage.

(vi) Not more frequently than every two (2) years, if, in the opinion of City, or of an insurance broker retained by City, the amount of the foregoing insurance coverages is not adequate, Licensee shall increase the insurance coverage as required by City.

(vii) The procuring of said insurance shall not be construed as a limitation on Licensee's liability or as full performance on Licensee's part of the indemnification and hold harmless provisions of this Agreement; and Licensee understands and agrees that, notwithstanding any insurance, Licensee's obligation

to defend, indemnify and hold City, its officials and employees harmless hereunder is for the full and total amount of any damage, injuries, loss, expense, costs or liabilities in any manner connected with or attributed to the acts or omissions of Licensee, its officers, agents, employees, patrons or visitors, or the operations conducted by Licensee, or the Licensee's use, misuse or neglect of the Premises.

(viii) Any modification or waiver of the insurance requirements herein shall only be made with the written approval of the City's Risk Manager or designee.

10. CITY'S NON-LIABILITY. Except as expressly provided for in this Agreement, City shall not be liable for any damage to Licensee or Licensee's property or any of Licensee's employees, agents, invitees, licensees, volunteers or visitors, and Licensee, as a material part of the consideration of this Agreement, hereby waives all claims and demands against City for any such damage, to the extent allowed by law, except to the extent that such damage is caused by City's negligence. Licensee assumes all risk of theft, misappropriation, damage, injury, claims or losses of its personal property kept, stored, held, placed or otherwise left on the Premises, except as expressly provided for in this Agreement. Licensee shall not be responsible for theft, misappropriation, damage, injury, claims or losses of personal property belonging to members of the public.

11. ASSIGNMENT AND SUBLETTING. Licensee may not assign or sub-license the Premises without the express written consent of the City, which may be withheld at City's sole discretion. Notwithstanding the preceding sentence,

Licensee may assign this Agreement to a purchaser of the Development. No assumption or sub-licensing of this Agreement will be effective without the express written assumption by such assignee of the obligations of Licensee under this Agreement, nor shall such sub-licensing or assignment alter the primary liability of Licensee for the payment of Parking Fees or for the performance of any other obligations to be performed by Licensee.

12. TAXES. Licensee shall pay all assessments or real estate taxes or possessory interest taxes, if any, levied against the Premises due to Licensee's periods of exclusive use; provided that Licensee shall only be responsible for its pro-rata share of taxes levied against the Premises.

13. INSPECTION AND ENTRY. City shall have the right, at all reasonable times, to enter the Premises to inspect them to determine if Licensee is complying with the terms, covenants and conditions of this Agreement, to comply with any law, order, or requirement of any governmental authority, and to serve or post any notice.

14. DEFAULT. The occurrence of any one or more of the following acts shall constitute a default by Licensee, if said failure is not cured within thrity (30) days after City gives notice to Licensee of said failure:

(i) Failure to use the Premises as described in Section 5;

(ii) Failure to pay Parking Fees;

(iii) Failure to maintain the insurance required herein;

(iv) Failure to execute a Lease with Molina Health Care Group respecting the Development with a term of at least ten (10) years;

(iv) Failure to comply with any applicable law, rule, ordinance, or regulation; or

(v) Any failure to perform any other term, covenant, or condition of this Agreement not specifically identified in this Section or in elsewhere in this Agreement. If the default cannot reasonably be cured in thirty (30) days, then Licensee shall not be in default if Licensee begins to cure within said period and diligently proceeds to cure to completion; provided that in no event shall such cure period extend beyond ninety (90) days.

15. NOTICE. Any notice or request given under this Agreement shall be in writing and personally delivered or deposited in the U.S. Postal Service, postage prepaid, first class, addressed as follows:

To City: City of Long Beach
333 West Ocean Boulevard, 13th Floor
Long Beach, CA 90802
Attn: City Manager

To Licensee: 6th & Pine Development, LLC
741 Atlantic Avenue
Long Beach, CA 90813
Attn: Michelle Molina

Notice shall be effective on the date of personal delivery or deposit in the mail, whichever first occurs. Notice of change of address or the person to whom notice shall be directed shall be given in the manner prescribed herein.

16. NO WAIVER. The failure or delay of either party to insist on strict enforcement of any term, covenant, or condition herein shall not be deemed a waiver of any right or remedy either party may have and shall not be deemed a waiver of any subsequent or other breach of any term, covenant, or condition. Any waiver or permission of any kind by either party shall be in writing and signed to be effective.

17. SURRENDER OF PREMISES. On the expiration or sooner termination of this Agreement, Licensee shall deliver to City possession of the Premises. Licensee shall remove its equipment, supplies and other items so as to leave the Premises in a condition which does not damage the Premises and the improvements thereto in any way.

18. CITY'S RIGHT TO RE-ENTER ON TERMINATION OR EXPIRATION. Licensee shall peaceably deliver possession of the Premises to City on the date of expiration or sooner termination of this Agreement. On giving notice of termination to Licensee, City shall have the right to re-enter and take possession of the Premises on the date such termination becomes effective without further notice of any kind and without instituting summary or regular legal proceedings.

19. RELOCATION WAIVER. Licensee expressly waives any rights to relocation benefits or other compensation pursuant to the California Relocation Act or applicable laws governing eminent domain.

20. PERMANENT PARKING. City and Licensee agree to work together in good faith to identify property suitable to provide for permanent parking for the Development, whether publicly-owned or privately-owned, it being the intent of the parties that such permanent parking would replace the Parking Spaces provided pursuant to this Agreement.

21. MISCELLANEOUS.

A. Each party shall bear its own costs and expenses in connection with the preparation of this Agreement. In the event any action is brought with respect to theenforcement of this Agreement, the prevailing party shall be entitled to recover its costs and expenses from the other party, including, but not limited to, attorney's fees and court costs.

B. This Agreement shall be binding on and inure to the benefit of the parties and their successors, heirs, personal representatives, and all of the parties shall be jointly and severally liable hereunder.

C. This Agreement constitutes the entire understanding between the parties and supersedes all prior negotiations, agreements and understandings, oral or written, with respect to the subject matter hereof.

D. This Agreement may not be amended except in a writing duly executed by both parties.

E. This Agreement shall be governed by and construed under the laws of the State of California, and no choice of laws or principles thereof shall apply.

F. The captions and numbers herein and the grouping of the provisions of this Agreement into separate sections and paragraphs are for the purpose of convenience only and shall not be considered a part hereof, and shall have no effect on the interpretation of this Agreement.

G. If any term, covenant, or condition of this Agreement is found to be invalid, ineffective, void, or unenforceable for any reason by a court of competent jurisdiction, the remaining terms, covenants and conditions shall remain in full force and effect.

H. Time is of the essence in this Agreement and all of its provisions.

I. This Agreement shall not be recorded.

J. The relationship of the parties hereto is that of City and Licensee, and the parties agree that nothing contained in this Agreement shall be deemed or construed as creating a partnership, joint venture, principal-agent relationship, association, or employer-employee relationship between them or between City and any third party.

K. This Agreement is created as a joint effort between the parties and fully negotiated as to its terms covenants and conditions. This Agreement shall not be construed against either party as the drafter.

L. Each provision of this Agreement shall be deemed both a covenant and a condition.

M. This Agreement is created for the benefit of the parties only and is not intended to benefit any third person or entity.

N. Where consent or approval is required from either Licensee or City by the provisions of this Agreement, the giving of consent or approval shall not be unreasonably withheld or delayed by the party from whom consent or approval is required.

O. All exhibits to this Agreement are hereby incorporated herein by reference.

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IN WITNESS WHEREOF, the parties have caused this document to be duly executed as of the date first stated above.

CITY OF LONG BEACH, a California municipal corporation

Dated: ___ By: ___
Name: ___
Title: ___
CITY

6TH & PINE DEVELOPMENT, LLC, a California limited liability company

Dated: ___ By: ___
Name: ___
Title: ___

LICENSEE

The foregoing Agreement is hereby approved as to form this _____day of _____, 2012.

ROBERT E. SHANNON, City Attorney

By _____

Deputy City Attorney

RFA;abcl
#07-03978

ESTOPPEL AND AGREEMENT REGARDING PARKING AGREEMENT

This **ESTOPPEL AND AGREEMENT REGADING PARKING AGREEMENT** (this "**Agreement**") dated _____, 2013, is made among **6TH & PINE DEVELOPMENT, LLC**, a California limited liability company, whose address is 741 Atlantic Avenue, Long Beach, California 90813 ("**Licensee**"), the **CITY OF LONG BEACH**, a California municipal corporation, whose address is 333 West Ocean Boulevard, 13th Floor, Long Beach, California 90802 (the "**City**"), and **MOLINA HEALTHCARE, INC.**, a Delaware corporation, whose address is 200 Oceangate, Suite 100, Long Beach, California 90802, Attention: General Counsel ("**Tenant**").

WHEREAS, Tenant and Licensee have entered into an Office Building Lease–Full Service Gross–Single Tenant Building(s), dated as of February 28, 2013 (the "**Lease**"), a Memorandum of which is to be recorded in the Official Records of Los Angeles County, California covering, among other property, the land (the "**Land**") described in **Exhibit "A"** which is attached hereto and incorporated herein by reference, and the improvements ("**Improvements**") thereon (or to be built thereon) (such Land and Improvements being herein together called the "**Property**");

WHEREAS, Licensee is the licensee under a Parking License Agreement by and between the City and Licensee entered into as of May 25, 2012 (as the same may from time to time be renewed, extended, amended or supplemented, the "**Parking Agreement**"), covering the use of up to five hundred (500) parking spaces located at one or more City-owned parking lots or structures, located within the City of Long Beach, California (herein referred to as the "**Parking Premises**"); and

WHEREAS, the term the "City" as used herein means the present licensor under the Parking Agreement, or, if the licensor's interest is transferred or assigned in any manner, the successor(s) or assign(s) occupying the position of licensor under the Parking Agreement at the time in question.

NOW THEREFORE, in consideration of the mutual agreements herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Estoppel Certificate. The City and Licensee agree to execute and deliver from time to time, upon the reasonable request of the other party or of Tenant, a certificate regarding the status of the Parking Agreement, consisting of statements, if true (or if not, specifying why not), (a) that the Parking Agreement is in full force and effect, (b) the date through which payments have been paid, (c) the nature of any amendments or modifications of the Parking Agreement, (d) to the best of the City's and Licensee's knowledge, respectively, no default exists under the Parking Agreement, (e) to the best of the City's and Licensee's knowledge, respectively, no setoffs, recoupments, estoppels, claims or counterclaims exist against the City, and (f) such other matters as may be reasonably requested.

2. Acknowledgement and Agreement by the City. The City acknowledges and agrees as follows:

(a) From and after the date hereof, in the event of a default by the Licensee under the Parking Agreement, the City shall give Tenant notice of such default concurrently at the time of delivery of notice of such default to the Licensee, and shall afford Tenant an opportunity to cure such default prior to termination of the Parking Agreement by the City, all pursuant to Section 14 of the Parking Agreement; provided, however, that Tenant shall have no duty or obligation to cure or remedy any breach or default. Notwithstanding the terms of the Parking Agreement, the City hereby grants Tenant, in addition to the period given to Licensee for remedying defaults, an additional thirty (30) days to remedy, or cause to be remedied, any such default. It is specifically agreed that the City shall not, as to Tenant, require cure of any such default which is personal to Licensee, and therefore not susceptible to cure by Tenant. In the event that such default shall be cured, either by Tenant or by Licensee, the City agrees that Tenant's use of the Parking Premises pursuant to the Parking Agreement shall not be disturbed and that the Parking Agreement shall not be subject to termination as a result of the occurrence of such default, which is cured either by Tenant or Licensee. The City shall accept performance by Tenant of any term, covenant, condition or agreement to be performed by Licensee under the Parking Agreement with the same force and effect as though performed by Licensee. No Licensee default under the Parking Agreement shall exist or shall be deemed to exist as long as Tenant, in good faith, shall have commenced to cure such default within the above referenced time period and shall be prosecuting the same to completion with reasonable diligence, subject to force majeure; provided that in no event shall such cure period exceed ninety (90) days.

(b) In the event of the termination of the Parking Agreement by reason of any default thereunder by Licensee, upon Tenant's written request, given within thirty (30) days after any such termination, the City, within fifteen (15) days after receipt of such request, shall execute and deliver to Tenant a new lease of the Parking Premises for the remainder of the term of the Parking Agreement upon all of the terms, covenants and conditions of the Parking Agreement. Tenant shall not become liable under the Parking Agreement unless and until Tenant becomes, and then only with respect to periods in which the Tenant succeeds to the interests of Licensee under the Parking Agreement.

(c) The City shall send a copy of any notice or statement under the Parking Agreement to Tenant at the same time such notice or statement is sent to Licensee if such notice or statement has a material impact on the economic terms, operating covenants or duration of the Parking Agreement. The City represents and warrants to Tenant that a true and complete copy of the Parking Agreement has been delivered by the City to Tenant.

3. Acknowledgment and Agreement by Licensee. Licensee, as licensee under the Parking Agreement, acknowledges and agrees for itself and its heirs, representatives, successors and assigns, that: (a) this Agreement does not constitute a waiver by Tenant of any of its rights under the Lease, or in any way release Licensee from its obligations to comply with the terms, provisions, conditions, covenants, agreements and clauses of the Lease; and (b) the provisions of the Lease remain in full force and effect and must be complied with by Licensee. Licensee shall send a copy of any notice or statement under the Parking Agreement to Tenant at the same time such notice or statement is sent the City if such notice or statement has a material impact on the economic terms, operating covenants or duration of the Parking Agreement.

4. Parking Agreement Status. The City and Licensee certify to Tenant that neither the City nor Licensee has knowledge of any default on the part of the other under the Parking Agreement, that the Parking Agreement is bona fide and contains all of the agreements of the parties thereto with respect to the letting of the Parking Premises, that the Parking Agreement has not been modified or amended and that all of the agreements and provisions therein contained are in full force and effect.

5. Notices. All notices, request, consents, demands and other communications required or which any party desires to give hereunder shall be in writing and shall be deemed sufficiently given or furnished if delivered by personal delivery, by expedited delivery service with proof of delivery, or by registered or certified United States mail, postage prepaid, at the addresses specified at the beginning of this Agreement (unless changed by similar notice in writing given by the particular party whose address is to be changed). Any such notice or communication shall be deemed to have been given either at the time of personal delivery or, in the case of delivery service or mail, as of the date of first attempted delivery at the address and in the manner provided herein. Notwithstanding the foregoing, no notice of change of address shall be effective except upon receipt. This Paragraph 5 shall not be construed in any way to affect or impair any waiver of notice or demand provided in this Agreement or in the Parking Agreement or to require giving notice or demand to or upon any persons in any situation or for any person.

6. Miscellaneous.

(a) Nothing contained in this Agreement shall be construed to derogate from or in any way impair, or affect the estate and rights created pursuant to the Lease.

(b) This Agreement shall inure to the benefit of the parties hereto, their respective successors and permitted assigns, and any subsequent owner of the Property, and its heirs, personal representatives, successors and assigns; provided, however, that in such event, the Parking Agreement shall remain in full force and effect, and thereupon all such obligations and liabilities shall be the responsibility of the party to whom Licensee's interest is assigned or transferred; and provided further that the interest of Licensee under this Agreement may not be assigned or transferred without the prior written consent of Tenant and the City.

(c) THIS AGREEMENT AND ITS VALIDITY, ENFORCEMENT AND INTERPRETATION SHALL BE GOVERNED BY THE LAWS OF THE STATE OF CALIFORNIA, WITHOUT REGARD TO CONFLICT OF LAW PRINCIPLES THAT WOULD RESULT IN THE APPLICATION OF ANY LAW OTHER THAN THE LAW OF THE STATE OF CALIFORNIA.

(d) The words "herein", "hereof", "hereunder" and other similar compounds of the word "here" as used in this Agreement refer to this entire Agreement and not to any particular section or provision.

(e) This Agreement may not be modified orally or in any manner other than by an agreement in writing signed by the parties hereto or their respective successors in interest.

(f) If any provision of the Agreement, shall be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality or unenforceability shall not apply to or affect any other provision hereof, but this Agreement shall be construed as if such invalidity, illegibility, or unenforceability did not exist.

(g) Each individual executing this Agreement on behalf of the parties hereto represents and warrants that s/he is duly authorized to execute and deliver this Agreement on behalf of such entity, and that this Agreement is binding upon such party, in accordance with the terms of this Agreement.

(h) This Agreement may be executed in any number of counterparts and all of such counterparts shall together constitute one and the same instrument.

[Signatures appear on the following page]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed and sealed as of the date first above written.

LICENSEE:

6TH & PINE DEVELOPMENT, LLC,
a California limited partnership

By: _____
Name: _____
Title: _____

CITY:

CITY OF LONG BEACH, a California municipal corporation

By: _____
Name:_____
Title:_____

Approved as to Form:

By: _____
Title: Deputy City Attorney

Attest:

By: _____
Title: City Clerk

TENANT:

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: _____
Name: _____
Title: _____

EXHIBIT 12.1

LIST OF SUBSIDIARIES

+ Wholly owned subsidiary of Molina Healthcare of New Mexico, Inc.

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2012	2011	2010	2009	2008
	(Dollars in Thousands)				
Earnings:					
Income before income taxes	$ 19,065	$ 64,654	$ 89,492	$ 38,157	$ 94,324
Add fixed charges:					
Interest expense, including amortization of debt discount and expense	16,769	15,519	15,509	13,777	13,231
Estimated interest portion of rental expense	2,865	2,542	4,522	5,181	4,370
Total fixed charges	19,634	18,061	20,031	18,958	17,601
Total earnings available for fixed charges	$ 38,699	$ 82,715	$ 109,523	$ 57,115	$ 111,925
Fixed charges from above:	$ 19,634	$ 18,061	$ 20,031	$ 18,958	$ 17,601
Ratio of Earnings to Fixed Charges	2.0	4.6	5.5	3.0	6.4
Total rent expense	$ 20,462	$ 23,110	$ 25,124	$ 20,723	$ 17,481
Interest factor	14%	11%	18%	25%	25%
Interest component of rental expense	$ 2,865	$ 2,542	$ 4,522	$ 5,181	$ 4,370

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Alliance for Community Health L.L.C	Missouri
American Family Care, Inc.	California
Molina Center LLC	Delaware
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company*	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California

* Wholly owned subsidiary of Molina Healthcare of Texas, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statements No. 333-108317, No. 333-138552, No. 333-153246, No. 333-170571, and No. 333-174912 on Form S-8 pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan; 2002 Equity Incentive Plan; 2002 Employee Stock Purchase Plan; 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and Registration Statement No. 333-181804 on Form S-3, of our reports dated February 28, 2013, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2012.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 28, 2013

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2012, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Joseph M. Molina

Joseph M. Molina
Chief Executive Officer and President

February 28, 2013

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2012, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

February 28, 2013

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2012, as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chief Executive Officer and President

February 28, 2013

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2012, as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

February 28, 2013

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended September 30, 2012

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2012

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

Molina Healthcare, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock outstanding as of October 19, 2012, was approximately 46,583,300.

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MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	September 30, 2012	December 31, 2011
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 715,480	$ 493,827
Investments	356,895	336,916
Receivables	156,909	167,898
Income tax refundable	33,530	11,679
Deferred income taxes	21,533	18,327
Prepaid expenses and other current assets	30,002	19,435
Total current assets	1,314,349	1,048,082
Property, equipment, and capitalized software, net	210,972	190,934
Deferred contract costs	67,516	54,582
Intangible assets, net	85,033	101,796
Goodwill and indefinite-lived intangible assets	151,088	153,954
Auction rate securities	13,523	16,134
Restricted investments	44,488	46,164
Receivable for ceded life and annuity contracts	—	23,401
Other assets	20,098	17,099
	$ 1,907,067	$ 1,652,146
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 536,463	$ 402,476
Accounts payable and accrued liabilities	151,029	147,214
Deferred revenue	143,301	50,947
Current maturities of long-term debt	1,143	1,197
Total current liabilities	831,936	601,834
Long-term debt	260,551	216,929
Deferred income taxes	37,478	33,127
Liability for ceded life and annuity contracts	—	23,401
Other long-term liabilities	22,101	21,782
Total liabilities	1,152,066	897,073
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 46,571 shares at September 30, 2012 and 45,815 shares at December 31, 2011	46	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	280,728	266,022
Accumulated other comprehensive loss	(330)	(1,405)
Retained earnings	474,557	490,410
Total stockholders' equity	755,001	755,073
	$ 1,907,067	$ 1,652,146

See accompanying notes.

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MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(Amounts in thousands, except net (loss) income per share) (Unaudited)			
Revenue:				
Premium revenue	$1,488,718	$ 1,138,230	$ 4,308,439	$ 3,348,438
Service revenue	48,422	37,728	132,351	111,290
Investment income	1,171	764	3,996	3,804
Rental income	1,879	—	5,408	—
Total revenue	1,540,190	1,176,722	4,450,194	3,463,532
Expenses:				
Medical care costs	1,314,571	959,158	3,823,136	2,822,049
Cost of service revenue	37,004	34,584	98,111	105,020
General and administrative expenses	127,500	99,610	379,208	290,967
Premium tax expenses	37,894	36,374	120,953	110,633
Depreciation and amortization	16,034	13,430	47,446	38,587
Total expenses	1,533,003	1,143,156	4,468,854	3,367,256
Operating income (loss)	7,187	33,566	(18,660)	96,276
Interest expense	4,315	4,380	12,421	11,666
Income (loss) before income taxes	2,872	29,186	(31,081)	84,610
Income tax (benefit) expense	(492)	10,236	(15,228)	30,832
Net income (loss)	$ 3,364	$ 18,950	$ (15,853)	$ 53,778
Net income (loss) per share:				
Basic	$ 0.07	$ 0.41	$ (0.34)	$ 1.18
Diluted	$ 0.07	$ 0.41	$ (0.34)	$ 1.16
Weighted average shares outstanding:				
Basic	46,546	45,834	46,301	45,693
Diluted	46,880	46,296	46,301	46,334

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(Amounts in thousands) (Unaudited)			
Net income (loss)	$ 3,364	$18,950	$(15,853)	$53,778
Other comprehensive income, net of tax:				
Unrealized gain (loss) on investments	455	(165)	1,075	430
Other comprehensive income (loss)	455	(165)	1,075	430
Comprehensive income (loss)	$3,819	$18,785	$ (14,778)	$ 54,208

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2012	2011
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net (loss) income	$ (15,853)	$ 53,778
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Depreciation and amortization	58,289	52,414
Deferred income taxes	1,166	8,069
Stock-based compensation	15,448	12,723
Gain on sale of subsidiary	(2,390)	—
Non-cash interest on convertible senior notes	4,414	4,095
Change in fair value of interest rate swap agreement	1,270	—
Amortization of premium/discount on investments	5,166	5,300
Amortization of deferred financing costs	825	2,451
Tax deficiency from employee stock compensation	(159)	(647)
Changes in operating assets and liabilities:		
Receivables	10,989	5,411
Prepaid expenses and other current assets	(10,574)	(1,819)
Medical claims and benefits payable	133,987	6,699
Accounts payable and accrued liabilities	(9,030)	246
Deferred revenue	92,354	25,400
Income taxes	(21,878)	(18,957)
Net cash provided by operating activities	264,024	155,163
Investing activities:		
Purchases of equipment	(52,548)	(45,921)
Purchases of investments	(234,465)	(258,209)
Sales and maturities of investments	213,665	226,413
Proceeds from sale of subsidiary, net of cash surrendered	9,162	—
Net cash paid in business combinations	—	(3,253)
Increase in deferred contract costs	(18,799)	(32,765)
Increase in restricted investments	(3,034)	(8,394)
Change in other noncurrent assets and liabilities	(4,775)	(533)
Net cash used in investing activities	(90,794)	(122,662)
Financing activities:		
Amount borrowed under credit facility	60,000	—
Repayment of amount borrowed under credit facility	(20,000)	—
Principal payments on term loan	(846)	—
Treasury stock purchases	—	(7,000)
Credit facility fees paid	—	(1,125)
Proceeds from employee stock plans	5,571	5,640
Excess tax benefits from employee stock compensation	3,698	1,590
Net cash provided by (used in) financing activities	48,423	(895)
Net increase in cash and cash equivalents	221,653	31,606
Cash and cash equivalents at beginning of period	493,827	455,886
Cash and cash equivalents at end of period	$ 715,480	$ 487,492

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Nine Months Ended September 30,	
	2012	2011
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 1,074	$43,550
Interest	$ 5,663	$ 5,026
Schedule of non-cash investing and financing activities:		
Common stock used for stock-based compensation	$ 9,852	$ 3,751
Details of sale of subsidiary:		
Decrease in carrying value of assets	$ 30,942	$ —
Decrease in carrying value of liabilities	(24,170)	—
Gain on sale	2,390	—
Proceeds from sale of subsidiary, net of cash surrendered	$ 9,162	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
September 30, 2012

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of September 30, 2012, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months with prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. For the six months ended June 30, 2012, our Missouri health plan contributed premium revenue of $113.8 million, or 4.1% of total premium revenue, and comprised 79,000 members, or 4.3% of total Health Plans segment membership as of June 30, 2012.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On July 13, 2012, our Molina Medicaid Solutions segment received full federal certification of its Medicaid Management Information System, or MMIS, in the state of Idaho from the Centers for Medicare and Medicaid Services, or CMS. As a result of the CMS certification, the state of Idaho is entitled to receive federal reimbursement of 75% of its MMIS operations costs retroactive to June 1, 2010, the date that the system first began processing claims.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement MMIS to another company For the nine months ended September 30, 2012, our revenue under the Louisiana MMIS contract was approximately $38.8 million, or 29.3% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize approximately $40 million in revenue annually under our Louisiana MMIS contract.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2012. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2011. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2011 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2011 audited financial statements.

Reclassifications

We have reclassified certain amounts in the 2011 consolidated statement of cash flows to conform to the 2012 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of $0.5 million and $1.0 million at September 30, 2012, and December 31, 2011, respectively.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both September 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. At both September 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of these contract provisions.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $3.2 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at September 30, 2012, and December 31, 2011, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At both September 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since medical expenses are not less than the contractual floor.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $1.7 million and $5.0 million for anticipated Medicare risk adjustment premiums as of September 30, 2012, and December 31, 2011, respectively.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30, 2012.

	Three Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 560	$ 532	$ —	$ 532	$ 84,797
Ohio	2,824	1,412	—	1,412	306,314
Texas	17,685	10,453	—	10,453	350,810
Wisconsin	419	—	246	246	16,279
	$ 21,488	$ 12,397	$ 246	$ 12,643	$ 758,200

	Three Months Ended September 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 566	$ 345	$ 46	$ 391	$ 79,644
Ohio	2,160	1,719	—	1,719	232,616
Texas	400	400	—	400	105,577
Wisconsin	420	362	—	362	17,269
	$ 3,546	$ 2,826	$ 46	$ 2,872	$ 435,106

	Nine Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,676	$ 1,350	$ 658	$ 2,008	$ 253,418
Ohio	8,222	6,810	966	7,776	896,908
Texas	41,687	30,487	—	30,487	908,532
Wisconsin	1,284	—	492	492	52,209
	$ 52,869	$ 38,647	$ 2,116	$ 40,763	$2,111,067

	Nine Months Ended September 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,712	$ 1,219	$ 364	$ 1,583	$ 246,223
Ohio	7,472	6,152	3,501	9,653	693,829
Texas	1,560	1,560	—	1,560	290,787
Wisconsin	1,292	362	—	362	51,526
	$ 12,036	$ 9,293	$ 3,865	$ 13,158	$1,282,365

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple –Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011 or 2012. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Premium Deficiency Charges

We assess the profitability of each contract by state for providing medical care services to our members and identify any contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared with the sum of anticipated future health care costs and maintenance costs. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. In the second quarter of 2012, our Texas and Wisconsin health plans recorded premium deficiency charges of $10.0 million and $3.0 million, respectively. Such charges were recorded to medical care costs. As of September 30, 2012, the aggregate premium deficiency reserve balance was $1.5 million.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of non-deductible compensation and state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $10.3 million as of September 30, 2012, and $10.7 million as of December 31, 2011. Approximately $8.4 million of the unrecognized tax benefits recorded at September 30, 2012, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.2 million as of September 30, 2012. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.6 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of September 30, 2012, and December 31, 2011, we had accrued $59,000 and $65,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

Balance Sheet Offsetting. In December 2011, the Financial Accounting Standards Board ("FASB") issued guidance for new disclosure requirements related to the nature of an entity's rights of setoff and related arrangements associated with its financial instruments and derivative instruments. The new guidance is effective for annual reporting periods, and interim periods within those years, beginning on or after January 1, 2013. While we do not expect the adoption of this guidance in 2013 to impact our financial position, results of operations or cash flows, we do expect it to change our disclosure policies relative to certain arrangements with rights of setoff.

Goodwill. In September 2011, the FASB issued guidance related to evaluating goodwill for impairment. The new guidance provides entities with the option to perform a qualitative assessment of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount before applying the quantitative two-step goodwill impairment test. If an entity concludes that it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, it would not be required to perform the quantitative two-step goodwill impairment test. Entities also have the option to bypass the assessment of qualitative factors for any reporting unit in any period and proceed directly to performing the first step of the quantitative two-step goodwill impairment test, as was required prior to the issuance of this new guidance. An entity may begin or resume performing the qualitative assessment in any subsequent period. The new guidance became effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2011, with early adoption permitted. The adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows.

Federal Premium-Based Assessment. In July 2011, the FASB issued guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (the "Affordable Care Act"). The Affordable Care Act imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014 that is allocated to health insurers based on the ratio of the amount of an entity's net premium revenues written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. The new guidance specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The new guidance is effective for annual reporting periods beginning after December 31, 2013, when the fee initially becomes effective. As enacted, this federal premium-based assessment is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this premium-based assessment will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this assessment as currently written could have a material impact on our financial position, results of operations, or cash flows in future periods.

Comprehensive Income. In June 2011, the FASB issued guidance, as amended in December 2011, related to the presentation of other comprehensive income. The new guidance provides entities with an option to either replace the statement of income with a statement of comprehensive income which would display both the components of net income and comprehensive income in a combined statement, or to present a separate statement of comprehensive income immediately following the statement of income. The new guidance does not affect the components of other comprehensive income or the calculation of earnings per share. To be applied retrospectively with early adoption permitted, the new guidance became effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2011. We have elected to present a separate statement of comprehensive income immediately following the statement of income. The adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows.

Fair Value. In May 2011, the FASB issued guidance related to fair value measurement and disclosure. The new guidance is a result of joint efforts by the FASB and the International Accounting Standards Board to develop a single converged fair value framework. The new guidance expands existing disclosure requirements for fair value measurements and makes other amendments; mostly to eliminate wording differences between U.S. generally accepted accounting principles ("GAAP") and international financial reporting standards. To be applied prospectively, the new guidance became effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2011. Although the adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows, it did change our disclosure policies relative to fair value measurements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Net Income (Loss) per Share

The following table sets forth the calculation of the denominators used to compute basic and diluted net income (loss) per share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(In thousands)			
Shares outstanding at the beginning of the period	46,527	46,062	45,815	45,463
Weighted-average number of shares repurchased	—	(235)	—	(160)
Weighted-average number of shares issued	19	7	486	390
Denominator for basic income (loss) per share	46,546	45,834	46,301	45,693
Dilutive effect of employee stock options and stock grants (1)	334	462	—	641
Denominator for diluted income (loss) per share (2)	46,880	46,296	46,301	46,334

(1) Unvested restricted shares are included in the calculation of diluted income per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. Options to purchase common shares are included in the calculation of diluted income per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended September 30, 2012 and 2011, there were approximately 370,000 and 57,000 anti-dilutive weighted restricted shares, respectively. For the three months ended September 30, 2012 and 2011 there were approximately 125,000 and 316,000 anti-dilutive weighted options, respectively. Potentially dilutive unvested restricted shares and stock options were not included in the computation of diluted loss per share for the nine months ended September 30, 2012, because to do so would have been anti-dilutive. For the nine months ended September 30, 2011, there were no anti-dilutive weighted restricted shares. For the nine months ended September 30, 2011 there were approximately 126,000 anti-dilutive weighted options.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted income (loss) per share for the three month and nine month periods ended September 30, 2012 and 2011, because to do so would have been anti-dilutive.

4. Share-Based Compensation

At September 30, 2012, we had employee equity incentives outstanding under three plans: (1) the 2011 Equity Incentive Plan; (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded); and (3) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). In March 2012, our chief executive officer, chief financial officer, and chief operating officer were awarded 94,050 performance units, 53,236 performance units, and 30,167 performance units, respectively, that would vest and be settled in shares of the Company's common stock equal in number to the units granted upon the achievement of certain service and performance conditions. Each of the grants shall vest in 2012, provided that: (i) the Company's total operating revenue for 2012 is equal to or greater than $5.5 billion, and (ii) the respective officer continues to be employed by the Company if and when the operating revenue target is met. As of September 30, 2012, we expect such performance awards to vest in full. In the event the vesting conditions are not achieved, the awards shall lapse. Also in March 2012, our chief executive officer, chief financial officer, chief operating officer, and chief accounting officer were awarded 8,000 shares, 8,000 shares, 8,000 shares, and 3,000 shares, respectively, of performance units that would vest and be settled in shares of the Company's common stock equal in number to the units granted upon the certification of our Idaho MMIS by CMS. Such awards vested when the Idaho MMIS was certified in July 2012.

Charged to general and administrative expenses, total share-based compensation expense was as follows for the three month and nine month periods ended September 30, 2012 and 2011:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(in thousands)			
Restricted share and performance/restricted unit awards	$ 5,093	$ 4,004	$ 13,943	$11,742
Stock options (including shares issued under our employee stock purchase plan)	543	345	1,505	981
Total share-based compensation expense	$5,636	$4,349	$15,448	$12,723

As of September 30, 2012, there was $19.0 million of total unrecognized compensation expense related to unvested restricted share awards, which we expect to recognize over a remaining weighted-average period of 2.3 years. As of September 30, 2012, there was $1.9 million of total unrecognized compensation expense related to performance and restricted units, which we expect to recognize in the fourth quarter of 2012.

Restricted share activity for the nine months ended September 30, 2012 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2011	1,435,882	$ 18.97
Granted	498,057	31.86
Vested	(744,360)	20.47
Forfeited	(79,999)	23.21
Unvested balance as of September 30, 2012	1,109,580	23.45

The total fair value of restricted shares vested during the nine months ended September 30, 2012 and 2011 was $24.3 million and $11.5 million, respectively.

Performance and restricted unit activity for the nine months ended September 30, 2012 is summarized below:

	Units	Weighted Average Grant Date Fair Value	Aggregate Intrinsic Value (In thousands)	Weighted Average Remaining Contractual term (Years)
Outstanding as of December 31, 2011	—	$ —		
Granted	213,022	33.59		
Vested	(31,285)	33.73	$ 823	
Outstanding as of September 30, 2012	181,737	33.56	$ 4,571	0.3
Performance and restricted units expected to vest as of September 30, 2012	181,737	33.56	$ 4,571	0.3

Stock option activity for the nine months ended September 30, 2012 is summarized below:

	Options	Weighted Average Exercise Price	Aggregate Intrinsic Value (In thousands)	Weighted Average Remaining Contractual term (Years)
Outstanding as of December 31, 2011	553,049	$ 20.91		
Granted	15,000	34.82		
Exercised	(114,229)	19.29	$ 1,553	
Forfeited	(750)	22.37		
Outstanding as of September 30, 2012	453,070	21.78	$ 1,966	3.4
Stock options exercisable and expected to vest as of September 30, 2012	453,070	21.78	$ 1,966	3.4
Exercisable as of September 30, 2012	438,070	21.33	$ 1,966	3.2

The weighted-average grant date fair value per share of the sole stock option awarded during the nine months ended September 30, 2012 was $13.97. No stock options were granted in 2011.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes that are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.
- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit that are classified as current investments in the accompanying consolidated balance sheets, and an interest rate swap derivative recorded as a noncurrent liability. Our investments classified as Level 2 are traded frequently though not necessarily daily. Fair value for the investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Fair value for the interest rate swap derivative is based on forward LIBOR rates that are and will be observable at commonly quoted intervals for the full term of the interest rate swap agreement. See Note 10, “Long-Term Debt,” for further information regarding the interest rate swap agreement.
- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* Our level 3 financial instruments recorded at fair value consist of non-current auction rate securities that are designated as available-for-sale, and are reported at fair value of $13.5 million (par value of $15.0 million) as of September 30, 2012. To estimate the fair value of these securities, we use valuations from third-party pricing models that include factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. To validate the reasonableness of these valuations, we compare such valuations to other third party valuations that provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of September 30, 2012.

Our financial instruments recorded at fair value on a recurring basis at September 30, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$208,862	$ —	$208,862	$ —
Government-sponsored enterprise securities (GSEs)	33,066	33,066	—	—
Municipal securities	73,899	—	73,899	—
U.S. treasury notes	33,691	33,691	—	—
Certificates of deposit	7,377	—	7,377	—
Auction rate securities	13,523	—	—	13,523
Total assets at fair value	$ 370,418	$66,757	$ 290,138	$13,523
Interest rate swap liability	$ 1,270	$ —	$ 1,270	$ —

Our financial instruments recorded at fair value on a recurring basis at December 31, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$231,634	$ —	$ 231,634	$ —
GSEs	33,949	33,949	—	—
Municipal securities	47,313	—	47,313	—
U.S. treasury notes	21,748	21,748	—	—
Certificates of deposit	2,272	—	2,272	—
Auction rate securities	16,134	—	—	16,134
Total assets at fair value	$353,050	$55,697	$281,219	$16,134
Interest rate swap liability	$ —	$ —	$ —	$ —

The following table presents activity for the nine months ended September 30, 2012, relating to our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2011	$ 16,134
Total gains (unrealized only):	
Included in other comprehensive income	1,439
Settlements	(4,050)
Balance at September 30, 2012	$ 13,523
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at September 30, 2012	$ 903

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our long-term debt as well as the applicable fair value hierarchy tier, at September 30, 2012, are contained in the table below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Borrowings under our credit facility and our term loan are classified as Level 3 financial instruments, because certain inputs used to determine the fair value of these agreements are unobservable. The carrying value of the credit facility at September 30, 2012 approximates fair value because of the short period of time between the borrowing under the credit facility in 2012, and September 30, 2012. The carrying value of the term loan at September 30, 2012, approximates its fair value because there has been no significant change to our credit risk relating to this instrument from the term loan's origination date in December 2011, to September 30, 2012.

	September 30, 2012				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
Convertible senior notes	$ 173,940	$ 209,040	$—	$ 209,040	$ —
Credit facility	40,000	40,000	—	—	40,000
Term loan	47,754	47,754	—	—	47,754
	$ 261,694	$296,794	$—	$ 209,040	$87,754

	December 31, 2011				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
			(In thousands)		
Convertible senior notes	$169,526	$ 192,049	$—	$192,049	$ —
Credit facility	—	—	—	—	—
Term loan	48,600	48,600	—	—	48,600
	$ 218,126	$ 240,649	$—	$192,049	$ 48,600

6. Investments

The following tables summarize our investments as of the dates indicated:

	September 30, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 208,217	$ 688	$ 43	$ 208,862
GSEs	33,015	55	4	33,066
Municipal securities	73,750	232	83	73,899
U.S. treasury notes	33,640	51	—	33,691
Certificates of deposit	7,377	—	—	7,377
Auction rate securities	14,950	—	1,427	13,523
	$ 370,949	$ 1,026	$ 1,557	$ 370,418

	December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 231,407	$ 442	$ 215	$ 231,634
GSEs	33,912	46	9	33,949
Municipal securities	47,099	232	18	47,313
U.S. treasury notes	21,627	121	—	21,748
Certificates of deposit	2,272	—	—	2,272
Auction rate securities	19,000	—	2,866	16,134
	$ 355,317	$ 841	$ 3,108	$ 353,050

The contractual maturities of our investments as of September 30, 2012 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 210,489	$ 210,828
Due one year through five years	145,510	146,067
Due after ten years	14,950	13,523
	$ 370,949	$ 370,418

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $76.8 million and $105.0 million for the three months ended September 30, 2012, and 2011, respectively. Total proceeds from sales and maturities of available-for-sale securities were $213.7 million and $226.4 million for the nine months ended September 30, 2012, and 2011, respectively. Net realized investment gains for the three months ended September 30, 2012, and 2011 were $12,000 and $153,000 respectively. Net realized investment gains for the nine months ended September 30, 2012, and 2011 were $250,000 and $331,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at September 30, 2012, and December 31, 2011, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Auction Rate Securities

Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 18 years to 35 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at September 30, 2012. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $67.1 million of these instruments at par value.

For the nine months ended September 30, 2012, and 2011, we recorded pretax unrealized gains of $1.4 million and $0.9 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of September 30, 2012.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 23,103	$ 43	15	$ —	$ —	—
GSEs	8,602	4	3	—	—	—
Municipal securities	15,077	81	30	3,693	2	2
Auction rate securities	—	—	—	13,523	1,427	22
U.S. treasury notes	—	—	—	—	—	—
Total temporarily impaired securities	$46,782	$ 128	48	$17,216	$1,429	24

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2011.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 72,766	$ 215	47	$ —	$ —	—
GSEs	11,493	9	9	—	—	—
Municipal securities	12,033	18	8	—	—	—
Auction rate securities	—	—	—	16,134	2,866	27
U.S. treasury notes	—	—	—	—	—	—
Total temporarily impaired securities	$96,292	$ 242	64	$16,134	$2,866	27

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	September 30, 2012	December 31, 2011
	(In thousands)	
Health Plans segment:		
California	$ 36,600	$ 22,175
Michigan	9,440	8,864
Missouri	1,240	27,092
New Mexico	7,908	9,350
Ohio	37,971	27,458
Texas	5,175	1,608
Utah	4,568	2,825
Washington	17,024	15,006
Wisconsin	2,661	4,909
Others	2,121	2,489
Total Health Plans segment	124,708	121,776
Molina Medicaid Solutions segment	32,201	46,122
	$156,909	$167,898

8. Restricted Investments

Pursuant to the regulations governing our Health Plan subsidiaries, we maintain statutory deposits and deposits required by state authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of restricted investments.

	September 30, 2012	December 31, 2011
	(In thousands)	
California	$ 373	$ 372
Florida	5,733	5,198
Insurance Company	—	4,711
Michigan	1,000	1,000
Missouri	500	504
New Mexico	15,911	15,905
Ohio	9,079	9,078
Texas	3,506	3,518
Utah	2,979	2,895
Washington	151	151
Other	5,256	2,832
	$ 44,488	$ 46,164

The contractual maturities of our held-to-maturity restricted investments as of September 30, 2012 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$44,177	$44,186
Due one year through five years	311	311
	$44,488	$44,497

9. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable as of and for the periods indicated. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30, 2012	Three Months Ended September 30, 2012	Year Ended Dec. 31, 2011
	(Dollars in thousands)		
Balances at beginning of period	$ 402,476	$ 525,538	$ 354,356
Components of medical care costs related to:			
Current period	3,860,825	1,361,539	3,911,803
Prior periods	(37,689)	(46,968)	(51,809)
Total medical care costs	3,823,136	1,314,571	3,859,994
Payments for medical care costs related to:			
Current period	3,332,896	875,236	3,516,994
Prior periods	356,253	428,410	294,880
Total paid	3,689,149	1,303,646	3,811,874
Balances at end of period	$ 536,463	$ 536,463	$ 402,476
Benefit from prior period as a percentage of:			
Balance at beginning of period	9.4%	8.9%	14.6%
Premium revenue	0.9%	3.2%	1.1%
Total medical care costs	1.0%	3.6%	1.3%

We recognized favorable prior period claims development in the amount of $37.7 million for the nine months ended September 30, 2012. This amount represents our estimate as of September 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2011 was due primarily to the following factors:

- For our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- For our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.
- Offsetting some of the overestimation items described above, our Missouri health plan reserves were underestimated as a result of an unusually large number of premature infants during the fourth quarter of 2011.

We recognized favorable prior period claims development in the amount of $47.0 million for the three months ended September 30, 2012. This amount represents our estimate as of September 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at June 30, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at June 30, 2012 was due primarily to the following factors:

- For our Texas health plan, we had only four months of paid claims data for the expansion regions that were added March 1, 2012. As a result, we overestimated the medical costs for those regions.
- Our contract with the state of Missouri expired without renewal on June 30, 2012; however we continue to be liable for services rendered to members who were admitted to the hospital on or before June 30, 2012, until the earlier of 90 days or their date of discharge. We overestimated the impact of 90 days of run-out claims for these members.
- For our Washington health plan, we overpaid certain outpatient claims during 2011 and early 2012, disrupting our payment patterns and leading to an overstatement of our liability at June 30, 2012.
- For our Michigan health plan, certain inpatient claims with an unusually long run-out were paid in late 2011 and early 2012, resulting in an artificial increase in the amount of time we typically apply for claims payments when estimating the reserve. In the process of developing the reserves as of June 30, 2012, an adjustment was applied to offset these late claim payments, but the adjustment did not completely remove the effect. As a result, reserves were overstated as of June 30, 2012.

We recognized favorable prior period claims development in the amount of $49.5 million and $51.8 million for the nine months ended September 30, 2011, and the year ended December 31, 2011, respectively. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2010, as a result of the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010.

In estimating our claims liability at September 30, 2012, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Our Texas health plan membership nearly doubled effective March 1, 2012. In addition, effective March 1, 2012, we assumed inpatient medical liability for ABD members for which we were not previously responsible. Reserves for new coverage and new regions are now based on the newly developing claims lag patterns and comparisons with similar coverage in other regions with more historical data. The lag patterns are still incomplete and therefore the true reserve liability is more uncertain than usual.
- Our California health plan has enrolled approximately 20,000 new ABD members since September 30, 2011, as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members converted from a fee-for-service environment. Due to the relatively recent transition of these members to managed care, their utilization of medical services is less predictable than it is for many of our other members.
- Our claims inventory had increased significantly during the first quarter of 2012, followed by a significant reduction in claims inventory in the second quarter of 2012 and a slight drop in the third quarter. Changes in claims inventory can impact historical claims lag patterns.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2011 and for the nine months ended September 30, 2012, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

10. Long-Term Debt

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility is used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of September 30, 2012 there was $40.0 million outstanding under the Credit Facility. Additionally, as of September 30, 2012, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain as of the end of any fiscal quarter (calculated for each four consecutive fiscal quarter period) a ratio of total consolidated debt to total consolidated EBITDA, as defined in the Credit Facility, of not more than 2.75 to 1.00, and a fixed charge coverage ratio of not less than 1.75 to 1.00. At September 30, 2012, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20.0 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

Convertible Senior Notes

As of September 30, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the Notes. This represents a conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of September 30, 2012, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 24 months. The Notes' if-converted value did not exceed their principal amount as of September 30, 2012. At September 30, 2012, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of September 30, 2012	As of December 31, 2011
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(13,060)	(17,474)
Net carrying amount	$ 173,940	$169,526

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(in thousands)			
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate of 3.75%	$ 1,753	$1,753	$5,259	$5,259
Amortization of the discount on the liability component	1,499	1,384	4,414	4,095
Total interest cost recognized	$ 3,252	$ 3,137	$ 9,673	$ 9,354

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81.0 million purchase price for the acquisition of the approximately 460,000 square foot office building, or Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. "Interest Period" means the period commencing on the first day of each calendar month and ending on the last day of such calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, or Swap Agreement, with an effective date of March 1, 2013. While not designated as a hedge instrument, the Swap Agreement is intended to reduce our exposure to fluctuations in the contractual variable interest rates under our Term Loan Agreement, and expires on the maturity date of the Term Loan Agreement, which is November 30, 2018. Under the Swap Agreement beginning on March 1, 2013, we will receive a variable rate of the one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. The Swap Agreement is measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. Gains and losses relating to changes in its fair value are reported in earnings in the current period. For the three months and nine months ended September 30, 2012, we have recorded losses of $0.2 million and $1.3 million, respectively, to general and administrative expense. As of September 30, 2012, the fair value of the Swap Agreement is a liability of $1.3 million, recorded to other noncurrent liabilities. We do not use derivatives for trading or speculative purposes. We believe that we are not exposed to more than a nominal amount of credit risk relating to the Swap Agreement because the counterparty is an established and well-capitalized financial institution.

11. Stockholders' Equity

Securities Repurchase Program. Effective as of October 26, 2011, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see Note 10, "Long-Term Debt"). The repurchase program expired October 25, 2012. No securities were purchased under this program in the nine months ended September 30, 2012.

Stock Plans. In connection with the plans described in Note 4, "Share-Based Compensation," we issued approximately 755,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the nine months ended September 30, 2012. Stock plan activity resulted in a $14.7 million increase to additional paid-in capital for the same period.

12. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans which serve Medicaid populations in nine states (subsequent to the termination of our Medicaid contract in Missouri effective June 30, 2012), and also includes our smaller direct delivery line of business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in an additional five states.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(In thousands)		(In thousands)	
Revenue:				
Health Plans:				
Premium revenue	$1,488,718	$ 1,138,230	$ 4,308,439	$ 3,348,438
Investment income	1,171	764	3,996	3,804
Rental income	1,879	—	5,408	—
Molina Medicaid Solutions:				
Service revenue	48,422	37,728	132,351	111,290
	$1,540,190	$1,176,722	$4,450,194	$3,463,532
Depreciation and amortization:				
Health Plans	$ 14,753	$ 12,207	$ 43,600	$ 34,915
Molina Medicaid Solutions	5,526	5,605	14,689	17,499
	$ 20,279	$ 17,812	$ 58,289	$ 52,414
Operating Income (Loss):				
Health Plans	$ (969)	$ 33,773	$ (41,867)	$ 100,273
Molina Medicaid Solutions	8,156	(207)	23,207	(3,997)
Total operating income (loss)	7,187	33,566	(18,660)	96,276
Interest expense	4,315	4,380	12,421	11,666
Income (loss) before income taxes	$ 2,872	$ 29,186	$ (31,081)	$ 84,610

	September 30, 2012	December 31, 2011
Goodwill and intangible assets, net:		
Health Plans	$ 145,021	$ 159,963
Molina Medicaid Solutions	91,100	95,787
	$ 236,121	$ 255,750
Total assets:		
Health Plans	$1,672,149	$ 1,425,764
Molina Medicaid Solutions	234,918	226,382
	$1,907,067	$1,652,146

13. Commitments and Contingencies

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Molina Medicaid Solutions

On April 6, 2012, Molina Medicaid Solutions received a schedule from the state of Maine purporting to represent approximately $32.6 million in unspecified damages suffered by the state related to the state's MMIS that was designed, developed, and implemented by Molina Medicaid Solutions. The level of detail provided in the schedule is not adequate for us to determine the specific nature of the damages claimed by the state. No formal claim has been asserted against us by the state, nor has any legal basis been asserted for any potential claims against us. To the extent that the state decides at some point in the future to pursue its alleged claims against us, Unisys Corporation, or Unisys, the former owner of the MMIS, has agreed to assume the defense of that portion of the claim related to the delay in the MMIS "go live" date from March 1, 2010 to August 1, 2010, since that delay had been agreed upon with the state prior to our May 1, 2010 acquisition of Molina Medicaid Solutions from Unisys. The amount of our potential liability related to this matter, if any, cannot be reasonably estimated at this time, nor can a range of such possible liability be established.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $519.2 million at September 30, 2012, and $492.4 million at December 31, 2011.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2012, our health plans had aggregate statutory capital and surplus of approximately $525.4 million compared with the required minimum aggregate statutory capital and surplus of approximately $270.0 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2012. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Receivable/Liability for Ceded Life and Annuity Contracts

Prior to February 17, 2012, we reported a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. Effective February 17, 2012, we sold Molina Healthcare Insurance Company. The transaction resulted in the elimination of both the noncurrent receivable and liability for ceded life and annuity contracts, each amounting to $23.4 million as of December 31, 2011. Additionally, a gain of approximately $2.4 million was recorded upon closing of the transaction, recorded to general and administrative expenses in the accompanying consolidated income statement.

We remain liable for benefits payable under the life insurance policies that were held by Molina Healthcare Insurance Company, in the event that both the reinsurer and the buyer of Molina Healthcare Insurance Company are unable to pay those benefits. We believe the possibility of our having to pay such benefits is remote, and no provision for the payment of such benefits is included in our consolidated financial statements.

14. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. For the three months ended September 30, 2012 and 2011, we paid $7.0 million, and $5.0 million, respectively, for medical service fees to this provider. For the nine months ended September 30, 2012 and 2011, we paid $20.6 million, and $16.8 million, respectively, for medical service fees to this provider.

Item 2. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- the effectiveness of our medical cost containment initiatives in Texas;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the implementation of the Patient Protection and Affordable Care Act, including the potential refusal of a state to expand Medicaid eligibility to its uninsured population, issues surrounding state insurance exchanges, the impact of the health insurance industry excise tax, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures;
- management of the Company's medical costs, including seasonal flu patterns and rates of utilization that are consistent with the Company's expectations, and the reduction over time of the high medical costs associated with new populations;
- the success of the Company's efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, including the pending RFP in New Mexico, and the Company's ability to grow the Company's revenues consistent with the Company's expectations;
- the accurate estimation of incurred but not reported medical costs across the Company's health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and the development of actuarially sound rates with respect to such new enrollees, including dually eligible enrollees;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- the continuation and renewal of the government contracts of both the Company's health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine or Idaho;
- additional administrative costs and the potential payment of additional amounts to providers and/or the state by Molina Medicaid Solutions as a result of MMIS implementation issues in Maine or Idaho;
- government audits and reviews, and any enrollment freeze or monitoring program that may result therefrom;
- changes with respect to the Company's provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;
- changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;

- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings;
- restrictions and covenants in the Company's credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of financing to fund and capitalize the Company's acquisitions and start-up activities and to meet the Company's liquidity needs;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2011, as updated in Part II, Item 1A —Risk Factors, in our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2012, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2011.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: Health Plans; and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. As of September 30, 2012, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our direct delivery business consists of primary care community clinics in California, Florida, New Mexico and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months with prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. For the six months ended June 30, 2012, our Missouri health plan contributed premium revenue of $113.8 million, or 4.1% of total premium revenue, and comprised 79,000 members, or 4.3% of total Health Plans segment membership as of June 30, 2012.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services.

With regard to our Ohio health plan, as a result of a lawsuit challenging the selection of several plans including our health plan for the new Medicaid managed care program in Ohio, the Ohio Office of Medical Assistance (OMA) announced on October 5, 2012 that the operation of the program is being delayed from the previously scheduled January 1, 2013 start date and will now commence on July 1, 2013. Following the trial court's dismissal of the lawsuit, the court of appeals has permitted the state of Ohio to move forward with working on implementing the new program and finalizing the provider agreements with our Ohio plan and the other selected managed care plans.

During fiscal year 2012, we expect to respond to several RFPs and invitations to negotiate with respect to new business, including proposals to serve dual eligible populations and applications to participate in CMS' Capitated Financial Alignment Demonstration project. On August 27, 2012, our Ohio health plan was chosen to participate in the Southwest, West Central, and Central markets under the Ohio Integrated Care Delivery System (ICDS). The Ohio ICDS is intended to improve care coordination for individuals enrolled in both Medicaid and Medicare. The selection of Molina of Ohio was made by the Ohio Department of Jobs and Family Services (ODJFS) pursuant to the request for applications for qualified health plans to serve in the ICDS issued in April 2012. The commencement of the ICDS is subject to the readiness review of the selected health plans, and the execution of three-way provider agreements between the health plans, ODJFS, and CMS. Enrollment of dual eligible members in the ICDS is expected to begin on April 1, 2013. Furthermore, on June 29, 2012, the Florida Agency for Health Care Administration (AHCA) issued invitations to negotiate for the Long-term Care Managed Care component of the Statewide Medicaid Managed Care program. We submitted a bid for eight of eleven regions on August 27, 2012, representing approximately thirty counties and 90,000 beneficiaries. We expect the state to announce contract awards in January 2013 with phased-in enrollment beginning August 2013 and extending through March 2014.

In addition, with regard to existing business, on August 31, 2012, the state of New Mexico issued an RFP for all covered Medicaid services (physical health, behavioral health, and long-term care), with such services expected to commence on January 1, 2014 under the new Medicaid contract. The awards are expected to be announced in January 2013.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

On October 12, 2012, the Governor of the U.S. Virgin Islands announced a partnership in which the Company will provide MMIS to the U.S. Virgin Islands through our West Virginia fiscal agent operation. The contract outlining the sharing of the Company's platform went through several rounds of review at the federal level and has been approved by CMS. The partnership will benefit both the Virgin Islands and taxpayers by circumventing the costs associated with establishing an independent system while gaining leverage from operating under a common platform. This partnership can serve as a model for the country by demonstrating that state and territorial governments can reduce local and federal costs by sharing such technologies for their Medicaid populations.

On July 13, 2012, our Molina Medicaid Solutions segment received full federal certification of its MMIS in the state of Idaho from the Centers for Medicare and Medicaid Services, or CMS. As a result of the CMS certification, the state of Idaho is entitled to receive federal reimbursement of 75% of its MMIS operations costs retroactive to June 1, 2010, the date that the system first began processing claims.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement MMIS to another company. For the nine months ended September 30, 2012, our revenue under the Louisiana MMIS contract was $38.8 million, or 29.3% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize approximately $40 million in revenue annually under our Louisiana MMIS contract.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the nine months ended September 30, 2012, we received approximately 96% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the nine months ended September 30, 2012, we recognized approximately 4% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $110 in California to $260 in Ohio. Among our ABD membership, PMPM premiums range from approximately $330 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums in the aggregate, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	September 30, 2012	June 30, 2012	December 31, 2011	September 30, 2011
Total Ending Membership by Health Plan:				
California	346,000	350,000	355,000	350,000
Florida	71,000	70,000	69,000	67,000
Michigan	219,000	220,000	222,000	217,000
Missouri (1)	—	79,000	79,000	78,000
New Mexico	90,000	89,000	88,000	89,000
Ohio	272,000	260,000	248,000	256,000
Texas	291,000	301,000	155,000	148,000
Utah	85,000	86,000	84,000	82,000
Washington	411,000	356,000	355,000	350,000
Wisconsin	41,000	42,000	42,000	41,000
Total	1,826,000	1,853,000	1,697,000	1,678,000
Total Ending Membership by State for our Medicare Advantage Plans:				
California	7,300	7,000	6,900	6,500
Florida	900	900	800	700
Michigan	9,300	8,900	8,200	7,600
New Mexico	900	900	800	800
Ohio	200	200	200	100
Texas	1,100	800	700	600
Utah	8,300	8,300	8,400	7,400
Washington	6,100	5,700	5,000	4,500
Total	34,100	32,700	31,000	28,200
Total Ending Membership by State for our Aged, Blind or Disabled Population:				
California	44,100	41,100	31,500	23,700
Florida	10,300	10,400	10,400	10,400
Michigan	40,700	40,000	37,500	31,600
New Mexico	5,600	5,600	5,600	5,600
Ohio	29,000	29,600	29,100	29,900
Texas	101,300	111,000	63,700	61,800
Utah	8,900	8,800	8,500	8,300
Washington	23,400	4,400	4,800	4,700
Wisconsin	1,600	1,700	1,700	1,700
Total	264,900	252,600	192,800	177,700

(1) Our contract with the state of Missouri expired without renewal on June 30, 2012.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.

- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $94.6 million, and $76.3 million, for the nine months ended September 30, 2012 and 2011, respectively, as well as certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Third Quarter Financial Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the three and nine months ended September 30, 2012. Comparable metrics for the third quarter of 2011 are also shown. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(Dollar amounts in thousands, except per share data)			
Net income (loss) per diluted share	$ 0.07	$ 0.41	$ (0.34)	$ 1.16
Premium revenue	$ 1,488,718	$ 1,138,230	$ 4,308,439	$ 3,348,438
Service revenue	$ 48,422	$ 37,728	$ 132,351	$ 111,290
Operating income (loss)	$ 7,187	$ 33,566	$ (18,660)	$ 96,276
Net income (loss)	$ 3,364	$ 18,950	$ (15,853)	$ 53,778
Total ending membership	1,826,000	1,678,000	1,826,000	1,678,000
Premium revenue	96.7%	96.7%	96.8%	96.7%
Service revenue	3.1	3.2	3.0	3.2
Investment income	0.1	0.1	0.1	0.1
Rental income	0.1	—	0.1	—
Total revenue	100.0%	100.0%	100.0%	100.0%
Medical care ratio	88.3%	84.3%	88.7%	84.3%
General and administrative expense ratio	8.3%	8.5%	8.5%	8.4%
Premium tax ratio	2.5%	3.2%	2.8%	3.3%
Operating income (loss)	0.5%	2.9%	(0.4)%	2.8%
Net income (loss)	0.2%	1.6%	(0.4)%	1.6%
Effective tax rate	(17.1)%	35.1%	49.0%	36.4%

Third Quarter 2012 Overview

For the third quarter of 2012, net income was $3.4 million, or $0.07 per diluted share, compared with net income of $19.0 million, or $0.41 per diluted share, for the third quarter of 2011.

Our financial performance in the third quarter of 2012 improved substantially over the second quarter of 2012 due to a significant improvement in the profitability of the Texas health plan. Revenue was consistent between the second and third quarters of 2012 as a 30% increase in revenue at the Washington health plan offset the termination of our Missouri enrollment and a slight decline in Texas enrollment.

Results of Operations

Three Months Ended September 30, 2012 Compared with the Three Months Ended September 30, 2011

Health Plans Segment

Premium Revenue

Premium revenue for the third quarter of 2012 increased 30.8% over the third quarter of 2011, due primarily to an increase in membership, a shift in member mix to populations generating higher premium revenue per member per month (PMPM), and benefit expansions. Medicare premium revenue was $116.1 million for the third quarter of 2012 compared with $101.5 million for the third quarter of 2011.

Membership at the Texas health plan nearly doubled year over year, while also growing significantly in Ohio and Washington. Growth in our ABD membership led to higher premium revenue PMPM in 2012. ABD membership, as a percent of total membership, has increased approximately 37% year over year. Premium revenue PMPM also increased in the third quarter of 2012 as a result of the inclusion of revenue from the pharmacy benefit for our Ohio health plan effective October 1, 2011, and as a result of the inclusion of revenue from the inpatient facility and pharmacy benefits across all of our Texas health plan membership effective March 1, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended September 30,					
	2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 908,201	$165.97	69.1%	$698,995	$140.55	72.9%
Pharmacy	219,823	40.17	16.7	89,191	17.93	9.3
Capitation	142,714	26.08	10.9	129,315	26.00	13.5
Other	43,833	8.03	3.3	41,657	8.39	4.3
Total	$1,314,571	$ 240.25	100.0%	$959,158	$192.87	100.0%

Medical care costs increased in the third quarter of 2012 primarily due to the same shifts in member mix and the benefit expansions that led to increased premium revenue. Medical care costs as a percentage of premium revenue (the medical care ratio) also increased in the third quarter of 2012 when compared with the third quarter of 2011 because increases in premium rates have not kept pace with increases in medical costs.

Individual Health Plan Analysis

The Texas health plan's financial performance improved dramatically in the third quarter from the second quarter of 2012. The medical care ratio of the Texas health plan was 90.3% in the third quarter of 2012 compared with 109.4% in the second quarter of 2012, and 93.7% in the third quarter of 2011. The medical care ratio for the Texas health plan's ABD membership declined to 94% in the third quarter of 2012 from 119% in the second quarter. We received a blended rate increase in Texas of approximately 4%, or $4.5 million per month, effective September 1, 2012. The loss before taxes at the Texas health plan was approximately $5 million for the third quarter of 2012, compared with approximately $68 million for the second quarter of 2012 (which included a premium deficiency reserve charge of $10 million). In our Quarterly Report on Form 10-Q for the period ended June 30, 2012, we discussed the steps we are taking to return the Texas health plan to profitability. We confirm the previously disclosed expectation that the Texas health plan will be operating at financial break even on a go forward basis by December 2012.

The medical care ratio at the California health plan increased to 96.1% in the third quarter of 2012 from 88.8% in the third quarter of 2011. The higher medical care ratio was primarily the result of a shift in member mix to include more ABD members. The medical care ratio for the California health plan's ABD membership was 110% in the third quarter of 2012, 100% for the nine months ended September 30, 2012, and 84% for the third quarter of 2011. The California Department of Health Care Services has recently solicited health plan input as to whether to conduct a review of the adequacy of ABD premium rates in California. The California health plan, which believes the ABD premium rates to be inadequate, has provided input supporting such a review. During the fourth quarter of 2012, we intend to exit an unprofitable service area in California, reducing enrollment by approximately 6,000 members.

The California health plan's medical care ratio also increased by 1.4% in the third quarter of 2012 due to reductions to premium revenue of $2.4 million related to the expected reduction in premium rates of 2.35% for the elimination of the gross premium tax effective July 1, 2012. The reduction in premium was offset by an equivalent decrease in premium tax of $2.4 million. Although the state has not yet reduced the premium rates, we believe that both premium taxes and premium rates will be reduced equivalently retroactive to July 1, 2012.

The medical care ratio of the Florida health plan decreased to 84.0% in the third quarter of 2012, from 89.2% in the third quarter of 2011 due to a premium rate increase effective September 1, 2011, the re-contracting of portions of the health plan's specialty care network, lower inpatient utilization and lower pharmacy costs.

The medical care ratio of the Michigan health plan increased to 89.3% in the third quarter of 2012, from 82.0% in the third quarter of 2011. The primary reason for the increase in the medical care ratio in 2012 was a reduction to premium rates linked to a decrease in premium taxes, in which both premium taxes and premium revenue were reduced equivalently effective April 1, 2012. The result was a higher medical care ratio in 2012, but there was no impact on profitability as premium tax expense was reduced by the same amount as premium revenue. The remainder of the deterioration in the Michigan plan's medical care ratio was the result of higher pharmacy and fee for service costs. We expect to receive a blended rate increase in Michigan of approximately 2%, effective October 1, 2012.

The medical care ratio of the New Mexico health plan increased to 86.9% in the third quarter of 2012, from 84.2% in the third quarter of 2011, primarily as a result of higher inpatient facility costs.

The medical care ratio of the Ohio health plan increased to 82.7% for the third quarter of 2012 from 78.4% for the third quarter of 2011. The increase in the Ohio health plan's medical care ratio was primarily the result of a 2% rate reduction effective January 1, 2012, together with the assumption of the lower margin pharmacy benefit effective October 1, 2011. Although the Ohio health plan's medical care ratio increased in 2012, the medical margin (measured as total premium revenue less total medical care costs) increased to $52.9 million in the third quarter of 2012, from $50.2 million in the third quarter of 2011.

The medical care ratio of the Utah health plan increased to 85.2% in the third quarter of 2012 from 79.3% in the third quarter of 2011. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2012.

The addition of ABD members to the Washington health plan effective July 1, 2012 increased its medical care ratio to 86.4% in the third quarter of 2012 compared with 82.8% in the third quarter of 2011. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio, so that income from operations was consistent between the third quarters of 2012 and 2011. The medical care ratio for the Washington health plan's new ABD membership was 93% in the third quarter of 2012.

The Wisconsin health plan reported a medical care ratio of 93.5% for the third quarter of 2012 compared with 79.1% for the third quarter of 2011. We believe that the state's premium rates in effect through December 31, 2012 are not adequate to cover the costs of servicing that contract. Accordingly, we recorded a premium deficiency reserve for the Wisconsin health plan at June 30, 2012 of $3.0 million. One-half of that reserve was reversed during the third quarter corresponding with the reduction in the number of months remaining in the rating period. Absent the $1.5 million partial reversal of the premium deficiency reserve, the medical care ratio of the Wisconsin health plan would have been approximately 102.6% for the third quarter of 2012. Inpatient costs in the TANF program are the primary driver of the increased costs in the third quarter of 2012, when compared with the third quarter 2011. The Wisconsin health plan will receive new premium rates effective January 1, 2013. Company management believes that premiums remain too low to cover medical costs and is working with the state and CMS to achieve actuarially sound rates. Additionally, our Wisconsin plan has implemented provider contracting initiatives and new utilization management techniques as a part of its efforts to improve profitability. If we are unable to achieve rates that are actuarially sound, it may no longer be feasible for us to continue as a health plan in the state.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended September 30, 2012							
		Premium Revenue		Medical Care Costs				
	Member Months (1)	Total	PMPM	Total	Expense	Medical Care Ratio	Premium Tax Expense	MCR Excluding Premium Tax Expense (4)
California	1,041	$ 162,389	$ 156.00	$ 156,106	$149.96	96.1%	$ —	96.1%
Florida	214	57,429	268.56	48,250	225.64	84.0	(5)	84.0
Michigan	656	160,637	244.91	143,513	218.80	89.3	1,046	89.9
Missouri (2)	—	—	—	—	—	—	—	—
New Mexico	269	84,797	315.49	73,721	274.28	86.9	1,761	88.8
Ohio	805	306,314	380.20	253,447	314.58	82.7	23,824	89.7
Texas	890	350,810	394.10	316,716	355.80	90.3	6,289	91.9
Utah	256	73,484	287.21	62,630	244.79	85.2	—	85.2
Washington	1,217	274,079	225.29	236,928	194.76	86.4	4,888	88.0
Wisconsin	124	16,279	131.21	15,217	122.65	93.5	—	93.5
Other (3)	—	2,500	—	8,043	—	—	91	—
	5,472	$1,488,718	$ 272.08	$1,314,571	$ 240.25	88.3%	$ 37,894	90.6%

	Three Months Ended September 30, 2011							
		Premium Revenue		Medical Care Costs				
	Member Months (1)	Total	PMPM	Total	Expense	Medical Care Ratio	Premium Tax Expense	MCR Excluding Premium Tax Expense (4)
California	1,049	$ 144,888	$ 138.11	$ 128,596	$ 122.58	88.8%	$ 1,114	89.4%
Florida	199	51,569	258.96	46,009	231.04	89.2	(17)	89.2
Michigan	656	165,636	252.46	135,899	207.13	82.0	9,644	87.1
Missouri (2)	234	58,196	248.80	45,428	194.22	78.1	—	78.1
New Mexico	267	79,644	297.82	67,043	250.70	84.2	2,084	86.4
Ohio	745	232,616	312.55	182,363	245.02	78.4	18,072	85.0
Texas	414	105,577	255.25	98,954	239.24	93.7	1,613	95.2
Utah	243	69,763	286.47	55,293	227.05	79.3	—	79.3
Washington	1,043	211,131	202.49	174,912	167.76	82.8	3,776	84.4
Wisconsin	123	17,269	139.95	13,656	110.67	79.1	—	79.1
Other (3)	—	1,941	—	11,005	—	—	88	—
	4,973	$ 1,138,230	$ 228.88	$ 959,158	$ 192.87	84.3%	$ 36,374	87.0%

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) Our contract with the state of Missouri expired without renewal on June 30, 2012. The Missouri health plan's claims run-out activity subsequent to June 30, 2012, is reported in "Other."

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

(4) The MCR Excluding Premium Tax Expense represents medical costs as a percentage of premium revenues, where premium revenue is reduced by premium tax expense.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended September 30, 2012	2011
	(In thousands)	
Service revenue before amortization	$ 48,958	$ 39,273
Amortization recorded as reduction of service revenue	(536)	(1,545)
Service revenue	48,422	37,728
Cost of service revenue	37,004	34,584
General and administrative costs	1,980	2,069
Amortization of customer relationship intangibles recorded as amortization	1,282	1,282
Operating income (loss)	$ 8,156	$ (207)

Operating income for our Molina Medicaid Solutions segment improved $8.4 million for the three months ended September 30, 2012, compared with the same prior year period. This improvement was primarily the result of stabilization of our newest Medicaid Management Information Systems, or MMIS, in Idaho and Maine. As discussed earlier, our Idaho MMIS has received full federal certification. Among the reasons cited by the Company for purchasing Molina Medicaid Solutions effective May 1, 2010, was the benefit of reducing our reliance on health plan operations. For the quarter ended September 30, 2012, the Molina Medicaid Solutions segment gross margin rate was 23.6%, compared with 11.7% for the Health Plans segment.

Nine Months Ended September 30, 2012 Compared with the Nine Months Ended September 30, 2011

Health Plans Segment

Premium Revenue

In the nine months ended September 30, 2012, compared with the nine months ended September 30, 2011, premium revenue grew 28.7% primarily due to an increase in membership, a shift in member mix to populations generating higher premium revenue per member per month (PMPM), and benefit expansions. Medicare premium revenue was $346.6 million for the nine months ended September 30, 2012, compared with $282.3 million for the nine months ended September 30, 2011.

Growth in our ABD membership led to higher premium revenue PMPM in 2012. ABD membership, as a percent of total membership, has increased approximately 37% year over year. Premium revenue PMPM also increased in the nine months ended September 30, 2012, as a result of the inclusion of revenue from the pharmacy benefit for our Ohio health plan effective October 1, 2011, and as a result of the inclusion of revenue from the inpatient facility and pharmacy benefits across all of our Texas health plan membership effective March 1, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Nine Months Ended September 30, 2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$2,666,470	$164.09	69.8%	$ 2,050,430	$ 138.40	72.7%
Pharmacy	606,004	37.29	15.9	268,637	18.13	9.5
Capitation	417,643	25.70	10.9	383,955	25.92	13.6
Other	133,019	8.19	3.4	119,027	8.03	4.2
Total	$ 3,823,136	$235.27	100.0%	$2,822,049	$190.48	100.0%

Our medical care ratio and medical margin deteriorated in the nine months ended September 30, 2012, when compared with the nine months ended September 30, 2011, for the same reasons described above in the “Three Months Ended September 30, 2012 Compared with the Three Months Ended September 30, 2011.”

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Nine Months Ended September 30, 2012							
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense	MCR Excluding Premium Tax Expense(4)
		Total	PMPM	Total	PMPM			
California	3,156	$ 491,718	$ 155.80	$ 446,694	$ 141.53	90.8%	$ 5,004	91.8%
Florida	632	170,922	270.47	146,261	231.44	85.6	(18)	85.6
Michigan	1,983	491,301	247.78	419,406	211.52	85.4	11,203	87.4
Missouri (2)	483	113,818	235.63	113,101	234.15	99.4	—	99.4
New Mexico	801	253,418	316.56	208,668	260.66	82.3	5,971	84.3
Ohio	2,313	896,908	387.74	735,432	317.93	82.0	69,689	88.9
Texas	2,389	908,532	380.30	890,042	372.57	98.0	16,155	99.7
Utah	767	225,533	293.93	183,930	239.71	81.6	—	81.6
Washington	3,352	697,065	207.97	592,398	176.75	85.0	12,599	86.5
Wisconsin	374	52,209	139.46	54,861	146.54	105.1	—	105.1
Other (3)	—	7,015	—	32,343	—	—	350	—
	16,250	$4,308,439	$ 265.14	$ 3,823,136	$ 235.27	88.7%	$120,953	91.3%

	Nine Months Ended September 30, 2011							
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense	MCR Excluding Premium Tax Expense(4)
		Total	PMPM	Total	PMPM			
California	3,133	$ 418,961	$ 133.71	$ 359,844	$ 114.84	85.9%	$ 4,937	86.9%
Florida	588	150,561	256.13	141,872	241.35	94.2	34	94.3
Michigan	2,002	495,971	247.70	399,952	199.75	80.6	29,219	85.7
Missouri (2)	722	169,988	235.45	148,135	205.18	87.1	—	87.1
New Mexico	808	246,223	304.71	205,659	254.51	83.5	6,472	85.8
Ohio	2,218	693,829	312.86	533,216	240.44	76.9	53,629	83.3
Texas	1,154	290,787	252.06	271,723	235.54	93.4	5,016	95.1
Utah	723	215,205	297.62	167,605	231.79	77.9	—	77.9
Washington	3,104	608,998	196.25	515,769	166.20	84.7	11,099	86.3
Wisconsin	364	51,526	141.42	47,450	130.23	92.1	44	92.2
Other (3)	—	6,389	—	30,824	—	—	183	—
	14,816	$ 3,348,438	$ 226.01	$2,822,049	$ 190.48	84.3%	$ 110,633	87.2%

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) Our contract with the state of Missouri expired without renewal on June 30, 2012. The Missouri health plan's claims run-out activity subsequent to June 30, 2012, is reported in "Other."

(3) "Other" medical care costs also include medically related administrative costs of the parent company.

(4) The MCR Excluding Premium Tax Expense represents medical costs as a percentage of premium revenues, where premium revenue is reduced by premium tax expense.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Nine Months Ended September 30, 2012	2011
	(In thousands)	
Service revenue before amortization	$ 133,193	$ 116,567
Amortization recorded as reduction of service revenue	(842)	(5,277)
Service revenue	132,351	111,290
Cost of service revenue	98,111	105,020
General and administrative costs	7,187	6,421
Amortization of customer relationship intangibles recorded as amortization	3,846	3,846
Operating income (loss)	$ 23,207	$ (3,997)

Operating income for our Molina Medicaid Solutions segment improved $27.2 million for the nine months ended September 30, 2012, compared with the same prior year period for the reasons discussed above in "Three Months Ended September 30, 2012 Compared with the Three Months Ended September 30, 2011."

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses decreased to 8.3% of total revenue for the three months ended September 30, 2012, compared with 8.5% of total revenue for the three months ended September 30, 2011. General and administrative expenses increased to 8.5% of total revenue for the nine months ended September 30, 2012, compared with 8.4% of total revenue for the nine months ended September 30, 2011. The increased ratio of general and administrative expenses to total revenue for the nine months ended September 30, 2012, was primarily due to investments in administrative infrastructure relating to our membership growth in Texas, and in anticipation of opportunities among the dual-eligible population.

Premium Tax Expense

Premium tax expense decreased to 2.5% of premium revenue for the three months ended September 30, 2012, from 3.2% in the three months ended September 30, 2011, and decreased to 2.8% of premium revenue, in the nine months ended September 30, 2012, from 3.3% in the nine months ended September 30, 2011. The quarter and year-to-date decreases were primarily due to the reduction of premium taxes at the Michigan and California health plans effective in 2012, as discussed in "Three Months Ended September 30, 2012 Compared with the Three Months Ended September 30, 2011," above, and the growth in revenue at our Texas health plan, which is subject to a lower premium tax rate (measured as a percentage of premium revenue) than our consolidated average.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended September 30,			
	2012		2011	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 11,201	0.7%	$ 8,234	0.7%
Amortization of intangible assets	4,833	0.3	5,196	0.4
Depreciation and amortization reported as such in the consolidated statements of income	16,034	1.0	13,430	1.1
Amortization recorded as reduction of service revenue	536	0.1	1,545	0.1
Amortization of capitalized software recorded as cost of service revenue	3,709	0.2	2,837	0.2
Total	$20,279	1.3%	$17,812	1.4%

	Nine Months Ended September 30,			
	2012		2011	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 31,524	0.7%	$22,859	0.7%
Amortization of intangible assets	15,922	0.4	15,728	0.5
Depreciation and amortization reported as such in the consolidated statements of income	47,446	1.1	38,587	1.2
Amortization recorded as reduction of service revenue	842	—	5,277	0.1
Amortization of capitalized software recorded as cost of service revenue	10,001	0.2	8,550	0.2
Total	$58,289	1.3%	$ 52,414	1.5%

Interest Expense

Interest expense decreased to $4.3 million for the three months ended September 30, 2012, from $4.4 million for the three months ended September 30, 2011, and increased to $12.4 million for the nine months ended September 30, 2012, from $11.7 million for the nine months ended September 30, 2011 primarily due to interest expense associated with the long-term debt we incurred to purchase our corporate headquarters building in December 2011. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $1.5 million and $1.4 million for the three months ended September 30, 2012, and 2011, respectively, and $4.4 million and $4.1 million for the nine months ended September 30, 2012, and 2011, respectively

Income Taxes

The provision for income taxes is recorded at an effective rate of (17.1%) for the three months ended September 30, 2012 compared with 35.1% for the three months ended September 30, 2011, and 49.0% for the nine months ended September 30, 2012 compared with 36.4% for the nine months ended September 30, 2011. The higher rate in 2012 is primarily due to the greater proportional impact of non-deductible on the effective tax rate as earnings before taxes decrease. We recorded a tax benefit for the three months ended September 30, 2012 primarily due to the incremental impact of the increase in our estimated annual tax rate relating to the year-to-date net loss.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of September 30, 2012, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased to $4.0 million for the nine months ended September 30, 2012, compared with $3.8 million for the nine months ended September 30, 2011. Our annualized portfolio yield for the nine months ended September 30, 2012 was 0.5% compared with 0.6% for the nine months ended September 30, 2011.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the nine months ended September 30, 2012 was $264.0 million compared with $155.2 million for the nine months ended September 30, 2011, an increase of $108.8 million. Higher medical claims and benefits payable at our Texas health plan was the primary reason for the increase in cash flow provided by operating activities, followed by an increase in deferred revenue. Medical claims and benefits payable were a source of operating cash of $134.0 million in the nine months ended September 30, 2012 compared with $6.7 million in the nine months ended September 30, 2011. Deferred revenue was a source of operating cash amounting to $92.4 million in the nine months ended September 30, 2012, compared with $25.4 million in the nine months ended September 30, 2011.

Reconciliation of Non-GAAP [1] to GAAP Financial Measures

EBITDA [2]

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
	(In thousands)			
Net income (loss)	$ 3,364	$18,950	$(15,853)	$ 53,778
Add back:				
Depreciation and amortization reported in the consolidated statements of cash flows	20,279	17,812	58,289	52,414
Interest expense	4,315	4,380	12,421	11,666
Income tax (benefit) expense	(492)	10,236	(15,228)	30,832
EBITDA	$27,466	$ 51,378	$ 39,629	$148,690

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At September 30, 2012, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $41.0 million, compared with approximately $23.6 million of cash and investments at December 31, 2011.

On a consolidated basis, at September 30, 2012, we had working capital of $482.4 million compared with $446.2 million at December 31, 2011. At September 30, 2012, and December 31, 2011, we had cash and investments, including restricted investments, of $1,130.4 million, and $893.0 million, respectively.

Effective as of October 26, 2011, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see discussion of "Convertible Senior Notes" below). This repurchase program expired October 25, 2012. No securities were purchased under this program in the nine months ended September 30, 2012.

We believe that our cash resources, Credit Facility (as defined below) and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility is used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of September 30, 2012 there was $40.0 million outstanding under the Credit Facility. Additionally, as of September 30, 2012, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain as of the end of any fiscal quarter (calculated for each four consecutive fiscal quarter period) a ratio of total consolidated debt to total consolidated EBITDA, as defined in the Credit Facility, of not more than 2.75 to 1.00, and a fixed charge coverage ratio of not less than 1.75 to 1.00. At September 30, 2012, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20.0 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

Convertible Senior Notes

As of September 30, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The conversion rate is 31.9601 shares of our common stock per $1,000 principal amount of the Notes. This represents a conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81.0 million purchase price for the acquisition of the approximately 460,000 square foot office building, or Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. "Interest Period" means the period commencing on the first day of each calendar month and ending on the last day of such calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, or Swap Agreement, with an effective date of March 1, 2013. While not designated as a hedge instrument, the Swap Agreement is intended to reduce our exposure to fluctuations in the contractual variable interest rates under our Term Loan Agreement, and expires on the maturity date of the Term Loan Agreement, which is November 30, 2018. Under the Swap Agreement beginning on March 1, 2013, we will receive a variable rate of the one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. The Swap Agreement is measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. Gains and losses relating to changes in its fair value are reported in earnings in the current period. For the three months and nine months ended September 30, 2012, we have recorded losses of $0.2 million and $1.3 million, respectively, to general and administrative expense. As of September 30, 2012, the fair value of the Swap Agreement is a liability of $1.3 million, recorded to other noncurrent liabilities. We do not use derivatives for trading or speculative purposes. We believe that we are not exposed to more than a nominal amount of credit risk relating to the Swap Agreement because the counterparty is an established and well-capitalized financial institution.

Shelf Registration Statement

In the second quarter of 2012, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the registration, issuance, and sale of an indeterminate amount of our securities, including common stock, preferred stock, senior or subordinated debt securities, or warrants. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $519.2 million at September 30, 2012, and $492.4 million at December 31, 2011.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2012, our health plans had aggregate statutory capital and surplus of approximately $525.4 million compared with the required minimum aggregate statutory capital and surplus of approximately $270.0 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2012. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2011, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of $0.5 million and $1.0 million at September 30, 2012, and December 31, 2011, respectively.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both September 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): Our contract with the state of New Mexico directs that a portion of premiums received may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. At both September 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of these contract provisions.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $3.2 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at September 30, 2012, and December 31, 2011, respectively.

Washington Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our Washington health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At both September 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since medical expenses are not less than the contractual floor.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $1.7 million and $5.0 million for anticipated Medicare risk adjustment premiums as of September 30, 2012, and December 31, 2011, respectively.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of September 30, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of September 30, 2012.

	Three Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 560	$ 532	$ —	$ 532	$ 84,797
Ohio	2,824	1,412	—	1,412	306,314
Texas	17,685	10,453	—	10,453	350,810
Wisconsin	419	—	246	246	16,279
	$ 21,488	$ 12,397	$ 246	$ 12,643	$ 758,200

	Three Months Ended September 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 566	$ 345	$ 46	$ 391	$ 79,644
Ohio	2,160	1,719	—	1,719	232,616
Texas	400	400	—	400	105,577
Wisconsin	420	362	—	362	17,269
	$ 3,546	$ 2,826	$ 46	$ 2,872	$ 435,106

	Nine Months Ended September 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,676	$ 1,350	$ 658	$ 2,008	$ 253,418
Ohio	8,222	6,810	966	7,776	896,908
Texas	41,687	30,487	—	30,487	908,532
Wisconsin	1,284	—	492	492	52,209
	$ 52,869	$ 38,647	$ 2,116	$ 40,763	$ 2,111,067

	Nine Months Ended September 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,712	$ 1,219	$ 364	$ 1,583	$ 246,223
Ohio	7,472	6,152	3,501	9,653	693,829
Texas	1,560	1,560	—	1,560	290,787
Wisconsin	1,292	362	—	362	51,526
	$ 12,036	$ 9,293	$ 3,865	$ 13,158	$ 1,282,365

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple –Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011 or 2012. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	September 30, 2012	Dec. 31, 2011	September 30, 2011
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 414,725	$ 301,020	$ 283,160
Capitation payable	55,314	53,532	49,259
Pharmacy	42,681	26,178	16,615
Other	23,743	21,746	12,021
	$536,463	$402,476	$361,055

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $414.7 million of our total medical claims and benefits payable of $536.5 million as of September 30, 2012. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider’s monthly capitation payment), our IBNP liability at September 30, 2012, was $408.3 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of September 30, 2012 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding September 30, 2012, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ 144,100
(4%)	96,067
(2%)	48,033
2%	(48,033)
4%	(96,067)
6%	(144,100)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of September 30, 2012 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ (76,155)
(4%)	(50,770)
(2%)	(25,385)
2%	25,385
4%	50,770
6%	76,155

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 46.3 million diluted shares outstanding for the nine months ended September 30, 2012. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at September 30, 2012, net income for the nine months ended September 30, 2012 would increase or decrease by approximately $15.0 million, or $0.32 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at September 30, 2012, net income for the nine months ended September 30, 2012 would increase or decrease by approximately $7.9 million, or $0.17 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $75.1 million, or $1.62 per diluted share, and $40.0 million, or $0.86 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $15.0 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2011, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 14.6%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2012 and 2011 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized favorable prior period claims development in the amount of $37.7 million for the nine months ended September 30, 2012. This amount represents our estimate as of September 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2011 was due primarily to the following factors:

- For our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- For our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.

- Offsetting some of the overestimation items described above, our Missouri health plan reserves were underestimated as a result of an unusually large number of premature infants during the fourth quarter of 2011.

We recognized favorable prior period claims development in the amount of $47.0 million for the three months ended September 30, 2012. This amount represents our estimate as of September 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at June 30, 2012 was more than the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at June 30, 2012 was due primarily to the following factors:

- For our Texas health plan, we had only four months of paid claims data for the expansion regions that were added March 1, 2012. As a result, we overestimated the medical costs for those regions.
- Our contract with the state of Missouri expired without renewal on June 30, 2012; however we continue to be liable for services rendered to members who were admitted to the hospital on or before June 30, 2012, until the earlier of 90 days or their date of discharge. We overestimated the impact of 90 days of run-out claims for these members.
- For our Washington health plan, we overpaid certain outpatient claims during 2011 and early 2012, disrupting our payment patterns and leading to an overstatement of our liability at June 30, 2012.
- For our Michigan health plan, certain inpatient claims with an unusually long run-out were paid in late 2011 and early 2012, resulting in an artificial increase in the amount of time we typically apply for claims payments when estimating the reserve. In the process of developing the reserves as of June 30, 2012, an adjustment was applied to offset these late claim payments, but the adjustment did not completely remove the effect. As a result, reserves were overstated as of June 30, 2012.

We recognized favorable prior period claims development in the amount of $49.5 million and $51.8 million for the nine months ended September 30, 2011, and the year ended December 31, 2011, respectively. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2010, as a result of the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010.

In estimating our claims liability at September 30, 2012, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Our Texas health plan membership nearly doubled effective March 1, 2012. In addition, effective March 1, 2012, we assumed inpatient medical liability for ABD members for which we were not previously responsible. Reserves for new coverage and new regions are now based on the newly developing claims lag patterns and comparisons with similar coverage in other regions with more historical data. The lag patterns are still incomplete and therefore the true reserve liability is more uncertain than usual.
- Our California health plan has enrolled approximately 20,000 new ABD members since September 30, 2011, as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members converted from a fee-for-service environment. Due to the relatively recent transition of these members to managed care, their utilization of medical services is less predictable than it is for many of our other members.
- Our claims inventory had increased significantly during the first quarter of 2012, followed by a significant reduction in claims inventory in the second quarter of 2012 and a slight drop in the third quarter. Changes in claims inventory can impact historical claims lag patterns.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2011 and for the nine months ended September 30, 2012, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended September 30,		Three Months Ended September 30,		Year Ended
	2012	2011	2012	2011	Dec. 31, 2011
	(Dollars in thousands, except per-member amounts)				
Balances at beginning of period	$ 402,476	$ 354,356	$ 525,538	$ 341,613	$ 354,356
Components of medical care costs related to:					
Current period	3,860,825	2,871,515	1,361,539	990,449	3,911,803
Prior periods	(37,689)	(49,466)	(46,968)	(31,291)	(51,809)
Total medical care costs	3,823,136	2,822,049	1,314,571	959,158	3,859,994
Payments for medical care costs related to:					
Current period	3,332,896	2,522,374	875,236	670,066	3,516,994
Prior periods	356,253	292,976	428,410	269,650	294,880
Total paid	3,689,149	2,815,350	1,303,646	939,716	3,811,874
Balances at end of period	$ 536,463	$ 361,055	$ 536,463	$ 361,055	$ 402,476
Benefit from prior period as a percentage of:					
Balance at beginning of period	9.4%	14.0%	8.9%	9.2%	14.6%
Premium revenue	0.9%	1.5%	3.2%	2.7%	1.1%
Total medical care costs	1.0%	1.8%	3.6%	3.3%	1.3%
Claims Data:					
Days in claims payable, fee for service	45	39	45	39	40
Number of members at end of period	1,826,000	1,678,000	1,826,000	1,678,000	1,697,000
Number of claims in inventory at end of period	163,600	132,200	163,600	132,200	111,100
Billed charges of claims in inventory at end of period	$ 304,600	$ 187,000	$ 304,600	$ 187,000	$ 207,600
Claims in inventory per member at end of period	0.09	0.08	0.09	0.08	0.07
Billed charges of claims in inventory per member at end of period	$ 166.81	$ 111.44	$ 166.81	$ 111.44	$ 122.33
Number of claims received during the period	15,455,000	12,864,800	5,079,200	4,149,600	17,207,500
Billed charges of claims received during the period	$ 14,339,700	$ 10,573,900	$ 4,951,000	$ 3,610,700	$ 14,306,500

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. *Quantitative and Qualitative Disclosures About Market Risk*

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

We are also exposed to interest rate risk relating to contractual variable interest rates under our Term Loan Agreement which matures on November 30, 2018. We manage this floating rate debt using an interest rate swap agreement that we expect will reduce our exposure to the impact of changing interest rates to our consolidated results of operations and future outflows for interest. The interest rate swap is not designated as a hedging instrument.

Item 4. *Controls and Procedures*

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2012 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. *Legal Proceedings*

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. *Risk Factors*

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2011, as updated in Part II, Item 1A—Risk Factors, in our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2012. The risk factors described herein and in our 2011 Annual Report on Form 10-K as updated by our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2012 are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

There have been no material changes to the risk factors disclosed in our 2011 Form 10-K as updated by our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2012.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

Issuer Purchases of Equity Securities

Effective as of October 26, 2011, our board of directors authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program expired October 25, 2012. No securities were purchased under this program in the nine months ended September 30, 2012.

Purchases of common stock made by or on behalf of the Company during the quarter ended September 30, 2012, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs
July 1—July 30	13,220	$ 26.48	—	$ —
August 1—August 31	2,444	$ 24.44	—	$ —
September 1—September 30	638	$ 24.24	—	$ —
Total	16,302	$ 26.09	—	

(a) During the three months ended September 30, 2012, we did not repurchase any shares of our common stock outside of our publicly announced stock repurchase program. During the quarter we withheld 16,302 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

Item 6. Exhibits

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS (1)	XBRL Taxonomy Instance Document.
101.SCH (1)	XBRL Taxonomy Extension Schema Document.
101.CAL (1)	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF (1)	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB (1)	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE (1)	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) Pursuant to Rule 406T of Regulation S-T, XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: October 26, 2012

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: October 26, 2012

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT INDEX

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EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2012 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 26, 2012

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2012 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 26, 2012

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2012 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 26, 2012

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2012 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 26, 2012

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended June 30, 2012

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2012

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

Molina Healthcare, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock outstanding as of July 27, 2012, was approximately 46,544,000.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	June 30, 2012	December 31, 2011
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 727,092	$ 493,827
Investments	344,910	336,916
Receivables	161,007	167,898
Income tax refundable	31,389	11,679
Deferred income taxes	26,858	18,327
Prepaid expenses and other current assets	29,780	19,435
Total current assets	1,321,036	1,048,082
Property, equipment, and capitalized software, net	206,489	190,934
Deferred contract costs	71,344	54,582
Intangible assets, net	90,402	101,796
Goodwill and indefinite-lived intangible assets	151,088	153,954
Auction rate securities	13,101	16,134
Restricted investments	43,608	46,164
Receivable for ceded life and annuity contracts	—	23,401
Other assets	20,400	17,099
	$1,917,468	$1,652,146
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 525,538	$ 402,476
Accounts payable and accrued liabilities	136,065	147,214
Deferred revenue	176,373	50,947
Current maturities of long-term debt	1,130	1,197
Total current liabilities	839,106	601,834
Long-term debt	269,338	216,929
Deferred income taxes	40,713	33,127
Liability for ceded life and annuity contracts	—	23,401
Other long-term liabilities	22,301	21,782
Total liabilities	1,171,458	897,073
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 46,527 shares at June 30, 2012 and 45,815 shares at December 31, 2011	46	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	275,556	266,022
Accumulated other comprehensive loss	(785)	(1,405)
Retained earnings	471,193	490,410
Total stockholders' equity	746,010	755,073
	$1,917,468	$1,652,146

See accompanying notes.

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MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(Amounts in thousands, except net (loss) income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 1,492,272	$ 1,128,770	$ 2,819,721	$ 2,210,208
Service revenue	41,724	36,888	83,929	73,562
Investment income	1,108	1,446	2,825	3,040
Rental income	1,320	—	3,529	—
Total revenue	1,536,424	1,167,104	2,910,004	2,286,810
Expenses:				
Medical care costs	1,377,577	949,359	2,508,565	1,862,891
Cost of service revenue	30,613	39,215	61,107	70,436
General and administrative expenses	131,485	96,921	251,708	191,357
Premium tax expenses	39,629	37,709	83,059	74,259
Depreciation and amortization	16,387	12,490	31,412	25,157
Total expenses	1,595,691	1,135,694	2,935,851	2,224,100
Operating (loss) income	(59,267)	31,410	(25,847)	62,710
Interest expense	3,808	3,683	8,106	7,286
(Loss) income before income taxes	(63,075)	27,727	(33,953)	55,424
Provision for income taxes	(25,769)	10,287	(14,736)	20,596
Net (loss) income	$ (37,306)	$ 17,440	$ (19,217)	$ 34,828
Net (loss) income per share:				
Basic	$ (0.80)	$ 0.38	$ (0.42)	$ 0.76
Diluted	$ (0.80)	$ 0.38	$ (0.42)	$ 0.75
Weighted average shares outstanding:				
Basic	46,355	45,897	46,176	45,743
Diluted	46,355	46,471	46,176	46,392

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(Amounts in thousands) (Unaudited)			
Net (loss) income	$ (37,306)	$ 17,440	$ (19,217)	$ 34,828
Other comprehensive income, net of tax:				
Unrealized gain on investments	324	712	620	595
Other comprehensive income	324	712	620	595
Comprehensive (loss) income	$ (36,982)	$ 18,152	$ (18,597)	$ 35,423

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2012	2011
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net (loss) income	$ (19,217)	$ 34,828
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Depreciation and amortization	38,010	34,602
Deferred income taxes	(621)	(2,839)
Stock-based compensation	9,812	8,374
Gain on sale of subsidiary	(2,390)	—
Non-cash interest on convertible senior notes	2,915	2,711
Change in fair value of interest rate swap agreement	1,086	—
Amortization of premium/discount on investments	3,615	3,439
Amortization of deferred financing costs	515	1,007
Tax deficiency from employee stock compensation	(50)	(489)
Changes in operating assets and liabilities:		
Receivables	6,891	26,999
Prepaid expenses and other current assets	(10,352)	(2,780)
Medical claims and benefits payable	123,062	(12,743)
Accounts payable and accrued liabilities	(22,982)	(8,715)
Deferred revenue	125,426	38,075
Income taxes	(19,737)	(7,571)
Net cash provided by operating activities	235,983	114,898
Investing activities:		
Purchases of equipment	(33,301)	(30,866)
Purchases of investments	(144,348)	(183,647)
Sales and maturities of investments	136,772	121,434
Proceeds from sale of subsidiary, net of cash surrendered	9,162	—
Net cash paid in business combinations	—	(3,253)
Increase in deferred contract costs	(23,055)	(16,405)
Increase in restricted investments	(2,154)	(8,230)
Change in other noncurrent assets and liabilities	(4,383)	2,190
Net cash used in investing activities	(61,307)	(118,777)
Financing activities:		
Amount borrowed under credit facility	60,000	—
Principal payments on term loan	(573)	—
Repayment of amount borrowed under credit facility	(10,000)	—
Proceeds from employee stock plans	5,485	5,640
Excess tax benefits from employee stock compensation	3,677	1,566
Net cash provided by financing activities	58,589	7,206
Net increase in cash and cash equivalents	233,265	3,327
Cash and cash equivalents at beginning of period	493,827	455,886
Cash and cash equivalents at end of period	$ 727,092	$ 459,213

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Six Months Ended June 30,	
	2012	2011
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 1,074	$30,863
Interest	$ 4,719	$ 4,385
Schedule of non-cash investing and financing activities:		
Common stock used for stock-based compensation	$ 9,390	$ 3,714
Details of sale of subsidiary:		
Decrease in carrying value of assets	$ 30,942	$ —
Decrease in carrying value of liabilities	(24,170)	—
Gain on sale	2,390	—
Proceeds from sale of subsidiary, net of cash surrendered	$ 9,162	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2012

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri (through June 30, 2012), New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. As of June 30, 2012, these health plans served approximately 1.9 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months with prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. For the six months ended June 30, 2012, our Missouri health plan contributed premium revenue of $113.8 million, or 4.1% of total premium revenue, and comprised 79,000 members, or 4.3% of total Health Plans segment membership as of June 30, 2012.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On July 13, 2012, our Molina Medicaid Solutions segment received full federal certification of its Medicaid Management Information System, or MMIS, from the Centers for Medicare and Medicaid Services, or CMS. As a result of the CMS certification, the state of Idaho is entitled to receive federal reimbursement of 75% of its MMIS operations costs retroactive to June 1, 2010, the date that the system first began processing claims.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement MMIS to another company For the six months ended June 30, 2012, our revenue under the Louisiana MMIS contract was approximately $24.7 million, or 29.4% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize approximately $40 million in revenue annually under our Louisiana MMIS contract.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2012. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2011. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2011 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2011 audited financial statements.

Reclassifications

We have reclassified certain amounts in the 2011 consolidated statement of cash flows to conform to the 2012 presentation.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue – Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of $0.5 million and $1.0 million at June 30, 2012, and December 31, 2011, respectively.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both June 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): A portion of premiums received by our New Mexico health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). The New Mexico health plan contract also contains certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At both June 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of these contract provisions.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $6.9 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at June 30, 2012, and December 31, 2011, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $13.4 million and $5.0 million for anticipated Medicare risk adjustment premiums as of June 30, 2012, and December 31, 2011, respectively.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. Effective February 1, 2010 through June 30, 2011, we were eligible to earn additional incremental revenue of up to 0.25% of our total premium if we met certain pharmacy specific performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state. Based upon our assessment of the performance measures at June 30, 2012, we have accrued an estimated $4.0 million of premiums that were not earned under this program.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2012.

	Three Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 561	$ 482	$ 630	$ 1,112	$ 85,360
Ohio	2,720	2,720	—	2,720	297,069
Texas	18,252	14,284	—	14,284	359,486
Wisconsin	449	—	246	246	18,788
	$ 21,982	$ 17,486	$ 876	$ 18,362	$ 760,703

	Three Months Ended June 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 565	$ 430	$ 486	$ 916	$ 81,973
Ohio	2,650	3,083	1,678	4,761	230,874
Texas	756	736	—	736	104,399
Wisconsin	456	—	—	—	17,840
	$ 4,427	$ 4,249	$ 2,164	$ 6,413	$ 435,086

	Six Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,116	$ 818	$ 658	$ 1,476	$ 168,621
Ohio	5,398	5,398	966	6,364	590,594
Texas	24,002	20,034	—	20,034	557,722
Wisconsin	865	—	246	246	35,930
	$ 31,381	$ 26,250	$ 1,870	$ 28,120	$1,352,867

	Six Months Ended June 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,146	$ 874	$ 318	$ 1,192	$166,579
Ohio	5,312	4,433	3,501	7,934	461,213
Texas	1,317	736	—	736	185,210
Wisconsin	872	—	—	—	34,257
	$ 8,647	$ 6,043	$ 3,819	$ 9,862	$ 847,259

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple –Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011 or 2012. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Premium Deficiency Charges

We assess the profitability of each contract by state for providing medical care services to our members and identify any contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared with the sum of anticipated future health care costs and maintenance costs. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. In the second quarter of 2012, our Texas and Wisconsin health plans recorded premium deficiency charges of $10.0 million and $3.0 million, respectively. Such charges were recorded to medical care costs.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of non-deductible compensation and state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $10.5 million as of June 30, 2012, and $10.7 million as of December 31, 2011. Approximately $8.4 million of the unrecognized tax benefits recorded at June 30, 2012, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.3 million as of June 30, 2012. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.6 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of June 30, 2012, and December 31, 2011, we had accrued $77,000 and $65,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

Goodwill. In September 2011, the Financial Accounting Standards Board ("FASB") issued new guidance related to evaluating goodwill for impairment. The new guidance provides entities with the option to perform a qualitative assessment of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount before applying the quantitative two-step goodwill impairment test. If an entity concludes that it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, it would not be required to perform the quantitative two-step goodwill impairment test. Entities also have the option to bypass the assessment of qualitative factors for any reporting unit in any period and proceed directly to performing the first step of the quantitative two-step goodwill impairment test, as was required prior to the issuance of this new guidance. An entity may begin or resume performing the qualitative assessment in any subsequent period. The new guidance became effective for fiscal years, and interim periods within those years, beginning after December 15, 2011, with early adoption permitted. The adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows.

Federal Premium-Based Assessment. In July 2011, the FASB issued new guidance related to accounting for the fees to be paid by health insurers to the federal government under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (the "Affordable Care Act"). The Affordable Care Act imposes an annual fee on health insurers for each calendar year beginning on or after January 1, 2014 that is allocated to health insurers based on the ratio of the amount of an entity's net premium revenues written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. The new guidance specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The new guidance is effective for calendar years beginning after December 31, 2013, when the fee initially becomes effective. As enacted, this federal premium-based assessment is non-deductible for income tax purposes, and is anticipated to be significant. It is yet undetermined how this premium-based assessment will be factored into the calculation of our premium rates, if at all. Accordingly, adoption of this guidance and the enactment of this assessment as currently written could have a material impact on our financial position, results of operations, or cash flows in future periods.

Comprehensive Income. In June 2011, the FASB issued new guidance, as amended in December 2011, related to the presentation of other comprehensive income. The new guidance provides entities with an option to either replace the statement of income with a statement of comprehensive income which would display both the components of net income and comprehensive income in a combined statement, or to present a separate statement of comprehensive income immediately following the statement of income. The new guidance does not affect the components of other comprehensive income or the calculation of earnings per share; became effective for fiscal years, and interim periods within those years, beginning after December 15, 2011; and is to be applied retrospectively with early adoption permitted. We have elected to present a separate statement of comprehensive income immediately following the statement of income. The adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows.

Fair Value. In May 2011, the FASB issued new guidance related to fair value measurement and disclosure. The new guidance is a result of joint efforts by the FASB and the International Accounting Standards Board to develop a single converged fair value framework. The new guidance expands existing disclosure requirements for fair value measurements and makes other amendments; mostly to eliminate wording differences between U.S. generally accepted accounting principles ("GAAP") and international financial reporting standards. The new guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2011; is to be applied prospectively; and early adoption was not permitted. Although the adoption of this new guidance in 2012 did not impact our financial position, results of operations or cash flows, it did change our disclosure policies relative to fair value measurements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(In thousands)			
Shares outstanding at the beginning of the period	46,347	45,828	45,815	45,463
Weighted-average number of shares issued	8	69	361	280
Denominator for basic earnings per share	46,355	45,897	46,176	45,743
Dilutive effect of employee stock options and stock grants (1)	—	574	—	649
Denominator for diluted earnings per share (2)	46,355	46,471	46,176	46,392

(1) Unvested restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. Potentially dilutive unvested restricted shares and stock options were not included in the computation of diluted loss per share for the three and six months ended June 30, 2012, because to do so would have been anti-dilutive. For the three and six months ended June 30, 2011, there were no anti-dilutive weighted restricted shares, respectively. For the three and six months ended June 30, 2011 there were approximately 81,200 and 122,100 anti-dilutive weighted options, respectively.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted (loss) earnings per share for the three month and six month periods ended June 30, 2012 and 2011, because to do so would have been anti-dilutive.

4. Share-Based Compensation

At June 30, 2012, we had employee equity incentives outstanding under three plans: (1) the 2011 Equity Incentive Plan; (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded); and (3) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). In March 2012, our chief executive officer, chief financial officer, and chief operating officer were awarded 94,050 performance units, 53,236 performance units, and 30,167 performance units, respectively, that would vest and be settled in shares of the Company's common stock equal in number to the units granted upon the achievement of certain service and performance conditions. Each of the grants shall vest in 2012, provided that: (i) the Company's total operating revenue for 2012 is equal to or greater than $5.5 billion, and (ii) the respective officer continues to be employed by the Company if and when the operating revenue target is met. As of June 30, 2012, we expect such performance awards to vest in full. In the event the vesting conditions are not achieved, the equity compensation awards shall lapse. Also in March 2012, our chief executive officer, chief financial officer, chief operating officer, and chief accounting officer were awarded 8,000 shares, 8,000 shares, 8,000 shares, and 3,000 shares, respectively, of performance units that would vest and be settled in shares of the Company's common stock equal in number to the units granted upon the certification of our Idaho MMIS by CMS. Such awards vested when the Idaho MMIS was certified in July 2012.

Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three month and six month periods ended June 30, 2012 and 2011:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(in thousands)			
Restricted stock/performance unit awards	$ 4,452	$3,932	$ 8,850	$7,738
Stock options (including shares issued under our employee stock purchase plan)	694	378	962	636
Total stock-based compensation expense	$5,146	$ 4,310	$9,812	$ 8,374

As of June 30, 2012, there was $21.5 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to recognize over a remaining weighted-average period of 2.5 years. As of June 30, 2012, there was $4.0 million of total unrecognized compensation expense related to performance units, which we expect to recognize by December 31, 2012.

Restricted stock/performance units activity for the six months ended June 30, 2012 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2011	1,435,882	$ 18.97
Restricted stock awards granted	483,057	32.10
Performance units granted	213,022	33.59
Vested	(714,699)	20.33
Performance units vested	(2,143)	35.01
Forfeited	(67,372)	22.58
Unvested balance as of June 30, 2012	1,347,747	25.06

The total fair value of restricted stock and stock unit awards, including those with performance conditions, granted during the six months ended June 30, 2012 and 2011 was $22.4 million and $17.7 million, respectively. The total fair value of restricted shares vested during the six months ended June 30, 2012 and 2011 was $23.6 million and $10.9 million, respectively.

Stock option activity for the six months ended June 30, 2012 is summarized below:

	Shares	Weighted Average Grant Date Fair Value	Average Intrinsic Value (In thousands)	Weighted Average Remaining Contractual term (Years)
Stock options outstanding as of December 31, 2011	553,049	$ 20.91		
Granted	15,000	34.82		
Exercised	(113,129)	19.30		
Forfeited	(750)	22.37		
Stock options outstanding as of June 30, 2012	454,170	21.77	$ 1,407	3.7
Stock options exercisable and expected to vest as of June 30, 2012	454,170	21.77	$ 1,407	3.7
Exercisable as of June 30, 2012	439,170	21.33	$ 1,407	3.5

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 financial instruments recorded at fair value consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes which Level 1 financial instruments are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.
- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 financial instruments recorded at fair value consist of investments including corporate debt securities, municipal securities, and certificates of deposit, which are classified as current investments in the accompanying consolidated balance sheets, and an interest rate swap derivative recorded as a noncurrent liability. Our investments classified as Level 2 are traded frequently though not necessarily daily. Fair value for the investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Fair value for the interest rate swap derivative is based on forward LIBOR rates that will be observable at commonly quoted intervals for the full term of the interest rate swap agreement. See Note 10, “Long-Term Debt,” for further information regarding the interest rate swap agreement.

- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* Our level 3 financial instruments recorded at fair value consist of auction rate securities which are designated as available-for-sale, and are reported at fair value of $13.1 million (par value of $15.0 million) as of June 30, 2012. To estimate the fair value of these securities, we use valuations from third-party pricing models that include factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. To validate the reasonableness of these valuations, we compare such valuations to other third party valuations that provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of June 30, 2012.

Our financial instruments recorded at fair value on a recurring basis at June 30, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$220,746	$ —	$220,746	$ —
Government-sponsored enterprise securities (GSEs)	28,508	28,508	—	—
Municipal securities	61,922	—	61,922	—
U.S. treasury notes	31,359	31,359	—	—
Certificates of deposit	2,375	—	2,375	—
Auction rate securities	13,101	—	—	13,101
Total assets at fair value	$358,011	$59,867	$285,043	$13,101
Interest rate swap liability	$ 1,086	$ —	$ 1,086	$ —

Our financial instruments recorded at fair value on a recurring basis at December 31, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$231,634	$ —	$ 231,634	$ —
GSEs	33,949	33,949	—	—
Municipal securities	47,313	—	47,313	—
U.S. treasury notes	21,748	21,748	—	—
Certificates of deposit	2,272	—	2,272	—
Auction rate securities	16,134	—	—	16,134
Total assets at fair value	$353,050	$55,697	$281,219	$16,134
Interest rate swap liability	$ —	$ —	$ —	$ —

The following table presents activity for the six months ended June 30, 2012, relating to our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2011	$ 16,134
Total gains (unrealized only):	
Included in other comprehensive income	1,017
Settlements	(4,050)
Balance at June 30, 2012	$ 13,101
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at June 30, 2012	$ 481

Fair Value Measurements – Disclosure Only

The carrying amounts and estimated fair values of our long-term debt as well as the applicable fair value hierarchy tier, at June 30, 2012, are contained in the table below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Borrowings under our credit facility and our term loan are classified as Level 3 financial instruments, because certain inputs used to determine the fair value of these agreements are unobservable. The carrying value of the credit facility at June 30, 2012 approximates fair value because of the short period of time between the borrowing under the credit facility in the second quarter of 2012, and June 30, 2012. The carrying value of the term loan at June 30, 2012, approximates its fair value because there has been no significant change to our credit risk relating to this instrument from the term loan's origination date of December 7, 2011 to June 30, 2012.

	June 30, 2012				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
Convertible senior notes	$ 172,441	$207,688	$—	$207,688	$ —
Credit facility	50,000	50,000	—	—	50,000
Term loan	48,027	48,027	—	—	48,027
	$270,468	$305,715	$—	$207,688	$98,027

	December 31, 2011				
	Carrying Value	Total Fair Value	Level 1	Level 2	Level 3
	(In thousands)				
Convertible senior notes	$169,526	$192,049	$—	$192,049	$ —
Credit facility	—	—	—	—	—
Term loan	48,600	48,600	—	—	48,600
	$ 218,126	$240,649	$—	$192,049	$48,600

6. Investments

The following tables summarize our investments as of the dates indicated:

	June 30, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 220,393	$ 437	$ 84	$220,746
GSEs	28,463	47	2	28,508
Municipal securities	61,771	177	26	61,922
U.S. treasury notes	31,325	36	2	31,359
Certificates of deposit	2,375	—	—	2,375
Auction rate securities	14,950	—	1,849	13,101
	$359,277	$697	$1,963	$358,011

	December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 231,407	$ 442	$ 215	$231,634
GSEs	33,912	46	9	33,949
Municipal securities	47,099	232	18	47,313
U.S. treasury notes	21,627	121	—	21,748
Certificates of deposit	2,272	—	—	2,272
Auction rate securities	19,000	—	2,866	16,134
	$355,317	$ 841	$ 3,108	$353,050

The contractual maturities of our investments as of June 30, 2012 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$198,369	$198,590
Due one year through five years	145,958	146,320
Due after ten years	14,950	13,101
	$359,277	$ 358,011

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $71.0 million and $60.1 million for the three months ended June 30, 2012, and 2011, respectively. Total proceeds from sales and maturities of available-for-sale securities were $136.8 million and $121.4 million for the six months ended June 30, 2012, and 2011, respectively. Net realized investment gains for the three months ended June 30, 2012, and 2011 were $174,000 and $21,000 respectively. Net realized investment gains for the six months ended June 30, 2012, and 2011 were $238,000 and $178,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, discussed below, we have determined that unrealized gains and losses at June 30, 2012, and December 31, 2011, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Auction Rate Securities

Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008, and such auctions have not resumed. Therefore, quoted prices in active markets have not been available since early 2008. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 3 years to 35 years. Considering the relative insignificance of these securities when compared with our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at June 30, 2012. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have settled $67.1 million of these instruments at par value.

For six months ended June 30, 2012, and 2011, we recorded pretax unrealized gains of $1.0 million and $0.7 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of June 30, 2012.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$41,975	$ 66	30	$ 1,998	$ 18	2
GSEs	2,761	2	2	—	—	—
Municipal securities	22,070	22	16	2,528	4	1
Auction rate securities	—	—	—	13,101	1,849	22
U.S. treasury notes	4,738	2	4	—	—	—
Total temporarily impaired securities	$ 71,544	$ 92	52	$17,627	$1,871	25

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2011.

	In a Continuous Loss Position for Less than 12 Months			In a Continuous Loss Position for 12 Months or More		
	Estimated Fair Value	Unrealized Losses	Total Number of Securities	Estimated Fair Value	Unrealized Losses	Total Number of Securities
	(Dollars in thousands)					
Corporate debt securities	$ 72,766	$ 215	47	$ —	$ —	—
GSEs	11,493	9	9	—	—	—
Municipal securities	12,033	18	8	—	—	—
Auction rate securities	—	—	—	16,134	2,866	27
U.S. treasury notes	—	—	—	—	—	—
Total temporarily impaired securities	$96,292	$ 242	64	$16,134	$2,866	27

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	June 30, 2012	December 31, 2011
	(In thousands)	
Health Plans segment:		
California	$ 21,319	$ 22,175
Michigan	12,462	8,864
Missouri	22,793	27,092
New Mexico	9,843	9,350
Ohio	37,838	27,458
Texas	6,237	1,608
Utah	4,647	2,825
Washington	14,139	15,006
Wisconsin	10,228	4,909
Others	2,134	2,489
Total Health Plans segment	141,640	121,776
Molina Medicaid Solutions segment	19,367	46,122
	$161,007	$167,898

8. Restricted Investments

Pursuant to the regulations governing our Health Plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of restricted investments.

	June 30, 2012	December 31, 2011
	(In thousands)	
California	$ 373	$ 372
Florida	5,526	5,198
Insurance Company	—	4,711
Michigan	1,000	1,000
Missouri	502	504
New Mexico	15,909	15,905
Ohio	9,078	9,078
Texas	3,510	3,518
Utah	2,985	2,895
Washington	151	151
Other	4,574	2,832
	$ 43,608	$ 46,164

The contractual maturities of our held-to-maturity restricted investments as of June 30, 2012 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$42,257	$41,581
Due one year through five years	1,351	1,357
	$ 43,608	$ 42,938

9. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable as of and for the periods indicated. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30, 2012	Three Months Ended June 30, 2012	Year Ended Dec. 31, 2011
	(Dollars in thousands)		
Balances at beginning of period	$ 402,476	$ 455,833	$ 354,356
Components of medical care costs related to:			
Current period	2,544,922	1,377,084	3,911,803
Prior periods	(36,357)	493	(51,809)
Total medical care costs	2,508,565	1,377,577	3,859,994
Payments for medical care costs related to:			
Current period	2,033,611	891,573	3,516,994
Prior periods	351,892	416,299	294,880
Total paid	2,385,503	1,307,872	3,811,874
Balances at end of period	$ 525,538	$ 525,538	$ 402,476
Benefit from prior period as a percentage of:			
Balance at beginning of period	9.0%	(0.1)%	14.6%
Premium revenue	1.3%	0.0%	1.1%
Total medical care costs	1.4%	0.0%	1.3%

We recognized favorable prior period claims development in the amount of $36.4 million for the six months ended June 30, 2012. This amount represents our estimate as of June 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2011 was due primarily to the following factors:

- For our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- For our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.
- Offsetting some of the overestimation items described above, our Missouri health plan reserves were underestimated as a result of an unusually large number of premature infants during the fourth quarter.

We recognized unfavorable prior period claims development in the amount of $0.5 million for the three months ended June 30, 2012. This amount represents our estimate as of June 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at March 31, 2012 was less than the amount that will ultimately be paid out in satisfaction of that liability. The underestimation of claims liability at March 31, 2012 was due primarily to the following factors:

- For our Texas health plan, our initial estimates of reserves at March 31, 2012 for new coverage (inpatient medical costs on STAR+PLUS members) and new regions were based on the state's pricing assumptions. We have since learned that the claims costs are much higher than initially expected.
- For our Missouri health plan, reserves were underestimated due to a large number of very high cost claims, including premature infants, during the first quarter of 2012.
- We underestimated the impact of a buildup in claims inventory in our Michigan and Ohio health plans as of March 31, 2012.

We recognized favorable prior period claims development in the amount of $45.4 million and $51.8 million for the six months ended June 30, 2011, and the year ended December 31, 2011, respectively. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2010, as a result of the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010, partially offsetting the impact of the two items above.

In estimating our claims liability at June 30, 2012, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Our Texas health plan membership has nearly doubled effective March 1, 2012. In addition, effective March 1, 2012, we assumed inpatient medical liability for STAR+PLUS (an area of coverage that was previously carved out). Reserves for new coverage and new regions are now based on the newly developing claims lag patterns and comparisons with similar coverage in other regions with more historical data.
- Our California health plan has enrolled approximately 24,000 new ABD members since June 30, 2011, as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members converted from a fee-for-service environment, and are higher cost than our base ABD members.
- Our claims inventory had increased significantly during the first quarter of 2012, followed by a significant reduction in claims inventory in the second quarter of 2012. Changes in claims inventory can impact historical claims lag patterns.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2011 and for the six months ended June 30, 2012, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

10. Long-Term Debt

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the “Credit Facility”) with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility is used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of June 30, 2012 there was $50.0 million outstanding under the Credit Facility. Additionally, as of June 30, 2012, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders’ commitments under the Credit Facility. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA for the trailing twelve month period of not more than 2.75 to 1.00, and a fixed charge coverage ratio of not less than 1.75 to 1.00. At June 30, 2012, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

Convertible Senior Notes

As of June 30, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the Notes. This represents a conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of June 30, 2012, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 27 months. The Notes' if-converted value did not exceed their principal amount as of June 30, 2012. At June 30, 2012, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of June 30, 2012	As of December 31, 2011
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(14,559)	(17,474)
Net carrying amount	$ 172,441	$ 169,526

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(in thousands)			
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,753	$ 3,506	$ 3,506
Amortization of the discount on the liability component	1,472	1,371	2,915	2,711
Total interest cost recognized	$ 3,225	$ 3,124	$ 6,421	$ 6,217

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the approximately 460,000 square foot office building, or Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. "Interest Period" means the period commencing on the first day of each calendar month and ending on the last day of such calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, or Swap Agreement, with an effective date of March 1, 2013. While not designated as a hedge during the quarter ended June 30, 2012, the Swap Agreement is intended to reduce our exposure to fluctuations in the contractual variable interest rates under our Term Loan Agreement, and expires on the maturity date of the Term Loan Agreement, November 30, 2018. Under the Swap Agreement, we will receive a variable rate of the one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. The Swap Agreement is measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. Gains and losses relating to changes in its fair value are reported in earnings in the current period. As of June 30, 2012, the fair value of the Swap Agreement is a liability of $1.1 million, recorded to other noncurrent liabilities. Because the fair value of the Swap Agreement was zero at its inception in May 2012, the entire amount of the liability was charged to general and administrative expense in the quarter ended June 30, 2012. We do not use derivatives for trading or speculative purposes. We believe that we are not exposed to more than a nominal amount of credit risk relating to the Swap Agreement because the counterparty is an established and well-capitalized financial institution.

11. Stockholders' Equity

Securities Repurchase Program. Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see Note 10, "Long-Term Debt"). The repurchase program will be funded with working capital or the Company's credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No securities were purchased under this program in the six months ended June 30, 2012.

Stock Plans. In connection with the plans described in Note 4, "Share-Based Compensation," we issued approximately 712,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the six months ended June 30, 2012. Stock plan activity resulted in a $9.5 million increase to additional paid-in capital for the same period.

12. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans which serve Medicaid populations in nine states (subsequent to the termination of our Medicaid contract in Missouri effective June 30, 2012), and also includes our smaller direct delivery line of business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in an additional five states.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(In thousands)		(In thousands)	
Revenue:				
Health Plans:				
Premium revenue	$1,492,272	$1,128,770	$2,819,721	$ 2,210,208
Investment income	1,108	1,446	2,825	3,040
Rental income	1,320	—	3,529	—
Molina Medicaid Solutions:				
Service revenue	41,724	36,888	83,929	73,562
	$1,536,424	$1,167,104	$ 2,910,004	$2,286,810
Depreciation and amortization:				
Health Plans	$ 15,104	$ 12,490	$ 28,847	$ 25,157
Molina Medicaid Solutions	4,567	4,018	9,163	9,445
	$ 19,671	$ 16,508	$ 38,010	$ 34,602
Operating (Loss) Income:				
Health Plans	$ (65,909)	$ 36,894	$ (40,898)	$ 66,500
Molina Medicaid Solutions	6,642	(5,484)	15,051	(3,790)
Total operating (loss) income	(59,267)	31,410	(25,847)	62,710
Interest expense	3,808	3,683	8,106	7,286
(Loss) income before income taxes	$ (63,075)	$ 27,727	$ (33,953)	$ 55,424

	June 30, 2012	December 31, 2011
Goodwill and intangible assets, net:		
Health Plans	$ 148,572	$ 159,963
Molina Medicaid Solutions	92,918	95,787
	$ 241,490	$ 255,750
Total assets:		
Health Plans	$1,682,970	$ 1,425,764
Molina Medicaid Solutions	234,498	226,382
	$1,917,468	$1,652,146

13. Commitments and Contingencies

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Molina Medicaid Solutions

On April 6, 2012, Molina Medicaid Solutions received a schedule from the state of Maine purporting to represent the approximately $32.6 million in damages suffered by the state related to the delay in the "go live" date for the state's MMIS from March 1, 2010 to September 1, 2010, and for other unspecified matters. The level of detail provided in the schedule is not adequate for us to determine the specific nature of the damages claimed by the state. No formal claim has been asserted against us by the state, nor has any legal basis been asserted for any potential claims against us. To the extent that the state decides to pursue its alleged claims against us, Unisys Corporation, or Unisys, the former owner of the MMIS, has agreed to assume the defense of that portion of the claim related to the delay in the "go live" date from March 1, 2010 to August 1, 2010, since that delay had been agreed upon with the state prior to our May 1, 2010 acquisition of Molina Medicaid Solutions from Unisys. The amount of our potential liability related to this matter, if any, cannot be reasonably estimated at this time, nor can a range of such possible liability be established.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $528.3 million at June 30, 2012, and $492.4 million at December 31, 2011.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2012, our health plans had aggregate statutory capital and surplus of approximately $542.1 million compared with the required minimum aggregate statutory capital and surplus of approximately $265.8 million. All of our health plans except our Wisconsin health plan were in compliance with the minimum capital requirements at June 30, 2012. In late July 2012 we contributed sufficient capital to our Wisconsin health plan to ensure compliance with its minimum capital requirements. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Receivable/Liability for Ceded Life and Annuity Contracts

Prior to February 17, 2012, we reported a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. Effective February 17, 2012, we sold Molina Healthcare Insurance Company. The transaction resulted in the elimination of both the noncurrent receivable and liability for ceded life and annuity contracts, each amounting to $23.4 million as of December 31, 2011. Additionally, a gain of approximately $2.4 million was recorded upon closing of the transaction, recorded to general and administrative expenses in the accompanying consolidated income statement.

We remain liable for benefits payable under the life insurance policies that were held by Molina Healthcare Insurance Company, in the event that both the reinsurer and the buyer of Molina Healthcare Insurance Company are unable to pay those benefits. We believe the possibility of our having to pay such benefits is remote, and no provision for the payment of such benefits is included in our consolidated financial statements.

14. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. For the three months ended June 30, 2012 and 2011, we paid $7.0 million, and $6.6 million, respectively, for medical service fees to this provider. For the six months ended June 30, 2012 and 2011, we paid $13.6 million, and $11.9 million, respectively, for medical service fees to this provider.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition, and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbour provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbour provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- the success and timing of our medical cost containment initiatives in Texas, the finalization of rate increases in Texas effective September 1, 2012, and other risks associated with the expansion of our Texas health plan's service areas as of March 1, 2012;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the implementation of the Patient Protection and Affordable Care Act, including the potential refusal of a state to expand Medicaid eligibility to its uninsured population, issues surrounding state insurance exchanges, the impact of the health insurance industry excise tax, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures;
- management of the Company's medical costs, including seasonal flu patterns and rates of utilization that are consistent with the Company's expectations, and the reduction over time of the high medical costs associated with new populations;
- the success of the Company's efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and the Company's ability to grow the Company's revenues consistent with the Company's expectations;
- the accurate estimation of incurred but not reported medical costs across the Company's health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and the development of actuarially sound rates with respect to such new enrollees, including dually eligible enrollees;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- the continuation and renewal of the government contracts of both the Company's health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;

- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine or Idaho;
- additional administrative costs and the potential payment of additional amounts to providers and/or the state by Molina Medicaid Solutions as a result of MMIS implementation issues in Maine or Idaho;
- government audits and reviews, and any enrollment freeze or monitoring program that may result therefrom;
- changes with respect to the Company's provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;
- changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, including the Medicaid RFA litigation and duals RFA protest matters now pending in the state of Ohio;
- restrictions and covenants in the Company's credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of financing to fund and capitalize the Company's acquisitions and start-up activities and to meet the Company's liquidity needs;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates; and
- increasing consolidation in the Medicaid industry.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2011, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2011.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in nine states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. We also have a direct delivery business that currently consists of primary care community clinics in California and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

We report our financial performance based on the following two reportable segments: Health Plans; and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. This segment serves approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our health plans' state Medicaid contracts generally have terms of three to four years with annual adjustments to premium rates. These contracts are renewable at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months with prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's prior contract with the state expired without renewal on June 30, 2012 subject to certain transition obligations. For the six months ended June 30, 2012, our Missouri health plan contributed premium revenue of $113.8 million, or 4.1% of total premium revenue, and comprised 79,000 members, or 4.3% of total Health Plans segment membership as of June 30, 2012.

Our state Medicaid contracts may be periodically adjusted to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations (such as the aged, blind or disabled, or ABD); and regions or service areas. For example, our Texas health plan added significant membership effective March 1, 2012, in service areas we had not previously served (the Hidalgo and El Paso service areas); and among populations we had not previously served within existing service areas, such as the Temporary Assistance for Needy Families, or TANF, population in the Dallas service area. Additionally, the health benefits provided to our TANF and ABD members in Texas under our contracts with the state were expanded to include inpatient facility and pharmacy services.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

On July 13, 2012, our Molina Medicaid Solutions segment received full federal certification of its MMIS from the Centers for Medicare and Medicaid Services, or CMS. As a result of the CMS certification, the state of Idaho is entitled to receive federal reimbursement of 75% of its MMIS operations costs retroactive to June 1, 2010, the date that the system first began processing claims.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement MMIS to another company. For the six months ended June 30, 2012, our revenue under the Louisiana MMIS contract was $24.7 million, or 29.4% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize approximately $40 million in revenue annually under our Louisiana MMIS contract.

During fiscal year 2012, we expect to respond to several RFPs and invitations to negotiate with respect to new business, including proposals to serve dual eligible populations and applications to participate in CMS' Capitated Financial Alignment Demonstration project. In addition, with regard to existing business, we expect the state of New Mexico to issue an RFP for all Medicaid services (Salud!, Behavioral Health, and Coordination of Long-Term Care Services (duals)) in September 2012, with the new Medicaid contract to start on January 1, 2014.

The Company's Board of Directors has organized a special committee of independent directors to consider and negotiate a possible transaction involving certain real property located in Long Beach, California. The property is owned by 6th and Pine Development, LLC, the members of which include John C. Molina, our chief financial officer and a director, and his wife. Negotiations between the special committee and 6th and Pine Development are currently ongoing. In the event we agree to enter into a transaction for space with 6th and Pine Development, we will promptly report our execution of such agreement in a current report on Form 8-K.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the six months ended June 30, 2012, we received approximately 95% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the six months ended June 30, 2012, we recognized approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $110 in California to $260 in Ohio. Among our ABD membership, PMPM premiums range from approximately $340 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	June 30, 2012	March 31, 2012	December 31, 2011	June 30, 2011
Total Ending Membership by Health Plan:				
California	350,000	351,000	355,000	348,000
Florida	70,000	69,000	69,000	66,000
Michigan	220,000	222,000	222,000	220,000
Missouri (1)	79,000	81,000	79,000	80,000
New Mexico	89,000	89,000	88,000	89,000
Ohio	260,000	249,000	248,000	245,000
Texas	301,000	280,000	155,000	129,000
Utah	86,000	86,000	84,000	82,000
Washington	356,000	356,000	355,000	345,000
Wisconsin	42,000	42,000	42,000	41,000
Total	1,853,000	1,825,000	1,697,000	1,645,000
Total Ending Membership by State for our Medicare Advantage Plans:				
California	7,000	6,900	6,900	6,000
Florida	900	800	800	600
Michigan	8,900	8,500	8,200	7,100
New Mexico	900	900	800	700
Ohio	200	200	200	200
Texas	800	800	700	600
Utah	8,300	8,100	8,400	7,000
Washington	5,700	5,200	5,000	4,000
Total	32,700	31,400	31,000	26,200
Total Ending Membership by State for our Aged, Blind or Disabled Population:				
California	41,100	37,300	31,500	17,000
Florida	10,400	10,500	10,400	10,300
Michigan	40,000	38,800	37,500	31,600
New Mexico	5,600	5,600	5,600	5,600
Ohio	29,600	29,700	29,100	28,700
Texas	111,000	109,000	63,700	52,000
Utah	8,800	8,700	8,500	8,300
Washington	4,400	4,700	4,800	4,400
Wisconsin	1,700	1,700	1,700	1,700
Total	252,600	246,000	192,800	159,600

(1) Our contract with the state of Missouri expired without renewal on June 30, 2012.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $62.6 million, and $49.6 million, for the six months ended June 30, 2012 and 2011, respectively, as well as certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Idaho, Louisiana, Maine, New Jersey, West Virginia, and Florida. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Second Quarter Financial Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the three and six months ended June 30, 2012. Comparable metrics for the second quarter of 2011 are also shown. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(Dollar amounts in thousands, except per share data)			
(Loss) earnings per diluted share	$ (0.80)	$ 0.38	$ (0.42)	$ 0.75
Premium revenue	$1,492,272	$1,128,770	$2,819,721	$2,210,208
Service revenue	$ 41,724	$ 36,888	$ 83,929	$ 73,562
Operating (loss) income	$ (59,267)	$ 31,410	$ (25,847)	$ 62,710
Net (loss) income	$ (37,306)	$ 17,440	$ (19,217)	$ 34,828
Total ending membership	1,853,000	1,645,000	1,853,000	1,645,000
Premium revenue	97.1 %	96.7 %	96.9 %	96.7 %
Service revenue	2.7	3.2	2.9	3.2
Investment income	0.1	0.1	0.1	0.1
Rental income	0.1	—	0.1	—
Total revenue	100.0 %	100.0 %	100.0 %	100.0 %
Medical care ratio	92.3 %	84.1 %	89.0 %	84.3 %
General and administrative expense ratio	8.6 %	8.3 %	8.6 %	8.4 %
Premium tax ratio	2.7 %	3.3 %	2.9 %	3.4 %
Operating (loss) income	(3.9)%	2.7 %	(0.9)%	2.7 %
Net (loss) income	(2.4)%	1.5 %	(0.7)%	1.5 %
Effective tax rate	(40.9) %	37.1 %	(43.4) %	37.2 %

Second Quarter 2012 Overview

For the second quarter of 2012, our net loss was $37.3 million, or $0.80 per diluted share, compared with net income of $17.4 million, or $0.38 per diluted share, for the second quarter of 2011.

Our financial performance in the second quarter of 2012 was impacted by challenges with our aged, blind or disabled, or ABD, contracts in Texas, particularly in the Hidalgo and El Paso service areas, and losses in Missouri (where our health plan terminated operations effective June 30, 2012), and in Wisconsin. We believe that our financial performance issues in the quarter were limited to our Texas, Missouri, and Wisconsin health plans. Excluding the Texas, Missouri and Wisconsin health plans, our overall medical care ratio was 85.3% and 84.4% for the three months and six months ended June 30, 2012, respectively. We will receive rate increases in Texas effective September 1, 2012, which together with various initiatives to reduce utilization and decrease unit costs, are expected to improve the performance of the Texas health plan.

Results of Operations

Three Months Ended June 30, 2012 Compared with the Three Months Ended June 30, 2011

Health Plans Segment

Premium Revenue

Premium revenue for the second quarter of 2012 increased 32% over the second quarter of 2011, due primarily to membership increases, a shift in member mix to populations generating higher premium revenue per member per month (PMPM), and increased revenue linked to benefit expansions.

Membership at the Texas health plan more than doubled year over year, while also growing significantly in Ohio and Washington. Growth in our ABD membership led to higher premium revenue PMPM in 2012. ABD membership, as a percent of total membership, has increased over 40% year over year. Premium revenue PMPM also increased in the second quarter of 2012 as a result of the inclusion of revenue from the pharmacy benefit for our Ohio health plan effective October 1, 2011, and as a result of the inclusion of revenue from the inpatient facility and pharmacy benefits across all of our Texas health plan membership effective March 1, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended June 30,					
	2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 981,002	$176.60	71.2 %	$695,551	$ 140.80	73.2 %
Capitation	138,891	25.00	10.1	125,958	25.50	13.2
Pharmacy	212,944	38.33	15.5	87,870	17.79	9.4
Other	44,740	8.07	3.2	39,980	8.09	4.2
Total	$1,377,577	$ 248.00	100.0 %	$ 949,359	$192.18	100.0 %

Medical care costs increased in the second quarter of 2012 primarily due to high costs at our Texas health plan and the addition of the pharmacy benefit in Ohio effective October 1, 2011. The Company's medical margin deteriorated year over year primarily due to:

- Higher medical costs in Texas and higher medical costs for ABD members in California; and
- Rate decreases of approximately 2% in Ohio effective January 1, 2012, and of approximately 3% in California effective July 1, 2011.

Individual Health Plan Analysis

The Texas health plan added 172,000 members and $255.1 million in revenue year over year. Most of this growth was due to regional and benefit expansions effective March 1, 2012. The medical care ratio of the Texas health plan was 109.4% for the second quarter of 2012, compared with 95.0% for the second quarter of 2011. Because revenues of the Texas health plan constituted nearly 25% of our total premium revenue for the second quarter of 2012, the high medical care ratio in that state had a disproportionately large impact on our overall financial results. Absent $14.1 million of unfavorable prior period development of claims reserves from the first quarter of 2012 and the impact of the $10.0 million premium deficiency reserve discussed below, the medical care ratio of the Texas health plan would have been approximately 102.7% in the second quarter of 2012. The following table captures the effect of prior period development and the premium deficiency reserve on the Texas health plan's medical care ratio and medical care costs for the three months ended June 30, 2012:

	Texas Results for the Quarter Ended June 30, 2012 (Dollars in thousands)	
	Medical Care Ratio	Medical Care Costs
Reported financial performance	109.4%	$ 393,237
Impact of prior period claims development	(3.9)	(14,100)
Impact of premium deficiency reserve (two months ending August 31, 2012)	(2.8)	(10,000)
Medical ratio and medical care costs adjusted to exclude impact of prior period development and premium deficiency reserve	102.7%	$369,137

We believe that premium rates associated with the ABD contracts in the Hidalgo and El Paso service areas are not adequate to cover the medical costs associated with serving members under existing conditions. Utilization of long term care services, including personal attendant services and adult day health care services, is currently far exceeding the utilization of those services elsewhere in the state, and also far exceeding the utilization assumptions used by the state of Texas in the development, and our evaluation of, premium rates.

We recorded a premium deficiency reserve for the Texas health plan at June 30, 2012 of $10.0 million. This premium deficiency reserve encompasses the contract period ending August 31, 2012. The state of Texas has released preliminary rates effective September 1, 2012. We believe that these preliminary rates, if enacted, will yield a blended rate increase of approximately 6% overall (approximately $7.4 million per month) for the Texas health plan. We believe that the premium rates effective in Texas on September 1, 2012, together with various medical cost containment initiatives, will allow the Texas health plan to return to profitability during Texas state fiscal year 2013 (September 1, 2012 through August 31, 2013).

The medical care ratio for the ABD membership in the Hidalgo and El Paso service areas was 139% and 146%, respectively, during the second quarter of 2012. Absent unfavorable prior period development from the first quarter of 2012 and the premium deficiency reserve, the medical care ratios of the ABD membership in the Hidalgo and El Paso service areas would have been 116% and 133%, respectively, consistent with our estimates. The medical care ratio for the aggregate ABD membership in Texas was approximately 119%. Absent unfavorable prior period development of claims reserves and the premium deficiency reserve, the medical care ratio for the aggregate ABD membership in Texas was approximately 109%. ABD membership overall constitutes approximately 70% of all Texas health plan revenue. ABD membership in the Hidalgo and El Paso service areas alone contributed 28% of the Texas health plan's total revenue for the second quarter of 2012.

We estimate that the current monthly loss before taxes for the Texas health plan overall is approximately $14 million, inclusive of payments made under its management services agreement with Molina Healthcare, Inc., the corporate parent of the Texas health plan. We believe that the profitability of the Texas health plan will improve over time by the estimated amounts shown below. We also believe that enrollment may decrease at the Texas health plan during the third quarter of 2012.

	Expected Monthly Increase to Profitability (In thousands)
Blended rate increase effective September 1, 2012	$ 7,400
Provider contract changes expected to be effective by December 2012	3,400
Other initiatives (including changes to hospital payments and prior authorizations) expected to be effective by December 2012)	3,200
	$ 14,000

The increase in the medical care ratio of the California health plan year over year was primarily due to premium rate reductions effective July 1, 2011, and the mandatory assignment of ABD members previously served under fee-for-service arrangements. These members were transitioned into managed care plans effective upon their month of birth beginning in June 2011. The last of these members were transitioned into managed care in May 2012. The medical care ratio for these new members is approximately 95% compared with a medical care ratio of approximately 85% for ABD members not subject to mandatory enrollment. Individuals who are new to managed care often have higher utilization of medical services upon initially enrolling into managed care plans. Utilization of heath care services is declining, however, for those ABD members added earlier in the mandatory enrollment process. This data leads us to believe that medical care costs will decrease for the mandatory ABD members over time.

Profitability at the Florida health plan improved substantially year over year due to a premium rate increase effective September 1, 2011, the re-contracting of portions of the health plan's specialty care network, and lower inpatient utilization.

The medical care ratio of the Michigan health plan increased to 87.1% in the second quarter of 2012, from 78.7% in the second quarter of 2011. The higher medical care ratio in 2012 was the result of a reduction to premium rates that was linked to a decrease in premium taxes, and higher pharmacy and inpatient facility costs. Partially offsetting the higher medical care ratio was a decrease of $8.7 million in premium tax expense. Both premium taxes and premium rates were reduced equivalently effective April 1, 2012. If the reduction to premium rates linked to a decrease in premium taxes had been in effect in the prior year, the medical care ratio for the second quarter of 2011 would have been approximately 82%.

The medical care ratio of the Missouri health plan increased to 104.9% in the second quarter of 2012 compared with 90.2% in the second quarter of 2011. The increase in the medical care ratio was primarily the result of higher inpatient utilization and high dollar claims. Unfavorable prior period development of claims reserves from the first quarter of 2012 was $7.6 million in the second quarter of 2012.

Profitability at the New Mexico health plan improved substantially year over year due to the absence in 2012 of contractually required reductions to revenue made in 2011.

The medical care ratio of the Ohio health plan increased to 82.6% for the second quarter of 2012 from 77.6% for the second quarter of 2011. The increase in the Ohio health plan's medical care ratio was primarily the result of a 2% rate reduction effective January 1, 2012, together with the assumption of the lower margin pharmacy benefit effective October 1, 2011. Although the Ohio health plan's medical care ratio increased in 2012, the medical margin (measured as total premium revenue less total medical care costs) remained constant.

Absent a one-time revenue benefit of $12.1 million recorded in the second quarter of 2011, the medical care ratio of the Utah health plan decreased to 82.5% in the second quarter of 2012 from 89.4% in the second quarter of 2011.

Lower inpatient facility costs tied to reduced inpatient utilization led the Washington health plan to report improved profitability year over year.

The Wisconsin health plan reported a medical care ratio of 121.1% for the second quarter of 2012 compared with 80.8% for the second quarter of 2011. We believe that premium rates associated with its contract in the state of Wisconsin are not adequate to cover the costs of servicing that contract. Accordingly, we recorded a premium deficiency reserve for the Wisconsin health plan at June 30, 2012 of $3.0 million. The Wisconsin health plan will receive new premium rates effective January 1, 2013. Absent the $3.0 million premium deficiency reserve, the medical care ratio of the Wisconsin health plan would have been approximately 105.2% for the second quarter of 2012.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended June 30, 2012						
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,056	$ 167,644	$ 158.77	$ 149,239	$ 141.34	89.0 %	$ 2,695
Florida	210	57,303	273.00	48,442	230.79	84.5	(20)
Michigan	662	162,758	245.89	141,682	214.04	87.1	1,073
Missouri (2)	240	57,205	237.97	59,981	249.52	104.9	—
New Mexico	266	85,360	320.92	67,836	255.03	79.5	2,257
Ohio	762	297,069	389.85	245,284	321.89	82.6	23,012
Texas	907	359,486	396.63	393,237	433.87	109.4	6,669
Utah	259	76,911	297.00	63,419	244.90	82.5	—
Washington	1,068	207,376	194.14	174,045	162.93	83.9	3,799
Wisconsin	125	18,788	150.12	22,758	181.84	121.1	—
Other (3)	—	2,372	—	11,654	—	—	144
	5,555	$1,492,272	$268.65	$1,377,577	$ 248.00	92.3 %	$ 39,629

	Three Months Ended June 30, 2011						
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,043	$ 139,097	$ 133.35	$ 117,511	$112.66	84.5 %	$ 1,921
Florida	197	49,770	252.78	48,294	245.29	97.0	34
Michigan	668	165,575	247.74	130,325	195.00	78.7	9,728
Missouri (2)	243	56,625	232.80	51,100	210.08	90.2	—
New Mexico	270	81,973	304.29	68,579	254.57	83.7	2,423
Ohio	736	230,874	313.36	179,102	243.09	77.6	17,782
Texas	391	104,399	267.06	99,154	253.64	95.0	2,063
Utah	244	77,507	318.32	58,473	240.15	75.4	—
Washington	1,027	202,595	197.39	171,742	167.33	84.8	3,662
Wisconsin	121	17,840	147.02	14,415	118.79	80.8	44
Other (3)	—	2,515	—	10,664	—	—	52
	4,940	$1,128,770	$ 228.50	$ 949,359	$192.18	84.1 %	$ 37,709

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) Our contract with the state of Missouri expired without renewal on June 30, 2012.
(3) "Other" medical care costs also include medically related administrative costs at the parent company.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended June 30, 2012	2011
	(In thousands)	
Service revenue before amortization	$ 41,877	$ 38,434
Amortization recorded as reduction of service revenue	(153)	(1,546)
Service revenue	41,724	36,888
Cost of service revenue	30,613	39,215
General and administrative costs	3,187	1,875
Amortization of customer relationship intangibles recorded as amortization	1,282	1,282
Operating income (loss)	$ 6,642	$ (5,484)

Operating income for our Molina Medicaid Solutions segment improved $12.1 million for the three months ended June 30, 2012, compared with the same prior year period. This improvement was primarily the result of stabilization of our newest Medicaid Management Information Systems, or MMIS, in Idaho and Maine. As discussed earlier, our Idaho MMIS has received full federal certification. Among the reasons cited by the Company for purchasing Molina Medicaid Solutions effective May 1, 2010, was the benefit of reducing our reliance on health plan operations. For the quarter ended June 30, 2012, the Molina Medicaid Solutions segment gross margin rate was 27%, compared with 8% for the Health Plans segment.

Six Months Ended June 30, 2012 Compared with the Six Months Ended June 30, 2011

Health Plans Segment

Premium Revenue

In the six months ended June 30, 2012, compared with the six months ended June 30, 2011, premium revenue grew 28% due to a membership increase of approximately 9.5% (on a member-month basis), and PMPM revenue increase of approximately 16.6%. Medicare premium revenue was $230.5 million for the six months ended June 30, 2012, compared with $180.8 million for the six months ended June 30, 2011.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Six Months Ended June 30,					
	2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$1,758,269	$ 163.13	70.1 %	$ 1,351,435	$ 137.31	72.5 %
Capitation	274,929	25.51	11.0	254,640	25.87	13.7
Pharmacy	386,181	35.83	15.4	179,446	18.23	9.6
Other	89,186	8.28	3.5	77,370	7.86	4.2
Total	$2,508,565	$232.75	100.0 %	$1,862,891	$189.27	100.0 %

Our medical care ratio and medical margin deteriorated in the six months ended June 30, 2012, when compared with the six months ended June 30, 2011, for the same reasons described above in the “Three Months Ended June 30, 2012 Compared with the Three Months Ended June 30, 2011.”

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Six Months Ended June 30, 2012						
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	2,115	$ 329,329	$ 155.70	$ 290,588	$ 137.39	88.2 %	$ 5,004
Florida	418	113,493	271.44	98,011	234.41	86.4	(13)
Michigan	1,327	330,664	249.20	275,893	207.92	83.4	10,157
Missouri (2)	483	113,818	235.63	113,101	234.15	99.4	—
New Mexico	532	168,621	317.10	134,947	253.78	80.0	4,210
Ohio	1,508	590,594	391.77	481,985	319.72	81.6	45,865
Texas	1,499	557,722	372.11	573,326	382.53	102.8	9,866
Utah	511	152,049	297.29	121,300	237.17	79.8	—
Washington	2,135	422,986	198.11	355,470	166.49	84.0	7,711
Wisconsin	250	35,930	143.54	39,644	158.31	110.3	—
Other (3)	—	4,515		24,300	—	—	259
	10,778	$2,819,721	$261.61	$2,508,565	$ 232.75	89.0 %	$ 83,059

	Six Months Ended June 30, 2011						
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	2,084	$ 274,073	$ 131.49	$ 231,248	$ 110.95	84.4 %	$ 3,823
Florida	389	98,992	254.68	95,863	246.63	96.8	51
Michigan	1,346	330,335	245.38	264,053	196.15	79.9	19,575
Missouri (2)	488	111,792	229.05	102,707	210.44	91.9	—
New Mexico	541	166,579	308.12	138,616	256.40	83.2	4,388
Ohio	1,473	461,213	313.02	350,853	238.12	76.1	35,557
Texas	740	185,210	250.28	172,769	233.47	93.3	3,403
Utah	480	145,442	303.28	112,312	234.20	77.2	—
Washington	2,061	397,867	193.09	340,857	165.42	85.7	7,323
Wisconsin	241	34,257	142.17	33,794	140.25	98.7	44
Other (3)	—	4,448	—	19,819	—	—	95
	9,843	$ 2,210,208	$ 224.56	$ 1,862,891	$ 189.27	84.3 %	$ 74,259

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) Our contract with the state of Missouri expired without renewal on June 30, 2012.
(3) "Other" medical care costs also include medically related administrative costs of the parent company.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Six Months Ended June 30,	
	2012	2011
	(In thousands)	
Service revenue before amortization	$ 84,235	$ 77,294
Amortization recorded as reduction of service revenue	(306)	(3,732)
Service revenue	83,929	73,562
Cost of service revenue	61,107	70,436
General and administrative costs	5,207	4,352
Amortization of customer relationship intangibles recorded as amortization	2,564	2,564
Operating income (loss)	$15,051	$ (3,790)

Operating income for our Molina Medicaid Solutions segment improved $18.8 million for the six months ended June 30, 2012, compared with the same prior year period for the reasons discussed above in "Three Months Ended June 30, 2012 Compared with the Three Months Ended June 30, 2011."

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 8.6% of total revenue for the three months ended June 30, 2012, compared with 8.3% of total revenue for the three months ended June 30, 2011. General and administrative expenses increased to 8.6% of total revenue for the six months ended June 30, 2012, compared with 8.4% of total revenue for the six months ended June 30, 2011. The increased ratio of general and administrative expenses to total revenue, for both the three months and six months ended June 30, 2012, was due primarily to investment in administrative infrastructure relating to our membership growth in Texas, and in anticipation of opportunities among the dual-eligible population.

Premium Tax Expense

Premium tax expense decreased to 2.7% of premium revenue for the three months ended June 30, 2012, from 3.3% in the three months ended June 30, 2011, and decreased to 2.9% of premium revenue, in the six months ended June 30, 2012, from 3.4% in the six months ended June 30, 2011. This decrease was primarily due to the reduction of premium taxes at the Michigan health plan effective April, 2012, as discussed in "Three Months Ended June 30, 2012 Compared with the Three Months Ended June 30, 2011," above, and the growth in revenue at our Texas health plan, which is subject to a lower premium tax (measured as a percentage of premium revenue) than our consolidated average.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of operations. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of operations as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of operations, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended June 30,			
	2012		2011	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 10,851	0.7 %	$ 7,225	0.6 %
Amortization of intangible assets	5,536	0.4	5,265	0.5
Depreciation and amortization reported as such in the consolidated statements of operations	16,387	1.1	12,490	1.1
Amortization recorded as reduction of service revenue	153	—	1,546	0.1
Amortization of capitalized software recorded as cost of service revenue	3,131	0.2	2,472	0.2
Total	$19,671	1.3 %	$16,508	1.4 %

	Six Months Ended June 30,			
	2012		2011	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 20,323	0.7 %	$ 14,625	0.6 %
Amortization of intangible assets	11,089	0.4	10,532	0.5
Depreciation and amortization reported as such in the consolidated statements of operations	31,412	1.1	25,157	1.1
Amortization recorded as reduction of service revenue	306	—	3,732	0.2
Amortization of capitalized software recorded as cost of service revenue	6,292	0.2	5,713	0.2
Total	$ 38,010	1.3 %	$ 34,602	1.5 %

Interest Expense

Interest expense increased to $3.8 million for the three months ended June 30, 2012, from $3.7 million for the three months ended June 30, 2011, and increased to $8.1 million for the six months ended June 30, 2012, from $7.3 million for the six months ended June 30, 2011 due primarily to interest expense associated with the Company's purchase of its corporate headquarters building in December 2011. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $1.5 million and $1.4 million for the three months ended June 30, 2012, and 2011, respectively, and $2.9 million and $2.7 million for the six months ended June 30, 2012, and 2011, respectively

Income Taxes

The provision for income taxes is recorded at an effective rate of 40.9% for the three months ended June 30, 2012 compared with 37.1% for the three months ended June 30, 2011, and 43.4% for the six months ended June 30, 2012 compared with 37.2% for the six months ended June 30, 2011. The higher rates in 2012 are primarily due to the greater proportional impact of non-deductible expenses on the effective tax rate as earnings before taxes decrease.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of June 30, 2012, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $2.8 million for the six months ended June 30, 2012, compared with $3.0 million for the six months ended June 30, 2011. Our annualized portfolio yield for the six months ended June 30, 2012 was 0.5% compared with 0.7% for the six months ended June 30, 2011.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the six months ended June 30, 2012 was $236.0 million compared with $114.9 million for the six months ended June 30, 2011, an increase of $121.1 million. Higher medical claims and benefits payable at our Texas health plan was the primary reason for the increase in cash flow provided by operating activities, followed by an increase in deferred revenue. Medical claims and benefits payable were a source of operating cash of $123.1 million in the six months ended June 30, 2012 compared with a use of operating cash of $12.7 million in the six months ended June 30, 2011. Deferred revenue was a source of operating cash amounting to $125.4 million in the six months ended June 30, 2012, compared with $38.1 million in the six months ended June 30, 2011.

Reconciliation of Non-GAAP [1] to GAAP Financial Measures

EBITDA [2]

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
	(In thousands)			
Net (loss) income	$ (37,306)	$ 17,440	$(19,217)	$ 34,828
Add back:				
Depreciation and amortization reported in the consolidated statements of cash flows	19,671	16,508	38,010	34,602
Interest expense	3,808	3,683	8,106	7,286
Provision for income taxes	(25,769)	10,287	(14,736)	20,596
EBITDA	$(39,596)	$47,918	$ 12,163	$ 97,312

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At June 30, 2012, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $39.8 million, compared with approximately $23.6 million of cash and investments at December 31, 2011.

On a consolidated basis, at June 30, 2012, we had working capital of $481.9 million compared with $446.2 million at December 31, 2011. At June 30, 2012 we had cash and investments of $1,128.7 million, compared with $893.0 million of cash and investments at December 31, 2011.

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see discussion of "Convertible Senior Notes" below). The repurchase program will be funded with working capital or draws under our credit facility (see discussion of "Credit Facility" below).

We believe that our cash resources, Credit Facility, and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility is used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of June 30, 2012 there was $50.0 million outstanding under the Credit Facility. Additionally, as of June 30, 2012, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA for the trailing twelve month period of not more than 2.75 to 1.00, and a fixed charge coverage ratio of not less than 1.75 to 1.00. At June 30, 2012, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

Convertible Senior Notes

As of June 30, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The conversion rate is 31.9601 shares of our common stock per $1,000 principal amount of the Notes. This represents a conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the approximately 460,000 square foot office building, or Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. "Interest Period" means the period commencing on the first day of each calendar month and ending on the last day of such calendar month. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Interest Rate Swap

In May 2012, we entered into a $42.5 million notional amount interest rate swap agreement, or Swap Agreement, with an effective date of March 1, 2013. While not designated as a hedge during the quarter ended June 30, 2012, the Swap Agreement is intended to reduce our exposure to fluctuations in the contractual variable interest rates under our Term Loan Agreement, and expires on the maturity date of the Term Loan Agreement, November 30, 2018. Under the Swap Agreement, we will receive a variable rate of the one-month LIBOR plus 3.25%, and pay a fixed rate of 5.34%. The Swap Agreement is measured and reported at fair value on a recurring basis, within Level 2 of the fair value hierarchy. Gains and losses relating to changes in its fair value are reported in earnings in the current period. As of June 30, 2012, the fair value of the Swap Agreement is a liability of $1.1 million, recorded to other noncurrent liabilities. Because the fair value of the Swap Agreement was zero at its inception in May 2012, the entire amount of the liability was charged to general and administrative expense in the quarter ended June 30, 2012. We do not use derivatives for trading or speculative purposes. We believe that we are not exposed to more than a nominal amount of credit risk relating to the Swap Agreement because the counterparty is an established and well-capitalized financial institution.

Shelf Registration Statement

In the second quarter of 2012, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the registration, issuance, and sale of an indeterminate amount of our securities, including common stock, preferred stock, senior or subordinated debt securities, or warrants. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $528.3 million at June 30, 2012, and $492.4 million at December 31, 2011.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2012, our health plans had aggregate statutory capital and surplus of approximately $542.1 million compared with the required minimum aggregate statutory capital and surplus of approximately $265.8 million. All of our health plans except our Wisconsin health plan were in compliance with the minimum capital requirements at June 30, 2012. In late July 2012 we contributed sufficient capital to our Wisconsin health plan to ensure compliance with its minimum capital requirements. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2011, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and;
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. We recorded a liability under the terms of these contract provisions of $0.5 million and $1.0 million at June 30, 2012, and December 31, 2011, respectively.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both June 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): A portion of premiums received by our New Mexico health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). The New Mexico health plan contract also contains certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At both June 30, 2012, and December 31, 2011, we had not recorded any liability under the terms of these contract provisions.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $6.9 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at June 30, 2012, and December 31, 2011, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to CMS our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $13.4 million and $5.0 million for anticipated Medicare risk adjustment premiums as of June 30, 2012, and December 31, 2011, respectively.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. Effective February 1, 2010 through June 30, 2011, we were eligible to earn additional incremental revenue of up to 0.25% of our total premium if we met certain pharmacy specific performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state. Based upon our assessment of the performance measures at June 30, 2012, we have accrued an estimated $4.0 million of premiums that were not earned under this program.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of June 30, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of June 30, 2012.

	Three Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 561	$ 482	$ 630	$ 1,112	$ 85,360
Ohio	2,720	2,720	—	2,720	297,069
Texas	18,252	14,284	—	14,284	359,486
Wisconsin	449	—	246	246	18,788
	$ 21,982	$ 17,486	$ 876	$ 18,362	$ 760,703

	Three Months Ended June 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 565	$ 430	$ 486	$ 916	$ 81,973
Ohio	2,650	3,083	1,678	4,761	230,874
Texas	756	736	—	736	104,399
Wisconsin	456	—	—	—	17,840
	$ 4,427	$ 4,249	$ 2,164	$ 6,413	$ 435,086

	Six Months Ended June 30, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,116	$ 818	$ 658	$ 1,476	$ 168,621
Ohio	5,398	5,398	966	6,364	590,594
Texas	24,002	20,034	—	20,034	557,722
Wisconsin	865	—	246	246	35,930
	$ 31,381	$ 26,250	$ 1,870	$ 28,120	$ 1,352,867

	Six Months Ended June 30, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 1,146	$ 874	$ 318	$ 1,192	$166,579
Ohio	5,312	4,433	3,501	7,934	461,213
Texas	1,317	736	—	736	185,210
Wisconsin	872	—	—	—	34,257
	$ 8,647	$ 6,043	$ 3,819	$ 9,862	$ 847,259

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple –Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011 or 2012. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	June 30, 2012	Dec. 31, 2011	June 30, 2011
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 378,782	$ 301,020	$270,558
Capitation payable	79,739	53,532	43,131
Pharmacy	34,848	26,178	15,094
Other	32,169	21,746	12,830
	$525,538	$402,476	$ 341,613

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $378.8 million of our total medical claims and benefits payable of $525.5 million as of June 30, 2012. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider’s monthly capitation payment), our IBNP liability at June 30, 2012, was $372.9 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of June 30, 2012 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding June 30, 2012, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ 125,335
(4%)	83,556
(2%)	41,778
2%	(41,778)
4%	(83,556)
6%	(125,335)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of June 30, 2012 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ (81,966)
(4%)	(54,644)
(2%)	(27,322)
2%	27,322
4%	54,644
6%	81,966

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 46.2 million diluted shares outstanding for the six months ended June 30, 2012. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at June 30, 2012, net income for the six months ended June 30, 2012 would increase or decrease by approximately $13.1 million, or $0.28 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at June 30, 2012, net income for the six months ended June 30, 2012 would increase or decrease by approximately $8.5 million, or $0.18 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $65.3 million, or $1.41 per diluted share, and $42.7 million, or $0.92 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $13.1 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2011, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 14.6%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2012 and 2011 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized favorable prior period claims development in the amount of $36.4 million for the six months ended June 30, 2012. This amount represents our estimate as of June 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 was more than the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2011 was due primarily to the following factors:

- For our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- For our Texas health plan, we overestimated the cost of new members in STAR+PLUS (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.
- Offsetting some of the overestimation items described above, our Missouri health plan reserves were underestimated as a result of an unusually large number of premature infants during the fourth quarter.

We recognized unfavorable prior period claims development in the amount of $0.5 million for the three months ended June 30, 2012. This amount represents our estimate as of June 30, 2012 of the extent to which our initial estimate of medical claims and benefits payable at March 31, 2012 was less than the amount that will ultimately be paid out in satisfaction of that liability. The underestimation of claims liability at March 31, 2012 was due primarily to the following factors:

- For our Texas health plan, our initial estimates of reserves at March 31, 2012 for new coverage (inpatient medical costs on STAR+PLUS members) and new regions were based on the state's pricing assumptions. We have since learned that the claims costs are much higher than initially expected.
- For our Missouri health plan, reserves were underestimated due to a large number of very high cost claims, including premature infants, during the first quarter of 2012.
- We underestimated the impact of a buildup in claims inventory in our Michigan and Ohio health plans as of March 31, 2012.

We recognized favorable prior period claims development in the amount of $45.4 million and $51.8 million for the six months ended June 30, 2011, and the year ended December 31, 2011, respectively. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2010, as a result of the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010, partially offsetting the impact of the two items above.

In estimating our claims liability at June 30, 2012, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Our Texas health plan membership has nearly doubled effective March 1, 2012. In addition, effective March 1, 2012, we assumed inpatient medical liability for STAR+PLUS (an area of coverage that was previously carved out). Reserves for new coverage and new regions are now based on the newly developing claims lag patterns and comparisons with similar coverage in other regions with more historical data.
- Our California health plan has enrolled approximately 24,000 new ABD members since June 30, 2011, as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members converted from a fee-for-service environment, and are higher cost than our base ABD members.
- Our claims inventory had increased significantly during the first quarter of 2012, followed by a significant reduction in claims inventory in the second quarter of 2012. Changes in claims inventory can impact historical claims lag patterns.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2011 and for the six months ended June 30, 2012, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period were (more) or less than the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended June 30,		Three Months Ended June 30,		Year Ended
	2012	2011	2012	2011	Dec. 31, 2011
	(Dollars in thousands, except per-member amounts)				
Balances at beginning of period	$ 402,476	$ 354,356	$ 455,833	$ 351,382	$ 354,356
Components of medical care costs related to:					
Current period	2,544,922	1,908,289	1,377,084	969,100	3,911,803
Prior periods	(36,357)	(45,398)	493	(19,741)	(51,809)
Total medical care costs	2,508,565	1,862,891	1,377,577	949,359	3,859,994
Payments for medical care costs related to:					
Current period	2,033,611	1,584,636	891,573	666,081	3,516,994
Prior periods	351,892	290,998	416,299	293,047	294,880
Total paid	2,385,503	1,875,634	1,307,872	959,128	3,811,874
Balances at end of period	$ 525,538	$ 341,613	$ 525,538	$ 341,613	$ 402,476
Benefit from prior period as a percentage of:					
Balance at beginning of period	9.0%	12.8%	(0.1)%	5.6%	14.6%
Premium revenue	1.3%	2.1%	0.0%	1.7%	1.1%
Total medical care costs	1.4%	2.4%	0.0%	2.1%	1.3%
Claims Data:					
Days in claims payable, fee for service	44	39	44	39	40
Number of members at end of period	1,853,000	1,645,000	1,853,000	1,645,000	1,697,000
Number of claims in inventory at end of period	209,200	121,900	209,200	121,900	111,100
Billed charges of claims in inventory at end of period	$ 324,500	$ 205,800	$ 324,500	$ 205,800	$ 207,600
Claims in inventory per member at end of period	0.11	0.07	0.11	0.07	0.07
Billed charges of claims in inventory per member at end of period	$ 175.12	$ 125.11	$ 175.12	$ 125.11	$ 122.33
Number of claims received during the period	10,375,700	8,715,200	5,520,100	4,373,000	17,207,500
Billed charges of claims received during the period	$ 9,388,700	$ 6,963,300	$ 5,051,800	$ 3,576,700	$ 14,306,500

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

We are also exposed to interest rate risk relating to contractual variable interest rates under our Term Loan Agreement which matures on November 30, 2018. We manage this floating rate debt using an interest rate swap agreement that we expect will reduce our exposure to the impact of changing interest rates to our consolidated results of operations and future outflows for interest. The interest rate swap is not designated as a hedging instrument.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2012 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. *Legal Proceedings*

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. *Risk Factors*

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, the following risk factors were identified by the Company during the second quarter of 2012, and is a supplement to, and should be read together with, the risk factors discussed in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2011. The risk factors described herein and in our 2011 Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

There are numerous risks associated with our medical cost containment initiatives in Texas.

We have estimated that the monthly profitability of our Texas health plan will improve by $14 million by December 2012 as a result of a blended rate increase effective September 1, 2012, provider contract changes, changes to hospital payments and prior authorization requirements, and other medical cost containment initiatives. No assurances can be given that the expected rate increase will be fully implemented on September 1, 2012 as proposed, that all of the described measures together will improve the profitability of our Texas health plan by $14 million, or that such measures will have become fully effective in lowering our medical costs by December 2012. The failure of these measures to have the expected effects could result in continued monthly losses at our Texas health plan, which could adversely affect our business, financial condition, cash flows, or results of operations.

There is continuing uncertainty regarding the full applicability of the Affordable Care Act with regard to the Medicaid expansion.

On June 28, 2012, the United States Supreme Court held, among other things, that states may opt out of the Medicaid expansion under the Affordable Care Act. Several state governors, including governors in states in which we operate health plans, have stated that they do not intend for their states to participate in the Medicaid expansion expected to occur in January 2014. In addition, some governors have contended that the Supreme Court's ruling calls into question the "maintenance of effort" requirement under the Affordable Care Act which requires states to maintain their Medicaid eligibility standards as they had existed prior to the enactment of the Affordable Care Act. If the states in which we operate our health plans do not participate in the Medicaid expansion, or if states in which we currently operate are determined to be not subject to the maintenance of effort requirement and change their eligibility standards, our Medicaid enrollment levels could be less than projected or could even drop, which could have a materially adverse effect on our business, financial condition, cash flows, or results of operations.

Item 2. *Unregistered Sales of Equity Securities and Use of Proceeds*

Issuer Purchases of Equity Securities

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program will be funded with working capital or draws under our credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No securities were purchased under this program as of June 30, 2012.

Purchases of common stock made by or on behalf of the Company during the quarter ended June 30, 2012, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs
April 1 - April 30	1,364	$ 33.63	—	$ —
May 1 - May 31	—	$ —	—	$ —
June 1 - June 30	2,732	$ 24.57	—	$ —
Total	4,096	$ 27.59	—	

(a) During the three months ended June 30, 2012, we did not repurchase any shares of our common stock outside of our publicly announced stock repurchase program. During the quarter we withheld 4,096 shares of common stock under our 2011 Equity Incentive Plan to settle our employees'

income tax obligations.

Item 6. Exhibits

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS (1)	XBRL Taxonomy Instance Document.
101.SCH (1)	XBRL Taxonomy Extension Schema Document.
101.CAL (1)	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF (1)	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB (1)	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE (1)	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) Pursuant to Rule 406T of Regulation S-T, XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: August 6, 2012

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: August 6, 2012

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT INDEX

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EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2012 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 6, 2012

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2012 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 6, 2012

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2012 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 6, 2012

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2012 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 6, 2012

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended March 31, 2012

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2012

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

Molina Healthcare, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	**(Zip Code)**

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The number of shares of the issuer's Common Stock outstanding as of April 30, 2012, was approximately 46,350,000.

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MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	March 31, 2012	December 31, 2011
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 517,723	$ 493,827
Investments	357,981	336,916
Receivables	222,254	167,898
Income tax refundable	15,315	11,679
Deferred income taxes	14,025	18,327
Prepaid expenses and other current assets	24,715	19,435
Total current assets	1,152,013	1,048,082
Property, equipment, and capitalized software, net	198,564	190,934
Deferred contract costs	64,414	54,582
Intangible assets, net	96,090	101,796
Goodwill and indefinite-lived intangible assets	151,088	153,954
Auction rate securities	16,129	16,134
Restricted investments	41,947	46,164
Receivable for ceded life and annuity contracts	—	23,401
Other assets	19,759	17,099
	$ 1,740,004	$1,652,146
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 455,833	$ 402,476
Accounts payable and accrued liabilities	124,649	147,214
Deferred revenue	95,490	50,947
Current maturities of long-term debt	1,118	1,197
Total current liabilities	677,090	601,834
Long-term debt	228,150	216,929
Deferred income taxes	37,209	33,127
Liability for ceded life and annuity contracts	—	23,401
Other long-term liabilities	22,243	21,782
Total liabilities	964,692	897,073
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 46,347 shares at March 31, 2012 and 45,815 shares at December 31, 2011	46	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	267,876	266,022
Accumulated other comprehensive loss	(1,109)	(1,405)
Retained earnings	508,499	490,410
Total stockholders' equity	775,312	755,073
	$ 1,740,004	$1,652,146

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2012	2011
	(Amounts in thousands, except per-share data) (Unaudited)	
Revenue:		
Premium revenue	$ 1,327,449	$ 1,081,438
Service revenue	42,205	36,674
Investment income	1,717	1,594
Rental income	2,209	—
Total revenue	1,373,580	1,119,706
Expenses:		
Medical care costs	1,130,988	913,532
Cost of service revenue	30,494	31,221
General and administrative expenses	120,223	94,436
Premium tax expenses	43,430	36,550
Depreciation and amortization	15,025	12,667
Total expenses	1,340,160	1,088,406
Operating income	33,420	31,300
Interest expense	4,298	3,603
Income before income taxes	29,122	27,697
Provision for income taxes	11,033	10,309
Net income	$ 18,089	$ 17,388
Net income per share (1):		
Basic	$ 0.39	$ 0.38
Diluted	$ 0.39	$ 0.38
Weighted average shares outstanding (1):		
Basic	45,998	45,588
Diluted	46,887	46,257

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2012	2011
	(Amounts in thousands) (Unaudited)	
Net income	$18,089	$17,388
Other comprehensive income (loss), net of tax:		
Unrealized gain (loss) on investments	296	(117)
Other comprehensive income (loss)	296	(117)
Comprehensive income	$18,385	$17,271

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2012	2011
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 18,089	$ 17,388
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	18,339	18,094
Deferred income taxes	8,906	1,619
Stock-based compensation	4,666	4,064
Gain on sale of subsidiary	(2,390)	—
Non-cash interest on convertible senior notes	1,443	1,340
Amortization of premium/discount on investments	1,850	1,644
Amortization of deferred financing costs	258	503
Tax deficiency from employee stock compensation	(31)	(264)
Changes in operating assets and liabilities:		
Receivables	(54,356)	19,388
Prepaid expenses and other current assets	(5,287)	(8,069)
Medical claims and benefits payable	53,357	(2,974)
Accounts payable and accrued liabilities	(35,149)	(25,796)
Deferred revenue	44,543	62,616
Income taxes	(3,663)	(5,430)
Net cash provided by operating activities	50,575	84,123
Investing activities:		
Purchases of equipment	(13,505)	(14,941)
Purchases of investments	(88,199)	(104,984)
Sales and maturities of investments	65,767	61,275
Proceeds from sale of subsidiary, net of cash surrendered	9,162	—
Net cash paid in business combinations	—	(3,253)
Increase in deferred contract costs	(12,993)	(9,635)
Increase in restricted investments	(493)	(7,207)
Change in other noncurrent assets and liabilities	(2,457)	(1,010)
Net cash used in investing activities	(42,718)	(79,755)
Financing activities:		
Amount borrowed under credit facility	10,000	—
Principal payments on term loan	(301)	—
Proceeds from employee stock plans	2,748	2,462
Excess tax benefits from employee stock compensation	3,592	1,076
Net cash provided by financing activities	16,039	3,538
Net increase in cash and cash equivalents	23,896	7,906
Cash and cash equivalents at beginning of period	493,827	455,886
Cash and cash equivalents at end of period	$517,723	$ 463,792

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Three Months Ended March 31,	
	2012	2011
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 1,057	$14,068
Interest	$ 799	$ 269
Schedule of non-cash investing and financing activities:		
Common stock used for stock-based compensation	$ 9,121	$ 3,161
Details of sale of subsidiary:		
Decrease in fair value of assets	$ 30,942	$ —
Decrease in fair value of liabilities	(24,170)	—
Gain on sale	2,390	
Proceeds from sale of subsidiary, net of cash surrendered	$ 9,162	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
March 31, 2012

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. As of March 31, 2012, these health plans served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our health plans' state Medicaid contracts generally have a term of one- to two-years and are renewable on an annual or biannual basis at the discretion of the state. Additionally, our state health plans submit proposals for additional membership opportunities that arise from time to time. For example, our Texas health plan has added significant membership since the first quarter of 2011, including approximately 76,000 Temporary Assistance for Needy Families, or TANF, members, 57,800 ABD members, and 18,000 Children's Health Insurance Program, or CHIP, members. At April 30, 2012, the Texas health plan's enrollment was approximately 300,000 members, an increase of 172,000 members since March 31, 2011. Our health plan subsidiaries have often been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. For example, in January 2012 our Washington health plan was named as a successful bidder in the request for proposal, or RFP, process for Medicaid and Basic Health coverage in the state of Washington through 2013. However, there can be no assurance that these contracts will continue to be renewed as in the case of our Ohio and Missouri health plans, described below.

On April 6, 2012, the Ohio Department of Jobs and Family Services notified our Ohio health plan that it had not been selected to participate under the recently issued Ohio Medicaid Managed Care Plan Request for Applications, or RFA. As a result, the Ohio health plan's existing Medicaid contract with the state is scheduled to expire without renewal on December 31, 2012. We appealed the outcome of the RFA process on April 16, 2012. The Ohio health plan's Medicaid contract comprises nearly all of its revenue and expenses; therefore should the appeal be unsuccessful most of its business activities will be suspended effective January 1, 2013. We intend to continue serving members under our Medicare Advantage contract in Ohio subsequent to December 31, 2012, and will also pursue other business opportunities. With statutory net worth in excess of $121 million at March 31, 2012, we believe our Ohio health plan has adequate resources to operate indefinitely in the absence of its Medicaid contract. For the three months ended March 31, 2012, our Ohio health plan contributed premium revenue of $293.5 million, or 22.1% of total premium revenue, and comprised 249,000 members, or 13.6% of total Health Plans segment membership.

On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's existing contract with the state is scheduled to expire without renewal on June 30, 2012. For the three months ended March 31, 2012, our Missouri health plan contributed premium revenue of $56.6 million, or 4.3% of total premium revenue, and comprised 81,000 members, or 4.4% of total Health Plans segment membership.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement Medicaid Management Information System, or MMIS, to another firm. For the three months ended March 31, 2012, our revenue under the Louisiana MMIS contract was approximately $12.3 million, or 29.3% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize between $45 million and $50 million in revenue annually under our Louisiana MMIS contract.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. Such variable interest entities are insignificant to our consolidated financial position and results of operations. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2012. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2011. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2011 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2011 audited financial statements.

Adjustments

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

2. Significant Accounting Policies

Revenue Recognition

Premium Revenue — Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At both March 31, 2012, and December 31, 2011, we recorded a liability of $1.0 million under the terms of these contract provisions.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both March 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): A portion of premiums received by our New Mexico health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). The New Mexico health plan contract also contains certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At both March 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of these contract provisions. In the fourth quarter of 2011, our New Mexico health plan entered into a contract amendment that more closely aligns the calculation of revenue with the methodology adopted under the Affordable Care Act. The contract amendment changed the calculation of the amount of revenue that may be recognized relative to medical costs.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $2.0 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at March 31, 2012, and December 31, 2011, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services, or CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $8.0 million for anticipated Medicare risk adjustment premiums at March 31, 2012. We recorded a net receivable of $5.0 million for anticipated Medicare risk adjustment premiums at December 31, 2011.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. Effective February 1, 2010 through June 30, 2011, we were eligible to earn additional incremental revenue of up to 0.25% of our total premium if we met certain pharmacy specific performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2012.

	Three Months Ended March 31, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 555	$ 336	$ 28	$ 364	$ 83,261
Ohio	2,678	2,678	966	3,644	293,525
Texas	5,750	5,750	—	5,750	198,236
Wisconsin	416	—	—	—	17,142
	$ 9,399	$ 8,764	$ 994	$ 9,758	$592,164

	Three Months Ended March 31, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 581	$ 444	$ (168)	$ 276	$ 84,606
Ohio	2,662	1,350	1,823	3,173	230,340
Wisconsin	416	—	—	—	16,417
	$ 3,659	$ 1,794	$ 1,655	$ 3,449	$ 331,363

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple –Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. We began to recognize revenue associated with our Maine contract upon state acceptance in September 2010. In Idaho, we will begin recognition of revenue upon state acceptance.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the MMIS in that state receives certification from CMS.

Premium Deficiency Charges

We assess the profitability of each contract by state for providing medical care services to our members and identify any contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. In the first quarter of 2011, our Wisconsin health plan recorded a premium deficiency charge in the amount of $3.35 million to medical claims and benefits payable. No premium deficiency charges were recorded in the first quarter of 2012.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of non-deductible compensation and state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $10.7 million as of March 31, 2012 and December 31, 2011. Approximately $8.4 million of the unrecognized tax benefits recorded at March 31, 2012, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.4 million as of March 31, 2012. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.9 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of March 31, 2012, and December 31, 2011, we had accrued $70,000 and $65,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

On May 12, 2011, the Financial Accounting Standards Board (“FASB”) ratified Accounting Standards Update (“ASU”) No. 2011-04, “Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRS.” This ASU establishes a global standard for measuring amounts at fair value, and although it did not have a material effect on our financial position or results of operations, it did change our disclosure policies for fair value. This ASU became effective for reporting periods (including interim periods) beginning after December 15, 2011, and we adopted this ASU for the interim period ending March 31, 2012.

On June 16, 2011, the FASB ratified ASU No. 2011-05, “Presentation of Comprehensive Income.” This ASU eliminates the previous option to report other comprehensive income and its components in the statement of changes in equity. Upon adoption, other comprehensive income must be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. We adopted this ASU for the interim period ending March 31, 2012, which is the period for which it became effective for calendar year-end entities, and have elected to utilize ‘two separate but consecutive statements’ disclosure for this interim presentation.

On September 15, 2011, the FASB ratified ASU No. 2011-08, “Intangibles-Goodwill and Other (Topic 350): Testing Goodwill for Impairment.” This ASU permits an entity to first assess qualitative factors to determine whether it is more likely than not (a likelihood of more than 50 percent) that the fair value of a reporting unit is less than its carrying amount. After assessing qualitative factors, if an entity determines that it is not more likely than not that the fair value of the reporting unit is less than its carrying amount, no further testing is necessary. If an entity determines that it is more likely than not that the fair value of the reporting unit is less than its carrying value, then the traditional two-step goodwill impairment test must be performed. This ASU became effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011, but early adoption was permitted. Although we did not early-adopt ASU No. 2011-08 during 2011, we will evaluate the standard when performing our future goodwill impairment tests.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended March 31,	
	2012	2011 (2)
	(In thousands)	
Shares outstanding at the beginning of the period	45,815	45,463
Weighted-average number of shares issued	183	125
Denominator for basic earnings per share	45,998	45,588
Dilutive effect of employee stock options and stock grants (1)	857	669
Dilutive effect of convertible senior notes	32	—
Denominator for diluted earnings per share	46,887	46,257

(1) Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the three months ended March 31, 2012 and 2011, there were approximately 199,700 and 112,500 antidilutive weighted restricted shares, respectively. Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended March 31, 2012, and 2011, there were approximately 7,900 and 138,000 antidilutive weighted options, respectively.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share for the three months ended March 31, 2011 because to do so would have been anti-dilutive.

4. Share-Based Compensation

At March 31, 2012, we had employee equity incentives outstanding under three plans: (1) the 2011 Equity Incentive Plan; (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded); and (3) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). On March 1, 2012, our chief executive officer, chief financial officer, and chief operating officer were awarded 94,050 shares, 53,236 shares, and 30,167 shares, respectively, of restricted units with performance and service conditions. Each of the grants shall vest on December 31, 2012, provided that: (i) the Company's total operating revenue for 2012 is equal to or greater than $5.5 billion, and (ii) the respective officer continues to be employed by the Company as of December 31, 2012. Also on March 1, 2012, our chief executive officer, chief financial officer, chief operating officer, and chief accounting officer were awarded 8,000 shares, 8,000 shares, 8,000 shares, and 3,000 shares, respectively, of restricted units subject to certification of our Idaho MMIS by CMS. The respective officers must also be employed by the Company when the performance conditions are met. In the event the vesting conditions are not achieved for both sets of awards, the equity compensation awards shall lapse. As of March 31, 2012, we expect both performance awards to vest in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three months ended March 31, 2012 and 2011:

	Three Months Ended March 31,	
	2012	2011
	(In thousands)	
Restricted stock/unit awards	$ 4,398	$ 3,806
Stock options (including shares issued under our employee stock purchase plan)	268	258
Total stock-based compensation expense	$ 4,666	$ 4,064

As of March 31, 2012, there was $22.0 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to recognize over a remaining weighted-average period of 2.8 years. As of March 31, 2012, there was $5.9 million of total unrecognized compensation expense related to restricted units with performance conditions, which we expect to recognize by December 31, 2012.

Unvested restricted stock and restricted stock activity for the three months ended March 31, 2012 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2011	1,435,882	$ 18.97
Restricted stock awards granted	385,457	33.54
Restricted stock units with performance conditions granted	204,453	33.53
Vested	(683,649)	20.24
Forfeited	(23,026)	20.38
Unvested balance as of March 31, 2012	1,319,117	24.80

The total fair value of restricted stock and stock unit awards, including those with performance conditions, granted during the three months ended March 31, 2012 and 2011 was $19.8 million and $15.6 million, respectively. The total fair value of restricted shares vested during the three months ended March 31, 2012 and 2011 was $22.8 million and $8.6 million, respectively.

Stock option activity for the three months ended March 31, 2012 is summarized below:

	Shares	Weighted Average Grant Date Fair Value	Average Intrinsic Value (In thousands)	Weighted Average Remaining Contractual term (Years)
Stock options outstanding as of December 31, 2011	553,049	$ 20.91		
Granted	15,000	34.82		
Exercised	(109,929)	19.30		
Stock options outstanding as of March 31, 2012	458,120	21.75	$ 5,458	3.9
Stock options exercisable and expected to vest as of March 31, 2012	458,120	21.75	$ 5,458	3.9
Exercisable as of March 31, 2012	443,120	21.31	$ 5,458	3.7

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our assets measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 financial instruments consist of investments including government-sponsored enterprise securities (GSEs) and U.S. treasury notes. Level 1 financial instruments are classified as current investments in the accompanying consolidated balance sheets. These financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.
- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 financial instruments consist of investments including corporate debt securities, municipal securities, and certificates of deposit, which are classified as current investments in the accompanying consolidated balance sheets. Our financial instruments classified as Level 2 are traded frequently though not necessarily daily. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.
- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* Our Level 3 financial instruments consist of auction rate securities which are designated as available-for-sale, and are reported at fair value of $16.1 million (par value of $18.8 million) as of March 31, 2012. To estimate the fair value of these securities, we use valuations from third-party pricing models that include factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. To validate the reasonableness of these valuations, we compare such valuations to other third party valuations that provide a range of prices representing indicative bids from potential buyers. We have concluded that these estimates, given the lack of market available pricing, provide a reasonable basis for determining the fair value of the auction rate securities as of March 31, 2012.

Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, 2009 through 2011, and continued to be unavailable as of March 31, 2012. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government, and the range of maturities for such securities is from 3 years to 35 years. Considering the relative insignificance of these securities in comparison to our liquid assets and other sources of liquidity, we have no current intention of selling these securities nor do we expect to be required to sell these securities before a recovery in their cost basis. For this reason, and because the decline in the fair value of the auction securities was not due to the credit quality of the issuers, we do not consider the auction rate securities to be other-than-temporarily impaired at March 31, 2012. At the time of the first failed auctions during first quarter 2008, we held a total of $82.1 million in auction rate securities at par value; since that time, we have sold $63.3 million of these instruments at par value.

For three months ended March 31, 2012, and 2011, we recorded pretax unrealized gains of $0.1 million and $0.3 million, respectively, to accumulated other comprehensive income for the changes in their fair value. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income (loss). If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Our assets measured at fair value on a recurring basis at March 31, 2012, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$235,759	$ —	$235,759	$ —
Government-sponsored enterprise securities (GSEs)	36,618	36,618	—	—
Municipal securities	52,240	—	52,240	—
U.S. treasury notes	30,990	30,990	—	—
Certificates of deposit	2,374	—	2,374	—
Auction rate securities	16,129	—	—	16,129
	$ 374,110	$67,608	$ 290,373	$16,129

Our assets measured at fair value on a recurring basis at December 31, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$231,634	$ —	$ 231,634	$ —
GSEs	33,949	33,949	—	—
Municipal securities	47,313	—	47,313	—
U.S. treasury notes	21,748	21,748	—	—
Certificates of deposit	2,272	—	2,272	—
Auction rate securities	16,134	—	—	16,134
	$353,050	$55,697	$281,219	$16,134

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3) (In thousands)
Balance at December 31, 2011	$ 16,134
Total gains (unrealized only):	
Included in other comprehensive income	145
Settlements	(150)
Balance at March 31, 2012	$ 16,129
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at March 31, 2012	$ 115

The carrying amounts and estimated fair values of our long-term debt as well as the applicable fair value hierarchy tier, at March 31, 2012, are contained in the table below. Our convertible senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Borrowings under our credit facility and our term loan are classified as Level 3 financial instruments, because certain inputs used to determine the fair value of these agreements are unobservable. The carrying value of the credit facility and the term loan at March 31, 2012 approximates fair value because of the short period of time between the borrowing under the credit facility in the first quarter of 2012, and the term loan's origination date of December 7, 2011, and March 31, 2012, respectively.

	Carrying Value	Estimated Fair Value	Fair Value Level Hierarchy
	(In thousands)		
Credit facility	$ 10,000	$ 10,000	Level 3
Term loan	48,299	48,299	Level 3
Convertible senior notes	170,969	239,117	Level 2
	$229,268	$297,416	

6. Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 235,184	$ 678	$ 103	$235,759
GSEs	36,574	50	6	36,618
Municipal securities	51,963	305	28	52,240
U.S. treasury notes	30,953	41	4	30,990
Certificates of deposit	2,374	—	—	2,374
Auction rate securities	18,850	—	2,721	16,129
	$ 375,898	$1,074	$ 2,862	$ 374,110

	December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 231,407	$ 442	$ 215	$231,634
GSEs	33,912	46	9	33,949
Municipal securities	47,099	232	18	47,313
U.S. treasury notes	21,627	121	—	21,748
Certificates of deposit	2,272	—	—	2,272
Auction rate securities	19,000	—	2,866	16,134
	$355,317	$ 841	$ 3,108	$353,050

The contractual maturities of our investments as of March 31, 2012 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$193,996	$194,299
Due one year through five years	163,552	164,118
Due after ten years	18,350	15,693
	$ 375,898	$ 374,110

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $65.8 million and $61.3 million for the three months ended March 31, 2012, and 2011, respectively. Net realized investment gains for the three months ended March 31, 2012, and 2011 were $64,000 and $157,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities discussed in Note 5, “Fair Value Measurements,” we have determined that unrealized gains and losses at March 31, 2012, and December 31, 2011, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2012.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 32,085	$ 103	$ —	$ —	$ 32,085	$ 103
GSEs	4,674	6	—	—	4,674	6
Municipal securities	12,565	28	—	—	12,565	28
Auction rate securities	—	—	16,129	2,721	16,129	2,721
U.S. treasury notes	7,052	4	—	—	7,052	4
	$ 56,376	$ 141	$16,129	$2,721	$ 72,505	$2,862

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2011.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 72,766	$ 215	$ —	$ —	$ 72,766	$ 215
GSEs	11,493	9	—	—	11,493	9
Municipal securities	12,033	18	—	—	12,033	18
Auction rate securities	—	—	16,134	2,866	16,134	2,866
	$96,292	$ 242	$16,134	$2,866	$112,426	$ 3,108

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	March 31, 2012	December 31, 2011
	(In thousands)	
Health Plans segment:		
California	$ 61,799	$ 22,175
Michigan	11,362	8,864
Missouri	24,390	27,092
New Mexico	10,728	9,350
Ohio	31,655	27,458
Texas	16,335	1,608
Utah	3,886	2,825
Washington	17,014	15,006
Wisconsin	2,001	4,909
Others	2,809	2,489
Total Health Plans segment	181,979	121,776
Molina Medicaid Solutions segment	40,275	46,122
	$ 222,254	$167,898

The increase in our California health plan receivables at March 31, 2012, compared with December 31, 2011 is due to a change in premium payment timing by the state of California. The state is now paying capitation one month in arrears, so the California health plan's receivables balance at March 31, 2012 includes an additional month of premiums receivable.

8. Restricted Investments

Pursuant to the regulations governing our health plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of restricted investments:

	March 31, 2012	December 31, 2011
	(In thousands)	
California	$ 373	$ 372
Florida	5,200	5,198
Insurance Company	—	4,711
Michigan	1,000	1,000
Missouri	503	504
New Mexico	15,907	15,905
Ohio	9,078	9,078
Texas	3,514	3,518
Utah	2,990	2,895
Washington	151	151
Other	3,231	2,832
	$ 41,947	$ 46,164

The contractual maturities of our held-to-maturity restricted investments as of March 31, 2012 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$40,906	$ 40,912
Due one year through five years	1,041	1,047
	$41,947	$41,959

9. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable as of and for the periods indicated. The negative amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31, 2012	Year Ended December 31, 2011
	(Dollars in thousands)	
Balances at beginning of period	$ 402,476	$ 354,356
Components of medical care costs related to:		
Current period	1,167,580	3,911,803
Prior periods	(36,592)	(51,809)
Total medical care costs	1,130,988	3,859,994
Payments for medical care costs related to:		
Current period	750,994	3,516,994
Prior periods	326,637	294,880
Total paid	1,077,631	3,811,874
Balances at end of period	$ 455,833	$ 402,476
Benefit from prior period as a percentage of:		
Balance at beginning of period	9.1%	14.6%
Premium revenue	2.8%	1.1%
Total medical care costs	3.2%	1.3%

We recognized a benefit from prior period claims development in the amount of $36.6 million for the three months ended March 31, 2012. This amount represents our estimate as of March 31, 2012 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2011 was due primarily to the following factors:

- For our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- For our Texas health plan, we overestimated the cost of new members in STAR+ (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all

of the claims overestimation.

- Offsetting some of the overestimation items described above, our Missouri health plan reserves were underestimated as a result of an unusually large number of premature infants during the fourth quarter.

We recognized a benefit from prior period claims development in the amount of $44.4 million and $51.8 million for the three months ended March 31, 2011, and the year ended December 31, 2011, respectively. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2010, as a result of the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010, partially offsetting the impact of the two items above.

In estimating our claims liability at March 31, 2012, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Our Texas health plan membership nearly doubled in March 2012. In addition, effective March 1, 2012, we have assumed inpatient medical liability for STAR+ (an area of coverage that was previously carved out). Reserves for new coverage and new regions are based on the state's pricing estimates.
- Our California health plan is enrolling about 2,000 new ABD members per month as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members are converting from fee-for-service and are higher cost than our base ABD members
- Our Michigan health plan's billed charges of claims in inventory at March 31, 2012 were about 2.5 times higher than the amount at December 31, 2011. This was due in part to approximately 6,000 new dual-eligible members that were enrolled for Medicaid benefits only in December 2011. As we are responsible only for the Medicaid portion of these benefits, the ratio of paid to billed claims for dual eligible members is very small, and this inventory buildup may not represent a large increase in liability.
- Our Wisconsin health plan converted from its legacy claims processing system to the Company's single managed care platform, or QNXT, effective February 1, 2012.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2011 and through March 31, 2012, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

10. Long-Term Debt

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility is used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of March 31, 2012 there was $10.0 million outstanding under the Credit Facility. Additionally, as of March 31, 2012, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of not less than 1.75 to 1.00. At March 31, 2012, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders

may enforce any and all rights and remedies created under the Credit Facility or applicable law.

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the approximately 460,000 square foot office building, or Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Convertible Senior Notes

As of March 31, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of March 31, 2012, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 30 months. The Notes' if-converted value did not exceed their principal amount as of March 31, 2012. At March 31, 2012, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of March 31, 2012	As of December 31, 2011
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(16,031)	(17,474)
Net carrying amount	$170,969	$169,526

	Three Months Ended March 31,	
	2012	2011
	(In thousands)	
Interest cost for the period relating to the:		
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,753
Amortization of the discount on the liability component	1,443	1,340
Total interest cost recognized	$ 3,196	$ 3,093

11. Stockholders' Equity

Securities Repurchase Program. Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see Note 10, "Long-Term Debt"). The repurchase program will be funded with working capital or the Company's credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No securities were purchased under this program in the three months ended March 31, 2012.

Stock Plans. In connection with the plans described in Note 4, "Share-Based Compensation," we issued approximately 531,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the three months ended March 31, 2012. Stock plan activity resulted in a $1.9 million increase to additional paid-in capital for the same period.

12. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans which serve Medicaid populations in ten states, and also includes our smaller direct delivery line of business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid

agencies in an additional five states.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, “Significant Accounting Policies.” The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

	Three Months Ended March 31,	
	2012	2011
	(In thousands)	
Revenue:		
Health Plans:		
Premium revenue	$1,327,449	$ 1,081,438
Investment income	1,717	1,594
Rental income	2,209	—
	1,331,375	1,083,032
Molina Medicaid Solutions:		
Service revenue	42,205	36,674
	$1,373,580	$1,119,706
Depreciation and amortization:		
Health Plans	$ 13,743	$ 11,385
Molina Medicaid Solutions	4,596	6,709
	$ 18,339	$ 18,094
Operating Income:		
Health Plans	$ 25,011	$ 29,606
Molina Medicaid Solutions	8,409	1,694
Total operating income	33,420	31,300
Interest expense	4,298	3,603
Income before income taxes	$ 29,122	$ 27,697

	March 31, 2012	December 31, 2011
Goodwill and intangible assets, net:		
Health Plans	$ 152,826	$ 159,963
Molina Medicaid Solutions	94,352	95,787
	$ 247,178	$ 255,750
Total assets:		
Health Plans	$1,501,964	$ 1,425,764
Molina Medicaid Solutions	238,040	226,382
	$ 1,740,004	$1,652,146

13. Commitments and Contingencies

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Molina Medicaid Solutions

On April 6, 2012, Molina Medicaid Solutions received a schedule from the state of Maine purporting to represent the approximately $32.6 million in damages suffered by the state related to the delay in the "go live" date for the state's MMIS from March 1, 2010 to September 1, 2010, and for other unspecified matters. The level of detail provided in the schedule is not adequate for us to determine the specific nature of the damages claimed by the state. No formal claim has been asserted against us by the state, nor has any legal basis been asserted for any potential claims against us. To the extent that the state decides to pursue its alleged claims against us, Unisys Corporation, or Unisys, the former owner of the MMIS, has agreed to assume the defense of that portion of the claim related to the delay in the "go live" date from March 1, 2010 to August 1, 2010, since that delay had been agreed upon with the state prior to our May 1, 2010 acquisition of Molina Medicaid Solutions from Unisys. The amount of our potential liability related to this matter, if any, cannot be reasonably estimated at this time, nor can a range of such possible liability be established.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $519.5 million at March 31, 2012, and $492.4 million at December 31, 2011.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of March 31, 2012, our health plans had aggregate statutory capital and surplus of approximately $536.3 million compared with the required minimum aggregate statutory capital and surplus of approximately $265.1 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2012. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Receivable/Liability for Ceded Life and Annuity Contracts

Prior to February 17, 2012, we reported a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. Effective February 17, 2012, we sold Molina Healthcare Insurance Company. The transaction resulted in the elimination of both the noncurrent receivable and liability for ceded life and annuity contracts, each amounting to $23.4 million as of December 31, 2011. Additionally, a gain of approximately $2.4 million was recorded upon closing of the transaction, recorded to general and administrative expenses in the accompanying consolidated income statement.

We remain liable for benefits payable under the life insurance policies that were held by Molina Healthcare Insurance Company, in the event that both the reinsurer and the buyer of Molina Healthcare Insurance Company are unable to pay those benefits. We believe the possibility of our having to pay such benefits is remote, and no provision for the payment of such benefits is included in our consolidated financial statements.

14. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of both March 31, 2012, and December 31, 2011, our carrying amount for this investment amounted to $3.9 million. For the three months ended March 31, 2012 and 2011, we paid $6.6 million, and $5.4 million, respectively, for medical service fees to this provider.

Item 2. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbour provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbour provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate or Medicaid expansion, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations, and the reduction over time of the high medical costs associated with new populations;
- the success of our efforts to retain existing government contracts and to obtain new government contracts (including those serving dual-eligible members) in connection with requests for proposals, or RFPs, in both existing and new states, and our ability to grow our revenues consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and the development of actuarially sound rates with respect to such new enrollees;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- the continuation without termination of the government contracts of both our health plans and Molina Medicaid Solutions;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine and Idaho;
- additional administrative costs and the potential payment of additional amounts to providers and/or the state by Molina Medicaid Solutions as a result of MMIS implementation issues in Maine or Idaho;
- government audits and reviews, and any enrollment freeze or monitoring program that may result therefrom;
- changes with respect to our provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;

- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, including our RFP protests or appeals;
- restrictions and covenants in our credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments; and
- changes in general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2011, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2011.

Adjustments

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. We also have a direct delivery business that currently consists of primary care community clinics in California and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

We report our financial performance based on the following two reportable segments: Health Plans; and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. This segment served approximately 1.8 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of March 31, 2012. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our health plans' state Medicaid contracts generally have a term of one- to two-years and are renewable on an annual or biannual basis at the discretion of the state. Additionally, our state health plans submit proposals for additional membership opportunities that arise from time to time. For example, our Texas health plan has added significant membership since the first quarter of 2011, including approximately 76,000 Temporary Assistance for Needy Families, or TANF, members, 57,800 ABD members, and 18,000 Children's Health Insurance Program, or CHIP, members. At April 30, 2012, the Texas health plan's enrollment was approximately 300,000 members, an increase of 172,000 members since March 31, 2011. Our health plan subsidiaries have often been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. For example, in January 2012 our Washington health plan was named as a successful bidder in the RFP process for Medicaid and Basic Health coverage in the state of Washington through 2013. However, there can be no assurance that these contracts will continue to be renewed as in the case of our Ohio and Missouri health plans, described below.

On April 6, 2012, the Ohio Department of Jobs and Family Services notified our Ohio health plan that it had not been selected to participate under the recently issued Ohio Medicaid Managed Care Plan Request for Applications, or RFA. As a result the Ohio health plan's existing Medicaid contract with the state is scheduled to expire without renewal on December 31, 2012. We appealed the outcome of the RFA process on April 16, 2012. The Ohio health plan's Medicaid contract comprises nearly all of its revenue and expenses; therefore should the appeal be unsuccessful most of its business activities will be suspended effective January 1, 2013. We intend to continue serving members under our Medicare Advantage contract in Ohio subsequent to December 31, 2012, and will also pursue other business opportunities. With statutory net worth in excess of $121 million at March 31, 2012, we believe our Ohio health plan has adequate resources to operate indefinitely in the absence of its Medicaid contract. For the three months ended March 31, 2012, our Ohio health plan contributed premium revenue of $293.5 million, or 22.1% of total premium revenue, and comprised 249,000 members, or 13.6% of total Health Plans segment membership.

On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's existing contract with the state is scheduled to expire without renewal on June 30, 2012. For the three months ended March 31, 2012, our Missouri health plan contributed premium revenue of $56.6 million, or 4.3% of total premium revenue, and comprised 81,000 members, or 4.4% of total Health Plans segment membership.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement Medicaid Management Information System, or MMIS, to another firm. For the three months ended March 31, 2012, our revenue under the Louisiana MMIS contract was $12.3 million, or 29.3% of total service revenue. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize between $45 million and $50 million in revenue annually under our Louisiana MMIS contract.

In the second quarter of 2012, we expect to respond to several RFPs and invitations to negotiate with respect to new business, including proposals to serve dual eligible populations and applications to participate in CMS' Capitated Financial Alignment Demonstration project. In addition, with regard to existing business, we expect the state of New Mexico to issue an RFP for its Salud! and State Coverage Insurance (SCI) programs in September 2012, with the new Salud! and SCI contract to start in late 2013 or early 2014.

The Company's Board of Directors has organized a special committee of independent directors to consider and negotiate a possible lease transaction involving certain real property located in Long Beach, California. The property is owned by 6th and Pine Development, LLC, the members of which include John C. Molina, our chief financial officer and a director, and his wife. Negotiations between the special committee and 6th and Pine Development are currently ongoing. In the event we agree to enter into a lease for space with 6th and Pine Development, we will promptly report our execution of such agreement in a current report on Form 8-K.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the three months ended March 31, 2012, we received approximately 95% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the three months ended March 31, 2012, we recognized approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $70 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the Temporary Assistance for Needy Families, or TANF, Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $110 in California to $260 in Ohio. Among our Medicaid Aged, Blind or Disabled, or ABD, membership, PMPM premiums range from approximately $340 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	March 31, 2012	December 31, 2011	March 31, 2011
Total Ending Membership by Health Plan:			
California	351,000	355,000	347,000
Florida	69,000	69,000	66,000
Michigan	222,000	222,000	225,000
Missouri (1)	81,000	79,000	82,000
New Mexico	89,000	88,000	90,000
Ohio (2)	249,000	248,000	248,000
Texas	280,000	155,000	128,000
Utah	86,000	84,000	80,000
Washington	356,000	355,000	341,000
Wisconsin	42,000	42,000	40,000
Total	1,825,000	1,697,000	1,647,000
Total Ending Membership by State for our Medicare Advantage Plans:			
California	6,900	6,900	5,300
Florida	800	800	600
Michigan	8,500	8,200	6,700
New Mexico	900	800	700
Ohio (2)	200	200	400
Texas	800	700	600
Utah	8,100	8,400	6,700
Washington	5,200	5,000	3,300
Total	31,400	31,000	24,300
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	37,300	31,500	14,100
Florida	10,500	10,400	10,300
Michigan	38,800	37,500	32,000
New Mexico	5,600	5,600	5,600
Ohio (2)	29,700	29,100	28,200
Texas	109,000	63,700	51,200
Utah	8,700	8,500	8,200
Washington	4,700	4,800	4,300
Wisconsin	1,700	1,700	1,700
Total	246,000	192,800	155,600

(1) Our existing contract with the state of Missouri is scheduled to expire without renewal on June 30, 2012.

(2) Our existing contract with the state of Ohio is scheduled to expire without renewal on December 31, 2012.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $32.1 million, and $24.4 million, for the three months ended March 31, 2012 and 2011, respectively, including certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Idaho, Louisiana, Maine, New Jersey, West Virginia, and Florida. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred contract costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contract costs in the second half of 2012, in a manner consistent with our anticipated recognition of revenue.

First Quarter Financial Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the three months ended March 31, 2012. Comparable metrics for the first quarter of 2011 are also shown. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended March 31,	
	2012	2011
	(Dollar amounts in thousands, except per-share data)	
Earnings per diluted share	$ 0.39	$ 0.38
Premium revenue	$1,327,449	$1,081,438
Service revenue	$ 42,205	$ 36,674
Operating income	$ 33,420	$ 31,300
Net income	$ 18,089	$ 17,388
Total ending membership	1,825,000	1,647,000
Premium revenue	96.6%	96.6%
Service revenue	3.1	3.3
Investment income	0.1	0.1
Rental income	0.2	—
Total revenue	100.0 %	100.0 %
Medical care ratio	85.2 %	84.5 %
General and administrative expense ratio	8.8 %	8.4 %
Premium tax ratio	3.3 %	3.4 %
Operating income	2.4 %	2.8 %
Net income	1.3 %	1.6 %
Effective tax rate	37.9 %	37.2 %

First Quarter 2012 Overview

For the first quarter of 2012, our net income was $18.1 million, or $0.39 per diluted share, compared with net income of $17.4 million, or $0.38 per diluted share, for the first quarter of 2011.

We recorded higher revenue in our Health Plans segment and experienced a higher margin in our Molina Medicaid Solutions segment. These increases were offset by lower margins in the Health Plans segment. In the aggregate, we achieved higher net income for the first quarter of 2012 when compared with the first quarter of 2011.

Our established health plans continue to perform well, with the Florida, Michigan, New Mexico, Utah, Texas, Washington and Wisconsin health plans reporting improved medical margins over the first quarter of 2011. The medical margin of our Ohio health plan was reduced as a result of a premium rate reduction effective January 1, 2012. In addition, the Ohio health plan is earning lower margins on the pharmacy benefit (added October 1, 2011) than on its business as a whole. The medical margin of our California health plan decreased primarily due to premium rate reductions effective July 1, 2011, and the mandatory assignment of SPD members to managed care plans starting June 1, 2011. The California health plan is currently experiencing a medical care ratio in excess of 90% for these members. It has been our experience that state funding agencies often underestimate the cost of serving new populations or of providing new benefits, requiring them to increase premium rates paid to managed care plans in subsequent periods.

Results of Operations

Three Months Ended March 31, 2012 Compared with the Three Months Ended March 31, 2011

Health Plans Segment

Premium Revenue

Premium revenue for the first quarter of 2012 increased 22.7% over the first quarter of 2011, due to a membership increase of approximately 6.5% (on a member-month basis), and a premium revenue PMPM increase of approximately 15.2%. Premium revenue PMPM increased as a result of both the extensions of additional benefits, such as pharmacy and inpatient facility care, to some of our membership and a shift in member mix to more medically intensive populations.

We also experienced notable membership growth at our Utah and Washington health plans. We care for a larger percentage of aged, blind or disabled, or ABD, members and Medicare members than a year ago. In the first quarter of 2012, 15% of our membership (on a member-month basis) comprised ABD members (including California SPD and Texas STAR+ members) and Medicare members, compared with just 11% of membership in the first quarter of 2011. Premium revenue PMPM also increased due to the inclusion of revenue from the pharmacy benefit for our Ohio health plan, which did not provide this benefit in the first quarter of 2011.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended March 31,					
	2012			2011		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 777,267	$ 148.81	68.7%	$655,884	$ 133.78	71.8%
Capitation	136,038	26.04	12.0	128,682	26.25	14.1
Pharmacy	173,237	33.17	15.3	91,576	18.68	10.0
Other	44,446	8.51	4.0	37,390	7.63	4.1
Total	$1,130,988	$216.53	100.0%	$ 913,532	$186.34	100.0%

Medical care costs increased in the first quarter of 2012 primarily due to the growth of membership in the Texas health plan. The Texas health plan experienced significant growth of members in its ABD program. These members have higher medical costs than other populations. The percentage of ABD member months in our Texas plan increased from 35% in the first quarter of 2011 to 40% in the first quarter of 2012. Overall, Texas health plan membership more than doubled when compared with the first quarter of 2011. The Company's medical margin deteriorated in the first quarter of 2012, when compared with the first quarter of 2011. The decrease in the medical margin was primarily due to:

- A shift in member mix to more costly members that are transitioning to a managed care environment, including Texas and California ABD members. These members start out with higher medical care ratios; and
- Rate decreases of approximately 2% in Ohio effective January 1, 2012, and approximately 3% in California effective July 1, 2011.

The medical care ratio of the California health plan increased to 87.4% in the three months ended March 31, 2012, from 84.3% in the three months ended March 31, 2011, primarily due to premium rate reductions of approximately 3% effective July 1, 2011. Additionally, the California health plan has added approximately 23,000 new ABD members since the first quarter of 2011. While this change in member mix has increased blended health plan premium revenue PMPM by 18% to $153 in the first quarter of 2012 from $130 in the first quarter of 2011, associated medical care costs are also higher for these members. The California health plan's aggregate medical care costs increased approximately 22% PMPM in the three months ended March 31, 2012 compared with the same period in 2011.

The medical care ratio of the Florida health plan decreased to 88.2% in the three months ended March 31, 2012, from 96.6% in the three months ended March 31, 2011, primarily due to initiatives that have reduced pharmacy and behavioral health costs, and a premium rate increase of approximately 7.5% effective September 1, 2011.

The medical care ratio of the Michigan health plan decreased to 79.9% in the three months ended March 31, 2012, from 81.2% in the three months ended March 31, 2011, primarily due to improved Medicare performance and lower inpatient facility costs.

The medical care ratio of the Missouri health plan increased to 93.8% in the three months ended March 31, 2012, from 93.6% in the three months ended March 31, 2011, primarily due to increased inpatient facility costs associated with an unusually large number of premature infants delivered. The health plan received a premium rate increase of approximately 5% effective July 1, 2011.

The medical care ratio of the New Mexico health plan decreased to 80.6% in the three months ended March 31, 2012, from 82.8% in the three months ended March 31, 2011. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011.

The medical care ratio of the Ohio health plan increased to 80.6% in the three months ended March 31, 2012, from 74.6% in the three months ended March 31, 2011, partially due to a premium rate reduction of approximately 2.0% PMPM effective January 1, 2012, Additionally, the restoration of the pharmacy benefit to all managed care plans in Ohio effective October 1, 2011 has increased the Ohio health plan's medical care ratio. The medical care ratio attributable to the pharmacy benefit alone was approximately 87%, which resulted in a 180 basis point increase to the Ohio health plan's aggregate medical care ratio for the first quarter of 2012.

The medical care ratio of the Texas health plan decreased to 90.8% in the three months ended March 31, 2012, from 91.1% in the three months ended March 31, 2011. Additionally, in March 2012 the Texas health plan received rate increases to provide for its assumption of inpatient and pharmacy risk for all existing populations. The Texas health plan has added significant membership since the first quarter of 2011, including approximately 76,000 Temporary Assistance for Needy Families, or TANF, members, 57,800 ABD members, and 18,000 Children's Health Insurance Program, or CHIP, members. At April 30, 2012 the Company's Texas enrollment was approximately 300,000 members.

The medical care ratio of the Utah health plan decreased to 77.0% in the three months ended March 31, 2012, from 79.3% in the three months ended March 31, 2011, primarily due to reduced fee-for-service inpatient and physician costs. Lower fee-for-service costs were the result of both lower unit costs and lower utilization. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2011.

The medical care ratio of the Washington health plan decreased to 84.1% in the three months ended March 31, 2012, from 86.6% in the three months ended March 31, 2011, primarily due to lower Medicaid fee-for-service utilization.

The medical care ratio of the Wisconsin health plan decreased to 98.5% in the three months ended March 31, 2012, from 118.1% in the three months ended March 31, 2011. In the first quarter of 2011, the Wisconsin health plan recorded a premium deficiency reserve amounting to $3.35 million; there was no such reserve recorded in the first quarter of 2012. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Wisconsin health plan.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended March 31, 2012						
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,059	$ 161,685	$152.65	$ 141,349	$ 133.45	87.4%	$ 2,309
Florida	208	56,190	269.87	49,569	238.07	88.2	7
Michigan	665	167,906	252.49	134,211	201.82	79.9	9,084
Missouri (2)	243	56,613	233.32	53,120	218.93	93.8	—
New Mexico	266	83,261	313.29	67,111	252.52	80.6	1,953
Ohio (3)	746	293,525	393.73	236,701	317.51	80.6	22,853
Texas	592	198,236	334.61	180,089	303.97	90.8	3,197
Utah	252	75,138	297.59	57,881	229.24	77.0	—
Washington	1,067	215,610	202.08	181,425	170.04	84.1	3,912
Wisconsin	125	17,142	136.97	16,886	134.92	98.5	—
Other (4)	—	2,143	—	12,646	—	—	115
	5,223	$1,327,449	$ 254.14	$1,130,988	$216.53	85.2%	$ 43,430

	Three Months Ended March 31, 2011						
	Member Months (1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,041	$ 134,976	$ 129.63	$ 113,737	$ 109.24	84.3%	$ 1,902
Florida	192	49,222	256.63	47,568	248.01	96.6	17
Michigan	678	164,760	243.06	133,728	197.28	81.2	9,846
Missouri (2)	245	55,166	225.33	51,608	210.79	93.6	—
New Mexico	271	84,606	311.93	70,038	258.21	82.8	1,965
Ohio (3)	737	230,340	312.68	171,752	233.15	74.6	17,775
Texas	349	80,811	231.49	73,615	210.88	91.1	1,340
Utah	236	67,935	287.77	53,839	228.06	79.3	—
Washington	1,034	195,272	188.81	169,116	163.52	86.6	3,642
Wisconsin	120	16,417	137.25	19,380	162.02	118.1	—
Other (4)	—	1,933	—	9,151	—	—	63
	4,903	$1,081,438	$ 220.58	$ 913,532	$ 186.34	84.5%	$ 36,550

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.
(2) Our existing contract with the state of Missouri is scheduled to expire without renewal on June 30, 2012.
(3) Our existing contract with the state of Ohio is scheduled to expire without renewal on December 31, 2012.
(4) "Other" medical care costs also include medically related administrative costs at the parent company.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended March 31,	
	2012	2011
	(In thousands)	
Service revenue before amortization	$ 42,358	$ 38,860
Amortization recorded as reduction of service revenue	(153)	(2,186)
Service revenue	42,205	36,674
Cost of service revenue	30,494	31,221
General and administrative costs	2,020	2,477
Amortization of customer relationship intangibles recorded as amortization	1,282	1,282
Operating income	$ 8,409	$ 1,694

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the MMIS in that state receives certification from CMS.

Consolidated Expenses

General and Administrative Expenses

General and administrative, or G&A, expenses for the consolidated entity were $120.2 million, or 8.8% of total revenue, for the three months ended March 31, 2012, compared with $94.4 million, or 8.4% of total revenue, for the three months ended March 31, 2011. The Company incurred additional expenses in the first quarter of 2012 due to investment in administrative infrastructure in anticipation of opportunities in Texas and among the dual-eligible population.

Premium Tax Expenses

Premium tax expense decreased to 3.3% of premium revenue in the three months ended March 31, 2012, from 3.4% in the three months ended March 31, 2011.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Three Months Ended March 31,			
	2012		2011	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 9,472	0.7%	$ 7,401	0.7%
Amortization of intangible assets	5,553	0.4	5,266	0.4
Depreciation and amortization reported as such in the consolidated statements of income	15,025	1.1	12,667	1.1
Amortization recorded as reduction of service revenue	153	—	2,186	0.2
Amortization of capitalized software recorded as cost of service revenue	3,161	0.2	3,241	0.3
Total	$ 18,339	1.3%	$ 18,094	1.6%

Interest Expense

Interest expense increased to $4.3 million for the three months ended March 31, 2012, from $3.6 million for the three months ended March 31, 2011, due primarily to interest expense associated with the purchase of our corporate headquarters building in December 2011. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $1.4 million and $1.3 million for the three months ended March 31, 2012, and 2011, respectively.

Income Taxes

Income tax expense is recorded at an effective rate of 37.9% for the three months ended March 31, 2012 compared with 37.2% for the three months ended March 31, 2011. The higher rate in 2012 is primarily due to current period share-based compensation expense that is expected to be non-deductible for tax purposes when related awards vest.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of March 31, 2012, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased to $1.7 million for the three months ended March 31, 2012, compared with $1.6 million for the three months ended March 31, 2011. Our annualized portfolio yield for the three months ended March 31, 2012 was 0.6% compared with 0.7% for the three months ended March 31, 2011.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the three months ended March 31, 2012 was $50.6 million compared with $84.1 million for the three months ended March 31, 2011, a decrease of $33.5 million. Deferred revenue was a source of operating cash amounting to $44.5 million in the three months ended March 31, 2012, compared with $62.6 million in the three months ended March 31, 2011.

Reconciliation of Non-GAAP [1] to GAAP Financial Measures

EBITDA [2]

	Three Months Ended March 31,	
	2012	2011
	(In thousands)	
Net income	$ 18,089	$17,388
Add back:		
Depreciation and amortization reported in the consolidated statements of cash flows	18,339	18,094
Interest expense	4,298	3,603
Provision for income taxes	11,033	10,309
EBITDA	$51,759	$49,394

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At March 31, 2012, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $37.8 million, compared with approximately $23.6 million of cash and investments at December 31, 2011.

On a consolidated basis, at March 31, 2012, we had working capital of $474.9 million compared with $446.2 million at December 31, 2011. At March 31, 2012 we had cash and investments of $933.8 million, compared with $893.0 million of cash and investments at December 31, 2011.

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see discussion of "Convertible Senior Notes" below). The repurchase program will be funded with working capital or draws under our credit facility (see discussion of "Credit Facility" below).

We believe that our cash resources, Credit Facility, and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility is used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of March 31, 2012 there was $10.0 million outstanding under the Credit Facility. Additionally, as of March 31, 2012, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of not less than 1.75 to 1.00. At March 31, 2012, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the approximately 460,000 square foot office building, or Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commenced on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Convertible Senior Notes

As of March 31, 2012, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Shelf Registration Statement

In the second quarter of 2012, we expect to file a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the registration, issuance, and sale of an indeterminate amount of our securities, including common stock, preferred stock, senior or subordinated debt securities, or warrants. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $519.5 million at March 31, 2012, and $492.4 million at December 31, 2011.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of March 31, 2012, our health plans had aggregate statutory capital and surplus of approximately $536.3 million compared with the required minimum aggregate statutory capital and surplus of approximately $265.1 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2012. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2011, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and;
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

California Health Plan Medical Cost Floors (Minimums): A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At both March 31, 2012, and December 31, 2011, we recorded a liability of $1.0 million under the terms of these contract provisions.

Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health: A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At both March 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums): A portion of premiums received by our New Mexico health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). The New Mexico health plan contract also contains certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At both March 31, 2012, and December 31, 2011, we had not recorded any liability under the terms of these contract provisions. In the fourth quarter of 2011, our New Mexico health plan entered into a contract amendment that more closely aligns the calculation of revenue with the methodology adopted under the Affordable Care Act. The contract amendment changed the calculation of the amount of revenue that may be recognized relative to medical costs.

Texas Health Plan Profit Sharing: Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had accrued an aggregate liability of approximately $2.0 million and $0.7 million pursuant to our profit-sharing agreement with the state of Texas at March 31, 2012, and December 31, 2011, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services, or CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of approximately $8.0 million for anticipated Medicare risk adjustment premiums at March 31, 2012. We recorded a net receivable of $5.0 million for anticipated Medicare risk adjustment premiums at December 31, 2011.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. Effective February 1, 2010 through June 30, 2011, we were eligible to earn additional incremental revenue of up to 0.25% of our total premium if we met certain pharmacy specific performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Effective March 1, 2012, under our contract with the state of Texas, incremental revenue of up to 5% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of March 31, 2012 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of March 31, 2012.

	Three Months Ended March 31, 2012				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 555	$ 336	$ 28	$ 364	$ 83,261
Ohio	2,678	2,678	966	3,644	293,525
Texas	5,750	5,750	—	5,750	198,236
Wisconsin	416	—	—	—	17,142
	$ 9,399	$ 8,764	$ 994	$ 9,758	$592,164

	Three Months Ended March 31, 2011				
	Maximum Available Quality Incentive Premium - Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 581	$ 444	$ (168)	$ 276	$ 84,606
Ohio	2,662	1,350	1,823	3,173	230,340
Wisconsin	416	—	—	—	16,417
	$ 3,659	$ 1,794	$ 1,655	$ 3,449	$ 331,363

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we are delivering extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. We receive progress payments from the state during the performance of DDI services based upon the attainment of predetermined milestones. We receive a flat monthly payment for BPO services under our Idaho and Maine contracts. The terms of our other Molina Medicaid Solutions contracts – which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) – are shorter in duration than our Idaho and Maine contracts.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple –Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. As noted above, the period of performance of BPO services under our Idaho and Maine contracts is five years. Therefore, absent any contingencies as discussed in the following paragraph, we would recognize all revenue associated with those contracts over a period of five years. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. We began to recognize revenue associated with our Maine contract upon state acceptance in September 2010. In Idaho, we will begin recognition of revenue upon state acceptance.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the MMIS in that state receives certification from CMS.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	March 31, 2012	December 31, 2011	March 31, 2011
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 347,307	$ 301,020	$ 273,378
Capitation payable	37,289	53,532	43,738
Pharmacy	38,443	26,178	16,953
Other	32,794	21,746	17,313
	$ 455,833	$ 402,476	$ 351,382

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $347.3 million of our total medical claims and benefits payable of $455.8 million as of March 31, 2012. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at March 31, 2012, was $340.4 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of March 31, 2012 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding March 31, 2012, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ 120,683
(4%)	80,456
(2%)	40,228
2%	(40,228)
4%	(80,456)
6%	(120,683)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of March 31, 2012 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ (83,846)
(4%)	(55,897)
(2%)	(27,949)
2%	27,949
4%	55,897
6%	83,846

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 46.9 million diluted shares outstanding for the three months ended March 31, 2012. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at March 31, 2012, net income for the three months ended March 31, 2012 would increase or decrease by approximately $12.6 million, or $0.27 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at March 31, 2012, net income for the three months ended March 31, 2012 would increase or decrease by approximately $8.7 million, or $0.19 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $62.9 million, or $1.34 per diluted share, and $43.7 million, or $0.93 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $12.6 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2011, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 14.6%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2012 and 2011 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized a benefit from prior period claims development in the amount of $36.6 million for the three months ended March 31, 2012. This amount represents our estimate as of March 31, 2012 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2011 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2011 was due primarily to the following factors:

- For our Washington health plan, we underestimated the amount of recoveries we would collect for certain high-cost newborn claims, resulting in an overestimation of reserves at year end.
- For our Texas health plan, we overestimated the cost of new members in STAR+ (the name of our ABD program in Texas), in the Dallas region.
- In early 2011, the state of Michigan was delayed in the enrollment of newborns in managed care plans; the delay was resolved by mid-2011. This caused a large number of claims with older dates of service to be paid during late 2011, resulting in an artificial increase in the lag time for claims payment at our Michigan health plan. We adjusted reserves downward for this issue at December 31, 2011, but the adjustment did not capture all of the claims overestimation.
- Offsetting some of the overestimation items described above, our Missouri health plan reserves were underestimated as a result of an unusually large number of premature infants during the fourth quarter.

We recognized a benefit from prior period claims development in the amount of $44.4 million and $51.8 million for the three months ended March 31, 2011, and the year ended December 31, 2011, respectively. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2010, as a result of the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010, partially offsetting the impact of the two items above.

In estimating our claims liability at March 31, 2012, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- Our Texas health plan membership nearly doubled in March 2012. In addition, effective March 1, 2012, we have assumed inpatient medical liability for STAR+ (an area of coverage that was previously carved out). Reserves for new coverage and new regions are based on the state's pricing estimates.
- Our California health plan is enrolling about 2,000 new ABD members per month as a result of the mandatory assignment of ABD members to managed care plans effective July 1, 2011. These new members are converting from fee-for-service and are higher cost than our base ABD members
- Our Michigan health plan's billed charges of claims in inventory at March 31, 2012 were about 2.5 times higher than the amount at December 31, 2011. This was due in part to approximately 6,000 new dual-eligible members that were enrolled for Medicaid benefits only in December 2011. As we are responsible only for the Medicaid portion of these benefits, the ratio of paid to billed claims for dual eligible members is very small, and this inventory buildup may not represent a large increase in liability.
- Our Wisconsin health plan converted from its legacy claims processing system to the Company's single managed care platform, or QNXT, effective February 1, 2012.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2011 and through March 31, 2012, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "Components of medical care costs related to: Prior year" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,		Year Ended
	2012	2011	Dec. 31, 2011
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of period	$ 402,476	$ 354,356	$ 354,356
Components of medical care costs related to:			
Current period	1,167,580	957,909	3,911,803
Prior periods	(36,592)	(44,377)	(51,809)
Total medical care costs	1,130,988	913,532	3,859,994
Payments for medical care costs related to:			
Current period	750,994	646,428	3,516,994
Prior periods	326,637	270,078	294,880
Total paid	1,077,631	916,506	3,811,874
Balances at end of period	$ 455,833	$ 351,382	$ 402,476
Benefit from prior period as a percentage of:			
Balance at beginning of period	9.1%	12.5%	14.6%
Premium revenue	2.8%	4.1%	1.1%
Total medical care costs	3.2%	4.9%	1.3%
Claims Data:			
Days in claims payable, fee for service	44(1)	41	40
Number of members at end of period	1,825,000	1,647,000	1,697,000
Number of claims in inventory at end of period	260,800	185,300	111,100
Billed charges of claims in inventory at end of period	$ 403,800	$ 250,600	$ 207,600
Claims in inventory per member at end of period	0.14	0.11	0.07
Billed charges of claims in inventory per member at end of period	$ 221.26	$ 152.16	$ 122.33
Number of claims received during the period	4,855,600	4,342,200	17,207,500
Billed charges of claims received during the period	$ 4,337,000	$3,386,600	$ 14,306,500

(1) The increase in the days in claims payable is primarily the result of the increased membership in the Texas health plan and the rise in medical claims reserves associated with that increased membership in the first quarter of 2012. Absent the increased Texas health plan membership, the days in claims payable would have been approximately 41 days.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. *Quantitative and Qualitative Disclosures About Market Risk*

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended March 31, 2012 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. *Legal Proceedings*

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. *Risk Factors*

In addition to the other information set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A — Risk Factors, in our 2011 Annual Report on Form 10-K, which risk factors could materially affect our business, financial condition, cash flows, or results of operations. The risks described in our 2011 Form 10-K are not the only risks facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, cash flows, or results of operations.

There have been no material changes to the risk factors disclosed in our 2011 Form 10-K.

Item 2. *Unregistered Sales of Equity Securities and Use of Proceeds*

Issuer Purchases of Equity Securities

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program will be funded with working capital or draws under our credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No securities were purchased under this program as of March 31, 2012.

Purchases of common stock made by or on behalf of the Company during the quarter ended March 31, 2012, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (b)	Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs (b)
January 1 — January 31	4,213	$ 22.95	—	$ —
February 1 — February 29	2,240	$ 31.85	—	$ —
March 1 — March 31	256,485	$ 33.53	—	$ —
Total	262,938	$ 33.35	—	

(a) During the three months ended March 31, 2012, we did not repurchase any shares of our common stock outside of our publicly announced stock repurchase program. During the quarter we withheld 262,938 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(b) Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No repurchases have been made by the Company pursuant to this repurchase plan during the quarter ended March 31, 2012.

Item 6. Exhibits

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS (1)	XBRL Taxonomy Instance Document.
101.SCH (1)	XBRL Taxonomy Extension Schema Document.
101.CAL (1)	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF (1)	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB (1)	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE (1)	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) Pursuant to Rule 406T of Regulation S-T, XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 9, 2012

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: May 9, 2012

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT INDEX

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
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EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2012 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 9, 2012

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2012 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 9, 2012

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2012 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 9, 2012

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2012 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 9, 2012

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

2011 MHI Form 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2011

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☐ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2011, the last business day of our most recently completed second fiscal quarter, was approximately $731 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2011).

As of February 24, 2012, approximately 45,838,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2012 Annual Meeting of Stockholders to be held on May 2, 2012, are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

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Form 10-K

PART I

Item 1: *Business*

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business focuses exclusively on government-sponsored health care programs, and includes our Health Plans segment, our Molina Medicaid Solutions℠ segment, and our smaller direct delivery line of business. Our Health Plans segment consists of licensed health maintenance organizations serving Medicaid populations in ten states. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. Our direct delivery line of business currently consists of 17 primary care community clinics in California, two clinics in Washington, and three county-owned clinics in Fairfax County, Virginia that we manage on behalf of the county. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today, we remain a provider-focused company led by his son, Dr. J. Mario Molina.

Our Health Plans segment currently operates Medicaid managed care plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin that serve a total of approximately 1.7 million members. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our Health Plans segment derives its revenue principally in the form of premiums paid under Medicaid contracts with the states in which our health plans operate. While the health plans receive fixed per-member per-month, or PMPM, premium payments from the states, the health plans are at risk for the medical costs associated with their members' health care. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements which limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS, a core information technology tool used to support the administration of state Medicaid and other health care entitlement programs. Our Molina Medicaid Solutions segment currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in May 2010 to expand our product offerings to include support of state Medicaid agency administrative needs; to reduce the variability in our earnings resulting from fluctuations in medical care costs; to improve our operating profit margin percentages; and to improve our cash flow by adding a business for which there are no restrictions on dividend payments.

From a strategic perspective, we believe our two business segments and our direct delivery business line allow us to participate in an expanding sector of the economy and continue our mission of serving low-income families and individuals eligible for government-sponsored health care programs. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is *www.molinahealthcare.com.*

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to "Molina Healthcare," the "Company," "we," "our," and "us" herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge under the "investors" tab of our website, *www.molinahealthcare.com*, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, Corporate Governance and Nominating Committee, and Compliance Committee Charters, are also available on our website. Such information is also available in print upon the request of any stockholder to our Investor Relations department at the address of our executive offices set forth above. In accordance with New York Stock Exchange, or NYSE, rules, on May 26, 2011, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Molina Healthcare, the Molina Healthcare logo, Molina Medicaid Solutions sm and motherhood matters! sm are registered servicemarks of Molina Healthcare, Inc.

Our Industry

The Medicaid and CHIP Programs. The Medicaid program is a federal entitlement program administered by the states. Medicaid provides health care and long-term care services and support to low-income Americans. Subject to federal rules, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states currently about 59 percent, and ranges from a federally established FMAP floor of 50 percent to as high as 74 percent.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced "TAN-if"). Another common state-administered Medicaid program is for the aged, blind or disabled, or ABD, Medicaid members. In addition, the Children's Health Insurance Program, or CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.

Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 50% of the costs incurred in operating an MMIS. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we now actively participate in this market.

In certain instances, states have elected to provide medical benefits to individuals and families who are not served by Medicaid. In New Mexico and Washington, our health plan segment participates in programs that are administered in a manner similar to Medicaid and CHIP, but without federal matching funds.

Medicare Advantage Plans. During 2011, each of our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, and Washington operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name, Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name, Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operate a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans at December 31, 2011 was approximately 31,000 members. Our 2011 premium revenues from Medicare across all health plans represented approximately 8.4% of our total premium revenues.

Overall, approximately 79% of our members are TANF, 11% are ABD, 8% are CHIP, and 2% are Medicare.

Our Strengths

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. Additionally, we support state Medicaid agencies by providing them with comprehensive solutions to their MMIS development and operating needs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, and cost management through our Health Plans segment, to state-level MMIS administration through our Molina Medicaid Solutions segment, to the direct delivery of health care services at our clinics. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. Our Molina Medicaid Solutions platform is based upon commercial off-the-shelf technology, or COTS. As a result, we believe that our Molina Medicaid Solutions platform has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our health plan segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The acquisition of our New Mexico and Wisconsin health plans demonstrated our ability to expand into new states. The establishment of our health plans in Utah, Ohio, Texas, and Florida reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Recognition for Quality of Care. The National Committee for Quality Assurance, or NCQA, has accredited nine of our ten Medicaid managed care plans. Our Wisconsin plan acquired in September 2010 currently plans to seek NCQA accreditation in early 2014. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our Company in 1980 to serve the Medicaid population in Southern California through a small network of primary care clinics, we have increased our membership to 1.7 million members, expanded our Health Plans segment to ten states, and added our Molina Medicaid Solutions segment. Our experience over the last 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Our Strategy

Our objective is to provide a comprehensive suite of Medicaid-related services to meet the health care needs of low-income families and individuals and the state Medicaid agencies that serve them. To achieve our objective, we intend to:

Continue to expand within existing markets. We plan to continue our growth in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, extending our services to new populations (including the aged, blind, or disabled), maintaining positive provider relationships, and integrating members from other health plans.

Continue to enter new strategic markets. We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. For example, on September 1, 2010, we acquired for approximately $16.8 million Abri Health Plan, a provider of Medicaid managed care services in Wisconsin. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size and, where practicable, mandated Medicaid managed care enrollment.

Continue to provide quality cost-effective care. We plan to use our strong provider networks and the knowledge gained through the operation of our clinics to further develop and utilize effective medical management and other coordinated programs that address the distinct needs of our members and improve the quality and cost-effectiveness of their care.

Leverage operational efficiencies. We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost.

Deliver administrative value to state Medicaid agencies. As Medicaid expenditures increase, we believe that an increasing number of states will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. For example, we can apply analytics to improve the functionality of care management processes. We believe that we can help strengthen these tools in ways that translate into both better care and cost containment. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs.

Open additional primary care clinics. The community clinic model offers an integrated approach that helps us improve both the quality and cost-effectiveness of the care our members receive. Our direct delivery line of business currently consists of 17 primary care community clinics in California, two in Washington, and three county-owned clinics in Fairfax County, Virginia that we manage on behalf of the county. We will also be opening up a clinic in each of New Mexico and Florida in March 2012, and intend to open up additional clinics in California, New Mexico, Florida, Ohio, and Texas during 2012. The growth and aging of the population of the United States foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to worsen this shortage. We believe the shortage will be felt most acutely among already underserved populations, such as the low income families and individuals we serve. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging our direct delivery capability on a selective basis we can improve access for our plan members in areas that are most underserved by primary care providers.

Pursue opportunities presented by ICD-10 conversion requirements. Over the next two years, health insurance plans are required to upgrade their systems for diagnosis, medical procedure coding, and claims processing under the tenth revisions of the International Statistical Classification of Diseases, or ICD-10. The United States Department of Health and Human Services will require payers and providers to transition to ICD-10 by October 2013. However, in February 2012, CMS announced that it will postpone implementation of ICD-10 and will be issuing shortly a notice with a new timeline governing the pace of implementation. Thus, although delayed, the transition to ICD-10 is still expected to occur. For many smaller health plans with less than one million members, the costs of making the necessary systems upgrades will be substantial. For companies like ours, the benefits of scale in this environment will be significant. We believe we will be positioned to reduce the cost per member for compliance with ICD-10. At the same time, the new requirements will create revenue opportunities for Molina Medicaid Solutions.

Prepare for health care reform. In preparation for the large scale changes associated with federal health care reform, we have organized a dedicated business unit to address issues of strategy, policy, reform readiness, and implementation. Health care reform opportunities include an estimated 16 million more members eligible for Medicaid by 2019, 30 million more individuals covered by health insurance exchanges, and increasing demand for long-term care and behavioral health services. In the next two years, we anticipate that many states will be offering new Medicaid RFP expansions in order to avoid disruptions in 2014 in connection with the full implementation of health care reform.

Medicaid Contracts

With the exception of our Missouri health plan, which does not serve ABD or Medicare members, and our Wisconsin health plan, which does not serve Medicare members, all of our health plans serve TANF, CHIP, ABD, and Medicare members. For its Medicare members, each health plan enters into a one-year annually renewable contract with the Centers for Medicare and Medicaid Services, or CMS. For its other members, each health plan enters into a contract with the state's Medicaid agency. The contractual relationship with the state is generally for a period of one- to two-years and renewable on an annual or biannual basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, on February 17, 2012, our Missouri health plan was notified that it was not awarded a new contract under that state's RFP, and therefore its contract will now expire on June 30, 2012.

Our contracts with the state determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and disenrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

We are usually paid a negotiated PMPM amount, with the PMPM amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also paid an additional amount for each newborn delivery from the Medicaid programs in all of our state health plans, except with respect to our New Mexico health plan.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations, or IPAs. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California health plan operates 16 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a non-licensed subsidiary in Virginia which manages three health care clinics for Fairfax County, and our Washington health plan operates two Company-owned primary care clinics.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*℠ is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *"breathe with ease!"* is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *"Healthy Living with Diabetes"* is a diabetes disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/Submit Authorizations.
- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/PCP.
- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (such as those that may be required by the Health Insurance Portability and Accountability Act of 1996, or HIPAA, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness Data and Information Set, or HEDIS, and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Nine of our ten health plans are accredited by the NCQA. Our Wisconsin plan acquired in September 2010 currently plans to seek NCQA accreditation in early 2014.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 3.4 system).

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan's ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- *Medicaid HMOs* — National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.

- *Prepaid Health Plans* — Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- *Primary Care Case Management Programs* — Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, or CSC, and CNSI.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules can occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organization, including those operating in the Medicaid and Medicare programs.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC, and are administered by the states. Our Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin health plans are subject to RBC requirements. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established in 1965 under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state governments jointly fund it, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states award contracts to any applicant demonstrating that it meets the state's requirements. Other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services, or CMS. Medicare beneficiaries have the option to enroll in a Medicare Advantage plan. Under Medicare Advantage, managed care plans contract with CMS to provide benefits that are comparable to original Medicare in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, made numerous changes to the Medicare program, including expanding the Medicare program to include a prescription drug benefit. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan. Plans are not required to offer the same benefits, but are required to provide coverage that is at least actuarially equivalent to the standard drug coverage delineated in the MMA.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, or MIPPA, became law and, in September 2008, CMS promulgated implementing regulations. MIPPA impacts a broad range of Medicare activities and impacts all types of Medicare managed care plans. MIPPA and subsequent CMS guidance place prohibitions and limitations on certain sales and marketing activities

of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. MIPPA also establishes certain restrictions on agent and broker compensation.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- Afford privacy to patient health information, and
- Protect the privacy of patient health information through physical and electronic security measures.

The Patient Protection and Affordable Care Act of 2010, or ACA, created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers. On September 23, 2010, CMS issued proposed regulations designed to implement these requirements. It is not clear at this time the degree to which managed care providers would have to comply with these new requirements, many of which resemble procedures that we already have in place.

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), a part of the ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. The U.S. Department of Health and Human Services, as required by the HITECH Act, has issued interim final rules that set forth the breach notification obligations applicable to covered entities and their business associates (the "HHS Breach Notification Rule"). The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as *"qui tam"* actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Action of 2005 ("DRA") encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2011, we had approximately 5,200 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Executive Officers of the Registrant

J. Mario Molina, M.D., 53, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 47, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 30 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He was recently named to the Los Angeles branch of the Federal Reserve Bank of San Francisco's board of directors. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Terry P. Bayer, 61, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has over 30 years of health care management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University.

Joseph W. White, 53, has served as our Chief Accounting Officer since 2003. In his role as Chief Accounting Officer, Mr. White is responsible for oversight of the Company's accounting, reporting, forecasting, budgeting, actuarial, procurement, treasury and facilities functions. Mr. White has over 25 years of financial management experience in the health care industry. Prior to joining the Company in 2003, Mr. White worked for Maxicare Health Plans, Inc. from 1987 through 2002. Mr. White holds a Master's degree in Business Administration and a Bachelor's degree in Commerce from the University of Virginia. Mr. White is a Certified Public Accountant.

Stephen T. O'Dell, 60, has served as our Senior Vice President, Growth & Corporate Development, since December 2010. Mr. O'Dell is responsible for leading the Company's strategic growth efforts, including mergers and acquisitions, business development and health care reform readiness strategy and implementation. Prior to this role, Mr. O'Dell served the Company as President and CEO of our California health plan and more recently as a Regional Vice President overseeing the strategic direction and operations of our health plans in Washington, Utah, New Mexico and Texas as well as the Company's medical clinics in California. Mr. O'Dell has more than 30 years of executive experience in the managed health care industry. He has held executive positions at First Consulting Group, Blue Cross Blue Shield of Colorado, Nevada and New Mexico and FHP International. Mr. O'Dell holds a Master of Science degree in Health Administration from the University of Colorado Health Sciences Center and a Bachelor of Arts degree in History from Lewis & Clark College in Oregon.

Item 1A: ***Risk Factors***

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This annual report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Business

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs are continuing to increase at the same time that state budgets are suffering from unprecedented deficits. Because governmental health care programs account for such a large portion of state budgets, efforts to contain overall government spending and to achieve a balanced budget often result in significant political pressure being directed at the funding for these health care programs. Resolving the budget shortfalls is now particularly difficult since program reductions and one-time strategies to plug the gaps have already been used in most states. In fiscal year 2011, 47 states implemented at least one new policy to control Medicaid costs and 50 states planned to do so in fiscal year 2012. Most states reported program reductions in multiple areas. However, the "maintenance of eligibility" requirements under the Patient Protection and Affordable Care Act generally prohibit states from restricting Medicaid eligibility or tightening enrollment procedures. States are also moving forward with a range of delivery system changes and programmatic initiatives designed to improve care and control costs.

Headed into state fiscal year 2013 (which in most instances starts on July 1, 2012), states do not expect revenue collections to recover to a level sufficient to avoid additional budget cuts. Already, 29 states have projected or have addressed shortfalls totaling $44 billion for fiscal year 2013. Among them are California and Texas, two of the most populous states in the country. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it is a prime target for cost-containment efforts. All of the states in which we currently operate our health plans are currently facing significant budgetary pressures. The mandate of health reform adding millions of individuals to Medicaid and CHIP will put further pressures on state Medicaid programs. These budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins.

Moreover, some federal deficit reduction proposals would fundamentally change the structure and financing of the Medicaid program. Recently, various proposals have been advanced to reduce annual federal deficits and to slow the increase in the national debt. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid. Some of the proposals relating to Medicaid would fundamentally change the structure and financing of the program, with major implications for providers and beneficiaries. One such proposal would be to convert Medicaid into a block grant, capping federal Medicaid payments to each state at a specified dollar amount, and limiting the growth in that dollar amount each year. Based on analysis of previous proposals to cap Medicaid, these dollar caps and growth limits would have to be set below the levels at which Medicaid is now expected to grow based on enrollment and health care inflation to save money. In the event the Medicaid program is fundamentally restructured, our business could be adversely affected.

Most recently, on August 2, 2011, the President signed into law the Budget Control Act of 2011, which, among other things, creates the Joint Select Committee on Deficit Reduction to recommend proposals in spending reductions to Congress. The Joint Select Committee was tasked with proposing legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021 by December 23, 2011. Reductions in Medicare and Medicaid spending were initially included as a part of these deficit reduction measures. On September 19, 2011, President Obama presented his Plan for Economic Growth and Deficit Reduction to the Joint Select Committee, which included $72 billion in Medicaid savings. The Joint Select Committee, however, failed to propose legislation by the December 23, 2011 deadline. Therefore, approximately $1.2 trillion in domestic and defense spending reductions will automatically begin on January 1, 2013 and will be split evenly between domestic and defense spending. Payments to Medicare providers are included in the automatic spending cuts; however, the Budget Control Act of 2011 provides that Medicare payments may be reduced by no more than 2% and certain other programs, including Medicaid, would be exempt from the automatic spending cuts. At this time, we are unable to determine how the automatic Congressional spending cuts will affect Medicare and Medicaid reimbursement in the future. We also cannot predict the initiatives that may be adopted in the future or their full impact. There likely will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could potentially have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The recently enacted health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act, commonly referred to together as the "ACA". This legislation enacts comprehensive changes to the U.S. health care system, components of which will be phased in at various stages over the next eight years. Among other things, by January 1, 2014, the Medicaid program will be expanded to provide eligibility to nearly all low-income people under age 65 with income below 133 percent of the federal poverty line. As a result, millions of low-income adults without children who currently cannot qualify for coverage, as well as many low-income parents and, in some instances, children now covered through CHIP, will be made eligible for Medicaid. In total, the Congressional Budget Office estimates that Medicaid and CHIP will cover an additional 16 million people by 2019. The legislation also imposes a franchise tax or premium excise tax of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes. As a result, several state officials have stated that the fiscal pressure that Medicaid puts on states is expected to increase if the federal health-care overhaul takes place in 2014. Although the federal government is required to pick up the costs for people newly eligible for the program, many who are now eligible but not enrolled are expected to be drawn in, and states must shoulder part of those costs.

There are many parts of the legislation that will require further guidance in the form of regulations. Due to the breadth and complexity of the health reform legislation, the lack of implementing regulations and interpretive guidance, and the phased-in nature of the implementation, the overall impact of the health reform legislation on our business over the coming years is difficult to predict and not yet fully known.

In addition, there have been a number of lawsuits filed that challenge all or part of the health care reform law. On January 31, 2011, a Florida District Court ruled that the entire health care reform law is unconstitutional. Other courts have ruled in favor of the law or have only struck down certain provisions of the law. These cases are under appeal and others are in process. The United States Supreme Court is scheduled to hear oral arguments on certain aspects of these cases in March 2012, including the constitutionality of the individual mandate and of the requirement imposed on states that they expand coverage under the Medicaid program. We cannot predict the ultimate outcome of any of the litigation. Further, various Congressional leaders have indicated a desire to revisit or repeal the health care reform law. While the U.S House of Representatives voted to repeal the whole health care reform law, the U.S. Senate voted against such a repeal. There have separately been a number of bills introduced that would change certain provisions of the law. Because of these challenges, we cannot predict whether any or all of the legislation will be implemented as enacted, overturned, repealed, or modified. Any partial or complete repeal or amendment or implementation difficulties, or uncertainty regarding such events, could materially and adversely impact our ability to capitalize on the opportunities presented by the ACA or may cause us to incur additional costs of compliance.

If we fail to effectively accommodate the growth in Medicaid enrollment anticipated under the health reform legislation, our business may be materially adversely affected. In addition, if the new $8 billion insurance industry assessment is imposed as enacted, or if we are unable to obtain premium increases to offset the impact of the assessment or otherwise adjust our business model to address the assessment, our business, financial condition, cash flows, or results of operations could be materially adversely affected.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio for 2011 of 83.9% had been one percentage point higher, or 84.9%, our earnings for 2011 would have been approximately $0.25 per diluted share rather than our actual 2011 earnings of $0.45 per diluted share, a 44% reduction in our earnings.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual flu season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid," or IBNP, medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to Medicare Advantage or aged, blind, and disabled Medicaid members, is impacted by the more limited experience we have had with those populations. Finally, with regard to the new Medicaid and CHIP members we expect to enroll in 2012 through organic growth due primarily to the recession, certain new members may be disproportionately costly due to high utilization in their first several months of Medicaid or CHIP membership as a result of their previously having been uninsured and therefore not seeking or deferring medical treatment.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

An increased incidence of flu in 2012 in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results during 2009 were significantly impacted by the widespread incidence of the H1N1 flu in the states in which we operate our health plans. An atypically high incidence of flu in 2012, or the outbreak and rapid spread of any other highly contagious and potentially virulent disease, could increase the utilization rates among our members, resulting in significantly increased outpatient, inpatient, emergency room, and pharmacy costs.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, the state contract of our Ohio and New Mexico health plans will be subject to competitive bidding during 2012. In the event the responsive bids of our Ohio or New Mexico health plans or those of our other health plans are not successful, we will lose our Medicaid contract in the applicable state, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of the unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. Further, most of our contracts are terminable without cause.

Our government contracts generally run for periods of one year to three years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. Although our health plans have generally been successful in obtaining the renewal and/or extension of their state contracts, there can be no guarantee that any of our state government contracts will be renewed or extended, as shown by the recent loss of our Missouri contract. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

There are numerous risks associated with the expansion of our Texas health plan's service areas and with any other expansion into new markets.

Effective March 1, 2012, our Texas health plan will be expanding into three new service delivery areas, representing the addition of approximately 148,000 additional members. There are numerous risks associated with a health plan's initial expansion into a new service area or the provision of medical services to a new population, including pent-up demand for medical services, elevated medical care costs, unfamiliarity with managed care processes, and our lack of actuarial experience in setting appropriate reserve levels. In the event the medical care costs of our Texas health plan or of our other health plans are higher than anticipated, we are unable to lower the medical care ratio associated with these new populations, our reserve levels are inadequate, or our enrollment projections are overestimated, the negative results of our Texas health plan could adversely affect our business, financial condition, cash flows, or results of operations.

In the event the expected reduction in the rates paid to our California health plan is not finally implemented, is not made effective retroactive to July 1, 2011, or is otherwise modified, our results of operations may be affected.

California Assembly Bill 97, or AB 97, is legislation that was signed by Governor Jerry Brown on March 24, 2011. Among other things, AB 97 proposes to effect a 10% reduction in Medi-Cal provider rates. The California Department of Health Care Services has preliminarily indicated that the 10% rate reduction could be effective retroactive to July 1, 2011. The Company believes that this reduction in provider payments, if effected, will translate into a premium reduction of approximately 3.5% for the California health plan.

The proposed rate reduction was submitted for approval to CMS, and on October 27, 2011, CMS indicated its general approval of the rate cut. However, the United States District Court for the Central District of California issued a series of injunctions barring the California Department of Health Care Services from implementing the rate reductions as to various classes of providers. The California Department of Health Care Services recently reported that CMS asked for a delay of the submission of the AB 97 managed care rates to allow CMS to research its authority to review and approve the AB 97 managed care rates in light of the current fee-for-service injunction.

If the proposed rate cut is not finally implemented, if it is not made retroactive to July 1, 2011, or if it is otherwise modified from its current form, the results of our California health plan could be affected — positively or negatively — depending on the action taken. In addition, recoveries from providers related to any final implemented rate cut could also affect the results of our California health plan.

States may not adequately compensate us for the value of drug rebates that were previously earned by the Company but that are now collectible by the states.

ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers are in the process of or have completed renegotiating their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours will likely decline significantly in the future. There are provisions in the ACA that require rates paid to Medicaid managed care to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from ten state health plans, and as of June 30, 2012, when the contract of our Missouri health plan is scheduled to end, we will derive premium revenues from nine state health plans. If we were unable to continue to operate in any of those nine states, or if our current operations in any portion of the states we are in were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

There are performance risks and other risks associated with certain provisions in the state Medicaid contracts of several of our health plans.

The state contracts of our New Mexico, Ohio, Texas, and Wisconsin health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, the health plan will be unable to recognize the revenue associated with that measure. Any failure of our health plan to satisfy one of these performance measure provisions could adversely affect our business, financial condition, cash flows, or results of operations.

In addition, the state contracts of our California, Florida, New Mexico, and Texas health plans contain provisions pertaining to medical cost floors, administrative cost and profit ceilings, and profit-sharing arrangements. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the sometimes complicated contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could adversely affect our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we were unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also create increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have an adverse impact on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could adversely affect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. During 2010, due to a prolonged budget impasse, some of the monthly premium payments made by the State of California to our California health plan were several months late. In January 2012, State Controller John Chiang warned that the State of California could run out of cash by March 2012 if quick action was not taken. Mr. Chiang added that revenue is $2.6 billion lower than projected for California's 2012 fiscal year while spending is higher by about the same amount. In a monthly report released by Mr. Chiang in February 2012 covering California's cash balance, receipts and disbursements for the prior month, it was noted that monthly revenues for the month of January had come in $528 million below the latest projections contained in the Governor's proposed 2012-13 budget and when compared against the 2011-12 Budget Act, January revenues were $1.2 billion below estimates. While the State Assembly of California passed a bill permitting short term borrowing from existing funds held by certain state departments in order to get the State of California through what is expected to be a seven-week cash shortfall, and though California also has access to an additional $865 million of internal borrowable funds due to recent legislation (SB 95) signed by the Governor, the State also warned that one of the consequences of such short term borrowing would be the delay of payments to providers of state services, including Medi-Cal. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse affect on our business, financial condition, cash flows, or results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets — particularly operators of large commercial health plans — have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,

- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

In addition, we may be unable to successfully identify, consummate and integrate future acquisitions, including integrating the acquired businesses on our information technology platform, or to implement our operations strategy in order to operate acquired businesses profitabley. Furthermore, we may incur significant transaction expenses in connection with a potential acquisition which may or may not be consummated. These expenses could impact our selling, general and administrative expense ratio.

For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws which may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our financial position, results of operations and cash flows.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as “fraud and abuse” laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties, and assessments. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the

claimant was out of compliance with program requirements. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. Many states, including states where we currently operate, have enacted parallel legislation. In the event we are subject to liability under a *qui tam* action, our business and operating results could be adversely affected.

Federal regulations require entities subject to HIPAA to update their transaction formats for electronic data exchange to the new HIPAA 5010 standards; however, some entities are currently in transition to the new standards which could adversely impact administrative expense and compliance.

A federal mandate known as HIPAA 5010 requires health plans to use new standards for conducting certain operational and administrative transactions electronically beginning in January 2012. These administrative transactions include: claims, remittance, eligibility and claims status requests and responses. The HIPAA 5010 upgrade was prompted by government and industry's shared goal of providing higher-quality, lower-cost health care and the need for a comprehensive electronic data exchange environment for the ICD-10 mandate to be implemented by October 2013. Upgrading to the new HIPAA 5010 standards should increase transaction uniformity, support pay for performance, and streamline reimbursement transactions. We, along with other health plans, faced significant pressure to make sure that we installed our software and tested it for compatibility with our business partners. Because HIPAA 5010 affects electronic transactions such as patient eligibility, claims filing, claims status, and remittance advice, we proceeded proactively to achieve full functionality of HIPAA 5010 transactions, and did so, before the January 1, 2012 deadline. However, in November 2011, CMS announced it would delay enforcement actions related to implementation of HIPAA 5010 until March 31, 2012. As the delayed implementation deadline approaches for full implementation of HIPAA 5010, we will continue to test our claims management systems to prevent any operational disruptions.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

The U.S. Department of Health and Human Services, or HHS, has released rules pursuant to HIPAA which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. Originally, the federal government required that health care organizations, including health insurers, upgrade to updated and expanded standardized code sets used for documenting health conditions by October 2013. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. However, in February 2012, it was reported that CMS will postpone implementation of ICD-10 and will be issuing shortly a notice with a new timeline governing the pace of implementation. While use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our cash flows, financial position, or results of operations. However, these changes may result in errors and otherwise negatively impact our service levels, and we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide, appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial position, cash flows, or results of operations.

The insolvency of a delegated provider could obligate us to pay their referral claims, which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped if the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which the Company does not participate. These actions and the resulting negative publicity could become associated with or imputed to the Company, regardless of the Company's actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which the Company does participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2011, 2010, and 2009 without approval of the regulatory authorities were approximately $17.6 million, $18.8 million, and $9.0 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our credit facility and/or our convertible senior notes.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our business, financial condition, cash flows, or results of operations.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process, and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The Health Information Technology for Economic and Clinical Health Act provisions of the ARRA further expand the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, increasing penalties for violations, and requiring public disclosure of improper disclosures of health information of more than 500 individuals.

Under ARRA, civil penalties for HIPAA violations by covered entities are increased up to an annual maximum of $1.5 million for uncorrected violations based on willful neglect. In addition, imposition of these penalties is now more likely because ARRA strengthens enforcement. For example, commencing February 2010, HHS was required to conduct periodic audits to confirm compliance. Investigations of violations that indicate willful neglect, for which penalties are now mandatory, are statutorily required. In addition, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Initially monies collected will be transferred to a division of HHS for further enforcement, and within three years, a methodology will be adopted for distributing a percentage of those monies to affected individuals to fund enforcement and provide incentive for individuals to report violations. In addition, ARRA requires us to notify affected individuals, HHS, and in some cases the media when unsecured personal health information is subject to a security breach.

ARRA also contains a number of provisions that provide incentives for states to initiate certain programs related to health care and health care technology, such as electronic health records. While provisions such as these do not apply to us directly, states wishing to apply for grants under ARRA, or otherwise participating in such programs, may impose new health care technology requirements on us through our contracts with state Medicaid agencies. We are unable to predict what such requirements may entail or what their effect on our business may be.

We will continue to assess our compliance obligations as regulations under ARRA are promulgated and more guidance becomes available from HHS and other federal agencies. The new privacy and security requirements, however, may require substantial operational and systems changes, employee education and resources and there is no guarantee that we be able to implement them adequately or prior to their effective date. Given HIPAA's complexity and the anticipated new regulations, which may be subject to changing and perhaps conflicting interpretation, our ongoing ability to comply with all of the HIPAA requirements is uncertain, which may expose us to the criminal and increased civil penalties provided under ARRA and may require us to incur significant costs in order to seek to comply with its requirements.

While we currently expend significant resources and implemented solutions, processes and procedures to protect against cyber attacks and security breaches and have no evidence to suggest that such attacks have resulted in a breach of our systems, we may need to expend additional significant resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target and may originate from less regulated and remote areas around the world, we may be unable to proactively address these techniques or to implement adequate preventive measures.

Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third-party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could subject us to civil and criminal penalties, divert management's time and energy and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Risks Related to the Operation of Our Molina Medicaid Solutions Business

MMIS operational problems in Idaho or Maine could result in reduced or withheld payments, damage assessments, increased administrative costs, or even contract termination, any of which could adversely affect our business, financial condition, cash flows, or results of operations.

From and after the MMIS operational or "go live" date of June 1, 2010 after which it began pilot operations, Molina Medicaid Solutions has experienced certain problems with the MMIS in Idaho. In the event Molina Medicaid Solutions is unsuccessful in correcting all of the identified problems, the Idaho Department of Administration may: (i) reduce or withhold its payments to Molina Medicaid Solutions, (ii) require Molina Medicaid Solutions to provide services at no additional cost to Idaho, (iii) require the payment of damages, or (iv) terminate its contract with Molina Medicaid Solutions. In addition, Molina Medicaid Solutions may incur much greater administrative costs than expected in correcting the MMIS problems, or in advancing interim payments to Idaho providers. For example, the consulting and outside service costs for Idaho following its go-live operational date have not declined from the pre-operational level as had been previously expected. Finally, Idaho DHW may not accept the MMIS developed and implemented by Molina Medicaid Solutions, or CMS may not certify such MMIS. All of such risks are also applicable to the MMIS in Maine which became operational and began pilot operations as of September 1, 2010. In addition, the state of Maine, in order to balance its budget, has requested that we renegotiate our contract with the state under terms which would reduce the amount of payments made under the life of the contract. The realization of any of the foregoing risks could adversely affect our business, financial condition, cash flows, or results of operations.

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently has management contracts in only six states. If we are unable to continue to operate in any of those six states, or if our current operations in any of those six states were significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, including its responsive bid in West Virginia during 2012, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, in 2011, the government

contract of Molina Medicaid Solutions in Louisiana was subject to competitive bidding, and we were unsuccessful in being awarded a new contract. During 2012, the state MMIS contract of West Virginia will be subject to competitive bidding. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event the responsive bid in West Virginia is not successful, we will lose our fiscal agent contract in that state, and our revenues could be materially reduced as a result. In addition, in the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or unanticipated delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our overall business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business may be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have an adverse effect on our business, financial condition, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results or damage our reputation.

Experienced computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming,

disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance on contracts, including those on which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties including software and hardware vendors to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenue and profitability.

Risks Related to our General Business Operations

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions or reduce our liquidity and capital resources.

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility with various lenders and U.S. Bank National Association. The credit facility imposes numerous restrictions and covenants, including, but not limited to, prescribed consolidated leverage and fixed charge coverage ratios, net worth requirements, and acquisition and disposition limitations that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends and other distributions without lender approval. Our ability to comply with these covenants may be affected by events beyond our control. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to react to market conditions, finance our operations, engage in strategic acquisitions or disposals, act with complete flexibility, or to use our credit facility in the manner intended. In addition, our credit facility matures in September 2016. If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, or if we are unable to renew or refinance our credit facility prior to its maturity, and if the default is not cured or waived, we may be unable to use the credit facility in the manner intended, and our operations, liquidity, and capital resources could be materially adversely affected.

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In fiscal year 2007, we had total premium revenue of $2.5 billion. In fiscal year 2011, we had total premium revenue of $4.6 billion, an increase of 87% over a five-year span. Continued rapid growth could place a significant strain on our management and on other Company resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems, could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of their employees. We maintain medical malpractice insurance for our clinics in an amount which we believe to be reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, cash flows, or results of operations, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles ("GAAP") and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations, or the accounting reversal of any tax benefits or revenue previously recognized by us, could have an adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. It is critical that we recruit, manage, enable and retain talent to successfully execute our strategic objections which requires aligned policies, a positive work environment and a robust succession and talent development process. Further, particularly in light of the changing healthcare environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. If we are unsuccessful in recruiting, retaining, managing and enabling such personnel and are unable to meet upcoming challenges and opportunities, our operations could be negatively impacted.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in the vendors' or service provider's operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition and results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could adversely impact our business, financial condition and results of operations.

An impairment charge with respect to our recorded goodwill or indefinite-lived intangible assets could have a material impact on our financial results.

We conduct formal impairment tests on material long-lived assets, such as goodwill and indefinite-lived intangible assets, and intangible assets, net, at least annually; additionally, we continually evaluate whether events or changes in business conditions suggest potential impairment of such assets. Our judgments regarding the existence of impairment indicators are based on legal factors, market conditions, and operational performance. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. The non-renewal of such a contract would be an indicator of impairment.

As of December 31, 2011, the balance of goodwill and indefinite-lived intangible assets was $154.0 million. Goodwill and indefinite-lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. As of December 31, 2011, the balance of intangible assets, net, was $101.8 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives. The determination of the value of goodwill and indefinite-lived intangible assets, and intangible assets, net, requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors.

If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and indefinite-lived intangible assets, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

We are subject to the risks of owning real property.

We own an approximately 460,000 square foot office building housing our principal executive offices, which we purchased in a transaction that closed on December 7, 2011. Accordingly, we are subject to all of the risks generally associated with owning and leasing real estate, which includes, but is not limited to: the possibility of environmental contamination, the costs associated with fixing any environmental problems and the risk of damages resulting from such contamination; adverse changes in the value of the property due to interest rate changes, changes in the neighborhood in which the property is located or other factors; ongoing

maintenance expenses and costs of improvements; the possible need for structural improvements in order to comply with changes in zoning, seismic, disability act, or other requirements; inability to renew or enter into leases for space not utilized by the Company on commercially acceptable terms or at all; and possible disputes with neighboring owners or other individuals and entities.

Because we have guaranteed one of our subsidiary's obligations under a loan agreement, if this subsidiary fails to meet its obligations under the loan agreement, we may be required to satisfy such obligations, and such an undertaking could have an adverse affect on our financial condition.

On December 7, 2011, Molina Center LLC, a wholly owned subsidiary of the Company, entered into a Term Loan Agreement with various lenders and East West Bank, as Administrative Agent, to borrow the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the office building housing our corporate headquarters. While all amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the office building in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement, the Company has additionally guaranteed Molina Center's obligations of payment and performance under the Term Loan Agreement, certain promissory notes executed in connection therewith, and other loan documents. The maximum amount of the promissory notes for which the Company is liable under the Guaranty will in no event exceed $20 million, but there is no cap on the Company's total liability under the Guaranty. Furthermore, Molina Center and the Company also entered into an Environmental Indemnity in favor of the Administrative Agent and the other lenders pursuant to which the Company, jointly and severally with Molina Center, has agreed to indemnify and hold harmless the Administrative Agent and each of the other lenders under the Term Loan Agreement from and against any loss, damage, cost, expense, claim, or liability directly or indirectly arising out of or attributable to the use, generation, storage, release, discharge or disposal, or presence of certain hazardous materials on or about the office building. Neither the Company's nor Molina Center's liability under the Environmental Indemnity is limited by a maximum dollar amount. If Molina Center is unable to comply with the various customary financial covenants of the Term Loan Agreement, if it defaults under the Term Loan Agreement or if there are major environmental liabilities attributed to hazardous materials, such events could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Risks Related to Our Common Stock

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $10.75 (on a split-adjusted basis) to a high of $36.83. A number of factors will continue to influence the market price of our common stock, including:

- state and federal budget pressures,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- changes in government payment levels,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies in the health care industry,
- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,

- regulatory or legislative change,
- general economic conditions, including unemployment rates, inflation, and interest rates, and
- the factors set forth under “Risk Factors” in this report.

Our stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our stock does not continue to develop, securities analysts may not maintain or initiate research coverage of our Company and our shares, and this could depress the market for our shares.

Members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate own or are entitled to receive upon certain events approximately 40% of our capital stock. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of our Company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, including securities that are convertible into or exchangeable for, or that represent the right to receive, common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 80,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2011, 45,815,392 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire our Company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our Company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

We do not anticipate paying any cash dividends in the foreseeable future.

We have never declared or paid any cash dividends. While we have in the past and may again in the future use our available cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Item 1B: ***Unresolved Staff Comments***

None.

Item 2: ***Properties***

We lease a total of 68 facilities. We own a 460,000 square foot office building housing our corporate headquarters in Long Beach, California, and we also own a nearby 32,000 square-foot office building in Long Beach, California, a 26,000 square-foot data center in Albuquerque, New Mexico, and a community clinic in Pomona, California. While we believe our current facilities are adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operations growth prospects to determine if additional space is required.

Item 3: ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. Based upon the evaluation of information currently available, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 4: ***Mine Safety Disclosures***

None.

PART II

Item 5: ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of February 15, 2012, there were 131 holders of record of our common stock. The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2011		
First Quarter (1)	$ 26.86	$ 17.77
Second Quarter (1)	$ 29.03	$ 24.72
Third Quarter	$ 28.21	$ 14.82
Fourth Quarter	$ 26.31	$ 13.93
2010 (1)		
First Quarter	$ 17.59	$ 13.35
Second Quarter	$ 20.80	$ 16.67
Third Quarter	$ 21.20	$ 16.85
Fourth Quarter	$ 18.85	$ 16.43

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

Dividends

We have never paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our business, and we do not anticipate paying any cash dividends in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Any future determination to pay dividends will be at the discretion of our Board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 — Management's Discussion and Analysis of Financial Condition and Results of Operations — Regulatory Capital and Dividends Restrictions.

Unregistered Issuances of Equity Securities

None.

Stock Repurchase Program

On July 27, 2011, our board of directors approved a stock repurchase program of up to $7 million to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Under this program, we purchased approximately 400,000 shares of our common stock for $7 million (average cost of approximately $17.47 per share) during August 2011. This repurchase program was funded with working capital.

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program will be funded with working capital or draws under our credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No securities were purchased under this program in 2011.

Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2011, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (b)(c)	Maximum Number (or Approximate Dollar Value) of Shares That May Yet Be Purchased Under the Plans or Programs (b)(c)
October 1 — October 31	2,431(d)	$ 15.44	—	$ 75,000,000
November 1 — November 30	2,150(d)	$ 20.53	—	$ 75,000,000
December 1 — December 31	1,213(d)	$ 21.82	—	$ 75,000,000
Total	5,794(d)	$ 18.66	—	

(a) During the three months ended December 31, 2011, we did not repurchase any shares of our common stock outside of our publicly announced stock repurchase program except 5,794 shares of common stock withheld to settle our employees' income tax obligations.

(b) On July 27, 2011, our board of directors approved a stock repurchase program of up to $7 million to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Our repurchases under this program were completed in August 2011.

(c) Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No repurchases have been made by the Company pursuant to this repurchase plan during the quarter ended December 31, 2011.

(d) Includes shares withheld by the Company to satisfy our employees' income tax withholdings.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2011)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	553,049	$ 20.91	7,377,188(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan, and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and 2002 Equity Incentive Plan have been suspended.

(2) Includes only shares remaining available to issue under the 2011 Equity Incentive Plan (the "2011 Incentive Plan"), and the 2011 Employee Stock Purchase Plan (the "ESPP"). Further grants under the 2002 Equity Incentive Plan and the 2002 Employee Stock Purchase Plan have been suspended.

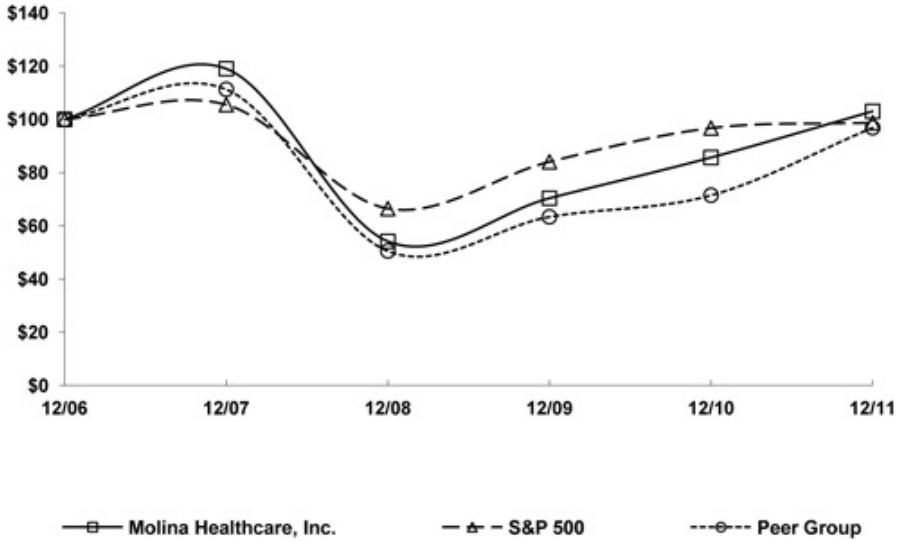
STOCK PERFORMANCE GRAPH

The following discussion shall not be deemed to be "soliciting material" or to be "filed" with the SEC nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500") and a peer group index for the five-year period from December 31, 2006 to December 31, 2011. The graph assumes an initial investment of $100 in Molina Healthcare, Inc. common stock and in each of the indices.

The peer group index consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN
Among Molina Healthcare, Inc, The S&P 500 Index
And A Peer Group



* $100 invested on 12/31/06 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.

Item 6. ***Selected Financial Data***

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics") for the five years ended December 31, 2011 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data. The data under the caption "Operating Statistics" has not been audited.

	Year Ended December 31,				
	2011	2010(1)	2009	2008	2007
Statements of Income Data:					
Revenue:					
Premium revenue	$ 4,603,407	$ 3,989,909	$ 3,660,207	$ 3,091,240	$ 2,462,369
Service revenue(1)	160,447	89,809	—	—	—
Investment income	5,539	6,259	9,149	21,126	30,085
Rental income	547	—	—		
Total revenue	4,769,940	4,085,977	3,669,356	3,112,366	2,492,454
Expenses:					
Medical care costs	3,859,994	3,370,857	3,176,236	2,621,312	2,080,083
Cost of service revenue(1)	143,987	78,647	—	—	—
General and administrative expenses	415,932	345,993	276,027	249,646	205,057
Premium tax expenses	154,589	139,775	128,581	100,165	81,020
Depreciation and amortization	50,690	45,704	38,110	33,688	27,967
Total expenses	4,625,192	3,980,976	3,618,954	3,004,811	2,394,127
Impairment of goodwill and intangible assets(2)	(64,575)	—	—	—	—
Gain on purchase of convertible senior notes	—	—	1,532	—	—
Operating income	80,173	105,001	51,934	107,555	98,327
Interest expense	15,519	15,509	13,777	13,231	5,605
Income before income taxes	64,654	89,492	38,157	94,324	92,722
Provision for income taxes	43,836	34,522	7,289	34,726	34,996
Net income	$ 20,818	$ 54,970	$ 30,868	$ 59,598	$ 57,726
Net income per share(3):					
Basic	$ 0.45	$ 1.34	$ 0.80	$ 1.44	$ 1.36
Diluted	$ 0.45	$ 1.32	$ 0.79	$ 1.43	$ 1.35
Weighted average number of common shares outstanding(3)	45,756,000	41,174,000	38,765,000	41,514,000	42,412,500
Weighted average number of common shares and potential dilutive common shares outstanding(3)	46,425,000	41,631,000	38,976,000	41,658,000	42,628,500
Operating Statistics:					
Medical care ratio(4)	83.9%	84.5%	86.8%	84.8%	84.5%
General and administrative expense ratio(5)	8.7%	8.5%	7.5%	8.0%	8.2%
Premium tax ratio(6)	3.4%	3.5%	3.5%	3.2%	3.3%
Members(7)	1,697,000	1,613,000	1,455,000	1,256,000	1,149,000

	Year Ended December 31,				
	2011	2010(1)	2009	2008	2007(9)
Balance Sheet Data:					
Cash and cash equivalents	$ 493,827	$ 455,886	$ 469,501	$ 387,162	$ 459,064
Total assets	1,652,146	1,509,214	1,244,035	1,148,068	1,170,016
Long-term debt (including current maturities)	218,126	164,014	158,900	164,873	160,166
Total liabilities	897,073	790,157	701,297	616,306	655,640
Stockholders' equity	755,073	719,057	542,738	531,762	514,376

(1) Service revenue and cost of service revenue represent revenue and costs generated by our Molina Medicaid Solutions segment. Because we acquired this business on May 1, 2010, results for the year ended December 31, 2010 include eight months of results for this segment.

(2) On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's existing contract with the state will expire without renewal on June 30, 2012. In connection with this notification, we recorded a non-cash impairment charge of approximately $64.6 million in the fourth quarter of 2011.

(3) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

(4) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, contract changes, and changes in accounting estimates related to incurred but not reported claims. See *Management's Discussion and Analysis of Financial Condition and Results of Operations* for further discussion.

(5) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(6) Premium tax ratio represents such expenses as a percentage of premium revenue.

(7) Number of members at end of period.

Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Adjustments

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. We also have a direct delivery business that currently consists of primary care community clinics in California and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

We report our financial performance based on the following two reportable segments: Health Plans; and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. This segment served approximately 1.7 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of December 31, 2011. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's existing contract with the state will expire without renewal on June 30, 2012. In connection with this notification, we recorded a non-cash impairment charge of approximately $64.6 million, or $1.34 per diluted share. Most of the impairment charge is not tax deductible, resulting in a disproportionate impact to net income. For the year ended December 31, 2011, our Missouri health plan contributed premium revenue of $229.6 million, or 5% of total premium revenue, and comprised 79,000 members, or 4.7% of total Health Plans segment membership.

On May 1, 2010, we acquired a health information management business which we operate under the name, Molina Medicaid Solutions. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement Medicaid Management Information System, or MMIS, to another firm. Our revenue under the Louisiana MMIS contract from May 1, 2010, the date we acquired Molina Medicaid Solutions, through December 31, 2010, was approximately $32 million. For the year ended December 31, 2011, our revenue under the Louisiana MMIS contract was approximately $57 million. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize between $45 million and $50 million in revenue annually under our Louisiana MMIS contract.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the year ended December 31, 2011, we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the year ended December 31, 2011, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. Premiums PMPM for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $70 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the Temporary Assistance for Needy Families, or TANF, Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $110 in California to $250 in Missouri. Among our Medicaid Aged, Blind or Disabled, or ABD, membership, PMPM premiums range from approximately $330 in Utah to $1,400 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest average PMPM premiums, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2011	2010	2009
Total Ending Membership by Health Plan:			
California	355,000	344,000	351,000
Florida	69,000	61,000	50,000
Michigan	222,000	227,000	223,000
Missouri	79,000	81,000	78,000
New Mexico	88,000	91,000	94,000
Ohio	248,000	245,000	216,000
Texas	155,000	94,000	40,000
Utah	84,000	79,000	69,000
Washington	355,000	355,000	334,000
Wisconsin (1)	42,000	36,000	—
Total	1,697,000	1,613,000	1,455,000
Total Ending Membership by State for our Medicare Advantage Plans(1):			
California	6,900	4,900	2,100
Florida	800	500	—
Michigan	8,200	6,300	3,300
New Mexico	800	600	400
Ohio	200	—	—
Texas	700	700	500
Utah	8,400	8,900	4,000
Washington	5,000	2,600	1,300
Total	31,000	24,500	11,600

	As of December 31,		
	2011	2010	2009
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	31,500	13,900	13,900
Florida	10,400	10,000	8,800
Michigan	37,500	31,700	32,200
New Mexico	5,600	5,700	5,700
Ohio	29,100	28,200	22,600
Texas	63,700	19,000	17,600
Utah	8,500	8,000	7,500
Washington	4,800	4,000	3,200
Wisconsin (1)	1,700	1,700	—
Total	192,800	122,200	111,500

(1) We acquired the Wisconsin health plan on September 1, 2010. As of December 31, 2011, the Wisconsin health plan had approximately 2,000 Medicare Advantage members covered under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. Most hospitals are paid on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. As discussed below, we also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed per-member per-month, or PMPM, payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2011, 2010, and 2009, medically related administrative costs were approximately $102.3 million, $85.5 million, and $74.6 million, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Idaho, Louisiana, Maine, New Jersey, West Virginia, and Florida. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred contract costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contract costs in 2012, in a manner consistent with our anticipated recognition of revenue.

2011 Financial Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the years ended December 31, 2011, 2010, and 2009. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Year Ended December 31,		
	2011	2010	2009
	(Dollar amounts in thousands, except per-share data)		
Earnings per diluted share	$ 0.45	$ 1.32	$ 0.79
Premium revenue	$ 4,603,407	$ 3,989,909	$ 3,660,207
Service revenue	$ 160,447	$ 89,809	$ —
Operating income	$ 80,173	$ 105,001	$ 51,934
Net income	$ 20,818	$ 54,970	$ 30,868
Total ending membership	1,697,000	1,613,000	1,455,000
Premium revenue	96.5%	97.6%	99.8%
Service revenue	3.4%	2.2%	—
Investment income	0.1%	0.2%	0.2%
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	83.9%	84.5%	86.8%
General and administrative expense ratio	8.7%	8.5%	7.5%
Premium tax ratio	3.4%	3.5%	3.5%
Operating income	1.7%	2.6%	1.4%
Net income	0.4%	1.3%	0.8%
Effective tax rate	67.8%	38.6%	19.1%

Year Ended December 31, 2011 Compared with the Year Ended December 31, 2010

Fiscal Year 2011 Overview and Highlights

For the year, our net income was $20.8 million, or $0.45 per diluted share, a decrease of 66% over 2010. As described above, we recorded a non-cash impairment charge of approximately $64.6 million, or $1.34 per diluted share, in connection with the expiration of our Missouri health plan's contract with the state of Missouri effective June 30, 2012. Absent this impairment charge, improved performance of the Health Plans segment drove our improved performance overall for the year ended December 31, 2011.

We earned premium revenues of $4.6 billion, up 15.4% over the previous year. Meanwhile, we achieved a medical care ratio of 83.9%, compared with a medical care ratio of 84.5% for fiscal year 2010. We have continued to lay the foundation for further growth, achieving certification of our Medicaid management information system in Maine, winning large contract awards in Texas, serving more of the ABD population in California, and preparing to serve dual-eligible members in many of our states.

During 2011, we continued to pursue the expansion of our Health Plans segment; membership grew 8.4% on a member-month basis over 2010. We have expanded our growing presence in Texas, where new contracts in 2010 and 2011 have led to the addition of approximately 61,000 members in 2011, which includes nearly 45,000 new ABD members. This membership growth not only provides increased scale for leveraging our resources in Texas, it makes us an increasingly important player in a state where the potential revenue opportunity will grow as new Medicaid beneficiaries qualify for coverage under health care reform.

Our Texas and Wisconsin health plans continue to face challenges. We have undertaken a number of measures—focused on both utilization and unit cost reductions—to improve the profitability of these health plans.

We remain concerned about state budget deficits, which are not expected to improve in 2012. Accordingly, the rate environment for our health plans remains uncertain, and we have received several rate reductions in 2011, including a 2.5% reduction in New Mexico effective July 1, 2011, a 2% reduction in Utah effective July 1, 2011, a 2% rate reduction in Texas effective September 1, 2011, and a 1% reduction in California effective October 1, 2011. Additionally, we have received a proposed rate reduction in California that we believe will translate into a premium reduction of approximately 3.5% retroactive to July 1, 2011. However, we have also received rate increases, including a 5% rate increase at our Missouri health plan effective July 1, 2011, a 7.5% rate increase at our Florida plan effective September 1, 2011, and a 1% rate increase at our Michigan plan effective October 1, 2011.

With respect to our Molina Medicaid Solutions business, our MMIS in Maine received full certification from CMS in December 2011. The state of Idaho has sent their formal request for system certification to CMS, and we anticipate certification review in early 2012, with formal certification in the second half of 2012.

Health Plans Segment

Premium Revenue

In the year ended December 31, 2011, compared with the year ended December 31, 2010, premium revenue increased 15.4% due to a membership increase of approximately 8.4% (on a member-month basis), and PMPM revenue increase of approximately 6.4%. Premium revenues were impacted by the following in 2011:

- In the fourth quarter of 2011, our New Mexico health plan entered into a contract amendment that more closely aligns the calculation of revenue with the methodology adopted under the Affordable Care Act. The contract amendment changed the calculation of the amount of revenue that may be recognized relative to medical costs, and resulted in the recognition of approximately $5.6 million of premium revenue which all related to periods prior to 2011.
- Also in the fourth quarter of 2011, the addition of pharmacy benefits at our Ohio health plan effective October 1, 2011, increased premium revenue.

Absent the adjustment to New Mexico premium revenue and the addition of the pharmacy benefit in Ohio, premium revenue PMPM increased approximately 4.4%, from $218 in 2010 to $227 in 2011. Increased enrollment among the ABD and Medicare populations contributed to the higher premium revenue PMPM. Medicare premium revenue was $388.2 million for the year ended December 31, 2011, compared with $265.2 million for the year ended December 31, 2010.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,764,309	$ 139.02	71.6 %	$ 2,360,858	$ 128.73	70.0 %
Capitation	518,835	26.09	13.4	555,487	30.29	16.5
Pharmacy	418,007	21.02	10.8	325,935	17.77	9.7
Other	158,843	8.00	4.2	128,577	7.01	3.8
Total	$ 3,859,994	$ 194.13	100.0 %	$ 3,370,857	$ 183.80	100.0 %

The medical care ratio decreased to 83.9% for the year ended December 31, 2011, compared with 84.5% for the year ended December 31, 2010. Absent that portion of the adjustment to New Mexico premium revenue that related to 2010, the medical care ratio was 84.0% for the year ended December 31, 2011. Total medical care costs increased less than 6% PMPM.

- Pharmacy costs (excluding the addition of pharmacy benefits at our Ohio health plan effective October 1, 2011) increased approximately 7% PMPM. Approximately two-thirds of the increase in pharmacy costs was attributable to higher unit costs, with the remainder due to increased utilization.
- Capitation costs decreased approximately 14% PMPM, primarily due to the transition of members in Michigan and Washington into fee-for-service networks.
- Fee-for-service costs increased approximately 8% PMPM, partially due to the transition of members from capitated provider networks into fee-for-service networks.
- Fee-for-service and capitation costs combined increased approximately 4% PMPM. Excluding the Texas health plan, fee-for-service and capitation costs combined increased approximately 2% PMPM.
- Hospital utilization decreased approximately 5%.

The medical care ratio of the California health plan increased to 85.8% for the year ended December 31, 2011, from 83.5% for the year ended December 31, 2010. The California health plan received premium reductions of approximately 3% and 1% effective July 1, 2011, and October 1, 2011, respectively. In the second half of 2011, the California health plan added approximately 14,500 new ABD members with average premium revenue of approximately $385 PMPM.

The medical care ratio of the Florida health plan decreased to 91.9% for the year ended December 31, 2011, from 95.4% for the year ended December 31, 2010, primarily due to initiatives that have reduced pharmacy and behavioural health costs, and a premium rate increase of approximately 7.5% effective September 1, 2011.

The medical care ratio of the Michigan health plan decreased to 81.2% for the year ended December 31, 2011, from 83.7% for the year ended December 31, 2010, primarily due to improved Medicare performance and lower inpatient facility costs. The Michigan health plan received a premium rate increase of approximately 1% effective October 1, 2011.

The medical care ratio of the Missouri health plan decreased to 85.3% for the year ended December 31, 2011, from 85.5% for the year ended December 31, 2010. The health plan received a premium rate increase of approximately 5% effective July 1, 2011.

The medical care ratio of the New Mexico health plan decreased to 80.2% for the year ended December 31, 2011, from 80.6 % for the year ended December 31, 2010. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011. As discussed above, the New Mexico health plan entered into a contract amendment changed the calculation of the amount of revenue that may be recognized relative to medical costs in the fourth quarter of 2011. Consequently, premium revenue recognized in the year ended December 31, 2011, includes $5.6 million related to periods prior to 2011.

The medical care ratio of the Ohio health plan decreased to 77.6% for the year ended December 31, 2011, from 79.1% for the year ended December 31, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011, and relatively flat fee-for-service costs. The pharmacy benefit was restored to all managed care plans in Ohio effective October 1, 2011.

The medical care ratio of the Texas health plan increased to 93.4% for the year ended December 31, 2011, from 86.2% for the year ended December 31, 2010. Effective February 1, 2011, we added approximately 30,000 ABD members in the Dallas-Fort Worth area and effective September 1, 2011, we added approximately 8,000 ABD members and 3,000 TANF members in the Jefferson Service area. Medical costs in the Dallas-Fort Worth area were well in excess of premium revenue. Excluding the ABD population in the Dallas-Fort Worth region, the medical care ratio of the Texas health plan was 85.7% for the year ended December 31, 2011.

The medical care ratio of the Utah health plan decreased to 78.1% for the year ended December 31, 2011, from 91.3% for the year ended December 31, 2010, primarily due to reduced fee-for-service inpatient and physician costs and an increase in Medicaid premiums PMPM. Effective July 1, 2010, the Utah health plan received a premium rate increase of approximately 7%. Lower fee-for-service costs were the result of both lower unit costs and lower utilization. During the second quarter of 2011 we settled certain claims with the state regarding the savings share provision of our contract in effect from 2003 through June of 2009. We settled for the contract years 2006 through 2009 and recognized $6.9 million in premium revenue without any corresponding charge to expense. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2011.

The medical care ratio of the Washington health plan remained flat at 83.9% for the year ended December 31, 2011 compared with the year ended December 31, 2010. Higher fee-for-service and pharmacy costs were offset by lower capitation costs.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 92.5% for the year ended December 31, 2011. The state of Wisconsin reduced capitation rates by 11% on January 1, 2011. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Wisconsin health plan. Significant improvements in inpatient utilization were realized in the second half of 2011.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2011						
		Premium Revenue		Medical Care Costs			
	Member Months(1)	Total	PMPM	Total	PMPM	Medical Care Ratio	Premium Tax Expense
California	4,190	$ 575,176	$ 137.27	$ 493,419	$ 117.75	85.8 %	$ 7,499
Florida	788	203,945	258.70	187,358	237.66	91.9	41
Michigan	2,660	662,127	248.91	537,779	202.16	81.2	38,733
Missouri	959	229,584	239.38	195,832	204.19	85.3	—
New Mexico	1,074	345,732	321.94	277,338	258.25	80.2	9,285
Ohio	2,966	988,896	333.40	766,949	258.57	77.6	76,677
Texas	1,616	409,295	253.40	382,390	236.74	93.4	7,117
Utah	972	287,290	295.51	224,513	230.94	78.1	—
Washington	4,171	823,323	197.42	690,513	165.57	83.9	14,865
Wisconsin(2)	488	69,596	142.56	64,346	131.81	92.5	44
Other(3)	—	8,443	—	39,557	—	—	328
	19,884	$ 4,603,407	$ 231.51	$ 3,859,994	$ 194.13	83.9 %	$ 154,589

	Year Ended December 31, 2010						
		Premium Revenue		Medical Care Costs			
	Member Months(1)	Total	PMPM	Total	PMPM	Medical Care Ratio	Premium Tax Expense
California	4,197	$ 506,871	$ 120.77	$ 423,021	$ 100.79	83.5 %	$ 6,912
Florida	664	170,683	256.87	162,839	245.07	95.4	1
Michigan	2,708	630,134	232.66	527,596	194.80	83.7	39,187
Missouri	946	210,852	222.98	180,291	190.66	85.5	—
New Mexico	1,104	366,784	332.02	295,633	267.61	80.6	9,300
Ohio	2,817	860,324	305.42	680,802	241.69	79.1	67,358
Texas	708	188,716	266.72	162,714	229.97	86.2	3,251
Utah	921	258,076	280.27	235,576	255.84	91.3	—
Washington	4,141	758,849	183.27	636,617	153.75	83.9	13,513
Wisconsin(2)	134	30,033	224.75	27,574	206.35	91.8	—
Other(3)	—	8,587	—	38,194	—	—	253
	18,340	$ 3,989,909	$ 217.56	$ 3,370,857	$ 183.80	84.5 %	$ 139,775

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs of the parent company.

Days in Medical Claims and Benefits Payable

The days in medical claims and benefits payable were as follows:

	December 31,		
	2011	2010	2009
Days in claims payable: fee-for-service only	40 days	42 days	44 days
Number of claims in inventory at end of period	111,100	143,600	93,100
Billed charges of claims in inventory at end of period (in thousands)	$ 207,600	$ 218,900	$ 131,400

Molina Medicaid Solutions Segment

We acquired Molina Medicaid Solutions on May 1, 2010; therefore, the year ended December 31, 2010 includes only eight months of operating results for this segment. Performance of the Molina Medicaid Solutions segment was as follows:

	Twelve Months Ended December 31, 2011	Eight Months Ended December 31, 2010
	(In thousands)	
Service revenue before amortization	$ 167,269	$ 98,125
Amortization recorded as reduction of service revenue	(6,822)	(8,316)
Service revenue	160,447	89,809
Cost of service revenue	143,987	78,647
General and administrative costs	9,270	5,135
Amortization of customer relationship intangibles recorded as amortization	5,127	3,418
Operating income	$ 2,063	$ 2,609

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the MMIS in that state receives certification from CMS. For the year ended December 31, 2011, cost of service revenue includes $11.5 million of direct costs associated with the Idaho contract that would otherwise have been recorded as deferred contract costs. In assessing the recoverability of the deferred contract costs associated with the Idaho contract during 2011, we determined that these costs should be expensed as a period cost. In December 2011, our MMIS in Maine received full certification from CMS.

Consolidated Expenses and Other

General and Administrative Expenses

General and administrative expenses were $415.9 million, or 8.7% of total revenue, for the year ended December 31, 2011, compared with $346.0 million, or 8.5% of total revenue, for the year ended December 31, 2010.

Premium Tax Expense

Premium tax expense decreased to 3.4% of premium revenue, for the year ended December 31, 2011, from 3.5% for the year ended December 31, 2010.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Year Ended December 31,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 30,864	0.7%	$ 27,230	0.7%
Amortization of intangible assets	19,826	0.4	18,474	0.4
Depreciation and amortization reported as such in the consolidated statements of income	50,690	1.1	45,704	1.1
Amortization recorded as reduction of service revenue	6,822	0.1	8,316	0.2
Amortization of capitalized software recorded as cost of service revenue	16,871	0.4	6,745	0.2
Total	$ 74,383	1.6%	$ 60,765	1.5%

Impairment of Goodwill and Intangible Assets

We recorded a non-cash impairment charge of approximately $64.6 million, or $1.34 per diluted share, in connection with the expiration of our Missouri health plan's contract with the state of Missouri effective June 30, 2012. Of the total charge, $58.5 million is not tax deductible, resulting in a disproportionate impact to net income.

Interest Expense

Interest expense was $15.5 million for the years ended December 31, 2011 and 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $5.5 million and $5.1 million for the years ended December 31, 2011 and 2010, respectively.

Income Taxes

Income tax expense is recorded at an effective rate of 67.8% for the year ended December 31, 2011, compared with 38.6% for the year ended December 31, 2010. The effective rate for the year ended December 31, 2011 reflects the non-deductible nature of the majority of the Missouri impairment charge, discrete tax benefits of $1.7 million recognized for statute closures, prior year tax return to provision reconciliations, and certain non-recurring income that is not subject to income tax. Excluding the impact from the Missouri impairment charge and discrete tax benefits, the effective tax rate for the year ended December 31, 2011 was 37.9%.

Year Ended December 31, 2010 Compared with the Year Ended December 31, 2009

Health Plans Segment

Premium Revenue

In the year ended December 31, 2010, compared with the year ended December 31, 2009, premium revenue increased 9.0% due to a membership increase of approximately 10.9% (on a member-month basis). On a PMPM basis, however, consolidated premium revenue decreased 2.1% because of declines in premium rates. The decrease in PMPM revenue was due to the transfer of the pharmacy benefit to the state fee-for-service programs in Ohio (effective February 1, 2010) and Missouri (effective October 1, 2009). Exclusive of the transfer of the pharmacy benefit in Ohio and Missouri, Medicaid premium revenue PMPM increased approximately 1.5% over the year ended December 31, 2009. Medicare enrollment exceeded 24,000 members at December 31, 2010, and Medicare premium revenue was $265.2 million for the year ended December 31, 2010, compared with $135.9 million for the year ended December 31, 2009.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 2,360,858	$ 128.73	70.0 %	$ 2,077,489	$ 126.14	65.4 %
Capitation	555,487	30.29	16.5	558,538	33.91	17.6
Pharmacy	325,935	17.77	9.7	414,785	25.18	13.1
Other	128,577	7.01	3.8	125,424	7.62	3.9
Total	$ 3,370,857	$ 183.80	100.0 %	$ 3,176,236	$ 192.85	100.0 %

The medical care ratio decreased to 84.5% for the year ended December 31, 2010, compared with 86.8% for the year ended December 31, 2009.

The medical care ratio of the California health plan decreased to 83.5% for the year ended December 31, 2010, from 92.2% for the year ended December 31, 2009, primarily due to lower inpatient facility fee-for-service costs resulting from provider network restructuring and improved medical management.

The medical care ratio of the Florida health plan increased to 95.4% for the year ended December 31, 2010, from 93.8% for the year ended December 31, 2009, primarily due to higher capitation costs and higher fee-for-service costs in the outpatient and physician categories.

The medical care ratio of the Michigan health plan increased to 83.7% for the year ended December 31, 2010, from 81.5% for the year ended December 31, 2009, primarily due to higher inpatient facility fee-for-service costs.

The medical care ratio of the New Mexico health plan decreased to 80.6% for the year ended December 31, 2010, from 85.7% for the year ended December 31, 2009, primarily due to reduced fee-for-service costs which more than offset decreased premium revenue PMPM.

The medical care ratio of the Ohio health plan decreased to 79.1% for the year ended December 31, 2010, from 86.1% for the year ended December 31, 2009, primarily due to an increase in Medicaid premium PMPM of approximately 6% effective January 1, 2010 (exclusive of the reduction related to pharmacy benefits), partially offset by higher inpatient facility fee-for-service costs.

The medical care ratio of the Utah health plan decreased to 91.3% for the year ended December 31, 2010, from 91.8% for the year ended December 31, 2009, due to improved financial performance in the second half of 2010. That improved financial performance was the result of reduced fee-for-service costs in the second half of 2010 and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010.

The medical care ratio of the Washington health plan decreased to 83.9% for the year ended December 31, 2010, from 84.5% for the year ended December 31, 2009, primarily due to reduced fee-for-service costs which more than offset decreased premium revenue PMPM. Premium revenue PMPM decreased for all of 2010 compared with 2009 because the rate increase of approximately 2.5% effective July 1, 2010 was not enough to offset decreases received during the second half of 2009.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2010						
		Premium Revenue		Medical Care Costs			
	Member Months(1)	Total	PMPM	Total	PMPM	Medical Care Ratio	Premium Tax Expense
California	4,197	$ 506,871	$ 120.77	$ 423,021	$ 100.79	83.5 %	$ 6,912
Florida	664	170,683	256.87	162,839	245.07	95.4	1
Michigan	2,708	630,134	232.66	527,596	194.80	83.7	39,187
Missouri	946	210,852	222.98	180,291	190.66	85.5	—
New Mexico	1,104	366,784	332.02	295,633	267.61	80.6	9,300
Ohio	2,817	860,324	305.42	680,802	241.69	79.1	67,358
Texas	708	188,716	266.72	162,714	229.97	86.2	3,251
Utah	921	258,076	280.27	235,576	255.84	91.3	—
Washington	4,141	758,849	183.27	636,617	153.75	83.9	13,513
Wisconsin(2)	134	30,033	224.75	27,574	206.35	91.8	—
Other(3)	—	8,587	—	38,194	—	—	253
	18,340	$ 3,989,909	$ 217.56	$ 3,370,857	$ 183.80	84.5 %	$ 139,775

	Year Ended December 31, 2009						
		Premium Revenue		Medical Care Costs			
	Member Months(1)	Total	PMPM	Total	PMPM	Medical Care Ratio	Premium Tax Expense
California	4,135	$ 481,717	$ 116.49	$ 443,892	$ 107.34	92.2 %	$ 16,446
Florida	386	102,232	264.94	95,936	248.62	93.8	16
Michigan	2,523	557,421	220.94	454,431	180.12	81.5	36,482
Missouri	927	230,222	248.25	191,585	206.59	83.2	—
New Mexico	1,042	404,026	387.67	346,044	332.03	85.7	11,043
Ohio	2,411	803,521	333.33	691,402	286.82	86.1	47,849
Texas	402	134,860	335.69	110,794	275.78	82.2	2,513
Utah	793	207,297	261.43	190,319	240.02	91.8	—
Washington	3,847	726,137	188.77	613,876	159.58	84.5	14,175
Wisconsin(2)	—	—	—	—	—	—	—
Other(3)(4)	—	12,774	—	37,957	—	—	57
	16,466	$ 3,660,207	$ 222.24	$ 3,176,236	$ 192.85	86.8 %	$ 128,581

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

(4) As of December 31, 2009, our Nevada health plan no longer served members. Premium revenue and medical care costs for the Nevada health plan have been included in "Other."

Molina Medicaid Solutions Segment

Molina Medicaid Solutions contributed $2.6 million to operating income for the year ended December 31, 2010, but reported an operating loss of $3.6 million for the quarter ended December 31, 2010. The operating loss for the fourth quarter of 2010 was primarily the result of system stabilization costs incurred for two of Molina Medicaid Solutions' contracts.

Performance of the Molina Medicaid Solutions segment for the year ended December 31, 2010 was as follows:

	(In thousands)
Service revenue before amortization	$ 98,125
Amortization recorded as reduction of service revenue	(8,316)
Service revenue	89,809
Cost of service revenue	78,647
General and administrative costs	5,135
Amortization of customer relationship intangibles recorded as amortization	3,418
Operating income	$ 2,609

Consolidated Expenses and Other

General and Administrative Expenses

General and administrative expenses were $346.0 million, or 8.5% of total revenue, for the year ended December 31, 2010, compared with 276.0 million, or 7.5% of total revenue, for the year ended December 31, 2009. The increase in the G&A ratio was the result of higher administrative expenses for the Health Plans segment, driven in part by the cost of our Medicare expansion, higher variable compensation expense as a result of substantially improved financial performance in 2010, employee severance and settlement costs, and costs relating to the acquisitions of Molina Medicaid Solutions and the Wisconsin health plan.

Premium Tax Expense

Premium tax expense relating to Health Plans segment premium revenue was 3.5% of revenue for both years ended December 31, 2010, and 2009.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Year Ended December 31,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation, and amortization of capitalized software	$ 27,230	0.7 %	$ 25,172	0.7 %
Amortization of intangible assets	18,474	0.4	12,938	0.3
Depreciation and amortization reported as such in the consolidated statements of income	45,704	1.1	38,110	1.0
Amortization recorded as reduction of service revenue	8,316	0.2	—	—
Amortization of capitalized software recorded as cost of service revenue	6,745	0.2	—	—
Total	$ 60,765	1.5 %	$ 38,110	1.0 %

Interest Expense

Interest expense increased to $15.5 million for the year ended December 31, 2010, from $13.8 million for the year ended December 31, 2009. We incurred higher interest expense relating to the $105 million draw on our credit facility (beginning May 1, 2010) to fund the acquisition of Molina Medicaid Solutions. Amounts borrowed to fund this acquisition were repaid in the third quarter using proceeds from our equity offering in the third quarter of 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $5.1 million and $4.8 million for the years ended December 31, 2010 and 2009, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 38.6% for the year ended December 31, 2010, compared with 19.1% for the year ended December 31, 2009. The lower rate in 2009 was primarily due to discrete tax benefits recorded in 2009 as a result of settling tax examinations, and higher than previously estimated tax credits.

Acquisitions

Molina Center. On December 7, 2011, our wholly owned subsidiary Molina Center LLC closed on its acquisition of the 460,000 square foot office building located in Long Beach, California. The building, or Molina Center, consists of two conjoined fourteen-story office towers on approximately five acres of land. For the last several years we have leased approximately 155,000 square feet of the Molina Center for use as our corporate headquarters and also for use by our California health plan subsidiary. The final purchase price was $81 million, which amount was paid with a combination of cash on hand and bank financing under a term loan agreement. We acquired this business primarily to facilitate space needs for the projected future growth of the Company.

Molina Medicaid Solutions. On May 1, 2010, we acquired a health information management business which we operate under the name, *Molina Medicaid Solutions*℠ as described in Overview, above.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2011, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $5.5 million for the year ended December 31, 2011, compared with $6.3 million for the year ended December 31, 2010. Our annualized portfolio yields for the years ended December 31, 2011, 2010, and 2009 were 0.6%, 0.7%, and 1.2%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the year ended December 31, 2011 was $225.4 million compared with $161.4 million for the year ended December 31, 2010, an increase of $64.0 million. This increase was primarily due to the change in deferred revenue. In 2011, deferred revenue was a use of cash amounting to $8.2 million, compared with $41.9 million in 2010.

Cash provided by financing activities decreased due to $111.1 million of net proceeds from our common stock offering in the third quarter of 2010, offset by the $48.6 million borrowed under a term loan used to purchase the Molina Center in 2011.

Reconciliation of Non-GAAP (1) to GAAP Financial Measures

EBITDA (2)

	Year Ended December 31,	
	2011	2010
	(In thousands)	
Net income	$ 20,818	$ 54,970
Add back:		
Depreciation and amortization reported in the consolidated statements of cash flows	74,383	60,765
Interest expense	15,519	15,509
Provision for income taxes	43,836	34,522
EBITDA	$ 154,556	$ 165,766

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At December 31, 2011, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $23.6 million, compared with approximately $65.1 million of cash and investments at December 31, 2010. This decline was primarily due to a capital contribution to our Texas health plan in the fourth quarter of 2011 and cash paid to acquire the Molina Center.

On a consolidated basis, at December 31, 2011, we had working capital of $446.2 million compared with $392.4 million at December 31, 2010. At December 31, 2011 we had cash and investments of $893.0 million, compared with $813.8 million of cash and investments at December 31, 2010.

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see discussion of “Convertible Senior Notes” below). The repurchase program will be funded with working capital or draws under our credit facility (see discussion of “Credit Facility” below).

On July 27, 2011, our board of directors approved a stock repurchase program of up to $7 million to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Under this program, we purchased approximately 400,000 shares of our common stock for $7 million (average cost of approximately $17.47 per share) during August 2011. These purchases did not materially impact diluted earnings per share for the year ended December 31, 2011. Subsequently, we retired the $7.0 million of treasury shares purchased, which reduced additional paid-in capital as of December 31, 2011.

We believe that our cash resources, Credit Facility, and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility will be used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of December 31, 2011, there was no outstanding principal balance under the Credit Facility. However, as of December 31, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million as required under the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduced the amount available under the Credit Facility by $10.3 million.

Borrowings under the Credit Facility will bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The initial commitment fee shall be set at 0.35% until our delivery of its financials for the year ended December 31, 2011. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of not less than 1.75 to 1.00. At December 31, 2011, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

In connection with our entrance into the Credit Facility, on September 9, 2011, we terminated our existing credit agreement with Bank of America, dated March 9, 2005, as amended to date, which had provided us with a $150 million revolving credit facility.

Convertible Senior Notes

As of December 31, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") were outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Term Loan

On December 7, 2011, our wholly owned subsidiary, Molina Center LLC, entered into a Term Loan Agreement, dated as of December 1, 2011, with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the approximately 460,000 square foot office building, now named "Molina Center," located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the rate of 4.25% per annum from the date of the closing of the loan through December 31, 2011, and at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commences on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. We have agreed to pay to the Administrative Agent a loan fee in the amount of $486,000 and an agency fee of $50,000. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $492.4 million at December 31, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2011, our health plans had aggregate statutory capital and surplus of approximately $509.9 million compared with the required minimum aggregate statutory capital and surplus of approximately $265.7 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2011. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;
- The recognition of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and;
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. Premium revenues are recognized in the month that members are entitled to receive health care services.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

- *California Health Plan Medical Cost Floors (Minimums):* A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At December 31, 2011, we recorded a liability of $1.0 million under the terms of these contract provisions.

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premiums received by our New Mexico health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). The New Mexico health plan contract also contains certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2011, we had not recorded any liability under the terms of these contract provisions. In the fourth quarter of 2011, our New Mexico health plan entered into a contract amendment that more closely aligns the calculation of revenue with the methodology adopted under the Affordable Care Act. The contract amendment changed the calculation of the amount of revenue that may be recognized relative to medical costs, and resulted in the recognition of approximately $5.6 million of premium revenue which all related to periods prior to 2011.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. The rebates, if any, are calculated separately for the TANF/CHIP and ABD products. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had an aggregate liability of approximately $0.7 million accrued pursuant to our profit-sharing agreement with the state of Texas at December 31, 2011.

- *Medicare Revenue Risk Adjustment:* Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member

requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a receivable of approximately $5.0 million for anticipated Medicare risk adjustment premiums at December 31, 2011.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. Effective February 1, 2010 through June 30, 2011, we were eligible to earn additional incremental revenue of up to 0.25% of our total premium if we met certain pharmacy specific performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Under our contract with the state of Texas, incremental revenue of up to 1% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state. The time period for the assessment of these performance measures previously followed the state's fiscal year, but effective January 1, 2011, it follows the calendar year. However, during 2011 the state of Texas notified us that it had discontinued the program for the 2011 calendar year. We anticipate that the program will be reinstituted in 2012.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2011 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2011.

	Year Ended December 31, 2011				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,271	$ 1,558	$ 378	$ 1,936	$ 345,732
Ohio	10,212	8,363	3,501	11,864	988,896
Texas	—	—	—	—	409,295
Wisconsin	1,705	542	—	542	69,596
	$ 14,188	$ 10,463	$ 3,879	$ 14,342	$ 1,813,519

	Year Ended December 31, 2010				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,581	$ 1,311	$ 579	$ 1,890	$ 366,784
Ohio	9,881	3,114	(1,248)	1,866	860,324
Texas	1,771	1,771	—	1,771	188,716
	$ 14,233	$ 6,196	$ (669)	$ 5,527	$ 1,415,824

	Year Ended December 31, 2009				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,378	$ 1,097	$ (171)	$ 926	$ 404,026
Ohio	7,040	5,715	937	6,652	803,521
Texas	1,322	1,322	—	1,322	134,860
	$ 10,740	$ 8,134	$ 766	$ 8,900	$ 1,342,407

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple–Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting and because we are unable to determine a pattern of performance of services during the contract period, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. We began to recognize revenue associated with our Maine contract upon state acceptance in September 2010. In Idaho, we will begin recognition of revenue upon state acceptance.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly

associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the MMIS in that state receives certification from CMS. For the year ended December 31, 2011, cost of service revenue includes $11.5 million of direct costs associated with the Idaho contract that would otherwise have been recorded as deferred contract costs. In assessing the recoverability of the deferred contract costs associated with the Idaho contract during 2011, we determined that these costs should be expensed as a period cost.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	December 31,		
	2011	2010	2009
	(In thousands)		
Fee-for-service claims incurred but not paid (IBNP)	$ 301,020	$ 275,259	$ 246,508
Capitation payable	53,532	49,598	39,995
Pharmacy	26,178	14,649	20,609
Other	21,746	14,850	8,204
	$ 402,476	$ 354,356	$ 315,316

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $301.0 million of our total medical claims and benefits payable of $402.5 million as of December 31, 2011. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at December 31, 2011, was $294.9 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2011 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2011, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ 119,317
(4%)	79,598
(2%)	39,799
2%	(39,799)
4%	(79,598)
6%	(119,317)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2011 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ (69,169)
(4%)	(46,113)
(2%)	(23,056)
2%	23,056
4%	46,113
6%	69,169

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 46.4 million diluted shares outstanding for the year ended December 31, 2011. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2011, net income for the year ended December 31, 2011 would increase or decrease by approximately $12.4 million, or $0.27 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2011, net income for the year ended December 31, 2011 would increase or decrease by approximately $7.2 million, or $0.16 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $62.2 million, or $1.34 per diluted share, and $36.0 million, or $0.78 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $12.4 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2011, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 14.6%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2010 and 2011 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized a benefit from prior period claims development in the amount of $51.8 million for the year ended December 31, 2011. This amount represents our estimate as of December 31, 2011 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2010 was due primarily to the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010, partially offsetting the impact of the two items above.

We recognized a benefit from prior period claims development in the amount of $49.4 million for the year ended 2010. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at December 31, 2011, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The increasing amount of claims recoveries in Texas.
- Recent increases in inpatient utilization in Missouri, as well as a substantial increase in inpatient claims inventory.
- A significant reduction to our outstanding claims recoveries in Ohio.
- An increase to our ABD membership in California.
- Late enrollment of newborns, and hence late claims payments, in Michigan due to issues with the state’s administration system, which has disrupted the normal completion pattern for claims in that state.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2010 and 2011, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "Components of medical care costs related to: Prior year" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year ended December 31,	
	2011	2010
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of period	$ 354,356	$ 315,316
Balance of acquired subsidiary	—	3,228
Components of medical care costs related to:		
Current year	3,911,803	3,420,235
Prior year	(51,809)	(49,378)
Total medical care costs	3,859,994	3,370,857
Payments for medical care costs related to:		
Current year	3,516,994	3,085,388
Prior year	294,880	249,657
Total paid	3,811,874	3,335,045
Balances at end of year	$ 402,476	$ 354,356
Benefit from prior years as a percentage of:		
Balance at beginning of year	14.6%	15.7%
Premium revenue	1.1%	1.2%
Total medical care costs	1.3%	1.5%
Claims Data (1):		
Days in claims payable, fee for service	40	42
Number of members at end of period	1,697,000	1,613,000
Number of claims in inventory at end of period	111,100	143,600
Billed charges of claims in inventory at end of period	$ 207,600	$ 218,900
Claims in inventory per member at end of period	0.07	0.09
Billed charges of claims in inventory per member end of period	$ 122.33	$ 135.71
Number of claims received during the period	17,207,500	14,554,800
Billed charges of claims received during the period	$ 14,306,500	$ 11,686,100

(1) "Claims Data" for the year ended December 31, 2010 does not include our Wisconsin health plan acquired September 1, 2010.

Commitments and Contingencies

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 18 to the accompanying audited consolidated financial statements for the year ended December 31, 2011.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2011. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2012	2013-2014	2015-2016	2017 and Beyond
Medical claims and benefits payable	$ 402,476	$ 402,476	$ —	$ —	$ —
Principal amount of long-term debt(1)	235,600	1,197	189,361	2,568	42,474
Operating leases	101,424	25,553	40,936	22,338	12,597
Interest on long-term debt	32,527	9,061	16,267	3,788	3,411
Purchase commitments	33,595	19,845	12,142	1,608	—
Total contractual obligations	$ 805,622	$ 458,132	$ 258,706	$ 30,302	$ 58,482

(1) Represents the principal amount due on our 3.75% Convertible Senior Notes due 2014, and our term loan due 2018.

As of December 31, 2011, we have recorded approximately $10.7 million of unrecognized tax benefits. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 13 to the accompanying audited consolidated financial statements for the year ended December 31, 2011 for further information.

Item 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2011 and 2010, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2011. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2011 and 2010, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2011, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 29, 2012 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 29, 2012

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31, 2011	2010
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 493,827	$ 455,886
Investments	336,916	295,375
Receivables	167,898	168,190
Income tax refundable	11,679	—
Deferred income taxes	18,327	15,716
Prepaid expenses and other current assets	19,435	25,050
Total current assets	1,048,082	960,217
Property, equipment, and capitalized software, net	190,934	100,537
Deferred contract costs	54,582	28,444
Intangible assets, net	101,796	105,500
Goodwill and indefinite-lived intangible assets	153,954	212,228
Auction rate securities	16,134	20,449
Restricted investments	46,164	42,100
Receivable for ceded life and annuity contracts	23,401	24,649
Other assets	17,099	15,090
	$ 1,652,146	$ 1,509,214
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 402,476	$ 354,356
Accounts payable and accrued liabilities	147,214	137,930
Deferred revenue	50,947	60,086
Income taxes payable	—	13,176
Current maturities of long-term debt	1,197	—
Total current liabilities	601,834	565,548
Long-term debt	216,929	164,014
Deferred income taxes	33,127	16,235
Liability for ceded life and annuity contracts	23,401	24,649
Other long-term liabilities	21,782	19,711
Total liabilities	897,073	790,157
Stockholders' equity (1):		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 45,815 shares at December 31, 2011 and 45,463 shares at December 31, 2010	46	45
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	266,022	251,612
Accumulated other comprehensive loss	(1,405)	(2,192)
Retained earnings	490,410	469,592
Total stockholders' equity	755,073	719,057
	$ 1,652,146	$ 1,509,214

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2011	2010	2009
	(In thousands, except per-share data)		
Revenue:			
Premium revenue	$ 4,603,407	$ 3,989,909	$ 3,660,207
Service revenue	160,447	89,809	—
Investment income	5,539	6,259	9,149
Rental income	547	—	—
Total revenue	4,769,940	4,085,977	3,669,356
Expenses:			
Medical care costs	3,859,994	3,370,857	3,176,236
Cost of service revenue	143,987	78,647	—
General and administrative expenses	415,932	345,993	276,027
Premium tax expenses	154,589	139,775	128,581
Depreciation and amortization	50,690	45,704	38,110
Total operating costs and expenses	4,625,192	3,980,976	3,618,954
Impairment of goodwill and intangible assets	(64,575)	—	—
Gain on purchase of convertible senior notes	—	—	1,532
Operating income	80,173	105,001	51,934
Interest expense	15,519	15,509	13,777
Income before income taxes	64,654	89,492	38,157
Provision for income taxes	43,836	34,522	7,289
Net income	$ 20,818	$ 54,970	$ 30,868
Net income per share (1):			
Basic	$ 0.45	$ 1.34	$ 0.80
Diluted	0.45	1.32	0.79
Weighted average shares outstanding (1):			
Basic	45,756	41,174	38,765
Diluted	46,425	41,631	38,976

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock (1)		Additional Paid-in	Accumulated Other	Retained	Treasury	
	Outstanding	Amount	Capital (1)	Comprehensive Loss	Earnings	Stock	Total
				(In thousands)			
Balance at January 1, 2009	40,087	$ 40	$ 170,668	$ (2,310)	$ 383,754	$ (20,390)	$ 531,762
Comprehensive income:							
Net income	—	—	—	—	30,868	—	30,868
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	498	—	—	498
Total comprehensive income	—	—	—	498	30,868	—	31,366
Purchase of treasury stock	—	—	—	—	—	(27,712)	(27,712)
Retirement of treasury stock	(2,028)	(2)	(48,100)	—	—	48,102	—
Retirement of convertible debt	—	—	(476)	—	—	—	(476)
Employee stock grants and employee stock plan purchases	351	—	8,516	—	—	—	8,516
Tax deficiency from employee stock compensation	—	—	(718)	—	—	—	(718)
Balance at December 31, 2009	38,410	38	129,890	(1,812)	414,622	—	542,738
Comprehensive income:							
Net income	—	—	—	—	54,970	—	54,970
Other comprehensive loss, net of tax:							
Unrealized loss on investments	—	—	—	(380)	—	—	(380)
Total comprehensive income				(380)	54,970		54,590
Common stock issued, net of issuance costs	6,525	7	111,124	—	—	—	111,131
Employee stock grants and employee stock plan purchases	528	—	11,271	—	—	—	11,271
Tax deficiency from employee stock compensation	—	—	(673)	—	—	—	(673)
Balance at December 31, 2010	45,463	45	251,612	(2,192)	469,592	—	719,057
Comprehensive income:							
Net income	—	—	—	—	20,818	—	20,818
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	787	—	—	787
Total comprehensive income				787	20,818		21,605
Purchase of treasury stock	—	—	—	—	—	(7,000)	(7,000)
Retirement of treasury stock	(400)	—	(7,000)	—	—	7,000	—
Employee stock grants and employee stock plan purchases	752	1	20,473	—	—	—	20,474
Tax benefit from employee stock compensation	—	—	937	—	—	—	937
Balance at December 31, 2011	45,815	$ 46	$ 266,022	$ (1,405)	$ 490,410	$ —	$ 755,073

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Operating activities:			
Net income	$ 20,818	$ 54,970	$ 30,868
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	74,383	60,765	38,110
Deferred income taxes	13,836	(4,092)	(1)
Stock-based compensation	17,052	9,531	7,485
Non-cash interest on convertible senior notes	5,512	5,114	4,782
Impairment of goodwill and intangible assets	64,575	—	—
Gain on purchase of convertible senior notes	—	—	(1,532)
Amortization of premium/discount on investments	7,242	2,029	—
Amortization of deferred financing costs	2,818	1,780	1,872
Gain on acquisition	(1,676)	—	—
Unrealized gain on trading securities	—	(4,170)	(3,394)
Loss on rights agreement	—	3,807	3,100
Tax deficiency from employee stock compensation	(714)	(968)	(749)
Changes in operating assets and liabilities:			
Receivables	352	(7,539)	(8,092)
Prepaid expenses and other current assets	3,308	(12,034)	383
Medical claims and benefits payable	48,120	34,363	22,874
Accounts payable and accrued liabilities	2,778	40,482	(26,467)
Deferred revenue	(8,154)	(41,899)	88,181
Income taxes	(24,855)	19,258	(2,049)
Net cash provided by operating activities	225,395	161,397	155,371
Investing activities:			
Purchases of equipment	(60,581)	(48,538)	(35,870)
Purchases of investments	(345,968)	(302,842)	(186,764)
Sales and maturities of investments	302,667	223,077	204,365
Net cash paid in business combinations	(84,253)	(130,743)	(11,294)
Increase in deferred contract costs	(42,830)	(29,319)	—
(Increase) decrease in restricted investments	(4,064)	(5,566)	1,928
Change in other noncurrent assets and liabilities	(1,898)	5,108	(10,078)
Net cash used in investing activities	(236,927)	(288,823)	(37,713)
Financing activities:			
Amount borrowed under term loan	48,600	—	—
Amount borrowed under credit facility	—	105,000	—
Proceeds from common stock offering, net of issuance costs	—	111,131	—
Repayment of amount borrowed under credit facility	—	(105,000)	—
Treasury stock purchases	(7,000)	—	(27,712)
Purchase of convertible senior notes	—	—	(9,653)
Credit facility fees paid	(1,125)	(1,671)	—
Proceeds from employee stock plans	7,347	4,056	2,015
Excess tax benefits from employee stock compensation	1,651	295	31
Net cash provided by (used in) financing activities	49,473	113,811	(35,319)
Net increase (decrease) in cash and cash equivalents	37,941	(13,615)	82,339
Cash and cash equivalents at beginning of period	455,886	469,501	387,162
Cash and cash equivalents at end of period	$ 493,827	$ 455,886	$ 469,501

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Supplemental cash flow information:			
Cash paid during the period for:			
Income taxes	$ 54,663	$ 18,299	$ 23,480
Interest	$ 11,399	$ 10,951	$ 8,205
Schedule of non-cash investing and financing activities:			
Retirement of treasury stock	$ 7,000	$ —	$ 48,102
Details of business combinations:			
Increase in fair value of assets acquired	$ (81,256)	$ (159,916)	$ (34,594)
(Decrease) increase in fair value of liabilities assumed	(1,045)	24,450	—
Release of deposit	—	—	18,000
(Decrease) increase in payable to seller	(1,952)	4,723	5,300
Net cash paid in business combinations	$ (84,253)	$ (130,743)	$ (11,294)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. As of December 31, 2011, these health plans served approximately 1.7 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that our Missouri health plan was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, our Missouri health plan's existing contract with the state will expire without renewal on June 30, 2012. In connection with this notification, we recorded a non-cash impairment charge of approximately $64.6 million, or $1.34 per diluted share. Most of the impairment charge is not tax deductible, resulting in a disproportionate impact to net income. For the year ended December 31, 2011, our Missouri health plan contributed premium revenue of $229.6 million, or 5% of total premium revenue, and comprised 79,000 members, or 4.7% of total Health Plans segment membership. For further discussion of the impairment charge, see Note 2, "Significant Accounting Policies."

Our Molina Medicaid Solutions segment, which we acquired during the second quarter of 2010, provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement Medicaid Management Information System, or MMIS, to another firm. Our revenue under the Louisiana MMIS contract from May 1, 2010, the date we acquired Molina Medicaid Solutions, through December 31, 2010, was approximately $32 million. For the year ended December 31, 2011, our revenue under the Louisiana MMIS contract was approximately $57 million. We expect that we will continue to perform under this contract through implementation and acceptance of the successor MMIS. Based upon our past experience and our knowledge of the Louisiana MMIS bid process, we believe that implementation and acceptance of the successor MMIS will not occur until 2014 at the earliest. Through implementation and acceptance of the successor MMIS we expect to recognize between $45 million and $50 million in revenue annually under our Louisiana MMIS contract.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. See Note 18, "Commitments and Contingencies," for the discussion of a financing arrangement classified as a variable interest entity that is included in our consolidated financial statements. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- Health plan contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract;
- Health plan quality incentives that allow us to recognize incremental revenue if certain quality standards are met;

- The determination of medical claims and benefits payable of our Health Plans segment;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Adjustments and Reclassifications

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

We have reclassified certain prior year balance sheet amounts to conform to the 2011 presentation.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis.

Our investment policy requires that all of our investments have final maturities of five years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be two years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. Our auction rate securities are classified as non-current assets. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," Note 6, "Investments" and Note 10, "Restricted Investments."

Receivables

Receivables consist primarily of amounts due from the various states in which we operate, and are subject to potential retroactive adjustment. Because such receivables are readily determinable and our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables." Additionally, we cede 100% of the financial responsibility for Medicare members covered by our Wisconsin health plan to third a party health reinsurer. In connection with the arrangement, as of December 31, 2011, we have recorded a receivable from the third party reinsurer of $3.0 million along with a corresponding current liability of $3.0 million.

Property, Equipment, and Capitalized Software

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 25 to 31.5 years. See Note 8, "Property, Equipment, and Capitalized Software."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Year Ended December 31,		
	2011	2010	2009
	(Dollar amounts in thousands)		
Depreciation, and amortization of capitalized software	$ 30,864	$ 27,230	$ 25,172
Amortization of intangible assets	19,826	18,474	12,938
Depreciation and amortization reported as such in the consolidated statements of income	50,690	45,704	38,110
Amortization recorded as reduction of service revenue	6,822	8,316	—
Amortization of capitalized software recorded as cost of service revenue	16,871	6,745	—
Total	$ 74,383	$ 60,765	$ 38,110

Long-Lived Assets, including Intangible Assets

Long-lived assets comprise primarily property, equipment, capitalized software and intangible assets. Finite-lived, separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at their fair values and are then amortized on a straight-line basis over their expected useful lives, generally between one and 15 years.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships as follows:

- The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to the acquisition. Because each acquired contract constitutes a single revenue stream, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a straight-line basis for each specific contract over periods generally ranging from one to six years.

- The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed as in the case of our Missouri health plan, described below.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

On February 17, 2012, we received notification that our Missouri health plan's existing contract with the state of Missouri will expire without renewal on June 30, 2012. In connection with this notification, we recorded a total non-cash impairment charge of $64.6 million in 2011, of which $6.1 million related to finite-lived intangible assets, and $58.5 million related to goodwill, discussed below. Because the existing contract expires without renewal on June 30, 2012, the impairment charge comprised substantially all intangible assets relating to contract rights and licenses, and provider networks recorded at the time of our acquisition of the Missouri health plan in 2007. As described in Note 19, "Segment Reporting," the Missouri health plan is a component of our Health Plans segment. No impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2010, and 2009.

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount.

To determine whether goodwill is impaired, we perform an impairment test. We measure the fair values of our reporting units and compare them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows. To determine fair values, we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

In connection with our Missouri health plan as described above, we recorded a non-cash impairment charge of $58.5 million in 2011. Because the existing contract expires without renewal on June 30, 2012, the impairment charge comprised all of the goodwill recorded at the time of our acquisition of the Missouri health plan in 2007. The goodwill impairment charge is not tax deductible. No impairment charges relating to goodwill were recorded in the years ended December 31, 2010, and 2009.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Receivable/Liability for Ceded Life and Annuity Contracts

We report a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. See Note 22, "Subsequent Events."

Other Assets

Significant items included in other assets include deferred financing costs associated with our convertible senior notes and with our credit facility, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see Note 17, "Related Party Transactions"). The deferred financing costs are being amortized on a straight-line basis over the seven-year term of the convertible senior notes and the five year term of the credit facility.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2011, or December 31, 2010.

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2011 we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue by health plan for the periods indicated:

	Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
California	$ 575,176	$ 506,871	$ 481,717
Florida	203,945	170,683	102,232
Michigan	662,127	630,134	557,421
Missouri	229,584	210,852	230,222
New Mexico	345,732	366,784	404,026
Ohio	988,896	860,324	803,521
Texas	409,295	188,716	134,860
Utah	287,290	258,076	207,297
Washington	823,323	758,849	726,137
Wisconsin(1)	69,596	30,033	—
Other	8,443	8,587	12,774
	$ 4,603,407	$ 3,989,909	$ 3,660,207

(1) We acquired the Wisconsin health plan on September 1, 2010.

For the year ended December 31, 2010, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates. The components of premium revenue subject to estimation fall into two categories:

Contractual provisions that may limit revenue based upon the costs incurred or the profits realized under a specific contract. These are contractual provisions that require the health plan to return premiums to the extent that certain thresholds are not met. In some instances premiums are returned when medical costs fall below a certain percentage of gross premiums; or when administrative costs or profits exceed a certain percentage of gross premiums. In other instances, premiums are partially determined by the acuity of care provided to members (risk adjustment). To the extent that our expenses and profits change from the amounts previously reported (due to changes in estimates) our revenue earned for those periods will also change. In all of these instances our revenue is only subject to estimate due to the fact that the thresholds themselves contain elements (expense or profit) that are subject to estimate. While we have adequate experience and data to make sound estimates of our expenses or profits, changes to those estimates may be necessary, which in turn will lead to changes in our estimates of revenue. In general, a change in estimate relating to expense or profit would offset any related change in estimate to premium, resulting in no or small impact to net income. The following contractual provisions fall into this category:

- *California Health Plan Medical Cost Floors (Minimums):* A portion of certain premiums received by our California health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs. At December 31, 2011, we recorded a liability of $1.0 million under the terms of these contract provisions.
- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premiums received by our Florida health plan may be returned to the state if certain minimum amounts are not spent on defined behavioral health care costs. At December 31, 2011, we had not recorded any liability under the terms of this contract provision since behavioral health expenses are not less than the contractual floor.
- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premiums received by our New Mexico health plan may be returned to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). The New Mexico health plan contract also contains certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2011, we had not recorded any liability under the terms of these contract provisions. In the fourth quarter of 2011, our New Mexico health

plan entered into a contract amendment that more closely aligns the calculation of revenue with the methodology adopted under the Affordable Care Act. The contract amendment changed the calculation of the amount of revenue that may be recognized relative to medical costs, and resulted in the recognition of approximately $5.6 million of premium revenue which all related to periods prior to 2011.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas, there is a profit-sharing agreement under which we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. The rebates, if any, are calculated separately for the TANF/CHIP and ABD products. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As a result of profits in excess of the amount we are allowed to fully retain, we had an aggregate liability of approximately $0.7 million accrued pursuant to our profit-sharing agreement with the state of Texas at December 31, 2011.

- *Medicare Revenue Risk Adjustment:* Based on member encounter data that we submit to CMS, our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a receivable of approximately $5.0 million for anticipated Medicare risk adjustment premiums at December 31, 2011.

Quality incentives that allow us to recognize incremental revenue if certain quality standards are met. These are contract provisions that allow us to earn additional premium revenue in certain states if we achieve certain quality-of-care or administrative measures. We estimate the amount of revenue that will ultimately be realized for the periods presented based on our experience and expertise in meeting the quality and administrative measures as well as our ongoing and current monitoring of our progress in meeting those measures. The amount of the revenue that we will realize under these contractual provisions is determinable based upon that experience. The following contractual provisions fall into this category:

New Mexico Health Plan Quality Incentive Premiums: Under our contract with the state of New Mexico, incremental revenue of up to 0.75% of our total premium is earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care and administrative measures dictated by the state.

Ohio Health Plan Quality Incentive Premiums: Under our contract with the state of Ohio, incremental revenue of up to 1% of our total premium is earned if certain performance measures are met. Effective February 1, 2010 through June 30, 2011, we are eligible to earn additional incremental revenue of up to 0.25% of our total premium if we meet certain pharmacy specific performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

Texas Health Plan Quality Incentive Premiums: Under our contract with the state of Texas, incremental revenue of up to 1% of our total premium may be earned if certain performance measures are met. These performance measures are generally linked to various quality-of-care measures established by the state. The time period for the assessment of these performance measures previously followed the state's fiscal year, but effective January 1, 2011, it follows the calendar year. The state of Texas has notified us that it has discontinued the program for the 2011 calendar year.

Wisconsin Health Plan Quality Incentive Premiums: Under our contract with the state of Wisconsin, effective beginning in 2011, up to 3.25% of the premium is withheld by the state. The withheld premiums can be earned by the health plan by meeting certain performance measures. These performance measures are generally linked to various quality-of-care measures dictated by the state.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2011 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2011.

	Year Ended December 31, 2011				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,271	$ 1,558	$ 378	$ 1,936	$ 345,732
Ohio	10,212	8,363	3,501	11,864	988,896
Texas	—	—	—	—	409,295
Wisconsin	1,705	542	—	542	69,596
	$ 14,188	$ 10,463	$ 3,879	$ 14,342	$ 1,813,519

	Year Ended December 31, 2010				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,581	$ 1,311	$ 579	$ 1,890	$ 366,784
Ohio	9,881	3,114	(1,248)	1,866	860,324
Texas	1,771	1,771	—	1,771	188,716
	$ 14,233	$ 6,196	$ (669)	$ 5,527	$ 1,415,824

	Year Ended December 31, 2009				
	Maximum Available Quality Incentive Premium – Current Year	Amount of Current Year Quality Incentive Premium Revenue Recognized	Amount of Quality Incentive Premium Revenue Recognized from Prior Year	Total Quality Incentive Premium Revenue Recognized	Total Revenue Recognized
	(In thousands)				
New Mexico	$ 2,378	$ 1,097	$ (171)	$ 926	$ 404,026
Ohio	7,040	5,715	937	6,652	803,521
Texas	1,322	1,322	—	1,322	134,860
	$ 10,740	$ 8,134	$ 766	$ 8,900	$ 1,342,407

Medical Care Costs

Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. Most hospitals are paid on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. As discussed below, we also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed per-member per-month, or PMPM, payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed

in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2011, 2010, and 2009, medically related administrative costs were approximately $102.3 million, $85.5 million, and $74.6 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2011			2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 2,764,309	$ 139.02	$ 71.6 %	$ 2,360,858	$ 128.73	$ 70.0 %	$ 2,077,489	$ 126.14	$ 65.4 %
Capitation	518,835	26.09	13.4	555,487	30.29	16.5	558,538	33.91	17.6
Pharmacy	418,007	21.02	10.8	325,935	17.77	9.7	414,785	25.18	13.1
Other	158,843	8.00	4.2	128,577	7.01	3.8	125,424	7.62	3.9
Total	$ 3,859,994	$ 194.13	$ 100.0 %	$ 3,370,857	$ 183.80	$ 100.0 %	$ 3,176,236	$ 192.85	$ 100.0 %

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates. See Note 11, “Medical Claims and Benefits Payable.”

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Our California, Florida, Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in premium tax expense.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2011, or 2010.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support and maintenance. We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element. As such, we have concluded that our Molina Medicaid Solutions contracts are multiple-element service arrangements under the scope of FASB Accounting Standards Codification Subtopic 605-25, *Revenue Recognition — Multiple–Element Arrangements,* and SEC Staff Accounting Bulletin Topic 13, *Revenue Recognition*.

Effective January 1, 2011, we adopted a new accounting standard that amends the guidance on the accounting for multiple-element arrangements. Pursuant to the new standard, each required deliverable is evaluated to determine whether it qualifies as a separate unit of accounting which is generally based on whether the deliverable has standalone value to the customer. In addition to standalone value, previous guidance also required objective and reliable evidence of fair value of a deliverable in order to treat the deliverable as a separate unit of accounting. The arrangement's consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent. We have adopted this guidance on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Our adoption of this guidance has not impacted the timing or pattern of our revenue recognition in 2011. Also, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. For contracts entered into prior to January 1, 2011, objective and reliable evidence of fair value would be required, in addition to DDI standalone value which we do not have, in order to treat DDI as a separate unit of accounting. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the service provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize revenue associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts. We began to recognize revenue associated with our Maine contract upon state acceptance in September 2010. In Idaho, we will begin recognition of revenue upon state acceptance.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs
- Employee costs incurred in performing transaction services
- Vendor costs incurred in performing transaction services
- Costs incurred in performing required monitoring of and reporting on contract performance
- Costs incurred in maintaining and processing member and provider eligibility
- Costs incurred in communicating with members and providers

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the MMIS in that state receives certification from CMS. For the year ended December 31, 2011, cost of service revenue includes $11.5 million of direct costs associated with the Idaho contract that would otherwise have been recorded as deferred contract costs. In assessing the recoverability of the deferred contract costs associated with the Idaho contract at December 31, 2011, we determined that these costs should be expensed as a period cost.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers. For further discussion and disclosure, see Note 13, “Income Taxes.”

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2011, and 2010, our investments with PFM totaled $209 million and $327 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2011, we operated health plans in 10 states, primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements

Goodwill Impairment Testing. The FASB issued the following guidance which modifies goodwill impairment testing.

- ASU No. 2011-08, Intangibles—Goodwill and Other (ASC Topic 350) — Testing Goodwill for Impairment, a consensus of the FASB Emerging Issues Task Force. This guidance allows an entity the option to first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. Under that option, an entity would no longer be required to calculate the fair value of a reporting unit unless the entity determines, based on the qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. This guidance is effective for interim and annual goodwill impairment tests performed for fiscal years beginning after December 15, 2011. We do not expect the adoption of this guidance to impact our consolidated financial position, results of operations, or cash flows.

Presentation of Financial Statements. In June 2011, the FASB and International Accounting Standards Board, or IASB, issued the following guidance which modifies how other comprehensive income, or OCI, is reported under U.S. Generally Accepted Accounting Principles, or GAAP, and International Financial Reporting Standards, or IFRS.

- *ASU No. 2011-05, Comprehensive Income (ASC Topic 220) — Presentation of Comprehensive Income,* a consensus of the FASB Emerging Issues Task Force. This guidance eliminates the option to present components of OCI as part of the statement of changes to stockholders' equity. All filers are required to present all non-owner changes in stockholders' equity in a single statement of comprehensive income or in two separate but consecutive statements. This guidance is effective for interim and annual reporting beginning on or after December 15, 2011. We do not expect the adoption of this guidance to impact our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	December 31,		
	2011	2010	2009
	(In thousands)		
Shares outstanding at the beginning of the period	45,463	38,410	40,088
Weighted-average number of shares issued under equity offering	—	2,506	—
Weighted-average number of shares purchased	(160)	—	(1,482)
Weighted-average number of shares issued under employee stock plans	453	258	159
Denominator for basic earnings per share	45,756	41,174	38,765
Dilutive effect of employee stock options and stock grants(1)	669	457	211
Denominator for diluted earnings per share(2)	46,425	41,631	38,976

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2011, 2010, and 2009 there were approximately 137,000, 478,000 and 620,000 antidilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2011, 2010, and 2009, anti-dilutive restricted shares were insignificant.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the years ended December 31, 2011, 2010, and 2009.

4. Business Combinations

Molina Center

On December 7, 2011, our wholly owned subsidiary Molina Center LLC closed on its acquisition of the 460,000 square foot office building located in Long Beach, California. The building, or Molina Center, consists of two conjoined fourteen-story office towers on approximately five acres of land. For the last several years we have leased approximately 155,000 square feet of the Molina Center for use as our corporate headquarters and also for use by our California health plan subsidiary. The final purchase price was $81 million, which amount was paid with a combination of cash on hand and bank financing under a term loan agreement (see Note 12, “Long-Term Debt”). This business combination included the acquisition of the business interests associated with the Molina Center, such as leases to third-party tenants in place as of the acquisition date, and the day-to-day management and operations of the Molina Center. We acquired this business primarily to facilitate space needs for the projected future growth of the Company.

We have recorded $0.5 million in rental income in 2011 since the acquisition date. We incurred approximately $2.3 million and $0.2 million in transaction costs relating to this acquisition in 2011 and 2010, respectively, recorded to general and administrative expenses. Additionally, we recorded $0.6 million in deferred loan costs that are being amortized over the seven-year term of the loan.

Recording of assets acquired: The transaction has been accounted for using the acquisition method of accounting which requires, among other things, that most assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date. The following table summarizes the acquisition-date fair values of the assets acquired as of December 7, 2011 (in thousands):

Allocation of purchase price:	
Building and improvements	$ 43,116
Land	10,570
Identifiable intangible assets	28,990
	82,676
Less fair value of total consideration:	
Cash paid	32,400
Term loan	48,600
Gain on acquisition	$ 1,676

A single estimate of fair value results from a complex series of judgments about future events and uncertainties and relies heavily on estimates and assumptions. Results that differ from the estimates and judgments used to determine the estimated fair value assigned to each class of assets acquired, as well as asset lives, can materially impact our results of operations.

Building and improvements: The fair value of the building amounted to $42.9 million, and will be amortized over a remaining useful life of 25 years. The fair value of improvements amounted to $0.2 million, to be amortized over a remaining useful life of 5 years.

Identifiable intangible assets: The fair value of the identifiable intangible assets we acquired amounted to $29.0 million, and was attributable to the value assigned to in-place leases of the Molina Center as of the acquisition date. This intangible asset has a weighted average useful life of 6.4 years. Accumulated amortization was approximately $0.4 million as of December 31, 2011, which reflects total amortization recorded since the acquisition date. For identifiable intangible assets recorded as of December 31, 2011, we expect to record amortization in future years as follows — 2012: $5.7 million, 2013: $5.6 million, 2014: $3.8 million, 2015: $3.5 million, and 2016: $3.1 million.

Gain on acquisition: In this acquisition, the fair value of the assets acquired exceeded the fair value of the total consideration paid by $1.7 million, resulting in a bargain purchase gain. This gain was recorded to general and administrative expenses in the accompanying consolidated income statement.

Wisconsin Health Plan

On September 1, 2010, we acquired 100% of the voting equity interests in Avatar Partners, LLC, which was the sole shareholder of Abri Health Plan, Inc., a Medicaid managed care organization based in Milwaukee, Wisconsin. Based on the final membership reconciliation performed in the first quarter of 2011, the final purchase price increased to $16.8 million as of December 31, 2011, from $15.5 million as of December 31, 2010. The $1.3 million increase was recorded to goodwill in 2011.

Additionally, we recorded a $2.8 million liability for contingent consideration in December 2010, based on an estimate of the Wisconsin health plan's minimum surplus requirements as of February 1, 2011. This liability was measured at fair value on a recurring basis using significant unobservable inputs, or Level 3 in the fair value measurement hierarchy. In 2011, we determined that there was no liability for contingent consideration. The following table presents a roll forward of this liability for 2011:

	Fair Value Hierarchy Level 3 (In thousands)
Balance at December 31, 2010	$ (2,800)
Total gains included in earnings	2,800
Balance at December 31, 2011	$ —

Molina Medicaid Solutions

On May 1, 2010, we acquired Molina Medicaid Solutions, previously an operating unit of Unisys Corporation for a purchase price of $131.3 million. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems. In the first quarter of 2011, we recorded a $1.0 million reduction to goodwill to adjust certain acquisition date accruals as a result of information obtained regarding facts and circumstances that existed as of the acquisition date.

Florida Health Plan

On December 31, 2009, we acquired 100% of the voting equity interests in Florida NetPASS, LLC, or NetPASS. The final purchase price for this acquisition totalled $29.6 million. In 2010 we entered into arbitration with the sellers of NetPASS regarding certain alleged breaches of contract. That arbitration was settled prior to final hearing in December 2011 for $4.1 million paid to the sellers. This amount is recorded to general and administrative expenses in the accompanying consolidated income statements.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

As described in Note 12, “Long-Term Debt,” the carrying amount of the convertible senior notes was $169.5 million and $164.0 million as of December 31, 2011 and 2010, respectively. Based on quoted market prices, the fair value of the convertible senior notes was approximately $192.0 million and $188.4 million as of December 31, 2011 and 2010, respectively. The carrying value of the term loan approximates fair value because of the short period of time between the loan origination date of December 7, 2011 and December 31, 2011.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 securities consist of government-sponsored enterprise securities (GSEs) and U.S. treasury notes. Level 1 securities are classified as current investments in the accompanying consolidated balance sheets. These securities are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 securities consist of corporate debt securities, municipal securities, and certificates of deposit, and are classified as current investments in the accompanying consolidated balance sheets. Our investments in securities classified as Level 2 are traded frequently though not necessarily daily. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* We hold investments in auction rate securities which are designated as available-for-sale, and are reported at fair value of $16.1 million (par value of $19.0 million) as of December 31, 2011. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2011. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, 2009, and 2010, and continued to be unavailable as of December 31, 2011. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining the fair value of the auction rate securities as of December 31, 2011. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As a result of changes in the fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized gains of $1.2 million and pretax unrealized losses of $0.2 million to accumulated other comprehensive loss for the year ended December 31, 2011, and 2010, respectively. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income (loss). If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Until July 2, 2010, we held certain auction rate securities (designated as trading securities) with an investment securities firm. In 2008, we entered into a rights agreement with this firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. On June 30, 2010, and July 1, 2010, all of the eligible auction rate securities remaining at that time were settled at par value. During 2010, the aggregate auction rate securities (designated as trading securities) settled amounted to $40.9 million par value (fair value $36.7 million). Substantially all of the difference between par value and fair value on these securities was recovered through the rights agreement. For the year ended December 31, 2010, we recorded pretax gains of $4.2 million on the auction rate securities underlying the Rights.

We accounted for the Rights as a freestanding financial instrument and, until July 2, 2010, recorded the value of the Rights under the fair value option. For the year ended December 31, 2010, we recorded pretax losses of $3.8 million on the Rights, attributable to the decline in the fair value of the Rights. When the remaining eligible auction rate securities were sold at par value on July 1, 2010, the value of the Rights was zero.

Our assets measured at fair value on a recurring basis at December 31, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 231,634	$ —	$ 231,634	$ —
Government-sponsored enterprise securities (GSEs)	33,949	33,949	—	—
Municipal securities	47,313	—	47,313	—
U.S. treasury notes	21,748	21,748	—	—
Auction rate securities	16,134	—	—	16,134
Certificates of deposit	2,272	—	2,272	—
	$ 353,050	$ 55,697	$ 281,219	$ 16,134

Our assets measured at fair value on a recurring basis at December 31, 2010, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 177,929	$ —	$ 177,929	$ —
Government-sponsored enterprise securities (GSEs)	59,713	59,713	—	—
Municipal securities	30,563	—	30,563	—
U.S. treasury notes	23,918	23,918	—	—
Auction rate securities	20,449	—	—	20,449
Certificates of deposit	3,252	—	3,252	—
	$ 315,824	$ 83,631	$ 211,744	$ 20,449

In prior periods we reported our investments in corporate debt securities, municipal securities and certificates of deposit in Level 1. As a result of analysis of the characteristics of our financial instruments in 2011, we have determined that these investments should be reported in Level 2, and have reclassified the tabular disclosure accordingly.

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3) (In thousands)
Balance at December 31, 2010	$ 20,449
Total gains (unrealized only):	
Included in other comprehensive income	1,235
Settlements	(5,550)
Balance at December 31, 2011	$ 16,134
The amount of total unrealized gains for the period included in other comprehensive income attributable to the change in accumulated other comprehensive losses relating to assets still held at December 31, 2011	$ 483

Our assets measured at fair value on a non-recurring basis in 2011, consisted of the goodwill and intangible assets associated with the acquisition of our Missouri health plan in 2007. As described in Note 1, "Basis of Presentation – Organization and Operations" we recorded a non-cash impairment charge of $64.6 million related to the loss of our Missouri health plan's existing contract with the state of Missouri. To arrive at this impairment charge, we conducted fair value measurements of the goodwill and intangible assets of our Missouri health plan. We used Level 3 inputs in applying an income approach to determining the fair value of these assets.

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 231,407	$ 442	$ 215	$ 231,634
GSEs	33,912	46	9	33,949
Municipal securities	47,099	232	18	47,313
U.S. treasury notes	21,627	121	—	21,748
Auction rate securities	19,000	—	2,866	16,134
Certificates of deposit	2,272	—	—	2,272
	$ 355,317	$ 841	$ 3,108	$ 353,050

	December 31, 2010			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 177,692	$ 419	$ 182	$ 177,929
GSEs	59,386	353	26	59,713
Municipal securities	30,483	111	31	30,563
U.S. treasury notes	23,836	118	36	23,918
Auction rate securities	24,550	—	4,101	20,449
Certificates of deposit	3,252	—	—	3,252
	$ 319,199	$ 1,001	$ 4,376	$ 315,824

The contractual maturities of our investments as of December 31, 2011 are summarized below:

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 183,607	$ 183,775
Due one year through five years	153,210	153,573
Due after ten years	18,500	15,702
	$ 355,317	$ 353,050

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $302.7 million, $182.3 million, and $201.9 million for the year ended December 31, 2011, 2010, and 2009, respectively. Net realized investment gains for the year ended December 31, 2011, 2010, and 2009 were $367,000, $110,000, and $267,000, respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our auction rate securities, we have determined that unrealized gains and losses at December 31, 2011, and 2010, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

As described in Note 5, "Fair Value Measurements," the unrealized losses on our auction rate securities were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at December 31, 2011.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2011.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 72,766	$ 215	$ —	$ —	$ 72,766	$ 215
GSEs	11,493	9	—	—	11,493	9
Municipal securities	12,033	18	—	—	12,033	18
Auction rate securities	—	—	16,134	2,866	16,134	2,866
	$ 96,292	$ 242	$ 16,134	$ 2,866	$ 112,426	$ 3,108

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2010.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 55,578	$ 167	$ 1,848	$ 14	$ 57,426	$ 181
GSEs	7,244	26	—	—	7,244	26
Municipal securities	12,629	31	—	—	12,629	31
Auction rate securities	—	—	20,449	4,101	20,449	4,101
U.S. treasury notes	3,414	37	—	—	3,414	37
	$ 78,865	$ 261	$ 22,297	$ 4,115	$ 101,162	$ 4,376

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	December 31,	
	2011	2010
	(In thousands)	
Health Plans segment:		
California	$ 22,175	$ 46,482
Michigan	8,864	13,596
Missouri	27,092	22,841
New Mexico	9,350	18,310
Ohio	27,458	21,622
Texas	1,608	1,221
Utah	2,825	1,589
Washington	15,006	14,486
Wisconsin	4,909	5,437
Others	2,489	2,377
Total Health Plans segment	121,776	147,961
Molina Medicaid Solutions segment	46,122	20,229
	$ 167,898	$ 168,190

During the second quarter of 2011, we settled certain claims we had made against the state of Utah regarding the savings share provision of our contract in effect from 2003 through June of 2009. Additionally, we recognized a liability for certain overpayments received from the state for the period 2003 through 2009. As a result of these developments, we recognized $6.9 million in premium revenue without any corresponding charge to expense during the second quarter of 2011.

8. Property, Equipment, and Capitalized Software

A summary of property and equipment is as follows:

	December 31,	
	2011	2010
	(In thousands)	
Land	$ 14,094	$ 3,524
Building and improvements	109,789	49,735
Furniture and equipment	79,112	60,074
Capitalized software	116,389	90,003
	319,384	203,336
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(65,518)	(54,341)
Less: accumulated amortization for capitalized software	(62,932)	(48,458)
	(128,450)	(102,799)
Property, equipment, and capitalized software, net	$ 190,934	$ 100,537

Depreciation recognized for building and improvements, and furniture and equipment was $17.5 million, $13.9 million, and $11.0 million for the years ended December 31, 2011, 2010 and 2009, respectively. Amortization of capitalized software was $30.2 million, $20.1 million, and $14.2 million for the years ended December 31, 2011, 2010 and 2009, respectively.

Molina Center

As described in Note 4, "Business Combinations," we acquired the Molina Center in December 2011. As of December 31, 2011, the carrying amount of the building was $42.9 million, and accumulated depreciation was insignificant. Future minimum rentals on noncancelable leases are as follows:

	(In thousands)
2012	$ 5,943
2013	6,053
2014	4,395
2015	4,545
2016	4,749
Thereafter	32,310
Total minimum future rentals	$ 57,995

9. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 10 years, for customer relationships is approximately 5 years, for backlog is approximately 2 years, and for provider networks is approximately 10 years. Based on the balances of our identifiable intangible assets as of December 31, 2011, we estimate that our intangible asset amortization will be $22.2 million in 2012, $21.6 million in 2013, $16.9 million in 2014, $9.7 million in 2015, and $8.8 million in 2016. The following table provides the details of identified intangible assets, by major class, for the periods indicated. As described in Note 2, "Significant Accounting Policies," we recorded impairment charges to goodwill and intangible assets amounting to $58.5 million and $6.1 million, respectively, for the year ended December 31, 2011. For a description of our goodwill and intangible assets by reportable segment, refer to Note 19, "Segment Reporting."

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses	$ 140,242	$ 69,515	$ 70,727
Customer relationships	24,550	8,546	16,004
Contract backlog	23,600	15,139	8,461
Provider networks	11,990	5,386	6,604
Balance at December 31, 2011	$ 200,382	$ 98,586	$ 101,796
Intangible assets:			
Contract rights and licenses	$ 121,017	$ 64,201	$ 56,816
Customer relationships	24,550	3,418	21,132
Contract backlog	23,600	8,316	15,284
Provider networks	18,525	6,257	12,268
Balance at December 31, 2010	$ 187,692	$ 82,192	$ 105,500

The changes in the carrying amount of goodwill and indefinite-lived intangible assets were as follows (in thousands):

Balance as of December 31, 2010	$ 212,228
Impairment of Missouri health plan goodwill	(58,530)
Goodwill adjustments relating to the acquisitions of Molina Medicaid Solutions and the Wisconsin health plan	256
Balance at December 31, 2011	$ 153,954

10. Restricted Investments

Pursuant to the regulations governing our health plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of restricted investments by health plan, and for our insurance company:

	December 31,	
	2011	2010
	(In thousands)	
California	$ 372	$ 372
Florida	5,198	4,508
Insurance Company	4,711	4,689
Michigan	1,000	1,000
Missouri	504	508
New Mexico	15,905	15,881
Ohio	9,078	9,066
Texas	3,518	3,501
Utah	2,895	1,279
Washington	151	151
Wisconsin	—	260
Other	2,832	885
	$ 46,164	$ 42,100

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2011 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 36,900	$ 36,909
Due one year through five years	9,264	9,307
	$ 46,164	$ 46,216

11. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2011 and 2010. The negative amounts displayed for "Components of medical care costs related to: Prior years" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2011	2010
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of year	$ 354,356	$ 315,316
Balance of acquired subsidiary	—	3,228
Components of medical care costs related to:		
Current year	3,911,803	3,420,235
Prior years	(51,809)	(49,378)
Total medical care costs	3,859,994	3,370,857
Payments for medical care costs related to:		
Current year	3,516,994	3,085,388
Prior years	294,880	249,657
Total paid	3,811,874	3,335,045
Balances at end of year	$ 402,476	$ 354,356
Benefit from prior years as a percentage of:		
Balance at beginning of year	14.6%	15.7%
Premium revenue	1.1%	1.2%
Total medical care costs	1.3%	1.5%

We recognized a benefit from prior period claims development in the amount of $51.8 million for the year ended December 31, 2011. This amount represents our estimate as of December 31, 2011 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2010 was due primarily to the following factors:

- We overestimated the impact of a buildup in claims inventory in Ohio.
- We overestimated the impact of the settlement of disputed provider claims in California.
- We underestimated the reduction in outpatient facility claims costs as a result of a fee schedule reduction in New Mexico effective November 2010, partially offsetting the impact of the two items above.

We recognized a benefit from prior period claims development in the amount of $49.4 million for the year ended 2010. This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at December 31, 2011, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The increasing amount of claims recoveries in Texas.
- Recent increases in inpatient utilization in Missouri, as well as a substantial increase in inpatient claims inventory.
- A significant reduction to our outstanding claims recoveries in Ohio.
- An increase to our aged blind and disabled membership in California.
- Late enrollment of newborns, and hence late claims payments, in Michigan due to issues with the State’s administration system, which has disrupted the normal completion pattern for claims in that state.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2010 and 2011, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

12. Long-Term Debt

Maturities of long-term debt for the years ending December 31 are as follows:

	Total	2012	2013	2014	2015	2016	Thereafter
Convertible senior notes	$ 187,000	$ —	$ —	$ 187,000	$ —	$ —	$ —
Term loan	48,600	1,197	1,155	1,206	1,259	1,309	42,474
	$ 235,600	$ 1,197	$ 1,155	$ 188,206	$ 1,259	$ 1,309	$ 42,474

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility will be used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of December 31, 2011 there was no outstanding principal balance under the Credit Facility. However, as of December 31, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility will bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The initial commitment fee shall be set at 0.35% until our delivery of its financials for the year ended December 31, 2011. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of not less than 1.75 to 1.00. At December 31, 2011, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

In connection with our entrance into the Credit Facility, on September 9, 2011, we terminated our existing credit agreement with Bank of America, dated March 9, 2005, as amended to date, which had provided us with a $150 million revolving credit facility. As of December 31, 2011 and December 31, 2010, there was no outstanding principal balance under this credit agreement.

Term Loan

On December 7, 2011, our wholly owned subsidiary Molina Center LLC entered into a Term Loan Agreement, dated as of December 1, 2011, with various lenders and East West Bank, as Administrative Agent (the "Administrative Agent"). Pursuant to the terms of the Term Loan Agreement, Molina Center LLC borrowed the aggregate principal amount of $48.6 million to finance a portion of the $81 million purchase price for the acquisition of the approximately 460,000 square foot office building, or Molina Center, located in Long Beach, California.

The outstanding principal amount under the Term Loan Agreement bears interest at the rate of 4.25% per annum from the date of the closing of the loan through December 31, 2011, and at the Eurodollar rate for each Interest Period (as defined below) commencing January 1, 2012. The Eurodollar rate is a per annum rate of interest equal to the greater of (a) the rate that is published in the Wall Street Journal as the London interbank offered rate for deposits in United States dollars, for a period of one month, two business days prior to the commencement of an Interest Period, multiplied by a statutory reserve rate established by the Board of Governors of the Federal Reserve System, or (b) 4.25%. The loan matures on November 30, 2018, and is subject to a 25-year amortization schedule that commences on January 1, 2012.

The Term Loan Agreement contains customary representations, warranties, and financial covenants. In the event of a default as described in the Term Loan Agreement, the outstanding principal amount under the Term Loan Agreement will bear interest at a rate 5.00% per annum higher than the otherwise applicable rate. We have agreed to pay to the Administrative Agent a loan fee in the amount of $486,000 and an agency fee of $50,000. All amounts due under the Term Loan Agreement and related loan documents are secured by a security interest in the Molina Center in favor of and for the benefit of the Administrative Agent and the other lenders under the Term Loan Agreement.

Convertible Senior Notes

As of December 31, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of December 31, 2011, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 33 months. The Notes' if-converted value did not exceed their principal amount as of December 31, 2011. At December 31, 2011, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	December 31,	
	2011	2010
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(17,474)	(22,986)
Net carrying amount	$ 169,526	$ 164,014

	Years Ended December 31,		
	2011	2010	2009
	(in thousands)		
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate of 3.75%	$ 7,012	$ 7,012	$ 7,076
Amortization of the discount on the liability component	5,512	5,114	4,782
Total interest cost recognized	$ 12,524	$ 12,126	$ 11,858

13. Income Taxes

The provision for income taxes consisted of the following:

	Years Ended December 31,		
	2011	2010	2009
	(in thousands)		
Current:			
Federal	$ 28,336	$ 36,395	$ 9,421
State	1,639	2,144	(1,558)
Total current	29,975	38,539	7,863
Deferred:			
Federal	14,028	(4,717)	1,924
State	(167)	700	(2,498)
Total deferred	13,861	(4,017)	(574)
Total provision for income taxes	$ 43,836	$ 34,522	$ 7,289

A reconciliation of the effective income tax rate to the statutory federal income tax rate is as follows:

	Years Ended December 31,		
	2011	2010	2009
	(in thousands)		
Taxes on income at statutory federal tax rate (35)%	$ 22,630	$ 31,323	$ 13,355
State income taxes, net of federal benefit	957	1,849	(2,637)
Benefit for unrecognized tax benefits	(396)	(57)	(3,315)
Nondeductible goodwill	20,485	—	—
Other	160	1,407	(114)
Reported income tax expense	43,836	34,522	7,289

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California enterprise zone credits.

During 2011, excess tax benefits from shared-based compensation were $937,000. This amount was recorded as a decrease to income taxes payable and an increase to additional paid-in capital. During 2010 and 2009, tax-related deficiencies on share-based compensation were $673,000 and $718,000, respectively. Such amounts were recorded as adjustments to income taxes payable with a corresponding decrease to additional paid-in capital.

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2011 and 2010 were as follows:

	December 31,	
	2011	2010
	(in thousands)	
Accrued expenses	$ 14,541	$ 12,618
Reserve liabilities	1,292	877
State taxes	(396)	(120)
Other accrued medical costs	2,051	2,126
Net operating losses	27	27
Unrealized gains	(316)	(254)
Unearned premiums	4,139	3,517
Prepaid expenses	(3,032)	(3,006)
Other, net	21	(69)
Deferred tax asset, net of valuation allowance — current	18,327	15,716
Accrued expenses	223	791
Reserve liabilities	3,015	3,071
State tax credit carryover	2,609	1,960
Net operating losses	2,694	1,362
Unrealized losses	1,176	1,559
Depreciation and amortization	(39,939)	(20,110)
Deferred compensation	7,904	6,829
Debt basis	(7,604)	(9,673)
Other, net	(278)	(830)
Valuation allowance	(2,927)	(1,194)
Deferred tax liability, net of valuation allowance — long term	(33,127)	(16,235)
Net deferred income tax liability	$ (14,800)	$ (519)

At December 31, 2011, we had federal and state net operating loss carryforwards of $397,000 and $57 million, respectively. The federal net operating loss begins expiring in 2018, and state net operating losses begin expiring in 2013. The utilization of the net operating losses is subject to certain limitations under federal law.

At December 31, 2011, we had California enterprise zone tax credit carryovers of $4 million which do not expire.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2011, $2.9 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state tax operating loss carryforwards. We increased our valuation allowance $1.7 million from $1.2 million at December 31, 2010 to $2.9 million as of December 31, 2011.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax

determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The rollforward of our unrecognized tax benefits is as follows:

	Years Ended December 31,		
	2011	2010	2009
	(in thousands)		
Gross unrecognized tax benefits at beginning of period	$ (10,962)	$ (4,128)	$ (11,676)
Increases in tax positions for prior years	(137)	(6,891)	(3,748)
Decreases in tax positions for prior years	—	—	6,804
Settlements	—	—	4,355
Lapse in statute of limitations	387	57	137
Gross unrecognized tax benefits at end of period	$ (10,712)	$ (10,962)	$ (4,128)

As of December 31, 2011, we had $10.7 million of unrecognized tax benefits of which $7.4 million, if fully recognized, would affect our effective tax rate. Approximately $8.4 million of the unrecognized tax benefits recorded at December 31, 2011 relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.9 million due the resolution to the state refund claim as well as the normal expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2011, December 31, 2010, and December 31, 2009, we had accrued $65,000, $82,000, and $75,000, respectively, for the payment of interest and penalties.

We may be subject to examination by the Internal Revenue Service (“IRS”) for calendar years 2008 through 2011. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Missouri, and Michigan, for the years 2004 through 2011. Our subsidiary, HCLB, entered into a closing agreement with the IRS in December 2009 that successfully concluded with certainty the IRS examination of HCLB for the year ended May 2006.

14. Stockholders’ Equity

Securities Repurchase Program. Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see Note 12, “Long-Term Debt”). The repurchase program will be funded with working capital or the Company’s credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No securities were purchased under this program in 2011.

In late July 2011, our board of directors approved a stock repurchase program of up to $7.0 million, to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Under this program, we purchased approximately 400,000 shares of our common stock for $7 million (average cost of approximately $17.47 per share) during August 2011. These purchases did not materially impact diluted earnings per share for the year ended December 31, 2011. Subsequently, we retired the $7.0 million of treasury shares purchased, which reduced additional paid-in capital as of December 31, 2011.

Stock Split. On April 27, 2011, we announced that our board of directors authorized a 3-for-2 stock split of our common stock to be effected in the form of a stock dividend of one share of our stock for every two shares outstanding. The dividend was distributed on May 20, 2011.

Stock Plans. In connection with the plans described in Note 16, “Share-Based Compensation,” we issued approximately 752,000 shares of common stock, net of shares used to settle employees’ income tax obligations, for the year ended December 31, 2011. Stock plan activity resulted in a $21.4 million increase to additional paid-in capital for the same period.

15. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $8.5 million, $5.9 million and $4.7 million in the years ended December 31, 2011, 2010, and 2009, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

16. Share-Based Compensation

In 2011, we adopted the 2011 Equity Incentive Plan (the "2011 Plan") , which provides for the award of stock options, restricted stock, performance shares, and stock bonuses to the company's officers, employees, directors, consultants, advisors, and other service providers. The 2011 Plan allows for the issuance of 4.5 million shares of common stock.

At December 31, 2011, we had employee equity incentives outstanding under three plans: (1) the 2011 Plan; (2) the 2002 Equity Incentive Plan (from which equity incentives are no longer awarded); and (3) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). On March 1, 2011, our chief executive officer, chief financial officer, and chief operating officer were awarded 150,000 shares, 112,500 shares, and 27,000 shares, respectively, of restricted stock with performance and service conditions. Each of the grants shall vest on March 1, 2012, provided that: (i) the Company's total operating revenue for 2011 is equal to or greater than $3.7 billion, and (ii) the respective officer continues to be employed by the Company as of March 1, 2012. In the event both vesting conditions are not achieved, the equity compensation awards shall lapse. As of December 31, 2011, we expect these awards to vest in full.

Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our employee stock purchase plan (the "ESPP"), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We issued 201,700 and 164,700 shares of our common stock under the ESPP during the years ended December 31, 2011 and 2010, respectively. In 2011, stockholders approved our 2011 ESPP, which superseded the 2002 Employee Stock Purchase Plan. The 2011 ESPP allows for the issuance of three million shares of common stock.

The following table illustrates the components of our stock-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2011		2010		2009	
	(In thousands)					
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Restricted stock awards	$ 15,914	$ 9,946	$ 8,007	$ 5,044	$ 5,789	$ 3,589
Stock options (including expense relating to our ESPP)	1,138	712	1,524	960	1,696	1,052
Total stock-based compensation expense	$ 17,052	$ 10,658	$ 9,531	$ 6,004	$ 7,485	$ 4,641

As of December 31, 2011, there was $14.2 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to recognize over a remaining weighted-average period of 1.8 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 6.6% as of December 31, 2011. As of December 31, 2011, there was no remaining unrecognized compensation expense related to unvested stock options.

Unvested restricted stock and restricted stock activity for the year ended December 31, 2011 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2010	1,253,624	$ 15.55
Granted	792,300	23.21
Vested	(520,071)	17.76
Forfeited	(89,971)	15.60
Unvested balance as of December 31, 2011	1,435,882	18.97

The total fair value of restricted shares granted during the year ended December 31, 2011, 2010, and 2009 was $18.4 million, $12.7 million, and $8.0 million, respectively. The total fair value of restricted shares vested during the year ended December 31, 2011, 2010, and 2009 was $12.2 million, $6.4 million, and $3.2 million, respectively.

Stock option activity for the year ended December 31, 2011 is summarized below:

	Shares	Weighted Average Grant Date Fair Value	Average Intrinsic Value (In thousands)	Weighted Average Remaining Contractual term (Years)
Stock options outstanding as of December 31, 2010	770,421	$ 20.39		
Exercised	(195,672)	18.82		
Forfeited	(21,700)	21.45		
Stock options outstanding as of December 31, 2011	553,049	20.91	$ 1,435	3.9
Stock options exercisable and expected to vest as of December 31, 2011	553,049	20.91	$ 1,435	3.9
Exercisable as of December 31, 2011	550,799	20.90	$ 1,435	3.9

The following is a summary of information about stock options outstanding and exercisable at December 31, 2011:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$11.32 – $19.11	231,861	3.2	$ 17.31	231,861	$ 17.31
$20.03 – $21.59	184,275	5.0	20.86	184,275	20.86
$21.72 – $29.53	136,913	3.7	27.07	134,663	27.13
	553,049			550,799	

17. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2011, and 2010 our carrying amount for this investment amounted to $3.9 million, and $3.8 million, respectively. For the years ended December 31, 2011, 2010, and 2009, we paid $24.3 million, $22.0 million, and $21.8 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Until October 2010, Pacific Hospital was owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $0.7 million, $1.0 million, and $0.7 million, for the years ended December 31, 2011, 2010 and 2009, respectively. As of October 2010, Pacific Hospital was no longer owned by Abrazos Healthcare, Inc. or any other related party to the Company.

18. Commitments and Contingencies

Leases

We lease office space, clinics, equipment, and automobiles under agreements that expire at various dates through 2018. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases consist of the following approximate amounts:

	(In thousands)
2012	$ 25,553
2013	22,425
2014	18,511
2015	14,544
2016	7,794
Thereafter	12,597
Total minimum lease payments	$ 101,424

Rental expense related to these leases amounted to $23.1 million, $25.1 million, and $20.8 million for the years ended December 31, 2011, 2010, and 2009, respectively.

Employment Agreements

In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which have been amended and restated as of December 31, 2009. These employment agreements had initial terms of one to three years and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for 18 months. If the executives are terminated for cause, no further payments are due under the contracts.

If termination occurs within two years following a change of control, the executives will receive two times their base salary and termination bonus, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for three years.

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered through our clinics in California, Virginia and Washington. Claims-made coverage under the policies for California and Washington is $1.0 million per occurrence with an annual aggregate limit of $3.0 million for Washington, beginning in 2010, and for California, each of the years ended December 31, 2011, 2010, and 2009. Claims-made coverage under the Virginia policy is $2.0 million per occurrence with an annual aggregate limit of $6.0 million for each of the years ended December 31, 2011 and 2010, and beginning July 1, 2008. We also carry claims-made managed care errors and omissions professional liability insurance for our health plan operations. This insurance is subject to a coverage limit of $15.0 million per occurrence and $15.0 million in the aggregate for each policy year.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $492.4 million at December 31, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2011, our health plans had aggregate statutory capital and surplus of approximately $509.9 million compared with the required minimum aggregate statutory capital and surplus of approximately $265.7 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2011. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

New Markets Tax Credit

During the fourth quarter of 2011 our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC, or Wells Fargo, its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC, or Investment Fund, and certain of Wells Fargo's affiliated Community Development Entities, or CDEs, in connection with our participation in the federal government's New Markets Tax Credit Program, or NMTC. The NMTC was established by Congress in 2000 to facilitate new or increased investments in businesses and real estate projects in low-income communities. The NMTC attracts investment capital to low-income communities by permitting investors to receive a tax credit against their federal income tax return in exchange for equity investments in specialized financial institutions called CDEs which provide financing to qualified active businesses operating in low-income communities. The credit totals 39 percent of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period.

In the fourth quarter of 2011, as a result of a series of simultaneous financing transactions, Wells Fargo made a capital contribution of $5.9 million in and Molina Healthcare, Inc. made a loan in the principal amount of $15.5 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $20.9 million to our New Mexico data center subsidiary. Wells Fargo will be entitled to claim the NMTC while we effectively received net loan proceeds equal to Wells Fargo contribution to the Investment Fund or approximately $5.9 million. Additionally, financing costs incurred in structuring the arrangement amounting to $1.2 million were deferred and will be recognized as expense over the term of the loans. This transaction also includes a put/call feature that becomes enforceable at the end of the seven-year compliance period. Wells Fargo may exercise its put option or we can exercise the call, both of which will serve to transfer the debt obligation to us. Incremental costs to maintain the structure during the compliance period will be recognized as incurred.

We have determined that the financing arrangement with Investment Fund and CDEs is a variable interest entity, or VIE, and that we are the primary beneficiary of the VIE. We reached this conclusion based on the following:

- The ongoing activities of the VIE—collecting and remitting interest and fees and NMTC compliance—were all considered in the initial design and are not expected to significantly affect economic performance throughout the life of the VIE;
- Contractual arrangements obligate us to comply with NMTC rules and regulations and provide various other guarantees to Investment Fund and CDEs;
- Wells Fargo lacks a material interest in the underling economics of the project; and
- We are obligated to absorb losses of the VIE.

Because we are the primary beneficiary of the VIE, we have included it in our consolidated financial statements. Wells Fargo's contribution of $5.9 million is included in cash at December 31, 2011 and the offsetting Wells Fargo interest in the financing arrangement is included in other liabilities in the accompanying consolidated balance sheets.

As described above, this transaction also includes a put/call provision whereby we may be obligated or entitled to repurchase Wells Fargo's interest in the Investment Fund. The value attributed to the put/call is nominal. The NMTC is subject to 100% recapture for a period of seven years as provided in the Internal Revenue Code and applicable U.S. Treasury regulations. We are required to be in compliance with various regulations and contractual provisions that apply to the NMTC arrangement. Non-compliance with applicable requirements could result in Wells Fargo's projected tax benefits not being realized and, therefore, require us to indemnify Wells Fargo for any loss or recapture of NMTCs related to the financing until such time as the recapture provisions have expired under the applicable statute of limitations. We do not anticipate any credit recaptures will be required in connection with this arrangement.

19. Segment Reporting

We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions. Our reportable segments are consistent with how we manage the business and view the markets we serve. Our Health Plans segment consists of our state health plans which serve Medicaid populations in ten states, and also includes our smaller direct delivery line of business. Our state health plans represent operating segments that have been aggregated for reporting purposes because they share similar economic characteristics.

Our Molina Medicaid Solutions segment provides design, development, implementation; business process outsourcing solutions; hosting services; and information technology support services to Medicaid agencies in an additional five states. The Molina Medicaid Solutions segment was added to our internal financial reporting structure when we acquired this business in the second quarter of 2010.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

Molina Medicaid Solutions was acquired on May 1, 2010; therefore, the year ended December 31, 2010 includes only eight months of operating results for this segment. Operating segment information is as follows:

	Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Segment Information:			
Revenue:			
Health Plans:			
Premium revenue	$ 4,603,407	$ 3,989,909	$ 3,660,207
Investment income	5,539	6,259	9,149
Rental income	547	—	—
Molina Medicaid Solutions:			
Service revenue	160,447	89,809	—
	$ 4,769,940	$ 4,085,977	$ 3,669,356
Depreciation and amortization:			
Health Plans	$ 45,734	$ 42,282	$ 38,110
Molina Medicaid Solutions	28,649	18,483	—
	$ 74,383	$ 60,765	$ 38,110
Operating Income:			
Health Plans	$ 78,110	$ 102,392	$ 51,934
Molina Medicaid Solutions	2,063	2,609	—
Total operating income	80,173	105,001	51,934
Interest expense	15,519	15,509	13,777
Income before income taxes	$ 64,654	$ 89,492	$ 38,157

	As of December 31,	
	2011	2010
Goodwill and intangible assets, net:		
Health Plans	$ 159,963	$ 208,945
Molina Medicaid Solutions	95,787	108,783
	$ 255,750	$ 317,728
Total assets:		
Health Plans	$ 1,425,764	$ 1,333,599
Molina Medicaid Solutions	226,382	175,615
	$ 1,652,146	$ 1,509,214

20. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2011 and 2010.

	For The Quarter Ended,			
	March 31, 2011	June 30, 2011	September 30, 2011	December 31, 2011
	(In thousands)			
Premium revenue	$ 1,081,438	$ 1,128,770	$ 1,138,230	$ 1,254,969
Service revenue	36,674	36,888	37,728	49,157
Operating income	31,300	31,410	33,566	(16,103)
Income before income taxes	27,697	27,727	29,186	(19,956)
Net income	17,388	17,440	18,950	(32,960)
Net income per share (1):				
Basic	$ 0.38	$ 0.38	$ 0.41	$ (0.72)
Diluted	$ 0.38	$ 0.38	$ 0.41	$ (0.72)

	For The Quarter Ended,			
	March 31, 2010	June 30, 2010	September 30, 2010	December 31, 2010
	(In thousands)			
Premium revenue	$ 965,220	$ 976,685	$ 1,005,115	$ 1,042,889
Service revenue	—	21,054	32,271	36,484
Operating income	20,438	21,178	29,953	33,432
Income before income taxes	17,081	17,079	25,353	29,979
Net income	10,590	10,579	16,173	17,628
Net income per share (1)(2):				
Basic	$ 0.28	$ 0.27	$ 0.38	$ 0.39
Diluted	$ 0.27	$ 0.27	$ 0.38	$ 0.39

(1) All applicable share and per-share amounts reflect retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

(2) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2011, and 2010.

21. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2011 and 2010, and our condensed statements of income and condensed statements of cash flows for each of the three years in the period ended December 31, 2011.

Condensed Balance Sheets

	December 31,	
	2011	2010
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 14,650	$ 57,020
Investments	2,010	2,000
Income tax refundable	14,126	1,928
Deferred income taxes	9,133	7,006
Due from affiliates	60,569	19,059
Prepaid and other current assets	10,467	11,009
Total current assets	110,955	98,022
Property and equipment, net	82,437	81,445
Goodwill	53,769	58,719
Auction rate securities	4,694	6,046
Investments in subsidiaries	740,345	702,096
Advances to related parties and other assets	32,473	16,397
	$ 1,024,673	$ 962,725
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 71,392	$ 56,910
Long-term debt	169,526	164,014
Deferred income taxes	16,909	8,425
Other long-term liabilities	11,773	14,319
Total liabilities	269,600	243,668
Stockholders' equity (1):		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding:		
45,815 shares at December 31, 2011 and 45,463 shares at December 31, 2010	46	45
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	266,022	251,612
Accumulated other comprehensive loss	(1,405)	(2,192)
Retained earnings	490,410	469,592
Total stockholders' equity	755,073	719,057
	$ 1,024,673	$ 962,725

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

Condensed Statements of Income

	Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Revenue:			
Management fees and other operating revenue	$ 308,287	$ 238,883	$ 218,911
Investment income	81	1,153	1,540
Total revenue	308,368	240,036	220,451
Expenses:			
Medical care costs	31,672	30,582	26,865
General and administrative expenses	272,302	218,834	160,792
Depreciation and amortization	31,355	27,166	25,223
Total expenses	335,329	276,582	212,880
Gain on purchase of convertible senior notes	—	—	1,532
Operating (loss) income	(26,961)	(36,546)	9,103
Interest expense	14,958	15,500	13,770
Loss before income taxes and equity in net income of subsidiaries	(41,919)	(52,046)	(4,667)
Income tax benefit	(14,826)	(16,936)	(3,755)
Net loss before equity in net income of subsidiaries	(27,093)	(35,110)	(912)
Equity in net income of subsidiaries	47,911	90,080	31,780
Net income	$ 20,818	$ 54,970	$ 30,868

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Operating activities:			
Cash provided by operating activities	$ 28,606	$ 19,380	$ 40,551
Investing activities:			
Net dividends from and capital contributions to subsidiaries	27,872	70,800	21,960
Purchases of investments	(2,020)	(2,019)	(3,844)
Sales and maturities of investments	3,760	14,083	12,669
Cash paid in business combinations	—	(139,762)	(2,894)
Purchases of equipment	(30,930)	(40,419)	(32,245)
Changes in amounts due to and due from affiliates	(50,090)	(5,723)	(17,074)
Change in other assets and liabilities	(20,441)	829	(540)
Net cash used in investing activities	(71,849)	(102,211)	(21,968)
Financing activities:			
Proceeds from common stock offering, net of issuance costs	—	111,131	—
Amount borrowed under credit facility	—	105,000	—
Repayment of amount borrowed under credit facility	—	(105,000)	—
Treasury stock repurchases	(7,000)	—	(27,712)
Purchase of convertible senior notes	—	—	(9,653)
Payment of credit facility fees	(1,125)	(1,671)	—
Excess tax benefits from employee stock compensation	1,651	295	31
Proceeds from exercise of stock options and employee stock plan purchases	7,347	4,056	2,015
Net cash provided by (used in) financing activities	873	113,811	(35,319)
Net (decrease) increase in cash and cash equivalents	(42,370)	30,980	(16,736)
Cash and cash equivalents at beginning of year	57,020	26,040	42,776
Cash and cash equivalents at end of year	$ 14,650	$ 57,020	$ 26,040

Notes to Condensed Financial Information of Registrant

Note A — Basis of Presentation

Molina Healthcare, Inc. (Registrant) was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The parent company-only financial statements should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B — Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2011, 2010, and 2009 for these services totaled $307.9 million, $238.5 million, and $218.6 million, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C — Capital Contribution and Dividends

During 2011, 2010, and 2009, the Registrant received dividends from its subsidiaries totaling $76.6 million, $81.3 million, and $76.7 million, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2011, 2010, and 2009, the Registrant made capital contributions to certain subsidiaries totaling $58.4 million, $10.5 million, and $54.7 million, respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D — Related Party Transactions

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because the Registrant has an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2010 and 2009, the Registrant's carrying amount for this investment totaled $3.9 million and $3.8 million, respectively. For the years ended December 31, 2011, 2010, and 2009, the Registrant paid $24.3 million, $22.0 million, and $21.8 million, respectively, for medical service fees to this provider.

The Registrant is a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Until October 2010, Pacific Hospital was owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $0.7 million, $1.0 million, and $0.7 million, for the years ended December 31, 2011, 2010, and 2009, respectively. As of October 2010, Pacific Hospital was no longer owned by Abrazos Healthcare, Inc. or any other related party to the Company.

22. Subsequent Events

Missouri Health Plan

On February 17, 2012, the Division of Purchasing of the Missouri Office of Administration notified us that we were not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal. As a result, our existing contract with the state will expire without renewal on June 30, 2012.

Molina Healthcare Insurance Company

Effective February 17, 2012, we sold our wholly owned insurance subsidiary, Molina Healthcare Insurance Company. To be recorded in the first quarter of 2012, the transaction will result in the elimination of both the noncurrent receivable and liability for ceded life and annuity contracts, each amounting to approximately $23.4 million as of December 31, 2011. Additionally, a gain of approximately $2 million is expected to be recorded upon closing of the transaction.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting that occurred during the quarter ended December 31, 2011, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2011. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework.*

Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2011, based on those criteria.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on page 110 of this Annual Report on Form 10-K, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2011.

Item 9B. ***Other Information***

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2011 and 2010, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2011 and our report dated February 29, 2012 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 29, 2012

PART III

Item 10. *Directors, Executive Officers, and Corporate Governance*

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our definitive proxy statement for our 2012 Annual Meeting of Stockholders. The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Election of Directors," "Corporate Governance," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Item 11. *Executive Compensation*

The information required by Items 402, 407(e)(4), and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Item 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference. The remaining information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Item 13. *Certain Relationships and Related Transactions, and Director Independence*

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

Item 14. *Principal Accountant Fees and Services*

The information required by Item 9(e) of Schedule 14A will be included under the heading "Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2012 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The Company's consolidated financial statements, the notes thereto and the report of the Independent Registered Public Accounting Firm are on pages 64 through 108 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets — At December 31, 2011 and 2010

Consolidated Statements of Income — Years ended December 31, 2011, 2010, and 2009

Consolidated Statements of Stockholders' Equity — Years ended December 31, 2011, 2010, and 2009

Consolidated Statements of Cash Flows — Years ended December 31, 2011, 2010, and 2009

Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 29 th day of February, 2012.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

EXHIBIT INDEX

Signature	Title	Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	February 29, 2012
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	February 29, 2012
/s/ Joseph W. White **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	February 29, 2012
/s/ Garrey E. Carruthers, Ph.D. **Garrey E. Carruthers, Ph.D.**	Director	February 29, 2012
/s/ Charles Z. Fedak **Charles Z. Fedak, CPA, MBA**	Director	February 29, 2012
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	February 29, 2012
/s/ Steven Orlando **Steven Orlando, CPA (inactive)**	Director	February 29, 2012
/s/ Sally K. Richardson **Sally K. Richardson**	Director	February 29, 2012
/s/ Ronna Romney **Ronna Romney**	Director	February 29, 2012
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	February 29, 2012

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

Number	Description	Method of Filing
2.1	Asset Purchase Agreement between Molina Healthcare, Inc. and Unisys Corporation dated as of January 18, 2010	Filed as Exhibit 2.1 to registrant's Form 8-K filed January 19, 2010.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.2 to registrant's Form 8-K filed February 17, 2009.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2007.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2007.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2007.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.4	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.5	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.6	2011 Equity Incentive Plan	Filed as Appendix A to registrant's Proxy Statement filed March 23, 2011.
10.7	2011 Employee Stock Purchase Plan	Filed as Appendix B to registrant's Proxy Statement filed March 23, 2011.
10.8	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.10	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.

Number	Description	Method of Filing
10.11	Form of Stock Option Agreement under Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.12	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.
10.13	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
10.14	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
10.15	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
10.16	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.17	Credit Agreement, dated as of September 9, 2011, among Molina Healthcare, Inc., as the Borrower, certain lenders, and U.S. Bank National Association, as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed September 13, 2011.
10.18	Term Loan Agreement, dated as of December 7, 2011, among Molina Center LLC, various lenders and East West Bank, as Administrative Agent	Filed herewith.
10.19	Guaranty, dated as of December 1, 2011, by Molina Healthcare, Inc. in favor of East West Bank, as Administrative Agent	Filed herewith.
10.20	Environmental Indemnity, dated as of December 1, 2011, by Molina Center LLC and Molina Healthcare, Inc. for the benefit of certain lenders and East West Bank, as Administrative Agent	Filed herewith.
10.21	Purchase Agreement, dated as of October 11, 2011, between Molina Center LLC and 200 Oceangate, LLC	Filed herewith.
10.22	First Amendment to Purchase Agreement, dated as of November 10, 2011, between Molina Center LLC and 200 Oceangate, LLC	Filed herewith.
10.23	Second Amendment to Purchase Agreement, dated as of November 30, 2011, between Molina Center LLC and 200 Oceangate, LLC	Filed herewith.
10.24	Hospital Services Agreement (fee-for-service) by and between Molina Healthcare of California, a California corporation, and Pacific Hospital of Long Beach	Filed as Exhibit 10.24 to registrant's Form 10-K filed March 16, 2010.
10.25	Hospital Services Agreement (capitation) by and between Molina Healthcare of California, a California corporation, and HealthSmart Pacific, Inc., dba Pacific Hospital of Long Beach	Filed as Exhibit 10.25 to registrant's Form 10-K filed March 16, 2010.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.

Number	Description	Method of Filing
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
101.INS	XBRL Taxonomy Instance Document.	To be furnished in a subsequent amendment to this Annual Report on Form 10-K.
101.SCH	XBRL Taxonomy Extension Schema Document.	To be furnished in a subsequent amendment to this Annual Report on Form 10-K.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.	To be furnished in a subsequent amendment to this Annual Report on Form 10-K.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.	To be furnished in a subsequent amendment to this Annual Report on Form 10-K.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.	To be furnished in a subsequent amendment to this Annual Report on Form 10-K.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.	To be furnished in a subsequent amendment to this Annual Report on Form 10-K.

Exhibit 10.18

TERM LOAN AGREEMENT

Dated as of December 1, 2011

among

MOLINA CENTER LLC

as Borrower,

EAST WEST BANK,

as Administrative Agent

and

EAST WEST BANK,
BANK OF CHINA, LOS ANGELES BRANCH,
CITY NATIONAL BANK,
UNION BANK, N.A.
and
THE BANK OF EAST ASIA (U.S.A.) N.A.

as Lenders

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EXHIBITS

SCHEDULES

TERM LOAN AGREEMENT

This TERM LOAN AGREEMENT, dated as of December 1, 2011 (the "Agreement"), is entered into by and among MOLINA CENTER LLC, a Delaware limited liability company ("Borrower"), EAST WEST BANK, a California banking corporation, as Administrative Agent (" Administrative Agent") and EAST WEST BANK, a California banking corporation, BANK OF CHINA, LOS ANGELES BRANCH, a federally chartered branch of Bank of China Limited, a joint stock company incorporated in the People's Republic of China with limited liability, CITY NATIONAL BANK, a national banking association, UNION BANK, N.A., a national banking association, and THE BANK OF EAST ASIA (U.S.A.) N.A., a national banking association, as Lenders (collectively, together with their assignees and successors permitted hereunder, " Lenders," and each a "Lender").

Administrative Agent, Lenders, and Borrower desire to enter into an agreement setting forth the terms and conditions under which Borrower may obtain from Lenders a term loan to finance its acquisition of certain real property in the City of Long Beach, California, improved with two office towers commonly known as the "Arco Towers."

In consideration of the foregoing and the mutual covenants and agreements herein contained, the parties hereto covenant and agree as follows:

ARTICLE 1
DEFINITIONS AND ACCOUNTING TERMS

1.1 Defined Terms. As used herein, the following terms shall have the meanings set forth below:

"Adjusted LIBOR Rate" means, with respect to any Interest Period, an interest rate per annum (rounded upwards, if necessary, to the next 1/16 of 1%) equal to (a) the LIBOR Rate for such Interest Period multiplied by (b) the Statutory Reserve Rate.

"Administrative Agent Advances " means advances which the Administrative Agent makes, from time to time, on behalf of Lenders, to pay any costs, fees and expenses as described herein or to pay costs reasonably deemed necessary by Administrative Agent in order to preserve or protect the Collateral or any portion thereof (including costs of property taxes, insurance premiums, completion of construction, operation, management, improvements, maintenance, repair, sale and disposition of any Foreclosed Real Property).

"Administrative Agent's Office" means Administrative Agent's address as set forth on the signature pages to this Agreement, or such other address as Administrative Agent hereafter may designate by written notice to Borrower.

"Advance" means a disbursement of principal of the Loan.

"Affected Lender" has the meaning set forth for that term in Section 2.14.

"Affiliate" means, as to any Person, any other Person which directly or indirectly controls, or is under common control with, or is controlled by, such Person. As used in this definition, "control" (and the correlative terms, "controlled by" and "under common control with") shall mean possession, directly or indirectly, of power to direct or cause the direction of management or policies (whether through ownership of securities or partnership or other membership or ownership interests, by contract or otherwise).

"Agreement" means this Term Loan Agreement, either as originally executed or as it may from time to time be supplemented, modified, amended, restated or extended.

"Applicable Margin" means 3.25%.

"Borrower" means Molina Center, LLC, a Delaware limited liability company.

"Business Day" means any Monday, Tuesday, Wednesday, Thursday or Friday, other than a day on which banks are authorized or required to be closed in California.

"Calculation Period" means the six (6) month period ending on the last day of the last month prior to the month in which a calculation of Debt Coverage is being made pursuant to Section 5.7(a).

"Capital Expenditure" means any expenditure by a Person for or related to fixed assets or purchased intangibles that is treated as a capital expenditure under GAAP, including any amount that is required to be treated as an asset subject to a Capital Lease Obligation. The amount of Capital Expenditures in respect of fixed assets purchased or constructed by a Person in any fiscal period shall be net of (a) any net sales proceeds received during such fiscal period by such Person for fixed assets sold by such Person and (b) any casualty insurance proceeds received during such fiscal period by such Person for casualties to fixed assets and applied to the repair or replacement thereof.

"Capital Lease Obligations" means all monetary obligations of a Person under any leasing or similar arrangement that, in accordance with GAAP, is classified as a capital lease.

"Cash" means, when used in connection with any Person, all monetary and non-monetary items owned by that Person that are treated as cash in accordance with GAAP.

"Cash Equivalents" means, when used in connection with any Person, such Person's Investments in:

(a) Government Securities, in each case due within one year after the date of the making of such an Investment;

(b) readily marketable direct obligations of any State of the United States of America or any political subdivision of any such State or any public agency or instrumentality thereof given on the date of such Investment a credit rating of at least Aa by Moody's Investors Service, Inc. or AA by Standard & Poor's Corporation, in each case due within one year after the date of the making of such an Investment;

(c) certificates of deposit issued by, bank deposits in, eurodollar deposits through, bankers' acceptances of, and reverse repurchase agreements covering Government Securities executed by, Lender or any other bank, savings and loan or savings bank doing business in and incorporated under the Laws of the United States of America or any State thereof and having on the date of such Investment combined capital, surplus and undivided profits of at least $250,000,000, in each case due within one year after the date of the making of such an Investment;

(d) certificates of deposit issued by, bank deposits in, eurodollar deposits through, bankers' acceptances of, and reverse repurchase agreements covering Government Securities executed by, any branch or office located in the United States of America of a bank incorporated under the Laws of any jurisdiction outside the United States of America having on the date of such Investment combined capital, surplus and undivided profits of at least $500,000,000, in each case due within one year after the date of the making of such an Investment; and

(e) readily marketable commercial paper of corporations doing business in and incorporated under the Laws of the United States of America or any State thereof given on the date of such Investment the highest credit rating by Moody's Investors Service, Inc. and Standard & Poor's Corporation, in each case due within 270 days after the date of the making of such an Investment.

"Change in Control" means an event or series of events by which:

(a) Borrower ceases to be wholly owned by Parent; or

(b) Parent ceases to control the management and day-to-day operations of Borrower.

"Closing Date" means the date upon which the conditions precedent set forth in Section 7.1 are fulfilled or waived by Lenders and the Loan are initially funded.

"Code" means the Internal Revenue Code of 1986, as amended or replaced and as in effect from time to time.

"Collateral" means, collectively, all of the collateral subject to the Liens, or intended to be subject to the Liens, created by the Collateral Documents, whether or not perfected.

"Collateral Documents" means, collectively, the Deed of Trust, this Agreement and any other security agreement, assignment, deed of trust, mortgage or similar instrument now or hereafter executed by any Loan Party to secure the Obligations.

"Commitment" means, as to any Lender, the amount set forth for that Lender in the Schedule of Commitments.

"Compliance Certificate" means a certificate in the form of Exhibit A.

"Contingent Obligation" means, as to any Person, any (a) direct or indirect guarantee of Indebtedness of, or other obligation performable by, any other Person, including any endorsement (other than for collection or deposit in the ordinary course of business), co-making or sale with recourse of the obligations of any other Person or (b) contractual assurance (not arising solely by operation of Law) given to an obligee with respect to the performance of an obligation by, or the financial condition of, any other Person, whether direct, indirect or contingent, including any purchase or repurchase agreement covering such obligation or any collateral security therefor, any agreement to provide funds (by means of loans, capital contributions or otherwise) to such other Person, any agreement to support the solvency or level of any balance sheet item to such other Person, or any other arrangement of whatever nature having the effect of assuring or holding harmless any obligee against loss with respect to any obligation of such other Person including without limitation any "keep-well", "take-or-pay" or "through put" agreement or arrangement. As of each date of determination, the amount of any Contingent Obligation shall be deemed to be an amount equal to the stated or determinable amount of the related primary obligation (unless the Contingent Obligation is limited by its terms to a lesser amount, in which case to the extent of such amount) or, if not stated or determinable, the maximum reasonably anticipated liability in respect thereof as determined by such Person in good faith.

"Contractual Obligation" means, as to any Person, any provision of any outstanding security issued by that Person or of any material agreement, instrument or undertaking to which that Person is a party or by which it or any of its Property is bound.

"DCR Collateral Account" means a deposit account which may be established in the name of Borrower and maintained with East West Bank under the circumstances described in Section 5.7(a).

"Debt Coverage Ratio" means the ratio of (a) Net Operating Income for the Calculation Period to (b) the sum (without duplication) of (i) Interest Charges during the Calculation Period plus (ii) principal payments on all Indebtedness that are required to be made during the Calculation Period; provided, that there shall be excluded from clauses (b) (i) and (b)(ii) all Interest Charges and scheduled principal payments on Indebtedness as to which the lenders' rights to receive payment are expressly subordinated to the right of the Lenders to receive payments of Debt Service and other payments on the Loan.

"Debt Service" means the actual principal and interest payable under the Loan during the applicable Calculation Period.

"Debtor Relief Laws" means the Bankruptcy Code of the United States of America, as amended from time to time, and all other applicable liquidation, conservatorship, bankruptcy, moratorium, rearrangement, receivership, insolvency, reorganization, or similar debtor relief Laws from time to time in effect and affecting the rights of creditors generally.

"Deed of Trust" means the Deed of Trust, Assignment of Rents and Fixture Filing of even date herewith executed by Borrower, as Trustor, in favor of Administrative Agent, for the benefit of the Secured Parties, as beneficiary, encumbering the Real Property, either as originally executed or as the same may from time to time be supplemented, modified, amended, renewed, extended or supplanted.

"Default" means any condition or event that, with the giving of any applicable notice or passage of time specified in Section 8.1, or both, would constitute an Event of Default.

"Default Rate" means the interest rate set forth in Section 2.5.

"Defaulting Lender" means a Lender that fails to pay its Pro Rata Share of a an Advance within three (3) Business Days after notice from Administrative Agent, until such Lender cures such failure as permitted in this Agreement.

"Designated Deposit Account" means deposit account number 8003018341 in the name of Borrower and maintained with East West Bank.

"Dollars" or "$" means United States dollars.

"East West Bank" means East West Bank, a California banking corporation.

"Environmental Indemnity" means the Environmental Indemnity of even date herewith by Borrower in favor of Lender, setting forth certain indemnification obligations relating to Hazardous Materials (as defined below), either as originally executed or as it may from time to time be supplemented, modified, amended, restated or extended.

"ERISA" means the Employee Retirement Income Security Act of 1974, and any regulations issued pursuant thereto, as amended or replaced and as in effect from time to time.

"ERISA Affiliate" means any Person (whether or not incorporated) that is required to be aggregated with a Borrower pursuant to Section 414 of the Code.

"Eurodollar Principal" means any principal of the Loan as to which interest is accruing at the Eurodollar Rate or at a Default Rate calculated with reference to the Eurodollar Rate.

"Eurodollar Rate" means, with respect to an Interest Period, a per annum rate of interest equal to the greater of (a) Adjusted LIBOR Rate for such Interest Period plus the Applicable Margin, or (b) 4.25%.

"Event of Default" has the meaning specified in Section 8.1.

"Fiscal Quarter" means the fiscal quarter of Borrower consisting of a three-month fiscal period ending on each March 31, June 30, September 30, and December 31.

"Fiscal Year" means the fiscal year of Borrower consisting of a twelve-month fiscal period ending on each December 31.

"GAAP" means generally accepted accounting principles in the United States set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession in the United States, that are applicable to the circumstances as of the date of determination, consistently applied. The term " consistently applied," as used in connection therewith, means that the accounting principles applied are consistent in all material respects to those applied at prior dates or for prior periods.

"Government Securities" means readily marketable direct full faith and credit obligations of the United States of America or obligations unconditionally guaranteed by the full faith and credit of the United States of America.

"Governmental Agency" means (a) any international, foreign, federal, state, county or municipal government, or political subdivision thereof, (b) any governmental or quasi-governmental agency, authority, board, bureau, commission, department, instrumentality or public body, (c) any court, administrative tribunal or public utility, or (d) any arbitration tribunal or other non-governmental authority to whose jurisdiction a Person has consented.

"Hazardous Materials" has the meaning set forth for that term in the Environmental Indemnity.

"Hazardous Materials Laws" has the meaning set forth for that term in the Environmental Indemnity.

"Indebtedness" means, as to any Person (without duplication), (a) indebtedness of such Person for borrowed money or for the deferred purchase price of Property (excluding trade and other accounts payable in the ordinary course of business in accordance with ordinary trade terms), including any Contingent Obligation for any such indebtedness, (b) indebtedness of such Person of the nature described in the foregoing clause (a) that is non-recourse to the credit of such Person but is secured by assets of such Person, to the extent of the fair market value of such assets as determined in good faith by such Person, (c) Capital Lease Obligations of such Person, (d) indebtedness of such Person arising under bankers' acceptance facilities or under facilities for the discount of accounts receivable of such Person, (e) any direct or contingent obligations of such Person under letters of credit issued for the account of such Person, and (f) any net obligations of such Person under written agreements with one or more financial institutions providing for "swap", "cap", "collar" or other interest rate protection with respect to any of the foregoing indebtedness. In no event shall the obligations of any Person in connection with foreign exchange contracts constitute Indebtedness.

"Indemnitee" has the meaning specified in Section 10.9.

"Intangible Assets" means assets that are considered intangible assets under GAAP, including customer lists, goodwill, computer software, copyrights, trade names, trademarks, patents, franchises, licenses, unamortized deferred charges, unamortized debt discount and capitalized research and development costs.

"Interest Charges" means, for any period, with respect to Borrower, the sum of (a) all interest paid or payable (without duplication) for such period by Borrower in connection with any of its funded Indebtedness or in connection with the deferred purchase price of assets,

in each case to the extent treated as "interest expense" in accordance with GAAP and (b) the portion of rent paid or payable (without duplication) for such fiscal period by Borrower under Capital Lease Obligations that should be treated as interest in accordance with Financial Accounting Standards Board Statement No. 13.

"Interest Period" means the period commencing on the day of each calendar month and ending on the last day of such calendar month.

"Investment" means, when used in connection with any Person, any investment by or of that Person, whether by means of purchase or other acquisition of capital stock or other Securities of any other Person or by means of loan, advance, capital contribution, guaranty or other debt or equity participation or interest, or otherwise, in any other Person, including any membership, partnership and joint venture interests of such Person in any other Person. The amount of any Investment shall be the amount actually invested, without adjustment for increases or decreases in the value of such Investment.

"Laws" means, collectively, all international, foreign, federal, state and local statutes, treaties, rules, guidelines, regulations, ordinances, codes and administrative or judicial precedents or authorities, including the interpretation or administration thereof by any Governmental Agency charged with the enforcement, interpretation or administration thereof, and all applicable administrative orders, directed duties, requests, licenses, authorizations and permits of, and agreements with, any Governmental Agency, in each case whether or not having the force of law.

"Lender" has the meaning specified in the preamble hereto.

"Lender's Office" means Lender's address as set forth on the signature pages to this Agreement, or such other address as Lender hereafter may designate by written notice to Borrower.

"LIBOR Rate" means, for any Interest Period, a rate of interest per annum equal to the rate that appears in the "Money Rates" section of the Wall Street Journal as the London interbank offered rate for deposits in US Dollars, for a period of one month, two Business Days prior to the commencement of such Interest Period. If such interest rate shall cease to be available from the Wall Street Journal, the LIBOR Rate shall be determined from such financial reporting service as Administrative Agent shall reasonably determine and use with respect to its other loan facilities on which interest is determined based on the London interbank offered rate. If a London interbank offered rate for deposits in US Dollars for a period of one month becomes unavailable, Administrative Agent shall designate a substitute index that is as closely comparable to the London interbank offered rate for deposits in US Dollars for a period of one month as is reasonably practicable, and shall give notice of such substitution to Borrower and the Lenders.

"Lien" means any mortgage, pledge, hypothecation, assignment, deposit arrangement, encumbrance, lien (statutory or other), charge, or preference, priority or other security interest or preferential arrangement in the nature of a security interest of any kind or nature whatsoever (including any conditional sale or other title retention agreement, any easement, right of way or other encumbrance on title to real property, and any financing lease having substantially the same economic effect as any of the foregoing).

"Loan" means the credit committed to be advanced by Lenders to Borrower, subject to the terms and conditions of this Agreement

"Loan Documents" means, collectively, this Agreement, the other Collateral Documents, the Notes, the Parent Guaranty, and any other agreements of any type or nature heretofore or hereafter executed and delivered by Borrower or any of their Affiliates to Administrative Agent in any way relating to or in furtherance of this Agreement (other than Swap Contracts), in each case either as originally executed or as the same may from time to time be supplemented, modified, amended, restated, extended or supplanted.

"Loan Party" means each of Borrower and Parent.

"Loan-to-Value Ratio" means the total committed amount of the Loan divided by the appraised "As-Is" value of the Property. The appraised "As-Is" value of the Property shall be based upon an appraisal prepared by a third-party appraiser acceptable to, and engaged directly by, Administrative Agent. The appraisal shall be satisfactory to the Required Lenders in all respects, and the value of the Property, as determined on the basis of such appraisal, shall be as reviewed, adjusted and approved by the Required Lenders.

"Material Adverse Effect" means any set of circumstances or events which (a) is material and adverse to the condition (financial or otherwise) or business operations of the Loan Parties taken as a whole, (b) materially impairs the ability of any Loan Party to perform its Obligations, (c) has a material, adverse effect on the Lien of any Loan Document or (d) materially impairs the ability of Administrative Agent or any of the Lenders to enforce a material right or remedy as provided in the Loan Documents.

"Maturity Date" means November 30, 2018; provided, however, that if such date is not a Business Day, the Maturity Date shall be the next following Business Day.

"Multiemployer Plan" means any employee benefit plan of the type described in Section 4001(a)(3) of ERISA to which any Borrower or any of its ERISA Affiliates contributes or is obligated to contribute.

"Negative Pledge" means a Contractual Obligation that contains a covenant binding on Borrower that prohibits Liens on any of such entity's Property, other than (a) any such covenant contained in a Contractual Obligation granting or relating to a particular Lien which affects only the Property that is the subject of such Lien and (b) any such covenant that does not apply to Liens securing the Obligations, and (c) customary permitted junior Liens to be agreed upon by Borrower and Lender.

"Net Operating Income" means, for any period, the difference between Operating Expenses and Operating Revenue.

"Notes" and "Notes" have the meanings specified in Section 2.1.

"Obligations" means all present and future obligations of every kind or nature of Borrower or any other Loan Party at any time and from time to time owed to (i) Administrative Agent or Lenders or any one or more of them under any one or more of the Loan Documents, or (ii) any Swap Counterparty in connection with any Swap Transaction, in each case whether due or to become due, matured or unmatured, liquidated or unliquidated, or contingent or noncontingent, including obligations of performance as well as obligations of payment, and including interest that accrues after the commencement of any proceeding under any Debtor Relief Law by or against Borrower or any Affiliate of Borrower.

"Operating Expenses" means, with respect to any period of time, the total of all expenses actually paid or payable during such period, of whatever kind relating to the ownership, operation, maintenance or management of the Property, including (without duplication) Interest Charges and principal payments on all Indebtedness (including, without limitation, Capital Lease Obligations) other than Debt Service, costs of utilities, costs of ordinary repairs and maintenance, insurance premiums, ground rents (if any), license fees, Taxes (including payroll and related taxes with respect to employees of Borrower, but excluding income taxes), advertising expenses, management fees actually paid under any management agreement, operational equipment or other lease payments as reasonably approved by Administrative Agent, but specifically excluding depreciation and amortization, income taxes, Debt Service, any item of expense that would otherwise be covered by the provisions hereof but which is paid by any tenant under such tenant's Lease or other agreement provided such reimbursement by tenant is not included in the calculation of Operating Revenue. Operating Expenses shall be subject to appropriate seasonal and other adjustments in Lender's reasonable discretion.

"Operating Revenue" means, with respect to any period of time, all revenue actually received from the ownership and operation of the Property from whatever source during such period (including rents from any affiliate of Borrower or Parent leasing space in the Property but otherwise excluding any source affiliated with Borrower or Parent), including rents, utility charges, escalations, service fees or charges, license fees, parking fees, and other required pass-throughs, but excluding proceeds of sales of furniture, fixtures and equipment (except to the extent such sale proceeds offset amounts included in Operating Expenses for costs of acquiring furniture, fixtures and equipment), condemnation awards, insurance proceeds (other than business interruption or other loss of income insurance), unforfeited security deposits, utility and other similar deposits, and non-recurring or extraordinary income, including lease termination payments; provided, however, lease termination payments shall be included in Operating Revenue (i) if and to the extent held in reserve to offset amounts included in Operating Expenses consisting of leasing commissions or tenant improvements, and (ii) if delivered to Lender and held in reserve by Lender, as rents received with respect to the terminated lease amortized over the remaining term of such terminated lease and applied to Operating Expenses for the applicable Calculation Period. No credit to Operating Revenue shall be given with respect to free rent periods, rent concessions and rent credits. Operating Revenue shall be subject to appropriate and reasonable seasonal and other adjustments by Administrative Agent.

"Opinion of Counsel" means the favorable written legal opinion of Boutin Jones Inc., counsel to Borrower and Parent, together with copies of all factual certificates and legal opinions upon which such counsel has relied.

"Pacific Time" means the prevailing time in Los Angeles, California.

"Parent" means Molina Healthcare, Inc., a Delaware corporation.

"Parent Credit Facility" means that certain Credit Agreement executed by US Bank National Association as Administrative Agent, Lead Arranger and Sole Book Runner, by City National Bank and Union Bank, N.A., as Co-Syndication Agents, and by U.S. Bank National Association, City National Bank, Union Bank, N.A., BMO Harris Bank, N.A., East West Bank, BOKF, NA dba Bank of Albuquerque, Santa Barbara Bank & Trust, Land Bank of Taiwan, Los Angeles Branch and Hua Nan Commercial Bank Ltd., Los Angeles Branch, as lenders and Parent as borrower, dated as of September 9, 2011, as amended from time to time.

"Parent Guaranty" means the Guaranty of even date herewith by Parent in favor of Lender, either as originally executed or as it may from time to time be supplemented, modified, amended, restated or extended.

"PBGC" means the Pension Benefit Guaranty Corporation or any successor thereof established under ERISA.

"Pension Plan" means any "employee pension benefit plan" (as such term is defined in Section 3(2) of ERISA), other than a Multiemployer Plan, which is subject to Title IV of ERISA and is maintained by any Borrower or to which any Borrower contributes or has an obligation to contribute.

"Permit" means any permit, approval, authorization, license, accreditation, certification, provider or supplier number, registration, certificate of authority, certificate of need, certificate of reimbursement, variance, qualification, filing or consent required under applicable Laws.

"Permitted Encumbrances" means:

(a) inchoate Liens incident to construction or maintenance of Property, or Liens incident to construction or maintenance of Property, now or hereafter filed of record for which adequate accounting reserves have been set aside (or deposits made pursuant to applicable Laws) and which are being contested in good faith by appropriate proceedings and have not proceeded to judgment; provided that, by reason of nonpayment of the obligations secured by such Liens, no such Property is subject to a material impending risk of loss or forfeiture, as reasonably determined by Administrative Agent;

(b) Liens for taxes and assessments on Property which are not yet past due, or Liens for taxes and assessments on Property for which adequate reserves have been set aside and are being contested in good faith by appropriate proceedings and have not proceeded to judgment; provided that, by reason of nonpayment of the obligations secured by such Liens, no such Property is subject to a material impending risk of loss or forfeiture, as reasonably determined by Administrative Agent;

(c) defects and irregularities in title to any Property which in the aggregate do not materially impair the fair market value or use of the Property for the purposes for which it is or may reasonably be expected to be held;

(d) easements, exceptions, reservations, or other agreements that: (i) exist on the date hereof and are described in the ALTA lender's title insurance policy issued by the Title Company in connection with this Agreement; (ii) are granted by Borrower after the date hereof for the purpose of pipelines, conduits, cables, wire communication lines, power lines and substations, streets, trails, walkways, drainage, irrigation, water, and sewerage purposes, dikes, canals, ditches, the removal of oil, gas, coal, or other minerals, and other like purposes affecting Property which in the aggregate do not materially burden or impair the fair market value or use of such Property for the purposes for which it is or may reasonably be expected to be held; or (iii) are granted by Borrower after the date hereof for the purpose of facilitating the joint or common use of Property in or adjacent to a shopping center or similar project affecting Property which in the aggregate do not materially burden or impair the fair market value or use of such Property for the purposes for which it is or may reasonably be expected to be held;

(e) rights reserved to or vested in any Governmental Agency to control or regulate, or obligations or duties to any Governmental Agency with respect to, the use of any Property;

(f) rights reserved to or vested in any Governmental Agency to control or regulate, or obligations or duties to any Governmental Agency with respect to, any right, power, franchise, grant, license, or permit;

(g) present or future zoning laws and ordinances or other laws and ordinances restricting the occupancy, use, or enjoyment of Property;

(h) statutory Liens, other than those described in clauses (a) or (b) above, arising in the ordinary course of business with respect to obligations which are not delinquent or are being contested in good faith; provided that, if delinquent, adequate reserves have been set aside with respect thereto and, by reason of nonpayment, no Property is subject to a material impending risk of loss or forfeiture;

(i) covenants, conditions, and restrictions affecting the use of Property that: (i) exist on the date hereof and are described in the ALTA lender's title insurance policy issued by the Title Company in connection with this Agreement; or (ii) arise after the date hereof and in the aggregate do not materially impair the fair market value or use of the Property for the purposes for which it is or may reasonably be expected to be held;

(j) rights of tenants under leases and rental agreements covering Property entered into in the ordinary course of business of the Person owning such Property;

(k) Liens consisting of pledges or deposits to secure obligations under workers' compensation laws or similar legislation, including Liens of judgments thereunder which are not currently dischargeable;

(l) Liens consisting of pledges or deposits of Property to secure performance in connection with operating leases made in the ordinary course of business; provided that the aggregate value of all such pledges and deposits in connection with any such lease does not at any time exceed 20% of the annual fixed rentals payable under such lease;

(m) Liens consisting of deposits of Property to secure statutory obligations of Borrower or any Subsidiary of Borrower in the ordinary course of its business;

(n) Liens consisting of deposits of Property to secure (or in lieu of) surety, appeal or customs bonds; and

(o) Liens created by or resulting from any litigation or legal proceeding in the ordinary course of business which is currently being contested in good faith by appropriate proceedings; provided that, adequate reserves have been set aside and no material Property is subject to a material impending risk of loss or forfeiture.

"Person" means any entity, whether an individual, trustee, corporation, general partnership, limited liability company, limited partnership, joint stock company, trust, estate, unincorporated organization, business association, tribe, firm, joint venture, Governmental Agency, or otherwise.

"Property" means any interest in any kind of property or asset, whether real, personal or mixed, or tangible or intangible, including any leasehold interest or fixtures.

"Pro Rata Share" means, with respect to each Lender, a fraction in which that Lender's Commitment is the numerator and the Total Commitment is the denominator.

"Real Property" means, collectively, the real property described in the Deed of Trust.

"Regulation T" means Regulation T, as at any time amended, of the Board of Governors of the Federal Reserve System, or any other regulation in substance substituted therefor.

"Regulation U" means Regulation U, as at any time amended, of the Board of Governors of the Federal Reserve System, or any other regulation in substance substituted therefor.

"Regulation X" means Regulation X, as at any time amended, of the Board of Governors of the Federal Reserve System, or any other regulation in substance substituted therefor.

"Replacement Reserve Account" means deposit account number 8003018317 in the name of Borrower and maintained with East West Bank.

"Required Lenders" means, as of any date of determination, either (a) East West Bank and other Lenders who, together with East West Bank, hold more than 50% of the aggregate Commitments of Lenders (other than Commitments held by Defaulting Lenders), or (b) all of the Lenders (other than Defaulting Lenders) other than East West Bank.

"Requirement of Law" means, as to any Person, the certificate of organization, articles or certificate of incorporation and bylaws, the partnership agreement and any related certificate of partnership, or other organizational or governing documents of such Person, and any Law, or judgment, award, decree, writ or determination of a Governmental Agency, in each case applicable to or binding upon such Person or any of its Property or to which such Person or any of its Property is subject.

"Responsible Officer" means chief executive officer, president, chief financial officer, treasurer, assistant treasurer or controller of the Person designated and, solely for purposes of the delivery of incumbency certificates pursuant to Section 7.1, the secretary or any assistant secretary of the Person designated. Any document delivered hereunder that is signed by a Responsible Officer of a Loan Party shall be conclusively presumed to have been authorized by all necessary corporate, partnership or other action on the part of such Loan Party and such Responsible Officer shall be conclusively presumed to have acted on behalf of such Loan Party.

"Schedule of Commitments" means the Schedule of Commitments of all of the Lenders; the initial Schedule of Commitments is attached hereto as Schedule 1.1(b)**,** and the Schedule of Commitments shall be adjusted whenever a Lender withdraws or is added.

"Secured Parties" means, collectively, the Administrative Agent (for the benefit of the Lenders and the Swap Counterparties) and the Swap Counterparties.

"Statutory Reserve Rate" means a fraction (expressed as a decimal), the numerator of which is the number one and the denominator of which is the number one minus the aggregate of the maximum reserve percentages (including any marginal, special, emergency or supplemental reserves) expressed as a decimal established by the Board of Governors of the Federal Reserve System with respect to the Adjusted LIBOR Rate, for eurocurrency funding (currently referred to as "Eurocurrency Liabilities" in Regulation D of the Board of Governors of the Federal Reserve System). Such reserve percentages shall include those imposed pursuant to such Regulation D. Eurodollar Loans shall be deemed to constitute eurocurrency fundings and to be subject to such reserve requirements without benefit of or credit for proration, exemptions or offsets that may be available from time to time to any Lender under such Regulation D or any comparable regulation. The Statutory Reserve Rate shall be adjusted automatically on and as of the effective date of any change in any reserve percentage.

"Subsidiary" of a Person means a corporation, partnership, joint venture, limited liability company or other business entity of which a majority of the shares of securities or other interests having ordinary voting power for the election of directors or other governing body (other than securities or interests having such power only by reason of the happening of a contingency) are at the time beneficially owned, or the management of which is otherwise controlled, directly, or indirectly through one or more intermediaries, or both, by such Person.

"Swap Contract" means any agreement, whether or not in writing, relating to any Swap Transaction, including, unless the context otherwise clearly requires, any form of master agreement (the "Master Agreement") published by the International Swaps and Derivatives Association, Inc., or any other master agreement, entered into prior to the date hereof or any time after the date hereof, between Swap Counterparty and Borrower (or its Affiliate), together with any related schedule and confirmation, as amended, supplemented, superseded or replaced from time to time.

"Swap Counterparty" means any Lender, or an Affiliate of Administrative Agent, in its capacity as counterparty under any Swap Contract; provided that if any Lender that is a counterparty to a Swap Contract shall cease to be a Lender, such entity (or its Affiliate, as the case may be) shall nevertheless remain a Swap Party for so long as it is a counterparty under such Swap Contract.

"Swap Transaction" means any transaction that is a rate swap, basis swap, forward rate transaction, commodity swap, commodity option, equity or equity index swap or option, bond option, note or bill option, interest rate option, forward foreign exchange transaction, cap transaction, collar transaction, floor transaction, currency swap transaction, cross-currency rate swap transaction, swap option, currency option, credit swap or default transaction, T-lock, or any other similar transaction (including any option to enter into the foregoing) or any combination of the foregoing, entered into prior to the date hereof or anytime after the date hereof between Swap Counterparty and Borrower (or its Affiliate) so long as a writing, such as a Swap Contract, evidences the parties' intent that Borrower's obligations arising under such transaction shall be secured by the Deed of Trust or are obligations of Borrower under a Swap Transaction hereunder.

"Taxes" means any and all present and future taxes, levies, imposts, duties, fees, deductions, withholdings or charges of a similar nature imposed or assessed by any Authority or taxing authority thereof, together with any interest thereon and any penalties with respect thereto.

"Title Company" means First American Title Insurance Company.

"Total Commitment" means the aggregate amount of credit that Borrower may obtain, at any one time under this Agreement, which amount shall not exceed $48,600,000,000.

"UCC" means the California Uniform Commercial Code, as amended from time to time.

1.2 Use of Defined Terms. Any defined term used in the plural shall refer to all members of the relevant class, and any defined term used in the singular shall refer to any one or more of the members of the relevant class.

1.3 Accounting Terms. All accounting terms not specifically defined in this Agreement shall be construed in conformity with, and all financial data required to be submitted by this Agreement shall be prepared in conformity with, GAAP applied on a consistent basis, except as otherwise specifically prescribed herein. In the event that GAAP changes during the term of this Agreement such that the financial covenants contained in ARTICLE 5 would then be calculated in a different manner or with different components, (a) Borrower and Lender agree to amend this Agreement in such respects as are necessary to conform those covenants as criteria for evaluating Borrower' financial condition to substantially the same criteria as were effective

prior to such change in GAAP and (b) Borrower shall be deemed to be in compliance with the financial covenants contained in ARTICLE 5 during the 60-day period following any such change in GAAP if and to the extent that Borrower would have been in compliance therewith under GAAP as in effect immediately prior to such change.

1.4 Rounding. Any financial ratios required to be maintained by Borrower pursuant to this Agreement shall be calculated by dividing the appropriate component by the other component, carrying the result to one place more than the number of places by which such ratio is expressed in this Agreement and rounding the result up or down to the nearest number (with a round-up if there is no nearest number) to the number of places by which such ratio is expressed in this Agreement.

1.5 Exhibits and Schedules. All Exhibits and Schedules to this Agreement, either as originally existing or as the same may from time to time be supplemented, modified or amended, are incorporated herein by this reference. A matter disclosed on any Schedule shall be deemed disclosed on all Schedules.

1.6 Miscellaneous Terms. The term "or" is disjunctive; the term "and" is conjunctive. The term "shall" is mandatory; the term "may" is permissive. Masculine terms also apply to females; feminine terms also apply to males. The term "including" is by way of example and not limitation. The words "herein," "hereto," "hereof" and "hereunder" and words of similar import when used in any Loan Document shall refer to such Loan Document as a whole and not to any particular provision thereof. Article, Section, Exhibit and Schedule references are to the Loan Document in which such reference appears. The term "documents" includes any and all instruments, documents, agreements, certificates, notices, reports, financial statements and other writings, however evidenced, whether in physical or electronic form. In the computation of periods of time from a specified date to a later specified date, the word "from" means "from and including"; the words "to" and "until" each mean "to but excluding"; and the word "through" means "to and including."

ARTICLE 2
CREDIT FACILITY

2.1 Amount and Terms of Loan. Subject to the terms and conditions set forth in this Agreement, each Lender shall advance to Borrower, within one (1) Business Day after satisfaction of the conditions in Section 7.1, its Pro Rata Share of Advances of principal of the Loan and shall advance to Administrative Agent, within two Business Days after demand therefor by Administrative Agent, its Pro Rata Share of Administrative Agent Advances. The total amount of Advances of principal of the Loan shall not exceed $48,600,000. The principal of the Loan shall be disbursed to Borrower by the Lenders as follows:

(a) $48,300,000 will be disbursed to Borrower in a single Advance on the Closing Date; and

(b) $300,000 will be disbursed into the Replacement Reserve Account on the Closing Date. Borrower shall have the right to withdraw funds from the Replacement Reserve Account monthly, within five (5) Business Days days after delivery by Borrower to Administrative Agent of a requisition therefor, together with evidence reasonably satisfactory to Administrative Agent that Borrower has incurred costs during the previous calendar month in connection with performance of the deferred maintenance items listed on the property inspection report prepared by Marx Okubo Associates, Inc., and dated October 14, 2011 that are at least equal to the amount requisitioned .

If all or any portion of the Loan is prepaid or repaid at any time, it may not be reborrowed. The obligation of Borrower to repay the Loan, and interest accrued thereon, shall be evidenced by the Promissory Notes of even date herewith made by Borrower to the order of each Lender (collectively, the " Notes," and each a "Note"). The liabilities and obligations of each Lender hereunder shall be several and not joint, and neither Administrative Agent nor any Lender shall be responsible for the performance by any other Lender of its obligations hereunder.

2.2 Interest. Subject to the provisions of Section 2.5, the outstanding principal amount of the Loan shall bear interest, computed on the basis of a year of 360 days and the actual number of days elapsed, as follows:

(a) from the date of closing of the Loan through December 31, 2011, at the rate of 4.25% per annum; and

(b) for each Interest Period commencing with the Interest Period that commences on January 1, 2012, at the Eurodollar Rate applicable to such Interest Period.

2.3 Amortization of Loan. Borrower shall repay principal and interest on the Loan on the first day of each month (commencing January 1, 2012 and continuing through November 1, 2018) in an aggregate monthly amount as follows:

(a) The payment due in January, 2012 shall be $264,966.49;

(b) The payment due on the first day of each subsequent month shall be the payment that would be required in such month in order to fully amortize the principal of the Loan that is outstanding immediately following receipt and application of the payment for the immediately preceding month in equal monthly combined payments of principal and interest, with interest at the Eurodollar Rate applicable as of the first day of the immediately preceding month, over the portion of a 25-year period commencing January 1, 2012 that remains as of the first day of the immediately preceding month; and

(c) The entire unpaid balance of the Loan shall be paid in full by Borrower on the Maturity Date.

Administrative Agent will deliver to Borrower during each month a payment invoice stating the Eurodollar Rate in effect for such month, the balance of principal outstanding and the payment required pursuant to Section 2.3(b) on the first day of the next month.

Prior to the occurrence of an Event of Default, each such payment shall be applied first to accrued interest and then to principal. Notwithstanding anything to the contrary contained herein, the Loan may be prepaid from time to time in accordance with Section 2.3. Any prepayments hereunder will be in addition to any scheduled payments and shall be applied in inverse order of maturity.

2.4 Prepayments.

(a) In the event of the payment of any Eurodollar Principal other than on the last day of an Interest Period applicable thereto (including as a result of a Default), Borrower shall compensate Lender for the loss, cost and expense attributable to such payment. Such loss, cost or expense to Lender shall be deemed to include an amount determined by Lender to be the excess, if any, of (i) the amount of interest which would have accrued on such Eurodollar Principal had such payment not occurred, at the Adjusted LIBOR Rate that would have been applicable to such Eurodollar Loan, for the period from the date of such event to the last day of the then current Interest Period therefor (or, in the case of a failure to borrow, convert or continue, for the period that would have been the Interest Period for such Eurodollar Principal), over (ii) the amount of interest which would accrue on such Eurodollar Principal for such period at the interest rate which Lender would bid were it to bid, at the commencement of such period, for dollar deposits of a comparable amount and period from other banks in the eurodollar market. A certificate of Lender setting forth any amount or amounts that such Lender is entitled to receive pursuant to this Section and the basis for such calculation shall be delivered to Borrower and shall be conclusive absent manifest error. Borrower shall pay Lender the amount shown as due on any such certificate within ten (10) Business Days after receipt thereof. Nothing contained herein shall affect any breakage costs or premiums due under any Swap Agreement.

(b) Upon prepayment of the balance of the Loan at any time and for any reason other than at the end of an Interest Period, Borrower shall be obligated to pay the applicable amounts provided for in Section 2.4, whether such prepayment is made or occurs (i) as the result of a voluntary acceptance by Lender of a prepayment tendered by Borrower; (ii) by acceleration as a result of a Default by Borrower; (iii) in connection with any reinstatement of the Loan under any foreclosure proceedings or in connection with the purchase of the property at a foreclosure sale; or (iv) in connection with any right of redemption exercised by Borrower or any other party having the right to redeem or prevent any foreclosure of the Deed of Trust.

(c) Prepayments shall not relieve Borrower of its obligations to continue to make payments under the payment schedule. Rather, prepayments shall reduce the principal balance due on the Loan and may result in Borrower's making fewer payments with respect thereto. Borrower agrees not to send Lenders payments marked "paid in full", "without recourse", or similar language. If Borrower send such a payment, any Lender may accept it without losing any of that Lender's rights under this Agreement, and Borrower shall remain obligated to pay any further amounts owing to that Lender.

2.5 Default Rate. Upon the occurrence and during the continuance of any Event of Default, the outstanding principal amount of the Loan shall, at the option of Lender, thereafter bear interest, payable by Borrower in the manner and at the times provided in this Agreement and the Notes, at a rate per annum which is 5.00% per annum higher than the otherwise applicable rate, to the fullest extent permitted by applicable Laws (the " Default Rate").

2.6 Loan Fee. On the Closing Date, Borrower shall pay to Administrative Agent a loan fee in the amount of $486,000. Such loan fee shall be paid to Administrative Agent at Administrative Agent's Office, and shall be distributed among the Lenders as of the Closing Date in accordance with their respective Pro Rata Shares.

2.7 Agency Fee. On the Closing Date, Borrower shall pay to Administrative Agent an agency fee pursuant to a separate letter agreement between Borrower and Administrative Agent.

2.8 Non-Business Days. If any payment to be made by Borrower or any other Loan Party under any Loan Document shall come due on a day other than a Business Day, payment shall instead be considered due on the next succeeding Business Day and the extension of time shall be reflected in computing interest.

2.9 Manner and Treatment of Payments. All payments to be made by Borrower shall be made without condition or deduction for any counterclaim, defense, recoupment or setoff. Except as otherwise expressly provided herein, each payment hereunder or on the Notes or under any other Loan Document shall be made to Administrative Agent at Administrative Agent's Office in immediately available funds not later than 11:00 a.m., Pacific Time, on the day of payment specified herein (which must be a Business Day). All payments received after 11:00 a.m., Pacific Time, on any particular Business Day, shall be deemed received on the next succeeding Business Day, and such extension of time shall be reflected in computing interest or fees, as the case may be. All payments shall be made in lawful money of the United States of America.

2.10 Authorization to Debit Account. Borrower authorizes Administrative Agent to debit the Designated Deposit Account to effectuate payment of amounts due and payable to Administrative Agent and the Lenders under this Agreement. Any resulting overdraft in the Designated Deposit Account shall be payable on the next following Business Day.

2.11 Funding Source. Nothing in this Agreement shall be deemed to obligate any Lender to obtain the funds for the Loan in any particular place or manner or to constitute a representation by such Lender that it has obtained or will obtain the funds for the Loan in any particular place or manner.

2.12 [Intentionally Deleted].

2.13 Collateral. The Loan, together with all other Obligations, shall be secured by the Liens created by the Collateral Documents.

2.14 Increased Loan Costs. If any Lender shall have determined that the introduction of any applicable Law, rule, regulation or guideline regarding capital adequacy, or any change therein or any change in the interpretation or administration thereof by any central bank or other Governmental Agency charged with the interpretation or administration thereof, or compliance by such Lender or any corporation controlling such Lender, with any request, guidelines or directive regarding capital adequacy (whether or not having the force of Law) of any such central bank or other authority, affects or would affect the amount of capital required or expected to be maintained by such Lender or any corporation controlling such Lender and (taking into consideration such Lender's or such corporation's policies with respect to capital adequacy), determines that the amount of such capital is increased as a consequence of its obligations under this Agreement, then, within five (5) Business Days after delivery to Borrower of a statement setting forth the amount for which Borrower is responsible hereunder, and the basis of calculation of such amount, Borrower shall pay to such Lender (an " Affected Lender") such amounts sufficient to compensate such Lender for such increase. If an Affected Lender requires payment by Borrower of any amount pursuant to this Section 2.14, Borrower shall be obligated to pay such amount, but shall have the right, exercisable at any time within ninety (90) days after its payment of such amount, to pay off the entire portion of the Loan held by such Affected Lender. Borrower shall not be obligated to pay any premium or penalty, but shall be obligated to pay any amounts that are payable pursuant to Section 2.4, and pursuant to any Swap Contract, in connection with such payoff. Any payoff made pursuant to this Section 2.14 shall be distributed solely to the Affected Lender, and not to other Lenders, by Administrative Agent.

2.15 Swap Contracts. Borrower shall have the right to enter into a Swap Contract with respect to the Loan with any one or more of the Lenders, or with Affiliates of any one or more of the Lenders, provided that Administrative Agent gives its prior written consent to such Swap Contract, which consent shall not be unreasonably withheld. Borrower shall not enter into any Swap Contract or Swap Transaction with any Swap Counterparty that is not a Lender, or an Affiliate of a Lender. No Swap Contract with respect to the Loan shall have a term that extends beyond the Maturity Date.

ARTICLE 3
REPRESENTATIONS AND WARRANTIES

Borrower represents and warrants to Administrative Agent and each Lender that:

3.1 Existence and Qualification; Power; Compliance with Laws . Borrower is duly formed, validly existing and in good standing under the Laws of Delaware. Parent is duly formed, validly existing and in good standing under the Laws of Delaware. Each of Borrower and Parent is duly qualified or registered to transact business, and is in good standing, in California and each other jurisdiction in which the conduct of its business or the ownership or leasing of its Properties makes such qualification or registration necessary. Each of Borrower and Parent has all requisite power and authority to conduct its business, to own and lease its Property, to execute and deliver each Loan Document to which it is a party, and to perform the Obligations to be performed by it. As of the Closing Date, the chief executive offices of each of Borrower and Parent are located at the respective addresses set forth for notices in the signature pages to this Agreement. Borrower (a) is in compliance with all Laws and other legal requirements applicable to its business, (b) has obtained from each applicable Governmental Agency all authorizations, consents, approvals, orders, licenses and permits that are necessary for the transaction of its businesses, (c) has accomplished with each applicable Governmental Agency all filings, registrations and qualifications that are necessary for the transaction of its businesses, or (d) obtained from each applicable Governmental Agency exemptions from any of the items described in the foregoing clauses (b) and (c), as necessary for the transaction of its businesses.

3.2 Authority; Compliance with Other Agreements and Instruments and Government Regulations . The execution, delivery and performance by each Loan Party of the Loan Documents to which it is a party have been duly authorized by all necessary corporate action, and do not:

(a) require any consent or approval not heretofore obtained of any equity holder, security holder or creditor of such Loan Party;

(b) violate or conflict with any provision of such Loan Party's limited liability company agreement, charter, partnership agreement, articles of incorporation or bylaws, as applicable;

(c) result in or require the creation or imposition of any Lien (other than pursuant to the Collateral Documents) upon or with respect to any Property now owned or leased or hereafter acquired by such Loan Party;

(d) violate any Requirement of Law applicable to such Loan Party;

(e) constitute a "transfer of an interest" or an "obligation incurred" that is avoidable by a trustee under Section 548 of the Bankruptcy Code of 1978, as amended, or constitute a "fraudulent conveyance," "fraudulent obligation" or "fraudulent transfer" within the meanings of the Uniform Fraudulent Conveyances Act or Uniform Fraudulent Transfer Act, as enacted in any applicable jurisdiction; and

(f) result in a breach of or default under, or would, with the giving of notice or the lapse of time or both, constitute a breach of or default under, or cause or permit the acceleration of any obligation owed under, any indenture or loan or credit agreement or any other Contractual Obligation to which such Loan Party is a party or by which such Loan Party or any of its Property is bound or affected.

(g) Neither Borrower nor Parent is in material violation of, or material default under, any Requirement of Law, Contractual Obligation, or any indenture, loan or credit agreement.

3.3 No Governmental Approvals Required. Except as set forth in Schedule 3.3, no authorization, consent, approval, order, license or permit from, or filing, registration or qualification with, any Governmental Agency is required to authorize or permit under applicable Laws the execution, delivery and performance by each Loan Party of the Loan Documents to which it is a party.

3.4 Operation of Property. Borrower has obtained all material Permits from each Governmental Agency and other Person, and made all required or appropriate filings, that are necessary for Borrower to own its assets, to carry on its business (without interruption or restriction), and to execute, deliver and perform the Loan Documents to which it is a party. Borrower has not been notified by any Governmental Agency or other Person during the immediately preceding 24-month period that such Governmental Agency or Person has rescinded, imposed any limitation or restriction upon, or not renewed, or intends to rescind, impose any limitation or restriction upon or not renew, any such Permit.

3.5 [Intentionally Deleted]

3.6 [Intentionally Deleted]

3.7 Title to Property. As of the Closing, Borrower will have good and valid title to all the Property (other than assets which are the subject of a Capital Lease Obligation) free and clear of all Liens, other than Permitted Encumbrances.

3.8 Intangible Assets. Borrower owns, or possesses the right to use to the extent necessary in its business, all trademarks, trade names, copyrights, patents, patent rights, computer software, licenses and other Intangible Assets that are used in the conduct of its business as now operated and which are material to the condition (financial or otherwise), business or operations of Borrower, and no such Intangible Asset, to the best knowledge of Borrower, conflicts with the valid trademark, trade name, copyright, patent, patent right or Intangible Asset of any other Person to the extent that such conflict constitutes a Material Adverse Effect.

3.9 Litigation. Except for (a) any matter fully covered (subject to applicable deductibles and retentions) by insurance and with respect to which the insurance carrier has not denied coverage, nor issued any denial of claim, nor any other statement that the claim is in excess of coverage, and (b) any matter, or series of related matters, not fully covered by insurance (subject to applicable deductibles and retentions) involving a claim against Borrower or Parent which is, in the reasonable opinion of Borrower's or Parent's legal counsel, in an

amount less than $100,000, as of the Closing Date, there are no actions, suits, proceedings or investigations pending as to which Borrower has been served or has received notice or, to the best knowledge of Borrower, threatened against or affecting Borrower or Parent or their respective properties before any Governmental Agency. As of the Closing Date, there is no reasonable basis for any action, suit, proceeding or investigation against or affecting Borrower or Parent or any of their respective properties before any Governmental Agency which would constitute a Material Adverse Effect.

3.10 Binding Obligations. Each of the Loan Documents to which the Loan Parties are parties, when executed and delivered by such Loan Parties, will constitute the legal, valid and binding obligation of such Loan Parties, enforceable against such Loan Parties in accordance with its terms, except as enforcement may be limited by Debtor Relief Laws or equitable principles relating to the granting of specific performance and other equitable remedies as a matter of judicial discretion.

3.11 No Default. No event has occurred and is continuing that is a Default or an Event of Default.

3.12 ERISA. Neither Borrower nor Parent maintains a Pension Plan.

3.13 Regulations T, U and X; Investment Company Act. No part of the proceeds of the Loan will be used to purchase or carry, or to extend credit to others for the purpose of purchasing or carrying, any "margin stock" (as such term is defined in Regulations U and X) or will otherwise be used in violation of Regulations T, U and X. None of the Loan Parties are engaged principally, or as one of their important activities, in the business of extending credit for the purpose of purchasing or carrying any such "margin stock." None of the Loan Parties are required to be registered as an "investment company" under the Investment Company Act of 1940.

3.14 Disclosure. No written statement made by any Loan Party to Administrative Agent in connection with this Agreement, or in connection with the Loan, contains any untrue statement of a material fact or omits a material fact necessary in order to make the statement made not misleading in light of all the circumstances existing at the date the statement was made.

3.15 Tax Liability. The Loan Parties have filed all tax returns which are required to be filed, and have paid, or made provision for the payment of, all taxes with respect to the periods, Property or transactions covered by said returns, or pursuant to any assessment received by the Loan Parties, except such taxes, if any, as are being contested in good faith by appropriate proceedings and as to which adequate reserves have been established and maintained.

3.16 [Intentionally Deleted].

3.17 Hazardous Materials. Borrower has not at any time disposed of, discharged, released or threatened the release of any Hazardous Materials on, from or under the Real Property in violation of any Hazardous Materials Law. To the best knowledge of Borrower, no condition exists that violates any Hazardous Material Law affecting the Real Property, except as described in Schedule 3.17. No portion of the Real Property is or has been utilized by any Loan Party as a site for the manufacture of any Hazardous Materials. To the extent that any Hazardous

Materials are used, generated or stored by any Loan Party or any of its Subsidiaries on the Real Property, or transported to or from the Real Property by any Loan Party or any of its Subsidiaries, such use, generation, storage and transportation are in compliance with all Hazardous Materials Laws.

3.18 Regulatory and Legal Compliance. Borrower is in compliance in all material respects with all applicable Laws. Borrower has not received any notice from any Governmental Agency or any other Person of any alleged violation or noncompliance with any such Laws.

ARTICLE 4
AFFIRMATIVE COVENANTS
(OTHER THAN INFORMATION AND
REPORTING REQUIREMENTS)

So long as the Loan remains unpaid, or any other Obligation remains unpaid or unperformed, Borrower shall, unless Administrative Agent otherwise consents:

4.1 Payment of Taxes and Other Potential Liens. Pay and discharge promptly all taxes, assessments and governmental charges or levies imposed upon Borrower or its Property or any part thereof and upon its respective income or profits or any part thereof, except that Borrower shall not be required to pay or cause to be paid any tax, assessment, charge or levy that is not yet past due, or is being contested in good faith by appropriate proceedings so long as Borrower has established and maintains adequate reserves for the payment of the same.

4.2 Preservation of Existence. Preserve and maintain its existence as a California limited liability company and all material authorizations, rights, franchises, privileges, consents, approvals, orders, licenses, permits, or registrations from any Governmental Agency that are necessary for the transaction of its business and qualify and remain qualified to transact business in each jurisdiction in which such qualification is necessary in view of its business or the ownership or leasing of its Property.

4.3 Single Purpose Entity. At all times be a limited liability company that: (a) is formed or organized solely for the purpose of holding a direct ownership interest in the Collateral; (b) does not engage in any business other than the ownership, management and operation of the Collateral; (c) does not have any assets other than its interest in the Collateral; (d) does not have any Indebtedness other than that expressly permitted by this Agreement; (e) maintains books and records, and keeps accounts, separate and distinct from the books and records and accounts of any other Person; (f) is subject to all of the limitations on powers set forth in the organizational documents of Borrower in effect on the date of this Agreement; (g) holds itself out as being a Person and a legal entity separate and distinct from any other Person; (h) does not make any loans or advances to any other Person; and (i) maintains adequate capital for the normal obligations reasonably foreseeable in a business of its size and character.

4.4 Maintenance of Properties. Maintain, preserve and protect all of its Property in good order and condition, subject to wear and tear in the ordinary course of business, and not permit any waste of its property, except that (a) the failure to maintain, preserve and protect a particular item of Property that is at the end of its useful life or that is not of significant value, either intrinsically or to the operations of Borrower, shall not constitute a violation of this covenant and (b) the failure to repair damage to any portion of its Property resulting from a casualty that generates payment of insurance proceeds, which insurance proceeds are not permitted by Administrative Agent to be applied to payment of costs of repair to such portion of such Property pursuant to Section 2.12 of the Deed of Trust, shall not constitute a violation of this covenant so long as Borrower restores the remaining portion of such Property to a safe and operational condition.

4.5 Maintenance of Insurance. Maintain liability, casualty and other insurance as required by Section 2.11 of the Deed of Trust.

4.6 Compliance With Laws. Comply in all material respects with all Requirements of Laws, except that the Loan Parties and their Subsidiaries need not comply with a Requirement of Law then being contested by any of them in good faith by appropriate proceeding.

4.7 Inspection Rights. Upon reasonable notice, at any time during regular business hours and as often as reasonably requested (but not so as to materially interfere with the business of Borrower or any of their Subsidiaries) permit Administrative Agent, or any authorized employee or representative thereof, to examine, audit and make copies and abstracts from the records and books of account of Borrower, to visit and inspect the Real Property, and to discuss the affairs, finances and accounts of Borrower with any of their officers, key employees or accountants.

4.8 Keeping of Records and Books of Account. Keep adequate records and books of account reflecting all financial transactions in conformity with GAAP and in material conformity with all applicable requirements of any Governmental Agency having regulatory jurisdiction over the Borrower.

4.9 Compliance With Agreements. Promptly and fully comply with all Contractual Obligations under all material agreements, indentures, leases or instruments to which Borrower is a party.

4.10 Use of Proceeds. Use the proceeds of the Loan to finance Borrower's purchase of the Real Property.

4.11 Hazardous Materials Laws. Keep and maintain the Real Property and each portion thereof in compliance in all material respects with all Hazardous Materials Laws and promptly advise Administrative Agent in writing of (a) any and all enforcement, cleanup, removal or other governmental or regulatory actions instituted, completed or threatened in writing pursuant to any applicable Hazardous Materials Laws, (b) any and all claims made or threatened in writing by any third party against Borrower or the Real Property relating to damage, contribution, cost recovery, compensation, loss or injury resulting from any Hazardous Materials and (c) discovery by a Responsible Officer of Borrower of any occurrence or condition on any real property adjoining or in the vicinity of the Real Property that could reasonably be expected to cause the Real Property or any part thereof to be subject to any restrictions on the ownership, occupancy, transferability or use of the Real Property under any Hazardous Materials Laws.

4.12 Replacement Reserve Account.

(a) Deposit at least the following amounts in Cash into the Replacement Reserve Account on or before the first day of each calendar month, commencing January 1, 2012:

(1) From January 1, 2012 through and including January 1, 2015, $100,000;

(2) From February 1, 2015 through the Maturity Date, an amount equal to $0.20 per square foot of floor area in the Improvements.

Provided, that Borrower shall have no obligation to make any deposit into the Replacement Reserve Account at any time when the balance therein is equal to or greater than $2,000,000, and Borrower shall have the right to withdraw (and Administrative Agent shall consent to the withdrawal) any amount in the Replacement Reserve Account that is in excess of $2,000,000.

(b) Apply funds from the Replacement Reserve Account only as follows:

(1) The $300,000 in Loan proceeds deposited into the Replacement Reserve Account pursuant to Section 2.1(b) shall be applied by Borrower, on or before December 1, 2012, to payment of costs of performance of the deferred maintenance items listed on the property inspection report prepared by Marx Okubo Associates, Inc., and dated October 14, 2011;

(2) Funds deposited into the Replacement Reserve Account by Borrower pursuant to Section 4.12(a) shall be applied as follows:

(A) First, for payment of costs of repair of the building heating, ventilation and air conditioning system; and

(B) Second, for payment of costs of the replacement of the building plaza deck;

(3) After completion of repair of the building heating, ventilation and air conditioning system and the replacement of the building plaza deck, for payment of costs of such other replacement, repair and maintenance of the buildings, fixtures, equipment and other capital assets on the Real Property as Borrower shall elect to conduct.

The Replacement Reserve Account shall be a "blocked" deposit account with Administrative Agent, from which no amounts may be withdrawn without the consent of Administrative Agent, and shall be subject to a security interest, securing performance of the Obligations pursuant to a pledge and security agreement in form and content satisfactory to Administrative Agent.

4.13 Bank Account. Maintain its operating bank accounts with Administrative Agent.

4.14 Estoppel Certificates.

(a) Deliver to Administrative Agent, within 30 days after request therefor by Administrative Agent, a written statement in form and content reasonably approved by Administrative Agent, confirming the outstanding balance of principal of the Loan, whether, to the best knowledge of Borrower, a Default or Event of Default exists under this Agreement and, if so, what actions are being taken to cure the same.

(b) Exercise reasonable best efforts to cause tenants of the Real Property to deliver to Administrative Agent, within 30 days after request therefor by Administrative Agent, a written statement in form and content reasonably approved by Administrative Agent, confirming the operative terms of their leases and whether any default or potential default exists thereunder.

4.15 Performance and Funding of Deferred Maintenance .

(a) Complete the work of repair of the the heating, ventilation and air conditioning systems of the buildings on the Real Property (the " HVAC Work") and replacement of the plaza deck on the Real Property (the " Plaza Deck Replacement") before December 1, 2014.

(b) Within 90 days after the date of funding of the first Advance of principal of the Loan, deliver to Administrative Agent (i) at least three bids from licensed contractors reasonably approved by Administrative Agent for entry into guaranteed maximum price contracts under which such contractors will perform the HVAC Work, and (ii) at least three bids from licensed contractors reasonably approved by Administrative Agent for entry into guaranteed maximum price contracts under which such contractors will perform the Plaza Deck Replacement. If the aggregate cost of the HVAC Work and the Plaza Deck Replacement, pursuant to such bids, will exceed $3,600,000, Borrower shall deposit into the Replacement Reserve Account, on or before the first day of each calendar month commencing with the fourth month after the month in which the first Advance of principal of the Loan is funded, an amount equal to one-thirty-sixth of the excess over $3,600,000.

ARTICLE 5
NEGATIVE COVENANTS

So long as the Loan remains unpaid, or any other Obligation remains unpaid or unperformed, Borrower shall not, unless Administrative Agent otherwise consents:

5.1 Investments. Make or suffer to exist any Investment, other than:

(a) Investments in existence on the Closing Date and disclosed on Schedule 5.1;

(b) Investments consisting of Cash Equivalents;

(c) Investments consisting of the extension of credit to customers or suppliers of the Loan Parties in the ordinary course of business and any Investments received in satisfaction or partial satisfaction thereof; and

(d) Investments representing all or a portion of the sales price of Property sold or services provided to another Person.

5.2 ERISA. At any time, permit any Pension Plan to: (a) engage in any non-exempt "prohibited transaction" (as defined in Section 4975 of the Code); (b) fail to comply with ERISA or any other applicable Laws; (c) incur any material "accumulated funding deficiency" (as defined in Section 302 of ERISA); or (d) terminate in any manner.

5.3 Change in Nature of Business. Conduct any business other than ownership and operation of the Real Property, or own any Property other than the Real Property and the other Collateral.

5.4 Liens; Negative Pledges; Sales and Leasebacks. Create, incur, assume or suffer to exist any Lien or Negative Pledge of any nature upon or with respect to any of its Property or Collateral or agree to grant a Negative Pledge for the benefit of any other party other than Administrative Agent, or engage in any sale and leaseback transaction with respect to any of its respective Property or Collateral, whether now owned or hereafter acquired, except:

(a) Liens and Negative Pledges under the Loan Documents; and

(b) Permitted Encumbrances.

5.5 Indebtedness and Contingent Obligations. Create, incur, assume or suffer to exist any Indebtedness, or any Contingent Obligation in an aggregate amount in excess of $1,000,000, except:

(a) Indebtedness and Contingent Obligations under the Loan Documents;

(b) Indebtedness under Swap Contracts entered into with Swap Counterparties; provided that no Swap Contract entered into with respect to the Loan shall have a scheduled termination date later than the Maturity Date;

(c) Indebtedness and Contingent Obligations owed by Borrower to Parent, so long as (i) no Event of Default exists or would result from such proposed Indebtedness or Contingent Obligation or from the application of the proceeds thereof; (ii) all such Indebtedness and Contingent Obligations shall be unsecured and subordinated in right of payment to the payment in full of the Obligations, and (iii) any such Indebtedness and Contingent Obligations has been approved in advance, in writing, by Administrative Agent, which approval shall not be unreasonably withheld; and

(d) Indebtedness consisting of Capital Lease Obligations, or otherwise incurred to finance the purchase or construction of capital assets (which shall be deemed to exist if the Indebtedness is incurred at or within 90 days before or after the purchase or construction of the capital asset), or to refinance any such Indebtedness.

5.6 Transactions with Affiliates. Enter into any transaction of any kind (including, without limitation, the extension of any credit or the incurrence of any indebtedness, the making or receipt of any distribution, the purchase, sale, lease or exchange of any property, or the payment of any fees) with any Affiliate of Borrower without the prior written consent of Lender; provided, however, Borrower may, without the prior consent of Lender, do the following: (i) distribute excess Cash to Parent; (ii) borrow money from Parent to the extent permitted pursuant to Section 5.5, above; (iii) obtain capital infusions from Parent; (iv) enter into leases for vacant space in the Property, on no less than then-current market terms.

5.7 Financial Covenants.

(a) Debt Coverage Ratio. Permit the Debt Coverage Ratio, as of the last day of each June and December to be less than 1.30:1, unless Borrower shall, within fifteen (15) days after receipt of demand therefor at any time in which the Debt Coverage Ratio is less than 1.30:1, deposit into the DCR Collateral Account Cash in an amount equal to twice the difference between Borrower's annualized Net Operating Income for the most recent Calculation Period and the amount of annual Net Operating Income that would have been needed in order to generate a Debt Coverage Ratio of 1.30:1 for such Calculation Period. The DCR Collateral Account shall be a "blocked" deposit account with Administrative Agent," from which no amounts may be withdrawn without the consent of the Administrative Agent (which consent shall only be given with approval from the Required Lenders), and shall be subject to a security interest, securing performance of the Obligations pursuant to a pledge and security agreement in form and content satisfactory to Administrative Agent. If, with respect to any later Calculation Period, the amount required to be deposited into such account is less than the amount in such account, Administrative Agent shall permit Borrower to withdraw the excess Cash from the DCR Collateral Account.

(b) Loan-to-Value Ratio. If, at any time during the term of the Loan, the Loan-to-Value Ratio is greater than seventy percent (70%), Borrower shall, within fifteen (15) days after receipt of demand therefor from Administrative Agent (which demand shall be made upon direction from the Required Lenders), make a payment in reduction of principal of the Loan in an amount sufficient to cause the Loan-to-Value Ratio to be sixty percent (60%); provided, however, that Administrative Agent and Lenders shall have the right to require a payment in reduction of principal pursuant to this Section 5.7(b) only once during the term of the Loan.

5.8 Leasing. Enter into any lease, license or other agreement under which any Person is granted any right to occupy any portion of the Real Property (a) which is not negotiated at arm's length (other than leases, licenses and other agreements with Affiliates of Parent, which shall not be at arm's length) and which does not provide for rent and other terms that are reasonably consistent with those terms that prevail, at the time of entry into such lease, license or other agreement, in the market for similar office space, and (b) without furnishing a copy of the lease, license or other agreement to Administrative Agent prior to execution thereof. Failure by Administrative Agent to give notice to Borrower that Administrative Agent believes that a proposed lease, license or agreement is not in compliance with this Section 5.8 within five (5) Business Days after Administrative Agent's receipt of the copy thereof furnished by Borrower shall be deemed a waiver by Administrative Agent to object to such lease, license or agreement.

5.9 Partition; Zoning. Without the prior written consent of the Required Lenders, seek to partition or subdivide the Real Property or alter the zoning or land use classification thereof.

ARTICLE 6
INFORMATION AND REPORTING REQUIREMENTS

6.1 Financial and Business Information. So long as the Loan remains unpaid, or any other Obligation remains unpaid or unperformed, Borrower shall, unless the Required Lenders otherwise consent, deliver to Administrative Agent at Borrower' sole expense:

(a) with respect to the Fiscal Year ended December 31, 2011, as soon as available and without unreasonable delay, and with respect to each Fiscal Year ending thereafter, as soon as available but in any event within 120 days after the end of such Fiscal Year:

(1) the balance sheet as at the end of such Fiscal Year and related statements of income, operations and cash flows of Borrower for such Fiscal Year, setting forth in each case in comparative form the figures for the previous Fiscal Year, all in reasonable detail, prepared using a methodology that may not conform to GAAP but fairly presents the financial condition of Borrower as of the dates and for the periods indicated, in conformity with Borrower's usual and customary practices consistently applied throughout the periods covered, accompanied by a certificate signed by the chief executive officer, chief financial officer, treasurer or controller of Borrower to the effect that such statements are true and correct in all material respects; and

(2) the consolidated and consolidating balance sheet of Parent and its Subsidiaries, as at the end of such Fiscal Year, and the related consolidated and consolidating statements of income, operations and cash flows of Parent and its Subsidiaries for such Fiscal Year, setting forth in comparative form the figures for the previous Fiscal Year and showing changes in shareholders' equity for such Fiscal Year, audited by Ernst & Young or another firm of certified public accountants reasonably approved by Administrative Agent.

(b) with respect to the Fiscal Quarter ended March 31, 2012, as soon as available and without unreasonable delay, and with respect to each Fiscal Quarter ending thereafter (other than the fourth Fiscal Quarter of any Fiscal Year), as soon as available but in any event within 45 days after the end of such Fiscal Quarter:

(1) the balance sheet of Borrower as at the end of such Fiscal Quarter and the related statements of income, operations and cash flows of Borrower for such Fiscal Quarter, all in reasonable detail, prepared using a methodology that may not conform to GAAP but fairly presents the financial condition of Borrower as of the dates and for the periods indicated, in conformity with Borrower's usual and customary practices consistently applied throughout the periods covered, accompanied by a certificate signed by the chief executive officer, chief financial officer, treasurer or controller of Borrower to the effect that such statements are true and correct in all material respects;

(2) the consolidated and consolidating balance sheets of Parent and its Subsidiaries, as at the end of such Fiscal Quarter, the related consolidated and consolidating statements of income or operations of Parent and its Subsidiaries for such Fiscal Quarter and for the portion of the Fiscal Year then ended, and the related consolidated and consolidating statements of changes in shareholders' equity and cash flows for the portion of the Fiscal Year then ended, in each case setting forth in comparative form, the figures for the corresponding Fiscal Quarter of the previous Fiscal Year and the corresponding portion of the previous Fiscal Year, all in reasonable detail, accompanied by a certificate signed by the chief executive officer, chief financial officer, treasurer or controller of each Loan Party to the effect that such statements were prepared in accordance with GAAP and are fairly stated in all material respects.

(c) within 45 days after each June 30 and December 31, an operating statement for the Real Property for the six months ended with such date, in form and level of detail reasonably acceptable to Administrative Agent;

(d) within 10 days after the end of each calendar month, (i) a rent roll for the Real Property stating the name of each tenant in occupancy, the suite number(s) occupied by such tenant, the date of such tenant's lease, the rent and CAM charges payable by such tenant, the amount of any prepaid rents or security deposits held with respect to such tenant, the amounts of any delinquencies in payment by such tenant, and a description of any disputes or defaults in connection with such tenant's lease or occupancy, and (ii) a statement of leasing activity with respect to all unoccupied space, in form and level of detail reasonably acceptable to Administrative Agent;

(e) promptly upon the request of Administrative Agent, copies of any detailed audit reports or recommendations submitted to Borrower or to Parent by independent accountants in connection with the accounts or books of Borrower or Parent or Parent's Subsidiaries or any audit thereof;

(f) as soon as practicable, and in any event within five (5) Business Days after a Responsible Officer of Borrower becomes aware of the existence of any condition or event which constitutes a Default, written notice specifying the nature and period of existence thereof and specifying what action the Borrower is taking or proposes to take with respect thereto;

(g) promptly upon a Responsible Officer of Borrower becoming aware that (i) any Person has commenced a legal proceeding with respect to a claim against Borrower that is $100,000 or more in excess of the amount thereof that is fully covered by insurance (subject to deductibles permitted hereunder) or (ii) any Person has commenced a legal proceeding with respect to a claim against Borrower under a contract with respect to a claim in excess of $100,000 or which otherwise may reasonably be expected to result in a Material Adverse Effect, a written notice describing the pertinent facts relating thereto and what action Borrower is taking or proposes to take with respect thereto;

(h) proof of payment of all taxes, including taxes on Real Property, upon the request of Administrative Agent;

(i) within ten (10) days after filing, but in any event within nine months after the end of each Fiscal Year (commencing with the Fiscal Year ended July 31, 2010), copies of each Borrower's and Parent's state and federal income tax returns, together with all schedules for the tax period ended in such Fiscal Year;

(j) any event, occurrence or condition that has had, or is reasonably likely to have, a Material Adverse Effect upon Borrower or Parent; and

(k) such other data and information regarding the Borrower's or Parent's Subsidiaries and their businesses as from time to time may be reasonably requested by Administrative Agent.

6.2 Compliance Certificates. So long as the Loan remains unpaid, or any other Obligation remains unpaid or unperformed, Borrower shall, unless Administrative Agent otherwise consents, deliver to Administrative Agent, at Borrower' sole expense, concurrently with the financial statements required pursuant to Sections 6.1(a) and 6.1(b), a duly completed Compliance Certificate signed by the chief executive officer, chief financial officer, treasurer or controller of the manager of Borrower.

ARTICLE 7
CONDITIONS

7.1 Conditions Precedent to Closing. The obligation of Lenders to make the Loan or to take, fulfill or perform any other action under this Agreement is subject to the following conditions precedent:

(a) Administrative Agent shall have received all of the following, each of which shall be originals unless otherwise specified, each properly executed by a Responsible Officer of each Loan Party that is party thereto, each dated as of the Closing Date and each in form and substance satisfactory to Administrative Agent and its legal counsel (unless otherwise specified or, in the case of the date of any of the following, unless Administrative Agent otherwise agrees or directs):

(i) this Agreement;

(ii) the Notes;

(iii) the Parent Guaranty;

(iv) the Deed of Trust in a form acceptable for recordation in the Official Records of Los Angeles County, California;

(v) proper financing statements in form appropriate for filing under the Uniform Commercial Code of all applicable jurisdictions, covering such portion of the Collateral (including fixtures) as Administrative Agent may deem necessary or desirable in order to perfect any Liens created under the Collateral Documents;

(vi) confirmation of the first priority of the UCC-1 financing statement that perfects Administrative Agent's security interest in personal property;

(vii) assurance from the Title Company that it is committed to issue its ALTA lender's title insurance policy insuring the validity and priority of the Lien of the Deed of Trust, subject only to such exceptions as may be acceptable to Lender, in the amount of $48,600,000, and with such endorsements as to coverage (other than a survey endorsement) and reinsurance commitments as Administrative Agent may require;

(viii) the Environmental Indemnity;

(ix) a subordination and nondisturbance agreement executed by Parent, covering all leases of space in the Real Property to Parent;

(x) estoppel certificates received by Borrower in accordance with the terms of the purchase and sale agreement pursuant to which Borrower acquired the Real Property;

(xi) the Opinion of Counsel;

(xii) such documentation as Administrative Agent may reasonably require to establish the due organization, valid existence and good standing of each Loan Party, its qualification to engage in business in each jurisdiction in which it is engaged in business or required to be so qualified, its authority to execute, deliver and perform any Loan Documents to which it is a party, and the identity, authority and capacity of each Responsible Officer thereof authorized to act on its behalf, including certified copies of charter documents and amendments thereto, bylaws and operating agreements and amendments thereto, certificates of good standing or qualification to engage in business, tax clearance certificates, certificates of corporate resolutions, incumbency certificates, certificates of Responsible Officers, and the like;

(xiii) evidence that all actions necessary or, in the opinion of Administrative Agent, desirable to perfect and protect the Liens of the Collateral Documents have been taken;

(xiv) if Administrative Agent requires, an environmental questionnaire prepared and certified by Borrower and an environmental survey of the Real Property prepared by an environmental consultant satisfactory to Administrative Agent;

(xv) evidence of the casualty, liability and other insurance coverage as required under this Agreement and Section 2.11 of the Deed of Trust; and

(xvi) such other assurances, certificates, documents, consents or opinions as Lender may reasonably require.

(b) Borrower shall have paid the loan fee pursuant to Section 2.6, the agency fee pursuant to Section 2.7, and the reasonable costs and expenses of Lender in connection with the negotiation, preparation, execution and delivery of the Loan Documents pursuant to Section 10.3.

(c) Unless waived by Lender, Borrower shall have paid all fees, charges and disbursements of counsel to Lender (directly to such counsel if requested by Lender) to the extent invoiced prior to or on the Closing Date, plus such additional amounts of such fees, charges and disbursements as shall constitute its reasonable estimate of such fees, charges and disbursements incurred or to be incurred by it through the closing proceedings; provided that such estimate shall not thereafter preclude a final settling of accounts between Borrower and Lender.

(d) Borrower shall have deposited Cash in an amount not less than $300,000 into the Replacement Reserve.

(e) The representations and warranties of Borrower contained in ARTICLE 3 shall be true and correct.

(f) No circumstance or event shall have occurred that constitutes a Material Adverse Effect as of the Closing Date.

(g) Borrower and any other Loan Parties shall be in compliance with all the terms and provisions of the Loan Documents, and no Default or Event of Default shall have occurred and be continuing.

ARTICLE 8

EVENTS OF DEFAULT AND REMEDIES UPON EVENT OF DEFAULT

8.1 Events of Default. The existence or occurrence of any one or more of the following events, whatever the reason therefor and under any circumstances whatsoever, shall constitute an "Event of Default":

(a) Borrower fails to pay any principal or interest on the Loan, or any portion thereof,

(1) in the case of a scheduled monthly payment under Section 2.3(b), on or before the later to occur of (A) the date that is ten (10) days after the same becomes due, or (B) the date that is two (2) Business Days after the date of Borrower's receipt of the monthly invoice required to be delivered by Administrative Agent pursuant to Section 2.3; or

(2) in the case of any payment of principal or interest on the Loan, or any portion thereof, other than a scheduled monthly payment under Section 2.3(b), on or before the date that is ten (10) days after the same becomes due; or

(b) Borrower fails to pay any fees or other amounts payable under this Agreement or the other Loan Documents, or any portion thereof, within the period specified in the applicable Loan Document or absent a specified period, within ten (10) days after demand therefor; or

(c) Borrower fails to perform or observe any of the covenants contained in Sections 4.2, 5.3, 5.7 or ARTICLE 6; or

(d) Borrower or Parent fails to perform or observe any other covenant or agreement (not specified in clauses (a) through (c) above) contained in any Loan Document on its part to be performed or observed and does not cure such failure for a period of ten (10) Business Days after notice from Administrative Agent of such failure; provided, if such failure is susceptible of cure but cannot reasonably be cured within such ten day period, Borrower or Parent fails to promptly commence to cure such failure and do not effect a cure within thirty (30) Business Days after such notice from Administrative Agent; or

(e) Any representation or warranty made in any Loan Document, or in any certificate delivered pursuant to any Loan Document, proves to have been incorrect in any material respect when made or reaffirmed; or

(f) Borrower or Parent (i) fails to pay the principal, or any principal installment, of any present or future Indebtedness, or any guaranty of present or future Indebtedness, on its part to be paid, when due (or within any stated grace period), whether at the stated maturity, upon acceleration, by reason of required prepayment or otherwise or (ii) fails to perform or observe any other term, covenant or agreement on its part to be performed or observed, or suffers any event of default to occur, in connection

with any present or future Indebtedness, or of any guaranty of present or future Indebtedness, if as a result of such failure or sufferance any holder or holders thereof (or a lender or trustee on its or their behalf) has the right to declare such Indebtedness due before the date on which it otherwise would become due or the right to require Borrower or Parent to redeem or purchase, or offer to redeem or purchase, all or any portion of such Indebtedness; or

(g) Any Loan Document, at any time after its execution and delivery and for any reason other than the agreement or action of Administrative Agent or the Lenders or satisfaction in full of all the Obligations, ceases to be in full force and effect or is declared by a court of competent jurisdiction to be null and void, invalid or unenforceable as to any material right or remedy on the part of Administrative Agent or Lenders (other than with respect to Article 9, to which this subsection (g) shall not be applicable); or any Collateral Document ceases to create a valid and effective Lien in any portion of the Collateral; or Borrower or Parent denies in writing that it has any or further liability or obligation under any Loan Document to which it is a party, or purports to revoke, terminate or rescind same; or

(h) A final judgment against Borrower or Parent is entered for the payment of money in excess of $100,000 (not covered by insurance or for which an insurer has reserved its rights) and, absent procurement of a stay of execution, such judgment remains unsatisfied for 30 calendar days after the date of entry of judgment, or in any event later than five days prior to the date of any proposed sale thereunder; or any writ or warrant of attachment or execution or similar process is issued or levied against all or any material part of the property of Borrower or Parent and is not released, vacated or fully bonded within 30 calendar days after its issue or levy; or

(i) Borrower or Parent institutes or consents to the institution of any proceeding under a Debtor Relief Law relating to it or to all or any material part of its Property, or is unable or admits in writing its inability to pay its debts as they mature, or makes an assignment for the benefit of creditors; or applies for or consents to the appointment of any receiver, trustee, custodian, conservator, liquidator, rehabilitator or similar officer for it or for all or any material part of its Property; or any receiver, trustee, custodian, conservator, liquidator, rehabilitator or similar officer is appointed without the application or consent of that Person and the appointment continues undischarged or unstayed for 30 calendar days; or any proceeding under a Debtor Relief Law relating to any such Person or to all or any part of its Property is instituted without the consent of that Person and continues undismissed or unstayed for 30 calendar days; or

(j) The occurrence of an Event of Default (as such term is or may hereafter be specifically defined in any other Loan Document) under any other Loan Document; or

(k) Any Pension Plan maintained by Parent is finally determined by the PBGC to have an “accumulated funding deficiency” as that term is defined in Section 302 of ERISA in excess of an amount equal to 5% of the consolidated total assets of such Borrower as of the most recently ended Fiscal Quarter; or

(l) The occurrence of any Change in Control with respect to Borrower; or

(m) The occurrence of any set of events or circumstances that constitute a Material Adverse Effect; provided, as to any such set of events or circumstances not described as an Event of Default under the preceding subparagraphs (a) through (l), Borrower shall have the right to notice and opportunity to cure such Material Adverse Effect in accordance with subparagraph (d) above; or

(n) The occurrence of an event of default (after expiration of applicable notice and cure periods without cure) under the Parent Credit Facility.

8.2 Remedies Upon Event of Default. If any Event of Default occurs and is continuing, Administrative Agent may (and shall, upon direction from the Required Lenders) take any or all of the following actions, without notice to (except as expressly provided for in any Loan Document) or demand upon Borrower, which are hereby expressly waived by each Borrower:

(a) Take possession of the Real Property in person or through a court-appointed receiver, and do anything required, necessary or advisable in Lender's sole discretion to fulfill the obligations of Borrower hereunder. Without restricting the generality of the foregoing, Borrower hereby appoints Administrative Agent as Borrower' lawful attorney-in-fact with full power of substitution in the premises to perform any of the following actions:

(i) without inquiring into and without respect to the validity thereof, pay, settle or compromise all existing bills and claims which may be Liens, or avoid such bills and claims becoming Liens, against the Real Property or any portion thereof;

(ii) prosecute and defend actions or proceedings in connection with the Real Property; and

(iii) do any and every act that Borrower might do on their own behalf with respect to the Real Property, it being expressly agreed that this power of attorney shall be a power coupled with an interest and cannot be revoked;

(b) Declare the unpaid principal amount of the Loan, all interest accrued and unpaid thereon, and all other amounts owing or payable hereunder or under any other Loan Document to be immediately due and payable, without presentment, demand, protest or other notice of any kind, all of which are hereby expressly waived by Borrower;

(c) Otherwise enforce any and all Liens and security interests created pursuant to the Collateral Documents (including, without limitation, foreclosure of the Deed of Trust by judicial action, implementation of the power of sale granted pursuant to the Deed of Trust), implement action of the assignment of rents made pursuant to the Deed of Trust and realization upon the security interests granted to Lender pursuant to the Deed of Trust and this Agreement;

(d) Suspend or terminate all obligations of Lender and all rights of Borrower and any other Loan Parties under the Loan Documents, except that Lender may waive the Event of Default, which waiver or determination shall apply equally to, and shall be binding upon, Lender;

(e) Proceed in accordance with applicable Laws to protect, exercise and enforce the rights and remedies of Lender under the Loan Documents against Borrower and any other Loan Party and such other rights and remedies as are provided by Law or equity;

provided, however, that upon the occurrence of any Event of Default described in Section 8.1(i), all obligations of Lenders and all rights of Borrower and any other Loan Parties under the Loan Documents shall automatically be terminated (except that Administrative Agent may waive the Event of Default, which waiver or determination shall apply equally to, and shall be binding upon, all Lenders), and all interest and other amounts as aforesaid shall automatically become due and payable without further act of Lender.

Borrower acknowledges and agrees that this Section does not limit the right of any Administrative Agent to (i) exercise self-help remedies such as but not limited to, set off against any account in which Administrative Agent holds a security interest as collateral security for the Obligations, (ii) initiate judicial or non-judicial foreclosure against any real or personal property Collateral, (iii) exercise any judicial or power of sale rights, or (iv) act in a court of Law to obtain an interim remedy such as, but not limited to, injunctive relief, writ of possession or appointment of a receiver, or additional or supplementary remedies.

8.3 Application of Funds. The order and manner in which Administrative Agent's rights and remedies are to be exercised shall be determined by Administrative Agent (subject to Article 9) in its sole discretion, and all payments received by Administrative Agent shall be applied first to the costs and expenses of Administrative Agent (including reasonable attorneys' fees and disbursements and the reasonably allocated costs of attorneys employed by Administrative Agent), second, to the payment of accrued and unpaid interest due under any Loan Documents to and including the date of such application, and third, to the payment of all other Obligations. No application by Administrative Agent of partial payments received from or on behalf of Borrower will cure any Event of Default, or prevent acceleration, or continued acceleration, of amounts payable under the Loan Documents or Swap Contracts, or prevent the exercise, or continued exercise, of rights or remedies of Administrative Agent, Lenders or Swap Counterparties hereunder or thereunder or at Law or in equity, except as required under applicable Laws.

ARTICLE 9

APPOINTMENT AND AUTHORIZATION OF ADMINISTRATIVE AGENT.

9.1 Authorization of Administrative Agent. Each Lender hereby irrevocably (subject to Section 9.11) appoints, designates and authorizes Administrative Agent to take such action on its behalf under the provisions of this Agreement and each other Loan Document and to exercise such powers and perform such duties as are expressly delegated to it by the terms of this Agreement and any other Loan Document, together with such powers as are reasonably incidental thereto. Notwithstanding any provision to the contrary contained elsewhere herein or in any other Loan Document, Administrative Agent shall not have any duties or responsibilities except those expressly set forth herein, nor shall Administrative Agent have or be deemed to have any fiduciary relationship with any Lender. No implied covenants, functions, responsibilities, duties, obligations or liabilities shall be read into this Agreement or any other Loan Document shall otherwise exist against Administrative Agent. Without limiting the generality of the foregoing sentence, the use of the term " agent" herein and in the other Loan Documents with reference to Administrative Agent is not intended to connote any fiduciary or other implied (or express) obligations arising under agency doctrine of any applicable law. Instead, such term is used merely as a matter of market custom, and is intended to create or reflect only an administrative relationship between independent contracting parties.

9.2 No Waiver by Lender. No individual Lender or group of Lenders shall have any right to amend or waive, or consent to the departure of any party from any provision of any Loan Document, or secure or enforce the obligations of Borrower or any other party pursuant to the Loan Documents or otherwise. All such rights, on behalf of Administrative Agent or any Lender or Lenders, shall be held and exercised solely by and at the option of Administrative Agent for the pro rata benefit of Lenders. Such rights, however, are subject to the rights of a Lender or Lenders, as expressly set forth in this Agreement and to approve matters or direct Administrative Agent to take or refrain from taking action as set forth in this Agreement. Except as expressly otherwise provided in this Agreement and the other Loan Documents, Administrative Agent shall have and may use its reasonable discretion with respect to exercising or refraining from exercising any discretionary rights or taking or refraining from taking any actions which Administrative Agent is expressly entitled to exercise or take under this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or the other Loan Documents, including (i) the determination if and to what extent matters or items subject to Administrative Agent's satisfaction are acceptable or otherwise within its discretion, (ii) the making of Administrative Agent Advances, and (iii) the exercise of remedies pursuant to this Agreement any other Loan Document and any action so taken or not taken shall be deemed consented to by Lenders.

9.3 Receivership or Insolvency. In case of the pendency of any receivership, insolvency, liquidation, bankruptcy, reorganization, arrangement, adjustment, composition or other judicial proceeding relative to Borrower or Parent, no individual Lender or group of Lenders shall have the right, and Administrative Agent (irrespective of whether the principal of the loan shall then be due and payable as herein expressed or by declaration or otherwise and irrespective of whether Administrative Agent shall have made any demand on Borrower) shall be exclusively entitled and empowered on behalf of itself and Lenders, by intervention in such proceeding or otherwise:

(a) to file and prove a claim for the whole amount of the principal and interest owing and unpaid in respect of the Loan and all other obligations that are owing and unpaid and to file such other documents as may be necessary or advisable in order to have the claims of Lenders and Administrative Agent (including any claim for the reasonable compensation, expenses, disbursements and advances of Lenders and Administrative Agent and their respective agents and counsel and all other amounts due Lenders and Administrative Agent); and

(b) to collect and receive any monies or other property payable or deliverable on any such claims and to distribute the same in accordance with the terms of this Agreement;

and any custodian, receiver, assignee, trustee, liquidator, sequestrator or other similar official in any such judicial proceeding is hereby authorized by each Lender to make such payments to Administrative Agent and, in the event that Administrative Agent shall consent to the making of such payments directly to Lenders, to pay to Administrative Agent any amount due for the reasonable compensation, expenses, disbursements and advances of Administrative Agent and its agents and counsel in accordance with the terms of this Agreement.

Nothing contained herein shall be deemed to authorize Administrative Agent to authorize or consent to or accept or adopt on behalf of any Lender any plan of reorganization, arrangement, adjustment or composition affecting the Indebtedness or the rights of Lenders except as approved by the Required Lenders or to authorize Administrative Agent to vote in respect of the claims of Lenders except as approved by the Required Lenders in any such proceeding.

9.4 Delegation of Duties. Administrative Agent may execute any of its duties under this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document by or through agents, employees or attorneys-in-fact and shall be entitled to advice of counsel and other consultant experts concerning all matters pertaining to such duties. Administrative Agent shall not be responsible for the negligence or misconduct of any agent or attorney-in-fact that it selects with reasonable care.

9.5 Liability of Administrative Agent. No Agent-Related Persons shall (i) be liable to any Lender for any action taken or omitted to be taken by any of them under or in connection with this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document or the transactions contemplated hereby (except for its own gross negligence or willful misconduct), or (ii) be responsible in any manner to any Lender for any recital, statement, representation or warranty made by Borrower or any subsidiary or Affiliate of Borrower, or any officer thereof, contained in this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document, or in any certificate, report, statement or other document referred to or provided for in, or received by Administrative Agent under or in connection with, this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document, or the validity, effectiveness, genuineness, enforceability or sufficiency of this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document, or for any failure of Borrower or any other party to any Loan Document to perform its obligations hereunder or thereunder. No Agent-Related Person shall be under any obligation to any Lender to ascertain or to inquire as to the observance or performance of any of the agreements contained in, or conditions of, this Agreement or any other Loan Document, or to inspect the properties, books or records of Borrower, Parent or any of their Affiliates.

9.6 Reliance by Administrative Agent. Administrative Agent shall be entitled to rely, and shall be fully protected in relying, upon any writing, resolution, notice, consent, certificate, affidavit, letter, telegram, facsimile, telex or telephone message, statement or other document or conversation believed by it to be genuine and correct and to have been signed, sent or made by the proper person or persons, and upon advice and statements of legal counsel (including counsel to any party to the Loan Documents), independent accountants and other experts selected by Administrative Agent with reasonable care. Administrative Agent shall be fully justified in failing or refusing to take any action under this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document unless it shall first receive such advice or concurrence of the Required Lenders or all Lenders if required hereunder as it deems appropriate and, if it so requests, it shall first be indemnified to its satisfaction by Lenders against any and all liability and expense which may be incurred by it by reason of taking or continuing to take any such action. Administrative Agent shall in all cases be fully protected in acting, or in refraining from acting, under this Agreement, the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document in accordance with a request or consent of the Required Lenders or such greater number of Lenders as may be expressly required hereby in any instance, and such request and any action taken or failure to act pursuant thereto shall be binding upon all Lenders. In the absence of written instructions from the Required Lenders or such greater number of Lenders, as expressly required hereunder, Administrative Agent may take or not take any action, at its discretion, unless this Agreement specifically requires the consent of the Required Lenders or such greater number of Lenders.

9.7 Notice of Default. Administrative Agent shall not be deemed to have knowledge or notice of the occurrence of any Event of Default, unless Administrative Agent shall have gained actual knowledge in its capacity as a Lender or shall have received written notice from a Lender or from Borrower referring to this Agreement, describing such Event of Default. Administrative Agent will notify Lenders promptly of its receipt of any such notice. Administrative Agent shall take such action with respect to such Event of Default as may be requested by the Required Lenders in accordance with Article 8; provided, however, that unless and until Administrative Agent has received any such request, Administrative Agent may (but shall not be obligated to) take such action, or refrain from taking such action, with respect to such Event of Default as it shall deem advisable or in the best interest of Lenders.

9.8 Credit Decision; Disclosure of Information by Administrative Agent.

(a) Each Lender acknowledges that no Agent-Related Person has made any representation or warranty to it, and that no act by Administrative Agent hereafter taken, including any consent to and acceptance of any assignment or review of the affairs of Borrower, and/or Parent, shall be deemed to constitute any representation or warranty by any Agent-Related Person to Lenders or any of them as to any matter. Each Lender represents to Administrative Agent that it has, independently and without reliance upon any Agent-Related Person and based on such documents and information as it has deemed appropriate, made its own appraisal of and investigation into the business, prospects, operations, property, financial and other condition and creditworthiness of

Borrower and Parent, and all applicable bank or other regulatory laws relating to the transactions contemplated hereby, and made its own decision to enter into this Agreement and to extend credit to Borrower hereunder. Each Lender also represents that it will, independently and without reliance upon any Agent-Related Person and based on such documents and information as it shall deem appropriate at the time, continue to make its own credit analysis, appraisals and decisions in taking or not taking action under this Agreement, the Notes, the Deed of Trust, the Parent Guaranty and the other Loan Documents, and to make inquiries of Administrative Agent as it deems necessary to inform itself as to the business, prospects, operations, property, financial and other condition and creditworthiness of Borrower and Parent. Notwithstanding the foregoing, no individual Lender shall have the right to require that Borrower or Parent provide to such Lender independent access to the Real Property or independent delivery to such Lender of notices, reports, documents or information not specifically required of Borrower under Article 6 of this Agreement.

(b) Administrative Agent upon its receipt shall provide each Lender such notices, reports and other documents expressly required to be furnished by Borrower or Parent to Administrative Agent. Administrative Agent shall also provide each Lender and/or make available for each Lender's inspection during reasonable business hours and at the Lender's expense, upon the Lender's written request therefor: (i) copies of the Loan Documents; (ii) such information as is then in Administrative Agent's possession in respect of the current status of principal and interest payments and accruals in respect of the Loan; (iii) copies of all current financial statements in respect of Borrower or Parent or other person liable for payment or performance by Borrower of any obligations under the Loan Documents, then in Administrative Agent's possession with respect to the Loan; and (iv) other current factual information then in Administrative Agent's possession with respect to the Loan and bearing on the continuing creditworthiness of Borrower or any Parent, or any of their respective Affiliates; provided, that Administrative Agent shall not be obligated to provide any Lender with any information in violation of law or any contractual restrictions on the disclosure thereof (provided such contractual restrictions shall not apply to distributing to a Lender factual and financial information expressly required to be provided herein). Except as set forth above, Administrative Agent shall not have any duty or responsibility to provide Lenders or any of them with any credit or other information concerning the business, prospects, operations, property, financial and other condition or creditworthiness of Borrower or Parent or any of their respective Affiliates which may come into the possession of any of Agent-Related Persons.

9.9 Indemnification of Administrative Agent. Whether or not the transactions contemplated hereby are consummated, Lenders hereby jointly and severally indemnify upon demand each Agent-Related Person (to the extent not reimbursed by or on behalf of Borrower and without limiting the obligation of Borrower to do so if required by applicable provisions of the Loan Documents), and hold harmless each Agent-Related Person from and against any and all indemnified liabilities incurred by it; provided, however, that no Lender shall be liable for the payment to any Agent-Related Person of any portion of such indemnified liabilities to the extent determined in a final, non-appealable judgment by a court of competent jurisdiction to have resulted from such Agent-Related Person's own gross negligence or willful misconduct; provided, further, that no action taken in accordance with the directions of the Required Lenders

shall be deemed to constitute gross negligence or willful misconduct for purposes of this Section 9.9. Without limitation of the foregoing, to the extent that Administrative Agent is not reimbursed by or on behalf of Borrower, each Lender shall reimburse Administrative Agent upon demand for its Pro Rata Share of any costs or out-of-pocket expenses (including attorneys' fees) incurred by Administrative Agent in the performance of its duties under this Agreement. The undertaking in this Section 9.9 shall survive the payment of all Indebtedness hereunder and the resignation or replacement of Administrative Agent.

9.10 Administrative Agent in Individual Capacity. Administrative Agent, in its individual capacity, and its Affiliates may make loans to, issue letters of credit for the account of, accept deposits from, acquire equity interests in and generally engage in any kind of banking, trust, financial advisory, underwriting or other business with any party to the Loan Documents and their respective Affiliates as though Administrative Agent were not Administrative Agent hereunder and without notice to or consent of Lenders. Lenders acknowledge that Borrower and East West Bank or its Affiliate have entered or may enter into Swap Contracts. A portion of the Loan may be funded to honor Borrower's payment obligations under the terms of such Swap Contracts, and Lenders shall have no right to share in any portion of such payments except to the extent of their rights as Swap Counterparties. Lenders acknowledge that, pursuant to such activities, East West Bank or its Affiliates may receive information regarding any party to the Loan Documents or their respective Affiliates (including information that may be subject to confidentiality obligations in favor of such parties or such parties' Affiliates) and acknowledge that Administrative Agent shall be under no obligation to provide such information to them. With respect to its Pro Rata Share of the Loan, East West Bank shall have the same rights and powers under this Agreement as any other Lenders and may exercise such rights and powers as though it were not Administrative Agent or party to Swap Contracts, and the terms "**Lender**" and "**Lenders**" include East West Bank in its individual capacity.

9.11 Successor Administrative Agent. Administrative Agent may, and at the request of the Required Lenders as a result of Administrative Agent's gross negligence or willful misconduct or default in performing its duties under this Agreement shall, resign as Administrative Agent upon 30 days' notice to Lenders. If Administrative Agent resigns under this Agreement, the Required Lenders shall appoint from among Lenders a successor administrative agent for Lenders, which successor administrative agent shall be consented to by Borrower at all times other than during the existence of an Event of Default (which consent of Borrower shall not be unreasonably withheld or delayed). If no successor administrative agent is appointed prior to the effective date of the resignation of Administrative Agent, Administrative Agent may, after consulting with Lenders and Borrower, appoint a successor administrative agent from among Lenders. Upon the acceptance of its appointment as successor administrative agent hereunder, such successor administrative agent shall succeed to all the rights, powers and duties of the retiring Administrative Agent and the term "Administrative Agent" shall mean such successor administrative agent, and the retiring Administrative Agent's appointment, powers and duties as Administrative Agent shall be terminated. After any retiring Administrative Agent's resignation hereunder as Administrative Agent, the provisions of this Section 9.12 and other applicable Sections of this Agreement shall inure to its benefit as to any actions taken or omitted to be taken by it while it was Administrative Agent under this Agreement. If no successor administrative agent has accepted appointment as Administrative Agent by the date which is thirty (30) days following a retiring Administrative Agent's notice of resignation, the retiring Administrative Agent's resignation shall nevertheless thereupon become effective and Lenders shall perform all of the duties of Administrative Agent hereunder until such time, if any, as the Required Lenders appoint a successor agent as provided for above.

9.12 Releases, Acquisition and Transfers of Collateral.

(a) Lenders hereby irrevocably authorize Administrative Agent to transfer or release any lien on, or after foreclosure or other acquisition of title by Administrative Agent on behalf of the Lenders to transfer or sell, any Collateral (A) upon the termination of the Commitments and payment and satisfaction in full of all Obligations, (B) in connection with a release, transfer or sale of a lien or property if such transfer or release is conditioned upon receipt by Administrative Agent of the payment required pursuant to Section 4.2(c), and (C) after foreclosure or other acquisition of title to any Foreclosed Real Property, (i) for a purchase price of not less than 80% of the value indicated in the most recent appraisal of such Foreclosed Real Property obtained by Administrative Agent made in accordance with regulations governing Administrative Agent, or (ii if approved by the Required Lenders.

(b) If an Event of Default has occurred hereunder, Administrative Agent may take title to any of the Collateral to which it is entitled as a result of exercise of its remedies under the Deed of Trust and applicable law, in its name and in its capacity as administrative agent, for the benefit of all Lenders according to their Pro Rata Shares.

(c) Administrative Agent may take title to Foreclosed Real Property in its name and in its capacity as administrative agent or in the name of an Affiliate of Administrative Agent, but for the benefit of all Lenders according to their Pro Rata Shares. Administrative Agent and all Lenders hereby expressly waive and relinquish any right of partition with respect to the Foreclosed Real Property so acquired. After Foreclosed Real Property is acquired, Administrative Agent shall appoint and retain one or more persons (individually and collectively, the "Property Manager") experienced in the management, leasing, sale and/or disposition of similar properties; provided, however, that Administrative Agent shall not appoint or retain any Affiliate of Administrative Agent as the Property Manager unless the terms of such appointment or retention are approved in writing by the Required Lenders. After consulting with the Property Manager, Administrative Agent shall prepare a written plan for completion of construction (if required), operation, management, improvement, maintenance, repair, sale and disposition of the Foreclosed Real Property and a budget for the aforesaid, which may include a reasonable management fee payable to Administrative Agent (the "Business Plan"). Administrative Agent will deliver the Business Plan not later than the sixtieth (60th) day after the on the date of the foreclosure sale or recordation of the deed in lieu of foreclosure (the " Acquisition Date") to each Lender with a written request for approval of the Business Plan. If the Business Plan is approved by the Required Lenders, Administrative Agent and the Property Manager shall adhere to the Business Plan until a different Business Plan is approved by the Required Lenders. Administrative Agent may propose an amendment to the Business Plan as it deems appropriate, which shall also be subject to Required Lender approval. If the Business Plan (as may be amended) proposed by Administrative Agent is not approved by the Required Lenders, or if

sixty (60) days have elapsed following the Acquisition Date without a Business Plan being proposed by Administrative Agent, any Lender may propose an alternative Business Plan, which Administrative Agent shall submit to all Lenders for approval by the Required Lenders. If an alternative Business Plan is approved by the Required Lenders, Administrative Agent may appoint one of the approving Lenders to implement the alternative Business Plan. Notwithstanding any other provision of this Agreement, unless in violation of an approved Business Plan or otherwise in an emergency situation, Administrative Agent shall have the right but not the obligation to take any action in connection with the Collateral (including those with respect to property taxes, insurance premiums, completion of construction, operation, management, improvement, maintenance, repair, sale and disposition), or any portion thereof.

(d) Upon request by Administrative Agent or Borrower at any time, Lenders will confirm in writing Administrative Agent's authority to sell, transfer or release any such liens of particular types or items of Collateral or Foreclosed Real Property pursuant to this Section 9.12; provided, however, that (i) Administrative Agent shall not be required to execute any document necessary to evidence such release, transfer or sale on terms that, in Administrative Agent's opinion, would expose Administrative Agent to liability or create any obligation or entail any consequence other than the transfer, release or sale without recourse, representation or warranty, and (ii) such transfer, release or sale shall not in any manner discharge, affect or impair the obligations of Borrower other than those expressly being released.

(e) Except as provided in Section 2.14 and except as otherwise provided below with respect to Defaulting Lenders, aggregate principal and interest payments, payments for indemnified liabilities, proceeds of foreclosure or sale of the Foreclosed Real Property, and net operating income from the collateral during any period it is owned by Administrative Agent on behalf of Lenders ("Payments") shall be apportioned among the Lenders in accordance with their Pro Rata Shares and payments of any fees (other than fees designated for Administrative Agent's separate account) shall, as applicable, be apportioned among the Lenders in accordance with their Pro Rata Shares. Notwithstanding anything to the contrary in this Agreement, all Payments that would otherwise be due and payable to Defaulting Lenders shall instead be paid to and specially apportioned among the Administrative Agent and Lenders other than Defaulting Lenders in accordance with their Pro Rata Shares. Such special apportionment shall be in the proportion that any amounts required to be paid by Lenders pursuant to this Agreement which are not paid by Defaulting Lenders and are paid by Administrative Agent or any Lender other than a Defaulting Lender bears to the total amount not paid by such Defaulting Lender. Such special apportionment shall be made until Administrative Agent and Lenders have been paid in full for all of the amounts they advanced in place of the Defaulting Lender. All Payments shall be remitted to Administrative Agent and all such Payments not constituting payment of specific fees, and all proceeds of the Collateral received by Administrative Agent, shall be applied first, to pay any fees, indemnities, costs, expenses and reimbursements then due to Administrative Agent from Borrower; second, to pay any fees, costs, expenses and reimbursements then due to Lenders from Borrower; third, to pay, pro rata, interest and late charges due in respect of the Obligations and Administrative Agent Advances; fourth, to pay or prepay, pro rata,

principal of the Obligations and Administrative Agent Advances; fifth, to pay any indebtedness of Borrower under Swap Contracts; and last, to Borrower, if required by law, or Lenders in accordance with their Pro Rata Shares at the termination of the Total Commitment.

9.13 Benefit. The terms and conditions of this Article 9 are inserted for the sole benefit of Administrative Agent and Lenders, and to the extent provided in this Section 9.13, for the benefit of Borrower. Except for those provisions described in this Section 9.13 which benefit Borrower, the terms and conditions of Article 9 may be waived by Administrative Agent and Lenders in whole or in part, with or without terms or conditions, without prejudicing Administrative Agent's or Lenders' rights to later assert them in whole or in part. Notwithstanding the foregoing or anything else in this Agreement to the contrary, Sections 9.1, 9.2, 9.3, 9.14 and 9.15 of this Article 9 are also for the benefit of Borrower, and may not be waived in whole or in part by Administrative Agent or any Lender or Lenders, or amended, without the prior written consent of Borrower.

9.14 No Obligation by Borrower; Right of Reliance. Borrower shall have no obligations under this Article 9, express or implied, and no duty of investigation or inquiry as to the performance or non-performance by Administrative Agent or any Lender of its obligations under this Article 9 or Section 10.2, or any other provision of this Agreement pursuant to which Administrative Agent may not act without the consent or approval of any one or more Lenders.

9.15 Right of Reliance on Administrative Agent. Borrower and Parent shall have the right to rely upon the written directions, authorizations, consents, approvals, waivers and decisions (collectively, "Directions") of the Administrative Agent in all matters pertaining to the Loan Documents and performance thereunder, without more and without investigation or inquiry as to the authority of Administrative Agent to so act and notwithstanding any actual knowledge on the part of Borrower or Parent to the contrary.

9.16 Timing of Payments by Administrative Agent. Administrative Agent shall exercise its reasonable best efforts to pay to each Lender its Pro Rata Share of any principal or interest paid by Borrower (except for payments under Section 2.14, which shall be paid only to the Affected Lender) within one (1) Business Day after Administrative Agent's receipt of payment thereof from Borrower, and shall in any event make each such payment within three (3) Business Days after Administrative Agent's receipt of payment thereof from Borrower.

9.17 Records of Advances and Payments. Each Lender shall use its best efforts to keep a record of the Loan made by it and payments received by it with respect to its Note, and such record shall be presumptive evidence of the amounts owing. Notwithstanding the foregoing sentence, no Lender shall be liable to any Loan Party for any failure to keep such a record, and no such failure shall affect the amount of the Obligations hereunder.

9.18 Required Lenders' Direction of Appraisal. Administrative Agent shall cause the Property to be appraised and shall invoke the provisions of Section 5.7(b) if it is directed to do so by the Required Lenders.

ARTICLE 10
MISCELLANEOUS

10.1 Cumulative Remedies; No Waiver. The rights, powers, privileges and remedies of Administrative Agent and the Lenders provided herein or in the Notes, the Deed of Trust, the Parent Guaranty or any other Loan Document are cumulative and not exclusive of any right, power, privilege or remedy provided by Law or equity. No failure or delay on the part of Administrative Agent or any Lender in exercising any right, power, privilege or remedy may be, or may be deemed to be, a waiver thereof; nor may any single or partial exercise of any right, power, privilege or remedy preclude any other or further exercise of the same or any other right, power, privilege or remedy.

10.2 Amendments; Consents. Administrative Agent and Lenders shall be entitled to amend (whether pursuant to a separate intercreditor agreement or otherwise) any of the terms, conditions or agreements set forth in Article 9 or as to any other matter in this Agreement or any other Loan Document respecting payments to Administrative Agent or Lenders as among themselves or the required number of Lenders to approve or disapprove any matter or to take or refrain from taking any action, without the consent of Borrower or any other person or entity or the execution by Borrower or any other person or entity of any such amendment or intercreditor agreement. Subject to the foregoing, Administrative Agent may amend or waive any provision of this Agreement, or any other Loan Document, or consent to any departure by any party to the Loan Documents therefrom with the prior written consent of the Required Lenders and Borrower or the applicable party to the Loan Documents, as the case may be, and each such waiver or consent shall be effective only in the specific instance and for the specific purpose for which given; provided further, however, no such amendment, waiver or consent shall, without the consent of all Lenders (other than Defaulting Lenders):

(a) extend or increase the Commitment of any Lender without the written consent of such Lender (it being understood that a waiver of an Event of Default shall not constitute an extension or increase in any Lender's Commitment);

(b) postpone any date fixed by this Agreement, the Notes or any other Loan Document for any payment or mandatory prepayment of principal, interest, fees or other amounts due to Lenders (or any of them) hereunder or under the Notes or any other Loan Document, without the written consent of each Lender directly affected thereby;

(c) reduce the principal of, or the rate of interest specified herein on, any portion of the Loan, or any fees or other amounts payable under this Agreement, the Notes or any other Loan Document, without the written consent of each Lender directly affected thereby; provided;

(d) change the definition of "Pro Rata Share" or "Required Lenders" or any other provision hereof specifying the number or percentage of Lenders required to amend, waive or otherwise modify any rights hereunder or make any determination or grant any consent hereunder, without the written consent of each Lender;

(e) amend this Section 10.2 without the written consent of each Lender;

(f) release the liability of Borrower or any existing Parent without the written consent of each Lender;

(g) permit the sale, transfer, pledge, mortgage or assignment of any Collateral or any direct or indirect interest in Borrower, except as expressly permitted under the Loan Documents as in effect on the Closing Date, without the written consent of each Lender;

(h) transfer or release any lien on, or after foreclosure or other acquisition of title by Administrative Agent on behalf of Lenders transfer or sell, any Collateral, except as provided in Section 9.12 as in effect on the Closing Date without the written consent of each Lender; or

(i) amend the Guaranty, or release Parent from any of its obligations thereunder;

and, provided, further, that no amendment, waiver or consent shall, unless in writing and signed by Administrative Agent in addition to the Lenders required above, affect the rights or duties of Administrative Agent under this Agreement, the Notes or any other Loan Document. Notwithstanding anything to the contrary herein, no Defaulting Lender shall have any right to approve or disapprove any amendment, waiver or consent hereunder, except that the Commitment of such Lender may not be increased without the consent of such Lender. The granting or withholding of the consents required pursuant to this Section 10.2 shall be within the sole discretion of the applicable Lenders.

10.3 Costs, Expenses and Taxes. Borrower shall pay on demand the reasonable costs and expenses of Administrative Agent in connection with the negotiation, preparation, execution and delivery of the Loan Documents, and of Administrative Agent in connection with the administration, amendment, waiver, refinancing, restructuring, reorganization (including a bankruptcy reorganization) and enforcement or attempted enforcement of the Loan Documents, and any matter related thereto, including, without limitation, filing fees, recording fees, title insurance fees, appraisal fees, search fees and other out-of-pocket expenses and the reasonable fees and out-of-pocket expenses of any legal counsel (including the allocated fees and all disbursements and other expenses of any internal legal counsel), independent public accountants and other outside experts retained by Administrative Agent, and including, without limitation, any costs, expenses or fees incurred or suffered by Administrative Agent in connection with or during the course of any bankruptcy or insolvency proceedings of Borrower; provided that Administrative Agent shall, in connection with any such amendment, waiver, refinancing, restructuring, reorganization, enforcement or attempted enforcement of the Loan Documents use commercially reasonable efforts to avoid duplicative efforts by legal counsel on behalf of Administrative Agent. Borrower shall pay any and all documentary and other taxes (other than income or gross receipts taxes generally applicable to banks) and all costs, expenses, fees and charges payable or determined to be payable in connection with the filing or recording of this Agreement, any other Loan Document or any other instrument or writing to be delivered hereunder or thereunder, or in connection with any transaction pursuant hereto or thereto, and

shall reimburse, hold harmless and indemnify Administrative Agent from and against any and all loss, liability or legal or other expense with respect to or resulting from any delay in paying or failure to pay any tax, cost, expense, fee or charge or that any of them may suffer or incur by reason of the failure of Borrower or Parent to perform any of its Obligations. Any amount payable to Administrative Agent under this Section 10.3 shall bear interest at the Default Rate from the fifth (5th) Business Day following a demand for payment specifying the costs demanded in reasonable detail. Notwithstanding anything in this Section 10.3 to the contrary, Borrower and Parent shall not be liable or responsible for costs or fees incurred by Administrative Agent or any Lender in connection with the syndication of the Loan, the negotiation or enforcement of Article 9 or any other agreement by or between the Lenders or the Administrative Agent, or any dispute by or between Administrative Agent or any Lenders with respect to their respective rights or obligations as between each other.

10.4 Survival of Representations and Warranties. All representations and warranties contained herein or in any other Loan Document, or in any certificate or other writing delivered by or on behalf of any one or more of the Loan Parties, will survive the making of the Loan hereunder and the execution and delivery of the Notes, and have been or will be relied upon by Lender, notwithstanding any investigation made by Administrative Agent or on its behalf.

10.5 Notices. Except as otherwise expressly provided in the Loan Documents, all notices, requests, demands, directions and other communications provided for hereunder or under any other Loan Document must be in writing and must be mailed, delivered or sent by overnight courier to the appropriate party at the address set forth on the signature pages of this Agreement or other applicable Loan Document or, as to any party to any Loan Document, at any other address as may be designated by it in a written notice sent to all other parties to such Loan Document in accordance with this Section 10.5. Except as otherwise expressly provided in any Loan Document, if any notice, request, demand, direction or other communication required or permitted by any Loan Document is given by mail it will be effective on the earlier of receipt or the third Business Day after deposit in the United States mail with first class or airmail postage prepaid; or if given by personal delivery, when actually delivered.

10.6 Execution of Loan Documents. Unless Lender otherwise specifies with respect to any Loan Document, this Agreement and any other Loan Document may be executed in any number of counterparts and any party hereto or thereto may execute any counterpart; as to each Loan Document, all of such executed counterparts, when taken together will be deemed to be the same instrument. The execution of this Agreement or any other Loan Document by any party hereto or thereto will not become effective until counterparts hereof or thereof, as the case may be, have been executed by all the parties hereto or thereto.

10.7 Binding Effect; Assignment.

(a) This Agreement and the other Loan Documents shall be binding upon and shall inure to the benefit of the parties hereto and thereto and their respective successors and assigns, subject to the other restrictions contained in this Section 10.7.

(b) Borrower may not assign its rights hereunder or thereunder or any interest herein or therein without the prior written consent of Administrative Agent. Any assignment by Borrower without the prior written consent of Administrative Agent shall be void; provided that no Person other than Administrative Agent and the Lenders shall have any rights under this sentence.

(c) No Lender shall have the right to assign all or a portion of its rights or delegate any of its obligations under the Loan Documents without the express prior written consent of Administrative Agent, which consent may be granted or withheld by Administrative Agent in its sole, but reasonable, discretion. In connection with exercise of its discretion, Administrative Agent shall have the right to consider the number of Lenders and the size of the Pro Rata Shares that would result from a proposed assignment, as well as the financial strength and sophistication of the proposed assignee. In any event, the proposed assignee must be a commercial bank that is either (i) organized under the laws of the United States of America or any state thereof, or (ii) organized under the laws of any other nation provided that such bank has a branch or agency located within the United States of America. If and to the extent a Lender receives the consent of Administrative Agent to make such an assignment, Borrower shall execute new Notes to reflect the changed Pro Rata Shares of the affected Lenders, and the assigning Lender and the assignee shall execute such documents to evidence the assignment as Administrative Agent shall reasonably require, including an assumption by the assignee of the obligations of the assigning Lender with respect to the portion of the Pro Rata Share of the Total Commitment and outstanding Advances and Administrative Agent Advances, a relinquishment of rights of the assigning Lender with respect to such portion of the Pro Rata Share of the Total Commitment and outstanding Advances and Administrative Agent Advances and a confirmation of the Pro Rata Shares of the assigning Lender and the assignee. Promptly following satisfaction of the foregoing conditions, Administrative Agent shall give notice to Borrower and all of the Lenders of the effectiveness of the assignment and of the revised Pro Rata Shares of the Lenders. Borrower shall not be obligated to pay or reimburse Administrative Agent or any Lender (including any assigning Lender or assignee Lender) for any costs incurred in connection with any assignment or prospective assignment by a Lender.

10.8 Lien on Deposits and Property in Possession of Administrative Agent . The only accounts maintained by Borrower with Administrative Agent which shall be subject to a security agreement in favor of Administrative Agent shall be the DCR Collateral Account and the Replacement Reserve Account. If an Event of Default has occurred and is continuing, Administrative Agent may, to the extent permitted by applicable Laws, exercise its rights under Article 9 of the Uniform Commercial Code and other applicable Laws and apply any funds in those accounts against the Obligations.

10.9 Indemnity by Borrower. Borrower agrees to indemnify, save and hold harmless Administrative Agent and each Lender and their respective directors, officers, agents, attorneys and employees, successors and assigns (each, an " Indemnitee," and collectively, the "Indemnitees") from and against: (a) any and all claims, demands, actions or causes of action that are asserted against any Indemnitee by any Person that relates to the Collateral, or the ownership or operation thereof by Borrower, (b) any and all claims, demands, actions or causes of action if the claim, demand, action or cause of action arises out of or relates to the Loan, the use or contemplated use of proceeds of the Loan, the relationship of Borrower and Lenders under

this Agreement or any transaction contemplated by this Agreement, in each instance other than with respect to Article 9 or the relationship by and between the Lenders and the Administrative Agent;, (c) any administrative or investigative proceeding by any Governmental Agency arising out of or related to a claim, demand, action or cause of action described in clauses (a) or (b) above other than related to Article 9 or the relationship by and between the Lenders and the Administrative Agent; and (d) any and all liabilities, losses, costs or expenses (including attorneys' fees and disbursements and other professional services) that any Indemnitee suffers or incurs as a result of the assertion of any foregoing claim, demand, action or cause of action; provided that no Indemnitee shall be entitled to indemnification for any loss caused by its own gross negligence or willful misconduct as finally determined in a non appealable decision by a court of competent jurisdiction. If any claim, demand, action or cause of action is asserted against any Indemnitee, such Indemnitee shall reasonably, promptly notify Borrower, but the failure to so promptly notify Borrower shall not affect Borrower' obligations under this Section. Any Indemnitee that proposes to settle or compromise any claim or proceeding for which Borrower may be liable for payment of indemnity hereunder shall give Borrower written notice of the terms of such proposed settlement or compromise reasonably in advance of settling or compromising such claim or proceeding and shall obtain Borrower' prior consent, which consent shall not unreasonably be withheld. Each Indemnitee is authorized to employ counsel in enforcing its rights hereunder and in defending any claim, demand, action or cause of action covered by this Section 10.9; provided that each Indemnitee shall endeavor, but shall not be obligated, in connection with any matter covered by this Section 10.9 which also involves other Indemnitees, to use reasonable efforts to avoid unnecessary duplication of effort by counsel for all Indemnitees. Any obligation or liability of Borrower to any Indemnitee under this Section 10.9 shall survive the expiration or termination of this Agreement and the repayment of all Loans and the payment and performance of all other Obligations owed to Lender. Notwithstanding anything in this Section 10.9 to the contrary, the foregoing obligations on the part of Borrower shall not apply to any claim, cause of action or dispute arising out of or related to the syndication of the Loan, the matters set forth in Article 9 of this Agreement, or the relationship by or between the Administrative Agent and any one or more Lenders, or any of them.

10.10 Nonliability of Administrative Agent and Lenders . Borrower acknowledges and agrees that:

(a) Any inspections of any Property of Borrower made by or through Administrative Agent or any Lender is for purposes of administration of the Loan Documents only and Borrower are not entitled to rely upon the same;

(b) By accepting or approving anything required to be observed, performed, fulfilled or given to Administrative Agent or any Lender pursuant to the Loan Documents, neither Administrative Agent nor any Lender shall be deemed to have warranted or represented the sufficiency, legality, effectiveness or legal effect of the same, or of any term, provision or condition thereof, and such acceptance or approval thereof shall not constitute a warranty or representation to anyone with respect thereto by Administrative Agent or any Lender;

(c) The relationship between Borrower and Administrative Agent or any Lender is, and shall at all times remain, solely that of a Borrower and Lender; neither Administrative Agent nor any Lender shall under any circumstance be construed to be partners or joint venturers of Borrower or Borrower's Affiliates; neither Administrative Agent nor any Lender shall under any circumstance be deemed to be in a relationship of confidence or trust or a fiduciary relationship with Borrower or Borrower's Affiliates, or to owe any fiduciary duty to Borrower or Borrower's Affiliates; neither Administrative Agent nor any Lender undertakes or assumes any responsibility or duty to Borrower or Borrower's Affiliates to select, review, inspect, supervise, pass judgment upon or inform Borrower or Borrower's Affiliates of any matter in connection with their Property or the operations of Borrower or Borrower's Affiliates; Borrower and Borrower's Affiliates shall rely entirely upon their own judgment with respect to such matters; and any review, inspection, supervision, exercise of judgment or supply of information undertaken or assumed by Administrative Agent or any Lender in connection with such matters is solely for the protection of Administrative Agent or such Lender and neither Borrower nor any other Person is entitled to rely thereon; and

(d) No Indemnitee shall be responsible or liable to any Person for any loss, damage, liability or claim of any kind relating to injury or death to Persons or damage to Property or other loss, damage, liability or claim caused by the actions, inaction or negligence of Borrower or its Affiliates and Borrower hereby indemnifies and holds each Indemnitee harmless from any such loss, damage, liability or claim. In no event shall any Indemnitee be responsible for any punitive, exemplary, consequential or special damages.

10.11 No Third Parties Benefited. This Agreement is made for the purpose of defining and setting forth certain obligations, rights and duties of Borrower, Administrative Agent and the Lenders in connection with the Loan, and is made for the sole benefit of Borrower, Administrative Agent and the Lenders, and their respective permitted successors and assigns. Except as provided in Sections 10.7 and 10.9, no other Person shall have any rights of any nature hereunder or by reason hereof.

10.12 Further Assurances. Borrower shall, at its sole expense and without expense to Administrative Agent or any Lender, do, execute and deliver such further acts and documents as Lender from time to time reasonably requires for the assuring and confirming unto Administrative Agent and the Lenders the rights hereby created or intended now or hereafter so to be, or for carrying out the intention or facilitating the performance of the terms of any Loan Document.

10.13 Integration. This Agreement, together with the other Loan Documents, comprises the complete and integrated agreement of the parties on the subject matter hereof and supersedes all prior agreements, written or oral, on the subject matter hereof. In the event of any conflict between the provisions of this Agreement and those of any other Loan Document, the provisions of this Agreement shall control and govern; provided that the inclusion of supplemental rights or remedies in favor of Administrative Agent or any Lender in any other Loan Document shall not be deemed a conflict with this Agreement. Each Loan Document was drafted with the joint participation of the respective parties thereto and shall be construed neither against nor in favor of any party, but rather in accordance with the fair meaning thereof.

10.14 Governing Law. This agreement and the other loan documents shall be governed by, and construed in accordance with, the law of the State of California.

10.15 Severability of Provisions. Any provision in any Loan Document that is held to be inoperative, unenforceable or invalid as to any party or in any jurisdiction shall, as to that party or jurisdiction, be inoperative, unenforceable or invalid without affecting the remaining provisions or the operation, enforceability or validity of that provision as to any other party or in any other jurisdiction, and to this end the provisions of all Loan Documents are declared to be severable.

10.16 Headings. Article and Section headings in this Agreement and the other Loan Documents are included for convenience of reference only and are not part of this Agreement or the other Loan Documents for any other purpose.

10.17 Time of the Essence. Time is of the essence of the Loan Documents.

10.18 JURY TRIAL WAIVER. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN ANY LEGAL PROCEEDING DIRECTLY OR INDIRECTLY ARISING OUT OF OR RELATING TO THIS AGREEMENT OR ANY OTHER LOAN DOCUMENT OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY (WHETHER BASED ON CONTRACT, TORT OR ANY OTHER THEORY). EACH PARTY HERETO (A) CERTIFIES THAT NO REPRESENTATIVE, AGENT OR ATTORNEY OF ANY OTHER PERSON HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PERSON WOULD NOT, IN THE EVENT OF LITIGATION, SEEK TO ENFORCE THE FOREGOING WAIVER AND (B) ACKNOWLEDGES THAT IT AND THE OTHER PARTIES HERETO HAVE BEEN INDUCED TO ENTER INTO THIS AGREEMENT AND THE OTHER LOAN DOCUMENTS BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION.

10.19 Purported Oral Amendments. BORROWER AND LENDER EXPRESSLY ACKNOWLEDGE THAT THIS AGREEMENT AND THE OTHER LOAN DOCUMENTS MAY ONLY BE AMENDED OR MODIFIED, OR THE PROVISIONS HEREOF OR THEREOF WAIVED OR SUPPLEMENTED, BY AN INSTRUMENT IN WRITING THAT COMPLIES WITH SECTION 10.2. EACH BORROWER AGREES THAT IT WILL NOT RELY ON ANY COURSE OF DEALING, COURSE OF PERFORMANCE, OR ORAL OR WRITTEN STATEMENTS BY ANY REPRESENTATIVE OF LENDER THAT DOES NOT COMPLY WITHSECTION 10.2 TO EFFECT AN AMENDMENT, MODIFICATION, WAIVER OR SUPPLEMENT TO THIS AGREEMENT OF THE OTHER LOAN DOCUMENTS.

10.20 USA PATRIOT Act Notice. Each Lender hereby notifies Borrower that pursuant to the requirements of the USA PATRIOT Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001)) (the "Act"), such Lender is required to obtain, verify and record information that identifies Borrower, which information includes the name and address of Borrower and other information that will allow such Lender to identify Borrower in accordance with the Act.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date first above written.

BORROWER:

MOLINA CENTER LLC,
a Delaware limited liability company
By: /s/ John C. Molina
John C. Molina
President

Address for Notices to Borrower:

Molina Center, LLC.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attention: Joseph W. White, Chief Accounting Officer
Facsimile: (562) 437-7235
Telephone: (916) 646-9193 x 111566

with a copy to:

Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attention: Jeff Barlow
General Counsel
Facsimile: (916) 646-4572
Telephone: (916) 646-9193 x 114663

ADMINISTRATIVE AGENT:

EAST WEST BANK,
a California banking corporation

By: /s/ Robert Lo
Robert Lo
Senior Vice President

Address for Notices:

East West Bank
135 N. Los Robles Ave., Suite 600
Pasadena, CA 91101
Attention: May Kwong
Facsimile: (626) 817-8899
Telephone: (626) 768-6718
Email: mkwong@eastwestbank.com

with a copy to:

East West Bank
Loan Servicing Department
9300 Flair Drive, 6th Floor
El Monte, CA 91731
Attention: Linda Lam
Facsimile: (626) 927-2088
Telephone: (626) 371-8688
Email: linda.lam@eastwestbank.com

LENDERS:

EAST WEST BANK,

a California banking corporation

By: /s/ May Kwong
May Kwong
First Vice President

Address for Notices:

East West Bank
135 N. Los Robles Ave., Suite 600
Pasadena, CA 91101
Attention: May Kwong
Facsimile: (626) 817-8899
Telephone: (626) 768-6718
Email: mkwong@eastwestbank.com

with a copy to:

East West Bank
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9300 Flair Drive, 6th Floor
El Monte, CA 91731
Attention: Linda Lam
Facsimile: (626) 927-2088
Telephone: (626) 371-8688
Email: linda.lam@eastwestbank.com

CITY NATIONAL BANK,
a national banking association

By: /s/ Lindsay Dun
Lindsay Dunn
Vice President

Address for notices:

City National Bank
555 S. Flower Street, 25th Floor
Los Angeles, CA 90071
Attention: Lyndsay Dunn
Facsimile: (213) 673-8299
Telephone: (213) 673-8269
Email: Lindsay.Dunn@cnb.com

Signature Page to
Term Loan Agreement

BANK OF CHINA, LOS ANGELES BRANCH,
a federally chartered branch of Bank of China Limited, a joint stock company incorporated in the People's Republic of China with limited liability

By: /s/ Jason Fu
Jason Fu aka Hou Yue Fu
Vice President

By: /s/ Edwin Chan
Edwin Chan
Assistant Vice President

Address for Notices:

Bank of China, Los Angeles Branch
444 S. Flower Street, Suite 3900
Los Angeles, CA 90071
Attention: Jason Fu
Facsimile: (213) 688-7720
Telephone: (213) 688-8700 x 235
Email: jfu@bocusa.com

With a copy to:

Bank of China, New York Branch
410 Madison Avenue
New York, NY 10017
Attention: Wenzhen Zhang
Facsimile: (212) 935-3101
Telephone: (212) 371-4185
Email: synloanadmin.nyb@bocusa.com

Signature Page to
Term Loan Agreement

UNION BANK, N.A.,
a national banking association

By: /s/ Susan Swerdloff
Susan Swerdloff
Vice President

Address for notices:

Union Bank, N.A.
445 S. Figueroa Street, 10th Floor
Los Angeles, CA 90071
Attention: Erik Siegfried
Facsimile: (213) 236-7637
Telephone: (213) 236-4028
Email: susan.swerdloff@unionbank.com

With a copy to:

Union Bank, N.A.
970 West 190th Street, Suite 995
Torrance, CA 90502
Attention: Charles D. Wilmot
Facsimile: (310) 767-5873
Telephone: (310) 767-5867
Email: charles.wilmot@unionbank.com

Signature Page to
Term Loan Agreement

THE BANK OF EAST ASIA (U.S.A.) N.A.,
a national banking association

By: /s/ Daisy Tung
Daisy Tung
Senior Vice President

By: /s/ Alise Weeling-Lee
Alise Weeling-Lee
Vice President & Credit Manager

Address for notices:

The Bank of East Asia (U.S.A.) N.A.
388 East Valley Boulevard, Suite 118
Alhambra, CA 91801 USA
Attention: Daisy Tung
Facsimile: (626) 284-4841
Telephone: (626) 457-2233
Email: tungdml@hkbea-us.com

Signature Page to
Term Loan Agreement

EXHIBIT A

COMPLIANCE CERTIFICATE

See attached.

FORM OF COMPLIANCE CERTIFICATE

To: The Lenders Party to the
Term Loan Agreement Described Below

This Compliance Certificate is furnished pursuant to that certain Term Loan Agreement dated as of December 1, 2011 (as amended, modified, renewed or extended from time to time, the "Agreement") among Molina Center LLC (the "Borrower"), the lenders from time to time party thereto (the "Lenders") and East West Bank, as Administrative Agent for the Lenders. Unless otherwise defined herein, capitalized terms used in this Compliance Certificate have the meanings ascribed thereto in the Agreement.

THE UNDERSIGNED HEREBY CERTIFIES THAT:

1. I am the duly *select one* [elected]/[appointed] *select one* [chief executive officer]/[chief financial officer]/[treasurer]/[controller] of the manager of the Borrower;

2. I have reviewed the terms of the Agreement and I have made, or have caused to be made under my supervision, a detailed review of the transactions and conditions of the Borrower and its Subsidiaries during the accounting period covered by the attached financial statements;

3. The examinations described in paragraph 2 did not disclose, and I have no knowledge of, the existence of any condition or event which constitutes a Default or Event of Default during or at the end of the accounting period covered by the attached financial statements or as of the date of this Compliance Certificate, except as follows(*if none, write "NONE;" otherwise describe in detail, the nature of the condition or event, the period during which it has existed and the action which the Borrower has taken, is taking, or proposes to take with respect to each such condition or event*):

_____

_____

_____

4. Schedule I attached hereto sets forth financial data and computations evidencing the Borrower's compliance with the covenant contained in Section 5.7(a) of the Agreement, all of which data and computations are true, complete and correct;

5. Schedule II attached hereto sets forth the various reports and deliveries which are required at this time under the Agreement and the other Loan Documents and the status of compliance.

The foregoing certifications, together with the computations set forth in Schedule I hereto and the financial statements delivered with this Certificate in support hereof, are made and delivered this day of , 20 .

Signature

Printed Name

Title

Exhibit A
Form of Compliance Certificate

SCHEDULE I TO COMPLIANCE CERTIFICATE

Compliance for Compliance Period ending , 20 with
Provisions of Section 5.7(a) of the Agreement

Numerator:	
Operating Revenue during Calculation Period: (attach detail)	$ _____
Less: Operating Revenue during Calculation Period: (attach detail)	$ _____
Difference: Net Operating Income	$ _____
Denominator:	
Interest Charges during Calculation Period:	$ _____
Plus: Principal payments required during Calculation Period on all Indebtedness other than Indebtedness subordinated to the Loan:	$ _____
Sum:	$ _____
Numerator divided by Denominator:	_____
Compliant? *select one*	[Yes] / [No]

SCHEDULE II TO COMPLIANCE CERTIFICATE

Reports and Deliveries Currently Due

Schedule 1.1(b)

(Schedule of Commitments)

Bank	Final Allocation	
	Loan Portion	%
East West Bank (Administrative Agent)	$ 13,000,000	26.748971%
Bank of China, Los Angeles Branch	$ 10,000,000	20.576132%
City National Bank	$ 13,000,000	26.748971%
Union Bank, N.A.	$ 6,300,000	12.962963%
The Bank of East (U.S.A.) N.A.	$ 6,300,000	12.962963%
Total:	**$ 48,600,000**	100%

Schedule 3.3

Governmental Approvals

None

Schedule 3.17

Known Violations of Hazardous Materials Law

In a letter dated October 24, 2011, 200 Oceangate, LLC (the former owner of the Real Property), received Waste Discharge Requirements and a National Pollutant Discharge Elimination System (NPDES) permit (the "NPDES Permit") from the California Regional Water Quality Control Board, Los Angeles Region (the "CRWQCB"), governing the discharge of seepage groundwater from the subbasement parking structure located on the premises of the Real Property. Reasonable Potential Analysis (RPA) of water quality data submitted to the CRWQCB indicated concentrations for arsenic and nickel at the cusp of their respective screening levels. As a result, the CRWQCB determined that effluent limitations for these parameters are not appropriate, but that long term monitoring for these parameters are necessary to ensure that the concentrations for these parameters remain insignificant. The Borrower intends to monitor the water quality of the groundwater discharge in accordance with the monitoring and reporting requirements set forth in the NPDES Permit.

Schedule 5.1

Investments

None

Exhibit 10.19

GUARANTY

This GUARANTY is made as of December 1, 2011, by MOLINA HEALTHCARE, INC., a Delaware corporation (" Guarantor"), in favor of EAST WEST BANK, a California banking corporation, in its capacity as administrative agent (in such capacity, " Administrative Agent") for itself and the other "Lenders," as such term is defined below.

RECITALS

A. Pursuant to the terms of the Term Loan Agreement dated as of even date herewith (as amended, extended, renewed, supplemented or otherwise modified from time to time, the "Term Loan Agreement") by and among Molina Center LLC, a Delaware limited liability company (" Borrower"), Administrative Agent, East West Bank, Bank of China, Los Angeles Branch, City National Bank, Union Bank, N.A. and The Bank of East Asia (USA) N.A. and their assignees and successors from time to time as "Lenders" thereunder (collectively, " Lenders," and each, a "Lender"), Lenders have agreed to make a term loan to Borrower in the aggregate principal amount of up to Forty Eight Million Six Hundred Thousand Dollars ($48,600,000) (the " Loan"). Capitalized terms used but not otherwise defined in this Guaranty shall have the meanings ascribed to such terms in the Term Loan Agreement.

B. The obligations of Borrower for repayment of the Loan are evidenced by Promissory Notes dated as of even date herewith (as amended, extended, renewed, replaced, split, supplemented or otherwise modified from time to time, the " Notes") made by Borrower to the order of each of the Lenders, in the aggregate principal amount of the Loan. The obligations of Borrower under the Term Loan Agreement and the Notes are secured by the Deed of Trust, Security Agreement, Assignment of Rents and Fixture Filing (as amended, extended, renewed, supplemented or otherwise modified from time to time, the " Deed of Trust") executed by Borrower as trustor, naming First American Title Insurance Company as trustee and Administrative Agent as beneficiary, encumbering the "Property" (as described in the Deed of Trust), and by other collateral security.

C. The Term Loan Agreement, the Notes, the Deed of Trust and all other agreements and documents evidencing or securing Borrower's obligations in connection with the Lenders' issuance of the Loan are referred to in this Guaranty as the " Loan Documents".

D. Guarantor's execution and delivery of this Guaranty is a condition precedent to Lenders' issuance of the Loan. Guarantor has an interest in Borrower and will directly benefit from Lenders' extension of the Loan to Borrower and is therefore willing to enter into this Guaranty to induce Lenders to extend the Loan.

AGREEMENT

1. Guaranty.

(a) Guarantor unconditionally and irrevocably guarantees the full and prompt payment of all obligations, principal, interest, fees, costs and other sums owed under the Loan Documents at the times and according to the terms expressed in the Loan Documents, including any interest, late charges, default interest, fees and costs (including reasonable attorneys' fees)

that would have accrued under the Loan Documents but for the commencement of a case under Title 11 of the United States Code or any successor statute (the "Bankruptcy Code"). Notwithstanding anything else to the contrary contained in this Guaranty, the maximum principal amount of the Notes for which the Guarantor shall be liable under this Guaranty shall in no event exceed Twenty Million Dollars ($20,000,000) (the " Cap").

(b) Guarantor's liability under this Guaranty is a guaranty of payment and performance and not a guaranty of collection.

2. Changes Do Not Affect Liability . Guarantor agrees that Administrative Agent, on behalf of the Lenders, may without notice to Guarantor and without limiting Guarantor's liability under, or affecting the enforceability of, this Guaranty:

(a) grant extensions of time, renewals or other indulgences and modifications to Borrower or any other party under the Loan Documents;

(b) change the rate of interest or rate or amount of fees under the Term Loan Agreement or any other Loan Document;

(c) change, amend or modify the Loan Documents;

(d) authorize the sale, exchange, release or subordination of any security or collateral in which Administrative Agent or the Lenders has an interest, or fails to create, perfect or maintain the priority of any security interest in any such collateral;

(e) take additional security for any obligation evidenced by the Loan Documents;

(f) discharge or release any party or parties liable under the Loan Documents;

(g) accept or make compositions or other arrangements or file or refrain from filing a claim in any bankruptcy proceeding of Borrower, any other guarantor, any pledgor of collateral for any person's obligations to any Lender or any other person related to the Loan Documents;

(h) make other or additional credit available to Borrower in such amounts and at such times as Administrative Agent may determine;

(i) credit payments in such manner and order of priority to principal, interest or other obligations as Administrative Agent may determine; and

(j) otherwise deal with Borrower, any other guarantor, any pledgor of collateral for any person's obligations to any Lender or any other person related to the Loan Documents as Administrative Agent may determine in its discretion.

3. Additional Waivers.

(a) Guarantor waives all benefits and defenses it may have under California Civil Code Section 2809 and agrees that Guarantor's liability may be larger in amount and more burdensome than that of Borrower. Guarantor's liability under this Guaranty shall continue until all sums due under the Loan Documents have been paid in full and shall not be limited or affected in any way by any impairment or any diminution or loss of value of any security or collateral for the obligations under the Loan Documents, from whatever cause, including, without limitation, Administrative Agent's or Lenders' failure to perfect a security interest in any such security or collateral or any disability or other defense of Borrower, any other guarantor, any pledgor of collateral for any person's obligations to Administrative Agent or any Lender or any other person related to the Loan Documents.

(b) Guarantor agrees that its liability under, and the enforceability of, this Guaranty are absolute and are not contingent upon the genuineness, validity or enforceability of any of the Loan Documents or the availability of any defense to Borrower, any other guarantor or surety, any pledgor of collateral for any person's obligations to Administrative Agent or any Lender or any other person related to the obligations under the Loan Documents. Guarantor waives all benefits and defenses it may have under California Civil Code Section 2810 and agrees that Guarantor shall be liable even if Borrower, any other guarantor, any pledgor of collateral for any person's obligations to Administrative Agent or any Lender or any other person related to the obligations outstanding under the Loan Documents had no liability at the time of execution of any Loan Documents or later ceases to be liable.

(c) Guarantor waives its rights under California Civil Code Section 2815 and agrees that by doing so Guarantor does not have any right to revoke this Guaranty until all obligations under the Loan Documents have been fully satisfied.

(d) Guarantor waives its rights under California Civil Code Section 2819 and agrees that by doing so Guarantor's liability and the enforceability of this Guaranty shall continue even if Administrative Agent or any Lender alters any obligations under the Loan Documents in any respect.

(e) Guarantor waives its rights under California Civil Code Section 2839 and agrees that by doing so (i) its obligations under this Guaranty shall not be deemed satisfied by a mere offer of payment by Borrower or any other person of the principal obligations under the Loan Documents and (ii) Guarantor's liability under and the enforceability of this Guaranty shall continue until all obligations under the Loan Documents have been fully satisfied.

(f) Guarantor waives all benefits and defenses it may have under California Civil Code Sections 2787 to 2855, inclusive, including, without limitation, the right to require Administrative Agent or any Lender to (i) proceed against Borrower, any other guarantor or surety, any pledgor of collateral for any person's obligations to Administrative Agent or any Lender or any other person related to the obligations outstanding under the Loan Documents, (ii) proceed against or exhaust any other security or collateral Administrative Agent may hold, or (iii) pursue any other right or remedy for Guarantor's benefit, and agrees that Administrative Agent and the Lenders may foreclose against all or a part of the Property or any other security

Administrative Agent or the Lenders may hold without taking any action against Borrower, any other guarantor or surety, any pledgor of collateral for any person's obligations to Administrative Agent or any Lender or any other person related to the obligations outstanding under the Loan Documents, and without proceeding against or exhausting any security or collateral Administrative Agent or any Lender holds.

(g) Guarantor waives its rights under California Civil Code Sections 2899 and 3433 and agrees that by doing so that neither Administrative Agent nor any Lender has an obligation regarding the order in which it exercises its remedies against the Property or any other collateral security encumbered pursuant to any of the Loan Documents.

(h) Guarantor waives diligence and all demands, protests, presentments and notices of every kind or nature, including notices of protest, dishonor, nonpayment, acceptance of this Guaranty and creation, renewal, extension, modification or accrual of any of the obligations under the Loan Documents. Guarantor also waives the right to plead all statutes of limitation as a defense to Guarantor's liability under, or the enforceability of, this Guaranty.

(i) Guarantor waives any rights or benefits it may have by reason of California Code of Civil Procedure Section 580a which could limit the amount which Administrative Agent and the Lenders could recover in a foreclosure of the Property to the difference between the amount owing under the Loan Documents and the fair value of the Property or other real property sold at a nonjudicial foreclosure sale or sales of any other real property held by Administrative Agent or any Lender as security for the obligations under the Loan Documents.

(j) Guarantor waives all rights and defenses arising out of an election of remedies by Administrative Agent or any Lender, even though that election of remedies, such as a nonjudicial foreclosure of the Property or any other real property given to secure the obligations under the Loan Documents, may destroy Guarantor's rights of subrogation and reimbursement against Borrower by the operation of Section 580d of the California Code of Civil Procedure or otherwise.

4. Guarantor Informed of Borrower's Condition. Guarantor acknowledges that it has had an opportunity to review the Loan Documents, the value of the security for the obligations under the Loan Documents, and Borrower's financial condition and ability to repay the obligations owing under the Loan Documents. Guarantor agrees to keep itself fully informed of all aspects of Borrower's financial condition and the performance of Borrower's obligations to Administrative Agent, on behalf of the Lenders and that neither Administrative Agent nor any of the Lenders has any duty to disclose to Guarantor any information pertaining to Borrower or any security for the obligations owing under the Loan Documents.

5. Subrogation, Reimbursement and Contribution Rights. Guarantor agrees that its rights of subrogation and reimbursement against Borrower, its right of subrogation against any other collateral or security for the obligations owing under the Loan Documents or the pledgor of such collateral or security and its right of contribution from any guarantor of the obligations owing under the Loan Documents shall be subordinate to Administrative Agent's and the Lenders' rights against Borrower, in such collateral or security, against any such pledgor and

against any such guarantor. Guarantor shall have no such rights of subrogation, reimbursement or contribution until all amounts due under the Loan Documents have been paid in full and Administrative Agent, on behalf of the Lenders, has released, transferred or disposed of all of its rights in any collateral or security. Guarantor waives its rights under California Civil Code Sections 2847, 2848 and 2849 to the extent inconsistent with the foregoing.

6. Confirmation of Waivers; Borrower's Obligations are Secured by Real Property .

(a) Guarantor is aware that it is waiving all rights and defenses that it may have because Borrower's obligations are secured by real property. This means, among other things:

(i) Administrative Agent or Lenders may collect from Guarantor without first foreclosing on the Property or any other real or personal property collateral for Borrower's obligations pledged by Borrower or any other person; and

(ii) if Administrative Agent or Lenders foreclose on the Property:

(A) the amount of Borrower's obligations outstanding may be reduced only by the price for which the Property is sold at the foreclosure sale, even if the Property is worth more than the sale price; and

(B) Administrative Agent or Lenders may collect from Guarantor even if Administrative Agent, by foreclosing on the Property, has destroyed any right Guarantor may have to collect from Borrower.

(b) These are unconditional and irrevocable waivers of any rights and defenses Guarantor may have because Borrower's debt is secured by real property. These rights and defenses include, but are not limited to, any rights or defenses based upon Section 580a, 580b, 580d or 726 of the California Code of Civil Procedure.

7. Guaranty Continues if Payments Are Avoided or Recovered from Administrative Agent or Lenders . If all or any portion of the obligations guaranteed under this Guaranty are paid or performed, Guarantor's obligations under this Guaranty shall continue and remain in full force and effect if all or any part of such payment or performance is avoided or recovered directly or indirectly from Administrative Agent or Lenders as a preference, fraudulent transfer or otherwise, irrespective of (a) any notice of revocation given by Guarantor prior to such avoidance or recovery, and (b) payment in full of the obligations under the Loan Documents.

8. Subordination. Any rights of Guarantor, whether now existing or later arising, to receive payment on account of any indebtedness (including interest) owed to it by Borrower or any subsequent owner of the Property, or to withdraw capital invested by it in Borrower, or to receive distributions from Borrower, shall at all times be subordinate as to lien and time of payment and in all other respects to the full and prior repayment to Administrative Agent and the Lenders of the obligations owing under the Loan Documents. Guarantor shall not be entitled to enforce or receive payment of any sums hereby subordinated until all obligations owing under the Loan Documents have been fully satisfied and any such sums received in violation of this

Guaranty shall be received by Guarantor in trust for Administrative Agent, on behalf of Lenders, except for distributions of provided, however, that Guarantor may receive distributions of excess Cash from Borrower as permitted pursuant to Section 5.6 of the Term Loan Agreement.

9. Representations and Warranties. Guarantor makes the following representations and warranties to Administrative Agent and Lenders:

(a) This Guaranty has been duly executed and delivered and is the legal, valid and binding obligation of Guarantor, enforceable against Guarantor in accordance with its terms.

(b) Guarantor's execution and delivery of, and its performance of its obligations under, this Guaranty do not and will not conflict with any (i) contractual or legal restriction or obligation, or (ii) court or regulatory order, binding on or affecting Guarantor.

(c) There is no pending or, to the actual knowledge of Guarantor, threatened action, proceeding or investigation before any court, governmental agency or arbitrator against or affecting Guarantor, the Property, any of the Collateral, or any of Guarantor's other assets which, if decided adversely to Guarantor, would materially and adversely affect the financial condition of Guarantor or of any of Guarantor's assets, or would materially and adversely affect the present or future ability of Guarantor to perform its obligations under the Guaranty.

(d) Guarantor is not insolvent nor will it be rendered insolvent by the transactions contemplated by the Loan Documents. After giving effect to the transactions contemplated by the Loan Documents, Guarantor will not be left with an unreasonably small amount of capital with which to engage in its business or undertakings, nor will Guarantor have intended to incur, or believe that it has incurred, debts beyond its ability to pay such debts as they mature.

(e) Except as disclosed to Administrative Agent in writing, the financial statements and all financial data delivered to Administrative Agent relating to Guarantor are true, correct and complete in all material respects. Such financial statements fairly present the financial position of Guarantor as of the dates indicated. No material adverse change has occurred in Guarantor's financial position since the date of such financial statements, and Guarantor has not incurred any indebtedness since the date of any such statements.

(f) Guarantor has filed all required federal, state and local tax returns. Guarantor has paid all federal, state and local taxes prior to delinquency (including any interest and penalties) other than taxes being promptly and actively contested in good faith and by appropriate proceedings.

(g) Guarantor is in material compliance with all laws, regulations and court orders applicable to it and its business.

(h) All of the representations and warranties made by Borrower with respect to "Parent" in the Term Loan Agreement are hereby incorporated herein as representations and warranties of Guarantor to Administrative Agent and the Lenders, with the same effect as though the same were fully stated herein.

(i) None of Guarantor's representations or warranties contained in this Guaranty, the Term Loan Agreement or any other document, certificate or written statement furnished to Administrative Agent and Lenders on behalf of Guarantor contains any untrue statement of a material fact or omits to state a material fact necessary in order to make the statements contained in this Guaranty or in such other document, certificate or written statement (when taken in their entirety) not misleading. There is no fact known to Guarantor which materially or adversely affects the business, operations, assets or condition (financial or otherwise) of Guarantor which has not been disclosed in this Guaranty or in another written statement delivered to Administrative Agent by Borrower or Guarantor.

10. Covenants.

(a) Guarantor shall deliver the following information to Administrative Agent in form and substance reasonably satisfactory to Administrative Agent:

(i) as soon as available, but in any event within 45 days after the end of each Fiscal Quarter (commencing with the Fiscal Quarter ended December 31, 2011), the financial statements required by Section 6.1(b) of the Term Loan Agreement as of the end of such Fiscal Quarter;

(ii) as soon as filed, but in any event within 120 days after the end of each Fiscal Year (commencing with the Fiscal Year ended December 31, 2011), the financial required by Section 6.1(a) of the Term Loan Agreement as of the end of such Fiscal Year; and

(iii) all other information, reports and notices relating to Guarantor that Administrative Agent shall reasonably request.

(b) Guarantor shall comply with all requirements applicable to Guarantor under the Term Loan Agreement, including, without limitation, Articles 4, 5 and 6 of the Term Loan Agreement.

11. Borrower. As used in this Guaranty, "Borrower" shall include any successor to Borrower with respect to the Loan Documents and any estate created by the commencement of a case under the Bankruptcy Code or any other insolvency, bankruptcy, reorganization or liquidation proceeding, or by any trustee under the Bankruptcy Code, liquidator, sequestrator or receiver of Borrower or Borrower's property or similar person duly appointed pursuant to any law generally governing any insolvency, bankruptcy, reorganization, liquidation, receivership or like proceeding.

12. Opportunity to Review. Guarantor acknowledges that it has had the opportunity to review the matters discussed and contemplated by the Loan Documents, including the remedies Administrative Agent or Lenders may pursue against Borrower in the event of a default under the Loan Documents, the value of the security or collateral for the obligations owing under the Loan Documents and Borrower's financial condition and ability to perform under the Loan Documents to which Borrower is a party. Guarantor has had the opportunity to review this Guaranty with its counsel.

13. Miscellaneous.

(a) Notices. Any notice, demand or request required under this Guaranty shall be given in writing at the addresses set forth below by personal service; telecopy; overnight courier; or registered or certified, first class mail, return receipt requested.

If to Guarantor:

Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attention: Joseph W. White, Chief Accounting Officer
Facsimile: (562) 437-7235
Telephone: (916) 646-9193 x 111566

With a copy to:

Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attention: Jeff Barlow
General Counsel
Facsimile: (916) 646-4572
Telephone: (916) 646-9193 x 114633

If to Administrative Agent:

East West Bank
135 N. Los Robles Ave., Suite 600
Pasadena, CA 91101
Attention: May Kwong
First Vice President
Facsimile: (626) 817-8899
Telephone: (626) 768-6718

With a copy to:

East West Bank
Loan Servicing Department
9300 Flair Drive, 6th Floor
El Monte, California 91731
Attention: _____
Facsimile: _____
Telephone: _____

Such addresses may be changed by notice to the other parties given in the same manner as required above. Any notice, demand or request shall be deemed received as follows: (i) if sent by personal service, at the time such personal service is effected; (ii) if sent by telecopy, upon the sender's receipt of a confirmation report indicating receipt by the recipient's telecopier; (iii) if sent by overnight courier, on the business day immediately following deposit with the overnight courier; and (iv) if sent by mail, three business days following deposit in the mail.

(b) Governing Law. All questions with respect to the construction of this Guaranty and the rights and liabilities of the parties to this Guaranty shall be governed by the laws of the State of California.

(c) Binding on Successors. This Guaranty shall inure to the benefit of, and shall be binding upon, the successors and assigns of each of the parties to this Guaranty. Administrative Agent or Lenders may assign this Guaranty with one or more of the Loan Documents, without in any way affecting Guarantor's liability under it or them.

(d) Attorneys' Fees.

(i) Guarantor shall reimburse Administrative Agent and Lenders for all reasonable attorneys' fees, costs and expenses, incurred by Administrative Agent and Lenders in connection with the enforcement of Administrative Agent and Lenders' rights under this Guaranty and each of the other Loan Documents, including, without limitation, reasonable attorneys' fees, costs and expenses for trial, appellate proceedings, out-of-court negotiations, workouts and settlements or for enforcement of rights under any state of federal statute, including, without limitation, reasonable attorneys' fees, costs and expenses incurred to protect Administrative Agent and Lenders' security and attorneys' fees, costs and expenses incurred in bankruptcy and insolvency proceedings such as (but not limited to) seeking relief from stay in a bankruptcy proceeding. The term "expenses" means any expenses incurred by Administrative Agent or Lenders in connection with any of the out-of-court, or state, federal or bankruptcy proceedings referred to above, including, without limitation, the fees and expenses of any appraisers, consultants and expert witnesses retained or consulted by Administrative Agent or Lenders in connection with any such proceeding.

(ii) Administrative Agent and Lenders shall also be entitled to its and their attorneys' fees, costs and expenses incurred in any post-judgment proceedings to collect and enforce the judgment. This provision is separate and several and shall survive the merger of this Guaranty into any judgment on this Guaranty.

(iii) Notwithstanding anything in this Section 13(d) to the contrary, Guarantor shall not be liable or responsible for costs or fees incurred by Administrative Agent or any Lender in connection with the syndication of the Loan, the negotiation or enforcement of Article 9 of the Term Loan Agreement or any other agreement by or between the Lenders or the Administrative Agent, or any dispute by or between Administrative Agent or any Lenders with respect to their respective rights or obligations as between each other.

(e) Counterparts. This Guaranty may be executed in any number of original counterparts, each of which shall be deemed an original, but all of which when taken together shall constitute one instrument. The original signature page of any counterpart may be detached from such counterpart and attached to any other counterpart identical to such counterpart (except having additional signature pages executed by other parties to this Guaranty) without impairing the legal effect of any such signature(s).

(f) Entire Agreement. This Guaranty constitutes the entire agreement and understanding between the parties in respect of the subject matter of this Guaranty and supersedes all prior agreements and understandings with respect to such subject matter, whether oral or written.

(g) Waivers. Waiver by Administrative Agent or Lenders of any term, covenant or condition under this Guaranty or the Loan Documents, or of any default by Guarantor under this Guaranty or the Loan Documents, or any failure by Administrative Agent or Lenders to insist upon strict performance by Guarantor of any term, covenant or condition contained in this Guaranty or the Loan Documents, shall be effective or binding on Administrative Agent and Lenders only if made in writing by Administrative Agent; no such waiver shall be implied from any omission by Administrative Agent or Lenders to take action with respect to any such term, covenant, condition or default. No express written waiver by Administrative Agent of any term, covenant, condition or default shall affect any other term, covenant, condition or default or cover any other time period than the application of any such term, covenant or condition to the matter as to which a waiver has been given or the default or time period specified in such express waiver. This Guaranty may be amended only by an instrument in writing signed by the parties to this Guaranty.

(h) Severability. If any part of this Guaranty is declared invalid for any reason, such shall not affect the validity of the rest of the Guaranty. The other parts of this Guaranty shall remain in effect as if this Guaranty had been executed without the invalid part. The parties declare that they intend and desire that the remaining parts of this Guaranty continue to be effective without any part or parts that have been declared invalid.

14. WAIVER OF TRIAL BY JURY. TO THE EXTENT PERMITTED BY LAW, EACH OF ADMINISTRATIVE AGENT AND GUARANTOR WAIVES TRIAL BY JURY WITH RESPECT TO ANY ACTION, CLAIM, SUIT OR PROCEEDING IN RESPECT OF OR ARISING OUT OF THIS GUARANTY OR THE OTHER LOAN DOCUMENTS OR THE CONDUCT OF THE RELATIONSHIP AMONG ADMINISTRATIVE AGENT, LENDERS AND GUARANTOR. EACH PARTY HAS OBTAINED THE ADVICE OF THEIR RESPECTIVE LEGAL COUNSEL BEFORE SIGNING THIS GUARANTY AND ACKNOWLEDGE THAT THEY VOLUNTARILY AGREED TO THIS WAIVER OF THEIR RIGHT TO TRIAL BY JURY WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE AND LEGAL CONSEQUENCE.

15. Right to Deal with Administrative Agent. Guarantor shall have the same rights as are provided to Borrower pursuant to Sections 9.13, 9.14 and 9.15 of the Term Loan Agreement.

[Signature page follows]

IN WITNESS WHEREOF, Guarantor has caused this Guaranty to be duly executed as of the date first written above.

GUARANTOR:

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: /s/ John C. Molina
John C. Molina
Chief Financial Officer

Exhibit 10.20

ENVIRONMENTAL INDEMNITY

This ENVIRONMENTAL INDEMNITY (this "Indemnity") is entered into as of December 1, 2011, by MOLINA CENTER LLC, a Delaware limited liability company ("Borrower") and MOLINA HEALTHCARE, INC. ("Guarantor"; collectively, jointly and severally with Borrower, "Indemnitor"), for the benefit of EAST WEST BANK, a California banking corporation, in its capacity as administrative agent (in such capacity, " Administrative Agent") for itself, Bank of China, Los Angeles Branch, City National Bank, Union Bank, N.A. and The Bank of East Asia (USA) N.A. and their assignees and successors from time to time as "Lenders" under the Term Loan Agreement defined below (collectively, "Lenders," and each, a "Lender"), Lenders and each of Administrative Agent's and Lenders' successors, assigns and participants, parents, subsidiaries and affiliated corporations, and its and their respective directors, officers, agents, attorneys and employees (each individually, an " Indemnitee" and collectively, "Indemnitees").

RECITALS

A. Pursuant to the terms of the Term Loan Agreement dated as of even date herewith (as amended, extended, renewed, supplemented or otherwise modified from time to time, the "Term Loan Agreement") by and among Administrative Agent, Lenders and Borrower, Lenders have agreed to make a term loan to Borrower in the principal amount of up to Forty Eight Million Six Hundred Thousand Dollars ($48,600,000) (the " Loan"). Capitalized terms used but not otherwise defined in this Indemnity shall have the meanings ascribed to such terms in the Term Loan Agreement. The obligations of Borrower for repayment of the Loan are evidenced by the Promissory Note dated as of even date herewith (as amended, extended, renewed, replaced, split, supplemented or otherwise modified from time to time, the "Note") made by Borrower to the order of Administrative Agent, on behalf of Lenders, in the principal amount of the Loan.

B. Borrower's obligations to Administrative Agent and Lenders under the Term Loan Agreement are secured by the Deed of Trust, Security Agreement, Assignment of Rents and Fixture Filing dated as of even date herewith (as amended, extended, renewed, supplemented or otherwise modified from time to time, the "Deed of Trust") executed by Borrower, as trustor, naming First American Title Insurance Company as trustee and Administrative Agent as beneficiary, and by other collateral security. The Deed of Trust encumbers the "Property" (as described in the Deed of Trust). The obligations of Indemnitor under this Indemnity are not secured by the Deed of Trust.

C. Indemnitor's execution of this Indemnity is a condition precedent to Lenders' issuance of the Loan. Indemnitor is willing to execute this Indemnity because of the benefits Lenders' issuance of the Loan will confer on Borrower and Guarantor.

AGREEMENT

1. Indemnity. Indemnitor shall be solely responsible for, and shall indemnify and hold harmless each Indemnitee from and against, any loss, damage, cost, expense, claim or liability directly or indirectly arising out of or attributable to the use; generation; storage; release;

threatened release, discharge or disposal; or presence of "Hazardous Materials" (as defined below) on or about the Property, including, without limitation: (a) all foreseeable consequential damages incurred by any Indemnitee; (b) the costs of any required or necessary repair, cleanup or detoxification of the Property and the preparation and implementation of any closure, remedial or other required plans; and (c) all reasonable costs and expenses incurred by any Indemnitee in connection with clauses (a) and (b), including, without limitation, reasonable attorneys' fees.

For purposes of this Indemnity, the following terms shall have the following definitions:

"Hazardous Materials" means (i) any chemical, compound, material, mixture or substance that is now or hereafter defined or listed in, or otherwise classified pursuant to, any "Hazardous Materials Law" (as defined below) as a "hazardous substance", "hazardous material", "hazardous waste", "extremely hazardous waste", "acutely hazardous waste", "radioactive waste", "infectious waste", "biohazardous waste", "toxic substance", "pollutant", "toxic pollutant", "contaminant" as well as any formulation not mentioned herein intended to define, list, or classify substances by reason of deleterious properties such as ignitability, corrosivity, reactivity, carcinogenicity, toxicity, reproductive toxicity "EP toxicity," or "TCLP toxicity"; (ii) petroleum, natural gas, natural gas liquids, liquified natural gas, synthetic gas usable for fuel (or mixtures of natural gas and such synthetic gas) and ash produced by a resource recovery facility utilizing a municipal solid waste stream, and drilling fluids, produced waters and other wastes associated with the exploration, development or production of crude oil, natural gas, or geothermal resources; (iii) "hazardous substance" as defined in Section 25281(f) of the California Health and Safety Code; (iv) "waste" as defined in Section 13050(d) of the California Water Code (v) asbestos in any form; (vi) urea formaldehyde foam insulation; (vii) transformers or other equipment which contain dielectric fluid containing levels of polychlorinated biphenyls (PCBs) in excess of fifty (50) parts per million; (viii) radon; and (ix) any other chemical, material, or substance that, because of its quantity, concentration, or physical or chemical characteristics, exposure to which is limited or regulated for health and safety reasons by any governmental authority, or which poses a significant present or potential hazard to human health and safety or to the environment if released into the workplace or the environment.

"Hazardous Materials Laws" means all present and future federal, state and local laws, ordinances, regulations, permits, guidance documents, policies, decrees, orders and any other requirements, whether statutory, regulatory or contractual, of governmental authorities relating to health, safety, the environment or the use, handling, disposal or transportation of any Hazardous Materials (including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act of 1980, the Resource Conservation Recovery Act, the Clean Water Act, the Clean Air Act, and the applicable provisions of the California Health and Safety Code and the California Water Code, as each such statute may from time to time be amended, and the rules, regulations, and guidance documents promulgated pursuant to any such statute).

Notwithstanding the foregoing, Indemnitor shall have no liability under this Indemnity for the release of any Hazardous Material on the Property by any Indemnitee or any such release occurring after foreclosure, a deed in lieu of foreclosure or the possession of the Property by a receiver.

2. Indemnity Procedure.

(a) If any Indemnitee notifies Indemnitor of any claim or notice of the commencement of any action, administrative or legal proceeding or investigation as to which Indemnitor's obligation to indemnify under Section 1 above applies, Indemnitor shall assume on behalf of such Indemnitee, and conduct with due diligence and in good faith, the investigation and defense of, and the response to, such claim, action, proceeding or investigation, with counsel reasonably satisfactory to the Indemnitee; provided, however, that such Indemnitee shall have the right to be represented by advisory counsel of its own selection and at its own expense; and provided, further, that if any such claim, action, proceeding, or investigation involves both Indemnitor and an Indemnitee, and such Indemnitee shall have reasonably concluded that there may be legal defenses available to it which are different from, additional to, or inconsistent with those available to Indemnitor, then the Indemnitee shall have the right to select separate counsel to participate in the investigation and defense of and response to such claim, action, proceeding or investigation on its own behalf at Indemnitor's expense.

(b) If any claim, action, proceeding, or investigation arises as to which Indemnitor's duty to indemnify under this Indemnity applies, and Indemnitor fails to assume promptly (and in any event within ten days after being notified of the claim, action, proceeding, or investigation) the defense of an Indemnitee, then such Indemnitee may contest and settle the claim, action, proceeding, or investigation at Indemnitor's expense using counsel selected by such Indemnitee; provided, however, that after any such failure by Indemnitor no such contest need be made by such Indemnitee and settlement or full payment of any claim may be made by such Indemnitee without Indemnitor's consent and without releasing Indemnitor from any obligations to such Indemnitee under this Indemnity.

3. Damages Unrelated to Credit. This Indemnity is given solely to protect Administrative Agent, Lenders and the other Indemnitees against claims, losses, damages, costs, expenses, claims and liabilities, and not as additional security for, or as a means of payment of, Indemnitor's obligations under the Term Loan Agreement or any other obligation secured by the Deed of Trust. The obligations of Indemnitor under this Indemnity are independent of, and shall not be measured or affected by (a) any amounts at any time owing under the Term Loan Agreement or secured by the Deed of Trust, (b) the sufficiency or insufficiency of any collateral (including, without limitation, the Property) given to Administrative Agent or Lenders to secure the performance of the Term Loan Agreement, the Note or any obligation in favor of Administrative Agent, on behalf of Lenders, (c) the consideration given by Administrative Agent, Lenders or any other party in order to acquire the Property, (d) the modification, expiration or termination of the Deed of Trust or any other document or instrument securing or otherwise relating to the obligations owing under the Term Loan Agreement, or (e) the payment in full of all obligations owing under the Term Loan Agreement, the Note or any obligation in favor of Administrative Agent or Lenders (including, without limitation, by amounts paid or credit bid at a foreclosure sale or by discharge in connection with a deed in lieu of foreclosure). Indemnitor's obligations under this Indemnity are not secured, whether by the Deed of Trust or otherwise.

4. Survival of Sale by Borrower. Except as otherwise provided in this Indemnity, Indemnitor's obligations under this Indemnity shall survive the sale or other transfer of the Property by Borrower. The rights of each Indemnitee under this Indemnity shall be in addition to any other rights and remedies of such Indemnitee against Indemnitor under any other document or instrument executed by Indemnitor, or at law or in equity (including, without limitation, any right of reimbursement or contribution pursuant to CERCLA), and shall not in any way be deemed a waiver of any of such rights.

5. Subrogation. If Indemnitor fails to indemnify the Indemnitees as provided in this Indemnity, the Indemnitees shall be subrogated to any rights Indemnitor may have against third parties relating to the matters covered by this Indemnity.

6. Payment of Costs. Indemnitor shall pay, upon demand, all costs and expenses (including, without limitation, reasonable attorneys fees) incurred by any Indemnitee in the enforcement of this Indemnity or the collection of any amounts due under this Indemnity.

7. Successors and Assigns. This Indemnity shall be binding upon Indemnitor, its successors and assigns, and shall inure to the benefit of and shall be enforceable by each Indemnitee, its successors, and assigns (including, without limitation, any entity to which a Lender assigns or sells all or any portion of its interest in the Note, and any successor to Administrative Agent under the Term Loan Agreement).

8. Notices. Any notice, demand or request required under this Indemnity shall be given in the manner required in the Deed of Trust.

9. Separate Actions. Multiple actions may be brought and judgments obtained under this Indemnity. A separate and new right of action arises each time that a claim or liability arises under this Indemnity.

10. Governing Law. This Indemnity shall be governed and construed in accordance with the laws of the State of California.

11. Severability. All provisions contained in this Indemnity are severable and the invalidity or unenforceability of any provision shall not affect or impair the validity or enforceability of the remaining provisions of this Indemnity.

12. Entire Agreement. This Indemnity constitutes the entire agreement and supersedes all prior agreements and understandings, both written and oral, between the parties with respect to the subject matter contained in this Indemnity.

[Signature page follows]

IN WITNESS WHEREOF, Indemnitor has caused this Indemnity to be duly executed as of the date first written above.

BORROWER:

MOLINA CENTER LLC,
a Delaware limited liability company

By: /s/ John C. Molina
John C. Molina
President

GUARANTOR:

MOLINA HEALTHCARE, INC.
a Delaware corporation

By: /s/ John C. Molina
John C. Molina
Chief Financial Officer

Signature Page to
Environmental Indemnity
Molina Center LLC

Exhibit 10.21

200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA

PURCHASE AGREEMENT

BETWEEN

200 OCEANGATE, LLC, A DELAWARE LIMITED LIABILITY COMPANY

AND

MOLINA CENTER LLC, A DELAWARE LIMITED LIABILITY COMPANY

OCTOBER 11, 2011

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LIST OF EXHIBITS

PURCHASE AGREEMENT

200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA

THIS AGREEMENT is entered into as of the 11th day of October, 2011 ("**Contract Date**"), by and between 200 OCEANGATE, LLC, a Delaware limited liability company ("**Seller**"), and MOLINA CENTER LLC, a Delaware limited liability company (" **Buyer**").

RECITALS

Seller owns and is offering for sale the land and improvements commonly known as 200 & 300 Oceangate, Long Beach, California, and more completely described below. Buyer has offered to buy the property, and the parties are entering into this Agreement to set forth the terms and conditions of the sale to Buyer.

NOW, THEREFORE, in consideration of the foregoing and the agreements set forth below, the parties hereto agree as follows:

1. Agreement of Sale.

1.1 Seller hereby agrees to sell to Buyer and Buyer hereby agrees to purchase from Seller that certain real property (the " **Land**") with street address of 200 & 300 Oceangate, Long Beach, California, and more particularly described in attached Exhibit A, together with Seller's right, title and interest in the following, which together with the Land, shall be termed the " **Property**" herein:

(a) the approximately 461,263 square foot office project located at 200 & 300 Oceangate, Long Beach, California and all fixtures and other improvements located upon the Land (collectively, the "**Improvements**");

(b) all easements, rights of way, privileges, licenses, appurtenances and other rights and benefits of Seller belonging to or in any way related to the Land, and the Improvements, including water rights, mineral rights, air rights and development rights, if any (together with the Land and Improvements, the "**Real Property**");

(c) all fixtures, furnishings, equipment and other tangible personal property owned by Seller that are used for the operation of the Property and that are located on the Property or that are used exclusively for the operation of the Property (the " **Personal Property**");

(d) the Leases and Service Contracts (as such terms are hereinafter defined) and all security deposits held by Seller with respect to the Leases;

(e) to the extent assignable, all certificate(s) of occupancy, building or equipment permits, consents, authorizations, variances, waivers, licenses, permits, certificates and approvals from any governmental or quasi-governmental authority necessary for the use of the Land or the Improvements (collectively, the "**Approvals**");

(f) all transferable or assignable warranties (the "**Warranties**") relating to the ownership, development, use and operation of the Land and Improvements;

(g) to the extent assignable, all of Seller's interest in all structural, soil, seismic, geologic, engineering and other reports and studies, all operating manuals for all systems, equipment and operating components of the Property, all marketing materials that are distributed or shown to potential tenants in the marketing of the Property for lease, photos and depictions, all architectural drawings, plans and specifications relating to all or any portion of the Real Property, and all intellectual property rights to the Property, including, without limitation, trade names, trademarks, service marks, logos or other source and business identifiers, trademark registrations and applications for registration used at or relating to the Real Property and any written agreement granting to Seller any right to use any trademark or trademark registration at or in connection with the Real Property (the " **Intangible Property**").

2. Purchase Price. The purchase price for the Property is Eighty-Three Million Dollars ($83,000,000.00) (" **Purchase Price**") and shall be paid in cash by Buyer at the Closing (as defined in Section 10.1 below).

3. Non-Refundable Payment and Deposit

3.1 Non-Refundable Payment. On the Contract Date, as consideration for Seller's agreement to enter into this Agreement and grant Buyer the right to conduct due diligence and terminate this Agreement on and subject to the terms of Section 7, and as a condition precedent to the effectiveness of this Agreement, Buyer shall deliver directly to Seller, by personal check, cash or wire transfer funds in the amount of One Hundred and No/100 ths Dollars ($100) (the "**Non-Refundable Payment**"). The Non-Refundable Payment shall be fully earned and retained by Seller immediately upon receipt and, notwithstanding any provisions of this Agreement to the contrary, the Non-Refundable Payment shall not be returned to Buyer in any circumstance.

3.2 Deposit; Liquidated Damages.

(a) Initial Deposit. Within one (1) business day after the Contract Date, Buyer shall deposit in an escrow (the " **Escrow**") established for the within contemplated transaction with First American Title Insurance Company, National Commercial Services, 1850 Mt. Diablo Blvd., Suite 300, Walnut Creek, California, 94596, Attention: Kitty Schlesinger, Order No. NCS-453433-CC (the " **Title Company**"), the sum of Five Hundred Thousand Dollars ($500,000) (the "**Initial Deposit**"), with instructions to the Title Company to hold the Initial Deposit in the Escrow in an interest-bearing account, with interest accruing for the benefit of Buyer. In the event the sale of the Property is consummated, the Initial Deposit and all interest earned thereon shall be applied towards the Purchase Price. If Buyer elects to terminate this Agreement pursuant to its terms or fails to notify Seller in writing that the Property is acceptable, as provided in Section 7, prior to the end of the Due Diligence Period (as defined in Section 7), the Initial Deposit and all interest thereon shall be returned to Buyer, and the parties shall be released from all further obligations and liability under this Agreement, except for those obligations that survive the termination of this Agreement.

(b) Additional Deposit. Concurrently with, and subject to, the delivery of the Approval Notice to Buyer as provided in Section 7, Buyer shall deposit in the Escrow the additional sum of Two Million and No/100ths Dollars ($2,000,000) (the " **Additional Deposit**" and together with the Initial Deposit, the "**Deposit**"), with instructions to the Title Company to hold such Additional Deposit in the Escrow, in an interest bearing account, with interest accruing for the benefit of Buyer. In the event the sale of the Property to Buyer is consummated, the Deposit and all interest earned thereon shall be applied towards the Purchase Price.

(c) Non-Refundable Deposit. Upon the delivery by Buyer to Seller of the Approval Notice, the Deposit shall be non-refundable to Buyer except in the following events, upon the occurrence of which the Deposit and all interest thereon shall be returned to Buyer: (i) the Closing fails to occur due to a material default by Seller under this Agreement; (ii) the Closing fails to occur as a result of a failure of a condition to Closing in favor of Buyer, but only if such failure occurs other than as a result of a material default by Buyer under this Agreement; or (iii) the terms of this Agreement expressly provide for the return of the Deposit to Buyer. On the Closing Date, the Deposit and all interest earned thereon shall be applied to the Purchase Price.

(d) **Liquidated Damages. If this Agreement does not terminate pursuant to Section 7, but Buyer fails to consummate this transaction on the scheduled Closing Date (as defined in Section 10.1) due to default by Buyer and any such default continues for five (5) business days after written notice from Seller to Buyer, which written notice shall detail such default, Seller shall be entitled to the Deposit, and all interest thereon, as liquidated damages. The parties have acknowledged and agreed that Seller's damages, in the event of a default by Buyer, would be extremely difficult or impracticable to determine. Therefore, by placing their initials below, the parties acknowledge that the Deposit, and all interest thereon, has been agreed upon, after negotiation, as the parties' reasonable estimate of Seller's damages. Notwithstanding the foregoing, in no event shall Seller's ability to recover from Buyer any loss, cost, damage or expense pursuant to any indemnification or other provision of this Agreement that survives the Closing be deemed limited in any respect by this provision or by Seller's receipt of the Deposit.** The parties agree that the Deposit is not intended as a forfeiture or penalty within the meaning of California Civil Code Sections 3275 or 3369 but shall be treated as liquidated damages pursuant to California Civil Code Sections 1671, 1676 and 1677.

/s/ Jeanne R Myerson, President	/s/ John C. Molina, CFO
Seller	Buyer

This Section 3.2 is not intended to limit Seller's remedies under Sections 6, 17.7 or 17.8.

4. Documents to be Delivered to Buyer.

4.1 Due Diligence Deliveries. Seller has provided Buyer with, and Buyer acknowledges receipt of, copies of the materials and documents identified in Exhibit B attached hereto.

4.2 Title Report. Seller has also provided to Buyer, and Buyer acknowledges receipt of that certain title commitment for the Property prepared under Order No. NCS-453433-CC, dated September 9, 2011, together with a copy of each document referred to therein (collectively, the " **Preliminary Title Report**").

4.3 Property Documents. Buyer shall have the right, at Buyer's sole cost and expense and with at least one (1) business day prior notice, to review Seller's real property transaction files (excluding any privileged or confidential information and excluding any valuation and appraisal information), lease files, plans and specification files, and other files relating to the Property and its ownership, operation, management and maintenance during regular business hours, which files are located in the management office at the Property.

4.4 Leases. Seller shall deliver to Buyer copies of the existing leases, license agreements and rental agreements covering any portion of the Property, any guarantees thereof, and all amendments, modifications and supplements thereto as listed on Exhibit C hereto (each a "**Lease**" and collectively, the "**Leases**").

4.5 Tenant Estoppels.

(a) Seller shall deliver to Buyer an estoppel certificate (a " **Tenant Estoppel**"), in the form of attached Exhibit D or, if the applicable Lease provides for a different form of estoppel in the form specified in the applicable Lease, dated no earlier than thirty (30) days prior to Closing, from as many of the tenants of the Property (the "**Tenants**") from whom Seller is able to obtain such Tenant Estoppels through the exercise of Seller's diligent, good faith efforts. Seller shall, at least ten (10) days prior to the expiration of the Due Diligence Period and prior to delivery to the Tenants for execution, deliver completed forms of Tenant Estoppels to Buyer for Buyer's review and approval, provided that Seller shall not be obligated to deliver the form of Tenant Estoppel for any of the following Tenants (collectively, the "**Government Tenants**"): (A) the State of California acting by and through the Director of the Department of General Services; and (B) the United States of America, Department of Veterans Affairs. Buyer may disapprove a Tenant Estoppel only if (i) it is not in the form of Exhibit D or, if the applicable Lease provides for a different form or content of estoppel in the form or content specified in the applicable Lease, the form or content provided by the applicable Lease, or (ii) if the information set forth in the Tenant Estoppel is not consistent with the terms set forth in the applicable Lease. If Buyer has not responded as to such approval within three (3) business days of receipt of a Tenant Estoppel, Buyer shall be deemed to have approved the Tenant Estoppel in question for delivery to Tenant. Seller shall deliver completed Tenant Estoppels to Buyer as they are received by Seller. Notwithstanding the foregoing, Seller shall not be obligated to prepare or seek Tenant Estoppels with respect to the following Leases, as amended and assigned to date: (1) License Agreement, dated November 30, 2000, by and between Pacific Towers Associates

and Captivate Network, Inc.; (2) Antenna Site License Agreement, dated as of November 30, 2006, by and between Seller and Direct America Satellite Services; (3) Telecommunications License Agreement, dated July 13, 2005, by and between Seller and Rocket Internetworking, Inc.; (4) Telecommunications Access and License Agreement, dated December 21, 2009, by and between Seller and TCG Los Angeles, Inc.; (5) License Agreement, dated December 21, 2000, by and between XO Communications, Inc., and Pacific Towers Associates; and (6) UPS Drop Box Agreement, dated February 2, 2010, by and between United Parcel Service, Inc., and Seller.

(b) Estoppel Thresholds. Buyer shall have a right to terminate this Agreement upon written notice prior to the Closing Date and receive a refund of the Deposit and all interest thereon as its sole remedy if Seller fails to deliver to Buyer at least three (3) days prior to the Closing Date, Tenant Estoppels from (i) the State of California acting by and through the Director of the Department of General Services, which is the contracting party under five (5) separate Leases – State Lands Commission (two Leases), California Coastal Commission, and Department of Industrial Relations (two Leases), confirming that such Leases are in effect, that the Tenant has no default claims against Seller, that the term of the Lease is consistent with the term reflected in the Lease, and that the base monthly rent payable is consistent with the base monthly rent shown in the Lease, (ii) the United States of America, Department of Veterans Affairs confirming that the Lease is in full force and effect, the date to which the rent and other charges have been paid in advance, if any; and whether any notice of default has been issued, and (iii) each of (1) AECOM Technology Corp., (2) Pacific Maritime Association, (3) Long Beach Publishing Company, Inc., and Medianews Group, Inc., (4) J. Perez Associates, Inc., and (5) Crowell Weedon & Co. (collectively, the "**Major Non-Government Tenants in Occupancy**") in the form approved or deemed approved by Buyer pursuant to Section 4.5(a) above. Buyer acknowledges and agrees that if the Major Non-Government Tenants in Occupancy delete or modify one or both of sections 20 and 21 of the form Tenant Estoppel attached as Exhibit D, such deletion(s) or modification(s) shall not constitute a change in the form approved or deemed approved by Buyer. As used in this Agreement, the term " **Major Non-Government Tenants**" shall mean the Major Non-Governmental Tenants in Occupancy.

4.6 Service Contracts. Seller has delivered to Buyer, and Buyer acknowledges receipt of, copies of the service, maintenance, management and other contracts and agreements related to the operation and management of the Property, excluding the property management agreement which will not be assigned at Closing, all of which are listed on the attached Exhibit E (the "**Service Contracts**"). If Buyer delivers the Approval Notice, Buyer shall be deemed to have agreed to assume at Closing all of the Service Contracts.

4.7 Survey. Seller shall deliver a copy of Seller's existing survey to Buyer (the " **Survey**"). Buyer may, at its sole cost and expense, cause the Survey to be updated and recertified as deemed necessary and appropriate by Buyer.

4.8 Discharge Permit. So long as this Agreement remains in effect, Seller shall endeavor, at its sole cost and expense, to obtain a discharge permit from an applicable regulatory authority (a "**Discharge Permit**") with respect to the operation of the water collection and discharge system at the Property (the "**Discharge System**"). Seller confirms that it has retained and shall continue to retain, at its sole cost and expense, Kennedy/Jenks Consultants to oversee

the necessary water quality testing, produce the reports and collect the data required in connection with obtaining a Discharge Permit (the " **Water Testing**"). Seller shall promptly provide, or cause to be promptly provided, to Buyer (on an ongoing basis for so long as this Agreement remains in effect) copies of all reports, studies and data obtained and/or generated by Seller's consultants with respect to any Discharge Permit, the Discharge System and/or the Water Testing and any applications or other materials submitted to, and any written correspondence with, any applicable regulatory authority with respect to a Discharge Permit, the Discharge System and/or the Water Testing. If a Discharge Permit is issued prior to Closing, from and after the issuance of such Discharge Permit and continuing until Closing, Seller shall perform all sampling, analysis and data collection as and when required under such Discharge Permit, and disclose the same promptly to Buyer. Buyer shall have the right, from time to time during the Due Diligence Period, to collect samples of water discharged via the Discharge System ("**Samples**"), and to perform water quality testing and analysis on such Samples, at Buyer's cost; provided, however: (i) Buyer shall not (without Seller's prior consent) collect Samples more often than once per calendar week (except that Buyer shall be allowed to collect a high tide sample followed by a low tide sample, or vice-versa, as long as such sampling collection is completed within a 24 hour period); (ii) Buyer's right to collect Samples shall cease upon Buyer's receipt of written notice from Seller confirming that a Discharge Permit covering the operation of the Discharge System has been formally issued and is currently effective; (iii) Samples shall be collected using sampling protocols acceptable to Seller (in Seller's commercially reasonable discretion); (iv) testing and analysis performed on any Samples shall be performed by laboratories (and in accordance with protocols) acceptable to Seller (in Seller's commercially reasonable discretion); and (v) access to the Property in connection with the collection of Samples shall be subject to the requirements of Section 6.

5. Title.

5.1 Title Commitment. Buyer shall be responsible for obtaining, no later than the end of the Due Diligence Period, a commitment from the Title Company to issue at Closing a policy of title insurance in a form acceptable to Buyer, which is not conditioned on the performance by any party or third party of any actions other than the express obligations of the parties under this Agreement (the " **Commitment**"). Seller will provide, at Closing, an affidavit to the Title Company in the form attached hereto as Exhibit J. Buyer shall deliver the Commitment to Seller together with a letter from Buyer to Seller stating that the exceptions to title reflected in the Commitment are approved by Buyer. If Buyer does not provide Seller with the Commitment and such letter prior to the expiration of the Due Diligence Period, the title reflected in the Preliminary Title Report (or any updated title report) shall be deemed unacceptable and disapproved, this Agreement shall terminate and the Deposit, together with all interest thereon, shall be returned to Buyer. Seller shall have no duty to cure, and Buyer shall not be entitled to any offset or credit against the Purchase Price due to, any defect in the title to the Property or any condition or aspect of the Property, to which Buyer may object, except as may be agreed by Seller in writing, in its sole and absolute discretion; provided, however, that Seller shall remove, bond over, or obtain a title endorsement for any liens (" **Seller Liens**") that affect the Property and that are not liens for taxes or assessments accruing on or after the Closing and that are not created by, or the result of actions of, Buyer, Molina or any of their respective affiliates, agents, employees or contractors. Any cure that Seller has so agreed to perform or is obligated to

perform shall become a condition precedent to Closing in favor of Buyer and shall be cured by the Closing Date. For purposes of this Section 5.1, a "cure" of a title exception means the elimination of such exception from title and shall not include the bonding of, or endorsement over unless such bonding is in an amount and on terms required by the Title Company for elimination of such exception from the Title Policy (as defined in Section 5.3) as reasonably determined by Buyer. If such cure is not accomplished by the Closing Date, Buyer, as its sole and exclusive remedy, may either terminate this Agreement, in which case the Deposit shall be returned to Buyer, or waive such objection and complete the Closing subject to such exception, provided that if Seller refuses to remove a Seller Lien at Closing, Buyer shall have the right to instruct the Title Company, as escrow agent, to apply a portion of the Purchase Price sufficient to discharge such Seller Lien at Closing.

5.2 Permitted Exceptions. The following shall constitute the "**Permitted Exceptions**": (a) the Title Company's standard exceptions; (b) all exceptions that are shown on the Commitment; (c) all of the Leases; and (d) all exceptions that arise after the expiration of the Due Diligence Period and prior to the Closing that are not Seller Liens and that are approved by Buyer, in writing, in its sole and absolute discretion, or are caused by Buyer or Molina, their agents, employees, contractors or representatives or result from any new survey of the Real Property or any update of any existing survey.

5.3 Title Policy. Evidence of title shall be the issuance by the Title Company at Closing of a policy of title insurance in the form of the Commitment, subject only to the Permitted Exceptions ("**Title Policy**"). Seller shall be responsible for the cost of a CLTA standard coverage policy of title insurance in the amount of the Purchase Price; Buyer shall be responsible for the incremental cost of an ALTA extended coverage policy of title insurance, the cost of any endorsements to the Title Policy and for providing any necessary surveys (other than the Survey) to the Title Company.

5.4 No Recording. Neither this Agreement nor any memorandum of this Agreement shall be recorded by, or on behalf of, Buyer in the Official Records of the County of Los Angeles. If Buyer violates the terms of this Section 5.4 by recording or attempting to record this Agreement or a memorandum thereof, such act shall not operate to bind or cloud the title to the Property, shall constitute a material breach and default by Buyer under this Agreement, and shall entitle Seller to terminate this Agreement by written notice to Buyer, which termination notice may be recorded against the Property.

6. Access.

6.1 Provided that Buyer has complied with the insurance requirements in Section 6.3 and gives Seller at least one (1) business day's prior notice (oral or written), Seller shall allow Buyer and authorized representatives of Buyer reasonable access, at reasonable times, to the Property for the purposes of satisfying Buyer with respect to the Property. In performing its examinations and inspections of the Property, Buyer shall use reasonable efforts to minimize any interference with Seller's and the Tenants' use and occupancy of the Property. Seller shall have the right at all times to have a representative of Seller accompany any of Buyer or Buyer's employees, agents, contractors, consultants, officers, directors, representatives, managers or

members (collectively, "**Buyer's Agents**") while such persons are on the Property. Buyer may conduct interviews with the Tenants, provided Buyer has given Seller no less than two (2) business days notice prior to any such interview, and provided further that Seller shall have the right to be present at all such interviews. Buyer's breach of this Section 6.1 (and all subsections) shall constitute a material breach and default by Buyer of this Agreement. All investigations and inspections shall be performed in compliance with this Section 6 and all local, state and federal laws, rules and regulations, including, without limitation, any and all permits required thereunder, which permits shall be obtained by and at the sole cost of Buyer.

(a) Buyer shall not conduct or allow any physically intrusive or destructive testing of, on or under the Property, without Seller's prior written consent, which consent may be withheld at Seller's sole and absolute discretion; provided, however, Buyer may, subject to its damage and repair obligations in this Section 6.1 and 6.2, inspect the Property for asbestos-related materials. Buyer shall provide Seller with two (2) days written notice prior to the commencement of any physically intrusive or destructive testing, accompanied by a detailed work plan describing the nature, scope, location and purpose of the proposed work. Buyer acknowledges and agrees that Seller's review of Buyer's work plan is solely for the purpose of protecting Seller's interests, and shall not be deemed to create any liability of any kind on the part of Seller in connection with such review that, for example, the work plan is adequate or appropriate for any purpose or complies with applicable legal requirements. All work and investigations shall be performed in compliance with all local, state and federal laws, rules and regulations, including, without limitation, any and all permits required thereunder, all of which shall be at the sole cost and expense of Buyer.

(b) During the performance of Buyer's investigations, Buyer shall promptly remove and properly dispose of all samples, substances and materials extracted from or generated by Buyer at the Property and, upon the completion of its investigations, shall return the Property to its original condition, including the removal of all equipment and materials used or generated during its investigations. Buyer shall name itself as the generator on any waste manifests required to dispose of said materials and shall obtain its own waste generator identification number with respect thereto. If Buyer fails to perform or cause such restoration, and such failure shall continue for two (2) days after Buyer receives written notice from Seller demanding the cure thereof, Seller may perform or cause to be performed such restoration work, and Buyer shall reimburse Seller for all the costs and expenses thereof within two (2) days after receipt of bills therefor from Seller.

6.2 Notwithstanding anything in this Agreement to the contrary, any entry upon, inspection, or investigation of the Property by Buyer or Buyer's Agents shall be performed at the sole risk and expense of Buyer, and Buyer shall be solely and absolutely responsible for the acts or omissions of any of Buyer's Agents. Furthermore, Buyer shall protect, indemnify, defend and hold Seller, and its successors, assigns, and affiliates harmless from and against any and all losses, damages (whether general, punitive or otherwise), liabilities, claims, causes of action, judgments, costs and legal or other expenses (including, but not limited to, attorneys' fees and costs) (collectively, "**Access Claims**") suffered or incurred by any or all of such indemnified parties to the extent resulting from any act or omission of Buyer or Buyer's Agents in connection with: (i) Buyer's inspection or investigations of the Property; (ii) Buyer's entry upon the

Property; (iii) any activities, studies or investigations conducted at, to, or on the Property by Buyer or Buyer's Agents; or (iv) the presence by Buyer or Buyer's Agents at or on the Property. If at any time prior to Closing, Buyer or Buyer's Agents cause any damage to the Property, Buyer shall, at its sole expense, immediately restore the Property to the same condition as existed immediately prior to the occurrence of such damage as determined by Seller in Seller's reasonable discretion. Buyer's obligations under this Section 6.2 shall survive the termination of this Agreement or the Closing, as the case may be, notwithstanding any other provisions herein to the contrary, and shall not be limited by the terms of Section 3. Buyer shall, at all times, keep the Property free and clear of any mechanics', materialmen's or design professional's claims or liens arising out of or relating to its investigations of the Property. The foregoing provisions of this Section 6.2 shall not apply to, and Buyer shall have no liability for, or obligation to protect, indemnify, defend or hold Seller (or any other person or party) harmless from or against any of the following: (i) the discovery by Buyer or any of Buyer's Agents of any Hazardous Material on, under or affecting the Property, except to the extent that Buyer and Buyer's Agents exacerbate such condition in any material respect; (ii) the discovery by Buyer or Buyer's Agents of adverse physical, environmental, economic, neighborhood or other conditions at, on, in, under, around or affecting the Property, except to the extent that Buyer and Buyer's Agents exacerbate such condition in any material respect; or (iii) events, occurrences or conditions resulting from the acts or omissions of Seller or Seller's agents or representatives, except to the extent Buyer and Buyer's Agents exacerbate such events, occurrences or condition in any material respect. Notwithstanding anything in this Section 6.2 to the contrary, Buyer shall have no duty or obligation to identify or repair any condition in, on or affecting the Property that Buyer or Buyer's Agents discover or of which they are aware that may or could be unsafe or dangerous unless and to the extent such unsafe or dangerous condition was caused by the Buyer or Buyer's Agents.

6.3 Buyer shall maintain in full force and effect during the term of this Agreement, the public liability insurance covering Buyer and its activities at the Property on the terms and with the coverages described in the ACORD Certificate of Liability Insurance attached hereto as Exhibit K, naming Seller as an additional insured under all such liability insurance.

7. Due Diligence Period. Buyer shall have until 5:00 p.m., California time, on the date that is thirty (30) days after the Contract Date ("Due Diligence Period") to inspect and investigate the Property, including roof, plumbing, soils, electrical, sprinkler, water, sewer, mechanical, engineering, heating, ventilation and air conditioning and life safety systems, structural integrity of the Improvements, measurement of the square footage of the Land and Improvements, legal status and requirements pertaining to the Property (including applicable building codes, zoning, environmental, public health and fire safety laws), hazardous substance inspections including preparation of an environmental assessment, suitability of the Property for Buyer's purposes and all other matters of significance to Buyer. Buyer agrees to keep the results of such testing and inspections confidential, except to the extent that disclosure is required by law (in which case Buyer will notify Seller in writing prior to making any such disclosure), which confidentiality obligations shall survive the termination of this Agreement. Buyer shall order and pay for all costs and expenses with respect to such inspections and investigations. If, in Buyer's sole and absolute discretion, Buyer desires to proceed with its acquisition of the Property, Buyer shall deliver written notice to Seller (the " **Approval Notice**"), prior to the expiration of the Due

Diligence Period, stating that it approves the Property, in which case the parties shall proceed to complete the Closing (subject to the terms and conditions of this Agreement). If Buyer fails to deliver the Approval Notice prior to the expiration of the Due Diligence Period or if such Approval Notice seeks to modify any of the terms or provisions of this Agreement, Buyer will be deemed to have disapproved the Property and to have exercised its right to terminate this Agreement pursuant to this Section 7, in which case this Agreement shall automatically terminate as of the expiration of the Due Diligence Period and the Initial Deposit, together with all interest earned thereon, shall be returned to Buyer. Further, if Buyer fails to deposit the full Additional Deposit in Escrow prior to the expiration of the Due Diligence Period, regardless of whether Buyer has delivered the Approval Notice, Buyer will be deemed to have disapproved the Property and to have exercised its right to terminate this Agreement pursuant to this Section 7, in which case this Agreement shall automatically terminate as of the expiration of the Due Diligence Period and the Initial Deposit, together with all interest earned thereon, shall be returned to Buyer. Notwithstanding anything in this Agreement to the contrary, Buyer may elect, at any time prior to the expiration of the Due Diligence Period, for any reason or no reason, to terminate this Agreement, upon which termination the Deposit and all interest earned thereon shall be refunded to Buyer and the parties shall have no further obligation to each other excepts for those obligations which expressly survive such termination.

8. Acceptance of Property "As Is". ACKNOWLEDGING BUYER'S OPPORTUNITY TO INSPECT AND INVESTIGATE THE PROPERTY AS PROVIDED IN THIS AGREEMENT, BUYER AGREES TO TAKE THE PROPERTY "AS IS" WITH ALL FAULTS AND CONDITIONS THEREON, SUBJECT ONLY TO THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER SET FORTH IN THIS AGREEMENT OR THE OTHER AGREEMENTS ENTERED INTO BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE. ANY INFORMATION, REPORTS, STATEMENTS, DOCUMENTS OR RECORDS ("**DISCLOSURES**") PROVIDED OR MADE TO BUYER OR ITS CONSTITUENTS BY SELLER, ITS AGENTS, REPRESENTATIVES OR EMPLOYEES CONCERNING THE PROPERTY SHALL NOT CONSTITUTE REPRESENTATIONS OR WARRANTIES. BUYER SHALL NOT RELY ON SUCH DISCLOSURES BUT, RATHER, BUYER SHALL RELY SOLELY ON ITS OWN INSPECTION OF THE PROPERTY AND THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT. ACCORDINGLY, BUYER'S DELIVERY OF THE APPROVAL NOTICE PURSUANT TO THE PROVISIONS OF SECTION 7 (DUE DILIGENCE PERIOD) ABOVE, SHALL CONSTITUTE BUYER'S ACKNOWLEDGMENT AND AGREEMENT TO THE FOLLOWING: (i) BUYER HAS REVIEWED, EVALUATED AND VERIFIED THE DISCLOSURES AND DOCUMENTS AND HAS CONDUCTED ALL INSPECTIONS, INVESTIGATIONS, TESTS, ANALYSES, APPRAISALS AND EVALUATIONS OF THE PROPERTY (INCLUDING FOR TOXIC OR HAZARDOUS MATERIALS, SUBSTANCES OR WASTES (DEFINED AND REGULATED AS SUCH PURSUANT TO SECTIONS 25316 AND 25501 OF THE CALIFORNIA HEALTH & SAFETY CODE, THE RESOURCE CONSERVATION AND RECOVERY ACT, THE COMPREHENSIVE ENVIRONMENTAL RESPONSE COMPENSATION AND LIABILITY ACT OF 1980, AS AMENDED ("**CERCLA**") OR ANY SIMILAR LAWS AND ALL REGULATIONS PROMULGATED THEREUNDER)) AS BUYER CONSIDERS NECESSARY OR APPROPRIATE TO SATISFY ITSELF FULLY WITH RESPECT TO THE CONDITION AND ACCEPTABILITY OF THE PROPERTY (ALL

OF SUCH INSPECTIONS, INVESTIGATIONS AND REPORTS BEING HEREIN COLLECTIVELY CALLED THE "**INVESTIGATIONS**"); (ii) SELLER HAS PERMITTED BUYER ACCESS TO THE PROPERTY AND HAS DELIVERED TO, OR MADE AVAILABLE TO, BUYER ALL OF THE MATERIALS REFERENCED IN SECTION 4 (INCLUDING THE DOCUMENTS AND MATERIALS IDENTIFIED ON EXHIBIT B) (COLLECTIVELY, THE "**DOCUMENTS**"); AND (iii) BUYER HAS COMPLETED ITS DUE DILIGENCE WITH RESPECT TO THE PROPERTY AND THE DOCUMENTS TO ITS SATISFACTION, IS THOROUGHLY FAMILIAR WITH THE PHYSICAL CONDITION OF THE PROPERTY, AND SUBJECT ONLY TO THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT OR THE OTHER AGREEMENTS ENTERED INTO BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE, IS ACQUIRING THE PROPERTY BASED EXCLUSIVELY UPON ITS OWN INVESTIGATIONS AND INSPECTIONS OF THE PROPERTY AND THE DOCUMENTS.

FURTHER, BUYER'S DELIVERY OF THE APPROVAL NOTICE PURSUANT TO THE PROVISIONS OF SECTION 7 (DUE DILIGENCE PERIOD) ABOVE, SHALL CONSTITUTE BUYER'S ACKNOWLEDGMENT AND AGREEMENT TO THE PROVISIONS OF THIS SECTION 8 AND THAT, REGARDLESS OF THE CONTENT OF ANY OF THE DOCUMENTS OR ANY STATEMENTS THAT SELLER, ITS AGENTS, EMPLOYEES, OFFICERS, CONTRACTORS, PARTNERS OR MEMBERS MAY HAVE MADE TO BUYER, ITS AGENTS, EMPLOYEES, OFFICERS, CONTRACTORS, PARTNERS OR MEMBERS PRIOR TO OR DURING THE DUE DILIGENCE PERIOD, OTHER THAN THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT AND THE OTHER AGREEMENTS ENTERED INTO BY AND BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE, SELLER HAS NOT MADE, DOES NOT MAKE AND SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS, WARRANTIES, PROMISES, COVENANTS, AGREEMENTS OR GUARANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, ORAL OR WRITTEN, PAST, PRESENT OR FUTURE, OF, AS TO, CONCERNING OR WITH RESPECT TO: (1) THE NATURE, QUALITY OR CONDITION OF THE PROPERTY, INCLUDING, WITHOUT LIMITATION, THE WATER, SOIL AND GEOLOGY; (2) THE INCOME TO BE DERIVED FROM THE PROPERTY; (3) THE SUITABILITY OF THE PROPERTY FOR ANY AND ALL ACTIVITIES AND USES THAT BUYER MAY CONDUCT THEREON; (4) THE COMPLIANCE OF OR BY THE PROPERTY OR ITS OPERATION WITH ANY LAWS, RULES, ORDINANCES OR REGULATIONS OF ANY APPLICABLE GOVERNMENTAL AUTHORITY OR BODY; (5) THE HABITABILITY, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OF THE PROPERTY; OR (6) ANY OTHER MATTER WITH RESPECT TO THE PROPERTY. BUYER SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS REGARDING TERMITES OR WASTES, AS DEFINED BY THE U.S. ENVIRONMENTAL PROTECTION AGENCY REGULATIONS AT 40 C.F.R., OR ANY HAZARDOUS SUBSTANCE, AS DEFINED BY CERCLA AND REGULATIONS PROMULGATED THEREUNDER.

EXCEPT WITH RESPECT TO HAZARDOUS MATERIALS THAT WERE DISCHARGED, RELEASED OR DISPOSED BY SELLER OR ITS MEMBERS, MANAGERS, PARTNERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES AND REPRESENTATIVES IN VIOLATION OF APPLICABLE ENVIRONMENTAL LAWS AS OF THE DATE OF SUCH DISCHARGE, DISPOSAL OR RELEASE, BUYER, ITS SUCCESSORS AND ASSIGNS, HEREBY WAIVE, RELEASE AND AGREE NOT TO MAKE ANY CLAIM OR BRING ANY COST RECOVERY ACTION OR CLAIM FOR CONTRIBUTION OR OTHER ACTION OR CLAIM AGAINST SELLER (COLLECTIVELY OR INDIVIDUALLY) OR ITS RELATED ENTITIES, AND ITS AND THEIR MEMBERS, MANAGERS, PARTNERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, HEIRS AND ASSIGNS (COLLECTIVELY, "SELLER AND ITS AFFILIATES") BASED ON, (x) ANY FEDERAL, STATE, OR LOCAL ENVIRONMENTAL OR HEALTH AND SAFETY LAW OR REGULATION, INCLUDING CERCLA OR ANY STATE EQUIVALENT, OR ANY SIMILAR LAW NOW EXISTING OR HEREAFTER ENACTED; (y) ANY DISCHARGE, DISPOSAL, RELEASE, OR ESCAPE OF ANY CHEMICAL, OR ANY MATERIAL WHATSOEVER, ON, AT, TO, OR FROM THE PROPERTY; OR (z) ANY CONDITIONS WHATSOEVER ON, IN, UNDER, OR IN THE VICINITY OF THE PROPERTY. EXCEPT WITH RESPECT TO ANY CLAIMS ARISING OUT OF ANY BREACH OF COVENANTS, REPRESENTATIONS OR WARRANTIES EXPRESSLY SET FORTH IN THIS AGREEMENT OR THE DOCUMENTS EXECUTED IN CONNECTION WITH THIS AGREEMENT, BUYER, ON BEHALF OF ITSELF AND ITS PARTNERS, MEMBERS, MANAGERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, HEIRS AND ASSIGNS HEREBY RELEASES, SELLER AND ITS AFFILIATES, FROM ANY AND ALL CLAIMS OF ANY KIND WHATSOEVER, KNOWN OR UNKNOWN, WITH RESPECT TO ANY ASPECT OF THE PROPERTY, INCLUDING THE FOREGOING MATTERS, AND SPECIFICALLY WAIVES WITH RESPECT TO ALL SUCH MATTERS THE PROVISIONS OF CALIFORNIA CIVIL CODE SECTION 1542, AND ANY COMPARABLE LAW APPLICABLE IN THE STATE WHERE THE PROPERTY IS LOCATED, REGARDING THE MATTERS COVERED BY A GENERAL RELEASE, WHICH PROVIDES AS FOLLOWS:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

BUYER AND SELLER REPRESENT AND ACKNOWLEDGE THAT THIS SECTION 8 WAS EXPLICITLY NEGOTIATED AND BARGAINED FOR AS A MATERIAL PART OF BUYER'S CONSIDERATION BEING PAID. Terms appearing in this Section 8 in all capital letters that have been defined elsewhere in this Agreement shall have the meanings set forth in such definitions.

9. Conditions to Closing.

9.1 Buyer's Conditions to Closing. Buyer's obligation to purchase the Property is conditioned upon the satisfaction of each of the following conditions each of which is for the exclusive benefit of Buyer. Buyer may, at any time or times before the Closing, waive one or more of the following conditions, but only in writing and any such waiver will not affect its rights and remedies with respect to the remaining conditions:

(a) Buyer shall have received the requisite Tenant Estoppels as and when required under Section 4.5(b). If Buyer has not received the requisite Tenant Estoppels at least six (6) business days prior to the Closing Date, Buyer shall have the one-time right to extend the Closing Date by an additional two (2) business days by delivering written notice of Buyer's exercise of such right to Seller no later than the date five (5) business days prior to the Closing Date. If Buyer timely exercises such right, the Closing Date shall be extended by two (2) business days.

(b) The Rent Roll and Delinquency Report (as defined in Sections 11.1(h) and 11.1(i) below) shall have been updated to a date not earlier than three (3) business days prior to the Closing Date, and such updated Rent Roll and Delinquency Report shall not identify any material adverse change (with a change being deemed to be material and adverse only if the change would expose Buyer to damages or a loss of income in excess of Thirty-Five Thousand and No/100ths Dollars ($35,000)) in the aggregate as to all Leases with the Government Tenants and Major Non-Governmental Tenants as compared to the status of such Leases as shown on the Rent Roll and Delinquency Report delivered to Buyer two (2) business days prior to the expiration of the Due Diligence Period pursuant to Sections 11.1(h) and 11.1(i) below;

(c) No Government Tenant or Major Non-Government Tenant shall have notified Seller or Buyer of any material adverse change in its Tenant Estoppel (with a change being deemed to be material and adverse only if the change would expose Buyer to damages or a loss of income in excess of Thirty-Five Thousand and No/100ths Dollars ($35,000) in the aggregate as to all such Tenant Estoppels); no proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against any of the Major Non-Government Tenants that have not been terminated; no general assignment for the benefit of creditors has been made by any of the Major Non-Government Tenants; and no trustee or receiver of any of the Major Non-Government Tenants' property has been appointed;

(d) Seller's performance of all its obligations hereunder;

(e) The truth, completeness and accuracy, in all material respects, of each representation and warranty made by Seller as of the Contract Date and the Closing; and

(f) The issuance at Closing of the Title Policy.

9.2 Seller's Conditions. Seller's obligation to sell the Property is conditioned upon the satisfaction of each of the following conditions, each of which is for the exclusive benefit of Seller. Seller may, at any time before the Closing, waive one or more of the following conditions, but only in writing and any such waiver will not affect its rights and remedies with respect to the remaining conditions:

(a) The performance by Buyer of all its obligations hereunder; and

(b) The truth, completeness and accuracy, in all material respects, of each representation and warranty made by Buyer as of the Contract Date and the Closing.

9.3 Seller Default. If, at the Closing, (i) Seller is in default of any of its obligations hereunder, or (ii) any of Seller's representations or warranties set forth in Section 11.1 are untrue, inaccurate or incorrect when given, in any material respect, or (iii) the Closing otherwise fails to occur by reason of Seller's failure or refusal to perform its obligations hereunder in a prompt and timely manner, and any such circumstance described in any of clauses (i), (ii) or (iii) continues for five (5) business days after written notice from Buyer to Seller, which written notice shall detail such default, untruth or failure, as applicable, then Buyer shall have the right, to elect, as its sole and exclusive remedy, to (a) terminate this Agreement by written notice to Seller, promptly after which (A) the Deposit and all interest earned thereon shall be returned to Buyer, and (B) Seller shall pay to Buyer any title, escrow, legal and inspection fees incurred by Buyer and any other expenses incurred by Buyer in connection with its review of the Property, and the negotiation, documentation and performance of this Agreement (including, without limitation, the fees and expenses of environmental and engineering consultants, legal and accounting fees and expenses, and other out-of-pocket third party charges related to the transactions contemplated by this Agreement and their consummation), subject to a cap of $125,000 (collectively, "**Buyer's Costs**"), in which case, the parties shall have no further rights or obligations hereunder except for obligations which expressly survive the termination of this Agreement, or (b) waive the condition and proceed to Closing, or (c) seek specific performance of this Agreement by Seller. As a condition precedent to Buyer exercising any right it may have to bring an action for specific performance hereunder, Buyer must commence such an action within ninety (90) days after the occurrence of Seller's default. Buyer agrees that its failure to timely commence such an action for specific performance within such ninety (90) day period shall be deemed a waiver by it of its right to commence an action for specific performance as well as a waiver by it of any right it may have to file or record a notice of *lis pendens* or notice of pendency of action or similar notice against any portion of the Property. Notwithstanding the foregoing, if by Seller's affirmative acts the remedy of specific performance has been rendered unavailable to Buyer, Buyer shall have and may assert against Seller as a result of Seller's default under this Agreement, any and all rights available at law and in equity, without imposition of the limitations in this Agreement on Buyer's rights, remedies or damages.

10. Closing.

10.1 Closing Date. The consummation of the purchase and sale of the Property (the "**Closing**") shall be held at the offices of the Title Company (or at such other location as the parties may agree) on the later to occur of: (i) the date that is twenty-one (21) days after Buyer's delivery of the Approval Notice; and (ii) the date that is ten (10) business days following the date upon which both Buyer and Seller have received written notice confirming that a Discharge Permit covering the operation of the Discharge System has been formally issued and is currently

effective (the "**Closing Date**"), which may be extended in accordance with the terms of Sections 9.1(a), this Section 10.1 and Section 11.2, but in any event shall not be later than January 13, 2012 (the "**Outside Closing Date**"). Buyer acknowledges that Seller is required to defease the existing securitized loan that is currently secured by a deed of trust on the Property (the "**Existing Loan**") in order to deliver title to the Property free and clear of the lien of such deed of trust (the "**Existing Deed of Trust**"). In connection with such defeasance, Buyer agrees to cooperate in good faith with all usual and customary requirements imposed by the master loan servicer, bond trustee and ratings agency for such defeasance transaction so long as Buyer is not required to incur any additional liability or expense in so doing. The parties acknowledge that, in light of the defeasance, the Grant Deed (as defined below) will be recorded, and the Seller's proceeds will be disbursed, one day after the Closing Date. Seller may extend the Closing Date by up to three (3) business days to accommodate such defeasance. Seller shall be solely responsible for any and all costs, fees and expenses in connection with such defeasance, and any yield maintenance or other premiums or payments required in connection with such defeasance. The defeasance of the Existing Loan shall not be a condition to Seller's obligation to close the Escrow.

10.2 Seller's Deposits Into Escrow. Seller shall deposit the following documents and items into escrow at least one (1) business day prior to the Closing Date:

(a) a duly executed and acknowledged grant deed conveying the Property and Improvements to Buyer in the form of the attached Exhibit F, together with a separate transfer tax affidavit (the "**Grant Deed**");

(b) a duly executed bill of sale and general assignment, in the form of the attached Exhibit G (the "**Assignment**"), transferring the Personal Property, Leases, Service Contracts, Approvals, Warranties and Intangible Property to Buyer;

(c) an affidavit in the form of the attached Exhibit H stating that Seller is not a "foreign person" under IRC Section 1445(f)(3);

(d) tenant notice letters for all tenants at the Property informing them of the sale of the Property and assignment of the Leases to Buyer, in the form of attached Exhibit I;

(e) a duly executed affidavit in the form required by the California Franchise Tax Board certifying that no withholding of any amount of the Purchase Price is required in connection with the Closing;

(f) Seller's share of the closing costs as described in Section 10.5 below or instructions to Title Company to deduct same from the Purchase Price;

(g) an owner's title affidavit in the form of the attached Exhibit J;

(h) the Rent Roll, updated to a date no earlier than three (3) business days prior to the Closing Date, certified by Seller as true and correct;

(i) A certification that all of the representations and warranties set forth in Section 11.1 remain true, complete and accurate, except to the extent of any exceptions to such representations and warranties identified in such certification; and

(j) such other documents as may reasonably be required to complete the Closing.

10.3 Seller's Deliveries to Buyer Outside of Escrow. Seller shall deliver to Buyer at the Property (except as otherwise provided below) on or before the Closing Date, all of the following:

(a) originals, to the extent in Seller's possession or control, or copies of the Leases and the Service Contracts, which copies are certified by Seller as true and correct;

(b) the original Estoppel Certificates, duly executed by the Tenants, which shall be delivered to Buyer's counsel, James Moore of Boutin Jones Inc.;

(c) all keys and security codes to the Property;

(d) electronic or hard copies of all Documents; and

(e) originals or copies of all Lease files and Property files, including all records, instruments and correspondence related to maintenance and repair, the Tenants, the Leases, construction and alteration of the Improvements (base building and tenant improvements), and operation of the Property, to the extent such files are located at the Real Property.

10.4 Buyer's Deposits into Escrow. Buyer shall deposit the following into escrow at least one (1) business day prior to the Closing Date:

(a) the balance of the Purchase Price in immediately available funds;

(b) Buyer's share of the closing costs as described in Section 10.5. below;

(c) two original duly executed counterparts of the Assignment; and

(d) such other documents as may reasonably be required to complete the Closing.

10.5 Adjustment and Proration. All accounts receivable and all accounts payable shall be prorated between Buyer and Seller as of 12:01 a.m. on the Closing Date, on the basis of a 365-day year, with Seller entitled to all accounts receivable and responsible for all accounts payable with respect to the period prior to such date and time, and with Buyer entitled to all accounts receivable and responsible for all accounts payable with respect to the period from and after such date and time. Prior to Closing, Seller shall prepare for review, comment and agreement by Buyer a proration statement for the Property, and each party shall be credited or charged at the Closing, in accordance with the following:

(a) Accounts Receivable. Seller shall account to Buyer for any Rents actually collected by Seller for the month in which the Closing occurs, and Buyer shall be credited for its pro rata share applicable to the period from and after the Closing Date. For purposes of this Agreement, the term " **Rents**" means and includes Fixed Rents and Additional Rents; "**Fixed Rents**" means the periodic fixed rent payable by a Tenant under its Lease; and "**Additional Rents**" means all amounts, other than Fixed Rents, due from any Tenant under any Lease, including without limitation, percentage rents, escalation charges for real estate taxes, parking charges, marketing fund charges, reimbursement of operating expenses or common area expenses, maintenance escalation rents or charges, cost of living increases or other charges of a similar nature, if any, and any additional charges and expenses payable under any Lease.

(b) Accounts Payable. For purposes of this Agreement, the term "**Expenses**" means all operating expenses normal to the operation and maintenance of the Property, including without limitation real property taxes and assessments, current installments of any improvement bonds or assessments which are a lien on the Property or which are pending and may become a lien on the Property, water, sewer and utility charges, amounts payable under any Service Contract for any period in which the Closing occurs, permits, licenses and inspection fees. Expenses shall not include expenses which are of a capital nature.

(i) Prepaid Expenses. To the extent Expenses have been paid prior to the Closing Date for any part of the period on or after the Closing Date, Seller shall account to Buyer for such prepaid Expenses, and Seller shall be credited for the amount of such prepaid expenses applicable to the period after the Closing Date.

(ii) Unpaid Expenses. To the extent Expenses relating to the period prior to the Closing Date are unpaid as of the Closing Date but are ascertainable, Buyer shall be credited for Seller's pro rata share of such Expenses for the period prior to the Closing Date.

(iii) Service Contracts. Payments due under any Service Contracts shall be prorated as of the Closing Date, and Buyer shall be liable for all payments accruing thereunder after the Closing. Seller shall be responsible for all payments under all contracts and agreements not assumed by Buyer

(c) Property Taxes. Seller shall be responsible for all real and personal property ad valorem taxes and special assessments applicable to the period prior to the Closing Date; Buyer shall be responsible for all real and personal property ad valorem taxes and special assessments applicable to the period from and after the Closing Date. With respect to any property tax appeal or reassessment filed by Seller for the current tax year or tax years (or portions thereof) prior to the Closing, Seller shall be entitled to the full amount of any refund or rebate resulting therefrom applicable to the period before the Closing Date, except to the extent such amounts are payable to, or otherwise accrue to the benefit of, the Tenants pursuant to the Leases, which amounts Seller shall promptly refund to such Tenants.

(d) Utility Charges. All utility (including electricity, gas, water, sewer and telephone) charges will be prorated to the Closing Date as Expenses. All refundable utility security deposits, if any, will be retained by Seller.

(e) Government Tenants. Buyer acknowledges that the Government Tenants pay Rents in arrears. Accordingly, Seller shall receive a credit at Closing for the Rents that accrue under the Leases of the Government Tenants in the month that Closing occurs, to the extent any rents accrue under such Leases.

(f) Molina Rents and Reimbursements. If, as of the Closing Date, Seller is due any amounts from Molina under its Lease that are ascertainable, Seller shall receive a credit at Closing for such amounts. Likewise, if any amounts are due and owing from Seller to Molina at Closing, Seller shall pay such amounts to Molina at or before Closing. Any amounts that are due and owing from Seller to Molina after Closing shall be paid by Seller to Molina as and when such amounts come due, after deduction for all amounts then due and owing to Seller by Molina or Buyer.

(g) Post-Closing. If the amount of any proration cannot be determined at the Closing, the adjustments will be made between the parties as soon after Closing as possible, as follows:

(i) Non-delinquent Rents. If after the Closing either Buyer or Seller collects any non-delinquent Rents applicable to the month in which the Closing occurred (or if Seller collects any Rents applicable to any month following the month in which the Closing occurred), such Rents shall be prorated as of the Closing Date and paid to the party entitled thereto not later than five (5) business days following receipt, except to the extent such party received a credit at Closing for such Rents.

(ii) Delinquent Rents for Month in which the Closing Occurred. If after the Closing Date either Buyer or Seller receives from any Tenant Rents that were delinquent as of the Closing Date and that relate to the rental period in which the Closing occurred, then such Rents shall be applied in the following order of priority: First, to reimburse Buyer for all out-of-pocket third-party collection costs actually incurred by Buyer in collecting such Rents; second, to satisfy such Tenant's Rent obligations relating to the period after the Closing Date; and third, to satisfy such delinquent Rent obligations relating to the period prior to the Closing Date. Buyer agrees to use commercially reasonable efforts to collect any such delinquent rents but Buyer has no obligation to institute any collection action or otherwise incur any material cost in connection therewith. Seller shall have no right to pursue or continue the collection of such delinquent Rents from any Tenant in occupancy as of the Closing Date, but Seller shall have the right to continue to prosecute any collection proceedings that were initiated prior to the Closing against any tenant no longer in occupancy as of the Closing Date. Notwithstanding the foregoing, if Molina owes any Rents for any period prior to Closing for which Seller did not receive a credit at Closing, Buyer shall pay all Rents received from Molina to Seller until such Rents owed to Seller have been paid in full.

(iii) Expenses. With respect to any invoice received by Buyer or Seller after the Closing Date for Expenses that relate to the period in which the Closing occurred, the party receiving such invoice shall give the other party written notice of such invoice, and the other party shall have thirty days to review and approve the accuracy of any such invoice. If the parties agree that the Invoice is accurate and should be paid, the parties shall compute each party's pro rata share, and deliver a check for that amount in favor of the vendor.

(h) Survival of Obligations. The obligations of Seller and Buyer under this Section 10.5 shall survive the Closing.

10.6 Items Not to be Prorated. There shall be no prorations or adjustments of any kind with respect to:

(a) Insurance Premiums. Insurance Premiums shall not be prorated. Seller will terminate its coverages as of the Closing Date, and Buyer shall be responsible for obtaining its own coverages as of the Closing Date.

(b) Delinquent Fixed Rents for Full Months Prior to the Month in which the Closing Occurred . Delinquent Fixed Rents with respect to Tenants under the Leases applicable to months prior to the calendar month in which the Closing occurred shall remain the property of Seller, and Buyer shall have no claim thereto whether collected by Seller or Buyer, before or after the Closing, and no responsibility of any kind with respect thereto except as specifically set forth herein. Seller shall not take or continue to take collection measures from or after the Closing. Buyer agrees to use commercially reasonable efforts to collect any delinquent Fixed Rents owed Seller, but Buyer has no obligation to institute any collection action or otherwise incur any material costs in connection therewith. Except with respect to the Rents collected from Molina, Fixed Rents collected from Tenants after the Closing Date shall be applied in the following order of priority: First, to reimburse Buyer for all out-of-pocket third-party collection costs actually incurred by Buyer in collecting such Rents; second, to satisfy such Tenant's Rent obligations relating to the period after the Closing Date; and third, to satisfy such delinquent Rent obligations relating to periods prior to the Closing Date. In the event that Buyer collects any such delinquent Fixed Rents, Buyer shall apply such Fixed Rents as contemplated above and shall promptly pay over to Seller any amounts properly owed to Seller.

(c) Additional Rents Relating to Full or Partial Months Prior to the Closing Date . If Additional Rents relating to full or partial months prior to the Closing Date are not finally adjusted between Seller and any Tenant until after the Closing Date, then any refund to which any Tenant may be entitled shall be the obligation of Seller, and any additional amounts due from the Tenant for such period shall be the property of Seller. Buyer shall have no obligation with respect to any such refund due to any Tenant and no claim to any such amounts due from any Tenant, except that Buyer shall promptly pay to Seller any such delinquent Additional Rent amounts as it actually collects. If Seller receives any refund of expenses paid prior to the Closing and relating to a period prior to the Closing, and such expenses were reimbursed in whole or in part by any Tenant, Seller shall refund to each Tenant its share of any such refund. Buyer agrees to use commercially reasonable efforts to collect any such Additional Rents but Buyer has no obligation to institute any collection action or otherwise incur any material cost in connection therewith.

(d) Security Deposits. Seller shall deliver to Buyer (or credit to Buyer at Closing) all prepaid rents, security deposits, letters of credit and other collateral actually held by Seller or any of its affiliates or successors in interest under any of the Leases, to the extent not applied by Seller prior to the Closing Date to the extent permitted under the Leases. From and after the Contract Date, Seller shall not apply any security deposits without the Buyer's prior written consent.

(e) Survival. The terms of Section 10.6 shall survive the Closing.

10.7 Closing Costs. The Closing costs for this transaction shall be paid as follows:

(a) Seller shall pay (i) any brokerage fees to the Selling Broker as required under Section 17.8 below; (ii) one-half of all transfer and sales taxes (including documentary transfer taxes); (iii) all costs, expenses and fees related to the defeasance of the Existing Loan; (iv) the cost of the Title Policy, up to but not to exceed an amount equal to the cost of owner's standard CLTA coverage title insurance in the amount of the Purchase Price; (v) one-half of the escrow fees; and (vi) all other costs and expenses allocated to Seller pursuant to this Agreement.

(b) Buyer shall pay (i) any brokerage fees to the Buying Broker as required under Section 17.8 below; (ii) one half of all transfer and sales taxes (including documentary transfer taxes); (iii) the increased cost of the Title Policy associated with ALTA extended coverage and endorsements requested by Buyer (except for "gap" coverage); (iv) all recording fees (other than in connection with any documents recorded in connection with the defeasance of the Existing Loan); (v) one-half of the escrow fees; and (vi) all other costs and expenses allocated to Buyer pursuant to this Agreement.

(c) All other costs shall be paid in accordance with customary practices in the County of Los Angeles.

10.8 Closing. Pursuant to Section 10.1 above, Title Company shall close the escrow for this transaction when it is in a position to issue the Title Policy and has received from Seller and Buyer the items required of each in Sections 10.2 and 10.4 above. Title Company shall close escrow by doing the following:

(a) Recording the Grant Deed in the Official Records of the County of Los Angeles;

(b) Delivering to Buyer the Title Policy, the original documents and items listed in Section 10.2 above, and a closing statement for the escrow consistent with this Agreement and signed by Buyer and Seller (the "**Closing Statement**"), and any refund due Buyer; and

(c) Delivering to Seller the amount due Seller as shown on the Closing Statement, the original documents listed in Section 10.4 above, and a signed original of Seller's Closing Statement.

10.9 Possession. Seller shall deliver possession of the Property to Buyer on the Closing Date, subject to the rights of the Tenants under the Leases.

11. Representations and Warranties.

11.1 Representations and Warranties of Seller. Seller hereby makes the following representations and warranties to Buyer, which representations and warranties shall survive the Closing, and all of which (i) are material and are being relied upon by Buyer, and (ii) are true, complete and accurate as of the date hereof.

(a) Organization. Seller is a limited liability company, duly organized, validly existing and in good standing under the laws of the State of Delaware, and qualified to do business, and in good standing, in the State of California.

(b) Authorization. This Agreement has been duly authorized, executed, and delivered by Seller; the obligations of Seller under this Agreement are legal, valid, and binding obligations of Seller; and this Agreement does not, and at the time of Closing will not, (i) violate or conflict with the organizational documents of Seller or any member of Seller acting on Seller's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Seller, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Seller is a party or by which Seller is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Seller. All documents that are executed by Seller and that are delivered to Buyer at the Closing will be, at the time of Closing, duly authorized, executed, and delivered by Seller; the obligations of Seller under such documents will be, at the time of Closing, legal, valid, and binding obligations of Seller; and such documents will not, at the time of Closing, (i) violate or conflict with the organizational documents of Seller or any member of Seller acting on Seller's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Seller, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Seller is a party or by which Seller is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Seller.

(c) Bankruptcy. No proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against Seller which have not been terminated; no general assignment for the benefit of creditors has been made by Seller; and no trustee or receiver of Seller's property has been appointed.

(d) Not a Foreign Person. Seller is not a foreign person within the meaning of section 1445(f)(3) of the Internal Revenue Code of 1986. Seller has read and understands the provisions of sections 18662 and 18668 of the California Revenue and Tax Code (the " **Act**") and has a "permanent place of business" within California within the meaning of the Act and the regulations and guidelines of the California Franchise Tax Board promulgated from time to time pursuant thereto.

(e) Litigation. Except as disclosed in writing to Buyer, no litigation or proceeding is pending or, to Seller's knowledge, threatened that affects the Property or Seller's ability to consummate the transactions contemplated by this Agreement.

(f) Violations. Except as disclosed in writing to Buyer, Seller has not received any written notice of any violation by the Property of any applicable rule, regulation, ordinance or government directive from any administrative or governmental authority that has not been cured.

(g) Leases; Landlord Defaults. There are no leases, rental agreements, license agreements or occupancy rights affecting the Property other than those listed on Exhibit C and any matters of record. Seller has not received any written notice of a default by Seller from any Tenant under any of the Leases that has not been cured, other than as set forth in the Tenant Estoppels.

(h) Rent Roll. Exhibit C contains a complete and correct list of all existing Leases, setting forth with respect to each Lease, the following minimum information (the "**Rent Roll**"): the name of the Tenant, the number of the room or suite occupied by the Tenant, the square footage of the space, the commencement and expiration dates, the amount of the monthly base rent payment, the current monthly additional rent payment for the Tenant share of Real Property expenses and taxes, the amount of any security deposit or prepaid rent, and the amount and due date of any payments due Tenants in the future as reimbursement for costs of tenant improvements. Seller shall deliver an updated Rent Roll to Buyer two (2) business days prior to the expiration of the Due Diligence Period, which shall be accurate as of the date set forth on the updated Rent Roll (which date shall not be more than three (3) business days prior to the date the updated Rent Roll is delivered to Buyer). Seller shall deliver a further updated Rent Roll to Buyer two (2) business days prior to the Closing Date, which shall be accurate as of the date set forth on the updated Rent Roll (which date shall not be more than three (3) business days prior to the Closing Date).

(i) Delinquency Report. With the exception of delinquencies in the payment of rents which are set forth on the Rent Roll, Seller has not delivered written notice to any Tenant of any default in the payment of rent under its Lease that has not been cured. Exhibit C contains a true and correct report (the "**Delinquency Report**") showing the name of each Tenant as to which a delinquency currently exists as to the payment of Rents and specifying the amount of each such delinquency, and the period of time during which each such delinquency has been outstanding. Seller shall deliver an updated Delinquency Report to Buyer two (2) business days prior to the expiration of the Due Diligence Period, which shall be accurate as of the date set forth on the updated Delinquency Report (which date shall not be more than three (3) business days prior to the date the updated Delinquency Report is delivered to Buyer). Seller shall deliver a further updated Delinquency Report to Buyer two (2) business days prior to the Closing Date, which shall be accurate as of the date set forth on the updated Delinquency Report (which date shall not be more than three (3) business days prior to the Closing Date).

(j) Leases. The Documents contain a true, correct and complete copy of each Lease. Each such Lease constitutes the entire agreement between Seller and each other party thereto. As of the Closing Date, no rents due under, or any other interest in, any of the Leases will be assigned to any party other than Buyer, or otherwise pledged or encumbered in any way.

(k) Tenant Improvements; Lease Costs. Except as set forth in Exhibit C, all of the improvements to be constructed by Seller under each of the Leases, have been fully completed and paid for. Except as set forth in Exhibit C, Seller has paid, in full, any leasing commissions, except for future contingent obligations set forth in the Rent Roll.

(l) Service Contracts. Exhibit E contains a true and complete list of all Service Contracts. The Documents include true and complete copies of all Service Contracts. To Seller's knowledge, there have been no material defaults by any Party to a Service Contract which have not been cured. To Seller's knowledge, Seller is not in breach or default under any Service Contract which has not been cured. The Service Contracts constitute the entire agreement between Seller and the other parties to the Service Contracts.

(m) Insurance. Exhibit L correctly identifies the policies of casualty and liability insurance currently in effect with respect to the Property. All premiums for such insurance have been paid in full. Seller has not received any notice or request from any insurance company or Board of Fire Underwriters (or organization exercising functions similar thereto) canceling or threatening to cancel any of said policies or denying or disputing coverage thereunder.

(n) Commission Agreements. Except as expressly set forth in the Leases or on Exhibit C, there are no lease brokerage agreements, leasing commission agreements or other agreements providing for payments of any amounts for leasing activities or procuring tenants with respect to the Property, other than such commissions as may be due on future lease renewals, expansions or extensions.

(o) Environmental Releases. To Seller's knowledge, no Hazardous Materials have been discharged, released or disposed of by Seller or its members, managers, partners, directors, officers, shareholders, trustees, beneficiaries, agents, employees and representatives in violation of applicable Environmental Laws as of the date of such discharge, disposal or release As used herein, the term "Hazardous Materials" means without regard to amount and/or concentration any hazardous or toxic substance, material or waste wherever located expressly including but not limited to petroleum and petroleum derived compounds, which is included within the definition of any hazardous or toxic material, substance or waste in any federal, state or local statutes, laws, ordinances or regulations applicable to the Property, as well as any soils, ground or surface waters, wetlands or other environmental media which may be contaminated by such Hazardous Material, including the following: (a) those substances defined as a hazardous substance, hazardous waste, hazardous material, toxic substance, solid waste, pollutant or contaminant under any Environmental Law, as defined below; (b) those substances listed in the United States Department of Transportation Table [49 CFR § 172.101], or by the Environmental Protection Agency, or any successor agency, as hazardous substances [40 CFR Part 302]; (c) other substances, materials, and wastes that are regulated or classified as hazardous or toxic under federal, state or local laws or regulations applicable to the Property; and (d) any material, waste, or substance that is a petroleum or refined petroleum product or byproduct, asbestos, or any rock, including serpentine rock, which contains or might contain asbestos, chlorinated solvents, biologic waste, polychlorinated biphenyl, designated as a hazardous substance pursuant to 33 USCS §1321 or listed pursuant to 33 USCS §1317, a flammable explosive, or a radioactive

material. As used herein, the term "Environmental Law" means all federal, state, local or municipal laws, rules, orders, regulations, statutes, ordinances, codes, decrees or requirements of any government authority applicable to the Property and regulating, relating to, or imposing liability or standards of conduct concerning any Hazardous Material, or pertaining to environmental conditions on or under the Property described in this Agreement, as now in effect, including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA) [42 USCS §§9601 et seq.]; the Resource Conservation and Recovery Act of 1976 (RCRA) [42 USCS §§6901 et seq.]; the Clean Water Act, also known as the Federal Water Pollution Control Act (FWPCA) [33 USCS §§1251 et seq.]; the Toxic Substances Control Act (TSCA) [15 USCS §§2601 et seq.]; the Hazardous Materials Transportation Act (HMTA) [49 USCS §§1801 et seq.]; the Insecticide, Fungicide, Rodenticide Act (7 USCS §§136 et seq.]; the Superfund Amendments and Reauthorization Act [42 USCS §§6901 et seq.]; the Clean Air Act [42 USCS §§7401 et seq.]; the Safe Drinking Water Act [42 USCS §§300f et seq.]; the Solid Waste Disposal Act [42 USCS §§6901 et seq.]; the Surface Mining Control and Reclamation Act [30 USCS §§1201 et seq.]; the Emergency Planning and Community Right to Know Act [42 USCS §§11001 et seq.]; the Occupational Safety and Health Act [29 USCS §§655 and 657]; the California Underground Storage of Hazardous Materials Act [Health and Safety Code §§25280 et seq.]; the California Hazardous Materials Account Act [Health and Safety Code §§25100 et seq.]; the California Safe Drinking Water and Toxic Enforcement Act [Health and Safety Code §§24249.5 et seq.]; the Porter-Cologne Water Quality Act [Water Code §§13000 et seq.], together with any amendments of or regulations promulgated under the statutes cited above, and any other federal, state or local law, statute, ordinance or regulation applicable to the Property now in effect that pertains to the regulation or protection of the environment, including ambient air, soil, soil vapor, groundwater, surface water, or land use.

For purposes of the representations and warranties given by Seller in this Agreement, the phrase "to Seller's knowledge" or other terms regarding the knowledge of Seller, shall mean the actual, current knowledge of Kennard P. Perry and Cory Kristoff, excluding constructive or imputed knowledge or duty of inquiry, existing as of the Contract Date and the Closing. In no event shall there be any personal liability on the part of any of the foregoing individuals on account of any breach of any representation or warranty of Seller herein.

11.2 Material Changes; Survival. Two (2) business days prior to the expiration of the Due Diligence Period, Seller shall deliver to Buyer a certification that all of the representations and warranties set forth in Section 11.1 remain true, complete and accurate, except to the extent of any exceptions to such representations and warranties identified in such certification. Further, if, prior to the Closing, Seller becomes aware of any fact or circumstance that would materially change a representation or warranty of Seller in this Agreement, then Seller shall promptly, and in all events at least five (5) business days prior to the Closing Date (which date shall be extended if necessary to give Buyer five business days to review such material change), give written notice of such changed fact or circumstance to Buyer. If, prior to Closing, upon Seller's notice or otherwise, Buyer becomes aware of the material untruth or inaccuracy of, or facts or circumstances that would change materially, any representation or warranty of Seller in this Agreement that was true when made by Seller, then Buyer shall have the option of: (i) waiving such breach of representation or warranty or material adverse change and completing its purchase of the Property pursuant to this Agreement; (ii) reaching agreement with Seller to

adjust the terms of this Agreement to compensate Buyer for such change; or (iii) terminating this Agreement and receiving the return of the Deposit as Buyer's sole remedy prior to Closing. All of Seller's representations and warranties shall survive the Closing; provided, however, that Seller's representations and warranties set forth in Sections 11.1(d) through 11.1(i) shall survive the Closing only with respect to written claims alleging a specific breach of one or more of those representations and warranties received by Seller prior to the first anniversary of the Closing Date. Buyer shall not be entitled to any right or remedy for any inaccuracy in or breach of any representation, warranty or covenant under this Agreement or any conveyance document unless the amount of damages, in the aggregate, proximately caused by all such breaches or inaccuracies exceeds Fifty Thousand and No/100ths Dollars ($50,000). If Buyer's aggregate damages exceed Fifty Thousand and No/100ths Dollars ($50,000), Buyer shall be entitled to recover the entire first Fifty Thousand and No/100ths Dollars ($50,000) of damages suffered by Buyer. Notwithstanding anything to the contrary in this Agreement the aggregate liability of Seller under this Agreement to Buyer for any and all actions or claims by Buyer with respect to these representations and warranties that survive the Closing shall be limited to One Million Five Hundred Thousand Dollars ($1,500,000).

11.3 Representations and Warranties of Buyer. Buyer hereby makes the following representations and warranties to Seller, which representations and warranties shall survive the Closing and all of which (i) are material and are being relied upon by Seller, (ii) are true, complete and accurate in all respects as of the date hereof and shall be true, complete and accurate as of the Closing Date, and (iii) shall survive the Closing:

(a) Organization. Buyer is a limited liability company, duly organized, validly existing and in good standing under the laws of the State of Delaware, and is qualified to do business, and is in good standing, in the State of California.

(b) Authorization. This Agreement has been duly authorized, executed, and delivered by Buyer; the obligations of Buyer under this Agreement are legal, valid, and binding obligations of Buyer; and this Agreement does not, and at the time of Closing will not, (i) violate or conflict with the organizational documents of Buyer or any member of Buyer acting on Buyer's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Buyer, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Buyer is a party or by which Buyer is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Buyer. All documents that are delivered to Seller at the Closing will be, at the time of Closing, duly authorized, executed, and delivered by Buyer; the obligations of Buyer under such documents will be, at the time of Closing, legal, valid, and binding obligations of Buyer; and such documents will not, at the time of Closing, (i) violate or conflict with the organizational documents of Buyer or any member of Buyer acting on Buyer's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Buyer, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Buyer is a party or by which Buyer is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Buyer.

(c) Bankruptcy. No proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against Buyer which have not been terminated; no general assignment for the benefit of creditors has been made by Buyer; and no trustee or receiver of Buyer's property has been appointed.

12. Risk of Loss; Insurance Proceeds; Condemnation.

12.1 Damage or Destruction. In the event of damage or destruction of the Improvements that occurs prior to the Closing Date that (i) would require the expenditure of an amount less than one percent (1%) of the Purchase Price to repair, and (ii) does not permit any Government Tenant or Major Non-Government Tenant to terminate its Lease (each of the foregoing events, a "**Material Damage Event**"), Buyer and Seller shall consummate this Agreement, and Seller shall (a) assign to Buyer at Closing all rights to insurance proceeds on account of such damage or destruction, including any insurance proceeds previously received by Seller with respect to such damage or destruction, and (b) pay to Buyer the amount of the deductible or retention applicable to such damage or destruction under the insurance policy. In the event such damage or destruction results in or causes a Material Damage Event, Buyer or Seller may elect to terminate this Agreement by written notice to the other within ten (10) days after the Material Damage Event. If neither party elects to terminate this Agreement, Seller shall assign the insurance proceeds and pay the applicable deductible or retention to Buyer at Closing and Seller shall have no further responsibility to Buyer for such damage or destruction. If either party elects to terminate this Agreement, the Deposit and all interest thereon shall be refunded to Buyer and the parties shall no further obligation to each other except for those obligations which expressly survive the termination of this Agreement.

12.2 Eminent Domain. If, prior to the Closing, a taking by eminent domain of all or any portion of the Land or Improvements is pending, and such taking would (i) materially and adversely interfere with the use of the Property for its current permitted uses, (ii) materially and adversely affect ingress, egress or parking for the Property or any Tenant's access to its space, (iii) would permit the termination of any Lease by any Government Tenant or Major Non-Government Tenant, or (iv) has a value exceeding one percent (1%) of the Purchase Price (each a "**Material Taking**"), Buyer or Seller shall have the right, by delivering written notice to the other within ten (10) days after Seller delivers written notice to Buyer of such pending taking, to terminate this Agreement, in which event the Deposit and all interest thereon shall be returned to Buyer. If neither party elects to terminate this Agreement or if the taking would not result in or cause a Material Taking, then this Agreement shall remain in effect, and Seller shall assign to Buyer at Closing its rights to the compensation and damages due Seller on account of such taking (and will not settle any proceedings relating to such taking without Buyer's prior written consent) and Seller shall have no further responsibility to Buyer for such taking. Seller shall promptly (and in any event prior to the Closing) notify Buyer of any condemnation affecting the Property.

The provisions of this Section 12 shall supersede the provisions of any applicable laws with respect to the subject matter of this Section 12.

13. Assignment. Buyer may not, at any time, assign this Agreement or Buyer's rights or obligations under this Agreement, either directly or indirectly, without the prior written consent of Seller, which Seller may withhold in its sole and absolute discretion. Subject to the foregoing, this Agreement shall be binding upon, inure to the benefit of, and be enforceable by the parties hereto and their respective heirs, devisees, executors, administrators, legal representatives, successors and assigns. In connection with any approved assignment, the assignee shall assume the assignor's obligations hereunder, but assignor shall nevertheless remain liable therefor.

14. Seller's Covenants During Contract Period. Between Seller's execution of this Agreement and the Closing, or earlier termination of this Agreement as permitted hereunder, Seller shall (i) maintain the Property in good order, condition and repair, reasonable wear and tear excepted; (ii) not make any material physical changes to the Improvements; (iii) continue to manage the Property in the manner in which it is being managed; (iv) not enter into any contracts or agreements affecting the Property unless such contracts can be completed or terminated prior to the Closing or Buyer, in its sole discretion, agrees to assume such contract or agreement as of the Closing Date, in which case such contracts shall be included within the term " **Service Contracts**"; (v) not enter into any lease, amendment of lease or other agreement pertaining to the Property, or permit any tenant of the Property to enter into any sublease or assignment of lease, except as provided in Section 14.1; (vi) after the end of the Due Diligence Period, not offer the Property for sale publicly or otherwise solicit, make, pursue, negotiate or accept offers for the sale of the Property to or from any party; (viii) maintain the insurance described on Exhibit L in full force and effect, except as otherwise approved by Buyer; and (ix) not dispose of or encumber the Property or any part thereof, except for dispositions of personal property in the ordinary course of business. From and after the Contract Date, Seller shall provide Buyer with regular written updates as to the status of any leasing activity at the Property.

14.1 New Leases and Lease Amendments; Lease Expenses.

(a) If Seller desires to enter into any new lease affecting the Property (each a " **New Lease**") or any termination, amendment, modification, expansion or renewal of any existing Lease (each, a " **Lease Amendment**"), after the Contract Date but prior to Closing, Seller shall provide Buyer with a copy of the proposed New Lease or Lease Amendment and a copy of the landlord's anticipated improvement costs, tenant improvement allowances, brokerage commissions and out-of-pocket costs and expenses in connection with the New Lease or Lease Amendment for Buyer's review and approval, which approval shall not be unreasonably withheld; provided, however, Buyer shall not have the right to disapprove any New Lease or Lease Amendment prior to the expiration of the Due Diligence Period. Buyer shall advise Seller, in writing, whether Buyer approves or reasonably disapproves such proposed New Lease or Lease Amendment within three (3) business days after Buyer's receipt of the proposed New Lease or Lease Amendment; provided, however, if Buyer fails to notify Seller within such three (3) business day period, Buyer shall be deemed to have approved the proposed transaction. If after the expiration of the Due Diligence Period, Buyer reasonably disapproves of the proposed New Lease or Lease Amendment, Seller shall not enter into such New Lease or Lease Amendment. If Buyer unreasonably disapproves of the proposed New Lease or Lease Amendment, Seller shall have the full right, power and authority to execute such New Lease or Lease Amendment so long as Seller delivers to Buyer at least three (3) business days' prior written notice of such execution; provided, however, that after receipt of such notice, Buyer shall have the right to terminate this Agreement, upon written notice delivered to Seller within three

(3) business days after receipt of Seller's notice of execution of such New Lease or Lease Amendment. If Buyer timely exercises such termination right, this Agreement shall terminate and the Deposit and all interest thereon shall be returned to Buyer. In all other events, this Agreement shall remain in full force and effect. Notwithstanding the foregoing, Seller acknowledges that it shall not enter into any extension or expansion of the AECOM Technology Corp. Lease during the term of this Agreement without Buyer's approval, which may be withheld at Buyer's sole discretion.

(b) New Lease Expenses. If the Closing occurs, Buyer shall assume and be responsible for (and to the extent previously paid by Seller, reimburse Seller on the Closing Date for) a pro rata portion of any and all improvement costs, tenant improvement allowances, brokerage commissions and out-of-pocket costs and expenses actually paid or incurred by Seller (collectively the " **New Lease Expenses**") arising out of or in connection with those New Leases and Lease Amendments entered into by Seller after the Contract Date pursuant to the foregoing provisions of this Section 14.1; such pro rata portion shall equal the product of (i) the New Lease Expenses multiplied by (ii) a fraction, the numerator of which is the number of months of the lease term of the New Lease (or the number of months of the term of any exercised extension period provided by any Lease Amendment, as applicable) remaining as of the Closing Date, and the denominator of which is the total number of months of such lease term (or exercised extension period, as applicable). Seller shall be responsible for the remaining pro rata portion of the New Lease Expenses. All New Leases and Lease Amendments entered into by Seller pursuant to this Section 14.1 shall be part of the Leases, shall be deemed included on Exhibit C and shall be assumed by Buyer upon Closing.

(c) Existing Lease Expenses. Seller shall be responsible for the cost of tenant improvement work, scheduled rent-free periods and leasing commissions required to be paid under or with respect to all Leases (and amendments thereto) entered into prior to the Contract Date and the cost of tenant improvement work, leasing commissions required to be paid under or with respect to Leases with Government Tenants and the scheduled rent-free periods set forth in the Leases with Government Tenants (collectively, "**Existing Lease Expenses**"), and if Seller fails to deliver Buyer evidence reasonably acceptable to Buyer confirming that such Existing Lease Expenses have been paid prior to the expiration of the Due Diligence Period, Seller shall give Buyer a credit therefore at Closing which shall be calculated as follows: Buyer and Seller shall attempt to agree on the amount of the credit for such Existing Lease Expenses during the Due Diligence Period, which amount shall equal 100% of the anticipated post-Closing Existing Lease Expenses (" **Closing Leasing Credit**"). If Seller and Buyer can agree on the Closing Leasing Credit on or before the expiration of the Due Diligence Period, such amount shall be credited against the Purchase Price due from Buyer at Closing. If Seller and Buyer cannot agree on the Closing Leasing Credit at least five (5) business days prior to the expiration of the Due Diligence Period, then at least three (3) business days prior to the expiration of the Due Diligence Period, Seller shall give Buyer written notice of the amount of the Closing Leasing Credit that Seller is willing to offer. If Buyer timely delivers the Approval Notice, Buyer shall be deemed to have accepted Seller's proposed Closing Leasing Credit and Buyer will proceed with the acquisition of the Property under the terms of this Agreement. Except as otherwise agreed to by Seller and Buyer, the Closing Leasing Credit shall constitute Seller's sole and only obligations with respect to the Existing Lease Expenses, and as of the Closing Date Buyer shall

assume all such obligations (as to leasing commissions only, up to the amount set forth for leasing commissions in the Closing Lease Credit) and indemnify and hold Seller harmless with respect thereto (as to leasing commissions only, up to the amount set forth for leasing commissions in the Closing Lease Credit).

15. ARBITRATION OF DISPUTES. IN THE EVENT OF ANY DISPUTE BETWEEN THE PARTIES ARISING UNDER OR RELATED TO THIS AGREEMENT, SUCH DISPUTE, SHALL BE RESOLVED BY BINDING ARBITRATION BEFORE A SINGLE ARBITRATOR. SUCH ARBITRATION MAY BE INITIATED BY EITHER PARTY BY DELIVERING WRITTEN NOTICE OF INTENT TO ARBITRATE TO THE OTHER PARTY AND TO THE SAN FRANCISCO OFFICE OF THE AMERICAN ARBITRATION ASSOCIATION ("**AAA**"), WHICH NOTICE SHALL DESCRIBE THE DISPUTE AND THE PARTY'S PROPOSAL FOR RESOLVING THE DISPUTE IN DETAIL. WITHIN THIRTY (30) DAYS AFTER DELIVERY OF SUCH NOTICE EACH PARTY SHALL PROVIDE ALL RELEVANT DOCUMENTS AND MATERIALS THAT PERTAIN TO THE DISPUTE. THE PARTIES SHALL FIRST ENDEAVOR TO AGREE ON THE ARBITRATOR, BUT IF THEY ARE UNABLE TO DO SO WITHIN TEN (10) DAYS AFTER THE ARBITRATION HAS BEEN INITIATED, THE ARBITRATOR SHALL BE SELECTED, WITHIN THIRTY (30) DAYS AFTER THE ARBITRATION WAS INITIATED, USING THE AAA PROCEDURES. THE ARBITRATOR SHALL BE A RETIRED SUPERIOR COURT JUDGE OR A LICENSED, PRACTICING ATTORNEY WHO IS SUBSTANTIALLY FAMILIAR WITH THE REAL ESTATE LAW, CUSTOM, PRACTICE, OR PROCEDURE, IN THE AREA IN WHICH THE PROPERTY IS LOCATED, PERTINENT TO THE DISPUTE BEING ARBITRATED, IN EITHER CASE WITH NOT LESS THAN TWENTY (20) YEARS CONTINUOUS EXPERIENCE AS A JUDGE AND/OR REAL ESTATE PRACTITIONER. IN ESTABLISHING WHETHER AN ARBITRATOR IS ABLE TO SERVE, THE PARTIES SHALL ADVISE HIM OR HER OF THE NAMES OF ALL PARTIES AND THEIR AFFILIATES AND PRINCIPAL OFFICERS AND OWNERS, AND CONFIRM THAT THERE IS NO CONFLICT OF INTEREST, WHICH FOR PURPOSES HEREOF SHALL MEAN NO BUSINESS OR PERSONAL CONNECTIONS WITH THE ARBITRATOR, OR HIS OR HER FIRM, WITH ANY OF SUCH PARTIES EITHER CURRENTLY OR AT ANY TIME DURING THE IMMEDIATELY PRECEDING THREE (3) YEARS. THE ARBITRATION SHALL BE CONDUCTED PURSUANT TO THE AAA'S COMMERCIAL ARBITRATION RULES, AS MODIFIED BY THIS SECTION 15, OR BY SUCH OTHER ORGANIZATION AND RULES AS THE PARTIES MAY MUTUALLY AGREE UPON. IF AAA IS NOT AVAILABLE AND THE PARTIES CANNOT AGREE ON AN ALTERNATE CHOICE, THE PROVISIONS OF CALIFORNIA CODE OF CIVIL PROCEDURE SECTION 1280 ET. SEQ. SHALL APPLY. ALL ARBITRATION PROCEEDINGS SHALL BE CONFIDENTIAL, AND NEITHER PARTY NOR THE ARBITRATOR MAY DISCLOSE THE CONTENT OR RESULTS OF ANY ARBITRATION HEREUNDER WITHOUT THE WRITTEN CONSENT OF BOTH PARTIES. THE ARBITRATOR SHALL FOLLOW THE LAW (INCLUDING APPLICABLE STATUTES OF LIMITATIONS) AND ALL RULES OF EVIDENCE UNLESS THE PARTIES STIPULATE TO THE CONTRARY. ANY PROVISIONAL REMEDY (INCLUDING PRELIMINARY OR PERMANENT INJUNCTIONS AND WRITS OF ATTACHMENT AND POSSESSION) WHICH WOULD BE AVAILABLE FROM A COURT OF LAW OR EQUITY SHALL BE AVAILABLE FROM

THE ARBITRATOR PENDING COMPLETION OF THE ARBITRATION. THE BENEFITED PARTY OF SUCH PROVISIONAL REMEDY SHALL BE ENTITLED TO ENFORCE SUCH REMEDY IN COURT IMMEDIATELY, EVEN THOUGH A FINAL ARBITRATION AWARD HAS NOT YET BEEN RENDERED. WITHIN THIRTY (30) DAYS AFTER HIS OR HER APPOINTMENT, THE ARBITRATOR SHALL HEAR AND DECIDE THE DISPUTE SUBMITTED TO ARBITRATION HEREUNDER AND SHALL PROMPTLY PREPARE A WRITTEN DECISION ON THE MERITS OF THE MATTERS IN DISPUTE, WHICH DECISION SHALL STATE THE FACTS AND LAW RELIED UPON AND THE REASONS FOR THE ARBITRATOR'S DECISION. THE ARBITRATOR MAY, AT HIS OR HER DISCRETION, ELECT WHETHER TO MEET WITH THE PARTIES AND WHETHER TO CONDUCT A HEARING ATTENDED BY ALL PARTIES; PROVIDED, HOWEVER, THAT FOR DISPUTES INVOLVING $50,000.00 OR MORE, THE ARBITRATOR SHALL CONDUCT A HEARING. DISCOVERY SHALL BE ALLOWED IN ACCORDANCE WITH CALIFORNIA CODE OF CIVIL PROCEDURE 1283.05. THE ARBITRATOR SHALL HAVE COMPLETE DISCRETION TO RESOLVE DISCOVERY DISPUTES, TO ORDER THE PRODUCTION OF DOCUMENTS AND PRESENTATION OF WITNESSES AND TO LIMIT SUCH DISCOVERY, INCLUDING THE NUMBER AND SCOPE OF DEPOSITIONS THAT MAY BE TAKEN BY THE PARTIES. PRIOR TO ISSUING HIS OR HER FINAL WRITTEN DECISION, THE ARBITRATOR SHALL INFORM THE PARTIES, IN WRITING, OF THE ARBITRATOR'S EXPECTED DECISION ON THE MATTER AND THE REASONS THEREFORE AND GIVE THE PARTIES FIVE (5) BUSINESS DAYS TO SUBMIT ADDITIONAL ARGUMENTS OR INFORMATION, IN WRITING, TO THE ARBITRATOR AND THE OTHER PARTIES. THE AWARD OR DECISION OF THE ARBITRATOR, WHICH MAY INCLUDE AN ORDER OF SPECIFIC PERFORMANCE, SHALL BE FINAL AND BINDING ON ALL PARTIES AND ENFORCEABLE IN ANY COURT OF COMPETENT JURISDICTION; PROVIDED, HOWEVER, THAT THE AWARD MAY BE VACATED OR CORRECTED FOR ANY OF THE REASONS PERMITTED UNDER AND PURSUANT TO CALIFORNIA CODE OF CIVIL PROCEDURE SECTIONS 1286.2 OR 1286.6. THE ARBITRATOR SHALL HAVE NO AUTHORITY TO MODIFY ANY OF THE TERMS OF THIS AGREEMENT. THE FEES AND EXPENSES OF THE ARBITRATOR AND THE COSTS AND ATTORNEYS' FEES OF THE PREVAILING PARTY SHALL BE PAID BY THE PARTY WHO IS NOT THE PREVAILING PARTY, AS DEFINED IN SECTION 17.7 (ATTORNEYS' FEES) AND DETERMINED BY THE ARBITRATOR IN ITS DECISION.

NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTE ARISING OUT OF THE MATTERS INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED BY CALIFORNIA LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE THE DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE CALIFORNIA CODE OF CIVIL PROCEDURE. YOUR AGREEMENT TO THIS ARBITRATION PROVISION IS VOLUNTARY.

WE HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION TO NEUTRAL ARBITRATION

/s/ Jeanne R Myerson, President	/s/ John C. Molina, CFO
Seller	Buyer

16. Indemnification. Each party hereby agrees to indemnify, defend, protect and hold harmless the other party from and against any and all claims, demands, liabilities, costs and damages, including without limitation, reasonable attorneys' fees (collectively, "**Claims**") suffered by the other party and resulting from or arising out of all third-party tort claims and similar claims of the type that would typically be insured under a Commercial General Liability Insurance Policy which are based on actions, facts or circumstances existing or occurring during the indemnifying party's ownership of the Property, excluding any Claims related to hazardous substances. In addition to the foregoing, Seller agrees to indemnify, defend, protect and hold harmless Buyer from and against any and all enforcement actions and all fines imposed and/or pursued by: (i) the State Water Resources Control Board, California Regional Water Quality Control Board, the United States Environmental Protection Agency, the County of Los Angeles, the City of Long Beach and/or any other governmental or quasi governmental agency or instrumentality; and/or (ii) any third party, resulting from or arising out of alleged or actual violations of federal, state or local laws, statutes, ordinances or regulations applicable to the collection and/or discharge of water from or through the Discharge System that occurred prior to the Closing. Notwithstanding the foregoing, in no event shall this Section 16 require Seller to be responsible for the costs of installing, operating and/or maintaining a water treatment system at the Property, regardless of whether such a system is determined to be necessary by the applicable regulatory authorities as a result of any pre-Closing violation by Seller. The provisions of this Section 16 shall survive the Closing and conveyance of the Property to Buyer for a period of three (3) years from the date of Closing.

17. Miscellaneous.

17.1 Notice. All notices and any other communications permitted or required under this Agreement must be in writing and will be effective (i) immediately upon delivery in person or by facsimile, provided delivery is made during regular business hours or receipt is acknowledged by a person reasonably believed by the delivering party to be employed by the recipient and that for all facsimiles, good and complete transmission is confirmed by the sending facsimile machine and a copy of the notice is concurrently mailed pursuant to clause (iii) below; or (ii) upon the actual delivery as evidenced by executed receipt of the recipient if delivered by a nationally recognized delivery service for overnight delivery, provided delivery is made during regular business hours or receipt is acknowledged by a person reasonably believed by the delivering party to be employed by the recipient; or (iii) or the date shown on the return receipt if delivered by the United States Postal Service, certified mail, return receipt requested, postage prepaid and with the return receipt returned to the sender marked as delivered, undeliverable or

rejected. In the case of any notices sent pursuant to clauses (ii) or (iii) above, the sender shall also send a copy of such notice by email, which email shall be sent no later than 6:00 p.m. (Pacific Time) on the date such notice is deposited with the delivery service or United States Postal Service. The inability to deliver because of a changed address of which no notice was given, or rejection or other refusal to accept any notice, shall be deemed to be the receipt of the notice as of the first date of such inability to deliver or rejection or refusal to accept. Any notice to be given by any party hereto may be given by the counsel for such party. All notices must be properly addressed and delivered to the parties at the addresses set forth below, or at such other addresses as either party may subsequently designate by written notice given in the manner provided in this Section 17.1:

Seller: **200 Oceangate, LLC**
c/o The Swig Company, LLC
220 Montgomery Street, 20th Floor
San Francisco, CA 94104
Attn: Kennard P. Perry
Telephone: (415) 291-1140
Facsimile: (415) 291-8373
Email: kperry@swigco.com

with copy to: Farella Braun + Martel LLP
235 Montgomery Street
San Francisco, CA 94104
Attn: Anthony D. Ratner
Telephone: (415) 954-4448
Facsimile: (415) 954-4480
Email: tratner@fbm.com

Buyer:

Prior to Closing: Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attn: General Counsel
Telephone: (916) 646-9193 x114663
Facsimile: (916) 646-4572
Email: Jeff.Barlow@Molinahealthcare.com

with copy to: Boutin Jones Inc.
555 Capitol Mall, Suite 1500
Sacramento, CA 95814
Attn: James R. Moore
Telephone: (916) 321-4444
Facsimile: (916) 441-7597
Email: jmoore@boutininc.com

After Closing: Molina Center LLC
200 Oceangate, Suite 100
Long Beach, CA 90802
Attn: John Molina
Telephone: (562) 435-3666 x111128
Facsimile: (562) 495-7770
Email: John.Molina@Molinahealthcare.com

with a copy to: Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attn: General Counsel
Telephone: (916) 646-9193 x114663
Facsimile: (916) 646-4572
Email: Jeff.Barlow@Molinahealthcare.com

17.2 Headings. The headings used herein are for purposes of convenience only and should not be used in construing the provisions hereof.

17.3 Covenant of Further Assurances. The parties hereby agree to execute and deliver such other documents and instruments (including, without limitation, additional escrow instructions in conformity with this Agreement), and to take such other actions, whether before or after Closing, as may reasonably be required and which may be necessary to consummate this transaction and to otherwise effectuate the agreements of the parties hereto; provided that such additional documents, instruments, or actions shall not impose upon the parties any obligations, duties, liabilities or responsibilities which are not expressly provided for in this Agreement.

17.4 Entire Agreement. This document, together with that certain Agreement Regarding Diligence Reports dated January 7, 2011, by and between Buyer and Seller (the "**Diligence Agreement**"), and that certain Notice and Acknowledgement by and between Seller and Molina relating to KPMG and dated January 10, 2011 (the "**KPMG Acknowledgement**"), together represent the final, entire and complete agreement between the parties with respect to the subject matter hereof and supersedes all other prior or contemporaneous agreements, communications or representations, whether oral or written, express or implied, including any letters of intent, including that certain Confidentiality Agreement 200 & 300 Oceangate by and between Molina and Seller. The parties acknowledge and agree that they may not and are not relying on any representation, promise, inducement, or other statement, whether oral or written and by whomever made, that is not contained expressly in this Agreement, the Diligence Agreement or the KPMG Acknowledgement. This Agreement may only be modified by a written instrument signed by representatives authorized to bind both parties. Oral modifications are unenforceable.

17.5 Partial Invalidity. If any term, covenant or condition of this Agreement or its application to any person or circumstances shall be held to be illegal, invalid or unenforceable, the remainder of this Agreement or the application of such term or provisions to other persons or

circumstances shall not be affected, and each term hereof shall be legal, valid and enforceable to the fullest extent permitted by law, unless an essential purpose of this Agreement would be defeated by the loss of the illegal, unenforceable, or invalid provision. In the event of such partial invalidity, the parties shall seek in good faith to agree on replacing any such legally invalid provisions with valid provisions which, in effect, will, from an economic viewpoint, most nearly and fairly approach the effect of the invalid provision and the intent of the parties in entering into this Agreement.

17.6 No Waiver. No consent or waiver by either party to or of any breach or non-performance of any representation, condition, covenant or warranty shall be enforceable unless in a writing signed by the party entitled to enforce performance, and such signed consent or waiver shall not be construed as a consent to or waiver of any other breach or non-performance of the same or any other representation, condition, covenant, or warranty.

17.7 Attorneys' Fees. In the event of any arbitration or litigation between the parties, whether based on contract, tort or other cause of action or involving bankruptcy or similar proceedings, in any way related to this Agreement, the non-prevailing party shall pay to the prevailing party all reasonable attorneys' fees and costs and expenses of any type, without restriction by statute, court rule or otherwise, incurred by the prevailing party in connection with any action or proceeding (including arbitration proceedings, any appeals and the enforcement of any judgment or award), whether or not the dispute is litigated or prosecuted to final judgment. The "prevailing party" shall be determined based upon an assessment of which party's major arguments or positions taken in the action or proceeding could fairly be said to have prevailed (whether by compromise, settlement, abandonment by the other party of its claim or defense, final decision, after any appeals, or otherwise) over the other party's major arguments or positions on major disputed issues.

17.8 Brokers and Finders. Neither party has had any contact or dealings regarding the Property, through any licensed real estate broker or other persons who can claim a right to a commission or finder's fee in connection with this transaction, except for CB Richard Ellis, Inc., representing Seller (the " **Selling Broker**") and McKinney Advisory Group, Inc., representing Buyer (the " **Buying Broker**"). The parties agree that Seller shall pay a brokerage commission to Selling Broker, pursuant to its separate agreement with the Selling Broker. The parties agree that Buyer shall pay any amount owing to Buying Broker pursuant to its separate agreement with the Buying Broker. In the event that any other party claims a commission or finder's fee in this transaction, the party through whom the party makes its claim shall be responsible for said commission or fee and shall indemnify the other against all costs and expenses (including reasonable attorneys' fees) incurred in defending against the same. This indemnification obligation shall survive the Closing or termination of this Agreement.

17.9 Time of the Essence. Time is of the essence of this Agreement.

17.10 Governing Law; Forum. This Agreement is entered into and shall be governed by and construed in accordance with the laws of the State of California (without giving effect to its choice of law principles).

17.11 Interpretation. All parties have been represented by counsel in the preparation and negotiation of this Agreement, and this Agreement shall be construed according to the fair meaning of its language. The rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be employed in interpreting this Agreement. Unless the context clearly requires otherwise, (i) the plural and singular numbers shall each be deemed to include the other; (ii) the masculine, feminine, and neuter genders shall each be deemed to include the others; (iii) "shall," "will," or "agrees" are mandatory, and "may" is permissive; (iv) "or" is not exclusive; (v) "includes" and "including" are not limiting, absent express language to the contrary; (vi) "days" means calendar days unless specifically provided otherwise; and (vii) "business day" means any day other than Saturday, Sunday, or any day that is an "optional bank holiday" under Section 7.1 of the California Civil Code, whether or not any particular bank is open for business on such optional bank holiday.

17.12 IRS Form 1099-S Designation. In order to comply with information reporting requirements of Section 6045(e) of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations thereunder, the parties agree (i) to execute an IRS Form 1099-S Designation Agreement to designate the Title Company (the "**Designee**") as the party who shall be responsible for reporting the contemplated sale of the Property to the Internal Revenue Service (the " **IRS**") on IRS Form 1099-S; and (ii) to provide the Designee with the information necessary to complete Form 1099-S.

17.13 Third Party Beneficiaries. This Agreement has been made solely for the benefit of the parties hereto and their respective successors and permitted assigns, and nothing in this Agreement is intended to, or shall, confer upon any other person any benefits, rights or remedies under or by reason of this Agreement.

17.14 Compliance With Laws. Each party shall comply with all applicable laws, rules, regulations, orders, consents and permits in the performance of all of their obligations under this Agreement.

17.15 Counterparts. This Agreement may be signed in any number of counterparts with the same effect as if the signatures to each counterpart were upon a single instrument, and is intended to be binding when all parties have delivered their signatures to the other parties. Signatures may be delivered by facsimile transmission or by e-mail in a portable document format (*pdf*). All counterparts shall be deemed an original of this Agreement.

17.16 Exhibits. All Recitals and Exhibits referred to in this Agreement are incorporated herein by reference and shall be deemed part of this Agreement.

17.17 Authority. The individuals executing this Agreement on behalf of Seller and Buyer individually represent and warrant that he or she has been authorized to do so and has the power to bind the party for whom they are signing.

17.18 Exchange Transaction. Buyer agrees upon the request of Seller to cooperate with Seller in closing all or part of this transaction as an exchange pursuant to Internal Revenue Code Section 1031, provided that:

(a) Buyer shall incur no additional expense or liability in connection therewith and shall not be required to make any representations or warranties, incur any personal liabilities or hold title to any property other than the Property;

(b) Seller shall indemnify, protect, defend and hold Buyer harmless from any claims, liabilities, demands, causes of action, judgments, expenses, costs and attorneys' fees in connection with such exchange or which result from Buyer's compliance with this paragraph, which obligation shall survive the Closing or termination of this Agreement; and

(c) The Closing is not extended or delayed by the exchange and the completion of the exchange is not a condition to Seller's obligation to close the Escrow.

17.19 Confidentiality. Buyer and Seller shall each maintain as confidential any and all material or information about the other, the terms of this Agreement, and the Property, and shall not disclose such information to any third party, except, in the case of Buyer, to Buyer's investment bankers, lender or prospective lenders, insurance and reinsurance firms, accountants, attorneys, environmental and other consultants, as may be reasonably required for the consummation of this transaction, as required by law or in connection with any arbitration or litigation between the parties, and except, in the case of Seller, to Seller's existing lender, attorneys, accountants and other professional consultants, as may be reasonably required for the consummation of this transaction, as required by law or in connection with any arbitration or litigation between the parties. Neither party shall issue a press release or other public statement about this Agreement or the transactions contemplated by this Agreement without the other party's prior written consent, unless such release or statement is required by law. Seller acknowledges that Buyer's ultimate parent is a publicly traded company and that Buyer is, therefore, subject to laws and regulations regarding the disclosure and dissemination of business information. Buyer acknowledges that in the event this Agreement terminates for any reason, Seller has the right and the obligation to disclose to subsequent purchasers of the Property the price and material terms of this Agreement, and Buyer agrees that such disclosure is a permitted disclosure under this Section 17.19.

[*Signatures on following page*]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Contract Date.

SELLER:

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.,
a Delaware corporation
its Manager

By: /s/ Jeanne R. Myerson
Jeanne R. Myerson
President

BUYER:

MOLINA CENTER LLC,
a Delaware limited liability company

By: Molina Healthcare, Inc., a Delaware corporation

By: /s/ John C. Molina
Name: John C. Molina
Title: Chief Financial Officer

NOTE: BOTH PARTIES MUST INITIAL THE AGREEMENT AT SECTIONS 3.2 AND 15.

EXHIBIT A

DESCRIPTION OF THE LAND

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGLES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURface OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY AND ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 and 7278-003-036

EXHIBIT B

MATERIALS AND DOCUMENTS DELIVERED TO BUYER

Information Provided in 2011

FINANCIAL

1. 7-2010 – 6-2011 RE Tax Invoice 7278 003 035
2. 7-2010 – 6-2011 RE Tax Invoice 7278 003 036
3. 200 Oceangate Balance Sheet as of 08-31-11
4. 2011-08 YTD Operating Statement
5. 2011-08-31 Oceangate Balance Sheet
6. 2011-09-06 200 – 300 Oceangate Rent Roll
7. 2011-09-19 200 Oceangate AR Aging
8. 2011-09-19 200 Oceangate Rent Roll
9. 2010 Escalation Reconciliation – Actual

LEASES

1. 2011-09 Perona B870
2. 2011-09 XO Comm Amendment
3. Crowell Weedon and Co B0800 – Lease 9-9-10

SERVICE CONTRACTS

1. 2011-09 Serv-Wel aka City Rent-A-Bin
2. 2011-09 Trashmaster aka Master Environmental
3. 2011-09 window Washing Able Acq aka UBS

2011-09-14 200 Oceangate First Am Commercial Commitment—Update

Information Provided in 2010

BOMA

10. BOMA Building Square Footage Calculations

Existing Loan Information

1. 2010-9-23-200 Oceangate Loan Abstract
2. Complete Set of Seller's Final Loan Docs

Financial Information

1. 200 and 300 Oceangate Utility Reimbursement Detail For YTD 2010
2. 2009 TAX and Operating Expenses Reconciliation Actuals

Leases

1. 2008-8-11 Molina Acceptance of Premises
2. 2010-11-04 Gunn Jerkens Stor Cancellation notice
3. 2010-11-04 Oasis Car Wash
4. 2010-11-04 United Parcel Service Drop Box Agmt
5. 2010-11-18 Rocket Inter Network Org Lease Basic Lease Information
6. Arco Center—Storage Rent Roll 4-14-2010
7. Arthritis National Research Foundation
8. Brandon and Yarc LLP
9. California Coastal Commission
10. California Coastal Commission (Missing Page 8)
11. California State Lands Commission

12. Children Today Storage Only
13. Conectateya Inc
14. Department of General Services
15. Department of Industrial Relations
16. Department of Veterans Affairs
17. Earth Tech Inc
18. Gunn-Jerkens Inc
19. High Rise Goodies Restaurant Group aka Trimana
20. J. Perez Associates Inc
21. Long Beach Publishing Company aka Press Telegram
22. Medco Health Solutions Inc
23. Michael W. Binning
24. Molina Healthcare Inc
25. Moyer Lynne E
26. MVP Energy LLC
27. Pacific Maritime Association
28. Reidman Dalessi and Dybens
29. Rocket Internetworking Inc
30. Rose Klein and Marias
31. State Lands Commission
32. Trainotti Michael

Amendments to Leases/Exhibits/License Agreements

1. Arthritis National—3rd Amend to Lease 8-25-10
2. California Coastal Com A1000—Exhibit B 10-16-96
3. California Coastal Commission Suite 10th Floor Plan 10-16-96
4. Captivate Network Inc – Letter RE: License Agreement 9-7-10
5. Crowell Weedon and Co B0800 – Lease dated 9-9-10
6. D. Michael Trainotti—3rd Amend to Lease 8-25-10
7. Dept of Industrial Relations B0850—Exhibit B Revised 4-28-00
8. Dept of Industrial Relations B200-300—Exhibit B 5-15-97
9. First Choice Coffee Service Agreement 10-26-10
10. Lease Agreements in File Summary Updated 11-9-10
11. License Agreements Schedule dated 11-10-2010
12. Long Beach Publishing Co—Temp Use Agreement 6-10-10
13. Lynn E Moyer—3rd Amend to lease 10-18-10
14. Michael W. Binning—4th Amend to Lease 8-25-10
15. Riedman Dalessi and Dybens—3rd Amend to Lease 8-25-10
16. Rocket InterNetworking—1st Amend to lease 9-17-2010
17. State Land Com A12—Exhibit A
18. State Lands Com A0900—Exhibit B 5-10-01
19. State Lands Com A1200—Exhibit B 3-1-93
20. State Lands Com A9—Exhibit A
21. US Dept of Vet Affairs—Exhibit D Letter3-21-10
22. Vendor Services Summary Updated 11-9-10

Misc Income

1. 200 Oceangate 2010 Income detail

Operating Statements

1. 200 Oceangate 2010 Income detail (same as above)

2. 2008- 12-31 Operating Statement
3. 2009-12-31 Operating Statement
4. 2010_05_31 200 Oceangate Operating Statement
5. 2010-7-14 Parking Break down by tenant

6. 2010-7-14 Parking Rates
7. 2010-7-8 Parking Invoices June 09—May 10
8. ARCO Parking Revenue June 2009-May 2010

Parking

1. 2010-7-8 Parking Invoices June 09—May 10
2. ARCO Parking Revenue June 2009-May 2010 (same as in the Operating Expense folder)

Rent Roll

1. 2010-8-19 200 and 300 Oceangate Rent Roll

Storage Rent Roll

1. 2010-11-04 Storage Rent Roll Schedule Revised Nov 1

Utility

1. 200 Oceangate Utility Reimbursement Detail for 2010

Leasing Status Update

1. Leasing Update Prepared by CBRE 9-23-2010

New Physical Property Reports

1. Phase 1 Environmental (Prepared by Partner Engineering and Science dated 9-21-2003)
2. Property Condition Assessment Report (Prepared by Property Solutions Incorporated dated 9-2-2003)
3. Structural Report (Prepared by Partner Engineering and Science dated 9-21-2003)

OM Argus

1. 200 & 300 Oceangate ARGUS file as of 8-5-2010

OTHER MISC DOCS

Insurance Certificate

1. Wachovia Bank 200 Oceangate Insurance Certificate dated 8-12-2009

Photographs

1. ARCO Center McConville 3
2. 200 and 300 Oceangate McConville

PHYSICAL INFORMATION

Building Measurement—Stevenson Systems—Individual Space Plans

Various 200 Oceangate Space Plans With the Following Sheet Titles:

1. 200OGA10 Model 1000.pdf
2. 200OGA10 Model 1050.pdf
3. 200OGA10 Model c.pdf
4. 200OGA11 Model 1100.pdf
5. 200OGA11 Model c.pdf
6. 200OGA12 Model 1200.pdf
7. 200OGA12 Model c.pdf
8. 200OGA14 Model 1400.pdf
9. 200OGA14 Model c.pdf
10. 200OGA15 Model 1500.pdf
11. 200OGA15 Model 1550.pdf
12. 200OGA15 Model 1560.pdf
13. 200OGA15 Model 1570.pdf

14. 200OGA15 Model 1580.pdf
15. 200OGA15 Model c.pdf
16. 200OGA2 Model 200.pdf
17. 200OGA2 Model c.pdf
18. 200OGA3 Model 300.pdf
19. 200OGA3 Model c.pdf
20. 200OGA4 Model 400.pdf
21. 200OGA4 Model c.pdf
22. 200OGA5 Model 500.pdf
23. 200OGA5 Model c.pdf
24. 200OGA6 Model 600.pdf
25. 200OGA6 Model c.pdf
26. 200OGA7 Model 700.pdf
27. 200OGA7 Model c.pdf
28. 200OGA8 Model 800.pdf
29. 200OGA8 Model 810.pdf
30. 200OGA8 Model 815.pdf
31. 200OGA8 Model 820.pdf
32. 200OGA8 Model 850.pdf
33. 200OGA8 Model c.pdf
34. 200OGA9 Model 900.pdf
35. 200OGA9 Model c.pdf

Various 300 Oceangate Space Plans With the Following Sheet Titles:

1. 200OGB10 Model 1000.pdf
2. 200OGB10 Model c.pdf
3. 200OGB11 Model 1100.pdf
4. 200OGB11 Model c.pdf
5. 200OGB12 Model 1200.pdf
6. 200OGB12 Model c.pdf
7. 200OGB14 Model 1400.pdf
8. 200OGB14 Model c.pdf
9. 200OGB15 Model 1500.pdf
10. 200OGB15 Model c.pdf
11. 200OGB2 Model 200.pdf
12. 200OGB2 Model c.pdf
13. 200OGB3 Model 300.pdf
14. 200OGB3 Model c.pdf
15. 200OGB4 Model 400.pdf
16. 200OGB4 Model 420.pdf
17. 200OGB4 Model 430.pdf
18. 200OGB4 Model 450.pdf
19. 200OGB4 Model c.pdf
20. 200OGB5 Model 500.pdf
21. 200OGB5 Model c.pdf
22. 200OGB6 Model 600.pdf
23. 200OGB6 Model c.pdf
24. 200OGB7 Model 700.pdf
25. 200OGB7 Model c.pdf
26. 200OGB8 Model 800.pdf

27. 200OGB8 Model 850.pdf
28. 200OGB8 Model c.pdf
29. 200OGB9 Model 900.pdf
30. 200OGB9 Model 910.pdf
31. 200OGB9 Model 930.pdf

32. 200OGB9 Model 950.pdf
33. 200OGB9 Model c.pdf
34. 200OGP Model A100.pdf
35. 200OGP Model B100.pdf
36. 200OGP Model B110.pdf
37. 200OGP Model B130.pdf
38. 200OGP Model B150.pdf
39. 200OGP Model c.pdf

Measurement Reports

1. 200-300 Oceangate—Final Measurement Report Prepared by Stevenson Systems, Inc. dated 2008-11-06
2. 200-300 Oceangate—Final Report Prepared by Stevenson Systems, Inc. dated 2008-11-06

Engineering

1. Engineering Report (Prepared by Property Solutions Incorporated dated 9-2-2003)

Environmental

1. Phase I Environmental (Prepared by Property Solutions Incorporated dated 9-2-2003)

Flood Report

1. Flood Report (Flood Hazard Determination Prepared by Federal Emergency Management Agency dated 10-31-2005)

Leasing Flyers

1. 200 Oceangate_15th Floor.pdf
2. 200 Oceangate_ste 1560.pdf
3. 300 Oceangate_ste 1500.pdf
4. 300 Oceangate_ste 800.pdf

Parking Plans

1. 2010-7-14 Parking Break down by tenant
2. 2010-7-14 Parking Rates
3. Parking Garage Plans Various Sheets P1 P2 P3

Restroom

1. Restroom ADA Work Memo of Completion dated 05-28-2010

Roof

1. 200 and 300 Oceangate Roof Report Prepared by Roofing and Waterproofing Forensics, Inc dated March 2006

Stacking Plan

1. 2010-528 200 Oceangate Stacking Plan
2. 2010-528 300 Oceangate Stacking Plan

PROPERTY FILES

Property Insurance Invoice

1. 200-300 Oceangate Property Insurance Invoice 6-30-09—06-30-10

Property Tax Invoice

1. Property Tax Invoices for the 2008-2009 Tax Period 200 Oceangate-Parcel 035
2. Property Tax Invoices for the 2008-2009 Tax Period 200 Oceangate-Parcel 036
3. Property Tax Invoices for the 2009-2010 Tax Period 200 Oceangate-Parcel 035
4. Property Tax Invoices for the 2009-2010 Tax Period 200 Oceangate-Parcel 036

Service Contracts For the Following Vendors:

1. Able Engineering
2. ABM Janitorial Services-Stone Maintenance
3. American City Pest Control
4. Ampco System Parking
5. ARCO Center Vendor Contracts
6. Arrowhead Mountain Spring Water
7. Associated Group
8. Captivate Network
9. Cogent Communications
10. Direct America
11. Federal Communications Commission FCC
12. Kinemetrics Inc
13. Master Environmental
14. Matsunaga Landscaping
15. Montgomery Technologies
16. Otis Elevator Company Service Contract Effective Oct 1 2010
17. Otis Elevator Company Modernization Contract dated 10-13-2009
18. Otis Elevator Company Pre-Modernization Contract dated 5-25-2004
19. PyroComm
20. Rocket Internetworking Inc
21. Serv-wel Disposal and Recycling
22. Sky Rider Equipment
23. Southland Exterior Bldg Services
24. TCG Los Angeles
25. Telepacific Communications
26. Union Contract Engineering
27. Union Contract Janitorial
28. Union Contract Security
29. United Building Services Able
30. Universal Protection Services
31. XO Communications

Various Utility Bills

1. City of Long Beach Acct 43514504 (Gas and Water)
2. City of Long Beach Acct 850031854 (Fire and Water)
3. Southern California Edison Acct 2-02-360-7070 (Electricity)
4. Southern California Edison Acct 2-24-515-6658 (Electricity)
5. Southern California Edison Acct 2-28-852-0869 (Electricity)

Title Info

1. 2010-08-29 200 Oceangate FirstAm Prelim Title Report
2. 2010-09-09 200 AND 300 Oceangate Updated ALTA Survey

SUPPLEMENTAL DUE DILIGENCE

Depart of Industrial Relations B0850

1. Depart of Industrial Relations B0850 Floor 2 Space Plan Prepared by Interni dated5-15-97
2. Depart of Industrial Relations B0850 Floor 3 Space Plan Prepared by Interni dated5-15-97

Depart of Industrial Relations B200-300

1. Depart of Industrial Relations B200-300 Oceangate 8th Floor dated 4-18-2000 Prepared by DGS

2. Depart of Industrial Relations B200-300 Oceangate 8th Floor dated 4-18-2000 Prepared by DGS Version 2

EXHIBIT C

RENT ROLL

[See attached]

Suite Id	Tenant Name	Rent Dates Start	Rent Dates Expire	GRA Square Footage	Monthly Base Rent	Annual Rate PSF	Monthly Cost Recovery	Expense Stop	Monthly Other Income	Security Deposit	Base Escalation Cat	Base Escalation Year	Base Escalation Pct	Base Escalation G/U %	Options Nc	Options Term	Options Amount	Options Lead	Future Rent Increases Cat	Future Rent Increases Date	Future Rent Increases Monthly	Future Rent Increases AmoiPSF
Vacant Suites																						
715 -A0810	Vacant			2,540																		
715 -A0820	Vacant			2,484																		
715 -A1550	Vacant			8,150																		
715 -A1560	Vacant			1,699																		
715 -A1580	Vacant			1,840																		
715 -B0420	Vacant			3,603																		
715 -B0450	Vacant			8,681																		
715 -B0830	Vacant			1,205																		
715 -B0900	Vacant			2,181																		
715 -B0950	Vacant			2,419																		
715 -B1500	Vacant			16,604																		
715 -Z0101	Vacant			378																		
Occupied Suites																						
715 -A0700	MOLINA HEALTHCARE, INC.	8/1/2006	12/31/2018	16,575	334,144.40	241.9145	16,514.06				ESC	2003	17.9721	95					REN	12/1/2012	344,168.75	27.5522
											TAX	2008	1.2005						REN	12/1/2013	354,493.80	28.3788
																			REN	12/1/2014	365,128.59	29.2302
																			REN	12/1/2015	376,082.45	30.1071
																			REN	12/1/2016	387,364.95	31.0103
																			REN	12/1/2017	398,985.90	31.9406
																			REN	12/1/2018	410,955.45	32.8988
	Additional Space 715 -A0100	7/1/2008		5,518			438.91															
	Additional Space 715 -A0200	8/1/2006		16,306																		
	Additional Space 715 -A0300	8/1/2006		16,575																		
	Additional Space 715 -A0400	8/1/2006		16,575																		
	Additional Space 715 -A0500	8/1/2006		12,568			2,512.57															
	Additional Space 715 -A0530	8/1/2006		2,846			801.07															
	Additional Space 715 A0533	8/1/2006		1,161																		
	Additional Space 715 -A0600	8/1/2006		16,575																		
	Additional Space 715 -A1050	9/1/2006		7,608			1,257.00															

Suite Id	Tenant Name			Rent Dates Start	Rent Dates Expire	GRA Square Footage	Monthly Base Rent	Annual Rate PSF	Monthly Cost Recovery	Expense Stop	Monthly Other Income	Security Deposit	Base Escalation Cat	Year	Pct	G/U %	Options Nc	Term	Amount	Lead	Future Rent Increases Cat	Date	Monthly Amoi	PSF
	Additional Space	715	A1100	11/1/2006	12/31/2018	16,541			2,732.95															
	Additional Space	715	A14TH	8/1/2006	12/31/2018	16,575			2,738.57															
	Additional Space	715	AA100	6/1/2007	12/31/2018	9,993			1,651.07															
					Total	155,416	334,144.40		28,646.20		0.00													
715 -A0800	ROCKET INTERNETWORKING, INC.			11/1/2010	2/28/2016	3,784	7,568.00	24.0000	343.16		243.75	9,273.39	ESC	2010	.8222	95					REN	11/1/2011	7,795.04	24.7200
													TAX	2010	.8222						REN	11/1/2012	8,028.89	25.4616
																					REN	11/1/2013	8,269.76	26.2255
																					REN	11/1/2014	8,517.85	27.0122
																					REN	11/1/2015	8,773.39	27.8226
																					SAT	11/1/2011	618.00	1.9598
																					SAT	11/1/2012	636.54	2.0186
																					SAT	11/1/2013	655.64	2.0792
																					SAT	11/1/2014	675.31	2.1416
																					SAT	11/1/2015	695.56	2.2058
715 -A0815	ROSE, KLEIN & MARIAS			12/11/2009	12/31/2011	1,398	1,475.00	12.6609				1,032.70	ESC											
													TAX											
715 -A0830	LYNN E. MOYER, ESQ			3/1/2011	5/31/2016	749	1,460.55	23.4000					ESC	2011	.1624	95	1	60	FMV		REN	3/1/2012	1,504.37	24.1021
													TAX	2011	.1624						REN	3/1/2013	1,549.50	24.8251
																					REN	3/1/2014	1,595.98	25.5698
																					REN	3/1/2015	1,643.86	26.3369
																					REN	3/1/2016	1,693.18	27.1270
715 -A0831	ARTHRITIS NATIONAL RESEARCH			3/1/2011	5/31/2016	584	1,138.80	23.4000					ESC	2011	.1266	95	1	60	FMV		REN	3/1/2012	1,172.96	24.1019
													TAX	2011	.1266						REN	3/1/2013	1,208.15	24.8250
																					REN	3/1/2014	1,244.40	25.5699
																					REN	3/1/2015	1,281.73	26.3369
																					REN	3/1/2016	1,320.18	27.1270
715 -A0840	D. MICHAEL TRAINOTTI			3/1/2011	5/31/2016	777	1,515.15	23.4000					ESC	2011	.1685	95	1	60	FMV		REN	3/1/2012	1,560.60	24.1019
													TAX	2011	.1685						REN	3/1/2013	1,607.42	24.8250
																					REN	3/1/2014	1,655.65	25.5699
																					REN	3/1/2015	1,705.31	26.3368
																					REN	3/1/2016	1,756.47	27.1269
715 -A0845	MICHAEL W. BINNING			3/1/2011	5/31/2016	745	1,452.75	23.4000					ESC	2011	.1615	95	1	60	FMV		REN	3/1/2012	1,496.33	24.1020
													TAX	2011	.1615						REN	3/1/2013	1,541.22	24.8250
																					REN	3/1/2014	1,587.46	25.5698
																					REN	3/1/2015	1,635.08	26.3369
																					REN	3/1/2016	1,684.14	27.1271
715 -A0850	BRUCE A. DYBENS, A PROF LAW			3/1/2011	5/31/2016	3,538	6,899.10	23.4000			500.00		ESC	2011	.767	95	1	60	FMV		REN	3/1/2012	7,106.07	24.1020
													TAX	2011	.767						REN	3/1/2013	7,319.26	24.8251
																					REN	3/1/2014	7,538.83	25.5698
																					REN	3/1/2015	7,765.00	26.3369
																					REN	3/1/2016	7,997.95	27.1270

	Suite Id	Tenant Name	Rent Dates Start	Rent Dates Expire	GRA Square Footage	Monthly Base Rent	Annual Rate PSF	Monthly Cost Recovery	Expense Stop	Monthly Other Income	Security Deposit	Base Escalation Cat	Year	Pct	G/U %	Options Nc	Term	Amount	Lead	Future Rent Increases Cat	Date	Monthly	AmoiPSF
715	-A0900	CALIFORNIA STATE LANDS COMM	12/1/2010	11/30/2018	16,599	29,197.35	21.1078					ESC								REN	12/1/2011	30,073.27	21.7410
												TAX								REN	12/1/2012	30,975.46	22.3932
																				REN	12/1/2013	31,904.73	23.0650
																				REN	12/1/2014	34,486.38	24.9314
																				REN	12/1/2015	35,952.05	25.9910
																				REN	12/1/2016	37,480.02	27.0956
																				REN	12/1/2017	39,072.91	28.2472
715	-A1000	CALIFORNIA COASTAL COMMISSION	12/1/2010	11/30/2018	8,950	15,730.14	21.0907					ESC								REN	12/1/2011	16,202.04	21.7234
												TAX								REN	12/1/2012	16,688.10	22.3751
																				REN	12/1/2013	17,188.74	23.0464
																				REN	12/1/2014	18,579.62	24.9112
																				REN	12/1/2015	19,369.25	25.9699
																				REN	12/1/2016	20,192.44	27.0737
																				REN	12/1/2017	21,050.62	28.2243
715	-A12TH	STATE LANDS COMMISSION	12/1/2010	11/30/2018	16,599	29,301.67	21.1832			119.00		ESC								REN	12/1/2011	30,180.71	21.8187
												TAX								REN	12/1/2012	31,086.14	22.4733
																				REN	12/1/2013	32,018.72	23.1475
																				REN	12/1/2014	34,609.60	25.0205
																				REN	12/1/2015	36,080.51	26.0839
																				REN	12/1/2016	37,613.93	27.1924
																				REN	12/1/2017	39,212.52	28.3481
																				STO	1/1/2012	101.00	0.0730
715	-A1500	LISA BRANDON, CFLS	2/1/2011	1/31/2016	2,918	5,690.10	23.4000				5,903.52	ESC	2011	.6326	95					REN	2/1/2012	5,860.80	24.1020
												TAX	2011	.6326						REN	2/1/2013	6,036.63	24.8251
																				REN	2/1/2014	6,217.73	25.5698
																				REN	2/1/2015	6,404.26	26.3369
715	-A1570	MVP ENERGY, LLC	3/1/2010	2/28/2015	1,992	3,795.76	22.8660	180.89			3,779.10	ESC	2010	.4334	95	1	60	FMV		REN	3/1/2012	3,909.63	23.5520
												TAX	2010	.4334						REN	9/1/2012	0.00	0.0000
																				REN	10/1/2012	3,909.63	23.5520
																				REN	3/1/2013	4,026.92	24.2586
																				REN	3/1/2014	4,147.73	24.9863
715	-B0100	HIGH RISE GOODES RESTAURANT	7/7/2005	7/31/2015	3,497	4,327.01	14.8482	664.11		25.00	4,500.09	ESC	2005	.761	95	1	60	FMV		REN	7/7/2013	4,500.09	15.4421
												TAX	2005	.761									
715	-B0130	GUNN JERKENS, INC.	6/1/2006	12/31/2011	3,562	7,302.10	24.6000	676.33		290.00	5,178.00	ESC	2005	.775	95	1	60			REN	10/15/2011	7,480.20	25.2000
												TAX	2005	.775									
715	-B0150	LONG BEACH PUBLISHING COMPANY	9/1/2008	10/31/2021	6,456	45,729.59	20.9345	4,329.87		285.00		ESC	2006	5.7015	95	1	120	FMV		REN	10/13/2011	47,101.48	21.5625
												TAX	2006	5.7015						REN	10/13/2012	48,514.52	22.2094
																				REN	10/13/2013	49,969.96	22.8757
																				REN	10/13/2014	51,469.06	23.5619
																				REN	10/13/2015	53,013.13	24.2688
																				REN	10/13/2016	0.00	0.0000
																				REN	1/13/2017	54,603.52	24.9968

Suite Id	Tenant Name			Rent Dates Start	Rent Dates Expire	GRA Square Footage	Monthly Base Rent	Annual Rate PSF	Monthly Cost Recovey	Expense Stop	Monthly Other Income	Security Deposit	Base Escalation Cat	Year	Pct	G/U %	Options Nc	Term	Amount	Lead	Future Rent Increases Cat	Date	Monthly	AmoiPSF
																					REN	10/13/2017	56,241.63	25.7468
																					REN	10/13/2018	57,928.88	26.5192
																					REN	10/13/2019	59,666.75	27.3147
																					REN	10/13/2020	61,456.75	28.1342
																					REN	10/13/2021	63,300.45	28.9782
	Additional Space	715	-B0110	9/1/2008	10/31/2021	1,224																		
	Additional Space	715	-B0430	9/1/2008	10/31/2021	1,953																		
	Additional Space	715	-B1400	9/1/2008	10/31/2021	16,580																		
					Total	26,213	45,729.59		4,329.87		285.00													
715 -B0200	DEPT OF INDUSTRIAL RELATIONS			12/1/2010	11/302018	16,334	57,688.53	21.0203					ESC								REN	12/1/2011	59,419.19	21.6509
													TAX								REN	12/1/2012	61,201.76	22.3005
																					REN	12/1/2013	63,037.82	22.9695
																					REN	12/1/2014	68,138.68	24.8281
																					REN	12/1/2015	71,034.58	25.8833
																					REN	12/1/2016	74,053.55	26.9833
																					REN	12/1/2017	77,200.82	28.1301
	Additional Space	715	-B0300	12/1/2010	11/30/2018	16,599																		
					Total	32,933	57,688.53		0.00		0.00													
715 -B0400	MANAGEMENT OFFICE			2/8/2003	12/31/2011	2,359							ESC											
													TAX											
715 -B0700	DEPT OF VETERANS AFFAIRS			8/1/2010	7/31/2015	16,599	36,401.61	26.3160									1	60	PSF		REN	8/1/2012	37,976.69	27.4547
																					REN	8/1/2013	39,584.08	28.6167
																					REN	8/1/2014	41,224.75	29.8028
715 -B0800	CROWELL, WEEDON & CO.			1/12/2011	6/30/2021	6,818	13,636.00	24.0000			90.00		ESC	2011	1.4781	95	1	60	FMV		ANT	2/1/2012	180.00	0.3168
													TAX	2011	1.4781						REN	1/12/2012	14,045.08	24.7200
																					REN	1/12/2013	14,466.43	25.4616
																					REN	1/12/2014	14,900.43	26.2255
																					REN	1/12/2015	15,347.44	27.0122
																					REN	1/12/2016	15,807.86	27.8226
																					REN	1/12/2017	16,282.10	28.6573
																					REN	1/12/2018	16,770.56	29.5170
																					REN	1/12/2019	17,273.68	30.4025
																					REN	1/12/2020	17,791.89	31.3146
																					REN	1/12/2021	18,325.64	32.2540
715 -B0850	DEPT.OF INDUSTRIAL RELATIONs			12/1/2010	11/30/2018	7,737	13,013.82	20.1843					ESC								REN	12/1/2011	13,404.24	20.7898
													TAX								REN	12/1/2012	13,806.36	21.4135
																					REN	12/1/2013	14,220.56	22.0559
																					REN	12/1/2014	15,371.25	23.8406
																					REN	12/1/2015	16,024.53	24.8539
																					REN	12/1/2016	16,705.57	25.9102

200 OCEANGATE LLC
9/19/2011

Suite Id	Tenant Name	Rent Dates Start	Rent Dates Expire	GRA Square Footage	Monthly Base Rent	Annual Rate PSF	Monthly Cost Recovey	Expense Stop	Monthly Other Income	Security Deposit	Base Escalation Cat	Year	Pct	G/U %	Options Nc	Term	Amount	Lead	Future Rent Increases Cat	Date	Monthly	AmoiPSF
																			REN	12/1/2017	17,415.56	27.0113
715 -B0870	PERONA, LANGER, BECK, SERBIN &	8/15/2011	11/30/2016	838						5,974.56	ESC	2011	.182	95					REN	12/15/2011	1,717.90	24.6000
											TAX	2011	.182	95					REN	8/15/2012	1,769.44	25.3380
																			REN	8/15/2013	1,822.52	26.0981
																			REN	8/15/2014	1,877.20	26.8811
																			REN	8/15/2015	1,933.51	27.6875
																			REN	8/15/2016	1,991.52	28.5182
																			REN	12/1/2016	3,485.16	49.9068
715 -B0910	J.PEREZ ASSOCIATES, INC.	7/1/2008	8/31/2013	6,516	15,508.08	28.5600	518.42		557.00	16,094.52	ESC	2008	1.418	95	1	60	FMV		REN	9/1/2012	16,094.52	29.6400
											TAX	2008	1.418									
715 -B1100	AECOM TECHNICAL SERVICES	12/15/2003	12/31/2013	16,580	150,727.50	25.2000	17,346.19			300,000.00	ESC	2004	15.6156	95								
											TAX	2004	15.6156									
	Additional Space 715 -B0500	12/15/2003	12/31/2013	16,575																		
	Additional Space 715 -B0600	12/15/2003	12/31/2013	16,575																		
	Additional Space 715 -B0930	12/15/2003	12/31/2013	3,115																		
	Additional Space 715 -B0980	12/15/2003	12/31/2013	2,350																		
	Additional Space 715 -B1000	12/15/2003	12/31/2013	16,580																		
			Total	71,775	150,727.50		17,346.19		0.00													
715 -B1200	PACIFIC MARITIME ASSOCIATION	11/1/2008	10/31/2018	16,580	36,938.42	26.7347	1,319.83				ESC	2008	3.61	95					REN	11/1/2011	38,046.57	27.5367
											TAX	2008	3.61						REN	11/1/2012	39,187.97	28.3628
																			REN	11/1/2013	40,363.60	29.2137
																			REN	11/1/2014	41,574.51	30.0901
																			REN	11/1/2015	42,821.75	30.9928
																			REN	11/1/2016	44,106.40	31.9226
																			REN	3/1/2018	45,429.59	32.8803
715 -CAPDE	APB CAR WASH & DETAILING SPEC	8/15/2011	12/31/2011	1	350.00	4,200.0000				700.00												
715 -CCUPS	UNITED PARCEL SERVICE, INC.	2/22/2011	2/1/2012	1																		
715 -CDIRE	DEPT OF INDUSTRIAL RELATIONS	1/12/2010	11/30/2018	1																		
715 -CTCLA	TCG LOS ANGELES, INC.	1/20/2010	1/19/2015	1											1	60	FMV	365.00	SAT	1/20/2012	324.48	3,893.71
																			SAT	1/20/2013	337.46	4,049.50
																			SAT	1/20/2014	350.96	4,211.50
715 -CXOCO	XO COMMUNICATIONS, INC.	12/28/2010	12/31/2011	1											1	60						
	Totals:	Occupied Sqft:	88.77%	409,481	820,991.43		54,025.00		2,109.75	352,435.88												
		Vacant Sqft:	11.23%	51,784	(12 Units)																	
		Total Sqft:		461,265	(63 Units)																	

Suite Id	Tenant Name	Rent Dates Start	Expire	GRA Square Footage	Monthly Base Rent	Annual Rate PSF	Monthly Cost Recovey	Expense Stop	Monthly Other Income	Security Deposit	Base Escalation Cat	Year	Pct	G/U %	Options Nc	Term	Amount	Lead	Future Rent Increases Cat	Date	Monthly AmoiPSF
	Total 200 OCEANGATE LLC:	Occupied Sqft:	88.77%	409,481	820,991.43		54,025.00		2,109.75	352,435.88											
		Vacant Sqft:	11.23%	51,784	(12 Units)																
		Total Sqft:		461,265	(63 Units)																
	Grand Total:	Occupied Sqft:	88.77%	409,481	820,991.43		54,025.00		2,109.75	352,435.88											
		Vacant Sqft:	11.23%	51,784	(12 Units)																
		Total Sqft:		461,265	(63 Units)																

200 OCEANGATE LLC **Date 9/19/11**

Exhibit C —License Agreements

Licensee	Commencement Date	Expiration Date	Monthly Rental Revenue	Termination	Comments
Captivate Network	11/30/2000	11/29/2015	Variable	Licensor can terminate with 30 days written notice.	7% of ad revenue. One 5 year option remaining.
Direct America	11/30/2006	MTM	Variable	Mutual Option: 30 days written notice	License fee is 10% net profit
UPS	2/2/2011	2/1/2012	$ 22.92 [1]	n/a	
Rocket Internetworking	11/1/2010	2/28/2016	$ 600	Licensor can terminate with 30 days written notice with sale of the building. Licensee can terminate with 30 days written notice if unable to obtain a permit	
TCG (AT&T)	1/20/2010	1/19/2015	$ 312	30 days written notice if licensee is unable to obtain a permit	One 5 year option remaining.
XO Communications [2]	12/29/2000	12/31/2011	$ 455.00	Mutual Option: 15 days written notice if either party is in default	

Notes:

1 — This is paid annually at a rate of $275 a year.

2 — XO Communications has not indicated a desire to renew.

200 OCEANGATE LLC **Date 9/19/11**

Aged Delinquencies & Prepayments — Exhibit C

A Negative Number Represents a Prepaid balance.

Tenant		Amount	Current	30 Days	60 Days	90 Days	120 Days
Molina Health Care		$ 7,982.88	$ 7,982.88	$ —	$ —	$ —	$ —
Conectateya, Inc	1	$ 5,291.21		$ —	$ —	$ —	$5,291.21
Perona, Langer, Beck & Serbin	2	$ (1,717.90)	$ (1,717.90)	$ —	$ —	$ —	$ —
Department of Industrial Relations	3	$ 87,269.20	$ 87,269.20	$ —	$ —	$ —	$ —
Department of Veterans Affairs	3	$ 40,401.61	$ 40,401.61	$ —	$ —	$ —	$ —
AECOM		$(68,661.21)	$(68,661.21)	$ —	$ —	$ —	$ —
California Costal Commission	3	$ 15,730.14	$ 15,730.14	$ —	$ —	$ —	$ —
California State Lands	3	$ 29,197.35	$ 29,197.35	$ —	$ —	$ —	$ —
Rocket Internetworking		$ 15,336.21	$ 12,707.43		$2,628.78		
XO Communications		$ (2,680.48)	$ (2,680.48)	$ —	$ —	$ —	$ —
High Rise Goodies		$ 5,738.78	$ 5,738.78	$ —	$ —	$ —	$ —
Total		**$ 133,887.79**	**$ 125,967.80**	**$ —**	**$ 2,628.78**	**$ —**	**$ 5,291.21**

Notes:

1 — This tenant is no longer in occupancy at the building

2 — Perona, Langer, Bech & Serbin is a new tenants to building has prepaid rent.

3 — The State and Federal Government pays their rent in arrears.

EXHIBIT D

FORM OF TENANT ESTOPPEL

TO: MOLINA CENTER, LLC [Lender]

Re: Suite , , (the "**Premises**")

This estoppel certificate is delivered by the undersigned ("**Tenant**") to MOLINA CENTER LLC, a Delaware limited liability company ("**Buyer**") in connection with its contemplated purchase of certain real property commonly known as 200 & 300 Oceangate, Long Beach, California (the "**Property**") from 200 Oceangate, LLC, a Delaware limited liability company ("**Landlord**") and to ("**Lender**") in connection with its making of a loan to Buyer to finance Buyer's purchase of the Property, which loan will be secured by a deed of trust (the "**Deed of Trust**") on the Property. Tenant hereby certifies the following information on which Buyer may rely in connection with its purchase of the Property, Lender may rely in connection with its making a loan secured by the Property, and Landlord may rely in connection with its sale of the Property to Buyer:

1. The undersigned is the tenant in possession of the Premises under a written lease with Landlord, dated , , **[as amended by]**, which lease **[as amended]** (the "**Lease**") is in full force and effect and each provision of which is binding on Tenant in accordance with its terms. The Lease has not been modified or amended in writing or orally or by course of conduct, except as specifically set forth above, and contains the entire understanding and agreement between Tenant and Landlord concerning the Premises. A true, complete and accurate copy of the Lease is attached hereto as Exhibit A.

2. The Premises consist of approximately **[net rentable]** or **[gross]** square feet of **[office] [retail]** space.

3. The term of the Lease commenced on and terminates on .

4. Current monthly base rent under the Lease is . **[Percentage rent of is due [annually or quarterly]]**. Base rent has been paid through the period ending . The Lease provides for the monthly rent to increase as follows: . As of the date hereof, Tenant has no existing right to free rent, partial rent, rent rebate, credit for improvements, rent abatement, or other rental concessions or any right to payments from Landlord to Tenant except as follows: .

5. The Lease requires Tenant to pay its pro rata share of increases in real estate taxes and operating expenses for the Property and appurtenant property over the **[base year real estate taxes and operating expenses of $]** or **[expense stop of $]**. Tenant's pro rata share of increases in common area operating expenses is

. For the calendar year , Tenant is obligated to pay monthly estimated amounts for real estate tax and operating expense increases of $, and has paid such estimates through the period ending . Tenant is owed no refund of real estate taxes or operating expense payments made for prior calendar years.

6. Tenant has no option to extend or to renew the term of the Lease, except as follows: .

7. The Lease contains no right of first refusal or offer to lease additional space, option to expand, option to terminate the Lease, or right of first refusal or offer or option to purchase the Property or any interest therein, except as follows: .

8. The actual cash amount of the security deposit currently held by Landlord is $. Landlord holds no other funds or deposits of cash or property for Tenant's account.

9. Tenant is not, and to the best of Tenant's knowledge Landlord is not, in default under any provision of the Lease nor has any event occurred which with the passage of time or giving of notice, or both, would constitute a default on the part of Tenant or Landlord, both parties having fully performed the obligations required to be performed by each party thereunder through the date hereof. Tenant asserts no claim of default against Landlord or any other person or offset or defense against the payment of rent or other charges payable by Tenant or the performance of any other obligations by Tenant under the Lease.

10. The Premises have been delivered to Tenant in accordance with the terms of the Lease, Tenant has accepted the Premises, and Landlord has fully completed all construction and improvements to the Premises required to be completed by Landlord under the Lease. Landlord has fulfilled all obligations to finance or provide an allowance or reimbursement for improvements to the Premises.

11. The Lease entitles Tenant to the **[non-exclusive]** or **[exclusive]** use of parking spaces at the Property.

12. Tenant has not assigned its rights under the Lease or sublet any portion of the Premises, or entered into any licenses or other agreements permitting occupancy of any portion of the Premises by any person or company other than Tenant. Tenant is in occupancy of the Premises.

13. Tenant has not (i) made a general assignment for the benefit of creditors, (ii) filed any voluntary petition in bankruptcy or suffered the filing of an involuntary petition by Tenant's creditors, (iii) suffered the appointment of a receiver to take possession of all or substantially all of Tenant's assets, (iv) suffered the attachment or other judicial seizure of all, or substantially all, of Tenant's assets or (v) admitted in writing its inability to pay its debts as they come due and no such proceeding is contemplated by Tenant or pending.

14. All insurance required of Tenant under the Lease has been obtained by Tenant and all premiums have been paid.

15. Tenant has not assigned, hypothecated, granted a security interest or pledged its interest in the Lease to any person or entity.

16. Tenant's current address for Notices is:

_____

_____

_____

17. Since taking possession of the Premises, Tenant has not received any written notice that the Premises or Tenant's use of the Premises violates any applicable law, regulation, ordinance or directive of any governmental authority or agency or insurance company, which violation has not been cured.

18. Since taking possession of the Premises, Tenant has not stored, generated, manufactured, refined, treated, transported, disposed or in any way used materials which are considered hazardous substances or wastes under applicable environmental laws and regulations (including, without limitation, petroleum or petroleum by-products) at the Premises or on any other part of the Property, except for de minimus quantities incidental to the cleaning or operation of Tenant's business.

19. Tenant is not identified on the list of specially designated nationals and blocked persons subject to financial sanctions that is maintained by the U.S. Treasury Department, Office of Foreign Assets Control (http://www.treas.gov/offices/enforcement/ofac/sdn/t11sdn.pdf) and any other similar list maintained by the Office of Foreign Assets Control pursuant to any authorizing United States law, regulation or Executive Order of the President of the United States ("OFAC List") nor is Tenant subject to trade embargo or economic sanctions pursuant to any authorizing United States law, regulation or Executive Order of the President of the United States.

20. Tenant understands that a condition of the Loan may require Lender's consent to any future amendment, waiver, expansion or renewal (except for expansion or renewal rights currently permitted to Tenant by the express terms of the Lease), and no modification, waiver, expansion or renewal made without Lender's written consent will be enforceable.

21. Tenant understands that a condition of the Loan may prohibit Landlord from accepting Tenant's rent more than 30 days prior to its due date, and no payment of rent by Tenant more than 30 days in advance will be binding on Lender.

Tenant agrees for a period of thirty (30) days from the date hereof to notify Landlord, Buyer and Lender in writing of any changes to the statements made by Tenant in this certificate promptly upon Tenant's learning of each such change.

The statements made herein shall be binding upon us, our successors and assigns, and shall inure to your benefit and the benefit of your successors and assigns. The officers executing this letter have been duly empowered to do so on behalf of the undersigned.

Dated:_____

Very truly yours,

By: _____
Name: _____
Its: _____

EXHIBIT E

SERVICE CONTRACTS

[See attached]

200 Oceangate
VENDOR CONTRACTS

Exhibit E — Assumed Contracts

	Company Name	Phone	Contract Start	Contract End	Cancellation	Renewal
1	**Able Engineering** 3300 W. Macarthur Blvd Santa Ana, CA 92704		11/1/2007	M-M	30 days written	N/A
2	**ABM Janitorial/Stone Maint** 5200 S. Eastern Avenue Los Angeles, CA 90040	(323) 727-7497	2/8/1999	M-M	Anytime	N/A
3	**American City Pest Con.** 614 W. 184th Street Gardena, CA 90248 (310) 346-1175 cell	(800) 842-3181	6/1/1999	M-M	30 days written	N/A
4	**Ampco System Parking** 165 Technology Dr. West Irvine, CA 92618	(949) 226-9760	12/1/1998	M-M	30 days written	N/A
5	**Arrowhead (Nestle)** 13109 S. Budlong Avenue Gardena, CA 90247 local office	(800) 950-9393	2/7/2006	M-M	30 days written	Automatic 12 months unless 30 days notice to terminate

200 Oceangate
VENDOR CONTRACTS

	Company Name	Phone	Contract Start	Contract End	Cancellation	Renewal
6	**Associated Group** I610 E. McFadden Ave Santa Ana, CA 92705	(714) 558-6100	10/1/1998	M-M	30 days written	N/A
7	**Cogent Communications** 1015 31st St. NW Washington, DC 20007	(212) 625-4769	7/21/2008	7/20/2010	30 days written	Automatic 12 months unless 30 day notice to terminate
8	**First Choice Coffee Services** 7373 Flores Street Downey, CA 90242	(562) 940-9401	10/26/2010	10/25/2012	30 days written	N/A
9	**Kinemetrics Systems** 222 Vista Avenue Pasadena, CA 91107	(626) 795-2220	10/1/2001	12/31/2010	30 days written	Not noted
10	**Master Environmental** (formerly Trashmaster) 17890 Castleton Street, Ste 311 City of Industry, CA 91748	(626) 839-5551	3/5/1993	3/4/2013	verbal 30 day	Automatic 2 yr
11	**Matsunaga Landscape** 13262 Cromwell Drive Tustin, CA 92780	(714) 541-0823	1/1/2004	M-M	30 day written	N/A

	Company Name	Phone	Contract Start	Contract End	Cancellation	Renewal
12	**Montgomery Technologies, LLC** 88 Keamy Street, 4th Floor San Francisco, Ca 94108	(866) 824-8362	1/1/2008	12/31/2012	30 days written for cause @n/c no cause @50% of the product of all License Revn times 3. Cancellable on sale of bldg/with 30 days	None
13	**Otis Elevator** 5 Year Serv Contract 711 E. Ball Rd, Ste 200 Anaheim, CA 92805 BRC# SAN391-400 Cont# SAN5081	(714) 563-7108	10/1/2010	9/30/2015	30 days written	
14	**PyroComm** 15531 Container Lane Huntington Bch, 92649	(714) 902-8000	1/1/2010	12/31/2011	30 days written	N/A
15	**Sky Rider Equipment** 1180 N. Blue Gum street Anaheim, CA 92806	(714) 632-6890	11/1/2009	10/31/2010	30 days written	M-M
16	**United Building Services (Able)** 3300 MacArthur Blvd. Santa Ana, CA 92704 (Janitorial)	(714) 434-9494	10/1/2003	9/30/2011	30 days written	Automatic 1 yr

	Company Name	Phone	Contract Start	Contract End	Cancellation	Renewal
17	**United Building Services (Able)** 3300 MacArthur Blvd. Santa Ana, CA 92704 (Window cleaning)	(714) 434-9494	8/22/2011	8/21/2012	30 days written	M-M
18	**Universal Protection Serv.** 340 Golden Shore, Suite 100 Long Beach, CA 90802	(562) 981-5700	11/1/2003	M-M	30 days written/ registered mail	N/A

Exhibit E-1 — Non-Terminatable Contracts

	Company Name	Phone	Contract Start	Contract End	Cancellation	Renewal
1	**Master Environmental** (formerly Trashmaster) 17890 Castleton Street, Ste 311 City of Industry, CA 91748	(626) 839-5551	3/5/1993	3/4/2011	Not noted	2 Years Automatic
2	**Serv-wel Disposal & Recycling** 901 S. Maple Avenue Moritebello, CA 90640	(323) 726-4056	4/1/2005	3/31/2011	90 days certified anytime before end of term	Automatic 2 Years
3	**Telepacific (formerly Mpower)** 9166 Anaheim Place Suite 100 Rancho Cucamonga, CA 91730	(909) 945-8421	5/27/2004	5/26/2012	90 days written anytime before end of term	Automatic 2 Years --

EXHIBIT F

GRANT DEED

RECORDING REQUESTED BY
AND WHEN RECORDED MAIL TO:

_____
_____
_____
_____

Space Above this Line for Recorder's Use

APN: 7278-003-035 and 7278-003-036

DOCUMENTARY TRANSFER TAX:
$ SEE SEPARATE STATEMENT

☐ computed on the full value of the interest or property conveyed; or

☐ computed on the full value less value of liens or encumbrances

GRANT DEED

THIS GRANT DEED is made and entered into this day of , 20 , by 200 OCEANGATE, LLC, a Delaware limited liability company ("**Grantor**"), in favor of MOLINA CENTER, LLC, a Delaware limited liability company (" **Grantee**").

W I T N E S S E T H :

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, GRANTOR hereby GRANTS to Grantee that certain real property in the County of Los Angeles, California (the "**Property**") more particularly described as follows:

LEGAL DESCRIPTION IS ATTACHED HERETO AS
EXHIBIT A AND INCORPORATED HEREIN BY THIS
REFERENCE.

The foregoing grant is expressly subject to all matters of record as of the date hereof and those certain unrecorded matters identified and described in Exhibit B attached hereto and incorporated herein by this reference.

EXECUTED as of the day and year set forth above.

GRANTOR:

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.
a Delaware corporation
its Manager

By: _____
Jeanne R. Myerson
President

[ALL SIGNATURES TO BE ACKNOWLEDGED]

CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT

File No:
APN No:

STATE OF **California**)SS
COUNTY OF _____)

On _____ before me, _____ , Notary Public, personally appeared

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

This area for official notarial seal.

OPTIONAL SECTION
CAPACITY CLAIMED BY SIGNER

Though statute does not require the Notary to fill in the data below, doing so may prove invaluable to persons relying on the documents.

- ☐ INDIVIDUAL
- ☐ CORPORATE OFFICER(S) TITLE(S)
- ☐ PARTNER(S) ☐ LIMITED ☐ GENERAL
- ☐ ATTORNEY-IN-FACT
- ☐ TRUSTEE(S)
- ☐ GUARDIAN/CONSERVATOR
- ☐ OTHER

SIGNER IS REPRESENTING:

Name of Person or Entity	Name of Person or Entity

OPTIONAL SECTION

Though the data requested here is not required by law, it could prevent fraudulent reattachment of this form.

THIS CERTIFICATE MUST BE ATTACHED TO THE DOCUMENT DESCRIBED BELOW

TITLE OR TYPE OF DOCUMENT: _____
NUMBER OF PAGES DATE OF DOCUMENT
SIGNER(S) OTHER THAN NAMED ABOVE _____

EXHIBIT A TO GRANT DEED

DESCRIPTION OF PROPERTY

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGLES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURface OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY AND ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 and 7278-003-036

EXHIBIT B TO GRANT DEED

OFF-RECORD MATTERS

1. All matters which a correct survey of the Property would disclose.
2. All matters which could be ascertained by a physical inspection of the Property.
3. A lien for non-delinquent taxes for real property and personal property, and any non-delinquent general or special assessments against the Property.
4. Zoning ordinances and regulations and any other laws, ordinances or governmental regulations restricting, regulating or relating to the use, occupancy or enjoyment of the Property.

EXHIBIT G

BILL OF SALE AND GENERAL ASSIGNMENT

THIS BILL OF SALE AND GENERAL ASSIGNMENT ("**Assignment**") is executed as of the day of , 20 , by 200 OCEANGATE, LLC, a Delaware limited liability company ("**Seller**") in favor of MOLINA CENTER LLC, a Delaware limited liability company (" **Buyer**").

RECITALS

A. Reference is made to certain real property and the improvements thereon commonly known as 200 & 300 Oceangate, Long Beach, California, which real property is more thoroughly described in attached Schedule I (the " **Property**"). Concurrently herewith, Seller is selling to Buyer and Buyer is purchasing from Seller all of Seller's interest in the Property pursuant to that certain Purchase Agreement dated as of , 2011, between Seller and Buyer, providing for the sale of the Property (the "**Purchase Agreement**"). Initially capitalized terms used herein but not otherwise defined herein shall have the meanings given them in the Purchase Agreement; and

B. In connection with the sale of the Property to Buyer, Seller desires to assign and transfer to Buyer all of Seller's interest in the Leases, Service Contracts, Personal Property, Approvals and Warranties.

IN CONSIDERATION OF THE FOREGOING, and for other good and valuable consideration, Seller agrees as follows:

1. Seller hereby grants, conveys, assigns and transfers to Buyer all of Seller's rights, title and interest in the leases referenced on Schedule II hereto and the service, utility, management, maintenance and other contracts or agreements listed on Schedule III hereto.

2. Concurrently herewith, Seller has assigned and delivered to Buyer the security deposits listed on Schedule II hereto.

3. Subject to the terms of the Purchase Agreement, including the representations, warranties and covenants by Seller therein and the waivers, releases and covenants by Buyer therein, Buyer hereby assumes all of Seller's obligations under the leases referenced on Schedule II hereto, acknowledges receipt of all of the security deposits listed on Schedule II hereto, and assumes all of Seller's obligations under the service, utility, management, maintenance and other contracts or agreements listed on Schedule III hereto.

4. Seller hereby grants, transfers and conveys to Buyer all of Seller's interest in:

(a) all personal property described on Schedule IV hereto; and

(b) all transferable or assignable certificate(s) of occupancy, building or equipment permits, consents, authorizations, variances, waivers, licenses, permits, certificates and approvals from any governmental or quasi-governmental authority with respect to the Land or the Improvements, and all transferable or assignable warranties, representations, guaranties, and miscellaneous rights relating to the ownership, development, use and operation of the Land and Improvements.

5. Buyer acknowledges and agrees that the Leases, Service Contracts, Personal Property, Approvals and Warranties assigned, transferred and conveyed hereby are being assigned, transferred, and conveyed "AS IS, WHERE IS" subject to, and in accordance with, the terms of Section 8 of the Purchase Agreement.

6. Any disputes under this Assignment shall be arbitrated in accordance with the provisions of Section 15 of the Purchase Agreement. In the event of any arbitration or litigation between the parties, whether based on contract, tort or other cause of action or involving bankruptcy or similar proceedings, in any way related to this Agreement, the non-prevailing party shall pay to the prevailing party all reasonable attorneys' fees and costs and expenses of any type, without restriction by statute, court rule or otherwise, incurred by the prevailing party in connection with any action or proceeding (including arbitration proceedings, any appeals and the enforcement of any judgment or award), whether or not the dispute is litigated or prosecuted to final judgment. The "prevailing party" shall be determined based upon an assessment of which party's major arguments or positions taken in the action or proceeding could fairly be said to have prevailed (whether by compromise, settlement, abandonment by the other party of its claim or defense, final decision, after any appeals, or otherwise) over the other party's major arguments or positions on major disputed issues.

7. The terms of this Assignment shall bind and inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns.

8. The parties agree to execute such other documents and perform such other acts as may be necessary or desirable to carry out the purposes of this Assignment. This Assignment may be signed in any number of counterparts with the same effect as if the signatures to each counterpart were upon a single instrument. All counterparts shall be deemed an original of this Assignment.

IN WITNESS WHEREOF, the parties have executed this Assignment as of the date and year first above written.

SELLER:

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.
a Delaware corporation
its Manager

By: _____
Jeanne R. Myerson
President

BUYER:

MOLINA CENTER LLC, a Delaware limited liability company

By: Molina Healthcare, Inc., a Delaware corporation

By: _____
Name: _____
Title: _____

SCHEDULE II TO BILL OF SALE AND GENERAL ASSIGNMENT

LIST OF LEASES AND SECURITY DEPOSITS

SCHEDULE III TO BILL OF SALE AND GENERAL ASSIGNMENT

LIST OF SERVICE CONTRACTS

SCHEDULE IV TO BILL OF SALE AND GENERAL ASSIGNMENT

ITEMIZATION OF PERSONAL PROPERTY

EXHIBIT H

FIRPTA AFFIDAVIT

Section 1445 of the Internal Revenue Code provides that a buyer of a U.S. real property interest must withhold tax if the seller is a foreign person. To inform MOLINA CENTER LLC, a Delaware limited liability company (the "**Buyer**"), that withholding tax is not required upon the disposition of a U.S. real property interest by 200 OCEANGATE, LLC, a Delaware limited liability company (the "**Seller**"), the undersigned hereby certifies the following on behalf of Seller:

1. Seller is not a foreign corporation, foreign partnership, foreign trust or foreign estate (as those terms are defined in the Internal Revenue Code and Income Tax Regulations);

2. Seller's U.S. employer identification number is ; and

3. Seller's office address is: 220 Montgomery Street, 20th Floor
San Francisco, CA 94104

4. I, understand that this certification may be disclosed to the Internal Revenue Service by the Buyer and that any false statement I have made here could be punished by fine, imprisonment or both.

Under penalties of perjury, I declare that I have examined this certification and to the best of my knowledge and belief it is true, correct and complete, and I further declare that I have authority to sign this document on behalf of Seller.

Dated: January , 201

By: _____
(Individual Signatory)

Name: _____
Title: Authorized Representative for Seller

EXHIBIT I

FORM OF NOTICE TO TENANTS

(tenant's name and address)

_____

_____

Re: Purchase of the building located at 200 & 300 Oceangate, Long Beach, California (" **Property**"), by Molina Center LLC, a Delaware limited liability company ("**New Owner**")

Dear Sir or Madam:

We hereby notify you that we have sold the Property, in which you are a tenant, and assigned your lease to New Owner, effective as of . New Owner will be your landlord effective immediately.

Prior to such sale, we were holding a security deposit from you under your lease in the amount of $, which amount has been transferred to New Owner.

From this date forward you are authorized and directed to make any payment due to the landlord under your lease to New Owner, which should be delivered to its managing agent, , at the following address: . Your checks should be made payable to New Owner.

New Owner and are looking forward to working with you.

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.
a Delaware corporation
its Manager

By: _____
Jeanne R. Myerson
President

Date: _____

EXHIBIT J

FORM OF OWNER'S AFFIDAVIT

OWNER'S AFFIDAVIT

The undersigned first being duly sworn, deposes and says:

1. That they are the owner of the certain real property in the State of California, described in your Commitment for Title Insurance or Preliminary Title Report No.

2. That the land is improved by a:

   ( ) Office Building

   ( ) Commercial Building

   ( ) Industrial Building

   ( ) Other:

3. First American Title Insurance Company (referred to as "First American") has been requested to issue a form of policy of title insurance showing as an exception to title in Schedule B therein all existing leases affecting the real property referred to above and described in the Commitment/Preliminary Title Report issued in connection with this transaction.

   In addition to any other requirements it may have, First American has requested that the undersigned provide it with a certified list of all of the lessees under existing leases.

   Therefore, in response to such request made by First American, the undersigned hereby declares that, to its knowledge, the rent roll attached hereto as Exhibit A, represents all of the lessees under all subsisting leases affecting the subject property.

   The undersigned also declares that to its knowledge, no leases contain provisions for either options to purchase or the rights of first refusal to purchase, or both, other than: the lease with Molina Healthcare, Inc.

4. That there have been no repairs, work of improvements or materials furnished to the premises by or on behalf of Grantor within 90 days, except:

   (Insert Info. or Specify "NONE", as applicable.)

   That the work of improvement, if any:

   ( ) Started on ( ) Was completed on

   ( ) Will be completed on

5. That there are no unpaid bills for labor or material because of any improvements made by or on behalf of Grantor to the above premises, except:

(Insert Info. or Specify "NONE", as applicable.)

6. That the undersigned has not received any supplemental tax bill which is unpaid.

7. That this Affidavit is given for the purpose of inducing First American Title Insurance Company and its Agents, Offices and Subsidiaries to issue its Policy(ies) of Title Insurance which may provide coverage as to the items mentioned above and that the statements made herein are true and correct to my/our own knowledge.

8. The undersigned acknowledge that they have read the foregoing and fully understand the legal aspects of any misrepresentation and/or untrue statements made herein and indemnify and hold harmless First American Title Insurance against liability occasioned by reason of reliance upon the statements made herein.

9. Grantor has not and will not, for the period commencing on the business day prior to close of escrow, at 7:30 a.m. through the recording of the Deed transferring title to the Property to the Grantee (such period is called the "Gap Period"), encumber, cause any defect to appear in the title to the Property or make any conveyance of all or any part of the Property except for the documents executed in favor of, or at the request of Grantee. Grantor agrees to hold harmless and indemnify First American Title Insurance Company ("Title Company") against all reasonable costs, expenses and attorneys' fees suffered or incurred by Title Company as a result of the failure of Grantor, upon receipt of written notice from the Title Company, to promptly remove, bond or otherwise dispose of any such encumbrance, defect or conveyance that may arise or be filed against the Property as a result of any act or omission of the Grantor during the Gap Period.

Date: _____

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.
a Delaware corporation
its Manager

By: _____
Jeanne R. Myerson
President

RENT ROLL—EXHIBIT A

( ) None

( ) Tenants based only on month-to-month rental agreements

( ) Leases as described below or attached hereto

EXHIBIT K

BUYER'S INSURANCE

[See attached]

Exhibit K

OP ID: C2

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 09/22/11

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER United Agencies, Inc. (F) CA License #0252636 P.O. Box 9 Downey, CA 90241-0009 562-373-9351 562-373-9356	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: PRODUCER CUSTOMER ID #: MOLINA1
INSURED Molina Center, LLC Molina Healthcare, Inc. Molina Healthcare of Ca., Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Continental Casualty Co. INSURER B : American Cas Co of Reading PA INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR X Contractual Liab GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PROJECT LOC			TCP2072786000	01/01/11	01/01/12	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
B	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			BUA2068803489	01/01/11	01/01/12	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000
A	UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DEDUCTIBLE X RETENTION $ 10,000			L4024356224	01/01/11	01/01/12	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		N/A				WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
**"10 Days notice of cancellation for non-payment of premium.
Additional Insured/Landlords as pertains to 200-300 Oceangate, Long Beach, CA**

CERTIFICATE HOLDER ARCO001

Arco Center
(see notepad)
300 Oceangate, Suite 400
Long Beach, CA 90802

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

NOTEPAD:	HOLDER CODE ARCO001 INSURED'S NAME Molina Center, LLC	MOLINA1 OP ID: C2	PAGE 2 DATE 09/22/11

200 Oceangate LLC, The Swig Company and Wachovia Bank

EXHIBIT L

SELLER'S INSURANCE

[See attached]

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/28/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Roger E. Lintlop
Frank Crystal & Co of CA, Inc. License #OB64537 575 Market Street San Francisco CA 94105-2852	PHONE (A/C, No, Ext): 415-946-7500 FAX (A/C, No): 415-946-7550 E-MAIL ADDRESS: lintlopr@fcrystal.com

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
SWIGCO1 200 Oceangate, LLC & The Swig Company, LLC 220 Montgomery Street, 20th Floor San Francisco, CA 94104	INSURER A: Travelers Property & Casualty Co.	36161
	INSURER B: Twin City Fire Ins. Co.	29459
	INSURER C: Federal Insurance Company	20281
	INSURER D: Fireman's Fund Insurance Co.	21873
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** 950121856 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			6606449N977TIL11	6/30/2011	6/30/2012	EACH OCCURRENCE	$1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$2,000,000
	POLICY PRO-JECT LOC							$
A	AUTOMOBILE LIABILITY			BA2A69695411CAG	6/30/2011	6/30/2012	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
D	UMBRELLA LIAB X OCCUR			SIRX00024131534	6/30/2011	6/30/2012	EACH OCCURRENCE	$50,000,000
C	EXCESS LIAB CLAIMS-MADE			79879828	6/30/2011	6/30/2012	AGGREGATE	$50,000,000
	DED RETENTION $						Excess of $50M	$50,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			57WECUJ2259	1/1/2011	1/1/2012	X WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N / N/A						E.L. EACH ACCIDENT	$1,000,000
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Arco Center- 200-300 Oceangate Avenue, Long Beach, CA 90802

CERTIFICATE HOLDER

For Information Only
.
.
. . .

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Frank Crystal & Co of California, Inc.

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY): 9/20/2011

THIS EVIDENCE OF COMMERCIAL PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

PRODUCER NAME, CONTACT PERSON AND ADDRESS Frank Crystal & Co of CA, Inc. License #OB64537 575 Market Street San Francisco, CA 94105	PHONE (A/C, No, Ext): 415-946-7500 FAX (A/C, No): 415-946-7550 E-MAIL ADDRESS: lintlopr@fcrystal.com
COMPANY NAME AND ADDRESS The Travelers P.O. Box 3556 Orlando FL 32802	NAIC NO: 36137 IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH
CODE: SUB CODE: AGENCY CUSTOMER ID #:	POLICY TYPE
NAMED INSURED AND ADDRESS 200 Oceangate, LLC & The Swig Company, LLC 220 Montgomery St. 20th Floor San Francisco CA 94104	LOAN NUMBER POLICY NUMBER: KTJCMB4265M13A11 EFFECTIVE DATE: 6/30/2011 EXPIRATION DATE: 6/30/2012 ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S)	THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION (Use REMARKS on page 2, if more space is required) ☐ BUILDING OR ☐ BUSINESS PERSONAL PROPERTY

LOCATION/DESCRIPTION
RE: 200-300 Oceangate Ave., Long Beach, CA 90802.

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

	YES	NO	N/A		
COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $500,000,000				DED: 25,000	
☐ BUSINESS INCOME ☐ RENTAL VALUE	X			If YES, LIMIT: 97,723,000	Actual Loss Sustained; # of months:
BLANKET COVERAGE	X			If YES, indicate value(s) reported on property identified above: $	
TERRORISM COVERAGE	X			Attach Disclosure Notice / DEC	
IS THERE A TERRORISM-SPECIFIC EXCLUSION?		X			
IS DOMESTIC TERRORISM EXCLUDED?	X				
LIMITED FUNGUS COVERAGE		X		If YES, LIMIT:	DED:
FUNGUS EXCLUSION (If "YES", specify organization's form used)		X			
REPLACEMENT COST	X				
AGREED VALUE	X				
COINSURANCE		X		If YES, %	
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT: Included	DED: 25,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	X				
- Demolition Costs	X			If YES, LIMIT: 10,000,000	DED:
- Incr. Cost of Construction	X			If YES, LIMIT: 10,000,000	DED:
EARTH MOVEMENT (If Applicable)		X		If YES, LIMIT:	DED:
FLOOD (If Applicable)		X		If YES, LIMIT:	DED:
WIND / HAIL (If Subject to Different Provisions)		X		If YES, LIMIT:	DED:
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS	X				

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

☐ MORTGAGEE ☐ CONTRACT OF SALE ☐ LENDERS LOSS PAYABLE NAME AND ADDRESS For Information Only c/o The Swig Company, LLC 220 Montgomery St., 20th Floor San Francisco CA 94104	LENDER SERVICING AGENT NAME AND ADDRESS AUTHORIZED REPRESENTATIVE Frank Crystal & Co of California, Inc

EVIDENCE OF COMMERCIAL PROPERTY INSURANCE REMARKS - Including Special Conditions (Use only if more space is required)

Exhibit 10.22

FIRST AMENDMENT TO PURCHASE AGREEMENT

THIS FIRST AMENDMENT TO PURCHASE AGREEMENT ("First Amendment"), dated November 10, 2011, and is made by and between 200 OCEANGATE, LLC, a Delaware limited liability company ("Seller"), and MOLINA CENTER LLC, a Delaware limited liability company (" Buyer").

Recitals

A. Seller and Buyer entered into that certain Purchase Agreement dated October 11, 2011 (the " Purchase Agreement"), whereby, upon the terms and conditions set forth therein, Seller agreed to sell and Buyer agreed to buy the Property and those associated rights and interest described in the Purchase Agreement.

B. On October 24, 2011, the California Regional Water Quality Control Board (Los Angeles Region) (" Water Board") issued a General NPDES Permit in connection with the operation of the Discharge System at the Property, a copy of which is attached hereto as Exhibit A (the "Permit").

C. Seller and Buyer now desire to amend the Purchase Agreement as set forth below.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound, the parties hereto agree that the Purchase Agreement is hereby amended as follows:

1. Additional Buyer Closing Conditions. In addition to the conditions to Closing for the benefit of Buyer set forth elsewhere in the Purchase Agreement, Buyer's obligation to purchase the Property is conditioned upon the satisfaction of each of the following conditions, each of which is for the exclusive benefit of Buyer. Buyer may, at any time or times before the Closing, waive one or more of the following conditions, but only in writing and any such waiver will not affect its rights and remedies with respect to any remaining conditions:

(i) The Permit shall be in full force and effect, shall be in the form attached hereto as Exhibit A (without modification or amendment), and Seller shall be in full compliance with the terms of the Permit.

(ii) Seller shall have submitted to the California Regional Water Quality Control Board—Los Angeles Region an NPDES Permit Transfer Form (Form No. R4-WRS #1) with respect to the Permit in the form attached as Exhibit B. If the California Regional Water Quality Control Board—Los Angeles Region (or its staff) requests any additional submissions with respect to such Permit Transfer Form prior to Closing, Seller shall provide such additional submissions.

(iii) All effluent sampling required to be performed prior to the date of Closing, pursuant to the Water Board's monitoring and reporting program prescribed by the Permit, shall have been collected and analyzed, and all such data shall have been delivered to Buyer for Buyer's review not less than three (3) business days prior to the Closing.

(iv) Discharge System effluent sampling data and analysis disclosed to Buyer after Buyer's delivery of the Approval Notice shall: (A) confirm that the effluent discharge is in full compliance with the terms and conditions of the Permit; and (B) be acceptable to Buyer in Buyer's commercially reasonable discretion.

(v) Neither the Water Board nor any other governmental or quasi-governmental agency or instrumentality shall have given any indication (either oral or written) to Seller or its consultants that: (A) the imposition of treatment and/or improvement requirements is being considered in connection with or in any way related to the operation of the Discharge System; and/or (B) any amendment, modification or revision to the Permit is being considered. If Seller or its consultants receive any indication (either oral or written) of the matters contemplated in (A) and/or (B) above, such information shall be immediately disclosed to Buyer in writing.

(vi) No claim, administrative action, enforcement action, order, or demand shall have been filed, threatened or initiated in any way related to the operation of the Discharge System, and there shall have been no challenge or threatened challenge to the Permit terms and/or conditions.

(vii) The installation of the flow meter and related improvements (collectively, "Flow Meter") necessary to comply with the Permit's continuous total waste flow monitoring requirement shall have been completed in accordance with applicable laws at Seller's expense, the Flow Meter shall be fully operational and in good working order and condition, and the Flow Meter shall be acceptable to Buyer in Buyer's commercially reasonable discretion. Buyer hereby acknowledges that installation of an Endress+Hauser Prosonic Flow Clamp On 91W Ultrasonic Flow Measuring System is acceptable. If this condition is not satisfied on or before the Closing Date, the Closing Date shall be extended until the date three (3) business days after the date this condition is satisfied or waived, provided that the Closing Date shall not be extended beyond the Outside Closing Date. If this condition has not been satisfied and Buyer elects to waive this condition, Buyer shall receive a credit at Closing in an amount equal to the cost that Seller would have otherwise incurred in connection with the installation or completion of the installation of the Flow Meter and the fact that the Flow Meter has not been installed shall not constitute a failure of the condition set forth in Section 1(i) above. If Buyer desires to so waive such condition, it shall do so not less than three (3) business days prior to the then scheduled Closing Date.

(viii) The United States of America, Department of Veterans Affairs (the "VA") shall not have given any indication (either oral or written) to Seller or its employees that the VA is not prepared to approve the assignment to Buyer of the VA's lease affecting the Property. Any demand of concessions by the VA shall be deemed to be an indication that the VA is not prepared to approve the assignment to Buyer of the VA's lease. If Seller or its employees receive any indication (either oral or written) that the VA is not prepared to approve the assignment to Buyer of the VA's lease, such information shall be immediately disclosed to Buyer in writing.

2. Closing Leasing Credit. No Closing Leasing Credit shall be due Buyer at Closing.

3. Purchase Price Reduction. Section 2 of the Purchase Agreement is amended and restated in its entirety as follows:

2. Purchase Price. The purchase price for the Property is Eighty-One Million Dollars ($81,000,000.00) (" **Purchase Price**") and shall be paid in cash by Buyer at the Closing (as defined in Section 10.1 below).

4. Notice Address for Seller. The notice address for Seller in section 17.1 of the Purchase Agreement is hereby deleted in its entirety, and replaced with the following:

Seller:	200 Oceangate, LLC c/o The Swig Company, LLC 220 Montgomery Street, 20th Floor San Francisco, CA 94104 Attn: Kennard P. Perry Telephone: (415) 291-1140 Facsimile: (415) 291-1101 Email: kperry@swigco.com
with copy to:	Farella Braun + Martel LLP 235 Montgomery Street San Francisco, CA 94104 Attn: Anthony D. Ratner Telephone: (415) 954-4448 Facsimile: (415) 954-4480 Email: tratner@fbm.com

5. Post-Closing Document Delivery. Following the Closing, Seller shall, at Buyer's request, coordinate and cooperate with Buyer in connect with the delivery and transfer to Buyer of all Documents (including, without limitation, electronic data, files and documents). This provision is in addition to, and not intended to limit, the delivery obligations of Seller in section 10.3 of the Purchase Agreement. The obligations set forth in this provision sale survive the Closing.

6. Miscellaneous. This First Amendment may be executed in counterparts, including facsimile counterparts or scanned and emailed counterparts, each of which shall be deemed an original, and all of which taken together shall constitute one and the same instrument. Capitalized terms used in this First Amendment shall have the meanings set forth in the Purchase Agreement, except as otherwise defined herein. Except as specifically set forth herein, the Purchase Agreement shall be unmodified, and shall remain in full force and effect.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties have executed this First Amendment as of the date first listed above.

SELLER:

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.,
a Delaware corporation
its Manager

By: /s/ Jeanne R. Myerson
Jeanne R. Myerson
President

BUYER:

MOLINA CENTER LLC,
a Delaware limited liability company

By: Molina Healthcare, Inc., a Delaware corporation

By: /s/ John C. Molina
Name: John C. Molina
Title: Chief Financial Officer

California Regional Water Quality Control Board
Los Angeles Region
320 West Fourth Street, Suite 200, Los Angeles, California 90013
(213) 576-6600 • FAX (213) 576-6640
http://www.waterboards.ca.gov/losangeles

Matthew Rodriquez
Secretary for
Environmental Protection

Edmund G. Brown Jr.
Governor

October 24, 2011

Mr. Kennard P. Perry, Chief Financial Officer
200 Oceangate, LLC
c/o The Swig Company LLC
220 Montgomery Street, 20th Floor
San Francisco, CA 94104

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
7000 0860 0006 4858 9272

Dear Mr. Perry:

COVERAGE UNDER GENERAL NATIONAL POLLUTANT DISCHARGE ELIMINATION SYSTEM AND WASTE DISCHARGE REQUIREMENTS—200 OCEANGATE LLC., ARCO CENTER, 300 OCEANGATE BLVD., LONG BEACH, CALIFORNIA (NPDES NO. CAG994004, CI–9766)

We have completed our review of your application for a permit to discharge groundwater under the National Pollutant Discharge Elimination System (NPDES).

Based on the information provided, the proposed discharge of groundwater from the above-referenced facility meets the conditions to be regulated under Order No. R4-2008-0032, *General National Pollutant Discharge Elimination System and Waste Discharge Requirements for Discharges of Groundwater from Construction and Project Dewatering to Surface Waters in Coastal Watersheds of Los Angeles and Ventura Counties*, adopted by this Board on June 5, 2008.

Enclosed are your Waste Discharge Requirements, which also serve as your NPDES permit, consisting of Order No. R4-2008-0032 and Monitoring and Reporting Program No. CI-9761. The discharge limitations in Part V.1.Table 1 of Order No. R4-2008-0032 for the specific constituents listed on the Table with the enclosed Fact Sheet are applicable to your discharge. The groundwater discharge flows into the Pacific Ocean. Therefore, discharge limitations in Attachment B of the Order No. R4-2008-0032 are not applicable to your discharge. Prior to starting discharge, a representative sample of the effluent shall be obtained and analyzed to determine compliance with the discharge limitations.

The Monitoring and Reporting Program requires you to implement the monitoring program on the effective date of coverage under this permit. All monitoring reports should be sent to the Regional Board, ATTN: Information Technology Unit. When submitting monitoring or technical reports to the Regional Board per these requirements, please include a reference to "Compliance File No. CI-9766 and NPDES No. CAG994004", which will assure that the reports are directed to the appropriate file and staff. Also, please do not combine other reports with your monitoring reports. Submit each type of report as a separate document.

To avoid paying future annual fees, please submit written request for termination of your enrollment under the general permit in a separate letter, when your project has been completed and the permit is no longer needed.

We are sending a copy of Order No. R4-2008-0032 only to the applicant. For those on the mailing list, please refer to the Board Order sent to you previously or download a copy of the Order from our website at *http://www.waterboards.ca.gov/losangeles/board_decisions.*

If you have any questions, please contact Namiraj Jain at (213) 620-6003.

Sincerely,

Samuel Unger
Executive Officer

Enclosures:

Order No. R4-2008-0032, General NPDES Permit No. CAG994004
Fact Sheet
Monitoring and Reporting Program No. CI-9766

cc: Environmental Protection Agency, Region 9, Permit Section (WTR-5)
State Water Resources Control Board, NPDES_Wastewater@waterboards.ca.gov
U.S. Army Corps of Engineers
NOAA, National Marine Fisheries Service
Department of Interior, U.S. Fish and Wildlife Service
California Department of Fish and Game, Marine Resources, Region 5
Los Angeles County Department of Public Works, Flood Control and Drainage
Los Angeles County Department of Environmental Program
Jae Kim, Tetratech

/nj

STATE OF CALIFORNIA
CALIFORNIA REGIONAL WATER QUALITY CONTROL BOARD
LOS ANGELES REGION
320 West 4th Street, Suite 200, Los Angeles, California 90013

FACT SHEET
WASTE DISCHARGE REQUIREMENTS
FOR

200 OCEANGATE LLC
ARCO CENTER, LONG BEACH
(ORDER NO. R4-2008-0032)
NPDES NO. CAG994004, SERIES NO.100
CI-9766

FACILITY ADDRESS
300 Oceangate Blvd.
Long Beach, CA 90802

FACILITY MAILING ADDRESS
220 Montgomery Street
San Francisco, CA 94104

PROJECT DESCRIPTION:

200 Oceangate LLC (Discharger) proposes to discharge seepage groundwater from the subbasement parking structure located at the above referenced facility. Groundwater dewatering is necessary to protect the integrity of the building structure from rising groundwater. Reasonable Potential Analysis (RPA) of water quality data submitted indicated concentrations for arsenic and nickel at the cusp of their respective screening levels. Therefore, effluent limitations for these parameters are not appropriate. However, long term monitoring for these parameters are necessary to ensure that the concentrations for these parameters remain insignificant. The site location map is shown in Figure 1.

VOLUME AND DESCRIPTION OF DISCHARGE:

Up to 50,000 gallons per day (gpd) of groundwater will be discharged from the project to the nearby storm drain system at Discharge Point M-001(Latitude: 33°45'56.9"Longitude:118° 11'59.9"). The discharge flows into the Pacific Ocean, waters of United States.

APPLICABLE EFFLUENT LIMITATIONS

Based on the information provided in the NPDES Application Supplemental Requirements, the following constituents listed in the Table below have been determined to show reasonable potential to exist in the discharge. The discharge flows to Pacific Ocean therefore the discharge limitations in Attachment B of Order No. R4-2008-0032 are not applicable to your discharge.

This Table lists the specific constituents and effluent limitations applicable to the discharge.

Constituents	Units	Discharge Limitations	
		Daily Maximum	Monthly Average
Total Suspended Solids	mg/L	150	50
Turbidity	NTU	150	50
BOD_5 20°C	mg/L	30	20
Oil and Grease	mg/L	15	10
Settleable Solids	ml/L	0.3	0.1
Sulfides	mg/L	1.0	---
Phenols	mg/L	1.0	---
Residual Chlorine	mg/L	0.1	---
Methylene Blue Active Substances (MBAS)	mg/L	0.5	---

FREQUENCY OF DISCHARGE:

The discharge of groundwater will be intermittent and last for life of the project.

REUSE OF WATER:

In the vicinity of the project site there are no other feasible reuse options, therefore the groundwater will be discharged to the storm drain in compliance with the requirements of the attached Order.

Figure 1. Site Location Map

STATE OF CALIFORNIA
CALIFORNIA REGIONAL WATER QUALITY CONTROL BOARD
LOS ANGELES REGION

MONITORING AND REPORTING PROGRAM NO. CI-9766
FOR
DISCHARGES OF GROUDWATER FROM CONSTRUCTION AND PROJECT DEWATERING TO SURFACE WATERS
IN
COASTAL WATERSHEDS OF LOS ANGELES AND VENTURA COUNTIES

(GENERAL NPDES PERMIT NO. CAG994004, SERIES NO.100)

This Order was adopted by the Regional Water Board on:	June 5, 2008
This Order shall become effective on:	October 24, 2011
This Order shall expire on:	June 5, 2013
The U.S. Environmental Protection Agency (USEPA) and the Regional Water Board have classified this discharge as a minor discharge.	

Ordered By: Samuel Unger
Samuel Unger
Executive Officer

Date: October 24, 2011

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ATTACHMENT E - Monitoring and Reporting Program (MRP)

LIST OF TABLES

Attachment E – Monitoring and Reporting Program (MRP)

The Code of Federal Regulations section 122.48 requires that all NPDES permits specify monitoring and reporting requirements. Water Code Sections 13267 and 13383 also authorize the Regional Water Quality Control Board (Regional Water Board) to require technical and monitoring reports. This MRP establishes monitoring and reporting requirements, which implement the federal and California regulations.

I. GENERAL MONITORING PROVISIONS

A. An effluent sampling station shall be established for Discharge Point M-001 and shall be located where representative samples of that effluent can be obtained. Provisions shall be made to enable visual inspections before discharge. In the event of presence of oil sheen, debris, and/or other objectionable materials or odors, discharge shall not commence until compliance with the requirements is demonstrated. All visual observations shall be included in the monitoring report.

B. This Regional Board shall be notified in writing of any change in the sampling stations once established or in the methods for determining the quantities of pollutants in the individual waste streams.

C. Effluent samples shall be taken downstream of any addition to treatment works and prior to mixing with the receiving waters.

D. Pollutants shall be analyzed using the analytical methods described in 40 CFR §§136.3, 136.4, and 136.5 (revised March 12, 2007); or, where no methods are specified for a given pollutant, by methods approved by this Regional Water Board or the State Water Board.

E. Laboratories analyzing effluent samples and receiving water samples shall be certified by the California Department of Public Health Environmental Laboratory Accreditation Program (ELAP) or approved by the Executive Officer and must include QA/QC data in their reports. A copy of the laboratory certification shall be provided each time a new certification and/or renewal of the certification is obtained from ELAP.

F. For any analyses performed for which no procedure is specified in the USEPA guidelines or in the MRP, the constituent or parameter analyzed and the method or procedure used must be specified in the monitoring report.

G. Each monitoring report must affirm in writing that "all analyses were conducted at a laboratory certified for such analyses by the Department of Public Health or approved by the Executive Officer and in accordance with current USEPA guideline procedures or as specified in this Monitoring and Reporting Program".

H. The monitoring reports shall specify the analytical method used, the MDL, and the ML for each pollutant. For the purpose of reporting compliance with numerical limitations, performance goals, and receiving water limitations, analytical data shall be reported by one of the following methods, as appropriate:

1. An actual numerical value for sample results greater than or equal to the ML; or

2. "DNQ" if results are greater than or equal to the laboratory's MDL but less than the ML; or,

3. "ND" for sample results less than the laboratory's MDL with the MDL indicated for the analytical method used.

Analytical data reported as "less than" for the purpose of reporting compliance with permit limitations shall be the same or lower than the permit limit(s) established for the given parameter.

Current MLs (Attachment G) are those published by the State Water Resources Control Board in the *Policy for the Implementation of Toxics Standards for Inland Surface Waters, Enclosed Bays, and Estuaries of California*, March 2, 2000.

I. Where possible, the MLs employed for effluent analyses shall be lower than the permit limitations established for a given parameter. If the ML value is not below the effluent limitation, then the lowest ML value and its associated analytical method shall be selected for compliance purposes. At least once a year, the Discharger shall submit a list of the analytical methods employed for each test and associated laboratory QA/QC procedures.

The Regional Water Board, in consultation with the State Water Board Quality Assurance Program, shall establish a ML that is not contained in Attachment G to be included in the Discharger's permit in any of the following situations:

1. When the pollutant under consideration is not included in Attachment G;

2. When the Discharger and Regional Water Board agree to include in the permit a test method that is more sensitive than that specified in 40 CFR Part 136 (revised March 12, 2007);

3. When the Discharger agrees to use an ML that is lower than that listed in Attachment G;

4. When the Discharger demonstrates that the calibration standard matrix is sufficiently different from that used to establish the ML in Attachment G, and proposes an appropriate ML for their matrix; or,

5. When the Discharger uses a method whose quantification practices are not consistent with the definition of an ML. Examples of such methods are the USEPA-approved method 1613 for dioxins and furans, method 1624 for volatile organic substances, and method 1625 for semi-volatile organic substances. In such cases, the Discharger, the Regional Water Board, and the State Water Board shall agree on a lowest quantifiable limit and that limit will substitute for the ML for reporting and compliance determination purposes.

g

J. Water/wastewater samples must be analyzed within allowable holding time limits as specified in 40 CFR §136.3. All QA/QC items must be run on the same dates the samples were actually analyzed, and the results shall be reported in the Regional Water Board format, when it becomes available, and submitted with the laboratory reports. Proper chain of custody procedures must be followed, and a copy of the chain of custody shall be submitted with the report.

K. All analyses shall be accompanied by the chain of custody, including but not limited to date and time of sampling, sample identification, and name of person who performed sampling, date of analysis, name of person who performed analysis, QA/QC data, method detection limits, analytical methods, copy of laboratory certification, and a perjury statement executed by the person responsible for the laboratory.

L. The Discharger shall calibrate and perform maintenance procedures on all monitoring instruments and to insure accuracy of measurements, or shall insure that both equipment activities will be conducted.

M. The analytical laboratory shall have an acceptable written quality assurance (QA) plan for laboratory analyses. The annual monitoring report shall also summarize the QA activities for the previous year. Duplicate chemical analyses must be conducted on a minimum of ten percent (10%) of the samples, or at least one sample per sampling period, whichever is greater. A similar frequency shall be maintained for analyzing spiked samples.

N. When requested by the Regional Water Board or USEPA, the Discharger will participate in the NPDES discharge monitoring report QA performance study. The Discharger must have a success rate equal to or greater than 80%.

O. For parameters that both monthly average and daily maximum limitations are specified and the monitoring frequency is less than four times a month, the following shall apply. If an analytical result is greater than the monthly average limitation, the Discharger shall collect four additional samples at approximately equal intervals during the month, until compliance with the monthly average limitation has been demonstrated. All five analytical results shall be reported in the monitoring report for that month, or 45 days after results for the additional samples were received, whichever is later. In the event of noncompliance with a monthly average effluent limitation, the sampling frequency for that constituent shall be increased to weekly and shall continue at this level until compliance with the monthly average effluent limitation has been demonstrated. The Discharger shall provide for the approval of the Executive Officer a program to ensure future compliance with the monthly average limitation.

P. In the event wastes are transported to a different disposal site during the report period, the following shall be reported in the monitoring report:

1. Types of wastes and quantity of each type;

2. Name and address for each hauler of wastes (or method of transport if other than by hauling); and

3. Location of the final point(s) of disposal for each type of waste.

If no wastes are transported off-site during the reporting period, a statement to that effect shall be submitted.

Q. Each monitoring report shall state whether or not there was any change in the discharge as described in the Order during the reporting period.

All monitoring reports shall include the discharge limitations in the Order, tabulated analytical data, the chain of custody form, and the laboratory report (including but not limited to date and time of sampling, date of analyses, method of analysis and detection limits).

R. Sample collection requirements (as appropriate)

1. Daily samples shall be collected each day.
2. Weekly samples shall be collected on a representative day of each week.
3. Monthly samples shall be collected on a representative day of each month.
4. Quarterly samples shall be collected in February, May, August, and November.
5. Semi-annual samples shall be collected in May and November.
6. Annual samples shall be collected in November.

S. Before commencing a new discharge, a representative sample of the effluent shall be collected and analyzed for toxicity and for all the constituents listed in Fact Sheet, and the test results must meet all applicable limitations of Order No. R4-2008-0032.

II. MONITORING LOCATIONS

The Discharger shall establish the following monitoring locations to demonstrate compliance with the effluent limitations, discharge specifications, and other requirements in this Order:

Table 1. Monitoring Location

Discharge Point Name	Monitoring Location Name	Monitoring Location Description
Discharge Point 1	M-001	Wastewater effluent before contact with the receiving water and/or dilution by any other water or waste.
Discharge Point 2	M-002	If more than one discharge point is authorized under the General Permit, compliance monitoring locations shall be named M-002, M-003, etc. and shall be located so as to allow collection of wastewater effluent before contact with receiving water and/or dilution by any other water or waste.

III. EFFLUENT MONITORING REQUIREMENTS

A. The Discharger shall monitor the effluent at Discharge Point M-001 as follows.

Table 2. Monitoring Constituents

Constituent	Unit	Type of Sample	Minimum Frequency of Analysis
Total Waste Flow	gal/day	totalizer	continuously[1]
pH	pH unit	grab	monthly
Temperature	°F	grab	monthly
Total Suspended Solids	mg/L	grab	monthly
Turbidity	NTU	grab	monthly
BOD_5 20°C	mg/L	grab	monthly
Oil and Grease	mg/L	grab	monthly
Settleable Solids	ml/L	grab	monthly
Sulfides	mg/L	grab	monthly
Phenols	mg/L	grab	monthly
Total Residual Chlorine	mg/L	grab	monthly
Methylene Blue Active Substances (MBAS)	mg/L	grab	monthly
Arsenic	µg/L	grab	monthly[2]
Nickel	µg/L	grab	monthly[2]
Acute Toxicity	% survival	grab	annually

1 Record the monthly total flow and report the calculated daily average flow and monthly flow in the quarterly and annual reports, as appropriate.

2 Monthly for four quarters. If concentrations remain below significant levels, the monitoring frequency will be reduced to quarterly or could be eliminated with the approval of the Executive Officer of this Regional Board.

IV. WHOLE EFFLUENT TOXICITY TESTING REQUIREMENTS

A. Definition of Toxicity

Acute Toxicity

The MRP requires an annual test for acute toxicity which measures primarily lethal effects that occur over a 96-hour period. Acute toxicity shall be measured in percent survival measured in undiluted (100%) effluent.

B. Acute Toxicity Effluent Monitoring Program

1. The Discharger shall conduct acute toxicity tests on effluent grab samples by methods specified in 40 CFR Part 136 which cites USEPA's *Methods for Measuring the Acute Toxicity of Effluents and Receiving Waters to Freshwater and Marine Organisms*, Fifth Edition, October 2002, USEPA, Office of Water, Washington D.C. (EPA/821-R-02-012) or a more recent edition to ensure compliance in 100 % effluent.

2. The fathead minnow, *Pimephales promelas*, shall be used as the test species for fresh water discharges and the topsmelt, *Atherinops affinis*, shall be used as the test species for brackish effluent. The method for topsmelt is found in USEPA's *Short-term Method for Estimating the Chronic Toxicity of Effluents and Receiving Waters to West Coast Marine and Estuarine Organisms*, First Edition, August 1995 (EPA/600/R-95/136), or a more recent edition.

3. In lieu of conducting the standard acute toxicity testing with the fathead minnow, the Discharger may elect to report the results or endpoint from the first 48 hours of the chronic toxicity test as the results of the acute toxicity test.

4. Accelerated Toxicity Monitoring: If the results of the toxicity test yield a survival of less than 90%, then the frequency of analyses shall increase to monthly until at least three test results have been obtained and full compliance with effluent limitations has been demonstrated, after which the frequency of analyses shall revert to annually. Results of toxicity tests shall be included in the first monitoring report following sampling.

5. Effluent samples shall be collected after all treatment processes and before discharge to the receiving water.

C. Reporting

1. The Discharger shall submit a full report of the toxicity test results, including any accelerated testing conducted during the month as required by this permit. Test results shall be reported as % survival for acute toxicity test results with the self monitoring reports (SMR) for the month in which the test is conducted.

2. If an initial investigation indicates the source of toxicity and accelerated testing is unnecessary, then those results also shall be submitted with the SMR for the period in which the investigation occurred.

   a. The full report shall be submitted on or before the end of the month in which the SMR is submitted.

   b. The full report shall consist of (1) the results; (2) the dates of sample collection and initiation of each toxicity test; (3) the acute toxicity average limit.

3. Test results for toxicity tests also shall be reported according to the appropriate manual chapter on Report Preparation and shall be attached to the SMR. Routine reporting shall include, at a minimum, as applicable, for each test:

   a. Sample date(s);

   b. Test initiation date;

   c. Test species;

   d. End point values for each dilution (e.g., number of young, growth rate, percent survival);

   e. Any applicable charts; and,

   f. Available water quality measurements for each test (e.g., pH, D.O., temperature, conductivity, hardness, salinity, ammonia).

4. The Discharger shall provide a compliance summary, which includes a summary table of toxicity data from all samples collected during that year.

   The Discharger shall notify by telephone or electronically, this Regional Water Board of any toxicity exceedance of the limit or trigger within 24 hours of receipt of the results followed by a written report within 14 calendar days of receipt of the results. The verbal or electronic notification shall include the exceedance and the plan the Discharger has taken or will take to investigate and correct the cause(s) of toxicity. It may also include a status report on any actions required by the permit, with a schedule for actions not yet completed. If no actions have been taken, the reasons shall be given.

V. LAND DISCHARGE MONITORING REQUIREMENTS

Not Applicable.

VI. RECLAMATION MONITORING REQUIREMENTS

Not Applicable.

VII. RECEIVING WATER MONITORING REQUIREMENTS – SURFACE WATER AND GROUNDWATER

Not Applicable.

VIII. OTHER MONITORING REQUIREMENTS

Not Applicable.

IX. REPORTING REQUIREMENTS

A. General Monitoring and Reporting Requirements

1. The Discharger shall comply with all Standard Provisions (Attachment D) related to monitoring, reporting, and recordkeeping.

2. If there is no discharge during any reporting period, the report shall so state.

3. Each monitoring report shall contain a separate section titled "Summary of Non-Compliance" which discusses the compliance record and corrective actions taken or planned that may be needed to bring the discharge into full compliance with waste discharge requirements. This section shall clearly list all non-compliance with waste discharge requirements, as well as all excursions of effluent limitations.

4. The Discharger shall inform the Regional Water Board well in advance of any proposed construction activity that could potentially affect compliance with applicable requirements.

B. Self Monitoring Reports (SMRs)

1. At any time during the term of this permit, the State or Regional Water Board may notify the Discharger to electronically submit Self-Monitoring Reports (SMRs) using the State Water Board's California Integrated Water Quality System (CIWQS) Program Web site (http://www.waterboards.ca.gov/ciwqs/index.html). Until such notification is given, the Discharger shall submit hard copy SMRs. The CIWQS Web site will provide additional directions for SMR submittal in the event there will be service interruption for electronic submittal.

2. The Discharger shall report in the SMR the results for all monitoring specified in this MRP. The Discharger shall submit SMRs including the results of all required monitoring using USEPA-approved test methods or other test methods specified in this Order. If the Discharger monitors any pollutant more frequently than required by this Order, the results of this monitoring shall be included in the calculations and reporting of the data submitted in the SMR.

3. Monitoring periods and reporting for all required monitoring shall be completed according to the following schedule:

Table 3. Monitoring Periods and Reporting Schedule

Sampling Frequency	Monitoring Period Begins On	Monitoring Period	SMR Due Date
Continuous	October 24, 2011	All	Submit with quarterly SMR
Weekly	Sunday following permit effective date or on permit effective date if on a Sunday	Sunday through Saturday	Submit with quarterly SMR
Monthly	First day of calendar month following permit effective date or on permit effective date if that date is first day of the month	1st day of calendar month through last day of calendar month	Submit with quarterly SMR
Quarterly	Closest of January 1, April 1, July 1, or October 1	January 1 through March 31. April 1 through June 30. July 1 through September 30. October 1 through December 31	45 days from the end of the monitoring period
Annually	January 1	January 1 through December 31	45 days from the end of the monitoring period

4. Reporting Protocols. The Discharger shall report with each sample result the applicable Reporting Level (RL) and the current Method Detection Limit (MDL), as determined by the procedure in Part 136.

   The Discharger shall report the results of analytical determinations for the presence of chemical constituents in a sample using the following reporting protocols:

   a. Sample results greater than or equal to the RL shall be reported as measured by the laboratory (i.e., the measured chemical concentration in the sample).

   b. Sample results less than the RL, but greater than or equal to the laboratory's MDL, shall be reported as "Detected, but Not Quantified," or DNQ. The estimated chemical concentration of the sample shall also be reported.

      For the purposes of data collection, the laboratory shall write the estimated chemical concentration next to DNQ as well as the words "Estimated Concentration" (may be shortened to "Est. Conc."). The laboratory may, if such information is available, include numerical estimates of the data quality for the reported result. Numerical estimates of data quality may be percent accuracy (± a percentage of the reported value), numerical ranges (low to high), or any other means considered appropriate by the laboratory.

c. Sample results less than the laboratory's MDL shall be reported as "Not Detected," or ND.

d. Dischargers are to instruct laboratories to establish calibration standards so that the ML value (or its equivalent if there is differential treatment of samples relative to calibration standards) is the lowest calibration standard. At no time is the Discharger to use analytical data derived from *extrapolation* beyond the lowest point of the calibration curve.

5. The Discharger shall submit SMRs in accordance with the following requirements:

a. The Discharger shall arrange all reported data in a tabular format. The data shall be summarized to clearly illustrate whether the facility is operating in compliance with interim and/or final effluent limitations. The Discharger is not required to duplicate the submittal of data that is entered in a tabular format within CIWQS. When electronic submittal of data is required and CIWQS does not provide for entry into a tabular format within the system, the Discharger shall electronically submit the data in a tabular format as an attachment.

b. The Discharger shall attach a cover letter to the SMR. The information contained in the cover letter shall clearly identify violations of the WDRs; discuss corrective actions taken or planned; and the proposed time schedule for corrective actions. Identified violations must include a description of the requirement that was violated and a description of the violation.

c. SMRs must be submitted to the Regional Water Board, signed and certified as required by the Standard Provisions (Attachment D), to the address listed below:

C. Notification

1. The Discharger shall notify the Executive Officer in writing prior to discharge of any chemical that may be toxic to aquatic life. Such notification shall include:

a. Name and general composition of the chemical,

b. Frequency of use,

c. Quantities to be used,

d. Proposed discharge concentrations, and,

e. EPA registration number, if applicable.

No discharge of such chemical shall be made prior to obtaining the Executive Officer's approval.

2. The Discharger shall notify the Regional Board via telephone and/or fax within 24 hours of noticing an exceedance above the effluent limits in Order No. R4-2009-0068. The Discharger shall provide to the Regional Board within 14 days of observing the exceedance a detailed statement of the actions undertaken or proposed that will bring the discharge into full compliance with the requirements and submit a timetable for correction.

D. Monitoring Frequencies Adjustment

Monitoring frequencies may be adjusted by the Executive Officer to a less frequent basis if the Discharger requests same and the request is backed by statistical trends of monitoring data submitted.

E. Discharge Monitoring Reports (DMRS)

1. At any time during the term of this permit, the State or Regional Water Board may notify the Discharger to electronically submit SMRs that will satisfy federal requirements for submittal of Discharge Monitoring Reports (DMRs). Until such notification is given, the Discharger shall submit SMRs in accordance with the requirements described below.

2. SMRs must be signed and certified as required by the standard provisions (Attachment D). The Discharge shall submit the original SMR to the address listed below:

California Regional Water Quality Control Board
Los Angeles Region
320 W. 4th Street, Suite 200
Los Angeles, CA 90013
Attention: Information and Technology Unit.

EXHIBIT B

NPDES Permit Transfer Form (Form No. R4-WRS #1)

California Regional Water Quality Control Board
Los Angeles Region

320 W. 4th Street, Suite 200, Los Angeles, California 90013
(213) 576-6600 • FAX (213) 576-6640
http://www.waterboards.ca.gov/losangeles

Matthew Rodriquez
Secretary for
Environmental Protection

Edmund G. Brown Jr.
Governor

NPDES PERMIT TRANSFER REQUEST FORM

NPDES Permit No. _____ CI No. _____

Facility Location: _____
Street Address City Zip

I hereby request the transfer of the above-referenced NPDES permit, including the transfer of responsibility, coverage, and liability for such permit, in accordance with the following:

TRANSFER FROM:

_____
Facility Name

_____
Owner

_____
Operator

TRANSFER TO:

_____
New Facility Name

_____
New Owner

_____
New Operator

TRANSFER EFFECTIVE DATE: _____

_____ _____
Signature of Former Owner/Authorized Representative Title

_____ _____
Name of Former Owner/Authorized Representative Date

I understand that I am responsible for compliance with the above-referenced NPDES permit. I certify that:

1. I have reviewed the NPDES permit;
2. The facility construction and nature/amount of discharges from the facility have not substantially changed: and
3. I will notify the Board of any material change in the facility and/or of the discharge, or any future change in the facility owner or operator.

_____ _____
Signature of New Owner/Authorized Representative Company name, if appropriate

_____ _____ _____
Name of New Owner/Authorized Representative Telephone No. Date

_____ _____
Title Email

Mailing Address: _____
Street Address City State Zip

_____ _____ _____
Name of Facility Contact Person Telephone No. Email

Facility Contact Mailing Address: _____
Street Address City State Zip

Form No. R4-WRS #1 9/2/11

California Environmental Protection Agency

Recycled Paper

Exhibit 10.23

SECOND AMENDMENT TO PURCHASE AGREEMENT

THIS SECOND AMENDMENT TO PURCHASE AGREEMENT ("Second Amendment"), dated November 30, 2011, and is made by and between 200 OCEANGATE, LLC, a Delaware limited liability company ("Seller"), and MOLINA CENTER LLC, a Delaware limited liability company ("Buyer").

Recitals

A. Seller and Buyer entered into that certain Purchase Agreement dated October 11, 2011, as amended by that certain First Amendment to Purchase Agreement dated November 10, 2011 (the "First Amendment"), and as further amended by that certain Closing Date extension notice dated November 22, 2011 (collectively, the "Purchase Agreement"), whereby, upon the terms and conditions set forth therein, Seller agreed to sell and Buyer agreed to buy the Property and those associated rights and interest described in the Purchase Agreement.

B. Seller and Buyer now desire to amend the Purchase Agreement as set forth below.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound, the parties hereto agree that the Purchase Agreement is hereby amended as follows:

1. Closing Date. The first full sentence of section 10.1 of the Purchase Agreement is amended and restated in its entirety as follows:

"The consummation of the purchase and sale of the Property (the " **Closing**") shall be held at the offices of the Title Company (or at such other location as the parties may agree) on December 7, 2011 (the "**Closing Date**"), which may be extended in accordance with the terms of this Section 10.1, Section 11.2, and Section 1(vii) of the First Amendment, but in any event shall not be later than January 13, 2012 (the " **Outside Closing Date**")."

2. Miscellaneous. This Second Amendment may be executed in counterparts, including facsimile counterparts or scanned and emailed counterparts, each of which shall be deemed an original, and all of which taken together shall constitute one and the same instrument. Capitalized terms used in this Second Amendment shall have the meanings set forth in the Purchase Agreement, except as otherwise defined herein. Except as specifically set forth herein, the Purchase Agreement shall be unmodified, and shall remain in full force and effect.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties have executed this Second Amendment as of the date first listed above.

SELLER: 200 OCEANGATE, LLC, a Delaware limited liability company

By: Pacific Towers Associates, a California limited partnership, its sole member

By: SIC – Long Beach, a California limited partnership, its general partner

By: SwigCo, Inc., a California corporation, its general partner

By: /s/ Jeanne R. Myerson
Jeanne R. Myerson,
President & Chief Executive Officer

BUYER: MOLINA CENTER LLC,
a Delaware limited liability company

By: Molina Healthcare, Inc., a Delaware corporation

By: /s/ John C. Molina
Name: John C. Molina
Title: Chief Financial Officer

Exhibit 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31, 2011				
	2011	2010	2009	2008	2007
	(Dollars in thousands)				
Earnings:					
Income before income taxes	$ 64,654	$ 89,492	$ 38,157	$ 94,324	$ 92,722
Add fixed charges:					
Interest expense, including amortization of debt discount and expense	15,519	15,509	13,777	13,231	5,605
Estimated interest portion of rental expense	2,542	4,524	5,181	4,370	3,988
Total fixed charges	18,061	20,033	18,958	17,601	9,593
Total earnings available for fixed charges	$ 82,715	$ 109,525	$ 57,115	$ 111,925	$ 102,315
Fixed charges from above:	$ 18,061	$ 20,033	$ 18,958	$ 17,601	$ 9,593
Ratio of Earnings to Fixed Charges	4.6	5.6	3.0	6.4	10.7
Total rent expense	$ 23,110	$ 25,134	$ 20,723	$ 17,481	$ 18,127
Interest factor	11%	18%	25%	25%	22%
Interest component of rental expense	$ 2,542	$ 4,524	$ 5,181	$ 4,370	$ 3,988

Exhibit 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
Alliance for Community Health L.L.C, dba Molina Healthcare of Missouri	Missouri
American Family Care, Inc.	California
Molina Center LLC	Delaware
Molina Healthcare Data Center, Inc.	New Mexico
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Georgia, Inc.	Georgia
Molina Healthcare of Illinois, Inc.	Illinois
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of New Mexico Medical Clinics, Inc. +	New Mexico
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company*	Texas
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Wisconsin, Inc.	Wisconsin
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Pathways, LLC	Delaware

\+ Wholly owned subsidiary of Molina Healthcare of New Mexico, Inc.

* Wholly owned subsidiary of Molina Healthcare of Texas, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the Registration Statements (Forms S-8, No. 333-108317, No. 333-138552, No. 333-153246, No. 333-170571, and No. 333-174912) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan, 2002 Employee Stock Purchase Plan, 2011 Equity Incentive Plan, and 2011 Employee Stock Purchase Plan, of our reports dated February 29, 2012, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2011.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 29, 2012

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2011, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ JOSEPH M. MOLINA

Joseph M. Molina
Chief Executive Officer and President

February 29, 2012

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2011, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ JOHN C. MOLINA

John C. Molina, J.D.
Chief Financial Officer and Treasurer

February 29, 2012

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2011, as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOSEPH M. MOLINA
Joseph M. Molina, M.D.
Chief Executive Officer and President

February 29, 2012

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2011, as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN C. MOLINA

John C. Molina, J.D.
Chief Financial Officer and Treasurer

February 29, 2012

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended September 30, 2011

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2011

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	*(Zip Code)*

(562) 435-3666

(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The number of shares of the issuer's Common Stock outstanding as of October 21, 2011, was approximately 45,696,400.

MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	September 30, 2011	December 31, 2010
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 487,492	$ 455,886
Investments	324,902	295,375
Receivables	180,039	168,190
Income tax refundable	5,781	—
Deferred income taxes	14,096	15,716
Prepaid expenses and other current assets	22,285	22,772
Total current assets	1,034,595	957,939
Property and equipment, net	127,657	100,537
Deferred contract costs	52,839	28,444
Intangible assets, net	84,495	105,500
Goodwill and indefinite-lived intangible assets	212,484	212,228
Auction rate securities	18,112	20,449
Restricted investments	50,494	42,100
Receivable for ceded life and annuity contracts	23,696	24,649
Other assets	13,932	17,368
	$ 1,618,304	$ 1,509,214
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 361,055	$ 354,356
Accounts payable and accrued liabilities	141,688	137,930
Deferred revenue	101,701	60,086
Income taxes payable	—	13,176
Total current liabilities	604,444	565,548
Long-term debt	168,109	164,014
Deferred income taxes	22,948	16,235
Liability for ceded life and annuity contracts	23,696	24,649
Other long-term liabilities	17,287	19,711
Total liabilities	836,484	790,157
Stockholders' equity (1):		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 45,690 shares at September 30, 2011 and 45,463 shares at December 31, 2010	46	45
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	260,166	251,612
Accumulated other comprehensive loss	(1,762)	(2,192)
Retained earnings	523,370	469,592
Total stockholders' equity	781,820	719,057
	$ 1,618,304	$ 1,509,214

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 1,138,230	$ 1,005,115	$ 3,348,438	$ 2,947,020
Service revenue	37,728	32,271	111,290	53,325
Investment income	764	1,760	3,804	4,880
Total revenue	1,176,722	1,039,146	3,463,532	3,005,225
Expenses:				
Medical care costs	959,158	845,937	2,822,049	2,508,366
Cost of service revenue	34,584	27,605	105,020	41,859
General and administrative expenses	99,610	88,660	290,967	245,619
Premium tax expenses	36,374	35,037	110,633	104,578
Depreciation and amortization	13,430	11,954	38,587	33,234
Total expenses	1,143,156	1,009,193	3,367,256	2,933,656
Operating income	33,566	29,953	96,276	71,569
Interest expense	4,380	4,600	11,666	12,056
Income before income taxes	29,186	25,353	84,610	59,513
Provision for income taxes	10,236	9,180	30,832	22,171
Net income	$ 18,950	$ 16,173	$ 53,778	$ 37,342
Net income per share (1):				
Basic	$ 0.41	$ 0.38	$ 1.18	$ 0.94
Diluted	$ 0.41	$ 0.38	$ 1.16	$ 0.93
Weighted average shares outstanding (1):				
Basic	45,834	42,177	45,693	39,767
Diluted	46,296	42,546	46,334	40,203

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(Amounts in thousands) (Unaudited)			
Net income	$ 18,950	$ 16,173	$ 53,778	$ 37,342
Other comprehensive income, net of tax:				
Unrealized (loss) gain on investments	(165)	(68)	430	(295)
Other comprehensive (loss) income	(165)	(68)	430	(295)
Comprehensive income	$ 18,785	$ 16,105	$ 54,208	$ 37,047

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2011	2010
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 53,778	$ 37,342
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	52,414	40,485
Deferred income taxes	8,069	4,463
Stock-based compensation	12,723	7,268
Non-cash interest on convertible senior notes	4,095	3,800
Amortization of premium/discount on investments	5,300	1,023
Amortization of deferred financing costs	2,451	1,278
Unrealized gain on trading securities	—	(4,170)
Loss on rights agreement	—	3,807
Tax deficiency from employee stock compensation	(647)	(676)
Changes in operating assets and liabilities:		
Receivables	(11,789)	(64,896)
Prepaid expenses and other current assets	(1,819)	(7,707)
Medical claims and benefits payable	6,699	33,347
Accounts payable and accrued liabilities	246	15,131
Deferred revenue	42,600	(64,337)
Income taxes	(18,957)	3,327
Net cash provided by operating activities	155,163	9,485
Investing activities:		
Purchases of equipment	(45,921)	(31,918)
Purchases of investments	(258,209)	(162,620)
Sales and maturities of investments	226,413	184,170
Net cash paid in business combinations	(3,253)	(127,231)
Increase in deferred contract costs	(32,765)	(20,616)
Increase in restricted investments	(8,394)	(8,513)
Change in other noncurrent assets and liabilities	(533)	2,340
Net cash used in investing activities	(122,662)	(164,388)
Financing activities:		
Amount borrowed under credit facility	—	105,000
Proceeds from common stock offering, net of issuance costs	—	111,246
Repayment of amount borrowed under credit facility	—	(105,000)
Treasury stock purchases	(7,000)	—
Credit facility fees paid	(1,125)	(1,671)
Proceeds from employee stock plans	5,640	1,862
Excess tax benefits from employee stock compensation	1,590	420
Net cash (used in) provided by financing activities	(895)	111,857
Net increase (decrease) in cash and cash equivalents	31,606	(43,046)
Cash and cash equivalents at beginning of period	455,886	469,501
Cash and cash equivalents at end of period	$ 487,492	$ 426,455

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Nine Months Ended September 30,	
	2011	**2010**
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 43,550	$ 12,129
Interest	$ 5,026	$ 7,175
Schedule of non-cash investing and financing activities:		
Common stock used for stock-based compensation	$ 3,751	$ 2,173
Details of business combinations:		
Increase in fair value of assets acquired	$ (256)	$ (161,862)
(Decrease) increase in fair value of liabilities assumed	(1,045)	25,880
(Decrease) increase in payable to seller	(1,952)	8,751
Net cash paid in business combinations	$ (3,253)	$ (127,231)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
September 30, 2011

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. As of September 30, 2011, these health plans served approximately 1.7 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our Molina Medicaid Solutions segment, which we acquired during the second quarter of 2010, provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award our contract for a replacement Medicaid Management Information System, or MMIS, to another firm. Our revenue under the Louisiana MMIS contract from May 1, 2010, the date we acquired Molina Medicaid Solutions, through December 31, 2010, was approximately $32 million. For the nine months ended September 30, 2011, our revenue under the Louisiana MMIS contract was approximately $36 million. Until the replacement MMIS is designed, developed, and implemented, we will continue to perform under the existing MMIS contract, a period which we expect to last at least two years.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated in consolidation. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2011. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2010. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2010 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2010 audited financial statements.

Adjustments and Reclassifications

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

We have reclassified certain amounts in the 2010 consolidated statement of cash flows to conform to the 2011 presentation.

2. Significant Accounting Policies

Recognition of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO, arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solutions contracts are multiple-element arrangements. The following discussion applies to our contracts with multiple elements entered into prior to January 1, 2011, before our prospective adoption of *Accounting Standards Update, or ASU, No. 2009-13, Revenue Recognition (Accounting Standards Codification, or ASC, Topic 605) — Multiple-Deliverable Revenue Arrangements*.

For those contracts entered into prior to January 1, 2011, we have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services, which vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our newer contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement prior to January 1, 2011 requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services, or training and support services) until the contingency has been removed. When we defer revenue recognition we also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the revenue deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

However, direct costs in excess of the estimated future net revenues associated with a contract may not be deferred. In circumstances where estimated direct costs over the life of a contract exceed estimated future net revenues of that contract, the excess of direct costs over revenue is expensed as a period cost.

In Idaho, revenue recognition is expected to begin during the second half of 2012. Consistent with the deferral of revenue, we have deferred recognition of a portion of the direct contract costs associated with that revenue. Deferred contract costs, if any, deferred through the date revenue recognition begins will be recognized simultaneously with revenue. As noted above, direct costs in excess of the estimated future net revenues associated with a contract may not be deferred. For the three and nine months ended September 30, 2011, we recorded $2.5 million and $9.5 million, respectively, of direct contract costs associated with our Idaho contract. We were not able to defer these direct contract costs because estimated future net revenues as of each measurement date did not exceed estimated future direct costs of the contract. We currently expect the Idaho contract to perform financially at a break even basis through its initial term. So long as we continue to defer revenue recognition under the contract, we will also continue to defer direct costs associated with the agreement. If our break-even assumptions were to change, we may not be able to continue to defer direct contract costs.

We began to recognize revenue and the related deferred costs associated with our Maine contract in September 2010.

Molina Medicaid Solutions' deferred revenue was $53.1 million at September 30, 2011, and $10.9 million at December 31, 2010, and unamortized deferred contract costs were $52.8 million at September 30, 2011, and $28.4 million at December 31, 2010.

For all new or materially modified revenue arrangements with multiple elements entered into on or after January 1, 2011, we apply the guidance contained in ASU No. 2009-13. For these arrangements, we allocate total arrangement consideration to the elements of the arrangement, which are expected to be DDI, BPO, and training and support services, because this is consistent with the current elements included in our Molina Medicaid Solutions contracts. The arrangement allocation is performed using the relative selling-price method. When determining the selling price of each element, VSOE should first be used, if available. Since VSOE is unavailable under our contracts, we will attempt to use third-party evidence, or TPE, of vendors selling similar services to similarly situated customers on a standalone basis, if available. If TPE is not available, we use our best estimate of the selling price for each element.

We then evaluate whether, at each stage in the life cycle of the contract, we are able to recognize revenue associated with that element. To the extent that our revenue arrangements have provisions that allow our state customers to refuse acceptance of services performed, we are still required to defer revenue recognition until such state customers accept our performance. Once this acceptance is achieved, we immediately recognize the revenue associated with any delivered elements, which differs from our current practice for arrangements entered into prior to January 1, 2011, where the revenue associated with delivered elements is recognized over the final service element of the arrangement because VSOE for the other elements does not exist. As such, we expect that the adoption of ASU No. 2009-13 will result in an overall acceleration of revenue recognition with respect to any multiple-element arrangements entered into on or after January 1, 2011. We have entered into no new or materially modified revenue arrangements with multiple elements since January 1, 2011.

Premium Deficiency Reserve

We assess the profitability of each contract by state for providing medical care services to our members and identify any contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. In the first quarter of 2011, our Wisconsin health plan recorded a premium deficiency reserve in the amount of $3.35 million to medical claims and benefits payable. As of September 30, 2011, the reserve balance was zero.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $10.9 million, and $11.0 million as of September 30, 2011 and December 31, 2010, respectively. Approximately $8.4 million of the unrecognized tax benefits recorded at September 30, 2011, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.6 million as of September 30, 2011. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.8 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of September 30, 2011, and December 31, 2010, we had accrued $61,000 and $82,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

Revenue Recognition. In late 2009, the Financial Accounting Standards Board, or FASB, issued the following accounting guidance relating to revenue recognition. Effective for interim and annual reporting beginning on or after December 15, 2010, we adopted this guidance in full effective January 1, 2011.

- *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies previous requirements by requiring the use of the "best estimate of selling price" in the absence of vendor-specific objective evidence ("VSOE") or verifiable objective evidence ("VOE") (now referred to as "TPE" or third-party evidence) for determining the selling price of a deliverable. A vendor is now required to use its best estimate of the selling price when more objective evidence of the selling price cannot be determined. By providing an alternative for determining the selling price of deliverables, this guidance allows companies to allocate arrangement consideration in multiple deliverable arrangements in a manner that better reflects the transaction's economics. In addition, the residual method of allocating arrangement consideration is no longer permitted under this new guidance. We have adopted this guidance effective January 1, 2011, and will apply it on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Because we did not enter into any new or materially modified agreements with multiple elements and fixed payments in the nine months ended September 30, 2011 that would have been impacted by this guidance, the adoption did not have a material impact on the timing or pattern of revenue recognition.

  For the year ended December 31, 2010, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

Goodwill Impairment Testing. The FASB issued the following guidance which modifies goodwill impairment testing.

- *ASU No. 2011-08, Intangibles—Goodwill and Other (ASC Topic 350) — Testing Goodwill for Impairment,* a consensus of the FASB Emerging Issues Task Force. This guidance allows an entity the option to first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. Under that option, an entity would no longer be required to calculate the fair value of a reporting unit unless the entity determines, based on the qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. We do not expect the adoption of this guidance to impact our consolidated financial position, results of operations or cash flows. This guidance is effective for interim and annual goodwill impairment tests performed for fiscal years beginning after December 15, 2011.

- *ASU No. 2010-28, Intangibles—Goodwill and Other (ASC Topic 350) — When to Perform Step 2 of the Goodwill Impairment Test for Reporting Units with Zero or Negative Carrying Amounts,* a consensus of the FASB Emerging Issues Task Force. This guidance modifies Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts. For those reporting units, an entity is required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists. In determining whether it is more likely than not that a goodwill impairment exists, an entity should consider whether there are any adverse qualitative factors indicating that an impairment may exist. The adoption of this guidance did not impact our consolidated financial position, results of operations or cash flows. Effective for interim and annual reporting beginning on or after December 15, 2010, we adopted this guidance in full effective January 1, 2011.

Presentation of Financial Statements. In June 2011, the FASB and International Accounting Standards Board, or IASB, issued the following guidance which modifies how other comprehensive income, or OCI, is reported under U.S. Generally Accepted Accounting Principles, or GAAP, and International Financial Reporting Standards, or IFRS. This guidance is effective for interim and annual reporting beginning on or after December 15, 2011.

- *ASU No. 2011-05, Comprehensive Income (ASC Topic 220) — Presentation of Comprehensive Income,* a consensus of the FASB Emerging Issues Task Force. This guidance eliminates the option to present components of OCI as part of the statement of changes to stockholders' equity. All filers are required to present all non-owner changes in stockholders' equity in a single statement of comprehensive income or in two separate but consecutive statements. We do not expect the adoption of this guidance to impact our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(In thousands)			
Shares outstanding at the beginning of the period	46,062	38,717	45,463	38,410
Weighted-average number of shares repurchased	(235)	—	(160)	—
Weighted-average number of shares issued	7	3,460	390	1,357
Denominator for basic earnings per share	45,834	42,177	45,693	39,767
Dilutive effect of employee stock options and stock grants (1)	462	369	641	436
Denominator for diluted earnings per share (2)	46,296	42,546	46,334	40,203

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended September 30, 2011, and 2010, there were approximately 316,000 and 708,000 antidilutive weighted options, respectively. For the nine months ended September 30, 2011, and 2010, there were approximately 126,000 and 738,000 antidilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the three months ended September 30, 2011 and 2010, there were approximately 57,000 and 9,000 antidilutive weighted restricted shares, respectively. For the nine months ended September 30, 2011 there were no antidilutive restricted shares. For the nine months ended September 30, 2010, there were approximately 9,000 antidilutive restricted shares.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the three month and nine month periods ended September 30, 2011 and 2010.

4. Share-Based Compensation

At September 30, 2011, we had employee equity incentives outstanding under three plans: (1) the 2011 Equity Incentive Plan; (2) the 2002 Equity Incentive Plan; and (3) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). On March 1, 2011, our chief executive officer, chief financial officer, and chief operating officer were awarded 150,000 shares, 112,500 shares, and 27,000 shares, respectively, of restricted stock with performance and service conditions. Each of the grants shall vest on March 1, 2012, provided that: (i) the Company's total operating revenue for 2011 is equal to or greater than $3.7 billion, and (ii) the respective officer continues to be employed by the Company as of March 1, 2012. In the event both vesting conditions are not achieved, the equity compensation awards shall lapse. As of September 30, 2011, we expect these awards to vest in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three month and nine month periods ended September 30, 2011 and 2010:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(In thousands)			
Restricted stock awards	$ 4,004	$ 2,367	$ 11,742	$ 6,113
Stock options (including shares issued under our employee stock purchase plan)	345	393	981	1,155
Total stock-based compensation expense	$ 4,349	$ 2,760	$ 12,723	$ 7,268

As of September 30, 2011, there was $17.7 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to recognize over a remaining weighted-average period of two years. As of September 30, 2011, there was no remaining unrecognized compensation expense related to unvested stock options.

Unvested restricted stock and restricted stock activity for the nine months ended September 30, 2011 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2010	1,253,624	$ 15.55
Granted	759,300	23.52
Vested	(483,735)	17.39
Forfeited	(69,531)	15.44
Unvested balance as of September 30, 2011	1,459,658	19.09

The total fair value of restricted shares granted during the nine months ended September 30, 2011 and 2010 was $17.9 million and $11.9 million, respectively. The total fair value of restricted shares vested during the nine months ended September 30, 2011 and 2010 was $11.5 million and $6.1 million, respectively.

Stock option activity for the nine months ended September 30, 2011 is summarized below:

	Shares	Weighted Average Grant Date Fair Value	Average Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Stock options outstanding as of December 31, 2010	770,421	$ 20.39		
Exercised	(185,672)	19.23		
Forfeited	(21,700)	21.45		
Stock options outstanding as of September 30, 2011	563,049	20.74	$ 204	4.2
Stock options exercisable and expected to vest as of September 30, 2011	562,965	20.74	$ 204	4.2
Exercisable as of September 30, 2011	560,799	20.73	$ 204	4.2

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

The carrying amount of the convertible senior notes was $168.1 million and $164.0 million as of September 30, 2011, and December 31, 2010, respectively. Based on quoted market prices, the fair value of the convertible senior notes was approximately $179.2 million and $188.4 million as of September 30, 2011, and December 31, 2010, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy as follows:

- *Level 1 — Observable inputs such as quoted prices in active markets:* Our Level 1 securities consist of government-sponsored enterprise securities (GSEs) and U.S. treasury notes. Level 1 securities are classified as current investments in the accompanying consolidated balance sheets. These securities are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

- *Level 2 — Inputs other than quoted prices in active markets that are either directly or indirectly observable:* Our Level 2 securities consist of corporate debt securities, municipal securities, and certificates of deposit, and are classified as current investments in the accompanying consolidated balance sheets. Our investments in securities classified as Level 2 are traded frequently though not necessarily daily. Fair value for these securities is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

- *Level 3 — Unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions:* We hold investments in auction rate securities which are designated as available-for-sale, and are reported at fair value of $18.1 million (par value of $21.3 million) as of September 30, 2011. Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of September 30, 2011. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, 2009, and 2010, and continued to be unavailable as of September 30, 2011. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining the fair value of the auction rate securities as of September 30, 2011. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As a result of changes in the fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized gains of $0.9 million and pretax unrealized losses of $0.5 million to accumulated other comprehensive income (loss) for the nine months ended September 30, 2011, and 2010, respectively. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income (loss). If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Until July 2, 2010, we held certain auction rate securities (designated as trading securities) with an investment securities firm. In 2008, we entered into a rights agreement with this firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. On June 30, 2010, and July 1, 2010, all of the eligible auction rate securities remaining at that time were settled at par value. During 2010, the aggregate auction rate securities (designated as trading securities) settled amounted to $40.9 million par value (fair value $36.7 million). Substantially all of the difference between par value and fair value on these securities was recovered through the rights agreement. For the nine months ended September 30, 2010, we recorded pretax gains of $4.2 million on the auction rate securities underlying the Rights.

We accounted for the Rights as a freestanding financial instrument and, until July 2, 2010, recorded the value of the Rights under the fair value option. For the nine months ended September 30, 2010, we recorded pretax losses of $3.8 million on the Rights, attributable to the decline in the fair value of the Rights. When the remaining eligible auction rate securities were sold at par value on July 1, 2010, the value of the Rights was zero.

Our assets measured at fair value on a recurring basis at September 30, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 215,875	$ —	$ 215,875	$ —
Government-sponsored enterprise securities (GSEs)	45,224	45,224	—	—
Municipal securities	36,088	—	36,088	—
U.S. treasury notes	24,454	24,454	—	—
Certificates of deposit	3,261	—	3,261	—
Auction rate securities	18,112	—	—	18,112
	$ 343,014	$ 69,678	$ 255,224	$ 18,112

In prior periods we reported our investments in corporate debt securities, municipal securities and certificates of deposit in Level 1. Upon re-evaluation of the inputs used to measure fair value within the fair value hierarchy, we have determined that these investments should be reported in Level 2, and have reclassified the tabular disclosure accordingly.

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2010	$ 20,449
Total gains (realized or unrealized):	
Included in other comprehensive income	913
Settlements	(3,250)
Balance at September 30, 2011	$ 18,112
The amount of total gains for the period included in other comprehensive income attributable to the change in unrealized gains relating to assets still held at September 30, 2011	$ 913

In 2010, we recorded a $2.8 million liability for contingent consideration related to the acquisition of our Wisconsin health plan. In the first quarter of 2011, we determined that there was no liability for contingent consideration relating to the acquisition. The liability for contingent consideration related to this acquisition was measured at fair value on a recurring basis using significant unobservable inputs (Level 3). The following table presents a roll forward of this liability for 2011:

	(Level 3)
	(In thousands)
Balance at December 31, 2010	$ (2,800)
Total gains included in earnings	2,800
Balance at September 30, 2011	$ —

6. Investments

The following tables summarize our investments as of the dates indicated:

	September 30, 2011			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 219,955	$ 98	$ 4,178	$ 215,875
GSEs	45,338	44	158	45,224
Municipal securities (including non-current auction rate securities)	57,477	165	3,442	54,200
U.S. treasury notes	24,323	136	5	24,454
Certificates of deposit	3,261	—	—	3,261
	$ 350,354	$ 443	$ 7,783	$ 343,014

	December 31, 2010			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 179,124	$ 193	$ 1,388	$ 177,929
GSEs	59,790	293	370	59,713
Municipal securities (including non-current auction rate securities)	55,247	78	4,313	51,012
U.S. treasury notes	23,864	114	60	23,918
Certificates of deposit	3,252	—	—	3,252
	$ 321,277	$ 678	$ 6,131	$ 315,824

The contractual maturities of our investments as of September 30, 2011 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 159,060	$ 156,445
Due one year through five years	170,494	168,888
Due after ten years	20,800	17,681
	$ 350,354	$ 343,014

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $105.0 million and $52.0 million for the three months ended September 30, 2011, and 2010, respectively. Total proceeds from sales and maturities of available-for-sale securities were $226.4 million and $143.3 million for the nine months ended September 30, 2011, and 2010, respectively. Net realized investment gains for the three months ended September 30, 2011, and 2010 were $153,000 and $21,000 respectively. Net realized investment gains for the nine months ended September 30, 2011, and 2010 were $331,000 and $81,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at September 30, 2011, and December 31, 2010, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Approximately 33% of our investment in municipal securities consists of auction rate securities. As described in Note 5, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at September 30, 2011.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of September 30, 2011.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 169,582	$ 3,625	$ 17,720	$ 553	$ 187,302	$ 4,178
GSEs	18,522	78	1,167	80	19,689	158
Municipal securities	22,731	188	21,055	3,254	43,786	3,442
U.S. treasury notes	4,705	5	—	—	4,705	5
	$ 215,540	$ 3,896	$ 39,942	$ 3,887	$ 255,482	$ 7,783

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2010.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 103,225	$ 1,060	$ 10,490	$ 328	$ 113,715	$ 1,388
GSEs	13,014	71	7,539	299	20,553	370
Municipal securities	18,884	117	25,271	4,196	44,155	4,313
U.S. treasury notes	5,480	40	6,806	20	12,286	60
	$ 140,603	$ 1,288	$ 50,106	$ 4,843	$ 190,709	$ 6,131

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	September 30, 2011	December 31, 2010
	(In thousands)	
Health Plans segment:		
California	$ 31,742	$ 46,482
Michigan	11,265	13,596
Missouri	24,025	22,841
New Mexico	9,722	18,310
Ohio	27,901	21,622
Washington	11,766	14,486
Wisconsin	7,777	5,437
Others	7,029	5,187
Total Health Plans segment	131,227	147,961
Molina Medicaid Solutions segment	48,812	20,229
	$ 180,039	$ 168,190

During the second quarter of 2011, we settled certain claims we had made against the state of Utah regarding the savings share provision of our contract in effect from 2003 through June of 2009. Additionally, we recognized a liability for certain overpayments received from the state for the period 2003 through 2009. As a result of these developments, we recognized $6.9 million in premium revenue without any corresponding charge to expense during the second quarter of 2011.

8. Restricted Investments

Pursuant to the regulations governing our Health Plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of certain capitated providers. The following table presents the balances of restricted investments by health plan, and for our insurance company:

	September 30, 2011	December 31, 2010
	(In thousands)	
California	$ 372	$ 372
Florida	8,196	4,508
Insurance Company	4,672	4,689
Michigan	1,000	1,000
Missouri	505	508
New Mexico	15,902	15,881
Ohio	9,077	9,066
Texas	3,500	3,501
Utah	2,799	1,279
Washington	151	151
Wisconsin	—	260
Other	4,320	885
	$ 50,494	$ 42,100

The contractual maturities of our held-to-maturity restricted investments as of September 30, 2011 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 45,281	$ 45,292
Due one year through five years	5,213	5,266
	$ 50,494	$ 50,558

9. Long-Term Debt

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the "Credit Facility") with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility will be used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of September 30, 2011 there was no outstanding principal balance under the Credit Facility. However, as of September 30, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility will bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The initial commitment fee shall be set at 0.35% until our delivery of its financials for the quarter ended September 30, 2011. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of not less than 1.75 to 1.00. At September 30, 2011, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

In connection with our entrance into the Credit Facility, on September 9, 2011, we terminated our existing credit agreement with Bank of America, dated March 9, 2005, as amended to date, which had provided us with a $150 million revolving credit facility. As of September 30, 2011 and December 31, 2010, there was no outstanding principal balance under this credit agreement.

Convertible Senior Notes

As of September 30, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of September 30, 2011, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 36 months. The Notes' if-converted value did not exceed their principal amount as of September 30, 2011. At September 30, 2011, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of September 30, 2011	As of December 31, 2010
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(18,891)	(22,986)
Net carrying amount	$ 168,109	$ 164,014

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(In thousands)			
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,753	$ 5,259	$ 5,259
Amortization of the discount on the liability component	1,384	1,291	4,095	3,800
Total interest cost recognized	$ 3,137	$ 3,044	$ 9,354	$ 9,059

10. Stockholders' Equity

Securities Repurchase Program. Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see Note 9, "Long-Term Debt"). The repurchase program will be funded with working capital or the Company's credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time.

On July 27, 2011, our board of directors approved a stock repurchase program of up to $7 million to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Under this program, we purchased approximately 400,000 shares of our common stock for $7 million (average cost of approximately $17.47 per share) during August 2011. These purchases did not materially impact diluted earnings per share for the three months or nine months ended September 30, 2011. Subsequently, we retired the $7.0 million of treasury shares purchased, which reduced additional paid-in capital as of September 30, 2011.

Stock Split. On April 27, 2011, we announced that our board of directors authorized a 3-for-2 stock split of our common stock to be effected in the form of a stock dividend of one share of our stock for every two shares outstanding. The dividend was distributed on May 20, 2011.

Stock Plans. In connection with the plans described in Note 4, "Share-Based Compensation," we issued approximately 627,000 shares of common stock, net of shares used to settle employees' income tax obligations, for the nine months ended September 30, 2011. Stock plan activity resulted in a $15.6 million increase to additional paid-in capital for the same period.

11. Segment Reporting

Our reportable segments are consistent with how we manage the business and view the markets we serve. In the second quarter of 2010, we added a segment to our internal financial reporting structure as a result of the acquisition of Molina Medicaid Solutions. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

Molina Medicaid Solutions was acquired on May 1, 2010; therefore, the nine months ended September 30, 2010 include only five months of operating results for this segment. Operating segment revenues and profitability for the three months and nine months ended September 30, 2011 and 2010 were as follows:

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
Three months ended September 30, 2011			
Premium revenue	$ 1,138,230	$ —	$ 1,138,230
Service revenue	—	37,728	37,728
Investment income	764	—	764
Total revenue	$ 1,138,994	$ 37,728	$ 1,176,722
Operating income (loss)	$ 33,773	$ (207)	$ 33,566
Nine months ended September 30, 2011			
Premium revenue	$ 3,348,438	$ —	$ 3,348,438
Service revenue	—	111,290	111,290
Investment income	3,804	—	3,804
Total revenue	$ 3,352,242	$ 111,290	$ 3,463,532
Operating income (loss)	$ 100,273	$ (3,997)	$ 96,276
Three months ended September 30, 2010			
Premium revenue	$ 1,005,115	$ —	$ 1,005,115
Service revenue	—	32,271	32,271
Investment income	1,760	—	1,760
Total revenue	$ 1,006,875	$ 32,271	$ 1,039,146
Operating income	$ 28,796	$ 1,157	$ 29,953
Nine months ended September 30, 2010			
Premium revenue	$ 2,947,020	$ —	$ 2,947,020
Service revenue	—	53,325	53,325
Investment income	4,880	—	4,880
Total revenue	$ 2,951,900	$ 53,325	$ 3,005,225
Operating income	$ 65,407	$ 6,162	$ 71,569

Reconciliation to Income before Income Taxes

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(In thousands)			
Segment operating income	$ 33,566	$ 29,953	$ 96,276	$ 71,569
Interest expense	4,380	4,600	11,666	12,056
Income before income taxes	$ 29,186	$ 25,353	$ 84,610	$ 59,513

Segment Assets

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
As of September 30, 2011	$ 1,389,940	$ 228,364	$ 1,618,304
As of December 31, 2010	$ 1,333,599	$ 175,615	$ 1,509,214

12. Commitments and Contingencies

Legal

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, consolidated financial position, cash flows, or results of operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $456.2 million at September 30, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2011, our health plans had aggregate statutory capital and surplus of approximately $463.1 million compared with the required minimum aggregate statutory capital and surplus of approximately $273.9 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2011. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

13. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of September 30, 2011, and December 31, 2010, our carrying amount for this investment amounted to $3.9 million, and $3.8 million, respectively. For the three months ended September 30, 2011 and 2010, we paid $5.0 million, and $6.0 million, respectively, for medical service fees to this provider. For the nine months ended September 30, 2011 and 2010, we paid $16.8 million, and $15.7 million, respectively, for medical service fees to this provider.

14. Subsequent Events

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see Note 9, “Long-Term Debt”). The repurchase program will be funded with working capital or the Company’s credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements regarding our business, financial condition and results of operations within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. We intend such forward-looking statements to be covered by the safe harbour provisions for forward-looking statements contained in the Private Securities Litigation reform Act of 1995, and we are including this statement for purposes of complying with these safe harbour provisions. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. Without limiting the foregoing, we use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," "could," "should" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- significant budget pressures on state governments which cause them to lower rates unexpectedly or to rescind expected rates increases, or their failure to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate or Medicaid expansion, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including costs associated with unexpectedly severe or widespread illnesses such as influenza, and rates of utilization that are consistent with our expectations;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states (including in Washington, Ohio, and Missouri), and our ability to grow our revenues consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including the California rate cut expected to be retroactive to July 1, 2011, and Medicaid pharmaceutical rebates;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine and Idaho;

- reductions to revenue, additional administrative costs and the potential payment of additional amounts to providers and/or the state by Molina Medicaid Solutions as a result of MMIS implementation issues in Maine and/or Idaho;
- government audits and reviews, including the audit of our Medicare plans by the Centers for Medicare and Medicaid Services, or CMS;
- changes with respect to our provider contracts and the loss of providers;
- the establishment, interpretation, and implementation of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- the successful integration of our acquisitions;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, and the costs associated therewith;
- restrictions and covenants in our credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs and the costs and fees associated therewith;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information by us or our business associates;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2010, as updated in Part II, Item 1A—Risk Factors, in our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2011 and in Part II, Item 1A—Risk Factors, of this report for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2010.

Adjustments

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. We also have a direct delivery business that currently consists of primary care community clinics in California and Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

We report our financial performance based on the following two reportable segments: Health Plans; and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, and includes our direct delivery business. This segment served approximately 1.7 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of September 30, 2011. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the nine months ended September 30, 2011, we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the nine months ended September 30, 2011, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the Temporary Assistance for Needy Families, or TANF, Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $110 in California to $250 in Missouri. Among our Medicaid Aged, Blind or Disabled, or ABD, membership, PMPM premiums range from approximately $325 in Utah to $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient, behavioral health and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums, at approximately $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	September 30, 2011	June 30, 2011	December 31, 2010	September 30, 2010
Total Ending Membership by Health Plan:				
California	350,000	348,000	344,000	349,000
Florida	67,000	66,000	61,000	57,000
Michigan	217,000	220,000	227,000	225,000
Missouri	78,000	80,000	81,000	79,000
New Mexico	89,000	89,000	91,000	91,000
Ohio	256,000	245,000	245,000	241,000
Texas	148,000	129,000	94,000	96,000
Utah	82,000	82,000	79,000	78,000
Washington	350,000	345,000	355,000	353,000
Wisconsin (1)	41,000	41,000	36,000	28,000
Total	1,678,000	1,645,000	1,613,000	1,597,000
Total Ending Membership by State for our Medicare Advantage Plans (1):				
California	6,500	6,000	4,900	4,300
Florida	700	600	500	500
Michigan	7,600	7,100	6,300	5,700
New Mexico	800	700	600	600
Ohio	100	200	—	—
Texas	600	600	700	600
Utah	7,400	7,000	8,900	8,600
Washington	4,500	4,000	2,600	2,300
Total	28,200	26,200	24,500	22,600
Total Ending Membership by State for our Aged, Blind or Disabled Population:				
California	23,700	17,000	13,900	13,500
Florida	10,400	10,300	10,000	9,500
Michigan	31,600	31,600	31,700	31,400
New Mexico	5,600	5,600	5,700	5,700
Ohio	29,900	28,700	28,200	27,900
Texas	61,800	52,000	19,000	18,900
Utah	8,300	8,300	8,000	7,900
Washington	4,700	4,400	4,000	3,700
Wisconsin (1)	1,700	1,700	1,700	1,700
Total	177,700	159,600	122,200	120,200

(1) We acquired the Wisconsin health plan on September 1, 2010. As of September 30, 2011, the Wisconsin health plan had approximately 2,200 Medicare Advantage members covered under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

Molina Medicaid Solutions' MMIS contracts extend over a number of years, and cover the life of the MMIS from inception through at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds. In some circumstances, revenue recognition may be delayed for long periods while we await formal customer acceptance of our products and/or services. In those circumstances, recognition of a portion of our costs may be deferred.

Under our contracts in Louisiana, New Jersey, and West Virginia, we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue as earned. In Maine we completed the DDI phase of our contract effective September 1, 2010 and are recognizing DDI revenue on a straight line basis over the remaining term of the contract. In Idaho, we expect to complete the DDI phase of our contract in 2011. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in the second half of 2012.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $76.3 million, and $61.9 million, for the nine months ended September 30, 2011 and 2010, respectively, including certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Idaho, Louisiana, Maine, New Jersey, West Virginia, and Florida. General and administrative costs consist primarily of indirect administrative costs and business development costs.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred contract costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contract costs in the second half of 2012, in a manner consistent with our anticipated recognition of revenue.

Third Quarter Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the three and nine months ended September 30, 2011. Comparable metrics for the third quarter of 2010 are also shown. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(Dollar amounts in thousands, except per share data)			
Earnings per diluted share	$ 0.41	$ 0.38	$ 1.16	$ 0.93
Premium revenue	$ 1,138,230	$ 1,005,115	$ 3,348,438	$ 2,947,020
Service revenue	$ 37,728	$ 32,271	$ 111,290	$ 53,325
Operating income	$ 33,566	$ 29,953	$ 96,276	$ 71,569
Net income	$ 18,950	$ 16,173	$ 53,778	$ 37,342
Total ending membership	1,678,000	1,597,000	1,678,000	1,597,000
Premium revenue	96.7%	96.7%	96.7%	98.1%
Service revenue	3.2	3.1	3.2	1.8
Investment income	0.1	0.2	0.1	0.1
Total revenue	100.0%	100.0%	100.0%	100.0%
Medical care ratio	84.3%	84.2%	84.3%	85.1%
General and administrative expense ratio	8.5%	8.5%	8.4%	8.2%
Premium tax ratio	3.2%	3.5%	3.3%	3.5%
Operating income	2.9%	2.9%	2.8%	2.4%
Net income	1.6%	1.6%	1.6%	1.2%
Effective tax rate	35.1%	36.2%	36.4%	37.3%

Compared with the third quarter of 2010, our third quarter of 2011 was marked by improved performance of our Health Plans segment due to a 13% increase in premium revenue, partially offset by a decrease in the profitability of our Molina Medicaid Solutions segment. Earnings per share in the third quarter of 2011 were up 8% over the third quarter of 2010, operating income was up 12%, and membership on a member-month basis grew by 8%. Our larger and more established health plans performed the strongest in the quarter, with each of Michigan, Ohio, and Utah having lower medical care ratios compared with the third quarter of 2010. Medicare enrollment exceeded 28,000 members at September 30, 2011, and Medicare premium revenue for the quarter was $101.5 million compared with $70.7 million in the third quarter of 2010.

Improved performance of our health plans segment, partially offset by a decrease in the profitability of our Molina Medicaid Solution segment, also led to improved performance for the nine months ended September 30, 2011 compared with the nine months ended September 30, 2010. Earnings per share in the nine months ended September 30, 2011 were up 25% over the comparable period in 2010, premium revenues were up 14%, operating income was up 35%, and membership on a member-month basis grew by 10%. Medicare premium revenue for the nine months ended September 30, 2011 was $282.3 million compared with $188.6 million for the nine months ended September 30, 2010.

In October 2011, our Missouri health plan received a “Commendable” rating from the National Committee for Quality Assurance, or NCQA. Nine of our ten health plans have now been accredited by NCQA, and our Wisconsin health plan will be seeking accreditation in the future.

Our Florida, Texas and Wisconsin health plans continue to face challenges. We have undertaken a number of measures—focused on both utilization and unit cost reductions—to improve the profitability of these health plans. All three health plans reported lower medical care ratios in the third quarter of 2011 than in the second quarter of 2011; and Florida and Wisconsin reported lower medical care ratios in the third quarter of 2011 than in the third quarter of 2010. The medical care ratio of the California health plan declined sequentially, as a result of an estimated 6% rate reduction that will be retroactive to July 1, 2011. The amount reserved for the estimated rate reduction was approximately $7.5 million.

We remain concerned about state budget deficits, which are not expected to improve during the remainder of 2011. Accordingly, the rate environment for our health plans remains uncertain, and we have received several rate reductions effective to date in 2011, including a blended 6% reduction in California retroactive to July 1, 2011, a 2.5% reduction in New Mexico effective July 1, 2011, a 2% reduction in Utah effective July 1, 2011, and a 2% rate reduction in Texas effective September 1, 2011. For the remainder of 2011, we anticipate a 1% reduction in California effective October 1, 2011. However, we have also received notifications of rate increases, including a 5% blended rate increase at our Missouri health plan effective July 1, 2011, a 7.5% rate increase at our Florida plan effective September 1, 2011, and a 1% rate increase at our Michigan plan effective October 1, 2011.

With respect to our Molina Medicaid Solutions business, our system stabilization efforts in Idaho and Maine are taking longer and are more costly than we had anticipated. However, our profit margins in our fiscal agent contracts in New Jersey, Louisiana, and West Virginia remain stable, and we believe that the profitability of the Molina Medicaid Solutions segment will improve as system development and stabilization costs in Idaho and Maine decline.

The state of Idaho has sent their formal request for system certification to CMS, and we anticipate certification review late in 2011 or early 2012, with formal certification in the second half of 2012. The certification process for our MMIS in Maine is also currently underway.

Results of Operations

Three Months Ended September 30, 2011 Compared with the Three Months Ended September 30, 2010

Health Plans Segment

Premium Revenue

In the three months ended September 30, 2011, compared with the three months ended September 30, 2010, premium revenue grew 13% due to a membership increase of approximately 8% (on a member-month basis), and PMPM revenue increase of approximately 5%. Medicare premium revenue was $101.5 million for the three months ended September 30, 2011, compared with $70.7 million for the three months ended September 30, 2010. In addition to the $7.5 million reduction to revenue in the third quarter of 2011 for the estimated premium reduction in California, we reduced revenue by $5.9 million in the third quarter of 2011 due to a minimum medical cost floor in New Mexico and a profit cap in Texas. In the third quarter of 2010 we reduced certain accruals for these items, resulting in an increase to revenue of $2.9 million.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended September 30,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 698,995	$ 140.55	72.9%	$ 601,836	$ 130.60	71.1%
Capitation	129,315	26.00	13.5	136,425	29.61	16.1
Pharmacy	89,191	17.93	9.3	76,049	16.50	9.0
Other	41,657	8.39	4.3	31,627	6.87	3.8
Total	$ 959,158	$ 192.87	100.0%	$ 845,937	$ 183.58	100.0%

The ratio of medical care costs to premium revenue (the medical care ratio, or MCR) was essentially flat, increasing to 84.3% in the three months ended September 30, 2011, compared with 84.2% for the three months ended September 30, 2010. Total medical care costs increased approximately 5% PMPM.

- Fee-for-service and capitation costs combined increased approximately 4%. Excluding the disproportionate impact of the Texas health plan, where we have experienced high utilization and unit costs for both physician and outpatient services (which include personal care services), fee-for-service costs were flat PMPM.
- Capitation costs decreased approximately 12% PMPM, primarily due to the transition of members in Michigan and Washington into fee-for-service networks.
- Fee-for-service costs increased approximately 8% PMPM, partially due to the transition of members from capitated provider networks into fee-for-service networks.
- Pharmacy costs increased approximately 9% PMPM.
- Hospital utilization decreased approximately 7%.

The medical care ratio of the California health plan increased to 88.8% in the three months ended September 30, 2011, from 80.3% in the three months ended September 30, 2010. The California health plan reduced premium revenue by approximately $7.5 million in the third quarter of 2011 for premium reductions estimated to be retroactive to July 1, 2011. The California Department of Health Care Services has indicated that it will reduce certain provider payments by approximately 10% retroactive to July 1, 2011. We believe that this reduction to provider payments will translate into a premium reduction of approximately 6% for the California health plan. At September 30, 2011 the California health plan had not recorded any potential recovery of provider payments related to this estimated premium reduction. Also in the third quarter of 2011, the California health plan added approximately 7,000 new ABD members with an average premium revenue of approximately $450 PMPM.

The medical care ratio of the Florida health plan decreased to 89.2% in the three months ended September 30, 2011, from 97.2% in the three months ended September 30, 2010, primarily due to initiatives implemented to reduce pharmacy and behavioral health costs. The Florida health plan received a premium rate increase of approximately 7.5% effective September 1, 2011.

The medical care ratio of the Michigan health plan decreased to 82.0% in the three months ended September 30, 2011, from 85.7% in the three months ended September 30, 2010, primarily due to improved Medicare performance and lower capitation and physician/outpatient costs combined. The Michigan health plan received a premium rate increase of approximately 1% effective October 1, 2011.

The medical care ratio of the Missouri health plan decreased to 78.1% in the three months ended September 30, 2011, from 86.7% in the three months ended September 30, 2010. Medical costs were flat compared to the prior period, while the health plan received a premium rate increase of approximately 5% effective July 1, 2011.

The medical care ratio of the New Mexico health plan increased to 84.2% in the three months ended September 30, 2011, from 83.5% in the three months ended September 30, 2010. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011. Premium revenues were further reduced due to a 1% increase in the minimum contractual amount the plan is required to spend on medical costs effective July 1, 2011. As a result of a minimum medical cost floor in our contract with the state of New Mexico, we reduced premium revenue by $4.4 million in the third quarter of 2011. In the third quarter of 2010, we reduced the accrual for the minimum medical cost floor, resulting in the recognition of an additional $2.8 million of revenue.

The medical care ratio of the Ohio health plan decreased to 78.4% in the three months ended September 30, 2011, from 81.2% in the three months ended September 30, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011, while fee for service costs have increased by only 2.0%.

The medical care ratio of the Texas health plan increased to 93.7% in the three months ended September 30, 2011, from 89.5% in the three months ended September 30, 2010. Effective September 1, 2011, the Texas health plan added approximately 8,000 ABD members and 3,000 TANF members in the Jefferson service area, and effective September 1, 2010, we added approximately 54,000 members state-wide who are covered under the Children's Health Insurance Program, or CHIP. Costs associated with ABD contracts, particularly in the Dallas-Fort Worth region, are running substantially higher than in our other markets, due to both high utilization and high unit costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Texas health plan. The medical care ratio of the Texas health plan fell from 95.0% in the second quarter of 2011 to 93.7% in the third quarter of 2011. Profitability of the CHIP line of business was proportionally higher in Texas, leading to a $1.5 million reduction of revenue as a result of a profit cap in our contract with the state of Texas. That profit cap is applied on a product by product basis. In the third quarter of 2010, we reduced the accrual for the profit cap, resulting in the recognition of an additional $0.1 million of revenue. The Texas health plan received a premium rate reduction of approximately 2% effective September 1, 2011.

The medical care ratio of the Utah health plan decreased to 79.3% in the three months ended September 30, 2011, from 84.9% in the three months ended September 30, 2010, primarily due to a reduction in inpatient utilization and a shift in member mix. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2011.

The medical care ratio of the Washington health plan increased to 82.8% in the three months ended September 30, 2011, from 79.4% in the three months ended September 30, 2010. Higher fee-for-service and pharmacy costs more than offset lower capitation costs. The Washington health plan received a premium rate reduction of approximately 1% effective October 1, 2011.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 79.1% in the three months ended September 30, 2011. The Wisconsin health plan recorded a premium deficiency reserve of $3.35 million in the first quarter of 2011. Based on improvements in the health plan's earnings forecast through the end of the contract period, this reserve was relieved during the second and third quarters. Absent the premium deficiency reduction, the Wisconsin plan's medical care ratio would have been approximately 88.1% in the three months ended September 30, 2011. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Wisconsin health plan.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended September 30, 2011						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,049	$ 144,888	$ 138.11	$ 128,596	$ 122.58	88.8%	$ 1,114
Florida	199	51,569	258.96	46,009	231.04	89.2	(17)
Michigan	656	165,636	252.46	135,899	207.13	82.0	9,644
Missouri	234	58,196	248.80	45,428	194.22	78.1	—
New Mexico	267	79,644	297.82	67,043	250.70	84.2	2,084
Ohio	745	232,616	312.55	182,363	245.02	78.4	18,072
Texas	414	105,577	255.25	98,954	239.24	93.7	1,613
Utah	243	69,763	286.47	55,293	227.05	79.3	—
Washington	1,043	211,131	202.49	174,912	167.76	82.8	3,776
Wisconsin(2)	123	17,269	139.95	13,656	110.67	79.1	—
Other(3)	—	1,941	—	11,005	—	—	88
	4,973	$1,138,230	$ 228.88	$ 959,158	$ 192.87	84.3%	$ 36,374

	Three Months Ended September 30, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,046	$ 128,350	$ 122.75	$ 103,002	$ 98.51	80.3%	$ 1,888
Florida	169	43,485	256.25	42,258	249.02	97.2	(14)
Michigan	675	156,609	232.05	134,238	198.90	85.7	9,655
Missouri	236	52,952	224.63	45,930	194.84	86.7	—
New Mexico	274	93,602	341.38	78,121	284.92	83.5	2,170
Ohio	715	210,651	294.55	171,051	239.18	81.2	16,734
Texas	180	48,188	267.95	43,129	239.82	89.5	861
Utah	234	67,566	289.28	57,381	245.67	84.9	—
Washington	1,051	195,578	186.03	155,307	147.73	79.4	3,622
Wisconsin(2)	28	6,310	224.18	6,154	218.65	97.5	—
Other(3)	—	1,824	—	9,366	—	—	121
	4,608	$1,005,115	$ 218.12	$ 845,937	$ 183.58	84.2%	$ 35,037

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

Days in Medical Claims and Benefits Payable

The days in medical claims and benefits payable were as follows:

(Dollars in thousands)	Sept. 30, 2011	June 30, 2011	Dec. 31, 2010	Sept. 30, 2010
Days in claims payable — fee-for-service only	39 days	39 days	42 days	42 days
Number of claims in inventory at end of period	132,200	121,900	143,600	110,200
Billed charges of claims in inventory at end of period (dollars in thousands)	$ 187,000	$ 205,800	$ 218,900	$ 158,900

Molina Medicaid Solutions Segment

Molina Medicaid Solutions was acquired on May 1, 2010. Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended September 30,	
	2011	2010
	(In thousands)	
Service revenue before amortization	$ 39,273	$ 34,926
Amortization recorded as reduction of service revenue	(1,545)	(2,655)
Service revenue	37,728	32,271
Cost of service revenue	34,584	27,605
General and administrative costs	2,069	2,195
Amortization of customer relationship intangibles recorded as amortization	1,282	1,314
Operating (loss) income	$ (207)	$ 1,157

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the Medicaid Management Information System, or MMIS, in that state receives certification from the Centers for Medicare and Medicaid Services, or CMS. Cost of service revenue includes $2.5 million of direct costs associated with the Idaho contract that would otherwise have been recorded as deferred contract costs. We were not able to defer these direct contract costs because estimated future net revenues as of each measurement date did not exceed estimated future direct costs of the contract. We currently expect the Idaho contract to perform financially at a break even basis through its initial term. So long as we continue to defer revenue recognition under the contract, we will also continue to defer direct costs associated with the agreement. If our break-even assumptions were to change, we may not be able to continue to defer direct contract costs.

Financial results remain strong under our Louisiana, New Jersey, and West Virginia MMIS contracts. Based upon our cost experience, we believe that the contract pricing agreed to by our predecessor under the Idaho and Maine MMIS contracts was inappropriately low. However, we believe that the profitability of the Molina Medicaid Solutions segment will improve as system development and stabilization costs in those two states decline.

Consolidated Expenses

General and Administrative Expenses

General and administrative, or G&A, expenses, were $99.6 million, or 8.5% of total revenue, for the three months ended September 30, 2011, compared with $88.7 million, or 8.5% of total revenue, for the three months ended September 30, 2010.

Premium Tax Expenses

Premium tax expense decreased to 3.2% of premium revenue in the three months ended September 30, 2011, from 3.5% in the three months ended September 30, 2010, due to a shift in revenue to states with comparatively low premium tax rates.

Interest Expense

Interest expense decreased to $4.4 million for the three months ended September 30, 2011, from $4.6 million for the three months ended September 30, 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $1.4 million and $1.3 million for the three months ended September 30, 2011, and 2010, respectively.

Income Taxes

Income tax expense is recorded at an effective rate of 35.1% for the three months ended September 30, 2011 compared with 36.2% for the three months ended September 30, 2010. The lower rate in 2011 is primarily due to differences in the amount of discrete tax benefits recorded during the respective periods.

Nine Months Ended September 30, 2011 Compared with the Nine Months Ended September 30, 2010

Health Plans Segment

Premium Revenue

In the nine months ended September 30, 2011, compared with the nine months ended September 30, 2010, premium revenue grew 14% due to a membership increase of approximately 10% (on a member-month basis), and PMPM revenue increase of approximately 4%. Medicare premium revenue was $282.3 million for the nine months ended September 30, 2011, compared with $188.6 million for the nine months ended September 30, 2010. Reductions to revenue due to a minimum medical cost floor in New Mexico and a profit cap in Texas amounted to $12.2 million for the nine months ended September 30, 2011. For the nine months ended September 30, 2010 we reduced certain accruals for these items, resulting in an increase to revenue of $0.1 million.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Nine Months Ended September 30,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$2,050,430	$ 138.40	72.7%	$1,763,675	$ 130.55	70.3%
Capitation	383,955	25.92	13.6	410,321	30.37	16.4
Pharmacy	268,637	18.13	9.5	241,290	17.86	9.6
Other	119,027	8.03	4.2	93,080	6.89	3.7
Total	$2,822,049	$ 190.48	100.0%	$2,508,366	$ 185.67	100.0%

The medical care ratio decreased to 84.3% in the nine months ended September 30, 2011, compared with 85.1% for the nine months ended September 30, 2010. Total medical care costs increased less than 3% PMPM.

- Pharmacy costs (adjusted for the state's retention of the pharmacy benefit in Ohio effective February 1, 2010) increased approximately 6% PMPM.
- Capitation costs decreased approximately 15% PMPM, primarily due to the transition of members in Michigan and Washington into fee-for-service networks.
- Fee-for-service costs increased approximately 6% PMPM, partially due to the transition of members from capitated provider networks into fee-for-service networks.
- Fee-for-service and capitation costs combined increased approximately 2% PMPM.
- Hospital utilization decreased approximately 7%.

The medical care ratio of the California health plan increased to 85.9% in the nine months ended September 30, 2011, from 84.0% in the nine months ended September 30, 2010. As noted above in "Three Months Ended September 30, 2011 Compared with the Three Months Ended September 30, 2010," the California health plan reduced premium revenue by approximately $7.5 million in the third quarter of 2011 for premium reductions estimated to be retroactive to July 1, 2011.

The medical care ratio of the Florida health plan increased to 94.2% in the nine months ended September 30, 2011, from 93.6% in the nine months ended September 30, 2010, primarily due to higher fee-for-service and capitation costs, which more than offset lower pharmacy and behavioral health costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Florida health plan. As noted above in "Three Months Ended September 30, 2011 Compared with the Three Months Ended September 30, 2010," profitability of the Florida health plan improved significantly in the third quarter of 2011.

The medical care ratio of the Michigan health plan decreased to 80.6% in the nine months ended September 30, 2011, from 84.4% in the nine months ended September 30, 2010, primarily due to improved Medicare performance, lower inpatient facility costs, and lower capitation and physician/outpatient costs combined.

The medical care ratio of the Missouri health plan increased to 87.1% in the nine months ended September 30, 2011, from 86.5% in the nine months ended September 30, 2010. The Missouri health plan received a premium rate increase of approximately 5% effective July 1, 2011. As noted above in "Three Months Ended September 30, 2011 Compared with the Three Months Ended September 30, 2010," profitability of the Missouri health plan improved significantly in the third quarter of 2011.

The medical care ratio of the New Mexico health plan increased to 83.5% in the nine months ended September 30, 2011, from 80.2% in the nine months ended September 30, 2010. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011. Additionally premium revenues were reduced due to a 1% increase in the minimum contractual amount the plan is required to spend on medical costs effective July 1, 2011. As a result of a minimum medical cost floor in our contract with the state of New Mexico, we reduced premium revenue by $10.9 million in the nine months ended September 30, 2011. The minimum medical cost floor had no impact on premium revenue in the nine months ended September 30, 2010.

The medical care ratio of the Ohio health plan decreased to 76.9% in the nine months ended September 30, 2011, from 80.7% in the nine months ended September 30, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011, and modestly lower fee-for-service costs.

The medical care ratio of the Texas health plan increased to 93.4% in the nine months ended September 30, 2011, from 87.6% in the nine months ended September 30, 2010. Effective February 1, 2011, we added approximately 30,000 ABD members in the Dallas-Fort Worth area and effective September 1, 2011, we added approximately 8,000 ABD members and 3,000 TANF members in the Jefferson Service area, and effective September 1, 2010, we added approximately 54,000 members state-wide who are covered under CHIP. Costs associated with our ABD contracts, particularly in the Dallas-Fort Worth region, are running substantially higher than in our other markets, due to both high utilization and high unit costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Texas health plan. As a result of a profit cap in our contract with the state of Texas, we reduced premium revenue by $1.3 million in the nine months ended September 30, 2011. In the nine months ended September 30, 2010, we reduced the accrual for the profit cap, resulting in the recognition of an additional $0.1 million of revenue.

The medical care ratio of the Utah health plan decreased to 77.9% in the nine months ended September 30, 2011, from 94.1% in the nine months ended September 30, 2010, primarily due to reduced fee-for-service outpatient and physician costs and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010. Lower fee-for-service costs were the result of both lower unit costs and lower utilization. During the second quarter of 2011 we settled certain claims with the state regarding the savings share provision of our contract in effect from 2003 through June of 2009. We settled for the contract years 2006 through 2009 and recognized $6.9 million in premium revenue without any corresponding charge to expense. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2011.

The medical care ratio of the Washington health plan increased to 84.7% in the nine months ended September 30, 2011, from 84.2% in the nine months ended September 30, 2010. Higher fee-for-service and pharmacy costs more than offset lower capitation costs.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 92.1% in the nine months ended September 30, 2011. The state of Wisconsin reduced capitation rates by 11% on January 1, 2011. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Wisconsin health plan.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Nine Months Ended September 30, 2011						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	3,133	$ 418,961	$ 133.71	$ 359,844	$ 114.84	85.9%	$ 4,937
Florida	588	150,561	256.13	141,872	241.35	94.2	34
Michigan	2,002	495,971	247.70	399,952	199.75	80.6	29,219
Missouri	722	169,988	235.45	148,135	205.18	87.1	—
New Mexico	808	246,223	304.71	205,659	254.51	83.5	6,472
Ohio	2,218	693,829	312.86	533,216	240.44	76.9	53,629
Texas	1,154	290,787	252.06	271,723	235.54	93.4	5,016
Utah	723	215,205	297.62	167,605	231.79	77.9	—
Washington	3,104	608,998	196.25	515,769	166.20	84.7	11,099
Wisconsin(2)	364	51,526	141.42	47,450	130.23	92.1	44
Other(3)	—	6,389	—	30,824	—	—	183
	14,816	$3,348,438	$ 226.01	$2,822,049	$ 190.48	84.3%	$ 110,633

	Nine Months Ended September 30, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	3,158	$ 376,811	$ 119.32	$ 316,569	$ 100.24	84.0%	$ 5,153
Florida	483	124,035	256.70	116,079	240.23	93.6	(2)
Michigan	2,029	468,723	230.98	395,450	194.87	84.4	29,305
Missouri	704	156,874	222.83	135,766	192.85	86.5	—
New Mexico	834	281,149	336.93	225,346	270.06	80.2	7,161
Ohio	2,083	641,683	308.11	517,951	248.70	80.7	50,251
Texas	426	130,881	307.51	114,593	269.24	87.6	2,247
Utah	685	191,040	278.99	179,816	262.60	94.1	—
Washington	3,080	562,836	182.75	473,609	153.78	84.2	10,278
Wisconsin(2)	28	6,310	224.18	6,154	218.65	97.5	—
Other(3)	—	6,678	—	27,033	—	—	185
	13,510	$2,947,020	$ 218.14	$2,508,366	$ 185.67	85.1%	$ 104,578

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs of the parent company.

Molina Medicaid Solutions Segment

Molina Medicaid Solutions was acquired on May 1, 2010; therefore, the nine months ended September 30, 2010 include only five months of operating results for this segment. Performance of the Molina Medicaid Solutions segment was as follows:

	Nine Months Ended September 30, 2011	Five Months Ended September 30, 2010
	(In thousands)	
Service revenue before amortization	$ 116,567	$ 57,571
Amortization recorded as reduction of service revenue	(5,277)	(4,246)
Service revenue	111,290	53,325
Cost of service revenue	105,020	41,859
General and administrative costs	6,421	3,161
Amortization of customer relationship intangibles recorded as amortization	3,846	2,143
Operating (loss) income	$ (3,997)	$ 6,162

Cost of service revenue for the nine months ended September 30, 2011 includes $9.5 million of direct costs associated with the Idaho contract that would otherwise have been recorded as deferred contract costs, for the same reasons discussed above, in "Three Months Ended September 30, 2011 Compared with the Three Months Ended September 30, 2010."

Consolidated Expenses and Other

General and Administrative Expenses

General and administrative expenses were $291.0 million, or 8.4% of total revenue, for the nine months ended September 30, 2011, compared with $245.6 million, or 8.2% of total revenue, for the nine months ended September 30, 2010.

Premium Tax Expense

Premium tax expense decreased to 3.3% of premium revenue, in the nine months ended September 30, 2011, from 3.5% in the nine months ended September 30, 2010, due to a shift in revenue to states with comparatively low premium tax rates.

Interest Expense

Interest expense decreased to $11.7 million for the nine months ended September 30, 2011, from $12.1 million for the nine months ended September 30, 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which amounted to $4.1 million and $3.8 million for the nine months ended September 30, 2011 and 2010, respectively.

Income Taxes

Income tax expense is recorded at an effective rate of 36.4% for the nine months ended September 30, 2011, compared with 37.3% for the nine months ended September 30, 2010. The lower rate in 2011 is primarily due to discrete tax benefits recognized for statute closures and prior year tax return to provision reconciliations. Excluding the discrete tax benefits, the effective tax rate for the nine months ended September 30, 2011 was 37.3%.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Depreciation is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Three Months Ended September 30,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation	$ 8,234	0.7%	$ 6,840	0.6%
Amortization of intangible assets	5,196	0.4	5,114	0.5
Depreciation and amortization reported as such in the consolidated statements of income	13,430	1.1	11,954	1.1
Amortization recorded as reduction of service revenue	1,545	0.1	2,655	0.3
Depreciation recorded as cost of service revenue	2,837	0.2	1,964	0.2
Total	$ 17,812	1.4%	$ 16,573	1.6%

	Nine Months Ended September 30,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation	$ 22,859	0.7%	$ 19,963	0.7%
Amortization of intangible assets	15,728	0.5	13,271	0.4
Depreciation and amortization reported as such in the consolidated statements of income	38,587	1.2	33,234	1.1
Amortization recorded as reduction of service revenue	5,277	0.1	4,246	0.1
Depreciation recorded as cost of service revenue	8,550	0.2	3,005	0.1
Total	$ 52,414	1.5%	$ 40,485	1.3%

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of September 30, 2011, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $3.8 million for the nine months ended September 30, 2011, compared with $4.9 million for the nine months ended September 30, 2010. Our annualized portfolio yield for the nine months ended September 30, 2011 was 0.6% compared with 0.8% for the nine months ended September 30, 2010.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the nine months ended September 30, 2011 was $155.2 million compared with $9.5 million for the nine months ended September 30, 2010, an increase of $145.7 million. Deferred revenue, which was a source of operating cash amounting to $42.6 million in 2011, was a use of operating cash amounting to $64.3 million in 2010.

Cash provided by financing activities decreased due to $111.2 million net proceeds from our common stock offering in the third quarter of 2010, with no comparable activity in the current year.

Reconciliation of Non-GAAP [1] to GAAP Financial Measures

EBITDA [2]

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
	(In thousands)			
Net income	$ 18,950	$ 16,173	$ 53,778	$ 37,342
Add back:				
Depreciation and amortization reported in the consolidated statements of cash flows	17,812	16,573	52,414	40,485
Interest expense	4,380	4,600	11,666	12,056
Provision for income taxes	10,236	9,180	30,832	22,171
EBITDA	$ 51,378	$ 46,526	$ 148,690	$ 112,054

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At September 30, 2011, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $54.3 million, compared with approximately $65.1 million of cash and investments at December 31, 2010. This decline was primarily due to capital contributions and /or advances to our Florida, Texas, and Wisconsin health plans in the first quarter of 2011.

On a consolidated basis, at September 30, 2011, we had working capital of $430.2 million compared with $392.4 million at December 31, 2010. At September 30, 2011 we had cash and investments of $881.0 million, compared with $813.8 million of cash and investments at December 31, 2010.

On October 11, 2011, Molina Center LLC, our wholly owned subsidiary, entered into a purchase agreement to acquire the approximately 460,000 square foot office project located at 200 and 300 Oceangate, Long Beach, California. The purchase price under the agreement is $83 million, to be paid in cash at closing. The transaction is contingent upon the satisfactory completion of our due diligence review and other customary closing conditions. Any closing is expected to occur during December 2011 or the first quarter of 2012.

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014 (see discussion of “Convertible Senior Notes” below). The repurchase program will be funded with working capital or draws under our credit facility (see discussion of “Credit Facility” below).

On July 27, 2011, our board of directors approved a stock repurchase program of up to $7 million to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Under this program, we purchased approximately 400,000 shares of our common stock for $7 million (average cost of approximately $17.47 per share) during August 2011. These purchases did not materially impact diluted earnings per share for the three months or nine months ended September 30, 2011. Subsequently, we retired the $7.0 million of treasury shares purchased, which reduced additional paid-in capital as of September 30, 2011.

We believe that our cash resources, Credit Facility, and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

On September 9, 2011, we entered into a credit agreement for a $170 million revolving credit facility (the “Credit Facility”) with various lenders and U.S. Bank National Association, as LC Issuer, Swing Line Lender, and Administrative Agent. The Credit Facility will be used for general corporate purposes.

The Credit Facility has a term of five years under which all amounts outstanding will be due and payable on September 9, 2016. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $195 million. As of September 30, 2011 there was no outstanding principal balance under the Credit Facility. However, as of September 30, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho, which reduces the amount available under the Credit Facility.

Borrowings under the Credit Facility will bear interest based, at our election, on the base rate plus an applicable margin or the Eurodollar rate. The base rate is, for any day, a rate of interest per annum equal to the highest of (i) the prime rate of interest announced from time to time by U.S. Bank or its parent, (ii) the sum of the federal funds rate for such day plus 0.50% per annum and (iii) the Eurodollar rate (without giving effect to the applicable margin) for a one month interest period on such day (or if such day is not a business day, the immediately preceding business day) plus 1.00%. The Eurodollar rate is a reserve adjusted rate at which Eurodollar deposits are offered in the interbank Eurodollar market plus an applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee of 0.25% to 0.50% (based upon our leverage ratio) of the unused amount of the lenders' commitments under the Credit Facility. The initial commitment fee shall be set at 0.35% until our delivery of its financials for the quarter ended September 30, 2011. The applicable margins range between 0.75% to 1.75% for base rate loans and 1.75% to 2.75% for Eurodollar loans, in each case, based upon our leverage ratio.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets, with the exception of certain of our real estate assets, and by a pledge of the capital stock or membership interests of our operating subsidiaries and health plans (with the exception of the California health plan).

The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of not less than 1.75 to 1.00. At September 30, 2011, we were in compliance with all financial covenants under the Credit Facility.

In the event of a default, including cross-defaults relating to specified other debt in excess of $20 million, the lenders may terminate the commitments under the Credit Facility and declare the amounts outstanding, including all accrued interest and unpaid fees, payable immediately. In addition, the lenders may enforce any and all rights and remedies created under the Credit Facility or applicable law.

In connection with our entrance into the Credit Facility, on September 9, 2011, we terminated our existing credit agreement with Bank of America, dated March 9, 2005, as amended to date, which had provided us with a $150 million revolving credit facility. As of September 30, 2011 and December 31, 2010, there was no outstanding principal balance under this credit agreement.

Shelf Registration Statement

Under a shelf registration statement on Form S-3 that was filed with the Securities and Exchange Commission in December 2008, we have up to $182.5 million available for the issuance of our securities, including common stock, warrants, or debt securities, that may be publicly offered from time to time at prices and terms to be determined at the time of the offering.

Convertible Senior Notes

As of September 30, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $456.2 million at September 30, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2011, our health plans had aggregate statutory capital and surplus of approximately $463.1 million compared with the required minimum aggregate statutory capital and surplus of approximately $273.9 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2011. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2010, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;
- The deferral of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and;
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Certain components of premium revenue are subject to accounting estimates, and are therefore subject to retroactive revision. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At September 30, 2011, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Effective July 1, 2008, our New Mexico health plan entered into a new four-year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At September 30, 2011, we had recorded a liability of $16.5 million under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 0.75% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. For the state fiscal year ended June 30, 2011, our New Mexico health plan has received $2.6 million in at-risk revenue for state fiscal year 2011. We have recognized $1.9 million of that amount as revenue, and recorded a liability of approximately $0.7 million as of September 30, 2011, for the remainder. For the state fiscal year ended June 30, 2012 we have received $0.6 million in at-risk revenue. We have recognized $0.4 million as revenue, and have recorded a liability of $0.2 million for the remainder. If the state of New Mexico disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. Effective February 1, 2010 through June 30, 2011, an additional 0.25% of the Ohio health plan's revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. For the state fiscal year ended June 30, 2011, our Ohio health plan received $10.3 million in at-risk revenue. We have recognized $8.6 million of that amount as revenue, and recorded a liability of approximately $1.7 million for the remainder. To date for the state fiscal year ended June 30, 2012, we have received $2.7 million in at-risk revenue, of which $2.3 million has been recognized as revenue, and $0.4 million was recorded as a liability as of September 30, 2011. If the state of Ohio disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required. For example, during the third quarter of 2010, we reversed the recognition of approximately $3.3 million of at-risk revenue, of which $1.9 million and $1.4 million were initially recognized in 2010, and 2009, respectively.

- *Utah Health Plan Premium Revenue:* Our Utah health plan was entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid during the period 2003 through August 31, 2009.

  During the second quarter of 2011 we settled all claims related to state contract years 2006 through 2009 and received payments amounting to $13.6 million in settlement of this matter. The state in turn has made demands upon us amounting to $9.6 million to recover alleged over payment of premium revenue to us for the period 2003 through 2009. We are disputing many of those claims and as of September 30, 2011 have recorded a liability of approximately $4.6 million in connection with the premium revenue overpayments.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas there is a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. The rebates, if any, are calculated separately for the TANF/CHIP and ABD products. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of September 30, 2011, we had an aggregate liability of approximately $1.3 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2011 and 2012 contract years (ending August 31st of each year). Because the final settlement calculations include a claims run-out period of nearly one year, an adjustment to the amounts owed may be required.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures established by the state. The time period for the assessment of these performance measures previously followed the state's fiscal year, but effective January 1, 2011, it follows the calendar year. The state of Texas has notified us that it has discontinued the program for the 2011 calendar year.

- *Wisconsin Health Plan incentive revenue*: Under our contract with the state of Wisconsin, a portion of the capitation premiums are withheld by the state and placed into an incentive pool. The amounts withheld are 3.25% of revenue in the southeast region of the state for the Badger Care program and 1% for the remaining membership in the state. If certain performance measures are met, the plan may be eligible to receive these additional funds as an incentive payment. As of September 30, 2011 we have determined that there is persuasive evidence that at least a portion of these funds have been earned and a receivable $0.4 million is established accordingly.

- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns, we have recorded a liability of approximately $1.2 million related to the potential recoupment of Medicare premium revenue at September 30, 2011. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

Recognition of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO, arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solutions contracts are multiple-element arrangements. The following discussion applies to our contracts with multiple elements entered into prior to January 1, 2011, before our prospective adoption of *Accounting Standards Update, or ASU, No. 2009-13, Revenue Recognition (Accounting Standards Codification, or ASC, Topic 605) — Multiple-Deliverable Revenue Arrangements*.

For those contracts entered into prior to January 1, 2011, we have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services, which vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our newer contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement prior to January 1, 2011 requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services, or training and support services) until the contingency has been removed. When we defer revenue recognition we also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the revenue deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

However, direct costs in excess of the estimated future net revenues associated with a contract may not be deferred. In circumstances where estimated direct costs over the life of a contract exceed estimated future net revenues of that contract, the excess of direct costs over revenue is expensed as a period cost.

In Idaho, revenue recognition is expected to begin during the second half of 2012. Consistent with the deferral of revenue, we have deferred recognition of a portion of the direct contract costs associated with that revenue. Deferred contract costs, if any, deferred through the date revenue recognition begins will be recognized simultaneously with revenue. As noted above, direct costs in excess of the estimated future net revenues associated with a contract may not be deferred. For the three and nine months ended September 30, 2011, we recorded $2.5 million and $9.5 million, respectively, of direct contract costs associated with our Idaho contract. We were not able to defer these direct contract costs because estimated future net revenues as of each measurement date did not exceed estimated future direct costs of the contract. We currently expect the Idaho contract to perform financially at a break even basis through its initial term. So long as we continue to defer revenue recognition under the contract, we will also continue to defer direct costs associated with the agreement. If our break-even assumptions were to change, we may not be able to continue to defer direct contract costs.

We began to recognize revenue and the related deferred costs associated with our Maine contract in September 2010.

Molina Medicaid Solutions' deferred revenue was $53.1 million at September 30, 2011, and $10.9 million at December 31, 2010, and unamortized deferred contract costs were $52.8 million at September 30, 2011, and $28.4 million at December 31, 2010.

For all new or materially modified revenue arrangements with multiple elements entered into on or after January 1, 2011, we apply the guidance contained in ASU No. 2009-13. For these arrangements, we allocate total arrangement consideration to the elements of the arrangement, which are expected to be DDI, BPO, and training and support services, because this is consistent with the current elements included in our Molina Medicaid Solutions contracts. The arrangement allocation is performed using the relative selling-price method. When determining the selling price of each element, VSOE should first be used, if available. Since VSOE is unavailable under our contracts, we will attempt to use third-party evidence, or TPE, of vendors selling similar services to similarly situated customers on a standalone basis, if available. If TPE is not available, we use our best estimate of the selling price for each element.

We then evaluate whether, at each stage in the life cycle of the contract, we are able to recognize revenue associated with that element. To the extent that our revenue arrangements have provisions that allow our state customers to refuse acceptance of services performed, we are still required to defer revenue recognition until such state customers accept our performance. Once this acceptance is achieved, we immediately recognize the revenue associated with any delivered elements, which differs from our current practice for arrangements entered into prior to January 1, 2011, where the revenue associated with delivered elements is recognized over the final service element of the arrangement because VSOE for the other elements does not exist. As such, we expect that the adoption of ASU No. 2009-13 will result in an overall acceleration of revenue recognition with respect to any multiple-element arrangements entered into on or after January 1, 2011. We have entered into no new or materially modified revenue arrangements with multiple elements since January 1, 2011.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	Sept. 30, 2011	Dec. 31, 2010	Sept. 30, 2010
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 283,160	$ 275,259	$ 271,285
Capitation payable	49,259	49,598	53,410
Pharmacy	16,615	14,649	14,663
Other	12,021	14,850	13,982
	$ 361,055	$ 354,356	$ 353,340

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $283.2 million of our total medical claims and benefits payable of $361.1 million as of September 30, 2011. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider’s monthly capitation payment), our IBNP liability at September 30, 2011, was $276.9 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of September 30, 2011 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding September 30, 2011, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ 113,904
(4%)	75,936
(2%)	37,968
2%	(37,968)
4%	(75,936)
6%	(113,904)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of September 30, 2011 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ (61,288)
(4%)	(40,859)
(2%)	(20,429)
2%	20,429
4%	40,859
6%	61,288

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 46.3 million diluted shares outstanding for the nine months ended September 30, 2011. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at September 30, 2011, net income for the nine months ended September 30, 2011 would increase or decrease by approximately $11.9 million, or $0.26 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at September 30, 2011, net income for the three months ended September 30, 2011 would increase or decrease by approximately $6.4 million, or $0.14 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $59.3 million, or $1.28 per diluted share, and $31.9 million, or $0.69 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $11.9 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations and regions such as the ABD population in the Dallas-Fort Worth area, changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2010, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 15.7%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2010 and through September 30, 2011 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized a benefit from prior period claims development in the amount of $49.5 million for the nine months ended September 30, 2011 (see table below). This amount represents our estimate as of September 30, 2011 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2010 was due primarily to the following factors:

- We overestimated the impact of an increase in pending high dollar claims at our Ohio health plan.
- We underestimated the lower cost associated with changes to provider fee schedules (primarily for outpatient facility costs) in New Mexico effective November 1, 2010.

The following developments partially offset the overestimation of our claims liability at December 31, 2010:

- In Missouri, delays in claims processing late in the fourth quarter of 2010 led us to underestimate the size of our claims liability at December 31, 2010.
- We underestimated the costs associated with our assumption of risk for a new population in Texas (rural CHIP members) effective September 1, 2010.

We recognized a benefit from prior period claims development in the amount of $49.4 million for the year ended December 31, 2010 (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at September 30, 2011, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The assumption of risk for new populations by our Texas health plan; Dallas-Fort Worth area ABD members effective February 1, 2011; Jefferson service area members effective September 30, 2011.
- The transition of certain members by our Washington and Michigan health plans from full-risk capitated provider arrangements to fee-for-service providers effective December 31, 2010. This change had the effect of transferring back to the Company risk that had previously been assumed by capitated medical providers.
- A substantial decline in Medicaid claims inventory at our Ohio health plan and for our overall Medicare membership.
- A substantial increase in Medicaid claims inventory in Missouri and New Mexico.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2010 and through September 30, 2011, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "Components of medical care costs related to: Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Nine Months Ended		Six Months Ended	Three Months Ended	Year Ended
	Sept. 30, 2011	Sept. 30, 2010	June 30, 2011	March 31, 2011	Dec. 31, 2010
	(Dollars in thousands, except per-member amounts)				
Balances at beginning of period	$ 354,356	$ 315,316	$ 354,356	$ 354,356	$ 315,316
Balance of acquired subsidiary	—	—	—	—	3,228
Components of medical care costs related to:					
Current period	2,871,515	2,554,579	1,908,289	957,909	3,420,235
Prior periods	(49,466)	(46,213)	(45,398)	(44,377)	(49,378)
Total medical care costs	2,822,049	2,508,366	1,862,891	913,532	3,370,857
Payments for medical care costs related to:					
Current period	2,522,374	2,219,896	1,584,636	646,428	3,085,388
Prior periods	292,976	250,446	290,998	270,078	249,657
Total paid	2,815,350	2,470,342	1,875,634	916,506	3,335,045
Balances at end of period	$ 361,055	$ 353,340	$ 341,613	$ 351,382	$ 354,356
Benefit from prior period as a percentage of:					
Balance at beginning of period	14.0%	14.7%	12.8%	12.5%	15.7%
Premium revenue	1.5%	1.6%	2.1%	4.1%	1.2%
Total medical care costs	1.8%	1.8%	2.4%	4.9%	1.5%
Claims Data:					
Days in claims payable, fee for service	39	42	39	41	42
Number of members at end of period	1,678,000	1,597,000	1,645,000	1,647,000	1,613,000
Number of claims in inventory at end of period	132,200	110,200	121,900	185,300	143,600
Billed charges of claims in inventory at end of period	$ 187,000	$ 158,900	$ 205,800	$ 250,600	$ 218,900
Claims in inventory per member at end of period	0.08	0.07	0.07	0.11	0.09
Billed charges of claims in inventory per member at end of period	$ 111.44	$ 99.50	$ 125.11	$ 152.16	$ 135.71
Number of claims received during the period	12,864,800	10,701,900	8,715,200	4,342,200	14,554,800
Billed charges of claims received during the period	$ 10,573,900	$ 8,615,500	$ 6,963,300	$ 3,386,600	$ 11,686,100

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the *"Exchange Act "*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: During the fiscal quarter ended June 30, 2011, we completed the implementation of a new enterprise resource planning, or ERP, software system. This system is used in the preparation of, among other things, our financial statements and required reports. There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2011 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. Based upon the evaluation of information currently available, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. In addition to the other information set forth in this report, the following risk factors were identified by the Company during the third quarter of 2011 and is a supplement to the risk factors identified in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2010, as updated in Part II, Item 1A — Risk Factors in our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2011. The risk factors described herein and in our Annual Report on Form 10-K, as updated by our quarterly report on Form 10-Q for the quarterly period ended June 30, 2011, are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions or reduce our liquidity and capital resources.

On September 9, 2011, we terminated our credit agreement with Bank of America which had provided us with a $150 million revolving credit facility and entered into a credit agreement for a $170 million revolving credit facility with various lenders and U.S. Bank National Association. The credit facility imposes numerous restrictions and covenants, including, but not limited to, prescribed consolidated leverage and fixed charge coverage ratios, net worth requirements, and acquisition and disposition limitations that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends and other distributions without lender approval. Our ability to comply with these covenants may be affected by events beyond our control. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to react to market conditions, finance our operations, engage in strategic acquisitions or disposals, act with complete flexibility, or to use our credit facility in the manner intended. In addition, our credit facility matures in September 2016. If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, or if we are unable to renew or refinance our credit facility prior to its maturity, and if the default is not cured or waived, we may be unable to use the credit facility in the manner intended, and our operations, liquidity, and capital resources could be materially adversely affected.

In the event the expected reduction in the rates paid to our California health plan is not finally implemented, is not made effective retroactive to July 1, 2011, or is otherwise modified, our results of operations may be affected.

California Assembly Bill 97, or AB 97, is legislation that was signed by Governor Jerry Brown on March 24, 2011. Among other things, AB 97 proposes to effect a 10% reduction in Medi-Cal provider rates. The California Department of Health Care Services has indicated that the 10% rate reduction will be effective retroactive to July 1, 2011. The Company believes that this reduction in provider payments, if effected, will translate into a premium reduction of approximately 6% for the California health plan. Because of the expected reduction in its rates effective July 1, 2011, the California health plan reduced its recognized premium revenue by approximately $7.5 million in the third quarter of 2011. However, at September 30, 2011, the California health plan had not recorded any potential recovery of provider payments related to this estimated premium reduction.

The proposed rate reduction was submitted for approval to CMS, and CMS had requested additional information from the state in support of the rate cut. On October 27, 2011, CMS indicated its general approval of the rate cut. However, the immediate effect of that approval is unclear, and it is anticipated that litigation will be commenced by providers or others to enjoin the implementation of the rate cut.

If the proposed rate cut is not finally implemented, if it is not made retroactive to July 1, 2011, or if it is otherwise modified from its current form, the results of our California health plan could be affected. In addition, recoveries from providers related to any final implemented rate cut could also affect the results of our California health plan.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

Issuer Purchases of Equity Securities

On July 27, 2011, our board of directors approved a stock repurchase program of up to $7 million to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Under this program, we purchased approximately 400,000 shares of our common stock for $7 million (average cost of approximately $17.47 per share) during August 2011. This repurchase program was funded with working capital.

Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program will be funded with working capital or the Company's credit facility, and repurchases may be made from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No repurchases have been made by the Company pursuant to this repurchase plan during the quarter ended September 30, 2011.

Purchases of common stock made by or on behalf of the Company during the quarter ended September 30, 2011, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (b)(c)	Maximum Number (or Approximate Dollar Value) of Shares That May Yet Be Purchased Under the Plans or Programs (b)(c)(d)
July 1 — July 31	1,361(e)	$ 27.77	—	$ 7,000,000
August 1 — August 31	402,800(e)	$ 17.50	399,900	$ —
September 1 — September 30	644(e)	$ 18.79	—	$ —
Total	404,805(e)	$ 17.53	399,900	

(a) During the three months ended September 30, 2011, we did not repurchase any shares of our common stock outside of our publicly announced stock repurchase program except 4,905 shares of common stock withheld to settle our employees' income tax obligations.

(b) On July 27, 2011, our board of directors approved a stock repurchase program of up to $7 million to be used to purchase shares of our common stock under a Rule 10b5-1 trading plan. Our repurchases under this program were completed in August 2011.

(c) Effective as of October 26, 2011, our board of directors has authorized the repurchase of $75 million in aggregate of either our common stock or our convertible senior notes due 2014. The repurchase program extends through October 25, 2012, but the Company reserves the right to suspend or discontinue the program at any time. No repurchases have been made by the Company pursuant to this repurchase plan during the quarter ended September 30, 2011.

(d) As the repurchase plan effective October 26, 2011 was not in effect during the quarter ended September 30, 2011, this column does not include the maximum value of shares that may be purchased pursuant to this plan.

(e) Includes shares withheld by the Company to satisfy our employees' income tax withholdings.

Item 6. ***Exhibits***

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS (1)	XBRL Taxonomy Instance Document.
101.SCH (1)	XBRL Taxonomy Extension Schema Document.
101.CAL (1)	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF (1)	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB (1)	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE (1)	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) Pursuant to Rule 406T of Regulation S-T, XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: October 28, 2011

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer and President
(Principal Executive Officer)

Dated: October 28, 2011

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT INDEX

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EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2011 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 28, 2011

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2011 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 28, 2011

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2011 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 28, 2011

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2011 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: October 28, 2011

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended June 30, 2011

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2011

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	*(Zip Code)*

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The number of shares of the issuer's Common Stock outstanding as of July 21, 2011, was approximately 46,065,000.

MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1. ***Financial Statements.***

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	June 30, 2011	December 31, 2010
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 459,213	$ 455,886
Investments	356,600	295,375
Receivables	172,674	168,190
Deferred income taxes	16,423	15,716
Prepaid expenses and other current assets	23,246	22,772
Total current assets	1,028,156	957,939
Property and equipment, net	117,836	100,537
Deferred contract costs	42,557	28,444
Intangible assets, net	91,237	105,500
Goodwill and indefinite-lived intangible assets	212,484	212,228
Auction rate securities	18,958	20,449
Restricted investments	50,330	42,100
Receivable for ceded life and annuity contracts	24,075	24,649
Other assets	14,788	17,368
	$ 1,600,421	$ 1,509,214
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 341,613	$ 354,356
Accounts payable and accrued liabilities	133,005	137,930
Deferred revenue	128,599	60,086
Income taxes payable	5,605	13,176
Total current liabilities	608,822	565,548
Long-term debt	166,725	164,014
Deferred income taxes	14,468	16,235
Liability for ceded life and annuity contracts	24,075	24,649
Other long-term liabilities	20,474	19,711
Total liabilities	834,564	790,157
Stockholders' equity (1):		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 46,062 shares at June 30, 2011 and 45,463 shares at December 31, 2010	46	45
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	262,988	251,612
Accumulated other comprehensive loss	(1,597)	(2,192)
Retained earnings	504,420	469,592
Total stockholders' equity	765,857	719,057
	$ 1,600,421	$ 1,509,214

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 1,128,770	$ 976,685	$ 2,210,208	$ 1,941,905
Service revenue	36,888	21,054	73,562	21,054
Investment income	1,446	1,599	3,040	3,120
Total revenue	1,167,104	999,338	2,286,810	1,966,079
Expenses:				
Medical care costs	949,359	839,613	1,862,891	1,662,429
Cost of service revenue	39,215	14,254	70,436	14,254
General and administrative expenses	96,921	78,079	191,357	156,959
Premium tax expenses	37,709	34,995	74,259	69,541
Depreciation and amortization	12,490	11,219	25,157	21,280
Total expenses	1,135,694	978,160	2,224,100	1,924,463
Operating income	31,410	21,178	62,710	41,616
Interest expense	3,683	4,099	7,286	7,456
Income before income taxes	27,727	17,079	55,424	34,160
Provision for income taxes	10,287	6,500	20,596	12,991
Net income	$ 17,440	$ 10,579	$ 34,828	$ 21,169
Net income per share (1):				
Basic	$ 0.38	$ 0.27	$ 0.76	$ 0.55
Diluted	$ 0.38	$ 0.27	$ 0.75	$ 0.54
Weighted average shares outstanding (1):				
Basic	45,897	38,611	45,743	38,541
Diluted	46,471	38,926	46,392	38,929

(1) All applicable share and per-share amounts reflect the retroactive effects of the three-for-two common stock split in the form of a stock dividend that was effective May 20, 2011.

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(Amounts in thousands) (Unaudited)			
Net income	$ 17,440	$ 10,579	$ 34,828	$ 21,169
Other comprehensive income, net of tax:				
Unrealized gain (loss) on investments	712	(355)	595	(227)
Other comprehensive income (loss)	712	(355)	595	(227)
Comprehensive income	$ 18,152	$ 10,224	$ 35,423	$ 20,942

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2011	2010
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 34,828	$ 21,169
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	34,602	23,912
Deferred income taxes	(2,839)	624
Stock-based compensation	8,374	4,508
Non-cash interest on convertible senior notes	2,711	2,509
Amortization of premium/discount on investments	3,439	560
Amortization of deferred financing costs	1,007	687
Unrealized gain on trading securities	—	(2,860)
Loss on rights agreement	—	2,611
Tax deficiency from employee stock compensation	(489)	(383)
Changes in operating assets and liabilities:		
Receivables	(4,424)	(1,598)
Prepaid expenses and other current assets	(2,780)	(6,348)
Medical claims and benefits payable	(12,743)	30,284
Accounts payable and accrued liabilities	(8,715)	27,958
Deferred revenue	69,498	(82,680)
Income taxes	(7,571)	4,910
Net cash provided by operating activities	114,898	25,863
Investing activities:		
Purchases of equipment	(30,866)	(17,523)
Purchases of investments	(183,647)	(91,768)
Sales and maturities of investments	121,434	116,276
Net cash paid in business combinations	(3,253)	(134,400)
Increase in deferred contract costs	(16,405)	(8,018)
Increase in restricted investments	(8,230)	(4,754)
Change in other noncurrent assets and liabilities	2,190	757
Net cash used in investing activities	(118,777)	(139,430)
Financing activities:		
Amount borrowed under credit facility	—	105,000
Credit facility fees paid	—	(1,671)
Proceeds from employee stock plans	5,640	1,543
Excess tax benefits from employee stock compensation	1,566	179
Net cash provided by financing activities	7,206	105,051
Net increase (decrease) in cash and cash equivalents	3,327	(8,516)
Cash and cash equivalents at beginning of period	455,886	469,501
Cash and cash equivalents at end of period	$ 459,213	$ 460,985

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Six Months Ended June 30,	
	2011	**2010**
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 30,863	$ 6,604
Interest	$ 4,385	$ 6,222
Schedule of non-cash investing and financing activities:		
Retirement of common stock used for stock-based compensation	$ 3,714	$ 1,673
Details of business combinations:		
Increase in fair value of assets acquired	$ (256)	$ (143,983)
(Decrease) increase in fair value of liabilities assumed	(1,045)	11,832
Decrease in payable to seller	(1,952)	(2,249)
Net cash paid in business combinations	$ (3,253)	$ (134,400)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2011

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. As of June 30, 2011, these health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our Molina Medicaid Solutions segment, which we acquired during the second quarter of 2010, provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement Medicaid Management Information System, or MMIS, to another firm. We have submitted a protest in connection with this notice, and in response the state has issued a stay of the intent to award and all contract negotiations have ceased. Our revenue under the Louisiana MMIS contract from May 1, 2010, the date we acquired Molina Medicaid Solutions, through December 31, 2010, was approximately $32 million. For the six months ended June 30, 2011, our revenue under the Louisiana MMIS contract was approximately $24 million. Until the replacement MMIS is designed, developed, and implemented by the vendor that ultimately enters into a contract with the state, we will continue to perform under the existing MMIS contract, a period which we expect to last at least two years.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated in consolidation. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2011. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2010. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2010 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2010 audited financial statements.

Adjustments and Reclassifications

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

We have reclassified certain amounts in the 2010 consolidated statement of cash flows to conform to the 2011 presentation.

2. Significant Accounting Policies

Recognition of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO, arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solutions contracts are multiple-element arrangements. The following discussion applies to our contracts with multiple elements entered into prior to January 1, 2011, before our prospective adoption of *Accounting Standards Update, or ASU, No. 2009-13, Revenue Recognition (Accounting Standards Codification, or ASC, Topic 605) — Multiple-Deliverable Revenue Arrangements*.

For those contracts entered into prior to January 1, 2011, we have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services, which vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our newer contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services, or training and support services) until the contingency has been removed. When we defer revenue recognition we also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the revenue deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

However, direct costs in excess of the estimated future net revenues associated with a contract may not be deferred. In circumstances where estimated direct costs over the life of a contract exceed estimated future net revenues of that contract, the excess of direct costs over revenue is expensed as a period cost. As noted below, we were unable to defer $7.0 million of direct contract costs associated with our Idaho contract during the second quarter of 2011 because estimated direct costs over the life of the contract exceed estimated future net revenues.

We began to recognize revenue and the related deferred costs associated with our Maine contract in September 2010.

In Idaho, revenue recognition is expected to begin during the second half of 2012. Consistent with the deferral of revenue, we have deferred recognition of the direct contract costs associated with that revenue. Deferred contract costs, if any, deferred through the date revenue recognition begins will be recognized simultaneously with revenue.

In late April of 2011, Idaho Department of Health and Welfare indicated that it wished to remit to us an amount approximately $5 to $6 million less than the amount of our invoices for the operation of the MMIS in that state for the period June 1, 2010 through December 31, 2010. The Department claimed at that time that we were not in compliance with certain contractual requirements during the period June 1, 2010 through December 31, 2010. We do not believe the basis of the proposed reduction was contractually sound. In June 2011, we reached tentative agreement with the Department regarding the determination of our monthly operating revenue in Idaho. As a result of the tentative agreement, we estimate that revenue from operations in Idaho will be reduced by approximately $3 million for the period June 1, 2010 through June 30, 2011, and by an additional $1 million for the period July 1, 2011 through December 31, 2011. We do not believe that the tentative agreement will result in any reduction to amounts previously expected to be received for operations subsequent to December 31, 2011. As noted above, all revenue associated with our Idaho MMIS contract is currently being deferred.

In assessing the recoverability of the deferred contract costs associated with the Idaho contract at June 30, 2011, we determined that our current estimate of expenses over the life of the Idaho MMIS contract exceeded our current estimate of net revenues to be derived from that contract by approximately $7.0 million. Accordingly, we expensed through cost of service revenue $7.0 million of direct costs associated with the Idaho contract that otherwise would have been recorded as deferred contract costs. The reduction in revenue discussed above, as well as higher expected costs over the term of the contract, have lowered the net amount that we expect to realize under the contract, requiring us to write down deferred contract costs. We currently expect the contract to perform financially at a break-even basis through its initial term. So long as we continue to defer revenue recognition under the contract, we will also continue to defer direct costs associated with the agreement, unless our analysis indicates that the contract is performing at less than break even.

Molina Medicaid Solutions' deferred revenue totalled $38.6 million at June 30, 2011, and $10.9 million at December 31, 2010, and unamortized deferred contract costs were $42.6 million at June 30, 2011, and $28.4 million at December 31, 2010.

For all new or materially modified revenue arrangements with multiple elements entered into on or after January 1, 2011, which we expect will consist of contracts entered into by our Molina Medicaid Solutions segment, we apply the guidance contained in ASU No. 2009-13. For these arrangements, we allocate total arrangement consideration to the elements of the arrangement, which are expected to be DDI, BPO, and training and support, because this is consistent with the current elements included in our Molina Medicaid Solutions contracts. The arrangement allocation is performed using the relative selling-price method. When determining the selling price of each element, we first attempt to use VSOE if available. If VSOE is not available, we attempt to use third-party evidence, or TPE, of vendors selling similar services to similarly situated customers on a standalone basis, if available. If neither VSOE nor TPE are available, we use our best estimate of the selling price for each element.

We then evaluate whether, at each stage in the life cycle of the contract, we are able to recognize revenue associated with that element. To the extent that our revenue arrangements have provisions that allow our state customers to refuse acceptance of services performed, we are still required to defer revenue recognition until such state customers accept our performance. Once this acceptance is achieved, we immediately recognize the revenue associated with any delivered elements which differs from our current practice for arrangements entered into prior to January 1, 2011, where the revenue associated with delivered elements is recognized over the final service element of the arrangement because VSOE for the other elements does not exist. As such, we expect that the adoption of ASU No. 2009-13 will result in an overall acceleration of revenue recognition with respect to any multiple-element arrangements entered into on or after January 1, 2011. We have entered into no new or materially modified revenue arrangements with multiple elements since January 1, 2011.

Premium Deficiency Reserve

We assess the profitability of each contract by state for providing medical care services to our members and identify any contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. In the first quarter of 2011, our Wisconsin health plan recorded a premium deficiency reserve in the amount of $3.35 million to medical claims and benefits payable. As of June 30, 2011, the reserve balance was $1.6 million.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $11.0 million as of June 30, 2011 and December 31, 2010. Approximately $8.4 million of the unrecognized tax benefits recorded at June 30, 2011, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.8 million as of June 30, 2011. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $8.9 million due to the expiration of statute of limitations and the resolution to the state refund claim described above.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of June 30, 2011, and December 31, 2010, we had accrued $95,000 and $82,000, respectively, for the payment of interest and penalties.

Recent Accounting Pronouncements

Revenue Recognition. In late 2009, the Financial Accounting Standards Board, or FASB, issued the following accounting guidance relating to revenue recognition. Effective for interim and annual reporting beginning on or after December 15, 2010, we adopted this guidance in full effective January 1, 2011.

- *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies previous requirements by requiring the use of the "best estimate of selling price" in the absence of vendor-specific objective evidence ("VSOE") or verifiable objective evidence ("VOE") (now referred to as "TPE" or third-party evidence) for determining the selling price of a deliverable. A vendor is now required to use its best estimate of the selling price when more objective evidence of the selling price cannot be determined. By providing an alternative for determining the selling price of deliverables, this guidance allows companies to allocate arrangement consideration in multiple deliverable arrangements in a manner that better reflects the transaction's economics. In addition, the residual method of allocating arrangement consideration is no longer permitted under this new guidance. We have adopted this guidance effective January 1, 2011, and will apply it on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Because we did not enter into any new or materially modified agreements with multiple elements and fixed payments in the six months ended June 30, 2011 that would have been impacted by this guidance, the adoption did not have a material impact on the timing or pattern of revenue recognition.

For the year ended December 31, 2010, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

Goodwill Impairment Testing. In December 2010, the FASB issued the following guidance which modifies goodwill impairment testing. Effective for interim and annual reporting beginning on or after December 15, 2010, we adopted this guidance in full effective January 1, 2011.

- *ASU No. 2010-28, Intangibles—Goodwill and Other (ASC Topic 350) — When to Perform Step 2 of the Goodwill Impairment Test for Reporting Units with Zero or Negative Carrying Amounts,* a consensus of the FASB Emerging Issues Task Force. This guidance modifies Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts. For those reporting units, an entity is required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists. In determining whether it is more likely than not that a goodwill impairment exists, an entity should consider whether there are any adverse qualitative factors indicating that an impairment may exist. The adoption of this guidance did not impact our consolidated financial position, results of operations or cash flows.

Presentation of Financial Statements. In June 2011, the FASB and International Accounting Standards Board, or IASB, issued the following guidance which modifies how other comprehensive income, or OCI, is reported under U.S. Generally Accepted Accounting Principles, or GAAP, and International Financial Reporting Standards, or IFRS. This guidance is effective for interim and annual reporting beginning on or after December 15, 2011.

- *ASU No. 2011-05, Comprehensive Income (ASC Topic 220) — Presentation of Comprehensive Income,* a consensus of the FASB Emerging Issues Task Force. This guidance eliminates the option to present components of OCI as part of the statement of changes to stockholders' equity. All filers are required to present all non-owner changes in stockholders' equity in a single statement of comprehensive income or in two separate but consecutive statements. We do not expect the adoption of this guidance to impact our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(In thousands)			
Shares outstanding at the beginning of the period	45,828	38,592	45,463	38,410
Weighted-average number of shares issued	69	19	280	131
Denominator for basic earnings per share	45,897	38,611	45,743	38,541
Dilutive effect of employee stock options and stock grants (1)	574	315	649	388
Denominator for diluted earnings per share (2)	46,471	38,926	46,392	38,929

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended June 30, 2011, and 2010, there were approximately 81,200 and 724,500 antidilutive weighted options, respectively. For the six months ended June 30, 2011, and 2010, there were approximately 122,100 and 745,500 antidilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. There were no antidilutive weighted restricted shares for the three months and six months ended June 30, 2011. For the three months and six months ended June 30, 2010, there were approximately 1,500, and 13,500 antidilutive weighted restricted shares, respectively.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the three month and six month periods ended June 30, 2011 and 2010.

4. Share-Based Compensation

At June 30, 2011, we had employee equity incentives outstanding under two plans: (1) the 2002 Equity Incentive Plan; and (2) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). On March 1, 2011, our chief executive officer, chief financial officer, and chief operating officer were awarded 150,000 shares, 112,500 shares, and 27,000 shares, respectively, of restricted stock with performance and service conditions. Each of the grants shall vest on March 1, 2012, provided that: (i) the Company's total operating revenue for 2011 is equal to or greater than $3.7 billion, and (ii) the respective officer continues to be employed by the Company as of March 1, 2012. In the event both vesting conditions are not achieved, the equity compensation awards shall lapse. As of June 30, 2011, we expect these awards to vest in full.

Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three month and six month periods ended June 30, 2011 and 2010:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(in thousands)			
Restricted stock awards	$ 3,932	$ 2,106	$ 7,738	$ 3,745
Stock options (including shares issued under our employee stock purchase plan)	378	265	636	763
Total stock-based compensation expense	$ 4,310	$ 2,371	$ 8,374	$ 4,508

As of June 30, 2011, there was $22.0 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to recognize over a remaining weighted-average period of 2.2 years. As of June 30, 2011, there was no remaining unrecognized compensation expense related to unvested stock options.

Unvested restricted stock and restricted stock activity for the six months ended June 30, 2011 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2010	1,253,624	$ 15.55
Granted	754,800	23.53
Vested	(450,324)	16.88
Forfeited	(53,029)	15.22
Unvested balance as of June 30, 2011	1,505,071	19.16

The total fair value of restricted shares granted during the six months ended June 30, 2011 and 2010 was $17.7 million and $11.2 million, respectively. The total fair value of restricted shares vested during the six months ended June 30, 2011 and 2010 was $10.9 million and $4.6 million, respectively.

Stock option activity for the six months ended June 30, 2011 is summarized below:

	Shares	Weighted Average Grant Date Fair Value	Average Intrinsic Value	Weighted Average Remaining Contractual term
			(In thousands)	(Years)
Stock options outstanding as of December 31, 2010	770,421	$ 20.39		
Exercised	(185,672)	19.23		
Forfeited	(8,275)	22.29		
Stock options outstanding as of June 30, 2011	576,474	20.75	$ 3,839	4.4
Stock options exercisable and expected to vest as of June 30, 2011	576,369	20.75	$ 3,838	4.3
Exercisable as of June 30, 2011	570,849	20.72	$ 3,817	4.4

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

The carrying amount of the convertible senior notes was $166.7 million and $164.0 million as of June 30, 2011, and December 31, 2010, respectively. Based on quoted market prices, the fair value of the convertible senior notes was approximately $215.8 million and $188.4 million as of June 30, 2011, and December 31, 2010, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of June 30, 2011, we held certain assets that are required to be measured at fair value on a recurring basis. These included current investments in investment-grade debt securities that are designated as available-for-sale, and are reported at fair value based on market prices that are readily available (Level 1). See Note 6, “Investments,” for further information regarding fair value.

We also held investments in auction rate securities which are designated as available-for-sale, and are reported at fair value of $19.0 million (par value of $22.4 million) as of June 30, 2011.

Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of June 30, 2011. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, 2009, and 2010, and continued to be unavailable as of June 30, 2011. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining the fair value of the auction rate securities as of June 30, 2011. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As a result of changes in the fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized gains of $0.7 million and pretax unrealized losses of $0.2 million to accumulated other comprehensive income (loss) for the six months ended June 30, 2011, and 2010, respectively. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income (loss). If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Until July 2, 2010, we held certain auction rate securities (designated as trading securities) with an investment securities firm. In 2008, we entered into a rights agreement with this firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. On June 30, 2010, and July 1, 2010, all of the eligible auction rate securities remaining at that time were settled at par value. During 2010, the aggregate auction rate securities (designated as trading securities) settled amounted to $40.9 million par value (fair value $36.7 million). Substantially all of the difference between par value and fair value on these securities was recovered through the rights agreement. For the six months ended 2010, we recorded pretax gains of $2.9 million on the auction rate securities underlying the Rights.

We accounted for the Rights as a freestanding financial instrument and, until July 2, 2010, recorded the value of the Rights under the fair value option. For the six months ended 2010, we recorded pretax losses of $2.6 million on the Rights, attributable to the decline in the fair value of the Rights. When the remaining eligible auction rate securities were sold at par value on July 1, 2010, the value of the Rights was zero.

Our assets measured at fair value on a recurring basis at June 30, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 243,277	$ 243,277	$ —	$ —
Government-sponsored enterprise securities (GSEs)	36,797	36,797	—	—
Municipal securities	41,028	41,028	—	—
U.S. treasury notes	32,240	32,240	—	—
Certificates of deposit	3,258	3,258	—	—
Auction rate securities	18,958	—	—	18,958
	$ 375,558	$ 356,600	$ —	$ 18,958

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2010	$ 20,449
Total gains (realized or unrealized):	
Included in other comprehensive income	659
Settlements	(2,150)
Balance at June 30, 2011	$ 18,958
The amount of total gains for the period included in other comprehensive income attributable to the change in unrealized gains relating to assets still held at June 30, 2011	$ 659

In 2010, we recorded a $2.8 million liability for contingent consideration related to the acquisition of our Wisconsin health plan. In the first quarter of 2011, we determined that there was no liability for contingent consideration relating to the acquisition. The liability for contingent consideration related to this acquisition was measured at fair value on a recurring basis using significant unobservable inputs (Level 3). The following table presents a roll forward of this liability for 2011:

	(Level 3) (In thousands)
Balance at December 31, 2010	$ (2,800)
Total gains included in earnings	2,800
Balance at June 30, 2011	$ —

6. Investments

The following tables summarize our investments as of the dates indicated:

	June 30, 2011			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 246,215	$ 230	$ 3,168	$ 243,277
GSEs	36,917	50	170	36,797
Municipal securities (including non-current auction rate securities)	63,772	70	3,856	59,986
U.S. treasury notes	32,132	119	11	32,240
Certificates of deposit	3,258	—	—	3,258
	$ 382,294	$ 469	$ 7,205	$ 375,558

	December 31, 2010			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 179,124	$ 193	$ 1,388	$ 177,929
GSEs	59,790	293	370	59,713
Municipal securities (including non-current auction rate securities)	55,247	78	4,313	51,012
U.S. treasury notes	23,864	114	60	23,918
Certificates of deposit	3,252	—	—	3,252
	$ 321,277	$ 678	$ 6,131	$ 315,824

The contractual maturities of our investments as of June 30, 2011 are summarized below:

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 190,202	$ 188,005
Due one year through five years	170,192	169,025
Due after ten years	21,900	18,528
	$ 382,294	$ 375,558

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $60.1 million and $42.8 million for the three months ended June 30, 2011, and 2010, respectively. Total proceeds from sales and maturities of available-for-sale securities were $121.4 million and $91.3 million for the six months ended June 30, 2011, and 2010, respectively. Net realized investment gains for the three months ended June 30, 2011, and 2010 were $21,000 and $43,000 respectively. Net realized investment gains for the six months ended June 30, 2011, and 2010 were $178,000 and $57,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at June 30, 2011, and December 31, 2010, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Approximately 32% of our investment in municipal securities consists of auction rate securities. As described in Note 5, “Fair Value Measurements,” the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at June 30, 2011.

The following tables segregate those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of June 30, 2011.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 159,261	$ 2,881	$ 12,715	$ 287	$ 171,976	$ 3,168
GSEs	14,745	102	2,034	68	16,779	170
Municipal securities	28,335	270	24,199	3,585	52,534	3,855
U.S. treasury notes	1,155	1	2,059	11	3,214	12
	$ 203,496	$ 3,254	$ 41,007	$ 3,951	$ 244,503	$ 7,205

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2010.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 103,225	$ 1,060	$ 10,490	$ 328	$ 113,715	$ 1,388
GSEs	13,014	71	7,539	299	20,553	370
Municipal securities	18,884	117	25,271	4,196	44,155	4,313
U.S. treasury notes	5,480	40	6,806	20	12,286	60
	$ 140,603	$ 1,288	$ 50,106	$ 4,843	$ 190,709	$ 6,131

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	June 30, 2011	December 31, 2010
	(In thousands)	
Health Plans segment:		
California	$ 30,501	$ 46,482
Michigan	14,974	13,596
Missouri	23,848	22,841
New Mexico	9,629	18,310
Ohio	19,511	21,622
Utah	5,634	1,589
Washington	12,371	14,486
Wisconsin	8,511	5,437
Others	3,796	3,598
Total Health Plans segment	128,775	147,961
Molina Medicaid Solutions segment	43,899	20,229
	$ 172,674	$ 168,190

During the second quarter of 2011, we settled certain claims we had made against the state of Utah regarding the savings share provision of our contract in effect from 2003 through June of 2009. Additionally, we recognized a liability for certain overpayments received from the state for the period 2003 through 2009. As a result of these developments, we recognized $6.9 million in premium revenue without any corresponding charge to expense during the second quarter of 2011.

8. Restricted Investments

Pursuant to the regulations governing our Health Plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the balances of restricted investments by health plan, and for our insurance company:

	June 30, 2011	December 31, 2010
	(In thousands)	
California	$ 372	$ 372
Florida	8,044	4,508
Insurance Company	4,680	4,689
Michigan	1,000	1,000
Missouri	506	508
New Mexico	15,894	15,881
Ohio	9,076	9,066
Texas	3,500	3,501
Utah	2,787	1,279
Washington	151	151
Wisconsin	—	260
Other	4,320	885
	$ 50,330	$ 42,100

The contractual maturities of our held-to-maturity restricted investments as of June 30, 2011 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 46,732	$ 46,756
Due one year through five years	3,598	3,642
	$ 50,330	$ 50,398

9. Long-Term Debt

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As of June 30, 2011, and December 31, 2010, there was no outstanding principal balance under the Credit Facility. However, as of June 30, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At June 30, 2011, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio under the Credit Facility is required to be no less than 3.00x.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.50 to 1.0 for the first and second quarters of 2010 and through August 14, 2010 (on a pro forma basis). Effective as of August 15, 2010, the maximum consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0.

Convertible Senior Notes

As of June 30, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of June 30, 2011, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 39 months. The Notes' if-converted value did not exceed their principal amount as of June 30, 2011. At June 30, 2011, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of June 30, 2011	As of December 31, 2010
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(20,275)	(22,986)
Net carrying amount	$ 166,725	$ 164,014

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(in thousands)			
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,753	$ 3,506	$ 3,506
Amortization of the discount on the liability component	1,371	1,266	2,711	2,509
Total interest cost recognized	$ 3,124	$ 3,019	$ 6,217	$ 6,015

10. Stockholders' Equity

On April 27, 2011, we announced that our board of directors authorized a 3-for-2 stock split of our common stock to be effected in the form of a stock dividend of one share of our stock for every two shares outstanding. The dividend was distributed on May 20, 2011.

In connection with the plans described in Note 4, "Share-Based Compensation," we issued approximately 599,000 shares of common stock, net of shares retired to settle employees' income tax obligations, for the six months ended June 30, 2011. For the six months ended June 30, 2011, the $11.4 million increase in additional paid-in capital was primarily generated by employee stock plan transactions.

11. Segment Reporting

Our reportable segments are consistent with how we manage the business and view the markets we serve. In the second quarter of 2010, we added a segment to our internal financial reporting structure as a result of the acquisition of Molina Medicaid Solutions. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

Molina Medicaid Solutions was acquired on May 1, 2010; therefore, the three months and six months ended June 30, 2011 include only two months of operating results for this segment. Operating segment revenues and profitability for the three months and six months ended June 30, 2011 and 2010 were as follows:

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
Three months ended June 30, 2011			
Premium revenue	$ 1,128,770	$ —	$ 1,128,770
Service revenue	—	36,888	36,888
Investment income	1,446	—	1,446
Total revenue	$ 1,130,216	$ 36,888	$ 1,167,104
Operating income (loss)	$ 36,894	$ (5,484)	$ 31,410
Six months ended June 30, 2011			
Premium revenue	$ 2,210,208	$ —	$ 2,210,208
Service revenue	—	73,562	73,562
Investment income	3,040	—	3,040
Total revenue	$ 2,213,248	$ 73,562	$ 2,286,810
Operating income (loss)	$ 66,500	$ (3,790)	$ 62,710
Three months ended June 30, 2010			
Premium revenue	$ 976,685	$ —	$ 976,685
Service revenue	—	21,054	21,054
Investment income	1,599	—	1,599
Total revenue	$ 978,284	$ 21,054	$ 999,338
Operating income	$ 16,173	$ 5,005	$ 21,178
Six months ended June 30, 2010			
Premium revenue	$ 1,941,905	$ —	$ 1,941,905
Service revenue	—	21,054	21,054
Investment income	3,120	—	3,120
Total revenue	$ 1,945,025	$ 21,054	$ 1,966,079
Operating income	$ 36,611	$ 5,005	$ 41,616

Reconciliation to Income before Income Taxes

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
		(In thousands)		
Segment operating income	$ 31,410	$ 21,178	$ 62,710	$ 41,616
Interest expense	(3,683)	(4,099)	(7,286)	(7,456)
Income before income taxes	$ 27,727	$ 17,079	$ 55,424	$ 34,160

Segment Assets

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
As of June 30, 2011	$ 1,382,365	$ 218,056	$ 1,600,421
As of December 31, 2010	$ 1,333,599	$ 175,615	$ 1,509,214

12. Commitments and Contingencies

Legal

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, consolidated financial position, cash flows, or results of operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $438.5 million at June 30, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2011, our health plans had aggregate statutory capital and surplus of approximately $448.0 million compared with the required minimum aggregate statutory capital and surplus of approximately $273.6 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2011. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

13. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of both June 30, 2011, and December 31, 2010, our carrying amount for this investment totaled $4.4 million. For the three months ended June 30, 2011 and 2010, we paid $6.6 million, and $5.3 million, respectively, for medical service fees to this provider. For the six months ended June 30, 2011 and 2010, we paid $11.9 million, and $9.7 million, respectively, for medical service fees to this provider.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate, the effect of various implementing regulations, and uncertainties regarding the likely impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to grow our revenues consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine and Idaho;
- additional administrative costs and the potential payment of additional amounts to providers and/or the state by Molina Medicaid Solutions as a result of MMIS implementation issues in Idaho;
- government audits and reviews, including the audit of our Medicare plans by CMS;
- changes with respect to our provider contracts and the loss of providers;

- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation or arbitration matters;
- restrictions and covenants in our credit facility;
- the relatively small number of states in which we operate health plans;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments; and
- changes in general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2010, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurance that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2010.

Adjustments

We have adjusted all applicable share and per-share amounts to reflect the retroactive effects of the three-for-two stock split in the form of a stock dividend that was effective May 20, 2011.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. We also have a direct delivery business that currently consists of 14 primary care community clinics in California and two primary care community clinics in Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

We report our financial performance based on the following two reportable segments: Health Plans; and Molina Medicaid Solutions.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of June 30, 2011. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the six months ended June 30, 2011, we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the six months ended June 30, 2011, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the Temporary Assistance for Needy Families, or TANF, Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $240 in Missouri. Among our Medicaid Aged, Blind or Disabled, or ABD, membership, PMPM premiums range from approximately $320 in Utah to $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy, inpatient and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums, at nearly $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	June 30, 2011	March 31, 2011	December 31, 2010	June 30, 2010
Total Ending Membership by Health Plan:				
California	348,000	347,000	344,000	348,000
Florida	66,000	66,000	61,000	54,000
Michigan	220,000	225,000	227,000	226,000
Missouri	80,000	82,000	81,000	78,000
New Mexico	89,000	90,000	91,000	93,000
Ohio	245,000	248,000	245,000	234,000
Texas	129,000	128,000	94,000	42,000
Utah	82,000	80,000	79,000	77,000
Washington	345,000	341,000	355,000	346,000
Wisconsin (1)	41,000	40,000	36,000	—
Total	1,645,000	1,647,000	1,613,000	1,498,000

	June 30, 2011	March 31, 2011	December 31, 2010	June 30, 2010
Total Ending Membership by State for our Medicare Advantage Plans (1):				
California	6,000	5,300	4,900	3,600
Florida	600	600	500	500
Michigan	7,100	6,700	6,300	5,000
New Mexico	700	700	600	600
Ohio	200	400	—	—
Texas	600	600	700	600
Utah	7,000	6,700	8,900	8,100
Washington	4,000	3,300	2,600	1,900
Total	26,200	24,300	24,500	20,300
Total Ending Membership by State for our Aged, Blind or Disabled Population:				
California	17,000	14,100	13,900	13,600
Florida	10,300	10,300	10,000	9,300
Michigan	31,600	32,000	31,700	31,600
New Mexico	5,600	5,600	5,700	5,800
Ohio	28,700	28,200	28,200	27,400
Texas	52,000	51,200	19,000	18,500
Utah	8,300	8,200	8,000	7,600
Washington	4,400	4,300	4,000	3,700
Wisconsin (1)	1,700	1,700	1,700	—
Total	159,600	155,600	122,200	117,500

(1) We acquired the Wisconsin health plan on September 1, 2010. As of June 30, 2011, the Wisconsin health plan had approximately 2,300 Medicare Advantage members covered under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

Molina Medicaid Solutions' MMIS contracts extend over a number of years, and cover the life of the MMIS from inception through at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds. In some circumstances, revenue recognition may be delayed for long periods while we await formal customer acceptance of our products and/or services. In those circumstances, recognition of a portion of our costs may be deferred.

Under our contracts in Louisiana, New Jersey, and West Virginia, we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue on a straight-line basis over the remaining term of the contract. In Maine we completed the DDI phase of our contract effective September 1, 2010. In Idaho, we expect to complete the DDI phase of our contract during 2011. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in the second half of 2012.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $49.6 million, and $41.0 million, for the six months ended June 30, 2011 and 2010, respectively, including certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Louisiana, Maine, New Jersey, West Virginia, and Florida, as well as certain selling, general and administrative expenses. Additionally, certain indirect costs incurred under our contracts in Maine (prior to exiting the DDI phase of that contract in September 2010) and Idaho are also expensed to cost of service revenue.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contract costs in the second half of 2012, in a manner consistent with our anticipated recognition of revenue.

Second Quarter Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the three and six months ended June 30, 2011. Comparable metrics for the second quarter of 2010 are also shown. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(Dollar amounts in thousands, except per share data)			
Earnings per diluted share	$ 0.38	$ 0.27	$ 0.75	$ 0.54
Premium revenue	$ 1,128,770	$ 976,685	$ 2,210,208	$ 1,941,905
Service revenue	$ 36,888	$ 21,054	$ 73,562	$ 21,054
Operating income	$ 31,410	$ 21,178	$ 62,710	$ 41,616
Net income	$ 17,440	$ 10,579	$ 34,828	$ 21,169
Total ending membership	1,645,000	1,498,000	1,645,000	1,498,000
Premium revenue	96.7%	97.7%	96.7%	98.8%
Service revenue	3.2	2.1	3.2	1.1
Investment income	0.1	0.2	0.1	0.1
Total revenue	100.0%	100.0%	100.0%	100.0%
Medical care ratio	84.1%	86.0%	84.3%	85.6%
General and administrative expense ratio	8.3%	7.8%	8.4%	8.0%
Premium tax ratio	3.3%	3.6%	3.4%	3.6%
Operating income	2.7%	2.1%	2.7%	2.1%
Net income	1.5%	1.1%	1.5%	1.1%
Effective tax rate	37.1%	38.1%	37.2%	38.0%

Compared with the second quarter of 2010, our second quarter of 2011 was marked by strong membership growth, increased PMPM revenue, and lower medical costs. Earnings per share in the second quarter of 2011 were up 41%, over the second quarter of 2010, premium revenues were up 16%, operating income was up 48%, and aggregate membership grew by 10%. Meanwhile, the aggregate medical care ratio of our health plans declined by 190 basis points. Our larger and more established health plans performed the strongest in the quarter, with each of California, Michigan, Ohio, Utah, and Washington having lower medical care ratios compared with the second quarter of 2010. Our Florida and Wisconsin health plans continue to face challenges, and our Texas health plan also experienced an increase in its medical care ratio in the second quarter. We have undertaken a number of measures—focused on both utilization and unit cost reductions—to improve the profitability of our Florida, Wisconsin, and Texas health plans. Our previous experiences in entering new states and in serving new populations —where we were able over time to reduce initially high medical care ratios—gives us confidence that we have the ability to improve the performance of our Florida, Wisconsin, and Texas health plans.

Medicare enrollment exceeded 26,000 members at June 30, 2011, and Medicare premium revenue for the quarter was $95.5 million compared with $67.6 million in the second quarter of 2010. With respect to our Molina Medicaid Solutions business, our system stabilization efforts in Idaho and Maine are taking longer and are more costly than we had anticipated. However, our profit margins in our fiscal agent contracts in New Jersey, Louisiana, and West Virginia remain stable, and we believe that the profitability of the Molina Medicaid Solutions segment will improve as system development and stabilization costs in Idaho and Maine decline.

We remain concerned about state budget deficits, which are not expected to improve during the remainder of 2011. Accordingly, the rate environment for our health plans remains uncertain, and in some instances we expect rate reductions during the second half of 2011, including a 2.5% reduction in New Mexico effective July 1, 2011, a 2% reduction in Utah effective July 1, 2011, and a modest rate reduction in Texas expected to be effective September 1, 2011. We also believe that the state of California intends to implement a rate reduction in the second half of 2011. However, our Missouri health plan has received notification that it will receive a blended rate increase of approximately 5% effective July 1, 2011.

On June 9, 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intends to award the contract for a replacement MMIS to another firm. We have submitted a protest in connection with this notice, and in response the state has issued a stay of the intent to award and all contract negotiations have ceased. Our revenue under the Louisiana MMIS contract from May 1, 2010, the date we acquired Molina Medicaid Solutions, through December 31, 2010, was approximately $32 million. For the six months ended June 30, 2011, our revenue under the Louisiana MMIS contract was $24 million. Until the replacement MMIS is designed, developed, and implemented by the vendor that ultimately enters into a contract with the state, we will continue to perform under the existing MMIS contract, a period which we expect to last at least two years.

Results of Operations

Three Months Ended June 30, 2011 Compared with the Three Months Ended June 30, 2010

Health Plans Segment

Premium Revenue

In the three months ended June 30, 2011 compared with the three months ended June 30, 2010, premium revenue grew 16% due to membership and PMPM revenue increases of approximately 10% and 5%, respectively. Medicare premium revenue was $95.5 million for the three months ended June 30, 2011, compared with $67.6 million for the three months ended June 30, 2010.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended June 30,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 695,551	$ 140.80	73.2%	$ 594,960	$ 132.95	70.9%
Capitation	125,958	25.50	13.2	136,764	30.56	16.3
Pharmacy	87,870	17.79	9.4	75,170	16.80	8.9
Other	39,980	8.09	4.2	32,719	7.31	3.9
Total	$ 949,359	$ 192.18	100.0%	$ 839,613	$ 187.62	100.0%

The ratio of medical care costs to premium revenue (the medical care ratio, or MCR) decreased to 84.1% in the three months ended June 30, 2011, compared with 86.0% for the three months ended June 30, 2010. Total medical care costs increased less than 3% PMPM, and less than 2% PMPM excluding the Texas health plan.

- Pharmacy costs increased approximately 6% PMPM.
- Capitation costs decreased approximately 17% PMPM, primarily due to the transition of members in Michigan and Washington into fee-for-service networks.
- Fee-for-service costs increased approximately 6% PMPM, partially due to the transition of members from capitated provider networks into fee-for-service networks.
- Fee-for-service and capitation costs combined increased less than 2% PMPM.
- Hospital utilization decreased approximately 8%.

The medical care ratio of the California health plan decreased to 84.5% in the three months ended June 30, 2011, from 85.1% in the three months ended June 30, 2010, as higher premium revenue PMPM more than offset increased pharmacy and fee-for-service costs. The California health plan added approximately 2,800 new Aged, Blind or Disabled, or ABD, members in June 2011 with an average premium revenue PMPM of approximately $450. We believe that the state of California intends to implement a rate reduction in the second half of 2011.

The medical care ratio of the Florida health plan increased to 97.0% in the three months ended June 30, 2011, from 94.4% in the three months ended June 30, 2010, primarily due to higher fee-for-service and capitation costs, which more than offset lower pharmacy costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Florida health plan.

The medical care ratio of the Michigan health plan decreased to 78.7% in the three months ended June 30, 2011, from 86.6% in the three months ended June 30, 2010, due to lower fee-for-service and capitation costs. Revenue at the Michigan health plan was reduced by approximately $5.5 million during the second quarter of 2010 due to retroactive rate reductions implemented by the state. Absent those reductions, the Michigan health plan's medical care ratio would have been approximately 83.7% for the three months ended June 30, 2010.

The medical care ratio of the Missouri health plan increased to 90.2% in the three months ended June 30, 2011, from 89.5% in the three months ended June 30, 2010, due to higher fee-for-service costs. The Missouri health plan received a premium rate increase of approximately 5% effective July 1, 2011.

The medical care ratio of the New Mexico health plan increased to 83.7% in the three months ended June 30, 2011, from 79.6% in the three months ended June 30, 2010, as lower fee-for-service costs failed to offset the impact of rate reductions. Additionally, premium revenues were reduced due to an increase—in the second half of 2010—in the minimum contractual amount the plan is required to spend on medical costs. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011.

The medical care ratio of the Ohio health plan decreased to 77.6% in the three months ended June 30, 2011, from 82.0% in the three months ended June 30, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011 and modestly lower fee-for-service costs.

The medical care ratio of the Texas health plan increased to 95.0% in the three months ended June 30, 2011, from 90.0% in the three months ended June 30, 2010. Effective February 1, 2011, we added approximately 30,000 ABD Medicaid members in the Dallas-Fort Worth area, and effective September 1, 2010, we added approximately 54,000 members state-wide who are covered under the Children's Health Insurance Program, or CHIP. Costs associated with our ABD contracts, particularly in the Dallas-Fort Worth region, are running substantially higher than in our other markets, due to both high utilization and high unit costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Texas health plan. We believe that the state of Texas intends to implement a modest rate reduction effective September 1, 2011.

The medical care ratio of the Utah health plan decreased to 75.4% in the three months ended June 30, 2011, from 93.9% in the three months ended June 30, 2010, primarily due to reduced fee-for-service costs and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010. Lower fee-for-service costs were the result of both lower unit costs and lower utilization. During the second quarter of 2011 we settled certain claims we had made against the state regarding the savings share provision of our contract in effect from 2003 through June of 2009. Additionally, we recognized a liability for certain overpayments received from the state for the period 2003 through 2009. As a result of these developments, we recognized $6.9 million in premium revenue without any corresponding charge to expense during the second quarter of 2011. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2011.

The medical care ratio of the Washington health plan increased to 84.8% in the three months ended June 30, 2011, from 83.1% in the three months ended June 30, 2010. Higher fee-for-service and pharmacy costs more than offset lower capitation costs.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 80.8% in the three months ended June 30, 2011. The Wisconsin health plan recorded a premium deficiency reserve of $3.35 million in the first quarter of 2011. That premium deficiency reserve was reduced by $1.8 million in the second quarter. Absent the premium deficiency reserve reduction, the Wisconsin plan's MCR would have been approximately 91% in the three months ended June 30, 2011. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Wisconsin health plan.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended June 30, 2011						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,043	$ 139,097	$ 133.35	$ 117,511	$ 112.66	84.5%	$ 1,921
Florida	197	49,770	252.78	48,294	245.29	97.0	34
Michigan	668	165,575	247.74	130,325	195.00	78.7	9,728
Missouri	243	56,625	232.80	51,100	210.08	90.2	—
New Mexico	270	81,973	304.29	68,579	254.57	83.7	2,423
Ohio	736	230,874	313.36	179,102	243.09	77.6	17,782
Texas	391	104,399	267.06	99,154	253.64	95.0	2,063
Utah	244	77,507	318.32	58,473	240.15	75.4	—
Washington	1,027	202,595	197.39	171,742	167.33	84.8	3,662
Wisconsin(2)	121	17,840	147.02	14,415	118.79	80.8	44
Other(3)	—	2,515	—	10,664	—	—	52
	4,940	$1,128,770	$ 228.50	$ 949,359	$ 192.18	84.1%	$ 37,709

	Three Months Ended June 30, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,050	$124,551	$ 118.57	$ 106,006	$ 100.92	85.1%	$ 1,637
Florida	160	41,462	260.32	39,134	245.70	94.4	6
Michigan	679	156,769	230.76	135,763	199.84	86.6	9,711
Missouri	234	51,779	220.86	46,320	197.58	89.5	—
New Mexico	280	91,949	328.48	73,210	261.54	79.6	2,987
Ohio	695	212,669	306.34	174,275	251.03	82.0	16,512
Texas	125	43,493	348.45	39,133	313.52	90.0	705
Utah	230	64,934	281.44	60,975	264.28	93.9	—
Washington	1,022	186,204	182.23	154,792	151.49	83.1	3,394
Wisconsin(2)	—	—	—	—	—	—	—
Other(3)	—	2,875	—	10,005	—	—	43
	4,475	$976,685	$ 218.25	$ 839,613	$ 187.62	86.0%	$ 34,995

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

Days in Medical Claims and Benefits Payable

The days in medical claims and benefits payable were as follows:

(Dollars in thousands)	June 30, 2011	March 31, 2011	Dec. 31, 2010	June 30, 2010
Days in claims payable — fee-for-service only	39 days	41 days	42 days	44 days
Number of claims in inventory at end of period	121,900	185,300	143,600	106,700
Billed charges of claims in inventory at end of period (dollars in thousands)	$ 205,800	$ 250,600	$ 218,900	$ 147,500

Molina Medicaid Solutions Segment

Molina Medicaid Solutions was acquired on May 1, 2010; therefore, the three months ended June 30, 2010 include only two months of operating results for this segment. Performance of the Molina Medicaid Solutions segment was as follows:

	Three Months Ended June 30, 2011	Two Months Ended June 30, 2010
	(In thousands)	
Service revenue before amortization	$ 38,434	$ 22,645
Less: amortization recorded as reduction of service revenue	(1,546)	(1,591)
Service revenue	36,888	21,054
Cost of service revenue	39,215	14,254
General and administrative costs	1,875	966
Amortization of customer relationship intangibles recorded as amortization	1,282	829
Operating (loss) income	$ (5,484)	$ 5,005

In late April of 2011, Idaho Department of Health and Welfare indicated that it wished to remit to us an amount approximately $5 to $6 million less than the amount of our invoices for the operation of the MMIS in that state for the period June 1, 2010 through December 31, 2010. The Department claimed at that time that we were not in compliance with certain contractual requirements during the period June 1, 2010 through December 31, 2010. We do not believe the basis of the proposed reduction was contractually sound. In June 2011, we reached tentative agreement with the Department regarding the determination of our monthly operating revenue in Idaho. As a result of the tentative agreement, we estimate that revenue from operations in Idaho will be reduced by approximately $3 million for the period June 1, 2010 through June 30, 2011, and by an additional $1 million for the period July 1, 2011 through December 31, 2011. We do not believe that the tentative agreement will result in any reduction to amounts previously expected to be received for operations subsequent to December 31, 2011.

We are currently deferring recognition of all revenue as well as all direct costs (to the extent that such costs are estimated to be recoverable) in Idaho until the MMIS in that state receives certification from the Centers for Medicare and Medicaid Services. Cost of service revenue for the second quarter of 2011 includes $7.0 million of direct costs associated with the Idaho contract that would otherwise have had been recorded as deferred contract costs. In assessing the recoverability of the deferred contract costs associated with the Idaho contract at June 30, 2011, we determined that these costs should be expensed as a period cost. The reduction in anticipated revenue discussed above, as well as higher expected costs over the term of the contract, have lowered the net amount that we expect to realize under the contract, requiring us to write down deferred contract costs.

Financial results remain strong under our Louisiana, New Jersey, and West Virginia MMIS contracts. Based upon our cost experience, we believe that the contract pricing agreed to by our predecessor under the Idaho and Maine MMIS contracts was inappropriately low. However, we believe that the profitability of the Molina Medicaid Solutions segment will improve as system development and stabilization costs in those two states decline.

A substantial milestone for the Idaho contract was reached in early July 2011, when we received notice from the Idaho Department of Health and Welfare that the exit of our MMIS from “pilot operations” and “user acceptance testing” had been approved, and that we may now invoice the state for certain payments associated with that approval.

Consolidated Expenses

General and Administrative Expenses

General and administrative, or G&A, expenses, were $96.9 million, or 8.3% of total revenue, for the three months ended June 30, 2011 compared with $78.1 million, or 7.8% of total revenue, for the three months ended June 30, 2010.

Premium Tax Expenses

Premium tax expense decreased to 3.3% of premium revenue, in the three months ended June 30, 2011, from 3.6% in the three months ended June 30, 2010, due to a shift in revenue to states with comparatively low premium tax rates.

Interest Expense

Interest expense decreased to $3.7 million for the three months ended June 30, 2011, from $4.1 million for the three months ended June 30, 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totalled $1.4 million and $1.3 million for the three months ended June 30, 2011, and 2010, respectively.

Income Taxes

Income tax expense is recorded at an effective rate of 37.1% for the three months ended June 30, 2011 compared with 38.1% for the three months ended June 30, 2010. The lower rate in 2011 is primarily due to lower state income taxes.

Six Months Ended June 30, 2011 Compared with the Six Months Ended June 30, 2010

Health Plans Segment

Premium Revenue

Premium revenue grew 14% in the six months ended June 30, 2011, compared with the six months ended June 30, 2010, due to membership and PMPM revenue increases of 10% and 3%, respectively. Medicare premium revenue was $180.8 million for the six months ended June 30, 2011, compared with $117.9 million for the six months ended June 30, 2010.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Six Months Ended June 30,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$1,351,435	$ 137.31	72.5%	$1,161,839	$ 130.52	69.9%
Capitation	254,640	25.87	13.7	273,896	30.77	16.5
Pharmacy	179,446	18.23	9.6	165,241	18.56	9.9
Other	77,370	7.86	4.2	61,453	6.90	3.7
Total	$1,862,891	$ 189.27	100.0%	$1,662,429	$ 186.75	100.0%

The medical care ratio decreased to 84.3% in the six months ended June 30, 2011, compared with 85.6% for the six months ended June 30, 2010. Total medical care costs increased less than 2% PMPM.

- Pharmacy costs (adjusted for the state's retention of the pharmacy benefit in Ohio effective February 1, 2010) increased approximately 5% PMPM.
- Capitation costs decreased approximately 16% PMPM, primarily due to the transition of members in Michigan and Washington into fee-for-service networks.
- Fee-for-service costs increased approximately 5% PMPM, partially due to the transition of members from capitated provider networks into fee-for-service networks.
- Fee-for-service and capitation costs combined increased approximately 1% PMPM.
- Hospital utilization decreased approximately 7%.

The medical care ratio of the California health plan decreased to 84.4% in the six months ended June 30, 2011, from 86.0% in the six months ended June 30, 2010, as higher premium revenue PMPM more than offset higher pharmacy and fee-for-service costs. We believe that the state of California intends to implement a rate reduction in the second half of 2011.

The medical care ratio of the Florida health plan increased to 96.8% in the six months ended June 30, 2011, from 91.7% in the six months ended June 30, 2010, primarily due to higher fee-for-service and capitation costs, which more than offset lower pharmacy costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Florida health plan.

The medical care ratio of the Michigan health plan decreased to 79.9% in the six months ended June 30, 2011, from 83.7% in the six months ended June 30, 2010 as lower pharmacy and capitation costs more than offset increased fee-for-service costs. As discussed above, the medical care ratio for the Michigan health plan was increased in the first half of 2011 by retroactive rate reductions implemented by the state. The total impact of those reductions was to decrease premium revenue by $8.7 million in the first half of 2010. Absent those reductions, the Michigan health plan's medical ratio would have been approximately 81.4% for the six months ended June 30, 2010.

The medical care ratio of the Missouri health plan increased to 91.9% in the six months ended June 30, 2011, from 86.5% in the six months ended June 30, 2010, due to higher fee-for-service costs. As noted above, the Missouri health plan received a premium rate increase of approximately 5% effective July 1, 2011.

The medical care ratio of the New Mexico health plan increased to 83.2% in the six months ended June 30, 2011, from 78.5% in the six months ended June 30, 2010, as lower fee-for-service costs failed to offset the impact of rate reductions. Additionally, premium revenues were reduced due to an increase—in the second half of 2010—in the minimum contractual amount the plan is required to spend on medical costs. The New Mexico health plan received a premium rate reduction of approximately 2.5% effective July 1, 2011.

The medical care ratio of the Ohio health plan decreased to 76.1% in the six months ended June 30, 2011, from 80.5% in the six months ended June 30, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011 and modestly lower fee-for-service costs.

The medical care ratio of the Texas health plan increased to 93.3% in the six months ended June 30, 2011, from 86.4% in the six months ended June 30, 2010. Effective February 1, 2011, we added approximately 30,000 ABD Medicaid members in the Dallas-Fort Worth area, and effective September 1, 2010, we added approximately 54,000 members state-wide who are covered under CHIP. Costs associated with our ABD contracts, particularly in the Dallas-Fort Worth region, are running substantially higher than in our other markets, due to both high utilization and high unit costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Texas health plan. We believe that the state of Texas intends to implement a modest rate reduction effective September 1, 2011.

The medical care ratio of the Utah health plan decreased to 77.2% in the six months ended June 30, 2011, from 99.2% in the six months ended June 30, 2010, primarily due to reduced fee-for-service outpatient and physician costs and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010. Lower fee-for-service costs were the result of both lower unit costs and lower utilization. During the second quarter we settled certain claims with the state regarding the savings share provision of our contract in effect from 2003 through June of 2009. We settled for the contract years 2006 through 2009 and recognized $6.9 million in premium revenue without any corresponding charge to expense. The Utah health plan received a premium rate reduction of approximately 2% effective July 1, 2011.

The medical care ratio of the Washington health plan decreased to 85.7% in the six months ended June 30, 2011, from 86.7% in the six months ended June 30, 2010. Lower capitation costs more than offset higher fee-for-service and higher pharmacy costs.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 98.7% in the six months ended June 30, 2011. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Wisconsin health plan.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Six Months Ended June 30, 2011						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	2,084	$ 274,073	$ 131.49	$ 231,248	$ 110.95	84.4%	$ 3,823
Florida	389	98,992	254.68	95,863	246.63	96.8	51
Michigan	1,346	330,335	245.38	264,053	196.15	79.9	19,575
Missouri	488	111,792	229.05	102,707	210.44	91.9	—
New Mexico	541	166,579	308.12	138,616	256.40	83.2	4,388
Ohio	1,473	461,213	313.02	350,853	238.12	76.1	35,557
Texas	740	185,210	250.28	172,769	233.47	93.3	3,403
Utah	480	145,442	303.28	112,312	234.20	77.2	—
Washington	2,061	397,867	193.09	340,857	165.42	85.7	7,323
Wisconsin(2)	241	34,257	142.17	33,794	140.25	98.7	44
Other(3)	—	4,448	—	19,819	—	—	95
	9,843	$2,210,208	$ 224.56	$1,862,891	$ 189.27	84.3%	$ 74,259

	Six Months Ended June 30, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	2,112	$ 248,461	$ 117.62	$ 213,567	$ 101.10	86.0%	$ 3,265
Florida	314	80,550	256.94	73,821	235.47	91.7	12
Michigan	1,354	312,114	230.45	261,212	192.87	83.7	19,650
Missouri	468	103,922	221.93	89,836	191.85	86.5	—
New Mexico	560	187,547	334.75	147,225	262.78	78.5	4,991
Ohio	1,368	431,032	315.20	346,900	253.68	80.5	33,517
Texas	246	82,693	336.46	71,464	290.77	86.4	1,386
Utah	451	123,474	273.66	122,435	271.36	99.2	—
Washington	2,029	367,258	181.05	318,302	156.91	86.7	6,656
Wisconsin(2)	—	—	—	—	—	—	—
Other(3)	—	4,854	—	17,667	—	—	64
	8,902	$1,941,905	$ 218.15	$1,662,429	$ 186.75	85.6%	$ 69,541

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs of the parent company.

Molina Medicaid Solutions Segment

Molina Medicaid Solutions was acquired on May 1, 2010; therefore, the six months ended June 30, 2010 include only two months of operating results for this segment. Performance of the Molina Medicaid Solutions segment was as follows:

	Six Months Ended June 30, 2011	Two Months Ended June 30, 2010
	(In thousands)	
Service revenue before amortization	$ 77,294	$ 22,645
Amortization recorded as reduction of service revenue	(3,732)	(1,591)
Service revenue	73,562	21,054
Cost of service revenue	70,436	14,254
General and administrative costs	4,352	966
Amortization of customer relationship intangibles recorded as amortization	2,564	829
Operating (loss) income	$ (3,790)	$ 5,005

Consolidated Expenses and Other

General and Administrative Expenses

General and administrative expenses were $191.4 million, or 8.4% of total revenue, for the six months ended June 30, 2011 compared with $157.0 million, or 8.0% of total revenue, for the six months ended June 30, 2010.

Premium Tax Expense

Premium tax expense decreased to 3.4% of premium revenue, in the six months ended June 30, 2011, from 3.6% in the six months ended June 30, 2010, due to a shift in revenue to states with comparatively low premium tax rates.

Interest Expense

Interest expense decreased to $7.3 million for the six months ended June 30, 2011, from $7.5 million for the six months ended June 30, 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totalled $2.7 million, and $2.5 million for the six months ended June 30, 2011 and 2010, respectively.

Income Taxes

Income tax expense is recorded at an effective rate of 37.2% for the six months ended June 30, 2011 compared with 38.0% for the six months ended June 30, 2010. The lower rate in 2011 is primarily due to lower state income taxes.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Depreciation is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Three Months Ended June 30,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation	$ 7,225	0.6%	$ 6,711	0.7%
Amortization of intangible assets	5,265	0.5	4,508	0.4
Depreciation and amortization reported as such in the consolidated statements of income	12,490	1.1	11,219	1.1
Amortization recorded as reduction of service revenue	1,546	0.1	1,591	0.2
Depreciation recorded as cost of service revenue	2,472	0.2	1,041	0.1
Total	$ 16,508	1.4%	$ 13,851	1.4%

	Six Months Ended June 30,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation	$ 14,625	0.6%	$ 13,123	0.7%
Amortization of intangible assets	10,532	0.5	8,157	0.4
Depreciation and amortization reported as such in the consolidated statements of income	25,157	1.1	21,280	1.1
Amortization recorded as reduction of service revenue	3,732	0.2	1,591	0.1
Depreciation recorded as cost of service revenue	5,713	0.2	1,041	—
Total	$ 34,602	1.5%	$ 23,912	1.2%

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of June 30, 2011, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $3.0 million for the six months ended June 30, 2011, compared with $3.1 million for the six months ended June 30, 2010. Our annualized portfolio yield for the six months ended June 30, 2011 was 0.7% compared with 0.9% for the six months ended June 30, 2010.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the six months ended June 30, 2011 was $114.9 million compared with $25.9 million for the six months ended June 30, 2010, an increase of $89.0 million. Deferred revenue, which was a source of operating cash totalling $69.5 million in 2011, was a use of operating cash totalling $82.7 million in 2010.

Cash provided by financing activities decreased due to $105 million borrowed under our credit facility in the second quarter of 2010 in connection with our acquisition of Molina Medicaid Solutions, with no comparable activity in the current year.

Reconciliation of Non-GAAP (1) to GAAP Financial Measures

EBITDA (2)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
	(In thousands)			
Operating income	$ 31,410	$ 21,178	$ 62,710	$ 41,616
Add back:				
Depreciation and amortization reported in the consolidated statements of cash flows	16,508	13,851	34,602	23,912
EBITDA	$ 47,918	$ 35,029	$ 97,312	$ 65,528

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) We calculate EBITDA consistently on a quarterly and annual basis by adding back depreciation and amortization to operating income. Operating income includes investment income. EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At June 30, 2011, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $49.6 million, compared with approximately $65.1 million of cash and investments at December 31, 2010. This decline was primarily due to capital contributions and /or advances to our Florida, Texas, and Wisconsin health plans in the first quarter of 2011.

On a consolidated basis, at June 30, 2011, we had working capital of $419.3 million compared with $392.4 million at December 31, 2010. At June 30, 2011 we had cash and investments of $885.1 million, compared with $813.8 million of cash and investments at December 31, 2010.

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As of June 30, 2011, and December 31, 2010, there was no outstanding principal balance under the Credit Facility. However, as of June 30, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the Molina Medicaid Solutions contracts with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At June 30, 2011, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio under the Credit Facility is required to be no less than 3.00x.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.50 to 1.0 for the first and second quarters of 2010 and through August 14, 2010 (on a pro forma basis). Effective as of August 15, 2010, the maximum consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0.

Shelf Registration Statement

Under a shelf registration statement on Form S-3 that was filed with the Securities and Exchange Commission in December 2008, we have up to $182.5 million available for the issuance of our securities, including common stock, warrants, or debt securities, that may be publicly offered from time to time at prices and terms to be determined at the time of the offering.

Convertible Senior Notes

As of June 30, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 31.9601 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $31.29 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Regulatory Capital and Dividend Restrictions

Our health plans are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $438.5 million at June 30, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2011, our health plans had aggregate statutory capital and surplus of approximately $448.0 million compared with the required minimum aggregate statutory capital and surplus of approximately $273.6 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2011. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2010, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;
- The deferral of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Certain components of premium revenue are subject to accounting estimates, and are therefore subject to retroactive revision. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At June 30, 2011, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.
- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Effective July 1, 2008, our New Mexico health plan entered into a new four-year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At June 30, 2011, we had recorded a liability of $12.1 million under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.
- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. For the twelve months ended through the end of the state fiscal year on June 30, 2011, our New Mexico health plan has received $2.6 million in at-risk revenue for state fiscal year 2011. We have recognized $1.9 million of that amount as revenue, and recorded a liability of approximately $0.7 million as of June 30, 2011, for the remainder. If the state of New Mexico disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. Effective February 1, 2010, an additional 0.25% of the Ohio health plan's revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. For the twelve months ended through the end of the state fiscal year on June 30, 2011, our Ohio health plan has received $10.3 million in at-risk revenue for state fiscal year 2011. We have recognized $8.6 million of that amount as revenue, and recorded a liability of approximately $1.7 million as of June 30, 2011, for the remainder. If the state of Ohio disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required. For example, during the third quarter of 2010, we reversed the recognition of approximately $3.3 million of at-risk revenue, of which $1.9 million and $1.4 million were initially recognized in 2010, and 2009, respectively.

- *Utah Health Plan Premium Revenue:* Our Utah health plan was entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid during the period 2003 through August 31, 2009.

  During the second quarter of 2011 we settled all claims related to state contract years 2006 through 2009 and received payments totalling $13.6 million in settlement of this matter. The state in turn has made demands upon us totalling $9.6 million to recover alleged over payment of premium revenue to us for the period 2003 through 2009. We are disputing many of those claims and have recorded a liability of approximately $6.7 million in connection with the premium revenue overpayments. We recognized approximately $6.9 million of revenue in connection with this matter during the second of quarter of 2011, without any corresponding increase to expense.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas there is a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of June 30, 2011, we had an aggregate liability of approximately $0.1 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2010 and 2011 contract years (ending August 31st of each year). Because the final settlement calculations include a claims run-out period of nearly one year, an adjustment to the amounts owed may be required.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures established by the state. The time period for the assessment of these performance measures previously followed the state's fiscal year, but effective January 1, 2011, it follows the calendar year. For the six months ended June 30, 2011, our Texas health plan has received $1.2 million in at-risk revenue for calendar year 2011. We have recognized $0.6 million of that amount as revenue, and recorded a liability of approximately $0.6 million as of June 30, 2011, for the remainder. If the state of Texas disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns, there is no liability related to the potential recoupment of Medicare premium revenue at June 30, 2011. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

Recognition of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO, arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solutions contracts are multiple-element arrangements. The following discussion applies to our contracts with multiple elements entered into prior to January 1, 2011, before our prospective adoption of *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*.

For those contracts entered into prior to January 1, 2011, we have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services, which vary significantly between contracts; and

- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our newer contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services, or training and support services) until the contingency has been removed. When we defer revenue recognition we also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the revenue deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

However, direct costs in excess of the estimated future net revenues associated with a contract may not be deferred. In circumstances where estimated direct costs over the life of a contract exceed estimated future net revenues of that contract, the excess of direct costs over revenue is expensed as a period cost. As noted below, we were unable to defer $7.0 million of direct contract costs associated with our Idaho contract during the second quarter of 2011 because estimated direct costs over the life of the contract exceed estimated future net revenues.

We began to recognize revenue and the related deferred costs associated with our Maine contract in September 2010.

In Idaho, revenue recognition is expected to begin during the second half of 2012. Consistent with the deferral of revenue, we have deferred recognition of the direct contract costs associated with that revenue. Deferred contract costs, if any, deferred through the date revenue recognition begins will be recognized simultaneously with revenue.

In late April of 2011, Idaho Department of Health and Welfare indicated that it wished to remit to us an amount approximately $5 to $6 million less than the amount of our invoices for the operation of the MMIS in that state for the period June 1, 2010 through December 31, 2010. The Department claimed at that time that we were not in compliance with certain contractual requirements during the period June 1, 2010 through December 31, 2010. We do not believe the basis of the proposed reduction was contractually sound. In June 2011, we reached tentative agreement with the Department regarding the determination of our monthly operating revenue in Idaho. As a result of the tentative agreement, we estimate that revenue from operations in Idaho will be reduced by approximately $3 million for the period June 1, 2010 through June 30, 2011, and by an additional $1 million for the period July 1, 2011 through December 31, 2011. We do not believe that the tentative agreement will result in any reduction to amounts previously expected to be received for operations subsequent to December 31, 2011. As noted above, all revenue associated with our Idaho MMIS contract is currently being deferred.

In assessing the recoverability of the deferred contract costs associated with the Idaho contract at June 30, 2011, we determined that our current estimate of expenses over the life of the Idaho MMIS contract exceeded our current estimate of net revenues to be derived from that contract by approximately $7.0 million. Accordingly, we expensed through cost of service revenue $7.0 million of direct costs associated with the Idaho contract that otherwise would have been recorded as deferred contract costs. The reduction in revenue discussed above, as well as higher expected costs over the term of the contract, have lowered the net amount that we expect to realize under the contract, requiring us to write down deferred contract costs. We currently expect the contract to perform financially at a break even basis through its initial term. So long as we continue to defer revenue recognition under the contract, we will also continue to defer direct costs associated with the agreement, unless our analysis indicates that the contract is performing at less than break even.

Molina Medicaid Solutions' deferred revenue totalled $38.6 million at June 30, 2011, and $10.9 million at December 31, 2010, and unamortized deferred contract costs were $42.6 million at June 30, 2011, and $28.4 million at December 31, 2010.

For all new or materially modified revenue arrangements with multiple elements entered into on or after January 1, 2011, which we expect will consist of contracts entered into by our Molina Medicaid Solutions segment, we apply the guidance contained in ASU No. 2009-13. For these arrangements, we allocate total arrangement consideration to the elements of the arrangement, which are expected to be DDI, BPO, and training and support, because this is consistent with the current elements included in our Molina Medicaid Solutions contracts. The arrangement allocation is performed using the relative selling-price method. When determining the selling price of each element, we first attempt to use VSOE if available. If VSOE is not available, we attempt to use third-party evidence, or TPE, of vendors selling similar services to similarly situated customers on a standalone basis, if available. If neither VSOE nor TPE are available, we use our best estimate of the selling price for each element.

We then evaluate whether, at each stage in the life cycle of the contract, we are able to recognize revenue associated with that element. To the extent that our revenue arrangements have provisions that allow our state customers to refuse acceptance of services performed, we are still required to defer revenue recognition until such state customers accept our performance. Once this acceptance is achieved, we immediately recognize the revenue associated with any delivered elements which differs from our current practice for arrangements entered into prior to January 1, 2011, where the revenue associated with delivered elements is recognized over the final service element of the arrangement because VSOE for the other elements does not exist. As such, we expect that the adoption of ASU No. 2009-13 will result in an overall acceleration of revenue recognition with respect to any multiple-element arrangements entered into on or after January 1, 2011. We have entered into no new or materially modified revenue arrangements with multiple elements since January 1, 2011.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	June 30, 2011	Dec. 31, 2010	June 30, 2010
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 270,558	$ 275,259	$ 268,652
Capitation payable	43,131	49,598	49,101
Pharmacy	15,094	14,649	13,385
Other	12,830	14,850	12,662
	$ 341,613	$ 354,356	$ 343,800

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $270.6 million of our total medical claims and benefits payable of $341.6 million as of June 30, 2011. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider’s monthly capitation payment), our IBNP liability at June 30, 2011, was $264.1 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of June 30, 2011 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding June 30, 2011, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ 106,455
(4%)	70,970
(2%)	35,485
2%	(35,485)
4%	(70,970)
6%	(106,455)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of June 30, 2011 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(6%)	$ (60,630)
(4%)	(40,420)
(2%)	(20,210)
2%	20,210
4%	40,420
6%	60,630

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 46.4 million diluted shares outstanding for the six months ended June 30, 2011. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at June 30, 2011, net income for the six months ended June 30, 2011 would increase or decrease by approximately $11.1 million, or $0.24 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at June 30, 2011, net income for the three months ended June 30, 2011 would increase or decrease by approximately $6.3 million, or $0.14 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $55.4 million, or $1.20 per diluted share, and $31.6 million, or $0.68 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $11.1 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2010, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 15.7%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2010 and through June 30, 2011 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized a benefit from prior period claims development in the amount of $45.4 million for the six months ended June 30, 2011 (see table below). This amount represents our estimate as of June 30, 2011 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2010 was due primarily to the following factors:

- We overestimated the impact of an increase in pending high dollar claims at our Ohio health plan.
- We underestimated the lower cost associated with changes to provider fee schedules (primarily for outpatient facility costs) in New Mexico effective November 1, 2010.

The following developments partially offset the overestimation of our claims liability at December 31, 2010:

- In Missouri, delays in claims processing late in the fourth quarter of 2010 led us to underestimate the size of our claims liability at December 31, 2010.
- We underestimated the costs associated with our assumption of risk for a new population in Texas (rural CHIP members) effective September 1, 2010.

We recognized a benefit from prior period claims development in the amount of $49.4 million for the year ended December 31, 2010 (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at June 30, 2011, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The assumption of risk for a new population by our Texas health plan (Dallas-Fort Worth area ABD members) effective February 1, 2011.
- The transition of certain members by our Washington and Michigan health plans from full-risk capitated provider arrangements to fee-for-service providers effective December 31, 2010. This change had the effect of transferring back to the Company risk that had previously been assumed by capitated medical providers.
- A substantial decline in claims inventory at our Michigan, Missouri, and Texas health plans.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2010 and through June 30, 2011, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "*Components of medical care costs related to:* Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Six Months Ended		Three Months Ended	Year Ended
	June 30, 2011	June 30, 2010	March 31, 2011	December 31, 2010
	(Dollars in thousands, except per-member amounts)			
Balances at beginning of period	$ 354,356	$ 315,316	$ 354,356	$ 315,316
Balance of acquired subsidiary	—	—	—	3,228
Components of medical care costs related to:				
Current period	1,908,289	1,705,411	957,909	3,420,235
Prior periods	(45,398)	(42,982)	(44,377)	(49,378)
Total medical care costs	1,862,891	1,662,429	913,532	3,370,857
Payments for medical care costs related to:				
Current period	1,584,636	1,389,907	646,428	3,085,388
Prior periods	290,998	244,038	270,078	249,657
Total paid	1,875,634	1,633,945	916,506	3,335,045
Balances at end of period	$ 341,613	$ 343,800	$ 351,382	$ 354,356
Benefit from prior period as a percentage of:				
Balance at beginning of period	12.8%	13.6%	12.5%	15.7%
Premium revenue	2.1%	2.2%	4.1%	1.2%
Total medical care costs	2.4%	2.6%	4.9%	1.5%
Claims Data:				
Days in claims payable, fee for service	39	44	41	42
Number of members at end of period	1,645,000	1,498,000	1,647,000	1,613,000
Number of claims in inventory at end of period	121,900	106,700	185,300	143,600
Billed charges of claims in inventory at end of period	$ 205,800	$ 147,500	$ 250,600	$ 218,900
Claims in inventory per member at end of period	0.07	0.07	0.11	0.09
Billed charges of claims in inventory per member at end of period	$ 125.11	$ 98.46	$ 152.16	$ 135.71
Number of claims received during the period	8,715,200	7,066,100	4,342,200	14,554,800
Billed charges of claims received during the period	$ 6,963,300	$ 5,605,400	$ 3,386,600	$ 11,686,100

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: During the fiscal quarter ended June 30, 2011, we completed the implementation of a new enterprise resource planning, or ERP, software system. This system is used in the preparation of, among other things, our financial statements and required reports. Other than the ERP implementation, there has been no change in our internal control over financial reporting during the fiscal quarter ended June 30, 2011 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. Based upon the evaluation of information currently available, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. The following risk factor was identified by the Company during the second quarter of 2011 and is a supplement to the risk factors identified in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2010 as filed with the SEC on March 8, 2011. The risk factor described herein and in our Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill or indefinite-lived intangible assets could have a material impact on our financial results.

We conduct formal impairment tests on material long-lived assets, such as goodwill and indefinite-lived intangible assets, and intangible assets, net, at least annually; additionally, we continually evaluate whether events or changes in business conditions suggest potential impairment of such assets. Our judgments regarding the existence of impairment indicators are based on legal factors, market conditions, and operational performance. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. The non-renewal of such a contract would be an indicator of impairment.

As of June 30, 2011, the balance of goodwill and indefinite-lived intangible assets was $212.5 million. Goodwill and indefinite-lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. As of June 30, 2011, the balance of intangible assets, net, was $91.2 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives. The determination of the value of goodwill and indefinite-lived intangible assets, and intangible assets, net, requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors.

If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and indefinite-lived intangible assets, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

Item 6. Exhibits

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS(1)	XBRL Taxonomy Instance Document.
101.SCH(1)	XBRL Taxonomy Extension Schema Document.
101.CAL(1)	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF(1)	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB(1)	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE(1)	XBRL Taxonomy Extension Presentation Linkbase Document.

(1) XBRL (Extensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: July 27, 2011

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: July 27, 2011

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT INDEX

Exhibit No.	Title
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EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2011 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 27, 2011

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2011 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: July 27, 2011

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2011 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 27, 2011

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2011 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 27, 2011

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended March 31, 2011

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2011

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	*(Zip Code)*

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The number of shares of the issuer's common stock outstanding as of April 21, 2011 was approximately 30,570,400.

MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1: ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	March 31, 2011	December 31, 2010
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 463,792	$ 455,886
Investments	337,514	295,375
Receivables	170,418	168,190
Deferred income taxes	15,395	15,716
Prepaid expenses and other current assets	28,608	22,772
Total current assets	1,015,727	957,939
Property and equipment, net	107,757	100,537
Deferred contract costs	37,891	28,444
Intangible assets, net	98,048	105,500
Goodwill and indefinite-lived intangible assets	212,484	212,228
Auction rate securities	20,187	20,449
Restricted investments	49,307	42,100
Receivable for ceded life and annuity contracts	24,155	24,649
Other assets	17,598	17,368
	$ 1,583,154	$ 1,509,214
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 351,382	$ 354,356
Accounts payable and accrued liabilities	113,697	137,930
Deferred revenue	143,273	60,086
Income taxes payable	7,746	13,176
Total current liabilities	616,098	565,548
Long-term debt	165,354	164,014
Deferred income taxes	17,462	16,235
Liability for ceded life and annuity contracts	24,155	24,649
Other long-term liabilities	19,580	19,711
Total liabilities	842,649	790,157
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 30,552 shares at March 31, 2011 and 30,309 shares at December 31, 2010	31	30
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	255,803	251,627
Accumulated other comprehensive loss	(2,309)	(2,192)
Retained earnings	486,980	469,592
Total stockholders' equity	740,505	719,057
	$ 1,583,154	$ 1,509,214

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2011	2010
	(In thousands, except per-share data) (Unaudited)	
Revenue:		
Premium revenue	$ 1,081,438	$ 965,220
Service revenue	36,674	—
Investment income	1,594	1,521
Total revenue	1,119,706	966,741
Expenses:		
Medical care costs	913,532	822,816
Cost of service revenue	31,221	—
General and administrative expenses	94,436	78,880
Premium tax expenses	36,550	34,546
Depreciation and amortization	12,667	10,061
Total expenses	1,088,406	946,303
Operating income	31,300	20,438
Interest expense	3,603	3,357
Income before income taxes	27,697	17,081
Provision for income taxes	10,309	6,491
Net income	$ 17,388	$ 10,590
Net income per share:		
Basic	$ 0.57	$ 0.41
Diluted	$ 0.56	$ 0.41
Weighted average shares outstanding:		
Basic	30,392	25,646
Diluted	30,838	25,837

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2011	**2010**
	(Amounts in thousands) (Unaudited)	
Net income	$ 17,388	$ 10,590
Other comprehensive (loss) gain, net of tax:		
Unrealized (loss) gain on investments	(117)	128
Other comprehensive (loss) gain	(117)	128
Comprehensive income	$ 17,271	$ 10,718

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2011	2010
	(Dollars in thousands) (Unaudited)	
Operating activities:		
Net income	$ 17,388	$ 10,590
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	18,094	10,061
Deferred income taxes	1,619	3,094
Stock-based compensation	4,064	2,136
Non-cash interest on convertible senior notes	1,340	1,243
Amortization of premium/discount on investments	1,644	259
Amortization of deferred financing costs	503	344
Unrealized gain on trading securities	—	(540)
Loss on rights agreement	—	493
Tax deficiency from employee stock compensation	(264)	(353)
Changes in operating assets and liabilities:		
Receivables	(2,168)	8,054
Prepaid expenses and other current assets	(8,142)	(668)
Medical claims and benefits payable	(2,974)	11,657
Accounts payable and accrued liabilities	(25,796)	15,134
Deferred revenue	84,172	(90,664)
Income taxes	(5,430)	2,935
Net cash provided by (used in) operating activities	84,050	(26,225)
Investing activities:		
Purchases of equipment	(14,941)	(5,976)
Purchases of investments	(104,984)	(49,439)
Sales and maturities of investments	61,275	52,967
Net cash paid in business combinations	(3,253)	(2,430)
Increase in deferred contract costs	(9,635)	—
Increase in restricted investments	(7,207)	(656)
Change in other noncurrent assets and liabilities	(937)	426
Net cash used in investing activities	(79,682)	(5,108)
Financing activities:		
Proceeds from employee stock plans	2,462	—
Excess tax benefits from employee stock compensation	1,076	113
Net cash provided by financing activities	3,538	113
Net increase (decrease) in cash and cash equivalents	7,906	(31,220)
Cash and cash equivalents at beginning of period	455,886	469,501
Cash and cash equivalents at end of period	$ 463,792	$ 438,281
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 14,068	$ 91
Interest	$ 269	$ 142
Schedule of non-cash investing and financing activities:		
Retirement of common stock used for stock-based compensation	$ 3,161	$ 1,526
Details of business combinations adjustments:		
Increase in fair value of assets acquired	$ (256)	$ —
Decrease in fair value of liabilities assumed	(1,045)	—
Decrease in payable to sellers	(1,952)	(2,430)
Net cash paid in business combinations	$ (3,253)	$ (2,430)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
March 31, 2011

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. As of March 31, 2011, these health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

Our Molina Medicaid Solutions segment, which we acquired during the second quarter of 2010, provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included; such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated in consolidation. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2011. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2010. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2010 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2010 audited financial statements.

Reclassifications

We have reclassified certain amounts in the 2010 consolidated statement of cash flows to conform to the 2011 presentation.

2. Significant Accounting Policies

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $11.0 million as of March 31, 2011, and $11.0 million as of December 31, 2010. Approximately $8.4 million of the unrecognized tax benefits recorded at March 31, 2011, relate to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.8 million as of March 31, 2011. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities will decrease by approximately $0.5 million due to the expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of March 31, 2011, and December 31, 2010, we had accrued $88,000 and $82,000, respectively, for the payment of interest and penalties.

Deferral of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO, arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solutions contracts are multiple-element arrangements. The following discussion applies to our contracts with multiple elements entered into prior to January 1, 2011, before our prospective adoption of *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*. *See* discussion below on page 9.

For those contracts entered into prior to January 1, 2011, we have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services, which vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our newer contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services, or training and support services) until the contingency has been removed. In these circumstances, we would also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the contract (whether DDI, BPO services, or training and support services) on which revenue recognition is being deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

For all new or materially modified revenue arrangements with multiple elements entered into on or after January 1, 2011, which we expect will consist of contracts entered into by our Molina Medicaid Solutions segment, we will apply the guidance contained in ASU No. 2009-13. For these arrangements, we will allocate total arrangement consideration to the elements of the arrangement, which are expected to be DDI, BPO, and training and support, because this is consistent with the current elements included in our Molina Medicaid Solutions contracts. The arrangement allocation will be performed using the relative selling-price method. When determining the selling price of each element, we will first attempt to use VSOE if available. If VSOE is not available, we will attempt to use third-party evidence, or TPE, of vendors selling similar services to similarly situated customers on a standalone basis, if available. If neither VSOE nor TPE are available, we will use our best estimate of the selling price for each element.

We will then evaluate whether, at each stage in the life cycle of the contract, we are able to recognize revenue associated with that element. To the extent that our revenue arrangements have provisions that allow our state customers to refuse acceptance of services performed, we will still be required to defer revenue recognition until such state customers accept our performance. Once this acceptance is achieved, we will immediately recognize the revenue associated with any delivered elements which differs from our current practice for arrangements entered into prior to January 1, 2011, where the revenue associated with delivered elements is recognized over the final service element of the arrangement because VSOE for the other elements does not exist. As such, we expect that the adoption of ASU No. 2009-13 will result in an overall acceleration of revenue recognition with respect to any multiple-element arrangements entered into on or after January 1, 2011.

We began to recognize revenue and the related deferred costs associated with our Maine contract in September 2010. In Idaho, we expect to begin recognition of deferred contact costs in 2012, in a manner consistent with our anticipated recognition of revenue. Molina Medicaid Solutions' deferred revenue totaled $36.1 million at March 31, 2011, and $10.9 million at December 31, 2010, and unamortized deferred contract costs were $37.9 million at March 31, 2011, and $28.4 million at December 31, 2010.

Recent Accounting Pronouncements

Revenue Recognition. In late 2009, the Financial Accounting Standards Board, or FASB, issued the following accounting guidance relating to revenue recognition. Effective for interim and annual reporting beginning on or after December 15, 2010, we adopted this guidance in full effective January 1, 2011.

- *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies previous requirements by requiring the use of the "best estimate of selling price" in the absence of vendor-specific objective evidence ("VSOE") or verifiable objective evidence ("VOE") (now referred to as "TPE" or third-party evidence) for determining the selling price of a deliverable. A vendor is now required to use its best estimate of the selling price when more objective evidence of the selling price cannot be determined. By providing an alternative for determining the selling price of deliverables, this guidance allows companies to allocate arrangement consideration in multiple deliverable arrangements in a manner that better reflects the transaction's economics. In addition, the residual method of allocating arrangement consideration is no longer permitted under this new guidance. We have adopted this guidance effective January 1, 2011, and will apply it on a prospective basis for all new or materially modified revenue arrangements with multiple deliverables entered into on or after January 1, 2011. Because we did not enter into any new or materially modified agreements with multiple elements and fixed payments in the first quarter of 2011 that would have been impacted by this guidance, the adoption did not have a material impact on the timing or pattern of revenue recognition.

  For the year ended December 31, 2010, there would have been no change in revenue recognized relating to multiple-element arrangements if we had adopted this guidance retrospectively for contracts entered into prior to January 1, 2011.

Goodwill Impairment Testing. In December 2010, the FASB issued the following guidance which modifies goodwill impairment testing. Effective for interim and annual reporting beginning on or after December 15, 2010, we adopted this guidance in full effective January 1, 2011.

- *ASU No. 2010-28, Intangibles—Goodwill and Other (Topic 350) — When to Perform Step 2 of the Goodwill Impairment Test for Reporting Units with Zero or Negative Carrying Amounts,* a consensus of the FASB Emerging Issues Task Force. This guidance modifies Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts. For those reporting units, an entity is required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists. In determining whether it is more likely than not that a goodwill impairment exists, an entity should consider whether there are any adverse qualitative factors indicating that an impairment may exist. The adoption of this guidance did not impact our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, or AICPA, and the Securities and Exchange Commission, or SEC, did not have, or are not believed by management to have, a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended March 31,	
	2011	2010
	(in thousands)	
Shares outstanding at the beginning of the period	30,309	25,607
Weighted-average number of shares issued	83	39
Denominator for basic earnings per share	30,392	25,646
Dilutive effect of employee stock options and stock grants (1)	446	191
Denominator for diluted earnings per share (2)	30,838	25,837

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended March 31, 2011, and 2010, there were approximately 92,000 and 613,000 anti-dilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the three months ended March 31, 2011, and 2010, there were approximately 75,000, and 15,000 anti-dilutive weighted restricted shares, respectively.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the quarters ended March 31, 2011 and 2010.

4. Share-Based Compensation

At March 31, 2011, we had employee equity incentives outstanding under two plans: (1) the 2002 Equity Incentive Plan; and (2) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). On March 1, 2011, our chief executive officer, chief financial officer, and chief operating officer were awarded 100,000 shares, 75,000 shares, and 18,000 shares, respectively, of restricted stock with performance and service conditions. Each of the grants shall vest on March 1, 2012, provided that: (i) the Company's total operating revenue for 2011 is equal to or greater than $3.7 billion, and (ii) the respective officer continues to be employed by the Company as of March 1, 2012. In the event both vesting conditions are not achieved, the equity compensation awards shall lapse. As of March 31, 2011, we expect these awards to vest in full.

Charged to general and administrative expenses, total stock-based compensation expense for the three months ended March 31, 2011 and 2010 was as follows:

	Three Months Ended March 31,	
	2011	2010
	(in thousands)	
Restricted stock awards	$ 3,806	$ 1,638
Stock options (including shares issued under our employee stock purchase plan)	258	498
Total stock-based compensation expense	$ 4,064	$ 2,136

As of March 31, 2011, there was $22.8 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to recognize over a remaining weighted-average period of 2.5 years. As of March 31, 2011, there was a nominal amount of unrecognized compensation expense related to unvested stock options, which we expect to recognize in 2011.

Unvested restricted stock and restricted stock activity for the three months ended March 31, 2011 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2010	835,749	$ 23.32
Granted	455,000	34.50
Vested	(244,321)	24.13
Forfeited	(45,687)	25.79
Unvested balance as of March 31, 2011	1,000,741	28.09

The total grant date fair value of restricted shares granted during the three months ended March 31, 2011 and 2010 was $15.6 million and $9.4 million, respectively. The total fair value of restricted shares vested during the three months ended March 31, 2011 and 2010 was $8.6 million and $4.2 million, respectively. Stock option activity during the three months ended March 31, 2011 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value (in Thousands)	Weighted Average Remaining Contractual Term (Years)
Stock options outstanding as of December 31, 2010	513,614	$ 30.59		
Exercised	(83,931)	28.29		
Forfeited	(7,267)	32.51		
Stock options outstanding as of March 31, 2011	422,416	31.02	$ 3,995	4.5
Stock options exercisable and expected to vest as of March 31, 2011	422,118	31.01	$ 3,994	4.5
Exercisable as of March 31, 2011	417,616	30.97	$ 3,973	4.5

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

The carrying amount of the convertible senior notes was $165.4 million and $164.0 million as of March 31, 2011, and December 31, 2010, respectively. Based on quoted market prices, the fair value of the convertible senior notes was approximately $213.1 million and $188.4 million as of March 31, 2011, and December 31, 2010, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of March 31, 2011, we held certain assets that are required to be measured at fair value on a recurring basis. These included current investments in investment-grade debt securities that are designated as available-for-sale, and are reported at fair value based on market prices that are readily available (Level 1). See Note 6, “Investments,” for further information regarding fair value.

We also held investments in auction rate securities which are designated as available-for-sale, and are reported at fair value of $20.2 million (par value of $24.0 million) as of March 31, 2011.

Our investments in auction rate securities are collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of March 31, 2011. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, 2009, and 2010, and continued to be unavailable as of March 31, 2011. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining the fair value of the auction rate securities as of March 31, 2011. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As a result of the increase in fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized gains of $0.3 million and $0.2 million to accumulated other comprehensive income (loss) for the three months ended March 31, 2011, and 2010, respectively. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive income (loss). If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Until July 2, 2010, we held certain auction rate securities (designated as trading securities) with an investment securities firm. In 2008, we entered into a rights agreement with this firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. On June 30, 2010, and July 1, 2010, all of the eligible auction rate securities remaining at that time were settled at par value. During 2010, the aggregate auction rate securities (designated as trading securities) settled amounted to $40.9 million par value (fair value $36.7 million). Substantially all of the difference between par value and fair value on these securities was recovered through the rights agreement. For the three months ended March 31, 2010, we recorded pretax gains of $0.5 million on the auction rate securities underlying the Rights.

We accounted for the Rights as a freestanding financial instrument and, until July 2, 2010, recorded the value of the Rights under the fair value option. For the three months ended March 31, 2010, we recorded pretax losses of $0.5 million on the Rights, attributable to the decline in the fair value of the Rights. When the remaining eligible auction rate securities were sold at par value on July 1, 2010, the value of the Rights was zero.

Our assets measured at fair value on a recurring basis at March 31, 2011, were as follows:

	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$ 224,985	$ 224,985	$ —	$ —
Government-sponsored enterprise securities	39,372	39,372	—	—
Municipal securities	37,906	37,906	—	—
U.S. treasury notes	31,996	31,996	—	—
Certificates of deposit	3,255	3,255	—	—
Auction rate securities (available-for-sale)	20,187	—	—	20,187
	$ 357,701	$ 337,514	$ —	$ 20,187

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2010	$ 20,449
Total gains (realized or unrealized):	
Included in other comprehensive income	288
Settlements	(550)
Balance at March 31, 2011	$ 20,187
The amount of total gains for the period included in other comprehensive income attributable to the change in unrealized gains relating to assets still held at March 31, 2011	$ 288

In 2010, we recorded a $2.8 million liability for contingent consideration related to the acquisition of our Wisconsin health plan. As of March 31, 2011, we have determined that there is no liability for contingent consideration relating to the acquisition. The liability for contingent consideration related to this acquisition was measured at fair value on a recurring basis using significant unobservable inputs (Level 3). The following table presents a roll forward of this liability for 2011:

	(Level 3) (In thousands)
Balance at December 31, 2010	$ (2,800)
Total gains included in earnings	2,800
Balance at March 31, 2011	$ —

6. Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2011			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 227,099	$ 176	$ 2,290	$ 224,985
Government-sponsored enterprise securities (GSEs)	39,668	75	371	39,372
Municipal securities (including non-current auction rate securities)	62,293	66	4,266	58,093
U.S. treasury notes	31,982	102	88	31,996
Certificates of deposit	3,255	—	—	3,255
	$ 364,297	$ 419	$ 7,015	$ 357,701

	December 31, 2010			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Corporate debt securities	$ 179,124	$ 193	$ 1,388	$ 177,929
GSEs	59,790	293	370	59,713
Municipal securities (including non-current auction rate securities)	55,247	78	4,313	51,012
U.S. treasury notes	23,864	114	60	23,918
Certificates of deposit	3,252	—	—	3,252
	$ 321,277	$ 678	$ 6,131	$ 315,824

The contractual maturities of our investments as of March 31, 2011 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 194,237	$ 192,592
Due one year through five years	146,330	145,064
Due after five years through ten years	230	286
Due after ten years	23,500	19,759
	$ 364,297	$ 357,701

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales and maturities of available-for-sale securities were $61.3 million and $48.5 million for the three months ended March 31, 2011 and 2010, respectively. Net realized investment gains for the three months ended March 31, 2011, and 2010 were $157,000 and $14,000, respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at March 31, 2011, and December 31, 2010, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Approximately 35% of our investment in municipal securities consists of auction rate securities. As described in Note 5, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at March 31, 2011.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2011.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 143,883	$ 1,962	$ 11,248	$ 328	$ 155,131	$ 2,290
GSEs	9,974	104	6,331	267	16,305	371
Municipal securities	25,274	330	24,765	3,936	50,039	4,266
U.S. treasury notes	17,455	66	5,722	22	23,177	88
	$ 196,586	$ 2,462	$ 48,066	$ 4,553	$ 244,652	$ 7,015

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2010.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Corporate debt securities	$ 103,225	$ 1,060	$ 10,490	$ 328	$ 113,715	$ 1,388
GSEs	13,014	71	7,539	299	20,553	370
Municipal securities	18,884	117	25,271	4,196	44,155	4,313
U.S. treasury notes	5,480	40	6,806	20	12,286	60
	$ 140,603	$ 1,288	$ 50,106	$ 4,843	$ 190,709	$ 6,131

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivables are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	March 31, 2011	December 31, 2010
	(In thousands)	
Heath Plans segment:		
California	$ 40,141	$ 46,482
Michigan	12,465	13,596
Missouri	22,623	22,841
New Mexico	10,382	18,310
Ohio	20,904	21,622
Washington	10,315	14,486
Wisconsin	6,639	5,437
Others	6,200	5,187
Total Health Plans segment	129,669	147,961
Molina Medicaid Solutions segment	40,749	20,229
	$ 170,418	$ 168,190

Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid during the period 2003 through August 31, 2009. The final resolution of this matter, and the amount that may be realized by the Utah health plan, is currently uncertain and contingent upon future events. When additional information is known or agreement is reached with the state, we will recognize the resulting amount of revenue, if any, in our consolidated financial statements. No receivables for this matter have been established at March 31, 2011.

In late April of 2011, the Idaho Department of Administration delivered a letter to Molina Medicaid Solutions indicating that it wished to remit to Molina an amount approximately $5 to $6 million less than the amount of Molina's invoices for its operation of the MMIS in that state for the period June 1, 2010 through December 31, 2010. We do not believe that the basis for the reduced payment amount is contractually sound, and have not adjusted our financial statements to reflect the requested reduction. We are currently deferring recognition of all revenue as well as all direct costs (which constitute the majority of our costs) in Idaho until the MMIS in that state receives certification from the Centers for Medicare and Medicaid Services, or CMS, which we expect to occur in 2012. Any adjustments, if necessary, to the amount of our receivable from the state of Idaho will be made as more information becomes available.

8. Restricted Investments

Pursuant to the regulations governing our health plans, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the balances of restricted investments by health plan, and for our insurance company:

	March 31, 2011	December 31, 2010
	(In thousands)	
California	$ 372	$ 372
Florida	7,981	4,508
Insurance Company	4,682	4,689
Michigan	1,000	1,000
Missouri	507	508
New Mexico	15,888	15,881
Ohio	9,069	9,066
Texas	3,501	3,501
Utah	2,791	1,279
Washington	151	151
Wisconsin	260	260
Other	3,105	885
	$ 49,307	$ 42,100

The contractual maturities of our held-to-maturity restricted investments as of March 31, 2011 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 46,432	$ 46,462
Due one year through five years	2,750	2,743
Due after five years through ten years	125	155
	$ 49,307	$ 49,360

9. Long-Term Debt

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As of March 31, 2011, and December 31, 2010, there was no outstanding principal balance under the Credit Facility. However, as of March 31, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the contract of MMS with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At March 31, 2011, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio under the Credit Facility is required to be no less than 3.00x.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.50 to 1.0 for the first and second quarters of 2010 and through August 14, 2010 (on a pro forma basis). Effective as of August 15, 2010, the maximum consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0.

Convertible Senior Notes

As of March 31, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

The proceeds from the issuance of such convertible debt instruments have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of March 31, 2011, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 42 months. The Notes' if-converted value did not exceed their principal amount as of March 31, 2011. At March 31, 2011, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of March 31, 2011	As of December 31, 2010
	(in thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(21,646)	(22,986)
Net carrying amount	$ 165,354	$ 164,014

	Three Months Ended March 31,	
	2011	2010
	(in thousands)	
Interest cost recognized for the period relating to the:		
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,753
Amortization of the discount on the liability component	1,340	1,243
Total interest cost recognized	$ 3,093	$ 2,996

10. Stockholders' Equity

In connection with the plans described in Note 4, "Share-Based Compensation," we issued approximately 243,000 shares of common stock, net of shares retired to settle employees' income taxes, for the three months ended March 31, 2011. For the three months ended March 31, 2011, the $4.2 million increase to additional paid-in capital was generated by employee stock plans transactions.

11. Segment Reporting

Our reportable segments are consistent with how we manage the business and view the markets we serve. In the second quarter of 2010, we added a segment to our internal financial reporting structure as a result of the acquisition of Molina Medicaid Solutions. We report our financial performance based on two reportable segments: Health Plans and Molina Medicaid Solutions.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

Operating segment revenues and profitability for the three months ended March 31, 2011 and 2010 were as follows:

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
Three months ended March 31, 2011			
Premium revenue	$ 1,081,438	$ —	$ 1,081,438
Service revenue	—	36,674	36,674
Investment income	1,594	—	1,594
Total revenue	$ 1,083,032	$ 36,674	$ 1,119,706
Operating income	$ 29,606	$ 1,694	$ 31,300
Three months ended March 31, 2010			
Premium revenue	$ 965,220	$ —	$ 965,220
Service revenue	—	—	—
Investment income	1,521	—	1,521
Total revenue	$ 966,741	$ —	$ 966,741
Operating income	$ 20,438	$ —	$ 20,438

Reconciliation to Income before Income Taxes

	Three Months Ended March 31,	
	2011	2010
	(In thousands)	
Segment operating income	$ 31,300	$ 20,438
Interest expense	(3,603)	(3,357)
Income before income taxes	$ 27,697	$ 17,081

Segment Assets

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
As of March 31, 2011	$ 1,383,447	$ 199,707	$ 1,583,154
As of December 31, 2010	$ 1,333,599	$ 175,615	$ 1,509,214

12. Commitments and Contingencies

Legal

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, consolidated financial position, cash flows, or results of operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was $432.4 million at March 31, 2011, and $397.8 million at December 31, 2010. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of March 31, 2011, our health plans had aggregate statutory capital and surplus of approximately $441.6 million compared with the required minimum aggregate statutory capital and surplus of approximately $274.1 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2011. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

13. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of both March 31, 2011 and December 31, 2010, our carrying amount for this investment totaled $4.4 million. For the three months ended March 31, 2011 and 2010, we paid $5.4 million and $4.4 million, respectively, for medical service fees to this provider.

14. Subsequent Event

On April 27, 2011, we announced that our board of directors authorized a 3-for-2 stock split of our common stock to be effected in the form of a stock dividend of one share of our stock for every two shares outstanding. The distribution of the dividend will be made on May 20, 2011.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate, the effect of various implementing regulations, and uncertainties regarding the likely impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including seasonal flu patterns and rates of utilization that are consistent with our expectations;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to grow our revenues consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including Medicaid pharmaceutical rebates;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine and Idaho;
- additional administrative costs and the potential payment of additional amounts to providers and/or the state by Molina Medicaid Solutions as a result of MMIS implementation issues in Idaho;
- government audits and reviews, including the audit of our Medicare plans by CMS;
- changes with respect to our provider contracts and the loss of providers;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation or arbitration matters;
- restrictions and covenants in our credit facility;

- the relatively small number of states in which we operate health plans;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments; and
- changes in general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2010, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2010.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. We also have a direct delivery business that currently consists of 16 primary care community clinics in California and two primary care community clinics in Washington; additionally, we manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of March 31, 2011. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

We report our financial performance based on the following two reportable segments: Health Plans; and Molina Medicaid Solutions.

First Quarter Performance Summary

The following table and narrative briefly summarizes our financial and operating performance for the three months ended March 31, 2011. Comparable metrics for the first quarter of 2010 are also shown. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended March 31,	
	2011	2010
	(Dollar amounts in thousands, except per-share data)	
Earnings per diluted share	$ 0.56	$ 0.41
Premium revenue	$ 1,081,438	$ 965,220
Service revenue	$ 36,674	$ —
Operating income	$ 31,300	$ 20,438
Net income	$ 17,388	$ 10,590
Total ending membership	1,647,000	1,482,000
Premium revenue	96.6%	99.8%
Service revenue	3.3	—
Investment income	0.1	0.2
Total revenue	100.0%	100.0%
Medical care ratio	84.5%	85.3%
General and administrative expense ratio	8.4%	8.2%
Premium tax ratio	3.4%	3.6%
Operating income	2.8%	2.1%
Net income	1.6%	1.1%
Effective tax rate	37.2%	38.0%

Our first quarter of 2011 was marked by strong membership growth, flat PMPM revenue, and lower medical costs. Compared with the first quarter of 2010, earnings per share in the first quarter of 2011 were up 37%, premium revenues were up 12%, operating income was up 53%, and aggregate membership grew by 11%. Meanwhile, the aggregate medical care ratio of our health plans declined by 80 basis points. Our larger and more established health plans performed the strongest in the quarter, with each of California, Ohio, Utah, and Washington having lower medical care ratios compared with the first quarter of 2010. Our Florida and Wisconsin health plans continue to face challenges, which we are working to address. Medicare enrollment exceeded 24,000 members at March 31, 2011, and Medicare premium revenue for the quarter was $85.4 million compared with $50.3 million in the first quarter of 2010. With respect to our Molina Medicaid Solutions business, our system stabilization efforts in Idaho and Maine are taking longer and are more costly than we had anticipated. However, our profit margins in our fiscal agent contracts in New Jersey, Louisiana, and West Virginia remain stable.

We remain concerned about state budget deficits, which are not expected to improve during the remainder of 2011. Accordingly, the rate environment for our health plans remains uncertain. However, our Missouri health plan has received notification that it will receive a blended rate increase of approximately 5% effective July 1, 2011. On May 5, 2011, we learned that our responsive bid in Arizona in connection with the re-procurement of the ALTCS program (Acute + Long Term Care Services) was not successful. The Company is in the process of reviewing and evaluating the bid scores and may file a protest as warranted. We continue to await the results of Molina Medicaid Solutions' responsive bid in Louisiana to retain its MMIS contract in that state.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the three months ended March 31, 2011, we received approximately 94% of our premium revenue as a fixed per-member per-month, or PMPM, amount, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the three months ended March 31, 2011, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for the Children's Health Insurance Program, or CHIP, members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the Temporary Assistance for Needy Families, or TANF, Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $230 in Missouri. Among our Medicaid Aged, Blind or Disabled, or ABD, membership, PMPM premiums range from approximately $320 in Utah to $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care

contract (most often pharmacy and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare membership generates the highest PMPM premiums, at nearly $1,200 PMPM.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	March 31, 2011	December 31, 2010	March 31, 2010
Total Ending Membership by Health Plan:			
California	347,000	344,000	353,000
Florida	66,000	61,000	52,000
Michigan	225,000	227,000	226,000
Missouri	82,000	81,000	78,000
New Mexico	90,000	91,000	92,000
Ohio	248,000	245,000	228,000
Texas	128,000	94,000	40,000
Utah	80,000	79,000	75,000
Washington	341,000	355,000	338,000
Wisconsin(1)	40,000	36,000	—
Total	1,647,000	1,613,000	1,482,000
Total Ending Membership by State for our Medicare Advantage Plans(1):			
California	5,300	4,900	2,700
Florida	600	500	300
Michigan	6,700	6,300	4,200
New Mexico	700	600	600
Ohio	400	—	—
Texas	600	700	500
Utah	6,700	8,900	7,100
Washington	3,300	2,600	1,600
Total	24,300	24,500	17,000
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	14,100	13,900	13,400
Florida	10,300	10,000	8,900
Michigan	32,000	31,700	32,700
New Mexico	5,600	5,700	5,800
Ohio	28,200	28,200	26,700
Texas	51,200	19,000	18,100
Utah	8,200	8,000	7,900
Washington	4,300	4,000	3,500
Wisconsin(1)	1,700	1,700	—
Total	155,600	122,200	117,000

(1) We acquired the Wisconsin health plan on September 1, 2010. As of March 31, 2011, the Wisconsin health plan had approximately 2,400 Medicare Advantage members that are ceded 100% under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

Molina Medicaid Solutions' MMIS contracts extend over a number of years, and cover the life of the MMIS from inception through at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds. In some circumstances, revenue recognition may be delayed for long periods while we await formal customer acceptance of our products and/or services. In those circumstances, recognition of a portion of our costs may also be deferred.

Under our contracts in Louisiana, New Jersey, and West Virginia, we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue on a straight-line basis over the remaining term of the contract. In Maine, we completed the DDI phase of our contract effective September 1, 2010. In Idaho, we expect to complete the DDI phase of our contract during 2011. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in 2012.

Additionally, Molina Medicaid Solutions provides pharmacy rebate administration services under a contract with the state of Florida.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- *Capitation* — Expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- *Pharmacy* — Expenses for all drug, injectible, and immunization costs paid primarily through our pharmacy benefit manager.
- *Other* — Expenses for medically related administrative costs of approximately $24.4 million, and $19.6 million, for the three months ended March 31, 2011, and 2010, respectively, including certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Louisiana, Maine, New Jersey, West Virginia, and Florida, as well as certain selling, general and administrative expenses. Additionally, certain indirect costs incurred under our contracts in Maine (prior to exiting the DDI phase of that contract in September, 2010) and Idaho are also expensed to cost of services.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contact costs in 2012, in a manner consistent with our anticipated recognition of revenue.

Results of Operations

Three Months Ended March 31, 2011 Compared with the Three Months Ended March 31, 2010

Health Plans Segment

Premium Revenue

Premium revenue grew 12% in the three months ended March 31, 2011 compared with the three months ended March 31, 2010, due to a membership increase of 11%. Consolidated premium revenue increased by approximately 1% on a PMPM basis. Medicare enrollment exceeded 24,000 members at March 31, 2011, and Medicare premium revenue was $85.4 million for the three months ended March 31, 2011, compared with $50.3 million for the three months ended March 31, 2010.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended March 31,					
	2011			2010		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$ 655,884	$ 133.78	71.8%	$ 566,879	$ 128.06	68.9%
Capitation	128,682	26.25	14.1	137,132	30.98	16.7
Pharmacy	91,576	18.68	10.0	90,071	20.35	10.9
Other	37,390	7.63	4.1	28,734	6.48	3.5
Total	$ 913,532	$ 186.34	100.0%	$ 822,816	$ 185.87	100.0%

The medical care ratio decreased to 84.5% in the three months ended March 31, 2011, compared with 85.3% for the three months ended March 31, 2010. Total medical care costs increased less than 1% PMPM, while medical care costs for our Medicaid membership decreased by approximately 2% PMPM.

- Pharmacy costs (adjusted for the state's retention of the pharmacy benefit in Ohio effective February 1, 2010) increased approximately 5% PMPM.
- Capitation costs decreased approximately 15% PMPM, primarily due to the transition of members in Michigan and Washington into fee-for-service networks.
- Fee-for-service costs increased approximately 4% PMPM, partially due to the transition of members from capitated provider networks into fee-for-service networks. Fee-for-service and capitation costs combined increased less than 1% PMPM.
- Hospital admissions per thousand members per year decreased approximately 7%.
- Pharmacy utilization was essentially flat, with the increase in costs being driven by higher costs per prescription.

The medical care ratio of the California health plan decreased to 84.3% in the three months ended March 31, 2011, from 86.8% in the three months ended March 31, 2010, as higher premium revenue PMPM more than offset an increase of approximately 27% in pharmacy costs and an increase of approximately 5% in fee-for-service costs.

The medical care ratio of the Florida health plan increased to 96.6% in the three months ended March 31, 2011, from 88.7% in the three months ended March 31, 2010, primarily due to higher fee-for-service and capitation costs, which more than offset lower pharmacy costs. We have undertaken a number of measures — focused on both utilization and unit cost reductions — to improve the profitability of the Florida health plan. The Florida health plan's medical care ratio decreased from 100.2% in the fourth quarter of 2010.

The medical care ratio of the Michigan health plan increased to 81.2% in the three months ended March 31, 2011, from 80.8% in the three months ended March 31, 2010, as higher physician and outpatient facility fee-for-service costs and higher pharmacy costs more than offset lower capitation costs.

The medical care ratio of the Missouri health plan increased to 93.6% in the three months ended March 31, 2011, from 83.5% in the three months ended March 31, 2010, due to higher fee-for-service costs.

The medical care ratio of the New Mexico health plan increased to 82.8% in the three months ended March 31, 2011, from 77.4% in the three months ended March 31, 2010, as lower fee-for-service costs failed to offset the impact of a premium rate decrease of approximately 8.5% PMPM.

The medical care ratio of the Ohio health plan decreased to 74.6% in the three months ended March 31, 2011, from 79.1% in the three months ended March 31, 2010, due to an increase in Medicaid premium PMPM of approximately 4.5% effective January 1, 2011, and flat fee-for-service costs.

The medical care ratio of the Texas health plan increased to 91.1% in the three months ended March 31, 2011, from 82.5% in the three months ended March 31, 2010. Effective February 1, 2011, we added approximately 30,000 ABD Medicaid members in the Dallas-Fort Worth area, and effective September 1, 2010, we added approximately 54,000 members state-wide who are covered under CHIP.

The medical care ratio of the Utah health plan decreased to 79.3% in the three months ended March 31, 2011, from 105.0% in the three months ended March 31, 2010, primarily due to reduced fee-for-service costs in the outpatient facility and physician categories and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010. Lower fee-for-service costs were the result of both lower unit costs and lower utilization.

The medical care ratio of the Washington health plan decreased to 86.6% in the first quarter of 2011 from 90.3% in the three months ended March 31, 2010. Lower capitation costs more than offset higher fee-for-service and higher pharmacy costs. Pharmacy costs for the Washington health plan's Medicaid members grew approximately 22% PMPM.

The medical care ratio of the Wisconsin health plan (acquired September 1, 2010) was 118.1% in the three months ended March 31, 2011. The Wisconsin health plan recorded a premium deficiency reserve of $3.35 million in the first quarter of 2011. Absent that premium deficiency reserve, the Wisconsin health plan's medical care ratio would have been approximately 98% for the three months ended March 31, 2011.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Three Months Ended March 31, 2011						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,041	$ 134,976	$ 129.63	$ 113,737	$ 109.24	84.3%	$ 1,902
Florida	192	49,222	256.63	47,568	248.01	96.6	17
Michigan	678	164,760	243.06	133,728	197.28	81.2	9,846
Missouri	245	55,166	225.33	51,608	210.79	93.6	—
New Mexico	271	84,606	311.93	70,038	258.21	82.8	1,965
Ohio	737	230,340	312.68	171,752	233.15	74.6	17,775
Texas	349	80,811	231.49	73,615	210.88	91.1	1,340
Utah	236	67,935	287.77	53,839	228.06	79.3	—
Washington	1,034	195,272	188.81	169,116	163.52	86.6	3,642
Wisconsin(2)	120	16,417	137.25	19,380	162.02	118.1	—
Other(3)	—	1,933	—	9,151	—	—	63
	4,903	$1,081,438	$ 220.58	$ 913,532	$ 186.34	84.5%	$ 36,550

	Three Months Ended March 31, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,062	$123,910	$ 116.67	$ 107,561	$ 101.28	86.8%	$ 1,628
Florida	154	39,088	253.45	34,687	224.91	88.7	6
Michigan	675	155,345	230.13	125,449	185.85	80.8	9,939
Missouri	234	52,143	223.01	43,516	186.11	83.5	—
New Mexico	280	95,598	341.02	74,015	264.03	77.4	2,004
Ohio	673	218,363	324.35	172,625	256.41	79.1	17,005
Texas	121	39,200	324.08	32,331	267.29	82.5	681
Utah	221	58,540	265.51	61,460	278.76	105.0	—
Washington	1,007	181,054	179.84	163,510	162.42	90.3	3,262
Wisconsin(2)	—	—	—	—	—	—	—
Other(3)	—	1,979	—	7,662	—	—	21
	4,427	$965,220	$ 218.04	$ 822,816	$ 185.87	85.3%	$ 34,546

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

Days in Medical Claims and Benefits Payable

The days in medical claims and benefits payable were as follows:

	March 31, 2011	Dec. 31, 2010	March 31, 2010
Days in claims payable — fee-for-service only	41 days	42 days	44 days
Number of claims in inventory at end of period	185,300	143,600	153,700
Billed charges of claims in inventory at end of period (in thousands)	$ 250,600	$ 218,900	$ 194,000

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment for the three months ended March 31, 2011 was as follows:

	(In thousands)
Service revenue before amortization	$ 38,860
Less: amortization of contract backlog recorded as contra-service revenue	(2,186)
Service revenue	36,674
Cost of service revenue	31,221
General and administrative costs	2,477
Amortization of customer relationship intangibles recorded as amortization	1,282
Operating income	$ 1,694

Consolidated Expenses

General and Administrative Expenses

General and administrative, or G&A, expenses, were $94.4 million, or 8.4% of total revenue, for the three months ended March 31, 2011 compared with $78.9 million, or 8.2% of total revenue, for the three months ended March 31, 2010.

Premium Tax Expense

Premium tax expense decreased to 3.4% of premium revenue in the three months ended March 31, 2011 from 3.6% in the three months ended March 31, 2010.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service Revenue;" and
- Depreciation is recorded within the heading "Cost of Service Revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue, and reconciles that amount to the consolidated statements of cash flows.

	Three Months Ended March 31,			
	2011		2010	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Depreciation	$ 7,401	0.7%	$ 6,412	0.7%
Amortization of intangible assets	5,266	0.4	3,649	0.3
Depreciation and amortization reported in the consolidated statements of income	12,667	1.1	10,061	1.0
Amortization recorded as reduction of service revenue	2,186	0.2	—	—
Depreciation recorded as cost of service revenue	3,241	0.3	—	—
Depreciation and amortization reported in the consolidated statements of cash flows	$ 18,094	1.6%	$ 10,061	1.0%

Interest Expense

Interest expense increased to $3.6 million for the three months ended March 31, 2011, from $3.4 million for the three months ended March 31, 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $1.3 million and $1.2 million for the three months ended March 31, 2011, and 2010, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 37.2% for the three months ended March 31, 2011 compared with 38.0% for the three months ended March 31, 2010. The lower rate in 2011 was primarily due to lower state income taxes.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our premium revenue or our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of March 31, 2011, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased slightly to $1.6 million for the three months ended March 31, 2011, compared with $1.5 million for the three months ended March 31, 2010.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect to incur significant losses due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our unregulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the three months ended March 31, 2011 was $84.1 million compared with $26.2 million used in operating activities for the three months ended March 31, 2010, an increase of $110.3 million. The change is primarily attributable to the advance premium payment made in March 2011 by the state of Ohio to our Ohio health plan in the amount of $72.7 million. Deferred revenue, which was a use of operating cash totaling $90.7 million in three months ended March 31, 2010, was a source of operating cash totaling $84.2 million in the three months ended March 31, 2011. The change in deferred revenue was offset by changes in other current assets and liabilities.

Reconciliation of Non-GAAP(1) to GAAP Financial Measures

EBITDA(2)

	Three Months Ended March 31,	
	2011	2010
	(In thousands)	
Operating income	$ 31,300	$ 20,438
Add back:		
Depreciation and amortization reported in the consolidated statements of cash flows	18,094	10,061
EBITDA	$ 49,394	$ 30,499

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) We calculate EBITDA consistently on a quarterly and annual basis by adding back depreciation and amortization to operating income. Operating income includes investment income. EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At March 31, 2011, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $25.6 million, compared with approximately $65.1 million of cash and investments at December 31, 2010. This decline was primarily due to capital contributions and/or advances to our Florida, Texas, and Wisconsin health plans in the first quarter of 2011.

On a consolidated basis, at March 31, 2011, we had working capital of $399.6 million compared with $392.4 million at December 31, 2010. At March 31, 2011, we had cash and investments of $870.8 million, compared with approximately $813.8 million of cash and investments at December 31, 2010.

We believe that our cash and credit resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As of March 31, 2011, and December 31, 2010, there was no outstanding principal debt balance under the Credit Facility. However, as of March 31, 2011, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the contract of MMS with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At March 31, 2011, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio under the Credit Facility is required to be no less than 3.00x.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.50 to 1.0 for the first and second quarters of 2010 and through August 14, 2010 (on a pro forma basis). Effective as of August 15, 2010, the maximum consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering. As a result of the offering described below, we may now offer up to $182.5 million of our securities from time to time under the shelf registration statement.

In August 2010, we sold 4,350,000 shares of common stock covered by this registration statement. The public offering price for this sale was $25.65 per share, net of the underwriting discount. Our proceeds from the sales totaled approximately $111.1 million, net of the issuance costs. We used the proceeds from these sales to repay the Credit Facility and for general corporate purposes. Also in August 2010, the Molina Siblings Trust, as a selling stockholder, sold 250,000 shares of outstanding common stock covered by this registration statement.

Convertible Senior Notes

As of March 31, 2011, $187.0 million in aggregate principal amount of our 3.75% Convertible Senior Notes due 2014 (the "Notes") remain outstanding. The Notes rank equally in right of payment with our existing and future senior indebtedness. The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $432.4 million at March 31, 2011, and $397.8 million at December 31, 2010.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At March 31, 2011, our health plans had aggregate statutory capital and surplus of approximately $441.6 million, compared to the required minimum aggregate statutory capital and surplus of approximately $274.1 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2011. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2011.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;
- The deferral of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Certain components of premium revenue of our Health Plans segment are subject to accounting estimates, and are therefore subject to retroactive revision. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At March 31, 2011, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At March 31, 2011, we had recorded a liability of $7.0 million under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. For the state fiscal year ending June 30, 2011 (the only contract year currently open for determination of at-risk premium revenue), our New Mexico health plan has received $1.9 million in at-risk revenue as of March 31, 2011. To date, we have recognized $0.9 million of that amount as revenue, and recorded a liability of approximately $1.0 million as of March 31, 2011, for the remainder. If the state of New Mexico disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. Effective February 1, 2010 an additional 0.25% of the Ohio health plan's revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Ohio's fiscal year ends June 30, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending June 30, 2011, our Ohio health plan has received $8.5 million in at-risk revenue as of March 31, 2011. To date, we have recognized $4.7 million of that amount as revenue and recorded a liability of approximately $3.8 million as of March 31, 2011, for the remainder. If the state of Ohio disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required. For example, during the third quarter of 2010, we reversed the recognition of approximately $3.3 million of at-risk revenue of which $1.9 million and $1.4 million were initially recognized in 2010, and 2009, respectively.

- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid during the period 2003 through August 31, 2009. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million.

Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. On April 19, 2011, the Director of the Utah Department of Health issued a Final Agency Order in an administrative proceeding initiated by our Utah health plan relating to the proper interpretation of the savings sharing language in the parties' state fiscal year 2006 contract. Pursuant to that Order, the Department adopted the administrative law judge's finding that the Utah health plan's interpretation of the contract was correct and that the savings sharing amount due to the Utah health plan should be calculated under the health plan's interpretation. The parties are in the process of calculating the net amounts due to the health plan for fiscal year 2006 and for all other years covered by the savings sharing language.

The final resolution of this matter, and the amount that may be realized by the Utah health plan, is currently uncertain and contingent upon future events. When additional information is known or agreement is reached with the state regarding the appropriate savings sharing payment amount, we will recognize that amount of savings sharing revenue, if any, in our financial statements. No receivables for saving sharing revenue have been established at March 31, 2011.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas there is a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of March 31, 2011, we had an aggregate liability of approximately $0.1 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2010 and 2011 contract years (ending August 31st of each year). Because the final settlement calculations include a claims run-out period of nearly one year, an adjustment to the amounts owed may be required.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures established by the state. The time period for the assessment of these performance measures had previously followed the state's fiscal year, but effective January 1, 2011, it follows the calendar year. As of March 31, 2011, our Texas health plan has received $0.6 million in at-risk revenue, none of which has been recognized as revenue as of March 31, 2011. If the state of Texas disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns, there is no liability related to the potential recoupment of Medicare premium revenue at March 31, 2011. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

Deferral of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solutions contracts are multiple-element arrangements. The following discussion applies to our contracts with multiple elements entered into prior to January 1, 2011, before our prospective adoption of *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*.

For those contracts entered into prior to January 1, 2011, we have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services, which vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our newer contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. Although the length of the DDI phase for any MMIS contract can vary considerably, the DDI phase typically takes about two years to complete. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services, or training and support services) until the contingency had been removed. In these circumstances, we would also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the contract (whether DDI, BPO services, or training and support services) on which revenue recognition is being deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

For all new or materially modified revenue arrangements with multiple elements entered into on or after January 1, 2011, which we expect will consist of contracts entered into by our Molina Medicaid Solutions segment, we will apply the guidance contained in ASU No. 2009-13. For these arrangements, we will allocate total arrangement consideration to the elements of the arrangement, which are expected to be DDI, BPO, and training and support, because this is consistent with the current elements included in our Molina Medicaid Solutions contracts. The arrangement allocation will be performed using the relative selling-price method. When determining the selling price of each element, we will first attempt to use VSOE if available. If VSOE is not available, we will attempt to use third-party evidence, or TPE, of vendors selling similar services to similarly situated customers on a standalone basis, if available. If neither VSOE nor TPE are available, we will use our best estimate of the selling price for each element.

We will then evaluate whether, at each stage in the life cycle of the contract, we are able to recognize revenue associated with that element. To the extent that our revenue arrangements have provisions that allow our state customers to refuse acceptance of services performed, we will still be required to defer revenue recognition until such state customers accept our performance. Once this acceptance is achieved, we will immediately recognize the revenue associated with any delivered elements which differs from our current practice for arrangements entered into prior to January 1, 2011, where the revenue associated with delivered elements is recognized over the final service element of the arrangement because VSOE for the other elements does not exist. As such, we expect that the adoption of ASU No. 2009-13 will result in an overall acceleration of revenue recognition with respect to any multiple-element arrangements entered into on or after January 1, 2011.

We began to recognize revenue and related deferred costs associated with our Maine contract in September 2010. In Idaho, we expect to begin recognition of deferred contact costs in 2012, in a manner consistent with our anticipated recognition of revenue. Molina Medicaid Solutions' deferred revenue totaled $36.1 million at March 31, 2011, and $10.9 million at December 31, 2010, and unamortized deferred contract costs were $37.9 million at March 31, 2011, and $28.4 million at December 31, 2010.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the long-lived asset is written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the long-lived asset to zero, any remaining deferred contract costs are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets and deferred contract costs exceed the fair value of those assets.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	March 31, 2011	Dec. 31, 2010
	(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 273,378	$ 275,259
Capitation payable	43,738	49,598
Pharmacy	16,953	14,649
Other	17,313	14,850
	$ 351,382	$ 354,356

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $273.4 million of our total medical claims and benefits payable of $351.4 million as of March 31, 2011. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at March 31, 2011, was $267.4 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of March 31, 2011 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding March 31, 2011 by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 83,261
(4)%	55,507
(2)%	27,754
2%	(27,754)
4%	(55,507)
6%	(83,261)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of March 31, 2011 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (67,651)
(4)%	(45,101)
(2)%	(22,550)
2%	22,550
4%	45,101
6%	67,651

The following per-share amounts are based on a combined federal and state statutory tax rate of 37.5%, and 30.8 million diluted shares outstanding for the three months ended March 31, 2011. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at March 31, 2011, net income for the three months ended March 31, 2011 would increase or decrease by approximately $8.7 million, or $0.28 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at March 31, 2011, net income for the three months ended March 31, 2011 would increase or decrease by approximately $7.0 million, or $0.23 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $43.4 million, or $1.41 per diluted share, and $35.2 million, or $1.14 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $8.7 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the

provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2010, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 15.7%.

As shown in greater detail in the table below, the amounts ultimately paid out on our prior period liabilities in fiscal years 2010 and through March 31, 2011, were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

We recognized a benefit from prior period claims development in the amount of $44.4 million for the three months ended March 31, 2011 (see table below). This amount represents our estimate as of March 31, 2011 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2010 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2010 was due primarily to the following factors:

- We overestimated the impact of an increase in pending high dollar claims at our Ohio health plan.
- We underestimated the lower cost associated with changes to provider fee schedules (primarily for outpatient facility costs) in New Mexico effective November 1, 2010.

The following developments partially offset the overestimation of our claims liability at December 31, 2010:

- In Missouri, delays in claims processing late in the fourth quarter of 2010 led us to underestimate the size of our claims liability at December 31, 2010.
- We underestimated the costs associated with our assumption of risk for a new population in Texas (rural CHIP members) effective September 1, 2010.

We recognized a benefit from prior period claims development in the amount of $38.5 million, and $49.4 million for the three months ended March 31, 2010, and the year ended December 31, 2010, respectively (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting, and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

In estimating our claims liability at March 31, 2011, we adjusted our base calculation to take account of the following factors that we believe are reasonably likely to change our final claims liability amount:

- The assumption of risk for a new population by our Texas health plan (Dallas-Fort Worth area ABD members) effective February 1, 2011.
- The transition of certain members by our Washington and Michigan health plans from full-risk capitated provider arrangements to fee-for-service providers effective December 31, 2010. This change had the effect of transferring back to the Company risk that had previously been assumed by capitated medical providers.
- A substantial decline in claims inventory at our Florida and New Mexico health plans.
- A substantial increase in claims inventory at our Michigan, Missouri, and Texas health plans.
- Our liability for an unknown number of maternity related claims that were mistakenly paid on our behalf by the state of Michigan.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the underestimation or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2010 and through March 31, 2011, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both periods, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "*Components of medical care costs related to:* Prior years" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Three Months Ended March 31,		Year Ended
	2011	2010	Dec. 31, 2010
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of year	$ 354,356	$ 315,316	$ 315,316
Balance of acquired subsidiary	—	—	3,228
Components of medical care costs related to:			
Current year	957,909	861,271	3,420,235
Prior years	(44,377)	(38,455)	(49,378)
Total medical care costs	913,532	822,816	3,370,857
Payments for medical care costs related to:			
Current year	646,428	581,389	3,085,388
Prior years	270,078	230,970	249,657
Total paid	916,506	812,359	3,335,045
Balances at end of year	$ 351,382	$ 325,773	$ 354,356
Benefit from prior years as a percentage of:			
Balance at beginning of year	12.5%	12.1%	15.7%
Premium revenue	4.1%	4.0%	1.2%
Medical care costs	4.9%	4.7%	1.5%
Claims Data:			
Days in claims payable, fee for service only	41	44	42
Number of members at end of period	1,647,000	1,482,000	1,613,000
Fee-for-service claims processing and inventory information:			
Number of claims in inventory at end of period	185,300	153,700	143,600
Billed charges of claims in inventory at end of period	$ 250,600	$ 194,000	$ 218,900
Claims in inventory per member at end of period	0.11	0.10	0.09
Billed charges of claims in inventory per member at end of period	$ 152.16	$ 130.90	$ 135.71
Number of claims received during the period	4,342,200	3,493,300	14,554,800
Billed charges of claims received during the period	$ 3,386,600	$ 2,760,500	$ 11,686,100

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures, and programs that we have not yet identified.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years or less and an average duration of two years or less. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our Health Plans segment and our Molina Medicaid Solutions segment operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the three months ended March 31, 2011 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. Based upon the evaluation of information currently available, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. There has been no material change to the risk factors identified in Part 1, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2010 as filed with the SEC on March 8, 2011.

Item 6. ***Exhibits***

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 9, 2011

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer and President (Principal Executive Officer)

Dated: May 9, 2011

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer (Principal Financial Officer)

EXHIBIT INDEX

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2011 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 9, 2011

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2011 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 9, 2011

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2011 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 9, 2011

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2011 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 9, 2011

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

2010 MHI Form 10-K

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SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

(562) 435-3666
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	
Common Stock, $0.001 Par Value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐ Yes ☑ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☐ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☑	Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☑ No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2010, the last business day of our most recently completed second fiscal quarter, was approximately $324 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2010).

As of March 2, 2011, approximately 30,523,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2010 Annual Meeting of Stockholders to be held on April 27, 2011, are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

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Form 10-K

PART I

Item 1: *Business*

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business focuses exclusively on government-sponsored health care programs, and includes our Health Plans segment, our Molina Medicaid Solutions℠ segment, and our smaller direct delivery line of business. Our Health Plans segment consists of licensed health maintenance organizations serving Medicaid populations in ten states. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to Medicaid agencies in an additional five states. Our direct delivery line of business consists of 16 primary care community clinics in California and two primary care community clinics in Washington, and we also manage three county-owned primary care community clinics under a contract with Fairfax County, Virginia. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today we remain a provider-focused company led by his son, Dr. J. Mario Molina.

Our Health Plans segment operates Medicaid managed care plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin that serve a total of approximately 1.6 million members. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Our Health Plans segment derives its revenue principally in the form of premiums paid under Medicaid contracts with the states in which our health plans operate. While the health plans receive fixed per-member per-month, or PMPM, premium payments from the states, the health plans are at risk for the medical costs associated with their members' health care. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements which limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS, a core information technology tool used to support the administration of state Medicaid and other health care entitlement programs. Our Molina Medicaid Solutions segment currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in May 2010 to expand our product offerings to include support of state Medicaid agency administrative needs; to reduce the variability in our earnings resulting from fluctuations in medical care costs; to improve our operating profit margin percentages; and to improve our cash flow by adding a business for which there are no restrictions on dividend payments.

From a strategic perspective, we believe our two business segments and our direct delivery business line allow us to participate in an expanding sector of the economy and continue our mission of serving low-income families and individuals eligible for government-sponsored health care programs. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is *www.molinahealthcare.com.*

Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to "Molina Healthcare," the "Company," "we," "our," and "us" herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge on our website, *www.molinahealthcare.com*, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers and directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, Corporate Governance and Nominating Committee, and Compliance Committee Charters, are also available on our website. Such information is also available in print upon the request

of any stockholder to our Investor Relations department at the address of our executive offices set forth above. In accordance with New York Stock Exchange, or NYSE, rules, on June 2, 2010, we filed the annual certification by our Chief Executive Officer certifying that he was unaware of any violation by us of the NYSE's corporate governance listing standards at the time of the certification.

Molina Healthcare, the Molina Healthcare logo, Molina Medicaid Solutions℠, motherhood matters!℠, breathe with ease!℠, and Healthy Living with Diabetes℠ are registered servicemarks of Molina Healthcare, Inc.

Our Industry

The Medicaid and CHIP Programs. The Medicaid program is a federal entitlement program administered by the states. Medicaid provides health care and long-term care services and support to low-income Americans. Subject to federal rules, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states prior to FY 2009 was 57 percent, but ranged from a federally established FMAP floor at 50 percent to as high as 76 percent. With the passage of the American Recovery and Reinvestment Act, or ARRA, stimulus package in 2009, FMAP rates for all states increased by a minimum of 6.2 percentage points between October 1, 2009 and December 31, 2010, plus an additional increase adjusted quarterly based on the state's unemployment rate. Congress has extended through June 2011 the increased FMAP, but at a reduced rate from the previous ARRA enhancement.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced "TAN-if"). Another common state-administered Medicaid program is for the aged, blind or disabled, or ABD, Medicaid members. In addition, the Children's Health Insurance Program, or CHIP, is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.

As a result of recently enacted health care reform legislation, the Patient Protection and Affordable Care Act, the Medicaid and CHIP population is expected to grow from approximately 60 million people today to approximately 82 million people by 2019. Over that same period, total Medicaid and CHIP expenditures are expected to grow from approximately $427 billion to approximately $896 billion.

Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a managed care delivery model. MMIS are used by states to support these administrative activities. The federal government typically reimburses the states for 90% of the costs incurred in the

design, development, and implementation of an MMIS and for 50% of the costs incurred in operating an MMIS. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we now actively participate in this market.

In certain instances, states have elected to provide medical benefits to individuals and families who are not served by Medicaid. In New Mexico and Washington, our health plan segment participates in programs that are administered in a manner similar to Medicaid and CHIP, but without federal matching funds.

Medicare Advantage Plans. During 2010, each of our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, and Washington operated Medicare Advantage plans, each of which included a mandatory Part D prescription drug benefit. Our Medicare Advantage special needs plans, or SNPs, operate under the trade name, Molina Medicare Options Plus, and serve those beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. Our Medicare Advantage Prescription Drug plans, or MA-PDs, operate under the trade name, Molina Medicare Options. Although our MA-PD benefit plans do not exclusively enroll dual eligible beneficiaries, the plans' benefit structure is designed to appeal to lower income beneficiaries. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically underserved families and individuals. None of our health plans operate a Medicare Advantage private fee-for-service plan. Total enrollment in our Medicare Advantage plans at December 31, 2010 was approximately 24,500 members. Our 2010 premium revenues from Medicare across all health plans represented approximately 6.6% of our total premium revenues.

Overall, approximately 82% of our members are TANF, 9% are CHIP, 8% are ABD, and 1% are Medicare.

Our Strengths

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. Additionally, we support state Medicaid agencies by providing them with comprehensive solutions to their MMIS development and operating needs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, and cost management through our Health Plans segment, to state-level MMIS administration through our Molina Medicaid Solutions segment, to the direct delivery of health care services at our clinics. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. Our Molina Medicaid Solutions platform is based upon commercial off-the-shelf technology, or COTS. As a result, we believe that our Molina Medicaid Solutions platform has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our health plan segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The successful acquisition of our New Mexico, Missouri, and Wisconsin health plans demonstrated our ability to expand into new states. The establishment of our health plans in Utah, Ohio, Texas, and Florida reflects our ability to replicate our business model on a start-up basis in new states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Recognition for Quality of Care. The National Committee for Quality Assurance, or NCQA, has accredited eight of our ten Medicaid managed care plans. Our Missouri health plan is currently seeking NCQA accreditation, and our recently acquired Wisconsin plan will be seeking NCQA accreditation in the future. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our Company in 1980 to serve the Medicaid population in Southern California through a small network of primary care clinics, we have increased our membership to 1.6 million members, expanded our Health Plans segment to ten states, and added our Molina Medicaid Solutions segment. Our experience over the last 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Our Strategy

Our objective is to provide a comprehensive suite of Medicaid-related services to meet the health care needs of low-income families and individuals and the state Medicaid agencies that serve them. To achieve our objective, we intend to:

Continue to expand within existing markets. We plan to continue our growth in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, extending our services to new populations (including the aged, blind, or disabled), maintaining positive provider relationships, and integrating members from other health plans.

Continue to enter new strategic markets. We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. For example, on September 1, 2010, we acquired for approximately $15.5 million Abri Health Plan, a provider of Medicaid managed care services in Wisconsin. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size and, where practicable, mandated Medicaid managed care enrollment.

Continue to provide quality cost-effective care. We plan to use our strong provider networks and the knowledge gained through the operation of our clinics to further develop and utilize effective medical management and other coordinated programs that address the distinct needs of our members and improve the quality and cost-effectiveness of their care.

Leverage operational efficiencies. We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost.

Deliver administrative value to state Medicaid agencies. As Medicaid expenditures increase, we believe that an increasing number of states will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. For example, we can apply analytics to improve the functionality of care management processes. We believe that we can help strengthen these tools in ways that translate into both better care and cost containment. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs.

Open additional primary care clinics. During 2010, we became more diversified and more efficient by expanding our involvement in the direct delivery of primary care. The community clinic model offers an integrated approach that helps us improve both the quality and cost-effectiveness of the care our members receive. In 2010 we opened two clinics in Washington so that we can serve our members' needs for primary and behavioral health services in one place. We also expanded the capacity of our existing clinics in California in anticipation of increases in the numbers of ABD members in our plans. Approximately 20% of our California health plan's membership is now being served by the health plan's 16 primary care clinics. The growth and aging of the population of the United States foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to

worsen this shortage. We believe the shortage will be felt most acutely among already underserved populations, such as the low income families and individuals we serve. We therefore intend to expand on the direct delivery component of our business by developing additional community care clinics at certain of our health plans during 2011. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging this capability selectively we can improve access for our plan members in areas that are most underserved by primary care providers.

Pursue opportunities presented by ICD-10 conversion requirements. Over the next three years, health insurance plans are required to upgrade their systems for diagnosis, medical procedure coding, and claims processing under the tenth revisions of the International Statistical Classification of Diseases, or ICD-10. The United States Department of Health and Human Services will require payers and providers to transition to ICD-10 by October 2013. For many smaller health plans with less than one million members, the costs of making the necessary systems upgrades will be substantial. For companies like ours, the benefits of scale in this environment will be significant. We believe we will be positioned to reduce the cost per member for compliance with ICD-10. At the same time, the new requirements will create revenue opportunities for Molina Medicaid Solutions.

Prepare for health care reform. In preparation for the large scale changes associated with federal health care reform, we have organized a dedicated business unit to address issues of strategy, policy, reform readiness, and implementation. Health care reform opportunities include an estimated 16 million more members eligible for Medicaid by 2019, 30 million more individuals covered by health insurance exchanges, and increasing demand for long-term care and behavioral health services. In the next three years, we anticipate that many states will be offering new Medicaid RFP expansions in order to avoid disruptions in 2014 in connection with the full implementation of health care reform. For instance, several states are currently evaluating transitioning their ABD populations into managed care. Pursuant to a Section 1115 waiver expansion in California, we will be enrolling new ABD members in California by year end 2011.

Medicaid Contracts

With the exception of our Missouri health plan, which does not serve ABD or Medicare members, and our Wisconsin health plan, which does not serve Medicare members, all of our health plans serve TANF, CHIP, ABD, and Medicare members. For its Medicare members, each health plan enters into a one-year annually renewable contract with the Centers for Medicare and Medicaid Services, or CMS. For its other members, each health plan enters into a contract with the state's Medicaid agency. The contractual relationship with the state is generally for a period of one- to two-years and renewable on an annual or biannual basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months prior written notice. Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals, or RFP, subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

Our contracts with the state determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and disenrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as many other reports in accordance with individual state requirements.

We are usually paid a negotiated PMPM amount, with the PMPM amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also

paid an additional amount for each newborn delivery from the Medicaid programs in all of our state health plans, except with respect to our New Mexico health plan.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations, or IPAs. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California health plan operates 16 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers. In addition, we have a non-licensed subsidiary in Virginia which manages three health care clinics for Fairfax County, and our Washington health plan operates two Company-owned primary care clinics.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*sm is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*sm is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*sm is a diabetes

disease management program. *"Heart Health Living"* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/Submit Authorizations.
- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/PCP.
- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (such as those that may be required by the Health Insurance Portability and Accountability Act of 1996, or HIPAA, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the Healthcare Effectiveness Data and Information Set, or HEDIS, and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Eight of our ten health plans are accredited by the NCQA.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT 3.4 system), with the exception of our newly acquired Wisconsin plan which we expect will be migrated to the Molina standard platform in January 2012.

Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan's ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- *Medicaid HMOs* — National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- *Prepaid Health Plans* — Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- *Primary Care Case Management Programs* — Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, or CSC, and CNSI.

Regulation

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules can occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and

rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organization, including those operating in the Medicaid and Medicare programs.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our operating health plans are licensed to operate as health maintenance organizations, or HMOs, in each of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC, and are administered by the states. Our Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin health plans are subject to RBC requirements. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute.

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established in 1965 under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state governments jointly fund it, Medicaid is a state-operated and state-implemented program. Our contracts with the state Medicaid programs impose various requirements on us in addition to those imposed by applicable federal and state laws and regulations. Within broad guidelines established by the federal government, each state:

- establishes its own member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care services; and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states award contracts to any applicant demonstrating that it meets the state's requirements. Other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;

- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Medicare. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services, or CMS. Medicare beneficiaries have the option to enroll in a Medicare Advantage plan. Under Medicare Advantage, managed care plans contract with CMS to provide benefits that are comparable to original Medicare in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, made numerous changes to the Medicare program, including expanding the Medicare program to include a prescription drug benefit. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan. Plans are not required to offer the same benefits, but are required to provide coverage that is at least actuarially equivalent to the standard drug coverage delineated in the MMA.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act, or MIPPA, became law and, in September 2008, CMS promulgated implementing regulations. MIPPA impacts a broad range of Medicare activities and impacts all types of Medicare managed care plans. MIPPA and subsequent CMS guidance place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. MIPPA also establishes certain restrictions on agent and broker compensation.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format,
- Afford privacy to patient health information, and
- Protect the privacy of patient health information through physical and electronic security measures.

The Patient Protection and Affordable Care Act of 2010, or ACA, created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers. On September 23, 2010, CMS issued proposed regulations designed to implement these requirements. It is not clear at this time the degree to which managed care providers would have to comply with these new requirements, many of which resemble procedures that we already have in place.

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), a part of the ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. The U.S. Department of Health and Human Services, as required by the HITECH Act, has issued interim final rules that set forth the breach notification obligations applicable to covered entities and their business associates (the "HHS Breach Notification Rule"). The various requirements of the HITECH Act and the HHS Breach Notification Rule have different compliance dates, some of which have passed and some of which will occur in the future. With respect to those requirements whose compliance dates have passed, we believe that we are

in compliance with these provisions. With respect to those requirements whose compliance dates are in the future, we are reviewing our current practices and identifying those which may be impacted by upcoming regulations. It is our intention to implement these new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as *"qui tam"* actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Action of 2005 ("DRA") encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators.

Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2010, we had approximately 4,200 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Executive Officers of the Registrant

J. Mario Molina, M.D., 52, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 46, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 30 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He was recently named to the Los Angeles branch of the Federal Reserve Bank of San Francisco's board of directors. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Terry P. Bayer, 60, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has 26 years of health care management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President

and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University.

Joseph W. White, 52, has served as our Chief Accounting Officer since 2003. In his role as Chief Accounting Officer, Mr. White is responsible for oversight of the Company's accounting, reporting, forecasting, budgeting, actuarial, procurement, treasury and facilities functions. Mr. White has 25 years of financial management experience in the health care industry. Prior to joining the Company in 2003, Mr. White worked for Maxicare Health Plans, Inc. from 1987 through 2002. Mr. White holds a Master's degree in Business Administration and a Bachelor's degree in Commerce from the University of Virginia. Mr. White is a Certified Public Accountant.

James W. Howatt, 64, served as our Chief Medical Officer from May 2007 to February 2011. Effective February 17, 2011, Dr. Howatt was reassigned to the position of medical director of MMS. As medical director of MMS, Dr. Howatt will serve as the clinical leader for existing and future MMS product offerings, and will direct efforts to incorporate care coordination solutions into the government health care programs served by MMS. Prior to joining Molina Healthcare in February 2006, Dr. Howatt was Western Regional Medical Director for Humana. Dr. Howatt received B.S. and M.D. degrees from the University of California, San Francisco, and also holds a Master of Business Administration degree with an emphasis in Health Management from the University of Phoenix.

Item 1A: ***Risk Factors***

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This annual report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management's analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Business

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs are continuing to increase at the same time that state budgets are suffering from unprecedented deficits. In June 2010, 50.3 million members were enrolled in the Medicaid program throughout the nation, over three million more than in June 2009. Because governmental health care programs account for such a large portion of state budgets, efforts to contain overall government spending and to achieve a balanced budget often result in significant political pressure being directed at the funding for these health care programs. For fiscal year 2011, 46 states have reported budget gaps of a total of $130 billion as of December 2010, and that gap could reach an estimated $160 billion. Resolving the budget shortfalls is now particularly difficult since program reductions and one-time strategies to plug the gaps have already been used in most states. Headed into fiscal year 2012, states do not expect revenue collections to recover to a level sufficient to avoid additional budget cuts. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it will likely be a prime target for cost-containment efforts. All of the states in which we currently operate our health plans are currently facing significant budgetary pressures. The mandate of health reform adding millions of individuals to Medicaid and CHIP will put further pressures on state Medicaid programs.

As part of ARRA, the federal government increased the amount of funding for federal Medicaid matching by approximately $87 billion for the period between October 1, 2008 and December 31, 2010. In August 2010, the President signed a bill extending the ARRA enhanced FMAP on a phased-down basis for two additional quarters through June 30, 2011. The unemployment adjustment remained in the extension, but the law phased down the across-the-board base increase of 6.2 percentage points to 3.2 percentage points from January 1, 2011 to March 31, 2011, and to 1.2 percentage points from April 1, 2011 to June 30, 2011. Almost every state legislature had enacted its 2011 budgets prior to enactment of the extension, and with the uncertainty about whether Congress would extend the enhanced FMAP, each state was forced to make an assumption about whether the higher FMAP would continue beyond December 2010. Even with fiscal relief provided by the extension of ARRA enhanced Medicaid matching rates and the fact that economists pegged June 2009 as the official "end" of the recession, state budgets remain under considerable stress in fiscal year 2011, and without exception state policy leaders expect the fiscal stress to extend into fiscal year 2012. Unemployment remains high, and state revenues remain depressed.

Since the start of the recession, all states have implemented programmatic changes of some kind, including provider rate cuts or freezes, benefit cuts and restrictions, provider taxes and assessments, utilization controls, fraud and abuse reduction strategies and numerous administrative cuts (travel bans, hiring freezes, furloughs and layoffs) to reduce Medicaid cost growth. 20 states reduced Medicaid benefits in fiscal year 2010, more than in any year in the past decade, and 14 states planned to reduce benefits in fiscal year 2011. With the expiration of the ARRA funds on June 30, 2011, states may have no choice but to further cut or revise health care programs, optional benefits, eligibility criteria and thresholds, or health plan rates. Such actions could materially reduce the funding under one or more of our state Medicaid contracts, thereby reducing our revenues and our health plan profit margins. We expect to obtain rate increases during our fiscal year 2011 from the states of California and Ohio, and for the rates at our other health plans (with the exception of our Wisconsin health plan where we expect an 11% rate cut) to remain unchanged during the year. In the event this expectation is undermined by state budget pressures and the rates of any of our health plans are reduced, our business, financial condition, cash flows, or results of operations could be adversely affected. In addition, the timing of payments we receive may be impacted by state budget shortfalls.

Moreover, some federal deficit reduction proposals would fundamentally change the structure and financing of the Medicaid program. Recently, various proposals have been advanced to reduce annual federal deficits and to slow the increase in the national debt. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid. Some of the proposals relating to Medicaid would fundamentally change the structure and financing of the program, with major implications for providers and beneficiaries. One such proposal would be to convert Medicaid into a block grant, capping federal Medicaid payments to each state at a specified dollar amount, and limiting the growth in that dollar amount each year. Based on analysis of previous proposals to cap Medicaid, these dollar caps and growth limits would have to be set below the levels at which Medicaid is now expected to grow based on enrollment and health care inflation to save money. In the event the Medicaid program is fundamentally restructured, our business could be adversely affected.

The recently enacted health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act, commonly referred to together as the "ACA". This legislation enacts comprehensive changes to the U.S. health care system, components of which will be phased in at various stages over the next eight years. Among other things, by January 1, 2014, the Medicaid program will be expanded to provide eligibility to nearly all low-income people under age 65 with income below 133 percent of the federal poverty line. As a result, millions of low-income adults without children who currently cannot qualify for coverage, as well as many low-income parents and, in some instances, children now covered through CHIP, will be made eligible for Medicaid. In total, the Congressional Budget Office estimates that Medicaid and CHIP will cover an additional 16 million people by 2019. The legislation also imposes a franchise tax or premium excise tax of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes.

There are many parts of the legislation that will require further guidance in the form of regulations. Due to the breadth and complexity of the health reform legislation, the lack of implementing regulations and interpretive

guidance, and the phased-in nature of the implementation, the overall impact of the health reform legislation on our business over the coming years is difficult to predict and not yet fully known.

In addition, there have been a number of lawsuits filed that challenge all or part of the health care reform law. On January 31, 2011, a Florida District Court ruled that the entire health care reform law is unconstitutional. Other courts have ruled in favor of the law or have only struck down certain provisions of the law. These cases are under appeal and others are in process. We cannot predict the ultimate outcome of any of the litigation. Further, various Congressional leaders have indicated a desire to revisit some or all of the health care reform law during 2011. While the U.S House of Representatives voted to repeal the whole health care reform law, the U.S. Senate voted against such a repeal, and there have separately been a number of bills introduced that would repeal or change certain provisions of the law. Because of these challenges, we cannot predict whether any or all of the legislation will be implemented as enacted, overturned, repealed, or modified.

If we fail to effectively accommodate the growth in Medicaid enrollment anticipated under the health reform legislation, our business may be materially adversely affected. In addition, if the new insurance industry assessment is imposed as enacted, or if we are unable to obtain premium increases to offset the impact of the assessment or otherwise adjust our business model to address the assessment, our business, financial condition, cash flows, or results of operations could be materially adversely affected.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio for 2010 of 84.5% had been one percentage point higher, or 85.5%, our earnings for 2010 would have been approximately $1.14 per diluted share rather than our actual 2010 earnings of $1.98 per diluted share, a 42% reduction in our earnings.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual flu season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions such as hemophilia for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid," or IBNP, medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to Medicare Advantage or aged,

blind, and disabled Medicaid members, is impacted by the more limited experience we have had with those populations. Finally, with regard to the new Medicaid and CHIP members we expect to enroll in 2011 through organic growth due primarily to the recession, certain new members may be disproportionately costly due to high utilization in their first several months of Medicaid or CHIP membership as a result of their previously having been uninsured and therefore not seeking or deferring medical treatment.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

Another flu epidemic in 2011 or other kind of epidemic in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results during 2009 were significantly impacted by the widespread incidence of the H1N1 flu in the states in which we operate our health plans. The recurrence in 2011 of the H1N1 flu, another variant of the flu, or the outbreak and rapid spread of any other highly contagious and potentially virulent disease, could increase the utilization rates among our members, resulting in significantly increased outpatient, inpatient, emergency room, and pharmacy costs.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, the state contract of our Washington health plan with respect to the Healthy Options program may be subject to competitive bidding during 2011 or 2012. In the event the responsive bids of our Washington health plan or those of other health plans are not successful, we will lose our Medicaid contract in the applicable state, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of the unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. Further, most of our contracts are terminable without cause.

Our government contracts generally run for periods of one year to three years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. Although our health plans have generally been successful in obtaining the renewal and/or extension of their state contracts, there can be no guarantee that any of our state government contracts will be renewed or extended. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

There are numerous risks associated with the expansion of our Texas health plan's service area under the CHIP Rural Service Area Program, with our acquisition of Abri Health Plan in Wisconsin, and with our ABD expansion in California.

In September 2010, our Texas health plan began arranging health care services for approximately 64,000 low-income children and pregnant women in 174 predominantly rural counties through Texas' CHIP Rural Service Area Program. In addition, on September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. As of December 31, 2010, Abri Health Plan served approximately 36,000 Medicaid members. During 2011, we will begin serving additional ABD members in Texas, and we expect to begin serving additional ABD members in California. There are numerous risks associated with a health plan's initial expansion into a new service area or the provision of medical services to a new population, including pent-up demand for medical services, elevated medical care costs, and our lack of actuarial experience in setting appropriate reserve levels. In the event the medical care costs of our Texas, Wisconsin, or California health plans are higher than anticipated, we are unable to lower the medical care ratio associated with these new populations, our reserve levels are inadequate, or our enrollment projections are overestimated, the negative results of our Texas, Wisconsin, or California health plan could adversely affect our business, financial condition, cash flows, or results of operations.

States may not adequately compensate us for the value of drug rebates that were previously earned by the Company but that are now collectible by the states.

ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers are in the process of or have completed renegotiating their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours will likely decline significantly in the future. There are provisions in the ACA that require rates paid to Medicaid managed care to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from 10 state health plans. If we were unable to continue to operate in any of those ten states, or if our current operations in any portion of the states we are in were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

There are performance and other risks associated with certain provisions in the state Medicaid contracts of our Florida, New Mexico, Ohio, and Texas health plans.

The state contracts of our New Mexico, Ohio, and Texas health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, the health plan will be unable to recognize the revenue associated with that measure. Any failure of our health plan to satisfy one of these performance measure provisions could adversely affect our business, financial condition, cash flows, or results of operations.

In addition, the state contracts of our Florida, New Mexico, and Texas health plans contain provisions pertaining to medical cost floors, administrative cost and profit ceilings, and profit-sharing arrangements. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could adversely affect our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we were unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also create increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have an adverse impact on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could adversely affect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. During 2010, due to a prolonged budget impasse, some of the monthly premium payments made by the state of California to our California health plan were several months late. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse affect on our business, financial condition, cash flows, or results of operations.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets — particularly operators of large commercial health plans — have significantly greater financial resources than we do.

Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or comply with these regulatory requirements in a timely manner, if at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. For example, from July 26 to July 30, 2010, the Center for Medicare and Medicaid Services, or CMS, conducted an on-site audit with respect to our Medicare Advantage and Prescription Drug Plan contracts in the compliance areas of prescription drug formulary administration, prescription drug coverage determinations and appeals, prescription drug grievances, enrollment and disenrollment, premium billing, and an evaluation of whether we had implemented an effective compliance program. On February 25, 2011, we received from CMS the audit and inspection report. The report provides that we will be given until April 26, 2011 to develop and implement a corrective action plan to correct the deficiencies noted in the report and to demonstrate to CMS that the underlying deficiencies have been corrected and are not likely to recur. If we are unable to correct the noted deficiencies, or become subject to material fines or other sanctions, whether as a result of this most recent CMS audit or otherwise, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for

whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws which may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our financial position, results of operations and cash flows.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties, and assessments. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. Many states, including states where we currently operate, have enacted parallel legislation. In the event we are subject to liability under a *qui tam* action, our business and operating results could be adversely affected.

Federal regulations require entities subject to HIPAA to update their transaction formats for electronic data exchange from current HIPAA 4010 requirement to the new HIPAA 5010 standards, which are not only burdensome and complex, but could adversely impact administrative expense and compliance.

A federal mandate known as HIPAA 5010 will require health plans to use new standards for conducting certain operational and administrative transactions electronically beginning in January 2012. These administrative transactions include: claims, remittance, eligibility and claims status requests and responses. The HIPAA 5010 upgrade was prompted by government and industry's shared goal of providing higher-quality, lower-cost health care and the need for a comprehensive electronic data exchange environment for the ICD-10 mandate to be implemented by October 2013. Upgrading to the new HIPAA 5010 standards should increase transaction uniformity, support pay for performance, and streamline reimbursement transactions. We, along with other health plans, face significant pressure to make sure that we have installed our software and tested it for compatibility with our business partners. Because HIPAA 5010 affects electronic transactions such as patient eligibility, claims filing, claims status, and remittance advice, we must proceed proactively to achieve full functionality of HIPAA 5010 transactions before the deadline. Otherwise we may face transaction rejections and subsequent payment delays, which could have a material adverse effect on our business, cash flows, and results of operations. As the deadline approaches, we continue to upgrade and test our claims management systems to accommodate HIPAA 5010 and prevent any operational disruptions.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

The U.S. Department of Health and Human Services, or HHS, has released rules pursuant to HIPAA which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. By October 2013, the federal government will require that health care organizations, including health insurers, upgrade to updated and expanded standardized code sets used for documenting health conditions. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. While use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our cash flows, financial position, or results of operations. However, these changes may result in errors and otherwise negatively impact our service levels, and we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide, appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial position, cash flows, or results of operations.

The insolvency of a delegated provider could obligate us to pay their referral claims, which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped if the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which the Company does not participate. These actions and the resulting negative publicity could become associated with or imputed to the Company, regardless of the Company's actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which the Company does participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2010, 2009, and 2008 without approval of the regulatory authorities were approximately $18.8 million, $9.0 million, and $7.6 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our credit facility and/or our convertible senior notes.

Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization

of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our business, financial condition, cash flows, or results of operations.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process, and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The Health Information Technology for Economic and Clinical Health Act provisions of the ARRA further expand the coverage of HIPAA by, among other things, extending the privacy and security provisions, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, increasing penalties for violations, and requiring public disclosure of improper disclosures of health information of more than 500 individuals.

Under ARRA, civil penalties for HIPAA violations by covered entities are increased up to an annual maximum of $1.5 million for uncorrected violations based on willful neglect. In addition, imposition of these penalties is now more likely because ARRA strengthens enforcement. For example, commencing February 2010, HHS was required to conduct periodic audits to confirm compliance. Investigations of violations that indicate willful neglect, for which penalties are mandatory beginning in February 2011, are statutorily required. In addition, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. Initially monies collected will be transferred to a division of HHS for further enforcement, and within three years, a methodology will be adopted for distributing a percentage of those monies to affected individuals to fund enforcement and provide incentive for individuals to report violations. In addition, ARRA requires us to notify affected individuals, HHS, and in some cases the media when unsecured personal health information is subject to a security breach.

ARRA also contains a number of provisions that provide incentives for states to initiate certain programs related to health care and health care technology, such as electronic health records. While provisions such as these do not apply to us directly, states wishing to apply for grants under ARRA, or otherwise participating in such programs, may impose new health care technology requirements on us through our contracts with state Medicaid agencies. We are unable to predict what such requirements may entail or what their effect on our business may be.

We will continue to assess our compliance obligations as regulations under ARRA are promulgated and more guidance becomes available from HHS and other federal agencies. The new privacy and security requirements, however, may require substantial operational and systems changes, employee education and resources and there is no guarantee that we be able to implement them adequately or prior to their effective date. Given HIPAA's complexity and the anticipated new regulations, which may be subject to changing and perhaps conflicting interpretation, our ongoing ability to comply with all of the HIPAA requirements is uncertain, which may expose us to the criminal and increased civil penalties provided under ARRA and may require us to incur significant costs in order to seek to comply with its requirements.

Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third-party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could subject us to civil and criminal penalties and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Risks Related to the Operation of Our Molina Medicaid Solutions Business

MMIS operational problems in Idaho or Maine could result in reduced or withheld payments, damage assessments, increased administrative costs, or even contract termination, any of which could adversely affect our business, financial condition, cash flows, or results of operations.

From and after the MMIS operational or "go live" date of June 1, 2010 after which it began pilot operations, Molina Medicaid Solutions has experienced certain problems with the MMIS in Idaho. On October 5, 2010, Molina Medicaid Solutions received from the Idaho Department of Administration a notice to cure letter with respect to its

alleged non-compliance with certain provisions of the MMIS project agreements. Molina Medicaid Solutions and the Idaho Department of Health and Welfare ("DHW") have been working together to resolve the MMIS problems, and Molina Medicaid Solutions has developed a corrective action plan with respect to the identified problems and defects. Molina Medicaid Solutions believes it has ameliorated or corrected many of the identified problems, and that it will ultimately be successful in resolving all of the MMIS issues in Idaho. However, in the event Molina Medicaid Solutions is unsuccessful in correcting all of the identified problems, the Idaho Department of Administration may: (i) reduce or withhold its payments to Molina Medicaid Solutions, (ii) require Molina Medicaid Solutions to provide services at no additional cost to Idaho, (iii) require the payment of damages, or (iv) terminate its contract with Molina Medicaid Solutions. In addition, Molina Medicaid Solutions may incur much greater administrative costs than expected in correcting the MMIS problems, or in advancing interim payments to Idaho providers. For example, the consulting and outside service costs for Idaho following its go-live operational date have not declined from the pre-operational level as had been previously expected. Finally, Idaho DHW may not accept the MMIS developed and implemented by Molina Medicaid Solutions, or CMS may not certify such MMIS.

All of such risks are also applicable to the MMIS in Maine which became operational and began pilot operations as of September 1, 2010. The realization of any of the foregoing risks could adversely affect our business, financial condition, cash flows, or results of operations.

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently has management contracts in only six states. If we are unable to continue to operate in any of those six states, or if our current operations in any of those six states were significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, including its responsive bid in Louisiana during 2011, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, the state MMIS contract of Louisiana is currently subject to competitive bidding. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event the responsive bid in Louisiana is not successful, we will lose our fiscal agent contract in that state, and our revenues could be materially reduced as a result. In addition, in the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or unanticipated delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our overall business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business may be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have an adverse effect on our business, financial condition, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results or damage our reputation.

Experienced computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition, sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance on contracts, including those on which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties including software and hardware vendors to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenue and profitability.

Risks Related to our General Business Operations

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions or reduce our liquidity and capital resources.

We have a $150 million senior secured credit facility that imposes numerous restrictions and covenants, including prescribed consolidated leverage and fixed charge coverage ratios, net worth requirements, and acquisition limitations that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends without lender approval. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to act with complete flexibility, or our inability to use our credit facility in the manner intended. In addition, our credit facility matures in May 2012. If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, or if we are unable to renew or refinance our credit facility prior to its maturity, we may be unable to use the credit facility in the manner intended, and our operations, liquidity, and capital resources could be materially adversely affected.

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In fiscal year 2006, we had total premium revenue of $2.0 billion. In fiscal year 2010, we had total premium revenue of $4.0 billion, an increase of 100% over a five-year span. Continued rapid growth could place a significant strain on our management and on other Company resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with

members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems, could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. Providers at our 16 primary care clinics in California and two in Washington are employees of our health plans. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of their employees. We maintain medical malpractice insurance for our clinics as we believe are reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, cash flows, or results of operations, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies

in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles ("GAAP") and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

Our investments in auction rate securities are subject to risks that may cause losses and have a material adverse effect on our liquidity.

As of December 31, 2010, our investments in auction rate securities included amounts designated as available-for-sale securities amounted to $24.6 million par value (fair value of $20.4 million). As a result of the decrease in fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized losses of $0.2 million to accumulated other comprehensive loss for the fiscal year ended December 31, 2010. We deem the cumulative unrealized losses on these securities to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost. However, if we were to sell these investments before recovery of their cost, we would be required to record a charge to earnings for any accumulated losses, which would impact our earnings for the quarter in which such event occurred.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations, or the accounting reversal of any tax benefits or revenue previously recognized by us, could have an adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel, which could negatively impact our operations.

Risks Related to Our Common Stock

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of $16.12 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

- state and federal budget pressures,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- changes in government payment levels,
- adverse publicity regarding health maintenance organizations and other managed care organizations,
- government action regarding member eligibility,
- changes in state mandatory programs,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies in the health care industry,
- the termination of our Medicaid or CHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change,
- general economic conditions, including unemployment rates, inflation, and interest rates, and
- the factors set forth under “Risk Factors” in this report.

Our stock may not trade at the same levels as the stock of other health care companies or the market in general. Also, if the trading market for our stock does not continue to develop, securities analysts may not maintain or initiate research coverage of our Company and our shares, and this could depress the market for our shares.

Members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate own or are entitled to receive upon certain events approximately 55% of our capital stock. Our president

and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of our Company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, including securities that are convertible into or exchangeable for, or that represent the right to receive, common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 80,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2010, 30,308,616 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire our Company, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our Company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

We do not anticipate paying any cash dividends in the foreseeable future.

We have never declared or paid any cash dividends. While we have in the past and may again in the future use our available cash to repurchase our securities, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

Item 1B: ***Unresolved Staff Comments***

None.

Item 2: ***Properties***

We lease a total of 67 facilities, including our corporate headquarters at 200 Oceangate in Long Beach, California. We own a 32,000 square-foot office building in Long Beach, California, our 26,000 square-foot data center in Albuquerque, New Mexico, and one of the community clinics in Pomona, California. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3: ***Legal Proceedings***

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 4: ***Reserved***

PART II

Item 5: *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities*

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of

February 15, 2011, there were 115 holders of record of our common stock. The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2010		
First Quarter	$ 26.39	$ 20.02
Second Quarter	$ 31.20	$ 25.00
Third Quarter	$ 31.80	$ 25.28
Fourth Quarter	$ 28.28	$ 24.65
2009		
First Quarter	$ 22.74	$ 16.22
Second Quarter	$ 25.75	$ 18.11
Third Quarter	$ 25.05	$ 19.36
Fourth Quarter	$ 23.49	$ 17.05

Dividends

We have never paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our business, and we do not anticipate paying any cash dividends in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Any future determination to pay dividends will be at the discretion of our Board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 — Management's Discussion and Analysis of Financial Condition and Results of Operations — Regulatory Capital and Dividends Restrictions.

Unregistered Issuances of Equity Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2010)

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	513,614(1)	$ 30.59	3,744,530(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and Incentive Plan have been suspended.

(2) Includes only shares remaining available to issue under the 2002 Equity Incentive Plan (the "2002 Incentive Plan") and the 2002 Employee Stock Purchase Plan (the "ESPP"). The 2002 Incentive Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares available for issuance under the 2002 Incentive Plan automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. The 400,000 share increase on January 1, 2011 increased the total number of shares reserved for issuance under the 2002 Incentive Plan to 4,800,000 shares. The ESPP initially allowed for the issuance of 600,000 shares of common stock. Beginning December 31, 2003, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares reserved for issuance under the ESPP automatically increased by 1% of total outstanding capital stock.

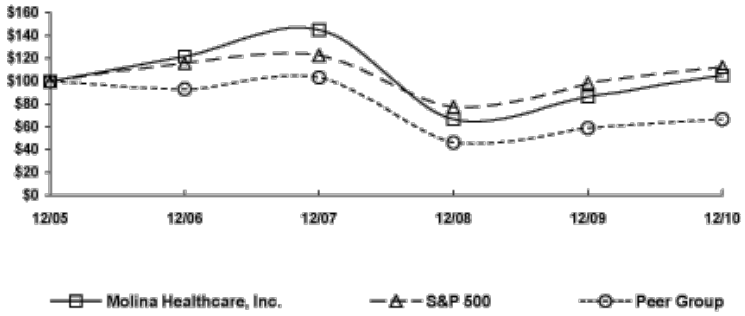
STOCK PERFORMANCE GRAPH

The following discussion shall not be deemed to be "soliciting material" or to be "filed" with the SEC nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (the "S&P 500") and a peer group index for the five-year period from December 31, 2005 to December 31, 2010. The graph assumes an initial investment of $100 in Molina Healthcare, Inc. common stock and in each of the indices.

The peer group index consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN*
Among Molina Healthcare, Inc, The S&P 500 Index
And A Peer Group



* $100 invested on 12/31/05 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.

Item 6. ***Selected Financial Data***

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics") for the five years ended December 31, 2010 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data. The data under the caption "Operating Statistics" has not been audited.

	Year Ended December 31,				
	2010(1)(3)	2009(2)(3)	2008(2)(3)	2007(2)(8)	2006(2)(9)
Statements of Income Data:					
Revenue:					
Premium revenue	$ 3,989,909	$ 3,660,207	$ 3,091,240	$ 2,462,369	$ 1,985,109
Service revenue(1)	89,809	—	—	—	—
Investment income	6,259	9,149	21,126	30,085	19,886
Total revenue	4,085,977	3,669,356	3,112,366	2,492,454	2,004,995
Expenses:					
Medical care costs	3,370,857	3,176,236	2,621,312	2,080,083	1,678,652
Cost of service revenue(1)	78,647	—	—	—	—
General and administrative expenses(2)	345,993	276,027	249,646	205,057	168,280
Premium tax expenses(2)(3)	139,775	128,581	100,165	81,020	60,777
Depreciation and amortization	45,704	38,110	33,688	27,967	21,475
Total expenses	3,980,976	3,618,954	3,004,811	2,394,127	1,929,184
Gain on purchase of convertible senior notes	—	1,532	—	—	—
Operating income	105,001	51,934	107,555	98,327	75,811
Interest expense	(15,509)	(13,777)	(13,231)	(5,605)	(2,353)
Income before income taxes	89,492	38,157	94,324	92,722	73,458
Provision for income taxes(3)	34,522	7,289	34,726	34,996	27,731
Net income	$ 54,970	$ 30,868	$ 59,598	$ 57,726	$ 45,727
Net income per share:					
Basic	$ 2.00	$ 1.19	$ 2.15	$ 2.04	$ 1.64
Diluted	$ 1.98	$ 1.19	$ 2.15	$ 2.03	$ 1.62
Weighted average number of common shares outstanding	27,449,000	25,843,000	27,676,000	28,275,000	27,966,000
Weighted average number of common shares and potential dilutive common shares outstanding	27,754,000	25,984,000	27,772,000	28,419,000	28,164,000
Operating Statistics:					
Medical care ratio(4)	84.5%	86.8%	84.8%	84.5%	84.6%
General and administrative expense ratio(5)	8.5%	7.5%	8.0%	8.2%	8.4%
Premium tax ratio(6)	3.5%	3.5%	3.2%	3.3%	2.3%
Members(7)	1,613,000	1,455,000	1,256,000	1,149,000	1,077,000

	As of December 31,				
	2010(1)	2009	2008	2007(8)	2006(9)
Balance Sheet Data:					
Cash and cash equivalents	$ 455,886	$ 469,501	$ 387,162	$ 459,064	$ 403,650
Total assets	1,509,214	1,244,035	1,148,068	1,170,016	864,475
Long-term debt (including current maturities)	164,014	158,900	164,873	160,166	45,000
Total liabilities	790,157	701,297	616,306	655,640	444,309
Stockholders' equity	719,057	542,738	531,762	514,376	420,166

(1) Service revenue and cost of service revenue represent revenue and costs generated by our Molina Medicaid Solutions segment. Because we acquired this business on May 1, 2010, results for the year ended December 31, 2010 include eight months of results for this segment.

(2) Prior to 2010, general and administrative expenses have included premium tax expenses. Beginning in 2010, we have reported premium tax expenses on a separate line in the statements of income data. Prior periods have been reclassified to conform to this presentation.

(3) Effective January 1, 2008 through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax. For the years ended December 31, 2009, and 2008, amounts for premium tax expense and income tax expense have been reclassified to conform to this presentation. The MGRT amounted to $6.2 million, $5.5 million, and $5.1 million for the years ended December 31, 2010, 2009, and 2008, respectively.

(4) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See *Management's Discussion and Analysis of Financial Condition and Results of Operations* for further discussion.

(5) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(6) Premium tax ratio represents such expenses as a percentage of premium revenue.

(7) Number of members at end of period.

(8) The balance sheet and operating results of the Mercy CarePlus acquisition, relating to our Missouri health plan, have been included since November 1, 2007, the effective date of the acquisition.

(9) The balance sheet and operating results of the Cape Health Plan acquisition, relating to our Michigan health plan, have been included since May 15, 2006, the effective date of the acquisition.

Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*

The following discussion of our financial condition and results of operations should be read in conjunction with the "Selected Financial Data" and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax, or MGRT, as a premium tax and not as an income tax. Prior periods have been reclassified to conform to this presentation.

In prior periods, general and administrative, or G&A, expenses have included premium tax expenses. Beginning in 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

Overview

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. Our business comprises our Health Plans segment, consisting of licensed health maintenance organizations serving Medicaid populations in ten states, and our Molina Medicaid Solutions segment, which provides design, development, implementation, and business processing solutions to Medicaid agencies in an additional five states. Our direct delivery business currently consists of 16 primary care community clinics in California and two primary care community clinics in Washington, and we also manage three county-owned primary care clinics under a contract with Fairfax County, Virginia.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of December 31, 2010. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010, we terminated operations at our small Medicare health plan in Nevada.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM. Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We paid $131.3 million to acquire Molina Medicaid Solutions. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility.

With the addition of Molina Medicaid Solutions, we have added a segment to our internal financial reporting structure in 2010. We now report our financial performance based on the following two reportable segments: (i) Health Plans; and (ii) Molina Medicaid Solutions.

Fiscal Year 2010 Overview and Highlights

During 2010, we experienced diversified revenue growth thanks to increased enrollment in our health plans, our successful entry into the Medicaid health information management business, and an acquisition that established us in a new state. Meanwhile, stronger medical management and disciplined cost control helped us realize improvements in our health plan medical margins. Many of these factors contributed to our Company's strong financial performance in 2010. For the year, our net income rose to $55.0 million, or $1.98 per diluted share, an increase of 78% over 2009. We earned premium revenues of $4.0 billion, up 9% over the previous year. Meanwhile, during a year when costs continued to rise for the health care industry, we achieved a medical care ratio of 84.5%, compared with a medical care ratio of 86.8% for fiscal year 2009.

During 2010, we continued to pursue the expansion of our Medicaid health plan business. In September 2010, we completed the $15.5 million acquisition of Abri Health Plan of Milwaukee, which served approximately 36,000 Medicaid beneficiaries as of December 31, 2010. We also expanded our growing presence in Texas, where we were already serving patients in the Houston, San Antonio, and Laredo service areas. In May 2010, we were awarded a contract to serve Medicaid managed care patients in the seven-county Dallas service area starting in February 2011. In September 2010, we won an additional contract to administer the CHIP program (including the CHIP Perinatal program) in 174 predominately rural counties across the state. As of December 31, 2010, we served approximately 63,000 children and pregnant women under this contract. The new contracts not only provide increased scale for leveraging our resources in Texas, they make Molina an increasingly important player in a state where the potential revenue opportunity will grow as new Medicaid beneficiaries qualify for coverage under health care reform.

In addition, during 2010 we expanded our operation of community-based primary care clinics — the business field in which Molina began over 30 years ago — so that we can serve the needs of our patients while also serving the states that pay for their health care.

Finally, on May 1, 2010, we acquired Molina Medicaid Solutions, an acquisition which has complemented our core business model of serving government programs, expanded our service offerings diversified our revenue base, and expanded our level of participation in the Medicaid program.

2010 Financial Performance Summary

The following table briefly summarizes our financial performance for the years ended December 31, 2010, 2009, and 2008. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are computed as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Year Ended December 31,		
	2010	2009	2008
	(Dollar amounts in thousands, except per-share data)		
Earnings per diluted share	$ 1.98	$ 1.19	$ 2.15
Premium revenue	$3,989,909	$3,660,207	$ 3,091,240
Service revenue	$ 89,809	$ —	$ —
Operating income	$ 105,001	$ 51,934	$ 107,555
Net income	$ 54,970	$ 30,868	$ 59,598
Total ending membership	1,613,000	1,455,000	1,256,000
Premium revenue	97.6%	99.8%	99.3%
Service revenue	2.2	—	—
Investment income	0.2	0.2	0.7
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	84.5%	86.8%	84.8%
General and administrative expense ratio	8.5%	7.5%	8.0%
Premium tax ratio	3.5%	3.5%	3.2%
Operating income	2.6%	1.4%	3.5%
Net income	1.3%	0.8%	1.9%
Effective tax rate	38.6%	19.1%	36.8%

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. The majority of medical costs associated with premium revenues are risk-based costs — while the health plans receive fixed per-member per-month, or PMPM, premium payments from the states, the health plans are at risk for the costs of their members' health care. Our Health Plans segment operates

in a highly regulated environment with stringent capitalization requirements. These capitalization requirements, among other things, limit the health plans' ability to pay dividends to us without regulatory approval.

As of December 31, 2010, our health plans were located in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. Additionally, we operate three county-owned primary care clinics in Virginia.

Molina Medicaid Solutions Segment

Our Molina Medicaid Solutions segment provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. Among the principle differences between the Molina Medicaid Solutions segment and the Health Plans segment are:

- The Molina Medicaid Solutions segment, unlike the Health Plans segment, does not assume risk for medical costs. We believe that over time the Molina Medicaid Solutions segment will experience less volatility in profits than the Health Plans segment because the costs incurred for the provision of business process outsourcing services are less volatile than those incurred for the provision of medical care.
- Revenue earned by the Molina Medicaid Solutions segment will be much less than that earned by the Health Plans segment. The revenue earned by our Health Plans segment is intended to include the cost of the medical care actually provided to our health plan membership. Such costs typically amount to approximately 85% of the revenue of the health plans segment. The revenue received by the Molina Medicaid Solutions segment is intended only to pay for certain administrative costs (plus profit) of the Medicaid program — not the actual cost of services provided to Medicaid members.
- In general, we expect the operating profit margin percentage generated by the Molina Medicaid Solutions segment to be higher than the operating profit margin percentage generated by the Health Plans segment. While total profit is likely to be lower for the Molina Medicaid Solutions segment than for the Health Plans segment, the percentage of revenue that we retain as profit is likely to be higher for the Molina Medicaid Solutions segment.
- The capital requirements of the Molina Medicaid Solutions segment are — except in the case of new contract start-ups — considerably less than those of our Health Plans segment.
- Regulatory approval is not required for the Molina Medicaid Solutions segment to pay dividends to us.

While we believe that the acquisition of the Molina Medicaid Solutions segment diversifies our risk profile, we also believe that the two segments are complementary from strategic and operating perspectives. From a strategic perspective, both segments allow us to participate in an expanding sector of the economy while continuing our mission to serve low-income families and individuals eligible for government-sponsored health care programs. Operationally, the segments share a common systems platform — allowing for efficiencies of scale — and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market various cost containment and quality practices used by our Health Plans segment (such as care management and care coordination programs) to state MMIS customers who wish to incorporate certain aspects of managed care programs into their own fee-for-service programs.

Composition of Revenue and Membership

Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the year ended December 31, 2010, we received approximately 94% of our premium revenue as a fixed PMPM amount, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the year ended December 31, 2010, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for CHIP members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $230 in Missouri. Among our Medicaid ABD membership, PMPM premiums range from approximately $320 in Utah to $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare premiums are almost $1,100 PMPM, with Medicare revenue totaling $265.2 million, $135.9 million, and $95.1 million, for the years ended December 31, 2010, 2009, and 2008, respectively.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	As of December 31,		
	2010	2009	2008
Total Ending Membership by Health Plan:			
California	344,000	351,000	322,000
Florida	61,000	50,000	—
Michigan	227,000	223,000	206,000
Missouri	81,000	78,000	77,000
New Mexico	91,000	94,000	84,000
Ohio	245,000	216,000	176,000
Texas	94,000	40,000	31,000
Utah	79,000	69,000	61,000
Washington	355,000	334,000	299,000
Wisconsin(1)	36,000	—	—
Total	1,613,000	1,455,000	1,256,000
Total Ending Membership by State for our Medicare Advantage Plans(1):			
California	4,900	2,100	1,500
Florida	500	—	—
Michigan	6,300	3,300	1,700
New Mexico	600	400	300
Texas	700	500	400
Utah	8,900	4,000	2,400
Washington	2,600	1,300	1,000
Total	24,500	11,600	7,300
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	13,900	13,900	12,700
Florida	10,000	8,800	—
Michigan	31,700	32,200	30,300
New Mexico	5,700	5,700	6,300
Ohio	28,200	22,600	19,000
Texas	19,000	17,600	16,200
Utah	8,000	7,500	7,300
Washington	4,000	3,200	3,000
Wisconsin(1)	1,700	—	—
Total	122,200	111,500	94,800

(1) We acquired the Wisconsin health plan on September 1, 2010. As of December 31, 2010, the Wisconsin health plan had approximately 3,000 Medicare Advantage members covered under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

Our Molina Medicaid Solutions segment provides technology solutions to state Medicaid programs that include system design, development, implementation, and technology outsourcing services. In addition, this segment offers business process outsourcing services such as claims processing, provider enrollment, pharmacy drug rebate services, recipient eligibility management, and pre-authorization services to state Medicaid agencies.

Molina Medicaid Solutions has contracts with five states to design, develop, implement, maintain, and operate Medicaid Management Information Systems (MMIS). These contracts extend over a number of years, and cover the life of the MMIS from inception through at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds. In some circumstances, revenue recognition may be delayed for long periods while we await formal customer acceptance of our products and/or services. In those circumstances, recognition of a portion of our costs may also be deferred.

Under our contracts in Louisiana, New Jersey, and West Virginia, we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue on a straight-line basis over the remaining term of the contract. In Maine, we completed the DDI phase of our contract effective September 1, 2010. In Idaho, we expect to complete the DDI phase of our contract during 2011. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in 2011.

Additionally, Molina Medicaid Solutions provides pharmacy rebate administration services under a contract with the state of Florida.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service* — Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with the providers. We pay hospitals on a fee-for-service basis in a variety of ways, including by per diem amounts, by diagnostic-related groups, or DRGs, as a percentage of billed charges, and by case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract; under certain circumstances, we pay escalated charges in connection with these stop-loss agreements. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.
- *Capitation* — Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management,

and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy* — Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other* — Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance costs, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2010, 2009 and 2008, medically related administrative costs were approximately $85.5 million, $74.6 million and $75.9 million, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Louisiana, Maine, New Jersey, West Virginia and Florida, as well as certain selling, general and administrative expenses. Additionally, certain indirect costs incurred under our contracts in Maine (prior to exiting the DDI phase of that contract in September, 2010) and Idaho are also expensed to cost of services.

In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. We began to recognize deferred costs for our Maine contract in September 2010, at the same time we began to recognize revenue associated with that contract. In Idaho, we expect to begin recognition of deferred contact costs during 2011, in a manner consistent with our anticipated recognition of revenue.

Results of Operations

Year Ended December 31, 2010 Compared with the Year Ended December 31, 2009

Health Plans Segment

Premium Revenue

Premium revenue grew 9.0% in the year ended December 31, 2010, compared with the year ended December 31, 2009, due to a membership increase of 10.9%. On a PMPM basis, however, consolidated premium revenue decreased 2.1% because of declines in premium rates. The decrease in PMPM revenue was due to the transfer of the pharmacy benefit to the state fee-for-service programs in Ohio (effective February 1, 2010) and Missouri (effective October 1, 2009). Exclusive of the transfer of the pharmacy benefit in Ohio and Missouri, Medicaid premium revenue PMPM increased approximately 1.5% over the year ended December 31, 2009. Medicare enrollment exceeded 24,000 members at December 31, 2010, and Medicare premium revenue was $265.2 million for the year ended December 31, 2010, compared with $135.9 million for the year ended December 31, 2009.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$2,360,858	$128.73	70.0%	$2,077,489	$126.14	65.4%
Capitation	555,487	30.29	16.5	558,538	33.91	17.6
Pharmacy	325,935	17.77	9.7	414,785	25.18	13.1
Other	128,577	7.01	3.8	125,424	7.62	3.9
Total	$3,370,857	$183.80	100.0%	$3,176,236	$192.85	100.0%

The medical care ratio decreased to 84.5% for the year ended December 31, 2010, compared with 86.8% for the year ended December 31, 2009.

The medical care ratio of the California health plan decreased to 83.5% for the year ended December 31, 2010, compared with 92.2% for the year ended December 31, 2009, primarily due to lower inpatient facility fee-for-service costs resulting from provider network restructuring and improved medical management.

The medical care ratio of the Florida health plan increased to 95.4% for the year ended December 31, 2010, from 93.8% for the year ended December 31, 2009, primarily due to higher capitation costs and higher fee-for-service costs in the outpatient and physician categories.

The medical care ratio of the Michigan health plan increased to 83.7% for the year ended December 31, 2010, from 81.5% for the year ended December 31, 2009, primarily due to higher inpatient facility fee-for-service costs.

The medical care ratio of the New Mexico health plan decreased to 80.6% for the year ended December 31, 2010, from 85.7% for the year ended December 31, 2009, primarily due to reduced fee-for-service costs which more than offset decreased premium revenue PMPM.

The medical care ratio of the Ohio health plan decreased to 79.1% for the year ended December 31, 2010, from 86.1% for the year ended December 31, 2009, primarily due to an increase in Medicaid premium PMPM of approximately 6% effective January 1, 2010 (exclusive of the reduction related to pharmacy benefits), partially offset by higher inpatient facility fee-for-service costs.

The medical care ratio of the Utah health plan decreased to 91.3% for the year ended December 31, 2010, from 91.8% for the year ended December 31, 2009, due to improved financial performance in the second half of 2010. That improved financial performance was the result of reduced fee-for-service costs in the second half of 2010 and an increase in Medicaid premium PMPM of approximately 7% effective July 1, 2010.

The medical care ratio of the Washington health plan decreased to 83.9% for the year ended December 31, 2010 from 84.5% for the year ended December 31, 2009, primarily due to reduced fee-for-service costs which more than offset decreased premium revenue PMPM. Premium revenue PMPM decreased for all of 2010 compared with 2009 because the rate increase of approximately 2.5% effective July 1, 2010 was not enough to offset decreases received during the second half of 2009.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	4,197	$ 506,871	$ 120.77	$ 423,021	$ 100.79	83.5%	$ 6,912
Florida	664	170,683	256.87	162,839	245.07	95.4	1
Michigan	2,708	630,134	232.66	527,596	194.80	83.7	39,187
Missouri	946	210,852	222.98	180,291	190.66	85.5	—
New Mexico	1,104	366,784	332.02	295,633	267.61	80.6	9,300
Ohio	2,817	860,324	305.42	680,802	241.69	79.1	67,358
Texas	708	188,716	266.72	162,714	229.97	86.2	3,251
Utah	921	258,076	280.27	235,576	255.84	91.3	—
Washington	4,141	758,849	183.27	636,617	153.75	83.9	13,513
Wisconsin(2)	134	30,033	224.75	27,574	206.35	91.8	—
Other(3)	—	8,587	—	38,194	—	—	253
	18,340	$3,989,909	$217.56	$3,370,857	$ 183.80	84.5%	$ 139,775

	Year Ended December 31, 2009						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	4,135	$ 481,717	$116.49	$ 443,892	$ 107.34	92.2%	$ 16,446
Florida	386	102,232	264.94	95,936	248.62	93.8	16
Michigan	2,523	557,421	220.94	454,431	180.12	81.5	36,482
Missouri	927	230,222	248.25	191,585	206.59	83.2	—
New Mexico	1,042	404,026	387.67	346,044	332.03	85.7	11,043
Ohio	2,411	803,521	333.33	691,402	286.82	86.1	47,849
Texas	402	134,860	335.69	110,794	275.78	82.2	2,513
Utah	793	207,297	261.43	190,319	240.02	91.8	—
Washington	3,847	726,137	188.77	613,876	159.58	84.5	14,175
Wisconsin(2)	—	—	—	—	—	—	—
Other(3),(4)	—	12,774	—	37,957	—	—	57
	16,466	$3,660,207	$ 222.24	$3,176,236	$ 192.85	86.8%	$ 128,581

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

(4) As of December 31, 2009, our Nevada health plan no longer served members. Premium revenue and medical care costs for the Nevada health plan have been included in "Other."

Days in Medical Claims and Benefits Payable

Beginning January 1, 2010, and for all prior periods presented, we are reporting days in medical claims and benefits payable relating to fee-for-service medical claims only. This computation includes only fee-for-service

medical care costs and related liabilities, and therefore calculates the extent of reserves for those liabilities that are most subject to estimation.

The days in medical claims and benefits payable amount previously reported included *all* medical care costs (fee-for-service, capitation, pharmacy, and administrative), and *all* medical claims liabilities, including those liabilities that are typically paid concurrently, or shortly after the costs are incurred, such as capitation costs and pharmacy costs. Medical claims liabilities in this calculation do not include accrued costs — such as salaries — associated with the administrative portion of medical costs. By including only fee-for-service medical costs and liabilities in this computation, our days in claims payable metric is more indicative of the size of our reserves for liabilities subject to a substantial degree of estimation. The days in medical claims and benefits payable, excluding our Wisconsin health plan which was acquired September 1, 2010, were as follows:

	December 31,		
	2010	2009	2008
Days in claims payable — fee-for-service only	42 days	44 days	51 days
Number of claims in inventory at end of period	143,600	93,100	87,300
Billed charges of claims in inventory at end of period (in thousands)	$218,900	$131,400	$115,400

Molina Medicaid Solutions Segment

Molina Medicaid Solutions contributed $2.6 million to operating income for the year ended December 31, 2010, but reported an operating loss of $3.6 million for the quarter ended December 31, 2010. The operating loss for the fourth quarter of 2010 was primarily the result of system stabilization costs incurred for two of Molina Medicaid Solutions' contracts.

Performance of the Molina Medicaid Solutions segment for the year ended December 31, 2010 was as follows:

	(In thousands)
Service revenue before amortization	$ 98,125
Less: amortization of contract backlog recorded as contra-service revenue	(8,316)
Service revenue	89,809
Cost of service revenue	78,647
General and administrative costs	5,135
Amortization of customer relationship intangibles recorded as amortization	3,418
Operating income	$ 2,609

Consolidated Expenses

General and Administrative Expenses

General and administrative, or G&A, expenses, were $346.0 million, or 8.5% of total revenue, for the year ended December 31, 2010 compared with $276.0 million, or 7.5% of total revenue, for the year ended December 31, 2009. The increase in the G&A ratio was the result of higher administrative expenses for the Health Plans segment, driven in part by the cost of our Medicare expansion, higher variable compensation expense as a result of substantially improved financial performance in 2010, employee severance and settlement costs, and costs relating to the acquisitions of Molina Medicaid Solutions and the Wisconsin health plan.

	Year Ended December 31,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 30,254	0.7%	$ 18,564	0.5%
Non Medicare-related administrative costs:				
Health Plans segment administrative payroll, including employee incentive compensation	239,146	5.9	204,432	5.6
Molina Medicaid Solutions segment administrative expenses	5,135	0.1	—	—
Employee severance and settlement costs	5,548	0.1	1,257	—
Molina Medicaid Solutions and Wisconsin plan acquisition costs	2,957	0.1	—	—
All other Health Plans segment administrative expense	62,953	1.6	51,774	1.4
	$345,993	8.5%	$276,027	7.5%

Premium Tax Expense

Premium tax expense relating to Health Plans segment premium revenue was 3.5% of revenue for both years ended December 31, 2010, and 2009.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different captions in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization in "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of service revenue; and
- Depreciation is recorded as cost of service revenue.

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue, and reconciles that amount to the consolidated statements of cash flows.

	Year Ended December 31,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Depreciation	$ 27,230	0.7%	$25,172	0.7%
Amortization of intangible assets	18,474	0.4	12,938	0.3
Depreciation and amortization reported in the consolidated statements of income	45,704	1.1	38,110	1.0
Amortization recorded as reduction of service revenue	8,316	0.2	—	—
Depreciation recorded as cost of service revenue	6,745	0.2	—	—
Depreciation and amortization reported in the consolidated statements of cash flows	$60,765	1.5%	$ 38,110	1.0%

Interest Expense

Interest expense increased to $15.5 million for the year ended December 31, 2010, from $13.8 million for the year ended December 31, 2009. We incurred higher interest expense relating to the $105 million draw on our credit facility (beginning May 1, 2010) to fund the acquisition of Molina Medicaid Solutions. Amounts borrowed to fund this acquisition were repaid in the third quarter using proceeds from our equity offering in the third quarter of 2010. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $5.1 million and $4.8 million for the years ended December 31, 2010, and 2009, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 38.6% for the year ended December 31, 2010 compared with 19.1% for the year ended December 31, 2009. The lower rate in 2009 was primarily due to discrete tax benefits recorded in 2009 as a result of settling tax examinations, and higher than previously estimated tax credits.

For the year ended December 31, 2009, amounts for premium tax expense and income tax expense have been reclassified to conform to the 2010 presentation of MGRT as a premium tax. The MGRT amounted to $6.2 million and $5.5 million for the years ended December 31, 2010, and 2009, respectively. There was no impact to net income for either period presented relating to this change.

Year Ended December 31, 2009 Compared with the Year Ended December 31, 2008

Health Plans Segment

Premium Revenue

Premium revenue grew approximately 18% in the year ended December 31, 2009 compared with the same period in 2008. During 2009, membership grew 16% overall, with Florida, California, Washington, and Ohio gaining the most members. Consolidated premium revenue increased 5.3% on a PMPM basis. Increased membership contributed 71% of the growth in premium revenue, and increases in PMPM revenue, as a result of both rate changes and shifts in member mix, contributed the remaining 29%.

We received PMPM premium reductions in 2009 that were in many cases correlated with reductions in the Medicaid fee schedule that also reduced our medical costs. However, PMPM premium reductions in Washington and Missouri in 2009 were not fully commensurate with changes in the Medicaid fee schedule in those states, and thus decreases in premiums were not matched by lower medical costs. In Washington, premium reductions not

linked to decreases in the Medicaid fee schedule lowered our medical margin by approximately $13 million in 2009. In Missouri, the transfer of the pharmacy benefit to the state fee-for-service program effective October 1, 2009 reduced our medical margin by approximately $1.2 million in 2009.

Medical care costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,					
	2009			2008		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for-service	$2,077,489	$ 126.14	65.4%	$1,709,806	$116.69	65.2%
Capitation	558,538	33.91	17.6	450,440	30.74	17.2
Pharmacy	414,785	25.18	13.1	356,184	24.31	13.6
Other	125,424	7.62	3.9	104,882	7.16	4.0
Total	$3,176,236	$192.85	100.0%	$2,621,312	$ 178.90	100.0%

Medical care costs, in the aggregate, increased 8% on a PMPM basis for the year ended December 31, 2009 compared with the same period in 2008. The medical care ratio was 86.8% for the year ended December 31, 2009, compared with 84.8% for the same period in 2008. Increased expenses were generally the result of higher utilization rather than higher unit costs (except in the case of outpatient costs, where both utilization and unit costs increased) and were most pronounced in connection with physician and outpatient emergency room facility services. Influenza-related illnesses and the costs associated with more recently enrolled members were key factors in the higher utilization. We estimate that the incremental costs associated with influenza-related illnesses were approximately $35 million, or $0.83 per diluted share, in the year ended December 31, 2009 compared with the year ended December 31, 2008.

Physician and outpatient costs exhibited the most significant unfavorable cost trend in the year ended December 31, 2009. Together, these costs increased approximately 13% on a PMPM basis compared with the same period in 2008. Consistent with our experience throughout 2009, emergency room utilization (up approximately 9%) and cost per visit (up approximately 8%) were the primary drivers of increased cost in the year ended December 31, 2009.

Inpatient costs were flat on a PMPM basis year-over-year despite increased utilization.

Pharmacy costs (including the benefit of rebates) increased 6% on a PMPM basis year-over-year, excluding the Missouri health plan, where the pharmacy benefit was transferred to the sate fee-for-service program effective October 1, 2009. Pharmacy utilization increased approximately 6% year-over-year, while unit costs (excluding rebates) were flat.

Capitated costs increased approximately 10% PMPM year-over-year, primarily as a result of rate increases received for members capitated on a percentage of premium basis at the New Mexico health plan, and the transition of members into capitated arrangements in California.

Health Plans Segment Operating Data

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2009						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	4,135	$ 481,717	$116.49	$ 443,892	$ 107.34	92.2%	$ 16,446
Florida(2)	386	102,232	264.94	95,936	248.62	93.8	16
Michigan	2,523	557,421	220.94	454,431	180.12	81.5	36,482
Missouri	927	230,222	248.25	191,585	206.59	83.2	—
New Mexico	1,042	404,026	387.67	346,044	332.03	85.7	11,043
Ohio	2,411	803,521	333.33	691,402	286.82	86.1	47,849
Texas	402	134,860	335.69	110,794	275.78	82.2	2,513
Utah	793	207,297	261.43	190,319	240.02	91.8	—
Washington	3,847	726,137	188.77	613,876	159.58	84.5	14,175
Other(3),(4)	—	12,774	—	37,957	—	—	57
	16,466	$3,660,207	$ 222.24	$3,176,236	$ 192.85	86.8%	$ 128,581

	Year Ended December 31, 2008						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	3,721	$ 417,027	$ 112.06	$ 363,776	$ 97.75	87.2%	$ 12,503
Florida(2)	—	—	—	—	—	—	—
Michigan	2,526	509,782	201.86	405,683	160.64	79.6	31,760
Missouri	910	225,280	247.62	184,298	202.58	81.8	—
New Mexico	970	348,576	359.45	286,004	294.92	82.1	11,713
Ohio	1,998	602,826	301.76	549,182	274.91	91.1	30,505
Texas	348	110,178	316.32	84,324	242.09	76.5	1,995
Utah	659	155,991	236.75	139,011	210.98	89.1	—
Washington	3,514	709,943	202.02	575,085	163.64	81.0	11,668
Other(3),(4)	—	11,637	—	33,949	—	—	21
	14,646	$ 3,091,240	$ 210.97	$2,621,312	$ 178.90	84.8%	$ 100,165

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) The Florida health plan began enrolling members in December 2008.

(3) "Other" medical care costs also include medically related administrative costs at the parent company.

(4) As of December 31, 2009, our Nevada health plan no longer served members. Premium revenue and medical care costs for the Nevada health plan have been included in "Other."

General and administrative expenses

G&A expenses were 7.5% of revenue in the year ended December 31, 2009, compared with 8.0% for the year ended December 31, 2008. Year-over-year, premium revenue grew faster than administrative costs, causing administrative costs, as a percentage of revenue, to decrease. On a PMPM basis, G&A decreased to $16.76 in 2009, from $17.04 for the same period in 2008.

	Year Ended December 31,			
	2009		2008	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Medicare-related administrative costs	$ 18,857	0.5%	$ 18,451	0.6%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	205,396	5.6	190,932	6.1
Florida health plan start up expenses	—	—	2,495	0.1
All other administrative expense	51,774	1.4	37,768	1.2
G&A expenses	$ 276,027	7.5%	$ 249,646	8.0%

Depreciation and Amortization

Depreciation and amortization expense increased $4.4 million for the year ended December 31, 2009 compared with 2008, primarily due to depreciation expense associated with investments in infrastructure. The following table presents the components of depreciation and amortization:

	Year Ended December 31,			
	2009		2008	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(In thousands)			
Depreciation	$ 25,172	0.7%	$ 20,718	0.7%
Amortization of intangible assets	12,938	0.3	12,970	0.4
Depreciation and amortization reported in the consolidated statements of cash flows	$ 38,110	1.0%	$ 33,688	1.1%

Gain on Retirement of Convertible Senior Notes

In February 2009, we purchased and retired $13.0 million face amount of our convertible senior notes. In connection with the purchase of the notes, we recorded a pretax gain of $1.5 million in 2009. There was no comparable transaction in 2008.

Interest Expense

Interest expense was $13.8 million for the year ended December 31, 2009, a slight increase over interest expense of $13.2 million for the year ended December 31, 2008. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $4.8 million, and $4.7 million for the years ended December 31, 2009, and 2008, respectively.

Income Taxes

Income taxes were recorded at an effective rate of 19.1% for the year ended December 31, 2009, compared with 36.8% in the prior year. The decrease in the effective tax rate was primarily due to discrete tax benefits recognized during the year relating to settling tax examinations, and higher than previously estimated California enterprise zone tax credits.

For the years ended December 31, 2009 and 2008, amounts for premium tax expense and income tax expense have been reclassified to conform to the presentation of MGRT as a premium tax. The MGRT amounted to $5.5 million and $5.1 million for the years ended December 31, 2009, and 2008, respectively. There was no impact to net income for either period presented relating to this change.

Acquisitions

Wisconsin Health Plan. On September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. As of December 31, 2010, we expect the final purchase price for the acquisition to be approximately $15.5 million, subject to adjustments. As of December 31, 2010, we had paid $8.5 million of the total purchase price. In the first quarter of 2011 we will compute the final purchase price based on the plan's membership on that date.

Molina Medicaid Solutions. On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM as described in "Overview," above.

Florida Health Plan. On December 31, 2009, we acquired 100% of the voting equity interests in Florida NetPASS, LLC, or NetPASS. The final purchase price totaled $29.6 million.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our premium revenue or our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2010, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $6.3 million for the year ended December 31, 2010, compared with $9.1 million for year ended December 31, 2009. This decline was primarily due to lower interest rates in 2010. The annualized portfolio yields for the years ended December 31, 2010, 2009, and 2008, were 0.7%, 1.2%, and 3.0%, respectively.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect to incur significantly losses due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the year ended December 31, 2010 was $161.6 million compared with $155.4 million for the year ended December 31, 2009, an increase of $6.2 million. Deferred revenue, which was a use of operating cash totaling $41.9 million in 2010, was a source of operating cash totaling $88.2 million in 2009. In 2009, the state of Ohio typically paid premiums in advance of the month the premium was earned. In 2010, the state of Ohio delayed its premium payments to mid-month for the month premium is earned. Therefore, we did not receive advance payments for the Ohio health plan's premiums during 2010. The change in deferred revenue was offset by increases in net income, depreciation and amortization, and other current liabilities.

Cash used in investing activities increased significantly in 2010 compared with 2009, due chiefly to the acquisition of Molina Medicaid Solutions, which totaled $131.3 million.

Cash provided by financing activities increased due to funds generated by our equity offering in the third quarter of 2010, which totaled $111.1 million, net of issuance costs. Amounts borrowed under our credit facility to fund the acquisition of Molina Medicaid Solutions in the second quarter of 2010 were repaid in the third quarter using proceeds from the equity offering.

Reconciliation of Non-GAAP(1) to GAAP Financial Measures

EBITDA(2)

	Year Ended December 31,	
	2010	2009
	(In thousands)	
Operating income	$ 105,001	$51,934
Add back:		
Depreciation and amortization reported in the consolidated statements of cash flows	60,765	38,110
EBITDA	$165,766	$ 90,044

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) We calculate EBITDA consistently on a quarterly and annual basis by adding back depreciation and amortization to operating income. Operating income includes investment income. EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At December 31, 2010, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $65.1 million, including $6.0 million in non-current auction rate securities, compared with $45.6 million of cash and investments at December 31, 2009.

On a consolidated basis, at December 31, 2010, we had working capital of $392.4 million compared with $321.2 million at December 31, 2009. At December 31, 2010 and December 31, 2009, cash and cash equivalents were $455.9 million and $469.5 million, respectively. At December 31, 2010, investments were $315.8 million, including $20.4 million in non-current auction rate securities, and at December 31, 2009, investments were $234.5 million, including $59.7 million in non-current auction rate securities.

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. We borrowed $105 million under the Credit Facility to acquire Molina Medicaid Solutions in the second quarter of 2010. During the third quarter of 2010, we repaid this amount using proceeds from our equity offering, described in Note 14 to the accompanying audited consolidated financial statements for the year ended December 31, 2010. As of December 31, 2010, and 2009, there was no outstanding principal debt balance under the Credit Facility. However, as of December 31, 2010, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the contract of MMS with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2010, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio set forth pursuant to the Credit Facility was 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first and second quarters of 2010, and through August 14, 2010. Effective as of August 15, 2010, the consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We also paid an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through August 15, 2010.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering. As a result of the offering described below, we may now offer up to $182.5 million of our securities from time to time under the shelf registration statement.

In August 2010, we sold 4,350,000 shares of common stock covered by this registration statement. The public offering price for this sale was $25.65 per share, net of the underwriting discount. Our proceeds from the sales totaled approximately $111.1 million, net of the issuance costs. We used the proceeds from these sales to repay the Credit Facility and for general corporate purposes. Also in August 2010, the Molina Siblings Trust, as a selling stockholder, sold 250,000 shares of outstanding common stock covered by this registration statement.

Securities Purchase Programs

Under securities purchase programs announced in 2009, we purchased and retired $13.0 million face amount of our convertible senior notes. Also during 2009, we purchased approximately 1,352,000 shares of our common stock for $28 million.

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). During 2009, we purchased and retired $13.0 million face amount of the Notes. As of December 31, 2010, the remaining aggregate principal amount of the Notes was $187.0 million. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $397.8 million at December 31, 2010, and $368.7 million at December 31, 2009.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At December 31, 2010, our health plans had aggregate statutory capital and surplus of approximately $416.6 million, compared to the required minimum aggregate statutory capital and surplus of approximately $278.0 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2010. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2011.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Our most significant accounting policies relate to:

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;

- The deferral of revenue and costs associated with contracts held by our Molina Medicaid Solutions segment; and
- The determination of medical claims and benefits payable.

Revenue Recognition — Health Plans Segment

Certain components of premium revenue of our Health Plans segment are subject to accounting estimates, and are therefore subject to retroactive revision. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At December 31, 2010, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.
- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At December 31, 2010, we had recorded a liability of $5.6 million under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the

existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. The state of New Mexico's fiscal year ends June 30, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending June 30, 2011, our New Mexico health plan has received $5.4 million in at-risk revenue as of December 31, 2010. To date, we have recognized $3.5 million of that amount as revenue, and recorded a liability of approximately $1.9 million as of December 31, 2010, for the remainder. If the state of New Mexico disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.
- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. Effective February 1, 2010 an additional 0.25% of the Ohio health plan's revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Ohio's fiscal year ends June 30, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending June 30, 2011, our Ohio health plan has received $13.8 million in at-risk revenue as of December 31, 2010. To date, we have recognized $4.5 million of that amount as revenue and recorded a liability of approximately $9.3 million as of December 31, 2010, for the remainder. If the state of Ohio disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required. During the third quarter of 2010, we reversed the recognition of approximately $3.3 million of at-risk revenue previously recognized.
- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at December 31, 2010.
- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas there is a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of December 31, 2010, we had an aggregate liability of approximately $0.6 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2010 and 2011 contract years (ending August 31 of each year). We paid $2.6 million to the state under the terms of this profit sharing agreement during the year ended December 31, 2010, for the 2009 and 2010 contract years. Because the final settlement

calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, an adjustment to the amounts owed may be required.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Texas's fiscal year ends August 31, and open contract years typically include the current state fiscal year and the immediately preceding state fiscal year (two state fiscal years in total). For the two open state fiscal years ending August 31, 2011, our Texas health plan has received $2.2 million in at-risk revenue, all of which has been recognized as revenue, as of December 31, 2010. If the state of Texas disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.
- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns we have recorded a liability of approximately $1.2 million related to the potential recoupment of Medicare premium revenue at December 31, 2010. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue.

Deferral of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solution segment contracts are multiple-element arrangements. We have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services. While all contracts support the system of record for state MMIS, the actual services and products we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. Although the length of the DDI phase for any MMIS contract can vary considerably, the DDI phase typically takes about two years to complete. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all

revenue will be recognized over the period that BPO services and training and IT support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services or training and IT support services) until the contingency had been removed. In these circumstances we would also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the contract (whether DDI, BPO services or training and IT support services) on which revenue recognition is being deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

We began to recognize revenue (and related deferred costs) associated with our Maine contract in September 2010. In Idaho, we expect to begin recognition of deferred contact costs during 2011, in a manner consistent with our anticipated recognition of revenue. Unamortized deferred contract costs relating to the Molina Medicaid Solutions segment at December 31, 2010 were $28.4 million.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Medical Claims and Benefits Payable — Health Plans Segment

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	December 31,		
	2010	2009	2008
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$275,259	$246,508	$236,492
Capitation payable	49,598	39,995	28,111
Pharmacy	14,649	20,609	18,837
Other	14,850	8,204	9,002
	$ 354,356	$315,316	$292,442

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately

pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $275.3 million of our total medical claims and benefits payable of $354.4 million as of December 31, 2010. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at December 31, 2010 was $268.3 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2010 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2010, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 80,667
(4)%	53,778
(2)%	26,889
2%	(26,889)
4%	(53,778)
6%	(80,667)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2010 that would have resulted had we altered our trend factors by the

percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (64,958)
(4)%	(43,305)
(2)%	(21,653)
2%	21,653
4%	43,305
6%	64,958

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 27.8 million diluted shares outstanding for the year ended December, 2010. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2010, net income for the year ended December 31, 2010 would increase or decrease by approximately $8.5 million, or $0.31 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2010, net income for the year ended December 31, 2010 would increase or decrease by approximately $6.8 million, or $0.25 per diluted share, net of tax. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $42.4 million, or $1.53 per diluted share, and $34.1 million, or $1.23 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $8.5 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously

reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2010, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 15.7%.

As shown in greater detail in the table below, the amounts ultimately paid out on our prior period liabilities in fiscal years 2009 and 2010 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

For the year ended December 31, 2010, we recognized a benefit from prior period claims development in the amount of $49.4 million (see table below). This amount represents our estimate as of December 31, 2010 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2009 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2009 was due primarily to the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

We recognized a benefit from prior period claims development in the amount of $51.6 million in the year ended December 31, 2009 (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2008. The overestimation of claims liability at December 31, 2008 was the result of the following factors:

- In New Mexico, we overestimated at December 31, 2008 the ultimate amounts we would need to pay to resolve certain high dollar provider claims.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008.
- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt

of paper claims would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

In estimating our claims liability at December 31, 2010, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The rapid growth of membership in our Medicare line of business between December 31, 2009 and December 31, 2010.
- Our assumption of risk for new populations in Texas (rural CHIP members) and Wisconsin (Medicaid members) effective September 1, 2010.
- An increase in claims inventory at our Florida, Michigan, New Mexico, Ohio and Texas health plans between September 30, 2010 and December 31, 2010.
- A decrease in claims inventory at our Utah health plan between September 30, 2010 and December 31, 2010.
- The transition of claims processing for our Missouri health plan from a third party service provider to our internal claims processing platform effective April 1, 2010.
- Changes to the Medicaid fee schedule in Utah effective July 1, 2010.
- Changes to provider reimbursement rates (primarily for outpatient facility costs) in New Mexico effective November 1, 2010.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. In 2009 and 2010, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "*Components of medical care costs related to:* Prior years" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2010	2009
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of year	$ 315,316	$ 292,442
Balance of acquired subsidiary	3,228	—
Components of medical care costs related to:		
Current year	3,420,235	3,227,794
Prior years	(49,378)	(51,558)
Total medical care costs	3,370,857	3,176,236
Payments for medical care costs related to:		
Current year	3,085,388	2,920,015
Prior years	249,657	233,347
Total paid	3,335,045	3,153,362
Balances at end of year	$ 354,356	$ 315,316
Benefit from prior years as a percentage of:		
Balance at beginning of year	15.7%	17.6%
Premium revenue	1.2%	1.4%
Medical care costs	1.5%	1.6%
Claims Data(1):		
Days in claims payable, fee for service only	42	44
Number of members at end of period	1,613,000	1,455,000
Fee-for-service claims processing and inventory information:		
Number of claims in inventory at end of period	143,600	93,100
Billed charges of claims in inventory at end of period	$ 218,900	$ 131,400
Claims in inventory per member at end of period	0.09	0.06
Billed charges of claims in inventory per member at end of period	$ 135.71	$ 90.31
Number of claims received during the period	14,554,800	12,930,100
Billed charges of claims received during the period	$ 11,686,100	$ 9,769,000

(1) "Claims Data" does not include our Wisconsin health plan acquired September 1, 2010.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2010, our lease obligations for the next five years and thereafter were as follows: $28.0 million in 2011, $23.8 million in 2012, $20.3 million in 2013, $17.4 million in 2014, $13.7 million in 2015, and an aggregate of $30.6 million thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 18 to the accompanying audited consolidated financial statements for the year ended December 31, 2010.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2010. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2011	2012-2013	2014-2015	2016 and Beyond
Medical claims and benefits payable	$354,356	$354,356	$ —	$ —	$ —
Principal amount of long-term debt(1)	187,000	—	—	187,000	—
Operating leases	133,806	28,004	44,143	31,037	30,622
Interest on long-term debt	26,297	7,012	14,025	5,260	—
Purchase commitments	28,557	13,401	14,828	328	—
Total contractual obligations	$ 730,016	$ 402,773	$72,996	$223,625	$ 30,622

(1) Represents the principal amount due on our 3.75% Convertible Senior Notes due 2014.

As of December 31, 2010, we have recorded approximately $11.0 million of unrecognized tax benefits. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 13 to the accompanying audited consolidated financial statements for the year ended December 31, 2010 for further information.

Item 7A. *Quantitative and Qualitative Disclosures About Market Risk*

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years. Restricted investments are invested principally in certificates of deposit and U.S. treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Inflation

Although the general rate of inflation has remained relatively stable and health care cost inflation has stabilized in recent years, the national health care cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. While we currently believe our strategies will mitigate health care cost inflation, competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

MOLINA HEALTHCARE, INC.

Item 8. ***Financial Statements and Supplementary Data***

INDEX TO FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2010 and 2009, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2010. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2010 and 2009, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2010, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 8, 2011 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 8, 2011

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2010	2009
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 455,886	$ 469,501
Investments	295,375	174,844
Receivables	168,190	136,654
Income tax refundable	—	6,067
Deferred income taxes	15,716	8,757
Prepaid expenses and other current assets	22,772	14,383
Total current assets	957,939	810,206
Property and equipment, net	100,537	78,171
Deferred contract costs	28,444	—
Intangible assets, net	105,500	80,846
Goodwill and indefinite-lived intangible assets	212,228	133,408
Investments	20,449	59,687
Restricted investments	42,100	36,274
Receivable for ceded life and annuity contracts	24,649	25,455
Other assets	17,368	19,988
	$1,509,214	$1,244,035
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 354,356	$ 315,316
Accounts payable and accrued liabilities	137,930	71,732
Deferred revenue	60,086	101,985
Income taxes payable	13,176	—
Total current liabilities	565,548	489,033
Long-term debt	164,014	158,900
Deferred income taxes	16,235	12,506
Liability for ceded life and annuity contracts	24,649	25,455
Other long-term liabilities	19,711	15,403
Total liabilities	790,157	701,297
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 30,309 shares at December 31, 2010 and 25,607 shares at December 31, 2009	30	26
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	251,627	129,902
Accumulated other comprehensive loss	(2,192)	(1,812)
Retained earnings	469,592	414,622
Total stockholders' equity	719,057	542,738
	$1,509,214	$1,244,035

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2010	2009	2008
	(In thousands, except per-share data)		
Revenue:			
Premium revenue	$3,989,909	$ 3,660,207	$ 3,091,240
Service revenue	89,809	—	—
Investment income	6,259	9,149	21,126
Total revenue	4,085,977	3,669,356	3,112,366
Expenses:			
Medical care costs	3,370,857	3,176,236	2,621,312
Cost of service revenue	78,647	—	—
General and administrative expenses	345,993	276,027	249,646
Premium tax expenses	139,775	128,581	100,165
Depreciation and amortization	45,704	38,110	33,688
Total expenses	3,980,976	3,618,954	3,004,811
Gain on purchase of convertible senior notes	—	1,532	—
Operating income	105,001	51,934	107,555
Interest expense	(15,509)	(13,777)	(13,231)
Income before income taxes	89,492	38,157	94,324
Provision for income taxes	34,522	7,289	34,726
Net income	$ 54,970	$ 30,868	$ 59,598
Net income per share:			
Basic	$ 2.00	$ 1.19	$ 2.15
Diluted	$ 1.98	$ 1.19	$ 2.15
Weighted average shares outstanding:			
Basic	27,449	25,843	27,676
Diluted	27,754	25,984	27,772

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
				(In thousands)			
Balance at January 1, 2008	28,444	$ 28	$210,310	$ 272	$324,156	$(20,390)	$514,376
Comprehensive income:							
Net income	—	—	—	—	59,598	—	59,598
Other comprehensive income, net of tax:							
Unrealized loss on investments	—	—	—	(7,025)	—	—	(7,025)
Other-than-temporary impairment of available-for-sale securities	—	—	—	4,443	—	—	4,443
Total comprehensive income	—	—	—	(2,582)	59,598	—	57,016
Purchase of treasury stock	—	—	—	—	—	(49,940)	(49,940)
Retirement of treasury stock	(1,943)	(1)	(49,939)	—	—	49,940	—
Stock issued in business purchase transaction	48	—	1,262	—	—	—	1,262
Stock options exercised, employee stock grants and employee stock plan purchases	176	—	9,340	—	—	—	9,340
Tax deficiency from employee stock compensation	—	—	(292)	—	—	—	(292)
Balance at December 31, 2008	26,725	27	170,681	(2,310)	383,754	(20,390)	531,762
Comprehensive income:							
Net income	—	—	—	—	30,868	—	30,868
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	498	—	—	498
Total comprehensive income	—	—	—	498	30,868	—	31,366
Purchase of treasury stock	—	—	—	—	—	(27,712)	(27,712)
Retirement of treasury stock	(1,352)	(1)	(48,101)	—	—	48,102	—
Retirement of convertible debt	—	—	(476)	—	—	—	(476)
Employee stock grants and employee stock plan purchases	234	—	8,516	—	—	—	8,516
Tax deficiency from employee stock compensation	—	—	(718)	—	—	—	(718)
Balance at December 31, 2009	25,607	26	129,902	(1,812)	414,622	—	542,738
Comprehensive income:							
Net income	—	—	—	—	54,970	—	54,970
Other comprehensive income, net of tax:							
Unrealized loss on investments	—	—	—	(380)	—	—	(380)
Total comprehensive income	—	—	—	(380)	54,970	—	54,590
Common stock issued, net of issuance costs	4,350	4	111,127	—	—		111,131
Employee stock grants and employee stock plan purchases	352	—	11,271	—	—	—	11,271
Tax deficiency from employee stock compensation	—	—	(673)	—	—	—	(673)
Balance at December 31, 2010	30,309	$ 30	$251,627	$ (2,192)	$469,592	$ —	$719,057

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Operating activities:			
Net income	$ 54,970	$ 30,868	$ 59,598
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	60,765	38,110	33,688
Unrealized (gain) loss on trading securities	(4,170)	(3,394)	399
Loss (gain) on rights agreement	3,807	3,100	(6,907)
Other-than-temporary impairment on available-for-sale securities	—	—	7,166
Deferred income taxes	(4,092)	(1)	(3,404)
Stock-based compensation	9,531	7,485	7,811
Non-cash interest on convertible senior notes	5,114	4,782	4,707
Gain on purchase of convertible senior notes	—	(1,532)	—
Amortization of deferred financing costs	1,780	1,872	1,435
Tax deficiency from employee stock compensation	(968)	(749)	(335)
Loss on disposal of property and equipment	—	—	142
Changes in operating assets and liabilities, net of effects of business combinations:			
Receivables	(7,539)	(8,092)	(17,025)
Prepaid expenses and other current assets	(9,756)	383	(2,245)
Medical claims and benefits payable	34,363	22,874	(19,164)
Accounts payable and accrued liabilities	40,482	(26,467)	10,830
Deferred revenue	(41,899)	88,181	(26,300)
Income taxes	19,258	(2,049)	(9,965)
Net cash provided by operating activities	161,646	155,371	40,431
Investing activities:			
Purchases of equipment	(48,538)	(35,870)	(34,690)
Purchases of investments	(302,842)	(186,764)	(263,229)
Sales and maturities of investments	225,106	204,365	246,524
Net cash paid in business combinations	(130,743)	(11,294)	(1,000)
Increase in deferred contract costs	(29,319)	—	—
(Increase) decrease in restricted investments	(5,566)	1,928	(9,183)
Change in other noncurrent assets and liabilities	2,830	(10,078)	(2,942)
Net cash used in investing activities	(289,072)	(37,713)	(64,520)
Financing activities:			
Proceeds from common stock offering, net of issuance costs	111,131	—	—
Amount borrowed under credit facility	105,000	—	—
Repayment of amount borrowed under credit facility	(105,000)	—	—
Treasury stock purchases	—	(27,712)	(49,940)
Purchase of convertible senior notes	—	(9,653)	—
Credit facility fees paid	(1,671)	—	—
Proceeds from employee stock plans	4,056	2,015	2,084
Excess tax benefits from employee stock compensation	295	31	43
Net cash provided by (used in) financing activities	113,811	(35,319)	(47,813)
Net (decrease) increase in cash and cash equivalents	(13,615)	82,339	(71,902)
Cash and cash equivalents at beginning of year	469,501	387,162	459,064
Cash and cash equivalents at end of year	$ 455,886	$ 469,501	$ 387,162

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (Continued)

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 18,299	$ 23,480	$ 46,088
Interest	$ 10,951	$ 8,205	$ 7,797
Schedule of non-cash investing and financing activities:			
Retirement of treasury stock	$ —	$ 48,102	$ 49,940
Details of business combinations:			
Fair value of assets acquired	$(159,916)	$(34,594)	$ (2,262)
Release of escrow and other deposits	—	18,000	—
Common stock issued to seller	—	—	1,262
Less payable to seller	4,723	5,300	—
Fair value of liabilities assumed	24,450	—	—
Net cash paid in business purchase transactions	$ (130,743)	$(11,294)	$ (1,000)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program.

Our Health Plans segment comprises health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. These health plans served approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals as of December 31, 2010. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010, we terminated operations at our small Medicare health plan in Nevada.

Our Molina Medicaid Solutions, which we acquired during 2010, segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

Consolidation and Presentation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. All significant intercompany transactions and balances have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition. Our operating results for the year ended December 31, 2010, include the results of the following businesses acquired during 2010:

- *Molina Medicaid Solutions.* On May 1, 2010, we acquired a health information management business which now operates under the name, *Molina Medicaid Solutions*SM. See Note 4, "Business Combinations," for more information relating to this acquisition.
- *Wisconsin Health Plan.* On September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. See Note 4, "Business Combinations," for more information relating to this acquisition.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. Principal areas requiring the use of estimates include:

- The determination of revenue to be recognized by our Health Plans segment under certain contracts that place revenue at risk dependent upon the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses, or requirements that we return a certain portion of our profits to state governments;
- The determination of medical claims and benefits payable of our Health Plans segment;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;

- The assessment of deferred contract costs, deferred revenue, long-lived and intangible assets, and goodwill for impairment;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax as a premium tax and not as an income tax. For the years ended December 31, 2009, and 2008, amounts for premium tax expense and income tax expense have been reclassified to conform to this presentation. See Note 2, "Significant Accounting Policies."

In prior periods, general and administrative expenses have included premium tax expenses. Beginning in 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

We have reclassified certain other prior year balance sheet amounts to conform to the 2010 presentation.

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income.

The cost of securities sold is determined using the specific-identification method, on an amortized cost basis. Fair values of securities are generally based on quoted prices in active markets.

Our investment policy requires that all of our investments have final maturities of five years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be two years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. Our auction rate securities are classified as non-current assets. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," and Note 6, "Investments" and Note 10, "Restricted Investments."

Receivables

Receivables consist primarily of amounts due from the various states in which we operate, and are subject to potential retroactive adjustment. Because such receivables are readily determinable and our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables." Additionally, we cede 100% of the financial responsibility for Medicare members covered by our Wisconsin health plan to third a party health reinsurer. In connection with the arrangement, as of December 31, 2010, we have recorded a receivable from the third party reinsurer of $5.0 million along with a corresponding current liability of $5.0 million.

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years. See Note 8, "Property and Equipment."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software, which may be ultimately transferred to our clients under fixed-price contracts, are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Deferral of Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of three elements of service. The first of these is the design, development and implementation, or DDI, of a Medicaid Management Information System, or MMIS. The second element, following completion of the DDI element, is the operation of the MMIS under a business process outsourcing, or BPO, arrangement. While providing BPO services, we also provide the state with the third contracted element — training and IT support and hosting services (training and support).

Because they include these three elements of service, our Molina Medicaid Solution segment contracts are multiple-element arrangements. We have no vendor specific objective evidence, or VSOE, of fair value for any of the individual elements in these contracts, and at no point in the contract will we have VSOE for the undelivered elements in the contract. We lack VSOE of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of products and services. While all contracts support the system of record for state MMIS, the actual services and products we provide vary significantly between contracts; and
- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

The absence of VSOE within the context of a multiple element arrangement requires us to delay recognition of any revenue for an MMIS contract until completion of the DDI phase of the contract. As a general principle, revenue recognition will therefore commence at the completion of the DDI phase, and all revenue will be recognized over the period that BPO services and training and IT support services are provided. Consistent with the deferral of revenue, recognition of all direct costs (such as direct labor, hardware, and software) associated with the DDI phase

of our contracts is deferred until the commencement of revenue recognition. Deferred costs are recognized on a straight-line basis over the period of revenue recognition.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances we defer recognition of any revenue at risk (whether DDI, BPO services or training and IT support services) until the contingency had been removed. In these circumstances we would also defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with the contract (whether DDI, BPO services or training and IT support services) on which revenue recognition is being deferred. Such deferred contract costs are recognized on a straight-line basis over the period of revenue recognition.

We began to recognize revenue (and related deferred costs) associated with our Maine contract in September 2010. In Idaho, we expect to begin recognition of deferred contact costs during 2011, in a manner consistent with our anticipated recognition of revenue. Unamortized deferred contract costs relating to the Molina Medicaid Solutions segment at December 31, 2010 were $28.4 million.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are amortized on a straight-line basis over the expected period to be benefited (generally between one and 15 years). See Note 9, “Goodwill and Intangible Assets.”

Goodwill and indefinite-lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. We use a discounted cash flow methodology to assess the fair values of our reporting units. If the carrying values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill and indefinite-lived asset balance derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite-lived asset balance. Based on the results of our impairment testing, no adjustments were required for the years ended December 31, 2010, 2009 and 2008.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships.

The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to the acquisition. The contract backlog intangible has been developed on a contract-by-contract basis. The amortization of that portion of the contract backlog intangible associated with contracts for which revenue recognition has not yet commenced is deferred until revenue recognition has begun. Because each acquired contract constitutes a single revenue stream, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a straight-line basis for each specific contract over periods generally ranging from one to six years.

The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

The determination of the value of identifiable intangible assets requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. In addition to annual impairment testing, we continually evaluate whether events and circumstances have occurred that indicate the balance of identifiable intangible assets may not be recoverable. In evaluating impairment, we compare the estimated fair value of the intangible asset to its underlying book value. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event occurs that would cause us to revise our estimates and assumptions used in analyzing the value of our identifiable intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different captions in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization in "Depreciation and Amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of service revenue; and
- Depreciation is recorded as cost of service revenue.

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue, and reconciles that amount to the consolidated statements of cash flows.

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Depreciation	$ 27,230	$25,172	$ 20,718
Amortization of intangible assets	18,474	12,938	12,970
Depreciation and amortization reported in our consolidated statements of income	45,704	38,110	33,688
Amortization recorded as reduction of service revenue	8,316	—	—
Depreciation recorded as cost of service revenue	6,745	—	—
Depreciation and amortization reported in our consolidated statements of cash flows	$60,765	$ 38,110	$ 33,688

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted expected cash flows associated with that asset. In such circumstances, the asset is deemed to be impaired. We review material long-lived assets for impairment when events or changes in business conditions suggest potential impairment. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that

these contracts will continue to be renewed. Impaired assets are written down to fair value. We have determined that no long-lived assets were impaired in the years ended December 31, 2010, 2009, and 2008.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Receivable/Liability for Ceded Life and Annuity Contracts

We report a 100% ceded reinsurance arrangement for life insurance policies written and held by our wholly owned insurance subsidiary, Molina Healthcare Insurance Company, by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts.

Other Assets

Significant items included in other assets include deferred financing costs associated with our convertible senior notes and with our credit facility, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see Note 17, "Related Party Transactions"). The deferred financing costs are being amortized on a straight-line basis over the seven-year term of the convertible senior notes and the five year term of the credit facility.

Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2010, or December 31, 2009.

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2010 we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies, Medicare and other managed care organizations for which we operate as a subcontractor. These

premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue by health plan for the periods indicated:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
California	$ 506,871	$ 481,717	$ 417,027
Florida(1)	170,683	102,232	—
Michigan	630,134	557,421	509,782
Missouri	210,852	230,222	225,280
New Mexico	366,784	404,026	348,576
Ohio	860,324	803,521	602,826
Texas	188,716	134,860	110,178
Utah	258,076	207,297	155,991
Washington	758,849	726,137	709,943
Wisconsin(2)	30,033	—	—
Other	8,587	12,774	11,637
	$3,989,909	$3,660,207	$ 3,091,240

(1) The Florida health plan began enrolling members in December 2008.

(2) We acquired the Wisconsin health plan on September 1, 2010.

For the year ended December 31, 2010, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in all of our state health plans except New Mexico. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates, and therefore are subject to retroactive revision. The most significant of these estimates involve:

- The recognition of premium revenue at our Florida, New Mexico, and Texas health plans, where we are subject to a number of requirements, that, among other things, require us to expend a minimum amount of revenue on certain defined medical costs, expend a maximum amount of revenue on certain defined administrative costs, and share our profits (as defined) above a certain percentage of revenue with the state;
- The recognition of premium revenue due to the achievement of certain performance measures (generally linked to quality of care and administrative efficiency) included in our contracts with the states of New Mexico, Ohio, and Texas;
- The recognition of premium revenue due to the achievement of certain medical cost savings (as measured against state fee-for-service costs) under our contract with the state of Utah; and
- The amount of Medicare premium revenue that we recognize, which may be retroactively adjusted to reflect the acuity of care required by our members.

Medical Care Costs

Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. Most hospitals are paid on a fee-for-service basis in a

variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, and case rates. As discussed below, we also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed per-member per-month, or PMPM, payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2010, 2009, and 2008, medically related administrative costs were approximately $85.5 million, $74.6 million, and $75.9 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,								
	2010			2009			2008		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee-for- service	$2,360,858	$128.73	70.0%	$2,077,489	$126.14	65.4%	$1,709,806	$116.69	65.2%
Capitation	555,487	30.29	16.5	558,538	33.91	17.6	450,440	30.74	17.2
Pharmacy	325,935	17.77	9.7	414,785	25.18	13.1	356,184	24.31	13.6
Other	128,577	7.01	3.8	125,424	7.62	3.9	104,882	7.16	4.0
Total	$3,370,857	$183.80	100.0%	$3,176,236	$192.85	100.0%	$2,621,312	$178.90	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been

paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates. See Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Our California, Florida, Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in premium tax expense.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2010, or 2009.

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers. For further discussion and disclosure, see Note 13, "Income Taxes."

Through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax, and prior years have been reclassified to conform to this presentation. We will continue to record the BIT as an income tax. The MGRT amounted to $6.2 million, $5.5 million and $5.1 million for the years ended December 31, 2010, 2009, and 2008 respectively.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers is defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of our Michigan plan's receipts and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Funds Prime Series — Institutional Class, and the PFM Funds Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. As of December 31, 2010, and 2009, our investments with PFM totaled $327 million and $296 million, respectively. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plan subsidiaries operate.

Risks and Uncertainties

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2010, we operated health plans in 10 states, primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Recent Accounting Pronouncements

Revenue Recognition. In late 2009, the Financial Accounting Standards Board, or FASB, issued the following new accounting guidance which is first applicable for our January 1, 2011 reporting:

- *ASU No. 2009-14, Software (ASC Topic 985) — Certain Revenue Arrangements That Include Software Elements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies the scope of ASC Subtopic 985-605 — *Software-Revenue Recognition* to exclude from its requirements (a) non-software components of tangible products and (b) software components of tangible products that are sold, licensed or leased with tangible products when the software components and non-software components of the tangible product function together to deliver the tangible product's essential functionality. We do not expect the update to impact our consolidated financial position, results of operations or cash flows.

- *ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — Multiple-Deliverable Revenue Arrangements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies previous requirements by allowing the use of the "best estimate of selling price" in the absence of vendor-specific objective evidence ("VSOE") or verifiable objective evidence ("VOE") (now referred to as "TPE" or third-party evidence) for determining the selling price of a deliverable. A vendor is now required to use its best estimate of the selling price when more objective evidence of the selling price cannot be determined. In addition, the residual method of allocating arrangement consideration is no longer permitted. As of December 31, 2010, we do not expect the update to impact our consolidated financial position, results of operations or cash flows; however, the future impact of the update will be dependent on future contracts and modifications to existing contracts.

Fair Value Measurements. In January 2010, the FASB issued the following guidance which expanded the required disclosures about fair value measurements. Effective for interim and annual reporting beginning after December 15, 2009, with one new disclosure effective beginning after December 15, 2010, we adopted this guidance in full during the interim period ended March 31, 2010.

- *ASU No. 2010-6, Fair Value Measurements and Disclosures (Topic 820) — Improving Disclosures about Fair Value Measurements*. This guidance requires (a) separate disclosure of the amounts of significant transfers in and out of Level 1 and Level 2 fair value measurements along with the reasons for such transfers, (b) information about purchases, sales, issuances and settlements to be presented separately in the reconciliation for Level 3 fair value measurements, (c) fair value measurement disclosures for each class of assets and liabilities and (d) disclosures about the valuation techniques and inputs used to measure fair value for both recurring and nonrecurring fair value measurements for fair value measurements that fall in either Level 2 or Level 3. The adoption of this guidance did not impact our consolidated financial position, results of operations or cash flows.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the AICPA, and the SEC did not, or are not believed by management to have a material impact on our present or future consolidated financial statements.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Shares outstanding at the beginning of the year	25,607	26,725	28,444
Weighted-average number of shares:			
Issued under equity offering	1,671	—	—
Purchased	—	(988)	(871)
Issued under employee stock plans	171	106	103
Denominator for basic earnings per share	27,449	25,843	27,676
Dilutive effect of employee stock options and stock grants(1)	305	141	96
Denominator for diluted earnings per share(2)	27,754	25,984	27,772

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the years ended December 31, 2010, 2009 and 2008, there were approximately 478,000, 620,000, and 532,000 anti-dilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the

periods presented. For the years ended December 31, 2010, 2009 and 2008, anti-dilutive weighted restricted shares were insignificant.

(2) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2010, 2009 and 2008.

4. Business Combinations

Wisconsin Health Plan

On September 1, 2010, Molina acquired 100% of the voting equity interests in Avatar Partners, LLC, which is the sole shareholder of Abri Health Plan, Inc. ("Abri"), a Medicaid managed care organization based in Milwaukee, Wisconsin. This acquisition is consistent with our stated strategy to enter markets with competitive provider communities, supportive regulatory environments, significant size and, where practicable, mandated Medicaid managed care enrollment.

We expect the final purchase price for the Abri acquisition to be approximately $15.5 million, subject to adjustments. As of December 31, 2010, we had paid $8.5 million of the total purchase price. We expect to finalize the amount due to the sellers based on the final membership reconciliation in the first quarter of 2011. Additionally, $2.8 million of the purchase price represents contingent consideration based on the plan's minimum surplus requirements as of February 1, 2011, which will also be computed in the first quarter of 2011. Any adjustments to the estimated amount of contingent consideration will be recorded to operations in the first quarter of 2011. Following the final membership reconciliation, 10% of the final purchase price for the membership acquired will be deposited to an escrow account payable at the later of 12 months or the resolution of all unresolved claims. We incurred approximately $0.5 million in acquisition costs relating to this acquisition in 2010, recorded to general and administrative expenses.

In connection with this acquisition, we recorded $5.5 million in goodwill, which is not deductible for tax purposes, and $3.4 million in various definite-lived identifiable intangible assets, with a weighted average useful life of 6.4 years. Accumulated amortization totaled approximately $0.4 million as of December 31, 2010, which reflects amortization recorded since the acquisition date. We expect to record amortization relating to this acquisition in future years as follows— 2011: $0.9 million, 2012: $0.4 million, 2013: $0.3 million, 2014: $0.3 million, and 2015: $0.2 million.

Molina Medicaid Solutions

On May 1, 2010, we acquired a health information management business that was previously an operating unit of Unisys Corporation. This business now operates under the name *Molina Medicaid Solutions*SM, or Molina Medicaid Solutions. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. As a result of this acquisition, we are diversifying our core health plan business, and we believe that the use of a common claims processing platform across our health plans and our new MMIS business will enable us to achieve synergies in the operations of both.

We paid $131.3 million to acquire Molina Medicaid Solutions. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility. In connection with the closing, both the fourth amendment and the fifth amendment to our credit facility became effective (see Note 12, "Long-Term Debt"). We incurred approximately $2.5 million in acquisition costs relating to this acquisition in 2010, recorded to general and administrative expenses. Additionally, effective on the acquisition date, we entered into a transition services

agreement with Unisys Corporation. Under this agreement, Unisys is providing Molina Medicaid Solutions various systems and infrastructure support services until April 30, 2011. During 2010, we recorded approximately $4.7 million to cost of service revenue relating to this agreement.

Recording of assets acquired and liabilities assumed: The transaction has been accounted for using the acquisition method of accounting which requires, among other things, that most assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date.

The following table summarizes the acquisition-date fair values of the assets acquired and liabilities assumed:

	(In thousands)
Assets	
Accounts receivable	$ 17,128
Other current assets	3,901
Equipment and other long-term assets	783
Identifiable intangible assets	48,150
Goodwill	72,367
	142,329
Less: liabilities	
Accounts payable and accrued liabilities	11,079
Net assets acquired	$ 131,250

A single estimate of fair value results from a complex series of judgments about future events and uncertainties and relies heavily on estimates and assumptions. Results that differ from the estimates and judgments used to determine the estimated fair value assigned to each class of assets acquired and liabilities assumed, as well as asset lives, can materially impact our results of operations.

Accounts receivable: Accounts receivable are stated at fair value, based on the gross contractual amounts receivable. We have collected substantially all of the accounts receivable as of the acquisition date.

Identifiable intangible assets: The following table is a summary of the fair value estimates of the identifiable intangible assets and their weighted-average useful lives:

	Estimated Fair Value (In thousands)	Weighted Average Useful Life (Years)
Customer relationships	$ 24,550	5.3
Contract backlog	23,600	2.4
	$ 48,150	

Accumulated amortization totaled approximately $11.7 million as of December 31, 2010, which reflects total amortization recorded since the acquisition date. For identifiable intangible assets recorded as of December 31, 2010, we expect to record amortization in future years as follows — 2011: $13.2 million, 2012: $7.6 million, 2013: $7.6 million, 2014: $5.6 million, and 2015: $0.8 million.

Goodwill: Goodwill in the amount of $72.4 million was recognized for this acquisition, all of which is expected to be deductible for tax purposes. The total goodwill amount was calculated as the excess of the consideration transferred over the net assets recognized and represents the future economic benefits arising from

other assets acquired that could not be individually identified and separately recognized. The goodwill recorded as part of the acquisition of Molina Medicaid Solutions includes:

- Expected synergies and other benefits that we believe will result from combining the operations of Molina Medicaid Solutions with the operations of Molina;
- Any intangible assets that do not qualify for separate recognition such as the assembled workforce; and
- The value of the going-concern element of Molina Medicaid Solutions' existing businesses (the higher rate of return on the assembled collection of net assets versus acquiring all of the net assets separately).

Accounts payable and accrued liabilities: Accounts payable and accrued liabilities include $1.3 million payable to the seller of Molina Medicaid Solutions, which represented a working capital adjustment provided in the purchase agreement. This working capital adjustment was paid to the seller in August 2010. The working capital adjustment provided that the net working capital, or current assets minus current liabilities, on Molina Medicaid Solutions' opening balance sheet would equal $10 million. To the extent the final net working capital conveyed by the seller exceeded $10 million, the amount would be payable back to the seller; conversely, to the extent that net working capital conveyed by the seller was less than $10 million, the shortage would be a receivable from the seller. Thus, the $1.3 million amount described above represented the amount payable to the seller for net working capital in excess of $10 million on the opening balance sheet.

Pro-forma impact of the acquisition: The unaudited pro-forma results presented below include the effects of the acquisition as if it had been consummated as of January 1, 2010, 2009 and 2008. The pro-forma results include the amortization associated with the acquired intangible assets and interest expense associated with debt used to fund the acquisition. To better reflect the combined operating results, material non-recurring charges directly attributable to the transaction have been excluded. In addition, the pro-forma results do not include any anticipated synergies or other expected benefits of the acquisition. Accordingly, the unaudited pro forma financial information below is not necessarily indicative of either future results of operations or results that might have been achieved had the acquisition been consummated as of January 1, 2010, January 1, 2009, or January 1, 2008.

	Year Ended December 31,		
	2010	2009	2008
Revenue	$4,124,058	$3,767,888	$3,202,581
Net income	$ 57,800	$ 26,192	$ 54,228
Diluted earnings per share	$ 2.08	$ 1.01	$ 1.95

Florida Health Plan

On December 31, 2009, we acquired 100% of the voting equity interests in Florida NetPASS, LLC, or NetPASS. The final purchase price for this acquisition totaled $29.6 million. As of the final membership reconciliation in the second quarter of 2010, we transitioned approximately 49,600 members from NetPASS to our Florida health plan, and have recorded $18.0 million in goodwill, and $11.6 million in intangible assets relating to these members.

On April 15, 2010, the former owners of NetPASS filed suit in federal court stating that we had not paid $12 million of the purchase price that was owed and based on a formula in the purchase agreement. Because the purchase agreement contained an arbitration clause, the Florida health plan filed a demand for arbitration seeking a declaration that the full purchase price had been paid and the purchase agreement had been fulfilled. The former owners of NetPASS filed a counter-demand for an additional $10 million and seeking a declaration regarding the anti-competition clause in the purchase agreement. The parties have exchanged documents and will start to take depositions. Arbitration is scheduled to commence June 10, 2011. We continue to believe that their claims do not have any merit and that we will prevail in this action.

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

As described in Note 12, "Long-Term Debt," the carrying amount of the convertible senior notes was $164.0 million, and $158.9 million as of December 31, 2010, and 2009, respectively. Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was approximately $188.4 million, and $160.8 million as of December 31, 2010, and 2009, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of December 31, 2010, we held certain assets that are required to be measured at fair value on a recurring basis. These included investments as follows:

Balance Sheet Classification	
Current assets:	
Investments	Investment-grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1). See Note 6, "Investments," for further information regarding fair value.
Non-current assets:	
Investments	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).

As of December 31, 2010, $24.6 million par value (fair value of $20.4 million) of our investments consisted of auction rate securities, all of which were collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of December 31, 2010. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, 2009, and continued to be unavailable as of December 31, 2010. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of December 31, 2010. For our investments in auction rate securities, we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost.

As of December 31, 2010, all of our auction rate securities were designated as available-for-sale securities. As a result of the decrease in fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized losses of $0.2 million to accumulated other comprehensive loss for the year ended December 31, 2010. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to

accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Until July 2, 2010, we held certain auction rate securities (designated as trading securities) with an investment securities firm. In the fourth quarter of 2008, we entered into a rights agreement with this firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. On June 30, 2010, and July 1, 2010, all of the eligible auction rate securities remaining at that time were settled at par value.

During 2010, the aggregate auction rate securities (designated as trading securities) settled amounted to $40.9 par value (fair value $36.7 million). For the years ended December 31, 2010, 2009, and 2008, we recorded pretax gains (losses) of $4.2 million, $3.4 million, and ($0.4) million, respectively, on the auction rate securities underlying the Rights.

We accounted for the Rights as a freestanding financial instrument and, until July 2, 2010, recorded the value of the Rights under the fair value option. When the remaining eligible auction rate securities were sold at par value on July 1, 2010, the value of the Rights was zero. For the years ended December 31, 2010, 2009, and 2008, we recorded pretax (losses) gains of ($3.8) million, ($3.1) million and $6.9 million, respectively, on the Rights.

Our assets measured at fair value on a recurring basis at December 31, 2010, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
		(In thousands)		
Corporate debt securities	$177,929	$177,929	$ —	$ —
Government-sponsored enterprise securities	59,713	59,713	—	—
Municipal securities	30,563	30,563	—	—
U.S. treasury notes	23,918	23,918	—	—
Certificates of deposit	3,252	3,252	—	—
Auction rate securities (available-for-sale)	20,449	—	—	20,449
	$ 315,824	$295,375	$ —	$20,449

The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2009	$ 63,494
Total gains (realized or unrealized):	
Included in earnings:	
Gain on auction rate securities designated as trading securities	4,170
Loss on change in fair value of Rights	(3,807)
Included in other comprehensive income	(208)
Settlements	(43,200)
Balance at December 31, 2010	$ 20,449
The amount of total losses for the period included in other comprehensive income attributable to the change in unrealized gains relating to assets still held at December 31, 2010	$ (208)

As described in Note 4, "Business Combinations," we have recorded a $2.8 million liability for contingent consideration related to the acquisition of our Wisconsin health plan. We have estimated the fair value of this liability based on our expectations regarding the Wisconsin health plan's statutory net worth as of January 31, 2011 as well as the Wisconsin health plan's minimum required statutory net worth as of that date. The liability for contingent consideration related to this acquisition was measured at fair value on a recurring basis using significant unobservable inputs (Level 3). The following table presents a roll forward of this liability for 2010:

	(Level 3) (In thousands)
Balance at December 31, 2009	$ —
Addition through acquisition — 2010	2,800
Balance at December 31, 2010	$ 2,800

6. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2010			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$179,124	$ 193	$ 1,388	$177,929
Government-sponsored enterprise securities (GSEs)	59,790	293	370	59,713
Municipal securities (including non-current auction rate securities)	55,247	78	4,313	51,012
U.S. treasury notes	23,864	114	60	23,918
Certificates of deposit	3,252	—	—	3,252
	$321,277	$678	$6,131	$ 315,824

	December 31, 2009			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Corporate debt securities	$ 32,543	$ 206	$ 185	$ 32,564
GSEs	89,451	504	281	89,674
Municipal securities (including non-current auction rate securities)	82,009	3,120	4,154	80,975
U.S. treasury notes	28,052	92	84	28,060
Certificates of deposit	3,258	—	—	3,258
	$235,313	$3,922	$ 4,704	$234,531

The contractual maturities of our investments as of December 31, 2010 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$168,948	$167,856
Due one year through five years	127,549	127,144
Due after five years through ten years	930	990
Due after ten years	23,850	19,834
	$ 321,277	$ 315,824

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $124.5 million, $60.3 million, and $55.3 million for the years ended December 31, 2010, 2009 and 2008, respectively. Net realized investment gains for the years ended December 31, 2010, 2009 and 2008 were $110,000, $267,000, and $342,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at December 31, 2010 and 2009 are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we do not intend to sell these securities prior to maturity, we are unlikely to experience gains or losses. In the unlikely event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Approximately 40% of our investment in municipal securities consists of auction rate securities. As described in Note 5, “Fair Value Measurements,” the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at December 31, 2010.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months and those that have been in a loss position for 12 months or more as of December 31, 2010.

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2010		In a Continuous Loss Position for 12 Months or More as of December 31, 2010		Total as of December 31, 2010	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
			(In thousands)			
Corporate debt securities	$ 103,225	$ 1,060	$ 10,490	$ 328	$ 113,715	$ 1,388
GSEs	13,014	71	7,539	299	20,553	370
Municipal securities	18,884	117	25,271	4,196	44,155	4,313
U.S. treasury notes	5,480	40	6,806	20	12,286	60
	$ 140,603	$ 1,288	$ 50,106	$ 4,843	$ 190,709	$ 6,131

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2009. At December 31, 2009, we previously reported only those available-for-sale investments in an unrealized loss position for at least two consecutive months. To conform to the current year presentation, we have

included all available-for-sale investments in an unrealized loss position at December 31, 2009. This presentation change increased the total amount of unrealized losses reported in the following table by $113,000 at December 31, 2009. The accompanying increase to the estimated fair value of the underlying investments amounted to $42.9 million at December 31, 2009.

	In a Continuous Loss Position for Less than 12 Months as of December 31, 2009		In a Continuous Loss Position for 12 Months or More as of December 31, 2009		Total as of December 31, 2009	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
			(In thousands)			
Corporate debt securities	$ 13,513	149	$ 1,203	$ 36	$ 14,716	$ 185
GSEs	30,460	187	7,297	94	37,757	281
Municipal securities	12,460	78	24,031	3,902	36,491	3,980
U.S. treasury notes	21,824	84	—	—	21,824	84
	$ 78,257	$ 498	$ 32,531	$ 4,032	$ 110,788	$ 4,530

7. Receivables

Health Plans segment receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	December 31,	
	2010	2009
	(In thousands)	
Health Plans Segment:		
California	$ 46,482	$ 34,289
Michigan	13,596	14,977
Missouri	22,841	19,670
New Mexico	18,310	11,919
Ohio	21,622	37,004
Utah	1,589	6,107
Washington	14,486	9,910
Wisconsin	5,437	—
Other	3,598	2,778
Total Health Plans	147,961	136,654
Molina Medicaid Solutions Segment	20,229	—
	$168,190	$136,654

8. Property and Equipment

A summary of property and equipment is as follows:

	December 31,	
	2010	2009
	(In thousands)	
Land	$ 3,524	$ 3,524
Building and improvements	49,735	41,476
Furniture and equipment	60,074	54,898
Capitalized computer software costs	90,003	66,526
	203,336	166,424
Less: accumulated depreciation and amortization on building and improvements, furniture and equipment	(54,341)	(50,911)
Less: accumulated amortization for capitalized computer software costs	(48,458)	(37,342)
	(102,799)	(88,253)
Property and equipment, net	$ 100,537	$ 78,171

Depreciation expense recognized for building and improvements, and furniture and equipment was $13.9 million, $11.0 million, and $9.0 million for the years ended December 31, 2010, 2009 and 2008, respectively. Amortization expense recognized for capitalized computer software costs was $20.1 million, $14.2 million, and $11.7 million for the years ended December 31, 2010, 2009, and 2008, respectively.

9. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 11 years, for customer relationships is approximately 5 years, for backlog is approximately 2 years, and for provider networks is approximately 10 years. Based on the balances of our identifiable intangible assets as of December 31, 2010, we estimate that our intangible asset amortization will be $27.5 million in 2011, $19.0 million in 2012, $15.8 million in 2013, $12.8 million in 2014, and $7.0 million in 2015. The following table provides the details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(In thousands)	
Intangible assets:			
Contract rights and licenses (Health Plans segment)	$ 120,920	$ 64,201	$ 56,719
Customer relationships (Molina Medicaid Solutions segment)	24,550	3,418	21,132
Backlog (Molina Medicaid Solutions segment)	23,600	8,316	15,284
Provider networks (Health Plans segment)	18,622	6,257	12,365
Balance at December 31, 2010	$187,692	$ 82,192	$105,500
Intangible assets:			
Contract rights and licenses	$ 119,101	$ 51,246	$ 67,855
Provider networks	17,146	4,155	12,991
Balance at December 31, 2009	$ 136,247	$ 55,401	$ 80,846

The changes in the carrying amount of goodwill and indefinite-lived intangible assets were as follows (in thousands):

Balance as of December 31, 2009	$ 133,408
Goodwill recorded for acquisition of Molina Medicaid Solutions on May 1, 2010	72,367
Goodwill recorded for acquisition of the Wisconsin health plan on September 1, 2010	5,474
Goodwill adjustment related to the 2009 acquisition of the Florida health plan	979
Balance at December 31, 2010	$212,228

10. Restricted Investments

Pursuant to the regulations governing our health plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the carrying value of restricted investments by health plan, and by our insurance company:

	December 31,	
	2010	2009
	(In thousands)	
California	$ 372	$ 368
Florida	4,508	2,052
Insurance Company	4,689	4,686
Michigan	1,000	1,000
Missouri	508	503
New Mexico	15,881	15,497
Ohio	9,066	9,036
Texas	3,501	1,515
Utah	1,279	578
Washington	151	151
Wisconsin	260	—
Other	885	888
	$ 42,100	$ 36,274

The contractual maturities of our held-to-maturity restricted investments as of December 31, 2010 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 40,757	$ 40,792
Due one year through five years	1,218	1,216
Due after five years through ten years	125	158
	$ 42,100	$ 42,166

11. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2010 and 2009. The negative amounts displayed for "*Components of medical care costs related to: Prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	Year Ended December 31,	
	2010	2009
	(Dollars in thousands, except per-member amounts)	
Balances at beginning of year	$ 315,316	$ 292,442
Balance of acquired subsidiary	3,228	—
Components of medical care costs related to:		
Current year	3,420,235	3,227,794
Prior years	(49,378)	(51,558)
Total medical care costs	3,370,857	3,176,236
Payments for medical care costs related to:		
Current year	3,085,388	2,920,015
Prior years	249,657	233,347
Total paid	3,335,045	3,153,362
Balances at end of year	$ 354,356	$ 315,316
Benefit from prior years as a percentage of:		
Balance at beginning of year	15.7%	17.6%
Premium revenue	1.2%	1.4%
Total medical care costs	1.5%	1.6%

For the year ended December 31, 2010, we recognized a benefit from prior period claims development in the amount of $49.4 million. This amount represents our estimate as of December 31, 2010 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2009 exceeded the amount that will ultimately be paid out in satisfaction of that liability. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting and medical management initiatives had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

For the year ended December 31, 2009, we recognized a benefit from prior period claims development in the amount of $51.6 million. This amount represented our estimate as of December 31, 2009 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2008 exceeded the amount that was ultimately be paid out in satisfaction of that liability. The overestimation of the claims liability at our Michigan, New Mexico, Ohio, and Washington health plans was principally the cause of the recognition of a benefit from prior period claims development. This was partially offset by the underestimation of our claims liability at December 31, 2008 at our California health plan.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or over-estimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. In 2010 and 2009 the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations as the amount of benefit recognized in each your was roughly consistent with that recognized in the previous year.

12. Long-Term Debt

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on April 29, 2010, and the fifth amendment on April 29, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As described below and in Note 4, "Business Combinations," we borrowed $105 million under the Credit Facility to acquire Molina Medicaid Solutions in the second quarter of 2010. During the third quarter of 2010, we repaid this amount using proceeds from our equity offering, described in Note 14, "Stockholders' Equity." As of December 31, 2010, and 2009, there was no outstanding principal balance under the Credit Facility. However, as of December 31, 2010, our lenders had issued two letters of credit in the aggregate principal amount of $10.3 million in connection with the contract of MMS with the states of Maine and Idaho.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2010, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio set forth pursuant to the Credit Facility was 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.00 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.00 for the first and second quarters of 2010, and through August 14, 2010. Effective as of August 15, 2010, the consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.00. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We also paid an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through August 15, 2010.

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, so the remaining aggregate principal amount totaled $187.0 million as of December 31, 2010 (see further discussion below regarding the purchase program). The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, the conversion rate will increase in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of the Notes have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of December 31, 2010, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 45 months. The Notes' if-converted value did not exceed their principal amount as of December 31, 2010. At December 31, 2010, the equity component of the Notes, net of the

impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	December 31,	
	2010	2009
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(22,986)	(28,100)
Net carrying amount	$ 164,014	$ 158,900

	Years Ended December 31,		
	2010	2009	2008
		(In thousands)	
Interest cost recognized for the period relating to the:			
Contractual interest coupon rate of 3.75%	$ 7,012	$ 7,076	$ 7,500
Amortization of the discount on the liability component	5,114	4,782	4,707
Total interest cost recognized	$12,126	$11,858	$12,207

Securities Purchase Program. Under the $25 million securities purchase program announced in January 2009, we purchased and retired $13.0 million face amount of the Notes during the first quarter of 2009. We purchased the Notes at an average price of $74.25 per $100 principal amount, for a total of $9.8 million, including accrued interest. The gain recognized during 2009 on the purchase of the Notes was $1.5 million.

In March 2009, our board of directors authorized the purchase of up to an additional $25 million in aggregate of either our common stock or the Notes. The purchase program was funded with working capital, and common stock purchases were made from time to time on the open market or through privately negotiated transactions during 2009. The purchase program extended through December 31, 2009. See the details regarding the common stock purchases at Note 14, “Stockholders’ Equity.”

13. Income Taxes

The provision for income taxes consisted of the following:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Current:			
Federal	$36,395	$ 9,421	$32,972
State	2,144	(1,558)	1,866
Total current	38,539	7,863	34,838
Deferred:			
Federal	(4,717)	1,924	378
State	700	(2,498)	(490)
Total deferred	(4,017)	(574)	(112)
Total provision for income taxes	$ 34,522	$ 7,289	$ 34,726

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

A reconciliation of the effective income tax rate to the statutory federal income tax rate is as follows:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Taxes on income at statutory federal tax rate (35)%	$ 31,323	$13,355	$ 33,014
State income taxes, net of federal benefit	1,849	(2,637)	894
(Benefit) liability for unrecognized tax benefits	(57)	(3,315)	450
Other	1,407	(114)	368
Reported income tax expense	$34,522	$ 7,289	$34,726

Through December 31, 2009, the Company's income tax expense included both the Michigan business income tax, or BIT, and the Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, the Company has recorded the MGRT as a premium tax and not as an income tax. The Company will continue to record the BIT as an income tax. For the years ended December 31, 2009 and December 31, 2008, premium tax expense and income tax expense have been reclassified to conform to this presentation.

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California enterprise zone credits.

During 2010, 2009, and 2008, tax-related deficiencies on share-based compensation were $673,000, $718,000, and $292,000, respectively. Such amounts were recorded as adjustments to income taxes payable with a corresponding decrease to additional paid-in capital.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2010 and 2009 were as follows:

	December 31,	
	2010	2009
	(In thousands)	
Accrued expenses	$ 12,618	$ 2,494
Reserve liabilities	877	285
State taxes	(120)	1,151
Other accrued medical costs	2,126	1,628
Net operating losses	27	27
Unrealized (gains) losses	(254)	(408)
Unearned premiums	3,517	6,554
Prepaid expenses	(3,006)	(2,894)
Other, net	(69)	(80)
Deferred tax asset, net of valuation allowance — current	15,716	8,757
Accrued expenses	791	(281)
Reserve liabilities	3,071	2,501
State taxes	1,960	—
Other accrued medical costs	(358)	(866)
Net operating losses	1,362	237
Unrealized losses	1,559	1,480
Unearned premiums	(135)	(264)
Depreciation and amortization	(20,110)	(10,415)
Deferred compensation	6,829	6,817
Debt basis	(9,673)	(11,555)
Other, net	(337)	(160)
Valuation allowance	(1,194)	—
Deferred tax liability, net of valuation allowance — long term	(16,235)	(12,506)
Net deferred income tax liability	$ (519)	$ (3,749)

At December 31, 2010, we had federal and state net operating loss carryforwards of $475,000 and $28 million, respectively. The federal net operating loss begins expiring in 2018, and state net operating losses begin expiring in 2015. The utilization of the net operating losses is subject to certain limitations under federal law.

At December 31, 2010, we had California enterprise zone tax credit carryovers of $3 million which do not expire.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2010, $1.2 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state tax operating loss carryforwards. We increased our valuation allowance from zero at December 31, 2009 to $1.2 million as of December 31, 2010.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the U.S. and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These

reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Gross unrecognized tax benefits at beginning of period	$ (4,128)	$(11,676)	$ (10,278)
Increases in tax positions for prior years	(6,891)	(3,748)	(3,310)
Decreases in tax positions for prior years	—	6,804	2,682
Increases in tax positions for current year	—	—	(2,061)
Decreases in tax positions for current year	—	—	892
Settlements	—	4,355	—
Lapse in statute of limitations	57	137	399
Gross unrecognized tax benefits at end of period	$(10,962)	$ (4,128)	$(11,676)

As of December 31, 2010, we had $11.0 million of unrecognized tax benefits of which $7.8 million, if fully recognized, would affect our effective tax rate. We anticipate a decrease of $499,000 to our liability for unrecognized tax benefits within the next twelve-month period due to normal expiration of tax statutes.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2010, December 31, 2009, and December 31, 2008, we had accrued $82,000, $75,000 and $1.4 million, respectively, for the payment of interest and penalties.

We may be subject to examination by the Internal Revenue Service ("IRS") for calendar years 2007 through 2010. We are under examination, or may be subject to examination, in certain state and local jurisdictions, with the major jurisdictions being California, Missouri, and Michigan, for the years 2004 through 2010. Our subsidiary, HCLB, entered into a closing agreement with the IRS in December 2009 that successfully concluded with certainty the IRS examination of HCLB for the year ended May 2006.

14. Stockholders' Equity

In August 2010, we commenced an underwritten public offering of 4,000,000 shares of our common stock, conducted pursuant to an effective registration statement filed with the Securities and Exchange Commission on December 8, 2008. In connection with the offering, we granted the underwriters an overallotment option to purchase up to 350,000 shares, and the single selling stockholder, the Molina Siblings Trust, granted the underwriters an option to purchase up to 250,000 shares. The overallotment option was subsequently exercised in August 2010. Our chief financial officer, John Molina, is the trustee of the Molina Siblings Trust, with sole voting and investment power. Dr. J. Mario Molina, our president and chief executive officer and the brother of John Molina, is a beneficiary of the Molina Siblings Trust, as is John Molina and each of his other three siblings.

We issued 4,350,000 shares in connection with the offering, including the overallotment option. Net of the issuance costs, proceeds from the offering totaled $111.1 million, or approximately $25.55 per share, resulting in an increase to additional paid-in capital. We used the net proceeds of the offering to repay the outstanding indebtedness under the Credit Facility and for general corporate purposes. We did not receive any proceeds from the sale of shares by the selling stockholder.

In connection with the plans described in Note 16, "Stock Plans," we issued approximately 352,000 shares and 234,000 shares of common stock, net of shares retired to settle employees' income taxes, for the years ended

December 31, 2010 and 2009, respectively. This resulted in increases to additional paid-in capital of $10.6 million, and $7.8 million, both net of deferred taxes, as of December 31, 2010, and December 31, 2009, respectively.

Under the purchase program described in Note 12, "Long-Term Debt," we purchased approximately 1.4 million shares of our common stock for $27.7 million (average cost of approximately $20.49 per share) during 2009. These purchases increased diluted earnings per share for the year ended December 31, 2009 by $0.04. In 2009, we retired the $27.7 million of treasury shares purchased in 2009, and we also retired $20.4 million of treasury shares that were purchased prior to 2009 ($48.1 million in aggregate), which reduced additional paid-in capital.

15. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $5.9 million, $4.7 million and $3.9 million in the years ended December 31, 2010, 2009, and 2008, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

16. Stock Plans

In 2002, we adopted the 2002 Equity Incentive Plan (the "2002 Plan"), which provides for the award of stock options, restricted stock, performance shares, and stock bonuses to the company's officers, employees, directors, consultants, advisors, and other service providers. The 2002 Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares eligible for issuance automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors affirmatively acts to nullify the automatic increase. There were 4.4 million shares reserved for issuance under the 2002 Plan as of January 1, 2010.

Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

Under our 2002 Employee Stock Purchase Plan (the "ESPP"), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. Under the ESPP, we issued 109,800 and 120,300 shares of our common stock during the years ended December 31, 2010 and 2009, respectively. Beginning January 1, 2004, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance was reached on December 31, 2008, shares available for issuance under the ESPP automatically increased by 1% of total outstanding capital stock. The aggregate number of unissued common shares available for future grants under the 2002 Plan and the ESPP combined was 3.7 million as of December 31, 2010, and 3.8 million as of December 31, 2009.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table illustrates the components of our stock-based compensation expense that are reported in general and administrative expenses in the consolidated statements of income:

	Year Ended December 31,					
	2010		2009		2008	
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Pretax Charges	Pretax Charges	Net-of-Tax Amount
Restricted stock awards	$ 8,007	$ 5,044	$5,789	$3,589	$5,171	$ 3,206
Stock options (including expense relating to our ESPP)	1,524	960	1,696	1,052	2,640	1,637
Total	$9,531	$ 6,004	$ 7,485	$ 4,641	$7,811	$ 4,843

For both restricted stock and stock option awards, the expense is recognized over the vesting period, generally straight-line over four years. As of December 31, 2010, there was $12.5 million of unrecognized compensation cost related to unvested restricted stock awards, which we expect to recognize over a weighted-average period of 2.5 years. This unrecognized compensation cost assumes an estimated forfeiture rate of 7.8% as of December 31, 2010. Also as of December 31, 2009, there was $0.2 million of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 0.3 years.

The total fair value of restricted shares vested during the years ended December 31, 2010, 2009, and 2008 was $6.4 million, $3.2 million, and $2.5 million, respectively. Unvested restricted stock activity for the year ended December 31, 2010 was as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested balance as of December 31, 2009	687,630	$ 24.64
Granted	554,475	$ 22.95
Vested	(271,381)	$ 25.95
Forfeited	(134,975)	$ 23.26
Unvested balance as of December 31, 2010	835,749	$ 23.32

The total intrinsic value of stock options exercised during the year ended December 31, 2010 was $0.3 million. No stock options were exercised during the year ended December 31, 2009; the total intrinsic value of stock options exercised during the year ended December 31, 2008 was nominal. Stock option activity for the year ended December 31, 2010 was as follows:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value (000s)
Outstanding at December 31, 2009	650,739	$ 30.25		
Exercised	(64,662)	$ 24.16		
Forfeited	(72,463)	$ 33.24		
Outstanding at December 31, 2010	513,614	$ 30.59	4.9	$ 528
Exercisable and expected to vest at December 31, 2010	512,381	$ 30.59	4.9	$ 528
Exercisable at December 31, 2010	468,564	$ 30.47	4.7	$ 528

The following is a summary of information about stock options outstanding and exercisable at December 31, 2010:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable	Weighted-Average Exercise Price
$16.98 - $28.66	243,889	4.1	$ 26.13	243,889	$ 28.66
$29.17 - $32.58	174,950	6.0	$ 31.33	135,200	$ 31.23
$33.56 - $44.29	94,775	4.7	$ 40.71	89,475	$ 39.73
	513,614			468,564	

17. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2010, and 2009, our carrying amount for this investment totaled $4.4 million, and $4.1 million, respectively. For the years ended December 31, 2010, 2009 and 2008, we paid $22.0 million, $21.8 million, and $15.4 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Until October 2010, Pacific Hospital was owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $1.0 million, $0.7 million, and $0.2 million, for the years ended December 31, 2010, 2009 and 2008, respectively. As of October 2010, Pacific Hospital is no longer owned by Abrazos Healthcare, Inc. or any other related party to the Company.

18. Commitments and Contingencies

Leases

We lease office space, clinics, equipment, and automobiles under agreements that expire at various dates through 2018. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases consist of the following approximate amounts:

Year ending December 31,	(In thousands)
2011	$ 28,004
2012	23,794
2013	20,349
2014	17,366
2015	13,671
Thereafter	30,622
Total minimum lease payments	$ 133,806

Rental expense related to these leases amounted to $25.1 million, $20.8 million, and $17.5 million for the years ended December 31, 2010, 2009, and 2008, respectively.

Employment Agreements

In 2002 we entered into employment agreements with our Chief Executive Officer and Chief Financial Officer, which have been amended and restated as of December 31, 2009. These employment agreements had initial terms of one to three years and are subject to automatic one-year extensions thereafter. Should the executives be terminated without cause or resign for good reason before a change of control, as defined, we will pay one year's base salary and termination bonus, as defined, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for 18 months. If the executives are terminated for cause, no further payments are due under the contracts.

If termination occurs within two years following a change of control, the executives will receive two times their base salary and termination bonus, in addition to full vesting of 401(k) employer contributions and stock-based awards, and a cash sum equal in value to health and welfare benefits provided for three years.

Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. The outcome of such legal actions is inherently uncertain. Nevertheless, we believe that these actions, when finally concluded and determined, are not likely to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Professional Liability Insurance

We carry medical professional liability insurance for health care services rendered through our clinics in California, Virginia and Washington. Claims-made coverage under the policies for California and Washington is $1.0 million per occurrence with an annual aggregate limit of $3.0 million for Washington, beginning in 2010, and for California, each of the years ended December 31, 2010, 2009 and 2008. Claims-made coverage under the Virginia policy is $2.0 million per occurrence with an annual aggregate limit of $6.0 million for each of the years ended December 31, 2010 and 2009, and beginning July 1, 2008. We also carry claims-made managed care errors and omissions professional liability insurance for our health plan operations. This insurance is subject to a coverage limit of $15.0 million per occurrence and $15.0 million in the aggregate for each policy year.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $397.8 million at December 31, 2010, and $368.7 million at December 31, 2009. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of December 31, 2010, our health plans had aggregate statutory capital and surplus of approximately $416.6 million compared with the required minimum aggregate statutory capital and surplus of approximately $278.0 million. All of our HMOs were in compliance with the minimum capital requirements at December 31, 2010. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

19. Segment Reporting

Our reportable segments are consistent with how we manage the business and view the markets we serve. In the second quarter of 2010, we added a segment to our internal financial reporting structure as a result of the acquisition of Molina Medicaid Solutions described in Note 4, “Business Combinations.” We now report our financial performance based on the following two reportable segments — Health Plans and Molina Medicaid Solutions. The Health Plans segment represents our former single-segment health plan operations. The Molina Medicaid Solutions segment represents the operations of our new MMIS solutions business.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, “Significant Accounting Policies.” The cost of services shared

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment. Operating segment revenues and profitability were as follows:

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
Year ended December 31, 2010			
Premium revenue	$3,989,909	$ —	$3,989,909
Service revenue	—	89,809	89,809
Investment income	6,259	—	6,259
Total revenue	$3,996,168	$89,809	$ 4,085,977
Operating income	$ 102,392	$ 2,609	$ 105,001
Year ended December 31, 2009			
Premium revenue	$ 3,660,207	$ —	$ 3,660,207
Service revenue	—	—	—
Investment income	9,149	—	9,149
Total revenue	$3,669,356	$ —	$3,669,356
Operating income	$ 51,934	$ —	$ 51,934
Year ended December 31, 2008			
Premium revenue	$ 3,091,240	$ —	$ 3,091,240
Service revenue	—	—	—
Investment income	21,126	—	21,126
Total revenue	$ 3,112,366	$ —	$ 3,112,366
Operating income	$ 107,555	$ —	$ 107,555

Reconciliation to Income before Income Taxes

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Segment operating income	$ 105,001	$ 51,934	$107,555
Interest expense	(15,509)	(13,777)	(13,231)
Income before income taxes	$ 89,492	$ 38,157	$ 94,324

Segment Assets

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
As of December 31, 2010	$1,333,599	$175,615	$1,509,214
As of December 31, 2009	$ 1,244,035	$ —	$ 1,244,035

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

20. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2010 and 2009.

	For The Quarter Ended			
	March 31, 2010	June 30, 2010	September 30, 2010	December 31, 2010
	(In thousands)			
Premium revenue	$965,220	$976,685	$ 1,005,115	$ 1,042,889
Service revenue	—	21,054	32,271	36,484
Operating income	20,438	21,178	29,953	33,432
Income before income taxes	17,081	17,079	25,353	29,979
Net income	10,590	10,579	16,173	17,628
Net income per share(1):				
Basic	$ 0.41	$ 0.41	$ 0.58	$ 0.58
Diluted	$ 0.41	$ 0.41	$ 0.57	$ 0.58

	For The Quarter Ended			
	March 31, 2009	June 30, 2009	September 30, 2009	December 31, 2009
	(In thousands)			
Premium revenue	$857,484	$925,507	$ 914,805	$ 962,411
Service revenue	—	—	—	—
Operating income (loss)(2)	23,161	19,488	15,089	(5,804)
Income (loss) before income taxes(2)	19,746	16,265	11,810	(9,664)
Net income (loss)	12,211	14,565	8,564	(4,472)
Net income (loss) per share(1),(3):				
Basic	$ 0.46	$ 0.56	$ 0.34	$ (0.18)
Diluted	$ 0.46	$ 0.56	$ 0.33	$ (0.18)

(1) Potentially dilutive shares issuable pursuant to our 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the years ended December 31, 2010 and 2009.

(2) Effective January 1, 2010, the Company has recorded the Michigan gross receipts tax as a premium tax and not as an income tax. For each of the quarters in the year ended December 31, 2009, premium tax expense and income tax expense have been reclassified to conform to this presentation.

(3) For the quarter ended December 31, 2009, no potentially dilutive options or unvested stock awards were included in the computation of our diluted loss per share because to do so would have been anti-dilutive for that period.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

21. Condensed Financial Information of Registrant

Following are our parent company only condensed balance sheets as of December 31, 2010 and 2009, and our condensed statements of income and condensed statements of cash flows for each of the three years in the period ended December 31, 2010.

Condensed Balance Sheets

	December 31,	
	2010	2009
	(In thousands except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 57,020	$ 26,040
Investments	2,000	3,002
Income tax receivable	1,928	—
Deferred income taxes	7,006	—
Due from affiliates	19,059	19,121
Prepaid and other current assets	11,009	11,435
Total current assets	98,022	59,598
Property and equipment, net	81,445	65,067
Goodwill	58,719	45,943
Investments	6,046	16,516
Investment in subsidiaries	702,096	545,731
Advances to related parties and other assets	16,397	16,742
	$962,725	$749,597
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	$ 56,910	$ 24,577
Long-term debt	164,014	158,900
Deferred income taxes	8,425	10,769
Other long-term liabilities	14,319	12,613
Total liabilities	243,668	206,859
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized, outstanding 30,309 shares at December 31, 2010 and 25,607 shares at December 31, 2009	30	26
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	251,627	129,902
Accumulated other comprehensive loss	(2,192)	(1,812)
Retained earnings	469,592	414,622
Total stockholders' equity	719,057	542,738
	$962,725	$749,597

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Income

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Revenue:			
Management fees and other operating revenue	$ 238,883	$218,911	$190,538
Investment income	1,153	1,540	2,733
Total revenue	240,036	220,451	193,271
Expenses:			
Medical care costs	30,582	26,865	21,759
General and administrative expenses	218,834	160,792	143,709
Depreciation and amortization	27,166	25,223	18,980
Total expenses	276,582	212,880	184,448
Gain on purchase of convertible senior notes	—	1,532	—
Operating (loss) income	(36,546)	9,103	8,823
Interest expense	(15,500)	(13,770)	(13,167)
Loss before income taxes and equity in net income of subsidiaries	(52,046)	(4,667)	(4,344)
Income tax benefit	(16,936)	(3,755)	(456)
Net loss before equity in net income of subsidiaries	(35,110)	(912)	(3,888)
Equity in net income of subsidiaries	90,080	31,780	63,486
Net income	$ 54,970	$ 30,868	$ 59,598

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Condensed Statements of Cash Flows

	Year Ended December 31,		
	2010	2009	2008
		(In thousands)	
Operating activities:			
Cash provided by operating activities	$ 19,380	$ 40,551	$ 17,532
Investing activities:			
Net dividends from and capital contributions to subsidiaries	70,800	21,960	42,872
Purchases of investments	(2,019)	(3,844)	(25,515)
Sales and maturities of investments	14,083	12,669	56,833
Cash paid in business purchase transactions	(139,762)	(2,894)	(1,000)
Purchases of equipment	(40,419)	(32,245)	(33,047)
Changes in amounts due to and due from affiliates	(5,723)	(17,074)	(6,542)
Change in other assets and liabilities	829	(540)	3,170
Net cash (used in) provided by investing activities	102,211	(21,968)	36,771
Financing activities:			
Proceeds from common stock offering, net of issuance costs	111,131	—	—
Amount borrowed under credit facility	105,000	—	—
Repayment of amount borrowed under credit facility	(105,000)	—	—
Treasury stock purchases	—	(27,712)	(49,940)
Purchase of convertible senior notes	—	(9,653)	—
Payment of credit facility fees	(1,671)	—	—
Excess tax benefits from employee stock compensation	295	31	43
Proceeds from exercise of stock options and employee stock plan purchases	4,056	2,015	2,084
Net cash provided (used in) by financing activities	113,811	(35,319)	(47,813)
Net increase (decrease) in cash and cash equivalents	30,980	(16,736)	6,490
Cash and cash equivalents at beginning of year	26,040	42,776	36,286
Cash and cash equivalents at end of year	$ 57,020	$ 26,040	$ 42,776

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Notes to Condensed Financial Information of Registrant

Note A — Basis of Presentation

Molina Healthcare, Inc. (Registrant) was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The parent company-only financial statements should be read in conjunction with the consolidated financial statements and accompanying notes.

Note B — Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2010, 2009, and 2008 for these services totaled $238.5 million, $218.6 million, and $190.4 million, respectively, which are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

Note C — Capital Contribution and Dividends

During 2010, 2009, and 2008, the Registrant received dividends from its subsidiaries totaling $81.3 million, $76.7 million, and $91.5 million, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2010, 2009, and 2008, the Registrant made capital contributions to certain subsidiaries totaling $10.5 million, $54.7 million, and $48.6 million, respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D — Related Party Transactions

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because the Registrant has an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of December 31, 2010 and 2009, the Registrant's carrying amount for this investment totaled $4.4 million and $4.1 million, respectively. For the years ended December 31, 2010, 2009 and 2008, the Registrant paid $22.0 million, $21.8 million, and $15.4 million, respectively, for medical service fees to this provider.

The Registrant is a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Until October 2010, Pacific Hospital was owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $1.0 million, $0.7 million, and $0.2 million, for the years ended December 31, 2010, 2009 and 2008, respectively. As of October 2010, Pacific Hospital is no longer owned by Abrazos Healthcare, Inc. or any other related party to the Company.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosures***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures: Our management is responsible for establishing and maintaining effective internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934 (the "Exchange Act"). Our internal control over financial reporting is designed to provide reasonable assurance to our management and board of directors regarding the preparation and fair presentation of published financial statements. We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the Securities and Exchange Commission, and to process, summarize and disclose this information within the time periods specified in the rules of the Securities and Exchange Commission.

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has conducted an evaluation of the design and operation of our "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

Changes in Internal Controls: There were no changes in our internal control over financial reporting during the three months ended December 31, 2010 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2010. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework.*

Our management's evaluation did not include an assessment of the effectiveness of internal control over financial reporting at Molina Medicaid Solutions, which was acquired on May 1, 2010. The assets and net assets of Molina Medicaid Solutions at December 31, 2010 were approximately $175.6 million and $133.1 million, respectively. Total revenue and net income of Molina Medicaid Solutions included in our consolidated results of operations for the year ended December 31, 2010 were approximately $89.8 million and $1.8 million, respectively. Our management has not had sufficient time to make an assessment of this subsidiary's internal control over financial reporting.

Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2010, based on those criteria.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on page 115 of this Annual Report on Form 10-K, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2010.

Item 9B. ***Other Information***

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Molina Medicaid Solutions (acquired May 1, 2010), which is included in the 2010 consolidated financial statements of Molina Healthcare, Inc. and constituted $175.6 million and $133.1 million of total and net assets, respectively, as of December 31, 2010, and $89.8 million and $1.8 million of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of Molina Healthcare, Inc. also did not include an evaluation of the internal control over financial reporting of Molina Medicaid Solutions.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2010 and 2009, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2010 and our report dated March 8, 2011 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 8, 2011

PART III

Item 10. *Directors, Executive Officers, and Corporate Governance*

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Proposal No. 1 — Election of Three Class III Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant," and will also appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders. Such portion of the Proxy Statement is incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Corporate Governance," "Corporate Governance and Nominating Committee," "Corporate Governance Guidelines," and "Code of Business Conduct and Ethics." These portions of our Proxy Statement are incorporated herein by reference.

(d) Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Exchange Act requires our executive officers and directors, and persons who own more than 10% of a registered class of our equity securities, to file reports of ownership and changes in ownership with the SEC, and to furnish us with copies of the forms. Purchases and sales of our equity securities by such persons are published on our website at www.molinahealthcare.com. Based on our review of the copies of such reports, on our involvement in assisting our reporting persons with such filings, and on written representations from our reporting persons, we believe that, during 2010, each of our executive officers, directors, and greater than ten percent stockholders complied with all such filing requirements on a timely basis.

Item 11. *Executive Compensation*

The information which will appear in our Proxy Statement for our 2011 Annual Meeting under the captions "Compensation Committee Interlocks," "Non-Employee Director Compensation," and "Compensation Discussion and Analysis," is incorporated herein by reference. The information which will appear in our Proxy Statement under the caption "Compensation Committee Report" is not incorporated herein by reference.

Item 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

Information concerning the security ownership of certain beneficial owners and management will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Information About Stock Ownership." This portion of the Proxy Statement is incorporated herein by reference. The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning certain relationships and related transactions will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Related Party Transactions." Information concerning director independence will appear in our Proxy Statement under "Director Independence." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2011 Annual Meeting of Stockholders under "Disclosure of Auditor Fees." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. *Exhibits and Financial Statement Schedules*

(a) The consolidated financial statements and exhibits listed below are filed as part of this report.

(1) The Company's consolidated financial statements, the notes thereto and the report of the Independent Registered Public Accounting Firm are on pages 67 through 113 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm
Consolidated Balance Sheets — At December 31, 2010 and 2009
Consolidated Statements of Income — Years ended December 31, 2010, 2009, and 2008
Consolidated Statements of Stockholders' Equity — Years ended December 31, 2010, 2009, and 2008
Consolidated Statements of Cash Flows — Years ended December 31, 2010, 2009, and 2008
Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 8th day of March, 2011.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature		Date
/s/ Joseph M. Molina **Joseph M. Molina, M.D.**	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	March 8, 2011
/s/ John C. Molina **John C. Molina, J.D.**	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	March 8, 2011
/s/ Joseph W. White **Joseph W. White, CPA, MBA**	Chief Accounting Officer (Principal Accounting Officer)	March 8, 2011
/s/ Charles Z. Fedak **Charles Z. Fedak, CPA, MBA**	Director	March 8, 2011
/s/ Frank E. Murray **Frank E. Murray, M.D.**	Director	March 8, 2011
/s/ Steven Orlando **Steven Orlando, CPA (inactive)**	Director	March 8, 2011
/s/ Sally K. Richardson **Sally K. Richardson**	Director	March 8, 2011
/s/ Ronna Romney **Ronna Romney**	Director	March 8, 2011
/s/ John P. Szabo, Jr. **John P. Szabo, Jr.**	Director	March 8, 2011

The following exhibits, which are furnished with this annual report or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Annual Report on Form 10-K contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Annual Report on Form 10-K not misleading.

INDEX TO EXHIBITS

Number		
2.1	Asset Purchase Agreement between Molina Healthcare, Inc. and Unisys Corporation dated as of January 18, 2010	Filed as Exhibit 2.1. to registrant's Form 8-K filed January 19, 2010.
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.2 to registrant's Form 8-K filed February 17, 2009.
4.1	Indenture dated as of October 11, 2008	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2007.
4.2	First Supplemental Indenture dated as of October 11, 2008	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2007.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2007.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	Form of Stock Option Agreement under 2002 Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.4	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.5	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.6	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.10	Amended and Restated Employment Agreement with J. Mario Molina, M.D. dated as of December 31, 2009	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 7, 2010.

Number		
10.11	Amended and Restated Employment Agreement with John C. Molina dated as of December 31, 2009	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 7, 2010.
10.12	Amended and Restated Employment Agreement with Mark L. Andrews dated as of December 31, 2009 (terminated July 29, 2010)	Filed as Exhibit 10.3 to registrant's Form 8-K filed January 7, 2010.
10.13	Separation Agreement, General Waiver, and Release of Claims with Mark L. Andrews entered into July 29, 2010	Filed as Exhibit 10.1 to registrant's Form 8-K filed August 2, 2010.
10.14	Amended and Restated Change in Control Agreement with Terry Bayer, dated as of December 31, 2009	Filed as Exhibit 10.4 to registrant's Form 8-K filed January 7, 2010.
10.15	Amended and Restated Change in Control Agreement with James W. Howatt, M.D., dated as of December 31, 2009	Filed as Exhibit 10.5 to registrant's Form 8-K filed January 7, 2010.
10.16	Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009	Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010.
10.17	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.18	Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare, Inc., as the Borrower, certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed March 10, 2005.
10.19	First Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of October 5, 2005, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed October 13, 2005.
10.20	Second Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of November 6, 2006, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 10-Q filed November 9, 2006.
10.21	Third Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of May 25, 2008, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 31, 2008.
10.22	Fourth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of April 29, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent (date to be inserted on Fourth Amendment Effective Date)	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 19, 2010.
10.23	Fifth Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of April 29, 2010, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.22 to registrant's Form 10-K filed March 16, 2010.
10.24	Office Lease with Pacific Towers Associates for 200 Oceangate Corporate Headquarters.	Filed as Exhibit 10.34 to registrant's Form 10-K filed March 17, 2008.
10.25	Hospital Services Agreement (fee-for-service) by and between Molina Healthcare of California, a California corporation, and Pacific Hospital of Long Beach	Filed as Exhibit 10.24 to registrant's Form 10-K filed March 16, 2010.

Number		
10.26	Hospital Services Agreement (capitation) by and between Molina Healthcare of California, a California corporation, and HealthSmart Pacific, Inc., dba Pacific Hospital of Long Beach	Filed as Exhibit 10.25 to registrant's Form 10-K filed March 16, 2010.
10.27	Purchase Agreement between 200 Oceangate, LLC and Molina Center LLC dated November 30, 2010 (which terminated effective as of December 30, 2010 in accordance with its terms)	Filed herewith.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	Filed herewith.

Exhibit 10.27

200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA

PURCHASE AGREEMENT

BETWEEN

200 OCEANGATE, LLC, A DELAWARE LIMITED LIABILITY COMPANY

AND

MOLINA CENTER LLC, A DELAWARE LIMITED LIABILITY COMPANY

NOVEMBER 30, 2010

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LIST OF EXHIBITS

PURCHASE AGREEMENT

200 & 300 OCEANGATE, LONG BEACH, CALIFORNIA

THIS AGREEMENT is entered into as of the 30th day of November, 2010 ("**Contract Date**"), by and between 200 OCEANGATE, LLC, a Delaware limited liability company ("**Seller**"), and MOLINA CENTER LLC, a Delaware limited liability company (" **Buyer**").

RECITALS

Seller owns and is offering for sale the land and improvements commonly known as 200 & 300 Oceangate, Long Beach, California, and more completely described below. Buyer has offered to buy the property, and the parties are entering into this Agreement to set forth the terms and conditions of the sale to Buyer.

NOW, THEREFORE, in consideration of the foregoing and the agreements set forth below, the parties hereto agree as follows:

1. Agreement of Sale.

1.1 Seller hereby agrees to sell to Buyer and Buyer hereby agrees to purchase from Seller that certain real property (the " **Land**") with street address of 200 & 300 Oceangate, Long Beach, California, and more particularly described in attached Exhibit A, together with Seller's right, title and interest in the following, which together with the Land, shall be termed the " **Property**" herein:

(a) the approximately 461,263 square foot office project located at 200 & 300 Oceangate, Long Beach, California and all fixtures and other improvements located upon the Land (collectively, the "**Improvements**");

(b) all easements, rights of way, privileges, licenses, appurtenances and other rights and benefits of Seller belonging to or in any way related to the Land, and the Improvements, including water rights, mineral rights, air rights and development rights, if any (together with the Land and Improvements, the "**Real Property**");

(c) all fixtures, furnishings, equipment and other tangible personal property owned by Seller that are used for the operation of the Property and that are located on the Property or that are used exclusively for the operation of the Property (the " **Personal Property**");

(d) the Leases and Service Contracts (as such terms are hereinafter defined) and all security deposits held by Seller with respect to the Leases;

(e) to the extent assignable, all certificate(s) of occupancy, building or equipment permits, consents, authorizations, variances, waivers, licenses, permits, certificates

and approvals from any governmental or quasi-governmental authority necessary for the use of the Land or the Improvements (collectively, the " **Approvals**");

(f) all transferable or assignable warranties (the "**Warranties**") relating to the ownership, development, use and operation of the Land and Improvements;

(g) to the extent assignable, all of Seller's interest in all structural, soil, seismic, geologic, engineering and other reports and studies, all operating manuals for all systems, equipment and operating components of the Property, all marketing materials that are distributed or shown to potential tenants in the marketing of the Property for lease, photos and depictions, all architectural drawings, plans and specifications relating to all or any portion of the Real Property, and all intellectual property rights to the Property, including, without limitation, trade names, trademarks, service marks, logos or other source and business identifiers, trademark registrations and applications for registration used at or relating to the Real Property and any written agreement granting to Seller any right to use any trademark or trademark registration at or in connection with the Real Property (the " **Intangible Property**").

2. Purchase Price. The purchase price for the Property is Eighty-Three Million Dollars ($83,000,000.00) (" **Purchase Price**") and shall be paid in cash by Buyer at the Closing (as defined in Section 10.1 below).

3. Non-Refundable Payment and Deposit

3.1 Non-Refundable Payment. On the Contract Date, as consideration for Seller's agreement to enter into this Agreement and grant Buyer the right to conduct due diligence and terminate this Agreement on and subject to the terms of Section 7, and as a condition precedent to the effectiveness of this Agreement, Buyer shall deliver directly to Seller, by personal check, cash or wire transfer funds in the amount of One Hundred and No/100 ths Dollars ($100) (the "**Non-Refundable Payment**"). The Non-Refundable Payment shall be fully earned and retained by Seller immediately upon receipt and, notwithstanding any provisions of this Agreement to the contrary, the Non-Refundable Payment shall not be returned to Buyer in any circumstance.

3.2 Deposit; Liquidated Damages.

(a) Initial Deposit. Within one (1) business day after the Contract Date, Buyer shall deposit in an escrow (the " **Escrow**") established for the within contemplated transaction with First American Title Insurance Company, National Commercial Services, 1850 Mt. Diablo Blvd., Suite 300, Walnut Creek, California, 94596, Attention: Kitty Schlesinger, Order No. NCS-453433-CC (the "**Title Company**"), the sum of Five Hundred Thousand Dollars ($500,000) (the "**Initial Deposit**"), with instructions to the Title Company to hold the Initial Deposit in the Escrow in an interest-bearing account, with interest accruing for the benefit of Buyer. In the event the sale of the Property is consummated, the Initial Deposit and all interest earned thereon shall be applied towards the Purchase Price. If Buyer elects to terminate this Agreement pursuant to its terms or fails to notify Seller in writing that the Property is acceptable, as provided in Section 7, prior to the end of the Due Diligence Period (as defined in Section 7), the Initial Deposit and all interest thereon shall be returned to Buyer, and the parties shall be

released from all further obligations and liability under this Agreement, except for those obligations that survive the termination of this Agreement.

(b) Additional Deposit. Concurrently with, and subject to, the delivery of the Approval Notice to Buyer as provided in Section 7, Buyer shall deposit in the Escrow the additional sum of Two Million and No/100ths Dollars ($2,000,000) (the **"Additional Deposit"** and together with the Initial Deposit, the "**Deposit**"), with instructions to the Title Company to hold such Additional Deposit in the Escrow, in an interest bearing account, with interest accruing for the benefit of Buyer. In the event the sale of the Property to Buyer is consummated, the Deposit and all interest earned thereon shall be applied towards the Purchase Price.

(c) Non-Refundable Deposit. Upon the delivery by Buyer to Seller of the Approval Notice, the Deposit shall be non-refundable to Buyer except in the following events, upon the occurrence of which the Deposit and all interest thereon shall be returned to Buyer: (i) the Closing fails to occur due to a material default by Seller under this Agreement; (ii) the Closing fails to occur as a result of a failure of a condition to Closing in favor of Buyer, but only if such failure occurs other than as a result of a material default by Buyer under this Agreement; or (iii) the terms of this Agreement expressly provide for the return of the Deposit to Buyer. On the Closing Date, the Deposit and all interest earned thereon shall be applied to the Purchase Price.

(d) **Liquidated Damages. If this Agreement does not terminate pursuant to Section 7, but Buyer fails to consummate this transaction on the scheduled Closing Date (as defined in Section 10.1) due to default by Buyer and any such default continues for five (5) business days after written notice from Seller to Buyer, which written notice shall detail such default, Seller shall be entitled to the Deposit, and all interest thereon, as liquidated damages. The parties have acknowledged and agreed that Seller's damages, in the event of a default by Buyer, would be extremely difficult or impracticable to determine. Therefore, by placing their initials below, the parties acknowledge that the Deposit, and all interest thereon, has been agreed upon, after negotiation, as the parties' reasonable estimate of Seller's damages. Notwithstanding the foregoing, in no event shall Seller's ability to recover from Buyer any loss, cost, damage or expense pursuant to any indemnification or other provision of this Agreement that survives the Closing be deemed limited in any respect by this provision or by Seller's receipt of the Deposit.** The parties agree that the Deposit is not intended as a forfeiture or penalty within the meaning of California Civil Code Sections 3275 or 3369 but shall be treated as liquidated damages pursuant to California Civil Code Sections 1671, 1676 and 1677.

Seller _____ Buyer _____

This Section 3.2 is not intended to limit Seller's remedies under Sections 6, 18.6 or 18.7.

4. Documents to be Delivered to Buyer.

4.1 Due Diligence Deliveries. Seller has provided Buyer with, and Buyer acknowledges receipt of, copies of the materials and documents identified in Exhibit B attached hereto.

4.2 Title Report. Seller has also provided to Buyer, and Buyer acknowledges receipt of that certain preliminary title report for the Property prepared under Order No. NCS-453433-CC, together with a copy of each document referred to therein (collectively, the " **Preliminary Title Report**").

4.3 Property Documents. Buyer shall have the right, at Buyer's sole cost and expense and with at least one (1) business day prior notice, to review Seller's real property transaction files (excluding any privileged or confidential information and excluding any valuation and appraisal information), lease files, plans and specification files, and other files relating to the Property and its ownership, operation, management and maintenance during regular business hours, which files are located in the management office at the Property.

4.4 Leases. Seller shall deliver to Buyer copies of the existing leases, license agreements and rental agreements covering any portion of the Property, any guarantees thereof, and all amendments, modifications and supplements thereto as listed on Exhibit C hereto (each a "**Lease**" and collectively, the "**Leases**").

4.5 Tenant Estoppels.

(a) Seller shall deliver to Buyer an estoppel certificate (a " **Tenant Estoppel**"), in the form of attached Exhibit D or, if the applicable Lease provides for a different form of estoppel in the form specified in the applicable Lease, dated no earlier than thirty (30) days prior to Closing, from as many of the tenants of the Property (the "**Tenants**") from whom Seller is able to obtain such Tenant Estoppels through the exercise of Seller's diligent, good faith efforts. Seller shall, at least ten (10) days prior to the expiration of the Due Diligence Period and prior to delivery to the Tenants for execution, deliver completed forms of Tenant Estoppels to Buyer for Buyer's review and approval, provided that Seller shall not be obligated to deliver the form of Tenant Estoppel for any of the following Tenants (collectively, the "**Government Tenants**"): (A) the State of California acting by and through the Director of the Department of General Services; and (B) the United States of America, Department of Veterans Affairs. Buyer may disapprove a Tenant Estoppel only if (i) it is not in the form of Exhibit D or, if the applicable Lease provides for a different form or content of estoppel in the form or content specified in the applicable Lease, the form or content provided by the applicable Lease, or (ii) if the information set forth in the Tenant Estoppel is not consistent with the terms set forth in the applicable Lease. If Buyer has not responded as to such approval within three (3) business days of receipt of a Tenant Estoppel, Buyer shall be deemed to have approved the Tenant Estoppel in question for delivery to Tenant. Seller shall deliver completed Tenant Estoppels to Buyer as they are received by Seller. Notwithstanding the foregoing, Seller shall not be obligated to prepare or seek Tenant Estoppels with respect to the following Leases, as amended and assigned to date: (1) License Agreement, dated November 30, 2000, by and between Pacific Towers Associates and Captivate Network, Inc.; (2) Antenna Site License Agreement, dated as of November 30, 2006, by and between Seller and Direct America Satellite Services; (3) Telecommunications

License Agreement, dated July 13, 2005, by and between Seller and Rocket Internetworking, Inc.; (4) Telecommunications Access and License Agreement, dated December 21, 2009, by and between Seller and TCG Los Angeles, Inc.; (5) License Agreement, dated December 21, 2000, by and between XO Communications, Inc., and Pacific Towers Associates; and (6) UPS Drop Box Agreement, dated February 2, 2010, by and between United Parcel Service, Inc., and Seller.

(b) Estoppel Thresholds. Buyer shall have a right to terminate this Agreement upon written notice prior to the Closing Date and receive a refund of the Deposit and all interest thereon as its sole remedy if Seller fails to deliver to Buyer at least three (3) days prior to the Closing Date, Tenant Estoppels from (i) the State of California acting by and through the Director of the Department of General Services, which is the contracting party under five (5) separate Leases – State Lands Commission (two Leases), California Coastal Commission, and Department of Industrial Relations (two Leases), confirming that such Leases are in effect, that the Tenant has no default claims against Seller, that the term of the Lease is consistent with the term reflected in the Lease, and that the base monthly rent payable is consistent with the base monthly rent shown in the Lease, (ii) the United States of America, Department of Veterans Affairs confirming that the Lease is in full force and effect, the date to which the rent and other charges have been paid in advance, if any; and whether any notice of default has been issued, (iii) each of (1) AECOM Technology Corp., (2) Pacific Maritime Association, (3) Long Beach Publishing Company, Inc., and Medianews Group, Inc., and (4) J. Perez Associates, Inc. (collectively, the "**Major Non-Government Tenants in Occupancy**") in the form approved or deemed approved by Buyer pursuant to Section 4.5(a) above, and (iv) an estoppel from Crowell Weedon & Co. certifying that its Lease has not been modified or amended in writing or orally or by course of conduct, and contains the entire understanding and agreement with Seller concerning the premises under the Lease. Buyer acknowledges and agrees that if the Major Non-Government Tenants in Occupancy delete or modify one or both of sections 20 and 21 of the form Tenant Estoppel attached as Exhibit D, such deletion(s) or modification(s) shall not constitute a change in the form approved or deemed approved by Buyer. As used in this Agreement, the term "**Major Non-Government Tenants**" shall mean the Major Non-Governmental Tenants in Occupancy and Crowelll Weedon & Co.

4.6 Service Contracts. Seller has delivered to Buyer, and Buyer acknowledges receipt of, copies of the service, maintenance, management and other contracts and agreements related to the operation and management of the Property, excluding the property management agreement which will not be assigned at Closing, all of which are listed on the attached Exhibit E (the "**Service Contracts**"). If Buyer delivers the Approval Notice, Buyer shall be deemed to have agreed to assume at Closing all of the Service Contracts.

4.7 Survey. Seller shall deliver a copy of Seller's existing survey to Buyer (the " **Survey**"). Buyer may, at its sole cost and expense, cause the Survey to be updated and recertified as deemed necessary and appropriate by Buyer.

5. Title.

5.1 Title Commitment. Buyer shall be responsible for obtaining, no later than the end of the Due Diligence Period, a commitment from the Title Company to issue at Closing a policy

of title insurance in a form acceptable to Buyer, which is not conditioned on the performance by any party or third party of any actions other than the express obligations of the parties under this Agreement (the "**Commitment**"). Seller will provide, at Closing, an affidavit to the Title Company in the form attached hereto as Exhibit J. Buyer shall deliver the Commitment to Seller together with a letter from Buyer to Seller stating that the exceptions to title reflected in the Commitment are approved by Buyer. If Buyer does not provide Seller with the Commitment and such letter prior to the expiration of the Due Diligence Period, the title reflected in the Preliminary Title Report (or any updated title report) shall be deemed unacceptable and disapproved, this Agreement shall terminate and the Deposit, together with all interest thereon, shall be returned to Buyer. Seller shall have no duty to cure, and Buyer shall not be entitled to any offset or credit against the Purchase Price due to, any defect in the title to the Property or any condition or aspect of the Property, to which Buyer may object, except as may be agreed by Seller in writing, in its sole and absolute discretion; provided, however, that Seller shall remove, bond over, or obtain a title endorsement for any liens ("**Seller Liens**") that affect the Property and that are not liens for taxes or assessments accruing on or after the Closing and that are not created by, or the result of actions of, Buyer, Molina or any of their respective affiliates, agents, employees or contractors. Any cure that Seller has so agreed to perform or is obligated to perform shall become a condition precedent to Closing in favor of Buyer and shall be cured by the Closing Date. For purposes of this Section 5.1, a "cure" of a title exception means the elimination of such exception from title and shall not include the bonding of, or endorsement over unless such bonding is in an amount and on terms required by the Title Company for elimination of such exception from the Title Policy (as defined in Section 5.3) as reasonably determined by Buyer. If such cure is not accomplished by the Closing Date, Buyer, as its sole and exclusive remedy, may either terminate this Agreement, in which case the Deposit shall be returned to Buyer, or waive such objection and complete the Closing subject to such exception, provided that if Seller refuses to remove a Seller Lien at Closing, Buyer shall have the right to instruct the Title Company, as escrow agent, to apply a portion of the Purchase Price sufficient to discharge such Seller Lien at Closing.

5.2 Permitted Exceptions. The following shall constitute the "**Permitted Exceptions**": (a) the Title Company's standard exceptions; (b) all exceptions that are shown on the Commitment; (c) all of the Leases; and (d) all exceptions that arise after the expiration of the Due Diligence Period and prior to the Closing that are not Seller Liens and that are approved by Buyer, in writing, in its sole and absolute discretion, or are caused by Buyer or Molina, their agents, employees, contractors or representatives or result from any new survey of the Real Property or any update of any existing survey.

5.3 Title Policy. Evidence of title shall be the issuance by the Title Company at Closing of a policy of title insurance in the form of the Commitment, subject only to the Permitted Exceptions ("**Title Policy**"). Seller shall be responsible for the cost of a CLTA standard coverage policy of title insurance in the amount of the Purchase Price; Buyer shall be responsible for the incremental cost of an ALTA extended coverage policy of title insurance, the cost of any endorsements to the Title Policy and for providing any necessary surveys (other than the Survey) to the Title Company.

5.4 No Recording. Neither this Agreement nor any memorandum of this Agreement shall be recorded by, or on behalf of, Buyer in the Official Records of the County of Los Angeles. If Buyer violates the terms of this Section 5.4 by recording or attempting to record this Agreement or a memorandum thereof, such act shall not operate to bind or cloud the title to the Property, shall constitute a material breach and default by Buyer under this Agreement, and shall entitle Seller to terminate this Agreement by written notice to Buyer, which termination notice may be recorded against the Property.

6. Access.

6.1 Provided that Buyer has complied with the insurance requirements in Section 6.3 and gives Seller at least one (1) business day's prior notice (oral or written), Seller shall allow Buyer and authorized representatives of Buyer reasonable access, at reasonable times, to the Property for the purposes of satisfying Buyer with respect to the Property. In performing its examinations and inspections of the Property, Buyer shall use reasonable efforts to minimize any interference with Seller's and the Tenants' use and occupancy of the Property. Seller shall have the right at all times to have a representative of Seller accompany any of Buyer or Buyer's employees, agents, contractors, consultants, officers, directors, representatives, managers or members (collectively, **"Buyer's Agents"**) while such persons are on the Property. Buyer may conduct interviews with the Tenants, provided Buyer has given Seller no less than two (2) business days notice prior to any such interview, and provided further that Seller shall have the right to be present at all such interviews. Buyer's breach of this Section 6.1 (and all subsections) shall constitute a material breach and default by Buyer of this Agreement. All investigations and inspections shall be performed in compliance with this Section 6 and all local, state and federal laws, rules and regulations, including, without limitation, any and all permits required thereunder, which permits shall be obtained by and at the sole cost of Buyer.

(a) Buyer shall not conduct or allow any physically intrusive or destructive testing of, on or under the Property, without Seller's prior written consent, which consent may be withheld at Seller's sole and absolute discretion; provided, however, Buyer may, subject to its damage and repair obligations in this Section 6.1 and 6.2, inspect the Property for asbestos-related materials. Buyer shall provide Seller with two (2) days written notice prior to the commencement of any physically intrusive or destructive testing, accompanied by a detailed work plan describing the nature, scope, location and purpose of the proposed work. Buyer acknowledges and agrees that Seller's review of Buyer's work plan is solely for the purpose of protecting Seller's interests, and shall not be deemed to create any liability of any kind on the part of Seller in connection with such review that, for example, the work plan is adequate or appropriate for any purpose or complies with applicable legal requirements. All work and investigations shall be performed in compliance with all local, state and federal laws, rules and regulations, including, without limitation, any and all permits required thereunder, all of which shall be at the sole cost and expense of Buyer.

(b) During the performance of Buyer's investigations, Buyer shall promptly remove and properly dispose of all samples, substances and materials extracted from or generated by Buyer at the Property and, upon the completion of its investigations, shall return the Property to its original condition, including the removal of all equipment and materials used or

generated during its investigations. Buyer shall name itself as the generator on any waste manifests required to dispose of said materials and shall obtain its own waste generator identification number with respect thereto. If Buyer fails to perform or cause such restoration, and such failure shall continue for two (2) days after Buyer receives written notice from Seller demanding the cure thereof, Seller may perform or cause to be performed such restoration work, and Buyer shall reimburse Seller for all the costs and expenses thereof within two (2) days after receipt of bills therefor from Seller.

6.2 Notwithstanding anything in this Agreement to the contrary, any entry upon, inspection, or investigation of the Property by Buyer or Buyer's Agents shall be performed at the sole risk and expense of Buyer, and Buyer shall be solely and absolutely responsible for the acts or omissions of any of Buyer's Agents. Furthermore, Buyer shall protect, indemnify, defend and hold Seller, and its successors, assigns, and affiliates harmless from and against any and all losses, damages (whether general, punitive or otherwise), liabilities, claims, causes of action, judgments, costs and legal or other expenses (including, but not limited to, attorneys' fees and costs) (collectively, "**Access Claims**") suffered or incurred by any or all of such indemnified parties to the extent resulting from any act or omission of Buyer or Buyer's Agents in connection with: (i) Buyer's inspection or investigations of the Property; (ii) Buyer's entry upon the Property; (iii) any activities, studies or investigations conducted at, to, or on the Property by Buyer or Buyer's Agents; or (iv) the presence by Buyer or Buyer's Agents at or on the Property. If at any time prior to Closing, Buyer or Buyer's Agents cause any damage to the Property, Buyer shall, at its sole expense, immediately restore the Property to the same condition as existed immediately prior to the occurrence of such damage as determined by Seller in Seller's reasonable discretion. Buyer's obligations under this Section 6.2 shall survive the termination of this Agreement or the Closing, as the case may be, notwithstanding any other provisions herein to the contrary, and shall not be limited by the terms of Section 3. Buyer shall, at all times, keep the Property free and clear of any mechanics', materialmen's or design professional's claims or liens arising out of or relating to its investigations of the Property. The foregoing provisions of this Section 6.2 shall not apply to, and Buyer shall have no liability for, or obligation to protect, indemnify, defend or hold Seller (or any other person or party) harmless from or against any of the following: (i) the discovery by Buyer or any of Buyer's Agents of any Hazardous Material on, under or affecting the Property, except to the extent that Buyer and Buyer's Agents exacerbate such condition in any material respect; (ii) the discovery by Buyer or Buyer's Agents of adverse physical, environmental, economic, neighborhood or other conditions at, on, in, under, around or affecting the Property, except to the extent that Buyer and Buyer's Agents exacerbate such condition in any material respect; or (iii) events, occurrences or conditions resulting from the acts or omissions of Seller or Seller's agents or representatives, except to the extent Buyer and Buyer's Agents exacerbate such events, occurrences or condition in any material respect. Notwithstanding anything in this Section 6.2 to the contrary, Buyer shall have no duty or obligation to identify or repair any condition in, on or affecting the Property that Buyer or Buyer's Agents discover or of which they are aware that may or could be unsafe or dangerous unless and to the extent such unsafe or dangerous condition was caused by the Buyer or Buyer's Agents.

6.3 Buyer shall maintain in full force and effect during the term of this Agreement, the public liability insurance covering Buyer and its activities at the Property on the terms and

with the coverages described in the ACORD Certificate of Liability Insurance attached hereto as Exhibit K, naming Seller as an additional insured under all such liability insurance.

7. Due Diligence Period. Buyer shall have until December 30, 2010, ("Due Diligence Period") to inspect and investigate the Property, including roof, plumbing, soils, electrical, sprinkler, water, sewer, mechanical, engineering, heating, ventilation and air conditioning and life safety systems, structural integrity of the Improvements, measurement of the square footage of the Land and Improvements, legal status and requirements pertaining to the Property (including applicable building codes, zoning, environmental, public health and fire safety laws), hazardous substance inspections including preparation of an environmental assessment, suitability of the Property for Buyer's purposes and all other matters of significance to Buyer. Buyer agrees to keep the results of such testing and inspections confidential, except to the extent that disclosure is required by law (in which case Buyer will notify Seller in writing prior to making any such disclosure). Buyer shall order and pay for all costs and expenses with respect to such inspections and investigations. If, in Buyer's sole and absolute discretion, Buyer desires to proceed with its acquisition of the Property, Buyer shall deliver written notice to Seller (the " **Approval Notice**"), prior to the expiration of the Due Diligence Period, stating that it approves the Property, in which case the parties shall proceed to complete the Closing (subject to the terms and conditions of this Agreement). If Buyer fails to deliver the Approval Notice prior to the expiration of the Due Diligence Period or if such Approval Notice seeks to modify any of the terms or provisions of this Agreement, Buyer will be deemed to have disapproved the Property and to have exercised its right to terminate this Agreement pursuant to this Section 7, in which case this Agreement shall automatically terminate as of the expiration of the Due Diligence Period and the Initial Deposit, together with all interest earned thereon, shall be returned to Buyer. Further, if Buyer fails to deposit the full Additional Deposit in Escrow prior to the expiration of the Due Diligence Period, regardless of whether Buyer has delivered the Approval Notice, Buyer will be deemed to have disapproved the Property and to have exercised its right to terminate this Agreement pursuant to this Section 7, in which case this Agreement shall automatically terminate as of the expiration of the Due Diligence Period and the Initial Deposit, together with all interest earned thereon, shall be returned to Buyer. Notwithstanding anything in this Agreement to the contrary, Buyer may elect, at any time prior to the expiration of the Due Diligence Period, for any reason or no reason, to terminate this Agreement, upon which termination the Deposit and all interest earned thereon shall be refunded to Buyer and the parties shall have no further obligation to each other excepts for those obligations which expressly survive such termination.

8. Acceptance of Property "As Is". ACKNOWLEDGING BUYER'S OPPORTUNITY TO INSPECT AND INVESTIGATE THE PROPERTY AS PROVIDED IN THIS AGREEMENT, BUYER AGREES TO TAKE THE PROPERTY "AS IS" WITH ALL FAULTS AND CONDITIONS THEREON, SUBJECT ONLY TO THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER SET FORTH IN THIS AGREEMENT OR THE OTHER AGREEMENTS ENTERED INTO BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE. ANY INFORMATION, REPORTS, STATEMENTS, DOCUMENTS OR RECORDS ("**DISCLOSURES**") PROVIDED OR MADE TO BUYER OR ITS CONSTITUENTS BY SELLER, ITS AGENTS, REPRESENTATIVES OR EMPLOYEES CONCERNING THE PROPERTY SHALL NOT CONSTITUTE REPRESENTATIONS OR

WARRANTIES. BUYER SHALL NOT RELY ON SUCH DISCLOSURES BUT, RATHER, BUYER SHALL RELY SOLELY ON ITS OWN INSPECTION OF THE PROPERTY AND THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT. ACCORDINGLY, BUYER'S DELIVERY OF THE APPROVAL NOTICE PURSUANT TO THE PROVISIONS OF SECTION 7 (DUE DILIGENCE PERIOD) ABOVE, SHALL CONSTITUTE BUYER'S ACKNOWLEDGMENT AND AGREEMENT TO THE FOLLOWING: (i) BUYER HAS REVIEWED, EVALUATED AND VERIFIED THE DISCLOSURES AND DOCUMENTS AND HAS CONDUCTED ALL INSPECTIONS, INVESTIGATIONS, TESTS, ANALYSES, APPRAISALS AND EVALUATIONS OF THE PROPERTY (INCLUDING FOR TOXIC OR HAZARDOUS MATERIALS, SUBSTANCES OR WASTES (DEFINED AND REGULATED AS SUCH PURSUANT TO SECTIONS 25316 AND 25501 OF THE CALIFORNIA HEALTH & SAFETY CODE, THE RESOURCE CONSERVATION AND RECOVERY ACT, THE COMPREHENSIVE ENVIRONMENTAL RESPONSE COMPENSATION AND LIABILITY ACT OF 1980, AS AMENDED (**"CERCLA"**) OR ANY SIMILAR LAWS AND ALL REGULATIONS PROMULGATED THEREUNDER)) AS BUYER CONSIDERS NECESSARY OR APPROPRIATE TO SATISFY ITSELF FULLY WITH RESPECT TO THE CONDITION AND ACCEPTABILITY OF THE PROPERTY (ALL OF SUCH INSPECTIONS, INVESTIGATIONS AND REPORTS BEING HEREIN COLLECTIVELY CALLED THE "**INVESTIGATIONS**"); (ii) SELLER HAS PERMITTED BUYER ACCESS TO THE PROPERTY AND HAS DELIVERED TO, OR MADE AVAILABLE TO, BUYER ALL OF THE MATERIALS REFERENCED IN SECTION 4 (INCLUDING THE DOCUMENTS AND MATERIALS IDENTIFIED ON EXHIBIT B) (COLLECTIVELY, THE "**DOCUMENTS**"); AND (iii) BUYER HAS COMPLETED ITS DUE DILIGENCE WITH RESPECT TO THE PROPERTY AND THE DOCUMENTS TO ITS SATISFACTION, IS THOROUGHLY FAMILIAR WITH THE PHYSICAL CONDITION OF THE PROPERTY, AND SUBJECT ONLY TO THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT OR THE OTHER AGREEMENTS ENTERED INTO BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE, IS ACQUIRING THE PROPERTY BASED EXCLUSIVELY UPON ITS OWN INVESTIGATIONS AND INSPECTIONS OF THE PROPERTY AND THE DOCUMENTS.

FURTHER, BUYER'S DELIVERY OF THE APPROVAL NOTICE PURSUANT TO THE PROVISIONS OF SECTION 7 (DUE DILIGENCE PERIOD) ABOVE, SHALL CONSTITUTE BUYER'S ACKNOWLEDGMENT AND AGREEMENT TO THE PROVISIONS OF THIS SECTION 8 AND THAT, REGARDLESS OF THE CONTENT OF ANY OF THE DOCUMENTS OR ANY STATEMENTS THAT SELLER, ITS AGENTS, EMPLOYEES, OFFICERS, CONTRACTORS, PARTNERS OR MEMBERS MAY HAVE MADE TO BUYER, ITS AGENTS, EMPLOYEES, OFFICERS, CONTRACTORS, PARTNERS OR MEMBERS PRIOR TO OR DURING THE DUE DILIGENCE PERIOD, OTHER THAN THE EXPRESS REPRESENTATIONS, WARRANTIES AND COVENANTS OF SELLER IN THIS AGREEMENT AND THE OTHER AGREEMENTS ENTERED INTO BY AND BETWEEN BUYER AND SELLER AS OF THE CLOSING DATE, SELLER HAS NOT MADE, DOES NOT MAKE AND SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS, WARRANTIES, PROMISES, COVENANTS, AGREEMENTS OR GUARANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, ORAL OR WRITTEN, PAST, PRESENT OR FUTURE, OF, AS TO,

CONCERNING OR WITH RESPECT TO: (1) THE NATURE, QUALITY OR CONDITION OF THE PROPERTY, INCLUDING, WITHOUT LIMITATION, THE WATER, SOIL AND GEOLOGY; (2) THE INCOME TO BE DERIVED FROM THE PROPERTY; (3) THE SUITABILITY OF THE PROPERTY FOR ANY AND ALL ACTIVITIES AND USES THAT BUYER MAY CONDUCT THEREON; (4) THE COMPLIANCE OF OR BY THE PROPERTY OR ITS OPERATION WITH ANY LAWS, RULES, ORDINANCES OR REGULATIONS OF ANY APPLICABLE GOVERNMENTAL AUTHORITY OR BODY; (5) THE HABITABILITY, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OF THE PROPERTY; OR (6) ANY OTHER MATTER WITH RESPECT TO THE PROPERTY. BUYER SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS REGARDING TERMITES OR WASTES, AS DEFINED BY THE U.S. ENVIRONMENTAL PROTECTION AGENCY REGULATIONS AT 40 C.F.R., OR ANY HAZARDOUS SUBSTANCE, AS DEFINED BY CERCLA AND REGULATIONS PROMULGATED THEREUNDER.

EXCEPT WITH RESPECT TO HAZARDOUS MATERIALS THAT WERE DISCHARGED, RELEASED OR DISPOSED BY SELLER OR ITS MEMBERS, MANAGERS, PARTNERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES AND REPRESENTATIVES IN VIOLATION OF APPLICABLE ENVIRONMENTAL LAWS AS OF THE DATE OF SUCH DISCHARGE, DISPOSAL OR RELEASE, BUYER, ITS SUCCESSORS AND ASSIGNS, HEREBY WAIVE, RELEASE AND AGREE NOT TO MAKE ANY CLAIM OR BRING ANY COST RECOVERY ACTION OR CLAIM FOR CONTRIBUTION OR OTHER ACTION OR CLAIM AGAINST SELLER (COLLECTIVELY OR INDIVIDUALLY) OR ITS RELATED ENTITIES, AND ITS AND THEIR MEMBERS, MANAGERS, PARTNERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, HEIRS AND ASSIGNS (COLLECTIVELY, '**SELLER AND ITS AFFILIATES**") BASED ON, (x) ANY FEDERAL, STATE, OR LOCAL ENVIRONMENTAL OR HEALTH AND SAFETY LAW OR REGULATION, INCLUDING CERCLA OR ANY STATE EQUIVALENT, OR ANY SIMILAR LAW NOW EXISTING OR HEREAFTER ENACTED; (y) ANY DISCHARGE, DISPOSAL, RELEASE, OR ESCAPE OF ANY CHEMICAL, OR ANY MATERIAL WHATSOEVER, ON, AT, TO, OR FROM THE PROPERTY; OR (z) ANY CONDITIONS WHATSOEVER ON, IN, UNDER, OR IN THE VICINITY OF THE PROPERTY. EXCEPT WITH RESPECT TO ANY CLAIMS ARISING OUT OF ANY BREACH OF COVENANTS, REPRESENTATIONS OR WARRANTIES EXPRESSLY SET FORTH IN THIS AGREEMENT OR THE DOCUMENTS EXECUTED IN CONNECTION WITH THIS AGREEMENT, BUYER, ON BEHALF OF ITSELF AND ITS PARTNERS, MEMBERS, MANAGERS, DIRECTORS, OFFICERS, SHAREHOLDERS, TRUSTEES, BENEFICIARIES, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS, HEIRS AND ASSIGNS HEREBY RELEASES, SELLER AND ITS AFFILIATES, FROM ANY AND ALL CLAIMS OF ANY KIND WHATSOEVER, KNOWN OR UNKNOWN, WITH RESPECT TO ANY ASPECT OF THE PROPERTY, INCLUDING THE FOREGOING MATTERS, AND SPECIFICALLY WAIVES WITH RESPECT TO ALL SUCH MATTERS THE PROVISIONS OF CALIFORNIA CIVIL CODE SECTION 1542, AND ANY COMPARABLE LAW APPLICABLE IN THE STATE WHERE THE PROPERTY IS LOCATED, REGARDING THE MATTERS COVERED BY A GENERAL RELEASE, WHICH PROVIDES AS FOLLOWS:

"A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

BUYER AND SELLER REPRESENT AND ACKNOWLEDGE THAT THIS SECTION 8 WAS EXPLICITLY NEGOTIATED AND BARGAINED FOR AS A MATERIAL PART OF BUYER'S CONSIDERATION BEING PAID. Terms appearing in this Section 8 in all capital letters that have been defined elsewhere in this Agreement shall have the meanings set forth in such definitions.

9. Conditions to Closing.

9.1 Buyer's Conditions to Closing. Buyer's obligation to purchase the Property is conditioned upon the satisfaction of each of the following conditions each of which is for the exclusive benefit of Buyer. Buyer may, at any time or times before the Closing, waive one or more of the following conditions, but only in writing and any such waiver will not affect its rights and remedies with respect to the remaining conditions:

(a) Buyer shall have received the requisite Tenant Estoppels as and when required under Section 4.5(b). If Buyer has not received the requisite Tenant Estoppels at least six (6) business days prior to the Closing Date, Buyer shall have the one-time right to extend the Closing Date by an additional two (2) business days by delivering written notice of Buyer's exercise of such right to Seller no later than the date five (5) business days prior to the Closing Date. If Buyer timely exercises such right, the Closing Date shall be extended by two (2) business days.

(b) The Rent Roll and Delinquency Report (as defined in Sections 11.1(h) and 11.1(i) below) shall have been updated to a date not earlier than three (3) business days prior to the Closing Date, and such updated Rent Roll and Delinquency Report shall not identify any material adverse change (with a change being deemed to be material and adverse only if the change would expose Buyer to damages or a loss of income in excess of Thirty-Five Thousand and No/100ths Dollars ($35,000)) in the aggregate as to all Leases with the Government Tenants and Major Non-Governmental Tenants as compared to the status of such Leases as shown on the Rent Roll and Delinquency Report delivered to Buyer two (2) business days prior to the expiration of the Due Diligence Period pursuant to Sections 11.1(h) and 11.1(i) below;

(c) No Government Tenant or Major Non-Government Tenant shall have notified Seller or Buyer of any material adverse change in its Tenant Estoppel (with a change being deemed to be material and adverse only if the change would expose Buyer to damages or a loss of income in excess of Thirty-Five Thousand and No/100ths Dollars ($35,000) in the aggregate as to all such Tenant Estoppels); no proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against any of the Major Non-Government Tenants that have not been terminated; no general assignment for the benefit of creditors has

been made by any of the Major Non-Government Tenants; and no trustee or receiver of any of the Major Non-Government Tenants' property has been appointed;

(d) Seller's performance of all its obligations hereunder;

(e) The truth, completeness and accuracy, in all material respects, of each representation and warranty made by Seller as of the Contract Date and the Closing; and

(f) The issuance at Closing of the Title Policy.

(g) Delivery of the fully executed amendments (the "**State Lease Amendments**") to each of the Leases with the State of California, acting by and through the Director of the Department of General Services, extending the term of such Leases, with such extension term commencing on the date the amendments are executed, for an additional eight (8) years (Buyer acknowledging that after the 53 rd month of such extension term the State will have an ongoing termination right exercisable with thirty (30) days notice).

9.2 Seller's Conditions. Seller's obligation to sell the Property is conditioned upon the satisfaction of each of the following conditions, each of which is for the exclusive benefit of Seller. Seller may, at any time before the Closing, waive one or more of the following conditions, but only in writing and any such waiver will not affect its rights and remedies with respect to the remaining conditions:

(a) The performance by Buyer of all its obligations hereunder; and

(b) The truth, completeness and accuracy, in all material respects, of each representation and warranty made by Buyer as of the Contract Date and the Closing.

9.3 Seller Default. If, at the Closing, (i) Seller is in default of any of its obligations hereunder, or (ii) any of Seller's representations or warranties set forth in Section 11.1 are untrue, inaccurate or incorrect when given, in any material respect, or (iii) the Closing otherwise fails to occur by reason of Seller's failure or refusal to perform its obligations hereunder in a prompt and timely manner, and any such circumstance described in any of clauses (i), (ii) or (iii) continues for five (5) business days after written notice from Buyer to Seller, which written notice shall detail such default, untruth or failure, as applicable, then Buyer shall have the right, to elect, as its sole and exclusive remedy, to (a) terminate this Agreement by written notice to Seller, promptly after which (A) the Deposit and all interest earned thereon shall be returned to Buyer, and (B) Seller shall pay to Buyer any title, escrow, legal and inspection fees incurred by Buyer and any other expenses incurred by Buyer in connection with its review of the Property, and the negotiation, documentation and performance of this Agreement (including, without limitation, the fees and expenses of environmental and engineering consultants, legal and accounting fees and expenses, and other out-of-pocket third party charges related to the transactions contemplated by this Agreement and their consummation), subject to a cap of $125,000 (collectively, "**Buyer's Costs**"), in which case, the parties shall have no further rights or obligations hereunder except for obligations which expressly survive the termination of this Agreement, or (b) waive the condition and proceed to Closing, or (c) seek specific performance

of this Agreement by Seller. As a condition precedent to Buyer exercising any right it may have to bring an action for specific performance hereunder, Buyer must commence such an action within ninety (90) days after the occurrence of Seller's default. Buyer agrees that its failure to timely commence such an action for specific performance within such ninety (90) day period shall be deemed a waiver by it of its right to commence an action for specific performance as well as a waiver by it of any right it may have to file or record a notice of *lis pendens* or notice of pendency of action or similar notice against any portion of the Property. Notwithstanding the foregoing, if by Seller's affirmative acts the remedy of specific performance has been rendered unavailable to Buyer, Buyer shall have and may assert against Seller as a result of Seller's default under this Agreement, any and all rights available at law and in equity, without imposition of the limitations in this Agreement on Buyer's rights, remedies or damages.

10. Closing.

10.1 Closing Date. The consummation of the purchase and sale of the Property (the "**Closing**") shall be held at the offices of the Title Company (or at such other location as the parties may agree) on January 19, 2011 (the "**Closing Date**"). Buyer acknowledges that Seller is required to defease the existing securitized loan that is currently secured by a deed of trust on the Property (the "**Existing Loan**") in order to deliver title to the Property free and clear of the lien of such deed of trust (the "**Existing Deed of Trust**"). In connection with such defeasance, Buyer agrees to cooperate in good faith with all usual and customary requirements imposed by the master loan servicer, bond trustee and ratings agency for such defeasance transaction so long as Buyer is not required to incur any additional liability or expense in so doing. The parties acknowledge that, in light of the defeasance, the Grant Deed (as defined below) will be recorded, and the Seller's proceeds will be disbursed, one day after the Closing Date. Seller may extend the Closing Date by up to three (3) business days to accommodate such defeasance. Seller shall be solely responsible for any and all costs, fees and expenses in connection with such defeasance, and any yield maintenance or other premiums or payments required in connection with such defeasance. The defeasance of the Existing Loan shall not be a condition to Seller's obligation to close the Escrow.

10.2 Seller's Deposits Into Escrow. Seller shall deposit the following documents and items into escrow at least one (1) business day prior to the Closing Date:

(a) a duly executed and acknowledged grant deed conveying the Property and Improvements to Buyer in the form of the attached Exhibit F, together with a separate transfer tax affidavit (the "**Grant Deed**");

(b) a duly executed bill of sale and general assignment, in the form of the attached Exhibit G (the "**Assignment**"), transferring the Personal Property, Leases, Service Contracts, Approvals, Warranties and Intangible Property to Buyer;

(c) an affidavit in the form of the attached Exhibit H stating that Seller is not a "foreign person" under IRC Section 1445(f)(3);

(d) tenant notice letters for all tenants at the Property informing them of the sale of the Property and assignment of the Leases to Buyer, in the form of attached Exhibit I;

(e) a duly executed affidavit in the form required by the California Franchise Tax Board certifying that no withholding of any amount of the Purchase Price is required in connection with the Closing;

(f) Seller's share of the closing costs as described in Section 10.5 below or instructions to Title Company to deduct same from the Purchase Price;

(g) an owner's title affidavit in the form of the attached Exhibit J;

(h) the Rent Roll, updated to a date no earlier than three (3) business days prior to the Closing Date, certified by Seller as true and correct;

(i) A certification that all of the representations and warranties set forth in Section 11.1 remain true, complete and accurate, except to the extent of any exceptions to such representations and warranties identified in such certification; and

(j) such other documents as may reasonably be required to complete the Closing.

10.3 Seller's Deliveries to Buyer Outside of Escrow. Seller shall deliver to Buyer at the Property (except as otherwise provided below) on or before the Closing Date, all of the following:

(a) originals, to the extent in Seller's possession or control, or copies of the Leases and the Service Contracts, which copies are certified by Seller as true and correct;

(b) the original Estoppel Certificates, duly executed by the Tenants, which shall be delivered to Buyer's counsel, James Moore of Boutin Jones Inc.;

(c) all keys and security codes to the Property;

(d) electronic or hard copies of all Documents; and

(e) originals or copies of all Lease files and Property files, including all records, instruments and correspondence related to maintenance and repair, the Tenants, the Leases, construction and alteration of the Improvements (base building and tenant improvements), and operation of the Property, to the extent such files are located at the Real Property.

10.4 Buyer's Deposits into Escrow. Buyer shall deposit the following into escrow at least one (1) business day prior to the Closing Date:

(a) the balance of the Purchase Price in immediately available funds;

(b) Buyer's share of the closing costs as described in Section 10.5. below;

(c) two original duly executed counterparts of the Assignment; and

(d) such other documents as may reasonably be required to complete the Closing.

10.5 Adjustment and Proration. All accounts receivable and all accounts payable shall be prorated between Buyer and Seller as of 12:01 a.m. on the Closing Date, on the basis of a 365-day year, with Seller entitled to all accounts receivable and responsible for all accounts payable with respect to the period prior to such date and time, and with Buyer entitled to all accounts receivable and responsible for all accounts payable with respect to the period from and after such date and time. Prior to Closing, Seller shall prepare for review, comment and agreement by Buyer a proration statement for the Property, and each party shall be credited or charged at the Closing, in accordance with the following:

(a) Accounts Receivable. Seller shall account to Buyer for any Rents actually collected by Seller for the month in which the Closing occurs, and Buyer shall be credited for its pro rata share applicable to the period from and after the Closing Date. For purposes of this Agreement, the term " **Rents**" means and includes Fixed Rents and Additional Rents; "**Fixed Rents**" means the periodic fixed rent payable by a Tenant under its Lease; and "**Additional Rents**" means all amounts, other than Fixed Rents, due from any Tenant under any Lease, including without limitation, percentage rents, escalation charges for real estate taxes, parking charges, marketing fund charges, reimbursement of operating expenses or common area expenses, maintenance escalation rents or charges, cost of living increases or other charges of a similar nature, if any, and any additional charges and expenses payable under any Lease.

(b) Accounts Payable. For purposes of this Agreement, the term "**Expenses**" means all operating expenses normal to the operation and maintenance of the Property, including without limitation real property taxes and assessments, current installments of any improvement bonds or assessments which are a lien on the Property or which are pending and may become a lien on the Property, water, sewer and utility charges, amounts payable under any Service Contract for any period in which the Closing occurs, permits, licenses and inspection fees. Expenses shall not include expenses which are of a capital nature.

(i) Prepaid Expenses. To the extent Expenses have been paid prior to the Closing Date for any part of the period on or after the Closing Date, Seller shall account to Buyer for such prepaid Expenses, and Seller shall be credited for the amount of such prepaid expenses applicable to the period after the Closing Date.

(ii) Unpaid Expenses. To the extent Expenses relating to the period prior to the Closing Date are unpaid as of the Closing Date but are ascertainable, Buyer shall be credited for Seller's pro rata share of such Expenses for the period prior to the Closing Date.

(iii) Service Contracts. Payments due under any Service Contracts shall be prorated as of the Closing Date, and Buyer shall be liable for all payments accruing

thereunder after the Closing. Seller shall be responsible for all payments under all contracts and agreements not assumed by Buyer

(c) Property Taxes. Seller shall be responsible for all real and personal property ad valorem taxes and special assessments applicable to the period prior to the Closing Date; Buyer shall be responsible for all real and personal property ad valorem taxes and special assessments applicable to the period from and after the Closing Date. With respect to any property tax appeal or reassessment filed by Seller for the current tax year or tax years (or portions thereof) prior to the Closing, Seller shall be entitled to the full amount of any refund or rebate resulting therefrom applicable to the period before the Closing Date, except to the extent such amounts are payable to, or otherwise accrue to the benefit of, the Tenants pursuant to the Leases, which amounts Seller shall promptly refund to such Tenants.

(d) Utility Charges. All utility (including electricity, gas, water, sewer and telephone) charges will be prorated to the Closing Date as Expenses. All refundable utility security deposits, if any, will be retained by Seller.

(e) Government Tenants. Buyer acknowledges that the Government Tenants pay Rents in arrears. Accordingly, Seller shall receive a credit at Closing for the Rents that accrue under the Leases of the Government Tenants in the month that Closing occurs, to the extent any rents accrue under such Leases.

(f) Molina Rents and Reimbursements. If, as of the Closing Date, Seller is due any amounts from Molina under its Lease that are ascertainable, Seller shall receive a credit at Closing for such amounts. Likewise, if any amounts are due and owing from Seller to Molina at Closing, Seller shall pay such amounts to Molina at or before Closing. Any amounts that are due and owing from Seller to Molina after Closing shall be paid by Seller to Molina as and when such amounts come due, after deduction for all amounts then due and owing to Seller by Molina or Buyer.

(g) Post-Closing. If the amount of any proration cannot be determined at the Closing, the adjustments will be made between the parties as soon after Closing as possible, as follows:

(i) Non-delinquent Rents. If after the Closing either Buyer or Seller collects any non-delinquent Rents applicable to the month in which the Closing occurred (or if Seller collects any Rents applicable to any month following the month in which the Closing occurred), such Rents shall be prorated as of the Closing Date and paid to the party entitled thereto not later than five (5) business days following receipt, except to the extent such party received a credit at Closing for such Rents.

(ii) Delinquent Rents for Month in which the Closing Occurred. If after the Closing Date either Buyer or Seller receives from any Tenant Rents that were delinquent as of the Closing Date and that relate to the rental period in which the Closing occurred, then such Rents shall be applied in the following order of priority: First, to reimburse Buyer for all out-of-pocket third-party collection costs actually incurred by Buyer in collecting

such Rents; second, to satisfy such Tenant's Rent obligations relating to the period after the Closing Date; and third, to satisfy such delinquent Rent obligations relating to the period prior to the Closing Date. Buyer agrees to use commercially reasonable efforts to collect any such delinquent rents but Buyer has no obligation to institute any collection action or otherwise incur any material cost in connection therewith. Seller shall have no right to pursue or continue the collection of such delinquent Rents from any Tenant in occupancy as of the Closing Date, but Seller shall have the right to continue to prosecute any collection proceedings that were initiated prior to the Closing against any tenant no longer in occupancy as of the Closing Date. Notwithstanding the foregoing, if Molina owes any Rents for any period prior to Closing for which Seller did not receive a credit at Closing, Buyer shall pay all Rents received from Molina to Seller until such Rents owed to Seller have been paid in full.

(iii) Expenses. With respect to any invoice received by Buyer or Seller after the Closing Date for Expenses that relate to the period in which the Closing occurred, the party receiving such invoice shall give the other party written notice of such invoice, and the other party shall have thirty days to review and approve the accuracy of any such invoice. If the parties agree that the Invoice is accurate and should be paid, the parties shall compute each party's pro rata share, and deliver a check for that amount in favor of the vendor.

(h) Survival of Obligations. The obligations of Seller and Buyer under this Section 10.5 shall survive the Closing.

10.6 Items Not to be Prorated. There shall be no prorations or adjustments of any kind with respect to:

(a) Insurance Premiums. Insurance Premiums shall not be prorated. Seller will terminate its coverages as of the Closing Date, and Buyer shall be responsible for obtaining its own coverages as of the Closing Date.

(b) Delinquent Fixed Rents for Full Months Prior to the Month in which the Closing Occurred . Delinquent Fixed Rents with respect to Tenants under the Leases applicable to months prior to the calendar month in which the Closing occurred shall remain the property of Seller, and Buyer shall have no claim thereto whether collected by Seller or Buyer, before or after the Closing, and no responsibility of any kind with respect thereto except as specifically set forth herein. Seller shall not take or continue to take collection measures from or after the Closing. Buyer agrees to use commercially reasonable efforts to collect any delinquent Fixed Rents owed Seller, but Buyer has no obligation to institute any collection action or otherwise incur any material costs in connection therewith. Except with respect to the Rents collected from Molina, Fixed Rents collected from Tenants after the Closing Date shall be applied in the following order of priority: First, to reimburse Buyer for all out-of-pocket third-party collection costs actually incurred by Buyer in collecting such Rents; second, to satisfy such Tenant's Rent obligations relating to the period after the Closing Date; and third, to satisfy such delinquent Rent obligations relating to periods prior to the Closing Date. In the event that Buyer collects any such delinquent Fixed Rents, Buyer shall apply such Fixed Rents as contemplated above and shall promptly pay over to Seller any amounts properly owed to Seller.

(c) Additional Rents Relating to Full or Partial Months Prior to the Closing Date . If Additional Rents relating to full or partial months prior to the Closing Date are not finally adjusted between Seller and any Tenant until after the Closing Date, then any refund to which any Tenant may be entitled shall be the obligation of Seller, and any additional amounts due from the Tenant for such period shall be the property of Seller. Buyer shall have no obligation with respect to any such refund due to any Tenant and no claim to any such amounts due from any Tenant, except that Buyer shall promptly pay to Seller any such delinquent Additional Rent amounts as it actually collects. If Seller receives any refund of expenses paid prior to the Closing and relating to a period prior to the Closing, and such expenses were reimbursed in whole or in part by any Tenant, Seller shall refund to each Tenant its share of any such refund. Buyer agrees to use commercially reasonable efforts to collect any such Additional Rents but Buyer has no obligation to institute any collection action or otherwise incur any material cost in connection therewith.

(d) Security Deposits. Seller shall deliver to Buyer (or credit to Buyer at Closing) all prepaid rents, security deposits, letters of credit and other collateral actually held by Seller or any of its affiliates or successors in interest under any of the Leases, to the extent not applied by Seller prior to the Closing Date to the extent permitted under the Leases. From and after the Contract Date, Seller shall not apply any security deposits without the Buyer's prior written consent.

(e) Survival. The terms of Section 10.6 shall survive the Closing.

10.7 Closing Costs. The Closing costs for this transaction shall be paid as follows:

(a) Seller shall pay (i) any brokerage fees to the Selling Broker as required under Section 18.7 below; (ii) one-half of all transfer and sales taxes (including documentary transfer taxes); (iii) all costs, expenses and fees related to the defeasance of the Existing Loan; (iv) the cost of the Title Policy, up to but not to exceed an amount equal to the cost of owner's standard CLTA coverage title insurance in the amount of the Purchase Price; (v) one-half of the escrow fees; and (vi) all other costs and expenses allocated to Seller pursuant to this Agreement.

(b) Buyer shall pay (i) any brokerage fees to the Buying Broker as required under Section 18.7 below; (ii) one half of all transfer and sales taxes (including documentary transfer taxes); (iii) the increased cost of the Title Policy associated with ALTA extended coverage and endorsements requested by Buyer (except for "gap" coverage); (iv) all recording fees (other than in connection with any documents recorded in connection with the defeasance of the Existing Loan); (v) one-half of the escrow fees; and (vi) all other costs and expenses allocated to Buyer pursuant to this Agreement.

(c) All other costs shall be paid in accordance with customary practices in the County of Los Angeles.

10.8 Closing. Pursuant to Section 10.1 above, Title Company shall close the escrow for this transaction when it is in a position to issue the Title Policy and has received from Seller

and Buyer the items required of each in Sections 10.2 and 10.4 above. Title Company shall close escrow by doing the following:

(a) Recording the Grant Deed in the Official Records of the County of Los Angeles;

(b) Delivering to Buyer the Title Policy, the original documents and items listed in Section 10.2 above, and a closing statement for the escrow consistent with this Agreement and signed by Buyer and Seller (the "**Closing Statement**"), and any refund due Buyer; and

(c) Delivering to Seller the amount due Seller as shown on the Closing Statement, the original documents listed in Section 10.4 above, and a signed original of Seller's Closing Statement.

10.9 Possession. Seller shall deliver possession of the Property to Buyer on the Closing Date, subject to the rights of the Tenants under the Leases.

11. Representations and Warranties.

11.1 Representations and Warranties of Seller. Seller hereby makes the following representations and warranties to Buyer, which representations and warranties shall survive the Closing, and all of which (i) are material and are being relied upon by Buyer, and (ii) are true, complete and accurate as of the date hereof.

(a) Organization. Seller is a limited liability company, duly organized, validly existing and in good standing under the laws of the State of Delaware, and qualified to do business, and in good standing, in the State of California.

(b) Authorization. This Agreement has been duly authorized, executed, and delivered by Seller; the obligations of Seller under this Agreement are legal, valid, and binding obligations of Seller; and this Agreement does not, and at the time of Closing will not, (i) violate or conflict with the organizational documents of Seller or any member of Seller acting on Seller's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Seller, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Seller is a party or by which Seller is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Seller. All documents that are executed by Seller and that are delivered to Buyer at the Closing will be, at the time of Closing, duly authorized, executed, and delivered by Seller; the obligations of Seller under such documents will be, at the time of Closing, legal, valid, and binding obligations of Seller; and such documents will not, at the time of Closing, (i) violate or conflict with the organizational documents of Seller or any member of Seller acting on Seller's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Seller, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Seller is a party or by which Seller is bound, or

(iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Seller.

(c) Bankruptcy. No proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against Seller which have not been terminated; no general assignment for the benefit of creditors has been made by Seller; and no trustee or receiver of Seller's property has been appointed.

(d) Not a Foreign Person. Seller is not a foreign person within the meaning of section 1445(f)(3) of the Internal Revenue Code of 1986. Seller has read and understands the provisions of sections 18662 and 18668 of the California Revenue and Tax Code (the " **Act**") and has a "permanent place of business" within California within the meaning of the Act and the regulations and guidelines of the California Franchise Tax Board promulgated from time to time pursuant thereto.

(e) Litigation. Except as disclosed in writing to Buyer, no litigation or proceeding is pending or, to Seller's knowledge, threatened that affects the Property or Seller's ability to consummate the transactions contemplated by this Agreement.

(f) Violations. Except as disclosed in writing to Buyer, Seller has not received any written notice of any violation by the Property of any applicable rule, regulation, ordinance or government directive from any administrative or governmental authority that has not been cured.

(g) Leases; Landlord Defaults. There are no leases, rental agreements, license agreements or occupancy rights affecting the Property other than those listed on Exhibit C and any matters of record. Seller has not received any written notice of a default by Seller from any Tenant under any of the Leases that has not been cured, other than as set forth in the Tenant Estoppels.

(h) Rent Roll. Exhibit C contains a complete and correct list of all existing Leases, setting forth with respect to each Lease, the following minimum information (the "**Rent Roll**"): the name of the Tenant, the number of the room or suite occupied by the Tenant, the square footage of the space, the commencement and expiration dates, the amount of the monthly base rent payment, the current monthly additional rent payment for the Tenant share of Real Property expenses and taxes, the amount of any security deposit or prepaid rent, and the amount and due date of any payments due Tenants in the future as reimbursement for costs of tenant improvements. Seller shall deliver an updated Rent Roll to Buyer two (2) business days prior to the expiration of the Due Diligence Period, which shall be accurate as of the date set forth on the updated Rent Roll (which date shall not be more than three (3) business days prior to the date the updated Rent Roll is delivered to Buyer). Seller shall deliver a further updated Rent Roll to Buyer three (3) business days prior to the Closing Date, which shall be accurate as of the date set forth on the updated Rent Roll (which date shall not be more than three (3) business days prior to the date the updated Rent Roll is delivered to Buyer).

(i) Delinquency Report. With the exception of delinquencies in the payment of rents which are set forth on the Rent Roll, Seller has not delivered written notice to any Tenant of any default in the payment of rent under its Lease that has not been cured. Exhibit C contains a true and correct report (the "**Delinquency Report**") showing the name of each Tenant as to which a delinquency currently exists as to the payment of Rents and specifying the amount of each such delinquency, and the period of time during which each such delinquency has been outstanding. Seller shall deliver an updated Delinquency Report to Buyer two (2) business days prior to the expiration of the Due Diligence Period, which shall be accurate as of the date set forth on the updated Delinquency Report (which date shall not be more than three (3) business days prior to the date the updated Delinquency Report is delivered to Buyer). Seller shall deliver a further updated Delinquency Report to Buyer three (3) business days prior to the Closing Date, which shall be accurate as of the date set forth on the updated Delinquency Report (which date shall not be more than three (3) business days prior to the date the updated Delinquency Report is delivered to Buyer).

(j) Leases. The Documents contain a true, correct and complete copy of each Lease. Each such Lease constitutes the entire agreement between Seller and each other party thereto. As of the Closing Date, no rents due under, or any other interest in, any of the Leases will be assigned to any party other than Buyer, or otherwise pledged or encumbered in any way.

(k) Tenant Improvements; Lease Costs. Except as set forth in Exhibit C, all of the improvements to be constructed by Seller under each of the Leases, have been fully completed and paid for. Except as set forth in Exhibit C, Seller has paid, in full, any leasing commissions, except for future contingent obligations set forth in the Rent Roll.

(l) Service Contracts. Exhibit E contains a true and complete list of all Service Contracts. The Documents include true and complete copies of all Service Contracts. To Seller's knowledge, there have been no material defaults by any Party to a Service Contract which have not been cured. To Seller's knowledge, Seller is not in breach or default under any Service Contract which has not been cured. The Service Contracts constitute the entire agreement between Seller and the other parties to the Service Contracts.

(m) Insurance. Exhibit L correctly identifies the policies of casualty and liability insurance currently in effect with respect to the Property. All premiums for such insurance have been paid in full. Seller has not received any notice or request from any insurance company or Board of Fire Underwriters (or organization exercising functions similar thereto) canceling or threatening to cancel any of said policies or denying or disputing coverage thereunder.

(n) Commission Agreements. Except as expressly set forth in the Leases or on Exhibit C, there are no lease brokerage agreements, leasing commission agreements or other agreements providing for payments of any amounts for leasing activities or procuring tenants with respect to the Property, other than such commissions as may be due on future lease renewals, expansions or extensions.

(o) Environmental Releases. To Seller's knowledge, no Hazardous Materials have been discharged, released or disposed of by Seller or its members, managers, partners, directors, officers, shareholders, trustees, beneficiaries, agents, employees and representatives in violation of applicable Environmental Laws as of the date of such discharge, disposal or release As used herein, the term "Hazardous Materials" means without regard to amount and/or concentration any hazardous or toxic substance, material or waste wherever located expressly including but not limited to petroleum and petroleum derived compounds, which is included within the definition of any hazardous or toxic material, substance or waste in any federal, state or local statutes, laws, ordinances or regulations applicable to the Property, as well as any soils, ground or surface waters, wetlands or other environmental media which may be contaminated by such Hazardous Material, including the following: (a) those substances defined as a hazardous substance, hazardous waste, hazardous material, toxic substance, solid waste, pollutant or contaminant under any Environmental Law, as defined below; (b) those substances listed in the United States Department of Transportation Table [49 CFR § 172.101], or by the Environmental Protection Agency, or any successor agency, as hazardous substances [40 CFR Part 302]; (c) other substances, materials, and wastes that are regulated or classified as hazardous or toxic under federal, state or local laws or regulations applicable to the Property; and (d) any material, waste, or substance that is a petroleum or refined petroleum product or byproduct, asbestos, or any rock, including serpentine rock, which contains or might contain asbestos, chlorinated solvents, biologic waste, polychlorinated biphenyl, designated as a hazardous substance pursuant to 33 USCS §1321 or listed pursuant to 33 USCS §1317, a flammable explosive, or a radioactive material. As used herein, the term "Environmental Law" means all federal, state, local or municipal laws, rules, orders, regulations, statutes, ordinances, codes, decrees or requirements of any government authority applicable to the Property and regulating, relating to, or imposing liability or standards of conduct concerning any Hazardous Material, or pertaining to environmental conditions on or under the Property described in this Agreement, as now in effect, including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA) [42 USCS §§9601 et seq.]; the Resource Conservation and Recovery Act of 1976 (RCRA) [42 USCS §§6901 et seq.]; the Clean Water Act, also known as the Federal Water Pollution Control Act (FWPCA) [33 USCS §§1251 et seq.]; the Toxic Substances Control Act (TSCA) [15 USCS §§2601 et seq.]; the Hazardous Materials Transportation Act (HMTA) [49 USCS §§1801 et seq.]; the Insecticide, Fungicide, Rodenticide Act (7 USCS §§136 et seq.]; the Superfund Amendments and Reauthorization Act [42 USCS §§6901 et seq.]; the Clean Air Act [42 USCS §§7401 et seq.]; the Safe Drinking Water Act [42 USCS §§300f et seq.]; the Solid Waste Disposal Act [42 USCS §§6901 et seq.]; the Surface Mining Control and Reclamation Act [30 USCS §§1201 et seq.]; the Emergency Planning and Community Right to Know Act [42 USCS §§11001 et seq.]; the Occupational Safety and Health Act [29 USCS §§655 and 657]; the California Underground Storage of Hazardous Materials Act [Health and Safety Code §§25280 et seq.]; the California Hazardous Materials Account Act [Health and Safety Code §§25100 et seq.]; the California Safe Drinking Water and Toxic Enforcement Act [Health and Safety Code §§24249.5 et seq.]; the Porter-Cologne Water Quality Act [Water Code §§13000 et seq.], together with any amendments of or regulations promulgated under the statutes cited above, and any other federal, state or local law, statute, ordinance or regulation applicable to the Property now in effect that pertains to the regulation or protection of the environment, including ambient air, soil, soil vapor, groundwater, surface water, or land use.

For purposes of the representations and warranties given by Seller in this Agreement, the phrase "to Seller's knowledge" or other terms regarding the knowledge of Seller, shall mean the actual, current knowledge of Kennard P. Perry and Cory Kristoff, excluding constructive or imputed knowledge or duty of inquiry, existing as of the Contract Date and the Closing. In no event shall there be any personal liability on the part of any of the foregoing individuals on account of any breach of any representation or warranty of Seller herein.

11.2 Material Changes; Survival. Two (2) business days prior to the expiration of the Due Diligence Period, Seller shall deliver to Buyer a certification that all of the representations and warranties set forth in Section 11.1 remain true, complete and accurate, except to the extent of any exceptions to such representations and warranties identified in such certification. Further, if, prior to the Closing, Seller becomes aware of any fact or circumstance that would materially change a representation or warranty of Seller in this Agreement, then Seller shall promptly, and in all events at least five (5) business days prior to the Closing Date (which date shall be extended if necessary to give Buyer five business days to review such material change), give written notice of such changed fact or circumstance to Buyer. If, prior to Closing, upon Seller's notice or otherwise, Buyer becomes aware of the material untruth or inaccuracy of, or facts or circumstances that would change materially, any representation or warranty of Seller in this Agreement that was true when made by Seller, then Buyer shall have the option of: (i) waiving such breach of representation or warranty or material adverse change and completing its purchase of the Property pursuant to this Agreement; (ii) reaching agreement with Seller to adjust the terms of this Agreement to compensate Buyer for such change; or (iii) terminating this Agreement and receiving the return of the Deposit as Buyer's sole remedy prior to Closing. All of Seller's representations and warranties shall survive the Closing; provided, however, that Seller's representations and warranties set forth in Sections 11.1(d) through 11.1(i) shall survive the Closing only with respect to written claims alleging a specific breach of one or more of those representations and warranties received by Seller prior to the first anniversary of the Closing Date. Buyer shall not be entitled to any right or remedy for any inaccuracy in or breach of any representation, warranty or covenant under this Agreement or any conveyance document unless the amount of damages, in the aggregate, proximately caused by all such breaches or inaccuracies exceeds Fifty Thousand and No/100ths Dollars ($50,000). If Buyer's aggregate damages exceed Fifty Thousand and No/100ths Dollars ($50,000), Buyer shall be entitled to recover the entire first Fifty Thousand and No/100ths Dollars ($50,000) of damages suffered by Buyer. Notwithstanding anything to the contrary in this Agreement the aggregate liability of Seller under this Agreement to Buyer for any and all actions or claims by Buyer with respect to these representations and warranties that survive the Closing shall be limited to One Million Five Hundred Thousand Dollars ($1,500,000).

11.3 Representations and Warranties of Buyer. Buyer hereby makes the following representations and warranties to Seller, which representations and warranties shall survive the Closing and all of which (i) are material and are being relied upon by Seller, (ii) are true, complete and accurate in all respects as of the date hereof and shall be true, complete and accurate as of the Closing Date, and (iii) shall survive the Closing:

(a) Organization. Buyer is a limited liability company, duly organized, validly existing and in good standing under the laws of the State of Delaware, and is qualified to do business, and is in good standing, in the State of California.

(b) Authorization. This Agreement has been duly authorized, executed, and delivered by Buyer; the obligations of Buyer under this Agreement are legal, valid, and binding obligations of Buyer; and this Agreement does not, and at the time of Closing will not, (i) violate or conflict with the organizational documents of Buyer or any member of Buyer acting on Buyer's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Buyer, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Buyer is a party or by which Buyer is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Buyer. All documents that are delivered to Seller at the Closing will be, at the time of Closing, duly authorized, executed, and delivered by Buyer; the obligations of Buyer under such documents will be, at the time of Closing, legal, valid, and binding obligations of Buyer; and such documents will not, at the time of Closing, (i) violate or conflict with the organizational documents of Buyer or any member of Buyer acting on Buyer's behalf, (ii) violate or conflict with any judgment, decree, or order of any court applicable to or affecting Buyer, (iii) breach the provisions of, or constitute a default under, any contract, agreement, instrument, or obligation to which Buyer is a party or by which Buyer is bound, or (iv) violate or conflict with any law, ordinance, or governmental regulation or permit applicable to Buyer.

(c) Bankruptcy. No proceedings under any federal or state bankruptcy or insolvency laws have been commenced by or against Buyer which have not been terminated; no general assignment for the benefit of creditors has been made by Buyer; and no trustee or receiver of Buyer's property has been appointed.

12. Risk of Loss; Insurance Proceeds; Condemnation.

12.1 Damage or Destruction. In the event of damage or destruction of the Improvements that occurs prior to the Closing Date that (i) would require the expenditure of an amount less than one percent (1%) of the Purchase Price to repair, and (ii) does not permit any Government Tenant or Major Non-Government Tenant to terminate its Lease (each of the foregoing events, a "**Material Damage Event**"), Buyer and Seller shall consummate this Agreement, and Seller shall (a) assign to Buyer at Closing all rights to insurance proceeds on account of such damage or destruction, including any insurance proceeds previously received by Seller with respect to such damage or destruction, and (b) pay to Buyer the amount of the deductible or retention applicable to such damage or destruction under the insurance policy. In the event such damage or destruction results in or causes a Material Damage Event, Buyer or Seller may elect to terminate this Agreement by written notice to the other within ten (10) days after the Material Damage Event. If neither party elects to terminate this Agreement, Seller shall assign the insurance proceeds and pay the applicable deductible or retention to Buyer at Closing and Seller shall have no further responsibility to Buyer for such damage or destruction. If either party elects to terminate this Agreement, the Deposit and all interest thereon shall be refunded to Buyer and the parties shall no further obligation to each other except for those obligations which expressly survive the termination of this Agreement.

12.2 Eminent Domain. If, prior to the Closing, a taking by eminent domain of all or any portion of the Land or Improvements is pending, and such taking would (i) materially and adversely interfere with the use of the Property for its current permitted uses, (ii) materially and adversely affect ingress, egress or parking for the Property or any Tenant's access to its space, (iii) would permit the termination of any Lease by any Government Tenant or Major Non-Government Tenant, or (iv) has a value exceeding one percent (1%) of the Purchase Price (each a " **Material Taking**"), Buyer or Seller shall have the right, by delivering written notice to the other within ten (10) days after Seller delivers written notice to Buyer of such pending taking, to terminate this Agreement, in which event the Deposit and all interest thereon shall be returned to Buyer. If neither party elects to terminate this Agreement or if the taking would not result in or cause a Material Taking, then this Agreement shall remain in effect, and Seller shall assign to Buyer at Closing its rights to the compensation and damages due Seller on account of such taking (and will not settle any proceedings relating to such taking without Buyer's prior written consent) and Seller shall have no further responsibility to Buyer for such taking. Seller shall promptly (and in any event prior to the Closing) notify Buyer of any condemnation affecting the Property.

The provisions of this Section 12 shall supersede the provisions of any applicable laws with respect to the subject matter of this Section 12.

13. Assignment. Buyer may not, at any time, assign this Agreement or Buyer's rights or obligations under this Agreement, either directly or indirectly, without the prior written consent of Seller, which Seller may withhold in its sole and absolute discretion. Subject to the foregoing, this Agreement shall be binding upon, inure to the benefit of, and be enforceable by the parties hereto and their respective heirs, devisees, executors, administrators, legal representatives, successors and assigns. In connection with any approved assignment, the assignee shall assume the assignor's obligations hereunder, but assignor shall nevertheless remain liable therefor.

14. Seller's Covenants During Contract Period. Between Seller's execution of this Agreement and the Closing, or earlier termination of this Agreement as permitted hereunder, Seller shall (i) maintain the Property in good order, condition and repair, reasonable wear and tear excepted; (ii) not make any material physical changes to the Improvements; (iii) continue to manage the Property in the manner in which it is being managed; (iv) not enter into any contracts or agreements affecting the Property unless such contracts can be completed or terminated prior to the Closing or Buyer, in its sole discretion, agrees to assume such contract or agreement as of the Closing Date, in which case such contracts shall be included within the term " **Service Contracts**"; (v) not enter into any lease, amendment of lease or other agreement pertaining to the Property, or permit any tenant of the Property to enter into any sublease or assignment of lease, except as provided in Section 14.1; (vi) after the end of the Due Diligence Period, not offer the Property for sale publicly or otherwise solicit, make, pursue, negotiate or accept offers for the sale of the Property to or from any party; (viii) maintain the insurance described on Exhibit L in full force and effect, except as otherwise approved by Buyer; and (ix) not dispose of or encumber the Property or any part thereof, except for dispositions of personal property in the ordinary course of business. From and after the Contract Date, Seller shall provide Buyer with regular written updates as to the status of any leasing activity at the Property.

14.1 New Leases and Lease Amendments; Lease Expenses .

(a) If Seller desires to enter into any new lease affecting the Property (each a " **New Lease**") or any termination, amendment, modification, expansion or renewal of any existing Lease (each, a "**Lease Amendment**"), after the Contract Date but prior to Closing, Seller shall provide Buyer with a copy of the proposed New Lease or Lease Amendment and a copy of the landlord's anticipated improvement costs, tenant improvement allowances, brokerage commissions and out-of-pocket costs and expenses in connection with the New Lease or Lease Amendment for Buyer's review and approval, which approval shall not be unreasonably withheld; provided, however, Buyer shall not have the right to disapprove any New Lease or Lease Amendment prior to the expiration of the Due Diligence Period. Buyer shall advise Seller, in writing, whether Buyer approves or reasonably disapproves such proposed New Lease or Lease Amendment within three (3) business days after Buyer's receipt of the proposed New Lease or Lease Amendment; provided, however, if Buyer fails to notify Seller within such three (3) business day period, Buyer shall be deemed to have approved the proposed transaction. If after the expiration of the Due Diligence Period, Buyer reasonably disapproves of the proposed New Lease or Lease Amendment, Seller shall not enter into such New Lease or Lease Amendment. If Buyer unreasonably disapproves of the proposed New Lease or Lease Amendment, Seller shall have the full right, power and authority to execute such New Lease or Lease Amendment so long as Seller delivers to Buyer at least three (3) business days' prior written notice of such execution; provided, however, that after receipt of such notice, Buyer shall have the right to terminate this Agreement, upon written notice delivered to Seller within three (3) business days after receipt of Seller's notice of execution of such New Lease or Lease Amendment. If Buyer timely exercises such termination right, this Agreement shall terminate and the Deposit and all interest thereon shall be returned to Buyer. In all other events, this Agreement shall remain in full force and effect. Notwithstanding the foregoing, Seller acknowledges that it shall not enter into any extension or expansion of the AECOM Technology Corp. Lease during the term of this Agreement without Buyer's approval, which may be withheld at Buyer's sole discretion.

(b) New Lease Expenses. If the Closing occurs, Buyer shall assume and be responsible for (and to the extent previously paid by Seller, reimburse Seller on the Closing Date for) a pro rata portion of any and all improvement costs, tenant improvement allowances, brokerage commissions and out-of-pocket costs and expenses actually paid or incurred by Seller (collectively the " **New Lease Expenses**") arising out of or in connection with those New Leases and Lease Amendments entered into by Seller pursuant to the foregoing provisions of this Section 14.1; such pro rata portion shall equal the product of (i) the New Lease Expenses multiplied by (ii) a fraction, the numerator of which is the number of months of the lease term of the New Lease (or the number of months of the term of any exercised extension period provided by any Lease Amendment, as applicable) remaining as of the Closing Date, and the denominator of which is the total number of months of such lease term (or exercised extension period, as applicable). Seller shall be responsible for the remaining pro rata portion of the New Lease Expenses. All New Leases and Lease Amendments entered into by Seller pursuant to this Section 14.1 shall be part of the Leases, shall be deemed included on Exhibit C and shall be assumed by Buyer upon Closing.

(c) Existing Lease Expenses. Seller shall be responsible for the cost of tenant improvement work and leasing commissions required to be paid under or with respect to all Leases (and amendments thereto) entered into prior to the Contract Date and the cost of tenant improvement work, leasing commissions required to be paid under or with respect to the State Lease Amendments and the scheduled rent-free periods set forth in the State Lease Amendments (collectively, "**Existing Lease Expenses**"), and if Seller fails to deliver Buyer evidence reasonably acceptable to Buyer confirming that such Existing Lease Expenses have been paid prior to the Approval Date, Seller shall give Buyer a credit therefore at Closing which shall be calculated as follows: Buyer and Seller shall attempt to agree on the amount of the credit for such Existing Lease Expenses during the Due Diligence Period, which amount shall equal 100% of the anticipated post-Closing Existing Lease Expenses ("**Closing Leasing Credit**"). If Seller and Buyer can agree on the Closing Leasing Credit on or before the Approval Date, such amount shall be credited against the Purchase Price due from Buyer at Closing. If Seller and Buyer cannot agree on the Closing Leasing Credit at least five (5) business days prior to the expiration of the Due Diligence Period, then at least three (3) business days prior to the expiration of the Due Diligence Period, Seller shall give Buyer written notice of the amount of the Closing Leasing Credit that Seller is willing to offer. If Buyer timely delivers the Approval Notice, Buyer shall be deemed to have accepted Seller's proposed Closing Leasing Credit and Buyer will proceed with the acquisition of the Property under the terms of this Agreement. Except as otherwise agreed to by Seller and Buyer, the Closing Leasing Credit shall constitute Seller's sole and only obligations with respect to the Existing Lease Expenses, and as of the Closing Date Buyer shall assume all such obligations (as to leasing commissions only, up to the amount set forth for leasing commissions in the Closing Lease Credit) and indemnify and hold Seller harmless with respect thereto (as to leasing commissions only, up to the amount set forth for leasing commissions in the Closing Lease Credit).

15. ARBITRATION OF DISPUTES. IN THE EVENT OF ANY DISPUTE BETWEEN THE PARTIES ARISING UNDER OR RELATED TO THIS AGREEMENT, SUCH DISPUTE, SHALL BE RESOLVED BY BINDING ARBITRATION BEFORE A SINGLE ARBITRATOR. SUCH ARBITRATION MAY BE INITIATED BY EITHER PARTY BY DELIVERING WRITTEN NOTICE OF INTENT TO ARBITRATE TO THE OTHER PARTY AND TO THE SAN FRANCISCO OFFICE OF THE AMERICAN ARBITRATION ASSOCIATION ("**AAA**"), WHICH NOTICE SHALL DESCRIBE THE DISPUTE AND THE PARTY'S PROPOSAL FOR RESOLVING THE DISPUTE IN DETAIL. WITHIN THIRTY (30) DAYS AFTER DELIVERY OF SUCH NOTICE EACH PARTY SHALL PROVIDE ALL RELEVANT DOCUMENTS AND MATERIALS THAT PERTAIN TO THE DISPUTE. THE PARTIES SHALL FIRST ENDEAVOR TO AGREE ON THE ARBITRATOR, BUT IF THEY ARE UNABLE TO DO SO WITHIN TEN (10) DAYS AFTER THE ARBITRATION HAS BEEN INITIATED, THE ARBITRATOR SHALL BE SELECTED, WITHIN THIRTY (30) DAYS AFTER THE ARBITRATION WAS INITIATED, USING THE AAA PROCEDURES. THE ARBITRATOR SHALL BE A RETIRED SUPERIOR COURT JUDGE OR A LICENSED, PRACTICING ATTORNEY WHO IS SUBSTANTIALLY FAMILIAR WITH THE REAL ESTATE LAW, CUSTOM, PRACTICE, OR PROCEDURE, IN THE AREA IN WHICH THE PROPERTY IS LOCATED, PERTINENT TO THE DISPUTE BEING ARBITRATED, IN EITHER CASE WITH NOT LESS THAN TWENTY (20) YEARS CONTINUOUS EXPERIENCE AS A JUDGE AND/OR REAL ESTATE PRACTITIONER. IN

ESTABLISHING WHETHER AN ARBITRATOR IS ABLE TO SERVE, THE PARTIES SHALL ADVISE HIM OR HER OF THE NAMES OF ALL PARTIES AND THEIR AFFILIATES AND PRINCIPAL OFFICERS AND OWNERS, AND CONFIRM THAT THERE IS NO CONFLICT OF INTEREST, WHICH FOR PURPOSES HEREOF SHALL MEAN NO BUSINESS OR PERSONAL CONNECTIONS WITH THE ARBITRATOR, OR HIS OR HER FIRM, WITH ANY OF SUCH PARTIES EITHER CURRENTLY OR AT ANY TIME DURING THE IMMEDIATELY PRECEDING THREE (3) YEARS. THE ARBITRATION SHALL BE CONDUCTED PURSUANT TO THE AAA'S COMMERCIAL ARBITRATION RULES, AS MODIFIED BY THIS SECTION 15, OR BY SUCH OTHER ORGANIZATION AND RULES AS THE PARTIES MAY MUTUALLY AGREE UPON. IF AAA IS NOT AVAILABLE AND THE PARTIES CANNOT AGREE ON AN ALTERNATE CHOICE, THE PROVISIONS OF CALIFORNIA CODE OF CIVIL PROCEDURE SECTION 1280 ET. SEQ. SHALL APPLY. ALL ARBITRATION PROCEEDINGS SHALL BE CONFIDENTIAL, AND NEITHER PARTY NOR THE ARBITRATOR MAY DISCLOSE THE CONTENT OR RESULTS OF ANY ARBITRATION HEREUNDER WITHOUT THE WRITTEN CONSENT OF BOTH PARTIES. THE ARBITRATOR SHALL FOLLOW THE LAW (INCLUDING APPLICABLE STATUTES OF LIMITATIONS) AND ALL RULES OF EVIDENCE UNLESS THE PARTIES STIPULATE TO THE CONTRARY. ANY PROVISIONAL REMEDY (INCLUDING PRELIMINARY OR PERMANENT INJUNCTIONS AND WRITS OF ATTACHMENT AND POSSESSION) WHICH WOULD BE AVAILABLE FROM A COURT OF LAW OR EQUITY SHALL BE AVAILABLE FROM THE ARBITRATOR PENDING COMPLETION OF THE ARBITRATION. THE BENEFITED PARTY OF SUCH PROVISIONAL REMEDY SHALL BE ENTITLED TO ENFORCE SUCH REMEDY IN COURT IMMEDIATELY, EVEN THOUGH A FINAL ARBITRATION AWARD HAS NOT YET BEEN RENDERED. WITHIN THIRTY (30) DAYS AFTER HIS OR HER APPOINTMENT, THE ARBITRATOR SHALL HEAR AND DECIDE THE DISPUTE SUBMITTED TO ARBITRATION HEREUNDER AND SHALL PROMPTLY PREPARE A WRITTEN DECISION ON THE MERITS OF THE MATTERS IN DISPUTE, WHICH DECISION SHALL STATE THE FACTS AND LAW RELIED UPON AND THE REASONS FOR THE ARBITRATOR'S DECISION. THE ARBITRATOR MAY, AT HIS OR HER DISCRETION, ELECT WHETHER TO MEET WITH THE PARTIES AND WHETHER TO CONDUCT A HEARING ATTENDED BY ALL PARTIES; PROVIDED, HOWEVER, THAT FOR DISPUTES INVOLVING $50,000.00 OR MORE, THE ARBITRATOR SHALL CONDUCT A HEARING. DISCOVERY SHALL BE ALLOWED IN ACCORDANCE WITH CALIFORNIA CODE OF CIVIL PROCEDURE 1283.05. THE ARBITRATOR SHALL HAVE COMPLETE DISCRETION TO RESOLVE DISCOVERY DISPUTES, TO ORDER THE PRODUCTION OF DOCUMENTS AND PRESENTATION OF WITNESSES AND TO LIMIT SUCH DISCOVERY, INCLUDING THE NUMBER AND SCOPE OF DEPOSITIONS THAT MAY BE TAKEN BY THE PARTIES. PRIOR TO ISSUING HIS OR HER FINAL WRITTEN DECISION, THE ARBITRATOR SHALL INFORM THE PARTIES, IN WRITING, OF THE ARBITRATOR'S EXPECTED DECISION ON THE MATTER AND THE REASONS THEREFORE AND GIVE THE PARTIES FIVE (5) BUSINESS DAYS TO SUBMIT ADDITIONAL ARGUMENTS OR INFORMATION, IN WRITING, TO THE ARBITRATOR AND THE OTHER PARTIES. THE AWARD OR DECISION OF THE ARBITRATOR, WHICH MAY INCLUDE AN ORDER OF SPECIFIC

PERFORMANCE, SHALL BE FINAL AND BINDING ON ALL PARTIES AND ENFORCEABLE IN ANY COURT OF COMPETENT JURISDICTION; PROVIDED, HOWEVER, THAT THE AWARD MAY BE VACATED OR CORRECTED FOR ANY OF THE REASONS PERMITTED UNDER AND PURSUANT TO CALIFORNIA CODE OF CIVIL PROCEDURE SECTIONS 1286.2 OR 1286.6. THE ARBITRATOR SHALL HAVE NO AUTHORITY TO MODIFY ANY OF THE TERMS OF THIS AGREEMENT. THE FEES AND EXPENSES OF THE ARBITRATOR AND THE COSTS AND ATTORNEYS' FEES OF THE PREVAILING PARTY SHALL BE PAID BY THE PARTY WHO IS NOT THE PREVAILING PARTY, AS DEFINED IN SECTION 18.6 (ATTORNEYS' FEES) AND DETERMINED BY THE ARBITRATOR IN ITS DECISION.

NOTICE: BY INITIALING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTE ARISING OUT OF THE MATTERS INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED BY CALIFORNIA LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE THE DISPUTE LITIGATED IN A COURT OR JURY TRIAL. BY INITIALING IN THE SPACE BELOW YOU ARE GIVING UP YOUR JUDICIAL RIGHTS TO DISCOVERY AND APPEAL, UNLESS THOSE RIGHTS ARE SPECIFICALLY INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE CALIFORNIA CODE OF CIVIL PROCEDURE. YOUR AGREEMENT TO THIS ARBITRATION PROVISION IS VOLUNTARY.

WE HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THE 'ARBITRATION OF DISPUTES' PROVISION TO NEUTRAL ARBITRATION

Seller	Buyer

16. Indemnification. Each party hereby agrees to indemnify, defend, protect and hold harmless the other party from and against any and all claims, demands, liabilities, costs and damages, including without limitation, reasonable attorneys' fees (collectively, "**Claims**") suffered by the other party and resulting from or arising out of all third-party tort claims and similar claims of the type that would typically be insured under a Commercial General Liability Insurance Policy which are based on actions, facts or circumstances existing or occurring during the indemnifying party's ownership of the Property, excluding any Claims related to hazardous substances. All of the indemnifications set forth in this Section 16 shall survive the Closing and conveyance of the Property to Buyer.

17. Miscellaneous.

18. Notice. All notices and any other communications permitted or required under this Agreement must be in writing and will be effective (i) immediately upon delivery in person or by facsimile, provided delivery is made during regular business hours or receipt is acknowledged by

a person reasonably believed by the delivering party to be employed by the recipient and that for all facsimiles, good and complete transmission is confirmed by the sending facsimile machine and a copy of the notice is concurrently mailed pursuant to clause (iii) below; or (ii) upon the actual delivery as evidenced by executed receipt of the recipient if delivered by a nationally recognized delivery service for overnight delivery, provided delivery is made during regular business hours or receipt is acknowledged by a person reasonably believed by the delivering party to be employed by the recipient; or (iii) or the date shown on the return receipt if delivered by the United States Postal Service, certified mail, return receipt requested, postage prepaid and with the return receipt returned to the sender marked as delivered, undeliverable or rejected. In the case of any notices sent pursuant to clauses (ii) or (iii) above, the sender shall also send a copy of such notice by email, which email shall be sent no later than 6:00 p.m. (Pacific Time) on the date such notice is deposited with the delivery service or United States Postal Service. The inability to deliver because of a changed address of which no notice was given, or rejection or other refusal to accept any notice, shall be deemed to be the receipt of the notice as of the first date of such inability to deliver or rejection or refusal to accept. Any notice to be given by any party hereto may be given by the counsel for such party. All notices must be properly addressed and delivered to the parties at the addresses set forth below, or at such other addresses as either party may subsequently designate by written notice given in the manner provided in this Section 18:

Seller:	200 Oceangate, LLC c/o The Swig Company, LLC 220 Montgomery Street, 20th Floor San Francisco, CA 94104 Attn: Kennard P. Perry Telephone: (415) 291-1140 Facsimile: (415) 291-8373 Email: kperry@swigco.com
with copy to:	Farella Braun + Martel LLP 235 Montgomery Street San Francisco, CA 94104 Attn: Anthony D. Ratner Telephone: (415) 954-4448 Facsimile: (415) 954-4480 Email: tratner@fbm.com
Buyer:	
Prior to Closing:	Molina Healthcare, Inc. 300 University Avenue, Suite 100 Sacramento, CA 95825 Attn: General Counsel Telephone: (916) 646-9193 x114663 Facsimile: (916) 646-4572 Email: Jeff.Barlow@Molinahealthcare.com

with copy to: Boutin Jones Inc.
555 Capitol Mall, Suite 1500
Sacramento, CA 95814
Attn: James R. Moore
Telephone: (916) 321-4444
Facsimile: (916) 441-7597
Email: jmoore@boutininc.com

After Closing: Molina Center LLC
200 Oceangate, Suite 100
Long Beach, CA 90802
Attn: John Molina
Telephone: (562) 435-3666 x111128
Facsimile: (562) 495-7770
Email: John.Molina@Molinahealthcare.com

with a copy to:
Molina Healthcare, Inc.
300 University Avenue, Suite 100
Sacramento, CA 95825
Attn: General Counsel
Telephone: (916) 646-9193 x114663
Facsimile: (916) 646-4572
Email: Jeff.Barlow@Molinahealthcare.com

18.1 Headings. The headings used herein are for purposes of convenience only and should not be used in construing the provisions hereof.

18.2 Covenant of Further Assurances. The parties hereby agree to execute and deliver such other documents and instruments (including, without limitation, additional escrow instructions in conformity with this Agreement), and to take such other actions, whether before or after Closing, as may reasonably be required and which may be necessary to consummate this transaction and to otherwise effectuate the agreements of the parties hereto; provided that such additional documents, instruments, or actions shall not impose upon the parties any obligations, duties, liabilities or responsibilities which are not expressly provided for in this Agreement.

18.3 Entire Agreement. This document represents the final, entire and complete agreement between the parties with respect to the subject matter hereof and supersedes all other prior or contemporaneous agreements, communications or representations, whether oral or written, express or implied, including any letters of intent, including that certain Confidentiality Agreement 200 & 300 Oceangate by and between Molina and Seller. The parties acknowledge and agree that they may not and are not relying on any representation, promise, inducement, or other statement, whether oral or written and by whomever made, that is not contained expressly in this Agreement. This Agreement may only be modified by a written instrument signed by representatives authorized to bind both parties. Oral modifications are unenforceable.

18.4 Partial Invalidity. If any term, covenant or condition of this Agreement or its application to any person or circumstances shall be held to be illegal, invalid or unenforceable, the remainder of this Agreement or the application of such term or provisions to other persons or circumstances shall not be affected, and each term hereof shall be legal, valid and enforceable to the fullest extent permitted by law, unless an essential purpose of this Agreement would be defeated by the loss of the illegal, unenforceable, or invalid provision. In the event of such partial invalidity, the parties shall seek in good faith to agree on replacing any such legally invalid provisions with valid provisions which, in effect, will, from an economic viewpoint, most nearly and fairly approach the effect of the invalid provision and the intent of the parties in entering into this Agreement.

18.5 No Waiver. No consent or waiver by either party to or of any breach or non-performance of any representation, condition, covenant or warranty shall be enforceable unless in a writing signed by the party entitled to enforce performance, and such signed consent or waiver shall not be construed as a consent to or waiver of any other breach or non-performance of the same or any other representation, condition, covenant, or warranty.

18.6 Attorneys' Fees. In the event of any arbitration or litigation between the parties, whether based on contract, tort or other cause of action or involving bankruptcy or similar proceedings, in any way related to this Agreement, the non-prevailing party shall pay to the prevailing party all reasonable attorneys' fees and costs and expenses of any type, without restriction by statute, court rule or otherwise, incurred by the prevailing party in connection with any action or proceeding (including arbitration proceedings, any appeals and the enforcement of any judgment or award), whether or not the dispute is litigated or prosecuted to final judgment. The "prevailing party" shall be determined based upon an assessment of which party's major arguments or positions taken in the action or proceeding could fairly be said to have prevailed (whether by compromise, settlement, abandonment by the other party of its claim or defense, final decision, after any appeals, or otherwise) over the other party's major arguments or positions on major disputed issues.

18.7 Brokers and Finders. Neither party has had any contact or dealings regarding the Property, through any licensed real estate broker or other persons who can claim a right to a commission or finder's fee in connection with this transaction, except for CB Richard Ellis, Inc., representing Seller (the " **Selling Broker**") and McKinney Advisory Group, Inc., representing Buyer (the " **Buying Broker**"). The parties agree that Seller shall pay a brokerage commission to Selling Broker, pursuant to its separate agreement with the Selling Broker. The parties agree that Buyer shall pay any amount owing to Buying Broker pursuant to its separate agreement with the Buying Broker. In the event that any other party claims a commission or finder's fee in this transaction, the party through whom the party makes its claim shall be responsible for said commission or fee and shall indemnify the other against all costs and expenses (including reasonable attorneys' fees) incurred in defending against the same. This indemnification obligation shall survive the Closing or termination of this Agreement.

18.8 Time of the Essence. Time is of the essence of this Agreement.

18.9 Governing Law; Forum. This Agreement is entered into and shall be governed by and construed in accordance with the laws of the State of California (without giving effect to its choice of law principles).

18.10 Interpretation. All parties have been represented by counsel in the preparation and negotiation of this Agreement, and this Agreement shall be construed according to the fair meaning of its language. The rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not be employed in interpreting this Agreement. Unless the context clearly requires otherwise, (i) the plural and singular numbers shall each be deemed to include the other; (ii) the masculine, feminine, and neuter genders shall each be deemed to include the others; (iii) "shall," "will," or "agrees" are mandatory, and "may" is permissive; (iv) "or" is not exclusive; (v) "includes" and "including" are not limiting, absent express language to the contrary; (vi) "days" means calendar days unless specifically provided otherwise; and (vii) "business day" means any day other than Saturday, Sunday, or any day that is an "optional bank holiday" under Section 7.1 of the California Civil Code, whether or not any particular bank is open for business on such optional bank holiday.

18.11 IRS Form 1099-S Designation. In order to comply with information reporting requirements of Section 6045(e) of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations thereunder, the parties agree (i) to execute an IRS Form 1099-S Designation Agreement to designate the Title Company (the "**Designee**") as the party who shall be responsible for reporting the contemplated sale of the Property to the Internal Revenue Service (the " **IRS**") on IRS Form 1099-S; and (ii) to provide the Designee with the information necessary to complete Form 1099-S.

18.12 Third Party Beneficiaries. This Agreement has been made solely for the benefit of the parties hereto and their respective successors and permitted assigns, and nothing in this Agreement is intended to, or shall, confer upon any other person any benefits, rights or remedies under or by reason of this Agreement.

18.13 Compliance With Laws. Each party shall comply with all applicable laws, rules, regulations, orders, consents and permits in the performance of all of their obligations under this Agreement.

18.14 Counterparts. This Agreement may be signed in any number of counterparts with the same effect as if the signatures to each counterpart were upon a single instrument, and is intended to be binding when all parties have delivered their signatures to the other parties. Signatures may be delivered by facsimile transmission or by e-mail in a portable document format (*pdf*). All counterparts shall be deemed an original of this Agreement.

18.15 Exhibits. All Recitals and Exhibits referred to in this Agreement are incorporated herein by reference and shall be deemed part of this Agreement.

18.16 Authority. The individuals executing this Agreement on behalf of Seller and Buyer individually represent and warrant that he or she has been authorized to do so and has the power to bind the party for whom they are signing.

18.17 Exchange Transaction. Buyer agrees upon the request of Seller to cooperate with Seller in closing all or part of this transaction as an exchange pursuant to Internal Revenue Code Section 1031, provided that:

(a) Buyer shall incur no additional expense or liability in connection therewith and shall not be required to make any representations or warranties, incur any personal liabilities or hold title to any property other than the Property;

(b) Seller shall indemnify, protect, defend and hold Buyer harmless from any claims, liabilities, demands, causes of action, judgments, expenses, costs and attorneys' fees in connection with such exchange or which result from Buyer's compliance with this paragraph, which obligation shall survive the Closing or termination of this Agreement; and

(c) The Closing is not extended or delayed by the exchange and the completion of the exchange is not a condition to Seller's obligation to close the Escrow.

18.18 Confidentiality. Buyer and Seller shall each maintain as confidential any and all material or information about the other, the terms of this Agreement, and the Property, and shall not disclose such information to any third party, except, in the case of Buyer, to Buyer's investment bankers, lender or prospective lenders, insurance and reinsurance firms, accountants, attorneys, environmental and other consultants, as may be reasonably required for the consummation of this transaction, as required by law or in connection with any arbitration or litigation between the parties, and except, in the case of Seller, to Seller's existing lender, attorneys, accountants and other professional consultants, as may be reasonably required for the consummation of this transaction, as required by law or in connection with any arbitration or litigation between the parties. Neither party shall issue a press release or other public statement about this Agreement or the transactions contemplated by this Agreement without the other party's prior written consent, unless such release or statement is required by law. Seller acknowledges that Buyer's ultimate parent is a publicly traded company and that Buyer is, therefore, subject to laws and regulations regarding the disclosure and dissemination of business information. Buyer acknowledges that in the event this Agreement terminates for any reason, Seller has the right and the obligation to disclose to subsequent purchasers of the Property the price and material terms of this Agreement, and Buyer agrees that such disclosure is a permitted disclosure under this Section 18.18.

[*Signatures on following page*]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Contract Date.

SELLER:

200 OCEANGATE, LLC,
a Delaware limited liability company

By: 200 Oceangate, Inc.,
a Delaware corporation
its Manager

By: _____
Jeanne R. Myerson
President

BUYER:

MOLINA CENTER LLC,
a Delaware limited liability company

By: Molina Healthcare, Inc., a Delaware corporation

By: _____
Name: _____
Title: _____

NOTE: BOTH PARTIES MUST INITIAL THE AGREEMENT AT SECTIONS 3.2 AND 15.

EXHIBIT A

DESCRIPTION OF THE LAND

PARCELS 2 AND 3, AS SHOWN ON PARCEL MAP NO. 5196, IN THE CITY OF LONG BEACH, COUNTY OF LOS ANGLES, STATE OF CALIFORNIA, FILED IN BOOK 71 PAGE 14 OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT THEREFROM, ALL OIL, GAS, HYDROCARBON SUBSTANCES AND MINERALS OF EVERY KIND AND CHARACTER LYING MORE THAN 500 FEET BELOW THE SURFACE OF SAID LAND, TOGETHER WITH THE RIGHT TO DRILL INTO, THROUGH AND TO USE AND OCCUPY ALL PARTS OF SAID LAND LYING MORE THAN 500 FEET BELOW THE SURFACE THEREOF FOR ANY AND ALL PURPOSES INCIDENTAL TO THE EXPLORATION FOR AND PRODUCTION OF OIL, GAS, HYDROCARBON SUBSTANCES OR MINERALS FROM SAID OR OTHER LANDS, BUT WITHOUT, HOWEVER, ANY RIGHT TO USE EITHER THE SURFACE OF SAID LAND OR ANY PORTION OF SAID LAND WITHIN 500 FEET OF THE SURFACE FOR ANY PURPOSE OR PURPOSES WHATSOEVER AS RESERVED BY VARIOUS DEEDS OF RECORD, AMONG THEM, BEING THE DEED RECORDED JULY 19, 1965 AS INSTRUMENT NO. 885 IN BOOK D2981 PAGE 153 OFFICIAL RECORDS.

APN: 7278-003-035 and 7278-003-036

Exhibit 12.1

Molina Healthcare, Inc.

Computation of Ratio of Earnings to Fixed Charges

	Year Ended December 31,				
	2010	2009(1)	2008(1)	2007	2006
	(Dollars in thousands)				
Earnings:					
Income before income taxes	$ 89,492	$ 38,157	$ 94,324	$ 92,722	$ 73,458
Add fixed charges:					
Interest expense, including amortization of debt discount and exp	15,509	13,777	13,231	5,605	2,353
Estimated interest portion of rental expense	4,524	5,181	4,370	3,988	2,682
Total fixed charges	20,033	18,958	17,601	9,593	5,035
Total earnings available for fixed charges	$109,525	$57,115	$111,925	$102,315	$ 78,493
Fixed Charges from above	$ 20,033	$18,958	$ 17,601	$ 9,593	$ 5,035
Ratio of Earnings to Fixed Charges	5.6	3.0	6.4	10.7	15.6
Total rent expense	$ 25,134	$ 20,723	$ 17,481	$ 18,127	$12,193
Interest factor	18%	25%	25%	22%	22%
Interest component of rental expense	$ 4,524	$ 5,181	$ 4,370	$ 3,988	$ 2,682

(1) Effective January 1, 2008 through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax. For the years ended December 31, 2009, and 2008, amounts for premium tax expense and income tax expense have been reclassified to conform to this presentation. The MGRT amounted to $6.2 million, $5.5 million, and $5.1 million for the years ended December 31, 2010, 2009, and 2008, respectively.

Exhibit 21.1

LIST OF SUBSIDIARIES

Name	
Molina Information Systems, LLC, dba Molina Medicaid Solutions	California
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Utah, Inc.	Utah
Molina Healthcare of New Mexico, Inc.	New Mexico
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Texas Insurance Company*	Texas
Molina Healthcare of Nevada, Inc.	Nevada
Molina Healthcare Insurance Company	Ohio
Alliance for Community Health LLC, dba Molina Healthcare of Missouri	Missouri
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Virginia, Inc.	Virginia
Abri Health Plan, Inc.	Wisconsin

* Subsidiary of Molina Healthcare of Texas, Inc.

EXHIBIT 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the Registration Statements (Forms S-8, No. 333-108317, No. 333-138552, No. 333-153246, and No. 333-170571) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan, and 2002 Employee Stock Purchase Plan, and in the Registration Statement (Form S-3, No. 333-155995) and related Prospectus of Molina Healthcare, Inc. for the registration of $300,000,000 of its securities, of our reports dated March 8, 2011, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2010.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 8, 2011

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2010 of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Joseph M. Molina

Joseph M. Molina
Chief Executive Officer and President

March 8, 2011

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2010, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

March 8, 2011

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2010 as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Joseph M. Molina

Joseph M. Molina, M.D.
Chief Executive Officer and President

March 8, 2011

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2010 as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ John C. Molina

John C. Molina, J.D.
Chief Financial Officer and Treasurer

March 8, 2011

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended September 30, 2010

UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2010

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
200 Oceangate, Suite 100 **Long Beach, California** *(Address of principal executive offices)*	**90802** *(Zip Code)*

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ Smaller reporting company ☐

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The number of shares of the issuer's Common Stock, par value $0.001 per share, outstanding as of October 29, 2010, was approximately 30,239,000.

MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1: ***Financial Statements.***

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	September 30, 2010	December 31, 2009
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 426,455	$ 469,501
Investments	195,358	174,844
Receivables	225,547	136,654
Income and related taxes refundable	2,755	6,067
Deferred income taxes	7,580	8,757
Prepaid expenses and other current assets	25,185	15,583
Total current assets	882,880	811,406
Property and equipment, net	91,826	78,171
Deferred contract costs	20,255	—
Intangible assets, net	115,270	80,846
Goodwill and indefinite-lived intangible assets	213,261	133,408
Investments	20,294	59,687
Restricted investments	45,047	36,274
Receivable for ceded life and annuity contracts	25,134	25,455
Other assets	17,463	19,988
	$ 1,431,430	$ 1,245,235
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 355,140	$ 316,516
Accounts payable and accrued liabilities	117,299	71,732
Deferred revenue	37,648	101,985
Total current liabilities	510,087	490,233
Long-term debt	162,700	158,900
Deferred income taxes	16,773	12,506
Liability for ceded life and annuity contracts	25,134	25,455
Other long-term liabilities	19,004	15,403
Total liabilities	733,698	702,497
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 30,207 shares at September 30, 2010 and 25,607 shares at December 31, 2009	30	26
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	247,845	129,902
Accumulated other comprehensive loss	(2,107)	(1,812)
Retained earnings	451,964	414,622
Total stockholders' equity	697,732	542,738
	$ 1,431,430	$ 1,245,235

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 1,005,115	$ 914,805	$ 2,947,020	$ 2,697,796
Service revenue	32,271	—	53,325	—
Investment income	1,760	1,707	4,880	7,336
Total revenue	1,039,146	916,512	3,005,225	2,705,132
Expenses:				
Medical care costs	845,937	792,771	2,508,366	2,333,865
Cost of service revenue	27,605	—	41,859	—
General and administrative expenses	88,660	68,563	245,619	198,981
Premium tax expenses	35,037	30,257	104,578	87,612
Depreciation and amortization	11,954	9,832	33,234	28,468
Total expenses	1,009,193	901,423	2,933,656	2,648,926
Gain on retirement of convertible senior notes	—	—	—	1,532
Operating income	29,953	15,089	71,569	57,738
Interest expense	(4,600)	(3,279)	(12,056)	(9,917)
Income before income taxes	25,353	11,810	59,513	47,821
Provision for income taxes	9,180	3,246	22,171	12,481
Net income	$ 16,173	$ 8,564	$ 37,342	$ 35,340
Net income per share:				
Basic	$ 0.58	$ 0.34	$ 1.41	$ 1.36
Diluted	$ 0.57	$ 0.33	$ 1.39	$ 1.36
Weighted average shares outstanding:				
Basic	28,118	25,539	26,511	25,944
Diluted	28,363	25,630	26,802	26,058

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(Amounts in thousands) (Unaudited)			
Net income	$ 16,173	$ 8,564	$ 37,342	$ 35,340
Other comprehensive income, net of tax:				
Unrealized (loss) gain on investments	(68)	37	(295)	645
Other comprehensive (loss) income	(68)	37	(295)	645
Comprehensive income	$ 16,105	$ 8,601	$ 37,047	$ 35,985

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2010	2009
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 37,342	$ 35,340
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	40,485	28,468
Unrealized gain on trading securities	(4,170)	(3,509)
Loss on rights agreement	3,807	3,204
Deferred income taxes	4,463	2,322
Stock-based compensation	7,268	5,730
Non-cash interest on convertible senior notes	3,800	3,563
Gain on repurchase and retirement of convertible senior notes	—	(1,532)
Amortization of deferred financing costs	1,278	1,040
Tax deficiency from employee stock compensation recorded as additional paid-in capital	(676)	(704)
Changes in operating assets and liabilities:		
Receivables	(64,896)	(15,567)
Prepaid expenses and other current assets	(8,307)	454
Medical claims and benefits payable	33,947	10,672
Accounts payable and accrued liabilities	15,131	(6,140)
Deferred revenue	(64,337)	61,381
Income taxes	3,327	5,561
Net cash provided by operating activities	8,462	130,283
Investing activities:		
Purchases of equipment	(31,918)	(28,390)
Purchases of investments	(162,620)	(127,335)
Sales and maturities of investments	185,193	149,770
Net cash paid in business combinations	(127,231)	(10,900)
Increase in deferred contract costs	(20,616)	—
Increase in restricted investments	(8,513)	(4,198)
Increase in other assets	(389)	(1,877)
Increase (decrease) in other long-term liabilities	2,729	(8,788)
Net cash used in investing activities	(163,365)	(31,718)
Financing activities:		
Amount borrowed under credit facility	105,000	—
Proceeds from common stock offering, net of underwriting discount	111,578	—
Repayment of amount borrowed under credit facility	(105,000)	—
Treasury stock purchases	—	(27,712)
Purchase of convertible senior notes	—	(9,653)
Credit facility fees paid	(1,671)	—
Equity offering costs paid	(332)	—
Proceeds from employee stock plans	1,862	1,081
Excess tax benefits from employee stock compensation	420	26
Net cash provided by (used in) financing activities	111,857	(36,258)
Net (decrease) increase in cash and cash equivalents	(43,046)	62,307
Cash and cash equivalents at beginning of period	469,501	387,162
Cash and cash equivalents at end of period	$ 426,455	$ 449,469

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Nine Months Ended September 30,	
	2010	2009
	(Amounts in thousands) (Unaudited)	
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 12,129	$ 16,305
Interest	$ 7,175	$ 4,254
Schedule of non-cash investing and financing activities:		
Unrealized (loss) gain on investments	$ (476)	$ 936
Deferred taxes	181	(291)
Net unrealized (loss) gain on investments	$ (295)	$ 645
Accrued purchases of equipment	$ 632	$ 366
Retirement of common stock used for stock-based compensation	$ 2,173	$ 920
Retirement of treasury stock	$ —	$ 48,102
Details of business combinations:		
Fair value of assets acquired	$ (161,862)	$ (30,600)
Fair value of liabilities assumed	25,880	—
Release of deposit	—	9,000
Payable to seller	8,751	10,700
Net cash paid in business combinations	$ (127,231)	$ (10,900)

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
September 30, 2010

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality and cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals and to assist state agencies in their administration of the Medicaid program. Our licensed health plans in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin currently serve approximately 1.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010, we terminated operations at our small Medicare health plan in Nevada. Our subsidiary, Molina Medicaid Solutions, provides business processing and information technology administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, and West Virginia, and drug rebate administration services in Florida.

On September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. As of September 30, 2010, Abri Health Plan served approximately 28,000 Medicaid members. See Note 3, "Business Combinations," for more information relating to this acquisition.

On May 1, 2010, we acquired a health information management business which now operates under the name, *Molina Medicaid Solutions*SM. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. See Note 3, "Business Combinations," for more information relating to this acquisition.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included. Except as described below under "Reclassifications," such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated in consolidation. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2010. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2009. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2009 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2009 audited financial statements.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax as a premium tax and not as an income tax. For the three month and nine month periods ended September 30, 2009, amounts for premium tax expense and income tax expense have been reclassified to conform to this presentation. See Note 2, "Significant Accounting Policies."

In prior periods, general and administrative expenses have included premium tax expenses. Beginning in the second quarter of 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

2. Significant Accounting Policies

Molina Medicaid Solutions Segment Revenue Recognition and Deferred Contract Costs

As a result of our recent acquisition of Molina Medicaid Solutions, we report on the results of our operations using two business segments. The Molina Medicaid Solutions segment derives its revenue from service arrangements. This segment provides technology solutions to state Medicaid programs that include system development, system integration, and technology outsourcing services. In addition, this segment offers business process outsourcing to state Medicaid agencies that handle key administrative functions such as claims processing, provider enrollment, pharmacy drug rebate services, recipient eligibility management, and pre-authorization services. The following is an update of our accounting policies on revenue recognition, as included in our December 31, 2009 audited financial statements, which specifically addresses revenue recognition for service arrangements.

Under certain of the contracts we acquired, the development of the MMIS solution has already been completed. Under these contracts, we provide business process outsourcing and technology outsourcing services, and recognize outsourcing services revenue on a straight-line basis over the remaining term of the contract.

For fixed-price contracts where the system design and development phase was in process as of the acquisition date, we apply contract accounting because we will deliver significantly modified and customized MMIS software to the customer under the terms of the contract. Additionally, these contracts contain multiple deliverables; once the system design and development phase is complete, we provide technology outsourcing services and business process outsourcing. We do not have vendor specific objective evidence of the fair value of the technology outsourcing and business process outsourcing components of the contracts because we do not have history of offering these services on a stand-alone basis. As such, we account for these fixed-price service contracts as a single element.

Therefore, in general, we recognize contract revenues as a single element ratably over the performance period, or contract term, of the outsourcing services because these are the last elements to be delivered under the contract. Such contract terms typically range from five to 10 years. In those service arrangements where final acceptance of a system or solution by the customer is required, contract revenues and costs are deferred until all material acceptance criteria have been met. Performance will often extend over long periods, and our right to receive future payment depends on our future performance in accordance with the agreement. Revenues earned in excess of related billings are accrued, whereas billings in excess of revenues earned are deferred until the related services are provided.

Deferred contract costs include direct and incremental costs such as direct labor, hardware and software. We also defer and subsequently amortize certain transition costs related to activities that transition the contract from the design, development, and implementation phase to the operational, or business process outsourcing, phase. Deferred contract costs, including transition costs, are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. Indirect costs associated with MMIS service contracts are generally expensed as incurred.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years.

As discussed in "Molina Medicaid Solutions Segment Revenue Recognition and Deferred Contract Costs" above, the costs associated with certain equipment and software, which may be ultimately transferred to our clients under fixed-price contracts, are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the performance period, consistent with the revenue recognition period.

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are amortized on a straight-line basis over the expected period to be benefited (generally between one and 15 years).

Goodwill and indefinite-lived assets are not amortized, but are subject to impairment tests on an annual basis or more frequently if indicators of impairment exist. We use a discounted cash flow methodology to assess the fair values of our reporting units. If the carrying values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite-lived asset balance.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships.

The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to the acquisition. The contract backlog intangible has been developed on a contract-by-contract basis. The amortization of that portion of the contract backlog intangible associated with contracts for which revenue recognition has not yet commenced is deferred until revenue recognition has begun. Because each acquired contract constitutes a single revenue element, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a straight-line basis for each specific contract over periods generally ranging from one to six years.

The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

The determination of the value of identifiable intangible assets requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. In addition to annual impairment testing, we continually evaluate whether events and circumstances have occurred that indicate the balance of identifiable intangible assets may not be recoverable. In evaluating impairment, we compare the estimated fair value of the intangible asset to its underlying book value. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event occurs that would cause us to revise our estimates and assumptions used in analyzing the value of our identifiable intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

Depreciation and Amortization

As noted above, the amortization of the contract backlog intangibles associated with the acquisition of Molina Medicaid Solutions is recorded as contra-service revenue, rather than as part of depreciation and amortization, to match revenues associated with contract performance that occurred prior to the acquisition date. Additionally, most of the depreciation associated with Molina Medicaid Solutions is recorded as cost of service revenue. The following table presents all depreciation and amortization recorded in our consolidated financial statements:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(In thousands)			
Depreciation and amortization	$ 11,954	$ 9,832	$ 33,234	$ 28,468
Amortization recorded as contra-service revenue	2,655	—	4,246	—
Depreciation recorded as cost of service revenue	1,964	—	3,005	—
Depreciation and amortization reported in our consolidated statements of cash flows	$ 16,573	$ 9,832	$ 40,485	$ 28,468

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $11.0 million and $4.1 million at September 30, 2010, and December 31, 2009, respectively. Approximately $8.4 million of the unrecognized tax benefits recorded at September 30, 2010, relates to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.8 million and $3.4 million as of September 30, 2010 and December 31, 2009, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities will decrease by approximately $0.5 million due to the expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Our accrual for the payment of interest relating to unrecognized tax benefits was $74,000 and $75,000 as of September 30, 2010 and December 31, 2009, respectively.

Through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax. The MGRT amounted to $4.6 million and $3.4 million for the nine months ended September 30, 2010, and 2009, respectively.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers is defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of our Michigan plan's receipts and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

Recent Accounting Pronouncements

Revenue Recognition. In late 2009, the Financial Accounting Standards Board, or FASB, issued the following new accounting guidance which is first applicable for our January 1, 2011 reporting:

- ASU No. 2009-14, Software (ASC Topic 985) — *Certain Revenue Arrangements That Include Software Elements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies the scope of ASC Subtopic 985-605 — *Software-Revenue Recognition* to exclude from its requirements (a) non-software components of tangible products and (b) software components of tangible products that are sold, licensed or leased with tangible products when the software components and non-software components of the tangible product function together to deliver the tangible product's essential functionality. We do not expect the update to impact our consolidated financial position, results of operations or cash flows.

- ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — *Multiple-Deliverable Revenue Arrangements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies previous requirements by allowing the use of the "best estimate of selling price" in the absence of vendor-specific objective evidence ("VSOE") or verifiable objective evidence ("VOE") (now referred to as "TPE" or third-party evidence) for determining the selling price of a deliverable. A vendor is now required to use its best estimate of the selling price when more objective evidence of the selling price cannot be determined. In addition, the residual method of allocating arrangement consideration is no longer permitted. We do not expect the update to impact our consolidated financial position, results of operations or cash flows.

Fair Value Measurements. In January 2010, the FASB issued the following guidance which expanded the required disclosures about fair value measurements. Effective for interim and annual reporting beginning after December 15, 2009, with one new disclosure effective after December 15, 2010, we adopted this guidance in full during the interim period ended March 31, 2010.

- ASU No. 2010-6, Fair Value Measurements and Disclosures (Topic 820) — *Improving Disclosures about Fair Value Measurements*. This guidance requires (a) separate disclosure of the amounts of significant transfers in and out of Level 1 and Level 2 fair value measurements along with the reasons for such transfers, (b) information about purchases, sales, issuances and settlements to be presented separately in the reconciliation for Level 3 fair value measurements, (c) fair value measurement disclosures for each class of assets and liabilities and (d) disclosures about the valuation techniques and inputs used to measure fair value for both recurring and nonrecurring fair value measurements for fair value measurements that fall in either Level 2 or Level 3. The adoption of this guidance did not impact our consolidated financial position, results of operations or cash flows.

3. Business Combinations

Wisconsin Health Plan

On September 1, 2010, Molina acquired 100% of the voting equity interests in Avatar Partners, LLC, which is the sole shareholder of Abri Health Plan, Inc. ("Abri"), a Medicaid managed care organization based in Milwaukee, Wisconsin. This acquisition is consistent with our stated strategy to enter markets with competitive provider communities, supportive regulatory environments, significant size and, where practicable, mandated Medicaid managed care enrollment.

We expect the final purchase price for the Abri acquisition to be approximately $16 million, subject to adjustments. As of September 30, 2010, we had paid $5 million of the total purchase price. There will be two subsequent measurement dates (November 1, 2010 and February 1, 2011) on which we will compute amounts due to the sellers based on the plan's membership on those dates. Following the final membership reconciliation on February 1, 2011, 10% of the final purchase price will be deposited to an escrow account payable at the later of 12 months or the resolution of all unresolved claims. In connection with this acquisition, we recorded $6.2 million in goodwill, and $3.9 million in various definite-lived identifiable intangible assets, with a weighted average useful life of 6.3 years. Accumulated amortization totaled approximately $135,000 as of September 30, 2010, which reflects amortization expense recorded since the acquisition date. We expect to record amortization relating to this acquisition in future years as follows— 2011: $1.1 million, 2012: $432,000, 2013: $396,000, 2014: $325,000, and 2015: $281,000.

Molina Medicaid Solutions

On May 1, 2010, we acquired a health information management business that was previously an operating unit of Unisys Corporation. This business now operates under the name *Molina Medicaid Solutions*SM, or Molina Medicaid Solutions. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. As a result of this acquisition, we are diversifying our core health plan business, and we believe that the use of a common claims processing platform across our health plans and our new MMIS business will enable us to achieve synergies in the operations of both.

We paid $131.3 million to acquire Molina Medicaid Solutions. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility. In connection with the closing, both the fourth amendment and the fifth amendment to our credit facility became effective (see Note 11, "Long-Term Debt").

Recording of assets acquired and liabilities assumed: The transaction has been accounted for using the acquisition method of accounting which requires, among other things, that most assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date. Accounts receivable are based on gross contractual amounts receivable, substantially all of which we expect to collect because the creditors are state governments.

The following table summarizes the provisional acquisition-date fair values of the assets acquired and liabilities assumed:

	May 1, 2010 (In thousands)
Assets	
Accounts receivable	$ 17,128
Other current assets	3,884
Equipment and other long-term assets	783
Identifiable intangible assets	48,150
Goodwill	72,943
	142,888
Less: liabilities	
Accounts payable and accrued liabilities	11,153
Deferred tax liability	115
Other long-term liabilities	370
Net assets acquired	$ 131,250

The recorded amounts for assets and liabilities are provisional and subject to change. We will finalize the amounts recognized as we obtain the information necessary to complete the analyses, but by no later than December 31, 2010.

A single estimate of fair value results from a complex series of judgments about future events and uncertainties and relies heavily on estimates and assumptions. Results that differ from the estimates and judgments used to determine the estimated fair value assigned to each class of assets acquired and liabilities assumed, as well as asset lives, can materially impact our results of operations.

Accounts receivable: Accounts receivable are stated at fair value, based on the gross contractual amounts receivable. We expect to collect substantially all of the accounts receivable because the creditors are state governments.

Identifiable intangible assets: The following table is a summary of the fair value estimates of the identifiable intangible assets and their weighted-average useful lives:

	Estimated Fair Value (In thousands)	Weighted Average Useful Life (years)
Customer relationships	$ 24,550	5.2
Contract backlog	23,600	3.3
	$ 48,150	

Accumulated amortization totaled approximately $6.4 million as of September 30, 2010, which reflects total amortization recorded since the acquisition date. For identifiable intangible assets recorded as of September 30, 2010, we expect to record amortization in future years as follows — 2011: $11.2 million, 2012: $10.6 million, 2013: $7.1 million, 2014: $5.3 million, and 2015: $1.7 million.

Goodwill: Goodwill in the amount of $72.9 million was recognized for this acquisition, of which approximately $70.9 million is expected to be deductible for tax purposes. The total goodwill amount was calculated as the excess of the consideration transferred over the net assets recognized and represents the future economic benefits arising from other assets acquired that could not be individually identified and separately recognized. The goodwill recorded as part of the acquisition of Molina Medicaid Solutions includes:

- Expected synergies and other benefits that we believe will result from combining the operations of Molina Medicaid Solutions with the operations of Molina;
- Any intangible assets that do not qualify for separate recognition such as the assembled workforce; and
- The value of the going-concern element of Molina Medicaid Solutions' existing businesses (the higher rate of return on the assembled collection of net assets versus acquiring all of the net assets separately).

Accounts payable and accrued liabilities: Accounts payable and accrued liabilities include $1.3 million payable to the seller of Molina Medicaid Solutions, which represented a working capital adjustment provided in the purchase agreement. The working capital adjustment provided that the net working capital, or current assets minus current liabilities, on Molina Medicaid Solutions' opening balance sheet would equal $10 million. To the extent the final net working capital conveyed by the seller exceeded $10 million, the amount would be payable back to the seller; conversely, to the extent that net working capital conveyed by the seller was less than $10 million, the shortage would be a receivable from the seller. Thus, the $1.3 million amount described above represents the amount payable to the seller for net working capital in excess of $10 million on the opening balance sheet, and was paid to the seller in August 2010.

Pro-forma impact of the acquisition: The unaudited pro-forma results presented below include the effects of the acquisition as if it had been consummated as of January 1, 2010 and 2009. The pro-forma results include the amortization associated with the acquired intangible assets and interest expense associated with debt used to fund the acquisition. To better reflect the combined operating results, material non-recurring charges directly attributable to the transaction have been excluded. In addition, the pro-forma results do not include any anticipated synergies or other expected benefits of the acquisition. Accordingly, the unaudited pro forma financial information below is not necessarily indicative of either future results of operations or results that might have been achieved had the acquisition been consummated as of January 1, 2010 or January 1, 2009.

	Three Months Ended Sept. 30,	Nine Months Ended Sept. 30,	
	2009	2010	2009
Revenue	$ 942,846	$ 3,044,149	$ 2,781,356
Net income	$ 8,557	$ 40,645	$ 34,369
Diluted earnings per share	$ 0.33	$ 1.52	$ 1.32

4. Segment Reporting

Our reportable segments are consistent with how we manage the business and view the markets we serve. In the second quarter of 2010, we added a segment to our internal financial reporting structure as a result of the acquisition of Molina Medicaid Solutions described in Note 3, "Business Combinations."

We now report our financial performance based on the following two reportable segments — Health Plans and Molina Medicaid Solutions. The Health Plans segment represents our former single-segment health plan operations. The Molina Medicaid Solutions segment represents the operations of our new MMIS solutions business.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

Operating segment revenues and profitability for the three months and nine months ended September 30, 2010 and 2009 were as follows:

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
Three months ended September 30, 2010			
Premium revenue	$ 1,005,115	$ —	$ 1,005,115
Service revenue	—	32,271	32,271
Investment income	1,760	—	1,760
Total revenue	$ 1,006,875	$ 32,271	$ 1,039,146
Operating income	$ 28,796	$ 1,157	$ 29,953
Nine months ended September 30, 2010			
Premium revenue	$ 2,947,020	$ —	$ 2,947,020
Service revenue	—	53,325	53,325
Investment income	4,880	—	4,880
Total revenue	$ 2,951,900	$ 53,325	$ 3,005,225
Operating income	$ 65,407	$ 6,162	$ 71,569
Three months ended September 30, 2009			
Premium revenue	$ 914,805	$ —	$ 914,805
Service revenue	—	—	—
Investment income	1,707	—	1,707
Total revenue	$ 916,512	$ —	$ 916,512
Operating income	$ 15,089	$ —	$ 15,089
Nine months ended September 30, 2009			
Premium revenue	$ 2,697,796	$ —	$ 2,697,796
Service revenue	—	—	—
Investment income	7,336	—	7,336
Total revenue	$ 2,705,132	$ —	$ 2,705,132
Operating income	$ 57,738	$ —	$ 57,738

Reconciliation to Income before Income Taxes

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
		(In thousands)		
Segment operating income	$ 29,953	$ 15,089	$ 71,569	$ 57,738
Interest expense	(4,600)	(3,279)	(12,056)	(9,917)
Income before income taxes	$ 25,353	$ 11,810	$ 59,513	$ 47,821

Segment Assets

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
As of September 30, 2010	$ 1,261,967	$ 169,463	$ 1,431,430
As of December 31, 2009	$ 1,245,235	$ —	$ 1,245,235

5. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(In thousands)			
Shares outstanding at the beginning of the period	25,811	25,529	25,607	26,725
Weighted-average number of shares issued	2,279	—	768	—
Weighted-average number of shares purchased	—	—	—	(865)
Weighted-average number of shares issued	28	10	136	84
Denominator for basic earnings per share	28,118	25,539	26,511	25,944
Dilutive effect of employee stock options and stock grants(1)	245	91	291	114
Denominator for diluted earnings per share(2)	28,363	25,630	26,802	26,058

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended September 30, 2010, and 2009, there were approximately 472,000 and 618,000 antidilutive weighted options, respectively. For the nine months ended September 30, 2010, and 2009, there were approximately 492,000 and 622,000 antidilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the three months ended September 30, 2010, and 2009, there were approximately 6,000, and 232,000 antidilutive weighted restricted shares, respectively. For the nine months ended September 30, 2010, and 2009, there were approximately 6,000, and 28,000 antidilutive weighted restricted shares, respectively.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the three month and nine month periods ended September 30, 2010 and 2009.

6. Share-Based Compensation

At September 30, 2010, we had employee equity incentives outstanding under two plans: (1) the 2002 Equity Incentive Plan; and (2) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three month and nine month periods ended September 30, 2010 and 2009:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(In thousands)			
Restricted stock awards	$ 2,367	$ 1,787	$ 6,113	$ 4,661
Stock options (including shares issued under our employee stock purchase plan)	393	485	1,155	1,069
Total stock-based compensation expense	$ 2,760	$ 2,272	$ 7,268	$ 5,730

As of September 30, 2010, there was $14.4 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to recognize over a remaining weighted-average period of 2.7 years. Also as of September 30, 2010, there was $352,000 of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a remaining weighted-average period of 0.6 years.

The total fair value of restricted shares granted during the nine months ended September 30, 2010 and 2009 was $11.9 million and $7.8 million, respectively. The total fair value of restricted shares vested during the nine months ended September 30, 2010 and 2009 was $6.1 million and $3.0 million, respectively. Restricted stock activity for the nine months ended September 30, 2010 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2009	687,630	$ 24.64
Granted	521,225	22.78
Vested	(257,781)	25.83
Forfeited	(87,875)	23.32
Unvested balance as of September 30, 2010	863,199	23.30

Stock option activity for the nine months ended September 30, 2010 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value (In thousands)	Weighted Average Remaining Contractual Term (Years)
Stock options outstanding as of December 31, 2009	650,739	$ 30.25		
Exercised	(29,702)	25.58		
Forfeited	(11,513)	32.39		
Stock options outstanding as of September 30, 2010	609,524	30.44	$ 583	4.4
Stock options exercisable and expected to vest as of September 30, 2010	606,816	30.43	$ 582	4.4
Exercisable as of September 30, 2010	559,974	30.29	$ 580	4.2

7. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was $181.4 million at September 30, 2010, and $160.8 million at December 31, 2009. The carrying amount of the convertible senior notes was $162.7 million at September 30, 2010, and $158.9 million at December 31, 2009.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of September 30, 2010, we held certain assets that are required to be measured at fair value on a recurring basis. These included investments as follows:

Balance Sheet Classification	Description
Current assets:	
Investments (see Note 8)	Investment grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1).
Non-current assets:	
Investments (see Note 8)	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).

As of September 30, 2010, $24.7 million par value ($20.3 million fair value) of our investments consisted of auction rate securities, all of which were collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of September 30, 2010. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, all of 2009, and continued to be unavailable as of September 30, 2010. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of September 30, 2010.

As of September 30, 2010, all of our auction rate securities were designated as available-for-sale securities. As a result of the decrease in fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized losses of $0.5 million to accumulated other comprehensive loss for the nine months ended September 30, 2010. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Until July 2, 2010, we held auction rate securities (designated as trading securities) with a certain investment securities firm. In the fourth quarter of 2008, we entered into a rights agreement with this firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. The remaining eligible auction rate securities, totaling $15.9 million as of June 30, 2010, were sold at par value on July 1, 2010. For the nine months ended September 30, 2010 and 2009, we recorded pretax gains of $4.2 million and $3.5 million, respectively, on the auction rate securities underlying the Rights.

We accounted for the Rights as a freestanding financial instrument and, until July 2, 2010, recorded the value of the Rights under the fair value option. When the remaining eligible auction rate securities were sold at par value on July 1, 2010, the value of the Rights was zero. For the nine months ended September 30, 2010 and 2009, we recorded pretax losses of $3.8 million and $3.2 million, respectively, on the Rights.

Our assets measured at fair value on a recurring basis at September 30, 2010, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
	(In thousands)			
Government -sponsored enterprise securities	$ 70,787	$ 70,787	$ —	$ —
Municipal securities	23,644	23,644	—	—
Corporate debt securities	79,354	79,354	—	—
U.S. treasury notes	18,296	18,296	—	—
Certificates of deposit	3,277	3,277	—	—
Auction rate securities (available-for-sale)	20,294	—	—	20,294
Total assets measured at fair value	$ 215,652	$ 195,358	$ —	$ 20,294

The following table presents a roll-forward of the balance of our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2009	$ 63,494
Total gains (losses):	
Included in earnings:	
Auction rate securities designated as trading securities	4,170
Change in fair value of Rights	(3,807)
Included in other comprehensive income	(513)
Settlements	(43,050)
Balance at September 30, 2010	$ 20,294
The amount of total losses for the period included in other comprehensive loss attributable to the change in unrealized losses relating to assets still held at September 30, 2010	$ (513)

8. Investments

The following tables summarize our investments as of the dates indicated:

	September 30, 2010			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Government-sponsored enterprise securities	$ 70,687	$ 426	$ 326	$ 70,787
Municipal securities (including non-current auction rate securities)	48,293	144	4,499	43,938
Corporate debt securities	79,892	163	701	79,354
U.S. treasury notes	18,169	137	10	18,296
Certificates of deposit	3,277	—	—	3,277
	$ 220,318	$ 870	$ 5,536	$ 215,652

	December 31, 2009			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Government-sponsored enterprise securities	$ 89,451	$ 504	$ 281	$ 89,674
Municipal securities (including non-current auction rate securities)	82,009	3,120	4,154	80,975
Corporate debt securities	32,543	206	185	32,564
U.S. treasury notes	28,052	92	84	28,060
Certificates of deposit	3,258	—	—	3,258
	$ 235,313	$ 3,922	$ 4,704	$ 234,531

The contractual maturities of our investments as of September 30, 2010 are summarized below.

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 100,109	$ 99,474
Due one year through five years	94,779	95,071
Due after five years through ten years	1,430	1,421
Due after ten years	24,000	19,686
	$ 220,318	$ 215,652

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $35.4 million and $66.9 million for the three months ended September 30, 2010, and 2009, respectively. Total proceeds from sales of available-for-sale securities were $101.3 million and $148.8 million for the nine months ended September 30, 2010, and 2009, respectively. Net realized investment gains for the three months and nine months ended September 30, 2010, and 2009 were not significant.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at September 30, 2010, and December 31, 2009, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Approximately half of our investment in municipal securities consists of auction rate securities. As described in Note 7, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at September 30, 2010.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of September 30, 2010.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Government-sponsored enterprise securities	$ 7,712	$ 17	$ 9,639	$ 309	$ 17,351	$ 326
Municipal securities	9,110	55	23,963	4,444	33,073	4,499
Corporate debt securities	45,090	331	12,350	370	57,440	701
U.S. treasury notes	8,558	10	—	—	8,558	10
	$ 70,470	$ 413	$ 45,952	$ 5,123	$ 116,422	$ 5,536

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2009. At December 31, 2009, we previously reported only those available-for-sale investments in an unrealized loss position for at least two consecutive months. To conform to the current year presentation, we have included all available-for-sale investments in an unrealized loss position at December 31, 2009. This presentation change increased the total amount of unrealized losses reported in the following table by $113,000 at December 31, 2009. The accompanying increase to the estimated fair value of the underlying investments amounted to $42.9 million at December 31, 2009.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Government-sponsored enterprise securities	$ 30,460	$ 187	$ 7,297	$ 94	$ 37,757	$ 281
Municipal securities	12,460	78	24,031	3,902	36,491	3,980
Corporate debt securities	13,513	149	1,203	36	14,716	185
U.S. treasury notes	21,824	84	—	—	21,824	84
	$ 78,257	$ 498	$ 32,531	$ 4,032	$ 110,788	$ 4,530

9. Receivables

Health Plans receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Molina Medicaid Solutions' receivables consist primarily of MMIS development milestone billings to states. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	Sept. 30, 2010	Dec. 31, 2009
	(In thousands)	
Health Plans:		
California	$ 96,797	$ 34,289
Michigan	14,285	14,977
Missouri	21,576	19,670
New Mexico	17,757	11,919
Ohio	23,142	37,004
Utah	5,220	6,107
Washington	14,281	9,910
Wisconsin	6,651	—
Others	3,424	2,778
	203,133	136,654
Molina Medicaid Solutions	22,414	—
Total receivables	$ 225,547	$ 136,654

10. Restricted Investments

Pursuant to the regulations governing our Health Plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the balances of restricted investments by health plan, and by our insurance company:

	Sept. 30, 2010	Dec. 31, 2009
	(In thousands)	
California	$ 369	$ 368
Florida	4,466	2,052
Michigan	1,000	1,000
Missouri	500	503
New Mexico	18,873	15,497
Ohio	9,061	9,036
Texas	3,501	1,515
Utah	1,280	578
Washington	151	151
Wisconsin	260	—
Insurance company	4,689	4,686
Other	897	888
Total	$ 45,047	$ 36,274

The contractual maturities of our held-to-maturity restricted investments as of September 30, 2010 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 36,148	$ 36,155
Due one year through five years	8,774	8,815
Due after five years through ten years	125	164
	$ 45,047	$ 45,134

11. Long-Term Debt

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on November 2009, and the fifth amendment on March 15, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. As described below and in Note 3, "Business Combinations," we borrowed $105 million under the Credit Facility to acquire Molina Medicaid Solutions in the second quarter of 2010. During the third quarter of 2010, we repaid this amount using proceeds from our equity offering, described in Note 12, "Stockholders' Equity." As of September 30, 2010, and December 31, 2009, there was no outstanding principal balance under the Credit Facility.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At September 30, 2010, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio set forth pursuant to the Credit Facility was 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first and second quarters of 2010, and through August 14, 2010. Effective as of August 15, 2010, the consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We also paid an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through August 15, 2010.

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, so the remaining aggregate principal amount totaled $187.0 million at September 30, 2010 and December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ended December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of such convertible debt instruments have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of September 30, 2010, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 48 months. The Notes' if-converted value did not exceed their principal amount as of September 30, 2010. At September 30, 2010, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of September 30, 2010	As of December 31, 2009
	(In thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(24,300)	(28,100)
Net carrying amount	$ 162,700	$ 158,900

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(In thousands)			
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,753	$ 5,259	$ 5,323
Amortization of the discount on the liability component	1,291	1,197	3,800	3,563
Total interest cost recognized	$ 3,044	$ 2,950	$ 9,059	$ 8,886

12. Stockholders' Equity

In August 2010, we commenced an underwritten public offering of 4,000,000 shares of our common stock, conducted pursuant to an effective registration statement filed with the Securities and Exchange Commission on December 8, 2008. In connection with the offering, we granted the underwriters an overallotment option to purchase up to 350,000 shares, and the single selling stockholder, the Molina Siblings Trust, granted the underwriters an option to purchase up to 250,000 shares. The overallotment option was subsequently exercised in August 2010. Our chief financial officer, John Molina, is the trustee of the Molina Siblings Trust, with sole voting and investment power. Dr. J. Mario Molina, our president and chief executive officer and the brother of John Molina, is a beneficiary of the Molina Siblings Trust, as is John Molina and each of his other three siblings.

We issued 4,350,000 shares in connection with the offering, including the overallotment option. Net of the underwriting discount, proceeds from the offering totaled $111.6 million, or $25.65 per share. We used the net proceeds of the offering to repay the outstanding indebtedness under the Credit Facility and for general corporate purposes. We did not receive any proceeds from the sale of shares by the selling stockholder.

13. Commitments and Contingencies

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, consolidated financial position, cash flows, or results of operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Contract Losses

Our MMIS service contracts with various states typically span several years. These contracts often involve the development and deployment of new computer systems and technologies. Substantial performance risk exists in each contract with these characteristics, and some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development and implementation phase. On occasion, these contracts have experienced delays in their design, development and implementation phase, the achievement of certain milestones has been delayed, and costs in excess of those anticipated have been incurred. We continuously review and reassess our estimates of contract profitability. If our estimates indicate that a contract loss will occur, a loss accrual is recorded in the period it is first identified, if allowed by relevant accounting guidance. Circumstances that could potentially result in contract losses over the life of the contract include variances from expected costs to deliver our services, and other factors affecting revenues and costs. It is reasonably possible that deferred costs associated with one or more of these contracts could become impaired due to changes in estimates of future contract cash flows.

Regulatory Capital and Dividend Restrictions

The principal operations of our Health Plans segment are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $380.0 million at September 30, 2010, and $368.7 million at December 31, 2009. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Washington, Wisconsin, and Utah have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of September 30, 2010, our health plans had aggregate statutory capital and surplus of approximately $401.3 million compared with the required minimum aggregate statutory capital and surplus of approximately $258.7 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2010. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

14. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of September 30, 2010, and December 31, 2009, our carrying amount for this investment totaled $4.4 million, and $4.1 million, respectively. For the three months ended September 30, 2010 and 2009, we paid $6.0 million, and $4.5 million, respectively, for medical service fees to this provider. For the nine months ended September 30, 2010 and 2009, we paid $15.7 million, and $15.0 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach (“Pacific Hospital”). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $0.8 million, and $0.5 million for the nine months ended September 30, 2010 and 2009, respectively. We believe that the fee-for-service with Pacific Hospital is based on prevailing market rates for similar services.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- budgetary pressures on the federal and state governments and their resulting inability to fully fund Medicaid, Medicare, or CHIP, or to maintain current payment rates, benefit packages, or membership eligibility thresholds and criteria;
- uncertainties regarding the impact of the recently enacted Patient Protection and Affordable Care Act, including the funding provisions related to health plans, and uncertainties regarding the likely impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including normal seasonal flu patterns and rates of utilization that are consistent with our expectations;
- the accurate estimation of incurred but not paid medical costs across our health plans;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments, including our ability to retain expected Medicaid pharmaceutical rebates;
- the continuation and renewal of the government contracts of our health plans and if renewed, the terms on which such contracts are renewed;
- our ability and the ability of our providers to maintain state accreditations to participate in certain state Medicaid programs;
- changes with respect to our provider contracts and the loss of providers;
- changes in services offered, number of our members, membership mix and membership demographics;
- performance of our principal vendors pursuant to our vendor contracts;
- the integration of Molina Medicaid Solutions, including its employees, systems, and operations;
- the retention and renewal of the Molina Medicaid Solutions' state government contracts on terms consistent with our expectations;
- the accuracy of our operating cost and capital outlay projections for Molina Medicaid Solutions;
- the timing of receipt and recognition of revenue and the amortization of expense under our various state contracts held by Molina Medicaid Solutions, including the state of Idaho's acceptance of the MMIS;
- additional administrative costs and the potential payment of damages amounts as a result of MMIS system issues in Idaho;
- the implementation of the expected 2% premium rate increase in California, retroactively effective October 1, 2010;
- the expansion of service in 174 rural counties by our Texas health plan under Texas' CHIP Rural Service Area Program;
- government audits and reviews, including the audit of our Medicare plans by CMS at the end of July 2010;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive;
- revenue recognition and the interpretation and implementation of medical cost expenditure floors, administrative cost and profit ceilings, and profit sharing arrangements in state contracts in New Mexico, Florida, and Texas;
- the interpretation and implementation of at-risk premium rules in Ohio, New Mexico, and Texas that require us to meet certain performance measures in order to earn all of our contract revenue in those states;

- rate increases that do not adequately compensate us for the loss of drug rebates as a result of health reform;
- up-coding by providers or billing in a manner at material variance with historic patterns;
- approval by state regulators of dividends and distributions by our subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation or arbitration matters;
- restrictions and covenants in our credit facility;
- the success of our efforts to leverage our administrative costs to address the needs associated with increased enrollment;
- the relatively small number of states in which we operate health plans and the impact on the consolidated entity of adverse developments in any single health plan;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;
- a state's failure to renew its federal Medicaid waiver;
- an unauthorized disclosure of confidential member information;
- changes in laws regarding the transmission, security and privacy of protected health information and costs associated to comply with such changes;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes and assessments; and
- general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2009, and to Part II, Item 1A — Risk Factors, in our Quarterly Reports on Form 10-Q for the quarters ended March 31, 2010, and June 30, 2010, and in this Quarterly Report, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution investors not to place undue reliance on these statements.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2009.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax, or MGRT, as a premium tax and not as an income tax. Prior periods have been reclassified to conform to this presentation.

In prior periods, general and administrative, or G&A, expenses have included premium tax expenses. Beginning in the second quarter of 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

Overview

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We paid $131.3 million to acquire Molina Medicaid Solutions. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility.

With the addition of Molina Medicaid Solutions, we have added a segment to our internal financial reporting structure in 2010. We will now report our financial performance based on the following two reportable segments:

- Health Plans; and
- Molina Medicaid Solutions.

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. The majority of medical costs associated with premium revenues are risk-based costs — while the health plans receive fixed per member per month premium payments from the states, the health plans are at risk for the costs of their members' health care. Our Health Plans segment operates in a highly regulated environment with minimum capitalization requirements. These capitalization requirements, among other things, limit the health plans' ability to pay dividends to us without regulatory approval.

As of September 30, 2010, our health plans were located in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. Additionally, we operate three county-owned primary care clinics in Virginia.

Molina Medicaid Solutions Segment

Unlike the Health Plans segment, the Molina Medicaid Solutions segment is a service-based business that adds to our revenue stream without assuming additional medical cost risk. Additionally, the capital requirements of the Molina Medicaid Solutions segment are — except in the case of new contract start-ups — considerably less than those of our Health Plans segment. Regulatory approval is not required for the Molina Medicaid Solutions segment to pay dividends to us.

While we believe that the acquisition of the Molina Medicaid Solutions segment diversifies our risk profile, we also believe that the two segments are complementary from strategic and operating perspectives. From a strategic perspective, both segments allow us to participate in an expanding sector of the economy while continuing our mission to serve low-income families and individuals eligible for government-sponsored health care programs. Operationally, the segments share a common systems platform — allowing for efficiencies of scale — and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market various cost containment and quality practices used by our Health Plans segment (such as care management and care coordination programs) to state MMIS customers who wish to incorporate certain aspects of managed care programs into their own fee-for-service programs.

The following table briefly summarizes our financial performance for the three month and nine month periods ended September 30, 2010 compared with the same periods in 2009. All ratios, with the exception of the medical care ratio and the premium tax ratio, are shown as a percentage of total revenue. The medical care ratio and the premium tax ratio are shown as a percentage of premium revenue because there are direct relationships between premium revenue earned, and the cost of health care and premium taxes.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(Amounts in thousands, except per share data)			
Earnings per diluted share	$ 0.57	$ 0.33	$ 1.39	$ 1.36
Premium revenue	$ 1,005,115	$ 914,805	$ 2,947,020	$ 2,697,796
Service revenue	$ 32,271	$ —	$ 53,325	$ —
Operating income	$ 29,953	$ 15,089	$ 71,569	$ 57,738
Net income	$ 16,173	$ 8,564	$ 37,342	$ 35,340
Total ending membership	1,597	1,411	1,597	1,411
Premium revenue	96.7%	99.8%	98.1%	99.7%
Service revenue	3.1	—	1.8	—
Investment income	0.2	0.2	0.1	0.3
Total revenue	100.0%	100.0%	100.0%	100.0%
Medical care ratio	84.2%	86.7%	85.1%	86.5%
General and administrative expense ratio	8.5%	7.5%	8.2%	7.4%
Premium tax ratio	3.5%	3.3%	3.5%	3.2%
Operating income	2.9%	1.6%	2.4%	2.1%
Net income	1.6%	0.9%	1.2%	1.3%
Effective tax rate	36.2%	27.5%	37.3%	26.1%

Composition of Revenue and Membership

Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the nine months ended September 30, 2010, we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the nine months ended September 30, 2010, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in California (effective October 1, 2009), Michigan, Missouri, Ohio, Texas, Utah (effective September 1, 2009), Washington, and Wisconsin. Such payments are recognized as revenue in the month the birth occurs.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	Sept. 30, 2010	Dec. 31, 2009	Sept. 30, 2009
Total Ending Membership by Health Plan:			
California	349,000	351,000	355,000
Florida	57,000	50,000	43,000
Michigan	225,000	223,000	210,000
Missouri	79,000	78,000	78,000
New Mexico	91,000	94,000	90,000
Ohio	241,000	216,000	208,000
Texas	96,000	40,000	31,000
Utah	78,000	69,000	69,000
Washington	353,000	334,000	327,000
Wisconsin (1)	28,000	—	—
Total	1,597,000	1,455,000	1,411,000
Total Ending Membership by State for our Medicare Advantage Plans (1):			
California	4,300	2,100	1,900
Florida	500	—	—
Michigan	5,700	3,300	2,700
New Mexico	600	400	400
Texas	600	500	500
Utah	8,600	4,000	3,500
Washington	2,300	1,300	1,100
Total	22,600	11,600	10,100
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	13,500	13,900	13,700
Florida	9,500	8,800	8,700
Michigan	31,400	32,200	30,200
New Mexico	5,700	5,700	5,700
Ohio	27,900	22,600	19,600
Texas	18,900	17,600	17,500
Utah	7,900	7,500	7,700
Washington	3,700	3,200	3,200
Wisconsin (1)	1,700	—	—
Total	120,200	111,500	106,300

(1) We acquired the Wisconsin health plan on September 1, 2010. As of September 30, 2010, the Wisconsin health plan had approximately 3,000 Medicare Advantage members covered under a reinsurance contract with a third party; these members are not included in the membership tables herein.

Molina Medicaid Solutions Segment

As a result of our recent acquisition of Molina Medicaid Solutions, a portion of our revenues is derived from service arrangements. This segment provides technology solutions to state Medicaid programs that include system design, development, implementation, and technology outsourcing services. In addition, this segment offer business process outsourcing to state Medicaid agencies that handle key administrative functions such as claims processing, provider enrollment, pharmacy drug rebate services, recipient eligibility management, and pre-authorization services. In general, we expect the operating profit margin percentage generated by the Molina Medicaid Solutions segment to be higher than the operating profit margin percentage generated by the Health Plans segment. See further discussion of our Molina Medicaid Solutions segment revenue recognition and deferred contract costs at “Critical Accounting Policies,” below.

Molina Medicaid Solutions has contracts with five states to design, develop, implement, maintain, and operate Medicaid Management Information Systems (MMIS). Additionally, Molina Medicaid Solutions provides pharmacy rebate administration services under a contract with the state of Florida.

These contracts extend over a number of years, and cover the life of the MMIS from inception though at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds.

Under our contracts in Louisiana, New Jersey, West Virginia and Florida we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue on a straight-line basis over the remaining term of the contract. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in November 2010.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- Fee-for-service — expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- Capitation — expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- Pharmacy — expenses for all drug, injectible, and immunization costs paid primarily through our pharmacy benefit manager.
- Other — expenses for medically related administrative costs ($61.9 million and $54.9 million for the nine months ended September 30, 2010 and 2009, respectively), certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Louisiana, New Jersey, West Virginia and Florida, as well as certain selling, general and administrative expenses. We began revenue and cost recognition for our Maine contract in September 2010, and expect to begin revenue and cost recognition for our Idaho contract in November 2010. Additionally, certain indirect costs incurred under our contracts in Idaho and Maine are also expensed to cost of services.

Deferred contract costs, which primarily relate to our contracts in Idaho and Maine, include direct and incremental costs such as direct labor, hardware, and software. We also defer and subsequently amortize certain transition costs related to activities that transition the contract from the design, development, and implementation phase to the operational or business process outsourcing phase. Deferred contract costs, including transition costs, are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Results of Operations

Three Months Ended September 30, 2010 Compared with the Three Months Ended September 30, 2009

Health Plans Segment

Premium Revenue

Premium revenue grew 10% in the third quarter of 2010 compared with the third quarter of 2009. The revenue increase was primarily due to a membership increase of 13% as of September 30, 2010 compared with membership as of September 30, 2009. Medicare enrollment exceeded 22,000 members at September 30, 2010, and Medicare premium revenue for the quarter was $70.7 million compared with $33.7 million in the third quarter of 2009.

On a per-member-per-month, or PMPM, basis, consolidated premium revenue was flat, because the impact of premium reductions tied to the elimination of the pharmacy benefit in Ohio and Missouri were offset by increased Medicare enrollment and higher Medicaid rates exclusive of the pharmacy cuts in Ohio and Missouri. Exclusive of the pharmacy cuts, premium revenue PMPM increased approximately 6.4%. Approximately one half of the percentage increase in PMPM revenue exclusive of the pharmacy cuts in Ohio and Missouri was due an increase in our Medicare enrollment as a percentage of total enrollment; the other half of the increase was due to higher Medicaid premium rates.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended September 30,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 601,836	$ 130.60	71.1%	$ 515,164	$ 122.86	65.0%
Capitation	136,425	29.61	16.1	140,551	33.52	17.7
Pharmacy	76,049	16.50	9.0	104,274	24.87	13.2
Other	31,627	6.87	3.8	32,782	7.82	4.1
Total	$ 845,937	$ 183.58	100.0%	$ 792,771	$ 189.07	100.0%

The medical care ratio decreased to 84.2% for the three months ended September 30, 2010, compared with 86.7% for the three months ended September 30, 2009.

The medical care ratio of the California health plan decreased to 80.3% in the third quarter of 2010 from 92.3% in the third quarter of 2009, primarily due to provider network restructuring and improved medical management. Lower inpatient costs were the greatest contributor to the decrease in the California health plan's medical care ratio.

The medical care ratio of the Ohio health plan decreased to 81.2% in the third quarter of 2010 from 85.6% in the third quarter of 2009, primarily due to an increase in Medicaid premium PMPM of approximately 6% effective January 1, 2010.

The medical care ratio of the Utah health plan decreased to 84.9% in the third quarter of 2010 from 92.5% in the third quarter of 2009, primarily due to a decrease in provider rates and an increase in Medicaid premium PMPM of approximately 8% effective July 1, 2010.

The medical care ratio of the Washington health plan decreased to 79.4% in the third quarter of 2010 from 83.0% in the third quarter of 2009, primarily due to reduced fee for service costs in the inpatient, outpatient and physician categories, and an increase in Medicaid premium PMPM of approximately 2.5% effective July 1, 2010.

The medical care ratio of the Michigan health plan increased to 85.7% in the third quarter of 2010 from 81.2% in the third quarter of 2009, primarily due to higher fee-for-service costs for Medicaid members and a shift in member mix towards high medical care ratio Medicare members.

The medical care ratio of the Missouri health plan increased to 86.7% in the third quarter of 2010 from 82.3% in the third quarter of 2009, primarily due to higher inpatient fee-for-service costs and a slight decrease (approximately 1%) in premium revenue PMPM effective July 1, 2010.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio and premium taxes by health plan for the three months ended September 30, 2010 and September 30, 2009 (in thousands except PMPM amounts):

	Three Months Ended September 30, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,046	$ 128,350	$ 122.75	$ 103,002	$ 98.51	80.3%	$ 1,888
Florida	169	43,485	256.25	42,258	249.02	97.2	(14)
Michigan	675	156,609	232.05	134,238	198.90	85.7	9,655
Missouri	236	52,952	224.63	45,930	194.84	86.7	—
New Mexico	274	93,602	341.38	78,121	284.92	83.5	2,170
Ohio	715	210,651	294.55	171,051	239.18	81.2	16,734
Texas	180	48,188	267.95	43,129	239.82	89.5	861
Utah	234	67,566	289.28	57,381	245.67	84.9	—
Washington	1,051	195,578	186.03	155,307	147.73	79.4	3,622
Wisconsin(2)	28	6,310	224.18	6,154	218.65	97.5	—
Other(3)	—	1,824	—	9,366	—	—	121
Total	4,608	$1,005,115	$ 218.12	$ 845,937	$ 183.58	84.2%	$ 35,037

	Three Months Ended September 30, 2009						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,065	$ 122,048	$ 114.61	$ 112,663	$ 105.80	92.3%	$ 3,700
Florida	109	27,292	250.27	25,931	237.80	95.0	10
Michigan	629	136,262	216.74	110,577	175.89	81.2	8,663
Missouri	232	60,867	261.76	50,075	215.35	82.3	—
New Mexico	264	105,721	400.04	86,678	327.99	82.0	2,953
Ohio	618	204,565	331.22	175,187	283.65	85.6	11,167
Texas	93	26,299	282.13	26,904	288.61	102.3	574
Utah	203	46,849	231.14	43,346	213.86	92.5	—
Washington	979	182,096	185.99	151,099	154.33	83.0	3,131
Wisconsin(2)	—	—	—	—	—	—	—
Other(3)	—	2,806	—	10,311	—	—	59
Total	4,192	$ 914,805	$ 218.17	$ 792,771	$ 189.07	86.7%	$ 30,257

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs represent primarily medically related administrative costs at the parent company.

Days in Medical Claims and Benefits Payable

Beginning January 1, 2010, and for all prior periods presented, we are reporting days in medical claims and benefits payable relating to fee-for-service medical claims only. This new computation includes only fee-for-service medical care costs and related liabilities, and therefore calculates the extent of reserves for those liabilities that are most subject to estimation.

The days in medical claims and benefits payable amount previously reported included *all* medical care costs (fee-for-service, capitation, pharmacy, and administrative), and *all* medical claims liabilities, including those liabilities that are typically paid concurrently, or shortly after the costs are incurred, such as capitation costs and pharmacy costs. Medical claims liabilities in this calculation do not include accrued costs — such as salaries — associated with the administrative portion of medical costs. By including only fee-for-service medical costs and liabilities in this computation, our days in claims payable metric will be more indicative of the adequacy of our reserves for liabilities subject to a substantial degree of estimation. The days in medical claims and benefits payable, excluding our new Wisconsin health plan, were as follows:

	Sept. 30, 2010	June 30, 2010	Dec. 31, 2009	Sept. 30, 2009
Days in claims payable — fee-for-service only	42 days	44 days	44 days	44 days
Number of claims in inventory at end of period	110,200	106,700	93,100	107,700
Billed charges of claims in inventory at end of period (dollars in thousands)	$ 158,900	$ 147,500	$ 131,400	$ 145,500

Molina Medicaid Solutions Segment

Molina Medicaid Solutions contributed $1.2 million to operating income for the three months ended September 30, 2010, with an operating profit margin of approximately 4%. As we expected, the operating profit for this segment has declined as a result of the revenue and cost recognition that commenced in Maine as of its September 1, 2010 "go-live" operational date. In addition, and contrary to our expectations, the consulting and outside service costs for both Idaho and Maine following their respective go-live operational dates have not declined from their pre-operational levels. Performance of the Molina Medicaid Solutions segment for the three months ended September 30, 2010 was as follows:

	(In thousands)
Service revenue before amortization	$ 34,926
Amortization of contract backlog recorded as contra-service revenue	(2,655)
Service revenue	32,271
Cost of service revenue	27,605
General and administrative costs	2,195
Amortization of customer relationship intangibles recorded as amortization	1,314
Operating income	$ 1,157

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses, or G&A, were $88.7 million, or 8.5% of total revenue, for the third quarter of 2010 compared with $68.6 million, or 7.5% of total revenue, for the third quarter of 2009. Absent the $4.7 million of employee severance and settlement costs indicated below, general and administrative expense would have been 8.1% of total revenue for the third quarter of 2010. The increase in the G&A ratio was the result of higher administrative expenses for the Health Plan segment, driven in part by the cost of our Medicare expansion, employee severance costs of $4.7 million for the quarter, and the acquisition of Molina Medicaid Solutions.

	Three Months Ended September 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Medicare-related administrative costs	$ 6,511	0.6%	$ 4,288	0.5%
Non Medicare-related administrative costs:				
Molina Medicaid Solutions segment administrative costs	2,195	0.2	—	—
Employee severance and settlement costs	4,654	0.4	132	—
Health Plans segment administrative payroll, including employee incentive compensation	57,741	5.6	53,042	5.8
All other Health Plans segment administrative expense	17,559	1.7	11,101	1.2
	$ 88,660	8.5%	$ 68,563	7.5%

Premium Tax Expenses

Premium tax expense relating to Health Plans segment premium revenue increased to 3.5% of revenue for the three months ended September 30, 2010, from 3.3% for the three months ended September 30, 2009, primarily due to the imposition of a higher premium tax rate in Ohio effective October 1, 2009.

Depreciation and Amortization

Depreciation and amortization specifically identified as such in the consolidated statements of income increased $2.1 million in the three months ended September 30, 2010 compared with the three months ended September 30, 2009, primarily due to depreciation of investments in infrastructure and the amortization of certain purchased intangibles associated with the acquisition of Molina Medicaid Solutions. Beginning in the second quarter of 2010, the amortization of contract backlog intangibles associated with the acquisition of Molina Medicaid Solutions is recorded as contra-service revenue. Additionally, most of the depreciation associated with Molina Medicaid Solutions is recorded as cost of service revenue. The following table presents all depreciation and amortization recorded in the consolidated financial statements:

	Three Months Ended September 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation and amortization	$ 11,954	1.1%	$ 9,832	1.1%
Amortization recorded as contra-service revenue	2,655	0.3	—	—
Depreciation recorded as cost of service revenue	1,964	0.2	—	—
	$ 16,573	1.6%	$ 9,832	1.1%

Interest Expense

Interest expense increased to $4.6 million for the three months ended September 30, 2010, compared with $3.3 million for the three months ended September 30, 2009. We incurred higher interest expense relating to the $105 million draw on our credit facility (beginning May 1, 2010) to fund the acquisition of Molina Medicaid Solutions. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $1.3 million, and $1.2 million for the three months ended September 30, 2010 and 2009, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 36.2% for the three months ended September 30, 2010, compared with 27.5% for the three months ended September 30, 2009. The lower rate in 2009 was primarily due to discrete tax benefits of $1.0 million recorded in the third quarter of 2009 primarily related to higher than previously estimated tax credits and a reassessment of liabilities for unrecognized tax benefits.

Through December 31, 2009, our income tax expense included both the Michigan business income tax, or BIT, and the Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers are defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of the Michigan plan's receipts, and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

For the three months ended September 30, 2009, amounts for premium tax expense (included in general and administrative expenses) and income tax expense have been reclassified to conform to the presentation of MGRT as a premium tax. The MGRT amounted to $1.5 million and $1.2 million for the three months ended September 30, 2010, and 2009, respectively. There was no impact to net income for either period presented relating to this change.

Nine Months Ended September 30, 2010 Compared with the Nine Months Ended September 30, 2009

Health Plans Segment

Premium Revenue

Premium revenue grew 9% in the nine months ended September 30, 2010, compared with the same period in 2009. The revenue increase was primarily due to a membership increase of 13% as of September 30, 2010, compared with membership as of September 30, 2009. Medicare enrollment exceeded 22,000 members at September 30, 2010, and Medicare premium revenue for the first nine months of 2010 was $188.6 million compared with $95.9 million for the same period in 2009.

On a PMPM basis, however, consolidated premium revenue decreased 1.8% because of declines in premium rates. The impact of premium reductions tied to the elimination of the pharmacy benefit in Ohio and Missouri more than offset increased Medicare enrollment and higher Medicaid rates exclusive of the pharmacy cuts in Ohio and Missouri. Exclusive of the pharmacy cuts, premium revenue PMPM increased approximately 4.6%. Approximately one half of the percentage increase in PMPM revenue exclusive of the pharmacy cuts in Ohio and Missouri was due an increase in our Medicare enrollment as a percentage of total enrollment; the other half of the increase was due to higher Medicaid premium rates.

Medical Care Costs

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Nine Months Ended September 30,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$1,763,675	$ 130.55	70.3%	$1,521,371	$ 125.24	65.2%
Capitation	410,321	30.37	16.4	413,351	34.03	17.7
Pharmacy	241,290	17.86	9.6	306,168	25.20	13.1
Other	93,080	6.89	3.7	92,975	7.65	4.0
Total	$2,508,366	$ 185.67	100.0%	$2,333,865	$ 192.12	100.0%

The medical care ratio decreased to 85.1% for the nine months ended September 30, 2010, compared with 86.5% for the nine months ended September 30, 2009.

The medical care ratio of the California health plan decreased to 84.0% for the nine months ended September 30, 2010, from 92.8% for the same period in 2009, primarily due to provider network restructuring and improved medical management. Lower inpatient costs were the greatest contributor to the decrease in the California health plan's medical care ratio.

The medical care ratio of the Ohio health plan decreased to 80.7% for the nine months ended September 30, 2010, from 85.5% for the same period in 2009, primarily due to an increase in Medicaid premium PMPM of approximately 6% effective January 1, 2010.

The medical care ratio of the Washington health plan increased to 84.2% for the nine months ended September 30, 2010, from 83.7% for the same period in 2009, primarily due to reduced premium rates implemented in the third quarter of 2009 that were only partially offset by the premium rate increase of approximately 2.5% that was received effective July 1, 2010.

The medical care ratio of the Michigan health plan increased to 84.4% for the nine months ended September 30, 2010, from 82.1% for the same period in 2009, primarily due to higher fee-for-service costs for Medicaid members and a shift in member mix towards high medical care ratio Medicare members.

The medical care ratio of the Missouri health plan increased to 86.5% for the nine months ended September 30, 2010, from 82.0% for the same period in 2009, primarily due to higher inpatient fee-for-service costs.

Health Plans Segment Operating Data

The following summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the nine months ended September 30, 2010 and September 30, 2009 (in thousands except PMPM amounts):

	Nine Months Ended September 30, 2010						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	3,158	$ 376,811	$ 119.32	$ 316,569	$ 100.24	84.0%	$ 5,153
Florida	483	124,035	256.70	116,079	240.23	93.6	(2)
Michigan	2,029	468,723	230.98	395,450	194.87	84.4	29,305
Missouri	704	156,874	222.83	135,766	192.85	86.5	—
New Mexico	834	281,149	336.93	225,346	270.06	80.2	7,161
Ohio	2,083	641,683	308.11	517,951	248.70	80.7	50,251
Texas	426	130,881	307.51	114,593	269.24	87.6	2,247
Utah	685	191,040	278.99	179,816	262.60	94.1	—
Washington	3,080	562,836	182.75	473,609	153.78	84.2	10,278
Wisconsin(2)	28	6,310	224.18	6,154	218.65	97.5	—
Other(3)	—	6,678	—	27,033	—	—	185
Total	13,510	$2,947,020	$ 218.14	$2,508,366	$ 185.67	85.1%	$ 104,578

	Nine Months Ended September 30, 2009						
	Member Months(1)	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	3,076	$ 354,001	$ 115.09	$ 328,386	$ 106.76	92.8%	$ 10,411
Florida	245	66,322	270.67	61,054	249.17	92.1	10
Michigan	1,872	405,576	216.72	332,974	177.93	82.1	26,039
Missouri	695	177,715	255.62	145,631	209.47	82.0	—
New Mexico	763	301,947	395.79	258,954	339.43	85.8	8,035
Ohio	1,774	586,672	330.73	501,606	282.77	85.5	32,090
Texas	283	93,655	330.78	79,161	279.59	84.5	1,830
Utah	587	155,385	264.67	140,791	239.81	90.6	—
Washington	2,850	546,520	191.76	457,625	160.57	83.7	9,142
Wisconsin(2)	—	—	—	—	—	—	—
Other(3)	—	10,003	—	27,683	—	—	55
Total	12,145	$2,697,796	$ 222.08	$2,333,865	$ 192.12	86.5%	$ 87,612

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) We acquired the Wisconsin health plan on September 1, 2010.

(3) "Other" medical care costs represent primarily medically related administrative costs at the parent company.

Molina Medicaid Solutions Segment

Molina Medicaid Solutions contributed $6.2 million to operating income from the date of its acquisition on May 1, 2010, through September 30, 2010, with an operating profit margin of approximately 12%. As we expected, the operating profit for this segment has declined as a result of the revenue and cost recognition that commenced in Maine as of its September 1, 2010 "go-live" operational date. In addition, and contrary to our expectations, the consulting and outside service costs for both Idaho and Maine following their respective go-live operational dates have not declined from their pre-operational levels. Performance of the Molina Medicaid Solutions segment for the five months ended September 30, 2010 was as follows:

	(In thousands)
Service revenue before amortization	$ 57,571
Amortization of contract backlog recorded as contra-service revenue	(4,246)
Service revenue	53,325
Cost of service revenue	41,859
General and administrative costs	3,161
Amortization of customer relationship intangibles recorded as amortization	2,143
Operating income	$ 6,162

Consolidated Expenses and Other

General and Administrative Expenses

General and administrative expenses were $245.6 million, or 8.2% of total revenue, for the nine months ended September 30, 2010, compared with $199.0 million, or 7.4% of total revenue, for the nine months ended September 30, 2009. The increase in the G&A ratio was the result of higher administrative expenses for the Health Plan segment, driven in part by the cost of Medicare expansion, employee severance and settlement costs of $5.2 million year to date, and the acquisitions of Molina Medicaid Solutions and the Wisconsin health plan.

	Nine Months Ended September 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Medicare-related administrative costs	$ 21,010	0.7%	$ 12,842	0.5%
Non Medicare-related administrative costs:				
Molina Medicaid Solutions segment administrative costs	3,161	0.1	—	—
Employee severance and settlement costs	5,152	0.2	538	—
Molina Medicaid Solutions and Wisconsin health plan acquisition costs	2,688	0.1	—	—
Health Plans segment administrative payroll, including employee incentive compensation	167,150	5.6	150,952	5.6
All other Health Plans segment administrative expense	46,458	1.5	34,649	1.3
	$ 245,619	8.2%	$ 198,981	7.4%

Premium Tax Expense

Premium tax expense relating to Health Plans segment premium revenue increased to 3.5% of revenue for the nine months ended September 30, 2010, from 3.2% for the nine months ended September 30, 2009, primarily due to the imposition of a higher premium tax rate in Ohio effective October 1, 2009.

Depreciation and Amortization

Depreciation and amortization specifically identified as such in the consolidated statements of income increased $4.8 million in the nine months ended September 30, 2010 compared with the nine months ended September 30, 2009, primarily due to depreciation of investments in infrastructure and the amortization of certain purchased intangibles associated with the acquisition of Molina Medicaid Solutions. Beginning in the second quarter of 2010, the amortization of acquired contracts associated with the acquisition of Molina Medicaid Solutions has been recorded as contra-service revenue. Additionally, most of the depreciation associated with the Molina Medicaid Solutions segment is recorded as cost of service revenue. The following table presents all depreciation and amortization recorded in the consolidated financial statements:

	Nine Months Ended September 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation and amortization	$ 33,234	1.1%	$ 28,468	1.1%
Amortization recorded as contra- service revenue	4,246	0.1	—	—
Depreciation recorded as cost of service revenue	3,005	0.1	—	—
Depreciation and amortization reported in the consolidated statements of cash flows	$ 40,485	1.3%	$ 28,468	1.1%

Gain on Retirement of Convertible Senior Notes

In February 2009, we purchased and retired $13.0 million face amount of our convertible senior notes. We purchased the notes at an average price of $74.25 per $100 principal amount, for a total of $9.7 million. Including accrued interest, our total payment was $9.8 million. In connection with the purchase of the Notes, we recorded a gain of $1.5 million ($0.04 per diluted share) in the first quarter of 2009.

Interest Expense

Interest expense increased to $12.1 million for the nine months ended September 30, 2010, from $9.9 million for the nine months ended September 30, 2009. We incurred higher interest expense relating to the $105 million draw on our credit facility (beginning May 1, 2010) to fund the acquisition of Molina Medicaid Solutions. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $3.8 million, and $3.6 million for the nine months ended September 30, 2010 and 2009, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 37.3% for the nine months ended September 30, 2010 compared with 26.1% for the nine months ended September 30, 2009. The lower rate in 2009 was primarily due to discrete tax benefits of $5.5 million recorded in the nine months ended September 30, 2009, as a result of settling tax examinations, a reassessment of the tax liability for unrecognized tax benefits, and higher than previously estimated tax credits.

For the nine months ended September 30, 2009, amounts for premium tax expense and income tax expense have been reclassified to conform to the presentation of MGRT as a premium tax. The MGRT amounted to $4.6 million and $3.4 million for the nine months ended September 30, 2010, and 2009, respectively. There was no impact to net income for either period presented relating to this change.

Acquisitions

On September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. We expect the final purchase price for the acquisition to be approximately $16 million, subject to adjustments. As of September 30, 2010, we had paid $5 million of the total purchase price. There will be two subsequent measurement dates (November 1, 2010 and February 1, 2011) on which we will compute the payments based on the plan's membership on those dates.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM as described in "Overview," above.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of September 30, 2010, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $4.9 million for the nine months ended September 30, 2010, compared with $7.3 million for the nine months ended September 30, 2009. This decline was primarily due to lower interest rates in 2010. Our annualized portfolio yield for the nine months ended September 30, 2010 was 0.8% compared with 1.4% for the nine months ended September 30, 2009.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the nine months ended September 30, 2010 was $8.5 million compared with $130.3 million for the nine months ended September 30, 2009, a decrease of $121.8 million. Deferred revenue, which was a source of operating cash totaling $61 million in 2009, was a use of operating cash totaling $64 million in 2010. In 2009, the state of Ohio typically paid premiums in advance of the month the premium was earned. Beginning in January 2010, the state of Ohio has delayed its premium payments to mid-month for the month premium is earned. We do not anticipate any advance payments for the Ohio health plan's premiums during 2010. Cash provided by operating activities was further reduced in the third quarter of 2010 as a result of the delayed passage of the California state budget for 2010-2011. Accounts receivable at the California health plan increased $65 million between the June 30, 2010 and September 30, 2010.

Cash used in investing activities increased significantly in the first nine months of 2010 compared with the first nine months of 2009, due chiefly to the acquisition of Molina Medicaid Solutions, which totaled $131.3 million.

Cash provided by financing activities increased due to funds generated by our equity offering in the third quarter of 2010, which totaled $111.6 million, net of the underwriting discount. Amounts borrowed under our credit facility to fund the acquisition of Molina Medicaid Solutions in the second quarter of 2010 were repaid in the third quarter using proceeds from the equity offering.

Reconciliation of Non-GAAP (1) to GAAP Financial Measures

EBITDA (2)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2010	2009	2010	2009
	(In thousands)			
Operating income	$ 29,953	$ 15,089	$ 71,569	$ 57,738
Add back:				
Depreciation and amortization expense	11,954	9,832	33,234	28,468
Amortization expense recorded as contra-service revenue	2,655	—	4,246	—
Depreciation expense recorded as cost of service revenue	1,964	—	3,005	—
EBITDA	$ 46,526	$ 24,921	$ 112,054	$ 86,206

(1) GAAP stands for U.S. generally accepted accounting principles.

(2) We calculate EBITDA consistently on a quarterly and annual basis by adding back depreciation and amortization expense to operating income. Operating income included interest income of $3.7 million and $6.6 million for the nine months ended September 30, 2010, and 2009, respectively. EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization expense, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to the GAAP measures of net income, operating income, operating margin, or cash provided by operating activities, nor should EBITDA be considered in isolation from these GAAP measures of operating performance. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At September 30, 2010, the parent company — Molina Healthcare, Inc. — held cash and investments of $49.6 million, including auction rate securities with a fair value of $5.9 million, compared with $45.6 million of cash and investments at December 31, 2009. On a consolidated basis, at September 30, 2010, we had working capital of $372.8 million compared with $321.2 million at December 31, 2009. At September 30, 2010 and December 31, 2009, cash and cash equivalents were $426.5 million and $469.5 million, respectively. At September 30, 2010, unrestricted investments were $215.7 million, including $20.3 million in non-current auction rate securities At December 31, 2009, unrestricted investments were $234.5 million, including $59.7 million in non-current auction rate securities.

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

We are a party to an Amended and Restated Credit Agreement, dated as of March 9, 2005, as amended by the first amendment on October 5, 2005, the second amendment on November 6, 2006, the third amendment on May 25, 2008, the fourth amendment on November 2009 and the fifth amendment on March 15, 2010, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility") for a revolving credit line of $150 million that matures in May 2012. The Credit Facility is intended to be used for general corporate purposes. We borrowed $105 million under the Credit Facility to acquire Molina Medicaid Solutions in the second quarter of 2010. During the third quarter of 2010, we repaid this amount using proceeds from our equity offering, described below, under "Shelf Registration Statement." As of September 30, 2010, and December 31, 2009, there was no outstanding principal balance under the Credit Facility.

To the extent that in the future we incur any obligations under the Credit Facility, such obligations will be secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At September 30, 2010, we were in compliance with all financial covenants in the Credit Facility.

The commitment fee on the total unused commitments of the lenders under the Credit Facility is 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans is 200 basis points at every level of the pricing grid. Thus, the applicable margins under the Credit Facility range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. The Credit Facility carves out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes, although the $187.0 million indebtedness is included in the calculation of our consolidated leverage ratio. The fixed charge coverage ratio set forth pursuant to the Credit Facility was 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first and second quarters of 2010, and through August 14, 2010. Effective as of August 15, 2010, the consolidated leverage ratio under the Credit Facility reverted back to 2.75 to 1.0. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We also paid an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through August 15, 2010.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering. As a result of the offering described below, we may now offer up to $182.5 million of our securities from time to time under the shelf registration statement.

On August 13, 2010, we sold 4,000,000 shares of common stock covered by this registration statement, and on August 23, 2010, we sold 350,000 shares of common stock covered by this registration statement. The public offering price for this sale was $25.65 per share, net of the underwriting discount. Our proceeds from these sales totaled approximately $111.6 million, net of the underwriting discount. We used the proceeds from these sales to repay the Credit Facility and for general corporate purposes. Also on August 13, 2010, the Molina Siblings Trust, as a selling stockholder, sold 250,000 shares of outstanding common stock covered by this registration statement.

Long-Term Debt

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, for a remaining aggregate principal amount of $187.0 million as of September 30, 2010, and December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;

- During the five business day period immediately following any five consecutive trading day period in which the trading price per $1,000 principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or

- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the “principal return”) equal to the sum of, for each of the 20 Volume-Weighted Average Price, or VWAP, trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and $50 (representing 1/20th of $1,000); and

- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above $50.

Regulatory Capital and Dividend Restrictions

The principal operations of our Health Plans segment are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $380.0 million at September 30, 2010, and $368.7 million at December 31, 2009.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At September 30, 2010, our health plans had aggregate statutory capital and surplus of approximately $401.3 million, compared with the required minimum aggregate statutory capital and surplus of approximately $258.7 million. All of our health plans were in compliance with the minimum capital requirements at September 30, 2010. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2010.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2009, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Principal areas requiring the use of estimates include those areas listed below. The most significant of these estimates is revenue recognition, the determination of deferred contract costs, and the determination of medical claims and benefits payable, which are discussed in further detail below:

- The recognition of revenue;
- The determination of deferred contract costs;
- The determination of medical claims and benefits payable;
- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon either the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The impairment of long-lived and intangible assets;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Revenue Recognition — Health Plans Segment

Certain components of premium revenue are subject to accounting estimates. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health:* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At September 30, 2010, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At September 30, 2010, there was no liability recorded under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. The state of New Mexico's fiscal year ends June 30, and open contract years typically include up to the two preceding years. For the open state fiscal years ending June 30, 2011, our New Mexico health plan has received $4.6 million in at-risk revenue to date. To date, we have recognized $2.2 million of that amount as revenue, and recorded a liability of approximately $2.4 million as of September 30, 2010, for the remainder. If the state of New Mexico disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. Effective January 1, 2010 an additional 0.25% of the Ohio health plan's revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Ohio's fiscal year ends June 30, and open contract years typically include up to the two preceding years. For the open state fiscal years ending June 30, 2011, our Ohio health plan has received $11.2 million in at-risk revenue to date. To date, we have recognized $3.7 million of that amount as revenue and recorded a liability of approximately $7.5 million as of September 30, 2010, for the remainder. If the state of Ohio disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required. During the third quarter of 2010, we reversed the recognition of approximately $3.3 million of at-risk revenue previously recognized.

- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at September 30, 2010 or December 31, 2009.

- *Texas Health Plan Profit Sharing:* Under our contract with the state of Texas there is a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of September 30, 2010, we had an aggregate liability of approximately $0.6 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2009 and 2010 contract years (ending August 31 of each year). We paid $1.4 million to the state under the terms of this profit sharing agreement during the nine months ended September 30, 2010. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. The state of Texas's fiscal year ends August 31, and open contract years typically include up to the two preceding years. For the open state fiscal years ending August 31, 2011, our Texas health plan received $1.2 million in at-risk revenue, all of which has been recognized as revenue. If the state of Texas disagrees with our estimation of our compliance with the at-risk premium requirements, an adjustment to the amounts owed may be required.

- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue. Based on our knowledge of member health care utilization patterns we have recorded a liability of approximately $1.3 million related to the potential recoupment of Medicare premium revenue at September 30, 2010.

Revenue Recognition and Determination of Deferred Contract Costs — Molina Medicaid Solutions Segment

As a result of our recent acquisition of Molina Medicaid Solutions, a portion of our revenues is derived from service arrangements. For fixed-price contracts where the system design and development phase were in process as of the acquisition date, we apply contract accounting because we will deliver significantly modified and customized MMIS software to the customer under the terms of the contract. Additionally, these contracts contain multiple deliverables; once the system design and development phase is complete, we provide technology outsourcing services and business process outsourcing. We do not have vendor specific objective evidence of the fair value of the technology outsourcing and business process outsourcing components of the contracts because we do not have history of offering these services on a stand-alone basis. As such we account for these fixed-price service contracts as a single element.

Therefore, in general, we recognize contract revenues as a single element ratably over the performance period, or contract term, of the outsourcing services (operations phase) because these services are the last element to be delivered under the contract. The contract terms typically range from five to 10 years. In those service arrangements where final acceptance of a system or solution by the customer is required, contract revenues and costs are deferred until all material acceptance criteria have been met. Performance will often extend over long periods, and our right to receive future payment depends on our future performance in accordance with the agreement. Revenues earned in excess of related billings are accrued, whereas billings in excess of revenues earned are deferred until the related services are provided. Amortization of certain identifiable intangible assets, relating to contract backlog, is recorded to contra-service revenue, to match revenues associated with contract performance that occurred prior to the acquisition date.

Deferred contract costs include direct and incremental costs such as direct labor, hardware and software. We also defer and subsequently amortize certain transition costs related to activities that transition the contract from the design, development, and implementation phase to the operational, or business process outsourcing, phase. Deferred contract costs, including transition costs, are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period. Indirect costs associated with MMIS service contracts are generally expensed as incurred.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	Sept. 30, 2010	Dec. 31, 2009	Sept. 30, 2009
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$ 271,285	$ 246,508	$ 237,495
Capitation payable	53,410	39,995	39,361
Pharmacy	14,663	20,609	21,100
Other	15,782	9,404	5,158
	$ 355,140	$ 316,516	$ 303,114

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Paid,” or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $271.3 million of our total medical claims and benefits payable of $355.1 million as of September 30, 2010. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider’s monthly capitation payment), our IBNP liability at September 30, 2010 was $263.8 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of September 30, 2010 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding September 30, 2010, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 80,718
(4)%	53,812
(2)%	26,906
2%	(26,906)
4%	(53,812)
6%	(80,718)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of September 30, 2010 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (65,330)
(4)%	(43,553)
(2)%	(21,777)
2%	21,777
4%	43,553
6%	65,330

The following per-share amounts are based on a combined federal and state statutory tax rate of 38%, and 26.8 million diluted shares outstanding for the nine months ended September 30, 2010. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at September 30, 2010, net income for the three months ended September 30, 2010 would increase or decrease by approximately $8.3 million, or $0.31 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at September 30, 2010, net income for the three months ended September 30, 2010 would increase or decrease by approximately $6.8 million, or $0.25 per diluted share, net of tax. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $41.7 million, or $1.56 per diluted share, and $33.8 million, or $1.26 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $8.3 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which much of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2009, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 17.6%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2009 and through September 30, 2010 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

For the nine months ended September 30, 2010, we recognized a benefit from prior period claims development in the amount of $46.2 million, This amount represents our estimate as of September 30, 2010 of the extent to which our initial estimate of medical claims and benefits payable at December 31, 2009 exceeded the amount that will ultimately be paid out in satisfaction of that liability.

At March 31, 2010 and June 30, 2010 we had estimated the benefit from prior period claims development at $38.5 million and $43.0 million, respectively. Our estimate of the benefit from prior period claims development has increased during 2010 as we have paid claims and gained more insight into the amount that will ultimately be paid in settlement of our estimated liability at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting and medical management imitative had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

We recognized a benefit from prior period claims development in the amount of $48.0 million and $51.6 million for the nine months ended September 30, 2009, and the year ended December 31, 2009, respectively (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2008. The overestimation of claims liability at December 31, 2008 was the result of the following factors:

- In New Mexico, we overestimated at December 31, 2008 the ultimate amounts we would need to pay to resolve certain high dollar provider claims.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008.
- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt of paper claims would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

In estimating our claims liability at September 30, 2010, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The rapid growth of membership in our Medicare line of business between December 31, 2009 and September 30, 2010.
- An increase in claims inventory at our Ohio health plan between June 30, 2010 and September 30, 2010.
- The transition of claims processing for our Missouri health plan from a third party service provider to our internal claims processing platform effective April l, 2010.
- Changes to the Medicaid fee schedule in Utah effective July 1, 2010.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability. In 2009 and through September 30, 2010, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

We seek to maintain a consistent claims reserving methodology across all periods. Accordingly, any prior period benefit from an un-utilized reserve for adverse claims development may be offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) in the current period, and thus the impact on earnings for the current period may be minimal.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "*Components of medical care costs related to:* Prior periods" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. Claims information presented below does not include our new Wisconsin health plan.

	As of and for the				
	Nine Months Ended		Six Months Ended	Three Months Ended	Year Ended
	September 30, 2010	September 30, 2009	June 30, 2010	March 31, 2010	Dec. 31, 2009
Balances at beginning of period	$ 316,516	$ 292,442	$ 316,516	$ 316,516	$ 292,442
Components of medical care costs related to:					
Current period	2,554,579	2,381,903	1,705,411	861,271	3,227,794
Prior periods	(46,213)	(48,038)	(42,982)	(38,455)	(51,558)
Total medical care costs	2,508,366	2,333,865	1,662,429	822,816	3,176,236
Payments for medical care costs related to:					
Current period	2,219,296	2,089,417	1,389,307	581,389	2,919,240
Prior periods	250,446	233,776	244,038	230,970	232,922
Total paid	2,469,742	2,323,193	1,633,345	812,359	3,152,162
Balances at end of period	$ 355,140	$ 303,114	$ 345,600	$ 326,973	$ 316,516
Benefit from prior period as a percentage of:					
Balance at beginning of period	14.6%	16.4%	13.6%	12.1%	17.6%
Premium revenue	1.5%	1.8%	2.2%	4.0%	1.4%
Total medical care costs	1.8%	2.1%	2.6%	4.7%	1.6%
Days in claims payable, fee for service only	42	44	44	44	44
Number of members at end of period	1,597,000	1,411,000	1,498,000	1,482,000	1,455,000
Number of claims in inventory at end of period	110,200	107,700	106,700	153,700	93,100
Billed charges of claims in inventory at end of period	$ 158,900	$ 145,500	$ 147,500	$ 194,000	$ 131,400
Claims in inventory per member at end of period	0.07	0.08	0.07	0.10	0.06
Billed charges of claims in inventory per member at end of period	$ 99.50	$ 103.12	$ 98.46	$ 130.90	$ 90.31
Number of claims received during the period	10,701,900	9,427,400	7,066,100	3,493,300	12,930,100
Billed charges of claims received during the period	$ 8,615,500	$ 7,180,800	$ 5,605,400	$ 2,760,500	$ 9,769,000

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. *Quantitative and Qualitative Disclosures About Market Risk.*

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our subsidiaries operate.

Item 4. *Controls and Procedures*

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's *"disclosure controls and procedures"* (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the *"Exchange Act"*)) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the fiscal quarter ended September 30, 2010 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. The following risk factors were identified or re-evaluated by the Company during the third quarter and are a supplement to those risk factors discussed in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2009, and to Part II, Item 1A — Risk Factors, in our Quarterly Reports on Form 10-Q for the quarters ended March 31, 2010 and June 30, 2010. The risks described herein and in our Annual Report on Form 10-K and Quarterly Reports on Form 10-Q are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

MMIS operational problems in Idaho or Maine could result in reduced or withheld payments, actual damage or liquidated damage assessments, increased administrative costs, or even contract termination, any of which could adversely affect our business, financial condition, cash flows, or results of operations.

From and after the MMIS operational or "go live" date of June 1, 2010, Molina Medicaid Solutions has experienced certain problems with the MMIS in Idaho. On October 5, 2010, Molina Medicaid Solutions received from the Idaho Department of Administration a notice to cure letter with respect to its alleged non-compliance with certain provisions of the MMIS project agreements. Molina Medicaid Solutions and the Idaho Department of Health and Welfare ("DHW") have been working together to resolve the MMIS problems, and Molina Medicaid Solutions has developed a corrective action plan with respect to the identified problems and defects. Molina Medicaid Solutions believes it has ameliorated or corrected many of the identified problems, and that it will ultimately be successful in resolving all of the MMIS issues in Idaho. However, in the event Molina Medicaid Solutions is unsuccessful in correcting all of the identified problems, the Idaho Department of Administration may: (i) reduce or withhold its payments to Molina Medicaid Solutions, (ii) require Molina Medicaid Solutions to provide services at no additional cost to Idaho, (iii) require the payment of actual damages or liquidated damages, or (iv) terminate its contract with Molina Medicaid Solutions. In addition, Molina Medicaid Solutions may incur much greater administrative costs than expected in correcting the MMIS problems, or in advancing interim payments to Idaho providers. For example, the consulting and outside service costs for Idaho following its go-live operational date have not declined from the pre-operational level as had been previously expected. Finally, Idaho DHW may not accept the MMIS developed and implemented by Molina Medicaid Solutions, or CMS may not certify such MMIS. All of such risks are also applicable to the MMIS in Maine which became operational as of September 1, 2010. The realization of any of the foregoing risks could adversely affect our business, financial condition, cash flows, or results of operations.

There are numerous risks associated with the expansion of our Texas health plan's service area under the CHIP Rural Service Area Program, and with our acquisition of Abri Health Plan in Wisconsin.

In September 2010, our Texas health plan began arranging health care services for approximately 64,000 low-income children and pregnant women in 174 predominantly rural counties through Texas' Children's Health Insurance Program (CHIP) and CHIP Perinatal Program. In addition, on September 1, 2010, we acquired Abri Health Plan, a Medicaid managed care organization based in Milwaukee, Wisconsin. As of September 30, 2010, Abri Health Plan served approximately 28,000 Medicaid members. There are numerous risks associated with a health plan's initial expansion into a new service area or the provision of medical services to a new population, including pent-up demand for medical services, elevated medical care costs, and our lack of actuarial experience in setting appropriate reserve levels. In the event the medical care costs of our Texas or Wisconsin health plans are higher than anticipated, we are unable to lower the medical care ratio associated with these new populations, or our reserve levels are inadequate, the negative results of our Texas or Wisconsin health plan could adversely affect our business, financial condition, cash flows, or results of operations.

There are numerous revenue recognition risks associated with certain provisions in the state Medicaid contracts of our New Mexico, Ohio, Florida, and Texas health plans.

The state contracts of our New Mexico, Florida, and Texas health plans contain provisions pertaining to medical cost floors, administrative cost and profit ceilings, and profit sharing arrangements. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could adversely affect our business, financial condition, cash flows, or results of operations.

In addition, the state contracts of our Ohio, New Mexico, and Texas health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures in order to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, our health plan will be unable to recognize the revenue associated with that measure. Any failure of our health plan to satisfy one of these performance measure provisions, or the interpretation or application of these performance measure provisions at variance with our health plan's interpretation, could adversely affect our business, financial condition, cash flows, or results of operations.

There are risks associated with the expected rate increase of approximately 2% effective October 1, 2010 for our California health plan.

On October 8, 2010, the state of California approved a budget for its state fiscal year 2011 running from July 1, 2010 to June 30, 2011. Based on the amounts budgeted for Medi-Cal managed care plans, our California health plan has projected that it will receive a blended PMPM rate increase of approximately 2% effective as of October 1, 2010. The fiscal year 2010 guidance we issued on October 26, 2010 assumes a rate increase at our California health plan of 2% effective as of October 1, 2010. In the event our California health plan does not receive the expected 2% rate increase, or the increase does not become effective as of October 1, 2010, our fiscal year 2010 financial results could be less favorable than projected in our guidance.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. For example, from July 26 to July 30, 2010, the Center for Medicare and Medicaid Services, or CMS, conducted an on-site audit with respect to our Medicare Advantage and Prescription Drug Plan contracts in the compliance areas of enrollment and disenrollment, premium billing, Part D formulary administration, Part D appeals, grievances and coverage determinations and compliance program. As of November 3, 2010, we have not been provided with any written notification of the results of the audit. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, whether as a result of this most recent CMS audit or otherwise, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

States may not adequately compensate us for the value of drug rebates that were previously earned by the Company but that are now collectible by the states.

The Patient Protection and Affordable Care Act includes certain provisions which change the way rebates for drugs are handled for Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and drug companies will be required to pay specified rebates directly to the state Medicaid programs. This will likely impact the level of rebates received by managed care plans from the drug companies for Medicaid managed care enrollees. Many drug companies are in the process of renegotiating their rebate contracts with Medicaid managed care plans and pharmacy benefits managers. As a result, the drug rebate amounts paid to managed care plans like ours will likely decline significantly in the future. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

Item 6. ***Exhibits***

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: November 4, 2010

/s/ JOSEPH M. MOLINA, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: November 4, 2010

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2010 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: November 4, 2010

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended September 30, 2010 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: November 4, 2010

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2010 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: November 4, 2010

/s/ Joseph M. Molina, M.D.

Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2010 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: November 4, 2010

/s/ John C. Molina, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer

MOLINA HEALTHCARE

MHI Form 10-Q for the Period Ended June 30, 2010

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2010

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
200 Oceangate, Suite 100 **Long Beach, California** *(Address of principal executive offices)*	**90802** *(Zip Code)*

(562) 435-3666

(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The number of shares of the issuer's Common Stock, par value $0.001 per share, outstanding as of July 30, 2010, was approximately 25,836,000.

MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1: ***Financial Statements.***

MOLINA HEALTHCARE, INC.

CONSOLIDATED BALANCE SHEETS

	June 30, 2010	December 31, 2009
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 460,985	$ 469,501
Investments	175,212	174,844
Receivables	155,380	136,654
Income and related taxes refundable	1,157	6,067
Deferred income taxes	4,726	8,757
Prepaid expenses and other current assets	23,843	15,583
Total current assets	821,303	811,406
Property and equipment, net	83,562	78,171
Deferred contract costs	8,018	—
Intangible assets, net	120,480	80,846
Goodwill and indefinite-lived intangible assets	205,749	133,408
Investments	36,745	59,687
Restricted investments	41,028	36,274
Receivable for ceded life and annuity contracts	25,277	25,455
Other assets	19,242	19,988
	$ 1,361,404	$ 1,245,235
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 345,600	$ 316,516
Accounts payable and accrued liabilities	111,022	71,732
Deferred revenue	19,305	101,985
Total current liabilities	475,927	490,233
Long-term debt	266,409	158,900
Deferred income taxes	9,075	12,506
Liability for ceded life and annuity contracts	25,277	25,455
Other long-term liabilities	16,862	15,403
Total liabilities	793,550	702,497
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 25,811 shares at June 30, 2010 and 25,607 shares at December 31, 2009	26	26
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	134,076	129,902
Accumulated other comprehensive loss	(2,039)	(1,812)
Retained earnings	435,791	414,622
Total stockholders' equity	567,854	542,738
	$ 1,361,404	$ 1,245,235

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$976,685	$925,507	$1,941,905	$1,782,991
Service revenue	21,054	—	21,054	—
Investment income	1,599	2,082	3,120	5,629
Total revenue	999,338	927,589	1,966,079	1,788,620
Expenses:				
Medical care costs	839,613	803,206	1,662,429	1,541,094
Cost of service revenue	14,254	—	14,254	—
General and administrative expenses	78,079	65,011	156,959	130,418
Premium tax expenses	34,995	30,300	69,541	57,355
Depreciation and amortization	11,219	9,584	21,280	18,636
Total expenses	978,160	908,101	1,924,463	1,747,503
Gain on retirement of convertible senior notes	—	—	—	1,532
Operating income	21,178	19,488	41,616	42,649
Interest expense	(4,099)	(3,223)	(7,456)	(6,638)
Income before income taxes	17,079	16,265	34,160	36,011
Provision for income taxes	6,500	1,700	12,991	9,235
Net income	$ 10,579	$ 14,565	$ 21,169	$ 26,776
Net income per share:				
Basic	$ 0.41	$ 0.56	$ 0.82	$ 1.02
Diluted	$ 0.41	$ 0.56	$ 0.82	$ 1.02
Weighted average shares outstanding:				
Basic	25,741	25,788	25,694	26,157
Diluted	25,951	25,870	25,952	26,241

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(Amounts in thousands) (Unaudited)			
Net income	$10,579	$14,565	$21,169	$26,776
Other comprehensive income, net of tax:				
Unrealized (loss) gain on investments	(355)	640	(227)	608
Other comprehensive (loss) income	(355)	640	(227)	608
Comprehensive income	$10,224	$15,205	$20,942	$27,384

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2010	2009
	(Amounts in thousands) (Unaudited)	
Operating activities:		
Net income	$ 21,169	$ 26,776
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	23,912	18,636
Unrealized gain on trading securities	(2,860)	(3,610)
Loss on rights agreement	2,611	3,296
Deferred income taxes	624	3,245
Stock-based compensation	4,508	3,458
Non-cash interest on convertible senior notes	2,509	2,366
Gain on repurchase and retirement of convertible senior notes	—	(1,532)
Amortization of deferred financing costs	687	696
Tax deficiency from employee stock compensation recorded as additional paid-in capital	(383)	(547)
Changes in operating assets and liabilities:		
Receivables	(1,598)	(22,878)
Prepaid expenses and other current assets	(5,148)	732
Medical claims and benefits payable	29,084	16,265
Accounts payable and accrued liabilities	27,958	(15,726)
Deferred revenue	(82,680)	54,638
Income taxes	4,910	9,025
Net cash provided by operating activities	25,303	94,840
Investing activities:		
Purchases of equipment	(17,523)	(19,924)
Purchases of investments	(91,768)	(72,182)
Sales and maturities of investments	116,836	82,292
Cash paid in business purchase transactions	(134,400)	—
Increase in deferred contract costs	(8,018)	—
Increase in restricted investments	(4,754)	(6,534)
Increase in other assets	(332)	(2,761)
Increase (decrease) in other long-term liabilities	1,089	(8,772)
Net cash used in investing activities	(138,870)	(27,881)
Financing activities:		
Borrowings under credit facility	105,000	—
Treasury stock purchases	—	(27,712)
Purchase of convertible senior notes	—	(9,653)
Payment of credit facility fees	(1,671)	—
Proceeds from employee stock plans	1,543	1,081
Excess tax benefits from employee stock compensation	179	—
Net cash provided by (used in) financing activities	105,051	(36,284)
Net (decrease) increase in cash and cash equivalents	(8,516)	30,675
Cash and cash equivalents at beginning of period	469,501	387,162
Cash and cash equivalents at end of period	$ 460,985	$ 417,837
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 6,604	$ 7,824
Interest	$ 6,222	$ 3,935

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS — (continued)

	Six Months Ended June 30,	
	2010	2009
	(Amounts in thousands) (Unaudited)	
Schedule of non-cash investing and financing activities:		
Unrealized (loss) gain on investments	$ (366)	$ 876
Deferred taxes	139	(268)
Net unrealized (loss) gain on investments	$ (227)	$ 608
Accrued purchases of equipment	$ 562	$ 394
Retirement of common stock used for stock-based compensation	$ 1,673	$ 775
Details of business purchase transactions:		
Fair value of assets acquired	$ (143,082)	$ (17,326)
Fair value of liabilities assumed	11,832	—
Release of deposit	—	9,000
Increase in payable to seller	—	8,326
Net cash paid in business purchase transactions	$ (131,250)	$ —
Business purchase transactions adjustments:		
Fair value of assets acquired	$ (901)	$ —
Decrease in payable to seller	(2,249)	—
Net cash paid in business purchase transactions adjustments	$ (3,150)	$ —

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2010

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010, we terminated operations at our small Medicare health plan in Nevada.

On May 1, 2010, we acquired a health information management business which now operates under the name, *Molina Medicaid Solutions*SM. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. See Note 3, "Business Purchase Transactions," for more information relating to this acquisition.

Consolidation and Interim Financial Information

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included. Except as described below, such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated in consolidation. The consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2010. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

The unaudited consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2009. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2009 audited consolidated financial statements have been omitted. These unaudited consolidated interim financial statements should be read in conjunction with our December 31, 2009 audited financial statements.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax as a premium tax and not as an income tax. For the three month and six month periods ended June 30, 2009, amounts for premium tax expense and income tax expense have been reclassified to conform to this presentation. See Note 2, "Significant Accounting Policies."

In prior periods, general and administrative expenses have included premium tax expenses. Beginning with the three month and six month periods ended June 30, 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

2. Significant Accounting Policies

Molina Medicaid Solutions Segment Revenue Recognition and Deferred Contract Costs

As a result of our recent acquisition of Molina Medicaid Solutions, a portion of our revenues is derived from service arrangements. This segment provides technology solutions to state Medicaid programs that include system development, system integration, and technology outsourcing services. In addition, this segment offers business process outsourcing to state Medicaid agencies that handle key administrative functions such as claims processing, provider enrollment, pharmacy drug rebate services, recipient eligibility management, and pre-authorization services. The following is an update of our accounting policy, as included in our December 31, 2009 audited financial statements, which specifically addresses revenue recognition for service arrangements.

Under certain of the contracts we acquired, the development of the MMIS solution has already been completed. Under these contracts, we provide business process outsourcing and technology outsourcing services, and recognize outsourcing services revenue on a straight-line basis over the remaining term of the contract.

For fixed-price contracts where the system design and development phase were in process as of the acquisition date, we apply contract accounting because we will deliver significantly modified and customized MMIS software to the customer under the terms of the contract. Additionally, these contracts contain multiple deliverables; once the system design and development phase is complete, we provide technology outsourcing services and business process outsourcing. We do not have vendor specific objective evidence of the fair value of the technology outsourcing and business process outsourcing components of the contracts because we do not have enough history of offering these services on a stand-alone basis. As such we account for these fixed-price service contracts as a single element.

Therefore, in general, we recognize contract revenues as a single element ratably over the performance period, or contract term, of the outsourcing services because these are the last elements to be delivered under the contract. Such contract terms typically range from five to 10 years. In those service arrangements where final acceptance of a system or solution by the customer is required, contract revenues and costs are deferred until all acceptance criteria have been met. Performance will often extend over long periods, and our right to receive future payment depends on our future performance in accordance with the agreement. Revenues earned in excess of related billings are accrued, whereas billings in excess of revenues earned are deferred until the related services are provided.

Deferred contract costs include direct and incremental costs such as direct labor, hardware and software. We also defer and subsequently amortize certain transition costs related to activities that transition the contract from the design, development, and implementation phase to the operational, or business process outsourcing phase. Deferred contract costs, including transition costs, are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets. Indirect costs associated with MMIS service contracts are generally expensed as incurred.

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years.

As discussed in "Molina Medicaid Solutions Segment Revenue Recognition and Deferred Contract Costs" above, the costs associated with certain equipment and software, which may be ultimately sold to our clients under fixed-price contracts, are capitalized and recorded as deferred contract costs. Such costs will be amortized on a straight-line basis over the performance period, consistent with the revenue recognition period.

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are generally amortized on a straight-line basis over the expected period to be benefited (between one and 15 years).

Goodwill and indefinite-lived assets are not amortized, but are subject to impairment tests on an annual basis or, more frequently, if indicators of impairment exist. We used a discounted cash flow methodology to assess the fair values of our reporting units. If the carrying values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite-lived asset balance.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships.

The contract backlog intangible asset is comprised of all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract. The contract backlog intangible has been developed on a contract-by-contract basis. The amortization of that portion of the contract backlog intangible associated with contracts for which revenue recognition has not yet commenced is deferred until revenue recognition has begun. As each acquired contract constitutes a single revenue element contract, amortization of the contract backlog intangible is recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. Amortization of the contract backlog intangible asset is recorded on a straight line basis for each specific contract over a period of one to six years.

The customer relationship intangible asset is comprised of all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. Amortization of the customer relationship intangible is recorded to amortization expense on a straight-line basis for each specific contract over a period of four to eight years.

The determination of the value of identifiable intangible assets requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. In addition to annual impairment testing, we continually evaluate whether events and circumstances have occurred that indicate the balance of identifiable intangible assets may not be recoverable. In evaluating impairment, we compare the estimated fair value of the intangible asset to its underlying book value. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event occurs that would cause us to revise our estimates and assumptions used in analyzing the value of our identifiable intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

Depreciation and Amortization

Beginning in the second quarter of 2010, the amortization of a portion of the purchased intangibles associated with the acquisition of Molina Medicaid Solutions is recorded as contra-service revenue, rather than as part of depreciation and amortization expense, to match revenues associated with contract performance that occurred prior to the acquisition date. Additionally, most of the depreciation expense associated with Molina Medicaid Solutions is

recorded as cost of service revenue. The following table presents all depreciation and amortization expense recorded in our consolidated financial statements:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(In thousands)			
Depreciation and amortization	$ 11,219	$ 9,584	$21,280	$18,636
Amortization expense recorded as contra-service revenue	1,591	—	1,591	—
Depreciation expense recorded as cost of service revenue	1,041	—	1,041	—
Depreciation and amortization reported in our consolidated statements of cash flows	$ 13,851	$ 9,584	$23,912	$18,636

Income Taxes

The provision for income taxes is determined using an estimated annual effective tax rate, which is generally greater than the U.S. federal statutory rate primarily because of state taxes. The effective tax rate may be subject to fluctuations during the year as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or derecognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The total amount of unrecognized tax benefits was $11.0 million and $4.1 million at June, 2010, and December 31, 2009, respectively. Approximately $8.4 million of the unrecognized tax benefits recorded at June 30, 2010, relates to a tax position claimed on a state refund claim that will not result in a cash payment for income taxes if our claim is denied. The total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $7.9 million and $3.4 million as of June 30, 2010 and December 31, 2009, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities will decrease by approximately $0.4 million due to the expiration of statute of limitations.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Our accrual for the payment of interest relating to unrecognized tax benefits was $88,000 and $75,000 as of June 30, 2010 and December 31, 2009, respectively.

Effective January 1, 2008 through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax. The MGRT amounted to $3.1 million and $2.2 million for the six months ended June 30, 2010, and 2009, respectively.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers is defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of our Michigan plan's receipts and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

Recent Accounting Pronouncements

Revenue Recognition. In late 2009, the Financial Accounting Standards Board, or FASB, issued the following new accounting guidance which is first applicable for our January 1, 2011 reporting:

- ASU No. 2009-14, Software (ASC Topic 985) — *Certain Revenue Arrangements That Include Software Elements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies the scope of ASC Subtopic 985-605 — *Software-Revenue Recognition* to exclude from its requirements (a) non-software components of tangible products and (b) software components of tangible products that are sold, licensed or leased with tangible products when the software components and non-software components of the tangible product function together to deliver the tangible product's essential functionality. We do not expect the update to impact our consolidated financial position, results of operations or cash flows.
- ASU No. 2009-13, Revenue Recognition (ASC Topic 605) — *Multiple-Deliverable Revenue Arrangements*, a consensus of the FASB Emerging Issues Task Force. This guidance modifies previous requirements by allowing the use of the "best estimate of selling price" in the absence of vendor-specific objective evidence ("VSOE") or verifiable objective evidence ("VOE") (now referred to as "TPE" or third-party evidence) for determining the selling price of a deliverable. A vendor is now required to use its best estimate of the selling price when more objective evidence of the selling price cannot be determined. In addition, the residual method of allocating arrangement consideration is no longer permitted. We are currently evaluating the impact of this update to our consolidated financial position, results of operations and cash flows.

Fair Value Measurements. In January 2010, the FASB issued guidance which expanded the required disclosures about fair value measurements. In particular, this guidance requires (a) separate disclosure of the amounts of significant transfers in and out of Level 1 and Level 2 fair value measurements along with the reasons for such transfers, (b) information about purchases, sales, issuances and settlements to be presented separately in the reconciliation for Level 3 fair value measurements, (c) fair value measurement disclosures for each class of assets and liabilities and (d) disclosures about the valuation techniques and inputs used to measure fair value for both recurring and nonrecurring fair value measurements for fair value measurements that fall in either Level 2 or Level 3. Effective for interim and annual reporting beginning after December 15, 2009, with one new disclosure effective after December 15, 2010, we adopted this guidance in full during the interim period ended March 31, 2010. The adoption of this guidance did not impact our consolidated financial position, results of operations or cash flows.

3. Business Purchase Transactions

Molina Medicaid Solutions

On May 1, 2010, we acquired a health information management business that was previously an operating unit of Unisys Corporation. This business now operates under the name *Molina Medicaid Solutions*SM, or Molina Medicaid Solutions. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. As a result of this acquisition, we are diversifying our core health plan business, and we believe that the use of a common claims processing platform across our health plans and our new MMIS business will enable us to achieve synergies in the operations of both.

We paid $131.3 million to acquire Molina Medicaid Solutions; the purchase price is subject to working capital adjustments. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility. In connection with the closing, both the fourth amendment and the fifth amendment to our credit facility became effective (see Note 11, "Long-Term Debt").

Recording of assets acquired and liabilities assumed: The transaction has been accounted for using the acquisition method of accounting which requires, among other things, that most assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date. Accounts receivable are based on gross

contractual amounts receivable, substantially all of which we expect to collect because the creditors are state governments.

The following table summarizes the provisional acquisition-date fair values of the assets acquired and liabilities assumed:

	May 1, 2010 (In thousands)
Assets	
Accounts receivable	$ 17,128
Other current assets	4,129
Equipment and other long-term assets	1,003
Identifiable intangible assets	49,460
Goodwill	71,362
	143,082
Less: liabilities	
Accounts payable and accrued liabilities	11,346
Deferred tax liability	115
Other long-term liabilities	371
Net assets acquired	$ 131,250

The recorded amounts for assets and liabilities are provisional and subject to change. We will finalize the amounts recognized as we obtain the information necessary to complete the analyses, but by no later than December 31, 2010. Among the items that may change are amounts for intangibles and deferred taxes pending finalization of valuation efforts and the purchase price consideration subject to working capital adjustments.

A single estimate of fair value results from a complex series of judgments about future events and uncertainties and relies heavily on estimates and assumptions. Results that differ from the estimates and judgments used to determine the estimated fair value assigned to each class of assets acquired and liabilities assumed, as well as asset lives, can materially impact our results of operations.

Accounts receivable: Accounts receivable are stated at fair value, based on the gross contractual amounts receivable. We expect to collect substantially all of the accounts receivable because the creditors are state governments.

Identifiable intangible assets: The following table is a summary of the fair value estimates of the identifiable intangible assets and their weighted-average useful lives:

	Estimated Fair Value	Estimated Useful Life	Weighted-Average Amortization Period
	(In thousands)	(In years)	
Customer relationships	$ 21,820	8.0	4.9
Contract backlog	27,640	4.0	3.7
	$ 49,460		

Goodwill: Goodwill in the amount of $71.4 million was recognized for this acquisition, of which approximately $70.9 million is expected to be deductible for tax purposes. The total goodwill amount was calculated as the excess of the consideration transferred over the net assets recognized and represents the future economic benefits

arising from other assets acquired that could not be individually identified and separately recognized. The goodwill recorded as part of the acquisition of Molina Medicaid Solutions includes:

- Expected synergies and other benefits that we believe will result from combining the operations of Medicaid Solutions with the operations of Molina;
- Any intangible assets that do not qualify for separate recognition such as the assembled workforce; and
- The value of the going-concern element of Molina Medicaid Solutions' existing businesses (the higher rate of return on the assembled collection of net assets versus acquiring all of the net assets separately).

Accounts payable and accrued liabilities: Accounts payable and accrued liabilities include $1.5 million payable to the seller of Molina Medicaid Solutions, which represents additional consideration for the acquisition based on a working capital adjustment provided in the purchase agreement. The working capital adjustment provides that the net working capital, or current assets minus current liabilities, on Molina Medicaid Solutions' opening balance sheet equals $10 million. To the extent the final net working capital conveyed by the seller exceeds $10 million, the amount is payable back to the seller; conversely, to the extent that net working capital conveyed by the seller is less than $10 million, the shortage is a receivable from the seller. Thus, the $1.5 million amount described above represents the amount payable to the seller for net working capital in excess of $10 million on the opening balance sheet. This amount may change based on final negotiations with the seller.

Pro-forma impact of the acquisition: The unaudited pro-forma results presented below include the effects of the acquisition as if it had been consummated as of January 1, 2010 and 2009. The pro-forma results include the amortization associated with an estimate for the acquired intangible assets and interest expense associated with debt used to fund the acquisition. To better reflect the combined operating results, material non-recurring charges directly attributable to the transaction have been excluded. In addition, the pro-forma results do not include any anticipated synergies or other expected benefits of the acquisition. Accordingly, the unaudited pro forma financial information below is not necessarily indicative of either future results of operations or results that might have been achieved had the acquisition been consummated as of January 1, 2010 or January 1, 2009.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(In thousands)			
Revenue	$1,009,500	$953,016	$2,005,814	$1,839,224
Net income	$ 11,725	$ 14,536	$ 25,011	$ 26,308
Diluted earnings per share	$ 0.45	$ 0.56	$ 0.96	$ 1.00

4. Segment Reporting

Our reportable segments are consistent with how we manage the business and view the markets we serve. In the second quarter of 2010, we added a segment to our internal financial reporting structure as a result of the acquisition of Molina Medicaid Solutions described in Note 3, "Business Purchase Transactions."

We will now report our financial performance based on the following two reportable segments — Health Plans and Molina Medicaid Solutions. The Health Plans segment represents our former single-segment health plan operations. The Molina Medicaid Solutions segment represents the operations of our new MMIS solutions business.

We rely on an internal management reporting process that provides segment information to the operating income level for purposes of making financial decisions and allocating resources. The accounting policies of the segments are the same as those described in Note 2, "Significant Accounting Policies." The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment.

Operating segment revenues and profitability for the three months and six months ended June 30, 2010 and 2009 were as follows:

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
Three months ended June 30, 2010			
Revenue from external customers:			
Premium revenue	$ 976,685	$ —	$ 976,685
Service revenue	—	21,054	21,054
Investment income	1,599	—	1,599
Total revenue	$ 978,284	$ 21,054	$ 999,338
Operating income	$ 16,173	$ 5,005	$ 21,178
Six months ended June 30, 2010			
Revenue from external customers:			
Premium revenue	$ 1,941,905	$ —	$ 1,941,905
Service revenue	—	21,054	21,054
Investment income	3,120	—	3,120
Total revenue	$ 1,945,025	$ 21,054	$ 1,966,079
Operating income	$ 36,611	$ 5,005	$ 41,616
Three months ended June 30, 2009			
Revenue from external customers:			
Premium revenue	$ 925,507	$ —	$ 925,507
Service revenue	—	—	—
Investment income	2,082	—	2,082
Total revenue	$ 927,589	$ —	$ 927,589
Operating income	$ 19,488	$ —	$ 19,488
Six months ended June 30, 2009			
Revenue from external customers:			
Premium revenue	$ 1,782,991	$ —	$ 1,782,991
Service revenue	—	—	—
Investment income	5,629	—	5,629
Total revenue	$ 1,788,620	$ —	$ 1,788,620
Operating income	$ 42,649	$ —	$ 42,649

Reconciliation to Income before Income Taxes

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(In thousands)			
Segment operating income	$21,178	$ 19,488	$41,616	$42,649
Interest expense	(4,099)	(3,223)	(7,456)	(6,638)
Income before income taxes	$17,079	$ 16,265	$34,160	$36,011

Segment Assets

	Health Plans	Molina Medicaid Solutions	Total
		(In thousands)	
As of June 30, 2010	$ 1,198,812	$162,592	$ 1,361,404
As of December 31, 2009	$ 1,044,938	$ —	$ 1,044,938

5. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
		(In thousands)		
Shares outstanding at the beginning of the period	25,728	25,991	25,607	26,725
Weighted-average number of shares repurchased	—	(205)	—	(618)
Weighted-average number of shares issued	13	2	87	50
Denominator for basic earnings per share	25,741	25,788	25,694	26,157
Dilutive effect of employee stock options and stock grants(1)	210	82	258	84
Denominator for diluted earnings per share(2)	25,951	25,870	25,952	26,241

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended June 30, 2010, and 2009, there were approximately 483,000 and 623,000 antidilutive weighted options, respectively. For the six months ended June 30, 2010, and 2009, there were approximately 497,000 and 625,000 antidilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the three months ended June 30, 2010, and 2009, there were approximately 1,000, and 292,000 antidilutive weighted restricted shares, respectively. For the six months ended June 30, 2010, and 2009, there were approximately 9,000, and 34,000 antidilutive weighted restricted shares, respectively.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the three month and six month periods ended June 30, 2010 and 2009.

6. Share-Based Compensation

At June 30, 2010, we had employee equity incentives outstanding under two plans: (1) the 2002 Equity Incentive Plan; and (2) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). Charged to general and administrative expenses, total stock-based compensation expense was as follows for the three month and six month periods ended June 30, 2010 and 2009:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
		(In thousands)		
Restricted stock awards	$ 2,106	$ 1,822	$ 3,745	$ 2,874
Stock options (including shares issued under our employee stock purchase plan)	265	202	763	584
Total stock-based compensation expense	$ 2,371	$ 2,024	$ 4,508	$ 3,458

As of June 30, 2010, there was $17.3 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to be recognized over a remaining weighted-average period of 2.9 years. Also as of June 30, 2010, there was $565,000 of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a remaining weighted-average period of 0.8 years.

Unvested restricted stock and restricted stock activity for the six months ended June 30, 2010 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2009	687,630	$ 24.64
Granted	498,125	22.51
Vested	(205,313)	25.38
Forfeited	(44,725)	23.61
Unvested balance as of June 30, 2010	935,717	23.40

The total fair value of restricted shares granted during the six months ended June 30, 2010 and 2009 was $11.2 million and $7.6 million, respectively. The total fair value of restricted shares vested during the six months ended June 30, 2010 and 2009 was $4.6 million and $2.4 million, respectively. Stock option activity during the six months ended June 30, 2010 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value (In thousands)	Weighted Average Remaining Contractual Term (Years)
Stock options outstanding as of December 31, 2009	650,739	$ 30.25		
Exercised	(19,460)	23.96		
Forfeited	(4,513)	32.39		
Stock options outstanding as of June 30, 2010	626,766	$ 30.43	$ 863	5.3
Stock options exercisable and expected to vest as of June 30, 2010	622,510	$ 30.42	$ 863	5.3
Exercisable as of June 30, 2010	570,099	$ 30.26	$ 860	5.2

7. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was $175.1 million at June 30, 2010, and $160.8 million at December 31, 2009. The carrying amount of the convertible senior notes was $161.4 million at June 30, 2010, and $158.9 million at December 31, 2009.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of June 30, 2010, we held certain assets that are required to be measured at fair value on a recurring basis. These included investments as follows:

Balance Sheet Classification	Description
Current assets: Investments (see Note 8)	Investment grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1).
Non-current assets: Investments (see Note 8)	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
	Auction rate securities; designated as trading; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Other assets	Other assets include auction rate securities rights (the "Rights"); reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).

As of June 30, 2010, $42.2 million par value (fair value of $36.7 million) of our investments consisted of auction rate securities, all of which were collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of June 30, 2010. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, all of 2009, and continued to be unavailable as of June 30, 2010. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of June 30, 2010.

As of June 30, 2010, we held $15.9 million par value (fair value of $14.6 million) auction rate securities (designated as trading securities) with a certain investment securities firm. In the fourth quarter of 2008, we entered into a rights agreement with this firm that (1) allows us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gives the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we receive the par value. On June 30, 2010, we began to exercise these Rights. The balance of the eligible auction rate securities, totaling $15.9 million as of June 30, 2010, was sold at par value on July 1, 2010 (see Note 14, "Subsequent Events").

We have accounted for the Rights as a freestanding financial instrument and have elected to record the value of the Rights under the fair value option. We recorded pretax losses on the Rights, attributable to the decline in the fair value of the Rights, totaling $2.6 million, and $3.3 million for the six months ended June 30, 2010, and 2009, respectively. To determine the fair value estimate of the Rights, we used a discounted cash-flow model based on the expectation that the auction rate securities will be put back to the investment securities firm at par on June 30, 2010, as permitted by the rights agreement. As of June 30, 2010, the recorded value of the Rights, totaling $1.3 million, equals the cumulative unrealized losses on the remaining auction rate securities underlying the Rights.

For the six months ended June 30, 2010 and 2009, we recorded pretax gains of $2.9 million and $3.6 million, respectively, on the auction rate securities underlying the Rights.

As of June 30, 2010, the remainder of our auction rate securities (designated as available-for-sale securities) amounted to $26.3 million par value (fair value of $22.2 million). As a result of the decrease in fair value of auction

rate securities designated as available-for-sale, we recorded pretax unrealized losses of $0.2 million to accumulated other comprehensive loss for the six months ended June 30, 2010. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Our assets measured at fair value on a recurring basis at June 30, 2010, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
		(In thousands)		
Investments	$175,212	$175,212	$ —	$ —
Auction rate securities (available-for-sale)	22,156	—	—	22,156
Auction rate securities (trading)	14,589	—	—	14,589
Auction rate securities rights	1,310	—	—	1,310
Total assets measured at fair value	$213,267	$175,212	$ —	$38,055

The following table presents a roll-forward of the balance of our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3)
	(In thousands)
Balance at December 31, 2009	$ 63,494
Total gains (unrealized):	
Included in earnings	363
Included in other comprehensive income	(202)
Settlements	(25,600)
Balance at June 30, 2010	$ 38,055
The amount of total losses for the period included in other comprehensive loss attributable to the change in unrealized losses relating to assets still held at June 30, 2010	$ (202)

8. Investments

The following tables summarize our investments as of the dates indicated:

	June 30, 2010			
		Gross Unrealized		Estimated Fair Value
	Cost	Gains	Losses	
		(In thousands)		
Government-sponsored enterprise securities	$ 83,695	$ 486	$ 228	$ 83,953
Municipal securities (including non-current auction rate securities)	64,045	1,265	4,216	61,094
Corporate debt securities	43,282	121	610	42,793
U.S. treasury notes	20,732	124	10	20,846
Certificates of deposit	3,271	—	—	3,271
	$215,025	$1,996	$5,064	$211,957

	December 31, 2009			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
		(In thousands)		
Government-sponsored enterprise securities	$ 89,451	$ 504	$ 281	$ 89,674
Municipal securities (including non-current auction rate securities)	82,009	3,120	4,154	80,975
Corporate debt securities	32,543	206	185	32,564
U.S. treasury notes	28,052	92	84	28,060
Certificates of deposit	3,258	—	—	3,258
	$235,313	$3,922	$4,704	$234,531

The contractual maturities of our investments as of June 30, 2010 are summarized below.

	Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 88,660	$ 88,305
Due one year through five years	86,232	86,378
Due after five years through ten years	1,430	1,411
Due after ten years	38,703	35,863
	$215,025	$211,957

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $29.9 million and $46.5 million for the three months ended June 30, 2010, and 2009, respectively. Total proceeds from sales of available-for-sale securities were $65.9 million and $82.0 million for the six months ended June 30, 2010, and 2009, respectively. Net realized investment gains for the three months ended June 30, 2010, and 2009 were $43,000 and $36,000 respectively. Net realized investment gains for the six months ended June 30, 2010, and 2009 were $57,000 and $195,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at June 30, 2010, and December 31, 2009, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Our investment in municipal securities consists primarily of auction rate securities. As described in Note 7, “Fair Value Measurements,” the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at June 30, 2010.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of June 30, 2010.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Government-sponsored enterprise securities	$ 6,008	$ 9	$ 8,468	$ 219	$14,476	$ 228
Municipal securities	15,049	110	23,287	4,106	38,336	4,216
Corporate debt securities	12,970	367	11,439	243	24,409	610
U.S. treasury notes	9,983	10	—	—	9,983	10
	$44,010	$ 496	$43,194	$ 4,568	$87,204	$ 5,064

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2009. At December 31, 2009, we previously reported only those available-for-sale investments in an unrealized loss position for at least two consecutive months. To conform to the current year presentation, we have included all available-for-sale investments in an unrealized loss position at December 31, 2009. This presentation change increased the total amount of unrealized losses reported in the following table by $113,000 at December 31, 2009. The accompanying increase to the estimated fair value of the underlying investments amounted to $42.9 million at December 31, 2009.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Government-sponsored enterprise securities	$30,460	$ 187	$ 7,297	$ 94	$ 37,757	$ 281
Municipal securities	12,460	78	24,031	3,902	36,491	3,980
Corporate debt securities	13,513	149	1,203	36	14,716	185
U.S. treasury notes	21,824	84	—	—	21,824	84
	$78,257	$ 498	$32,531	$ 4,032	$110,788	$ 4,530

9. Receivables

Health Plans receivables consist primarily of amounts due from the various states in which we operate. Such receivables are subject to potential retroactive adjustment. Molina Medicaid Solutions' receivables consist primarily of MMIS development milestone billings to states. Because all of our receivable amounts are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable were as follows:

	June 30, 2010	Dec. 31, 2009
	(In thousands)	
Health Plans:		
California	$ 32,196	$ 34,289
Michigan	19,017	14,977
Missouri	19,756	19,670
New Mexico	7,012	11,919
Ohio	24,157	37,004
Utah	4,691	6,107
Washington	16,373	9,910
Others	4,240	2,778
	127,442	136,654
Molina Medicaid Solutions	27,938	—
Total receivables	$155,380	$136,654

10. Restricted Investments

Pursuant to the regulations governing our Health Plan subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the balances of restricted investments by health plan, and by our insurance company:

	June 30, 2010	Dec. 31, 2009
	(In thousands)	
California	$ 369	$ 368
Florida	3,454	2,052
Insurance company	4,714	4,686
Michigan	1,000	1,000
Missouri	501	503
New Mexico	16,116	15,497
Ohio	9,053	9,036
Texas	3,501	1,515
Utah	1,281	578
Washington	151	151
Other	888	888
Total	$41,028	$36,274

The contractual maturities of our held-to-maturity restricted investments as of June 30, 2010 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 31,209	$ 31,212
Due one year through five years	9,677	9,709
Due after five years through ten years	142	161
	$ 41,028	$ 41,082

11. Long-Term Debt

Credit Facility

In 2005, we entered into an Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2008, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for general corporate purposes. Borrowings under the Credit Facility totaled $105.0 million at June 30, 2010.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At June 30, 2010, we were in compliance with all financial covenants in the Credit Facility.

Subject to the closing of the Molina Medicaid Solutions acquisition, in November 2009 we agreed to enter into a fourth amendment to the Credit Facility. The fourth amendment became effective upon the closing of the acquisition of Molina Medicaid Solutions on May 1, 2010. The fourth amendment was required because the $135 million purchase price for this acquisition exceeded the applicable deal size threshold under the terms of the Credit Facility. Pursuant to the fourth amendment, the lenders consented to our acquisition of Molina Medicaid Solutions.

Upon its effectiveness at the closing, the fourth amendment increased the commitment fee on the total unused commitments of the lenders under the facility to 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans was raised by 200 basis points at every level of the pricing grid. Thus, the applicable margins now range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. Until the delivery of a compliance certificate with respect to our financial statements for the second quarter of 2010, the applicable margin shall be fixed at 3.5% for LIBOR loans and 2.5% for base rate loans. In connection with the lenders' approval of the fourth amendment, a consent fee of 10 basis points was paid on the amount of each consenting lender's commitment. In addition, the fourth amendment carved out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of our convertible senior notes (although the $187.0 million indebtedness is still included in the calculation of our consolidated leverage ratio); increased the amount of surety bond obligations we may incur; increased our allowable capital expenditures; and reduced the fixed charge coverage ratio from 3.50x to 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

On March 15, 2010, we agreed to enter into a fifth amendment to the Credit Facility. The fifth amendment also became effective upon the closing of the acquisition of Molina Medicaid Solutions. The fifth amendment was required because, after giving effect to the acquisition of Molina Medicaid Solutions on a pro forma basis, and inclusive of our fourth quarter 2009 EBITDA of only $5.9 million, our consolidated leverage ratio for the preceding four fiscal quarters exceeded the currently applicable ratio of 2.75 to 1.0. The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro

forma basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if we have actually reduced our consolidated leverage ratio to no more than 2.75 to 1.0 on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010. As of June 30, 2010, our consolidated leverage ratio was 2.9%, as computed per the terms of the Credit Facility.

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, so the remaining aggregate principal amount totaled $187.0 million at June 30, 2010 and December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ended December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of such convertible debt instruments have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate

credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of June 30, 2010, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 51 months. The Notes' if-converted value did not exceed their principal amount as of June 30, 2010. At June 30, 2010, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of June 30, 2010	As of December 31, 2009
	(In thousands)	
Details of the liability component:		
Principal amount	$187,000	$ 187,000
Unamortized discount	(25,591)	(28,100)
Net carrying amount	$161,409	$ 158,900

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(In thousands)			
Interest cost recognized for the period relating to the:				
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,753	$ 3,506	$ 3,570
Amortization of the discount on the liability component	1,266	1,172	2,509	2,366
Total interest cost recognized	$ 3,019	$ 2,925	$ 6,015	$ 5,936

12. Commitments and Contingencies

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, consolidated financial position, cash flows, or results of operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Contract Losses

Our MMIS service contracts with various states typically span several years. These contracts often involve the development and deployment of new computer systems and technologies. Substantial performance risk exists in

each contract with these characteristics, and some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development and implementation phase. On occasion, these contracts have experienced delays in their design, development and implementation phase, the achievement of certain milestones has been delayed, and costs in excess of those anticipated have been incurred. We continuously review and reassess our estimates of contract profitability. If our estimates indicate that a contract loss will occur, a loss accrual is recorded in the period it is first identified, if allowed by relevant accounting guidance. Circumstances that could potentially result in contract losses over the life of the contract include variances from expected costs to deliver our services, and other factors affecting revenues and costs. It is reasonably possible that deferred costs associated with one or more of these contracts could become impaired due to changes in estimates of future contract cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $362.3 million at June 30, 2010, and $368.7 million at December 31, 2009. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Washington, and Utah have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of June 30, 2010, our health plans had aggregate statutory capital and surplus of approximately $376.2 million compared with the required minimum aggregate statutory capital and surplus of approximately $253.2 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2010. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

13. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of both June 30, 2010 and December 31, 2009, our carrying amount for this investment totaled $4.1 million. For the three months ended June 30, 2010 and 2009, we paid $5.3 million, and $5.7 million, respectively, for medical service fees to this provider. For the six months ended June 30, 2010 and 2009, we paid $9.7 million, and $10.4 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach (“Pacific Hospital”). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $0.5 million, and $0.3 million for the six months ended June 30, 2010 and 2009, respectively. We believe that the fee-for-service with Pacific Hospital is based on prevailing market rates for similar services.

14. Subsequent Events

Wisconsin Health Plan Acquisition

On July 12, 2010, we announced a definitive agreement to acquire Abri Health Plan, a provider of Medicaid managed care services to BadgerCare Plus and SSI Managed Care enrollees in Wisconsin. Abri Health Plan currently serves Medicaid beneficiaries in 23 counties in Wisconsin. In April 2010, Abri received a notice of intent to award a new contract to provide Medicaid managed care services to BadgerCare Plus enrollees in Wisconsin's southeast region (Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties), to be implemented between September 1 and November 1, 2010.

The purchase price for the acquisition is expected to be approximately $16 million, subject to adjustments, and will be funded with available cash and/or the Credit Facility. Subject to regulatory approvals and the satisfaction of other closing conditions, the closing of the transaction is expected to occur by August 31, 2010.

Auction Rate Securities

In the fourth quarter of 2008, we entered into a rights agreement with an investment securities firm that (1) allowed us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gave the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we received the par value. On June 30, 2010, we began to exercise the Rights, and completed sales of all of the eligible auction rate securities under the Rights agreement on July 1, 2010. By the close of business on July 1, 2010, we had sold all of our auction rate securities that were designated as trading securities as of June 30, 2010. At June 30, 2010, these securities had a par value of $15.9 million and a fair value of $14.6 million. We sold these securities at par value on July 1, 2010, while simultaneously extinguishing our auction rate securities rights (valued at $1.3 million as of June 30, 2010). The impact on net income of the sale of the action rate securities on July 1, 2010 was not significant.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would," and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- budgetary pressures on the federal and state governments and their resulting inability to fully fund Medicaid, Medicare, or CHIP, or to maintain current payment rates, benefit packages, or membership eligibility thresholds and criteria;
- uncertainties regarding the impact of the recently enacted Patient Protection and Affordable Care Act, including the funding provisions related to health plans, and uncertainties regarding the likely impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including rates of utilization that are consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- the continuation and renewal of the government contracts of our health plans;
- the integration of Molina Medicaid Solutions, including its employees, systems, and operations;
- the retention and renewal of the Molina Medicaid Solutions' state government contracts on terms consistent with our expectations;
- the accuracy of our operating cost and capital outlay projections for Molina Medicaid Solutions;
- the timing of receipt and recognition of revenue under our various state contracts held by Molina Medicaid Solutions, including any changes to the anticipated start date of operation at our Maine location;
- cost recovery efforts by the state of Michigan from Michigan health plans with respect to allegedly incorrect statewide rates and enrollment errors;
- governmental audits and reviews;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive;
- the required establishment of a premium deficiency reserve in any of the states in which we operate;
- up-coding by providers or billing in a manner at material variance with historic patterns;
- approval by state regulators of dividends and distributions by our subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;

- the favorable resolution of litigation or arbitration matters;
- restrictions and covenants in our credit facility;
- the success of our efforts to leverage our administrative costs to address the needs associated with increased enrollment;
- the relatively small number of states in which we operate health plans and the impact on the consolidated entity of adverse developments in any single health plan;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments;
- a state's failure to renew its federal Medicaid waiver;
- an unauthorized disclosure of confidential member information;
- changes generally affecting the managed care or Medicaid management information system industries; and
- general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2009, and to Part II, Item 1A — Risk Factors, in our Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, and in this Quarterly Report, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution investors not to place undue reliance on these statements.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2009.

Reclassifications

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax, or MGRT, as a premium tax and not as an income tax. Prior periods have been reclassified to conform to this presentation.

In prior periods, general and administrative, or G&A, expenses have included premium tax expenses. Beginning with the three month and six month periods ended June 30, 2010, we have reported premium tax expenses on a separate line in the accompanying consolidated statements of income. Prior periods have been reclassified to conform to this presentation.

Overview

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO.

On May 1, 2010, we acquired a health information management business which we now operate under the name, *Molina Medicaid Solutions*SM. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems, or MMIS. MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho,

Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program. We paid $131.3 million to acquire Molina Medicaid Solutions, subject to working capital adjustments which we expect to be insignificant. The acquisition was funded with available cash of $26 million and $105 million drawn under our credit facility.

With the addition of Molina Medicaid Solutions, we have added a segment to our internal financial reporting structure in 2010. We will now report our financial performance based on the following two reportable segments:

- Health Plans; and
- Molina Medicaid Solutions.

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate. The majority of medical costs associated with premium revenues are risk-based costs — while the health plans receive fixed per member per month premium payments from the states, the health plans are at risk for the costs of their members' health care. Our Health Plans segment operates in a highly regulated environment with minimum capitalization requirements. These capitalization requirements, among other things, limit the health plans' ability to pay dividends to us without regulatory approval.

As of June 30, 2010, our health plans were located in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Additionally, we operate three county primary care clinics in Virginia. An overview of our health plans and their principal governmental program contracts with the relevant state health care agency is provided below:

State	Renewal Date	Contract Description or Covered Program
California	3-31-12	Subcontract with Health Net for services to Medi-Cal members under Health Net's Los Angeles County Two-Plan Model Medi-Cal contract with the California Department of Health Services (DHS).
California	12-31-12	Medi-Cal contract for Sacramento Geographic Managed Care Program with DHS.
California	3-31-11	Two Plan Model Medi-Cal contract for Riverside and San Bernardino Counties (Inland Empire) with DHS.
California	9-30-10	Medi-Cal contract for San Diego Geographic Managed Care Program with DHS.
California	9-30-10	Healthy Families contract (California's CHIP program) with California Managed Risk Medical Insurance Board (MRMIB).
Florida	8-31-12	Medicaid contract with the Florida Agency for Health Care Administration.
Michigan	9-30-12	Medicaid contract with state of Michigan.
Missouri	6-30-11	Medicaid contract with the Missouri Department of Social Services.
New Mexico	6-30-12	Salud! Medicaid Managed Care Program contract (including CHIP) with New Mexico Human Services Department (HSD).
Ohio	6-30-11	Medicaid contract with Ohio Department of Job and Family Services (ODJFS).
Texas	8-31-13	Medicaid contract with Texas Health and Human Services Commission (HHSC).
Utah	6-30-14	Medicaid contract with Utah Department of Health.
Utah	12-31-11	CHIP contract with Utah Department of Health.
Washington	12-31-10	Basic Health Plan and Basic Health Plus Programs contract with Washington State Health Care Authority (HCA).
Washington	6-30-11	Healthy Options Program (including Medicaid and CHIP) contract with state of Washington Department of Social and Health Services.

In addition to the foregoing, our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington have entered into a standardized form of contract with CMS with respect to their operation of a MA SNP, and our health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington have also entered into a standardized form of contract with CMS with respect to their operations of a MA-PD plan. These contracts are renewed annually and were most recently renewed as of January 1, 2010.

Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the expiration of the contract. However, there can be no assurance that these contracts will continue to be renewed. In addition, in the event a state Medicaid agency issues a Request for Proposals, or RFP, in connection with a new Medicaid contract award, our incumbent health plan could potentially be unsuccessful and lose its contract to a competitive health plan bidder. We do not anticipate the issuance of any RFPs with respect to any of our health plan contracts in 2010.

The PMPM rates the states pay to our health plans change from time to time. We are expecting a blended PMPM rate increase at our Utah health plan of approximately 8% effective July 1, 2010; a blended PMPM rate decrease at our Texas health plan of approximately 1% effective September 1, 2010; and a blended PMPM rate increase at our California health plan of approximately 2% effective October 1, 2010. However, no assurances can be given that these expected rate adjustments will be obtained.

Molina Medicaid Solutions Segment

Unlike the Health Plans segment, the Molina Medicaid Solutions segment is a service-based business that adds to our revenue stream without assuming additional medical cost risk. Although revenue for the Health Plans segment far exceeded that of the Molina Medicaid Solutions segment for the three months ended June 30, 2010, operating income as a percent of revenue for the Molina Medicaid Solutions segment far exceeded that of the Health Plans segment for that period. For example, the Molina Medicaid Solutions segment reported revenue of $21.1 million and an operating profit of $5 million for the two months of its operations that were included in our results for the three months ended June 30, 2010, representing an operating profit margin percentage of 24%. Over the course of three months of operations included in that same reporting period, our Health Plans segment reported revenue of $976.7 million and an operating profit of $16.2 million, representing an operating profit margin percentage of 2%. Although we expect the operating profit margin percentage of our Molina Medicaid Solutions segment to decline as our Idaho and Maine contracts commence full operations, we nevertheless believe that the operating profit margin percentage of that segment will remain significantly greater than that of the Health Plans segment, albeit on a much lower revenue base. Additionally, the capital requirements of the Molina Medicaid Solutions segment are — except in the case of new contract start-ups — considerably less than those of our Health Plans segment. Regulatory approval is not required for the Molina Medicaid Solutions segment to pay dividends to us.

While we believe that the acquisition of the Molina Medicaid Solutions segment diversifies our risk profile, we also believe that the two segments are complementary from strategic and operating perspectives. From a strategic perspective, both segments allow us to participate in an expanding sector of the economy while continuing our mission to serve low-income families and individuals eligible for government-sponsored health care programs. Operationally, the segments share a common systems platform — allowing for efficiencies of scale — and common experience in meeting the needs of state Medicaid programs. We also believe that we have opportunities to market various cost containment and quality practices used by our Health Plans segment (such as care management and care coordination programs) to state MMIS customers who wish to incorporate certain aspects of managed care programs into their own fee-for-service programs.

The following table briefly summarizes our financial performance for the three month and six month periods ended June 30, 2010 compared with the same periods in 2009. All ratios, with the exception of the medical care

ratio, are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium revenue earned and the cost of health care.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(Amounts in thousands, except per share data)			
Earnings per diluted share	$ 0.41	$ 0.56	$ 0.82	$ 1.02
Premium revenue	$ 976,685	$ 925,507	$ 1,941,905	$ 1,782,991
Service revenue	$ 21,054	$ —	$ 21,054	$ —
Operating income	$ 21,178	$ 19,488	$ 41,616	$ 42,649
Net income	$ 10,579	$ 14,565	$ 21,169	$ 26,776
Total ending membership	1,498	1,368	1,498	1,368
Premium revenue	97.7%	99.8%	98.8%	99.7%
Service revenue	2.1	—	1.1	—
Investment income	0.2	0.2	0.1	0.3
Total revenue	100.0%	100.0%	100.0%	100.0%
Medical care ratio	86.0%	86.8%	85.6%	86.4%
General and administrative expense ratio	7.8%	7.0%	8.0%	7.3%
Premium tax ratio	3.6%	3.3%	3.6%	3.2%
Operating income	2.1%	2.1%	2.1%	2.4%
Net income	1.1%	1.6%	1.1%	1.5%
Effective tax rate	38.1%	10.5%	38.0%	25.6%

Composition of Revenue and Membership

Health Plans Segment

Premium revenue is fixed in advance of the periods covered and, except as described in "Critical Accounting Policies" below, is not generally subject to significant accounting estimates. For the six months ended June 30, 2010, we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with the Centers for Medicare and Medicaid Services, or CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

For the six months ended June 30, 2010, we received approximately 6% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in California (effective October 1, 2009), Michigan, Missouri, Ohio, Texas, Utah (effective September 1, 2009), and Washington. Such payments are recognized as revenue in the month the birth occurs.

The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	June 30, 2010	Dec. 31, 2009	June 30, 2009
Total Ending Membership by Health Plan:			
California	348,000	351,000	349,000
Florida	54,000	50,000	29,000
Michigan	226,000	223,000	207,000
Missouri	78,000	78,000	78,000
New Mexico	93,000	94,000	85,000
Ohio	234,000	216,000	203,000
Texas	42,000	40,000	30,000
Utah	77,000	69,000	64,000
Washington	346,000	334,000	323,000
Total	1,498,000	1,455,000	1,368,000
Total Ending Membership by State for our Medicare Advantage Plans:			
California	3,600	2,100	1,600
Florida	500	—	—
Michigan	5,000	3,300	2,100
New Mexico	600	400	400
Texas	600	500	400
Utah	8,100	4,000	3,100
Washington	1,900	1,300	1,000
Total	20,300	11,600	8,600
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	13,600	13,900	13,100
Florida	9,300	8,800	6,000
Michigan	31,600	32,200	29,900
New Mexico	5,800	5,700	5,700
Ohio	27,400	22,600	19,700
Texas	18,500	17,600	17,000
Utah	7,600	7,500	7,600
Washington	3,700	3,200	3,000
Total	117,500	111,500	102,000

Molina Medicaid Solutions Segment

As a result of our recent acquisition of Molina Medicaid Solutions, a portion of our revenues is derived from service arrangements. This segment provides technology solutions to state Medicaid programs that include system design, development, implementation, and technology outsourcing services. In addition, this segment offer business process outsourcing to state Medicaid agencies that handle key administrative functions such as claims processing, provider enrollment, pharmacy drug rebate services, recipient eligibility management, and pre-authorization services. In general, we expect the operating profit margin percentage generated by the Molina Medicaid Solutions segment to be higher than the operating profit margin percentage generated by the Health Plans segment. See further discussion of our Molina Medicaid Solutions segment revenue recognition and deferred contract costs at "Critical Accounting Policies," below.

Molina Medicaid Solutions has contracts with five states to design, develop, implement, maintain, and operate Medicaid Management Information Systems (MMIS). Additionally, Molina Medicaid Solutions provides pharmacy rebate administration services under a contract with the state of Florida.

These contracts extend over a number of years, and cover the life of the MMIS from inception though at least the first five years of its operation. The contracts are subject to extension by the exercise of an option, and also by renewal of the base contract. The contracts have a life cycle beginning with the design, development, and implementation of the MMIS and continuing through the operation of the system. Payment during the design, development, and implementation phase of the contract, or the DDI phase, is generally based upon the attainment of specific milestones in systems development as agreed upon ahead of time by the parties. Payment during the operations phase typically takes the form of either a flat monthly fee or payment for specific measures of capacity or activity, such as the number of claims processed, or the number of Medicaid beneficiaries served by the MMIS. Contracts may also call for the adjustment of amounts paid if certain activity measures exceed or fall below certain thresholds.

Under our contracts in Louisiana, New Jersey, West Virginia and Florida we provide primarily business process outsourcing and technology outsourcing services, because the development of the MMIS solution has been completed. Under these contracts, we recognize outsourcing service revenue on a straight-line basis over the remaining term of the contract. We have not substantially completed the installation of the MMIS solutions in Idaho and Maine. Accordingly, we have deferred recognition and all revenue and the majority of the expenses incurred under those contracts.

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services, G&A expenses, and premium tax expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- Fee-for-service — expenses paid for specific encounters or episodes of care according to a fee schedule or other basis established by the state or by contract with the provider.
- Capitation — expenses for PMPM payments to the provider without regard to the frequency, extent, or nature of the medical services actually furnished.
- Pharmacy — expenses for all drug, injectible, and immunization costs paid through our pharmacy benefit manager.
- Other — expenses for medically related administrative costs ($41.0 million and $35.8 million for the six months ended June 30, 2010 and 2009, respectively), certain provider incentive costs, reinsurance, costs to operate our medical clinics, and other medical expenses.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide business process outsourcing and technology outsourcing services under our contracts in Louisiana, New Jersey, West Virginia and Florida, as well as certain selling, general and administrative expenses. Additionally, certain indirect costs incurred under our contracts in Idaho and Maine are also expensed to cost of services.

Deferred contract costs, which primarily relate to our contracts in Idaho and Maine, include direct and incremental costs such as direct labor, hardware, and software. We also defer and subsequently amortize certain transition costs related to activities that transition the contract from the design, development, and implementation phase to the operational or business process outsourcing phase. Deferred contract costs, including transition costs, are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

Results of Operations

Three Months Ended June 30, 2010 Compared with the Three Months Ended June 30, 2009

Summary of Consolidated Operating Results

Operating results for the three months ended June 30, 2010, compared with the three months ended June 30, 2009, were most significantly impacted by the following:

- Increased premium revenue for the Health Plans segment due to higher enrollment, partially offset by lower revenue PMPM. Medicare enrollment exceeded 20,000 members at June 30, 2010, and Medicare premium revenue for the three months ended June 30, 2010, was $67.6 million compared with $35.2 million for the three months ended June 30, 2009.
- Lower PMPM medical costs for the Health Plan segment due to lower incidence of influenza-related illnesses in 2010, improved hospital utilization, the transfer of pharmacy costs back to the states of Ohio and Missouri, and the implementation of various contracting and medical management initiatives. Medical margin (defined as the difference between premium revenue and medical costs) increased by approximately $15 million for the three months ended June 30, 2010, compared with the three months ended June 30, 2009.
- Higher administrative and premium tax expenses for the Health Plan segment, driven in part by the cost of our Medicare expansion and the acquisition of the Molina Medicaid Solutions business.
- The acquisition of Molina Medicaid Solutions effective May 1, 2010. The Molina Medicaid Solutions segment contributed $5 million to operating income for the three months ended June 30, 2010.

Health Plans Segment

Summary of Health Plans Segment Operating Results

Operating income for the three months ended June 30, 2010 decreased $3.3 million compared with the three months ended June 30, 2009. Improved medical margins during the three months ended June 30, 2010 were more than offset by:

- $5.5 million in premium reductions retroactive to October 1, 2009 that were imposed by the state of Michigan;
- $1.7 million in acquisition costs related to the purchase of Molina Medicaid Solutions;
- $4.7 million in additional premium tax; and
- $10.4 million of additional administrative expense.

Premium Revenue

Premium revenue grew 5.5% in the three months ended June 30, 2010 compared with the three months ended June 30, 2009, due to a membership increase of nearly 10%. Premium revenue was reduced during the three months ended June 30, 2010 by $5.5 million due to rate reductions in Michigan that were retroactive to October 1, 2009. The related reduction to medical expense was only $0.5 million. On a PMPM basis consolidated premium revenue decreased 4.4% because of declines in premium rates at several of our health plans. The most significant declines in premium rates were in Ohio and Missouri, due to the transfer of pharmacy risk back to the states, and in Washington. Washington premiums PMPM were lower during the three months ended June 30, 2010, compared with the three months ended June 30, 2009, as result of reductions made to both Medicaid premiums and fee schedules during the third quarter of 2009.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three Months Ended June 30,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$594,960	$132.95	70.9%	$517,066	$127.59	64.4%
Capitation	136,764	30.56	16.3	154,386	38.10	19.2
Pharmacy	75,170	16.80	8.9	99,256	24.49	12.4
Other	32,719	7.31	3.9	32,498	8.02	4.0
Total	$839,613	$187.62	100.0%	$803,206	$198.20	100.0%

Medical care costs, in the aggregate, decreased 5.3% on a PMPM basis for the three months ended June 30, 2010 compared with the three months ended June 30, 2009, primarily due to the following:

- The transfer of pharmacy risk back to the states of Ohio and Missouri,
- A less severe flu season in 2010,
- Reductions in Medicaid fee schedules subsequent to June 30, 2009, and
- The implementation of various contracting and medical management initiatives.

Excluding pharmacy costs, medical care costs decreased 1.7% on a PMPM basis for the three months ended June 30, 2010 compared with the three months ended June 30, 2009. Medical care costs as a percentage of premium revenue (the medical care ratio) were 86.0% for the three months ended June 30, 2010 compared with 86.8% for the three months ended June 30, 2009.

Physician and outpatient costs increased 1.9% on a PMPM basis for the three months ended June 30, 2010, compared with the three months ended June 30, 2009. Although we continued to observe hospitals billing for more intensive levels of care for the quarter ended June 30, 2010, compared with the quarter ended June 30, 2009, emergency room costs PMPM were stable as both utilization and cost per visit remained essentially unchanged. We attribute stable emergency room costs to, among other things, a less severe flu season when compared with 2009; changes in provider contracts and fee schedules; and our efforts to reduce inappropriate utilization.

Inpatient facility costs increased 6.4% on a PMPM basis for the three months ended June 30, 2010, compared with the three months ended June 30, 2009. Both utilization and unit costs increased slightly compared with the three months ended June 30, 2009.

Pharmacy costs (including the benefit of rebates) decreased 31.4% on a PMPM basis for the three months ended June 30, 2010, including our Missouri and Ohio health plans. The pharmacy benefit was transferred to the state of Missouri effective October 1, 2009, and was transferred to the state of Ohio effective February 1, 2010. Excluding these health plans, pharmacy costs increased 5.8% on a PMPM basis compared with the three months ended June 30, 2009 as a result of increases in unit costs that more than offset decreases in utilization.

Capitated costs decreased 19.8% on a PMPM basis compared with three months ended June 30, 2009 as a result of the recognition, in the three months ended June 30, 2009, of $22 million in retroactive capitation expense at the New Mexico health plan that related to 2009 and 2008. The retroactive capitation expense at the New Mexico health plan was directly related to the receipt of $25.3 million in retroactive premium revenue in the second quarter of 2009. There was no corresponding retroactive adjustment in the three months ended June 30, 2010.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio and premium taxes by health plan for the three months ended June 30, 2010 and June 30, 2009 (dollar amounts in thousands except for PMPM amounts):

	Three Months Ended June 30, 2010						
	Member Months	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,050,000	$124,551	$118.57	$106,006	$100.92	85.1%	$ 1,637
Florida	160,000	41,462	260.32	39,134	245.70	94.4	6
Michigan	679,000	156,769	230.76	135,763	199.84	86.6	9,711
Missouri	234,000	51,779	220.86	46,320	197.58	89.5	—
New Mexico	280,000	91,949	328.48	73,210	261.54	79.6	2,987
Ohio	695,000	212,669	306.34	174,275	251.03	82.0	16,512
Texas	125,000	43,493	348.45	39,133	313.52	90.0	705
Utah	230,000	64,934	281.44	60,975	264.28	93.9	—
Washington	1,022,000	186,204	182.23	154,792	151.49	83.1	3,394
Other(1)	—	2,875	—	10,005	—	—	43
Total	4,475,000	$976,685	$218.25	$839,613	$187.62	86.0%	$ 34,995

	Three Months Ended June 30, 2009						
	Member Months	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	1,031,000	$121,918	$118.23	$111,750	$108.37	91.7%	$ 3,395
Florida	75,000	19,339	257.22	17,355	230.83	89.7	—
Michigan	623,000	136,549	219.44	112,402	180.64	82.3	9,538
Missouri	232,000	58,141	251.06	48,582	209.78	83.6	—
New Mexico	251,000	114,408	456.80	100,255	400.30	87.6	2,989
Ohio	596,000	194,885	327.02	168,639	282.98	86.5	10,731
Texas	92,000	34,345	372.13	24,851	269.26	72.4	572
Utah	200,000	57,918	288.99	53,182	265.35	91.8	—
Washington	952,000	183,720	192.96	156,981	164.88	85.5	3,064
Other(1)	—	4,284	—	9,209	—	—	11
Total	4,052,000	$925,507	$228.38	$803,206	$198.20	86.8%	$ 30,300

(1) "Other" medical care costs represent primarily medically related administrative costs at the parent company.

Days in Medical Claims and Benefits Payable

Beginning January 1, 2010, and for all prior periods presented, we are reporting days in medical claims and benefits payable relating to fee-for-service medical claims only. This new computation includes only fee-for-service medical care costs and related liabilities, and therefore calculates the extent of reserves for those liabilities that are most subject to estimation risk.

The days in medical claims and benefits payable amount previously reported included *all* medical care costs (fee-for-service, capitation, pharmacy, and administrative), and *all* medical claims liabilities, including those liabilities that are typically paid concurrently, or shortly after the costs are incurred, such as capitation costs and pharmacy costs. Medical claims liabilities in this calculation do not include accrued costs — such as salaries — associated with the administrative portion of medical costs.

By including only fee-for-service medical costs and liabilities in this computation, our days in claims payable metric will be more indicative of the adequacy of our reserves for liabilities subject to a substantial degree of estimation. The days in medical claims and benefits payable computed under each method were as follows:

	June 30, 2010	March 31, 2010	Dec. 31, 2009	June 30, 2009
Days in claims payable — fee-for-service only	44 days	44 days	44 days	47 days
Days in claims payable — all medical costs	39 days	37 days	37 days	39 days
Number of claims in inventory at end of period	106,300	153,700	93,100	117,100
Billed charges of claims in inventory at end of period (dollars in thousands)	$146,600	$194,000	$131,400	$173,400

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment for the two months ended June 30, 2010 was as follows:

	(In thousands)
Service revenue	$ 22,645
Amortization of purchased intangibles recorded as contra-service revenue	(1,591)
Net service revenue	21,054
Cost of service revenue	14,254
General and administrative costs	966
Amortization of purchased intangibles recorded as amortization expense	829
Operating income	$ 5,005

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses, or G&A, were $78.1 million, or 7.8% of total revenue, for the three months ended June 30, 2010, compared with $65.0 million, or 7.0% of total revenue, for the for the three months ended June 30, 2009.

The increase in the G&A ratio was primarily due to higher administrative expenses for the Health Plans segment, which includes all corporate related administrative costs. Costs of the continuing build out of our Medicare administrative structure added $2.7 million to administrative costs when compared with the three months ended June 30, 2009. Acquisition expenses associated with the purchase of Molina Medicaid Solutions were $1.7 million during the three months ended June 30, 2010. Network and product expansions other than the Medicare line of business added $1.1 million to administrative expense during the three months ended June 30, 2010. All other Health Plans segment administrative costs increased $6.5 million during the three months ended June 30, 2010. The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment. A portion of the $6.5 million increase in other administrative costs recorded at the Health Plans segment supported the integration of Molina Medicaid Solutions into our consolidated operations. Stand- alone administrative expenses of the Molina Medicaid Solutions segment totaled approximately $1.0 million.

	Three Months Ended June 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Medicare-related administrative costs	$ 6,589	0.7%	$ 3,879	0.4%
Non Medicare-related administrative costs:				
Molina Medicaid Solutions segment administrative costs	966	0.1	—	—
Molina Medicaid Solutions acquisition costs	1,724	0.2	—	—
Health Plans segment administrative payroll, including employee incentive compensation	53,675	5.4	49,317	5.3
All other Health Plans segment administrative expense	15,125	1.4	11,815	1.3
G&A expenses	$78,079	7.8%	$65,011	7.0%

Premium Tax Expenses

Premium tax expense relating to Health Plans segment premium revenue increased to 3.6% of revenue for the three months ended June 30, 2010, from 3.3% for the three months ended June 30, 2009, primarily due to the imposition of a higher premium tax rate in Ohio effective October 1, 2009.

Depreciation and Amortization

Depreciation and amortization expense specifically identified as such in the consolidated statements of income increased $1.6 million in the three months ended June 30, 2010 compared with the three months ended June 30, 2009, primarily due to depreciation of investments in infrastructure and the amortization of certain purchased intangibles associated with the acquisition of Molina Medicaid Solutions. Beginning in the three months ended June 30, 2010, the amortization of a portion of the purchased intangibles associated with the acquisition of Molina Medicaid Solutions is recorded as contra-service revenue, rather than as part of depreciation and amortization expense. Additionally, most of the depreciation expense associated with Molina Medicaid Solutions is recorded as cost of service revenue. The following table presents all depreciation and amortization expense recorded in the consolidated financial statements:

	Three Months Ended June 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation and amortization	$11,219	1.1%	$9,584	1.0%
Amortization expense recorded as contra-service revenue	1,591	0.2	—	—
Depreciation expense recorded as cost of service revenue	1,041	0.1	—	—
Depreciation and amortization reported in the consolidated statements of cash flows	$13,851	1.4%	$9,584	1.0%

Interest Expense

Interest expense increased to $4.1 million for the three months ended June 30, 2010, compared with $3.2 million for the three months ended June 30, 2009. We incurred higher interest expense relating to the $105 million draw on our credit facility (beginning May 1, 2010) to fund the acquisition. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $1.3 million, and $1.2 million for the six months ended June 30, 2010 and 2009, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 38.1% for the three months ended June 30, 2010, compared with 10.5% in three months ended June 30, 2009. The lower rate in 2009 was primarily due to discrete tax benefits of $4.4 million recorded in the second quarter of 2009 as a result of settling tax examinations and the voluntary filing of certain accounting method changes.

Effective January 1, 2008 through December 31, 2009, our income tax expense included both the Michigan business income tax, or BIT, and the Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers are defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of the Michigan plan's receipts, and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

For the three months ended June 30, 2009, amounts for premium tax expense (included in general and administrative expenses) and income tax expense have been reclassified to conform to the presentation of MGRT as a premium tax. The MGRT amounted to $1.5 million and $1.2 million for the three months ended June 30, 2010, and 2009, respectively. There was no impact to net income for either period presented relating to this change.

Six Months Ended June 30, 2010 Compared with the Six Months Ended June 30, 2009

Summary of Consolidated Operating Results

Operating results for the six months ended June 30, 2010, compared with the six months ended June 30, 2009, were most significantly impacted by the following:

- Increased premium revenue due to higher enrollment, partially offset by lower revenue PMPM. Medicare enrollment exceeded 20,000 members at June 30, 2010, and Medicare premium revenue was $117.9 million and $62.2 million for the six months ended June 30, 2010, and 2009, respectively.
- Lower PMPM medical costs due to lower incidence of the influenza-related illnesses in 2010, improved hospital utilization, the transfer of pharmacy costs back to the states of Ohio and Missouri, and the implementation of various contracting and medical management initiatives.
- Higher administrative and premium tax expenses for the Health Plan segment, driven in part by the cost of our Medicare expansion and the acquisition of Molina Medicaid Solutions.
- A $1.5 million gain on the purchase of our convertible senior notes recognized in the first quarter of 2009, with no comparable event in the first quarter of 2010.
- The acquisition of Molina Medicaid Solutions effective May 1, 2010. The Molina Medicaid Solutions segment contributed $5.0 million to operating income for the six months ended June 30, 2010.

Health Plans Segment

Summary of Health Plans Segment Operating Results

Operating income for the six months ended June 30, 2010 decreased $6.0 million compared with the six months ended June 30, 2009. Improved medical margins during the six ended June 30, 2010 were more than offset by:

- $8.7 million in premium reductions retroactive to October 1, 2009 that were imposed by the state of Michigan;
- $1.7 million in acquisition costs related to the purchase of Molina Medicaid Solutions;

- $12.2 million in additional premium tax; and
- $23.3 million of additional administrative expense.

Premium Revenue

Premium revenue grew 8.9% in the six months ended June 30, 2010 compared with the six months ended June 30, 2009, due to a membership increase of nearly 10%. Premium revenue was reduced $8.7 million during the six months ended June 30, 2010 due to rate reductions in Michigan that were retroactive to October 1, 2009. The related reduction to medical expense was only $0.5 million. On a PMPM basis consolidated premium revenue decreased 2.7% because of declines in premium rates at several of our health plans. The most significant declines in premium rates were in Ohio and Missouri, due to the transfer of pharmacy risk back to the state, and in Washington. Washington premiums PMPM were lower during the six months ended June 30, 2010 compared with the six months ended June 30, 2009, as result of reductions made to both Medicaid premiums and fee schedules during the third quarter of 2009.

Medical Care Costs

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Six Months Ended June 30,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$1,161,839	$130.52	69.9%	$1,006,207	$126.49	65.3%
Capitation	273,896	30.77	16.5	272,800	34.29	17.7
Pharmacy	165,241	18.56	9.9	201,894	25.38	13.1
Other	61,453	6.90	3.7	60,193	7.57	3.9
Total	$1,662,429	$186.75	100.0%	$1,541,094	$193.73	100.0%

Medical care costs, in the aggregate, decreased 3.6% on a PMPM basis for the six months ended June 30, 2010 compared with the six months ended June 30, 2009, primarily due to the following:

- The transfer of pharmacy risk back to the states of Ohio and Missouri,
- A less severe flu season in 2010,
- Reductions in Medicaid fee schedules subsequent to June 30, 2009, and
- The implementation of various contracting and medical management initiatives.

Excluding pharmacy costs, medical care costs were flat on a PMPM basis for the six months ended June 30, 2010 compared with the six months ended June 30, 2009. Medical care costs as a percentage of premium revenue were 85.6% for the six months ended June 30, 2010 compared with 86.4% for the six months ended June 30, 2009.

Physician and outpatient costs increased 2.6% on a PMPM basis for the six months ended June 30, 2010, compared with the six months ended June 30, 2009. Although we continued to observe hospitals billing for more intensive levels of care for the six months ended June 30, 2010, compared with the six months ended June 30, 2009, emergency room costs PMPM were stable as both utilization and cost per visit remained essentially unchanged. We attribute stable emergency room costs to, among other things, a less severe flu season when compared to 2009; changes in provider contracts and fee schedules; and our efforts to reduce inappropriate utilization.

Inpatient facility costs increased 2.5% on a PMPM basis for the six months ended June 30, 2010, compared with the six months ended June 30, 2009. Both utilization and unit costs increased slightly compared with the six months ended June 30, 2009.

Pharmacy costs (including the benefit of rebates) decreased 26.9% on a PMPM basis for the six months ended June 30, 2010, including our Missouri and Ohio health plans. The pharmacy benefit was transferred to the state of

Missouri effective October 1, 2009, and was transferred to the state of Ohio effective February 1, 2010. Excluding these health plans, pharmacy costs increased 3.7% on a PMPM basis compared with the six months ended June 30, 2009 as a result of flat utilization and a moderate increase in unit costs.

Capitated costs decreased 10.3% on a PMPM basis compared with six months ended June 30, 2009 as a result of the recognition, in the second quarter of 2009, of $22 million in retroactive capitation expense at the New Mexico health plan that related to 2009 and 2008. The retroactive capitation expense at the New Mexico health plan was directly related to the receipt of $25.3 million in retroactive premium revenue in the second quarter of 2009. There was no corresponding retroactive adjustment in the second quarter of 2010.

Health Plans Segment Operating Data

The following summarizes member months, premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the six months ended June 30, 2010 and June 30, 2009 (dollars in thousands except PMPM amounts):

	Six Months Ended June 30, 2010						
	Member Months	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	2,112,000	$ 248,461	$117.62	$ 213,567	$101.10	86.0%	$ 3,265
Florida	314,000	80,550	256.94	73,821	235.47	91.7	12
Michigan	1,354,000	312,114	230.45	261,212	192.87	83.7	19,650
Missouri	468,000	103,922	221.93	89,836	191.85	86.5	—
New Mexico	560,000	187,547	334.75	147,225	262.78	78.5	4,991
Ohio	1,368,000	431,032	315.20	346,900	253.68	80.5	33,517
Texas	246,000	82,693	336.46	71,464	290.77	86.4	1,386
Utah	451,000	123,474	273.66	122,435	271.36	99.2	—
Washington	2,029,000	367,258	181.05	318,302	156.91	86.7	6,656
Other(1)	—	4,854	—	17,667	—	—	64
Total	8,902,000	$1,941,905	$218.15	$1,662,429	$186.75	85.6%	$ 69,541

	Six Months Ended June 30, 2009						
	Member Months	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
		Total	PMPM	Total	PMPM		
California	2,011,000	$ 231,953	$115.34	$ 215,723	$107.27	93.0%	$ 6,711
Florida	136,000	39,030	287.03	35,123	258.29	90.0	—
Michigan	1,243,000	269,314	216.71	222,397	178.96	82.6	17,376
Missouri	463,000	116,848	252.53	95,556	206.51	81.8	—
New Mexico	499,000	196,226	393.53	172,276	345.50	87.8	5,082
Ohio	1,156,000	382,107	330.46	326,419	282.30	85.4	20,923
Texas	190,000	67,356	354.66	52,257	275.15	77.6	1,256
Utah	384,000	108,536	282.34	97,445	253.49	89.8	—
Washington	1,871,000	364,424	194.78	306,526	163.83	84.1	6,011
Other(1)	—	7,197	—	17,372	—	—	(4)
Total	7,953,000	$1,782,991	$224.14	$1,541,094	$193.73	86.4%	$ 57,355

(1) "Other" medical care costs represent primarily medically related administrative costs at the parent company.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment for the two months ended June 30, 2010 was as follows:

	(In thousands)
Service revenue	$ 22,645
Amortization of purchased intangibles recorded as contra-service revenue	(1,591)
Net service revenue	21,054
Cost of service revenue	14,254
General and administrative costs	966
Amortization of purchased intangibles recorded as amortization expense	829
Operating income	$ 5,005

Consolidated Expenses and Other

General and Administrative Expenses

General and administrative expenses were $157.0 million, or 8.0% of total revenue, for the six months ended June 30, 2010, compared with $130.4 million, or 7.3% of total revenue, for the for the six months ended June 30, 2009.

The increase in the G&A ratio was primarily due to higher administrative expenses for the Health Plans segment, which includes all corporate related administrative costs. Costs of the continuing build out of the Medicare administrative structure added $5.7 million to administrative costs when compared with the six months ended June 30, 2009. Acquisition expenses associated with the acquisition of Molina Medicaid Solutions were $2.3 million during the six months ended June 30, 2010. Network and product expansions other than the Medicare line of business added $2.3 million to administrative expense during the six months ended June 30, 2010. Higher regulatory fees added $1.3 million to administrative expense during the six months ended June 30, 2010. All other Health Plans segment administrative costs increased by $14.0 million during the six months ended June 30, 2010. The cost of services shared between the Health Plans and Molina Medicaid Solutions segments is charged to the Health Plans segment. A portion of the $14.0 million increase in other administrative costs recorded at the Health Plans segment supported the integration of Molina Medicaid Solutions into our consolidated operations. Stand alone administrative expenses of the Molina Medicaid Solutions segment were approximately $1.0 million.

	Six Months Ended June 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Medicare-related administrative costs	$ 14,521	0.7%	$ 8,847	0.5%
Non Medicare-related administrative costs:				
Molina Medicaid Solutions segment administrative costs	966	0.1	—	—
Molina Medicaid Solutions acquisition costs	2,250	0.1	—	—
Health Plans segment administrative payroll, including employee incentive compensation	109,885	5.6	98,316	5.5
All other Health Plans segment administrative expense	29,337	1.5	23,255	1.3
G&A expenses	$156,959	8.0%	$130,418	7.3%

Premium Tax Expense

Premium tax expense relating to health plan premium revenue increased to 3.6% of revenue for the six months ended June 30, 2010, from 3.2% for the six months ended June 30, 2009, primarily due to the imposition of a higher premium tax rate in Ohio effective October 1, 2009.

Depreciation and Amortization

Depreciation and amortization expense specifically identified as such in the consolidated statements of income increased $2.6 million in the six months ended June 30, 2010 compared with the six months ended June 30, 2009, primarily due to depreciation of investments in infrastructure and the amortization of certain purchased intangibles associated with the acquisition of Molina Medicaid Solutions. Beginning in the second quarter of 2010, a portion of amortization expense has been recorded as contra-service revenue, rather than as part of depreciation and amortization expense. Additionally, most of the depreciation expense associated with the Molina Medicaid Solutions segment is recorded as cost of service revenue. The following table presents all depreciation and amortization expense recorded in the consolidated financial statements:

	Six Months Ended June 30,			
	2010		2009	
	Amount	% of Total Revenue	Amount	% of Total Revenue
	(Dollar amounts in thousands)			
Depreciation and amortization	$21,280	1.1%	$18,636	1.0%
Amortization expense recorded as contra- service revenue	1,591	0.1	—	—
Depreciation expense recorded as cost of service revenue	1,041	—	—	—
Depreciation and amortization reported in the consolidated statements of cash flows	$23,912	1.2%	$18,636	1.0%

Gain on Retirement of Convertible Senior Notes

In February 2009, we purchased and retired $13.0 million face amount of our convertible senior notes. We purchased the notes at an average price of $74.25 per $100 principal amount, for a total of $9.7 million. Including accrued interest, our total payment was $9.8 million. In connection with the purchase of the Notes, we recorded a gain of $1.5 million ($0.04 per diluted share) in the first quarter of 2009.

Interest Expense

Interest expense increased to $7.5 million for the six months ended June 30, 2010, from $6.6 million for the six months ended June 30, 2009. We incurred higher interest expense relating to the $105 million draw on our credit facility (beginning May 1, 2010) to fund the acquisition. Interest expense includes non-cash interest expense relating to our convertible senior notes, which totaled $2.5 million, and $2.4 million for the six months ended June 30, 2010 and 2009, respectively.

Income Taxes

Income tax expense was recorded at an effective rate of 38.0% for the six months ended June 30, 2010 compared with 25.6% for the six months ended June 30, 2009. The lower rate in 2009 was primarily due to discrete tax benefits of $4.4 million recorded in the second quarter of 2009 as a result of settling tax examinations and the voluntary filing of certain accounting method changes.

Effective January 1, 2008 through December 31, 2009, our income tax expense included both the Michigan business income tax, or BIT, and the Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax.

For the six months ended June 30, 2009, amounts for premium tax expense and income tax expense have been reclassified to conform to the presentation of MGRT as a premium tax. The MGRT amounted to $3.1 million and

$2.2 million for the six months ended June 30, 2010, and 2009, respectively. There was no impact to net income for either period presented relating to this change.

Acquisitions

In addition to the acquisition of Molina Medicaid Solutions, described in "Overview" above, on July 12, 2010, we announced a definitive agreement to acquire Abri Health Plan, a provider of Medicaid managed care services to BadgerCare Plus and SSI Managed Care enrollees in Wisconsin. Abri Health Plan currently serves Medicaid beneficiaries in 23 counties in Wisconsin. In April 2010, Abri received a notice of intent to award a new contract to provide Medicaid managed care services to BadgerCare Plus enrollees in Wisconsin's southeast region (Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties), to be implemented between September 1 and November 1, 2010.

The purchase price for the acquisition is expected to be approximately $16 million, subject to adjustments, and will be funded with available cash and/or the Credit Facility. Subject to regulatory approvals and the satisfaction of other closing conditions, the closing of the transaction is expected to occur by August 31, 2010.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of five years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be two years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of June 30, 2010, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income decreased to $3.1 million for the six months ended June 30, 2010 compared with $5.6 million for the six months ended June 30, 2009. This decline was primarily due to lower interest rates in 2010. Our annualized portfolio yield for the six months ended June 30, 2010 was 0.8% compared with 1.6% for the six months ended June 30, 2009.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash provided by operating activities for the six months ended June 30, 2010, was $25.3 million, compared with $94.8 million for the six months ended June 30, 2009, a decrease of $69.5 million. This decrease was primarily

due to the timing of the Ohio health plan's receipt of premium payments from the state of Ohio. In 2009, the state of Ohio typically paid premiums in advance of the month the premium was earned. Beginning in January 2010, the state of Ohio has delayed its premium payments to mid-month for the month premium is earned. The Company does not anticipate any advance payments for the Ohio plan's premiums during 2010.

Cash used in investing activities was $137.3 million for the six months ended June 30, 2010, compared with $27.9 million for the six months ended June 30, 2009, due chiefly to the acquisition of Molina Medicaid Solutions, which totaled $131 million.

Cash provided by financing activities was $138.9 million for the six months ended June 30, 2010, compared with $36.3 million used in financing activities for the six months ended June 30, 2009. In the second quarter of 2010 we borrowed $105 million on our credit facility to fund the acquisition of Molina Medicaid Solutions (see "Capital Resources," below). The primary use of cash in the six months ended June 30, 2009 was under our securities purchase programs, where we purchased $27.7 million of our common stock, and $9.7 million of our convertible senior notes.

EBITDA (1)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
	(In thousands)			
Operating income	$21,178	$ 19,488	$41,616	$42,649
Add back:				
Depreciation and amortization expense	11,219	9,584	21,280	18,636
Amortization expense recorded as contra-service revenue	1,591	—	1,591	—
Depreciation expense recorded as cost of service revenue	1,041	—	1,041	—
EBITDA	$35,029	$ 29,072	$65,528	$61,285

(1) We calculate EBITDA by adding back depreciation and amortization expense to operating income, including $1.6 million amortization expense recorded as contra-service revenue, and $1.0 million depreciation expense recorded as cost of service revenue for both the three months and six months ended June 30, 2010, respectively. Operating income included interest income of $2.5 million and $5.0 million for the six months ended June 30, 2010, and 2009, respectively. EBITDA is not prepared in conformity with GAAP because it excludes depreciation and amortization expense, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to net income, operating income, operating margin, or cash provided by operating activities. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At June 30, 2010, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $47.4 million, including auction rate securities with a fair value of $7.6 million, compared with $45.6 million of cash and investments at December 31, 2009. On a consolidated basis, at June 30, 2010, we had working capital of $345.4 million compared with $321.2 million at December 31, 2009. At June 30, 2010 and December 31, 2009, cash and cash equivalents were $461.0 million and $469.5 million, respectively. At June 30, 2010, investments were $212.0 million, including $36.7 million in non-current auction rate securities, and at December 31, 2009, investments were $234.5 million, including $59.7 million in non-current auction rate securities.

In connection with the May 1, 2010 closing of our acquisition of Molina Medicaid Solutions, we used a draw on our credit facility, which previously had had no outstanding balance, to fund $105 million of the $131 million purchase price. The $26 million balance of the purchase price was funded with available cash.

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

In 2005, we entered into an Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2008, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for general corporate purposes.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At June 30, 2010, we were in compliance with all financial covenants in the Credit Facility.

Subject to the closing of the Molina Medicaid Solutions acquisition, in November 2009 we agreed to enter into a fourth amendment to the Credit Facility. The fourth amendment became effective upon the closing of the acquisition of Molina Medicaid Solutions. The fourth amendment was required because the $131 million purchase price for this acquisition exceeded the applicable deal size threshold under the terms of the Credit Facility. Pursuant to the fourth amendment, the lenders consented to our acquisition of Molina Medicaid Solutions.

Upon its effectiveness at the closing, the fourth amendment increased the commitment fee on the total unused commitments of the lenders under the facility to 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans was raised by 200 basis points at every level of the pricing grid. Thus, the applicable margins now range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. Until the delivery of a compliance certificate with respect to our financial statements for the second quarter of 2010, the applicable margin shall be fixed at 3.5% for LIBOR loans and 2.5% for base rate loans. In connection with the lenders' approval of the fourth amendment, a consent fee of 10 basis points was paid on the amount of each consenting lender's commitment. In addition, the fourth amendment carved out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the convertible senior notes (although the $187.0 million indebtedness is still included in the calculation of our consolidated leverage ratio); increased the amount of surety bond obligations we may incur; increased our allowable capital expenditures; and reduced the fixed charge coverage ratio from 3.50x to 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

On March 15, 2010, we agreed to enter into a fifth amendment to the Credit Facility. The fifth amendment also became effective upon the closing of the acquisition of Molina Medicaid Solutions. The fifth amendment was required because, after giving effect to the acquisition of Molina Medicaid Solutions on a pro forma basis, and inclusive of our fourth quarter 2009 EBITDA of only $5.9 million, our consolidated leverage ratio for the preceding four fiscal quarters exceeded the currently applicable ratio of 2.75 to 1.0. The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if we have actually reduced our consolidated leverage ratio to no more than 2.75 to 1.0 on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a

pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010. At June 30, 2010, our consolidated leverage ratio was 2.9%, as computed per the terms of the Credit Facility.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

On August 4, 2010, we issued a press release announcing a proposed offering of 4,000,000 shares of common stock covered by this registration statement. We intend to use the proceeds from this offering to repay the Credit Facility and for general corporate purposes.

Long-Term Debt

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, for a remaining aggregate principal amount of $187.0 million as of December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per $1,000 principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price, or VWAP, trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and $50 (representing 1/20th of $1,000); and

- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above $50.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $362.3 million at June 30, 2010, and $368.7 million at December 31, 2009.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At June 30, 2010, our health plans had aggregate statutory capital and surplus of approximately $376.2 million, compared with the required minimum aggregate statutory capital and surplus of approximately $253.2 million. All of our health plans were in compliance with the minimum capital requirements at June 30, 2010. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2010.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2009, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Principal areas requiring the use of estimates include those areas listed below. The most significant of these estimates is revenue recognition, the determination of deferred contract costs, and the determination of medical claims and benefits payable, which are discussed in further detail below:

- The recognition of revenue;
- The determination of deferred contract costs;
- The determination of medical claims and benefits payable;
- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon either the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses;
- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The impairment of long-lived and intangible assets;

- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Revenue Recognition — Health Plans Segment

Certain components of premium revenue are subject to accounting estimates. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health.* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At June 30, 2010, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.
- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At June 30, 2010, we had recorded a liability of approximately $2.8 million under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.
- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. For the twelve months ended through the end of the state fiscal year on June 30, 2010, our New Mexico health plan had received $3.7 million in at-risk revenue for state fiscal year 2010. We have recognized $1.8 million of that amount as revenue, and recorded a liability of approximately $1.9 million for the remainder.
- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. Effective January 1, 2010 an additional 0.25% of the Ohio health plan's revenue became refundable if certain pharmacy specific performance measures were not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. For the twelve months ended through the end of the state fiscal year on June 30, 2010, our Ohio health plan had received $8.7 million in at-risk revenue for state fiscal year 2010. We have recognized $6.2 million of that amount as revenue and recorded a liability of approximately $2.5 million for the remainder at June 30, 2010.

- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at June 30, 2010 or December 31, 2009.
- *Texas Health Plan Premium Revenue:* The contract entered into between our Texas health plan and the state of Texas includes a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of June 30, 2010, we had an aggregate liability of approximately $2.1 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2009 and 2010 contract years (ending August 31 of each year). We made no payments to the state under the terms of this profit sharing agreement during the first half of 2010. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.
- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. For the twelve months ended through the end of the state fiscal year on June 30, 2010, our Texas health plan had received $1.1 million in at-risk revenue for state fiscal year 2010, which has all been recognized revenue.
- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue. Based upon our knowledge of member health care utilization patterns we have recorded a liability of approximately $1.5 million related to the potential recoupment of Medicare premium revenue at June 30, 2010.

Revenue Recognition and Determination of Deferred Contract Costs — Molina Medicaid Solutions Segment

As a result of our recent acquisition of Molina Medicaid Solutions, a portion of our revenues is derived from service arrangements. For fixed-price contracts where the system design and development phase were in process as of the acquisition date, we apply contract accounting because we will deliver significantly modified and customized MMIS software to the customer under the terms of the contract. Additionally, these contracts contain multiple

deliverables; once the system design and development phase is complete, we provide technology outsourcing services and business process outsourcing. We do not have vendor specific objective evidence of the fair value of the technology outsourcing and business process outsourcing components of the contracts because we do not have enough history of offering these services on a stand-alone basis. As such we account for these fixed-price service contracts as a single element.

In general, we recognize contract revenues as a single element ratably over the performance period, or contract term, of the outsourcing services (operations phase) because these services are the last element to be delivered under the contract. The contract terms typically range from five to 10 years. In those service arrangements where final acceptance of a system or solution by the customer is required, contract revenues and costs are deferred until all material acceptance criteria have been met and performance is substantially complete. Performance will often extend over long periods, and our right to receive future payment depends on our future performance in accordance with the agreement. Revenues earned in excess of related billings are accrued, whereas billings in excess of revenues earned are deferred until the related services are provided. Amortization of certain identifiable intangible assets, relating to contract backlog, is recorded to contra-service revenue, to match revenues associated with contract performance that occurred prior to the acquisition date.

Deferred contract costs include direct and incremental costs such as direct labor, hardware and software. We also defer and subsequently amortize certain transition costs related to activities that transition the contract from the design, development, and implementation phase to the operational, or business process outsourcing phase. Deferred contract costs, including transition costs, are amortized on a straight-line basis over the remaining original contract term, consistent with the revenue recognition period.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets. Indirect costs associated with MMIS service contracts are generally expensed as incurred.

Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable as of the dates indicated:

	June 30, 2010	Dec. 31, 2009	June 30, 2009
		(In thousands)	
Fee-for-service claims incurred but not paid (IBNP)	$268,652	$246,508	$244,987
Capitation payable	49,101	39,995	34,657
Pharmacy	13,385	20,609	22,367
Other	14,462	9,404	6,696
Total	$345,600	$316,516	$308,707

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $268.7 million of our total medical claims and benefits payable of $345.6 million as of June 30, 2010. Excluding amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at June 30, 2010 was $261.6 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of June 30, 2010 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding June 30, 2010, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 77,755
(4)%	51,837
(2)%	25,918
2%	(25,918)
4%	(51,837)
6%	(77,755)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of June 30, 2010 that would have resulted had we altered our trend factors by the percentages

indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (65,606)
(4)%	(43,738)
(2)%	(21,869)
2%	21,869
4%	43,738
6%	65,606

The following per-share amounts are based on a combined federal and state statutory tax rate of 38%, and 26.0 million diluted shares outstanding for the six months ended June 30, 2010. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at June 30, 2010, net income for the three months ended June 30, 2010 would increase or decrease by approximately $8.0 million, or $0.31 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at June 30, 2010, net income for the three months ended June 30, 2010 would increase or decrease by approximately $6.8 million, or $0.26 per diluted share, net of tax. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $40.2 million, or $1.55 per diluted share, and $33.9 million, or $1.31 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $8.0 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which much of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously

reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2009, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 17.6%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2009 and through June 30, 2010 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

For the three months and six months ended June 30, 2010, we recognized a benefit from prior period claims development in the amount of $38.5 million, and $43.0 million, respectively (see table below). This benefit was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting and medical management imitative had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

We recognized a benefit from prior period claims development in the amount of $46.4 million and $51.6 million for the six months ended June 30, 2009, and the year ended December 31, 2009, respectively (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2008. The overestimation of claims liability at December 31, 2008 was the result of the following factors:

- In New Mexico, we overestimated at December 31, 2008 the ultimate amounts we would need to pay to resolve certain high dollar provider claims.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008.
- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt

of paper claims would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

In estimating our claims liability at June 30, 2010, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The rapid growth of membership in our Medicare line of business between December 31, 2009 and June 30, 2010.
- A decrease in claims inventory at our Ohio health plan between March 31, 2010 and June 30, 2010.
- The impact of reductions to the state Medicaid fee schedules in New Mexico effective December 1, 2009.
- The transition of claims processing for our Missouri health plan from a third party service provider to our internal claims processing platform effective April l, 2010.
- Provider contracting changes reducing outpatient facilities costs at our Utah health plan effective April 1, 2010.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability. In 2009 and through June 30, 2010, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

We seek to maintain a consistent claims reserving methodology across all periods. In 2009, the prior period benefit from an un-utilized reserve for adverse claims development was offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) during the year, and thus the impact on earnings for the current period was minimal.

The following table presents the components of the change in our medical claims and benefits payable for the periods presented. The negative amounts displayed for "*Components of medical care costs related to: Prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period

exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	As of and for the			
	Six Months Ended		Three Months Ended	Year Ended
	June 30, 2010	June 30, 2009	March 31, 2010	Dec. 31, 2009
Balances at beginning of period	$ 316,516	$ 292,442	$ 316,516	$ 292,442
Components of medical care costs related to:				
Current period	1,705,411	1,587,469	861,271	3,227,794
Prior periods	(42,982)	(46,375)	(38,455)	(51,558)
Total medical care costs	1,662,429	1,541,094	822,816	3,176,236
Payments for medical care costs related to:				
Current period	1,389,307	1,297,946	581,389	2,919,240
Prior periods	244,038	226,883	230,970	232,922
Total paid	1,633,345	1,524,829	812,359	3,152,162
Balances at end of period	$ 345,600	$ 308,707	$ 326,973	$ 316,516
Benefit from prior period as a percentage of:				
Balance at beginning of period	13.6%	15.9%	12.1%	17.6%
Premium revenue	2.2%	2.6%	4.0%	1.4%
Total medical care costs	2.6%	3.0%	4.7%	1.6%
Days in claims payable, fee for service only	44	47	44	44
Number of members at end of period	1,498,000	1,368,000	1,482,000	1,455,000
Number of claims in inventory at end of period	106,300	117,100	153,700	93,100
Billed charges of claims in inventory at end of period	$ 146,600	$ 173,400	$ 194,000	$ 131,400
Claims in inventory per member at end of period	0.07	0.09	0.10	0.06
Billed charges of claims in inventory per member at end of period	$ 97.86	$ 126.75	$ 130.90	$ 90.31
Number of claims received during the period	7,029,600	6,287,300	3,493,300	12,930,100
Billed charges of claims received during the period	$ 5,580,400	$ 4,707,200	$ 2,760,500	$ 9,769,000

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plans operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the six months ended June 30, 2010 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. The following risk factors were identified or re-evaluated by the Company during the second quarter and are a supplement to those risk factors discussed in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2009, and to Part II, Item 1A — Risk Factors, in our Quarterly Report on Form 10-Q for the quarter ended June 30, 2010. The risks described herein and in our Annual Report on Form 10-K and Quarterly Report on Form 10-Q are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

Continuing state budget pressures, as well as the scheduled expiration as of December 31, 2010 of the enhanced Medicaid federal medical assistance percentage paid to states under the American Recovery and Reinvestment Act of 2009 (ARRA), could result in premium rate decreases or the recoupment of previously paid amounts, either of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Several of the states in which we operate our health plans continue to face severe budget shortfalls stemming from high unemployment, record declines in revenue, and increasing demand for public assistance programs such as Medicaid. These continuing budget pressures could result in states' unexpectedly and abruptly seeking to reduce the premium rates paid to our health plans, or even to their seeking to recoup premium amounts previously paid to our health plans, as has recently occurred with respect to our Michigan plan. Any such rate reductions or recoupment of previously paid premium amounts could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, the increase in the federal share of Medicaid funding provided to states under ARRA will expire as of December 31, 2010. The increased funds have helped states reduce their deficits and support their Medicaid programs. The scheduled expiration of the ARRA funds as of December 31, 2010 will create a financing cliff in the middle of many state fiscal years at a time when their budgets are already under severe financial strain. There have been several unsuccessful attempts in Congress to pass an extension of the increased federal share of Medicaid funding. As of August 3, 2010, Congress is once again considering an extension of Medicaid funding under ARRA. However, there can be no assurances that a Medicaid funding extension will be passed by Congress and signed into law, or, if passed, that it will be sufficient for states to maintain the same level of Medicaid funding as they had prior to December 31, 2010. In the event the increased federal share of Medicaid funding is not extended beyond December 31, 2010, the resulting budget pressure on the states in which we operate our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. For example, by letter dated July 7, 2010 from the Center for Medicare and Medicaid Services, or CMS, we were notified that we had been selected for an on-site audit with respect to certain specified Medicare Advantage and Prescription Drug Plan contracts in the compliance areas of enrollment and disenrollment, premium billing, Part D formulary administration, Part D appeals, grievances and coverage determinations and compliance program. The on-site audit was conducted from July 26 to July 30, 2010. We do not expect to receive written notification of the results of this audit until September 2010. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, whether as a result of this most recent CMS audit or otherwise, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject

to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could adversely affect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. During 2008, due to a prolonged budget impasse, some of the monthly premium payments made by the state of California to our California health plan were several months late. The state of California is once again in a budget impasse, and may be unable to make monthly premium payments to our California health plan if a budget is not passed by the end of the third quarter of 2010. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse affect on our business, financial condition, cash flows, or results of operations.

Item 6. ***Exhibits***

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: August 4, 2010

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: August 4, 2010

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

EXHIBIT INDEX

Exhibit No.	Title
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32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2010 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 4, 2010

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended June 30, 2010 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: August 4, 2010

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2010 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 4, 2010

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended June 30, 2010 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: August 4, 2010

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

MHI Form 10-Q for the Period Ended March 31, 2010

UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2010

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	*(Zip Code)*

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐	Accelerated filer ☑	Non-accelerated filer ☐	Smaller reporting company ☐

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The number of shares of the issuer's Common Stock, par value $0.001 per share, outstanding as of April 30, 2010, was approximately 25,730,000.

MOLINA HEALTHCARE, INC.

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PART I — FINANCIAL INFORMATION

Item 1: ***Financial Statements.***

MOLINA HEALTHCARE, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS

	March 31, 2010	December 31, 2009
	(Amounts in thousands, except per-share data) (Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 438,281	$ 469,501
Investments	175,911	174,844
Receivables	128,600	136,654
Income and related taxes refundable	3,132	6,067
Deferred income taxes	4,279	8,757
Prepaid expenses and other current assets	15,051	15,583
Total current assets	765,254	811,406
Property and equipment, net	77,879	78,171
Goodwill and intangible assets, net	210,605	214,254
Investments	55,580	59,687
Restricted investments	36,930	36,274
Receivable for ceded life and annuity contracts	25,378	25,455
Other assets	19,322	19,988
	$ 1,190,948	$ 1,245,235
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 326,973	$ 316,516
Accounts payable and accrued liabilities	86,033	71,732
Deferred revenue	11,321	101,985
Total current liabilities	424,327	490,233
Long-term debt	160,143	158,900
Deferred income taxes	11,201	12,506
Liability for ceded life and annuity contracts	25,378	25,455
Other long-term liabilities	16,073	15,403
Total liabilities	637,122	702,497
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized; outstanding: 25,728 shares at March 31, 2010 and 25,607 shares at December 31, 2009	26	26
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	130,272	129,902
Accumulated other comprehensive loss	(1,684)	(1,812)
Retained earnings	425,212	414,622
Total stockholders' equity	553,826	542,738
	$ 1,190,948	$ 1,245,235

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2010	2009
	(Amounts in thousands, except per share data) (Unaudited)	
Revenue:		
Premium revenue	$ 965,220	$ 857,484
Investment income	1,521	3,547
Total revenue	966,741	861,031
Expenses:		
Medical care costs	822,816	737,888
General and administrative expenses	113,426	92,462
Depreciation and amortization	10,061	9,052
Total expenses	946,303	839,402
Gain on retirement of convertible senior notes	—	1,532
Operating income	20,438	23,161
Interest expense	(3,357)	(3,415)
Income before income taxes	17,081	19,746
Income tax expense	6,491	7,535
Net income	$ 10,590	$ 12,211
Net income per share:		
Basic	$ 0.41	$ 0.46
Diluted (1)	$ 0.41	$ 0.46
Weighted average shares outstanding:		
Basic	25,646	26,530
Diluted (1)	25,837	26,561

(1) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted net income per share because to do so would have been anti-dilutive for the quarters ended March 31, 2010 and 2009.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended March 31,	
	2010	2009
	(Amounts in thousands) (Unaudited)	
Net income	$ 10,590	$ 12,211
Other comprehensive gain (loss), net of tax:		
Unrealized gain (loss) on investments	128	(32)
Other comprehensive gain (loss)	128	(32)
Comprehensive income	$ 10,718	$ 12,179

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Three Months Ended March 31,	
	2010	2009
	(Dollars in thousands) (Unaudited)	
Operating activities:		
Net income	$ 10,590	$ 12,211
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	10,061	9,052
Unrealized gain on trading securities	(540)	(3,639)
Loss on rights agreement	493	3,323
Deferred income taxes	3,094	4,988
Stock-based compensation	2,136	1,434
Non-cash interest on convertible senior notes	1,243	1,194
Gain on repurchase and retirement of convertible senior notes	—	(1,532)
Amortization of deferred financing costs	344	352
Tax deficiency from employee stock compensation recorded as additional paid-in capital	(353)	(533)
Changes in operating assets and liabilities:		
Receivables	8,054	(29,613)
Prepaid expenses and other current assets	532	(2,912)
Medical claims and benefits payable	10,457	19,185
Accounts payable and accrued liabilities	15,134	(2,922)
Deferred revenue	(90,664)	52,968
Income taxes	2,935	3,359
Net cash (used in) provided by operating activities	(26,484)	66,915
Investing activities:		
Purchases of equipment	(5,976)	(10,367)
Purchases of investments	(49,439)	(48,127)
Sales and maturities of investments	53,226	35,627
Cash paid in business purchase transactions	(2,430)	—
(Increase) decrease in restricted investments	(656)	445
Increase in other assets	(244)	(1,708)
Increase (decrease) in other long-term liabilities	670	(131)
Net cash used in investing activities	(4,849)	(24,261)
Financing activities:		
Treasury stock purchases	—	(14,976)
Purchase of convertible senior notes	—	(9,653)
Excess tax benefits from employee stock compensation	113	—
Net cash provided by (used in) financing activities	113	(24,629)
Net (decrease) increase in cash and cash equivalents	(31,220)	18,025
Cash and cash equivalents at beginning of period	469,501	387,162
Cash and cash equivalents at end of period	$ 438,281	$ 405,187
Supplemental cash flow information:		
Cash paid during the period for:		
Income taxes	$ 91	$ 63
Interest	$ 142	$ 339
Schedule of non-cash investing and financing activities:		
Unrealized gain (loss) on investments	$ 207	$ (156)
Deferred taxes	(79)	124
Net unrealized gain (loss) on investments	$ 128	$ (32)
Accrued purchases of equipment	$ 71	$ 139
Retirement of common stock used for stock-based compensation	$ 1,526	$ 695
Details of business purchase transactions:		
Other assets	$ —	$ 9,000
Accounts payable and accrued liabilities	—	2,847
Deferred taxes	—	—
Goodwill and intangible assets, net	$ —	$ 11,847

MOLINA HEALTHCARE, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
March 31, 2010

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of healthcare services to persons eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. We conduct our business primarily through licensed health plans in the states of California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization, or HMO. Effective January 1, 2010, we terminated operations at our small Medicare health plan in Nevada.

Effective May 1, 2010, we closed on our acquisition of the Healthcare Information Management, or HIM, business of Unisys Corporation. See Note 13, "Subsequent Events."

Consolidation and Interim Financial Information

The condensed consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented have been included. Except as described below, such adjustments consist of normal recurring adjustments. All significant intercompany balances and transactions have been eliminated in consolidation. The condensed consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2010. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

The unaudited condensed consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2009. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2009 audited consolidated financial statements have been omitted. These unaudited condensed consolidated interim financial statements should be read in conjunction with our December 31, 2009 audited financial statements.

Reclassifications

We have reclassified certain prior year income statement amounts to conform to the 2010 presentation. Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax as a premium tax and not as an income tax. For the three months ended March 31, 2009, amounts for premium tax expense (included in general and administrative expenses) and income tax expense have been reclassified to conform to this presentation. See Note 2, "Significant Accounting Policies."

2. Significant Accounting Policies

Investments

Our investments are principally held in debt securities, which are grouped into three separate categories for accounting and reporting purposes: available-for-sale securities, held-to-maturity securities, and trading securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. Trading securities are recorded at fair value, and holding gains and losses are recognized in net income.

Except for restricted investments and certain student loan portfolios (the "auction rate securities"), our debt securities are designated as available-for-sale and are carried at fair value. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis. Fair values of securities are generally based on quoted prices in active markets.

Our investment policy requires that all of our investments have final maturities of ten years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be four years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. During 2008, our auction rate securities were classified as non-current assets. During the fourth quarter of 2008, certain auction rate securities were designated as trading securities. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," and Note 6, "Investments."

Income Taxes

We record accruals for uncertain tax positions by applying a two-step process. First, we determine whether it is more likely than not that a tax position will be sustained upon examination. In the second step, a tax position that meets the more-likely-than-not recognition threshold is measured to determine the amount of benefit to recognize in the financial statements.

Our accrual for unrecognized tax benefits was $4.1 million as of both March 31, 2010 and December 31, 2009. This accrual is included in "Other long-term liabilities" in the accompanying condensed consolidated balance sheets. Approximately $3.4 million of the $4.1 million in unrecognized tax benefits at March 31, 2010 would affect our effective tax rate, if recognized. We anticipate a decrease of $0.4 million to our liability for unrecognized tax benefits within the next twelve-month period.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Our accrual for the payment of interest relating to unrecognized tax benefits was $75,000 as of March 31, 2010 and December 31, 2009.

Effective January 1, 2008 through December 31, 2009, income tax expense included both the Michigan business income tax, or BIT, and Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax (included in general and administrative expenses) and not as an income tax. We will continue to record the BIT as an income tax. The MGRT amounted to $1.5 million, and $1.0 million for the three months ended March 31, 2010, and 2009, respectively.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers is defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of our Michigan plan's receipts and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

Recent Accounting Pronouncements

Fair Value Measurements. In January 2010, the Financial Accounting Standards Board ("FASB") issued guidance which expanded the required disclosures about fair value measurements. In particular, this guidance requires (a) separate disclosure of the amounts of significant transfers in and out of Level 1 and Level 2 fair value measurements along with the reasons for such transfers, (b) information about purchases, sales, issuances and settlements to be presented separately in the reconciliation for Level 3 fair value measurements, (c) fair value measurement disclosures for each class of assets and liabilities and (d) disclosures about the valuation techniques and inputs used to measure fair value for both recurring and nonrecurring fair value measurements for fair value measurements that fall in either Level 2 or Level 3. Effective for interim and annual reporting beginning after December 15, 2009, with one new disclosure effective after December 15, 2010, we have adopted this guidance in full with respect to the interim period ended March 31, 2010. The adoption of this guidance did not impact our financial condition or results of operations.

3. Earnings per Share

The denominators for the computation of basic and diluted earnings per share were calculated as follows:

	Three Months Ended March 31,	
	2010	2009
	(in thousands)	
Shares outstanding at the beginning of the period	25,607	26,725
Weighted-average number of shares repurchased	—	(218)
Weighted-average number of shares issued	39	23
Denominator for basic earnings per share	25,646	26,530
Dilutive effect of employee stock options and stock grants (1)	191	31
Denominator for diluted earnings per share (2)	25,837	26,561

(1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are below the average fair value of the common shares for each of the periods presented. For the three months ended March 31, 2010, and 2009, there were approximately 613,000 and 626,000 antidilutive weighted options, respectively. Restricted shares are included in the calculation of diluted earnings per share when their grant date fair values are below the average fair value of the common shares for each of the periods presented. For the three months ended March 31, 2010, and 2009, there were approximately 15,000, and 330,000 antidilutive weighted restricted shares, respectively.

(2) Potentially dilutive shares issuable pursuant to our convertible senior notes were not included in the computation of diluted earnings per share because to do so would have been anti-dilutive for the quarters ended March 31, 2010 and 2009.

4. Share-Based Compensation

At March 31, 2010, we had employee equity incentives outstanding under two plans: (1) the 2002 Equity Incentive Plan; and (2) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). Charged to general and administrative expenses, total stock-based compensation expense for the three months ended March 31, 2010 and 2009 was as follows:

	Three Months Ended March 31,	
	2010	2009
	(in thousands)	
Restricted stock awards	$ 1,638	$ 1,052
Stock options (including shares issued under our employee stock purchase plan)	498	382
Total stock-based compensation expense	$ 2,136	$ 1,434

As of March 31, 2010, there was $19.5 million of total unrecognized compensation expense related to unvested restricted stock awards, which we expect to be recognized over a remaining weighted-average period of 3.1 years. Also as of March 31, 2010, there was $751,000 of unrecognized compensation expense related to unvested stock options, which we expect to recognize over a remaining weighted-average period of 1.1 years.

Unvested restricted stock and restricted stock activity for the three months ended March 31, 2010 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Unvested balance as of December 31, 2009	687,630	$ 24.64
Granted	432,625	21.77
Vested	(191,426)	25.22
Forfeited	(3,950)	24.74
Unvested balance as of March 31, 2010	924,879	23.18

The total fair value of restricted shares granted during the three months ended March 31, 2010 and 2009 was $9.4 million and $6.8 million, respectively. The total fair value of restricted shares vested during the three months ended March 31, 2010 and 2009 was $4.2 million and $2.1 million, respectively. Stock option activity during the three months ended March 31, 2010 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value (in Thousands)	Weighted Average Remaining Contractual Term (Years)
Stock options outstanding as of December 31, 2009	650,739	$ 30.25		
Stock options outstanding as of March 31, 2010	650,739	$ 30.25	$ 379	5.6
Stock options exercisable and expected to vest as of March 31, 2010	644,579	$ 30.23	$ 379	5.6
Exercisable as of March 31, 2010	588,272	$ 30.04	$ 378	5.4

5. Fair Value Measurements

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, trade accounts payable, medical claims and benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For a comprehensive discussion of fair value measurements with regard to our current and non-current investments, see below.

Based on quoted market prices, the fair value of our convertible senior notes issued in October 2007 was $172.8 million as of March 31, 2010, and $160.8 million as of December 31, 2009. The carrying amount of the convertible senior notes was $160.1 million, and $158.9 million as of March 31, 2010, and December 31, 2009, respectively.

To prioritize the inputs we use in measuring fair value, we apply a three-tier fair value hierarchy. These tiers include: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of March 31, 2010, we held certain assets that are required to be measured at fair value on a recurring basis. These included investments as follows:

Balance Sheet Classification	Description
Current assets:	
Investments (see Note 6)	Investment grade debt securities; designated as available-for-sale; reported at fair value based on market prices that are readily available (Level 1).
Non-current assets:	
Investments (see Note 6)	Auction rate securities; designated as available-for-sale; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
	Auction rate securities; designated as trading; reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).
Other assets	Other assets include auction rate securities rights (the “Rights”); reported at fair value based on discounted cash flow analysis or other type of valuation model (Level 3).

As of March 31, 2010, $62.9 million par value (fair value of $55.6 million) of our investments consisted of auction rate securities, all of which were collateralized by student loan portfolios guaranteed by the U.S. government. We continued to earn interest on substantially all of these auction rate securities as of March 31, 2010. Due to events in the credit markets, the auction rate securities held by us experienced failed auctions beginning in the first quarter of 2008. As such, quoted prices in active markets were not readily available during the majority of 2008, all of 2009, and continued to be unavailable as of March 31, 2010. To estimate the fair value of these securities, we used pricing models that included factors such as the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. We concluded that these estimates, given the lack of market available pricing, provided a reasonable basis for determining fair value of the auction rate securities as of March 31, 2010.

As of March 31, 2010, we held $36.4 million par value (fair value of $32.8 million) auction rate securities (designated as trading securities) with a certain investment securities firm. In the fourth quarter of 2008, we entered into a rights agreement with this firm that (1) allows us to exercise rights (the "Rights") to sell the eligible auction rate securities at par value to this firm between June 30, 2010 and July 2, 2012, and (2) gives the investment securities firm the right to purchase the auction rate securities from us any time after the agreement date as long as we receive the par value.

We account for the Rights as a freestanding financial instrument and have elected to record the value of the Rights under the fair value option. We recorded pretax losses on the Rights, attributable to the decline in the fair value of the Rights, totaling $493,000 and $3.3 million for the three months ended March 31, 2010, and 2009, respectively. To determine the fair value estimate of the Rights, we use a discounted cash-flow model based on the expectation that the auction rate securities will be put back to the investment securities firm at par on June 30, 2010, as permitted by the rights agreement.

For the three months ended March 31, 2010 and 2009, we recorded pretax gains of $540,000 and $3.6 million, respectively, on the auction rate securities underlying the Rights. We expect that the future changes in the fair value of the Rights will continue to be substantially offset by the fair value movements in the underlying auction rate securities.

As of March 31, 2010, the remainder of our auction rate securities (designated as available-for-sale securities) amounted to $26.5 million par value (fair value of $22.8 million). As a result of the increase in fair value of auction rate securities designated as available-for-sale, we recorded pretax unrealized gains of $203,000 and $320,000 to accumulated other comprehensive loss for the three months ended March 31, 2010, and 2009, respectively. We have deemed these unrealized losses to be temporary and attribute the decline in value to liquidity issues, as a result of the failed auction market, rather than to credit issues. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive loss. If we determine that any future valuation adjustment was other-than-temporary, we would record a charge to earnings as appropriate.

Our assets measured at fair value on a recurring basis at March 31, 2010, were as follows:

	Fair Value Measurements at Reporting Date Using			
	Total	Level 1	Level 2	Level 3
	(In thousands)			
Investments	$ 175,911	$ 175,911	$ —	$ —
Auction rate securities (available-for-sale)	22,810	—	—	22,810
Auction rate securities (trading)	32,770	—	—	32,770
Auction rate securities rights	3,314	—	—	3,314
Total assets measured at fair value	$ 234,805	$ 175,911	$ —	$ 58,894

The following table presents a rollforward of the balance of our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3):

	(Level 3) (In thousands)
Balance at December 31, 2009	$ 63,494
Total gains (unrealized):	
Included in earnings	47
Included in other comprehensive income	203
Settlements	(4,850)
Balance at March 31, 2010	$ 58,894
The amount of total gains for the period included in other comprehensive loss attributable to the change in unrealized gains relating to assets still held at March 31, 2010	$ 203

6. Investments

The following tables summarize our investments as of the dates indicated:

	March 31, 2010			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Government-sponsored enterprise securities	$ 84,712	$ 471	$ 230	$ 84,953
Municipal securities (including non-current auction rate securities)	78,086	2,534	3,904	76,716
Corporate debt securities	39,145	176	231	39,090
U.S. treasury notes	27,405	90	27	27,468
Certificates of deposit	3,264	—	—	3,264
	$ 232,612	$ 3,271	$ 4,392	$ 231,491

	December 31, 2009			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
	(In thousands)			
Government-sponsored enterprise securities	$ 89,451	$ 504	$ 281	$ 89,674
Municipal securities (including non-current auction rate securities)	82,009	3,120	4,154	80,975
Corporate debt securities	32,543	206	185	32,564
U.S. treasury notes	28,052	92	84	28,060
Certificates of deposit	3,258	—	—	3,258
	$ 235,313	$ 3,922	$ 4,704	$ 234,531

The contractual maturities of our investments as of March 31, 2010 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 72,561	$ 72,448
Due one year through five years	102,559	102,943
Due after five years through ten years	1,430	1,403
Due after ten years	56,062	54,697
	$ 232,612	$ 231,491

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were $36.0 million and $35.5 million for the three months ended March 31, 2010, and 2009, respectively. Net realized investment gains for the three months ended March 31, 2010, and 2009 were $14,000 and $158,000 respectively.

We monitor our investments for other-than-temporary impairment. For investments other than our municipal securities, we have determined that unrealized gains and losses at March 31, 2010, and December 31, 2009, are temporary in nature, because the change in market value for these securities has resulted from fluctuating interest rates, rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial.

Our investment in municipal securities consists primarily of auction rate securities. As described in Note 5, "Fair Value Measurements," the unrealized losses on these investments were caused primarily by the illiquidity in the auction markets. Because the decline in market value is not due to the credit quality of the issuers, and because we do not intend to sell, nor is it more likely than not that we will be required to sell, these investments before recovery of their cost, we do not consider the auction rate securities that are designated as available-for-sale to be other-than-temporarily impaired at March 31, 2010.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of March 31, 2010.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Government-sponsored enterprise securities	$ 23,646	$ 50	$ 10,331	$ 180	$ 33,977	$ 230
Municipal securities	10,700	47	24,101	3,698	34,801	3,745
Corporate debt securities	11,193	109	9,409	122	20,602	231
U.S. treasury notes	15,603	27	—	—	15,603	27
	$ 61,142	$ 233	$ 43,841	$ 4,000	$ 104,983	$ 4,233

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a loss position for 12 months or more as of December 31, 2009. At December 31, 2009, we previously reported only those available-for-sale investments in an unrealized loss position for at least two consecutive months. To conform to the current year presentation, we have included all available-for-sale investments in an unrealized loss position at December 31, 2009. This presentation change increased the total amount of unrealized losses reported in the following table by $113,000 at December 31, 2009. The accompanying increase to the estimated fair value of the underlying investments amounted to $42.9 million at December 31, 2009.

	In a Continuous Loss Position for Less than 12 Months		In a Continuous Loss Position for 12 Months or More		Total	
	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses	Estimated Fair Value	Unrealized Losses
	(In thousands)					
Government-sponsored enterprise securities	$ 30,460	$ 187	$ 7,297	$ 94	$ 37,757	$ 281
Municipal securities	12,460	78	24,031	3,902	36,491	3,980
Corporate debt securities	13,513	149	1,203	36	14,716	185
U.S. treasury notes	21,824	84	—	—	21,824	84
	$ 78,257	$ 498	$ 32,531	$ 4,032	$ 110,788	$ 4,530

7. Receivables

Receivables consist primarily of amounts due from the various states in which we operate. All receivables are subject to potential retroactive adjustment. As the amounts of all receivables are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable by health plan operating subsidiary were as follows:

	March 31, 2010	December 31, 2009
	(In thousands)	
California	$ 28,250	$ 34,289
Michigan	17,122	14,977
Missouri	21,082	19,670
New Mexico	12,389	11,919
Ohio	31,286	37,004
Utah	3,630	6,107
Washington	11,953	9,910
Others	2,888	2,778
Total receivables	$ 128,600	$ 136,654

8. Restricted Investments

Pursuant to the regulations governing our subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities in certificates of deposit and U.S. treasury securities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the balances of restricted investments by health plan, and by our insurance company:

	March 31, 2010	December 31, 2009
	(In thousands)	
California	$ 369	$ 368
Florida	2,053	2,052
Insurance company	4,729	4,686
Michigan	1,000	1,000
Missouri	502	503
New Mexico	16,108	15,497
Ohio	9,044	9,036
Texas	1,506	1,515
Utah	576	578
Washington	151	151
Other	892	888
Total	$ 36,930	$ 36,274

The contractual maturities of our held-to-maturity restricted investments as of March 31, 2010 are summarized below.

	Amortized Cost	Estimated Fair Value
	(In thousands)	
Due in one year or less	$ 31,151	$ 31,153
Due one year through five years	5,637	5,611
Due after five years through ten years	142	155
	$ 36,930	$ 36,919

9. Other Assets

Other assets include deferred financing costs associated with long-term debt, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see Note 12, "Related Party Transactions"). The deferred financing costs are being amortized on a straight-line basis over the seven-year term of the convertible senior notes maturing in 2014.

10. Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, so the remaining aggregate principal amount totaled $187.0 million as of December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ended December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

The proceeds from the issuance of such convertible debt instruments have been allocated between a liability component and an equity component. We have determined that the effective interest rate of the Notes is 7.5%, principally based on the seven-year U.S. treasury note rate as of the October 2007 issuance date, plus an appropriate credit spread. The resulting debt discount is being amortized over the period the Notes are expected to be outstanding, as additional non-cash interest expense. As of March 31, 2010, we expect the Notes to be outstanding until their October 1, 2014 maturity date, for a remaining amortization period of 54 months. The Notes' if-converted value did not exceed their principal amount as of March 31, 2010. At March 31, 2010, the equity component of the Notes, net of the impact of deferred taxes, was $24.0 million. The following table provides the details of the liability amounts recorded:

	As of March 31, 2010	As of December 31, 2009
	(in thousands)	
Details of the liability component:		
Principal amount	$ 187,000	$ 187,000
Unamortized discount	(26,857)	(28,100)
Net carrying amount	$ 160,143	$ 158,900

	Three Months Ended March 31,	
	2010	2009
	(in thousands)	
Interest cost recognized for the period relating to the:		
Contractual interest coupon rate of 3.75%	$ 1,753	$ 1,817
Amortization of the discount on the liability component	1,243	1,194
Total interest cost recognized	$ 2,996	$ 3,011

11. Commitments and Contingencies

Legal

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, consolidated financial position, cash flows, or results of operations.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was $356.3 million at March 31, 2010, and $368.7 million at December 31, 2009. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Missouri, New Mexico, Ohio, Texas, Washington, and Utah have adopted these rules, which may vary from state to state. California and Florida have not yet adopted NAIC risk-based capital requirements for HMOs and have not formally given notice of their intention to do so. Such requirements, if adopted by California and Florida, may increase the minimum capital required for those states.

As of March 31, 2010, our health plans had aggregate statutory capital and surplus of approximately $367.0 million compared with the required minimum aggregate statutory capital and surplus of approximately $253.4 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2010. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

12. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee that confers significant influence over operating and financial policies of the investee. As of both March 31, 2010 and December 31, 2009, our carrying amount for this investment totaled $4.1 million. For the three months ended March 31, 2010 and 2009, we paid $4.4 million, and $4.8 million, respectively, for medical service fees to this provider.

We are a party to a fee-for-service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the sister of Dr. J. Mario Molina, our Chief Executive Officer, and John Molina, our Chief Financial Officer. Amounts paid to Pacific Hospital under the terms of this fee-for-service agreement were $297,000, and $172,000 for the three months ended March 31, 2010 and 2009, respectively. We also had a capitation arrangement with Pacific Hospital, where we paid Pacific Hospital a fixed monthly fee per member. This contract was terminated by the parties effective August 31, 2009. Amounts paid to Pacific Hospital for capitated services totaled approximately $460,000 for the three months ended March 31, 2009. We believe that both arrangements with Pacific Hospital are based on prevailing market rates for similar services.

13. Subsequent Events

Effective May 1, 2010, we closed our acquisition of the HIM business of Unisys Corporation. HIM will operate as a subsidiary of Molina Healthcare under the name, *Molina Medicaid Solutions*SM. Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia, as well as a contract to provide drug rebate administration services for the Florida Medicaid program.

The consideration for the acquisition was $135 million, subject to working capital adjustments. The acquisition was funded with available cash of $30 million and $105 million drawn under our credit facility. In connection with the HIM closing, both the fourth amendment and fifth amendment to our credit facility became effective.

Based on our preliminary valuation, we acquired current assets of approximately $19 million, current liabilities of approximately $9 million, and goodwill and intangible assets of approximately $125 million.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. All statements, other than statements of historical facts, included in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected, estimated, expected, or contemplated as a result of, but not limited to, risk factors related to the following:

- budgetary pressures on the federal and state governments and their resulting inability to fully fund Medicaid, Medicare, or CHIP, or to maintain current payment rates, benefit packages, or membership eligibility thresholds and criteria;
- uncertainties regarding the impact of the recently enacted Patient Protection and Affordable Care Act, including the funding provisions related to health plans, and uncertainties regarding the likely impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including rates of utilization that are consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- the continuation and renewal of the government contracts of our health plans;
- the integration of the HIM business of Molina Medicaid Solutions, including its employees, systems, and operations;
- the retention and renewal of the Molina Medicaid Solutions' state government contracts on terms consistent with our expectations;
- the accuracy of our operating cost and capital outlay projections for Molina Medicaid Solutions;
- the timing of receipt and recognition of revenue under our various state contracts held by Molina Medicaid Solutions, including any changes to the anticipated start dates of operation at our Maine and Idaho locations;
- cost recovery efforts by the state of Michigan from Michigan health plans with respect to allegedly incorrect statewide rates and enrollment errors;
- the establishment of a federal or state medical cost expenditure floor as a percentage of the premiums we receive;
- the required establishment of a premium deficiency reserve in any of the states in which we operate;
- up-coding by providers or billing in a manner at material variance with historic patterns;
- approval by state regulators of dividends and distributions by our subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation or arbitration matters;
- restrictions and covenants in our credit facility;
- the success of our efforts to leverage our administrative costs to address the needs associated with increased enrollment;
- the relatively small number of states in which we operate health plans and the impact on the consolidated entity of adverse developments in any single health plan;
- the transition from a non-risk to a risk-based capitation contract by our Utah health plan;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs;
- governmental audits and reviews;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments;
- a state's failure to renew its federal Medicaid waiver;
- an unauthorized disclosure of confidential member information;

- changes generally affecting the managed care industry; and
- general economic conditions, including unemployment rates.

Investors should refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2009, for a discussion of certain risk factors that could materially affect our business, financial condition, cash flows, or results of operations. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution investors not to place undue reliance on these statements.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2009.

Reclassification

Effective January 1, 2010, we have recorded the Michigan modified gross receipts tax, or MGRT as a premium tax and not as an income tax. For the three months ended March 31, 2009, amounts for premium tax expense (included in general and administrative expenses) and income tax expense have been reclassified to conform to this presentation.

Overview

Our financial performance for the three months ended March 31, 2010 compared with our financial performance for the three months ended March 31, 2009 is briefly summarized as follows:

	Three Months Ended March 31,	
	2010	2009
	(Dollar amounts in thousands, except per share data)	
Earnings per diluted share	$ 0.41	$ 0.46
Premium revenue	$ 965,220	$ 857,484
Operating income	$ 20,438	$ 23,161
Net income	$ 10,590	$ 12,211
Medical care ratio	85.3%	86.1%
G&A expenses as a percentage of total revenue	11.7%	10.7%
Total ending membership	1,482,000	1,303,000

Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the three months ended March 31, 2010, we received approximately 94% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our Medicaid contracts with state agencies, our Medicare contracts with CMS, and our contracts with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The amount of the premiums paid to us may vary substantially between states and among various government programs. PMPM premiums for Children's Health Insurance Program, or CHIP members are generally among our lowest, with rates as low as approximately $75 PMPM in California. Premium revenues for Medicaid members are generally higher. Among the Temporary Assistance for Needy Families, or TANF Medicaid population — the Medicaid group that includes mostly mothers and children — PMPM premiums range between approximately $100 in California to $235 in New Mexico. Among our Medicaid Aged, Blind or Disabled, or ABD membership, PMPM premiums range from approximately $320 in Utah to over $1,000 in Ohio. Contributing to the variability in Medicaid rates among the states is the practice of some states to exclude certain benefits from the managed care contract (most often pharmacy and catastrophic case benefits) and retain responsibility for those benefits at the state level. Medicare premiums are nearly $1,100 PMPM on average. Medicare revenue totaled $50.3 million and $27.1 million for the three months ended March 31, 2010 and 2009, respectively.

For the three months ended March 31, 2010, we received approximately 5% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in California (effective October 1, 2009), Michigan, Missouri, Ohio, Texas, Utah (effective September 1, 2009), and Washington. Such payments are recognized as revenue in the month the birth occurs.

Certain components of premium revenue are subject to accounting estimates. Chief among these are:

- *Florida Health Plan Medical Cost Floor (Minimum) for Behavioral Health.* A portion of premium revenue paid to our Florida health plan by the state of Florida may be refunded to the state if certain minimum amounts are not spent on defined behavioral health care costs. At March 31, 2010, we had not recorded any liability under the terms of this contract provision. If the state of Florida disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of this provision, including revisions to the definitions of premium revenue or behavioral health care costs, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our Florida health plan.

- *New Mexico Health Plan Medical Cost Floors (Minimums) and Administrative Cost and Profit Ceilings (Maximums):* A portion of premium revenue paid to our New Mexico health plan by the state of New Mexico may be refunded to the state if certain minimum amounts are not spent on defined medical care costs, or if administrative costs or profit (as defined) exceed certain amounts. Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs (the medical cost floor). Our contract is for a three-year period, and the medical cost floor is based on premiums and medical care costs over the entire contract period. Effective July 1, 2008, our New Mexico health plan entered into a new three year contract that, in addition to retaining the medical cost floor, added certain limits on the amount our New Mexico health plan can: (a) expend on administrative costs; and (b) retain as profit. At March 31, 2010, we had not recorded any liability under the terms of these contract provisions. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to the amounts owed may be required. Any changes to the terms of these provisions, including revisions to the definitions of premium revenue, medical care costs, administrative costs or profit, the period of time over which performance is measured or the manner of its measurement, or the percentages used in the calculations, may affect the profitability of our New Mexico health plan.

- *New Mexico Health Plan At-Risk Premium Revenue:* Under our contract with the state of New Mexico, up to 1% of our New Mexico health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality of care and administrative measures dictated by the state. For the three months ended March 31, 2010, our New Mexico health plan had received $2.8 million in at-risk revenue for state fiscal year 2010. We have recognized $1.2 million of that amount as revenue, and recorded a liability of approximately $1.6 million for the remainder.

- *Ohio Health Plan At-Risk Premium Revenue:* Under our contract with the state of Ohio, up to 1% of our Ohio health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. For the three months ended March 31, 2010, our Ohio health plan had received $6.5 million in at-risk revenue for state fiscal year 2010. We have recognized $4.0 million of that amount as revenue and recorded a liability of approximately $2.6 million for the remainder at March 31, 2010.

- *Utah Health Plan Premium Revenue:* Our Utah health plan may be entitled to receive additional premium revenue from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid. In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize from prior years may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to assert its claim to the amounts believed to be due under the savings share agreement. When additional information is known, or resolution is reached with the state regarding the appropriate savings sharing payment amount for prior years, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement. No receivables for saving sharing revenue have been established at March 31, 2010 or December 31, 2009.

- *Texas Health Plan Premium Revenue:* The contract entered into between our Texas health plan and the state of Texas includes a profit-sharing agreement, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, as defined in the contract, above a certain specified percentage, as determined in accordance with a tiered rebate schedule. We are limited in the amount of administrative costs that we may deduct in calculating the rebate, if any. As of March 31, 2010, we had an aggregate liability of approximately $3.7 million accrued pursuant to our profit-sharing agreement with the state of Texas for the 2009 and 2010 contract years (ending August 31 of each year). We made no payments to the state under the terms of this profit sharing agreement during the first quarter of 2010. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimates.

- *Texas Health Plan At-Risk Premium Revenue:* Under our contract with the state of Texas, up to 1% of our Texas health plan's revenue may be refundable to the state if certain performance measures are not met. These performance measures are generally linked to various quality-of-care measures dictated by the state. For the three months ended March 31, 2010, our Texas health plan had received $0.9 million in at-risk revenue for state fiscal year 2010, which has all been recognized revenue.

- *Medicare Premium Revenue:* Based on member encounter data that we submit to CMS, our Medicare revenue is subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. That analysis is similar to the process for the adjustment of member risk scores, but is further complicated by member pharmacy cost sharing provisions attached to the Medicare pharmacy benefit that do not apply to the services measured by the member risk adjustment process. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' heath care utilization patterns and CMS practices. To the extent that the premium revenue ultimately received from CMS differs from recorded amounts, we will adjust reported Medicare revenue. Based upon our knowledge of member health care utilization patterns we have recorded a liability of approximately $0.6 million related to the potential recoupment of Medicare premium revenue at March 31, 2010.

Historically, membership growth has been the primary reason for our increasing revenues, although more recently our revenues have also grown due to the more care intensive benefits and related higher premiums associated with our ABD and Medicare members. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate total number of members by state health plan as of the dates indicated:

	March 31, 2010	December 31, 2009	March 31, 2009
Total Ending Membership by Health Plan:			
California	353,000	351,000	327,000
Florida	52,000	50,000	17,000
Michigan	226,000	223,000	207,000
Missouri	78,000	78,000	77,000
New Mexico	92,000	94,000	83,000
Ohio	228,000	216,000	190,000
Texas	40,000	40,000	33,000
Utah	75,000	69,000	60,000
Washington	338,000	334,000	309,000
Total	1,482,000	1,455,000	1,303,000
Total Ending Membership by State for our Medicare Advantage Special Needs Plans:			
California	2,700	2,100	1,500
Florida	300	—	—
Michigan	4,200	3,300	2,000
New Mexico	600	400	400
Texas	500	500	400
Utah	7,100	4,000	2,800
Washington	1,600	1,300	1,000
Total	17,000	11,600	8,100
Total Ending Membership by State for our Aged, Blind or Disabled Population:			
California	13,400	13,900	12,600
Florida	8,900	8,800	4,200
Michigan	32,700	32,200	30,100
New Mexico	5,800	5,700	6,200
Ohio	26,700	22,600	19,700
Texas	18,100	17,600	16,700
Utah	7,900	7,500	7,500
Washington	3,500	3,200	3,000
Total	117,000	111,500	100,000

The following table provides details of member months (defined as the aggregation of each month's ending membership for the period) by health plan for the periods indicated:

	Three Months Ended March 31,		
Total Member Months by Health Plan:	**2010**	**2009**	**% of Increase**
California	1,062,000	980,000	8.4%
Florida	154,000	61,000	152.5
Michigan	675,000	620,000	8.9
Missouri	234,000	231,000	1.3
New Mexico	280,000	248,000	12.9
Ohio	673,000	560,000	20.2
Texas	121,000	98,000	23.5
Utah	221,000	184,000	20.1
Washington	1,007,000	919,000	9.6
Total	4,427,000	3,901,000	13.5%

Expenses

Our operating expenses include expenses related to the provision of medical care services and general and administrative, or G&A, expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals on a fee-for-service basis in a variety of ways, including per diem amounts, diagnostic-related groups, or DRGs, percentage of billed charges, and case rates. We also pay a small portion of hospitals on a capitated basis. We also have stop-loss agreements with the hospitals with which we contract; under certain circumstances, we pay escalated charges in connection with these stop-loss agreements. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, costs of operating our medical clinics, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the three month periods ended March 31, 2010 and 2009, medically related administrative costs were approximately $19.6 million and $17.6 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Three months ended March 31,					
	2010			2009		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 566,879	$ 128.06	68.9%	$ 489,141	$ 125.35	66.3%
Capitation	137,132	30.98	16.7	118,414	30.34	16.1
Pharmacy	90,071	20.35	10.9	102,638	26.30	13.9
Other	28,734	6.48	3.5	27,695	7.10	3.7
Total	$ 822,816	$ 185.87	100.0%	$ 737,888	$ 189.09	100.0%

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

The following table provides the details of our medical claims and benefits payable as of the dates indicated (in thousands):

	March 31, 2010	Dec. 31, 2009	March 31, 2009
Fee-for-service claims incurred but not paid (IBNP)	$ 260,456	$ 246,508	$ 247,111
Capitation payable	42,461	39,995	31,815
Pharmacy	16,196	20,609	24,047
Other	7,860	9,404	8,654
Total	$ 326,973	$ 316,516	$ 311,627

G&A expenses largely consist of wage and benefit costs for our employees, premium taxes, and other administrative expenses. Some G&A services are provided locally, while others are delivered to our health plans from a centralized location. The primary centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally provided functions include member services, plan administration, and provider relations. G&A expenses include premium taxes for each of our health plans in California, Florida, Michigan, New Mexico, Ohio, Texas, and Washington.

Results of Operations

The following table sets forth selected operating ratios. All ratios with the exception of the medical care ratio are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium revenue earned and the cost of health care.

	Three Months Ended March 31,	
	2010	2009
Premium revenue	99.8%	99.6%
Investment income	0.2	0.4
Total revenue	100.0%	100.0%
Medical care ratio	85.3%	86.1%
General and administrative expense ratio, excluding premium taxes	8.2%	7.6%
Premium taxes included in general and administrative expenses	3.5	3.1
Total general and administrative expense ratio	11.7%	10.7%
Operating income	2.1%	2.7%
Net income	1.1%	1.4%

The following table summarizes premium revenue, medical care costs, medical care ratio and premium taxes by health plan for the three months ended March 31, 2010 and March 31, 2009 (dollar amounts in thousands except for PMPM amounts):

	Three Months Ended March 31, 2010					
	Premium Revenue		Medical Care Costs		Medical	Premium Tax
	Total	PMPM	Total	PMPM	Care Ratio	Total
California	$ 123,910	$ 116.67	$ 107,561	$ 101.28	86.8%	$ 1,628
Florida	39,088	253.45	34,687	224.91	88.7	6
Michigan	155,345	230.13	125,449	185.85	80.8	9,939
Missouri	52,143	223.01	43,516	186.11	83.5	—
New Mexico	95,598	341.02	74,015	264.03	77.4	2,004
Ohio	218,363	324.35	172,625	256.41	79.1	17,005
Texas	39,200	324.08	32,331	267.29	82.5	681
Utah	58,540	265.51	61,460	278.76	105.0	—
Washington	181,054	179.84	163,510	162.42	90.3	3,262
Other (1)	1,979	—	7,662	—	—	21
Total	$ 965,220	$ 218.04	$ 822,816	$ 185.87	85.3%	$ 34,546

	Three Months Ended March 31, 2009					
	Premium Revenue		Medical Care Costs		Medical	Premium Tax
	Total	PMPM	Total	PMPM	Care Ratio	Total
California	$ 110,035	$ 112.29	$ 103,973	$ 106.10	94.5%	$ 3,316
Florida	19,691	323.89	17,768	292.25	90.2	—
Michigan	132,765	213.98	109,995	177.28	82.9	7,838
Missouri	58,707	254.00	46,974	203.24	80.0	—
New Mexico	81,818	329.68	72,021	290.20	88.0	2,093
Ohio	187,222	334.13	157,780	281.58	84.3	10,192
Texas	33,011	338.14	27,406	280.73	83.0	684
Utah	50,618	275.11	44,263	240.57	87.5	—
Washington	180,704	196.66	149,545	162.75	82.8	2,947
Other (1)	2,913	—	8,163	—	—	(15)
Total	$ 857,484	$ 219.73	$ 737,888	$ 189.09	86.1%	$ 27,055

(1) "Other" medical care costs represent primarily medically related administrative costs at the parent company.

Three Months Ended March 31, 2010 Compared with the Three Months Ended March 31, 2009

Operating results for the three months ended March 31, 2010, compared with the three months ended March 31, 2009, were most significantly impacted by the following:

- Increased premium revenue due to higher enrollment, partially offset by lower revenue PMPM.
- Lower PMPM medical costs due to lower incidence of the influenza-related illnesses in 2010, improved hospital utilization, the transfer of pharmacy costs back to the states of Ohio and Missouri, and various contracting and medical management initiatives implemented by the Company.
- Higher administrative costs incurred for premium taxes, insurance assessments, and the support of Medicare and other programs not linked to the Medicaid risk business.
- In the first quarter of 2009, we recognized a $1.5 million gain on the purchase of our convertible senior notes, with no comparable event in the first quarter of 2010.

Net Income

For the three months ended March 31, 2010, net income was $10.6 million, or $0.41 per diluted share, compared with $12.2 million, or $0.46 per diluted share, for the three months ended March 31, 2009.

Premium Revenue

Premium revenue grew 12.6% in the three months ended March 31, 2010 compared with the three months ended March 31, 2009, due to a membership increase of nearly 14%. On a PMPM basis, however, consolidated premium revenue decreased 0.8% because of declines in premium rates at several of our health plans. The most significant declines in premium rates were in Ohio and Missouri, due to the transfer of pharmacy risk back to the states, and in Washington.

Investment Income

Investment income decreased to $1.5 million for the three months ended March 31, 2010 compared with $3.5 million for the three months ended March 31, 2009. This decline was primarily due to lower interest rates in 2010. Our annualized portfolio yield for the three months ended March 31, 2010 was 0.8% compared with 1.9% for the three months ended March 31, 2009.

Medical Care Costs

Medical care costs, in the aggregate, decreased 1.7% on a PMPM basis for the three months ended March 31, 2010 compared with the three months ended March 31, 2009, primarily due to the following:

- A less severe flu season in 2010,
- The transfer of pharmacy risk back to the states of Ohio and Missouri,
- Reductions in Medicaid fee schedules subsequent to March 31, 2009, and
- Our implementation of various contracting and medical management initiatives.

Excluding pharmacy costs, medical care costs increased 1.7% on a PMPM basis for the three months ended March 31, 2010 compared with the three months ended March 31, 2009. Medical care costs as a percentage of premium revenue (the medical care ratio) were 85.3% for the three months ended March 31, 2010 compared with 86.1% for the three months ended March 31, 2009.

Physician and outpatient costs increased 3.4% on a PMPM basis for the three months ended March 31, 2010, compared with the three months ended March 31, 2009. Emergency room utilization increased approximately 6%, while emergency room cost per visit dropped approximately 2%. Despite the decrease in emergency room cost per visit, we continued to observe hospitals billing for more intensive levels of care for the three months ended March 31, 2010, compared with the three months ended March 31, 2009.

Inpatient facility costs were down 1.5% on a PMPM basis for the three months ended March 31, 2010, compared with the three months ended March 31, 2009. Both utilization and unit costs were relatively stable compared with the three months ended March 31, 2009.

Pharmacy costs (including the benefit of rebates) decreased nearly 23% on a PMPM basis for the three months ended March 31, 2010, including our Missouri and Ohio health plans. The pharmacy benefit was transferred to the state of Missouri effective October 1, 2009, and was transferred to the state of Ohio effective February 1, 2010. Excluding these health plans, pharmacy costs increased 1.5% on a PMPM basis compared with the three months ended March 31, 2009 as a result of slight increases in utilization and unit costs.

Capitated costs increased 2.1% on a PMPM basis compared with three months ended March 31, 2009 as a result of rate increases received for members capitated on a percentage of premium basis at the New Mexico health plan subsequent to the first quarter of 2009, and the transition of members into capitated arrangements at the California health plan throughout 2009.

Days in Medical Claims and Benefits Payable

Beginning January 1, 2010, and for all prior periods presented, we are reporting days in medical claims and benefits payable relating to fee-for-service medical claims only. This new computation includes only fee-for-service medical care costs and medical claims that are incurred but not paid (IBNP), and therefore calculates the extent of reserves for those liabilities that are most subject to estimation risk.

The days in medical claims and benefits payable amount previously reported included *all* medical care costs (fee-for-service, capitation, pharmacy, and administrative), and *all* medical claims liabilities, including those liabilities that are typically paid concurrently, or shortly after the costs are incurred, such as capitation costs and pharmacy costs. Medical claims liabilities in this calculation do not include accrued costs — such as salaries — associated with the administrative portion of medical costs.

By including only fee-for-service medical costs and liabilities in this computation, our days in claims payable metric will be more indicative of the adequacy of our reserves for liabilities subject to a substantial degree of estimation. The days in medical claims and benefits payable computed under each method were as follows:

	March 31, 2010	Dec. 31, 2009	March 31, 2009
Days in claims payable — fee-for-service only	44 days	44 days	51 days
Days in claims payable — all medical costs	37 days	37 days	42 days

General and Administrative Expenses

General and administrative expenses were $113.4 million, or 11.7% of total revenue, for the three months ended March 31, 2010, compared with $92.5 million, or 10.7% of total revenue, for the for the three months ended March 31, 2009. Included in G&A expenses were premium tax expenses totaling $34.5 million in 2010 and $27.1 million in 2009.

Core G&A expenses, which we define as G&A expenses less premium taxes, were 8.2% of revenue for the three months ended March 31, 2010, compared with 7.6% for the three months ended March 31, 2009. The increase in the core G&A ratio was primarily due to costs associated with insurance assessments and the support of Medicare and other programs not linked to the Medicaid risk business. On a PMPM basis, core G&A increased to $17.82 for the three months ended March 31, 2010 compared with $16.76 for the three months ended March 31, 2009. Net of the incremental cost of insurance assessments and the cost of supporting new programs, core G&A PMPM would have been unchanged compared with the three months ended March 31, 2009.

	Three Months Ended March 31,			
	2010		2009	
(dollar amounts in thousands)	Amount	% of Total Revenue	Amount	% of Total Revenue
Medicare-related administrative costs	$ 7,932	0.8%	$ 4,968	0.6%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	56,210	5.8	49,000	5.7
All other administrative expense	14,738	1.6	11,439	1.3
Core G&A expenses	$ 78,880	8.2%	$ 65,407	7.6%

Premium Tax Expense

Premium tax expense increased to 3.5% of revenue for the three months ended March 31, 2010, from 3.1% for the three months ended March 31, 2009, primarily due to the imposition of a higher premium tax rate in Ohio effective October 1, 2009.

Depreciation and Amortization

Depreciation and amortization expense increased $1.0 million in the three months ended March 31, 2010 compared with the three months ended March 31, 2009, primarily due to depreciation relating to investments in infrastructure.

Gain on Retirement of Convertible Senior Notes

In February 2009, we purchased and retired $13.0 million face amount of our convertible senior notes. We purchased the notes at an average price of $74.25 per $100 principal amount, for a total of $9.7 million. Including accrued interest, our total payment was $9.8 million. In connection with the purchase of the Notes, we recorded a gain of $1.5 million ($0.04 per diluted share) in the three months ended March 31, 2009.

Interest Expense

Interest expense was $3.4 million for each of the three month periods ended March 31, 2010 and 2009. Interest expense for both periods presented includes non-cash interest expense relating to our convertible senior notes. The amounts recorded for this additional interest expense totaled approximately $1.2 million for each of the three month periods ended March 31, 2010 and 2009.

Income Taxes

Income tax expense was recorded at an effective rate of 38.0% for the three months ended March 31, 2010 compared with 38.2% in three months ended March 31, 2009. Effective January 1, 2008 through December 31, 2009, our income tax expense included both the Michigan business income tax, or BIT, and the Michigan modified gross receipts tax, or MGRT. Effective January 1, 2010, we have recorded the MGRT as a premium tax and not as an income tax. We will continue to record the BIT as an income tax. For the three months ended March 31, 2009, amounts for premium tax expense (included in general and administrative expenses) and income tax expense have been reclassified to conform to this presentation. The MGRT amounted to $1.5 million and $1.0 million for the three months ended March 31, 2010, and 2009, respectively. There was no impact to net income for either period presented relating to this change.

Generally, the MGRT is a 0.976% tax (statutory rate of 0.8% plus 21.99% surtax) on modified gross receipts, which for most taxpayers are defined as receipts less purchases from other firms. Managed care organizations, however, are not currently allowed to deduct payments to providers in determining modified gross receipts. As a result, the MGRT is 0.976% of the Michigan plan's receipts, and does not vary with levels of pretax income or margins. We believe that presentation of the MGRT as a premium tax produces financial statements that are more useful to the reader.

Liquidity and Capital Resources

We manage our cash, investments, and capital structure to meet the short- and long-term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy.

Our regulated subsidiaries generate significant cash flows from premium revenue and investment income. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue in advance of the payment of claims for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of ten years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be four years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of March 31, 2010, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use.

Cash flow from operations was $(26.5) million, primarily as a result of a $90.7 million decrease in deferred revenue from December 31, 2009. In 2009, the state of Ohio typically paid premiums in advance of the month the premium was earned. Beginning in January 2010, the state of Ohio has delayed its premium payments to mid-month for the month premium is earned. Therefore, only two monthly premium payments were received by the Ohio plan during the first quarter of 2010. We do not anticipate any advance payments for the Ohio plan's premiums during 2010.

Cash provided by financing activities was nominal for the three months ended March 31, 2010, compared with $24.6 million used in financing activities for the three months ended March 31, 2009. The primary use of cash in the three months ended March 31, 2009 was under our securities purchase programs, where we purchased $15.0 million of our common stock, and $9.7 million of our convertible senior notes.

EBITDA (1)

	Three Months Ended March 31,	
	2010	2009
	(In thousands)	
Operating income	$ 20,438	$ 23,161
Add back:		
Depreciation and amortization expense	10,061	9,052
EBITDA	$ 30,499	$ 32,213

(1) We calculate EBITDA by adding back depreciation and amortization expense to operating income. Operating income included interest income of $1.3 million and $2.9 million for the three months ended March 31, 2010, and 2009, respectively. EBITDA is not prepared in conformity with GAAP since it excludes depreciation and amortization expense, as well as interest expense, and the provision for income taxes. This non-GAAP financial measure should not be considered as an alternative to net income, operating income, operating margin, or cash provided by operating activities. Management uses EBITDA as a supplemental metric in evaluating our financial performance, in evaluating financing and business development decisions, and in forecasting and analyzing future periods. For these reasons, management believes that EBITDA is a useful supplemental measure to investors in evaluating our performance and the performance of other companies in our industry.

Capital Resources

At March 31, 2010, the parent company — Molina Healthcare, Inc. — held cash and investments of approximately $79.7 million, including auction rate securities with a fair value of $14.9 million, compared with $45.6 million of cash and investments at December 31, 2009. On a consolidated basis, at March 31, 2010, we had working capital of $340.9 million compared with $321.2 million at December 31, 2009. At March 31, 2010 and December 31, 2009, cash and cash equivalents were $438.3 million and $469.5 million, respectively. At March 31, 2010, investments were $231.5 million, including $55.6 million in non-current auction rate securities, and at December 31, 2009, investments were $234.5 million, including $59.7 million in non-current auction rate securities.

In connection with the May 1, 2010 closing of your acquisition of the HIM business, we used a draw on our credit facility, which previously had had no outstanding balance, to fund $105 million of the $135 million purchase price of the HIM business. The $30 million balance of the purchase price was funded with available cash.

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Credit Facility

In 2005, we entered into an Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2008, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from $180.0 million to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for general corporate purposes.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our health plan subsidiaries (with the exception of the California health plan). The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At March 31, 2010, we were in compliance with all financial covenants in the Credit Facility.

Subject to the closing of the HIM acquisition, in November 2009 we agreed to enter into a fourth amendment to the Credit Facility. The fourth amendment would become effective upon the closing of the acquisition of the HIM business. The fourth amendment was required because the $135 million purchase price for the HIM business exceeded the applicable deal size threshold under the terms of the Credit Facility. Pursuant to the fourth amendment, the lenders consented to our acquisition of the HIM business.

Upon its effectiveness at the closing, the fourth amendment increased the commitment fee on the total unused commitments of the lenders under the facility to 50 basis points on all levels of the pricing grid, with the pricing grid referring to our ratio of consolidated funded debt to consolidated EBITDA. The pricing for LIBOR loans and base rate loans was raised by 200 basis points at every level of the pricing grid. Thus, the applicable margins now range between 2.75% and 3.75% for LIBOR loans, and between 1.75% and 2.75% for base rate loans. Until the delivery of a compliance certificate with respect to our financial statements for the second quarter of 2010, the applicable margin shall be fixed at 3.5% for LIBOR loans and 2.5% for base rate loans. In connection with the lenders' approval of the fourth amendment, a consent fee of 10 basis points was paid on the amount of each consenting lender's commitment. In addition, the fourth amendment carved out from our indebtedness and restricted payment covenants under the Credit Facility the $187.0 million current principal amount of the Notes (although the $187.0 million indebtedness is still included in the calculation of our consolidated leverage ratio); increased the amount of surety bond obligations we may incur; increased our allowable capital expenditures; and reduced the fixed charge coverage ratio from 3.50x to 2.75x (on a pro forma basis) at December 31, 2009, and 3.00x thereafter.

On March 15, 2010, we agreed to enter into a fifth amendment to the Credit Facility. The fifth amendment also would become effective upon the closing of the acquisition of the HIM business. The fifth amendment was required because, after giving effect to the acquisition of the HIM business on a pro forma basis, and inclusive of the Company's fourth quarter 2009 EBITDA of only $5.9 million, the Company's consolidated leverage ratio for the preceding four fiscal quarters exceeded the currently applicable ratio of 2.75 to 1.0. The fifth amendment increased the maximum consolidated leverage ratio under the Credit Facility to 3.25 to 1.0 for the fourth quarter of 2009 (on a pro forma basis), and to 3.50 to 1.0 for the first, second, and third quarters of 2010, excluding the single date of September 30, 2010. On September 30, 2010, the maximum consolidated leverage ratio shall revert back to 2.75 to 1.0. However, if the Company has actually reduced its consolidated leverage ratio to no more than 2.75 to 1.0 on or before August 15, 2010, the consolidated leverage ratio under the Credit Facility will revert back to 2.75 to 1.0 on August 15, 2010. On the date that the consolidated leverage ratio reverts to 2.75 to 1.0 — whether August 15, 2010 or September 30, 2010 — the aggregate commitments of the lenders under the Credit Facility shall be reduced on a pro rata basis from $200 million to $150 million. In connection with the lenders' approval of the fifth amendment, we paid an amendment fee of 25 basis points on the amount of each consenting lender's commitment. We will also pay an incremental commitment fee of 12.5 basis points based on each lender's unfunded commitment during the period from the effective date of the fifth amendment through the date that the maximum consolidated leverage ratio is reduced to 2.75 to 1.0, plus a potential duration fee of 50 basis points payable on August 15, 2010 in the event that the consolidated leverage ratio has not been reduced to 2.75 to 1.0 by August 15, 2010.

Shelf Registration Statement

In December 2008, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to $300 million of our securities, including common stock, warrants, or debt securities, and up to 250,000 shares of outstanding common stock that may be sold from time to time by the Molina Siblings Trust as a selling stockholder. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Long-Term Debt

Convertible Senior Notes

In October 2007, we sold $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling $193.4 million. During 2009, we purchased and retired $13.0 million face amount of the Notes, for a remaining aggregate principal amount of $187.0 million as of December 31, 2009. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per $1,000 principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;

- During the five business day period immediately following any five consecutive trading day period in which the trading price per $1,000 principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or

- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash (the "principal return") equal to the sum of, for each of the 20 Volume-Weighted Average Price, or VWAP, trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and $50 (representing 1/20th of $1,000); and

- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above $50.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends totaled $356.3 million at March 31, 2010, and $368.7 million at December 31, 2009.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Missouri, New Mexico, Ohio, Texas, Utah, and Washington. California and Florida have not adopted RBC rules and have not given notice of any intention to do so. The RBC rules, if adopted by California and Florida, may increase the minimum capital required by those states.

At March 31, 2010, our health plans had aggregate statutory capital and surplus of approximately $367.0 million, compared to the required minimum aggregate statutory capital and surplus of approximately $253.4 million. All of our health plans were in compliance with the minimum capital requirements at March 31, 2010. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2010.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2009, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates. Principal areas requiring the use of estimates include those areas listed below. The most significant of these estimates is the determination of medical claims and benefits payable, which is discussed in further detail below:

- The determination of medical claims and benefits payable;

- The determination of the amount of revenue to be recognized under certain contracts that place revenue at risk dependent upon either the achievement of certain quality or administrative measurements, or the expenditure of certain percentages of revenue on defined expenses;

- The determination of allowances for uncollectible accounts;
- The valuation of certain investments;
- Settlements under risk or savings sharing programs;
- The impairment of long-lived and intangible assets;
- The determination of professional and general liability claims, and reserves for potential absorption of claims unpaid by insolvent providers;
- The determination of reserves for the outcome of litigation;
- The determination of valuation allowances for deferred tax assets; and
- The determination of unrecognized tax benefits.

Medical Claims and Benefits Payable

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Paid," or IBNP. Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. Our estimated IBNP liability represented $260.5 million of our total medical claims and benefits payable of $327.0 million as of March 31, 2010. Excluding amounts related to our cost-plus Medicaid contract in Utah (which contract was replaced with a prepaid capitation contract effective September 1, 2009), and amounts that we anticipate paying on behalf of a capitated provider in Ohio (which we will subsequently withhold from that provider's monthly capitation payment), our IBNP liability at March 31, 2010 was $251.8 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of March 31, 2010 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding March 31, 2010, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 72,603
(4)%	48,402
(2)%	24,201
2%	(24,201)
4%	(48,402)
6%	(72,603)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of March 31, 2010 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (64,122)
(4)%	(42,748)
(2)%	(21,374)
2%	21,374
4%	42,748
6%	64,122

The following per-share amounts are based on a combined federal and state statutory tax rate of 38%, and 25.8 million diluted shares outstanding for the three months ended March 31, 2010. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at March 31, 2010, net income for the three months ended March 31, 2010 would increase or decrease by approximately $7.5 million, or $0.29 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at March 31, 2010, net income for the three months ended March 31, 2010 would increase or decrease by approximately $6.6 million, or $0.26 per diluted share, net of tax. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $37.5 million, or $1.45 per diluted share, and $33.1 million, or $1.28 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $7.5 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which much of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNP.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results for the year ended December 31, 2009, when the amounts ultimately paid out were less than the amount of the reserves we had established as of the beginning of that year by 17.6%.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities in fiscal years 2009 and through March 31, 2010 were less than what we had expected when we had established our reserves. While the specific reasons for the overestimation of our liabilities were different in each of the periods presented, in general the overestimations were tied to our assessment of specific circumstances at our individual health plans which were unique to those reporting periods.

For the three months ended March 31, 2010, we recognized a benefit from prior period claims development in the amount of $38.5 million (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2009. The overestimation of claims liability at December 31, 2009 was the result of the following factors:

- In New Mexico, we underestimated the degree to which cuts to the Medicaid fees schedule would reduce our liability as of December 31, 2009.
- In California, we underestimated the extent to which various network restructuring, provider contracting and medical management imitative had reduced our medical care costs during the second half of 2009, thereby resulting in a lower liability at December 31, 2009.

We recognized a benefit from prior period claims development in the amount of $42.2 million and $51.6 million for the three months ended March 31, 2009, and the year ended December 31, 2009, respectively (see table below). This was primarily caused by the overestimation of our liability for claims and medical benefits payable at December 31, 2008. The overestimation of claims liability at December 31, 2008 was the result of the following factors:

- In New Mexico, we overestimated at December 31, 2008 the ultimate amounts we would need to pay to resolve certain high dollar provider claims.
- In Ohio, we underestimated the degree to which certain operational initiatives had reduced our medical costs in the last few months of 2008.
- In Washington, we overestimated the impact that certain adverse utilization trends would have on our liability at December 31, 2008.
- In California, we underestimated utilization trends at the end of 2008, leading to an underestimation of our liability at December 31, 2008. Additionally, we underestimated the impact that certain delays in the receipt of paper claims would have on our liability, leading to a further underestimation of our liability at December 31, 2008.

In estimating our claims liability at March 31, 2010, we adjusted our base calculation to take account of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The rapid growth of membership in our Medicare line of business between December 31, 2009 and March 31, 2010.
- An increase in claims inventory at our Ohio, Florida and Utah health plans between December 31, 2009 and March 31, 2010.
- The impact of reductions to the state Medicaid fee schedules in New Mexico effective December 1, 2009 and in Utah (outpatient only) effective March 1, 2010.

The use of a consistent methodology in estimating our liability for claims and medical benefits payable minimizes the degree to which the under- or overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. Any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability. In 2009 and through March 31, 2010, the absence of adverse development of the liability for claims and medical benefits payable at the close of the previous period resulted in the recognition of substantial favorable prior period development. In both years, however, the recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations because the amount of benefit recognized in each year was roughly consistent with that recognized in the previous year.

We seek to maintain a consistent claims reserving methodology across all periods. In 2009, the prior period benefit from an un-utilized reserve for adverse claims development was offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) during the year, and thus the impact on earnings for the current period was minimal.

The following table presents the components of the change in our medical claims and benefits payable for the three months ended March 31, 2010 and 2009, and for the year ended December 31, 2009. The negative amounts displayed for "*Components of medical care costs related to: Prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported.

	As of and for the three months ended March 31,		As of and for the year ended December 31,
	(Dollars in thousands, except per-member amounts)		
	2010	2009	2009
Balances at beginning of period	$ 316,516	$ 292,442	$ 292,442
Components of medical care costs related to:			
Current year	861,271	780,112	3,227,794
Prior years	(38,455)	(42,224)	(51,558)
Total medical care costs	822,816	737,888	3,176,236
Payments for medical care costs related to:			
Current year	581,389	510,075	2,919,240
Prior years	230,970	208,628	232,922
Total paid	812,359	718,703	3,152,162
Balances at end of period	$ 326,973	$ 311,627	$ 316,516
Benefit from prior period as a percentage of:			
Balance at beginning of period	12.1%	14.4%	17.6%
Premium revenue	4.0%	4.9%	1.4%
Total medical care costs	4.7%	5.7%	1.6%
Days in claims payable, fee for service only	44	51	44
Number of members at end of period	1,482,000	1,303,000	1,455,000
Fee-for-service claims processing and inventory information:			
Number of claims in inventory at end of period	153,700	158,900	93,100
Billed charges of claims in inventory at end of period	$ 194,000	$ 208,900	$ 131,400
Claims in inventory per member at end of period	0.10	0.12	0.06
Billed charges of claims in inventory per member at end of period	$ 130.90	$ 160.32	$ 90.31
Number of claims received during the period	3,493,300	3,051,600	12,930,100
Billed charges of claims received during the period	$ 2,760,500	$ 2,280,100	$ 9,769,000

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. We invest a substantial portion of our cash in the PFM Fund Prime Series — Institutional Class, and the PFM Fund Government Series. These funds represent a portfolio of highly liquid money market securities that are managed by PFM Asset Management LLC (PFM), a Virginia business trust registered as an open-end management investment fund. Our investments and a portion of our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. No investment that is in a loss position can be sold by our managers without our prior approval. Our investments consist solely of investment grade debt securities with a maximum maturity of ten years and an average duration of four years. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our health plans operate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the three months ended March 31, 2010 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

We are involved in various legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1A. ***Risk Factors***

Certain risk factors may have a material adverse effect on our business, financial condition, cash flows, or results of operations, and you should carefully consider them. The following risk factors were identified or re-evaluated by the Company during the first quarter and are a supplement to those risk factors discussed in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2009. The risks described herein and in our Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, cash flows, or results of operations.

The recently enacted health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act. This legislation enacts comprehensive changes to the U.S. health care system, components of which will be phased in at various stages over the next eight years. Among other things, by January 1, 2014, the Medicaid program will be expanded to provide eligibility to nearly all low-income people under age 65 with income below 133 percent of the federal poverty line. As a result, millions of low-income adults without children who currently cannot qualify for coverage, as well as many low-income parents and, in some instances, children now covered through CHIP, will be made eligible for Medicaid. In total, the Congressional Budget Office estimates that Medicaid and CHIP will cover an additional 16 million people by 2019. The legislation also imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes.

There are many parts of the legislation that will require further guidance in the form of regulations. Due to the breadth and complexity of the health reform legislation, the lack of implementing regulations and interpretive guidance, and the phased-in nature of the implementation, the overall impact of the health reform legislation on our business over the coming years is difficult to predict and not yet fully known.

If we fail to effectively accommodate the growth in Medicaid enrollment anticipated under the health reform legislation, our business may be materially adversely affected. In addition, if the new insurance industry assessment is imposed as enacted, or if we are unable to obtain premium increases to offset the impact of the assessment or otherwise adjust our business model to address the assessment, our business, financial condition, cash flows, or results of operations could be materially adversely affected.

The state of Michigan may seek to reduce the rates paid to our Michigan health plan in order to compensate for or recover amounts allegedly overpaid on a statewide basis to Michigan health plans.

The Michigan Department of Community Health, or MDCH, has identified approximately 7,000 individuals whom MDCH claims were incorrectly enrolled as dual eligible members, allegedly resulting in an overpayment to all health plans operating in the state. In addition, MDCH has claimed that TANF rates for Michigan state fiscal year 2010 have been overstated due to new program code changes. These statewide issues could result in MDCH's seeking to reduce the premium rates paid to our Michigan health plan, or even to recover a portion of premiums already paid to the health plan, thereby reducing the health plan's revenue for the remainder of 2010. Any reduction to Michigan premium rates or successful recovery of previously paid amounts could adversely affect our business, financial condition, cash flows, or results of operations.

The timing of both the receipt and the recognition of revenue under the contracts of Molina Medicaid Solutions with the states of Idaho and Maine is uncertain.

Molina Medicaid Solutions provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems. The systems being designed by Molina Medicaid Solutions for the states of Idaho and Maine have not yet become operative, or "gone live," including the actual processing of Medicaid claims by the systems. We expect that the Idaho system will begin live operations effective June 1, 2010, and that the Maine system will begin live operations effective August 1, 2010. The revenues to be received under the Idaho and Maine contracts, as well as the recognition of such revenues under applicable accounting principles, is contingent upon the applicable "go live" date. The projected "go live" dates for the Idaho and Maine systems may be delayed for reasons beyond our control. In the event either or both "go live" dates are delayed, our cash flows and results of operations could be adversely affected.

Item 6. ***Exhibits***

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 10, 2010

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer and President (Principal Executive Officer)

Dated: May 10, 2010

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer (Principal Financial Officer)

EXHIBIT INDEX

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32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2010 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 10, 2010

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer
and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the period ended March 31, 2010 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 10, 2010

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2010 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 10, 2010

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board, Chief Executive Officer
and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2010 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 10, 2010

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer